



## 2024 Formulary

List of Covered Drugs

### Troy Medicare (HMO)

PLEASE READ: THIS DOCUMENT CONTAINS INFORMATION  
ABOUT THE DRUGS WE COVER IN THIS PLAN

This formulary was updated on 2/29/2024. For more recent information or other questions, please contact Troy Medicare (HMO) Pharmacy Member Service at 1-866-423-8065 (TTY users should call 711), Monday through Sunday, 24 hours a day, or visit <http://www.troymedicare.com>.

**Important Message About What You Pay for Vaccines** - Our plan covers most Part D vaccines at no cost to you. Call Member Services for more information.

**Important Message About What You Pay for Insulin** - You won't pay more than \$35 for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on. You won't pay more than \$10 for a one-month supply of generic insulin products covered by our plan on Tier 1.



**Note to existing members:** This formulary has changed since last year. Please review this document to make sure that it still contains the drugs you take. When this drug list (formulary) refers to “we,” “us”, or “our,” it means Troy Health, Inc. When it refers to “plan” or “our plan,” it means Troy Medicare (HMO). This document includes a list of the drugs (formulary) for our plan which is current as of March 2024. For an updated formulary, please contact us. Our contact information, along with the date we last updated the formulary, appears on the front and back cover pages. You must generally use network pharmacies to use your prescription drug benefit. Benefits, formulary, pharmacy network, and/or copayments/coinsurance may change on January 1, 2024, and from time to time during the year.

### **What is the Troy Medicare (HMO) Formulary?**

A formulary is a list of covered drugs selected by Troy Medicare (HMO) in consultation with a team of health care providers, which represents the prescription therapies believed to be a necessary part of a quality treatment program. Troy Medicare (HMO) will generally cover the drugs listed in our formulary as long as the drug is medically necessary, the prescription is filled at a Troy Medicare (HMO) network pharmacy, and other plan rules are followed. For more information on how to fill your prescriptions, please review your Evidence of Coverage.

### **Can the Formulary (Drug List) change?**

Most changes in drug coverage happen on January 1, but we may add or remove drugs on the Drug List during the year, move them to different cost-sharing tiers, or add new restrictions. We must follow the Medicare rules in making these changes.

**Changes that can affect you this year:** In the below cases, you will be affected by coverage changes during the year:

- **New generic drugs.** We may immediately remove a brand-name drug on our Drug List if we are replacing it with a new generic drug that will appear on the same or lower cost-sharing tier and with the same or fewer restrictions. Also, when adding the new generic drug, we may decide to keep the brand-name drug on our Drug List, but immediately move it to a different cost-sharing tier or add new restrictions. If you are currently taking that brand-name drug, we may not tell you in advance before we make that change, but we will later provide you with information about the specific change(s) we have made.
  - If we make such a change, you or your prescriber can ask us to make an exception and continue to cover the brand-name drug for you. The notice we provide you will also include information on how to request an exception, and you can find information in the section below titled **“How do I request an exception to the Troy Medicare (HMO) Formulary?”**

- **Drugs removed from the market.** If the Food and Drug Administration deems a drug on our formulary to be unsafe or the drug's manufacturer removes the drug from the market, we will immediately remove the drug from our formulary and provide notice to members who take the drug.
- **Other changes.** We may make other changes that affect members currently taking a drug. For instance, we may add a generic drug that is not new to the market to replace a brand-name drug currently on the formulary, or add new restrictions to the brand-name drug or move it to a different cost-sharing tier or both. Or we may make changes based on new clinical guidelines. If we remove drugs from our formulary, add prior authorization, quantity limits and/or step therapy restrictions on a drug, or move a drug to a higher cost-sharing tier, we must notify affected members of the change at least 30 days before the change becomes effective, or at the time the member requests a refill of the drug, at which time the member will receive a 30-day supply of the drug.
  - If we make these other changes, you or your prescriber can ask us to make an exception and continue to cover the brand-name drug for you. The notice we provide you will also include information on how to request an exception, and you can also find information in the section below entitled "**How do I request an exception to the Troy Medicare (HMO) Formulary?**"

**Changes that will not affect you if you are currently taking the drug.** Generally, if you are taking a drug on our 2024 formulary that was covered at the beginning of the year, we will not discontinue or reduce coverage of the drug during the 2024 coverage year except as described above. This means these drugs will remain available at the same cost-sharing and with no new restrictions for those members taking them for the remainder of the coverage year. You will not get direct notice this year about changes that do not affect you. However, on January 1 of the next year, such changes would affect you, and it is important to check the Drug List for the new benefit year for any changes to drugs.

The enclosed formulary is current as of March 2024. To get updated information about the drugs covered by Troy Medicare (HMO), please contact us. Our contact information appears on the front and back cover pages. We will update the printable formularies each month and they will be available at <http://www.troymedicare.com/prescription-drugs>.

## How do I use the Formulary?

There are two ways to find your drug within the formulary:

### **Medical Condition**

The formulary begins on Page 11. The drugs in this formulary are grouped into categories depending on the type of medical conditions that they are used to treat. For example, drugs used to treat a heart condition are listed under the category, "Cardiovascular Agents - Treatment Of Conditions Affecting The Heart And Blood Vessels". If you know what your drug is used for, look for the category name in the list that begins on Page 11. Then look under the category name for your drug.

### **Alphabetical Listing**

If you are not sure what category to look under, you should look for your drug in the Index that begins on Page 138. The Index provides an alphabetical list of all of the drugs included in this document. Both brand-name drugs and generic drugs are listed in the Index. Look in the Index and find your drug. Next to your drug, you will see the page number where you can find coverage information. Turn to the page listed in the Index and find the name of your drug in the first column of the list.

## What are generic drugs?

Troy Medicare (HMO) covers both brand-name drugs and generic drugs. A generic drug is approved by the FDA as having the same active ingredient as the brand-name drug. Generally, generic drugs cost less than brand-name drugs.

## Are there any restrictions on my coverage?

Some covered drugs may have additional requirements or limits on coverage. These requirements and limits may include:

- **Prior Authorization (PA):** Troy Medicare (HMO) requires you or your physician to get prior authorization for certain drugs. This means that you will need to get approval from us before you fill your prescriptions. If you do not get approval, we may not cover the drug.
- **Quantity Limits (QL):** For certain drugs, Troy Medicare (HMO) limits the amount of the drug that we will cover. For example, Troy Medicare (HMO) provides up to twelve (12) capsules per prescription for *gabapentin oral capsule 300 mg* per day. This may be in addition to a standard one-month or three-month supply.
- **Step Therapy (ST):** In some cases, Troy Medicare (HMO) requires you to first try certain drugs to treat your medical condition before we will cover another drug for that condition. For example, if Drug A and Drug B both treat your medical condition, Troy Medicare (HMO) may not cover Drug B unless you try Drug A first. If Drug A does not work for you, we will then cover Drug B.

You can find out if your drug has any additional requirements or limits by looking in the formulary that begins on Page 11. You can also get more information about the restrictions applied to specific covered drugs by visiting our website. We have posted online documents that explain our prior authorization and step therapy restrictions. You may also ask us to send you a copy. Our contact information, along with the date we last updated the formulary, appears on the front and back cover pages.

You can ask us to make an exception to these restrictions or limits or for a list of other, similar drugs that may treat your health condition. See the section, “**How do I request an exception to the Troy Medicare (HMO) Formulary?**” on Page 5 for information about how to request an exception.

### **What if my drug is not on the Formulary?**

If your drug is not included in this formulary (list of covered drugs), you should first contact Pharmacy Member Services and ask if your drug is covered.

If you learn that Troy Medicare (HMO) does not cover your drug, you have two options:

- You can ask Member Services for a list of similar drugs that are covered by Troy Medicare (HMO). When you receive the list, show it to your doctor and ask them to prescribe a similar drug that is covered by Troy Medicare (HMO).
- You can ask Troy Medicare (HMO) to make an exception and cover your drug. See below for information about how to request an exception.

### **How do I request an exception to the Troy Medicare (HMO) Formulary?**

You can ask us to make an exception to our coverage rules. There are several types of exceptions that you can ask us to make.

- You can ask us to cover a drug even if it is not on our formulary. If approved, this drug will be covered at a pre-determined cost-sharing level, and you would not be able to ask us to provide the drug at a lower cost-sharing level.
- You can ask us to cover a formulary drug at a lower cost-sharing level unless the drug is on the specialty tier. If approved, this would lower the amount you must pay for your drug.
- You can ask us to waive coverage restrictions or limits on your drug. For example, for certain drugs, Troy Medicare (HMO) limits the amount of the drug that we will cover. If your drug has a quantity limit, you can ask us to waive the limit and cover a greater amount.

Generally, we will only approve your request for an exception if the alternative drugs included on the plan's formulary, the lower cost-sharing drug or additional utilization restrictions would not be as effective in treating your condition and/or would cause you to have adverse medical effects.

You should contact us to ask us for an initial coverage decision for a formulary, tier, or utilization restriction exception. **When you request a formulary, tier, or utilization restriction exception, you should submit a statement from your prescriber or physician supporting your request.** Generally, we must make our decision within 72 hours of receiving your prescriber's supporting statement. You can request an expedited (fast) exception if you or your doctor believe that your health could be seriously harmed by waiting up to 72 hours for a decision. If your request to expedite is granted, we must give you a decision no later than 24 hours after we get a supporting statement from your doctor or other prescriber.

### **What do I do before I can talk to my doctor about changing my drugs or requesting an exception?**

As a new or continuing member in our plan, you may be taking drugs that are not on our formulary. Or, you may be taking a drug that is on our formulary but your ability to get it is limited. For example, you may need a prior authorization from us before you can fill your prescription. You should talk to your doctor to decide if you should switch to an appropriate drug that we cover or request a formulary exception so that we will cover the drug you take. While you talk to your doctor to determine the right course of action for you, we may cover your drug in certain cases during the first 90 days you are a member of our plan.

For each of your drugs that is not on our formulary or if your ability to get your drugs is limited, we will cover a temporary 30-day supply. If your prescription is written for fewer days, we will allow refills to provide up to a maximum 30-day supply of medication. After your first 30-day supply, we will not pay for these drugs, even if you have been a member of the plan less than 90 days.

If you are a resident of a long-term care facility and you need a drug that is not on our formulary or if your ability to get your drugs is limited, but you are past the first 90 days of membership in our plan, we will cover a 31-day emergency supply of that drug while you pursue a formulary exception.

Throughout the plan year, your treatment setting (the place where you receive and take your medicine) may change. These changes include members who:

- Enter long-term care (LTC) facilities from hospitals.
- Are discharged from a hospital to a home.
- End their skilled nursing facility Medicare Part A stay (where payments include all pharmacy charges) and who need to revert to their Part D plan formulary.
- End an LTC facility stay and return to the community.

For these changes in treatment settings, we will cover up to a one-time 30-day transition supply per drug. If a member has more than one change in level of care in a month, the pharmacy must call our plan to request an extension of the transition policy. During the time when you are getting a temporary supply of a drug, you should talk with your provider to decide what to do when your temporary supply runs out. You can either switch to a different drug covered by the plan or ask the plan to make an exception for you and cover your current drug. You can find more information about our prescription drug transition process by visiting our website.

### **For More Information**

For more detailed information about your Troy Medicare (HMO) prescription drug coverage, please review your Evidence of Coverage and other plan materials.

If you have questions about Troy Medicare (HMO), please contact us. Our contact information, along with the date we last updated the formulary, appears on the front and back cover pages.

If you have general questions about Medicare prescription drug coverage, please call Medicare at 1-800-MEDICARE (1-800-633-4227) 24 hours a day / 7 days a week. TTY users should call 1-877-486-2048. Or, visit <http://www.medicare.gov>.

### **Troy Medicare (HMO) Formulary**

The formulary below provides coverage information about the drugs covered by Troy Medicare (HMO). If you have trouble finding your drug in the list, turn to the Index that begins on Page 138.

The first column of the chart lists the drug name. Brand-name drugs are capitalized (e.g., TRESIBA FLEXTOUCH SUBCUTANEOUS SOLUTION PEN-INJECTOR 200 UNIT/ML) and generic drugs are listed in lower-case italics (e.g., *insulin lispro (1 unit dial) subcutaneous solution pen-injector 100 unit/ml*).

The information in the Requirements/Limits column tells you if Troy Medicare (HMO) has special requirements for coverage of your drug.

- **Prior Authorization (PA):** Troy Medicare (HMO) requires you or your physician to get prior authorization for certain drugs. This means that you will need to get approval from us before you fill your prescriptions. If you do not get approval, we may not cover the drug.
- **Quantity Limits (QL):** For certain drugs, Troy Medicare (HMO) limits the amount of the drug that the plan will cover. Each quantity limit is defined in our formulary below as a quantity of each (EA) dosage form (e.g., capsule, patch, tablet, etc.) or milliliters (mL) for solutions or suspensions that we will cover within a specific time period. For example, Troy Medicare (HMO) provides 360 per prescription for *gabapentin oral capsule 300 mg every 30 days*.

- **Step Therapy (ST):** In some cases, Troy Medicare (HMO) requires you to first try certain drugs to treat your medical condition before we will cover another drug for that condition. For example, if Drug A and Drug B both treat your medical condition, Troy Medicare (HMO) may not cover Drug B unless you try Drug A first. If Drug A does not work for you, we will then cover Drug B.
- **Medicare Part B or Part D (B/D):** Depending on how this drug is used, it may be covered by either Medicare Part B (doctor and outpatient health care) or Medicare Part D (prescription drugs). Your doctor may need to provide the plan with more information about how this drug will be used to make sure it is correctly covered by Troy Medicare (HMO).
- **Morphine Milligram Equivalent (MME):** Additional quantity limits may apply across all drugs in the opioid class used for the treatment of pain. This additional limit is called a cumulative morphine milligram equivalent (MME) and is designed to monitor safe dosing levels of opioids for individuals who may be taking more than 1 opioid drug for pain management. If your prescriber prescribes more than this amount or thinks the limit is not right for your situation, you or your prescriber can ask the plan to cover the additional quantity.

### **Prescription drugs are grouped into one of six tiers.**

Troy Medicare (HMO) covers both brand-name drugs and generic drugs. Generally, generic drugs cost less than brand-name drugs.

- Tier 1: Generic or brand-name drugs that are available at the lowest cost share for the plan.
- Tier 2: Generic or brand-name drugs that the plan offers at a higher cost to you than Tier 1 drugs.
- Tier 3: Brand-name drugs that the plan offers at a lower cost to you than Tier 4 drugs.
- Tier 4: Generic or brand-name drugs that the plan offers at a higher cost to you than Tier 3 drugs.
- Tier 5: Specialty drugs.
- Tier 6: Vaccines.

### **How much will I pay for covered drugs?**

Troy Medicare (HMO) pays part of the costs for your covered drugs and you pay part of the costs, too. The amount you pay depends on:

- The tier that your drug is on.
- Whether or not you fill your prescription at a network pharmacy.
- Your current drug payment stage - please read your Evidence of Coverage for more information.





If you need help or have any questions about your drug costs, please review your Evidence of Coverage or contact Troy Medicare (HMO) Member Service. Our contact information appears on the front and back cover pages.

**Additional Coverage for Tier 1 Drugs in the Coverage Gap**

Troy Medicare (HMO) provides additional coverage for all Tier 1 drugs in the Coverage Gap phase of the Part D benefit. These Tier 1 drugs are indicated in the formulary with an **asterisk (\*)**.

**If you qualified for “Extra Help” with your drug costs, your costs may be different from those described above. Please refer to your Evidence of Coverage or call Member Services to find out what your costs are.**



Plans are offered through Troy Medicare, a Medicare Advantage HMO and HMO D-SNP organization with a Medicare contract. Enrollment in these plans depends on the plan's contract renewal with Medicare. Troy Medicare for Dual-eligible Beneficiaries (HMO D-SNP) also has a contract with state Medicaid.

The Formulary may change at any time. You will receive notice when necessary.

Benefits, formulary, pharmacy network, provider network, premium and/or copay/coinsurance may change on January 1 of each year. Member premiums, copays, coinsurance, and deductibles may vary based on the level of "Extra Help" you receive. Please contact the plan for further details.

This information is available for free in other languages and other formats, such as Braille and large print. Please call our Member Services number at 1-888-494-TROY (8769). TTY users should call 711. During the months of April through September, we are available from 8:00 am to 8:00 pm (ET), Monday through Friday. During the months of October through March, we are available from 8:00 am to 8:00 pm (ET), seven (7) days a week. Member Services also has free language interpreter services available for non-English speakers.

You must generally use network pharmacies to use your prescription drug benefit.

Troy does not discriminate or exclude people because of their race, color, national origin, ancestry, age, disability, ethnicity, sex, sexual orientation, gender, gender identity or expression, marital status, religion, or language.

# Troy Medicare (HMO)

## 2024 Member Formulary

Formulary ID 24420

**CURRENT AS OF 3/1/2024**

Name of Drug	Drug Tier	Requirements/Limits
<b>Analgesics - Treatment Of Pain</b>		
<b>Analgesics</b>		
ASCOMP-CODEINE ORAL CAPSULE 50-325-40-30 MG	2	PA; MME
BAC ORAL TABLET 50-325-40 MG	2	PA
<i>butalbital-acetaminophen oral tablet 50-325 mg</i>	2	PA
<i>butalbital-apap-caff-cod oral capsule 50-325-40-30 mg</i>	2	PA; MME
<i>butalbital-apap-caffeine oral capsule 50-325-40 mg</i>	2	PA
<i>butalbital-apap-caffeine oral tablet 50-325-40 mg</i>	2	PA
<i>butalbital-asa-caff-codeine oral capsule 50-325-40-30 mg</i>	2	PA; MME
<i>butalbital-aspirin-caffeine oral capsule 50-325-40 mg</i>	2	PA
<i>nalbuphine hcl injection solution 10 mg/ml</i>	2	MME
<b>Nonsteroidal Anti-Inflammatory Drugs</b>		
<i>celecoxib oral capsule 100 mg, 200 mg, 400 mg, 50 mg*</i>	1	
<i>diclofenac potassium oral tablet 50 mg</i>	2	
<i>diclofenac sodium er oral tablet extended release 24 hour 100 mg*</i>	1	
<i>diclofenac sodium external gel 1 %, 3 %</i>	2	
<i>diclofenac sodium oral tablet delayed release 25 mg, 50 mg, 75 mg*</i>	1	
<i>diflunisal oral tablet 500 mg</i>	2	

\*We provide additional coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-9.

<b>Name of Drug</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>ec-naproxen oral tablet delayed release 375 mg, 500 mg</i>	2	
<i>etodolac er oral tablet extended release 24 hour 400 mg, 500 mg, 600 mg</i>	2	
<i>etodolac oral capsule 200 mg, 300 mg</i>	2	
<i>etodolac oral tablet 400 mg, 500 mg</i>	2	
<i>flurbiprofen oral tablet 100 mg</i>	2	
<b>IBU ORAL TABLET 400 MG, 600 MG, 800 MG*</b>	1	
<i>ibuprofen oral suspension 100 mg/5 ml*</i>	1	
<i>ibuprofen oral tablet 400 mg, 600 mg, 800 mg*</i>	1	
<i>indomethacin er oral capsule extended release 75 mg</i>	2	PA
<i>indomethacin oral capsule 25 mg, 50 mg</i>	2	PA
<i>ketorolac tromethamine oral tablet 10 mg</i>	2	PA; QL (20 EA per 30 days)
<i>meclofenamate sodium oral capsule 100 mg, 50 mg</i>	2	
<i>meloxicam oral tablet 15 mg, 7.5 mg*</i>	1	
<i>nabumetone oral tablet 500 mg, 750 mg</i>	2	
<i>naproxen oral suspension 125 mg/5 ml</i>	4	
<i>naproxen oral tablet 250 mg, 375 mg, 500 mg*</i>	1	
<i>naproxen oral tablet delayed release 375 mg, 500 mg</i>	2	
<i>naproxen sodium oral tablet 275 mg, 550 mg</i>	2	
<i>piroxicam oral capsule 10 mg, 20 mg</i>	2	
<i>sulindac oral tablet 150 mg, 200 mg</i>	2	

\*We provide additional coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-9.

<b>Name of Drug</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>Opioid Analgesics, Long-Acting</b>		
<i>buprenorphine transdermal patch weekly 10 mcg/hr, 15 mcg/hr, 20 mcg/hr, 5 mcg/hr, 7.5 mcg/hr</i>	2	QL (4 EA per 28 days)
<i>fentanyl transdermal patch 72 hour 100 mcg/hr, 12 mcg/hr, 25 mcg/hr, 37.5 mcg/hr, 50 mcg/hr, 75 mcg/hr</i>	2	MME; QL (10 EA per 30 days)
<i>fentanyl transdermal patch 72 hour 62.5 mcg/hr, 87.5 mcg/hr</i>	4	MME; QL (10 EA per 30 days)
<i>methadone hcl oral solution 10 mg/5 ml</i>	2	MME; QL (1200 ML per 30 days)
<i>methadone hcl oral solution 5 mg/5 ml</i>	2	MME; QL (2400 ML per 30 days)
<i>methadone hcl oral tablet 10 mg</i>	2	MME; QL (240 EA per 30 days)
<i>methadone hcl oral tablet 5 mg</i>	2	MME; QL (180 EA per 30 days)
<i>morphine sulfate er oral tablet extended release 100 mg, 15 mg, 200 mg, 30 mg, 60 mg</i>	2	MME; QL (60 EA per 30 days)
<i>oxycodone hcl er oral tablet er 12 hour abuse-deterrent 10 mg, 20 mg, 40 mg, 80 mg</i>	2	PA; MME
XTAMPZA ER ORAL CAPSULE ER 12 HOUR ABUSE-DETERRENT 13.5 MG, 18 MG, 27 MG, 36 MG, 9 MG	3	PA; MME
<b>Opioid Analgesics, Short-Acting</b>		
<i>acetaminophen-codeine oral solution 120-12 mg/5 ml</i>	2	MME
<i>acetaminophen-codeine oral tablet 300-15 mg, 300-30 mg, 300-60 mg</i>	2	MME
<i>butorphanol tartrate nasal solution 10 mg/ml</i>	2	MME; QL (5 ML per 30 days)
ENDOCET ORAL TABLET 10-325 MG, 2.5-325 MG, 5-325 MG, 7.5-325 MG	2	MME

\*We provide additional coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-9.

<b>Name of Drug</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>fentanyl citrate buccal lozenge on a handle 1200 mcg, 1600 mcg, 600 mcg, 800 mcg</i>	5	PA; MME; QL (120 EA per 30 days)
<i>fentanyl citrate buccal lozenge on a handle 200 mcg, 400 mcg</i>	4	PA; MME; QL (120 EA per 30 days)
<i>hydrocodone-acetaminophen oral tablet 10-325 mg, 5-325 mg, 7.5-325 mg</i>	2	MME
<i>hydrocodone-ibuprofen oral tablet 10-200 mg, 5-200 mg, 7.5-200 mg</i>	2	MME
<i>hydromorphone hcl oral tablet 2 mg, 4 mg, 8 mg</i>	2	MME; QL (120 EA per 30 days)
<i>hydromorphone hcl pf injection solution 1 mg/ml, 10 mg/ml, 4 mg/ml, 50 mg/5 ml, 500 mg/50 ml</i>	2	MME
<i>morphine sulfate (concentrate) oral solution 100 mg/5 ml, 20 mg/ml</i>	2	MME; QL (240 ML per 30 days)
<i>morphine sulfate oral tablet 15 mg, 30 mg</i>	2	MME; QL (120 EA per 30 days)
<i>oxycodone hcl oral solution 5 mg/5 ml</i>	2	MME; QL (5400 ML per 30 days)
<i>oxycodone hcl oral tablet 10 mg, 15 mg, 20 mg, 30 mg, 5 mg</i>	2	MME; QL (120 EA per 30 days)
<i>oxycodone-acetaminophen oral tablet 10-325 mg, 2.5-325 mg, 5-325 mg, 7.5-325 mg</i>	2	MME
<i>pentazocine-naloxone hcl oral tablet 50-0.5 mg</i>	2	PA; MME
<i>tramadol hcl oral tablet 100 mg</i>	2	MME; QL (120 EA per 30 days)
<i>tramadol hcl oral tablet 25 mg</i>	2	MME; QL (120 EA per 30 days)
<i>tramadol hcl oral tablet 50 mg</i>	2	MME; QL (240 EA per 30 days)
<i>tramadol-acetaminophen oral tablet 37.5-325 mg</i>	2	MME

\*We provide additional coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-9.

Name of Drug	Drug Tier	Requirements/Limits
<b>Anesthetics - Local Treatment Of Pain</b>		
<b>Local Anesthetics</b>		
<i>lidocaine external ointment 5 %</i>	2	
<i>lidocaine external patch 5 %</i>	2	PA; QL (90 EA per 30 days)
<i>lidocaine hcl external solution 4 %</i>	2	
<i>lidocaine hcl urethral/mucosal external gel 2 %</i>	2	
<i>lidocaine hcl urethral/mucosal external prefilled syringe 2 %</i>	2	
<i>lidocaine viscous hcl mouth/throat solution 2 %</i>	2	
<i>lidocaine-prilocaine external cream 2.5-2.5 %</i>	2	
ZTLIDO EXTERNAL PATCH 1.8 %	4	PA; QL (90 EA per 30 days)
<b>Anti-Addiction/Substance Abuse Treatment Agents - Treatment Of Substance Abuse Disorders</b>		
<b>Alcohol Deterrents/Anti-Craving</b>		
<i>acamprosate calcium oral tablet delayed release 333 mg</i>	2	
<i>disulfiram oral tablet 250 mg, 500 mg</i>	2	
<b>Opioid Dependence</b>		
<i>buprenorphine hcl sublingual tablet sublingual 2 mg, 8 mg</i>	2	
<i>buprenorphine hcl-naloxone hcl sublingual film 12-3 mg, 2-0.5 mg, 4-1 mg, 8-2 mg</i>	2	
<i>buprenorphine hcl-naloxone hcl sublingual tablet sublingual 2-0.5 mg, 8-2 mg</i>	2	
LUCEMYRA ORAL TABLET 0.18 MG	5	PA; QL (224 EA per 14 days)
<i>naltrexone hcl oral tablet 50 mg*</i>	1	
<b>Opioid Reversal Agents</b>		
<i>naloxone hcl injection solution 0.4 mg/ml, 4 mg/10 ml*</i>	1	

\*We provide additional coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-9.

<b>Name of Drug</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>naloxone hcl injection solution cartridge 0.4 mg/ml*</i>	1	
<i>naloxone hcl injection solution prefilled syringe 2 mg/2 ml*</i>	1	
<i>naloxone hcl nasal liquid 4 mg/0.1 ml*</i>	1	
<b>Smoking Cessation Agents</b>		
<i>bupropion hcl er (smoking det) oral tablet extended release 12 hour 150 mg*</i>	1	
NICOTROL INHALATION INHALER 10 MG	4	
NICOTROL NS NASAL SOLUTION 10 MG/ML	4	
<i>varenicline tartrate (starter) oral tablet therapy pack 0.5 mg x 11 &amp; 1 mg x 42</i>	2	QL (56 EA per 28 days)
<i>varenicline tartrate oral tablet 0.5 mg, 1 mg</i>	2	QL (56 EA per 28 days)
<i>varenicline tartrate (continue) oral tablet 1 mg</i>	2	QL (56 EA per 28 days)
<b>Antibacterials - Treatment Of Bacterial Infections</b>		
<b>Aminoglycosides</b>		
<i>amikacin sulfate injection solution 500 mg/2 ml</i>	2	
<i>gentamicin in saline intravenous solution 0.8-0.9 mg/ml-%, 1-0.9 mg/ml-%, 1.2-0.9 mg/ml-%, 1.6-0.9 mg/ml-%</i>	2	
<i>gentamicin sulfate injection solution 40 mg/ml</i>	2	
<i>neomycin sulfate oral tablet 500 mg</i>	2	
<i>paromomycin sulfate oral capsule 250 mg</i>	2	
<i>streptomycin sulfate intramuscular solution reconstituted 1 gm</i>	4	
<i>tobramycin sulfate injection solution 1.2 gm/30 ml, 10 mg/ml, 2 gm/50 ml, 80 mg/2 ml</i>	2	

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<b>Name of Drug</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>tobramycin sulfate injection solution reconstituted 1.2 gm</i>	2	
<b>Antibacterials, Other</b>		
<i>aztreonam injection solution reconstituted 1 gm, 2 gm</i>	2	
<i>clindamycin hcl oral capsule 150 mg, 300 mg, 75 mg*</i>	1	
<i>clindamycin palmitate hcl oral solution reconstituted 75 mg/5 ml</i>	2	
<i>clindamycin phosphate in d5w intravenous solution 300 mg/50 ml, 600 mg/50 ml, 900 mg/50 ml</i>	2	
<i>clindamycin phosphate in nacl intravenous solution 300-0.9 mg/50 ml-%, 600-0.9 mg/50 ml-%, 900-0.9 mg/50 ml-%</i>	2	
<i>clindamycin phosphate injection solution 300 mg/2 ml, 600 mg/4 ml, 900 mg/6 ml</i>	2	
<i>clindamycin phosphate vaginal cream 2 %</i>	2	
<i>colistimethate sodium (cba) injection solution reconstituted 150 mg</i>	2	
<i>daptomycin intravenous solution reconstituted 350 mg</i>	2	
<i>daptomycin intravenous solution reconstituted 500 mg</i>	4	
<i>linezolid in sodium chloride intravenous solution 600-0.9 mg/300 ml-%</i>	2	
<i>linezolid intravenous solution 600 mg/300 ml</i>	2	
<i>linezolid oral suspension reconstituted 100 mg/5 ml</i>	5	
<i>linezolid oral tablet 600 mg</i>	2	
<i>methenamine hippurate oral tablet 1 gm</i>	2	

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<b>Name of Drug</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>metronidazole intravenous solution 500 mg/100 ml</i>	2	
<i>metronidazole oral capsule 375 mg</i>	2	
<i>metronidazole oral tablet 250 mg, 500 mg*</i>	1	
<i>metronidazole vaginal gel 0.75 %</i>	2	
<i>nitrofurantoin macrocrystal oral capsule 100 mg, 25 mg, 50 mg</i>	2	
<i>nitrofurantoin monohyd macro oral capsule 100 mg</i>	2	
<i>polymyxin b sulfate injection solution reconstituted 500000 unit</i>	2	
<i>tinidazole oral tablet 250 mg, 500 mg</i>	2	
<i>trimethoprim oral tablet 100 mg*</i>	1	
<i>vancomycin hcl intravenous solution reconstituted 1 gm, 10 gm, 100 gm, 5 gm, 500 mg, 750 mg</i>	2	
<i>vancomycin hcl oral capsule 125 mg, 250 mg</i>	2	
<b>Beta-Lactam, Cephalosporins</b>		
<i>cefaclor er oral tablet extended release 12 hour 500 mg</i>	2	
<i>cefaclor oral capsule 250 mg, 500 mg</i>	2	
<i>cefadroxil oral capsule 500 mg*</i>	1	
<i>cefadroxil oral suspension reconstituted 250 mg/5 ml, 500 mg/5 ml</i>	2	
<i>cefadroxil oral tablet 1 gm</i>	2	
<i>cefazolin sodium injection solution reconstituted 1 gm, 2 gm, 500 mg</i>	2	
<i>cefazolin sodium intravenous solution reconstituted 1 gm, 2 gm, 3 gm</i>	2	
<i>cefazolin sodium-dextrose intravenous solution 1-4 gm/50 ml-%</i>	2	
<i>cefazolin sodium-dextrose intravenous solution reconstituted 1-4 gm-% (50 ml)</i>	2	

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<b>Name of Drug</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>cefdinir oral capsule 300 mg*</i>	1	
<i>cefdinir oral suspension reconstituted 125 mg/5 ml, 250 mg/5 ml</i>	2	
<i>cefepime hcl injection solution reconstituted 1 gm</i>	2	
<i>cefepime hcl intravenous solution 1 gm/50 ml, 2 gm/100 ml</i>	2	
<i>cefepime hcl intravenous solution reconstituted 2 gm</i>	2	
<i>cefepime-dextrose intravenous solution reconstituted 1-5 gm-% (50 ml), 2-5 gm-% (50 ml)</i>	2	
<i>cefixime oral capsule 400 mg</i>	2	
<i>cefotaxime sodium injection solution reconstituted 1 gm</i>	2	
<i>cefoxitin sodium intravenous solution reconstituted 1 gm, 10 gm, 2 gm</i>	2	
<i>cefoxitin sodium-dextrose intravenous solution reconstituted 1-4 gm-% (50 ml), 2-2.2 gm-% (50 ml)</i>	2	
<i>cefpodoxime proxetil oral suspension reconstituted 100 mg/5 ml, 50 mg/5 ml</i>	2	
<i>cefpodoxime proxetil oral tablet 100 mg, 200 mg</i>	2	
<i>cefprozil oral suspension reconstituted 125 mg/5 ml, 250 mg/5 ml</i>	2	
<i>cefprozil oral tablet 250 mg, 500 mg</i>	2	
<i>ceftazidime and dextrose intravenous solution reconstituted 1-5 gm-% (50 ml), 2-5 gm-% (50 ml)</i>	2	
<i>ceftazidime injection solution reconstituted 1 gm, 6 gm</i>	2	
<i>ceftazidime intravenous solution reconstituted 2 gm</i>	2	
<i>ceftriaxone sodium in dextrose intravenous solution 20 mg/ml, 40 mg/ml</i>	2	

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<b>Name of Drug</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>ceftriaxone sodium injection solution reconstituted 1 gm, 100 gm, 2 gm, 250 mg, 500 mg</i>	2	
<i>ceftriaxone sodium intravenous solution reconstituted 1 gm, 10 gm, 2 gm</i>	2	
<i>ceftriaxone sodium-dextrose intravenous solution reconstituted 1-3.74 gm-% (50 ml), 2-2.22 gm-% (50 ml)</i>	2	
<i>cefuroxime axetil oral tablet 250 mg, 500 mg</i>	2	
<i>cefuroxime sodium injection solution reconstituted 750 mg</i>	2	
<i>cefuroxime sodium intravenous solution reconstituted 1.5 gm</i>	2	
<i>cephalexin oral capsule 250 mg, 500 mg*</i>	1	
<i>cephalexin oral suspension reconstituted 125 mg/5 ml, 250 mg/5 ml*</i>	1	
<i>cephalexin oral tablet 250 mg, 500 mg</i>	2	
TEFLARO INTRAVENOUS SOLUTION RECONSTITUTED 400 MG, 600 MG	5	PA
<b>Beta-Lactam, Penicillins</b>		
<i>amoxicillin oral capsule 250 mg, 500 mg*</i>	1	
<i>amoxicillin oral suspension reconstituted 125 mg/5 ml, 200 mg/5 ml, 250 mg/5 ml, 400 mg/5 ml*</i>	1	
<i>amoxicillin oral tablet 500 mg, 875 mg*</i>	1	
<i>amoxicillin oral tablet chewable 125 mg, 250 mg*</i>	1	
<i>amoxicillin-pot clavulanate er oral tablet extended release 12 hour 1000-62.5 mg</i>	2	

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<b>Name of Drug</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>amoxicillin-pot clavulanate oral suspension reconstituted 200-28.5 mg/5 ml, 250-62.5 mg/5 ml, 400-57 mg/5 ml, 600-42.9 mg/5 ml</i>	2	
<i>amoxicillin-pot clavulanate oral tablet 250-125 mg, 500-125 mg, 875-125 mg</i>	2	
<i>amoxicillin-pot clavulanate oral tablet chewable 200-28.5 mg, 400-57 mg</i>	2	
<i>ampicillin oral capsule 500 mg*</i>	1	
<i>ampicillin sodium injection solution reconstituted 1 gm, 125 mg</i>	2	
<i>ampicillin sodium intravenous solution reconstituted 1 gm, 10 gm</i>	2	
<i>ampicillin-sulbactam sodium injection solution reconstituted 1.5 (1-0.5) gm, 3 (2-1) gm</i>	2	
<i>ampicillin-sulbactam sodium intravenous solution reconstituted 1.5 (1-0.5) gm, 15 (10-5) gm, 3 (2-1) gm</i>	2	
BICILLIN L-A INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 1200000 UNIT/2 ML, 2400000 UNIT/4 ML, 600000 UNIT/ML	4	
<i>dicloxacillin sodium oral capsule 250 mg, 500 mg</i>	2	
<i>nafcillin sodium in dextrose intravenous solution 1 gm/50 ml</i>	2	
<i>nafcillin sodium in dextrose intravenous solution 2 gm/100 ml</i>	4	
<i>nafcillin sodium injection solution reconstituted 1 gm</i>	2	
<i>nafcillin sodium injection solution reconstituted 2 gm</i>	4	
<i>nafcillin sodium intravenous solution reconstituted 2 gm</i>	4	
<i>penicillin g procaine intramuscular suspension 600000 unit/ml</i>	4	

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<b>Name of Drug</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>penicillin g sodium injection solution reconstituted 5000000 unit</i>	2	
<i>penicillin v potassium oral solution reconstituted 125 mg/5 ml, 250 mg/5 ml</i>	2	
<i>penicillin v potassium oral tablet 250 mg, 500 mg*</i>	1	
<i>piperacillin sod-tazobactam so intravenous solution reconstituted 13.5 (12-1.5) gm, 2.25 (2-0.25) gm, 3-0.375 gm, 3.375 (3-0.375) gm, 4-0.5 gm, 4.5 (4-0.5) gm, 40.5 (36-4.5) gm</i>	2	
<b>Carbapenems</b>		
<i>ertapenem sodium injection solution reconstituted 1 gm</i>	4	
<i>imipenem-cilastatin intravenous solution reconstituted 250 mg, 500 mg</i>	2	
<i>meropenem intravenous solution reconstituted 1 gm, 2 gm, 500 mg</i>	2	
<i>meropenem-sodium chloride intravenous solution reconstituted 1 gm/50 ml, 500 mg/50 ml</i>	2	
<b>Macrolides</b>		
<i>azithromycin intravenous solution reconstituted 500 mg</i>	2	
<i>azithromycin oral packet 1 gm</i>	2	
<i>azithromycin oral suspension reconstituted 100 mg/5ml, 200 mg/5 ml</i>	2	
<i>azithromycin oral tablet 250 mg, 250 mg (6 pack), 500 mg, 500 mg (3 pack), 600 mg*</i>	1	
<i>clarithromycin er oral tablet extended release 24 hour 500 mg</i>	2	
<i>clarithromycin oral suspension reconstituted 125 mg/5 ml, 250 mg/5 ml</i>	2	
<i>clarithromycin oral tablet 250 mg, 500 mg</i>	2	

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<b>Name of Drug</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
DIFICID ORAL SUSPENSION RECONSTITUTED 40 MG/ML	5	PA
DIFICID ORAL TABLET 200 MG	5	PA
ERYTHROCIN LACTOBIONATE INTRAVENOUS SOLUTION RECONSTITUTED 500 MG	4	
ERYTHROCIN STEARATE ORAL TABLET 250 MG	2	
<i>erythromycin base oral tablet 250 mg, 500 mg</i>	2	
<i>erythromycin ethylsuccinate oral suspension reconstituted 200 mg/5 ml</i>	2	
<i>erythromycin ethylsuccinate oral tablet 400 mg</i>	2	
<b>Quinolones</b>		
<i>ciprofloxacin hcl oral tablet 250 mg, 500 mg, 750 mg*</i>	1	
<i>ciprofloxacin in d5w intravenous solution 200 mg/100 ml</i>	2	
<i>levofloxacin in d5w intravenous solution 500 mg/100 ml, 750 mg/150 ml</i>	2	
<i>levofloxacin intravenous solution 25 mg/ml</i>	2	
<i>levofloxacin oral solution 25 mg/ml</i>	2	
<i>levofloxacin oral tablet 250 mg, 500 mg, 750 mg*</i>	1	
<i>moxifloxacin hcl in nacl intravenous solution 400 mg/250 ml</i>	2	
<i>moxifloxacin hcl intravenous solution 400 mg/250 ml</i>	2	
<i>moxifloxacin hcl oral tablet 400 mg</i>	2	
<i>ofloxacin oral tablet 300 mg, 400 mg</i>	2	
<b>Sulfonamides</b>		
<i>sulfacetamide sodium (acne) external lotion 10 %</i>	2	
<i>sulfadiazine oral tablet 500 mg</i>	2	

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<b>Name of Drug</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>sulfamethoxazole-trimethoprim oral suspension 200-40 mg/5 ml</i>	2	
<i>sulfamethoxazole-trimethoprim oral tablet 400-80 mg, 800-160 mg*</i>	1	
<b>Tetracyclines</b>		
DOXY 100 INTRAVENOUS SOLUTION RECONSTITUTED 100 MG	2	
<i>doxycycline hyclate intravenous solution reconstituted 100 mg</i>	2	
<i>doxycycline hyclate oral capsule 100 mg, 50 mg</i>	2	
<i>doxycycline hyclate oral tablet 100 mg, 20 mg</i>	2	
<i>doxycycline monohydrate oral capsule 100 mg, 50 mg*</i>	1	
<i>doxycycline monohydrate oral tablet 100 mg, 150 mg, 50 mg, 75 mg</i>	2	
<i>minocycline hcl oral capsule 100 mg, 50 mg, 75 mg*</i>	1	
<i>minocycline hcl oral tablet 100 mg, 50 mg, 75 mg</i>	2	
<i>tetracycline hcl oral capsule 250 mg, 500 mg</i>	2	
<b>Anticonvulsants - Treatment Of Seizures</b>		
<b>Anticonvulsants, Other</b>		
BRIVIACT ORAL SOLUTION 10 MG/ML	5	
BRIVIACT ORAL TABLET 10 MG, 100 MG, 25 MG, 50 MG, 75 MG	5	
DIACOMIT ORAL CAPSULE 250 MG, 500 MG	5	PA
DIACOMIT ORAL PACKET 250 MG, 500 MG	5	PA
<i>divalproex sodium er oral tablet extended release 24 hour 250 mg, 500 mg</i>	2	

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<b>Name of Drug</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>divalproex sodium oral capsule delayed release sprinkle 125 mg</i>	2	
<i>divalproex sodium oral tablet delayed release 125 mg, 250 mg, 500 mg</i>	2	
EPIDIOLEX ORAL SOLUTION 100 MG/ML	5	PA
EPRONTIA ORAL SOLUTION 25 MG/ML	4	PA
<i>felbamate oral suspension 600 mg/5 ml</i>	2	
<i>felbamate oral tablet 400 mg, 600 mg</i>	2	
FINTEPLA ORAL SOLUTION 2.2 MG/ML	5	PA
FYCOMPA ORAL SUSPENSION 0.5 MG/ML	5	ST; QL (720 ML per 30 days)
FYCOMPA ORAL TABLET 10 MG, 12 MG, 4 MG, 6 MG, 8 MG	5	ST; QL (30 EA per 30 days)
FYCOMPA ORAL TABLET 2 MG	4	ST; QL (30 EA per 30 days)
<i>lamotrigine er oral tablet extended release 24 hour 100 mg, 200 mg, 25 mg, 250 mg, 300 mg, 50 mg</i>	2	
<i>lamotrigine oral tablet 100 mg, 150 mg, 200 mg, 25 mg*</i>	1	
<i>lamotrigine oral tablet chewable 25 mg, 5 mg</i>	2	
<i>lamotrigine starter kit-blue oral kit 35 x 25 mg</i>	2	
<i>lamotrigine starter kit-green oral kit 84 x 25 mg &amp; 14 x 100 mg</i>	4	
<i>lamotrigine starter kit-orange oral kit 42 x 25 mg &amp; 7 x 100 mg</i>	2	
<i>levetiracetam er oral tablet extended release 24 hour 500 mg, 750 mg</i>	2	
<i>levetiracetam oral solution 100 mg/ml*</i>	1	
<i>levetiracetam oral tablet 1000 mg, 250 mg, 500 mg, 750 mg*</i>	1	
ROWEEPRA ORAL TABLET 500 MG*	1	

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<b>Name of Drug</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
SPRITAM ORAL TABLET DISINTEGRATING SOLUBLE 1000 MG, 250 MG, 500 MG	4	ST; QL (60 EA per 30 days)
SPRITAM ORAL TABLET DISINTEGRATING SOLUBLE 750 MG	4	ST; QL (120 EA per 30 days)
<i>topiramate oral capsule sprinkle 15 mg, 25 mg</i>	2	
<i>topiramate oral tablet 100 mg, 200 mg, 25 mg, 50 mg*</i>	1	
<i>valproic acid oral capsule 250 mg</i>	2	
<i>valproic acid oral solution 250 mg/5 ml</i>	2	
XCOPRI (250 MG DAILY DOSE) ORAL TABLET THERAPY PACK 100 & 150 MG	4	ST
XCOPRI (350 MG DAILY DOSE) ORAL TABLET THERAPY PACK 150 & 200 MG	4	ST
XCOPRI ORAL TABLET 100 MG, 150 MG, 200 MG, 50 MG	4	ST
XCOPRI ORAL TABLET THERAPY PACK 14 X 12.5 MG & 14 X 25 MG, 14 X 150 MG & 14 X 200 MG, 14 X 50 MG & 14 X 100 MG	4	ST
<b>Calcium Channel Modifying Agents</b>		
<i>ethosuximide oral capsule 250 mg</i>	2	
<i>ethosuximide oral solution 250 mg/5 ml</i>	2	
<i>methsuximide oral capsule 300 mg</i>	2	
<b>Gamma-Aminobutyric Acid (GABA) Augmenting Agents</b>		
<i>clobazam oral suspension 2.5 mg/ml</i>	2	QL (480 ML per 30 days)
<i>clobazam oral tablet 10 mg, 20 mg</i>	2	QL (60 EA per 30 days)
<i>diazepam rectal gel 10 mg, 2.5 mg, 20 mg</i>	2	
<i>gabapentin oral capsule 100 mg, 400 mg*</i>	1	QL (270 EA per 30 days)
<i>gabapentin oral capsule 300 mg*</i>	1	QL (360 EA per 30 days)
<i>gabapentin oral solution 250 mg/5 ml, 300 mg/6 ml</i>	2	QL (2160 ML per 30 days)

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<b>Name of Drug</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>gabapentin oral tablet 600 mg*</i>	1	QL (180 EA per 30 days)
<i>gabapentin oral tablet 800 mg*</i>	1	QL (120 EA per 30 days)
NAYZILAM NASAL SOLUTION 5 MG/0.1 ML	4	PA; QL (10 EA per 30 days)
<i>phenobarbital oral elixir 20 mg/5 ml</i>	2	PA
<i>phenobarbital oral tablet 100 mg, 15 mg, 16.2 mg, 30 mg, 32.4 mg, 60 mg, 64.8 mg, 97.2 mg</i>	2	PA
<i>pregabalin oral capsule 100 mg, 150 mg, 200 mg, 25 mg, 50 mg, 75 mg*</i>	1	QL (90 EA per 30 days)
<i>pregabalin oral capsule 225 mg, 300 mg*</i>	1	QL (60 EA per 30 days)
<i>pregabalin oral solution 20 mg/ml*</i>	1	QL (900 ML per 30 days)
<i>primidone oral tablet 250 mg, 50 mg</i>	2	
SYMPAZAN ORAL FILM 10 MG, 20 MG	5	ST; QL (60 EA per 30 days)
SYMPAZAN ORAL FILM 5 MG	4	ST; QL (60 EA per 30 days)
<i>tiagabine hcl oral tablet 12 mg, 16 mg, 2 mg, 4 mg</i>	2	
VALTOCO 10 MG DOSE NASAL LIQUID 10 MG/0.1 ML	4	PA; QL (10 EA per 30 days)
VALTOCO 15 MG DOSE NASAL LIQUID THERAPY PACK 7.5 MG/0.1 ML	4	PA; QL (10 EA per 30 days)
VALTOCO 20 MG DOSE NASAL LIQUID THERAPY PACK 10 MG/0.1 ML	4	PA; QL (10 EA per 30 days)
VALTOCO 5 MG DOSE NASAL LIQUID 5 MG/0.1 ML	4	PA; QL (10 EA per 30 days)
<i>vigabatrin oral packet 500 mg</i>	5	PA; QL (180 EA per 30 days)
<i>vigabatrin oral tablet 500 mg</i>	5	PA; QL (180 EA per 30 days)
ZTALMY ORAL SUSPENSION 50 MG/ML	5	PA
<b>Sodium Channel Agents</b>		
APTIOM ORAL TABLET 200 MG, 400 MG	3	QL (30 EA per 30 days)
APTIOM ORAL TABLET 600 MG, 800 MG	3	QL (60 EA per 30 days)
<i>carbamazepine er oral capsule extended release 12 hour 100 mg, 200 mg, 300 mg</i>	2	

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<b>Name of Drug</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>carbamazepine er oral tablet extended release 12 hour 100 mg, 200 mg, 400 mg</i>	2	
<i>carbamazepine oral suspension 100 mg/5 ml</i>	2	
<i>carbamazepine oral tablet 200 mg*</i>	1	
<i>carbamazepine oral tablet chewable 100 mg</i>	2	
DILANTIN ORAL CAPSULE 100 MG, 30 MG	3	
EPITOL ORAL TABLET 200 MG*	1	
<i>lacosamide oral solution 10 mg/ml</i>	2	QL (1200 ML per 30 days)
<i>lacosamide oral tablet 100 mg, 150 mg, 200 mg, 50 mg</i>	2	QL (60 EA per 30 days)
<i>oxcarbazepine oral suspension 300 mg/5 ml</i>	2	
<i>oxcarbazepine oral tablet 150 mg, 300 mg, 600 mg*</i>	1	
PHENYTOIN INFATABS ORAL TABLET CHEWABLE 50 MG	2	
<i>phenytoin oral suspension 100 mg/4 ml, 125 mg/5 ml</i>	2	
<i>phenytoin oral tablet chewable 50 mg</i>	2	
<i>phenytoin sodium extended oral capsule 100 mg, 200 mg, 300 mg</i>	2	
<i>rufinamide oral suspension 40 mg/ml</i>	2	PA; QL (2400 ML per 30 days)
<i>rufinamide oral tablet 200 mg, 400 mg</i>	2	PA; QL (240 EA per 30 days)
ZONISADE ORAL SUSPENSION 100 MG/5 ML	4	ST
<i>zonisamide oral capsule 100 mg, 25 mg, 50 mg</i>	2	
<b>Antidementia Agents - Management Of Dementia</b>		
<b>Cholinesterase Inhibitors</b>		
<i>donepezil hcl oral tablet 10 mg, 5 mg*</i>	1	

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<b>Name of Drug</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>donepezil hcl oral tablet 23 mg</i>	2	
<i>donepezil hcl oral tablet dispersible 10 mg, 5 mg*</i>	1	
<i>galantamine hydrobromide er oral capsule extended release 24 hour 16 mg, 24 mg, 8 mg*</i>	1	
<i>galantamine hydrobromide oral tablet 12 mg, 4 mg, 8 mg*</i>	1	
<i>rivastigmine tartrate oral capsule 1.5 mg, 3 mg, 4.5 mg, 6 mg*</i>	1	
<i>rivastigmine transdermal patch 24 hour 13.3 mg/24 hr, 4.6 mg/24 hr, 9.5 mg/24 hr</i>	2	ST
<b>N-Methyl-D-Aspartate (NMDA) Receptor Antagonist</b>		
<i>memantine hcl er oral capsule extended release 24 hour 14 mg, 21 mg, 28 mg, 7 mg</i>	2	QL (30 EA per 30 days)
<i>memantine hcl oral tablet 10 mg, 28 x 5 mg &amp; 21 x 10 mg, 5 mg*</i>	1	
<b>Antidepressants - Treatment Of Depression</b>		
<b>Antidepressants, Other</b>		
AUVELITY ORAL TABLET EXTENDED RELEASE 45-105 MG	5	PA
<i>bupropion hcl er (sr) oral tablet extended release 12 hour 100 mg, 150 mg, 200 mg*</i>	1	
<i>bupropion hcl er (xl) oral tablet extended release 24 hour 150 mg, 300 mg, 450 mg*</i>	1	
<i>bupropion hcl oral tablet 100 mg, 75 mg*</i>	1	
<i>mirtazapine oral tablet 15 mg, 30 mg, 45 mg, 7.5 mg*</i>	1	
<i>mirtazapine oral tablet dispersible 15 mg, 30 mg, 45 mg</i>	2	

\*We provide additional coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-9.

<b>Name of Drug</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>perphenazine-amitriptyline oral tablet</i> 2-10 mg, 2-25 mg, 4-10 mg, 4-25 mg, 4-50 mg	2	PA
ZURZUVAE ORAL CAPSULE 20 MG, 25 MG, 30 MG	5	PA
<b>Monoamine Oxidase Inhibitors</b>		
EMSAM TRANSDERMAL PATCH 24 HOUR 12 MG/24 HR, 6 MG/24 HR, 9 MG/24 HR	5	PA
MARPLAN ORAL TABLET 10 MG	4	
<i>phenelzine sulfate oral tablet 15 mg</i>	2	
<i>tranylcypromine sulfate oral tablet</i> 10 mg	2	
<b>SSRI/SNRI (Selective Serotonin Reuptake Inhibitor/Serotonin And Norepinephrine Reuptake Inhibitor)</b>		
<i>citalopram hydrobromide oral solution</i> 10 mg/5 ml	2	
<i>citalopram hydrobromide oral tablet</i> 10 mg, 20 mg, 40 mg*	1	
<i>desvenlafaxine succinate er oral tablet</i> extended release 24 hour 100 mg, 25 mg, 50 mg	2	
<i>escitalopram oxalate oral solution</i> 5 mg/5 ml	2	
<i>escitalopram oxalate oral tablet 10 mg,</i> 20 mg, 5 mg*	1	
FETZIMA ORAL CAPSULE EXTENDED RELEASE 24 HOUR 120 MG, 20 MG, 40 MG, 80 MG	4	ST
FETZIMA TITRATION ORAL CAPSULE ER 24 HOUR THERAPY PACK 20 & 40 MG	4	ST
<i>fluoxetine hcl oral capsule 10 mg,</i> 20 mg, 40 mg*	1	
<i>fluoxetine hcl oral capsule delayed</i> release 90 mg	2	
<i>fluoxetine hcl oral solution 20 mg/5 ml*</i>	1	

\*We provide additional coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-9.

<b>Name of Drug</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>fluoxetine hcl oral tablet 10 mg, 20 mg</i>	2	
<i>fluvoxamine maleate oral tablet 100 mg, 25 mg, 50 mg</i>	2	
<i>nefazodone hcl oral tablet 100 mg, 150 mg, 200 mg, 250 mg, 50 mg</i>	2	
<i>paroxetine hcl er oral tablet extended release 24 hour 12.5 mg, 25 mg, 37.5 mg</i>	2	
<i>paroxetine hcl oral suspension 10 mg/5 ml</i>	2	
<i>paroxetine hcl oral tablet 10 mg, 20 mg, 30 mg, 40 mg*</i>	1	
<i>sertraline hcl oral concentrate 20 mg/ml</i>	2	
<i>sertraline hcl oral tablet 100 mg, 25 mg, 50 mg*</i>	1	
<i>trazodone hcl oral tablet 100 mg, 150 mg, 50 mg*</i>	1	
<i>trazodone hcl oral tablet 300 mg</i>	2	
TRINTELLIX ORAL TABLET 10 MG, 20 MG, 5 MG	3	
<i>venlafaxine hcl er oral capsule extended release 24 hour 150 mg, 37.5 mg, 75 mg</i>	2	
<i>venlafaxine hcl er oral tablet extended release 24 hour 150 mg, 225 mg, 37.5 mg, 75 mg</i>	2	
<i>venlafaxine hcl oral tablet 100 mg, 25 mg, 37.5 mg, 50 mg, 75 mg</i>	2	
<i>vilazodone hcl oral tablet 10 mg, 20 mg, 40 mg</i>	2	
<b>Tricyclics</b>		
<i>amitriptyline hcl oral tablet 10 mg, 100 mg, 150 mg, 25 mg, 50 mg, 75 mg</i>	2	PA
<i>amoxapine oral tablet 100 mg, 150 mg, 25 mg, 50 mg</i>	2	PA

\*We provide additional coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-9.

<b>Name of Drug</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>clomipramine hcl oral capsule 25 mg, 50 mg, 75 mg</i>	2	PA
<i>desipramine hcl oral tablet 10 mg, 100 mg, 150 mg, 25 mg, 50 mg, 75 mg</i>	2	
<i>doxepin hcl oral capsule 10 mg, 100 mg, 150 mg, 25 mg, 50 mg, 75 mg*</i>	1	PA
<i>doxepin hcl oral concentrate 10 mg/ml</i>	2	PA
<i>imipramine hcl oral tablet 10 mg, 25 mg, 50 mg</i>	2	PA
<i>imipramine pamoate oral capsule 100 mg, 125 mg, 150 mg, 75 mg</i>	2	PA
<i>nortriptyline hcl oral capsule 10 mg, 25 mg, 50 mg, 75 mg*</i>	1	
<i>nortriptyline hcl oral solution 10 mg/5 ml</i>	2	
<i>protriptyline hcl oral tablet 10 mg, 5 mg</i>	2	PA
<i>trimipramine maleate oral capsule 100 mg, 25 mg, 50 mg</i>	2	PA

## **Antiemetics - Treatment Of Vomiting Or Nausea**

### **Antiemetics, Other**

<i>chlorpromazine hcl oral concentrate 100 mg/ml, 30 mg/ml</i>	2	
<i>chlorpromazine hcl oral tablet 10 mg, 100 mg, 200 mg, 25 mg, 50 mg</i>	2	
<i>meclizine hcl oral tablet 12.5 mg, 25 mg</i>	2	
<i>metoclopramide hcl oral solution 10 mg/10 ml, 5 mg/5 ml</i>	2	
<i>metoclopramide hcl oral tablet 10 mg, 5 mg*</i>	1	
<i>perphenazine oral tablet 16 mg, 2 mg, 4 mg, 8 mg</i>	2	
<i>prochlorperazine maleate oral tablet 10 mg, 5 mg*</i>	1	
<i>prochlorperazine rectal suppository 25 mg</i>	2	

\*We provide additional coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-9.



<b>Name of Drug</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>promethazine hcl oral syrup 6.25 mg/5 ml</i>	2	PA
<i>promethazine hcl oral tablet 12.5 mg, 25 mg, 50 mg</i>	2	PA
<i>promethazine hcl rectal suppository 12.5 mg, 25 mg</i>	2	PA
PROMETHEGAN RECTAL SUPPOSITORY 50 MG	2	PA
<i>scopolamine transdermal patch 72 hour 1 mg/3 days</i>	2	
<i>trimethobenzamide hcl oral capsule 300 mg</i>	2	
<b>Emetogenic Therapy Adjuncts</b>		
<i>aprepitant oral 80 &amp; 125 mg</i>	2	B/D
<i>aprepitant oral capsule 125 mg, 40 mg, 80 &amp; 125 mg, 80 mg</i>	2	B/D
<i>dronabinol oral capsule 10 mg, 2.5 mg, 5 mg</i>	2	B/D
EMEND ORAL SUSPENSION RECONSTITUTED 125 MG/5 ML	4	B/D
<i>granisetron hcl oral tablet 1 mg</i>	2	B/D
<i>ondansetron hcl oral solution 4 mg/5 ml</i>	2	B/D
<i>ondansetron hcl oral tablet 24 mg</i>	2	B/D
<i>ondansetron hcl oral tablet 4 mg, 8 mg*</i>	1	B/D
<i>ondansetron oral tablet dispersible 4 mg, 8 mg</i>	2	B/D
<b>Antifungals - Treatment Of Fungal Or Yeast Infections</b>		
<b>Antifungals</b>		
ABELCET INTRAVENOUS SUSPENSION 5 MG/ML	4	B/D
<i>amphotericin b intravenous solution reconstituted 50 mg</i>	2	B/D
<i>amphotericin b liposome intravenous suspension reconstituted 50 mg</i>	5	B/D

\*We provide additional coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-9.

<b>Name of Drug</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>caspofungin acetate intravenous solution reconstituted 50 mg, 70 mg</i>	4	PA
<i>clotrimazole external cream 1 %</i>	2	
<i>clotrimazole external solution 1 %</i>	2	
<i>clotrimazole mouth/throat troche 10 mg</i>	2	
<i>econazole nitrate external cream 1 %</i>	2	
<i>fluconazole in sodium chloride intravenous solution 200-0.9 mg/100 ml-%, 400-0.9 mg/200 ml-%</i>	2	
<i>fluconazole oral suspension reconstituted 10 mg/ml, 40 mg/ml</i>	2	
<i>fluconazole oral tablet 100 mg, 150 mg, 200 mg, 50 mg</i>	2	
<i>flucytosine oral capsule 250 mg, 500 mg</i>	5	PA
<i>griseofulvin microsize oral suspension 125 mg/5 ml</i>	2	
<i>itraconazole oral capsule 100 mg</i>	2	
<i>itraconazole oral solution 10 mg/ml</i>	2	
<i>ketconazole external cream 2 %</i>	2	
<i>ketconazole external shampoo 2 %*</i>	1	
<i>ketconazole oral tablet 200 mg</i>	2	
<i>micalfungin sodium intravenous solution reconstituted 100 mg</i>	5	
<i>micalfungin sodium intravenous solution reconstituted 50 mg</i>	2	
<i>nystatin external cream 100000 unit/gm*</i>	1	
<i>nystatin external ointment 100000 unit/gm*</i>	1	
<i>nystatin external powder 100000 unit/gm*</i>	1	
<i>nystatin mouth/throat suspension 100000 unit/ml</i>	2	

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<b>Name of Drug</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>nystatin oral tablet 500000 unit</i>	2	
<i>posaconazole oral suspension 40 mg/ml</i>	5	PA
<i>posaconazole oral tablet delayed release 100 mg</i>	2	PA
<i>terbinafine hcl oral tablet 250 mg*</i>	1	
<i>terconazole vaginal cream 0.4 %, 0.8 %</i>	2	
<i>terconazole vaginal suppository 80 mg</i>	2	
<i>voriconazole intravenous solution reconstituted 200 mg</i>	4	PA
<i>voriconazole oral suspension reconstituted 40 mg/ml</i>	5	
<i>voriconazole oral tablet 200 mg, 50 mg</i>	2	

### **Antigout Agents - Treatment Or Prevention Of Gouty Arthritis**

#### **Antigout Agents**

<i>allopurinol oral tablet 100 mg, 300 mg*</i>	1	
<i>colchicine oral capsule 0.6 mg</i>	2	
<i>colchicine oral tablet 0.6 mg</i>	2	
<i>colchicine-probenecid oral tablet 0.5-500 mg</i>	2	
<i>febuxostat oral tablet 40 mg, 80 mg</i>	2	
<i>probenecid oral tablet 500 mg</i>	2	

### **Antimigraine Agents - Treatment Of Migraine Headaches**

#### **Antimigraine Agents**

NURTEC ORAL TABLET DISPERSIBLE 75 MG	5	PA; QL (18 EA per 30 days)
UBRELVY ORAL TABLET 100 MG, 50 MG	3	PA; QL (16 EA per 30 days)
ZAVZPRET NASAL SOLUTION 10 MG/ACT	5	PA; QL (8 EA per 30 days)

#### **Ergot Alkaloids**

<i>dihydroergotamine mesylate nasal solution 4 mg/ml</i>	5	QL (8 ML per 30 days)
<i>ergotamine-caffeine oral tablet 1-100 mg</i>	2	

\*We provide additional coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-9.

Name of Drug	Drug Tier	Requirements/Limits
<b>Prophylactic</b>		
AIMOVIG SUBCUTANEOUS SOLUTION AUTO-INJECTOR 140 MG/ML, 70 MG/ML	3	PA
EMGALITY (300 MG DOSE) SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML	3	PA
EMGALITY SUBCUTANEOUS SOLUTION AUTO-INJECTOR 120 MG/ML	3	PA
EMGALITY SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 120 MG/ML	3	PA
<b>Serotonin (5-HT) Receptor Agonist</b>		
<i>rizatriptan benzoate oral tablet 10 mg, 5 mg</i>	2	QL (12 EA per 30 days)
<i>rizatriptan benzoate oral tablet dispersible 10 mg, 5 mg</i>	2	QL (12 EA per 30 days)
<i>sumatriptan nasal solution 20 mg/act, 5 mg/act</i>	2	QL (12 EA per 30 days)
<i>sumatriptan succinate oral tablet 100 mg, 25 mg, 50 mg</i>	2	QL (9 EA per 30 days)
<i>sumatriptan succinate refill subcutaneous solution cartridge 4 mg/0.5 ml, 6 mg/0.5 ml</i>	2	QL (4 ML per 30 days)
<i>sumatriptan succinate subcutaneous solution 6 mg/0.5 ml</i>	2	QL (4 ML per 30 days)
<i>sumatriptan succinate subcutaneous solution auto-injector 4 mg/0.5 ml, 6 mg/0.5 ml</i>	2	QL (4 ML per 30 days)
<b>Antimyasthenic Agents - Treatment Of Myasthenia</b>		
<b>Parasympathomimetics</b>		
<i>pyridostigmine bromide er oral tablet extended release 180 mg</i>	2	
<i>pyridostigmine bromide oral tablet 60 mg*</i>	1	

\*We provide additional coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-9.

Name of Drug	Drug Tier	Requirements/Limits
<b>Antimycobacterials - Treatment For Infections By Tuberculosis-Type Organisms</b>		
<b>Antimycobacterials, Other</b>		
<i>dapsone oral tablet 100 mg, 25 mg</i>	2	
<i>rifabutin oral capsule 150 mg</i>	4	
<b>Antituberculars</b>		
<i>ethambutol hcl oral tablet 100 mg, 400 mg</i>	2	
<i>isoniazid oral tablet 100 mg, 300 mg*</i>	1	
<i>pretomanid oral tablet 200 mg</i>	4	PA
PRIFTIN ORAL TABLET 150 MG	4	
<i>pyrazinamide oral tablet 500 mg</i>	2	
<i>rifampin intravenous solution reconstituted 600 mg</i>	4	
<i>rifampin oral capsule 150 mg, 300 mg</i>	2	
SIRTURO ORAL TABLET 100 MG, 20 MG	5	PA
TRECTOR ORAL TABLET 250 MG	4	
<b>Antineoplastics - Treatment Of Cancer</b>		
<b>Alkylating Agents</b>		
<i>cyclophosphamide oral capsule 25 mg, 50 mg</i>	2	B/D
<i>cyclophosphamide oral tablet 25 mg, 50 mg</i>	2	B/D
GLEOSTINE ORAL CAPSULE 10 MG, 40 MG	3	
GLEOSTINE ORAL CAPSULE 100 MG	5	
LEUKERAN ORAL TABLET 2 MG	5	
MATULANE ORAL CAPSULE 50 MG	5	
VALCHLOR EXTERNAL GEL 0.016 %	5	PA
<b>Antiandrogens</b>		
<i>abiraterone acetate oral tablet 250 mg</i>	2	PA
<i>abiraterone acetate oral tablet 500 mg</i>	5	PA
<i>bicalutamide oral tablet 50 mg*</i>	1	

\*We provide additional coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-9.

<b>Name of Drug</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
ERLEADA ORAL TABLET 240 MG, 60 MG	5	PA
<i>nilutamide oral tablet 150 mg</i>	5	PA
NUBEQA ORAL TABLET 300 MG	5	PA
XTANDI ORAL CAPSULE 40 MG	5	PA
XTANDI ORAL TABLET 40 MG, 80 MG	5	PA
YONSA ORAL TABLET 125 MG	5	PA
<b>Antiangiogenic Agents</b>		
<i>lenalidomide oral capsule 10 mg, 15 mg, 2.5 mg, 20 mg, 25 mg, 5 mg</i>	5	PA
POMALYST ORAL CAPSULE 1 MG, 2 MG, 3 MG, 4 MG	5	PA
REVLIMID ORAL CAPSULE 10 MG, 15 MG, 2.5 MG, 20 MG, 25 MG, 5 MG	5	PA
THALOMID ORAL CAPSULE 100 MG, 150 MG, 200 MG, 50 MG	5	PA
<b>Antiestrogens/Modifiers</b>		
EMCYT ORAL CAPSULE 140 MG	5	
SOLTAMOX ORAL SOLUTION 10 MG/5ML	5	PA
<i>tamoxifen citrate oral tablet 10 mg, 20 mg*</i>	1	
<i>toremifene citrate oral tablet 60 mg</i>	5	PA
<b>Antimetabolites</b>		
DROXIA ORAL CAPSULE 200 MG, 300 MG, 400 MG	4	
<i>hydroxyurea oral capsule 500 mg</i>	2	
INQOVI ORAL TABLET 35-100 MG	5	PA
<i>mercaptopurine oral tablet 50 mg</i>	2	
ONUREG ORAL TABLET 200 MG, 300 MG	5	PA
PURIXAN ORAL SUSPENSION 2000 MG/100 ML	5	PA
TABLOID ORAL TABLET 40 MG	4	PA

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Name of Drug	Drug Tier	Requirements/Limits
<b>Antineoplastics, Other</b>		
AKEEGA ORAL TABLET 100-500 MG, 50-500 MG	5	PA
BESREMI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 500 MCG/ML	5	PA
IDHIFA ORAL TABLET 100 MG, 50 MG	5	PA
KISQALI FEMARA (200 MG DOSE) ORAL TABLET THERAPY PACK 200 & 2.5 MG	5	PA
KISQALI FEMARA (400 MG DOSE) ORAL TABLET THERAPY PACK 200 & 2.5 MG	5	PA
KISQALI FEMARA (600 MG DOSE) ORAL TABLET THERAPY PACK 200 & 2.5 MG	5	PA
KRAZATI ORAL TABLET 200 MG	5	PA
LONSURF ORAL TABLET 15-6.14 MG, 20-8.19 MG	5	PA
LUMAKRAS ORAL TABLET 120 MG, 320 MG	5	PA
LYSODREN ORAL TABLET 500 MG	5	
NINLARO ORAL CAPSULE 2.3 MG, 3 MG, 4 MG	5	PA
OJJAARA ORAL TABLET 100 MG, 150 MG, 200 MG	5	PA
ORSERDU ORAL TABLET 345 MG, 86 MG	5	PA
REZLIDHIA ORAL CAPSULE 150 MG	5	PA
RYLAZE INTRAMUSCULAR SOLUTION 10 MG/0.5 ML	5	PA
TIBSOVO ORAL TABLET 250 MG	5	PA
TICE BCG INTRAVESICAL SUSPENSION RECONSTITUTED 50 MG	3	
WELIREG ORAL TABLET 40 MG	5	PA
XATMEP ORAL SOLUTION 2.5 MG/ML	4	PA
XPOVIO (100 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 50 MG	5	PA
XPOVIO (40 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 40 MG	5	PA

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<b>Name of Drug</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
XPOVIO (40 MG TWICE WEEKLY) ORAL TABLET THERAPY PACK 40 MG	5	PA
XPOVIO (60 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 60 MG	5	PA
XPOVIO (60 MG TWICE WEEKLY) ORAL TABLET THERAPY PACK 20 MG	5	PA
XPOVIO (80 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 40 MG	5	PA
XPOVIO (80 MG TWICE WEEKLY) ORAL TABLET THERAPY PACK 20 MG	5	PA
ZOLINZA ORAL CAPSULE 100 MG	5	PA
<b>Aromatase Inhibitors, 3rd Generation</b>		
<i>anastrozole oral tablet 1 mg*</i>	1	
<i>exemestane oral tablet 25 mg</i>	2	
<i>letrozole oral tablet 2.5 mg*</i>	1	
<b>Molecular Target Inhibitors</b>		
ALECENSA ORAL CAPSULE 150 MG	5	PA
ALUNBRIG ORAL TABLET 180 MG, 30 MG, 90 MG	5	PA
ALUNBRIG ORAL TABLET THERAPY PACK 90 & 180 MG	5	PA
AUGTYRO ORAL CAPSULE 40 MG	5	PA
AYVAKIT ORAL TABLET 100 MG, 200 MG, 25 MG, 300 MG, 50 MG	5	PA
BALVERSA ORAL TABLET 3 MG, 4 MG, 5 MG	5	PA
BOSULIF ORAL CAPSULE 100 MG, 50 MG	5	PA
BOSULIF ORAL TABLET 100 MG, 400 MG, 500 MG	5	PA
BRAFTOVI ORAL CAPSULE 75 MG	5	PA
BRUKINSA ORAL CAPSULE 80 MG	5	PA
CABOMETYX ORAL TABLET 20 MG, 40 MG, 60 MG	5	PA
CALQUENCE ORAL CAPSULE 100 MG	5	PA

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<b>Name of Drug</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
CALQUENCE ORAL TABLET 100 MG	5	PA
CAPRELSA ORAL TABLET 100 MG, 300 MG	5	PA
COMETRIQ (100 MG DAILY DOSE) ORAL KIT 80 & 20 MG	5	PA
COMETRIQ (140 MG DAILY DOSE) ORAL KIT 3 X 20 MG & 80 MG	5	PA
COMETRIQ (60 MG DAILY DOSE) ORAL KIT 20 MG	5	PA
COPIKTRA ORAL CAPSULE 15 MG, 25 MG	5	PA
COTELLIC ORAL TABLET 20 MG	5	PA
DAURISMO ORAL TABLET 100 MG, 25 MG	5	PA
ERIVEDGE ORAL CAPSULE 150 MG	5	PA
<i>erlotinib hcl oral tablet 100 mg, 150 mg, 25 mg</i>	5	PA
<i>everolimus oral tablet 10 mg, 2.5 mg, 5 mg, 7.5 mg</i>	5	PA
<i>everolimus oral tablet soluble 2 mg, 3 mg, 5 mg</i>	5	PA
EXKIVITY ORAL CAPSULE 40 MG	5	PA
FOTIVDA ORAL CAPSULE 0.89 MG, 1.34 MG	5	PA
FRUZAQLA ORAL CAPSULE 1 MG, 5 MG	5	PA
GAVRETO ORAL CAPSULE 100 MG	5	PA
<i>gefitinib oral tablet 250 mg</i>	5	PA
GILOTRIF ORAL TABLET 20 MG, 30 MG, 40 MG	5	PA
IBRANCE ORAL CAPSULE 100 MG, 125 MG, 75 MG	5	PA
IBRANCE ORAL TABLET 100 MG, 125 MG, 75 MG	5	PA
ICLUSIG ORAL TABLET 10 MG, 15 MG, 30 MG, 45 MG	5	PA

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<b>Name of Drug</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>imatinib mesylate oral tablet 100 mg, 400 mg</i>	2	PA
IMBRUVICA ORAL CAPSULE 140 MG, 70 MG	5	PA
IMBRUVICA ORAL SUSPENSION 70 MG/ML	5	PA
IMBRUVICA ORAL TABLET 140 MG, 280 MG, 420 MG, 560 MG	5	PA
INLYTA ORAL TABLET 1 MG, 5 MG	5	PA
INREBIC ORAL CAPSULE 100 MG	5	PA
JAKAFI ORAL TABLET 10 MG, 15 MG, 20 MG, 25 MG, 5 MG	5	PA
JAYPIRCA ORAL TABLET 100 MG, 50 MG	5	PA
KISQALI (200 MG DOSE) ORAL TABLET THERAPY PACK 200 MG	5	PA
KISQALI (400 MG DOSE) ORAL TABLET THERAPY PACK 200 MG	5	PA
KISQALI (600 MG DOSE) ORAL TABLET THERAPY PACK 200 MG	5	PA
KOSELUGO ORAL CAPSULE 10 MG, 25 MG	5	PA
<i>lapatinib ditosylate oral tablet 250 mg</i>	5	PA
LENVIMA (10 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 10 MG	5	PA
LENVIMA (12 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 3 X 4 MG	5	PA
LENVIMA (14 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 10 & 4 MG	5	PA
LENVIMA (18 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 10 MG & 2 X 4 MG	5	PA
LENVIMA (20 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 2 X 10 MG	5	PA
LENVIMA (24 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 2 X 10 MG & 4 MG	5	PA

\*We provide additional coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-9.

<b>Name of Drug</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
LENVIMA (4 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 4 MG	5	PA
LENVIMA (8 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 2 X 4 MG	5	PA
LORBRENA ORAL TABLET 100 MG, 25 MG	5	PA
LYNPARZA ORAL TABLET 100 MG, 150 MG	5	PA
LYTGOBI (12 MG DAILY DOSE) ORAL TABLET THERAPY PACK 4 MG	5	PA
LYTGOBI (16 MG DAILY DOSE) ORAL TABLET THERAPY PACK 4 MG	5	PA
LYTGOBI (20 MG DAILY DOSE) ORAL TABLET THERAPY PACK 4 MG	5	PA
MEKINIST ORAL SOLUTION RECONSTITUTED 0.05 MG/ML	5	PA
MEKINIST ORAL TABLET 0.5 MG, 2 MG	5	PA
MEKTOVI ORAL TABLET 15 MG	5	PA
NERLYNX ORAL TABLET 40 MG	5	PA
ODOMZO ORAL CAPSULE 200 MG	5	PA
OGSIVEO ORAL TABLET 50 MG	5	PA
<i>pazopanib hcl oral tablet 200 mg</i>	5	PA
PEMAZYRE ORAL TABLET 13.5 MG, 4.5 MG, 9 MG	5	PA
PIQRAY (200 MG DAILY DOSE) ORAL TABLET THERAPY PACK 200 MG	5	PA
PIQRAY (250 MG DAILY DOSE) ORAL TABLET THERAPY PACK 200 & 50 MG	5	PA
PIQRAY (300 MG DAILY DOSE) ORAL TABLET THERAPY PACK 2 X 150 MG	5	PA
QINLOCK ORAL TABLET 50 MG	5	PA
RETEVMO ORAL CAPSULE 40 MG, 80 MG	5	PA
ROZLYTREK ORAL CAPSULE 100 MG, 200 MG	5	PA
ROZLYTREK ORAL PACKET 50 MG	5	PA

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<b>Name of Drug</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
RUBRACA ORAL TABLET 200 MG, 250 MG, 300 MG	5	PA
RYDAPT ORAL CAPSULE 25 MG	5	PA
SCEMBLIX ORAL TABLET 20 MG, 40 MG	5	PA
<i>sorafenib tosylate oral tablet 200 mg</i>	5	PA
SPRYCEL ORAL TABLET 100 MG, 140 MG, 20 MG, 50 MG, 70 MG, 80 MG	5	PA
STIVARGA ORAL TABLET 40 MG	5	PA
<i>sunitinib malate oral capsule 12.5 mg, 25 mg, 37.5 mg, 50 mg</i>	5	PA
TABRECTA ORAL TABLET 150 MG, 200 MG	5	PA
TAFINLAR ORAL CAPSULE 50 MG, 75 MG	5	PA
TAFINLAR ORAL TABLET SOLUBLE 10 MG	5	PA
TAGRISSE ORAL TABLET 40 MG, 80 MG	5	PA
TALZENNA ORAL CAPSULE 0.1 MG, 0.25 MG, 0.35 MG, 0.5 MG, 0.75 MG, 1 MG	5	PA
TASIGNA ORAL CAPSULE 150 MG, 200 MG, 50 MG	5	PA
TAZVERIK ORAL TABLET 200 MG	5	PA
TEPMETKO ORAL TABLET 225 MG	5	PA
TRUQAP ORAL TABLET 160 MG, 200 MG	5	PA
TRUSELTIQ (100MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 100 MG	5	PA
TRUSELTIQ (125MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 100 & 25 MG	5	PA
TRUSELTIQ (50MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 25 MG	5	PA
TRUSELTIQ (75MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 25 MG	5	PA
TUKYSA ORAL TABLET 150 MG, 50 MG	5	PA
TURALIO ORAL CAPSULE 125 MG, 200 MG	5	PA

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<b>Name of Drug</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
VANFLYTA ORAL TABLET 17.7 MG, 26.5 MG	5	PA
VENCLEXTA ORAL TABLET 10 MG	4	PA
VENCLEXTA ORAL TABLET 100 MG, 50 MG	5	PA
VENCLEXTA STARTING PACK ORAL TABLET THERAPY PACK 10 & 50 & 100 MG	5	PA
VERZENIO ORAL TABLET 100 MG, 150 MG, 200 MG, 50 MG	5	PA
VIJOICE ORAL TABLET THERAPY PACK 125 MG, 200 & 50 MG, 50 MG	5	PA
VITRAKVI ORAL CAPSULE 100 MG, 25 MG	5	PA
VITRAKVI ORAL SOLUTION 20 MG/ML	5	PA
VIZIMPRO ORAL TABLET 15 MG, 30 MG, 45 MG	5	PA
VONJO ORAL CAPSULE 100 MG	5	PA
XALKORI ORAL CAPSULE 200 MG, 250 MG	5	PA
XALKORI ORAL CAPSULE SPRINKLE 150 MG, 20 MG, 50 MG	5	PA
XOSPATA ORAL TABLET 40 MG	5	PA
ZEJULA ORAL CAPSULE 100 MG	5	PA
ZEJULA ORAL TABLET 100 MG, 200 MG, 300 MG	5	PA
ZELBORAF ORAL TABLET 240 MG	5	PA
ZYDELIG ORAL TABLET 100 MG, 150 MG	5	PA
ZYKADIA ORAL TABLET 150 MG	5	PA
<b>Retinoids</b>		
<i>bexarotene external gel 1 %</i>	5	PA
<i>bexarotene oral capsule 75 mg</i>	5	PA
PANRETIN EXTERNAL GEL 0.1 %	5	PA
<i>tretinoin oral capsule 10 mg</i>	5	PA

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Name of Drug	Drug Tier	Requirements/Limits
<b>Treatment Adjuncts</b>		
<i>leucovorin calcium oral tablet 10 mg, 15 mg, 25 mg, 5 mg</i>	2	
MESNEX ORAL TABLET 400 MG	4	
<b>Antiparasitics - Treatment Of Infections From Parasites</b>		
<b>Anthelmintics</b>		
<i>albendazole oral tablet 200 mg</i>	2	
<i>ivermectin oral tablet 3 mg*</i>	1	
<i>praziquantel oral tablet 600 mg</i>	2	
<b>Antiprotozoals</b>		
<i>atovaquone oral suspension 750 mg/5 ml</i>	2	
<i>atovaquone-proguanil hcl oral tablet 250-100 mg, 62.5-25 mg</i>	2	
<i>chloroquine phosphate oral tablet 250 mg, 500 mg</i>	2	
COARTEM ORAL TABLET 20-120 MG	4	
<i>hydroxychloroquine sulfate oral tablet 100 mg, 200 mg, 300 mg, 400 mg*</i>	1	
<i>mefloquine hcl oral tablet 250 mg</i>	2	
<i>nitazoxanide oral tablet 500 mg</i>	4	
<i>pentamidine isethionate inhalation solution reconstituted 300 mg</i>	2	B/D
<i>pentamidine isethionate injection solution reconstituted 300 mg</i>	4	PA
<i>primaquine phosphate oral tablet 26.3 (15 base) mg</i>	2	
<i>pyrimethamine oral tablet 25 mg</i>	5	QL (90 EA per 30 days)
<i>quinine sulfate oral capsule 324 mg</i>	2	
<b>Antiparkinson Agents - Treatment Of Parkinson's Disease</b>		
<b>Anticholinergics</b>		
<i>benztropine mesylate oral tablet 0.5 mg, 1 mg, 2 mg*</i>	1	

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<b>Name of Drug</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>trihexyphenidyl hcl oral solution</i> 0.4 mg/ml	2	PA
<i>trihexyphenidyl hcl oral tablet</i> 2 mg, 5 mg*	1	PA
<b>Antiparkinson Agents, Other</b>		
<i>amantadine hcl oral capsule</i> 100 mg*	1	
<i>amantadine hcl oral solution</i> 50 mg/5 ml*	1	
<i>amantadine hcl oral tablet</i> 100 mg*	1	
<i>carbidopa-levodopa-entacapone oral</i> <i>tablet</i> 12.5-50-200 mg, 18.75-75-200 mg, 25-100-200 mg, 31.25-125-200 mg, 37.5-150-200 mg, 50-200-200 mg	2	
<i>entacapone oral tablet</i> 200 mg	2	
GOCOVRI ORAL CAPSULE EXTENDED RELEASE 24 HOUR 137 MG, 68.5 MG	5	PA
ONGENTYS ORAL CAPSULE 25 MG, 50 MG	4	ST
<b>Dopamine Agonists</b>		
<i>apomorphine hcl subcutaneous</i> <i>solution cartridge</i> 30 mg/3 ml	5	PA
<i>bromocriptine mesylate oral capsule</i> 5 mg	2	
<i>bromocriptine mesylate oral tablet</i> 2.5 mg	2	
NEUPRO TRANSDERMAL PATCH 24 HOUR 1 MG/24 HR, 2 MG/24 HR, 3 MG/24 HR, 4 MG/24 HR, 6 MG/24 HR, 8 MG/24 HR	4	
<i>pramipexole dihydrochloride er oral</i> <i>tablet extended release 24 hour</i> 0.375 mg, 0.75 mg, 1.5 mg, 2.25 mg, 3 mg, 3.75 mg, 4.5 mg	2	
<i>pramipexole dihydrochloride oral tablet</i> 0.125 mg, 0.25 mg, 0.5 mg, 0.75 mg, 1 mg, 1.5 mg*	1	

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<b>Name of Drug</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>ropinirole hcl er oral tablet extended release 24 hour 12 mg, 2 mg, 4 mg, 6 mg, 8 mg</i>	2	
<i>ropinirole hcl oral tablet 0.25 mg, 0.5 mg, 1 mg, 2 mg, 3 mg, 4 mg, 5 mg*</i>	1	
<b>Dopamine Precursors And/Or L-Amino Acid Decarboxylase Inhibitors</b>		
<i>carbidopa oral tablet 25 mg</i>	2	
<i>carbidopa-levodopa er oral tablet extended release 25-100 mg, 50-200 mg*</i>	1	
<i>carbidopa-levodopa oral tablet 10-100 mg, 25-100 mg, 25-250 mg*</i>	1	
<i>carbidopa-levodopa oral tablet dispersible 10-100 mg, 25-100 mg, 25-250 mg*</i>	1	
<b>Monoamine Oxidase B (MAO-B) Inhibitors</b>		
<i>rasagiline mesylate oral tablet 0.5 mg, 1 mg</i>	2	
<i>selegiline hcl oral capsule 5 mg</i>	2	
<i>selegiline hcl oral tablet 5 mg</i>	2	
<b>Antipsychotics - Treatment Of Behavioral And Emotional Disorders</b>		
<b>1st Generation/Typical</b>		
<i>fluphenazine decanoate injection solution 25 mg/ml</i>	2	
<i>fluphenazine hcl injection solution 2.5 mg/ml</i>	4	
<i>fluphenazine hcl oral concentrate 5 mg/ml</i>	2	
<i>fluphenazine hcl oral elixir 2.5 mg/5 ml</i>	2	
<i>fluphenazine hcl oral tablet 1 mg, 10 mg, 2.5 mg, 5 mg</i>	2	
<i>haloperidol decanoate intramuscular solution 100 mg/ml, 100 mg/ml (1 ml), 50 mg/ml, 50 mg/ml (1 ml)</i>	2	
<i>haloperidol lactate injection solution 5 mg/ml</i>	2	

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<b>Name of Drug</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>haloperidol lactate oral concentrate 2 mg/ml*</i>	1	
<i>haloperidol oral tablet 0.5 mg, 1 mg, 10 mg, 2 mg, 20 mg, 5 mg*</i>	1	
<i>loxapine succinate oral capsule 10 mg, 25 mg, 5 mg, 50 mg</i>	2	
<i>molindone hcl oral tablet 10 mg, 25 mg, 5 mg</i>	4	
<i>pimozide oral tablet 1 mg, 2 mg</i>	2	
<i>thioridazine hcl oral tablet 10 mg, 100 mg, 25 mg, 50 mg</i>	2	
<i>thiothixene oral capsule 1 mg, 10 mg, 2 mg, 5 mg</i>	2	
<i>trifluoperazine hcl oral tablet 1 mg, 10 mg, 2 mg, 5 mg</i>	2	
<b>2nd Generation/Atypical</b>		
ABILIFY ASIMTUFII INTRAMUSCULAR PREFILLED SYRINGE 720 MG/2.4 ML, 960 MG/3.2 ML	5	PA
ABILIFY MAINTENA INTRAMUSCULAR PREFILLED SYRINGE 300 MG, 400 MG	4	QL (1 EA per 28 days)
ABILIFY MAINTENA INTRAMUSCULAR SUSPENSION RECONSTITUTED ER 300 MG, 400 MG	4	QL (1 EA per 28 days)
<i>aripiprazole oral solution 1 mg/ml</i>	2	QL (750 ML per 30 days)
<i>aripiprazole oral tablet 10 mg, 15 mg, 2 mg, 20 mg, 30 mg, 5 mg</i>	2	QL (30 EA per 30 days)
<i>aripiprazole oral tablet dispersible 10 mg, 15 mg</i>	4	QL (60 EA per 30 days)
ARISTADA INITIO INTRAMUSCULAR PREFILLED SYRINGE 675 MG/2.4 ML	5	PA
ARISTADA INTRAMUSCULAR PREFILLED SYRINGE 1064 MG/3.9 ML	5	PA; QL (3.9 ML per 56 days)
ARISTADA INTRAMUSCULAR PREFILLED SYRINGE 441 MG/1.6 ML	5	PA; QL (1.6 ML per 28 days)

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<b>Name of Drug</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
ARISTADA INTRAMUSCULAR PREFILLED SYRINGE 662 MG/2.4 ML	5	PA; QL (2.4 ML per 28 days)
ARISTADA INTRAMUSCULAR PREFILLED SYRINGE 882 MG/3.2 ML	5	PA; QL (3.2 ML per 28 days)
<i>asenapine maleate sublingual tablet sublingual 10 mg, 2.5 mg, 5 mg</i>	2	QL (60 EA per 30 days)
CAPLYTA ORAL CAPSULE 10.5 MG, 21 MG, 42 MG	5	PA
FANAPT ORAL TABLET 1 MG, 10 MG, 12 MG, 2 MG, 4 MG, 6 MG, 8 MG	5	PA; QL (60 EA per 30 days)
FANAPT TITRATION PACK ORAL TABLET 1 & 2 & 4 & 6 MG	4	PA
INVEGA SUSTENNA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 117 MG/0.75 ML	5	PA; QL (0.75 ML per 28 days)
INVEGA SUSTENNA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 156 MG/ML	5	PA; QL (1 ML per 28 days)
INVEGA SUSTENNA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 234 MG/1.5 ML	5	PA; QL (1.5 ML per 28 days)
INVEGA SUSTENNA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 39 MG/0.25 ML	4	PA; QL (0.25 ML per 28 days)
INVEGA SUSTENNA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 78 MG/0.5 ML	5	PA; QL (0.5 ML per 28 days)
INVEGA TRINZA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 273 MG/0.88 ML	5	PA; QL (0.88 ML per 84 days)
INVEGA TRINZA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 410 MG/1.32 ML	5	PA; QL (1.32 ML per 84 days)
INVEGA TRINZA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 546 MG/1.75 ML	5	PA; QL (1.75 ML per 84 days)

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<b>Name of Drug</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
INVEGA TRINZA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 819 MG/2.63 ML	5	PA; QL (2.63 ML per 84 days)
<i>lurasidone hcl oral tablet 120 mg, 20 mg, 40 mg, 60 mg</i>	2	QL (30 EA per 30 days)
<i>lurasidone hcl oral tablet 80 mg</i>	2	QL (60 EA per 30 days)
LYBALVI ORAL TABLET 10-10 MG, 15-10 MG, 20-10 MG, 5-10 MG	5	PA
NUPLAZID ORAL CAPSULE 34 MG	5	PA; QL (30 EA per 30 days)
NUPLAZID ORAL TABLET 10 MG	5	PA; QL (30 EA per 30 days)
<i>olanzapine intramuscular solution reconstituted 10 mg</i>	4	QL (90 EA per 30 days)
<i>olanzapine oral tablet 10 mg, 15 mg, 2.5 mg, 20 mg, 5 mg, 7.5 mg*</i>	1	QL (30 EA per 30 days)
<i>olanzapine oral tablet dispersible 10 mg, 15 mg, 20 mg, 5 mg</i>	2	QL (30 EA per 30 days)
<i>paliperidone er oral tablet extended release 24 hour 1.5 mg, 3 mg, 9 mg</i>	2	PA; QL (30 EA per 30 days)
<i>paliperidone er oral tablet extended release 24 hour 6 mg</i>	2	PA; QL (60 EA per 30 days)
PERSERIS SUBCUTANEOUS PREFILLED SYRINGE 120 MG, 90 MG	5	PA; QL (1 EA per 28 days)
<i>quetiapine fumarate er oral tablet extended release 24 hour 150 mg, 200 mg</i>	2	QL (30 EA per 30 days)
<i>quetiapine fumarate er oral tablet extended release 24 hour 300 mg, 400 mg, 50 mg</i>	2	QL (60 EA per 30 days)
<i>quetiapine fumarate oral tablet 100 mg, 150 mg, 200 mg, 300 mg, 400 mg*</i>	1	QL (60 EA per 30 days)
<i>quetiapine fumarate oral tablet 25 mg, 50 mg*</i>	1	QL (90 EA per 30 days)
REXULTI ORAL TABLET 0.25 MG, 0.5 MG, 1 MG, 2 MG, 3 MG, 4 MG	5	PA; QL (30 EA per 30 days)

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<b>Name of Drug</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
RISPERDAL CONSTA INTRAMUSCULAR SUSPENSION RECONSTITUTED ER 12.5 MG	4	PA; QL (2 EA per 28 days)
RISPERDAL CONSTA INTRAMUSCULAR SUSPENSION RECONSTITUTED ER 25 MG, 37.5 MG, 50 MG	5	PA; QL (2 EA per 28 days)
<i>risperidone microspheres er intramuscular suspension reconstituted er 12.5 mg, 25 mg, 37.5 mg, 50 mg</i>	4	PA; QL (2 EA per 28 days)
<i>risperidone oral solution 1 mg/ml</i>	2	QL (480 ML per 30 days)
<i>risperidone oral tablet 0.25 mg, 0.5 mg, 1 mg, 2 mg*</i>	1	QL (60 EA per 30 days)
<i>risperidone oral tablet 3 mg, 4 mg*</i>	1	QL (120 EA per 30 days)
<i>risperidone oral tablet dispersible 0.25 mg, 0.5 mg, 1 mg, 2 mg</i>	2	QL (60 EA per 30 days)
<i>risperidone oral tablet dispersible 3 mg, 4 mg</i>	2	QL (120 EA per 30 days)
RYKINDO INTRAMUSCULAR SUSPENSION RECONSTITUTED ER 25 MG, 37.5 MG, 50 MG	5	PA
SECUADO TRANSDERMAL PATCH 24 HOUR 3.8 MG/24 HR, 5.7 MG/24 HR, 7.6 MG/24 HR	5	PA; QL (30 EA per 30 days)
UZEDY SUBCUTANEOUS SUSPENSION PREFILLED SYRINGE 100 MG/0.28 ML, 125 MG/0.35 ML, 150 MG/0.42 ML, 200 MG/0.56 ML, 250 MG/0.7 ML, 50 MG/0.14 ML, 75 MG/0.21 ML	5	PA
VRAYLAR ORAL CAPSULE 1.5 MG, 3 MG, 4.5 MG, 6 MG	5	PA; QL (30 EA per 30 days)
VRAYLAR ORAL CAPSULE THERAPY PACK 1.5 & 3 MG	4	PA; QL (14 EA per 365 days)
<i>ziprasidone hcl oral capsule 20 mg, 40 mg, 60 mg, 80 mg</i>	2	QL (60 EA per 30 days)
<i>ziprasidone mesylate intramuscular solution reconstituted 20 mg</i>	2	QL (6 EA per 3 days)

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<b>Name of Drug</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
ZYPREXA RELPREVV INTRAMUSCULAR SUSPENSION RECONSTITUTED 210 MG, 300 MG	5	PA; QL (2 EA per 28 days)
ZYPREXA RELPREVV INTRAMUSCULAR SUSPENSION RECONSTITUTED 405 MG	5	PA; QL (1 EA per 28 days)
<b>Treatment-Resistant</b>		
<i>clozapine oral tablet 100 mg</i>	2	QL (270 EA per 30 days)
<i>clozapine oral tablet 200 mg</i>	2	QL (120 EA per 30 days)
<i>clozapine oral tablet 25 mg, 50 mg</i>	2	QL (90 EA per 30 days)
<i>clozapine oral tablet dispersible 100 mg</i>	2	QL (270 EA per 30 days)
<i>clozapine oral tablet dispersible 12.5 mg</i>	2	
<i>clozapine oral tablet dispersible 150 mg</i>	2	QL (180 EA per 30 days)
<i>clozapine oral tablet dispersible 200 mg</i>	2	QL (120 EA per 30 days)
<i>clozapine oral tablet dispersible 25 mg</i>	2	QL (90 EA per 30 days)
VERSACLOZ ORAL SUSPENSION 50 MG/ML	4	QL (540 ML per 30 days)
<b>Antispasticity Agents - Treatment Of Muscle Spasms</b>		
<b>Antispasticity Agents</b>		
<i>baclofen oral tablet 10 mg, 20 mg, 5 mg*</i>	1	
<i>dantrolene sodium oral capsule 100 mg, 25 mg, 50 mg</i>	2	
<i>tizanidine hcl oral tablet 2 mg, 4 mg*</i>	1	
<b>Antivirals - Treatment Of Infections By Viruses</b>		
<b>Anti-Cytomegalovirus (CMV) Agents</b>		
PREVYMIS ORAL TABLET 240 MG, 480 MG	5	PA
<i>valganciclovir hcl oral solution reconstituted 50 mg/ml</i>	5	
<i>valganciclovir hcl oral tablet 450 mg</i>	2	
<b>Anti-Hepatitis B (HBV) Agents</b>		
<i>adefovir dipivoxil oral tablet 10 mg</i>	4	QL (30 EA per 30 days)

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<b>Name of Drug</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
BARACLUDE ORAL SOLUTION 0.05 MG/ML	4	
<i>entecavir oral tablet 0.5 mg, 1 mg</i>	2	
EPIVIR HBV ORAL SOLUTION 5 MG/ML	4	
<i>lamivudine oral solution 10 mg/ml</i>	2	QL (960 ML per 30 days)
<i>lamivudine oral tablet 100 mg, 300 mg</i>	2	QL (30 EA per 30 days)
<i>lamivudine oral tablet 150 mg</i>	2	QL (60 EA per 30 days)
<i>tenofovir disoproxil fumarate oral tablet 300 mg</i>	2	QL (30 EA per 30 days)
VEMLIDY ORAL TABLET 25 MG	5	PA
VIREAD ORAL POWDER 40 MG/GM	5	QL (240 GM per 30 days)
VIREAD ORAL TABLET 150 MG, 200 MG, 250 MG	5	QL (30 EA per 30 days)
<b>Anti-Hepatitis C (HCV) Agents</b>		
MAVYRET ORAL PACKET 50-20 MG	5	PA
MAVYRET ORAL TABLET 100-40 MG	5	PA
<i>ribavirin oral capsule 200 mg</i>	2	
<i>ribavirin oral tablet 200 mg</i>	2	
<i>sofosbuvir-velpatasvir oral tablet 400-100 mg</i>	5	PA
VOSEVI ORAL TABLET 400-100-100 MG	5	PA
<b>Antiherpetic Agents</b>		
<i>acyclovir oral capsule 200 mg*</i>	1	
<i>acyclovir oral suspension 200 mg/5 ml*</i>	1	
<i>acyclovir oral tablet 400 mg, 800 mg*</i>	1	
<i>acyclovir sodium intravenous solution 50 mg/ml</i>	2	B/D
<i>famciclovir oral tablet 125 mg, 250 mg, 500 mg</i>	2	
<i>trifluridine ophthalmic solution 1 %</i>	2	
<i>valacyclovir hcl oral tablet 1 gm, 500 mg</i>	2	
<b>Anti-HIV Agents, Integrase Inhibitors (INSTI)</b>		
ISENTRRESS HD ORAL TABLET 600 MG	5	QL (60 EA per 30 days)

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<b>Name of Drug</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
ISENTRESS ORAL PACKET 100 MG	4	QL (60 EA per 30 days)
ISENTRESS ORAL TABLET 400 MG	5	QL (120 EA per 30 days)
ISENTRESS ORAL TABLET CHEWABLE 100 MG, 25 MG	4	QL (180 EA per 30 days)
TIVICAY ORAL TABLET 10 MG	4	QL (120 EA per 30 days)
TIVICAY ORAL TABLET 25 MG	5	QL (30 EA per 30 days)
TIVICAY ORAL TABLET 50 MG	5	QL (60 EA per 30 days)
TIVICAY PD ORAL TABLET SOLUBLE 5 MG	4	QL (180 EA per 30 days)
VOCABRIA ORAL TABLET 30 MG	4	QL (30 EA per 30 days)
<b>Anti-HIV Agents, Non-Nucleoside Reverse Transcriptase Inhibitors (NNRTI)</b>		
EDURANT ORAL TABLET 25 MG	5	QL (60 EA per 30 days)
<i>efavirenz oral capsule 200 mg</i>	2	QL (120 EA per 30 days)
<i>efavirenz oral capsule 50 mg</i>	2	QL (180 EA per 30 days)
<i>efavirenz oral tablet 600 mg</i>	2	QL (30 EA per 30 days)
<i>etravirine oral tablet 100 mg</i>	2	QL (120 EA per 30 days)
<i>etravirine oral tablet 200 mg</i>	5	QL (60 EA per 30 days)
INTELENCE ORAL TABLET 25 MG	4	QL (120 EA per 30 days)
<i>nevirapine er oral tablet extended release 24 hour 400 mg</i>	2	QL (30 EA per 30 days)
<i>nevirapine oral suspension 50 mg/5 ml</i>	2	QL (1200 ML per 30 days)
<i>nevirapine oral tablet 200 mg*</i>	1	QL (60 EA per 30 days)
PIFELTRO ORAL TABLET 100 MG	5	QL (30 EA per 30 days)
<b>Anti-HIV Agents, Nucleoside And Nucleotide Reverse Transcriptase Inhibitors (NRTI)</b>		
<i>abacavir sulfate oral solution 20 mg/ml</i>	2	QL (960 ML per 30 days)
<i>abacavir sulfate oral tablet 300 mg</i>	2	QL (60 EA per 30 days)
<i>abacavir sulfate-lamivudine oral tablet 600-300 mg</i>	2	QL (30 EA per 30 days)
CIMDUO ORAL TABLET 300-300 MG	5	QL (30 EA per 30 days)
DESCOVY ORAL TABLET 120-15 MG, 200-25 MG	5	QL (30 EA per 30 days)
<i>emtricitabine oral capsule 200 mg</i>	2	QL (30 EA per 30 days)

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<b>Name of Drug</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>emtricitabine-tenofovir df oral tablet 100-150 mg, 133-200 mg, 167-250 mg, 200-300 mg*</i>	1	QL (30 EA per 30 days)
EMTRIVA ORAL SOLUTION 10 MG/ML	4	
<i>lamivudine-zidovudine oral tablet 150-300 mg</i>	2	QL (60 EA per 30 days)
TRIZIVIR ORAL TABLET 300-150-300 MG	5	QL (60 EA per 30 days)
<i>zidovudine oral capsule 100 mg</i>	2	QL (180 EA per 30 days)
<i>zidovudine oral syrup 50 mg/5 ml</i>	2	QL (1920 ML per 30 days)
<i>zidovudine oral tablet 300 mg</i>	2	QL (60 EA per 30 days)
<b>Anti-HIV Agents, Other</b>		
BIKTARVY ORAL TABLET 30-120-15 MG, 50-200-25 MG	5	QL (30 EA per 30 days)
COMPLERA ORAL TABLET 200-25-300 MG	5	QL (30 EA per 30 days)
DELSTRIGO ORAL TABLET 100-300-300 MG	5	QL (30 EA per 30 days)
DOVATO ORAL TABLET 50-300 MG	5	QL (30 EA per 30 days)
<i>efavirenz-emtricitab-tenofo df oral tablet 600-200-300 mg</i>	2	QL (30 EA per 30 days)
<i>efavirenz-lamivudine-tenofovir oral tablet 400-300-300 mg, 600-300-300 mg</i>	5	QL (30 EA per 30 days)
EVOTAZ ORAL TABLET 300-150 MG	5	QL (30 EA per 30 days)
FUZEON SUBCUTANEOUS SOLUTION RECONSTITUTED 90 MG	5	
GENVOYA ORAL TABLET 150-150-200-10 MG	5	QL (30 EA per 30 days)
JULUCA ORAL TABLET 50-25 MG	5	QL (30 EA per 30 days)
<i>maraviroc oral tablet 150 mg</i>	5	QL (60 EA per 30 days)
<i>maraviroc oral tablet 300 mg</i>	5	QL (120 EA per 30 days)
ODEFSEY ORAL TABLET 200-25-25 MG	5	QL (30 EA per 30 days)
PREZCOBIX ORAL TABLET 800-150 MG	5	QL (30 EA per 30 days)
RUKOBIA ORAL TABLET EXTENDED RELEASE 12 HOUR 600 MG	5	QL (60 EA per 30 days)

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<b>Name of Drug</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
SELZENTRY ORAL SOLUTION 20 MG/ML	3	QL (1840 ML per 30 days)
SELZENTRY ORAL TABLET 25 MG	3	QL (240 EA per 30 days)
SELZENTRY ORAL TABLET 75 MG	3	QL (120 EA per 30 days)
STRIBILD ORAL TABLET 150-150-200-300 MG	5	QL (30 EA per 30 days)
SUNLENCA ORAL TABLET THERAPY PACK 4 X 300 MG	5	QL (8 EA per 365 days)
SUNLENCA ORAL TABLET THERAPY PACK 5 X 300 MG	5	QL (10 EA per 365 days)
SUNLENCA SUBCUTANEOUS SOLUTION 463.5 MG/1.5 ML	5	QL (6 ML per 365 days)
SYMTUZA ORAL TABLET 800-150-200-10 MG	5	QL (30 EA per 30 days)
TRIUMEQ ORAL TABLET 600-50-300 MG	5	QL (30 EA per 30 days)
TRIUMEQ PD ORAL TABLET SOLUBLE 60-5-30 MG	2	QL (180 EA per 30 days)
TYBOST ORAL TABLET 150 MG	3	QL (30 EA per 30 days)
<b>Anti-HIV Agents, Protease Inhibitors (PI)</b>		
APTIVUS ORAL CAPSULE 250 MG	5	QL (120 EA per 30 days)
<i>atazanavir sulfate oral capsule 150 mg, 300 mg</i>	2	QL (30 EA per 30 days)
<i>atazanavir sulfate oral capsule 200 mg</i>	2	QL (60 EA per 30 days)
<i>darunavir oral tablet 600 mg</i>	2	QL (60 EA per 30 days)
<i>darunavir oral tablet 800 mg</i>	5	QL (30 EA per 30 days)
<i>fosamprenavir calcium oral tablet 700 mg</i>	5	QL (120 EA per 30 days)
LEXIVA ORAL SUSPENSION 50 MG/ML	4	
<i>lopinavir-ritonavir oral solution 400-100 mg/5ml</i>	2	QL (390 ML per 30 days)
<i>lopinavir-ritonavir oral tablet 100-25 mg</i>	2	QL (300 EA per 30 days)
<i>lopinavir-ritonavir oral tablet 200-50 mg</i>	2	QL (120 EA per 30 days)
NORVIR ORAL PACKET 100 MG	4	QL (360 EA per 30 days)

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<b>Name of Drug</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
PREZISTA ORAL SUSPENSION 100 MG/ML	5	QL (400 ML per 30 days)
PREZISTA ORAL TABLET 150 MG	4	QL (180 EA per 30 days)
PREZISTA ORAL TABLET 75 MG	4	QL (300 EA per 30 days)
REYATAZ ORAL PACKET 50 MG	4	
<i>ritonavir oral tablet 100 mg</i>	2	QL (360 EA per 30 days)
VIRACEPT ORAL TABLET 250 MG	5	QL (300 EA per 30 days)
VIRACEPT ORAL TABLET 625 MG	5	QL (120 EA per 30 days)
<b>Anti-Influenza Agents</b>		
<i>oseltamivir phosphate oral capsule 30 mg</i>	2	QL (84 EA per 180 days)
<i>oseltamivir phosphate oral capsule 45 mg, 75 mg</i>	2	QL (42 EA per 180 days)
<i>oseltamivir phosphate oral suspension reconstituted 6 mg/ml</i>	2	QL (540 ML per 180 days)
RELENZA DISKHALER INHALATION AEROSOL POWDER BREATH ACTIVATED 5 MG/ACT	4	QL (60 EA per 180 days)
<i>rimantadine hcl oral tablet 100 mg</i>	2	
<b>Antivirals</b>		
LAGEVRIO ORAL CAPSULE 200 MG*	1	QL (40 EA per 5 days)
PAXLOVID (150/100) ORAL TABLET THERAPY PACK 10 X 150 MG & 10 X 100 MG*	1	QL (20 EA per 5 days)
PAXLOVID (300/100) ORAL TABLET THERAPY PACK 20 X 150 MG & 10 X 100 MG*	1	QL (30 EA per 5 days)
<b>Anxiolytics - Treatment Of Anxiety Or Nervousness</b>		
<b>Anxiolytics, Other</b>		
<i>buspirone hcl oral tablet 10 mg, 15 mg, 30 mg, 5 mg, 7.5 mg*</i>	1	
<i>hydroxyzine pamoate oral capsule 100 mg, 25 mg, 50 mg</i>	2	

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Name of Drug	Drug Tier	Requirements/Limits
<b>Benzodiazepines</b>		
ALPRAZOLAM INTENSOL ORAL CONCENTRATE 1 MG/ML	2	QL (300 ML per 30 days)
<i>alprazolam oral tablet 0.25 mg, 0.5 mg, 1 mg</i>	2	QL (120 EA per 30 days)
<i>alprazolam oral tablet 2 mg</i>	2	QL (150 EA per 30 days)
<i>clonazepam oral tablet 0.5 mg, 1 mg</i>	2	QL (90 EA per 30 days)
<i>clonazepam oral tablet 2 mg</i>	2	QL (300 EA per 30 days)
<i>clonazepam oral tablet dispersible 0.125 mg, 0.25 mg, 0.5 mg, 1 mg</i>	2	QL (90 EA per 30 days)
<i>clonazepam oral tablet dispersible 2 mg</i>	2	QL (300 EA per 30 days)
<i>clorazepate dipotassium oral tablet 15 mg</i>	2	QL (180 EA per 30 days)
<i>clorazepate dipotassium oral tablet 3.75 mg, 7.5 mg</i>	2	QL (90 EA per 30 days)
DIAZEPAM INTENSOL ORAL CONCENTRATE 5 MG/ML	2	QL (240 ML per 30 days)
<i>diazepam oral concentrate 5 mg/ml</i>	2	QL (240 ML per 30 days)
<i>diazepam oral solution 5 mg/5 ml</i>	2	QL (1200 ML per 30 days)
<i>diazepam oral tablet 10 mg, 2 mg, 5 mg</i>	2	QL (120 EA per 30 days)
LORAZEPAM INTENSOL ORAL CONCENTRATE 2 MG/ML	2	QL (150 ML per 30 days)
<i>lorazepam oral concentrate 2 mg/ml</i>	2	QL (150 ML per 30 days)
<i>lorazepam oral tablet 0.5 mg, 1 mg</i>	2	QL (90 EA per 30 days)
<i>lorazepam oral tablet 2 mg</i>	2	QL (150 EA per 30 days)
<b>Bipolar Agents - Treatment For Bipolar Illnesses</b>		
<b>Mood Stabilizers</b>		
EQUETRO ORAL CAPSULE EXTENDED RELEASE 12 HOUR 100 MG, 200 MG, 300 MG	4	
<i>lithium carbonate er oral tablet extended release 300 mg, 450 mg</i>	2	
<i>lithium carbonate oral capsule 150 mg, 300 mg, 600 mg</i>	2	

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<b>Name of Drug</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>lithium carbonate oral tablet 300 mg</i>	2	
<i>lithium oral solution 8 meq/5 ml</i>	2	
<b>Blood Glucose Regulators - Control Of Diabetes</b>		
<b>Antidiabetic Agents</b>		
<i>acarbose oral tablet 100 mg, 25 mg, 50 mg</i>	2	QL (90 EA per 30 days)
FARXIGA ORAL TABLET 10 MG, 5 MG	3	QL (30 EA per 30 days)
<i>glimepiride oral tablet 1 mg*</i>	1	QL (240 EA per 30 days)
<i>glimepiride oral tablet 2 mg*</i>	1	QL (120 EA per 30 days)
<i>glimepiride oral tablet 4 mg*</i>	1	QL (60 EA per 30 days)
<i>glipizide er oral tablet extended release 24 hour 10 mg*</i>	1	QL (60 EA per 30 days)
<i>glipizide er oral tablet extended release 24 hour 2.5 mg*</i>	1	QL (240 EA per 30 days)
<i>glipizide er oral tablet extended release 24 hour 5 mg*</i>	1	QL (120 EA per 30 days)
<i>glipizide oral tablet 10 mg*</i>	1	QL (120 EA per 30 days)
<i>glipizide oral tablet 2.5 mg*</i>	1	QL (60 EA per 30 days)
<i>glipizide oral tablet 5 mg*</i>	1	QL (240 EA per 30 days)
<i>glipizide xl oral tablet extended release 24 hour 10 mg*</i>	1	QL (60 EA per 30 days)
<i>glipizide xl oral tablet extended release 24 hour 2.5 mg*</i>	1	QL (240 EA per 30 days)
<i>glipizide xl oral tablet extended release 24 hour 5 mg*</i>	1	QL (120 EA per 30 days)
<i>glipizide-metformin hcl oral tablet 2.5-250 mg*</i>	1	QL (240 EA per 30 days)
<i>glipizide-metformin hcl oral tablet 2.5-500 mg, 5-500 mg*</i>	1	QL (120 EA per 30 days)
<i>glyburide micronized oral tablet 1.5 mg, 3 mg*</i>	1	PA; QL (90 EA per 30 days)
<i>glyburide micronized oral tablet 6 mg*</i>	1	PA; QL (60 EA per 30 days)
<i>glyburide oral tablet 1.25 mg, 2.5 mg*</i>	1	PA; QL (60 EA per 30 days)
<i>glyburide oral tablet 5 mg*</i>	1	PA; QL (120 EA per 30 days)

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<b>Name of Drug</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>glyburide-metformin oral tablet 1.25-250 mg</i>	2	PA; QL (240 EA per 30 days)
<i>glyburide-metformin oral tablet 2.5-500 mg, 5-500 mg</i>	2	PA; QL (120 EA per 30 days)
GLYXAMBI ORAL TABLET 10-5 MG, 25-5 MG	3	QL (30 EA per 30 days)
JANUMET ORAL TABLET 50-1000 MG, 50-500 MG	3	QL (60 EA per 30 days)
JANUMET XR ORAL TABLET EXTENDED RELEASE 24 HOUR 100-1000 MG	3	QL (30 EA per 30 days)
JANUMET XR ORAL TABLET EXTENDED RELEASE 24 HOUR 50-1000 MG, 50-500 MG	3	QL (60 EA per 30 days)
JANUVIA ORAL TABLET 100 MG, 25 MG, 50 MG	3	QL (30 EA per 30 days)
JARDIANCE ORAL TABLET 10 MG, 25 MG	3	QL (30 EA per 30 days)
JENTADUETO ORAL TABLET 2.5-1000 MG, 2.5-500 MG, 2.5-850 MG	3	QL (60 EA per 30 days)
JENTADUETO XR ORAL TABLET EXTENDED RELEASE 24 HOUR 2.5-1000 MG	3	QL (60 EA per 30 days)
JENTADUETO XR ORAL TABLET EXTENDED RELEASE 24 HOUR 5-1000 MG	3	QL (30 EA per 30 days)
<i>metformin hcl er oral tablet extended release 24 hour 500 mg*</i>	1	QL (120 EA per 30 days)
<i>metformin hcl er oral tablet extended release 24 hour 750 mg*</i>	1	QL (60 EA per 30 days)
<i>metformin hcl oral tablet 1000 mg*</i>	1	QL (75 EA per 30 days)
<i>metformin hcl oral tablet 500 mg*</i>	1	QL (150 EA per 30 days)
<i>metformin hcl oral tablet 850 mg*</i>	1	QL (90 EA per 30 days)
MOUNJARO SUBCUTANEOUS SOLUTION PEN-INJECTOR 10 MG/0.5 ML, 12.5 MG/0.5 ML, 15 MG/0.5 ML, 2.5 MG/0.5 ML, 5 MG/0.5 ML, 7.5 MG/0.5 ML	3	ST; QL (2 ML per 28 days)
<i>nateglinide oral tablet 120 mg, 60 mg</i>	2	QL (90 EA per 30 days)

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<b>Name of Drug</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
OZEMPIC (0.25 OR 0.5 MG/DOSE) SUBCUTANEOUS SOLUTION PEN- INJECTOR 2 MG/1.5 ML	3	ST; QL (1.5 ML per 28 days)
OZEMPIC (0.25 OR 0.5 MG/DOSE) SUBCUTANEOUS SOLUTION PEN- INJECTOR 2 MG/3 ML	3	ST; QL (3 ML per 28 days)
OZEMPIC (1 MG/DOSE) SUBCUTANEOUS SOLUTION PEN- INJECTOR 4 MG/3 ML	3	ST; QL (3 ML per 28 days)
OZEMPIC (2 MG/DOSE) SUBCUTANEOUS SOLUTION PEN- INJECTOR 8 MG/3 ML	3	ST; QL (3 ML per 28 days)
<i>pioglitazone hcl oral tablet 15 mg, 30 mg, 45 mg</i>	2	QL (30 EA per 30 days)
<i>pioglitazone hcl-metformin hcl oral tablet 15-500 mg, 15-850 mg</i>	2	QL (90 EA per 30 days)
<i>repaglinide oral tablet 0.5 mg, 1 mg</i>	2	QL (120 EA per 30 days)
<i>repaglinide oral tablet 2 mg</i>	2	QL (240 EA per 30 days)
RYBELSUS ORAL TABLET 14 MG, 3 MG, 7 MG	3	ST; QL (30 EA per 30 days)
SYMLINPEN 120 SUBCUTANEOUS SOLUTION PEN-INJECTOR 2700 MCG/2.7 ML	5	PA
SYMLINPEN 60 SUBCUTANEOUS SOLUTION PEN-INJECTOR 1500 MCG/1.5 ML	5	PA
SYNJARDY ORAL TABLET 12.5-1000 MG, 12.5-500 MG, 5-1000 MG, 5-500 MG	3	QL (60 EA per 30 days)
SYNJARDY XR ORAL TABLET EXTENDED RELEASE 24 HOUR 10-1000 MG, 12.5-1000 MG, 5-1000 MG	3	QL (60 EA per 30 days)
SYNJARDY XR ORAL TABLET EXTENDED RELEASE 24 HOUR 25-1000 MG	3	QL (30 EA per 30 days)
TRADJENTA ORAL TABLET 5 MG	3	QL (30 EA per 30 days)

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<b>Name of Drug</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
TRULICITY SUBCUTANEOUS SOLUTION PEN-INJECTOR 0.75 MG/0.5 ML, 1.5 MG/0.5 ML, 3 MG/0.5 ML, 4.5 MG/0.5 ML	3	ST; QL (2 ML per 28 days)
VICTOZA SUBCUTANEOUS SOLUTION PEN-INJECTOR 18 MG/3ML	3	ST; QL (9 ML per 30 days)
XIGDUO XR ORAL TABLET EXTENDED RELEASE 24 HOUR 10-1000 MG, 10-500 MG, 5-500 MG	3	QL (30 EA per 30 days)
XIGDUO XR ORAL TABLET EXTENDED RELEASE 24 HOUR 2.5-1000 MG, 5-1000 MG	3	QL (60 EA per 30 days)
<b>Glycemic Agents</b>		
BAQSIMI ONE PACK NASAL POWDER 3 MG/DOSE	3	QL (4 EA per 30 days)
BAQSIMI TWO PACK NASAL POWDER 3 MG/DOSE	3	QL (4 EA per 30 days)
<i>diazoxide oral suspension 50 mg/ml</i>	2	
GLUCAGEN HYPOKIT INJECTION SOLUTION RECONSTITUTED 1 MG	3	QL (4 EA per 30 days)
<i>glucagon emergency injection kit 1 mg</i>	3	QL (4 EA per 30 days)
<i>glucagon emergency injection solution reconstituted 1 mg/ml</i>	3	QL (4 EA per 30 days)
KORLYM ORAL TABLET 300 MG	5	PA
<i>mifepristone oral tablet 300 mg</i>	5	PA
<b>Insulins</b>		
ADMELOG INJECTION SOLUTION 100 UNIT/ML	3	
ADMELOG SOLOSTAR SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML	3	
AFREZZA INHALATION POWDER 12 UNIT, 4 UNIT, 60 X 4 & 60 X 8 & 60 X 12 UNIT, 8 UNIT, 90 X 4 UNIT & 90 X 8 UNIT, 90 X 8 UNIT & 90 X 12 UNIT	3	
APIDRA INJECTION SOLUTION 100 UNIT/ML	3	

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<b>Name of Drug</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
APIDRA SOLOSTAR SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML	3	
BASAGLAR KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML	3	
BASAGLAR TEMPO PEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML	3	
FIASP FLEXTOUCH SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML	3	
FIASP INJECTION SOLUTION 100 UNIT/ML	3	
FIASP PENFILL SUBCUTANEOUS SOLUTION CARTRIDGE 100 UNIT/ML	3	
<i>gauze pad 2"x2"</i> *	1	
GAUZE PAD 2"X2"*	1	
HUMALOG INJECTION SOLUTION 100 UNIT/ML	3	
HUMALOG JUNIOR KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML	3	
HUMALOG KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML, 200 UNIT/ML	3	
HUMALOG MIX 50/50 KWIKPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR (50-50) 100 UNIT/ML	3	
HUMALOG MIX 50/50 SUBCUTANEOUS SUSPENSION (50-50) 100 UNIT/ML	3	
HUMALOG MIX 75/25 KWIKPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR (75-25) 100 UNIT/ML	3	
HUMALOG MIX 75/25 SUBCUTANEOUS SUSPENSION (75-25) 100 UNIT/ML	3	
HUMALOG SUBCUTANEOUS SOLUTION CARTRIDGE 100 UNIT/ML	3	

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<b>Name of Drug</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
HUMALOG TEMPO PEN SUBCUTANEOUS SOLUTION PEN- INJECTOR 100 UNIT/ML	3	
HUMULIN 70/30 KWIKPEN SUBCUTANEOUS SUSPENSION PEN- INJECTOR (70-30) 100 UNIT/ML	3	
HUMULIN 70/30 SUBCUTANEOUS SUSPENSION (70-30) 100 UNIT/ML	3	
HUMULIN N KWIKPEN SUBCUTANEOUS SUSPENSION PEN- INJECTOR 100 UNIT/ML	3	
HUMULIN N SUBCUTANEOUS SUSPENSION 100 UNIT/ML	3	
HUMULIN R INJECTION SOLUTION 100 UNIT/ML	3	
HUMULIN R U-500 (CONCENTRATED) SUBCUTANEOUS SOLUTION 500 UNIT/ML	3	
HUMULIN R U-500 KWIKPEN SUBCUTANEOUS SOLUTION PEN- INJECTOR 500 UNIT/ML	3	
<i>insulin asp prot &amp; asp flexpen subcutaneous suspension pen-injector (70-30) 100 unit/ml*</i>	1	
<i>insulin aspart flexpen subcutaneous solution pen-injector 100 unit/ml*</i>	1	
<i>insulin aspart injection solution 100 unit/ml*</i>	1	
<i>insulin aspart penfill subcutaneous solution cartridge 100 unit/ml*</i>	1	
<i>insulin aspart prot &amp; aspart subcutaneous suspension (70-30) 100 unit/ml*</i>	1	
<i>insulin degludec flextouch subcutaneous solution pen-injector 100 unit/ml, 200 unit/ml*</i>	1	
<i>insulin degludec subcutaneous solution 100 unit/ml*</i>	1	

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<b>Name of Drug</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>insulin glargine max solostar subcutaneous solution pen-injector 300 unit/ml*</i>	1	
<i>insulin glargine solostar subcutaneous solution pen-injector 100 unit/ml, 300 unit/ml*</i>	1	
<i>insulin glargine subcutaneous solution 100 unit/ml*</i>	1	
<i>insulin glargine-yfgn subcutaneous solution 100 unit/ml*</i>	1	
<i>insulin glargine-yfgn subcutaneous solution pen-injector 100 unit/ml*</i>	1	
<i>insulin lispro (1 unit dial) subcutaneous solution pen-injector 100 unit/ml*</i>	1	
<i>insulin lispro injection solution 100 unit/ml*</i>	1	
<i>insulin lispro junior kwikpen subcutaneous solution pen-injector 100 unit/ml*</i>	1	
<i>insulin lispro prot &amp; lispro subcutaneous suspension pen-injector (75-25) 100 unit/ml*</i>	1	
<i>insulin syringe 27g x 1/2" 0.5 ml, 27g x 1/2" 1 ml, 28g x 1/2" 0.5 ml, 28g x 1/2" 1 ml, 29g x 1/2" 0.3 ml, 29g x 1/2" 0.5 ml, 29g x 1/2" 1 ml, 30g x 1/2" 0.3 ml, 30g x 1/2" 0.5 ml, 30g x 1/2" 1 ml, 30g x 5/16" 0.3 ml, 30g x 5/16" 0.5 ml, 30g x 5/16" 1 ml, 31g x 1/2" 0.3 ml, 31g x 1/4" 0.3 ml, 31g x 1/4" 0.5 ml, 31g x 1/4" 1 ml, 31g x 5/16" 0.3 ml, 31g x 5/16" 0.5 ml, 31g x 5/16" 1 ml*</i>	1	

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Name of Drug	Drug Tier	Requirements/Limits
INSULIN SYRINGE 27G X 1/2" 1 ML, 27G X 5/8" 1 ML, 28G X 1/2" 0.5 ML, 28G X 1/2" 1 ML, 29G 0.3 ML, 29G X 1/2" 0.3 ML, 29G X 1/2" 0.5 ML, 29G X 1/2" 1 ML, 30G X 5/16" 0.3 ML, 30G X 5/16" 0.5 ML, 30G X 5/16" 1 ML, 31G X 15/64" 0.3 ML, 31G X 15/64" 0.5 ML, 31G X 15/64" 1 ML, 31G X 5/16" 0.3 ML, 31G X 5/16" 0.5 ML, 31G X 5/16" 1 ML, 31G X 6MM 0.5 ML, U-100 1 ML*	1	
LANTUS SOLOSTAR SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML	3	
LANTUS SUBCUTANEOUS SOLUTION 100 UNIT/ML	3	
LEVEMIR FLEXPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML	3	
LEVEMIR FLEXTOUCH SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML	3	
LEVEMIR SUBCUTANEOUS SOLUTION 100 UNIT/ML	3	
LYUMJEV INJECTION SOLUTION 100 UNIT/ML	3	
LYUMJEV KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML, 200 UNIT/ML	3	
LYUMJEV TEMPO PEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML	3	
NOVOLIN 70/30 FLEXPEN RELION SUBCUTANEOUS SUSPENSION PEN-INJECTOR (70-30) 100 UNIT/ML	3	
NOVOLIN 70/30 FLEXPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR (70-30) 100 UNIT/ML	3	
NOVOLIN 70/30 RELION SUBCUTANEOUS SUSPENSION (70-30) 100 UNIT/ML	3	

\*We provide additional coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-9.

<b>Name of Drug</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
NOVOLIN 70/30 SUBCUTANEOUS SUSPENSION (70-30) 100 UNIT/ML	3	
NOVOLIN N FLEXPEN RELION SUBCUTANEOUS SUSPENSION PEN-INJECTOR 100 UNIT/ML	3	
NOVOLIN N FLEXPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR 100 UNIT/ML	3	
NOVOLIN N RELION SUBCUTANEOUS SUSPENSION 100 UNIT/ML	3	
NOVOLIN N SUBCUTANEOUS SUSPENSION 100 UNIT/ML	3	
NOVOLIN R FLEXPEN INJECTION SOLUTION PEN-INJECTOR 100 UNIT/ML	3	
NOVOLIN R FLEXPEN RELION INJECTION SOLUTION PEN-INJECTOR 100 UNIT/ML	3	
NOVOLIN R INJECTION SOLUTION 100 UNIT/ML	3	
NOVOLIN R RELION INJECTION SOLUTION 100 UNIT/ML	3	
NOVOLOG 70/30 FLEXPEN RELION SUBCUTANEOUS SUSPENSION PEN-INJECTOR (70-30) 100 UNIT/ML	3	
NOVOLOG FLEXPEN RELION SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML	3	
NOVOLOG FLEXPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML	3	
NOVOLOG INJECTION SOLUTION 100 UNIT/ML	3	
NOVOLOG MIX 70/30 FLEXPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR (70-30) 100 UNIT/ML	3	
NOVOLOG MIX 70/30 RELION SUBCUTANEOUS SUSPENSION (70-30) 100 UNIT/ML	3	

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<b>Name of Drug</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
NOVOLOG MIX 70/30 SUBCUTANEOUS SUSPENSION (70-30) 100 UNIT/ML	3	
NOVOLOG PENFILL SUBCUTANEOUS SOLUTION CARTRIDGE 100 UNIT/ML	3	
NOVOLOG RELION INJECTION SOLUTION 100 UNIT/ML	3	
PEN NEEDLES 29G X 12 MM, 30G X 5 MM, 30G X 8 MM, 31G X 4 MM, 31G X 5 MM, 31G X 6 MM, 31G X 8 MM, 32G X 4 MM, 32G X 6 MM*	1	
<i>pen needles 30g x 5 mm, 31g x 5 mm, 31g x 6 mm, 31g x 8 mm, 32g x 4 mm, 32g x 5 mm*</i>	1	
REZVOGLAR KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML*	1	
SEMGLEE (YFGN) SUBCUTANEOUS SOLUTION 100 UNIT/ML	3	
SEMGLEE (YFGN) SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML	3	
SOLIQUA SUBCUTANEOUS SOLUTION PEN-INJECTOR 100-33 UNT-MCG/ML	3	QL (30 ML per 30 days)
TOUJEO MAX SOLOSTAR SUBCUTANEOUS SOLUTION PEN-INJECTOR 300 UNIT/ML	3	
TOUJEO SOLOSTAR SUBCUTANEOUS SOLUTION PEN-INJECTOR 300 UNIT/ML	3	
TRESIBA FLEXTOUCH SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML, 200 UNIT/ML	3	
TRESIBA SUBCUTANEOUS SOLUTION 100 UNIT/ML	3	
XULTOPHY SUBCUTANEOUS SOLUTION PEN-INJECTOR 100-3.6 UNIT-MG/ML	3	QL (15 ML per 30 days)

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Name of Drug	Drug Tier	Requirements/Limits
<b>Blood Products And Modifiers - Prevention Of Clotting And Increasing Blood Cell Production</b>		
<b>Anticoagulants</b>		
ELIQUIS DVT/PE STARTER PACK ORAL TABLET THERAPY PACK 5 MG	3	QL (74 EA per 30 days)
ELIQUIS ORAL TABLET 2.5 MG	3	QL (60 EA per 30 days)
ELIQUIS ORAL TABLET 5 MG	3	QL (74 EA per 30 days)
<i>enoxaparin sodium injection solution 300 mg/3ml</i>	2	
<i>enoxaparin sodium injection solution prefilled syringe 100 mg/ml, 120 mg/0.8 ml, 150 mg/ml, 30 mg/0.3 ml, 40 mg/0.4 ml, 60 mg/0.6 ml, 80 mg/0.8 ml</i>	2	
<i>fondaparinux sodium subcutaneous solution 10 mg/0.8 ml, 5 mg/0.4 ml, 7.5 mg/0.6 ml</i>	5	
<i>fondaparinux sodium subcutaneous solution 2.5 mg/0.5 ml</i>	2	
FRAGMIN SUBCUTANEOUS SOLUTION 95000 UNIT/3.8 ML	5	
FRAGMIN SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 10000 UNIT/ML, 12500 UNIT/0.5 ML, 15000 UNIT/0.6 ML, 18000 UNT/0.72 ML, 5000 UNIT/0.2 ML, 7500 UNIT/0.3 ML	5	
FRAGMIN SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 2500 UNIT/0.2 ML	4	
<i>heparin sodium (porcine) injection solution 1000 unit/ml, 10000 unit/ml, 5000 unit/ml</i>	2	
JANTOVEN ORAL TABLET 1 MG, 10 MG, 2 MG, 2.5 MG, 3 MG, 4 MG, 5 MG, 6 MG, 7.5 MG*	1	
<i>warfarin sodium oral tablet 1 mg, 10 mg, 2 mg, 2.5 mg, 3 mg, 4 mg, 5 mg, 6 mg, 7.5 mg*</i>	1	

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<b>Name of Drug</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
XARELTO ORAL TABLET 10 MG, 20 MG	3	QL (30 EA per 30 days)
XARELTO ORAL TABLET 15 MG	3	QL (60 EA per 30 days)
XARELTO ORAL TABLET 2.5 MG	3	QL (120 EA per 30 days)
XARELTO STARTER PACK ORAL TABLET THERAPY PACK 15 & 20 MG	3	QL (51 EA per 30 days)
<b>Blood Products And Modifiers, Other</b>		
<i>anagrelide hcl oral capsule 0.5 mg, 1 mg</i>	2	
ARANESP (ALBUMIN FREE) INJECTION SOLUTION 100 MCG/ML, 200 MCG/ML, 60 MCG/ML	5	PA
ARANESP (ALBUMIN FREE) INJECTION SOLUTION 25 MCG/ML, 40 MCG/ML	4	PA
ARANESP (ALBUMIN FREE) INJECTION SOLUTION PREFILLED SYRINGE 10 MCG/0.4 ML, 25 MCG/0.42 ML, 40 MCG/0.4 ML	4	PA
ARANESP (ALBUMIN FREE) INJECTION SOLUTION PREFILLED SYRINGE 100 MCG/0.5 ML, 150 MCG/0.3 ML, 200 MCG/0.4 ML, 300 MCG/0.6 ML, 500 MCG/ML, 60 MCG/0.3 ML	5	PA
EPOGEN INJECTION SOLUTION 10000 UNIT/ML, 2000 UNIT/ML, 3000 UNIT/ML, 4000 UNIT/ML	4	PA
EPOGEN INJECTION SOLUTION 20000 UNIT/ML	5	PA
FULPHILA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 6 MG/0.6 ML	5	PA
FYLNETRA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 6 MG/0.6 ML	5	PA
LEUKINE INJECTION SOLUTION RECONSTITUTED 250 MCG	4	PA
NEULASTA ONPRO SUBCUTANEOUS PREFILLED SYRINGE KIT 6 MG/0.6 ML	5	PA
NEULASTA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 6 MG/0.6 ML	5	PA

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<b>Name of Drug</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
NYVEPRIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 6 MG/0.6 ML	5	PA
OXBRYTA ORAL TABLET 300 MG, 500 MG	5	PA
OXBRYTA ORAL TABLET SOLUBLE 300 MG	5	PA
PROCRIT INJECTION SOLUTION 10000 UNIT/ML, 20000 UNIT/ML, 40000 UNIT/ML	5	PA
PROCRIT INJECTION SOLUTION 2000 UNIT/ML, 3000 UNIT/ML, 4000 UNIT/ML	4	PA
PROMACTA ORAL PACKET 12.5 MG	5	PA; QL (360 EA per 30 days)
PROMACTA ORAL PACKET 25 MG	5	PA; QL (180 EA per 30 days)
PROMACTA ORAL TABLET 12.5 MG, 25 MG	5	PA; QL (30 EA per 30 days)
PROMACTA ORAL TABLET 50 MG, 75 MG	5	PA; QL (60 EA per 30 days)
PYRUKYND ORAL TABLET 20 MG, 5 MG, 50 MG	5	PA
PYRUKYND TAPER PACK ORAL TABLET THERAPY PACK 5 MG, 7 X 20 MG & 7 X 5 MG, 7 X 50 MG & 7 X 20 MG	5	PA
RETACRIT INJECTION SOLUTION 10000 UNIT/ML, 10000 UNIT/ML (1 ML), 2000 UNIT/ML, 20000 UNIT/ML, 3000 UNIT/ML, 4000 UNIT/ML, 40000 UNIT/ML	4	PA
TAVNEOS ORAL CAPSULE 10 MG	5	PA
<i>tranexamic acid oral tablet 650 mg</i>	2	
UDENYCA ONBODY SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 6 MG/0.6 ML	5	PA
UDENYCA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 6 MG/0.6 ML	5	PA

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<b>Name of Drug</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
UDENYCA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 6 MG/0.6 ML	5	PA
ZARXIO INJECTION SOLUTION PREFILLED SYRINGE 300 MCG/0.5 ML, 480 MCG/0.8 ML	5	PA
ZIEXTENZO SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 6 MG/0.6 ML	5	PA
<b>Platelet Modifying Agents</b>		
<i>aspirin-dipyridamole er oral capsule extended release 12 hour 25-200 mg</i>	2	
BRILINTA ORAL TABLET 60 MG, 90 MG	3	
<i>cilostazol oral tablet 100 mg, 50 mg*</i>	1	
<i>clopidogrel bisulfate oral tablet 75 mg*</i>	1	
<i>dipyridamole oral tablet 25 mg, 50 mg, 75 mg</i>	2	PA
DOPTELET ORAL TABLET 20 MG, 20 MG (10 PACK), 20 MG (15 PACK)	5	PA
<i>prasugrel hcl oral tablet 10 mg, 5 mg</i>	2	
<b>Cardiovascular Agents - Treatment Of Conditions Affecting The Heart And Blood Vessels</b>		
<b>Alpha-Adrenergic Agonists</b>		
<i>clonidine hcl oral tablet 0.1 mg, 0.2 mg, 0.3 mg*</i>	1	
<i>clonidine transdermal patch weekly 0.1 mg/24 hr, 0.2 mg/24 hr, 0.3 mg/24 hr</i>	2	
<i>droxidopa oral capsule 100 mg, 200 mg, 300 mg</i>	2	
<i>guanfacine hcl oral tablet 1 mg, 2 mg*</i>	1	PA
<i>midodrine hcl oral tablet 10 mg, 2.5 mg, 5 mg</i>	2	
<b>Alpha-Adrenergic Blocking Agents</b>		
<i>doxazosin mesylate oral tablet 1 mg, 2 mg, 4 mg, 8 mg*</i>	1	

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<b>Name of Drug</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>phenoxybenzamine hcl oral capsule 10 mg</i>	5	PA
<i>prazosin hcl oral capsule 1 mg, 2 mg, 5 mg*</i>	1	
<i>terazosin hcl oral capsule 1 mg, 10 mg, 2 mg, 5 mg*</i>	1	
<b>Angiotensin II Receptor Antagonists</b>		
<i>candesartan cilexetil oral tablet 16 mg, 32 mg, 4 mg, 8 mg</i>	2	
<i>irbesartan oral tablet 150 mg, 300 mg, 75 mg*</i>	1	
<i>losartan potassium oral tablet 100 mg, 25 mg, 50 mg*</i>	1	
<i>olmesartan medoxomil oral tablet 20 mg, 40 mg, 5 mg*</i>	1	
<i>telmisartan oral tablet 20 mg, 40 mg, 80 mg*</i>	1	
<i>valsartan oral tablet 160 mg, 320 mg, 40 mg, 80 mg*</i>	1	
<b>Angiotensin-Converting Enzyme (ACE) Inhibitors</b>		
<i>benazepril hcl oral tablet 10 mg, 20 mg, 40 mg, 5 mg*</i>	1	
<i>captopril oral tablet 100 mg, 12.5 mg, 25 mg, 50 mg</i>	2	
<i>enalapril maleate oral tablet 10 mg, 2.5 mg, 20 mg, 5 mg*</i>	1	
<i>fosinopril sodium oral tablet 10 mg, 20 mg, 40 mg*</i>	1	
<i>lisinopril oral tablet 10 mg, 2.5 mg, 20 mg, 30 mg, 40 mg, 5 mg*</i>	1	
<i>moexipril hcl oral tablet 15 mg, 7.5 mg</i>	2	
<i>perindopril erbumine oral tablet 2 mg, 4 mg, 8 mg</i>	2	
<i>quinapril hcl oral tablet 10 mg, 20 mg, 40 mg, 5 mg*</i>	1	

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<b>Name of Drug</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>ramipril oral capsule 1.25 mg, 10 mg, 2.5 mg, 5 mg*</i>	1	
<i>trandolapril oral tablet 1 mg, 2 mg, 4 mg*</i>	1	
<b>Antiarrhythmics</b>		
<i>amiodarone hcl oral tablet 100 mg, 200 mg, 400 mg*</i>	1	
<i>disopyramide phosphate oral capsule 100 mg, 150 mg</i>	2	PA
<i>dofetilide oral capsule 125 mcg, 250 mcg, 500 mcg*</i>	1	
<i>flecainide acetate oral tablet 100 mg, 150 mg, 50 mg</i>	2	
<i>mexiletine hcl oral capsule 150 mg, 200 mg, 250 mg</i>	2	
MULTAQ ORAL TABLET 400 MG	4	
NORPACE CR ORAL CAPSULE EXTENDED RELEASE 12 HOUR 100 MG, 150 MG	4	PA
<i>propafenone hcl er oral capsule extended release 12 hour 225 mg, 325 mg, 425 mg*</i>	1	
<i>propafenone hcl oral tablet 150 mg, 225 mg, 300 mg*</i>	1	
<i>quinidine gluconate er oral tablet extended release 324 mg</i>	2	
<i>quinidine sulfate oral tablet 200 mg, 300 mg</i>	2	
<i>sotalol hcl (af) oral tablet 120 mg, 160 mg, 80 mg*</i>	1	
<i>sotalol hcl oral tablet 120 mg, 160 mg, 240 mg, 80 mg*</i>	1	
<b>Beta-Adrenergic Blocking Agents</b>		
<i>acebutolol hcl oral capsule 200 mg, 400 mg*</i>	1	

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<b>Name of Drug</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>atenolol oral tablet 100 mg, 25 mg, 50 mg*</i>	1	
<i>betaxolol hcl oral tablet 10 mg, 20 mg</i>	2	
<i>bisoprolol fumarate oral tablet 10 mg, 5 mg*</i>	1	
<i>carvedilol oral tablet 12.5 mg, 25 mg, 3.125 mg, 6.25 mg*</i>	1	
<i>labetalol hcl oral tablet 100 mg, 200 mg, 300 mg</i>	2	
<i>metoprolol succinate er oral tablet extended release 24 hour 100 mg, 200 mg, 25 mg, 50 mg*</i>	1	
<i>metoprolol tartrate oral tablet 100 mg, 25 mg, 50 mg*</i>	1	
<i>nadolol oral tablet 20 mg, 40 mg, 80 mg</i>	2	
<i>nebivolol hcl oral tablet 10 mg, 2.5 mg, 20 mg, 5 mg*</i>	1	
<i>pindolol oral tablet 10 mg, 5 mg</i>	2	
<i>propranolol hcl er oral capsule extended release 24 hour 120 mg, 160 mg, 60 mg, 80 mg</i>	2	
<i>propranolol hcl oral solution 20 mg/5 ml, 40 mg/5 ml</i>	2	
<i>propranolol hcl oral tablet 10 mg, 20 mg, 40 mg, 60 mg, 80 mg*</i>	1	
<i>timolol maleate oral tablet 10 mg, 20 mg, 5 mg</i>	2	
<b>Calcium Channel Blocking Agents, Dihydropyridines</b>		
<i>amlodipine besylate oral tablet 10 mg, 2.5 mg, 5 mg*</i>	1	
<i>felodipine er oral tablet extended release 24 hour 10 mg, 2.5 mg, 5 mg</i>	2	
<i>isradipine oral capsule 2.5 mg, 5 mg</i>	2	
<i>nifedipine er oral tablet extended release 24 hour 30 mg, 60 mg, 90 mg*</i>	1	

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<b>Name of Drug</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>nifedipine er osmotic release oral tablet extended release 24 hour 30 mg, 60 mg, 90 mg*</i>	1	
<i>nifedipine oral capsule 10 mg, 20 mg</i>	2	PA
<i>nimodipine oral capsule 30 mg</i>	2	
<b>Calcium Channel Blocking Agents, Nondihydropyridines</b>		
<i>CARTIA XT ORAL CAPSULE EXTENDED RELEASE 24 HOUR 120 MG, 180 MG, 240 MG, 300 MG</i>	2	
<i>diltiazem hcl er beads oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg, 420 mg</i>	2	
<i>diltiazem hcl er coated beads oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg</i>	2	
<i>diltiazem hcl er oral capsule extended release 12 hour 120 mg, 60 mg, 90 mg</i>	2	
<i>diltiazem hcl er oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg</i>	2	
<i>diltiazem hcl oral tablet 120 mg, 30 mg, 60 mg, 90 mg*</i>	1	
<i>dilt-xr oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg</i>	2	
<i>verapamil hcl er oral capsule extended release 24 hour 100 mg, 120 mg, 180 mg, 200 mg, 240 mg, 300 mg, 360 mg</i>	2	
<i>verapamil hcl er oral tablet extended release 120 mg, 180 mg, 240 mg</i>	2	
<i>verapamil hcl oral tablet 120 mg, 40 mg, 80 mg*</i>	1	
<b>Cardiovascular Agents, Other</b>		
<i>acetazolamide oral tablet 125 mg, 250 mg</i>	2	
<i>aliskiren fumarate oral tablet 150 mg, 300 mg</i>	2	

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<b>Name of Drug</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>amiloride-hydrochlorothiazide oral tablet 5-50 mg*</i>	1	
<i>amlodipine besy-benazepril hcl oral capsule 10-20 mg, 10-40 mg, 2.5-10 mg, 5-10 mg, 5-20 mg, 5-40 mg*</i>	1	
<i>amlodipine besylate-valsartan oral tablet 10-160 mg, 10-320 mg, 5-160 mg, 5-320 mg*</i>	1	
<i>amlodipine-atorvastatin oral tablet 10-10 mg, 10-20 mg, 10-40 mg, 10-80 mg, 2.5-10 mg, 2.5-20 mg, 2.5-40 mg, 5-10 mg, 5-20 mg, 5-40 mg, 5-80 mg</i>	2	
<i>amlodipine-olmesartan oral tablet 10-20 mg, 10-40 mg, 5-20 mg, 5-40 mg*</i>	1	
<i>amlodipine-valsartan-hctz oral tablet 10-160-12.5 mg, 10-160-25 mg, 10-320-25 mg, 5-160-12.5 mg, 5-160-25 mg</i>	2	
<i>atenolol-chlorthalidone oral tablet 100-25 mg, 50-25 mg*</i>	1	
<i>benazepril-hydrochlorothiazide oral tablet 10-12.5 mg, 20-12.5 mg, 20-25 mg, 5-6.25 mg</i>	2	
<i>bisoprolol-hydrochlorothiazide oral tablet 10-6.25 mg, 2.5-6.25 mg, 5-6.25 mg*</i>	1	
CAMZYOS ORAL CAPSULE 10 MG, 15 MG, 2.5 MG, 5 MG	5	PA; QL (30 EA per 30 days)
<i>candesartan cilexetil-hctz oral tablet 16-12.5 mg, 32-12.5 mg, 32-25 mg</i>	2	
CORLANOR ORAL SOLUTION 5 MG/5 ML	4	PA
CORLANOR ORAL TABLET 5 MG, 7.5 MG	4	PA
<i>digoxin oral solution 0.05 mg/ml</i>	2	QL (150 ML per 30 days)
<i>digoxin oral tablet 125 mcg, 250 mcg*</i>	1	QL (30 EA per 30 days)
<i>enalapril-hydrochlorothiazide oral tablet 10-25 mg, 5-12.5 mg*</i>	1	

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<b>Name of Drug</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
ENTRESTO ORAL TABLET 24-26 MG, 49-51 MG, 97-103 MG	3	QL (60 EA per 30 days)
<i>fosinopril sodium-hctz oral tablet 10-12.5 mg, 20-12.5 mg</i>	2	
<i>irbesartan-hydrochlorothiazide oral tablet 150-12.5 mg, 300-12.5 mg*</i>	1	
KERENDIA ORAL TABLET 10 MG, 20 MG	4	PA; QL (30 EA per 30 days)
<i>lisinopril-hydrochlorothiazide oral tablet 10-12.5 mg, 20-12.5 mg, 20-25 mg*</i>	1	
LODOCO ORAL TABLET 0.5 MG	4	PA
<i>losartan potassium-hctz oral tablet 100-12.5 mg, 100-25 mg, 50-12.5 mg*</i>	1	
<i>metoprolol-hydrochlorothiazide oral tablet 100-25 mg, 100-50 mg, 50-25 mg</i>	2	
<i>metyrosine oral capsule 250 mg</i>	5	PA
NEXLETOL ORAL TABLET 180 MG	3	PA
NEXLIZET ORAL TABLET 180-10 MG	3	PA
<i>olmesartan medoxomil-hctz oral tablet 20-12.5 mg, 40-12.5 mg, 40-25 mg*</i>	1	
<i>olmesartan-amlodipine-hctz oral tablet 20-5-12.5 mg, 40-10-12.5 mg, 40-10-25 mg, 40-5-12.5 mg, 40-5-25 mg</i>	2	
<i>pentoxifylline er oral tablet extended release 400 mg*</i>	1	
<i>quinapril-hydrochlorothiazide oral tablet 10-12.5 mg, 20-12.5 mg, 20-25 mg*</i>	1	
<i>ranolazine er oral tablet extended release 12 hour 1000 mg, 500 mg</i>	2	
<i>spironolactone-hctz oral tablet 25-25 mg</i>	2	
<i>telmisartan-amlodipine oral tablet 40-10 mg, 40-5 mg, 80-10 mg, 80-5 mg</i>	2	
<i>telmisartan-hctz oral tablet 40-12.5 mg, 80-12.5 mg, 80-25 mg</i>	2	
<i>triamterene-hctz oral capsule 37.5-25 mg*</i>	1	

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<b>Name of Drug</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>triamterene-hctz oral tablet 37.5-25 mg, 75-50 mg*</i>	1	
<i>valsartan-hydrochlorothiazide oral tablet 160-12.5 mg, 160-25 mg, 320-12.5 mg, 320-25 mg, 80-12.5 mg*</i>	1	
VERQUVO ORAL TABLET 10 MG, 2.5 MG, 5 MG	3	QL (30 EA per 30 days)
<b>Diuretics, Loop</b>		
<i>bumetanide oral tablet 0.5 mg, 1 mg, 2 mg</i>	2	
<i>furosemide injection solution 10 mg/ml, 10 mg/ml (4 ml syringe)</i>	2	
<i>furosemide oral solution 10 mg/ml, 8 mg/ml*</i>	1	
<i>furosemide oral tablet 20 mg, 40 mg, 80 mg*</i>	1	
<i>toremide oral tablet 10 mg, 100 mg, 20 mg, 5 mg</i>	2	
<b>Diuretics, Potassium-Sparing</b>		
<i>amiloride hcl oral tablet 5 mg*</i>	1	
<i>eplerenone oral tablet 25 mg, 50 mg</i>	2	
<i>spironolactone oral tablet 100 mg, 25 mg, 50 mg*</i>	1	
<b>Diuretics, Thiazide</b>		
<i>chlorthalidone oral tablet 25 mg, 50 mg*</i>	1	
<i>hydrochlorothiazide oral capsule 12.5 mg*</i>	1	
<i>hydrochlorothiazide oral tablet 12.5 mg, 25 mg, 50 mg*</i>	1	
<i>indapamide oral tablet 1.25 mg, 2.5 mg*</i>	1	
<i>metolazone oral tablet 10 mg, 2.5 mg, 5 mg</i>	2	

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<b>Name of Drug</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>Dyslipidemics, Fibric Acid Derivatives</b>		
<i>fenofibrate micronized oral capsule 134 mg, 200 mg, 43 mg, 67 mg</i>	2	
<i>fenofibrate oral capsule 134 mg, 200 mg, 67 mg</i>	2	
<i>fenofibrate oral tablet 145 mg, 160 mg, 48 mg, 54 mg</i>	2	
<i>fenofibric acid oral capsule delayed release 135 mg, 45 mg</i>	2	
<i>fenofibric acid oral tablet 35 mg</i>	2	
<i>gemfibrozil oral tablet 600 mg*</i>	1	
<b>Dyslipidemics, HMG-CoA Reductase Inhibitors</b>		
<i>atorvastatin calcium oral tablet 10 mg, 20 mg, 40 mg, 80 mg*</i>	1	
<i>lovastatin oral tablet 10 mg, 20 mg, 40 mg*</i>	1	
<i>pravastatin sodium oral tablet 10 mg, 20 mg, 40 mg, 80 mg*</i>	1	
<i>rosuvastatin calcium oral tablet 10 mg, 20 mg, 40 mg, 5 mg*</i>	1	
<i>simvastatin oral tablet 10 mg, 20 mg, 40 mg, 5 mg, 80 mg*</i>	1	
<b>Dyslipidemics, Other</b>		
<i>cholestyramine light oral packet 4 gm</i>	2	
<i>cholestyramine light oral powder 4 gm/dose</i>	2	
<i>cholestyramine oral packet 4 gm</i>	2	
<i>cholestyramine oral powder 4 gm/dose</i>	2	
<i>colesevelam hcl oral packet 3.75 gm</i>	2	
<i>colesevelam hcl oral tablet 625 mg</i>	2	
<i>colestipol hcl oral granules 5 gm</i>	2	
<i>colestipol hcl oral packet 5 gm</i>	2	
<i>colestipol hcl oral tablet 1 gm</i>	2	
<i>ezetimibe oral tablet 10 mg*</i>	1	

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<b>Name of Drug</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>ezetimibe-rosuvastatin oral tablet 10-10 mg, 10-20 mg, 10-40 mg, 10-5 mg</i>	2	
<i>ezetimibe-simvastatin oral tablet 10-10 mg, 10-20 mg, 10-40 mg, 10-80 mg</i>	2	
<i>icosapent ethyl oral capsule 0.5 gm, 1 gm</i>	2	PA
<i>niacin er (antihyperlipidemic) oral tablet extended release 1000 mg, 500 mg, 750 mg</i>	2	
<i>omega-3-acid ethyl esters oral capsule 1 gm</i>	2	
PRALUENT SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML, 75 MG/ML	3	PA
PREVALITE ORAL PACKET 4 GM	2	
PREVALITE ORAL POWDER 4 GM/DOSE	2	
REPATHA PUSHTRONEX SYSTEM SUBCUTANEOUS SOLUTION CARTRIDGE 420 MG/3.5 ML	3	PA
REPATHA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 140 MG/ML	3	PA
REPATHA SURECLICK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 140 MG/ML	3	PA
<b>Vasodilators, Direct-Acting Arterial</b>		
<i>hydralazine hcl oral tablet 10 mg, 100 mg, 25 mg, 50 mg</i>	2	
<i>isosorb dinitrate-hydralazine oral tablet 20-37.5 mg</i>	2	
<i>minoxidil oral tablet 10 mg, 2.5 mg</i>	2	
<b>Vasodilators, Direct-Acting Arterial/Venous</b>		
<i>isosorbide dinitrate oral tablet 10 mg, 20 mg, 30 mg, 5 mg*</i>	1	
<i>isosorbide mononitrate er oral tablet extended release 24 hour 120 mg, 30 mg, 60 mg*</i>	1	

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<b>Name of Drug</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>isosorbide mononitrate oral tablet 10 mg, 20 mg*</i>	1	
NITRO-BID TRANSDERMAL OINTMENT 2 %	4	
NITRO-DUR TRANSDERMAL PATCH 24 HOUR 0.3 MG/HR, 0.8 MG/HR	4	
<i>nitroglycerin sublingual tablet sublingual 0.3 mg, 0.4 mg, 0.6 mg</i>	2	
<i>nitroglycerin transdermal patch 24 hour 0.1 mg/hr, 0.2 mg/hr, 0.4 mg/hr, 0.6 mg/hr</i>	2	
<i>nitroglycerin translingual solution 0.4 mg/spray</i>	2	
RECTIV RECTAL OINTMENT 0.4 %	4	

## **Central Nervous System Agents - Treatment Of Disorders Of The Brain And Spinal Column**

### **Attention Deficit Hyperactivity Disorder Agents, Amphetamines**

<i>amphetamine-dextroamphetamine oral capsule extended release 24 hour 10 mg, 15 mg, 20 mg, 25 mg, 30 mg, 5 mg</i>	2	QL (30 EA per 30 days)
<i>amphetamine-dextroamphetamine oral tablet 10 mg, 20 mg, 30 mg, 5 mg, 7.5 mg</i>	2	QL (60 EA per 30 days)
<i>amphetamine-dextroamphetamine oral tablet 12.5 mg</i>	2	QL (120 EA per 30 days)
<i>amphetamine-dextroamphetamine oral tablet 15 mg</i>	2	QL (90 EA per 30 days)
<i>dextroamphetamine sulfate er oral capsule extended release 24 hour 10 mg</i>	2	QL (150 EA per 30 days)
<i>dextroamphetamine sulfate er oral capsule extended release 24 hour 15 mg</i>	2	QL (120 EA per 30 days)
<i>dextroamphetamine sulfate er oral capsule extended release 24 hour 5 mg</i>	2	QL (90 EA per 30 days)

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<b>Name of Drug</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>dextroamphetamine sulfate oral tablet 10 mg, 5 mg</i>	2	QL (180 EA per 30 days)
<b>Attention Deficit Hyperactivity Disorder Agents, Non-Amphetamines</b>		
<i>atomoxetine hcl oral capsule 10 mg, 100 mg, 18 mg, 25 mg, 40 mg, 60 mg, 80 mg</i>	2	
<i>clonidine hcl er oral tablet extended release 12 hour 0.1 mg</i>	2	QL (120 EA per 30 days)
<i>dexmethylphenidate hcl er oral capsule extended release 24 hour 10 mg, 15 mg, 20 mg, 25 mg, 30 mg, 35 mg, 40 mg, 5 mg</i>	2	QL (30 EA per 30 days)
<i>dexmethylphenidate hcl oral tablet 10 mg</i>	2	QL (60 EA per 30 days)
<i>dexmethylphenidate hcl oral tablet 2.5 mg, 5 mg</i>	2	QL (90 EA per 30 days)
<i>guanfacine hcl er oral tablet extended release 24 hour 1 mg, 2 mg, 3 mg, 4 mg*</i>	1	PA
<i>methylphenidate hcl er (cd) oral capsule extended release 10 mg, 20 mg, 30 mg, 40 mg, 50 mg, 60 mg</i>	2	QL (30 EA per 30 days)
<i>methylphenidate hcl er (la) oral capsule extended release 24 hour 10 mg, 20 mg, 30 mg, 40 mg, 60 mg</i>	2	QL (30 EA per 30 days)
<i>methylphenidate hcl er (osm) oral tablet extended release 18 mg</i>	2	QL (120 EA per 30 days)
<i>methylphenidate hcl er (osm) oral tablet extended release 27 mg, 54 mg, 72 mg</i>	2	QL (30 EA per 30 days)
<i>methylphenidate hcl er (osm) oral tablet extended release 36 mg</i>	2	QL (60 EA per 30 days)
<i>methylphenidate hcl er (xr) oral capsule extended release 24 hour 10 mg, 15 mg, 20 mg, 30 mg, 40 mg, 50 mg, 60 mg</i>	2	QL (30 EA per 30 days)
<i>methylphenidate hcl er oral tablet extended release 10 mg</i>	2	QL (30 EA per 30 days)

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<b>Name of Drug</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>methylphenidate hcl er oral tablet extended release 20 mg</i>	2	QL (90 EA per 30 days)
<i>methylphenidate hcl er oral tablet extended release 24 hour 18 mg</i>	2	QL (120 EA per 30 days)
<i>methylphenidate hcl er oral tablet extended release 24 hour 27 mg, 54 mg</i>	2	QL (30 EA per 30 days)
<i>methylphenidate hcl er oral tablet extended release 24 hour 36 mg</i>	2	QL (60 EA per 30 days)
<i>methylphenidate hcl oral solution 10 mg/5 ml</i>	2	QL (900 ML per 30 days)
<i>methylphenidate hcl oral solution 5 mg/5 ml</i>	2	QL (1800 ML per 30 days)
<i>methylphenidate hcl oral tablet 10 mg, 20 mg, 5 mg</i>	2	QL (90 EA per 30 days)
<i>methylphenidate hcl oral tablet chewable 10 mg</i>	2	QL (180 EA per 30 days)
<i>methylphenidate hcl oral tablet chewable 2.5 mg, 5 mg</i>	2	QL (90 EA per 30 days)
<b>Central Nervous System, Other</b>		
AUSTEDO ORAL TABLET 12 MG, 6 MG, 9 MG	5	PA
AUSTEDO PATIENT TITRATION KIT ORAL TABLET THERAPY PACK 6 & 9 & 12 MG	5	PA
EVRYSDI ORAL SOLUTION RECONSTITUTED 0.75 MG/ML	5	PA
FIRDAPSE ORAL TABLET 10 MG	5	PA
INGREZZA ORAL CAPSULE 40 MG, 60 MG, 80 MG	5	PA; QL (30 EA per 30 days)
INGREZZA ORAL CAPSULE THERAPY PACK 40 & 80 MG	5	PA; QL (56 EA per 365 days)
NUEDEXTA ORAL CAPSULE 20-10 MG	5	PA
RADICAVA ORS ORAL SUSPENSION 105 MG/5 ML	5	PA
RADICAVA ORS STARTER KIT ORAL SUSPENSION 105 MG/5 ML	5	PA

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<b>Name of Drug</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
RELYVRIO ORAL PACKET 3-1 GM	5	PA
<i>riluzole oral tablet 50 mg</i>	2	
<i>tetrabenazine oral tablet 12.5 mg</i>	4	PA
<i>tetrabenazine oral tablet 25 mg</i>	5	PA
<b>Fibromyalgia Agents</b>		
<i>duloxetine hcl oral capsule delayed release particles 20 mg, 30 mg, 60 mg</i>	2	
SAVELLA ORAL TABLET 100 MG, 12.5 MG, 25 MG, 50 MG	4	ST
SAVELLA TITRATION PACK ORAL 12.5 & 25 & 50 MG	4	ST
<b>Multiple Sclerosis Agents</b>		
BAFIERTAM ORAL CAPSULE DELAYED RELEASE 95 MG	5	PA
BETASERON SUBCUTANEOUS KIT 0.3 MG	5	PA
<i>dalfampridine er oral tablet extended release 12 hour 10 mg</i>	2	PA
<i>dimethyl fumarate oral capsule delayed release 120 mg, 240 mg</i>	2	PA
<i>dimethyl fumarate starter pack oral capsule delayed release therapy pack 120 &amp; 240 mg</i>	2	PA
EXTAVIA SUBCUTANEOUS KIT 0.3 MG	5	PA
<i>fingolimod hcl oral capsule 0.5 mg</i>	5	PA
<i>glatiramer acetate subcutaneous solution prefilled syringe 20 mg/ml, 40 mg/ml</i>	5	PA
GLATOPA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 20 MG/ML, 40 MG/ML	5	PA
KESIMPTA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 20 MG/0.4 ML	5	PA
MAVENCLAD (10 TABS) ORAL TABLET THERAPY PACK 10 MG	5	PA

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<b>Name of Drug</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
MAVENCLAD (4 TABS) ORAL TABLET THERAPY PACK 10 MG	5	PA
MAVENCLAD (5 TABS) ORAL TABLET THERAPY PACK 10 MG	5	PA
MAVENCLAD (6 TABS) ORAL TABLET THERAPY PACK 10 MG	5	PA
MAVENCLAD (7 TABS) ORAL TABLET THERAPY PACK 10 MG	5	PA
MAVENCLAD (8 TABS) ORAL TABLET THERAPY PACK 10 MG	5	PA
MAVENCLAD (9 TABS) ORAL TABLET THERAPY PACK 10 MG	5	PA
MAYZENT ORAL TABLET 0.25 MG, 1 MG, 2 MG	5	PA
MAYZENT STARTER PACK ORAL TABLET THERAPY PACK 12 X 0.25 MG, 7 X 0.25 MG	4	PA
PONVORY ORAL TABLET 20 MG	5	PA
PONVORY STARTER PACK ORAL TABLET THERAPY PACK 2-3-4-5-6-7-8-9 & 10 MG	5	PA
REBIF REBIDOSE SUBCUTANEOUS SOLUTION AUTO-INJECTOR 22 MCG/0.5 ML, 44 MCG/0.5 ML	5	PA
REBIF REBIDOSE TITRATION PACK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 6 X 8.8 & 6 X 22 MCG	5	PA
REBIF SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 22 MCG/0.5 ML, 44 MCG/0.5 ML	5	PA
REBIF TITRATION PACK SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 6 X 8.8 & 6 X 22 MCG	5	PA
TASCENSO ODT ORAL TABLET DISPERSIBLE 0.25 MG, 0.5 MG	5	PA
<i>teriflunomide oral tablet 14 mg, 7 mg</i>	2	PA

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<b>Name of Drug</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
ZEPOSIA 7-DAY STARTER PACK ORAL CAPSULE THERAPY PACK 4 X 0.23 MG & 3 X 0.46 MG	5	PA
ZEPOSIA ORAL CAPSULE 0.92 MG	5	PA
ZEPOSIA STARTER KIT ORAL CAPSULE THERAPY PACK 0.23MG & 0.46 MG & 0.92 MG (21)	5	PA

## **Dental And Oral Agents - Treatment Of Mouth And Gum Disorders**

### **Dental And Oral Agents**

<i>cevimeline hcl oral capsule 30 mg</i>	2	
<i>chlorhexidine gluconate mouth/throat solution 0.12 %*</i>	1	
<i>pilocarpine hcl oral tablet 5 mg, 7.5 mg</i>	2	
<i>triamcinolone acetonide mouth/throat paste 0.1 %</i>	2	

## **Dermatological Agents - Treatment Of Skin Conditions**

### **Acne And Rosacea Agents**

<i>acitretin oral capsule 10 mg, 17.5 mg, 25 mg</i>	2	PA
<i>adapalene external gel 0.1 %</i>	2	
<i>adapalene-benzoyl peroxide external gel 0.1-2.5 %</i>	2	
AMNESTEEM ORAL CAPSULE 10 MG, 20 MG, 40 MG	2	
<i>benzoyl peroxide-erythromycin external gel 5-3 %</i>	2	
CLARAVIS ORAL CAPSULE 10 MG, 20 MG, 30 MG, 40 MG	2	
<i>clindamycin phos-benzoyl perox external gel 1-5 %, 1.2-2.5 %, 1.2-5 %</i>	2	
<i>isotretinoin oral capsule 10 mg, 20 mg, 30 mg, 40 mg</i>	2	
MYORISAN ORAL CAPSULE 10 MG, 20 MG, 30 MG, 40 MG	2	
<i>tazarotene external cream 0.1 %</i>	2	

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<b>Name of Drug</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>tazarotene external gel 0.05 %, 0.1 %</i>	2	
TAZORAC EXTERNAL CREAM 0.05 %	4	
<i>tretinoin external cream 0.025 %, 0.05 %, 0.1 %</i>	2	
<i>tretinoin external gel 0.01 %, 0.025 %</i>	2	
ZENATANE ORAL CAPSULE 10 MG, 20 MG, 30 MG, 40 MG	2	
<b>Dermatitis And Pruritus Agents</b>		
<i>alclometasone dipropionate external cream 0.05 %</i>	2	
<i>alclometasone dipropionate external ointment 0.05 %</i>	2	
<i>ammonium lactate external cream 12 %</i>	2	
<i>ammonium lactate external lotion 12 %</i>	2	
<i>betamethasone dipropionate aug external cream 0.05 %</i>	2	
<i>betamethasone dipropionate aug external gel 0.05 %</i>	2	
<i>betamethasone dipropionate aug external lotion 0.05 %</i>	2	
<i>betamethasone dipropionate aug external ointment 0.05 %</i>	2	
<i>betamethasone dipropionate external cream 0.05 %</i>	2	
<i>betamethasone dipropionate external lotion 0.05 %</i>	2	
<i>betamethasone dipropionate external ointment 0.05 %</i>	2	
<i>betamethasone valerate external cream 0.1 %</i>	2	
<i>betamethasone valerate external lotion 0.1 %</i>	2	
<i>betamethasone valerate external ointment 0.1 %</i>	2	

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<b>Name of Drug</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>clobetasol prop emollient base external cream 0.05 %</i>	2	
<i>clobetasol propionate e external cream 0.05 %</i>	2	
<i>clobetasol propionate external cream 0.05 %</i>	2	
<i>clobetasol propionate external gel 0.05 %</i>	2	
<i>clobetasol propionate external ointment 0.05 %</i>	2	
<i>clobetasol propionate external solution 0.05 %</i>	2	
<i>desonide external cream 0.05 %</i>	2	
<i>desonide external lotion 0.05 %</i>	2	
<i>desonide external ointment 0.05 %</i>	2	
<i>desoximetasone external cream 0.05 %, 0.25 %</i>	2	
<i>desoximetasone external gel 0.05 %</i>	2	
<i>desoximetasone external ointment 0.05 %, 0.25 %</i>	2	
<i>doxepin hcl external cream 5 %</i>	2	PA; QL (45 GM per 30 days)
EUCRISA EXTERNAL OINTMENT 2 %	4	PA
<i>fluocinolone acetonide external cream 0.01 %, 0.025 %</i>	2	
<i>fluocinolone acetonide external ointment 0.025 %</i>	2	
<i>fluocinolone acetonide external solution 0.01 %</i>	2	
<i>fluocinonide emulsified base external cream 0.05 %</i>	2	
<i>fluocinonide external cream 0.05 %</i>	2	
<i>fluocinonide external gel 0.05 %</i>	2	
<i>fluocinonide external ointment 0.05 %</i>	2	
<i>fluocinonide external solution 0.05 %</i>	2	

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<b>Name of Drug</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>fluticasone propionate external cream 0.05 %</i>	2	
<i>fluticasone propionate external lotion 0.05 %</i>	2	
<i>fluticasone propionate external ointment 0.005 %</i>	2	
<i>halobetasol propionate external cream 0.05 %</i>	2	
<i>halobetasol propionate external ointment 0.05 %</i>	2	
<i>hydrocortisone (perianal) external cream 1 %, 2.5 %*</i>	1	
<i>hydrocortisone butyr lipo base external cream 0.1 %</i>	2	
<i>hydrocortisone butyrate external cream 0.1 %</i>	2	
<i>hydrocortisone butyrate external ointment 0.1 %</i>	2	
<i>hydrocortisone butyrate external solution 0.1 %</i>	2	
<i>hydrocortisone external cream 1 %, 2.5 %*</i>	1	
<i>hydrocortisone external lotion 2.5 %*</i>	1	
<i>hydrocortisone external ointment 1 %, 2.5 %*</i>	1	
<i>hydrocortisone valerate external cream 0.2 %</i>	2	
<i>hydrocortisone valerate external ointment 0.2 %</i>	2	
<b>HYFTOR EXTERNAL GEL 0.2 %</b>	5	PA
<i>mometasone furoate external cream 0.1 %</i>	2	
<i>mometasone furoate external ointment 0.1 %</i>	2	
<i>mometasone furoate external solution 0.1 %</i>	2	

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<b>Name of Drug</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>pimecrolimus external cream 1 %</i>	2	ST
<i>prednicarbate external ointment 0.1 %</i>	2	
<i>selenium sulfide external lotion 2.5 %</i>	2	
<i>tacrolimus external ointment 0.03 %, 0.1 %</i>	2	ST
<i>triamcinolone acetonide external cream 0.025 %, 0.1 %, 0.5 %</i>	2	
<i>triamcinolone acetonide external lotion 0.025 %, 0.1 %</i>	2	
<i>triamcinolone acetonide external ointment 0.025 %, 0.05 %, 0.1 %, 0.5 %</i>	2	
<i>triamcinolone in absorbbase external ointment 0.05 %</i>	2	
<b>Dermatological Agents, Other</b>		
ALCOHOL PAD 70 %*	1	
<i>alcohol pad 70 %*</i>	1	
<i>alcohol sheet 70 %*</i>	1	
<i>calcipotriene external cream 0.005 %</i>	2	
<i>calcipotriene external ointment 0.005 %</i>	2	
<i>calcipotriene external solution 0.005 %</i>	2	
<i>calcitriol external ointment 3 mcg/gm</i>	2	
<i>clotrimazole-betamethasone external cream 1-0.05 %</i>	2	
<i>clotrimazole-betamethasone external lotion 1-0.05 %</i>	2	
<i>fluorouracil external cream 0.5 %</i>	5	PA
<i>fluorouracil external cream 5 %</i>	2	
<i>fluorouracil external solution 2 %, 5 %</i>	2	
<i>imiquimod external cream 5 %</i>	2	
<i>methoxsalen rapid oral capsule 10 mg</i>	2	
<i>nystatin-triamcinolone external cream 100000-0.1 unit/gm-%</i>	2	
<i>nystatin-triamcinolone external ointment 100000-0.1 unit/gm-%</i>	2	

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<b>Name of Drug</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
OTEZLA ORAL TABLET 30 MG	5	PA
OTEZLA ORAL TABLET THERAPY PACK 10 & 20 & 30 MG	5	PA
<i>podofilox external solution 0.5 %</i>	2	
REGRANEX EXTERNAL GEL 0.01 %	5	PA; QL (15 GM per 30 days)
SANTYL EXTERNAL OINTMENT 250 UNIT/GM	3	QL (90 GM per 30 days)
<i>silver sulfadiazine external cream 1 %</i>	2	
<i>sodium chloride irrigation solution 0.9 %</i>	2	
<b>Pediculicides/Scabicides</b>		
<i>malathion external lotion 0.5 %</i>	2	
<i>permethrin external cream 5 %</i>	2	
<b>Topical Anti-Infectives</b>		
<i>acyclovir external cream 5 %</i>	2	
<i>acyclovir external ointment 5 %</i>	2	
<i>ciclopirox external solution 8 %</i>	2	
<i>ciclopirox olamine external cream 0.77 %</i>	2	
<i>ciclopirox olamine external suspension 0.77 %</i>	2	
<i>clindamycin phosphate external gel 1 %</i>	2	
<i>clindamycin phosphate external lotion 1 %</i>	2	
<i>clindamycin phosphate external solution 1 %</i>	2	
<i>clindamycin phosphate external swab 1 %</i>	2	
<i>ery external pad 2 %</i>	2	
<i>erythromycin external gel 2 %</i>	2	
<i>erythromycin external solution 2 %</i>	2	
<i>gentamicin sulfate external cream 0.1 %*</i>	1	

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Name of Drug	Drug Tier	Requirements/Limits
<i>gentamicin sulfate external ointment 0.1 %*</i>	1	
<i>metronidazole external cream 0.75 %</i>	2	
<i>metronidazole external gel 0.75 %, 1 %</i>	2	
<i>metronidazole external lotion 0.75 %</i>	2	
<i>mupirocin external ointment 2 %</i>	2	QL (88 GM per 30 days)
<i>penciclovir external cream 1 %</i>	2	

## Electrolytes/Minerals/Metals/Vitamins - Products That Supplement Or Replace Electrolytes, Minerals, Metals Or Vitamins

### Electrolyte/Mineral Replacement

<i>carglumic acid oral tablet soluble 200 mg</i>	5	PA
ISOLYTE-S INTRAVENOUS SOLUTION	4	
ISOLYTE-S PH 7.4 INTRAVENOUS SOLUTION	4	
<i>kcl in dextrose-nacl intravenous solution 20-5-0.45 meq/l-%-%</i>	2	
KLOR-CON 10 ORAL TABLET EXTENDED RELEASE 10 MEQ	3	
KLOR-CON M10 ORAL TABLET EXTENDED RELEASE 10 MEQ	2	
KLOR-CON M15 ORAL TABLET EXTENDED RELEASE 15 MEQ	2	
KLOR-CON M20 ORAL TABLET EXTENDED RELEASE 20 MEQ	2	
KLOR-CON ORAL TABLET EXTENDED RELEASE 8 MEQ	3	
<i>magnesium sulfate injection solution 50 %, 50 % (10 ml syringe)</i>	2	
<i>potassium chloride crys er oral tablet extended release 10 meq, 15 meq, 20 meq*</i>	1	
<i>potassium chloride er oral capsule extended release 10 meq, 8 meq*</i>	1	

\*We provide additional coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-9.

<b>Name of Drug</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>potassium chloride er oral tablet extended release 10 meq, 15 meq, 20 meq, 8 meq*</i>	1	
<i>potassium chloride intravenous solution 2 meq/ml, 2 meq/ml (20 ml), 40 meq/100 ml</i>	2	
<i>potassium chloride oral solution 10 %, 20 meq/15 ml (10%), 40 meq/15 ml (20%)</i>	2	
<i>potassium citrate er oral tablet extended release 10 meq (1080 mg), 15 meq (1620 mg), 5 meq (540 mg)</i>	2	
<i>sodium chloride (pf) injection solution 0.9 %</i>	2	
<i>sodium chloride intravenous solution 0.45 %, 0.9 %, 3 %</i>	2	
<i>sodium fluoride oral tablet 2.2 (1 f) mg</i>	2	
<b>Electrolyte/Mineral/Metal Modifiers</b>		
CUVRIOR ORAL TABLET 300 MG	5	PA
<i>deferasirox granules oral packet 180 mg, 360 mg, 90 mg</i>	5	PA
<i>deferasirox oral packet 180 mg, 360 mg, 90 mg</i>	5	PA
<i>deferasirox oral tablet 180 mg</i>	5	PA
<i>deferasirox oral tablet 360 mg, 90 mg</i>	2	PA
<i>deferasirox oral tablet soluble 125 mg</i>	2	PA
<i>deferasirox oral tablet soluble 250 mg, 500 mg</i>	5	PA
<i>deferiprone oral tablet 1000 mg, 500 mg</i>	5	PA
<i>penicillamine oral tablet 250 mg</i>	5	PA
<i>tolvaptan oral tablet 15 mg, 30 mg</i>	5	PA
<i>trientine hcl oral capsule 250 mg</i>	5	PA
<b>Electrolytes/Minerals/Metals/Vitamins</b>		
CLINISOL SF INTRAVENOUS SOLUTION 15 %	4	B/D

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<b>Name of Drug</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>dextrose intravenous solution 10 %, 5 %</i>	2	
<i>dextrose-nacl intravenous solution 10-0.2 %, 10-0.45 %, 2.5-0.45 %, 5-0.2 %, 5-0.33 %, 5-0.45 %, 5-0.9 %</i>	2	
<i>dextrose-sodium chloride intravenous solution 2.5-0.45 %, 5-0.45 %, 5-0.9 %</i>	2	
INTRALIPID INTRAVENOUS EMULSION 20 %, 30 %	4	B/D
ISOLYTE-P IN D5W INTRAVENOUS SOLUTION	4	
<i>levocarnitine oral solution 1 gm/10 ml</i>	2	
<i>levocarnitine oral tablet 330 mg</i>	2	
<i>levocarnitine sf oral solution 1 gm/10 ml</i>	2	
NUTRILIPID INTRAVENOUS EMULSION 20 %	4	B/D
PLENAMINE INTRAVENOUS SOLUTION 15 %	4	B/D
<i>prenatal oral tablet 27-1 mg</i>	2	
<b>Phosphate Binders</b>		
<i>calcium acetate (phos binder) oral capsule 667 mg</i>	2	
<i>lanthanum carbonate oral tablet chewable 1000 mg, 500 mg, 750 mg</i>	2	
<i>sevelamer carbonate oral packet 0.8 gm, 2.4 gm</i>	2	
<i>sevelamer carbonate oral tablet 800 mg</i>	2	
<b>Potassium Binders</b>		
LOKELMA ORAL PACKET 10 GM, 5 GM	3	
<i>sodium polystyrene sulfonate oral powder</i>	2	
SPS ORAL SUSPENSION 15 GM/60 ML	2	
<b>Vitamins</b>		
<i>m-natal plus oral tablet 27-1 mg</i>	2	
<i>trinatal rx 1 oral tablet 60-1 mg</i>	2	

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Name of Drug	Drug Tier	Requirements/Limits
<b>Gastrointestinal Agents - Treatment Of Stomach And Intestinal Conditions</b>		
<b>Anti-Constipation Agents</b>		
<i>constulose oral solution 10 gm/15 ml</i>	2	
<i>enulose oral solution 10 gm/15 ml</i>	2	
GAVILYTE-C ORAL SOLUTION RECONSTITUTED 240 GM	2	
GAVILYTE-G ORAL SOLUTION RECONSTITUTED 236 GM	2	
<i>generlac oral solution 10 gm/15 ml</i>	2	
<i>lactulose encephalopathy oral solution 10 gm/15 ml</i>	2	
<i>lactulose oral solution 10 gm/15 ml, 20 gm/30 ml</i>	2	
LINZESS ORAL CAPSULE 145 MCG, 290 MCG, 72 MCG	3	QL (30 EA per 30 days)
<i>lubiprostone oral capsule 24 mcg, 8 mcg</i>	2	QL (60 EA per 30 days)
MOVANTIK ORAL TABLET 12.5 MG, 25 MG	3	QL (30 EA per 30 days)
<i>peg 3350-kcl-na bicarb-nacl oral solution reconstituted 420 gm</i>	2	
<i>peg-3350/electrolytes oral solution reconstituted 236 gm</i>	2	
RELISTOR ORAL TABLET 150 MG	4	PA
RELISTOR SUBCUTANEOUS SOLUTION 12 MG/0.6 ML, 12 MG/0.6 ML (0.6 ML SYRINGE), 8 MG/0.4 ML	5	PA
<b>Anti-Diarrheal Agents</b>		
<i>alosetron hcl oral tablet 0.5 mg</i>	2	QL (60 EA per 30 days)
<i>alosetron hcl oral tablet 1 mg</i>	4	QL (60 EA per 30 days)
<i>diphenoxylate-atropine oral liquid 2.5-0.025 mg/5 ml</i>	2	

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<b>Name of Drug</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>diphenoxylate-atropine oral tablet 2.5-0.025 mg</i>	2	
<i>loperamide hcl oral capsule 2 mg</i>	2	
XERMELO ORAL TABLET 250 MG	5	PA
XIFAXAN ORAL TABLET 200 MG	4	PA
XIFAXAN ORAL TABLET 550 MG	5	PA
<b>Antispasmodics, Gastrointestinal</b>		
<i>dicyclomine hcl oral capsule 10 mg*</i>	1	
<i>dicyclomine hcl oral solution 10 mg/5 ml</i>	2	
<i>dicyclomine hcl oral tablet 20 mg*</i>	1	
<i>glycopyrrolate oral solution 1 mg/5 ml</i>	2	
<i>glycopyrrolate oral tablet 1 mg, 2 mg</i>	2	
<b>Gastrointestinal Agents, Other</b>		
GATTEX SUBCUTANEOUS KIT 5 MG	5	PA
LIVMARLI ORAL SOLUTION 9.5 MG/ML	5	PA
OCALIVA ORAL TABLET 10 MG, 5 MG	5	PA
<i>ursodiol oral capsule 300 mg</i>	2	
<i>ursodiol oral tablet 250 mg, 500 mg</i>	2	
VOWST ORAL CAPSULE	5	PA
<b>Histamine-2 (H2) Receptor Antagonists</b>		
<i>cimetidine hcl oral solution 300 mg/5 ml, 400 mg/6.67 ml</i>	2	
<i>cimetidine oral tablet 200 mg, 300 mg, 400 mg, 800 mg</i>	2	
<i>famotidine oral tablet 20 mg, 40 mg*</i>	1	
<b>Protectants</b>		
<i>misoprostol oral tablet 100 mcg, 200 mcg</i>	2	
<i>sucralfate oral tablet 1 gm*</i>	1	
<b>Proton Pump Inhibitors</b>		
DEXILANT ORAL CAPSULE DELAYED RELEASE 30 MG, 60 MG	3	

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<b>Name of Drug</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>dexlansoprazole oral capsule delayed release 30 mg, 60 mg*</i>	1	
<i>esomeprazole magnesium oral capsule delayed release 20 mg, 40 mg*</i>	1	
<i>lansoprazole oral capsule delayed release 15 mg, 30 mg*</i>	1	
<i>omeprazole oral capsule delayed release 10 mg, 20 mg, 40 mg*</i>	1	
<i>pantoprazole sodium oral tablet delayed release 20 mg, 40 mg*</i>	1	

**Genetic Or Enzyme Or Protein Disorder: Replacement, Modifiers, Treatment - Products That Replace, Modify, Or Treat Genetic Or Enzyme Disorders**

**Genetic Or Enzyme Or Protein Disorder: Replacement, Modifiers, Treatment**

ARALAST NP INTRAVENOUS SOLUTION RECONSTITUTED 1000 MG, 500 MG	5	PA
<i>betaine oral powder</i>	5	
CERDELGA ORAL CAPSULE 84 MG	5	PA
CHOLBAM ORAL CAPSULE 250 MG, 50 MG	5	PA
CREON ORAL CAPSULE DELAYED RELEASE PARTICLES 12000-38000 UNIT, 24000-76000 UNIT, 3000-9500 UNIT, 36000-114000 UNIT, 6000-19000 UNIT	3	
CYSTAGON ORAL CAPSULE 150 MG, 50 MG	4	PA
<i>dichlorphenamide oral tablet 50 mg</i>	5	PA
ENDARI ORAL PACKET 5 GM	5	PA
GALAFOLD ORAL CAPSULE 123 MG	5	PA
GLASSIA INTRAVENOUS SOLUTION 1000 MG/50ML	5	PA
<i>miglustat oral capsule 100 mg</i>	5	PA
<i>nitisinone oral capsule 10 mg, 2 mg, 20 mg, 5 mg</i>	5	PA

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<b>Name of Drug</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
ORFADIN ORAL SUSPENSION 4 MG/ML	5	PA
PROLASTIN-C INTRAVENOUS SOLUTION 1000 MG/20 ML	5	PA
PROLASTIN-C INTRAVENOUS SOLUTION RECONSTITUTED 1000 MG	5	PA
RAVICTI ORAL LIQUID 1.1 GM/ML	5	PA
<i>sapropterin dihydrochloride oral packet 100 mg, 500 mg</i>	5	PA
<i>sapropterin dihydrochloride oral tablet 100 mg</i>	5	PA
<i>sodium phenylbutyrate oral powder 3 gm/tsp</i>	5	PA
<i>sodium phenylbutyrate oral tablet 500 mg</i>	5	PA
SUCRAID ORAL SOLUTION 8500 UNIT/ML	5	PA
XURIDEN ORAL PACKET 2 GM	5	PA
ZEMAIRA INTRAVENOUS SOLUTION RECONSTITUTED 1000 MG, 4000 MG, 5000 MG	5	PA
ZENPEP ORAL CAPSULE DELAYED RELEASE PARTICLES 10000-32000 UNIT, 15000-47000 UNIT, 20000-63000 UNIT, 25000-79000 UNIT, 3000-10000 UNIT, 40000-126000 UNIT, 5000-24000 UNIT, 60000-189600 UNIT	3	

## **Genitourinary Agents - Treatment Of Urinary Tract And Prostate Conditions**

### **Antispasmodics, Urinary**

<i>darifenacin hydrobromide er oral tablet extended release 24 hour 15 mg, 7.5 mg</i>	2	ST
<i>fesoterodine fumarate er oral tablet extended release 24 hour 4 mg, 8 mg</i>	2	ST
<i>flavoxate hcl oral tablet 100 mg</i>	2	
MYRBETRIQ ORAL SUSPENSION RECONSTITUTED ER 8 MG/ML	3	QL (300 ML per 30 days)

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<b>Name of Drug</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
MYRBETRIQ ORAL TABLET EXTENDED RELEASE 24 HOUR 25 MG, 50 MG	3	QL (30 EA per 30 days)
<i>oxybutynin chloride er oral tablet extended release 24 hour 10 mg, 15 mg, 5 mg*</i>	1	
<i>oxybutynin chloride oral solution 5 mg/5 ml*</i>	1	
<i>oxybutynin chloride oral tablet 5 mg*</i>	1	
<i>solifenacin succinate oral tablet 10 mg, 5 mg</i>	2	
<i>tolterodine tartrate er oral capsule extended release 24 hour 2 mg, 4 mg</i>	2	
<i>tolterodine tartrate oral tablet 1 mg, 2 mg</i>	2	
<i>trospium chloride er oral capsule extended release 24 hour 60 mg</i>	2	ST
<i>trospium chloride oral tablet 20 mg</i>	2	
<b>Benign Prostatic Hypertrophy Agents</b>		
<i>alfuzosin hcl er oral tablet extended release 24 hour 10 mg*</i>	1	
<i>dutasteride oral capsule 0.5 mg</i>	2	
<i>finasteride oral tablet 5 mg*</i>	1	
<i>tamsulosin hcl oral capsule 0.4 mg*</i>	1	
<b>Genitourinary Agents, Other</b>		
<i>bethanechol chloride oral tablet 10 mg, 25 mg, 5 mg, 50 mg</i>	2	
ELMIRON ORAL CAPSULE 100 MG	4	
FILSPARI ORAL TABLET 200 MG, 400 MG	5	PA
THIOLA EC ORAL TABLET DELAYED RELEASE 100 MG, 300 MG	5	PA
<i>tiopronin oral tablet 100 mg</i>	5	PA

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<b>Name of Drug</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>Hormonal Agents, Stimulant/Replacement/Modifying (Adrenal) - Treatment Of Conditions Requiring Steroids</b>		
<b>Hormonal Agents, Stimulant/Replacement/Modifying (Adrenal)</b>		
ACTHAR INJECTION GEL 80 UNIT/ML	5	PA
CORTROPHIN INJECTION GEL 80 UNIT/ML	5	PA
<i>dexamethasone oral solution 0.5 mg/5 ml</i>	2	
<i>dexamethasone oral tablet 0.5 mg, 0.75 mg, 1 mg, 1.5 mg, 2 mg, 4 mg, 6 mg*</i>	1	
<i>fludrocortisone acetate oral tablet 0.1 mg</i>	2	
<i>hydrocortisone oral tablet 10 mg, 20 mg, 5 mg</i>	2	
<i>methylprednisolone oral tablet 16 mg, 32 mg, 4 mg, 8 mg</i>	2	
<i>methylprednisolone oral tablet therapy pack 4 mg</i>	2	
<i>prednisolone oral solution 15 mg/5 ml</i>	2	
<i>prednisolone sodium phosphate oral solution 25 mg/5 ml, 6.7 (5 base) mg/5 ml</i>	2	
<b>Hormonal Agents, Stimulant/Replacement/Modifying (Pituitary) - Treatment Of Pituitary Gland Conditions</b>		
<b>Hormonal Agents, Stimulant/Replacement/Modifying (Pituitary)</b>		
<i>desmopressin ace spray refrig nasal solution 0.01 %</i>	2	
<i>desmopressin acetate oral tablet 0.1 mg, 0.2 mg</i>	2	
<i>desmopressin acetate spray nasal solution 0.01 %</i>	2	
EGRIFTA SV SUBCUTANEOUS SOLUTION RECONSTITUTED 2 MG	5	PA

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<b>Name of Drug</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
GENOTROPIN MINIQUICK SUBCUTANEOUS PREFILLED SYRINGE 0.2 MG	4	PA
GENOTROPIN MINIQUICK SUBCUTANEOUS PREFILLED SYRINGE 0.4 MG, 0.6 MG, 0.8 MG, 1 MG, 1.2 MG, 1.4 MG, 1.6 MG, 1.8 MG, 2 MG	5	PA
GENOTROPIN SUBCUTANEOUS CARTRIDGE 12 MG	5	PA
GENOTROPIN SUBCUTANEOUS CARTRIDGE 5 MG	4	PA
HUMATROPE INJECTION CARTRIDGE 12 MG, 24 MG, 6 MG	5	PA
INCRELEX SUBCUTANEOUS SOLUTION 40 MG/4 ML	5	PA
NGENLA SUBCUTANEOUS SOLUTION PEN-INJECTOR 24 MG/1.2 ML, 60 MG/1.2 ML	5	PA
NORDITROPIN FLEXP SUBCUTANEOUS SOLUTION PEN- INJECTOR 10 MG/1.5 ML, 15 MG/1.5 ML, 30 MG/3 ML, 5 MG/1.5 ML	5	PA
NUTROPIN AQ NUSPIN 10 SUBCUTANEOUS SOLUTION PEN- INJECTOR 10 MG/2 ML	5	PA
NUTROPIN AQ NUSPIN 20 SUBCUTANEOUS SOLUTION PEN- INJECTOR 20 MG/2 ML	5	PA
NUTROPIN AQ NUSPIN 5 SUBCUTANEOUS SOLUTION PEN- INJECTOR 5 MG/2 ML	5	PA
OMNITROPE SUBCUTANEOUS SOLUTION CARTRIDGE 10 MG/1.5 ML, 5 MG/1.5 ML	5	PA
OMNITROPE SUBCUTANEOUS SOLUTION RECONSTITUTED 5.8 MG	5	PA
SEROSTIM SUBCUTANEOUS SOLUTION RECONSTITUTED 4 MG, 5 MG, 6 MG	5	PA

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<b>Name of Drug</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
SKYTROFA SUBCUTANEOUS CARTRIDGE 11 MG, 13.3 MG, 3 MG, 3.6 MG, 4.3 MG, 5.2 MG, 6.3 MG, 7.6 MG, 9.1 MG	5	PA
<b>Hormonal Agents, Stimulant/Replacement/Modifying (Sex Hormones/Modifiers) - For The Replacement Or Modification Of Sex Hormones</b>		
<b>Anabolic Steroids</b>		
<i>oxandrolone oral tablet 10 mg, 2.5 mg</i>	2	
<b>Androgens</b>		
<i>danazol oral capsule 100 mg, 200 mg, 50 mg</i>	2	
<i>methyltestosterone oral capsule 10 mg</i>	5	PA
<i>testosterone cypionate injection solution 200 mg/ml</i>	2	
<i>testosterone cypionate intramuscular solution 100 mg/ml, 200 mg/ml, 200 mg/ml (1 ml)</i>	2	
<i>testosterone enanthate intramuscular solution 200 mg/ml</i>	2	
<i>testosterone transdermal gel 1.62 %, 12.5 mg/act (1%), 20.25 mg/1.25 gm (1.62%), 20.25 mg/act (1.62%), 25 mg/2.5 gm (1%), 40.5 mg/2.5 gm (1.62%), 50 mg/5 gm (1%)</i>	2	PA
<i>testosterone transdermal solution 30 mg/act</i>	2	PA
<b>Estrogens</b>		
<i>estradiol oral tablet 0.5 mg, 1 mg, 2 mg*</i>	1	
<i>estradiol transdermal patch twice weekly 0.025 mg/24 hr, 0.0375 mg/24 hr, 0.05 mg/24 hr, 0.075 mg/24 hr, 0.1 mg/24 hr</i>	2	
<i>estradiol transdermal patch weekly 0.025 mg/24 hr, 0.0375 mg/24 hr, 0.05 mg/24 hr, 0.06 mg/24 hr, 0.075 mg/24 hr, 0.1 mg/24 hr</i>	2	

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<b>Name of Drug</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>estradiol vaginal cream 0.1 mg/gm</i>	2	
<i>estradiol vaginal tablet 10 mcg</i>	2	
<i>estradiol valerate intramuscular oil 10 mg/ml, 20 mg/ml, 40 mg/ml</i>	2	
MENEST ORAL TABLET 0.3 MG, 0.625 MG, 1.25 MG, 2.5 MG	4	PA
PREMARIN ORAL TABLET 0.3 MG, 0.45 MG, 0.625 MG, 0.9 MG, 1.25 MG	3	
PREMARIN VAGINAL CREAM 0.625 MG/GM	3	
YUVAFEM VAGINAL TABLET 10 MCG	2	
<b>Hormonal Agents, Stimulant/Replacement/Modifying (Sex Hormones/Modifiers)</b>		
AFIRMELLE ORAL TABLET 0.1-20 MG-MCG	2	
ALTAVERA ORAL TABLET 0.15-30 MG-MCG	2	
<i>alyacen 1/35 oral tablet 1-35 mg-mcg</i>	2	
<i>alyacen 7/7/7 oral tablet 0.5/0.75/1-35 mg-mcg</i>	2	
AMABELZ ORAL TABLET 0.5-0.1 MG	2	
APRI ORAL TABLET 0.15-30 MG-MCG	2	
ARANELLE ORAL TABLET 0.5/1/0.5-35 MG-MCG	2	
AUBRA EQ ORAL TABLET 0.1-20 MG-MCG	2	
AUROVELA 1.5/30 ORAL TABLET 1.5-30 MG-MCG	2	
AUROVELA FE 1.5/30 ORAL TABLET 1.5-30 MG-MCG	2	
AUROVELA FE 1/20 ORAL TABLET 1-20 MG-MCG	2	
AVIANE ORAL TABLET 0.1-20 MG-MCG	2	
AYUNA ORAL TABLET 0.15-30 MG-MCG	2	
BALZIVA ORAL TABLET 0.4-35 MG-MCG	2	

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<b>Name of Drug</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
BLISOVI FE 1.5/30 ORAL TABLET 1.5-30 MG-MCG	2	
BLISOVI FE 1/20 ORAL TABLET 1-20 MG-MCG	2	
<i>briellyn oral tablet 0.4-35 mg-mcg</i>	2	
CHATEAL EQ ORAL TABLET 0.15-30 MG-MCG	2	
COMBIPATCH TRANSDERMAL PATCH TWICE WEEKLY 0.05-0.14 MG/DAY, 0.05-0.25 MG/DAY	4	
CRYSSELLE-28 ORAL TABLET 0.3-30 MG-MCG	2	
CYRED EQ ORAL TABLET 0.15-30 MG-MCG	2	
<i>desogestrel-ethinyl estradiol oral tablet 0.15-0.02/0.01 mg (21/5), 0.15-30 mg-mcg</i>	2	
<i>drospirenone-ethinyl estradiol oral tablet 3-0.02 mg, 3-0.03 mg</i>	2	
ELURYNG VAGINAL RING 0.12-0.015 MG/24 HR	2	
ENPRESSE-28 ORAL TABLET 50-30/75-40/ 125-30 MCG	2	
ENSKYCE ORAL TABLET 0.15-30 MG-MCG	2	
ESTARYLLA ORAL TABLET 0.25-35 MG-MCG	2	
<i>estradiol-norethindrone acet oral tablet 0.5-0.1 mg, 1-0.5 mg</i>	2	
<i>ethynodiol diac-eth estradiol oral tablet 1-35 mg-mcg, 1-50 mg-mcg</i>	2	
<i>etonogestrel-ethinyl estradiol vaginal ring 0.12-0.015 mg/24 hr</i>	2	
FALMINA ORAL TABLET 0.1-20 MG-MCG	2	
FEMYNOR ORAL TABLET 0.25-35 MG-MCG	2	
FYAVOLV ORAL TABLET 0.5-2.5 MG-MCG, 1-5 MG-MCG	2	

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<b>Name of Drug</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
HAILEY 24 FE ORAL TABLET 1-20 MG-MCG (24)	2	
HAILEY FE 1.5/30 ORAL TABLET 1.5-30 MG-MCG	2	
HAILEY FE 1/20 ORAL TABLET 1-20 MG-MCG	2	
INTROVALE ORAL TABLET 0.15-0.03 MG	2	
ISIBLOOM ORAL TABLET 0.15-30 MG-MCG	2	
JINTELI ORAL TABLET 1-5 MG-MCG	2	
JULEBER ORAL TABLET 0.15-30 MG-MCG	2	
JUNEL 1.5/30 ORAL TABLET 1.5-30 MG-MCG	2	
JUNEL 1/20 ORAL TABLET 1-20 MG-MCG	2	
JUNEL FE 1.5/30 ORAL TABLET 1.5-30 MG-MCG	2	
JUNEL FE 1/20 ORAL TABLET 1-20 MG-MCG	2	
KARIVA ORAL TABLET 0.15-0.02/0.01 MG (21/5)	2	
KELNOR 1/35 ORAL TABLET 1-35 MG-MCG	2	
KELNOR 1/50 ORAL TABLET 1-50 MG-MCG	2	
KURVELO ORAL TABLET 0.15-30 MG-MCG	2	
LARIN 1.5/30 ORAL TABLET 1.5-30 MG-MCG	2	
LARIN 1/20 ORAL TABLET 1-20 MG-MCG	2	
LARIN FE 1.5/30 ORAL TABLET 1.5-30 MG-MCG	2	
LARIN FE 1/20 ORAL TABLET 1-20 MG-MCG	2	
LEENA ORAL TABLET 0.5/1/0.5-35 MG-MCG	2	

\*We provide additional coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-9.

<b>Name of Drug</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
LESSINA ORAL TABLET 0.1-20 MG-MCG	2	
LEVONEST ORAL TABLET 50-30/75-40/ 125-30 MCG	2	
<i>levonorgest-eth estrad 91-day oral tablet 0.1-0.02 &amp; 0.01 mg, 0.15-0.03 &amp; 0.01 mg, 0.15-0.03 mg</i>	2	
<i>levonorgestrel-ethinyl estrad oral tablet 0.1-20 mg-mcg, 0.15-30 mg-mcg</i>	2	
<i>levonorg-eth estrad triphasic oral tablet 50-30/75-40/ 125-30 mcg</i>	2	
LEVORA 0.15/30 (28) ORAL TABLET 0.15-30 MG-MCG	2	
LOW-OGESTREL ORAL TABLET 0.3-30 MG-MCG	2	
LUTERA ORAL TABLET 0.1-20 MG-MCG	2	
<i>marlissa oral tablet 0.15-30 mg-mcg</i>	2	
MICROGESTIN 1.5/30 ORAL TABLET 1.5-30 MG-MCG	2	
MICROGESTIN 1/20 ORAL TABLET 1-20 MG-MCG	2	
MICROGESTIN 24 FE ORAL TABLET 1-20 MG-MCG	2	
MICROGESTIN FE 1.5/30 ORAL TABLET 1.5-30 MG-MCG	2	
MICROGESTIN FE 1/20 ORAL TABLET 1-20 MG-MCG	2	
MILI ORAL TABLET 0.25-35 MG-MCG	2	
MIMVEY ORAL TABLET 1-0.5 MG	2	
NECON 0.5/35 (28) ORAL TABLET 0.5-35 MG-MCG	2	
<i>norelgestromin-eth estradiol transdermal patch weekly 150-35 mcg/24 hr</i>	2	
<i>norethin ace-eth estrad-fe oral tablet 1-20 mg-mcg, 1.5-30 mg-mcg</i>	2	

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<b>Name of Drug</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>norethindrone acet-ethinyl est oral tablet 1-20 mg-mcg, 1.5-30 mg-mcg</i>	2	
<i>norethindrone-eth estradiol oral tablet 0.5-2.5 mg-mcg, 1-5 mg-mcg</i>	2	
<i>norethindron-ethinyl estrad-fe oral tablet 1-20/1-30/1-35 mg-mcg</i>	2	
<i>norgestimate-eth estradiol oral tablet 0.25-35 mg-mcg</i>	2	
<i>norgestim-eth estrad triphasic oral tablet 0.18/0.215/0.25 mg-35 mcg</i>	2	
NORTREL 0.5/35 (28) ORAL TABLET 0.5-35 MG-MCG	2	
NORTREL 1/35 (21) ORAL TABLET 1-35 MG-MCG	2	
NORTREL 1/35 (28) ORAL TABLET 1-35 MG-MCG	2	
NORTREL 7/7/7 ORAL TABLET 0.5/0.75/1-35 MG-MCG	2	
NYLIA 1/35 ORAL TABLET 1-35 MG-MCG	2	
NYLIA 7/7/7 ORAL TABLET 0.5/0.75/1-35 MG-MCG	2	
OCELLA ORAL TABLET 3-0.03 MG	2	
PIMTREA ORAL TABLET 0.15-0.02/0.01 MG (21/5)	2	
PIRMELLA 1/35 ORAL TABLET 1-35 MG-MCG	2	
PORTIA-28 ORAL TABLET 0.15-30 MG-MCG	2	
PREMPHASE ORAL TABLET 0.625-5 MG	3	
PREMPRO ORAL TABLET 0.3-1.5 MG, 0.45-1.5 MG, 0.625-2.5 MG, 0.625-5 MG	3	
RECLIPSEN ORAL TABLET 0.15-30 MG-MCG	2	
SETLAKIN ORAL TABLET 0.15-0.03 MG	2	
SPRINTEC 28 ORAL TABLET 0.25-35 MG-MCG	2	

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<b>Name of Drug</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
SRONYX ORAL TABLET 0.1-20 MG-MCG	2	
TARINA FE 1/20 EQ ORAL TABLET 1-20 MG-MCG	2	
TRI FEMYNOR ORAL TABLET 0.18/0.215/0.25 MG-35 MCG	2	
TRI-ESTARYLLA ORAL TABLET 0.18/0.215/0.25 MG-35 MCG	2	
TRI-LEGEST FE ORAL TABLET 1-20/1-30/1-35 MG-MCG	2	
TRI-MILI ORAL TABLET 0.18/0.215/0.25 MG-35 MCG	2	
TRI-SPRINTEC ORAL TABLET 0.18/0.215/0.25 MG-35 MCG	2	
TRIVORA (28) ORAL TABLET 50-30/75-40/ 125-30 MCG	2	
TRI-VYLIBRA ORAL TABLET 0.18/0.215/0.25 MG-35 MCG	2	
VELIVET ORAL TABLET 0.1/0.125/0.15 -0.025 MG	2	
VIENVA ORAL TABLET 0.1-20 MG-MCG	2	
VYFEMLA ORAL TABLET 0.4-35 MG-MCG	2	
VYLIBRA ORAL TABLET 0.25-35 MG-MCG	2	
XULANE TRANSDERMAL PATCH WEEKLY 150-35 MCG/24 HR	2	
ZAFEMY TRANSDERMAL PATCH WEEKLY 150-35 MCG/24 HR	2	
ZOVIA 1/35 (28) ORAL TABLET 1-35 MG-MCG	2	
<b>Progestins</b>		
CAMILA ORAL TABLET 0.35 MG	2	
DEBLITANE ORAL TABLET 0.35 MG	2	
DEPO-SUBQ PROVERA 104 SUBCUTANEOUS SUSPENSION PREFILLED SYRINGE 104 MG/0.65 ML	4	

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<b>Name of Drug</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
ERRIN ORAL TABLET 0.35 MG	2	
INCASSIA ORAL TABLET 0.35 MG	2	
LYZA ORAL TABLET 0.35 MG	2	
<i>medroxyprogesterone acetate intramuscular suspension 150 mg/ml</i>	2	
<i>medroxyprogesterone acetate intramuscular suspension prefilled syringe 150 mg/ml</i>	2	
<i>medroxyprogesterone acetate oral tablet 10 mg, 2.5 mg, 5 mg*</i>	1	
<i>megestrol acetate oral suspension 40 mg/ml, 400 mg/10 ml, 625 mg/5 ml, 800 mg/20 ml</i>	2	PA
<i>megestrol acetate oral tablet 20 mg, 40 mg</i>	2	PA
NORA-BE ORAL TABLET 0.35 MG	2	
<i>norethindrone acetate oral tablet 5 mg</i>	2	
<i>norethindrone oral tablet 0.35 mg</i>	2	
NORLYROC ORAL TABLET 0.35 MG	2	
<i>progesterone oral capsule 100 mg, 200 mg</i>	2	
SHAROBEL ORAL TABLET 0.35 MG	2	
<b>Selective Estrogen Receptor Modifying Agents</b>		
DUAVEE ORAL TABLET 0.45-20 MG	3	
<i>raloxifene hcl oral tablet 60 mg</i>	2	
<b>Hormonal Agents, Stimulant/Replacement/Modifying (Thyroid) - Treatment Of Thyroid Conditions</b>		
<b>Hormonal Agents, Stimulant/Replacement/Modifying (Thyroid)</b>		
EUTHYROX ORAL TABLET 100 MCG, 112 MCG, 125 MCG, 137 MCG, 150 MCG, 175 MCG, 200 MCG, 25 MCG, 50 MCG, 75 MCG, 88 MCG	3	

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<b>Name of Drug</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
LEVO-T ORAL TABLET 100 MCG, 112 MCG, 125 MCG, 137 MCG, 150 MCG, 175 MCG, 200 MCG, 25 MCG, 300 MCG, 50 MCG, 75 MCG, 88 MCG	4	
<i>levothyroxine sodium oral tablet 100 mcg, 112 mcg, 125 mcg, 137 mcg, 150 mcg, 175 mcg, 200 mcg, 25 mcg, 300 mcg, 50 mcg, 75 mcg, 88 mcg*</i>	1	
LEVOXYL ORAL TABLET 100 MCG, 112 MCG, 125 MCG, 137 MCG, 150 MCG, 175 MCG, 200 MCG, 25 MCG, 50 MCG, 75 MCG, 88 MCG	4	
<i>liothyronine sodium oral tablet 25 mcg, 5 mcg, 50 mcg</i>	2	
SYNTHROID ORAL TABLET 100 MCG, 112 MCG, 125 MCG, 137 MCG, 150 MCG, 175 MCG, 200 MCG, 25 MCG, 300 MCG, 50 MCG, 75 MCG, 88 MCG	3	
UNITHROID ORAL TABLET 100 MCG, 112 MCG, 125 MCG, 137 MCG, 150 MCG, 175 MCG, 200 MCG, 25 MCG, 300 MCG, 50 MCG, 75 MCG, 88 MCG	4	

### **Hormonal Agents, Suppressant (Pituitary) - Treatment Of Or Modification Of Pituitary Hormone Secretion**

#### **Hormonal Agents, Suppressant (Pituitary)**

<i>cabergoline oral tablet 0.5 mg</i>	2	
CAMCEVI SUBCUTANEOUS PREFILLED SYRINGE 42 MG	4	PA
ELIGARD SUBCUTANEOUS KIT 22.5 MG, 30 MG, 45 MG, 7.5 MG	4	PA
FIRMAGON (240 MG DOSE) SUBCUTANEOUS SOLUTION RECONSTITUTED 120 MG/VIAL	5	PA
FIRMAGON SUBCUTANEOUS SOLUTION RECONSTITUTED 80 MG	4	PA
<i>leuprolide acetate (3 month) intramuscular injectable 22.5 mg</i>	2	PA

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<b>Name of Drug</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>leuprolide acetate injection kit 1 mg/0.2 ml</i>	5	
LUPRON DEPOT (1-MONTH) INTRAMUSCULAR KIT 3.75 MG, 7.5 MG	5	PA
LUPRON DEPOT (3-MONTH) INTRAMUSCULAR KIT 11.25 MG, 22.5 MG	5	PA
LUPRON DEPOT (4-MONTH) INTRAMUSCULAR KIT 30 MG	5	PA
LUPRON DEPOT (6-MONTH) INTRAMUSCULAR KIT 45 MG	5	PA
MYFEMBREE ORAL TABLET 40-1-0.5 MG	5	PA
<i>octreotide acetate injection solution 100 mcg/ml, 200 mcg/ml, 50 mcg/ml</i>	2	PA
<i>octreotide acetate injection solution 1000 mcg/ml, 500 mcg/ml</i>	5	PA
<i>octreotide acetate subcutaneous solution prefilled syringe 100 mcg/ml, 50 mcg/ml</i>	2	
<i>octreotide acetate subcutaneous solution prefilled syringe 500 mcg/ml</i>	5	
ORGOVYX ORAL TABLET 120 MG	5	PA
ORIAHNN ORAL CAPSULE THERAPY PACK 300-1-0.5 & 300 MG	5	PA
ORLISSA ORAL TABLET 150 MG, 200 MG	5	PA
RECORLEV ORAL TABLET 150 MG	5	PA
SIGNIFOR SUBCUTANEOUS SOLUTION 0.3 MG/ML, 0.6 MG/ML, 0.9 MG/ML	5	PA
SOMAVERT SUBCUTANEOUS SOLUTION RECONSTITUTED 10 MG, 15 MG, 20 MG, 25 MG, 30 MG	5	PA
SYNAREL NASAL SOLUTION 2 MG/ML	5	PA
TARPEYO ORAL CAPSULE DELAYED RELEASE 4 MG	5	PA
TRELSTAR MIXJECT INTRAMUSCULAR SUSPENSION RECONSTITUTED 11.25 MG, 22.5 MG, 3.75 MG	4	PA

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Name of Drug	Drug Tier	Requirements/Limits
<b>Hormonal Agents, Suppressant (Thyroid) - Treatment For Overactive Thyroid</b>		
<b>Antithyroid Agents</b>		
<i>methimazole oral tablet 10 mg, 5 mg*</i>	1	
<i>propylthiouracil oral tablet 50 mg</i>	2	
<b>Immunological Agents - Medications That Alter The Immune System Including Vaccinations</b>		
<b>Angioedema Agents</b>		
CINRYZE INTRAVENOUS SOLUTION RECONSTITUTED 500 UNIT	5	PA
HAEGARDA SUBCUTANEOUS SOLUTION RECONSTITUTED 2000 UNIT, 3000 UNIT	5	PA
<i>icatibant acetate subcutaneous solution prefilled syringe 30 mg/3 ml</i>	5	PA
ORLADEYO ORAL CAPSULE 110 MG, 150 MG	5	PA
<b>Immunoglobulins</b>		
GAMMAGARD INJECTION SOLUTION 1 GM/10 ML, 10 GM/100 ML, 2.5 GM/25 ML, 20 GM/200 ML, 30 GM/300 ML, 5 GM/50 ML	5	B/D
GAMMAGARD S/D LESS IGA INTRAVENOUS SOLUTION RECONSTITUTED 10 GM, 5 GM	5	B/D
GAMMAKED INJECTION SOLUTION 1 GM/10 ML	5	B/D
GAMMAPLEX INTRAVENOUS SOLUTION 10 GM/100 ML, 10 GM/200 ML, 20 GM/200 ML, 5 GM/50 ML	5	B/D
GAMUNEX-C INJECTION SOLUTION 1 GM/10 ML	5	B/D
PRIVIGEN INTRAVENOUS SOLUTION 10 GM/100 ML, 20 GM/200 ML, 40 GM/400 ML, 5 GM/50 ML	5	B/D

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Name of Drug	Drug Tier	Requirements/Limits
<b>Immunological Agents, Other</b>		
ACTEMRA ACTPEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 162 MG/0.9 ML	5	PA
ACTEMRA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 162 MG/0.9 ML	5	PA
ARCALYST SUBCUTANEOUS SOLUTION RECONSTITUTED 220 MG	5	PA
BENLYSTA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 200 MG/ML	5	PA
BENLYSTA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 200 MG/ML	5	PA
CIBINQO ORAL TABLET 100 MG, 200 MG, 50 MG	5	PA
COSENTYX (300 MG DOSE) SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML	5	PA
COSENTYX INTRAVENOUS SOLUTION 125 MG/5 ML	5	PA
COSENTYX SENSOREADY (300 MG) SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML	5	PA
COSENTYX SENSOREADY PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML	5	PA
COSENTYX SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML, 75 MG/0.5 ML	5	PA
COSENTYX UNOREADY SUBCUTANEOUS SOLUTION AUTO-INJECTOR 300 MG/2 ML	5	PA
ENTYVIO SUBCUTANEOUS SOLUTION PEN-INJECTOR 108 MG/0.68 ML	5	PA
ILARIS SUBCUTANEOUS SOLUTION 150 MG/ML	5	PA
ILUMYA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML	5	PA

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<b>Name of Drug</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
KEVZARA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/1.14 ML, 200 MG/1.14 ML	5	PA
KEVZARA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/1.14 ML, 200 MG/1.14 ML	5	PA
KINERET SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/0.67 ML	5	PA
LITFULO ORAL CAPSULE 50 MG	5	PA
OLUMIANT ORAL TABLET 1 MG, 2 MG, 4 MG	5	PA
ORENCIA CLICKJECT SUBCUTANEOUS SOLUTION AUTO-INJECTOR 125 MG/ML	5	PA
ORENCIA INTRAVENOUS SOLUTION RECONSTITUTED 250 MG	5	PA
ORENCIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 125 MG/ML, 50 MG/0.4 ML, 87.5 MG/0.7 ML	5	PA
RINVOQ ORAL TABLET EXTENDED RELEASE 24 HOUR 15 MG, 30 MG, 45 MG	5	PA
SILIQ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 210 MG/1.5 ML	5	PA
SKYRIZI INTRAVENOUS SOLUTION 600 MG/10 ML	5	PA
SKYRIZI PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML	5	PA
SKYRIZI SUBCUTANEOUS SOLUTION CARTRIDGE 180 MG/1.2 ML, 360 MG/2.4 ML	5	PA
SKYRIZI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML	5	PA
SOTYKTU ORAL TABLET 6 MG	5	PA
STELARA INTRAVENOUS SOLUTION 130 MG/26 ML	5	PA
STELARA SUBCUTANEOUS SOLUTION 45 MG/0.5 ML	5	PA

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<b>Name of Drug</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
STELARA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 45 MG/0.5 ML, 90 MG/ML	5	PA
TALTZ SUBCUTANEOUS SOLUTION AUTO-INJECTOR 80 MG/ML	5	PA
TALTZ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 80 MG/ML	5	PA
TREMFYA SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 MG/ML	5	PA
TREMFYA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML	5	PA
XELJANZ ORAL SOLUTION 1 MG/ML	5	PA
XELJANZ ORAL TABLET 10 MG, 5 MG	5	PA
XELJANZ XR ORAL TABLET EXTENDED RELEASE 24 HOUR 11 MG, 22 MG	5	PA
<b>Immunostimulants</b>		
ACTIMMUNE SUBCUTANEOUS SOLUTION 2000000 UNIT/0.5 ML	5	PA
INTRON A INJECTION SOLUTION RECONSTITUTED 10000000 UNIT, 18000000 UNIT, 50000000 UNIT	5	PA
PEGASYS SUBCUTANEOUS SOLUTION 180 MCG/ML	5	PA
PEGASYS SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 180 MCG/0.5 ML	5	PA
<b>Immunosuppressants</b>		
ASTAGRAF XL ORAL CAPSULE EXTENDED RELEASE 24 HOUR 0.5 MG, 1 MG	4	B/D
ASTAGRAF XL ORAL CAPSULE EXTENDED RELEASE 24 HOUR 5 MG	5	B/D
<i>azathioprine oral tablet 50 mg</i>	2	B/D
CIMZIA STARTER KIT SUBCUTANEOUS PREFILLED SYRINGE KIT 6 X 200 MG/ML	5	PA

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<b>Name of Drug</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
CIMZIA SUBCUTANEOUS KIT 2 X 200 MG	5	PA
CIMZIA SUBCUTANEOUS PREFILLED SYRINGE KIT 2 X 200 MG/ML	5	PA
<i>cyclosporine modified oral capsule 100 mg, 25 mg, 50 mg</i>	2	B/D
<i>cyclosporine modified oral solution 100 mg/ml</i>	2	B/D
<i>cyclosporine oral capsule 100 mg, 25 mg</i>	2	B/D
ENBREL MINI SUBCUTANEOUS SOLUTION CARTRIDGE 50 MG/ML	5	PA
ENBREL SUBCUTANEOUS SOLUTION 25 MG/0.5 ML	5	PA
ENBREL SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 25 MG/0.5 ML, 50 MG/ML	5	PA
ENBREL SUBCUTANEOUS SOLUTION RECONSTITUTED 25 MG	5	PA
ENBREL SURECLICK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 50 MG/ML	5	PA
ENVARSUS XR ORAL TABLET EXTENDED RELEASE 24 HOUR 0.75 MG, 1 MG	4	B/D
ENVARSUS XR ORAL TABLET EXTENDED RELEASE 24 HOUR 4 MG	5	B/D
<i>everolimus oral tablet 0.25 mg, 0.5 mg</i>	2	B/D
<i>everolimus oral tablet 0.75 mg, 1 mg</i>	5	B/D
GENGRAF ORAL CAPSULE 100 MG, 25 MG	2	B/D
GENGRAF ORAL SOLUTION 100 MG/ML	2	B/D
HADLIMA PUSHTOUCH SUBCUTANEOUS SOLUTION AUTO- INJECTOR 40 MG/0.4 ML, 40 MG/0.8 ML	5	PA
HADLIMA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/0.4 ML, 40 MG/0.8 ML	5	PA

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<b>Name of Drug</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
HUMIRA (2 PEN) SUBCUTANEOUS PEN-INJECTOR KIT 40 MG/0.4 ML, 40 MG/0.8 ML, 80 MG/0.8 ML	5	PA
HUMIRA (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 10 MG/0.1 ML, 20 MG/0.2 ML, 40 MG/0.4 ML, 40 MG/0.8 ML	5	PA
HUMIRA-CD/UC/HS STARTER SUBCUTANEOUS PEN-INJECTOR KIT 40 MG/0.8 ML, 80 MG/0.8 ML	5	PA
HUMIRA-PED < 40KG CROHNS STARTER SUBCUTANEOUS PREFILLED SYRINGE KIT 80 MG/0.8 ML & 40MG/0.4 ML	5	PA
HUMIRA-PED >= 40 KG CROHNS START SUBCUTANEOUS PREFILLED SYRINGE KIT 80 MG/0.8 ML	5	PA
HUMIRA-PED >= 40 KG UC STARTER SUBCUTANEOUS PEN-INJECTOR KIT 80 MG/0.8 ML	5	PA
HUMIRA-PS/UV/ADOL HS STARTER SUBCUTANEOUS PEN-INJECTOR KIT 40 MG/0.8 ML	5	PA
HUMIRA-PSORIASIS/UEVIT STARTER SUBCUTANEOUS PEN-INJECTOR KIT 80 MG/0.8 ML & 40MG/0.4 ML	5	PA
<i>leflunomide oral tablet 10 mg, 20 mg</i>	2	
LUPKYNIS ORAL CAPSULE 7.9 MG	5	PA
<i>methotrexate sodium (pf) injection solution 50 mg/2 ml</i>	2	
<i>methotrexate sodium injection solution 250 mg/10 ml, 50 mg/2 ml</i>	2	
<i>methotrexate sodium oral tablet 2.5 mg*</i>	1	
<i>mycophenolate mofetil oral capsule 250 mg</i>	2	B/D
<i>mycophenolate mofetil oral suspension reconstituted 200 mg/ml</i>	2	B/D

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<b>Name of Drug</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>mycophenolate mofetil oral tablet 500 mg</i>	2	B/D
<i>mycophenolate sodium oral tablet delayed release 180 mg, 360 mg</i>	2	B/D
<i>mycophenolic acid oral tablet delayed release 180 mg, 360 mg</i>	2	B/D
NULOJIX INTRAVENOUS SOLUTION RECONSTITUTED 250 MG	5	B/D
PROGRAF INTRAVENOUS SOLUTION 5 MG/ML	5	B/D
PROGRAF ORAL PACKET 0.2 MG, 1 MG	4	B/D
REZUROCK ORAL TABLET 200 MG	5	PA
SANDIMMUNE ORAL SOLUTION 100 MG/ML	4	B/D
SIMPONI SUBCUTANEOUS SOLUTION AUTO-INJECTOR 100 MG/ML, 50 MG/0.5 ML	5	PA
SIMPONI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML, 50 MG/0.5 ML	5	PA
<i>sirolimus oral solution 1 mg/ml</i>	5	B/D
<i>sirolimus oral tablet 0.5 mg, 1 mg, 2 mg</i>	2	B/D
<i>tacrolimus oral capsule 0.5 mg, 1 mg, 5 mg</i>	2	B/D
<b>Vaccines</b>		
ABRYSVO INTRAMUSCULAR SOLUTION RECONSTITUTED 120 MCG/0.5 ML	6	
ACTHIB INTRAMUSCULAR SOLUTION RECONSTITUTED	6	
ADACEL INTRAMUSCULAR SUSPENSION 5-2-15.5 (PREFILLED SYRINGE), 5-2-15.5 LF-MCG/0.5 ML	6	
AREXVY INTRAMUSCULAR SUSPENSION RECONSTITUTED 120 MCG/0.5 ML	6	

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<b>Name of Drug</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>bcg vaccine injection solution reconstituted 50 mg</i>	6	
BEXSERO INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE	6	
BEYFORTUS INTRAMUSCULAR SOLUTION PREFILLED SYRINGE 100 MG/ML, 50 MG/0.5 ML	6	
BOOSTRIX INTRAMUSCULAR SUSPENSION 5-2.5-18.5 LF-MCG/0.5 ML	6	
BOOSTRIX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 5-2.5-18.5 LF-MCG/0.5 ML	6	
DAPTACEL INTRAMUSCULAR SUSPENSION 23-15-5	6	
<i>diphtheria-tetanus toxoids dt intramuscular suspension 25-5 lfu/0.5 ml</i>	6	B/D
ENGERIX-B INJECTION SUSPENSION 20 MCG/ML	6	B/D
ENGERIX-B INJECTION SUSPENSION PREFILLED SYRINGE 10 MCG/0.5 ML, 20 MCG/ML	6	B/D
GARDASIL 9 INTRAMUSCULAR SUSPENSION	6	
GARDASIL 9 INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE	6	
HAVRIX INTRAMUSCULAR SUSPENSION 1440 EL U/ML, 720 EL U/0.5 ML	6	
HEPLISAV-B INTRAMUSCULAR SOLUTION PREFILLED SYRINGE 20 MCG/0.5 ML	6	B/D
HIBERIX INJECTION SOLUTION RECONSTITUTED 10 MCG	6	
IMOVAX RABIES INTRAMUSCULAR SUSPENSION RECONSTITUTED 2.5 UNIT/ML	6	B/D

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<b>Name of Drug</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
INFANRIX INTRAMUSCULAR SUSPENSION 25-58-10	6	
IPOL INJECTION INJECTABLE	6	
IXIARO INTRAMUSCULAR SUSPENSION	6	
JYNNEOS SUBCUTANEOUS SUSPENSION 0.5 ML	6	
KINRIX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.5 ML	6	
MENACTRA INTRAMUSCULAR SOLUTION	6	
MENQUADFI INTRAMUSCULAR SOLUTION	6	
MENVEO INTRAMUSCULAR SOLUTION	6	
MENVEO INTRAMUSCULAR SOLUTION RECONSTITUTED	6	
M-M-R II INJECTION SOLUTION RECONSTITUTED	6	
PEDIARIX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE	6	
PEDVAX HIB INTRAMUSCULAR SUSPENSION 7.5 MCG/0.5 ML	6	
PENBRAYA INTRAMUSCULAR SUSPENSION RECONSTITUTED	6	
PENTACEL INTRAMUSCULAR SUSPENSION RECONSTITUTED	6	
PREHEVBRIO INTRAMUSCULAR SUSPENSION 10 MCG/ML	6	B/D
PRIORIX SUBCUTANEOUS SUSPENSION RECONSTITUTED	6	
PROQUAD SUBCUTANEOUS SUSPENSION RECONSTITUTED	6	
QUADRACEL INTRAMUSCULAR SUSPENSION (58 UNT/ML)	6	
QUADRACEL INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.5 ML	6	

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<b>Name of Drug</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
RABAVERT INTRAMUSCULAR SUSPENSION RECONSTITUTED	6	B/D
RECOMBIVAX HB INJECTION SUSPENSION 10 MCG/ML, 40 MCG/ML, 5 MCG/0.5 ML	6	B/D
RECOMBIVAX HB INJECTION SUSPENSION PREFILLED SYRINGE 10 MCG/ML, 5 MCG/0.5 ML	6	B/D
ROTARIX ORAL SUSPENSION	6	
ROTARIX ORAL SUSPENSION RECONSTITUTED	6	
ROTATEQ ORAL SOLUTION	6	
SHINGRIX INTRAMUSCULAR SUSPENSION RECONSTITUTED 50 MCG/0.5 ML	6	QL (2 EA per 999 days)
TDVAX INTRAMUSCULAR SUSPENSION 2-2 LF/0.5 ML	6	B/D
TENIVAC INTRAMUSCULAR INJECTABLE 5-2 LFU, 5-2 LFU (INJECTION)	6	B/D
<i>tetanus-diphtheria toxoids td intramuscular suspension 2-2 lf/0.5 ml</i>	6	B/D
TICOVAC INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 1.2 MCG/0.25 ML, 2.4 MCG/0.5 ML	6	
TRUMENBA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE	6	
TWINRIX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 720-20 ELU-MCG/ML	6	
TYPHIM VI INTRAMUSCULAR SOLUTION 25 MCG/0.5 ML	6	
TYPHIM VI INTRAMUSCULAR SOLUTION PREFILLED SYRINGE 25 MCG/0.5 ML	6	
VAQTA INTRAMUSCULAR SUSPENSION 25 UNIT/0.5 ML, 25 UNIT/0.5 ML (0.5 ML), 50 UNIT/ML, 50 UNIT/ML (1 ML)	6	

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<b>Name of Drug</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
VARIVAX SUBCUTANEOUS INJECTABLE 1350 PFU/0.5 ML	6	
VAXCHORA ORAL SUSPENSION RECONSTITUTED	6	
VAXELIS INTRAMUSCULAR SUSPENSION	6	
VAXELIS INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE	6	
YF-VAX SUBCUTANEOUS INJECTABLE (2.5 ML IN 1 VIAL, MULTI-DOSE)	6	

## **Inflammatory Bowel Disease Agents - Treatment Of Ulcerative Colitis Or Crohn's Disease**

### **Aminosalicylates**

<i>balsalazide disodium oral capsule 750 mg</i>	2	
<i>mesalamine oral capsule delayed release 400 mg</i>	2	
<i>mesalamine oral tablet delayed release 1.2 gm</i>	2	
<i>mesalamine rectal enema 4 gm</i>	2	
<i>mesalamine rectal suppository 1000 mg</i>	2	
<i>mesalamine-cleanser rectal kit 4 gm</i>	2	
<i>sulfasalazine oral tablet 500 mg</i>	2	
<i>sulfasalazine oral tablet delayed release 500 mg</i>	2	

### **Glucocorticoids**

<i>budesonide er oral tablet extended release 24 hour 9 mg</i>	4	PA
<i>budesonide oral capsule delayed release particles 3 mg</i>	2	
DEXAMETHASONE INTENSOL ORAL CONCENTRATE 1 MG/ML	2	
<i>dexamethasone oral elixir 0.5 mg/5 ml</i>	2	

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<b>Name of Drug</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>dexamethasone sodium phosphate injection solution 120 mg/30 ml, 20 mg/5 ml, 4 mg/ml</i>	2	
<i>hydrocortisone rectal enema 100 mg/60 ml</i>	2	
<i>methylprednisolone acetate injection suspension 40 mg/ml, 80 mg/ml</i>	2	
<i>prednisolone sodium phosphate oral solution 15 mg/5 ml</i>	2	
PREDNISONO INTENSOL ORAL CONCENTRATE 5 MG/ML	2	
<i>prednisone oral solution 5 mg/5 ml</i>	2	
<i>prednisone oral tablet 1 mg, 10 mg, 2.5 mg, 20 mg, 5 mg, 50 mg*</i>	1	
<i>prednisone oral tablet therapy pack 10 mg (21)*</i>	1	
<i>prednisone oral tablet therapy pack 10 mg (48), 5 mg (21), 5 mg (48)</i>	2	

## **Metabolic Bone Disease Agents - Treatment Of Bone Diseases Including Osteoporosis**

### **Metabolic Bone Disease Agents**

<i>alendronate sodium oral tablet 10 mg, 35 mg, 5 mg, 70 mg*</i>	1	
<i>calcitonin (salmon) nasal solution 200 unit/act</i>	2	
<i>calcitriol oral capsule 0.25 mcg, 0.5 mcg</i>	2	
<i>calcitriol oral solution 1 mcg/ml</i>	2	
<i>cinacalcet hcl oral tablet 30 mg, 60 mg</i>	2	QL (60 EA per 30 days)
<i>cinacalcet hcl oral tablet 90 mg</i>	2	QL (120 EA per 30 days)
<i>doxercalciferol oral capsule 0.5 mcg, 1 mcg, 2.5 mcg</i>	2	
<i>ibandronate sodium oral tablet 150 mg*</i>	1	
NATPARA SUBCUTANEOUS CARTRIDGE 100 MCG, 25 MCG, 50 MCG, 75 MCG	5	PA

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<b>Name of Drug</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>paricalcitol oral capsule 1 mcg, 2 mcg, 4 mcg</i>	2	
PROLIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 60 MG/ML	3	PA
<i>risedronate sodium oral tablet 150 mg, 35 mg, 35 mg (12 pack), 35 mg (4 pack), 5 mg</i>	2	
<i>risedronate sodium oral tablet 30 mg</i>	4	
<i>teriparatide (recombinant) subcutaneous solution pen-injector 620 mcg/2.48 ml</i>	5	PA
TYMLOS SUBCUTANEOUS SOLUTION PEN-INJECTOR 3120 MCG/1.56 ML	5	PA
XGEVA SUBCUTANEOUS SOLUTION 120 MG/1.7 ML	5	PA

## **Ophthalmic Agents - Treatment Of Eye Conditions**

### **Ophthalmic Agents, Other**

<i>atropine sulfate ophthalmic solution 1 %</i>	2	
<i>brimonidine tartrate-timolol ophthalmic solution 0.2-0.5 %</i>	2	
<i>cyclosporine ophthalmic emulsion 0.05 %</i>	2	QL (60 EA per 30 days)
CYSTARAN OPHTHALMIC SOLUTION 0.44 %	5	PA
<i>dorzolamide hcl-timolol mal ophthalmic solution 2-0.5 %</i>	2	
<i>neomycin-polymyxin-dexameth ophthalmic ointment 3.5-10000-0.1*</i>	1	
<i>neomycin-polymyxin-dexameth ophthalmic suspension 3.5-10000-0.1*</i>	1	
<i>neomycin-polymyxin-gramicidin ophthalmic solution 1.75-10000-.025</i>	2	
OXERVATE OPHTHALMIC SOLUTION 0.002 %	5	PA

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<b>Name of Drug</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>proparacaine hcl ophthalmic solution 0.5 %</i>	2	
<i>sulfacetamide-prednisolone ophthalmic solution 10-0.23 %</i>	2	
<i>tobramycin-dexamethasone ophthalmic suspension 0.3-0.1 %</i>	2	
<b>Ophthalmic Anti-Allergy Agents</b>		
<i>azelastine hcl ophthalmic solution 0.05 %*</i>	1	
<i>cromolyn sodium ophthalmic solution 4 %*</i>	1	
<b>Ophthalmic Anti-Infectives</b>		
<i>ak-poly-bac ophthalmic ointment 500-10000 unit/gm*</i>	1	
<i>bacitracin ophthalmic ointment 500 unit/gm</i>	2	
<i>bacitracin-polymyxin b ophthalmic ointment 500-10000 unit/gm*</i>	1	
<i>ciprofloxacin hcl ophthalmic solution 0.3 %</i>	2	
<i>erythromycin ophthalmic ointment 5 mg/gm*</i>	1	
<i>gentamicin sulfate ophthalmic solution 0.3 %*</i>	1	
<i>moxifloxacin hcl ophthalmic solution 0.5 %</i>	2	
NATACYN OPHTHALMIC SUSPENSION 5 %	4	
<i>ofloxacin ophthalmic solution 0.3 %</i>	2	
<i>polymyxin b-trimethoprim ophthalmic solution 10000-0.1 unit/ml-%*</i>	1	
<i>sulfacetamide sodium ophthalmic ointment 10 %</i>	2	
<i>sulfacetamide sodium ophthalmic solution 10 %</i>	2	
<i>tobramycin ophthalmic solution 0.3 %*</i>	1	

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<b>Name of Drug</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>Ophthalmic Anti-Inflammatories</b>		
<i>dexamethasone sodium phosphate ophthalmic solution 0.1 %</i>	2	
<i>diclofenac sodium ophthalmic solution 0.1 %</i>	2	
<i>difluprednate ophthalmic emulsion 0.05 %</i>	2	
<i>fluorometholone ophthalmic suspension 0.1 %</i>	2	
<i>flurbiprofen sodium ophthalmic solution 0.03 %</i>	2	
<i>ketorolac tromethamine ophthalmic solution 0.4 %, 0.5 %</i>	2	
<i>prednisolone acetate ophthalmic suspension 1 %</i>	2	
<i>prednisolone sodium phosphate ophthalmic solution 1 %</i>	2	
<b>Ophthalmic Beta-Adrenergic Blocking Agents</b>		
<i>carteolol hcl ophthalmic solution 1 %</i>	2	
<i>levobunolol hcl ophthalmic solution 0.5 %*</i>	1	
<i>timolol maleate ophthalmic solution 0.25 %, 0.5 %*</i>	1	
<b>Ophthalmic Intraocular Pressure Lowering Agents, Other</b>		
<i>acetazolamide er oral capsule extended release 12 hour 500 mg</i>	2	
<i>brimonidine tartrate ophthalmic solution 0.1 %</i>	2	
<i>brimonidine tartrate ophthalmic solution 0.2 %*</i>	1	
<i>brinzolamide ophthalmic suspension 1 %</i>	2	ST
<i>dorzolamide hcl ophthalmic solution 2 %</i>	2	
<i>methazolamide oral tablet 25 mg, 50 mg</i>	2	

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<b>Name of Drug</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>pilocarpine hcl ophthalmic solution 1 %, 2 %, 4 %</i>	2	
RHOPRESSA OPHTHALMIC SOLUTION 0.02 %	3	ST
ROCKLATAN OPHTHALMIC SOLUTION 0.02-0.005 %	3	ST
SIMBRINZA OPHTHALMIC SUSPENSION 1-0.2 %	3	
<b>Ophthalmic Prostaglandin And Prostanoid Analogs</b>		
<i>bimatoprost ophthalmic solution 0.03 %*</i>	1	
<i>latanoprost ophthalmic solution 0.005 %*</i>	1	
LUMIGAN OPHTHALMIC SOLUTION 0.01 %	3	
<i>travoprost (bak free) ophthalmic solution 0.004 %*</i>	1	
ZIOPTAN OPHTHALMIC SOLUTION 0.0015 %	3	
<b>Otic Agents - Treatment Of Ear Conditions</b>		
<b>Otic Agents</b>		
<i>acetic acid otic solution 2 %</i>	2	
<i>hydrocortisone-acetic acid otic solution 1-2 %</i>	2	
<i>neomycin-polymyxin-hc otic solution 1 %, 3.5-10000-1</i>	2	
<i>neomycin-polymyxin-hc otic suspension 3.5-10000-1</i>	2	
<i>ofloxacin otic solution 0.3 %</i>	2	
<b>Respiratory Tract/Pulmonary Agents - Treatment Of Breathing Conditions</b>		
<b>Antihistamines</b>		
<i>azelastine hcl nasal solution 0.1 %, 137 mcg/spray(</i>	1	
<i>azelastine hcl nasal solution 0.15 %</i>	2	

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<b>Name of Drug</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>cetirizine hcl oral solution 1 mg/ml, 5 mg/5 ml*</i>	1	
<i>clemastine fumarate oral tablet 2.68 mg</i>	2	PA
<i>cyproheptadine hcl oral syrup 2 mg/5 ml</i>	2	PA
<i>cyproheptadine hcl oral tablet 4 mg</i>	2	PA
<i>hydroxyzine hcl oral syrup 10 mg/5 ml</i>	2	
<i>hydroxyzine hcl oral tablet 10 mg, 25 mg, 50 mg*</i>	1	
<i>levocetirizine dihydrochloride oral solution 2.5 mg/5 ml</i>	2	
<i>levocetirizine dihydrochloride oral tablet 5 mg*</i>	1	
<i>promethazine hcl oral solution 6.25 mg/5 ml</i>	2	PA
<b>Anti-Inflammatories, Inhaled Corticosteroids</b>		
ARNUIITY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100 MCG/ACT, 200 MCG/ACT, 50 MCG/ACT	3	
<i>budesonide inhalation suspension 0.25 mg/2 ml, 0.5 mg/2 ml, 1 mg/2 ml</i>	2	B/D
<i>flunisolide nasal solution 25 mcg/act (0.025%)</i>	2	
<i>fluticasone propionate diskus inhalation aerosol powder breath activated 100 mcg/act, 250 mcg/act, 50 mcg/act</i>	2	
<i>fluticasone propionate hfa inhalation aerosol 110 mcg/act, 220 mcg/act, 44 mcg/act</i>	2	
<i>fluticasone propionate nasal suspension 50 mcg/act*</i>	1	
<i>mometasone furoate nasal suspension 50 mcg/act</i>	2	

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Name of Drug	Drug Tier	Requirements/Limits
QVAR REDHALER INHALATION AEROSOL BREATH ACTIVATED 40 MCG/ACT, 80 MCG/ACT	4	
<b>Bronchodilators, Anticholinergic</b>		
ATROVENT HFA INHALATION AEROSOL SOLUTION 17 MCG/ACT	4	
INCRUSE ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 62.5 MCG/ACT	3	
<i>ipratropium bromide inhalation solution 0.02 %</i>	2	B/D
<i>ipratropium bromide nasal solution 0.03 %, 0.06 %</i>	2	
SPIRIVA RESPIMAT INHALATION AEROSOL SOLUTION 1.25 MCG/ACT, 2.5 MCG/ACT	3	
<i>tiotropium bromide monohydrate inhalation capsule 18 mcg</i>	2	
<b>Bronchodilators, Sympathomimetic</b>		
<i>albuterol sulfate hfa inhalation aerosol solution 108 (90 base) mcg/act, 108 (90 base) mcg/act (nda020503), 108 (90 base) mcg/act (nda020983)*</i>	1	
<i>albuterol sulfate inhalation nebulization solution (2.5 mg/3 ml) 0.083%, (5 mg/ml) 0.5%, 0.63 mg/3 ml, 1.25 mg/3 ml, 2.5 mg/0.5 ml*</i>	1	B/D
<i>albuterol sulfate oral syrup 2 mg/5 ml*</i>	1	
<i>albuterol sulfate oral tablet 2 mg, 4 mg</i>	2	
<i>epinephrine injection solution auto-injector 0.15 mg/0.15 ml, 0.15 mg/0.3 ml, 0.3 mg/0.3 ml*</i>	1	QL (2 EA per 30 days)
<i>formoterol fumarate inhalation nebulization solution 20 mcg/2 ml</i>	2	B/D

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<b>Name of Drug</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>levalbuterol hcl inhalation nebulization solution 0.31 mg/3 ml, 0.63 mg/3 ml, 1.25 mg/3 ml</i>	2	B/D
SEREVENT DISKUS INHALATION AEROSOL POWDER BREATH ACTIVATED 50 MCG/ACT	3	
STRIVERDI RESPIMAT INHALATION AEROSOL SOLUTION 2.5 MCG/ACT	4	
<i>terbutaline sulfate oral tablet 2.5 mg, 5 mg</i>	2	
VENTOLIN HFA INHALATION AEROSOL SOLUTION 108 (90 BASE) MCG/ACT	3	
<b>Cystic Fibrosis Agents</b>		
BRONCHITOL INHALATION CAPSULE 40 MG	5	PA
CAYSTON INHALATION SOLUTION RECONSTITUTED 75 MG	5	PA
KALYDECO ORAL PACKET 13.4 MG, 25 MG, 5.8 MG, 50 MG, 75 MG	5	PA
KALYDECO ORAL TABLET 150 MG	5	PA
ORKAMBI ORAL PACKET 100-125 MG, 150-188 MG, 75-94 MG	5	PA
ORKAMBI ORAL TABLET 100-125 MG, 200-125 MG	5	PA
PULMOZYME INHALATION SOLUTION 2.5 MG/2.5ML	5	B/D
SYMDEKO ORAL TABLET THERAPY PACK 100-150 & 150 MG, 50-75 & 75 MG	5	PA
<i>tobramycin inhalation nebulization solution 300 mg/5 ml</i>	3	B/D; QL (280 ML per 56 days)
TRIKAFTA ORAL TABLET THERAPY PACK 100-50-75 & 150 MG, 50-25-37.5 & 75 MG	5	PA
TRIKAFTA ORAL THERAPY PACK 100-50-75 & 75 MG, 80-40-60 & 59.5 MG	5	PA

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<b>Name of Drug</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>Mast Cell Stabilizers</b>		
<i>cromolyn sodium inhalation nebulization solution 20 mg/2 ml</i>	4	B/D
<i>cromolyn sodium oral concentrate 100 mg/5 ml</i>	2	
<b>Phosphodiesterase Inhibitors, Airways Disease</b>		
<i>roflumilast oral tablet 250 mcg, 500 mcg</i>	2	
<i>theophylline er oral tablet extended release 12 hour 100 mg, 200 mg, 300 mg, 450 mg</i>	2	
<i>theophylline er oral tablet extended release 24 hour 400 mg, 600 mg</i>	2	
<i>theophylline oral elixir 80 mg/15 ml</i>	2	
<i>theophylline oral solution 80 mg/15 ml</i>	2	
<b>Pulmonary Antihypertensives</b>		
ADEMPAS ORAL TABLET 0.5 MG, 1 MG, 1.5 MG, 2 MG, 2.5 MG	5	PA
<i>ambrisentan oral tablet 10 mg, 5 mg</i>	5	PA
<i>bosentan oral tablet 125 mg, 62.5 mg</i>	5	PA
<i>sildenafil citrate oral suspension reconstituted 10 mg/ml</i>	5	PA
<i>sildenafil citrate oral tablet 20 mg</i>	2	PA
<i>tadalafil (pah) oral tablet 20 mg</i>	2	PA
TADLIQ ORAL SUSPENSION 20 MG/5 ML	5	PA
TYVASO DPI MAINTENANCE KIT INHALATION POWDER 112 X 32 MCG & 112 X 48 MCG, 16 MCG, 32 MCG, 48 MCG, 64 MCG	5	PA
TYVASO DPI TITRATION KIT INHALATION POWDER 112 X 16 MCG & 84 X 32MCG, 16 & 32 & 48 MCG	5	PA

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<b>Name of Drug</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
UPTRAVI ORAL TABLET 1000 MCG, 1200 MCG, 1400 MCG, 1600 MCG, 200 MCG, 400 MCG, 600 MCG, 800 MCG	5	PA
UPTRAVI TITRATION ORAL TABLET THERAPY PACK 200 & 800 MCG	5	PA
VENTAVIS INHALATION SOLUTION 10 MCG/ML, 20 MCG/ML	5	PA
<b>Pulmonary Fibrosis Agents</b>		
OFEV ORAL CAPSULE 100 MG, 150 MG	5	PA
<i>pirfenidone oral capsule 267 mg</i>	5	PA
<i>pirfenidone oral tablet 267 mg</i>	2	PA
<i>pirfenidone oral tablet 534 mg, 801 mg</i>	5	PA
<b>Respiratory Tract Agents, Other</b>		
<i>acetylcysteine inhalation solution 10 %, 20 %</i>	2	B/D
ADVAIR HFA INHALATION AEROSOL 115-21 MCG/ACT, 230-21 MCG/ACT, 45-21 MCG/ACT	3	
ANORO ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 62.5-25 MCG/ACT	3	
BEVESPI AEROSPHERE INHALATION AEROSOL 9-4.8 MCG/ACT	3	
BREO ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100-25 MCG/ACT, 200-25 MCG/ACT, 50-25 MCG/INH	3	
BREZTRI AEROSPHERE INHALATION AEROSOL 160-9-4.8 MCG/ACT	3	
<i>budesonide-formoterol fumarate inhalation aerosol 160-4.5 mcg/act, 80-4.5 mcg/act*</i>	1	
COMBIVENT RESPIMAT INHALATION AEROSOL SOLUTION 20-100 MCG/ACT	3	
DUPIXENT SUBCUTANEOUS SOLUTION PEN-INJECTOR 200 MG/1.14 ML, 300 MG/2 ML	5	PA

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<b>Name of Drug</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
DUPIXENT SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/0.67 ML, 200 MG/1.14 ML, 300 MG/2 ML	5	PA
FASENRA PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 30 MG/ML	5	PA
FASENRA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 30 MG/ML	5	PA
<i>fluticasone furoate-vilanterol inhalation aerosol powder breath activated 100-25 mcg/act, 200-25 mcg/act</i>	2	
<i>fluticasone-salmeterol inhalation aerosol 115-21 mcg/act, 230-21 mcg/act, 45-21 mcg/act*</i>	1	
<i>fluticasone-salmeterol inhalation aerosol powder breath activated 100-50 mcg/act, 250-50 mcg/act, 500-50 mcg/act*</i>	1	
<i>fluticasone-salmeterol inhalation aerosol powder breath activated 113-14 mcg/act, 232-14 mcg/act, 55-14 mcg/act</i>	2	
<i>ipratropium-albuterol inhalation solution 0.5-2.5 (3) mg/3 ml</i>	2	B/D
<i>montelukast sodium oral packet 4 mg</i>	2	
<i>montelukast sodium oral tablet 10 mg*</i>	1	
<i>montelukast sodium oral tablet chewable 4 mg, 5 mg*</i>	1	
NUCALA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 100 MG/ML	5	PA
NUCALA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML, 40 MG/0.4 ML	5	PA
NUCALA SUBCUTANEOUS SOLUTION RECONSTITUTED 100 MG	5	PA
<i>promethazine vc oral syrup 6.25-5 mg/5 ml</i>	2	PA

\*We provide additional coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-9.

Name of Drug	Drug Tier	Requirements/Limits
<i>promethazine-phenylephrine oral syrup 6.25-5 mg/5 ml</i>	2	PA
STIOLTO RESPIMAT INHALATION AEROSOL SOLUTION 2.5-2.5 MCG/ACT	3	
TRELEGY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100-62.5-25 MCG/ACT, 200-62.5-25 MCG/ACT	3	
WIXELA INHUB INHALATION AEROSOL POWDER BREATH ACTIVATED 100-50 MCG/ACT, 250-50 MCG/ACT, 500-50 MCG/ACT*	1	
XOLAIR SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML, 75 MG/0.5 ML	5	PA
XOLAIR SUBCUTANEOUS SOLUTION RECONSTITUTED 150 MG	5	PA

### Skeletal Muscle Relaxants - Treatment Of Muscle Tightness

#### Skeletal Muscle Relaxants

<i>carisoprodol oral tablet 250 mg, 350 mg</i>	2	PA; QL (90 EA per 30 days)
<i>chlorzoxazone oral tablet 500 mg</i>	2	PA; QL (180 EA per 30 days)
<i>cyclobenzaprine hcl oral tablet 10 mg, 5 mg*</i>	1	QL (90 EA per 30 days)
<i>metaxalone oral tablet 800 mg</i>	2	PA; QL (120 EA per 30 days)
<i>methocarbamol oral tablet 500 mg, 750 mg*</i>	1	PA
<i>orphenadrine citrate er oral tablet extended release 12 hour 100 mg</i>	2	PA

### Sleep Disorder Agents - Treatment Of Insomnia

#### Sleep Promoting Agents

<i>doxepin hcl oral tablet 3 mg, 6 mg</i>	2	QL (30 EA per 30 days)
<i>eszopiclone oral tablet 1 mg, 2 mg, 3 mg</i>	2	PA; QL (30 EA per 30 days)
HETLIOZ LQ ORAL SUSPENSION 4 MG/ML	5	PA

\*We provide additional coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-9.



<b>Name of Drug</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>ramelteon oral tablet 8 mg</i>	2	QL (30 EA per 30 days)
<i>tasimelteon oral capsule 20 mg</i>	5	PA
<i>temazepam oral capsule 15 mg, 22.5 mg, 30 mg, 7.5 mg</i>	2	PA; QL (30 EA per 30 days)
<i>zaleplon oral capsule 10 mg, 5 mg</i>	2	PA; QL (30 EA per 30 days)
<i>zolpidem tartrate er oral tablet extended release 12.5 mg, 6.25 mg</i>	2	PA; QL (30 EA per 30 days)
<i>zolpidem tartrate oral tablet 10 mg*</i>	1	PA; QL (30 EA per 30 days)
<i>zolpidem tartrate oral tablet 5 mg*</i>	1	QL (30 EA per 30 days)
<b>Wakefulness Promoting Agents</b>		
<i>armodafinil oral tablet 150 mg, 200 mg, 250 mg, 50 mg</i>	2	PA
<i>modafinil oral tablet 100 mg, 200 mg</i>	2	PA
<i>sodium oxybate oral solution 500 mg/ml</i>	5	PA
XYREM ORAL SOLUTION 500 MG/ML	5	PA
XYWAV ORAL SOLUTION 500 MG/ML	5	PA

\*We provide additional coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-9.

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<i>tropium chloride</i> .....	101	<i>varenicline tartrate</i> .....	16	.....	71
<i>tropium chloride er</i> .....	101	<i>varenicline tartrate</i>		XATMEP.....	39
TRULICITY.....	63	( <i>starter</i> ).....	16	XCOPRI.....	26
TRUMENBA.....	123	<i>varenicline</i>		XCOPRI (250 MG DAILY	
TRUQAP.....	44	<i>tartrate(continue)</i> .....	16	DOSE).....	26
TRUSELTIQ (100MG DAILY		VARIVAX.....	124	XCOPRI (350 MG DAILY	
DOSE).....	44	VAXCHORA.....	124	DOSE).....	26
TRUSELTIQ (125MG DAILY		VAXELIS.....	124	XELJANZ.....	117
DOSE).....	44	VELIVET.....	110	XELJANZ XR.....	117
TRUSELTIQ (50MG DAILY		VEMLIDY.....	54	XERMELO.....	98
DOSE).....	44	VENCLEXTA.....	45	XGEVA.....	126
TRUSELTIQ (75MG DAILY		VENCLEXTA STARTING		XIFAXAN.....	98
DOSE).....	44	PACK.....	45	XIGDUO XR.....	63
TUKYSA.....	44	<i>venlafaxine hcl</i> .....	31	XOLAIR.....	136
TURALIO.....	44	<i>venlafaxine hcl er</i> .....	31	XOSPATA.....	45
TWINRIX.....	123	VENTAVIS.....	134	XPOVIO (100 MG ONCE	
TYBOST.....	57	VENTOLIN HFA.....	132	WEEKLY).....	39
TYMLOS.....	126	<i>verapamil hcl</i> .....	77	XPOVIO (40 MG ONCE	
TYPHIM VI.....	123	<i>verapamil hcl er</i> .....	77	WEEKLY).....	39
TYVASO DPI		VERQUOVO.....	80	XPOVIO (40 MG TWICE	
MAINTENANCE KIT.....	133	VERSACLOZ.....	53	WEEKLY).....	40
TYVASO DPI TITRATION		VERZENIO.....	45	XPOVIO (60 MG ONCE	
KIT.....	133	VICTOZA.....	63	WEEKLY).....	40
<b>U</b>		VIENVA.....	110	XPOVIO (60 MG TWICE	
UBRELVY.....	35	<i>vigabatrin</i> .....	27	WEEKLY).....	40
UDENYCA.....	72, 73	VIJOICE.....	45	XPOVIO (80 MG ONCE	
UDENYCA ONBODY.....	72	<i>vilazodone hcl</i> .....	31	WEEKLY).....	40
UNITHROID.....	112	VIRACEPT.....	58		

XPOVIO (80 MG TWICE WEEKLY) .....	40	<i>zaleplon</i> .....	137	<i>ziprasidone hcl</i> .....	52
XTAMPZA ER.....	13	ZARXIO .....	73	<i>ziprasidone mesylate</i> .....	52
XTANDI .....	38	ZAVZPRET.....	35	ZOLINZA .....	40
XULANE .....	110	ZEJULA .....	45	<i>zolpidem tartrate</i> .....	137
XULTOPHY.....	69	ZELBORAF.....	45	<i>zolpidem tartrate er</i> .....	137
XURIDEN.....	100	ZEMAIRA .....	100	ZONISADE.....	28
XYREM .....	137	ZENATANE.....	89	<i>zonisamide</i> .....	28
XYWAV .....	137	ZENPEP.....	100	ZOVIA 1/35 (28) .....	110
<b>Y</b>		ZEPOSIA.....	88	ZTALMY .....	27
YF-VAX.....	124	ZEPOSIA 7-DAY STARTER		ZTLIDO.....	15
YONSA .....	38	PACK .....	88	ZURZUVAE.....	30
YUVAFEM .....	105	ZEPOSIA STARTER KIT ..	88	ZYDELIG.....	45
<b>Z</b>		<i>zidovudine</i> .....	56	ZYKADIA .....	45
ZAFEMY .....	110	ZIEXTENZO.....	73	ZYPREXA RELPREVV.....	53
		ZIOPTAN.....	129		



**Troy Medicare (HMO)**  
**2024 Prior Authorization Criteria**  
CURRENT AS OF 03/01/2024

## ABILIFY ASIMTUFII

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### Products Affected

- ABILIFY ASIMTUFII

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	The member has a documented history of receiving oral aripiprazole without any clinically significant side effects.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Request will be authorized until the end of the contract year.
<b>Other Criteria</b>	Trial of, contraindication to, or medical reason (e.g. intolerance, hypersensitivity or contraindication) for not using Abilify Maintena.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# ACITRETIN

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## Products Affected

- *acitretin*

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

# ACTEMRA

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## Products Affected

- ACTEMRA ACTPEN
- ACTEMRA SUBCUTANEOUS

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

# ACTHAR

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## Products Affected

- ACTHAR

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	New starts for MS exacerbation, rheumatic disorders, collagen diseases, dermatologic diseases, serum sickness, edematous state (e.g. nephrotic syndrome without uremia), and respiratory diseases: trial of, contraindication to, or medical reason for not using 1) oral corticosteroids AND 2) Cortrophin. New starts for ophthalmic disease: trial of, contraindication to, or medical reason for not using 1) oral or ophthalmic corticosteroids AND 2) Cortrophin. Continuation of therapy or reauthorization for MS exacerbation: documentation of symptom improvement and current use of a multiple sclerosis disease modifying agent for maintenance therapy. Continuation of therapy or reauthorization for all other conditions: documented evidence of response to treatment and symptom improvement.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Specialist for submitted diagnosis.
<b>Coverage Duration</b>	MS exacerbation: 1 month. Other conditions: new start for 3 months and reauth end of contract year.
<b>Other Criteria</b>	N/A
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

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

# ACTIMMUNE

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## Products Affected

- ACTIMMUNE

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

# ADEMPAS

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## Products Affected

- ADEMPAS

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Concomitant use with PDE inhibitor or nitrate therapy
<b>Required Medical Information</b>	Documentation of pulmonary arterial hypertension (PAH) WHO Group I and IV classification and PAH Functional Class. Reviewer will verify available patient claim history to confirm patient is not using PDE inhibitors or nitrates.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescriber must be a pulmonologist or cardiologist.
<b>Coverage Duration</b>	Request will be authorized until the end of the contract year.
<b>Other Criteria</b>	N/A
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# ALPHA-1 PROTEINASE INHIBITORS

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## Products Affected

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

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



# AMBRISENTAN

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## Products Affected

- *ambrisentan*

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

# APOMORPHINE

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## Products Affected

- *apomorphine hcl subcutaneous*

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

# ARCALYST

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## Products Affected

- ARCALYST

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

# ARISTADA

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## Products Affected

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

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	The member has a documented history of receiving oral aripiprazole without any clinically significant side effects.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Request will be authorized until the end of the contract year.
<b>Other Criteria</b>	Trial of, contraindication to, or medical reason for not using Abilify Maintena.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# AUVELITY

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## Products Affected

- AUVELITY

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

# AZTREONAM LYSINE

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## Products Affected

- CAYSTON

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

# BENLYSTA

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## Products Affected

- BENLYSTA SUBCUTANEOUS

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescriber must be a rheumatologist, nephrologist, or specialist in the treatment of autoimmune disorders.
<b>Coverage Duration</b>	New starts will be authorized for 6 months. Cont of therapy or reauth until end of contract year.
<b>Other Criteria</b>	For new starts for systemic lupus erythematosus (SLE): concurrent use of two of the following or medical reason for not using glucocorticoids, azathioprine, methotrexate, mycophenolate, or hydroxychloroquine, chloroquine, and cyclophosphamide. For continuation of therapy or reauthorization for SLE: documentation of clinical response to therapy (i.e. fewer flares that required steroid treatment, lower average daily oral prednisone dose, improved daily function either as measured through a validated functional scale or through improved daily performance documented at clinic visits, etc.) For new starts for lupus nephritis (LN): concurrent use of or medical reason for not using background immunosuppressive therapy regimen. For continuation of therapy or reauthorization for LN: Documentation of improvement in renal function (i.e. reduction in UPCR).
<b>Indications</b>	All Medically-accepted Indications.

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



# BESREMI

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## Products Affected

- BESREMI

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

# BOSENTAN

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## Products Affected

- *bosentan*

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

# BUDESONIDE ER 9 MG

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## Products Affected

- budesonide er oral tablet  
extended release 24 hour*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Request will be authorized for 8 weeks.
<b>Other Criteria</b>	Patient must have a documented trial of, contraindication to, or medical reason for not using sulfasalazine, balsalazide, or an oral mesalamine product.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# CAMZYOS

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## Products Affected

- CAMZYOS

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

<b>PA Criteria</b>	<b>Criteria Details</b>
	ventricular ejection fraction (LVEF) greater than or equal to 50%.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# CARGLUMIC ACID

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## Products Affected

- *carglumic acid oral tablet soluble*

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

# CASPOFUNGIN

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## Products Affected

- *caspofungin acetate*

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

# CERDELGA

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## Products Affected

- CERDELGA

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



# CGRP ANTAGONISTS

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## Products Affected

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

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

<b>PA Criteria</b>	<b>Criteria Details</b>
	(Nurtec, Emgality, Aimovig), must show a benefit of 1 headache day per month reduction since initiation of therapy. For episodic cluster headache treatment, must show documentation of reduction in frequency of headaches
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# CHOLBAM

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## Products Affected

- CHOLBAM

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

# CIBINQO

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## Products Affected

- CIBINQO

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

# CIMZIA

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## Products Affected

- CIMZIA STARTER KIT  
SUBCUTANEOUS PREFILLED  
SYRINGE KIT
- CIMZIA SUBCUTANEOUS KIT  
2 X 200 MG
- CIMZIA SUBCUTANEOUS  
PREFILLED SYRINGE KIT

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Specialist for submitted diagnosis.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	For ankylosing spondylitis: Either 1) Trial of, medical reason for not using, or contraindication to 2 of the following therapies: Enbrel, Humira, Hadlima, Rinvoq or Xeljanz or 2) If utilized within the past 120 days, approve for continuation of therapy. For Crohns Disease: Either 1) Trial of, medical reason for not using, or contraindication to 2 of the following therapies: Humira, Hadlima, Skyrizi or Stelara or 2) If utilized within the past 120 days, approve for continuation of therapy. For non-radiographic axial spondyloarthritis: approve. For psoriasis: Either 1) Trial of, medical reason for not using, or contraindication to 2 of the following therapies: Skyrizi, Tremfya, Stelara, Enbrel, Hadlima, or Humira 2) If utilized within the past 120 days, approve for continuation of therapy. For PsA: Either 1) Trial of, medical reason for not using, or contraindication to 2 of the following therapies: Stelara, Skyrizi, Tremfya, Xeljanz, Rinvoq, Enbrel, Hadlima, or

<b>PA Criteria</b>	<b>Criteria Details</b>
	Humira, or 2) If utilized within the past 120 days, approve for continuation of therapy. For RA: Either 1) Trial of, medical reason for not using, or contraindication to 2 of the following: Enbrel, Humira, Hadlima, Rinvoq or Xeljanz or 2) If utilized within the past 120 days, approve for continuation of therapy
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# CORLANOR

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## Products Affected

- CORLANOR

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Blood pressure less than 90/50 mmHg
<b>Required Medical Information</b>	New starts for chronic heart failure must have all of the following: 1) LVEF of 35% or less 2) Sinus rhythm and have resting heart rate greater than or equal to 70 bpm 3) Blood pressure greater than or equal to 90/50 mmHg
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescriber must be a cardiologist.
<b>Coverage Duration</b>	Request will be authorized until the end of the contract year.
<b>Other Criteria</b>	Trial of, contraindication to, or medical reason for not receiving a beta blocker.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# CORTROPHIN

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## Products Affected

- CORTROPHIN

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



# COSENTYX

## Products Affected

- COSENTYX
- COSENTYX (300 MG DOSE)
- COSENTYX SENSOREADY (300 MG)
- COSENTYX SENSOREADY PEN
- COSENTYX UNOREADY

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Specialist for submitted diagnosis.
<b>Coverage Duration</b>	Request will be authorized until the end of the contract year.
<b>Other Criteria</b>	For ankylosing spondylitis: Either 1) Trial of, medical reason for not using, or contraindication to 2 of the following therapies: Enbrel, Humira, Hadlima, Rinvoq or Xeljanz, or 2) If utilized within the past 120 days, approve for continuation of therapy. For non-radiographic axial spondyloarthritis: approve. For psoriasis: Either 1) Trial of, medical reason for not using, or contraindication to 2 of the following therapies: Stelara, Skyrizi, Tremfya, Enbrel, Hadlima, or Humira, or 2) If utilized within the past 120 days, approve for continuation of therapy. For PsA: Either 1) Trial of, medical reason for not using, or contraindication (e.g., safety concerns, not indicated for patients age) to 2 of the following therapies: Stelara, Skyrizi, Tremfya, Xeljanz, Rinvoq, Enbrel, Hadlima, or Humira, or 2) If utilized within the past 120 days, approve for continuation of therapy. For enthesitis-related arthritis: approve.

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

# CYSTAGON

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## Products Affected

- CYSTAGON

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

# CYSTARAN

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## Products Affected

- CYSTARAN

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

# DALFAMPRIDINE ER

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## Products Affected

- *dalfampridine er*

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

# DEFERASIROX

## Products Affected

- *deferasirox*
- *deferasirox granules*

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

# DEFERIPRONE

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## Products Affected

- *deferiprone*

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

# DIACOMIT

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## Products Affected

- DIACOMIT

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



# DICHLORPHENAMIDE

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## Products Affected

- *dichlorphenamide*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a geneticist, neurologist, or endocrinologist.
<b>Coverage Duration</b>	New starts will be authorized for 2 months. Cont of therapy or reauth until end of contract year.
<b>Other Criteria</b>	Continuation of therapy or reauthorization: documentation of clinical improvement with therapy.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# DIFICID

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## Products Affected

- DIFICID

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Request will be authorized for 10 days.
<b>Other Criteria</b>	N/A
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# DOPTELET

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## Products Affected

- DOPTELET

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

# DOXEPIN CREAM

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## Products Affected

- doxepin hcl external*

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

# DUPIXENT

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## Products Affected

- DUPIXENT

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Specialist for submitted diagnosis.
<b>Coverage Duration</b>	New starts will be authorized for 6 months. Cont of therapy or reauth until end of contract year.
<b>Other Criteria</b>	New starts for atopic dermatitis in patients 2 years old or older: trial of, contraindication to, or medical reason for not using: 1) topical tacrolimus or pimecrolimus and 2) Eucrisa. New starts for atopic dermatitis in patients less than 2 years old: trial of, contraindication to, or medical reason for not using Eucrisa. New starts for asthma with eosinophilic phenotype: 1) blood eosinophil count greater than or equal to 150 cells per microliter, and 2) symptoms persist with at least 1 exacerbation in the last 12 months requiring additional treatment (e.g. oral systemic steroids) while on a high dose inhaled corticosteroid with an additional controller medication (ie. long-acting B2 agonist). New starts for oral corticosteroid dependent asthma: symptoms persist with at least 1 exacerbation in the last 12 months requiring additional treatment, (e.g. oral systemic steroids) while on a high dose inhaled corticosteroid with an additional controller medication (ie. long-acting B2 agonist). New starts for chronic rhinosinusitis with nasal polyps: trial of, contraindication to, or medical reason for not using nasal

<b>PA Criteria</b>	<b>Criteria Details</b>
	corticosteroids OR member has had prior surgery for nasal polyps. New starts for prurigo nodularis: attestation is provided confirming diagnosis. Continuation of therapy or reauthorization for all indications: clinical benefit from use of the drug.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# EGRIFTA

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## Products Affected

- EGRIFTA SV

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

# EMSAM

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## Products Affected

- EMSAM

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



# ENBREL

## Products Affected

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

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Specialist for submitted diagnosis.
<b>Coverage Duration</b>	Request will be authorized until the end of the contract year.
<b>Other Criteria</b>	For RA: Trial of, medical reason for not using, or contraindication to 1 disease modifying antirheumatic drug (DMARD) (methotrexate, leflunomide, or sulfasalazine). For pJIA: Trial of, medical reason for not using, or contraindication to 1 of the following DMARDs: methotrexate or leflunomide. For PsA or psoriasis: approve. For ankylosing spondylitis: Trial of, medical reason for not using, or contraindication to naproxen.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# ENDARI

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## Products Affected

- ENDARI

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

# ENTYVIO

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## Products Affected

- ENTYVIO SUBCUTANEOUS

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

# EPIDIOLEX

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## Products Affected

- EPIDIOLEX

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

# EPRONTIA

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## Products Affected

- EPRONTIA

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

# ERYTHROPOETIN STIMULATING AGENTS

## Products Affected

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

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	For new starts for all indications: Hgb within compendia range for treatment of the requested medical condition. For continuation of therapy or re-authorization: Hgb must not exceed 10 g/dL (anemia related to cancer), 11 g/dL (anemia of CKD), 12 g/dL (zidovudine-related anemia in members with HIV and ribavirin-induced anemia), 13 g/dL (elective, noncardiac, nonvascular surgery needing red blood cell allogeneic transfusion reduction).
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Request will be authorized for 6 months.
<b>Other Criteria</b>	N/A
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

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

# EUCRISA

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## Products Affected

- EUCRISA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescriber must be a dermatologist, immunologist or an allergist.
<b>Coverage Duration</b>	Request will be authorized until the end of the contract year.
<b>Other Criteria</b>	Trial of, contraindication to, or medical reason for not using topical tacrolimus or pimecrolimus.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No



# EVRYSDI

## Products Affected

- EVRYSDI

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

# FASENRA

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## Products Affected

- FASENRA
- FASENRA PEN

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Specialist for submitted diagnosis.
<b>Coverage Duration</b>	New starts will be authorized for 6 months. Cont of therapy or reauth until end of contract year.
<b>Other Criteria</b>	New starts for severe asthma with an eosinophilic phenotype: 1) Baseline blood eosinophil count greater than or equal to 150 cells per microliter AND 2) symptoms persist with at least 1 exacerbation in the last 12 months requiring additional treatment (e.g. oral systemic steroids) while on a high dose inhaled corticosteroid with an additional controller medication (ie. long-acting B2 agonist). Continuation of therapy or re-authorization for severe asthma with an eosinophilic phenotype: clinical benefit from use of the drug.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# FENTANYL CITRATE TRANSMUCOSAL PRODUCTS

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## Products Affected

- *fentanyl citrate buccal lozenge on a handle*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Documentation must be provided for the all of the following: 1) fentanyl citrate oral transmucosal is being prescribed to treat cancer-related breakthrough pain AND 2) Patient has been taking opioids at a dose equal to 60 MME per day for at least one week.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Request will be authorized until the end of the contract year.
<b>Other Criteria</b>	N/A
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# FILSPARI

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## Products Affected

- FILSPARI

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

# FINTEPLA

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## Products Affected

- FINTEPLA

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

# FIRDAPSE

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## Products Affected

- FIRDAPSE

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

# FLUCYTOSINE

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## Products Affected

- *flucytosine oral*

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

# FLUOROURACIL

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## Products Affected

- *fluorouracil external cream 0.5 %*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a dermatologist or oncologist.
<b>Coverage Duration</b>	Request will be authorized for 12 weeks.
<b>Other Criteria</b>	N/A
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No



# GALAFOLD

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## Products Affected

- GALAFOLD

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

# GATTEX

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## Products Affected

- GATTEX

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

# GNRH AGONISTS

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## Products Affected

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

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

# GOCOVRI

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## Products Affected

- GOCOVRI

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

# GROWTH HORMONES

## Products Affected

- GENOTROPIN MINIQUICK SUBCUTANEOUS PREFILLED SYRINGE
- GENOTROPIN SUBCUTANEOUS CARTRIDGE
- HUMATROPE INJECTION CARTRIDGE
- NGENLA
- NORDITROPIN FLEXPRO SUBCUTANEOUS SOLUTION PEN-INJECTOR
- NUTROPIN AQ NUSPIN 10 SUBCUTANEOUS SOLUTION PEN-INJECTOR
- NUTROPIN AQ NUSPIN 20 SUBCUTANEOUS SOLUTION PEN-INJECTOR
- NUTROPIN AQ NUSPIN 5 SUBCUTANEOUS SOLUTION PEN-INJECTOR
- OMNITROPE SUBCUTANEOUS SOLUTION CARTRIDGE
- OMNITROPE SUBCUTANEOUS SOLUTION RECONSTITUTED
- SKYTROFA

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	For new starts for growth hormone deficiency: Documentation showing bone age testing, height, weight, and Growth Hormone Stimulation Test results OR Insulin Growth Factor 1 level. For continuation of therapy or reauthorization for growth hormone deficiency: documentation (medical records) showing positive response to treatment.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescriber must be an endocrinologist or nephrologist.
<b>Coverage Duration</b>	New starts will be authorized for 6 months. Cont of therapy or reauth until end of contract year.
<b>Other Criteria</b>	For new starts for growth hormone deficiency: 1) If the request is not for Genotropin, trial of, contraindication to, or medical reason for not using Genotropin. For requests for all

<b>PA Criteria</b>	<b>Criteria Details</b>
	other medically accepted indications other than growth hormone deficiency, the request will be approved for products other than Skytrofa.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# HADLIMA

## Products Affected

- HADLIMA
- HADLIMA PUSHTOUCH

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

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



# HEREDITARY ANGIOEDEMA AGENTS

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## Products Affected

- CINRYZE
- HAEGARDA
- ORLADEYO

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

# HETLIOZ

## Products Affected

- HETLIOZ LQ
- *tasimelteon*

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

# HIGH RISK MEDICATION

## Products Affected

- *clemastine fumarate oral tablet* 2.68 mg
- *cyproheptadine hcl oral*
- *dipyridamole oral*
- *disopyramide phosphate oral*
- *glyburide micronized oral tablet* 1.5 mg, 3 mg, 6 mg
- *glyburide oral tablet* 1.25 mg, 2.5 mg, 5 mg
- *glyburide-metformin oral tablet* 1.25-250 mg, 2.5-500 mg
- *glyburide-metformin oral tablet* 5-500 mg
- *guanfacine hcl er*
- *guanfacine hcl oral*
- *indomethacin er*
- *indomethacin oral capsule* 25 mg, 50 mg
- *ketorolac tromethamine oral*
- *megestrol acetate oral suspension*
- *nifedipine oral*
- NORPACE CR
- *pentazocine-naloxone hcl*
- *promethazine hcl oral*
- *promethazine hcl rectal suppository* 12.5 mg, 25 mg
- *promethazine vc*
- *promethazine-phenylephrine*
- PROMETHEGAN RECTAL SUPPOSITORY 50 MG
- *trihexyphenidyl hcl*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	For patients 65 years old and older the prescriber has documented: 1) the benefits of treatment with the drug outweigh the potential risks identified for people 65 years old and older, and 2) the risks and side effects have been discussed and will be monitored.
<b>Age Restrictions</b>	Prior authorization only applies to members 65 years old or older.
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Request will be authorized until the end of the contract year.
<b>Other Criteria</b>	N/A
<b>Indications</b>	All Medically-accepted Indications.

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

# HIGH RISK MEDICATION - PROTECTED CLASS DRUGS

## Products Affected

- *amitriptyline hcl oral*
- *amoxapine*
- *clomipramine hcl oral*
- *doxepin hcl oral capsule*
- *doxepin hcl oral concentrate*
- *imipramine hcl oral*
- *imipramine pamoate*
- *megestrol acetate oral tablet*
- MENEST
- *perphenazine-amitriptyline*
- *phenobarbital oral elixir*
- *phenobarbital oral tablet*
- *protriptyline hcl*
- *trimipramine maleate oral*

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

# HIGH RISK MEDICATION, BUTALBITAL

## Products Affected

- ASCOMP-CODEINE
- BAC
- *butalbital-acetaminophen oral tablet 50-325 mg*
- *butalbital-apap-caff-cod oral capsule 50-325-40-30 mg*
- *butalbital-apap-caffeine oral capsule 50-325-40 mg*
- *butalbital-apap-caffeine oral tablet 50-325-40 mg*
- *butalbital-asa-caff-codeine*
- *butalbital-aspirin-caffeine oral capsule*

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

# HIGH RISK MEDICATION, SHORT TERM MUSCLE RELAXANT

## Products Affected

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

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

# HIGH RISK MEDICATION, SLEEP AGENTS

## Products Affected

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

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



# HUMIRA

## Products Affected

- HUMIRA (2 PEN)
- HUMIRA (2 SYRINGE)  
SUBCUTANEOUS PREFILLED SYRINGE KIT 10 MG/0.1ML, 20 MG/0.2ML, 40 MG/0.4ML, 40 MG/0.8ML
- HUMIRA-CD/UC/HS STARTER
- HUMIRA-PED<40KG CROHNS STARTER
- HUMIRA-PED>=40KG CROHNS STARTER
- HUMIRA-PED>=40KG UC STARTER
- HUMIRA-PS/UV/ADOL HS STARTER
- HUMIRA-PSORIASIS/UEVIT STARTER

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Specialist for submitted diagnosis.
<b>Coverage Duration</b>	Request will be authorized until the end of the contract year.
<b>Other Criteria</b>	For ankylosing spondylitis: Trial of, medical reason for not using, or contraindication to naproxen. For Crohns Disease: Trial of, medical reason for not using (i.e. severe Crohns disease), or contraindication to 1 of the following: mercaptopurine, azathioprine, sulfasalazine, methotrexate or corticosteroid (e.g., prednisone, methylprednisolone). For pJIA: Trial of, medical reason for not using, or contraindication to 1 of the following DMARDs: methotrexate or leflunomide. For RA: Trial of, medical reason for not using, or contraindication to 1 disease modifying antirheumatic drug (DMARD) (methotrexate, leflunomide, or sulfasalazine). For UC: Trial of, medical

<b>PA Criteria</b>	<b>Criteria Details</b>
	reason for not using, or contraindication to 1 of the following conventional therapies: mercaptopurine, an aminosalicylate (i.e. mesalamine, sulfasalazine, azathioprine), or a corticosteroid (i.e. prednisone, methylprednisolone). For PsA, psoriasis, Hidradenitis Suppurativa, or Uveitis: approve.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# HYFTOR

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## Products Affected

- HYFTOR

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

# ICATIBANT

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## Products Affected

- *icatibant acetate subcutaneous solution prefilled syringe*

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

# ICOSAPENT

## Products Affected

- *icosapent ethyl*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Request will be authorized until the end of the contract year.
<b>Other Criteria</b>	For a diagnosis of hypertriglyceridemia: Documented trial of, contraindication to, or medical reason for not using statins at maximum tolerated dose OR documented statin intolerance AND omega-3-acid ethyl esters capsule. For a diagnosis of cardiovascular risk reduction, ALL the following are required: 1) Documentation of hypertriglyceridemia greater than or equal to 150 mg/dL: 2) Documented trial of, contraindication to, or medical reason for not using statins at maximum tolerated dose for 3 months OR documented statin intolerance AND 3) Documentation of one of the following: Established atherosclerotic cardiovascular disease (e.g., coronary artery disease, cerebrovascular accident, carotid disease, peripheral artery disease) OR age greater than or equal to 50 years old with established diabetes and at least one additional risk factor for cardiovascular disease (e.g., hypertension, renal dysfunction, retinopathy, albuminuria, males age greater than or equal to 55 years old or females age greater than or equal to 65 years old).
<b>Indications</b>	All Medically-accepted Indications.

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

# ILARIS

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## Products Affected

- ILARIS SUBCUTANEOUS SOLUTION

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

# ILUMYA

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## Products Affected

- ILUMYA

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



# IMBRUVICA

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## Products Affected

- IMBRUVICA

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

# INCRELEX

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## Products Affected

- INCRELEX

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

# INTRON-A

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## Products Affected

- INTRON A INJECTION SOLUTION RECONSTITUTED

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

# JAKAFI

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## Products Affected

- JAKAFI

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

# KALYDECO

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## Products Affected

- KALYDECO

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

# KERENDIA

## Products Affected

- KERENDIA

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	New starts will be authorized for 3 months. Cont of therapy or reauth until end of contract year.
Other Criteria	For new starts: 1) Documentation of diagnosis of chronic kidney disease due to type 2 diabetes mellitus AND 2) Documentation of serum potassium levels less than or equal to 5 mEq/L AND 3) eGFR greater than or equal to 25ml/min/1.73 m <sup>2</sup> AND 4) Documentation that member is taking Kerendia in combination with an angiotensin-converting enzyme inhibitor (ACEi) or angiotensin receptor blocker (ARB) at maximum tolerated doses or documentation has been provided that the member is unable to tolerate ACEi or ARB AND 4) Documented trial of, contraindication to, or medical reason for not using a sodium-glucose cotransporter-2 (SGLT2) inhibitor. For continuation of therapy or reauthorization: 1) Documentation of serum potassium levels less than or equal to 5.5 mEq/L AND 2) Documentation that member is taking Kerendia in combination with an ACEi or ARB at maximum tolerated doses or documentation has been provided that the member is unable to tolerate ACEi or ARB.
Indications	All Medically-accepted Indications.

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

# KEVZARA

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## Products Affected

- KEVZARA

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



# KINERET

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## Products Affected

- KINERET SUBCUTANEOUS SOLUTION PREFILLED SYRINGE

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

# KORLYM

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## Products Affected

- KORLYM
- *mifepristone oral tablet 300 mg*

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

# LITFULO

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## Products Affected

- LITFULO

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

# LIVMARLI

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## Products Affected

- LIVMARLI

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

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

# LODOCO

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## Products Affected

- LODOCO

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

# LUCEMYRA

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## Products Affected

- LUCEMYRA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Request will be authorized for 14 days.
<b>Other Criteria</b>	For new starts, patient must have trial of, contraindication to, or medical reason for not using clonidine. Reauthorization criteria: chart notes that show positive response to prior treatment.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# LUPKYNIS

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## Products Affected

- LUPKYNIS

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



# LYBALVI

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## Products Affected

- LYBALVI

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

# MANNITOL INHALATION

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## Products Affected

- BRONCHITOL

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

# MAVYRET

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## Products Affected

- MAVYRET

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

# METHYLTESTOSTERONE

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## Products Affected

- *methyltestosterone oral*

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

# METYROSINE

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## Products Affected

- *metyrosine*

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

# MIGLUSTAT

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## Products Affected

- *miglustat*

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

# MULTIPLE SCLEROSIS AGENTS

## Products Affected

- BAFIERTAM
- BETASERON SUBCUTANEOUS KIT
- *dimethyl fumarate oral*
- *dimethyl fumarate starter pack oral capsule delayed release therapy pack*
- EXTAVIA SUBCUTANEOUS KIT
- *fingolimod hcl*
- *glatiramer acetate*
- GLATOPA
- KESIMPTA
- MAVENCLAD (10 TABS)
- MAVENCLAD (4 TABS)
- MAVENCLAD (5 TABS)
- MAVENCLAD (6 TABS)
- MAVENCLAD (7 TABS)
- MAVENCLAD (8 TABS)
- MAVENCLAD (9 TABS)
- MAYZENT
- MAYZENT STARTER PACK
- PONVORY
- PONVORY STARTER PACK
- REBIF REBIDOSE SUBCUTANEOUS SOLUTION AUTO-INJECTOR
- REBIF REBIDOSE TITRATION PACK SUBCUTANEOUS SOLUTION AUTO-INJECTOR
- REBIF SUBCUTANEOUS SOLUTION PREFILLED SYRINGE
- REBIF TITRATION PACK SUBCUTANEOUS SOLUTION PREFILLED SYRINGE
- TASCENSO ODT
- *teriflunomide*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Specialist for submitted diagnosis.
<b>Coverage Duration</b>	Request will be authorized until the end of the contract year.
<b>Other Criteria</b>	If the medication request is for glatiramer, Glatopa, or dimethyl fumarate, the request will be approved. If the member is over 17 years of age and the request is not for

<b>PA Criteria</b>	<b>Criteria Details</b>
	glatiramer, Glatopa, or dimethyl fumarate for multiple sclerosis, the member must have a documented trial of, contraindication to or a medical reason for not using both dimethyl fumarate AND glatiramer or Glatopa. If the request is for fingolimod and the member is 17 years of age or younger, the request will be approved.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No



# MYFEMBREE

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## Products Affected

- MYFEMBREE

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Patient has history of osteoporosis or hepatic impairment.
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescriber must be an OB, gynecologist or reproductive endocrinologist.
<b>Coverage Duration</b>	New starts will be authorized for 6 months. Cont of therapy or reauth until end of contract year.
<b>Other Criteria</b>	For new starts for menorrhagia: Trial of, contraindication to, or medical reason for not using an estrogen-progestin contraceptive therapy. For new starts if one of the following drugs has been tried previously, a trial of estrogen-progestin contraceptive therapy is not required: gonadotropin-releasing hormone (GnRH) agonists or tranexamic acid. New starts for endometriosis: Trial of, contraindication to, or medical reason for not using the following concurrently for endometriosis: analgesic pain reliever (e.g. NSAIDs, COX-2 inhibitors) AND either combined estrogen-progestin oral contraceptive, progestin (e.g. medroxyprogesterone acetate, norethindrone), gonadotropin-releasing hormone (GnRH) agonists (e.g. Lupron Depot), OR danazol. For continuation of therapy or reauthorization both of the following are required: 1) Treatment does not exceed the eligible maximum lifetime treatment duration of 2 years, and 2) Documentation has been provided that the member has obtained clinical benefit from medication (e.g. reduced menstrual bleeding from baseline, pain relief).

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

# NASAL ANTISEIZURE AGENTS

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## Products Affected

- NAYZILAM
- VALTOCO 10 MG DOSE
- VALTOCO 15 MG DOSE
- VALTOCO 20 MG DOSE
- VALTOCO 5 MG DOSE

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

# NATPARA

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## Products Affected

- NATPARA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Documentation of serum calcium greater than 7.5 mg/dL and vitamin D level (within 30 days of request).
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescriber is an endocrinologist.
<b>Coverage Duration</b>	Request will be authorized until the end of the contract year.
<b>Other Criteria</b>	N/A
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# NEXLETOL

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## Products Affected

- NEXLETOL

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescriber must be a cardiologist, endocrinologist, or a specialist in treatment of lipid disorders.
<b>Coverage Duration</b>	New starts will be authorized for 4 months. Cont of therapy or reauth until end of contract year.
<b>Other Criteria</b>	For new starts ALL of the following must be provided: 1) Documentation of baseline low density lipoprotein cholesterol (LDL-C) 2) Member has tried and failed a high-intensity statin (i.e. atorvastatin 40-80 mg, rosuvastatin 20-40 mg) at maximum tolerated dose for 3 months via claim history or chart notes OR documentation has been provided that the member is not able to tolerate a statin 3) Member has tried and failed ezetimibe at a maximum tolerated dose or documentation has been provided that the patient is not able to tolerate ezetimibe AND 4) Member will continue on maximum tolerated statin dose and ezetimibe dose while receiving Nexletol or documentation has been provided that the member is not able to tolerate a statin and/or ezetimibe. In addition to the initial criteria above if the new start is for the diagnosis of hyperlipidemia and atherosclerotic cardiovascular disease (ASCVD), the following are required: 1) Documentation of history of at least one of the following: myocardial infarction or acute coronary syndrome, stroke or transient ischemic attack,

<b>PA Criteria</b>	<b>Criteria Details</b>
	<p>coronary artery disease with stable angina, coronary or other arterial revascularization, peripheral vascular disease, or aortic aneurysm AND 2) Member must have a fasting LDL-C greater than or equal to 70 mg/dL. For continuation of therapy or reauthorization requests for all indications: 1) Documentation provided that the member has obtained clinical benefit from medication (e.g. LDL-C lowering from baseline) AND 2) Member will continue on maximum tolerated statin and ezetimibe dose while receiving Nexletol or documentation has been provided that the member is not able to tolerate a statin and/or ezetimibe.</p>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# NEXLIZET

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## Products Affected

- NEXLIZET

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescriber must be a cardiologist, endocrinologist, or a specialist in treatment of lipid disorders.
<b>Coverage Duration</b>	New starts will be authorized for 4 months. Cont of therapy or reauth until end of contract year.
<b>Other Criteria</b>	For new starts ALL of the following must be provided: 1) Documentation of baseline low density lipoprotein cholesterol (LDL-C), 2) Member has tried and failed a high-intensity statin (i.e. atorvastatin 40-80 mg, rosuvastatin 20-40 mg) at maximum tolerated dose for 3 months via claim history or chart notes OR documentation has been provided that the member is not able to tolerate a statin, AND 3) Member will continue on maximum tolerated statin dose while receiving Nexlizet or documentation has been provided that the member is not able to tolerate a statin. In addition to the initial criteria above if the new start is for the diagnosis of hyperlipidemia and atherosclerotic cardiovascular disease (ASCVD), the following are required: 1) Documentation of history of at least one of the following: myocardial infarction or acute coronary syndrome, stroke or transient ischemic attack, coronary artery disease with stable angina, coronary or other arterial revascularization, peripheral vascular disease, or aortic aneurysm, AND 2) Member must have a fasting LDL-C greater than or equal to

<b>PA Criteria</b>	<b>Criteria Details</b>
	70 mg/dL. For continuation of therapy or reauthorization requests for all indications: 1) Documentation provided that the member has obtained clinical benefit from medication (e.g. LDL-C lowering from baseline), AND 2) Member will continue on maximum tolerated statin while receiving Nexlizet or documentation has been provided that the member is not able to tolerate a statin.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No



# NITISINONE

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## Products Affected

- *nitisinone*
- ORFADIN ORAL SUSPENSION

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

# NON-AMPHETAMINE CENTRAL NERVOUS SYSTEM AGENTS

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## Products Affected

- *armodafinil*
- *modafinil oral*

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

# NUCALA

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## Products Affected

- NUCALA

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

<b>PA Criteria</b>	<b>Criteria Details</b>
	authorization for all indications: clinical benefit from use of the drug.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# NUEDEXTA

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## Products Affected

- NUEDEXTA

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

# NUPLAZID

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## Products Affected

- NUPLAZID ORAL CAPSULE
- NUPLAZID ORAL TABLET 10 MG

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

# OCALIVA

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## Products Affected

- OCALIVA

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Members with decompensated cirrhosis, a prior decompensation event, compensated cirrhosis who have evidence of portal hypertension, or complete biliary obstruction.
<b>Required Medical Information</b>	For new starts: 1) Attestation that the member has failed at least a 12 month trial of ursodiol, or has a medical reason (e.g. intolerance, hypersensitivity) for being unable to tolerate ursodiol AND 2) lab results for baseline ALT/AST, alkaline phosphatase (ALP), and bilirubin within 90 days of request. For continuation of therapy or reauthorization: Documentation that that the member has responded to Ocaliva (e.g. improved biochemical markers (e.g., ALP, bilirubin, GGT, AST, ALT levels)).
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescriber must be a gastroenterologist, hepatologist, or transplant specialist.
<b>Coverage Duration</b>	New starts will be authorized for 6 months. Cont of therapy or reauth until end of contract year.
<b>Other Criteria</b>	N/A
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# OCTREOTIDE

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## Products Affected

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

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



# OFEV

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## Products Affected

- OFEV

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

# OLUMIANT

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## Products Affected

- OLUMIANT

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Specialist for submitted diagnosis.
<b>Coverage Duration</b>	Request will be authorized until the end of the contract year.
<b>Other Criteria</b>	For RA: Either 1) Trial of, medical reason for not using, or contraindication to 2 of the following: Enbrel, Humira, Hadlima, Rinvoq, or Xeljanz, or 2) If utilized within the past 120 days, approve for continuation of therapy. For alopecia areata: Documentation of confirmed diagnosis and other causes of hair loss have been ruled out.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# ORAL ANTINEOPLASTIC AGENTS

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## Products Affected

- *abiraterone acetate*
- AKEEGA
- ALECENSA
- ALUNBRIG
- AUGTYRO
- AYVAKIT
- BALVERSA
- *bexarotene*
- BOSULIF
- BRAFTOVI ORAL CAPSULE 75 MG
- BRUKINSA
- CABOMETYX
- CALQUENCE
- CAPRELSA
- COMETRIQ (100 MG DAILY DOSE) ORAL KIT 80 & 20 MG
- COMETRIQ (140 MG DAILY DOSE) ORAL KIT 3 X 20 MG & 80 MG
- COMETRIQ (60 MG DAILY DOSE)
- COPIKTRA
- COTELLIC
- DAURISMO
- ERIVEDGE
- ERLEADA
- *erlotinib hcl*
- *everolimus oral tablet 10 mg, 2.5 mg, 5 mg, 7.5 mg*
- *everolimus oral tablet soluble*
- EXKIVITY
- FOTIVDA
- FRUZAQLA
- GAVRETO
- *gefitinib*
- GILOTRIF
- IBRANCE
- ICLUSIG
- IDHIFA
- *imatinib mesylate*
- IMBRUVICA
- INLYTA
- INQOVI
- INREBIC
- JAYPIRCA
- KISQALI (200 MG DOSE)
- KISQALI (400 MG DOSE)
- KISQALI (600 MG DOSE)
- KISQALI FEMARA (200 MG DOSE)
- KISQALI FEMARA (400 MG DOSE)
- KISQALI FEMARA (600 MG DOSE)
- KOSELUGO
- KRAZATI
- *lapatinib ditosylate*
- *lenalidomide*
- LENVIMA (10 MG DAILY DOSE)
- LENVIMA (12 MG DAILY DOSE)
- LENVIMA (14 MG DAILY DOSE)
- LENVIMA (18 MG DAILY DOSE)
- LENVIMA (20 MG DAILY DOSE)
- LENVIMA (24 MG DAILY DOSE)
- LENVIMA (4 MG DAILY DOSE)
- LENVIMA (8 MG DAILY DOSE)
- LONSURF
- LORBRENA
- LUMAKRAS
- LYNPARZA ORAL TABLET
- LYTGOBI (12 MG DAILY DOSE)
- LYTGOBI (16 MG DAILY DOSE)
- LYTGOBI (20 MG DAILY DOSE)
- MEKINIST
- MEKTOVI
- NERLYNX
- *nilutamide*
- NINLARO
- NUBEQA
- ODOMZO
- OGSIVEO
- OJJAARA
- ONUREG

- ORGOVYX
- ORSERDU
- *pazopanib hcl*
- PEMAZYRE
- PIQRAY (200 MG DAILY DOSE)
- PIQRAY (250 MG DAILY DOSE)
- PIQRAY (300 MG DAILY DOSE)
- POMALYST
- PURIXAN
- QINLOCK
- RETEVMO
- REVLIMID
- REZLIDHIA
- ROZLYTREK
- RUBRACA
- RYDAPT
- SCEMBLIX
- SOLTAMOX
- *sorafenib tosylate*
- SPRYCEL
- STIVARGA
- *sunitinib malate*
- TABLOID
- TABRECTA
- TAFINLAR
- TAGRISSO
- TALZENNA
- TASIGNA
- TAZVERIK
- TEPMETKO
- THALOMID
- TIBSOVO
- *toremifene citrate*
- *tretinoin oral*
- TRUQAP
- TRUSELTIQ (100MG DAILY DOSE)
- TRUSELTIQ (125MG DAILY DOSE)
- TRUSELTIQ (50MG DAILY DOSE)
- TRUSELTIQ (75MG DAILY DOSE)
- TUKYSA
- TURALIO
- VANFLYTA
- VENCLEXTA
- VENCLEXTA STARTING PACK
- VERZENIO
- VITRAKVI
- VIZIMPRO
- VONJO
- WELIREG
- XALKORI
- XOSPATA
- XPOVIO (100 MG ONCE WEEKLY)  
ORAL TABLET THERAPY PACK  
50 MG
- XPOVIO (40 MG ONCE WEEKLY)  
ORAL TABLET THERAPY PACK  
40 MG
- XPOVIO (40 MG TWICE WEEKLY)  
ORAL TABLET THERAPY PACK  
40 MG
- XPOVIO (60 MG ONCE WEEKLY)  
ORAL TABLET THERAPY PACK  
60 MG
- XPOVIO (60 MG TWICE WEEKLY)
- XPOVIO (80 MG ONCE WEEKLY)  
ORAL TABLET THERAPY PACK  
40 MG
- XPOVIO (80 MG TWICE WEEKLY)
- XTANDI
- YONSA
- ZEJULA
- ZELBORAF
- ZOLINZA
- ZYDELIG
- ZYKADIA ORAL TABLET

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A

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

# ORAL ANTIPSYCHOTICS

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## Products Affected

- CAPLYTA
- FANAPT
- FANAPT TITRATION PACK
- VRAYLAR ORAL CAPSULE
- VRAYLAR ORAL CAPSULE THERAPY PACK

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

# ORENCIA

## Products Affected

- ORENCIA CLICKJECT
- ORENCIA INTRAVENOUS
- ORENCIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Specialist for submitted diagnosis.
<b>Coverage Duration</b>	Request will be authorized until the end of the contract year.
<b>Other Criteria</b>	For pJIA: Either 1) Trial of, medical reason for not using, or contraindication to 2 of the following: Enbrel, Humira, Hadlima, or Xeljanz or 2) If utilized within the past 120 days, approve for continuation of therapy. For PsA: Either 1) Trial of, medical reason for not using, or contraindication to 2 of the following therapies: Stelara, Skyrizi, Tremfya, Xeljanz, Rinvoq, Enbrel, Hadlima, or Humira, or 2) If utilized within the past 120 days, approve for continuation of therapy. For RA: Either 1) Trial of, medical reason for not using, or contraindication to 2 of the following: Enbrel, Humira, Hadlima, Rinvoq or Xeljanz or 2) If utilized within the past 120 days, approve for continuation of therapy. For acute graft versus host disease: Attestation member is taking in combination with a calcineurin inhibitor and methotrexate.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

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



# ORIAHNN

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## Products Affected

- ORIAHNN

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

# ORILISSA

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## Products Affected

- ORILISSA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Patient has osteoporosis or severe hepatic impairment.
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescriber must be an OB or gynecologist.
<b>Coverage Duration</b>	Request will be authorized until the end of the contract year.
<b>Other Criteria</b>	Trial of, contraindication to, or medical reason for not using the following concurrently for endometriosis: analgesic pain reliever (e.g. NSAIDs, COX-2 inhibitors) AND either combined estrogen-progestin oral contraceptive, progestin (e.g. medroxyprogesterone acetate, norethindrone), gonadotropin-releasing hormone (GnRH) agonists (e.g. Lupron Depot), OR danazol. For continuation of therapy or reauthorization both of the following are required: 1) Treatment does not exceed the eligible maximum lifetime treatment duration of 2 years for 150mg tablet or 6 months for 200mg tablet, and 2) Documentation has been provided that the member has obtained clinical benefit from the medication.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

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

# ORKAMBI

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## Products Affected

- ORKAMBI

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

# OTEZLA

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## Products Affected

- OTEZLA

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

# OXBRYTA

## Products Affected

- OXBRYTA

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	New starts: Documentation is provided for all of the following: 1) baseline labs: Hemoglobin (Hb) level less than 10.5 g/dL, indirect bilirubin, and reticulocytes, 2) member has had 1 or more pain crises in the last 12 months, and 3) member has been taking hydroxyurea at the maximum tolerated dose (or a medical reason was provided why the patient is unable to use hydroxyurea). Continuation of therapy or reauthorization at 6 months from initiation and at subsequent 12-month intervals: Documentation of 1 of the following: 1) Hb increase from baseline (at 6 months from initiation) or maintenance of such Hb increase (at 12-month intervals thereafter), or 2) reduced number of vaso-occlusive/pain crises since Oxbryta was started, or 3) decrease in indirect bilirubin from baseline, or decrease in percentage of reticulocytes from baseline.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescriber must be a hematologist.
<b>Coverage Duration</b>	New starts will be authorized for 6 months. Cont of therapy or reauth until end of contract year.
<b>Other Criteria</b>	N/A
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

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

# OXERVATE

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## Products Affected

- OXERVATE

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescriber must be an ophthalmologist.
<b>Coverage Duration</b>	Request will be authorized for 8 weeks.
<b>Other Criteria</b>	N/A
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No



# OXYCODONE ER

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## Products Affected

- *oxycodone hcl er oral tablet er 12 hour abuse-deterrent 10 mg, 20 mg, 40 mg, 80 mg*

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

<b>PA Criteria</b>	<b>Criteria Details</b>
	is on concurrent benzodiazepines and/or muscle relaxant therapy, the prescriber attests that concurrent therapy is medically necessary, (4) Member is not being treated for substance abuse with buprenorphine-containing products.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# PALIPERIDONE INJECTABLE

## Products Affected

- INVEGA SUSTENNA  
INTRAMUSCULAR SUSPENSION  
PREFILLED SYRINGE  
117 MG/0.75ML, 156 MG/ML,  
234 MG/1.5ML, 39 MG/0.25ML,  
78 MG/0.5ML
- INVEGA TRINZA  
INTRAMUSCULAR SUSPENSION  
PREFILLED SYRINGE  
273 MG/0.88ML, 410 MG/1.32ML,  
546 MG/1.75ML, 819 MG/2.63ML

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	The member has a documented history of receiving oral risperidone or oral paliperidone without any clinically significant side effects. For requests for Invega Trinza, the member has documented treatment with Invega Sustenna for at least 4 months.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Request will be authorized until the end of the contract year.
<b>Other Criteria</b>	Trial of, contraindication to, or medical reason for not using Abilify Maintena.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# PALIPERIDONE ORAL

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## Products Affected

- *paliperidone er oral tablet*  
*extended release 24 hour 1.5 mg,*  
*3 mg, 6 mg, 9 mg*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Request will be authorized until the end of the contract year.
<b>Other Criteria</b>	For schizophrenia: trial of, contraindication to, or medical reason for not using an alternative generic second generation atypical antipsychotic.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# PCSK9 INHIBITORS

## Products Affected

- PRALUENT SUBCUTANEOUS SOLUTION AUTO-INJECTOR
- REPATHA
- REPATHA PUSHTRONEX SYSTEM
- REPATHA SURECLICK

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescriber must be a cardiologist, endocrinologist, or a specialist in treatment of lipid disorders.
<b>Coverage Duration</b>	New starts will be authorized for 4 months. Cont of therapy or reauth until end of contract year.
<b>Other Criteria</b>	For ALL diagnoses (including primary hyperlipidemia) for new starts, attestations of the following: 1) Two fasting lipid panel reports within the past 12 months with abnormal LDL cholesterol results (above 70mg/dL) after treatment for a minimum of 3 months with two high potency statins (atorvastatin and rosuvastatin) or a medical reason (contraindication or intolerance) has been provided as to why the patient is unable to use these therapies, and 2) If patient experiences statin intolerance, trial of statin re-challenge with maximally tolerated dose of statins with continued abnormal LDL cholesterol results (above 70mg/dL) or with attestation of return of side effects. For familial hypercholesterolemia (FH), attestation of TWO of the following: 1) genetic testing confirming FH diagnosis, 2) clinical manifestations of FH such as xanthomas or inflamed tendons, 3) a clinical diagnosis of FH using the Dutch Lipid Clinic Diagnostic criteria (total score greater than 8 points), OR Simon-Broome Diagnostic criteria (total cholesterol

<b>PA Criteria</b>	<b>Criteria Details</b>
	greater than 290 mg/dL or LDL-C greater than 190 mg/dL, plus tendon xanthoma in patient, first-degree parent, sibling or child) or second-degree relative (grandparent, uncle or aunt). For ASCVD, additional attestation of history of acute coronary syndromes, history of MI, stable or unstable angina, coronary or other arterial revascularization, stroke, TIA, or peripheral arterial disease presumed to be of atherosclerotic origin. For ALL diagnoses for continuation of therapy or reauthorization: attestation of improvement in LDL from new start.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# PEGINTERFERON

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## Products Affected

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

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

# PENICILLAMINE

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## Products Affected

- *penicillamine oral tablet*

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



# PENTAMIDINE SOLUTION FOR INJECTION

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## Products Affected

- *pentamidine isethionate injection*

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

# PERSERIS

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## Products Affected

- PERSERIS

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

# PHENOXYBENZAMINE

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## Products Affected

- *phenoxybenzamine hcl oral*

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

# PIRFENIDONE

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## Products Affected

- *pirfenidone*

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

# POSACONAZOLE

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## Products Affected

- *posaconazole oral*

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

# PRETOMANID

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## Products Affected

- *pretomanid*

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

# PREVYMIS

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## Products Affected

- PREVYMIS ORAL

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

# PROLIA

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## Products Affected

- PROLIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	For new starts for a diagnosis of osteoporosis: Documentation showing patient falls into one of the following categories: Postmenopausal woman or a male patient who has a bone mineral density (BMD) value consistent with osteoporosis (i.e., T-scores equal to or less than - 2.5) or who has had an osteoporotic fracture. Postmenopausal woman or man with a T-score between -1 and -2.5 at the femoral neck or spine and a 10 year hip fracture probability greater than 3% or a 10 year major osteoporosis-related fracture probability greater than 20% based on the US-adapted WHO absolute fracture risk model. For continuation of therapy or reauthorization: Prescriber attests that patient has clinically benefited from medication.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Request will be authorized until the end of the contract year.
<b>Other Criteria</b>	The following criteria is also applicable for new starts: trial of, contraindication to, or medical reason for not using an oral bisphosphonate.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A



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

# PROMACTA

## Products Affected

- PROMACTA ORAL PACKET  
12.5 MG, 25 MG
- PROMACTA ORAL TABLET  
12.5 MG, 25 MG, 50 MG, 75 MG

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	For chronic immune (idiopathic) thrombocytopenia (ITP): Documented baseline platelet count less than 30,000 cells/microL. For severe aplastic anemia: Documentation of baseline platelet count less than 20,000 cells/microL OR platelet count less than 30,000 cells/microL with bleeding OR reticulocyte count less than 20,000 cells/microL OR absolute neutrophil count less than 500 cells/microL. For thrombocytopenia in patients with Hepatitis C infection: documented baseline platelet count less than 75,000 cells/microL.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Specialist for submitted diagnosis.
<b>Coverage Duration</b>	Request will be authorized until the end of the contract year.
<b>Other Criteria</b>	For chronic immune (idiopathic) thrombocytopenia (ITP): Trial of, contraindication to, or medical reason for not using glucocorticosteroids. For severe aplastic anemia: Trial of, contraindication to, or medical reason for not using at least one immunosuppressive agent.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

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

# PYRUKYND

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## Products Affected

- PYRUKYND
- PYRUKYND TAPER PACK

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

# RADICAVA

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## Products Affected

- RADICAVA ORS
- RADICAVA ORS STARTER KIT

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

# RAVICTI

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## Products Affected

- RAVICTI

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

# RECORLEV

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## Products Affected

- RECORLEV

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

# REGRANEX

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## Products Affected

- REGRANEX

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



# RELISTOR

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## Products Affected

- RELISTOR ORAL
- RELISTOR SUBCUTANEOUS SOLUTION

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	Patient must have documented trial of or medical reason for not using the following: 1) lubiprostone, AND 2) lactulose AND 3) Movantik. Additionally, patient must have a medical reason for not being able to use oral Relistor in order to receive Relistor injection.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

# RELYVRIO

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## Products Affected

- RELYVRIO

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	For new starts: Documentation of diagnosis of ALS. For continuation of therapy or reauthorization: Documentation or provider attestation of positive clinical response (such as improvement in the Revised ALS Functional Rating Scale (ALSFRS-R) total score)
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a neurologist, neuromuscular specialist, or physician specializing in the treatment of amyotrophic lateral sclerosis.
<b>Coverage Duration</b>	New starts: 6 months. Cont. of therapy or reauthorization: until end of contract year.
<b>Other Criteria</b>	N/A
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# REXULTI

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## Products Affected

- REXULTI

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	For schizophrenia: trial of, contraindication to, or medical reason for not using two generic antipsychotics. For major depressive disorder: trial of, contraindication to, or medical reason for not using two generic antidepressants. For agitation associated with dementia: approve.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

# REZUROCK

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## Products Affected

- REZUROCK

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

# RINVOQ

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## Products Affected

- RINVOQ

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Specialist for submitted diagnosis.
<b>Coverage Duration</b>	Request will be authorized until the end of the contract year.
<b>Other Criteria</b>	<p>For RA: Trial of, medical reason for not using, or contraindication to 1 disease modifying antirheumatic drug (DMARD) (methotrexate, leflunomide, or sulfasalazine) and 1 tumor necrosis factor (TNF) blocker (Enbrel, Hadlima, or Humira). For PsA: Trial of, medical reason for not using, or contraindication to 1 TNF blocker (Enbrel, Hadlima, or Humira). For atopic dermatitis: trial of, contraindication to, or medical reason for not using: 1) topical tacrolimus or pimecrolimus and 2) Eucrisa. For ankylosing spondylitis: Trial of, medical reason for not using, or contraindication to naproxen and 1 TNF blocker (Enbrel, Hadlima, or Humira). For UC: Trial of, medical reason for not using, or contraindication to 1 of the following conventional therapies: mercaptopurine, an aminosalicylate (i.e. mesalamine, sulfasalazine, azathioprine), or a corticosteroid (i.e. prednisone, methylprednisolone) and Humira, or Hadlima. For non-radiographic axial spondyloarthritis: Trial of, medical reason for not using, or contraindication to</p>

<b>PA Criteria</b>	<b>Criteria Details</b>
	naproxen. For Crohns Disease: trial of, medical reason for not using, or contraindication to 1 TNF blocker.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# RISPERDAL CONSTA

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## Products Affected

- RISPERDAL CONSTA  
INTRAMUSCULAR SUSPENSION  
RECONSTITUTED ER

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	The member has a documented history of receiving oral risperidone without any clinically significant side effects.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Request will be authorized until the end of the contract year.
<b>Other Criteria</b>	Trial of, contraindication to, or medical reason for not using Abilify Maintena.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# RISPERIDONE INJECTABLE

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## Products Affected

- *risperidone microspheres er*

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



# RUFINAMIDE

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## Products Affected

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

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

# RYKINDO

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## Products Affected

- RYKINDO

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

# RYLAZE

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## Products Affected

- RYLAZE

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

# SAPROPTERIN

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## Products Affected

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

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

# SECUADO

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## Products Affected

- SECUADO

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

# SEROSTIM

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## Products Affected

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

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

# SIGNIFOR

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## Products Affected

- SIGNIFOR

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

# SILDENAFIL ORAL

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## Products Affected

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

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



# SILIQ

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## Products Affected

- SILIQ

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

# SIMPONI

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## Products Affected

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

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Specialist for submitted diagnosis.
<b>Coverage Duration</b>	Request will be authorized until the end of the contract year.
<b>Other Criteria</b>	For ankylosing spondylitis: Either 1) Trial of, medical reason for not using, or contraindication to 2 of the following therapies: Enbrel, Humira, Hadlima, Rinvoq or Xeljanz, or 2) If utilized within the past 120 days, approve for continuation of therapy. For PsA: Either 1) Trial of, medical reason for not using, or contraindication to 2 of the following therapies: Stelara, Skyrizi, Tremfya, Xeljanz, Rinvoq, Enbrel, Hadlima, or Humira, or 2) If utilized within the past 120 days, approve for continuation of therapy. For RA: Either 1) Trial of, medical reason for not using, or contraindication to 2 of the following: Enbrel, Humira, Hadlima, Rinvoq or Xeljanz or 2) If utilized within the past 120 days, approve for continuation of therapy. For UC: Either 1) Trial of, medical reason for not using, or contraindication to 2 of the following: Humira, Hadlima, Rinvoq, Stelara or Xeljanz or 2) If utilized within the past 120 days, approve for continuation of therapy.
<b>Indications</b>	All Medically-accepted Indications.

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

# SIRTURO

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## Products Affected

- SIRTURO

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

# SKYRIZI

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## Products Affected

- SKYRIZI
- SKYRIZI PEN

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Specialist for submitted diagnosis.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	For PsA or psoriasis: approve. For Crohns Disease: Either 1) Trial of, medical reason for not using (i.e. severe Crohns disease), or contraindication to 1 of the following: mercaptopurine, azathioprine, sulfasalazine, methotrexate or corticosteroid (e.g., prednisone, methylprednisolone) or 2) If utilized within the past 120 days, approve for continuation of therapy.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

# SODIUM PHENYL BUTYRATE

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## Products Affected

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

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

# SOFOSBUVIR/VELPATASVIR

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## Products Affected

- *sofosbuvir-velpatasvir*

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

# SOMAVERT

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## Products Affected

- SOMAVERT

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



# SOTYKTU

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## Products Affected

- SOTYKTU

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

# STELARA

## Products Affected

- STELARA INTRAVENOUS
- STELARA SUBCUTANEOUS SOLUTION 45 MG/0.5ML
- STELARA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE

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

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

# SUCRAID

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## Products Affected

- SUCRAID

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

# SYMDEKO

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## Products Affected

- SYMDEKO

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

# SYMLIN

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## Products Affected

- SYMLINPEN 120 SUBCUTANEOUS SOLUTION PEN-INJECTOR
- SYMLINPEN 60 SUBCUTANEOUS SOLUTION PEN-INJECTOR

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Patient has confirmed gastroparesis.
<b>Required Medical Information</b>	For new starts: HbA1C values within 90 days of request is greater than or equal to 7% despite receiving insulin therapy.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Request will be authorized until the end of the contract year.
<b>Other Criteria</b>	Trial of, contraindication to, or medical reason for not using two alternative anti-diabetic agents.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# SYNAREL

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## Products Affected

- SYNAREL

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

# TADALAFIL

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## Products Affected

- *tadalafil (pah)*
- TADLIQ

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



# TALTZ

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## Products Affected

- TALTZ

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Specialist for submitted diagnosis.
<b>Coverage Duration</b>	Request will be authorized until the end of the contract year.
<b>Other Criteria</b>	For ankylosing spondylitis: Either 1) Trial of, medical reason for not using, or contraindication to 2 of the following therapies: Enbrel, Humira, Hadlima, Rinvoq or Xeljanz, or 2) If utilized within the past 120 days, approve for continuation of therapy. For non-radiographic axial spondyloarthritis: approve. For psoriasis: Either 1) Trial of, medical reason for not using, or contraindication (e.g., safety concerns, not indicated for patient's age) to 2 of the following therapies: Stelara, Skyrizi, Tremfya, Enbrel, Hadlima, or Humira, or 2) If utilized within the past 120 days, approve for continuation of therapy. For PsA: Either 1) Trial of, medical reason for not using, or contraindication to 2 of the following therapies: Stelara, Skyrizi, Tremfya, Xeljanz, Rinvoq, Enbrel, Hadlima, or Humira, or 2) If utilized within the past 120 days, approve for continuation of therapy.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

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

# TARPEYO

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## Products Affected

- TARPEYO

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

# TAVNEOS

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## Products Affected

- TAVNEOS

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

<b>PA Criteria</b>	<b>Criteria Details</b>
	limit of normal) 3) Prescriber attestation that patient has no active HBV infection.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# TEFLARO

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## Products Affected

- TEFLARO

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Documentation of a consultation with an infectious disease specialist.
<b>Coverage Duration</b>	Request will be authorized for 14 days.
<b>Other Criteria</b>	N/A
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# TERIPARATIDE

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## Products Affected

- *teriparatide (recombinant) subcutaneous solution pen-injector 620 mcg/2.48ml*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Documentation showing patient falls into one of the following categories: Postmenopausal woman who has a bone mineral density (BMD) value consistent with osteoporosis (i.e., T-scores equal to or less than -2.5) or postmenopausal woman who has had an osteoporotic fracture. Postmenopausal woman who has T-scores from -1.5 to -2.5 and at least one of the following risk factors for fracture: thinness [low body mass index (less than 21 kg/m <sup>2</sup> )], history of fragility fracture since menopause, or history of hip fracture in a parent. Male greater than or equal to 65 years of age with T-score of -2.5 or less. Male less than 65 years of age with T-score of -2.5 or less and 2 or more risk factors for fractures or previous osteoporotic fracture.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Request will be authorized until the end of the contract year.
<b>Other Criteria</b>	In addition, the following criteria is also applicable: 1) Trial of, medical reason for not using, or contraindication to an oral bisphosphonate and Prolia and 2) therapy does not exceed the therapy maximum of 2 years.
<b>Indications</b>	All Medically-accepted Indications.

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



# THIOLA

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## Products Affected

- THIOLA EC
- *tiopronin oral*

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

# TOLVAPTAN

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## Products Affected

- *tolvaptan*

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

# TOPICAL ANTINEOPLASTIC RETINOIDS

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## Products Affected

- *bexarotene*
- PANRETIN

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

# TOPICAL TESTOSTERONE

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## Products Affected

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

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

# TRANSDERMAL LIDOCAINE

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## Products Affected

- *lidocaine external patch 5 %*
- ZTLIDO

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

# TREMFYA

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## Products Affected

- TREMFYA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Specialist for submitted diagnosis.
<b>Coverage Duration</b>	Request will be authorized until the end of the contract year.
<b>Other Criteria</b>	For PsA or psoriasis: approve.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# TRIENTINE

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## Products Affected

- CUVRIOR
- *trientine hcl oral capsule 250 mg*

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

# TRIKAFTA

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## Products Affected

- TRIKAFTA

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



# TYMLOS

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## Products Affected

- TYMLOS

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

# TYVASO

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## Products Affected

- TYVASO DPI MAINTENANCE KIT
- TYVASO DPI TITRATION KIT

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

# UPTRAVI

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## Products Affected

- UPTRAVI ORAL
- UPTRAVI TITRATION

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

# UZEDY

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## Products Affected

- UZEDY

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

# VALCHLOR

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## Products Affected

- VALCHLOR

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

# VEMLIDY

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## Products Affected

- VEMLIDY

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

# VENTAVIS

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## Products Affected

- VENTAVIS

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

# VIGABATRIN

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## Products Affected

- *vigabatrin*

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



# VIJOICE

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## Products Affected

- VIJOICE

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

# VMAT-2 INHIBITORS

## Products Affected

- AUSTEDO
- AUSTEDO PATIENT TITRATION KIT
- INGREZZA ORAL CAPSULE
- INGREZZA ORAL CAPSULE THERAPY PACK
- *tetrabenazine*

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

# VORICONAZOLE

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## Products Affected

- *voriconazole intravenous*

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

# VOSEVI

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## Products Affected

- VOSEVI

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

# VOWST

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## Products Affected

- VOWST

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

# WHITE BLOOD CELL STIMULATORS

## Products Affected

- FULPHILA
- FYLNETRA
- LEUKINE INJECTION SOLUTION RECONSTITUTED
- NEULASTA ONPRO
- NEULASTA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE
- NYVEPRIA
- UDENYCA
- UDENYCA ONBODY
- ZARXIO
- ZIEXTENZO

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

# XATMEP

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## Products Affected

- XATMEP

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

# XELJANZ

## Products Affected

- XELJANZ
- XELJANZ XR

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Specialist for submitted diagnosis.
<b>Coverage Duration</b>	Request will be authorized until the end of the contract year.
<b>Other Criteria</b>	For ankylosing spondylitis: Trial of, medical reason for not using, or contraindication to naproxen and 1 TNF blocker (Enbrel, Hadlima, or Humira) For pJIA: Trial of, medical reason for not using, or contraindication to 1 of the following DMARDs: methotrexate or leflunomide and 1 TNF blocker (Enbrel, Hadlima, or Humira). For PsA: Trial of, medical reason for not using, or contraindication to 1 TNF blocker (Enbrel, Hadlima, or Humira). For RA: Trial of, medical reason for not using, or contraindication to 1 disease modifying antirheumatic drug (DMARD) (methotrexate, leflunomide, or sulfasalazine) and 1 tumor necrosis factor (TNF) blocker (Enbrel, Hadlima, or Humira). For UC: Trial of, medical reason for not using, or contraindication to 1 of the following conventional therapies: mercaptopurine, an aminosalicylate (i.e. mesalamine, sulfasalazine, azathioprine), or a corticosteroid (i.e. prednisone, methylprednisolone) and Humira or Hadlima.
<b>Indications</b>	All Medically-accepted Indications.



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

# XERMELO

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## Products Affected

- XERMELO

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

# XGEVA

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## Products Affected

- XGEVA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Patients with baseline hypocalcemia
<b>Required Medical Information</b>	New starts: Serum calcium levels. Reauthorization criteria for malignant hypercalcemia: albumin-adjusted serum calcium level below 12.5mg/dl within 30 days of request.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Request will be authorized until the end of the contract year.
<b>Other Criteria</b>	N/A
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# XIFAXAN

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## Products Affected

- XIFAXAN

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

# XOLAIR

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## Products Affected

- XOLAIR

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

<b>PA Criteria</b>	<b>Criteria Details</b>
	<p>disease must be severe enough to warrant short term systemic corticosteroid therapy for management of urticaria. Continuation of therapy or reauthorization criteria for chronic idiopathic urticaria: 1) improvement from baseline of symptoms associated with urticaria within 6 months of Xolair use. New starts for nasal polyps: 1) currently using an intranasal corticosteroid, will be prescribed an intranasal corticosteroid with request, or has a medical reason for not using an intranasal corticosteroid. Continuation of therapy or reauthorization criteria for nasal polyps: 1) Documentation has been provided that demonstrates a clinical benefit (e.g. improvements in symptom severity, nasal polyp score [NPS], sino-nasal outcome test-22 [SNOT-22], nasal congestion score [NCS]) AND 2) continued use of intranasal corticosteroid, or has a medical reason for not using one.</p>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# XTAMPZA ER

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## Products Affected

- XTAMPZA ER

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

# XURIDEN

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## Products Affected

- XURIDEN

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescriber must be an endocrinologist, metabolic specialist, clinical geneticist or hematologist.
<b>Coverage Duration</b>	Request will be authorized until the end of the contract year.
<b>Other Criteria</b>	N/A
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No



# XYREM

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## Products Affected

- *sodium oxybate*
- XYREM

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

# XYWAV

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## Products Affected

- XYWAV

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

# ZEPOSIA

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## Products Affected

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

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

# ZTALMY

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## Products Affected

- ZTALMY

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

# ZURZUVAE

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## Products Affected

- ZURZUVAE

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

# ZYPREXA RELPREVV

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## Products Affected

- ZYPREXA RELPREVV  
INTRAMUSCULAR SUSPENSION  
RECONSTITUTED 210 MG, 300 MG,  
405 MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	The member has a documented history of receiving oral olanzapine without any clinically significant side effects.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Request will be authorized until the end of the contract year.
<b>Other Criteria</b>	Trial of, contraindication to, or medical reason for not using Abilify Maintena.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# PART B VERSUS PART D

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## Products Affected

- ABELCET INTRAVENOUS SUSPENSION 5 MG/ML
- *acetylcysteine inhalation solution 10 %, 20 %*
- *acyclovir sodium intravenous solution 50 mg/ml*
- *albuterol sulfate inhalation nebulization solution (2.5 mg/3 ml) 0.083%, (5 mg/ml) 0.5%, 0.63 mg/3 ml, 1.25 mg/3 ml, 2.5 mg/0.5 ml*
- *amphotericin b intravenous solution reconstituted 50 mg*
- *amphotericin b liposome intravenous suspension reconstituted 50 mg*
- *aprepitant oral 80 & 125 mg*
- *aprepitant oral capsule 125 mg, 40 mg, 80 & 125 mg, 80 mg*
- ASTAGRAF XL ORAL CAPSULE EXTENDED RELEASE 24 HOUR 0.5 MG, 1 MG, 5 MG
- *azathioprine oral tablet 50 mg*
- *budesonide inhalation suspension 0.25 mg/2 ml, 0.5 mg/2 ml, 1 mg/2 ml*
- CLINISOL SF INTRAVENOUS SOLUTION 15 %
- *cromolyn sodium inhalation nebulization solution 20 mg/2 ml*
- *cyclophosphamide oral capsule 25 mg, 50 mg*
- *cyclophosphamide oral tablet 25 mg, 50 mg*
- *cyclosporine modified oral capsule 100 mg, 25 mg, 50 mg*
- *cyclosporine modified oral solution 100 mg/ml*
- *cyclosporine oral capsule 100 mg, 25 mg*
- *diphtheria-tetanus toxoids dt intramuscular suspension 25-5 lfu/0.5 ml*
- *dronabinol oral capsule 10 mg, 2.5 mg, 5 mg*
- EMEND ORAL SUSPENSION RECONSTITUTED 125 MG/5 ML
- ENGERIX-B INJECTION SUSPENSION 20 MCG/ML
- ENGERIX-B INJECTION SUSPENSION PREFILLED SYRINGE 10 MCG/0.5 ML, 20 MCG/ML
- ENVARSUS XR ORAL TABLET EXTENDED RELEASE 24 HOUR 0.75 MG, 1 MG, 4 MG
- *everolimus oral tablet 0.25 mg, 0.5 mg, 0.75 mg, 1 mg*
- *formoterol fumarate inhalation nebulization solution 20 mcg/2 ml*
- GAMMAGARD INJECTION SOLUTION 1 GM/10 ML, 10 GM/100 ML, 2.5 GM/25 ML, 20 GM/200 ML, 30 GM/300 ML, 5 GM/50 ML
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- *granisetron hcl oral tablet 1 mg*
- HEPLISAV-B INTRAMUSCULAR SOLUTION PREFILLED SYRINGE 20 MCG/0.5 ML
- IMOVAX RABIES INTRAMUSCULAR SUSPENSION RECONSTITUTED 2.5 UNIT/ML
- INTRALIPID INTRAVENOUS EMULSION 20 %, 30 %
- *ipratropium bromide inhalation solution 0.02 %*
- *ipratropium-albuterol inhalation solution 0.5-2.5 (3) mg/3 ml*
- *levalbuterol hcl inhalation nebulization solution 0.31 mg/3 ml, 0.63 mg/3 ml, 1.25 mg/3 ml*
- *mycophenolate mofetil oral capsule 250 mg*
- *mycophenolate mofetil oral suspension reconstituted 200 mg/ml*
- *mycophenolate mofetil oral tablet 500 mg*
- *mycophenolate sodium oral tablet delayed release 180 mg, 360 mg*
- *mycophenolic acid oral tablet delayed release 180 mg, 360 mg*
- NULOJIX INTRAVENOUS SOLUTION RECONSTITUTED 250 MG
- NUTRILIPID INTRAVENOUS EMULSION 20 %
- *ondansetron hcl oral solution 4 mg/5 ml*
- *ondansetron hcl oral tablet 24 mg, 4 mg, 8 mg*
- *ondansetron oral tablet dispersible 4 mg, 8 mg*
- *pentamidine isethionate inhalation solution reconstituted 300 mg*
- PLENAMINE INTRAVENOUS SOLUTION 15 %
- PREHEVBRIO INTRAMUSCULAR SUSPENSION 10 MCG/ML
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- PROGRAF INTRAVENOUS SOLUTION 5 MG/ML
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- RECOMBIVAX HB INJECTION SUSPENSION 10 MCG/ML, 40 MCG/ML, 5 MCG/0.5 ML
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- TDVAX INTRAMUSCULAR SUSPENSION 2-2 LF/0.5 ML
- TENIVAC INTRAMUSCULAR INJECTABLE 5-2 LFU, 5-2 LFU (INJECTION)
- *tetanus-diphtheria toxoids td intramuscular suspension 2-2 lf/0.5 ml*
- *tobramycin inhalation nebulization solution 300 mg/5 ml*



**Details**

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

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# Troy Medicare (HMO)

## 2024 Step Therapy Criteria

CURRENT AS OF 03/01/2024

### anticonvulsant step therapy

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#### Products Affected

- FYCOMPA SUSPENSION 0.5 MG/ML ORAL
- FYCOMPA TABLET 10 MG ORAL
- FYCOMPA TABLET 12 MG ORAL
- FYCOMPA TABLET 2 MG ORAL
- FYCOMPA TABLET 4 MG ORAL
- FYCOMPA TABLET 6 MG ORAL
- FYCOMPA TABLET 8 MG ORAL
- SPRITAM TABLET DISINTEGRATING SOLUBLE 1000 MG ORAL
- SPRITAM TABLET DISINTEGRATING SOLUBLE 250 MG ORAL
- SPRITAM TABLET DISINTEGRATING SOLUBLE 500 MG ORAL
- SPRITAM TABLET DISINTEGRATING SOLUBLE 750 MG ORAL
- SYMPAZAN FILM 10 MG ORAL
- SYMPAZAN FILM 20 MG ORAL
- SYMPAZAN FILM 5 MG ORAL
- XCOPRI (250 MG DAILY DOSE) TABLET THERAPY PACK 100 & 150 MG ORAL
- XCOPRI (350 MG DAILY DOSE) TABLET THERAPY PACK 150 & 200 MG ORAL
- XCOPRI TABLET 100 MG ORAL
- XCOPRI TABLET 150 MG ORAL
- XCOPRI TABLET 200 MG ORAL
- XCOPRI TABLET 50 MG ORAL
- XCOPRI TABLET THERAPY PACK 14 X 12.5 MG & 14 X 25 MG ORAL
- XCOPRI TABLET THERAPY PACK 14 X 150 MG & 14 X 200 MG ORAL
- XCOPRI TABLET THERAPY PACK 14 X 50 MG & 14 X 100 MG ORAL
- ZONISADE SUSPENSION 100 MG/5 ML ORAL

#### Details

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<b>Criteria</b>	Step 1: First line therapy should be a documented trial of two generic anticonvulsants. Step 2: Once two generic anticonvulsants have been tried, patients can receive therapy with Spritam, Sympazan, Xcopri, Fycompa or Zonisade.
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# antidepressant step therapy

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## Products Affected

- FETZIMA CAPSULE EXTENDED RELEASE 24 HOUR 120 MG ORAL
- FETZIMA CAPSULE EXTENDED RELEASE 24 HOUR 20 MG ORAL
- FETZIMA CAPSULE EXTENDED RELEASE 24 HOUR 40 MG ORAL
- FETZIMA CAPSULE EXTENDED RELEASE 24 HOUR 80 MG ORAL
- FETZIMA TITRATION CAPSULE ER 24 HOUR THERAPY PACK 20 & 40 MG ORAL

## Details

<b>Criteria</b>	Step 1: First line therapy should be a documented trial of two generic antidepressants. Step 2: Once two generic antidepressants have been tried, patient can receive therapy with Fetzima.
-----------------	---

# brinzolamide step therapy

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## Products Affected

- *brinzolamide suspension 1 %  
ophthalmic*

## Details

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<b>Criteria</b>	Step 1: First line therapy should be a documented trial of formulary dorzolamide or dorzolamide/timolol. Step 2: Once dorzolamide or dorzolamide/timolol has been tried, the patient can receive therapy with brinzolamide.
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# glp-1 agonists

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## Products Affected

- MOUNJARO SOLUTION PEN-INJECTOR 10 MG/0.5 ML SUBCUTANEOUS
- MOUNJARO SOLUTION PEN-INJECTOR 12.5 MG/0.5 ML SUBCUTANEOUS
- MOUNJARO SOLUTION PEN-INJECTOR 15 MG/0.5 ML SUBCUTANEOUS
- MOUNJARO SOLUTION PEN-INJECTOR 2.5 MG/0.5 ML SUBCUTANEOUS
- MOUNJARO SOLUTION PEN-INJECTOR 5 MG/0.5 ML SUBCUTANEOUS
- MOUNJARO SOLUTION PEN-INJECTOR 7.5 MG/0.5 ML SUBCUTANEOUS
- OZEMPIC (0.25 OR 0.5 MG/DOSE) SOLUTION PEN-INJECTOR 2 MG/1.5 ML SUBCUTANEOUS
- OZEMPIC (0.25 OR 0.5 MG/DOSE) SOLUTION PEN-INJECTOR 2 MG/3 ML SUBCUTANEOUS
- OZEMPIC (1 MG/DOSE) SOLUTION PEN-INJECTOR 4 MG/3 ML SUBCUTANEOUS
- OZEMPIC (2 MG/DOSE) SOLUTION PEN-INJECTOR 8 MG/3 ML SUBCUTANEOUS
- RYBELSUS TABLET 14 MG ORAL
- RYBELSUS TABLET 3 MG ORAL
- RYBELSUS TABLET 7 MG ORAL
- TRULICITY SOLUTION PEN-INJECTOR 0.75 MG/0.5 ML SUBCUTANEOUS
- TRULICITY SOLUTION PEN-INJECTOR 1.5 MG/0.5 ML SUBCUTANEOUS
- TRULICITY SOLUTION PEN-INJECTOR 3 MG/0.5 ML SUBCUTANEOUS
- TRULICITY SOLUTION PEN-INJECTOR 4.5 MG/0.5 ML SUBCUTANEOUS
- VICTOZA SOLUTION PEN-INJECTOR 18 MG/3 ML SUBCUTANEOUS

## Details

<b>Criteria</b>	Step 1: First line therapy should be a trial of at least one diabetic agent. Step 2: Once a diabetic agent has been tried, patients can receive therapy with Ozempic, Victoza, Trulicity, Rybelsus, or Mounjaro.
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# netarsudil step therapy

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## Products Affected

- RHOPRESSA SOLUTION  
0.02 % OPHTHALMIC
- ROCKLATAN SOLUTION  
0.02-0.005 % OPHTHALMIC

## Details

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<b>Criteria</b>	Step 1: First line therapy should be a documented trial of latanoprost or travoprost. Step 2: Once latanoprost or travoprost has been tried, patients can receive therapy with Rhopressa or Rocklatan.
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# ongentys step therapy

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## Products Affected

- ONGENTYS CAPSULE 25 MG  
ORAL
- ONGENTYS CAPSULE 50 MG  
ORAL

## Details

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<b>Criteria</b>	Step 1: First line therapy should be a documented trial of entacapone or carbidopa-levodopa-entacapone. Step 2: Once entacapone or carbidopa-levodopa-entacapone has been tried, patients can receive therapy with Ongentys.
-----------------	--

# rivastigmine patch step therapy

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## Products Affected

- *rivastigmine patch 24 hour*  
*13.3 mg/24 hr transdermal*
- *rivastigmine patch 24 hour*  
*4.6 mg/24 hr transdermal*
- *rivastigmine patch 24 hour*  
*9.5 mg/24 hr transdermal*

## Details

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<b>Criteria</b>	Step 1: First line therapy should be a documented trial of rivastigmine capsule. Step 2: Once rivastigmine capsule has been tried, patients can receive therapy with rivastigmine patches.
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# savella step therapy

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## Products Affected

- SAVELLA TABLET 100 MG ORAL
- SAVELLA TABLET 12.5 MG ORAL
- SAVELLA TABLET 25 MG ORAL
- SAVELLA TABLET 50 MG ORAL
- SAVELLA TITRATION PACK 12.5 MG & 25 MG & 50 MG ORAL

## Details

<b>Criteria</b>	Step 1: First line therapy should be a documented trial of generic duloxetine. Step 2: Once generic duloxetine has been tried, patients can receive therapy with Savella.
-----------------	---

# topical immunomodulators step therapy

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## Products Affected

- *pimecrolimus cream 1 % external*
- *tacrolimus ointment 0.1 % external*
- *tacrolimus ointment 0.03 % external*

## Details

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<b>Criteria</b>	Step 1: First line therapy should be a documented trial of two topical corticosteroids. Step 2: Once two topical corticosteroids have been tried, patients can receive therapy with generic pimecrolimus or generic topical tacrolimus.
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# urinary incontinence agents step therapy

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## Products Affected

- *darifenacin hydrobromide er tablet extended release 24 hour 15 mg oral*
- *darifenacin hydrobromide er tablet extended release 24 hour 7.5 mg oral*
- *fesoterodine fumarate er tablet extended release 24 hour 4 mg oral*
- *fesoterodine fumarate er tablet extended release 24 hour 8 mg oral*
- *trospium chloride er capsule extended release 24 hour 60 mg oral*

## Details

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<b>Criteria</b>	Step 1: First line therapy should be a documented trial of oxybutynin, oxybutynin ER, trospium, tolterodine, tolterodine ER or solifenacin. Step 2: Once one of the medications listed in Step 1 have been tried, patients can receive therapy with trospium ER, darifenacin ER or fesoterodine ER
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 XCOPRI (350 MG DAILY DOSE) TABLET THERAPY PACK 150 & 200 MG ORAL .....413  
 XCOPRI TABLET 100 MG ORAL ....413  
 XCOPRI TABLET 150 MG ORAL.....413  
 XCOPRI TABLET 200 MG ORAL....413  
 XCOPRI TABLET 50 MG ORAL .....413  
 XCOPRI TABLET THERAPY PACK 14 X 12.5 MG & 14 X 25 MG ORAL.....413  
 XCOPRI TABLET THERAPY PACK 14 X 150 MG & 14 X200 MG ORAL...413  
 XCOPRI TABLET THERAPY PACK 14 X 50 MG & 14 X100 MG ORAL.....413

**Z**

ZONISADE SUSPENSION 100 MG/5ML ORAL.....413





## 2024 Formulary

List of Covered Drugs

### Troy Medicare (HMO)

PLEASE READ: THIS DOCUMENT CONTAINS INFORMATION  
ABOUT THE DRUGS WE COVER IN THIS PLAN

This formulary was updated on 2/29/2024. For more recent information or other questions, please contact Troy Medicare (HMO) Pharmacy Member Service at 1-866-423-8065 (TTY users should call 711), Monday through Sunday, 24 hours a day, or visit <http://www.troymedicare.com>.

**Important Message About What You Pay for Vaccines** - Our plan covers most Part D vaccines at no cost to you. Call Member Services for more information.

**Important Message About What You Pay for Insulin** - You won't pay more than \$35 for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on. You won't pay more than \$10 for a one-month supply of generic insulin products covered by our plan on Tier 1.