2024 Formulary

List of Covered Drugs

Troy Medicare for Dual-eligible Beneficiaries (HMO D-SNP)

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 for Dual-eligible Beneficiaries (HMO D-SNP) 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 for Dual-eligible Beneficiaries (HMO D-SNP). 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 Troy Medicare for Dual-eligible Beneficiaries (HMO D-SNP) Formulary?
A formulary is a list of covered drugs selected by Troy Medicare for Dual-eligible Beneficiaries (HMO D-SNP) 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 for Dual-eligible Beneficiaries (HMO D-SNP) 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 for Dual-eligible Beneficiaries (HMO D-SNP) 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 for Dual-eligible Beneficiaries (HMO D-SNP) 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 for Dual-eligible Beneficiaries (HMO D-SNP) 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 for Dual-eligible Beneficiaries (HMO D-SNP), 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 132. 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 for Dual-eligible Beneficiaries (HMO D-SNP) 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 for Dual-eligible Beneficiaries (HMO D-SNP) 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 for Dual-eligible Beneficiaries (HMO D-SNP) limits the amount of the drug that we will cover. For example, Troy Medicare for Dual-eligible Beneficiaries (HMO D-SNP) 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 for Dual-eligible Beneficiaries (HMO D-SNP) 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 for Dual-eligible Beneficiaries (HMO D-SNP) 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 for Dual-eligible Beneficiaries (HMO D-SNP) 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 for Dual-eligible Beneficiaries (HMO D-SNP) 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 for Dual-eligible Beneficiaries (HMO D-SNP). When you receive the list, show it to your doctor and ask them to prescribe a similar drug that is covered by Troy Medicare for Dual-eligible Beneficiaries (HMO D-SNP).
- You can ask Troy Medicare for Dual-eligible Beneficiaries (HMO D-SNP) 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 for Dual-eligible Beneficiaries (HMO D-SNP) 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 for Dual-eligible Beneficiaries (HMO D-SNP) 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 for Dual-eligible Beneficiaries (HMO D-SNP) prescription drug coverage, please review your Evidence of Coverage and other plan materials.

If you have questions about Troy Medicare for Dual-eligible Beneficiaries (HMO D-SNP), 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 for Dual-eligible Beneficiaries (HMO D-SNP) Formulary
The formulary below provides coverage information about the drugs covered by Troy Medicare for Dual-eligible Beneficiaries (HMO D-SNP). If you have trouble finding your drug in the list, turn to the Index that begins on Page 132.

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 for Dual-eligible Beneficiaries (HMO D-SNP) has special requirements for coverage of your drug.

- **Prior Authorization (PA):** Troy Medicare for Dual-eligible Beneficiaries (HMO D-SNP) 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 for Dual-eligible Beneficiaries (HMO D-SNP) 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 for Dual-eligible Beneficiaries (HMO D-SNP) provides 360 per prescription for *gabapentin oral capsule 300 mg* every 30 days.

- **Step Therapy (ST):** In some cases, Troy Medicare for Dual-eligible Beneficiaries (HMO D-SNP) 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 for Dual-eligible Beneficiaries (HMO D-SNP) 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 for Dual-eligible Beneficiaries (HMO D-SNP).
- **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 tier.
Troy Medicare for Dual-eligible Beneficiaries (HMO D-SNP) 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.

How much will I pay for covered drugs?
Troy Medicare for Dual-eligible Beneficiaries (HMO D-SNP) 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 for Dual-eligible Beneficiaries (HMO D-SNP) Member Service. Our contact information appears on the front and back cover pages.

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. Members enrolled in Troy Medicare for Dual-eligible Beneficiaries (HMO D-SNP) that qualify for "Extra Help" have a $0 copayment for Medicare-covered Part D prescription drugs, because our plan participates in the Value Based Insurance Design (VBID) Model.

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.

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

Name of Drug	Drug Tier	Requirements/Limits
ec-naproxen oral tablet delayed release 375 mg, 500 mg	1	
etodolac er oral tablet extended release 24 hour 400 mg, 500 mg, 600 mg	1	
etodolac oral capsule 200 mg, 300 mg	1	
etodolac oral tablet 400 mg, 500 mg	1	
flurbiprofen oral tablet 100 mg	1	
IBU ORAL TABLET 400 MG, 600 MG, 800 MG	1	
ibuprofen oral suspension 100 mg/5 ml	1	
ibuprofen oral tablet 400 mg, 600 mg, 800 mg	1	
indomethacin er oral capsule extended release 75 mg	1	PA
indomethacin oral capsule 25 mg, 50 mg	1	PA
ketorolac tromethamine oral tablet 10 mg	1	PA; QL (20 EA per 30 days)
meclofenamate sodium oral capsule 100 mg, 50 mg	1	
meloxicam oral tablet 15 mg, 7.5 mg	1	
nabumetone oral tablet 500 mg, 750 mg	1	
naproxen oral suspension 125 mg/5 ml	1	
naproxen oral tablet 250 mg, 375 mg, 500 mg	1	
naproxen oral tablet delayed release 375 mg, 500 mg	1	
naproxen sodium oral tablet 275 mg, 550 mg	1	
piroxicam oral capsule 10 mg, 20 mg	1	
sulindac oral tablet 150 mg, 200 mg	1	
Opioid Analgesics, Long-Acting		
buprenorphine transdermal patch weekly 10 mcg/hr, 15 mcg/hr, 20 mcg/hr, 5 mcg/hr, 7.5 mcg/hr	1	QL (4 EA per 28 days)

Name of Drug	Drug Tier	Requirements/Limits
fentanyl transdermal patch 72 hour 100 mcg/hr, 12 mcg/hr, 25 mcg/hr, 37.5 mcg/hr, 50 mcg/hr, 62.5 mcg/hr, 75 mcg/hr, 87.5 mcg/hr	1	MME; QL (10 EA per 30 days)
methadone hcl oral solution 10 mg/5 ml	1	MME; QL (1200 ML per 30 days)
methadone hcl oral solution 5 mg/5 ml	1	MME; QL (2400 ML per 30 days)
methadone hcl oral tablet 10 mg	1	MME; QL (240 EA per 30 days)
methadone hcl oral tablet 5 mg	1	MME; QL (180 EA per 30 days)
morphine sulfate er oral tablet extended release 100 mg, 15 mg, 200 mg, 30 mg, 60 mg	1	MME; QL (60 EA per 30 days)
oxycodone hcl er oral tablet er 12 hour abuse-deterrent 10 mg, 20 mg, 40 mg, 80 mg	1	PA; MME
XTAMPZA ER ORAL CAPSULE ER 12 HOUR ABUSE-DETERRENT 13.5 MG, 18 MG, 27 MG, 36 MG, 9 MG	1	PA; MME
Opioid Analgesics, Short-Acting		
acetaminophen-codeine oral solution 120-12 mg/5 ml	1	MME
acetaminophen-codeine oral tablet 300-15 mg, 300-30 mg, 300-60 mg	1	MME
butorphanol tartrate nasal solution 10 mg/ml	1	MME; QL (5 ML per 30 days)
ENDOCET ORAL TABLET 10-325 MG, 2.5-325 MG, 5-325 MG, 7.5-325 MG	1	MME
fentanyl citrate buccal lozenge on a handle 1200 mcg, 1600 mcg, 200 mcg, 400 mcg, 600 mcg, 800 mcg	1	PA; MME; QL (120 EA per 30 days)
hydrocodone-acetaminophen oral tablet 10-325 mg, 5-325 mg, 7.5-325 mg	1	MME
hydrocodone-ibuprofen oral tablet 10-200 mg, 5-200 mg, 7.5-200 mg	1	MME
hydromorphone hcl oral tablet 2 mg, 4 mg, 8 mg	1	MME; QL (120 EA per 30 days)

Name of Drug	Drug Tier	Requirements/Limits
hydromorphone hcl pf injection solution 1 mg/ml, 10 mg/ml, 4 mg/ml, 50 mg/5 ml, 500 mg/50 ml	1	MME
morphine sulfate (concentrate) oral solution 100 mg/5 ml, 20 mg/ml	1	MME; QL (240 ML per 30 days)
morphine sulfate oral tablet 15 mg, 30 mg	1	MME; QL (120 EA per 30 days)
oxycodone hcl oral solution 5 mg/5 ml	1	MME; QL (5400 ML per 30 days)
oxycodone hcl oral tablet 10 mg, 15 mg, 20 mg, 30 mg, 5 mg	1	MME; QL (120 EA per 30 days)
oxycodone-acetaminophen oral tablet 10-325 mg, 2.5-325 mg, 5-325 mg, 7.5-325 mg	1	MME
pentazocine-naloxone hcl oral tablet 50-0.5 mg	1	PA; MME
tramadol hcl oral tablet 100 mg	1	MME; QL (120 EA per 30 days)
tramadol hcl oral tablet 25 mg	1	MME; QL (120 EA per 30 days)
tramadol hcl oral tablet 50 mg	1	MME; QL (240 EA per 30 days)
tramadol-acetaminophen oral tablet 37.5-325 mg	1	MME
Anesthetics - Local Treatment Of Pain		
Local Anesthetics		
lidocaine external ointment 5 %	1	
lidocaine external patch 5 %	1	PA; QL (90 EA per 30 days)
lidocaine hcl external solution 4 %	1	
lidocaine hcl urethral/mucosal external gel 2 %	1	
lidocaine hcl urethral/mucosal external prefilled syringe 2 %	1	
lidocaine viscous hcl mouth/throat solution 2 %	1	
lidocaine-prilocaine external cream 2.5-2.5 %	1	

Name of Drug	Drug Tier	Requirements/Limits
ZTLIDO EXTERNAL PATCH 1.8 %	1	PA; QL (90 EA per 30 days)
Anti-Addiction/Substance Abuse Treatment Agents - Treatment Of Substance Abuse Disorders		
Alcohol Deterrents/Anti-Craving		
acamprosate calcium oral tablet delayed release 333 mg	1	
disulfiram oral tablet 250 mg, 500 mg	1	
Opioid Dependence		
buprenorphine hcl sublingual tablet sublingual 2 mg, 8 mg	1	
buprenorphine hcl-naloxone hcl sublingual film 12-3 mg, 2-0.5 mg, 4-1 mg, 8-2 mg	1	
buprenorphine hcl-naloxone hcl sublingual tablet sublingual 2-0.5 mg, 8-2 mg	1	
LUCEMYRA ORAL TABLET 0.18 MG	1	PA; QL (224 EA per 14 days)
naltrexone hcl oral tablet 50 mg	1	
Opioid Reversal Agents		
naloxone hcl injection solution 0.4 mg/ml, 4 mg/10 ml	1	
naloxone hcl injection solution cartridge 0.4 mg/ml	1	
naloxone hcl injection solution prefilled syringe 2 mg/2 ml	1	
naloxone hcl nasal liquid 4 mg/0.1 ml	1	
Smoking Cessation Agents		
bupropion hcl er (smoking det) oral tablet extended release 12 hour 150 mg	1	
NICOTROL INHALATION INHALER 10 MG	1	
NICOTROL NS NASAL SOLUTION 10 MG/ML	1	
varenicline tartrate (starter) oral tablet therapy pack 0.5 mg x 11 & 1 mg x 42	1	QL (56 EA per 28 days)

Name of Drug	Drug Tier	Requirements/Limits
varenicline tartrate oral tablet 0.5 mg, 1 mg	1	QL (56 EA per 28 days)
varenicline tartrate(continue) oral tablet 1 mg	1	QL (56 EA per 28 days)
Antibacterials - Treatment Of Bacterial Infections		
Aminoglycosides		
amikacin sulfate injection solution 500 mg/2 ml	1	
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-%	1	
gentamicin sulfate injection solution 40 mg/ml	1	
neomycin sulfate oral tablet 500 mg	1	
paromomycin sulfate oral capsule 250 mg	1	
streptomycin sulfate intramuscular solution reconstituted 1 gm	1	
tobramycin sulfate injection solution 1.2 gm/30 ml, 10 mg/ml, 2 gm/50 ml, 80 mg/2 ml	1	
tobramycin sulfate injection solution reconstituted 1.2 gm	1	
Antibacterials, Other		
aztreonam injection solution reconstituted 1 gm, 2 gm	1	
clindamycin hcl oral capsule 150 mg, 300 mg, 75 mg	1	
clindamycin palmitate hcl oral solution reconstituted 75 mg/5 ml	1	
clindamycin phosphate in d5w intravenous solution 300 mg/50 ml, 600 mg/50 ml, 900 mg/50 ml	1	

Name of Drug	Drug Tier	Requirements/Limits
clindamycin phosphate in nacl intravenous solution 300-0.9 mg/50 ml-%, 600-0.9 mg/50 ml-%, 900-0.9 mg/50 ml-%	1	
clindamycin phosphate injection solution 300 mg/2 ml, 600 mg/4 ml, 900 mg/6 ml	1	
clindamycin phosphate vaginal cream 2 %	1	
colistimethate sodium (cba) injection solution reconstituted 150 mg	1	
daptomycin intravenous solution reconstituted 350 mg, 500 mg	1	
linezolid in sodium chloride intravenous solution 600-0.9 mg/300 ml-%	1	
linezolid intravenous solution 600 mg/300 ml	1	
linezolid oral suspension reconstituted 100 mg/5 ml	1	
linezolid oral tablet 600 mg	1	
methenamine hippurate oral tablet 1 gm	1	
metronidazole intravenous solution 500 mg/100 ml	1	
metronidazole oral capsule 375 mg	1	
metronidazole oral tablet 250 mg, 500 mg	1	
metronidazole vaginal gel 0.75 %	1	
nitrofurantoin macrocrystal oral capsule 100 mg, 25 mg, 50 mg	1	
nitrofurantoin monohyd macro oral capsule 100 mg	1	
polymyxin b sulfate injection solution reconstituted 500000 unit	1	
tinidazole oral tablet 250 mg, 500 mg	1	
trimethoprim oral tablet 100 mg	1	

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
vancomycin hcl intravenous solution reconstituted 1 gm, 10 gm, 100 gm, 5 gm, 500 mg, 750 mg	1	
vancomycin hcl oral capsule 125 mg, 250 mg	1	
Beta-Lactam, Cephalosporins		
cefaclor er oral tablet extended release 12 hour 500 mg	1	
cefaclor oral capsule 250 mg, 500 mg	1	
cefadroxil oral capsule 500 mg	1	
cefadroxil oral suspension reconstituted 250 mg/5 ml, 500 mg/5 ml	1	
cefadroxil oral tablet 1 gm	1	
cefazolin sodium injection solution reconstituted 1 gm, 2 gm, 500 mg	1	
cefazolin sodium intravenous solution reconstituted 1 gm, 2 gm, 3 gm	1	
cefazolin sodium-dextrose intravenous solution 1-4 gm/50 ml-%	1	
cefazolin sodium-dextrose intravenous solution reconstituted 1-4 gm-% (50 ml)	1	
cefdinir oral capsule 300 mg	1	
cefdinir oral suspension reconstituted 125 mg/5 ml, 250 mg/5 ml	1	
cefepime hcl injection solution reconstituted 1 gm	1	
cefepime hcl intravenous solution 1 gm/50 ml, 2 gm/100 ml	1	
cefepime hcl intravenous solution reconstituted 2 gm	1	
cefepime-dextrose intravenous solution reconstituted 1-5 gm-% (50 ml), 2-5 gm-% (50 ml)	1	
cefixime oral capsule 400 mg	1	
cefotaxime sodium injection solution reconstituted 1 gm	1	

Name of Drug	Drug Tier	Requirements/Limits
cefoxitin sodium intravenous solution reconstituted 1 gm, 10 gm, 2 gm	1	
cefoxitin sodium-dextrose intravenous solution reconstituted 1-4 gm-% (50 ml), 2-2.2 gm-% (50 ml)	1	
cefpodoxime proxetil oral suspension reconstituted 100 mg/5 ml, 50 mg/5 ml	1	
cefpodoxime proxetil oral tablet 100 mg, 200 mg	1	
cefprozil oral suspension reconstituted 125 mg/5 ml, 250 mg/5 ml	1	
cefprozil oral tablet 250 mg, 500 mg	1	
ceftazidime and dextrose intravenous solution reconstituted 1-5 gm-% (50 ml), 2-5 gm-% (50 ml)	1	
ceftazidime injection solution reconstituted 1 gm, 6 gm	1	
ceftazidime intravenous solution reconstituted 2 gm	1	
ceftriaxone sodium in dextrose intravenous solution 20 mg/ml, 40 mg/ml	1	
ceftriaxone sodium injection solution reconstituted 1 gm, 100 gm, 2 gm, 250 mg, 500 mg	1	
ceftriaxone sodium intravenous solution reconstituted 1 gm, 10 gm, 2 gm	1	
ceftriaxone sodium-dextrose intravenous solution reconstituted 1-3.74 gm-% (50 ml), 2-2.22 gm-% (50 ml)	1	
cefuroxime axetil oral tablet 250 mg, 500 mg	1	
cefuroxime sodium injection solution reconstituted 750 mg	1	
cefuroxime sodium intravenous solution reconstituted 1.5 gm	1	
cephalexin oral capsule 250 mg, 500 mg	1	

Name of Drug	Drug Tier	Requirements/Limits
cephalexin oral suspension reconstituted 125 mg/5 ml, 250 mg/5 ml	1	
cephalexin oral tablet 250 mg, 500 mg	1	
TEFLARO INTRAVENOUS SOLUTION RECONSTITUTED 400 MG, 600 MG	1	PA
Beta-Lactam, Penicillins		
amoxicillin oral capsule 250 mg, 500 mg	1	
amoxicillin oral suspension reconstituted 125 mg/5 ml, 200 mg/5 ml, 250 mg/5 ml, 400 mg/5 ml	1	
amoxicillin oral tablet 500 mg, 875 mg	1	
amoxicillin oral tablet chewable 125 mg, 250 mg	1	
amoxicillin-pot clavulanate er oral tablet extended release 12 hour 1000-62.5 mg	1	
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	1	
amoxicillin-pot clavulanate oral tablet 250-125 mg, 500-125 mg, 875-125 mg	1	
amoxicillin-pot clavulanate oral tablet chewable 200-28.5 mg, 400-57 mg	1	
ampicillin oral capsule 500 mg	1	
ampicillin sodium injection solution reconstituted 1 gm, 125 mg	1	
ampicillin sodium intravenous solution reconstituted 1 gm, 10 gm	1	
ampicillin-sulbactam sodium injection solution reconstituted 1.5 (1-0.5) gm, 3 (2-1) gm	1	
ampicillin-sulbactam sodium intravenous solution reconstituted 1.5 (1-0.5) gm, 15 (10-5) gm, 3 (2-1) gm	1	

Name of Drug	Drug Tier	Requirements/Limits
BICILLIN L-A INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 1200000 UNIT/2 ML, 2400000 UNIT/4 ML, 600000 UNIT/ML	1	
dicloxacillin sodium oral capsule 250 mg, 500 mg	1	
nafcillin sodium in dextrose intravenous solution 1 gm/50 ml, 2 gm/100 ml	1	
nafcillin sodium injection solution reconstituted 1 gm, 2 gm	1	
nafcillin sodium intravenous solution reconstituted 2 gm	1	
penicillin g procaine intramuscular suspension 600000 unit/ml	1	
penicillin g sodium injection solution reconstituted 5000000 unit	1	
penicillin v potassium oral solution reconstituted 125 mg/5 ml, 250 mg/5 ml	1	
penicillin v potassium oral tablet 250 mg, 500 mg	1	
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	1	
Carbapenems		
ertapenem sodium injection solution reconstituted 1 gm	1	
imipenem-cilastatin intravenous solution reconstituted 250 mg, 500 mg	1	
meropenem intravenous solution reconstituted 1 gm, 2 gm, 500 mg	1	
meropenem-sodium chloride intravenous solution reconstituted 1 gm/50 ml, 500 mg/50 ml	1	
Macrolides		

Name of Drug	Drug Tier	Requirements/Limits
azithromycin intravenous solution reconstituted 500 mg	1	
azithromycin oral packet 1 gm	1	
azithromycin oral suspension reconstituted 100 mg/5 ml, 200 mg/5 ml	1	
azithromycin oral tablet 250 mg, 250 mg (6 pack), 500 mg, 500 mg (3 pack), 600 mg	1	
clarithromycin er oral tablet extended release 24 hour 500 mg	1	
clarithromycin oral suspension reconstituted 125 mg/5 ml, 250 mg/5 ml	1	
clarithromycin oral tablet 250 mg, 500 mg	1	
DIFICID ORAL SUSPENSION RECONSTITUTED 40 MG/ML	1	PA
DIFICID ORAL TABLET 200 MG	1	PA
ERYTHROCIN LACTOBIONATE INTRAVENOUS SOLUTION RECONSTITUTED 500 MG	1	
ERYTHROCIN STEARATE ORAL TABLET 250 MG	1	
erythromycin base oral tablet 250 mg, 500 mg	1	
erythromycin ethylsuccinate oral suspension reconstituted 200 mg/5 ml	1	
erythromycin ethylsuccinate oral tablet 400 mg	1	
Quinolones		
ciprofloxacin hcl oral tablet 250 mg, 500 mg, 750 mg	1	
ciprofloxacin in d5w intravenous solution 200 mg/100 ml	1	
levofloxacin in d5w intravenous solution 500 mg/100 ml, 750 mg/150 ml	1	
levofloxacin intravenous solution 25 mg/ml	1	
levofloxacin oral solution 25 mg/ml	1	

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
levofloxacin oral tablet 250 mg, 500 mg, 750 mg	1	
moxifloxacin hcl in nacl intravenous solution 400 mg/250 ml	1	
moxifloxacin hcl intravenous solution 400 mg/250 ml	1	
moxifloxacin hcl oral tablet 400 mg	1	
ofloxacin oral tablet 300 mg, 400 mg	1	
Sulfonamides		
sulfacetamide sodium (acne) external lotion 10 %	1	
sulfadiazine oral tablet 500 mg	1	
sulfamethoxazole-trimethoprim oral suspension 200-40 mg/5 ml	1	
sulfamethoxazole-trimethoprim oral tablet 400-80 mg, 800-160 mg	1	
Tetracyclines		
DOXY 100 INTRAVENOUS SOLUTION RECONSTITUTED 100 MG	1	
doxycycline hyclate intravenous solution reconstituted 100 mg	1	
doxycycline hyclate oral capsule 100 mg, 50 mg	1	
doxycycline hyclate oral tablet 100 mg, 20 mg	1	
doxycycline monohydrate oral capsule 100 mg, 50 mg	1	
doxycycline monohydrate oral tablet 100 mg, 150 mg, 50 mg, 75 mg	1	
minocycline hcl oral capsule 100 mg, 50 mg, 75 mg	1	
minocycline hcl oral tablet 100 mg, 50 mg, 75 mg	1	
tetracycline hcl oral capsule 250 mg, 500 mg	1	

Name of Drug	Drug Tier	Requirements/Limits
Anticonvulsants - Treatment Of Seizures		
Anticonvulsants, Other		
BRIVIACT ORAL SOLUTION 10 MG/ML	1	
BRIVIACT ORAL TABLET 10 MG, 100 MG, 25 MG, 50 MG, 75 MG	1	
DIACOMIT ORAL CAPSULE 250 MG, 500 MG	1	PA
DIACOMIT ORAL PACKET 250 MG, 500 MG	1	PA
divalproex sodium er oral tablet extended release 24 hour 250 mg, 500 mg	1	
divalproex sodium oral capsule delayed release sprinkle 125 mg	1	
divalproex sodium oral tablet delayed release 125 mg, 250 mg, 500 mg	1	
EPIDIOLEX ORAL SOLUTION 100 MG/ML	1	PA
EPRONTIA ORAL SOLUTION 25 MG/ML	1	PA
felbamate oral suspension 600 mg/5 ml	1	
felbamate oral tablet 400 mg, 600 mg	1	
FINTEPLA ORAL SOLUTION 2.2 MG/ML	1	PA
FYCOMPA ORAL SUSPENSION 0.5 MG/ML	1	ST; QL (720 ML per 30 days)
FYCOMPA ORAL TABLET 10 MG, 12 MG, 2 MG, 4 MG, 6 MG, 8 MG	1	ST; QL (30 EA per 30 days)
lamotrigine er oral tablet extended release 24 hour 100 mg, 200 mg, 25 mg, 250 mg, 300 mg, 50 mg	1	
lamotrigine oral tablet 100 mg, 150 mg, 200 mg, 25 mg	1	
lamotrigine oral tablet chewable 25 mg, 5 mg	1	
lamotrigine starter kit-blue oral kit 35 x 25 mg	1	
lamotrigine starter kit-green oral kit 84 x 25 mg & 14x100 mg	1	

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
lamotrigine starter kit-orange oral kit 42 x 25 mg & 7 x 100 mg	1	
levetiracetam er oral tablet extended release 24 hour 500 mg, 750 mg	1	
levetiracetam oral solution 100 mg/ml	1	
levetiracetam oral tablet 1000 mg, 250 mg, 500 mg, 750 mg	1	
ROWEEPRA ORAL TABLET 500 MG	1	
SPRITAM ORAL TABLET DISINTEGRATING SOLUBLE 1000 MG, 250 MG, 500 MG	1	ST; QL (60 EA per 30 days)
SPRITAM ORAL TABLET DISINTEGRATING SOLUBLE 750 MG	1	ST; QL (120 EA per 30 days)
topiramate oral capsule sprinkle 15 mg, 25 mg	1	
topiramate oral tablet 100 mg, 200 mg, 25 mg, 50 mg	1	
valproic acid oral capsule 250 mg	1	
valproic acid oral solution 250 mg/5 ml	1	
XCOPRI (250 MG DAILY DOSE) ORAL TABLET THERAPY PACK 100 & 150 MG	1	ST
XCOPRI (350 MG DAILY DOSE) ORAL TABLET THERAPY PACK 150 & 200 MG	1	ST
XCOPRI ORAL TABLET 100 MG, 150 MG, 200 MG, 50 MG	1	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	1	ST
Calcium Channel Modifying Agents		
ethosuximide oral capsule 250 mg	1	
ethosuximide oral solution 250 mg/5 ml	1	
methsuximide oral capsule 300 mg	1	
Gamma-Aminobutyric Acid (Gaba) Augmenting Agents		
clobazam oral suspension 2.5 mg/ml	1	QL (480 ML per 30 days)
clobazam oral tablet 10 mg, 20 mg	1	QL (60 EA per 30 days)

Name of Drug	Drug Tier	Requirements/Limits
diazepam rectal gel 10 mg, 2.5 mg, 20 mg	1	
gabapentin oral capsule 100 mg, 400 mg	1	QL (270 EA per 30 days)
gabapentin oral capsule 300 mg	1	QL (360 EA per 30 days)
gabapentin oral solution 250 mg/5 ml, 300 mg/6 ml	1	QL (2160 ML per 30 days)
gabapentin oral tablet 600 mg	1	QL (180 EA per 30 days)
gabapentin oral tablet 800 mg	1	QL (120 EA per 30 days)
NAYZILAM NASAL SOLUTION 5 MG/0.1 ML	1	PA; QL (10 EA per 30 days)
phenobarbital oral elixir 20 mg/5 ml	1	PA
phenobarbital oral tablet 100 mg, 15 mg, 16.2 mg, 30 mg, 32.4 mg, 60 mg, 64.8 mg, 97.2 mg	1	PA
pregabalin oral capsule 100 mg, 150 mg, 200 mg, 25 mg, 50 mg, 75 mg	1	QL (90 EA per 30 days)
pregabalin oral capsule 225 mg, 300 mg	1	QL (60 EA per 30 days)
pregabalin oral solution 20 mg/ml	1	QL (900 ML per 30 days)
primidone oral tablet 250 mg, 50 mg	1	
SYMPAZAN ORAL FILM 10 MG, 20 MG, 5 MG	1	ST; QL (60 EA per 30 days)
tiagabine hcl oral tablet 12 mg, 16 mg, 2 mg, 4 mg	1	
VALTOCO 10 MG DOSE NASAL LIQUID 10 MG/0.1 ML	1	PA; QL (10 EA per 30 days)
VALTOCO 15 MG DOSE NASAL LIQUID THERAPY PACK 7.5 MG/0.1 ML	1	PA; QL (10 EA per 30 days)
VALTOCO 20 MG DOSE NASAL LIQUID THERAPY PACK 10 MG/0.1 ML	1	PA; QL (10 EA per 30 days)
VALTOCO 5 MG DOSE NASAL LIQUID 5 MG/0.1 ML	1	PA; QL (10 EA per 30 days)
vigabatrin oral packet 500 mg	1	PA; QL (180 EA per 30 days)
vigabatrin oral tablet 500 mg	1	PA; QL (180 EA per 30 days)
ZTALMY ORAL SUSPENSION 50 MG/ML	1	PA

Name of Drug	Drug Tier	Requirements/Limits
Sodium Channel Agents		
APTIOM ORAL TABLET 200 MG, 400 MG	1	QL (30 EA per 30 days)
APTIOM ORAL TABLET 600 MG, 800 MG	1	QL (60 EA per 30 days)
carbamazepine er oral capsule extended release 12 hour 100 mg, 200 mg, 300 mg	1	
carbamazepine er oral tablet extended release 12 hour 100 mg, 200 mg, 400 mg	1	
carbamazepine oral suspension 100 mg/5 ml	1	
carbamazepine oral tablet 200 mg	1	
carbamazepine oral tablet chewable 100 mg	1	
DILANTIN ORAL CAPSULE 100 MG, 30 MG	1	
EPITOL ORAL TABLET 200 MG	1	
lacosamide oral solution 10 mg/ml	1	QL (1200 ML per 30 days)
lacosamide oral tablet 100 mg, 150 mg, 200 mg, 50 mg	1	QL (60 EA per 30 days)
oxcarbazepine oral suspension 300 mg/5 ml	1	
oxcarbazepine oral tablet 150 mg, 300 mg, 600 mg	1	
PHENYTOIN INFATABS ORAL TABLET CHEWABLE 50 MG	1	
phenytoin oral suspension 100 mg/4 ml, 125 mg/5 ml	1	
phenytoin oral tablet chewable 50 mg	1	
phenytoin sodium extended oral capsule 100 mg, 200 mg, 300 mg	1	
rufinamide oral suspension 40 mg/ml	1	PA; QL (2400 ML per 30 days)
rufinamide oral tablet 200 mg, 400 mg	1	PA; QL (240 EA per 30 days)
ZONISADE ORAL SUSPENSION 100 MG/5 ML	1	ST

Name of Drug	Drug Tier	Requirements/Limits
zonisamide oral capsule 100 mg, 25 mg, 50 mg	1	
Antidementia Agents - Management Of Dementia		
Cholinesterase Inhibitors		
donepezil hcl oral tablet 10 mg, 23 mg, 5 mg	1	
donepezil hcl oral tablet dispersible 10 mg, 5 mg	1	
galantamine hydrobromide er oral capsule extended release 24 hour 16 mg, 24 mg, 8 mg	1	
galantamine hydrobromide oral tablet 12 mg, 4 mg, 8 mg	1	
rivastigmine tartrate oral capsule 1.5 mg, 3 mg, 4.5 mg, 6 mg	1	
rivastigmine transdermal patch 24 hour 13.3 mg/24 hr, 4.6 mg/24 hr, 9.5 mg/24 hr	1	ST
N-Methyl-D-Aspartate (Nmda) Receptor Antagonist		
memantine hcl er oral capsule extended release 24 hour 14 mg, 21 mg, 28 mg, 7 mg	1	QL (30 EA per 30 days)
memantine hcl oral tablet 10 mg, 28 x 5 mg & 21 x 10 mg, 5 mg	1	
Antidepressants - Treatment Of Depression		
Antidepressants, Other		
AUVELITY ORAL TABLET EXTENDED RELEASE 45-105 MG	1	PA
bupropion hcl er (sr) oral tablet extended release 12 hour 100 mg, 150 mg, 200 mg	1	
bupropion hcl er (xl) oral tablet extended release 24 hour 150 mg, 300 mg, 450 mg	1	
bupropion hcl oral tablet 100 mg, 75 mg	1	
mirtazapine oral tablet 15 mg, 30 mg, 45 mg, 7.5 mg	1	

Name of Drug	Drug Tier	Requirements/Limits
mirtazapine oral tablet dispersible 15 mg, 30 mg, 45 mg	1	
perphenazine-amitriptyline oral tablet 2-10 mg, 2-25 mg, 4-10 mg, 4-25 mg, 4-50 mg	1	PA
ZURZUVAE ORAL CAPSULE 20 MG, 25 MG, 30 MG	1	PA
Monoamine Oxidase Inhibitors		
EMSAM TRANSDERMAL PATCH 24 HOUR 12 MG/24 HR, 6 MG/24 HR, 9 MG/24 HR	1	PA
MARPLAN ORAL TABLET 10 MG	1	
phenelzine sulfate oral tablet 15 mg	1	
tranylcypromine sulfate oral tablet 10 mg	1	
SSRI/SNRI (Selective Serotonin Reuptake Inhibitor/Serotonin And Norepinephrine Reuptake Inhibitor)		
citalopram hydrobromide oral solution 10 mg/5 ml	1	
citalopram hydrobromide oral tablet 10 mg, 20 mg, 40 mg	1	
desvenlafaxine succinate er oral tablet extended release 24 hour 100 mg, 25 mg, 50 mg	1	
escitalopram oxalate oral solution 5 mg/5 ml	1	
escitalopram oxalate oral tablet 10 mg, 20 mg, 5 mg	1	
FETZIMA ORAL CAPSULE EXTENDED RELEASE 24 HOUR 120 MG, 20 MG, 40 MG, 80 MG	1	ST
FETZIMA TITRATION ORAL CAPSULE ER 24 HOUR THERAPY PACK 20 & 40 MG	1	ST
fluoxetine hcl oral capsule 10 mg, 20 mg, 40 mg	1	
fluoxetine hcl oral capsule delayed release 90 mg	1	
fluoxetine hcl oral solution 20 mg/5 ml	1	

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

Name of Drug	Drug Tier	Requirements/Limits
doxepin hcl oral capsule 10 mg, 100 mg, 150 mg, 25 mg, 50 mg, 75 mg	1	PA
doxepin hcl oral concentrate 10 mg/ml	1	PA
imipramine hcl oral tablet 10 mg, 25 mg, 50 mg	1	PA
imipramine pamoate oral capsule 100 mg, 125 mg, 150 mg, 75 mg	1	PA
nortriptyline hcl oral capsule 10 mg, 25 mg, 50 mg, 75 mg	1	
nortriptyline hcl oral solution 10 mg/5 ml	1	
protriptyline hcl oral tablet 10 mg, 5 mg	1	PA
trimipramine maleate oral capsule 100 mg, 25 mg, 50 mg	1	PA
Antiemetics - Treatment Of Vomiting Or Nausea		
Antiemetics, Other		
chlorpromazine hcl oral concentrate 100 mg/ml, 30 mg/ml	1	
chlorpromazine hcl oral tablet 10 mg, 100 mg, 200 mg, 25 mg, 50 mg	1	
meclizine hcl oral tablet 12.5 mg, 25 mg	1	
metoclopramide hcl oral solution 10 mg/10 ml, 5 mg/5 ml	1	
metoclopramide hcl oral tablet 10 mg, 5 mg	1	
perphenazine oral tablet 16 mg, 2 mg, 4 mg, 8 mg	1	
prochlorperazine maleate oral tablet 10 mg, 5 mg	1	
prochlorperazine rectal suppository 25 mg	1	
promethazine hcl oral syrup 6.25 mg/5 ml	1	PA
promethazine hcl oral tablet 12.5 mg, 25 mg, 50 mg	1	PA
promethazine hcl rectal suppository 12.5 mg, 25 mg	1	PA

Name of Drug	Drug Tier	Requirements/Limits
PROMETHEGAN RECTAL SUPPOSITORY 50 MG	1	PA
scopolamine transdermal patch 72 hour 1 mg/3 days	1	
trimethobenzamide hcl oral capsule 300 mg	1	
Emetogenic Therapy Adjuncts		
aprepitant oral 80 & 125 mg	1	B/D
aprepitant oral capsule 125 mg, 40 mg, 80 & 125 mg, 80 mg	1	B/D
dronabinol oral capsule 10 mg, 2.5 mg, 5 mg	1	B/D
EMEND ORAL SUSPENSION RECONSTITUTED 125 MG/5 ML	1	B/D
granisetron hcl oral tablet 1 mg	1	B/D
ondansetron hcl oral solution 4 mg/5 ml	1	B/D
ondansetron hcl oral tablet 24 mg, 4 mg, 8 mg	1	B/D
ondansetron oral tablet dispersible 4 mg, 8 mg	1	B/D
Antifungals - Treatment Of Fungal Or Yeast Infections		
Antifungals		
ABELCET INTRAVENOUS SUSPENSION 5 MG/ML	1	B/D
amphotericin b intravenous solution reconstituted 50 mg	1	B/D
amphotericin b liposome intravenous suspension reconstituted 50 mg	1	B/D
caspofungin acetate intravenous solution reconstituted 50 mg, 70 mg	1	PA
clotrimazole external cream 1 %	1	
clotrimazole external solution 1 %	1	
clotrimazole mouth/throat troche 10 mg	1	
econazole nitrate external cream 1 %	1	

Name of Drug	Drug Tier	Requirements/Limits
fluconazole in sodium chloride intravenous solution 200-0.9 mg/100 ml-%, 400-0.9 mg/200 ml-%	1	
fluconazole oral suspension reconstituted 10 mg/ml, 40 mg/ml	1	
fluconazole oral tablet 100 mg, 150 mg, 200 mg, 50 mg	1	
flucytosine oral capsule 250 mg, 500 mg	1	PA
griseofulvin microsize oral suspension 125 mg/5 ml	1	
itraconazole oral capsule 100 mg	1	
itraconazole oral solution 10 mg/ml	1	
ketoconazole external cream 2 %	1	
ketoconazole external shampoo 2 %	1	
ketoconazole oral tablet 200 mg	1	
micafungin sodium intravenous solution reconstituted 100 mg, 50 mg	1	
nystatin external cream 100000 unit/gm	1	
nystatin external ointment 100000 unit/gm	1	
nystatin external powder 100000 unit/gm	1	
nystatin mouth/throat suspension 100000 unit/ml	1	
nystatin oral tablet 500000 unit	1	
posaconazole oral suspension 40 mg/ml	1	PA
posaconazole oral tablet delayed release 100 mg	1	PA
terbinafine hcl oral tablet 250 mg	1	
terconazole vaginal cream 0.4 %, 0.8 %	1	
terconazole vaginal suppository 80 mg	1	
voriconazole intravenous solution reconstituted 200 mg	1	PA

Name of Drug	Drug Tier	Requirements/Limits
voriconazole oral suspension reconstituted 40 mg/ml	1	
voriconazole oral tablet 200 mg, 50 mg	1	
Antigout Agents - Treatment Or Prevention Of Gouty Arthritis		
Antigout Agents		
allopurinol oral tablet 100 mg, 300 mg	1	
colchicine oral capsule 0.6 mg	1	
colchicine oral tablet 0.6 mg	1	
colchicine-probenecid oral tablet 0.5-500 mg	1	
febuxostat oral tablet 40 mg, 80 mg	1	
probenecid oral tablet 500 mg	1	
Antimigraine Agents - Treatment Of Migraine Headaches		
Antimigraine Agents		
NURTEC ORAL TABLET DISPERSIBLE 75 MG	1	PA; QL (18 EA per 30 days)
UBRELVY ORAL TABLET 100 MG, 50 MG	1	PA; QL (16 EA per 30 days)
ZAVZPRET NASAL SOLUTION 10 MG/ACT	1	PA; QL (8 EA per 30 days)
Ergot Alkaloids		
dihydroergotamine mesylate nasal solution 4 mg/ml	1	QL (8 ML per 30 days)
ergotamine-caffeine oral tablet 1-100 mg	1	
Prophylactic		
AIMOVIG SUBCUTANEOUS SOLUTION AUTO-INJECTOR 140 MG/ML, 70 MG/ML	1	PA
EMGALITY (300 MG DOSE) SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML	1	PA
EMGALITY SUBCUTANEOUS SOLUTION AUTO-INJECTOR 120 MG/ML	1	PA
EMGALITY SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 120 MG/ML	1	PA

Name of Drug	Drug Tier	Requirements/Limits
Serotonin (5-HT) Receptor Agonist		
rizatriptan benzoate oral tablet 10 mg, 5 mg	1	QL (12 EA per 30 days)
rizatriptan benzoate oral tablet dispersible 10 mg, 5 mg	1	QL (12 EA per 30 days)
sumatriptan nasal solution 20 mg/act, 5 mg/act	1	QL (12 EA per 30 days)
sumatriptan succinate oral tablet 100 mg, 25 mg, 50 mg	1	QL (9 EA per 30 days)
sumatriptan succinate refill subcutaneous solution cartridge 4 mg/0.5 ml, 6 mg/0.5 ml	1	QL (4 ML per 30 days)
sumatriptan succinate subcutaneous solution 6 mg/0.5 ml	1	QL (4 ML per 30 days)
sumatriptan succinate subcutaneous solution auto-injector 4 mg/0.5 ml, 6 mg/0.5 ml	1	QL (4 ML per 30 days)
Antimyasthenic Agents - Treatment Of Myasthenia		
Parasympathomimetics		
pyridostigmine bromide er oral tablet extended release 180 mg	1	
pyridostigmine bromide oral tablet 60 mg	1	
Antimycobacterials - Treatment For Infections By Tuberculosis-Type Organisms		
Antimycobacterials, Other		
dapsone oral tablet 100 mg, 25 mg	1	
rifabutin oral capsule 150 mg	1	
Antituberculars		
ethambutol hcl oral tablet 100 mg, 400 mg	1	
isoniazid oral tablet 100 mg, 300 mg	1	
pretomanid oral tablet 200 mg	1	PA
PRIFTIN ORAL TABLET 150 MG	1	
pyrazinamide oral tablet 500 mg	1	

Name of Drug	Drug Tier	Requirements/Limits
rifampin intravenous solution reconstituted 600 mg	1	
rifampin oral capsule 150 mg, 300 mg	1	
SIRTURO ORAL TABLET 100 MG, 20 MG	1	PA
TRECATOR ORAL TABLET 250 MG	1	
Antineoplastics - Treatment Of Cancer		
Alkylating Agents		
cyclophosphamide oral capsule 25 mg, 50 mg	1	B/D
cyclophosphamide oral tablet 25 mg, 50 mg	1	B/D
GLEOSTINE ORAL CAPSULE 10 MG, 100 MG, 40 MG	1	
LEUKERAN ORAL TABLET 2 MG	1	
MATULANE ORAL CAPSULE 50 MG	1	
VALCHLOR EXTERNAL GEL 0.016 %	1	PA
Antiandrogens		
abiraterone acetate oral tablet 250 mg, 500 mg	1	PA
bicalutamide oral tablet 50 mg	1	
ERLEADA ORAL TABLET 240 MG, 60 MG	1	PA
nilutamide oral tablet 150 mg	1	PA
NUBEQA ORAL TABLET 300 MG	1	PA
XTANDI ORAL CAPSULE 40 MG	1	PA
XTANDI ORAL TABLET 40 MG, 80 MG	1	PA
YONSA ORAL TABLET 125 MG	1	PA
Antiangiogenic Agents		
lenalidomide oral capsule 10 mg, 15 mg, 2.5 mg, 20 mg, 25 mg, 5 mg	1	PA
POMALYST ORAL CAPSULE 1 MG, 2 MG, 3 MG, 4 MG	1	PA
REVLIMID ORAL CAPSULE 10 MG, 15 MG, 2.5 MG, 20 MG, 25 MG, 5 MG	1	PA
THALOMID ORAL CAPSULE 100 MG, 150 MG, 200 MG, 50 MG	1	PA

Name of Drug	Drug Tier	Requirements/Limits
Antiestrogens/Modifiers		
EMCYT ORAL CAPSULE 140 MG	1	
SOLTAMOX ORAL SOLUTION 10 MG/5 ML	1	PA
tamoxifen citrate oral tablet 10 mg, 20 mg	1	
toremifene citrate oral tablet 60 mg	1	PA
Antimetabolites		
DROXIA ORAL CAPSULE 200 MG, 300 MG, 400 MG	1	
hydroxyurea oral capsule 500 mg	1	
INQOVI ORAL TABLET 35-100 MG	1	PA
mercaptopurine oral tablet 50 mg	1	
ONUREG ORAL TABLET 200 MG, 300 MG	1	PA
PURIXAN ORAL SUSPENSION 2000 MG/100 ML	1	PA
TABLOID ORAL TABLET 40 MG	1	PA
Antineoplastics, Other		
AKEEGA ORAL TABLET 100-500 MG, 50-500 MG	1	PA
BESREMI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 500 MCG/ML	1	PA
IDHIFA ORAL TABLET 100 MG, 50 MG	1	PA
KISQALI FEMARA (200 MG DOSE) ORAL TABLET THERAPY PACK 200 & 2.5 MG	1	PA
KISQALI FEMARA (400 MG DOSE) ORAL TABLET THERAPY PACK 200 & 2.5 MG	1	PA
KISQALI FEMARA (600 MG DOSE) ORAL TABLET THERAPY PACK 200 & 2.5 MG	1	PA
KRAZATI ORAL TABLET 200 MG	1	PA
LONSURF ORAL TABLET 15-6.14 MG, 20-8.19 MG	1	PA
LUMAKRAS ORAL TABLET 120 MG, 320 MG	1	PA
LYSODREN ORAL TABLET 500 MG	1	

Name of Drug	Drug Tier	Requirements/Limits
NINLARO ORAL CAPSULE 2.3 MG, 3 MG, 4 MG	1	PA
OJJAARA ORAL TABLET 100 MG, 150 MG, 200 MG	1	PA
ORSERDU ORAL TABLET 345 MG, 86 MG	1	PA
REZLIDHIA ORAL CAPSULE 150 MG	1	PA
RYLAZE INTRAMUSCULAR SOLUTION 10 MG/0.5 ML	1	PA
TIBSOVO ORAL TABLET 250 MG	1	PA
TICE BCG INTRAVESICAL SUSPENSION RECONSTITUTED 50 MG	1	
WELIREG ORAL TABLET 40 MG	1	PA
XATMEP ORAL SOLUTION 2.5 MG/ML	1	PA
XPOVIO (100 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 50 MG	1	PA
XPOVIO (40 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 40 MG	1	PA
XPOVIO (40 MG TWICE WEEKLY) ORAL TABLET THERAPY PACK 40 MG	1	PA
XPOVIO (60 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 60 MG	1	PA
XPOVIO (60 MG TWICE WEEKLY) ORAL TABLET THERAPY PACK 20 MG	1	PA
XPOVIO (80 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 40 MG	1	PA
XPOVIO (80 MG TWICE WEEKLY) ORAL TABLET THERAPY PACK 20 MG	1	PA
ZOLINZA ORAL CAPSULE 100 MG	1	PA
Aromatase Inhibitors, 3rd Generation		
anastrozole oral tablet 1 mg	1	
exemestane oral tablet 25 mg	1	
letrozole oral tablet 2.5 mg	1	
Molecular Target Inhibitors		
ALECENSA ORAL CAPSULE 150 MG	1	PA

Name of Drug	Drug Tier	Requirements/Limits
ALUNBRIG ORAL TABLET 180 MG, 30 MG, 90 MG	1	PA
ALUNBRIG ORAL TABLET THERAPY PACK 90 & 180 MG	1	PA
AUGTYRO ORAL CAPSULE 40 MG	1	PA
AYVAKIT ORAL TABLET 100 MG, 200 MG, 25 MG, 300 MG, 50 MG	1	PA
BALVERSA ORAL TABLET 3 MG, 4 MG, 5 MG	1	PA
BOSULIF ORAL CAPSULE 100 MG, 50 MG	1	PA
BOSULIF ORAL TABLET 100 MG, 400 MG, 500 MG	1	PA
BRAFTOVI ORAL CAPSULE 75 MG	1	PA
BRUKINSA ORAL CAPSULE 80 MG	1	PA
CABOMETYX ORAL TABLET 20 MG, 40 MG, 60 MG	1	PA
CALQUENCE ORAL CAPSULE 100 MG	1	PA
CALQUENCE ORAL TABLET 100 MG	1	PA
CAPRELSA ORAL TABLET 100 MG, 300 MG	1	PA
COMETRIQ (100 MG DAILY DOSE) ORAL KIT 80 & 20 MG	1	PA
COMETRIQ (140 MG DAILY DOSE) ORAL KIT 3 X 20 MG & 80 MG	1	PA
COMETRIQ (60 MG DAILY DOSE) ORAL KIT 20 MG	1	PA
COPIKTRA ORAL CAPSULE 15 MG, 25 MG	1	PA
COTELLIC ORAL TABLET 20 MG	1	PA
DAURISMO ORAL TABLET 100 MG, 25 MG	1	PA
ERIVEDGE ORAL CAPSULE 150 MG	1	PA
erlotinib hcl oral tablet 100 mg, 150 mg, 25 mg	1	PA
everolimus oral tablet 10 mg, 2.5 mg, 5 mg, 7.5 mg	1	PA

Name of Drug	Drug Tier	Requirements/Limits
everolimus oral tablet soluble 2 mg, 3 mg, 5 mg	1	PA
EXKIVITY ORAL CAPSULE 40 MG	1	PA
FOTIVDA ORAL CAPSULE 0.89 MG, 1.34 MG	1	PA
FRUZAQLA ORAL CAPSULE 1 MG, 5 MG	1	PA
GAVRETO ORAL CAPSULE 100 MG	1	PA
gefitinib oral tablet 250 mg	1	PA
GILOTRIF ORAL TABLET 20 MG, 30 MG, 40 MG	1	PA
IBRANCE ORAL CAPSULE 100 MG, 125 MG, 75 MG	1	PA
IBRANCE ORAL TABLET 100 MG, 125 MG, 75 MG	1	PA
ICLUSIG ORAL TABLET 10 MG, 15 MG, 30 MG, 45 MG	1	PA
imatinib mesylate oral tablet 100 mg, 400 mg	1	PA
IMBRUVICA ORAL CAPSULE 140 MG, 70 MG	1	PA
IMBRUVICA ORAL SUSPENSION 70 MG/ML	1	PA
IMBRUVICA ORAL TABLET 140 MG, 280 MG, 420 MG, 560 MG	1	PA
INLYTA ORAL TABLET 1 MG, 5 MG	1	PA
INREBIC ORAL CAPSULE 100 MG	1	PA
JAKAFI ORAL TABLET 10 MG, 15 MG, 20 MG, 25 MG, 5 MG	1	PA
JAYPIRCA ORAL TABLET 100 MG, 50 MG	1	PA
KISQALI (200 MG DOSE) ORAL TABLET THERAPY PACK 200 MG	1	PA
KISQALI (400 MG DOSE) ORAL TABLET THERAPY PACK 200 MG	1	PA
KISQALI (600 MG DOSE) ORAL TABLET THERAPY PACK 200 MG	1	PA
KOSELUGO ORAL CAPSULE 10 MG, 25 MG	1	PA

Name of Drug	Drug Tier	Requirements/Limits
lapatinib ditosylate oral tablet 250 mg	1	PA
LENVIMA (10 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 10 MG	1	PA
LENVIMA (12 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 3 X 4 MG	1	PA
LENVIMA (14 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 10 & 4 MG	1	PA
LENVIMA (18 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 10 MG & 2 X 4 MG	1	PA
LENVIMA (20 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 2 X 10 MG	1	PA
LENVIMA (24 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 2 X 10 MG & 4 MG	1	PA
LENVIMA (4 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 4 MG	1	PA
LENVIMA (8 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 2 X 4 MG	1	PA
LORBRENA ORAL TABLET 100 MG, 25 MG	1	PA
LYNPARZA ORAL TABLET 100 MG, 150 MG	1	PA
LYTGOBI (12 MG DAILY DOSE) ORAL TABLET THERAPY PACK 4 MG	1	PA
LYTGOBI (16 MG DAILY DOSE) ORAL TABLET THERAPY PACK 4 MG	1	PA
LYTGOBI (20 MG DAILY DOSE) ORAL TABLET THERAPY PACK 4 MG	1	PA
MEKINIST ORAL SOLUTION RECONSTITUTED 0.05 MG/ML	1	PA
MEKINIST ORAL TABLET 0.5 MG, 2 MG	1	PA
MEKTOVI ORAL TABLET 15 MG	1	PA
NERLYNX ORAL TABLET 40 MG	1	PA
ODOMZO ORAL CAPSULE 200 MG	1	PA
OGSIVEO ORAL TABLET 50 MG	1	PA
pazopanib hcl oral tablet 200 mg	1	PA

Name of Drug	Drug Tier	Requirements/Limits
PEMAZYRE ORAL TABLET 13.5 MG, 4.5 MG, 9 MG	1	PA
PIQRAY (200 MG DAILY DOSE) ORAL TABLET THERAPY PACK 200 MG	1	PA
PIQRAY (250 MG DAILY DOSE) ORAL TABLET THERAPY PACK 200 & 50 MG	1	PA
PIQRAY (300 MG DAILY DOSE) ORAL TABLET THERAPY PACK 2 X 150 MG	1	PA
QINLOCK ORAL TABLET 50 MG	1	PA
RETEVMO ORAL CAPSULE 40 MG, 80 MG	1	PA
ROZLYTREK ORAL CAPSULE 100 MG, 200 MG	1	PA
ROZLYTREK ORAL PACKET 50 MG	1	PA
RUBRACA ORAL TABLET 200 MG, 250 MG, 300 MG	1	PA
RYDAPT ORAL CAPSULE 25 MG	1	PA
SCEMBLIX ORAL TABLET 20 MG, 40 MG	1	PA
sorafenib tosylate oral tablet 200 mg	1	PA
SPRYCEL ORAL TABLET 100 MG, 140 MG, 20 MG, 50 MG, 70 MG, 80 MG	1	PA
STIVARGA ORAL TABLET 40 MG	1	PA
sunitinib malate oral capsule 12.5 mg, 25 mg, 37.5 mg, 50 mg	1	PA
TABRECTA ORAL TABLET 150 MG, 200 MG	1	PA
TAFINLAR ORAL CAPSULE 50 MG, 75 MG	1	PA
TAFINLAR ORAL TABLET SOLUBLE 10 MG	1	PA
TAGRISSO ORAL TABLET 40 MG, 80 MG	1	PA
TALZENNA ORAL CAPSULE 0.1 MG, 0.25 MG, 0.35 MG, 0.5 MG, 0.75 MG, 1 MG	1	PA
TASIGNA ORAL CAPSULE 150 MG, 200 MG, 50 MG	1	PA
TAZVERIK ORAL TABLET 200 MG	1	PA
TEPMETKO ORAL TABLET 225 MG	1	PA

Name of Drug	Drug Tier	Requirements/Limits
TRUQAP ORAL TABLET 160 MG, 200 MG	1	PA
TRUSELTIQ (100MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 100 MG	1	PA
TRUSELTIQ (125MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 100 & 25 MG	1	PA
TRUSELTIQ (50MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 25 MG	1	PA
TRUSELTIQ (75MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 25 MG	1	PA
TUKYSA ORAL TABLET 150 MG, 50 MG	1	PA
TURALIO ORAL CAPSULE 125 MG, 200 MG	1	PA
VANFLYTA ORAL TABLET 17.7 MG, 26.5 MG	1	PA
VENCLEXTA ORAL TABLET 10 MG, 100 MG, 50 MG	1	PA
VENCLEXTA STARTING PACK ORAL TABLET THERAPY PACK 10 & 50 & 100 MG	1	PA
VERZENIO ORAL TABLET 100 MG, 150 MG, 200 MG, 50 MG	1	PA
VIJOICE ORAL TABLET THERAPY PACK 125 MG, 200 & 50 MG, 50 MG	1	PA
VITRAKVI ORAL CAPSULE 100 MG, 25 MG	1	PA
VITRAKVI ORAL SOLUTION 20 MG/ML	1	PA
VIZIMPRO ORAL TABLET 15 MG, 30 MG, 45 MG	1	PA
VONJO ORAL CAPSULE 100 MG	1	PA
XALKORI ORAL CAPSULE 200 MG, 250 MG	1	PA
XALKORI ORAL CAPSULE SPRINKLE 150 MG, 20 MG, 50 MG	1	PA
XOSPATA ORAL TABLET 40 MG	1	PA
ZEJULA ORAL CAPSULE 100 MG	1	PA
ZEJULA ORAL TABLET 100 MG, 200 MG, 300 MG	1	PA

Name of Drug	Drug Tier	Requirements/Limits
ZELBORAF ORAL TABLET 240 MG	1	PA
ZYDELIG ORAL TABLET 100 MG, 150 MG	1	PA
ZYKADIA ORAL TABLET 150 MG	1	PA
Retinoids		
bexarotene external gel 1 %	1	PA
bexarotene oral capsule 75 mg	1	PA
PANRETIN EXTERNAL GEL 0.1 %	1	PA
tretinoin oral capsule 10 mg	1	PA
Treatment Adjuncts		
leucovorin calcium oral tablet 10 mg, 15 mg, 25 mg, 5 mg	1	
MESNEX ORAL TABLET 400 MG	1	
Antiparasitics - Treatment Of Infections From Parasites		
Anthelmintics		
albendazole oral tablet 200 mg	1	
ivermectin oral tablet 3 mg	1	
praziquantel oral tablet 600 mg	1	
Antiprotozoals		
atovaquone oral suspension 750 mg/5 ml	1	
atovaquone-proguanil hcl oral tablet 250-100 mg, 62.5-25 mg	1	
chloroquine phosphate oral tablet 250 mg, 500 mg	1	
COARTEM ORAL TABLET 20-120 MG	1	
hydroxychloroquine sulfate oral tablet 100 mg, 200 mg, 300 mg, 400 mg	1	
mefloquine hcl oral tablet 250 mg	1	
nitazoxanide oral tablet 500 mg	1	
pentamidine isethionate inhalation solution reconstituted 300 mg	1	B/D
pentamidine isethionate injection solution reconstituted 300 mg	1	PA
primaquine phosphate oral tablet 26.3 (15 base) mg	1	

Name of Drug	Drug Tier	Requirements/Limits
pyrimethamine oral tablet 25 mg	1	QL (90 EA per 30 days)
quinine sulfate oral capsule 324 mg	1	
Antiparkinson Agents - Treatment Of Parkinson's Disease		
Anticholinergics		
benztropine mesylate oral tablet 0.5 mg, 1 mg, 2 mg	1	
trihexyphenidyl hcl oral solution 0.4 mg/ml	1	PA
trihexyphenidyl hcl oral tablet 2 mg, 5 mg	1	PA
Antiparkinson Agents, Other		
amantadine hcl oral capsule 100 mg	1	
amantadine hcl oral solution 50 mg/5 ml	1	
amantadine hcl oral tablet 100 mg	1	
carbidopa-levodopa-entacapone oral tablet 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	1	
entacapone oral tablet 200 mg	1	
GOCOVRI ORAL CAPSULE EXTENDED RELEASE 24 HOUR 137 MG, 68.5 MG	1	PA
ONGENTYS ORAL CAPSULE 25 MG, 50 MG	1	ST
Dopamine Agonists		
apomorphine hcl subcutaneous solution cartridge 30 mg/3 ml	1	PA
bromocriptine mesylate oral capsule 5 mg	1	
bromocriptine mesylate oral tablet 2.5 mg	1	
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	1	

Name of Drug	Drug Tier	Requirements/Limits
pramipexole dihydrochloride er oral tablet extended release 24 hour 0.375 mg, 0.75 mg, 1.5 mg, 2.25 mg, 3 mg, 3.75 mg, 4.5 mg	1	
pramipexole dihydrochloride oral tablet 0.125 mg, 0.25 mg, 0.5 mg, 0.75 mg, 1 mg, 1.5 mg	1	
ropinirole hcl er oral tablet extended release 24 hour 12 mg, 2 mg, 4 mg, 6 mg, 8 mg	1	
ropinirole hcl oral tablet 0.25 mg, 0.5 mg, 1 mg, 2 mg, 3 mg, 4 mg, 5 mg	1	
Dopamine Precursors And/Or L-Amino Acid Decarboxylase Inhibitors		
carbidopa oral tablet 25 mg	1	
carbidopa-levodopa er oral tablet extended release 25-100 mg, 50-200 mg	1	
carbidopa-levodopa oral tablet 10-100 mg, 25-100 mg, 25-250 mg	1	
carbidopa-levodopa oral tablet dispersible 10-100 mg, 25-100 mg, 25-250 mg	1	
Monoamine Oxidase B (Mao-B) Inhibitors		
rasagiline mesylate oral tablet 0.5 mg, 1 mg	1	
selegiline hcl oral capsule 5 mg	1	
selegiline hcl oral tablet 5 mg	1	
Antipsychotics - Treatment Of Behavioral And Emotional Disorders		
1st Generation/Typical		
fluphenazine decanoate injection solution 25 mg/ml	1	
fluphenazine hcl injection solution 2.5 mg/ml	1	
fluphenazine hcl oral concentrate 5 mg/ml	1	
fluphenazine hcl oral elixir 2.5 mg/5 ml	1	
fluphenazine hcl oral tablet 1 mg, 10 mg, 2.5 mg, 5 mg	1	

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

Name of Drug	Drug Tier	Requirements/Limits
ARISTADA INTRAMUSCULAR PREFILLED SYRINGE 441 MG/1.6 ML	1	PA; QL (1.6 ML per 28 days)
ARISTADA INTRAMUSCULAR PREFILLED SYRINGE 662 MG/2.4 ML	1	PA; QL (2.4 ML per 28 days)
ARISTADA INTRAMUSCULAR PREFILLED SYRINGE 882 MG/3.2 ML	1	PA; QL (3.2 ML per 28 days)
asenapine maleate sublingual tablet sublingual 10 mg, 2.5 mg, 5 mg	1	QL (60 EA per 30 days)
CAPLYTA ORAL CAPSULE 10.5 MG, 21 MG, 42 MG	1	PA
FANAPT ORAL TABLET 1 MG, 10 MG, 12 MG, 2 MG, 4 MG, 6 MG, 8 MG	1	PA; QL (60 EA per 30 days)
FANAPT TITRATION PACK ORAL TABLET 1 & 2 & 4 & 6 MG	1	PA
INVEGA SUSTENNA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 117 MG/0.75 ML	1	PA; QL (0.75 ML per 28 days)
INVEGA SUSTENNA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 156 MG/ML	1	PA; QL (1 ML per 28 days)
INVEGA SUSTENNA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 234 MG/1.5 ML	1	PA; QL (1.5 ML per 28 days)
INVEGA SUSTENNA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 39 MG/0.25 ML	1	PA; QL (0.25 ML per 28 days)
INVEGA SUSTENNA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 78 MG/0.5 ML	1	PA; QL (0.5 ML per 28 days)
INVEGA TRINZA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 273 MG/0.88 ML	1	PA; QL (0.88 ML per 84 days)
INVEGA TRINZA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 410 MG/1.32 ML	1	PA; QL (1.32 ML per 84 days)
INVEGA TRINZA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 546 MG/1.75 ML	1	PA; QL (1.75 ML per 84 days)

Name of Drug	Drug Tier	Requirements/Limits
INVEGA TRINZA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 819 MG/2.63 ML	1	PA; QL (2.63 ML per 84 days)
lurasidone hcl oral tablet 120 mg, 20 mg, 40 mg, 60 mg	1	QL (30 EA per 30 days)
lurasidone hcl oral tablet 80 mg	1	QL (60 EA per 30 days)
LYBALVI ORAL TABLET 10-10 MG, 15-10 MG, 20-10 MG, 5-10 MG	1	PA
NUPLAZID ORAL CAPSULE 34 MG	1	PA; QL (30 EA per 30 days)
NUPLAZID ORAL TABLET 10 MG	1	PA; QL (30 EA per 30 days)
olanzapine intramuscular solution reconstituted 10 mg	1	QL (90 EA per 30 days)
olanzapine oral tablet 10 mg, 15 mg, 2.5 mg, 20 mg, 5 mg, 7.5 mg	1	QL (30 EA per 30 days)
olanzapine oral tablet dispersible 10 mg, 15 mg, 20 mg, 5 mg	1	QL (30 EA per 30 days)
paliperidone er oral tablet extended release 24 hour 1.5 mg, 3 mg, 9 mg	1	PA; QL (30 EA per 30 days)
paliperidone er oral tablet extended release 24 hour 6 mg	1	PA; QL (60 EA per 30 days)
PERSERIS SUBCUTANEOUS PREFILLED SYRINGE 120 MG, 90 MG	1	PA; QL (1 EA per 28 days)
quetiapine fumarate er oral tablet extended release 24 hour 150 mg, 200 mg	1	QL (30 EA per 30 days)
quetiapine fumarate er oral tablet extended release 24 hour 300 mg, 400 mg, 50 mg	1	QL (60 EA per 30 days)
quetiapine fumarate oral tablet 100 mg, 150 mg, 200 mg, 300 mg, 400 mg	1	QL (60 EA per 30 days)
quetiapine fumarate oral tablet 25 mg, 50 mg	1	QL (90 EA per 30 days)
REXULTI ORAL TABLET 0.25 MG, 0.5 MG, 1 MG, 2 MG, 3 MG, 4 MG	1	PA; QL (30 EA per 30 days)
RISPERDAL CONSTA INTRAMUSCULAR SUSPENSION RECONSTITUTED ER 12.5 MG, 25 MG, 37.5 MG, 50 MG	1	PA; QL (2 EA per 28 days)

Name of Drug	Drug Tier	Requirements/Limits
risperidone microspheres er intramuscular suspension reconstituted er 12.5 mg, 25 mg, 37.5 mg, 50 mg	1	PA; QL (2 EA per 28 days)
risperidone oral solution 1 mg/ml	1	QL (480 ML per 30 days)
risperidone oral tablet 0.25 mg, 0.5 mg, 1 mg, 2 mg	1	QL (60 EA per 30 days)
risperidone oral tablet 3 mg, 4 mg	1	QL (120 EA per 30 days)
risperidone oral tablet dispersible 0.25 mg, 0.5 mg, 1 mg, 2 mg	1	QL (60 EA per 30 days)
risperidone oral tablet dispersible 3 mg, 4 mg	1	QL (120 EA per 30 days)
RYKINDO INTRAMUSCULAR SUSPENSION RECONSTITUTED ER 25 MG, 37.5 MG, 50 MG	1	PA
SECUADO TRANSDERMAL PATCH 24 HOUR 3.8 MG/24 HR, 5.7 MG/24 HR, 7.6 MG/24 HR	1	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	1	PA
VRAYLAR ORAL CAPSULE 1.5 MG, 3 MG, 4.5 MG, 6 MG	1	PA; QL (30 EA per 30 days)
VRAYLAR ORAL CAPSULE THERAPY PACK 1.5 & 3 MG	1	PA; QL (14 EA per 365 days)
ziprasidone hcl oral capsule 20 mg, 40 mg, 60 mg, 80 mg	1	QL (60 EA per 30 days)
ziprasidone mesylate intramuscular solution reconstituted 20 mg	1	QL (6 EA per 3 days)
ZYPREXA RELPREVV INTRAMUSCULAR SUSPENSION RECONSTITUTED 210 MG, 300 MG	1	PA; QL (2 EA per 28 days)
ZYPREXA RELPREVV INTRAMUSCULAR SUSPENSION RECONSTITUTED 405 MG	1	PA; QL (1 EA per 28 days)
Treatment-Resistant		
clozapine oral tablet 100 mg	1	QL (270 EA per 30 days)

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
clozapine oral tablet 200 mg	1	QL (120 EA per 30 days)
clozapine oral tablet 25 mg, 50 mg	1	QL (90 EA per 30 days)
clozapine oral tablet dispersible 100 mg	1	QL (270 EA per 30 days)
clozapine oral tablet dispersible 12.5 mg	1	
clozapine oral tablet dispersible 150 mg	1	QL (180 EA per 30 days)
clozapine oral tablet dispersible 200 mg	1	QL (120 EA per 30 days)
clozapine oral tablet dispersible 25 mg	1	QL (90 EA per 30 days)
VERSACLOZ ORAL SUSPENSION 50 MG/ML	1	QL (540 ML per 30 days)
Antispasticity Agents - Treatment Of Muscle Spasms		
Antispasticity Agents		
baclofen oral tablet 10 mg, 20 mg, 5 mg	1	
dantrolene sodium oral capsule 100 mg, 25 mg, 50 mg	1	
tizanidine hcl oral tablet 2 mg, 4 mg	1	
Antivirals - Treatment Of Infections By Viruses		
Anti-Cytomegalovirus (CMV) Agents		
PREVYMIS ORAL TABLET 240 MG, 480 MG	1	PA
valganciclovir hcl oral solution reconstituted 50 mg/ml	1	
valganciclovir hcl oral tablet 450 mg	1	
Anti-Hepatitis B (HBV) Agents		
adefovir dipivoxil oral tablet 10 mg	1	QL (30 EA per 30 days)
BARACLUDE ORAL SOLUTION 0.05 MG/ML	1	
entecavir oral tablet 0.5 mg, 1 mg	1	
EPIVIR HBV ORAL SOLUTION 5 MG/ML	1	
lamivudine oral solution 10 mg/ml	1	QL (960 ML per 30 days)
lamivudine oral tablet 100 mg, 300 mg	1	QL (30 EA per 30 days)
lamivudine oral tablet 150 mg	1	QL (60 EA per 30 days)
tenofovir disoproxil fumarate oral tablet 300 mg	1	QL (30 EA per 30 days)
VEMLIDY ORAL TABLET 25 MG	1	PA

Name of Drug	Drug Tier	Requirements/Limits
VIREAD ORAL POWDER 40 MG/GM	1	QL (240 GM per 30 days)
VIREAD ORAL TABLET 150 MG, 200 MG, 250 MG	1	QL (30 EA per 30 days)
Anti-Hepatitis C (HCV) Agents		
MAVYRET ORAL PACKET 50-20 MG	1	PA
MAVYRET ORAL TABLET 100-40 MG	1	PA
ribavirin oral capsule 200 mg	1	
ribavirin oral tablet 200 mg	1	
sofosbuvir-velpatasvir oral tablet 400-100 mg	1	PA
VOSEVI ORAL TABLET 400-100-100 MG	1	PA
Antiherpetic Agents		
acyclovir oral capsule 200 mg	1	
acyclovir oral suspension 200 mg/5 ml	1	
acyclovir oral tablet 400 mg, 800 mg	1	
acyclovir sodium intravenous solution 50 mg/ml	1	B/D
famciclovir oral tablet 125 mg, 250 mg, 500 mg	1	
trifluridine ophthalmic solution 1 %	1	
valacyclovir hcl oral tablet 1 gm, 500 mg	1	
Anti-HIV Agents, Integrase Inhibitors (INSTI)		
ISENTRESS HD ORAL TABLET 600 MG	1	QL (60 EA per 30 days)
ISENTRESS ORAL PACKET 100 MG	1	QL (60 EA per 30 days)
ISENTRESS ORAL TABLET 400 MG	1	QL (120 EA per 30 days)
ISENTRESS ORAL TABLET CHEWABLE 100 MG, 25 MG	1	QL (180 EA per 30 days)
TIVICAY ORAL TABLET 10 MG	1	QL (120 EA per 30 days)
TIVICAY ORAL TABLET 25 MG	1	QL (30 EA per 30 days)
TIVICAY ORAL TABLET 50 MG	1	QL (60 EA per 30 days)
TIVICAY PD ORAL TABLET SOLUBLE 5 MG	1	QL (180 EA per 30 days)
VOCABRIA ORAL TABLET 30 MG	1	QL (30 EA per 30 days)

Name of Drug	Drug Tier	Requirements/Limits
Anti-HIV Agents, Non-Nucleoside Reverse Transcriptase Inhibitors (NNRTI)		
EDURANT ORAL TABLET 25 MG	1	QL (60 EA per 30 days)
efavirenz oral capsule 200 mg	1	QL (120 EA per 30 days)
efavirenz oral capsule 50 mg	1	QL (180 EA per 30 days)
efavirenz oral tablet 600 mg	1	QL (30 EA per 30 days)
etravirine oral tablet 100 mg	1	QL (120 EA per 30 days)
etravirine oral tablet 200 mg	1	QL (60 EA per 30 days)
INTELENCE ORAL TABLET 25 MG	1	QL (120 EA per 30 days)
nevirapine er oral tablet extended release 24 hour 400 mg	1	QL (30 EA per 30 days)
nevirapine oral suspension 50 mg/5 ml	1	QL (1200 ML per 30 days)
nevirapine oral tablet 200 mg	1	QL (60 EA per 30 days)
PIFELTRO ORAL TABLET 100 MG	1	QL (30 EA per 30 days)
Anti-HIV Agents, Nucleoside And Nucleotide Reverse Transcriptase Inhibitors (NRTI)		
abacavir sulfate oral solution 20 mg/ml	1	QL (960 ML per 30 days)
abacavir sulfate oral tablet 300 mg	1	QL (60 EA per 30 days)
abacavir sulfate-lamivudine oral tablet 600-300 mg	1	QL (30 EA per 30 days)
CIMDUO ORAL TABLET 300-300 MG	1	QL (30 EA per 30 days)
DESCOVY ORAL TABLET 120-15 MG, 200-25 MG	1	QL (30 EA per 30 days)
emtricitabine oral capsule 200 mg	1	QL (30 EA per 30 days)
emtricitabine-tenofovir df oral tablet 100-150 mg, 133-200 mg, 167-250 mg, 200-300 mg	1	QL (30 EA per 30 days)
EMTRIVA ORAL SOLUTION 10 MG/ML	1	
lamivudine-zidovudine oral tablet 150-300 mg	1	QL (60 EA per 30 days)
TRIZIVIR ORAL TABLET 300-150-300 MG	1	QL (60 EA per 30 days)
zidovudine oral capsule 100 mg	1	QL (180 EA per 30 days)
zidovudine oral syrup 50 mg/5 ml	1	QL (1920 ML per 30 days)
zidovudine oral tablet 300 mg	1	QL (60 EA per 30 days)

Name of Drug	Drug Tier	Requirements/Limits
Anti-HIV Agents, Other		
BIKTARVY ORAL TABLET 30-120-15 MG, 50-200-25 MG	1	QL (30 EA per 30 days)
COMPLERA ORAL TABLET 200-25-300 MG	1	QL (30 EA per 30 days)
DELSTRIGO ORAL TABLET 100-300-300 MG	1	QL (30 EA per 30 days)
DOVATO ORAL TABLET 50-300 MG	1	QL (30 EA per 30 days)
efavirenz-emtricitab-tenofo df oral tablet 600-200-300 mg	1	QL (30 EA per 30 days)
efavirenz-lamivudine-tenofovir oral tablet 400-300-300 mg, 600-300-300 mg	1	QL (30 EA per 30 days)
EVOTAZ ORAL TABLET 300-150 MG	1	QL (30 EA per 30 days)
FUZEON SUBCUTANEOUS SOLUTION RECONSTITUTED 90 MG	1	
GENVOYA ORAL TABLET 150-150-200-10 MG	1	QL (30 EA per 30 days)
JULUCA ORAL TABLET 50-25 MG	1	QL (30 EA per 30 days)
maraviroc oral tablet 150 mg	1	QL (60 EA per 30 days)
maraviroc oral tablet 300 mg	1	QL (120 EA per 30 days)
ODEFSEY ORAL TABLET 200-25-25 MG	1	QL (30 EA per 30 days)
PREZCOBIX ORAL TABLET 800-150 MG	1	QL (30 EA per 30 days)
RUKOBIA ORAL TABLET EXTENDED RELEASE 12 HOUR 600 MG	1	QL (60 EA per 30 days)
SELZENTRY ORAL SOLUTION 20 MG/ML	1	QL (1840 ML per 30 days)
SELZENTRY ORAL TABLET 25 MG	1	QL (240 EA per 30 days)
SELZENTRY ORAL TABLET 75 MG	1	QL (120 EA per 30 days)
STRIBILD ORAL TABLET 150-150-200-300 MG	1	QL (30 EA per 30 days)
SUNLENCA ORAL TABLET THERAPY PACK 4 X 300 MG	1	QL (8 EA per 365 days)
SUNLENCA ORAL TABLET THERAPY PACK 5 X 300 MG	1	QL (10 EA per 365 days)
SUNLENCA SUBCUTANEOUS SOLUTION 463.5 MG/1.5ML	1	QL (6 ML per 365 days)

Name of Drug	Drug Tier	Requirements/Limits
SYMTUZA ORAL TABLET 800-150-200-10 MG	1	QL (30 EA per 30 days)
TRIUMEQ ORAL TABLET 600-50-300 MG	1	QL (30 EA per 30 days)
TRIUMEQ PD ORAL TABLET SOLUBLE 60-5-30 MG	1	QL (180 EA per 30 days)
TYBOST ORAL TABLET 150 MG	1	QL (30 EA per 30 days)
Anti-HIV Agents, Protease Inhibitors (PI)		
APTIVUS ORAL CAPSULE 250 MG	1	QL (120 EA per 30 days)
atazanavir sulfate oral capsule 150 mg, 300 mg	1	QL (30 EA per 30 days)
atazanavir sulfate oral capsule 200 mg	1	QL (60 EA per 30 days)
darunavir oral tablet 600 mg	1	QL (60 EA per 30 days)
darunavir oral tablet 800 mg	1	QL (30 EA per 30 days)
fosamprenavir calcium oral tablet 700 mg	1	QL (120 EA per 30 days)
LEXIVA ORAL SUSPENSION 50 MG/ML	1	
lopinavir-ritonavir oral solution 400-100 mg/5 ml	1	QL (390 ML per 30 days)
lopinavir-ritonavir oral tablet 100-25 mg	1	QL (300 EA per 30 days)
lopinavir-ritonavir oral tablet 200-50 mg	1	QL (120 EA per 30 days)
NORVIR ORAL PACKET 100 MG	1	QL (360 EA per 30 days)
PREZISTA ORAL SUSPENSION 100 MG/ML	1	QL (400 ML per 30 days)
PREZISTA ORAL TABLET 150 MG	1	QL (180 EA per 30 days)
PREZISTA ORAL TABLET 75 MG	1	QL (300 EA per 30 days)
REYATAZ ORAL PACKET 50 MG	1	
ritonavir oral tablet 100 mg	1	QL (360 EA per 30 days)
VIRACEPT ORAL TABLET 250 MG	1	QL (300 EA per 30 days)
VIRACEPT ORAL TABLET 625 MG	1	QL (120 EA per 30 days)
Anti-Influenza Agents		
oseltamivir phosphate oral capsule 30 mg	1	QL (84 EA per 180 days)
oseltamivir phosphate oral capsule 45 mg, 75 mg	1	QL (42 EA per 180 days)

Name of Drug	Drug Tier	Requirements/Limits
oseltamivir phosphate oral suspension reconstituted 6 mg/ml	1	QL (540 ML per 180 days)
RELENZA DISKHALER INHALATION AEROSOL POWDER BREATH ACTIVATED 5 MG/ACT	1	QL (60 EA per 180 days)
rimantadine hcl oral tablet 100 mg	1	
Antivirals		
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)
Anxiolytics - Treatment Of Anxiety Or Nervousness		
Anxiolytics, Other		
buspirone hcl oral tablet 10 mg, 15 mg, 30 mg, 5 mg, 7.5 mg	1	
hydroxyzine pamoate oral capsule 100 mg, 25 mg, 50 mg	1	
Benzodiazepines		
ALPRAZOLAM INTENSOL ORAL CONCENTRATE 1 MG/ML	1	QL (300 ML per 30 days)
alprazolam oral tablet 0.25 mg, 0.5 mg, 1 mg	1	QL (120 EA per 30 days)
alprazolam oral tablet 2 mg	1	QL (150 EA per 30 days)
clonazepam oral tablet 0.5 mg, 1 mg	1	QL (90 EA per 30 days)
clonazepam oral tablet 2 mg	1	QL (300 EA per 30 days)
clonazepam oral tablet dispersible 0.125 mg, 0.25 mg, 0.5 mg, 1 mg	1	QL (90 EA per 30 days)
clonazepam oral tablet dispersible 2 mg	1	QL (300 EA per 30 days)
clorazepate dipotassium oral tablet 15 mg	1	QL (180 EA per 30 days)
clorazepate dipotassium oral tablet 3.75 mg, 7.5 mg	1	QL (90 EA per 30 days)

Name of Drug	Drug Tier	Requirements/Limits
DIAZEPAM INTENSOL ORAL CONCENTRATE 5 MG/ML	1	QL (240 ML per 30 days)
diazepam oral concentrate 5 mg/ml	1	QL (240 ML per 30 days)
diazepam oral solution 5 mg/5 ml	1	QL (1200 ML per 30 days)
diazepam oral tablet 10 mg, 2 mg, 5 mg	1	QL (120 EA per 30 days)
LORAZEPAM INTENSOL ORAL CONCENTRATE 2 MG/ML	1	QL (150 ML per 30 days)
lorazepam oral concentrate 2 mg/ml	1	QL (150 ML per 30 days)
lorazepam oral tablet 0.5 mg, 1 mg	1	QL (90 EA per 30 days)
lorazepam oral tablet 2 mg	1	QL (150 EA per 30 days)
Bipolar Agents - Treatment For Bipolar Illnesses		
Mood Stabilizers		
EQUETRO ORAL CAPSULE EXTENDED RELEASE 12 HOUR 100 MG, 200 MG, 300 MG	1	
lithium carbonate er oral tablet extended release 300 mg, 450 mg	1	
lithium carbonate oral capsule 150 mg, 300 mg, 600 mg	1	
lithium carbonate oral tablet 300 mg	1	
lithium oral solution 8 meq/5 ml	1	
Blood Glucose Regulators - Control Of Diabetes		
Antidiabetic Agents		
acarbose oral tablet 100 mg, 25 mg, 50 mg	1	QL (90 EA per 30 days)
FARXIGA ORAL TABLET 10 MG, 5 MG	1	QL (30 EA per 30 days)
glimepiride oral tablet 1 mg	1	QL (240 EA per 30 days)
glimepiride oral tablet 2 mg	1	QL (120 EA per 30 days)
glimepiride oral tablet 4 mg	1	QL (60 EA per 30 days)
glipizide er oral tablet extended release 24 hour 10 mg	1	QL (60 EA per 30 days)
glipizide er oral tablet extended release 24 hour 2.5 mg	1	QL (240 EA per 30 days)
glipizide er oral tablet extended release 24 hour 5 mg	1	QL (120 EA per 30 days)

Name of Drug	Drug Tier	Requirements/Limits
glipizide oral tablet 10 mg	1	QL (120 EA per 30 days)
glipizide oral tablet 2.5 mg	1	QL (60 EA per 30 days)
glipizide oral tablet 5 mg	1	QL (240 EA per 30 days)
glipizide xl oral tablet extended release 24 hour 10 mg	1	QL (60 EA per 30 days)
glipizide xl oral tablet extended release 24 hour 2.5 mg	1	QL (240 EA per 30 days)
glipizide xl oral tablet extended release 24 hour 5 mg	1	QL (120 EA per 30 days)
glipizide-metformin hcl oral tablet 2.5-250 mg	1	QL (240 EA per 30 days)
glipizide-metformin hcl oral tablet 2.5-500 mg, 5-500 mg	1	QL (120 EA per 30 days)
glyburide micronized oral tablet 1.5 mg, 3 mg	1	PA; QL (90 EA per 30 days)
glyburide micronized oral tablet 6 mg	1	PA; QL (60 EA per 30 days)
glyburide oral tablet 1.25 mg, 2.5 mg	1	PA; QL (60 EA per 30 days)
glyburide oral tablet 5 mg	1	PA; QL (120 EA per 30 days)
glyburide-metformin oral tablet 1.25-250 mg	1	PA; QL (240 EA per 30 days)
glyburide-metformin oral tablet 2.5-500 mg, 5-500 mg	1	PA; QL (120 EA per 30 days)
GLYXAMBI ORAL TABLET 10-5 MG, 25-5 MG	1	QL (30 EA per 30 days)
JANUMET ORAL TABLET 50-1000 MG, 50-500 MG	1	QL (60 EA per 30 days)
JANUMET XR ORAL TABLET EXTENDED RELEASE 24 HOUR 100-1000 MG	1	QL (30 EA per 30 days)
JANUMET XR ORAL TABLET EXTENDED RELEASE 24 HOUR 50-1000 MG, 50-500 MG	1	QL (60 EA per 30 days)
JANUVIA ORAL TABLET 100 MG, 25 MG, 50 MG	1	QL (30 EA per 30 days)
JARDIANCE ORAL TABLET 10 MG, 25 MG	1	QL (30 EA per 30 days)
JENTADUETO ORAL TABLET 2.5-1000 MG, 2.5-500 MG, 2.5-850 MG	1	QL (60 EA per 30 days)

Name of Drug	Drug Tier	Requirements/Limits
JENTADUETO XR ORAL TABLET EXTENDED RELEASE 24 HOUR 2.5-1000 MG	1	QL (60 EA per 30 days)
JENTADUETO XR ORAL TABLET EXTENDED RELEASE 24 HOUR 5-1000 MG	1	QL (30 EA per 30 days)
metformin hcl er oral tablet extended release 24 hour 500 mg	1	QL (120 EA per 30 days)
metformin hcl er oral tablet extended release 24 hour 750 mg	1	QL (60 EA per 30 days)
metformin hcl oral tablet 1000 mg	1	QL (75 EA per 30 days)
metformin hcl oral tablet 500 mg	1	QL (150 EA per 30 days)
metformin hcl oral tablet 850 mg	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	1	ST; QL (2 ML per 28 days)
nateglinide oral tablet 120 mg, 60 mg	1	QL (90 EA per 30 days)
OZEMPIC (0.25 OR 0.5 MG/DOSE) SUBCUTANEOUS SOLUTION PEN-INJECTOR 2 MG/1.5 ML	1	ST; QL (1.5 ML per 28 days)
OZEMPIC (0.25 OR 0.5 MG/DOSE) SUBCUTANEOUS SOLUTION PEN-INJECTOR 2 MG/3 ML	1	ST; QL (3 ML per 28 days)
OZEMPIC (1 MG/DOSE) SUBCUTANEOUS SOLUTION PEN-INJECTOR 4 MG/3 ML	1	ST; QL (3 ML per 28 days)
OZEMPIC (2 MG/DOSE) SUBCUTANEOUS SOLUTION PEN-INJECTOR 8 MG/3 ML	1	ST; QL (3 ML per 28 days)
pioglitazone hcl oral tablet 15 mg, 30 mg, 45 mg	1	QL (30 EA per 30 days)
pioglitazone hcl-metformin hcl oral tablet 15-500 mg, 15-850 mg	1	QL (90 EA per 30 days)
repaglinide oral tablet 0.5 mg, 1 mg	1	QL (120 EA per 30 days)
repaglinide oral tablet 2 mg	1	QL (240 EA per 30 days)
RYBELSUS ORAL TABLET 14 MG, 3 MG, 7 MG	1	ST; QL (30 EA per 30 days)

Name of Drug	Drug Tier	Requirements/Limits
SYMLINPEN 120 SUBCUTANEOUS SOLUTION PEN-INJECTOR 2700 MCG/2.7 ML	1	PA
SYMLINPEN 60 SUBCUTANEOUS SOLUTION PEN-INJECTOR 1500 MCG/1.5 ML	1	PA
SYNJARDY ORAL TABLET 12.5-1000 MG, 12.5-500 MG, 5-1000 MG, 5-500 MG	1	QL (60 EA per 30 days)
SYNJARDY XR ORAL TABLET EXTENDED RELEASE 24 HOUR 10-1000 MG, 12.5-1000 MG, 5-1000 MG	1	QL (60 EA per 30 days)
SYNJARDY XR ORAL TABLET EXTENDED RELEASE 24 HOUR 25-1000 MG	1	QL (30 EA per 30 days)
TRADJENTA ORAL TABLET 5 MG	1	QL (30 EA per 30 days)
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	1	ST; QL (2 ML per 28 days)
VICTOZA SUBCUTANEOUS SOLUTION PEN-INJECTOR 18 MG/3 ML	1	ST; QL (9 ML per 30 days)
XIGDUO XR ORAL TABLET EXTENDED RELEASE 24 HOUR 10-1000 MG, 10-500 MG, 5-500 MG	1	QL (30 EA per 30 days)
XIGDUO XR ORAL TABLET EXTENDED RELEASE 24 HOUR 2.5-1000 MG, 5-1000 MG	1	QL (60 EA per 30 days)
Glycemic Agents		
BAQSIMI ONE PACK NASAL POWDER 3 MG/DOSE	1	QL (4 EA per 30 days)
BAQSIMI TWO PACK NASAL POWDER 3 MG/DOSE	1	QL (4 EA per 30 days)
diazoxide oral suspension 50 mg/ml	1	
GLUCAGEN HYPOKIT INJECTION SOLUTION RECONSTITUTED 1 MG	1	QL (4 EA per 30 days)
glucagon emergency injection kit 1 mg	1	QL (4 EA per 30 days)
glucagon emergency injection solution reconstituted 1 mg/ml	1	QL (4 EA per 30 days)

Name of Drug	Drug Tier	Requirements/Limits
KORLYM ORAL TABLET 300 MG	1	PA
mifepristone oral tablet 300 mg	1	PA
Insulins		
ADMELOG INJECTION SOLUTION 100 UNIT/ML	1	
ADMELOG SOLOSTAR SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML	1	
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	1	
APIDRA INJECTION SOLUTION 100 UNIT/ML	1	
APIDRA SOLOSTAR SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML	1	
BASAGLAR KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML	1	
BASAGLAR TEMPO PEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML	1	
FIASP FLEXTOUCH SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML	1	
FIASP INJECTION SOLUTION 100 UNIT/ML	1	
FIASP PENFILL SUBCUTANEOUS SOLUTION CARTRIDGE 100 UNIT/ML	1	
gauze pad 2"x2"	1	
GAUZE PAD 2"X2"	1	
HUMALOG INJECTION SOLUTION 100 UNIT/ML	1	
HUMALOG JUNIOR KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML	1	
HUMALOG KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML, 200 UNIT/ML	1	

Name of Drug	Drug Tier	Requirements/Limits
HUMALOG MIX 50/50 KWIKPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR (50-50) 100 UNIT/ML	1	
HUMALOG MIX 50/50 SUBCUTANEOUS SUSPENSION (50-50) 100 UNIT/ML	1	
HUMALOG MIX 75/25 KWIKPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR (75-25) 100 UNIT/ML	1	
HUMALOG MIX 75/25 SUBCUTANEOUS SUSPENSION (75-25) 100 UNIT/ML	1	
HUMALOG SUBCUTANEOUS SOLUTION CARTRIDGE 100 UNIT/ML	1	
HUMALOG TEMPO PEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML	1	
HUMULIN 70/30 KWIKPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR (70-30) 100 UNIT/ML	1	
HUMULIN 70/30 SUBCUTANEOUS SUSPENSION (70-30) 100 UNIT/ML	1	
HUMULIN N KWIKPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR 100 UNIT/ML	1	
HUMULIN N SUBCUTANEOUS SUSPENSION 100 UNIT/ML	1	
HUMULIN R INJECTION SOLUTION 100 UNIT/ML	1	
HUMULIN R U-500 (CONCENTRATED) SUBCUTANEOUS SOLUTION 500 UNIT/ML	1	
HUMULIN R U-500 KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 500 UNIT/ML	1	
insulin asp prot & asp flexpen subcutaneous suspension pen-injector (70-30) 100 unit/ml	1	
insulin aspart flexpen subcutaneous solution pen-injector 100 unit/ml	1	

Name of Drug	Drug Tier	Requirements/Limits
insulin aspart injection solution 100 unit/ml	1	
insulin aspart penfill subcutaneous solution cartridge 100 unit/ml	1	
insulin aspart prot & aspart subcutaneous suspension (70-30) 100 unit/ml	1	
insulin degludec flextouch subcutaneous solution pen-injector 100 unit/ml, 200 unit/ml	1	
insulin degludec subcutaneous solution 100 unit/ml	1	
insulin glargine max solostar subcutaneous solution pen-injector 300 unit/ml	1	
insulin glargine solostar subcutaneous solution pen-injector 100 unit/ml, 300 unit/ml	1	
insulin glargine subcutaneous solution 100 unit/ml	1	
insulin glargine-yfgn subcutaneous solution 100 unit/ml	1	
insulin glargine-yfgn subcutaneous solution pen-injector 100 unit/ml	1	
insulin lispro (1 unit dial) subcutaneous solution pen-injector 100 unit/ml	1	
insulin lispro injection solution 100 unit/ml	1	
insulin lispro junior kwikpen subcutaneous solution pen-injector 100 unit/ml	1	
insulin lispro prot & lispro subcutaneous suspension pen-injector (75-25) 100 unit/ml	1	

Name of Drug	Drug Tier	Requirements/Limits
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	1	
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	1	
LANTUS SUBCUTANEOUS SOLUTION 100 UNIT/ML	1	
LEVEMIR FLEXPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML	1	
LEVEMIR FLEXTOUCH SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML	1	
LEVEMIR SUBCUTANEOUS SOLUTION 100 UNIT/ML	1	
LYUMJEV INJECTION SOLUTION 100 UNIT/ML	1	
LYUMJEV KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML, 200 UNIT/ML	1	
LYUMJEV TEMPO PEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML	1	

Name of Drug	Drug Tier	Requirements/Limits
NOVOLIN 70/30 FLEXPEN RELION SUBCUTANEOUS SUSPENSION PEN-INJECTOR (70-30) 100 UNIT/ML	1	
NOVOLIN 70/30 FLEXPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR (70-30) 100 UNIT/ML	1	
NOVOLIN 70/30 RELION SUBCUTANEOUS SUSPENSION (70-30) 100 UNIT/ML	1	
NOVOLIN 70/30 SUBCUTANEOUS SUSPENSION (70-30) 100 UNIT/ML	1	
NOVOLIN N FLEXPEN RELION SUBCUTANEOUS SUSPENSION PEN-INJECTOR 100 UNIT/ML	1	
NOVOLIN N FLEXPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR 100 UNIT/ML	1	
NOVOLIN N RELION SUBCUTANEOUS SUSPENSION 100 UNIT/ML	1	
NOVOLIN N SUBCUTANEOUS SUSPENSION 100 UNIT/ML	1	
NOVOLIN R FLEXPEN INJECTION SOLUTION PEN-INJECTOR 100 UNIT/ML	1	
NOVOLIN R FLEXPEN RELION INJECTION SOLUTION PEN-INJECTOR 100 UNIT/ML	1	
NOVOLIN R INJECTION SOLUTION 100 UNIT/ML	1	
NOVOLIN R RELION INJECTION SOLUTION 100 UNIT/ML	1	
NOVOLOG 70/30 FLEXPEN RELION SUBCUTANEOUS SUSPENSION PEN-INJECTOR (70-30) 100 UNIT/ML	1	
NOVOLOG FLEXPEN RELION SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML	1	
NOVOLOG FLEXPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML	1	

Name of Drug	Drug Tier	Requirements/Limits
NOVOLOG INJECTION SOLUTION 100 UNIT/ML	1	
NOVOLOG MIX 70/30 FLEXPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR (70-30) 100 UNIT/ML	1	
NOVOLOG MIX 70/30 RELION SUBCUTANEOUS SUSPENSION (70-30) 100 UNIT/ML	1	
NOVOLOG MIX 70/30 SUBCUTANEOUS SUSPENSION (70-30) 100 UNIT/ML	1	
NOVOLOG PENFILL SUBCUTANEOUS SOLUTION CARTRIDGE 100 UNIT/ML	1	
NOVOLOG RELION INJECTION SOLUTION 100 UNIT/ML	1	
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	
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	1	
REZVOGLAR KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML	1	
SEMGLEE (YFGN) SUBCUTANEOUS SOLUTION 100 UNIT/ML	1	
SEMGLEE (YFGN) SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML	1	
SOLIQUA SUBCUTANEOUS SOLUTION PEN-INJECTOR 100-33 UNT-MCG/ML	1	QL (30 ML per 30 days)
TOUJEO MAX SOLOSTAR SUBCUTANEOUS SOLUTION PEN-INJECTOR 300 UNIT/ML	1	
TOUJEO SOLOSTAR SUBCUTANEOUS SOLUTION PEN-INJECTOR 300 UNIT/ML	1	
TRESIBA FLEXTOUCH SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML, 200 UNIT/ML	1	

Name of Drug	Drug Tier	Requirements/Limits
TRESIBA SUBCUTANEOUS SOLUTION 100 UNIT/ML	1	
XULTOPHY SUBCUTANEOUS SOLUTION PEN-INJECTOR 100-3.6 UNIT-MG/ML	1	QL (15 ML per 30 days)
Blood Products And Modifiers - Prevention Of Clotting And Increasing Blood Cell Production		
Anticoagulants		
ELIQUIS DVT/PE STARTER PACK ORAL TABLET THERAPY PACK 5 MG	1	QL (74 EA per 30 days)
ELIQUIS ORAL TABLET 2.5 MG	1	QL (60 EA per 30 days)
ELIQUIS ORAL TABLET 5 MG	1	QL (74 EA per 30 days)
enoxaparin sodium injection solution 300 mg/3 ml	1	
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	1	
fondaparinux sodium subcutaneous solution 10 mg/0.8 ml, 2.5 mg/0.5 ml, 5 mg/0.4 ml, 7.5 mg/0.6 ml	1	
FRAGMIN SUBCUTANEOUS SOLUTION 95000 UNIT/3.8 ML	1	
FRAGMIN SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 10000 UNIT/ML, 12500 UNIT/0.5 ML, 15000 UNIT/0.6 ML, 18000 UNT/0.72 ML, 2500 UNIT/0.2 ML, 5000 UNIT/0.2 ML, 7500 UNIT/0.3 ML	1	
heparin sodium (porcine) injection solution 1000 unit/ml, 10000 unit/ml, 5000 unit/ml	1	
JANTOVEN ORAL TABLET 1 MG, 10 MG, 2 MG, 2.5 MG, 3 MG, 4 MG, 5 MG, 6 MG, 7.5 MG	1	
warfarin sodium oral tablet 1 mg, 10 mg, 2 mg, 2.5 mg, 3 mg, 4 mg, 5 mg, 6 mg, 7.5 mg	1	
XARELTO ORAL TABLET 10 MG, 20 MG	1	QL (30 EA per 30 days)

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

Name of Drug	Drug Tier	Requirements/Limits
PROCRIT INJECTION SOLUTION 10000 UNIT/ML, 2000 UNIT/ML, 20000 UNIT/ML, 3000 UNIT/ML, 4000 UNIT/ML, 40000 UNIT/ML	1	PA
PROMACTA ORAL PACKET 12.5 MG	1	PA; QL (360 EA per 30 days)
PROMACTA ORAL PACKET 25 MG	1	PA; QL (180 EA per 30 days)
PROMACTA ORAL TABLET 12.5 MG, 25 MG	1	PA; QL (30 EA per 30 days)
PROMACTA ORAL TABLET 50 MG, 75 MG	1	PA; QL (60 EA per 30 days)
PYRUKYND ORAL TABLET 20 MG, 5 MG, 50 MG	1	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	1	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	1	PA
TAVNEOS ORAL CAPSULE 10 MG	1	PA
tranexamic acid oral tablet 650 mg	1	
UDENYCA ONBODY SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 6 MG/0.6 ML	1	PA
UDENYCA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 6 MG/0.6 ML	1	PA
UDENYCA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 6 MG/0.6 ML	1	PA
ZARXIO INJECTION SOLUTION PREFILLED SYRINGE 300 MCG/0.5 ML, 480 MCG/0.8 ML	1	PA
ZIEXTENZO SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 6 MG/0.6 ML	1	PA
Platelet Modifying Agents		
aspirin-dipyridamole er oral capsule extended release 12 hour 25-200 mg	1	

Name of Drug	Drug Tier	Requirements/Limits
BRILINTA ORAL TABLET 60 MG, 90 MG	1	
cilostazol oral tablet 100 mg, 50 mg	1	
clopidogrel bisulfate oral tablet 75 mg	1	
dipyridamole oral tablet 25 mg, 50 mg, 75 mg	1	PA
DOPTELET ORAL TABLET 20 MG, 20 MG (10 PACK), 20 MG (15 PACK)	1	PA
prasugrel hcl oral tablet 10 mg, 5 mg	1	
Cardiovascular Agents - Treatment Of Conditions Affecting The Heart And Blood Vessels		
Alpha-Adrenergic Agonists		
clonidine hcl oral tablet 0.1 mg, 0.2 mg, 0.3 mg	1	
clonidine transdermal patch weekly 0.1 mg/24 hr, 0.2 mg/24 hr, 0.3 mg/24 hr	1	
droxidopa oral capsule 100 mg, 200 mg, 300 mg	1	
guanfacine hcl oral tablet 1 mg, 2 mg	1	PA
midodrine hcl oral tablet 10 mg, 2.5 mg, 5 mg	1	
Alpha-Adrenergic Blocking Agents		
doxazosin mesylate oral tablet 1 mg, 2 mg, 4 mg, 8 mg	1	
phenoxybenzamine hcl oral capsule 10 mg	1	PA
prazosin hcl oral capsule 1 mg, 2 mg, 5 mg	1	
terazosin hcl oral capsule 1 mg, 10 mg, 2 mg, 5 mg	1	
Angiotensin II Receptor Antagonists		
candesartan cilexetil oral tablet 16 mg, 32 mg, 4 mg, 8 mg	1	
irbesartan oral tablet 150 mg, 300 mg, 75 mg	1	
losartan potassium oral tablet 100 mg, 25 mg, 50 mg	1	

Name of Drug	Drug Tier	Requirements/Limits
olmesartan medoxomil oral tablet 20 mg, 40 mg, 5 mg	1	
telmisartan oral tablet 20 mg, 40 mg, 80 mg	1	
valsartan oral tablet 160 mg, 320 mg, 40 mg, 80 mg	1	
Angiotensin-Converting Enzyme (ACE) Inhibitors		
benazepril hcl oral tablet 10 mg, 20 mg, 40 mg, 5 mg	1	
captopril oral tablet 100 mg, 12.5 mg, 25 mg, 50 mg	1	
enalapril maleate oral tablet 10 mg, 2.5 mg, 20 mg, 5 mg	1	
fosinopril sodium oral tablet 10 mg, 20 mg, 40 mg	1	
lisinopril oral tablet 10 mg, 2.5 mg, 20 mg, 30 mg, 40 mg, 5 mg	1	
moexipril hcl oral tablet 15 mg, 7.5 mg	1	
perindopril erbumine oral tablet 2 mg, 4 mg, 8 mg	1	
quinapril hcl oral tablet 10 mg, 20 mg, 40 mg, 5 mg	1	
ramipril oral capsule 1.25 mg, 10 mg, 2.5 mg, 5 mg	1	
trandolapril oral tablet 1 mg, 2 mg, 4 mg	1	
Antiarrhythmics		
amiodarone hcl oral tablet 100 mg, 200 mg, 400 mg	1	
disopyramide phosphate oral capsule 100 mg, 150 mg	1	PA
dofetilide oral capsule 125 mcg, 250 mcg, 500 mcg	1	
flecainide acetate oral tablet 100 mg, 150 mg, 50 mg	1	
mexiletine hcl oral capsule 150 mg, 200 mg, 250 mg	1	

Name of Drug	Drug Tier	Requirements/Limits
MULTAQ ORAL TABLET 400 MG	1	
NORPACE CR ORAL CAPSULE EXTENDED RELEASE 12 HOUR 100 MG, 150 MG	1	PA
propafenone hcl er oral capsule extended release 12 hour 225 mg, 325 mg, 425 mg	1	
propafenone hcl oral tablet 150 mg, 225 mg, 300 mg	1	
quinidine gluconate er oral tablet extended release 324 mg	1	
quinidine sulfate oral tablet 200 mg, 300 mg	1	
sotalol hcl (af) oral tablet 120 mg, 160 mg, 80 mg	1	
sotalol hcl oral tablet 120 mg, 160 mg, 240 mg, 80 mg	1	
Beta-Adrenergic Blocking Agents		
acebutolol hcl oral capsule 200 mg, 400 mg	1	
atenolol oral tablet 100 mg, 25 mg, 50 mg	1	
betaxolol hcl oral tablet 10 mg, 20 mg	1	
bisoprolol fumarate oral tablet 10 mg, 5 mg	1	
carvedilol oral tablet 12.5 mg, 25 mg, 3.125 mg, 6.25 mg	1	
labetalol hcl oral tablet 100 mg, 200 mg, 300 mg	1	
metoprolol succinate er oral tablet extended release 24 hour 100 mg, 200 mg, 25 mg, 50 mg	1	
metoprolol tartrate oral tablet 100 mg, 25 mg, 50 mg	1	
nadolol oral tablet 20 mg, 40 mg, 80 mg	1	
nebivolol hcl oral tablet 10 mg, 2.5 mg, 20 mg, 5 mg	1	

Name of Drug	Drug Tier	Requirements/Limits
pindolol oral tablet 10 mg, 5 mg	1	
propranolol hcl er oral capsule extended release 24 hour 120 mg, 160 mg, 60 mg, 80 mg	1	
propranolol hcl oral solution 20 mg/5 ml, 40 mg/5 ml	1	
propranolol hcl oral tablet 10 mg, 20 mg, 40 mg, 60 mg, 80 mg	1	
timolol maleate oral tablet 10 mg, 20 mg, 5 mg	1	
Calcium Channel Blocking Agents, Dihydropyridines		
amlodipine besylate oral tablet 10 mg, 2.5 mg, 5 mg	1	
felodipine er oral tablet extended release 24 hour 10 mg, 2.5 mg, 5 mg	1	
isradipine oral capsule 2.5 mg, 5 mg	1	
nifedipine er oral tablet extended release 24 hour 30 mg, 60 mg, 90 mg	1	
nifedipine er osmotic release oral tablet extended release 24 hour 30 mg, 60 mg, 90 mg	1	
nifedipine oral capsule 10 mg, 20 mg	1	PA
nimodipine oral capsule 30 mg	1	
Calcium Channel Blocking Agents, Nondihydropyridines		
CARTIA XT ORAL CAPSULE EXTENDED RELEASE 24 HOUR 120 MG, 180 MG, 240 MG, 300 MG	1	
diltiazem hcl er beads oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg, 420 mg	1	
diltiazem hcl er coated beads oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg	1	
diltiazem hcl er oral capsule extended release 12 hour 120 mg, 60 mg, 90 mg	1	

Name of Drug	Drug Tier	Requirements/Limits
diltiazem hcl er oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg	1	
diltiazem hcl oral tablet 120 mg, 30 mg, 60 mg, 90 mg	1	
dilt-xr oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg	1	
verapamil hcl er oral capsule extended release 24 hour 100 mg, 120 mg, 180 mg, 200 mg, 240 mg, 300 mg, 360 mg	1	
verapamil hcl er oral tablet extended release 120 mg, 180 mg, 240 mg	1	
verapamil hcl oral tablet 120 mg, 40 mg, 80 mg	1	
Cardiovascular Agents, Other		
acetazolamide oral tablet 125 mg, 250 mg	1	
aliskiren fumarate oral tablet 150 mg, 300 mg	1	
amiloride-hydrochlorothiazide oral tablet 5-50 mg	1	
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	1	
amlodipine besylate-valsartan oral tablet 10-160 mg, 10-320 mg, 5-160 mg, 5-320 mg	1	
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	1	
amlodipine-olmesartan oral tablet 10-20 mg, 10-40 mg, 5-20 mg, 5-40 mg	1	
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	1	
atenolol-chlorthalidone oral tablet 100-25 mg, 50-25 mg	1	

Name of Drug	Drug Tier	Requirements/Limits
benazepril-hydrochlorothiazide oral tablet 10-12.5 mg, 20-12.5 mg, 20-25 mg, 5-6.25 mg	1	
bisoprolol-hydrochlorothiazide oral tablet 10-6.25 mg, 2.5-6.25 mg, 5-6.25 mg	1	
CAMZYOS ORAL CAPSULE 10 MG, 15 MG, 2.5 MG, 5 MG	1	PA; QL (30 EA per 30 days)
candesartan cilexetil-hctz oral tablet 16-12.5 mg, 32-12.5 mg, 32-25 mg	1	
CORLANOR ORAL SOLUTION 5 MG/5 ML	1	PA
CORLANOR ORAL TABLET 5 MG, 7.5 MG	1	PA
digoxin oral solution 0.05 mg/ml	1	QL (150 ML per 30 days)
digoxin oral tablet 125 mcg, 250 mcg	1	QL (30 EA per 30 days)
enalapril-hydrochlorothiazide oral tablet 10-25 mg, 5-12.5 mg	1	
ENTRESTO ORAL TABLET 24-26 MG, 49-51 MG, 97-103 MG	1	QL (60 EA per 30 days)
fosinopril sodium-hctz oral tablet 10-12.5 mg, 20-12.5 mg	1	
irbesartan-hydrochlorothiazide oral tablet 150-12.5 mg, 300-12.5 mg	1	
KERENDIA ORAL TABLET 10 MG, 20 MG	1	PA; QL (30 EA per 30 days)
lisinopril-hydrochlorothiazide oral tablet 10-12.5 mg, 20-12.5 mg, 20-25 mg	1	
LODOCO ORAL TABLET 0.5 MG	1	PA
losartan potassium-hctz oral tablet 100-12.5 mg, 100-25 mg, 50-12.5 mg	1	
metoprolol-hydrochlorothiazide oral tablet 100-25 mg, 100-50 mg, 50-25 mg	1	
metyrosine oral capsule 250 mg	1	PA
NEXLETOL ORAL TABLET 180 MG	1	PA
NEXLIZET ORAL TABLET 180-10 MG	1	PA
olmesartan medoxomil-hctz oral tablet 20-12.5 mg, 40-12.5 mg, 40-25 mg	1	

Name of Drug	Drug Tier	Requirements/Limits
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	1	
pentoxifylline er oral tablet extended release 400 mg	1	
quinapril-hydrochlorothiazide oral tablet 10-12.5 mg, 20-12.5 mg, 20-25 mg	1	
ranolazine er oral tablet extended release 12 hour 1000 mg, 500 mg	1	
spironolactone-hctz oral tablet 25-25 mg	1	
telmisartan-amlodipine oral tablet 40-10 mg, 40-5 mg, 80-10 mg, 80-5 mg	1	
telmisartan-hctz oral tablet 40-12.5 mg, 80-12.5 mg, 80-25 mg	1	
triamterene-hctz oral capsule 37.5-25 mg	1	
triamterene-hctz oral tablet 37.5-25 mg, 75-50 mg	1	
valsartan-hydrochlorothiazide oral tablet 160-12.5 mg, 160-25 mg, 320-12.5 mg, 320-25 mg, 80-12.5 mg	1	
VERQUVO ORAL TABLET 10 MG, 2.5 MG, 5 MG	1	QL (30 EA per 30 days)
Diuretics, Loop		
bumetanide oral tablet 0.5 mg, 1 mg, 2 mg	1	
furosemide injection solution 10 mg/ml, 10 mg/ml (4 ml syringe)	1	
furosemide oral solution 10 mg/ml, 8 mg/ml	1	
furosemide oral tablet 20 mg, 40 mg, 80 mg	1	
torsemide oral tablet 10 mg, 100 mg, 20 mg, 5 mg	1	
Diuretics, Potassium-Sparing		
amiloride hcl oral tablet 5 mg	1	
eplerenone oral tablet 25 mg, 50 mg	1	

Name of Drug	Drug Tier	Requirements/Limits
spironolactone oral tablet 100 mg, 25 mg, 50 mg	1	
Diuretics, Thiazide		
chlorthalidone oral tablet 25 mg, 50 mg	1	
hydrochlorothiazide oral capsule 12.5 mg	1	
hydrochlorothiazide oral tablet 12.5 mg, 25 mg, 50 mg	1	
indapamide oral tablet 1.25 mg, 2.5 mg	1	
metolazone oral tablet 10 mg, 2.5 mg, 5 mg	1	
Dyslipidemics, Fibric Acid Derivatives		
fenofibrate micronized oral capsule 134 mg, 200 mg, 43 mg, 67 mg	1	
fenofibrate oral capsule 134 mg, 200 mg, 67 mg	1	
fenofibrate oral tablet 145 mg, 160 mg, 48 mg, 54 mg	1	
fenofibric acid oral capsule delayed release 135 mg, 45 mg	1	
fenofibric acid oral tablet 35 mg	1	
gemfibrozil oral tablet 600 mg	1	
Dyslipidemics, HMG-CoA Reductase Inhibitors		
atorvastatin calcium oral tablet 10 mg, 20 mg, 40 mg, 80 mg	1	
lovastatin oral tablet 10 mg, 20 mg, 40 mg	1	
pravastatin sodium oral tablet 10 mg, 20 mg, 40 mg, 80 mg	1	
rosuvastatin calcium oral tablet 10 mg, 20 mg, 40 mg, 5 mg	1	
simvastatin oral tablet 10 mg, 20 mg, 40 mg, 5 mg, 80 mg	1	
Dyslipidemics, Other		
cholestyramine light oral packet 4 gm	1	

Name of Drug	Drug Tier	Requirements/Limits
cholestyramine light oral powder 4 gm/dose	1	
cholestyramine oral packet 4 gm	1	
cholestyramine oral powder 4 gm/dose	1	
colesevelam hcl oral packet 3.75 gm	1	
colesevelam hcl oral tablet 625 mg	1	
colestipol hcl oral granules 5 gm	1	
colestipol hcl oral packet 5 gm	1	
colestipol hcl oral tablet 1 gm	1	
ezetimibe oral tablet 10 mg	1	
ezetimibe-rosuvastatin oral tablet 10-10 mg, 10-20 mg, 10-40 mg, 10-5 mg	1	
ezetimibe-simvastatin oral tablet 10-10 mg, 10-20 mg, 10-40 mg, 10-80 mg	1	
icosapent ethyl oral capsule 0.5 gm, 1 gm	1	PA
niacin er (antihyperlipidemic) oral tablet extended release 1000 mg, 500 mg, 750 mg	1	
omega-3-acid ethyl esters oral capsule 1 gm	1	
PRALUENT SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML, 75 MG/ML	1	PA
PREVALITE ORAL PACKET 4 GM	1	
PREVALITE ORAL POWDER 4 GM/DOSE	1	
REPATHA PUSHTRONEX SYSTEM SUBCUTANEOUS SOLUTION CARTRIDGE 420 MG/3.5 ML	1	PA
REPATHA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 140 MG/ML	1	PA
REPATHA SURECLICK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 140 MG/ML	1	PA
Vasodilators, Direct-Acting Arterial		
hydralazine hcl oral tablet 10 mg, 100 mg, 25 mg, 50 mg	1	

Name of Drug	Drug Tier	Requirements/Limits
isosorb dinitrate-hydralazine oral tablet 20-37.5 mg	1	
minoxidil oral tablet 10 mg, 2.5 mg	1	
Vasodilators, Direct-Acting Arterial/Venous		
isosorbide dinitrate oral tablet 10 mg, 20 mg, 30 mg, 5 mg	1	
isosorbide mononitrate er oral tablet extended release 24 hour 120 mg, 30 mg, 60 mg	1	
isosorbide mononitrate oral tablet 10 mg, 20 mg	1	
NITRO-BID TRANSDERMAL OINTMENT 2 %	1	
NITRO-DUR TRANSDERMAL PATCH 24 HOUR 0.3 MG/HR, 0.8 MG/HR	1	
nitroglycerin sublingual tablet sublingual 0.3 mg, 0.4 mg, 0.6 mg	1	
nitroglycerin transdermal patch 24 hour 0.1 mg/hr, 0.2 mg/hr, 0.4 mg/hr, 0.6 mg/hr	1	
nitroglycerin translingual solution 0.4 mg/spray	1	
RECTIV RECTAL OINTMENT 0.4 %	1	
Central Nervous System Agents - Treatment Of Disorders Of The Brain And Spinal Column		
Attention Deficit Hyperactivity Disorder Agents, Amphetamines		
amphetamine-dextroamphet er oral capsule extended release 24 hour 10 mg, 15 mg, 20 mg, 25 mg, 30 mg, 5 mg	1	QL (30 EA per 30 days)
amphetamine-dextroamphetamine oral tablet 10 mg, 20 mg, 30 mg, 5 mg, 7.5 mg	1	QL (60 EA per 30 days)
amphetamine-dextroamphetamine oral tablet 12.5 mg	1	QL (120 EA per 30 days)
amphetamine-dextroamphetamine oral tablet 15 mg	1	QL (90 EA per 30 days)

Name of Drug	Drug Tier	Requirements/Limits
dextroamphetamine sulfate er oral capsule extended release 24 hour 10 mg	1	QL (150 EA per 30 days)
dextroamphetamine sulfate er oral capsule extended release 24 hour 15 mg	1	QL (120 EA per 30 days)
dextroamphetamine sulfate er oral capsule extended release 24 hour 5 mg	1	QL (90 EA per 30 days)
dextroamphetamine sulfate oral tablet 10 mg, 5 mg	1	QL (180 EA per 30 days)
Attention Deficit Hyperactivity Disorder Agents, Non-Amphetamines		
atomoxetine hcl oral capsule 10 mg, 100 mg, 18 mg, 25 mg, 40 mg, 60 mg, 80 mg	1	
clonidine hcl er oral tablet extended release 12 hour 0.1 mg	1	QL (120 EA per 30 days)
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	1	QL (30 EA per 30 days)
dexmethylphenidate hcl oral tablet 10 mg	1	QL (60 EA per 30 days)
dexmethylphenidate hcl oral tablet 2.5 mg, 5 mg	1	QL (90 EA per 30 days)
guanfacine hcl er oral tablet extended release 24 hour 1 mg, 2 mg, 3 mg, 4 mg	1	PA
methylphenidate hcl er (cd) oral capsule extended release 10 mg, 20 mg, 30 mg, 40 mg, 50 mg, 60 mg	1	QL (30 EA per 30 days)
methylphenidate hcl er (la) oral capsule extended release 24 hour 10 mg, 20 mg, 30 mg, 40 mg, 60 mg	1	QL (30 EA per 30 days)
methylphenidate hcl er (osm) oral tablet extended release 18 mg	1	QL (120 EA per 30 days)
methylphenidate hcl er (osm) oral tablet extended release 27 mg, 54 mg, 72 mg	1	QL (30 EA per 30 days)
methylphenidate hcl er (osm) oral tablet extended release 36 mg	1	QL (60 EA per 30 days)

Name of Drug	Drug Tier	Requirements/Limits
methylphenidate hcl er (xr) oral capsule extended release 24 hour 10 mg, 15 mg, 20 mg, 30 mg, 40 mg, 50 mg, 60 mg	1	QL (30 EA per 30 days)
methylphenidate hcl er oral tablet extended release 10 mg	1	QL (30 EA per 30 days)
methylphenidate hcl er oral tablet extended release 20 mg	1	QL (90 EA per 30 days)
methylphenidate hcl er oral tablet extended release 24 hour 18 mg	1	QL (120 EA per 30 days)
methylphenidate hcl er oral tablet extended release 24 hour 27 mg, 54 mg	1	QL (30 EA per 30 days)
methylphenidate hcl er oral tablet extended release 24 hour 36 mg	1	QL (60 EA per 30 days)
methylphenidate hcl oral solution 10 mg/5 ml	1	QL (900 ML per 30 days)
methylphenidate hcl oral solution 5 mg/5 ml	1	QL (1800 ML per 30 days)
methylphenidate hcl oral tablet 10 mg, 20 mg, 5 mg	1	QL (90 EA per 30 days)
methylphenidate hcl oral tablet chewable 10 mg	1	QL (180 EA per 30 days)
methylphenidate hcl oral tablet chewable 2.5 mg, 5 mg	1	QL (90 EA per 30 days)
Central Nervous System, Other		
AUSTEDO ORAL TABLET 12 MG, 6 MG, 9 MG	1	PA
AUSTEDO PATIENT TITRATION KIT ORAL TABLET THERAPY PACK 6 & 9 & 12 MG	1	PA
EVRYSDI ORAL SOLUTION RECONSTITUTED 0.75 MG/ML	1	PA
FIRDAPSE ORAL TABLET 10 MG	1	PA
INGREZZA ORAL CAPSULE 40 MG, 60 MG, 80 MG	1	PA; QL (30 EA per 30 days)
INGREZZA ORAL CAPSULE THERAPY PACK 40 & 80 MG	1	PA; QL (56 EA per 365 days)
NUEDEXTA ORAL CAPSULE 20-10 MG	1	PA

Name of Drug	Drug Tier	Requirements/Limits
RADICAVA ORS ORAL SUSPENSION 105 MG/5 ML	1	PA
RADICAVA ORS STARTER KIT ORAL SUSPENSION 105 MG/5 ML	1	PA
RELYVRIO ORAL PACKET 3-1 GM	1	PA
riluzole oral tablet 50 mg	1	
tetrabenazine oral tablet 12.5 mg, 25 mg	1	PA
Fibromyalgia Agents		
duloxetine hcl oral capsule delayed release particles 20 mg, 30 mg, 60 mg	1	
SAVELLA ORAL TABLET 100 MG, 12.5 MG, 25 MG, 50 MG	1	ST
SAVELLA TITRATION PACK ORAL 12.5 & 25 & 50 MG	1	ST
Multiple Sclerosis Agents		
BAFIERTAM ORAL CAPSULE DELAYED RELEASE 95 MG	1	PA
BETASERON SUBCUTANEOUS KIT 0.3 MG	1	PA
dalfampridine er oral tablet extended release 12 hour 10 mg	1	PA
dimethyl fumarate oral capsule delayed release 120 mg, 240 mg	1	PA
dimethyl fumarate starter pack oral capsule delayed release therapy pack 120 & 240 mg	1	PA
EXTAVIA SUBCUTANEOUS KIT 0.3 MG	1	PA
fingolimod hcl oral capsule 0.5 mg	1	PA
glatiramer acetate subcutaneous solution prefilled syringe 20 mg/ml, 40 mg/ml	1	PA
GLATOPA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 20 MG/ML, 40 MG/ML	1	PA
KESIMPTA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 20 MG/0.4 ML	1	PA

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

Name of Drug	Drug Tier	Requirements/Limits
ZEPOSIA 7-DAY STARTER PACK ORAL CAPSULE THERAPY PACK 4 X 0.23 MG & 3 X 0.46 MG	1	PA
ZEPOSIA ORAL CAPSULE 0.92 MG	1	PA
ZEPOSIA STARTER KIT ORAL CAPSULE THERAPY PACK 0.23 MG & 0.46 MG & 0.92 MG (21)	1	PA
Dental And Oral Agents - Treatment Of Mouth And Gum Disorders		
Dental And Oral Agents		
cevimeline hcl oral capsule 30 mg	1	
chlorhexidine gluconate mouth/throat solution 0.12 %	1	
pilocarpine hcl oral tablet 5 mg, 7.5 mg	1	
triamcinolone acetonide mouth/throat paste 0.1 %	1	
Dermatological Agents - Treatment Of Skin Conditions		
Acne And Rosacea Agents		
acitretin oral capsule 10 mg, 17.5 mg, 25 mg	1	PA
adapalene external gel 0.1 %	1	
adapalene-benzoyl peroxide external gel 0.1-2.5 %	1	
AMNESTEEM ORAL CAPSULE 10 MG, 20 MG, 40 MG	1	
benzoyl peroxide-erythromycin external gel 5-3 %	1	
CLARAVIS ORAL CAPSULE 10 MG, 20 MG, 30 MG, 40 MG	1	
clindamycin phos-benzoyl perox external gel 1-5 %, 1.2-2.5 %, 1.2-5 %	1	
isotretinoin oral capsule 10 mg, 20 mg, 30 mg, 40 mg	1	
MYORISAN ORAL CAPSULE 10 MG, 20 MG, 30 MG, 40 MG	1	
tazarotene external cream 0.1 %	1	
tazarotene external gel 0.05 %, 0.1 %	1	

Name of Drug	Drug Tier	Requirements/Limits
TAZORAC EXTERNAL CREAM 0.05 %	1	
tretinoin external cream 0.025 %, 0.05 %, 0.1 %	1	
tretinoin external gel 0.01 %, 0.025 %	1	
ZENATANE ORAL CAPSULE 10 MG, 20 MG, 30 MG, 40 MG	1	
Dermatitis And Pruritus Agents		
alclometasone dipropionate external cream 0.05 %	1	
alclometasone dipropionate external ointment 0.05 %	1	
ammonium lactate external cream 12 %	1	
ammonium lactate external lotion 12 %	1	
betamethasone dipropionate aug external cream 0.05 %	1	
betamethasone dipropionate aug external gel 0.05 %	1	
betamethasone dipropionate aug external lotion 0.05 %	1	
betamethasone dipropionate aug external ointment 0.05 %	1	
betamethasone dipropionate external cream 0.05 %	1	
betamethasone dipropionate external lotion 0.05 %	1	
betamethasone dipropionate external ointment 0.05 %	1	
betamethasone valerate external cream 0.1 %	1	
betamethasone valerate external lotion 0.1 %	1	
betamethasone valerate external ointment 0.1 %	1	
clobetasol prop emollient base external cream 0.05 %	1	
clobetasol propionate e external cream 0.05 %	1	

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
clobetasol propionate external cream 0.05 %	1	
clobetasol propionate external gel 0.05 %	1	
clobetasol propionate external ointment 0.05 %	1	
clobetasol propionate external solution 0.05 %	1	
desonide external cream 0.05 %	1	
desonide external lotion 0.05 %	1	
desonide external ointment 0.05 %	1	
desoximetasone external cream 0.05 %, 0.25 %	1	
desoximetasone external gel 0.05 %	1	
desoximetasone external ointment 0.05 %, 0.25 %	1	
doxepin hcl external cream 5 %	1	PA; QL (45 GM per 30 days)
EUCRISA EXTERNAL OINTMENT 2 %	1	PA
fluocinolone acetonide external cream 0.01 %, 0.025 %	1	
fluocinolone acetonide external ointment 0.025 %	1	
fluocinolone acetonide external solution 0.01 %	1	
fluocinonide emulsified base external cream 0.05 %	1	
fluocinonide external cream 0.05 %	1	
fluocinonide external gel 0.05 %	1	
fluocinonide external ointment 0.05 %	1	
fluocinonide external solution 0.05 %	1	
fluticasone propionate external cream 0.05 %	1	
fluticasone propionate external lotion 0.05 %	1	
fluticasone propionate external ointment 0.005 %	1	

Name of Drug	Drug Tier	Requirements/Limits
halobetasol propionate external cream 0.05 %	1	
halobetasol propionate external ointment 0.05 %	1	
hydrocortisone (perianal) external cream 1 %, 2.5 %	1	
hydrocortisone butyr lipo base external cream 0.1 %	1	
hydrocortisone butyrate external cream 0.1 %	1	
hydrocortisone butyrate external ointment 0.1 %	1	
hydrocortisone butyrate external solution 0.1 %	1	
hydrocortisone external cream 1 %, 2.5 %	1	
hydrocortisone external lotion 2.5 %	1	
hydrocortisone external ointment 1 %, 2.5 %	1	
hydrocortisone valerate external cream 0.2 %	1	
hydrocortisone valerate external ointment 0.2 %	1	
HYFTOR EXTERNAL GEL 0.2 %	1	PA
mometasone furoate external cream 0.1 %	1	
mometasone furoate external ointment 0.1 %	1	
mometasone furoate external solution 0.1 %	1	
pimecrolimus external cream 1 %	1	ST
prednicarbate external ointment 0.1 %	1	
selenium sulfide external lotion 2.5 %	1	
tacrolimus external ointment 0.03 %, 0.1 %	1	ST
triamcinolone acetonide external cream 0.025 %, 0.1 %, 0.5 %	1	

Name of Drug	Drug Tier	Requirements/Limits
triamcinolone acetonide external lotion 0.025 %, 0.1 %	1	
triamcinolone acetonide external ointment 0.025 %, 0.05 %, 0.1 %, 0.5 %	1	
triamcinolone in absorbase external ointment 0.05 %	1	
Dermatological Agents, Other		
ALCOHOL PAD 70 %	1	
alcohol pad 70 %	1	
alcohol sheet 70 %	1	
calcipotriene external cream 0.005 %	1	
calcipotriene external ointment 0.005 %	1	
calcipotriene external solution 0.005 %	1	
calcitriol external ointment 3 mcg/gm	1	
clotrimazole-betamethasone external cream 1-0.05 %	1	
clotrimazole-betamethasone external lotion 1-0.05 %	1	
fluorouracil external cream 0.5 %	1	PA
fluorouracil external cream 5 %	1	
fluorouracil external solution 2 %, 5 %	1	
imiquimod external cream 5 %	1	
methoxsalen rapid oral capsule 10 mg	1	
nystatin-triamcinolone external cream 100000-0.1 unit/gm-%	1	
nystatin-triamcinolone external ointment 100000-0.1 unit/gm-%	1	
OTEZLA ORAL TABLET 30 MG	1	PA
OTEZLA ORAL TABLET THERAPY PACK 10 & 20 & 30 MG	1	PA
podofilox external solution 0.5 %	1	
REGRANEX EXTERNAL GEL 0.01 %	1	PA; QL (15 GM per 30 days)
SANTYL EXTERNAL OINTMENT 250 UNIT/GM	1	QL (90 GM per 30 days)
silver sulfadiazine external cream 1 %	1	

Name of Drug	Drug Tier	Requirements/Limits
sodium chloride irrigation solution 0.9 %	1	
Pediculicides/Scabicides		
malathion external lotion 0.5 %	1	
permethrin external cream 5 %	1	
Topical Anti-Infectives		
acyclovir external cream 5 %	1	
acyclovir external ointment 5 %	1	
ciclopirox external solution 8 %	1	
ciclopirox olamine external cream 0.77 %	1	
ciclopirox olamine external suspension 0.77 %	1	
clindamycin phosphate external gel 1 %	1	
clindamycin phosphate external lotion 1 %	1	
clindamycin phosphate external solution 1 %	1	
clindamycin phosphate external swab 1 %	1	
ery external pad 2 %	1	
erythromycin external gel 2 %	1	
erythromycin external solution 2 %	1	
gentamicin sulfate external cream 0.1 %	1	
gentamicin sulfate external ointment 0.1 %	1	
metronidazole external cream 0.75 %	1	
metronidazole external gel 0.75 %, 1 %	1	
metronidazole external lotion 0.75 %	1	
mupirocin external ointment 2 %	1	QL (88 GM per 30 days)
penciclovir external cream 1 %	1	

Name of Drug	Drug Tier	Requirements/Limits
Electrolytes/Minerals/Metals/Vitamins - Products That Supplement Or Replace Electrolytes, Minerals, Metals Or Vitamins		
Electrolyte/Mineral Replacement		
carglumic acid oral tablet soluble 200 mg	1	PA
ISOLYTE-S INTRAVENOUS SOLUTION	1	
ISOLYTE-S PH 7.4 INTRAVENOUS SOLUTION	1	
kcl in dextrose-nacl intravenous solution 20-5-0.45 meq/l-%-%	1	
KLOR-CON 10 ORAL TABLET EXTENDED RELEASE 10 MEQ	1	
KLOR-CON M10 ORAL TABLET EXTENDED RELEASE 10 MEQ	1	
KLOR-CON M15 ORAL TABLET EXTENDED RELEASE 15 MEQ	1	
KLOR-CON M20 ORAL TABLET EXTENDED RELEASE 20 MEQ	1	
KLOR-CON ORAL TABLET EXTENDED RELEASE 8 MEQ	1	
magnesium sulfate injection solution 50 %, 50 % (10ml syringe)	1	
potassium chloride crys er oral tablet extended release 10 meq, 15 meq, 20 meq	1	
potassium chloride er oral capsule extended release 10 meq, 8 meq	1	
potassium chloride er oral tablet extended release 10 meq, 15 meq, 20 meq, 8 meq	1	
potassium chloride intravenous solution 2 meq/ml, 2 meq/ml (20 ml), 40 meq/100 ml	1	
potassium chloride oral solution 10 %, 20 meq/15 ml (10%), 40 meq/15 ml (20%)	1	
potassium citrate er oral tablet extended release 10 meq (1080 mg), 15 meq (1620 mg), 5 meq (540 mg)	1	

Name of Drug	Drug Tier	Requirements/Limits
sodium chloride (pf) injection solution 0.9 %	1	
sodium chloride intravenous solution 0.45 %, 0.9 %, 3 %	1	
sodium fluoride oral tablet 2.2 (1 f) mg	1	
Electrolyte/Mineral/Metal Modifiers		
CUVRIOR ORAL TABLET 300 MG	1	PA
deferasirox granules oral packet 180 mg, 360 mg, 90 mg	1	PA
deferasirox oral packet 180 mg, 360 mg, 90 mg	1	PA
deferasirox oral tablet 180 mg, 360 mg, 90 mg	1	PA
deferasirox oral tablet soluble 125 mg, 250 mg, 500 mg	1	PA
deferiprone oral tablet 1000 mg, 500 mg	1	PA
penicillamine oral tablet 250 mg	1	PA
tolvaptan oral tablet 15 mg, 30 mg	1	PA
trientine hcl oral capsule 250 mg	1	PA
Electrolytes/Minerals/Metals/Vitamins		
CLINISOL SF INTRAVENOUS SOLUTION 15 %	1	B/D
dextrose intravenous solution 10 %, 5 %	1	
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 %	1	
dextrose-sodium chloride intravenous solution 2.5-0.45 %, 5-0.45 %, 5-0.9 %	1	
INTRALIPID INTRAVENOUS EMULSION 20 %, 30 %	1	B/D
ISOLYTE-P IN D5W INTRAVENOUS SOLUTION	1	
levocarnitine oral solution 1 gm/10 ml	1	
levocarnitine oral tablet 330 mg	1	
levocarnitine sf oral solution 1 gm/10 ml	1	

Name of Drug	Drug Tier	Requirements/Limits
NUTRILIPID INTRAVENOUS EMULSION 20 %	1	B/D
PLENAMINE INTRAVENOUS SOLUTION 15 %	1	B/D
prenatal oral tablet 27-1 mg	1	
Phosphate Binders		
calcium acetate (phos binder) oral capsule 667 mg	1	
lanthanum carbonate oral tablet chewable 1000 mg, 500 mg, 750 mg	1	
sevelamer carbonate oral packet 0.8 gm, 2.4 gm	1	
sevelamer carbonate oral tablet 800 mg	1	
Potassium Binders		
LOKELMA ORAL PACKET 10 GM, 5 GM	1	
sodium polystyrene sulfonate oral powder	1	
SPS ORAL SUSPENSION 15 GM/60 ML	1	
Vitamins		
m-natal plus oral tablet 27-1 mg	1	
trinatal rx 1 oral tablet 60-1 mg	1	
Gastrointestinal Agents - Treatment Of Stomach And Intestinal Conditions		
Anti-Constipation Agents		
constulose oral solution 10 gm/15 ml	1	
enulose oral solution 10 gm/15 ml	1	
GAVILYTE-C ORAL SOLUTION RECONSTITUTED 240 GM	1	
GAVILYTE-G ORAL SOLUTION RECONSTITUTED 236 GM	1	
generlac oral solution 10 gm/15 ml	1	
lactulose encephalopathy oral solution 10 gm/15 ml	1	
lactulose oral solution 10 gm/15 ml, 20 gm/30 ml	1	

Name of Drug	Drug Tier	Requirements/Limits
LINZESS ORAL CAPSULE 145 MCG, 290 MCG, 72 MCG	1	QL (30 EA per 30 days)
lubiprostone oral capsule 24 mcg, 8 mcg	1	QL (60 EA per 30 days)
MOVANTIK ORAL TABLET 12.5 MG, 25 MG	1	QL (30 EA per 30 days)
peg 3350-kcl-na bicarb-nacl oral solution reconstituted 420 gm	1	
peg-3350/electrolytes oral solution reconstituted 236 gm	1	
RELISTOR ORAL TABLET 150 MG	1	PA
RELISTOR SUBCUTANEOUS SOLUTION 12 MG/0.6 ML, 12 MG/0.6ML (0.6 ML SYRINGE), 8 MG/0.4 ML	1	PA
Anti-Diarrheal Agents		
alosetron hcl oral tablet 0.5 mg, 1 mg	1	QL (60 EA per 30 days)
diphenoxylate-atropine oral liquid 2.5-0.025 mg/5ml	1	
diphenoxylate-atropine oral tablet 2.5-0.025 mg	1	
loperamide hcl oral capsule 2 mg	1	
XERMELO ORAL TABLET 250 MG	1	PA
XIFAXAN ORAL TABLET 200 MG, 550 MG	1	PA
Antispasmodics, Gastrointestinal		
dicyclomine hcl oral capsule 10 mg	1	
dicyclomine hcl oral solution 10 mg/5 ml	1	
dicyclomine hcl oral tablet 20 mg	1	
glycopyrrolate oral solution 1 mg/5 ml	1	
glycopyrrolate oral tablet 1 mg, 2 mg	1	
Gastrointestinal Agents, Other		
GATTEX SUBCUTANEOUS KIT 5 MG	1	PA
LIVMARLI ORAL SOLUTION 9.5 MG/ML	1	PA
OCALIVA ORAL TABLET 10 MG, 5 MG	1	PA
ursodiol oral capsule 300 mg	1	

Name of Drug	Drug Tier	Requirements/Limits
ursodiol oral tablet 250 mg, 500 mg	1	
VOWST ORAL CAPSULE	1	PA
Histamine-2 (H2) Receptor Antagonists		
cimetidine hcl oral solution 300 mg/5 ml, 400 mg/6.67 ml	1	
cimetidine oral tablet 200 mg, 300 mg, 400 mg, 800 mg	1	
famotidine oral tablet 20 mg, 40 mg	1	
Protectants		
misoprostol oral tablet 100 mcg, 200 mcg	1	
sucralfate oral tablet 1 gm	1	
Proton Pump Inhibitors		
DEXILANT ORAL CAPSULE DELAYED RELEASE 30 MG, 60 MG	1	
dexlansoprazole oral capsule delayed release 30 mg, 60 mg	1	
esomeprazole magnesium oral capsule delayed release 20 mg, 40 mg	1	
lansoprazole oral capsule delayed release 15 mg, 30 mg	1	
omeprazole oral capsule delayed release 10 mg, 20 mg, 40 mg	1	
pantoprazole sodium oral tablet delayed release 20 mg, 40 mg	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	1	PA
betaine oral powder	1	
CERDELGA ORAL CAPSULE 84 MG	1	PA
CHOLBAM ORAL CAPSULE 250 MG, 50 MG	1	PA

Name of Drug	Drug Tier	Requirements/Limits
CREON ORAL CAPSULE DELAYED RELEASE PARTICLES 12000-38000 UNIT, 24000-76000 UNIT, 3000-9500 UNIT, 36000-114000 UNIT, 6000-19000 UNIT	1	
CYSTAGON ORAL CAPSULE 150 MG, 50 MG	1	PA
dichlorphenamide oral tablet 50 mg	1	PA
ENDARI ORAL PACKET 5 GM	1	PA
GALAFOLD ORAL CAPSULE 123 MG	1	PA
GLASSIA INTRAVENOUS SOLUTION 1000 MG/50 ML	1	PA
miglustat oral capsule 100 mg	1	PA
nitisinone oral capsule 10 mg, 2 mg, 20 mg, 5 mg	1	PA
ORFADIN ORAL SUSPENSION 4 MG/ML	1	PA
PROLASTIN-C INTRAVENOUS SOLUTION 1000 MG/20 ML	1	PA
PROLASTIN-C INTRAVENOUS SOLUTION RECONSTITUTED 1000 MG	1	PA
RAVICTI ORAL LIQUID 1.1 GM/ML	1	PA
sapropterin dihydrochloride oral packet 100 mg, 500 mg	1	PA
sapropterin dihydrochloride oral tablet 100 mg	1	PA
sodium phenylbutyrate oral powder 3 gm/tsp	1	PA
sodium phenylbutyrate oral tablet 500 mg	1	PA
SUCRAID ORAL SOLUTION 8500 UNIT/ML	1	PA
XURIDEN ORAL PACKET 2 GM	1	PA
ZEMAIRA INTRAVENOUS SOLUTION RECONSTITUTED 1000 MG, 4000 MG, 5000 MG	1	PA

Name of Drug	Drug Tier	Requirements/Limits
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	1	
Genitourinary Agents - Treatment Of Urinary Tract And Prostate Conditions		
Antispasmodics, Urinary		
darifenacin hydrobromide er oral tablet extended release 24 hour 15 mg, 7.5 mg	1	ST
fesoterodine fumarate er oral tablet extended release 24 hour 4 mg, 8 mg	1	ST
flavoxate hcl oral tablet 100 mg	1	
MYRBETRIQ ORAL SUSPENSION RECONSTITUTED ER 8 MG/ML	1	QL (300 ML per 30 days)
MYRBETRIQ ORAL TABLET EXTENDED RELEASE 24 HOUR 25 MG, 50 MG	1	QL (30 EA per 30 days)
oxybutynin chloride er oral tablet extended release 24 hour 10 mg, 15 mg, 5 mg	1	
oxybutynin chloride oral solution 5 mg/5 ml	1	
oxybutynin chloride oral tablet 5 mg	1	
solifenacin succinate oral tablet 10 mg, 5 mg	1	
tolterodine tartrate er oral capsule extended release 24 hour 2 mg, 4 mg	1	
tolterodine tartrate oral tablet 1 mg, 2 mg	1	
trospium chloride er oral capsule extended release 24 hour 60 mg	1	ST
trospium chloride oral tablet 20 mg	1	
Benign Prostatic Hypertrophy Agents		
alfuzosin hcl er oral tablet extended release 24 hour 10 mg	1	
dutasteride oral capsule 0.5 mg	1	

Name of Drug	Drug Tier	Requirements/Limits
finasteride oral tablet 5 mg	1	
tamsulosin hcl oral capsule 0.4 mg	1	
Genitourinary Agents, Other		
bethanechol chloride oral tablet 10 mg, 25 mg, 5 mg, 50 mg	1	
ELMIRON ORAL CAPSULE 100 MG	1	
FILSPARI ORAL TABLET 200 MG, 400 MG	1	PA
THIOLA EC ORAL TABLET DELAYED RELEASE 100 MG, 300 MG	1	PA
tiopronin oral tablet 100 mg	1	PA
Hormonal Agents, Stimulant/Replacement/Modifying (Adrenal) - Treatment Of Conditions Requiring Steroids		
Hormonal Agents, Stimulant/Replacement/Modifying (Adrenal)		
ACTHAR INJECTION GEL 80 UNIT/ML	1	PA
CORTROPHIN INJECTION GEL 80 UNIT/ML	1	PA
dexamethasone oral solution 0.5 mg/5 ml	1	
dexamethasone oral tablet 0.5 mg, 0.75 mg, 1 mg, 1.5 mg, 2 mg, 4 mg, 6 mg	1	
fludrocortisone acetate oral tablet 0.1 mg	1	
hydrocortisone oral tablet 10 mg, 20 mg, 5 mg	1	
methylprednisolone oral tablet 16 mg, 32 mg, 4 mg, 8 mg	1	
methylprednisolone oral tablet therapy pack 4 mg	1	
prednisolone oral solution 15 mg/5 ml	1	
prednisolone sodium phosphate oral solution 25 mg/5 ml, 6.7 (5 base) mg/5 ml	1	

Name of Drug	Drug Tier	Requirements/Limits
Hormonal Agents, Stimulant/Replacement/Modifying (Pituitary) - Treatment Of Pituitary Gland Conditions		
Hormonal Agents, Stimulant/Replacement/Modifying (Pituitary)		
desmopressin ace spray refrig nasal solution 0.01 %	1	
desmopressin acetate oral tablet 0.1 mg, 0.2 mg	1	
desmopressin acetate spray nasal solution 0.01 %	1	
EGRIFTA SV SUBCUTANEOUS SOLUTION RECONSTITUTED 2 MG	1	PA
GENOTROPIN MINIQUICK SUBCUTANEOUS PREFILLED SYRINGE 0.2 MG, 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	1	PA
GENOTROPIN SUBCUTANEOUS CARTRIDGE 12 MG, 5 MG	1	PA
HUMATROPE INJECTION CARTRIDGE 12 MG, 24 MG, 6 MG	1	PA
INCRELEX SUBCUTANEOUS SOLUTION 40 MG/4ML	1	PA
NGENLA SUBCUTANEOUS SOLUTION PEN-INJECTOR 24 MG/1.2 ML, 60 MG/1.2 ML	1	PA
NORDITROPIN FLEXPRO SUBCUTANEOUS SOLUTION PEN-INJECTOR 10 MG/1.5 ML, 15 MG/1.5 ML, 30 MG/3 ML, 5 MG/1.5 ML	1	PA
NUTROPIN AQ NUSPIN 10 SUBCUTANEOUS SOLUTION PEN-INJECTOR 10 MG/2 ML	1	PA
NUTROPIN AQ NUSPIN 20 SUBCUTANEOUS SOLUTION PEN-INJECTOR 20 MG/2 ML	1	PA
NUTROPIN AQ NUSPIN 5 SUBCUTANEOUS SOLUTION PEN-INJECTOR 5 MG/2 ML	1	PA

Name of Drug	Drug Tier	Requirements/Limits
OMNITROPE SUBCUTANEOUS SOLUTION CARTRIDGE 10 MG/1.5 ML, 5 MG/1.5 ML	1	PA
OMNITROPE SUBCUTANEOUS SOLUTION RECONSTITUTED 5.8 MG	1	PA
SEROSTIM SUBCUTANEOUS SOLUTION RECONSTITUTED 4 MG, 5 MG, 6 MG	1	PA
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	1	PA
Hormonal Agents, Stimulant/Replacement/Modifying (Sex Hormones/ Modifiers) - For The Replacement Or Modification Of Sex Hormones		
Anabolic Steroids		
oxandrolone oral tablet 10 mg, 2.5 mg	1	
Androgens		
danazol oral capsule 100 mg, 200 mg, 50 mg	1	
methyltestosterone oral capsule 10 mg	1	PA
testosterone cypionate injection solution 200 mg/ml	1	
testosterone cypionate intramuscular solution 100 mg/ml, 200 mg/ml, 200 mg/ml (1 ml)	1	
testosterone enanthate intramuscular solution 200 mg/ml	1	
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%)	1	PA
testosterone transdermal solution 30 mg/act	1	PA
Estrogens		
estradiol oral tablet 0.5 mg, 1 mg, 2 mg	1	

Name of Drug	Drug Tier	Requirements/Limits
estradiol transdermal patch twice weekly 0.025 mg/24 hr, 0.0375 mg/24 hr, 0.05 mg/2 4hr, 0.075 mg/24 hr, 0.1 mg/24 hr	1	
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	1	
estradiol vaginal cream 0.1 mg/gm	1	
estradiol vaginal tablet 10 mcg	1	
estradiol valerate intramuscular oil 10 mg/ml, 20 mg/ml, 40 mg/ml	1	
MENEST ORAL TABLET 0.3 MG, 0.625 MG, 1.25 MG, 2.5 MG	1	PA
PREMARIN ORAL TABLET 0.3 MG, 0.45 MG, 0.625 MG, 0.9 MG, 1.25 MG	1	
PREMARIN VAGINAL CREAM 0.625 MG/GM	1	
YUVAFEM VAGINAL TABLET 10 MCG	1	
Hormonal Agents, Stimulant/Replacement/Modifying (Sex Hormones/ Modifiers)		
AFIRMELLE ORAL TABLET 0.1-20 MG-MCG	1	
ALTAVERA ORAL TABLET 0.15-30 MG-MCG	1	
alyacen 1/35 oral tablet 1-35 mg-mcg	1	
alyacen 7/7/7 oral tablet 0.5/0.75/1-35 mg-mcg	1	
AMABELZ ORAL TABLET 0.5-0.1 MG	1	
APRI ORAL TABLET 0.15-30 MG-MCG	1	
ARANELLE ORAL TABLET 0.5/1/0.5-35 MG-MCG	1	
AUBRA EQ ORAL TABLET 0.1-20 MG-MCG	1	
AUROVELA 1.5/30 ORAL TABLET 1.5-30 MG-MCG	1	
AUROVELA FE 1.5/30 ORAL TABLET 1.5-30 MG-MCG	1	

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

Name of Drug	Drug Tier	Requirements/Limits
FEMYNOR ORAL TABLET 0.25-35 MG-MCG	1	
FYAVOLV ORAL TABLET 0.5-2.5 MG-MCG, 1-5 MG-MCG	1	
HAILEY 24 FE ORAL TABLET 1-20 MG-MCG (24)	1	
HAILEY FE 1.5/30 ORAL TABLET 1.5-30 MG-MCG	1	
HAILEY FE 1/20 ORAL TABLET 1-20 MG-MCG	1	
INTROVALE ORAL TABLET 0.15-0.03 MG	1	
ISIBLOOM ORAL TABLET 0.15-30 MG-MCG	1	
JINTELI ORAL TABLET 1-5 MG-MCG	1	
JULEBER ORAL TABLET 0.15-30 MG-MCG	1	
JUNEL 1.5/30 ORAL TABLET 1.5-30 MG-MCG	1	
JUNEL 1/20 ORAL TABLET 1-20 MG-MCG	1	
JUNEL FE 1.5/30 ORAL TABLET 1.5-30 MG-MCG	1	
JUNEL FE 1/20 ORAL TABLET 1-20 MG-MCG	1	
KARIVA ORAL TABLET 0.15-0.02/0.01 MG (21/5)	1	
KELNOR 1/35 ORAL TABLET 1-35 MG-MCG	1	
KELNOR 1/50 ORAL TABLET 1-50 MG-MCG	1	
KURVELO ORAL TABLET 0.15-30 MG-MCG	1	
LARIN 1.5/30 ORAL TABLET 1.5-30 MG-MCG	1	
LARIN 1/20 ORAL TABLET 1-20 MG-MCG	1	
LARIN FE 1.5/30 ORAL TABLET 1.5-30 MG-MCG	1	
LARIN FE 1/20 ORAL TABLET 1-20 MG-MCG	1	

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

Name of Drug	Drug Tier	Requirements/Limits
norethindrone acet-ethinyl est oral tablet 1-20 mg-mcg, 1.5-30 mg-mcg	1	
norethindrone-eth estradiol oral tablet 0.5-2.5 mg-mcg, 1-5 mg-mcg	1	
norethindron-ethinyl estrad-fe oral tablet 1-20/1-30/1-35 mg-mcg	1	
norgestimate-eth estradiol oral tablet 0.25-35 mg-mcg	1	
norgestim-eth estrad triphasic oral tablet 0.18/0.215/0.25 mg-35 mcg	1	
NORTREL 0.5/35 (28) ORAL TABLET 0.5-35 MG-MCG	1	
NORTREL 1/35 (21) ORAL TABLET 1-35 MG-MCG	1	
NORTREL 1/35 (28) ORAL TABLET 1-35 MG-MCG	1	
NORTREL 7/7/7 ORAL TABLET 0.5/0.75/1-35 MG-MCG	1	
NYLIA 1/35 ORAL TABLET 1-35 MG-MCG	1	
NYLIA 7/7/7 ORAL TABLET 0.5/0.75/1-35 MG-MCG	1	
OCELLA ORAL TABLET 3-0.03 MG	1	
PIMTREA ORAL TABLET 0.15-0.02/0.01 MG (21/5)	1	
PIRMELLA 1/35 ORAL TABLET 1-35 MG-MCG	1	
PORTIA-28 ORAL TABLET 0.15-30 MG-MCG	1	
PREMPHASE ORAL TABLET 0.625-5 MG	1	
PREMPRO ORAL TABLET 0.3-1.5 MG, 0.45-1.5 MG, 0.625-2.5 MG, 0.625-5 MG	1	
RECLIPSEN ORAL TABLET 0.15-30 MG-MCG	1	
SETLAKIN ORAL TABLET 0.15-0.03 MG	1	
SPRINTEC 28 ORAL TABLET 0.25-35 MG-MCG	1	
SRONYX ORAL TABLET 0.1-20 MG-MCG	1	

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

Name of Drug	Drug Tier	Requirements/Limits
LYZA ORAL TABLET 0.35 MG	1	
medroxyprogesterone acetate intramuscular suspension 150 mg/ml	1	
medroxyprogesterone acetate intramuscular suspension prefilled syringe 150 mg/ml	1	
medroxyprogesterone acetate oral tablet 10 mg, 2.5 mg, 5 mg	1	
megestrol acetate oral suspension 40 mg/ml, 400 mg/10 ml, 625 mg/5 ml, 800 mg/20 ml	1	PA
megestrol acetate oral tablet 20 mg, 40 mg	1	PA
NORA-BE ORAL TABLET 0.35 MG	1	
norethindrone acetate oral tablet 5 mg	1	
norethindrone oral tablet 0.35 mg	1	
NORLYROC ORAL TABLET 0.35 MG	1	
progesterone oral capsule 100 mg, 200 mg	1	
SHAROBEL ORAL TABLET 0.35 MG	1	
Selective Estrogen Receptor Modifying Agents		
DUAVEE ORAL TABLET 0.45-20 MG	1	
raloxifene hcl oral tablet 60 mg	1	
Hormonal Agents, Stimulant/Replacement/Modifying (Thyroid) - Treatment Of Thyroid Conditions		
Hormonal Agents, Stimulant/Replacement/Modifying (Thyroid)		
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	1	
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	1	

Name of Drug	Drug Tier	Requirements/Limits
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	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	1	
liothyronine sodium oral tablet 25 mcg, 5 mcg, 50 mcg	1	
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	1	
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	1	
Hormonal Agents, Suppressant (Pituitary) - Treatment Of Or Modification Of Pituitary Hormone Secretion		
Hormonal Agents, Suppressant (Pituitary)		
cabergoline oral tablet 0.5 mg	1	
CAMCEVI SUBCUTANEOUS PREFILLED SYRINGE 42 MG	1	PA
ELIGARD SUBCUTANEOUS KIT 22.5 MG, 30 MG, 45 MG, 7.5 MG	1	PA
FIRMAGON (240 MG DOSE) SUBCUTANEOUS SOLUTION RECONSTITUTED 120 MG/VIAL	1	PA
FIRMAGON SUBCUTANEOUS SOLUTION RECONSTITUTED 80 MG	1	PA
leuprolide acetate (3 month) intramuscular injectable 22.5 mg	1	PA
leuprolide acetate injection kit 1 mg/0.2 ml	1	
LUPRON DEPOT (1-MONTH) INTRAMUSCULAR KIT 3.75 MG, 7.5 MG	1	PA
LUPRON DEPOT (3-MONTH) INTRAMUSCULAR KIT 11.25 MG, 22.5 MG	1	PA

Name of Drug	Drug Tier	Requirements/Limits
LUPRON DEPOT (4-MONTH) INTRAMUSCULAR KIT 30 MG	1	PA
LUPRON DEPOT (6-MONTH) INTRAMUSCULAR KIT 45 MG	1	PA
MYFEMBREE ORAL TABLET 40-1-0.5 MG	1	PA
octreotide acetate injection solution 100 mcg/ml, 1000 mcg/ml, 200 mcg/ml, 50 mcg/ml, 500 mcg/ml	1	PA
octreotide acetate subcutaneous solution prefilled syringe 100 mcg/ml, 50 mcg/ml, 500 mcg/ml	1	
ORGOVYX ORAL TABLET 120 MG	1	PA
ORIAHNN ORAL CAPSULE THERAPY PACK 300-1-0.5 & 300 MG	1	PA
ORILISSA ORAL TABLET 150 MG, 200 MG	1	PA
RECORLEV ORAL TABLET 150 MG	1	PA
SIGNIFOR SUBCUTANEOUS SOLUTION 0.3 MG/ML, 0.6 MG/ML, 0.9 MG/ML	1	PA
SOMAVERT SUBCUTANEOUS SOLUTION RECONSTITUTED 10 MG, 15 MG, 20 MG, 25 MG, 30 MG	1	PA
SYNAREL NASAL SOLUTION 2 MG/ML	1	PA
TARPEYO ORAL CAPSULE DELAYED RELEASE 4 MG	1	PA
TRELSTAR MIXJECT INTRAMUSCULAR SUSPENSION RECONSTITUTED 11.25 MG, 22.5 MG, 3.75 MG	1	PA
Hormonal Agents, Suppressant (Thyroid) - Treatment For Overactive Thyroid		
Antithyroid Agents		
methimazole oral tablet 10 mg, 5 mg	1	
propylthiouracil oral tablet 50 mg	1	

Name of Drug	Drug Tier	Requirements/Limits
Immunological Agents - Medications That Alter The Immune System Including Vaccinations		
Angioedema Agents		
CINRYZE INTRAVENOUS SOLUTION RECONSTITUTED 500 UNIT	1	PA
HAEGARDA SUBCUTANEOUS SOLUTION RECONSTITUTED 2000 UNIT, 3000 UNIT	1	PA
icatibant acetate subcutaneous solution prefilled syringe 30 mg/3 ml	1	PA
ORLADEYO ORAL CAPSULE 110 MG, 150 MG	1	PA
Immunoglobulins		
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	1	B/D
GAMMAGARD S/D LESS IGA INTRAVENOUS SOLUTION RECONSTITUTED 10 GM, 5 GM	1	B/D
GAMMAKED INJECTION SOLUTION 1 GM/10 ML	1	B/D
GAMMAPLEX INTRAVENOUS SOLUTION 10 GM/100 ML, 10 GM/200 ML, 20 GM/200 ML, 5 GM/50 ML	1	B/D
GAMUNEX-C INJECTION SOLUTION 1 GM/10 ML	1	B/D
PRIVIGEN INTRAVENOUS SOLUTION 10 GM/100 ML, 20 GM/200 ML, 40 GM/400 ML, 5 GM/50 ML	1	B/D
Immunological Agents, Other		
ACTEMRA ACTPEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 162 MG/0.9 ML	1	PA
ACTEMRA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 162 MG/0.9 ML	1	PA

Name of Drug	Drug Tier	Requirements/Limits
ARCALYST SUBCUTANEOUS SOLUTION RECONSTITUTED 220 MG	1	PA
BENLYSTA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 200 MG/ML	1	PA
BENLYSTA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 200 MG/ML	1	PA
CIBINQO ORAL TABLET 100 MG, 200 MG, 50 MG	1	PA
COSENTYX (300 MG DOSE) SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML	1	PA
COSENTYX INTRAVENOUS SOLUTION 125 MG/5 ML	1	PA
COSENTYX SENSOREADY (300 MG) SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML	1	PA
COSENTYX SENSOREADY PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML	1	PA
COSENTYX SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML, 75 MG/0.5 ML	1	PA
COSENTYX UNOREADY SUBCUTANEOUS SOLUTION AUTO-INJECTOR 300 MG/2 ML	1	PA
ENTYVIO SUBCUTANEOUS SOLUTION PEN-INJECTOR 108 MG/0.68 ML	1	PA
ILARIS SUBCUTANEOUS SOLUTION 150 MG/ML	1	PA
ILUMYA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML	1	PA
KEVZARA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/1.14 ML, 200 MG/1.14 ML	1	PA
KEVZARA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/1.14 ML, 200 MG/1.14 ML	1	PA
KINERET SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/0.67 ML	1	PA

Name of Drug	Drug Tier	Requirements/Limits
LITFULO ORAL CAPSULE 50 MG	1	PA
OLUMIANT ORAL TABLET 1 MG, 2 MG, 4 MG	1	PA
ORENCIA CLICKJECT SUBCUTANEOUS SOLUTION AUTO-INJECTOR 125 MG/ML	1	PA
ORENCIA INTRAVENOUS SOLUTION RECONSTITUTED 250 MG	1	PA
ORENCIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 125 MG/ML, 50 MG/0.4 ML, 87.5 MG/0.7 ML	1	PA
RINVOQ ORAL TABLET EXTENDED RELEASE 24 HOUR 15 MG, 30 MG, 45 MG	1	PA
SILIQ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 210 MG/1.5 ML	1	PA
SKYRIZI INTRAVENOUS SOLUTION 600 MG/10 ML	1	PA
SKYRIZI PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML	1	PA
SKYRIZI SUBCUTANEOUS SOLUTION CARTRIDGE 180 MG/1.2 ML, 360 MG/2.4 ML	1	PA
SKYRIZI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML	1	PA
SOTYKTU ORAL TABLET 6 MG	1	PA
STELARA INTRAVENOUS SOLUTION 130 MG/26 ML	1	PA
STELARA SUBCUTANEOUS SOLUTION 45 MG/0.5 ML	1	PA
STELARA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 45 MG/0.5 ML, 90 MG/ML	1	PA
TALTZ SUBCUTANEOUS SOLUTION AUTO-INJECTOR 80 MG/ML	1	PA
TALTZ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 80 MG/ML	1	PA
TREMFYA SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 MG/ML	1	PA

Name of Drug	Drug Tier	Requirements/Limits
TREMFYA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML	1	PA
XELJANZ ORAL SOLUTION 1 MG/ML	1	PA
XELJANZ ORAL TABLET 10 MG, 5 MG	1	PA
XELJANZ XR ORAL TABLET EXTENDED RELEASE 24 HOUR 11 MG, 22 MG	1	PA
Immunostimulants		
ACTIMMUNE SUBCUTANEOUS SOLUTION 2000000 UNIT/0.5 ML	1	PA
INTRON A INJECTION SOLUTION RECONSTITUTED 10000000 UNIT, 18000000 UNIT, 50000000 UNIT	1	PA
PEGASYS SUBCUTANEOUS SOLUTION 180 MCG/ML	1	PA
PEGASYS SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 180 MCG/0.5 ML	1	PA
Immunosuppressants		
ASTAGRAF XL ORAL CAPSULE EXTENDED RELEASE 24 HOUR 0.5 MG, 1 MG, 5 MG	1	B/D
azathioprine oral tablet 50 mg	1	B/D
CIMZIA STARTER KIT SUBCUTANEOUS PREFILLED SYRINGE KIT 6 X 200 MG/ML	1	PA
CIMZIA SUBCUTANEOUS KIT 2 X 200 MG	1	PA
CIMZIA SUBCUTANEOUS PREFILLED SYRINGE KIT 2 X 200 MG/ML	1	PA
cyclosporine modified oral capsule 100 mg, 25 mg, 50 mg	1	B/D
cyclosporine modified oral solution 100 mg/ml	1	B/D
cyclosporine oral capsule 100 mg, 25 mg	1	B/D
ENBREL MINI SUBCUTANEOUS SOLUTION CARTRIDGE 50 MG/ML	1	PA
ENBREL SUBCUTANEOUS SOLUTION 25 MG/0.5 ML	1	PA

Name of Drug	Drug Tier	Requirements/Limits
ENBREL SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 25 MG/0.5 ML, 50 MG/ML	1	PA
ENBREL SUBCUTANEOUS SOLUTION RECONSTITUTED 25 MG	1	PA
ENBREL SURECLICK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 50 MG/ML	1	PA
ENVARSUS XR ORAL TABLET EXTENDED RELEASE 24 HOUR 0.75 MG, 1 MG, 4 MG	1	B/D
everolimus oral tablet 0.25 mg, 0.5 mg, 0.75 mg, 1 mg	1	B/D
GENGRAF ORAL CAPSULE 100 MG, 25 MG	1	B/D
GENGRAF ORAL SOLUTION 100 MG/ML	1	B/D
HADLIMA PUSHTOUCH SUBCUTANEOUS SOLUTION AUTO-INJECTOR 40 MG/0.4 ML, 40 MG/0.8 ML	1	PA
HADLIMA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/0.4 ML, 40 MG/0.8 ML	1	PA
HUMIRA (2 PEN) SUBCUTANEOUS PEN-INJECTOR KIT 40 MG/0.4 ML, 40 MG/0.8 ML, 80 MG/0.8 ML	1	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	1	PA
HUMIRA-CD/UC/HS STARTER SUBCUTANEOUS PEN-INJECTOR KIT 40 MG/0.8 ML, 80 MG/0.8 ML	1	PA
HUMIRA-PED < 40 KG CROHNS STARTER SUBCUTANEOUS PREFILLED SYRINGE KIT 80 MG/0.8 ML & 40MG/0.4 ML	1	PA
HUMIRA-PED >/= 40 KG CROHNS START SUBCUTANEOUS PREFILLED SYRINGE KIT 80 MG/0.8 ML	1	PA

Name of Drug	Drug Tier	Requirements/Limits
HUMIRA-PED >/= 40 KG UC STARTER SUBCUTANEOUS PEN-INJECTOR KIT 80 MG/0.8 ML	1	PA
HUMIRA-PS/UV/ADOL HS STARTER SUBCUTANEOUS PEN-INJECTOR KIT 40 MG/0.8 ML	1	PA
HUMIRA-PSORIASIS/UVEIT STARTER SUBCUTANEOUS PEN-INJECTOR KIT 80 MG/0.8 ML & 40MG/0.4 ML	1	PA
leflunomide oral tablet 10 mg, 20 mg	1	
LUPKYNIS ORAL CAPSULE 7.9 MG	1	PA
methotrexate sodium (pf) injection solution 50 mg/2 ml	1	
methotrexate sodium injection solution 250 mg/10 ml, 50 mg/2 ml	1	
methotrexate sodium oral tablet 2.5 mg	1	
mycophenolate mofetil oral capsule 250 mg	1	B/D
mycophenolate mofetil oral suspension reconstituted 200 mg/ml	1	B/D
mycophenolate mofetil oral tablet 500 mg	1	B/D
mycophenolate sodium oral tablet delayed release 180 mg, 360 mg	1	B/D
mycophenolic acid oral tablet delayed release 180 mg, 360 mg	1	B/D
NULOJIX INTRAVENOUS SOLUTION RECONSTITUTED 250 MG	1	B/D
PROGRAF INTRAVENOUS SOLUTION 5 MG/ML	1	B/D
PROGRAF ORAL PACKET 0.2 MG, 1 MG	1	B/D
REZUROCK ORAL TABLET 200 MG	1	PA
SANDIMMUNE ORAL SOLUTION 100 MG/ML	1	B/D
SIMPONI SUBCUTANEOUS SOLUTION AUTO-INJECTOR 100 MG/ML, 50 MG/0.5 ML	1	PA

Name of Drug	Drug Tier	Requirements/Limits
SIMPONI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML, 50 MG/0.5 ML	1	PA
sirolimus oral solution 1 mg/ml	1	B/D
sirolimus oral tablet 0.5 mg, 1 mg, 2 mg	1	B/D
tacrolimus oral capsule 0.5 mg, 1 mg, 5 mg	1	B/D
Vaccines		
ABRYSVO INTRAMUSCULAR SOLUTION RECONSTITUTED 120 MCG/0.5 ML	1	
ACTHIB INTRAMUSCULAR SOLUTION RECONSTITUTED	1	
ADACEL INTRAMUSCULAR SUSPENSION 5-2-15.5 (PREFILLED SYRINGE), 5-2-15.5 LF-MCG/0.5 ML	1	
AREXVY INTRAMUSCULAR SUSPENSION RECONSTITUTED 120 MCG/0.5 ML	1	
bcg vaccine injection solution reconstituted 50 mg	1	
BEXSERO INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE	1	
BEYFORTUS INTRAMUSCULAR SOLUTION PREFILLED SYRINGE 100 MG/ML, 50 MG/0.5 ML	1	
BOOSTRIX INTRAMUSCULAR SUSPENSION 5-2.5-18.5 LF-MCG/0.5 ML	1	
BOOSTRIX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 5-2.5-18.5 LF-MCG/0.5 ML	1	
DAPTACEL INTRAMUSCULAR SUSPENSION 23-15-5	1	
diphtheria-tetanus toxoids dt intramuscular suspension 25-5 lfu/0.5 ml	1	B/D
ENGERIX-B INJECTION SUSPENSION 20 MCG/ML	1	B/D

Name of Drug	Drug Tier	Requirements/Limits
ENGERIX-B INJECTION SUSPENSION PREFILLED SYRINGE 10 MCG/0.5 ML, 20 MCG/ML	1	B/D
GARDASIL 9 INTRAMUSCULAR SUSPENSION	1	
GARDASIL 9 INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE	1	
HAVRIX INTRAMUSCULAR SUSPENSION 1440 EL U/ML, 720 EL U/0.5 ML	1	
HEPLISAV-B INTRAMUSCULAR SOLUTION PREFILLED SYRINGE 20 MCG/0.5 ML	1	B/D
HIBERIX INJECTION SOLUTION RECONSTITUTED 10 MCG	1	
IMOVAX RABIES INTRAMUSCULAR SUSPENSION RECONSTITUTED 2.5 UNIT/ML	1	B/D
INFANRIX INTRAMUSCULAR SUSPENSION 25-58-10	1	
IPOL INJECTION INJECTABLE	1	
IXIARO INTRAMUSCULAR SUSPENSION	1	
JYNNEOS SUBCUTANEOUS SUSPENSION 0.5 ML	1	
KINRIX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.5 ML	1	
MENACTRA INTRAMUSCULAR SOLUTION	1	
MENQUADFI INTRAMUSCULAR SOLUTION	1	
MENVEO INTRAMUSCULAR SOLUTION	1	
MENVEO INTRAMUSCULAR SOLUTION RECONSTITUTED	1	
M-M-R II INJECTION SOLUTION RECONSTITUTED	1	
PEDIARIX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE	1	

Name of Drug	Drug Tier	Requirements/Limits
PEDVAX HIB INTRAMUSCULAR SUSPENSION 7.5 MCG/0.5 ML	1	
PENBRAYA INTRAMUSCULAR SUSPENSION RECONSTITUTED	1	
PENTACEL INTRAMUSCULAR SUSPENSION RECONSTITUTED	1	
PREHEVBRIO INTRAMUSCULAR SUSPENSION 10 MCG/ML	1	B/D
PRIORIX SUBCUTANEOUS SUSPENSION RECONSTITUTED	1	
PROQUAD SUBCUTANEOUS SUSPENSION RECONSTITUTED	1	
QUADRACEL INTRAMUSCULAR SUSPENSION (58 UNT/ML)	1	
QUADRACEL INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.5 ML	1	
RABAVERT INTRAMUSCULAR SUSPENSION RECONSTITUTED	1	B/D
RECOMBIVAX HB INJECTION SUSPENSION 10 MCG/ML, 40 MCG/ML, 5 MCG/0.5 ML	1	B/D
RECOMBIVAX HB INJECTION SUSPENSION PREFILLED SYRINGE 10 MCG/ML, 5 MCG/0.5 ML	1	B/D
ROTARIX ORAL SUSPENSION	1	
ROTARIX ORAL SUSPENSION RECONSTITUTED	1	
ROTATEQ ORAL SOLUTION	1	
SHINGRIX INTRAMUSCULAR SUSPENSION RECONSTITUTED 50 MCG/0.5 ML	1	QL (2 EA per 999 days)
TDVAX INTRAMUSCULAR SUSPENSION 2-2 LF/0.5 ML	1	B/D
TENIVAC INTRAMUSCULAR INJECTABLE 5-2 LFU, 5-2 LFU (INJECTION)	1	B/D
tetanus-diphtheria toxoids td intramuscular suspension 2-2 lf/0.5 ml	1	B/D

Name of Drug	Drug Tier	Requirements/Limits
TICOVAC INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 1.2 MCG/0.25 ML, 2.4 MCG/0.5 ML	1	
TRUMENBA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE	1	
TWINRIX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 720-20 ELU-MCG/ML	1	
TYPHIM VI INTRAMUSCULAR SOLUTION 25 MCG/0.5 ML	1	
TYPHIM VI INTRAMUSCULAR SOLUTION PREFILLED SYRINGE 25 MCG/0.5 ML	1	
VAQTA INTRAMUSCULAR SUSPENSION 25 UNIT/0.5 ML, 25 UNIT/0.5 ML (0.5 ML), 50 UNIT/ML, 50 UNIT/ML (1 ML)	1	
VARIVAX SUBCUTANEOUS INJECTABLE 1350 PFU/0.5 ML	1	
VAXCHORA ORAL SUSPENSION RECONSTITUTED	1	
VAXELIS INTRAMUSCULAR SUSPENSION	1	
VAXELIS INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE	1	
YF-VAX SUBCUTANEOUS INJECTABLE (2.5 ML IN 1 VIAL, MULTI-DOSE)	1	
Inflammatory Bowel Disease Agents - Treatment Of Ulcerative Colitis Or Crohn's Disease		
Aminosalicylates		
balsalazide disodium oral capsule 750 mg	1	
mesalamine oral capsule delayed release 400 mg	1	
mesalamine oral tablet delayed release 1.2 gm	1	
mesalamine rectal enema 4 gm	1	
mesalamine rectal suppository 1000 mg	1	

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
mesalamine-cleanser rectal kit 4 gm	1	
sulfasalazine oral tablet 500 mg	1	
sulfasalazine oral tablet delayed release 500 mg	1	
Glucocorticoids		
budesonide er oral tablet extended release 24 hour 9 mg	1	PA
budesonide oral capsule delayed release particles 3 mg	1	
DEXAMETHASONE INTENSOL ORAL CONCENTRATE 1 MG/ML	1	
dexamethasone oral elixir 0.5 mg/5 ml	1	
dexamethasone sodium phosphate injection solution 120 mg/30 ml, 20 mg/5 ml, 4 mg/ml	1	
hydrocortisone rectal enema 100 mg/60 ml	1	
methylprednisolone acetate injection suspension 40 mg/ml, 80 mg/ml	1	
prednisolone sodium phosphate oral solution 15 mg/5 ml	1	
PREDNISONE INTENSOL ORAL CONCENTRATE 5 MG/ML	1	
prednisone oral solution 5 mg/5 ml	1	
prednisone oral tablet 1 mg, 10 mg, 2.5 mg, 20 mg, 5 mg, 50 mg	1	
prednisone oral tablet therapy pack 10 mg (21), 10 mg (48), 5 mg (21), 5 mg (48)	1	
Metabolic Bone Disease Agents - Treatment Of Bone Diseases Including Osteoporosis		
Metabolic Bone Disease Agents		
alendronate sodium oral tablet 10 mg, 35 mg, 5 mg, 70 mg	1	
calcitonin (salmon) nasal solution 200 unit/act	1	
calcitriol oral capsule 0.25 mcg, 0.5 mcg	1	

Name of Drug	Drug Tier	Requirements/Limits
calcitriol oral solution 1 mcg/ml	1	
cinacalcet hcl oral tablet 30 mg, 60 mg	1	QL (60 EA per 30 days)
cinacalcet hcl oral tablet 90 mg	1	QL (120 EA per 30 days)
doxercalciferol oral capsule 0.5 mcg, 1 mcg, 2.5 mcg	1	
ibandronate sodium oral tablet 150 mg	1	
NATPARA SUBCUTANEOUS CARTRIDGE 100 MCG, 25 MCG, 50 MCG, 75 MCG	1	PA
paricalcitol oral capsule 1 mcg, 2 mcg, 4 mcg	1	
PROLIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 60 MG/ML	1	PA
risedronate sodium oral tablet 150 mg, 30 mg, 35 mg, 35 mg (12 pack), 35 mg (4 pack), 5 mg	1	
teriparatide (recombinant) subcutaneous solution pen-injector 620 mcg/2.48 ml	1	PA
TYMLOS SUBCUTANEOUS SOLUTION PEN-INJECTOR 3120 MCG/1.56 ML	1	PA
XGEVA SUBCUTANEOUS SOLUTION 120 MG/1.7 ML	1	PA
Ophthalmic Agents - Treatment Of Eye Conditions		
Ophthalmic Agents, Other		
atropine sulfate ophthalmic solution 1 %	1	
brimonidine tartrate-timolol ophthalmic solution 0.2-0.5 %	1	
cyclosporine ophthalmic emulsion 0.05 %	1	QL (60 EA per 30 days)
CYSTARAN OPHTHALMIC SOLUTION 0.44 %	1	PA
dorzolamide hcl-timolol mal ophthalmic solution 2-0.5 %	1	
neomycin-polymyxin-dexameth ophthalmic ointment 3.5-10000-0.1	1	

Name of Drug	Drug Tier	Requirements/Limits
neomycin-polymyxin-dexameth ophthalmic suspension 3.5-10000-0.1	1	
neomycin-polymyxin-gramicidin ophthalmic solution 1.75-10000-.025	1	
OXERVATE OPHTHALMIC SOLUTION 0.002 %	1	PA
proparacaine hcl ophthalmic solution 0.5 %	1	
sulfacetamide-prednisolone ophthalmic solution 10-0.23 %	1	
tobramycin-dexamethasone ophthalmic suspension 0.3-0.1 %	1	
Ophthalmic Anti-Allergy Agents		
azelastine hcl ophthalmic solution 0.05 %	1	
cromolyn sodium ophthalmic solution 4 %	1	
Ophthalmic Anti-Infectives		
ak-poly-bac ophthalmic ointment 500-10000 unit/gm	1	
bacitracin ophthalmic ointment 500 unit/gm	1	
bacitracin-polymyxin b ophthalmic ointment 500-10000 unit/gm	1	
ciprofloxacin hcl ophthalmic solution 0.3 %	1	
erythromycin ophthalmic ointment 5 mg/gm	1	
gentamicin sulfate ophthalmic solution 0.3 %	1	
moxifloxacin hcl ophthalmic solution 0.5 %	1	
NATACYN OPHTHALMIC SUSPENSION 5 %	1	
ofloxacin ophthalmic solution 0.3 %	1	
polymyxin b-trimethoprim ophthalmic solution 10000-0.1 unit/ml-%	1	

Name of Drug	Drug Tier	Requirements/Limits
sulfacetamide sodium ophthalmic ointment 10 %	1	
sulfacetamide sodium ophthalmic solution 10 %	1	
tobramycin ophthalmic solution 0.3 %	1	
Ophthalmic Anti-Inflammatories		
dexamethasone sodium phosphate ophthalmic solution 0.1 %	1	
diclofenac sodium ophthalmic solution 0.1 %	1	
difluprednate ophthalmic emulsion 0.05 %	1	
fluorometholone ophthalmic suspension 0.1 %	1	
flurbiprofen sodium ophthalmic solution 0.03 %	1	
ketorolac tromethamine ophthalmic solution 0.4 %, 0.5 %	1	
prednisolone acetate ophthalmic suspension 1 %	1	
prednisolone sodium phosphate ophthalmic solution 1 %	1	
Ophthalmic Beta-Adrenergic Blocking Agents		
carteolol hcl ophthalmic solution 1 %	1	
levobunolol hcl ophthalmic solution 0.5 %	1	
timolol maleate ophthalmic solution 0.25 %, 0.5 %	1	
Ophthalmic Intraocular Pressure Lowering Agents, Other		
acetazolamide er oral capsule extended release 12 hour 500 mg	1	
brimonidine tartrate ophthalmic solution 0.1 %, 0.2 %	1	
brinzolamide ophthalmic suspension 1 %	1	ST
dorzolamide hcl ophthalmic solution 2 %	1	

Name of Drug	Drug Tier	Requirements/Limits
methazolamide oral tablet 25 mg, 50 mg	1	
pilocarpine hcl ophthalmic solution 1 %, 2 %, 4 %	1	
RHOPRESSA OPHTHALMIC SOLUTION 0.02 %	1	ST
ROCKLATAN OPHTHALMIC SOLUTION 0.02-0.005 %	1	ST
SIMBRINZA OPHTHALMIC SUSPENSION 1-0.2 %	1	
Ophthalmic Prostaglandin And Prostamide Analogs		
bimatoprost ophthalmic solution 0.03 %	1	
latanoprost ophthalmic solution 0.005 %	1	
LUMIGAN OPHTHALMIC SOLUTION 0.01 %	1	
travoprost (bak free) ophthalmic solution 0.004 %	1	
ZIOPTAN OPHTHALMIC SOLUTION 0.0015 %	1	
Otic Agents - Treatment Of Ear Conditions		
Otic Agents		
acetic acid otic solution 2 %	1	
hydrocortisone-acetic acid otic solution 1-2 %	1	
neomycin-polymyxin-hc otic solution 1 %, 3.5-10000-1	1	
neomycin-polymyxin-hc otic suspension 3.5-10000-1	1	
ofloxacin otic solution 0.3 %	1	
Respiratory Tract/Pulmonary Agents - Treatment Of Breathing Conditions		
Antihistamines		
azelastine hcl nasal solution 0.1 %, 0.15 %, 137 mcg/spray	1	
cetirizine hcl oral solution 1 mg/ml, 5 mg/5 ml	1	

Name of Drug	Drug Tier	Requirements/Limits
clemastine fumarate oral tablet 2.68 mg	1	PA
cyproheptadine hcl oral syrup 2 mg/5 ml	1	PA
cyproheptadine hcl oral tablet 4 mg	1	PA
hydroxyzine hcl oral syrup 10 mg/5 ml	1	
hydroxyzine hcl oral tablet 10 mg, 25 mg, 50 mg	1	
levocetirizine dihydrochloride oral solution 2.5 mg/5 ml	1	
levocetirizine dihydrochloride oral tablet 5 mg	1	
promethazine hcl oral solution 6.25 mg/5 ml	1	PA
Anti-Inflammatories, Inhaled Corticosteroids		
ARNUITY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100 MCG/ACT, 200 MCG/ACT, 50 MCG/ACT	1	
budesonide inhalation suspension 0.25 mg/2 ml, 0.5 mg/2 ml, 1 mg/2 ml	1	B/D
flunisolide nasal solution 25 mcg/act (0.025%)	1	
fluticasone propionate diskus inhalation aerosol powder breath activated 100 mcg/act, 250 mcg/act, 50 mcg/act	1	
fluticasone propionate hfa inhalation aerosol 110 mcg/act, 220 mcg/act, 44 mcg/act	1	
fluticasone propionate nasal suspension 50 mcg/act	1	
mometasone furoate nasal suspension 50 mcg/act	1	
QVAR REDIHALER INHALATION AEROSOL BREATH ACTIVATED 40 MCG/ACT, 80 MCG/ACT	1	

Name of Drug	Drug Tier	Requirements/Limits
Bronchodilators, Anticholinergic		
ATROVENT HFA INHALATION AEROSOL SOLUTION 17 MCG/ACT	1	
INCRUSE ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 62.5 MCG/ACT	1	
ipratropium bromide inhalation solution 0.02 %	1	B/D
ipratropium bromide nasal solution 0.03 %, 0.06 %	1	
SPIRIVA RESPIMAT INHALATION AEROSOL SOLUTION 1.25 MCG/ACT, 2.5 MCG/ACT	1	
tiotropium bromide monohydrate inhalation capsule 18 mcg	1	
Bronchodilators, Sympathomimetic		
albuterol sulfate hfa inhalation aerosol solution 108 (90 base) mcg/act, 108 (90 base) mcg/act (nda020503), 108 (90 base) mcg/act (nda020983)	1	
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	1	B/D
albuterol sulfate oral syrup 2 mg/5 ml	1	
albuterol sulfate oral tablet 2 mg, 4 mg	1	
epinephrine injection solution auto-injector 0.15 mg/0.15 ml, 0.15 mg/0.3 ml, 0.3 mg/0.3 ml	1	QL (2 EA per 30 days)
formoterol fumarate inhalation nebulization solution 20 mcg/2 ml	1	B/D
levalbuterol hcl inhalation nebulization solution 0.31 mg/3 ml, 0.63 mg/3 ml, 1.25 mg/3 ml	1	B/D
SEREVENT DISKUS INHALATION AEROSOL POWDER BREATH ACTIVATED 50 MCG/ACT	1	

Name of Drug	Drug Tier	Requirements/Limits
STRIVERDI RESPIMAT INHALATION AEROSOL SOLUTION 2.5 MCG/ACT	1	
terbutaline sulfate oral tablet 2.5 mg, 5 mg	1	
VENTOLIN HFA INHALATION AEROSOL SOLUTION 108 (90 BASE) MCG/ACT	1	
Cystic Fibrosis Agents		
BRONCHITOL INHALATION CAPSULE 40 MG	1	PA
CAYSTON INHALATION SOLUTION RECONSTITUTED 75 MG	1	PA
KALYDECO ORAL PACKET 13.4 MG, 25 MG, 5.8 MG, 50 MG, 75 MG	1	PA
KALYDECO ORAL TABLET 150 MG	1	PA
ORKAMBI ORAL PACKET 100-125 MG, 150-188 MG, 75-94 MG	1	PA
ORKAMBI ORAL TABLET 100-125 MG, 200-125 MG	1	PA
PULMOZYME INHALATION SOLUTION 2.5 MG/2.5 ML	1	B/D
SYMDEKO ORAL TABLET THERAPY PACK 100-150 & 150 MG, 50-75 & 75 MG	1	PA
tobramycin inhalation nebulization solution 300 mg/5 ml	1	B/D; QL (280 ML per 56 days)
TRIKAFTA ORAL TABLET THERAPY PACK 100-50-75 & 150 MG, 50-25-37.5 & 75 MG	1	PA
TRIKAFTA ORAL THERAPY PACK 100-50-75 & 75 MG, 80-40-60 & 59.5 MG	1	PA
Mast Cell Stabilizers		
cromolyn sodium inhalation nebulization solution 20 mg/2 ml	1	B/D
cromolyn sodium oral concentrate 100 mg/5 ml	1	
Phosphodiesterase Inhibitors, Airways Disease		
roflumilast oral tablet 250 mcg, 500 mcg	1	

Name of Drug	Drug Tier	Requirements/Limits
theophylline er oral tablet extended release 12 hour 100 mg, 200 mg, 300 mg, 450 mg	1	
theophylline er oral tablet extended release 24 hour 400 mg, 600 mg	1	
theophylline oral elixir 80 mg/15 ml	1	
theophylline oral solution 80 mg/15 ml	1	
Pulmonary Antihypertensives		
ADEMPAS ORAL TABLET 0.5 MG, 1 MG, 1.5 MG, 2 MG, 2.5 MG	1	PA
ambrisentan oral tablet 10 mg, 5 mg	1	PA
bosentan oral tablet 125 mg, 62.5 mg	1	PA
sildenafil citrate oral suspension reconstituted 10 mg/ml	1	PA
sildenafil citrate oral tablet 20 mg	1	PA
tadalafil (pah) oral tablet 20 mg	1	PA
TADLIQ ORAL SUSPENSION 20 MG/5 ML	1	PA
TYVASO DPI MAINTENANCE KIT INHALATION POWDER 112 X 32 MCG & 112 X48 MCG, 16 MCG, 32 MCG, 48 MCG, 64 MCG	1	PA
TYVASO DPI TITRATION KIT INHALATION POWDER 112 X 16 MCG & 84 X 32 MCG, 16 & 32 & 48 MCG	1	PA
UPTRAVI ORAL TABLET 1000 MCG, 1200 MCG, 1400 MCG, 1600 MCG, 200 MCG, 400 MCG, 600 MCG, 800 MCG	1	PA
UPTRAVI TITRATION ORAL TABLET THERAPY PACK 200 & 800 MCG	1	PA
VENTAVIS INHALATION SOLUTION 10 MCG/ML, 20 MCG/ML	1	PA
Pulmonary Fibrosis Agents		
OFEV ORAL CAPSULE 100 MG, 150 MG	1	PA
pirfenidone oral capsule 267 mg	1	PA

Name of Drug	Drug Tier	Requirements/Limits
pirfenidone oral tablet 267 mg, 534 mg, 801 mg	1	PA
Respiratory Tract Agents, Other		
acetylcysteine inhalation solution 10 %, 20 %	1	B/D
ADVAIR HFA INHALATION AEROSOL 115-21 MCG/ACT, 230-21 MCG/ACT, 45-21 MCG/ACT	1	
ANORO ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 62.5-25 MCG/ACT	1	
BEVESPI AEROSPHERE INHALATION AEROSOL 9-4.8 MCG/ACT	1	
BREO ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100-25 MCG/ACT, 200-25 MCG/ACT, 50-25 MCG/INH	1	
BREZTRI AEROSPHERE INHALATION AEROSOL 160-9-4.8 MCG/ACT	1	
budesonide-formoterol fumarate inhalation aerosol 160-4.5 mcg/act, 80-4.5 mcg/act	1	
COMBIVENT RESPIMAT INHALATION AEROSOL SOLUTION 20-100 MCG/ACT	1	
DUPIXENT SUBCUTANEOUS SOLUTION PEN-INJECTOR 200 MG/1.14 ML, 300 MG/2 ML	1	PA
DUPIXENT SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/0.67 ML, 200 MG/1.14 ML, 300 MG/2 ML	1	PA
FASENRA PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 30 MG/ML	1	PA
FASENRA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 30 MG/ML	1	PA
fluticasone furoate-vilanterol inhalation aerosol powder breath activated 100-25 mcg/act, 200-25 mcg/act	1	

Name of Drug	Drug Tier	Requirements/Limits
fluticasone-salmeterol inhalation aerosol 115-21 mcg/act, 230-21 mcg/act, 45-21 mcg/act	1	
fluticasone-salmeterol inhalation aerosol powder breath activated 100-50 mcg/act, 113-14 mcg/act, 232-14 mcg/act, 250-50 mcg/act, 500-50 mcg/act, 55-14 mcg/act	1	
ipratropium-albuterol inhalation solution 0.5-2.5 (3) mg/3ml	1	B/D
montelukast sodium oral packet 4 mg	1	
montelukast sodium oral tablet 10 mg	1	
montelukast sodium oral tablet chewable 4 mg, 5 mg	1	
NUCALA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 100 MG/ML	1	PA
NUCALA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML, 40 MG/0.4 ML	1	PA
NUCALA SUBCUTANEOUS SOLUTION RECONSTITUTED 100 MG	1	PA
promethazine vc oral syrup 6.25-5 mg/5 ml	1	PA
promethazine-phenylephrine oral syrup 6.25-5 mg/5 ml	1	PA
STIOLTO RESPIMAT INHALATION AEROSOL SOLUTION 2.5-2.5 MCG/ACT	1	
TRELEGY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100-62.5-25 MCG/ACT, 200-62.5-25 MCG/ACT	1	
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	1	PA

Name of Drug	Drug Tier	Requirements/Limits
XOLAIR SUBCUTANEOUS SOLUTION RECONSTITUTED 150 MG	1	PA
Skeletal Muscle Relaxants - Treatment Of Muscle Tightness		
Skeletal Muscle Relaxants		
carisoprodol oral tablet 250 mg, 350 mg	1	PA; QL (90 EA per 30 days)
chlorzoxazone oral tablet 500 mg	1	PA; QL (180 EA per 30 days)
cyclobenzaprine hcl oral tablet 10 mg, 5 mg	1	QL (90 EA per 30 days)
metaxalone oral tablet 800 mg	1	PA; QL (120 EA per 30 days)
methocarbamol oral tablet 500 mg, 750 mg	1	PA
orphenadrine citrate er oral tablet extended release 12 hour 100 mg	1	PA
Sleep Disorder Agents - Treatment Of Insomnia		
Sleep Promoting Agents		
doxepin hcl oral tablet 3 mg, 6 mg	1	QL (30 EA per 30 days)
eszopiclone oral tablet 1 mg, 2 mg, 3 mg	1	PA; QL (30 EA per 30 days)
HETLIOZ LQ ORAL SUSPENSION 4 MG/ML	1	PA
ramelteon oral tablet 8 mg	1	QL (30 EA per 30 days)
tasimelteon oral capsule 20 mg	1	PA
temazepam oral capsule 15 mg, 22.5 mg, 30 mg, 7.5 mg	1	PA; QL (30 EA per 30 days)
zaleplon oral capsule 10 mg, 5 mg	1	PA; QL (30 EA per 30 days)
zolpidem tartrate er oral tablet extended release 12.5 mg, 6.25 mg	1	PA; QL (30 EA per 30 days)
zolpidem tartrate oral tablet 10 mg	1	PA; QL (30 EA per 30 days)
zolpidem tartrate oral tablet 5 mg	1	QL (30 EA per 30 days)
Wakefulness Promoting Agents		
armodafinil oral tablet 150 mg, 200 mg, 250 mg, 50 mg	1	PA
modafinil oral tablet 100 mg, 200 mg	1	PA
sodium oxybate oral solution 500 mg/ml	1	PA

Name of Drug	Drug Tier	Requirements/Limits
XYREM ORAL SOLUTION 500 MG/ML	1	PA
XYWAV ORAL SOLUTION 500 MG/ML	1	PA

Index

A

abacavir sulfate 53
abacavir sulfate-lamivudine 53
ABELCET 32
ABILIFY ASIMTUFII 47
ABILIFY MAINTENA 47
abiraterone acetate 36
ABRYSVO 115
acamprosate calcium 15
acarbose 57
acebutolol hcl 72
acetaminophen-codeine 13
acetazolamide 74
acetazolamide er 122
acetic acid 123
acetylcysteine 128
acitretin 84
ACTEMRA 109
ACTEMRA ACTPEN 109
ACTHAR 97
ACTHIB 115
ACTIMMUNE 112
acyclovir 52, 89
acyclovir sodium 52
ADACEL 115
adapalene 84
adapalene-benzoyl peroxide 84
adefovir dipivoxil 51
ADEMPAS 127
ADMELOG 61
ADMELOG SOLOSTAR 61
ADVAIR HFA 128
AFIRMELLE 100
AFREZZA 61
AIMOVIG 34
AKEEGA 37
ak-poly-bac 121
albendazole 44
albuterol sulfate 125
albuterol sulfate hfa 125
alclometasone dipropionate 85
alcohol 88
ALCOHOL 88
ALECENSA 38
alendronate sodium 119
alfuzosin hcl er 96
aliskiren fumarate 74
allopurinol 34
alosetron hcl 93
alprazolam 56
ALPRAZOLAM INTENSOL 56
ALTAVERA 100
ALUNBRIG 39
alyacen 1/35 100
alyacen 7/7/7 100
AMABELZ 100
amantadine hcl 45
ambrisentan 127
amikacin sulfate 16
amiloride hcl 76
amiloride-hydrochlorothiazide 74
amiodarone hcl 71
amitriptyline hcl 30
amlodipine besy-benazepril hcl 74
amlodipine besylate 73
amlodipine besylate-valsartan 74
amlodipine-atorvastatin 74
amlodipine-olmesartan 74
amlodipine-valsartan-hctz 74
ammonium lactate 85
AMNESTEEM 84
amoxapine 30
amoxicillin 20
amoxicillin-pot clavulanate 20
amoxicillin-pot clavulanate er 20
amphetamine-dextroamphet er 79
amphetamine-dextroamphetamine 79
amphotericin b 32
amphotericin b liposome 32
ampicillin 20
ampicillin sodium 20
ampicillin-sulbactam sodium 20
anagrelide hcl 68
anastrozole 38
ANORO ELLIPTA 128
APIDRA 61
APIDRA SOLOSTAR 61
apomorphine hcl 45
aprepitant 32
APRI 100
APTIOM 27
APTIVUS 55
ARALAST NP 94
ARANELLE 100
ARANESP (ALBUMIN FREE) 68
ARCALYST 110
AREXVY 115
aripiprazole 47
ARISTADA 47, 48
ARISTADA INITIO 47
armodafinil 130
ARNUITY ELLIPTA 124
ASCOMP-CODEINE 11
asenapine maleate 48
aspirin-dipyridamole er 69
ASTAGRAF XL 112
atazanavir sulfate 55
atenolol 72
atenolol-chlorthalidone 74
atomoxetine hcl 80
atorvastatin calcium 77
atovaquone 44
atovaquone-proguanil hcl 44
atropine sulfate 120
ATROVENT HFA 125
AUBRA EQ 100

AUGTYRO 39
AUROVELA 1.5/30 100
AUROVELA FE 1.5/30 100
AUROVELA FE 1/20 101
AUSTEDO 81
AUSTEDO PATIENT TITRATION KIT 81
AUVELITY 28
AVIANE 101
AYUNA 101
AYVAKIT 39
azathioprine 112
azelastine hcl 121, 123
azithromycin 22
aztreonam 16

B

BAC 11
bacitracin 121
bacitracin-polymyxin b 121
baclofen 51
BAFIERTAM 82
balsalazide disodium 118
BALVERSA 39
BALZIVA 101
BAQSIMI ONE PACK 60
BAQSIMI TWO PACK 60
BARACLUDE 51
BASAGLAR KWIKPEN 61
BASAGLAR TEMPO PEN 61
bcg vaccine 115
benazepril hcl 71
benazepril-hydrochlorothiazide 75
BENLYSTA 110
benzoyl peroxide-erythromycin 84
benztropine mesylate 45
BESREMI 37
betaine 94
betamethasone dipropionate 85
betamethasone dipropionate aug 85
betamethasone valerate 85
BETASERON 82
betaxolol hcl 72
bethanechol chloride 97
BEVESPI AEROSPHERE 128
bexarotene 44
BEXSERO 115
BEYFORTUS 115
bicalutamide 36
BICILLIN L-A 21
BIKTARVY 54
bimatoprost 123
bisoprolol fumarate 72
bisoprolol-hydrochlorothiazide 75
BLISOVI FE 1.5/30 101
BLISOVI FE 1/20 101
BOOSTRIX 115
bosentan 127
BOSULIF 39
BRAFTOVI 39
BREO ELLIPTA 128
BREZTRI AEROSPHERE 128
briellyn 101
BRILINTA 70
brimonidine tartrate 122
brimonidine tartrate-timolol 120
brinzolamide 122
BRIVIACT 24
bromocriptine mesylate 45
BRONCHITOL 126
BRUKINSA 39
budesonide 119, 124
budesonide er 119
budesonide-formoterol fumarate 128
bumetanide 76
buprenorphine 12
buprenorphine hcl 15
buprenorphine hcl-naloxone hcl 15
bupropion hcl 28
bupropion hcl er (smoking det) 15
bupropion hcl er (sr) 28
bupropion hcl er (xl) 28
buspirone hcl 56
butalbital-acetaminophen 11
butalbital-apap-caff-cod 11
butalbital-apap-caffeine 11
butalbital-asa-caff-codeine 11
butalbital-aspirin-caffeine 11
butorphanol tartrate 13

C

cabergoline 107
CABOMETYX 39
calcipotriene 88
calcitonin (salmon) 119
calcitriol 88, 119, 120
calcium acetate (phos binder) 92
CALQUENCE 39
CAMCEVI 107
CAMILA 105
CAMZYOS 75
candesartan cilexetil 70
candesartan cilexetil-hctz 75
CAPLYTA 48
CAPRELSA 39
captopril 71
carbamazepine 27
carbamazepine er 27
carbidopa 46
carbidopa-levodopa 46
carbidopa-levodopa er 46
carbidopa-levodopa-entacapone 45
carglumic acid 90
carisoprodol 130
carteolol hcl 122
CARTIA XT 73
carvedilol 72
caspofungin acetate 32
CAYSTON 126
cefaclor 18
cefaclor er 18
cefadroxil 18

cefazolin sodium 18
cefazolin sodium-dextrose 18
cefdinir 18
cefepime hcl 18
cefepime-dextrose 18
cefixime 18
cefotaxime sodium 18
cefoxitin sodium 19
cefoxitin sodium-dextrose 19
cefpodoxime proxetil 19
cefprozil 19
ceftazidime 19
ceftazidime and dextrose 19
ceftriaxone sodium 19
ceftriaxone sodium in dextrose 19
ceftriaxone sodium-dextrose 19
cefuroxime axetil 19
cefuroxime sodium 19
celecoxib 11
cephalexin 19, 20
CERDELGA 94
cetirizine hcl 123
cevimeline hcl 84
CHATEAL EQ 101
chlorhexidine gluconate 84
chloroquine phosphate 44
chlorpromazine hcl 31
chlorthalidone 77
chlorzoxazone 130
CHOLBAM 94
cholestyramine 78
cholestyramine light 77, 78
CIBINQO 110
ciclopirox 89
ciclopirox olamine 89
cilostazol 70
CIMDUO 53
cimetidine 94
cimetidine hcl 94
CIMZIA 112
CIMZIA STARTER KIT 112
cinacalcet hcl 120
CINRYZE 109
ciprofloxacin hcl 22, 121
ciprofloxacin in d5w 22
citalopram hydrobromide 29
CLARAVIS 84
clarithromycin 22
clarithromycin er 22
clemastine fumarate ... 124
clindamycin hcl 16
clindamycin palmitate hcl 16
clindamycin phos-benzoyl perox 84
clindamycin phosphate 17, 89
clindamycin phosphate in d5w 16
clindamycin phosphate in nacl 17
CLINISOL SF 91
clobazam 25
clobetasol prop emollient base 85
clobetasol propionate ... 86
clobetasol propionate e 85
clomipramine hcl 30
clonazepam 56
clonidine 70
clonidine hcl 70
clonidine hcl er 80
clopidogrel bisulfate 70
clorazepate dipotassium 56
clotrimazole 32
clotrimazole-betamethasone 88
clozapine 50, 51
COARTEM 44
colchicine 34
colchicine-probenecid ... 34
colesevelam hcl 78
colestipol hcl 78
colistimethate sodium (cba) 17
COMBIPATCH 101
COMBIVENT RESPIMAT 128
COMETRIQ (100 MG DAILY DOSE) 39
COMETRIQ (140 MG DAILY DOSE) 39
COMETRIQ (60 MG DAILY DOSE) 39
COMPLERA 54
constulose 92
COPIKTRA 39
CORLANOR 75
CORTROPHIN 97
COSENTYX 110
COSENTYX (300 MG DOSE) 110
COSENTYX SENSOREADY (300 MG) 110
COSENTYX SENSOREADY PEN 110
COSENTYX UNOREADY 110
COTELLIC 39
CREON 95
cromolyn sodium 121, 126
CRYSELLE-28 101
CUVRIOR 91
cyclobenzaprine hcl 130
cyclophosphamide 36
cyclosporine 112, 120
cyclosporine modified ... 112
cyproheptadine hcl 124
CYRED EQ 101
CYSTAGON 95
CYSTARAN 120

D

dalfampridine er 82
danazol 99
dantrolene sodium 51
dapsone 35
DAPTACEL 115
daptomycin 17
darifenacin hydrobromide er 96
darunavir 55
DAURISMO 39
DEBLITANE 105

deferasirox 91
deferasirox granules 91
deferiprone 91
DELSTRIGO 54
DEPO-SUBQ PROVERA 104 105
DESCOVY 53
desipramine hcl 30
desmopressin ace spray refrig 98
desmopressin acetate ... 98
desmopressin acetate spray 98
desogestrel-ethinyl estradiol 101
desonide 86
desoximetasone 86
desvenlafaxine succinate er 29
dexamethasone 97, 119
DEXAMETHASONE INTENSOL 119
dexamethasone sodium phosphate 119, 122
DEXILANT 94
dexlansoprazole 94
dexmethylphenidate hcl 80
dexmethylphenidate hcl er 80
dextroamphetamine sulfate 80
dextroamphetamine sulfate er 80
dextrose 91
dextrose-nacl 91
dextrose-sodium chloride 91
DIACOMIT 24
diazepam 26, 57
DIAZEPAM INTENSOL 57
diazoxide 60
dichlorphenamide 95
diclofenac potassium 11
diclofenac sodium 11, 122
diclofenac sodium er 11
dicloxacillin sodium 21
dicyclomine hcl 93
DIFICID 22
diflunisal 11
difluprednate 122
digoxin 75
dihydroergotamine mesylate 34
DILANTIN 27
diltiazem hcl 74
diltiazem hcl er 73, 74
diltiazem hcl er beads ... 73
diltiazem hcl er coated beads 73
dilt-xr 74
dimethyl fumarate 82
dimethyl fumarate starter pack 82
diphenoxylate-atropine 93
diphtheria-tetanus toxoids dt 115
dipyridamole 70
disopyramide phosphate 71
disulfiram 15
divalproex sodium 24
divalproex sodium er 24
dofetilide 71
donepezil hcl 28
DOPTELET 70
dorzolamide hcl 122
dorzolamide hcl-timolol mal 120
DOVATO 54
doxazosin mesylate 70
doxepin hcl 31, 86, 130
doxercalciferol 120
DOXY 100 23
doxycycline hyclate 23
doxycycline monohydrate 23
dronabinol 32
drospirenone-ethinyl estradiol 101
DROXIA 37
droxidopa 70
DUAVEE 106
duloxetine hcl 82
DUPIXENT 128
dutasteride 96

E

ec-naproxen 11
econazole nitrate 32
EDURANT 53
efavirenz 53
efavirenz-emtricitab-tenofo df 54
efavirenz-lamivudine-tenofovir 54
EGRIFTA SV 98
ELIGARD 107
ELIQUIS 67
ELIQUIS DVT/PE STARTER PACK 67
ELMIRON 97
ELURYNG 101
EMCYT 37
EMEND 32
EMGALITY 34
EMGALITY (300 MG DOSE) 34
EMSAM 29
emtricitabine 53
emtricitabine-tenofovir df 53
EMTRIVA 53
enalapril maleate 71
enalapril-hydrochlorothiazide ... 75
ENBREL 112, 113
ENBREL MINI 112
ENBREL SURECLICK 113
ENDARI 95
ENDOCET 13
ENGERIX-B 115, 116
enoxaparin sodium 67
ENPRESSE-28 101
ENSKYCE 101
entacapone 45
entecavir 51
ENTRESTO 75
ENTYVIO 110
enulose 92
ENVARSUS XR 113
EPIDIOLEX 24

epinephrine 125
EPITOL 27
EPIVIR HBV 51
eplerenone 76
EPOGEN 68
EPRONTIA 24
EQUETRO 57
ergotamine-caffeine 34
ERIVEDGE 39
ERLEADA 36
erlotinib hcl 39
ERRIN 105
ertapenem sodium 21
ery 89
ERYTHROCIN LACTOBIONATE 22
ERYTHROCIN STEARATE 22
erythromycin 89, 121
erythromycin base 22
erythromycin ethylsuccinate 22
escitalopram oxalate 29
esomeprazole magnesium 94
ESTARYLLA 101
estradiol 99, 100
estradiol valerate 100
estradiol-norethindrone acet 101
eszopiclone 130
ethambutol hcl 35
ethosuximide 25
ethynodiol diac-eth estradiol 101
etodolac 12
etodolac er 12
etonogestrel-ethinyl estradiol 101
etravirine 53
EUCRISA 86
EUTHYROX 106
everolimus 39, 40, 113
EVOTAZ 54
EVRYSDI 81
exemestane 38
EXKIVITY 40
EXTAVIA 82
ezetimibe 78
ezetimibe-rosuvastatin 78
ezetimibe-simvastatin 78

F

FALMINA 101
famciclovir 52
famotidine 94
FANAPT 48
FANAPT TITRATION PACK 48
FARXIGA 57
FASENRA 128
FASENRA PEN 128
febuxostat 34
felbamate 24
felodipine er 73
FEMYNOR 102
fenofibrate 77
fenofibrate micronized 77
fenofibric acid 77
fentanyl 13
fentanyl citrate 13
fesoterodine fumarate er 96
FETZIMA 29
FETZIMA TITRATION 29
FIASP 61
FIASP FLEXTOUCH 61
FIASP PENFILL 61
FILSPARI 97
finasteride 97
fingolimod hcl 82
FINTEPLA 24
FIRDAPSE 81
FIRMAGON 107
FIRMAGON (240 MG DOSE) 107
flavoxate hcl 96
flecainide acetate 71
fluconazole 33
fluconazole in sodium chloride 33
flucytosine 33
fludrocortisone acetate 97
flunisolide 124
fluocinolone acetonide 86
fluocinonide 86
fluocinonide emulsified base 86
fluorometholone 122
fluorouracil 88
fluoxetine hcl 29, 30
fluphenazine decanoate 46
fluphenazine hcl 46
flurbiprofen 12
flurbiprofen sodium 122
fluticasone furoate-vilanterol 128
fluticasone propionate 86, 124
fluticasone propionate diskus 124
fluticasone propionate hfa 124
fluticasone-salmeterol 129
fluvoxamine maleate 30
fondaparinux sodium 67
formoterol fumarate 125
fosamprenavir calcium 55
fosinopril sodium 71
fosinopril sodium-hctz 75
FOTIVDA 40
FRAGMIN 67
FRUZAQLA 40
FULPHILA 68
furosemide 76
FUZEON 54
FYAVOLV 102
FYCOMPA 24
FYLNETRA 68

G

gabapentin 26
GALAFOLD 95
galantamine hydrobromide 28
galantamine hydrobromide er 28
GAMMAGARD 109
GAMMAGARD S/D LESS IGA 109
GAMMAKED 109
GAMMAPLEX 109

GAMUNEX-C.....109
GARDASIL 9.....116
GATTEX.....93
gauze.....61
GAUZE.....61
GAVILYTE-C.....92
GAVILYTE-G.....92
GAVRETO.....40
gefitinib.....40
gemfibrozil.....77
generlac.....92
GENGRAF.....113
GENOTROPIN.....98
GENOTROPIN MINIQUICK.....98
gentamicin in saline.....16
gentamicin sulfate...16, 89, 121
GENVOYA.....54
GILOTRIF.....40
GLASSIA.....95
glatiramer acetate.....82
GLATOPA.....82
GLEOSTINE.....36
glimepiride.....57
glipizide.....58
glipizide er.....57
glipizide xl.....58
*glipizide-metformin hcl*58
GLUCAGEN HYPOKIT.....60
glucagon emergency.....60
glyburide.....58
glyburide micronized.....58
glyburide-metformin.....58
glycopyrrolate.....93
GLYXAMBI.....58
GOCOVRI.....45
granisetron hcl.....32
griseofulvin microsize.....33
guanfacine hcl.....70
guanfacine hcl er.....80

H

HADLIMA.....113
HADLIMA PUSHTOUCH113
HAEGARDA.....109
HAILEY 24 FE.....102
HAILEY FE 1.5/30.....102
HAILEY FE 1/20.....102
*halobetasol propionate*87
haloperidol.....47
haloperidol decanoate.47
haloperidol lactate.....47
HAVRIX.....116
heparin sodium (porcine).....67
HEPLISAV-B.....116
HETLIOZ LQ.....130
HIBERIX.....116
HUMALOG.....61, 62
HUMALOG JUNIOR KWIKPEN.....61
HUMALOG KWIKPEN.....61
HUMALOG MIX 50/50.....62
HUMALOG MIX 50/50 KWIKPEN.....62
HUMALOG MIX 75/25.....62
HUMALOG MIX 75/25 KWIKPEN.....62
HUMALOG TEMPO PEN62
HUMATROPE.....98
HUMIRA (2 PEN).....113
HUMIRA (2 SYRINGE).....113
HUMIRA-CD/UC/HS STARTER.....113
HUMIRA-PED<40KG CROHNS STARTER.....113
HUMIRA-PED>/=40KG CROHNS START.....113
HUMIRA-PED>/=40KG UC STARTER.....114
HUMIRA-PS/UV/ADOL HS STARTER.....114
HUMIRA-PSORIASIS/UVEIT STARTER.....114
HUMULIN 70/30.....62
HUMULIN 70/30 KWIKPEN.....62
HUMULIN N.....62
HUMULIN N KWIKPEN..62
HUMULIN R.....62
HUMULIN R U-500 (CONCENTRATED).....62
HUMULIN R U-500 KWIKPEN.....62
hydralazine hcl.....78
hydrochlorothiazide.....77
hydrocodone-acetaminophen.....13
hydrocodone-ibuprofen 13
hydrocortisone....87, 97, 119
hydrocortisone (perianal).....87
hydrocortisone butyr lipo base.....87
hydrocortisone butyrate.....87
hydrocortisone valerate.....87
hydrocortisone-acetic acid.....123
hydromorphone hcl.....13
hydromorphone hcl pf... 14
hydroxychloroquine sulfate.....44
hydroxyurea.....37
hydroxyzine hcl.....124
hydroxyzine pamoate....56
HYFTOR.....87

I

ibandronate sodium.....120
IBRANCE.....40
IBU.....12
ibuprofen.....12
icatibant acetate.....109
ICLUSIG.....40
icosapent ethyl.....78
IDHIFA.....37
ILARIS.....110
ILUMYA.....110
imatinib mesylate.....40
IMBRUVICA.....40
imipenem-cilastatin.....21
imipramine hcl.....31
imipramine pamoate.....31
imiquimod.....88
IMOVAX RABIES.....116
INCASSIA.....105
INCRELEX.....98
INCRUSE ELLIPTA.....125

indapamide 77
indomethacin 12
indomethacin er 12
INFANRIX 116
INGREZZA 81
INLYTA 40
INQOVI 37
INREBIC 40
insulin asp prot & asp flexpen 62
insulin aspart 63
insulin aspart flexpen 62
insulin aspart penfill 63
insulin aspart prot & aspart 63
insulin degludec 63
insulin degludec flextouch 63
insulin glargine 63
insulin glargine max solostar 63
insulin glargine solostar 63
insulin glargine-yfgn 63
insulin lispro 63
insulin lispro (1 unit dial) 63
insulin lispro junior kwikpen 63
insulin lispro prot & lispro 63
insulin syringe 64
INSULIN SYRINGE 64
INTELENCE 53
INTRALIPID 91
INTRON A 112
INTROVALE 102
INVEGA SUSTENNA 48
INVEGA TRINZA 48, 49
IPOL 116
ipratropium bromide 125
ipratropium-albuterol 129
irbesartan 70
irbesartan-hydrochlorothiazide 75
ISENTRESS 52
ISENTRESS HD 52
ISIBLOOM 102
ISOLYTE-P IN D5W 91
ISOLYTE-S 90
ISOLYTE-S PH 7.4 90
isoniazid 35
isosorb dinitrate-hydralazine 79
isosorbide dinitrate 79
isosorbide mononitrate 79
isosorbide mononitrate er 79
isotretinoin 84
isradipine 73
itraconazole 33
ivermectin 44
IXIARO 116

J

JAKAFI 40
JANTOVEN 67
JANUMET 58
JANUMET XR 58
JANUVIA 58
JARDIANCE 58
JAYPIRCA 40
JENTADUETO 58
JENTADUETO XR 59
JINTELI 102
JULEBER 102
JULUCA 54
JUNEL 1.5/30 102
JUNEL 1/20 102
JUNEL FE 1.5/30 102
JUNEL FE 1/20 102
JYNNEOS 116

K

KALYDECO 126
KARIVA 102
kcl in dextrose-nacl 90
KELNOR 1/35 102
KELNOR 1/50 102
KERENDIA 75
KESIMPTA 82
ketoconazole 33
ketorolac tromethamine 12, 122
KEVZARA 110
KINERET 110
KINRIX 116
KISQALI (200 MG DOSE) 40
KISQALI (400 MG DOSE) 40
KISQALI (600 MG DOSE) 40
KISQALI FEMARA (200 MG DOSE) 37
KISQALI FEMARA (400 MG DOSE) 37
KISQALI FEMARA (600 MG DOSE) 37
KLOR-CON 90
KLOR-CON 10 90
KLOR-CON M10 90
KLOR-CON M15 90
KLOR-CON M20 90
KORLYM 61
KOSELUGO 40
KRAZATI 37
KURVELO 102

L

labetalol hcl 72
lacosamide 27
lactulose 92
lactulose encephalopathy 92
LAGEVRIO 56
lamivudine 51
lamivudine-zidovudine 53
lamotrigine 24
lamotrigine er 24
lamotrigine starter kit-blue 24
lamotrigine starter kit-green 24
lamotrigine starter kit-orange 25
lansoprazole 94
lanthanum carbonate 92
LANTUS 64
LANTUS SOLOSTAR 64
lapatinib ditosylate 41
LARIN 1.5/30 102
LARIN 1/20 102
LARIN FE 1.5/30 102
LARIN FE 1/20 102

latanoprost 123
LEENA 103
leflunomide 114
lenalidomide 36
LENVIMA (10 MG DAILY DOSE) 41
LENVIMA (12 MG DAILY DOSE) 41
LENVIMA (14 MG DAILY DOSE) 41
LENVIMA (18 MG DAILY DOSE) 41
LENVIMA (20 MG DAILY DOSE) 41
LENVIMA (24 MG DAILY DOSE) 41
LENVIMA (4 MG DAILY DOSE) 41
LENVIMA (8 MG DAILY DOSE) 41
LESSINA 103
letrozole 38
leucovorin calcium 44
LEUKERAN 36
LEUKINE 68
leuprolide acetate 107
leuprolide acetate (3 month) 107
levalbuterol hcl 125
LEVEMIR 64
LEVEMIR FLEXPEN 64
LEVEMIR FLEXTOUCH 64
levetiracetam 25
levetiracetam er 25
levobunolol hcl 122
levocarnitine 91
levocarnitine sf 91
levocetirizine dihydrochloride 124
levofloxacin 22, 23
levofloxacin in d5w 22
LEVONEST 103
levonorgest-eth estrad 91-day 103
levonorgestrel-ethinyl estrad 103
levonorg-eth estrad triphasic 103
LEVORA 0.15/30 (28) 103
LEVO-T 106
levothyroxine sodium 107
LEVOXYL 107
LEXIVA 55
lidocaine 14
lidocaine hcl 14
lidocaine hcl urethral/mucosal 14
lidocaine viscous hcl 14
lidocaine-prilocaine 14
linezolid 17
linezolid in sodium chloride 17
LINZESS 93
liothyronine sodium 107
lisinopril 71
lisinopril-hydrochlorothiazide 75
LITFULO 111
lithium 57
lithium carbonate 57
lithium carbonate er 57
LIVMARLI 93
LODOCO 75
LOKELMA 92
LONSURF 37
loperamide hcl 93
lopinavir-ritonavir 55
lorazepam 57
LORAZEPAM INTENSOL 57
LORBRENA 41
losartan potassium 70
losartan potassium-hctz 75
lovastatin 77
LOW-OGESTREL 103
loxapine succinate 47
lubiprostone 93
LUCEMYRA 15
LUMAKRAS 37
LUMIGAN 123
LUPKYNIS 114
LUPRON DEPOT (1-MONTH) 107
LUPRON DEPOT (3-MONTH) 107
LUPRON DEPOT (4-MONTH) 108
LUPRON DEPOT (6-MONTH) 108
lurasidone hcl 49
LUTERA 103
LYBALVI 49
LYNPARZA 41
LYSODREN 37
LYTGOBI (12 MG DAILY DOSE) 41
LYTGOBI (16 MG DAILY DOSE) 41
LYTGOBI (20 MG DAILY DOSE) 41
LYUMJEV 64
LYUMJEV KWIKPEN 64
LYUMJEV TEMPO PEN 64
LYZA 106

M

magnesium sulfate 90
malathion 89
maraviroc 54
marlissa 103
MARPLAN 29
MATULANE 36
MAVENCLAD (10 TABS) 83
MAVENCLAD (4 TABS) 83
MAVENCLAD (5 TABS) 83
MAVENCLAD (6 TABS) 83
MAVENCLAD (7 TABS) 83
MAVENCLAD (8 TABS) 83
MAVENCLAD (9 TABS) 83
MAVYRET 52
MAYZENT 83
MAYZENT STARTER PACK 83
meclizine hcl 31
meclofenamate sodium 12
medroxyprogesterone acetate 106
mefloquine hcl 44
megestrol acetate 106
MEKINIST 41
MEKTOVI 41

meloxicam 12
memantine hcl 28
memantine hcl er 28
MENACTRA 116
MENEST 100
MENQUADFI 116
MENVEO 116
mercaptopurine 37
meropenem 21
meropenem-sodium chloride 21
mesalamine 118
mesalamine-cleanser 119
MESNEX 44
metaxalone 130
metformin hcl 59
metformin hcl er 59
methadone hcl 13
methazolamide 123
methenamine hippurate 17
methimazole 108
methocarbamol 130
methotrexate sodium 114
methotrexate sodium (pf) 114
methoxsalen rapid 88
methsuximide 25
methylphenidate hcl 81
methylphenidate hcl er 81
methylphenidate hcl er (cd) 80
methylphenidate hcl er (la) 80
methylphenidate hcl er (osm) 80
methylphenidate hcl er (xr) 81
methylprednisolone 97
methylprednisolone acetate 119
methyltestosterone 99
metoclopramide hcl 31
metolazone 77
metoprolol succinate er 72
metoprolol tartrate 72
metoprolol-hydrochlorothiazide 75
metronidazole 17, 89
metyrosine 75
mexiletine hcl 71
micafungin sodium 33
MICROGESTIN 1.5/30 103
MICROGESTIN 1/20 103
MICROGESTIN 24 FE 103
MICROGESTIN FE 1.5/30 103
MICROGESTIN FE 1/20 103
midodrine hcl 70
mifepristone 61
miglustat 95
MILI 103
MIMVEY 103
minocycline hcl 23
minoxidil 79
mirtazapine 28, 29
misoprostol 94
M-M-R II 116
m-natal plus 92
modafinil 130
moexipril hcl 71
molindone hcl 47
mometasone furoate 87, 124
montelukast sodium 129
morphine sulfate 14
morphine sulfate (concentrate) 14
morphine sulfate er 13
MOUNJARO 59
MOVANTIK 93
moxifloxacin hcl 23, 121
moxifloxacin hcl in nacl 23
MULTAQ 72
mupirocin 89
mycophenolate mofetil 114
mycophenolate sodium 114
mycophenolic acid 114
MYFEMBREE 108
MYORISAN 84
MYRBETRIQ 96

N

nabumetone 12
nadolol 72
nafcillin sodium 21
nafcillin sodium in dextrose 21
nalbuphine hcl 11
naloxone hcl 15
naltrexone hcl 15
naproxen 12
naproxen sodium 12
NATACYN 121
nateglinide 59
NATPARA 120
NAYZILAM 26
nebivolol hcl 72
NECON 0.5/35 (28) 103
nefazodone hcl 30
neomycin sulfate 16
neomycin-polymyxin-dexameth 120, 121
neomycin-polymyxin-gramicidin 121
neomycin-polymyxin-hc 123
NERLYNX 41
NEULASTA 68
NEULASTA ONPRO 68
NEUPRO 45
nevirapine 53
nevirapine er 53
NEXLETOL 75
NEXLIZET 75
NGENLA 98
niacin er (antihyperlipidemic) 78
NICOTROL 15
NICOTROL NS 15
nifedipine 73
nifedipine er 73
nifedipine er osmotic release 73
nilutamide 36
nimodipine 73
NINLARO 38
nitazoxanide 44
nitisinone 95

NITRO-BID 79
NITRO-DUR 79
nitrofurantoin macrocrystal 17
nitrofurantoin monohyd macro 17
nitroglycerin 79
NORA-BE 106
NORDITROPIN FLEXPRO 98
norelgestromin-eth estradiol 103
norethin ace-eth estrad-fe 103
norethindrone 106
norethindrone acetate 106
norethindrone acet-ethinyl est 104
norethindrone-eth estradiol 104
norethindron-ethinyl estrad-fe 104
norgestimate-eth estradiol 104
norgestim-eth estrad triphasic 104
NORLYROC 106
NORPACE CR 72
NORTREL 0.5/35 (28) 104
NORTREL 1/35 (21) 104
NORTREL 1/35 (28) 104
NORTREL 7/7/7 104
nortriptyline hcl 31
NORVIR 55
NOVOLIN 70/30 65
NOVOLIN 70/30 FLEXPEN 65
NOVOLIN 70/30 FLEXPEN RELION 65
NOVOLIN 70/30 RELION 65
NOVOLIN N 65
NOVOLIN N FLEXPEN 65
NOVOLIN N FLEXPEN RELION 65
NOVOLIN N RELION 65
NOVOLIN R 65
NOVOLIN R FLEXPEN 65
NOVOLIN R FLEXPEN RELION 65
NOVOLIN R RELION 65
NOVOLOG 66
NOVOLOG 70/30 FLEXPEN RELION 65
NOVOLOG FLEXPEN 65
NOVOLOG FLEXPEN RELION 65
NOVOLOG MIX 70/30 66
NOVOLOG MIX 70/30 FLEXPEN 66
NOVOLOG MIX 70/30 RELION 66
NOVOLOG PENFILL 66
NOVOLOG RELION 66
NUBEQA 36
NUCALA 129
NUEDEXTA 81
NULOJIX 114
NUPLAZID 49
NURTEC 34
NUTRILIPID 92
NUTROPIN AQ NUSPIN 10 98
NUTROPIN AQ NUSPIN 20 98
NUTROPIN AQ NUSPIN 5 98
NYLIA 1/35 104
NYLIA 7/7/7 104
nystatin 33
nystatin-triamcinolone 88
NYVEPRIA 68

O

OCALIVA 93
OCELLA 104
octreotide acetate 108
ODEFSEY 54
ODOMZO 41
OFEV 127
ofloxacin 23, 121, 123
OGSIVEO 41
OJJAARA 38
olanzapine 49
olmesartan medoxomil .71
olmesartan medoxomil-hctz 75
olmesartan-amlodipine-hctz 76
OLUMIANT 111
omega-3-acid ethyl esters 78
omeprazole 94
OMNITROPE 99
ondansetron 32
ondansetron hcl 32
ONGENTYS 45
ONUREG 37
ORENCIA 111
ORENCIA CLICKJECT 111
ORFADIN 95
ORGOVYX 108
ORIAHNN 108
ORILISSA 108
ORKAMBI 126
ORLADEYO 109
orphenadrine citrate er 130
ORSERDU 38
oseltamivir phosphate .55, 56
OTEZLA 88
oxandrolone 99
OXBRYTA 68
oxcarbazepine 27
OXERVATE 121
oxybutynin chloride 96
oxybutynin chloride er 96
oxycodone hcl 14
oxycodone hcl er 13
oxycodone-acetaminophen 14
OZEMPIC (0.25 OR 0.5 MG/DOSE) 59
OZEMPIC (1 MG/DOSE) ..59
OZEMPIC (2 MG/DOSE) .59

P

paliperidone er 49
PANRETIN 44
pantoprazole sodium 94
paricalcitol 120
paromomycin sulfate 16

paroxetine hcl 30
paroxetine hcl er 30
PAXLOVID (150/100) 56
PAXLOVID (300/100) 56
pazopanib hcl 41
PEDIARIX 116
PEDVAX HIB 117
peg 3350-kcl-na bicarb-nacl 93
peg-3350/electrolytes 93
PEGASYS 112
PEMAZYRE 42
pen needles 66
PEN NEEDLES 66
PENBRAYA 117
penciclovir 89
penicillamine 91
penicillin g procaine 21
penicillin g sodium 21
penicillin v potassium 21
PENTACEL 117
pentamidine isethionate 44
pentazocine-naloxone hcl 14
pentoxifylline er 76
perindopril erbumine 71
permethrin 89
perphenazine 31
perphenazine-amitriptyline 29
PERSERIS 49
phenelzine sulfate 29
phenobarbital 26
phenoxybenzamine hcl 70
phenytoin 27
PHENYTOIN INFATABS 27
phenytoin sodium extended 27
PIFELTRO 53
pilocarpine hcl 84, 123
pimecrolimus 87
pimozide 47
PIMTREA 104
pindolol 73
pioglitazone hcl 59
pioglitazone hcl-metformin hcl 59
piperacillin sod-tazobactam so 21
PIQRAY (200 MG DAILY DOSE) 42
PIQRAY (250 MG DAILY DOSE) 42
PIQRAY (300 MG DAILY DOSE) 42
pirfenidone 127, 128
PIRMELLA 1/35 104
piroxicam 12
PLENAMINE 92
podofilox 88
polymyxin b sulfate 17
polymyxin b-trimethoprim 121
POMALYST 36
PONVORY 83
PONVORY STARTER PACK 83
PORTIA-28 104
posaconazole 33
potassium chloride 90
potassium chloride crys er 90
potassium chloride er ... 90
potassium citrate er 90
PRALUENT 78
pramipexole dihydrochloride 46
pramipexole dihydrochloride er 46
prasugrel hcl 70
pravastatin sodium 77
praziquantel 44
prazosin hcl 70
prednicarbate 87
prednisolone 97
prednisolone acetate ... 122
prednisolone sodium phosphate 97, 119, 122
prednisone 119
PREDNISONE INTENSOL 119
pregabalin 26
PREHEVBRIO 117
PREMARIN 100
PREMPHASE 104
PREMPRO 104
prenatal 92
pretomanid 35
PREVALITE 78
PREVYMIS 51
PREZCOBIX 54
PREZISTA 55
PRIFTIN 35
primaquine phosphate 44
primidone 26
PRIORIX 117
PRIVIGEN 109
probenecid 34
prochlorperazine 31
prochlorperazine maleate 31
PROCRIT 69
progesterone 106
PROGRAF 114
PROLASTIN-C 95
PROLIA 120
PROMACTA 69
promethazine hcl 31, 124
promethazine vc 129
promethazine-phenylephrine 129
PROMETHEGAN 32
propafenone hcl 72
propafenone hcl er 72
proparacaine hcl 121
propranolol hcl 73
propranolol hcl er 73
propylthiouracil 108
PROQUAD 117
protriptyline hcl 31
PULMOZYME 126
PURIXAN 37
pyrazinamide 35
pyridostigmine bromide 35
pyridostigmine bromide er 35
pyrimethamine 45
PYRUKYND 69

PYRUKYND TAPER PACK 69
Q
QINLOCK 42
QUADRACEL 117
quetiapine fumarate 49
quetiapine fumarate er 49
quinapril hcl 71
quinapril-hydrochlorothiazide ... 76
quinidine gluconate er .. 72
quinidine sulfate 72
quinine sulfate 45
QVAR REDIHALER 124
R
RABAVERT 117
RADICAVA ORS 82
RADICAVA ORS STARTER KIT 82
raloxifene hcl 106
ramelteon 130
ramipril 71
ranolazine er 76
rasagiline mesylate 46
RAVICTI 95
REBIF 83
REBIF REBIDOSE 83
REBIF REBIDOSE TITRATION PACK 83
REBIF TITRATION PACK 83
RECLIPSEN 104
RECOMBIVAX HB 117
RECORLEV 108
RECTIV 79
REGRANEX 88
RELENZA DISKHALER 56
RELISTOR 93
RELYVRIO 82
repaglinide 59
REPATHA 78
REPATHA PUSHTRONEX SYSTEM 78
REPATHA SURECLICK 78
RETACRIT 69
RETEVMO 42
REVLIMID 36
REXULTI 49
REYATAZ 55
REZLIDHIA 38
REZUROCK 114
REZVOGLAR KWIKPEN 66
RHOPRESSA 123
ribavirin 52
rifabutin 35
rifampin 36
riluzole 82
rimantadine hcl 56
RINVOQ 111
risedronate sodium 120
RISPERDAL CONSTA 49
risperidone 50
risperidone microspheres er 50
ritonavir 55
rivastigmine 28
rivastigmine tartrate 28
rizatriptan benzoate 35
ROCKLATAN 123
roflumilast 126
ropinirole hcl 46
ropinirole hcl er 46
rosuvastatin calcium 77
ROTARIX 117
ROTATEQ 117
ROWEEPRA 25
ROZLYTREK 42
RUBRACA 42
rufinamide 27
RUKOBIA 54
RYBELSUS 59
RYDAPT 42
RYKINDO 50
RYLAZE 38
S
SANDIMMUNE 114
SANTYL 88
sapropterin dihydrochloride 95
SAVELLA 82
SAVELLA TITRATION PACK 82
SCEMBLIX 42
scopolamine 32
SECUADO 50
selegiline hcl 46
selenium sulfide 87
SELZENTRY 54
SEMGLEE (YFGN) 66
SEREVENT DISKUS 125
SEROSTIM 99
sertraline hcl 30
SETLAKIN 104
sevelamer carbonate 92
SHAROBEL 106
SHINGRIX 117
SIGNIFOR 108
sildenafil citrate 127
SILIQ 111
silver sulfadiazine 88
SIMBRINZA 123
SIMPONI 114, 115
simvastatin 77
sirolimus 115
SIRTURO 36
SKYRIZI 111
SKYRIZI PEN 111
SKYTROFA 99
sodium chloride 89, 91
sodium chloride (pf) 91
sodium fluoride 91
sodium oxybate 130
sodium phenylbutyrate 95
sodium polystyrene sulfonate 92
sofosbuvir-velpatasvir 52
solifenacin succinate 96
SOLIQUA 66
SOLTAMOX 37
SOMAVERT 108
sorafenib tosylate 42
sotalol hcl 72
sotalol hcl (af) 72
SOTYKTU 111
SPIRIVA RESPIMAT 125
spironolactone 77
spironolactone-hctz 76
SPRINTEC 28 104
SPRITAM 25
SPRYCEL 42
SPS 92
SRONYX 104

STELARA 111
STIOLTO RESPIMAT 129
STIVARGA 42
streptomycin sulfate 16
STRIBILD 54
STRIVERDI RESPIMAT .. 126
SUCRAID 95
sucralfate 94
sulfacetamide sodium 122
sulfacetamide sodium (acne) 23
sulfacetamide-prednisolone 121
sulfadiazine 23
sulfamethoxazole-trimethoprim 23
sulfasalazine 119
sulindac 12
sumatriptan 35
sumatriptan succinate . 35
sumatriptan succinate refill 35
sunitinib malate 42
SUNLENCA 54
SYMDEKO 126
SYMLINPEN 120 60
SYMLINPEN 60 60
SYMPAZAN 26
SYMTUZA 55
SYNAREL 108
SYNJARDY 60
SYNJARDY XR 60
SYNTHROID 107

T

TABLOID 37
TABRECTA 42
tacrolimus 87, 115
tadalafil (pah) 127
TADLIQ 127
TAFINLAR 42
TAGRISSO 42
TALTZ 111
TALZENNA 42
tamoxifen citrate 37
tamsulosin hcl 97
TARINA FE 1/20 EQ 105
TARPEYO 108
TASCENSO ODT 83
TASIGNA 42
tasimelteon 130
TAVNEOS 69
tazarotene 84
TAZORAC 85
TAZVERIK 42
TDVAX 117
TEFLARO 20
telmisartan 71
telmisartan-amlodipine 76
telmisartan-hctz 76
temazepam 130
TENIVAC 117
tenofovir disoproxil fumarate 51
TEPMETKO 42
terazosin hcl 70
terbinafine hcl 33
terbutaline sulfate 126
terconazole 33
teriflunomide 83
teriparatide (recombinant) 120
testosterone 99
testosterone cypionate . 99
testosterone enanthate 99
tetanus-diphtheria toxoids td 117
tetrabenazine 82
tetracycline hcl 23
THALOMID 36
theophylline 127
theophylline er 127
THIOLA EC 97
thioridazine hcl 47
thiothixene 47
tiagabine hcl 26
TIBSOVO 38
TICE BCG 38
TICOVAC 118
timolol maleate 73, 122
tinidazole 17
tiopronin 97
tiotropium bromide monohydrate 125
TIVICAY 52
TIVICAY PD 52
tizanidine hcl 51
tobramycin 122, 126
tobramycin sulfate 16
tobramycin-dexamethasone 121
tolterodine tartrate 96
tolterodine tartrate er 96
tolvaptan 91
topiramate 25
toremifene citrate 37
torsemide 76
TOUJEO MAX SOLOSTAR 66
TOUJEO SOLOSTAR 66
TRADJENTA 60
tramadol hcl 14
tramadol-acetaminophen 14
trandolapril 71
tranexamic acid 69
tranylcypromine sulfate 29
travoprost (bak free) 123
trazodone hcl 30
TRECATOR 36
TRELEGY ELLIPTA 129
TRELSTAR MIXJECT 108
TREMFYA 111, 112
TRESIBA 67
TRESIBA FLEXTOUCH 66
tretinoin 44, 85
TRI FEMYNOR 105
triamcinolone acetonide 84, 87, 88
triamcinolone in absorbase 88
triamterene-hctz 76
trientine hcl 91
TRI-ESTARYLLA 105
trifluoperazine hcl 47
trifluridine 52
trihexyphenidyl hcl 45
TRIKAFTA 126

TRI-LEGEST FE 105
trimethobenzamide hcl 32
trimethoprim 17
TRI-MILI 105
trimipramine maleate ... 31
trinatal rx 1 92
TRINTELLIX 30
TRI-SPRINTEC 105
TRIUMEQ 55
TRIUMEQ PD 55
TRIVORA (28) 105
TRI-VYLIBRA 105
TRIZIVIR 53
trospium chloride 96
trospium chloride er 96
TRULICITY 60
TRUMENBA 118
TRUQAP 43
TRUSELTIQ (100MG DAILY DOSE) 43
TRUSELTIQ (125MG DAILY DOSE) 43
TRUSELTIQ (50MG DAILY DOSE) 43
TRUSELTIQ (75MG DAILY DOSE) 43
TUKYSA 43
TURALIO 43
TWINRIX 118
TYBOST 55
TYMLOS 120
TYPHIM VI 118
TYVASO DPI MAINTENANCE KIT 127
TYVASO DPI TITRATION KIT 127

U

UBRELVY 34
UDENYCA 69
UDENYCA ONBODY 69
UNITHROID 107
UPTRAVI 127
UPTRAVI TITRATION 127
ursodiol 93, 94
UZEDY 50

V

valacyclovir hcl 52
VALCHLOR 36
valganciclovir hcl 51
valproic acid 25
valsartan 71
valsartan-hydrochlorothiazide ... 76
VALTOCO 10 MG DOSE .. 26
VALTOCO 15 MG DOSE .. 26
VALTOCO 20 MG DOSE . 26
VALTOCO 5 MG DOSE 26
vancomycin hcl 18
VANFLYTA 43
VAQTA 118
varenicline tartrate 16
varenicline tartrate (starter) 15
varenicline tartrate(continue) 16
VARIVAX 118
VAXCHORA 118
VAXELIS 118
VELIVET 105
VEMLIDY 51
VENCLEXTA 43
VENCLEXTA STARTING PACK 43
venlafaxine hcl 30
venlafaxine hcl er 30
VENTAVIS 127
VENTOLIN HFA 126
verapamil hcl 74
verapamil hcl er 74
VERQUVO 76
VERSACLOZ 51
VERZENIO 43
VICTOZA 60
VIENVA 105
vigabatrin 26
VIJOICE 43
vilazodone hcl 30
VIRACEPT 55
VIREAD 52
VITRAKVI 43
VIZIMPRO 43
VOCABRIA 52
VONJO 43
voriconazole 33, 34
VOSEVI 52
VOWST 94
VRAYLAR 50
VYFEMLA 105
VYLIBRA 105

W

warfarin sodium 67
WELIREG 38
WIXELA INHUB 129

X

XALKORI 43
XARELTO 67, 68
XARELTO STARTER PACK 68
XATMEP 38
XCOPRI 25
XCOPRI (250 MG DAILY DOSE) 25
XCOPRI (350 MG DAILY DOSE) 25
XELJANZ 112
XELJANZ XR 112
XERMELO 93
XGEVA 120
XIFAXAN 93
XIGDUO XR 60
XOLAIR 129, 130
XOSPATA 43
XPOVIO (100 MG ONCE WEEKLY) 38
XPOVIO (40 MG ONCE WEEKLY) 38
XPOVIO (40 MG TWICE WEEKLY) 38
XPOVIO (60 MG ONCE WEEKLY) 38
XPOVIO (60 MG TWICE WEEKLY) 38
XPOVIO (80 MG ONCE WEEKLY) 38
XPOVIO (80 MG TWICE WEEKLY) 38
XTAMPZA ER 13
XTANDI 36
XULANE 105
XULTOPHY 67
XURIDEN 95

XYREM 131
XYWAV 131
Y
YF-VAX 118
YONSA 36
YUVAFEM 100
Z
ZAFEMY 105
zaleplon 130
ZARXIO 69
ZAVZPRET 34
ZEJULA 43
ZELBORAF 44
ZEMAIRA 95
ZENATANE 85
ZENPEP 96
ZEPOSIA 84
ZEPOSIA 7-DAY STARTER PACK 84
ZEPOSIA STARTER KIT .. 84
zidovudine 53
ZIEXTENZO 69
ZIOPTAN 123
ziprasidone hcl 50
ziprasidone mesylate 50
ZOLINZA 38
zolpidem tartrate 130
zolpidem tartrate er 130
ZONISADE 27
zonisamide 28
ZOVIA 1/35 (28) 105
ZTALMY 26
ZTLIDO 15
ZURZUVAE 29
ZYDELIG 44
ZYKADIA 44
ZYPREXA RELPREVV 50

ABILIFY ASIMTUFII

Products Affected

- ABILIFY ASIMTUFII

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	The member has a documented history of receiving oral aripiprazole without any clinically significant side effects.
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 (e.g. intolerance, hypersensitivity or contraindication) for not using Abilify Maintena.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

ACITRETIN

Products Affected

- *acitretin*

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

ACTEMRA

Products Affected

- ACTEMRA ACTPEN
- ACTEMRA SUBCUTANEOUS

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 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
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

ACTHAR

Products Affected

- ACTHAR

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	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.
Age Restrictions	N/A
Prescriber Restrictions	Specialist for submitted diagnosis.
Coverage Duration	MS exacerbation: 1 month. Other conditions: new start for 3 months and reauth end of contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

PA Criteria	Criteria Details
Part B Prerequisite	No

ACTIMMUNE

Products Affected

- ACTIMMUNE

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

ADEMPAS

Products Affected

- ADEMPAS

PA Criteria	Criteria Details
Exclusion Criteria	Concomitant use with PDE inhibitor or nitrate therapy
Required Medical Information	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.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a pulmonologist or cardiologist.
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

ALPHA-1 PROTEINASE INHIBITORS

Products Affected

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

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

AMBRISENTAN

Products Affected

- *ambrisentan*

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Documentation of pulmonary arterial hypertension (PAH) WHO Group I classification and PAH Functional Class.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a pulmonologist or cardiologist.
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

APOMORPHINE

Products Affected

- *apomorphine hcl subcutaneous*

PA Criteria	Criteria Details
Exclusion Criteria	Concomitant use with serotonin 5-HT3 receptor antagonists.
Required Medical Information	Reviewer will verify available patient claim history to confirm patient is not using 5-HT3 receptor antagonists.
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	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.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

ARCALYST

Products Affected

- ARCALYST

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 deficiency of interleukein-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.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

ARISTADA

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
Exclusion Criteria	N/A
Required Medical Information	The member has a documented history of receiving oral aripiprazole without any clinically significant side effects.
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 Abilify Maintena.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

AUVELITY

Products Affected

- AUVELITY

PA Criteria	Criteria Details
Exclusion Criteria	Seizure disorder
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 two generic antidepressants.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

AZTREONAM LYSINE

Products Affected

- CAYSTON

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a pulmonologist, infectious disease specialist, or an expert in the treatment of cystic fibrosis.
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

BENLYSTA

Products Affected

- BENLYSTA SUBCUTANEOUS

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a rheumatologist, nephrologist, or specialist in the treatment of autoimmune disorders.
Coverage Duration	New starts will be authorized for 6 months. Cont of therapy or reauth until end of contract year.
Other Criteria	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).
Indications	All Medically-accepted Indications.

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

BESREMI

Products Affected

- BESREMI

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

BOSENTAN

Products Affected

- *bosentan*

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Documentation of pulmonary arterial hypertension (PAH) WHO Group I classification and PAH Functional Class.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a pulmonologist or cardiologist.
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

BUDESONIDE ER 9 MG

Products Affected

- *budesonide er oral tablet extended release 24 hour*

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 for 8 weeks.
Other Criteria	Patient must have a documented trial of, contraindication to, or medical reason for not using sulfasalazine, balsalazide, or an oral mesalamine product.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

CAMZYOS

Products Affected

- CAMZYOS

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 cardiologist.
Coverage Duration	New starts will be authorized for 6 months. Cont of therapy or reauth until end of contract year.
Other Criteria	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

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

CARGLUMIC ACID

Products Affected

- *carglumic acid oral tablet soluble*

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

CASPOFUNGIN

Products Affected

- *caspofungin acetate*

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Documentation of a consultation with an infectious disease 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

CERDELGA

Products Affected

- CERDELGA

PA Criteria	Criteria Details
Exclusion Criteria	Patients with undetermined CYP2D6 metabolizer status.
Required Medical Information	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).
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a specialist in treatment of Gaucher's disease.
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

CGRP ANTAGONISTS

Products Affected

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

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 6 months. Cont of therapy or reauth until end of contract year.
Other Criteria	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

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

CHOLBAM

Products Affected

- CHOLBAM

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	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
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a hepatologist, gastroenterologist, or metabolic specialist
Coverage Duration	New starts will be authorized for 3 months. Cont of therapy or reauth until end of contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

CIBINQO

Products Affected

- CIBINQO

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 atopic dermatitis: Trial of, contraindication to, or medical reason for not using Rinvoq
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

CIMZIA

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

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

CORLANOR

Products Affected

- CORLANOR

PA Criteria	Criteria Details
Exclusion Criteria	Blood pressure less than 90/50 mmHg
Required Medical Information	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
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a cardiologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	Trial of, contraindication to, or medical reason for not receiving a beta blocker.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

CORTROPHIN

Products Affected

- CORTROPHIN

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	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.
Age Restrictions	N/A
Prescriber Restrictions	Specialist for submitted diagnosis.
Coverage Duration	MS exacerbation: 1 month. Other conditions: new start for 3 months and reauth end of contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

COSENTYX

Products Affected

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

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 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.

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

CYSTAGON

Products Affected

- CYSTAGON

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

CYSTARAN

Products Affected

- CYSTARAN

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Documentation of diagnosis for cystinosis with corneal cystine crystal accumulation.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an ophthalmologist or metabolic disease 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

DALFAMPRIDINE ER

Products Affected

- *dalfampridine er*

PA Criteria	Criteria Details
Exclusion Criteria	History of seizure or moderate/severe renal impairment (CrCl less than or equal to 50 mL/min).
Required Medical Information	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.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be 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

DEFERASIROX

Products Affected

- *deferasirox*
- *deferasirox granules*

PA Criteria	Criteria Details
Exclusion Criteria	Creatinine clearance less than 40 mL/min or platelet counts less than 50,000/mm3.
Required Medical Information	For all indications: platelet count greater than or equal to 50,000/mm3 (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).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	For deferasirox granules oral packets, the member must have medical reason for not using deferasirox tablets or oral soluble tablets.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

DEFERIPRONE

Products Affected

- *deferiprone*

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 new starts: 1) serum ferritin level above 1,000 mcg/L and absolute neutrophil count (ANC) greater than 1.5x10^9/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.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

DIACOMIT

Products Affected

- DIACOMIT

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

DICHLORPHENAMIDE

Products Affected

- *dichlorphenamide*

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 geneticist, neurologist, or endocrinologist.
Coverage Duration	New starts will be authorized for 2 months. Cont of therapy or reauth until end of contract year.
Other Criteria	Continuation of therapy or reauthorization: documentation of clinical improvement with therapy.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

DIFICID

Products Affected

- DIFICID

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 for 10 days.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

DOPTELET

Products Affected

- DOPTELET

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

DOXEPIN CREAM

Products Affected

- *doxepin hcl external*

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 for 1 month.
Other Criteria	Trial of, contraindication to, or medical reason for not using a topical corticosteroid or topical calcineurin inhibitor.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

DUPIXENT

Products Affected

- DUPIXENT

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	New starts will be authorized for 6 months. Cont of therapy or reauth until end of contract year.
Other Criteria	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

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

EGRIFTA

Products Affected

- EGRIFTA SV

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Documentation of active antiretroviral therapy for at least 8 weeks.
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

EMSAM

Products Affected

- EMSAM

PA Criteria	Criteria Details
Exclusion Criteria	concomitant use with SSRIs, SNRIs, clomipramine and imipramine, meperidine, tramadol, methadone, pentazocine, and propoxyphene, and the antitussive agent dextromethorphan or carbamazepine
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 new starts: Trial of, contraindication to, or medical reason for not using two generic antidepressants.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	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
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 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.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

ENDARI

Products Affected

- ENDARI

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Documentation that two or more painful sickle cell crises have occurred in the past 12 months.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a hematologist.
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 hydroxyurea for at least three months.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

ENTYVIO

Products Affected

- ENTYVIO SUBCUTANEOUS

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 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.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

EPIDIOLEX

Products Affected

- EPIDIOLEX

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a neurologist.
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 one generic anticonvulsant for appropriate indications.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

EPRONTIA

Products Affected

- EPRONTIA

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	The request will be authorized until the end of the contract year.
Other Criteria	Documented trial of, contraindication to, or medical reason for not using topiramate.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	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
Exclusion Criteria	N/A
Required Medical Information	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).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized for 6 months.
Other Criteria	N/A
Indications	All Medically-accepted Indications.

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

EUCRISA

Products Affected

- EUCRISA

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a dermatologist, immunologist or an allergist.
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 topical tacrolimus or pimecrolimus.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

EVRYSDI

Products Affected

- EVRYSDI

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	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 1 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).
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a neurologist.
Coverage Duration	New starts will be authorized for 6 months. Cont of therapy or reauth until end of contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

FASENRA

Products Affected

- FASENRA
- FASENRA 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	New starts will be authorized for 6 months. Cont of therapy or reauth until end of contract year.
Other Criteria	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.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

FENTANYL CITRATE TRANSMUCOSAL PRODUCTS

Products Affected

- *fentanyl citrate buccal lozenge on a handle*

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	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.
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

FILSPARI

Products Affected

- FILSPARI

PA Criteria	Criteria Details
Exclusion Criteria	Coadministration with renin-angiotensin-aldosterone system (RAAS) inhibitors, endothelin receptor antagonists, or aliskiren
Required Medical Information	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(2) and proteinuria. For continuation of therapy or reauthorization: Documentation of positive clinical response (ie. decrease in urine protein-to-creatinine ratio (UPCR)).
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a nephrologist.
Coverage Duration	New starts will be authorized for 9 months. Cont of therapy or reauth until end of contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

FINTEPLA

Products Affected

- FINTEPLA

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a neurologist.
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 one generic anticonvulsant for appropriate indications.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

FIRDAPSE

Products Affected

- FIRDAPSE

PA Criteria	Criteria Details
Exclusion Criteria	History of seizures.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be 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

FLUCYTOSINE

Products Affected

- *flucytosine oral*

PA Criteria	Criteria Details
Exclusion Criteria	Complete dihydropyrimidine dehydrogenase (DPD) enzyme deficiency
Required Medical Information	Attestation member is taking in combination with amphotericin B.
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

FLUOROURACIL

Products Affected

- *fluorouracil external cream 0.5 %*

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 dermatologist or oncologist.
Coverage Duration	Request will be authorized for 12 weeks.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

GALAFOLD

Products Affected

- GALAFOLD

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

GATTEX

Products Affected

- GATTEX

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	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).
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a gastroenterologist.
Coverage Duration	New starts will be authorized for 6 months. Cont of therapy or reauth until end of contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

GNRH AGONISTS

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
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 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.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

GOCOVRI

Products Affected

- GOCOVRI

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	New starts will be authorized for 3 months. Cont of therapy or reauth until end of contract year.
Other Criteria	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).
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	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
Exclusion Criteria	N/A
Required Medical Information	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.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be an endocrinologist or nephrologist.
Coverage Duration	New starts will be authorized for 6 months. Cont of therapy or reauth until end of contract year.
Other Criteria	For new starts for growth hormone deficiency: 1) If the request is not for Genotropin, trial of, contraindication to, or

PA Criteria	Criteria Details
	medical reason for not using Genotropin. For requests for all other medically accepted indications other than growth hormone deficiency, the request will be approved for products other than Skytrofa.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

HADLIMA

Products Affected

- HADLIMA
- HADLIMA PUSHTOUCH

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: 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, sulfsalazine, 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.
Indications	All Medically-accepted Indications.

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

HEREDITARY ANGIOEDEMA AGENTS

Products Affected

- CINRYZE
- HAEGARDA
- ORLADEYO

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

HETLIOZ

Products Affected

- HETLIOZ LQ
- *tasimelteon*

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	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
Age Restrictions	N/A
Prescriber Restrictions	Provider is a sleep specialist or 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

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
Exclusion Criteria	N/A
Required Medical Information	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.
Age Restrictions	Prior authorization only applies to members 65 years old or older.
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	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
Exclusion Criteria	N/A
Required Medical Information	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.
Age Restrictions	Prior authorization only applies to members 65 years old or older.
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

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
Exclusion Criteria	N/A
Required Medical Information	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.
Age Restrictions	Prior authorization only applies to members 65 years old or older.
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 an oral NSAID.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	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
Exclusion Criteria	N/A
Required Medical Information	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.
Age Restrictions	Prior authorization only applies to members 65 years old or older.
Prescriber Restrictions	N/A
Coverage Duration	New starts will be authorized for 30 days. Continuation of therapy or reauth will be for 90 days.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

HIGH RISK MEDICATION, SLEEP AGENTS

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	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.
Age Restrictions	Prior authorization only applies to members 65 years old or older.
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

HUMIRA

Products Affected

- HUMIRA (2 PEN)
- 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
- HUMIRA-CD/UC/HS STARTER
- HUMIRA-PED < 40 KG CROHNS STARTER
- HUMIRA-PED >/= 40 KG CROHNS START
- HUMIRA-PED >/= 40 KG UC STARTER
- HUMIRA-PS/UV/ADOL HS STARTER
- HUMIRA-PSORIASIS/UVEIT STARTER

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: 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, sulfsalazine, 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

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

HYFTOR

Products Affected

- HYFTOR

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	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).
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a neurologist or provider who specializes in the treatment of genetic or dermatologic disorders.
Coverage Duration	New starts: 3 months. Cont. of therapy or reauthorization: until end of contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

ICATIBANT

Products Affected

- *icatibant acetate subcutaneous solution prefilled syringe*

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be an immunologist, allergist, rheumatologist, or hematologist.
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

ICOSAPENT

Products Affected

- *icosapent ethyl*

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 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).

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

ILARIS

Products Affected

- ILARIS SUBCUTANEOUS SOLUTION

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Documentation was submitted indicating that the member was evaluated for active or latent TB infection (i.e. tuberculin skin test)
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 sJIA: approve.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

ILUMYA

Products Affected

- ILUMYA

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 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.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

IMBRUVICA

Products Affected

- IMBRUVICA

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

INCRELEX

Products Affected

- INCRELEX

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 an endocrinologist.
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

INTRON-A

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

Products Affected

- JAKAFI

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

KALYDECO

Products Affected

- KALYDECO

PA Criteria	Criteria Details
Exclusion Criteria	Combination use with Orkambi, Symdeko, or Trikafta.
Required Medical Information	Documentation of CFTR gene that is responsive to ivacaftor treatment.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a pulmonologist or an expert in the treatment of cystic fibrosis.
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

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 m2 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.

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

KEVZARA

Products Affected

- KEVZARA

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 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.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

KINERET

Products Affected

- KINERET SUBCUTANEOUS SOLUTION PREFILLED SYRINGE

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 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.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

KORLYM

Products Affected

- KORLYM
- *mifepristone oral tablet 300 mg*

PA Criteria	Criteria Details
Exclusion Criteria	For all members patient must not be currently on simvastatin, lovastatin, cyclosporine, dihydroergotamine, ergotamine, fentanyl, pimozide, quinidine, sirolimus, and tacrolimus.
Required Medical Information	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.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be an endocrinologist.
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

LITFULO

Products Affected

- LITFULO

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

LIVMARLI

Products Affected

- LIVMARLI

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 gastroenterologist or hepatologist.
Coverage Duration	New starts will be authorized for 6 months. Cont of therapy or reauth until end of contract year.
Other Criteria	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.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

PA Criteria	Criteria Details
Part B Prerequisite	No

LODOCO

Products Affected

- LODOCO

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be, or in consultation with a specialist in the treatment of cardiovascular disease, such as a cardiologist
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	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
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

LUCEMYRA

Products Affected

- LUCEMYRA

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 for 14 days.
Other Criteria	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.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

LUPKYNIS

Products Affected

- LUPKYNIS

PA Criteria	Criteria Details
Exclusion Criteria	Concurrent use with cyclophosphamide.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be rheumatologist, nephrologist, or other specialist in the treatment of autoimmune disorders.
Coverage Duration	New starts will be authorized for 6 months. Cont of therapy or reauth until end of contract year.
Other Criteria	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/1.73m2 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%).
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

LYBALVI

Products Affected

- LYBALVI

PA Criteria	Criteria Details
Exclusion Criteria	Concomitant use with opioids.
Required Medical Information	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.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	Documented trial of, contraindication to, or medical reason for not using at least two generic antipsychotics, one of which must be generic olanzapine.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

MANNITOL INHALATION

Products Affected

- BRONCHITOL

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a pulmonologist or an expert in the treatment of cystic fibrosis.
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

MAVYRET

Products Affected

- MAVYRET

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	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.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized for 8-16 weeks as per AASLD-IDSA guidance.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

METHYLTESTOSTERONE

Products Affected

- *methyltestosterone 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

METYROSINE

Products Affected

- *metyrosine*

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	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.
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

MIGLUSTAT

Products Affected

- *miglustat*

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	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).
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a specialist in treatment of Gaucher's disease
Coverage Duration	New starts will be authorized for 6 months. Cont of therapy or reauth until end of contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	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
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	If the medication request is for glatiramer, Glatopa, or dimethyl fumarate, the request will be approved. If the

PA Criteria	Criteria Details
	member is over 17 years of age and the request is not for 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.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

MYFEMBREE

Products Affected

- MYFEMBREE

PA Criteria	Criteria Details
Exclusion Criteria	Patient has history of osteoporosis or hepatic impairment.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be an OB, gynecologist or reproductive endocrinologist.
Coverage Duration	New starts will be authorized for 6 months. Cont of therapy or reauth until end of contract year.
Other Criteria	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).

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

NASAL ANTISEIZURE AGENTS

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

Products Affected

- NATPARA

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Documentation of serum calcium greater than 7.5 mg/dL and vitamin D level (within 30 days of request).
Age Restrictions	N/A
Prescriber Restrictions	Prescriber is an endocrinologist.
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

NEXLETOL

Products Affected

- NEXLETOL

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a cardiologist, endocrinologist, or a specialist in treatment of lipid disorders.
Coverage Duration	New starts will be authorized for 4 months. Cont of therapy or reauth until end of contract year.
Other Criteria	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,

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

NEXLIZET

Products Affected

- NEXLIZET

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a cardiologist, endocrinologist, or a specialist in treatment of lipid disorders.
Coverage Duration	New starts will be authorized for 4 months. Cont of therapy or reauth until end of contract year.
Other Criteria	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

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

NITISINONE

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

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

Products Affected

- NUCALA

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	New starts will be authorized for 6 months. Cont of therapy or reauth until end of contract year.
Other Criteria	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-

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

NUEDEXTA

Products Affected

- NUEDEXTA

PA Criteria	Criteria Details
Exclusion Criteria	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.
Required Medical Information	Confirmation diagnosis is for Part D indication.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a neurologist or psychiatrist.
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

NUPLAZID

Products Affected

- NUPLAZID ORAL CAPSULE
- NUPLAZID ORAL TABLET 10 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	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

OCALIVA

Products Affected

- OCALIVA

PA Criteria	Criteria Details
Exclusion Criteria	Members with decompensated cirrhosis, a prior decompensation event, compensated cirrhosis who have evidence of portal hypertension, or complete biliary obstruction.
Required Medical Information	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)).
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a gastroenterologist, hepatologist, or transplant specialist.
Coverage Duration	New starts will be authorized for 6 months. Cont of therapy or reauth until end of contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

OCTREOTIDE

Products Affected

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

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

OFEV

Products Affected

- OFEV

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

OLUMIANT

Products Affected

- OLUMIANT

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 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.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

ORAL ANTINEOPLASTIC AGENTS

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 (100 MG DAILY DOSE)
- TRUSELTIQ (125 MG DAILY DOSE)
- TRUSELTIQ (50 MG DAILY DOSE)
- TRUSELTIQ (75 MG 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

PA Criteria	Criteria Details
Exclusion Criteria	N/A

PA Criteria	Criteria Details
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be an oncologist or 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

ORAL ANTIPSYCHOTICS

Products Affected

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

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 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.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

ORENCIA

Products Affected

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

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 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.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

PA Criteria	Criteria Details
Part B Prerequisite	No

ORIAHNN

Products Affected

- ORIAHNN

PA Criteria	Criteria Details
Exclusion Criteria	Patient has history of osteoporosis or hepatic impairment.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be an OB, gynecologist or reproductive endocrinologist.
Coverage Duration	New starts will be authorized for 6 months. Cont of therapy or reauth until end of contract year.
Other Criteria	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).
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

ORILISSA

Products Affected

- ORILISSA

PA Criteria	Criteria Details
Exclusion Criteria	Patient has osteoporosis or severe hepatic impairment.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be an OB or gynecologist.
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 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.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

PA Criteria	Criteria Details
Part B Prerequisite	No

ORKAMBI

Products Affected

- ORKAMBI

PA Criteria	Criteria Details
Exclusion Criteria	Combination use with Kalydeco, Symdeko, or Trikafta.
Required Medical Information	Documentation of CFTR gene that is responsive to lumacaftor-ivacaftor treatment.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a pulmonologist or an expert in the treatment of cystic fibrosis.
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

OTEZLA

Products Affected

- OTEZLA

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 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.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

OXBRYTA

Products Affected

- OXBRYTA

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	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.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a hematologist.
Coverage Duration	New starts will be authorized for 6 months. Cont of therapy or reauth until end of contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

PA Criteria	Criteria Details
Part B Prerequisite	No

OXERVATE

Products Affected

- OXERVATE

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

OXYCODONE ER

Products Affected

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

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

PALIPERIDONE INJECTABLE

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	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.
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 Abilify Maintena.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

PALIPERIDONE ORAL

Products Affected

- *paliperidone er oral tablet extended release 24 hour 1.5 mg, 3 mg, 6 mg, 9 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	For schizophrenia: trial of, contraindication to, or medical reason for not using an alternative generic second generation atypical antipsychotic.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

PCSK9 INHIBITORS

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a cardiologist, endocrinologist, or a specialist in treatment of lipid disorders.
Coverage Duration	New starts will be authorized for 4 months. Cont of therapy or reauth until end of contract year.
Other Criteria	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

PA Criteria	Criteria Details
	Clinic Diagnostic criteria (total score greater than 8 points), OR Simon-Broome Diagnostic criteria (total cholesterol 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.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

PEGINTERFERON

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	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.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a gastroenterologist, hepatologist, infectious disease doctor or transplant specialist.
Coverage Duration	Request will be authorized for 24 to 48 weeks as defined by compendia.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

PENICILLAMINE

Products Affected

- *penicillamine oral tablet*

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 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.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

PENTAMIDINE SOLUTION FOR INJECTION

Products Affected

- *pentamidine isethionate injection*

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

PERSERIS

Products Affected

- PERSERIS

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	The member has a documented history of receiving oral risperidone without any clinically significant side effects.
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 (e.g. intolerance, hypersensitivity or contraindication) for not using Abilify Maintena
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

PHENOXYBENZAMINE

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

Products Affected

- *pirfenidone*

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	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.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a pulmonologist or lung 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

POSACONAZOLE

Products Affected

- *posaconazole oral*

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Documentation of a consultation with an infectious disease specialist, a transplant specialist, or an oncologist.
Coverage Duration	28 days for oropharyngeal candidiasis, end of contract year for other indications
Other Criteria	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.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

PRETOMANID

Products Affected

- *pretomanid*

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

PREVYMIS

Products Affected

- PREVYMIS ORAL

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

PROLIA

Products Affected

- PROLIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	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.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	The following criteria is also applicable for new starts: trial of, contraindication to, or medical reason for not using an oral bisphosphonate.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

PA Criteria	Criteria Details
Part B Prerequisite	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
Exclusion Criteria	N/A
Required Medical Information	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.
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 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.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

PA Criteria	Criteria Details
Part B Prerequisite	No

PYRUKYND

Products Affected

- PYRUKYND
- PYRUKYND TAPER PACK

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	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.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a hematologist.
Coverage Duration	New starts: 6 mo. Cont of therapy or reauth: end of contract yr. Denial: 14 days for dose tapering.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

RADICAVA

Products Affected

- RADICAVA ORS
- RADICAVA ORS STARTER KIT

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a neurologist.
Coverage Duration	New starts: 6 months. Cont. of therapy or reauthorization: until end of contract year.
Other Criteria	For new starts: 1) documentation of ALS functional rating scale (ALSFRS-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 (ALSFRS-R) score).
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

RAVICTI

Products Affected

- RAVICTI

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Provider is a geneticist, metabolic specialist, gastroenterologist, hepatologist, or liver transplant specialist.
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 sodium phenylbutyrate.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

RECORLEV

Products Affected

- RECORLEV

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	Trial of, contraindication to, or medical reason for not using ketoconazole tablets.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

REGRANEX

Products Affected

- REGRANEX

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 for 20 weeks.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

RELISTOR

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

Products Affected

- RELYVRIO

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	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)
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a neurologist, neuromuscular specialist, or physician specializing in the treatment of amyotrophic lateral sclerosis.
Coverage Duration	New starts: 6 months. Cont. of therapy or reauthorization: until end of contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

REXULTI

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 to two generic antidepressants. For agitation associated with dementia: approve.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

REZUROCK

Products Affected

- REZUROCK

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a hematologist, oncologist, or transplant specialist.
Coverage Duration	New starts: 3 months. Cont. of therapy or reauthorization: until end of contract year.
Other Criteria	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).
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

RINVOQ

Products Affected

- RINVOQ

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 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

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

RISPERDAL CONSTA

Products Affected

- RISPERDAL CONSTA INTRAMUSCULAR SUSPENSION RECONSTITUTED ER

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	The member has a documented history of receiving oral risperidone without any clinically significant side effects.
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 Abilify Maintena.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

RISPERIDONE INJECTABLE

Products Affected

- *risperidone microspheres er*

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	The member has a documented history of receiving oral risperidone without any clinically significant side effects.
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 (e.g. intolerance, hypersensitivity or contraindication) for not using Abilify Maintena.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

RUFINAMIDE

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	History of familial Short QT syndrome
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a neurologist.
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 one alternative generic anticonvulsant for appropriate indications.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

RYKINDO

Products Affected

- RYKINDO

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	The member has a documented history of receiving oral risperidone without any clinically significant side effects.
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 (e.g. intolerance, hypersensitivity or contraindication) for not using Abilify Maintena.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

RYLAZE

Products Affected

- RYLAZE

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be an oncologist, hematologist, or 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

SAPROPTERIN

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	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.
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	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

SECUADO

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

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

Products Affected

- SIGNIFOR

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Member is not a candidate for surgery or surgery was not curative.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an endocrinologist.
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

SILDENAFIL ORAL

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	Documentation of concurrent nitrate or Adempas use.
Required Medical Information	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.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a pulmonologist or cardiologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	For sildenafil suspension: Documentation of trial of, contraindication to, or medical reason for not using sildenafil tablet.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

SILIQ

Products Affected

- SILIQ

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 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.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

SIMPONI

Products Affected

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

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 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.
Indications	All Medically-accepted Indications.

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

SIRTURO

Products Affected

- SIRTURO

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	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.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an infectious disease specialist.
Coverage Duration	Request will be authorized for 24 weeks.
Other Criteria	Documentation of prior trial of or medical reason for not using first-line TB regimen containing isoniazid and rifampin.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

SKYRIZI

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, sulfsalazine, 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 PHENYLBUTYRATE

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Provider is a geneticist, metabolic specialist, gastroenterologist, 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

SOFOSBUVIR/VELPATASVIR

Products Affected

- *sofosbuvir-velpatasvir*

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	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.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized for 12-24 weeks based on AASLD-IDSA guidelines
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

SOMAVERT

Products Affected

- SOMAVERT

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	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.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an endocrinologist.
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

SOTYKTU

Products Affected

- SOTYKTU

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 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.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

STELARA

Products Affected

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

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 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.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

PA Criteria	Criteria Details
Part B Prerequisite	No

SUCRAID

Products Affected

- SUCRAID

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	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)
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	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

SYMDEKO

Products Affected

- SYMDEKO

PA Criteria	Criteria Details
Exclusion Criteria	Combination use with Kalydeco, Orkambi, or Trikafta.
Required Medical Information	Documentation of CFTR gene that is responsive to tezacaftor-ivacaftor treatment.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a pulmonologist or an expert in the treatment of cystic fibrosis.
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

SYMLIN

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	Patient has confirmed gastroparesis.
Required Medical Information	For new starts: HbA1C values within 90 days of request is greater than or equal to 7% despite receiving insulin therapy.
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 two alternative anti-diabetic agents.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

SYNAREL

Products Affected

- SYNAREL

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 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)
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

TADALAFIL

Products Affected

- *tadalafil (pah)*
- TADLIQ

PA Criteria	Criteria Details
Exclusion Criteria	Documentation of concurrent nitrate or Adempas use.
Required Medical Information	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.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a pulmonologist or cardiologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	For Tadliq: Documentation of trial of, contraindication to, or medical reason for not using tadalafil tablets.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

TALTZ

Products Affected

- TALTZ

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 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.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

PA Criteria	Criteria Details
Part B Prerequisite	No

TARPEYO

Products Affected

- TARPEYO

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	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.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a nephrologist.
Coverage Duration	Request will be authorized for 9 months.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

TAVNEOS

Products Affected

- TAVNEOS

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 rheumatologist or hematologist.
Coverage Duration	New starts will be authorized for 6 months. Cont of therapy or reauth until end of contract year.
Other Criteria	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

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

TEFLARO

Products Affected

- TEFLARO

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

TERIPARATIDE

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	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/m2)], 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.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	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.
Indications	All Medically-accepted Indications.

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

THIOLA

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

Products Affected

- *tolvaptan*

PA Criteria	Criteria Details
Exclusion Criteria	Concomitant use with strong CYP3A4 inhibitors (i.e. clarithromycin, ketoconazole, itraconazole, ritonavir, lopinavir-ritonavir, indinavir-ritonavir, indinavir, nelfinavir, saquinavir, nefazodone, conivaptan, and telithromycin).
Required Medical Information	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).
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a cardiologist, endocrinologist, hepatologist, or nephrologist.
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 ANTINEOPLASTIC RETINOIDS

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

Products Affected

- *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%)*
- *testosterone transdermal solution*

PA Criteria	Criteria Details
Exclusion Criteria	Patient has history of prostate cancer or breast cancer.
Required Medical Information	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.
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

TRANSDERMAL LIDOCAINE

Products Affected

- *lidocaine external patch 5 %*
- ZTLIDO

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 the product ZTlido, must provide medical reason for not being able to use generic lidocaine 5% patch
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

TREMFYA

Products Affected

- TREMFYA

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.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

TRIENTINE

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

Products Affected

- TRIKAFTA

PA Criteria	Criteria Details
Exclusion Criteria	Combination use with Kalydeco, Orkambi, or Symdeko.
Required Medical Information	Documentation of CFTR gene that is responsive to elexacaftor-tezacaftor-ivacaftor treatment.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a pulmonologist or an expert in the treatment of cystic fibrosis.
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

TYMLOS

Products Affected

- TYMLOS

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

TYVASO

Products Affected

- TYVASO DPI MAINTENANCE KIT
- TYVASO DPI TITRATION KIT

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

UPTRAVI

Products Affected

- UPTRAVI ORAL
- UPTRAVI TITRATION

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Documentation of pulmonary arterial hypertension (PAH) WHO Group I and PAH Functional Class.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a pulmonologist or cardiologist.
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 a generic phosphodiesterase inhibitor and a generic endothelin receptor antagonist.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

UZEDY

Products Affected

- UZEDY

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	The member has a documented history of receiving oral risperidone without any clinically significant side effects.
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 (e.g. intolerance, hypersensitivity or contraindication) for not using Abilify Maintena.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

VALCHLOR

Products Affected

- VALCHLOR

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 an oncologist or dermatologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	Trial of, contraindication to, or medical reason for not being able to use one of the following: a topical corticosteroids or a topical retinoids.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

VEMLIDY

Products Affected

- VEMLIDY

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	For new starts: attestation that member has been tested for HIV infection. If member is HIV-positive, Vemlidy is not used alone.
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

VENTAVIS

Products Affected

- VENTAVIS

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Documentation of pulmonary arterial hypertension (PAH) WHO Group I classification and PAH Functional Class.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a pulmonologist or cardiologist.
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

VIGABATRIN

Products Affected

- *vigabatrin*

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	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.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be 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

VIJOICE

Products Affected

- VIJOICE

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	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.).
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a geneticist, dermatologist, vascular surgeon, hematologist/oncologist, or other specialist in the treatment of PIK3CA-Related Overgrowth Spectrum(PROS).
Coverage Duration	New starts will be authorized for 6 months. Cont of therapy or reauth until end of contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

VMAT-2 INHIBITORS

Products Affected

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

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

VORICONAZOLE

Products Affected

- *voriconazole intravenous*

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

VOSEVI

Products Affected

- VOSEVI

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	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.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized for 12 weeks as per AASLD-IDSA guidance.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

VOWST

Products Affected

- VOWST

PA Criteria	Criteria Details
Exclusion Criteria	Treatment of Clostridioides difficile infection (CDI)
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	If all the criteria are met, the request will be approved for 1 month
Other Criteria	Diagnosis of at least 1 recurrent episode of CDI
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	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
Exclusion Criteria	N/A
Required Medical Information	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.
Age Restrictions	N/A
Prescriber Restrictions	Specialist for submitted diagnosis.
Coverage Duration	New starts will be authorized for 4 months. Cont of therapy or reauth until end of contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

XATMEP

Products Affected

- XATMEP

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be an oncologist or rheumatologist.
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

XELJANZ

Products Affected

- XELJANZ
- XELJANZ XR

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: 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.
Indications	All Medically-accepted Indications.

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

XERMELO

Products Affected

- XERMELO

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 gastroenterologist or an oncologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	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.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

XGEVA

Products Affected

- XGEVA

PA Criteria	Criteria Details
Exclusion Criteria	Patients with baseline hypocalcemia
Required Medical Information	New starts: Serum calcium levels. Reauthorization criteria for malignant hypercalcemia: albumin-adjusted serum calcium level below 12.5mg/dl within 30 days of request.
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

XIFAXAN

Products Affected

- XIFAXAN

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	For HE: gastroenterologist or hepatologist. For IBS-D: gastroenterologist.
Coverage Duration	For HE: contract year. For IBSD: 14 days (cannot exceed 3 courses of 14 days each). For TD: 3 days.
Other Criteria	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.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

XOLAIR

Products Affected

- XOLAIR

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a pulmonologist, allergist, immunologist, dermatologist, or otolaryngologist.
Coverage Duration	New starts will be authorized for 6 months. Cont of therapy or reauth until end of contract year.
Other Criteria	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)

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

XTAMPZA ER

Products Affected

- XTAMPZA ER

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

XURIDEN

Products Affected

- XURIDEN

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be an endocrinologist, metabolic specialist, clinical geneticist or hematologist.
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

XYREM

Products Affected

- *sodium oxybate*
- XYREM

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

XYWAV

Products Affected

- XYWAV

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

ZEPOSIA

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

Products Affected

- ZTALMY

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

ZURZUVAE

Products Affected

- ZURZUVAE

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	The member has a documented diagnosis of postpartum depression
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a psychiatrist or obstetrician/gynecologist
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

ZYPREXA RELPREVV

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	The member has a documented history of receiving oral olanzapine without any clinically significant side effects.
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 Abilify Maintena.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

PART B VERSUS PART D

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
- GAMMAGARD S/D LESS IGA INTRAVENOUS SOLUTION RECONSTITUTED 10 GM, 5 GM
- GAMMAKED INJECTION SOLUTION 1 GM/10 ML
- GAMMAPLEX INTRAVENOUS SOLUTION 10 GM/100 ML, 10 GM/200 ML, 20 GM/200 ML, 5 GM/50 ML
- GAMUNEX-C INJECTION SOLUTION 1 GM/10 ML
- GENGRAF ORAL CAPSULE 100 MG, 25 MG
- GENGRAF ORAL SOLUTION 100 MG/ML

- *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
- PRIVIGEN INTRAVENOUS SOLUTION 10 GM/100 ML, 20 GM/200 ML, 40 GM/400 ML, 5 GM/50 ML
- PROGRAF INTRAVENOUS SOLUTION 5 MG/ML
- PROGRAF ORAL PACKET 0.2 MG, 1 MG
- PULMOZYME INHALATION SOLUTION 2.5 MG/2.5 ML
- RABAVERT INTRAMUSCULAR SUSPENSION RECONSTITUTED
- RECOMBIVAX HB INJECTION SUSPENSION 10 MCG/ML, 40 MCG/ML, 5 MCG/0.5 ML
- RECOMBIVAX HB INJECTION SUSPENSION PREFILLED SYRINGE 10 MCG/ML, 5 MCG/0.5 ML
- SANDIMMUNE ORAL SOLUTION 100 MG/ML
- *sirolimus oral solution 1 mg/ml*
- *sirolimus oral tablet 0.5 mg, 1 mg, 2 mg*
- *tacrolimus oral capsule 0.5 mg, 1 mg, 5 mg*
- 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.

Index

A

ABELCET INTRAVENOUS SUSPENSION 5 MG/ML 393
ABILIFY ASIMTUFII 147
abiraterone acetate 277, 278, 279
acetylcysteine inhalation solution 10 %, 20 % 393
acitretin 148
ACTEMRA ACTPEN 149
ACTEMRA SUBCUTANEOUS 149
ACTHAR 150, 151
ACTIMMUNE 152
acyclovir sodium intravenous solution 50 mg/ml 393
ADEMPAS 153
AIMOVIG 171, 172
AKEEGA 277, 278, 279
albuterol sulfate inhalation nebulization solution (2.5 mg/3ml) 0.083%, (5 mg/ml) 0.5%, 0.63 mg/3ml, 1.25 mg/3ml, 2.5 mg/0.5ml 393
ALECENSA 277, 278, 279
ALUNBRIG 277, 278, 279
ambrisentan 155
amitriptyline hcl oral 223
amoxapine 223
amphotericin b intravenous solution reconstituted 50 mg .. 393
amphotericin b liposome intravenous suspension reconstituted 50 mg 393
apomorphine hcl subcutaneous. 156
aprepitant oral 80 & 125 mg 393
aprepitant oral capsule 125 mg, 40 mg, 80 & 125 mg, 80 mg 393
ARALAST NP INTRAVENOUS SOLUTION RECONSTITUTED 1000 MG, 500 MG 154
ARANESP (ALBUMIN FREE) INJECTION SOLUTION 100 MCG/ML, 200 MCG/ML, 25 MCG/ML, 40 MCG/ML, 60 MCG/ML 200, 201
ARANESP (ALBUMIN FREE) INJECTION SOLUTION PREFILLED SYRINGE 200, 201
ARCALYST 157
ARISTADA INITIO 158
ARISTADA INTRAMUSCULAR PREFILLED SYRINGE 1064 MG/3.9ML, 441 MG/1.6ML, 662 MG/2.4ML, 882 MG/3.2ML 158
armodafinil 268
ASCOMP-CODEINE 224
ASTAGRAF XL ORAL CAPSULE EXTENDED RELEASE 24 HOUR 0.5 MG, 1 MG, 5 MG 393
AUGTYRO 277, 278, 279
AUSTEDO 372
AUSTEDO PATIENT TITRATION KIT 372
AUVELITY 159
AYVAKIT 277, 278, 279
azathioprine oral tablet 50 mg 393

B

BAC 224
BAFIERTAM 257, 258
BALVERSA 277, 278, 279
BENLYSTA SUBCUTANEOUS 161, 162
BESREMI 163
BETASERON SUBCUTANEOUS KIT 257, 258
bexarotene 277, 278, 279, 357
bosentan 164
BOSULIF 277, 278, 279
BRAFTOVI ORAL CAPSULE 75 MG 277, 278, 279
BRONCHITOL 252
BRUKINSA 277, 278, 279
budesonide er oral tablet extended release 24 hour 165

budesonide inhalation suspension 0.25 mg/2ml, 0.5 mg/2ml, 1 mg/2ml 393
butalbital-acetaminophen oral tablet 50-325 mg 224
butalbital-apap-caff-cod oral capsule 50-325-40-30 mg 224
butalbital-apap-caffeine oral capsule 50-325-40 mg 224
butalbital-apap-caffeine oral tablet 50-325-40 mg 224
butalbital-asa-caff-codeine 224
butalbital-aspirin-caffeine oral capsule 224

C

CABOMETYX 277, 278, 279
CALQUENCE 277, 278, 279
CAMCEVI 213
CAMZYOS 166, 167
CAPLYTA 280
CAPRELSA 277, 278, 279
carglumic acid oral tablet soluble 168
carisoprodol oral 225
caspofungin acetate 169
CAYSTON 160
CERDELGA 170
chlorzoxazone oral tablet 500 mg 225
CHOLBAM 173
CIBINQO 174
CIMZIA STARTER KIT SUBCUTANEOUS PREFILLED SYRINGE KIT 175, 176
CIMZIA SUBCUTANEOUS KIT 2 X 200 MG 175, 176
CIMZIA SUBCUTANEOUS PREFILLED SYRINGE KIT 175, 176
CINRYZE 219
clemastine fumarate oral tablet 2.68 mg 221, 222
CLINISOL SF INTRAVENOUS SOLUTION 15 % 393
clomipramine hcl oral 223
COMETRIQ (100 MG DAILY DOSE) ORAL KIT 80 & 20 MG 277, 278, 279
COMETRIQ (140 MG DAILY DOSE) ORAL KIT 3 X 20 MG & 80 MG .. 277, 278, 279
COMETRIQ (60 MG DAILY DOSE) 277, 278, 279
COPIKTRA 277, 278, 279
CORLANOR 177
CORTROPHIN 178
COSENTYX 179, 180
COSENTYX (300 MG DOSE) ... 179, 180
COSENTYX SENSOREADY (300 MG) 179, 180
COSENTYX SENSOREADY PEN ... 179, 180
COSENTYX UNOREADY 179, 180
COTELLIC 277, 278, 279
cromolyn sodium inhalation nebulization solution 20 mg/2ml 393
CUVRIOR 361
cyclophosphamide oral capsule 25 mg, 50 mg 393
cyclophosphamide oral tablet 25 mg, 50 mg 393
cyclosporine modified oral capsule 100 mg, 25 mg, 50 mg 393
cyclosporine modified oral solution 100 mg/ml 393
cyclosporine oral capsule 100 mg, 25 mg 393
cyproheptadine hcl oral 221, 222
CYSTAGON 181
CYSTARAN 182

D

dalfampridine er 183
DAURISMO 277, 278, 279
deferasirox 184
deferasirox granules 184
deferiprone 185
DIACOMIT 186
dichlorphenamide 187
DIFICID 188

dimethyl fumarate oral 257, 258
dimethyl fumarate starter pack oral capsule delayed release therapy pack 257, 258
diphtheria-tetanus toxoids dt intramuscular suspension 25-5 lfu/0.5ml 393
dipyridamole oral 221, 222
disopyramide phosphate oral 221, 222
DOPTELET 189
doxepin hcl external 190
doxepin hcl oral capsule 223
doxepin hcl oral concentrate 223
dronabinol oral capsule 10 mg, 2.5 mg, 5 mg 393
DUPIXENT 191, 192
E
EGRIFTA SV 193
ELIGARD 213
EMEND ORAL SUSPENSION RECONSTITUTED 125 MG/5ML 393
EMGALITY 171, 172
EMGALITY (300 MG DOSE) 171, 172
EMSAM 194
ENBREL MINI 195
ENBREL SUBCUTANEOUS SOLUTION 25 MG/0.5ML 195
ENBREL SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 195
ENBREL SUBCUTANEOUS SOLUTION RECONSTITUTED 195
ENBREL SURECLICK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 195
ENDARI 196
ENGERIX-B INJECTION SUSPENSION 20 MCG/ML 393
ENGERIX-B INJECTION SUSPENSION PREFILLED SYRINGE 10 MCG/0.5ML, 20 MCG/ML 393
ENTYVIO SUBCUTANEOUS 197
ENVARSUS XR ORAL TABLET EXTENDED RELEASE 24 HOUR 0.75 MG, 1 MG, 4 MG 393
EPIDIOLEX 198
EPOGEN INJECTION SOLUTION 10000 UNIT/ML, 2000 UNIT/ML, 20000 UNIT/ML, 3000 UNIT/ML, 4000 UNIT/ML 200, 201
EPRONTIA 199
ERIVEDGE 277, 278, 279
ERLEADA 277, 278, 279
erlotinib hcl 277, 278, 279
eszopiclone 226
EUCRISA 202
everolimus oral tablet 0.25 mg, 0.5 mg, 0.75 mg, 1 mg 393
everolimus oral tablet 10 mg, 2.5 mg, 5 mg, 7.5 mg 277, 278, 279
everolimus oral tablet soluble 277, 278, 279
EVRYSDI 203
EXKIVITY 277, 278, 279
EXTAVIA SUBCUTANEOUS KIT 257, 258
F
FANAPT 280
FANAPT TITRATION PACK 280
FASENRA 204
FASENRA PEN 204
fentanyl citrate buccal lozenge on a handle 205
FILSPARI 206
fingolimod hcl 257, 258
FINTEPLA 207
FIRDAPSE 208
FIRMAGON (240 MG DOSE) 213
FIRMAGON SUBCUTANEOUS SOLUTION RECONSTITUTED 80 MG 213
flucytosine oral 209
fluorouracil external cream 0.5 % 210
formoterol fumarate inhalation nebulization solution 20 mcg/2ml 393

FOTIVDA.....277, 278, 279
FRUZAQLA.....277, 278, 279
FULPHILA.....376
FYLNETRA.....376
G
GALAFOLD.....211
GAMMAGARD INJECTION SOLUTION 1 GM/10ML, 10 GM/100ML, 2.5 GM/25ML, 20 GM/200ML, 30 GM/300ML, 5 GM/50ML.....393
GAMMAGARD S/D LESS IGA INTRAVENOUS SOLUTION RECONSTITUTED 10 GM, 5 GM 393
GAMMAKED INJECTION SOLUTION 1 GM/10ML.....393
GAMMAPLEX INTRAVENOUS SOLUTION 10 GM/100ML, 10 GM/200ML, 20 GM/200ML, 5 GM/50ML.....393
GAMUNEX-C INJECTION SOLUTION 1 GM/10ML.....393
GATTEX.....212
GAVRETO.....277, 278, 279
gefitinib.....277, 278, 279
GENGRAF ORAL CAPSULE 100 MG, 25 MG.....393
GENGRAF ORAL SOLUTION 100 MG/ML.....393
GENOTROPIN MINIQUICK SUBCUTANEOUS PREFILLED SYRINGE.....215, 216
GENOTROPIN SUBCUTANEOUS CARTRIDGE.....215, 216
GILOTRIF.....277, 278, 279
GLASSIA.....154
glatiramer acetate.....257, 258
GLATOPA.....257, 258
glyburide micronized oral tablet 1.5 mg, 3 mg, 6 mg.....221, 222
glyburide oral tablet 1.25 mg, 2.5 mg, 5 mg.....221, 222
glyburide-metformin oral tablet 1.25-250 mg, 2.5-500 mg.....221, 222
glyburide-metformin oral tablet 5-500 mg.....221, 222
GOCOVRI.....214
granisetron hcl oral tablet 1 mg..394
guanfacine hcl er.....221, 222
guanfacine hcl oral.....221, 222
H
HADLIMA.....217, 218
HADLIMA PUSHTOUCH.....217, 218
HAEGARDA.....219
HEPLISAV-B INTRAMUSCULAR SOLUTION PREFILLED SYRINGE 20 MCG/0.5ML.....394
HETLIOZ LQ.....220
HUMATROPE INJECTION CARTRIDGE.....215, 216
HUMIRA (2 PEN).....227, 228
HUMIRA (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 10 MG/0.1ML, 20 MG/0.2ML, 40 MG/0.4ML, 40 MG/0.8ML.....227, 228
HUMIRA-CD/UC/HS STARTER.....227, 228
HUMIRA-PED<40KG CROHNS STARTER.....227, 228
HUMIRA-PED>/=40KG CROHNS START.....227, 228
HUMIRA-PED>/=40KG UC STARTER.....227, 228
HUMIRA-PS/UV/ADOL HS STARTER.....227, 228
HUMIRA-PSORIASIS/UVEIT STARTER.....227, 228
HYFTOR.....229
I
IBRANCE.....277, 278, 279
icatibant acetate subcutaneous solution prefilled syringe.....230
ICLUSIG.....277, 278, 279
icosapent ethyl.....231, 232
IDHIFA.....277, 278, 279
ILARIS SUBCUTANEOUS SOLUTION.....233

ILUMYA....234
imatinib mesylate....277, 278, 279
IMBRUVICA....235, 277, 278, 279
imipramine hcl oral....223
imipramine pamoate....223
IMOVAX RABIES INTRAMUSCULAR SUSPENSION RECONSTITUTED 2.5 UNIT/ML....394
INCRELEX....236
indomethacin er....221, 222
indomethacin oral capsule 25 mg, 50 mg....221, 222
INGREZZA ORAL CAPSULE....372
INGREZZA ORAL CAPSULE THERAPY PACK....372
INLYTA....277, 278, 279
INQOVI....277, 278, 279
INREBIC....277, 278, 279
INTRALIPID INTRAVENOUS EMULSION 20 %, 30 %....394
INTRON A INJECTION SOLUTION RECONSTITUTED....237
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....293
INVEGA TRINZA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 273 MG/0.88ML, 410 MG/1.32ML, 546 MG/1.75ML, 819 MG/2.63ML....293
ipratropium bromide inhalation solution 0.02 %....394
ipratropium-albuterol inhalation solution 0.5-2.5 (3) mg/3ml....394

J

JAKAFI....238
JAYPIRCA....277, 278, 279

K

KALYDECO....239
KERENDIA....240, 241
KESIMPTA....257, 258
ketorolac tromethamine oral....221, 222
KEVZARA....242
KINERET SUBCUTANEOUS SOLUTION PREFILLED SYRINGE....243
KISQALI (200 MG DOSE)....277, 278, 279
KISQALI (400 MG DOSE)....277, 278, 279
KISQALI (600 MG DOSE)....277, 278, 279
KISQALI FEMARA (200 MG DOSE)....277, 278, 279
KISQALI FEMARA (400 MG DOSE)....277, 278, 279
KISQALI FEMARA (600 MG DOSE)....277, 278, 279
KORLYM....244
KOSELUGO....277, 278, 279
KRAZATI....277, 278, 279

L

lapatinib ditosylate....277, 278, 279
lenalidomide....277, 278, 279
LENVIMA (10 MG DAILY DOSE)....277, 278, 279
LENVIMA (12 MG DAILY DOSE)....277, 278, 279
LENVIMA (14 MG DAILY DOSE)....277, 278, 279
LENVIMA (18 MG DAILY DOSE)....277, 278, 279
LENVIMA (20 MG DAILY DOSE)....277, 278, 279
LENVIMA (24 MG DAILY DOSE)....277, 278, 279
LENVIMA (4 MG DAILY DOSE)....277, 278, 279
LENVIMA (8 MG DAILY DOSE)....277, 278, 279
LEUKINE INJECTION SOLUTION RECONSTITUTED....376
leuprolide acetate (3 month)....213

levalbuterol hcl inhalation nebulization solution 0.31 mg/3ml, 0.63 mg/3ml, 1.25 mg/3ml 394
lidocaine external patch 5 % 359
LITFULO 245
LIVMARLI 246, 247
LODOCO 248
LONSURF 277, 278, 279
LORBRENA 277, 278, 279
LUCEMYRA 249
LUMAKRAS 277, 278, 279
LUPKYNIS 250
LUPRON DEPOT (1-MONTH) 213
LUPRON DEPOT (3-MONTH) 213
LUPRON DEPOT (4-MONTH) 213
LUPRON DEPOT (6-MONTH) 213
LYBALVI 251
LYNPARZA ORAL TABLET ... 277, 278, 279
LYTGOBI (12 MG DAILY DOSE) 277, 278, 279
LYTGOBI (16 MG DAILY DOSE) 277, 278, 279
LYTGOBI (20 MG DAILY DOSE) ... 277, 278, 279

M

MAVENCLAD (10 TABS) 257, 258
MAVENCLAD (4 TABS) 257, 258
MAVENCLAD (5 TABS) 257, 258
MAVENCLAD (6 TABS) 257, 258
MAVENCLAD (7 TABS) 257, 258
MAVENCLAD (8 TABS) 257, 258
MAVENCLAD (9 TABS) 257, 258
MAVYRET 253
MAYZENT 257, 258
MAYZENT STARTER PACK ... 257, 258
megestrol acetate oral suspension 221, 222
megestrol acetate oral tablet 223
MEKINIST 277, 278, 279
MEKTOVI 277, 278, 279
MENEST 223
metaxalone oral tablet 800 mg .. 225
methocarbamol oral tablet 500 mg, 750 mg 225
methyltestosterone oral 254
metyrosine 255
mifepristone oral tablet 300 mg 244
miglustat 256
modafinil oral 268
mycophenolate mofetil oral capsule 250 mg 394
mycophenolate mofetil oral suspension reconstituted 200 mg/ml 394
mycophenolate mofetil oral tablet 500 mg 394
mycophenolate sodium oral tablet delayed release 180 mg, 360 mg 394
mycophenolic acid oral tablet delayed release 180 mg, 360 mg 394
MYFEMBREE 259, 260

N

NATPARA 262
NAYZILAM 261
NERLYNX 277, 278, 279
NEULASTA ONPRO 376
NEULASTA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 376
NEXLETOL 263, 264
NEXLIZET 265, 266
NGENLA 215, 216
nifedipine oral 221, 222
nilutamide 277, 278, 279
NINLARO 277, 278, 279
nitisinone 267
NORDITROPIN FLEXPRO SUBCUTANEOUS SOLUTION PEN-INJECTOR 215, 216
NORPACE CR 221, 222
NUBEQA 277, 278, 279
NUCALA 269, 270
NUEDEXTA 271

NULOJIX INTRAVENOUS SOLUTION RECONSTITUTED 250 MG.....394
NUPLAZID ORAL CAPSULE.....272
NUPLAZID ORAL TABLET 10 MG 272
NURTEC.....171, 172
NUTRILIPID INTRAVENOUS EMULSION 20 %.....394
NUTROPIN AQ NUSPIN 10 SUBCUTANEOUS SOLUTION PEN-INJECTOR.....215, 216
NUTROPIN AQ NUSPIN 20 SUBCUTANEOUS SOLUTION PEN-INJECTOR.....215, 216
NUTROPIN AQ NUSPIN 5 SUBCUTANEOUS SOLUTION PEN-INJECTOR.....215, 216
NYVEPRIA.....376
O
OCALIVA.....273
octreotide acetate injection solution 100 mcg/ml, 1000 mcg/ml, 200 mcg/ml, 50 mcg/ml, 500 mcg/ml.....274
ODOMZO.....277, 278, 279
OFEV.....275
OGSIVEO.....277, 278, 279
OJJAARA.....277, 278, 279
OLUMIANT.....276
OMNITROPE SUBCUTANEOUS SOLUTION CARTRIDGE.....215, 216
OMNITROPE SUBCUTANEOUS SOLUTION RECONSTITUTED...215, 216
ondansetron hcl oral solution 4 mg/5ml.....394
ondansetron hcl oral tablet 24 mg, 4 mg, 8 mg.....394
ondansetron oral tablet dispersible 4 mg, 8 mg.....394
ONUREG.....277, 278, 279
ORENCIA CLICKJECT.....281, 282
ORENCIA INTRAVENOUS.....281, 282
ORENCIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE.....281, 282
ORFADIN ORAL SUSPENSION.....267
ORGOVYX.....278, 279
ORIAHNN.....283
ORILISSA.....284, 285
ORKAMBI.....286
ORLADEYO.....219
orphenadrine citrate er.....225
ORSERDU.....278, 279
OTEZLA.....287
OXBRYTA.....288, 289
OXERVATE.....290
oxycodone hcl er oral tablet er 12 hour abuse-deterrent 10 mg, 20 mg, 40 mg, 80 mg.....291, 292
P
paliperidone er oral tablet extended release 24 hour 1.5 mg, 3 mg, 6 mg, 9 mg.....294
PANRETIN.....357
pazopanib hcl.....278, 279
PEGASYS SUBCUTANEOUS SOLUTION 180 MCG/ML.....297
PEGASYS SUBCUTANEOUS SOLUTION PREFILLED SYRINGE.....297
PEMAZYRE.....278, 279
penicillamine oral tablet.....298
pentamidine isethionate inhalation solution reconstituted 300 mg.....394
pentamidine isethionate injection.....299
pentazocine-naloxone hcl.....221, 222
perphenazine-amitriptyline.....223
PERSERIS.....300
phenobarbital oral elixir.....223
phenobarbital oral tablet.....223
phenoxybenzamine hcl oral.....301
PIQRAY (200 MG DAILY DOSE)...278, 279

PIQRAY (250 MG DAILY DOSE) ... 278, 279
PIQRAY (300 MG DAILY DOSE) .. 278, 279
pirfenidone ... 302
PLENAMINE INTRAVENOUS SOLUTION 15 % ... 394
POMALYST ... 278, 279
PONVORY ... 257, 258
PONVORY STARTER PACK .. 257, 258
posaconazole oral ... 303
PRALUENT SUBCUTANEOUS SOLUTION AUTO-INJECTOR ... 295, 296
PREHEVBRIO INTRAMUSCULAR SUSPENSION 10 MCG/ML ... 394
pretomanid ... 304
PREVYMIS ORAL ... 305
PRIVIGEN INTRAVENOUS SOLUTION 10 GM/100ML, 20 GM/200ML, 40 GM/400ML, 5 GM/50ML ... 394
PROCRIT ... 200, 201
PROGRAF INTRAVENOUS SOLUTION 5 MG/ML ... 394
PROGRAF ORAL PACKET 0.2 MG, 1 MG ... 394
PROLASTIN-C ... 154
PROLIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE ... 306, 307
PROMACTA ORAL PACKET 12.5 MG, 25 MG ... 308, 309
PROMACTA ORAL TABLET 12.5 MG, 25 MG, 50 MG, 75 MG ... 308, 309
promethazine hcl oral ... 221, 222
promethazine hcl rectal suppository 12.5 mg, 25 mg ... 221, 222
promethazine vc ... 221, 222
promethazine-phenylephrine ... 221, 222
PROMETHEGAN RECTAL SUPPOSITORY 50 MG ... 221, 222
protriptyline hcl ... 223
PULMOZYME INHALATION SOLUTION 2.5 MG/2.5ML ... 394
PURIXAN ... 278, 279
PYRUKYND ... 310
PYRUKYND TAPER PACK ... 310

Q

QINLOCK ... 278, 279

R

RABAVERT INTRAMUSCULAR SUSPENSION RECONSTITUTED ... 394
RADICAVA ORS ... 311
RADICAVA ORS STARTER KIT ... 311
RAVICTI ... 312
REBIF REBIDOSE SUBCUTANEOUS SOLUTION AUTO-INJECTOR ... 257, 258
REBIF REBIDOSE TITRATION PACK SUBCUTANEOUS SOLUTION AUTO-INJECTOR ... 257, 258
REBIF SUBCUTANEOUS SOLUTION PREFILLED SYRINGE ... 257, 258
REBIF TITRATION PACK SUBCUTANEOUS SOLUTION PREFILLED SYRINGE ... 257, 258
RECOMBIVAX HB INJECTION SUSPENSION 10 MCG/ML, 40 MCG/ML, 5 MCG/0.5ML ... 394
RECOMBIVAX HB INJECTION SUSPENSION PREFILLED SYRINGE 10 MCG/ML, 5 MCG/0.5ML ... 394
RECORLEV ... 313
REGRANEX ... 314
RELISTOR ORAL ... 315
RELISTOR SUBCUTANEOUS SOLUTION ... 315
RELYVRIO ... 316
REPATHA ... 295, 296
REPATHA PUSHTRONEX SYSTEM ... 295, 296
REPATHA SURECLICK ... 295, 296

RETACRIT INJECTION SOLUTION 10000 UNIT/ML, 10000 UNIT/ML(1ML), 2000 UNIT/ML, 20000 UNIT/ML, 3000 UNIT/ML, 4000 UNIT/ML, 40000 UNIT/ML 200, 201
RETEVMO 278, 279
REVLIMID 278, 279
REXULTI 317
REZLIDHIA 278, 279
REZUROCK 318
RINVOQ 319, 320
RISPERDAL CONSTA INTRAMUSCULAR SUSPENSION RECONSTITUTED ER 321
risperidone microspheres er 322
ROZLYTREK 278, 279
RUBRACA 278, 279
rufinamide oral suspension 323
rufinamide oral tablet 323
RYDAPT 278, 279
RYKINDO 324
RYLAZE 325

S

SANDIMMUNE ORAL SOLUTION 100 MG/ML 394
sapropterin dihydrochloride oral packet 326
sapropterin dihydrochloride oral tablet 326
SCEMBLIX 278, 279
SECUADO 327
SEROSTIM SUBCUTANEOUS SOLUTION RECONSTITUTED 4 MG, 5 MG, 6 MG 328
SIGNIFOR 329
sildenafil citrate oral suspension reconstituted 330
sildenafil citrate oral tablet 20 mg 330
SILIQ 331
SIMPONI SUBCUTANEOUS SOLUTION AUTO-INJECTOR 332, 333
SIMPONI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 332, 333
sirolimus oral solution 1 mg/ml 394
sirolimus oral tablet 0.5 mg, 1 mg, 2 mg 394
SIRTURO 334
SKYRIZI 335
SKYRIZI PEN 335
SKYTROFA 215, 216
sodium oxybate 387
sodium phenylbutyrate oral powder 3 gm/tsp 336
sodium phenylbutyrate oral tablet 336
sofosbuvir-velpatasvir 337
SOLTAMOX 278, 279
SOMAVERT 338
sorafenib tosylate 278, 279
SOTYKTU 339
SPRYCEL 278, 279
STELARA INTRAVENOUS 340, 341
STELARA SUBCUTANEOUS SOLUTION 45 MG/0.5ML 340, 341
STELARA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 340, 341
STIVARGA 278, 279
SUCRAID 342
sunitinib malate 278, 279
SYMDEKO 343
SYMLINPEN 120 SUBCUTANEOUS SOLUTION PEN-INJECTOR 344
SYMLINPEN 60 SUBCUTANEOUS SOLUTION PEN-INJECTOR 344
SYNAREL 345

T

TABLOID 278, 279
TABRECTA 278, 279
tacrolimus oral capsule 0.5 mg, 1 mg, 5 mg 394
tadalafil (pah) 346
TADLIQ 346
TAFINLAR 278, 279

TAGRISSO 278, 279
TALTZ 347, 348
TALZENNA 278, 279
TARPEYO 349
TASCENSO ODT 257, 258
TASIGNA 278, 279
tasimelteon 220
TAVNEOS 350, 351
TAZVERIK 278, 279
TDVAX INTRAMUSCULAR SUSPENSION 2-2 LF/0.5ML 394
TEFLARO 352
temazepam 226
TENIVAC INTRAMUSCULAR INJECTABLE 5-2 LFU, 5-2 LFU (INJECTION) 394
TEPMETKO 278, 279
teriflunomide 257, 258
teriparatide (recombinant) subcutaneous solution pen-injector 620 mcg/2.48ml 353, 354
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%) 358
testosterone transdermal solution 358
tetanus-diphtheria toxoids td intramuscular suspension 2-2 lf/0.5ml 394
tetrabenazine 372
THALOMID 278, 279
THIOLA EC 355
TIBSOVO 278, 279
tiopronin oral 355
tobramycin inhalation nebulization solution 300 mg/5ml 394
tolvaptan 356
toremifene citrate 278, 279
TRELSTAR MIXJECT 213
TREMFYA 360
tretinoin oral 278, 279
trientine hcl oral capsule 250 mg 361
trihexyphenidyl hcl 221, 222
TRIKAFTA 362
trimipramine maleate oral 223
TRUQAP 278, 279
TRUSELTIQ (100MG DAILY DOSE) 278, 279
TRUSELTIQ (125MG DAILY DOSE) 278, 279
TRUSELTIQ (50MG DAILY DOSE) 278, 279
TRUSELTIQ (75MG DAILY DOSE) 278, 279
TUKYSA 278, 279
TURALIO 278, 279
TYMLOS 363
TYVASO DPI MAINTENANCE KIT 364
TYVASO DPI TITRATION KIT 364

U

UBRELVY 171, 172
UDENYCA 376
UDENYCA ONBODY 376
UPTRAVI ORAL 365
UPTRAVI TITRATION 365
UZEDY 366

V

VALCHLOR 367
VALTOCO 10 MG DOSE 261
VALTOCO 15 MG DOSE 261
VALTOCO 20 MG DOSE 261
VALTOCO 5 MG DOSE 261
VANFLYTA 278, 279
VEMLIDY 368
VENCLEXTA 278, 279
VENCLEXTA STARTING PACK 278, 279
VENTAVIS 369
VERZENIO 278, 279
vigabatrin 370
VIJOICE 371
VITRAKVI 278, 279
VIZIMPRO 278, 279
VONJO 278, 279
voriconazole intravenous 373
VOSEVI 374

VOWST 375
VRAYLAR ORAL CAPSULE 280
VRAYLAR ORAL CAPSULE THERAPY PACK 280
W
WELIREG 278, 279
X
XALKORI 278, 279
XATMEP 377
XELJANZ 378, 379
XELJANZ XR 378, 379
XERMELO 380
XGEVA 381
XIFAXAN 382
XOLAIR 383, 384
XOSPATA 278, 279
XPOVIO (100 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 50 MG 278, 279
XPOVIO (40 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 40 MG 278, 279
XPOVIO (40 MG TWICE WEEKLY) ORAL TABLET THERAPY PACK 40 MG 278, 279
XPOVIO (60 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 60 MG 278, 279
XPOVIO (60 MG TWICE WEEKLY) 278, 279
XPOVIO (80 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 40 MG 278, 279
XPOVIO (80 MG TWICE WEEKLY) 278, 279
XTAMPZA ER 385
XTANDI 278, 279
XURIDEN 386
XYREM 387
XYWAV 388
Y
YONSA 278, 279
Z
zaleplon 226
ZARXIO 376
ZAVZPRET 171, 172
ZEJULA 278, 279
ZELBORAF 278, 279
ZEMAIRA 154
ZEPOSIA 389
ZEPOSIA 7-DAY STARTER PACK 389
ZEPOSIA STARTER KIT ORAL CAPSULE THERAPY PACK 0.23MG &0.46MG 0.92MG(21) 389
ZIEXTENZO 376
ZOLINZA 278, 279
zolpidem tartrate er 226
zolpidem tartrate oral tablet 10 mg 226
ZTALMY 390
ZTLIDO 359
ZURZUVAE 391
ZYDELIG 278, 279
ZYKADIA ORAL TABLET 278, 279
ZYPREXA RELPREVV INTRAMUSCULAR SUSPENSION RECONSTITUTED 210 MG, 300 MG, 405 MG 392

anticonvulsant step therapy

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

Criteria	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.

antidepressant step therapy

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

Criteria	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

Products Affected

- *brinzolamide suspension 1 % ophthalmic*

Details

Criteria	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.

glp-1 agonists

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

Criteria	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.

netarsudil step therapy

Products Affected

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

Details

Criteria	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.

ongentys step therapy

Products Affected

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

Details

Criteria	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

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

Criteria	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.

savella step therapy

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 & 25 & 50 MG ORAL

Details

Criteria	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

Products Affected

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

Details

Criteria	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.

urinary incontinence agents step therapy

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

Criteria	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

Index

B

brinzolamide suspension 1 % ophthalmic 409

D

darifenacin hydrobromide er tablet extended release 24 hour 15 mg oral 416

darifenacin hydrobromide er tablet extended release 24 hour 7.5 mg oral 416

F

fesoterodine fumarate er tablet extended release 24 hour 4 mg oral 416

fesoterodine fumarate er tablet extended release 24 hour 8 mg oral 416

FETZIMA CAPSULE EXTENDED RELEASE 24 HOUR 120 MG ORAL 408

FETZIMA CAPSULE EXTENDED RELEASE 24 HOUR 20 MG ORAL 408

FETZIMA CAPSULE EXTENDED RELEASE 24 HOUR 40 MG ORAL 408

FETZIMA CAPSULE EXTENDED RELEASE 24 HOUR 80 MG ORAL 408

FETZIMA TITRATION CAPSULE ER 24 HOUR THERAPY PACK 20 & 40 MG ORAL 408

FYCOMPA SUSPENSION 0.5 MG/ML ORAL 407

FYCOMPA TABLET 10 MG ORAL 407

FYCOMPA TABLET 12 MG ORAL. 407

FYCOMPA TABLET 2 MG ORAL .. 407

FYCOMPA TABLET 4 MG ORAL .. 407

FYCOMPA TABLET 6 MG ORAL .. 407

FYCOMPA TABLET 8 MG ORAL .. 407

M

MOUNJARO SOLUTION PEN-INJECTOR 10 MG/0.5ML SUBCUTANEOUS 410

MOUNJARO SOLUTION PEN-INJECTOR 12.5 MG/0.5ML SUBCUTANEOUS 410

MOUNJARO SOLUTION PEN-INJECTOR 15 MG/0.5ML SUBCUTANEOUS 410

MOUNJARO SOLUTION PEN-INJECTOR 2.5 MG/0.5ML SUBCUTANEOUS 410

MOUNJARO SOLUTION PEN-INJECTOR 5 MG/0.5ML SUBCUTANEOUS 410

MOUNJARO SOLUTION PEN-INJECTOR 7.5 MG/0.5ML SUBCUTANEOUS 410

O

ONGENTYS CAPSULE 25 MG ORAL 412

ONGENTYS CAPSULE 50 MG ORAL 412

OZEMPIC (0.25 OR 0.5 MG/DOSE) SOLUTION PEN-INJECTOR 2 MG/1.5ML SUBCUTANEOUS 410

OZEMPIC (0.25 OR 0.5 MG/DOSE) SOLUTION PEN-INJECTOR 2 MG/3ML SUBCUTANEOUS 410

OZEMPIC (1 MG/DOSE) SOLUTION PEN-INJECTOR 4 MG/3ML SUBCUTANEOUS 410

OZEMPIC (2 MG/DOSE) SOLUTION PEN-INJECTOR 8 MG/3ML SUBCUTANEOUS 410

P

pimecrolimus cream 1 % external 415

R

RHOPRESSA SOLUTION 0.02 % OPHTHALMIC 411

rivastigmine patch 24 hour 13.3 mg/24hr transdermal 413
rivastigmine patch 24 hour 4.6 mg/24hr transdermal 413
rivastigmine patch 24 hour 9.5 mg/24hr transdermal 413
ROCKLATAN SOLUTION 0.02-0.005 % OPHTHALMIC 411
RYBELSUS TABLET 14 MG ORAL 410
RYBELSUS TABLET 3 MG ORAL .. 410
RYBELSUS TABLET 7 MG ORAL .. 410
S
SAVELLA TABLET 100 MG ORAL. 414
SAVELLA TABLET 12.5 MG ORAL. 414
SAVELLA TABLET 25 MG ORAL.... 414
SAVELLA TABLET 50 MG ORAL ... 414
SAVELLA TITRATION PACK 12.5 & 25 & 50 MG ORAL 414
SPRITAM TABLET DISINTEGRATING SOLUBLE 1000 MG ORAL..... 407
SPRITAM TABLET DISINTEGRATING SOLUBLE 250 MG ORAL 407
SPRITAM TABLET DISINTEGRATING SOLUBLE 500 MG ORAL..... 407
SPRITAM TABLET DISINTEGRATING SOLUBLE 750 MG ORAL 407
SYMPAZAN FILM 10 MG ORAL.... 407
SYMPAZAN FILM 20 MG ORAL... 407
SYMPAZAN FILM 5 MG ORAL..... 407
T
tacrolimus ointment 0.03 % external 415
tacrolimus ointment 0.1 % external 415
trospium chloride er capsule extended release 24 hour 60 mg oral 416
TRULICITY SOLUTION PEN-INJECTOR 0.75 MG/0.5ML SUBCUTANEOUS 410
TRULICITY SOLUTION PEN-INJECTOR 1.5 MG/0.5ML SUBCUTANEOUS 410
TRULICITY SOLUTION PEN-INJECTOR 3 MG/0.5ML SUBCUTANEOUS 410
TRULICITY SOLUTION PEN-INJECTOR 4.5 MG/0.5ML SUBCUTANEOUS 410
V
VICTOZA SOLUTION PEN-INJECTOR 18 MG/3ML SUBCUTANEOUS 410
X
XCOPRI (250 MG DAILY DOSE) TABLET THERAPY PACK 100 & 150 MG ORAL 407
XCOPRI (350 MG DAILY DOSE) TABLET THERAPY PACK 150 & 200 MG ORAL 407
XCOPRI TABLET 100 MG ORAL ... 407
XCOPRI TABLET 150 MG ORAL.... 407
XCOPRI TABLET 200 MG ORAL .. 407
XCOPRI TABLET 50 MG ORAL 407
XCOPRI TABLET THERAPY PACK 14 X 12.5 MG & 14 X 25 MG ORAL... 407
XCOPRI TABLET THERAPY PACK 14 X 150 MG & 14 X200 MG ORAL. 407
XCOPRI TABLET THERAPY PACK 14 X 50 MG & 14 X100 MG ORAL.... 407
Z
ZONISADE SUSPENSION 100 MG/5ML ORAL 407

2024 Formulary

List of Covered Drugs

Troy Medicare for Dual-eligible Beneficiaries (HMO D-SNP)

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 for Dual-eligible Beneficiaries (HMO D-SNP) 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.