

NUPLAZID

Products Affected

- Nuplazid CAPS
- Nuplazid TABS 10MG

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For hallucinations and delusions associated with Parkinson's disease psychosis, the diagnosis of Parkinson's disease must be made prior to the onset of psychotic symptoms.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

OCTREOTIDE

Products Affected

- Octreotide Acetate INJ
1000MCG/ML, 100MCG/ML,
200MCG/ML, 500MCG/ML,
50MCG/ML

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Tumor control of thymomas and thymic carcinomas.
Exclusion Criteria	N/A
Required Medical Information	For acromegaly (initial): 1) patient has a high pretreatment insulin-like growth factor-1 (IGF-1) level for age and/or gender based on the laboratory reference range, and 2) patient had an inadequate or partial response to surgery or radiotherapy OR there is a clinical reason for why the patient has not had surgery or radiotherapy. For acromegaly (continuation of therapy): patient's IGF-1 level has decreased or normalized since initiation of therapy. For tumor control of thymomas and thymic carcinomas, the requested drug will be used as second-line systemic therapy in patients with unresectable or extrathoracic metastatic disease.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

ODOMZO

Products Affected

- Odomzo

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

OFEV

Products Affected

- Ofev

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

ONCASPAR

Products Affected

- Oncaspar

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Extranodal natural killer/T-cell lymphoma (nasal type), hepatosplenic gamma-delta T-cell lymphoma
Exclusion Criteria	N/A
Required Medical Information	For extranodal natural killer/T-cell lymphoma (nasal type), acute lymphoblastic leukemia, and hepatosplenic gamma-delta T-cell lymphoma: the requested drug must be used in conjunction with multi-agent chemotherapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

ONUREG

Products Affected

- Onureg

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

OPSUMIT

Products Affected

- Opsumit

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For pulmonary arterial hypertension (PAH) (World Health Organization [WHO] Group 1): Diagnosis was confirmed by right heart catheterization. For PAH new starts only: 1) Pretreatment mean pulmonary arterial pressure is greater than 20 mmHg, 2) Pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, and 3) Pretreatment pulmonary vascular resistance is greater than or equal to 3 Wood units.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

ORACEA

Products Affected

- Doxycycline CPDR
- Oracea

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Patient must have experienced an inadequate treatment response, intolerance, or has a contraindication to formulary generic topical metronidazole.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

ORAL-INTRANASAL FENTANYL

Products Affected

- Fentanyl Citrate Oral Transmucosal

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	1) The requested drug is indicated for the treatment of breakthrough CANCER-related pain only. The requested drug is being prescribed for the management of breakthrough pain in a CANCER patient with underlying CANCER pain AND 2) The International Classification of Diseases (ICD) diagnosis code provided supports the CANCER-RELATED diagnosis. [Note: For drug coverage approval, ICD diagnosis code provided MUST support the CANCER-RELATED diagnosis.] AND 3) The patient is currently receiving, and will continue to receive, around-the-clock opioid therapy for underlying CANCER pain AND 4) The requested drug is intended only for use in opioid tolerant patients. The patient can safely take the requested dose based on their current opioid use history. [Note: Patients considered opioid tolerant are those who are taking around-the-clock medicine consisting of at least 60 mg of oral morphine per day, at least 25 mcg per hour of transdermal fentanyl, at least 30 mg of oral oxycodone per day, at least 60 mg of oral hydrocodone per day, at least 8 mg of oral hydromorphone per day, at least 25 mg of oral oxymorphone per day, or an equianalgesic dose of another opioid medication daily for one week or longer.].
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

ORGOVYX

Products Affected

- Orgovyx

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

ORKAMBI

Products Affected

- Orkambi

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For cystic fibrosis (CF): The requested medication will not be used in combination with other medications containing ivacaftor.
Age Restrictions	2 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

OXANDROLONE

Products Affected

- Oxandrolone TABS

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Cachexia associated with AIDS (HIV wasting), To enhance growth in patients with Turners Syndrome
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Turners Syndrome: Plan Year, All other diagnoses: 6 months
Other Criteria	Coverage will be denied if request is for an indication excluded from Medicare Part D.

OXAZEPAM - 65

Products Affected

- Oxazepam

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For all indications: the prescriber must acknowledge the benefit of therapy with the requested drug outweighs the potential risks for the patient. (Note: The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) For the management of anxiety disorders, anxiety associated with depression, and the management of anxiety, tension, agitation and irritability in older patients: 1) the requested drug is being used concurrently with a selective serotonin reuptake inhibitor (SSRI) or serotonin-norepinephrine reuptake inhibitor (SNRI) until the SSRI/SNRI becomes effective for the symptoms of anxiety, OR 2) the patient has experienced an inadequate treatment response, intolerance, or a has a contraindication to AT LEAST TWO agents from the following classes: a) selective serotonin reuptake inhibitors (SSRIs), b) serotonin-norepinephrine reuptake inhibitors (SNRIs).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Short-term relief anxiety-1 month, Anxiety Disorders-4 months, Alcohol Withdrawal-Plan Year
Other Criteria	This Prior Authorization requirement only applies to patients 65 years of age or older.

PADCEV

Products Affected

- Padcev

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Recurrent primary carcinoma of the urethra, recurrent or persistent urothelial carcinoma of the bladder.
Exclusion Criteria	N/A
Required Medical Information	For urothelial carcinoma, the requested drug will be used as subsequent therapy for any of the following: a) locally advanced or metastatic urothelial carcinoma, b) urothelial carcinoma of the bladder with muscle invasive local recurrence or persistent disease in a preserved bladder, c) urothelial carcinoma of the bladder with metastatic or local recurrence post cystectomy, or d) recurrent primary carcinoma of the urethra.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

PEGASYS

Products Affected

- Pegasys

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Myeloproliferative neoplasm (essential thrombocythemia, polycythemia vera, symptomatic low risk myelofibrosis), systemic mastocytosis, adult T-cell leukemia/lymphoma, mycosis fungoides/Sezary syndrome, primary cutaneous CD30+ T-cell lymphoproliferative disorders.
Exclusion Criteria	N/A
Required Medical Information	For chronic hepatitis C: Hepatitis C virus (HCV) confirmed by presence of hepatitis C virus HCV RNA in serum prior to starting treatment and the planned treatment regimen.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	HCV: 12-48 weeks depending on regimen. HBV: 48 weeks. All Other: Plan Year.
Other Criteria	N/A

PEMAZYRE

Products Affected

- Pemazyre

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

PEPAXTO

Products Affected

- Pepaxto

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

PHENYLBUTYRATE

Products Affected

- Sodium Phenylbutyrate POWD
3GM/TSP
- Sodium Phenylbutyrate TABS

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For urea cycle disorder: Diagnosis of urea cycle disorder (UCD) was confirmed by enzymatic, biochemical or genetic testing.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

PHESGO

Products Affected

- Phesgo

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Recurrent human epidermal growth factor receptor 2 (HER2)-positive breast cancer
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Neoadjuvant therapy for breast cancer: 6 months. Other: Plan Year
Other Criteria	N/A

PIQRAY

Products Affected

- Piqray 200mg Daily Dose
- Piqray 250mg Daily Dose
- Piqray 300mg Daily Dose

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Recurrent hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative, PIK3CA-mutated breast cancer in combination with fulvestrant.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

POLIVY

Products Affected

- Polivy

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	High-grade B-cell lymphomas, histologic transformation of follicular to diffuse large B-cell lymphoma without translocations of MYC and BCL2 and/or BCL6, monomorphic post-transplant lymphoproliferative disorders (B-cell type), acquired immunodeficiency syndrome (AIDS)-related B-cell lymphomas (AIDS-related diffuse large B-cell lymphoma, primary effusion lymphoma, and human herpesvirus-8 (HHV8)-positive diffuse large B-cell lymphoma), histologic transformation of nodal marginal zone lymphoma to diffuse large B-cell lymphoma, follicular lymphoma.
Exclusion Criteria	N/A
Required Medical Information	For diffuse large B-cell lymphomas and high-grade B-cell lymphomas: 1) The requested drug is used as a single agent or in combination with bendamustine with or without a rituximab product, AND 2) Patient has received at least two prior therapies.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

POMALYST

Products Affected

- Pomalyst

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Systemic light chain amyloidosis, primary central nervous system (CNS) lymphoma, POEMS syndrome.
Exclusion Criteria	N/A
Required Medical Information	For multiple myeloma: The patient has previously received at least two prior therapies for multiple myeloma, including an immunomodulatory agent AND a proteasome inhibitor. For Kaposi sarcoma, patient meets one of the following: 1) patient has acquired immunodeficiency syndrome (AIDS), or 2) patient is negative for human immunodeficiency virus (HIV).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

POTELIGEO

Products Affected

- Poteligeo

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Adult T-cell leukemia/lymphoma
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

PRALUENT

Products Affected

- Praluent

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

PREGABALIN

Products Affected

- Pregabalin CAPS
- Pregabalin SOLN

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Cancer-Related Neuropathic Pain, Cancer Treatment-Related Neuropathic Pain
Exclusion Criteria	N/A
Required Medical Information	1) The requested drug is being prescribed for the management of postherpetic neuralgia, the management of neuropathic pain associated with diabetic peripheral neuropathy, cancer-related neuropathic pain, or cancer treatment-related neuropathic pain AND 2) The patient has experienced an inadequate treatment response, intolerance, or contraindication to gabapentin OR 3) The requested drug is being prescribed as adjunctive therapy for the treatment of partial onset seizures OR 4) The requested drug is being prescribed for the management of fibromyalgia or the management of neuropathic pain associated with spinal cord injury.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

PRETOMANID

Products Affected

- Pretomanid

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

PROMACTA

Products Affected

- Promacta

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	<p>For chronic or persistent immune thrombocytopenia (ITP): 1) For new starts: a) Patient has had an inadequate response or is intolerant to a prior therapy such as corticosteroids or immunoglobulins, b) Untransfused platelet (plt) count at any point prior to the initiation of the requested medication is less than 30,000/mcL OR 30,000-50,000/mcL with symptomatic bleeding or risk factor(s) for bleeding (e.g., undergoing a medical or dental procedure where blood loss is anticipated, comorbidities such as peptic ulcer disease and hypertension, anticoagulation therapy, profession or lifestyle that predisposes patient to trauma) AND c) For chronic ITP only: patient has had an inadequate response or intolerance to avatrombopag. 2) For continuation of therapy, plt count response to the requested drug: a) Current plt count is less than or equal to 200,000/mcL OR b) Current plt count is greater than 200,000/mcL to less than or equal to 400,000/mcL and dosing will be adjusted to a plt count sufficient to avoid clinically important bleeding. For thrombocytopenia associated with chronic hepatitis C: 1) For new starts: the requested drug is used for initiation and maintenance of interferon-based therapy. 2) For continuation of therapy: patient is receiving interferon-based therapy. For severe aplastic anemia (AA): For continuation of therapy following the initial 6 month approval for severe aplastic anemia: The patient must meet one of the following: 1) Current plt count is 50,000-200,000/mcL OR 2) Current plt count is less than 50,000/mcL and patient has not received appropriately titrated therapy for at least 16 weeks, OR 3) Current plt count is less than 50,000/mcL and patient is transfusion-independent, OR 4) Current plt count is greater than 200,000/mcL to less than or equal to 400,000/mcL and dosing will be adjusted to achieve and maintain an appropriate target plt count.</p>
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	HCV: 6mo, ITP/AA initial: 6mo, ITP reauth: Plan Year, AA reauth: APR-Plan Year, IPR-16 wks

Other Criteria	APR: adequate platelet response (greater than 50,000/mcL), IPR: inadequate platelet response (less than 50,000/mcL).
-----------------------	--

PULMOZYME

Products Affected

- Pulmozyme SOLN 2.5MG/2.5ML

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For cystic fibrosis: Diagnosis of cystic fibrosis was confirmed by appropriate diagnostic or genetic testing.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.

QINLOCK

Products Affected

- Qinlock

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

QUETIAPINE XR

Products Affected

- Quetiapine Fumarate Er

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Maintenance monotherapy treatment in bipolar I disorder, monotherapy treatment of generalized anxiety disorder, monotherapy treatment of major depressive disorder
Exclusion Criteria	N/A
Required Medical Information	For schizophrenia, acute treatment of manic or mixed episodes associated with bipolar I disorder, both as monotherapy and as an adjunct to lithium or divalproex, the acute treatment of depressive episodes associated with bipolar disorder, maintenance treatment of bipolar I disorder, as an adjunct to lithium or divalproex, adjunctive treatment of major depressive disorder, or maintenance monotherapy treatment in bipolar I disorder: The patient experienced an inadequate treatment response, intolerance, or contraindication to one of the following generic products: A) aripiprazole, B) asenapine, C) olanzapine, D) quetiapine immediate-release, E) risperidone, F) ziprasidone. For all indications: If the patient is 65 years of age or older AND is using two or more additional central nervous system (CNS) active medications (e.g., lorazepam, sertraline, clonazepam, escitalopram, alprazolam, zolpidem) with the requested drug, the prescriber determined that taking multiple central nervous system (CNS) active medications is medically necessary. [Note: Use of multiple central nervous system (CNS) active medications in older adults is associated with an increased risk of falls.].
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

QUININE SULFATE

Products Affected

- Quinine Sulfate CAPS 324MG

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Babesiosis, uncomplicated Plasmodium vivax malaria
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 month
Other Criteria	N/A

REGRANEX

Products Affected

- Regranex

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For the treatment of lower extremity diabetic neuropathic ulcers that extend into the subcutaneous tissue or beyond and have an adequate blood supply.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	20 weeks
Other Criteria	N/A

RETEVMO

Products Affected

- Retevmo

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Recurrent or advanced rearranged during transfection (RET)-rearrangement positive non-small cell lung cancer
Exclusion Criteria	N/A
Required Medical Information	For non-small cell lung cancer, patient must meet all of the following: 1) The disease is recurrent, advanced or metastatic, and 2) Tumor is RET fusion-positive or RET rearrangement-positive.
Age Restrictions	Non-small cell lung cancer: 18 years of age or older. Medullary thyroid cancer and thyroid cancer: 12 years of age or older.
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

REVLIMID

Products Affected

- Revlimid

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Systemic light chain amyloidosis, classical Hodgkin lymphoma, myelodysplastic syndrome without the 5q deletion cytogenetic abnormality, myelofibrosis-associated anemia, POEMS syndrome, myeloproliferative neoplasms, non-Hodgkin's lymphoma with the following subtypes: acquired immunodeficiency syndrome (AIDS)-related non-germinal center diffuse large B-cell lymphoma, primary central nervous system (CNS) lymphoma, monomorphic post-transplant lymphoproliferative disorder, chronic lymphocytic leukemia (CLL)/small lymphocytic lymphoma (SLL), diffuse large B-cell lymphoma, multicentric Castleman's disease, adult T-cell leukemia/lymphoma, mycosis fungoides (MF)/Sezary syndrome (SS), angioimmunoblastic T-cell lymphoma (AITL), peripheral T-cell lymphoma not otherwise specified (PTCL NOS), enteropathy-associated T-cell lymphoma, monomorphic epitheliotropic intestinal T-cell lymphoma, nodal peripheral T-cell lymphoma, primary cutaneous anaplastic large cell lymphoma (ALCL), hepatosplenic T-cell lymphoma, high-grade B-cell lymphomas, histologic transformation of nodal marginal zone lymphoma to diffuse large B-cell lymphoma, histologic transformation of follicular lymphoma to diffuse large B-cell lymphoma, AIDS-related Kaposi sarcoma, smoldering myeloma
Exclusion Criteria	N/A
Required Medical Information	For myelodysplastic syndrome (MDS): Lower risk MDS with symptomatic anemia per the Revised International Prognostic Scoring System (IPSS-R), International Prognostic Scoring System (IPSS), or World Health organization (WHO) classification-based Prognostic Scoring System (WPSS).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

REZUROCK

Products Affected

- Rezurock

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	12 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

RINVOQ

Products Affected

- Rinvoq

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For moderately to severely active rheumatoid arthritis (new starts only): 1) inadequate response, intolerance or contraindication to methotrexate (MTX) OR 2) inadequate response or intolerance to a prior biologic disease-modifying antirheumatic drug (DMARD) or a targeted synthetic DMARD.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

RITUXAN HYCELA

Products Affected

- Rituxan Hycela

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Castleman's disease (CD), high-grade B-cell lymphoma, histologic transformation of nodal marginal zone lymphoma to diffuse large B-cell lymphoma, marginal zone lymphomas (nodal marginal zone lymphoma, gastric mucosa-associated lymphoid tissue (MALT) lymphoma, nongastric MALT lymphoma, and splenic marginal zone lymphoma), mantle cell lymphoma, post-transplant lymphoproliferative disorder (PTLD), primary cutaneous B-cell lymphoma (e.g., cutaneous marginal zone lymphoma or cutaneous follicle center lymphomas), hairy cell leukemia, small lymphocytic lymphoma (SLL).
Exclusion Criteria	N/A
Required Medical Information	Malignancies must be CD20 positive. Patient must receive at least one full dose of a rituximab product by intravenous infusion without experiencing severe adverse reactions.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

RITUXIMAB

Products Affected

- Rituxan
- Ruxience

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Non-Hodgkin's lymphoma subtypes [small lymphocytic lymphoma (SLL), mantle cell lymphoma, marginal zone lymphomas (nodal, splenic, gastric mucosa-associated lymphoid tissue [MALT], nongastric MALT), Burkitt lymphoma, primary cutaneous B-cell lymphoma, high-grade B-cell lymphoma with translocations of MYC and BCL2 and/or BCL6 (double/triple hit lymphoma), high-grade B-cell lymphoma not otherwise specified, histological transformation from follicular lymphoma to diffuse large B-cell lymphoma, histological transformation from nodal marginal zone lymphoma to diffuse large B-cell lymphoma, Castleman's disease, acquired immunodeficiency syndrome (AIDS)-related B-cell lymphoma, hairy cell leukemia, post-transplant lymphoproliferative disorder (PTLD), B-cell lymphoblastic lymphoma], refractory immune or idiopathic thrombocytopenic purpura (ITP), autoimmune hemolytic anemia, Waldenstrom's macroglobulinemia/lymphoplasmacytic lymphoma, chronic graft-versus-host disease (GVHD), Sjogren syndrome, thrombotic thrombocytopenic purpura, refractory myasthenia gravis, Hodgkin's lymphoma (nodular lymphocyte-predominant), primary central nervous system (CNS) lymphoma, leptomeningeal metastases from lymphomas, acute lymphoblastic leukemia, prevention of Epstein-Barr virus (EBV)-related PTLD, multiple sclerosis, and immune checkpoint inhibitor-related toxicities
Exclusion Criteria	N/A
Required Medical Information	For moderately to severely active rheumatoid arthritis (new starts only): 1) patient meets ANY of the following: a) requested drug will be used in combination with methotrexate (MTX) OR b) patient has intolerance or contraindication to MTX, AND 2) patient meets ANY of the following: a) inadequate response, intolerance, or contraindication to MTX OR b) inadequate response or intolerance to a prior biologic disease-modifying antirheumatic drug (DMARD) or a targeted synthetic DMARD. Hematologic malignancies must be CD20-positive. For multiple sclerosis: 1) patient has a diagnosis of relapsing remitting multiple sclerosis and 2) patient has had an inadequate response to two or more disease-modifying drugs indicated for multiple sclerosis despite adequate duration of treatment.
Age Restrictions	N/A
Prescriber Restrictions	N/A

Coverage Duration	Immune checkpoint inhibitor-related toxicities: 3 months, All other: Plan Year
Other Criteria	N/A

ROZLYTREK

Products Affected

- Rozlytrek

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Recurrent or advanced ROS1-positive non-small cell lung cancer (NSCLC), advanced, recurrent, or persistent neurotrophic tyrosine receptor kinase (NTRK) gene fusion-positive solid tumors, first-line treatment of NTRK gene fusion-positive solid tumors.
Exclusion Criteria	N/A
Required Medical Information	For all neurotrophic tyrosine receptor kinase (NTRK) gene fusion-positive solid tumors, the disease is without a known acquired resistance mutation.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

RUBRACA

Products Affected

- Rubraca

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For metastatic castration-resistant prostate cancer with a deleterious breast cancer susceptibility gene (BRCA) mutation (germline and/or somatic): 1) patient has been treated with androgen receptor-directed therapy, 2) patient has been treated with a taxane-based chemotherapy or the patient is not fit for chemotherapy, 3) the requested drug will be used in combination with a gonadotropin-releasing hormone (GnRH) analog or after bilateral orchiectomy, and 4) patient experienced an unacceptable toxicity with a trial of Lynparza (olaparib). For maintenance treatment of patients with recurrent epithelial ovarian, fallopian tube, or primary peritoneal cancer who are in a complete or partial response to platinum-based chemotherapy, patient experienced an unacceptable toxicity with a trial of Lynparza (olaparib). For treatment of patients with a deleterious breast cancer susceptibility gene (BRCA) mutation (germline and/or somatic)-associated epithelial ovarian, fallopian tube, or primary peritoneal cancer who have been treated with two or more chemotherapies: if prescribed for deleterious germline BRCA-mutated advanced ovarian cancer treated with two or more prior chemotherapies, the patient experienced an unacceptable toxicity with a trial of Lynparza (olaparib).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

RYDAPT

Products Affected

- Rydapt

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Relapsed or refractory acute myeloid leukemia (AML), myeloid, lymphoid, or mixed lineage neoplasms with eosinophilia and FGFR1 or FLT3 rearrangements, post-remission maintenance therapy for acute myeloid leukemia (AML), re-induction in residual disease for acute myeloid leukemia (AML)
Exclusion Criteria	N/A
Required Medical Information	For acute myeloid leukemia (AML): AML must be FLT3 mutation-positive. For myeloid, lymphoid, or mixed lineage neoplasms with eosinophilia and FGFR1 or FLT3 rearrangements: the disease is in chronic or blast phase.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

SANDOSTATIN LAR

Products Affected

- Sandostatin Lar Depot

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Tumor control of thymomas and thymic carcinomas, neuroendocrine tumors (NETs) of the gastrointestinal (GI) tract, lung, thymus (carcinoid tumors), unresected primary gastrinoma, NETs of the pancreas, and pheochromocytoma/paraganglioma.
Exclusion Criteria	N/A
Required Medical Information	For acromegaly (initial): 1) patient has a high pretreatment insulin-like growth factor-1 (IGF-1) level for age and/or gender based on the laboratory reference range, and 2) patient had an inadequate or partial response to surgery or radiotherapy OR there is a clinical reason for why the patient has not had surgery or radiotherapy. For acromegaly (continuation of therapy): patient's IGF-1 level has decreased or normalized since initiation of therapy. For tumor control, the requested drug will be used for any of the following: 1) neuroendocrine tumors of the gastrointestinal tract or pancreas in patients with locoregional advanced disease and/or distant metastatic disease, OR 2) neuroendocrine tumors of the thymus or lung in patients with locoregional unresectable disease and/or distant metastatic disease, OR 3) unresected primary gastrinoma, OR 4) thymomas and thymic carcinomas as second-line systemic therapy in patients with unresectable or extrathoracic metastatic disease, OR 5) pheochromocytomas and paragangliomas, used for either of the following: a) symptomatic locally unresectable disease with somatostatin receptor positive imaging, OR b) secreting tumors in metastatic disease.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

SARCLISA

Products Affected

- Sarclisa

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

SCSEMBLIX

Products Affected

- Scemblix

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For chronic myeloid leukemia (CML) in the chronic phase: 1) the diagnosis was confirmed by detection of the Philadelphia chromosome or BCR-ABL gene AND the patient meets either of the following: A) the patient has previously been treated with 2 or more tyrosine kinase inhibitors (TKIs) AND at least one of those was imatinib or dasatinib, OR B) the patient is positive for the T315I mutation.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

SIGNIFOR

Products Affected

- Signifor

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Endocrinologist
Coverage Duration	Plan Year
Other Criteria	N/A

SILDENAFIL

Products Affected

- Sildenafil INJ
- Sildenafil Citrate TABS 20MG

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For pulmonary arterial hypertension (PAH) (World Health Organization [WHO] Group 1): Diagnosis was confirmed by right heart catheterization. For PAH new starts only: 1) Pretreatment mean pulmonary arterial pressure is greater than 20 mmHg, 2) Pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, and 3) Pretreatment pulmonary vascular resistance is greater than or equal to 3 Wood units.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

SIRTURO

Products Affected

- Sirturo

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an infectious disease specialist.
Coverage Duration	Plan Year
Other Criteria	N/A

SKYRIZI

Products Affected

- Skyrizi
- Skyrizi Pen

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For moderate to severe plaque psoriasis (new starts only): 1) at least 3% of body surface area (BSA) is affected OR crucial body areas (e.g., feet, hands, face, neck, groin, intertriginous areas) are affected at the time of diagnosis, AND 2) patient meets any of the following: a) patient has experienced an inadequate response or intolerance to either phototherapy (e.g., UVB, PUVA) or pharmacologic treatment with methotrexate, cyclosporine, or acitretin, or b) pharmacologic treatment with methotrexate, cyclosporine, or acitretin is contraindicated, or c) patient has severe psoriasis that warrants a biologic disease-modifying antirheumatic drug (DMARD) as first-line therapy (i.e. at least 10% of the body surface area or crucial body areas [e.g., hands, feet, face, neck, scalp, genitals/groin, intertriginous areas] are affected).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

SOMATULINE DEPOT

Products Affected

- Somatuline Depot

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Tumor control of neuroendocrine tumors (NETs) of the lung, thymus (carcinoid tumors) or unresected primary gastrinoma, and pheochromocytoma/paraganglioma.
Exclusion Criteria	N/A
Required Medical Information	For acromegaly (initial): 1) patient has a high pretreatment insulin-like growth factor-1 (IGF-1) level for age and/or gender based on the laboratory reference range, and 2) patient had an inadequate or partial response to surgery or radiotherapy OR there is a clinical reason for why the patient has not had surgery or radiotherapy. For acromegaly continuation of therapy: patient's IGF-1 level has decreased or normalized since initiation of therapy. For tumor control, the requested drug will be used for any of the following: 1) neuroendocrine tumor of the thymus or lung in patients with locoregional unresectable disease and/or distant metastatic disease, OR 2) unresected primary carcinoma, OR 3) pheochromocytomas and paragangliomas, used for either of the following: a) symptomatic locally unresectable disease with somatostatin receptor positive imaging OR b) secreting tumor in metastatic disease.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

SOMAVERT

Products Affected

- Somavert

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For acromegaly (initial): 1) patient has a high pretreatment insulin-like growth factor-1 (IGF-1) level for age and/or gender based on the laboratory reference range, and 2) patient had an inadequate or partial response to surgery or radiotherapy OR there is a clinical reason for why the patient has not had surgery or radiotherapy. For acromegaly continuation of therapy: patient's IGF-1 level has decreased or normalized since initiation of therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

SPRITAM

Products Affected

- Spritam

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Partial-Onset Seizures: 4 years of age or older. Myoclonic Seizures: 12 years of age or older. Primary Generalized Tonic-Clonic Seizures: 6 years of age or older.
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

SPRYCEL

Products Affected

- Sprycel

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Gastrointestinal stromal tumor (GIST), metastatic chondrosarcoma, recurrent chordoma, T-cell acute lymphoblastic leukemia (ALL), Philadelphia (Ph)-like B-ALL
Exclusion Criteria	N/A
Required Medical Information	For chronic myeloid leukemia (CML), including patients who have received a hematopoietic stem cell transplant: diagnosis was confirmed by detection of the Philadelphia (Ph) chromosome or BCR-ABL gene. If patient experienced resistance to an alternative tyrosine kinase inhibitor for CML, patient is negative for T315I/A, F317L/V/I/C, and V299L mutations. For acute lymphoblastic leukemia (ALL), the patient has a diagnosis of one of the following: 1) Philadelphia chromosome positive ALL that has been confirmed by detection of the Ph chromosome or BCR-ABL gene, OR 2) Ph-like B-ALL with ABL-class kinase fusion, OR 3) relapsed or refractory T-cell ALL with ABL-class translocation. For GIST, patient must have progressed on imatinib, sunitinib, and regorafenib.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

STELARA

Products Affected

- Stelara INJ 45MG/0.5ML, 90MG/ML

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For moderate to severe plaque psoriasis (new starts only): 1) At least 3% of body surface area (BSA) is affected OR crucial body areas (e.g., feet, hands, face, neck, groin, intertriginous areas) are affected at the time of diagnosis and 2) Patient had an inadequate response, intolerance, or contraindication to two of the following products: Enbrel (etanercept), Humira (adalimumab), Skyrizi (risankizumab-rzaa). For active psoriatic arthritis (PsA) (new starts): patient had an inadequate response, intolerance, or contraindication to two of the following products: Enbrel (etanercept), Humira (adalimumab), Skyrizi (risankizumab-rzaa), Xeljanz (tofacitinib)/Xeljanz XR (tofacitinib extended-release). For moderately to severely active Crohn's disease (new starts): patient had an inadequate response, intolerance, or contraindication to Humira (adalimumab). For moderately to severely active ulcerative colitis (new starts): patient had an inadequate response, intolerance, or contraindication to Humira (adalimumab).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

STIVARGA

Products Affected

- Stivarga

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Progressive gastrointestinal stromal tumors (GIST), osteosarcoma, glioblastoma, angiosarcoma, retroperitoneal/intra-abdominal soft tissue sarcoma, rhabdomyosarcoma, solitary fibrous tumor, and soft tissue sarcomas of the extremities, body wall, head and neck, advanced colorectal cancer.
Exclusion Criteria	N/A
Required Medical Information	For gastrointestinal stromal tumors: The disease is progressive, locally advanced, unresectable, or metastatic.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

SUTENT

Products Affected

- Sunitinib Malate
- Sutent

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Thyroid carcinoma (follicular, medullary, papillary, and Hurthle cell), soft tissue sarcoma (angiosarcoma, solitary fibrous tumor, and alveolar soft part sarcoma subtypes), recurrent chordoma, thymic carcinoma.
Exclusion Criteria	N/A
Required Medical Information	For renal cell carcinoma, the disease is relapsed, advanced, or stage IV.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

SYMLIN

Products Affected

- Symlinpen 120
- Symlinpen 60

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

SYMPAZAN

Products Affected

- Sympazan

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	2 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

SYNRIBO

Products Affected

- Synribo

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Follow-up therapy for chronic myeloid leukemia (CML) patients after hematopoietic stem cell transplant (HSCT)
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

TABRECTA

Products Affected

- Tabrecta

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Treatment of recurrent or advanced non-small cell lung cancer (NSCLC).
Exclusion Criteria	N/A
Required Medical Information	For recurrent, advanced, or metastatic NSCLC: Tumor is positive for mesenchymal-epithelial transition (MET) exon 14 skipping mutation.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

TADALAFIL (PAH)

Products Affected

- Alyq
- Tadalafil TABS 20MG

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For pulmonary arterial hypertension (PAH) (World Health Organization [WHO] Group 1): Diagnosis was confirmed by right heart catheterization. For PAH new starts only: 1) Pretreatment mean pulmonary arterial pressure is greater than 20 mmHg, 2) Pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, and 3) Pretreatment pulmonary vascular resistance is greater than or equal to 3 Wood units.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

TAFINLAR

Products Affected

- Tafinlar

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Brain metastases from melanoma, thyroid carcinoma (papillary carcinoma, follicular carcinoma, and Hurthle cell carcinoma), central nervous system (CNS) cancer (i.e., glioma, meningioma, astrocytoma)
Exclusion Criteria	N/A
Required Medical Information	For brain metastases from melanoma, adjuvant treatment of melanoma, and central nervous system (CNS) cancer (i.e., glioma, meningioma, astrocytoma): 1) The tumor is positive for a BRAF V600 activating mutation (e.g., V600E or V600K), and 2) The requested drug will be used in combination with trametinib. For unresectable or metastatic melanoma: 1) The tumor is positive for a BRAF V600 activating mutation (e.g., V600E or V600K), and 2) The requested drug will be used as a single agent or in combination with trametinib. For non-small cell lung cancer: 1) The tumor is positive for a BRAF V600E mutation, and 2) The requested drug will be used in combination with trametinib. For thyroid carcinoma with papillary, follicular, or Hurthle histology: The tumor is positive for BRAF activating mutation (e.g., V600E or V600K).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

TAGRISSE

Products Affected

- Tagrisso

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Sensitizing epidermal growth factor receptor (EGFR) mutation-positive recurrent or advanced non-small cell lung cancer (NSCLC), brain metastases from sensitizing EGFR mutation-positive NSCLC, leptomeningeal metastases from EGFR mutation-positive NSCLC
Exclusion Criteria	N/A
Required Medical Information	For NSCLC, the requested drug is used in any of the following settings: 1) The patient meets both of the following: a) patient has metastatic, advanced, or recurrent NSCLC (including brain and/or leptomeningeal metastases from NSCLC) and b) patient has a sensitizing EGFR mutation OR 2) Patient meets both of the following: a) request is for adjuvant treatment of NSCLC following tumor resection and b) patient has EGFR mutation-positive disease.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

TALTZ

Products Affected

- Taltz

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For moderate to severe plaque psoriasis (new starts only): 1) At least 3% of body surface area (BSA) is affected OR crucial body areas (e.g., feet, hands, face, neck, groin, intertriginous areas) are affected at the time of diagnosis AND 2) the patient had an inadequate response, intolerance, or contraindication to one of the following products: Enbrel (etanercept), Humira (adalimumab), Skyrizi (risankizumab-rzaa). For active ankylosing spondylitis (new starts only): the patient had an inadequate response, intolerance, or contraindication to either Enbrel (etanercept) or Humira (adalimumab). For active psoriatic arthritis (PsA) (new starts only): the patient had an inadequate response, intolerance, or contraindication to one of the following products: Enbrel (etanercept), Humira (adalimumab), Skyrizi (risankizumab-rzaa), Xeljanz (tofacitinib)/Xeljanz XR (tofacitinib extended-release). For active axial spondyloarthritis (new starts only): Patient meets any of the following: 1) has had an inadequate response to a non-steroidal anti-inflammatory drug (NSAID) trial or 2) has an intolerance or contraindication to NSAIDs.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

TALZENNA

Products Affected

- Talzenna CAPS 0.25MG, 1MG

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Recurrent germline breast cancer susceptibility gene (BRCA)-mutated breast cancer
Exclusion Criteria	N/A
Required Medical Information	For germline BRCA-mutated (gBRCAm) metastatic or recurrent breast cancer, the patient experienced an unacceptable toxicity with a trial of Lynparza (olaparib).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

TARGRETIN TOPICAL

Products Affected

- Targretin GEL

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Mycosis fungoides, chronic or smoldering adult T-cell leukemia/lymphoma, primary cutaneous marginal zone lymphoma, primary cutaneous follicle center lymphoma.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

TASIGNA

Products Affected

- Tasigna

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Philadelphia chromosome positive acute lymphoblastic leukemia (Ph+ ALL), gastrointestinal stromal tumor (GIST)
Exclusion Criteria	N/A
Required Medical Information	For chronic myeloid leukemia (CML) or acute lymphoblastic leukemia (ALL), diagnosis was confirmed by detection of the Philadelphia chromosome or BCR-ABL gene. For CML, including patients newly diagnosed with CML and patients who have received a hematopoietic stem cell transplant: patient has experienced resistance or intolerance to imatinib or dasatinib. If patient experienced resistance to an alternative tyrosine kinase inhibitor for CML, patient is negative for T315I, Y253H, E255K/V, and F359V/C/I mutations. For GIST, patient must have progressed on imatinib, sunitinib, and regorafenib.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

TAZAROTENE

Products Affected

- Tazarotene CREA
- Tazorac CREA 0.05%

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For plaque psoriasis: 1) The requested drug is being prescribed to treat less than 20 percent of the patient's body surface area AND 2) The patient experienced an inadequate treatment response or intolerance to at least one topical corticosteroid OR has a contraindication that would prohibit a trial of topical corticosteroids.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

TAZVERIK

Products Affected

- Tazverik

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Epithelioid sarcoma: 16 years of age or older, Follicular lymphoma: 18 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

TECENTRIQ

Products Affected

- Tecentriq

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Recurrent or advanced non-small cell lung cancer, PD-L1 positive triple negative recurrent breast cancer in combination with paclitaxel protein-bound
Exclusion Criteria	N/A
Required Medical Information	For urothelial carcinoma, patient meets one of the following criteria: 1) Patient is ineligible for cisplatin therapy and tumors express PD-L1 (defined as PD-L1 stained tumor-infiltrating immune cells [IC] covering greater than or equal to 5 percent of the tumor area) OR 2) Patient is ineligible for any platinum containing chemotherapy. For non-small cell lung cancer (NSCLC): 1) the patient has recurrent, advanced or metastatic disease AND the requested drug will be used as any of the following: a) first-line treatment of tumors with high PD-L1 expression (defined as PD-L1 stained greater than or equal to 50 percent of tumor cells or PD-L1 stained tumor-infiltrating immune cells [IC] covering greater than or equal to 10 percent of the tumor area) and no EGFR or ALK genomic tumor aberrations, b) used in combination with carboplatin, paclitaxel, and bevacizumab, or in combination with carboplatin and albumin-bound paclitaxel for nonsquamous NSCLC, or c) the requested drug will be used as subsequent therapy or continuation maintenance therapy, OR 2) the patient has stage II to IIIA disease AND the requested drug will be used as adjuvant treatment following resection and platinum-based chemotherapy for tumors with PD-L1 expression on greater than or equal to 1 percent of tumor cells. For hepatocellular carcinoma, the requested drug will be used as initial treatment in combination with bevacizumab.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

TECFIDERA

Products Affected

- Tecfidera
- Tecfidera Starter Pack

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

TEMAZEPAM 30MG - 65

Products Affected

- Temazepam CAPS 30MG

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Prescriber must acknowledge that the benefit of therapy with the requested drug outweighs the potential risks for the patient. (Note: The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to doxepin (3 mg or 6 mg).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	This Prior Authorization requirement only applies to patients 65 years of age or older.

TEPMETKO

Products Affected

- Tepmetko

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

TESTOSTERONE CYPIONATE INJ

Products Affected

- Testosterone Cypionate INJ
100MG/ML, 200MG/ML

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Gender Dysphoria
Exclusion Criteria	N/A
Required Medical Information	Primary or hypogonadotropic hypogonadism: 1) Request is for continuation of testosterone therapy and the patient had a confirmed low morning testosterone level according to current practice guidelines or your standard lab reference values before starting testosterone therapy [Note: Safety and efficacy of testosterone products in patients with "age-related hypogonadism" (also referred to as "late-onset hypogonadism") have not been established.] OR 2) Request is not for continuation of testosterone therapy and the patient has at least two confirmed low morning testosterone levels according to current practice guidelines or your standard lab reference values [Note: Safety and efficacy of testosterone products in patients with "age-related hypogonadism" (also referred to as "late-onset hypogonadism") have not been established.]. Gender dysphoria: The patient is able to make an informed decision to engage in hormone therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

TESTOSTERONE ENANTHATE INJ

Products Affected

- Testosterone Enanthate INJ

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Gender Dysphoria
Exclusion Criteria	N/A
Required Medical Information	Primary or hypogonadotropic hypogonadism: 1) Request is for continuation of testosterone therapy and the patient had a confirmed low morning testosterone level according to current practice guidelines or your standard lab reference values before starting testosterone therapy [Note: Safety and efficacy of testosterone products in patients with "age-related hypogonadism" (also referred to as "late-onset hypogonadism") have not been established.] OR 2) Request is not for continuation of testosterone therapy and the patient has at least two confirmed low morning testosterone levels according to current practice guidelines or your standard lab reference values [Note: Safety and efficacy of testosterone products in patients with "age-related hypogonadism" (also referred to as "late-onset hypogonadism") have not been established.]. Gender dysphoria: The patient is able to make an informed decision to engage in hormone therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

TETRABENAZINE

Products Affected

- Tetrabenazine

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Tic disorders, tardive dyskinesia, hemiballismus, chorea not associated with Huntington's disease.
Exclusion Criteria	N/A
Required Medical Information	For treatment of chorea associated with Huntington's disease: The patient must have a prior inadequate response or intolerable adverse event with deutetrabenazine therapy. For treatment of tardive dyskinesia: The patient must have a prior inadequate response or intolerable adverse event with deutetrabenazine or valbenazine therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

THALOMID

Products Affected

- Thalomid

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Myelofibrosis-related anemia, recurrent aphthous stomatitis, recurrent human immunodeficiency virus (HIV)-associated aphthous ulcers, cachexia, HIV-associated diarrhea, acquired immunodeficiency syndrome (AIDS)-related Kaposi's sarcoma, Behcet's syndrome, chronic graft-versus-host disease, Crohn's disease, multicentric Castleman's disease.
Exclusion Criteria	N/A
Required Medical Information	For cachexia: Cachexia must be due to cancer or HIV infection.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

TIBSOVO

Products Affected

- Tibsovo

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Conventional (grades 1-3) or dedifferentiated chondrosarcoma
Exclusion Criteria	N/A
Required Medical Information	Patient has disease with a susceptible isocitrate dehydrogenase-1 (IDH1) mutation. For acute myeloid leukemia (AML): 1) patient has newly-diagnosed AML and meets one of the following: a) 75 years of age or older, b) patient has comorbidities that preclude use of intensive induction chemotherapy, or c) patient is 60 physiologic years of age or older and declines intensive induction chemotherapy, OR 2) patient is 60 physiologic years of age or older and the requested drug will be used as post-induction therapy following response to induction therapy with the requested drug, OR 3) patient has relapsed or refractory AML. For unresectable or metastatic cholangiocarcinoma: the requested drug will be used as subsequent treatment for progression on or after systemic treatment.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

TOBRAMYCIN

Products Affected

- Tobramycin NEBU 300MG/5ML

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Non-cystic fibrosis bronchiectasis
Exclusion Criteria	N/A
Required Medical Information	For cystic fibrosis and non-cystic fibrosis bronchiectasis, the patient must meet one of the following: 1) Pseudomonas aeruginosa is present in the patient's airway cultures, OR 2) the patient has a history of Pseudomonas aeruginosa infection or colonization in the airways.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.

TOPICAL DOXEPIN

Products Affected

- Doxepin Hydrochloride CREA

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	The patient has experienced an inadequate response to a topical corticosteroid or a topical calcineurin inhibitor (e.g., tacrolimus).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 month
Other Criteria	N/A

TOPICAL LIDOCAINE

Products Affected

- Lidocaine OINT 5%
- Lidocaine Hcl EXTERNAL SOLN 4%
- Lidocaine/prilocaine CREA

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	1) The requested drug is being used for topical anesthesia, AND 2) If the requested drug will be used as part of a compounded product, then all the active ingredients in the compounded product are Food and Drug Administration (FDA) approved for topical use.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 months
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.

TOPICAL TESTOSTERONES

Products Affected

- Androderm PT24 2MG/24HR, 4MG/24HR
- Testosterone GEL 10MG/ACT, 25MG/2.5GM, 50MG/5GM
- Testosterone Pump GEL 1%
- Testosterone Topical Solution

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Gender Dysphoria
Exclusion Criteria	N/A
Required Medical Information	Primary or hypogonadotropic hypogonadism: 1) Request is for continuation of testosterone therapy and the patient had a confirmed low morning testosterone level according to current practice guidelines or your standard lab reference values before starting testosterone therapy [Note: Safety and efficacy of testosterone products in patients with "age-related hypogonadism" (also referred to as "late-onset hypogonadism") have not been established.] OR 2) Request is not for continuation of testosterone therapy and the patient has at least two confirmed low morning testosterone levels according to current practice guidelines or your standard lab reference values [Note: Safety and efficacy of testosterone products in patients with "age-related hypogonadism" (also referred to as "late-onset hypogonadism") have not been established.]. Gender dysphoria: The patient is able to make an informed decision to engage in hormone therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

TOPICAL TRETINOIN

Products Affected

- Tretinoin CREA
- Tretinoin GEL
- Tretinoin Microsphere
- Tretinoin Microsphere Pump

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

TOREMIFENE

Products Affected

- Toremifene Citrate

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	Congenital/acquired QT prolongation (long QT syndrome), uncorrected hypokalemia, or uncorrected hypomagnesemia.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

TRELSTAR

Products Affected

- Trelstar Mixject INJ 11.25MG, 3.75MG

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Gender dysphoria
Exclusion Criteria	N/A
Required Medical Information	For gender dysphoria, patient meets either of the following (1 or 2): 1) the requested drug is used to suppress puberty and the patient is at Tanner stage 2 or greater, OR 2) patient is undergoing gender transition, and the patient will receive the requested drug concomitantly with gender-affirming hormones.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

TREPROSTINIL INJ

Products Affected

- Treprostinil

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For pulmonary arterial hypertension (World Health Organization [WHO] Group 1), the diagnosis was confirmed by right heart catheterization. For new starts only: 1) pretreatment mean pulmonary arterial pressure is greater than 20 mmHg, 2) pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, AND 3) pretreatment pulmonary vascular resistance is greater than or equal to 3 Wood units.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.

TRIENTINE

Products Affected

- Trientine Hydrochloride

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

TRIKAFTA

Products Affected

- Trikafta

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	The requested medication will not be used in combination with other medications containing ivacaftor.
Age Restrictions	6 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

TRODELVY

Products Affected

- Trodelvy

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Recurrent triple-negative breast cancer
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

TRUSELTIQ

Products Affected

- Truseltiq

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

TUKYSA

Products Affected

- Tukysa

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Recurrent human epidermal growth factor receptor 2 (HER2)-positive breast cancer, including patients with brain metastases, who have received one or more lines of prior HER2-targeted therapy in the metastatic setting.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

TURALIO

Products Affected

- Turalio

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

UBRELVY

Products Affected

- Ubrelyvy

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	The patient has experienced an inadequate treatment response, intolerance, or the patient has a contraindication to one triptan 5-HT1 receptor agonist.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

UKONIQ

Products Affected

- Ukoniq

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

VALCHLOR

Products Affected

- Valchlor

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Chronic or smoldering adult T-cell leukemia/lymphoma, Stage 2 or higher mycosis fungoides/Sezary syndrome, primary cutaneous marginal zone lymphoma, primary cutaneous follicle center lymphoma, lymphomatoid papulosis.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

VALTOCO

Products Affected

- Valtoco

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	6 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

VELCADE

Products Affected

- Bortezomib
- Velcade

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Systemic light chain amyloidosis, Waldenstrom's macroglobulinemia/lymphoplasmacytic lymphoma, multicentric Castleman's disease, adult T-cell leukemia/lymphoma, acute lymphoblastic leukemia, AIDS-related Kaposi's sarcoma, Hodgkin lymphoma, POEMS syndrome
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.

VELTASSA

Products Affected

- Veltassa

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to Lokelma.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

VENCLEXTA

Products Affected

- Venclexta
- Venclexta Starting Pack

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Mantle cell lymphoma, blastic plasmacytoid dendritic cell neoplasm (BPDCN), multiple myeloma, relapsed or refractory acute myeloid leukemia (AML), AML in patients 60 physiologic years of age or older.
Exclusion Criteria	N/A
Required Medical Information	For acute myeloid leukemia (AML), any of the following criteria must be met: 1) the patient's physiologic age is 60 years of age or older OR 2) the requested drug will be used as a component of repeating the initial successful induction regimen if late relapse OR 3) the patient has comorbidities that preclude use of intensive induction chemotherapy OR 4) the requested drug will be used for relapsed or refractory disease. For blastic plasmacytoid dendritic cell neoplasm (BPDCN), any of the following criteria must be met: 1) patient has systemic disease treated with palliative intent OR 2) patient has relapsed or refractory disease. For multiple myeloma, all of the following must be met: 1) the disease is relapsed or progressive AND 2) the requested drug will be used in combination with dexamethasone AND 3) patient has t(11:14) translocation.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

VENTAVIS

Products Affected

- Ventavis

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For pulmonary arterial hypertension (World Health Organization [WHO] Group 1), the diagnosis was confirmed by right heart catheterization. For new starts only: 1) pretreatment mean pulmonary arterial pressure is greater than 20 mmHg, 2) pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, AND 3) pretreatment pulmonary vascular resistance is greater than or equal to 3 Wood units.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.

VERSACLOZ

Products Affected

- Versacloz

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For the treatment of a severely ill patient with schizophrenia who failed to respond adequately to standard antipsychotic treatment (i.e., treatment-resistant schizophrenia), 1) the patient experienced an inadequate treatment response, intolerance, or contraindication to one of the following generic products: A) aripiprazole, B) asenapine, C) olanzapine, D) quetiapine, E) risperidone, F) ziprasidone AND 2) The patient experienced an inadequate treatment response, intolerance, or contraindication to one of the following brand products: A) Latuda, B) Rexulti, C) Secuado.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

VERZENIO

Products Affected

- Verzenio

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Recurrent hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative breast cancer in combination with fulvestrant or an aromatase inhibitor, or as a single agent if progression on prior endocrine therapy and prior chemotherapy in the metastatic setting.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

VIGABATRIN

Products Affected

- Vigabatrin
- Vigadrone

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For complex partial seizures (CPS): patient had an inadequate response to at least 2 antiepileptic drugs for CPS.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

VITRAKVI

Products Affected

- Vitrakvi

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Advanced, recurrent, or persistent neurotrophic tyrosine receptor kinase (NTRK) gene fusion-positive solid tumors, first-line treatment of NTRK gene fusion-positive solid tumors.
Exclusion Criteria	N/A
Required Medical Information	For all neurotrophic tyrosine receptor kinase (NTRK) gene fusion-positive solid tumors, the disease is without a known acquired resistance mutation.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

VIZIMPRO

Products Affected

- Vizimpro

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Recurrent or advanced non-small cell lung cancer (NSCLC).
Exclusion Criteria	N/A
Required Medical Information	For non-small cell lung cancer (NSCLC): 1) the disease is recurrent, advanced or metastatic, and 2) the patient has sensitizing EGFR mutation-positive disease.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

VORICONAZOLE

Products Affected

- Voriconazole INJ
- Voriconazole SUSR

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	The patient will use the requested drug orally or intravenously.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	6 months
Other Criteria	N/A

VOSEVI

Products Affected

- Vosevi

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	Decompensated cirrhosis/moderate or severe hepatic impairment (Child Turcotte Pugh class B or C)
Required Medical Information	For hepatitis C: Infection confirmed by presence of HCV RNA in the serum prior to starting treatment. Planned treatment regimen, genotype, prior treatment history, presence or absence of cirrhosis (compensated or decompensated [Child Turcotte Pugh class B or C]), presence or absence of HIV coinfection, presence or absence of resistance-associated substitutions where applicable, liver and kidney transplantation status if applicable. Coverage conditions and specific durations of approval will be based on current AASLD treatment guidelines.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Criteria will be applied consistent with current AASLD-IDSA guidance.
Other Criteria	N/A

VOTRIENT

Products Affected

- Votrient

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Thyroid carcinoma (follicular, papillary, Hurthle cell, or medullary), uterine sarcoma.
Exclusion Criteria	N/A
Required Medical Information	For renal cell carcinoma: The disease is advanced, relapsed, or stage IV. For soft tissue sarcoma (STS): The patient does not have an adipocytic soft tissue sarcoma. For uterine sarcoma: The disease is recurrent or metastatic.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

WELIREG

Products Affected

- Welireg

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

XALKORI

Products Affected

- Xalkori

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Recurrent non-small cell lung cancer (NSCLC), NSCLC with high-level MET amplification or MET exon 14 skipping mutation, inflammatory myofibroblastic tumors (IMT).
Exclusion Criteria	N/A
Required Medical Information	For NSCLC, the requested drug is used in any of the following settings: 1) the patient has recurrent, advanced or metastatic ALK-positive NSCLC, 2) the patient has recurrent, advanced or metastatic ROS-1 positive NSCLC, or 3) the patient has NSCLC with high-level MET amplification or MET exon 14 skipping mutation. For IMT, the disease is ALK-positive. For anaplastic large cell lymphoma, the disease is relapsed or refractory and ALK-positive.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

XELJANZ

Products Affected

- Xeljanz
- Xeljanz Jr

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For moderately to severely active rheumatoid arthritis (new starts only): 1) Inadequate response, intolerance or contraindication to methotrexate (MTX), OR 2) Inadequate response or intolerance to a prior biologic disease-modifying antirheumatic drug (DMARD) or a targeted synthetic DMARD. For active psoriatic arthritis (new starts only): The requested drug is used in combination with a nonbiologic DMARD. For moderately to severely active ulcerative colitis (new starts only): Inadequate response, intolerance or contraindication to a tumor necrosis factor (TNF) blocker.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

XERMELO

Products Affected

- Xermelo

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

XGEVA

Products Affected

- Xgeva

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For hypercalcemia of malignancy: condition is refractory to intravenous (IV) bisphosphonate therapy or there is a clinical reason to avoid IV bisphosphonate therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.

XIFAXAN

Products Affected

- Xifaxan TABS 550MG

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	1) The requested drug is being prescribed to reduce the risk of overt hepatic encephalopathy (HE) recurrence OR 2) The patient has the diagnosis of irritable bowel syndrome with diarrhea (IBS-D) AND 3) If the patient has previously received treatment with the requested drug, the patient has experienced a recurrence of symptoms AND 4) The patient has not already received an initial 14-day course of treatment and two additional 14-day courses of treatment with the requested drug OR 5) The patient has not previously received treatment with the requested drug.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Reduction in risk of overt HE recurrence: 6 months, IBS-D: 14 days
Other Criteria	N/A

XOLAIR

Products Affected

- Xolair

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For allergic asthma initial therapy: 1) Patient has positive skin test (or blood test) to at least 1 perennial aeroallergen, 2) Patient has baseline IgE level greater than or equal to 30 IU/mL, and 3) Patient has inadequate asthma control despite current treatment with both of the following medications at optimized doses: a) Inhaled corticosteroid, and b) Additional controller (long acting beta2-agonist, leukotriene modifier, or sustained-release theophylline) unless patient has an intolerance or contraindication to such therapies. For allergic asthma continuation therapy only: Patient's asthma control has improved on treatment with the requested drug since initiation of therapy. For chronic idiopathic urticaria (CIU) initial therapy: 1) Patient has been evaluated for other causes of urticaria, including bradykinin-related angioedema and IL-1-associated urticarial syndromes (auto-inflammatory disorders, urticarial vasculitis), and 2) Patient has experienced a spontaneous onset of wheals, angioedema, or both, for at least 6 weeks. For CIU continuation therapy: Patient has experienced a response (e.g., improved symptoms) since initiation of therapy.
Age Restrictions	For CIU: 12 years of age or older. For allergic asthma: 6 years of age or older. For nasal polyps: 18 years of age or older.
Prescriber Restrictions	N/A
Coverage Duration	Allergic asthma and nasal polyps: Plan Year. CIU initial: 6 months. CIU continuation: Plan Year
Other Criteria	N/A

XOSPATA

Products Affected

- Xospata

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Myeloid, lymphoid, or mixed lineage neoplasms with eosinophilia and FLT3 rearrangement
Exclusion Criteria	N/A
Required Medical Information	For myeloid, lymphoid, or mixed lineage neoplasms with eosinophilia and FLT3 rearrangement: the disease is in chronic or blast phase.
Age Restrictions	18 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

XPOVIO

Products Affected

- Xpovio
- Xpovio 100 Mg Once Weekly
- Xpovio 40 Mg Once Weekly
- Xpovio 40 Mg Twice Weekly
- Xpovio 60 Mg Once Weekly
- Xpovio 60 Mg Twice Weekly
- Xpovio 80 Mg Once Weekly
- Xpovio 80 Mg Twice Weekly

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

XTANDI

Products Affected

- Xtandi

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	The requested drug will be used in combination with a gonadotropin-releasing hormone (GnRH) analog or after bilateral orchiectomy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

XYREM

Products Affected

- Xyrem

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	1) The requested drug is being prescribed for the treatment of excessive daytime sleepiness in a patient 7 years of age or older with narcolepsy AND 2) The diagnosis has been confirmed by sleep lab evaluation AND 3)The patient experienced an inadequate treatment response or intolerance to at least one central nervous system (CNS) stimulant drug (e.g., amphetamine, dextroamphetamine, or methylphenidate) OR has a contraindication that would prohibit a trial of central nervous system (CNS) stimulant drugs (e.g., amphetamine, dextroamphetamine, or methylphenidate) [Note: Coverage of amphetamines may require prior authorization.] AND 4) If the patient is 18 years of age or older, the patient experienced an inadequate treatment response or intolerance to at least one central nervous system (CNS) wakefulness promoting drug (e.g., armodafinil) OR has a contraindication that would prohibit a trial of central nervous system (CNS) wakefulness promoting drugs (e.g., armodafinil) [Note: coverage of armodafinil may require prior authorization.] OR 5) The requested drug is being prescribed for the treatment of cataplexy in a patient 7 years of age or older with narcolepsy AND 6) The diagnosis has been confirmed by sleep lab evaluation.
Age Restrictions	7 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with a sleep disorder specialist or neurologist.
Coverage Duration	Plan Year
Other Criteria	If the request is for a continuation of therapy, then the patient experienced a decrease in daytime sleepiness with narcolepsy or a decrease in cataplexy episodes with narcolepsy.

YERVOY

Products Affected

- Yervoy

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

ZARXIO

Products Affected

- Zarxio

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Neutropenia in myelodysplastic syndromes (MDS), agranulocytosis, neutropenia in aplastic anemia, human immunodeficiency virus (HIV)-related neutropenia, neutropenia related to renal transplant.
Exclusion Criteria	Use of the requested product within 24 hours prior to or following chemotherapy.
Required Medical Information	For prophylaxis or treatment of myelosuppressive chemotherapy-induced febrile neutropenia (FN) patient must meet both of the following: 1) Patient has a solid tumor or non-myeloid cancer, and 2) Patient has received, is currently receiving, or will be receiving treatment with myelosuppressive anti-cancer therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	6 months
Other Criteria	N/A

ZEJULA

Products Affected

- Zejula

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	In combination with bevacizumab for persistent or recurrent epithelial ovarian, fallopian tube, or primary peritoneal cancer for platinum-sensitive disease.
Exclusion Criteria	N/A
Required Medical Information	For ovarian, fallopian tube, or primary peritoneal cancer, the requested drug is used in any of the following settings: 1) as maintenance treatment of stage II-IV epithelial ovarian, fallopian tube, or primary peritoneal cancer in patients who are in a complete or partial response to first-line platinum-based chemotherapy AND if it is known that the patient has breast cancer susceptibility gene (BRCA)-mutated disease, the patient experienced an unacceptable toxicity with a trial of Lynparza (olaparib), 2) as maintenance treatment of recurrent epithelial ovarian, fallopian tube, or primary peritoneal cancer in patients who are in a complete or partial response to chemotherapy AND the patient experienced an unacceptable toxicity with a trial of Lynparza (olaparib), 3) as treatment of advanced, persistent, or recurrent ovarian, fallopian tube, or primary peritoneal cancer in patients treated with three or more prior chemotherapy regimens and whose cancer is associated with homologous recombination deficiency (HRD) positive status defined by either a) a deleterious or suspected deleterious BRCA mutation AND if prescribed for advanced, persistent, or recurrent ovarian cancer with deleterious or suspected deleterious germline BRCA mutation, the patient experienced an unacceptable toxicity with a trial of Lynparza (olaparib), or b) genomic instability and progression more than six months after response to the last platinum-based chemotherapy, or 4) in combination with bevacizumab for platinum-sensitive persistent or recurrent epithelial ovarian, fallopian tube, or primary peritoneal cancer.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

ZELBORAF

Products Affected

- Zelboraf

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Non-small cell lung cancer, hairy cell leukemia, thyroid carcinoma (i.e., papillary carcinoma, follicular carcinoma, and Hurthle cell carcinoma), central nervous system cancer (i.e., glioma, meningioma, astrocytoma), adjuvant systemic therapy for cutaneous melanoma.
Exclusion Criteria	N/A
Required Medical Information	For adjuvant treatment of melanoma, and central nervous system (CNS) cancer (i.e., glioma, meningioma, astrocytoma): 1) The tumor is positive for BRAF V600 activating mutation (e.g., V600E or V600K) and 2) The requested drug will be used in combination with cobimetinib. For unresectable or metastatic melanoma: 1) The tumor is positive for BRAF V600 activating mutation (e.g., V600E or V600K) and 2) the requested drug will be used as a single agent, or in combination with cobimetinib (with or without atezolizumab). For Erdheim-Chester Disease: Tumor is positive for BRAF V600 mutation. For non-small cell lung cancer: 1) Tumor is positive for the BRAF V600E mutation, and 2) The patient has recurrent, advanced, or metastatic disease. For thyroid carcinoma: 1) Tumor is positive for BRAF mutation, and 2) Patient has radioiodine refractory follicular, Hurthle cell, or papillary thyroid carcinoma. For hairy cell leukemia: The requested drug will be used for subsequent therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

ZEPZELCA

Products Affected

- Zepzelca

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Relapsed small cell lung cancer, primary progressive small cell lung cancer.
Exclusion Criteria	N/A
Required Medical Information	For small cell lung cancer: the requested medication will be used as a single agent in one of the following settings: 1) the disease has relapsed following complete or partial response or stable disease with initial treatment, 2) the patient has primary progressive disease, or 3) the patient has metastatic disease following disease progression on or after platinum-based chemotherapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

ZOLINZA

Products Affected

- Zolinza

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Mycosis fungoides, Sezary syndrome.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

ZYDELIG

Products Affected

- Zydelig

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Relapsed or refractory chronic lymphocytic leukemia (CLL)/small lymphocytic lymphoma (SLL), relapsed or refractory follicular lymphoma, and marginal zone lymphomas [nodal marginal zone lymphoma, gastric mucosa associated lymphoid tissue (MALT) lymphoma, non-gastric MALT lymphoma, and splenic marginal zone lymphoma].
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

ZYKADIA

Products Affected

- Zykadia TABS

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Recurrent or advanced ALK-positive non-small cell lung cancer (NSCLC), recurrent, advanced, or metastatic ROS1-positive NSCLC, inflammatory myofibroblastic tumor (IMT), brain metastases from NSCLC.
Exclusion Criteria	N/A
Required Medical Information	For NSCLC: the patient has recurrent, advanced, or metastatic ALK-positive or ROS1-positive disease. For inflammatory myofibroblastic tumor: the disease is ALK-positive. For brain metastases from NSCLC: the patient has ALK-positive NSCLC.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

ZYPREXA RELPREVV

Products Affected

- Zyprexa Relprevv

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Tolerability with oral olanzapine has been established.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

PART B VERSUS PART D

Products Affected

- Abelcet
- Acetylcysteine INHALATION SOLN
- Acyclovir Sodium INJ 50MG/ML
- Albuterol Sulfate NEBU 0.083%,
0.63MG/3ML, 1.25MG/3ML,
2.5MG/0.5ML
- Ambisome
- Aminosyn-pf 7% INJ 32.5MEQ/L;
490MG/100ML; 861MG/100ML;
370MG/100ML; 576MG/100ML;
270MG/100ML; 220MG/100ML;
534MG/100ML; 831MG/100ML;
475MG/100ML; 125MG/100ML;
10.69GM/L; 300MG/100ML;
570MG/100ML; 70GM/L;
347MG/100ML; 50MG/100ML;
360MG/100ML; 125MG/100ML;
44MG/100ML; 452MG/100ML
- Amphotericin B INJ
- Aprepitant CAPS
- Azathioprine INJ
- Azathioprine TABS 50MG
- Bleomycin Sulfate INJ
- Budesonide SUSP
- Cladribine
- Clinimix 4.25%/dextrose 10%
- Clinimix 4.25%/dextrose 5%
- Clinimix 5%/dextrose 15%
- Clinimix 5%/dextrose 20%
- Clinimix 6/5
- Clinimix 8/10
- Clinimix 8/14
- Clinisol Sf 15%
- Clinolipid
- Cromolyn Sodium NEBU
- Cyclophosphamide CAPS
- Cyclophosphamide TABS
- Cyclosporine CAPS
- Cyclosporine INJ
- Cyclosporine Modified
- Cytarabine INJ 100MG/ML
- Cytarabine Aqueous

- Dextrose 50%
- Dextrose 70%
- Diphtheria/tetanus Toxoids Adsorbed Pediatric
- Emend SUSR
- Engerix-b
- Epoprostenol Sodium
- Everolimus TABS 0.25MG, 0.5MG, 0.75MG, 1MG
- Fluorouracil INJ 1GM/20ML, 2.5GM/50ML, 500MG/10ML, 5GM/100ML
- Freamine Hbc 6.9%
- Freamine III INJ 89MEQ/L; 710MG/100ML; 950MG/100ML; 3MEQ/L; 24MG/100ML; 1400MG/100ML; 280MG/100ML; 690MG/100ML; 910MG/100ML; 730MG/100ML; 530MG/100ML; 560MG/100ML; 10MMOLE/L; 120MG/100ML; 1120MG/100ML; 590MG/100ML; 10MEQ/L; 400MG/100ML; 150MG/100ML; 660MG/100ML
- Gamastan
- Ganciclovir INJ 500MG, 500MG/10ML
- Gengraf CAPS 100MG, 25MG
- Gengraf SOLN
- Granisetron Hcl TABS
- Hepatamine INJ 62MEQ/L; 770MG/100ML; 600MG/100ML; 3MEQ/L; 20MG/100ML; 900MG/100ML; 240MG/100ML; 900MG/100ML; 1100MG/100ML; 610MG/100ML; 100MG/100ML; 100MG/100ML; 115MG/100ML; 800MG/100ML; 500MG/100ML; 450MG/100ML; 66MG/100ML; 840MG/100ML
- Humulin R U-500 (concentrated)
- Hydromorphone Hcl INJ 10MG/ML, 1MG/ML, 4MG/ML

- Plenamine INJ 147.4MEQ/L;
2.17GM/100ML; 1.47GM/100ML;
434MG/100ML; 749MG/100ML;
1.04GM/100ML; 894MG/100ML;
749MG/100ML; 1.04GM/100ML;
1.18GM/100ML; 749MG/100ML;
1.04GM/100ML; 894MG/100ML;
592MG/100ML; 749MG/100ML;
250MG/100ML; 39MG/100ML;
960MG/100ML
- Prednisolone SOLN
- Prednisolone Sodium Phosphate
ORAL SOLN 10MG/5ML,
15MG/5ML, 20MG/5ML,
25MG/5ML, 5MG/5ML
- Prednisone SOLN
- Prednisone TABS 10MG, 1MG,
2.5MG, 20MG, 50MG, 5MG
- Prednisone Intensol
- Premasol INJ 52MEQ/L;
1760MG/100ML; 880MG/100ML;
34MEQ/L; 1760MG/100ML;
372MG/100ML; 406MG/100ML;
526MG/100ML; 492MG/100ML;
492MG/100ML; 526MG/100ML;
356MG/100ML; 356MG/100ML;
390MG/100ML; 34MG/100ML;
152MG/100ML
- Procalamine
- Prograf PACK
- Prosol
- Rabavert
- Recombivax Hb
- Sandimmune SOLN
- Sirolimus SOLN
- Sirolimus TABS
- Tacrolimus CAPS
- Tdvax
- Tenivac
- Tpn Electrolytes INJ
29.5MEQ/20ML; 4.5MEQ/20ML;
35MEQ/20ML; 5MEQ/20ML;
20MEQ/20ML; 35MEQ/20ML

- Trivasol INJ 52MEQ/L;
1760MG/100ML; 880MG/100ML;
34MEQ/L; 1760MG/100ML;
372MG/100ML; 406MG/100ML;
526MG/100ML; 492MG/100ML;
492MG/100ML; 526MG/100ML;
356MG/100ML; 500MG/100ML;
356MG/100ML; 390MG/100ML;
34MG/100ML; 152MG/100ML
- Trophamine INJ 97MEQ/L;
0.54GM/100ML; 1.2GM/100ML;
0.32GM/100ML; 0; 0;
0.5GM/100ML; 0.36GM/100ML;
0.48GM/100ML; 0.82GM/100ML;
1.4GM/100ML; 1.2GM/100ML;
0.34GM/100ML; 0.48GM/100ML;
0.68GM/100ML; 0.38GM/100ML;
5MEQ/L; 0.025GM/100ML;
0.42GM/100ML; 0.2GM/100ML;
0.24GM/100ML; 0.78GM/100ML
- Vinblastine Sulfate INJ 1MG/ML
- Vincristine Sulfate INJ
- Zortress TABS 1MG

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	338
Abiraterone.....	1
Abiraterone Acetate.....	1
Accutane.....	153
Acetylcysteine	338
Acitretin.....	3
Actimmune	4
Acyclovir Sodium	338
Adempas.....	5
Afinitor	83
Afinitor Disperz.....	83
Aimovig.....	6
Albuterol Sulfate	338
Alecensa	7
Alosetron	8
Alosetron Hydrochloride.....	8
Alpha1-proteinase Inhibitor	9
Alunbrig	10
Alyq.....	266
Ambisome	338
Ambrisentan	11
Aminosyn-pf 7%	338
Amitriptyline Hcl	127
Amitriptyline Hydrochloride.....	127
Amnesteem.....	153
Amphotericin B.....	338
Androderm	288
Apo-varenicline	45
Aprepitant.....	338
Arcalyst	12
Armodafinil	13
Asparlas.....	14
Atovaquone	187
Austedo	15
Avonex	16
Avonex Pen	16

Ayvakit.....	17
Azathioprine.....	338

B

Balversa.....	18
Banzel	19
Beleodaq	20
Benlysta.....	21
Benzotropine Mesylate	116
Besremi	22
Betaseron.....	23
Bevacizumab.....	24
Bexarotene	26
Bivigam.....	156
Blenrep.....	27
Bleomycin Sulfate.....	338
Bortezomib.....	303
Bosentan.....	28
Bosulif.....	29
Braftovi	30
Briviact.....	31, 32
Briviact Inj	32
Brukisa	33
Budesonide.....	338
Buprenorphine.....	34, 35
Buprenorphine Hcl.....	34
Buprenorphine Patch.....	35

C

Cabometyx	36
Calcipotriene	37
Calcipotriene/betamethasone Dipropionate	37
Calcitriol	37
Calquence.....	38
Caplyta	39
Caprelsa.....	40
Carac	41
Carbaglu.....	42

Carbinoxamine Maleate	129
Cayston.....	43
Cerdelga	44
Chantix	45
Chantix Continuing Month Pak	45
Chantix Starting Month Pak.....	45
Chlordiazepoxide - 65	46
Chlordiazepoxide Hcl.....	46
Chlordiazepoxide Hydrochloride	46
Chlordiazepoxide/amitriptyline.....	110
Chlorzoxazone.....	133
Cladribine	338
Claravis.....	153
Clemastine Fumarate.....	130
Clinimix 4.25%/dextrose 10%	338
Clinimix 4.25%/dextrose 5%	338
Clinimix 5%/dextrose 15%	338
Clinimix 5%/dextrose 20%	338
Clinimix 6/5	338
Clinimix 8/10	338
Clinimix 8/14	338
Clinisol Sf 15%	338
Clinolipid.....	338
Clobazam.....	47
Clomipramine.....	48
Clomipramine Hcl	48
Clorazepate.....	49
Clorazepate Dipotassium.....	49
Clozapine Odt.....	50
Colistimethate Sodium	51
Coly-mycin.....	51
Cometriq.....	52
Copaxone.....	101
Copiktra.....	53
Cotellic	54
Cromolyn Sodium	338
Cyclobenzaprine Hydrochloride	133
Cyclophosphamide.....	338
Cyclosporine	338
Cyclosporine Modified.....	338
Cyproheptadine Hcl.....	118
Cyproheptadine Hydrochloride.....	118
Cystagon.....	55

Cystaran	56
Cytarabine.....	338
Cytarabine Aqueous.....	338

D

Dalfampridine	57
Dalfampridine Er	57
Daurismo.....	58
Deferasirox.....	59
Demser	60
Desipramine Hydrochloride.....	127
Desvenlafaxine.....	61
Desvenlafaxine Er	61
Dextrose 50%.....	339
Dextrose 70%.....	339
Dhe Nasal.....	62
Diacomit.....	63
Diazepam	64
Diclofenac Gel 1%.....	65
Diclofenac Sodium.....	65
Diclofenac Soln.....	66
Dicyclomine Hcl	110
Dicyclomine Hydrochloride.....	110
Dihydroergotamine Mesylate.....	62, 110
Diphenhydramine Hcl	110
Diphtheria/tetanus Toxoids Adsorbed Pediatric	339
Dipyridamole	110
Disopyramide Phosphate	110
Doptelet.....	67
Doxepin Hcl	119
Doxepin Hydrochloride	119, 286
Doxycycline	208
Drizalma.....	68
Drizalma Sprinkle	68
Dronabinol	69
Droxidopa	198
Duexis	70

E

Emend	339
Emsam.....	71
Enbrel.....	72
Enbrel Mini	72

Enbrel Sureclick	72
Engerix-b	339
Enhertu	74
Enstilar	37
Epclusa	75
Epidiolex	76
Epo	77
Epoprostenol Sodium	339
Erivedge	79
Erleada.....	80
Erlotinib.....	81
Erlotinib Hydrochloride	81
Esbriet.....	82
Eszopiclone	113
Everolimus	83, 339
Exkivity	84

F

Fanapt.....	85
Fanapt Titration Pack	85
Farydak.....	86
Fasenra	87
Fasenra Pen	87
Fentanyl.....	88
Fentanyl Citrate Oral Transmucosal	209
Fentanyl Patch.....	88
Fetzima	89
Fetzima Titration Pack	89
Fintepla.....	90
Flebogamma Dif.....	156
Fluoroplex	91
Fluorouracil	41, 91, 339
Fortamet/glumetza.....	92
Forteo	93
Fotivda.....	95
Freamine Hbc 6.9%.....	339
Freamine III.....	339
Fycompa.....	96

G

Gamastan.....	339
Gammagard Liquid	156
Gammagard S/d Iga Less Than 1mcg/ml.....	156

Gammaked	156
Gammaplex	156
Gamunex-c.....	156
Ganciclovir.....	339
Gattex	97
Gavreto.....	98
Gengraf	339
Genotropin	102
Genotropin Miniquick.....	102
Gilenya.....	99
Gilotrif.....	100
Glatiramer	101
Granisetron Hcl.....	339
Growth Hormone	102
Guanfacine Er	110
Guanfacine Hcl	110
Guanfacine Hydrochloride.....	110

H

Haegarda	105
Harvoni	106
Hepatamine	339
Herceptin Hylecta	107
Hetlioz.....	108
Hetlioz Lq	109
High Risk Medication - 65.....	110
Hrm - Anticonvulsants - 65.....	112
Hrm - Hypnotics - 65	113
Hrm - Scopolamine - 65.....	115
Hrm-antiparkinson - 65.....	116
Hrm-cyproheptadine - 65.....	118
Hrm-doxepin - 65.....	119
Hrm-hydroxyzine - 65.....	121
Hrm-hydroxyzine Inj - 65	123
Hrm-promethazine - 65.....	125
Hrms - Antidepressants.....	127
Hrms - Carbinoxamine.....	129
Hrms - Clemastine- 65	130
Hrms - Meclizine - 65	131
Hrms - Tcas.....	132
Hrm-skeletal Muscle Relaxants - 65.....	133
Humira	134
Humira Pediatric Crohns Disease Starter Pack..	134

Humira Pen.....	134
Humira Pen-cd/uc/hs Starter	134
Humira Pen-pediatric Uc Starter Pack	134
Humira Pen-ps/uv Starter	134
Humulin R U-500 (concentrated).....	339
Hydrocodone Bitartrate Er	150
Hydromorphone Hcl.....	339
Hydromorphone Hydrochloride	340
Hydroxyzine Hcl	121, 123
Hydroxyzine Hydrochloride.....	121, 123
Hydroxyzine Pamoate	121
Hyperlyte-cr	340
Hypnotic-benzodiazepines - 65	136
Hysingla Er.....	150

I

Ibrance.....	137
Ibuprofen/famotidine.....	70
Icatibant.....	138
Icatibant Acetate.....	138
Iclusig.....	139
Idhifa	140
Imatinib	141
Imatinib Mesylate.....	141
Imbruvica	142
Imipramine Hcl	127
Imipramine Hydrochloride.....	127
Imipramine Pamoate	127
Imlygic	145
Imovax Rabies (h.d.c.v.)	340
Increlex.....	146
Inlyta.....	147
Inqovi	148
Inrebic.....	149
Ipratropium Bromide.....	340
Ipratropium Bromide/albuterol Sulfate	340
Ir Before Er.....	150
Iressa.....	152
Isolyte-s	340
Isolyte-s Ph 7.4.....	340
Isotretinoin	153
Itraconazole	154
Ivermectin.....	155

Ivermectin Tab	155
Ivig.....	156

J

Jakafi.....	158
-------------	-----

K

Kalydeco	159
Kesimpta	160
Ketoconazole.....	161
Ketorolac Tromethamine	110
Keytruda.....	162
Khapzory.....	340
Kisqali	163
Kisqali Femara 200 Dose.....	163
Kisqali Femara 400 Dose.....	163
Kisqali Femara 600 Dose.....	163
Korlym	165
Kristalose	166
Kuvan.....	167
Kynmobi	168

L

Lapatinib	169
Lapatinib Ditosylate.....	169
Lenvima	170
Lenvima 10 Mg Daily Dose.....	170
Lenvima 12mg Daily Dose	170
Lenvima 14 Mg Daily Dose.....	170
Lenvima 18 Mg Daily Dose.....	170
Lenvima 20 Mg Daily Dose.....	170
Lenvima 24 Mg Daily Dose.....	170
Lenvima 4 Mg Daily Dose.....	170
Lenvima 8 Mg Daily Dose.....	170
Leuprolide	171
Leuprolide Acetate.....	171
Levalbuterol	340
Levalbuterol Hcl	340
Libtayo	172
Lidocaine.....	173, 287
Lidocaine Hcl.....	287
Lidocaine Patches	173
Lidocaine/prilocaine	287
Linezolid	174

Lonsurf	175
Lorbrena	176
Lumakras	177
Lumoxiti	178
Lupron Depot (1-month)	180
Lupron Depot (3-month)	180
Lupron Depot-ped (1-month)	179
Lupron Depot-ped (3-month)	179
Lupron Ped	179
Lupron-endometriosis	180
Lynparza	181
Lyrica Cr	182

M

Mavyret	183
Meclizine Hcl	131
Meclizine Hydrochloride	131
Mekinist	184
Mektovi	185
Melphalan	340
Memantine	186
Memantine Hcl Titration Pak	186
Memantine Hydrochloride	186
Memantine Hydrochloride Er	186
Meprobamate	110
Mepron	187
Metformin Hydrochloride Er	92
Methadone Hcl	150
Methadone Hydrochloride	150
Methscopolamine Bromide	110
Methyl dopa	110
Methylprednisolone	340
Methylprednisolone Acetate	340
Methylprednisolone Sodium Succinate	340
Methylprednisolone Sodiumsuccinate	340
Metyrosine	60
Modafinil	188
Monjuvi	189
Morphine Sulfate	340
Morphine Sulfate Er	150
Mycophenolate Mofetil	340
Mycophenolic Acid Dr	340
Mylotarg	190

Myorisan	153
----------------	-----

N

Naproxen/esomeprazole Magnesium	191
Naproxen-esomeprazole	191
Natpara	192
Nayzilam	193
Nephramine	340
Nerlynx	194
Nexavar	195
Ninlaro	196
Nitisinone	197
Northera	198
Nubeqa	199
Nuedexta	200
Nulojix	340
Nuplazid	201
Nutrilipid	340

O

Octagam	156
Octreotide	202
Octreotide Acetate	202
Odomzo	203
Ofev	204
Oncaspar	205
Ondansetron Hcl	340
Ondansetron Hydrochloride	340
Ondansetron Odt	340
Onureg	206
Opsumit	207
Oracea	208
Oral-intranasal Fentanyl	209
Orgovyx	210
Orkambi	211
Oxandrolone	212
Oxazepam	213
Oxazepam - 65	213

P

Padcev	214
Panzyga	156
Part B Versus Part D	337
Pegasys	215

Pemazyre	216
Pennsaid	66
Pentamidine Isethionate	340
Pepaxto	217
Perphenazine/amitriptyline.....	110
Phenobarbital.....	112
Phenobarbital Sodium	112
Phenylbutyrate.....	218
Phesgo	219
Piqray	220
Piqray 200mg Daily Dose	220
Piqray 250mg Daily Dose	220
Piqray 300mg Daily Dose	220
Plenamine	341
Polivy	221
Pomalyst.....	222
Poteligeo.....	223
Praluent.....	224
Prednisolone	341
Prednisolone Sodium Phosphate	341
Prednisone	341
Prednisone Intensol	341
Pregabalin.....	225
Pregabalin Er	182
Premasol	341
Pretomanid	226
Privigen	156
Procalamine.....	341
Procrit.....	77
Prograf.....	341
Prolastin-c.....	9
Promacta.....	227
Promethazine Hcl	125
Promethazine Hcl Plain.....	125
Promethazine Hydrochloride.....	125
Promethegan.....	125
Prosol.....	341
Protriptyline Hcl.....	132
Pulmozyme.....	230

Q

Qinlock.....	231
Quetiapine Fumarate Er	232

Quetiapine Xr.....	232
Quinine Sulfate	233

R

Rabavert	341
Recombivax Hb	341
Regranex	234
Retevmo	235
Revlimid.....	236
Rezurock	238
Rinvoq.....	239
Rituxan.....	241
Rituxan Hycela.....	240
Rituximab.....	241
Rozlytrek.....	244
Rubraca	245
Rufinamide.....	19
Ruxience	241
Rydapt	246

S

Sajazir	138
Sandimmune	341
Sandostatin Lar	247
Sandostatin Lar Depot.....	247
Sapropterin Dihydrochloride	167
Sarclisa.....	249
Scemblix	250
Scopolamine.....	115
Signifor	251
Sildenafil	252
Sildenafil Citrate	252
Sirolimus	341
Sirturo	253
Skyrizi	254
Skyrizi Pen	254
Sodium Phenylbutyrate	218
Somatuline Depot.....	255
Somavert	256
Spritam	257
Sprycel	258
Stelara	259
Stivarga	260

Sunitinib Malate	261
Sutent.....	261
Symlin	262
Symlinpen 120	262
Symlinpen 60	262
Sympazan	263
Synribo	264

T

Tabrecta.....	265
Tacrolimus.....	341
Tadalafil	266
Tadalafil (pah)	266
Tafinlar	267
Tagrisso	268
Taltz.....	269
Talzenna	270
Targretin	271
Targretin Topical.....	271
Tasigna	272
Tazarotene	273
Tazorac	273
Tazverik.....	274
Tdvax.....	341
Tecentriq.....	275
Tecfidera.....	277
Tecfidera Starter Pack	277
Temazepam	136, 278
Temazepam 30mg - 65.....	278
Tenivac	341
Tepmetko.....	279
Testosterone	288
Testosterone Cypionate	280
Testosterone Cypionate Inj	280
Testosterone Enanthate	281
Testosterone Enanthate Inj	281
Testosterone Pump	288
Testosterone Topical Solution.....	288
Tetrabenazine	282
Thalomid	283
Thioridazine Hcl.....	110
Tibsovo.....	284
Tobramycin	285
Topical Doxepin.....	286
Topical Lidocaine	287
Topical Testosterones	288
Topical Tretinoin	289
Toremifene.....	290
Toremifene Citrate	290
Tpn Electrolytes	341
Tracleer	28
Tramadol Hcl Er	150
Travasol.....	342
Trelstar	291
Trelstar Mixject.....	291
Treprostinil.....	292
Treprostinil Inj	292
Tretinoin.....	289
Tretinoin Microsphere	289
Tretinoin Microsphere Pump	289
Triazolam	136
Trientine.....	293
Trientine Hydrochloride.....	293
Trihexyphenidyl Hcl	116
Trihexyphenidyl Hydrochloride.....	116
Trikafta.....	294
Trimethobenzamide Hydrochloride	110
Trimipramine Maleate	132
Trodelvy	295
Trophamine	342
Truseltiq	296
Tukysa.....	297
Turalio.....	298

U

Ubrelvy	299
Ukoniq.....	300

V

Valchlor.....	301
Valtoco.....	302
Varenicline Tartrate	45
Velcade	303
Veltassa.....	304
Venclexta	305
Venclexta Starting Pack.....	305

Ventavis.....	306
Versacloz.....	307
Verzenio	308
Vigabatrin.....	309
Vigadrone.....	309
Vinblastine Sulfate	342
Vincristine Sulfate.....	342
Vitrakvi.....	310
Vizimpro.....	311
Voriconazole	312
Vosevi	313
Votrient.....	314

W

Welireg.....	315
--------------	-----

X

Xalkori.....	316
Xeljanz	317
Xeljanz Xr	317
Xermelo.....	318
Xgeva	319
Xifaxan.....	320
Xolair.....	321
Xospata.....	322
Xpovio.....	323
Xpovio 100 Mg Once Weekly	323

Xpovio 40 Mg Once Weekly	323
Xpovio 40 Mg Twice Weekly.....	323
Xpovio 60 Mg Once Weekly	323
Xpovio 60 Mg Twice Weekly.....	323
Xpovio 80 Mg Once Weekly	323
Xpovio 80 Mg Twice Weekly.....	323
Xtandi.....	324
Xyrem	325

Y

Yervoy.....	327
-------------	-----

Z

Zaleplon	113
Zarxio.....	328
Zejula	329
Zelboraf.....	331
Zenatane.....	153
Zepzelca	332
Zirabev	24
Zolinza	333
Zolpidem Tartrate	113
Zortress	342
Zydelig.....	334
Zykadia	335
Zyprexa Relprevv.....	336
Zytiga	1