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

2026 Formulary

List of Covered Drugs

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

Formulary ID#: 26314

This formulary was updated on 10/30/2026. For more recent information or other questions, please contact Troy Medicare for Pharmacy Member Service at 1-866-423-8065 (TTY users should call 711), Monday through Sunday, 24 hours a day, or visit **http://www.troymedicare.com**.

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

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

Note to existing members: This formulary has changed since last year. Please review this document to make sure that it still contains the drugs you take. When this drug list (formulary) refers to "we," "us", or "our," it means Troy Health, Inc. When it refers to "plan" or "our plan," it means Troy Medicare for Dual-eligible Beneficiaries (HMO D-SNP)/Troy Medicare (HMO). This document includes a list of the drugs (formulary) for our plan which is current as of November 2026. For an updated formulary, please contact us. Our contact information, along with the date we last updated the formulary, appears on the front and back cover pages. You must generally use network pharmacies to use your prescription drug benefit. Benefits, formulary, pharmacy network, and/or copayments/coinsurance may change on January 1, 2026, and from time to time during the year.

What is Troy Medicare for Dual-eligible Beneficiaries (HMO D-SNP)/Troy Medicare (HMO) Formulary?
In this document, we use the terms Drug List and formulary to mean the same thing. A formulary is a list of covered drugs selected by Troy Medicare for Dual-eligible Beneficiaries (HMO D-SNP)/Troy Medicare (HMO) in consultation with a team of health care providers, which represents the prescription therapies believed to be a necessary part of a quality treatment program. Troy Medicare for Dual-eligible Beneficiaries (HMO D-SNP)/Troy Medicare (HMO) will generally cover the drugs listed in our formulary as long as the drug is medically necessary, the prescription is filled at a Troy Medicare for Dual-eligible Beneficiaries (HMO D-SNP)/Troy Medicare (HMO) network pharmacy, and other plan rules are followed. For more information on how to fill your prescriptions, please review your Evidence of Coverage.

Can the Formulary (Drug List) change?
Most changes in drug coverage happen on January 1, but we may add or remove drugs on the Drug List during the year, move them to different cost-sharing tiers, or add new restrictions. We must follow the Medicare rules in making these changes. Updates to the formulary are posted monthly to our website here: www.troymedicare.com/prescription-drugs

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

- **Immediate substitutions of certain new versions of brand name drugs and original biological products.** We may immediately remove a drug from our formulary if we are replacing it with a certain new version of that drug that will appear on the same or lower cost-sharing tier and with the same or fewer restrictions. When we add a new version of a drug to our formulary, we may decide to keep the brand name drug or original biological product on our formulary, but immediately move it to a different cost-sharing tier or add new restrictions. We can make these immediate changes only if we are adding a new generic version of a brand name drug, or adding certain new biosimilar versions of an original biological product, that was already on the formulary (for example, adding an interchangeable biosimilar that can be substituted for an original biological

product by a pharmacy without a new prescription). If you are currently taking the brand name drug or original biological product, we may not tell you in advance before we make an immediate change, but we will later provide you with information about the specific change(s) we have made. If we make such a change, you or your prescriber can ask us to make an exception and continue to cover for you the drug that is being changed. For more information, see the section below titled **"How do I request an exception to the Troy Medicare's Formulary?"** Some of these drug types may be new to you. For more information, see the section below titled **"What are original biological products and how are they related to biosimilars?"**

- **Drugs removed from the market.** If a drug is withdrawn from sale by the manufacturer or the Food and Drug Administration (FDA) determines to be withdrawn for safety or effectiveness reasons, we may immediately remove the drug from our formulary and later provide notice to members who take the drug.
- **Other changes.** We may make other changes that affect members currently taking a drug. For instance, we may remove a brand name drug from the formulary when adding a generic equivalent or remove an original biological product when adding a biosimilar. We may also apply new restrictions to the brand name drug or original biological product, or move it to a different cost-sharing tier, or both. We may make changes based on new clinical guidelines. If we remove drugs from our formulary, add prior authorization, quantity limits and/or step therapy restrictions on a drug, or move a drug to a higher cost-sharing tier, we must notify affected members of the change at least 30 days before the change becomes effective. Alternatively, when a member requests a refill of the drug, they may receive a 30-day supply of the drug and notice of the change. If we make these other changes, you or your prescriber can ask us to make an exception for you and continue to cover the drug you have been taking. The notice we provide you will also include information on how to request an exception, and you can also find information in the section below entitled **"How do I request an exception to the Troy Medicare's Formulary?"**

Changes that will not affect you if you are currently taking the drug. Generally, if you are taking a drug on our 2026 formulary that was covered at the beginning of the year, we will not discontinue or reduce coverage of the drug during the 2026 coverage year except as described above. This means these drugs will remain available at the same cost-sharing and with no new restrictions for those members taking them for the remainder of the coverage year. You will not get direct notice this year about changes that do not affect you. However, on January 1 of the next year, such changes would affect you, and it is important to check the Drug List for the new benefit year for any changes to drugs.

The enclosed formulary is current as of November 2026. To get updated information about the drugs covered by Troy Medicare for Dual-eligible Beneficiaries (HMO D-SNP)/Troy Medicare (HMO), please contact us. Our contact information appears on the

front and back cover pages. We will update the printable formularies each month and they will be available at **http://www.troymedicare.com/prescription-drugs**.

How do I use the Formulary?
There are two ways to find your drug within the formulary:

Medical Condition
The formulary begins on Page 10. The drugs in this formulary are grouped into categories depending on the type of medical conditions that they are used to treat. For example, drugs used to treat a heart condition are listed under the category, "Cardiovascular Agents - Treatment Of Conditions Affecting The Heart And Blood Vessels". If you know what your drug is used for, look for the category name in the list that begins on Page 10. Then look under the category name for your drug.

Alphabetical Listing
If you are not sure what category to look under, you should look for your drug in the Index that begins on Page 123. The Index provides an alphabetical list of all of the drugs included in this document. Both brand-name drugs and generic drugs are listed in the Index. Look in the Index and find your drug. Next to your drug, you will see the page number where you can find coverage information. Turn to the page listed in the Index and find the name of your drug in the first column of the list.

What are generic drugs?
Troy Medicare for Dual-eligible Beneficiaries (HMO D-SNP)/Troy Medicare (HMO) covers both brand-name drugs and generic drugs. A generic drug is approved by the FDA as having the same active ingredient as the brand-name drug. Generally, generic drugs cost less than brand-name drugs. There are generic drug substitutes available for many brand name drugs. Generic drugs usually can be substituted for the brand name drug at the pharmacy without needing a new prescription, depending on state laws.

What are original biological products and how are they related to biosimilars?
On the formulary, when we refer to drugs, this could mean a drug or a biological product. Biological products are drugs that are more complex than typical drugs. Since biological products are more complex than typical drugs, instead of having a generic form, they have alternatives that are called biosimilars. Generally, biosimilars work just as well as the original biological product and may cost less. There are biosimilar alternatives for some original biological products. Some biosimilars are interchangeable biosimilars and, depending on state laws, may be substituted for the original biological product at the pharmacy without needing a new prescription, just like generic drugs can be substituted for brand name drugs.
For discussion of drug types, please see the Evidence of Coverage, Chapter 5, Section 3.1, "The 'Drug List' tells which Part D drugs are covered."*]*

Are there any restrictions on my coverage?

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

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

You can find out if your drug has any additional requirements or limits by looking in the formulary that begins on Page 10. You can also get more information about the restrictions applied to specific covered drugs by visiting our website. We have posted online documents that explain our prior authorization and step therapy restrictions. You may also ask us to send you a copy. Our contact information, along with the date we last updated the formulary, appears on the front and back cover pages.

You can ask us to make an exception to these restrictions or limits or for a list of other, similar drugs that may treat your health condition. See the section, "**How do I request an exception to the Troy Medicare for Dual-eligible Beneficiaries (HMO D-SNP)/Troy Medicare (HMO) Formulary?**" on Page 6 for information about how to request an exception.

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

If you learn that Troy Medicare for Dual-eligible Beneficiaries (HMO D-SNP)/Troy Medicare (HMO) does not cover your drug, you have two options:

- You can ask Member Services for a list of similar drugs that are covered by our plan. When you receive the list, show it to your doctor and ask them to prescribe a similar drug that is covered by Troy Medicare for Dual-eligible Beneficiaries (HMO D-SNP).

- You can ask Troy Medicare for Dual-eligible Beneficiaries (HMO D-SNP) to make an exception and cover your drug. See below for information about how to request an exception.

How do I request an exception to the Troy Medicare for Dual-eligible Beneficiaries (HMO D-SNP)/Troy Medicare (HMO) Formulary?
You can ask us to make an exception to our coverage rules. There are several types of exceptions that you can ask us to make.

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

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

You or your prescriber should contact us to ask for a tiering or formulary exception, including an exception to a coverage restriction. **When you request an exception, your prescriber will need to explain the medical reasons why you need the exception.** Generally, we must make our decision within 72 hours of getting your prescriber's supporting statement. You can ask for an expedited (fast) decision if you believe, and we agree, that your health could be seriously harmed by waiting up to 72 hours for a decision. If we agree, or if your prescriber asks for a fast decision, we must give you a decision no later than 24 hours after we get your prescriber's supporting statement.

What can I do if my drug is not on the formulary or has a restriction?
As a new or continuing member in our plan you may be taking drugs that are not on our formulary. Or, you may be taking a drug that is on our formulary but has a coverage restriction, such as prior authorization. You should talk to your prescriber about requesting a coverage decision to show that you meet the criteria for approval, switching to an alternative drug that we cover, or requesting a formulary exception so that we will cover the drug you take. While you and your doctor determine the right course of action for you, we may cover your drug in certain cases during the first *90* days you are a member of our plan.

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

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

For More Information
For more detailed information about your Troy Medicare for Dual-eligible Beneficiaries (HMO D-SNP)/Troy Medicare (HMO) prescription drug coverage, please review your Evidence of Coverage and other plan materials.

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

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

Troy Medicare for Dual-eligible Beneficiaries (HMO D-SNP)/Troy Medicare Formulary
The formulary below provides coverage information about the drugs covered by Troy Medicare for Dual-eligible Beneficiaries (HMO D-SNP). If you have trouble finding your drug in the list, turn to the Index that begins on Page 123.

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

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

- **Prior Authorization (PA):** Troy Medicare for Dual-eligible Beneficiaries (HMO D-SNP) requires you or your physician to get prior authorization for certain drugs. This means that you will need to get approval from us before you fill your prescriptions. If you do not get approval, we may not cover the drug.
- **Quantity Limits (QL):** For certain drugs, Troy Medicare for Dual-eligible Beneficiaries (HMO D-SNP) limits the amount of the drug that the plan will cover. Each quantity limit is defined in our formulary below as a quantity of each (EA) dosage form (e.g., capsule, patch, tablet, etc.) or milliliters (mL) for solutions or

suspensions that we will cover within a specific time period. For example, Troy Medicare for Dual-eligible Beneficiaries (HMO D-SNP) provides 360 per prescription for *gabapentin oral capsule 300 mg* every 30 days.

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

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

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

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

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

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

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

2026 Troy Medicare

2026 Member Formulary

Formulary ID 26314

CURRENT AS OF 11/1/2026

Name of Drug	Drug Tier	Requirements/Limits
Analgesics - Treatment Of Pain		
Analgesics		
BAC (BUTALBITAL-ACETAMIN-CAFF) ORAL TABLET 50-325-40 MG	2	PA
butalbital-acetaminophen oral tablet 50-325 mg	2	PA
butalbital-apap-caff-cod oral capsule 50-325-40-30 mg	2	PA; MME
butalbital-apap-caffeine oral capsule 50-325-40 mg	2	PA
butalbital-apap-caffeine oral solution 50-325-40 mg/15ml	2	PA
butalbital-apap-caffeine oral tablet 50-325-40 mg	2	PA
butalbital-asa-caff-codeine oral capsule 50-325-40-30 mg	2	PA; MME
butalbital-aspirin-caffeine oral capsule 50-325-40 mg	2	PA
nalbuphine hcl injection solution 10 mg/ml	2	MME
Nonsteroidal Anti-Inflammatory Drugs		
celecoxib oral capsule 100 mg, 200 mg, 400 mg, 50 mg	1	
diclofenac epolamine external patch 1.3 %	2	
diclofenac potassium oral tablet 50 mg	2	
diclofenac sodium er oral tablet extended release 24 hour 100 mg	1	
diclofenac sodium external gel 3 %	2	
diclofenac sodium external solution 1.5 %	2	
diclofenac sodium oral tablet delayed release 25 mg, 50 mg, 75 mg	1	
diflunisal oral tablet 500 mg	2	
etodolac er oral tablet extended release 24 hour 400 mg, 500 mg, 600 mg	2	

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

Name of Drug	Drug Tier	Requirements/Limits
etodolac oral capsule 200 mg, 300 mg	2	
etodolac oral tablet 400 mg, 500 mg	2	
flurbiprofen oral tablet 100 mg	2	
IBU ORAL TABLET 400 MG, 600 MG, 800 MG	1	
ibuprofen oral suspension 100 mg/5ml	1	
ibuprofen oral tablet 400 mg, 600 mg, 800 mg	1	
indomethacin er oral capsule extended release 75 mg	2	
indomethacin oral capsule 25 mg, 50 mg	2	PA
ketorolac tromethamine oral tablet 10 mg	2	PA; QL (20 EA per 30 days)
meclofenamate sodium oral capsule 100 mg, 50 mg	2	
meloxicam oral tablet 15 mg, 7.5 mg	1	
nabumetone oral tablet 500 mg, 750 mg	2	
naproxen dr oral tablet delayed release 500 mg	3	
naproxen oral suspension 125 mg/5ml	2	
naproxen oral tablet 250 mg, 375 mg, 500 mg	1	
naproxen oral tablet delayed release 375 mg, 500 mg	3	
naproxen sodium oral tablet 275 mg, 550 mg	2	
piroxicam oral capsule 10 mg, 20 mg	2	
sulindac oral tablet 150 mg, 200 mg	2	
Opioid Analgesics, Long-Acting		
buprenorphine transdermal patch weekly 10 mcg/hr, 15 mcg/hr, 20 mcg/hr, 5 mcg/hr, 7.5 mcg/hr	2	QL (4 EA per 28 days)
fentanyl transdermal patch 72 hour 100 mcg/hr, 12 mcg/hr, 25 mcg/hr, 37.5 mcg/hr, 50 mcg/hr, 75 mcg/hr	2	MME; QL (10 EA per 30 days)
fentanyl transdermal patch 72 hour 62.5 mcg/hr, 87.5 mcg/hr	4	MME; QL (10 EA per 30 days)
methadone hcl oral solution 10 mg/5ml	2	MME; QL (1200 ML per 30 days)
methadone hcl oral solution 5 mg/5ml	2	MME; QL (2400 ML per 30 days)
methadone hcl oral tablet 10 mg	2	MME; QL (240 EA per 30 days)
methadone hcl oral tablet 5 mg	2	MME; QL (180 EA per 30 days)
morphine sulfate er oral tablet extended release 100 mg, 15 mg, 200 mg, 30 mg, 60 mg	2	MME; QL (60 EA per 30 days)

Name of Drug	Drug Tier	Requirements/Limits
OXYCONTIN ORAL TABLET ER 12 HOUR ABUSE-DETERRENT 10 MG, 15 MG, 20 MG, 30 MG, 40 MG	4	PA; MME; QL (90 EA per 30 days)
OXYCONTIN ORAL TABLET ER 12 HOUR ABUSE-DETERRENT 60 MG, 80 MG	4	PA; MME; QL (60 EA per 30 days)
Opioid Analgesics, Short-Acting		
acetaminophen-codeine oral solution 120-12 mg/5ml	2	MME
acetaminophen-codeine oral tablet 300-15 mg, 300-30 mg, 300-60 mg	2	MME
butorphanol tartrate nasal solution 10 mg/ml	2	MME; QL (5 ML per 30 days)
ENDOCET ORAL TABLET 10-325 MG, 2.5-325 MG, 5-325 MG, 7.5-325 MG	2	MME
hydrocodone-acetaminophen oral tablet 10-325 mg, 5-325 mg, 7.5-325 mg	2	MME
hydrocodone-ibuprofen oral tablet 10-200 mg, 5-200 mg, 7.5-200 mg	2	MME
hydromorphone hcl oral tablet 2 mg, 4 mg, 8 mg	2	MME; QL (120 EA per 30 days)
hydromorphone hcl pf injection solution 1 mg/ml, 10 mg/ml, 4 mg/ml, 50 mg/5ml, 500 mg/50ml	2	MME
morphine sulfate (concentrate) oral solution 100 mg/5ml	2	MME
morphine sulfate oral tablet 15 mg, 30 mg	2	MME; QL (120 EA per 30 days)
oxycodone hcl oral solution 5 mg/5ml	2	MME; QL (5400 ML per 30 days)
oxycodone hcl oral tablet 10 mg, 15 mg, 20 mg, 30 mg, 5 mg	2	MME; QL (120 EA per 30 days)
oxycodone hcl oral tablet abuse-deterrent 15 mg	2	MME; QL (120 EA per 30 days)
oxycodone-acetaminophen oral tablet 10-325 mg, 5-325 mg, 7.5-325 mg	3	MME
oxycodone-acetaminophen oral tablet 2.5-325 mg	2	MME
pentazocine-naloxone hcl oral tablet 50-0.5 mg	2	MME
tramadol hcl oral tablet 50 mg	2	MME; QL (240 EA per 30 days)
tramadol-acetaminophen oral tablet 37.5-325 mg	2	MME
Anesthetics - Local Treatment Of Pain		
Local Anesthetics		
lidocaine external ointment 5 %	2	QL (50 GM per 30 days)
lidocaine external patch 5 %	2	PA; QL (90 EA per 30 days)

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

Name of Drug	Drug Tier	Requirements/Limits
lidocaine hcl external solution 4 %	2	
lidocaine viscous hcl mouth/throat solution 2 %	2	
lidocaine-prilocaine external cream 2.5-2.5 %	2	
ZTLIDO EXTERNAL PATCH 1.8 %	4	PA; QL (90 EA per 30 days)
Anti-Addiction/Substance Abuse Treatment Agents - Treatment Of Substance Abuse Disorders		
Alcohol Deterrents/Anti-Craving		
acamprosate calcium oral tablet delayed release 333 mg	2	
disulfiram oral tablet 250 mg, 500 mg	2	
VIVITROL INTRAMUSCULAR SUSPENSION RECONSTITUTED 380 MG	5	QL (1 EA per 28 days)
Opioid Dependence		
buprenorphine hcl sublingual tablet sublingual 2 mg, 8 mg	2	
buprenorphine hcl-naloxone hcl sublingual film 12-3 mg	2	QL (90 EA per 30 days)
buprenorphine hcl-naloxone hcl sublingual film 2-0.5 mg	2	QL (150 EA per 30 days)
buprenorphine hcl-naloxone hcl sublingual film 4-1 mg, 8-2 mg	2	QL (120 EA per 30 days)
buprenorphine hcl-naloxone hcl sublingual tablet sublingual 2-0.5 mg, 8-2 mg	2	QL (120 EA per 30 days)
lofexidine hcl oral tablet 0.18 mg	5	PA; QL (224 EA per 14 days)
naloxone hcl injection solution prefilled syringe 0.4 mg/ml	1	
naltrexone hcl oral tablet 50 mg	1	
ZURNAI INJECTION SOLUTION AUTO-INJECTOR 1.5 MG/0.5ML	3	
Opioid Reversal Agents		
KLOXXADO NASAL LIQUID 8 MG/0.1ML	3	
naloxone hcl injection solution 0.4 mg/ml, 4 mg/10ml	1	
naloxone hcl injection solution cartridge 0.4 mg/ml	1	

Name of Drug	Drug Tier	Requirements/Limits
naloxone hcl injection solution prefilled syringe 2 mg/2ml	1	
OPVEE NASAL SOLUTION 2.7 MG/0.1ML	3	
REXTOVY NASAL LIQUID 4 MG/0.25ML	3	
REZENOPY NASAL LIQUID 10 MG/0.11ML	6	
Smoking Cessation Agents		
bupropion hcl er (smoking det) oral tablet extended release 12 hour 150 mg	1	
NICOTROL NS NASAL SOLUTION 10 MG/ML	4	
varenicline tartrate (starter) oral tablet therapy pack 0.5 mg x 11 & 1 mg x 42	2	QL (56 EA per 28 days)
varenicline tartrate oral tablet 0.5 mg, 1 mg, 1 mg (56 pack)	2	QL (56 EA per 28 days)
varenicline tartrate(continue) oral tablet 1 mg	2	QL (56 EA per 28 days)
Antibacterials - Treatment Of Bacterial Infections		
Aminoglycosides		
amikacin sulfate injection solution 500 mg/2ml	2	
ARIKAYCE INHALATION SUSPENSION 590 MG/8.4ML	5	PA
gentamicin in saline intravenous solution 0.8-0.9 mg/ml-%, 1-0.9 mg/ml-%, 1.2-0.9 mg/ml-%, 1.6-0.9 mg/ml-%, 2-0.9 mg/ml-%	2	
gentamicin sulfate injection solution 40 mg/ml	2	
neomycin sulfate oral tablet 500 mg	2	
streptomycin sulfate intramuscular solution reconstituted 1 gm	4	
tobramycin sulfate injection solution 1.2 gm/30ml, 10 mg/ml, 2 gm/50ml, 80 mg/2ml	2	
tobramycin sulfate injection solution reconstituted 1.2 gm	2	
Antibacterials, Other		
aztreonam injection solution reconstituted 1 gm, 2 gm	2	
BLUJEPA ORAL TABLET 750 MG	4	PA; QL (8 EA per 1 day)

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

Name of Drug	Drug Tier	Requirements/Limits
clindamycin hcl oral capsule 150 mg, 300 mg, 75 mg	1	
clindamycin palmitate hcl oral solution reconstituted 75 mg/5ml	2	
clindamycin phosphate in d5w intravenous solution 300 mg/50ml, 600 mg/50ml, 900 mg/50ml	2	
clindamycin phosphate in nacl intravenous solution 300-0.9 mg/50ml-%, 600-0.9 mg/50ml-%, 900-0.9 mg/50ml-%	2	
clindamycin phosphate injection solution 300 mg/2ml, 900 mg/6ml	2	
clindamycin phosphate vaginal cream 2 %	2	
colistimethate sodium (cba) injection solution reconstituted 150 mg	2	
daptomycin intravenous solution reconstituted 350 mg	2	
daptomycin intravenous solution reconstituted 500 mg	4	
fosfomycin tromethamine oral packet 3 gm	2	
linezolid intravenous solution 600 mg/300ml	2	
linezolid oral suspension reconstituted 100 mg/5ml	5	
linezolid oral tablet 600 mg	2	
methenamine hippurate oral tablet 1 gm	2	
metronidazole intravenous solution 500 mg/100ml	2	
metronidazole oral capsule 375 mg	2	
metronidazole oral tablet 250 mg, 500 mg	1	
metronidazole vaginal gel 0.75 %	2	
nitrofurantoin macrocrystal oral capsule 100 mg, 25 mg, 50 mg	2	
nitrofurantoin monohyd macro oral capsule 100 mg	2	
polymyxin b sulfate injection solution reconstituted 500000 unit	2	
PRIMAXIN IV INTRAVENOUS SOLUTION RECONSTITUTED 500-500 MG	4	
sulfamethoxazole-trimethoprim intravenous solution 400-80 mg/5ml	2	

Name of Drug	Drug Tier	Requirements/Limits
tigecycline intravenous solution reconstituted 50 mg	4	PA
tinidazole oral tablet 250 mg, 500 mg	2	
trimethoprim oral tablet 100 mg	1	
TYZAVAN INTRAVENOUS SOLUTION 1000 MG/200ML, 1250 MG/250ML, 1500 MG/300ML, 1750 MG/350ML, 2000 MG/400ML, 500 MG/100ML, 750 MG/150ML	4	
vancomycin hcl in nacl intravenous solution 1-0.9 gm/200ml-%, 500-0.9 mg/100ml-%, 750-0.9 mg/150ml-%	2	
vancomycin hcl intravenous solution 1000 mg/200ml, 1250 mg/250ml, 1500 mg/300ml, 1750 mg/350ml, 2000 mg/400ml, 500 mg/100ml, 750 mg/150ml	2	
vancomycin hcl intravenous solution reconstituted 1 gm, 1.25 gm, 1.5 gm, 1.75 gm, 10 gm, 2 gm, 5 gm, 500 mg, 750 mg	2	
vancomycin hcl oral capsule 125 mg, 250 mg	2	
ZOSYN INTRAVENOUS SOLUTION 2-0.25 GM/50ML	4	
Beta-Lactam, Cephalosporins		
cefaclor er oral tablet extended release 12 hour 500 mg	2	
cefaclor oral capsule 250 mg, 500 mg	2	
cefadroxil oral capsule 500 mg	1	
cefadroxil oral suspension reconstituted 250 mg/5ml, 500 mg/5ml	2	
cefadroxil oral tablet 1 gm	2	
cefazolin sodium injection solution reconstituted 1 gm, 2 gm, 3 gm, 500 mg	2	
cefazolin sodium intravenous solution reconstituted 1 gm, 2 gm, 3 gm	2	
cefdinir oral capsule 300 mg	1	
cefdinir oral suspension reconstituted 125 mg/5ml, 250 mg/5ml	2	
cefepime hcl injection solution reconstituted 1 gm	2	
cefepime hcl intravenous solution 1 gm/50ml, 2 gm/100ml	2	

Name of Drug	Drug Tier	Requirements/Limits
cefepime hcl intravenous solution reconstituted 2 gm	2	
cefepime-dextrose intravenous solution reconstituted 1-5 gm-%(50ml), 2-5 gm-%(50ml)	2	
cefixime oral capsule 400 mg	2	
cefoxitin sodium intravenous solution reconstituted 1 gm, 10 gm, 2 gm	2	
cefpodoxime proxetil oral suspension reconstituted 100 mg/5ml, 50 mg/5ml	2	
cefpodoxime proxetil oral tablet 100 mg, 200 mg	2	
cefprozil oral suspension reconstituted 125 mg/5ml, 250 mg/5ml	2	
cefprozil oral tablet 250 mg, 500 mg	2	
ceftaroline fosamil intravenous solution reconstituted 400 mg, 600 mg	5	
ceftazidime injection solution reconstituted 1 gm, 6 gm	2	
ceftazidime intravenous solution reconstituted 2 gm	2	
ceftriaxone sodium in dextrose intravenous solution 20 mg/ml, 40 mg/ml	2	
ceftriaxone sodium injection solution reconstituted 1 gm, 2 gm, 250 mg, 500 mg	2	
ceftriaxone sodium intravenous solution reconstituted 1 gm, 10 gm, 2 gm	2	
ceftriaxone sodium-dextrose intravenous solution reconstituted 1-3.74 gm-%(50ml), 2-2.22 gm-%(50ml)	2	
cefuroxime axetil oral tablet 250 mg, 500 mg	2	
cefuroxime sodium injection solution reconstituted 750 mg	2	
cefuroxime sodium intravenous solution reconstituted 1.5 gm	2	
cephalexin oral capsule 250 mg, 500 mg	1	
cephalexin oral suspension reconstituted 125 mg/5ml, 250 mg/5ml	1	
cephalexin oral tablet 250 mg, 500 mg	2	
TAZICEF INJECTION SOLUTION RECONSTITUTED 1 GM	4	

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

Name of Drug	Drug Tier	Requirements/Limits
TAZICEF INTRAVENOUS SOLUTION RECONSTITUTED 1 GM, 2 GM, 6 GM	4	
TEFLARO INTRAVENOUS SOLUTION RECONSTITUTED 400 MG, 600 MG	5	
Beta-Lactam, Penicillins		
amoxicillin oral capsule 250 mg, 500 mg	1	
amoxicillin oral suspension reconstituted 125 mg/5ml, 200 mg/5ml, 250 mg/5ml, 400 mg/5ml	1	
amoxicillin oral tablet 500 mg, 875 mg	1	
amoxicillin oral tablet chewable 125 mg, 250 mg	1	
amoxicillin-pot clavulanate er oral tablet extended release 12 hour 1000-62.5 mg	2	
amoxicillin-pot clavulanate oral suspension reconstituted 200-28.5 mg/5ml, 250-62.5 mg/5ml, 400-57 mg/5ml, 600-42.9 mg/5ml	2	
amoxicillin-pot clavulanate oral tablet 250-125 mg, 500-125 mg, 875-125 mg	2	
ampicillin oral capsule 500 mg	1	
ampicillin sodium injection solution reconstituted 1 gm, 2 gm	2	
ampicillin sodium intravenous solution reconstituted 1 gm, 10 gm, 2 gm	2	
ampicillin-sulbactam sodium injection solution reconstituted 1.5 (1-0.5) gm, 3 (2-1) gm	2	
ampicillin-sulbactam sodium intravenous solution reconstituted 1.5 (1-0.5) gm, 15 (10-5) gm, 3 (2-1) gm	2	
BICILLIN L-A INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 1200000 UNIT/2ML, 2400000 UNIT/4ML, 600000 UNIT/ML	4	
dicloxacillin sodium oral capsule 250 mg, 500 mg	2	
nafcillin sodium injection solution reconstituted 1 gm	2	
nafcillin sodium injection solution reconstituted 2 gm	4	
oxacillin sodium in dextrose intravenous solution 2 gm/50ml	2	

Name of Drug	Drug Tier	Requirements/Limits
penicillin g pot in dextrose intravenous solution 40000 unit/ml, 60000 unit/ml	2	
penicillin g sodium injection solution reconstituted 5000000 unit	2	
penicillin v potassium oral solution reconstituted 125 mg/5ml, 250 mg/5ml	1	
penicillin v potassium oral tablet 250 mg, 500 mg	1	
piperacillin sod-tazobactam so intravenous solution reconstituted 13.5 (12-1.5) gm, 2.25 (2-0.25) gm, 3-0.375 gm, 3.375 (3-0.375) gm, 4.5 (4-0.5) gm, 40.5 (36-4.5) gm	2	
piperacillin-tazobactam-nacl intravenous solution reconstituted 2-0.25 gm/50ml, 3-0.375 gm/50ml, 4-0.5 gm/100ml	2	
Carbapenems		
ertapenem sodium injection solution reconstituted 1 gm	4	
imipenem-cilastatin intravenous solution reconstituted 250 mg, 500 mg	2	
meropenem intravenous solution reconstituted 1 gm, 500 mg	2	
meropenem-sodium chloride intravenous solution reconstituted 1 gm/50ml, 500 mg/50ml	2	
Macrolides		
azithromycin intravenous solution reconstituted 500 mg	2	
azithromycin oral suspension reconstituted 100 mg/5ml, 200 mg/5ml	2	
azithromycin oral tablet 250 mg, 250 mg (6 pack), 500 mg, 500 mg (3 pack), 600 mg	1	
clarithromycin er oral tablet extended release 24 hour 500 mg	2	
clarithromycin oral suspension reconstituted 125 mg/5ml, 250 mg/5ml	2	
clarithromycin oral tablet 250 mg, 500 mg	2	
DIFICID ORAL SUSPENSION RECONSTITUTED 40 MG/ML	5	

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Name of Drug	Drug Tier	Requirements/Limits
ERYTHROCIN LACTOBIONATE INTRAVENOUS SOLUTION RECONSTITUTED 500 MG	4	
erythromycin base oral tablet 250 mg, 500 mg	2	
erythromycin ethylsuccinate oral suspension reconstituted 200 mg/5ml	2	
erythromycin ethylsuccinate oral tablet 400 mg	2	
erythromycin lactobionate intravenous solution reconstituted 500 mg	4	
fidaxomicin oral tablet 200 mg	5	
ZITHROMAX INTRAVENOUS SOLUTION RECONSTITUTED 500 MG	4	
Quinolones		
ciprofloxacin hcl oral tablet 250 mg, 500 mg, 750 mg	1	
ciprofloxacin in d5w intravenous solution 200 mg/100ml	2	
levofloxacin in d5w intravenous solution 500 mg/100ml, 750 mg/150ml	2	
levofloxacin intravenous solution 25 mg/ml	2	
levofloxacin oral solution 25 mg/ml	2	
levofloxacin oral tablet 250 mg, 500 mg, 750 mg	1	
moxifloxacin hcl in nacl intravenous solution 400 mg/250ml	2	
moxifloxacin hcl intravenous solution 400 mg/250ml	2	
moxifloxacin hcl oral tablet 400 mg	2	
ofloxacin oral tablet 400 mg	2	
Sulfonamides		
sulfacetamide sodium (acne) external lotion 10 %	2	
sulfadiazine oral tablet 500 mg	2	
sulfamethoxazole-trimethoprim oral suspension 200-40 mg/5ml	2	
sulfamethoxazole-trimethoprim oral tablet 400-80 mg, 800-160 mg	1	
Tetracyclines		

Name of Drug	Drug Tier	Requirements/Limits
DOXY 100 INTRAVENOUS SOLUTION RECONSTITUTED 100 MG	2	
doxycycline hyclate intravenous solution reconstituted 100 mg	2	
doxycycline hyclate oral capsule 100 mg, 50 mg	2	
doxycycline hyclate oral tablet 100 mg, 20 mg	2	
doxycycline monohydrate oral capsule 100 mg, 50 mg	1	
doxycycline monohydrate oral tablet 100 mg, 150 mg, 50 mg, 75 mg	2	
minocycline hcl oral capsule 100 mg, 50 mg, 75 mg	1	
minocycline hcl oral tablet 100 mg, 50 mg, 75 mg	2	
tetracycline hcl oral capsule 250 mg, 500 mg	2	
Anticonvulsants - Treatment Of Seizures		
Anticonvulsants, Other		
brivaracetam oral solution 10 mg/ml	2	QL (600 ML per 30 days)
brivaracetam oral tablet 10 mg, 100 mg, 25 mg, 50 mg, 75 mg	2	QL (60 EA per 30 days)
DIACOMIT ORAL CAPSULE 250 MG, 500 MG	5	PA
DIACOMIT ORAL PACKET 250 MG, 500 MG	5	PA
divalproex sodium er oral tablet extended release 24 hour 250 mg, 500 mg	2	
divalproex sodium oral capsule delayed release sprinkle 125 mg	2	
divalproex sodium oral tablet delayed release 125 mg, 250 mg, 500 mg	2	
EPIDIOLEX ORAL SOLUTION 100 MG/ML	5	PA
felbamate oral suspension 600 mg/5ml	2	
felbamate oral tablet 400 mg, 600 mg	2	
FINTEPLA ORAL SOLUTION 2.2 MG/ML	5	PA
lamotrigine er oral tablet extended release 24 hour 100 mg, 200 mg, 25 mg, 250 mg, 300 mg, 50 mg	2	
lamotrigine oral tablet 100 mg, 150 mg, 200 mg, 25 mg	1	

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

Name of Drug	Drug Tier	Requirements/Limits
lamotrigine oral tablet chewable 25 mg, 5 mg	2	
lamotrigine starter kit-blue oral kit 35 x 25 mg	2	
lamotrigine starter kit-green oral kit 84 x 25 mg & 14x100 mg	4	
lamotrigine starter kit-orange oral kit 42 x 25 mg & 7 x 100 mg	2	
levetiracetam er oral tablet extended release 24 hour 500 mg, 750 mg	1	
levetiracetam oral solution 100 mg/ml, 500 mg/5ml	1	
levetiracetam oral tablet 1000 mg, 250 mg, 500 mg, 750 mg	1	
levetiracetam oral tablet disintegrating soluble 250 mg, 500 mg	2	ST; QL (60 EA per 30 days)
perampanel oral suspension 0.5 mg/ml	5	ST; QL (720 ML per 30 days)
perampanel oral tablet 10 mg, 12 mg, 4 mg, 6 mg, 8 mg	5	ST; QL (30 EA per 30 days)
perampanel oral tablet 2 mg	4	ST; QL (30 EA per 30 days)
SPRITAM ORAL TABLET DISINTEGRATING SOLUBLE 250 MG, 500 MG	4	ST; QL (60 EA per 30 days)
SUBVENITE ORAL SUSPENSION 10 MG/ML	4	
topiramate oral capsule sprinkle 15 mg, 25 mg, 50 mg	2	
topiramate oral solution 25 mg/ml	2	PA
topiramate oral tablet 100 mg, 200 mg, 25 mg, 50 mg	1	
valproic acid oral capsule 250 mg	2	
valproic acid oral solution 250 mg/5ml	2	
XCOPRI (250 MG DAILY DOSE) ORAL TABLET THERAPY PACK 100 & 150 MG	4	ST
XCOPRI (350 MG DAILY DOSE) ORAL TABLET THERAPY PACK 150 & 200 MG	4	ST
XCOPRI ORAL TABLET 100 MG, 150 MG, 200 MG, 25 MG, 50 MG	4	ST
XCOPRI ORAL TABLET THERAPY PACK 14 X 12.5 MG & 14 X 25 MG, 14 X 150 MG & 14 X200 MG, 14 X 50 MG & 14 X100 MG	4	ST
Calcium Channel Modifying Agents		

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Name of Drug	Drug Tier	Requirements/Limits
ethosuximide oral capsule 250 mg	2	
ethosuximide oral solution 250 mg/5ml	2	
methsuximide oral capsule 300 mg	2	
Gamma-Aminobutyric Acid (Gaba) Augmenting Agents		
clobazam oral suspension 2.5 mg/ml	2	QL (480 ML per 30 days)
clobazam oral tablet 10 mg, 20 mg	2	QL (60 EA per 30 days)
diazepam rectal gel 10 mg, 2.5 mg, 20 mg	2	
gabapentin oral capsule 100 mg, 400 mg	1	QL (270 EA per 30 days)
gabapentin oral capsule 200 mg	5	QL (120 EA per 30 days)
gabapentin oral capsule 300 mg	1	QL (360 EA per 30 days)
gabapentin oral solution 250 mg/5ml, 300 mg/6ml	2	QL (2160 ML per 30 days)
gabapentin oral tablet 600 mg	1	QL (180 EA per 30 days)
gabapentin oral tablet 800 mg	1	QL (120 EA per 30 days)
midazolam intramuscular solution auto-injector 10 mg/0.7ml	2	QL (2.8 ML per 30 days)
NAYZILAM NASAL SOLUTION 5 MG/0.1ML	4	PA; QL (10 EA per 30 days)
phenobarbital oral elixir 20 mg/5ml, 30 mg/7.5ml, 60 mg/15ml	2	PA
phenobarbital oral tablet 100 mg, 15 mg, 16.2 mg, 30 mg, 32.4 mg, 60 mg, 64.8 mg, 97.2 mg	2	PA
pregabalin oral capsule 100 mg, 150 mg, 200 mg, 25 mg, 50 mg, 75 mg	1	QL (90 EA per 30 days)
pregabalin oral capsule 225 mg, 300 mg	1	QL (60 EA per 30 days)
pregabalin oral solution 20 mg/ml	1	QL (900 ML per 30 days)
primidone oral tablet 250 mg, 50 mg	2	
RELGAABI ORAL CAPSULE 200 MG	5	ST; QL (120 EA per 30 days)
RELGAABI ORAL CAPSULE 300 MG	5	ST; QL (360 EA per 30 days)
RELGAABI ORAL CAPSULE 400 MG	5	ST; QL (270 EA per 30 days)
SYMPAZAN ORAL FILM 10 MG, 20 MG	5	ST; QL (60 EA per 30 days)
SYMPAZAN ORAL FILM 5 MG	4	ST; QL (60 EA per 30 days)
tiagabine hcl oral tablet 12 mg, 16 mg, 2 mg, 4 mg	2	
VALTOCO 10 MG DOSE NASAL LIQUID 10 MG/0.1ML	4	PA; QL (10 EA per 30 days)

Name of Drug	Drug Tier	Requirements/Limits
VALTOCO 15 MG DOSE NASAL LIQUID THERAPY PACK 2 X 7.5 MG/0.1ML	4	PA; QL (10 EA per 30 days)
VALTOCO 20 MG DOSE NASAL LIQUID THERAPY PACK 2 X 10 MG/0.1ML	4	PA; QL (10 EA per 30 days)
VALTOCO 5 MG DOSE NASAL LIQUID 5 MG/0.1ML	4	PA; QL (10 EA per 30 days)
vigabatrin oral packet 500 mg	5	PA; QL (180 EA per 30 days)
vigabatrin oral tablet 500 mg	5	PA; QL (180 EA per 30 days)
VIGAFYDE ORAL SOLUTION 100 MG/ML	5	PA
ZTALMY ORAL SUSPENSION 50 MG/ML	5	PA
Sodium Channel Agents		
carbamazepine er oral capsule extended release 12 hour 100 mg, 200 mg, 300 mg	2	
carbamazepine er oral tablet extended release 12 hour 100 mg, 200 mg, 400 mg	2	
carbamazepine oral suspension 100 mg/5ml	2	
carbamazepine oral tablet 200 mg	1	
carbamazepine oral tablet chewable 100 mg, 200 mg	2	
DILANTIN ORAL CAPSULE 100 MG, 30 MG	4	
eslicarbazepine acetate oral tablet 200 mg, 400 mg	2	QL (30 EA per 30 days)
eslicarbazepine acetate oral tablet 600 mg, 800 mg	2	QL (60 EA per 30 days)
lacosamide oral solution 10 mg/ml, 100 mg/10ml, 50 mg/5ml	2	QL (1200 ML per 30 days)
lacosamide oral tablet 100 mg, 150 mg, 200 mg, 50 mg	2	QL (60 EA per 30 days)
oxcarbazepine er oral tablet extended release 24 hour 150 mg, 300 mg	2	
oxcarbazepine er oral tablet extended release 24 hour 600 mg	5	
oxcarbazepine oral suspension 300 mg/5ml	2	
oxcarbazepine oral tablet 150 mg, 300 mg, 600 mg	1	
PHENYTEK ORAL CAPSULE 200 MG, 300 MG	4	

Name of Drug	Drug Tier	Requirements/Limits
PHENYTOIN INFATABS ORAL TABLET CHEWABLE 50 MG	2	
phenytoin oral suspension 125 mg/5ml	2	
phenytoin oral tablet chewable 50 mg	2	
phenytoin sodium extended oral capsule 100 mg, 200 mg, 300 mg	2	
rufinamide oral suspension 40 mg/ml	2	PA; QL (2400 ML per 30 days)
rufinamide oral tablet 200 mg, 400 mg	2	PA; QL (240 EA per 30 days)
ZONISADE ORAL SUSPENSION 100 MG/5ML	4	ST
zonisamide oral capsule 100 mg, 25 mg, 50 mg	2	
Antidementia Agents - Management Of Dementia		
Antidementia Agents, Other		
memantine hcl-donepezil hcl er oral capsule extended release 24 hour 14-10 mg, 21-10 mg, 28-10 mg	2	
NAMZARIC ORAL CAPSULE EXTENDED RELEASE 24 HOUR 7-10 MG	4	
Cholinesterase Inhibitors		
donepezil hcl oral tablet 10 mg, 5 mg	1	
donepezil hcl oral tablet 23 mg	2	
donepezil hcl oral tablet dispersible 10 mg, 5 mg	1	
galantamine hydrobromide er oral capsule extended release 24 hour 16 mg, 24 mg, 8 mg	1	
galantamine hydrobromide oral tablet 12 mg, 4 mg, 8 mg	1	
rivastigmine tartrate oral capsule 1.5 mg, 3 mg, 4.5 mg, 6 mg	1	QL (60 EA per 30 days)
rivastigmine transdermal patch 24 hour 13.3 mg/24hr, 4.6 mg/24hr, 9.5 mg/24hr	2	QL (30 EA per 30 days)
N-Methyl-D-Aspartate (Nmda) Receptor Antagonist		
memantine hcl er oral capsule extended release 24 hour 14 mg, 21 mg, 28 mg, 7 mg	2	QL (30 EA per 30 days)
memantine hcl oral tablet 10 mg, 28 x 5 mg & 21 x 10 mg, 5 mg	1	

Name of Drug	Drug Tier	Requirements/Limits
Antidepressants - Treatment Of Depression		
Antidepressants, Other		
AUVELITY ORAL TABLET EXTENDED RELEASE 45-105 MG	5	PA
AUVELITY TITRATION PACK ORAL TABLET EXTENDED RELEASE THERAPY PACK 30-105 MG & 45-105 MG	5	PA
bupropion hcl er (sr) oral tablet extended release 12 hour 100 mg, 150 mg, 200 mg	1	
bupropion hcl er (xl) oral tablet extended release 24 hour 150 mg, 300 mg, 450 mg	1	
bupropion hcl oral tablet 100 mg, 75 mg	1	
duloxetine hcl oral capsule delayed release particles 120 mg, 80 mg, 90 mg	2	QL (30 EA per 30 days)
EXXUA ORAL TABLET EXTENDED RELEASE 24 HOUR 18.2 MG, 36.3 MG, 54.5 MG, 72.6 MG	5	ST
EXXUA TITRATION PACK ORAL TABLET EXTENDED RELEASE 24 HOUR 18.2 MG	5	ST
mirtazapine oral tablet 15 mg, 30 mg, 45 mg, 7.5 mg	1	
mirtazapine oral tablet dispersible 15 mg, 30 mg, 45 mg	2	
perphenazine-amitriptyline oral tablet 2-10 mg, 2-25 mg, 4-10 mg, 4-25 mg, 4-50 mg	2	PA
ZURZUVAE ORAL CAPSULE 20 MG, 25 MG, 30 MG	5	PA
Monoamine Oxidase Inhibitors		
EMSAM TRANSDERMAL PATCH 24 HOUR 12 MG/24HR, 6 MG/24HR, 9 MG/24HR	5	PA
MARPLAN ORAL TABLET 10 MG	4	
phenelzine sulfate oral tablet 15 mg	2	
tranylcypromine sulfate oral tablet 10 mg	2	
Ssri/Snri (Selective Serotonin Reuptake Inhibitor/Serotonin And Norepinephrine Reuptake Inhibitor)		

Name of Drug	Drug Tier	Requirements/Limits
citalopram hydrobromide oral solution 10 mg/5ml	2	
citalopram hydrobromide oral tablet 10 mg, 20 mg, 40 mg	1	
desvenlafaxine succinate er oral tablet extended release 24 hour 100 mg	2	QL (60 EA per 30 days)
desvenlafaxine succinate er oral tablet extended release 24 hour 25 mg, 50 mg	2	QL (30 EA per 30 days)
escitalopram oxalate oral solution 10 mg/10ml, 5 mg/5ml	2	
escitalopram oxalate oral tablet 10 mg, 20 mg, 5 mg	1	
FETZIMA ORAL CAPSULE EXTENDED RELEASE 24 HOUR 120 MG, 20 MG, 40 MG, 80 MG	4	ST; QL (30 EA per 30 days)
FETZIMA TITRATION ORAL CAPSULE ER 24 HOUR THERAPY PACK 20 & 40 MG	4	ST; QL (28 EA per 180 days)
fluoxetine hcl oral capsule 10 mg, 20 mg, 40 mg	1	
fluoxetine hcl oral capsule delayed release 90 mg	2	
fluoxetine hcl oral solution 20 mg/5ml	1	
fluoxetine hcl oral tablet 10 mg, 20 mg, 60 mg	2	
fluvoxamine maleate oral tablet 100 mg, 25 mg, 50 mg	2	
nefazodone hcl oral tablet 100 mg, 150 mg, 200 mg, 250 mg, 50 mg	2	
paroxetine hcl er oral tablet extended release 24 hour 12.5 mg, 25 mg, 37.5 mg	2	
paroxetine hcl oral suspension 10 mg/5ml	2	
paroxetine hcl oral tablet 10 mg, 20 mg, 30 mg, 40 mg	1	
RALDESY ORAL SOLUTION 10 MG/ML	4	
sertraline hcl oral concentrate 20 mg/ml	2	
sertraline hcl oral tablet 100 mg, 25 mg, 50 mg	1	
trazodone hcl oral tablet 100 mg, 150 mg, 50 mg	1	
trazodone hcl oral tablet 300 mg	2	
TRINTELLIX ORAL TABLET 10 MG, 20 MG, 5 MG	3	QL (30 EA per 30 days)

Name of Drug	Drug Tier	Requirements/Limits
venlafaxine hcl er oral capsule extended release 24 hour 150 mg, 37.5 mg, 75 mg	2	
venlafaxine hcl er oral tablet extended release 24 hour 225 mg	2	
venlafaxine hcl oral tablet 100 mg, 25 mg, 37.5 mg, 50 mg, 75 mg	2	
vilazodone hcl oral tablet 10 mg, 20 mg, 40 mg	2	
Tricyclics		
amitriptyline hcl oral tablet 10 mg, 100 mg, 150 mg, 25 mg, 50 mg, 75 mg	2	PA
amoxapine oral tablet 100 mg, 150 mg, 25 mg, 50 mg	2	PA
clomipramine hcl oral capsule 25 mg, 50 mg, 75 mg	2	PA
desipramine hcl oral tablet 10 mg, 100 mg, 150 mg, 25 mg, 50 mg, 75 mg	2	
doxepin hcl oral capsule 10 mg, 100 mg, 150 mg, 25 mg, 50 mg, 75 mg	2	
doxepin hcl oral concentrate 10 mg/ml	2	
imipramine hcl oral tablet 10 mg, 25 mg, 50 mg	2	
imipramine pamoate oral capsule 100 mg, 125 mg, 150 mg, 75 mg	2	
nortriptyline hcl oral capsule 10 mg, 25 mg, 50 mg, 75 mg	1	PA
nortriptyline hcl oral solution 10 mg/5ml	2	PA
protriptyline hcl oral tablet 10 mg, 5 mg	2	
trimipramine maleate oral capsule 100 mg, 25 mg, 50 mg	2	
Antiemetics - Treatment Of Vomiting Or Nausea		
Antiemetics, Other		
chlorpromazine hcl oral concentrate 100 mg/ml, 30 mg/ml	2	
chlorpromazine hcl oral tablet 10 mg, 100 mg, 200 mg, 25 mg, 50 mg	2	
meclizine hcl oral tablet 12.5 mg, 25 mg	2	
metoclopramide hcl oral solution 5 mg/5ml	2	
metoclopramide hcl oral tablet 10 mg, 5 mg	1	

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

Name of Drug	Drug Tier	Requirements/Limits
perphenazine oral tablet 16 mg, 2 mg, 4 mg, 8 mg	2	
prochlorperazine maleate oral tablet 10 mg, 5 mg	1	
prochlorperazine rectal suppository 25 mg	2	
promethazine hcl oral tablet 12.5 mg, 25 mg, 50 mg	2	PA
promethazine hcl rectal suppository 12.5 mg, 25 mg	2	PA
PROMETHEGAN RECTAL SUPPOSITORY 50 MG	4	PA
scopolamine transdermal patch 72 hour 1 mg/3days	2	
trimethobenzamide hcl oral capsule 300 mg	2	
Emetogenic Therapy Adjuncts		
aprepitant oral capsule 125 mg, 40 mg, 80 mg	2	B/D
aprepitant oral capsule therapy pack 80 & 125 mg	2	B/D
dronabinol oral capsule 10 mg, 2.5 mg, 5 mg	2	B/D
EMEND ORAL SUSPENSION RECONSTITUTED 125 MG/5ML	4	B/D
granisetron hcl oral tablet 1 mg	2	B/D
ondansetron hcl oral solution 4 mg/5ml	2	B/D
ondansetron hcl oral tablet 24 mg	2	B/D
ondansetron hcl oral tablet 4 mg, 8 mg	1	B/D
ondansetron oral tablet dispersible 4 mg, 8 mg	2	B/D
Antifungals - Treatment Of Fungal Or Yeast Infections		
Antifungals		
amphotericin b intravenous solution reconstituted 50 mg	2	B/D
amphotericin b liposome intravenous suspension reconstituted 50 mg	5	B/D
caspofungin acetate intravenous solution reconstituted 50 mg, 70 mg	4	PA
clotrimazole external cream 1 %	2	QL (45 GM per 28 days)
clotrimazole external solution 1 %	2	QL (30 ML per 28 days)
clotrimazole mouth/throat troche 10 mg	2	

Name of Drug	Drug Tier	Requirements/Limits
CRESEMBA ORAL CAPSULE 186 MG, 74.5 MG	5	PA
econazole nitrate external cream 1 %	2	
fluconazole in sodium chloride intravenous solution 200-0.9 mg/100ml-%, 400-0.9 mg/200ml-%	2	
fluconazole oral suspension reconstituted 10 mg/ml, 40 mg/ml	2	
fluconazole oral tablet 100 mg, 150 mg, 200 mg, 50 mg	2	
flucytosine oral capsule 250 mg, 500 mg	5	PA
griseofulvin microsize oral suspension 125 mg/5ml	2	
itraconazole oral capsule 100 mg	2	
itraconazole oral solution 10 mg/ml	2	
ketoconazole external cream 2 %	2	
ketoconazole external shampoo 2 %	1	
ketoconazole oral tablet 200 mg	2	
KLAYESTA EXTERNAL POWDER 100000 UNIT/GM	1	
micafungin sodium intravenous solution reconstituted 100 mg	4	
micafungin sodium intravenous solution reconstituted 50 mg	2	
NYAMYC EXTERNAL POWDER 100000 UNIT/GM	1	
nystatin external cream 100000 unit/gm	1	
nystatin external ointment 100000 unit/gm	1	
nystatin external powder 100000 unit/gm	1	
nystatin mouth/throat suspension 100000 unit/ml	2	
nystatin oral tablet 500000 unit	2	
NYSTOP EXTERNAL POWDER 100000 UNIT/GM	1	
posaconazole intravenous solution 300 mg/16.7ml	2	
posaconazole oral suspension 40 mg/ml	5	PA
posaconazole oral tablet delayed release 100 mg	2	PA
terbinafine hcl oral tablet 250 mg	1	

Name of Drug	Drug Tier	Requirements/Limits
terconazole vaginal cream 0.4 %, 0.8 %	2	
terconazole vaginal suppository 80 mg	2	
voriconazole intravenous solution 200 mg/20ml	2	PA
voriconazole intravenous solution reconstituted 200 mg	4	PA
voriconazole oral suspension reconstituted 40 mg/ml	5	
voriconazole oral tablet 200 mg, 50 mg	2	
Antigout Agents - Treatment Or Prevention Of Gouty Arthritis		
Antigout Agents		
allopurinol oral tablet 100 mg, 300 mg	1	
colchicine oral capsule 0.6 mg	2	
colchicine oral tablet 0.6 mg	2	
colchicine-probenecid oral tablet 0.5-500 mg	2	
febuxostat oral tablet 40 mg, 80 mg	2	ST
probenecid oral tablet 500 mg	2	
Antimigraine Agents - Treatment Of Migraine Headaches		
Antimigraine Agents		
NURTEC ORAL TABLET DISPERSIBLE 75 MG	3	PA; QL (18 EA per 30 days)
UBRELVY ORAL TABLET 100 MG, 50 MG	3	PA; QL (16 EA per 30 days)
ZAVZPRET NASAL SOLUTION 10 MG/ACT	5	PA; QL (8 EA per 30 days)
Ergot Alkaloids		
dihydroergotamine mesylate nasal solution 4 mg/ml	5	PA; QL (8 ML per 30 days)
ergotamine-caffeine oral tablet 1-100 mg	2	PA
Prophylactic		
AIMOVIG SUBCUTANEOUS SOLUTION AUTO-INJECTOR 140 MG/ML, 70 MG/ML	3	PA; QL (1 ML per 30 days)
EMGALITY (300 MG DOSE) SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML	3	PA; QL (3 ML per 30 days)
EMGALITY SUBCUTANEOUS SOLUTION AUTO-INJECTOR 120 MG/ML	3	PA; QL (2 ML per 30 days)

Name of Drug	Drug Tier	Requirements/Limits
EMGALITY SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 120 MG/ML	3	PA; QL (2 ML per 30 days)
QULIPTA ORAL TABLET 10 MG, 30 MG, 60 MG	3	PA; QL (30 EA per 30 days)
Serotonin (5-Ht) Receptor Agonist		
naratriptan hcl oral tablet 1 mg, 2.5 mg	2	QL (9 EA per 28 days)
rizatriptan benzoate oral tablet 10 mg, 5 mg	2	QL (12 EA per 30 days)
rizatriptan benzoate oral tablet dispersible 10 mg, 5 mg	2	QL (12 EA per 30 days)
sumatriptan nasal solution 20 mg/act, 5 mg/act	2	QL (12 EA per 30 days)
sumatriptan succinate oral tablet 100 mg, 25 mg, 50 mg	2	QL (9 EA per 30 days)
sumatriptan succinate subcutaneous solution 6 mg/0.5ml	2	QL (4 ML per 30 days)
sumatriptan succinate subcutaneous solution auto-injector 6 mg/0.5ml	2	QL (4 ML per 30 days)
zolmitriptan oral tablet 2.5 mg, 5 mg	2	QL (9 EA per 28 days)
zolmitriptan oral tablet dispersible 2.5 mg, 5 mg	2	QL (9 EA per 28 days)
Antimyasthenic Agents - Treatment Of Myasthenia		
Parasympathomimetics		
pyridostigmine bromide er oral tablet extended release 180 mg	2	
pyridostigmine bromide er oral tablet extended release 24 hour 105 mg	2	
pyridostigmine bromide oral tablet 60 mg	1	
Antimycobacterials - Treatment For Infections By Tuberculosis-Type Organisms		
Antimycobacterials, Other		
dapsone oral tablet 100 mg, 25 mg	2	
rifabutin oral capsule 150 mg	4	
Antituberculars		
ethambutol hcl oral tablet 100 mg, 400 mg	2	
isoniazid oral tablet 100 mg, 300 mg	1	
pretomanid oral tablet 200 mg	4	PA

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

Name of Drug	Drug Tier	Requirements/Limits
PRIFTIN ORAL TABLET 150 MG	4	
pyrazinamide oral tablet 500 mg	2	
rifampin intravenous solution reconstituted 600 mg	4	
rifampin oral capsule 150 mg, 300 mg	2	
rifapentine oral tablet 150 mg	2	
SIRTURO ORAL TABLET 100 MG, 20 MG	5	PA
Antineoplastics - Treatment Of Cancer		
Alkylating Agents		
cyclophosphamide oral capsule 25 mg, 50 mg	2	B/D
cyclophosphamide oral tablet 25 mg, 50 mg	2	B/D
LEUKERAN ORAL TABLET 2 MG	5	PA
lomustine oral capsule 10 mg	4	
lomustine oral capsule 100 mg, 40 mg	5	
MATULANE ORAL CAPSULE 50 MG	5	
VALCHLOR EXTERNAL GEL 0.016 %	5	PA
Antiandrogens		
abiraterone acetate oral tablet 250 mg	2	PA
abiraterone acetate oral tablet 500 mg	5	PA
ABIRTEGA ORAL TABLET 250 MG	4	PA; QL (120 EA per 30 days)
bicalutamide oral tablet 50 mg	1	
ERLEADA ORAL TABLET 240 MG, 60 MG	5	PA
EULEXIN ORAL CAPSULE 125 MG	5	PA
nilutamide oral tablet 150 mg	5	PA
NUBEQA ORAL TABLET 300 MG	5	PA
XTANDI ORAL CAPSULE 40 MG	5	PA
XTANDI ORAL TABLET 40 MG, 80 MG	5	PA
YONSA ORAL TABLET 125 MG	5	PA
Antiangiogenic Agents		
lenalidomide oral capsule 10 mg, 15 mg, 2.5 mg, 20 mg, 25 mg, 5 mg	5	PA
pomalidomide oral capsule 1 mg, 2 mg, 3 mg, 4 mg	5	PA
REVLIMID ORAL CAPSULE 10 MG, 15 MG, 2.5 MG, 20 MG, 25 MG, 5 MG	5	PA

Name of Drug	Drug Tier	Requirements/Limits
THALOMID ORAL CAPSULE 100 MG, 50 MG	5	PA
Antiestrogens/Modifiers		
SOLTAMOX ORAL SOLUTION 10 MG/5ML	5	PA
tamoxifen citrate oral tablet 10 mg, 20 mg	1	
toremifene citrate oral tablet 60 mg	5	PA
VEPPANU ORAL TABLET 100 MG, 200 MG	5	PA; QL (30 EA per 30 days)
Antimetabolites		
DROXIA ORAL CAPSULE 200 MG, 300 MG, 400 MG	4	
hydroxyurea oral capsule 500 mg	2	
INQOVI ORAL TABLET 35-100 MG	5	PA
mercaptopurine oral suspension 2000 mg/100ml	5	PA
mercaptopurine oral tablet 50 mg	2	
ONUREG ORAL TABLET 200 MG, 300 MG	5	PA
SIKLOS ORAL TABLET 100 MG, 1000 MG	4	
TABLOID ORAL TABLET 40 MG	4	PA
XROMI ORAL SOLUTION 100 MG/ML	4	
Antineoplastics, Other		
AKEEGA ORAL TABLET 100-500 MG, 50-500 MG	5	PA
AVMAPKI FAKZYNJA CO-PACK ORAL THERAPY PACK 0.8 & 200 MG	5	PA; QL (66 EA per 28 days)
BESREMI PEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 500 MCG/0.5ML	5	PA
BESREMI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 500 MCG/ML	5	PA
DANZITEN ORAL TABLET 71 MG, 95 MG	5	PA
GOMEKLI ORAL CAPSULE 1 MG, 2 MG	5	PA
GOMEKLI ORAL TABLET SOLUBLE 1 MG	5	PA
IDHIFA ORAL TABLET 100 MG, 50 MG	5	PA
INLURIYO ORAL TABLET 200 MG	5	PA
IWILFIN ORAL TABLET 192 MG	5	PA
JYLAMVO ORAL SOLUTION 2 MG/ML	4	PA
KOMZIFTI ORAL CAPSULE 200 MG	5	PA
KRAZATI ORAL TABLET 200 MG	5	PA

Name of Drug	Drug Tier	Requirements/Limits
LAZCLUZE ORAL TABLET 240 MG, 80 MG	5	PA
LIFYORLI (125 MG DOSE) ORAL CAPSULE THERAPY PACK 1 X 25 MG & 1 X 100 MG	5	PA
LIFYORLI (150 MG DOSE) ORAL CAPSULE THERAPY PACK 2 X 25 MG & 1 X 100 MG	5	PA
LONSURF ORAL TABLET 15-6.14 MG, 20-8.19 MG	5	PA
LUMAKRAS ORAL TABLET 120 MG, 240 MG, 320 MG	5	PA
LYSODREN ORAL TABLET 500 MG	5	
MODEYSO ORAL CAPSULE 125 MG	5	PA; QL (20 EA per 28 days)
NINLARO ORAL CAPSULE 2.3 MG, 3 MG, 4 MG	5	PA
OJJAARA ORAL TABLET 100 MG, 150 MG, 200 MG	5	PA
ORSERDU ORAL TABLET 345 MG, 86 MG	5	PA
REVUFORJ ORAL TABLET 110 MG, 160 MG, 25 MG	5	PA
REZLIDHIA ORAL CAPSULE 150 MG	5	PA
ROMVIMZA ORAL CAPSULE 14 MG, 20 MG, 30 MG	5	PA; QL (8 EA per 28 days)
RYLAZE INTRAMUSCULAR SOLUTION 10 MG/0.5ML	5	PA
TIBSOVO ORAL TABLET 250 MG	5	PA
VORANIGO ORAL TABLET 10 MG, 40 MG	5	PA
WELIREG ORAL TABLET 40 MG	5	PA
XATMEP ORAL SOLUTION 2.5 MG/ML	4	PA
XPOVIO (100 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 50 MG	5	PA
XPOVIO (40 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 10 MG, 40 MG	5	PA
XPOVIO (40 MG TWICE WEEKLY) ORAL TABLET THERAPY PACK 40 MG	5	PA
XPOVIO (60 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 60 MG	5	PA
XPOVIO (60 MG TWICE WEEKLY) ORAL TABLET THERAPY PACK 20 MG	5	PA

Name of Drug	Drug Tier	Requirements/Limits
XPOVIO (80 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 40 MG, 80 MG	5	PA
XPOVIO (80 MG TWICE WEEKLY) ORAL TABLET THERAPY PACK 20 MG	5	PA
ZOLINZA ORAL CAPSULE 100 MG	5	PA
Aromatase Inhibitors, 3Rd Generation		
anastrozole oral tablet 1 mg	1	
exemestane oral tablet 25 mg	2	
letrozole oral tablet 2.5 mg	1	
Molecular Target Inhibitors		
ALECENSA ORAL CAPSULE 150 MG	5	PA
ALUNBRIG ORAL TABLET 180 MG, 30 MG, 90 MG	5	PA
ALUNBRIG ORAL TABLET THERAPY PACK 90 & 180 MG	5	PA
AUGTYRO ORAL CAPSULE 160 MG, 40 MG	5	PA
AYVAKIT ORAL TABLET 100 MG, 200 MG, 25 MG, 300 MG, 50 MG	5	PA
BALVERSA ORAL TABLET 3 MG, 4 MG, 5 MG	5	PA
BOSULIF ORAL CAPSULE 100 MG, 50 MG	5	PA
BOSULIF ORAL TABLET 100 MG, 500 MG	5	PA
bosutinib oral tablet 100 mg, 400 mg, 500 mg	5	PA
BRAFTOVI ORAL CAPSULE 75 MG	5	PA
BRUKINSA ORAL CAPSULE 80 MG	5	PA
BRUKINSA ORAL TABLET 160 MG	5	PA
CABOMETYX ORAL TABLET 20 MG, 40 MG, 60 MG	5	PA
CALQUENCE ORAL TABLET 100 MG	5	PA
CAPRELSA ORAL TABLET 100 MG, 300 MG	5	PA
CAVHANZA ORAL TABLET DISPERSIBLE 60 MG, 80 MG	5	PA
COMETRIQ (100 MG DAILY DOSE) ORAL KIT 80 & 20 MG	5	PA
COMETRIQ (140 MG DAILY DOSE) ORAL KIT 3 X 20 MG & 80 MG	5	PA

Name of Drug	Drug Tier	Requirements/Limits
COMETRIQ (60 MG DAILY DOSE) ORAL KIT 20 MG	5	PA
COPIKTRA ORAL CAPSULE 15 MG, 25 MG	5	PA
COTELLIC ORAL TABLET 20 MG	5	PA
dasatinib oral tablet 100 mg, 140 mg, 20 mg, 50 mg, 70 mg, 80 mg	5	PA
DAURISMO ORAL TABLET 100 MG, 25 MG	5	PA
ENSACOVE ORAL CAPSULE 100 MG, 25 MG	5	PA; QL (30 EA per 30 days)
ERIVEDGE ORAL CAPSULE 150 MG	5	PA
erlotinib hcl oral tablet 100 mg, 150 mg, 25 mg	5	PA
everolimus oral tablet 10 mg, 2.5 mg, 5 mg, 7.5 mg	5	PA
everolimus oral tablet soluble 2 mg, 3 mg, 5 mg	5	PA
FOTIVDA ORAL CAPSULE 0.89 MG, 1.34 MG	5	PA
FRUZAQLA ORAL CAPSULE 1 MG, 5 MG	5	PA
GAVRETO ORAL CAPSULE 100 MG	5	PA
gefitinib oral tablet 250 mg	5	PA
GILOTRIF ORAL TABLET 20 MG, 30 MG, 40 MG	5	PA
HERNEXEOS ORAL TABLET 60 MG	5	PA; QL (90 EA per 30 days)
HYRNUO ORAL TABLET 10 MG	5	PA; QL (120 EA per 30 days)
IBRANCE ORAL CAPSULE 100 MG, 125 MG, 75 MG	5	PA
IBRANCE ORAL TABLET 100 MG, 125 MG, 75 MG	5	PA
IBTROZI ORAL CAPSULE 200 MG	5	PA
ICLUSIG ORAL TABLET 10 MG, 15 MG, 30 MG, 45 MG	5	PA
imatinib mesylate oral tablet 100 mg, 400 mg	2	PA
IMBRUVICA ORAL CAPSULE 140 MG, 70 MG	5	PA
IMBRUVICA ORAL SUSPENSION 70 MG/ML	5	PA
IMBRUVICA ORAL TABLET 140 MG, 280 MG, 420 MG	5	PA
imkeldi oral solution 80 mg/ml	5	PA
INLYTA ORAL TABLET 1 MG, 5 MG	5	PA
INREBIC ORAL CAPSULE 100 MG	5	PA

Name of Drug	Drug Tier	Requirements/Limits
ITOVEBI ORAL TABLET 3 MG, 9 MG	5	PA
JAKAFI ORAL TABLET 10 MG, 15 MG, 20 MG, 25 MG, 5 MG	5	PA
JAKAFI XR ORAL TABLET EXTENDED RELEASE 24 HOUR 11 MG, 22 MG, 33 MG, 44 MG, 55 MG	5	PA
JAYPIRCA ORAL TABLET 100 MG, 50 MG	5	PA
JIDEYTRO ORAL TABLET 100 MG, 25 MG	5	PA
KISQALI (200 MG DOSE) ORAL TABLET THERAPY PACK 200 MG	5	PA
KISQALI (400 MG DOSE) ORAL TABLET THERAPY PACK 200 MG	5	PA
KISQALI (600 MG DOSE) ORAL TABLET THERAPY PACK 200 MG	5	PA
KOSELUGO ORAL CAPSULE 10 MG, 25 MG	5	PA
KOSELUGO ORAL CAPSULE SPRINKLE 5 MG, 7.5 MG	5	PA
lapatinib ditosylate oral tablet 250 mg	5	PA
LENVIMA (10 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 10 MG	5	PA
LENVIMA (12 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 3 X 4 MG	5	PA
LENVIMA (14 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 10 & 4 MG	5	PA
LENVIMA (18 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 10 MG & 2 X 4 MG	5	PA
LENVIMA (20 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 2 X 10 MG	5	PA
LENVIMA (24 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 2 X 10 MG & 4 MG	5	PA
LENVIMA (4 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 4 MG	5	PA
LENVIMA (8 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 2 X 4 MG	5	PA
LORBRENA ORAL TABLET 100 MG, 25 MG	5	PA
LYNPARZA ORAL TABLET 100 MG, 150 MG	5	PA

Name of Drug	Drug Tier	Requirements/Limits
LYTGOBI (12 MG DAILY DOSE) ORAL TABLET THERAPY PACK 4 MG	5	PA
LYTGOBI (16 MG DAILY DOSE) ORAL TABLET THERAPY PACK 4 MG	5	PA
LYTGOBI (20 MG DAILY DOSE) ORAL TABLET THERAPY PACK 4 MG	5	PA
MEKINIST ORAL SOLUTION RECONSTITUTED 0.05 MG/ML	5	PA
MEKINIST ORAL TABLET 0.5 MG, 2 MG	5	PA
MEKTOVI ORAL TABLET 15 MG	5	PA
NERLYNX ORAL TABLET 40 MG	5	PA
nilotinib d-tartrate oral capsule 150 mg, 200 mg, 50 mg	5	PA
nilotinib hcl oral capsule 150 mg, 200 mg, 50 mg	5	PA
ODOMZO ORAL CAPSULE 200 MG	5	PA
OGSIVEO ORAL TABLET 100 MG, 150 MG	5	PA
OJEMDA ORAL SUSPENSION RECONSTITUTED 25 MG/ML	5	PA
OJEMDA ORAL TABLET 100 MG, 100 MG (16 PACK), 100 MG (24 PACK)	5	PA
pazopanib hcl oral tablet 200 mg, 400 mg	5	PA
PEMAZYRE ORAL TABLET 13.5 MG, 4.5 MG, 9 MG	5	PA
PIQRAY (200 MG DAILY DOSE) ORAL TABLET THERAPY PACK 200 MG	5	PA
PIQRAY (250 MG DAILY DOSE) ORAL TABLET THERAPY PACK 200 & 50 MG	5	PA
PIQRAY (300 MG DAILY DOSE) ORAL TABLET THERAPY PACK 2 X 150 MG	5	PA
QINLOCK ORAL TABLET 50 MG	5	PA
RASONQUE ORAL TABLET 100 MG, 150 MG	5	PA
RETEVMO ORAL TABLET 120 MG, 160 MG, 40 MG, 80 MG	5	PA
ROZLYTREK ORAL CAPSULE 100 MG, 200 MG	5	PA
ROZLYTREK ORAL PACKET 50 MG	5	PA
RUBRACA ORAL TABLET 200 MG, 250 MG, 300 MG	5	PA

Name of Drug	Drug Tier	Requirements/Limits
RYDAPT ORAL CAPSULE 25 MG	5	PA
SCEMBLIX ORAL TABLET 100 MG, 20 MG, 40 MG	5	PA
sorafenib tosylate oral tablet 200 mg	5	PA
STIVARGA ORAL TABLET 40 MG	5	PA
sunitinib malate oral capsule 12.5 mg, 25 mg, 37.5 mg, 50 mg	5	PA
TABRECTA ORAL TABLET 150 MG, 200 MG	5	PA
TAFINLAR ORAL CAPSULE 50 MG, 75 MG	5	PA
TAFINLAR ORAL TABLET SOLUBLE 10 MG	5	PA
TAGRISSO ORAL TABLET 40 MG, 80 MG	5	PA
TALZENNA ORAL CAPSULE 0.1 MG, 0.25 MG, 0.35 MG, 0.5 MG, 0.75 MG, 1 MG	5	PA
TAZVERIK ORAL TABLET 200 MG	5	PA
TEPMETKO ORAL TABLET 225 MG	5	PA
TRUQAP ORAL TABLET 200 MG	5	PA
TRUQAP ORAL TABLET THERAPY PACK 160 MG, 200 MG	5	PA
TUKYSA ORAL TABLET 150 MG, 50 MG	5	PA
TURALIO ORAL CAPSULE 125 MG	5	PA
VANFLYTA ORAL TABLET 17.7 MG, 26.5 MG	5	PA
VENCLEXTA ORAL TABLET 10 MG	4	PA
VENCLEXTA ORAL TABLET 100 MG, 50 MG	5	PA
VENCLEXTA STARTING PACK ORAL TABLET THERAPY PACK 10 & 50 & 100 MG	5	PA
VERZENIO ORAL TABLET 100 MG, 150 MG, 200 MG, 50 MG	5	PA
VIJOICE ORAL PACKET 50 MG	5	PA
VIJOICE ORAL TABLET THERAPY PACK 125 MG, 200 & 50 MG, 50 MG	5	PA
VITRAKVI ORAL CAPSULE 100 MG, 25 MG	5	PA
VITRAKVI ORAL SOLUTION 20 MG/ML	5	PA
VIZIMPRO ORAL TABLET 15 MG, 30 MG, 45 MG	5	PA
VONJO ORAL CAPSULE 100 MG	5	PA
XALKORI ORAL CAPSULE 200 MG, 250 MG	5	PA

Name of Drug	Drug Tier	Requirements/Limits
XALKORI ORAL CAPSULE SPRINKLE 150 MG, 20 MG, 50 MG	5	PA
XOSPATA ORAL TABLET 40 MG	5	PA
YULITHIRA ORAL TABLET 10 MG, 2.5 MG, 5 MG, 7.5 MG	2	PA
ZEJULA ORAL TABLET 100 MG, 200 MG, 300 MG	5	PA
ZELBORAF ORAL TABLET 240 MG	5	PA
ZENBEXUS ORAL CAPSULE 0.75 MG, 1 MG	5	PA
ZYDELIG ORAL TABLET 100 MG, 150 MG	5	PA
ZYKADIA ORAL TABLET 150 MG	5	PA
Retinoids		
bexarotene external gel 1 %	5	PA
bexarotene oral capsule 75 mg	5	PA
PANRETIN EXTERNAL GEL 0.1 %	5	PA
tretinoin oral capsule 10 mg	5	PA
Treatment Adjuncts		
LEDERLE LEUCOVORIN ORAL TABLET 5 MG	2	
leucovorin calcium oral tablet 10 mg, 15 mg, 25 mg, 5 mg	2	
mesna oral tablet 400 mg	2	
Antiparasitics - Treatment Of Infections From Parasites		
Anthelmintics		
albendazole oral tablet 200 mg	2	
ivermectin oral tablet 3 mg	1	
praziquantel oral tablet 600 mg	2	
Antiprotozoals		
atovaquone oral suspension 750 mg/5ml	2	
atovaquone-proguanil hcl oral tablet 250-100 mg, 62.5-25 mg	2	
chloroquine phosphate oral tablet 250 mg, 500 mg	2	
COARTEM ORAL TABLET 20-120 MG	4	

Name of Drug	Drug Tier	Requirements/Limits
hydroxychloroquine sulfate oral tablet 100 mg, 200 mg, 300 mg, 400 mg	1	
mefloquine hcl oral tablet 250 mg	2	
nitazoxanide oral tablet 500 mg	4	
pentamidine isethionate inhalation solution reconstituted 300 mg	2	B/D
pentamidine isethionate injection solution reconstituted 300 mg	4	
primaquine phosphate oral tablet 26.3 (15 base) mg	2	
pyrimethamine oral tablet 25 mg	5	QL (90 EA per 30 days)
quinine sulfate oral capsule 324 mg	2	
Antiparkinson Agents - Treatment Of Parkinson's Disease		
Anticholinergics		
benztropine mesylate oral tablet 0.5 mg, 1 mg, 2 mg	1	PA
trihexyphenidyl hcl oral solution 0.4 mg/ml	2	
trihexyphenidyl hcl oral tablet 2 mg, 5 mg	1	
Antiparkinson Agents, Other		
amantadine hcl oral capsule 100 mg	1	
amantadine hcl oral solution 50 mg/5ml	1	
amantadine hcl oral tablet 100 mg	1	
carbidopa-levodopa-entacapone oral tablet 12.5-50-200 mg, 18.75-75-200 mg, 25-100-200 mg, 31.25-125-200 mg, 37.5-150-200 mg, 50-200-200 mg	2	
entacapone oral tablet 200 mg	2	
GOCOVRI ORAL CAPSULE EXTENDED RELEASE 24 HOUR 137 MG, 68.5 MG	5	PA
ONGENTYS ORAL CAPSULE 25 MG, 50 MG	4	ST
Dopamine Agonists		
apomorphine hcl subcutaneous solution cartridge 30 mg/3ml	5	PA
bromocriptine mesylate oral capsule 5 mg	2	
bromocriptine mesylate oral tablet 2.5 mg	2	

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

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

Name of Drug	Drug Tier	Requirements/Limits
haloperidol lactate injection solution 5 mg/ml	2	
haloperidol lactate oral concentrate 2 mg/ml	1	
haloperidol oral tablet 0.5 mg, 1 mg, 10 mg, 2 mg, 20 mg, 5 mg	1	
loxapine succinate oral capsule 10 mg, 25 mg, 5 mg, 50 mg	2	
molindone hcl oral tablet 10 mg, 25 mg, 5 mg	4	
pimozide oral tablet 1 mg, 2 mg	2	
thioridazine hcl oral tablet 10 mg, 100 mg, 25 mg, 50 mg	2	
thiothixene oral capsule 1 mg, 10 mg, 2 mg, 5 mg	2	
trifluoperazine hcl oral tablet 1 mg, 10 mg, 2 mg, 5 mg	2	
2Nd Generation/Atypical		
ABILIFY ASIMTUFII INTRAMUSCULAR PREFILLED SYRINGE 720 MG/2.4ML	3	QL (2.4 ML per 56 days)
ABILIFY ASIMTUFII INTRAMUSCULAR PREFILLED SYRINGE 960 MG/3.2ML	3	QL (3.2 ML per 56 days)
ABILIFY MAINTENA INTRAMUSCULAR PREFILLED SYRINGE 300 MG, 400 MG	3	QL (1 EA per 28 days)
ABILIFY MAINTENA INTRAMUSCULAR SUSPENSION RECONSTITUTED ER 300 MG, 400 MG	3	QL (1 EA per 28 days)
aripiprazole oral solution 1 mg/ml	2	QL (900 ML per 30 days)
aripiprazole oral tablet 10 mg, 15 mg, 2 mg, 20 mg, 30 mg, 5 mg	1	QL (30 EA per 30 days)
aripiprazole oral tablet dispersible 10 mg, 15 mg	4	QL (60 EA per 30 days)
ARISTADA INITIO INTRAMUSCULAR PREFILLED SYRINGE 675 MG/2.4ML	5	PA; QL (4.8 ML per 365 days)
ARISTADA INTRAMUSCULAR PREFILLED SYRINGE 1064 MG/3.9ML	5	PA; QL (3.9 ML per 56 days)
ARISTADA INTRAMUSCULAR PREFILLED SYRINGE 441 MG/1.6ML	5	PA; QL (1.6 ML per 28 days)
ARISTADA INTRAMUSCULAR PREFILLED SYRINGE 662 MG/2.4ML	5	PA; QL (2.4 ML per 28 days)
ARISTADA INTRAMUSCULAR PREFILLED SYRINGE 882 MG/3.2ML	5	PA; QL (3.2 ML per 28 days)

Name of Drug	Drug Tier	Requirements/Limits
asenapine maleate sublingual tablet sublingual 10 mg, 2.5 mg, 5 mg	2	QL (60 EA per 30 days)
CAPLYTA ORAL CAPSULE 10.5 MG, 21 MG, 42 MG	5	PA
ERZOFRI INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 117 MG/0.75ML	5	PA; QL (0.75 ML per 28 days)
ERZOFRI INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 156 MG/ML	5	PA; QL (1 ML per 28 days)
ERZOFRI INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 234 MG/1.5ML	5	PA; QL (1.5 ML per 28 days)
ERZOFRI INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 351 MG/2.25ML	5	PA; QL (2.25 ML per 28 days)
ERZOFRI INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 39 MG/0.25ML	4	PA; QL (0.25 ML per 28 days)
ERZOFRI INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 78 MG/0.5ML	5	PA; QL (0.5 ML per 28 days)
FANAPT ORAL TABLET 1 MG, 10 MG, 12 MG, 2 MG, 4 MG, 6 MG, 8 MG	5	PA; QL (60 EA per 30 days)
FANAPT TITRATION PACK A ORAL TABLET 1 & 2 & 4 & 6 MG	4	PA; QL (8 EA per 180 days)
FANAPT TITRATION PACK B ORAL TABLET 1 & 2 & 6 & 8 MG	4	PA; QL (12 EA per 180 days)
FANAPT TITRATION PACK C ORAL TABLET 1 & 2 & 6 MG	4	PA; QL (8 EA per 180 days)
INVEGA HAFYERA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 1092 MG/3.5ML	5	PA; QL (3.5 ML per 180 days)
INVEGA HAFYERA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 1560 MG/5ML	5	PA; QL (5 ML per 180 days)
INVEGA SUSTENNA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 117 MG/0.75ML	5	PA; QL (0.75 ML per 28 days)
INVEGA SUSTENNA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 156 MG/ML	5	PA; QL (1 ML per 28 days)
INVEGA SUSTENNA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 234 MG/1.5ML	5	PA; QL (1.5 ML per 28 days)

Name of Drug	Drug Tier	Requirements/Limits
INVEGA SUSTENNA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 39 MG/0.25ML	4	PA; QL (0.25 ML per 28 days)
INVEGA SUSTENNA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 78 MG/0.5ML	5	PA; QL (0.5 ML per 28 days)
INVEGA TRINZA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 273 MG/0.88ML	5	PA; QL (0.88 ML per 84 days)
INVEGA TRINZA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 410 MG/1.32ML	5	PA; QL (1.32 ML per 84 days)
INVEGA TRINZA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 546 MG/1.75ML	5	PA; QL (1.75 ML per 84 days)
INVEGA TRINZA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 819 MG/2.63ML	5	PA; QL (2.63 ML per 84 days)
lurasidone hcl oral tablet 120 mg, 20 mg, 40 mg, 60 mg	2	QL (30 EA per 30 days)
lurasidone hcl oral tablet 80 mg	2	QL (60 EA per 30 days)
LYBALVI ORAL TABLET 10-10 MG, 15-10 MG, 20-10 MG, 5-10 MG	5	PA
NUPLAZID ORAL CAPSULE 34 MG	5	PA; QL (30 EA per 30 days)
NUPLAZID ORAL TABLET 10 MG	5	PA; QL (30 EA per 30 days)
olanzapine intramuscular solution reconstituted 10 mg	4	QL (90 EA per 30 days)
olanzapine oral tablet 10 mg, 15 mg, 2.5 mg, 20 mg, 5 mg, 7.5 mg	1	QL (30 EA per 30 days)
olanzapine oral tablet dispersible 10 mg, 15 mg, 20 mg, 5 mg	2	QL (30 EA per 30 days)
OPIPZA ORAL FILM 10 MG, 5 MG	5	PA; QL (90 EA per 30 days)
OPIPZA ORAL FILM 2 MG	5	PA; QL (30 EA per 30 days)
paliperidone er oral tablet extended release 24 hour 1.5 mg, 3 mg, 9 mg	2	QL (30 EA per 30 days)
paliperidone er oral tablet extended release 24 hour 6 mg	2	QL (60 EA per 30 days)
PERSERIS SUBCUTANEOUS PREFILLED SYRINGE 120 MG, 90 MG	5	PA; QL (1 EA per 28 days)

Name of Drug	Drug Tier	Requirements/Limits
quetiapine fumarate er oral tablet extended release 24 hour 150 mg, 200 mg	2	QL (30 EA per 30 days)
quetiapine fumarate er oral tablet extended release 24 hour 300 mg, 400 mg, 50 mg	2	QL (60 EA per 30 days)
quetiapine fumarate oral tablet 100 mg, 150 mg, 200 mg, 300 mg, 400 mg	1	QL (60 EA per 30 days)
quetiapine fumarate oral tablet 25 mg, 50 mg	1	QL (90 EA per 30 days)
REXULTI ORAL TABLET 0.25 MG, 0.5 MG, 1 MG, 2 MG, 3 MG, 4 MG	5	PA; QL (30 EA per 30 days)
risperidone microspheres er intramuscular suspension reconstituted er 12.5 mg, 25 mg, 37.5 mg, 50 mg	2	QL (2 EA per 28 days)
risperidone oral solution 1 mg/ml	2	QL (360 ML per 30 days)
risperidone oral tablet 0.25 mg, 0.5 mg, 1 mg, 2 mg	1	QL (60 EA per 30 days)
risperidone oral tablet 3 mg	1	QL (120 EA per 30 days)
risperidone oral tablet 4 mg	1	QL (90 EA per 30 days)
risperidone oral tablet dispersible 0.25 mg, 0.5 mg, 1 mg, 2 mg	2	QL (60 EA per 30 days)
risperidone oral tablet dispersible 3 mg	2	QL (120 EA per 30 days)
risperidone oral tablet dispersible 4 mg	2	QL (90 EA per 30 days)
RYKINDO INTRAMUSCULAR SUSPENSION RECONSTITUTED ER 25 MG, 37.5 MG, 50 MG	5	PA; QL (2 EA per 28 days)
SECUADO TRANSDERMAL PATCH 24 HOUR 3.8 MG/24HR, 5.7 MG/24HR, 7.6 MG/24HR	5	PA; QL (30 EA per 30 days)
UZEDY SUBCUTANEOUS SUSPENSION PREFILLED SYRINGE 100 MG/0.28ML	5	PA; QL (0.28 ML per 28 days)
UZEDY SUBCUTANEOUS SUSPENSION PREFILLED SYRINGE 125 MG/0.35ML	5	PA; QL (0.35 ML per 28 days)
UZEDY SUBCUTANEOUS SUSPENSION PREFILLED SYRINGE 150 MG/0.42ML	5	PA; QL (0.42 ML per 56 days)
UZEDY SUBCUTANEOUS SUSPENSION PREFILLED SYRINGE 200 MG/0.56ML	5	PA; QL (0.56 ML per 56 days)
UZEDY SUBCUTANEOUS SUSPENSION PREFILLED SYRINGE 250 MG/0.7ML	5	PA; QL (0.7 ML per 56 days)
UZEDY SUBCUTANEOUS SUSPENSION PREFILLED SYRINGE 50 MG/0.14ML	5	PA; QL (0.14 ML per 28 days)

Name of Drug	Drug Tier	Requirements/Limits
UZEDY SUBCUTANEOUS SUSPENSION PREFILLED SYRINGE 75 MG/0.21ML	5	PA; QL (0.21 ML per 28 days)
VRAYLAR ORAL CAPSULE 0.5 MG, 0.75 MG, 1.5 MG, 3 MG, 4.5 MG, 6 MG	5	PA; QL (30 EA per 30 days)
ziprasidone hcl oral capsule 20 mg, 40 mg, 60 mg, 80 mg	2	QL (60 EA per 30 days)
ziprasidone mesylate intramuscular solution reconstituted 20 mg	2	QL (6 EA per 3 days)
Treatment-Resistant		
clozapine oral tablet 100 mg	2	QL (270 EA per 30 days)
clozapine oral tablet 200 mg	2	QL (120 EA per 30 days)
clozapine oral tablet 25 mg, 50 mg	2	QL (90 EA per 30 days)
clozapine oral tablet dispersible 100 mg	2	QL (270 EA per 30 days)
clozapine oral tablet dispersible 12.5 mg	2	
clozapine oral tablet dispersible 150 mg	2	QL (180 EA per 30 days)
clozapine oral tablet dispersible 200 mg	2	QL (120 EA per 30 days)
clozapine oral tablet dispersible 25 mg	2	QL (90 EA per 30 days)
VERSACLOZ ORAL SUSPENSION 50 MG/ML	4	QL (600 ML per 30 days)
Antispasticity Agents - Treatment Of Muscle Spasms		
Antispasticity Agents		
baclofen oral tablet 10 mg, 20 mg, 5 mg	1	
dantrolene sodium oral capsule 100 mg, 25 mg, 50 mg	2	
tizanidine hcl oral tablet 2 mg, 4 mg	1	
Antivirals - Treatment Of Infections By Viruses		
Anti-Cytomegalovirus (Cmv) Agents		
LIVTENCITY ORAL TABLET 200 MG	5	PA
PREVYMIS ORAL PACKET 120 MG, 20 MG	5	PA
PREVYMIS ORAL TABLET 240 MG, 480 MG	5	PA
valganciclovir hcl oral solution reconstituted 50 mg/ml	5	
valganciclovir hcl oral tablet 450 mg	2	
Anti-Hepatitis B (Hbv) Agents		
adefovir dipivoxil oral tablet 10 mg	4	QL (30 EA per 30 days)

Name of Drug	Drug Tier	Requirements/Limits
BARACLUDE ORAL SOLUTION 0.05 MG/ML	4	
entecavir oral tablet 0.5 mg, 1 mg	2	QL (30 EA per 30 days)
HEPCLUDEX SUBCUTANEOUS SOLUTION RECONSTITUTED 8.5 MG	5	PA; QL (30 EA per 30 days)
lamivudine oral solution 10 mg/ml, 300 mg/30ml	2	QL (960 ML per 30 days)
lamivudine oral tablet 100 mg, 300 mg	2	QL (30 EA per 30 days)
lamivudine oral tablet 150 mg	2	QL (60 EA per 30 days)
tenofovir disoproxil fumarate oral tablet 300 mg	2	QL (30 EA per 30 days)
VEMLIDY ORAL TABLET 25 MG	5	PA; QL (30 EA per 30 days)
VIREAD ORAL POWDER 40 MG/GM	5	QL (240 GM per 30 days)
VIREAD ORAL TABLET 150 MG, 200 MG, 250 MG	5	QL (30 EA per 30 days)
Anti-Hepatitis C (Hcv) Agents		
MAVYRET ORAL PACKET 50-20 MG	5	PA
MAVYRET ORAL TABLET 100-40 MG	5	PA
ribavirin oral capsule 200 mg	2	
ribavirin oral tablet 200 mg	2	
sofosbuvir-velpatasvir oral tablet 400-100 mg	5	PA
VOSEVI ORAL TABLET 400-100-100 MG	5	PA
Antiherpetic Agents		
acyclovir oral capsule 200 mg	1	
acyclovir oral suspension 200 mg/5ml	1	
acyclovir oral tablet 400 mg, 800 mg	1	
acyclovir sodium intravenous solution 50 mg/ml	2	B/D
famciclovir oral tablet 125 mg, 250 mg, 500 mg	2	
trifluridine ophthalmic solution 1 %	2	
valacyclovir hcl oral tablet 1 gm, 500 mg	2	
Anti-Hiv Agents, Integrase Inhibitors (Insti)		
ISENTRESS HD ORAL TABLET 600 MG	5	QL (60 EA per 30 days)
ISENTRESS ORAL PACKET 100 MG	4	QL (60 EA per 30 days)
ISENTRESS ORAL TABLET 400 MG	5	QL (120 EA per 30 days)
ISENTRESS ORAL TABLET CHEWABLE 100 MG, 25 MG	4	QL (180 EA per 30 days)
TIVICAY ORAL TABLET 50 MG	5	QL (60 EA per 30 days)

Name of Drug	Drug Tier	Requirements/Limits
TIVICAY PD ORAL TABLET SOLUBLE 5 MG	4	QL (180 EA per 30 days)
Anti-Hiv Agents, Non-Nucleoside Reverse Transcriptase Inhibitors (Nnrti)		
EDURANT PED ORAL TABLET SOLUBLE 2.5 MG	4	QL (180 EA per 30 days)
efavirenz oral tablet 600 mg	2	QL (30 EA per 30 days)
etravirine oral tablet 100 mg	2	QL (120 EA per 30 days)
etravirine oral tablet 200 mg	5	QL (60 EA per 30 days)
IDVYNSO ORAL TABLET 100-0.25 MG	5	QL (30 EA per 30 days)
INTELENCE ORAL TABLET 25 MG	4	QL (120 EA per 30 days)
nevirapine er oral tablet extended release 24 hour 400 mg	2	QL (30 EA per 30 days)
nevirapine oral suspension 50 mg/5ml	2	QL (1200 ML per 30 days)
nevirapine oral tablet 200 mg	1	QL (60 EA per 30 days)
PIFELTRO ORAL TABLET 100 MG	5	QL (30 EA per 30 days)
rilpivirine hcl oral tablet 25 mg	5	QL (30 EA per 30 days)
Anti-Hiv Agents, Nucleoside And Nucleotide Reverse Transcriptase Inhibitors (Nrti)		
abacavir sulfate oral solution 20 mg/ml	2	QL (960 ML per 30 days)
abacavir sulfate oral tablet 300 mg	2	QL (60 EA per 30 days)
abacavir sulfate-lamivudine oral tablet 600-300 mg	2	QL (30 EA per 30 days)
CIMDUO ORAL TABLET 300-300 MG	5	QL (30 EA per 30 days)
DESCOVY ORAL TABLET 120-15 MG, 200-25 MG	5	QL (30 EA per 30 days)
emtricitabine oral capsule 200 mg	2	QL (30 EA per 30 days)
emtricitabine-tenofovir df oral tablet 100-150 mg, 133-200 mg, 167-250 mg, 200-300 mg	2	QL (30 EA per 30 days)
EMTRIVA ORAL SOLUTION 10 MG/ML	4	
lamivudine-zidovudine oral tablet 150-300 mg	2	QL (60 EA per 30 days)
zidovudine oral capsule 100 mg	2	QL (180 EA per 30 days)
zidovudine oral syrup 50 mg/5ml	2	QL (1920 ML per 30 days)
zidovudine oral tablet 300 mg	2	QL (90 EA per 30 days)
Anti-Hiv Agents, Other		

Name of Drug	Drug Tier	Requirements/Limits
BIKTARVY ORAL TABLET 30-120-15 MG, 50-200-25 MG	5	QL (30 EA per 30 days)
BIXLENVO ORAL TABLET 75-50 MG	5	QL (30 EA per 30 days)
DELSTRIGO ORAL TABLET 100-300-300 MG	5	QL (30 EA per 30 days)
DOVATO ORAL TABLET 50-300 MG	5	QL (30 EA per 30 days)
efavirenz-emtricitab-tenofo df oral tablet 600-200-300 mg	2	QL (30 EA per 30 days)
efavirenz-lamivudine-tenofovir oral tablet 400-300-300 mg, 600-300-300 mg	5	QL (30 EA per 30 days)
emtricitab-rilpivir-tenofov df oral tablet 200-25-300 mg	5	QL (30 EA per 30 days)
EVOTAZ ORAL TABLET 300-150 MG	5	QL (30 EA per 30 days)
GENVOYA ORAL TABLET 150-150-200-10 MG	5	QL (30 EA per 30 days)
JULUCA ORAL TABLET 50-25 MG	5	QL (30 EA per 30 days)
maraviroc oral tablet 150 mg	5	QL (60 EA per 30 days)
maraviroc oral tablet 300 mg	5	QL (120 EA per 30 days)
ODEFSEY ORAL TABLET 200-25-25 MG	5	QL (30 EA per 30 days)
PREZCOBIX ORAL TABLET 675-150 MG, 800-150 MG	5	QL (30 EA per 30 days)
RUKOBIA ORAL TABLET EXTENDED RELEASE 12 HOUR 600 MG	5	QL (60 EA per 30 days)
SELZENTRY ORAL SOLUTION 20 MG/ML	3	QL (1840 ML per 30 days)
STRIBILD ORAL TABLET 150-150-200-300 MG	5	QL (30 EA per 30 days)
SUNLENCA ORAL TABLET 300 MG	5	QL (10 EA per 365 days)
SUNLENCA ORAL TABLET THERAPY PACK 4 X 300 MG	5	QL (8 EA per 365 days)
SUNLENCA ORAL TABLET THERAPY PACK 5 X 300 MG	5	QL (10 EA per 365 days)
SUNLENCA SUBCUTANEOUS SOLUTION 463.5 MG/1.5ML	5	QL (6 ML per 365 days)
SYMTUZA ORAL TABLET 800-150-200-10 MG	5	QL (30 EA per 30 days)
TRIUMEQ ORAL TABLET 600-50-300 MG	5	QL (30 EA per 30 days)
triumeq pd oral tablet soluble 60-5-30 mg	2	QL (180 EA per 30 days)
TYBOST ORAL TABLET 150 MG	3	QL (30 EA per 30 days)

Name of Drug	Drug Tier	Requirements/Limits
Anti-Hiv Agents, Protease Inhibitors (Pi)		
APTIVUS ORAL CAPSULE 250 MG	5	QL (120 EA per 30 days)
atazanavir sulfate oral capsule 150 mg, 300 mg	2	QL (30 EA per 30 days)
atazanavir sulfate oral capsule 200 mg	2	QL (60 EA per 30 days)
darunavir oral tablet 600 mg	2	QL (60 EA per 30 days)
darunavir oral tablet 800 mg	2	QL (30 EA per 30 days)
fosamprenavir calcium oral tablet 700 mg	5	QL (120 EA per 30 days)
KALETRA ORAL SOLUTION 400-100 MG/5ML	4	QL (390 ML per 30 days)
lopinavir-ritonavir oral tablet 100-25 mg	2	QL (300 EA per 30 days)
lopinavir-ritonavir oral tablet 200-50 mg	2	QL (120 EA per 30 days)
NORVIR ORAL PACKET 100 MG	4	QL (360 EA per 30 days)
PREZISTA ORAL SUSPENSION 100 MG/ML	5	QL (400 ML per 30 days)
PREZISTA ORAL TABLET 150 MG	4	QL (180 EA per 30 days)
PREZISTA ORAL TABLET 75 MG	4	QL (300 EA per 30 days)
REYATAZ ORAL PACKET 50 MG	4	
ritonavir oral tablet 100 mg	2	QL (360 EA per 30 days)
VIRACEPT ORAL TABLET 250 MG	5	QL (300 EA per 30 days)
VIRACEPT ORAL TABLET 625 MG	5	QL (120 EA per 30 days)
Anti-Influenza Agents		
oseltamivir phosphate oral capsule 30 mg	2	QL (84 EA per 180 days)
oseltamivir phosphate oral capsule 45 mg, 75 mg	2	QL (42 EA per 180 days)
oseltamivir phosphate oral suspension reconstituted 6 mg/ml	2	QL (540 ML per 180 days)
RELENZA DISKHALER INHALATION AEROSOL POWDER BREATH ACTIVATED 5 MG/ACT	4	QL (60 EA per 180 days)
rimantadine hcl oral tablet 100 mg	2	
Antiviral, Coronavirus Agents		
LAGEVRIO ORAL CAPSULE 200 MG	3	QL (40 EA per 5 days)
PAXLOVID (150/100) ORAL TABLET THERAPY PACK 10 X 150 MG & 10 X 100MG	3	QL (20 EA per 5 days)
PAXLOVID (300/100 & 150/100) ORAL TABLET THERAPY PACK 6 X 150 MG & 5 X 100MG	3	QL (11 EA per 5 days)

Name of Drug	Drug Tier	Requirements/Limits
PAXLOVID (300/100) ORAL TABLET THERAPY PACK 20 X 150 MG & 10 X 100MG	3	QL (30 EA per 5 days)
Anxiolytics - Treatment Of Anxiety Or Nervousness		
Anxiolytics, Other		
buspirone hcl oral tablet 10 mg, 15 mg, 30 mg, 5 mg, 7.5 mg	1	
hydroxyzine pamoate oral capsule 100 mg, 25 mg, 50 mg	2	
Benzodiazepines		
ALPRAZOLAM INTENSOL ORAL CONCENTRATE 1 MG/ML	2	QL (300 ML per 30 days)
alprazolam oral tablet 0.25 mg, 0.5 mg, 1 mg	2	QL (120 EA per 30 days)
alprazolam oral tablet 2 mg	2	QL (150 EA per 30 days)
clonazepam oral tablet 0.5 mg, 1 mg	2	QL (90 EA per 30 days)
clonazepam oral tablet 2 mg	2	QL (300 EA per 30 days)
clonazepam oral tablet dispersible 0.125 mg, 0.25 mg, 0.5 mg, 1 mg	2	QL (90 EA per 30 days)
clonazepam oral tablet dispersible 2 mg	2	QL (300 EA per 30 days)
clorazepate dipotassium oral tablet 15 mg	2	QL (180 EA per 30 days)
clorazepate dipotassium oral tablet 3.75 mg, 7.5 mg	2	QL (90 EA per 30 days)
DIAZEPAM INTENSOL ORAL CONCENTRATE 5 MG/ML	2	QL (240 ML per 30 days)
diazepam oral concentrate 5 mg/ml	2	QL (240 ML per 30 days)
diazepam oral solution 5 mg/5ml	2	QL (1200 ML per 30 days)
diazepam oral tablet 10 mg, 2 mg, 5 mg	2	QL (120 EA per 30 days)
LORAZEPAM INTENSOL ORAL CONCENTRATE 2 MG/ML	2	QL (150 ML per 30 days)
lorazepam oral concentrate 2 mg/ml	2	QL (150 ML per 30 days)
lorazepam oral tablet 0.5 mg, 1 mg	2	QL (90 EA per 30 days)
lorazepam oral tablet 2 mg	2	QL (150 EA per 30 days)
Bipolar Agents - Treatment For Bipolar Illnesses		
Mood Stabilizers		

Name of Drug	Drug Tier	Requirements/Limits
EQUETRO ORAL CAPSULE EXTENDED RELEASE 12 HOUR 100 MG, 200 MG, 300 MG	4	
lithium carbonate er oral tablet extended release 300 mg, 450 mg	2	
lithium carbonate oral capsule 150 mg, 300 mg, 600 mg	2	
lithium carbonate oral tablet 300 mg	2	
lithium oral solution 8 meq/5ml	2	
Blood Glucose Regulators - Control Of Diabetes		
Antidiabetic Agents		
acarbose oral tablet 100 mg, 25 mg, 50 mg	2	QL (90 EA per 30 days)
dapagliflozin oral tablet 10 mg, 5 mg	2	QL (30 EA per 30 days)
dapagliflozin-metformin hcl er oral tablet extended release 24 hour 10-1000 mg, 10-500 mg	2	QL (30 EA per 30 days)
dapagliflozin-metformin hcl er oral tablet extended release 24 hour 5-1000 mg, 5-500 mg	2	QL (60 EA per 30 days)
glimepiride oral tablet 1 mg	1	QL (240 EA per 30 days)
glimepiride oral tablet 2 mg	1	QL (120 EA per 30 days)
glimepiride oral tablet 4 mg	1	QL (60 EA per 30 days)
glipizide er oral tablet extended release 24 hour 10 mg	1	QL (60 EA per 30 days)
glipizide er oral tablet extended release 24 hour 2.5 mg	1	QL (240 EA per 30 days)
glipizide er oral tablet extended release 24 hour 5 mg	1	QL (120 EA per 30 days)
glipizide oral tablet 10 mg	1	QL (120 EA per 30 days)
glipizide oral tablet 15 mg, 2.5 mg	1	QL (60 EA per 30 days)
glipizide oral tablet 5 mg	1	QL (240 EA per 30 days)
glipizide-metformin hcl oral tablet 2.5-250 mg	1	QL (240 EA per 30 days)
glipizide-metformin hcl oral tablet 2.5-500 mg, 5-500 mg	1	QL (120 EA per 30 days)
glyburide micronized oral tablet 3 mg	1	PA; QL (90 EA per 30 days)
glyburide micronized oral tablet 6 mg	1	PA; QL (60 EA per 30 days)
glyburide oral tablet 1.25 mg, 2.5 mg	1	PA; QL (60 EA per 30 days)
glyburide oral tablet 5 mg	1	PA; QL (120 EA per 30 days)
glyburide-metformin oral tablet 1.25-250 mg	2	PA; QL (240 EA per 30 days)

Name of Drug	Drug Tier	Requirements/Limits
glyburide-metformin oral tablet 2.5-500 mg, 5-500 mg	2	PA; QL (120 EA per 30 days)
GLYXAMBI ORAL TABLET 10-5 MG, 25-5 MG	3	QL (30 EA per 30 days)
JANUMET ORAL TABLET 50-1000 MG, 50-500 MG	3	QL (60 EA per 30 days)
JANUMET XR ORAL TABLET EXTENDED RELEASE 24 HOUR 100-1000 MG	3	QL (30 EA per 30 days)
JANUMET XR ORAL TABLET EXTENDED RELEASE 24 HOUR 50-1000 MG, 50-500 MG	3	QL (60 EA per 30 days)
JANUVIA ORAL TABLET 100 MG, 25 MG, 50 MG	3	QL (30 EA per 30 days)
JARDIANCE ORAL TABLET 10 MG, 25 MG	3	QL (30 EA per 30 days)
JENTADUETO ORAL TABLET 2.5-1000 MG, 2.5-500 MG, 2.5-850 MG	3	QL (60 EA per 30 days)
JENTADUETO XR ORAL TABLET EXTENDED RELEASE 24 HOUR 2.5-1000 MG	3	QL (60 EA per 30 days)
JENTADUETO XR ORAL TABLET EXTENDED RELEASE 24 HOUR 5-1000 MG	3	QL (30 EA per 30 days)
liraglutide subcutaneous solution pen-injector 18 mg/3ml	2	PA; QL (9 ML per 30 days)
metformin hcl er oral tablet extended release 24 hour 500 mg	1	QL (120 EA per 30 days)
metformin hcl er oral tablet extended release 24 hour 750 mg	1	QL (60 EA per 30 days)
metformin hcl oral tablet 1000 mg	1	QL (75 EA per 30 days)
metformin hcl oral tablet 500 mg	1	QL (150 EA per 30 days)
metformin hcl oral tablet 850 mg	1	QL (90 EA per 30 days)
MOUNJARO SUBCUTANEOUS SOLUTION AUTO-INJECTOR 10 MG/0.5ML, 12.5 MG/0.5ML, 15 MG/0.5ML, 2.5 MG/0.5ML, 5 MG/0.5ML, 7.5 MG/0.5ML	3	PA; QL (2 ML per 28 days)
nateglinide oral tablet 120 mg, 60 mg	2	QL (90 EA per 30 days)
OZEMPIC (0.25 OR 0.5 MG/DOSE) SUBCUTANEOUS SOLUTION PEN-INJECTOR 2 MG/3ML	3	PA; QL (3 ML per 28 days)
OZEMPIC (1 MG/DOSE) SUBCUTANEOUS SOLUTION PEN-INJECTOR 4 MG/3ML	3	PA; QL (3 ML per 28 days)

Name of Drug	Drug Tier	Requirements/Limits
OZEMPIC (2 MG/DOSE) SUBCUTANEOUS SOLUTION PEN-INJECTOR 8 MG/3ML	3	PA; QL (3 ML per 28 days)
OZEMPIC ORAL TABLET 1.5 MG, 4 MG, 9 MG	3	PA; QL (30 EA per 30 days)
pioglitazone hcl oral tablet 15 mg, 30 mg, 45 mg	2	QL (30 EA per 30 days)
pioglitazone hcl-metformin hcl oral tablet 15-500 mg, 15-850 mg	2	QL (90 EA per 30 days)
repaglinide oral tablet 0.5 mg, 1 mg	2	QL (120 EA per 30 days)
repaglinide oral tablet 2 mg	2	QL (240 EA per 30 days)
RYBELSUS ORAL TABLET 14 MG, 3 MG, 7 MG	3	PA; QL (30 EA per 30 days)
SYMLINPEN 120 SUBCUTANEOUS SOLUTION PEN-INJECTOR 2700 MCG/2.7ML	5	
SYMLINPEN 60 SUBCUTANEOUS SOLUTION PEN-INJECTOR 1500 MCG/1.5ML	5	
SYNJARDY ORAL TABLET 12.5-1000 MG, 12.5-500 MG, 5-1000 MG, 5-500 MG	3	QL (60 EA per 30 days)
SYNJARDY XR ORAL TABLET EXTENDED RELEASE 24 HOUR 10-1000 MG, 12.5-1000 MG, 5-1000 MG	3	QL (60 EA per 30 days)
SYNJARDY XR ORAL TABLET EXTENDED RELEASE 24 HOUR 25-1000 MG	3	QL (30 EA per 30 days)
TRADJENTA ORAL TABLET 5 MG	3	QL (30 EA per 30 days)
TRIJARDY XR ORAL TABLET EXTENDED RELEASE 24 HOUR 10-5-1000 MG, 25-5-1000 MG	3	QL (30 EA per 30 days)
TRIJARDY XR ORAL TABLET EXTENDED RELEASE 24 HOUR 12.5-2.5-1000 MG, 5-2.5-1000 MG	3	QL (60 EA per 30 days)
TRULICITY SUBCUTANEOUS SOLUTION AUTO-INJECTOR 0.75 MG/0.5ML, 1.5 MG/0.5ML, 3 MG/0.5ML, 4.5 MG/0.5ML	3	PA; QL (2 ML per 28 days)
XIGDUO XR ORAL TABLET EXTENDED RELEASE 24 HOUR 10-1000 MG, 10-500 MG, 5-500 MG	3	QL (30 EA per 30 days)
XIGDUO XR ORAL TABLET EXTENDED RELEASE 24 HOUR 2.5-1000 MG, 5-1000 MG	3	QL (60 EA per 30 days)
Glycemic Agents		

Name of Drug	Drug Tier	Requirements/Limits
BAQSIMI ONE PACK NASAL POWDER 3 MG/DOSE	3	QL (4 EA per 30 days)
BAQSIMI TWO PACK NASAL POWDER 3 MG/DOSE	3	QL (4 EA per 30 days)
diazoxide oral suspension 50 mg/ml	2	
glucagon emergency injection solution reconstituted 1 mg, 1 mg/ml	3	QL (4 EA per 30 days)
mifepristone oral tablet 300 mg	5	PA
Insulins		
FIASP FLEXTOUCH SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML	3	
FIASP INJECTION SOLUTION 100 UNIT/ML	3	
FIASP PENFILL SUBCUTANEOUS SOLUTION CARTRIDGE 100 UNIT/ML	3	
gauze pad 2"x2"	1	
GAUZE PAD 2"X2"	1	
HUMALOG INJECTION SOLUTION 100 UNIT/ML	3	
HUMALOG JUNIOR KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML	3	
HUMALOG KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML, 200 UNIT/ML	3	
HUMALOG MIX 50/50 KWIKPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR (50-50) 100 UNIT/ML	3	
HUMALOG MIX 75/25 KWIKPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR (75-25) 100 UNIT/ML	3	
HUMALOG MIX 75/25 SUBCUTANEOUS SUSPENSION (75-25) 100 UNIT/ML	3	
HUMALOG SUBCUTANEOUS SOLUTION CARTRIDGE 100 UNIT/ML	3	
HUMALOG TEMPO PEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML	3	
HUMULIN 70/30 KWIKPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR (70-30) 100 UNIT/ML	3	

Name of Drug	Drug Tier	Requirements/Limits
HUMULIN 70/30 SUBCUTANEOUS SUSPENSION (70-30) 100 UNIT/ML	3	
HUMULIN N KWIKPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR 100 UNIT/ML	3	
HUMULIN N SUBCUTANEOUS SUSPENSION 100 UNIT/ML	3	
HUMULIN R INJECTION SOLUTION 100 UNIT/ML	3	
HUMULIN R U-500 KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 500 UNIT/ML	3	
insulin asp prot & asp flexpen subcutaneous suspension pen-injector (70-30) 100 unit/ml	2	
insulin aspart flexpen subcutaneous solution pen-injector 100 unit/ml	2	
insulin aspart injection solution 100 unit/ml	2	
insulin aspart prot & aspart subcutaneous suspension (70-30) 100 unit/ml	2	
insulin lispro (1 unit dial) subcutaneous solution pen-injector 100 unit/ml	2	
insulin lispro injection solution 100 unit/ml	2	
insulin lispro junior kwikpen subcutaneous solution pen-injector 100 unit/ml	2	
insulin lispro prot & lispro subcutaneous suspension pen-injector (75-25) 100 unit/ml	2	
insulin syringe 27g x 1/2" 0.5 ml, 27g x 1/2" 1 ml, 28g x 1/2" 0.5 ml, 28g x 1/2" 1 ml, 29g x 1/2" 0.3 ml, 29g x 1/2" 0.5 ml, 29g x 1/2" 1 ml, 29g x 5/16" 1 ml, 30g x 1/2" 0.3 ml, 30g x 1/2" 0.5 ml, 30g x 1/2" 1 ml, 30g x 5/16" 0.3 ml, 30g x 5/16" 0.5 ml, 30g x 5/16" 1 ml, 31g x 1/2" 0.3 ml, 31g x 1/4" 0.3 ml, 31g x 1/4" 0.5 ml, 31g x 1/4" 1 ml, 31g x 5/16" 0.3 ml, 31g x 5/16" 0.5 ml, 31g x 5/16" 1 ml	1	

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

Name of Drug	Drug Tier	Requirements/Limits
NOVOLOG 70/30 FLEXPEN RELION SUBCUTANEOUS SUSPENSION PEN-INJECTOR (70-30) 100 UNIT/ML	3	
NOVOLOG FLEXPEN RELION SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML	3	
NOVOLOG FLEXPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML	3	
NOVOLOG INJECTION SOLUTION 100 UNIT/ML	3	
NOVOLOG MIX 70/30 FLEXPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR (70-30) 100 UNIT/ML	3	
NOVOLOG MIX 70/30 RELION SUBCUTANEOUS SUSPENSION (70-30) 100 UNIT/ML	3	
NOVOLOG MIX 70/30 SUBCUTANEOUS SUSPENSION (70-30) 100 UNIT/ML	3	
NOVOLOG PENFILL SUBCUTANEOUS SOLUTION CARTRIDGE 100 UNIT/ML	3	
NOVOLOG RELION INJECTION SOLUTION 100 UNIT/ML	3	
OMNIPOD 5 DEXG7G6 INTRO GEN 5 KIT	3	
OMNIPOD 5 DEXG7G6 PODS GEN 5	3	
OMNIPOD 5 G7 INTRO (GEN 5) KIT	3	
OMNIPOD 5 G7 PODS (GEN 5)	3	
OMNIPOD 5 LIBRE INTRO KIT	3	
OMNIPOD 5 LIBRE PODS	3	
OMNIPOD DASH INTRO (GEN 4) KIT	3	
OMNIPOD DASH PODS (GEN 4)	3	
PEN NEEDLES 29G X 12.7MM , 29G X 12MM , 30G X 5 MM , 30G X 8 MM , 31G X 4 MM , 31G X 5 MM , 31G X 6 MM , 31G X 8 MM , 32G X 4 MM , 32G X 6 MM	1	
pen needles 29g x 4mm , 30g x 5 mm , 31g x 5 mm , 31g x 6 mm , 31g x 8 mm , 32g x 4 mm , 32g x 5 mm , 32g x 6 mm , 32g x 8 mm	1	
SOLIQUA SUBCUTANEOUS SOLUTION PEN-INJECTOR 100-33 UNT-MCG/ML	3	QL (15 ML per 25 days)

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

Name of Drug	Drug Tier	Requirements/Limits
TOUJEO MAX SOLOSTAR SUBCUTANEOUS SOLUTION PEN-INJECTOR 300 UNIT/ML	3	
TOUJEO SOLOSTAR SUBCUTANEOUS SOLUTION PEN-INJECTOR 300 UNIT/ML	3	
Blood Products And Modifiers - Prevention Of Clotting And Increasing Blood Cell Production		
Anticoagulants		
dabigatran etexilate mesylate oral capsule 110 mg, 150 mg, 75 mg	2	QL (60 EA per 30 days)
ELIQUIS (1.5 MG PACK) ORAL TABLET SOLUBLE 3 X 0.5 MG	3	
ELIQUIS (2 MG PACK) ORAL TABLET SOLUBLE 4 X 0.5 MG	3	
ELIQUIS DVT/PE STARTER PACK ORAL TABLET THERAPY PACK 5 MG	3	QL (148 EA per 365 days)
ELIQUIS ORAL CAPSULE SPRINKLE 0.15 MG	3	QL (74 EA per 30 days)
ELIQUIS ORAL TABLET 2.5 MG	3	QL (60 EA per 30 days)
ELIQUIS ORAL TABLET 5 MG	3	QL (74 EA per 30 days)
ELIQUIS ORAL TABLET SOLUBLE 0.5 MG	3	
enoxaparin sodium injection solution 300 mg/3ml	2	
enoxaparin sodium injection solution prefilled syringe 100 mg/ml, 120 mg/0.8ml, 150 mg/ml, 30 mg/0.3ml, 40 mg/0.4ml, 60 mg/0.6ml, 80 mg/0.8ml	2	
fondaparinux sodium subcutaneous solution 10 mg/0.8ml, 5 mg/0.4ml, 7.5 mg/0.6ml	5	
fondaparinux sodium subcutaneous solution 2.5 mg/0.5ml	2	
heparin sodium (porcine) injection solution 10000 unit/ml, 5000 unit/ml	2	
heparin sodium (porcine) pf injection solution 1000 unit/ml	2	
JANTOVEN ORAL TABLET 1 MG, 10 MG, 2 MG, 2.5 MG, 3 MG, 4 MG, 5 MG, 6 MG, 7.5 MG	1	
warfarin sodium oral tablet 1 mg, 10 mg, 2 mg, 2.5 mg, 3 mg, 4 mg, 5 mg, 6 mg, 7.5 mg	1	

Name of Drug	Drug Tier	Requirements/Limits
XARELTO ORAL SUSPENSION RECONSTITUTED 1 MG/ML	3	QL (900 ML per 30 days)
XARELTO ORAL TABLET 10 MG, 20 MG	3	QL (30 EA per 30 days)
XARELTO ORAL TABLET 15 MG, 2.5 MG	3	QL (60 EA per 30 days)
XARELTO STARTER PACK ORAL TABLET THERAPY PACK 15 & 20 MG	3	QL (102 EA per 365 days)
Blood Products And Modifiers, Other		
anagrelide hcl oral capsule 0.5 mg, 1 mg	2	
ARANESP (ALBUMIN FREE) INJECTION SOLUTION 100 MCG/ML, 200 MCG/ML	5	PA
ARANESP (ALBUMIN FREE) INJECTION SOLUTION 25 MCG/ML, 40 MCG/ML, 60 MCG/ML	4	PA
ARANESP (ALBUMIN FREE) INJECTION SOLUTION PREFILLED SYRINGE 10 MCG/0.4ML, 25 MCG/0.42ML, 40 MCG/0.4ML	4	PA
ARANESP (ALBUMIN FREE) INJECTION SOLUTION PREFILLED SYRINGE 100 MCG/0.5ML, 150 MCG/0.3ML, 200 MCG/0.4ML, 300 MCG/0.6ML, 500 MCG/ML, 60 MCG/0.3ML	5	PA
eltrombopag olamine oral packet 12.5 mg	5	PA; QL (360 EA per 30 days)
eltrombopag olamine oral packet 25 mg	5	PA; QL (180 EA per 30 days)
eltrombopag olamine oral tablet 12.5 mg, 25 mg	5	PA; QL (30 EA per 30 days)
eltrombopag olamine oral tablet 50 mg, 75 mg	5	PA; QL (60 EA per 30 days)
EPOGEN INJECTION SOLUTION 10000 UNIT/ML, 2000 UNIT/ML, 20000 UNIT/ML, 3000 UNIT/ML, 4000 UNIT/ML	4	PA
FULPHILA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 6 MG/0.6ML	5	PA
FYLNETRA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 6 MG/0.6ML	5	PA
LEUKINE INJECTION SOLUTION RECONSTITUTED 250 MCG	4	PA
NEULASTA ONPRO SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 6 MG/0.6ML	5	PA
NEULASTA SUBCUTANEOUS SOLUTION 4 MG/0.4ML	5	PA

Name of Drug	Drug Tier	Requirements/Limits
NEULASTA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 6 MG/0.6ML	5	PA
PROCRIT INJECTION SOLUTION 10000 UNIT/ML, 2000 UNIT/ML, 3000 UNIT/ML, 4000 UNIT/ML	4	PA
PROCRIT INJECTION SOLUTION 20000 UNIT/ML, 40000 UNIT/ML	5	PA
PYRUKYND ORAL TABLET 20 MG, 5 MG, 50 MG	5	PA
PYRUKYND TAPER PACK ORAL TABLET THERAPY PACK 5 MG, 7 X 20 MG & 7 X 5 MG, 7 X 50 MG & 7 X 20 MG	5	PA
RETACRIT INJECTION SOLUTION 10000 UNIT/ML, 10000 UNIT/ML(1ML), 2000 UNIT/ML, 20000 UNIT/ML, 3000 UNIT/ML, 4000 UNIT/ML, 40000 UNIT/ML	4	PA
TAVNEOS ORAL CAPSULE 10 MG	5	PA
tranexamic acid oral tablet 650 mg	2	
XOLREMDI ORAL CAPSULE 100 MG	5	PA
ZARXIO INJECTION SOLUTION PREFILLED SYRINGE 300 MCG/0.5ML, 480 MCG/0.8ML	5	PA
Platelet Modifying Agents		
aspirin-dipyridamole er oral capsule extended release 12 hour 25-200 mg	2	
BRILINTA ORAL TABLET 90 MG	4	
cilostazol oral tablet 100 mg, 50 mg	1	
clopidogrel bisulfate oral tablet 75 mg	1	
dipyridamole oral tablet 25 mg, 50 mg, 75 mg	2	PA
DOPTELET ORAL TABLET 20 MG, 20 MG (10 PACK), 20 MG(15 PACK)	5	PA
DOPTELET SPRINKLE ORAL CAPSULE SPRINKLE 10 MG	5	PA
prasugrel hcl oral tablet 10 mg, 5 mg	2	
ticagrelor oral tablet 60 mg, 90 mg	2	
Cardiovascular Agents - Treatment Of Conditions Affecting The Heart And Blood Vessels		
Alpha-Adrenergic Agonists		

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Name of Drug	Drug Tier	Requirements/Limits
clonidine hcl oral tablet 0.1 mg, 0.2 mg, 0.3 mg	1	
clonidine transdermal patch weekly 0.1 mg/24hr, 0.2 mg/24hr, 0.3 mg/24hr	2	
droxidopa oral capsule 100 mg, 200 mg, 300 mg	2	
guanfacine hcl oral tablet 1 mg, 2 mg	1	PA
midodrine hcl oral tablet 10 mg, 2.5 mg, 5 mg	2	
Alpha-Adrenergic Blocking Agents		
doxazosin mesylate oral tablet 1 mg, 2 mg, 4 mg, 8 mg	1	
phenoxybenzamine hcl oral capsule 10 mg	5	PA
prazosin hcl oral capsule 1 mg, 2 mg, 5 mg	1	
terazosin hcl oral capsule 1 mg, 10 mg, 2 mg, 5 mg	1	
Angiotensin Ii Receptor Antagonists		
candesartan cilexetil oral tablet 16 mg, 32 mg, 4 mg, 8 mg	2	
irbesartan oral tablet 150 mg, 300 mg, 75 mg	1	
losartan potassium oral tablet 100 mg, 25 mg, 50 mg	1	
olmesartan medoxomil oral tablet 20 mg, 40 mg, 5 mg	1	
telmisartan oral tablet 20 mg, 40 mg, 80 mg	1	
valsartan oral tablet 160 mg, 320 mg, 40 mg, 80 mg	1	
Angiotensin-Converting Enzyme (Ace) Inhibitors		
benazepril hcl oral tablet 10 mg, 20 mg, 40 mg, 5 mg	1	
captopril oral tablet 100 mg, 12.5 mg, 25 mg, 50 mg	2	
enalapril maleate oral tablet 10 mg, 2.5 mg, 20 mg, 5 mg	1	
fosinopril sodium oral tablet 10 mg, 20 mg, 40 mg	1	
lisinopril oral tablet 10 mg, 2.5 mg, 20 mg, 30 mg, 40 mg, 5 mg	1	
moexipril hcl oral tablet 15 mg, 7.5 mg	2	

Name of Drug	Drug Tier	Requirements/Limits
perindopril erbumine oral tablet 2 mg, 4 mg, 8 mg	2	
quinapril hcl oral tablet 10 mg, 20 mg, 40 mg, 5 mg	1	
ramipril oral capsule 1.25 mg, 10 mg, 2.5 mg, 5 mg	1	
trandolapril oral tablet 1 mg, 2 mg, 4 mg	1	
Antiarrhythmics		
amiodarone hcl oral tablet 100 mg, 200 mg, 400 mg	2	
disopyramide phosphate oral capsule 100 mg, 150 mg	2	
dofetilide oral capsule 125 mcg, 250 mcg, 500 mcg	2	
flecainide acetate oral tablet 100 mg, 150 mg, 50 mg	2	
mexiletine hcl oral capsule 150 mg, 200 mg, 250 mg	2	
NORPACE CR ORAL CAPSULE EXTENDED RELEASE 12 HOUR 100 MG, 150 MG	4	
propafenone hcl oral tablet 150 mg, 225 mg, 300 mg	2	
quinidine gluconate er oral tablet extended release 324 mg	2	
quinidine sulfate oral tablet 200 mg, 300 mg	2	
sotalol hcl (af) oral tablet 120 mg, 160 mg, 80 mg	1	
sotalol hcl oral tablet 120 mg, 160 mg, 240 mg, 80 mg	1	
Beta-Adrenergic Blocking Agents		
acebutolol hcl oral capsule 200 mg, 400 mg	1	
atenolol oral tablet 100 mg, 25 mg, 50 mg	1	
betaxolol hcl oral tablet 10 mg, 20 mg	2	
bisoprolol fumarate oral tablet 10 mg, 5 mg	1	
carvedilol oral tablet 12.5 mg, 25 mg, 3.125 mg, 6.25 mg	1	
labetalol hcl oral tablet 100 mg, 200 mg, 300 mg	2	
metoprolol succinate er oral tablet extended release 24 hour 100 mg, 200 mg, 25 mg, 50 mg	1	

Name of Drug	Drug Tier	Requirements/Limits
metoprolol tartrate oral tablet 100 mg, 25 mg, 50 mg	1	
nadolol oral tablet 20 mg, 40 mg, 80 mg	2	
nebivolol hcl oral tablet 10 mg, 2.5 mg, 5 mg	1	QL (30 EA per 30 days)
nebivolol hcl oral tablet 20 mg	1	QL (60 EA per 30 days)
pindolol oral tablet 10 mg, 5 mg	2	
propranolol hcl er oral capsule extended release 24 hour 120 mg, 160 mg, 60 mg, 80 mg	1	
propranolol hcl oral solution 20 mg/5ml, 40 mg/5ml	2	
propranolol hcl oral tablet 10 mg, 20 mg, 40 mg, 60 mg, 80 mg	1	
timolol maleate oral tablet 10 mg, 20 mg, 5 mg	2	
Calcium Channel Blocking Agents, Dihydropyridines		
amlodipine besylate oral tablet 10 mg, 2.5 mg, 5 mg	1	
felodipine er oral tablet extended release 24 hour 10 mg, 2.5 mg, 5 mg	2	
isradipine oral capsule 2.5 mg, 5 mg	2	
nifedipine er oral tablet extended release 24 hour 30 mg, 60 mg, 90 mg	1	
nifedipine er osmotic release oral tablet extended release 24 hour 30 mg, 60 mg, 90 mg	1	
nifedipine oral capsule 10 mg, 20 mg	2	PA
nimodipine oral capsule 30 mg	2	
Calcium Channel Blocking Agents, Nondihydropyridines		
CARDAMYST NASAL SOLUTION 2 X 70 MG/DOSE	5	PA; QL (4 EA per 30 days)
CARTIA XT ORAL CAPSULE EXTENDED RELEASE 24 HOUR 120 MG, 180 MG, 240 MG, 300 MG	2	
diltiazem hcl er beads oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg, 420 mg	2	

Name of Drug	Drug Tier	Requirements/Limits
diltiazem hcl er coated beads oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg	2	
diltiazem hcl er oral capsule extended release 12 hour 120 mg, 60 mg, 90 mg	2	
diltiazem hcl er oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg	2	
diltiazem hcl oral tablet 120 mg, 30 mg, 60 mg, 90 mg	1	
dilt-xr oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg	2	
verapamil hcl er oral capsule extended release 24 hour 100 mg, 120 mg, 180 mg, 200 mg, 240 mg, 300 mg, 360 mg	2	
verapamil hcl er oral tablet extended release 120 mg, 180 mg, 240 mg	1	
verapamil hcl oral tablet 120 mg, 40 mg, 80 mg	1	
Cardiovascular Agents, Other		
acetazolamide oral tablet 125 mg, 250 mg	2	
aliskiren fumarate oral tablet 150 mg, 300 mg	2	
amiloride-hydrochlorothiazide oral tablet 5-50 mg	1	
amlodipine besy-benazepril hcl oral capsule 10-20 mg, 10-40 mg, 2.5-10 mg, 5-10 mg, 5-20 mg, 5-40 mg	1	
amlodipine besylate-valsartan oral tablet 10-160 mg, 10-320 mg, 5-160 mg, 5-320 mg	1	
amlodipine-atorvastatin oral tablet 10-10 mg, 10-20 mg, 10-40 mg, 10-80 mg, 2.5-10 mg, 2.5-20 mg, 2.5-40 mg, 5-10 mg, 5-20 mg, 5-40 mg, 5-80 mg	2	
amlodipine-olmesartan oral tablet 10-20 mg, 10-40 mg, 5-20 mg, 5-40 mg	1	
amlodipine-valsartan-hctz oral tablet 10-160-12.5 mg, 10-160-25 mg, 10-320-25 mg, 5-160-12.5 mg, 5-160-25 mg	2	
atenolol-chlorthalidone oral tablet 100-25 mg, 50-25 mg	1	
benazepril-hydrochlorothiazide oral tablet 10-12.5 mg, 20-12.5 mg, 20-25 mg, 5-6.25 mg	2	

Name of Drug	Drug Tier	Requirements/Limits
bisoprolol-hydrochlorothiazide oral tablet 10-6.25 mg, 2.5-6.25 mg, 5-6.25 mg	1	
CAMZYOS ORAL CAPSULE 10 MG, 15 MG, 2.5 MG, 5 MG	5	PA; QL (30 EA per 30 days)
candesartan cilexetil-hctz oral tablet 16-12.5 mg, 32-12.5 mg, 32-25 mg	2	
CORLANOR ORAL SOLUTION 5 MG/5ML	4	PA; QL (450 ML per 30 days)
digoxin oral solution 0.05 mg/ml	2	QL (150 ML per 30 days)
digoxin oral tablet 125 mcg, 250 mcg	1	QL (30 EA per 30 days)
enalapril-hydrochlorothiazide oral tablet 10-25 mg, 5-12.5 mg	1	
ENTRESTO ORAL CAPSULE SPRINKLE 15-16 MG, 6-6 MG	3	QL (240 EA per 30 days)
ENTRESTO ORAL TABLET 24-26 MG, 49-51 MG, 97-103 MG	3	QL (60 EA per 30 days)
fosinopril sodium-hctz oral tablet 10-12.5 mg, 20-12.5 mg	2	
irbesartan-hydrochlorothiazide oral tablet 150-12.5 mg, 300-12.5 mg	1	
ivabradine hcl oral tablet 5 mg, 7.5 mg	2	PA
KERENDIA ORAL TABLET 10 MG, 20 MG, 40 MG	4	PA; QL (30 EA per 30 days)
lisinopril-hydrochlorothiazide oral tablet 10-12.5 mg, 20-12.5 mg, 20-25 mg	1	
LODOCO ORAL TABLET 0.5 MG	4	PA
losartan potassium-hctz oral tablet 100-12.5 mg, 100-25 mg, 50-12.5 mg	1	
metoprolol-hydrochlorothiazide oral tablet 100-25 mg, 100-50 mg, 50-25 mg	2	
metyrosine oral capsule 250 mg	5	PA
MYQORZO ORAL TABLET 10 MG, 15 MG, 20 MG, 5 MG	5	PA; QL (30 EA per 30 days)
NEXLETOL ORAL TABLET 180 MG	3	PA; QL (30 EA per 30 days)
NEXLIZET ORAL TABLET 180-10 MG	3	PA; QL (30 EA per 30 days)
olmesartan medoxomil-hctz oral tablet 20-12.5 mg, 40-12.5 mg, 40-25 mg	1	
olmesartan-amlodipine-hctz oral tablet 20-5-12.5 mg, 40-10-12.5 mg, 40-10-25 mg, 40-5-12.5 mg, 40-5-25 mg	2	

Name of Drug	Drug Tier	Requirements/Limits
pentoxifylline er oral tablet extended release 400 mg	1	
quinapril-hydrochlorothiazide oral tablet 10-12.5 mg, 20-12.5 mg, 20-25 mg	1	
ranolazine er oral tablet extended release 12 hour 1000 mg, 500 mg	2	
spironolactone-hctz oral tablet 25-25 mg	2	
telmisartan-amlodipine oral tablet 40-10 mg, 40-5 mg, 80-10 mg, 80-5 mg	2	
telmisartan-hctz oral tablet 40-12.5 mg, 80-12.5 mg, 80-25 mg	2	
triamterene-hctz oral capsule 37.5-25 mg	1	
triamterene-hctz oral tablet 37.5-25 mg, 75-50 mg	1	
valsartan-hydrochlorothiazide oral tablet 160-12.5 mg, 160-25 mg, 320-12.5 mg, 320-25 mg, 80-12.5 mg	1	
VERQUVO ORAL TABLET 10 MG, 2.5 MG, 5 MG	3	QL (30 EA per 30 days)
WEGOVY ORAL TABLET 1.5 MG, 25 MG, 4 MG, 9 MG	5	PA; QL (30 EA per 30 days)
WEGOVY SUBCUTANEOUS SOLUTION AUTO-INJECTOR 0.25 MG/0.5ML, 0.5 MG/0.5ML, 1 MG/0.5ML	5	PA; QL (2 ML per 28 days)
WEGOVY SUBCUTANEOUS SOLUTION AUTO-INJECTOR 1.7 MG/0.75ML, 2.4 MG/0.75ML	5	PA; QL (3 ML per 28 days)
Diuretics, Loop		
bumetanide oral tablet 0.5 mg, 1 mg, 2 mg	2	
furosemide injection solution 10 mg/ml	2	
furosemide oral solution 10 mg/ml, 8 mg/ml	1	
furosemide oral tablet 20 mg, 40 mg, 80 mg	1	
torsemide oral tablet 10 mg, 100 mg, 20 mg, 5 mg	2	
Diuretics, Potassium-Sparing		
amiloride hcl oral tablet 5 mg	1	
eplerenone oral tablet 25 mg, 50 mg	2	
spironolactone oral tablet 100 mg, 25 mg, 50 mg	1	
Diuretics, Thiazide		

Name of Drug	Drug Tier	Requirements/Limits
chlorthalidone oral tablet 25 mg, 50 mg	1	
hydrochlorothiazide oral capsule 12.5 mg	1	
hydrochlorothiazide oral tablet 12.5 mg, 25 mg, 50 mg	1	
indapamide oral tablet 1.25 mg, 2.5 mg	1	
metolazone oral tablet 10 mg, 2.5 mg, 5 mg	2	
Dyslipidemics, Fibric Acid Derivatives		
fenofibrate micronized oral capsule 134 mg, 200 mg, 43 mg, 67 mg	2	
fenofibrate oral capsule 134 mg, 200 mg, 67 mg	2	
fenofibrate oral tablet 145 mg, 160 mg, 48 mg, 54 mg	2	
fenofibric acid oral capsule delayed release 135 mg, 45 mg	2	
gemfibrozil oral tablet 600 mg	1	
Dyslipidemics, Hmg Coa Reductase Inhibitors		
atorvastatin calcium oral tablet 10 mg, 20 mg, 40 mg, 80 mg	1	
lovastatin oral tablet 10 mg, 20 mg, 40 mg	1	
pravastatin sodium oral tablet 10 mg, 20 mg, 40 mg, 80 mg	1	
rosuvastatin calcium oral tablet 10 mg, 20 mg, 40 mg, 5 mg	1	
simvastatin oral tablet 10 mg, 20 mg, 40 mg, 5 mg, 80 mg	1	
Dyslipidemics, Other		
cholestyramine light oral packet 4 gm	2	
cholestyramine light oral powder 4 gm/dose	2	
cholestyramine oral packet 4 gm	2	
cholestyramine oral powder 4 gm/dose	2	
colesevelam hcl oral packet 3.75 gm	2	
colesevelam hcl oral tablet 625 mg	2	
colestipol hcl oral granules 5 gm	2	
colestipol hcl oral packet 5 gm	2	
colestipol hcl oral tablet 1 gm	2	

Name of Drug	Drug Tier	Requirements/Limits
ezetimibe oral tablet 10 mg	1	
ezetimibe-simvastatin oral tablet 10-10 mg, 10-20 mg, 10-40 mg, 10-80 mg	2	
icosapent ethyl oral capsule 0.5 gm, 1 gm	2	
niacin er (antihyperlipidemic) oral tablet extended release 1000 mg, 500 mg, 750 mg	2	
omega-3-acid ethyl esters oral capsule 1 gm	2	
PREVALITE ORAL PACKET 4 GM	2	
PREVALITE ORAL POWDER 4 GM/DOSE	2	
REPATHA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 140 MG/ML	3	PA; QL (3 ML per 28 days)
REPATHA SURECLICK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 140 MG/ML	3	PA; QL (3 ML per 28 days)
Vasodilators, Direct-Acting Arterial		
hydralazine hcl oral tablet 10 mg, 100 mg, 25 mg, 50 mg	2	
isosorb dinitrate-hydralazine oral tablet 20-37.5 mg	2	
minoxidil oral tablet 10 mg, 2.5 mg	2	
Vasodilators, Direct-Acting Arterial/ Venous		
isosorbide dinitrate oral tablet 10 mg, 20 mg, 30 mg, 5 mg	1	
isosorbide mononitrate er oral tablet extended release 24 hour 120 mg, 30 mg, 60 mg	1	
isosorbide mononitrate oral tablet 10 mg, 20 mg	1	
NITRO-BID TRANSDERMAL OINTMENT 2 %	4	
NITRO-DUR TRANSDERMAL PATCH 24 HOUR 0.3 MG/HR, 0.8 MG/HR	4	
nitroglycerin rectal ointment 0.4 %	2	
nitroglycerin sublingual tablet sublingual 0.3 mg, 0.4 mg, 0.6 mg	2	
nitroglycerin transdermal ointment 2 %	4	
nitroglycerin transdermal patch 24 hour 0.1 mg/hr, 0.2 mg/hr, 0.4 mg/hr, 0.6 mg/hr	2	
nitroglycerin translingual solution 0.4 mg/spray	2	

Name of Drug	Drug Tier	Requirements/Limits
Central Nervous System Agents - Treatment Of Disorders Of The Brain And Spinal Column		
Attention Deficit Hyperactivity Disorder Agents, Amphetamines		
amphetamine-dextroamphet er oral capsule extended release 24 hour 10 mg, 15 mg, 20 mg, 25 mg, 30 mg, 5 mg	2	QL (30 EA per 30 days)
amphetamine-dextroamphetamine oral tablet 10 mg, 20 mg, 30 mg, 5 mg, 7.5 mg	2	QL (60 EA per 30 days)
amphetamine-dextroamphetamine oral tablet 12.5 mg	2	QL (120 EA per 30 days)
amphetamine-dextroamphetamine oral tablet 15 mg	2	QL (90 EA per 30 days)
dextroamphetamine sulfate er oral capsule extended release 24 hour 10 mg	2	QL (150 EA per 30 days)
dextroamphetamine sulfate er oral capsule extended release 24 hour 15 mg	2	QL (120 EA per 30 days)
dextroamphetamine sulfate er oral capsule extended release 24 hour 5 mg	2	QL (90 EA per 30 days)
dextroamphetamine sulfate oral tablet 10 mg, 5 mg	2	QL (180 EA per 30 days)
Attention Deficit Hyperactivity Disorder Agents, Non-Amphetamines		
atomoxetine hcl oral capsule 10 mg, 100 mg, 18 mg, 25 mg, 40 mg, 60 mg, 80 mg	2	
clonidine hcl er oral tablet extended release 12 hour 0.1 mg	2	QL (120 EA per 30 days)
dexmethylphenidate hcl er oral capsule extended release 24 hour 10 mg, 15 mg, 20 mg, 25 mg, 30 mg, 35 mg, 40 mg, 5 mg	2	QL (30 EA per 30 days)
dexmethylphenidate hcl oral tablet 10 mg	2	QL (60 EA per 30 days)
dexmethylphenidate hcl oral tablet 2.5 mg, 5 mg	2	QL (90 EA per 30 days)
guanfacine hcl er oral tablet extended release 24 hour 1 mg, 2 mg, 4 mg	1	PA; QL (30 EA per 30 days)
guanfacine hcl er oral tablet extended release 24 hour 3 mg	1	PA; QL (60 EA per 30 days)

Name of Drug	Drug Tier	Requirements/Limits
methylphenidate hcl er (cd) oral capsule extended release 10 mg, 20 mg, 30 mg, 40 mg, 50 mg, 60 mg	2	QL (30 EA per 30 days)
methylphenidate hcl er (la) oral capsule extended release 24 hour 10 mg, 20 mg, 30 mg, 40 mg, 60 mg	2	QL (30 EA per 30 days)
methylphenidate hcl er (osm) oral tablet extended release 18 mg	2	QL (120 EA per 30 days)
methylphenidate hcl er (osm) oral tablet extended release 27 mg, 54 mg, 72 mg	2	QL (30 EA per 30 days)
methylphenidate hcl er (osm) oral tablet extended release 36 mg	2	QL (60 EA per 30 days)
methylphenidate hcl er (xr) oral capsule extended release 24 hour 10 mg, 15 mg, 20 mg, 30 mg, 40 mg, 50 mg, 60 mg	2	QL (30 EA per 30 days)
methylphenidate hcl er oral tablet extended release 10 mg	2	QL (30 EA per 30 days)
methylphenidate hcl er oral tablet extended release 20 mg	2	QL (90 EA per 30 days)
methylphenidate hcl er oral tablet extended release 24 hour 18 mg	2	QL (120 EA per 30 days)
methylphenidate hcl er(diffus) oral tablet extended release 27 mg, 54 mg	2	QL (30 EA per 30 days)
methylphenidate hcl er(diffus) oral tablet extended release 36 mg	2	QL (60 EA per 30 days)
methylphenidate hcl oral solution 10 mg/5ml	2	QL (900 ML per 30 days)
methylphenidate hcl oral solution 5 mg/5ml	2	QL (1800 ML per 30 days)
methylphenidate hcl oral tablet 10 mg, 20 mg, 5 mg	2	QL (90 EA per 30 days)
methylphenidate hcl oral tablet chewable 10 mg	2	QL (180 EA per 30 days)
methylphenidate hcl oral tablet chewable 2.5 mg, 5 mg	2	QL (90 EA per 30 days)
Central Nervous System, Other		
AQNEURSA ORAL PACKET 1 GM	5	PA; QL (120 EA per 30 days)
AUSTEDO ORAL TABLET 12 MG, 6 MG, 9 MG	5	PA
AUSTEDO XR ORAL TABLET EXTENDED RELEASE 24 HOUR 12 MG, 18 MG, 24 MG, 30 MG, 36 MG, 42 MG, 48 MG, 6 MG	5	PA

Name of Drug	Drug Tier	Requirements/Limits
AUSTEDO XR PATIENT TITRATION ORAL TABLET EXTENDED RELEASE THERAPY PACK 12 & 18 & 24 & 30 MG	5	PA
BYSANTI ORAL TABLET 1 MG, 10 MG, 12 MG, 2 MG, 4 MG, 6 MG, 8 MG	5	PA; QL (60 EA per 30 days)
BYSANTI TITRATION PACK A ORAL TABLET THERAPY PACK 1 & 2 & 4 & 6 MG	4	PA; QL (8 EA per 180 days)
BYSANTI TITRATION PACK B ORAL TABLET THERAPY PACK 1 & 2 & 6 & 8 MG	4	PA; QL (12 EA per 180 days)
BYSANTI TITRATION PACK C ORAL TABLET THERAPY PACK 1 & 2 & 6 MG	4	PA; QL (8 EA per 180 days)
COBENFY ORAL CAPSULE 100-20 MG, 125-30 MG, 50-20 MG	5	PA; QL (56 EA per 28 days)
COBENFY STARTER PACK ORAL CAPSULE THERAPY PACK 50-20 & 100-20 MG	5	PA; QL (56 EA per 180 days)
dextromethorphan-quinidine oral capsule 20-10 mg	5	PA
EVRYSDI ORAL SOLUTION RECONSTITUTED 0.75 MG/ML	5	PA
EVRYSDI ORAL TABLET 5 MG	5	PA
FIRDAPSE ORAL TABLET 10 MG	5	PA
INGREZZA ORAL CAPSULE 40 MG, 60 MG, 80 MG	5	PA; QL (30 EA per 30 days)
INGREZZA ORAL CAPSULE SPRINKLE 40 MG, 60 MG, 80 MG	5	PA; QL (30 EA per 30 days)
INGREZZA ORAL CAPSULE THERAPY PACK 40 & 80 MG	5	PA; QL (56 EA per 365 days)
LEQEMBI IQLIK (500 MG DOSE) SUBCUTANEOUS SOLUTION AUTO-INJECTOR 2 X 250 MG/1.25ML	5	PA
LEQEMBI IQLIK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 360 MG/1.8ML	5	PA
NUEDEXTA ORAL CAPSULE 20-10 MG	5	PA
RADICAVA ORS ORAL SUSPENSION 105 MG/5ML	5	PA
RADICAVA ORS STARTER KIT ORAL SUSPENSION 105 MG/5ML	5	PA
riluzole oral tablet 50 mg	2	
tetrabenazine oral tablet 12.5 mg	4	PA

Name of Drug	Drug Tier	Requirements/Limits
tetrabenazine oral tablet 25 mg	5	PA
VEOZAH ORAL TABLET 45 MG	4	PA
Fibromyalgia Agents		
DRIZALMA SPRINKLE ORAL CAPSULE DELAYED RELEASE SPRINKLE 20 MG, 30 MG, 40 MG, 60 MG	4	ST
duloxetine hcl oral capsule delayed release particles 20 mg, 30 mg, 60 mg	2	QL (60 EA per 30 days)
milnacipran hcl oral 12.5 & 25 & 50 mg	2	
milnacipran hcl oral tablet 100 mg, 12.5 mg, 25 mg, 50 mg	2	
SAVELLA TITRATION PACK ORAL 12.5 & 25 & 50 MG	4	ST
Multiple Sclerosis Agents		
BAFIERTAM ORAL CAPSULE DELAYED RELEASE 95 MG	5	PA
BETASERON SUBCUTANEOUS KIT 0.3 MG	5	PA
cladribine (10 tabs) oral tablet therapy pack 10 mg	5	PA
cladribine (4 tabs) oral tablet therapy pack 10 mg	5	PA
cladribine (5 tabs) oral tablet therapy pack 10 mg	5	PA
cladribine (6 tabs) oral tablet therapy pack 10 mg	5	PA
cladribine (7 tabs) oral tablet therapy pack 10 mg	5	PA
cladribine (8 tabs) oral tablet therapy pack 10 mg	5	PA
cladribine (9 tabs) oral tablet therapy pack 10 mg	5	PA
cladribine 10 mg tablet therapy pack oral oral tablet therapy pack 10 mg	5	PA
dalfampridine er oral tablet extended release 12 hour 10 mg	2	PA
dimethyl fumarate oral capsule delayed release 120 mg	2	PA; QL (56 EA per 28 days)
dimethyl fumarate oral capsule delayed release 240 mg	2	PA; QL (60 EA per 30 days)
dimethyl fumarate starter pack oral capsule delayed release therapy pack 120 & 240 mg	2	PA
fingolimod hcl oral capsule 0.5 mg	4	PA; QL (30 EA per 30 days)
glatiramer acetate subcutaneous solution prefilled syringe 20 mg/ml	5	PA; QL (30 ML per 30 days)

Name of Drug	Drug Tier	Requirements/Limits
glatiramer acetate subcutaneous solution prefilled syringe 40 mg/ml	5	PA; QL (12 ML per 28 days)
GLATOPA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 20 MG/ML	5	PA; QL (30 ML per 30 days)
GLATOPA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/ML	5	PA; QL (12 ML per 28 days)
KESIMPTA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 20 MG/0.4ML	5	PA
MAYZENT ORAL TABLET 0.25 MG, 1 MG, 2 MG	5	PA
MAYZENT STARTER PACK ORAL TABLET THERAPY PACK 12 X 0.25 MG	5	PA
MAYZENT STARTER PACK ORAL TABLET THERAPY PACK 7 X 0.25 MG	4	PA
PONVORY ORAL TABLET 20 MG	5	PA
PONVORY STARTER PACK ORAL TABLET THERAPY PACK 2-3-4-5-6-7-8-9 & 10 MG	5	PA
REBIF REBIDOSE SUBCUTANEOUS SOLUTION AUTO-INJECTOR 22 MCG/0.5ML, 44 MCG/0.5ML	5	PA
REBIF REBIDOSE TITRATION PACK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 6X8.8 & 6X22 MCG	5	PA
REBIF SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 22 MCG/0.5ML, 44 MCG/0.5ML	5	PA
REBIF TITRATION PACK SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 6X8.8 & 6X22 MCG	5	PA
TASCENSO ODT ORAL TABLET DISPERSIBLE 0.25 MG, 0.5 MG	5	PA
teriflunomide oral tablet 14 mg, 7 mg	2	PA; QL (30 EA per 30 days)
ZEPOSIA 7-DAY STARTER PACK ORAL CAPSULE THERAPY PACK 4 X 0.23MG & 3 X 0.46MG	5	PA
ZEPOSIA ORAL CAPSULE 0.92 MG	5	PA
ZEPOSIA STARTER KIT ORAL CAPSULE THERAPY PACK 0.23MG &0.46MG 0.92MG(21)	5	PA

Name of Drug	Drug Tier	Requirements/Limits
Dental And Oral Agents - Treatment Of Mouth And Gum Disorders		
Dental And Oral Agents		
cevimeline hcl oral capsule 30 mg	2	
chlorhexidine gluconate mouth/throat solution 0.12 %	1	
pilocarpine hcl oral tablet 5 mg, 7.5 mg	2	
triamcinolone acetonide mouth/throat paste 0.1 %	2	
Dermatological Agents - Treatment Of Skin Conditions		
Acne And Rosacea Agents		
acitretin oral capsule 10 mg, 17.5 mg, 25 mg	2	PA
adapalene external gel 0.3 %	2	
adapalene-benzoyl peroxide external gel 0.1-2.5 %	2	
AMNESTEEM ORAL CAPSULE 10 MG, 20 MG, 30 MG, 40 MG	2	
benzoyl peroxide-erythromycin external gel 5-3 %	2	
CLARAVIS ORAL CAPSULE 10 MG, 20 MG, 30 MG, 40 MG	2	
clindamycin phos-benzoyl perox external gel 1-5 %, 1.2-2.5 %, 1.2-5 %	2	
isotretinoin oral capsule 10 mg, 20 mg, 30 mg, 40 mg	2	
tazarotene external cream 0.05 %, 0.1 %	2	
tazarotene external gel 0.05 %, 0.1 %	2	
tretinoin external cream 0.025 %, 0.05 %, 0.1 %	2	
tretinoin external gel 0.01 %, 0.025 %	2	
ZENATANE ORAL CAPSULE 10 MG, 20 MG, 30 MG, 40 MG	2	
Dermatitis And Pruritus Agents		
alclometasone dipropionate external cream 0.05 %	2	
alclometasone dipropionate external ointment 0.05 %	2	
ammonium lactate external cream 12 %	2	

Name of Drug	Drug Tier	Requirements/Limits
ammonium lactate external lotion 12 %	2	
betamethasone dipropionate aug external cream 0.05 %	2	
betamethasone dipropionate aug external gel 0.05 %	2	
betamethasone dipropionate aug external lotion 0.05 %	2	
betamethasone dipropionate aug external ointment 0.05 %	2	
betamethasone dipropionate external cream 0.05 %	2	
betamethasone dipropionate external lotion 0.05 %	2	
betamethasone dipropionate external ointment 0.05 %	2	
betamethasone valerate external cream 0.1 %	2	
betamethasone valerate external lotion 0.1 %	2	
betamethasone valerate external ointment 0.1 %	2	
clobetasol prop emollient base external cream 0.05 %	2	QL (60 GM per 30 days)
clobetasol propionate e external cream 0.05 %	2	
clobetasol propionate external cream 0.05 %	2	QL (60 GM per 30 days)
clobetasol propionate external gel 0.05 %	2	QL (60 GM per 30 days)
clobetasol propionate external ointment 0.05 %	2	QL (60 GM per 30 days)
clobetasol propionate external solution 0.05 %	2	QL (50 ML per 30 days)
desonide external cream 0.05 %	2	
desonide external lotion 0.05 %	2	
desonide external ointment 0.05 %	2	
desoximetasone external cream 0.05 %, 0.25 %	2	
desoximetasone external gel 0.05 %	2	
desoximetasone external ointment 0.05 %, 0.25 %	2	
doxepin hcl external cream 5 %	2	PA; QL (45 GM per 30 days)
EUCRISA EXTERNAL OINTMENT 2 %	4	PA
fluocinolone acetonide external cream 0.01 %, 0.025 %	2	
fluocinolone acetonide external ointment 0.025 %	2	
fluocinolone acetonide external solution 0.01 %	2	

Name of Drug	Drug Tier	Requirements/Limits
fluocinonide emulsified base external cream 0.05 %	2	
fluocinonide external cream 0.05 %	2	QL (120 GM per 30 days)
fluocinonide external gel 0.05 %	2	QL (120 GM per 30 days)
fluocinonide external ointment 0.05 %	2	QL (60 GM per 30 days)
fluocinonide external solution 0.05 %	2	QL (60 ML per 30 days)
fluticasone propionate external cream 0.05 %	2	
fluticasone propionate external lotion 0.05 %	2	
fluticasone propionate external ointment 0.005 %	2	
halobetasol propionate external cream 0.05 %	2	
halobetasol propionate external ointment 0.05 %	2	
hydrocortisone (perianal) external cream 1 %, 2.5 %	1	
hydrocortisone butyrate external cream 0.1 %	2	
hydrocortisone butyrate external ointment 0.1 %	2	
hydrocortisone butyrate external solution 0.1 %	2	
hydrocortisone external cream 1 %, 2.5 %	1	
hydrocortisone external lotion 2.5 %	1	
hydrocortisone external ointment 1 %, 2.5 %	1	
hydrocortisone valerate external cream 0.2 %	2	
hydrocortisone valerate external ointment 0.2 %	2	
HYFTOR EXTERNAL GEL 0.2 %	5	PA
mometasone furoate external cream 0.1 %	2	
mometasone furoate external ointment 0.1 %	2	
mometasone furoate external solution 0.1 %	2	
pimecrolimus external cream 1 %	2	ST
selenium sulfide external lotion 2.5 %	2	
tacrolimus external ointment 0.03 %, 0.1 %	2	ST
triamcinolone acetonide external cream 0.025 %, 0.1 %, 0.5 %	2	
triamcinolone acetonide external lotion 0.025 %, 0.1 %	2	
triamcinolone acetonide external ointment 0.025 %, 0.05 %, 0.1 %, 0.5 %	2	
triamcinolone in absorbase external ointment 0.05 %	2	

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

Name of Drug	Drug Tier	Requirements/Limits
Dermatological Agents, Other		
alcohol pad , 70 %	1	
ALCOHOL PAD 70 %	1	
alcohol sheet , 70 %	1	
calcipotriene external cream 0.005 %	2	QL (120 GM per 30 days)
calcipotriene external ointment 0.005 %	2	QL (120 GM per 30 days)
calcipotriene external solution 0.005 %	2	QL (120 ML per 30 days)
calcitriol external ointment 3 mcg/gm	2	
clotrimazole-betamethasone external cream 1-0.05 %	2	QL (45 GM per 28 days)
clotrimazole-betamethasone external lotion 1-0.05 %	2	QL (60 ML per 28 days)
fluorouracil external cream 5 %	2	QL (40 GM per 30 days)
fluorouracil external solution 2 %, 5 %	2	
imiquimod external cream 5 %	2	
methoxsalen rapid oral capsule 10 mg	2	
nystatin-triamcinolone external cream 100000-0.1 unit/gm-%	2	
nystatin-triamcinolone external ointment 100000-0.1 unit/gm-%	2	
OTEZLA ORAL TABLET 20 MG, 30 MG	5	PA
OTEZLA ORAL TABLET THERAPY PACK 10 & 20 & 30 MG, 4 X 10 & 51 X20 MG	5	PA
OTEZLA XR ORAL TABLET EXTENDED RELEASE 24 HOUR 75 MG	5	PA
OTEZLA/OTEZLA XR INITIATION PK ORAL TABLET THERAPY PACK 10&20&30&(ER)75 MG	5	PA
podofilox external solution 0.5 %	2	
SANTYL EXTERNAL OINTMENT 250 UNIT/GM	3	QL (90 GM per 30 days)
silver sulfadiazine external cream 1 %	2	
sodium chloride irrigation solution 0.9 %	2	
Pediculicides/Scabicides		
malathion external lotion 0.5 %	2	
permethrin external cream 5 %	2	QL (60 GM per 30 days)

Name of Drug	Drug Tier	Requirements/Limits
Topical Anti-Infectives		
acyclovir external cream 5 %	2	
acyclovir external ointment 5 %	2	
ciclopirox external solution 8 %	2	
ciclopirox olamine external cream 0.77 %	2	
ciclopirox olamine external suspension 0.77 %	2	
clindamycin phos (once-daily) external gel 1 %	2	
clindamycin phos (twice-daily) external gel 1 %	2	
clindamycin phosphate external lotion 1 %	2	
clindamycin phosphate external solution 1 %	2	
clindamycin phosphate external swab 1 %	2	
ery external pad 2 %	2	
erythromycin external gel 2 %	2	
erythromycin external solution 2 %	2	
gentamicin sulfate external cream 0.1 %	1	
gentamicin sulfate external ointment 0.1 %	1	
metronidazole external cream 0.75 %	2	
metronidazole external gel 0.75 %, 1 %	2	
metronidazole external lotion 0.75 %	2	
mupirocin external ointment 2 %	2	QL (88 GM per 30 days)
penciclovir external cream 1 %	2	
Electrolytes/Minerals/ Metals/ Vitamins - Products That Supplement Or Replace Electrolytes, Minerals, Metals Or Vitamins		
Electrolyte/ Mineral Replacement		
carglumic acid oral tablet soluble 200 mg	5	PA
ISOLYTE-S INTRAVENOUS SOLUTION	4	
ISOLYTE-S PH 7.4 INTRAVENOUS SOLUTION	4	
kcl in dextrose-nacl intravenous solution 20-5-0.45 meq/l-%-%	2	
KLOR-CON 10 ORAL TABLET EXTENDED RELEASE 10 MEQ	3	
KLOR-CON M10 ORAL TABLET EXTENDED RELEASE 10 MEQ	3	

Name of Drug	Drug Tier	Requirements/Limits
KLOR-CON M15 ORAL TABLET EXTENDED RELEASE 15 MEQ	3	
KLOR-CON M20 ORAL TABLET EXTENDED RELEASE 20 MEQ	3	
KLOR-CON ORAL TABLET EXTENDED RELEASE 8 MEQ	3	
magnesium sulfate injection solution 50 %, 50 % (10ml syringe)	2	
potassium chloride crys er oral tablet extended release 10 meq, 15 meq, 20 meq	1	
potassium chloride er oral capsule extended release 10 meq, 8 meq	1	
potassium chloride er oral tablet extended release 10 meq, 15 meq, 20 meq, 8 meq	1	
potassium chloride intravenous solution 2 meq/ml, 2 meq/ml (20 ml), 40 meq/100ml	2	
potassium chloride oral solution 10 %, 20 meq/15ml (10%), 40 meq/15ml (20%)	2	
potassium citrate er oral tablet extended release 10 meq (1080 mg), 15 meq (1620 mg), 5 meq (540 mg)	2	
sodium chloride (pf) injection solution 0.9 %	2	
sodium chloride intravenous solution 0.45 %, 0.9 %, 3 %	2	
sodium fluoride oral tablet 2.2 (1 f) mg	2	
Electrolyte/Mineral/Metal Modifiers		
CUVRIOR ORAL TABLET 300 MG	5	PA
deferasirox granules oral packet 180 mg, 360 mg, 90 mg	5	PA
deferasirox oral packet 180 mg, 360 mg, 90 mg	5	PA
deferasirox oral tablet 180 mg, 360 mg, 90 mg	2	PA
deferasirox oral tablet soluble 125 mg	2	PA
deferasirox oral tablet soluble 250 mg, 500 mg	5	PA
deferiprone oral tablet 1000 mg, 500 mg	5	PA
penicillamine oral tablet 250 mg	5	PA
tolvaptan (hyponatremia) oral tablet 15 mg, 30 mg	5	PA
tolvaptan oral tablet 15 mg, 30 mg	5	PA

Name of Drug	Drug Tier	Requirements/Limits
tolvaptan oral tablet therapy pack 15 mg, 30 & 15 mg, 45 & 15 mg, 60 & 30 mg, 90 & 30 mg	5	PA
trientine hcl oral capsule 250 mg	5	PA
Electrolytes/Minerals/Metals/Vitamins		
CLINISOL SF INTRAVENOUS SOLUTION 15 %	4	B/D
dextrose intravenous solution 10 %, 5 %	2	
dextrose-sodium chloride intravenous solution 10-0.2 %, 10-0.45 %, 2.5-0.45 %, 5-0.2 %, 5-0.45 %, 5-0.9 %	2	
INTRALIPID INTRAVENOUS EMULSION 20 %, 30 %	4	B/D
ISOLYTE-P IN D5W INTRAVENOUS SOLUTION	4	
levocarnitine oral solution 1 gm/10ml	2	
levocarnitine oral tablet 330 mg	2	
levocarnitine sf oral solution 1 gm/10ml	2	
NUTRILIPID INTRAVENOUS EMULSION 20 %	4	B/D
PLENAMINE INTRAVENOUS SOLUTION 15 %	4	B/D
pnv 27-ca/fe/fa oral tablet 60-1 mg	2	
prenatal oral tablet 27-1 mg	2	
Phosphate Binders		
calcium acetate (phos binder) oral capsule 667 mg	2	
lanthanum carbonate oral tablet chewable 1000 mg, 500 mg, 750 mg	2	
sevelamer carbonate oral packet 0.8 gm, 2.4 gm	2	
sevelamer carbonate oral tablet 800 mg	2	
Potassium Binders		
LOKELMA ORAL PACKET 10 GM, 5 GM	3	
sodium polystyrene sulfonate combination suspension 15 gm/60ml	2	
sodium polystyrene sulfonate oral powder	2	
SPS (SODIUM POLYSTYRENE SULF) COMBINATION SUSPENSION 15 GM/60ML	2	

Name of Drug	Drug Tier	Requirements/Limits
SPS (SODIUM POLYSTYRENE SULF) RECTAL SUSPENSION 30 GM/120ML	2	
VELTASSA ORAL PACKET 16.8 GM, 25.2 GM	5	QL (30 EA per 30 days)
VELTASSA ORAL PACKET 8.4 GM	5	QL (90 EA per 30 days)
Vitamins		
trinatal rx 1 oral tablet 60-1 mg	2	
Gastrointestinal Agents - Treatment Of Stomach And Intestinal Conditions		
Anti-Constipation Agents		
constulose oral solution 10 gm/15ml	2	
enulose oral solution 10 gm/15ml	2	
GAVILYTE-C ORAL SOLUTION RECONSTITUTED 240 GM	2	
GAVILYTE-G ORAL SOLUTION RECONSTITUTED 236 GM	2	
GAVILYTE-N WITH FLAVOR PACK ORAL SOLUTION RECONSTITUTED 420 GM	2	
generlac oral solution 10 gm/15ml	2	
lactulose encephalopathy oral solution 10 gm/15ml	2	
lactulose oral solution 10 gm/15ml, 20 gm/30ml	2	
LINZESS ORAL CAPSULE 145 MCG, 290 MCG, 72 MCG	3	QL (30 EA per 30 days)
lubiprostone oral capsule 24 mcg, 8 mcg	2	QL (60 EA per 30 days)
MOVANTIK ORAL TABLET 12.5 MG, 25 MG	3	QL (30 EA per 30 days)
peg 3350-kcl-na bicarb-nacl oral solution reconstituted 420 gm	2	
peg-3350/electrolytes oral solution reconstituted 236 gm	2	
RELISTOR ORAL TABLET 150 MG	4	PA
RELISTOR SUBCUTANEOUS SOLUTION 12 MG/0.6ML, 12 MG/0.6ML (0.6ML SYRINGE)	5	PA
RELISTOR SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 12 MG/0.6ML, 8 MG/0.4ML	5	PA
TRULANCE ORAL TABLET 3 MG	3	QL (30 EA per 30 days)

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

Name of Drug	Drug Tier	Requirements/Limits
Anti-Diarrheal Agents		
alosetron hcl oral tablet 0.5 mg	2	QL (60 EA per 30 days)
alosetron hcl oral tablet 1 mg	4	QL (60 EA per 30 days)
diphenoxylate-atropine oral liquid 2.5-0.025 mg/5ml	2	PA
diphenoxylate-atropine oral tablet 2.5-0.025 mg	2	PA
loperamide hcl oral capsule 2 mg	2	
XERMELO ORAL TABLET 250 MG	5	PA
XIFAXAN ORAL TABLET 200 MG	4	PA
XIFAXAN ORAL TABLET 550 MG	5	PA
Antispasmodics, Gastrointestinal		
dicyclomine hcl oral capsule 10 mg	1	
dicyclomine hcl oral solution 10 mg/5ml	2	
dicyclomine hcl oral tablet 20 mg	1	
glycopyrrolate oral solution 1 mg/5ml	2	
glycopyrrolate oral tablet 1 mg, 2 mg	2	
Gastrointestinal Agents, Other		
GATTEX SUBCUTANEOUS KIT 5 MG	5	PA
LIVMARLI ORAL SOLUTION 19 MG/ML, 9.5 MG/ML	5	PA
LIVMARLI ORAL TABLET 10 MG, 15 MG, 20 MG, 30 MG	5	PA
ursodiol oral capsule 300 mg	2	
ursodiol oral tablet 250 mg, 500 mg	2	
VOQUEZNA DUAL PAK ORAL THERAPY PACK 500-20 MG	4	QL (112 EA per 14 days)
VOQUEZNA ORAL TABLET 10 MG, 20 MG	4	QL (30 EA per 30 days)
VOQUEZNA TRIPLE PAK ORAL THERAPY PACK 500-500-20 MG	4	QL (112 EA per 14 days)
VOWST ORAL CAPSULE	5	PA
Histamine2 (H2) Receptor Antagonists		
cimetidine oral tablet 200 mg, 300 mg, 400 mg, 800 mg	2	
famotidine oral tablet 20 mg, 40 mg	1	
Protectants		

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Name of Drug	Drug Tier	Requirements/Limits
misoprostol oral tablet 100 mcg, 200 mcg	2	
sucralfate oral tablet 1 gm	1	
Proton Pump Inhibitors		
esomeprazole magnesium oral capsule delayed release 20 mg	1	QL (30 EA per 30 days)
esomeprazole magnesium oral capsule delayed release 40 mg	1	QL (60 EA per 30 days)
lansoprazole oral capsule delayed release 15 mg, 30 mg	1	
omeprazole oral capsule delayed release 10 mg, 20 mg	1	QL (30 EA per 30 days)
omeprazole oral capsule delayed release 40 mg	1	QL (60 EA per 30 days)
pantoprazole sodium oral tablet delayed release 20 mg	1	QL (30 EA per 30 days)
pantoprazole sodium oral tablet delayed release 40 mg	1	QL (60 EA per 30 days)
Genetic Or Enzyme Or Protein Disorder: Replacement, Modifiers, Treatment - Products That Replace, Modify, Or Treat Genetic Or Enzyme Disorders		
Genetic Or Enzyme Or Protein Disorder: Replacement, Modifiers, Treatment		
ARALAST NP INTRAVENOUS SOLUTION RECONSTITUTED 1000 MG, 500 MG	5	PA
betaine oral powder	5	
CERDELGA ORAL CAPSULE 84 MG	5	PA
CHOLBAM ORAL CAPSULE 250 MG, 50 MG	5	PA
CREON ORAL CAPSULE DELAYED RELEASE PARTICLES 12000-38000 UNIT, 24000-76000 UNIT, 3000-9500 UNIT, 36000-114000 UNIT, 6000-19000 UNIT	3	
CYSTAGON ORAL CAPSULE 150 MG, 50 MG	4	PA
GALAFOLD ORAL CAPSULE 123 MG	5	PA
GLASSIA INTRAVENOUS SOLUTION 1000 MG/50ML	5	PA

Name of Drug	Drug Tier	Requirements/Limits
GLASSIA INTRAVENOUS SOLUTION 4 GM/200ML, 5 GM/250ML	4	PA
glycerol phenylbutyrate oral liquid 1.1 gm/ml	5	PA
l-glutamine oral packet 5 gm	5	PA
miglustat oral capsule 100 mg	5	PA
nitisinone oral capsule 10 mg, 2 mg, 20 mg, 5 mg	5	PA
ORFADIN ORAL SUSPENSION 4 MG/ML	5	PA
PROLASTIN-C INTRAVENOUS SOLUTION 1000 MG/20ML	5	PA
REVCOVI INTRAMUSCULAR SOLUTION 2.4 MG/1.5ML	5	PA
sapropterin dihydrochloride oral packet 100 mg, 500 mg	5	PA
sapropterin dihydrochloride oral tablet 100 mg	5	PA
sodium phenylbutyrate oral powder 3 gm/tsp	5	PA
sodium phenylbutyrate oral tablet 500 mg	5	PA
SUCRAID ORAL SOLUTION 8500 UNIT/ML	5	PA
ZEMAIRA INTRAVENOUS SOLUTION RECONSTITUTED 1000 MG, 4000 MG, 5000 MG	5	PA
ZENPEP ORAL CAPSULE DELAYED RELEASE PARTICLES 10000-32000 UNIT, 15000-47000 UNIT, 20000-63000 UNIT, 25000-79000 UNIT, 3000-10000 UNIT, 40000-126000 UNIT, 5000-24000 UNIT, 60000-189600 UNIT	3	
Genitourinary Agents - Treatment Of Urinary Tract And Prostate Conditions		
Antispasmodics, Urinary		
darifenacin hydrobromide er oral tablet extended release 24 hour 15 mg, 7.5 mg	2	ST
fesoterodine fumarate er oral tablet extended release 24 hour 4 mg, 8 mg	2	QL (30 EA per 30 days)
flavoxate hcl oral tablet 100 mg	2	
GEMTESA ORAL TABLET 75 MG	3	QL (30 EA per 30 days)
MYRBETRIQ ORAL SUSPENSION RECONSTITUTED ER 8 MG/ML	3	QL (300 ML per 30 days)
MYRBETRIQ ORAL TABLET EXTENDED RELEASE 24 HOUR 25 MG, 50 MG	3	QL (30 EA per 30 days)

Name of Drug	Drug Tier	Requirements/Limits
oxybutynin chloride er oral tablet extended release 24 hour 10 mg, 15 mg	1	QL (60 EA per 30 days)
oxybutynin chloride er oral tablet extended release 24 hour 5 mg	1	QL (30 EA per 30 days)
oxybutynin chloride oral solution 5 mg/5ml	1	
oxybutynin chloride oral tablet 5 mg	1	
solifenacin succinate oral tablet 10 mg, 5 mg	2	QL (30 EA per 30 days)
tolterodine tartrate er oral capsule extended release 24 hour 2 mg, 4 mg	2	
tolterodine tartrate oral tablet 1 mg, 2 mg	2	
trospium chloride er oral capsule extended release 24 hour 60 mg	2	ST
trospium chloride oral tablet 20 mg	2	
Benign Prostatic Hypertrophy Agents		
alfuzosin hcl er oral tablet extended release 24 hour 10 mg	1	
dutasteride oral capsule 0.5 mg	2	
finasteride oral tablet 5 mg	1	
tadalafil oral tablet 5 mg	2	PA
tamsulosin hcl oral capsule 0.4 mg	1	
Genitourinary Agents, Other		
bethanechol chloride oral tablet 10 mg, 25 mg, 5 mg, 50 mg	2	
ELMIRON ORAL CAPSULE 100 MG	4	
FILSPARI ORAL TABLET 200 MG, 400 MG	5	PA
tiopronin oral tablet 100 mg	5	PA
tiopronin oral tablet delayed release 100 mg, 300 mg	5	PA
Hormonal Agents, Stimulant/ Replacement/ Modifying (Adrenal) - Treatment Of Conditions Requiring Steroids		
Hormonal Agents, Stimulant/ Replacement/ Modifying (Adrenal)		
CORTROPHIN GEL SUBCUTANEOUS PREFILLED SYRINGE 40 UNIT/0.5ML, 80 UNIT/ML	5	PA

Name of Drug	Drug Tier	Requirements/Limits
CORTROPHIN INJECTION GEL 80 UNIT/ML	5	PA
dexamethasone oral solution 0.5 mg/5ml	2	
dexamethasone oral tablet 0.5 mg, 0.75 mg, 1 mg, 1.5 mg, 2 mg, 4 mg, 6 mg	1	
fludrocortisone acetate oral tablet 0.1 mg	2	
hydrocortisone oral tablet 10 mg, 20 mg, 5 mg	2	
KYMBEE ORAL SUSPENSION 22.75 MG/ML	5	PA
KYMBEE ORAL TABLET 18 MG, 30 MG, 36 MG, 6 MG	5	PA
methylprednisolone oral tablet 16 mg, 32 mg, 4 mg, 8 mg	2	
methylprednisolone oral tablet therapy pack 4 mg	2	
prednisolone oral solution 15 mg/5ml	2	
prednisolone sodium phosphate oral solution 25 mg/5ml, 5 mg/5ml	2	
Hormonal Agents, Stimulant/ Replacement/ Modifying (Pituitary) - Treatment Of Pituitary Gland Conditions		
Hormonal Agents, Stimulant/ Replacement/ Modifying (Pituitary)		
desmopressin ace spray refrig nasal solution 0.01 %	2	
desmopressin acetate oral tablet 0.1 mg, 0.2 mg	2	
desmopressin acetate spray nasal solution 0.01 %	2	
EGRIFTA SV SUBCUTANEOUS SOLUTION RECONSTITUTED 2 MG	5	PA
EGRIFTA WR SUBCUTANEOUS KIT 11.6 MG	5	PA
GENOTROPIN MINIQUICK SUBCUTANEOUS PREFILLED SYRINGE 0.2 MG	4	PA
GENOTROPIN MINIQUICK SUBCUTANEOUS PREFILLED SYRINGE 0.4 MG, 0.6 MG, 0.8 MG, 1 MG, 1.2 MG, 1.4 MG, 1.6 MG, 1.8 MG, 2 MG	5	PA
GENOTROPIN SUBCUTANEOUS CARTRIDGE 12 MG	5	PA

Name of Drug	Drug Tier	Requirements/Limits
GENOTROPIN SUBCUTANEOUS CARTRIDGE 5 MG	4	PA
INCRELEX SUBCUTANEOUS SOLUTION 40 MG/4ML	5	PA
NGENLA SUBCUTANEOUS SOLUTION PEN-INJECTOR 24 MG/1.2ML, 60 MG/1.2ML	5	PA
OMNITROPE SUBCUTANEOUS SOLUTION CARTRIDGE 10 MG/1.5ML, 5 MG/1.5ML	5	PA
OMNITROPE SUBCUTANEOUS SOLUTION RECONSTITUTED 5.8 MG	5	PA
SEROSTIM SUBCUTANEOUS SOLUTION RECONSTITUTED 4 MG, 5 MG, 6 MG	5	PA
SKYTROFA SUBCUTANEOUS CARTRIDGE 0.7 MG, 1.4 MG, 1.8 MG, 11 MG, 13.3 MG, 2.1 MG, 2.5 MG, 3 MG, 3.6 MG, 4.3 MG, 5.2 MG, 6.3 MG, 7.6 MG, 9.1 MG	5	PA
Hormonal Agents, Stimulant/ Replacement/ Modifying (Sex Hormones/ Modifiers) - For The Replacement Or Modification Of Sex Hormones		
Androgens		
danazol oral capsule 100 mg, 200 mg, 50 mg	2	
methyltestosterone oral capsule 10 mg	5	PA
testosterone cypionate intramuscular solution 100 mg/ml, 200 mg/ml, 200 mg/ml (1 ml)	2	
testosterone enanthate intramuscular solution 200 mg/ml	2	
testosterone transdermal gel 1.62 %, 12.5 mg/act (1%), 20.25 mg/1.25gm (1.62%), 20.25 mg/act (1.62%), 25 mg/2.5gm (1%), 40.5 mg/2.5gm (1.62%), 50 mg/5gm (1%)	2	PA
testosterone transdermal solution 30 mg/act	2	PA
Estrogens		
estradiol oral tablet 0.5 mg, 1 mg, 2 mg	1	
estradiol transdermal patch twice weekly 0.025 mg/24hr, 0.0375 mg/24hr, 0.05 mg/24hr, 0.075 mg/24hr, 0.1 mg/24hr	2	QL (8 EA per 28 days)

Name of Drug	Drug Tier	Requirements/Limits
estradiol transdermal patch weekly 0.025 mg/24hr, 0.0375 mg/24hr, 0.05 mg/24hr, 0.06 mg/24hr, 0.075 mg/24hr, 0.1 mg/24hr	2	QL (4 EA per 28 days)
estradiol vaginal cream 0.01 %	2	
estradiol vaginal tablet 10 mcg	2	
estradiol valerate intramuscular oil 10 mg/ml, 20 mg/ml, 40 mg/ml	2	
PREMARIN ORAL TABLET 0.3 MG, 0.45 MG, 0.625 MG, 0.9 MG, 1.25 MG	3	
PREMARIN VAGINAL CREAM 0.625 MG/GM	3	
Hormonal Agents, Stimulant/ Replacement/ Modifying (Sex Hormones/ Modifiers)		
ABIGALE LO ORAL TABLET 0.5-0.1 MG	2	
ABIGALE ORAL TABLET 1-0.5 MG	2	
ALTAVERA ORAL TABLET 0.15-30 MG-MCG	2	
alyacen 1/35 oral tablet 1-35 mg-mcg	2	
APRI ORAL TABLET 0.15-30 MG-MCG	2	
ARANELLE ORAL TABLET 0.5/1/0.5-35 MG-MCG	2	
ASHLYNA ORAL TABLET 0.15-0.03 &0.01 MG	2	
AUBRA EQ ORAL TABLET 0.1-20 MG-MCG	2	
AUROVELA 1.5/30 ORAL TABLET 1.5-30 MG-MCG	2	
AUROVELA 1/20 ORAL TABLET 1-20 MG-MCG	2	
AUROVELA 24 FE ORAL TABLET 1-20 MG-MCG(24)	2	
AUROVELA FE 1.5/30 ORAL TABLET 1.5-30 MG-MCG	2	
AUROVELA FE 1/20 ORAL TABLET 1-20 MG-MCG	2	
AVIANE ORAL TABLET 0.1-20 MG-MCG	2	
AYUNA ORAL TABLET 0.15-30 MG-MCG	2	
AZURETTE ORAL TABLET 0.15-0.02/0.01 MG (21/5)	2	

Name of Drug	Drug Tier	Requirements/Limits
BALZIVA ORAL TABLET 0.4-35 MG-MCG	2	
BLISOVI 24 FE ORAL TABLET 1-20 MG-MCG(24)	2	
BLISOVI FE 1.5/30 ORAL TABLET 1.5-30 MG-MCG	2	
BLISOVI FE 1/20 ORAL TABLET 1-20 MG-MCG	2	
briellyn oral tablet 0.4-35 mg-mcg	2	
CHARLOTTE 24 FE ORAL TABLET CHEWABLE 1-20 MG-MCG(24)	2	
CHATEAL EQ ORAL TABLET 0.15-30 MG-MCG	2	
COMBIPATCH TRANSDERMAL PATCH TWICE WEEKLY 0.05-0.14 MG/DAY, 0.05-0.25 MG/DAY	4	
CRYSELLE ORAL TABLET 0.3-30 MG-MCG	2	
CRYSELLE-28 ORAL TABLET 0.3-30 MG-MCG	2	
CYRED EQ ORAL TABLET 0.15-30 MG-MCG	2	
DASETTA 1/35 (28) ORAL TABLET 1-35 MG-MCG	2	
DASETTA 7/7/7 ORAL TABLET 0.5/0.75/1-35 MG-MCG	2	
DAYSEE ORAL TABLET 0.15-0.03 &0.01 MG	2	
DEPO-PROVERA INTRAMUSCULAR SUSPENSION 150 MG/ML	3	
DEPO-PROVERA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 150 MG/ML	3	
drospirenone-ethinyl estradiol oral tablet 3-0.02 mg, 3-0.03 mg	2	
ELINEST ORAL TABLET 0.3-30 MG-MCG	2	
ELURYNG VAGINAL RING 0.12-0.015 MG/24HR	2	
EMZAHH ORAL TABLET 0.35 MG	2	
ENILLORING VAGINAL RING 0.12-0.015 MG/24HR	2	
ENSKYCE ORAL TABLET 0.15-30 MG-MCG	2	

Name of Drug	Drug Tier	Requirements/Limits
ESTARYLLA ORAL TABLET 0.25-35 MG-MCG	2	
estradiol-norethindrone acet oral tablet 0.5-0.1 mg, 1-0.5 mg	2	
etonogestrel-ethinyl estradiol vaginal ring 0.12-0.015 mg/24hr	2	
FALMINA ORAL TABLET 0.1-20 MG-MCG	2	
FINZALA ORAL TABLET CHEWABLE 1-20 MG-MCG(24)	2	
FYAVOLV ORAL TABLET 0.5-2.5 MG-MCG, 1-5 MG-MCG	2	
HAILEY 1.5/30 ORAL TABLET 1.5-30 MG-MCG	2	
HAILEY 24 FE ORAL TABLET 1-20 MG-MCG(24)	2	
HAILEY FE 1.5/30 ORAL TABLET 1.5-30 MG-MCG	2	
HAILEY FE 1/20 ORAL TABLET 1-20 MG-MCG	2	
HALOETTE VAGINAL RING 0.12-0.015 MG/24HR	2	
HEATHER ORAL TABLET 0.35 MG	2	
ICLEVIA ORAL TABLET 0.15-0.03 MG	2	
INTROVALE ORAL TABLET 0.15-0.03 MG	2	
ISIBLOOM ORAL TABLET 0.15-30 MG-MCG	2	
JAIMIESS ORAL TABLET 0.15-0.03 &0.01 MG	2	
JASMIEL ORAL TABLET 3-0.02 MG	2	
JENCYCLA ORAL TABLET 0.35 MG	2	
JINTELI ORAL TABLET 1-5 MG-MCG	2	
JOLESSA ORAL TABLET 0.15-0.03 MG	2	
JULEBER ORAL TABLET 0.15-30 MG-MCG	2	
JUNEL 1.5/30 ORAL TABLET 1.5-30 MG-MCG	2	
JUNEL 1/20 ORAL TABLET 1-20 MG-MCG	2	
JUNEL FE 1.5/30 ORAL TABLET 1.5-30 MG-MCG	2	
JUNEL FE 1/20 ORAL TABLET 1-20 MG-MCG	2	

Name of Drug	Drug Tier	Requirements/Limits
JUNEL FE 24 ORAL TABLET 1-20 MG-MCG(24)	2	
KALLIGA ORAL TABLET 0.15-30 MG-MCG	2	
KARIVA ORAL TABLET 0.15-0.02/0.01 MG (21/5)	2	
KELNOR 1/35 ORAL TABLET 1-35 MG-MCG	2	
KURVELO ORAL TABLET 0.15-30 MG-MCG	2	
KYLEENA INTRAUTERINE INTRAUTERINE DEVICE 19.5 MG	4	
LARIN 1.5/30 ORAL TABLET 1.5-30 MG-MCG	2	
LARIN 1/20 ORAL TABLET 1-20 MG-MCG	2	
LARIN 24 FE ORAL TABLET 1-20 MG-MCG(24)	2	
LARIN FE 1.5/30 ORAL TABLET 1.5-30 MG-MCG	2	
LARIN FE 1/20 ORAL TABLET 1-20 MG-MCG	2	
LESSINA ORAL TABLET 0.1-20 MG-MCG	2	
LEVONEST ORAL TABLET 50-30/75-40/ 125-30 MCG	2	
levonorgest-eth estrad 91-day oral tablet 0.1-0.02 & 0.01 mg, 0.15-0.03 &0.01 mg, 0.15-0.03 mg	2	
levonorgestrel-ethinyl estrad oral tablet 0.1-20 mg-mcg	2	
levonorg-eth estrad triphasic oral tablet 50-30/75-40/ 125-30 mcg	2	
LILETTA (52 MG) INTRAUTERINE INTRAUTERINE DEVICE 20.1 MCG/DAY	4	
LOJAIMIESS ORAL TABLET 0.1-0.02 & 0.01 MG	2	
LORYNA ORAL TABLET 3-0.02 MG	2	
LOW-OGESTREL ORAL TABLET 0.3-30 MG-MCG	2	
LO-ZUMANDIMINE ORAL TABLET 3-0.02 MG	2	
LUIZZA 1.5/30 ORAL TABLET 1.5-30 MG-MCG	2	
LUIZZA 1/20 ORAL TABLET 1-20 MG-MCG	2	

Name of Drug	Drug Tier	Requirements/Limits
LUTERA ORAL TABLET 0.1-20 MG-MCG	2	
LYLEQ ORAL TABLET 0.35 MG	2	
marlissa oral tablet 0.15-30 mg-mcg	2	
MIBELAS 24 FE ORAL TABLET CHEWABLE 1-20 MG-MCG(24)	2	
MICROGESTIN 1.5/30 ORAL TABLET 1.5-30 MG-MCG	2	
MICROGESTIN 1/20 ORAL TABLET 1-20 MG-MCG	2	
MICROGESTIN FE 1.5/30 ORAL TABLET 1.5-30 MG-MCG	2	
MICROGESTIN FE 1/20 ORAL TABLET 1-20 MG-MCG	2	
MILI ORAL TABLET 0.25-35 MG-MCG	2	
MIMVEY ORAL TABLET 1-0.5 MG	2	
MIRENA (52 MG) INTRAUTERINE INTRAUTERINE DEVICE 21 MCG/DAY	4	
MONO-LINYAH ORAL TABLET 0.25-35 MG-MCG	2	
NECON 0.5/35 (28) ORAL TABLET 0.5-35 MG-MCG	2	
NEXPLANON SUBCUTANEOUS IMPLANT 68 MG	3	
NIKKI ORAL TABLET 3-0.02 MG	2	
norelgestromin-eth estradiol transdermal patch weekly 150-35 mcg/24hr	2	
norethin ace-eth estrad-fe oral tablet chewable 1-20 mg-mcg(24)	2	
norethindrone acet-ethinyl est oral tablet 1-20 mg-mcg	2	
norethindrone-eth estradiol oral tablet 0.5-2.5 mg-mcg, 1-5 mg-mcg	2	
norgestimate-eth estradiol oral tablet 0.25-35 mg-mcg	2	
norgestim-eth estrad triphasic oral tablet 0.18/0.215/0.25 mg-25 mcg, 0.18/0.215/0.25 mg-35 mcg	2	
NORTREL 0.5/35 (28) ORAL TABLET 0.5-35 MG-MCG	2	

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

Name of Drug	Drug Tier	Requirements/Limits
NORTREL 1/35 (21) ORAL TABLET 1-35 MG-MCG	2	
NORTREL 1/35 (28) ORAL TABLET 1-35 MG-MCG	2	
NORTREL 7/7/7 ORAL TABLET 0.5/0.75/1-35 MG-MCG	2	
NYLIA 1/35 ORAL TABLET 1-35 MG-MCG	2	
NYLIA 7/7/7 ORAL TABLET 0.5/0.75/1-35 MG-MCG	2	
PHILITH ORAL TABLET 0.4-35 MG-MCG	2	
PIMTREA ORAL TABLET 0.15-0.02/0.01 MG (21/5)	2	
PORTIA-28 ORAL TABLET 0.15-30 MG-MCG	2	
PREMPHASE ORAL TABLET 0.625-5 MG	3	
PREMPRO ORAL TABLET 0.3-1.5 MG, 0.45-1.5 MG, 0.625-2.5 MG, 0.625-5 MG	3	
RECLIPSEN ORAL TABLET 0.15-30 MG-MCG	2	
SETLAKIN ORAL TABLET 0.15-0.03 MG	2	
SIMLIYA ORAL TABLET 0.15-0.02/0.01 MG (21/5)	2	
SIMPESSE ORAL TABLET 0.15-0.03 &0.01 MG	2	
SKYLA INTRAUTERINE INTRAUTERINE DEVICE 13.5 MG	3	
SPRINTEC 28 ORAL TABLET 0.25-35 MG-MCG	2	
SYEDA ORAL TABLET 3-0.03 MG	2	
TARINA 24 FE ORAL TABLET 1-20 MG-MCG(24)	2	
TARINA FE 1/20 EQ ORAL TABLET 1-20 MG-MCG	2	
TILIA FE ORAL TABLET 1-20/1-30/1-35 MG-MCG	2	
TRI-ESTARYLLA ORAL TABLET 0.18/0.215/0.25 MG-35 MCG	2	
TRI-LEGEST FE ORAL TABLET 1-20/1-30/1-35 MG-MCG	2	

Name of Drug	Drug Tier	Requirements/Limits
TRI-LINYAH ORAL TABLET 0.18/0.215/0.25 MG-35 MCG	2	
TRI-LO-ESTARYLLA ORAL TABLET 0.18/0.215/0.25 MG-25 MCG	2	
TRI-LO-MARZIA ORAL TABLET 0.18/0.215/0.25 MG-25 MCG	2	
TRI-LO-MILI ORAL TABLET 0.18/0.215/0.25 MG-25 MCG	2	
TRI-LO-SPRINTEC ORAL TABLET 0.18/0.215/0.25 MG-25 MCG	2	
TRI-MILI ORAL TABLET 0.18/0.215/0.25 MG-35 MCG	2	
TRI-SPRINTEC ORAL TABLET 0.18/0.215/0.25 MG-35 MCG	2	
TRI-VYLIBRA LO ORAL TABLET 0.18/0.215/0.25 MG-25 MCG	2	
TRI-VYLIBRA ORAL TABLET 0.18/0.215/0.25 MG-35 MCG	2	
TURQOZ ORAL TABLET 0.3-30 MG-MCG	2	
VELIVET ORAL TABLET 0.1/0.125/0.15 -0.025 MG	2	
VESTURA ORAL TABLET 3-0.02 MG	2	
VIENVA ORAL TABLET 0.1-20 MG-MCG	2	
viorele oral tablet 0.15-0.02/0.01 mg (21/5)	2	
VOLNEA ORAL TABLET 0.15-0.02/0.01 MG (21/5)	2	
VYFEMLA ORAL TABLET 0.4-35 MG-MCG	2	
VYLIBRA ORAL TABLET 0.25-35 MG-MCG	2	
WERA ORAL TABLET 0.5-35 MG-MCG	2	
WYMZYA FE ORAL TABLET CHEWABLE 0.4-35 MG-MCG	2	
XULANE TRANSDERMAL PATCH WEEKLY 150-35 MCG/24HR	2	
ZAFEMY TRANSDERMAL PATCH WEEKLY 150-35 MCG/24HR	2	
ZOVIA 1/35 (28) ORAL TABLET 1-35 MG-MCG	2	
ZUMANDIMINE ORAL TABLET 3-0.03 MG	2	

Name of Drug	Drug Tier	Requirements/Limits
Progestins		
CAMILA ORAL TABLET 0.35 MG	2	
DEBLITANE ORAL TABLET 0.35 MG	2	
DEPO-SUBQ PROVERA 104 SUBCUTANEOUS SUSPENSION PREFILLED SYRINGE 104 MG/0.65ML	3	
ERRIN ORAL TABLET 0.35 MG	2	
INCASSIA ORAL TABLET 0.35 MG	2	
LYZA ORAL TABLET 0.35 MG	2	
medroxyprogesterone acetate intramuscular suspension 150 mg/ml	2	
medroxyprogesterone acetate intramuscular suspension prefilled syringe 150 mg/ml	2	
medroxyprogesterone acetate oral tablet 10 mg, 2.5 mg, 5 mg	1	
megestrol acetate oral suspension 40 mg/ml, 400 mg/10ml, 625 mg/5ml	2	PA
megestrol acetate oral tablet 20 mg, 40 mg	2	PA
MELEYA ORAL TABLET 0.35 MG	2	
NORA-BE ORAL TABLET 0.35 MG	2	
norethindrone acetate oral tablet 5 mg	2	
norethindrone oral tablet 0.35 mg	2	
NORLYROC ORAL TABLET 0.35 MG	2	
ORQUIDEA ORAL TABLET 0.35 MG	2	
progesterone oral capsule 100 mg, 200 mg	2	
SHAROBEL ORAL TABLET 0.35 MG	2	
Selective Estrogen Receptor Modifying Agents		
DUAVEE ORAL TABLET 0.45-20 MG	3	
raloxifene hcl oral tablet 60 mg	2	
Hormonal Agents, Stimulant/ Replacement/ Modifying (Thyroid) - Treatment Of Thyroid Conditions		
Hormonal Agents, Stimulant/ Replacement/ Modifying (Thyroid)		

Name of Drug	Drug Tier	Requirements/Limits
LEVO-T ORAL TABLET 100 MCG, 112 MCG, 125 MCG, 137 MCG, 150 MCG, 175 MCG, 200 MCG, 25 MCG, 300 MCG, 50 MCG, 75 MCG, 88 MCG	4	
levothyroxine sodium oral tablet 100 mcg, 112 mcg, 125 mcg, 137 mcg, 150 mcg, 175 mcg, 200 mcg, 25 mcg, 300 mcg, 50 mcg, 75 mcg, 88 mcg	1	
LEVOXYL ORAL TABLET 100 MCG, 112 MCG, 125 MCG, 137 MCG, 150 MCG, 175 MCG, 200 MCG, 25 MCG, 50 MCG, 75 MCG, 88 MCG	4	
liothyronine sodium oral tablet 25 mcg, 5 mcg, 50 mcg	2	
REZDIFFRA ORAL TABLET 100 MG, 60 MG, 80 MG	5	PA; QL (30 EA per 30 days)
SYNTHROID ORAL TABLET 100 MCG, 112 MCG, 125 MCG, 137 MCG, 150 MCG, 175 MCG, 200 MCG, 25 MCG, 300 MCG, 50 MCG, 75 MCG, 88 MCG	4	
UNITHROID ORAL TABLET 100 MCG, 112 MCG, 125 MCG, 137 MCG, 150 MCG, 175 MCG, 200 MCG, 25 MCG, 300 MCG, 50 MCG, 75 MCG, 88 MCG	4	
Hormonal Agents, Suppressant (Pituitary) - Treatment Of Or Modification Of Pituitary Hormone Secretion		
Hormonal Agents, Suppressant (Pituitary)		
cabergoline oral tablet 0.5 mg	2	
ELIGARD SUBCUTANEOUS KIT 22.5 MG, 30 MG, 45 MG, 7.5 MG	4	PA
FIRMAGON (240 MG DOSE) SUBCUTANEOUS SOLUTION RECONSTITUTED 120 MG/VIAL	5	PA
FIRMAGON SUBCUTANEOUS SOLUTION RECONSTITUTED 80 MG	4	PA
leuprolide acetate (3 month) intramuscular injectable 22.5 mg	2	PA
leuprolide acetate injection kit 1 mg/0.2ml	4	PA

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

Name of Drug	Drug Tier	Requirements/Limits
Hormonal Agents, Suppressant (Thyroid) - Treatment For Overactive Thyroid		
Antithyroid Agents		
methimazole oral tablet 10 mg, 5 mg	1	
propylthiouracil oral tablet 50 mg	2	
Immunological Agents - Medications That Alter The Immune System Including Vaccinations		
Angioedema Agents		
CINRYZE INTRAVENOUS SOLUTION RECONSTITUTED 500 UNIT	5	PA
HAEGARDA SUBCUTANEOUS SOLUTION RECONSTITUTED 2000 UNIT, 3000 UNIT	5	PA
icatibant acetate subcutaneous solution prefilled syringe 30 mg/3ml	5	PA
ORLADEYO ORAL CAPSULE 110 MG, 150 MG	5	PA
ORLADEYO ORAL PACKET 108 MG, 132 MG, 72 MG, 96 MG	5	PA
Immunoglobulins		
GAMMAGARD ERC INJECTION SOLUTION 10 GM/100ML, 5 GM/50ML	5	B/D
GAMMAGARD INJECTION SOLUTION 1 GM/10ML, 10 GM/100ML, 2.5 GM/25ML, 20 GM/200ML, 30 GM/300ML, 5 GM/50ML	5	B/D
GAMMAGARD S/D LESS IGA INTRAVENOUS SOLUTION RECONSTITUTED 10 GM, 5 GM	5	B/D
GAMMAKED INJECTION SOLUTION 1 GM/10ML, 10 GM/100ML, 20 GM/200ML, 5 GM/50ML	5	B/D
GAMMAPLEX INTRAVENOUS SOLUTION 10 GM/100ML, 10 GM/200ML, 20 GM/200ML, 20 GM/400ML, 5 GM/100ML, 5 GM/50ML	5	B/D
GAMUNEX-C INJECTION SOLUTION 1 GM/10ML, 10 GM/100ML, 2.5 GM/25ML, 20 GM/200ML, 40 GM/400ML, 5 GM/50ML	5	B/D

Name of Drug	Drug Tier	Requirements/Limits
OCTAGAM INTRAVENOUS SOLUTION 1 GM/20ML, 10 GM/100ML, 10 GM/200ML, 2 GM/20ML, 2.5 GM/50ML, 20 GM/200ML, 30 GM/300ML, 5 GM/100ML, 5 GM/50ML	5	B/D
PRIVIGEN INTRAVENOUS SOLUTION 10 GM/100ML, 20 GM/200ML, 40 GM/400ML, 5 GM/50ML	5	B/D
Immunological Agents, Other		
ACTEMRA ACTPEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 162 MG/0.9ML	5	PA; QL (3.6 ML per 28 days)
ACTEMRA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 162 MG/0.9ML	5	PA; QL (3.6 ML per 28 days)
ARCALYST SUBCUTANEOUS SOLUTION RECONSTITUTED 220 MG	5	PA
AVTOZMA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 162 MG/0.9ML	5	PA; QL (3.6 ML per 30 days)
AVTOZMA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 162 MG/0.9ML	5	PA; QL (3.6 ML per 30 days)
BENLYSTA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 200 MG/ML	5	PA
BENLYSTA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 200 MG/ML	5	PA
CIBINQO ORAL TABLET 100 MG, 200 MG, 50 MG	5	PA; QL (30 EA per 30 days)
COSENTYX (300 MG DOSE) SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML	5	PA; QL (10 ML per 28 days)
COSENTYX INTRAVENOUS SOLUTION 125 MG/5ML	5	PA
COSENTYX SENSOREADY (300 MG) SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML	5	PA; QL (10 ML per 28 days)
COSENTYX SENSOREADY PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML	5	PA; QL (10 ML per 28 days)
COSENTYX SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML	5	PA; QL (10 ML per 28 days)
COSENTYX SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 75 MG/0.5ML	5	PA; QL (2.5 ML per 28 days)

Name of Drug	Drug Tier	Requirements/Limits
COSENTYX UNOREADY SUBCUTANEOUS SOLUTION AUTO-INJECTOR 300 MG/2ML	5	PA; QL (10 ML per 28 days)
ENTYVIO PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 108 MG/0.68ML	5	PA
FABHALTA ORAL CAPSULE 200 MG	5	PA
ILARIS SUBCUTANEOUS SOLUTION 150 MG/ML	5	PA
ILUMYA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML	5	PA
IMULDOSA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 45 MG/0.5ML	3	PA; QL (0.5 ML per 28 days)
IMULDOSA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 90 MG/ML	3	PA; QL (1 ML per 28 days)
KEVZARA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/1.14ML, 200 MG/1.14ML	5	PA; QL (2.28 ML per 28 days)
KEVZARA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/1.14ML, 200 MG/1.14ML	5	PA; QL (2.28 ML per 28 days)
KINERET SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/0.67ML	5	PA
LEQSELVI ORAL TABLET 8 MG	5	PA; QL (60 EA per 30 days)
LITFULO ORAL CAPSULE 50 MG	5	PA
ORENCIA CLICKJECT SUBCUTANEOUS SOLUTION AUTO-INJECTOR 125 MG/ML	5	PA; QL (4 ML per 28 days)
ORENCIA INTRAVENOUS SOLUTION RECONSTITUTED 250 MG	5	PA; QL (4 EA per 28 days)
ORENCIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 125 MG/ML	5	PA; QL (4 ML per 28 days)
ORENCIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 50 MG/0.4ML	5	PA; QL (1.6 ML per 28 days)
ORENCIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 87.5 MG/0.7ML	5	PA; QL (2.8 ML per 28 days)
SELARSDI INTRAVENOUS SOLUTION 130 MG/26ML	3	PA; QL (104 ML per 180 days)
SELARSDI SUBCUTANEOUS SOLUTION 45 MG/0.5ML	3	PA; QL (0.5 ML per 28 days)
SELARSDI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 45 MG/0.5ML	3	PA; QL (0.5 ML per 28 days)

Name of Drug	Drug Tier	Requirements/Limits
SELARSDI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 90 MG/ML	3	PA; QL (1 ML per 28 days)
SILIQ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 210 MG/1.5ML	5	PA; QL (4.5 ML per 28 days)
SOTYKTU ORAL TABLET 6 MG	5	PA
STARJEMZA INTRAVENOUS SOLUTION 130 MG/26ML	3	PA; QL (104 ML per 180 days)
STARJEMZA SUBCUTANEOUS SOLUTION 45 MG/0.5ML	3	PA; QL (0.5 ML per 28 days)
STARJEMZA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 45 MG/0.5ML	3	PA; QL (0.5 ML per 28 days)
STARJEMZA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 90 MG/ML	3	PA; QL (1 ML per 28 days)
STELARA INTRAVENOUS SOLUTION 130 MG/26ML	3	PA; QL (104 ML per 180 days)
STELARA SUBCUTANEOUS SOLUTION 45 MG/0.5ML	3	PA; QL (0.5 ML per 28 days)
STELARA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 45 MG/0.5ML	3	PA; QL (0.5 ML per 28 days)
STELARA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 90 MG/ML	3	PA; QL (1 ML per 28 days)
STEQEYMA INTRAVENOUS SOLUTION 130 MG/26ML	3	PA; QL (104 ML per 180 days)
STEQEYMA SUBCUTANEOUS SOLUTION 45 MG/0.5ML	3	PA; QL (0.5 ML per 28 days)
STEQEYMA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 45 MG/0.5ML	3	PA; QL (0.5 ML per 28 days)
STEQEYMA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 90 MG/ML	3	PA; QL (1 ML per 28 days)
TALTZ SUBCUTANEOUS SOLUTION AUTO-INJECTOR 80 MG/ML	5	PA; QL (3 ML per 28 days)
TALTZ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 20 MG/0.25ML	5	PA; QL (0.75 ML per 28 days)
TALTZ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/0.5ML	5	PA; QL (1.5 ML per 28 days)
TALTZ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 80 MG/ML	5	PA; QL (3 ML per 28 days)
tofacitinib citrate er oral tablet extended release 24 hour 11 mg	2	PA; QL (30 EA per 30 days)

Name of Drug	Drug Tier	Requirements/Limits
tofacitinib citrate er oral tablet extended release 24 hour 22 mg	5	PA; QL (30 EA per 30 days)
tofacitinib citrate oral solution 1 mg/ml	5	PA; QL (480 ML per 24 days)
tofacitinib citrate oral tablet 10 mg, 5 mg	2	PA; QL (60 EA per 30 days)
TREMFYA ONE-PRESS SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 MG/ML	5	PA; QL (1 ML per 28 days)
TREMFYA PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 100 MG/ML	5	PA; QL (1 ML per 28 days)
TREMFYA PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 200 MG/2ML	5	PA; QL (4 ML per 28 days)
TREMFYA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML	5	PA; QL (1 ML per 28 days)
TREMFYA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 200 MG/2ML	5	PA; QL (4 ML per 28 days)
TREMFYA-CD/UC INDUCTION SUBCUTANEOUS SOLUTION AUTO-INJECTOR 200 MG/2ML	5	PA
ustekinumab subcutaneous solution 45 mg/0.5ml	3	PA; QL (0.5 ML per 28 days)
ustekinumab subcutaneous solution prefilled syringe 45 mg/0.5ml	3	PA; QL (0.5 ML per 28 days)
ustekinumab subcutaneous solution prefilled syringe 90 mg/ml	3	PA; QL (1 ML per 28 days)
ustekinumab-aauz subcutaneous solution prefilled syringe 45 mg/0.5ml	3	PA; QL (0.5 ML per 28 days)
ustekinumab-aauz subcutaneous solution prefilled syringe 90 mg/ml	3	PA; QL (1 ML per 28 days)
ustekinumab-aekn subcutaneous solution prefilled syringe 45 mg/0.5ml	3	PA; QL (0.5 ML per 28 days)
ustekinumab-aekn subcutaneous solution prefilled syringe 90 mg/ml	3	PA; QL (1 ML per 28 days)
YESINTEK INTRAVENOUS SOLUTION 130 MG/26ML	3	PA; QL (104 ML per 180 days)
YESINTEK SUBCUTANEOUS SOLUTION 45 MG/0.5ML	3	PA; QL (0.5 ML per 28 days)
YESINTEK SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 45 MG/0.5ML	3	PA; QL (0.5 ML per 28 days)
YESINTEK SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 90 MG/ML	3	PA; QL (1 ML per 28 days)

Name of Drug	Drug Tier	Requirements/Limits
ZILBRYSQ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 16.6 MG/0.416ML, 23 MG/0.574ML, 32.4 MG/0.81ML	5	PA
Immunostimulants		
ACTIMMUNE SUBCUTANEOUS SOLUTION 100 MCG/0.5ML	5	
PEGASYS SUBCUTANEOUS SOLUTION 180 MCG/ML	5	PA
PEGASYS SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 180 MCG/0.5ML	5	PA
Immunosuppressants		
adalimumab-fkjp (2 pen) subcutaneous auto-injector kit 40 mg/0.8ml	3	PA; QL (6 EA per 28 days)
adalimumab-fkjp (2 syringe) subcutaneous prefilled syringe kit 20 mg/0.4ml	3	PA; QL (4 EA per 28 days)
adalimumab-fkjp (2 syringe) subcutaneous prefilled syringe kit 40 mg/0.8ml	3	PA; QL (6 EA per 28 days)
ASTAGRAF XL ORAL CAPSULE EXTENDED RELEASE 24 HOUR 0.5 MG, 1 MG	4	B/D
ASTAGRAF XL ORAL CAPSULE EXTENDED RELEASE 24 HOUR 5 MG	5	B/D
azathioprine oral tablet 50 mg	2	B/D
CIMZIA (1 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 200 MG/ML	5	PA; QL (2 EA per 28 days)
CIMZIA (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 200 MG/ML	5	PA; QL (2 EA per 28 days)
CIMZIA SUBCUTANEOUS KIT 2 X 200 MG	5	PA; QL (2 EA per 28 days)
CIMZIA-STARTER SUBCUTANEOUS PREFILLED SYRINGE KIT 200 MG/ML	5	PA; QL (3 EA per 28 days)
cyclosporine modified oral capsule 100 mg, 25 mg, 50 mg	2	B/D
cyclosporine modified oral solution 100 mg/ml	2	B/D
cyclosporine oral capsule 100 mg, 25 mg	2	B/D
ENBREL MINI SUBCUTANEOUS SOLUTION CARTRIDGE 50 MG/ML	5	PA; QL (8 ML per 28 days)
ENBREL SUBCUTANEOUS SOLUTION 25 MG/0.5ML	5	PA; QL (8 ML per 28 days)

Name of Drug	Drug Tier	Requirements/Limits
ENBREL SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 25 MG/0.5ML, 50 MG/ML	5	PA; QL (8 ML per 28 days)
ENBREL SURECLICK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 50 MG/ML	5	PA; QL (8 ML per 28 days)
ENVARSUS XR ORAL TABLET EXTENDED RELEASE 24 HOUR 0.75 MG, 1 MG	4	B/D
ENVARSUS XR ORAL TABLET EXTENDED RELEASE 24 HOUR 4 MG	5	B/D
everolimus oral tablet 0.25 mg, 0.5 mg	2	B/D
everolimus oral tablet 0.75 mg, 1 mg	5	B/D
GENGRAF ORAL CAPSULE 100 MG, 25 MG	2	B/D
leflunomide oral tablet 10 mg, 20 mg	2	
LUPKYNIS ORAL CAPSULE 7.9 MG	5	PA
methotrexate sodium (pf) injection solution 50 mg/2ml	2	
methotrexate sodium injection solution 250 mg/10ml, 50 mg/2ml	2	
methotrexate sodium oral tablet 2.5 mg	1	
mycophenolate mofetil oral capsule 250 mg	2	B/D
mycophenolate mofetil oral suspension reconstituted 200 mg/ml	2	B/D
mycophenolate mofetil oral tablet 500 mg	2	B/D
mycophenolate sodium oral tablet delayed release 180 mg, 360 mg	2	B/D
PROGRAF INTRAVENOUS SOLUTION 5 MG/ML	5	B/D
PROGRAF ORAL PACKET 0.2 MG, 1 MG	4	B/D
REZUROCK ORAL TABLET 200 MG	5	PA
SIMLANDI (1 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT 40 MG/0.4ML	3	PA; QL (6 EA per 28 days)
SIMLANDI (1 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT 80 MG/0.8ML	3	PA; QL (3 EA per 28 days)
SIMLANDI (1 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 80 MG/0.8ML	3	PA; QL (3 EA per 28 days)
SIMLANDI (2 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT 40 MG/0.4ML	3	PA; QL (6 EA per 28 days)

Name of Drug	Drug Tier	Requirements/Limits
SIMLANDI (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 20 MG/0.2ML	3	PA; QL (4 EA per 28 days)
SIMLANDI (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 40 MG/0.4ML	3	PA; QL (6 EA per 28 days)
SIMPONI SUBCUTANEOUS SOLUTION AUTO-INJECTOR 100 MG/ML, 50 MG/0.5ML	5	PA
SIMPONI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML, 50 MG/0.5ML	5	PA
sirolimus oral solution 1 mg/ml	4	B/D
sirolimus oral tablet 0.5 mg, 1 mg, 2 mg	2	B/D
tacrolimus er oral capsule extended release 24 hour 0.5 mg, 1 mg	2	B/D
tacrolimus er oral capsule extended release 24 hour 5 mg	4	B/D
tacrolimus intravenous solution 5 mg/ml	5	B/D
tacrolimus oral capsule 0.5 mg, 1 mg, 5 mg	2	B/D
Vaccines		
ABRYSVO INTRAMUSCULAR SOLUTION RECONSTITUTED 120 MCG/0.5ML	6	
ACTHIB INTRAMUSCULAR SOLUTION RECONSTITUTED	6	
ADACEL INTRAMUSCULAR SUSPENSION 5-2-15.5 (PREFILLED SYRINGE), 5-2-15.5 LF-MCG/0.5	6	
ADACEL INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 5-2-15.5 LF-MCG/0.5	6	
AREXVY INTRAMUSCULAR SUSPENSION RECONSTITUTED 120 MCG/0.5ML	6	
bcg vaccine injection solution reconstituted 50 mg	6	
BEXSERO INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.5 ML	6	
BEYFORTUS INTRAMUSCULAR SOLUTION PREFILLED SYRINGE 100 MG/ML, 50 MG/0.5ML	6	
BOOSTRIX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 5-2.5-18.5 LF-MCG/0.5	6	

Name of Drug	Drug Tier	Requirements/Limits
DAPTACEL INTRAMUSCULAR SUSPENSION 23-15-5	6	
ENFLONSIA INTRAMUSCULAR SOLUTION PREFILLED SYRINGE 105 MG/0.7ML	6	
ENGERIX-B INJECTION SUSPENSION 20 MCG/ML	6	B/D
ENGERIX-B INJECTION SUSPENSION PREFILLED SYRINGE 10 MCG/0.5ML, 20 MCG/ML	6	B/D
ERVEBO INTRAMUSCULAR SUSPENSION	6	
GARDASIL 9 INTRAMUSCULAR SUSPENSION 0.5 ML	6	
GARDASIL 9 INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.5 ML	6	
HAVRIX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 1440 EL U/ML, 720 EL U/0.5ML	6	
HEPLISAV-B INTRAMUSCULAR SOLUTION PREFILLED SYRINGE 20 MCG/0.5ML	6	B/D
HIBERIX INJECTION SOLUTION RECONSTITUTED 10 MCG	6	
IMOVAX RABIES INTRAMUSCULAR SUSPENSION RECONSTITUTED 2.5 UNIT/ML	6	B/D
INFANRIX INTRAMUSCULAR SUSPENSION 25-58-10	6	
IPOL INJECTION SUSPENSION	6	
IXIARO INTRAMUSCULAR SUSPENSION	6	
JYNNEOS SUBCUTANEOUS SUSPENSION 0.5 ML	6	
KINRIX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.5 ML	6	
MENQUADFI INTRAMUSCULAR SOLUTION 0.5 ML	6	
MENVEO INTRAMUSCULAR SOLUTION	6	
MENVEO INTRAMUSCULAR SOLUTION RECONSTITUTED	6	
M-M-R II INJECTION SOLUTION RECONSTITUTED	6	

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

Name of Drug	Drug Tier	Requirements/Limits
MRESVIA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 50 MCG/0.5ML	6	
PEDIARIX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE	6	
PEDVAXHIB INTRAMUSCULAR SUSPENSION 7.5 MCG/0.5ML	6	
PENBRAYA INTRAMUSCULAR SUSPENSION RECONSTITUTED	6	
penmenvy intramuscular suspension reconstituted	6	
PENTACEL INTRAMUSCULAR SUSPENSION RECONSTITUTED	6	
PRIORIX SUBCUTANEOUS SUSPENSION RECONSTITUTED	6	
PROQUAD SUBCUTANEOUS SUSPENSION RECONSTITUTED	6	
QUADRACEL INTRAMUSCULAR SUSPENSION	6	
QUADRACEL INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.5 ML	6	
RABAVERT INTRAMUSCULAR SUSPENSION RECONSTITUTED	6	B/D
RECOMBIVAX HB INJECTION SUSPENSION 10 MCG/ML, 40 MCG/ML, 5 MCG/0.5ML	6	B/D
RECOMBIVAX HB INJECTION SUSPENSION PREFILLED SYRINGE 10 MCG/ML, 5 MCG/0.5ML	6	B/D
ROTARIX ORAL SUSPENSION	6	
ROTATEQ ORAL SOLUTION	6	
SHINGRIX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 50 MCG/0.5ML	6	QL (2 ML per 999 days)
SHINGRIX INTRAMUSCULAR SUSPENSION RECONSTITUTED 50 MCG/0.5ML	6	QL (2 EA per 999 days)
TENIVAC INTRAMUSCULAR INJECTABLE 5-2 LFU (INJECTION)	6	B/D
TENIVAC INTRAMUSCULAR SUSPENSION 5-2 LF/0.5ML	6	B/D
TICOVAC INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 1.2 MCG/0.25ML, 2.4 MCG/0.5ML	6	

Name of Drug	Drug Tier	Requirements/Limits
TRUMENBA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.5 ML	6	
TWINRIX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 720-20 ELU-MCG/ML	6	
TYPHIM VI INTRAMUSCULAR SOLUTION 25 MCG/0.5ML	6	
TYPHIM VI INTRAMUSCULAR SOLUTION PREFILLED SYRINGE 25 MCG/0.5ML	6	
VAQTA INTRAMUSCULAR SUSPENSION 25 UNIT/0.5ML, 25 UNIT/0.5ML 0.5 ML, 50 UNIT/ML, 50 UNIT/ML 1 ML	6	
VAQTA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 25 UNIT/0.5ML, 50 UNIT/ML	6	
VARIVAX INJECTION SUSPENSION RECONSTITUTED 1350 PFU/0.5ML	6	
VAXCHORA ORAL SUSPENSION RECONSTITUTED	6	
VIMKUNYA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 40 MCG/0.8ML	6	
VIVOTIF ORAL CAPSULE DELAYED RELEASE	6	
YF-VAX SUBCUTANEOUS SUSPENSION RECONSTITUTED	6	
Inflammatory Bowel Disease Agents - Treatment Of Ulcerative Colitis Or Crohn's Disease		
Aminosalicylates		
balsalazide disodium oral capsule 750 mg	2	
mesalamine er oral capsule extended release 24 hour 0.375 gm	2	
mesalamine oral capsule delayed release 400 mg	2	
mesalamine oral tablet delayed release 1.2 gm	2	
mesalamine rectal enema 4 gm	2	
mesalamine rectal suppository 1000 mg	2	
sulfasalazine oral tablet 500 mg	2	
sulfasalazine oral tablet delayed release 500 mg	2	

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

Name of Drug	Drug Tier	Requirements/Limits
Glucocorticoids		
budesonide er oral tablet extended release 24 hour 9 mg	4	
budesonide oral capsule delayed release particles 3 mg	2	
DEXAMETHASONE INTENSOL ORAL CONCENTRATE 1 MG/ML	2	
dexamethasone oral elixir 0.5 mg/5ml	2	
dexamethasone sodium phosphate injection solution 120 mg/30ml, 20 mg/5ml, 4 mg/ml	2	
hydrocortisone rectal enema 100 mg/60ml	2	
methylprednisolone acetate injection suspension 40 mg/ml, 80 mg/ml	2	
prednisolone sodium phosphate oral solution 15 mg/5ml	2	
PREDNISONE INTENSOL ORAL CONCENTRATE 5 MG/ML	2	
prednisone oral solution 5 mg/5ml	2	
prednisone oral tablet 1 mg, 10 mg, 2.5 mg, 20 mg, 5 mg, 50 mg	1	
prednisone oral tablet therapy pack 10 mg (21)	1	
prednisone oral tablet therapy pack 10 mg (48), 5 mg (21), 5 mg (48)	2	
Metabolic Bone Disease Agents - Treatment Of Bone Diseases Including Osteoporosis		
Metabolic Bone Disease Agents		
alendronate sodium oral tablet 10 mg	1	QL (30 EA per 30 days)
alendronate sodium oral tablet 35 mg, 70 mg	1	QL (4 EA per 28 days)
BONSITY SUBCUTANEOUS SOLUTION PEN-INJECTOR 560 MCG/2.24ML	5	PA
calcitonin (salmon) nasal solution 200 unit/act	2	
calcitriol oral capsule 0.25 mcg, 0.5 mcg	2	
calcitriol oral solution 1 mcg/ml	2	
cinacalcet hcl oral tablet 30 mg, 60 mg	2	QL (60 EA per 30 days)
cinacalcet hcl oral tablet 90 mg	2	QL (120 EA per 30 days)

Name of Drug	Drug Tier	Requirements/Limits
doxercalciferol oral capsule 0.5 mcg, 1 mcg, 2.5 mcg	2	
ENOBY SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 60 MG/ML	3	QL (1 ML per 180 days)
ibandronate sodium oral tablet 150 mg	1	
JUBBONTI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 60 MG/ML	3	
OSENVELT SUBCUTANEOUS SOLUTION 120 MG/1.7ML	5	
paricalcitol oral capsule 1 mcg, 2 mcg, 4 mcg	2	
risedronate sodium oral tablet 150 mg, 35 mg, 35 mg (12 pack), 35 mg (4 pack), 5 mg	2	
risedronate sodium oral tablet 30 mg	4	
STOBOCLO SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 60 MG/ML	3	
teriparatide subcutaneous solution pen-injector 560 mcg/2.24ml	5	PA
TYMLOS SUBCUTANEOUS SOLUTION PEN-INJECTOR 3120 MCG/1.56ML	5	PA
WYOST SUBCUTANEOUS SOLUTION 120 MG/1.7ML	5	
XTRENBO SUBCUTANEOUS SOLUTION 120 MG/1.7ML	4	
YORVIPATH SUBCUTANEOUS SOLUTION PEN-INJECTOR 168 MCG/0.56ML, 294 MCG/0.98ML, 420 MCG/1.4ML	5	PA
Ophthalmic Agents - Treatment Of Eye Conditions		
Ophthalmic Agents, Other		
atropine sulfate ophthalmic solution 1 %	2	
brimonidine tartrate-timolol ophthalmic solution 0.2-0.5 %	2	
cyclosporine (pf) ophthalmic emulsion 0.05 %	2	QL (60 EA per 30 days)
CYSTARAN OPHTHALMIC SOLUTION 0.44 %	5	PA
dorzolamide hcl-timolol mal ophthalmic solution 2-0.5 %	2	

Name of Drug	Drug Tier	Requirements/Limits
dorzolamide hcl-timolol mal pf ophthalmic solution 2-0.5 %	2	ST
neomycin-polymyxin-dexameth ophthalmic ointment 3.5-10000-0.1	1	
neomycin-polymyxin-dexameth ophthalmic suspension 0.1 %, 3.5-10000-0.1	1	
neomycin-polymyxin-gramicidin ophthalmic solution 1.75-10000-.025	2	
OXERVATE OPHTHALMIC SOLUTION 0.002 %	5	PA
sulfacetamide-prednisolone ophthalmic solution 10-0.23 %	2	
TEPEZZA INTRAVENOUS SOLUTION RECONSTITUTED 500 MG	5	PA
tobramycin-dexamethasone ophthalmic suspension 0.3-0.1 %	2	
XDEMVY OPHTHALMIC SOLUTION 0.25 %	5	PA
Ophthalmic Anti-Allergy Agents		
azelastine hcl ophthalmic solution 0.05 %	1	
cromolyn sodium ophthalmic solution 4 %	1	
Ophthalmic Anti-Infectives		
bacitracin-polymyxin b ophthalmic ointment 500-10000 unit/gm	1	
ciprofloxacin hcl ophthalmic solution 0.3 %	2	
erythromycin ophthalmic ointment 5 mg/gm	1	
gentamicin sulfate ophthalmic solution 0.3 %	1	
moxifloxacin hcl ophthalmic solution 0.5 %	2	
NATACYN OPHTHALMIC SUSPENSION 5 %	4	
ofloxacin ophthalmic solution 0.3 %	2	
polymyxin b-trimethoprim ophthalmic solution 10000-0.1 unit/ml-%	1	
sulfacetamide sodium ophthalmic solution 10 %	2	
tobramycin ophthalmic solution 0.3 %	1	
Ophthalmic Anti-Inflammatories		
dexamethasone sodium phosphate ophthalmic solution 0.1 %	2	
diclofenac sodium ophthalmic solution 0.1 %	2	

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

Name of Drug	Drug Tier	Requirements/Limits
difluprednate ophthalmic emulsion 0.05 %	2	
fluorometholone ophthalmic suspension 0.1 %	2	
flurbiprofen sodium ophthalmic solution 0.03 %	2	
ketorolac tromethamine ophthalmic solution 0.4 %, 0.5 %	2	
prednisolone acetate ophthalmic suspension 1 %	2	
prednisolone sodium phosphate ophthalmic solution 1 %	2	
Ophthalmic Beta-Adrenergic Blocking Agents		
carteolol hcl ophthalmic solution 1 %	2	
levobunolol hcl ophthalmic solution 0.5 %	1	
timolol maleate ophthalmic solution 0.25 %, 0.5 %	1	
Ophthalmic Intraocular Pressure Lowering Agents, Other		
acetazolamide er oral capsule extended release 12 hour 500 mg	2	
brimonidine tartrate ophthalmic solution 0.1 %	2	
brimonidine tartrate ophthalmic solution 0.2 %	1	
brinzolamide ophthalmic suspension 1 %	2	ST
dorzolamide hcl ophthalmic solution 2 %	2	
methazolamide oral tablet 25 mg, 50 mg	2	
pilocarpine hcl ophthalmic solution 1 %, 1.25 %, 2 %, 4 %	2	
RHOPRESSA OPHTHALMIC SOLUTION 0.02 %	3	ST
ROCKLATAN OPHTHALMIC SOLUTION 0.02-0.005 %	3	ST
SIMBRINZA OPHTHALMIC SUSPENSION 1-0.2 %	3	
Ophthalmic Prostaglandin And Prostamide Analogs		
latanoprost ophthalmic solution 0.005 %	1	
LUMIGAN OPHTHALMIC SOLUTION 0.01 %	3	
travoprost (bak free) ophthalmic solution 0.004 %	2	

Name of Drug	Drug Tier	Requirements/Limits
Otic Agents - Treatment Of Ear Conditions		
Otic Agents		
acetic acid otic solution 2 %	2	
hydrocortisone-acetic acid otic solution 1-2 %	2	
neomycin-polymyxin-hc otic solution 1 %, 3.5-10000-1	2	
neomycin-polymyxin-hc otic suspension 3.5-10000-1	2	
ofloxacin otic solution 0.3 %	2	
Respiratory Tract/ Pulmonary Agents - Treatment Of Breathing Conditions		
Antihistamines		
azelastine hcl nasal solution 0.1 %, 137 mcg/spray	1	
cetirizine hcl oral solution 1 mg/ml, 5 mg/5ml	1	
clemastine fumarate oral tablet 2.68 mg	2	
cyproheptadine hcl oral syrup 2 mg/5ml	2	PA
cyproheptadine hcl oral tablet 4 mg	2	PA
hydroxyzine hcl oral syrup 10 mg/5ml	2	PA
hydroxyzine hcl oral tablet 10 mg, 25 mg, 50 mg	1	PA
levocetirizine dihydrochloride oral solution 2.5 mg/5ml	2	
levocetirizine dihydrochloride oral tablet 5 mg	1	
promethazine hcl oral solution 6.25 mg/5ml	2	PA
Anti-Inflammatories, Inhaled Corticosteroids		
ARNUITY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100 MCG/ACT, 200 MCG/ACT, 50 MCG/ACT	3	
budesonide inhalation suspension 0.25 mg/2ml, 0.5 mg/2ml	2	B/D; QL (120 ML per 30 days)
budesonide inhalation suspension 1 mg/2ml	2	B/D; QL (60 ML per 30 days)
flunisolide nasal solution 25 mcg/act (0.025%)	2	
fluticasone propionate diskus inhalation aerosol powder breath activated 100 mcg/act, 250 mcg/act, 50 mcg/act	2	

Name of Drug	Drug Tier	Requirements/Limits
fluticasone propionate hfa inhalation aerosol 110 mcg/act	2	QL (12 GM per 30 days)
fluticasone propionate hfa inhalation aerosol 220 mcg/act	2	QL (24 GM per 30 days)
fluticasone propionate hfa inhalation aerosol 44 mcg/act	2	QL (10.6 GM per 30 days)
fluticasone propionate nasal suspension 50 mcg/act	2	QL (16 GM per 30 days)
mometasone furoate nasal suspension 50 mcg/act	2	
Bronchodilators, Anticholinergic		
INCRUSE ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 62.5 MCG/ACT	3	QL (30 EA per 30 days)
ipratropium bromide hfa inhalation aerosol solution 17 mcg/act	2	QL (25.8 GM per 30 days)
ipratropium bromide inhalation solution 0.02 %	2	B/D
ipratropium bromide nasal solution 0.03 %, 0.06 %	2	
SPIRIVA RESPIMAT INHALATION AEROSOL SOLUTION 1.25 MCG/ACT, 2.5 MCG/ACT	3	QL (4 GM per 30 days)
tiotropium bromide inhalation capsule 18 mcg	2	QL (90 EA per 90 days)
Bronchodilators, Sympathomimetic		
albuterol sulfate hfa inhalation aerosol solution 108 (90 base) mcg/act, 108 (90 base) mcg/act (nda020503), 108 (90 base) mcg/act (nda020983)	1	QL (36 GM per 30 days)
albuterol sulfate inhalation nebulization solution (2.5 mg/3ml) 0.083%, (5 mg/ml) 0.5%, 0.63 mg/3ml, 1.25 mg/3ml, 2.5 mg/0.5ml	1	B/D
albuterol sulfate oral syrup 2 mg/5ml	1	
albuterol sulfate oral tablet 2 mg, 4 mg	2	
epinephrine injection solution auto-injector 0.15 mg/0.15ml, 0.15 mg/0.3ml, 0.3 mg/0.3ml	2	QL (2 EA per 30 days)
formoterol fumarate inhalation nebulization solution 20 mcg/2ml	2	B/D
levalbuterol hcl inhalation nebulization solution 0.31 mg/3ml, 0.63 mg/3ml, 1.25 mg/3ml	2	B/D

Name of Drug	Drug Tier	Requirements/Limits
SEREVENT DISKUS INHALATION AEROSOL POWDER BREATH ACTIVATED 50 MCG/ACT	3	QL (60 EA per 30 days)
terbutaline sulfate oral tablet 2.5 mg, 5 mg	2	
VENTOLIN HFA INHALATION AEROSOL SOLUTION 108 (90 BASE) MCG/ACT	3	QL (36 GM per 30 days)
Cystic Fibrosis Agents		
ALYFTREK ORAL TABLET 10-50-125 MG	5	PA; QL (56 EA per 28 days)
ALYFTREK ORAL TABLET 4-20-50 MG	5	PA; QL (84 EA per 28 days)
CAYSTON INHALATION SOLUTION RECONSTITUTED 75 MG	5	PA
KALYDECO ORAL PACKET 13.4 MG, 25 MG, 5.8 MG, 50 MG, 75 MG	5	PA
KALYDECO ORAL TABLET 150 MG	5	PA
ORKAMBI ORAL PACKET 100-125 MG, 150-188 MG, 75-94 MG	5	PA
ORKAMBI ORAL TABLET 100-125 MG, 200-125 MG	5	PA
PULMOZYME INHALATION SOLUTION 2.5 MG/2.5ML	5	B/D
SYMDEKO ORAL TABLET THERAPY PACK 100-150 & 150 MG, 50-75 & 75 MG	5	PA
TOBI PODHALER INHALATION CAPSULE 28 MG	5	PA; QL (224 EA per 56 days)
tobramycin inhalation nebulization solution 300 mg/4ml	3	B/D
tobramycin inhalation nebulization solution 300 mg/5ml	3	B/D; QL (280 ML per 56 days)
TRIKAFTA ORAL TABLET THERAPY PACK 100-50-75 & 150 MG, 50-25-37.5 & 75 MG	5	PA
TRIKAFTA ORAL THERAPY PACK 100-50-75 & 75 MG, 80-40-60 & 59.5 MG	5	PA
Mast Cell Stabilizers		
cromolyn sodium inhalation nebulization solution 20 mg/2ml	3	B/D
cromolyn sodium oral concentrate 100 mg/5ml	2	
Phosphodiesterase Inhibitors, Airways Disease		

Name of Drug	Drug Tier	Requirements/Limits
roflumilast oral tablet 250 mcg, 500 mcg	2	
theophylline er oral tablet extended release 12 hour 100 mg, 200 mg, 300 mg, 450 mg	2	
theophylline er oral tablet extended release 24 hour 400 mg, 600 mg	2	
theophylline oral solution 80 mg/15ml	2	
Pulmonary Antihypertensives		
ADEMPAS ORAL TABLET 0.5 MG, 1 MG, 1.5 MG, 2 MG, 2.5 MG	5	PA
ambrisentan oral tablet 10 mg, 5 mg	5	PA
bosentan oral tablet 125 mg, 62.5 mg	5	PA
macitentan oral tablet 10 mg	4	PA; QL (30 EA per 30 days)
OPSUMIT ORAL TABLET 10 MG	5	PA; QL (30 EA per 30 days)
sildenafil citrate oral suspension reconstituted 10 mg/ml	4	PA; QL (720 ML per 30 days)
sildenafil citrate oral tablet 20 mg	2	PA
tadalafil (pah) oral tablet 20 mg	2	PA
TADLIQ ORAL SUSPENSION 20 MG/5ML	5	PA
TYVASO DPI MAINTENANCE KIT INHALATION POWDER 112 X 32MCG & 112 X64MCG, 112 X 48MCG & 112 X64MCG, 112 X 48MCG & 112 X80MCG, 16 MCG, 32 MCG, 48 MCG, 64 MCG, 80 MCG	5	PA
TYVASO DPI TITRATION KIT INHALATION POWDER 16 & 32 & 48 MCG	5	PA
UPTRAVI ORAL TABLET 100 MCG, 1000 MCG, 1200 MCG, 1400 MCG, 150 MCG, 1600 MCG, 200 MCG, 400 MCG, 600 MCG, 800 MCG	5	PA
UPTRAVI TITRATION ORAL TABLET THERAPY PACK 200 & 800 MCG	5	PA
WINREVAIR SUBCUTANEOUS KIT 2 X 45 MG, 2 X 60 MG, 45 MG, 60 MG	5	PA
YUTREPIA INHALATION CAPSULE 106 MCG, 26.5 MCG, 53 MCG, 79.5 MCG	5	PA
Pulmonary Fibrosis Agents		
nintedanib esylate oral capsule 100 mg, 150 mg	5	PA
OFEV ORAL CAPSULE 100 MG, 150 MG	5	PA

Name of Drug	Drug Tier	Requirements/Limits
pirfenidone oral capsule 267 mg	5	PA
pirfenidone oral tablet 267 mg	2	PA
pirfenidone oral tablet 534 mg, 801 mg	5	PA
Respiratory Tract Agents, Other		
acetylcysteine inhalation solution 10 %, 20 %	2	B/D
ADVAIR HFA INHALATION AEROSOL 115-21 MCG/ACT, 230-21 MCG/ACT, 45-21 MCG/ACT	3	QL (12 GM per 30 days)
ANORO ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 62.5-25 MCG/ACT	3	QL (60 EA per 30 days)
BEVESPI AEROSPHERE INHALATION AEROSOL 9-4.8 MCG/ACT	3	
BREO ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100-25 MCG/ACT, 200-25 MCG/ACT, 50-25 MCG/INH	3	QL (60 EA per 30 days)
BREZTRI AEROSPHERE INHALATION AEROSOL 160-18-4.8 MCG/ACT, 160-9-4.8 MCG/ACT	3	QL (10.7 GM per 30 days)
BRINSUPRI ORAL TABLET 10 MG, 25 MG	5	PA; QL (30 EA per 30 days)
budesonide-formoterol fumarate inhalation aerosol 160-4.5 mcg/act, 80-4.5 mcg/act	2	QL (10.2 GM per 30 days)
COMBIVENT RESPIMAT INHALATION AEROSOL SOLUTION 20-100 MCG/ACT	4	QL (8 GM per 30 days)
DUPIXENT SUBCUTANEOUS SOLUTION AUTO-INJECTOR 200 MG/1.14ML, 300 MG/2ML	5	PA
DUPIXENT SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 200 MG/1.14ML, 300 MG/2ML	5	PA
FASENRA PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 30 MG/ML	5	PA
FASENRA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 10 MG/0.5ML, 30 MG/ML	5	PA
fluticasone-salmeterol inhalation aerosol powder breath activated 100-50 mcg/act, 113-14 mcg/act, 232-14 mcg/act, 250-50 mcg/act, 500-50 mcg/act, 55-14 mcg/act	2	QL (60 EA per 30 days)

Name of Drug	Drug Tier	Requirements/Limits
ipratropium-albuterol inhalation solution 0.5-2.5 (3) mg/3ml	2	B/D
montelukast sodium oral packet 4 mg	2	
montelukast sodium oral tablet 10 mg	1	
montelukast sodium oral tablet chewable 4 mg, 5 mg	1	
NUCALA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 100 MG/ML	5	PA
NUCALA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML, 40 MG/0.4ML	5	PA
NUCALA SUBCUTANEOUS SOLUTION RECONSTITUTED 100 MG	5	PA
promethazine-phenylephrine oral syrup 6.25-5 mg/5ml	2	PA
STIOLTO RESPIMAT INHALATION AEROSOL SOLUTION 2.5-2.5 MCG/ACT	3	QL (4 GM per 30 days)
TRELEGY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100-62.5-25 MCG/ACT, 200-62.5-25 MCG/ACT	3	QL (60 EA per 30 days)
WIXELA INHUB INHALATION AEROSOL POWDER BREATH ACTIVATED 100-50 MCG/ACT, 250-50 MCG/ACT, 500-50 MCG/ACT	2	QL (60 EA per 30 days)
XOLAIR SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML, 300 MG/2ML, 75 MG/0.5ML	5	PA
XOLAIR SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML, 300 MG/2ML, 75 MG/0.5ML	5	PA
XOLAIR SUBCUTANEOUS SOLUTION RECONSTITUTED 150 MG	5	PA
Skeletal Muscle Relaxants - Treatment Of Muscle Tightness		
Skeletal Muscle Relaxants		
carisoprodol oral tablet 250 mg, 350 mg	2	PA; QL (90 EA per 30 days)
chlorzoxazone oral tablet 500 mg	2	PA; QL (180 EA per 30 days)
cyclobenzaprine hcl oral tablet 10 mg, 5 mg	1	QL (90 EA per 30 days)
metaxalone oral tablet 800 mg	2	PA; QL (120 EA per 30 days)

Name of Drug	Drug Tier	Requirements/Limits
methocarbamol oral tablet 500 mg, 750 mg	1	PA
orphenadrine citrate er oral tablet extended release 12 hour 100 mg	2	PA
Sleep Disorder Agents - Treatment Of Insomnia		
Sleep Promoting Agents		
doxepin hcl oral tablet 3 mg, 6 mg	2	QL (30 EA per 30 days)
eszopiclone oral tablet 1 mg, 2 mg, 3 mg	2	PA; QL (30 EA per 30 days)
HETLIOZ LQ ORAL SUSPENSION 4 MG/ML	5	PA
ramelteon oral tablet 8 mg	2	QL (30 EA per 30 days)
tasimelteon oral capsule 20 mg	5	PA
temazepam oral capsule 15 mg, 22.5 mg, 30 mg, 7.5 mg	2	PA; QL (30 EA per 30 days)
zaleplon oral capsule 10 mg	2	PA; QL (60 EA per 30 days)
zaleplon oral capsule 5 mg	2	PA; QL (30 EA per 30 days)
ZEPBOUND KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 10 MG/0.6ML, 12.5 MG/0.6ML, 15 MG/0.6ML, 2.5 MG/0.6ML, 5 MG/0.6ML, 7.5 MG/0.6ML	4	PA; QL (2.4 ML per 28 days)
ZEPBOUND SUBCUTANEOUS SOLUTION AUTO-INJECTOR 10 MG/0.5ML, 12.5 MG/0.5ML, 15 MG/0.5ML, 2.5 MG/0.5ML, 5 MG/0.5ML, 7.5 MG/0.5ML	5	PA; QL (2 ML per 28 days)
zolpidem tartrate er oral tablet extended release 12.5 mg, 6.25 mg	2	PA; QL (30 EA per 30 days)
zolpidem tartrate oral tablet 10 mg	2	PA; QL (30 EA per 30 days)
zolpidem tartrate oral tablet 5 mg	2	QL (30 EA per 30 days)
Wakefulness Promoting Agents		
armodafinil oral tablet 150 mg, 200 mg, 250 mg, 50 mg	2	PA
modafinil oral tablet 100 mg, 200 mg	2	PA
sodium oxybate oral solution 500 mg/ml	5	PA; QL (540 ML per 30 days)
XYWAV ORAL SOLUTION 500 MG/ML	5	PA

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Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

ACITRETIN

Products Affected

- *acitretin*

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

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

ACL INHIBITORS

Products Affected

- NEXLETOL
- NEXLIZET

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	18 years or older
Prescriber Restrictions	Prescriber must be a cardiologist or specialist in the treatment of lipid disorders
Coverage Duration	New starts will be authorized for 4 months. Cont of therapy or reauth until end of contract year.
Other Criteria	For new starts ALL of the following must be provided: 1) Documentation of baseline low density lipoprotein cholesterol (LDL-C), 2) Member has tried and failed a high-intensity statin (i.e. atorvastatin 40-80 mg, rosuvastatin 20-40 mg) at maximum tolerated dose for 3 months via claim history or chart notes OR documentation has been provided that the member is not able to tolerate a statin. In addition to the initial criteria above if the new start is for the diagnosis of hypercholesterolemia, the following are required: 1) Member has a diagnosis of heterozygous familial hypercholesterolemia (FH) OR hypercholesterolemia, 2) Member has tried ezetimibe at a maximum tolerated dose and LDL-C is not at goal, or documentation has been provided that the patient is not able to tolerate ezetimibe. In addition to the initial criteria above if the new start is for cardiovascular risk reduction, the following are required: 1) Member has established cardiovascular disease (documented history of coronary artery disease, symptomatic peripheral artery disease, and/or cerebrovascular atherosclerotic disease, 2) Member does not have established cardiovascular disease but is considered high risk (one of the following): Diabetes Mellitus (Type 1 or Type 2) in females over 65 years of age or males over 60 years of age OR a Reynolds Risk score greater than 30% or a SCORE Risk score greater than 7.5% over 10 years OR a coronary artery

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

PA Criteria	Criteria Details
	calcium score greater than 400 Agaston units at any time in the past. For continuation of therapy or reauthorization requests for all indications: Documentation provided that the member has obtained clinical benefit from medication (e.g., LDL-C lowering from baseline)
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

ACTEMRA

Products Affected

- ACTEMRA ACTPEN
- ACTEMRA SUBCUTANEOUS
- AVTOZMA SUBCUTANEOUS

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

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

ADALIMUMAB

Products Affected

- *adalimumab-fkjp (2 pen)*
- *adalimumab-fkjp (2 syringe) subcutaneous prefilled syringe kit 20 mg/0.4ml, 40 mg/0.8ml*
- SIMLANDI (1 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT 40 MG/0.4ML, 80 MG/0.8ML
- SIMLANDI (1 SYRINGE)
- SIMLANDI (2 PEN)
- SIMLANDI (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 20 MG/0.2ML, 40 MG/0.4ML

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

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

ADEMPAS

Products Affected

- ADEMPAS

PA Criteria	Criteria Details
Exclusion Criteria	Concurrent use with Phosphodiesterase Inhibitors used for Pulmonary Hypertension or Other Soluble Guanylate Cyclase Stimulators.
Required Medical Information	Pulmonary arterial hypertension (PAH) (World Health Organization [WHO] Group 1)- Initial: [Note: documentation required] (1) PAH was confirmed by right heart catheterization AND (2) pretreatment mean pulmonary arterial pressure is greater than 20 mmHg AND (3) pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, AND (4) pretreatment pulmonary vascular resistance is greater than or equal to 3 Wood units. Continuation of therapy: patient has positive clinical response to treatment. Chronic thromboembolic pulmonary hypertension (CTEPH) (WHO Group 4) - Initial: [Note: documentation required] (1) Patient has persistent or recurrent CTEPH after pulmonary endarterectomy (PEA) OR (2) patient has inoperable CTEPH with the diagnosis confirmed by right heart catheterization AND by computed tomography (CT), magnetic resonance imaging (MRI), or pulmonary angiography. Continuation of therapy: patient has positive clinical response to treatment.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a cardiologist or pulmonologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

PA Criteria	Criteria Details
Prerequisite Therapy Required	No

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

ALPHA-1 PROTEINASE INHIBITORS

Products Affected

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

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

ALYFTREK

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	Concurrent use with Trikafta, Kalydeco, Orkambi, or Symdeko. Patients with unknown CFTR gene mutations.
Required Medical Information	Documentation of CFTR gene that is responsive to vanzacaftor-tezacaftor-deutivacaftor treatment.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a pulmonologist or a provider who specializes in treatment of CF.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	Cystic Fibrosis (CF) - Initial: patient must have at least one F508del mutation in the CFTR gene or a mutation in the CFTR gene that is responsive to the requested medication. Continuation of therapy: approve.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	No

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

AMBRISENTAN

Products Affected

- *ambrisentan*

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Pulmonary arterial hypertension (PAH) (World Health Organization [WHO] Group 1)- Initial: [Note: documentation required] (1) PAH was confirmed by right heart catheterization AND (2) pretreatment mean pulmonary arterial pressure is greater than 20 mmHg AND (3) pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, AND (4) pretreatment pulmonary vascular resistance is greater than or equal to 3 Wood units. Continuation of therapy: patient has positive clinical response to treatment.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a cardiologist or pulmonologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	No

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

ANTINEOPLASTIC AGENTS

Products Affected

- *abiraterone acetate*
- ABIRTEGA
- AKEEGA
- ALECENSA
- ALUNBRIG
- AUGTYRO
- AVMAPKI FAKZYNJA CO-PACK
- AYVAKIT
- BALVERSA
- *bexarotene*
- BOSULIF ORAL CAPSULE
- BOSULIF ORAL TABLET 100 MG, 500 MG
- *bosutinib*
- BRAFTOVI ORAL CAPSULE 75 MG
- BRUKINSA
- CABOMETYX
- CALQUENCE ORAL TABLET
- CAPRELSA
- CAVHANZA
- COMETRIQ (100 MG DAILY DOSE) ORAL KIT 80 & 20 MG
- COMETRIQ (140 MG DAILY DOSE) ORAL KIT 3 X 20 MG & 80 MG
- COMETRIQ (60 MG DAILY DOSE)
- COPIKTRA
- COTELLIC
- DANZITEN
- *dasatinib*
- DAURISMO
- ENSACOVE
- ERIVEDGE
- ERLEADA
- *erlotinib hcl*
- EULEXIN
- *everolimus oral tablet 10 mg, 2.5 mg, 5 mg, 7.5 mg*
- *everolimus oral tablet soluble*
- FOTIVDA
- FRUZAQLA
- GAVRETO
- *gefitinib*
- GILOTRIF
- GOMEKLI
- HERNEXEOS
- HYRNUO
- IBRANCE
- IBTROZI
- ICLUSIG
- IDHIFA
- *imatinib mesylate oral*
- *imkeldi*
- INLURIYO
- INLYTA
- INQOVI
- INREBIC
- ITOVEBI
- IWILFIN
- JAYPIRCA
- JIDEYTRO
- KISQALI (200 MG DOSE)
- KISQALI (400 MG DOSE)
- KISQALI (600 MG DOSE)
- KOMZIFTI
- KOSELUGO
- KRAZATI
- *lapatinib ditosylate*
- LAZCLUZE
- *lenalidomide*
- LENVIMA (10 MG DAILY DOSE)
- LENVIMA (12 MG DAILY DOSE)
- LENVIMA (14 MG DAILY DOSE)
- LENVIMA (18 MG DAILY DOSE)
- LENVIMA (20 MG DAILY DOSE)
- LENVIMA (24 MG DAILY DOSE)
- LENVIMA (4 MG DAILY DOSE)
- LENVIMA (8 MG DAILY DOSE)
- LEUKERAN

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

- LIFYORLI (125 MG DOSE) ORAL CAPSULE THERAPY PACK 1 X 25 MG & 1 X 100 MG
- LIFYORLI (150 MG DOSE) ORAL CAPSULE THERAPY PACK 2 X 25 MG & 1 X 100 MG
- LONSURF
- LORBRENA
- LUMAKRAS
- LYNPARZA ORAL TABLET
- LYTGOBI (12 MG DAILY DOSE)
- LYTGOBI (16 MG DAILY DOSE)
- LYTGOBI (20 MG DAILY DOSE)
- MEKINIST
- MEKTOVI
- *mercaptopurine oral suspension*
- MODEYSO
- NERLYNX
- *nilotinib d-tartrate*
- *nilotinib hcl*
- *nilutamide*
- NINLARO
- NUBEQA
- ODOMZO
- OGSIVEO ORAL TABLET 100 MG, 150 MG
- OJEMDA
- OJJAARA
- ONUREG
- ORGOVYX
- ORSERDU
- *pazopanib hcl*
- PEMAZYRE
- PIQRAY (200 MG DAILY DOSE)
- PIQRAY (250 MG DAILY DOSE)
- PIQRAY (300 MG DAILY DOSE)
- *pomalidomide*
- QINLOCK
- RASONQUE
- RETEVMO ORAL TABLET
- REVLIMID
- REVUFORJ
- REZLIDHIA
- ROMVIMZA
- ROZLYTREK
- RUBRACA
- RYDAPT
- SCEMBLIX
- SOLTAMOX
- *sorafenib tosylate*
- STIVARGA
- *sunitinib malate*
- TABLOID
- TABRECTA
- TAFINLAR
- TAGRISSO
- TALZENNA
- TAZVERIK
- TEPMETKO
- THALOMID ORAL CAPSULE 100 MG, 50 MG
- TIBSOVO
- *toremifene citrate*
- *tretinoin oral*
- TRUQAP ORAL TABLET 200 MG
- TRUQAP ORAL TABLET THERAPY PACK
- TUKYSA
- TURALIO ORAL CAPSULE 125 MG
- VANFLYTA
- VENCLEXTA
- VENCLEXTA STARTING PACK
- VEPPANU
- VERZENIO
- VITRAKVI
- VIZIMPRO
- VONJO
- VORANIGO
- WELIREG
- XALKORI
- XOSPATA
- XPOVIO (100 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 50 MG
- XPOVIO (40 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 10 MG, 40 MG

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

- XPOVIO (40 MG TWICE WEEKLY) ORAL TABLET THERAPY PACK 40 MG
- XPOVIO (60 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 60 MG
- XPOVIO (60 MG TWICE WEEKLY)
- XPOVIO (80 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 40 MG, 80 MG
- XPOVIO (80 MG TWICE WEEKLY)
- XTANDI
- YONSA
- YULITHIRA
- ZEJULA ORAL TABLET
- ZELBORAF
- ZENBEXUS
- ZOLINZA
- ZYDELIG
- ZYKADIA ORAL TABLET

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

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

APOMORPHINE

Products Affected

- *apomorphine hcl subcutaneous*

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

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

AQNEURSA

Products Affected

- AQNEURSA

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Specialist for submitted diagnosis.
Coverage Duration	New starts will be authorized for 6 months. Cont of therapy or reauth until end of contract year.
Other Criteria	For new starts: 1) The member has a documented diagnosis of Niemann-Pick disease type C (NPC) AND 2) Documentation of genetic testing identifying disease-causing alleles in NPC1 or NPC2 AND 3) Documentation of disease-related neurological symptoms (e.g., developmental delay/regression, ataxia, cataplexy, seizures, motor-function decline, tremors, dysphagia) For reauthorization: Documentation that member has had positive response to therapy (e.g., stabilization in neurological status, decrease in functional Scale for Assessment and Rating of Ataxia [fSARA] score).
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	No

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

ARCALYST

Products Affected

- ARCALYST

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

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

ARIKAYCE

Products Affected

- ARIKAYCE

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Mycobacterium avium complex (MAC): (1) Documented diagnosis of MAC lung disease as verified by failure to acheive at least 2 negative sputum cultures following 6 consecutive months of a combination antibacterial drug regimen AND (2) Provider attestation that medication is being used as part of a combination antibacterial drug regimen.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a pulmonologist or an infectious disease specialist
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	No

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

ARISTADA

Products Affected

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

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

AUVELITY

Products Affected

- AUVELITY ORAL TABLET EXTENDED RELEASE 45-105 MG
- AUVELITY TITRATION PACK

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

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

AZTREONAM LYSINE

Products Affected

- CAYSTON

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

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

BENLYSTA

Products Affected

- BENLYSTA SUBCUTANEOUS

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a rheumatologist, nephrologist, or specialist in the treatment of autoimmune disorders.
Coverage Duration	New starts will be authorized for 6 months. Cont of therapy or reauth until end of contract year.
Other Criteria	For new starts for systemic lupus erythematosus (SLE): concurrent use of two of the following or medical reason for not using glucocorticoids, azathioprine, methotrexate, mycophenolate, or hydroxychloroquine, chloroquine, and cyclophosphamide. For continuation of therapy or reauthorization for SLE: documentation of clinical response to therapy (i.e. fewer flares that required steroid treatment, lower average daily oral prednisone dose, improved daily function either as measured through a validated functional scale or through improved daily performance documented at clinic visits, etc.) For new starts for lupus nephritis (LN): concurrent use of or medical reason for not using background immunosuppressive therapy regimen. For continuation of therapy or reauthorization for LN: Documentation of improvement in renal function (i.e. reduction in UPCR).
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

PA Criteria	Criteria Details
Prerequisite Therapy Required	No

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

BESREMI

Products Affected

- BESREMI
- BESREMI PEN

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

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

BLUJEPA

Products Affected

- BLUJEPA

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	uUTI: 5 days. Gonorrhea: 1 day.
Other Criteria	For uncomplicated urinary tract infection (uUTI): (1) the patient has a documented diagnosis of uncomplicated urinary tract infection AND (2) the patient has a documented trial of, contraindication to, or medical reason for not using at least 2 alternative oral antibiotics (e.g., ciprofloxacin, trimethoprim/sulfamethoxazole, trimethoprim, nitrofurantoin, fosfomycin). For gonorrhea: (1) the patient has a documented diagnosis of uncomplicated urogenital gonorrhea AND (2) the patient has a documented trial of, contraindication to, or medical reason for not using ceftriaxone.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

BOSENTAN

Products Affected

- *bosentan oral tablet*

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

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

BRINSUPRI

Products Affected

- BRINSUPRI

PA Criteria	Criteria Details
Exclusion Criteria	Patients with bronchiectasis due to cystic fibrosis.
Required Medical Information	N/A
Age Restrictions	12 years of age and older.
Prescriber Restrictions	Prescribed by or in consultation with a pulmonologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	For non-cystic fibrosis bronchiectasis - Initial: (1) patient has documented history of bronchiectasis diagnosed by chest computed tomography scan AND (2) prescriber confirmation that bronchiectasis is not primarily driven by chronic obstructive pulmonary disease or asthma. Continuation of therapy: patient has positive clinical response to treatment.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	No

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

CAMZYOS

Products Affected

- CAMZYOS

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a cardiologist.
Coverage Duration	New starts will be authorized for 6 months. Cont of therapy or reauth until end of contract year.
Other Criteria	For all new starts, documentation of ALL of the following must be provided: 1) Diagnosis of symptomatic New York Heart Association (NYHA) class II or III obstructive hypertrophic cardiomyopathy (oHCM) AND 2) Patient has a left ventricular ejection fraction (LVEF) greater than or equal to 55% AND 3) Assessment of Valsalva left ventricular outflow tract (LVOT) gradient AND 4) Trial of, medical reason for not using or contraindication to BOTH of the following: Beta blockers (i.e. metoprolol, propranolol, atenolol) AND Non-dihydropyridine calcium channel blockers (i.e. verapamil, diltiazem) AND 5) Prescriber attests that patient is not using moderate to strong CYP2C19 or CYP3A4 inhibitors or inducers. For continuation of therapy or reauthorization, all of the following must be provided: 1) Documentation of clinical benefit as evidenced by an improvement from baseline in oHCM symptoms (i.e., improvement in fatigue, chest pain, shortness of breath, LVOT, peak oxygen consumption, etc.) OR improvement or no worsening of NYHA functional class AND 2) Member must also have a left ventricular ejection fraction (LVEF) greater than or equal to 50%.
Indications	All Medically-accepted Indications.

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

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

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

CARDAMYST

Products Affected

- CARDAMYST

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a cardiologist or specialist for submitted diagnosis.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	Documented history of acute symptomatic episodes of paroxysmal supraventricular tachycardia.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	No

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

CARGLUMIC ACID

Products Affected

- *carglumic acid oral tablet soluble*

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

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

CASPOFUNGIN

Products Affected

- *caspofungin acetate*

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

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

CERDELGA

Products Affected

- CERDELGA

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

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

CGRP ANTAGONISTS

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	New starts will be authorized for 6 months. Cont of therapy or reauth until end of contract year.
Other Criteria	For acute migraine new starts - for Ubrelvy and Nurtec requests, must have trial of, contraindication to or medical reason for not using a triptan. For Zavzpret requests, must have trial of, contraindication to or medical reason for not using Ubrelvy or Nurtec. For migraine prophylaxis new starts - at least 4 migraine days per month or one or more severe migraine attacks lasting for greater than 12 hours despite use of abortive therapy (e.g. triptans or NSAIDs). For Emgality requests for episodic cluster headache new starts - approve. For continuation of therapy or reauthorization - For acute migraine (Nurtec, Ubrelvy, Zavzpret), must show documentation of improvement in migraine symptoms (pain, photophobia, phonophobia). For migraine prevention (Nurtec, Emgality, Qulipta, Aimovig), must show documentation of improvement in migraine symptoms. For episodic cluster headache treatment, must show documentation of reduction in frequency of headaches.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

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

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

CHOLBAM

Products Affected

- CHOLBAM

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

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

CIBINQO

Products Affected

- CIBINQO

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

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

CIMZIA

Products Affected

- CIMZIA (1 SYRINGE)
- CIMZIA (2 SYRINGE)
- CIMZIA SUBCUTANEOUS KIT 2 X 200 MG
- CIMZIA-STARTER

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

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

PA Criteria	Criteria Details
	of therapy. Polyarticular juvenile idiopathic arthritis (pJIA) - Initial: trial of, medical reason for not using, or contraindication to 2 of the following: Enbrel, an adalimumab product or Xeljanz or or 2) If utilized within the past 120 days, approve for continuation of therapy.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

CORLANOR

Products Affected

- CORLANOR ORAL SOLUTION
- *ivabradine hcl*

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

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

CORTROPHIN

Products Affected

- CORTROPHIN
- CORTROPHIN GEL

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

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

COSENTYX

Products Affected

- COSENTYX (300 MG DOSE)
- COSENTYX INTRAVENOUS
- COSENTYX SENSOREADY (300 MG)
- COSENTYX SENSOREADY PEN
- COSENTYX SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML, 75 MG/0.5ML
- COSENTYX UNOREADY

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	1) Documented diagnosis of ankylosing spondylitis, non-radiographic axial spondyloarthritis, plaque psoriasis, psoriatic arthritis, enthesitis-related arthritis, rheumatoid arthritis or hidradenitis suppurativa. 2) If utilized within the past 120 days, approve for continuation of therapy.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	No

CRESEMBA

Products Affected

- CRESEMBA ORAL

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Documented diagnosis of medically accepted indication.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an infectious disease specialist or oncologist
Coverage Duration	Request will be authorized for 3 months.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	No

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

CYSTAGON

Products Affected

- CYSTAGON

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

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CYSTARAN

Products Affected

- CYSTARAN

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

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

DALFAMPRIDINE ER

Products Affected

- *dalfampridine er*

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

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DEFERASIROX

Products Affected

- *deferasirox*
- *deferasirox granules*

PA Criteria	Criteria Details
Exclusion Criteria	Creatinine clearance less than 40 mL/min or platelet counts less than 50,000/mm3.
Required Medical Information	For all indications: platelet count greater than or equal to 50,000/mm3 (within 30 days). For chronic iron overload due to transfusions: serum ferritin concentration greater than 1000 mcg/L (lab result within 30 days). For chronic iron overload in non-transfusion-dependent thalassemia syndromes: serum ferritin concentration greater than 300 mcg/L (lab result within 30 days).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	For deferasirox granules oral packets, the member must have medical reason for not using deferasirox tablets or oral soluble tablets.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

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DEFERIPRONE

Products Affected

- *deferiprone*

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	For new starts: 1) serum ferritin level above 1,000 mcg/L and absolute neutrophil count (ANC) greater than 1.5x10^9/L within 30 days of request, and 2) Trial of, contraindication to, or medical reason for not using deferasirox tablets. For continuation of therapy or reauthorization, decrease in serum ferritin from baseline.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

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DEFLAZACORT

Products Affected

- KYMBEE

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	1) Member has a documented diagnosis of Duchenne Muscular Dystrophy as evidenced by one of the following: a) documented mutation of dystrophin gene OR b) muscle biopsy indicating absence of the dystrophin protein AND 2) Patient has trial and failure with, contraindication to or medical reason for not taking prednisone.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a neurologist or specialist for submitted diagnosis.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

DIACOMIT

Products Affected

- DIACOMIT

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

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DIHYDROERGOTAMINE NASAL

Products Affected

- *dihydroergotamine mesylate nasal*

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	For new starts: Member has a diagnosis of migraine headaches with or without aura. Prescriber attestation that it will be used for the acute treatment of migraine. For continuation of therapy or reauthorization: Documentation or provider attestation of positive clinical response (e.g., improvement in pain, photophobia, phonophobia).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Requests will be authorized for 12 weeks.
Other Criteria	Trial of, contraindication to, or medical reason (e.g. intolerance or hypersensitivity) for not using a triptan (e.g., rizatriptan, sumatriptan).
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

DOPTELET

Products Affected

- DOPTELET
- DOPTELET SPRINKLE

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

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

DOXEPIN CREAM

Products Affected

- *doxepin hcl external*

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

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DUPIXENT

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Chronic spontaneous urticaria (CSU) - Initial: patient has inadequate symptomatic relief despite trial of two weeks of a second-generation oral antihistamine (unless contraindicated). Continuation of therapy: patient has positive clinical response to treatment. Bullous pemphigoid - Initial: patient has had trial of, contraindication to, or medical reason for not using a topical corticosteroid, oral corticosteroid, or an immunosuppressive agent. Continuation of therapy: patient has positive clinical response to treatment. Allergic Fungal Rhinosinusitis: Initial (1) patient is 6 years of age and older with history of sino-nasal surgery AND (2) patient has a trial of, contraindication to, or medical reason for not using nasal corticosteroids. Continuation of therapy: patient has positive clinical response to treatment.
Age Restrictions	N/A
Prescriber Restrictions	Initial therapy only: prescribed by or in consultation with specialist for submitted diagnosis.
Coverage Duration	PN: Initial 6 mo. Cont of therapy and all others initial: end of contract year.
Other Criteria	Atopic dermatitis (AD) in patients 6 months of age and older - Initial: (1) patient has diagnosis of moderate to severe AD, AND (2) has had trial of, contraindication to, or medical reason for not using either a topical corticosteroid or topical calcineurin inhibitor. Continuation of therapy: patient has positive clinical response to treatment. Asthma with eosinophilic phenotype - Initial: (1) patient has baseline blood eosinophil count greater than or equal to 150 cells per microliter, AND (2) asthma remains inadequately controlled despite current treatment with or medical reasons for not using BOTH (i) medium to high dose inhaled corticosteroid AND (ii) additional controller (i.e. leukotriene modifier, long acting beta-2-

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

PA Criteria	Criteria Details
	agoinist, long acting muscarinic antagonist, and sustained released theophylline). Asthma, oral corticosteroid dependent - Initial: asthma remains inadequately controlled despite current treatment with or medical reasons for not using BOTH (i) high dose inhaled corticosteroid AND (ii) additional controller (i.e. leukotriene modifier, long acting beta-2-agoinist, long acting muscarinic antagonist, and sustained released theophylline). Asthma with eosinophilic phenotype or oral corticosteroid dependent - Continuation of therapy: clinical improvement in asthma control (i.e. reduction in frequency and/or severity of exacerbations and symptoms OR reduction in daily maintenance oral corticosteroid dose). Chronic rhinosinusitis with nasal polyps (CRSwNP) - Initial: (1) Dupixent is used as add-on maintenance treatment, AND (2) patient has a trial of, contraindication to, or medical reason for not using nasal corticosteroids. Continuation of therapy: patient has positive clinical response to treatment. Prurigo nodularis (PN): attestation is provided confirming diagnosis. Eosinophilic esophagitis (EoE) - Initial: (1) diagnosis has been confirmed by esophageal biopsy AND (2) patient weighs at least 15 kilograms AND (3) patient experienced an inadequate treatment response, intolerance, or has a contraindication to a topical or oral corticosteroid (i.e. fluticasone propionate or budesonide). Continuation of therapy: patient has positive clinical response to treatment. Chronic Obstructive Pulmonary Disease (COPD) - Initial: (1) documented diagnosis of COPD with an eosinophilic phenotype, AND (2) Dupixent is used as an add-on maintenance treatment, AND (3) documentation that patient's COPD is inadequately controlled. Continuation of therapy: patient has positive clinical response to treatment.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

EGRIFTA

Products Affected

- EGRIFTA SV
- EGRIFTA WR

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

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

EMSAM

Products Affected

- EMSAM

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

ENBREL

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Specialist for submitted diagnosis.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	For RA: Trial of, medical reason for not using, or contraindication to 1 disease modifying antirheumatic drug (DMARD) (methotrexate, leflunomide, or sulfasalazine). For pJIA: Trial of, medical reason for not using, or contraindication to 1 of the following DMARDs: methotrexate or leflunomide. For PsA or psoriasis: approve. For ankylosing spondylitis: Trial of, medical reason for not using, or contraindication to naproxen. Continuation of therapy: patient has been receiving Enbrel for a minimum of 4 months and has positive clinical response to treatment.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

ENDARI

Products Affected

- *l-glutamine oral packet*

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

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

ENTYVIO

Products Affected

- ENTYVIO PEN

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

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

EPIDIOLEX

Products Affected

- EPIDIOLEX

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

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

EPRONTIA

Products Affected

- *topiramate oral solution 25 mg/ml*

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

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

ERYTHROPOIETIN STIMULATING AGENTS

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	For new starts for all indications: Hgb within compendia range for treatment of the requested medical condition. For continuation of therapy or re-authorization: Hgb must not exceed 10 g/dL (anemia related to cancer), 11 g/dL (anemia of CKD), 12 g/dL (zidovudine-related anemia in members with HIV and ribavirin-induced anemia), 13 g/dL (elective, noncardiac, nonvascular surgery needing red blood cell allogeneic transfusion reduction).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized for 6 months.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

PA Criteria	Criteria Details
Prerequisite Therapy Required	No

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

ERZOFRI

Products Affected

- ERZOFRI INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 117 MG/0.75ML, 156 MG/ML, 234 MG/1.5ML, 351 MG/2.25ML, 39 MG/0.25ML, 78 MG/0.5ML

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	The member has a documented history of receiving oral paliperidone or oral risperidone without any clinically significant side effects.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	For schizophrenia: Trial and failure of, contraindication, or medical reason (e.g. intolerance, hypersensitivity or contraindication) for not using at least two of the following: Abilify Maintena, Abilify Asimtufii, or Risperidone Microsphere ER. For schizoaffective disorder: approve.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

EUCRISA

Products Affected

- EUCRISA

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a dermatologist, immunologist or an allergist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	For patients 2 years of age and older: Trial of, contraindication to, or medical reason for not using topical tacrolimus or pimecrolimus. For patients less than 2 years of age: approve.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

EVRYSDI

Products Affected

- EVRYSDI

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	For new starts, all of the following must be included: 1) Documentation of genetic testing confirming diagnosis AND 2) Documentation of baseline motor function or motor milestone achievement [e.g. CHOP Infant Test of Neuromuscular Disorders (CHOP-INTEND) or Hammersmith Infant Neurological Examination (HINE) for Type 1 or Hammersmith Functional Motor Scale Expanded Scores (HFMSE), or Total Motor Function Measure 32 (MFM-32) for Type II and Type III, or 6 minute walk test in subjects able to walk]. For continuation of therapy or reauthorization, documentation of clinical response has been submitted (e.g. improvement in motor function/motor milestone achievement scores using CHOP-INTEND or HFMSE, MFM-32, 6 minute walk test or HINE improvement in more categories of motor milestones than worsening).
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a neurologist.
Coverage Duration	New starts will be authorized for 6 months. Cont of therapy or reauth until end of contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	No

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

FABHALTA

Products Affected

- FABHALTA

PA Criteria	Criteria Details
Exclusion Criteria	Concurrent use with another complement inhibitor for the treatment of PNH (i.e. Empaveli, Soliris, or Ultomiris).
Required Medical Information	PNH - Initial: patient has documented diagnosis of paroxysmal nocturnal hemoglobinuria (PNH) confirmed by (1) flow cytometry analysis confirming presence of PNH clones AND (2) patient has signs and symptoms of PNH (i.e. anemia, abdominal pain, dyspnea, kidney disease, pulmonary hypertension, hemolysis/hemoglobinuria, etc.). Continuation of therapy: patient has documented positive clinical response to treatment (i.e. decrease in LDH, increased or stabilization of hemoglobin levels, reduction in transfusions, increased reticulocyte count, etc.). Reduction of proteinuria in adults with immunoglobulin A (IgA) nephropathy - Initial: patient has documented diagnosis of IgA nephropathy AND IgA nephropathy at risk of rapid disease progression (i.e. clinical evidence of rapid disease progression generally a urine protein-to-creatinine ratio or UPCR greater or equal to 1.5g/g OR other clinically relevant tests). Continuation of therapy: patient has documented positive clinical response to treatment.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a hematologist, nephrologist or oncologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

PA Criteria	Criteria Details
Prerequisite Therapy Required	No

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

FASENRA

Products Affected

- FASENRA
- FASENRA PEN

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Specialist for submitted diagnosis.
Coverage Duration	New starts will be authorized for 6 months. Cont of therapy or reauth until end of contract year.
Other Criteria	New starts for severe asthma with an eosinophilic phenotype: 1)Baseline blood eosinophil count greater than or equal to 150 cells per microliter AND 2) symptoms persist with at least 1 exacerbation in the last 12 months requiring additional treatment (e.g. oral systemic steroids) while on a high dose inhaled corticosteroid with an additional controller medication (ie. long-acting B2 agonist). Continuation of therapy or re-authorization for severe asthma with an eosinophilic phenotype: clinical benefit from use of the drug. New starts for eosinophilic granulomatosis with polyangiitis (EGPA)- Initial: patient has a documented history or the presence of an eosinophil count of more than 1000 cells per microliter or a blood eosinophil level of greater than 10 percent AND trial of, contraindication to, or medical reason for not using one of the following medications: cyclophosphamide or methotrexate. Continuation of therapy: patient has a beneficial response to treatment with the requested drug (i.e. a reduction in the frequency of relapses, decrease in the daily oral corticosteroid dose, or no active vasculitis).
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

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

FILSPARI

Products Affected

- FILSPARI

PA Criteria	Criteria Details
Exclusion Criteria	Coadministration with renin-angiotensin-aldosterone system (RAAS) inhibitors, endothelin receptor antagonists, or aliskiren
Required Medical Information	For new starts for IgAN: Documentation is provided that the member has diagnosis of primary immunoglobulin A nephropathy (IgAN) at risk of rapid disease progression. Member has proteinuria. For new starts for focal segmental glomerulosclerosis (FSGS): Documentation is provided that the member has a diagnosis of FSGS confirmed by renal biopsy OR documented genetic mutation in a podocyte protein associated with FSGS AND (2) used to reduce proteinuria AND (3) patient is not currently in nephrotic syndrome (i.e. has proteinuria greater than 3.5 g/day in adults or UPCR greater than 2.0 g/g in pediatric patients, serum albumin less than 3.0 g/dL, and edema). For continuation of therapy or reauthorization: Documentation of positive clinical response (ie. decrease in urine protein-to-creatinine ratio (UPCR))
Age Restrictions	FSGS: 8 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with a nephrologist.
Coverage Duration	New starts will be authorized for 9 months. Cont of therapy or reauth until end of contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	No

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

FINTEPLA

Products Affected

- FINTEPLA

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

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

FIRDAPSE

Products Affected

- FIRDAPSE

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

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

FLUCYTOSINE

Products Affected

- *flucytosine oral*

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

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GALAFOLD

Products Affected

- GALAFOLD

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

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

GATTEX

Products Affected

- GATTEX

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	For new starts: attestation of 1) Colonoscopy and upper gastrointestinal endoscopy with removal of polyps within six months prior to starting treatment for adults or 2) Fecal occult blood testing within six months prior to starting treatment for pediatric patients and 3) Baseline laboratory assessments (bilirubin, alkalinephosphatase, lipase, and amylase). For continuation of therapy or reauthorization: Documentation is provided that the member has obtained a clinical benefit (e.g. reduction in parenteral fluid volume, reduction in number of days receiving parenteral nutrition).
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a gastroenterologist.
Coverage Duration	New starts will be authorized for 6 months. Cont of therapy or reauth until end of contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	No

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

GLP-1 AGONISTS

Products Affected

- *liraglutide*
- MOUNJARO SUBCUTANEOUS SOLUTION AUTO-INJECTOR
- OZEMPIC
- OZEMPIC (0.25 OR 0.5 MG/DOSE) SUBCUTANEOUS SOLUTION PEN-INJECTOR 2 MG/3ML
- OZEMPIC (1 MG/DOSE) SUBCUTANEOUS SOLUTION PEN-INJECTOR 4 MG/3ML
- OZEMPIC (2 MG/DOSE)
- RYBELSUS
- TRULICITY SUBCUTANEOUS SOLUTION AUTO-INJECTOR

PA Criteria	Criteria Details
Exclusion Criteria	The member has an indication of weight loss/obesity only or type 1 diabetes. The member has concurrent use of any GLP-1 receptor agonist.
Required Medical Information	The member has a documented diagnosis via chart notes of type 2 diabetes.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	Diabetes: patient has diagnosis of type 2 diabetes mellitus. All other indications: patient must have medically accepted indication.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	No

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

GNRH AGONISTS

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Fibroids and endometriosis: 6 months. All other indications: end of contract year.
Other Criteria	If the medication request is for the treatment of prostate cancer and if the request is for any other GnRH agonist other than Eligard or leuprolide, the patient must have a documented trial of, contraindication to, or medical reason for not using Eligard or leuprolide to treat their prostate cancer.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

GOCOVRI

Products Affected

- GOCOVRI

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

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

GROWTH HORMONES

Products Affected

- GENOTROPIN MINIQUICK SUBCUTANEOUS PREFILLED SYRINGE
- GENOTROPIN SUBCUTANEOUS CARTRIDGE
- NGENLA
- OMNITROPE SUBCUTANEOUS SOLUTION CARTRIDGE
- OMNITROPE SUBCUTANEOUS SOLUTION RECONSTITUTED
- SKYTROFA

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	For new starts for growth hormone deficiency: Documentation showing bone age testing, height, weight, and Growth Hormone Stimulation Test results OR Insulin Growth Factor 1 level. For continuation of therapy or reauthorization for growth hormone deficiency: documentation (medical records) showing positive response to treatment.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be an endocrinologist or nephrologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	For new starts for growth hormone deficiency: 1) If the request is not for Genotropin, trial of, contraindication to, or medical reason for not using Genotropin. For requests for all other medically accepted indications other than growth hormone deficiency, the request will be approved for products other than Skytrofa.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

HEPCLUDEX

Products Affected

- HEPCLUDEX

PA Criteria	Criteria Details
Exclusion Criteria	Patients with decompensated cirrhosis
Required Medical Information	N/A
Age Restrictions	18 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with a hepatologist, gastroenterologist, or infectious disease specialist
Coverage Duration	Request will be authorized until the end of the contract year
Other Criteria	Initial therapy: (1) documented diagnosis of viral hepatitis D infection confirmed with a positive HDV antibody test or HDV RNA PCR 6 months prior to the start of treatment AND (2) current positive HDV RNA PCR result AND (3) documentation of elevated pretreatment ALT AND (4) patient does not have cirrhosis OR has compensated cirrhosis. Continuation of therapy: patient demonstrates clinical benefit (e.g. undetectable HDV RNA or decrease from baseline, ALT decline, decrease in liver stiffness, etc.).
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	No

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

HEREDITARY ANGIOEDEMA AGENTS

Products Affected

- CINRYZE
- HAEGARDA
- ORLADEYO

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

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

HIGH RISK MEDICATION

Products Affected

- *benztropine mesylate oral*
- *cyproheptadine hcl oral syrup 2 mg/5ml*
- *cyproheptadine hcl oral tablet*
- *diphenoxylate-atropine oral liquid*
- *diphenoxylate-atropine oral tablet 2.5-0.025 mg*
- *dipyridamole oral*
- *ergotamine-caffeine*
- *glyburide micronized oral tablet 3 mg, 6 mg*
- *glyburide oral tablet 1.25 mg, 2.5 mg, 5 mg*
- *glyburide-metformin oral tablet 1.25-250 mg*
- *glyburide-metformin oral tablet 2.5-500 mg, 5-500 mg*
- *guanfacine hcl er oral tablet extended release 24 hour 1 mg, 2 mg, 3 mg, 4 mg*
- *guanfacine hcl oral*
- *hydroxyzine hcl oral syrup 10 mg/5ml*
- *hydroxyzine hcl oral tablet*
- *indomethacin oral capsule 25 mg, 50 mg*
- *ketorolac tromethamine oral*
- *nifedipine oral*
- *promethazine hcl oral solution 6.25 mg/5ml*
- *promethazine hcl oral tablet*
- *promethazine hcl rectal suppository 12.5 mg, 25 mg*
- *promethazine-phenylephrine*
- PROMETHEGAN RECTAL SUPPOSITORY 50 MG

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

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

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

HIGH RISK MEDICATION - PROTECTED CLASS DRUGS

Products Affected

- *amitriptyline hcl oral*
- *amoxapine*
- *clomipramine hcl oral*
- *nortriptyline hcl oral*
- *perphenazine-amitriptyline*
- *phenobarbital oral elixir*
- *phenobarbital oral tablet*

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

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

HIGH RISK MEDICATION, BUTALBITAL

Products Affected

- BAC (BUTALBITAL-ACETAMIN-CAFF)
- *butalbital-acetaminophen oral tablet 50-325 mg*
- *butalbital-apap-caff-cod oral capsule 50-325-40-30 mg*
- *butalbital-apap-caffeine oral capsule 50-325-40 mg*
- *butalbital-apap-caffeine oral solution*
- *butalbital-apap-caffeine oral tablet 50-325-40 mg*
- *butalbital-asa-caff-codeine*
- *butalbital-aspirin-caffeine oral capsule*

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

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

HIGH RISK MEDICATION, MEGESTROL

Products Affected

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

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

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

HIGH RISK MEDICATION, SHORT TERM MUSCLE RELAXANT

Products Affected

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

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

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

HIGH RISK MEDICATION, SLEEP AGENTS

Products Affected

- *eszopiclone*
- *temazepam*
- *zaleplon oral capsule 10 mg, 5 mg*
- *zolpidem tartrate er*
- *zolpidem tartrate oral tablet 10 mg*

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

HYFTOR

Products Affected

- HYFTOR

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

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

ICATIBANT

Products Affected

- *icatibant acetate subcutaneous solution prefilled syringe*

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

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

ILARIS

Products Affected

- ILARIS SUBCUTANEOUS SOLUTION

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

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

ILUMYA

Products Affected

- ILUMYA

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

IMBRUVICA

Products Affected

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

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

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

INCRELEX

Products Affected

- INCRELEX

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

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

JAKAFI

Products Affected

- JAKAFI
- JAKAFI XR

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

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

KALYDECO

Products Affected

- KALYDECO

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

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

KERENDIA

Products Affected

- KERENDIA

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	For new starts: 1) Documentation of diagnosis of chronic kidney disease (CKD) due to type 2 diabetes mellitus OR heart failure (HF) with left ventricular ejection fraction (LVEF) greater than or equal to 40% AND AND 2) Documentation of serum potassium levels less than or equal to 5 mEq/L AND 3) eGFR greater than or equal to 25ml/min/1.73 m2 AND 4) Documentation that member is taking Kerendia in combination with an angiotensin-converting enzyme inhibitor (ACEi) or angiotensin receptor blocker (ARB) at maximum tolerated doses or documentation has been provided that the member is unable to tolerate ACEi or ARB. For continuation of therapy or reauthorization for patients with CKD due to type 2 diabetes mellitus: 1) Documentation of serum potassium levels less than or equal to 5.5 mEq/L AND 2) Documentation that member is taking Kerendia in combination with an ACEi or ARB at maximum tolerated doses or documentation has been provided that the member is unable to tolerate ACEi or ARB. For continuation of therapy or reauthorization for patients with HF with LVEF greater than or equal to 40%: 1) Documentation of serum potassium levels less than 6 mEq/L AND 2) Documentation that member is taking Kerendia in combination with an ACEi or ARB at maximum tolerated doses or documentation has been provided that the member is unable to tolerate ACEi or ARB.

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

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

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

KEVZARA

Products Affected

- KEVZARA

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

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

KINERET

Products Affected

- KINERET SUBCUTANEOUS SOLUTION PREFILLED SYRINGE

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

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

LEQEMBI IQLIK

Products Affected

- LEQEMBI IQLIK
- LEQEMBI IQLIK (500 MG DOSE)

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a neurologist, geriatric psychiatrist, or geriatrician who specializes in treating dementia
Coverage Duration	Initial: 6 months. Continuation of therapy: end of the contract year.
Other Criteria	Initiation: (1) the patient has documentation of 18 months of treatment with intravenous Leqembi prior to initiation of subcutaneous maintenance therapy & (2) prior to initation with intravenous Leqembi, the patient has an initial diagnosis of mild cognitive impairment (MCI) caused by Alzheimer's Disease (AD) or mild AD consistent with Stage 3 or Stage 4 Alzheimer's disease & (3) documentation of both of the following: a positive result for the presence of beta-amyloid plaques & baseline Magnetic Resonance Imaging (MRI) scan prior to intiation with intravenous Leqembi. Continuation of therapy: patient has a positive clinical response to treatment.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	No

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

LEQSELVI

Products Affected

- LEQSELVI

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

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

LITFULO

Products Affected

- LITFULO

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Initial: (1) documented diagnosis via chart notes of severe alopecia areata AND (2) patient is not receiving in combination with either of the following: (i) Targeted immunomodulator (i.e. Olumiant, Enbrel, Cimzia, Simponi, Orencia, adalimumab, Xeljanz, Rinvoq) OR (ii) potent immunosuppressant. Continuation of therapy: documentation of positive clinical response to treatment.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	Documentation of confirmed diagnosis and other causes of hair loss have been ruled out.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	No

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

LIVMARLI

Products Affected

- LIVMARLI

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

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

LIVTENCITY

Products Affected

- LIVTENCITY

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Cytomegalovirus (CMV): (1) Documented diagnosis of CMV infection AND (2) Member is a recipient of one of the following: (a) hematopoietic stem cell transplant, (b) solid organ transplant AND (3) patient has tried and failed treatment with valganciclovir, ganciclovir, cidofivir, or foscarnet AND (4) patient weighs greater than or equal to 35 kg.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a transplant, oncologist, or infectious disease specialist.
Coverage Duration	Request will be authorized for 8 weeks.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

LODOCO

Products Affected

- LODOCO

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

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

LUCEMYRA

Products Affected

- *lofexidine hcl*

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized for 14 days.
Other Criteria	Patient must have trial of, contraindication to, or medical reason for not using clonidine.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

LUPKYNIS

Products Affected

- LUPKYNIS

PA Criteria	Criteria Details
Exclusion Criteria	Concurrent use with cyclophosphamide.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be rheumatologist, nephrologist, or other specialist in the treatment of autoimmune disorders.
Coverage Duration	New starts will be authorized for 6 months. Cont of therapy or reauth until end of contract year.
Other Criteria	For new starts: 1) Documentation of urine protein/creatinine ratio (UPCR), 2) Documentation that the member has a baseline eGFR greater than 45 mL/min/1.73m2 or that benefit outweighs risk of using this medication at current eGFR, and 3) Concurrent use of or medical reason for not using background immunosuppressive therapy regimen. For continuation of therapy or reauthorization: Documentation of improvement in renal function (i.e. reduction in UPCR or no confirmed decrease from baseline eGFR greater than or equal to 20%).
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	No

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

LYBALVI

Products Affected

- LYBALVI

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

MAVYRET

Products Affected

- MAVYRET

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

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

METHOTREXATE ORAL SOLUTION

Products Affected

- JYLAMVO
- XATMEP

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be an oncologist, a rheumatologist, a dermatologist, or other appropriate specialist
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	Polyarticular Juvenile Idiopathic Arthritis (pJIA) - Initial: (1) patient had been diagnosed with pJIA AND (2) patient had tried, intolerant or has medical reason for not using at least one non-steroidal anti-inflammatory agents (NSAIDs) AND methotrexate.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

METHYLTESTOSTERONE

Products Affected

- *methyltestosterone oral*

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

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

METYROSINE

Products Affected

- *metyrosine*

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

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

MIFEPRISTONE

Products Affected

- *mifepristone oral tablet 300 mg*

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

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

MIGLUSTAT

Products Affected

- *miglustat*

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

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

MULTIPLE SCLEROSIS AGENTS

Products Affected

- BAFIERTAM
- BETASERON SUBCUTANEOUS KIT
- *cladribine (10 tabs)*
- *cladribine (4 tabs)*
- *cladribine (5 tabs)*
- *cladribine (6 tabs)*
- *cladribine (7 tabs)*
- *cladribine (8 tabs)*
- *cladribine (9 tabs)*
- *cladribine 10 mg tablet therapy pack oral*
- *dimethyl fumarate oral capsule delayed release 120 mg, 240 mg*
- *dimethyl fumarate starter pack oral capsule delayed release therapy pack*
- *fingolimod hcl*
- *glatiramer acetate subcutaneous solution prefilled syringe 20 mg/ml, 40 mg/ml*
- GLATOPA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 20 MG/ML, 40 MG/ML
- KESIMPTA
- MAYZENT
- MAYZENT STARTER PACK
- PONVORY
- PONVORY STARTER PACK
- REBIF REBIDOSE SUBCUTANEOUS SOLUTION AUTO-INJECTOR
- REBIF REBIDOSE TITRATION PACK SUBCUTANEOUS SOLUTION AUTO-INJECTOR
- REBIF SUBCUTANEOUS SOLUTION PREFILLED SYRINGE
- REBIF TITRATION PACK SUBCUTANEOUS SOLUTION PREFILLED SYRINGE
- TASCENSO ODT
- *teriflunomide*

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Specialist for submitted diagnosis.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	If the medication request is for glatiramer, Glatopa, or dimethyl fumarate, the request will be approved. If the member is over 17 years of age and the

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

PA Criteria	Criteria Details
	request is not for glatiramer, Glatopa, or dimethyl fumarate for multiple sclerosis, the member must have a documented trial of, contraindication to or a medical reason for not using 2 of the following dimethyl fumarate, glatiramer, Glatopa, teriflunomide, or fingolimod. If the request is for fingolimod and the member is 17 years of age or younger, the request will be approved.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

MYFEMBREE

Products Affected

- MYFEMBREE

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

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

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

MYQORZO

Products Affected

- MYQORZO

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a cardiologist.
Coverage Duration	Initial: 6 months. Continuation of therapy: end of contract year.
Other Criteria	For all new starts, documentation of ALL of the following must be provided: 1) Diagnosis of symptomatic obstructive hypertrophic cardiomyopathy (oHCM) AND 2) Patient has a left ventricular ejection fraction (LVEF) greater than or equal to 55% AND 3) Assessment of Valsalva left ventricular outflow tract (LVOT) gradient AND 4) Trial of, medical reason for not using or contraindication to BOTH of the following: Beta blockers (i.e. metoprolol, propranolol, atenolol) AND Non-dihydropyridine calcium channel blockers (i.e. verapamil, diltiazem). For continuation of therapy or reauthorization, all of the following must be provided: 1) Provider attests that the member has demonstrated a clinically meaningful benefit from therapy AND 2) Member must also have a left ventricular ejection fraction (LVEF) greater than or equal to 40%.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

NASAL ANTISEIZURE AGENTS

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Nayzilam: 12 years of age or older. Valtoco: 2 years of age or older.
Prescriber Restrictions	Initial therapy only: prescribed by or in consultation with a neurologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	No

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

NITISINONE

Products Affected

- *nitisinone*
- ORFADIN ORAL SUSPENSION

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a geneticist, metabolic specialist, hepatologist, or liver transplant specialist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	Hereditary Tyrosinemia Type 1 (HT-1): diagnosis was confirmed by genetic testing confirming a mutation of the FAH gene OR elevated levels of succinylacetone.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	No

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

NON-AMPHETAMINE CENTRAL NERVOUS SYSTEM AGENTS

Products Affected

- *armodafinil*
- *modafinil oral*

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

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

NUCALA

Products Affected

- NUCALA

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Specialist for submitted diagnosis.
Coverage Duration	New starts will be authorized for 6 months. Cont of therapy or reauth until end of contract year.
Other Criteria	New starts for severe asthma: 1) Baseline blood eosinophil count greater than or equal to 150 cells per microliter AND 2) symptoms with equal to or greater than 1 exacerbations in the previous 12 months while on a high-dose inhaled corticosteroid AND 3) the patient has a documented trial of, contraindication to, or medical reason for not using both Dupixent and Fasenra. New starts for eosinophilic granulomatosis with polyangiitis (EGPA): 1) trial of, contraindication to, or medical reason for not using one of the following medications: cyclophosphamide or methotrexate AND 2) the patient has a documented trial of, contraindication to, or medical reason for not using Fasenra. New starts for hypereosinophilic syndrome without an identifiable non-hematologic secondary cause: 1) 2 or more flares within the past 12 months AND 2) trial of, contraindication to, or medical reason for not using oral corticosteroids. New starts for chronic rhinosinusitis with nasal polyps: 1) the patient has a documented trial of, contraindication to, or medical reason for not using both Dupixent and Xolair. Continuation of therapy or re-authorization for all indications: clinical benefit from use of the drug. COPD - initial: (1) documented diagnosis of COPD AND (2) Documentation of blood eosinophil count of greater than or equal to 300 cells/microliter AND (3) Nucala is used as add-on maintenance treatment AND (4) patient has had a trial of, contraindication to, or medical reason

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

PA Criteria	Criteria Details
	for not using at least two of the following: a) long acting beta2-agonist (LABA), b) long acting muscarinic antagonist (LAMA) or c) inhaled corticosteroid (ICS) AND (5) documentation of COPD exacerbation within the past 12 months. Continuation of therapy: patient has positive clinical response to treatment.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

NUEDEXTA

Products Affected

- *dextromethorphan-quinidine*
- NUEDEXTA

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

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

NUPLAZID

Products Affected

- NUPLAZID ORAL CAPSULE
- NUPLAZID ORAL TABLET 10 MG

PA Criteria	Criteria Details
Exclusion Criteria	Patient has a history of dementia-related psychosis.
Required Medical Information	For hallucinations and delusions associated with Parkinson's disease psychosis: documented 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	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	No

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

OCTREOTIDE

Products Affected

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

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

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

OFEV

Products Affected

- *nintedanib esylate*
- OFEV

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

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

OPSUMIT

Products Affected

- *macitentan*
- OPSUMIT

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Pulmonary arterial hypertension (PAH) World Health Organization (WHO) Group I - Initial: [Note: documentation required] (1) PAH was confirmed by right heart catheterization AND (2) pretreatment mean pulmonary arterial pressure is greater than 20 mmHg AND (3) pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg AND (4) pretreatment pulmonary vascular resistance is greater than or equal to 3 Wood units. Continuation of therapy: patient has positive clinical response to treatment.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a pulmonologist or cardiologist
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	Trial of, contraindication to, or medical reason for not using sildenafil.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

ORAL ANTIPSYCHOTICS

Products Affected

- BYSANTI
- BYSANTI TITRATION PACK A
- BYSANTI TITRATION PACK B
- BYSANTI TITRATION PACK C
- CAPLYTA
- COBENFY
- COBENFY STARTER PACK
- FANAPT
- FANAPT TITRATION PACK A
- FANAPT TITRATION PACK B ORAL TABLET
- FANAPT TITRATION PACK C ORAL TABLET
- OPIPZA ORAL FILM 10 MG, 2 MG, 5 MG
- VRAYLAR ORAL CAPSULE

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	Schizophrenia: 1) request is for Caplyta, Cobenfy, Fanapt, Opipza, Bysanti, or Vraylar AND 2) trial of, contraindication to, or medical reason for not using two generic antipsychotics. Manic or mixed episodes associated with bipolar l disorder: 1) request is for Fanapt, Opipza, Bysanti, or Vraylar AND 2) trial of, contraindication to, or medical reason for not using two generic antipsychotics. Major depressive disorder associated with bipolar l or II disorder: 1) request is for Caplyta AND 2) trial of, contraindication to, or medical reason for not using two generic antipsychotics. Adjunctive treatment of major depressive disorder: 1) request is for Caplyta, Opipza or Vraylar AND 2) trial of, contraindication to, or medical reason for not using two generic antipsychotics AND 3) if the request is for Vraylar: provider attestation that the member is concurrently using an antidepressant. Irritability associated with autistic disorder: 1) request is for

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

PA Criteria	Criteria Details
	Opipza AND 2) trial of, contraindication to, or medical reason for not using two generic antipsychotics. Treatment of Tourette's disorder: 1) request is for Opipza AND 2) trial of, contraindication to, or medical reason for not using two generic antipsychotics. Bipolar I disorder: 1) request is for Opipza AND 2) trial of, contraindication to, or medical reason for not using two generic antipsychotics. Depressed bipolar I disorder: 1) request is for Vraylar AND 2) trial of, contraindication to, or medical reason for not using two generic antipsychotics.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

ORENCIA

Products Affected

- ORENCIA CLICKJECT
- ORENCIA INTRAVENOUS
- ORENCIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 125 MG/ML, 50 MG/0.4ML, 87.5 MG/0.7ML

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

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

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

ORIAHNN

Products Affected

- ORIAHNN

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

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

ORILISSA

Products Affected

- ORILISSA

PA Criteria	Criteria Details
Exclusion Criteria	Patient has osteoporosis or severe hepatic impairment.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be an OB or gynecologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	Trial of, contraindication to, or medical reason for not using the following concurrently for endometriosis: analgesic pain reliever (e.g. NSAIDs, COX-2 inhibitors) AND either combined estrogen-progestin oral contraceptive, progestin (e.g. medroxyprogesterone acetate, norethindrone), gonadotropin-releasing hormone (GnRH) agonists (e.g. Lupron Depot), OR danazol. For continuation of therapy or reauthorization both of the following are required: 1) Treatment does not exceed the eligible maximum lifetime treatment duration of 2 years for 150mg tablet or 6 months for 200mg tablet, and 2) Documentation has been provided that the member has obtained clinical benefit from the medication.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

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ORKAMBI

Products Affected

- ORKAMBI

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

OTEZLA

Products Affected

- OTEZLA
- OTEZLA XR
- OTEZLA/OTEZLA XR INITIATION PK

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

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

OXERVATE

Products Affected

- OXERVATE

PA Criteria	Criteria Details
Exclusion Criteria	Treatment duration greater than 16 weeks per affected eye(s).
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by an ophthalmologist or an optometrist.
Coverage Duration	Initial: 8 weeks. Continuation of therapy: additional 8 weeks.
Other Criteria	Initial: confirmed diagnosis. Continuation of therapy: patient has previously received less than or equal to 8 weeks of treatment per affected eye(s) and the patient has a recurrence of neurotrophic keratitis.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	No

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

OXYCODONE ER

Products Affected

- OXYCONTIN ORAL TABLET ER 12 HOUR ABUSE-DETERRENT 10 MG, 15 MG, 20 MG, 30 MG, 40 MG, 60 MG, 80 MG

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

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

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

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

PALIPERIDONE INJECTABLE

Products Affected

- INVEGA HAFYERA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 1092 MG/3.5ML, 1560 MG/5ML
- INVEGA SUSTENNA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 117 MG/0.75ML, 156 MG/ML, 234 MG/1.5ML, 39 MG/0.25ML, 78 MG/0.5ML
- INVEGA TRINZA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 273 MG/0.88ML, 410 MG/1.32ML, 546 MG/1.75ML, 819 MG/2.63ML

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	The member has a documented history of receiving oral risperidone or oral paliperidone without any clinically significant side effects. For requests for Invega Trinza, the member has documented treatment with Invega Sustenna for at least 4 months. For requests for Invega Hafyera, the member has documented treatment with Invega Sustenna for at least 4 months OR the member has documented treatment with Invega Trinza for at least one three-month cycle.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	For requests for Invega Sustenna, Invega Trinza, or Invega Hafyera for schizophrenia: Trial and failure of, contraindication, or medical reason (e.g. intolerance, hypersensitivity or contraindication) for not using at least two of the following: Abilify Maintena, Abilify Asimtufii, or Risperidone Microsphere ER. For requests for Invega Sustenna for schizoaffective disorder: approve.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

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

PCSK9 INHIBITORS

Products Affected

- REPATHA
- REPATHA SURECLICK

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	For all diagnoses (besides for risk reduction of major cardiovascular events): documented diagnosis of medically accepted indication. For risk reduction of major cardiovascular (CV) events (CV death, myocardial infarction, stroke, unstable angina requiring hospitalization, or coronary revascularization): 1) Patient has an increased risk of major CV events such as death from CV disease, heart attack, stroke, certain types of chest pain conditions (including but not limited to, unstable angina) requiring hospitalization or certain types of heart surgery and (2) tried or has contraindication to high intensity statin.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

PEGINTERFERON

Products Affected

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

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

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

PENICILLAMINE

Products Affected

- *penicillamine oral tablet*

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

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

PERSERIS

Products Affected

- PERSERIS

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

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

PHENOXYBENZAMINE

Products Affected

- *phenoxybenzamine hcl oral*

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

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

PIRFENIDONE

Products Affected

- *pirfenidone*

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

POSACONAZOLE

Products Affected

- *posaconazole oral*

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

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

PRETOMANID

Products Affected

- *pretomanid*

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

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

PREVYMIS

Products Affected

- PREVYMIS ORAL

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

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

PROMACTA

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	For persistent or chronic immune thrombocytopenia (ITP): Documented baseline platelet count less than 30,000 cells/ microL. For severe aplastic anemia: Documentation of baseline platelet count less than 20,000 cells/microL OR platelet count less than 30,000 cells/microL with bleeding OR reticulocyte count less than 20,000 cells/microL OR absolute neutrophil count less than 500 cells/microL. For thrombocytopenia in patients with Hepatitis C infection: documented baseline platelet count less than 75,000 cells/microL.
Age Restrictions	N/A
Prescriber Restrictions	Specialist for submitted diagnosis.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	For persistent or chronic immune thrombocytopenia (ITP):Trial of, contraindication to, or medical reason for not using glucocorticosteroids. For severe aplastic anemia: Trial of, contraindication to, or medical reason for not using at least one immunosuppressive agent.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

PYRUKYND

Products Affected

- PYRUKYND
- PYRUKYND TAPER PACK

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

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

RADICAVA

Products Affected

- RADICAVA ORS
- RADICAVA ORS STARTER KIT

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

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

RAVICTI

Products Affected

- *glycerol phenylbutyrate*

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

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

RECORLEV

Products Affected

- RECORLEV

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

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

RELISTOR

Products Affected

- RELISTOR ORAL
- RELISTOR SUBCUTANEOUS SOLUTION
- RELISTOR SUBCUTANEOUS SOLUTION PREFILLED SYRINGE

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	For opioid induced constipation, chronic non-cancer pain: Patient must have documented trial of or medical reason for not using at least two the following: 1) lubiprostone, OR 2) lactulose OR 3) Movantik. Additionally, patient must have a medical reason for not being able to use oral Relistor in order to receive Relistor injection. For opioid-induced constipation, in patients with advanced illness or pain caused by active cancer requiring opioid dosage escalation for palliative care: Approve.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

REVCOVI

Products Affected

- REVCOVI

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Patient has diagnosis of adenosine deaminase severe combined immune deficiency (ADA-SCID) confirmed by one of the following: 1) documentation of deficiency or absence of adenosine deaminase OR 2) genetic testing revealing mutations in both alleles of the ADA1 gene
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be an immunologist, geneticist, hematologist, oncologist, or provider who specializes in the treatment of ADA-SCID or related disorders.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	No

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

REXULTI

Products Affected

- REXULTI

PA Criteria	Criteria Details
Exclusion Criteria	Dementia-related psychosis
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	For schizophrenia: trial of, contraindication to, or medical reason for not using two generic antipsychotics. For major depressive disorder: trial of, contraindication to, or medical reason for not using to two generic antidepressants. For agitation due to dementia: 1) patient has documented diagnosis of Alzheimer's disease AND 2) medication will not be used on an "as needed" basis
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

REZDIFFRA

Products Affected

- REZDIFFRA

PA Criteria	Criteria Details
Exclusion Criteria	Patients with decompensated cirrhosis.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a hepatologist, gastroenterologist, endocrinologist or specialist in the treatment of liver disease.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	Initial therapy: (1) documented diagnosis of noncirrhotic nonalcoholic steatohepatitis (NASH) with moderate to advanced liver fibrosis, (2) documentation of stage F2 to F3 fibrosis as confirmed by a biopsy or a non-invasive test (NIT), (3) the drug is being prescribed at an FDA approved dose according to the member's weight and (4) prescriber attestation to providing lifestyle counseling on nutrition, exercise and avoiding excessive alcohol intake. For reauthorization: (1) the member has shown clinical benefit from the medication (e.g., the resolution of steatohepatitis and no worsening of liver fibrosis, or at least one stage improvement in liver fibrosis and no worsening of steatohepatitis), (2) the member continues to have a fibrosis stage of 3 or less and (3) the drug continues to be prescribed at an FDA approved dose according to the member's weight.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

PA Criteria	Criteria Details
Prerequisite Therapy Required	No

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

REZUROCK

Products Affected

- REZUROCK

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

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

RUFINAMIDE

Products Affected

- *rufinamide oral suspension 40 mg/ml*
- *rufinamide oral tablet*

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

RYKINDO

Products Affected

- RYKINDO

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

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

RYLAZE

Products Affected

- RYLAZE

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

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

SAPROPTERIN

Products Affected

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

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

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

SECUADO

Products Affected

- SECUADO

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

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

SEROSTIM

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a HIV specialist, gastroenterologist, nutritional support specialist or ID specialist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	For initial starts for HIV wasting/cachexia: 1) Member must be on anti-retroviral therapy and 2) Alternative causes of wasting have been ruled out (diarrhea, malignancies, inadequate caloric intake, etc)
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

SIGNIFOR

Products Affected

- SIGNIFOR

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

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

SILDENAFIL ORAL

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	Documentation of concurrent nitrate or Adempas use.
Required Medical Information	Pulmonary Arterial Hypertension: Documentation of pulmonary arterial hypertension (PAH) WHO Group I and PAH Functional Class. Reviewer will verify available patient claim history to confirm patient is not using nitrates or Adempas. Secondary Raynaud's phenomenon- Initial: [Note: documentation required] (1) diagnosis of secondary Raynaud's phenomenon AND (2) diagnosis of primary condition which Raynaud's phenomenon is secondary to (e.g., lupus, scleroderma, rheumatoid arthritis, Sjogren's syndrome, thyroid disease). Continuation of therapy: patient has positive clinical response to treatment.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a pulmonologist, cardiologist, or rheumatologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	For sildenafil suspension: Documentation of trial of, contraindication to, or medical reason for not using sildenafil tablet.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

SILIQ

Products Affected

- SILIQ

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

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

SIMPONI

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Specialist for submitted diagnosis.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	For ankylosing spondylitis: Either 1) Trial of, medical reason for not using, or contraindication to 2 of the following therapies: Enbrel, an adalimumab product, Cosentyx, or Xeljanz, or 2) If utilized within the past 120 days, approve for continuation of therapy. For PsA: Either 1) Trial of, medical reason for not using, or contraindication to 2 of the following therapies: an ustekinumab product, Cosentyx, Tremfya, Xeljanz, Enbrel, or an adalimumab product or 2) If utilized within the past 120 days, approve for continuation of therapy. For RA: Either 1) Trial of, medical reason for not using, or contraindication to 2 of the following: Enbrel, an adalimumab product, or Xeljanz or 2) If utilized within the past 120 days, approve for continuation of therapy. For adults with UC: Either 1) Trial of, medical reason for not using, or contraindication to 2 of the following: an adalimumab product, an ustekinumab product, Tremfya, or Xeljanz or 2) If utilized within the past 120 days, approve for continuation of therapy. For pediatric patients with UC: approve.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

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

SIRTURO

Products Affected

- SIRTURO

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

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

SODIUM OXYBATE

Products Affected

- *sodium oxybate*

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

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

SODIUM PHENYLBUTYRATE

Products Affected

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

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

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

SOFOSBUVIR/VELPATASVIR

Products Affected

- *sofosbuvir-velpatasvir*

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

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

SOMAVERT

Products Affected

- SOMAVERT

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

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

SOTYKTU

Products Affected

- SOTYKTU

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

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

SUCRAID

Products Affected

- SUCRAID

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

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

SYMDEKO

Products Affected

- SYMDEKO

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

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

SYNAREL

Products Affected

- SYNAREL

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

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

TADALAFIL

Products Affected

- *tadalafil (pah)*
- TADLIQ

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

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

TADALAFIL, BPH

Products Affected

- *tadalafil oral tablet 5 mg*

PA Criteria	Criteria Details
Exclusion Criteria	Diagnosis of erectile dysfunction
Required Medical Information	Diagnosis of Benign prostatic hyperplasia (BPH) required AND trial of, contraindication to, or medical reason for not using an alpha blocker (e.g. tamsulosin, terazosin).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

TALTZ

Products Affected

- TALTZ SUBCUTANEOUS SOLUTION AUTO-INJECTOR
- TALTZ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 20 MG/0.25ML, 40 MG/0.5ML, 80 MG/ML

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

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

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

TARPEYO

Products Affected

- TARPEYO

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	For new starts: documentation is required that the member has 1) Diagnosis of primary immunoglobulin A nephropathy (IgAN) and 2) at risk of disease progression. Member has proteinuria greater than or equal to 0.5 g/day. For continuation of therapy: documentation that member has been on Tarpeyo for less than 9 months. For reauthorizations: Requests will not be allowed as the safety and efficacy of subsequent courses of Tarpeyo have not been established.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a nephrologist.
Coverage Duration	Request will be authorized for 9 months.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	No

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

TASIMELTEON

Products Affected

- HETLIOZ LQ
- *tasimelteon*

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

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

TAVNEOS

Products Affected

- TAVNEOS

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

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

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

TEPEZZA

Products Affected

- TEPEZZA

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Documentation of moderate to severe active thyroid eye disease (TED) as evidenced by one or more of the following: a) eyelid retraction greater than or equal to 2 mm, b) moderate or severe soft tissue involvement, c) exophthalmos greater than or equal to 3 mm above normal for race and sex or d) periodic or constant diplopia OR Documentation of chronic TED with one or more of the following: a) a 3 mm or greater increase in exophthalmos from before diagnosis of TED, b) exophthalmos greater than or equal to 3 mm above normal for race and sex.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be an ophthalmologist or endocrinologist
Coverage Duration	Request will be authorized for 6 months.
Other Criteria	For active TED: member has had a trial and failure, contraindication to, or medical reason for not using oral or IV glucocorticoids.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

TERIPARATIDE

Products Affected

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

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

THIOLA

Products Affected

- *tiopronin oral*

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

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

TIGECYCLINE

Products Affected

- *tigecycline*

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	(1) Patient must have documented diagnosis of one of the following infections: (a) complicated skin and skin structure infection, (b) complicated intraabdominal infection, (c) community-acquired pneumonia AND (2) Trial of, contraindication to, or medical reason (e.g. intolerance, hypersensitivity or contraindication) for not using at least 2 preferred first-line antibiotics.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an infectious disease specialist.
Coverage Duration	Request will be authorized for 14 days.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

TOBI PODHALER

Products Affected

- TOBI PODHALER

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Patient has documented diagnosis of both: 1) cystic fibrosis AND 2) pseudomonas aeruginosa
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	No

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

TOLVAPTAN

Products Affected

- *tolvaptan*
- *tolvaptan (hyponatremia)*

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

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

TOPICAL ANTINEOPLASTIC RETINOIDS

Products Affected

- *bexarotene*
- PANRETIN

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

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

TOPICAL TESTOSTERONE

Products Affected

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

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

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

TRANSDERMAL LIDOCAINE

Products Affected

- *lidocaine external patch 5 %*
- ZTLIDO

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

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

TREMFYA

Products Affected

- TREMFYA ONE-PRESS SUBCUTANEOUS SOLUTION PEN-INJECTOR
- TREMFYA PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 100 MG/ML, 200 MG/2ML
- TREMFYA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML, 200 MG/2ML
- TREMFYA-CD/UC INDUCTION

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Specialist for submitted diagnosis.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	For UC: Approve. Crohn's Disease (CD) - Initial: Trial of, contraindication to, or medical reason (i.e. patient has a diagnosis of severe Crohn's disease) for not using (i.e. severe Crohns disease), or contraindication to 1 of the following: mercaptopurine, azathioprine, methotrexate, sulfasalazine, or corticosteroid (e.g., prednisone, methylprednisolone). Continuation of therapy: patient has been receiving Tremfya for a minimum of 4 months and has a positive clinical response to therapy.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

TRIENTINE

Products Affected

- CUVRIOR
- *trientine hcl oral capsule 250 mg*

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

TRIKAFTA

Products Affected

- TRIKAFTA

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

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

TYMLOS

Products Affected

- TYMLOS

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

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

TYVASO

Products Affected

- TYVASO DPI MAINTENANCE KIT INHALATION POWDER 112 X 32MCG & 112 X64MCG, 112 X 48MCG & 112 X64MCG, 112 X 48MCG & 112 X80MCG, 16 MCG, 32 MCG, 48 MCG, 64 MCG, 80 MCG
- TYVASO DPI TITRATION KIT INHALATION POWDER 16 & 32 & 48 MCG

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

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

UPTRAVI

Products Affected

- UPTRAVI ORAL
- UPTRAVI TITRATION

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

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

USTEKINUMAB

Products Affected

- IMULDOSA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 45 MG/0.5ML, 90 MG/ML
- SELARSDI INTRAVENOUS
- SELARSDI SUBCUTANEOUS SOLUTION
- SELARSDI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 45 MG/0.5ML, 90 MG/ML
- STARJEMZA INTRAVENOUS
- STARJEMZA SUBCUTANEOUS SOLUTION
- STARJEMZA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 45 MG/0.5ML, 90 MG/ML
- STELARA INTRAVENOUS
- STELARA SUBCUTANEOUS SOLUTION 45 MG/0.5ML
- STELARA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 45 MG/0.5ML, 90 MG/ML
- STEQEYMA INTRAVENOUS
- STEQEYMA SUBCUTANEOUS SOLUTION
- STEQEYMA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 45 MG/0.5ML, 90 MG/ML
- *ustekinumab subcutaneous solution*
- *ustekinumab subcutaneous solution prefilled syringe 45 mg/0.5ml, 90 mg/ml*
- *ustekinumab-aauz subcutaneous solution prefilled syringe 45 mg/0.5ml, 90 mg/ml*
- *ustekinumab-aekn subcutaneous solution prefilled syringe 45 mg/0.5ml, 90 mg/ml*
- YESINTEK INTRAVENOUS
- YESINTEK SUBCUTANEOUS SOLUTION
- YESINTEK SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 45 MG/0.5ML, 90 MG/ML

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Specialist for submitted diagnosis.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A

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

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

UZEDY

Products Affected

- UZEDY SUBCUTANEOUS SUSPENSION PREFILLED SYRINGE 100 MG/0.28ML, 125 MG/0.35ML, 150 MG/0.42ML, 200 MG/0.56ML, 250 MG/0.7ML, 50 MG/0.14ML, 75 MG/0.21ML

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

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

VALCHLOR

Products Affected

- VALCHLOR

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

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

VEMLIDY

Products Affected

- VEMLIDY

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

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

VEOZAH

Products Affected

- VEOZAH

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Initial: (1) Documented diagnosis of moderate to severe vasomotor symptoms due to menopause AND (2) Trial of, contraindication to, or medical reason (e.g. intolerance, hypersensitivity or contraindication) for not using a hormonal therapy (e.g., estradiol, oral Premarin, Prempro). Reauthorization: (1) Documentation of positive clinical response to therapy (e.g., decrease in frequency or severity of vasomotor symptoms from baseline)
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

VIGABATRIN

Products Affected

- *vigabatrin*
- VIGAFYDE

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

VIJOICE

Products Affected

- VIJOICE

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

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

VMAT-2 INHIBITORS

Products Affected

- AUSTEDO
- AUSTEDO XR
- AUSTEDO XR PATIENT TITRATION ORAL TABLET EXTENDED RELEASE THERAPY PACK 12 & 18 & 24 & 30 MG
- INGREZZA ORAL CAPSULE
- INGREZZA ORAL CAPSULE SPRINKLE
- INGREZZA ORAL CAPSULE THERAPY PACK
- *tetrabenazine*

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

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

VORICONAZOLE

Products Affected

- *voriconazole intravenous*

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

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

VOSEVI

Products Affected

- VOSEVI

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

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

VOWST

Products Affected

- VOWST

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

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

WEGOVY

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	The member has an indication of only weight reduction or maintenance for overweight or obesity. The member has concurrent use of any GLP-1 receptor agonist. The member has a personal history of medullary thyroid carcinoma. The member has Multiple Endocrine Neoplasia syndrome type 2.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	Reduction of the risk of major adverse cardiovascular events in adults with established cardiovascular disease and either obesity or overweight- For new starts: The member has an indication for reducing the risk of adverse cardiovascular events (cardiovascular death, non-fatal myocardial infarction, or non-fatal stroke) in adults with established cardiovascular disease. Documentation demonstrates patient has established cardiovascular disease (e.g., prior myocardial infarction, prior stroke, symptomatic peripheral arterial disease). Documentation is provided that the patient is overweight or obese (defined as a BMI of greater than or equal to 27 kg/m2). Treatment of noncirrhotic metabolic dysfunction-associated steatohepatitis (MASH) - For new starts: The member has a documented diagnosis of MASH with documentation of moderate to advanced liver fibrosis (fibrosis stage 2 or 3) as evidenced by liver biopsy, biomarker testing (AST to platelet ratio index score, fibrosis 4 score, NAFLD fibrosis score, etc.), transient elastography or ultrasonography. For

PA Criteria	Criteria Details
	continuation of therapy or reauthorization: Documentation is provided that the patient has a positive clinical response to treatment.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	No

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

WEGOVY TABLETS

Products Affected

- WEGOVY ORAL

PA Criteria	Criteria Details
Exclusion Criteria	The member has an indication of only weight reduction or maintenance for overweight or obesity. The member has concurrent use of any GLP-1 receptor agonist. The member has a personal history of medullary thyroid carcinoma. The member has Multiple Endocrine Neoplasia syndrome type 2.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	Reduction of the risk of major adverse cardiovascular events in adults with established cardiovascular disease and either obesity or overweight - For new starts: The member has an indication for reducing the risk of adverse cardiovascular events (cardiovascular death, non-fatal myocardial infarction, or non-fatal stroke) in adults with established cardiovascular disease. Documentation demonstrates patient has established cardiovascular disease (i.e., prior myocardial infarction, prior stroke, symptomatic peripheral arterial disease). Documentation is provided that the patient is overweight or obese (defined as a BMI of greater than or equal to 27 kg/m2). The member must have documentation or a medical reason for not being able to use the Wegovy injection. For continuation of therapy or reauthorization: Documentation is provided that the patient has a positive clinical response to treatment.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

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

WHITE BLOOD CELL STIMULATORS

Products Affected

- FULPHILA
- FYLNETRA
- LEUKINE INJECTION SOLUTION RECONSTITUTED
- NEULASTA ONPRO SUBCUTANEOUS SOLUTION PREFILLED SYRINGE
- NEULASTA SUBCUTANEOUS SOLUTION 4 MG/0.4ML
- NEULASTA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE
- ZARXIO

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

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

WINREVAIR

Products Affected

- WINREVAIR

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Pulmonary arterial hypertension (PAH) (World Health Organization [WHO] Group 1)- Initial: [Note: documentation required] (1) PAH was confirmed by right heart catheterization AND (2) pretreatment mean pulmonary arterial pressure is greater than 20 mmHg AND (3) pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, AND (4) pretreatment pulmonary vascular resistance is greater than or equal to 3 Wood units. Continuation of therapy: patient has positive clinical response to treatment.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a cardiologist or pulmonologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	Documented trial and failure of, or contraindication to combination therapy including one PDE-5 inhibitor AND one endothelin receptor antagonist. Documentation of platelet count of greater than 50,000/mm3.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

XDEMVY

Products Affected

- XDEMVY

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

XELJANZ

Products Affected

- *tofacitinib citrate er*
- *tofacitinib citrate oral solution*
- *tofacitinib citrate oral tablet*

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Specialist for submitted diagnosis.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	For ankylosing spondylitis: Trial of, medical reason for not using, or contraindication to naproxen and 1 of the following: an adalimumab product, Enbrel, or Cosentyx. For pJIA: Trial of, medical reason for not using, or contraindication to 1 of the following DMARDs: methotrexate or leflunomide and 1 of the following: an adalimumab product or Enbrel. For PsA: Trial of, medical reason for not using, or contraindication to 1 of the following: Enbrel, an adalimumab product, or Cosentyx. For RA: Trial of, medical reason for not using, or contraindication to 1 disease modifying antirheumatic drug (DMARD) (methotrexate, leflunomide, or sulfasalazine) and 1 of the following: Enbrel or an adalimumab product. For UC: Approve. Continuation of therapy: patient has been receiving tofacitinib for a minimum of 4 months and has a positive clinical response.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

XERMELO

Products Affected

- XERMELO

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

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

XIFAXAN

Products Affected

- XIFAXAN

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

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

XOLAIR

Products Affected

- XOLAIR

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

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

PA Criteria	Criteria Details
	corticosteroid, will be prescribed an intranasal corticosteroid with request, or has a medical reason for not using an intranasal corticosteroid. Continuation of therapy or reauthorization criteria for nasal polyps: 1) Documentation has been provided that demonstrates a clinical benefit (e.g. improvements in symptom severity, nasal polyp score [NPS], sino-nasal outcome test-22 [SNOT-22], nasal congestion score [NCS]) AND 2) continued use of intranasal corticosteroid, or has a medical reason for not using one. New starts for food allergy: 1) diagnosis of IgE-mediated food allergy 2) Xolair will be used in conjunction with food allergen avoidance. Continuation of therapy or reauthorization criteria for food allergy: 1) Documentation of clinical benefit
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

XOLREMDI

Products Affected

- XOLREMDI

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be an immunologist or a hematologist
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	For new starts: 1) A documented diagnosis of WHIM (warts, hypogammaglobulinemia, infections and myelokathexis) syndrome confirmed by genotype variant of chemokine receptor 4 (CXCR4) and absolute neutrophil count (ANC) of less than or equal to 400 cells/microliter or white blood cells (WBC) less than or equal to 400 cells/microliter and 2) Documentation of baseline ANC and absolute lymphocyte count (ALC). For renewal 1) Documentation or provider attestation of positive clinical response (i.e. improvement from baseline in ANC, WBC and/or ALC or reduced frequency, duration, or severity of infections, fewer warts, or improved or stabilized clinical signs and/or symptoms of WHIM).
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

PA Criteria	Criteria Details
Prerequisite Therapy Required	No

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

XYWAV

Products Affected

- XYWAV

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

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

YORVIPATH

Products Affected

- YORVIPATH

PA Criteria	Criteria Details
Exclusion Criteria	Diagnosis of acute post-surgical hypoparathyroidism.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an endocrinologist.
Coverage Duration	New starts will be authorized for 6 months. Cont of therapy or reauth until end of contract year.
Other Criteria	For new starts: 1) Documented diagnosis of chronic hypoparathyroidism AND 2) Provider attestation that patient is currently receiving or has medical reason for not receiving calcium supplementation and active vitamin D treatment AND 3) An albumin-corrected serum calcium level of 7.8 mg/dL or greater. For reauthorization: Documentation of improvement in albumin-corrected serum calcium from baseline.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	No

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

YUTREPIA

Products Affected

- YUTREPIA

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

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

ZEPBOUND

Products Affected

- ZEPBOUND KWIKPEN
- ZEPBOUND SUBCUTANEOUS SOLUTION AUTO-INJECTOR

PA Criteria	Criteria Details
Exclusion Criteria	The member has an indication of only weight reduction or maintenance for overweight or obesity. The member has concurrent use of any GLP-1 receptor agonist. The member has a personal history of medullary thyroid carcinoma. The member has Multiple Endocrine Neoplasia syndrome type 2.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a sleep disorder specialist, pulmonologist, ENT, or other provider specializing in obstructive sleep apnea.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	For new starts: The member has an indication for moderate to severe obstructive sleep apnea (OSA) in adults with obesity. Documentation of diagnosis of OSA through polysomnography (sleep study) with an apnea-hypopnea index of 15 or more events per hour, or five or more events per hour in the presence of symptoms (e.g., cognitive impairment, fatigue, insomnia, loud snoring) or cardiovascular comorbidities (e.g., hypertension, ischemic heart disease, previous stroke). Documentation is provided that the patient is obese (defined as a BMI of greater than or equal to 30 kg/m2). For continuation of therapy: Documentation of positive response to treatment. Documentation member has achieved and/or maintained a decrease in weight since baseline.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

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

ZEPOSIA

Products Affected

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

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

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

ZILBRYSQ

Products Affected

- ZILBRYSQ

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a neurologist, rheumatologist, or other appropriate specialist
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	Patient has tried and failed, a medical reason for not using, or has a contraindication to two (2) or more conventional therapies (i.e. pyridostigmine, corticosteroids, or non-steroidal immunosuppressive therapies)
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

ZTALMY

Products Affected

- ZTALMY

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

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

ZURZUVAE

Products Affected

- ZURZUVAE

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

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

PART B VERSUS PART D

Products Affected

- *acetylcysteine inhalation solution 10 %, 20 %*
- *acyclovir sodium intravenous solution 50 mg/ml*
- *albuterol sulfate inhalation nebulization solution (2.5 mg/3ml) 0.083%, (5 mg/ml) 0.5%, 0.63 mg/3ml, 1.25 mg/3ml, 2.5 mg/0.5ml*
- *amphotericin b intravenous solution reconstituted 50 mg*
- *amphotericin b liposome intravenous suspension reconstituted 50 mg*
- *aprepitant oral capsule 125 mg, 40 mg, 80 mg*
- *aprepitant oral capsule therapy pack 80 & 125 mg*
- ASTAGRAF XL ORAL CAPSULE EXTENDED RELEASE 24 HOUR 0.5 MG, 1 MG, 5 MG
- *azathioprine oral tablet 50 mg*
- *budesonide inhalation suspension 0.25 mg/2ml, 0.5 mg/2ml, 1 mg/2ml*
- CLINISOL SF INTRAVENOUS SOLUTION 15 %
- *cromolyn sodium inhalation nebulization solution 20 mg/2ml*
- *cyclophosphamide oral capsule 25 mg, 50 mg*
- *cyclophosphamide oral tablet 25 mg, 50 mg*
- *cyclosporine modified oral capsule 100 mg, 25 mg, 50 mg*
- *cyclosporine modified oral solution 100 mg/ml*
- *cyclosporine oral capsule 100 mg, 25 mg*
- *dronabinol oral capsule 10 mg, 2.5 mg, 5 mg*
- EMEND ORAL SUSPENSION RECONSTITUTED 125 MG/5ML
- ENGERIX-B INJECTION SUSPENSION 20 MCG/ML
- ENGERIX-B INJECTION SUSPENSION PREFILLED SYRINGE 10 MCG/0.5ML, 20 MCG/ML
- ENVARSUS XR ORAL TABLET EXTENDED RELEASE 24 HOUR 0.75 MG, 1 MG, 4 MG
- *everolimus oral tablet 0.25 mg, 0.5 mg, 0.75 mg, 1 mg*
- *formoterol fumarate inhalation nebulization solution 20 mcg/2ml*
- GAMMAGARD ERC INJECTION SOLUTION 10 GM/100ML, 5 GM/50ML
- GAMMAGARD INJECTION SOLUTION 1 GM/10ML, 10 GM/100ML, 2.5 GM/25ML, 20 GM/200ML, 30 GM/300ML, 5 GM/50ML
- GAMMAGARD S/D LESS IGA INTRAVENOUS SOLUTION RECONSTITUTED 10 GM, 5 GM
- GAMMAKED INJECTION SOLUTION 1 GM/10ML, 10 GM/100ML, 20 GM/200ML, 5 GM/50ML
- GAMMAPLEX INTRAVENOUS SOLUTION 10 GM/100ML, 10 GM/200ML, 20 GM/200ML, 20 GM/400ML, 5 GM/100ML, 5 GM/50ML
- GAMUNEX-C INJECTION SOLUTION 1 GM/10ML, 10 GM/100ML, 2.5 GM/25ML, 20 GM/200ML, 40 GM/400ML, 5 GM/50ML
- GENGRAF ORAL CAPSULE 100 MG, 25 MG
- *granisetron hcl oral tablet 1 mg*
- HEPLISAV-B INTRAMUSCULAR SOLUTION PREFILLED SYRINGE 20 MCG/0.5ML

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

- IMOVAX RABIES INTRAMUSCULAR SUSPENSION RECONSTITUTED 2.5 UNIT/ML
- INTRALIPID INTRAVENOUS EMULSION 20 %, 30 %
- *ipratropium bromide inhalation solution 0.02 %*
- *ipratropium-albuterol inhalation solution 0.5-2.5 (3) mg/3ml*
- *levalbuterol hcl inhalation nebulization solution 0.31 mg/3ml, 0.63 mg/3ml, 1.25 mg/3ml*
- *mycophenolate mofetil oral capsule 250 mg*
- *mycophenolate mofetil oral suspension reconstituted 200 mg/ml*
- *mycophenolate mofetil oral tablet 500 mg*
- *mycophenolate sodium oral tablet delayed release 180 mg, 360 mg*
- NUTRILIPID INTRAVENOUS EMULSION 20 %
- OCTAGAM INTRAVENOUS SOLUTION 1 GM/20ML, 10 GM/100ML, 10 GM/200ML, 2 GM/20ML, 2.5 GM/50ML, 20 GM/200ML, 30 GM/300ML, 5 GM/100ML, 5 GM/50ML
- *ondansetron hcl oral solution 4 mg/5ml*
- *ondansetron hcl oral tablet 24 mg, 4 mg, 8 mg*
- *ondansetron oral tablet dispersible 4 mg, 8 mg*
- *pentamidine isethionate inhalation solution reconstituted 300 mg*
- PLENAMINE INTRAVENOUS SOLUTION 15 %
- PRIVIGEN INTRAVENOUS SOLUTION 10 GM/100ML, 20 GM/200ML, 40 GM/400ML, 5 GM/50ML
- PROGRAF INTRAVENOUS SOLUTION 5 MG/ML
- PROGRAF ORAL PACKET 0.2 MG, 1 MG
- PULMOZYME INHALATION SOLUTION 2.5 MG/2.5ML
- RABAVERT INTRAMUSCULAR SUSPENSION RECONSTITUTED
- RECOMBIVAX HB INJECTION SUSPENSION 10 MCG/ML, 40 MCG/ML, 5 MCG/0.5ML
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- *tacrolimus intravenous solution 5 mg/ml*
- *tacrolimus oral capsule 0.5 mg, 1 mg, 5 mg*
- TENIVAC INTRAMUSCULAR INJECTABLE 5-2 LFU (INJECTION)
- TENIVAC INTRAMUSCULAR SUSPENSION 5-2 LF/0.5ML
- *tobramycin inhalation nebulization solution 300 mg/4ml, 300 mg/5ml*

Details

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

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Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

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Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

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Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

anticonvulsant step therapy

Products Affected

- *levetiracetam tablet disintegrating soluble 250 mg oral*
- *levetiracetam tablet disintegrating soluble 500 mg oral*
- *perampanel suspension 0.5 mg/ml oral*
- *perampanel tablet 10 mg oral*
- *perampanel tablet 12 mg oral*
- *perampanel tablet 2 mg oral*
- *perampanel tablet 4 mg oral*
- *perampanel tablet 6 mg oral*
- *perampanel tablet 8 mg oral*
- RELGAABI CAPSULE 200 MG ORAL
- RELGAABI CAPSULE 300 MG ORAL
- RELGAABI CAPSULE 400 MG ORAL
- SPRITAM TABLET DISINTEGRATING SOLUBLE 250 MG ORAL
- SPRITAM TABLET DISINTEGRATING SOLUBLE 500 MG ORAL
- SYMPAZAN FILM 10 MG ORAL
- SYMPAZAN FILM 20 MG ORAL
- SYMPAZAN FILM 5 MG ORAL
- XCOPRI (250 MG DAILY DOSE) TABLET THERAPY PACK 100 & 150 MG ORAL
- XCOPRI (350 MG DAILY DOSE) TABLET THERAPY PACK 150 & 200 MG ORAL
- XCOPRI TABLET 100 MG ORAL
- XCOPRI TABLET 150 MG ORAL
- XCOPRI TABLET 200 MG ORAL
- XCOPRI TABLET 25 MG ORAL
- XCOPRI TABLET 50 MG ORAL
- XCOPRI TABLET THERAPY PACK 14 X 12.5 MG & 14 X 25 MG ORAL
- XCOPRI TABLET THERAPY PACK 14 X 150 MG & 14 X200 MG ORAL
- XCOPRI TABLET THERAPY PACK 14 X 50 MG & 14 X100 MG ORAL
- ZONISADE SUSPENSION 100 MG/5ML ORAL

Details

Criteria	Step 1: First line therapy should be a documented trial, failure, or contraindication of two generic anticonvulsants. Step 2: Once two generic anticonvulsants have been tried, failed, or contraindicated patients can receive therapy with Spritam, Sympazan, Xcopri, generic perampanel, generic levetiracetam tablet for oral suspension, Relgaabi, or Zonisade oral solution.

antidepressant step therapy

Products Affected

- EXXUA TABLET EXTENDED RELEASE 24 HOUR 18.2 MG ORAL
- EXXUA TABLET EXTENDED RELEASE 24 HOUR 36.3 MG ORAL
- EXXUA TABLET EXTENDED RELEASE 24 HOUR 54.5 MG ORAL
- EXXUA TABLET EXTENDED RELEASE 24 HOUR 72.6 MG ORAL
- EXXUA TITRATION PACK TABLET EXTENDED RELEASE 24 HOUR 18.2 MG ORAL
- FETZIMA CAPSULE EXTENDED RELEASE 24 HOUR 120 MG ORAL
- FETZIMA CAPSULE EXTENDED RELEASE 24 HOUR 20 MG ORAL
- FETZIMA CAPSULE EXTENDED RELEASE 24 HOUR 40 MG ORAL
- FETZIMA CAPSULE EXTENDED RELEASE 24 HOUR 80 MG ORAL
- FETZIMA TITRATION CAPSULE ER 24 HOUR THERAPY PACK 20 & 40 MG ORAL

Details

Criteria	Step 1: First line therapy should be a documented trial, failure, or contraindication of two generic antidepressants. Step 2: Once two generic antidepressants have been tried, failed, or contraindicated patient can receive therapy with Fetzima or Exxua.

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

brinzolamide and dorzolamide-timolol PF step therapy

Products Affected

- *brinzolamide suspension 1 % ophthalmic*
- *dorzolamide hcl-timolol mal pf solution 2-0.5 % ophthalmic*

Details

Criteria	Step 1: First line therapy should be a documented trial, failure, or contraindication of formulary dorzolamide or dorzolamide/timolol ophthalmic solution. Step 2: Once dorzolamide or dorzolamide/timolol ophthalmic solution has been tried, failed, or contraindicated the patient can receive therapy with brinzolamide or dorzolamide-timolol PF ophthalmic Solution.

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

drizalma step therapy

Products Affected

- DRIZALMA SPRINKLE CAPSULE DELAYED RELEASE SPRINKLE 20 MG ORAL
- DRIZALMA SPRINKLE CAPSULE DELAYED RELEASE SPRINKLE 30 MG ORAL
- DRIZALMA SPRINKLE CAPSULE DELAYED RELEASE SPRINKLE 40 MG ORAL
- DRIZALMA SPRINKLE CAPSULE DELAYED RELEASE SPRINKLE 60 MG ORAL

Details

Criteria	Step 1: First line therapy should be a documented trial, failure, or contraindication of generic formulary duloxetine. Step 2: Once generic formulary duloxetine has been tried, failed, or contraindicated the patient can receive therapy with drizalma.

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

febuxostat step therapy

Products Affected

- *febuxostat tablet 40 mg oral*
- *febuxostat tablet 80 mg oral*

Details

Criteria	Step 1: First line therapy should be a documented trial, failure, or contraindication of allopurinol tablet. Step 2: Once allopurinol tablet has been tried, failed, or contraindicated patients can receive therapy with Febuxostat.

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

netarsudil step therapy

Products Affected

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

Details

Criteria	Step 1: First line therapy should be a documented trial, failure, or contraindication of latanoprost or travoprost. Step 2: Once latanoprost or travoprost has been tried, failed, or contraindicated patients can receive therapy with Rhopressa or Rocklatan.

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

ongentys step therapy

Products Affected

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

Details

Criteria	Step 1: First line therapy should be a documented trial, failure, or contraindication of entacapone or carbidopa-levodopa-entacapone. Step 2: Once entacapone or carbidopa-levodopa-entacapone has been tried, failed, or contraindicated patients can receive therapy with Ongentys.

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

savella step therapy

Products Affected

- SAVELLA TITRATION PACK 12.5 & 25 & 50 MG ORAL

Details

Criteria	Step 1: First line therapy should be a documented trial, failure, or contraindication to duloxetine, milnacipran or pregabalin. Step 2: Once duloxetine, milnacipran or pregabalin has been tried, failed or contraindicated patients can receive therapy with Savella.

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

topical immunomodulators step therapy

Products Affected

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

Details

Criteria	Step 1: First line therapy should be a documented trial, failure, or contraindication of two topical corticosteroids. Step 2: Once two topical corticosteroids have been tried, failed, or contraindicated patients can receive therapy with generic pimecrolimus or generic topical tacrolimus.

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

urinary incontinence agents step therapy

Products Affected

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

Details

Criteria	Step 1: First line therapy should be a documented trial, failure or contraindication of 2 of the following: oxybutynin, oxybutynin ER, trospium, tolterodine, tolterodine ER, fesoterodine ER, or solifenacin. Step 2: Once two of the medications listed in Step 1 have been tried, failed, or contraindicated, patients can receive therapy with trospium ER or darifenacin ER

Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

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EXXUA TABLET EXTENDED RELEASE 24 HOUR 54.5 MG ORAL 404
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Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

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Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to Pages 7-8.

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

2026 Formulary

List of Covered Drugs
Formulary ID#: 26314

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

This formulary was updated on 10/30/2026. For more recent information or other questions, please contact Pharmacy Member Service at 1-866-423-8065 (TTY users should call 711), Monday through Sunday, 24 hours a day, or visit **http://www.troymedicare.com**.

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

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