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

2027 Formulary

List of Covered Drugs

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

Formulary ID#: 27383

This formulary was updated on 10/7/2026. 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 October 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, 2027, 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 2027 formulary that was covered at the beginning of the year, we will not discontinue or reduce coverage of the drug during the 2027 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 October 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 11. The drugs in this formulary are grouped into categories depending on the type of medical conditions that they are used to treat. For example, drugs used to treat a heart condition are listed under the category, "Cardiovascular Agents - Treatment Of Conditions Affecting The Heart And Blood Vessels". If you know what your drug is used for, look for the category name in the list that begins on Page 11. Then look under the category name for your drug.

Alphabetical Listing
If you are not sure what category to look under, you should look for your drug in the Index that begins on Page 140. 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.
- **Prior Authorization New Start Only (PA NSO):** For certain medications Troy Medicare for Dual-eligible Beneficiaries (HMO D-SNP)/Troy Medicare (HMO) requires you or your physician to get prior authorization if it is your first time starting that drug therapy. 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.
- **Prior Authorization High Risk Medications (PA-HRM):** This drug has been deemed by CMS to be potentially harmful and therefore a High-Risk Medication for Medicare beneficiaries 65 years or older. Without prior authorization, this drug may not be covered.
- **PA New Starts Only High Risk Medications (PA NSO-HRM):** If you are a new member, you (or your physician) are required to get a prior authorization before you fill your prescription for this drug. This drug has been deemed by CMS to be potentially harmful and therefore a High-Risk Medication for Medicare beneficiaries 65 years or older. Without prior authorization, this drug may not be covered.
- **Prior Authorization BvD (PA BvD):** 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).
- **Age Limit (AGE):** Limits use of medication dependent on age.
- **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.
- **Limited Access (LA):** This prescription may be available only at certain pharmacies. For more information consult your Pharmacy Directory or call Member Services at 888-274-1750, 24 hours a day, 7 days a week. TTY/TDD users should call 711 TTY.

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

You can ask us to make an exception to these restrictions or limits or for a list of other, similar drugs that may treat your health condition. See the section, "**How do I request an exception to the Troy Medicare for Dual-eligible Beneficiaries (HMO D-SNP)/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 140.

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)/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.
- **Prior Authorization New Start Only (PA NSO):** For certain medications Troy Medicare for Dual-eligible Beneficiaries (HMO D-SNP)/Troy Medicare (HMO) requires you or your physician to get prior authorization if it is your first time starting that drug therapy. 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.
- **Prior Authorization High Risk Medications (PA-HRM):** This drug has been deemed by CMS to be potentially harmful and therefore a High-Risk Medication for Medicare beneficiaries 65 years or older. Without prior authorization, this drug may not be covered.
- **PA New Starts Only High Risk Medications (PA NSO-HRM):** If you are a new member, you (or your physician) are required to get a prior authorization before you fill your prescription for this drug. This drug has been deemed by CMS to be potentially harmful and therefore a High-Risk Medication for Medicare beneficiaries 65 years or older. Without prior authorization, this drug may not be covered.
- **Prior Authorization BvD (PA BvD):** 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).
- **Age Limit (AGE):** Limits use of medication dependent on age.
- **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.
- **Limited Access (LA):** This prescription may be available only at certain pharmacies. For more information consult your Pharmacy Directory or call Member Services at 888-274-1750, 24 hours a day, 7 days a week. TTY/TDD users should call 711 TTY.

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.

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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.

Drug Name	Drug Tier	Requirements/Limits
Analgesics		
Analgesics, Miscellaneous		
acetaminophen-codeine 300-30 mg/12.5 ml cup inner 300 mg-30 mg /12.5 ml	2	QL (4500 per 30 days)
acetaminophen-codeine oral solution 120-12 mg/5 ml	2	QL (4500 per 30 days)
acetaminophen-codeine oral tablet 300-15 mg, 300-30 mg	2	QL (360 per 30 days)
acetaminophen-codeine oral tablet 300-60 mg	2	QL (180 per 30 days)
buprenorphine transdermal patch weekly 10 mcg/hour, 15 mcg/hour, 20 mcg/hour, 5 mcg/hour, 7.5 mcg/hour	2	QL (4 per 28 days)
butalbital-acetaminop-caf-cod oral capsule 50-325-40-30 mg	2	PA-HRM; QL (180 per 30 days); AGE (Max 64 Years)
butalbital-acetaminophen-caff oral tablet 50-325-40 mg	2	PA-HRM; QL (180 per 30 days); AGE (Max 64 Years)
endocet oral tablet 10-325 mg	2	QL (180 per 30 days)
endocet oral tablet 2.5-325 mg, 5-325 mg	2	QL (360 per 30 days)
endocet oral tablet 7.5-325 mg	2	QL (240 per 30 days)
fentanyl citrate buccal lozenge on a handle 1,200 mcg, 1,600 mcg, 400 mcg, 600 mcg, 800 mcg	5	PA; QL (120 per 30 days)
fentanyl citrate buccal lozenge on a handle 200 mcg	2	PA; QL (120 per 30 days)
fentanyl transdermal patch 72 hour 100 mcg/hr, 12 mcg/hr, 25 mcg/hr, 50 mcg/hr, 75 mcg/hr	2	QL (10 per 30 days)
hydrocodone-acetaminophen oral solution 10-300 mg/15 ml, 10-325 mg/15 ml, 7.5-325 mg/15 ml	2	QL (2700 per 30 days)
hydrocodone-acetaminophen oral tablet 10-325 mg, 7.5-325 mg	2	QL (180 per 30 days)
hydrocodone-acetaminophen oral tablet 5-325 mg	2	QL (240 per 30 days)
hydromorphone oral tablet 2 mg, 4 mg, 8 mg	2	QL (180 per 30 days)
methadone oral solution 10 mg/5 ml	2	QL (600 per 30 days)
methadone oral solution 5 mg/5 ml	2	QL (1200 per 30 days)
methadone oral tablet 10 mg	2	QL (120 per 30 days)
methadone oral tablet 5 mg	2	QL (180 per 30 days)
morphine concentrate oral solution 100 mg/5 ml (20 mg/ml)	2	PA; QL (180 per 30 days)
morphine oral solution 10 mg/5 ml (2 mg/ml)	2	QL (700 per 30 days)

Drug Name	Drug Tier	Requirements/Limits
morphine oral solution 20 mg/5 ml (4 mg/ml)	2	QL (300 per 30 days)
MORPHINE ORAL TABLET 15 MG	4	QL (180 per 30 days)
MORPHINE ORAL TABLET 30 MG	4	QL (120 per 30 days)
morphine oral tablet extended release 100 mg, 60 mg	2	QL (60 per 30 days)
morphine oral tablet extended release 15 mg, 30 mg	2	QL (90 per 30 days)
morphine oral tablet extended release 200 mg	4	QL (60 per 30 days)
oxycodone oral capsule 5 mg	2	QL (180 per 30 days)
oxycodone oral tablet 10 mg, 5 mg	2	QL (180 per 30 days)
oxycodone oral tablet 15 mg, 20 mg, 30 mg	2	QL (120 per 30 days)
oxycodone-acetaminophen oral tablet 10-325 mg	2	QL (180 per 30 days)
oxycodone-acetaminophen oral tablet 2.5-325 mg, 5-325 mg	2	QL (360 per 30 days)
oxycodone-acetaminophen oral tablet 7.5-325 mg	2	QL (240 per 30 days)
tramadol oral tablet 50 mg	1	QL (240 per 30 days)
tramadol-acetaminophen oral tablet 37.5-325 mg	2	QL (300 per 30 days)
Nonsteroidal Anti-Inflammatory Agents		
celecoxib oral capsule 100 mg, 200 mg, 400 mg, 50 mg	2	QL (60 per 30 days)
diclofenac potassium oral tablet 50 mg	2	QL (120 per 30 days)
diclofenac sodium oral tablet extended release 24 hr 100 mg	2	
diclofenac sodium oral tablet,delayed release (dr/ec) 25 mg	2	
diclofenac sodium oral tablet,delayed release (dr/ec) 50 mg	2	QL (120 per 30 days)
diclofenac sodium oral tablet,delayed release (dr/ec) 75 mg	2	QL (60 per 30 days)
diclofenac-misoprostol oral tablet,ir,delayed rel,biphasic 50-200 mg-mcg, 75-200 mg-mcg	2	
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/5 ml	2	
ibuprofen oral tablet 400 mg, 600 mg, 800 mg	1	
indomethacin oral capsule 25 mg, 50 mg	2	PA-HRM; AGE (Max 64 Years)
ketorolac oral tablet 10 mg	2	PA-HRM; QL (20 per 30 days); AGE (Max 64 Years)

Please refer to our Evidence of Coverage for 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.

Drug Name	Drug Tier	Requirements/Limits
meloxicam oral tablet 15 mg, 7.5 mg	1	
nabumetone oral tablet 500 mg, 750 mg	2	
naproxen oral tablet 250 mg, 375 mg, 500 mg	1	
naproxen oral tablet,delayed release (dr/ec) 375 mg	2	
sulindac oral tablet 150 mg, 200 mg	2	
Anesthetics		
Local Anesthetics		
dermacinrx lidocan 5% patch outer	2	PA; QL (90 per 30 days)
glydo mucous membrane jelly in applicator 2 %	2	QL (30 per 30 days)
lidocaine hcl mucous membrane jelly in applicator 2 %	2	QL (30 per 30 days)
lidocaine hcl mucous membrane solution 2 %	2	
lidocaine topical adhesive patch,medicated 5 %	2	PA; QL (90 per 30 days)
lidocaine topical ointment 5 %	2	PA; QL (240 per 30 days)
lidocaine-prilocaine topical cream 2.5-2.5 %	2	PA; QL (30 per 30 days)
lidocan iii topical adhesive patch,medicated 5 %	2	PA; QL (90 per 30 days)
Anti-Addiction/Substance Abuse Treatment Agents		
Anti-Addiction/Substance Abuse Treatment Agents		
acamprosate oral tablet,delayed release (dr/ec) 333 mg	2	
buprenorphine hcl sublingual tablet 2 mg, 8 mg	2	
buprenorphine-naloxone sublingual film 12-3 mg, 2-0.5 mg, 4-1 mg, 8-2 mg	4	
buprenorphine-naloxone sublingual tablet 2-0.5 mg, 8-2 mg	2	
bupropion hcl (smoking deter) oral tablet extended release 12 hr 150 mg	2	
disulfiram oral tablet 250 mg, 500 mg	2	
KLOXXADO NASAL SPRAY,NON-AEROSOL 8 MG/ACTUATION	3	QL (4 per 30 days)
naloxone injection solution 0.4 mg/ml	2	
naloxone injection syringe 0.4 mg/ml, 0.4 mg/ml (prefilled syringe), 1 mg/ml	2	
naltrexone oral tablet 50 mg	2	
NICOTROL NS NASAL SPRAY,NON-AEROSOL 10 MG/ML	4	QL (240 per 180 days)

Drug Name	Drug Tier	Requirements/Limits
varenicline tartrate oral tablet 0.5 mg, 1 mg, 1 mg (56 pack)	2	QL (336 per 365 days)
varenicline tartrate oral tablets,dose pack 0.5 mg (11)- 1 mg (42)	2	
Antianxiety Agents		
Benzodiazepines		
alprazolam oral tablet 0.25 mg, 0.5 mg, 1 mg	1	QL (120 per 30 days)
alprazolam oral tablet 2 mg	1	QL (150 per 30 days)
chlordiazepoxide hcl oral capsule 10 mg, 25 mg, 5 mg	2	QL (120 per 30 days)
clonazepam oral tablet 0.5 mg, 1 mg	1	QL (90 per 30 days)
clonazepam oral tablet 2 mg	1	QL (300 per 30 days)
clonazepam oral tablet,disintegrating 0.125 mg, 0.25 mg, 0.5 mg, 1 mg	2	QL (90 per 30 days)
clonazepam oral tablet,disintegrating 2 mg	2	QL (300 per 30 days)
clorazepate dipotassium oral tablet 15 mg, 3.75 mg, 7.5 mg	2	QL (180 per 30 days)
diazepam injection solution 5 mg/ml	2	QL (10 per 28 days)
diazepam injection syringe 5 mg/ml	2	
diazepam intensol oral concentrate 5 mg/ml	2	QL (1200 per 30 days)
diazepam oral solution 5 mg/5 ml (1 mg/ml)	2	QL (1200 per 30 days)
diazepam oral tablet 10 mg, 2 mg, 5 mg	1	QL (120 per 30 days)
lorazepam 2 mg/ml oral concent	2	QL (150 per 30 days)
lorazepam 4 mg/ml vial inner	1	QL (2 per 30 days)
lorazepam injection solution 2 mg/ml	1	QL (2 per 30 days)
lorazepam injection solution 4 mg/ml	4	QL (2 per 30 days)
lorazepam injection syringe 2 mg/ml	1	QL (2 per 30 days)
lorazepam intensol oral concentrate 2 mg/ml	2	QL (150 per 30 days)
lorazepam oral tablet 0.5 mg, 1 mg	1	QL (90 per 30 days)
lorazepam oral tablet 2 mg	1	QL (150 per 30 days)
temazepam oral capsule 15 mg, 30 mg	1	QL (30 per 30 days)
temazepam oral capsule 22.5 mg	2	QL (30 per 30 days)
temazepam oral capsule 7.5 mg	2	QL (120 per 30 days)
Antibacterials		
Aminoglycosides		
amikacin injection solution 500 mg/2 ml	2	
ARIKAYCE INHALATION SUSPENSION FOR NEBULIZATION 590 MG/8.4 ML	5	PA; QL (235.2 per 28 days)
gentamicin injection solution 40 mg/ml	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.

Drug Name	Drug Tier	Requirements/Limits
gentamicin sulfate (ped) (pf) injection solution 20 mg/2 ml	2	
neomycin oral tablet 500 mg	2	
streptomycin intramuscular recon soln 1 gram	5	
TOBI PODHALER INHALATION CAPSULE, W/INHALATION DEVICE 28 MG	5	QL (224 per 28 days)
tobramycin in 0.225 % nacl inhalation solution for nebulization 300 mg/5 ml	5	PA BvD
tobramycin sulfate injection solution 10 mg/ml, 40 mg/ml	2	
Antibacterials, Miscellaneous		
clindamycin hcl oral capsule 150 mg, 300 mg, 75 mg	2	
clindamycin phosphate injection solution 150 (mg/ml) (4 ml), 150 (mg/ml) (6 ml), 150 mg/ml	2	
colistin (colistimethate na) injection recon soln 150 mg	2	
daptomycin intravenous recon soln 350 mg, 500 mg	2	PA BvD
fosfomycin tromethamine oral packet 3 gram	2	
linezolid in dextrose 5% intravenous piggyback 600 mg/300 ml	2	PA BvD
linezolid oral suspension for reconstitution 100 mg/5 ml	5	
linezolid oral tablet 600 mg	2	
methenamine hippurate oral tablet 1 gram	2	
metronidazole in nacl (iso-os) intravenous piggyback 500 mg/100 ml	2	PA BvD
metronidazole oral tablet 250 mg, 500 mg	2	
nitrofurantoin macrocrystal oral capsule 100 mg, 50 mg	2	QL (120 per 30 days)
nitrofurantoin monohyd/m-cryst oral capsule 100 mg	2	QL (60 per 30 days)
SIVEXTRO INTRAVENOUS RECON SOLN 200 MG	5	PA BvD
SIVEXTRO ORAL TABLET 200 MG	5	
trimethoprim oral tablet 100 mg	2	
vancomycin intravenous recon soln 1,000 mg, 10 gram, 500 mg, 750 mg	2	PA BvD
vancomycin oral capsule 125 mg	2	QL (77 per 28 days)

Drug Name	Drug Tier	Requirements/Limits
vancomycin oral capsule 250 mg	2	QL (112 per 14 days)
XIFAXAN ORAL TABLET 200 MG	3	PA; QL (9 per 30 days)
XIFAXAN ORAL TABLET 550 MG	3	PA; QL (90 per 30 days)
Cephalosporins		
cefaclor oral capsule 250 mg, 500 mg	2	
cefadroxil oral capsule 500 mg	2	
cefadroxil oral suspension for reconstitution 250 mg/5 ml, 500 mg/5 ml	2	
cefazolin injection recon soln 1 gram, 500 mg	2	
cefazolin intravenous recon soln 10 gram	2	
cefdinir oral capsule 300 mg	2	
cefdinir oral suspension for reconstitution 125 mg/5 ml, 250 mg/5 ml	2	
cefepime injection recon soln 1 gram, 2 gram	2	
cefixime oral capsule 400 mg	2	
cefixime oral tablet 400 mg	2	
cefpodoxime oral tablet 100 mg, 200 mg	2	
cefprozil oral tablet 250 mg, 500 mg	2	
ceftaroline fosamil intravenous recon soln 400 mg, 600 mg	5	PA BvD
ceftazidime injection recon soln 1 gram, 2 gram, 6 gram	2	
ceftriaxone injection recon soln 1 gram, 10 gram, 2 gram, 250 mg, 500 mg	2	
cefuroxime axetil oral tablet 250 mg, 500 mg	2	
cefuroxime sodium injection recon soln 750 mg	2	
cefuroxime sodium intravenous recon soln 1.5 gram, 7.5 gram	2	PA BvD
cephalexin oral capsule 250 mg, 500 mg	1	
cephalexin oral suspension for reconstitution 125 mg/5 ml, 250 mg/5 ml	2	
tazicef injection recon soln 1 gram, 2 gram, 6 gram	2	
Macrolides		
azithromycin intravenous recon soln 500 mg	2	
azithromycin oral suspension for reconstitution 100 mg/5 ml, 200 mg/5 ml	2	
azithromycin oral tablet 250 mg, 250 mg (6 pack), 500 mg, 500 mg (3 pack), 600 mg	1	

Drug Name	Drug Tier	Requirements/Limits
clarithromycin oral suspension for reconstitution 125 mg/5 ml, 250 mg/5 ml	2	
clarithromycin oral tablet 250 mg, 500 mg	2	
erythromycin ethylsuccinate oral suspension for reconstitution 200 mg/5 ml, 400 mg/5 ml	2	
erythromycin oral tablet 250 mg, 500 mg	2	
fidaxomicin oral tablet 200 mg	5	QL (20 per 10 days)
Miscellaneous B-Lactam Antibiotics		
aztreonam injection recon soln 1 gram, 2 gram	2	
CAYSTON INHALATION SOLUTION FOR NEBULIZATION 75 MG/ML	5	PA; LA
cefoxitin intravenous recon soln 1 gram, 10 gram, 2 gram	2	PA BvD
ertapenem injection recon soln 1 gram	2	
imipenem-cilastatin intravenous recon soln 250 mg, 500 mg	2	PA BvD
meropenem intravenous recon soln 1 gram, 2 gram, 500 mg	2	PA BvD
Penicillins		
amoxicillin oral capsule 250 mg, 500 mg	1	
amoxicillin oral suspension for reconstitution 125 mg/5 ml, 200 mg/5 ml	2	
amoxicillin oral suspension for reconstitution 250 mg/5 ml, 400 mg/5 ml	1	
amoxicillin oral tablet 500 mg, 875 mg	1	
amoxicillin oral tablet,chewable 125 mg, 250 mg	2	
amoxicillin-pot clavulanate oral suspension for reconstitution 200-28.5 mg/5 ml, 250-62.5 mg/5 ml, 400-57 mg/5 ml, 600-42.9 mg/5 ml	2	
amoxicillin-pot clavulanate oral tablet 250-125 mg, 500-125 mg, 875-125 mg	2	
ampicillin oral capsule 500 mg	2	
ampicillin sodium injection recon soln 1 gram, 10 gram, 125 mg	2	
ampicillin-sulbactam injection recon soln 1.5 gram, 15 gram, 3 gram	2	
BICILLIN L-A INTRAMUSCULAR SYRINGE 1,200,000 UNIT/2 ML, 2,400,000 UNIT/4 ML, 600,000 UNIT/ML	4	
dicloxacillin oral capsule 250 mg, 500 mg	2	

Drug Name	Drug Tier	Requirements/Limits
EXTENCILLINE INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION 1.2 MILLION UNIT, 2.4 MILLION UNIT	4	
LENTOCILIN S (WITH LIDOCAINE) INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION 1.2 MILLION UNIT-1.5 %	4	
nafcillin injection recon soln 1 gram, 10 gram, 2 gram	2	
penicillin g potassium injection recon soln 20 million unit	2	
penicillin v potassium oral recon soln 125 mg/5 ml, 250 mg/5 ml	2	
penicillin v potassium oral tablet 250 mg, 500 mg	1	
piperacillin-tazobactam intravenous recon soln 2.25 gram, 3.375 gram, 4.5 gram, 40.5 gram	2	PA BvD
Quinolones		
ciprofloxacin hcl oral tablet 250 mg, 500 mg, 750 mg	2	
ciprofloxacin in 5 % dextrose intravenous piggyback 200 mg/100 ml, 400 mg/200 ml	2	PA BvD
levofloxacin in d5w intravenous piggyback 250 mg/50 ml, 500 mg/100 ml, 750 mg/150 ml	2	PA BvD
levofloxacin oral tablet 250 mg, 500 mg, 750 mg	2	
moxifloxacin 400 mg/250 ml bag suv, p/f, inner	2	PA BvD
moxifloxacin oral tablet 400 mg	2	
moxifloxacin-sod.chloride(iso) intravenous piggyback 400 mg/250 ml	2	PA BvD
Sulfonamides		
sulfadiazine oral tablet 500 mg	5	
sulfamethoxazole-trimethoprim oral suspension 200-40 mg/5 ml	2	
sulfamethoxazole-trimethoprim oral tablet 400-80 mg, 800-160 mg	1	
Tetracyclines		
doxy-100 intravenous recon soln 100 mg	2	PA BvD
doxycycline hyclate intravenous recon soln 100 mg	2	PA BvD
doxycycline hyclate oral capsule 100 mg, 50 mg	2	
doxycycline hyclate oral tablet 100 mg, 20 mg	2	

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Drug Name	Drug Tier	Requirements/Limits
doxycycline monohydrate oral capsule 100 mg, 50 mg	2	
doxycycline monohydrate oral suspension for reconstitution 25 mg/5 ml	2	
doxycycline monohydrate oral tablet 100 mg, 50 mg	2	
minocycline oral capsule 100 mg, 50 mg, 75 mg	2	
tetracycline oral capsule 250 mg, 500 mg	2	
tigecycline intravenous recon soln 50 mg	2	PA BvD
Anticancer Agents		
Anticancer Agents		
abiraterone oral tablet 250 mg	2	PA NSO; QL (120 per 30 days)
abirtega oral tablet 250 mg	2	PA NSO; QL (120 per 30 days)
adrucil intravenous solution 2.5 gram/50 ml	2	PA BvD
AKEEGA ORAL TABLET 100-500 MG, 50-500 MG	5	PA NSO; QL (60 per 30 days)
ALECENSA ORAL CAPSULE 150 MG	5	PA NSO; QL (240 per 30 days)
ALUNBRIG ORAL TABLET 180 MG, 90 MG	5	PA NSO; QL (30 per 30 days)
ALUNBRIG ORAL TABLET 30 MG	5	PA NSO; QL (120 per 30 days)
ALUNBRIG ORAL TABLETS,DOSE PACK 90 MG (7)- 180 MG (23)	5	PA NSO
anastrozole oral tablet 1 mg	1	
AUGTYRO ORAL CAPSULE 160 MG	5	PA NSO; QL (60 per 30 days)
AUGTYRO ORAL CAPSULE 40 MG	5	PA NSO; QL (240 per 30 days)
AVMAPKI ORAL CAPSULE 0.8 MG	5	PA NSO; QL (24 per 28 days)
AVMAPKI-FAKZYNJA ORAL COMBO PACK 0.8-200 MG	5	PA NSO; QL (66 per 28 days)
AYVAKIT ORAL TABLET 100 MG, 200 MG, 25 MG, 300 MG, 50 MG	5	PA NSO; QL (30 per 30 days)
azacitidine injection recon soln 100 mg	5	
BALVERSA ORAL TABLET 3 MG	5	PA NSO; QL (84 per 28 days)
BALVERSA ORAL TABLET 4 MG	5	PA NSO; QL (56 per 28 days)
BALVERSA ORAL TABLET 5 MG	5	PA NSO; QL (28 per 28 days)
bendamustine intravenous recon soln 25 mg	2	PA NSO
BESREMI PEN SUBCUTANEOUS PEN INJECTOR 500 MCG/0.5 ML	5	PA NSO; QL (1 per 28 days)
BESREMI SUBCUTANEOUS SYRINGE 500 MCG/ML	5	PA NSO; QL (2 per 28 days)
bexarotene oral capsule 75 mg	2	PA NSO

Drug Name	Drug Tier	Requirements/Limits
bexarotene topical gel 1 %	5	PA NSO
bicalutamide oral tablet 50 mg	2	
bleomycin injection recon soln 15 unit, 30 unit	2	
bortezomib injection recon soln 1 mg, 2.5 mg	4	PA NSO
bortezomib injection recon soln 3.5 mg	5	PA NSO
BOSULIF ORAL CAPSULE 100 MG	5	PA NSO; QL (180 per 30 days)
BOSULIF ORAL CAPSULE 50 MG	5	PA NSO; QL (30 per 30 days)
BOSULIF ORAL TABLET 100 MG	5	PA NSO; QL (180 per 30 days)
BOSULIF ORAL TABLET 500 MG	5	PA NSO; QL (30 per 30 days)
bosutinib oral tablet 100 mg	5	PA NSO; QL (180 per 30 days)
bosutinib oral tablet 400 mg, 500 mg	5	PA NSO; QL (30 per 30 days)
BRAFTOVI ORAL CAPSULE 75 MG	5	PA NSO; QL (180 per 30 days)
BRUKINSA ORAL CAPSULE 80 MG	5	PA NSO; QL (120 per 30 days)
BRUKINSA ORAL TABLET 160 MG	5	PA NSO; QL (60 per 30 days)
CABOMETYX ORAL TABLET 20 MG, 60 MG	5	PA NSO; QL (30 per 30 days)
CABOMETYX ORAL TABLET 40 MG	5	PA NSO; QL (60 per 30 days)
CALQUENCE (ACALABRUTINIB MAL) ORAL TABLET 100 MG	5	PA NSO; QL (60 per 30 days)
CAMCEVI (6 MONTH) SUBCUTANEOUS SYRINGE 42 MG	4	PA NSO
CAPRELSA ORAL TABLET 100 MG	5	PA NSO; QL (60 per 30 days)
CAPRELSA ORAL TABLET 300 MG	5	PA NSO; QL (30 per 30 days)
COMETRIQ ORAL CAPSULE 100 MG/DAY(80 MG X1-20 MG X1), 60 MG/DAY (20 MG X 3/DAY)	5	PA NSO
COMETRIQ ORAL CAPSULE 140 MG/DAY(80 MG X1-20 MG X3)	5	PA NSO; QL (112 per 28 days)
COPIKTRA ORAL CAPSULE 15 MG, 25 MG	5	PA NSO; QL (56 per 28 days)
COTELLIC ORAL TABLET 20 MG	5	PA NSO; LA; QL (63 per 28 days)
cyclophosphamide intravenous recon soln 1 gram	2	PA BvD
cyclophosphamide intravenous recon soln 2 gram, 500 mg	5	PA BvD
cyclophosphamide intravenous solution 200 mg/ml	5	PA BvD
cyclophosphamide oral capsule 25 mg, 50 mg	2	PA BvD; ST
cyclophosphamide oral tablet 25 mg, 50 mg	3	PA BvD; ST
DANZITEN ORAL TABLET 71 MG, 95 MG	5	PA NSO; QL (112 per 28 days)
dasatinib oral tablet 100 mg, 140 mg, 50 mg, 70 mg, 80 mg	5	PA NSO; QL (30 per 30 days)

Drug Name	Drug Tier	Requirements/Limits
dasatinib oral tablet 20 mg	5	PA NSO; QL (90 per 30 days)
DAURISMO ORAL TABLET 100 MG	5	PA NSO; QL (30 per 30 days)
DAURISMO ORAL TABLET 25 MG	5	PA NSO; QL (60 per 30 days)
decitabine intravenous recon soln 50 mg	2	
doxorubicin, peg-liposomal intravenous suspension 2 mg/ml	5	PA BvD
ELIGARD (3 MONTH) SUBCUTANEOUS SYRINGE 22.5 MG	4	PA NSO
ELIGARD (4 MONTH) SUBCUTANEOUS SYRINGE 30 MG	4	PA NSO
ELIGARD (6 MONTH) SUBCUTANEOUS SYRINGE 45 MG	4	PA NSO
ELIGARD SUBCUTANEOUS SYRINGE 7.5 MG (1 MONTH)	4	PA NSO
ENSACOVE ORAL CAPSULE 100 MG	5	PA NSO; QL (60 per 30 days)
ENSACOVE ORAL CAPSULE 25 MG	5	PA NSO; QL (270 per 30 days)
ERIVEDGE ORAL CAPSULE 150 MG	5	PA NSO; QL (28 per 28 days)
ERLEADA ORAL TABLET 240 MG	5	PA NSO; QL (30 per 30 days)
ERLEADA ORAL TABLET 60 MG	5	PA NSO; QL (120 per 30 days)
erlotinib oral tablet 100 mg	5	PA NSO; QL (60 per 30 days)
erlotinib oral tablet 150 mg	5	PA NSO; QL (90 per 30 days)
erlotinib oral tablet 25 mg	2	PA NSO; QL (60 per 30 days)
etoposide intravenous solution 20 mg/ml	2	
EULEXIN ORAL CAPSULE 125 MG	5	
everolimus (antineoplastic) oral tablet 10 mg	5	PA NSO; QL (60 per 30 days)
everolimus (antineoplastic) oral tablet 2.5 mg, 5 mg	2	PA NSO; QL (30 per 30 days)
everolimus (antineoplastic) oral tablet 7.5 mg	2	PA NSO; QL (60 per 30 days)
everolimus (antineoplastic) oral tablet for suspension 2 mg, 3 mg, 5 mg	5	PA NSO; QL (112 per 28 days)
exemestane oral tablet 25 mg	2	
FIRMAGON KIT W DILUENT SYRINGE SUBCUTANEOUS RECON SOLN 120 MG	5	PA BvD
FIRMAGON KIT W DILUENT SYRINGE SUBCUTANEOUS RECON SOLN 80 MG	3	PA BvD
floxuridine injection recon soln 0.5 gram	2	PA BvD
fluorouracil intravenous solution 1 gram/20 ml, 5 gram/100 ml, 500 mg/10 ml	2	PA BvD
FOTIVDA ORAL CAPSULE 0.89 MG, 1.34 MG	5	PA NSO; QL (21 per 28 days)

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Drug Name	Drug Tier	Requirements/Limits
FRUZAQLA ORAL CAPSULE 1 MG	5	PA NSO; QL (84 per 28 days)
FRUZAQLA ORAL CAPSULE 5 MG	5	PA NSO; QL (21 per 28 days)
fulvestrant intramuscular syringe 250 mg/5 ml	2	
GAVRETO ORAL CAPSULE 100 MG	5	PA NSO; QL (120 per 30 days)
gefitinib oral tablet 250 mg	5	PA NSO; QL (60 per 30 days)
GILOTRIF ORAL TABLET 20 MG, 30 MG, 40 MG	5	PA NSO; QL (30 per 30 days)
GOMEKLI ORAL CAPSULE 1 MG	5	PA NSO; QL (224 per 28 days)
GOMEKLI ORAL CAPSULE 2 MG	5	PA NSO; QL (112 per 28 days)
GOMEKLI ORAL TABLET FOR SUSPENSION 1 MG	5	PA NSO; QL (224 per 28 days)
HERCEPTIN HYLECTA SUBCUTANEOUS SOLUTION 600 MG-10,000 UNIT/5 ML	5	PA NSO; QL (5 per 21 days)
HERNEXEOS ORAL TABLET 60 MG	5	PA NSO; QL (90 per 30 days)
hydroxyurea oral capsule 500 mg	2	
HYRNUO ORAL TABLET 10 MG	5	PA NSO; QL (120 per 30 days)
IBRANCE ORAL CAPSULE 100 MG, 125 MG, 75 MG	5	PA NSO; QL (21 per 28 days)
IBRANCE ORAL TABLET 100 MG, 125 MG, 75 MG	5	PA NSO; QL (21 per 28 days)
IBTROZI ORAL CAPSULE 200 MG	5	PA NSO; QL (90 per 30 days)
ICLUSIG ORAL TABLET 10 MG, 15 MG, 30 MG, 45 MG	5	PA NSO; QL (30 per 30 days)
IDHIFA ORAL TABLET 100 MG, 50 MG	5	PA NSO; QL (30 per 30 days)
ifosfamide intravenous recon soln 1 gram	2	
ifosfamide intravenous solution 1 gram/20 ml, 3 gram/60 ml	2	
imatinib oral tablet 100 mg	2	PA NSO; QL (180 per 30 days)
imatinib oral tablet 400 mg	2	PA NSO; QL (60 per 30 days)
IMBRUVICA ORAL CAPSULE 140 MG	5	PA NSO; QL (120 per 30 days)
IMBRUVICA ORAL CAPSULE 70 MG	5	PA NSO; QL (28 per 28 days)
IMBRUVICA ORAL SUSPENSION 70 MG/ML	5	PA NSO; QL (216 per 30 days)
IMBRUVICA ORAL TABLET 140 MG, 280 MG, 420 MG	5	PA NSO; QL (28 per 28 days)
IMKELDI ORAL SOLUTION 80 MG/ML	5	PA NSO; QL (280 per 28 days)
INLEXZO INTRAVESICAL IMPLANT 225 MG	5	PA BvD
INLURIYO ORAL TABLET 200 MG	5	PA NSO; QL (60 per 30 days)
INLYTA ORAL TABLET 1 MG	5	PA NSO; QL (180 per 30 days)

Drug Name	Drug Tier	Requirements/Limits
INLYTA ORAL TABLET 5 MG	5	PA NSO; QL (120 per 30 days)
INQOVI ORAL TABLET 35-100 MG	5	PA NSO; QL (5 per 28 days)
INREBIC ORAL CAPSULE 100 MG	5	PA NSO; QL (120 per 30 days)
ITOVEBI ORAL TABLET 3 MG	5	PA NSO; QL (60 per 30 days)
ITOVEBI ORAL TABLET 9 MG	5	PA NSO; QL (30 per 30 days)
IWILFIN ORAL TABLET 192 MG	5	PA NSO; QL (240 per 30 days)
JAKAFI ORAL TABLET 10 MG, 15 MG, 20 MG, 25 MG, 5 MG	5	PA NSO; QL (60 per 30 days)
JAKAFI XR ORAL TABLET EXTENDED RELEASE 24 HR 11 MG, 22 MG, 33 MG, 44 MG, 55 MG	5	PA NSO; QL (30 per 30 days)
JAYPIRCA ORAL TABLET 100 MG	5	PA NSO; QL (60 per 30 days)
JAYPIRCA ORAL TABLET 50 MG	5	PA NSO; QL (90 per 30 days)
JYLAMVO ORAL SOLUTION 2 MG/ML	4	PA BvD; ST
KEYTRUDA INTRAVENOUS SOLUTION 25 MG/ML	5	PA NSO
KEYTRUDA QLEX SUBCUTANEOUS SOLUTION 395 MG-4,800 UNIT/2.4 ML, 790 MG-9,600 UNIT/4.8 ML	5	PA NSO
KISQALI 200 MG DAILY DOSE 200 MG/DAY (200 MG X 1)	5	PA NSO; QL (21 per 28 days)
KISQALI FEMARA CO-PACK ORAL TABLET 200 MG/DAY(200 MG X 1)-2.5 MG	5	PA NSO; QL (49 per 28 days)
KISQALI FEMARA CO-PACK ORAL TABLET 400 MG/DAY(200 MG X 2)-2.5 MG	5	PA NSO; QL (70 per 28 days)
KISQALI FEMARA CO-PACK ORAL TABLET 600 MG/DAY(200 MG X 3)-2.5 MG	5	PA NSO; QL (91 per 28 days)
KISQALI ORAL TABLET 200 MG/DAY (200 MG X 1)	5	PA NSO; QL (21 per 28 days)
KISQALI ORAL TABLET 400 MG/DAY (200 MG X 2)	5	PA NSO; QL (42 per 28 days)
KISQALI ORAL TABLET 600 MG/DAY (200 MG X 3)	5	PA NSO; QL (63 per 28 days)
KOMZIFTI ORAL CAPSULE 200 MG	5	PA NSO
KOSELUGO ORAL CAPSULE 10 MG	5	PA NSO; QL (300 per 30 days)
KOSELUGO ORAL CAPSULE 25 MG	5	PA NSO; QL (120 per 30 days)
KOSELUGO ORAL CAPSULE, SPRINKLE 5 MG	5	PA NSO; QL (600 per 30 days)
KOSELUGO ORAL CAPSULE, SPRINKLE 7.5 MG	5	PA NSO; QL (390 per 30 days)

Drug Name	Drug Tier	Requirements/Limits
KRAZATI ORAL TABLET 200 MG	5	PA NSO; QL (180 per 30 days)
lapatinib oral tablet 250 mg	5	PA NSO
LAZCLUZE ORAL TABLET 240 MG	5	PA NSO; QL (30 per 30 days)
LAZCLUZE ORAL TABLET 80 MG	5	PA NSO; QL (60 per 30 days)
lenalidomide oral capsule 10 mg, 15 mg, 2.5 mg, 20 mg, 25 mg, 5 mg	5	PA NSO; QL (28 per 28 days)
LENVIMA ORAL CAPSULE 10 MG/DAY (10 MG X 1), 12 MG/DAY (4 MG X 3), 14 MG/DAY(10 MG X 1-4 MG X 1), 18 MG/DAY (10 MG X 1-4 MG X2), 20 MG/DAY (10 MG X 2), 24 MG/DAY(10 MG X 2-4 MG X 1), 4 MG, 8 MG/DAY (4 MG X 2)	5	PA NSO
letrozole oral tablet 2.5 mg	1	
LEUKERAN ORAL TABLET 2 MG	5	
leuprolide acetate (3 month) intramuscular suspension for reconstitution 22.5 mg	4	PA NSO
leuprolide subcutaneous kit 1 mg/0.2 ml	2	PA NSO
LIFYORLI ORAL CAPSULE 125 MG/DAY(100 MG X1-25MG X1), 125 MG/DAY(100 MG X1-25MG X3), 125 MG/DAY(100 MG X1-25MG X9), 150 MG/DAY(100 MG X1-25MG X2), 150 MG/DAY(100 MG X1-25MG X3), 150 MG/DAY(100 MG X1-25MG X9)	5	PA NSO
lomustine oral capsule 10 mg, 40 mg	2	
lomustine oral capsule 100 mg	5	
LONSURF ORAL TABLET 15-6.14 MG	5	PA NSO; QL (100 per 28 days)
LONSURF ORAL TABLET 20-8.19 MG	5	PA NSO; QL (80 per 28 days)
LORBRENA ORAL TABLET 100 MG	5	PA NSO; QL (30 per 30 days)
LORBRENA ORAL TABLET 25 MG	5	PA NSO; QL (90 per 30 days)
LUMAKRAS ORAL TABLET 120 MG	5	PA NSO; QL (240 per 30 days)
LUMAKRAS ORAL TABLET 240 MG	5	PA NSO; QL (120 per 30 days)
LUMAKRAS ORAL TABLET 320 MG	5	PA NSO; QL (90 per 30 days)
LUNSUMIO VELO SUBCUTANEOUS SOLUTION 45 MG/ML, 5 MG/0.5 ML	5	PA BvD
LUPRON DEPOT (3 MONTH) INTRAMUSCULAR SYRINGE KIT 22.5 MG	5	PA NSO
LUPRON DEPOT (4 MONTH) INTRAMUSCULAR SYRINGE KIT 30 MG	5	PA NSO

Drug Name	Drug Tier	Requirements/Limits
LUPRON DEPOT (6 MONTH) INTRAMUSCULAR SYRINGE KIT 45 MG	5	PA NSO
LUPRON DEPOT INTRAMUSCULAR SYRINGE KIT 7.5 MG	5	PA NSO
LUTRATE DEPOT (3 MONTH) INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION 22.5 MG	4	PA NSO
LYNPARZA ORAL TABLET 100 MG, 150 MG	5	PA NSO; QL (120 per 30 days)
LYSODREN ORAL TABLET 500 MG	5	
LYTGOBI ORAL TABLET 12 MG/DAY (4 MG X 3), 16 MG/DAY (4 MG X 4), 20 MG/DAY (4 MG X 5)	5	PA NSO; QL (140 per 28 days)
MATULANE ORAL CAPSULE 50 MG	5	
megestrol oral tablet 20 mg, 40 mg	2	PA NSO-HRM; AGE (Max 64 Years)
MEKINIST ORAL RECON SOLN 0.05 MG/ML	5	PA NSO; QL (1260 per 30 days)
MEKINIST ORAL TABLET 0.5 MG	5	PA NSO; QL (90 per 30 days)
MEKINIST ORAL TABLET 2 MG	5	PA NSO; QL (30 per 30 days)
MEKTOVI ORAL TABLET 15 MG	5	PA NSO; QL (180 per 30 days)
mercaptopurine oral suspension 20 mg/ml	5	
mercaptopurine oral tablet 50 mg	2	
methotrexate sodium (pf) injection recon soln 1 gram	2	
methotrexate sodium (pf) injection solution 25 mg/ml	2	
methotrexate sodium injection solution 25 mg/ml	2	
methotrexate sodium oral tablet 2.5 mg	2	PA BvD; ST
mitoxantrone intravenous concentrate 2 mg/ml	2	
MODEYSO ORAL CAPSULE 125 MG	5	PA NSO; QL (20 per 28 days)
NERLYNX ORAL TABLET 40 MG	5	PA NSO; QL (180 per 30 days)
nilotinib hcl oral capsule 150 mg, 200 mg	5	PA NSO; QL (112 per 28 days)
nilotinib hcl oral capsule 50 mg	5	PA NSO; QL (120 per 30 days)
nilutamide oral tablet 150 mg	5	
NINLARO ORAL CAPSULE 2.3 MG, 3 MG, 4 MG	5	PA NSO; QL (3 per 28 days)
NUBEQA ORAL TABLET 300 MG	5	PA NSO; QL (120 per 30 days)
ODOMZO ORAL CAPSULE 200 MG	5	PA NSO; LA
OGIVRI INTRAVENOUS RECON SOLN 150 MG, 420 MG	5	PA NSO
OGSIVEO ORAL TABLET 100 MG, 150 MG	5	PA NSO; QL (60 per 30 days)

Drug Name	Drug Tier	Requirements/Limits
OGSIVEO ORAL TABLET 50 MG	5	PA NSO; QL (180 per 30 days)
OJEMDA ORAL SUSPENSION FOR RECONSTITUTION 25 MG/ML	5	PA NSO; QL (96 per 28 days)
OJEMDA ORAL TABLET 400 MG/WEEK (100 MG X 4), 500 MG/WEEK (100 MG X 5), 600 MG/WEEK (100 MG X 6)	5	PA NSO; QL (24 per 28 days)
OJJAARA ORAL TABLET 100 MG, 150 MG, 200 MG	5	PA NSO; QL (30 per 30 days)
ONUREG ORAL TABLET 200 MG, 300 MG	5	PA NSO; QL (14 per 28 days)
OPDIVO INTRAVENOUS SOLUTION 100 MG/10 ML, 120 MG/12 ML, 240 MG/24 ML, 40 MG/4 ML	5	PA NSO
OPDIVO QVANTIG SUBCUTANEOUS SOLUTION 300 MG-5,000 UNIT/2.5 ML, 600 MG-10,000 UNIT/5 ML	5	PA NSO
ORSERDU ORAL TABLET 345 MG	5	PA NSO; QL (30 per 30 days)
ORSERDU ORAL TABLET 86 MG	5	PA NSO; QL (90 per 30 days)
paclitaxel protein-bound intravenous suspension for reconstitution 100 mg	5	PA BvD
pazopanib oral tablet 200 mg	5	PA NSO; QL (120 per 30 days)
pazopanib oral tablet 400 mg	5	PA NSO; QL (60 per 30 days)
PEMAZYRE ORAL TABLET 13.5 MG, 4.5 MG, 9 MG	5	PA NSO; QL (30 per 30 days)
pemetrexed disodium intravenous recon soln 1,000 mg, 100 mg	2	
pemetrexed disodium intravenous recon soln 500 mg, 750 mg	5	
pemetrexed disodium intravenous solution 25 mg/ml	5	
PIQRAY ORAL TABLET 200 MG/DAY (200 MG X 1)	5	PA NSO; QL (28 per 28 days)
PIQRAY ORAL TABLET 250 MG/DAY (200 MG X1-50 MG X1), 300 MG/DAY (150 MG X 2)	5	PA NSO; QL (56 per 28 days)
pomalidomide oral capsule 1 mg, 2 mg, 3 mg, 4 mg	5	PA NSO; QL (21 per 28 days)
POMALYST ORAL CAPSULE 1 MG, 2 MG, 3 MG, 4 MG	5	PA NSO; QL (21 per 28 days)
QINLOCK ORAL TABLET 50 MG	5	PA NSO; QL (90 per 30 days)

Drug Name	Drug Tier	Requirements/Limits
RETEVMO ORAL TABLET 120 MG, 160 MG, 80 MG	5	PA NSO; QL (60 per 30 days)
RETEVMO ORAL TABLET 40 MG	5	PA NSO; QL (90 per 30 days)
REVUFORJ ORAL TABLET 110 MG	5	PA NSO; QL (120 per 30 days)
REVUFORJ ORAL TABLET 160 MG	5	PA NSO; QL (60 per 30 days)
REVUFORJ ORAL TABLET 25 MG	5	PA NSO; QL (240 per 30 days)
REZLIDHIA ORAL CAPSULE 150 MG	5	PA NSO; QL (60 per 30 days)
ROMVIMZA ORAL CAPSULE 14 MG, 20 MG, 30 MG	5	PA NSO; QL (8 per 28 days)
ROZLYTREK ORAL CAPSULE 100 MG	5	PA NSO; QL (180 per 30 days)
ROZLYTREK ORAL CAPSULE 200 MG	5	PA NSO; QL (90 per 30 days)
ROZLYTREK ORAL PELLETS IN PACKET 50 MG	5	PA NSO; QL (360 per 30 days)
RUBRACA ORAL TABLET 200 MG, 250 MG, 300 MG	5	PA NSO; QL (120 per 30 days)
RYBREVANT FASPRO SUBCUTANEOUS SOLUTION 1,600 MG-20,000 UNIT/10 ML, 2,240 MG-28,000 UNIT/14 ML, 2,400 MG-30,000 UNIT/15 ML, 3,520 MG-44,000 UNIT/22 ML	5	PA NSO
RYBREVANT INTRAVENOUS SOLUTION 50 MG/ML	5	PA NSO
RYDAPT ORAL CAPSULE 25 MG	5	PA NSO; QL (224 per 28 days)
SCEMBLIX ORAL TABLET 100 MG	5	PA NSO; QL (120 per 30 days)
SCEMBLIX ORAL TABLET 20 MG	5	PA NSO; QL (60 per 30 days)
SCEMBLIX ORAL TABLET 40 MG	5	PA NSO; QL (300 per 30 days)
SOLTAMOX ORAL SOLUTION 20 MG/10 ML	5	
sorafenib oral tablet 200 mg	5	PA NSO; QL (120 per 30 days)
STIVARGA ORAL TABLET 40 MG	5	PA NSO; QL (84 per 28 days)
sunitinib malate oral capsule 12.5 mg, 25 mg, 37.5 mg, 50 mg	5	PA NSO; QL (28 per 28 days)
TABLOID ORAL TABLET 40 MG	5	
TABRECTA ORAL TABLET 150 MG, 200 MG	5	PA NSO; QL (112 per 28 days)
TAFINLAR ORAL CAPSULE 50 MG, 75 MG	5	PA NSO; QL (120 per 30 days)
TAFINLAR ORAL TABLET FOR SUSPENSION 10 MG	5	PA NSO; QL (900 per 30 days)
TAGRISSO ORAL TABLET 40 MG, 80 MG	5	PA NSO; LA; QL (30 per 30 days)
TALZENNA ORAL CAPSULE 0.1 MG, 0.25 MG, 0.35 MG, 0.5 MG, 0.75 MG, 1 MG	5	PA NSO; QL (30 per 30 days)
tamoxifen oral tablet 10 mg, 20 mg	2	

Drug Name	Drug Tier	Requirements/Limits
TEPMETKO ORAL TABLET 225 MG	5	PA NSO; QL (60 per 30 days)
TIBSOVO ORAL TABLET 250 MG	5	PA NSO; QL (60 per 30 days)
TICE BCG INTRAVESICAL SUSPENSION FOR RECONSTITUTION 50 MG	4	
toremifene oral tablet 60 mg	2	
torpenz oral tablet 10 mg	5	PA NSO; QL (60 per 30 days)
torpenz oral tablet 2.5 mg, 5 mg, 7.5 mg	5	PA NSO; QL (30 per 30 days)
tretinoin (antineoplastic) oral capsule 10 mg	5	
TRUQAP ORAL TABLET 160 MG, 200 MG	5	PA NSO; QL (64 per 28 days)
TUKYSA ORAL TABLET 150 MG	5	PA NSO; QL (120 per 30 days)
TUKYSA ORAL TABLET 50 MG	5	PA NSO; QL (300 per 30 days)
TURALIO ORAL CAPSULE 125 MG	5	PA NSO; QL (120 per 30 days)
VANFLYTA ORAL TABLET 17.7 MG, 26.5 MG	5	PA NSO
VENCLEXTA ORAL TABLET 10 MG	3	PA NSO; LA; QL (60 per 30 days)
VENCLEXTA ORAL TABLET 100 MG	5	PA NSO; LA; QL (180 per 30 days)
VENCLEXTA ORAL TABLET 50 MG	5	PA NSO; LA; QL (30 per 30 days)
VENCLEXTA STARTING PACK ORAL TABLETS,DOSE PACK 10 MG-50 MG- 100 MG	5	PA NSO; LA
VERZENIO ORAL TABLET 100 MG, 150 MG, 200 MG, 50 MG	5	PA NSO; QL (56 per 28 days)
vinorelbine intravenous solution 10 mg/ml, 50 mg/5 ml	2	
VITRAKVI ORAL CAPSULE 100 MG	5	PA NSO; QL (60 per 30 days)
VITRAKVI ORAL CAPSULE 25 MG	5	PA NSO; QL (180 per 30 days)
VITRAKVI ORAL SOLUTION 20 MG/ML	5	PA NSO; QL (300 per 30 days)
VIZIMPRO ORAL TABLET 15 MG, 30 MG, 45 MG	5	PA NSO; QL (30 per 30 days)
VONJO ORAL CAPSULE 100 MG	5	PA NSO; QL (120 per 30 days)
VORANIGO ORAL TABLET 10 MG, 40 MG	5	PA NSO
WELIREG ORAL TABLET 40 MG	5	PA NSO; QL (90 per 30 days)
XALKORI ORAL CAPSULE 200 MG, 250 MG	5	PA NSO; QL (120 per 30 days)
XALKORI ORAL PELLET 150 MG	5	PA NSO; QL (180 per 30 days)
XALKORI ORAL PELLET 20 MG	5	PA NSO; QL (240 per 30 days)
XALKORI ORAL PELLET 50 MG	5	PA NSO; QL (120 per 30 days)
XATMEP ORAL SOLUTION 2.5 MG/ML	4	PA BvD; ST
XOSPATA ORAL TABLET 40 MG	5	PA NSO; QL (90 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.

Drug Name	Drug Tier	Requirements/Limits
XPOVIO ORAL TABLET 100 MG/WEEK (50 MG X 2), 40MG TWICE WEEK (40 MG X 2), 80 MG/WEEK (40 MG X 2), 80 MG/WEEK (80 MG X 1)	5	PA NSO; QL (8 per 28 days)
XPOVIO ORAL TABLET 40 MG/WEEK (10 MG X 4)	5	PA NSO; QL (16 per 28 days)
XPOVIO ORAL TABLET 40 MG/WEEK (40 MG X 1), 60 MG/WEEK (60 MG X 1)	5	PA NSO; QL (4 per 28 days)
XPOVIO ORAL TABLET 60MG TWICE WEEK (120 MG/WEEK)	5	PA NSO; QL (24 per 28 days)
XPOVIO ORAL TABLET 80MG TWICE WEEK (160 MG/WEEK)	5	PA NSO; QL (32 per 28 days)
XTANDI ORAL CAPSULE 40 MG	5	PA NSO; QL (120 per 30 days)
XTANDI ORAL TABLET 40 MG	5	PA NSO; QL (120 per 30 days)
XTANDI ORAL TABLET 80 MG	5	PA NSO; QL (60 per 30 days)
YONSA ORAL TABLET 125 MG	5	PA NSO; QL (120 per 30 days)
yulithira oral tablet 10 mg, 7.5 mg	2	PA NSO; QL (60 per 30 days)
yulithira oral tablet 2.5 mg, 5 mg	2	PA NSO; QL (30 per 30 days)
ZEJULA ORAL TABLET 100 MG, 200 MG, 300 MG	5	PA NSO; QL (30 per 30 days)
ZELBORAF ORAL TABLET 240 MG	5	PA NSO; QL (240 per 30 days)
ZIRABEV INTRAVENOUS SOLUTION 25 MG/ML	5	PA BvD
ZOLINZA ORAL CAPSULE 100 MG	5	
ZYDELIG ORAL TABLET 100 MG, 150 MG	5	PA NSO; QL (60 per 30 days)
ZYKADIA ORAL TABLET 150 MG	5	PA NSO; QL (84 per 28 days)
Anticonvulsants		
Anticonvulsants		
brivaracetam intravenous solution 50 mg/5 ml	5	QL (80 per 30 days)
brivaracetam oral solution 10 mg/ml	2	QL (600 per 30 days)
brivaracetam oral tablet 10 mg, 100 mg, 25 mg, 50 mg, 75 mg	5	QL (60 per 30 days)
carbamazepine oral capsule, er multiphase 12 hr 100 mg, 200 mg, 300 mg	2	
carbamazepine oral suspension 100 mg/5 ml	2	
carbamazepine oral tablet 200 mg	2	
carbamazepine oral tablet extended release 12 hr 100 mg, 200 mg, 400 mg	2	
carbamazepine oral tablet,chewable 100 mg, 200 mg	2	

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Drug Name	Drug Tier	Requirements/Limits
clobazam oral suspension 2.5 mg/ml	2	QL (480 per 30 days)
clobazam oral tablet 10 mg, 20 mg	2	QL (60 per 30 days)
DIACOMIT ORAL CAPSULE 250 MG	5	PA NSO; QL (360 per 30 days)
DIACOMIT ORAL CAPSULE 500 MG	5	PA NSO; QL (180 per 30 days)
DIACOMIT ORAL POWDER IN PACKET 250 MG	5	PA NSO; QL (360 per 30 days)
DIACOMIT ORAL POWDER IN PACKET 500 MG	5	PA NSO; QL (180 per 30 days)
diazepam rectal kit 12.5-15-17.5-20 mg, 2.5 mg, 5-7.5-10 mg	2	
DILANTIN ORAL CAPSULE 30 MG	4	
divalproex oral capsule, delayed rel sprinkle 125 mg	2	
divalproex oral tablet extended release 24 hr 250 mg, 500 mg	2	
divalproex oral tablet,delayed release (dr/ec) 125 mg, 250 mg, 500 mg	2	
EPIDIOLEX ORAL SOLUTION 100 MG/ML	5	PA NSO
epitol oral tablet 200 mg	2	
eslicarbazepine oral tablet 200 mg, 400 mg	2	ST; QL (30 per 30 days)
eslicarbazepine oral tablet 600 mg, 800 mg	2	ST; QL (60 per 30 days)
ethosuximide oral capsule 250 mg	2	
ethosuximide oral solution 250 mg/5 ml	2	
felbamate oral suspension 600 mg/5 ml	2	
felbamate oral tablet 400 mg, 600 mg	2	
FINTEPLA ORAL SOLUTION 2.2 MG/ML	5	PA NSO
fosphenytoin injection solution 100 mg pe/2 ml, 500 mg pe/10 ml	2	
gabapentin oral capsule 100 mg, 300 mg	1	QL (360 per 30 days)
gabapentin oral capsule 400 mg	1	QL (270 per 30 days)
gabapentin oral solution 250 mg/5 ml	2	QL (2160 per 30 days)
gabapentin oral tablet 600 mg	2	QL (180 per 30 days)
gabapentin oral tablet 800 mg	2	QL (120 per 30 days)
lacosamide oral solution 10 mg/ml	2	QL (1200 per 30 days)
lacosamide oral tablet 100 mg, 150 mg, 200 mg, 50 mg	2	QL (60 per 30 days)
lamotrigine oral tablet 100 mg, 150 mg, 200 mg, 25 mg	1	

Drug Name	Drug Tier	Requirements/Limits
lamotrigine oral tablet, chewable dispersible 25 mg, 5 mg	2	
lamotrigine oral tablet,disintegrating 100 mg, 200 mg, 25 mg, 50 mg	2	
levetiracetam intravenous solution 500 mg/5 ml	2	
levetiracetam oral solution 100 mg/ml	2	
levetiracetam oral tablet 1,000 mg, 250 mg, 500 mg, 750 mg	2	
levetiracetam oral tablet extended release 24 hr 500 mg, 750 mg	2	
levetiracetam oral tablet for suspension 250 mg, 500 mg	4	ST
methsuximide oral capsule 300 mg	2	
NAYZILAM NASAL SPRAY,NON-AEROSOL 5 MG/SPRAY (0.1 ML)	4	PA NSO; QL (10 per 30 days)
oxcarbazepine oral suspension 300 mg/5 ml (60 mg/ml)	2	
oxcarbazepine oral tablet 150 mg, 300 mg, 600 mg	2	
perampanel oral suspension 0.5 mg/ml	5	ST; QL (720 per 30 days)
perampanel oral tablet 10 mg, 12 mg, 2 mg, 8 mg	2	ST; QL (30 per 30 days)
perampanel oral tablet 4 mg, 6 mg	2	ST; QL (60 per 30 days)
phenobarbital oral elixir 20 mg/5 ml (4 mg/ml)	2	PA NSO-HRM; AGE (Max 64 Years)
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 NSO-HRM; AGE (Max 64 Years)
phenytek oral capsule 200 mg, 300 mg	2	
phenytoin oral suspension 125 mg/5 ml	2	
phenytoin oral tablet,chewable 50 mg	2	
phenytoin sodium extended oral capsule 100 mg, 200 mg, 300 mg	2	
phenytoin sodium intravenous solution 50 mg/ml	2	
phenytoin sodium intravenous syringe 50 mg/ml	2	
pregabalin oral capsule 100 mg, 150 mg, 200 mg, 25 mg, 50 mg, 75 mg	2	QL (90 per 30 days)
pregabalin oral capsule 225 mg, 300 mg	2	QL (60 per 30 days)
pregabalin oral solution 20 mg/ml	2	QL (900 per 30 days)
primidone oral tablet 125 mg, 250 mg, 50 mg	2	
rufinamide oral suspension 40 mg/ml	5	ST
rufinamide oral tablet 200 mg, 400 mg	2	ST

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Drug Name	Drug Tier	Requirements/Limits
SPRITAM ORAL TABLET FOR SUSPENSION 1,000 MG, 750 MG	4	ST
SUBVENITE ORAL SUSPENSION 10 MG/ML	4	PA NSO
subvenite oral tablet 100 mg, 150 mg, 200 mg, 25 mg	1	
SYMPAZAN ORAL FILM 10 MG, 20 MG	5	PA NSO; QL (60 per 30 days)
SYMPAZAN ORAL FILM 5 MG	4	PA NSO; QL (60 per 30 days)
tiagabine oral tablet 12 mg, 16 mg, 2 mg, 4 mg	2	
topiramate oral capsule, sprinkle 15 mg, 25 mg, 50 mg	2	
topiramate oral solution 25 mg/ml	2	ST
topiramate oral tablet 100 mg, 200 mg, 25 mg, 50 mg	1	
valproate sodium intravenous solution 500 mg/5 ml (100 mg/ml)	2	
valproic acid (as sodium salt) oral solution 250 mg/5 ml	2	
valproic acid oral capsule 250 mg	2	
VALTOCO NASAL SPRAY,NON-AEROSOL 10 MG/SPRAY (0.1 ML), 15 MG/2 SPRAY (7.5/0.1ML X 2), 20 MG/2 SPRAY (10MG/0.1ML X2), 5 MG/SPRAY (0.1 ML)	5	PA NSO; QL (10 per 30 days)
vigabatrin oral powder in packet 500 mg	5	PA NSO; QL (180 per 30 days)
vigabatrin oral tablet 500 mg	5	PA NSO; QL (180 per 30 days)
vigadrone oral powder in packet 500 mg	5	PA NSO; QL (180 per 30 days)
vigadrone oral tablet 500 mg	5	PA NSO; QL (180 per 30 days)
vigpoder oral powder in packet 500 mg	5	PA NSO; QL (180 per 30 days)
XCOPRI MAINTENANCE PACK ORAL TABLET 250MG/DAY(150 MG X1-100MG X1), 350 MG/DAY (200 MG X1-150MG X1)	5	QL (56 per 28 days)
XCOPRI ORAL TABLET 100 MG, 25 MG, 50 MG	5	QL (30 per 30 days)
XCOPRI ORAL TABLET 150 MG, 200 MG	5	QL (60 per 30 days)
XCOPRI TITRATION PACK ORAL TABLETS,DOSE PACK 12.5 MG (14)- 25 MG (14)	4	
XCOPRI TITRATION PACK ORAL TABLETS,DOSE PACK 150 MG (14)- 200 MG (14), 50 MG (14)- 100 MG (14)	5	

Drug Name	Drug Tier	Requirements/Limits
ZONISADE ORAL SUSPENSION 100 MG/5 ML	5	
zonisamide oral capsule 100 mg, 25 mg, 50 mg	2	
ZTALMY ORAL SUSPENSION 50 MG/ML	5	PA NSO; QL (1080 per 30 days)
Antidementia Agents		
Antidementia Agents		
donepezil oral tablet 10 mg, 5 mg	1	QL (30 per 30 days)
donepezil oral tablet 23 mg	2	QL (30 per 30 days)
donepezil oral tablet,disintegrating 10 mg	2	
donepezil oral tablet,disintegrating 5 mg	2	QL (30 per 30 days)
ergoloid oral tablet 1 mg	2	
galantamine oral capsule,ext rel. pellets 24 hr 16 mg, 24 mg, 8 mg	2	QL (30 per 30 days)
galantamine oral solution 4 mg/ml	2	QL (200 per 30 days)
galantamine oral tablet 12 mg, 4 mg, 8 mg	2	QL (60 per 30 days)
LEQEMBI IQLIK SUBCUTANEOUS AUTO-INJECTOR 360 MG/1.8 ML	5	PA; QL (7.2 per 28 days)
memantine oral capsule,sprinkle,er 24hr 14 mg, 21 mg, 28 mg, 7 mg	2	ST; QL (30 per 30 days)
memantine oral solution 2 mg/ml	2	QL (300 per 30 days)
memantine oral tablet 10 mg, 5 mg	2	QL (60 per 30 days)
rivastigmine tartrate oral capsule 1.5 mg, 3 mg, 4.5 mg, 6 mg	2	
rivastigmine transdermal patch 24 hour 13.3 mg/24 hour, 4.6 mg/24 hour, 9.5 mg/24 hour	2	QL (30 per 30 days)
Antidepressants		
Antidepressants		
amitriptyline oral tablet 10 mg, 100 mg, 150 mg, 25 mg, 50 mg, 75 mg	2	
amoxapine oral tablet 100 mg, 150 mg, 25 mg, 50 mg	2	
AUVELITY ORAL TABLET, IR AND ER, BIPHASIC 45-105 MG	5	
AUVELITY ORAL TABLET,IR ER BIPHASIC,DOSEPACK 30 MG-105 MG /45 MG-105 MG	5	
bupropion hcl oral tablet 100 mg, 75 mg	2	
bupropion hcl oral tablet extended release 24 hr 150 mg, 300 mg	2	

Drug Name	Drug Tier	Requirements/Limits
bupropion hcl oral tablet sustained-release 12 hr 100 mg, 150 mg, 200 mg	1	
citalopram oral solution 10 mg/5 ml	2	
citalopram oral tablet 10 mg	1	QL (120 per 30 days)
citalopram oral tablet 20 mg, 40 mg	1	QL (30 per 30 days)
clomipramine oral capsule 25 mg, 50 mg, 75 mg	2	
desipramine oral tablet 10 mg, 100 mg, 150 mg, 25 mg, 50 mg, 75 mg	2	
desvenlafaxine succinate oral tablet extended release 24 hr 100 mg, 25 mg, 50 mg	2	QL (30 per 30 days)
doxepin oral capsule 10 mg, 100 mg, 150 mg, 25 mg, 50 mg, 75 mg	2	
doxepin oral concentrate 10 mg/ml	2	
DRIZALMA SPRINKLE ORAL CAPSULE, DELAYED REL SPRINKLE 20 MG, 30 MG, 60 MG	4	ST; QL (60 per 30 days)
DRIZALMA SPRINKLE ORAL CAPSULE, DELAYED REL SPRINKLE 40 MG	4	ST; QL (30 per 30 days)
duloxetine oral capsule,delayed release(dr/ec) 20 mg	2	QL (120 per 30 days)
duloxetine oral capsule,delayed release(dr/ec) 30 mg	2	QL (90 per 30 days)
duloxetine oral capsule,delayed release(dr/ec) 60 mg	2	QL (60 per 30 days)
EMSAM TRANSDERMAL PATCH 24 HOUR 12 MG/24 HR, 6 MG/24 HR, 9 MG/24 HR	5	ST; QL (30 per 30 days)
escitalopram oxalate oral solution 5 mg/5 ml	2	
escitalopram oxalate oral tablet 10 mg, 20 mg, 5 mg	1	
EXXUA ORAL TABLET EXTENDED RELEASE 24 HR 18.2 MG, 36.3 MG, 54.5 MG, 72.6 MG	5	PA NSO; QL (30 per 30 days)
EXXUA ORAL TABLET, EXT REL 24HR DOSE PACK 18.2 MG (32 TABS)	5	PA NSO; QL (30 per 30 days)
FETZIMA ORAL CAPSULE,EXT REL 24HR DOSE PACK 20 MG (2)- 40 MG (26)	4	ST
FETZIMA ORAL CAPSULE,EXTENDED RELEASE 24 HR 120 MG, 20 MG, 40 MG, 80 MG	4	ST; QL (30 per 30 days)
fluoxetine oral capsule 10 mg, 20 mg, 40 mg	1	

Drug Name	Drug Tier	Requirements/Limits
fluoxetine oral solution 20 mg/5 ml (4 mg/ml)	2	
fluvoxamine oral tablet 100 mg, 25 mg, 50 mg	2	
imipramine hcl oral tablet 10 mg, 25 mg, 50 mg	1	
MARPLAN ORAL TABLET 10 MG	4	
mirtazapine oral tablet 15 mg, 30 mg, 45 mg	1	
mirtazapine oral tablet 7.5 mg	2	
mirtazapine oral tablet,disintegrating 15 mg, 30 mg, 45 mg	2	
nefazodone oral tablet 100 mg, 150 mg, 200 mg, 250 mg, 50 mg	2	
nortriptyline oral capsule 10 mg, 25 mg, 50 mg, 75 mg	1	
nortriptyline oral solution 10 mg/5 ml	2	
paroxetine hcl oral suspension 10 mg/5 ml	2	PA NSO-HRM; AGE (Max 64 Years)
paroxetine hcl oral tablet 10 mg, 20 mg, 30 mg, 40 mg	1	PA NSO-HRM; AGE (Max 64 Years)
paroxetine hcl oral tablet extended release 24 hr 12.5 mg, 25 mg, 37.5 mg	2	PA NSO-HRM; AGE (Max 64 Years)
perphenazine-amitriptyline oral tablet 2-10 mg, 2-25 mg, 4-10 mg, 4-25 mg, 4-50 mg	2	
phenelzine oral tablet 15 mg	2	
protriptyline oral tablet 10 mg, 5 mg	2	
RALDESY ORAL SOLUTION 10 MG/ML	5	PA NSO; QL (1200 per 30 days)
sertraline oral concentrate 20 mg/ml	2	
sertraline oral tablet 100 mg, 25 mg, 50 mg	1	
tranylcypromine oral tablet 10 mg	2	
trazodone oral tablet 100 mg, 150 mg, 300 mg, 50 mg	1	
trimipramine oral capsule 100 mg, 25 mg, 50 mg	2	
TRINTELLIX ORAL TABLET 10 MG, 20 MG, 5 MG	4	QL (30 per 30 days)
venlafaxine oral capsule,extended release 24hr 150 mg	2	QL (30 per 30 days)
venlafaxine oral capsule,extended release 24hr 37.5 mg, 75 mg	2	QL (90 per 30 days)
venlafaxine oral tablet 100 mg, 25 mg, 37.5 mg, 50 mg, 75 mg	2	
vilazodone oral tablet 10 mg, 20 mg, 40 mg	2	QL (30 per 30 days)
ZURZUVAE ORAL CAPSULE 20 MG, 25 MG	5	PA NSO; QL (28 per 14 days)
ZURZUVAE ORAL CAPSULE 30 MG	5	PA NSO; QL (14 per 14 days)

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Drug Name	Drug Tier	Requirements/Limits
Antidiabetic Agents		
Antidiabetic Agents, Miscellaneous		
acarbose oral tablet 100 mg, 25 mg, 50 mg	2	
dapagliflozin oral tablet 10 mg, 5 mg	2	QL (30 per 30 days)
dapagliflozin-metformin oral tablet, ir - er, biphasic 24hr 10-1,000 mg, 10-500 mg, 5-1,000 mg, 5-500 mg	2	
FARXIGA ORAL TABLET 10 MG, 5 MG	3	QL (30 per 30 days)
GLYXAMBI ORAL TABLET 10-5 MG, 25-5 MG	3	QL (30 per 30 days)
JANUMET XR ORAL TABLET, ER MULTIPHASE 24 HR 100-1,000 MG	3	QL (30 per 30 days)
JANUMET XR ORAL TABLET, ER MULTIPHASE 24 HR 50-1,000 MG, 50-500 MG	3	QL (60 per 30 days)
JARDIANCE ORAL TABLET 10 MG, 25 MG	3	QL (30 per 30 days)
JENTADUETO ORAL TABLET 2.5-1,000 MG, 2.5-500 MG, 2.5-850 MG	3	QL (60 per 30 days)
JENTADUETO XR ORAL TABLET, IR - ER, BIPHASIC 24HR 2.5-1,000 MG	3	QL (60 per 30 days)
JENTADUETO XR ORAL TABLET, IR - ER, BIPHASIC 24HR 5-1,000 MG	3	QL (30 per 30 days)
metformin oral tablet 1,000 mg	1	QL (75 per 30 days)
metformin oral tablet 500 mg	1	QL (150 per 30 days)
metformin oral tablet 850 mg	1	QL (90 per 30 days)
metformin oral tablet extended release 24 hr 500 mg	1	QL (120 per 30 days)
metformin oral tablet extended release 24 hr 750 mg	1	QL (60 per 30 days)
mifepristone oral tablet 300 mg	5	PA; QL (112 per 28 days)
nateglinide oral tablet 120 mg, 60 mg	2	QL (90 per 30 days)
pioglitazone oral tablet 15 mg, 30 mg, 45 mg	1	QL (30 per 30 days)
pioglitazone-metformin oral tablet 15-500 mg, 15-850 mg	2	QL (90 per 30 days)
repaglinide oral tablet 0.5 mg, 1 mg	2	QL (120 per 30 days)
repaglinide oral tablet 2 mg	2	QL (240 per 30 days)
sitagliptin phos-metformin oral tablet 50-1,000 mg, 50-500 mg	2	QL (60 per 30 days)
sitagliptin phosphate oral tablet 100 mg, 25 mg, 50 mg	2	QL (30 per 30 days)

Drug Name	Drug Tier	Requirements/Limits
SYNJARDY ORAL TABLET 12.5-1,000 MG, 12.5-500 MG, 5-1,000 MG, 5-500 MG	3	QL (60 per 30 days)
SYNJARDY XR ORAL TABLET, IR - ER, BIPHASIC 24HR 10-1,000 MG, 25-1,000 MG	3	QL (30 per 30 days)
SYNJARDY XR ORAL TABLET, IR - ER, BIPHASIC 24HR 12.5-1,000 MG, 5-1,000 MG	3	QL (60 per 30 days)
TRADJENTA ORAL TABLET 5 MG	3	QL (30 per 30 days)
TRIJARDY XR ORAL TABLET, IR - ER, BIPHASIC 24HR 10-5-1,000 MG, 25-5-1,000 MG	3	QL (30 per 30 days)
TRIJARDY XR ORAL TABLET, IR - ER, BIPHASIC 24HR 12.5-2.5-1,000 MG, 5-2.5-1,000 MG	3	QL (60 per 30 days)
Insulins		
FIASP FLEXTOUCH U-100 INSULIN SUBCUTANEOUS INSULIN PEN 100 UNIT/ML (3 ML)	3	max $35 copay per month supply; QL (30 per 28 days)
FIASP PENFILL U-100 INSULIN SUBCUTANEOUS CARTRIDGE 100 UNIT/ML (3 ML)	3	max $35 copay per month supply; QL (30 per 28 days)
FIASP U-100 INSULIN SUBCUTANEOUS SOLUTION 100 UNIT/ML	3	max $35 copay per month supply; QL (40 per 28 days)
HUMULIN R U-500 (CONC) INSULIN SUBCUTANEOUS SOLUTION 500 UNIT/ML	3	max $35 copay per month supply; QL (40 per 28 days)
HUMULIN R U-500 (CONC) KWIKPEN SUBCUTANEOUS INSULIN PEN 500 UNIT/ML (3 ML)	3	max $35 copay per month supply; QL (24 per 28 days)
insulin glargine-yfgn subcutaneous insulin pen 100 unit/ml (3 ml)	3	max $35 copay per month supply; QL (30 per 28 days)
insulin glargine-yfgn subcutaneous solution 100 unit/ml	3	max $35 copay per month supply; QL (40 per 28 days)
insulin lispro subcutaneous solution 100 unit/ml	3	max $35 copay per month supply; QL (40 per 28 days)
LANTUS SOLOSTAR U-100 INSULIN SUBCUTANEOUS INSULIN PEN 100 UNIT/ML (3 ML)	3	max $35 copay per month supply; QL (30 per 28 days)
LANTUS U-100 INSULIN SUBCUTANEOUS SOLUTION 100 UNIT/ML	3	max $35 copay per month supply; QL (40 per 28 days)
NOVOLIN 70/30 U-100 INSULIN SUBCUTANEOUS SUSPENSION 100 UNIT/ML (70-30)	3	max $35 copay per month supply; QL (40 per 28 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.

Drug Name	Drug Tier	Requirements/Limits
NOVOLIN 70-30 FLEXPEN U-100 SUBCUTANEOUS INSULIN PEN 100 UNIT/ML (70-30)	3	max $35 copay per month supply; QL (30 per 28 days)
NOVOLIN N FLEXPEN SUBCUTANEOUS INSULIN PEN 100 UNIT/ML (3 ML)	3	max $35 copay per month supply; QL (30 per 28 days)
NOVOLIN N NPH U-100 INSULIN SUBCUTANEOUS SUSPENSION 100 UNIT/ML	3	max $35 copay per month supply; QL (40 per 28 days)
NOVOLIN R FLEXPEN SUBCUTANEOUS INSULIN PEN 100 UNIT/ML (3 ML)	3	max $35 copay per month supply; QL (30 per 28 days)
NOVOLIN R REGULAR U100 INSULIN INJECTION SOLUTION 100 UNIT/ML	3	max $35 copay per month supply; QL (40 per 28 days)
NOVOLOG FLEXPEN U-100 INSULIN SUBCUTANEOUS INSULIN PEN 100 UNIT/ML (3 ML)	3	max $35 copay per month supply; QL (30 per 28 days)
NOVOLOG MIX 70-30 U-100 INSULN SUBCUTANEOUS SOLUTION 100 UNIT/ML (70-30)	3	max $35 copay per month supply; QL (40 per 28 days)
NOVOLOG MIX 70-30FLEXPEN U-100 SUBCUTANEOUS INSULIN PEN 100 UNIT/ML (70-30)	3	max $35 copay per month supply; QL (30 per 28 days)
NOVOLOG PENFILL U-100 INSULIN SUBCUTANEOUS CARTRIDGE 100 UNIT/ML	3	max $35 copay per month supply; QL (30 per 28 days)
NOVOLOG U-100 INSULIN ASPART SUBCUTANEOUS SOLUTION 100 UNIT/ML	3	max $35 copay per month supply; QL (40 per 28 days)
SOLIQUA 100/33 SUBCUTANEOUS INSULIN PEN 100 UNIT-33 MCG/ML	3	max $35 copay per month supply; QL (15 per 25 days)
TOUJEO MAX U-300 SOLOSTAR SUBCUTANEOUS INSULIN PEN 300 UNIT/ML (3 ML)	3	max $35 copay per month supply; QL (18 per 28 days)
TOUJEO SOLOSTAR U-300 INSULIN SUBCUTANEOUS INSULIN PEN 300 UNIT/ML (1.5 ML)	3	max $35 copay per month supply; QL (13.5 per 28 days)
XULTOPHY 100/3.6 SUBCUTANEOUS INSULIN PEN 100 UNIT-3.6 MG /ML (3 ML)	3	max $35 copay per month supply; QL (15 per 28 days)
Sulfonylureas		
glimepiride oral tablet 1 mg, 2 mg	1	QL (30 per 30 days)
glimepiride oral tablet 4 mg	1	QL (60 per 30 days)
glipizide oral tablet 10 mg	1	QL (120 per 30 days)
glipizide oral tablet 2.5 mg	1	QL (90 per 30 days)

Drug Name	Drug Tier	Requirements/Limits
glipizide oral tablet 5 mg	1	QL (240 per 30 days)
glipizide oral tablet extended release 24hr 10 mg	1	QL (60 per 30 days)
glipizide oral tablet extended release 24hr 2.5 mg, 5 mg	1	QL (30 per 30 days)
glipizide-metformin oral tablet 2.5-250 mg	2	QL (240 per 30 days)
glipizide-metformin oral tablet 2.5-500 mg, 5-500 mg	2	QL (120 per 30 days)
glyburide micronized oral tablet 1.5 mg, 3 mg, 6 mg	1	PA-HRM; AGE (Max 64 Years)
glyburide oral tablet 1.25 mg, 2.5 mg, 5 mg	1	PA-HRM; AGE (Max 64 Years)
glyburide-metformin oral tablet 1.25-250 mg, 2.5-500 mg, 5-500 mg	1	PA-HRM; AGE (Max 64 Years)
Antifungals		
Antifungals		
ABELCET INTRAVENOUS SUSPENSION 5 MG/ML	4	PA BvD
amphotericin b injection recon soln 50 mg	2	PA BvD
amphotericin b liposome intravenous suspension for reconstitution 50 mg	5	PA BvD
ciclopirox topical cream 0.77 %	2	QL (180 per 30 days)
ciclopirox topical solution 8 %	2	QL (19.8 per 30 days)
ciclopirox topical suspension 0.77 %	4	QL (180 per 30 days)
clotrimazole mucous membrane troche 10 mg	2	
clotrimazole topical cream 1 %	2	
clotrimazole topical solution 1 %	2	
clotrimazole-betamethasone topical cream 1-0.05 %	2	QL (90 per 30 days)
CRESEMBA INTRAVENOUS RECON SOLN 372 MG	5	
CRESEMBA ORAL CAPSULE 186 MG, 74.5 MG	5	PA
econazole nitrate topical cream 1 %	2	QL (170 per 30 days)
fluconazole in nacl (iso-osm) intravenous piggyback 200 mg/100 ml, 400 mg/200 ml	2	
fluconazole oral suspension for reconstitution 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	

Drug Name	Drug Tier	Requirements/Limits
griseofulvin microsize oral suspension 125 mg/5 ml	2	
griseofulvin microsize oral tablet 500 mg	4	
griseofulvin ultramicrosize oral tablet 125 mg, 250 mg	4	
itraconazole oral capsule 100 mg	2	
ketoconazole oral tablet 200 mg	2	
ketoconazole topical cream 2 %	2	QL (180 per 30 days)
ketoconazole topical shampoo 2 %	2	QL (360 per 30 days)
micafungin intravenous recon soln 100 mg, 50 mg	2	
miconazole-3 vaginal suppository 200 mg	2	
nyamyc topical powder 100,000 unit/gram	2	QL (60 per 30 days)
nystatin oral suspension 100,000 unit/ml	2	
nystatin oral tablet 500,000 unit	2	
nystatin topical cream 100,000 unit/gram	2	QL (60 per 30 days)
nystatin topical ointment 100,000 unit/gram	2	QL (60 per 30 days)
nystatin topical powder 100,000 unit/gram	2	QL (60 per 30 days)
nystatin-triamcinolone topical cream 100,000-0.1 unit/g-%	2	
nystatin-triamcinolone topical ointment 100,000-0.1 unit/gram-%	2	
nystop topical powder 100,000 unit/gram	2	QL (60 per 30 days)
posaconazole oral tablet,delayed release (dr/ec) 100 mg	2	PA
terbinafine hcl oral tablet 250 mg	1	
voriconazole intravenous recon soln 200 mg	2	PA BvD
voriconazole intravenous solution 10 mg/ml	2	PA BvD
voriconazole oral suspension for reconstitution 200 mg/5 ml (40 mg/ml)	5	PA
voriconazole oral tablet 200 mg, 50 mg	2	
Antigout Agents		
Antigout Agents, Other		
allopurinol oral tablet 100 mg, 300 mg	1	
colchicine oral tablet 0.6 mg	2	QL (120 per 30 days)
febuxostat oral tablet 40 mg, 80 mg	4	QL (30 per 30 days)
probenecid oral tablet 500 mg	2	
probenecid-colchicine oral tablet 500-0.5 mg	2	
Antihistamines		

Please refer to our Evidence of Coverage for 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.

Drug Name	Drug Tier	Requirements/Limits
Antihistamines		
hydroxyzine hcl oral tablet 10 mg, 25 mg, 50 mg	1	
levocetirizine oral tablet 5 mg	1	
Antihypoglycemic Agents		
Antihypoglycemic Agents, Miscellaneous		
diazoxide oral suspension 50 mg/ml	5	
Antimigraine Agents		
Antimigraine Agents		
AIMOVIG AUTOINJECTOR SUBCUTANEOUS AUTO-INJECTOR 140 MG/ML, 70 MG/ML	3	PA; QL (1 per 30 days)
dihydroergotamine nasal spray,non-aerosol 0.5 mg/pump act. (4 mg/ml)	2	PA; QL (8 per 28 days)
EMGALITY PEN SUBCUTANEOUS PEN INJECTOR 120 MG/ML	3	PA; QL (2 per 30 days)
EMGALITY SYRINGE SUBCUTANEOUS SYRINGE 120 MG/ML	3	PA; QL (2 per 30 days)
EMGALITY SYRINGE SUBCUTANEOUS SYRINGE 300 MG/3 ML (100 MG/ML X 3)	3	PA; QL (3 per 30 days)
naratriptan oral tablet 1 mg, 2.5 mg	2	QL (18 per 30 days)
NURTEC ODT ORAL TABLET,DISINTEGRATING 75 MG	3	PA; QL (18 per 30 days)
QULIPTA ORAL TABLET 10 MG, 30 MG, 60 MG	3	PA; QL (30 per 30 days)
rizatriptan oral tablet 10 mg, 5 mg	2	QL (18 per 30 days)
rizatriptan oral tablet,disintegrating 10 mg, 5 mg	2	QL (18 per 30 days)
sumatriptan 4 mg/0.5 ml inject outer, suv	2	QL (4 per 28 days)
sumatriptan 6 mg/0.5 ml autoinj suv	4	QL (4 per 28 days)
sumatriptan nasal spray,non-aerosol 20 mg/actuation, 5 mg/actuation	2	QL (12 per 30 days)
sumatriptan succinate oral tablet 100 mg	2	QL (9 per 30 days)
sumatriptan succinate oral tablet 25 mg, 50 mg	2	QL (18 per 30 days)
sumatriptan succinate subcutaneous pen injector 4 mg/0.5 ml	4	QL (4 per 28 days)
sumatriptan succinate subcutaneous pen injector 6 mg/0.5 ml	2	QL (4 per 28 days)
sumatriptan succinate subcutaneous solution 6 mg/0.5 ml	2	QL (5 per 28 days)
UBRELVY ORAL TABLET 100 MG, 50 MG	3	PA; QL (16 per 30 days)

Drug Name	Drug Tier	Requirements/Limits
Antimycobacterials		
Antimycobacterials		
dapsone oral tablet 100 mg, 25 mg	2	
ethambutol oral tablet 100 mg, 400 mg	2	
isoniazid oral tablet 100 mg, 300 mg	1	
PRETOMANID ORAL TABLET 200 MG	4	QL (30 per 30 days)
PRIFTIN ORAL TABLET 150 MG	4	
pyrazinamide oral tablet 500 mg	2	
rifabutin oral capsule 150 mg	2	
rifampin intravenous recon soln 600 mg	2	
rifampin oral capsule 150 mg, 300 mg	2	
SIRTURO ORAL TABLET 100 MG, 20 MG	5	PA
TRECATOR ORAL TABLET 250 MG	4	
Antinausea Agents		
Antinausea Agents		
aprepitant oral capsule 125 mg	2	PA BvD; QL (2 per 28 days)
aprepitant oral capsule 40 mg	2	PA BvD; QL (1 per 28 days)
aprepitant oral capsule 80 mg	2	PA BvD; QL (8 per 28 days)
aprepitant oral capsule,dose pack 125 mg (1)- 80 mg (2)	2	PA BvD
compro rectal suppository 25 mg	2	
dronabinol oral capsule 10 mg, 2.5 mg, 5 mg	2	PA; QL (60 per 30 days)
meclizine oral tablet 12.5 mg, 25 mg	1	
ondansetron hcl oral tablet 4 mg, 8 mg	2	PA BvD
ondansetron oral tablet,disintegrating 4 mg, 8 mg	2	PA BvD
prochlorperazine edisylate injection solution 10 mg/2 ml (5 mg/ml)	2	
prochlorperazine maleate oral tablet 10 mg, 5 mg	2	
prochlorperazine rectal suppository 25 mg	2	
promethazine oral tablet 12.5 mg, 25 mg, 50 mg	1	PA-HRM; AGE (Max 64 Years)
scopolamine base transdermal patch 3 day 1 mg over 3 days	2	PA-HRM; QL (10 per 30 days); AGE (Max 64 Years)
Antiparasite Agents		
Antiparasite Agents		
albendazole oral tablet 200 mg	2	
atovaquone oral suspension 750 mg/5 ml	2	
atovaquone-proguanil oral tablet 250-100 mg, 62.5-25 mg	2	

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Drug Name	Drug Tier	Requirements/Limits
chloroquine phosphate oral tablet 250 mg, 500 mg	2	
COARTEM ORAL TABLET 20-120 MG	4	
hydroxychloroquine oral tablet 100 mg	2	QL (180 per 30 days)
hydroxychloroquine oral tablet 200 mg	2	QL (90 per 30 days)
hydroxychloroquine oral tablet 300 mg, 400 mg	2	QL (60 per 30 days)
IMPAVIDO ORAL CAPSULE 50 MG	5	PA; QL (84 per 28 days)
ivermectin oral tablet 3 mg, 6 mg	2	
mefloquine oral tablet 250 mg	2	
nitazoxanide oral tablet 500 mg	5	QL (60 per 30 days)
pentamidine inhalation recon soln 300 mg	2	PA BvD
pentamidine injection recon soln 300 mg	2	
praziquantel oral tablet 600 mg	2	
PRIMAQUINE ORAL TABLET 26.3 MG (15 MG BASE)	4	
pyrimethamine oral tablet 25 mg	5	PA
quinine sulfate oral capsule 324 mg	2	PA
tinidazole oral tablet 250 mg, 500 mg	2	
Antiparkinsonian Agents		
Antiparkinsonian Agents		
amantadine hcl oral capsule 100 mg	2	
amantadine hcl oral solution 50 mg/5 ml	2	
amantadine hcl oral tablet 100 mg	2	
benztropine oral tablet 0.5 mg, 1 mg, 2 mg	2	
bromocriptine oral tablet 2.5 mg	2	
cabergoline oral tablet 0.5 mg	2	
carbidopa-levodopa oral tablet 10-100 mg, 25-100 mg, 25-250 mg	2	
carbidopa-levodopa oral tablet extended release 25-100 mg, 50-200 mg	2	
carbidopa-levodopa oral tablet,disintegrating 10-100 mg, 25-100 mg, 25-250 mg	2	
entacapone oral tablet 200 mg	2	
ONAPGO SUBCUTANEOUS CARTRIDGE 4.9 MG/ ML	5	PA; QL (600 per 30 days)
pramipexole oral tablet 0.125 mg, 0.25 mg, 0.5 mg, 0.75 mg, 1 mg, 1.5 mg	1	
rasagiline oral tablet 0.5 mg, 1 mg	2	

Drug Name	Drug Tier	Requirements/Limits
ropinirole oral tablet 0.25 mg, 0.5 mg, 1 mg, 2 mg, 3 mg, 4 mg, 5 mg	1	
ropinirole oral tablet extended release 24 hr 2 mg, 4 mg	2	
selegiline hcl oral capsule 5 mg	2	
selegiline hcl oral tablet 5 mg	2	
trihexyphenidyl oral tablet 2 mg, 5 mg	2	
VYALEV CONTIN. SUBCUTANEOUS INFUSION SOLUTION 12-240 MG/ML	5	PA; QL (560 per 28 days)
Antipsychotic Agents		
Antipsychotic Agents		
ABILIFY ASIMTUFII INTRAMUSCULAR SUSPENSION,EXTENDED REL SYRING 720 MG/2.4 ML	5	QL (2.4 per 42 days)
ABILIFY ASIMTUFII INTRAMUSCULAR SUSPENSION,EXTENDED REL SYRING 960 MG/3.2 ML	5	QL (3.2 per 42 days)
ABILIFY MAINTENA INTRAMUSCULAR SUSPENSION,EXTENDED REL RECON 300 MG, 400 MG	5	QL (2 per 28 days)
ABILIFY MAINTENA INTRAMUSCULAR SUSPENSION,EXTENDED REL SYRING 300 MG, 400 MG	5	QL (2 per 28 days)
aripiprazole oral solution 1 mg/ml	2	
aripiprazole oral tablet 10 mg, 15 mg, 2 mg, 20 mg, 30 mg, 5 mg	2	
aripiprazole oral tablet,disintegrating 10 mg	2	ST; QL (90 per 30 days)
aripiprazole oral tablet,disintegrating 15 mg	2	ST; QL (60 per 30 days)
ARISTADA INITIO INTRAMUSCULAR SUSPENSION,EXTENDED REL SYRING 675 MG/2.4 ML	5	QL (4.8 per 365 days)
ARISTADA INTRAMUSCULAR SUSPENSION,EXTENDED REL SYRING 1,064 MG/3.9 ML	5	QL (3.9 per 14 days)
ARISTADA INTRAMUSCULAR SUSPENSION,EXTENDED REL SYRING 441 MG/1.6 ML	5	QL (1.6 per 14 days)
ARISTADA INTRAMUSCULAR SUSPENSION,EXTENDED REL SYRING 662 MG/2.4 ML	5	QL (2.4 per 14 days)

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Drug Name	Drug Tier	Requirements/Limits
ARISTADA INTRAMUSCULAR SUSPENSION,EXTENDED REL SYRING 882 MG/3.2 ML	5	QL (3.2 per 14 days)
asenapine maleate sublingual tablet 10 mg, 2.5 mg, 5 mg	2	QL (60 per 30 days)
BYSANTI ORAL TABLET 1 MG, 10 MG, 12 MG, 2 MG, 4 MG, 6 MG, 8 MG	5	ST; QL (60 per 30 days)
BYSANTI TITRATION PACK A ORAL TABLETS,DOSE PACK 1MG(2)-2MG(2)-4MG(2)-6MG(2)	4	ST
BYSANTI TITRATION PACK B ORAL TABLETS,DOSE PACK 1 MG(6)-2MG(2)- 6 MG(2)-8 MG(2)	4	ST
BYSANTI TITRATION PACK C ORAL TABLETS,DOSE PACK 1 MG(4)-2MG(2)- 6 MG (2)	4	ST
CAPLYTA ORAL CAPSULE 10.5 MG, 21 MG, 42 MG	5	ST; QL (30 per 30 days)
chlorpromazine oral concentrate 100 mg/ml, 30 mg/ml	2	
chlorpromazine oral tablet 10 mg, 100 mg, 200 mg, 25 mg, 50 mg	2	
clozapine oral tablet 100 mg, 200 mg, 25 mg, 50 mg	2	
clozapine oral tablet,disintegrating 100 mg, 12.5 mg, 25 mg	2	ST; QL (90 per 30 days)
clozapine oral tablet,disintegrating 150 mg	2	ST; QL (180 per 30 days)
clozapine oral tablet,disintegrating 200 mg	2	ST; QL (120 per 30 days)
COBENFY ORAL CAPSULE 100-20 MG, 125-30 MG, 50-20 MG	5	ST; QL (60 per 30 days)
COBENFY STARTER PACK ORAL CAPSULE,DOSE PACK 50 MG-20 MG /100 MG-20 MG	5	ST
FANAPT ORAL TABLET 1 MG, 10 MG, 12 MG, 2 MG, 4 MG, 6 MG, 8 MG	5	ST; QL (60 per 30 days)
FANAPT TITRATION PACK A ORAL TABLETS,DOSE PACK 1MG(2)-2MG(2)-4MG(2)-6MG(2)	4	ST
FANAPT TITRATION PACK B ORAL TABLETS,DOSE PACK 1 MG(6)-2MG(2)- 6 MG(2)-8 MG(2)	4	ST

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Drug Name	Drug Tier	Requirements/Limits
FANAPT TITRATION PACK C ORAL TABLETS,DOSE PACK 1 MG(4)-2 MG(2) -6 MG (2)	4	ST
fluphenazine decanoate injection solution 25 mg/ml	2	
fluphenazine hcl injection solution 2.5 mg/ml	2	
fluphenazine hcl oral concentrate 5 mg/ml	2	
fluphenazine hcl oral elixir 2.5 mg/5 ml	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	
haloperidol lactate injection solution 5 mg/ml	2	
haloperidol lactate intramuscular syringe 5 mg/ml	2	
haloperidol lactate oral concentrate 2 mg/ml	2	
haloperidol oral tablet 0.5 mg, 1 mg, 10 mg, 2 mg, 20 mg, 5 mg	2	
INVEGA HAFYERA INTRAMUSCULAR SYRINGE 1,092 MG/3.5 ML	5	QL (3.5 per 166 days)
INVEGA HAFYERA INTRAMUSCULAR SYRINGE 1,560 MG/5 ML	5	QL (5 per 166 days)
INVEGA SUSTENNA INTRAMUSCULAR SYRINGE 117 MG/0.75 ML	5	QL (0.75 per 21 days)
INVEGA SUSTENNA INTRAMUSCULAR SYRINGE 156 MG/ML	5	QL (1 per 21 days)
INVEGA SUSTENNA INTRAMUSCULAR SYRINGE 234 MG/1.5 ML	5	QL (1.5 per 21 days)
INVEGA SUSTENNA INTRAMUSCULAR SYRINGE 39 MG/0.25 ML	3	QL (0.25 per 21 days)
INVEGA SUSTENNA INTRAMUSCULAR SYRINGE 78 MG/0.5 ML	5	QL (0.5 per 21 days)
INVEGA TRINZA INTRAMUSCULAR SYRINGE 273 MG/0.88 ML	5	QL (0.88 per 70 days)
INVEGA TRINZA INTRAMUSCULAR SYRINGE 410 MG/1.32 ML	5	QL (1.32 per 70 days)
INVEGA TRINZA INTRAMUSCULAR SYRINGE 546 MG/1.75 ML	5	QL (1.75 per 70 days)

Drug Name	Drug Tier	Requirements/Limits
INVEGA TRINZA INTRAMUSCULAR SYRINGE 819 MG/2.63 ML	5	QL (2.63 per 70 days)
loxapine succinate oral capsule 10 mg, 25 mg, 5 mg, 50 mg	2	
lurasidone oral tablet 120 mg, 20 mg, 40 mg, 60 mg, 80 mg	2	
LYBALVI ORAL TABLET 10-10 MG, 15-10 MG, 20-10 MG, 5-10 MG	5	QL (30 per 30 days)
molindone oral tablet 10 mg, 5 mg	2	QL (120 per 30 days)
molindone oral tablet 25 mg	2	QL (270 per 30 days)
NUPLAZID ORAL CAPSULE 34 MG	5	PA NSO; QL (30 per 30 days)
NUPLAZID ORAL TABLET 10 MG	5	PA NSO; QL (30 per 30 days)
olanzapine intramuscular recon soln 10 mg	2	QL (30 per 30 days)
olanzapine oral tablet 10 mg, 15 mg, 2.5 mg, 20 mg, 5 mg, 7.5 mg	2	
olanzapine oral tablet,disintegrating 10 mg, 15 mg, 20 mg, 5 mg	2	
OPIPZA ORAL FILM 10 MG, 2 MG, 5 MG	5	ST
paliperidone oral tablet extended release 24hr 1.5 mg, 3 mg, 9 mg	2	QL (30 per 30 days)
paliperidone oral tablet extended release 24hr 6 mg	2	QL (60 per 30 days)
perphenazine oral tablet 16 mg, 2 mg, 4 mg, 8 mg	2	
pimozide oral tablet 1 mg, 2 mg	2	
quetiapine oral tablet 100 mg, 200 mg, 25 mg, 300 mg, 400 mg, 50 mg	2	
quetiapine oral tablet extended release 24 hr 150 mg, 200 mg, 300 mg, 400 mg, 50 mg	2	
REXULTI ORAL TABLET 0.25 MG, 0.5 MG, 1 MG, 2 MG, 3 MG, 4 MG	5	QL (30 per 30 days)
risperidone microspheres intramuscular suspension,extended rel recon 12.5 mg/2 ml, 25 mg/2 ml	2	QL (2 per 28 days)
risperidone microspheres intramuscular suspension,extended rel recon 37.5 mg/2 ml, 50 mg/2 ml	5	QL (2 per 28 days)
risperidone oral solution 1 mg/ml	2	QL (480 per 30 days)
risperidone oral tablet 0.25 mg, 0.5 mg, 1 mg, 2 mg, 3 mg, 4 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.

Drug Name	Drug Tier	Requirements/Limits
risperidone oral tablet,disintegrating 0.25 mg, 0.5 mg, 1 mg, 2 mg, 3 mg	2	QL (60 per 30 days)
risperidone oral tablet,disintegrating 4 mg	2	QL (120 per 30 days)
RYKINDO INTRAMUSCULAR SUSPENSION,EXTENDED REL RECON 25 MG/2 ML, 37.5 MG/2 ML, 50 MG/2 ML	5	QL (2 per 28 days)
SECUADO TRANSDERMAL PATCH 24 HOUR 3.8 MG/24 HOUR, 5.7 MG/24 HOUR, 7.6 MG/24 HOUR	5	ST; QL (30 per 30 days)
thioridazine oral tablet 10 mg, 100 mg, 25 mg, 50 mg	2	
thiothixene oral capsule 1 mg, 10 mg, 2 mg, 5 mg	2	
trifluoperazine oral tablet 1 mg, 10 mg, 2 mg, 5 mg	2	
VERSACLOZ ORAL SUSPENSION 50 MG/ML	5	ST; QL (540 per 30 days)
VRAYLAR ORAL CAPSULE 0.5 MG, 0.75 MG, 1.5 MG, 3 MG, 4.5 MG, 6 MG	3	QL (30 per 30 days)
ziprasidone hcl oral capsule 20 mg, 40 mg, 60 mg, 80 mg	2	
ziprasidone mesylate intramuscular recon soln 20 mg/ml (final conc.)	2	QL (6 per 28 days)
ZYPREXA RELPREVV INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION 210 MG	4	QL (2 per 28 days)
ZYPREXA RELPREVV INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION 300 MG	5	QL (2 per 28 days)
ZYPREXA RELPREVV INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION 405 MG	5	QL (1 per 28 days)
Antivirals (Systemic)		
Antiretrovirals		
abacavir oral solution 20 mg/ml	2	
abacavir oral tablet 300 mg	2	
abacavir-lamivudine oral tablet 600-300 mg	2	
APTIVUS ORAL CAPSULE 250 MG	5	
atazanavir oral capsule 150 mg, 200 mg, 300 mg	2	
BIKTARVY ORAL TABLET 30-120-15 MG, 50-200-25 MG	5	QL (30 per 30 days)

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Drug Name	Drug Tier	Requirements/Limits
CABENUVA INTRAMUSCULAR SUSPENSION,EXTENDED RELEASE 400 MG/2 ML- 600 MG/2 ML, 600 MG/3 ML- 900 MG/3 ML	5	
cabotegravir intramuscular suspension,extended release 400 mg/2 ml (200 mg/ml), 600 mg/3 ml (200 mg/ml)	5	QL (24 per 365 days)
CIMDUO ORAL TABLET 300-300 MG	5	
darunavir oral tablet 600 mg, 800 mg	2	
DELSTRIGO ORAL TABLET 100-300-300 MG	5	
DESCOVY ORAL TABLET 120-15 MG, 200-25 MG	5	
didanosine oral capsule,delayed release(dr/ec) 250 mg, 400 mg	2	
DOVATO ORAL TABLET 50-300 MG	5	
EDURANT PED ORAL TABLET FOR SUSPENSION 2.5 MG	5	
efavirenz oral capsule 200 mg, 50 mg	2	
efavirenz oral tablet 600 mg	2	
efavirenz-emtricitabin-tenofov oral tablet 600-200-300 mg	2	
efavirenz-lamivu-tenofov disop oral tablet 400-300-300 mg, 600-300-300 mg	5	
emtricitabine oral capsule 200 mg	2	
emtricitabine-tenofovir (tdf) oral tablet 100-150 mg, 133-200 mg, 167-250 mg, 200-300 mg	2	
emtricita-rilpivirine-tenof df oral tablet 200-25-300 mg	5	
EMTRIVA ORAL SOLUTION 10 MG/ML	4	
etravirine oral tablet 100 mg, 200 mg	2	
EVOTAZ ORAL TABLET 300-150 MG	5	
fosamprenavir oral tablet 700 mg	2	
GENVOYA ORAL TABLET 150-150-200-10 MG	5	
IDVYNSO ORAL TABLET 100-0.25 MG	5	QL (30 per 30 days)
INTELENCE ORAL TABLET 25 MG	4	
ISENTRESS HD ORAL TABLET 600 MG	5	
ISENTRESS ORAL POWDER IN PACKET 100 MG	5	
ISENTRESS ORAL TABLET 400 MG	5	

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Drug Name	Drug Tier	Requirements/Limits
ISENTRESS ORAL TABLET,CHEWABLE 100 MG	5	
ISENTRESS ORAL TABLET,CHEWABLE 25 MG	3	
JULUCA ORAL TABLET 50-25 MG	5	
KALETRA ORAL SOLUTION 400-100 MG/5 ML	4	QL (480 per 30 days)
lamivudine oral solution 10 mg/ml	2	
lamivudine oral tablet 100 mg, 150 mg, 300 mg	2	
lamivudine-zidovudine oral tablet 150-300 mg	2	
lopinavir-ritonavir oral solution 400-100 mg/5 ml	2	QL (480 per 30 days)
lopinavir-ritonavir oral tablet 100-25 mg	2	QL (300 per 30 days)
lopinavir-ritonavir oral tablet 200-50 mg	2	QL (120 per 30 days)
maraviroc oral tablet 150 mg, 300 mg	5	
nevirapine oral suspension 50 mg/5 ml	2	QL (1200 per 30 days)
nevirapine oral tablet 200 mg	2	QL (60 per 30 days)
nevirapine oral tablet extended release 24 hr 100 mg	2	QL (90 per 30 days)
nevirapine oral tablet extended release 24 hr 400 mg	2	QL (30 per 30 days)
NORVIR ORAL POWDER IN PACKET 100 MG	4	
ODEFSEY ORAL TABLET 200-25-25 MG	5	
PIFELTRO ORAL TABLET 100 MG	5	
PREZCOBIX ORAL TABLET 675-150 MG, 800-150 MG-MG	5	
PREZISTA ORAL SUSPENSION 100 MG/ML	5	
PREZISTA ORAL TABLET 150 MG	5	
PREZISTA ORAL TABLET 75 MG	4	
REYATAZ ORAL POWDER IN PACKET 50 MG	5	
rilpivirine hcl oral tablet 25 mg	5	
rilpivirine intramuscular suspension,extended release 600 mg/2 ml (300 mg/ml), 900 mg/3 ml (300 mg/ml)	5	
ritonavir oral tablet 100 mg	2	
RUKOBIA ORAL TABLET EXTENDED RELEASE 12 HR 600 MG	5	
SELZENTRY ORAL SOLUTION 20 MG/ML	5	
SELZENTRY ORAL TABLET 25 MG	3	

Drug Name	Drug Tier	Requirements/Limits
SELZENTRY ORAL TABLET 75 MG	5	
stavudine oral capsule 15 mg, 20 mg, 30 mg, 40 mg	2	
STRIBILD ORAL TABLET 150-150-200-300 MG	5	
SUNLENCA ORAL TABLET 300 MG, 300 MG (4-TABLET PACK), 300 MG (5-TABLET PACK)	5	
SYMTUZA ORAL TABLET 800-150-200-10 MG	5	
tenofovir disoproxil fumarate oral tablet 300 mg	2	
TIVICAY ORAL TABLET 10 MG	4	
TIVICAY ORAL TABLET 25 MG, 50 MG	5	
TIVICAY PD ORAL TABLET FOR SUSPENSION 5 MG	5	
TRIUMEQ ORAL TABLET 600-50-300 MG	5	QL (30 per 30 days)
TRIUMEQ PD ORAL TABLET FOR SUSPENSION 60-5-30 MG	4	
TYBOST ORAL TABLET 150 MG	3	QL (30 per 30 days)
VIRACEPT ORAL TABLET 250 MG, 625 MG	5	
VIREAD ORAL POWDER 40 MG/SCOOP (40 MG/GRAM)	5	
VIREAD ORAL TABLET 150 MG, 200 MG, 250 MG	5	
zidovudine oral capsule 100 mg	2	
zidovudine oral syrup 10 mg/ml	2	
zidovudine oral tablet 300 mg	2	
Antivirals, Miscellaneous		
LIVTENCITY ORAL TABLET 200 MG	5	PA
oseltamivir oral capsule 30 mg	2	QL (84 per 180 days)
oseltamivir oral capsule 45 mg	2	QL (48 per 180 days)
oseltamivir oral capsule 75 mg	2	QL (42 per 180 days)
oseltamivir oral suspension for reconstitution 6 mg/ml	2	QL (540 per 180 days)
PAXLOVID ORAL TABLETS,DOSE PACK 150 MG (10)- 100 MG (10)	2	QL (20 per 5 days)
PAXLOVID ORAL TABLETS,DOSE PACK 150 MG (6)- 100 MG (5)	2	QL (11 per 28 days)
PAXLOVID ORAL TABLETS,DOSE PACK 300 MG (150 MG X 2)-100 MG	2	QL (30 per 5 days)

Drug Name	Drug Tier	Requirements/Limits
PEGASYS SUBCUTANEOUS SOLUTION 180 MCG/ML	5	PA
PEGASYS SUBCUTANEOUS SYRINGE 180 MCG/0.5 ML	5	PA
PREVYMIS ORAL TABLET 240 MG, 480 MG	5	PA; QL (28 per 28 days)
RELENZA DISKHALER INHALATION BLISTER WITH DEVICE 5 MG/ACTUATION	4	QL (60 per 180 days)
Hcv Antivirals		
EPCLUSA ORAL PELLETS IN PACKET 150-37.5 MG	5	PA; QL (28 per 28 days)
EPCLUSA ORAL PELLETS IN PACKET 200-50 MG	5	PA; QL (56 per 28 days)
EPCLUSA ORAL TABLET 200-50 MG, 400-100 MG	5	PA; QL (28 per 28 days)
VOSEVI ORAL TABLET 400-100-100 MG	5	PA; QL (28 per 28 days)
Nucleosides And Nucleotides		
acyclovir oral capsule 200 mg	2	
acyclovir oral suspension 200 mg/5 ml	4	
acyclovir oral tablet 400 mg, 800 mg	2	
acyclovir sodium intravenous solution 50 mg/ml	2	PA BvD
adefovir oral tablet 10 mg	2	
entecavir oral tablet 0.5 mg, 1 mg	2	
famciclovir oral tablet 125 mg, 250 mg, 500 mg	2	
ribavirin oral capsule 200 mg	2	
ribavirin oral tablet 200 mg	2	
valacyclovir oral tablet 1 gram, 500 mg	2	
valganciclovir oral recon soln 50 mg/ml	5	
valganciclovir oral tablet 450 mg	2	
VEMLIDY ORAL TABLET 25 MG	5	QL (30 per 30 days)
Blood Products/Modifiers/Volume Expanders		
Anticoagulants		
dabigatran etexilate oral capsule 110 mg, 150 mg, 75 mg	2	QL (60 per 30 days)
ELIQUIS DVT-PE TREAT 30D START ORAL TABLETS,DOSE PACK 5 MG (74 TABS)	3	
ELIQUIS ORAL TABLET 2.5 MG	3	QL (60 per 30 days)
ELIQUIS ORAL TABLET 5 MG	3	QL (74 per 30 days)

Drug Name	Drug Tier	Requirements/Limits
ELIQUIS ORAL TABLET FOR SUSPENSION 0.5 MG, 1.5 MG (0.5 MG X 3), 2 MG (0.5 MG X 4)	3	QL (960 per 30 days)
ELIQUIS SPRINKLE ORAL CAPSULE, SPRINKLE 0.15 MG	3	QL (120 per 30 days)
enoxaparin subcutaneous syringe 100 mg/ml, 150 mg/ml	2	QL (60 per 30 days)
enoxaparin subcutaneous syringe 120 mg/0.8 ml, 80 mg/0.8 ml	2	QL (48 per 30 days)
enoxaparin subcutaneous syringe 30 mg/0.3 ml	2	QL (18 per 30 days)
enoxaparin subcutaneous syringe 40 mg/0.4 ml	2	QL (24 per 30 days)
enoxaparin subcutaneous syringe 60 mg/0.6 ml	2	QL (36 per 30 days)
fondaparinux subcutaneous syringe 10 mg/0.8 ml	5	QL (24 per 30 days)
fondaparinux subcutaneous syringe 2.5 mg/0.5 ml	2	QL (15 per 30 days)
fondaparinux subcutaneous syringe 5 mg/0.4 ml	5	QL (12 per 30 days)
fondaparinux subcutaneous syringe 7.5 mg/0.6 ml	2	QL (18 per 30 days)
heparin (porcine) injection solution 1,000 unit/ml, 10,000 unit/ml, 20,000 unit/ml, 5,000 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	
rivaroxaban oral suspension for reconstitution 1 mg/ml	2	QL (600 per 30 days)
rivaroxaban oral tablet 2.5 mg	2	
warfarin oral tablet 1 mg, 10 mg, 2 mg, 2.5 mg, 3 mg, 4 mg, 5 mg, 6 mg, 7.5 mg	1	
Blood Formation Modifiers		
eltrombopag olamine oral powder in packet 12.5 mg	5	PA; QL (90 per 30 days)
eltrombopag olamine oral powder in packet 25 mg	5	PA; QL (180 per 30 days)
eltrombopag olamine oral tablet 12.5 mg	5	PA; QL (90 per 30 days)
eltrombopag olamine oral tablet 25 mg	5	PA; QL (30 per 30 days)
eltrombopag olamine oral tablet 50 mg, 75 mg	5	PA; QL (60 per 30 days)
HAEGARDA SUBCUTANEOUS RECON SOLN 2,000 UNIT	5	PA; QL (30 per 30 days)
HAEGARDA SUBCUTANEOUS RECON SOLN 3,000 UNIT	5	PA; QL (20 per 30 days)
LEUKINE INJECTION RECON SOLN 250 MCG	5	PA

Drug Name	Drug Tier	Requirements/Limits
NIVESTYM INJECTION SOLUTION 300 MCG/ML, 480 MCG/1.6 ML	5	PA
NIVESTYM SUBCUTANEOUS SYRINGE 300 MCG/0.5 ML, 480 MCG/0.8 ML	5	PA
NYVEPRIA SUBCUTANEOUS SYRINGE 6 MG/0.6 ML	5	PA
RETACRIT INJECTION SOLUTION 10,000 UNIT/ML, 2,000 UNIT/ML, 20,000 UNIT/2 ML, 20,000 UNIT/ML, 3,000 UNIT/ML, 4,000 UNIT/ML	3	PA; QL (12 per 28 days)
RETACRIT INJECTION SOLUTION 40,000 UNIT/ML	3	PA; QL (4 per 28 days)
UDENYCA ONBODY SUBCUTANEOUS SYRINGE, W/ WEARABLE INJECTOR 6 MG/0.6 ML	5	PA
Hematologic Agents, Miscellaneous		
anagrelide oral capsule 0.5 mg, 1 mg	2	
tranexamic acid oral tablet 650 mg	2	
Platelet-Aggregation Inhibitors		
aspirin-dipyridamole oral capsule, er multiphase 12 hr 25-200 mg	2	
cilostazol oral tablet 100 mg, 50 mg	2	
clopidogrel oral tablet 75 mg	1	
dipyridamole oral tablet 25 mg, 50 mg, 75 mg	2	PA-HRM; AGE (Max 64 Years)
pentoxifylline oral tablet extended release 400 mg	2	
prasugrel hcl oral tablet 10 mg, 5 mg	2	
ticagrelor oral tablet 60 mg, 90 mg	2	
Caloric Agents		
Caloric Agents		
CLINIMIX 6%-D5W (SULFITE-FREE) INTRAVENOUS PARENTERAL SOLUTION 6-5 %	4	PA BvD
CLINIMIX 8%-D10W(SULFITE-FREE) INTRAVENOUS PARENTERAL SOLUTION 8-10 %	4	PA BvD
CLINIMIX 8%-D14W(SULFITE-FREE) INTRAVENOUS PARENTERAL SOLUTION 8-14 %	4	PA BvD

Drug Name	Drug Tier	Requirements/Limits
CLINIMIX E 8%-D10W SULFITEFREE INTRAVENOUS PARENTERAL SOLUTION 8-10 %	4	PA BvD
CLINIMIX E 8%-D14W SULFITEFREE INTRAVENOUS PARENTERAL SOLUTION 8-14 %	4	PA BvD
d5 % (d-glucose)-0.9 % sodchlr intravenous parenteral solution	2	
d5 % and 0.9 % sodium chloride intravenous parenteral solution	2	
d5 %-0.45 % sodium chloride intravenous parenteral solution	2	
dextrose 5 % in water (d5w) intravenous parenteral solution	2	PA BvD
PROSOL 20 % INTRAVENOUS PARENTERAL SOLUTION	4	PA BvD
Cardiovascular Agents		
Alpha-Adrenergic Agents		
clonidine hcl oral tablet 0.1 mg, 0.2 mg, 0.3 mg	1	
clonidine transdermal patch weekly 0.1 mg/24 hr, 0.2 mg/24 hr, 0.3 mg/24 hr	2	
guanfacine oral tablet 1 mg, 2 mg	2	
midodrine oral tablet 10 mg, 2.5 mg, 5 mg	2	
Alpha-Adrenergic Blocking Agents		
doxazosin oral tablet 1 mg, 2 mg, 4 mg, 8 mg	1	
prazosin oral capsule 1 mg, 2 mg, 5 mg	2	
Angiotensin Ii Receptor Antagonists		
candesartan oral tablet 16 mg, 32 mg, 4 mg, 8 mg	2	
candesartan-hydrochlorothiazid oral tablet 16-12.5 mg, 32-12.5 mg, 32-25 mg	2	
irbesartan oral tablet 150 mg, 300 mg, 75 mg	1	
irbesartan-hydrochlorothiazide oral tablet 150-12.5 mg, 300-12.5 mg	2	
losartan oral tablet 100 mg, 25 mg, 50 mg	1	
losartan-hydrochlorothiazide oral tablet 100-12.5 mg, 100-25 mg, 50-12.5 mg	1	
olmesartan oral tablet 20 mg, 40 mg, 5 mg	1	
olmesartan-amlodipin-hcthiazid 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	

Drug Name	Drug Tier	Requirements/Limits
olmesartan-hydrochlorothiazide oral tablet 20-12.5 mg, 40-12.5 mg, 40-25 mg	2	
sacubitril-valsartan oral tablet 24-26 mg	2	QL (180 per 30 days)
sacubitril-valsartan oral tablet 49-51 mg, 97-103 mg	2	QL (60 per 30 days)
telmisartan oral tablet 20 mg, 40 mg, 80 mg	2	
telmisartan-hydrochlorothiazid oral tablet 40-12.5 mg, 80-12.5 mg, 80-25 mg	2	
valsartan oral tablet 160 mg, 320 mg, 40 mg, 80 mg	2	
valsartan-hydrochlorothiazide oral tablet 160-12.5 mg, 160-25 mg, 320-12.5 mg, 320-25 mg, 80-12.5 mg	2	
Angiotensin-Converting Enzyme Inhibitors		
benazepril oral tablet 10 mg, 20 mg, 40 mg, 5 mg	1	
benazepril-hydrochlorothiazide oral tablet 10-12.5 mg, 20-12.5 mg, 20-25 mg, 5-6.25 mg	2	
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	
enalapril-hydrochlorothiazide oral tablet 10-25 mg, 5-12.5 mg	1	
fosinopril oral tablet 10 mg, 20 mg, 40 mg	1	
fosinopril-hydrochlorothiazide oral tablet 10-12.5 mg, 20-12.5 mg	2	
lisinopril oral tablet 10 mg, 2.5 mg, 20 mg, 30 mg, 40 mg, 5 mg	1	
lisinopril-hydrochlorothiazide oral tablet 10-12.5 mg, 20-12.5 mg, 20-25 mg	1	
moexipril oral tablet 15 mg, 7.5 mg	2	
perindopril erbumine oral tablet 2 mg, 4 mg, 8 mg	2	
quinapril oral tablet 10 mg, 20 mg, 40 mg, 5 mg	1	
quinapril-hydrochlorothiazide oral tablet 10-12.5 mg, 20-12.5 mg, 20-25 mg	2	
ramipril oral capsule 1.25 mg, 10 mg, 2.5 mg, 5 mg	1	
trandolapril oral tablet 1 mg, 2 mg, 4 mg	2	
Antiarrhythmic Agents		

Please refer to our Evidence of Coverage for 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.

Drug Name	Drug Tier	Requirements/Limits
amiodarone oral tablet 100 mg, 200 mg, 400 mg	2	
dofetilide oral capsule 125 mcg, 250 mcg, 500 mcg	2	
flecainide oral tablet 100 mg, 150 mg, 50 mg	2	
MULTAQ ORAL TABLET 400 MG	3	
pacerone oral tablet 100 mg, 200 mg, 400 mg	2	
propafenone oral capsule,extended release 12 hr 225 mg, 325 mg, 425 mg	2	
propafenone oral tablet 150 mg, 225 mg, 300 mg	2	
quinidine sulfate oral tablet 200 mg, 300 mg	2	
Beta-Adrenergic Blocking Agents		
acebutolol oral capsule 200 mg, 400 mg	2	
atenolol oral tablet 100 mg, 25 mg, 50 mg	1	
atenolol-chlorthalidone oral tablet 100-25 mg, 50-25 mg	2	
bisoprolol fumarate oral tablet 10 mg, 2.5 mg, 5 mg	2	
bisoprolol-hydrochlorothiazide oral tablet 10-6.25 mg, 2.5-6.25 mg, 5-6.25 mg	2	
carvedilol oral tablet 12.5 mg, 25 mg, 3.125 mg, 6.25 mg	1	
labetalol oral tablet 100 mg, 200 mg, 300 mg	2	
metoprolol succinate oral tablet extended release 24 hr 100 mg, 200 mg, 25 mg, 50 mg	1	
metoprolol tartrate oral tablet 100 mg, 25 mg, 37.5 mg, 50 mg, 75 mg	1	
nebivolol oral tablet 10 mg, 2.5 mg, 20 mg, 5 mg	2	
propranolol oral capsule,extended release 24 hr 120 mg, 160 mg, 60 mg, 80 mg	2	
propranolol oral solution 20 mg/5 ml (4 mg/ml), 40 mg/5 ml (8 mg/ml)	2	
propranolol oral tablet 10 mg, 20 mg, 40 mg, 60 mg, 80 mg	2	
sotalol af oral tablet 120 mg, 160 mg, 80 mg	2	
sotalol oral tablet 120 mg, 160 mg, 240 mg, 80 mg	2	
timolol maleate oral tablet 10 mg, 20 mg, 5 mg	4	
Calcium-Channel Blocking Agents		
amlodipine oral tablet 10 mg, 2.5 mg, 5 mg	1	

Drug Name	Drug Tier	Requirements/Limits
amlodipine-benazepril oral capsule 10-20 mg, 10-40 mg, 2.5-10 mg, 5-10 mg, 5-20 mg, 5-40 mg	1	
amlodipine-olmesartan oral tablet 10-20 mg, 10-40 mg, 5-20 mg, 5-40 mg	2	
amlodipine-valsartan oral tablet 10-160 mg, 10-320 mg, 5-160 mg, 5-320 mg	2	
amlodipine-valsartan-hcthiazid 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	
cartia xt oral capsule,extended release 24hr 120 mg, 180 mg, 240 mg, 300 mg	2	
diltiazem hcl oral capsule,extended release 12 hr 120 mg, 60 mg, 90 mg	4	
diltiazem hcl oral capsule,extended release 24 hr 360 mg, 420 mg	2	
diltiazem hcl oral capsule,extended release 24hr 120 mg, 180 mg, 240 mg, 300 mg	2	
diltiazem hcl oral tablet 120 mg, 30 mg, 60 mg, 90 mg	2	
dilt-xr oral capsule,ext.rel 24h degradable 120 mg, 180 mg, 240 mg	2	
felodipine oral tablet extended release 24 hr 10 mg, 2.5 mg, 5 mg	1	
nifedipine oral tablet extended release 24hr 30 mg, 60 mg, 90 mg	2	
nifedipine oral tablet extended release 30 mg, 60 mg, 90 mg	2	
taztia xt oral capsule,extended release 24 hr 120 mg, 180 mg, 240 mg, 300 mg, 360 mg	2	
tiadylt er oral capsule,extended release 24 hr 120 mg, 180 mg, 240 mg, 300 mg, 360 mg, 420 mg	2	
verapamil oral capsule,ext rel. pellets 24 hr 120 mg, 180 mg, 240 mg	2	
verapamil oral capsule,ext rel. pellets 24 hr 360 mg	4	
verapamil oral tablet 120 mg, 40 mg, 80 mg	1	
verapamil oral tablet extended release 120 mg, 180 mg, 240 mg	2	
Cardiovascular Agents, Miscellaneous		

Please refer to our Evidence of Coverage for 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.

Drug Name	Drug Tier	Requirements/Limits
digoxin oral tablet 125 mcg (0.125 mg), 250 mcg (0.25 mg)	1	
icatibant subcutaneous syringe 30 mg/3 ml	5	PA; QL (18 per 30 days)
ivabradine oral tablet 5 mg, 7.5 mg	2	ST; QL (60 per 30 days)
metyrosine oral capsule 250 mg	5	PA
nitroglycerin transdermal patch 24 hour 0.1 mg/hr, 0.2 mg/hr, 0.4 mg/hr, 0.6 mg/hr	2	
ranolazine oral tablet extended release 12 hr 1,000 mg, 500 mg	2	
VYNDAMAX ORAL CAPSULE 61 MG	5	PA; QL (30 per 30 days)
Diuretics		
amiloride oral tablet 5 mg	1	
amiloride-hydrochlorothiazide oral tablet 5-50 mg	2	
bumetanide oral tablet 0.5 mg, 1 mg, 2 mg	2	
chlorthalidone oral tablet 25 mg, 50 mg	1	
furosemide injection solution 10 mg/ml	1	
furosemide oral solution 10 mg/ml, 40 mg/5 ml (8 mg/ml)	1	
furosemide oral tablet 20 mg, 40 mg, 80 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	
spironolactone oral tablet 100 mg, 25 mg, 50 mg	1	
spironolacton-hydrochlorothiaz oral tablet 25-25 mg	2	
tolvaptan (polycys kidney dis) oral tablet 15 mg, 30 mg	5	PA; QL (120 per 30 days)
tolvaptan (polycys kidney dis) oral tablets, sequential 15 mg (am)/ 15 mg (pm), 30 mg (am)/ 15 mg (pm), 45 mg (am)/ 15 mg (pm), 60 mg (am)/ 30 mg (pm), 90 mg (am)/ 30 mg (pm)	5	PA; QL (56 per 28 days)
torsemide oral tablet 10 mg, 100 mg, 20 mg, 5 mg	1	
triamterene-hydrochlorothiazid oral capsule 37.5-25 mg	1	
triamterene-hydrochlorothiazid oral tablet 37.5-25 mg, 75-50 mg	1	
Dyslipidemics		

Drug Name	Drug Tier	Requirements/Limits
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	
atorvastatin oral tablet 10 mg, 20 mg, 40 mg, 80 mg	1	
cholestyramine (with sugar) oral powder in packet 4 gram	2	
cholestyramine light oral powder in packet 4 gram	2	
colesevelam oral tablet 625 mg	2	
colestipol oral packet 5 gram	2	
colestipol oral tablet 1 gram	2	
ezetimibe oral tablet 10 mg	1	QL (30 per 30 days)
ezetimibe-simvastatin oral tablet 10-10 mg, 10-20 mg, 10-40 mg, 10-80 mg	2	QL (30 per 30 days)
fenofibrate micronized oral capsule 134 mg, 200 mg, 67 mg	1	
fenofibrate nanocrystallized oral tablet 145 mg, 48 mg	1	
fenofibrate oral tablet 160 mg, 54 mg	1	
fluvastatin oral capsule 20 mg, 40 mg	2	QL (60 per 30 days)
fluvastatin oral tablet extended release 24 hr 80 mg	2	
gemfibrozil oral tablet 600 mg	1	
icosapent ethyl oral capsule 0.5 gram	2	QL (240 per 30 days)
icosapent ethyl oral capsule 1 gram	2	QL (120 per 30 days)
lovastatin oral tablet 10 mg, 20 mg, 40 mg	1	
NEXLETOL ORAL TABLET 180 MG	3	ST; QL (30 per 30 days)
NEXLIZET ORAL TABLET 180-10 MG	3	ST; QL (30 per 30 days)
niacin oral tablet extended release 24 hr 1,000 mg, 500 mg, 750 mg	2	
omega-3 acid ethyl esters oral capsule 1 gram	2	ST; QL (120 per 30 days)
pitavastatin calcium oral tablet 1 mg, 2 mg, 4 mg	2	QL (30 per 30 days)
pravastatin oral tablet 10 mg, 20 mg, 40 mg, 80 mg	1	
prevalite oral powder in packet 4 gram	2	
REPATHA PUSHTRONEX SUBCUTANEOUS WEARABLE INJECTOR 420 MG/3.5 ML	3	ST; QL (7 per 28 days)

Drug Name	Drug Tier	Requirements/Limits
REPATHA SURECLICK SUBCUTANEOUS PEN INJECTOR 140 MG/ML	3	ST; QL (6 per 28 days)
REPATHA SYRINGE SUBCUTANEOUS SYRINGE 140 MG/ML	3	ST; QL (6 per 28 days)
rosuvastatin 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	
TRYNGOLZA SUBCUTANEOUS AUTO-INJECTOR 50 MG/0.8 ML, 80 MG/0.8 ML	5	PA; QL (0.8 per 28 days)
Renin-Angiotensin-Aldosterone System Inhibitors		
aliskiren oral tablet 150 mg, 300 mg	2	
eplerenone oral tablet 25 mg, 50 mg	2	
KERENDIA ORAL TABLET 10 MG, 20 MG, 40 MG	3	PA; QL (30 per 30 days)
Vasodilators		
hydralazine oral tablet 10 mg, 100 mg, 25 mg, 50 mg	1	
isosorbide dinitrate oral tablet 10 mg, 20 mg, 30 mg, 5 mg	2	
isosorbide mononitrate oral tablet 10 mg, 20 mg	2	
isosorbide mononitrate oral tablet extended release 24 hr 120 mg, 30 mg, 60 mg	1	
minoxidil oral tablet 10 mg, 2.5 mg	2	
nitroglycerin sublingual tablet 0.3 mg, 0.4 mg, 0.6 mg	2	
VERQUVO ORAL TABLET 10 MG, 2.5 MG, 5 MG	4	PA; QL (30 per 30 days)
Central Nervous System Agents		
Central Nervous System Agents		
atomoxetine oral capsule 10 mg, 18 mg, 25 mg, 40 mg	2	QL (60 per 30 days)
atomoxetine oral capsule 100 mg, 60 mg, 80 mg	2	QL (30 per 30 days)
AUSTEDO ORAL TABLET 12 MG, 9 MG	5	PA; QL (120 per 30 days)
AUSTEDO ORAL TABLET 6 MG	5	PA; QL (60 per 30 days)
AUSTEDO XR ORAL TABLET EXTENDED RELEASE 24 HR 12 MG	5	PA; QL (90 per 30 days)
AUSTEDO XR ORAL TABLET EXTENDED RELEASE 24 HR 18 MG, 24 MG	5	PA; QL (60 per 30 days)

Drug Name	Drug Tier	Requirements/Limits
AUSTEDO XR ORAL TABLET EXTENDED RELEASE 24 HR 30 MG, 36 MG, 42 MG, 48 MG	5	PA; QL (30 per 30 days)
AUSTEDO XR ORAL TABLET EXTENDED RELEASE 24 HR 6 MG	5	PA; QL (210 per 30 days)
AUSTEDO XR TITRATION KT(WK1-4) ORAL TABLET, EXT REL 24HR DOSE PACK 12-18-24-30 MG, 6 MG (14)-12 MG (14)-24 MG (14)	5	PA
dextroamphetamine-amphetamine oral capsule,extended release 24hr 10 mg, 15 mg, 5 mg	2	QL (30 per 30 days)
dextroamphetamine-amphetamine oral capsule,extended release 24hr 20 mg, 25 mg, 30 mg	2	QL (60 per 30 days)
dextroamphetamine-amphetamine oral tablet 10 mg, 12.5 mg, 15 mg, 20 mg, 30 mg, 5 mg, 7.5 mg	2	QL (60 per 30 days)
guanfacine oral tablet extended release 24 hr 1 mg, 2 mg, 3 mg, 4 mg	2	
INGREZZA INITIATION PK(TARDIV) ORAL CAPSULE,DOSE PACK 40 MG (7)- 80 MG (21)	5	PA
INGREZZA ORAL CAPSULE 40 MG, 60 MG, 80 MG	5	PA; QL (30 per 30 days)
INGREZZA SPRINKLE ORAL CAPSULE, SPRINKLE 40 MG, 60 MG, 80 MG	5	PA; QL (30 per 30 days)
lithium carbonate oral capsule 150 mg, 300 mg, 600 mg	1	
lithium carbonate oral tablet 300 mg	1	
lithium carbonate oral tablet extended release 300 mg, 450 mg	2	
lithium citrate oral solution 8 meq/5 ml	2	
methylphenidate hcl oral solution 10 mg/5 ml, 5 mg/5 ml	2	QL (900 per 30 days)
methylphenidate hcl oral tablet 10 mg, 20 mg, 5 mg	2	QL (90 per 30 days)
riluzole oral tablet 50 mg	2	
tetrabenazine oral tablet 12.5 mg, 25 mg	2	PA; QL (112 per 28 days)
VEOZAH ORAL TABLET 45 MG	4	PA; QL (30 per 30 days)
Contraceptives		

Please refer to our Evidence of Coverage for 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.

Drug Name	Drug Tier	Requirements/Limits
Contraceptives		
afirmelle oral tablet 0.1-20 mg-mcg	2	
altavera (28) oral tablet 0.15-0.03 mg	1	
alyacen 1/35 (28) oral tablet 1-35 mg-mcg	2	
alyacen 7/7/7 (28) oral tablet 0.5/0.75/1 mg- 35 mcg	2	
amethia oral tablets,dose pack,3 month 0.15 mg-30 mcg (84)/10 mcg (7)	1	QL (91 per 84 days)
amethyst (28) oral tablet 90-20 mcg (28)	2	
apri oral tablet 0.15-0.03 mg	1	
ashlyna oral tablets,dose pack,3 month 0.15 mg-30 mcg (84)/10 mcg (7)	1	QL (91 per 84 days)
aubra eq oral tablet 0.1-20 mg-mcg	2	
aurovela 1.5/30 (21) oral tablet 1.5-30 mg-mcg	2	
aurovela 1/20 (21) oral tablet 1-20 mg-mcg	2	
aurovela 24 fe oral tablet 1 mg-20 mcg (24)/75 mg (4)	1	
aurovela fe 1.5/30 (28) oral tablet 1.5 mg-30 mcg (21)/75 mg (7)	2	
aurovela fe 1-20 (28) oral tablet 1 mg-20 mcg (21)/75 mg (7)	2	
aviane oral tablet 0.1-20 mg-mcg	1	
ayuna oral tablet 0.15-0.03 mg	2	
azurette (28) oral tablet 0.15-0.02 mgx21 /0.01 mg x 5	2	
blisovi 24 fe oral tablet 1 mg-20 mcg (24)/75 mg (4)	2	
blisovi fe 1.5/30 (28) oral tablet 1.5 mg-30 mcg (21)/75 mg (7)	1	
blisovi fe 1/20 (28) oral tablet 1 mg-20 mcg (21)/75 mg (7)	1	
camila oral tablet 0.35 mg	2	
camrese lo oral tablets,dose pack,3 month 0.1 mg-20 mcg (84)/10 mcg (7)	1	QL (91 per 84 days)
camrese oral tablets,dose pack,3 month 0.15 mg-30 mcg (84)/10 mcg (7)	1	QL (91 per 84 days)
chateal eq (28) oral tablet 0.15-0.03 mg	2	
cryselle (28) oral tablet 0.3-30 mg-mcg	2	
cyred eq oral tablet 0.15-0.03 mg	2	
dasetta 1/35 (28) oral tablet 1-35 mg-mcg	2	

Drug Name	Drug Tier	Requirements/Limits
dasetta 7/7/7 (28) oral tablet 0.5/0.75/1 mg- 35 mcg	2	
daysee oral tablets,dose pack,3 month 0.15 mg-30 mcg (84)/10 mcg (7)	1	QL (91 per 84 days)
deblitane oral tablet 0.35 mg	1	
desog-e.estradiol/e.estradiol oral tablet 0.15-0.02 mgx21 /0.01 mg x 5	2	
dolishale oral tablet 90-20 mcg (28)	2	
drospirenone-ethinyl estradiol oral tablet 3-0.02 mg, 3-0.03 mg	1	
elinest oral tablet 0.3-30 mg-mcg	2	
eluryng vaginal ring 0.12-0.015 mg/24 hr	2	QL (1 per 28 days)
emzahh oral tablet 0.35 mg	1	
enilloring vaginal ring 0.12-0.015 mg/24 hr	2	QL (1 per 28 days)
enpresse oral tablet 50-30 (6)/75-40 (5)/125-30(10)	2	
enskyce oral tablet 0.15-0.03 mg	1	
errin oral tablet 0.35 mg	1	
estarylla oral tablet 0.25-0.035 mg	2	
ethynodiol diac-eth estradiol oral tablet 1-35 mg-mcg, 1-50 mg-mcg	2	
etonogestrel-ethinyl estradiol vaginal ring 0.12-0.015 mg/24 hr	2	QL (1 per 28 days)
falmina (28) oral tablet 0.1-20 mg-mcg	1	
feirza oral tablet 1 mg-20 mcg (21)/75 mg (7), 1.5 mg-30 mcg (21)/75 mg (7)	2	
hailey 24 fe oral tablet 1 mg-20 mcg (24)/75 mg (4)	2	
hailey fe 1.5/30 (28) oral tablet 1.5 mg-30 mcg (21)/75 mg (7)	1	
hailey fe 1/20 (28) oral tablet 1 mg-20 mcg (21)/75 mg (7)	1	
haloette vaginal ring 0.12-0.015 mg/24 hr	2	QL (1 per 28 days)
heather oral tablet 0.35 mg	1	
iclevia oral tablets,dose pack,3 month 0.15 mg-30 mcg (91)	2	QL (91 per 84 days)
incassia oral tablet 0.35 mg	1	
introvale oral tablets,dose pack,3 month 0.15 mg-30 mcg (91)	2	QL (91 per 84 days)
isibloom oral tablet 0.15-0.03 mg	2	

Drug Name	Drug Tier	Requirements/Limits
jaimiess oral tablets,dose pack,3 month 0.15 mg-30 mcg (84)/10 mcg (7)	1	QL (91 per 84 days)
jencycla oral tablet 0.35 mg	1	
jolessa oral tablets,dose pack,3 month 0.15 mg-30 mcg (91)	4	QL (91 per 84 days)
juleber oral tablet 0.15-0.03 mg	1	
junel 1.5/30 (21) oral tablet 1.5-30 mg-mcg	2	
junel 1/20 (21) oral tablet 1-20 mg-mcg	2	
junel fe 1.5/30 (28) oral tablet 1.5 mg-30 mcg (21)/75 mg (7)	1	
junel fe 1/20 (28) oral tablet 1 mg-20 mcg (21)/75 mg (7)	1	
junel fe 24 oral tablet 1 mg-20 mcg (24)/75 mg (4)	1	
kariva (28) oral tablet 0.15-0.02 mgx21 /0.01 mg x 5	2	
kelnor 1/35 (28) oral tablet 1-35 mg-mcg	2	
kelnor 1/50 (28) oral tablet 1-50 mg-mcg	2	
kurvelo (28) oral tablet 0.15-0.03 mg	1	
KYLEENA INTRAUTERINE INTRAUTERINE DEVICE 17.5 MCG/24 HR (5 YRS) 19.5 MG	4	
l norgest/e.estradiol-e.estrad oral tablets,dose pack,3 month 0.1 mg-20 mcg (84)/10 mcg (7), 0.15 mg-20 mcg/ 0.15 mg-25 mcg, 0.15 mg-30 mcg (84)/10 mcg (7)	1	QL (91 per 84 days)
larin 1.5/30 (21) oral tablet 1.5-30 mg-mcg	2	
larin 1/20 (21) oral tablet 1-20 mg-mcg	2	
larin 24 fe oral tablet 1 mg-20 mcg (24)/75 mg (4)	1	
larin fe 1.5/30 (28) oral tablet 1.5 mg-30 mcg (21)/75 mg (7)	2	
larin fe 1/20 (28) oral tablet 1 mg-20 mcg (21)/75 mg (7)	2	
lessina oral tablet 0.1-20 mg-mcg	1	
levonest (28) oral tablet 50-30 (6)/75-40 (5)/125-30(10)	2	
levonorgest-eth.estradiol-iron oral tablet 0.1 mg-0.02 mg (21)/iron (7)	4	
levonorgestrel-ethinyl estrad oral tablet 0.1-20 mg-mcg, 0.15-0.03 mg	1	

Drug Name	Drug Tier	Requirements/Limits
levonorgestrel-ethinyl estrad oral tablet 90-20 mcg (28)	2	
levonorgestrel-ethinyl estrad oral tablets,dose pack,3 month 0.15 mg-30 mcg (91)	1	QL (91 per 84 days)
levonorg-eth estrad triphasic oral tablet 50-30 (6)/75-40 (5)/125-30(10)	2	
levora-28 oral tablet 0.15-0.03 mg	2	
LILETTA INTRAUTERINE INTRAUTERINE DEVICE 20.4 MCG/24 HR (8 YRS) 52 MG	3	
lojaimiess oral tablets,dose pack,3 month 0.1 mg-20 mcg (84)/10 mcg (7)	1	QL (91 per 84 days)
low-ogestrel (28) oral tablet 0.3-30 mg-mcg	2	
lo-zumandimine (28) oral tablet 3-0.02 mg	1	
luizza oral tablet 1-20 mg-mcg, 1.5-30 mg-mcg	2	
lutera (28) oral tablet 0.1-20 mg-mcg	1	
lyleq oral tablet 0.35 mg	2	
lyza oral tablet 0.35 mg	2	
marlissa (28) oral tablet 0.15-0.03 mg	1	
meleya oral tablet 0.35 mg	1	
microgestin 1.5/30 (21) oral tablet 1.5-30 mg-mcg	2	
microgestin 1/20 (21) oral tablet 1-20 mg-mcg	2	
microgestin fe 1.5/30 (28) oral tablet 1.5 mg-30 mcg (21)/75 mg (7)	1	
microgestin fe 1/20 (28) oral tablet 1 mg-20 mcg (21)/75 mg (7)	1	
mili oral tablet 0.25-0.035 mg	1	
MIRENA INTRAUTERINE INTRAUTERINE DEVICE 21 MCG/24HR (UP TO 8 YRS) 52 MG	4	
mono-linyah oral tablet 0.25-0.035 mg	1	
NEXPLANON SUBDERMAL IMPLANT 68 MG	3	
nikki (28) oral tablet 3-0.02 mg	1	
norelgestromin-ethin.estradiol transdermal patch weekly 150-35 mcg/24 hr	2	QL (3 per 28 days)
norethindrone (contraceptive) oral tablet 0.35 mg	1	
norethindrone-e.estradiol-iron oral tablet 1 mg-20 mcg (21)/75 mg (7), 1.5 mg-30 mcg (21)/75 mg (7)	1	

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Drug Name	Drug Tier	Requirements/Limits
norethindrone-e.estradiol-iron oral tablet 1-20(5)/1-30(7) /1mg-35mcg (9)	2	
norgestimate-ethinyl estradiol oral tablet 0.18/0.215/0.25 mg-0.025 mg, 0.18/0.215/0.25 mg-0.035mg (28), 0.25-0.035 mg	1	
nortrel 0.5/35 (28) oral tablet 0.5-35 mg-mcg	2	
nortrel 1/35 (21) oral tablet 1-35 mg-mcg (21)	2	
nortrel 1/35 (28) oral tablet 1-35 mg-mcg	2	
nortrel 7/7/7 (28) oral tablet 0.5/0.75/1 mg- 35 mcg	2	
nylia 1/35 (28) oral tablet 1-35 mg-mcg	1	
nylia 7/7/7 (28) oral tablet 0.5/0.75/1 mg- 35 mcg	1	
orquidea oral tablet 0.35 mg	2	
pimtrea (28) oral tablet 0.15-0.02 mgx21 /0.01 mg x 5	2	
portia 28 oral tablet 0.15-0.03 mg	2	
reclipsen (28) oral tablet 0.15-0.03 mg	2	
rivelsa oral tablets,dose pack,3 month 0.15 mg-20 mcg/ 0.15 mg-25 mcg	1	QL (91 per 84 days)
rosyrah oral tablets,dose pack,3 month 0.15 mg-20 mcg/ 0.15 mg-25 mcg	1	QL (91 per 84 days)
setlakin oral tablets,dose pack,3 month 0.15 mg-30 mcg (91)	1	QL (91 per 84 days)
sharobel oral tablet 0.35 mg	2	
simliya (28) oral tablet 0.15-0.02 mgx21 /0.01 mg x 5	2	
simpesse oral tablets,dose pack,3 month 0.15 mg-30 mcg (84)/10 mcg (7)	1	QL (91 per 84 days)
SKYLA INTRAUTERINE INTRAUTERINE DEVICE 14 MCG/24 HR (3 YRS) 13.5 MG	4	
sprintec (28) oral tablet 0.25-0.035 mg	1	
sronyx oral tablet 0.1-20 mg-mcg	2	
tarina 24 fe oral tablet 1 mg-20 mcg (24)/75 mg (4)	1	
tarina fe 1-20 eq (28) oral tablet 1 mg-20 mcg (21)/75 mg (7)	2	
tilia fe oral tablet 1-20(5)/1-30(7) /1mg-35mcg (9)	2	
tri-estarylla oral tablet 0.18/0.215/0.25 mg-0.035mg (28)	2	

Drug Name	Drug Tier	Requirements/Limits
tri-legest fe oral tablet 1-20(5)/1-30(7) /1mg-35mcg (9)	2	
tri-linyah oral tablet 0.18/0.215/0.25 mg-0.035mg (28)	2	
tri-lo-estarylla oral tablet 0.18/0.215/0.25 mg-0.025 mg	1	
tri-lo-marzia oral tablet 0.18/0.215/0.25 mg-0.025 mg	1	
tri-lo-mili oral tablet 0.18/0.215/0.25 mg-0.025 mg	2	
tri-lo-sprintec oral tablet 0.18/0.215/0.25 mg-0.025 mg	2	
tri-mili oral tablet 0.18/0.215/0.25 mg-0.035mg (28)	2	
tri-nymyo oral tablet 0.18/0.215/0.25 mg-35 mcg (28)	2	
tri-sprintec (28) oral tablet 0.18/0.215/0.25 mg-0.035mg (28)	1	
trivora (28) oral tablet 50-30 (6)/75-40 (5)/125-30(10)	2	
tri-vylibra lo oral tablet 0.18/0.215/0.25 mg-0.025 mg	1	
tri-vylibra oral tablet 0.18/0.215/0.25 mg-0.035mg (28)	2	
turqoz (28) oral tablet 0.3-30 mg-mcg	2	
tyblume oral tablet,chewable 0.1 mg- 20 mcg	4	
valtya oral tablet 1-35 mg-mcg, 1-50 mg-mcg	2	
vienva oral tablet 0.1-20 mg-mcg	1	
viorele (28) oral tablet 0.15-0.02 mgx21 /0.01 mg x 5	2	
volnea (28) oral tablet 0.15-0.02 mgx21 /0.01 mg x 5	2	
vylibra oral tablet 0.25-0.035 mg	2	
xarah fe oral tablet 1-20(5)/1-30(7) /1mg-35mcg (9)	2	
xulane transdermal patch weekly 150-35 mcg/24 hr	2	QL (3 per 28 days)
zafemy transdermal patch weekly 150-35 mcg/24 hr	2	QL (3 per 28 days)
zovia 1-35 (28) oral tablet 1-35 mg-mcg	2	

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Drug Name	Drug Tier	Requirements/Limits
Dental And Oral Agents		
Dental And Oral Agents		
cevimeline oral capsule 30 mg	4	
chlorhexidine gluconate mucous membrane mouthwash 0.12 %	1	
periogard mucous membrane mouthwash 0.12 %	1	
pilocarpine hcl oral tablet 5 mg	2	
pilocarpine hcl oral tablet 7.5 mg	4	
triamcinolone acetonide dental paste 0.1 %	2	
Dermatological Agents		
Anti-Infectives (Skin And Mucous Membrane)		
acyclovir topical ointment 5 %	2	QL (30 per 30 days)
clindamycin phosphate vaginal cream 2 %	2	
metronidazole vaginal gel 0.75 % (37.5mg/5 gram)	2	
terconazole vaginal cream 0.4 %, 0.8 %	2	
terconazole vaginal suppository 80 mg	4	
Dermatological Agents, Other		
acitretin oral capsule 10 mg, 17.5 mg, 25 mg	2	
ALTRENO TOPICAL LOTION 0.05 %	4	PA
ammonium lactate topical cream 12 %	2	
ammonium lactate topical lotion 12 %	2	
calcipotriene scalp solution 0.005 %	2	QL (120 per 30 days)
calcipotriene topical cream 0.005 %	2	QL (120 per 30 days)
calcipotriene topical ointment 0.005 %	2	QL (120 per 30 days)
fluorouracil topical cream 5 %	2	
fluorouracil topical solution 2 %, 5 %	2	
imiquimod topical cream in packet 5 %	2	QL (24 per 30 days)
KLISYRI (250 MG) TOPICAL OINTMENT IN PACKET 1 %	5	ST; QL (5 per 5 days)
methoxsalen oral capsule,liqd-filled,rapid rel 10 mg	5	
nitroglycerin rectal ointment 0.4 % (w/w)	2	QL (30 per 30 days)
PANRETIN TOPICAL GEL 0.1 %	5	QL (60 per 28 days)
podofilox topical solution 0.5 %	2	
SANTYL TOPICAL OINTMENT 250 UNIT/GRAM	4	QL (180 per 30 days)
selenium sulfide topical lotion 2.5 %	2	
silver sulfadiazine topical cream 1 %	2	

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Drug Name	Drug Tier	Requirements/Limits
ssd topical cream 1 %	4	
tazarotene topical cream 0.1 %	2	
tretinoin topical cream 0.025 %, 0.05 %, 0.1 %	2	PA
VALCHLOR TOPICAL GEL 0.016 %	5	PA NSO
zenatane oral capsule 10 mg, 20 mg, 30 mg, 40 mg	2	
Dermatological Antibacterials		
clindamycin phosphate topical solution 1 %	2	QL (180 per 30 days)
clindamycin phosphate topical swab 1 %	2	
erythromycin with ethanol topical solution 2 %	2	
gentamicin topical cream 0.1 %	2	QL (90 per 30 days)
metronidazole topical cream 0.75 %	2	
metronidazole topical gel 0.75 %, 1 %	4	
mupirocin topical ointment 2 %	1	QL (220 per 30 days)
rosadan topical cream 0.75 %	2	
Dermatological Anti-Inflammatory Agents		
ala-cort topical cream 1 %	2	
betamethasone dipropionate topical cream 0.05 %	2	
betamethasone dipropionate topical lotion 0.05 %	2	
betamethasone dipropionate topical ointment 0.05 %	2	
betamethasone valerate topical cream 0.1 %	2	
betamethasone valerate topical lotion 0.1 %	2	
betamethasone valerate topical ointment 0.1 %	2	
betamethasone, augmented topical cream 0.05 %	2	
betamethasone, augmented topical gel 0.05 %	2	
betamethasone, augmented topical lotion 0.05 %	2	
betamethasone, augmented topical ointment 0.05 %	2	
clobetasol scalp solution 0.05 %	2	
clobetasol topical cream 0.05 %	2	
clobetasol topical gel 0.05 %	4	
clobetasol topical ointment 0.05 %	2	
clobetasol topical shampoo 0.05 %	2	
clobetasol-emollient topical cream 0.05 %	2	
diclofenac sodium topical drops 1.5 %	2	QL (300 per 30 days)

Drug Name	Drug Tier	Requirements/Limits
diclofenac sodium topical solution in metered-dose pump 20 mg/gram /actuation(2 %)	2	PA; QL (224 per 28 days)
EUCRISA TOPICAL OINTMENT 2 %	3	
fluocinolone topical cream 0.01 %, 0.025 %	2	
fluocinolone topical ointment 0.025 %	2	
fluocinonide topical cream 0.05 %, 0.1 %	2	
fluocinonide topical gel 0.05 %	2	
fluocinonide topical ointment 0.05 %	2	
fluocinonide topical solution 0.05 %	2	
fluticasone propionate topical cream 0.05 %	2	
halobetasol propionate topical cream 0.05 %	2	
halobetasol propionate topical ointment 0.05 %	2	
hydrocortisone 2.5% cream	2	
hydrocortisone topical cream 1 %	2	
hydrocortisone topical cream with perineal applicator 2.5 %	2	
hydrocortisone topical lotion 2.5 %	2	
hydrocortisone topical ointment 1 %, 2.5 %	1	
hydrocortisone valerate topical cream 0.2 %	2	
mometasone topical cream 0.1 %	2	
mometasone topical ointment 0.1 %	2	
mometasone topical solution 0.1 %	2	
procto-med hc topical cream with perineal applicator 2.5 %	2	
proctosol hc topical cream with perineal applicator 2.5 %	2	
proctozone-hc topical cream with perineal applicator 2.5 %	2	
triamcinolone acetonide topical cream 0.025 %, 0.1 %, 0.5 %	1	
triamcinolone acetonide topical lotion 0.025 %, 0.1 %	2	
triamcinolone acetonide topical ointment 0.025 %, 0.1 %, 0.5 %	2	
Scabicides And Pediculicides		
malathion topical lotion 0.5 %	2	
permethrin topical cream 5 %	2	QL (60 per 30 days)
Devices		
Devices		

Please refer to our Evidence of Coverage for 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.

Drug Name	Drug Tier	Requirements/Limits
1ST TIER UNIFINE PENTP 5MM 31G 31 GAUGE X 3/16"	2	PA; ST
1ST TIER UNIFINE PNTIP 4MM 32G 32 GAUGE X 5/32"	2	PA; ST
1ST TIER UNIFINE PNTIP 6MM 31G 31 GAUGE X 1/4"	2	PA; ST
1ST TIER UNIFINE PNTIP 8MM 31G STRL,SINGLE-USE,SHRT 31 GAUGE X 5/16"	2	PA; ST
1ST TIER UNIFINE PNTP 29GX1/2" 29 GAUGE X 1/2"	2	PA; ST
1ST TIER UNIFINE PNTP 31GX3/16 31 GAUGE X 3/16"	2	PA; ST
1ST TIER UNIFINE PNTP 32GX5/32 32 GAUGE X 5/32"	2	PA; ST
ADVOCATE INS 0.3 ML 30GX5/16" 0.3 ML 30 GAUGE X 5/16"	2	PA; ST
ADVOCATE INS 0.3 ML 31GX5/16" 0.3 ML 31 GAUGE X 5/16"	2	PA; ST
ADVOCATE INS 0.5 ML 30GX5/16" 0.5 ML 30 GAUGE X 5/16"	2	PA; ST
ADVOCATE INS 0.5 ML 31GX5/16" 0.5 ML 31 GAUGE X 5/16"	2	PA; ST
ADVOCATE INS 1 ML 31GX5/16" 1 ML 31 GAUGE X 5/16	2	PA; ST
ADVOCATE INS SYR 1 ML 30GX5/16 1 ML 30 GAUGE X 5/16	2	PA; ST
ADVOCATE PEN NEEDLE 32G 4MM 32 GAUGE X 5/32"	2	PA; ST
ADVOCATE PEN NEEDLE 4MM 33G 33 GAUGE X 5/32"	2	PA; ST
ADVOCATE PEN NEEDLES 5MM 31G 31 GAUGE X 3/16"	2	PA; ST
ADVOCATE PEN NEEDLES 8MM 31G 31 GAUGE X 5/16"	2	PA; ST
ALCOHOL PADS TOPICAL PADS, MEDICATED	1	PA; ST
AQINJECT PEN NEEDLE 31G 5MM 31 GAUGE X 3/16"	2	PA; ST
AQINJECT PEN NEEDLE 32G 4MM 32 GAUGE X 5/32"	2	PA; ST

Drug Name	Drug Tier	Requirements/Limits
ASSURE ID DUO PRO NDL 31G 5MM 31 GAUGE X 3/16"	2	PA; ST
ASSURE ID DUO-SHIELD 30GX3/16" 30 GAUGE X 3/16"	2	PA; ST
ASSURE ID DUO-SHIELD 30GX5/16" 30 GAUGE X 5/16"	2	PA; ST
ASSURE ID INSULIN SAFETY SYRINGE 1 ML 29 GAUGE X 1/2"	2	PA; ST
ASSURE ID PEN NEEDLE 30GX5/16" 30 GAUGE X 5/16"	2	PA; ST
ASSURE ID PRO PEN NDL 30G 5MM 30 GAUGE X 3/16"	2	PA; ST
ASSURE ID SYR 0.5 ML 31GX15/64" 0.5 ML 31 GAUGE X 15/64"	2	PA; ST
ASSURE ID SYR 1 ML 31GX15/64" 1 ML 31 GAUGE X 15/64"	2	PA; ST
BD AUTOSHIELD DUO NDL 5MMX30G 30 GAUGE X 3/16"	2	PA; ST
BD ECLIPSE 30GX1/2" SYRINGE 1 ML 30 GAUGE X 1/2"	2	PA; ST
BD INS SYR 0.3 ML 8MMX31G(1/2) 0.3 ML 31 GAUGE X 5/16"	2	PA; ST
BD INS SYR UF 0.3 ML 12.7MMX30G 0.3 ML 30 GAUGE X 1/2"	2	PA; ST
BD INS SYR UF 0.5 ML 12.7MMX30G NOT FOR RETAIL SALE 0.5 ML 30 GAUGE X 1/2"	2	PA; ST
BD INSULIN SYR 1 ML 27GX12.7MM 1 ML 27 GAUGE X 1/2"	2	PA; ST
BD INSULIN SYR 1 ML 27GX5/8" MICRO-FINE 1 ML 27 GAUGE X 5/8"	2	PA; ST
BD SAFETGLD INS 0.3 ML 29G 13MM 0.3 ML 29 GAUGE X 1/2"	2	PA; ST
BD SAFETYGLD INS 0.3 ML 31G 8MM 0.3 ML 31 GAUGE X 5/16"	2	PA; ST
BD SAFETYGLD INS 0.5 ML 30G 8MM 0.5 ML 30 GAUGE X 5/16"	2	PA; ST
BD SAFETYGLD INS 1 ML 29G 13MM 1 ML 29 GAUGE X 1/2"	2	PA; ST
BD SAFETYGLID INS 1 ML 6MMX31G 1 ML 31 GAUGE X 15/64"	2	PA; ST

Please refer to our Evidence of Coverage for 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.

Drug Name	Drug Tier	Requirements/Limits
BD SAFETYGLIDE SYRINGE 27GX5/8 1 ML 27 GAUGE X 5/8"	2	PA; ST
BD SAFTYGLD INS 0.3 ML 6MMX31G 0.3 ML 31 GAUGE X 15/64"	2	PA; ST
BD SAFTYGLD INS 0.5 ML 29G 13MM 0.5 ML 29 GAUGE X 1/2"	2	PA; ST
BD SAFTYGLD INS 0.5 ML 6MMX31G 0.5 ML 31 GAUGE X 15/64"	2	PA; ST
BD SINGLE USE SWAB	1	PA; ST
BD UF MICRO PEN NEEDLE 6MMX32G 32 GAUGE X 1/4"	2	PA; ST
BD UF MINI PEN NEEDLE 5MMX31G 31 GAUGE X 3/16"	2	PA; ST
BD UF NANO PEN NEEDLE 4MMX32G 32 GAUGE X 5/32"	2	PA; ST
BD UF ORIG PEN NDL 12.7MMX29G 29 GAUGE X 1/2"	2	PA; ST
BD UF SHORT PEN NEEDLE 8MMX31G 31 GAUGE X 5/16"	2	PA; ST
BD VEO INS 0.3 ML 6MMX31G (1/2) 0.3 ML 31 GAUGE X 15/64"	2	PA; ST
BD VEO INS SYRING 1 ML 6MMX31G 1 ML 31 GAUGE X 15/64"	2	PA; ST
BD VEO INS SYRN 0.3 ML 6MMX31G 0.3 ML 31 GAUGE X 15/64"	2	PA; ST
BD VEO INS SYRN 0.5 ML 6MMX31G 1/2 ML 31 GAUGE X 15/64"	2	PA; ST
BORDERED GAUZE 2"X2" 2 X 2 "	1	PA; ST
CAREFINE PEN NEEDLE 12.7MM 29G HRI 29 GAUGE X 1/2"	2	PA; ST
CAREFINE PEN NEEDLE 4MM 32G 32 GAUGE X 5/32"	2	PA; ST
CAREFINE PEN NEEDLE 5MM 32G 32 GAUGE X 3/16"	2	PA; ST
CAREFINE PEN NEEDLE 6MM 31G HRI 31 GAUGE X 1/4"	2	PA; ST
CAREFINE PEN NEEDLE 8MM 30G HRI 30 GAUGE X 5/16"	2	PA; ST
CAREFINE PEN NEEDLES 6MM 32G 32 GAUGE X 1/4"	2	PA; ST

Drug Name	Drug Tier	Requirements/Limits
CAREFINE PEN NEEDLES 8MM 31G 31 GAUGE X 5/16"	2	PA; ST
CARETOUCH ALCOHOL 70% PREP PAD	1	PA; ST
CARETOUCH PEN NEEDLE 29G 12MM 29 GAUGE X 1/2"	2	PA; ST
CARETOUCH PEN NEEDLE 31GX1/4" 31 GAUGE X 1/4"	2	PA; ST
CARETOUCH PEN NEEDLE 31GX3/16" 31 GAUGE X 3/16"	2	PA; ST
CARETOUCH PEN NEEDLE 31GX5/16" 31 GAUGE X 5/16"	2	PA; ST
CARETOUCH PEN NEEDLE 32GX3/16" 32 GAUGE X 3/16"	2	PA; ST
CARETOUCH PEN NEEDLE 32GX5/32" 32 GAUGE X 5/32"	2	PA; ST
CARETOUCH SYR 0.3 ML 31GX5/16" 0.3 ML 31 GAUGE X 5/16"	2	PA; ST
CARETOUCH SYR 0.5 ML 30GX5/16" 0.5 ML 30 GAUGE X 5/16"	2	PA; ST
CARETOUCH SYR 0.5 ML 31GX5/16" 0.5 ML 31 GAUGE X 5/16"	2	PA; ST
CARETOUCH SYR 1 ML 28GX5/16" 1 ML 28 X 5/16"	2	PA; ST
CARETOUCH SYR 1 ML 29GX5/16" 1 ML 29 GAUGE X 5/16	2	PA; ST
CARETOUCH SYR 1 ML 30GX5/16" 1 ML 30 GAUGE X 5/16	2	PA; ST
CARETOUCH SYR 1 ML 31GX5/16" 1 ML 31 GAUGE X 5/16	2	PA; ST
CLICKFINE PEN NEEDLE 32GX5/32" 32GX4MM, STERILE 32 GAUGE X 5/32"	2	PA; ST
CLICKFINE UNIVERSAL 31G X 1/4" 6MM, STORE BRAND 31 GAUGE X 1/4"	2	PA; ST
COMFORT EZ 0.3 ML 31G 15/64" 0.3 ML 31 GAUGE X 15/64"	2	PA; ST
COMFORT EZ 0.5 ML 31G 15/64" 1/2 ML 31 GAUGE X 15/64"	2	PA; ST
COMFORT EZ INS 0.3 ML 30GX1/2" 0.3 ML 30 GAUGE X 1/2"	2	PA; ST

Drug Name	Drug Tier	Requirements/Limits
COMFORT EZ INS 0.3 ML 30GX5/16" 0.3 ML 30 GAUGE X 5/16"	2	PA; ST
COMFORT EZ INS 1 ML 31G 15/64" 1 ML 31 GAUGE X 15/64"	2	PA; ST
COMFORT EZ INS 1 ML 31GX5/16" 1 ML 31 GAUGE X 5/16	2	PA; ST
COMFORT EZ INSULIN SYR 0.3 ML 0.3 ML 31 GAUGE X 5/16"	2	PA; ST
COMFORT EZ INSULIN SYR 0.5 ML 0.5 ML 30 GAUGE X 5/16", 0.5 ML 31 GAUGE X 5/16"	2	PA; ST
COMFORT EZ PEN NEEDLE 12MM 29G 29 GAUGE X 1/2"	2	PA; ST
COMFORT EZ PEN NEEDLES 4MM 32G SINGLE USE, MICRO 32 GAUGE X 5/32"	2	PA; ST
COMFORT EZ PEN NEEDLES 4MM 33G 33 GAUGE X 5/32"	2	PA; ST
COMFORT EZ PEN NEEDLES 5MM 31G MINI 31 GAUGE X 3/16"	2	PA; ST
COMFORT EZ PEN NEEDLES 5MM 32G SINGLE USE,MINI,HRI 32 GAUGE X 3/16"	2	PA; ST
COMFORT EZ PEN NEEDLES 5MM 33G 33 GAUGE X 3/16"	2	PA; ST
COMFORT EZ PEN NEEDLES 6MM 31G 31 GAUGE X 1/4"	2	PA; ST
COMFORT EZ PEN NEEDLES 6MM 32G 32 GAUGE X 1/4"	2	PA; ST
COMFORT EZ PEN NEEDLES 6MM 33G 33 GAUGE X 1/4"	2	PA; ST
COMFORT EZ PEN NEEDLES 8MM 31G SHORT 31 GAUGE X 5/16"	2	PA; ST
COMFORT EZ PEN NEEDLES 8MM 32G 32 GAUGE X 5/16"	2	PA; ST
COMFORT EZ PEN NEEDLES 8MM 33G 33 GAUGE X 5/16"	2	PA; ST
COMFORT EZ PRO PEN NDL 30G 8MM 30 GAUGE X 5/16"	2	PA; ST
COMFORT EZ PRO PEN NDL 31G 4MM 31 GAUGE X 5/32"	2	PA; ST
COMFORT EZ PRO PEN NDL 31G 5MM 31 GAUGE X 3/16"	2	PA; ST

Drug Name	Drug Tier	Requirements/Limits
COMFORT EZ SYR 0.3 ML 29GX1/2" 0.3 ML 29 GAUGE X 1/2"	2	PA; ST
COMFORT EZ SYR 0.5 ML 28GX1/2" 1/2 ML 28 GAUGE X 1/2"	2	PA; ST
COMFORT EZ SYR 0.5 ML 29GX1/2" 0.5 ML 29 GAUGE X 1/2"	2	PA; ST
COMFORT EZ SYR 0.5 ML 30GX1/2" 0.5 ML 30 GAUGE X 1/2"	2	PA; ST
COMFORT EZ SYR 1 ML 27G 12.7MM 1 ML 27 GAUGE X 1/2"	2	PA; ST
COMFORT EZ SYR 1 ML 28GX1/2" 1 ML 28 GAUGE X 1/2"	2	PA; ST
COMFORT EZ SYR 1 ML 29GX1/2" 1 ML 29 GAUGE X 1/2"	2	PA; ST
COMFORT EZ SYR 1 ML 30GX1/2" 1 ML 30 GAUGE X 1/2"	2	PA; ST
COMFORT EZ SYR 1 ML 30GX5/16" 1 ML 30 GAUGE X 5/16	2	PA; ST
COMFORT POINT PEN NDL 31GX1/3" 31 GAUGE X 1/3"	2	PA; ST
COMFORT POINT PEN NDL 31GX1/6" 31 GAUGE X 1/6"	2	PA; ST
COMFORT TOUCH PEN NDL 31G 4MM 31 GAUGE X 5/32"	2	PA; ST
COMFORT TOUCH PEN NDL 31G 5MM 31 GAUGE X 3/16"	2	PA; ST
COMFORT TOUCH PEN NDL 31G 6MM 31 GAUGE X 1/4"	2	PA; ST
COMFORT TOUCH PEN NDL 31G 8MM 31 GAUGE X 5/16"	2	PA; ST
COMFORT TOUCH PEN NDL 32G 4MM 32 GAUGE X 5/32"	2	PA; ST
COMFORT TOUCH PEN NDL 32G 5MM 32 GAUGE X 3/16"	2	PA; ST
COMFORT TOUCH PEN NDL 32G 6MM 32 GAUGE X 1/4"	2	PA; ST
COMFORT TOUCH PEN NDL 32G 8MM 32 GAUGE X 5/16"	2	PA; ST
COMFORT TOUCH PEN NDL 33G 4MM 33 GAUGE X 5/32"	2	PA; ST

Drug Name	Drug Tier	Requirements/Limits
COMFORT TOUCH PEN NDL 33G 6MM 33 GAUGE X 1/4"	2	PA; ST
COMFORT TOUCH PEN NDL 33GX5MM 33 GAUGE X 3/16"	2	PA; ST
CURITY ALCOHOL PREPS 2 PLY,MEDIUM	1	PA; ST
CURITY GAUZE PADS 2 X 2 "	1	PA; ST
CURITY GAUZE SPONGES (12 PLY)-200/BAG 2 X 2 "	1	PA; ST
DERMACEA 2"X2" GAUZE 12 PLY, USP TYPE VII 2 X 2 "	1	PA; ST
DERMACEA GAUZE 2"X2" SPONGE 8 PLY 2 X 2 "	1	PA; ST
DERMACEA NON-WOVEN 2"X2" SPNGE 2 X 2 "	1	PA; ST
DROPLET 0.3 ML 29G 12.7MM(1/2) OUTER 0.3 ML 29 GAUGE X 1/2"	2	PA; ST
DROPLET 0.3 ML 30G 12.7MM(1/2) OUTER 0.3 ML 30 GAUGE X 1/2"	2	PA; ST
DROPLET 0.5 ML 29GX12.5MM(1/2) 0.5 ML 29 GAUGE X 1/2"	2	PA; ST
DROPLET 0.5 ML 30GX12.5MM(1/2) 0.5 ML 30 GAUGE X 1/2"	2	PA; ST
DROPLET INS 0.3 ML 29GX12.5MM 0.3 ML 29 GAUGE X 1/2"	2	PA; ST
DROPLET INS 0.3 ML 30G 8MM(1/2) OUTER 0.3 ML 30 GAUGE X 5/16"	2	PA; ST
DROPLET INS 0.3 ML 30GX12.5MM 0.3 ML 30 GAUGE X 1/2"	2	PA; ST
DROPLET INS 0.3 ML 31G 6MM(1/2) OUTER 0.3 ML 31 GAUGE X 15/64"	2	PA; ST
DROPLET INS 0.3 ML 31G 8MM(1/2) OUTER 0.3 ML 31 GAUGE X 5/16"	2	PA; ST
DROPLET INS 0.5 ML 29G 12.7MM OUTER 0.5 ML 29 GAUGE X 1/2"	2	PA; ST
DROPLET INS 0.5 ML 30G 12.7MM OUTER 0.5 ML 30 GAUGE X 1/2"	2	PA; ST
DROPLET INS 0.5 ML 30GX6MM(1/2) 0.5ML 30 GAUGE X 15/64"	2	PA; ST
DROPLET INS 0.5 ML 30GX8MM(1/2) 0.5 ML 30 GAUGE X 5/16"	2	PA; ST

Drug Name	Drug Tier	Requirements/Limits
DROPLET INS 0.5 ML 31GX6MM(1/2) 0.5 ML 31 GAUGE X 15/64"	2	PA; ST
DROPLET INS 0.5 ML 31GX8MM(1/2) 0.5 ML 31 GAUGE X 5/16"	2	PA; ST
DROPLET INS SYR 0.3 ML 30GX6MM 0.3 ML 30 GAUGE X 15/64"	2	PA; ST
DROPLET INS SYR 0.3 ML 30GX8MM 0.3 ML 30 GAUGE X 5/16"	2	PA; ST
DROPLET INS SYR 0.3 ML 31GX6MM 0.3 ML 31 GAUGE X 15/64"	2	PA; ST
DROPLET INS SYR 0.3 ML 31GX8MM 0.3 ML 31 GAUGE X 5/16"	2	PA; ST
DROPLET INS SYR 0.5 ML 30G 8MM OUTER 0.5 ML 30 GAUGE X 5/16"	2	PA; ST
DROPLET INS SYR 0.5 ML 31G 6MM OUTER 1/2 ML 31 GAUGE X 15/64"	2	PA; ST
DROPLET INS SYR 0.5 ML 31G 8MM OUTER 0.5 ML 31 GAUGE X 5/16"	2	PA; ST
DROPLET INS SYR 1 ML 29G 12.7MM OUTER 1 ML 29 GAUGE X 1/2"	2	PA; ST
DROPLET INS SYR 1 ML 30G 12.5MM 1 ML 30 GAUGE X 1/2"	2	PA; ST
DROPLET INS SYR 1 ML 30G 6MM 1 ML 30 GAUGE X 15/64"	2	PA; ST
DROPLET INS SYR 1 ML 30G 8MM OUTER 1 ML 30 GAUGE X 5/16	2	PA; ST
DROPLET INS SYR 1 ML 31G 6MM OUTER 1 ML 31 GAUGE X 15/64"	2	PA; ST
DROPLET INS SYR 1 ML 31G 8MM 1 ML 31 GAUGE X 5/16	2	PA; ST
DROPLET MICRON 34G X 9/64" 34 GAUGE X 9/64"	2	PA; ST
DROPLET PEN NEEDLE 29G 10MM 29 GAUGE X 3/8"	2	PA; ST
DROPLET PEN NEEDLE 29G 12MM 29 GAUGE X 1/2"	2	PA; ST
DROPLET PEN NEEDLE 30G 8MM 30 GAUGE X 5/16"	2	PA; ST
DROPLET PEN NEEDLE 31G 5MM 31 GAUGE X 3/16"	2	PA; ST

Drug Name	Drug Tier	Requirements/Limits
DROPLET PEN NEEDLE 31G 6MM 31 GAUGE X 1/4"	2	PA; ST
DROPLET PEN NEEDLE 31G 8MM 31 GAUGE X 5/16"	2	PA; ST
DROPLET PEN NEEDLE 32G 4MM 32 GAUGE X 5/32"	2	PA; ST
DROPLET PEN NEEDLE 32G 5MM 32 GAUGE X 3/16"	2	PA; ST
DROPLET PEN NEEDLE 32G 6MM 32 GAUGE X 1/4"	2	PA; ST
DROPLET PEN NEEDLE 32G 8MM 32 GAUGE X 5/16"	2	PA; ST
DROPSAFE ALCOHOL 70% PREP PADS	1	PA; ST
DROPSAFE INS SYR 0.3 ML 31G 6MM 0.3 ML 31 GAUGE X 15/64"	2	PA; ST
DROPSAFE INS SYR 0.3 ML 31G 8MM 0.3 ML 31 GAUGE X 5/16"	2	PA; ST
DROPSAFE INS SYR 0.5 ML 31G 6MM 0.5 ML 31 GAUGE X 15/64"	2	PA; ST
DROPSAFE INS SYR 0.5 ML 31G 8MM 0.5 ML 31 GAUGE X 5/16"	2	PA; ST
DROPSAFE INSUL SYR 1 ML 31G 6MM 1 ML 31 GAUGE X 15/64"	2	PA; ST
DROPSAFE INSUL SYR 1 ML 31G 8MM 1 ML 31 GAUGE X 5/16"	2	PA; ST
DROPSAFE INSULN 1 ML 29G 12.5MM 1 ML 29 GAUGE X 1/2"	2	PA; ST
DROPSAFE PEN NEEDLE 31G 4MM 31 GAUGE X 5/32"	2	PA; ST
DROPSAFE PEN NEEDLE 31G 5MM 31 GAUGE X 3/16"	2	PA; ST
DROPSAFE PEN NEEDLE 31G 8MM 31 GAUGE X 5/16"	2	PA; ST
DROPSAFE PEN NEEDLE 31GX1/4" 31 GAUGE X 1/4"	2	PA; ST
EASY CMFT SFTY PEN NDL 31G 5MM 31 GAUGE X 3/16"	2	PA; ST
EASY CMFT SFTY PEN NDL 31G 6MM 31 GAUGE X 1/4"	2	PA; ST

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Drug Name	Drug Tier	Requirements/Limits
EASY CMFT SFTY PEN NDL 32G 4MM 32 GAUGE X 5/32"	2	PA; ST
EASY COMFORT 0.3 ML 31G 1/2" 0.3 ML 31 X 1/2"	2	PA; ST
EASY COMFORT 0.3 ML 31G 5/16" 0.3 ML 31 GAUGE X 5/16"	2	PA; ST
EASY COMFORT 0.5 ML 30GX1/2" 0.5 ML 30 GAUGE X 1/2"	2	PA; ST
EASY COMFORT 0.5 ML 31GX5/16" 0.5 ML 31 GAUGE X 5/16"	2	PA; ST
EASY COMFORT 0.5 ML 32GX5/16" 1/2 ML 32 GAUGE X 5/16"	2	PA; ST
EASY COMFORT 0.5 ML SYRINGE 0.5 ML 30 GAUGE X 5/16"	2	PA; ST
EASY COMFORT 1 ML 31GX5/16" 1 ML 31 GAUGE X 5/16	2	PA; ST
EASY COMFORT 1 ML 32GX5/16" 1 ML 32 GAUGE X 5/16"	2	PA; ST
EASY COMFORT ALCOHOL 70% PAD	1	PA; ST
EASY COMFORT INSULIN 1 ML SYR 1 ML 30 GAUGE X 5/16	2	PA; ST
EASY COMFORT PEN NDL 29G 4MM 29 GAUGE X 5/32"	2	PA; ST
EASY COMFORT PEN NDL 29G 5MM 29 GAUGE X 3/16"	2	PA; ST
EASY COMFORT PEN NDL 31GX1/4" 31 GAUGE X 1/4"	2	PA; ST
EASY COMFORT PEN NDL 31GX3/16" 31 GAUGE X 3/16"	2	PA; ST
EASY COMFORT PEN NDL 31GX5/16" 31 GAUGE X 5/16"	2	PA; ST
EASY COMFORT PEN NDL 32GX5/32" 32 GAUGE X 5/32"	2	PA; ST
EASY COMFORT PEN NDL 33G 4MM 33 GAUGE X 5/32"	2	PA; ST
EASY COMFORT PEN NDL 33G 5MM 33 GAUGE X 3/16"	2	PA; ST
EASY COMFORT PEN NDL 33G 6MM 33 GAUGE X 1/4"	2	PA; ST

Drug Name	Drug Tier	Requirements/Limits
EASY COMFORT SYR 0.5 ML 29G 8MM 1/2 ML 29 X5/16 "	2	PA; ST
EASY COMFORT SYR 1 ML 29G 8MM 1 ML 29 GAUGE X 5/16	2	PA; ST
EASY COMFORT SYR 1 ML 30GX1/2" 1 ML 30 GAUGE X 1/2"	2	PA; ST
EASY GLIDE INS 0.3 ML 31GX6MM 0.3 ML 31 GAUGE X 15/64"	2	PA; ST
EASY GLIDE INS 0.5 ML 31GX6MM 1/2 ML 31 GAUGE X 15/64"	2	PA; ST
EASY GLIDE INS 1 ML 31GX6MM 1 ML 31 GAUGE X 15/64"	2	PA; ST
EASY GLIDE PEN NEEDLE 4MM 33G 33 GAUGE X 5/32"	2	PA; ST
EASY TOUCH 0.3 ML 30G 8MM(1/2) 0.3 ML 30 GAUGE X 5/16"	2	PA; ST
EASY TOUCH 0.3 ML 31G 6MM(1/2) 0.3 ML 31 GAUGE X 1/4"	2	PA; ST
EASY TOUCH 0.3 ML 31G 8MM(1/2) 0.3 ML 31 GAUGE X 5/16"	2	PA; ST
EASY TOUCH 0.3 ML SYR 30GX1/2" 0.3 ML 30 GAUGE X 1/2"	2	PA; ST
EASY TOUCH 0.5 ML SYR 27GX1/2" 1/2 ML 27 GAUGE X 1/2"	2	PA; ST
EASY TOUCH 0.5 ML SYR 29GX1/2" 0.5 ML 29 GAUGE X 1/2"	2	PA; ST
EASY TOUCH 0.5 ML SYR 30GX1/2" 0.5 ML 30 GAUGE X 1/2"	2	PA; ST
EASY TOUCH 0.5 ML SYR 30GX5/16 0.5 ML 30 GAUGE X 5/16"	2	PA; ST
EASY TOUCH 1 ML SYR 29GX1/2" 1 ML 29 GAUGE X 1/2"	2	PA; ST
EASY TOUCH 1 ML SYR 30GX1/2" 1 ML 30 GAUGE X 1/2"	2	PA; ST
EASY TOUCH ALCOHOL 70% PADS GAMMA-STERILIZED	1	PA; ST
EASY TOUCH AUTO 0.5 ML 30G 6MM 0.5 ML 30 GAUGE X 1/4"	2	PA; ST
EASY TOUCH AUTO 0.5 ML 30G 8MM 0.5 ML 30 GAUGE X 5/16"	2	PA; ST

Drug Name	Drug Tier	Requirements/Limits
EASY TOUCH AUTORET 1 ML 30G 6MM 1 ML 30 GAUGE X 1/4"	2	PA; ST
EASY TOUCH AUTORET 1 ML 30G 8MM 1 ML 30 GAUGE X 5/16"	2	PA; ST
EASY TOUCH FLIPLOK 1 ML 27GX0.5 1 ML 27 GAUGE X 1/2"	2	PA; ST
EASY TOUCH INS 0.3 ML 30G 8MM 0.3 ML 30 GAUGE X 5/16"	2	PA; ST
EASY TOUCH INS 0.3 ML 31G 8MM 0.3 ML 31 GAUGE X 5/16"	2	PA; ST
EASY TOUCH INS 0.5 ML 30G 8MM 0.5 ML 30 GAUGE X 5/16"	2	PA; ST
EASY TOUCH INS 0.5 ML 31G 6MM 1/2 ML 31 GAUGE X 1/4"	2	PA; ST
EASY TOUCH INS 0.5 ML 31G 8MM 0.5 ML 31 GAUGE X 5/16"	2	PA; ST
EASY TOUCH INS 1 ML 27G 1/2" 1 ML 27 GAUGE X 1/2"	2	PA; ST
EASY TOUCH INS 1 ML 28G 12.7MM 1 ML 28 GAUGE X 1/2"	2	PA; ST
EASY TOUCH INS SYR 1 ML 30G 8MM 1 ML 30 GAUGE X 5/16	2	PA; ST
EASY TOUCH INS SYR 1 ML 31G 6MM 1 ML 31 GAUGE X 1/4"	2	PA; ST
EASY TOUCH INS SYR 1 ML 31G 8MM 1 ML 31 GAUGE X 5/16	2	PA; ST
EASY TOUCH INSULIN 1 ML 29GX1/2 1 ML 29 GAUGE X 1/2"	2	PA; ST
EASY TOUCH INSULIN 1 ML 30GX1/2 1 ML 30 GAUGE X 1/2"	2	PA; ST
EASY TOUCH INSULIN SYR 1 ML 1 ML 29 GAUGE X 1/2"	2	PA; ST
EASY TOUCH INSULIN SYR 1 ML RETRACTABLE 1 ML 30 GAUGE X 1/2"	2	PA; ST
EASY TOUCH INSULN 1 ML 29GX1/2" 1 ML 29 GAUGE X 1/2"	2	PA; ST
EASY TOUCH INSULN 1 ML 30GX1/2" 1 ML 30 GAUGE X 1/2"	2	PA; ST
EASY TOUCH INSULN 1 ML 30GX5/16 1 ML 30 GAUGE X 5/16"	2	PA; ST

Drug Name	Drug Tier	Requirements/Limits
EASY TOUCH INSULN 1 ML 30GX5/16 1 ML 30 GAUGE X 5/16"	2	PA; ST
EASY TOUCH INSULN 1 ML 31GX5/16 1 ML 31 GAUGE X 5/16"	2	PA; ST
EASY TOUCH INSULN 1 ML 31GX5/16 1 ML 31 GAUGE X 5/16"	2	PA; ST
EASY TOUCH LUER LOK INSUL 1 ML	2	PA; ST
EASY TOUCH PEN NEEDLE 29GX1/2" 29 GAUGE X 1/2"	2	PA; ST
EASY TOUCH PEN NEEDLE 30GX5/16 30 GAUGE X 5/16"	2	PA; ST
EASY TOUCH PEN NEEDLE 31GX1/4" 31 GAUGE X 1/4"	2	PA; ST
EASY TOUCH PEN NEEDLE 31GX3/16 31 GAUGE X 3/16"	2	PA; ST
EASY TOUCH PEN NEEDLE 31GX5/16 31 GAUGE X 5/16"	2	PA; ST
EASY TOUCH PEN NEEDLE 32GX1/4" 32 GAUGE X 1/4"	2	PA; ST
EASY TOUCH PEN NEEDLE 32GX3/16 32 GAUGE X 3/16"	2	PA; ST
EASY TOUCH PEN NEEDLE 32GX5/32 32 GAUGE X 5/32"	2	PA; ST
EASY TOUCH SAF PEN NDL 29G 5MM 29 GAUGE X 3/16"	2	PA; ST
EASY TOUCH SAF PEN NDL 29G 8MM 29 GAUGE X 5/16"	2	PA; ST
EASY TOUCH SAF PEN NDL 30G 5MM 30 GAUGE X 3/16"	2	PA; ST
EASY TOUCH SAF PEN NDL 30G 8MM 30 GAUGE X 5/16"	2	PA; ST
EASY TOUCH SYR 0.5 ML 28G 12.7MM 1/2 ML 28 GAUGE X 1/2"	2	PA; ST
EASY TOUCH SYR 0.5 ML 29G 12.7MM 0.5 ML 29 GAUGE X 1/2"	2	PA; ST
EASY TOUCH SYR 1 ML 27G 16MM 1 ML 27 GAUGE X 5/8"	2	PA; ST
EASY TOUCH UNI-SLIP SYR 1 ML	2	PA; ST
EASYLIFE ALCOHOL 70% PADS	1	PA; ST

Drug Name	Drug Tier	Requirements/Limits
EASYLIFE INS PEN NDL 29G 12MM 29 GAUGE X 1/2"	2	PA; ST
EASYLIFE INS PEN NDL 31G 4MM 31 GAUGE X 5/32"	2	PA; ST
EASYLIFE INS PEN NDL 31G 5MM 31 GAUGE X 3/16"	2	PA; ST
EASYLIFE INS PEN NDL 31G 6MM 31 GAUGE X 1/4"	2	PA; ST
EASYLIFE INS PEN NDL 31G 8MM 31 GAUGE X 5/16"	2	PA; ST
EASYLIFE INS PEN NDL 32G 4MM 32 GAUGE X 5/32"	2	PA; ST
EASYLIFE INS PEN NDL 32G 5MM 32 GAUGE X 3/16"	2	PA; ST
EASYLIFE INS PEN NDL 32G 6MM 32 GAUGE X 1/4"	2	PA; ST
EASYLIFE INS PEN NDL 32G 8MM 32 GAUGE X 5/16"	2	PA; ST
EASYLIFE INS PEN NDL 33G 4MM 33 GAUGE X 5/32"	2	PA; ST
EASYLIFE INS PEN NDL 33G 5MM 33 GAUGE X 3/16"	2	PA; ST
EASYLIFE INS PEN NDL 33G 6MM 33 GAUGE X 1/4"	2	PA; ST
EASYLIFE INS PEN NDL 33G 8MM 33 GAUGE X 5/16"	2	PA; ST
EASYLIFE INS SYR 0.5 ML 30G 8MM 0.5 ML 30 GAUGE X 5/16"	2	PA; ST
EASYLIFE INS SYR 1 ML 30G 8MM 1 ML 30 GAUGE X 5/16	2	PA; ST
EASYLIFE INS SYR 1 ML 31G 8MM 1 ML 31 GAUGE X 5/16	2	PA; ST
EASYLIFE SAFTY PEN NDL 31G 4MM 31 GAUGE X 5/32"	2	PA; ST
EASYLIFE SAFTY PEN NDL 31G 5MM 31 GAUGE X 3/16"	2	PA; ST
EASYLIFE SYR 1 ML 30G 12.7MM 1 ML 30 GAUGE X 1/2"	2	PA; ST
EASYTOUCH SAF PEN NDL 30G 6MM 30 GAUGE X 1/4"	2	PA; ST

Drug Name	Drug Tier	Requirements/Limits
EMBRACE PEN NEEDLE 29G 12MM 29 GAUGE X 1/2"	2	PA; ST
EMBRACE PEN NEEDLE 30G 5MM 30 GAUGE X 3/16"	2	PA; ST
EMBRACE PEN NEEDLE 30G 8MM 30 GAUGE X 5/16"	2	PA; ST
EMBRACE PEN NEEDLE 31G 5MM 31 GAUGE X 3/16"	2	PA; ST
EMBRACE PEN NEEDLE 31G 6MM 31 GAUGE X 1/4"	2	PA; ST
EMBRACE PEN NEEDLE 31G 8MM 31 GAUGE X 5/16"	2	PA; ST
EMBRACE PEN NEEDLE 32G 4MM 32 GAUGE X 5/32"	2	PA; ST
EXEL U100 0.3 ML 29GX1/2" 0.3 ML 29 GAUGE X 1/2"	2	PA; ST
EXEL U100 0.3 ML 30GX5/16" 0.3 ML 30 GAUGE X 5/16"	2	PA; ST
FT STERILE PADS 2" X 2" 2 X 2 "	1	PA; ST
GAUZE PAD TOPICAL BANDAGE 2 X 2 "	1	PA; ST
GNP ALCOHOL SWAB STERILE, TWO PLY	1	PA; ST
GNP PEN NEEDLE 31G 5MM 31 GAUGE X 3/16"	2	PA; ST
GNP PEN NEEDLE 32G 6MM 32 GAUGE X 1/4"	2	PA; ST
GNP SIMPLI PEN NEEDLE 32G 4MM 32 GAUGE X 5/32"	2	PA; ST
GNP ULT C 0.3 ML 29GX1/2" (1/2) 1/2 UNIT 0.3 ML 29 GAUGE X 1/2"	2	PA; ST
GNP ULT CMFRT 0.5 ML 29GX1/2" 1/2 ML 29	2	PA; ST
GNP ULTR CMFRT 0.5 ML 30GX5/16 1/2 ML 30 GAUGE	2	PA; ST
GNP ULTRA COMFORT 1 ML SYRINGE 1 ML 30 GAUGE X 7/16"	2	PA; ST
GNP ULTRA COMFORT 3/10 ML SYR 0.3 ML 30	2	PA; ST
GS PEN NEEDLE 31G X 8MM 31 GAUGE X 5/16"	2	PA; ST
HEALTHWISE INS 0.3 ML 30GX5/16" 0.3 ML 30 GAUGE X 5/16"	2	PA; ST

Drug Name	Drug Tier	Requirements/Limits
HEALTHWISE INS 0.3 ML 31GX5/16" 0.3 ML 31 GAUGE X 5/16"	2	PA; ST
HEALTHWISE INS 0.5 ML 30GX5/16" 0.5 ML 30 GAUGE X 5/16"	2	PA; ST
HEALTHWISE INS 0.5 ML 31GX5/16" 0.5 ML 31 GAUGE X 5/16"	2	PA; ST
HEALTHWISE INS 1 ML 30GX5/16" 1 ML 30 GAUGE X 5/16	2	PA; ST
HEALTHWISE INS 1 ML 31GX5/16" 1 ML 31 GAUGE X 5/16	2	PA; ST
HEALTHWISE PEN NEEDLE 31G 5MM 31 GAUGE X 3/16"	2	PA; ST
HEALTHWISE PEN NEEDLE 31G 8MM 31 GAUGE X 5/16"	2	PA; ST
HEALTHWISE PEN NEEDLE 32G 4MM 32 GAUGE X 5/32"	2	PA; ST
HEALTHY ACCENTS PENTIP 5MM 31G 31 GAUGE X 3/16"	2	PA; ST
HEALTHY ACCENTS PENTIP 6MM 31G 31 GAUGE X 1/4"	2	PA; ST
HEALTHY ACCENTS PENTIP 8MM 31G 31 GAUGE X 5/16"	2	PA; ST
HEALTHY ACCENTS PENTP 12MM 29G 29 GAUGE X 1/2"	2	PA; ST
HEB INCONTROL ALCOHOL 70% PADS	1	PA; ST
INCONTROL PEN NEEDLE 12MM 29G 29 GAUGE X 1/2"	2	PA; ST
INCONTROL PEN NEEDLE 4MM 32G 32 GAUGE X 5/32"	2	PA; ST
INCONTROL PEN NEEDLE 5MM 31G 31 GAUGE X 3/16"	2	PA; ST
INCONTROL PEN NEEDLE 6MM 31G 31 GAUGE X 1/4"	2	PA; ST
INCONTROL PEN NEEDLE 8MM 31G 31 GAUGE X 5/16"	2	PA; ST
INPEN (FOR HUMALOG) BLUE SUBCUTANEOUS INSULIN PEN	3	
INPEN (FOR HUMALOG) GREY SUBCUTANEOUS INSULIN PEN	3	

Drug Name	Drug Tier	Requirements/Limits
INPEN (FOR HUMALOG) PINK SUBCUTANEOUS INSULIN PEN	3	
INPEN (NOVOLOG OR FIASP) BLUE SUBCUTANEOUS INSULIN PEN	3	
INPEN (NOVOLOG OR FIASP) GREY SUBCUTANEOUS INSULIN PEN	3	
INPEN (NOVOLOG OR FIASP) PINK SUBCUTANEOUS INSULIN PEN	3	
INSULIN 1 ML SYRINGE 1 ML 29 GAUGE X 7/16", 1 ML 30 GAUGE X 7/16"	2	PA; ST
INSULIN 1/2 ML SYRINGE 1/2 ML 29 , 1/2 ML 30 GAUGE	2	PA; ST
INSULIN 3/10 ML SYRINGE 0.3 ML 30	2	PA; ST
INSULIN SYR 0.3 ML 31GX1/4(1/2) 0.3 ML 31 GAUGE X 1/4"	2	PA; ST
INSULIN SYRIN 0.5 ML 28GX1/2" (OTC) 1/2 ML 28 GAUGE X 1/2"	2	PA; ST
INSULIN SYRIN 0.5 ML 29GX1/2" (OTC) 0.5 ML 29 GAUGE X 1/2"	2	PA; ST
INSULIN SYRIN 0.5 ML 30GX1/2" (RX) 0.5 ML 30 GAUGE X 1/2"	2	PA; ST
INSULIN SYRIN 0.5 ML 30GX5/16" SHORT NEEDLE (OTC) 0.5 ML 30 GAUGE X 5/16"	2	PA; ST
INSULIN SYRING 0.5 ML 27G 1/2" INNER 1/2 ML 27 GAUGE X 1/2"	2	PA; ST
INSULIN SYRINGE 0.3 ML 0.3 ML 29 GAUGE	2	PA; ST
INSULIN SYRINGE 0.3 ML 31GX1/4 0.3 ML 31 GAUGE X 1/4"	2	PA; ST
INSULIN SYRINGE 0.5 ML 1/2 ML 29	2	PA; ST
INSULIN SYRINGE 0.5 ML 31GX1/4 1/2 ML 31 GAUGE X 1/4"	2	PA; ST
INSULIN SYRINGE 1 ML 1 ML 29 GAUGE	2	PA; ST
INSULIN SYRINGE 1 ML 27G 1/2" INNER 1 ML 27 GAUGE X 1/2"	2	PA; ST
INSULIN SYRINGE 1 ML 28GX1/2" (OTC) 1 ML 28 GAUGE X 1/2"	2	PA; ST
INSULIN SYRINGE 1 ML 30GX1/2" SHORT NEEDLE (OTC) 1 ML 30 GAUGE X 1/2"	2	PA; ST
INSULIN SYRINGE 1 ML 30GX5/16" SHORT NEEDLE (OTC) 1 ML 30 GAUGE X 5/16	2	PA; ST

Drug Name	Drug Tier	Requirements/Limits
INSULIN SYRINGE 1 ML 31GX1/4" 1 ML 31 GAUGE X 1/4"	2	PA; ST
INSULIN SYRINGE 1 ML 31GX5/16" SHORT NEEDLE,THIN II (OTC) 1 ML 31 GAUGE X 5/16	2	PA; ST
INSULIN SYRINGE-NEEDLE U-100 SYRINGE 0.3 ML 29 GAUGE, 1 ML 29 GAUGE X 1/2", 1/2 ML 28 GAUGE	2	PA; ST
INSULIN U-500 SYRINGE-NEEDLE SYRINGE 1/2 ML 31 GAUGE X 15/64"	2	PA; ST
INSUPEN PEN NEEDLE 29GX1/2" 29 GAUGE X 1/2"	2	PA; ST
INSUPEN PEN NEEDLE 31G 8MM 31 GAUGE X 5/16"	2	PA; ST
INSUPEN PEN NEEDLE 31GX3/16" 31 GAUGE X 3/16"	2	PA; ST
INSUPEN PEN NEEDLE 32G 4MM 32 GAUGE X 5/32"	2	PA; ST
INSUPEN PEN NEEDLE 32G 6MM (RX) 32 GAUGE X 1/4"	2	PA; ST
IV ANTISEPTIC WIPES	1	PA; ST
KENDALL ALCOHOL 70% PREP PAD	1	PA; ST
LISCO SPONGES 100/BAG 2 X 2 "	1	PA; ST
MAGELLAN INSUL SYRINGE 0.3 ML 0.3 ML 30 X 5/16"	2	PA; ST
MAGELLAN INSUL SYRINGE 0.5 ML 0.5 ML 30 GAUGE X 5/16"	2	PA; ST
MAGELLAN INSULIN SYR 0.3 ML 0.3 ML 29 GAUGE X 1/2"	2	PA; ST
MAGELLAN INSULIN SYR 0.5 ML 0.5 ML 29 GAUGE X 1/2"	2	PA; ST
MAGELLAN INSULIN SYRINGE 1 ML 1 ML 29 GAUGE X 1/2", 1 ML 30 GAUGE X 5/16"	2	PA; ST
MAXICOMFORT II PEN NDL 31GX6MM 31 GAUGE X 1/4"	2	PA; ST
MAXICOMFORT INS 0.5 ML 27GX1/2" 1/2 ML 27 GAUGE X 1/2"	2	PA; ST
MAXI-COMFORT INS 0.5 ML 28G 1/2 ML 28 GAUGE X 1/2"	2	PA; ST

Drug Name	Drug Tier	Requirements/Limits
MAXICOMFORT INS 1 ML 27GX1/2" 1 ML 27 GAUGE X 1/2"	2	PA; ST
MAXI-COMFORT INS 1 ML 28GX1/2" 1 ML 28 GAUGE X 1/2"	2	PA; ST
MAXICOMFORT PEN NDL 29G X 5MM 29 GAUGE X 3/16"	2	PA; ST
MAXICOMFORT PEN NDL 29G X 8MM 29 GAUGE X 5/16"	2	PA; ST
MICRODOT PEN NEEDLE 31GX6MM 31 GAUGE X 1/4"	2	PA; ST
MICRODOT PEN NEEDLE 32GX4MM 32 GAUGE X 5/32"	2	PA; ST
MICRODOT PEN NEEDLE 33GX4MM 33 GAUGE X 5/32"	2	PA; ST
MICRODOT READYGARD NDL 31G 5MM OUTER 31 GAUGE X 3/16"	2	PA; ST
MINI PEN NEEDLE 32G 5MM 32 GAUGE X 3/16"	2	PA; ST
MINI PEN NEEDLE 32G 8MM 32 GAUGE X 5/16"	2	PA; ST
MINI PEN NEEDLE 33G 5MM 33 GAUGE X 3/16"	2	PA; ST
MINI PEN NEEDLE 33G 6MM 33 GAUGE X 1/4"	2	PA; ST
MINI ULTRA-THIN II PEN NDL 31G STERILE 31 GAUGE X 3/16"	2	PA; ST
MONOJECT 0.5 ML SYRN 28GX1/2" 1/2 ML 28 GAUGE	2	PA; ST
MONOJECT 1 ML SYRN 27X1/2" 1 ML 27 GAUGE X 1/2"	2	PA; ST
MONOJECT 1 ML SYRN 28GX1/2" (OTC) 1 ML 28 GAUGE X 1/2"	2	PA; ST
MONOJECT INSUL SYR U100 (OTC) 0.3 ML 29 GAUGE X 1/2"	2	PA; ST
MONOJECT INSUL SYR U100 .5ML,29GX1/2" (OTC) 0.5 ML 29 GAUGE X 1/2"	2	PA; ST
MONOJECT INSUL SYR U100 0.5 ML CONVERTS TO 29G (OTC) 1/2 ML 28 GAUGE X 1/2"	2	PA; ST
MONOJECT INSUL SYR U100 1 ML 1 ML 25 GAUGE X 5/8"	2	PA; ST

Please refer to our Evidence of Coverage for 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.

Drug Name	Drug Tier	Requirements/Limits
MONOJECT INSUL SYR U100 1 ML 3'S, 29GX1/2" (OTC) 1 ML 29 GAUGE X 1/2"	2	PA; ST
MONOJECT INSUL SYR U100 1 ML W/O NEEDLE (OTC)	2	PA; ST
MONOJECT INSULIN SYR 0.3 ML (OTC) 0.3 ML 30 GAUGE X 5/16"	2	PA; ST
MONOJECT INSULIN SYR 0.3 ML 0.3 ML 30 GAUGE X 5/16"	2	PA; ST
MONOJECT INSULIN SYR 0.5 ML (OTC) 0.5 ML 30 GAUGE X 5/16"	2	PA; ST
MONOJECT INSULIN SYR 0.5 ML 0.5 ML 30 GAUGE X 5/16"	2	PA; ST
MONOJECT INSULIN SYR 1 ML 3'S (OTC) 1 ML 30 GAUGE X 5/16	2	PA; ST
MONOJECT INSULIN SYR U-100 0.5 ML 29 GAUGE X 1/2", 1 ML 29 GAUGE X 1/2"	2	PA; ST
MONOJECT SYRINGE 0.3 ML 0.3 ML 31 GAUGE X 5/16"	2	PA; ST
MONOJECT SYRINGE 0.5 ML 0.5 ML 31 GAUGE X 5/16"	2	PA; ST
MONOJECT SYRINGE 1 ML 1 ML 31 GAUGE X 5/16	2	PA; ST
NANO 2 GEN PEN NEEDLE 32G 4MM 32 GAUGE X 5/32"	2	PA; ST
NANO PEN NEEDLE 32G 4MM 32 GAUGE X 5/32"	2	PA; ST
NOVOFINE 32G NEEDLES 32 GAUGE X 1/4"	2	PA; ST
NOVOFINE AUTOCOVER 30G NEEDLE 30 GAUGE X 1/3"	2	PA; ST
NOVOFINE PLUS PEN NDL 32GX1/6" 32 GAUGE X 1/6"	2	PA; ST
OMNIPOD 5 (LIBRE 2/3 PLUS) SUBCUTANEOUS CARTRIDGE	3	QL (10 per 30 days)
OMNIPOD 5 G6-G7 INTRO KT(GEN5) SUBCUTANEOUS CARTRIDGE	3	QL (1 per 365 days)
OMNIPOD 5 G6-G7 PODS (GEN 5) SUBCUTANEOUS CARTRIDGE	3	QL (10 per 30 days)
OMNIPOD 5 INTRO (LIBRE2/3PLUS) SUBCUTANEOUS CARTRIDGE	3	QL (1 per 365 days)

Drug Name	Drug Tier	Requirements/Limits
OMNIPOD CLASSIC PODS (GEN 3) SUBCUTANEOUS CARTRIDGE	3	QL (10 per 30 days)
OMNIPOD DASH INTRO KIT (GEN 4) SUBCUTANEOUS CARTRIDGE	3	QL (1 per 365 days)
OMNIPOD DASH PDM KIT (GEN 4)	3	QL (1 per 365 days)
OMNIPOD DASH PODS (GEN 4) SUBCUTANEOUS CARTRIDGE	3	QL (10 per 30 days)
PEN NEEDLE 30G 5MM OUTER 30 GAUGE X 3/16"	2	PA; ST
PEN NEEDLE 30G 8MM INNER 30 GAUGE X 5/16"	2	PA; ST
PEN NEEDLE 30G X 5/16" 30 GAUGE X 5/16"	2	PA; ST
PEN NEEDLE 31G X 1/4" HRI 31 GAUGE X 1/4"	2	PA; ST
PEN NEEDLE 33G 4MM 33 GAUGE X 5/32"	2	PA; ST
PEN NEEDLE, DIABETIC NEEDLE 29 GAUGE X 1/2"	2	PA; ST
PEN NEEDLES 12MM 29G 29GX12MM,STRL 29 GAUGE X 1/2"	2	PA; ST
PEN NEEDLES 4MM 32G 32 GAUGE X 5/32"	2	PA; ST
PEN NEEDLES 5MM 31G 31GX5MM,STRL,MINI (OTC) 31 GAUGE X 3/16"	2	PA; ST
PEN NEEDLES 8MM 31G 31GX8MM,STRL,SHORT (OTC) 31 GAUGE X 5/16"	2	PA; ST
PENTIPS PEN NEEDLE 29G 1/2" 29 GAUGE X 1/2"	2	PA; ST
PENTIPS PEN NEEDLE 31G 1/4" 31 GAUGE X 1/4"	2	PA; ST
PENTIPS PEN NEEDLE 31GX3/16" MINI, 5MM 31 GAUGE X 3/16"	2	PA; ST
PENTIPS PEN NEEDLE 31GX5/16" SHORT, 8MM 31 GAUGE X 5/16"	2	PA; ST
PENTIPS PEN NEEDLE 32G 1/4" 32 GAUGE X 1/4"	2	PA; ST
PENTIPS PEN NEEDLE 32GX5/32" 32 GAUGE X 5/32"	2	PA; ST
PIP PEN NEEDLE 31G X 5MM 31 GAUGE X 3/16"	2	PA; ST

Drug Name	Drug Tier	Requirements/Limits
PIP PEN NEEDLE 32G X 4MM 32 GAUGE X 5/32"	2	PA; ST
PREVENT PEN NEEDLE 31GX1/4" 31 GAUGE X 1/4"	2	PA; ST
PREVENT PEN NEEDLE 31GX5/16" 31 GAUGE X 5/16"	2	PA; ST
PRO COMFORT 0.5 ML 30GX1/2" 0.5 ML 30 GAUGE X 1/2"	2	PA; ST
PRO COMFORT 0.5 ML 30GX5/16" 0.5 ML 30 GAUGE X 5/16"	2	PA; ST
PRO COMFORT 0.5 ML 31GX5/16" 0.5 ML 31 GAUGE X 5/16"	2	PA; ST
PRO COMFORT 1 ML 30GX1/2" 1 ML 30 GAUGE X 1/2"	2	PA; ST
PRO COMFORT 1 ML 30GX5/16" 1 ML 30 GAUGE X 5/16	2	PA; ST
PRO COMFORT 1 ML 31GX5/16" 1 ML 31 GAUGE X 5/16	2	PA; ST
PRO COMFORT ALCOHOL 70% PADS	1	PA; ST
PRO COMFORT PEN NDL 32G 8MM 32 GAUGE X 5/16"	2	PA; ST
PRO COMFORT PEN NDL 32G X 1/4" 32 GAUGE X 1/4"	2	PA; ST
PRO COMFORT PEN NDL 4MM 32G 32 GAUGE X 5/32"	2	PA; ST
PRO COMFORT PEN NDL 5MM 32G 32 GAUGE X 3/16"	2	PA; ST
PRO-COMFORT ALCOHOL 70% PADS	1	PA; ST
PRODIGY INS SYR 1 ML 28GX1/2" 1 ML 28 GAUGE X 1/2"	2	PA; ST
PRODIGY SYRNG 0.5 ML 31GX5/16" 0.5 ML 31 GAUGE X 5/16"	2	PA; ST
PRODIGY SYRNGE 0.3 ML 31GX5/16" 0.3 ML 31 GAUGE X 5/16"	2	PA; ST
PURE CMFT SFTY PEN NDL 31G 5MM 31 GAUGE X 3/16"	2	PA; ST
PURE CMFT SFTY PEN NDL 31G 6MM 31 GAUGE X 1/4"	2	PA; ST
PURE CMFT SFTY PEN NDL 32G 4MM 32 GAUGE X 5/32"	2	PA; ST

Drug Name	Drug Tier	Requirements/Limits
PURE COMFORT ALCOHOL 70% PADS	1	PA; ST
PURE COMFORT PEN NDL 32G 4MM 32 GAUGE X 5/32"	2	PA; ST
PURE COMFORT PEN NDL 32G 5MM 32 GAUGE X 3/16"	2	PA; ST
PURE COMFORT PEN NDL 32G 6MM 32 GAUGE X 1/4"	2	PA; ST
PURE COMFORT PEN NDL 32G 8MM 32 GAUGE X 5/16"	2	PA; ST
RA ISOPROPYL ALCOHOL 70% WIPES	1	PA; ST
RA STERILE PADS 2"X 2" 2 X 2 "	1	PA; ST
RAYA SURE PEN NEEDLE 29G 12MM 29 GAUGE X 15/32"	2	PA; ST
RAYA SURE PEN NEEDLE 31G 4MM 31 GAUGE X 5/32"	2	PA; ST
RAYA SURE PEN NEEDLE 31G 5MM 31 GAUGE X 13/64"	2	PA; ST
RAYA SURE PEN NEEDLE 31G 6MM 31 GAUGE X 15/64"	2	PA; ST
RELION INS SYR 0.3 ML 31GX6MM 0.3 ML 31 GAUGE X 15/64"	2	PA; ST
RELION INS SYR 0.5 ML 31GX6MM 1/2 ML 31 GAUGE X 15/64"	2	PA; ST
RELION INS SYR 1 ML 31GX15/64" 1 ML 31 GAUGE X 15/64"	2	PA; ST
RELION PEN NEEDLE 32GX5/32" 32 GAUGE X 5/32"	2	PA; ST
RELION SYRING 0.3 ML 31GX5/16" INNER 0.3 ML 31 GAUGE X 5/16"	2	PA; ST
RELION SYRING 0.5 ML 31GX5/16" INNER (OTC) 0.5 ML 31 GAUGE X 5/16"	2	PA; ST
SAFESNAP INS SYR UNITS-100 0.3 ML 30GX5/16",10X10 0.3 ML 30 GAUGE X 5/16"	2	PA; ST
SAFESNAP INS SYR UNITS-100 0.5 ML 29GX1/2",10X10 0.5 ML 29 GAUGE X 1/2"	2	PA; ST
SAFESNAP INS SYR UNITS-100 0.5 ML 30GX5/16",10X10 0.5 ML 30 GAUGE X 5/16"	2	PA; ST
SAFESNAP INS SYR UNITS-100 1 ML 28GX1/2",10X10 1 ML 28 GAUGE X 1/2"	2	PA; ST

Drug Name	Drug Tier	Requirements/Limits
SAFESNAP INS SYR UNITS-100 1 ML 29GX1/2",10X10 1 ML 29 GAUGE X 1/2"	2	PA; ST
SAFETY PEN NEEDLE 31G 4MM 31 GAUGE X 5/32"	2	PA; ST
SAFETY PEN NEEDLE 5MM X 31G 31 GAUGE X 3/16"	2	PA; ST
SAFETY SYRINGE 0.5 ML 30G 1/2" 0.5 ML 30 GAUGE X 1/2"	2	PA; ST
SECURESAFE PEN NDL 30GX5/16" OUTER 30 GAUGE X 5/16"	2	PA; ST
SECURESAFE PEN NEEDLE 31G 5MM OUTER 31 GAUGE X 3/16"	2	PA; ST
SECURESAFE SYR 0.5 ML 29G 1/2" OUTER 0.5 ML 29 GAUGE X 1/2"	2	PA; ST
SECURESAFE SYRNG 1 ML 29G 1/2" OUTER 1 ML 29 GAUGE X 1/2"	2	PA; ST
SKY SAFETY PEN NEEDLE 30G 5MM 30 GAUGE X 3/16"	2	PA; ST
SKY SAFETY PEN NEEDLE 30G 8MM 30 GAUGE X 5/16"	2	PA; ST
SURE CMFT SFTY PEN NDL 31G 6MM 31 GAUGE X 1/4"	2	PA; ST
SURE CMFT SFTY PEN NDL 32G 4MM 32 GAUGE X 5/32"	2	PA; ST
NEEDLES, INSULIN DISP., SAFETY	2	PA; ST
SURE COMFORT 0.5 ML SYRINGE 0.5 ML 30 GAUGE X 1/2", 0.5 ML 30 GAUGE X 5/16", 0.5 ML 31 GAUGE X 5/16", 1/2 ML 28 GAUGE X 1/2"	2	PA; ST
SURE COMFORT 1 ML SYRINGE 1 ML 28 GAUGE X 1/2", 1 ML 29 GAUGE X 1/2", 1 ML 30 GAUGE X 1/2", 1 ML 30 GAUGE X 5/16, 1 ML 31 GAUGE X 5/16	2	PA; ST
SURE COMFORT 3/10 ML SYRINGE 0.3 ML 29 GAUGE X 1/2", 0.3 ML 30 GAUGE X 1/2", 0.3 ML 30 GAUGE X 5/16"	2	PA; ST
SURE COMFORT 3/10 ML SYRINGE INSULIN SYRINGE 0.3 ML 31 GAUGE X 5/16"	2	PA; ST
SURE COMFORT 30G PEN NEEDLE 30 GAUGE X 5/16"	2	PA; ST

Drug Name	Drug Tier	Requirements/Limits
SURE COMFORT ALCOHOL PREP PADS	1	PA; ST
SURE COMFORT INS 0.3 ML 31GX1/4 0.3 ML 31 GAUGE X 1/4"	2	PA; ST
SURE COMFORT INS 0.5 ML 31GX1/4 1/2 ML 31 GAUGE X 1/4"	2	PA; ST
SURE COMFORT INS 1 ML 31GX1/4" 1 ML 31 GAUGE X 1/4"	2	PA; ST
SURE COMFORT PEN NDL 29GX1/2" 12.7MM 29 GAUGE X 1/2"	2	PA; ST
SURE COMFORT PEN NDL 31G 5MM 31 GAUGE X 3/16"	2	PA; ST
SURE COMFORT PEN NDL 31G 8MM 31 GAUGE X 5/16"	2	PA; ST
SURE COMFORT PEN NDL 32G 4MM 32 GAUGE X 5/32"	2	PA; ST
SURE COMFORT PEN NDL 32G 6MM 32 GAUGE X 1/4"	2	PA; ST
SURE-FINE PEN NEEDLES 12.7MM 29 GAUGE X 1/2"	2	PA; ST
SURE-FINE PEN NEEDLES 5MM 31 GAUGE X 3/16"	2	PA; ST
SURE-FINE PEN NEEDLES 8MM 31 GAUGE X 5/16"	2	PA; ST
SURE-JECT INSU SYR U100 0.3 ML 0.3 ML 29 GAUGE X 1/2", 0.3 ML 30 GAUGE X 5/16"	2	PA; ST
SURE-JECT INSU SYR U100 0.5 ML 0.5 ML 29 GAUGE X 1/2", 0.5 ML 30 GAUGE X 5/16", 1/2 ML 28 GAUGE X 1/2"	2	PA; ST
SURE-JECT INSU SYR U100 1 ML 1 ML 28 GAUGE X 1/2"	2	PA; ST
SURE-JECT INSUL SYR U100 1 ML 1 ML 29 GAUGE X 1/2", 1 ML 30 GAUGE X 5/16	2	PA; ST
SURE-JECT INSULIN SYRINGE 1 ML 1 ML 31 GAUGE X 5/16	2	PA; ST
SURE-PREP ALCOHOL PREP PADS	1	PA; ST
TECHLITE 0.3 ML 29GX12MM (1/2) 0.3 ML 29 GAUGE X 1/2"	2	PA; ST
TECHLITE 0.3 ML 30GX8MM (1/2) 0.3 ML 30 GAUGE X 5/16"	2	PA; ST

Drug Name	Drug Tier	Requirements/Limits
TECHLITE 0.3 ML 31GX6MM (1/2) 0.3 ML 31 GAUGE X 15/64"	2	PA; ST
TECHLITE 0.3 ML 31GX8MM (1/2) 0.3 ML 31 GAUGE X 5/16"	2	PA; ST
TECHLITE 0.5 ML 30GX12MM (1/2) 0.5 ML 30 GAUGE X 1/2"	2	PA; ST
TECHLITE 0.5 ML 30GX8MM (1/2) 0.5 ML 30 GAUGE X 5/16"	2	PA; ST
TECHLITE 0.5 ML 31GX6MM (1/2) 0.5 ML 31 GAUGE X 15/64"	2	PA; ST
TECHLITE 0.5 ML 31GX8MM (1/2) 0.5 ML 31 GAUGE X 5/16"	2	PA; ST
TECHLITE INS SYR 1 ML 29GX12MM 1 ML 29 GAUGE X 1/2"	2	PA; ST
TECHLITE INS SYR 1 ML 30GX12MM 1 ML 30 GAUGE X 1/2"	2	PA; ST
TECHLITE INS SYR 1 ML 31GX6MM 1 ML 31 GAUGE X 15/64"	2	PA; ST
TECHLITE INS SYR 1 ML 31GX8MM 1 ML 31 GAUGE X 5/16	2	PA; ST
TECHLITE PEN NEEDLE 29GX1/2" 29 GAUGE X 1/2"	2	PA; ST
TECHLITE PEN NEEDLE 29GX3/8" 29 GAUGE X 3/8"	2	PA; ST
TECHLITE PEN NEEDLE 31GX1/4" 31 GAUGE X 1/4"	2	PA; ST
TECHLITE PEN NEEDLE 31GX3/16" 31 GAUGE X 3/16"	2	PA; ST
TECHLITE PEN NEEDLE 31GX5/16" 31 GAUGE X 5/16"	2	PA; ST
TECHLITE PEN NEEDLE 32GX1/4" 32 GAUGE X 1/4"	2	PA; ST
TECHLITE PEN NEEDLE 32GX5/16" 32 GAUGE X 5/16"	2	PA; ST
TECHLITE PEN NEEDLE 32GX5/32" 32 GAUGE X 5/32"	2	PA; ST
TECHLITE PLUS PEN NDL 32G 4MM 32 GAUGE X 5/32"	2	PA; ST
TERUMO INS SYRINGE U100-1 ML 1 ML 27 GAUGE X 1/2", 1 ML 28 GAUGE X 1/2", 1 ML 29 GAUGE X 1/2"	2	PA; ST

Please refer to our Evidence of Coverage for 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.

Drug Name	Drug Tier	Requirements/Limits
TERUMO INS SYRINGE U100-1 ML 1 ML 30 GAUGE X 3/8"	2	PA; ST
TERUMO INS SYRINGE U100-1/2 ML 1/2 ML 30 X 3/8"	2	PA; ST
TERUMO INS SYRINGE U100-1/3 ML 0.3 ML 30 X 3/8"	2	PA; ST
TERUMO INS SYRNG U100-1/2 ML 0.5 ML 29 GAUGE X 1/2", 1/2 ML 27 GAUGE X 1/2", 1/2 ML 28 GAUGE X 1/2"	2	PA; ST
THINPRO INS SYRIN U100-0.3 ML 0.3 ML 29 GAUGE X 1/2", 0.3 ML 30 X 3/8", 0.3 ML 31 X 3/8"	2	PA; ST
THINPRO INS SYRIN U100-0.5 ML 0.5 ML 29 GAUGE X 1/2", 0.5 ML 31 X 3/8", 1/2 ML 28 GAUGE X 1/2", 1/2 ML 30 X 3/8"	2	PA; ST
THINPRO INS SYRIN U100-1 ML 1 ML 28 GAUGE X 1/2", 1 ML 29 GAUGE X 1/2", 1 ML 30 GAUGE X 3/8", 1 ML 31 X 3/8"	2	PA; ST
TOPFINE INSULN PEN NDL 32G 4MM 32 GAUGE X 5/32"	2	PA; ST
TRUE CMFRT PRO 0.5 ML 30G 5/16" 0.5 ML 30 GAUGE X 5/16"	2	PA; ST
TRUE CMFRT PRO 0.5 ML 31G 5/16" 0.5 ML 31 GAUGE X 5/16"	2	PA; ST
TRUE CMFRT PRO 0.5 ML 32G 5/16" 1/2 ML 32 GAUGE X 5/16"	2	PA; ST
TRUE CMFT SFTY PEN NDL 31G 5MM 31 GAUGE X 3/16"	2	PA; ST
TRUE CMFT SFTY PEN NDL 31G 6MM 31 GAUGE X 1/4"	2	PA; ST
TRUE CMFT SFTY PEN NDL 32G 4MM 32 GAUGE X 5/32"	2	PA; ST
TRUE COMFORT 0.5 ML 30G 1/2" 0.5 ML 30 GAUGE X 1/2"	2	PA; ST
TRUE COMFORT 0.5 ML 30G 5/16" 0.5 ML 30 GAUGE X 5/16"	2	PA; ST
TRUE COMFORT 0.5 ML 31G 5/16" 0.5 ML 31 GAUGE X 5/16"	2	PA; ST
TRUE COMFORT 0.5 ML 31GX5/16" 0.5 ML 31 GAUGE X 5/16"	2	PA; ST

Drug Name	Drug Tier	Requirements/Limits
TRUE COMFORT 1 ML 31GX5/16" 1 ML 31 GAUGE X 5/16	2	PA; ST
TRUE COMFORT ALCOHOL 70% PADS	1	PA; ST
TRUE COMFORT PEN NDL 31G 8MM 31 GAUGE X 5/16"	2	PA; ST
TRUE COMFORT PEN NDL 31GX5MM 31 GAUGE X 3/16"	2	PA; ST
TRUE COMFORT PEN NDL 31GX6MM 31 GAUGE X 1/4"	2	PA; ST
TRUE COMFORT PEN NDL 32G 5MM 32 GAUGE X 3/16"	2	PA; ST
TRUE COMFORT PEN NDL 32G 6MM 32 GAUGE X 1/4"	2	PA; ST
TRUE COMFORT PEN NDL 32GX4MM 32 GAUGE X 5/32"	2	PA; ST
TRUE COMFORT PEN NDL 33G 4MM 33 GAUGE X 5/32"	2	PA; ST
TRUE COMFORT PEN NDL 33G 5MM 33 GAUGE X 3/16"	2	PA; ST
TRUE COMFORT PEN NDL 33G 6MM 33 GAUGE X 1/4"	2	PA; ST
TRUE COMFORT PRO 1 ML 30G 1/2" 1 ML 30 GAUGE X 1/2"	2	PA; ST
TRUE COMFORT PRO 1 ML 30G 5/16" 1 ML 30 GAUGE X 5/16	2	PA; ST
TRUE COMFORT PRO 1 ML 31G 5/16" 1 ML 31 GAUGE X 5/16	2	PA; ST
TRUE COMFORT PRO 1 ML 32G 5/16" 1 ML 32 GAUGE X 5/16"	2	PA; ST
TRUE COMFORT PRO ALCOHOL PADS	1	PA; ST
TRUE COMFORT SFTY 1 ML 30G 1/2" 1 ML 30 GAUGE X 1/2"	2	PA; ST
TRUE COMFRT PRO 0.5 ML 30G 1/2" 0.5 ML 30 GAUGE X 1/2"	2	PA; ST
TRUE COMFRT SFTY 1 ML 30G 5/16" 1 ML 30 GAUGE X 5/16"	2	PA; ST
TRUE COMFRT SFTY 1 ML 31G 5/16" 1 ML 31 GAUGE X 5/16"	2	PA; ST
TRUE COMFRT SFTY 1 ML 32G 5/16" 1 ML 32 GAUGE X 5/16"	2	PA; ST

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Drug Name	Drug Tier	Requirements/Limits
TRUE-CMFRT PRO PEN NDL 31G 5MM 31 GAUGE X 3/16"	2	PA; ST
TRUE-CMFRT PRO PEN NDL 31G 6MM 31 GAUGE X 15/64"	2	PA; ST
TRUE-CMFRT PRO PEN NDL 31G 8MM 31 GAUGE X 5/16"	2	PA; ST
TRUE-CMFRT PRO PEN NDL 32G 4MM 32 GAUGE X 5/32"	2	PA; ST
TRUEPLUS PEN NEEDLE 29GX1/2" 29 GAUGE X 1/2"	2	PA; ST
TRUEPLUS PEN NEEDLE 31G X 1/4" 31 GAUGE X 1/4"	2	PA; ST
TRUEPLUS PEN NEEDLE 31GX3/16" 31 GAUGE X 3/16"	2	PA; ST
TRUEPLUS PEN NEEDLE 31GX5/16" 31 GAUGE X 5/16"	2	PA; ST
TRUEPLUS PEN NEEDLE 32GX5/32" 32 GAUGE X 5/32"	2	PA; ST
TRUEPLUS SYR 0.3 ML 29GX1/2" 0.3 ML 29 GAUGE X 1/2"	2	PA; ST
TRUEPLUS SYR 0.3 ML 30GX5/16" 0.3 ML 30 GAUGE X 5/16"	2	PA; ST
TRUEPLUS SYR 0.3 ML 31GX5/16" 0.3 ML 31 GAUGE X 5/16"	2	PA; ST
TRUEPLUS SYR 0.5 ML 28GX1/2" 1/2 ML 28 GAUGE X 1/2"	2	PA; ST
TRUEPLUS SYR 0.5 ML 29GX1/2" 0.5 ML 29 GAUGE X 1/2"	2	PA; ST
TRUEPLUS SYR 0.5 ML 30GX5/16" 0.5 ML 30 GAUGE X 5/16"	2	PA; ST
TRUEPLUS SYR 0.5 ML 31GX5/16" 0.5 ML 31 GAUGE X 5/16"	2	PA; ST
TRUEPLUS SYR 1 ML 28GX1/2" 1 ML 28 GAUGE X 1/2"	2	PA; ST
TRUEPLUS SYR 1 ML 29GX1/2" 1 ML 29 GAUGE X 1/2"	2	PA; ST
TRUEPLUS SYR 1 ML 30GX5/16" 1 ML 30 GAUGE X 5/16	2	PA; ST
TRUEPLUS SYR 1 ML 31GX5/16" 1 ML 31 GAUGE X 5/16	2	PA; ST

Drug Name	Drug Tier	Requirements/Limits
ULT CFT 0.3 ML 31GX5/16" (1/2) 1/2 UNIT 0.3 ML 31 GAUGE X 5/16"	2	PA; ST
ULTICAR INS 0.3 ML 31GX1/4(1/2) 0.3 ML 31 GAUGE X 1/4"	2	PA; ST
ULTICARE INS 0.3 ML 31GX1/4" 0.3 ML 31 GAUGE X 1/4"	2	PA; ST
ULTICARE INS 0.5 ML 31GX1/4" 1/2 ML 31 GAUGE X 1/4"	2	PA; ST
ULTICARE INS 1 ML 31GX1/4" 1 ML 31 GAUGE X 1/4"	2	PA; ST
ULTICARE INS SYR 1 ML 30GX1/2" 1 ML 30 GAUGE X 1/2"	2	PA; ST
ULTICARE PEN NEEDLE 31GX3/16" 31 GAUGE X 3/16"	2	PA; ST
ULTICARE PEN NEEDLE 6MM 31G 31 GAUGE X 1/4"	2	PA; ST
ULTICARE PEN NEEDLE 8MM 31G 31 GAUGE X 5/16"	2	PA; ST
ULTICARE PEN NEEDLES 12MM 29G 29 GAUGE X 1/2"	2	PA; ST
ULTICARE PEN NEEDLES 4MM 32G MICRO, 32GX4MM 32 GAUGE X 5/32"	2	PA; ST
ULTICARE PEN NEEDLES 6MM 32G 32 GAUGE X 1/4"	2	PA; ST
ULTICARE SAFE PEN NDL 30G 8MM 30 GAUGE X 5/16"	2	PA; ST
ULTICARE SAFE PEN NDL 5MM 30G 30 GAUGE X 3/16"	2	PA; ST
ULTICARE SYR 0.3 ML 30GX1/2" 0.3 ML 30 GAUGE X 1/2"	2	PA; ST
ULTICARE SYR 0.3 ML 31GX5/16" SHORT NDL 0.3 ML 31 GAUGE X 5/16"	2	PA; ST
ULTICARE SYR 0.5 ML 30GX1/2" 0.5 ML 30 GAUGE X 1/2"	2	PA; ST
ULTICARE SYR 0.5 ML 31GX5/16" SHORT NDL 0.5 ML 31 GAUGE X 5/16"	2	PA; ST
ULTICARE SYR 1 ML 31GX5/16" 1 ML 31 GAUGE X 5/16	2	PA; ST
ULTIGUARD SAFE 1 ML 30G 12.7MM 1 ML 30 X 1/2"	2	PA; ST

Drug Name	Drug Tier	Requirements/Limits
ULTIGUARD SAFE0.3 ML 30G 12.7MM 0.3 ML 30 X 1/2"	2	PA; ST
ULTIGUARD SAFE0.5 ML 30G 12.7MM 1/2 ML 30 X 1/2"	2	PA; ST
ULTIGUARD SAFEPACK 1 ML 31G 8MM 1 ML 31 X 5/16"	2	PA; ST
ULTIGUARD SAFEPACK 29G 12.7MM 29 GAUGE X 1/2"	2	PA; ST
ULTIGUARD SAFEPACK 31G 5MM 31 GAUGE X 3/16"	2	PA; ST
ULTIGUARD SAFEPACK 31G 6MM 31 GAUGE X 1/4"	2	PA; ST
ULTIGUARD SAFEPACK 31G 8MM 31 GAUGE X 5/16"	2	PA; ST
ULTIGUARD SAFEPACK 32G 4MM 32 GAUGE X 5/32"	2	PA; ST
ULTIGUARD SAFEPACK 32G 6MM 32 GAUGE X 1/4"	2	PA; ST
ULTIGUARD SAFEPK 0.3 ML 31G 8MM 0.3 ML 31 X 5/16"	2	PA; ST
ULTIGUARD SAFEPK 0.5 ML 31G 8MM 1/2 ML 31 X 5/16"	2	PA; ST
ULTILET ALCOHOL STERL SWAB	1	PA; ST
ULTILET INSULIN SYRINGE 0.3 ML 0.3 ML 29 GAUGE X 1/2", 0.3 ML 30 GAUGE X 5/16", 0.3 ML 31 GAUGE X 5/16"	2	PA; ST
ULTILET INSULIN SYRINGE 0.5 ML 0.5 ML 29 GAUGE X 1/2", 0.5 ML 30 GAUGE X 5/16", 0.5 ML 31 GAUGE X 5/16"	2	PA; ST
ULTILET INSULIN SYRINGE 1 ML 1 ML 29 GAUGE X 1/2", 1 ML 30 GAUGE X 5/16, 1 ML 31 GAUGE X 5/16	2	PA; ST
ULTILET PEN NEEDLE 29 GAUGE	2	PA; ST
ULTILET PEN NEEDLE 4MM 32G 32 GAUGE X 5/32"	2	PA; ST
ULTRA COMFORT 0.3 ML 29GX1/2" 0.3 ML 29 GAUGE X 1/2"	2	PA; ST
ULTRA COMFORT 0.3 ML SYRINGE 0.3 ML 30 GAUGE X 5/16"	2	PA; ST
ULTRA COMFORT 0.5 ML 28GX1/2" CONVERTS TO 29G 1/2 ML 28 GAUGE X 1/2"	2	PA; ST

Drug Name	Drug Tier	Requirements/Limits
ULTRA COMFORT 0.5 ML 29GX1/2" 0.5 ML 29 GAUGE X 1/2"	2	PA; ST
ULTRA COMFORT 0.5 ML 31GX5/16" 0.5 ML 31 GAUGE X 5/16"	2	PA; ST
ULTRA COMFORT 0.5 ML SYRINGE 0.5 ML 30 GAUGE X 5/16"	2	PA; ST
ULTRA COMFORT 0.5 ML SYRINGE 1/2 ML 28 GAUGE	2	PA; ST
ULTRA COMFORT 1 ML 29GX1/2" 1 ML 29 GAUGE X 1/2"	2	PA; ST
ULTRA COMFORT 1 ML 30GX5/16" 1 ML 30 GAUGE X 5/16	2	PA; ST
ULTRA COMFORT 1 ML 31GX5/16" 1 ML 31 GAUGE X 5/16	2	PA; ST
ULTRA COMFORT 1 ML SYRINGE 1 ML 28 GAUGE X 1/2"	2	PA; ST
ULTRA FLO 0.3 ML 30G 1/2" (1/2) 0.3 ML 30 GAUGE X 1/2"	2	PA; ST
ULTRA FLO 0.3 ML 30G 5/16"(1/2) 0.3 ML 30 GAUGE X 5/16"	2	PA; ST
ULTRA FLO 0.3 ML 31G 5/16"(1/2) 0.3 ML 31 GAUGE X 5/16"	2	PA; ST
ULTRA FLO PEN NEEDLE 31G 5MM 31 GAUGE X 3/16"	2	PA; ST
ULTRA FLO PEN NEEDLE 31G 8MM 31 GAUGE X 5/16"	2	PA; ST
ULTRA FLO PEN NEEDLE 32G 4MM 32 GAUGE X 5/32"	2	PA; ST
ULTRA FLO PEN NEEDLE 33G 4MM 33 GAUGE X 5/32"	2	PA; ST
ULTRA FLO PEN NEEDLES 12MM 29G 29 GAUGE X 1/2"	2	PA; ST
ULTRA FLO SYR 0.3 ML 29GX1/2" 0.3 ML 29 GAUGE X 1/2"	2	PA; ST
ULTRA FLO SYR 0.3 ML 30G 5/16" 0.3 ML 30 GAUGE X 5/16"	2	PA; ST
ULTRA FLO SYR 0.3 ML 31G 5/16" 0.3 ML 31 GAUGE X 5/16"	2	PA; ST
ULTRA FLO SYR 0.5 ML 29G 1/2" 0.5 ML 29 GAUGE X 1/2"	2	PA; ST

Drug Name	Drug Tier	Requirements/Limits
ULTRA THIN PEN NDL 32G X 4MM 32 GAUGE X 5/32"	2	PA; ST
ULTRACARE INS 0.3 ML 30GX5/16" 0.3 ML 30 GAUGE X 5/16"	2	PA; ST
ULTRACARE INS 0.3 ML 31GX5/16" 0.3 ML 31 GAUGE X 5/16"	2	PA; ST
ULTRACARE INS 0.5 ML 30GX1/2" 0.5 ML 30 GAUGE X 1/2"	2	PA; ST
ULTRACARE INS 0.5 ML 30GX5/16" 0.5 ML 30 GAUGE X 5/16"	2	PA; ST
ULTRACARE INS 0.5 ML 31GX5/16" 0.5 ML 31 GAUGE X 5/16"	2	PA; ST
ULTRACARE INS 1 ML 30G X 5/16" 1 ML 30 GAUGE X 5/16	2	PA; ST
ULTRACARE INS 1 ML 30GX1/2" 1 ML 30 GAUGE X 1/2"	2	PA; ST
ULTRACARE INS 1 ML 31G X 5/16" 1 ML 31 GAUGE X 5/16	2	PA; ST
ULTRACARE PEN NEEDLE 31GX1/4" 31 GAUGE X 1/4"	2	PA; ST
ULTRACARE PEN NEEDLE 31GX3/16" 31 GAUGE X 3/16"	2	PA; ST
ULTRACARE PEN NEEDLE 31GX5/16" 31 GAUGE X 5/16"	2	PA; ST
ULTRACARE PEN NEEDLE 32GX1/4" 32 GAUGE X 1/4"	2	PA; ST
ULTRACARE PEN NEEDLE 32GX3/16" 32 GAUGE X 3/16"	2	PA; ST
ULTRACARE PEN NEEDLE 32GX5/32" 32 GAUGE X 5/32"	2	PA; ST
ULTRACARE PEN NEEDLE 33GX5/32" 33 GAUGE X 5/32"	2	PA; ST
ULTRA-FINE 0.3 ML 30G 12.7MM 0.3 ML 30 GAUGE X 1/2"	2	PA; ST
ULTRA-FINE 0.3 ML 31G 6MM (1/2) 0.3 ML 31 GAUGE X 15/64"	2	PA; ST
ULTRA-FINE 0.3 ML 31G 8MM (1/2) 0.3 ML 31 GAUGE X 5/16"	2	PA; ST
ULTRA-FINE 0.5 ML 30G 12.7MM 0.5 ML 30 GAUGE X 1/2"	2	PA; ST

Drug Name	Drug Tier	Requirements/Limits
ULTRA-FINE INS SYR 1 ML 31G 6MM 1 ML 31 GAUGE X 15/64"	2	PA; ST
ULTRA-FINE INS SYR 1 ML 31G 8MM 1 ML 31 GAUGE X 5/16	2	PA; ST
ULTRA-FINE PEN NDL 29G 12.7MM 29 GAUGE X 1/2"	2	PA; ST
ULTRA-FINE PEN NEEDLE 31G 5MM 31 GAUGE X 3/16"	2	PA; ST
ULTRA-FINE PEN NEEDLE 31G 8MM 31 GAUGE X 5/16"	2	PA; ST
ULTRA-FINE PEN NEEDLE 32G 6MM 32 GAUGE X 1/4"	2	PA; ST
ULTRA-FINE SYR 0.3 ML 31G 6MM 0.3 ML 31 GAUGE X 15/64"	2	PA; ST
ULTRA-FINE SYR 0.3 ML 31G 8MM 0.3 ML 31 GAUGE X 5/16"	2	PA; ST
ULTRA-FINE SYR 0.5 ML 31G 6MM 1/2 ML 31 GAUGE X 15/64"	2	PA; ST
ULTRA-FINE SYR 0.5 ML 31G 8MM 0.5 ML 31 GAUGE X 5/16"	2	PA; ST
ULTRA-FINE SYR 1 ML 30G 12.7MM 1 ML 30 GAUGE X 1/2"	2	PA; ST
ULTRA-THIN II 1 ML 31GX5/16" 1 ML 31 GAUGE X 5/16	2	PA; ST
ULTRA-THIN II INS 0.3 ML 30G 0.3 ML 30 GAUGE X 5/16"	2	PA; ST
ULTRA-THIN II INS 0.3 ML 31G 0.3 ML 31 GAUGE X 5/16"	2	PA; ST
ULTRA-THIN II INS 0.5 ML 29G 0.5 ML 29 GAUGE X 1/2"	2	PA; ST
ULTRA-THIN II INS 0.5 ML 30G 0.5 ML 30 GAUGE X 5/16"	2	PA; ST
ULTRA-THIN II INS 0.5 ML 31G 0.5 ML 31 GAUGE X 5/16"	2	PA; ST
ULTRA-THIN II INS SYR 1 ML 29G 1 ML 29 GAUGE X 1/2"	2	PA; ST
ULTRA-THIN II INS SYR 1 ML 30G 1 ML 30 GAUGE X 5/16	2	PA; ST
ULTRA-THIN II PEN NDL 29GX1/2" 29 GAUGE X 1/2"	2	PA; ST

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Drug Name	Drug Tier	Requirements/Limits
ULTRA-THIN II PEN NDL 31GX5/16 31 GAUGE X 5/16"	2	PA; ST
UNIFINE OTC PEN NEEDLE 31G 5MM 31 GAUGE X 3/16"	2	PA; ST
UNIFINE OTC PEN NEEDLE 32G 4MM 32 GAUGE X 5/32"	2	PA; ST
UNIFINE PENTIPS 12MM 29G 29GX12MM, STRL 29 GAUGE X 1/2"	2	PA; ST
UNIFINE PENTIPS 31GX3/16" 31GX5MM,STRL,MINI 31 GAUGE X 3/16"	2	PA; ST
UNIFINE PENTIPS 32G 4MM 32 GAUGE X 5/32"	2	PA; ST
UNIFINE PENTIPS 32GX1/4" 32 GAUGE X 1/4"	2	PA; ST
UNIFINE PENTIPS 33GX5/32" 33 GAUGE X 5/32"	2	PA; ST
UNIFINE PENTIPS 6MM 31G 31 GAUGE X 1/4"	2	PA; ST
UNIFINE PENTIPS 8MM 31G 31GX8MM, SHORT, STRL 31 GAUGE X 5/16"	2	PA; ST
UNIFINE PENTIPS MAX 30GX3/16" 30 GAUGE X 3/16"	2	PA; ST
UNIFINE PENTIPS PLUS 29GX1/2" 12MM 29 GAUGE X 1/2"	2	PA; ST
UNIFINE PENTIPS PLUS 30GX3/16" 30 GAUGE X 3/16"	2	PA; ST
UNIFINE PENTIPS PLUS 31G 5MM 31 GAUGE X 3/16"	2	PA; ST
UNIFINE PENTIPS PLUS 31GX1/4" ULTRA SHORT, 6MM 31 GAUGE X 1/4"	2	PA; ST
UNIFINE PENTIPS PLUS 32GX5/32" 32 GAUGE X 5/32"	2	PA; ST
UNIFINE PENTIPS PLUS 33GX5/32" 33 GAUGE X 5/32"	2	PA; ST
UNIFINE PROTECT 30G 5MM 30 GAUGE X 3/16"	2	PA; ST
UNIFINE PROTECT 30G 8MM 30 GAUGE X 5/16"	2	PA; ST
UNIFINE PROTECT 32G 4MM 32 GAUGE X 5/32"	2	PA; ST

Drug Name	Drug Tier	Requirements/Limits
UNIFINE SAFECONTROL 30G 5MM 30 GAUGE X 3/16"	2	PA; ST
UNIFINE SAFECONTROL 30G 8MM 30 GAUGE X 5/16"	2	PA; ST
UNIFINE SAFECONTROL 31G 5MM 31 GAUGE X 3/16"	2	PA; ST
UNIFINE SAFECONTROL 31G 6MM 31 GAUGE X 1/4"	2	PA; ST
UNIFINE SAFECONTROL 31G 8MM 31 GAUGE X 5/16"	2	PA; ST
UNIFINE SAFECONTROL 32G 4MM 32 GAUGE X 5/32"	2	PA; ST
UNIFINE ULTR PEN NDL 34G 3.5MM 34 GAUGE X 9/64"	2	PA; ST
UNIFINE ULTRA PEN NDL 29G 12MM 29 GAUGE X 1/2"	2	PA; ST
UNIFINE ULTRA PEN NDL 31G 5MM 31 GAUGE X 3/16"	2	PA; ST
UNIFINE ULTRA PEN NDL 31G 6MM 31 GAUGE X 1/4"	2	PA; ST
UNIFINE ULTRA PEN NDL 31G 8MM 31 GAUGE X 5/16"	2	PA; ST
UNIFINE ULTRA PEN NDL 32G 4MM 32 GAUGE X 5/32"	2	PA; ST
UNIFINE ULTRA PEN NDL 32G 6MM 32 GAUGE X 1/4"	2	PA; ST
VANISHPOINT 0.5 ML 30GX1/2" SY OUTER 0.5 ML 30 GAUGE X 1/2"	2	PA; ST
VANISHPOINT INS 0.5 ML 30G 8MM OUTER 0.5 ML 30 GAUGE X 5/16"	2	PA; ST
VANISHPOINT INS 1 ML 30GX3/16" 1 ML 30 GAUGE X 3/16"	2	PA; ST
VANISHPOINT U-100 29X1/2 SYR 1 ML 29 GAUGE X 1/2"	2	PA; ST
VERIFINE INS SYR 1 ML 29G 1/2" 1 ML 29 GAUGE X 1/2"	2	PA; ST
VERIFINE PEN NEEDLE 29G 12MM 29 GAUGE X 1/2"	2	PA; ST
VERIFINE PEN NEEDLE 31G 5MM 31 GAUGE X 3/16"	2	PA; ST

Please refer to our Evidence of Coverage for 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.

Drug Name	Drug Tier	Requirements/Limits
VERIFINE PEN NEEDLE 31G X 6MM 31 GAUGE X 1/4"	2	PA; ST
VERIFINE PEN NEEDLE 31G X 8MM 31 GAUGE X 5/16"	2	PA; ST
VERIFINE PEN NEEDLE 32G 6MM 32 GAUGE X 1/4"	2	PA; ST
VERIFINE PEN NEEDLE 32G X 4MM 32 GAUGE X 5/32"	2	PA; ST
VERIFINE PEN NEEDLE 32G X 5MM 32 GAUGE X 3/16"	2	PA; ST
VERIFINE PLUS PEN NDL 31G 5MM 31 GAUGE X 3/16"	2	PA; ST
VERIFINE PLUS PEN NDL 31G 8MM 31 GAUGE X 5/16"	2	PA; ST
VERIFINE PLUS PEN NDL 32G 4MM 32 GAUGE X 5/32"	2	PA; ST
VERIFINE PLUS PEN NDL 32G 4MM-SHARPS CONTAINER 32 GAUGE X 5/32"	2	PA; ST
VERIFINE SYRING 0.5 ML 29G 1/2" 0.5 ML 29 GAUGE X 1/2"	2	PA; ST
VERIFINE SYRING 1 ML 31G 5/16" 1 ML 31 GAUGE X 5/16	2	PA; ST
VERIFINE SYRNG 0.3 ML 31G 5/16" 0.3 ML 31 GAUGE X 5/16"	2	PA; ST
VERIFINE SYRNG 0.5 ML 31G 5/16" 0.5 ML 31 GAUGE X 5/16"	2	PA; ST
VERSALON ALL PURPOSE SPONGE 25'S,N-STERILE,3PLY 2 X 2 "	1	PA; ST
WEBCOL ALCOHOL PREPS 20'S,LARGE	1	PA; ST
WM UNIFINE PENTIP PLUS 8MM 31G W/ SAFETY CLICK 31 GAUGE X 5/16"	2	PA; ST
Enzyme Replacement/Modifiers		
Enzyme Replacement/Modifiers		
CREON ORAL CAPSULE,DELAYED RELEASE(DR/EC) 12,000-38,000 -60,000 UNIT, 24,000-76,000 -120,000 UNIT, 3,000-9,500- 15,000 UNIT, 36,000-114,000- 180,000 UNIT, 6,000-19,000 -30,000 UNIT	3	
javygtor oral tablet,soluble 100 mg	5	PA
nitisinone oral capsule 10 mg, 2 mg, 20 mg, 5 mg	5	PA

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Drug Name	Drug Tier	Requirements/Limits
ORFADIN ORAL SUSPENSION 4 MG/ML	5	PA
REVCOVI INTRAMUSCULAR SOLUTION 2.4 MG/1.5 ML (1.6 MG/ML)	5	PA
sapropterin oral tablet,soluble 100 mg	5	PA
STRENSIQ SUBCUTANEOUS SOLUTION 28 MG/0.7 ML, 40 MG/ML, 80 MG/0.8 ML	5	PA; LA
ZENPEP ORAL CAPSULE,DELAYED RELEASE(DR/EC) 10,000-32,000 -42,000 UNIT, 15,000-47,000 -63,000 UNIT, 20,000-63,000- 84,000 UNIT, 25,000-79,000- 105,000 UNIT, 3,000-10,000 -14,000-UNIT, 40,000-126,000- 168,000 UNIT, 5,000-17,000- 24,000 UNIT, 60,000-189,600- 252,600 UNIT	3	
Eye, Ear, Nose, Throat Agents		
Eye, Ear, Nose, Throat Agents, Miscellaneous		
atropine ophthalmic (eye) drops 1 %	2	
azelastine nasal spray,non-aerosol 137 mcg (0.1 %)	2	QL (60 per 30 days)
azelastine nasal spray,non-aerosol 205.5 mcg (0.15 %)	2	QL (30 per 25 days)
azelastine ophthalmic (eye) drops 0.05 %	2	
cromolyn ophthalmic (eye) drops 4 %	2	
epinastine ophthalmic (eye) drops 0.05 %	4	
ipratropium bromide nasal spray,non-aerosol 21 mcg (0.03 %)	2	QL (30 per 28 days)
ipratropium bromide nasal spray,non-aerosol 42 mcg (0.06 %)	2	QL (15 per 10 days)
olopatadine ophthalmic (eye) drops 0.1 %, 0.2 %	2	
Eye, Ear, Nose, Throat Anti-Infectives Agents		
acetic acid otic (ear) solution 2 %	2	
bacitracin ophthalmic (eye) ointment 500 unit/gram	2	
bacitracin-polymyxin b ophthalmic (eye) ointment 500-10,000 unit/gram	2	
ciprofloxacin hcl ophthalmic (eye) drops 0.3 %	2	
ciprofloxacin-dexamethasone otic (ear) drops,suspension 0.3-0.1 %	2	QL (7.5 per 7 days)
erythromycin ophthalmic (eye) ointment 5 mg/gram (0.5 %)	2	QL (3.5 per 4 days)
gentamicin ophthalmic (eye) drops 0.3 %	2	

Drug Name	Drug Tier	Requirements/Limits
hydrocortisone-acetic acid otic (ear) drops 1-2 %	2	
moxifloxacin ophthalmic (eye) drops 0.5 %	2	
NATACYN OPHTHALMIC (EYE) DROPS,SUSPENSION 5 %	4	
neomycin-bacitracin-poly-hc ophthalmic (eye) ointment 3.5-400-10,000 mg-unit/g-1%	2	
neomycin-bacitracin-polymyxin ophthalmic (eye) ointment 3.5-400-10,000 mg-unit-unit/g	2	
neomycin-polymyxin b-dexameth ophthalmic (eye) drops,suspension 3.5mg/ml-10,000 unit/ml-0.1 %	2	
neomycin-polymyxin-gramicidin ophthalmic (eye) drops 1.75 mg-10,000 unit-0.025mg/ml	2	
neomycin-polymyxin-hc otic (ear) drops,suspension 3.5-10,000-1 mg/ml-unit/ml-%	2	
neomycin-polymyxin-hc otic (ear) solution 3.5-10,000-1 mg/ml-unit/ml-%	2	
neo-polycin hc ophthalmic (eye) ointment 3.5-400-10,000 mg-unit/g-1%	2	
neo-polycin ophthalmic (eye) ointment 3.5-400-10,000 mg-unit-unit/g	2	
ofloxacin ophthalmic (eye) drops 0.3 %	2	
ofloxacin otic (ear) drops 0.3 %	2	
polycin ophthalmic (eye) ointment 500-10,000 unit/gram	2	
polymyxin b sulf-trimethoprim ophthalmic (eye) drops 10,000 unit- 1 mg/ml	1	
sulfacetamide sodium ophthalmic (eye) drops 10 %	2	
sulfacetamide sodium ophthalmic (eye) ointment 10 %	2	
tobramycin ophthalmic (eye) drops 0.3 %	1	
tobramycin-dexamethasone ophthalmic (eye) drops,suspension 0.3-0.1 %	2	
tobramycin-lotepred ophthalmic (eye) drops,suspension 0.3-0.5 %	2	
trifluridine ophthalmic (eye) drops 1 %	2	
XDEMVY OPHTHALMIC (EYE) DROPS 0.25 %	5	PA; QL (10 per 42 days)
ZIRGAN OPHTHALMIC (EYE) GEL 0.15 %	4	

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Drug Name	Drug Tier	Requirements/Limits
Eye, Ear, Nose, Throat Anti-Inflammatory Agents		
bromfenac ophthalmic (eye) drops 0.07 %	2	
cyclosporine ophthalmic (eye) dropperette 0.05 %	2	QL (60 per 30 days)
dexamethasone sodium phosphate ophthalmic (eye) drops 0.1 %	2	
diclofenac sodium ophthalmic (eye) drops 0.1 %	2	
difluprednate ophthalmic (eye) drops 0.05 %	4	
EYSUVIS OPHTHALMIC (EYE) DROPS,SUSPENSION 0.25 %	3	QL (8.3 per 14 days)
flunisolide nasal spray,non-aerosol 25 mcg (0.025 %)	4	QL (50 per 25 days)
fluocinolone acetonide oil otic (ear) drops 0.01 %	2	
fluorometholone ophthalmic (eye) drops,suspension 0.1 %	2	
flurbiprofen sodium ophthalmic (eye) drops 0.03 %	2	
fluticasone propionate nasal spray,suspension 50 mcg/actuation	1	QL (16 per 30 days)
ILEVRO OPHTHALMIC (EYE) DROPS,SUSPENSION 0.3 %	3	
INVELTYS OPHTHALMIC (EYE) DROPS,SUSPENSION 1 %	3	QL (5.6 per 14 days)
ketorolac ophthalmic (eye) drops 0.5 %	2	QL (10 per 25 days)
LOTEMAX OPHTHALMIC (EYE) OINTMENT 0.5 %	3	QL (3.5 per 14 days)
LOTEMAX SM OPHTHALMIC (EYE) DROPS,GEL 0.38 %	3	QL (5 per 16 days)
loteprednol etabonate ophthalmic (eye) drops,gel 0.5 %	4	QL (10 per 14 days)
loteprednol etabonate ophthalmic (eye) drops,suspension 0.2 %	2	ST
loteprednol etabonate ophthalmic (eye) drops,suspension 0.5 %	4	QL (15 per 19 days)
MIEBO (PF) OPHTHALMIC (EYE) DROPS 100 %	3	QL (12 per 28 days)
mometasone nasal spray,non-aerosol 50 mcg/actuation	2	QL (34 per 30 days)

Drug Name	Drug Tier	Requirements/Limits
neomycin-polymyxin b-dexameth ophthalmic (eye) ointment 3.5 mg/g-10,000 unit/g-0.1 %	2	
prednisolone acetate ophthalmic (eye) drops,suspension 1 %	2	
sulfacetamide-prednisolone ophthalmic (eye) drops 10 %-0.23 % (0.25 %)	2	
XIIDRA OPHTHALMIC (EYE) DROPPERETTE 5 %	3	QL (60 per 30 days)
Gastrointestinal Agents		
Antiulcer Agents And Acid Suppressants		
cimetidine hcl oral solution 300 mg/5 ml	2	
esomeprazole magnesium oral capsule,delayed release(dr/ec) 20 mg, 40 mg	1	
famotidine oral tablet 20 mg, 40 mg	1	
lansoprazole oral capsule,delayed release(dr/ec) 15 mg	2	QL (30 per 30 days)
lansoprazole oral capsule,delayed release(dr/ec) 30 mg	2	QL (60 per 30 days)
misoprostol oral tablet 100 mcg, 200 mcg	2	
omeprazole oral capsule,delayed release(dr/ec) 10 mg, 20 mg, 40 mg	1	
pantoprazole oral tablet,delayed release (dr/ec) 20 mg, 40 mg	1	
rabeprazole oral tablet,delayed release (dr/ec) 20 mg	2	
sucralfate oral tablet 1 gram	2	
TALICIA ORAL CAPSULE,IR - DELAY REL,BIPHASE 10-250-12.5 MG	4	QL (168 per 14 days)
VOQUEZNA ORAL TABLET 10 MG, 20 MG	4	PA
Gastrointestinal Agents, Other		
bismuth subcit k-metronidz-tcn oral capsule 140-125-125 mg	2	QL (168 per 14 days)
calcium acetate(phosphat bind) oral capsule 667 mg	2	
calcium acetate(phosphat bind) oral tablet 667 mg	2	
carglumic acid oral tablet, dispersible 200 mg	5	PA
constulose oral solution 10 gram/15 ml	2	
cromolyn oral concentrate 100 mg/5 ml	2	
dicyclomine oral capsule 10 mg	2	

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Drug Name	Drug Tier	Requirements/Limits
dicyclomine oral solution 10 mg/5 ml	2	
dicyclomine oral tablet 20 mg	2	
diphenoxylate-atropine oral tablet 2.5-0.025 mg	2	PA-HRM; AGE (Max 64 Years)
enulose oral solution 10 gram/15 ml	2	
generlac oral solution 10 gram/15 ml	2	
glycopyrrolate oral tablet 1 mg, 2 mg	2	
kionex oral suspension 15 gram/60 ml	2	
lactulose oral solution 10 gram/15 ml	2	
LINZESS ORAL CAPSULE 145 MCG, 290 MCG, 72 MCG	3	QL (30 per 30 days)
LOKELMA ORAL POWDER IN PACKET 10 GRAM	3	QL (34 per 30 days)
LOKELMA ORAL POWDER IN PACKET 5 GRAM	3	QL (30 per 30 days)
loperamide oral capsule 2 mg	2	
lubiprostone oral capsule 24 mcg	2	QL (60 per 30 days)
lubiprostone oral capsule 8 mcg	2	QL (120 per 30 days)
metoclopramide hcl oral solution 5 mg/5 ml	2	
metoclopramide hcl oral tablet 10 mg, 5 mg	1	
MOVANTIK ORAL TABLET 12.5 MG, 25 MG	3	QL (30 per 30 days)
sevelamer carbonate oral powder in packet 0.8 gram, 2.4 gram	2	
sevelamer carbonate oral tablet 800 mg	2	
sevelamer hcl oral tablet 400 mg, 800 mg	2	
sodium polystyrene sulfonate oral powder 15 gram	2	
sodium polystyrene sulfonate oral suspension 15 gram/60 ml	2	
sps (with sorbitol) oral suspension 15-20 gram/60 ml	2	
TRULANCE ORAL TABLET 3 MG	3	QL (30 per 30 days)
ursodiol oral capsule 300 mg	2	
ursodiol oral tablet 250 mg, 500 mg	2	
VELTASSA ORAL POWDER IN PACKET 1 GRAM, 16.8 GRAM, 25.2 GRAM, 8.4 GRAM	3	
VOWST ORAL CAPSULE 1 X 10EXP6 TO 3 X 10EXP7 CELL	5	PA; QL (12 per 30 days)
XERMELO ORAL TABLET 250 MG	5	PA; QL (84 per 28 days)
Inflammatory Bowel Disease Agents		

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Drug Name	Drug Tier	Requirements/Limits
alosetron oral tablet 0.5 mg, 1 mg	2	
balsalazide oral capsule 750 mg	2	
budesonide oral capsule,delayed,extend.release 3 mg	2	
budesonide rectal foam 2 mg/actuation	2	
hydrocortisone rectal enema 100 mg/60 ml	2	
mesalamine oral capsule, extended release 500 mg	2	
mesalamine oral capsule,extended release 24hr 0.375 gram	4	
mesalamine oral tablet,delayed release (dr/ec) 1.2 gram	4	QL (120 per 30 days)
mesalamine rectal enema 4 gram/60 ml	2	
mesalamine rectal suppository 1,000 mg	2	
sulfasalazine oral tablet 500 mg	2	
sulfasalazine oral tablet,delayed release (dr/ec) 500 mg	4	
Laxatives		
gavilyte-c oral recon soln 240-22.72-6.72 -5.84 gram	2	
gavilyte-g oral recon soln 236-22.74-6.74 -5.86 gram	2	
gavilyte-n oral recon soln 420 gram	2	
peg 3350-electrolytes oral recon soln 236-22.74-6.74 -5.86 gram	2	
peg-electrolyte soln oral recon soln 420 gram	2	
sodium,potassium,mag sulfates oral recon soln 17.5-3.13-1.6 gram, 17.5-3.13-1.6 gram 2 pack (480ml)	2	
Genitourinary Agents		
Antispasmodics, Urinary		
bethanechol chloride oral tablet 10 mg, 25 mg, 5 mg, 50 mg	2	
darifenacin oral tablet extended release 24 hr 15 mg, 7.5 mg	2	
fesoterodine oral tablet extended release 24 hr 4 mg, 8 mg	2	
flavoxate oral tablet 100 mg	2	
MYRBETRIQ ORAL TABLET EXTENDED RELEASE 24 HR 25 MG, 50 MG	2	

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Drug Name	Drug Tier	Requirements/Limits
oxybutynin chloride oral syrup 5 mg/5 ml	2	
oxybutynin chloride oral tablet 5 mg	1	
oxybutynin chloride oral tablet extended release 24hr 10 mg, 15 mg, 5 mg	2	
solifenacin oral tablet 10 mg, 5 mg	2	
tolterodine oral capsule,extended release 24hr 2 mg, 4 mg	2	
tolterodine oral tablet 1 mg, 2 mg	2	
trospium oral tablet 20 mg	2	
Genitourinary Agents, Miscellaneous		
alfuzosin oral tablet extended release 24 hr 10 mg	1	QL (30 per 30 days)
dutasteride oral capsule 0.5 mg	2	
finasteride oral tablet 5 mg	1	
tamsulosin oral capsule 0.4 mg	1	
terazosin oral capsule 1 mg, 10 mg, 2 mg, 5 mg	1	
Heavy Metal Antagonists		
Heavy Metal Antagonists		
deferasirox oral granules in packet 180 mg, 360 mg, 90 mg	5	PA
deferasirox oral tablet 180 mg, 360 mg, 90 mg	2	PA
penicillamine oral tablet 250 mg	5	PA
trientine oral capsule 250 mg	5	PA; QL (240 per 30 days)
Hormonal Agents, Stimulant/Replacement/Modifying		
Androgens		
danazol oral capsule 100 mg, 200 mg, 50 mg	2	
testosterone cypionate intramuscular oil 100 mg/ml, 200 mg/ml, 200 mg/ml (1 ml)	2	PA
testosterone enanthate intramuscular oil 200 mg/ml	2	PA; QL (5 per 28 days)
testosterone transdermal gel in metered-dose pump 12.5 mg/ 1.25 gram (1 %)	4	PA; QL (300 per 30 days)
testosterone transdermal gel in metered-dose pump 20.25 mg/1.25 gram (1.62 %)	4	PA; QL (150 per 30 days)
testosterone transdermal gel in packet 1 % (25 mg/2.5gram), 1 % (50 mg/5 gram)	4	PA; QL (300 per 30 days)
Estrogens And Antiestrogens		
abigale lo oral tablet 0.5-0.1 mg	1	

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Drug Name	Drug Tier	Requirements/Limits
abigale oral tablet 1-0.5 mg	2	PA-HRM; AGE (Max 64 Years)
conjugated estrogens oral tablet 0.3 mg, 0.45 mg, 0.625 mg, 0.9 mg, 1.25 mg	2	
dotti transdermal patch semiweekly 0.025 mg/24 hr, 0.0375 mg/24 hr, 0.05 mg/24 hr, 0.075 mg/24 hr, 0.1 mg/24 hr	2	QL (8 per 28 days)
estradiol oral tablet 0.5 mg, 1 mg, 2 mg	1	
estradiol transdermal patch semiweekly 0.025 mg/24 hr, 0.0375 mg/24 hr, 0.05 mg/24 hr, 0.075 mg/24 hr, 0.1 mg/24 hr	2	QL (8 per 28 days)
estradiol transdermal patch weekly 0.025 mg/24 hr, 0.0375 mg/24 hr, 0.05 mg/24 hr, 0.06 mg/24 hr, 0.075 mg/24 hr, 0.1 mg/24 hr	2	QL (4 per 28 days)
estradiol vaginal cream 0.01 % (0.1 mg/gram)	2	
estradiol vaginal tablet 10 mcg	4	QL (18 per 28 days)
estradiol-norethindrone acet oral tablet 0.5-0.1 mg, 1-0.5 mg	2	PA-HRM; AGE (Max 64 Years)
mimvey oral tablet 1-0.5 mg	2	PA-HRM; AGE (Max 64 Years)
PREMARIN VAGINAL CREAM 0.625 MG/GRAM	3	
PREMPHASE ORAL TABLET 0.625 MG (14)/ 0.625MG-5MG(14)	3	PA-HRM; AGE (Max 64 Years)
PREMPRO ORAL TABLET 0.3-1.5 MG, 0.45-1.5 MG, 0.625-2.5 MG, 0.625-5 MG	3	PA-HRM; AGE (Max 64 Years)
raloxifene oral tablet 60 mg	2	
yuvafem vaginal tablet 10 mcg	4	QL (18 per 28 days)
Glucocorticoids/Mineralocorticoids		
dexamethasone oral solution 0.5 mg/5 ml	2	
dexamethasone oral tablet 0.5 mg, 0.75 mg, 1 mg, 1.5 mg, 2 mg, 4 mg, 6 mg	2	
dexamethasone sodium phosphate injection solution 10 mg/ml, 4 mg/ml	1	
fludrocortisone oral tablet 0.1 mg	2	
hydrocortisone oral tablet 10 mg, 20 mg, 5 mg	2	
ISTURISA ORAL TABLET 1 MG	5	PA; QL (240 per 30 days)
ISTURISA ORAL TABLET 5 MG	5	PA; QL (360 per 30 days)
methylprednisolone acetate injection suspension 40 mg/ml	2	
methylprednisolone oral tablet 16 mg, 32 mg, 4 mg, 8 mg	2	

Drug Name	Drug Tier	Requirements/Limits
methylprednisolone oral tablets,dose pack 4 mg	1	
prednisolone 15 mg/5 ml soln d/f 15 mg/5 ml (3 mg/ml)	2	
prednisolone oral solution 15 mg/5 ml	2	
prednisolone sodium phosphate oral solution 25 mg/5 ml (5 mg/ml), 5 mg base/5 ml (6.7 mg/5 ml)	2	
prednisone oral solution 5 mg/5 ml	2	PA BvD
prednisone oral tablet 1 mg, 10 mg, 2.5 mg, 20 mg, 5 mg, 50 mg	1	PA BvD
prednisone oral tablets,dose pack 10 mg, 10 mg (48 pack), 5 mg, 5 mg (48 pack)	2	
TARPEYO ORAL CAPSULE,DELAYED RELEASE(DR/EC) 4 MG	5	PA; QL (120 per 30 days)
triamcinolone acetonide injection suspension 40 mg/ml	2	
Incretin Mimetics		
MOUNJARO SUBCUTANEOUS PEN INJECTOR 10 MG/0.5 ML, 12.5 MG/0.5 ML, 15 MG/0.5 ML, 2.5 MG/0.5 ML, 5 MG/0.5 ML, 7.5 MG/0.5 ML	3	PA; QL (2 per 28 days)
OZEMPIC ORAL TABLET 1.5 MG, 4 MG, 9 MG	3	PA; QL (30 per 30 days)
OZEMPIC SUBCUTANEOUS PEN INJECTOR 0.25 MG OR 0.5 MG (2 MG/3 ML), 1 MG/DOSE (4 MG/3 ML), 2 MG/DOSE (8 MG/3 ML)	3	PA; QL (3 per 28 days)
RYBELSUS ORAL TABLET 1.5 MG, 14 MG, 3 MG, 4 MG, 7 MG, 9 MG	3	PA; QL (30 per 30 days)
TRULICITY SUBCUTANEOUS PEN INJECTOR 0.75 MG/0.5 ML, 1.5 MG/0.5 ML, 3 MG/0.5 ML, 4.5 MG/0.5 ML	3	PA; QL (2 per 28 days)
WEGOVY ORAL TABLET 1.5 MG, 25 MG, 4 MG, 9 MG	3	PA; QL (30 per 30 days)
WEGOVY SUBCUTANEOUS PEN INJECTOR 0.25 MG/0.5 ML, 0.5 MG/0.5 ML, 1 MG/0.5 ML	3	PA; QL (2 per 28 days)
WEGOVY SUBCUTANEOUS PEN INJECTOR 1.7 MG/0.75 ML, 2.4 MG/0.75 ML	3	PA; QL (3 per 28 days)
Pituitary		
CORTROPHIN GEL INJECTION GEL 80 UNIT/ML	5	PA; QL (35 per 28 days)

Drug Name	Drug Tier	Requirements/Limits
desmopressin 10 mcg/0.1 ml spr 10 mcg/spray (0.1 ml)	2	
desmopressin nasal spray,non-aerosol 10 mcg/spray (0.1 ml)	2	
desmopressin oral tablet 0.1 mg, 0.2 mg	2	
INCRELEX SUBCUTANEOUS SOLUTION 10 MG/ML	5	PA
lanreotide subcutaneous syringe 120 mg/0.5 ml	5	PA NSO; QL (0.5 per 28 days)
LUPRON DEPOT (3 MONTH) INTRAMUSCULAR SYRINGE KIT 11.25 MG	5	PA NSO
LUPRON DEPOT INTRAMUSCULAR SYRINGE KIT 3.75 MG	5	PA NSO
LUPRON DEPOT-PED (3 MONTH) INTRAMUSCULAR SYRINGE KIT 11.25 MG, 30 MG	5	PA
LUPRON DEPOT-PED INTRAMUSCULAR SYRINGE KIT 45 MG	5	PA
NORDITROPIN FLEXPRO SUBCUTANEOUS PEN INJECTOR 10 MG/1.5 ML (6.7 MG/ML), 15 MG/1.5 ML (10 MG/ML), 30 MG/3 ML (10 MG/ML), 5 MG/1.5 ML (3.3 MG/ML)	5	PA
octreotide acetate injection solution 1,000 mcg/ml, 100 mcg/ml, 200 mcg/ml, 50 mcg/ml, 500 mcg/ml	2	
ORGOVYX ORAL TABLET 120 MG	5	PA NSO
ORILISSA ORAL TABLET 150 MG	5	PA; QL (28 per 28 days)
ORILISSA ORAL TABLET 200 MG	5	PA; QL (56 per 28 days)
SEROSTIM SUBCUTANEOUS RECON SOLN 4 MG, 5 MG, 6 MG	5	PA
SIGNIFOR SUBCUTANEOUS SOLUTION 0.3 MG/ML (1 ML), 0.6 MG/ML (1 ML), 0.9 MG/ML (1 ML)	5	PA; QL (60 per 30 days)
SOMATULINE DEPOT SUBCUTANEOUS SYRINGE 60 MG/0.2 ML	5	PA NSO; QL (0.2 per 28 days)
SOMATULINE DEPOT SUBCUTANEOUS SYRINGE 90 MG/0.3 ML	5	PA NSO; QL (0.3 per 28 days)
SOMAVERT SUBCUTANEOUS RECON SOLN 10 MG, 15 MG, 20 MG, 25 MG, 30 MG	5	PA
Progestins		

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Drug Name	Drug Tier	Requirements/Limits
DEPO-SUBQ PROVERA 104 SUBCUTANEOUS SYRINGE 104 MG/0.65 ML	3	QL (0.65 per 84 days)
gallifrey oral tablet 5 mg	2	
medroxyprogesterone intramuscular suspension 150 mg/ml	1	
medroxyprogesterone intramuscular syringe 150 mg/ml	2	
medroxyprogesterone oral tablet 10 mg, 2.5 mg, 5 mg	1	
megestrol 400 mg/10 ml susp cup outer 400 mg/10 ml (10 ml)	2	PA-HRM; AGE (Max 64 Years)
megestrol oral suspension 400 mg/10 ml (40 mg/ml), 625 mg/5 ml (125 mg/ml)	2	PA-HRM; AGE (Max 64 Years)
norethindrone acetate oral tablet 5 mg	2	
progesterone micronized oral capsule 100 mg, 200 mg	2	
Thyroid And Antithyroid Agents		
levothyroxine 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	
liomny oral tablet 25 mcg, 5 mcg, 50 mcg	2	
liothyronine oral tablet 25 mcg, 5 mcg, 50 mcg	2	
methimazole oral tablet 10 mg, 5 mg	1	
propylthiouracil oral tablet 50 mg	2	
REZDIFFRA ORAL TABLET 100 MG, 60 MG, 80 MG	5	PA
Immunological Agents		
Immunological Agents		
ACTIMMUNE SUBCUTANEOUS SOLUTION 100 MCG/0.5 ML	5	PA
adalimumab-aaty subcutaneous auto-injector, kit 40 mg/0.4 ml, 80 mg/0.8 ml	5	PA
adalimumab-aaty subcutaneous syringe kit 20 mg/0.2 ml, 40 mg/0.4 ml	5	PA
adalimumab-aaty(cf) ai crohns subcutaneous auto-injector, kit 80 mg/0.8 ml	5	PA
ARCALYST SUBCUTANEOUS RECON SOLN 220 MG	5	PA
AVONEX INTRAMUSCULAR PEN INJECTOR KIT 30 MCG/0.5 ML	5	PA; QL (1 per 28 days)

Drug Name	Drug Tier	Requirements/Limits
AVONEX INTRAMUSCULAR SYRINGE KIT 30 MCG/0.5 ML	5	PA; QL (1 per 28 days)
azathioprine oral tablet 50 mg	2	PA BvD
azathioprine sodium injection recon soln 100 mg	2	PA BvD
BENLYSTA SUBCUTANEOUS AUTO-INJECTOR 200 MG/ML	5	PA; QL (8 per 28 days)
BENLYSTA SUBCUTANEOUS SYRINGE 200 MG/ML	5	PA; QL (8 per 28 days)
BETASERON SUBCUTANEOUS KIT 0.3 MG	5	PA; QL (15 per 30 days)
COSENTYX (2 SYRINGES) SUBCUTANEOUS SYRINGE 150 MG/ML	5	PA
COSENTYX PEN (2 PENS) SUBCUTANEOUS PEN INJECTOR 150 MG/ML	5	PA
COSENTYX SUBCUTANEOUS SYRINGE 75 MG/0.5 ML	5	PA
COSENTYX UNOREADY PEN SUBCUTANEOUS PEN INJECTOR 300 MG/2 ML	5	PA
cyclosporine intravenous solution 250 mg/5 ml	2	PA BvD
cyclosporine modified oral capsule 100 mg, 25 mg, 50 mg	2	PA BvD
cyclosporine modified oral solution 100 mg/ml	2	PA BvD
cyclosporine oral capsule 100 mg, 25 mg	2	PA BvD
dimethyl fumarate oral capsule,delayed release(dr/ec) 120 mg	2	PA; QL (14 per 7 days)
dimethyl fumarate oral capsule,delayed release(dr/ec) 120 mg (14)- 240 mg (46)	2	PA
dimethyl fumarate oral capsule,delayed release(dr/ec) 240 mg	2	PA; QL (60 per 30 days)
DUPIXENT PEN SUBCUTANEOUS PEN INJECTOR 200 MG/1.14 ML, 300 MG/2 ML	5	PA
DUPIXENT SYRINGE SUBCUTANEOUS SYRINGE 200 MG/1.14 ML, 300 MG/2 ML	5	PA
ENBREL MINI SUBCUTANEOUS CARTRIDGE 50 MG/ML (1 ML)	5	PA
ENBREL SUBCUTANEOUS SOLUTION 25 MG/0.5 ML	5	PA
ENBREL SUBCUTANEOUS SYRINGE 25 MG/0.5 ML (0.5), 50 MG/ML (1 ML)	5	PA

Drug Name	Drug Tier	Requirements/Limits
ENBREL SURECLICK SUBCUTANEOUS PEN INJECTOR 50 MG/ML (1 ML)	5	PA
ENTYVIO INTRAVENOUS RECON SOLN 300 MG	5	PA
ENTYVIO PEN SUBCUTANEOUS PEN INJECTOR 108 MG/0.68 ML	5	PA
ENVARSUS XR ORAL TABLET EXTENDED RELEASE 24 HR 0.75 MG, 1 MG, 4 MG	4	PA BvD
everolimus (immunosuppressive) oral tablet 0.25 mg, 0.5 mg, 0.75 mg	2	PA BvD
everolimus (immunosuppressive) oral tablet 1 mg	5	PA BvD
FASENRA PEN SUBCUTANEOUS AUTO-INJECTOR 30 MG/ML	5	PA; QL (1 per 28 days)
FASENRA SUBCUTANEOUS SYRINGE 10 MG/0.5 ML, 30 MG/ML	5	PA; QL (1 per 28 days)
fingolimod oral capsule 0.5 mg	2	PA; QL (30 per 30 days)
GAMUNEX-C INJECTION SOLUTION 1 GRAM/10 ML (10 %)	5	PA BvD
gengraf oral capsule 100 mg, 25 mg	2	PA BvD
gengraf oral solution 100 mg/ml	2	PA BvD
glatiramer subcutaneous syringe 20 mg/ml	5	PA; QL (30 per 30 days)
glatiramer subcutaneous syringe 40 mg/ml	5	PA; QL (12 per 28 days)
glatopa subcutaneous syringe 20 mg/ml	5	PA; QL (30 per 30 days)
glatopa subcutaneous syringe 40 mg/ml	5	PA; QL (12 per 28 days)
HADLIMA PUSHTOUCH SUBCUTANEOUS AUTO-INJECTOR 40 MG/0.8 ML	5	PA
HADLIMA SUBCUTANEOUS SYRINGE 40 MG/0.8 ML	5	PA
HADLIMA(CF) PUSHTOUCH SUBCUTANEOUS AUTO-INJECTOR 40 MG/0.4 ML	5	PA
HADLIMA(CF) SUBCUTANEOUS SYRINGE 40 MG/0.4 ML	5	PA
HUMIRA PEN SUBCUTANEOUS PEN INJECTOR KIT 40 MG/0.8 ML	5	PA; Only NDCs starting with 00074
HUMIRA SUBCUTANEOUS SYRINGE KIT 40 MG/0.8 ML	5	PA; Only NDCs starting with 00074
HUMIRA(CF) PEN CROHNS-UC-HS SUBCUTANEOUS PEN INJECTOR KIT 80 MG/0.8 ML	5	PA; Only NDCs starting with 00074

Drug Name	Drug Tier	Requirements/Limits
HUMIRA(CF) PEN PEDIATRIC UC SUBCUTANEOUS PEN INJECTOR KIT 80 MG/0.8 ML	5	PA; Only NDCs starting with 00074
HUMIRA(CF) PEN PSOR-UV-ADOL HS SUBCUTANEOUS PEN INJECTOR KIT 80 MG/0.8 ML-40 MG/0.4 ML	5	PA; Only NDCs starting with 00074
HUMIRA(CF) PEN SUBCUTANEOUS PEN INJECTOR KIT 40 MG/0.4 ML, 80 MG/0.8 ML	5	PA; Only NDCs starting with 00074
HUMIRA(CF) SUBCUTANEOUS SYRINGE KIT 10 MG/0.1 ML, 20 MG/0.2 ML, 40 MG/0.4 ML	5	PA; Only NDCs starting with 00074
infliximab intravenous recon soln 100 mg	5	PA
KESIMPTA PEN SUBCUTANEOUS PEN INJECTOR 20 MG/0.4 ML	5	PA; QL (1.2 per 28 days)
KEVZARA SUBCUTANEOUS PEN INJECTOR 150 MG/1.14 ML, 200 MG/1.14 ML	5	PA
KEVZARA SUBCUTANEOUS SYRINGE 150 MG/1.14 ML, 200 MG/1.14 ML	5	PA
KINERET SUBCUTANEOUS SYRINGE 100 MG/0.67 ML	5	PA
leflunomide oral tablet 10 mg, 20 mg	2	
mycophenolate mofetil (hcl) intravenous recon soln 500 mg	2	PA BvD
mycophenolate mofetil oral capsule 250 mg	2	PA BvD
mycophenolate mofetil oral suspension for reconstitution 200 mg/ml	2	PA BvD
mycophenolate mofetil oral tablet 500 mg	2	PA BvD
mycophenolate sodium oral tablet,delayed release (dr/ec) 180 mg, 360 mg	2	PA BvD
NUCALA SUBCUTANEOUS AUTO-INJECTOR 100 MG/ML	5	PA; LA; QL (3 per 28 days)
NUCALA SUBCUTANEOUS RECON SOLN 100 MG	5	PA; LA; QL (3 per 28 days)
NUCALA SUBCUTANEOUS SYRINGE 100 MG/ML	5	PA; LA; QL (3 per 28 days)
NUCALA SUBCUTANEOUS SYRINGE 40 MG/0.4 ML	5	PA; LA; QL (0.4 per 28 days)
OTEZLA ORAL TABLET 20 MG, 30 MG	5	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.

Drug Name	Drug Tier	Requirements/Limits
OTEZLA STARTER ORAL TABLETS,DOSE PACK 10 MG (4)- 20 MG (51), 10 MG (4)-20 MG (4)-30 MG (47), 10 MG (4)-20 MG (4)-30 MG(19)	5	PA
OTEZLA XR INITIATION ORAL TABLET AND TABLET ER DOSE PACK 10-20-30-75 MG	5	PA
OTEZLA XR ORAL TABLET EXTENDED RELEASE 24 HR 75 MG	5	PA
OTULFI INTRAVENOUS SOLUTION 130 MG/26 ML	5	PA
OTULFI SUBCUTANEOUS SOLUTION 45 MG/0.5 ML	3	PA
OTULFI SUBCUTANEOUS SYRINGE 45 MG/0.5 ML	3	PA
OTULFI SUBCUTANEOUS SYRINGE 90 MG/ML	5	PA
PLEGRIDY SUBCUTANEOUS PEN INJECTOR 125 MCG/0.5 ML	5	PA; QL (1 per 28 days)
PLEGRIDY SUBCUTANEOUS PEN INJECTOR 63 MCG/0.5 ML- 94 MCG/0.5 ML	5	PA
PLEGRIDY SUBCUTANEOUS SYRINGE 125 MCG/0.5 ML	5	PA; QL (1 per 28 days)
PLEGRIDY SUBCUTANEOUS SYRINGE 63 MCG/0.5 ML- 94 MCG/0.5 ML	5	PA
PROGRAF ORAL GRANULES IN PACKET 0.2 MG, 1 MG	4	PA BvD
REZUROCK ORAL TABLET 200 MG	5	PA NSO
RINVOQ LQ ORAL SOLUTION 1 MG/ML	5	PA; QL (360 per 30 days)
RINVOQ ORAL TABLET EXTENDED RELEASE 24 HR 15 MG, 30 MG, 45 MG	5	PA
SAPHNELO PEN SUBCUTANEOUS AUTO-INJECTOR 120 MG/0.8 ML	5	PA; QL (3.2 per 28 days)
SELARSDI INTRAVENOUS SOLUTION 130 MG/26 ML	5	PA
SELARSDI SUBCUTANEOUS SOLUTION 45 MG/0.5 ML	3	PA
SELARSDI SUBCUTANEOUS SYRINGE 45 MG/0.5 ML	3	PA
SELARSDI SUBCUTANEOUS SYRINGE 90 MG/ML	5	PA

Drug Name	Drug Tier	Requirements/Limits
sirolimus oral solution 1 mg/ml	2	PA BvD
sirolimus oral tablet 0.5 mg, 1 mg, 2 mg	2	PA BvD
SKYRIZI INTRAVENOUS SOLUTION 60 MG/ML	5	PA
SKYRIZI SUBCUTANEOUS PEN INJECTOR 150 MG/ML	5	PA
SKYRIZI SUBCUTANEOUS SYRINGE 150 MG/ML, 55 MG/0.37 ML	5	PA
SKYRIZI SUBCUTANEOUS WEARABLE INJECTOR 180 MG/1.2 ML (150 MG/ML), 360 MG/2.4 ML (150 MG/ML)	5	PA
tacrolimus intravenous solution 5 mg/ml	2	PA BvD
tacrolimus oral capsule 0.5 mg, 1 mg, 5 mg	2	PA BvD
tacrolimus oral capsule,extended release 24hr 0.5 mg, 1 mg, 5 mg	2	PA BvD
tacrolimus topical ointment 0.03 %, 0.1 %	2	QL (100 per 30 days)
TAVNEOS ORAL CAPSULE 10 MG	5	PA; QL (180 per 30 days)
THALOMID ORAL CAPSULE 100 MG	5	PA NSO; QL (120 per 30 days)
THALOMID ORAL CAPSULE 150 MG, 200 MG	5	PA NSO; QL (56 per 28 days)
THALOMID ORAL CAPSULE 50 MG	5	PA NSO; QL (224 per 28 days)
tofacitinib oral solution 1 mg/ml	5	PA
tofacitinib oral tablet 10 mg, 5 mg	5	PA
tofacitinib oral tablet extended release 24 hr 11 mg, 22 mg	5	PA
TREMFYA INTRAVENOUS SOLUTION 200 MG/20 ML (10 MG/ML)	5	PA
TREMFYA ONE-PRESS SUBCUTANEOUS AUTO-INJECTOR 100 MG/ML	5	PA
TREMFYA PEN INDUCTION PK(2PEN) SUBCUTANEOUS PEN INJECTOR 200 MG/2 ML	5	PA
TREMFYA PEN SUBCUTANEOUS PEN INJECTOR 200 MG/2 ML	5	PA
TREMFYA SUBCUTANEOUS SYRINGE 100 MG/ML, 200 MG/2 ML	5	PA
TYENNE AUTOINJECTOR SUBCUTANEOUS PEN INJECTOR 162 MG/0.9 ML	5	PA

Drug Name	Drug Tier	Requirements/Limits
TYENNE INTRAVENOUS SOLUTION 200 MG/10 ML (20 MG/ML), 400 MG/20 ML (20 MG/ML), 80 MG/4 ML (20 MG/ML)	5	PA
TYENNE SUBCUTANEOUS SYRINGE 162 MG/0.9 ML	5	PA
VELSIPITY ORAL TABLET 2 MG	5	PA; QL (30 per 30 days)
VUMERITY ORAL CAPSULE,DELAYED RELEASE(DR/EC) 231 MG	5	PA; QL (120 per 30 days)
YESINTEK INTRAVENOUS SOLUTION 130 MG/26 ML	5	PA
YESINTEK SUBCUTANEOUS SOLUTION 45 MG/0.5 ML	3	PA
YESINTEK SUBCUTANEOUS SYRINGE 45 MG/0.5 ML	3	PA
YESINTEK SUBCUTANEOUS SYRINGE 90 MG/ML	5	PA
ZYMFENTRA SUBCUTANEOUS PEN INJECTOR KIT 120 MG/ML	5	PA
ZYMFENTRA SUBCUTANEOUS SYRINGE KIT 120 MG/ML	5	PA
Vaccines		
ABRYSVO (PF) INTRAMUSCULAR RECON SOLN 120 MCG/0.5 ML	3	$0 copay
ACTHIB (PF) INTRAMUSCULAR RECON SOLN 10 MCG/0.5 ML	3	
ADACEL(TDAP ADOLESN/ADULT)(PF) INTRAMUSCULAR SUSPENSION 2 LF-(2.5-5-3-5 MCG)-5LF/0.5 ML	3	$0 copay
ADACEL(TDAP ADOLESN/ADULT)(PF) INTRAMUSCULAR SYRINGE 2 LF-(2.5-5-3-5 MCG)-5LF/0.5 ML	3	$0 copay
AREXVY (PF) INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION 120 MCG/0.5 ML	3	$0 copay
BCG VACCINE, LIVE (PF) PERCUTANEOUS SUSPENSION FOR RECONSTITUTION 50 MG	3	$0 copay
BEXSERO INTRAMUSCULAR SYRINGE 50-50-50-25 MCG/0.5 ML	3	$0 copay
BOOSTRIX TDAP INTRAMUSCULAR SUSPENSION 2.5-8-5 LF-MCG-LF/0.5ML	3	$0 copay

Drug Name	Drug Tier	Requirements/Limits
BOOSTRIX TDAP INTRAMUSCULAR SYRINGE 2.5-8-5 LF-MCG-LF/0.5ML	3	$0 copay
DAPTACEL (DTAP PEDIATRIC) (PF) INTRAMUSCULAR SUSPENSION 15-10-5 LF-MCG-LF/0.5ML	3	
DENGVAXIA (PF) SUBCUTANEOUS SUSPENSION FOR RECONSTITUTION 10EXP4.5-6 CCID50/0.5 ML	3	QL (3 per 365 days)
ENGERIX-B (PF) INTRAMUSCULAR SUSPENSION 20 MCG/ML	3	PA BvD; $0 copay
ENGERIX-B (PF) INTRAMUSCULAR SYRINGE 20 MCG/ML	3	PA BvD; $0 copay
ENGERIX-B PEDIATRIC (PF) INTRAMUSCULAR SYRINGE 10 MCG/0.5 ML	3	PA BvD; $0 copay
GARDASIL 9 (PF) INTRAMUSCULAR SUSPENSION 0.5 ML	3	$0 copay
GARDASIL 9 (PF) INTRAMUSCULAR SYRINGE 0.5 ML	3	$0 copay
HAVRIX (PF) INTRAMUSCULAR SYRINGE 1,440 ELISA UNIT/ML	3	$0 copay
HAVRIX (PF) INTRAMUSCULAR SYRINGE 720 ELISA UNIT/0.5 ML	3	
HEPLISAV-B (PF) INTRAMUSCULAR SYRINGE 20 MCG/0.5 ML	3	PA BvD; $0 copay
HIBERIX (PF) INTRAMUSCULAR RECON SOLN 10 MCG/0.5 ML	3	
IMOVAX RABIES VACCINE (PF) INTRAMUSCULAR RECON SOLN 2.5 UNIT	3	PA BvD; $0 copay
INFANRIX (DTAP) (PF) INTRAMUSCULAR SYRINGE 25-58-10 LF-MCG-LF/0.5ML	3	
IPOL INJECTION SUSPENSION 40-8-32 UNIT/0.5 ML	3	$0 copay
IXIARO (PF) INTRAMUSCULAR SYRINGE 6 MCG/0.5 ML	3	$0 copay
JYNNEOS (PF) SUBCUTANEOUS SUSPENSION 0.5X TO 3.95X 10EXP8 UNIT/0.5	3	$0 copay
KINRIX (PF) INTRAMUSCULAR SYRINGE 25 LF-58 MCG-10 LF/0.5 ML	3	

Drug Name	Drug Tier	Requirements/Limits
MENQUADFI (PF) INTRAMUSCULAR SOLUTION 10 MCG/0.5 ML	3	$0 copay
MENVEO A-C-Y-W-135-DIP (PF) INTRAMUSCULAR KIT 10-5 MCG/0.5 ML	3	$0 copay
M-M-R II (PF) SUBCUTANEOUS RECON SOLN 1,000-12,500 TCID50/0.5 ML	3	$0 copay
MRESVIA (PF) INTRAMUSCULAR SYRINGE 50 MCG/0.5 ML	3	$0 copay
PEDIARIX (PF) INTRAMUSCULAR SYRINGE 10 MCG-25LF-25 MCG-10LF/0.5 ML	3	
PEDVAX HIB (PF) INTRAMUSCULAR SOLUTION 7.5 MCG/0.5 ML	3	
PENBRAYA (PF) INTRAMUSCULAR KIT 5-120 MCG/0.5 ML	3	$0 copay
PENBRAYA MENACWY COMPONENT(PF) INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION 5 MCG/0.5 ML	3	$0 copay
PENBRAYA MENB COMPONENT (PF) INTRAMUSCULAR SYRINGE 120 MCG/0.5 ML	3	$0 copay
PENMENVY MEN A-B-C-W-Y (PF) INTRAMUSCULAR KIT 0.5 ML	3	$0 copay
PENMENVY MENACWY COMPONENT(PF) INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION 10-5 MCG	3	$0 copay
PENMENVY MENB COMPONENT (PF) INTRAMUSCULAR SYRINGE 50-50-50-25 MCG/0.5 ML	3	$0 copay
PENTACEL (PF) INTRAMUSCULAR KIT 15LF-20MCG-5LF- 62 DU/0.5 ML	3	
PRIORIX (PF) SUBCUTANEOUS SUSPENSION FOR RECONSTITUTION 10EXP3.4-4.2- 3.3CCID50/0.5ML	3	$0 copay
PROQUAD (PF) SUBCUTANEOUS SUSPENSION FOR RECONSTITUTION 10EXP3-4.3-3- 3.99 TCID50/0.5	3	
QUADRACEL (PF) INTRAMUSCULAR SUSPENSION 15 LF-48 MCG- 5 LF UNIT/0.5ML	3	

Drug Name	Drug Tier	Requirements/Limits
QUADRACEL (PF) INTRAMUSCULAR SYRINGE 15 LF-48 MCG- 5 LF UNIT/0.5ML	3	
RABAVERT (PF) INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION 2.5 UNIT	3	PA BvD; $0 copay
RECOMBIVAX HB (PF) INTRAMUSCULAR SUSPENSION 10 MCG/ML, 40 MCG/ML, 5 MCG/0.5 ML	3	PA BvD; $0 copay
RECOMBIVAX HB (PF) INTRAMUSCULAR SYRINGE 10 MCG/ML, 5 MCG/0.5 ML	3	PA BvD; $0 copay
ROTARIX ORAL SUSPENSION 10EXP6 CCID50 /1.5 ML	3	
ROTATEQ VACCINE ORAL SOLUTION 2 ML	3	
SHINGRIX (PF) INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION 50 MCG/0.5 ML	3	$0 copay; QL (2 per 365 days)
SHINGRIX (PF) INTRAMUSCULAR SYRINGE 50 MCG/0.5 ML	3	$0 copay; QL (2 per 365 days)
TDVAX INTRAMUSCULAR SUSPENSION 2-2 LF UNIT/0.5 ML	3	$0 copay
TENIVAC (PF) INTRAMUSCULAR SUSPENSION 5 LF UNIT- 2 LF UNIT/0.5ML	3	$0 copay
TENIVAC (PF) INTRAMUSCULAR SYRINGE 5-2 LF UNIT/0.5 ML	3	$0 copay
TICOVAC INTRAMUSCULAR SYRINGE 1.2 MCG/0.25 ML	3	
TICOVAC INTRAMUSCULAR SYRINGE 2.4 MCG/0.5 ML	3	$0 copay
TRUMENBA INTRAMUSCULAR SYRINGE 120 MCG/0.5 ML	3	$0 copay
TWINRIX (PF) INTRAMUSCULAR SYRINGE 720 ELISA UNIT- 20 MCG/ML	3	$0 copay
TYPHIM VI INTRAMUSCULAR SOLUTION 25 MCG/0.5 ML	3	$0 copay
TYPHIM VI INTRAMUSCULAR SYRINGE 25 MCG/0.5 ML	3	$0 copay
VAQTA (PF) INTRAMUSCULAR SUSPENSION 25 UNIT/0.5 ML	3	
VAQTA (PF) INTRAMUSCULAR SUSPENSION 50 UNIT/ML	3	$0 copay

Drug Name	Drug Tier	Requirements/Limits
VAQTA (PF) INTRAMUSCULAR SYRINGE 25 UNIT/0.5 ML	3	
VAQTA (PF) INTRAMUSCULAR SYRINGE 50 UNIT/ML	3	$0 copay
VARIVAX (PF) SUBCUTANEOUS SUSPENSION FOR RECONSTITUTION 1,350 UNIT/0.5 ML	3	$0 copay
VAXCHORA VACCINE ORAL SUSPENSION FOR RECONSTITUTION 4X10EXP8 TO 2X 10EXP9 CF UNIT	3	$0 copay
VIMKUNYA (PF) INTRAMUSCULAR SYRINGE 40 MCG/0.8 ML	3	$0 copay
VIVOTIF ORAL CAPSULE,DELAYED RELEASE(DR/EC) 2 BILLION UNIT	3	$0 copay
YF-VAX (PF) SUBCUTANEOUS SUSPENSION FOR RECONSTITUTION 10 EXP4.74 UNIT/0.5 ML	3	$0 copay
Metabolic Bone Disease Agents		
Metabolic Bone Disease Agents		
alendronate oral tablet 10 mg	1	QL (30 per 30 days)
alendronate oral tablet 35 mg, 70 mg	1	QL (4 per 28 days)
calcitonin (salmon) nasal spray,non-aerosol 200 unit/actuation	2	
calcitriol oral capsule 0.25 mcg, 0.5 mcg	1	
cinacalcet oral tablet 30 mg, 60 mg	2	QL (60 per 30 days)
cinacalcet oral tablet 90 mg	2	QL (120 per 30 days)
ibandronate oral tablet 150 mg	1	QL (1 per 28 days)
OSENVELT SUBCUTANEOUS SOLUTION 120 MG/1.7 ML (70 MG/ML)	5	PA
paricalcitol oral capsule 1 mcg, 2 mcg, 4 mcg	4	
RAYALDEE ORAL CAPSULE,EXTENDED RELEASE 24 HR 30 MCG	5	QL (60 per 30 days)
STOBOCLO SUBCUTANEOUS SYRINGE 60 MG/ML	3	QL (1 per 180 days)
teriparatide subcutaneous pen injector 20 mcg/dose (560mcg/2.24ml)	5	PA; QL (2.24 per 28 days)
TYMLOS SUBCUTANEOUS PEN INJECTOR 80 MCG (3,120 MCG/1.56 ML)	5	PA; QL (1.56 per 30 days)
Miscellaneous Therapeutic Agents		
Miscellaneous Therapeutic Agents		

Please refer to our Evidence of Coverage for 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.

Drug Name	Drug Tier	Requirements/Limits
BAQSIMI NASAL SPRAY,NON-AEROSOL 3 MG/ACTUATION	3	
betaine oral powder 1 gram/scoop	5	PA
buspirone oral tablet 10 mg, 15 mg, 30 mg, 5 mg, 7.5 mg	1	
dalfampridine oral tablet extended release 12 hr 10 mg	2	PA; QL (60 per 30 days)
FILSPARI ORAL TABLET 200 MG, 400 MG	5	PA; QL (30 per 30 days)
glutamine (sickle cell) oral powder in packet 5 gram	5	PA; QL (180 per 30 days)
GVOKE HYPOPEN 2-PACK SUBCUTANEOUS AUTO-INJECTOR 0.5 MG/0.1 ML, 1 MG/0.2 ML	3	
GVOKE PFS 1-PACK SYRINGE SUBCUTANEOUS SYRINGE 0.5 MG/0.1 ML, 1 MG/0.2 ML	3	
GVOKE SUBCUTANEOUS SOLUTION 1 MG/0.2 ML	3	
hydroxyzine pamoate oral capsule 100 mg, 25 mg, 50 mg	1	
leucovorin calcium oral tablet 10 mg, 15 mg, 25 mg, 5 mg	2	
mesna oral tablet 400 mg	2	
Ophthalmic Agents		
Antiglaucoma Agents		
acetazolamide oral capsule, extended release 500 mg	2	
acetazolamide oral tablet 125 mg, 250 mg	2	
acetazolamide sodium injection recon soln 500 mg	2	
betaxolol ophthalmic (eye) drops 0.5 %	4	
bimatoprost ophthalmic (eye) drops 0.01 %	2	
bimatoprost ophthalmic (eye) drops 0.03 %	4	QL (2.5 per 25 days)
brimonidine ophthalmic (eye) drops 0.1 %	4	
brimonidine ophthalmic (eye) drops 0.15 %, 0.2 %	2	
brimonidine-timolol ophthalmic (eye) drops 0.2-0.5 %	2	
brinzolamide ophthalmic (eye) drops,suspension 1 %	2	

Drug Name	Drug Tier	Requirements/Limits
carteolol ophthalmic (eye) drops 1 %	1	
dorzolamide ophthalmic (eye) drops 2 %	2	
dorzolamide-timolol ophthalmic (eye) drops 22.3-6.8 mg/ml	1	
latanoprost ophthalmic (eye) drops 0.005 %	1	QL (2.5 per 25 days)
levobunolol ophthalmic (eye) drops 0.5 %	2	
methazolamide oral tablet 25 mg, 50 mg	4	
pilocarpine hcl ophthalmic (eye) drops 1 %, 2 %, 4 %	2	
RHOPRESSA OPHTHALMIC (EYE) DROPS 0.02 %	3	QL (2.5 per 25 days)
ROCKLATAN OPHTHALMIC (EYE) DROPS 0.02-0.005 %	3	QL (2.5 per 25 days)
SIMBRINZA OPHTHALMIC (EYE) DROPS,SUSPENSION 1-0.2 %	3	
timolol maleate ophthalmic (eye) drops 0.25 %, 0.5 %	1	
timolol ophthalmic (eye) drops 0.5 %	1	
travoprost ophthalmic (eye) drops 0.004 %	4	QL (2.5 per 25 days)
VYZULTA OPHTHALMIC (EYE) DROPS 0.024 %	4	QL (5 per 30 days)
Parasympathomimetic (Cholinergic Agents)		
Parasympathomimetic (Cholinergic Agents)		
pyridostigmine bromide oral tablet 60 mg	2	
Replacement Preparations		
Replacement Preparations		
klor-con m10 oral tablet,er particles/crystals 10 meq	2	
klor-con m15 oral tablet,er particles/crystals 15 meq	2	
klor-con m20 oral tablet,er particles/crystals 20 meq	2	
magnesium sulfate injection solution 500 mg/ml (50 %)	2	
magnesium sulfate injection syringe 500 mg/ml (50 %)	2	
potassium chloride intravenous solution 2 meq/ml	2	

Drug Name	Drug Tier	Requirements/Limits
potassium chloride oral capsule, extended release 10 meq, 8 meq	2	
potassium chloride oral liquid 20 meq/15 ml, 40 meq/15 ml	4	
potassium chloride oral tablet extended release 10 meq, 15 meq, 20 meq, 8 meq	2	
potassium chloride oral tablet,er particles/crystals 10 meq, 15 meq, 20 meq	2	
potassium citrate oral tablet extended release 10 meq (1,080 mg), 15 meq, 5 meq (540 mg)	2	
sodium chloride 0.45 % intravenous parenteral solution 0.45 %	2	
sodium chloride 0.9 % intravenous parenteral solution	2	
sodium chloride 0.9% solution mini-bag, single use	2	
Respiratory Tract Agents		
Anti-Inflammatories, Inhaled Corticosteroids		
ARNUITY ELLIPTA INHALATION BLISTER WITH DEVICE 100 MCG/ACTUATION, 200 MCG/ACTUATION	3	QL (30 per 30 days)
ARNUITY ELLIPTA INHALATION BLISTER WITH DEVICE 50 MCG/ACTUATION	3	QL (30 per 30 days)
budesonide inhalation suspension for nebulization 0.25 mg/2 ml, 0.5 mg/2 ml, 1 mg/2 ml	2	PA BvD; QL (120 per 30 days)
fluticasone propionate inhalation hfa aerosol inhaler 110 mcg/actuation	2	QL (12 per 30 days)
fluticasone propionate inhalation hfa aerosol inhaler 220 mcg/actuation	2	QL (24 per 30 days)
fluticasone propionate inhalation hfa aerosol inhaler 44 mcg/actuation	2	QL (21.2 per 30 days)
Antileukotrienes		
montelukast oral tablet 10 mg	1	
montelukast oral tablet,chewable 4 mg, 5 mg	1	
zafirlukast oral tablet 10 mg, 20 mg	2	
Bronchodilators		
ADVAIR HFA INHALATION HFA AEROSOL INHALER 115-21 MCG/ACTUATION, 230-21 MCG/ACTUATION, 45-21 MCG/ACTUATION	3	QL (12 per 30 days)

Drug Name	Drug Tier	Requirements/Limits
AIRSUPRA INHALATION HFA AEROSOL INHALER 90-80 MCG/ACTUATION	3	QL (32.1 per 30 days)
albuterol sulfate inhalation hfa aerosol inhaler 90 mcg/actuation	2	QL (17 per 30 days)
albuterol sulfate inhalation hfa aerosol inhaler 90 mcg/actuation (nda020503)	2	QL (13.4 per 30 days)
albuterol sulfate inhalation hfa aerosol inhaler 90 mcg/actuation (nda020983)	2	QL (36 per 30 days)
albuterol sulfate inhalation solution for nebulization 0.63 mg/3 ml, 1.25 mg/3 ml, 2.5 mg /3 ml (0.083 %), 2.5 mg/0.5 ml	2	PA BvD
ANORO ELLIPTA INHALATION BLISTER WITH DEVICE 62.5-25 MCG/ACTUATION	3	QL (60 per 30 days)
BREO ELLIPTA INHALATION BLISTER WITH DEVICE 100-25 MCG/DOSE, 200-25 MCG/DOSE	3	QL (60 per 30 days)
BREO ELLIPTA INHALATION BLISTER WITH DEVICE 50-25 MCG/DOSE	3	QL (60 per 30 days)
breyna inhalation hfa aerosol inhaler 160-4.5 mcg/actuation, 80-4.5 mcg/actuation	2	QL (30.9 per 30 days)
BREZTRI AEROSPHERE INHALATION HFA AEROSOL INHALER 160-18-4.8 MCG/ACTUATION, 160-9-4.8 MCG/ACTUATION	3	QL (10.7 per 30 days)
COMBIVENT RESPIMAT INHALATION MIST 20-100 MCG/ACTUATION	3	QL (8 per 30 days)
fluticasone furoate-vilanterol inhalation blister with device 100-25 mcg/dose, 200-25 mcg/dose	3	QL (60 per 30 days)
fluticasone propion-salmeterol inhalation blister with device 100-50 mcg/dose, 250-50 mcg/dose, 500-50 mcg/dose	2	QL (60 per 30 days)
ipratropium bromide inhalation hfa aerosol inhaler 17 mcg/actuation	2	QL (25.8 per 28 days)
ipratropium bromide inhalation solution 0.02 %	2	PA BvD
ipratropium-albuterol inhalation solution for nebulization 0.5 mg-3 mg(2.5 mg base)/3 ml	2	PA BvD; QL (540 per 30 days)
SEREVENT DISKUS INHALATION BLISTER WITH DEVICE 50 MCG/DOSE	3	QL (60 per 30 days)
SPIRIVA RESPIMAT INHALATION MIST 1.25 MCG/ACTUATION	3	QL (4 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.

Drug Name	Drug Tier	Requirements/Limits
SPIRIVA RESPIMAT INHALATION MIST 2.5 MCG/ACTUATION	3	QL (4 per 30 days)
STIOLTO RESPIMAT INHALATION MIST 2.5-2.5 MCG/ACTUATION	3	QL (4 per 30 days)
STRIVERDI RESPIMAT INHALATION MIST 2.5 MCG/ACTUATION	3	QL (4 per 28 days)
theophylline oral solution 80 mg/15 ml	2	
theophylline oral tablet extended release 12 hr 100 mg, 200 mg	2	
theophylline oral tablet extended release 12 hr 450 mg	4	
theophylline oral tablet extended release 24 hr 400 mg, 600 mg	2	
tiotropium bromide inhalation capsule, w/inhalation device 18 mcg	2	QL (30 per 30 days)
TRELEGY ELLIPTA INHALATION BLISTER WITH DEVICE 100-62.5-25 MCG, 200-62.5-25 MCG	3	QL (60 per 30 days)
wixela inhub inhalation blister with device 100-50 mcg/dose, 250-50 mcg/dose, 500-50 mcg/dose	2	QL (60 per 30 days)
Respiratory Tract Agents, Other		
acetylcysteine solution 100 mg/ml (10 %), 200 mg/ml (20 %)	2	PA BvD
BRONCHITOL INHALATION CAPSULE, W/INHALATION DEVICE 40 MG	5	QL (560 per 28 days)
cromolyn inhalation solution for nebulization 20 mg/2 ml	2	PA BvD
JASCAYD ORAL TABLET 18 MG, 9 MG	5	PA; QL (60 per 30 days)
KALYDECO ORAL GRANULES IN PACKET 13.4 MG, 25 MG, 5.8 MG, 50 MG, 75 MG	5	PA; QL (56 per 28 days)
KALYDECO ORAL TABLET 150 MG	5	PA; QL (56 per 28 days)
nintedanib oral capsule 100 mg, 150 mg	5	PA; QL (60 per 30 days)
OFEV ORAL CAPSULE 100 MG, 150 MG	5	PA; QL (60 per 30 days)
ORKAMBI ORAL TABLET 100-125 MG, 200-125 MG	5	PA; QL (112 per 28 days)
pirfenidone oral capsule 267 mg	2	PA; QL (270 per 30 days)
pirfenidone oral tablet 267 mg	5	PA; QL (270 per 30 days)
pirfenidone oral tablet 534 mg	5	PA; QL (90 per 30 days)
pirfenidone oral tablet 801 mg	2	PA; QL (90 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.

Drug Name	Drug Tier	Requirements/Limits
PROLASTIN-C INTRAVENOUS SOLUTION 1,000 MG (+/-)/20 ML	5	PA BvD
PULMOZYME INHALATION SOLUTION 1 MG/ML	5	PA BvD
roflumilast oral tablet 250 mcg	2	QL (28 per 28 days)
roflumilast oral tablet 500 mcg	2	QL (30 per 30 days)
TRIKAFTA ORAL GRANULES IN PACKET, SEQUENTIAL 100-50-75MG (D) /75 MG (N), 80-40-60 MG (D) /59.5 MG (N)	5	PA; QL (56 per 28 days)
TRIKAFTA ORAL TABLETS, SEQUENTIAL 100-50-75 MG(D) /150 MG (N), 50-25-37.5 MG (D)/75 MG (N)	5	PA; QL (84 per 28 days)
WINREVAIR SUBCUTANEOUS KIT 120 MG (60 MG X 2), 45 MG, 60 MG, 90 MG (45 MG X 2)	5	PA; QL (1 per 21 days)
XOLAIR SUBCUTANEOUS AUTO-INJECTOR 150 MG/ML, 300 MG/2 ML, 75 MG/0.5 ML	5	PA
XOLAIR SUBCUTANEOUS RECON SOLN 150 MG	5	PA
XOLAIR SUBCUTANEOUS SYRINGE 150 MG/ML, 300 MG/2 ML, 75 MG/0.5 ML	5	PA
Skeletal Muscle Relaxants		
Skeletal Muscle Relaxants		
baclofen oral tablet 10 mg, 20 mg, 5 mg	2	
cyclobenzaprine oral tablet 10 mg, 5 mg	1	
dantrolene oral capsule 100 mg, 25 mg, 50 mg	4	
methocarbamol oral tablet 500 mg, 750 mg	2	
tizanidine oral tablet 2 mg, 4 mg	2	
Sleep Disorder Agents		
Sleep Disorder Agents		
armodafinil oral tablet 150 mg, 200 mg, 250 mg, 50 mg	2	PA; QL (30 per 30 days)
BELSOMRA ORAL TABLET 10 MG, 15 MG, 20 MG, 5 MG	3	QL (30 per 30 days)
doxepin oral tablet 3 mg, 6 mg	2	QL (30 per 30 days)
eszopiclone oral tablet 1 mg, 2 mg, 3 mg	2	QL (30 per 30 days)
modafinil oral tablet 100 mg	2	PA; QL (30 per 30 days)
modafinil oral tablet 200 mg	2	PA; QL (60 per 30 days)
sodium oxybate oral solution 500 mg/ml	5	PA; LA; QL (540 per 30 days)

Drug Name	Drug Tier	Requirements/Limits
zaleplon oral capsule 10 mg, 5 mg	2	QL (30 per 30 days)
zolpidem oral tablet 10 mg, 5 mg	1	QL (30 per 30 days)
Sympathomimetic (Adrenergic) Agents		
Sympathomimetic (Adrenergic) Agents		
droxidopa oral capsule 100 mg, 300 mg	2	PA; QL (180 per 30 days)
droxidopa oral capsule 200 mg	5	PA; QL (180 per 30 days)
epinephrine injection auto-injector 0.15 mg/0.15 ml, 0.3 mg/0.3 ml	3	QL (4 per 30 days)
epinephrine injection auto-injector 0.15 mg/0.3 ml, 0.3 mg/0.3 ml	2	QL (4 per 30 days)
Vasodilating Agents		
Vasodilating Agents		
ADEMPAS ORAL TABLET 0.5 MG, 1 MG, 1.5 MG, 2 MG, 2.5 MG	5	PA; QL (90 per 30 days)
alyq oral tablet 20 mg	2	PA; QL (60 per 30 days)
ambrisentan oral tablet 10 mg	2	PA; QL (30 per 30 days)
ambrisentan oral tablet 5 mg	5	PA; QL (30 per 30 days)
macitentan oral tablet 10 mg	5	PA; QL (30 per 30 days)
sildenafil (pulm.hypertension) oral tablet 20 mg	2	PA; QL (360 per 30 days)
tadalafil oral tablet 2.5 mg, 5 mg	2	PA; QL (30 per 30 days)
UPTRAVI ORAL TABLET 1,000 MCG, 1,200 MCG, 1,400 MCG, 1,600 MCG, 400 MCG, 600 MCG, 800 MCG	5	PA; QL (60 per 30 days)
UPTRAVI ORAL TABLET 200 MCG	5	PA; QL (240 per 30 days)
UPTRAVI ORAL TABLETS,DOSE PACK 200 MCG (140)- 800 MCG (60)	5	PA
YUTREPIA INHALATION CAPSULE, W/INHALATION DEVICE 106 MCG, 26.5 MCG, 53 MCG, 79.5 MCG	5	PA
Vitamins And Minerals		
Vitamins And Minerals		
bal-care dha combo pack 27-1-430 mg	1	
bal-care dha essential pack 27 mg iron-1 mg -374 mg	1	
c-nate dha softgel 28 mg iron-1 mg -200 mg	1	
folivane-ob capsule 85-1 mg	1	
marnatal-f capsule 60 mg iron-1 mg	1	
m-natal plus tablet 27 mg iron- 1 mg	1	
mynatal advance oral tablet 90-1-50 mg	1	

Drug Name	Drug Tier	Requirements/Limits
mynatal oral tablet 90-1-50 mg	1	
mynate 90 plus oral tablet extended release 90 mg iron-1 mg	1	
obstetrix dha oral combo pack,tablet and cap,dr 29 mg iron-1 mg -50 mg	1	
pnv-dha + docusate oral capsule 27-1.25-55-300 mg	1	
pnv-omega softgel 28-1-300 mg	1	
pnv-select tablet 27-1 mg	1	
pr natal 400 combo pack 29-1-400 mg	1	
pr natal 400 ec combo pack 29-1-400 mg	1	
pr natal 430 combo pack 29 mg iron-1 mg -430 mg	1	
pr natal 430 ec combo pack 29-1-430 mg	1	
prenaissance oral capsule 29-1.25-55-325 mg	1	
prenaissance plus oral capsule 28-1-50-250 mg	1	
prenatabs fa tablet 29-1 mg	1	
prenatal 19 (with docusate) oral tablet 29 mg iron- 1 mg-25 mg	1	
prenatal 19 chewable tablet 29 mg iron- 1 mg	1	
prenatal plus iron tablet (rx) 29 mg iron- 1 mg	1	
prenatal vitamin plus low iron oral tablet 27 mg iron- 1 mg	1	
prenatal-u capsule 106.5-1 mg	1	
select-ob chewable caplet 29 mg iron- 1 mg	1	
select-ob chewable caplet 29 mg iron- 1 mg	1	
se-natal 19 chewable tablet 29 mg iron- 1 mg	1	
taron-c dha capsule 35-1-200 mg	1	
taron-prex prenatal-dha oral capsule 30 mg iron-1.2 mg-55 mg-265 mg	1	
vitafol-ob+dha combo pack 65-1-250 mg	1	
vp-ch-pnv oral capsule 30 mg iron-1 mg -50 mg-260 mg	1	
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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.

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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.

ABALOPARATIDE

Products Affected

- TYMLOS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	OSTEOPOROSIS: HAS NOT RECEIVED A TOTAL OF 24 MONTHS CUMULATIVE TREATMENT WITH ANY PARATHYROID HORMONE THERAPY.
Indications	All FDA-approved Indications.
Off Label Uses	
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.

ABEMACICLIB

Products Affected

- VERZENIO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
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.

ABIRATERONE

Products Affected

- *abiraterone oral tablet 250 mg*
- *abirtega*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	METASTATIC HIGH-RISK CASTRATION-SENSITIVE PROSTATE CANCER (MCSPC), METASTATIC CASTRATION-RESISTANT PROSTATE CANCER (MCRPC): 1) RECEIVED A BILATERAL ORCHIECTOMY, 2) CASTRATE LEVEL OF TESTOSTERONE (I.E., LESS THAN 50 NG/DL), OR 3) CONCURRENT USE WITH A GONADOTROPIN RELEASING HORMONE (GNRH) ANALOG
Indications	All FDA-approved Indications.
Off Label Uses	
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.

ABIRATERONE SUBMICRONIZED

Products Affected

- YONSA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	METASTATIC CASTRATION-RESISTANT PROSTATE CANCER (MCRPC): 1) RECEIVED A BILATERAL ORCHIECTOMY, 2) CASTRATE LEVEL OF TESTOSTERONE (I.E., LESS THAN 50 NG/DL), OR 3) CONCURRENT USE WITH A GONADOTROPIN RELEASING HORMONE (GNRH) ANALOG.
Indications	All FDA-approved Indications.
Off Label Uses	
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.

ACALABRUTINIB

Products Affected

- CALQUENCE (ACALABRUTINIB MAL)

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

ADAGRASIB

Products Affected

- KRAZATI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
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.

ADALIMUMAB

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: PLAQUE PSORIASIS (PSO): PSORIASIS COVERING 3 PERCENT OR MORE OF BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, FACE, SCALP, OR GENITAL AREA.
Age Restrictions	
Prescriber Restrictions	INITIAL: RA, PJIA, ANKYLOSING SPONDYLITIS (AS): PRESCRIBED BY OR IN CONSULTATION WITH RHEUMATOLOGIST. PSORIATIC ARTHRITIS (PSA): PRESCRIBED BY OR IN CONSULTATION WITH DERMATOLOGIST OR RHEUMATOLOGIST. PSO, HIDRADENITIS SUPPURATIVA (HS): PRESCRIBED BY OR IN CONSULTATION WITH DERMATOLOGIST. CROHNS DISEASE (CD), ULCERATIVE COLITIS (UC): PRESCRIBED BY OR IN CONSULTATION WITH GASTROENTEROLOGIST. UVEITIS: PRESCRIBED BY OR IN CONSULTATION WITH OPHTHALMOLOGIST.
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
Other Criteria	INITIAL: RHEUMATOID ARTHRITIS (RA): TRIAL OF OR CONTRAINDICATION TO 3 MONTHS OF TREATMENT WITH ONE CLINICAL STANDARD OF CARE AGENT: A CONVENTIONAL SYNTHETIC DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG) - IF PATIENT TRIED METHOTREXATE, THEN TRIAL OF AT LEAST 20 MG PER WEEK OR MAXIMALLY TOLERATED DOSE IS REQUIRED. AS: TRIAL OF OR CONTRAINDICATION TO ONE CLINICAL STANDARD OF CARE AGENT: AN NSAID. PSO: 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.

PA Criteria	Criteria Details
	AT LEAST A 3 MONTH TRIAL OF ONE OF THE FOLLOWING CLINICAL STANDARD OF CARE AGENTS: AN ORAL IMMUNOSUPPRESSANT (CYCLOSPORINE, METHOTREXATE, TACROLIMUS), PUVA (PHOTOTHERAPY), 2) CONTRAINDICATION OR INTOLERANCE TO BOTH OF THE FOLLOWING CLINICAL STANDARD OF CARE AGENTS: AN IMMUNOSUPPRESSANT, PUVA, OR 3) PATIENT IS SWITCHING FROM A DIFFERENT BIOLOGIC, PDE-4 INHIBITOR, OR JAK INHIBITOR FOR THE SAME INDICATION. UVEITIS: 1) DOES NOT HAVE ISOLATED ANTERIOR UVEITIS, AND 2) FOR POSTERIOR UVEITIS, TRIAL OF OR CONTRAINDICATION TO ONE CLINICAL STANDARD OF CARE AGENT: A GLUCOCORTICOID. INITIAL/RENEWAL: ALL INDICATIONS: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR THE SAME INDICATION. RENEWAL: RA, POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS (PJIA), PSA, AS, PSO, HS, UVEITIS: CONTINUES TO BENEFIT FROM THE MEDICATION.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

ADALIMUMAB-AATY

Products Affected

- *adalimumab-aaty*
- *adalimumab-aaty(cf) ai crohns*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: PLAQUE PSORIASIS (PSO): PSORIASIS COVERING 3 PERCENT OR MORE OF BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, FACE, SCALP, OR GENITAL AREA.
Age Restrictions	
Prescriber Restrictions	INITIAL: RA, PJIA, ANKYLOSING SPONDYLITIS (AS): PRESCRIBED BY OR IN CONSULTATION WITH RHEUMATOLOGIST. PSORIATIC ARTHRITIS (PSA): PRESCRIBED BY OR IN CONSULTATION WITH DERMATOLOGIST OR RHEUMATOLOGIST. PSO, HIDRADENITIS SUPPURATIVA (HS): PRESCRIBED BY OR IN CONSULTATION WITH DERMATOLOGIST. CROHNS DISEASE (CD), ULCERATIVE COLITIS (UC): PRESCRIBED BY OR IN CONSULTATION WITH GASTROENTEROLOGIST. UVEITIS: PRESCRIBED BY OR IN CONSULTATION WITH OPHTHALMOLOGIST.
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
Other Criteria	INITIAL: RHEUMATOID ARTHRITIS (RA): TRIAL OF OR CONTRAINDICATION TO 3 MONTHS OF TREATMENT WITH ONE CLINICAL STANDARD OF CARE AGENT: A CONVENTIONAL SYNTHETIC DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG) - IF PATIENT TRIED METHOTREXATE, THEN TRIAL OF AT LEAST 20 MG PER WEEK OR MAXIMALLY TOLERATED DOSE IS REQUIRED. AS: TRIAL OF OR CONTRAINDICATION TO ONE CLINICAL STANDARD OF CARE AGENT: AN NSAID. PSO: 1) AT LEAST A 3 MONTH TRIAL OF ONE OF THE FOLLOWING CLINICAL STANDARD OF CARE AGENTS: AN ORAL IMMUNOSUPPRESSANT (CYCLOSPORINE, METHOTREXATE,

Please refer to our Evidence of Coverage for 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
	TACROLIMUS), PUVA (PHOTOTHERAPY), 2) CONTRAINDICATION OR INTOLERANCE TO BOTH OF THE FOLLOWING CLINICAL STANDARD OF CARE AGENTS: AN IMMUNOSUPPRESSANT, PUVA, OR 3) PATIENT IS SWITCHING FROM A DIFFERENT BIOLOGIC, PDE-4 INHIBITOR, OR JAK INHIBITOR FOR THE SAME INDICATION. UVEITIS: 1) DOES NOT HAVE ISOLATED ANTERIOR UVEITIS, AND 2) FOR POSTERIOR UVEITIS, TRIAL OF OR CONTRAINDICATION TO ONE CLINICAL STANDARD OF CARE AGENT: A GLUCOCORTICOID. INITIAL/RENEWAL: ALL INDICATIONS: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR THE SAME INDICATION. RENEWAL: RA, POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS (PJIA), PSA, AS, PSO, HS, UVEITIS: CONTINUES TO BENEFIT FROM THE MEDICATION.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

ADALIMUMAB-BWWD

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: PLAQUE PSORIASIS (PSO): PSORIASIS COVERING 3 PERCENT OR MORE OF BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, FACE, SCALP, OR GENITAL AREA.
Age Restrictions	
Prescriber Restrictions	INITIAL: RA, PJIA, ANKYLOSING SPONDYLITIS (AS): PRESCRIBED BY OR IN CONSULTATION WITH RHEUMATOLOGIST. PSORIATIC ARTHRITIS (PSA): PRESCRIBED BY OR IN CONSULTATION WITH DERMATOLOGIST OR RHEUMATOLOGIST. PSO, HIDRADENITIS SUPPURATIVA (HS): PRESCRIBED BY OR IN CONSULTATION WITH DERMATOLOGIST. CROHNS DISEASE (CD), ULCERATIVE COLITIS (UC): PRESCRIBED BY OR IN CONSULTATION WITH GASTROENTEROLOGIST. UVEITIS: PRESCRIBED BY OR IN CONSULTATION WITH OPHTHALMOLOGIST.
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
Other Criteria	INITIAL: RHEUMATOID ARTHRITIS (RA): TRIAL OF OR CONTRAINDICATION TO 3 MONTHS OF TREATMENT WITH ONE CLINICAL STANDARD OF CARE AGENT: A CONVENTIONAL SYNTHETIC DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG) - IF PATIENT TRIED METHOTREXATE, THEN TRIAL OF AT LEAST 20 MG PER WEEK OR MAXIMALLY TOLERATED DOSE IS REQUIRED. AS: TRIAL OF OR CONTRAINDICATION TO ONE CLINICAL STANDARD OF CARE AGENT: AN NSAID. PSO: 1) AT LEAST A 3 MONTH TRIAL OF ONE OF THE FOLLOWING CLINICAL STANDARD OF CARE AGENTS: AN ORAL

Please refer to our Evidence of Coverage for 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
	IMMUNOSUPPRESSANT (CYCLOSPORINE, METHOTREXATE, TACROLIMUS), PUVA (PHOTOTHERAPY), 2) CONTRAINDICATION OR INTOLERANCE TO BOTH OF THE FOLLOWING CLINICAL STANDARD OF CARE AGENTS: AN IMMUNOSUPPRESSANT, PUVA, OR 3) PATIENT IS SWITCHING FROM A DIFFERENT BIOLOGIC, PDE-4 INHIBITOR, OR JAK INHIBITOR FOR THE SAME INDICATION. UVEITIS: 1) DOES NOT HAVE ISOLATED ANTERIOR UVEITIS, AND 2) FOR POSTERIOR UVEITIS, TRIAL OF OR CONTRAINDICATION TO ONE CLINICAL STANDARD OF CARE AGENT: A GLUCOCORTICOID. INITIAL/RENEWAL: ALL INDICATIONS: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR THE SAME INDICATION. RENEWAL: RA, POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS (PJIA), PSA, AS, PSO, HS, UVEITIS: CONTINUES TO BENEFIT FROM THE MEDICATION.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

AFATINIB

Products Affected

- GILOTRIF

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

Please refer to our Evidence of Coverage for 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.

ALECTINIB

Products Affected

- ALECENSA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
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.

ALPELISIB-PIQRAY

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
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	
Required Medical Information	PULMONARY ARTERIAL HYPERTENSION (PAH): INITIAL: DIAGNOSIS CONFIRMED BY RIGHT HEART CATHETERIZATION WITH THE FOLLOWING PARAMETERS: 1) MEAN PULMONARY ARTERY PRESSURE (PAP) GREATER THAN 20 MMHG, 2) PULMONARY CAPILLARY WEDGE PRESSURE (PCWP) OF 15 MMHG OR LESS, AND 3) PULMONARY VASCULAR RESISTANCE (PVR) GREATER THAN 2 WOOD UNITS.
Age Restrictions	
Prescriber Restrictions	PAH: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A CARDIOLOGIST OR PULMONOLOGIST.
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
Other Criteria	PAH: INITIAL: DOES NOT HAVE IDIOPATHIC PULMONARY FIBROSIS.
Indications	All FDA-approved Indications.
Off Label Uses	
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.

AMIKACIN LIPOSOMAL INH

Products Affected

- ARIKAYCE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	MYCOBACTERIUM AVIUM COMPLEX (MAC) LUNG DISEASE: RENEWAL: 1) NO POSITIVE MAC SPUTUM CULTURE AFTER CONSECUTIVE NEGATIVE CULTURES, AND 2) IMPROVEMENT IN SYMPTOMS. ADDITIONALLY, FOR FIRST RENEWAL, APPROVAL REQUIRES AT LEAST ONE NEGATIVE SPUTUM CULTURE FOR MAC BY SIX MONTHS OF ARIKAYCE TREATMENT. FOR SECOND AND SUBSEQUENT RENEWALS, APPROVAL REQUIRES AT LEAST THREE NEGATIVE SPUTUM CULTURES FOR MAC BY 12 MONTHS OF ARIKAYCE TREATMENT.
Age Restrictions	
Prescriber Restrictions	MAC LUNG DISEASE: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A PULMONOLOGIST OR INFECTIOUS DISEASE SPECIALIST.
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
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.

AMIVANTAMAB-HYALURONIDASE-LPUJ

Products Affected

- RYBREVANT FASPRO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
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.

AMIVANTAMAB-VMJW

Products Affected

- RYBREVANT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
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.

ANAKINRA

Products Affected

- KINERET

PA Criteria	Criteria Details
Exclusion Criteria	CORONAVIRUS DISEASE 2019 (COVID-19) IN HOSPITALIZED ADULTS.
Required Medical Information	INITIAL: CRYOPYRIN-ASSOCIATED PERIODIC SYNDROMES (CAPS): 1) ONE OF THE FOLLOWING: (A) GENETIC TEST FOR GAIN-OF-FUNCTION MUTATIONS IN THE NLRP3 GENE, OR (B) HAS INFLAMMATORY MARKERS (I.E., ELEVATED CRP, ESR, SERUM AMYLOID A PROTEIN (SAA) OR S100 PROTEINS), AND 2) TWO OF THE FOLLOWING: URTICARIAL-LIKE RASH (NEUTROPHILIC DERMATITIS), COLD-TRIGGERED EPISODES, SENSORINEURAL HEARING LOSS, MUSCULOSKELETAL SYMPTOMS, CHRONIC ASEPTIC MENINGITIS, SKELETAL ABNORMALITIES. DEFICIENCY OF INTERLEUKIN-1 RECEPTOR ANTAGONIST (DIRA): 1) ONE OF THE FOLLOWING: (A) GENETIC TEST FOR GAIN-OF-FUNCTION MUTATIONS IN THE IL1RN GENE, OR (B) HAS INFLAMMATORY MARKERS (I.E., ELEVATED CRP, ESR), AND 2) ONE OF THE FOLLOWING: PUSTULAR PSORIASIS-LIKE RASHES, OSTEOMYELITIS, ABSENCE OF BACTERIAL OSTEOMYELITIS, ONYCHOMADESIS.
Age Restrictions	
Prescriber Restrictions	INITIAL: RHEUMATOID ARTHRITIS (RA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST.
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
Other Criteria	INITIAL: ALL INDICATIONS: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR THE SAME INDICATION. RA: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA/ADALIMUMAB-AATY/HADLIMA, XELJANZ, RINVOQ. RENEWAL: RA: 1) CONTINUES TO BENEFIT FROM 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
	MEDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR THE SAME INDICATION.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

ANIFROLUMAB-FNIA

Products Affected

- SAPHNELO PEN

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	SYSTEMIC LUPUS ERYTHEMATOSUS (SLE): INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST.
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
Other Criteria	SLE: INITIAL: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR SLE. RENEWAL: 1) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR SLE, 2) CLINICAL IMPROVEMENT WHILE ON THERAPY.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

APALUTAMIDE

Products Affected

- ERLEADA ORAL TABLET 240 MG, 60 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	NON-METASTATIC CASTRATION-RESISTANT PROSTATE CANCER (NMCRPC), METASTATIC CASTRATION-SENSITIVE PROSTATE CANCER (MCSPC): 1) RECEIVED A BILATERAL ORCHIECTOMY, 2) CASTRATE LEVEL OF TESTOSTERONE (I.E., LESS THAN 50 NG/DL), OR 3) CONCURRENT USE WITH A GONADOTROPIN RELEASING HORMONE (GNRH) ANALOG.
Indications	All FDA-approved Indications.
Off Label Uses	
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.

APOMORPHINE - ONAPGO

Products Affected

- ONAPGO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	PARKINSONS DISEASE (PD): INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST.
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
Other Criteria	PD: RENEWAL: IMPROVEMENT IN MOTOR SYMPTOMS WHILE ON THERAPY.
Indications	All FDA-approved Indications.
Off Label Uses	
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.

APREMILAST

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: MILD PLAQUE PSORIASIS (PSO): 1) PSORIASIS COVERING LESS THAN 3 PERCENT OF BODY SURFACE AREA (BSA), 2) STATIC PHYSICIAN GLOBAL ASSESSMENT (SPGA) SCORE OF 2, OR 3) PSORIASIS AREA AND SEVERITY INDEX (PASI) SCORE OF 2 TO 9. MODERATE TO SEVERE PSO: PSORIASIS COVERING 3 PERCENT OR MORE OF BSA, OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, FACE, SCALP, OR GENITAL AREA.
Age Restrictions	
Prescriber Restrictions	INITIAL: PSORIATIC ARTHRITIS (PSA): PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST OR RHEUMATOLOGIST. PSO: PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST. BEHCETS DISEASE: PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST.
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
Other Criteria	INITIAL: MILD PSO: TRIAL OF OR CONTRAINDICATION TO ONE OF THE FOLLOWING CLINICAL STANDARD OF CARE AGENTS: A CONVENTIONAL SYSTEMIC THERAPY (E.G., METHOTREXATE, ACITRETIN, CYCLOSPORINE), A CONVENTIONAL TOPICAL THERAPY (E.G., TOPICAL CORTICOSTEROIDS). MODERATE TO SEVERE PSO: 1) AT LEAST A 3 MONTH TRIAL OF ONE OF THE FOLLOWING CLINICAL STANDARD OF CARE AGENTS: AN ORAL IMMUNOSUPPRESSANT (CYCLOSPORINE, METHOTREXATE, TACROLIMUS), PUVA (PHOTOTHERAPY), 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
	CONTRAINDICATION OR INTOLERANCE TO BOTH OF THE FOLLOWING CLINICAL STANDARD OF CARE AGENTS: IMMUNOSUPPRESSANT, PUVA, OR 3) PATIENT IS SWITCHING FROM A DIFFERENT BIOLOGIC, PDE-4 INHIBITOR, OR JAK INHIBITOR FOR THE SAME INDICATION. BEHCETS DISEASE: 1) HAS ORAL ULCERS OR A HISTORY OF RECURRENT ORAL ULCERS BASED ON CLINICAL SYMPTOMS, AND 2) TRIAL OF OR CONTRAINDICATION TO ONE OR MORE CONSERVATIVE TREATMENTS (E.G., COLCHICINE, TOPICAL CORTICOSTEROID, ORAL CORTICOSTEROID). INITIAL/RENEWAL: ALL INDICATIONS: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR THE SAME INDICATION. RENEWAL: ALL INDICATIONS: CONTINUES TO BENEFIT FROM THE MEDICATION.
Indications	All FDA-approved Indications.
Off Label Uses	
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.

ARMODAFINIL

Products Affected

- *armodafinil*

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

ASCIMINIB

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	PREVIOUSLY TREATED OR T315I MUTATION PHILADELPHIA CHROMOSOME-POSITIVE CHRONIC MYELOID LEUKEMIA (Ph+ CML): MUTATIONAL ANALYSIS PRIOR TO INITIATION AND SCEMBLIX IS APPROPRIATE PER NCCN GUIDELINE TABLE FOR TREATMENT RECOMMENDATIONS BASED ON BCR-ABL1 MUTATION PROFILE.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
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.

ASFOTASE ALFA

Products Affected

- STRENSIQ SUBCUTANEOUS SOLUTION 28 MG/0.7 ML, 40 MG/ML, 80 MG/0.8 ML

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	HYPOPHOSPHATASIA (HPP): INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH AN ENDOCRINOLOGIST, GENETICIST, OR METABOLIC SPECIALIST.
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
Other Criteria	INITIAL: PERINATAL/INFANTILE-ONSET HPP: 1) 6 MONTHS OF AGE OR YOUNGER AT ONSET OF HPP, AND 2) POSITIVE FOR A TISSUE NON-SPECIFIC ALKALINE PHOSPHATASE (TNSALP) (ALPL) GENE MUTATION AS CONFIRMED BY GENETIC TESTING OR TWO OF THE FOLLOWING: (A) SERUM ALKALINE PHOSPHATASE (ALP) LEVEL BELOW THAT OF NORMAL RANGE FOR PATIENT AGE, (B) ELEVATED SERUM PYRIDOXAL-5'-PHOSPHATE (PLP) LEVELS AND NO VITAMIN B6 SUPPLEMENTATION IN THE PREVIOUS WEEK, (C) URINE PHOSPHOETHANOLAMINE (PEA) LEVEL ABOVE THAT OF NORMAL RANGE FOR PATIENT AGE, (D) RADIOGRAPHIC EVIDENCE OF HPP, (E) AT LEAST TWO OF THE FOLLOWING: (I) RACHITIC CHEST DEFORMITY, (II) CRANIOSYNOSTOSIS, (III) DELAY IN SKELETAL GROWTH RESULTING IN DELAY OF MOTOR DEVELOPMENT, (IV) HISTORY OF VITAMIN B6 DEPENDENT SEIZURES, (V) NEPHROCALCINOSIS OR HISTORY OF ELEVATED SERUM CALCIUM, (VI) HISTORY OR PRESENCE

Please refer to our Evidence of Coverage for 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 NON-TRAUMATIC POSTNATAL FRACTURE AND DELAYED FRACTURE HEALING. JUVENILE-ONSET HPP: 1) 18 YEARS OF AGE OR YOUNGER AT ONSET OF HPP, AND 2) POSITIVE FOR A TNSALP ALPL GENE MUTATION AS CONFIRMED BY GENETIC TESTING OR TWO OF THE FOLLOWING: (A) SERUM ALP LEVEL BELOW THAT OF NORMAL RANGE FOR PATIENT AGE, (B) ELEVATED SERUM PLP LEVELS AND NO VITAMIN B6 SUPPLEMENTATION IN THE PREVIOUS WEEK, (C) URINE PEA LEVEL ABOVE THAT OF NORMAL RANGE FOR PATIENT AGE, (D) RADIOGRAPHIC EVIDENCE OF HPP, (E) AT LEAST TWO OF THE FOLLOWING: (I) RACHITIC DEFORMITIES, (II) PREMATURE LOSS OF PRIMARY TEETH PRIOR TO 5 YEARS OF AGE, (III) DELAY IN SKELETAL GROWTH RESULTING IN DELAY OF MOTOR DEVELOPMENT, (IV) HISTORY OR PRESENCE OF NON-TRAUMATIC FRACTURES OR DELAYED FRACTURE HEALING. ALL INDICATIONS: 1) NOT CURRENTLY RECEIVING TREATMENT WITH A BISPHOSPHONATE, 2) CALCIUM OR PHOSPHATE LEVELS ARE NOT BELOW THE NORMAL RANGE, 3) NOT HAVE A TREATABLE FORM OF RICKETS. RENEWAL: ALL INDICATIONS: 1) IMPROVEMENT IN THE SKELETAL CHARACTERISTICS OF HPP, AND 2) NOT CURRENTLY RECEIVING TREATMENT WITH A BISPHOSPHONATE.
Indications	All FDA-approved Indications.
Off Label Uses	
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.

ATOGEPANT

Products Affected

- QULIPTA

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

AVACOPAN

Products Affected

- TAVNEOS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	ANTI-NEUTROPHIL CYTOPLASMIC AUTOANTIBODY (ANCA)-ASSOCIATED VASCULITIS: INITIAL: ANCA SEROPOSITIVE (ANTI-PR3 OR ANTI-MPO).
Age Restrictions	
Prescriber Restrictions	ANCA-ASSOCIATED VASCULITIS: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST OR NEPHROLOGIST.
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
Other Criteria	ANCA-ASSOCIATED VASCULITIS: RENEWAL: CONTINUES TO BENEFIT FROM THERAPY.
Indications	All FDA-approved Indications.
Off Label Uses	
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.

AVAPRITINIB

Products Affected

- AYVAKIT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
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.

AVUTOMETINIB-DEFACTINIB

Products Affected

- AVMAPKI
- AVMAPKI-FAKZYNJA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
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.

AXITINIB

Products Affected

- INLYTA ORAL TABLET 1 MG, 5 MG

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

AZACITIDINE

Products Affected

- ONUREG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
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.

AZTREONAM INHALED

Products Affected

- CAYSTON

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	7 YEARS OF AGE OR OLDER
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
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.

BEDAQUILINE

Products Affected

- SIRTURO

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

BELIMUMAB

Products Affected

- BENLYSTA SUBCUTANEOUS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	INITIAL: SYSTEMIC LUPUS ERYTHEMATOSUS (SLE): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST. LUPUS NEPHRITIS (LN): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST OR NEPHROLOGIST.
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
Other Criteria	INITIAL: SLE: CURRENTLY TAKING CORTICOSTEROIDS, ANTIMALARIALS, NSAIDS, OR IMMUNOSUPPRESSIVE AGENTS. RENEWAL: SLE: CLINICAL IMPROVEMENT WHILE ON THERAPY. LN: CLINICAL IMPROVEMENT IN RENAL RESPONSE FROM BASELINE LABORATORY VALUES (I.E., EGFR OR PROTEINURIA) AND/OR CLINICAL PARAMETERS. INITIAL/RENEWAL: ALL INDICATIONS: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR THE SAME INDICATION.
Indications	All FDA-approved Indications.
Off Label Uses	
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.

BELUMOSUDIL

Products Affected

- REZUROCK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	CHRONIC GRAFT VS HOST DISEASE (CGVHD): 1) FAILURE OF AT LEAST TWO LINES OF SYSTEMIC THERAPY, ONE OF WHICH MUST BE A TRIAL OF OR CONTRAINDICATION TO JAKAFI, AND 2) NO CONCURRENT USE WITH JAKAFI, NIKTIMVO, OR IMBRUVICA.
Indications	All FDA-approved Indications.
Off Label Uses	
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.

BELZUTIFAN

Products Affected

- WELIREG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
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.

BENDAMUSTINE

Products Affected

- *bendamustine intravenous recon soln 25 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
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.

BENRALIZUMAB

Products Affected

- FASENRA
- FASENRA PEN

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: ASTHMA: BLOOD EOSINOPHIL LEVEL OF AT LEAST 150 CELLS/MCL WITHIN THE PAST 12 MONTHS.
Age Restrictions	
Prescriber Restrictions	INITIAL: ASTHMA: PRESCRIBED BY OR IN CONSULTATION WITH A PHYSICIAN SPECIALIZING IN ALLERGY OR PULMONARY MEDICINE.
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
Other Criteria	INITIAL: ASTHMA: 1) CONCURRENT THERAPY WITH A MEDIUM, HIGH-DOSE, OR MAXIMALLY TOLERATED DOSE OF AN INHALED CORTICOSTEROID (ICS) AND ONE OTHER MAINTENANCE MEDICATION, AND 2) ONE ASTHMA EXACERBATION REQUIRING SYSTEMIC CORTICOSTEROID BURST LASTING AT LEAST 3 DAYS WITHIN THE PAST 12 MONTHS, OR AT LEAST ONE SERIOUS EXACERBATION REQUIRING HOSPITALIZATION OR ER VISIT WITHIN THE PAST 12 MONTHS, OR POOR SYMPTOM CONTROL DESPITE CURRENT THERAPY AS EVIDENCED BY AT LEAST THREE OF THE FOLLOWING WITHIN THE PAST 4 WEEKS: (A) DAYTIME ASTHMA SYMPTOMS MORE THAN TWICE/WEEK, (B) ANY NIGHT WAKING DUE TO ASTHMA, (C) SABA RELIEVER FOR SYMPTOMS MORE THAN TWICE/WEEK, (D) ANY ACTIVITY LIMITATION DUE TO ASTHMA. INITIAL/RENEWAL: ALL INDICATIONS: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR THE SAME INDICATION. RENEWAL: ASTHMA: 1) CONTINUED USE OF ICS AND ONE

Please refer to our Evidence of Coverage for 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
	OTHER MAINTENANCE MEDICATION, AND 2) CLINICAL RESPONSE AS EVIDENCED BY: (A) REDUCTION IN ASTHMA EXACERBATIONS FROM BASELINE, (B) DECREASED UTILIZATION OF RESCUE MEDICATIONS, (C) INCREASE IN PERCENT PREDICTED FEV1 FROM PRETREATMENT BASELINE, OR (D) REDUCTION IN SEVERITY OR FREQUENCY OF ASTHMA-RELATED SYMPTOMS. EOSINOPHILIC GRANULOMATOSIS WITH POLYANGIITIS (EGPA): REDUCTION IN EGPA SYMPTOMS COMPARED TO BASELINE OR ABILITY TO REDUCE/ELIMINATE CORTICOSTEROID USE.
Indications	All FDA-approved Indications.
Off Label Uses	
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.

BETAINE

Products Affected

- *betaine*

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

BEXAROTENE

Products Affected

- *bexarotene*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
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.

BINIMETINIB

Products Affected

- MEKTOVI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
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.

BORTEZOMIB

Products Affected

- *bortezomib injection*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
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.

BOSUTINIB

Products Affected

- BOSULIF ORAL CAPSULE 100 MG, 50 MG
- BOSULIF ORAL TABLET 100 MG, 500 MG
- *bosutinib oral tablet 100 mg, 400 mg, 500 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	PREVIOUSLY TREATED PHILADELPHIA CHROMOSOME-POSITIVE CHRONIC MYELOID LEUKEMIA (Ph+ CML): MUTATIONAL ANALYSIS PRIOR TO INITIATION AND BOSULIF IS APPROPRIATE PER NCCN GUIDELINE TABLE FOR TREATMENT RECOMMENDATIONS BASED ON BCR-ABL1 MUTATION PROFILE.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
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.

BRIGATINIB

Products Affected

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

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

BUDESONIDE-TARPEYO

Products Affected

- TARPEYO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	PRIMARY IMMUNOGLOBULIN A NEPHROPATHY (IGAN): INITIAL: 1) DIAGNOSIS IS CONFIRMED BY A RENAL BIOPSY, 2) EGFR OF AT LEAST 35 ML/MIN/1.73 M2, AND 3) PROGRESSIVELY DECLINING GLOMERULAR FILTRATION RATE AND/OR WORSENING PROTEINURIA.
Age Restrictions	
Prescriber Restrictions	PRIMARY IGAN: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A NEPHROLOGIST.
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
Other Criteria	PRIMARY IGAN: INITIAL: 1) TRIAL AND CONTINUATION OF AN ACE INHIBITOR OR AN ARB AT MAXIMUM TOLERATED DOSE FOR AT LEAST 3 MONTHS OR CONTRAINDICATION TO BOTH CLASSES, AND 2) TRIAL AND CONTINUATION OF OR CONTRAINDICATION TO SGLT2 INHIBITOR. RENEWAL: 1) IMPROVED OR STABLE KIDNEY FUNCTION COMPARED TO BASELINE, OR 2) REDUCTION IN PROTEINURIA.
Indications	All FDA-approved Indications.
Off Label Uses	
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.

C1 ESTERASE INHIBITOR-HAEGARDA

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	HEREDITARY ANGIOEDEMA (HAE): INITIAL: 1) TYPE I OR II HAE CONFIRMED BY ONE OF THE FOLLOWING COMPLEMENT TESTS: C1-INH PROTEIN LEVELS, C4 PROTEIN LEVELS, C1-INH FUNCTIONAL LEVELS, C1Q, OR 2) TYPE III HAE CONFIRMED BY: (A) RECURRENT, NON-URTICARIAL ANGIOEDEMA INVOLVING THE SKIN, GASTROINTESTINAL TRACT, OR AIRWAY, CONSISTENT WITH BRADYKININ-MEDIATED HAE AND ATTACKS NOT EXPLAINED BY HISTAMINERGIC/URTICARIAL ANGIOEDEMA, AND (B) OTHER CAUSES OF ANGIOEDEMA HAVE BEEN EXCLUDED, INCLUDING ACE-INHIBITOR/ARB-ASSOCIATED ANGIOEDEMA, ACQUIRED C1-INH DEFICIENCY, AND MAST-CELL/HISTAMINERGIC ANGIOEDEMA.
Age Restrictions	
Prescriber Restrictions	HAE: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A HEMATOLOGIST, IMMUNOLOGIST, ALLERGIST OR PULMONOLOGIST.
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
Other Criteria	HAE: INITIAL/RENEWAL: NOT ON CONCURRENT TREATMENT WITH ALTERNATIVE PROPHYLACTIC AGENT FOR HAE ATTACKS.
Indications	All FDA-approved Indications.
Off Label Uses	

Please refer to our Evidence of Coverage for 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

Please refer to our Evidence of Coverage for 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.

CABOZANTINIB CAPSULE

Products Affected

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

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

CABOZANTINIB TABLET

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
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.

CANNABIDIOL

Products Affected

- EPIDIOLEX

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	INITIAL: DRAVET SYNDROME (DS), LENNOX-GASTAUT SYNDROME (LGS), TUBEROUS SCLEROSIS COMPLEX (TSC): PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST.
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
Other Criteria	INITIAL: LGS: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING ANTIEPILEPTIC MEDICATIONS: RUFINAMIDE, FELBAMATE, CLOBAZAM, TOPIRAMATE, LAMOTRIGINE, CLONAZEPAM.
Indications	All FDA-approved Indications.
Off Label Uses	
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.

CAPIVASERTIB

Products Affected

- TRUQAP

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
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.

CAPMATINIB

Products Affected

- TABRECTA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
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*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: ACUTE OR CHRONIC HYPERAMMONEMIA (HA) DUE TO N ACETYLGLUTAMATE SYNTHASE (NAGS) DEFICIENCY: NAGS GENE MUTATION IS CONFIRMED BY BIOCHEMICAL OR GENETIC TESTING. ACUTE HA DUE TO PROPIONIC ACIDEMIA (PA): 1) CONFIRMED BY ELEVATED METHYLCITRIC ACID AND NORMAL METHYLMALONIC ACID, OR 2) GENETIC TESTING CONFIRMS MUTATION IN THE PCCA OR PCCB GENE. ACUTE HA DUE TO METHYLMALONIC ACIDEMIA (MMA): 1) CONFIRMED BY ELEVATED METHYLMALONIC ACID, METHYLCITRIC ACID, OR 2) GENETIC TESTING CONFIRMS MUTATION IN THE MMUT, MMA, MMAB OR MMADHC GENES.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	ACUTE HA DUE TO NAGS/PA/MMA: 7 DAYS. CHRONIC HA DUE TO NAGS: INITIAL/RENEWAL: PLAN YEAR.
Other Criteria	RENEWAL: CHRONIC HA DUE TO NAGS: PATIENT HAS SHOWN CLINICAL IMPROVEMENT.
Indications	All FDA-approved Indications.
Off Label Uses	
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.

CERITINIB

Products Affected

- ZYKADIA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
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.

CLOBAZAM-SYMPAZAN

Products Affected

- SYMPAZAN

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

COBIMETINIB

Products Affected

- COTELLIC

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
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.

CORTICOTROPIN-CORTROPHIN

Products Affected

- CORTROPHIN GEL INJECTION

PA Criteria	Criteria Details
Exclusion Criteria	INITIAL: NOT APPROVED FOR DIAGNOSTIC PURPOSES.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	INITIAL: ALL FDA APPROVED INDICATIONS EXCEPT INFANTILE SPASMS AND MULTIPLE SCLEROSIS (MS): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST, DERMATOLOGIST, ALLERGIST/IMMUNOLOGIST, OPHTHALMOLOGIST, PULMONOLOGIST OR NEPHROLOGIST.
Coverage Duration	INFANTILE SPASMS AND MS: 28 DAYS. ALL OTHER FDA APPROVED INDICATIONS: INITIAL/RENEWAL: PLAN YEAR.
Other Criteria	INITIAL: ALL FDA APPROVED INDICATIONS EXCEPT INFANTILE SPASMS: TRIAL OF OR CONTRAINDICATION TO THE CLINICAL STANDARD OF CARE AGENT: INTRAVENOUS (IV) CORTICOSTEROIDS. RENEWAL: ALL FDA APPROVED INDICATIONS EXCEPT INFANTILE SPASMS AND MS: DEMONSTRATED CLINICAL BENEFIT WHILE ON THERAPY AS INDICATED BY SYMPTOM RESOLUTION AND/OR NORMALIZATION OF LABORATORY TESTS. PART B BEFORE PART D STEP THERAPY, APPLIES ONLY TO BENEFICIARIES IN AN MA-PD PLAN.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	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.

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.

CRIZOTINIB CAPSULE

Products Affected

- XALKORI ORAL CAPSULE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
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.

CRIZOTINIB PELLETS

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	NON-SMALL CELL LUNG CANCER (NSCLC), ANAPLASTIC LARGE CELL LYMPHOMA (ALCL), INFLAMMATORY MYOFIBROBLASTIC TUMOR (IMT): UNABLE TO SWALLOW CAPSULES.
Indications	All FDA-approved Indications.
Off Label Uses	
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.

DABRAFENIB CAPSULES

Products Affected

- TAFINLAR ORAL CAPSULE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
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.

DABRAFENIB SUSPENSION

Products Affected

- TAFINLAR ORAL TABLET FOR SUSPENSION

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	UNABLE TO SWALLOW TAFINILAR CAPSULES.
Indications	All FDA-approved Indications.
Off Label Uses	
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.

DACOMITINIB

Products Affected

- VIZIMPRO

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

Please refer to our Evidence of Coverage for 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

Products Affected

- *dalfampridine*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	MULTIPLE SCLEROSIS (MS): INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST.
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
Other Criteria	MS: INITIAL: HAS SYMPTOMS OF A WALKING DISABILITY (E.G., MILD TO MODERATE BILATERAL LOWER EXTREMITY WEAKNESS, UNILATERAL WEAKNESS PLUS LOWER EXTREMITY OR TRUNCAL ATAXIA). RENEWAL: IMPROVEMENT IN WALKING ABILITY.
Indications	All FDA-approved Indications.
Off Label Uses	
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.

DAROLUTAMIDE

Products Affected

- NUBEQA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	NON-METASTATIC CASTRATION-RESISTANT PROSTATE CANCER (NMCRPC), METASTATIC CASTRATION-SENSITIVE PROSTATE CANCER (MCSPC): 1) RECEIVED A BILATERAL ORCHIECTOMY, 2) CASTRATE LEVEL OF TESTOSTERONE (I.E., LESS THAN 50 NG/DL), OR 3) CONCURRENT USE WITH A GONADOTROPIN RELEASING HORMONE (GNRH) ANALOG.
Indications	All FDA-approved Indications.
Off Label Uses	
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.

DASATINIB-SPRYCEL

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	PREVIOUSLY TREATED PHILADELPHIA CHROMOSOME-POSITIVE CHRONIC MYELOID LEUKEMIA (Ph+ CML): MUTATIONAL ANALYSIS PRIOR TO INITIATION AND DASATINIB IS APPROPRIATE PER NCCN GUIDELINE TABLE FOR TREATMENT RECOMMENDATIONS BASED ON BCR-ABL1 MUTATION PROFILE.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
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.

DECITABINE/CEDAZURIDINE

Products Affected

- INQOVI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
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.

DEFERASIROX

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: CHRONIC IRON OVERLOAD DUE TO BLOOD TRANSFUSIONS: SERUM FERRITIN LEVEL CONSISTENTLY ABOVE 1000 MCG/L. CHRONIC IRON OVERLOAD IN NON-TRANSFUSION DEPENDENT THALASSEMIA (NTDT): 1) SERUM FERRITIN LEVEL CONSISTENTLY ABOVE 300 MCG/L (AT LEAST TWO LAB VALUES IN THE PREVIOUS THREE MONTHS), AND 2) LIVER IRON CONCENTRATION (LIC) OF 5 MG FE/G OF LIVER DRY WEIGHT OR GREATER. RENEWAL: CHRONIC IRON OVERLOAD DUE TO BLOOD TRANSFUSIONS: SERUM FERRITIN LEVEL CONSISTENTLY ABOVE 500 MCG/L. NTDT: 1) SERUM FERRITIN LEVEL CONSISTENTLY ABOVE 300 MCG/L (AT LEAST TWO LAB VALUES IN THE PREVIOUS THREE MONTHS) OR 2) LIC OF 3 MG FE/G OF LIVER DRY WEIGHT OR GREATER.
Age Restrictions	
Prescriber Restrictions	INITIAL: CHRONIC IRON OVERLOAD DUE TO BLOOD TRANSFUSIONS OR NTDT: PRESCRIBED BY OR IN CONSULTATION WITH A HEMATOLOGIST OR HEMATOLOGIST/ONCOLOGIST.
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
Other Criteria	INITIAL: CHRONIC IRON OVERLOAD DUE TO BLOOD TRANSFUSIONS OR NTDT: DEFERASIROX SPRINKLE PACKETS: TRIAL OF OR CONTRAINDICATION TO GENERIC DEFERASIROX ORAL TABLET OR TABLET FOR ORAL SUSPENSION.
Indications	All FDA-approved Indications.
Off Label Uses	

Please refer to our Evidence of Coverage for 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.

DENOSUMAB-BMWO - OSENVELT

Products Affected

- OSENVELT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
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.

DEUTETRABENAZINE

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	HUNTINGTON DISEASE: PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST OR MOVEMENT DISORDER SPECIALIST. TARDIVE DYSKINESIA: PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST, PSYCHIATRIST, OR MOVEMENT DISORDER SPECIALIST.
Coverage Duration	PLAN YEAR
Other Criteria	TARDIVE DYSKINESIA: HISTORY OF USING AGENTS THAT CAUSE TARDIVE DYSKINESIA.
Indications	All FDA-approved Indications.
Off Label Uses	
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.

DIAZEPAM

Products Affected

- VALTOCO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	EPILEPSY: AGES 12 YEARS OR OLDER: TRIAL OF OR CONTRAINDICATION TO THE PREFERRED AGENT: NAYZILAM.
Indications	All FDA-approved Indications.
Off Label Uses	
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.

DICLOFENAC TOPICAL SOLUTION

Products Affected

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

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

Please refer to our Evidence of Coverage for 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.

DIHYDROERGOTAMINE - NASAL

Products Affected

- *dihydroergotamine nasal*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	ACUTE MIGRAINE TREATMENT: 1) NO CONCURRENT USE WITH ANY OTHER DIHYDROERGOTAMINE OR ERGOTAMINE MEDICATIONS, AND 2) TRIAL OF OR CONTRAINDICATION TO BOTH OF THE FOLLOWING PREFERRED AGENTS: TRIPTAN (E.G., SUMATRIPTAN, RIZATRIPTAN), CGRP INHIBITOR FOR ACUTE MIGRAINE TREATMENT (NURTEC ODT, UBRELVY).
Indications	All FDA-approved Indications.
Off Label Uses	
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.

DIMETHYL FUMARATE

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
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.

DIROXIMEL FUMARATE

Products Affected

- VUMERITY

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
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.

DORDAVIPRONE

Products Affected

- MODEYSO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
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.

DRONABINOL CAPSULE

Products Affected

- *dronabinol oral capsule*

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

Please refer to our Evidence of Coverage for 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.

DROXIDOPA

Products Affected

- *droxidopa*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	NEUROGENIC ORTHOSTATIC HYPOTENSION (NOH): INITIAL: 1) BASELINE BLOOD PRESSURE READINGS WHILE THE PATIENT IS SITTING AND ALSO WITHIN 3 MINUTES OF STANDING FROM A SUPINE POSITION. 2) A DECREASE OF AT LEAST 20 MMHG IN SYSTOLIC BLOOD PRESSURE OR 10 MMHG DIASTOLIC BLOOD PRESSURE WITHIN THREE MINUTES AFTER STANDING FROM A SITTING POSITION.
Age Restrictions	
Prescriber Restrictions	NOH: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST OR CARDIOLOGIST.
Coverage Duration	INITIAL: 3 MONTHS. RENEWAL: PLAN YEAR.
Other Criteria	NOH: RENEWAL: CONTINUES TO BENEFIT FROM THE MEDICATION.
Indications	All FDA-approved Indications.
Off Label Uses	
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.

DUPILUMAB

Products Affected

- DUPIXENT PEN
- DUPIXENT SYRINGE SUBCUTANEOUS SYRINGE 200 MG/1.14 ML, 300 MG/2 ML

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: EOSINOPHILIC ASTHMA: BLOOD EOSINOPHIL LEVEL OF 150 TO 1500 CELLS/MCL WITHIN THE PAST 12 MONTHS. EOSINOPHILIC ESOPHAGITIS (EOE): DIAGNOSIS CONFIRMED BY ESOPHAGOGASTRODUODENOSCOPY (EGD) WITH BIOPSY. EOSINOPHILIC CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD): BLOOD EOSINOPHIL LEVEL OF AT LEAST 300 CELLS/MCL.
Age Restrictions	
Prescriber Restrictions	INITIAL: AD,PN,CSU: PRESCRIBED OR IN CONSULTATION WITH A DERMATOLOGIST, ALLERGIST OR IMMUNOLOGIST. ASTHMA: PRESCRIBED OR IN CONSULTATION WITH ALLERGIST OR PULMONOLOGIST. CRSWNP,AFRS: PRESCRIBED OR IN CONSULTATION WITH OTOLARYNGOLOGIST, ALLERGIST OR IMMUNOLOGIST. EOE: PRESCRIBED OR IN CONSULTATION WITH GASTROENTEROLOGIST, ALLERGIST, OR IMMUNOLOGIST. COPD: PRESCRIBED OR IN CONSULTATION WITH PULMONOLOGIST. RENEWAL: CSU: PRESCRIBED OR IN CONSULTATION WITH ALLERGIST, DERMATOLOGIST, OR IMMUNOLOGIST.
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
Other Criteria	INITIAL: AD: 1) INTRACTABLE PRURITUS OR CRACKING/OOZING/BLEEDING OF AFFECTED SKIN, AND 2) TRIAL OF OR CONTRAINDICATION TO ONE TOPICAL (CORTICOSTEROID, CALCINEURIN INHIBITOR, PDE4 INHIBITOR, OR JAK INHIBITOR). ASTHMA: 1) CONCURRENT

Please refer to our Evidence of Coverage for 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
	THERAPY WITH A MEDIUM, HIGH-DOSE OR MAXIMALLY-TOLERATED DOSE OF AN INHALED CORTICOSTEROID (ICS) AND ONE OTHER MAINTENANCE MEDICATION, AND 2) ONE ASTHMA EXACERBATION REQUIRING SYSTEMIC CORTICOSTEROID BURST LASTING AT LEAST 3 DAYS WITHIN THE PAST 12 MONTHS, OR ONE SERIOUS EXACERBATION REQUIRING HOSPITALIZATION OR ER VISIT WITHIN THE PAST 12 MONTHS, OR POOR SYMPTOM CONTROL DESPITE CURRENT THERAPY AS EVIDENCED BY AT LEAST THREE OF THE FOLLOWING WITHIN THE PAST 4 WEEKS: (A) DAYTIME ASTHMA SYMPTOMS MORE THAN TWICE/WEEK, (B) ANY NIGHT WAKING DUE TO ASTHMA, (C) SABA RELIEVER FOR SYMPTOMS MORE THAN TWICE/WEEK, (D) ANY ACTIVITY LIMITATION DUE TO ASTHMA. CHRONIC RHINOSINUSITIS WITH NASAL POLYPS (CRSWNP): 1) A 56 DAY TRIAL OF ONE CLINICAL STANDARD OF CARE AGENT: A TOPICAL NASAL CORTICOSTEROID, 2) EVIDENCE OF NASAL POLYPS BY DIRECT EXAMINATION, ENDOSCOPY, OR SINUS CT SCAN, AND 3) INADEQUATELY CONTROLLED DISEASE. PRURIGO NODULARIS (PN): CHRONIC PRURITUS (ITCH MORE THAN 6 WEEKS), MULTIPLE PRURIGINOUS LESIONS, AND HISTORY OR SIGN OF A PROLONGED SCRATCHING BEHAVIOR. EOSINOPHILIC COPD: USED IN COMBINATION WITH A LAMA/LABA/ICS. CHRONIC SPONTANEOUS URTICARIA (CSU): 1) TRIAL OF AND MAINTAINED ON, OR CONTRAINDICATION TO, FOUR TIMES THE MAXIMALLY LABELED DOSE OF A SECOND GENERATION H1 ANTI-HISTAMINE, AND 2) STILL EXPERIENCES HIVES OR ANGIOEDEMA MOST DAYS OF THE WEEK FOR AT LEAST 6 WEEKS. ALLERGIC FUNGAL RHINOSINUSITIS (AFRS): 1) INADEQUATELY CONTROLLED DISEASE POST ENDOSCOPIC SINUS SURGERY, AND 2) A 56 DAY TRIAL OF ONE CLINICAL STANDARD OF CARE AGENT: A TOPICAL NASAL CORTICOSTEROID. INITIAL/RENEWAL: ALL INDICATIONS EXCEPT BULLOUS PEMPHIGOID (BP) AND AFRS: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR THE SAME INDICATION. RENEWAL: AD, CRSWNP, EOE: IMPROVEMENT WHILE ON THERAPY. ASTHMA: 1) CONTINUED USE OF ICS AND ONE OTHER MAINTENANCE MEDICATION, AND 2) CLINICAL RESPONSE AS EVIDENCED BY:

PA Criteria	Criteria Details
	(A) REDUCTION IN ASTHMA EXACERBATIONS FROM BASELINE, (B) DECREASED UTILIZATION OF RESCUE MEDICATIONS, (C) INCREASE IN PERCENT PREDICTED FEV1 FROM PRETREATMENT BASELINE, OR (D) REDUCTION IN SEVERITY OR FREQUENCY OF ASTHMA-RELATED SYMPTOMS. PN: IMPROVEMENT OR REDUCTION OF PRURITUS OR PRURIGINOUS LESIONS. EOSINOPHILIC COPD: 1) USED IN COMBINATION WITH A LAMA/LABA/ICS, AND 2) CLINICAL RESPONSE AS EVIDENCED BY ONE OF THE FOLLOWING: (A) REDUCTION IN COPD EXACERBATIONS FROM BASELINE, OR (B) REDUCTION IN SEVERITY OR FREQUENCY OF COPD-RELATED SYMPTOMS. CSU: MAINTAINED ON OR CONTRAINDICATION TO A SECOND GENERATION H1 ANTI-HISTAMINE. AFRS: CONTINUES TO BENEFIT FROM THE MEDICATION.
Indications	All FDA-approved Indications.
Off Label Uses	
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.

DUVELISIB

Products Affected

- COPIKTRA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
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.

EFLORNITHINE

Products Affected

- IWILFIN

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
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.

ELACESTRANT

Products Affected

- ORSERDU ORAL TABLET 345 MG, 86 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
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.

ELAGOLIX

Products Affected

- ORILISSA ORAL TABLET 150 MG, 200 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	MODERATE TO SEVERE PAIN ASSOCIATED WITH ENDOMETRIOSIS: INITIAL: DIAGNOSIS IS CONFIRMED VIA SURGICAL OR DIRECT VISUALIZATION (E.G., PELVIC ULTRASOUND) OR HISTOPATHOLOGICAL CONFIRMATION (E.G., LAPAROSCOPY OR LAPAROTOMY) IN THE LAST 10 YEARS.
Age Restrictions	MODERATE TO SEVERE PAIN ASSOCIATED WITH ENDOMETRIOSIS: INITIAL: 18 YEARS OF AGE OR OLDER.
Prescriber Restrictions	MODERATE TO SEVERE PAIN ASSOCIATED WITH ENDOMETRIOSIS: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH AN OBSTETRICIAN/GYNECOLOGIST.
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
Other Criteria	MODERATE TO SEVERE PAIN ASSOCIATED WITH ENDOMETRIOSIS: INITIAL: 1) NO CONCURRENT USE WITH ANOTHER GNRH-MODULATING AGENT, AND 2) TRIAL OF OR CONTRAINDICATION TO AN NSAID AND A PROGESTIN-CONTAINING PREPARATION. RENEWAL: 1) IMPROVEMENT IN PAIN ASSOCIATED WITH ENDOMETRIOSIS WHILE ON THERAPY, AND 2) NO CONCURRENT USE WITH ANOTHER GNRH-MODULATING AGENT
Indications	All FDA-approved Indications.
Off Label Uses	
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.

ELAPEGADEMASE-LVLR

Products Affected

- REVCOVI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	ADENOSINE DEAMINASE SEVERE COMBINED IMMUNE DEFICIENCY (ADA-SCID): INITIAL: ADA-SCID AS MANIFESTED BY: 1) CONFIRMATORY GENETIC TEST, OR 2) SUGGESTIVE LABORATORY FINDINGS (E.G., ELEVATED DEOXYADENOSINE NUCLEOTIDE [DAXP] LEVELS, LYMPHOPENIA) AND HALLMARK SIGNS/SYMPTOMS (E.G., RECURRENT INFECTIONS, FAILURE TO THRIVE, PERSISTENT DIARRHEA).
Age Restrictions	
Prescriber Restrictions	ADA-SCID: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH IMMUNOLOGIST, HEMATOLOGIST/ONCOLOGIST, OR PHYSICIAN SPECIALIZING IN INHERITED METABOLIC DISORDERS.
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
Other Criteria	ADA-SCID: RENEWAL: 1) IMPROVEMENT OR MAINTENANCE OF IMMUNE FUNCTION FROM BASELINE, AND 2) HAS NOT RECEIVED SUCCESSFUL HCT OR GENE THERAPY.
Indications	All FDA-approved Indications.
Off Label Uses	
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.

ELEXACAFTOR-TEZACAFTOR-IVACAFTOR

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	CYSTIC FIBROSIS (CF): INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A PULMONOLOGIST OR CYSTIC FIBROSIS EXPERT.
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
Other Criteria	CF: INITIAL: NO CONCURRENT USE WITH ANOTHER CYSTIC FIBROSIS TRANSMEMBRANE CONDUCTANCE REGULATOR (CFTR) MODULATOR. RENEWAL: 1) IMPROVEMENT IN CLINICAL STATUS, AND 2) NO CONCURRENT USE WITH ANOTHER CFTR MODULATOR.
Indications	All FDA-approved Indications.
Off Label Uses	
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.

ELTROMBOPAG - PROMACTA

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	PERSISTENT OR CHRONIC IMMUNE THROMBOCYTOPENIA (ITP): INITIAL: 1) PLATELET COUNT OF LESS THAN 30 X 10^9/L, OR 2) PLATELET COUNT OF LESS THAN 50 X 10^9/L AND A PRIOR BLEEDING EVENT.
Age Restrictions	
Prescriber Restrictions	INITIAL: ITP: PRESCRIBED BY OR IN CONSULTATION WITH A HEMATOLOGIST OR IMMUNOLOGIST.
Coverage Duration	ITP: INITIAL/RENEWAL: PLAN YEAR. HEPATITIS C, SEVERE APLASTIC ANEMIA: PLAN YEAR.
Other Criteria	INITIAL: ITP: 1) INSUFFICIENT RESPONSE TO SPLENECTOMY, OR TRIAL OF OR CONTRAINDICATION TO ONE OF THE FOLLOWING CLINICAL STANDARD OF CARE AGENTS: CORTICOSTEROID, INTRAVENOUS IMMUNOGLOBULIN (IVIG). ALL INDICATIONS: REQUESTS FOR BRAND PROMACTA REQUIRE A TRIAL OF OR CONTRAINDICATION TO THE PREFERRED AGENT: GENERIC ELTROMBOPAG OLAMINE. INITIAL/RENEWAL: ITP: NO CONCURRENT USE WITH OTHER THROMBOPOIETIN RECEPTOR AGONISTS (TPO-RAS). RENEWAL: ITP: IMPROVEMENT IN PLATELET COUNTS FROM BASELINE OR REDUCTION IN BLEEDING EVENTS.
Indications	All FDA-approved Indications.
Off Label Uses	
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.

ENASIDENIB

Products Affected

- IDHIFA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
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.

ENCORAFENIB

Products Affected

- BRAFTOVI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
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.

ENSARTINIB

Products Affected

- ENSACOVE ORAL CAPSULE 100 MG, 25 MG

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

ENTRECTINIB CAPSULES

Products Affected

- ROZLYTREK ORAL CAPSULE 100 MG, 200 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
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.

ENTRECTINIB PELLETS

Products Affected

- ROZLYTREK ORAL PELLETS IN PACKET

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	METASTATIC NON-SMALL CELL LUNG CANCER (NSCLC), SOLID TUMORS: 1) TRIAL OF OR CONTRAINDICATION TO ROZLYTREK CAPSULES MADE INTO AN ORAL SUSPENSION, AND 2) DIFFICULTY OR UNABLE TO SWALLOW CAPSULES.
Indications	All FDA-approved Indications.
Off Label Uses	
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.

ENZALUTAMIDE

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	NON-METASTATIC CASTRATION-SENSITIVE PROSTATE CANCER (NMCSPC): HIGH RISK FOR METASTASIS (I.E. PSA DOUBLING TIME OF 9 MONTHS OR LESS). METASTATIC CASTRATION-RESISTANT PROSTATE CANCER (MCRPC), NON-METASTATIC CRPC (NMCRPC), METASTATIC CSPC (MCSPC), NMCSPC: 1) RECEIVED A BILATERAL ORCHIECTOMY, 2) CASTRATE LEVEL OF TESTOSTERONE (I.E., LESS THAN 50 NG/DL), OR 3) CONCURRENT USE WITH A GONADOTROPIN RELEASING HORMONE (GNRH) ANALOG.
Indications	All FDA-approved Indications.
Off Label Uses	
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.

EPOETIN ALFA-EPBX

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: ANEMIA DUE TO CHRONIC KIDNEY DISEASE (CKD), ZIDOVUDINE OR CANCER CHEMOTHERAPY: HEMOGLOBIN (HGB) LEVEL IS LESS THAN 10G/DL. ELECTIVE, NON-CARDIAC, NON-VASCULAR SURGERY: HGB LEVEL IS 13G/DL OR LESS. RENEWAL: ANEMIA DUE TO CKD: 1) ADULTS: (A) HGB LEVEL IS LESS THAN 10G/DL, OR (B) HGB LEVEL HAS REACHED 10G/DL AND THE DOSE IS BEING OR HAS BEEN REDUCED/INTERRUPTED TO DECREASE THE NEED FOR BLOOD TRANSFUSIONS, OR 2) PEDIATRICS: (A) HGB LEVEL IS LESS THAN 10G/DL, OR (B) HGB LEVEL HAS APPROACHED OR EXCEEDS 12G/DL AND THE DOSE IS BEING OR HAS BEEN REDUCED/INTERRUPTED TO DECREASE THE NEED FOR BLOOD TRANSFUSIONS. ANEMIA RELATED TO ZIDOVUDINE: HGB LEVEL IS BETWEEN 10G/DL AND 12G/DL. ANEMIA DUE TO CHEMO: 1) HGB LEVEL IS LESS THAN 10G/DL, OR 2) HGB LEVEL DOES NOT EXCEED A LEVEL NEEDED TO AVOID RED BLOOD CELL (RBC) TRANSFUSION.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	ANEMIA FROM CHEMO/CKD WITHOUT DIALYSIS/ZIDOVUDINE: INITIAL/RENEWAL: PLAN YEAR. SURGERY: 1 MONTH.
Other Criteria	INITIAL: SURGERY: NO CONCURRENT USE WITH ANOTHER ERYTHROPOIESIS-STIMULATING AGENT (ESA) OR A HYPOXIA-INDUCIBLE FACTOR PROLYL HYDROXYLASE INHIBITOR (HIF-PHI). INITIAL/RENEWAL: ANEMIA DUE TO CKD/ZIDOVUDINE/CHEMO: NO CONCURRENT USE WITH

Please refer to our Evidence of Coverage for 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
	ANOTHER ESA OR A HIF-PHI. RENEWAL: ANEMIA DUE TO CKD: NOT RECEIVING DIALYSIS TREATMENT.
Indications	All FDA-approved Indications.
Off Label Uses	
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.

ERDAFITINIB

Products Affected

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

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

ERENUMAB-AOOE

Products Affected

- AIMOVIG AUTOINJECTOR

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

Please refer to our Evidence of Coverage for 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.

ERLOTINIB

Products Affected

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

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

Please refer to our Evidence of Coverage for 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.

ETANERCEPT

Products Affected

- ENBREL MINI
- ENBREL SUBCUTANEOUS SOLUTION
- ENBREL SUBCUTANEOUS SYRINGE
- ENBREL SURECLICK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: PLAQUE PSORIASIS (PSO): PSORIASIS COVERING 3 PERCENT OR MORE OF BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, FACE, SCALP, OR GENITAL AREA.
Age Restrictions	
Prescriber Restrictions	INITIAL: RHEUMATOID ARTHRITIS (RA), POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS (PJIA), ANKYLOSING SPONDYLITIS (AS): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST. PSORIATIC ARTHRITIS (PSA): PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST OR RHEUMATOLOGIST. PSO: PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST.
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
Other Criteria	INITIAL: RA: 1) TRIAL OF OR CONTRAINDICATION TO 3 MONTHS OF TREATMENT WITH ONE CLINICAL STANDARD OF CARE AGENT: A CONVENTIONAL SYNTHETIC DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG) - IF PATIENT TRIED METHOTREXATE, THEN TRIAL OF AT LEAST 20 MG PER WEEK OR MAXIMALLY TOLERATED DOSE IS REQUIRED, AND 2) TRIAL OF OR CONTRAINDICATION TO ONE OF THE FOLLOWING PREFERRED AGENTS: ADALIMUMAB-AATY, HADLIMA. PJIA: TRIAL OF OR CONTRAINDICATION TO ONE OF THE FOLLOWING PREFERRED AGENTS: ADALIMUMAB-AATY, HADLIMA. PSA: TRIAL OF OR CONTRAINDICATION TO ONE OF THE FOLLOWING PREFERRED AGENTS, WHERE AGES ALIGN: ADALIMUMAB-AATY, HADLIMA. AS: 1) TRIAL OF OR

Please refer to our Evidence of Coverage for 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
	CONTRAINDICATION TO ONE CLINICAL STANDARD OF CARE AGENT: AN NSAID, AND 2) TRIAL OF OR CONTRAINDICATION TO ONE OF THE FOLLOWING PREFERRED AGENTS: ADALIMUMAB-AATY, HADLIMA. PSO: 1) ONE OF THE FOLLOWING: (A) AT LEAST A 3 MONTH TRIAL OF ONE OF THE FOLLOWING CLINICAL STANDARD OF CARE AGENTS: AN ORAL IMMUNOSUPPRESSANT (CYCLOSPORINE, METHOTREXATE, TACROLIMUS), PUVA (PHOTOTHERAPY), (B) CONTRAINDICATION OR INTOLERANCE TO BOTH OF THE FOLLOWING CLINICAL STANDARD OF CARE AGENTS: AN IMMUNOSUPPRESSANT, PUVA, OR (C) PATIENT IS SWITCHING FROM A DIFFERENT BIOLOGIC, PDE-4 INHIBITOR, OR JAK INHIBITOR FOR THE SAME INDICATION, AND 2) TRIAL OF OR CONTRAINDICATION TO ONE OF THE FOLLOWING PREFERRED AGENTS, WHERE AGES ALIGN: ADALIMUMAB-AATY, HADLIMA. INITIAL/RENEWAL: ALL INDICATIONS: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR THE SAME INDICATION. RENEWAL: ALL INDICATIONS: CONTINUES TO BENEFIT FROM THE MEDICATION.
Indications	All FDA-approved Indications.
Off Label Uses	
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.

ETRASIMOD

Products Affected

- VELSIPITY

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	ULCERATIVE COLITIS (UC): INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A GASTROENTEROLOGIST.
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
Other Criteria	UC: INITIAL: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: SELARSDI/YESINTEK/OTULFI, XELJANZ, HUMIRA/ADALIMUMAB-AATY/HADLIMA, RINVOQ, SKYRIZI, TREMFYA. INITIAL/RENEWAL: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR THE SAME INDICATION.
Indications	All FDA-approved Indications.
Off Label Uses	
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.

EVEROLIMUS-AFINITOR

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
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.

EVEROLIMUS-AFINITOR DISPERZ

Products Affected

- *everolimus (antineoplastic) oral tablet for suspension*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	TUBEROUS SCLEROSIS COMPLEX (TSC) ASSOCIATED PARTIAL-ONSET SEIZURES: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST.
Coverage Duration	PLAN YEAR
Other Criteria	TSC ASSOCIATED PARTIAL-ONSET SEIZURES: INITIAL: TRIAL OF OR CONTRAINDICATION TO THE PREFERRED AGENTS: 1) EPIDIOLEX, AND 2) ONE OTHER ANTIEPILEPTIC AGENT.
Indications	All FDA-approved Indications.
Off Label Uses	
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.

FECAL MICROBIOTA CAPSULE

Products Affected

- VOWST

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	CLOSTRIDIOIDES DIFFICILE INFECTION (CDI): PRESCRIBED BY OR IN CONSULTATION WITH GASTROENTEROLOGIST OR INFECTIOUS DISEASE SPECIALIST.
Coverage Duration	30 DAYS
Other Criteria	CDI: 1) HAS NOT PREVIOUSLY RECEIVED VOWST: COMPLETION OF ANTIBIOTIC TREATMENT FOR RECURRENT CDI (AT LEAST 3 CDI EPISODES), OR 2) PREVIOUSLY RECEIVED VOWST: (A) TREATMENT FAILURE (DEFINED AS THE PRESENCE OF CDI DIARRHEA WITHIN 8 WEEKS OF FIRST DOSE OF VOWST AND A POSITIVE STOOL TEST FOR C. DIFFICILE), AND (B) HAS NOT RECEIVED MORE THAN ONE TREATMENT COURSE OF VOWST WHICH WAS AT LEAST 12 DAYS AND NOT MORE THAN 8 WEEKS PRIOR.
Indications	All FDA-approved Indications.
Off Label Uses	
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.

FEDRATINIB

Products Affected

- INREBIC

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
Other Criteria	MYELOFIBROSIS: INITIAL: TRIAL OF OR CONTRAINDICATION TO JAKAFI (RUXOLITINIB). RENEWAL: CONTINUES TO BENEFIT FROM THE MEDICATION.
Indications	All FDA-approved Indications.
Off Label Uses	
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.

FENFLURAMINE

Products Affected

- FINTEPLA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	INITIAL: DRAVET SYNDROME, LENNOX-GASTAUT SYNDROME (LGS): PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST.
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
Other Criteria	INITIAL: LGS: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING ANTIEPILEPTIC MEDICATIONS: RUFINAMIDE, FELBAMATE, CLOBAZAM, TOPIRAMATE, LAMOTRIGINE, CLONAZEPAM.
Indications	All FDA-approved Indications.
Off Label Uses	
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.

FENTANYL CITRATE

Products Affected

- *fentanyl citrate buccal lozenge on a handle*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	CANCER RELATED PAIN: 1) CURRENTLY ON A MAINTENANCE DOSE OF CONTROLLED-RELEASE OPIOID PAIN MEDICATION, AND 2) TRIAL OF OR CONTRAINDICATION TO AT LEAST ONE IMMEDIATE-RELEASE ORAL OPIOID PAIN AGENT OR PATIENT HAS DIFFICULTY SWALLOWING TABLETS/CAPSULES.
Indications	All FDA-approved Indications.
Off Label Uses	
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.

FEZOLINETANT

Products Affected

- VEOZAH

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
Other Criteria	MENOPAUSAL VASOMOTOR SYMPTOMS (VMS): INITIAL: 1) TRIAL OF OR CONTRAINDICATION TO HORMONAL THERAPY (E.G., ESTRADIOL TRANSDERMAL PATCH, ORAL CONJUGATED ESTROGENS), 2) LABORATORY TESTING TO ESTABLISH BASELINE HEPATIC FUNCTION AND CONTINUED MONITORING OF THESE VALUES IN ACCORDANCE WITH THE FDA CURRENT LABEL RECOMMENDATION, AND 3) NO CONCURRENT USE WITH ANOTHER HORMONAL (E.G., PREMPRO) OR NON-HORMONAL (E.G., BRISDELLE) AGENT FOR VMS. RENEWAL: 1) CONTINUED NEED FOR VMS TREATMENT (PERSISTENT HOT FLASHES), 2) REDUCTION IN VMS FREQUENCY OR SEVERITY DUE TO VEOZAH TREATMENT, AND 3) NO NEW SYMPTOMS OF LIVER INJURY AND/OR WORSENING LAB VALUES (E.G., ALT, AST, TOTAL BILIRUBIN).
Indications	All FDA-approved Indications.
Off Label Uses	
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.

FILGRASTIM-AAFI

Products Affected

- NIVESTYM

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR IN CONSULTATION WITH A HEMATOLOGIST OR ONCOLOGIST.
Coverage Duration	PLAN YEAR
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
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.

FINERENONE

Products Affected

- KERENDIA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: HEART FAILURE (HF): 1) NEW YORK HEART ASSOCIATION (NYHA) CLASS II-IV, AND 2) LEFT VENTRICULAR EJECTION FRACTION OF AT LEAST 40 PERCENT NOT DUE TO AN UNDERLYING CAUSE (E.G., INFILTRATIVE CARDIOMYOPATHY, HYPERTROPHIC CARDIOMYOPATHY, VALVULAR DISEASE, PERICARDIAL DISEASE, HIGH-OUTPUT HEART FAILURE).
Age Restrictions	
Prescriber Restrictions	INITIAL: HF: PRESCRIBED BY OR IN CONSULTATION WITH A CARDIOLOGIST.
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
Other Criteria	CHRONIC KIDNEY DISEASE (CKD) ASSOCIATED WITH TYPE 2 DIABETES (T2D): INITIAL: HISTORY OF AND WILL CONTINUE ON, HAS A CONTRAINDICATION, OR INTOLERANCE TO AN ANGIOTENSIN CONVERTING ENZYME INHIBITOR (ACE-I) OR AN ANGIOTENSIN RECEPTOR BLOCKER (ARB). HF: INITIAL/RENEWAL: NO CONCURRENT USE WITH ANOTHER MINERALOCORTICOID (ALDOSTERONE) RECEPTOR ANTAGONIST.
Indications	All FDA-approved Indications.
Off Label Uses	
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.

FINGOLIMOD

Products Affected

- *fingolimod*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
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.

FOSCARBIDOPA-FOSLEVODOPA

Products Affected

- VYALEV

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	PARKINSONS DISEASE (PD): INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST.
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
Other Criteria	PD: INITIAL: ONE OF THE FOLLOWING: 1) UNABLE TO SWALLOW EXTENDED-RELEASE (ER) TABLETS OR ADMINISTER ER CAPSULES VIA A FEEDING TUBE, OR 2) FAILURE TO ADHERE OR TOLERATE VIA A FEEDING TUBE AN ORAL CARBIDOPA/LEVODOPA REGIMEN. RENEWAL: IMPROVEMENT IN MOTOR SYMPTOMS WHILE ON THERAPY.
Indications	All FDA-approved Indications.
Off Label Uses	
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.

FRUQUINTINIB

Products Affected

- FRUZAQLA ORAL CAPSULE 1 MG, 5 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
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.

FUTIBATINIB

Products Affected

- LYTGOBI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INTRAHEPATIC CHOLANGIOCARCINOMA (ICCA): COMPLETE A COMPREHENSIVE OPHTHALMOLOGICAL EXAMINATION, INCLUDING OPTICAL COHERENCE TOMOGRAPHY (OCT), PRIOR TO THE INITIATION OF THERAPY AND AT THE RECOMMENDED SCHEDULED INTERVALS.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
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.

GALCANEZUMAB-GNLM

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL: MIGRAINE PREVENTION: PLAN YEAR. EPISODIC CLUSTER HEADACHE: 3 MOS. RENEWAL (ALL): PLAN YEAR.
Other Criteria	MIGRAINE PREVENTION: INITIAL/RENEWAL: NO CONCURRENT USE WITH OTHER CGRP INHIBITORS FOR MIGRAINE PREVENTION. RENEWAL: REDUCTION IN MIGRAINE OR HEADACHE FREQUENCY, MIGRAINE SEVERITY, OR MIGRAINE DURATION WITH THERAPY. EPISODIC CLUSTER HEADACHE: INITIAL: SYMPTOMS WERE NOT ADEQUATELY MANAGED WITH ABORTIVE THERAPIES (E.G., IMITREX, ZOMIG). RENEWAL: IMPROVEMENT IN EPISODIC CLUSTER HEADACHE FREQUENCY AS COMPARED TO BASELINE.
Indications	All FDA-approved Indications.
Off Label Uses	
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.

GANAXOLONE

Products Affected

- ZTALMY

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
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.

GEFITINIB

Products Affected

- *gefitinib*

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

Please refer to our Evidence of Coverage for 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.

GEPIRONE

Products Affected

- EXXUA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
Other Criteria	MAJOR DEPRESSIVE DISORDER: INITIAL: TRIAL OF OR CONTRAINDICATION TO THE PREFERRED AGENTS: TRINTELLIX AND ONE GENERIC ANTIDEPRESSANT. INITIAL/RENEWAL: NO CONCURRENT USE WITH ANOTHER 5-HT1A RECEPTOR AGONIST (E.G., BUSPIRONE). RENEWAL: RESPONSE TO OR REMISSION OF DEPRESSIVE SYMPTOMS WITH THERAPY.
Indications	All FDA-approved Indications.
Off Label Uses	
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.

GILTERITINIB

Products Affected

- XOSPATA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
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.

GLASDEGIB

Products Affected

- DAURISMO ORAL TABLET 100 MG, 25 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
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.

GLATIRAMER

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
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.

GLP1-DULAGLUTIDE

Products Affected

- TRULICITY

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
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.

GLP1-SEMAGLUTIDE

Products Affected

- OZEMPIC ORAL
- OZEMPIC SUBCUTANEOUS
- RYBELSUS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
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.

GLP1-TIRZEPATIDE

Products Affected

- MOUNJARO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
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.

GUSELKUMAB

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: PLAQUE PSORIASIS (PSO): PSORIASIS COVERING 3 PERCENT OR MORE OF BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, FACE, SCALP, OR GENITAL AREA.
Age Restrictions	
Prescriber Restrictions	INITIAL: PSO: PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST. PSORIATIC ARTHRITIS (PSA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST OR DERMATOLOGIST. ULCERATIVE COLITIS (UC), CROHNS DISEASE (CD): PRESCRIBED BY OR IN CONSULTATION WITH A GASTROENTEROLOGIST.
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
Other Criteria	INITIAL: PSO: 1) AT LEAST A 3 MONTH TRIAL OF ONE OF THE FOLLOWING CLINICAL STANDARD OF CARE AGENTS: AN ORAL IMMUNOSUPPRESSANT (CYCLOSPORINE, METHOTREXATE, TACROLIMUS), PUVA (PHOTOTHERAPY), 2) CONTRAINDICATION OR INTOLERANCE TO BOTH OF THE FOLLOWING CLINICAL STANDARD OF CARE AGENTS: AN IMMUNOSUPPRESSANT, PUVA, OR 3) PATIENT IS SWITCHING FROM A DIFFERENT BIOLOGIC, PDE-4 INHIBITOR, OR JAK INHIBITOR FOR THE SAME INDICATION. INITIAL/RENEWAL: ALL INDICATIONS: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR THE SAME INDICATION.

Please refer to our Evidence of Coverage for 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
	RENEWAL: PSO, PSA: CONTINUES TO BENEFIT FROM THE MEDICATION.
Indications	All FDA-approved Indications.
Off Label Uses	
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 DRUGS IN THE ELDERLY - BUTALBITAL/APAP/CAF

Products Affected

- *butalbital-acetaminophen-caff oral tablet*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	PRESCRIBER ACKNOWLEDGEMENT/AWARENESS DRUG IS CONSIDERED HIGH RISK FOR PATIENTS 65 YEARS AND OLDER. HOSPICE PATIENTS ARE APPROVED WITHOUT REQUIRING ADDITIONAL CRITERIA.
Indications	All FDA-approved Indications.
Off Label Uses	
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 DRUGS IN THE ELDERLY - BUTALBITAL/APAP/CAF/COD

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	PRESCRIBER ACKNOWLEDGEMENT/AWARENESS DRUG IS CONSIDERED HIGH RISK FOR PATIENTS 65 YEARS AND OLDER. HOSPICE PATIENTS ARE APPROVED WITHOUT REQUIRING ADDITIONAL CRITERIA.
Indications	All FDA-approved Indications.
Off Label Uses	
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 DRUGS IN THE ELDERLY - DIPYRIDAMOLE

Products Affected

- *dipyridamole oral*

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

Please refer to our Evidence of Coverage for 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 DRUGS IN THE ELDERLY - ESTRADIOL-NORETHINDRONE

Products Affected

- *abigale*
- *estradiol-norethindrone acet*
- *mimvey*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	VULVAR/VAGINAL ATROPHY, OSTEOPOROSIS, AND VASOMOTOR SYMPTOMS OF MENOPAUSE: PRESCRIBER ACKNOWLEDGEMENT/AWARENESS THAT THE DRUG IS CONSIDERED HIGH RISK FOR PATIENTS 65 YEARS AND OLDER. HYPOESTROGENISM TREATMENT AND HOSPICE PATIENTS WILL BE APPROVED WITHOUT REQUIRING ADDITIONAL CRITERIA.
Indications	All FDA-approved Indications.
Off Label Uses	
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 DRUGS IN THE ELDERLY - ESTROGEN-MEDROXYPROGESTERONE

Products Affected

- PREMPHASE
- PREMPRO

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

Please refer to our Evidence of Coverage for 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 DRUGS IN THE ELDERLY - GLYBURIDE

Products Affected

- *glyburide*
- *glyburide micronized*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	TYPE 2 DIABETES MELLITUS (DM): 1) TRIAL OF OR CONTRAINDICATION TO ONE OF THE FOLLOWING CLINICAL STANDARD OF CARE AGENTS: GLIMEPIRIDE, GLIPIZIDE, OR 2) PRESCRIBER ACKNOWLEDGEMENT/AWARENESS THAT THE DRUG IS CONSIDERED HIGH RISK FOR PATIENTS 65 YEARS AND OLDER. HOSPICE PATIENTS ARE APPROVED WITHOUT REQUIRING ADDITIONAL CRITERIA.
Indications	All FDA-approved Indications.
Off Label Uses	
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 DRUGS IN THE ELDERLY - GLYBURIDE/METFORMIN

Products Affected

- *glyburide-metformin*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	TYPE 2 DIABETES MELLITUS (DM): 1) TRIAL OF OR CONTRAINDICATION TO ONE OF THE FOLLOWING CLINICAL STANDARD OF CARE AGENTS: GLIMEPIRIDE, GLIPIZIDE, OR 2) PRESCRIBER ACKNOWLEDGEMENT/AWARENESS THAT THE DRUG IS CONSIDERED HIGH RISK FOR PATIENTS 65 YEARS AND OLDER. HOSPICE PATIENTS ARE APPROVED WITHOUT REQUIRING ADDITIONAL CRITERIA.
Indications	All FDA-approved Indications.
Off Label Uses	
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 DRUGS IN THE ELDERLY - KETOROLAC

Products Affected

- *ketorolac oral*

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

Please refer to our Evidence of Coverage for 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 DRUGS IN THE ELDERLY - PHENOBARBITAL

Products Affected

- *phenobarbital*

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

Please refer to our Evidence of Coverage for 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 DRUGS IN THE ELDERLY - PROMETHAZINE

Products Affected

- *promethazine oral tablet*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	PRURITUS/URTICARIA/SEASONAL/PERENNIAL ALLERGY: 1) TRIAL OF OR CONTRAINDICATION TO A NON-SEDATING ANTIHISTAMINE SUCH AS LEVOCETIRIZINE, OR 2) PRESCRIBER ACKNOWLEDGEMENT/AWARENESS THAT THE DRUG IS CONSIDERED HIGH RISK FOR PATIENTS 65 YEARS AND OLDER. NAUSEA AND VOMITING: PRESCRIBER ACKNOWLEDGEMENT/AWARENESS THAT THE DRUG IS CONSIDERED HIGH-RISK FOR PATIENTS 65 YEARS AND OLDER. HOSPICE PATIENTS REQUIRE PHYSICIAN ATTESTATION THAT REQUESTED MEDICATION IS USED TO TREAT A DIAGNOSIS UNRELATED TO THE TERMINAL ILLNESS OR RELATED CONDITION, AND ARE APPROVED WITHOUT TRIAL OF FORMULARY ALTERNATIVES NOR REQUIRING PRESCRIBER ACKNOWLEDGEMENT.
Indications	All FDA-approved Indications.
Off Label Uses	

Please refer to our Evidence of Coverage for 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.

HIGH RISK DRUGS IN THE ELDERLY - SCOPOLAMINE

Products Affected

- *scopolamine base*

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

Please refer to our Evidence of Coverage for 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 DRUGS IN THE ELDERLY-DIPHENOXYLATE-ATROPINE

Products Affected

- *diphenoxylate-atropine oral tablet*

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

Please refer to our Evidence of Coverage for 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 DRUGS IN THE ELDERLY-INDOMETHACIN

Products Affected

- *indomethacin oral capsule*

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

HIGH RISK DRUGS IN THE ELDERLY-MEGESTROL

Products Affected

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

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

Please refer to our Evidence of Coverage for 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 DRUGS IN THE ELDERLY-PAROXETINE

Products Affected

- *paroxetine hcl*

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

Please refer to our Evidence of Coverage for 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.

IBRUTINIB

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	CHRONIC GRAFT VS HOST DISEASE (CGVHD): NO CONCURRENT USE WITH JAKAFI, NIKTIMVO, OR REZUROCK.
Indications	All FDA-approved Indications.
Off Label Uses	
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*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	HEREDITARY ANGIOEDEMA (HAE): INITIAL: 1) TYPE I OR II HAE CONFIRMED BY ONE OF THE FOLLOWING COMPLEMENT TESTS: C1-INH PROTEIN LEVELS, C4 PROTEIN LEVELS, C1-INH FUNCTIONAL LEVELS, C1Q, OR 2) TYPE III HAE CONFIRMED BY: (A) RECURRENT, NON-URTICARIAL ANGIOEDEMA INVOLVING THE SKIN, GASTROINTESTINAL TRACT, OR AIRWAY, CONSISTENT WITH BRADYKININ-MEDIATED HAE AND ATTACKS NOT EXPLAINED BY HISTAMINERGIC/URTICARIAL ANGIOEDEMA, AND (B) OTHER CAUSES OF ANGIOEDEMA HAVE BEEN EXCLUDED, INCLUDING ACE-INHIBITOR/ARB-ASSOCIATED ANGIOEDEMA, ACQUIRED C1-INH DEFICIENCY, AND MAST-CELL/HISTAMINERGIC ANGIOEDEMA.
Age Restrictions	
Prescriber Restrictions	HAE: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH AN ALLERGIST, IMMUNOLOGIST, HEMATOLOGIST OR PULMONOLOGIST.
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
Other Criteria	HAE: INITIAL/RENEWAL: NO CONCURRENT USE WITH OTHER MEDICATIONS FOR THE TREATMENT OF ACUTE HAE ATTACKS.
Indications	All FDA-approved Indications.
Off Label Uses	
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.

IDELALISIB

Products Affected

- ZYDELIG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
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.

IMATINIB

Products Affected

- *imatinib oral tablet 100 mg, 400 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	PHILADELPHIA CHROMOSOME POSITIVE CHRONIC MYELOID LEUKEMIA: PATIENT HAS NOT RECEIVED A PREVIOUS TREATMENT WITH ANOTHER TYROSINE KINASE INHIBITOR.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Please refer to our Evidence of Coverage for 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.

IMATINIB SOLUTION

Products Affected

- IMKELDI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	PHILADELPHIA CHROMOSOME POSITIVE CHRONIC MYELOID LEUKEMIA: PATIENT HAS NOT RECEIVED A PREVIOUS TREATMENT WITH ANOTHER TYROSINE KINASE INHIBITOR. ALL INDICATIONS: UNABLE TO SWALLOW GENERIC IMATINIB TABLETS.
Indications	All FDA-approved Indications.
Off Label Uses	
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.

IMLUNESTRANT

Products Affected

- INLURIYO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
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.

INAVOLISIB

Products Affected

- ITOVEBI ORAL TABLET 3 MG, 9 MG

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

INFLIXIMAB

Products Affected

- *infliximab*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: PLAQUE PSORIASIS (PSO): PSORIASIS COVERING 3 PERCENT OR MORE OF BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, GENITAL AREA, SCALP, OR FACE.
Age Restrictions	
Prescriber Restrictions	INITIAL: RHEUMATOID ARTHRITIS (RA), ANKYLOSING SPONDYLITIS (AS): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST. PSORIATIC ARTHRITIS (PSA): PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST OR RHEUMATOLOGIST. PSO: PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST. CROHNS DISEASE (CD), ULCERATIVE COLITIS (UC): PRESCRIBED BY OR IN CONSULTATION WITH A GASTROENTEROLOGIST.
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
Other Criteria	INITIAL: RA: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA/ADALIMUMAB-AATY/HADLIMA, XELJANZ, RINVOQ. PSA: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: COSENTYX, HUMIRA/ADALIMUMAB-AATY/HADLIMA, SELARSDI/YESINTEK/OTULFI, XELJANZ, RINVOQ, SKYRIZI, TREMFYA, OTEZLA. PSO: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: COSENTYX, HUMIRA/ADALIMUMAB-AATY/HADLIMA, SELARSDI/YESINTEK/OTULFI, SKYRIZI, TREMFYA, OTEZLA. AS: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: COSENTYX,

Please refer to our Evidence of Coverage for 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
	HUMIRA/ADALIMUMAB-AATY/HADLIMA, XELJANZ, RINVOQ. MODERATE TO SEVERE CD: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS, WHERE AGES ALIGN: SELARSDI/YESINTEK/OTULFI, HUMIRA/ADALIMUMAB-AATY/HADLIMA, RINVOQ, SKYRIZI, TREMFYA. UC: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS, WHERE AGES ALIGN: SELARSDI/YESINTEK/OTULFI, XELJANZ, HUMIRA/ADALIMUMAB-AATY/HADLIMA, RINVOQ, SKYRIZI, TREMFYA. INITIAL/RENEWAL: RA, PSA, AS, PSO, MODERATE TO SEVERE CD, UC: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR THE SAME INDICATION. RENEWAL: RA, PSA, AS, PSO: CONTINUES TO BENEFIT FROM THE MEDICATION.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

INFLIXIMAB-DYYB SQ

Products Affected
- ZYMFENTRA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	INITIAL: ULCERATIVE COLITIS (UC), CROHNS DISEASE (CD): PRESCRIBED BY OR IN CONSULTATION WITH A GASTROENTEROLOGIST.
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
Other Criteria	INITIAL: UC: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: SELARSDI/YESINTEK/OTULFI, XELJANZ, HUMIRA/ADALIMUMAB-AATY/HADLIMA, RINVOQ, SKYRIZI, TREMFYA. CD: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: SELARSDI/YESINTEK/OTULFI, HUMIRA/ADALIMUMAB-AATY/HADLIMA, RINVOQ, SKYRIZI, TREMFYA. INITIAL/RENEWAL: ALL INDICATIONS: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR THE SAME INDICATION.
Indications	All FDA-approved Indications.
Off Label Uses	
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.

INSULIN SUPPLIES PAYMENT DETERMINATION

Products Affected

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

Please refer to our Evidence of Coverage for 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.

- CARETOUCH ALCOHOL 70% PREP PAD
- CARETOUCH PEN NEEDLE 29G 12MM
- CARETOUCH PEN NEEDLE 31GX1/4"
- CARETOUCH PEN NEEDLE 31GX3/16"
- CARETOUCH PEN NEEDLE 31GX5/16"
- CARETOUCH PEN NEEDLE 32GX3/16"
- CARETOUCH PEN NEEDLE 32GX5/32"
- CARETOUCH SYR 0.3 ML 31GX5/16"
- CARETOUCH SYR 0.5 ML 30GX5/16"
- CARETOUCH SYR 0.5 ML 31GX5/16"
- CARETOUCH SYR 1 ML 28GX5/16"
- CARETOUCH SYR 1 ML 29GX5/16"
- CARETOUCH SYR 1 ML 30GX5/16"
- CARETOUCH SYR 1 ML 31GX5/16"
- CLICKFINE PEN NEEDLE 32GX5/32" 32GX4MM, STERILE
- CLICKFINE UNIVERSAL 31G X 1/4" 6MM, STORE BRAND
- COMFORT EZ 0.3 ML 31G 15/64"
- COMFORT EZ 0.5 ML 31G 15/64"
- COMFORT EZ INS 0.3 ML 30GX1/2"
- COMFORT EZ INS 0.3 ML 30GX5/16"
- COMFORT EZ INS 1 ML 31G 15/64"
- COMFORT EZ INS 1 ML 31GX5/16"
- COMFORT EZ INSULIN SYR 0.3 ML
- COMFORT EZ INSULIN SYR 0.5 ML
- COMFORT EZ PEN NEEDLE 12MM 29G
- COMFORT EZ PEN NEEDLES 4MM 32G SINGLE USE, MICRO
- COMFORT EZ PEN NEEDLES 4MM 33G
- COMFORT EZ PEN NEEDLES 5MM 31G MINI
- COMFORT EZ PEN NEEDLES 5MM 32G SINGLE USE,MINI,HRI
- COMFORT EZ PEN NEEDLES 5MM 33G
- COMFORT EZ PEN NEEDLES 6MM 31G
- COMFORT EZ PEN NEEDLES 6MM 32G
- COMFORT EZ PEN NEEDLES 6MM 33G
- COMFORT EZ PEN NEEDLES 8MM 31G SHORT
- COMFORT EZ PEN NEEDLES 8MM 32G
- COMFORT EZ PEN NEEDLES 8MM 33G
- COMFORT EZ PRO PEN NDL 30G 8MM
- COMFORT EZ PRO PEN NDL 31G 4MM
- COMFORT EZ PRO PEN NDL 31G 5MM
- COMFORT EZ SYR 0.3 ML 29GX1/2"
- COMFORT EZ SYR 0.5 ML 28GX1/2"
- COMFORT EZ SYR 0.5 ML 29GX1/2"
- COMFORT EZ SYR 0.5 ML 30GX1/2"
- COMFORT EZ SYR 1 ML 27G 12.7MM
- COMFORT EZ SYR 1 ML 28GX1/2"
- COMFORT EZ SYR 1 ML 29GX1/2"
- COMFORT EZ SYR 1 ML 30GX1/2"
- COMFORT EZ SYR 1 ML 30GX5/16"
- COMFORT POINT PEN NDL 31GX1/3"
- COMFORT POINT PEN NDL 31GX1/6"
- COMFORT TOUCH PEN NDL 31G 4MM
- COMFORT TOUCH PEN NDL 31G 5MM
- COMFORT TOUCH PEN NDL 31G 6MM
- COMFORT TOUCH PEN NDL 31G 8MM
- COMFORT TOUCH PEN NDL 32G 4MM
- COMFORT TOUCH PEN NDL 32G 5MM

Please refer to our Evidence of Coverage for 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.

- COMFORT TOUCH PEN NDL 32G 6MM
- COMFORT TOUCH PEN NDL 32G 8MM
- COMFORT TOUCH PEN NDL 33G 4MM
- COMFORT TOUCH PEN NDL 33G 6MM
- COMFORT TOUCH PEN NDL 33GX5MM
- CURITY ALCOHOL PREPS 2 PLY,MEDIUM
- CURITY GAUZE PADS
- CURITY GAUZE SPONGES (12 PLY)-200/BAG
- DERMACEA 2"X2" GAUZE 12 PLY, USP TYPE VII
- DERMACEA GAUZE 2"X2" SPONGE 8 PLY
- DERMACEA NON-WOVEN 2"X2" SPNGE
- DROPLET 0.3 ML 29G 12.7MM(1/2) OUTER
- DROPLET 0.3 ML 30G 12.7MM(1/2) OUTER
- DROPLET 0.5 ML 29GX12.5MM(1/2)
- DROPLET 0.5 ML 30GX12.5MM(1/2)
- DROPLET INS 0.3 ML 29GX12.5MM
- DROPLET INS 0.3 ML 30G 8MM(1/2) OUTER
- DROPLET INS 0.3 ML 30GX12.5MM
- DROPLET INS 0.3 ML 31G 6MM(1/2) OUTER
- DROPLET INS 0.3 ML 31G 8MM(1/2) OUTER
- DROPLET INS 0.5 ML 29G 12.7MM OUTER
- DROPLET INS 0.5 ML 30G 12.7MM OUTER
- DROPLET INS 0.5 ML 30GX6MM(1/2)
- DROPLET INS 0.5 ML 30GX8MM(1/2)
- DROPLET INS 0.5 ML 31GX6MM(1/2)
- DROPLET INS 0.5 ML 31GX8MM(1/2)
- DROPLET INS SYR 0.3 ML 30GX6MM
- DROPLET INS SYR 0.3 ML 30GX8MM
- DROPLET INS SYR 0.3 ML 31GX6MM
- DROPLET INS SYR 0.3 ML 31GX8MM
- DROPLET INS SYR 0.5 ML 30G 8MM OUTER
- DROPLET INS SYR 0.5 ML 31G 6MM OUTER
- DROPLET INS SYR 0.5 ML 31G 8MM OUTER
- DROPLET INS SYR 1 ML 29G 12.7MM OUTER
- DROPLET INS SYR 1 ML 30G 12.5MM
- DROPLET INS SYR 1 ML 30G 6MM
- DROPLET INS SYR 1 ML 30G 8MM OUTER
- DROPLET INS SYR 1 ML 31G 6MM OUTER
- DROPLET INS SYR 1 ML 31G 8MM
- DROPLET MICRON 34G X 9/64"
- DROPLET PEN NEEDLE 29G 10MM
- DROPLET PEN NEEDLE 29G 12MM
- DROPLET PEN NEEDLE 30G 8MM
- DROPLET PEN NEEDLE 31G 5MM
- DROPLET PEN NEEDLE 31G 6MM
- DROPLET PEN NEEDLE 31G 8MM
- DROPLET PEN NEEDLE 32G 4MM
- DROPLET PEN NEEDLE 32G 5MM
- DROPLET PEN NEEDLE 32G 6MM
- DROPLET PEN NEEDLE 32G 8MM
- DROPSAFE ALCOHOL 70% PREP PADS
- DROPSAFE INS SYR 0.3 ML 31G 6MM
- DROPSAFE INS SYR 0.3 ML 31G 8MM
- DROPSAFE INS SYR 0.5 ML 31G 6MM
- DROPSAFE INS SYR 0.5 ML 31G 8MM
- DROPSAFE INSUL SYR 1 ML 31G 6MM
- DROPSAFE INSUL SYR 1 ML 31G 8MM
- DROPSAFE INSULN 1 ML 29G 12.5MM
- DROPSAFE PEN NEEDLE 31G 4MM

Please refer to our Evidence of Coverage for 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.

- DROPSAFE PEN NEEDLE 31G 5MM
- DROPSAFE PEN NEEDLE 31G 8MM
- DROPSAFE PEN NEEDLE 31GX1/4"
- EASY CMFT SFTY PEN NDL 31G 5MM
- EASY CMFT SFTY PEN NDL 31G 6MM
- EASY CMFT SFTY PEN NDL 32G 4MM
- EASY COMFORT 0.3 ML 31G 1/2"
- EASY COMFORT 0.3 ML 31G 5/16"
- EASY COMFORT 0.5 ML 30GX1/2"
- EASY COMFORT 0.5 ML 31GX5/16"
- EASY COMFORT 0.5 ML 32GX5/16"
- EASY COMFORT 0.5 ML SYRINGE
- EASY COMFORT 1 ML 31GX5/16"
- EASY COMFORT 1 ML 32GX5/16"
- EASY COMFORT ALCOHOL 70% PAD
- EASY COMFORT INSULIN 1 ML SYR
- EASY COMFORT PEN NDL 29G 4MM
- EASY COMFORT PEN NDL 29G 5MM
- EASY COMFORT PEN NDL 31GX1/4"
- EASY COMFORT PEN NDL 31GX3/16"
- EASY COMFORT PEN NDL 31GX5/16"
- EASY COMFORT PEN NDL 32GX5/32"
- EASY COMFORT PEN NDL 33G 4MM
- EASY COMFORT PEN NDL 33G 5MM
- EASY COMFORT PEN NDL 33G 6MM
- EASY COMFORT SYR 0.5 ML 29G 8MM
- EASY COMFORT SYR 1 ML 29G 8MM
- EASY COMFORT SYR 1 ML 30GX1/2"
- EASY GLIDE INS 0.3 ML 31GX6MM
- EASY GLIDE INS 0.5 ML 31GX6MM
- EASY GLIDE INS 1 ML 31GX6MM
- EASY GLIDE PEN NEEDLE 4MM 33G
- EASY TOUCH 0.3 ML 30G 8MM(1/2)
- EASY TOUCH 0.3 ML 31G 6MM(1/2)
- EASY TOUCH 0.3 ML 31G 8MM(1/2)
- EASY TOUCH 0.3 ML SYR 30GX1/2"
- EASY TOUCH 0.5 ML SYR 27GX1/2"
- EASY TOUCH 0.5 ML SYR 29GX1/2"
- EASY TOUCH 0.5 ML SYR 30GX1/2"
- EASY TOUCH 0.5 ML SYR 30GX5/16
- EASY TOUCH 1 ML SYR 29GX1/2"
- EASY TOUCH 1 ML SYR 30GX1/2"
- EASY TOUCH ALCOHOL 70% PADS GAMMA-STERILIZED
- EASY TOUCH AUTO 0.5 ML 30G 6MM
- EASY TOUCH AUTO 0.5 ML 30G 8MM
- EASY TOUCH AUTORET 1 ML 30G 6MM
- EASY TOUCH AUTORET 1 ML 30G 8MM
- EASY TOUCH FLIPLOK 1 ML 27GX0.5
- EASY TOUCH INS 0.3 ML 30G 8MM
- EASY TOUCH INS 0.3 ML 31G 8MM
- EASY TOUCH INS 0.5 ML 30G 8MM
- EASY TOUCH INS 0.5 ML 31G 6MM
- EASY TOUCH INS 0.5 ML 31G 8MM
- EASY TOUCH INS 1 ML 27G 1/2"
- EASY TOUCH INS 1 ML 28G 12.7MM
- EASY TOUCH INS SYR 1 ML 30G 8MM
- EASY TOUCH INS SYR 1 ML 31G 6MM
- EASY TOUCH INS SYR 1 ML 31G 8MM
- EASY TOUCH INSULIN 1 ML 29GX1/2
- EASY TOUCH INSULIN 1 ML 30GX1/2
- EASY TOUCH INSULIN SYR 1 ML
- EASY TOUCH INSULIN SYR 1 ML RETRACTABLE
- EASY TOUCH INSULN 1 ML 29GX1/2"
- EASY TOUCH INSULN 1 ML 30GX1/2"
- EASY TOUCH INSULN 1 ML 30GX5/16
- EASY TOUCH INSULN 1 ML 31GX5/16
- EASY TOUCH LUER LOK INSUL 1 ML
- EASY TOUCH PEN NEEDLE 29GX1/2"
- EASY TOUCH PEN NEEDLE 30GX5/16
- EASY TOUCH PEN NEEDLE 31GX1/4"
- EASY TOUCH PEN NEEDLE 31GX3/16
- EASY TOUCH PEN NEEDLE 31GX5/16
- EASY TOUCH PEN NEEDLE 32GX1/4"
- EASY TOUCH PEN NEEDLE 32GX3/16
- EASY TOUCH PEN NEEDLE 32GX5/32

Please refer to our Evidence of Coverage for 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.

- EASY TOUCH SAF PEN NDL 29G 5MM
- EASY TOUCH SAF PEN NDL 29G 8MM
- EASY TOUCH SAF PEN NDL 30G 5MM
- EASY TOUCH SAF PEN NDL 30G 8MM
- EASY TOUCH SYR 0.5 ML 28G 12.7MM
- EASY TOUCH SYR 0.5 ML 29G 12.7MM
- EASY TOUCH SYR 1 ML 27G 16MM
- EASY TOUCH UNI-SLIP SYR 1 ML
- EASYLIFE ALCOHOL 70% PADS
- EASYLIFE INS PEN NDL 29G 12MM
- EASYLIFE INS PEN NDL 31G 4MM
- EASYLIFE INS PEN NDL 31G 5MM
- EASYLIFE INS PEN NDL 31G 6MM
- EASYLIFE INS PEN NDL 31G 8MM
- EASYLIFE INS PEN NDL 32G 4MM
- EASYLIFE INS PEN NDL 32G 5MM
- EASYLIFE INS PEN NDL 32G 6MM
- EASYLIFE INS PEN NDL 32G 8MM
- EASYLIFE INS PEN NDL 33G 4MM
- EASYLIFE INS PEN NDL 33G 5MM
- EASYLIFE INS PEN NDL 33G 6MM
- EASYLIFE INS PEN NDL 33G 8MM
- EASYLIFE INS SYR 0.5 ML 30G 8MM
- EASYLIFE INS SYR 1 ML 30G 8MM
- EASYLIFE INS SYR 1 ML 31G 8MM
- EASYLIFE SAFTY PEN NDL 31G 4MM
- EASYLIFE SAFTY PEN NDL 31G 5MM
- EASYLIFE SYR 1 ML 30G 12.7MM
- EASYTOUCH SAF PEN NDL 30G 6MM
- EMBRACE PEN NEEDLE 29G 12MM
- EMBRACE PEN NEEDLE 30G 5MM
- EMBRACE PEN NEEDLE 30G 8MM
- EMBRACE PEN NEEDLE 31G 5MM
- EMBRACE PEN NEEDLE 31G 6MM
- EMBRACE PEN NEEDLE 31G 8MM
- EMBRACE PEN NEEDLE 32G 4MM
- EXEL U100 0.3 ML 29GX1/2"
- EXEL U100 0.3 ML 30GX5/16"
- FT STERILE PADS 2" X 2"
- GAUZE PAD TOPICAL BANDAGE 2 X 2 "
- GNP ALCOHOL SWAB STERILE, TWO PLY
- GNP PEN NEEDLE 31G 5MM
- GNP PEN NEEDLE 32G 6MM
- GNP SIMPLI PEN NEEDLE 32G 4MM
- GNP ULT C 0.3 ML 29GX1/2" (1/2) 1/2 UNIT
- GNP ULT CMFRT 0.5 ML 29GX1/2"
- GNP ULTR CMFRT 0.5 ML 30GX5/16
- GNP ULTRA COMFORT 1 ML SYRINGE
- GNP ULTRA COMFORT 3/10 ML SYR
- GS PEN NEEDLE 31G X 8MM
- HEALTHWISE INS 0.3 ML 30GX5/16"
- HEALTHWISE INS 0.3 ML 31GX5/16"
- HEALTHWISE INS 0.5 ML 30GX5/16"
- HEALTHWISE INS 0.5 ML 31GX5/16"
- HEALTHWISE INS 1 ML 30GX5/16"
- HEALTHWISE INS 1 ML 31GX5/16"
- HEALTHWISE PEN NEEDLE 31G 5MM
- HEALTHWISE PEN NEEDLE 31G 8MM
- HEALTHWISE PEN NEEDLE 32G 4MM
- HEALTHY ACCENTS PENTIP 5MM 31G
- HEALTHY ACCENTS PENTIP 6MM 31G
- HEALTHY ACCENTS PENTIP 8MM 31G
- HEALTHY ACCENTS PENTP 12MM 29G
- HEB INCONTROL ALCOHOL 70% PADS
- INCONTROL PEN NEEDLE 12MM 29G
- INCONTROL PEN NEEDLE 4MM 32G
- INCONTROL PEN NEEDLE 5MM 31G
- INCONTROL PEN NEEDLE 6MM 31G

Please refer to our Evidence of Coverage for 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.

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

Please refer to our Evidence of Coverage for 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.

- MONOJECT INSULIN SYR 0.5 ML
- MONOJECT INSULIN SYR 0.5 ML (OTC)
- MONOJECT INSULIN SYR 1 ML 3'S (OTC)
- MONOJECT INSULIN SYR U-100
- MONOJECT SYRINGE 0.3 ML
- MONOJECT SYRINGE 0.5 ML
- MONOJECT SYRINGE 1 ML
- NANO 2 GEN PEN NEEDLE 32G 4MM
- NANO PEN NEEDLE 32G 4MM
- NOVOFINE 32G NEEDLES
- NOVOFINE AUTOCOVER 30G NEEDLE
- NOVOFINE PLUS PEN NDL 32GX1/6"
- PEN NEEDLE 30G 5MM OUTER
- PEN NEEDLE 30G 8MM INNER
- PEN NEEDLE 30G X 5/16"
- PEN NEEDLE 31G X 1/4" HRI
- PEN NEEDLE 33G 4MM
- PEN NEEDLE, DIABETIC NEEDLE 29 GAUGE X 1/2"
- PEN NEEDLES 12MM 29G 29GX12MM,STRL
- PEN NEEDLES 4MM 32G
- PEN NEEDLES 5MM 31G 31GX5MM,STRL,MINI (OTC)
- PEN NEEDLES 8MM 31G 31GX8MM,STRL,SHORT (OTC)
- PENTIPS PEN NEEDLE 29G 1/2"
- PENTIPS PEN NEEDLE 31G 1/4"
- PENTIPS PEN NEEDLE 31GX3/16" MINI, 5MM
- PENTIPS PEN NEEDLE 31GX5/16" SHORT, 8MM
- PENTIPS PEN NEEDLE 32G 1/4"
- PENTIPS PEN NEEDLE 32GX5/32"
- PIP PEN NEEDLE 31G X 5MM
- PIP PEN NEEDLE 32G X 4MM
- PREVENT PEN NEEDLE 31GX1/4"
- PREVENT PEN NEEDLE 31GX5/16"
- PRO COMFORT 0.5 ML 30GX1/2"
- PRO COMFORT 0.5 ML 30GX5/16"
- PRO COMFORT 0.5 ML 31GX5/16"
- PRO COMFORT 1 ML 30GX1/2"
- PRO COMFORT 1 ML 30GX5/16"
- PRO COMFORT 1 ML 31GX5/16"
- PRO COMFORT ALCOHOL 70% PADS
- PRO COMFORT PEN NDL 32G 8MM
- PRO COMFORT PEN NDL 32G X 1/4"
- PRO COMFORT PEN NDL 4MM 32G
- PRO COMFORT PEN NDL 5MM 32G
- PRO-COMFORT ALCOHOL 70% PADS
- PRODIGY INS SYR 1 ML 28GX1/2"
- PRODIGY SYRNG 0.5 ML 31GX5/16"
- PRODIGY SYRNGE 0.3 ML 31GX5/16"
- PURE CMFT SFTY PEN NDL 31G 5MM
- PURE CMFT SFTY PEN NDL 31G 6MM
- PURE CMFT SFTY PEN NDL 32G 4MM
- PURE COMFORT ALCOHOL 70% PADS
- PURE COMFORT PEN NDL 32G 4MM
- PURE COMFORT PEN NDL 32G 5MM
- PURE COMFORT PEN NDL 32G 6MM
- PURE COMFORT PEN NDL 32G 8MM
- RA ISOPROPYL ALCOHOL 70% WIPES
- RA STERILE PADS 2"X 2"
- RAYA SURE PEN NEEDLE 29G 12MM
- RAYA SURE PEN NEEDLE 31G 4MM
- RAYA SURE PEN NEEDLE 31G 5MM
- RAYA SURE PEN NEEDLE 31G 6MM
- RELION INS SYR 0.3 ML 31GX6MM
- RELION INS SYR 0.5 ML 31GX6MM
- RELION INS SYR 1 ML 31GX15/64"
- RELION PEN NEEDLE 32GX5/32"
- RELION SYRING 0.3 ML 31GX5/16" INNER
- RELION SYRING 0.5 ML 31GX5/16" INNER (OTC)
- SAFESNAP INS SYR UNITS-100 0.3 ML 30GX5/16",10X10
- SAFESNAP INS SYR UNITS-100 0.5 ML 29GX1/2",10X10
- SAFESNAP INS SYR UNITS-100 0.5 ML 30GX5/16",10X10

Please refer to our Evidence of Coverage for 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.

- SAFESNAP INS SYR UNITS-100 1 ML 28GX1/2",10X10
- SAFESNAP INS SYR UNITS-100 1 ML 29GX1/2",10X10
- SAFETY PEN NEEDLE 31G 4MM
- SAFETY PEN NEEDLE 5MM X 31G
- SAFETY SYRINGE 0.5 ML 30G 1/2"
- SECURESAFE PEN NDL 30GX5/16" OUTER
- SECURESAFE PEN NEEDLE 31G 5MM OUTER
- SECURESAFE SYR 0.5 ML 29G 1/2" OUTER
- SECURESAFE SYRNG 1 ML 29G 1/2" OUTER
- SKY SAFETY PEN NEEDLE 30G 5MM
- SKY SAFETY PEN NEEDLE 30G 8MM
- SURE CMFT SFTY PEN NDL 31G 6MM
- SURE CMFT SFTY PEN NDL 32G 4MM
- SURE COMFORT 0.5 ML SYRINGE
- SURE COMFORT 1 ML SYRINGE
- SURE COMFORT 3/10 ML SYRINGE
- SURE COMFORT 3/10 ML SYRINGE INSULIN SYRINGE
- SURE COMFORT 30G PEN NEEDLE
- SURE COMFORT ALCOHOL PREP PADS
- SURE COMFORT INS 0.3 ML 31GX1/4
- SURE COMFORT INS 0.5 ML 31GX1/4
- SURE COMFORT INS 1 ML 31GX1/4"
- SURE COMFORT PEN NDL 29GX1/2" 12.7MM
- SURE COMFORT PEN NDL 31G 5MM
- SURE COMFORT PEN NDL 31G 8MM
- SURE COMFORT PEN NDL 32G 4MM
- SURE COMFORT PEN NDL 32G 6MM
- SURE-FINE PEN NEEDLES 12.7MM
- SURE-FINE PEN NEEDLES 5MM
- SURE-FINE PEN NEEDLES 8MM
- SURE-JECT INSU SYR U100 0.3 ML
- SURE-JECT INSU SYR U100 0.5 ML
- SURE-JECT INSU SYR U100 1 ML
- SURE-JECT INSUL SYR U100 1 ML
- SURE-JECT INSULIN SYRINGE 1 ML
- SURE-PREP ALCOHOL PREP PADS
- TECHLITE 0.3 ML 29GX12MM (1/2)
- TECHLITE 0.3 ML 30GX8MM (1/2)
- TECHLITE 0.3 ML 31GX6MM (1/2)
- TECHLITE 0.3 ML 31GX8MM (1/2)
- TECHLITE 0.5 ML 30GX12MM (1/2)
- TECHLITE 0.5 ML 30GX8MM (1/2)
- TECHLITE 0.5 ML 31GX6MM (1/2)
- TECHLITE 0.5 ML 31GX8MM (1/2)
- TECHLITE INS SYR 1 ML 29GX12MM
- TECHLITE INS SYR 1 ML 30GX12MM
- TECHLITE INS SYR 1 ML 31GX6MM
- TECHLITE INS SYR 1 ML 31GX8MM
- TECHLITE PEN NEEDLE 29GX1/2"
- TECHLITE PEN NEEDLE 29GX3/8"
- TECHLITE PEN NEEDLE 31GX1/4"
- TECHLITE PEN NEEDLE 31GX3/16"
- TECHLITE PEN NEEDLE 31GX5/16"
- TECHLITE PEN NEEDLE 32GX1/4"
- TECHLITE PEN NEEDLE 32GX5/16"
- TECHLITE PEN NEEDLE 32GX5/32"
- TECHLITE PLUS PEN NDL 32G 4MM
- TERUMO INS SYRINGE U100-1 ML
- TERUMO INS SYRINGE U100-1/2 ML
- TERUMO INS SYRINGE U100-1/3 ML
- TERUMO INS SYRNG U100-1/2 ML
- THINPRO INS SYRIN U100-0.3 ML
- THINPRO INS SYRIN U100-0.5 ML
- THINPRO INS SYRIN U100-1 ML
- TOPFINE INSULN PEN NDL 32G 4MM
- TRUE CMFRT PRO 0.5 ML 30G 5/16"
- TRUE CMFRT PRO 0.5 ML 31G 5/16"
- TRUE CMFRT PRO 0.5 ML 32G 5/16"
- TRUE CMFT SFTY PEN NDL 31G 5MM
- TRUE CMFT SFTY PEN NDL 31G 6MM
- TRUE CMFT SFTY PEN NDL 32G 4MM
- TRUE COMFORT 0.5 ML 30G 1/2"
- TRUE COMFORT 0.5 ML 30G 5/16"
- TRUE COMFORT 0.5 ML 31G 5/16"

Please refer to our Evidence of Coverage for 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.

- TRUE COMFORT 0.5 ML 31GX5/16"
- TRUE COMFORT 1 ML 31GX5/16"
- TRUE COMFORT ALCOHOL 70% PADS
- TRUE COMFORT PEN NDL 31G 8MM
- TRUE COMFORT PEN NDL 31GX5MM
- TRUE COMFORT PEN NDL 31GX6MM
- TRUE COMFORT PEN NDL 32G 5MM
- TRUE COMFORT PEN NDL 32G 6MM
- TRUE COMFORT PEN NDL 32GX4MM
- TRUE COMFORT PEN NDL 33G 4MM
- TRUE COMFORT PEN NDL 33G 5MM
- TRUE COMFORT PEN NDL 33G 6MM
- TRUE COMFORT PRO 1 ML 30G 1/2"
- TRUE COMFORT PRO 1 ML 30G 5/16"
- TRUE COMFORT PRO 1 ML 31G 5/16"
- TRUE COMFORT PRO 1 ML 32G 5/16"
- TRUE COMFORT PRO ALCOHOL PADS
- TRUE COMFORT SFTY 1 ML 30G 1/2"
- TRUE COMFRT PRO 0.5 ML 30G 1/2"
- TRUE COMFRT SFTY 1 ML 30G 5/16"
- TRUE COMFRT SFTY 1 ML 31G 5/16"
- TRUE COMFRT SFTY 1 ML 32G 5/16"
- TRUE-CMFRT PRO PEN NDL 31G 5MM
- TRUE-CMFRT PRO PEN NDL 31G 6MM
- TRUE-CMFRT PRO PEN NDL 31G 8MM
- TRUE-CMFRT PRO PEN NDL 32G 4MM
- TRUEPLUS PEN NEEDLE 29GX1/2"
- TRUEPLUS PEN NEEDLE 31G X 1/4"
- TRUEPLUS PEN NEEDLE 31GX3/16"
- TRUEPLUS PEN NEEDLE 31GX5/16"
- TRUEPLUS PEN NEEDLE 32GX5/32"
- TRUEPLUS SYR 0.3 ML 29GX1/2"
- TRUEPLUS SYR 0.3 ML 30GX5/16"
- TRUEPLUS SYR 0.3 ML 31GX5/16"
- TRUEPLUS SYR 0.5 ML 28GX1/2"
- TRUEPLUS SYR 0.5 ML 29GX1/2"
- TRUEPLUS SYR 0.5 ML 30GX5/16"
- TRUEPLUS SYR 0.5 ML 31GX5/16"
- TRUEPLUS SYR 1 ML 28GX1/2"
- TRUEPLUS SYR 1 ML 29GX1/2"
- TRUEPLUS SYR 1 ML 30GX5/16"
- TRUEPLUS SYR 1 ML 31GX5/16"
- ULT CFT 0.3 ML 31GX5/16" (1/2) 1/2 UNIT
- ULTICAR INS 0.3 ML 31GX1/4(1/2)
- ULTICARE INS 0.3 ML 31GX1/4"
- ULTICARE INS 0.5 ML 31GX1/4"
- ULTICARE INS 1 ML 31GX1/4"
- ULTICARE INS SYR 1 ML 30GX1/2"
- ULTICARE PEN NEEDLE 31GX3/16"
- ULTICARE PEN NEEDLE 6MM 31G
- ULTICARE PEN NEEDLE 8MM 31G
- ULTICARE PEN NEEDLES 12MM 29G
- ULTICARE PEN NEEDLES 4MM 32G MICRO, 32GX4MM
- ULTICARE PEN NEEDLES 6MM 32G
- ULTICARE SAFE PEN NDL 30G 8MM
- ULTICARE SAFE PEN NDL 5MM 30G
- ULTICARE SYR 0.3 ML 30GX1/2"
- ULTICARE SYR 0.3 ML 31GX5/16" SHORT NDL
- ULTICARE SYR 0.5 ML 30GX1/2"
- ULTICARE SYR 0.5 ML 31GX5/16" SHORT NDL
- ULTICARE SYR 1 ML 31GX5/16"
- ULTIGUARD SAFE 1 ML 30G 12.7MM
- ULTIGUARD SAFE0.3 ML 30G 12.7MM
- ULTIGUARD SAFE0.5 ML 30G 12.7MM
- ULTIGUARD SAFEPACK 1 ML 31G 8MM
- ULTIGUARD SAFEPACK 29G 12.7MM
- ULTIGUARD SAFEPACK 31G 5MM
- ULTIGUARD SAFEPACK 31G 6MM
- ULTIGUARD SAFEPACK 31G 8MM
- ULTIGUARD SAFEPACK 32G 4MM
- ULTIGUARD SAFEPACK 32G 6MM
- ULTIGUARD SAFEPK 0.3 ML 31G 8MM

Please refer to our Evidence of Coverage for 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.

- ULTIGUARD SAFEPK 0.5 ML 31G 8MM
- ULTILET ALCOHOL STERL SWAB
- ULTILET INSULIN SYRINGE 0.3 ML
- ULTILET INSULIN SYRINGE 0.5 ML
- ULTILET INSULIN SYRINGE 1 ML
- ULTILET PEN NEEDLE
- ULTILET PEN NEEDLE 4MM 32G
- ULTRA COMFORT 0.3 ML 29GX1/2"
- ULTRA COMFORT 0.3 ML SYRINGE
- ULTRA COMFORT 0.5 ML 28GX1/2" CONVERTS TO 29G
- ULTRA COMFORT 0.5 ML 29GX1/2"
- ULTRA COMFORT 0.5 ML 31GX5/16"
- ULTRA COMFORT 0.5 ML SYRINGE
- ULTRA COMFORT 1 ML 29GX1/2"
- ULTRA COMFORT 1 ML 30GX5/16"
- ULTRA COMFORT 1 ML 31GX5/16"
- ULTRA COMFORT 1 ML SYRINGE
- ULTRA FLO 0.3 ML 30G 1/2" (1/2)
- ULTRA FLO 0.3 ML 30G 5/16"(1/2)
- ULTRA FLO 0.3 ML 31G 5/16"(1/2)
- ULTRA FLO PEN NEEDLE 31G 5MM
- ULTRA FLO PEN NEEDLE 31G 8MM
- ULTRA FLO PEN NEEDLE 32G 4MM
- ULTRA FLO PEN NEEDLE 33G 4MM
- ULTRA FLO PEN NEEDLES 12MM 29G
- ULTRA FLO SYR 0.3 ML 29GX1/2"
- ULTRA FLO SYR 0.3 ML 30G 5/16"
- ULTRA FLO SYR 0.3 ML 31G 5/16"
- ULTRA FLO SYR 0.5 ML 29G 1/2"
- ULTRA THIN PEN NDL 32G X 4MM
- ULTRA-FINE 0.3 ML 30G 12.7MM
- ULTRA-FINE 0.3 ML 31G 6MM (1/2)
- ULTRA-FINE 0.3 ML 31G 8MM (1/2)
- ULTRA-FINE 0.5 ML 30G 12.7MM
- ULTRA-FINE INS SYR 1 ML 31G 6MM
- ULTRA-FINE INS SYR 1 ML 31G 8MM
- ULTRA-FINE PEN NDL 29G 12.7MM
- ULTRA-FINE PEN NEEDLE 31G 5MM
- ULTRA-FINE PEN NEEDLE 31G 8MM
- ULTRA-FINE PEN NEEDLE 32G 6MM
- ULTRA-FINE SYR 0.3 ML 31G 6MM
- ULTRA-FINE SYR 0.3 ML 31G 8MM
- ULTRA-FINE SYR 0.5 ML 31G 6MM
- ULTRA-FINE SYR 0.5 ML 31G 8MM
- ULTRA-FINE SYR 1 ML 30G 12.7MM
- ULTRA-THIN II 1 ML 31GX5/16"
- ULTRA-THIN II INS 0.3 ML 30G
- ULTRA-THIN II INS 0.3 ML 31G
- ULTRA-THIN II INS 0.5 ML 29G
- ULTRA-THIN II INS 0.5 ML 30G
- ULTRA-THIN II INS 0.5 ML 31G
- ULTRA-THIN II INS SYR 1 ML 29G
- ULTRA-THIN II INS SYR 1 ML 30G
- ULTRA-THIN II PEN NDL 29GX1/2"
- ULTRA-THIN II PEN NDL 31GX5/16
- ULTRACARE INS 0.3 ML 30GX5/16"
- ULTRACARE INS 0.3 ML 31GX5/16"
- ULTRACARE INS 0.5 ML 30GX1/2"
- ULTRACARE INS 0.5 ML 30GX5/16"
- ULTRACARE INS 0.5 ML 31GX5/16"
- ULTRACARE INS 1 ML 30G X 5/16"
- ULTRACARE INS 1 ML 30GX1/2"
- ULTRACARE INS 1 ML 31G X 5/16"
- ULTRACARE PEN NEEDLE 31GX1/4"
- ULTRACARE PEN NEEDLE 31GX3/16"
- ULTRACARE PEN NEEDLE 31GX5/16"
- ULTRACARE PEN NEEDLE 32GX1/4"
- ULTRACARE PEN NEEDLE 32GX3/16"
- ULTRACARE PEN NEEDLE 32GX5/32"
- ULTRACARE PEN NEEDLE 33GX5/32"
- UNIFINE OTC PEN NEEDLE 31G 5MM
- UNIFINE OTC PEN NEEDLE 32G 4MM
- UNIFINE PENTIPS 12MM 29G 29GX12MM, STRL
- UNIFINE PENTIPS 31GX3/16" 31GX5MM,STRL,MINI
- UNIFINE PENTIPS 32G 4MM
- UNIFINE PENTIPS 32GX1/4"
- UNIFINE PENTIPS 33GX5/32"
- UNIFINE PENTIPS 6MM 31G
- UNIFINE PENTIPS 8MM 31G 31GX8MM, SHORT, STRL
- UNIFINE PENTIPS MAX 30GX3/16"

Please refer to our Evidence of Coverage for 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.

- UNIFINE PENTIPS PLUS 29GX1/2" 12MM
- UNIFINE PENTIPS PLUS 30GX3/16"
- UNIFINE PENTIPS PLUS 31G 5MM
- UNIFINE PENTIPS PLUS 31GX1/4" ULTRA SHORT, 6MM
- UNIFINE PENTIPS PLUS 32GX5/32"
- UNIFINE PENTIPS PLUS 33GX5/32"
- UNIFINE PROTECT 30G 5MM
- UNIFINE PROTECT 30G 8MM
- UNIFINE PROTECT 32G 4MM
- UNIFINE SAFECONTROL 30G 5MM
- UNIFINE SAFECONTROL 30G 8MM
- UNIFINE SAFECONTROL 31G 5MM
- UNIFINE SAFECONTROL 31G 6MM
- UNIFINE SAFECONTROL 31G 8MM
- UNIFINE SAFECONTROL 32G 4MM
- UNIFINE ULTR PEN NDL 34G 3.5MM
- UNIFINE ULTRA PEN NDL 29G 12MM
- UNIFINE ULTRA PEN NDL 31G 5MM
- UNIFINE ULTRA PEN NDL 31G 6MM
- UNIFINE ULTRA PEN NDL 31G 8MM
- UNIFINE ULTRA PEN NDL 32G 4MM
- UNIFINE ULTRA PEN NDL 32G 6MM
- VANISHPOINT 0.5 ML 30GX1/2" SY OUTER
- VANISHPOINT INS 0.5 ML 30G 8MM OUTER
- VANISHPOINT INS 1 ML 30GX3/16"
- VANISHPOINT U-100 29X1/2 SYR
- VERIFINE INS SYR 1 ML 29G 1/2"
- VERIFINE PEN NEEDLE 29G 12MM
- VERIFINE PEN NEEDLE 31G 5MM
- VERIFINE PEN NEEDLE 31G X 6MM
- VERIFINE PEN NEEDLE 31G X 8MM
- VERIFINE PEN NEEDLE 32G 6MM
- VERIFINE PEN NEEDLE 32G X 4MM
- VERIFINE PEN NEEDLE 32G X 5MM
- VERIFINE PLUS PEN NDL 31G 5MM
- VERIFINE PLUS PEN NDL 31G 8MM
- VERIFINE PLUS PEN NDL 32G 4MM
- VERIFINE PLUS PEN NDL 32G 4MM-SHARPS CONTAINER
- VERIFINE SYRING 0.5 ML 29G 1/2"
- VERIFINE SYRING 1 ML 31G 5/16"
- VERIFINE SYRNG 0.3 ML 31G 5/16"
- VERIFINE SYRNG 0.5 ML 31G 5/16"
- VERSALON ALL PURPOSE SPONGE 25'S,N-STERILE,3PLY
- WEBCOL ALCOHOL PREPS 20'S,LARGE
- WM UNIFINE PENTIP PLUS 8MM 31G W/ SAFETY CLICK

PA Criteria	Criteria Details
Exclusion Criteria	ONLY COVERED UNDER PART D WHEN USED CONCURRENTLY WITH INSULIN.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	

Please refer to our Evidence of Coverage for 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
Coverage Duration	PLAN YEAR
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

INTERFERON FOR MS-AVONEX

Products Affected

- AVONEX INTRAMUSCULAR PEN INJECTOR KIT
- AVONEX INTRAMUSCULAR SYRINGE KIT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
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.

INTERFERON FOR MS-BETASERON

Products Affected

- BETASERON SUBCUTANEOUS KIT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
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.

INTERFERON FOR MS-PLEGRIDY

Products Affected

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

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

INTERFERON GAMMA-1B

Products Affected

- ACTIMMUNE

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

Please refer to our Evidence of Coverage for 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.

ISAVUCONAZONIUM

Products Affected

- CRESEMBA ORAL

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	INVASIVE ASPERGILLOSIS, INVASIVE MUCORMYCOSIS: PRESCRIBED BY OR IN CONSULTATION WITH AN INFECTIOUS DISEASE SPECIALIST.
Coverage Duration	PLAN YEAR
Other Criteria	INVASIVE ASPERGILLOSIS: TRIAL OF OR CONTRAINDICATION TO VORICONAZOLE. CONTINUATION OF THERAPY AFTER HOSPITAL DISCHARGE REQUIRES NO EXTRA CRITERIA.
Indications	All FDA-approved Indications.
Off Label Uses	
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.

IVACAFTOR

Products Affected

- KALYDECO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	CYSTIC FIBROSIS (CF): INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A PULMONOLOGIST OR CYSTIC FIBROSIS EXPERT
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
Other Criteria	CF: INITIAL: 1) NOT HOMOZYGOUS FOR F508DEL MUTATION IN THE CYSTIC FIBROSIS TRANSMEMBRANE CONDUCTANCE REGULATOR (CFTR) GENE, AND 2) NO CONCURRENT USE WITH ANOTHER CFTR MODULATOR. RENEWAL: 1) IMPROVEMENT IN CLINICAL STATUS, AND 2) NO CONCURRENT USE WITH ANOTHER CFTR MODULATOR.
Indications	All FDA-approved Indications.
Off Label Uses	
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.

IVOSIDENIB

Products Affected

- TIBSOVO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
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.

IXAZOMIB

Products Affected

- NINLARO

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

LAMOTRIGINE

Products Affected

- SUBVENITE ORAL SUSPENSION

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	ALL INDICATIONS: CONTRAINDICATION TO OR UNABLE TO SWALLOW LAMOTRIGINE TABLETS.
Indications	All FDA-approved Indications.
Off Label Uses	
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.

LANREOTIDE

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	ACROMEGALY: INITIAL: THERAPY IS PRESCRIBED BY OR IN CONSULTATION WITH AN ENDOCRINOLOGIST.
Coverage Duration	ACROMEGALY: INITIAL/RENEWAL: PLAN YEAR. GEP-NETS, CARCINOID SYNDROME: PLAN YEAR.
Other Criteria	ACROMEGALY: INITIAL: SERUM INSULIN-LIKE GROWTH FACTOR 1 (IGF-1) LEVEL (ADJUSTED FOR AGE) IS ELEVATED OR UNEQUIVOCAL WITH INADEQUATE SUPPRESSION OF GROWTH HORMONE AFTER A GLUCOSE LOAD. RENEWAL: 1) REDUCTION, NORMALIZATION, OR MAINTENANCE OF IGF-1 LEVELS BASED ON AGE AND GENDER, AND 2) IMPROVEMENT OR SUSTAINED REMISSION OF CLINICAL SYMPTOMS.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Please refer to our Evidence of Coverage for 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.

LAPATINIB

Products Affected

- *lapatinib*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
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.

LAROTRECTINIB

Products Affected

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

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

LAZERTINIB

Products Affected

- LAZCLUZE ORAL TABLET 240 MG, 80 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
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.

LECANEMAB-IRMB

Products Affected

- LEQEMBI IQLIK SUBCUTANEOUS AUTO-INJECTOR 360 MG/1.8 ML

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	ALZHEIMERS DISEASE: INITIAL: 1) CLINICAL DEMENTIA RATING GLOBAL SCORE OF 0.5 OR 1.0, OR 2) MINI MENTAL STATUS EXAM SCORE OF 22-30.
Age Restrictions	
Prescriber Restrictions	ALZHEIMERS DISEASE: INITIAL: THERAPY IS PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST, GERIATRICIAN, OR PSYCHIATRIST.
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
Other Criteria	ALZHEIMERS DISEASE: INITIAL: 1) PRESENCE OF AMYLOID-BETA PLAQUES, 2) BASELINE BRAIN MRI WITHIN ONE YEAR PRIOR TO TREATMENT, 3) NO HISTORY OF A CLOTTING DISORDER, AND 4) NO CONCURRENT USE WITH ANY ANTICOAGULANT OR ANTIPLATELET THERAPY EXCEPT FOR ASPIRIN AT 81MG DAILY OR LESS. RENEWAL: 1) COGNITIVE DECLINE HAS SLOWED OR STOPPED, 2) NOT EXPERIENCING ANY SEVERE, UNSTABLE, OR SYMPTOMATIC AMYLOID-RELATED IMAGING ABNORMALITIES, AND 3) NO CONCURRENT USE WITH ANY ANTICOAGULANT OR ANTIPLATELET THERAPY EXCEPT FOR ASPIRIN AT 81MG DAILY OR LESS.
Indications	All FDA-approved Indications.
Off Label Uses	
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.

LENALIDOMIDE

Products Affected

- *lenalidomide*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
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.

LENVATINIB

Products Affected

- LENVIMA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
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.

LETERMOVIR

Products Affected

- PREVYMIS ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	CYTOMEGALOVIRUS (CMV) PROPHYLAXIS: PRESCRIBED BY OR IN CONSULTATION WITH A TRANSPLANT SPECIALIST OR INFECTIOUS DISEASE SPECIALIST.
Coverage Duration	CMV PROPHYLAXIS: 7 MONTHS
Other Criteria	CMV PROPHYLAXIS FOR HSCT: 1) THERAPY WILL BE INITIATED BETWEEN DAY 0 AND DAY 28 POST TRANSPLANT, AND 2) WILL NOT RECEIVE THE MEDICATION BEYOND 200 DAYS POST TRANSPLANT. CMV PROPHYLAXIS FOR KIDNEY TRANSPLANT: 1) THERAPY WILL BE INITIATED BETWEEN DAY 0 AND DAY 7 POST TRANSPLANT, AND 2) WILL NOT RECEIVE THE MEDICATION BEYOND 200 DAYS POST TRANSPLANT.
Indications	All FDA-approved Indications.
Off Label Uses	
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.

LEUPROLIDE

Products Affected

- *leuprolide subcutaneous kit*

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

LEUPROLIDE DEPOT

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
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.

LEUPROLIDE MESYLATE

Products Affected

- CAMCEVI (6 MONTH)

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

LEUPROLIDE-ELIGARD

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
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.

LEUPROLIDE-LUPRON DEPOT

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: ENDOMETRIOSIS: DIAGNOSIS IS CONFIRMED VIA SURGICAL OR DIRECT VISUALIZATION (E.G., PELVIC ULTRASOUND) OR HISTOPATHOLOGICAL CONFIRMATION (E.G., LAPAROSCOPY OR LAPAROTOMY) IN THE LAST 10 YEARS.
Age Restrictions	
Prescriber Restrictions	INITIAL: ENDOMETRIOSIS, UTERINE FIBROIDS: PRESCRIBED BY OR IN CONSULTATION WITH AN OBSTETRICIAN/GYNECOLOGIST.
Coverage Duration	PROSTATE CA: PLAN YEAR. UTERINE FIBROIDS: 3 MOS. ENDOMETRIOSIS: INITIAL/RENEWAL: PLAN YEAR.
Other Criteria	INITIAL: ENDOMETRIOSIS, UTERINE FIBROIDS: NO CONCURRENT USE WITH ANOTHER GNRH-MODULATING AGENT. ENDOMETRIOSIS: 1) TRIAL OF OR CONTRAINDICATION TO BOTH OF THE FOLLOWING CLINICAL STANDARD OF CARE AGENTS: AN NSAID, A PROGESTIN-CONTAINING PREPARATION, AND 2) HAS NOT RECEIVED A TOTAL OF 12 MONTHS OF TREATMENT PER LIFETIME. RENEWAL: ENDOMETRIOSIS: 1) IMPROVEMENT OF PAIN RELATED TO ENDOMETRIOSIS WHILE ON THERAPY, 2) RECEIVING CONCOMITANT ADD-BACK THERAPY (I.E., COMBINATION ESTROGEN-PROGESTIN OR PROGESTIN-ONLY CONTRACEPTIVE PREPARATION), 3) NO CONCURRENT USE WITH ANOTHER GNRH-MODULATING AGENT, AND 4) HAS NOT RECEIVED A TOTAL OF 12 MONTHS OF TREATMENT PER LIFETIME.

Please refer to our Evidence of Coverage for 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 FDA-approved Indications.
Off Label Uses	
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.

LEUPROLIDE-LUPRON DEPOT-PED

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	CENTRAL PRECOCIOUS PUBERTY (CPP): INITIAL: FEMALES: ELEVATED LEVEL OF LUTEINIZING HORMONE (LH) LEVEL GREATER THAN 0.2 TO 0.3 MIU/ML AT DIAGNOSIS. MALES: ELEVATED LEVEL OF LH LEVEL GREATER THAN 0.2 TO 0.3 MIU/ML AT DIAGNOSIS.
Age Restrictions	
Prescriber Restrictions	CPP: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH AN ENDOCRINOLOGIST.
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
Other Criteria	CPP: INITIAL: FEMALES: 1) YOUNGER THAN 8 YEARS OF AGE AT ONSET OF CPP, AND 2) AT TANNER STAGE 2 OR ABOVE FOR BREAST DEVELOPMENT AND PUBIC HAIR GROWTH. MALES: 1) YOUNGER THAN 9 YEARS OF AGE AT ONSET OF CPP, AND 2) AT TANNER STAGE 2 OR ABOVE FOR GENITAL DEVELOPMENT AND PUBIC HAIR GROWTH. RENEWAL: 1) TANNER STAGING AT INITIAL DIAGNOSIS HAS STABILIZED OR REGRESSED DURING THREE SEPARATE MEDICAL VISITS IN THE PREVIOUS YEAR, AND 2) HAS NOT REACHED ACTUAL AGE WHICH CORRESPONDS TO CURRENT PUBERTAL AGE.
Indications	All FDA-approved Indications.
Off Label Uses	
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.

L-GLUTAMINE

Products Affected

- *glutamine (sickle cell)*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	SICKLE CELL DISEASE(SCD): INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A HEMATOLOGIST
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
Other Criteria	SCD: INITIAL: AGES 18 YEARS OR OLDER: 1) AT LEAST 2 SICKLE CELL CRISES IN THE PAST YEAR, 2) SICKLE-CELL ASSOCIATED SYMPTOMS WHICH ARE INTERFERING WITH ACTIVITIES OF DAILY LIVING, OR 3) HISTORY OF OR HAS RECURRENT ACUTE CHEST SYNDROME. AGES 5 TO 17 YEARS: APPROVED WITHOUT ADDITIONAL CRITERIA. RENEWAL: MAINTAINED OR EXPERIENCED A REDUCTION IN ACUTE COMPLICATIONS OF SCD.
Indications	All FDA-approved Indications.
Off Label Uses	
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.

LIDOCAINE OINTMENT

Products Affected

- *lidocaine topical ointment*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
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.

LIDOCAINE PATCH

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	1) PAIN ASSOCIATED WITH POST-HERPETIC NEURALGIA, 2) NEUROPATHY DUE TO DIABETES MELLITUS, 3) CHRONIC BACK PAIN, OR 4) OSTEOARTHRITIS OF THE KNEE OR HIP.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
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.

LIDOCAINE PRILOCAINE

Products Affected

- *lidocaine-prilocaine topical cream*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
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.

LORLATINIB

Products Affected

- LORBRENA ORAL TABLET 100 MG, 25 MG

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

LOTILANER

Products Affected

- XDEMVY

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	DEMODEX BLEPHARITIS: PRESENCE OF DEMODEX MITES CONFIRMED BY LIGHT MICROSCOPY OR SLIT LAMP EXAMINATION.
Age Restrictions	DEMODEX BLEPHARITIS: 18 YEARS OF AGE OR OLDER
Prescriber Restrictions	DEMODEX BLEPHARITIS: PRESCRIBED BY OR IN CONSULTATION WITH AN OPHTHALMOLOGIST OR OPTOMETRIST.
Coverage Duration	6 WEEKS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
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.

LUMACAFTOR-IVACAFTOR

Products Affected

- ORKAMBI ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	CYSTIC FIBROSIS (CF): INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A PULMONOLOGIST OR CF EXPERT.
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
Other Criteria	CF: INITIAL: NO CONCURRENT USE WITH ANOTHER CYSTIC FIBROSIS TRANSMEMBRANE CONDUCTANCE REGULATOR (CFTR) MODULATOR. RENEWAL: 1) IMPROVEMENT IN CLINICAL STATUS, AND 2) NO CONCURRENT USE WITH ANOTHER CFTR MODULATOR.
Indications	All FDA-approved Indications.
Off Label Uses	
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.

MACITENTAN

Products Affected

- *macitentan*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	PULMONARY ARTERIAL HYPERTENSION (PAH): INITIAL: DIAGNOSIS CONFIRMED BY RIGHT HEART CATHETERIZATION WITH THE FOLLOWING PARAMETERS: 1) MEAN PULMONARY ARTERY PRESSURE (PAP) GREATER THAN 20 MMHG, 2) PULMONARY CAPILLARY WEDGE PRESSURE (PCWP) OF 15 MMHG OR LESS, AND 3) PULMONARY VASCULAR RESISTANCE (PVR) GREATER THAN 2 WOOD UNITS.
Age Restrictions	
Prescriber Restrictions	PAH: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A CARDIOLOGIST OR PULMONOLOGIST.
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
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.

MARIBAVIR

Products Affected

- LIVTENCITY

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	CYTOMEGALOVIRUS (CMV): PRESCRIBED BY OR IN CONSULTATION WITH A TRANSPLANT SPECIALIST OR INFECTIOUS DISEASE SPECIALIST.
Coverage Duration	8 WEEKS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
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.

MECASERMIN

Products Affected

- INCRELEX

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	GROWTH FAILURE: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH AN ENDOCRINOLOGIST OR NEPHROLOGIST.
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
Other Criteria	GROWTH FAILURE: INITIAL: OPEN EPIPHYSES AS CONFIRMED BY RADIOGRAPH OF WRIST AND HAND. INITIAL/RENEWAL: NO CONCURRENT USE WITH ANOTHER GROWTH HORMONE MEDICATION. RENEWAL: IMPROVEMENT WHILE ON THERAPY (INCREASE IN HEIGHT OR INCREASE IN HEIGHT VELOCITY).
Indications	All FDA-approved Indications.
Off Label Uses	
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.

MECHLORETHAMINE

Products Affected

- VALCHLOR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
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.

MEPOLIZUMAB

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: ASTHMA: BLOOD EOSINOPHIL LEVEL OF AT LEAST 150 CELLS/MCL WITHIN THE PAST 12 MONTHS. EOSINOPHILIC CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD): BLOOD EOSINOPHIL LEVEL OF AT LEAST 150 CELLS/MCL AT SCREENING (I.E., WITHIN THE PAST 3 MONTHS) OR AT LEAST 300 CELLS/MCL WITHIN THE PAST 12 MONTHS.
Age Restrictions	
Prescriber Restrictions	INITIAL: ASTHMA: PRESCRIBED BY OR IN CONSULTATION WITH A PHYSICIAN SPECIALIZING IN PULMONARY OR ALLERGY MEDICINE. CRSWNP: PRESCRIBED BY OR IN CONSULTATION WITH AN OTOLARYNGOLOGIST, ALLERGIST OR IMMUNOLOGIST. EOSINOPHILIC COPD: PRESCRIBED BY OR IN CONSULTATION WITH A PULMONOLOGIST.
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
Other Criteria	INITIAL: ALL INDICATIONS: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR THE SAME INDICATION. ASTHMA: 1) CONCURRENT THERAPY WITH A MEDIUM, HIGH-DOSE OR MAXIMALLY TOLERATED DOSE OF AN INHALED CORTICOSTEROID (ICS) AND AT LEAST ONE OTHER MAINTENANCE MEDICATION, AND 2) ONE OF THE FOLLOWING: (A) AT LEAST ONE ASTHMA EXACERBATION REQUIRING SYSTEMIC CORTICOSTEROID BURST LASTING AT LEAST 3 DAYS WITHIN THE PAST 12 MONTHS OR AT LEAST ONE SERIOUS EXACERBATION REQUIRING HOSPITALIZATION

Please refer to our Evidence of Coverage for 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
	OR ER VISIT WITHIN THE PAST 12 MONTHS, OR (B) POOR SYMPTOM CONTROL DESPITE CURRENT THERAPY AS EVIDENCED BY AT LEAST THREE OF THE FOLLOWING WITHIN THE PAST 4 WEEKS: DAYTIME ASTHMA SYMPTOMS MORE THAN TWICE/WEEK, ANY NIGHT WAKING DUE TO ASTHMA, SABA RELIEVER FOR SYMPTOMS MORE THAN TWICE/WEEK, ANY ACTIVITY LIMITATION DUE TO ASTHMA. CHRONIC RHINOSINUSITIS WITH NASAL POLYPS (CRSWNP): 1) A 56 DAY TRIAL OF ONE TOPICAL NASAL CORTICOSTEROID, 2) EVIDENCE OF NASAL POLYPS BY DIRECT EXAMINATION, ENDOSCOPY, OR SINUS CT SCAN, AND 3) INADEQUATELY CONTROLLED DISEASE. EOSINOPHILIC COPD: USED IN COMBINATION WITH A LAMA/LABA/ICS. RENEWAL: ASTHMA: 1) CONTINUED USE OF ICS AND AT LEAST ONE OTHER MAINTENANCE MEDICATION, 2) CLINICAL RESPONSE AS EVIDENCED BY: (A) REDUCTION IN ASTHMA EXACERBATIONS FROM BASELINE, (B) DECREASED UTILIZATION OF RESCUE MEDICATIONS, (C) REDUCTION IN SEVERITY OR FREQUENCY OF ASTHMA-RELATED SYMPTOMS, OR (D) INCREASE IN PERCENT PREDICTED FEV1 FROM PRETREATMENT BASELINE, AND 3) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR THE SAME INDICATION. CRSWNP: 1) CLINICAL BENEFIT COMPARED TO BASELINE, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR THE SAME INDICATION. EOSINOPHILIC GRANULOMATOSIS WITH POLYANGIITIS (EGPA): 1) REDUCTION IN EGPA SYMPTOMS COMPARED TO BASELINE OR ABILITY TO REDUCE/ELIMINATE CORTICOSTEROID USE, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR THE SAME INDICATION. EOSINOPHILIC COPD: 1) USED IN COMBINATION WITH A LAMA/LABA/ICS, 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR THE SAME INDICATION, AND 3) CLINICAL RESPONSE AS EVIDENCED BY ONE OF THE FOLLOWING: (A) REDUCTION IN COPD EXACERBATIONS FROM BASELINE, OR (B) REDUCTION IN SEVERITY OR FREQUENCY OF COPD-RELATED SYMPTOMS.
Indications	All FDA-approved 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	
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.

METYROSINE

Products Affected

- *metyrosine*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	PHEOCHROMOCYTOMA: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH AN ENDOCRINOLOGIST, ENDOCRINE SURGEON, OR HEMATOLOGIST-ONCOLOGIST.
Coverage Duration	PHEOCHROMOCYTOMA: PRE-OP SURGERY: 30 DAYS, TREATMENT: PLAN YEAR.
Other Criteria	PHEOCHROMOCYTOMA: INITIAL: HAS NON-METASTATIC PHEOCHROMOCYTOMA. PREOPERATIVE PREPARATION FOR SURGERY: USE IN COMBINATION WITH AN ALPHA-ADRENERGIC RECEPTOR BLOCKER. RENEWAL: MALIGNANT PHEOCHROMOCYTOMA: STABLE OR CLINICAL IMPROVEMENT WHILE ON THERAPY.
Indications	All FDA-approved Indications.
Off Label Uses	
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.

MIDAZOLAM

Products Affected

- NAYZILAM

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
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.

MIDOSTAURIN

Products Affected

- RYDAPT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
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.

MIFEPRISTONE

Products Affected

- *mifepristone oral tablet 300 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	CUSHINGS SYNDROME (CS): INITIAL: DIAGNOSIS CONFIRMED BY: 1) 24-HR URINE FREE CORTISOL (AT LEAST 2 TESTS TO CONFIRM), 2) OVERNIGHT 1MG DEXAMETHASONE TEST, OR 3) LATE NIGHT SALIVARY CORTISOL (AT LEAST 2 TESTS TO CONFIRM).
Age Restrictions	
Prescriber Restrictions	CS: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH AN ENDOCRINOLOGIST.
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
Other Criteria	CS: INITIAL: HYPERCORTISOLISM IS NOT A RESULT OF CHRONIC GLUCOCORTICOIDS. INITIAL/RENEWAL: NO CONCURRENT USE WITH OTHER AGENTS USED TO LOWER CORTISOL LEVELS FOR CS. RENEWAL: 1) CONTINUES TO HAVE IMPROVEMENT OF GLUCOSE TOLERANCE OR STABLE GLUCOSE TOLERANCE (E.G., REDUCED A1C, IMPROVED FASTING GLUCOSE), 2) CONTINUES TO HAVE TOLERABILITY TO THERAPY, AND 3) CONTINUES TO NOT BE A CANDIDATE FOR SURGICAL TREATMENT OR HAS FAILED SURGERY.
Indications	All FDA-approved Indications.
Off Label Uses	
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.

MILTEFOSINE

Products Affected

- IMPAVIDO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
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.

MIRDAMETINIB

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
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.

MODAFINIL

Products Affected

- *modafinil oral tablet 100 mg, 200 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
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.

MOMELOTINIB

Products Affected

- OJJAARA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
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.

MORPHINE SOLUTION

Products Affected

- *morphine concentrate oral solution*

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

Please refer to our Evidence of Coverage for 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.

NERANDOMILAST

Products Affected

- JASCAYD

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: IDIOPATHIC PULMONARY FIBROSIS (IPF): A USUAL INTERSTITIAL PNEUMONIA (UIP) PATTERN AS EVIDENCED BY HIGH-RESOLUTION COMPUTED TOMOGRAPHY (HRCT) ALONE OR VIA A COMBINATION OF SURGICAL LUNG BIOPSY AND HRCT. PROGRESSIVE PULMONARY FIBROSIS (PPF): 1) AT LEAST 10% FIBROSIS ON A CHEST HRCT, AND 2) INTERSTITIAL LUNG DISEASE WITH A PROGRESSIVE PHENOTYPE (PF-ILD).
Age Restrictions	
Prescriber Restrictions	INITIAL: IPF: PRESCRIBED BY OR IN CONSULTATION WITH A PULMONOLOGIST. PPF: PRESCRIBED BY OR IN CONSULTATION WITH A PULMONOLOGIST OR RHEUMATOLOGIST.
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
Other Criteria	INITIAL: IPF: 1) DOES NOT HAVE OTHER KNOWN CAUSES OF INTERSTITIAL LUNG DISEASE (E.G., CONNECTIVE TISSUE DISEASE, DRUG TOXICITY, ASBESTOS OR BERYLLIUM EXPOSURE, HYPERSENSITIVITY PNEUMONITIS, SYSTEMIC SCLEROSIS, RHEUMATOID ARTHRITIS, RADIATION, SARCOIDOSIS, BRONCHIOLITIS OBLITERANS ORGANIZING PNEUMONIA, HUMAN IMMUNODEFICIENCY VIRUS (HIV) INFECTION, VIRAL HEPATITIS, CANCER), AND 2) TRIAL OF OR CONTRAINDICATION TO ONE OF THE FOLLOWING PREFERRED AGENTS: OFEV, PIRFENIDONE. PPF: 1) LUNG FUNCTION AND RESPIRATORY SYMPTOMS OR CHEST IMAGING HAVE WORSENED/PROGRESSED DESPITE TREATMENT WITH MEDICATIONS USED IN CLINICAL PRACTICE FOR ILD (NOT ATTRIBUTABLE TO COMORBIDITIES SUCH AS INFECTION, HEART FAILURE), AND 2) TRIAL OF OR CONTRAINDICATION

Please refer to our Evidence of Coverage for 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
	TO THE PREFERRED AGENT: OFEV (NINTEDANIB). RENEWAL: IPF, PPF: CLINICAL MEANINGFUL IMPROVEMENT OR MAINTENANCE IN ANNUAL RATE OF DECLINE.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

NERATINIB

Products Affected

- NERLYNX

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	EARLY-STAGE (STAGE I-III) BREAST CANCER: MEDICATION IS BEING REQUESTED WITHIN 2 YEARS OF COMPLETING THE LAST TRASTUZUMAB DOSE. ALL OTHER FDA APPROVED INDICATIONS ARE COVERED WITHOUT ADDITIONAL CRITERIA, EXCEPT THOSE CRITERIA IN THE FDA APPROVED LABEL.
Indications	All FDA-approved Indications.
Off Label Uses	
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.

NILOTINIB - TASIGNA

Products Affected

- *nilotinib hcl oral capsule 150 mg, 200 mg, 50 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	PREVIOUSLY TREATED PHILADELPHIA CHROMOSOME-POSITIVE CHRONIC MYELOID LEUKEMIA (Ph+ CML): MUTATIONAL ANALYSIS PRIOR TO INITIATION AND MEDICATION IS APPROPRIATE PER NCCN GUIDELINE TABLE FOR TREATMENT RECOMMENDATIONS BASED ON BCR-ABL1 MUTATION PROFILE.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
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.

NILOTINIB-DANZITEN

Products Affected

- DANZITEN

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	PREVIOUSLY TREATED PHILADELPHIA CHROMOSOME-POSITIVE CHRONIC MYELOID LEUKEMIA (Ph+ CML): 1) PERFORMED MUTATIONAL ANALYSIS PRIOR TO INITIATION OF THERAPY, AND 2) THERAPY IS APPROPRIATE PER NCCN GUIDELINE TABLE FOR TREATMENT RECOMMENDATIONS BASED ON BCR-ABL1 MUTATION PROFILE.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
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.

NINTEDANIB

Products Affected

- *nintedanib*
- OFEV

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: IDIOPATHIC PULMONARY FIBROSIS (IPF): A USUAL INTERSTITIAL PNEUMONIA (UIP) PATTERN AS EVIDENCED BY HIGH-RESOLUTION COMPUTED TOMOGRAPHY (HRCT) ALONE OR VIA A COMBINATION OF SURGICAL LUNG BIOPSY AND HRCT. SYSTEMIC SCLEROSIS-ASSOCIATED INTERSTITIAL LUNG DISEASE (SSC-ILD): 1) AT LEAST 10% FIBROSIS ON A CHEST HRCT, AND 2) BASELINE FVC AT LEAST 40% OF PREDICTED VALUE. CHRONIC FIBROSING INTERSTITIAL LUNG DISEASE WITH A PROGRESSIVE PHENOTYPE (PF-ILD): AT LEAST 10% FIBROSIS ON A CHEST HRCT.
Age Restrictions	
Prescriber Restrictions	INITIAL: IPF: PRESCRIBED BY OR IN CONSULTATION WITH A PULMONOLOGIST. SSC-ILD, PF-ILD: PRESCRIBED BY OR IN CONSULTATION WITH A PULMONOLOGIST OR RHEUMATOLOGIST.
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
Other Criteria	INITIAL: IPF: 1) DOES NOT HAVE OTHER KNOWN CAUSES OF INTERSTITIAL LUNG DISEASE (E.G., CONNECTIVE TISSUE DISEASE, DRUG TOXICITY, ASBESTOS OR BERYLLIUM EXPOSURE, HYPERSENSITIVITY PNEUMONITIS), AND 2) TRIAL OF OR CONTRAINDICATION TO THE PREFERRED AGENT: ESBRIET (PIRFENIDONE). SSC-ILD: DOES NOT HAVE OTHER KNOWN CAUSES OF INTERSTITIAL LUNG DISEASE (E.G., HEART FAILURE/FLUID OVERLOAD, DRUG-INDUCED LUNG TOXICITY, RECURRENT ASPIRATION). PF-ILD: LUNG FUNCTION AND RESPIRATORY SYMPTOMS OR CHEST IMAGING HAVE WORSENED/PROGRESSED DESPITE TREATMENT WITH

Please refer to our Evidence of Coverage for 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
	MEDICATIONS USED IN CLINICAL PRACTICE FOR ILD (NOT ATTRIBUTABLE TO COMORBIDITIES SUCH AS INFECTION, HEART FAILURE). INITIAL/RENEWAL: IPF, PF-ILD: NO CONCURRENT USE WITH ESBRIET. RENEWAL: IPF, SSC-ILD, PF-ILD: CLINICAL MEANINGFUL IMPROVEMENT OR MAINTENANCE IN ANNUAL RATE OF DECLINE.
Indications	All FDA-approved Indications.
Off Label Uses	
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.

NIRAPARIB

Products Affected

- ZEJULA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	RECURRENT EPITHELIAL OVARIAN, FALLOPIAN TUBE, OR PRIMARY PERITONEAL CANCER: 1) ZEJULA WILL BE USED AS MONOTHERAPY, AND 2) ZEJULA IS STARTED NO LATER THAN 8 WEEKS AFTER THE MOST RECENT PLATINUM-CONTAINING REGIMEN.
Indications	All FDA-approved Indications.
Off Label Uses	
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.

NIRAPARIB-ABIRATERONE

Products Affected

- AKEEGA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	METASTATIC CASTRATION-RESISTANT PROSTATE CANCER (MCRPC), METASTATIC CASTRATION-SENSITIVE PROSTATE CANCER (MCSPC): 1) RECEIVED A BILATERAL ORCHIECTOMY, 2) CASTRATE LEVEL OF TESTOSTERONE (I.E., LESS THAN 50 NG/DL), OR 3) CONCURRENT USE WITH A GONADOTROPIN RELEASING HORMONE (GNRH) ANALOG.
Indications	All FDA-approved Indications.
Off Label Uses	
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.

NIROGACESTAT

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
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	
Required Medical Information	HEREDITARY TYROSINEMIA TYPE 1 (HT-1): INITIAL: DIAGNOSIS CONFIRMED BY ELEVATED URINARY OR PLASMA SUCCINYLACETONE LEVELS OR A MUTATION IN THE FUMARYLACETOACETATE HYDROLASE GENE. RENEWAL: URINARY OR PLASMA SUCCINYLACETONE LEVELS HAVE DECREASED FROM BASELINE WHILE ON TREATMENT WITH NITISINONE.
Age Restrictions	
Prescriber Restrictions	HT-1: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A PRESCRIBER SPECIALIZING IN INHERITED METABOLIC DISEASES.
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
Other Criteria	HT-1: INITIAL: ORFADIN SUSPENSION: TRIAL OF OR CONTRAINDICATION TO PREFERRED NITISINONE TABLETS OR CAPSULES.
Indications	All FDA-approved Indications.
Off Label Uses	
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.

NIVOLUMAB

Products Affected

- OPDIVO

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

Please refer to our Evidence of Coverage for 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.

NIVOLUMAB-HYALURONIDASE-NVHY

Products Affected

- OPDIVO QVANTIG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
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.

OFATUMUMAB SQ

Products Affected

- KESIMPTA PEN

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
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.

OLAPARIB

Products Affected
- LYNPARZA

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

OLEZARSEN

Products Affected

- TRYNGOLZA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
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.

OLUTASIDENIB

Products Affected

- REZLIDHIA

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

OMALIZUMAB

Products Affected

- XOLAIR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: ASTHMA: POSITIVE SKIN PRICK OR BLOOD TEST (E.G., ELISA, FEIA) TO A PERENNIAL AEROALLERGEN AND A BASELINE IGE SERUM LEVEL OF AT LEAST 30 IU/ML. FOOD ALLERGY: 1) IGE SERUM LEVEL OF AT LEAST 30 IU/ML, AND 2) POSITIVE SKIN PRICK TEST TO AT LEAST ONE FOOD, OR POSITIVE MEDICALLY MONITORED FOOD CHALLENGE TO AT LEAST ONE FOOD.
Age Restrictions	
Prescriber Restrictions	INITIAL/RENEWAL: CHRONIC SPONTANEOUS URTICARIA (CSU): PRESCRIBED BY OR IN CONSULTATION WITH AN ALLERGIST, DERMATOLOGIST, OR IMMUNOLOGIST. INITIAL: CHRONIC RHINOSINUSITIS WITH NASAL POLYPS (CRSWNP): PRESCRIBED BY OR IN CONSULTATION WITH AN OTOLARYNGOLOGIST, ALLERGIST OR IMMUNOLOGIST. ASTHMA: PRESCRIBED BY OR IN CONSULTATION WITH A PHYSICIAN SPECIALIZING IN ALLERGY OR PULMONARY MEDICINE. FOOD ALLERGY: PRESCRIBED BY OR IN CONSULTATION WITH ALLERGIST OR IMMUNOLOGIST.
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
Other Criteria	INITIAL: CSU: 1) TRIAL OF AND MAINTAINED ON, OR CONTRAINDICATION TO, FOUR TIMES THE MAXIMALLY LABELED DOSE OF A SECOND GENERATION H1 ANTI-HISTAMINE, 2) STILL EXPERIENCES HIVES OR ANGIOEDEMA ON MOST DAYS OF THE WEEK FOR AT LEAST 6 WEEKS, AND 3) TRIAL OF OR CONTRAINDICATION TO THE PREFERRED AGENT: DUPIXENT. CRSWNP: 1) A 56 DAY TRIAL OF ONE CLINICAL STANDARD OF CARE AGENT: A TOPICAL NASAL

Please refer to our Evidence of Coverage for 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, 2) TRIAL OF OR CONTRAINDICATION TO ONE OF THE FOLLOWING PREFERRED AGENTS: NUCALA, DUPIXENT, 3) EVIDENCE OF NASAL POLYPS BY DIRECT EXAMINATION, ENDOSCOPY, OR SINUS CT SCAN, AND 4) INADEQUATELY CONTROLLED DISEASE. ASTHMA: 1) CONCURRENT THERAPY WITH A MEDIUM, HIGH-DOSE OR MAXIMALLY TOLERATED DOSE OF AN INHALED CORTICOSTEROID (ICS) AND AT LEAST ONE OTHER MAINTENANCE MEDICATION, AND 2) ONE OF THE FOLLOWING: (A) AT LEAST ONE ASTHMA EXACERBATION REQUIRING SYSTEMIC CORTICOSTEROID BURST LASTING AT LEAST 3 DAYS WITHIN THE PAST 12 MONTHS OR AT LEAST ONE SERIOUS EXACERBATION REQUIRING HOSPITALIZATION OR ER VISIT WITHIN THE PAST 12 MONTHS, OR (B) POOR SYMPTOM CONTROL DESPITE CURRENT THERAPY AS EVIDENCED BY AT LEAST THREE OF THE FOLLOWING WITHIN THE PAST 4 WEEKS: DAYTIME ASTHMA SYMPTOMS MORE THAN TWICE/WEEK, ANY NIGHT WAKING DUE TO ASTHMA, SABA RELIEVER FOR SYMPTOMS MORE THAN TWICE/WEEK, ANY ACTIVITY LIMITATION DUE TO ASTHMA. FOOD ALLERGY: CONCURRENT USE WITH AN ACTIVE PRESCRIPTION FOR EPINEPHRINE AUTO-INJECTOR/INJECTION. INITIAL/RENEWAL: ALL INDICATIONS: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR THE SAME INDICATION. RENEWAL: CSU: MAINTAINED ON OR CONTRAINDICATION TO A SECOND GENERATION H1 ANTI-HISTAMINE. CRSWNP: CLINICAL BENEFIT COMPARED TO BASELINE. ASTHMA: 1) CONTINUED USE OF ICS AND AT LEAST ONE OTHER MAINTENANCE MEDICATION, AND 2) CLINICAL RESPONSE AS EVIDENCED BY ONE OF THE FOLLOWING: (A) REDUCTION IN ASTHMA EXACERBATIONS FROM BASELINE, (B) DECREASED UTILIZATION OF RESCUE MEDICATIONS, (C) REDUCTION IN SEVERITY OR FREQUENCY OF ASTHMA-RELATED SYMPTOMS, OR (D) INCREASE IN PERCENT PREDICTED FEV1 FROM PRETREATMENT BASELINE. FOOD ALLERGY: 1) PERSISTENT IGE-MEDIATED FOOD ALLERGY, AND 2) CONCURRENT USE WITH AN ACTIVE PRESCRIPTION FOR EPINEPHRINE AUTO-INJECTOR/INJECTION.

Please refer to our Evidence of Coverage for 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 FDA-approved Indications.
Off Label Uses	
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.

OSILODROSTAT

Products Affected

- ISTURISA ORAL TABLET 1 MG, 5 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	CUSHINGS SYNDROME: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH AN ENDOCRINOLOGIST.
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
Other Criteria	CUSHINGS SYNDROME: RENEWAL: 1) CONTINUED IMPROVEMENT OF CUSHINGS DISEASE/SYNDROME, AND 2) MAINTAINS TOLERABILITY TO ISTURISA.
Indications	All FDA-approved Indications.
Off Label Uses	
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.

OSIMERTINIB

Products Affected

- TAGRISSO

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

PACRITINIB

Products Affected

- VONJO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
Other Criteria	MYELOFIBROSIS: RENEWAL: CONTINUES TO BENEFIT FROM THE MEDICATION
Indications	All FDA-approved Indications.
Off Label Uses	
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.

PALBOCICLIB

Products Affected

- IBRANCE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
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.

PASIREOTIDE DIASPARTATE

Products Affected

- SIGNIFOR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	CUSHINGS DISEASE (CD): INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH AN ENDOCRINOLOGIST.
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
Other Criteria	CD: RENEWAL: 1) CONTINUED IMPROVEMENT OF CUSHINGS DISEASE, AND 2) MAINTAINED TOLERABILITY TO SIGNIFOR.
Indications	All FDA-approved Indications.
Off Label Uses	
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.

PAZOPANIB

Products Affected

- *pazopanib oral tablet 200 mg, 400 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	ADVANCED SOFT TISSUE SARCOMA (STS): NOT USED FOR ADIPOCYTIC STS OR GASTROINTESTINAL STROMAL TUMORS (GIST)
Indications	All FDA-approved Indications.
Off Label Uses	
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.

PEGFILGRASTIM - APGF

Products Affected

- NYVEPRIA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR IN CONSULTATION WITH A HEMATOLOGIST OR ONCOLOGIST.
Coverage Duration	PLAN YEAR
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
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.

PEGFILGRASTIM - CBQV

Products Affected

- UDENYCA ONBODY

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR IN CONSULTATION WITH A HEMATOLOGIST OR ONCOLOGIST.
Coverage Duration	PLAN YEAR
Other Criteria	NON MYELOID MALIGNANCY: UDENYCA: TRIAL OF OR CONTRAINDICATION TO THE PREFERRED AGENT NYVEPRIA. UDENYCA ONBODY: 1) TRIAL OF OR CONTRAINDICATION TO THE PREFERRED AGENT NYVEPRIA, OR 2) BARRIER TO ACCESS (E.G., TRAVEL BARRIERS, UNABLE TO RETURN TO CLINIC FOR INJECTIONS).
Indications	All FDA-approved Indications.
Off Label Uses	
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 ALFA-2A

Products Affected

- PEGASYS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	HEPATITIS B: PRESCRIBED BY OR IN CONSULTATION WITH A GASTROENTEROLOGIST, INFECTIOUS DISEASE SPECIALIST, OR PHYSICIAN SPECIALIZING IN THE TREATMENT OF HEPATITIS (E.G., HEPATOLOGIST).
Coverage Duration	PLAN YEAR
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
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.

PEGVISOMANT

Products Affected

- SOMAVERT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	ACROMEGALY: PRESCRIBED BY OR IN CONSULTATION WITH AN ENDOCRINOLOGIST.
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
Other Criteria	ACROMEGALY: INITIAL: SERUM INSULIN-LIKE GROWTH FACTOR 1 (IGF-1) LEVEL (ADJUSTED FOR AGE) IS ELEVATED OR UNEQUIVOCAL WITH INADEQUATE SUPPRESSION OF GROWTH HORMONE AFTER A GLUCOSE LOAD. RENEWAL: 1) REDUCTION, NORMALIZATION, OR MAINTENANCE OF IGF-1 LEVELS BASED ON AGE AND GENDER, AND 2) IMPROVEMENT OR SUSTAINED REMISSION OF CLINICAL SYMPTOMS.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	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.

PEMBROLIZUMAB

Products Affected

- KEYTRUDA

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

Please refer to our Evidence of Coverage for 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.

PEMBROLIZUMAB-BERAHYALURONIDASE ALFA-PMPH

Products Affected

- KEYTRUDA QLEX

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
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.

PEMIGATINIB

Products Affected

- PEMAZYRE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	CHOLANGIOCARCINOMA, MYELOID/LYMPHOID NEOPLASMS: COMPREHENSIVE OPHTHALMOLOGICAL EXAMINATION, INCLUDING OPTICAL COHERENCE TOMOGRAPHY (OCT), WILL BE COMPLETED PRIOR TO INITIATION OF THERAPY AND AT THE RECOMMENDED SCHEDULED INTERVALS.
Indications	All FDA-approved Indications.
Off Label Uses	
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 TABLET

Products Affected

- *penicillamine oral tablet*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	WILSONS DISEASE: 1) GENETIC TESTING CONFIRMING AN ATP7B MUTATION, 2) 24-HOUR URINARY COPPER EXCRETION (GREATER THAN 40 MICROGRAMS/24 HOURS), 3) LIVER BIOPSY WITH COPPER DRY WEIGHT GREATER THAN 75 MICROGRAMS/GRAM, OR 4) SERUM CERULOPLASMIN LEVEL OF LESS THAN 20 MG/DL. INITIAL: CYSTINURIA: HAS NEPHROLITHIASIS AND ONE OF THE FOLLOWING: 1) STONE ANALYSIS SHOWING PRESENCE OF CYSTINE, 2) PRESENCE OF PATHOGNOMONIC HEXAGONAL CYSTINE CRYSTALS ON URINALYSIS, OR 3) FAMILY HISTORY OF CYSTINURIA AND POSITIVE CYANIDE-NITROPRUSSIDE SCREENING.
Age Restrictions	
Prescriber Restrictions	WILSONS DISEASE: PRESCRIBED BY OR IN CONSULTATION WITH A HEPATOLOGIST OR GASTROENTEROLOGIST. INITIAL: CYSTINURIA: PRESCRIBED BY OR IN CONSULTATION WITH A NEPHROLOGIST. RHEUMATOID ARTHRITIS (RA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST.
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
Other Criteria	INITIAL: RA: 1) NO HISTORY OR OTHER EVIDENCE OF RENAL INSUFFICIENCY, AND 2) TRIAL OF OR CONTRAINDICATION TO 3 MONTHS OF TREATMENT WITH ONE DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG) - IF PATIENT TRIED METHOTREXATE, THEN TRIAL OF AT LEAST 20 MG PER WEEK OR MAXIMALLY TOLERATED DOSE IS REQUIRED. RENEWAL: RA: 1) NO HISTORY OR OTHER EVIDENCE OF RENAL INSUFFICIENCY, AND 2) EXPERIENCED OR MAINTAINED IMPROVEMENT IN TENDER JOINT COUNT OR SWOLLEN JOINT

Please refer to our Evidence of Coverage for 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
	COUNT COMPARED TO BASELINE. CYSTINURIA: CONTINUES TO BENEFIT FROM THE MEDICATION.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

PEXIDARTINIB

Products Affected

- TURALIO

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

PIMAVANSERIN

Products Affected

- NUPLAZID

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	PSYCHOSIS IN PARKINSONS DISEASE (PD): INITIAL: 18 YEARS OR OLDER
Prescriber Restrictions	PSYCHOSIS IN PD: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST, GERIATRICIAN, OR A BEHAVIORAL HEALTH SPECIALIST (E.G., PSYCHIATRIST).
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
Other Criteria	PSYCHOSIS IN PD: RENEWAL: IMPROVEMENT IN PSYCHOSIS SYMPTOMS FROM BASELINE AND DEMONSTRATES A CONTINUED NEED FOR TREATMENT.
Indications	All FDA-approved Indications.
Off Label Uses	
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.

PIRFENIDONE

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	IDIOPATHIC PULMONARY FIBROSIS (IPF): INITIAL: A USUAL INTERSTITIAL PNEUMONIA (UIP) PATTERN AS EVIDENCED BY HIGH-RESOLUTION COMPUTED TOMOGRAPHY (HRCT) ALONE OR VIA A COMBINATION OF SURGICAL LUNG BIOPSY AND HRCT.
Age Restrictions	
Prescriber Restrictions	IPF: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A PULMONOLOGIST.
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
Other Criteria	IPF: INITIAL: 1) DOES NOT HAVE OTHER KNOWN CAUSES OF INTERSTITIAL LUNG DISEASE (E.G., CONNECTIVE TISSUE DISEASE, DRUG TOXICITY, ASBESTOS OR BERYLLIUM EXPOSURE, HYPERSENSITIVITY PNEUMONITIS, SYSTEMIC SCLEROSIS, RHEUMATOID ARTHRITIS, RADIATION, SARCOIDOSIS, BRONCHIOLITIS OBLITERANS ORGANIZING PNEUMONIA, HUMAN IMMUNODEFICIENCY VIRUS (HIV) INFECTION, VIRAL HEPATITIS, OR CANCER). INITIAL/RENEWAL: NO CONCURRENT USE WITH OFEV. RENEWAL: CLINICAL MEANINGFUL IMPROVEMENT OR MAINTENANCE IN ANNUAL RATE OF DECLINE.
Indications	All FDA-approved Indications.
Off Label Uses	
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.

PIRTOBRUTINIB

Products Affected

- JAYPIRCA ORAL TABLET 100 MG, 50 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
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.

POMALIDOMIDE

Products Affected

- *pomalidomide*
- POMALYST

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
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.

PONATINIB

Products Affected

- ICLUSIG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	CHRONIC MYELOID LEUKEMIA (CML): MUTATIONAL ANALYSIS PRIOR TO INITIATION AND ICLUSIG IS APPROPRIATE PER NCCN GUIDELINE TABLE FOR TREATMENT RECOMMENDATIONS BASED ON BCR-ABL1 MUTATION PROFILE.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
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.

POSACONAZOLE TABLET

Products Affected

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

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

Please refer to our Evidence of Coverage for 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.

PRALSETINIB

Products Affected

- GAVRETO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
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.

PYRIMETHAMINE

Products Affected

- *pyrimethamine*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	TOXOPLASMOSIS: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH AN INFECTIOUS DISEASE SPECIALIST.
Coverage Duration	TOXOPLASMOSIS: INITIAL: 8 WEEKS, RENEWAL: 6 MOS.
Other Criteria	TOXOPLASMOSIS: RENEWAL: ONE OF THE FOLLOWING: (1) PERSISTENT CLINICAL DISEASE (HEADACHE, NEUROLOGICAL SYMPTOMS, OR FEVER) AND PERSISTENT RADIOGRAPHIC DISEASE (ONE OR MORE MASS LESIONS ON BRAIN IMAGING), OR (2) CD4 COUNT LESS THAN 200 CELLS/MM3 AND CURRENTLY TAKING AN ANTI-RETROVIRAL THERAPY IF HIV POSITIVE.
Indications	All FDA-approved Indications.
Off Label Uses	
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.

QUININE

Products Affected

- *quinine sulfate*

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

QUIZARTINIB

Products Affected

- VANFLYTA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
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.

REGORAFENIB

Products Affected

- STIVARGA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
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.

RELACORILANT

Products Affected

- LIFYORLI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
Other Criteria	RENEWAL: 1) CLINICAL BENEFIT WHILE ON THERAPY, AND 2) CONTINUATION OF NAB-PACLITAXEL THERAPY.
Indications	All FDA-approved Indications.
Off Label Uses	
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.

RELUGOLIX

Products Affected

- ORGOVYX

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
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.

REPOTRECTINIB

Products Affected

- AUGTYRO ORAL CAPSULE 160 MG, 40 MG

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

RESMETIROM

Products Affected

- REZDIFFRA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	NONALCOHOLIC STEATOHEPATITIS (NASH): INITIAL: DIAGNOSIS CONFIRMED BY BIOPSY OR NONINVASIVE TESTING, OBTAINED IN THE PAST 12 MONTHS, DEMONSTRATING ONE OF THE FOLLOWING: 1) LIVER FIBROSIS STAGE 2 OR 3, OR 2) NONALCOHOLIC FATTY LIVER DISEASE (NAFLD) ACTIVITY SCORE OF 4 OR MORE.
Age Restrictions	
Prescriber Restrictions	NASH: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A HEPATOLOGIST, GASTROENTEROLOGIST, OR ENDOCRINOLOGIST.
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
Other Criteria	NASH: INITIAL: TRIAL OF OR CONTRAINDICATION TO THE PREFERRED AGENT: WEGOVY. RENEWAL: CONTINUES TO HAVE NONCIRRHOTIC NASH WITH MODERATE TO ADVANCED LIVER FIBROSIS (CONSISTENT WITH STAGES F2 TO F3 FIBROSIS). INITIAL/RENEWAL: NO CONCURRENT USE WITH WEGOVY FOR THE TREATMENT OF NASH.
Indications	All FDA-approved Indications.
Off Label Uses	
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.

REVUMENIB

Products Affected

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

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

RIBOCICLIB

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
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.

RIBOCICLIB-LETROZOLE

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
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.

RIFAXIMIN

Products Affected

- XIFAXAN ORAL TABLET 200 MG, 550 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	TRAVELERS DIARRHEA, HEPATIC ENCEPHALOPATHY (HE): PLAN YEAR. IBS-D: 8 WKS.
Other Criteria	HE: TRIAL OF THE CLINICAL STANDARD OF CARE AGENT: LACTULOSE OR CURRENTLY ON LACTULOSE MONOTHERAPY. IRRITABLE BOWEL SYNDROME WITH DIARRHEA (IBS-D): TRIAL OF OR CONTRAINDICATION TO THE CLINICAL STANDARD OF CARE AGENT: DICYCLOMINE. TRAVELERS DIARRHEA (TD): TRIAL OF OR CONTRAINDICATION TO ONE OF THE FOLLOWING CLINICAL STANDARD OF CARE AGENTS: GENERIC ORAL CIPROFLOXACIN, AZITHROMYCIN, OFLOXACIN, LEVOFLOXACIN.
Indications	All FDA-approved Indications.
Off Label Uses	
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.

RILONACEPT

Products Affected

- ARCALYST

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: CRYOPYRIN-ASSOCIATED PERIODIC SYNDROMES (CAPS): 1) GENETIC TEST FOR GAIN-OF-FUNCTION MUTATIONS IN THE NLRP3 GENE, OR HAS INFLAMMATORY MARKERS (I.E., ELEVATED CRP, ESR, SERUM AMYLOID A PROTEIN (SAA) OR S100 PROTEINS), AND 2) TWO OF THE FOLLOWING: URTICARIAL-LIKE RASH (NEUTROPHILIC DERMATITIS), COLD-TRIGGERED EPISODES, SENSORINEURAL HEARING LOSS, MUSCULOSKELETAL SYMPTOMS, CHRONIC ASEPTIC MENINGITIS, SKELETAL ABNORMALITIES. DEFICIENCY OF INTERLEUKIN-1 RECEPTOR ANTAGONIST (DIRA): 1) GENETIC TEST FOR GAIN-OF-FUNCTION MUTATIONS IN THE IL1RN GENE, OR HAS INFLAMMATORY MARKERS (I.E., ELEVATED CRP, ESR), AND 2) HAS PUSTULAR PSORIASIS-LIKE RASHES, OSTEOMYELITIS, ABSENCE OF BACTERIAL OSTEOMYELITIS, OR ONYCHOMADESIS. RECURRENT PERICARDITIS (RP): TWO OF THE FOLLOWING: CHEST PAIN CONSISTENT WITH PERICARDITIS, PERICARDIAL FRICTION RUB, ECG SHOWING DIFFUSE ST-SEGMENT ELEVATION OR PR-SEGMENT DEPRESSION, NEW OR WORSENING PERICARDIAL EFFUSION.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
Other Criteria	INITIAL: CAPS: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR CAPS. DIRA: 1) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR

Please refer to our Evidence of Coverage for 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
	TARGETED SMALL MOLECULES FOR DIRA, AND 2) TRIAL OF THE PREFERRED AGENT: KINERET. RP: 1) HAD AN EPISODE OF ACUTE PERICARDITIS, AND 2) SYMPTOM-FREE FOR 4 TO 6 WEEKS. INITIAL/RENEWAL: RP: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR RP. RENEWAL: RP: REDUCTION OF PERICARDITIS RECURRENCE OR IMPROVEMENT IN SYMPTOMS.
Indications	All FDA-approved Indications.
Off Label Uses	
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.

RIMEGEPANT

Products Affected

- NURTEC ODT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
Other Criteria	ACUTE MIGRAINE TREATMENT: 1) TRIAL OF OR CONTRAINDICATION TO ONE CLINICAL STANDARD OF CARE AGENT: A TRIPTAN (E.G., SUMATRIPTAN, RIZATRIPTAN) AND 2) NO CONCURRENT USE WITH OTHER CGRP INHIBITORS FOR ACUTE MIGRAINE TREATMENT. EPISODIC MIGRAINE PREVENTION: INITIAL/RENEWAL: NO CONCURRENT USE WITH OTHER CGRP INHIBITORS FOR MIGRAINE PREVENTION. RENEWAL: REDUCTION IN MIGRAINE OR HEADACHE FREQUENCY, MIGRAINE SEVERITY, OR MIGRAINE DURATION WITH THERAPY.
Indications	All FDA-approved Indications.
Off Label Uses	
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.

RIOCIGUAT

Products Affected

- ADEMPAS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: PULMONARY ARTERIAL HYPERTENSION (PAH): DIAGNOSIS CONFIRMED BY RIGHT HEART CATHETERIZATION WITH THE FOLLOWING PARAMETERS: 1) MEAN PULMONARY ARTERY PRESSURE (PAP) GREATER THAN 20 MMHG, 2) PULMONARY CAPILLARY WEDGE PRESSURE (PCWP) OF 15 MMHG OR LESS, AND 3) PULMONARY VASCULAR RESISTANCE (PVR) GREATER THAN 2 WOOD UNITS. PERSISTENT/RECURRENT CHRONIC THROMBOEMBOLIC PULMONARY HYPERTENSION (CTEPH) (WHO GROUP 4): WHO FUNCTIONAL CLASS II-IV SYMPTOMS.
Age Restrictions	
Prescriber Restrictions	INITIAL: PAH, CTEPH: PRESCRIBED BY OR IN CONSULTATION WITH A CARDIOLOGIST OR PULMONOLOGIST.
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
Other Criteria	INITIAL: PAH: NO CONCURRENT USE WITH NITRATES, NITRIC OXIDE DONORS, PHOSPHODIESTERASE (PDE) INHIBITORS, OR NON-SPECIFIC PDE INHIBITORS. CTEPH: 1) NO CONCURRENT USE WITH NITRATES, NITRIC OXIDE DONORS, PDE INHIBITORS, OR NON-SPECIFIC PDE INHIBITORS, AND 2) NOT A CANDIDATE FOR SURGERY OR HAS INOPERABLE CTEPH OR HAS PERSISTENT OR RECURRENT DISEASE AFTER SURGICAL TREATMENT. RENEWAL: PAH, CTEPH: NO CONCURRENT USE WITH NITRATES, NITRIC OXIDE DONORS, PDE INHIBITORS, OR NON-SPECIFIC PDE INHIBITORS.
Indications	All FDA-approved 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	
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.

RIPRETINIB

Products Affected

- QINLOCK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
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.

RISANKIZUMAB-RZAA

Products Affected

- SKYRIZI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: PLAQUE PSORIASIS (PSO): PLAQUE PSORIASIS COVERING 3 PERCENT OR MORE OF BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, FACE, SCALP, OR GENITAL AREA.
Age Restrictions	
Prescriber Restrictions	INITIAL: PSO: PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST. PSORIATIC ARTHRITIS (PSA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST OR DERMATOLOGIST. CROHNS DISEASE (CD), ULCERATIVE COLITIS (UC): PRESCRIBED BY OR IN CONSULTATION WITH A GASTROENTEROLOGIST.
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
Other Criteria	INITIAL: PSO: 1) AT LEAST A 3 MONTH TRIAL OF ONE OF THE FOLLOWING CLINICAL STANDARD OF CARE AGENTS: AN ORAL IMMUNOSUPPRESSANT (CYCLOSPORINE, METHOTREXATE, TACROLIMUS), PUVA (PHOTOTHERAPY), 2) CONTRAINDICATION OR INTOLERANCE TO BOTH OF THE FOLLOWING CLINICAL STANDARD OF CARE AGENTS: AN IMMUNOSUPPRESSANT, PUVA, OR 3) PATIENT IS SWITCHING FROM A DIFFERENT BIOLOGIC, PDE-4 INHIBITOR, OR JAK INHIBITOR FOR THE SAME INDICATION. INITIAL/RENEWAL: ALL INDICATIONS: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR THE SAME INDICATION. RENEWAL: PSO, PSA: CONTINUES TO BENEFIT FROM THE MEDICATION.

Please refer to our Evidence of Coverage for 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 FDA-approved Indications.
Off Label Uses	
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.

ROPEGINTERFERON ALFA-2B-NJFT

Products Affected

- BESREMI
- BESREMI PEN

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

RUCAPARIB

Products Affected

- RUBRACA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	METASTATIC CASTRATION-RESISTANT PROSTATE CANCER: 1) RECEIVED A BILATERAL ORCHIECTOMY, 2) CASTRATE LEVEL OF TESTOSTERONE (I.E., LESS THAN 50 NG/DL), OR 3) CONCURRENT USE WITH A GONADOTROPIN RELEASING HORMONE (GNRH) ANALOG.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
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.

RUXOLITINIB

Products Affected

- JAKAFI
- JAKAFI XR

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

Please refer to our Evidence of Coverage for 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

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	HYPERPHENYLALANINEMIA (HPA) WITH PHENYLKETONURIA (PKU): INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A METABOLIC OR GENETIC DISEASE SPECIALIST.
Coverage Duration	INITIAL: 2 MONTHS. RENEWAL: PLAN YEAR.
Other Criteria	HPA WITH PKU: INITIAL/RENEWAL: NO CONCURRENT USE WITH ANOTHER AGENT INDICATED FOR THE TREATMENT OF PKU. RENEWAL: CONTINUES TO BENEFIT FROM TREATMENT.
Indications	All FDA-approved Indications.
Off Label Uses	
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.

SARGRAMOSTIM

Products Affected

- LEUKINE INJECTION RECON SOLN

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR IN CONSULTATION WITH HEMATOLOGIST OR ONCOLOGIST.
Coverage Duration	PLAN YEAR
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
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.

SARILUMAB

Products Affected

- KEVZARA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	RHEUMATOID ARTHRITIS (RA), POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS (PJIA): INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST.
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
Other Criteria	INITIAL: RA: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA/ADALIMUMAB-AATY/HADLIMA, XELJANZ, RINVOQ. PJIA: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA/ADALIMUMAB-AATY/HADLIMA, XELJANZ IR, RINVOQ. PMR: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR PMR. INITIAL/RENEWAL: RA, PJIA: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR THE SAME INDICATION. RENEWAL: RA, PJIA: CONTINUES TO BENEFIT FROM THE MEDICATION.
Indications	All FDA-approved Indications.
Off Label Uses	
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.

SECUKINUMAB SQ

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: PLAQUE PSORIASIS (PSO): PSORIASIS COVERING 3 PERCENT OR MORE OF BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, GENITAL AREA, SCALP, OR FACE. NON-RADIOGRAPHIC AXIAL SPONDYLOARTHRITIS (NR-AXSPA): 1) C-REACTIVE PROTEIN (CRP) LEVELS ABOVE THE UPPER LIMIT OF NORMAL, OR 2) SACROILIITIS ON MAGNETIC RESONANCE IMAGING (MRI).
Age Restrictions	
Prescriber Restrictions	INITIAL: PSO, HIDRADENITIS SUPPURATIVA (HS): PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST. PSORIATIC ARTHRITIS (PSA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST OR A DERMATOLOGIST. ANKYLOSING SPONDYLITIS (AS), NR-AXSPA, ENTHESITIS-RELATED ARTHRITIS (ERA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST.
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
Other Criteria	INITIAL: PSO: 1) AT LEAST A 3 MONTH TRIAL OF ONE OF THE FOLLOWING CLINICAL STANDARD OF CARE AGENTS: AN ORAL IMMUNOSUPPRESSANT (CYCLOSPORINE, METHOTREXATE, TACROLIMUS), PUVA (PHOTOTHERAPY), 2) CONTRAINDICATION OR INTOLERANCE TO BOTH OF THE FOLLOWING CLINICAL STANDARD OF CARE AGENTS: IMMUNOSUPPRESSANT, PUVA, OR 3) PATIENT IS SWITCHING FROM A DIFFERENT BIOLOGIC, PDE-4 INHIBITOR, OR JAK INHIBITOR FOR THE SAME INDICATION. AS, NR-AXSPA: TRIAL

Please refer to our Evidence of Coverage for 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 OR CONTRAINDICATION TO ONE CLINICAL STANDARD OF CARE AGENT: AN NSAID. ERA: TRIAL OF OR CONTRAINDICATION TO ONE OF THE FOLLOWING CLINICAL STANDARD OF CARE AGENTS: AN NSAID, SULFASALAZINE, METHOTREXATE. INITIAL/RENEWAL: ALL INDICATIONS: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR THE SAME INDICATION. RENEWAL: ALL INDICATIONS: CONTINUES TO BENEFIT FROM THE MEDICATION.
Indications	All FDA-approved Indications.
Off Label Uses	
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.

SELEXIPAG

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	PULMONARY ARTERIAL HYPERTENSION (PAH): INITIAL: DIAGNOSIS CONFIRMED BY RIGHT HEART CATHETERIZATION WITH THE FOLLOWING PARAMETERS: 1) MEAN PULMONARY ARTERY PRESSURE (PAP) GREATER THAN 20 MMHG, 2) PULMONARY CAPILLARY WEDGE PRESSURE (PCWP) OF 15 MMHG OR LESS, AND 3) PULMONARY VASCULAR RESISTANCE (PVR) GREATER THAN 2 WOOD UNITS.
Age Restrictions	
Prescriber Restrictions	PAH: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A CARDIOLOGIST OR PULMONOLOGIST.
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
Other Criteria	PAH: INITIAL: TRIAL OF OR CONTRAINDICATION TO ONE OF THE FOLLOWING AGENTS: 1) FORMULARY VERSION OF AN ORAL ENDOTHELIN RECEPTOR ANTAGONIST, 2) FORMULARY VERSION OF AN ORAL PHOSPHODIESTERASE TYPE-5 INHIBITOR FOR PAH, 3) FORMULARY VERSION OF AN ORAL CGMP STIMULATOR.
Indications	All FDA-approved Indications.
Off Label Uses	
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.

SELINEXOR

Products Affected

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

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

SELPERCATINIB

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
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.

SELUMETINIB

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
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.

SEMAGLUTIDE - WEGOVY

Products Affected

- WEGOVY ORAL ML, 1 MG/0.5 ML, 1.7 MG/0.75 ML, 2.4 MG/0.75 ML
- WEGOVY SUBCUTANEOUS PEN INJECTOR 0.25 MG/0.5 ML, 0.5 MG/0.5

PA Criteria	Criteria Details
Exclusion Criteria	TREATMENT OF OBESITY
Required Medical Information	INITIAL: MAJOR ADVERSE CARDIOVASCULAR EVENTS (MACE): 1) BODY MASS INDEX (BMI) OF AT LEAST 27 KG/M(2), OR 2) BMI OF AT LEAST 25 KG/M(2) IF ASIAN. NONCIRRHOTIC METABOLIC DYSFUNCTION ASSOCIATED STEATOHEPATITIS (MASH): HAD A BIOPSY OR NON-INVASIVE TEST OBTAINED IN THE PAST 12 MONTHS DEMONSTRATING LIVER FIBROSIS OF STAGE 2 OR 3.
Age Restrictions	
Prescriber Restrictions	INITIAL: MASH: PRESCRIBED BY OR IN CONSULTATION WITH A HEPATOLOGIST, GASTROENTEROLOGIST, OR ENDOCRINOLOGIST.
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
Other Criteria	MACE: INITIAL/RENEWAL: 1) NO CONCURRENT USE WITH ANOTHER GLP-1 OR GLP-1/GIP RECEPTOR AGONIST, AND 2) HAS A HISTORY OF AND WILL CONTINUE ON, OR HAS A CONTRAINDICATION TO ALL OF THE FOLLOWING CLINICAL STANDARD OF CARE TREATMENTS: (A) AN ANTIPLATELET MEDICATION (REQUIREMENT DOES NOT APPLY TO PATIENTS WITH A HISTORY OF A HEMORRHAGIC STROKE), (B) A HMG-COA REDUCTASE INHIBITOR, AND (C) A BLOOD PRESSURE MEDICATION. MASH: INITIAL: NO CONCURRENT USE WITH REZDIFFRA, ANOTHER GLP-1 OR GLP-1/GIP RECEPTOR AGONIST. RENEWAL: 1) HAS DISEASE STABILITY OR IMPROVEMENT FROM BASELINE, AND 2) NO CONCURRENT USE WITH REZDIFFRA, ANOTHER GLP-1 OR GLP-1/GIP RECEPTOR AGONIST.

Please refer to our Evidence of Coverage for 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 FDA-approved Indications.
Off Label Uses	
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.

SEVABERTINIB

Products Affected

- HYRNUO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
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 TABLET

Products Affected

- *sildenafil (pulm.hypertension) oral tablet*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	PULMONARY ARTERIAL HYPERTENSION (PAH): INITIAL: AGES 18 YEARS OR OLDER: DIAGNOSIS CONFIRMED BY RIGHT HEART CATHETERIZATION WITH THE FOLLOWING PARAMETERS: 1) MEAN PULMONARY ARTERY PRESSURE (PAP) GREATER THAN 20 MMHG, 2) PULMONARY CAPILLARY WEDGE PRESSURE (PCWP) OF 15 MMHG OR LESS, AND 3) PULMONARY VASCULAR RESISTANCE (PVR) GREATER THAN 2 WOOD UNITS. AGES 1 TO 17 YEARS: DIAGNOSIS CONFIRMED BY RIGHT HEART CATHETERIZATION WITH THE FOLLOWING PARAMETERS: 1) MEAN PAP GREATER THAN 20 MMHG, 2) PCWP OF 15 MMHG OR LESS, AND 3) PVR OF 3 WOOD UNITS OR GREATER.
Age Restrictions	
Prescriber Restrictions	PAH: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A CARDIOLOGIST OR PULMONOLOGIST.
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
Other Criteria	PAH: INITIAL/RENEWAL: 1) NOT CONCURRENTLY OR INTERMITTENTLY TAKING ORAL ERECTILE DYSFUNCTION AGENTS (E.G. CIALIS, VIAGRA) OR ANY ORGANIC NITRATES IN ANY FORM AND 2) NO CONCURRENT USE WITH GUANYLATE CYCLASE STIMULATORS.
Indications	All Medically-accepted Indications.
Off Label Uses	
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.

SODIUM OXYBATE-XYREM

Products Affected

- *sodium oxybate*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	INITIAL: CATAPLEXY IN NARCOLEPSY, EXCESSIVE DAYTIME SLEEPINESS (EDS) IN NARCOLEPSY: PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST, PSYCHIATRIST, OR SPECIALIST IN SLEEP MEDICINE
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
Other Criteria	INITIAL: EDS IN NARCOLEPSY: 1) NO CONCURRENT USE WITH A SEDATIVE HYPNOTIC AGENT, AND 2) AGES 18 YEARS OR OLDER: TRIAL, FAILURE OF, OR CONTRAINDICATION TO A FORMULARY VERSION OF MODAFINIL, ARMODAFINIL, OR SUNOSI AND ONE GENERIC STIMULANT INDICATED FOR EDS IN NARCOLEPSY. CATAPLEXY IN NARCOLEPSY: NO CONCURRENT USE WITH A SEDATIVE HYPNOTIC AGENT. RENEWAL: CATAPLEXY IN NARCOLEPSY, EDS IN NARCOLEPSY: 1) SUSTAINED IMPROVEMENT OF SYMPTOMS COMPARED TO BASELINE, AND 2) NO CONCURRENT USE WITH A SEDATIVE HYPNOTIC AGENT.
Indications	All FDA-approved Indications.
Off Label Uses	
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.

SOFOSBUVIR/VELPATASVIR

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	HCV RNA LEVEL WITHIN PAST 6 MONTHS.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE.
Other Criteria	1) CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE, 2) NOT CONCURRENTLY TAKING ANY OF THE FOLLOWING MEDICATIONS: AMIODARONE, CARBAMAZEPINE, PHENYTOIN, PHENOBARBITAL, OXCARBAZEPINE, RIFAMPIN, RIFABUTIN, RIFAPENTINE, HIV REGIMEN THAT CONTAINS EFAVIRENZ, ROSUVASTATIN AT DOSES ABOVE 10MG, TIPRANAVIR/RITONAVIR, TOPOTECAN, SOVALDI (AS A SINGLE AGENT), HARVONI, ZEPATIER, MAVYRET, OR VOSEVI, AND 3) PATIENTS WITH DECOMPENSATED CIRRHOSIS REQUIRE CONCURRENT RIBAVIRIN UNLESS RIBAVIRIN INELIGIBLE.
Indications	All FDA-approved Indications.
Off Label Uses	
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.

SOFOSBUVIR/VELPATASVIR/VOXILAPREVIR

Products Affected

- VOSEVI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	HCV RNA LEVEL WITHIN PAST 6 MONTHS
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE.
Other Criteria	1) CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE, 2) NOT CONCURRENTLY TAKING ANY OF THE FOLLOWING MEDICATIONS: AMIODARONE, CARBAMAZEPINE, PHENYTOIN, PHENOBARBITAL, OXCARBAZEPINE, RIFAMPIN, RIFABUTIN, RIFAPENTINE, CYCLOSPORINE, PITAVASTATIN, PRAVASTATIN (DOSES ABOVE 40MG), ROSUVASTATIN, METHOTREXATE, MITOXANTRONE, IMATINIB, IRINOTECAN, LAPATINIB, SULFASALAZINE, TOPOTECAN, OR HIV REGIMEN THAT CONTAINS EFAVIRENZ, ATAZANAVIR, LOPINAVIR, TIPRANAVIR/RITONAVIR, SOVALDI (AS A SINGLE AGENT), EPCLUSA, HARVONI, ZEPATIER, OR MAVYRET, AND 3) DOES NOT HAVE MODERATE OR SEVERE HEPATIC IMPAIRMENT (CHILD-PUGH B OR C).
Indications	All FDA-approved Indications.
Off Label Uses	
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.

SOMATROPIN - NORDITROPIN

Products Affected

- NORDITROPIN FLEXPRO

PA Criteria	Criteria Details
Exclusion Criteria	INITIAL/RENEWAL: ATHLETIC ENHANCEMENT, ANTI-AGING PURPOSES.
Required Medical Information	INITIAL: PEDIATRIC GROWTH HORMONE DEFICIENCY (GHD), IDIOPATHIC SHORT STATURE (ISS), SMALL FOR GESTATIONAL AGE (SGA), NOONAN SYNDROME: HEIGHT AT LEAST 2 STANDARD DEVIATIONS BELOW THE MEAN HEIGHT FOR CHILDREN OF THE SAME AGE AND GENDER. TURNER SYNDROME (TS): CONFIRMED BY CHROMOSOMAL ANALYSIS (KARYOTYPING). PRADER WILLI SYNDROME (PWS): CONFIRMED GENETIC DIAGNOSIS OF PWS. ADULT GHD: 1) HAS A CONGENITAL, GENETIC, OR ORGANIC DISEASE (E.G., CRANIOPHARYNGIOMA, PITUITARY HYPOPLASIA, ECTOPIC POSTERIOR PITUITARY, PREVIOUS CRANIAL IRRADIATION), OR 2) GHD CONFIRMED BY ONE OF THE FOLLOWING GROWTH HORMONE (GH) STIMULATION TESTS: (A) INSULIN TOLERANCE TEST (PEAK GH OF 5 NG/ML OR LESS), (B) GLUCAGON-STIMULATION TEST (ONE OF THE FOLLOWING: (I) PEAK RESPONSE OF 3 NG/ML OR LESS AND BMI LESS THAN 25 KG/M2, (II) PEAK RESPONSE OF 3 NG/ML OR LESS AND BMI IS BETWEEN 25 - 30 KG/M2 WITH A PRE-TEST PROBABILITY, (III) PEAK RESPONSE OF 1 NG/ML OR LESS AND BMI IS BETWEEN 25 - 30 KG/M2 WITH LOW TEST PROBABILITY, OR (IV) PEAK RESPONSE OF 1 NG/ML OR LESS AND BMI IS GREATER THAN 30 KG/M2), OR (C) MACIMORELIN TEST (PEAK GH OF 2.8 NG/ML OR LESS).
Age Restrictions	SGA: 2 YEARS OF AGE OR OLDER.
Prescriber Restrictions	INITIAL/RENEWAL: ALL INDICATIONS: PRESCRIBED BY OR IN CONSULTATION WITH AN ENDOCRINOLOGIST.
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.

Please refer to our Evidence of Coverage for 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
Other Criteria	INITIAL: PEDIATRIC GHD, ISS, SGA, TS, NOONAN SYNDROME: OPEN EPIPHYSES AS CONFIRMED BY RADIOGRAPH OF THE WRIST AND HAND. INITIAL/RENEWAL: ADULT GHD, PEDIATRIC GHD, SGA, TS, PWS, NOONAN SYNDROME: NO CONCURRENT USE WITH INCRELEX. RENEWAL: ISS: 1) IMPROVEMENT WHILE ON THERAPY (INCREASED HEIGHT OR INCREASED GROWTH VELOCITY), AND 2) OPEN EPIPHYSES AS CONFIRMED BY RADIOGRAPH OF THE WRIST AND HAND. PEDIATRIC GHD, SGA, TS, NOONAN SYNDROME: 1) IMPROVEMENT WHILE ON THERAPY (INCREASED HEIGHT OR INCREASED GROWTH VELOCITY), AND 2) OPEN EPIPHYSES AS CONFIRMED BY RADIOGRAPH OF THE WRIST AND HAND OR HAS NOT COMPLETED PREPUBERTAL GROWTH. PWS: IMPROVEMENT IN BODY COMPOSITION.
Indications	All FDA-approved Indications.
Off Label Uses	
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.

SOMATROPIN - SEROSTIM

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	INITIAL/RENEWAL: ATHLETIC ENHANCEMENT, ANTI-AGING PURPOSES
Required Medical Information	HIV/WASTING: INITIAL: 1) FOR NON-SUPPRESSED HIV VIREMIA (VIRAL LOAD GREATER THAN 200 COPIES/ML), ONE OF THE FOLLOWING: (A) GREATER THAN 10% LOSS OF BASELINE BODY WEIGHT AND HAS CHRONIC DIARRHEA, CHRONIC WEAKNESS OR A FEVER FOR AT LEAST 30 DAYS, (B) 90% IDEAL BODY WEIGHT OR BODY MASS INDEX (BMI) LESS THAN 18.5 KG/M2 AND A GREATER THAN 10% WEIGHT LOSS FROM PREMORBID MAXIMUM OVER A 12-MONTH PERIOD, OR (C) 90% IDEAL BODY WEIGHT OR BMI LESS THAN 18.5 KG/M2 AND A GREATER THAN 5% WEIGHT LOSS IN THE PREVIOUS 6 MONTHS, OR 2) FOR SUPPRESSED HIV VIREMIA (VIRAL LOAD LESS THAN 200 COPIES/ML), ONE OF THE FOLLOWING: (A) GREATER THAN 5% LOSS OF PREMORBID BODY WEIGHT OVER 6 MONTHS, (B) GREATER THAN 10% LOSS OF PREMORBID BODY WEIGHT OVER 12 MONTHS, (C) LOW BMI (LESS THAN 20 KG/M2) IF OBJECTIVE WEIGHT LOSS IS NOT AVAILABLE.
Age Restrictions	
Prescriber Restrictions	HIV/WASTING: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A GASTROENTEROLOGIST, NUTRITIONAL SUPPORT SPECIALIST, OR INFECTIOUS DISEASE SPECIALIST.
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
Other Criteria	HIV/WASTING: INITIAL/RENEWAL: PATIENT IS ON OPTIMIZED HIV ANTI-RETROVIRAL THERAPY. RENEWAL: POSITIVE RESPONSE TO TREATMENT (E.G., IMPROVEMENT IN BMI OR

Please refer to our Evidence of Coverage for 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
	WEIGHT, PHYSICAL IMPROVEMENTS SUCH AS TIMED WALK OR CHAIR RISE).
Indications	All FDA-approved Indications.
Off Label Uses	
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.

SONIDEGIB

Products Affected

- ODOMZO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	LOCALLY ADVANCED BASAL CELL CARCINOMA (BCC): BASELINE SERUM CREATINE KINASE (CK) AND SERUM CREATININE LEVELS
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
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.

SORAFENIB

Products Affected

- *sorafenib*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
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.

SOTATERCEPT-CSRK

Products Affected
- WINREVAIR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	PULMONARY ARTERIAL HYPERTENSION (PAH): INITIAL: DIAGNOSIS CONFIRMED BY RIGHT HEART CATHETERIZATION WITH THE FOLLOWING PARAMETERS: 1) MEAN PULMONARY ARTERY PRESSURE (PAP) GREATER THAN 20 MMHG, 2) PULMONARY CAPILLARY WEDGE PRESSURE (PCWP) OF 15 MMHG OR LESS, AND 3) PULMONARY VASCULAR RESISTANCE (PVR) GREATER THAN 2 WOOD UNITS.
Age Restrictions	
Prescriber Restrictions	PAH: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A CARDIOLOGIST OR PULMONOLOGIST.
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
Other Criteria	PAH: INITIAL: 1) ON BACKGROUND PAH THERAPY (FOR AT LEAST 3 MONTHS) WITH AT LEAST TWO OF THE FOLLOWING AGENTS FROM DIFFERENT DRUG CLASSES: A) ORAL ENDOTHELIN RECEPTOR ANTAGONIST, B) ORAL PHOSPHODIESTERASE TYPE-5 INHIBITOR FOR PAH, C) ORAL CGMP STIMULATOR, D) IV/SQ PROSTACYCLIN, OR 2) ON ONE AGENT FROM ONE OF THE ABOVE DRUG CLASSES, AND HAS A CONTRAINDICATION OR INTOLERANCE TO ALL OF THE OTHER DRUG CLASSES.
Indications	All FDA-approved Indications.
Off Label Uses	
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.

SOTORASIB

Products Affected

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

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

SPARSENTAN

Products Affected

- FILSPARI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	PRIMARY IMMUNOGLOBULIN A NEPHROPATHY (IGAN): INITIAL: 1) DIAGNOSIS CONFIRMED BY BIOPSY, 2) PROTEINURIA OF AT LEAST 0.5G/DAY, AND 3) EGFR OF AT LEAST 30ML/MIN/1.73M2.
Age Restrictions	
Prescriber Restrictions	PRIMARY IGAN: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A NEPHROLOGIST.
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
Other Criteria	INITIAL: PRIMARY IGAN: 1) TRIED AND WILL CONTINUE TO USE AN SGLT2 INHIBITOR, OR HAS A CONTRAINDICATION TO AN SGLT2 INHIBITOR, AND 2) NO CONCURRENT USE WITH AN ACE INHIBITOR, ARB, ENDOTHELIN RECEPTOR ANTAGONIST, ALISKIREN, FABHALTA, VANRAFIA, OR VOYXACT. FSGS: 1) TRIAL OF OR CONTRAINDICATION TO AT LEAST 3 MONTHS OF TREATMENT WITH ONE OF THE FOLLOWING CLINICAL STANDARD OF CARE AGENTS: AN ACE INHIBITOR OR AN ARB, AND 2) NO CONCURRENT USE WITH AN ACE INHIBITOR OR AN ARB. RENEWAL: PRIMARY IGAN: 1) NO CONCURRENT USE WITH AN ACE INHIBITOR, ARB, ENDOTHELIN RECEPTOR ANTAGONIST, ALISKIREN, FABHALTA, VANRAFIA, OR VOYXACT, AND 2) REDUCTION IN PROTEINURIA, OR IMPROVED OR STABLE KIDNEY FUNCTION COMPARED TO BASELINE. FSGS: 1) REDUCTION IN PROTEINURIA FROM BASELINE, 2) REDUCTION IN UPCR, AND 3) NO CONCURRENT USE WITH AN ACE INHIBITOR OR AN ARB.
Indications	All FDA-approved 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	
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.

STIRIPENTOL

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	DRAVET SYNDROME: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST.
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
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.

SUNITINIB

Products Affected

- *sunitinib malate*

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

Please refer to our Evidence of Coverage for 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 - ADCIRCA, ALYQ

Products Affected

- *alyq*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	PULMONARY ARTERIAL HYPERTENSION (PAH): INITIAL: DIAGNOSIS CONFIRMED BY RIGHT HEART CATHETERIZATION WITH THE FOLLOWING PARAMETERS: 1) MEAN PULMONARY ARTERY PRESSURE (PAP) GREATER THAN 20 MMHG, 2) PULMONARY CAPILLARY WEDGE PRESSURE (PCWP) OF 15 MMHG OR LESS, AND 3) PULMONARY VASCULAR RESISTANCE (PVR) GREATER THAN 2 WOOD UNITS.
Age Restrictions	
Prescriber Restrictions	PAH: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A CARDIOLOGIST OR PULMONOLOGIST.
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
Other Criteria	PAH: INITIAL/RENEWAL: 1) NOT CONCURRENTLY OR INTERMITTENTLY TAKING ORAL ERECTILE DYSFUNCTION AGENTS (E.G. CIALIS, VIAGRA) OR ANY ORGANIC NITRATES IN ANY FORM, AND 2) NO CONCURRENT USE WITH GUANYLATE CYCLASE STIMULATORS.
Indications	All Medically-accepted Indications.
Off Label Uses	
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.

TADALAFIL-CIALIS

Products Affected

- *tadalafil oral tablet 2.5 mg, 5 mg*

PA Criteria	Criteria Details
Exclusion Criteria	ERECTILE DYSFUNCTION WITHOUT DIAGNOSIS OF BENIGN PROSTATIC HYPERPLASIA (BPH).
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	BPH: 1) TRIAL OF ONE ALPHA BLOCKER (E.G., DOXAZOSIN, TERAZOSIN, TAMSULOSIN, ALFUZOSIN), AND 2) TRIAL OF ONE 5-ALPHA-REDUCTASE INHIBITOR (E.G., FINASTERIDE, DUTASTERIDE). APPLIES TO 2.5MG AND 5MG STRENGTHS ONLY
Indications	All FDA-approved Indications.
Off Label Uses	
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.

TAFAMIDIS

Products Affected

- VYNDAMAX

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

TALAZOPARIB

Products Affected

- TALZENNA

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

Please refer to our Evidence of Coverage for 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.

TALETRECTINIB

Products Affected

- IBTROZI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
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.

TELOTRISTAT

Products Affected

- XERMELO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	CARCINOID SYNDROME DIARRHEA: PRESCRIBED BY OR IN CONSULTATION WITH AN ONCOLOGIST OR GASTROENTEROLOGIST
Coverage Duration	PLAN YEAR
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
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.

TEPOTINIB

Products Affected

- TEPMETKO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
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.

TERIPARATIDE

Products Affected

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

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

Please refer to our Evidence of Coverage for 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.

TESTOSTERONE

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	MALE HYPOGONADISM: INITIAL: CONFIRMED BY: 1) AT LEAST TWO TOTAL SERUM TESTOSTERONE LEVELS OF LESS THAN 300 NG/DL TAKEN ON SEPARATE OCCASIONS, OR 2) FREE SERUM TESTOSTERONE LEVEL OF LESS THAN 5 NG/DL.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
Other Criteria	MALE HYPOGONADISM: INITIAL/RENEWAL: 40 YEARS OR OLDER: PROSTATE SPECIFIC ANTIGEN (PSA) HAS BEEN EVALUATED WITHIN THE PAST 12 MONTHS, AND 1) PSA LEVEL IS LESS THAN OR EQUAL TO 4 NG/ML, OR 2) PSA LEVEL IS GREATER THAN 4 NG/ML AND THE BENEFITS OF ONGOING THERAPY OUTWEIGH THE RISKS OF ELEVATED PSA. RENEWAL: IMPROVED SYMPTOMS COMPARED TO BASELINE AND TOLERANCE TO TREATMENT.
Indications	All FDA-approved Indications.
Off Label Uses	
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.

TESTOSTERONE CYPIONATE - DEPO

Products Affected

- *testosterone cypionate*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	MALE HYPOGONADISM: INITIAL: CONFIRMED BY: 1) AT LEAST TWO TOTAL SERUM TESTOSTERONE LEVELS OF LESS THAN 300 NG/DL TAKEN ON SEPARATE OCCASIONS, OR 2) FREE SERUM TESTOSTERONE LEVEL OF LESS THAN 5 NG/DL.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
Other Criteria	MALE HYPOGONADISM: INITIAL/RENEWAL: 40 YEARS OR OLDER: PROSTATE SPECIFIC ANTIGEN (PSA) HAS BEEN EVALUATED WITHIN THE PAST 12 MONTHS, AND 1) PSA LEVEL IS LESS THAN OR EQUAL TO 4 NG/ML, OR 2) PSA LEVEL IS GREATER THAN 4 NG/ML AND THE BENEFITS OF ONGOING THERAPY OUTWEIGH THE RISKS OF ELEVATED PSA. RENEWAL: IMPROVED SYMPTOMS COMPARED TO BASELINE AND TOLERANCE TO TREATMENT.
Indications	All FDA-approved Indications.
Off Label Uses	
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.

TESTOSTERONE ENANTHATE

Products Affected

- *testosterone enanthate*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	MALE HYPOGONADISM: INITIAL: CONFIRMED BY: 1) AT LEAST TWO TOTAL SERUM TESTOSTERONE LEVELS OF LESS THAN 300 NG/DL TAKEN ON SEPARATE OCCASIONS, OR 2) FREE SERUM TESTOSTERONE LEVEL OF LESS THAN 5 NG/DL.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL/RENEWAL: MALE HYPOGONADISM/ MALE DELAYED PUBERTY: PLAN YEAR. OTHER INDICATIONS: PLAN YEAR.
Other Criteria	INITIAL/RENEWAL: MALE HYPOGONADISM: 40 YEARS OR OLDER: PROSTATE SPECIFIC ANTIGEN (PSA) HAS BEEN EVALUATED WITHIN THE PAST 12 MONTHS, AND 1) PSA LEVEL IS LESS THAN OR EQUAL TO 4 NG/ML, OR 2) PSA LEVEL IS GREATER THAN 4 NG/ML AND THE BENEFITS OF ONGOING THERAPY OUTWEIGH THE RISKS OF ELEVATED PSA. RENEWAL: MALE HYPOGONADISM: IMPROVED SYMPTOMS COMPARED TO BASELINE AND TOLERANCE TO TREATMENT. MALE DELAYED PUBERTY: HAS NOT RECEIVED MORE THAN TWO 6-MONTH COURSES OF TESTOSTERONE REPLACEMENT THERAPY.
Indications	All FDA-approved Indications.
Off Label Uses	
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.

TETRABENAZINE

Products Affected

- *tetrabenazine*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	HUNTINGTONS DISEASE: PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST OR MOVEMENT DISORDER SPECIALIST
Coverage Duration	PLAN YEAR
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
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.

THALIDOMIDE

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
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.

TIVOZANIB

Products Affected

- FOTIVDA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
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.

TOCILIZUMAB-AAZG IV

Products Affected

- TYENNE

PA Criteria	Criteria Details
Exclusion Criteria	CORONAVIRUS DISEASE 2019 (COVID-19) IN HOSPITALIZED ADULTS
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	INITIAL: RHEUMATOID ARTHRITIS (RA), POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS (PJIA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST. SYSTEMIC JUVENILE IDIOPATHIC ARTHRITIS (SJIA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST, DERMATOLOGIST, OR IMMUNOLOGIST.
Coverage Duration	INITIAL/RENEWAL: RA, PJIA, SJIA, GCA: PLAN YEAR. CRS: 1 MONTH.
Other Criteria	INITIAL: ALL INDICATIONS: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR THE SAME INDICATION. RA: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA/ADALIMUMAB-AATY/HADLIMA, XELJANZ, RINVOQ. GIANT CELL ARTERITIS (GCA): 1) HAS COMPLETED, STARTED, OR WILL SOON START A TAPERING COURSE OF GLUCOCORTICOIDS, AND 2) TRIAL OF OR CONTRAINDICATION TO THE PREFERRED AGENT: RINVOQ. PJIA: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA/ADALIMUMAB-AATY/HADLIMA, XELJANZ IR, RINVOQ. RENEWAL: RA, PJIA, SJIA: 1) CONTINUES TO BENEFIT FROM THE MEDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR THE SAME

Please refer to our Evidence of Coverage for 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
	INDICATION. GCA: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR THE SAME INDICATION.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

TOCILIZUMAB-AAZG SQ

Products Affected

- TYENNE
- TYENNE AUTOINJECTOR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	INITIAL: RHEUMATOID ARTHRITIS (RA), POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS (PJIA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST. SYSTEMIC JUVENILE IDIOPATHIC ARTHRITIS (SJIA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST, DERMATOLOGIST, OR IMMUNOLOGIST.
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
Other Criteria	INITIAL: RA: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA/ADALIMUMAB-AATY/HADLIMA, XELJANZ, RINVOQ. GIANT CELL ARTERITIS (GCA): 1) HAS COMPLETED, STARTED, OR WILL SOON START A TAPERING COURSE OF GLUCOCORTICOIDS, AND 2) TRIAL OF OR CONTRAINDICATION TO THE PREFERRED AGENT: RINVOQ. PJIA: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA/ADALIMUMAB-AATY/HADLIMA, XELJANZ IR, RINVOQ. INITIAL/RENEWAL: ALL INDICATIONS: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR THE SAME INDICATION. RENEWAL: RA, PJIA, SJIA: CONTINUES TO BENEFIT FROM THE MEDICATION.

Please refer to our Evidence of Coverage for 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 FDA-approved Indications.
Off Label Uses	
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.

TOFACITINIB

Products Affected

- *tofacitinib*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	INITIAL: RHEUMATOID ARTHRITIS (RA), ANKYLOSING SPONDYLITIS (AS), POLYARTICULAR COURSE JUVENILE IDIOPATHIC ARTHRITIS (PCJIA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST. PSORIATIC ARTHRITIS (PSA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST OR DERMATOLOGIST. ULCERATIVE COLITIS (UC): PRESCRIBED BY OR IN CONSULTATION WITH A GASTROENTEROLOGIST.
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
Other Criteria	INITIAL: RA: TRIAL OF OR CONTRAINDICATION TO 3 MONTHS OF TREATMENT WITH ONE CLINICAL STANDARD OF CARE AGENT: A CONVENTIONAL SYNTHETIC DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG) - IF PATIENT TRIED METHOTREXATE, THEN TRIAL OF AT LEAST 20 MG PER WEEK OR MAXIMALLY TOLERATED DOSE IS REQUIRED. AS: TRIAL OF OR CONTRAINDICATION TO ONE CLINICAL STANDARD OF CARE AGENT: AN NSAID. INITIAL/RENEWAL: ALL INDICATIONS: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR THE SAME INDICATION. RENEWAL: RA, PSA, AS, PCJIA: CONTINUES TO BENEFIT FROM THE MEDICATION.

Please refer to our Evidence of Coverage for 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 FDA-approved Indications.
Off Label Uses	
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.

TOLVAPTAN

Products Affected

- *tolvaptan (polycys kidney dis) oral tablet*
- *tolvaptan (polycys kidney dis) oral tablets, sequential*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	AUTOSOMAL DOMINANT POLYCYSTIC KIDNEY DISEASE (ADPKD): INITIAL: CONFIRMED POLYCYSTIC KIDNEY DISEASE VIA CT, MRI, OR ULTRASOUND.
Age Restrictions	
Prescriber Restrictions	ADPKD: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A NEPHROLOGIST.
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
Other Criteria	ADPKD: INITIAL: DOES NOT HAVE ESRD (I.E., RECEIVING DIALYSIS). RENEWAL: HAS NOT PROGRESSED TO ESRD/DIALYSIS.
Indications	All FDA-approved Indications.
Off Label Uses	
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 TRETINOIN

Products Affected

- ALTRENO
- *tretinoin topical cream*

PA Criteria	Criteria Details
Exclusion Criteria	COSMETIC INDICATIONS SUCH AS WRINKLES, PHOTOAGING, MELASMA.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	ACNE VULGARIS: BRAND TOPICAL TRETINOIN REQUIRES TRIAL OF OR CONTRAINDICATION TO A GENERIC TOPICAL TRETINOIN PRODUCT.
Indications	All FDA-approved Indications.
Off Label Uses	
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.

TOVORAFENIB

Products Affected

- OJEMDA ORAL SUSPENSION FOR RECONSTITUTION
- OJEMDA ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
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.

TRAMETINIB SOLUTION

Products Affected

- MEKINIST ORAL RECON SOLN

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	UNRESECTABLE OR METASTATIC MELANOMA, MELANOMA, METASTATIC NON-SMALL CELL LUNG CANCER (NSCLC), LOCALLY ADVANCED OR METASTATIC ANAPLASTIC THYROID CANCER (ATC), UNRESECTABLE OR METASTATIC SOLID TUMOR, LOW-GRADE GLIOMA (LGG): UNABLE TO SWALLOW MEKINIST TABLETS.
Indications	All FDA-approved Indications.
Off Label Uses	
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.

TRAMETINIB TABLET

Products Affected

- MEKINIST ORAL TABLET 0.5 MG, 2 MG

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

TRASTUZUMAB-DKST

Products Affected

- OGIVRI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
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.

TRASTUZUMAB-HYALURONIDASE-OYSK

Products Affected

- HERCEPTIN HYLECTA

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

Please refer to our Evidence of Coverage for 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.

TRAZODONE

Products Affected

- RALDESY

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	MAJOR DEPRESSIVE DISORDER (MDD): CONTRAINDICATION TO OR UNABLE TO SWALLOW TRAZODONE TABLETS.
Indications	All FDA-approved Indications.
Off Label Uses	
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.

TREPROSTINIL-YUTREPIA

Products Affected

- YUTREPIA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: PULMONARY ARTERIAL HYPERTENSION (PAH), PULMONARY HYPERTENSION-INTERSTITIAL LUNG DISEASE (PH-ILD): DIAGNOSIS CONFIRMED BY RIGHT HEART CATHETERIZATION WITH THE FOLLOWING PARAMETERS: 1) MEAN PULMONARY ARTERY PRESSURE (PAP) GREATER THAN 20 MMHG, 2) PULMONARY CAPILLARY WEDGE PRESSURE (PCWP) OF 15 MMHG OR LESS, AND 3) PULMONARY VASCULAR RESISTANCE (PVR) GREATER THAN 2 WOOD UNITS.
Age Restrictions	
Prescriber Restrictions	INITIAL: PAH, PH-ILD: PRESCRIBED BY OR IN CONSULTATION WITH A CARDIOLOGIST OR PULMONOLOGIST.
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
Other Criteria	INITIAL: PAH: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING AGENTS FROM DIFFERENT DRUG CLASSES: 1) ORAL ENDOTHELIN RECEPTOR ANTAGONIST, 2) ORAL PHOSPHODIESTERASE TYPE-5 INHIBITOR FOR PAH, 3) ORAL CGMP STIMULATOR, 4) IV/SQ PROSTACYCLIN.
Indications	All FDA-approved Indications.
Off Label Uses	
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.

TRIENTINE CAPSULE

Products Affected

- *trientine oral capsule 250 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	WILSONS DISEASE: 1) GENETIC TESTING CONFIRMING AN ATP7B MUTATION, 2) 24-HOUR URINARY COPPER EXCRETION (GREATER THAN 40 MICROGRAMS/24 HOURS), 3) LIVER BIOPSY WITH COPPER DRY WEIGHT GREATER THAN 75 MICROGRAMS/GRAM, OR 4) SERUM CERULOPLASMIN LEVEL OF LESS THAN 20 MG/DL.
Age Restrictions	
Prescriber Restrictions	WILSONS DISEASE: PRESCRIBED BY OR IN CONSULTATION WITH A HEPATOLOGIST OR GASTROENTEROLOGIST.
Coverage Duration	PLAN YEAR
Other Criteria	WILSONS DISEASE: TRIAL OF OR CONTRAINDICATION TO THE PREFERRED AGENT: PENICILLAMINE TABLET.
Indications	All FDA-approved Indications.
Off Label Uses	
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.

TRIFLURIDINE/TIPIRACIL

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
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.

TUCATINIB

Products Affected

- TUKYSA ORAL TABLET 150 MG, 50 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
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.

UBROGEPANT

Products Affected

- UBRELVY

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
Other Criteria	ACUTE MIGRAINE TREATMENT: 1) TRIAL OF OR CONTRAINDICATION TO ONE PREFERRED AGENT: A TRIPTAN (E.G., SUMATRIPTAN, RIZATRIPTAN), AND 2) NO CONCURRENT USE WITH OTHER CGRP INHIBITORS FOR ACUTE MIGRAINE TREATMENT.
Indications	All FDA-approved Indications.
Off Label Uses	
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.

UPADACITINIB

Products Affected

- RINVOQ
- RINVOQ LQ

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: NON-RADIOGRAPHIC AXIAL SPONDYLOARTHRITIS (NR-AXSPA): 1) C-REACTIVE PROTEIN LEVELS ABOVE THE UPPER LIMIT OF NORMAL, OR 2) SACROILIITIS ON MAGNETIC RESONANCE IMAGING (MRI).
Age Restrictions	
Prescriber Restrictions	INITIAL: RHEUMATOID ARTHRITIS (RA), ANKYLOSING SPONDYLITIS (AS), NR-AXSPA, POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS (PJIA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST. PSORIATIC ARTHRITIS (PSA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST OR DERMATOLOGIST. ATOPIC DERMATITIS (AD): PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST, ALLERGIST, OR IMMUNOLOGIST. ULCERATIVE COLITIS (UC), CROHNS DISEASE (CD): PRESCRIBED BY OR IN CONSULTATION WITH A GASTROENTEROLOGIST.
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
Other Criteria	INITIAL: RA: TRIAL OF OR CONTRAINDICATION TO 3 MONTHS OF TREATMENT WITH ONE CLINICAL STANDARD OF CARE AGENT: A CONVENTIONAL SYNTHETIC DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG) - IF PATIENT TRIED METHOTREXATE, THEN TRIAL OF AT LEAST 20 MG PER WEEK OR MAXIMALLY TOLERATED DOSE IS REQUIRED. AD: 1) INTRACTABLE PRURITUS OR CRACKING/OOZING/BLEEDING OF AFFECTED SKIN, AND 2) TRIAL OF OR CONTRAINDICATION TO ONE OF THE FOLLOWING CLINICAL STANDARD OF CARE AGENTS: A TOPICAL CORTICOSTEROID, TOPICAL

Please refer to our Evidence of Coverage for 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
	CALCINEURIN INHIBITOR, TOPICAL PDE4 INHIBITOR, OR TOPICAL JAK INHIBITOR. AS, NR-AXSPA: TRIAL OF OR CONTRAINDICATION TO ONE CLINICAL STANDARD OF CARE AGENT: AN NSAID (NON-STEROIDAL ANTI-INFLAMMATORY DRUG). GIANT CELL ARTERITIS (GCA): HAS COMPLETED, STARTED, OR WILL SOON START A TAPERING COURSE OF GLUCOCORTICOIDS. INITIAL/RENEWAL: ALL INDICATIONS: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR THE SAME INDICATION. RENEWAL: RA, PSA, AS, NR-AXSPA, PJIA: CONTINUES TO BENEFIT FROM THE MEDICATION. AD: IMPROVEMENT WHILE ON THERAPY.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

USTEKINUMAB-AAUZ IV

Products Affected

- OTULFI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: PLAQUE PSORIASIS (PSO): PSORIASIS COVERING 3 PERCENT OR MORE OF BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, GENITAL AREA, SCALP OR FACE.
Age Restrictions	
Prescriber Restrictions	INITIAL: PSORIATIC ARTHRITIS (PSA): PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST OR RHEUMATOLOGIST. PSO: PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST. CROHNS DISEASE (CD), ULCERATIVE COLITIS (UC): PRESCRIBED BY OR IN CONSULTATION WITH A GASTROENTEROLOGIST.
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
Other Criteria	INITIAL: PSO: 1) AT LEAST A 3 MONTH TRIAL OF ONE OF THE FOLLOWING CLINICAL STANDARD OF CARE AGENTS: AN ORAL IMMUNOSUPPRESSANT (CYCLOSPORINE, METHOTREXATE, TACROLIMUS), PUVA (PHOTOTHERAPY), 2) CONTRAINDICATION OR INTOLERANCE TO BOTH OF THE FOLLOWING CLINICAL STANDARD OF CARE AGENTS: AN IMMUNOSUPPRESSANT, PUVA, OR 3) PATIENT IS SWITCHING FROM A DIFFERENT BIOLOGIC, PDE-4 INHIBITOR, OR JAK INHIBITOR FOR THE SAME INDICATION. INITIAL/RENEWAL: ALL INDICATIONS: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR THE SAME INDICATION. RENEWAL: PSA, PSO: CONTINUES TO BENEFIT FROM THE MEDICATION.

Please refer to our Evidence of Coverage for 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 FDA-approved Indications.
Off Label Uses	
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-AAUZ SQ

Products Affected

- OTULFI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: PLAQUE PSORIASIS (PSO): PSORIASIS COVERING 3 PERCENT OR MORE OF BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, GENITAL AREA, SCALP OR FACE.
Age Restrictions	
Prescriber Restrictions	INITIAL: PSORIATIC ARTHRITIS (PSA): PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST OR RHEUMATOLOGIST. PSO: PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST. CROHNS DISEASE (CD), ULCERATIVE COLITIS (UC): PRESCRIBED BY OR IN CONSULTATION WITH A GASTROENTEROLOGIST.
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
Other Criteria	INITIAL: PSO: 1) AT LEAST A 3 MONTH TRIAL OF ONE OF THE FOLLOWING CLINICAL STANDARD OF CARE AGENTS: AN ORAL IMMUNOSUPPRESSANT (CYCLOSPORINE, METHOTREXATE, TACROLIMUS), PUVA (PHOTOTHERAPY), 2) CONTRAINDICATION OR INTOLERANCE TO BOTH OF THE FOLLOWING CLINICAL STANDARD OF CARE AGENTS: AN IMMUNOSUPPRESSANT, PUVA, OR 3) PATIENT IS SWITCHING FROM A DIFFERENT BIOLOGIC, PDE-4 INHIBITOR, OR JAK INHIBITOR FOR THE SAME INDICATION. INITIAL/RENEWAL: ALL INDICATIONS: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR THE SAME INDICATION. RENEWAL: PSA, PSO: CONTINUES TO BENEFIT FROM THE MEDICATION.

Please refer to our Evidence of Coverage for 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 FDA-approved Indications.
Off Label Uses	
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-AEKN IV

Products Affected

- SELARSDI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: PLAQUE PSORIASIS (PSO): PSORIASIS COVERING 3 PERCENT OR MORE OF BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, GENITAL AREA, SCALP OR FACE.
Age Restrictions	
Prescriber Restrictions	INITIAL: PSORIATIC ARTHRITIS (PSA): PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST OR RHEUMATOLOGIST. PSO: PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST. CROHNS DISEASE (CD), ULCERATIVE COLITIS (UC): PRESCRIBED BY OR IN CONSULTATION WITH A GASTROENTEROLOGIST.
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
Other Criteria	INITIAL: PSO: 1) AT LEAST A 3 MONTH TRIAL OF ONE OF THE FOLLOWING CLINICAL STANDARD OF CARE AGENTS: AN ORAL IMMUNOSUPPRESSANT (CYCLOSPORINE, METHOTREXATE, TACROLIMUS), PUVA (PHOTOTHERAPY), 2) CONTRAINDICATION OR INTOLERANCE TO BOTH OF THE FOLLOWING CLINICAL STANDARD OF CARE AGENTS: AN IMMUNOSUPPRESSANT, PUVA, OR 3) PATIENT IS SWITCHING FROM A DIFFERENT BIOLOGIC, PDE-4 INHIBITOR, OR JAK INHIBITOR FOR THE SAME INDICATION. INITIAL/RENEWAL: ALL INDICATIONS: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR THE SAME INDICATION. RENEWAL: PSA, PSO: CONTINUES TO BENEFIT FROM THE MEDICATION.

Please refer to our Evidence of Coverage for 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 FDA-approved Indications.
Off Label Uses	
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-AEKN SQ

Products Affected
- SELARSDI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: PLAQUE PSORIASIS (PSO): PSORIASIS COVERING 3 PERCENT OR MORE OF BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, GENITAL AREA, SCALP OR FACE.
Age Restrictions	
Prescriber Restrictions	INITIAL: PSORIATIC ARTHRITIS (PSA): PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST OR RHEUMATOLOGIST. PSO: PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST. CROHNS DISEASE (CD), ULCERATIVE COLITIS (UC): PRESCRIBED BY OR IN CONSULTATION WITH A GASTROENTEROLOGIST.
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
Other Criteria	INITIAL: PSO: 1) AT LEAST A 3 MONTH TRIAL OF ONE OF THE FOLLOWING CLINICAL STANDARD OF CARE AGENTS: AN ORAL IMMUNOSUPPRESSANT (CYCLOSPORINE, METHOTREXATE, TACROLIMUS), PUVA (PHOTOTHERAPY), 2) CONTRAINDICATION OR INTOLERANCE TO BOTH OF THE FOLLOWING CLINICAL STANDARD OF CARE AGENTS: AN IMMUNOSUPPRESSANT, PUVA, OR 3) PATIENT IS SWITCHING FROM A DIFFERENT BIOLOGIC, PDE-4 INHIBITOR, OR JAK INHIBITOR FOR THE SAME INDICATION. INITIAL/RENEWAL: ALL INDICATIONS: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR THE SAME INDICATION. RENEWAL: PSA, PSO: CONTINUES TO BENEFIT FROM THE MEDICATION.

Please refer to our Evidence of Coverage for 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 FDA-approved Indications.
Off Label Uses	
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-KFCE IV

Products Affected

- YESINTEK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: PLAQUE PSORIASIS (PSO): PSORIASIS COVERING 3 PERCENT OR MORE OF BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, GENITAL AREA, SCALP OR FACE.
Age Restrictions	
Prescriber Restrictions	INITIAL: PSORIATIC ARTHRITIS (PSA): PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST OR RHEUMATOLOGIST. PSO: PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST. CROHNS DISEASE (CD), ULCERATIVE COLITIS (UC): PRESCRIBED BY OR IN CONSULTATION WITH A GASTROENTEROLOGIST.
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
Other Criteria	INITIAL: PSO: 1) AT LEAST A 3 MONTH TRIAL OF ONE OF THE FOLLOWING CLINICAL STANDARD OF CARE AGENTS: AN ORAL IMMUNOSUPPRESSANT (CYCLOSPORINE, METHOTREXATE, TACROLIMUS), PUVA (PHOTOTHERAPY), 2) CONTRAINDICATION OR INTOLERANCE TO BOTH OF THE FOLLOWING CLINICAL STANDARD OF CARE AGENTS: AN IMMUNOSUPPRESSANT, PUVA, OR 3) PATIENT IS SWITCHING FROM A DIFFERENT BIOLOGIC, PDE-4 INHIBITOR, OR JAK INHIBITOR FOR THE SAME INDICATION. INITIAL/RENEWAL: ALL INDICATIONS: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR THE SAME INDICATION. RENEWAL: PSA, PSO: CONTINUES TO BENEFIT FROM THE MEDICATION.

Please refer to our Evidence of Coverage for 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 FDA-approved Indications.
Off Label Uses	
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-KFCE SQ

Products Affected

- YESINTEK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: PLAQUE PSORIASIS (PSO): PSORIASIS COVERING 3 PERCENT OR MORE OF BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, GENITAL AREA, SCALP OR FACE.
Age Restrictions	
Prescriber Restrictions	INITIAL: PSORIATIC ARTHRITIS (PSA): PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST OR RHEUMATOLOGIST. PSO: PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST. CROHNS DISEASE (CD), ULCERATIVE COLITIS (UC): PRESCRIBED BY OR IN CONSULTATION WITH A GASTROENTEROLOGIST.
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
Other Criteria	INITIAL: PSO: 1) AT LEAST A 3 MONTH TRIAL OF ONE OF THE FOLLOWING CLINICAL STANDARD OF CARE AGENTS: AN ORAL IMMUNOSUPPRESSANT (CYCLOSPORINE, METHOTREXATE, TACROLIMUS), PUVA (PHOTOTHERAPY), 2) CONTRAINDICATION OR INTOLERANCE TO BOTH OF THE FOLLOWING CLINICAL STANDARD OF CARE AGENTS: AN IMMUNOSUPPRESSANT, PUVA, OR 3) PATIENT IS SWITCHING FROM A DIFFERENT BIOLOGIC, PDE-4 INHIBITOR, OR JAK INHIBITOR FOR THE SAME INDICATION. INITIAL/RENEWAL: ALL INDICATIONS: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR THE SAME INDICATION. RENEWAL: PSA, PSO: CONTINUES TO BENEFIT FROM THE MEDICATION.

Please refer to our Evidence of Coverage for 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 FDA-approved Indications.
Off Label Uses	
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.

VALBENAZINE

Products Affected

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

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

Please refer to our Evidence of Coverage for 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.

VANDETANIB

Products Affected

- CAPRELSA ORAL TABLET 100 MG, 300 MG

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

VEDOLIZUMAB

Products Affected

- ENTYVIO
- ENTYVIO PEN

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	INITIAL: CROHNS DISEASE (CD), ULCERATIVE COLITIS (UC): PRESCRIBED BY OR IN CONSULTATION WITH A GASTROENTEROLOGIST.
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
Other Criteria	INITIAL: CD: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: SELARSDI/YESINTEK/OTULFI, HUMIRA/ADALIMUMAB-AATY/HADLIMA, RINVOQ, SKYRIZI, TREMFYA. UC: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: SELARSDI/YESINTEK/OTULFI, XELJANZ, HUMIRA/ADALIMUMAB-AATY/HADLIMA, RINVOQ, SKYRIZI, TREMFYA. INITIAL/RENEWAL: ALL INDICATIONS: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR THE SAME INDICATION.
Indications	All FDA-approved Indications.
Off Label Uses	
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.

VEMURAFENIB

Products Affected

- ZELBORAF

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	MELANOMA: ZELBORAF WILL BE USED ALONE OR IN COMBINATION WITH COTELLIC
Indications	All FDA-approved Indications.
Off Label Uses	
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.

VENETOCLAX

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
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.

VERICIGUAT

Products Affected

- VERQUVO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	HEART FAILURE (HF): INITIAL/RENEWAL: PRESCRIBED BY OR IN CONSULTATION WITH A CARDIOLOGIST.
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
Other Criteria	HF: INITIAL: HIGH-RISK WITH WORSENING HF AS EVIDENCED BY HOSPITALIZATION FOR HF OR NEED FOR INTRAVENOUS DIURETICS. INITIAL/RENEWAL: 1) NO CONCURRENT USE WITH RIOCIGUAT OR PDE-5 INHIBITORS, AND 2) HISTORY OF AND CONTINUATION OF, OR CONTRAINDICATION OR INTOLERANCE TO, ONE AGENT FROM ANY OF THE FOLLOWING GUIDELINE-DIRECTED MEDICAL THERAPY (GDMT) MEDICATION CLASSES: (A) ACE INHIBITOR, ARB, OR ARNI, (B) BETA BLOCKER, (C) ALDOSTERONE ANTAGONIST, (D) SGLT-2 INHIBITOR.
Indications	All FDA-approved Indications.
Off Label Uses	
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*
- *vigadrone*
- *vigpoder*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	INITIAL: REFRACTORY COMPLEX PARTIAL SEIZURES (CPS), INFANTILE SPASMS: PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST.
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
Other Criteria	INITIAL: CPS: TRIAL OF OR CONTRAINDICATION TO TWO ANTIEPILEPTIC AGENTS.
Indications	All FDA-approved Indications.
Off Label Uses	
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.

VIMSELTINIB

Products Affected

- ROMVIMZA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
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.

VISMODEGIB

Products Affected

- ERIVEDGE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
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.

VONOPRAZAN

Products Affected

- VOQUEZNA

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

VORASIDENIB

Products Affected

- VORANIGO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
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.

VORICONAZOLE SUSPENSION

Products Affected

- *voriconazole oral suspension for reconstitution*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	CANDIDA INFECTIONS: 3 MOS. CONTINUATION OF THERAPY, ALL OTHER INDICATIONS: PLAN YEAR.
Other Criteria	CANDIDA INFECTIONS: CONTRAINDICATION TO OR UNABLE TO SWALLOW FLUCONAZOLE TABLETS. ALL INDICATIONS EXCEPT ESOPHAGEAL CANDIDIASIS: UNABLE TO SWALLOW TABLETS. CONTINUATION OF THERAPY AFTER HOSPITAL DISCHARGE REQUIRES NO EXTRA CRITERIA.
Indications	All FDA-approved Indications.
Off Label Uses	
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.

ZANUBRUTINIB

Products Affected

- BRUKINSA ORAL CAPSULE
- BRUKINSA ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	MANTLE CELL LYMPHOMA: INTOLERANCE TO CALQUENCE. CHRONIC LYMPHOCYTIC LEUKEMIA, SMALL LYMPHOCYTIC LYMPHOMA: INTOLERANCE TO CALQUENCE OR IMBRUVICA. WALDENSTROMS MACROGLOBULINEMIA: NO STEP REQUIRED.
Indications	All FDA-approved Indications.
Off Label Uses	
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.

ZIFTOMENIB

Products Affected

- KOMZIFTI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
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.

ZONGERTINIB

Products Affected

- HERNEXEOS

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

ZURANOLONE

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	14 DAYS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
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.

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ZELBORAF 541
ZTALMY 285

Please refer to our Evidence of Coverage for 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 ORAL CAPSULE 20 MG, 25 MG, 30 MG..... 553
ZYDELIG 315
ZYKADIA 217
ZYMFENTRA 322, 323

Please refer to our Evidence of Coverage for 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.

ARIPIPRAZOLE FILM

Products Affected

Step 2:

- OPIPZA 10 MG ORAL FILM
- OPIPZA 2 MG ORAL FILM
- OPIPZA 5 MG ORAL FILM

Please refer to our Evidence of Coverage for 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.

Details

Criteria	TRIAL OF GENERIC ARIPIPRAZOLE TABLETS IN THE PAST 120 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.

ARIPIPRAZOLE ODT

Products Affected

Step 2:

- *aripiprazole 10 mg disintegrating tablet*
- *aripiprazole 15 mg disintegrating tablet*

Details

Criteria	PRIOR CLAIM FOR ONE FORMULARY ORAL ANTIPSYCHOTIC: RISPERIDONE, CLOZAPINE TABLET, OLANZAPINE, IMMEDIATE RELEASE QUETIAPINE FUMARATE, ZIPRASIDONE, ARIPIPRAZOLE (TAB, FILM, SOLN) ASENAPINE, PALIPERIDONE, LURASIDONE WITHIN THE PAST 120 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.

ASENAPINE PATCH

Products Affected

Step 2:

- SECUADO 3.8 MG/24 HOUR TRANSDERMAL 24 HOUR PATCH
- SECUADO 5.7 MG/24 HOUR TRANSDERMAL 24 HOUR PATCH
- SECUADO 7.6 MG/24 HOUR TRANSDERMAL 24 HOUR PATCH

Details

Criteria	CLAIM FOR 2 FORMULARY ORAL GENERIC ANTIPSYCHOTICS: LURASIDONE, RISPERIDONE, CLOZAPINE TAB, OLANZAPINE, IR QUETIAPINE FUMARATE, ZIPRASIDONE, ARIPIPRAZOLE, ASENAPINE, PALIPERIDONE WITHIN PAST 365 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.

B VERSUS D ADMINISTRATIVE STEP

Products Affected

Step 2:

- *cyclophosphamide 25 mg capsule*
- *cyclophosphamide 25 mg tablet*
- *cyclophosphamide 50 mg capsule*
- *cyclophosphamide 50 mg tablet*
- JYLAMVO 2 MG/ML ORAL SOLUTION
- *methotrexate sodium 2.5 mg tablet*
- XATMEP 2.5 MG/ML ORAL SOLUTION

Details

Criteria	IN ORDER TO ASSIST IN A PART B VS. D PAYMENT DETERMINATION, A PRIOR CLAIM SEEN FOR A RHEUMATOID ARTHRITIS, PSORIASIS OR ACTIVE POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS DRUG WITHIN THE PAST 120 DAYS WILL QUALIFY FOR PART D PAYMENT. ALL OTHER INDICATIONS WILL HAVE A PART B VS. D PAYMENT DETERMINATION MADE THROUGH THE FORMULARY EXCEPTION PROCESS PRIOR TO THE APPROVAL OF THE DRUG.

Please refer to our Evidence of Coverage for 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.

CLOZAPINE

Products Affected

Step 2:

- *clozapine 100 mg disintegrating tablet*
- *clozapine 12.5 mg disintegrating tablet*
- *clozapine 150 mg disintegrating tablet*
- *clozapine 200 mg disintegrating tablet*
- *clozapine 25 mg disintegrating tablet*
- VERSACLOZ 50 MG/ML ORAL SUSPENSION

Details

Criteria	PRIOR CLAIM FOR ONE FORMULARY ORAL ANTIPSYCHOTIC: RISPERIDONE, CLOZAPINE TABLET, OLANZAPINE, IMMEDIATE RELEASE QUETIAPINE FUMARATE, ZIPRASIDONE, ARIPIPRAZOLE, ASENAPINE, PALIPERIDONE, LURASIDONE WITHIN THE PAST 120 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.

DRIZALMA SPRINKLE

Products Affected

Step 2:

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

Details

Criteria	PRIOR CLAIM FOR FORMULARY GENERIC DULOXETINE CAPSULE WITHIN THE PAST 120 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.

ESLICARBAZEPINE ACETATE

Products Affected

Step 2:

- *eslicarbazepine 200 mg tablet*
- *eslicarbazepine 400 mg tablet*
- *eslicarbazepine 600 mg tablet*
- *eslicarbazepine 800 mg tablet*

Details

Criteria	PRIOR CLAIM FOR 2 GENERIC ANTICONVULSANT AGENTS (CARBAMAZEPINE, DIVALPROEX SODIUM, GABAPENTIN, LAMOTRIGINE, LEVETIRACETAM, OXCARBAZEPINE, TIAGABINE, TOPIRAMATE, VALPROIC ACID, ZONISAMIDE OR LACOSAMIDE), WITHIN THE PAST 365 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.

FIBRATES

Products Affected

Step 2:

- *omega-3 acid ethyl esters 1 gram capsule*

Details

Criteria	PRIOR CLAIM FOR GENERIC FENOFIBRATE IN THE LAST 120 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.

HIGH INTENSITY STATIN

Products Affected

Step 2:

- NEXLETOL 180 MG TABLET
- NEXLIZET 180 MG-10 MG TABLET
- REPATHA PUSHTRONEX 420 MG/3.5 ML SUBCUTANEOUS WEARABLE INJECTOR
- REPATHA SURECLICK 140 MG/ML SUBCUTANEOUS PEN INJECTOR
- REPATHA SYRINGE 140 MG/ML SUBCUTANEOUS SYRINGE

Details

Criteria	PRIOR 25 DAY TRIAL OF GENERIC HIGH INTENSITY STATIN: FORMULARY VERSION OF ATORVASTATIN (40 MG or 80 MG) OR ROSUVASTATIN (20 MG or 40 MG) WITHIN THE PAST 120 DAYS. OTHERWISE, A STEP EXCEPTION REQUEST IS REQUIRED IF PATIENT CANNOT TOLERATE A STATIN.

Please refer to our Evidence of Coverage for 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.

ILOPERIDONE

Products Affected

Step 2:

- FANAPT 1 MG TABLET
- FANAPT 10 MG TABLET
- FANAPT 12 MG TABLET
- FANAPT 2 MG TABLET
- FANAPT 4 MG TABLET
- FANAPT 6 MG TABLET
- FANAPT 8 MG TABLET
- FANAPT TITRATION PACK A 1 MG (2)-2 MG (2)-4 MG (2)-6 MG (2) TABLETS
- FANAPT TITRATION PACK B 1 MG (6)-2 MG (2)-6 MG (2)-8 MG (2) TABLETS
- FANAPT TITRATION PACK C 1 MG (4)-2 MG (2)-6 MG (2) TABLETS

Details

Criteria	CLAIM FOR 2 FORMULARY ORAL GENERIC ANTIPSYCHOTICS: LURASIDONE, RISPERIDONE, CLOZAPINE TAB, OLANZAPINE, IR QUETIAPINE FUMARATE, ZIPRASIDONE, ARIPIPRAZOLE, ASENAPINE, PALIPERIDONE WITHIN THE PAST 365 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.

INSULIN SUPPLY PAYMENT DETERMINATION ST

Products Affected

Step 2:

- 1ST TIER UNIFINE PENTIPS 31 GAUGE X 1/4" NEEDLE
- 1ST TIER UNIFINE PENTIPS 31 GAUGE X 3/16" NEEDLE
- 1ST TIER UNIFINE PENTIPS 31 GAUGE X 5/16" NEEDLE
- 1ST TIER UNIFINE PENTIPS 32 GAUGE X 5/32" NEEDLE
- 1ST TIER UNIFINE PENTIPS PLUS 29 GAUGE X 1/2" NEEDLE
- 1ST TIER UNIFINE PENTIPS PLUS 31 GAUGE X 3/16" NEEDLE
- 1ST TIER UNIFINE PENTIPS PLUS 32 GAUGE X 5/32" NEEDLE
- ADVOCATE PEN NEEDLE 31 GAUGE X 3/16"
- ADVOCATE PEN NEEDLE 31 GAUGE X 5/16"
- ADVOCATE PEN NEEDLE 32 GAUGE X 5/32"
- ADVOCATE PEN NEEDLE 33 GAUGE X 5/32"
- ADVOCATE SYRINGES 0.3 ML 30 GAUGE X 5/16"
- ADVOCATE SYRINGES 0.3 ML 31 GAUGE X 5/16"
- ADVOCATE SYRINGES 0.5 ML 30 GAUGE X 5/16"
- ADVOCATE SYRINGES 0.5 ML 31 GAUGE X 5/16"
- ADVOCATE SYRINGES 1 ML 30 GAUGE X 5/16"
- ADVOCATE SYRINGES 1 ML 31 GAUGE X 5/16"
- ALCOHOL PADS
- ALCOHOL PREP PADS
- ALCOHOL SWABS
- ALCOHOL WIPES
- AQINJECT PEN NEEDLE 31 GAUGE X 3/16"
- AQINJECT PEN NEEDLE 32 GAUGE X 5/32"
- ASSURE ID DUO PRO SAFETY PEN NEEDLE 31 GAUGE X 3/16"
- ASSURE ID DUO-SHIELD 30 GAUGE X 3/16" NEEDLE
- ASSURE ID DUO-SHIELD 30 GAUGE X 5/16" NEEDLE
- ASSURE ID INSULIN SAFETY 0.5 ML 31 GAUGE X 15/64" SYRINGE
- ASSURE ID INSULIN SAFETY 1 ML 29 GAUGE X 1/2" SYRINGE
- ASSURE ID INSULIN SAFETY 1 ML 31 GAUGE X 15/64" SYRINGE
- ASSURE ID PEN NEEDLE 30 GAUGE X 5/16"
- ASSURE ID PRO PEN NEEDLE 30 GAUGE X 3/16"
- BD ALCOHOL SWABS
- BD AUTOSHIELD DUO PEN NEEDLE 30 GAUGE X 3/16"
- BD ECLIPSE LUER-LOK 1 ML 30 GAUGE X 1/2" SYRINGE
- BD INSULIN SYRINGE 1 ML 27 GAUGE X 1/2"
- BD INSULIN SYRINGE ULTRA-FINE (HALF UNIT) 0.3 ML 31 GAUGE X 5/16"
- BD INSULIN SYRINGE ULTRA-FINE 0.3 ML 30 GAUGE X 1/2"
- BD INSULIN SYRINGE ULTRA-FINE 0.5 ML 30 GAUGE X 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.

- BD SAFETYGLIDE INSULIN SYRINGE 0.3 ML 29 GAUGE X 1/2"
- BD SAFETYGLIDE INSULIN SYRINGE 0.3 ML 31 GAUGE X 15/64"
- BD SAFETYGLIDE INSULIN SYRINGE 0.3 ML 31 GAUGE X 5/16"
- BD SAFETYGLIDE INSULIN SYRINGE 0.5 ML 29 GAUGE X 1/2"
- BD SAFETYGLIDE INSULIN SYRINGE 0.5 ML 30 GAUGE X 5/16"
- BD SAFETYGLIDE INSULIN SYRINGE 0.5 ML 31 GAUGE X 15/64"
- BD SAFETYGLIDE INSULIN SYRINGE 1 ML 29 GAUGE X 1/2"
- BD SAFETYGLIDE INSULIN SYRINGE 1 ML 31 GAUGE X 15/64"
- BD SAFETYGLIDE SYRINGE 1 ML 27 GAUGE X 5/8"
- BD ULTRA-FINE MICRO PEN NEEDLE 32 GAUGE X 1/4"
- BD ULTRA-FINE MINI PEN NEEDLE 31 GAUGE X 3/16"
- BD ULTRA-FINE NANO PEN NEEDLE 32 GAUGE X 5/32"
- BD ULTRA-FINE ORIGINAL PEN NEEDLE 29 GAUGE X 1/2"
- BD ULTRA-FINE SHORT PEN NEEDLE 31 GAUGE X 5/16"
- BD VEO INSULIN SYRINGE ULTRA-FINE (HALF UNIT) 0.3 ML 31 GAUGE X 15/64"
- BD VEO INSULIN SYRINGE ULTRA-FINE 0.3 ML 31 GAUGE X 15/64"
- BD VEO INSULIN SYRINGE ULTRA-FINE 1 ML 31 GAUGE X 15/64"
- BD VEO INSULIN SYRINGE ULTRA-FINE 1/2 ML 31 GAUGE X 15/64"
- BORDERED GAUZE 2" X 2" BANDAGE
- CAREFINE PEN NEEDLE 29 GAUGE X 1/2"
- CAREFINE PEN NEEDLE 30 GAUGE X 5/16"
- CAREFINE PEN NEEDLE 31 GAUGE X 1/4"
- CAREFINE PEN NEEDLE 31 GAUGE X 5/16"
- CAREFINE PEN NEEDLE 32 GAUGE X 1/4"
- CAREFINE PEN NEEDLE 32 GAUGE X 3/16"
- CAREFINE PEN NEEDLE 32 GAUGE X 5/32"
- CARETOUCH ALCOHOL PREP PAD TOPICAL PADS
- CARETOUCH INSULIN SYRINGE 0.3 ML 31 GAUGE X 5/16"
- CARETOUCH INSULIN SYRINGE 0.5 ML 30 GAUGE X 5/16"
- CARETOUCH INSULIN SYRINGE 0.5 ML 31 GAUGE X 5/16"
- CARETOUCH INSULIN SYRINGE 1 ML 28 GAUGE X 5/16"
- CARETOUCH INSULIN SYRINGE 1 ML 29 GAUGE X 5/16"
- CARETOUCH INSULIN SYRINGE 1 ML 30 GAUGE X 5/16"
- CARETOUCH INSULIN SYRINGE 1 ML 31 GAUGE X 5/16"
- CARETOUCH PEN NEEDLE 29 GAUGE X 1/2"
- CARETOUCH PEN NEEDLE 31 GAUGE X 1/4"
- CARETOUCH PEN NEEDLE 31 GAUGE X 3/16"
- CARETOUCH PEN NEEDLE 31 GAUGE X 5/16"
- CARETOUCH PEN NEEDLE 32 GAUGE X 3/16"
- CARETOUCH PEN NEEDLE 32 GAUGE X 5/32"
- CLICKFINE PEN NEEDLE 31 GAUGE X 1/4"
- CLICKFINE PEN NEEDLE 32 GAUGE X 5/32"
- COMFORT EZ INSULIN SYRINGE 0.3 ML 29 GAUGE X 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.

- COMFORT EZ INSULIN SYRINGE 0.3 ML 30 GAUGE X 1/2"
- COMFORT EZ INSULIN SYRINGE 0.3 ML 30 GAUGE X 5/16"
- COMFORT EZ INSULIN SYRINGE 0.3 ML 31 GAUGE X 15/64"
- COMFORT EZ INSULIN SYRINGE 0.3 ML 31 GAUGE X 5/16"
- COMFORT EZ INSULIN SYRINGE 0.5 ML 29 GAUGE X 1/2"
- COMFORT EZ INSULIN SYRINGE 0.5 ML 30 GAUGE X 1/2"
- COMFORT EZ INSULIN SYRINGE 0.5 ML 30 GAUGE X 5/16"
- COMFORT EZ INSULIN SYRINGE 0.5 ML 31 GAUGE X 5/16"
- COMFORT EZ INSULIN SYRINGE 1 ML 27 GAUGE X 1/2"
- COMFORT EZ INSULIN SYRINGE 1 ML 28 GAUGE X 1/2"
- COMFORT EZ INSULIN SYRINGE 1 ML 29 GAUGE X 1/2"
- COMFORT EZ INSULIN SYRINGE 1 ML 30 GAUGE X 1/2"
- COMFORT EZ INSULIN SYRINGE 1 ML 30 GAUGE X 5/16"
- COMFORT EZ INSULIN SYRINGE 1 ML 31 GAUGE X 15/64"
- COMFORT EZ INSULIN SYRINGE 1 ML 31 GAUGE X 5/16"
- COMFORT EZ INSULIN SYRINGE 1/2 ML 28 GAUGE X 1/2"
- COMFORT EZ INSULIN SYRINGE 1/2 ML 31 GAUGE X 15/64"
- COMFORT EZ PEN NEEDLES 29 GAUGE X 1/2"
- COMFORT EZ PEN NEEDLES 31 GAUGE X 1/4"
- COMFORT EZ PEN NEEDLES 31 GAUGE X 3/16"
- COMFORT EZ PEN NEEDLES 31 GAUGE X 5/16"
- COMFORT EZ PEN NEEDLES 32 GAUGE X 1/4"
- COMFORT EZ PEN NEEDLES 32 GAUGE X 3/16"
- COMFORT EZ PEN NEEDLES 32 GAUGE X 5/16"
- COMFORT EZ PEN NEEDLES 32 GAUGE X 5/32"
- COMFORT EZ PEN NEEDLES 33 GAUGE X 1/4"
- COMFORT EZ PEN NEEDLES 33 GAUGE X 3/16"
- COMFORT EZ PEN NEEDLES 33 GAUGE X 5/16"
- COMFORT EZ PEN NEEDLES 33 GAUGE X 5/32"
- COMFORT EZ PRO SAFETY PEN NEEDLE 30 GAUGE X 5/16"
- COMFORT EZ PRO SAFETY PEN NEEDLE 31 GAUGE X 3/16"
- COMFORT EZ PRO SAFETY PEN NEEDLE 31 GAUGE X 5/32"
- COMFORT TOUCH PEN NEEDLE 31 GAUGE X 1/4"
- COMFORT TOUCH PEN NEEDLE 31 GAUGE X 3/16"
- COMFORT TOUCH PEN NEEDLE 31 GAUGE X 5/16"
- COMFORT TOUCH PEN NEEDLE 31 GAUGE X 5/32"
- COMFORT TOUCH PEN NEEDLE 32 GAUGE X 1/4"
- COMFORT TOUCH PEN NEEDLE 32 GAUGE X 3/16"
- COMFORT TOUCH PEN NEEDLE 32 GAUGE X 5/16"
- COMFORT TOUCH PEN NEEDLE 32 GAUGE X 5/32"
- COMFORT TOUCH PEN NEEDLE 33 GAUGE X 1/4"
- COMFORT TOUCH PEN NEEDLE 33 GAUGE X 3/16"
- COMFORT TOUCH PEN NEEDLE 33 GAUGE X 5/32"
- CURITY ALCOHOL SWABS
- CURITY GAUZE 2" X 2" BANDAGE

Please refer to our Evidence of Coverage for 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.

- CURITY GAUZE 2" X 2" SPONGE
- DERMACEA 2" X 2" BANDAGE
- DERMACEA 2" X 2" SPONGE
- DERMACEA NON-WOVEN 2" X 2" SPONGE
- DROPLET INSULIN SYRINGE (HALF UNIT) 0.3 ML 29 GAUGE X 1/2"
- DROPLET INSULIN SYRINGE (HALF UNIT) 0.3 ML 30 GAUGE X 1/2"
- DROPLET INSULIN SYRINGE (HALF UNIT) 0.3 ML 30 GAUGE X 5/16"
- DROPLET INSULIN SYRINGE (HALF UNIT) 0.3 ML 31 GAUGE X 15/64"
- DROPLET INSULIN SYRINGE (HALF UNIT) 0.3 ML 31 GAUGE X 5/16"
- DROPLET INSULIN SYRINGE (HALF UNIT) 0.5 ML 29 GAUGE X 1/2"
- DROPLET INSULIN SYRINGE (HALF UNIT) 0.5 ML 30 GAUGE X 1/2"
- DROPLET INSULIN SYRINGE (HALF UNIT) 0.5 ML 30 GAUGE X 15/64"
- DROPLET INSULIN SYRINGE (HALF UNIT) 0.5 ML 30 GAUGE X 5/16"
- DROPLET INSULIN SYRINGE (HALF UNIT) 0.5 ML 31 GAUGE X 15/64"
- DROPLET INSULIN SYRINGE (HALF UNIT) 0.5 ML 31 GAUGE X 5/16"
- DROPLET INSULIN SYRINGE 0.3 ML 29 GAUGE X 1/2"
- DROPLET INSULIN SYRINGE 0.3 ML 30 GAUGE X 1/2"
- DROPLET INSULIN SYRINGE 0.3 ML 30 GAUGE X 15/64"
- DROPLET INSULIN SYRINGE 0.3 ML 30 GAUGE X 5/16"
- DROPLET INSULIN SYRINGE 0.3 ML 31 GAUGE X 15/64"
- DROPLET INSULIN SYRINGE 0.3 ML 31 GAUGE X 5/16"
- DROPLET INSULIN SYRINGE 0.5 ML 29 GAUGE X 1/2"
- DROPLET INSULIN SYRINGE 0.5 ML 30 GAUGE X 1/2"
- DROPLET INSULIN SYRINGE 0.5 ML 30 GAUGE X 5/16"
- DROPLET INSULIN SYRINGE 0.5 ML 31 GAUGE X 5/16"
- DROPLET INSULIN SYRINGE 1 ML 29 GAUGE X 1/2"
- DROPLET INSULIN SYRINGE 1 ML 30 GAUGE X 1/2"
- DROPLET INSULIN SYRINGE 1 ML 30 GAUGE X 15/64"
- DROPLET INSULIN SYRINGE 1 ML 30 GAUGE X 5/16"
- DROPLET INSULIN SYRINGE 1 ML 31 GAUGE X 15/64"
- DROPLET INSULIN SYRINGE 1 ML 31 GAUGE X 5/16"
- DROPLET INSULIN SYRINGE 1/2 ML 31 GAUGE X 15/64"
- DROPLET MICRON PEN NEEDLE 34 GAUGE X 9/64"
- DROPLET PEN NEEDLE 29 GAUGE X 1/2"
- DROPLET PEN NEEDLE 29 GAUGE X 3/8"
- DROPLET PEN NEEDLE 30 GAUGE X 5/16"
- DROPLET PEN NEEDLE 31 GAUGE X 1/4"
- DROPLET PEN NEEDLE 31 GAUGE X 3/16"
- DROPLET PEN NEEDLE 31 GAUGE X 5/16"
- DROPLET PEN NEEDLE 32 GAUGE X 1/4"
- DROPLET PEN NEEDLE 32 GAUGE X 3/16"
- DROPLET PEN NEEDLE 32 GAUGE X 5/16"
- DROPLET PEN NEEDLE 32 GAUGE X 5/32"
- DROPSAFE ALCOHOL PREP PADS
- DROPSAFE INSULIN SYRINGE 0.3 ML 31 GAUGE X 15/64"

Please refer to our Evidence of Coverage for 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.

- DROPSAFE INSULIN SYRINGE 0.3 ML 31 GAUGE X 5/16"
- DROPSAFE INSULIN SYRINGE 0.5 ML 31 GAUGE X 15/64"
- DROPSAFE INSULIN SYRINGE 0.5 ML 31 GAUGE X 5/16"
- DROPSAFE INSULIN SYRINGE 1 ML 29 GAUGE X 1/2"
- DROPSAFE INSULIN SYRINGE 1 ML 31 GAUGE X 15/64"
- DROPSAFE INSULIN SYRINGE 1 ML 31 GAUGE X 5/16"
- DROPSAFE PEN NEEDLE 31 GAUGE X 1/4"
- DROPSAFE PEN NEEDLE 31 GAUGE X 3/16"
- DROPSAFE PEN NEEDLE 31 GAUGE X 5/16"
- DROPSAFE PEN NEEDLE 31 GAUGE X 5/32"
- EASY COMFORT ALCOHOL PAD TOPICAL PADS
- EASY COMFORT INSULIN SYRINGE 0.3 ML 31 GAUGE X 5/16"
- EASY COMFORT INSULIN SYRINGE 0.3 ML 31 X 1/2"
- EASY COMFORT INSULIN SYRINGE 0.5 ML 30 GAUGE X 1/2"
- EASY COMFORT INSULIN SYRINGE 0.5 ML 30 GAUGE X 5/16"
- EASY COMFORT INSULIN SYRINGE 0.5 ML 31 GAUGE X 5/16"
- EASY COMFORT INSULIN SYRINGE 1 ML 29 GAUGE X 5/16"
- EASY COMFORT INSULIN SYRINGE 1 ML 30 GAUGE X 1/2"
- EASY COMFORT INSULIN SYRINGE 1 ML 30 GAUGE X 5/16"
- EASY COMFORT INSULIN SYRINGE 1 ML 31 GAUGE X 5/16"
- EASY COMFORT INSULIN SYRINGE 1 ML 32 GAUGE X 5/16"
- EASY COMFORT INSULIN SYRINGE 1/2 ML 29 X 5/16"
- EASY COMFORT INSULIN SYRINGE 1/2 ML 32 GAUGE X 5/16"
- EASY COMFORT PEN NEEDLES 29 GAUGE X 3/16"
- EASY COMFORT PEN NEEDLES 29 GAUGE X 5/32"
- EASY COMFORT PEN NEEDLES 31 GAUGE X 1/4"
- EASY COMFORT PEN NEEDLES 31 GAUGE X 3/16"
- EASY COMFORT PEN NEEDLES 31 GAUGE X 5/16"
- EASY COMFORT PEN NEEDLES 32 GAUGE X 5/32"
- EASY COMFORT PEN NEEDLES 33 GAUGE X 1/4"
- EASY COMFORT PEN NEEDLES 33 GAUGE X 3/16"
- EASY COMFORT PEN NEEDLES 33 GAUGE X 5/32"
- EASY COMFORT SAFETY PEN NEEDLE 31 GAUGE X 1/4"
- EASY COMFORT SAFETY PEN NEEDLE 31 GAUGE X 3/16"
- EASY COMFORT SAFETY PEN NEEDLE 32 GAUGE X 5/32"
- EASY GLIDE INSULIN SYRINGE 0.3 ML 31 GAUGE X 15/64"
- EASY GLIDE INSULIN SYRINGE 1 ML 31 GAUGE X 15/64"
- EASY GLIDE INSULIN SYRINGE 1/2 ML 31 GAUGE X 15/64"
- EASY GLIDE PEN NEEDLE 33 GAUGE X 5/32"
- EASY TOUCH 29 GAUGE X 1/2" NEEDLE
- EASY TOUCH 31 GAUGE X 1/4" NEEDLE
- EASY TOUCH 31 GAUGE X 3/16" NEEDLE
- EASY TOUCH 31 GAUGE X 5/16" NEEDLE
- EASY TOUCH 32 GAUGE X 1/4" NEEDLE

Please refer to our Evidence of Coverage for 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.

- EASY TOUCH 32 GAUGE X 3/16" NEEDLE
- EASY TOUCH 32 GAUGE X 5/32" NEEDLE
- EASY TOUCH ALCOHOL PREP PADS
- EASY TOUCH AUTORETRACT SYRINGE 0.5 ML 30 GAUGE X 1/4"
- EASY TOUCH AUTORETRACT SYRINGE 0.5 ML 30 GAUGE X 5/16"
- EASY TOUCH AUTORETRACT SYRINGE 1 ML 30 GAUGE X 1/4"
- EASY TOUCH AUTORETRACT SYRINGE 1 ML 30 GAUGE X 5/16"
- EASY TOUCH FLIPLOCK INSULIN 1 ML 29 GAUGE X 1/2" SYRINGE
- EASY TOUCH FLIPLOCK INSULIN 1 ML 31 GAUGE X 5/16" SYRINGE
- EASY TOUCH FLIPLOCK INSULIN SYRINGE 1 ML 30 GAUGE X 1/2"
- EASY TOUCH FLIPLOCK INSULIN SYRINGE 1 ML 30 GAUGE X 5/16"
- EASY TOUCH FLIPLOCK SYRINGE 1 ML 27 GAUGE X 1/2"
- EASY TOUCH INSULIN SAFETY SYRINGE 0.5 ML 29 GAUGE X 1/2"
- EASY TOUCH INSULIN SAFETY SYRINGE 0.5 ML 30 GAUGE X 5/16"
- EASY TOUCH INSULIN SAFETY SYRINGE 1 ML 29 GAUGE X 1/2"
- EASY TOUCH INSULIN SAFETY SYRINGE 1 ML 30 GAUGE X 1/2"
- EASY TOUCH INSULIN SYRINGE (HALF UNIT) 0.3 ML 30 GAUGE X 5/16"
- EASY TOUCH INSULIN SYRINGE (HALF UNIT) 0.3 ML 31 GAUGE X 1/4"
- EASY TOUCH INSULIN SYRINGE (HALF UNIT) 0.3 ML 31 GAUGE X 5/16"
- EASY TOUCH INSULIN SYRINGE 0.3 ML 30 GAUGE X 1/2"
- EASY TOUCH INSULIN SYRINGE 0.3 ML 30 GAUGE X 5/16"
- EASY TOUCH INSULIN SYRINGE 0.3 ML 31 GAUGE X 5/16"
- EASY TOUCH INSULIN SYRINGE 0.5 ML 29 GAUGE X 1/2"
- EASY TOUCH INSULIN SYRINGE 0.5 ML 30 GAUGE X 1/2"
- EASY TOUCH INSULIN SYRINGE 0.5 ML 30 GAUGE X 5/16"
- EASY TOUCH INSULIN SYRINGE 0.5 ML 31 GAUGE X 5/16"
- EASY TOUCH INSULIN SYRINGE 1 ML 27 GAUGE X 1/2"
- EASY TOUCH INSULIN SYRINGE 1 ML 27 GAUGE X 5/8"
- EASY TOUCH INSULIN SYRINGE 1 ML 28 GAUGE X 1/2"
- EASY TOUCH INSULIN SYRINGE 1 ML 29 GAUGE X 1/2"
- EASY TOUCH INSULIN SYRINGE 1 ML 30 GAUGE X 1/2"
- EASY TOUCH INSULIN SYRINGE 1 ML 30 GAUGE X 5/16"
- EASY TOUCH INSULIN SYRINGE 1 ML 31 GAUGE X 1/4"
- EASY TOUCH INSULIN SYRINGE 1 ML 31 GAUGE X 5/16"
- EASY TOUCH INSULIN SYRINGE 1/2 ML 27 GAUGE X 1/2"
- EASY TOUCH INSULIN SYRINGE 1/2 ML 28 GAUGE X 1/2"
- EASY TOUCH INSULIN SYRINGE 1/2 ML 31 GAUGE X 1/4"
- EASY TOUCH LUER LOCK INSULIN 1 ML SYRINGE
- EASY TOUCH PEN NEEDLE 30 GAUGE X 5/16"
- EASY TOUCH SAFETY PEN NEEDLE 29 GAUGE X 3/16"
- EASY TOUCH SAFETY PEN NEEDLE 29 GAUGE X 5/16"
- EASY TOUCH SAFETY PEN NEEDLE 30 GAUGE X 1/4"
- EASY TOUCH SAFETY PEN NEEDLE 30 GAUGE X 3/16"

Please refer to our Evidence of Coverage for 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.

- EASY TOUCH SAFETY PEN NEEDLE 30 GAUGE X 5/16"
- EASY TOUCH SHEATHLOCK INSULIN 1 ML 29 GAUGE X 1/2" SYRINGE
- EASY TOUCH SHEATHLOCK INSULIN 1 ML 30 GAUGE X 5/16" SYRINGE
- EASY TOUCH SHEATHLOCK INSULIN 1 ML 31 GAUGE X 5/16" SYRINGE
- EASY TOUCH SHEATHLOCK INSULIN SYRINGE 1 ML 30 GAUGE X 1/2"
- EASY TOUCH UNI-SLIP 1 ML SYRINGE
- EASYLIFE ALCOHOL PADS
- EASYLIFE INSULIN PEN NEEDLE 29 GAUGE X 1/2"
- EASYLIFE INSULIN PEN NEEDLE 31 GAUGE X 1/4"
- EASYLIFE INSULIN PEN NEEDLE 31 GAUGE X 3/16"
- EASYLIFE INSULIN PEN NEEDLE 31 GAUGE X 5/16"
- EASYLIFE INSULIN PEN NEEDLE 31 GAUGE X 5/32"
- EASYLIFE INSULIN PEN NEEDLE 32 GAUGE X 1/4"
- EASYLIFE INSULIN PEN NEEDLE 32 GAUGE X 3/16"
- EASYLIFE INSULIN PEN NEEDLE 32 GAUGE X 5/16"
- EASYLIFE INSULIN PEN NEEDLE 32 GAUGE X 5/32"
- EASYLIFE INSULIN PEN NEEDLE 33 GAUGE X 1/4"
- EASYLIFE INSULIN PEN NEEDLE 33 GAUGE X 3/16"
- EASYLIFE INSULIN PEN NEEDLE 33 GAUGE X 5/16"
- EASYLIFE INSULIN PEN NEEDLE 33 GAUGE X 5/32"
- EASYLIFE INSULIN SYRINGE 0.5 ML 30 GAUGE X 5/16"
- EASYLIFE INSULIN SYRINGE 1 ML 30 GAUGE X 1/2"
- EASYLIFE INSULIN SYRINGE 1 ML 30 GAUGE X 5/16"
- EASYLIFE INSULIN SYRINGE 1 ML 31 GAUGE X 5/16"
- EASYLIFE SAFETY PEN NEEDLE 31 GAUGE X 3/16"
- EASYLIFE SAFETY PEN NEEDLE 31 GAUGE X 5/32"
- EMBRACE PEN NEEDLE 29 GAUGE X 1/2"
- EMBRACE PEN NEEDLE 30 GAUGE X 3/16"
- EMBRACE PEN NEEDLE 30 GAUGE X 5/16"
- EMBRACE PEN NEEDLE 31 GAUGE X 1/4"
- EMBRACE PEN NEEDLE 31 GAUGE X 3/16"
- EMBRACE PEN NEEDLE 31 GAUGE X 5/16"
- EMBRACE PEN NEEDLE 32 GAUGE X 5/32"
- EXEL INSULIN 0.3 ML 29 GAUGE X 1/2" SYRINGE
- GAUZE BANDAGE 2" X 2"
- GAUZE PAD 2" X 2" BANDAGE
- HEALTHWISE INSULIN SYRINGE 0.3 ML 30 GAUGE X 5/16"
- HEALTHWISE INSULIN SYRINGE 0.3 ML 31 GAUGE X 5/16"
- HEALTHWISE INSULIN SYRINGE 0.5 ML 30 GAUGE X 5/16"
- HEALTHWISE INSULIN SYRINGE 0.5 ML 31 GAUGE X 5/16"
- HEALTHWISE INSULIN SYRINGE 1 ML 30 GAUGE X 5/16"
- HEALTHWISE INSULIN SYRINGE 1 ML 31 GAUGE X 5/16"
- HEALTHWISE PEN NEEDLE 31 GAUGE X 3/16"

Please refer to our Evidence of Coverage for 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.

- HEALTHWISE PEN NEEDLE 31 GAUGE X 5/16"
- HEALTHWISE PEN NEEDLE 32 GAUGE X 5/32"
- HEALTHY ACCENTS UNIFINE PENTIP 29 GAUGE X 1/2" NEEDLE
- HEALTHY ACCENTS UNIFINE PENTIP 31 GAUGE X 1/4" NEEDLE
- HEALTHY ACCENTS UNIFINE PENTIP 31 GAUGE X 3/16" NEEDLE
- HEALTHY ACCENTS UNIFINE PENTIP 31 GAUGE X 5/16" NEEDLE
- INCONTROL ALCOHOL PADS
- INCONTROL PEN NEEDLE 29 GAUGE X 1/2"
- INCONTROL PEN NEEDLE 31 GAUGE X 1/4"
- INCONTROL PEN NEEDLE 31 GAUGE X 3/16"
- INCONTROL PEN NEEDLE 31 GAUGE X 5/16"
- INCONTROL PEN NEEDLE 32 GAUGE X 5/32"
- INSULIN SYRINGE MICROFINE 1 ML 27 GAUGE X 5/8"
- INSULIN SYRINGE U-100 WITH NEEDLE 0.3 ML 29 GAUGE
- INSULIN SYRINGE U-100 WITH NEEDLE 0.3 ML 30
- INSULIN SYRINGE U-100 WITH NEEDLE 0.3 ML 30 GAUGE X 5/16"
- INSULIN SYRINGE U-100 WITH NEEDLE 0.3 ML 31 GAUGE X 1/4"
- INSULIN SYRINGE U-100 WITH NEEDLE 0.3 ML 31 GAUGE X 15/64"
- INSULIN SYRINGE U-100 WITH NEEDLE 0.3 ML 31 GAUGE X 5/16"
- INSULIN SYRINGE U-100 WITH NEEDLE 0.5 ML 29 GAUGE X 1/2"
- INSULIN SYRINGE U-100 WITH NEEDLE 0.5 ML 30 GAUGE X 1/2"
- INSULIN SYRINGE U-100 WITH NEEDLE 0.5 ML 30 GAUGE X 5/16"
- INSULIN SYRINGE U-100 WITH NEEDLE 0.5 ML 31 GAUGE X 5/16"
- INSULIN SYRINGE U-100 WITH NEEDLE 1 ML 27 GAUGE X 1/2"
- INSULIN SYRINGE U-100 WITH NEEDLE 1 ML 28 GAUGE X 1/2"
- INSULIN SYRINGE U-100 WITH NEEDLE 1 ML 29 GAUGE X 1/2"
- INSULIN SYRINGE U-100 WITH NEEDLE 1 ML 29 GAUGE X 7/16"
- INSULIN SYRINGE U-100 WITH NEEDLE 1 ML 30 GAUGE X 1/2"
- INSULIN SYRINGE U-100 WITH NEEDLE 1 ML 30 GAUGE X 3/8"
- INSULIN SYRINGE U-100 WITH NEEDLE 1 ML 30 GAUGE X 5/16"
- INSULIN SYRINGE U-100 WITH NEEDLE 1 ML 30 GAUGE X 7/16"
- INSULIN SYRINGE U-100 WITH NEEDLE 1 ML 31 GAUGE X 1/4"
- INSULIN SYRINGE U-100 WITH NEEDLE 1 ML 31 GAUGE X 15/64"
- INSULIN SYRINGE U-100 WITH NEEDLE 1 ML 31 GAUGE X 5/16"
- INSULIN SYRINGE U-100 WITH NEEDLE 1/2 ML 27 GAUGE X 1/2"
- INSULIN SYRINGE U-100 WITH NEEDLE 1/2 ML 28 GAUGE
- INSULIN SYRINGE U-100 WITH NEEDLE 1/2 ML 28 GAUGE X 1/2"
- INSULIN SYRINGE U-100 WITH NEEDLE 1/2 ML 29
- INSULIN SYRINGE U-100 WITH NEEDLE 1/2 ML 30 GAUGE
- INSULIN SYRINGE U-100 WITH NEEDLE 1/2 ML 31 GAUGE X 1/4"
- INSULIN SYRINGE U-100 WITH NEEDLE 1/2 ML 31 GAUGE X 15/64"
- INSULIN SYRINGE-NEEDLE U-100 HALF UNIT MARKING 0.3 ML 31 GAUGE X 1/4"
- INSULIN U-500 SYRINGE-NEEDLE 1/2 ML 31 GAUGE X 15/64"

Please refer to our Evidence of Coverage for 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.

- INSUPEN PEN NEEDLE 29 GAUGE X 1/2"
- INSUPEN PEN NEEDLE 31 GAUGE X 3/16"
- INSUPEN PEN NEEDLE 31 GAUGE X 5/16"
- INSUPEN PEN NEEDLE 32 GAUGE X 1/4"
- INSUPEN PEN NEEDLE 32 GAUGE X 5/32"
- IV PREP WIPES MEDICATED
- LISCO 2" X 2" SPONGE
- MAGELLAN INSULIN SAFETY SYRINGE 0.3 ML 29 GAUGE X 1/2"
- MAGELLAN INSULIN SAFETY SYRINGE 0.5 ML 29 GAUGE X 1/2"
- MAGELLAN INSULIN SAFETY SYRINGE 1 ML 29 GAUGE X 1/2"
- MAGELLAN INSULIN SAFETY SYRINGE 1 ML 30 GAUGE X 5/16"
- MAGELLAN SYRINGE 0.3 ML 30 X 5/16"
- MAGELLAN SYRINGE 0.5 ML 30 GAUGE X 5/16"
- MAXICOMFORT II PEN NEEDLE 31 GAUGE X 1/4"
- MAXICOMFORT INSULIN SYRINGE 1 ML 27 GAUGE X 1/2"
- MAXI-COMFORT INSULIN SYRINGE 1 ML 28 GAUGE X 1/2"
- MAXICOMFORT INSULIN SYRINGE 1/2 ML 27 GAUGE X 1/2"
- MAXI-COMFORT INSULIN SYRINGE 1/2 ML 28 GAUGE X 1/2"
- MAXICOMFORT SAFETY PEN NEEDLE 29 GAUGE X 3/16"
- MAXICOMFORT SAFETY PEN NEEDLE 29 GAUGE X 5/16"
- MICRODOT INSULIN PEN NEEDLE 31 GAUGE X 1/4"
- MICRODOT INSULIN PEN NEEDLE 32 GAUGE X 5/32"
- MICRODOT INSULIN PEN NEEDLE 33 GAUGE X 5/32"
- MICRODOT READYGARD PEN NEEDLE 31 GAUGE X 3/16"
- MINI ULTRA-THIN II 31 GAUGE X 3/16" NEEDLE
- MONOJECT INSULIN SAFETY SYRINGE 0.3 ML 30 GAUGE X 5/16"
- MONOJECT INSULIN SAFETY SYRINGE 0.5 ML 29 GAUGE X 1/2"
- MONOJECT INSULIN SAFETY SYRINGE 0.5 ML 30 GAUGE X 5/16"
- MONOJECT INSULIN SAFETY SYRINGE 1 ML 29 GAUGE X 1/2"
- MONOJECT INSULIN SYRINGE 0.3 ML 29 GAUGE X 1/2"
- MONOJECT INSULIN SYRINGE 0.3 ML 30 GAUGE X 5/16"
- MONOJECT INSULIN SYRINGE 0.3 ML 31 GAUGE X 5/16"
- MONOJECT INSULIN SYRINGE 0.5 ML 29 GAUGE X 1/2"
- MONOJECT INSULIN SYRINGE 0.5 ML 30 GAUGE X 5/16"
- MONOJECT INSULIN SYRINGE 0.5 ML 31 GAUGE X 5/16"
- MONOJECT INSULIN SYRINGE 1 ML
- MONOJECT INSULIN SYRINGE 1 ML 25 GAUGE X 5/8"
- MONOJECT INSULIN SYRINGE 1 ML 27 GAUGE X 1/2"
- MONOJECT INSULIN SYRINGE 1 ML 28 GAUGE X 1/2"
- MONOJECT INSULIN SYRINGE 1 ML 29 GAUGE X 1/2"
- MONOJECT INSULIN SYRINGE 1 ML 30 GAUGE X 5/16"
- MONOJECT INSULIN SYRINGE 1 ML 31 GAUGE X 5/16"
- MONOJECT INSULIN SYRINGE 1/2 ML 28 GAUGE X 1/2"
- MONOJECT SYRINGE 1/2 ML 28 GAUGE
- MONOJECT ULTRA COMFORT INSULIN 1/2 ML 28 GAUGE SYRINGE

Please refer to our Evidence of Coverage for 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.

- NANO 2ND GEN PEN NEEDLE 32 GAUGE X 5/32"
- NANO PEN NEEDLE 32 GAUGE X 5/32"
- NOVOFINE 32 32 GAUGE X 1/4" NEEDLE
- NOVOFINE AUTOCOVER 30 GAUGE X 1/3" NEEDLE
- NOVOFINE PLUS 32 GAUGE X 1/6" NEEDLE
- PEN NEEDLE 29 GAUGE X 1/2"
- PEN NEEDLE 30 GAUGE X 5/16"
- PEN NEEDLE 31 GAUGE X 3/16"
- PEN NEEDLE 31 GAUGE X 5/16"
- PEN NEEDLE 32 GAUGE X 5/32"
- PEN NEEDLE, DIABETIC 29 GAUGE X 1/2"
- PEN NEEDLE, DIABETIC 29 GAUGE X 15/32"
- PEN NEEDLE, DIABETIC 30 GAUGE X 3/16"
- PEN NEEDLE, DIABETIC 30 GAUGE X 5/16"
- PEN NEEDLE, DIABETIC 31 GAUGE X 1/3"
- PEN NEEDLE, DIABETIC 31 GAUGE X 1/4"
- PEN NEEDLE, DIABETIC 31 GAUGE X 1/6"
- PEN NEEDLE, DIABETIC 31 GAUGE X 13/64"
- PEN NEEDLE, DIABETIC 31 GAUGE X 15/64"
- PEN NEEDLE, DIABETIC 31 GAUGE X 3/16"
- PEN NEEDLE, DIABETIC 31 GAUGE X 5/16"
- PEN NEEDLE, DIABETIC 31 GAUGE X 5/32"
- PEN NEEDLE, DIABETIC 32 GAUGE X 1/4"
- PEN NEEDLE, DIABETIC 32 GAUGE X 3/16"
- PEN NEEDLE, DIABETIC 32 GAUGE X 5/16"
- PEN NEEDLE, DIABETIC 32 GAUGE X 5/32"
- PEN NEEDLE, DIABETIC 33 GAUGE X 1/4"
- PEN NEEDLE, DIABETIC 33 GAUGE X 3/16"
- PEN NEEDLE, DIABETIC 33 GAUGE X 5/32"
- PEN NEEDLE, DIABETIC, SAFETY 31 GAUGE X 5/32"
- PENTIPS PEN NEEDLE 29 GAUGE X 1/2"
- PENTIPS PEN NEEDLE 31 GAUGE X 1/4"
- PENTIPS PEN NEEDLE 31 GAUGE X 3/16"
- PENTIPS PEN NEEDLE 31 GAUGE X 5/16"
- PENTIPS PEN NEEDLE 32 GAUGE X 1/4"
- PENTIPS PEN NEEDLE 32 GAUGE X 5/32"
- PIP PEN NEEDLE 31 GAUGE X 3/16"
- PIP PEN NEEDLE 32 GAUGE X 5/32"
- PREVENT DROPSAFE PEN NEEDLE 31 GAUGE X 1/4"
- PREVENT DROPSAFE PEN NEEDLE 31 GAUGE X 5/16"
- PRO COMFORT ALCOHOL PADS
- PRO COMFORT INSULIN SYRINGE 0.5 ML 30 GAUGE X 1/2"
- PRO COMFORT INSULIN SYRINGE 0.5 ML 30 GAUGE X 5/16"
- PRO COMFORT INSULIN SYRINGE 0.5 ML 31 GAUGE X 5/16"
- PRO COMFORT INSULIN SYRINGE 1 ML 30 GAUGE X 1/2"
- PRO COMFORT INSULIN SYRINGE 1 ML 30 GAUGE X 5/16"
- PRO COMFORT INSULIN SYRINGE 1 ML 31 GAUGE X 5/16"

Please refer to our Evidence of Coverage for 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.

- PRO COMFORT PEN NEEDLE 32 GAUGE X 1/4"
- PRO COMFORT PEN NEEDLE 32 GAUGE X 3/16"
- PRO COMFORT PEN NEEDLE 32 GAUGE X 5/16"
- PRO COMFORT PEN NEEDLE 32 GAUGE X 5/32"
- PRO-COMFORT ALCOHOL PADS
- PRODIGY INSULIN SYRINGE 0.3 ML 31 GAUGE X 5/16"
- PRODIGY INSULIN SYRINGE 0.5 ML 31 GAUGE X 5/16"
- PRODIGY INSULIN SYRINGE 1 ML 28 GAUGE X 1/2"
- PURE COMFORT ALCOHOL PADS
- PURE COMFORT PEN NEEDLE 32 GAUGE X 1/4"
- PURE COMFORT PEN NEEDLE 32 GAUGE X 3/16"
- PURE COMFORT PEN NEEDLE 32 GAUGE X 5/16"
- PURE COMFORT PEN NEEDLE 32 GAUGE X 5/32"
- PURE COMFORT SAFETY PEN NEEDLE 31 GAUGE X 1/4"
- PURE COMFORT SAFETY PEN NEEDLE 31 GAUGE X 3/16"
- PURE COMFORT SAFETY PEN NEEDLE 32 GAUGE X 5/32"
- SAFESNAP INSULIN SYRINGE 0.3 ML 30 GAUGE X 5/16"
- SAFESNAP INSULIN SYRINGE 0.5 ML 29 GAUGE X 1/2"
- SAFESNAP INSULIN SYRINGE 0.5 ML 30 GAUGE X 5/16"
- SAFESNAP INSULIN SYRINGE 1 ML 28 GAUGE X 1/2"
- SAFESNAP INSULIN SYRINGE 1 ML 29 GAUGE X 1/2"
- SAFETY PEN NEEDLE 31 GAUGE X 3/16"
- SECURESAFE INSULIN SYRINGE 0.5 ML 29 GAUGE X 1/2"
- SECURESAFE INSULIN SYRINGE 1 ML 29 GAUGE X 1/2"
- SECURESAFE PEN NEEDLE 30 GAUGE X 5/16"
- SECURESAFE PEN NEEDLE 31 GAUGE X 3/16"
- SIMPLI PEN NEEDLE 32 GAUGE X 5/32"
- SKY SAFETY PEN NEEDLE 30 GAUGE X 3/16"
- SKY SAFETY PEN NEEDLE 30 GAUGE X 5/16"
- STERILE PADS 2" X 2" BANDAGE
- SURE COMFORT ALCOHOL PREP PADS
- SURE COMFORT INSULIN SYRINGE 0.3 ML 29 GAUGE X 1/2"
- SURE COMFORT INSULIN SYRINGE 0.3 ML 30 GAUGE X 1/2"
- SURE COMFORT INSULIN SYRINGE 0.3 ML 30 GAUGE X 5/16"
- SURE COMFORT INSULIN SYRINGE 0.3 ML 31 GAUGE X 1/4"
- SURE COMFORT INSULIN SYRINGE 0.3 ML 31 GAUGE X 5/16"
- SURE COMFORT INSULIN SYRINGE 0.5 ML 30 GAUGE X 1/2"
- SURE COMFORT INSULIN SYRINGE 0.5 ML 30 GAUGE X 5/16"
- SURE COMFORT INSULIN SYRINGE 0.5 ML 31 GAUGE X 5/16"
- SURE COMFORT INSULIN SYRINGE 1 ML 28 GAUGE X 1/2"
- SURE COMFORT INSULIN SYRINGE 1 ML 29 GAUGE X 1/2"
- SURE COMFORT INSULIN SYRINGE 1 ML 30 GAUGE X 1/2"
- SURE COMFORT INSULIN SYRINGE 1 ML 30 GAUGE X 5/16"
- SURE COMFORT INSULIN SYRINGE 1 ML 31 GAUGE X 1/4"
- SURE COMFORT INSULIN SYRINGE 1 ML 31 GAUGE X 5/16"

Please refer to our Evidence of Coverage for 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.

- SURE COMFORT INSULIN SYRINGE 1/2 ML 28 GAUGE X 1/2"
- SURE COMFORT INSULIN SYRINGE 1/2 ML 31 GAUGE X 1/4"
- SURE COMFORT INSULIN SYRINGE U-100 0.5 ML 29 GAUGE X 1/2"
- SURE COMFORT PEN NEEDLE 29 GAUGE X 1/2"
- SURE COMFORT PEN NEEDLE 30 GAUGE X 5/16"
- SURE COMFORT PEN NEEDLE 31 GAUGE X 3/16"
- SURE COMFORT PEN NEEDLE 31 GAUGE X 5/16"
- SURE COMFORT PEN NEEDLE 32 GAUGE X 1/4"
- SURE COMFORT PEN NEEDLE 32 GAUGE X 5/32"
- SURE COMFORT SAFETY PEN NEEDLE 31 GAUGE X 1/4"
- SURE COMFORT SAFETY PEN NEEDLE 32 GAUGE X 5/32"
- SURE-FINE PEN NEEDLES 29 GAUGE X 1/2"
- SURE-FINE PEN NEEDLES 31 GAUGE X 3/16"
- SURE-FINE PEN NEEDLES 31 GAUGE X 5/16"
- SURE-JECT INSULIN SYRINGE 0.3 ML 29 GAUGE X 1/2"
- SURE-JECT INSULIN SYRINGE 0.3 ML 30 GAUGE X 5/16"
- SURE-JECT INSULIN SYRINGE 0.5 ML 29 GAUGE X 1/2"
- SURE-JECT INSULIN SYRINGE 0.5 ML 30 GAUGE X 5/16"
- SURE-JECT INSULIN SYRINGE 1 ML 28 GAUGE X 1/2"
- SURE-JECT INSULIN SYRINGE 1 ML 29 GAUGE X 1/2"
- SURE-JECT INSULIN SYRINGE 1 ML 30 GAUGE X 5/16"
- SURE-JECT INSULIN SYRINGE 1 ML 31 GAUGE X 5/16"
- SURE-JECT INSULIN SYRINGE 1/2 ML 28 GAUGE X 1/2"
- SURE-PREP ALCOHOL PREP PADS
- SYRINGE WITH NEEDLE, SAFETY 0.5 ML 30 GAUGE X 1/2"
- TECHLITE INSULIN SYRINGE (HALF UNIT) 0.3 ML 29 GAUGE X 1/2"
- TECHLITE INSULIN SYRINGE (HALF UNIT) 0.3 ML 30 GAUGE X 5/16"
- TECHLITE INSULIN SYRINGE (HALF UNIT) 0.3 ML 31 GAUGE X 15/64"
- TECHLITE INSULIN SYRINGE (HALF UNIT) 0.3 ML 31 GAUGE X 5/16"
- TECHLITE INSULIN SYRINGE (HALF UNIT) 0.5 ML 30 GAUGE X 1/2"
- TECHLITE INSULIN SYRINGE (HALF UNIT) 0.5 ML 30 GAUGE X 5/16"
- TECHLITE INSULIN SYRINGE (HALF UNIT) 0.5 ML 31 GAUGE X 15/64"
- TECHLITE INSULIN SYRINGE (HALF UNIT) 0.5 ML 31 GAUGE X 5/16"
- TECHLITE INSULIN SYRINGE 1 ML 29 GAUGE X 1/2"
- TECHLITE INSULIN SYRINGE 1 ML 30 GAUGE X 1/2"
- TECHLITE INSULIN SYRINGE 1 ML 31 GAUGE X 15/64"
- TECHLITE INSULIN SYRINGE 1 ML 31 GAUGE X 5/16"
- TECHLITE PEN NEEDLE 29 GAUGE X 1/2"
- TECHLITE PEN NEEDLE 29 GAUGE X 3/8"
- TECHLITE PEN NEEDLE 31 GAUGE X 1/4"
- TECHLITE PEN NEEDLE 31 GAUGE X 3/16"
- TECHLITE PEN NEEDLE 31 GAUGE X 5/16"
- TECHLITE PEN NEEDLE 32 GAUGE X 1/4"
- TECHLITE PEN NEEDLE 32 GAUGE X 5/16"

Please refer to our Evidence of Coverage for 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.

- TECHLITE PEN NEEDLE 32 GAUGE X 5/32"
- TECHLITE PLUS PEN NEEDLE 32 GAUGE X 5/32"
- TERUMO INSULIN SYRINGE 0.3 ML 30 X 3/8"
- TERUMO INSULIN SYRINGE 0.5 ML 29 GAUGE X 1/2"
- TERUMO INSULIN SYRINGE 1 ML 27 GAUGE X 1/2"
- TERUMO INSULIN SYRINGE 1 ML 28 GAUGE X 1/2"
- TERUMO INSULIN SYRINGE 1 ML 29 GAUGE X 1/2"
- TERUMO INSULIN SYRINGE 1/2 ML 27 GAUGE X 1/2"
- TERUMO INSULIN SYRINGE 1/2 ML 28 GAUGE X 1/2"
- TERUMO INSULIN SYRINGE 1/2 ML 30 X 3/8"
- THINPRO INSULIN SYRINGE 0.3 ML 29 GAUGE X 1/2"
- THINPRO INSULIN SYRINGE 0.3 ML 30 X 3/8"
- THINPRO INSULIN SYRINGE 0.3 ML 31 X 3/8"
- THINPRO INSULIN SYRINGE 0.5 ML 29 GAUGE X 1/2"
- THINPRO INSULIN SYRINGE 0.5 ML 31 X 3/8"
- THINPRO INSULIN SYRINGE 1 ML 28 GAUGE X 1/2"
- THINPRO INSULIN SYRINGE 1 ML 29 GAUGE X 1/2"
- THINPRO INSULIN SYRINGE 1 ML 30 GAUGE X 3/8"
- THINPRO INSULIN SYRINGE 1 ML 31 X 3/8"
- THINPRO INSULIN SYRINGE 1/2 ML 28 GAUGE X 1/2"
- THINPRO INSULIN SYRINGE 1/2 ML 30 X 3/8"
- TOPFINE INSULIN PEN NEEDLE 32 GAUGE X 5/32"
- TRUE COMFORT ALCOHOL PADS
- TRUE COMFORT INSULIN SYRINGE 0.5 ML 31 GAUGE X 5/16"
- TRUE COMFORT INSULIN SYRINGE 1 ML 31 GAUGE X 5/16"
- TRUE COMFORT PEN NEEDLE 31 GAUGE X 1/4"
- TRUE COMFORT PEN NEEDLE 31 GAUGE X 3/16"
- TRUE COMFORT PEN NEEDLE 31 GAUGE X 5/16"
- TRUE COMFORT PEN NEEDLE 32 GAUGE X 1/4"
- TRUE COMFORT PEN NEEDLE 32 GAUGE X 3/16"
- TRUE COMFORT PEN NEEDLE 32 GAUGE X 5/32"
- TRUE COMFORT PEN NEEDLE 33 GAUGE X 1/4"
- TRUE COMFORT PEN NEEDLE 33 GAUGE X 3/16"
- TRUE COMFORT PEN NEEDLE 33 GAUGE X 5/32"
- TRUE COMFORT PRO ALCOHOL PADS
- TRUE COMFORT PRO INS SYRINGE 0.5 ML 30 GAUGE X 1/2"
- TRUE COMFORT PRO INS SYRINGE 0.5 ML 30 GAUGE X 5/16"
- TRUE COMFORT PRO INS SYRINGE 0.5 ML 31 GAUGE X 5/16"
- TRUE COMFORT PRO INS SYRINGE 1 ML 30 GAUGE X 1/2"
- TRUE COMFORT PRO INS SYRINGE 1 ML 30 GAUGE X 5/16"
- TRUE COMFORT PRO INS SYRINGE 1 ML 31 GAUGE X 5/16"
- TRUE COMFORT PRO INS SYRINGE 1 ML 32 GAUGE X 5/16"
- TRUE COMFORT PRO INS SYRINGE 1/2 ML 32 GAUGE X 5/16"
- TRUE COMFORT SAFETY INSULIN SYRINGE 0.5 ML 30 GAUGE X 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.

- TRUE COMFORT SAFETY INSULIN SYRINGE 0.5 ML 30 GAUGE X 5/16"
- TRUE COMFORT SAFETY INSULIN SYRINGE 0.5 ML 31 GAUGE X 5/16"
- TRUE COMFORT SAFETY INSULIN SYRINGE 1 ML 30 GAUGE X 1/2"
- TRUE COMFORT SAFETY INSULIN SYRINGE 1 ML 30 GAUGE X 5/16"
- TRUE COMFORT SAFETY INSULIN SYRINGE 1 ML 31 GAUGE X 5/16"
- TRUE COMFORT SAFETY INSULIN SYRINGE 1 ML 32 GAUGE X 5/16"
- TRUE COMFORT SAFETY PEN NEEDLE 31 GAUGE X 1/4"
- TRUE COMFORT SAFETY PEN NEEDLE 31 GAUGE X 3/16"
- TRUE COMFORT SAFETY PEN NEEDLE 32 GAUGE X 5/32"
- TRUE-COMFORT PRO PEN NEEDLE 31 GAUGE X 15/64"
- TRUE-COMFORT PRO PEN NEEDLE 31 GAUGE X 3/16"
- TRUE-COMFORT PRO PEN NEEDLE 31 GAUGE X 5/16"
- TRUE-COMFORT PRO PEN NEEDLE 32 GAUGE X 5/32"
- TRUEPLUS INSULIN 0.3 ML 29 GAUGE X 1/2" SYRINGE
- TRUEPLUS INSULIN 0.3 ML 30 GAUGE X 5/16" SYRINGE
- TRUEPLUS INSULIN 0.3 ML 31 GAUGE X 5/16" SYRINGE
- TRUEPLUS INSULIN 0.5 ML 29 GAUGE X 1/2" SYRINGE
- TRUEPLUS INSULIN 0.5 ML 30 GAUGE X 5/16" SYRINGE
- TRUEPLUS INSULIN 0.5 ML 31 GAUGE X 5/16" SYRINGE
- TRUEPLUS INSULIN 1 ML 28 GAUGE X 1/2" SYRINGE
- TRUEPLUS INSULIN 1 ML 29 GAUGE X 1/2" SYRINGE
- TRUEPLUS INSULIN 1 ML 30 GAUGE X 5/16" SYRINGE
- TRUEPLUS INSULIN 1 ML 31 GAUGE X 5/16" SYRINGE
- TRUEPLUS INSULIN 1/2 ML 28 GAUGE X 1/2" SYRINGE
- TRUEPLUS PEN NEEDLE 29 GAUGE X 1/2"
- TRUEPLUS PEN NEEDLE 31 GAUGE X 1/4"
- TRUEPLUS PEN NEEDLE 31 GAUGE X 3/16"
- TRUEPLUS PEN NEEDLE 31 GAUGE X 5/16"
- TRUEPLUS PEN NEEDLE 32 GAUGE X 5/32"
- ULTICARE 0.3 ML 30 GAUGE X 1/2" SYRINGE
- ULTICARE 0.3 ML 31 GAUGE X 5/16" SYRINGE
- ULTICARE 0.5 ML 30 GAUGE X 1/2" SYRINGE
- ULTICARE 0.5 ML 31 GAUGE X 5/16" SYRINGE
- ULTICARE 1 ML 30 GAUGE X 1/2" SYRINGE
- ULTICARE 1 ML 31 GAUGE X 5/16" SYRINGE
- ULTICARE INSULIN SYRINGE (HALF UNIT) 0.3 ML 31 GAUGE X 1/4"
- ULTICARE INSULIN SYRINGE 0.3 ML 31 GAUGE X 1/4"
- ULTICARE INSULIN SYRINGE 1 ML 31 GAUGE X 1/4"
- ULTICARE INSULIN SYRINGE 1/2 ML 31 GAUGE X 1/4"
- ULTICARE PEN NEEDLE 29 GAUGE X 1/2"
- ULTICARE PEN NEEDLE 31 GAUGE X 1/4"
- ULTICARE PEN NEEDLE 31 GAUGE X 3/16"
- ULTICARE PEN NEEDLE 31 GAUGE X 5/16"
- ULTICARE PEN NEEDLE 32 GAUGE X 1/4"

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.

- ULTICARE PEN NEEDLE 32 GAUGE X 5/32"
- ULTICARE SAFETY PEN NEEDLE 30 GAUGE X 3/16"
- ULTICARE SAFETY PEN NEEDLE 30 GAUGE X 5/16"
- ULTIGUARD SAFEPACK-INSULIN SYRINGE 0.3 ML 30 X 1/2"
- ULTIGUARD SAFEPACK-INSULIN SYRINGE 0.3 ML 31 X 5/16"
- ULTIGUARD SAFEPACK-INSULIN SYRINGE 1 ML 30 X 1/2"
- ULTIGUARD SAFEPACK-INSULIN SYRINGE 1 ML 31 X 5/16"
- ULTIGUARD SAFEPACK-INSULIN SYRINGE 1/2 ML 30 X 1/2"
- ULTIGUARD SAFEPACK-INSULIN SYRINGE 1/2 ML 31 X 5/16"
- ULTIGUARD SAFEPACK-PEN NEEDLE 29 GAUGE X 1/2"
- ULTIGUARD SAFEPACK-PEN NEEDLE 31 GAUGE X 1/4"
- ULTIGUARD SAFEPACK-PEN NEEDLE 31 GAUGE X 3/16"
- ULTIGUARD SAFEPACK-PEN NEEDLE 31 GAUGE X 5/16"
- ULTIGUARD SAFEPACK-PEN NEEDLE 32 GAUGE X 1/4"
- ULTIGUARD SAFEPACK-PEN NEEDLE 32 GAUGE X 5/32"
- ULTILET ALCOHOL SWAB
- ULTILET INSULIN SYRINGE 0.3 ML 29 GAUGE
- ULTILET INSULIN SYRINGE 0.3 ML 29 GAUGE X 1/2"
- ULTILET INSULIN SYRINGE 0.3 ML 30 GAUGE X 5/16"
- ULTILET INSULIN SYRINGE 0.3 ML 31 GAUGE X 5/16"
- ULTILET INSULIN SYRINGE 0.5 ML 29 GAUGE X 1/2"
- ULTILET INSULIN SYRINGE 0.5 ML 30 GAUGE X 5/16"
- ULTILET INSULIN SYRINGE 0.5 ML 31 GAUGE X 5/16"
- ULTILET INSULIN SYRINGE 1 ML 29 GAUGE
- ULTILET INSULIN SYRINGE 1 ML 29 GAUGE X 1/2"
- ULTILET INSULIN SYRINGE 1 ML 30 GAUGE X 5/16"
- ULTILET INSULIN SYRINGE 1 ML 31 GAUGE X 5/16"
- ULTILET INSULIN SYRINGE 1/2 ML 29
- ULTILET PEN NEEDLE 29 GAUGE
- ULTILET PEN NEEDLE 32 GAUGE X 5/32"
- ULTRA COMFORT INSULIN SYRINGE (HALF UNIT) 0.3 ML 29 GAUGE X 1/2"
- ULTRA COMFORT INSULIN SYRINGE (HALF UNIT) 0.3 ML 31 GAUGE X 5/16"
- ULTRA COMFORT INSULIN SYRINGE 0.3 ML 29 GAUGE X 1/2"
- ULTRA COMFORT INSULIN SYRINGE 0.3 ML 30
- ULTRA COMFORT INSULIN SYRINGE 0.3 ML 30 GAUGE X 5/16"
- ULTRA COMFORT INSULIN SYRINGE 0.5 ML 29 GAUGE X 1/2"
- ULTRA COMFORT INSULIN SYRINGE 0.5 ML 30 GAUGE X 5/16"
- ULTRA COMFORT INSULIN SYRINGE 0.5 ML 31 GAUGE X 5/16"
- ULTRA COMFORT INSULIN SYRINGE 1 ML 28 GAUGE X 1/2"
- ULTRA COMFORT INSULIN SYRINGE 1 ML 29 GAUGE X 1/2"
- ULTRA COMFORT INSULIN SYRINGE 1 ML 30 GAUGE X 5/16"
- ULTRA COMFORT INSULIN SYRINGE 1 ML 30 GAUGE X 7/16"
- ULTRA COMFORT INSULIN SYRINGE 1 ML 31 GAUGE X 5/16"

Please refer to our Evidence of Coverage for 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.

- ULTRA COMFORT INSULIN SYRINGE 1/2 ML 28 GAUGE X 1/2"
- ULTRA COMFORT INSULIN SYRINGE 1/2 ML 29
- ULTRA COMFORT INSULIN SYRINGE 1/2 ML 30 GAUGE
- ULTRA FLO INSULIN SYRINGE (HALF UNIT) 0.3 ML 30 GAUGE X 1/2"
- ULTRA FLO INSULIN SYRINGE (HALF UNIT) 0.3 ML 30 GAUGE X 5/16"
- ULTRA FLO INSULIN SYRINGE (HALF UNIT) 0.3 ML 31 GAUGE X 5/16"
- ULTRA FLO INSULIN SYRINGE 0.3 ML 29 GAUGE X 1/2"
- ULTRA FLO INSULIN SYRINGE 0.3 ML 30 GAUGE X 5/16"
- ULTRA FLO INSULIN SYRINGE 0.3 ML 31 GAUGE X 5/16"
- ULTRA FLO INSULIN SYRINGE 0.5 ML 29 GAUGE X 1/2"
- ULTRA FLO PEN NEEDLE 29 GAUGE X 1/2"
- ULTRA FLO PEN NEEDLE 31 GAUGE X 3/16"
- ULTRA FLO PEN NEEDLE 31 GAUGE X 5/16"
- ULTRA FLO PEN NEEDLE 32 GAUGE X 5/32"
- ULTRA FLO PEN NEEDLE 33 GAUGE X 5/32"
- ULTRA THIN PEN NEEDLE 32 GAUGE X 5/32"
- ULTRACARE INSULIN SYRINGE 0.3 ML 30 GAUGE X 5/16"
- ULTRACARE INSULIN SYRINGE 0.3 ML 31 GAUGE X 5/16"
- ULTRACARE INSULIN SYRINGE 0.5 ML 30 GAUGE X 1/2"
- ULTRACARE INSULIN SYRINGE 0.5 ML 30 GAUGE X 5/16"
- ULTRACARE INSULIN SYRINGE 0.5 ML 31 GAUGE X 5/16"
- ULTRACARE INSULIN SYRINGE 1 ML 30 GAUGE X 1/2"
- ULTRACARE INSULIN SYRINGE 1 ML 30 GAUGE X 5/16"
- ULTRACARE INSULIN SYRINGE 1 ML 31 GAUGE X 5/16"
- ULTRACARE PEN NEEDLE 31 GAUGE X 1/4"
- ULTRACARE PEN NEEDLE 31 GAUGE X 3/16"
- ULTRACARE PEN NEEDLE 31 GAUGE X 5/16"
- ULTRACARE PEN NEEDLE 32 GAUGE X 1/4"
- ULTRACARE PEN NEEDLE 32 GAUGE X 3/16"
- ULTRACARE PEN NEEDLE 32 GAUGE X 5/32"
- ULTRACARE PEN NEEDLE 33 GAUGE X 5/32"
- ULTRA-FINE INSULIN SYRINGE (HALF UNIT) 0.3 ML 31 GAUGE X 15/64"
- ULTRA-FINE INSULIN SYRINGE (HALF UNIT) 0.3 ML 31 GAUGE X 5/16"
- ULTRA-FINE INSULIN SYRINGE 0.3 ML 30 GAUGE X 1/2"
- ULTRA-FINE INSULIN SYRINGE 0.3 ML 31 GAUGE X 15/64"
- ULTRA-FINE INSULIN SYRINGE 0.3 ML 31 GAUGE X 5/16"
- ULTRA-FINE INSULIN SYRINGE 0.5 ML 30 GAUGE X 1/2"
- ULTRA-FINE INSULIN SYRINGE 0.5 ML 31 GAUGE X 5/16"
- ULTRA-FINE INSULIN SYRINGE 1 ML 30 GAUGE X 1/2"
- ULTRA-FINE INSULIN SYRINGE 1 ML 31 GAUGE X 15/64"
- ULTRA-FINE INSULIN SYRINGE 1 ML 31 GAUGE X 5/16"
- ULTRA-FINE INSULIN SYRINGE 1/2 ML 31 GAUGE X 15/64"

Please refer to our Evidence of Coverage for 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.

- ULTRA-FINE PEN NEEDLE 29 GAUGE X 1/2"
- ULTRA-FINE PEN NEEDLE 31 GAUGE X 3/16"
- ULTRA-FINE PEN NEEDLE 31 GAUGE X 5/16"
- ULTRA-FINE PEN NEEDLE 32 GAUGE X 1/4"
- ULTRA-THIN II (SHORT) INSULIN SYRINGE 0.3 ML 30 GAUGE X 5/16"
- ULTRA-THIN II (SHORT) INSULIN SYRINGE 0.3 ML 31 GAUGE X 5/16"
- ULTRA-THIN II (SHORT) INSULIN SYRINGE 0.5 ML 30 GAUGE X 5/16"
- ULTRA-THIN II (SHORT) INSULIN SYRINGE 0.5 ML 31 GAUGE X 5/16"
- ULTRA-THIN II (SHORT) INSULIN SYRINGE 1 ML 30 GAUGE X 5/16"
- ULTRA-THIN II (SHORT) INSULIN SYRINGE 1 ML 31 GAUGE X 5/16"
- ULTRA-THIN II (SHORT) PEN NDL 31 GAUGE X 5/16" NEEDLE
- ULTRA-THIN II INSULIN PEN NEEDLES 29 GAUGE X 1/2"
- ULTRA-THIN II INSULIN SYRINGE 0.5 ML 29 GAUGE X 1/2"
- ULTRA-THIN II INSULIN SYRINGE 1 ML 29 GAUGE X 1/2"
- UNIFINE OTC PEN NEEDLE 31 GAUGE X 3/16"
- UNIFINE OTC PEN NEEDLE 32 GAUGE X 5/32"
- UNIFINE PENTIPS 29 GAUGE X 1/2" NEEDLE
- UNIFINE PENTIPS 31 GAUGE X 1/4" NEEDLE
- UNIFINE PENTIPS 31 GAUGE X 3/16" NEEDLE
- UNIFINE PENTIPS 31 GAUGE X 5/16" NEEDLE
- UNIFINE PENTIPS 32 GAUGE X 1/4" NEEDLE
- UNIFINE PENTIPS 32 GAUGE X 5/32" NEEDLE
- UNIFINE PENTIPS 33 GAUGE X 5/32" NEEDLE
- UNIFINE PENTIPS MAXFLOW 30 GAUGE X 3/16" NEEDLE
- UNIFINE PENTIPS PLUS 29 GAUGE X 1/2" NEEDLE
- UNIFINE PENTIPS PLUS 31 GAUGE X 1/4" NEEDLE
- UNIFINE PENTIPS PLUS 31 GAUGE X 3/16" NEEDLE
- UNIFINE PENTIPS PLUS 31 GAUGE X 5/16" NEEDLE
- UNIFINE PENTIPS PLUS 32 GAUGE X 5/32" NEEDLE
- UNIFINE PENTIPS PLUS 33 GAUGE X 5/32" NEEDLE
- UNIFINE PENTIPS PLUS MAXFLOW 30 GAUGE X 3/16" NEEDLE
- UNIFINE PROTECT 30 GAUGE X 3/16" NEEDLE
- UNIFINE PROTECT 30 GAUGE X 5/16" NEEDLE
- UNIFINE PROTECT 32 GAUGE X 5/32" NEEDLE
- UNIFINE SAFECONTROL PEN NEEDLE 30 GAUGE X 3/16"
- UNIFINE SAFECONTROL PEN NEEDLE 30 GAUGE X 5/16"
- UNIFINE SAFECONTROL PEN NEEDLE 31 GAUGE X 1/4"
- UNIFINE SAFECONTROL PEN NEEDLE 31 GAUGE X 3/16"
- UNIFINE SAFECONTROL PEN NEEDLE 31 GAUGE X 5/16"
- UNIFINE SAFECONTROL PEN NEEDLE 32 GAUGE X 5/32"
- UNIFINE ULTRA PEN NEEDLE 29 GAUGE X 1/2"
- UNIFINE ULTRA PEN NEEDLE 31 GAUGE X 1/4"
- UNIFINE ULTRA PEN NEEDLE 31 GAUGE X 3/16"
- UNIFINE ULTRA PEN NEEDLE 31 GAUGE X 5/16"

Please refer to our Evidence of Coverage for 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.

- UNIFINE ULTRA PEN NEEDLE 32 GAUGE X 1/4"
- UNIFINE ULTRA PEN NEEDLE 32 GAUGE X 5/32"
- UNIFINE ULTRA PEN NEEDLE 34 GAUGE X 9/64"
- VANISHPOINT INSULIN SYRINGE 0.5 ML 30 GAUGE X 5/16"
- VANISHPOINT INSULIN SYRINGE 1 ML 30 GAUGE X 3/16"
- VANISHPOINT SYRINGE 0.5 ML 30 GAUGE X 1/2"
- VANISHPOINT SYRINGE 1 ML 29 GAUGE X 1/2"
- VERIFINE INSULIN SYRINGE 0.3 ML 31 GAUGE X 5/16"
- VERIFINE INSULIN SYRINGE 0.5 ML 29 GAUGE X 1/2"
- VERIFINE INSULIN SYRINGE 0.5 ML 31 GAUGE X 5/16"
- VERIFINE INSULIN SYRINGE 1 ML 29 GAUGE X 1/2"
- VERIFINE INSULIN SYRINGE 1 ML 31 GAUGE X 5/16"
- VERIFINE PEN NEEDLE 29 GAUGE X 1/2"
- VERIFINE PEN NEEDLE 31 GAUGE X 1/4"
- VERIFINE PEN NEEDLE 31 GAUGE X 3/16"
- VERIFINE PEN NEEDLE 31 GAUGE X 5/16"
- VERIFINE PEN NEEDLE 32 GAUGE X 1/4"
- VERIFINE PEN NEEDLE 32 GAUGE X 3/16"
- VERIFINE PEN NEEDLE 32 GAUGE X 5/32"
- VERIFINE PLUS PEN NEEDLE 31 GAUGE X 3/16"
- VERIFINE PLUS PEN NEEDLE 31 GAUGE X 5/16"
- VERIFINE PLUS PEN NEEDLE 32 GAUGE X 5/32"
- VERIFINE PLUS PEN NEEDLE-SHARPS CONTAINER 32 GAUGE X 5/32"
- VERSALON 2" X 2" SPONGE
- WEBCOL TOPICAL PADS

Details

Criteria	IN ORDER TO ASSIST IN PAYMENT DETERMINATION, A PRIOR CLAIM SEEN FOR AN INJECTABLE INSULIN WITHIN THE PAST 120 DAYS WILL QUALIFY FOR PART D PAYMENT.

Please refer to our Evidence of Coverage for 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.

IVABRADINE

Products Affected

Step 2:

- *ivabradine 5 mg tablet*
- *ivabradine 7.5 mg tablet*

Details

Criteria	PRIOR CLAIM FOR GENERIC FORMULARY VERSION OF BISOPROLOL, CARVEDILOL, OR METOPROLOL SUCCINATE WITHIN THE PAST 120 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.

KLISYRI

Products Affected

Step 2:

- KLISYRI 1 % (250 MG) TOPICAL OINTMENT IN PACKET

Details

Criteria	PRIOR CLAIM FOR GENERIC TOPICAL FLUOROURACIL IN THE LAST 120 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.

LEVOMILNACIPRAN

Products Affected

Step 2:

- FETZIMA 120 MG CAPSULE,EXTENDED RELEASE
- FETZIMA 20 MG (2)-40 MG (26) CAPSULE,EXTENDED RELEASE,24 HR,DOSE PACK
- FETZIMA 20 MG CAPSULE,EXTENDED RELEASE
- FETZIMA 40 MG CAPSULE,EXTENDED RELEASE
- FETZIMA 80 MG CAPSULE,EXTENDED RELEASE

Details

Criteria	PRIOR CLAIM FOR TRINTELLIX AND 1 GENERIC ANTIDEPRESSANT: BUPROPION, CITALOPRAM, ESCITALOPRAM, FLUOXETINE, MIRTAZAPINE, PAROXETINE, SERTRALINE, VENLAFAXINE, or VILAZODONE IN THE PAST 365 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.

LUMATEPERONE TOSYLATE

Products Affected

Step 2:

- CAPLYTA 10.5 MG CAPSULE
- CAPLYTA 21 MG CAPSULE
- CAPLYTA 42 MG CAPSULE

Details

Criteria	CLAIM FOR 2 FORMULARY ORAL GENERIC ANTIPSYCHOTICS: LURASIDONE, RISPERIDONE, OLANZAPINE, IMMEDIATE RELEASE QUETIAPINE FUMARATE, ZIPRASIDONE, ARIPIPRAZOLE, ASENAPINE WITHIN THE PAST 365 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.

MEMANTINE ER

Products Affected

Step 2:

- *memantine 14 mg capsule sprinkle,extended release 24hr*
- *memantine 21 mg capsule sprinkle,extended release 24hr*
- *memantine 28 mg capsule sprinkle,extended release 24hr*
- *memantine 7 mg capsule sprinkle,extended release 24hr*

Details

Criteria	PRIOR CLAIM FOR FORMULARY VERSION OF MEMANTINE IR WITHIN THE PAST 120 DAYS

MILSAPERIDONE

Products Affected

Step 2:

- BYSANTI 1 MG TABLET
- BYSANTI 10 MG TABLET
- BYSANTI 12 MG TABLET
- BYSANTI 2 MG TABLET
- BYSANTI 4 MG TABLET
- BYSANTI 6 MG TABLET
- BYSANTI 8 MG TABLET
- BYSANTI TITRATION PACK A 1MG(2)-2 MG(2)-4MG(2)-6 MG(2) TABLET PK
- BYSANTI TITRATION PACK B 1MG(6)-2MG(2)-6MG(2)-8MG(2) TABLET PK
- BYSANTI TITRATION PACK C 1 MG (4)-2 MG (2)-6 MG (2) TABLET PK

Details

Criteria	CLAIM FOR 1 GEN ATYPICAL ANTIPSYCHOTIC (LURASIDONE, RISPERIDONE, OLANZAPINE, QUETIAPINE FUMARATE IR, ZIPRASIDONE, ARIPIPRAZOLE, ASENAPINE) AND 1 PREF AGENT: VRAYLAR, REXULTI, OR LYBALVI IN LAST 365 D

Please refer to our Evidence of Coverage for 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.

OPHTHALMIC ALLERGY - NO OTC

Products Affected

Step 2:

- *loteprednol etabonate 0.2 % eye drops,suspension*

Details

Criteria	PRIOR CLAIM FOR FEDERAL LEGEND LEVOCETIRIZINE , CROMOLYN SODIUM, OR EPINASTINE WITHIN THE PAST 120 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.

PERAMPANEL

Products Affected

Step 2:

- *perampanel 0.5 mg/ml oral suspension*
- *perampanel 10 mg tablet*
- *perampanel 12 mg tablet*
- *perampanel 2 mg tablet*
- *perampanel 4 mg tablet*
- *perampanel 6 mg tablet*
- *perampanel 8 mg tablet*

Details

Criteria	PRIOR CLAIM FOR 2 GENERIC ANTICONVULSANT AGENTS (CARBAMAZEPINE, DIVALPROEX SODIUM, GABAPENTIN, LAMOTRIGINE, LEVETIRACETAM, OXCARBAZEPINE, TIAGABINE, TOPIRAMATE, VALPROIC ACID, ZONISAMIDE OR LACOSAMIDE), WITHIN THE PAST 365 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.

RUFINAMIDE

Products Affected

Step 2:

- *rufinamide 200 mg tablet*
- *rufinamide 400 mg tablet*
- *rufinamide 40 mg/ml oral suspension*

Details

Criteria	PRIOR CLAIM FOR GENERIC ANTICONVULSANT AGENT (CARBAMAZEPINE, DIVALPROEX SODIUM, GABAPENTIN, LAMOTRIGINE, LEVETIRACETAM, OXCARBAZEPINE, TIAGABINE, TOPIRAMATE, VALPROIC ACID, OR ZONISAMIDE), WITHIN THE PAST 120 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.

SELEGILINE PATCH

Products Affected

Step 2:

- EMSAM 12 MG/24 HR TRANSDERMAL 24 HOUR PATCH
- EMSAM 6 MG/24 HR TRANSDERMAL 24 HOUR PATCH
- EMSAM 9 MG/24 HR TRANSDERMAL 24 HOUR PATCH

Details

Criteria	PRIOR CLAIM OF FORMULARY ORAL VERSION OF SSRI (CITALOPRAM, ESCITALOPRAM, FLUOXETINE, PAROXETINE OR SERTRALINE), SNRI (DESVENLAFAXINE, DULOXETINE OR VENLAFAXINE), MIRTAZAPINE, OR BUPROPION IR/SR/XL IN THE PAST 120 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.

SPRITAM

Products Affected

Step 2:

- *levetiracetam 250 mg tablet for oral suspension*
- *levetiracetam 500 mg tablet for oral suspension*
- SPRITAM 1,000 MG TABLET FOR ORAL SUSPENSION
- SPRITAM 750 MG TABLET FOR ORAL SUSPENSION

Details

Criteria	PRIOR CLAIM FOR GENERIC LEVETIRACETAM SOLUTION IN THE PAST 120 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.

TOPIRAMATE SOLUTION

Products Affected

Step 2:

- *topiramate 25 mg/ml oral solution*

Details

Criteria	PRIOR CLAIM FOR GENERIC TOPIRAMATE (TABLETS OR CAPSULES) WITHIN THE PAST 120 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.

XANOMELINE/TROSPIUM

Products Affected

Step 2:

- COBENFY 100 MG-20 MG CAPSULE
- COBENFY 125 MG-30 MG CAPSULE
- COBENFY 50 MG-20 MG CAPSULE
- COBENFY STARTER PACK 50 MG-20 MG/100 MG-20 MG CAPSULES IN A DOSE PACK

Details

Criteria	CLAIM FOR ONE FORMULARY ORAL ANTIPSYCHOTIC: LURASIDONE, RISPERIDONE, CLOZAPINE TAB, OLANZAPINE, IR QUETIAPINE FUMARATE, ZIPRASIDONE, ARIPIPRAZOLE, ASENAPINE, PALIPERIDONE WITHIN THE PAST 120 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.

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ADVOCATE SYRINGES 1 ML 31 GAUGE X 5/16..... 589, 606
ALCOHOL PADS 589, 606
ALCOHOL PREP PADS..... 589, 606
ALCOHOL SWABS..... 589, 606
ALCOHOL WIPES 589, 606
AQINJECT PEN NEEDLE 31 GAUGE X 3/16 ..... 589, 606
AQINJECT PEN NEEDLE 32 GAUGE X 5/32 ..... 589, 606
aripiprazole 10 mg disintegrating tablet . 580
aripiprazole 15 mg disintegrating tablet . 580
ASSURE ID DUO PRO SAFETY PEN NEEDLE 31 GAUGE X 3/16..... 589, 606
ASSURE ID DUO-SHIELD 30 GAUGE X 3/16 ..... 589, 606
ASSURE ID DUO-SHIELD 30 GAUGE X 5/16 ..... 589, 606
ASSURE ID INSULIN SAFETY 0.5 ML 31 GAUGE X 15/64..... 589, 606
ASSURE ID INSULIN SAFETY 1 ML 29 GAUGE X 1/2..... 589, 606
ASSURE ID INSULIN SAFETY 1 ML 31 GAUGE X 15/64..... 589, 606
ASSURE ID PEN NEEDLE 30 GAUGE X 5/16 ..... 589, 606
ASSURE ID PRO PEN NEEDLE 30 GAUGE X 3/16..... 589, 606
B
BD ALCOHOL SWABS 589, 606
BD AUTOSHIELD DUO PEN NEEDLE 30 GAUGE X 3/16..... 589, 606
BD ECLIPSE LUER-LOK 1 ML 30 GAUGE X 1/2..... 589, 606
BD INSULIN SYRINGE 1 ML 27 GAUGE X 1/2..... 589, 606
BD INSULIN SYRINGE ULTRA-FINE (HALF UNIT) 0.3 ML 31 GAUGE X 5/16 ..... 589, 606
BD INSULIN SYRINGE ULTRA-FINE 0.3 ML 30 GAUGE X 1/2..... 589, 606
BD INSULIN SYRINGE ULTRA-FINE 0.5 ML 30 GAUGE X 1/2..... 589, 606
BD SAFETYGLIDE INSULIN SYRINGE 0.3 ML 29 GAUGE X 1/2..... 590, 606
BD SAFETYGLIDE INSULIN SYRINGE 0.3 ML 31 GAUGE X 15/64..... 590, 606
BD SAFETYGLIDE INSULIN SYRINGE 0.3 ML 31 GAUGE X 5/16..... 590, 606

Please refer to our Evidence of Coverage for 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.

BD SAFETYGLIDE INSULIN SYRINGE 0.5 ML 29 GAUGE X 1/2..... 590, 606
BD SAFETYGLIDE INSULIN SYRINGE 0.5 ML 30 GAUGE X 5/16..... 590, 606
BD SAFETYGLIDE INSULIN SYRINGE 0.5 ML 31 GAUGE X 15/64..... 590, 606
BD SAFETYGLIDE INSULIN SYRINGE 1 ML 29 GAUGE X 1/2..... 590, 606
BD SAFETYGLIDE INSULIN SYRINGE 1 ML 31 GAUGE X 15/64..... 590, 606
BD SAFETYGLIDE SYRINGE 1 ML 27 GAUGE X 5/8..... 590, 606
BD ULTRA-FINE MICRO PEN NEEDLE 32 GAUGE X 1/4..... 590, 606
BD ULTRA-FINE MINI PEN NEEDLE 31 GAUGE X 3/16..... 590, 606
BD ULTRA-FINE NANO PEN NEEDLE 32 GAUGE X 5/32..... 590, 606
BD ULTRA-FINE ORIGINAL PEN NEEDLE 29 GAUGE X 1/2 ..... 590, 606
BD ULTRA-FINE SHORT PEN NEEDLE 31 GAUGE X 5/16..... 590, 606
BD VEO INSULIN SYRINGE ULTRA-FINE (HALF UNIT) 0.3 ML 31 GAUGE X 15/64..... 590, 606
BD VEO INSULIN SYRINGE ULTRA-FINE 0.3 ML 31 GAUGE X 15/64.... 590, 606
BD VEO INSULIN SYRINGE ULTRA-FINE 1 ML 31 GAUGE X 15/64 590, 606
BD VEO INSULIN SYRINGE ULTRA-FINE 1/2 ML 31 GAUGE X 15/64.... 590, 606
BORDERED GAUZE 2 ..... 590, 606
BYSANTI 1 MG TABLET 612
BYSANTI 10 MG TABLET 612
BYSANTI 12 MG TABLET 612
BYSANTI 2 MG TABLET 612
BYSANTI 4 MG TABLET 612
BYSANTI 6 MG TABLET 612
BYSANTI 8 MG TABLET 612
BYSANTI TITRATION PACK A 1MG(2)-2 MG(2)-4MG(2)-6 MG(2) TABLET PK 612
BYSANTI TITRATION PACK B 1MG(6)-2MG(2)-6MG(2)-8MG(2) TABLET PK 612
BYSANTI TITRATION PACK C 1 MG (4)-2 MG (2)-6 MG (2) TABLET PK. 612
C
CAPLYTA 10.5 MG CAPSULE..... 610
CAPLYTA 21 MG CAPSULE..... 610
CAPLYTA 42 MG CAPSULE..... 610
CAREFINE PEN NEEDLE 29 GAUGE X 1/2 ..... 590, 606
CAREFINE PEN NEEDLE 30 GAUGE X 5/16 ..... 590, 606
CAREFINE PEN NEEDLE 31 GAUGE X 1/4 ..... 590, 606
CAREFINE PEN NEEDLE 31 GAUGE X 5/16 ..... 590, 606
CAREFINE PEN NEEDLE 32 GAUGE X 1/4 ..... 590, 606
CAREFINE PEN NEEDLE 32 GAUGE X 3/16 ..... 590, 606
CAREFINE PEN NEEDLE 32 GAUGE X 5/32 ..... 590, 606
CARETOUCH ALCOHOL PREP PAD TOPICAL PADS 590, 606
CARETOUCH INSULIN SYRINGE 0.3 ML 31 GAUGE X 5/16..... 590, 606
CARETOUCH INSULIN SYRINGE 0.5 ML 30 GAUGE X 5/16..... 590, 606
CARETOUCH INSULIN SYRINGE 0.5 ML 31 GAUGE X 5/16..... 590, 606
CARETOUCH INSULIN SYRINGE 1 ML 28 GAUGE X 5/16..... 590, 606
CARETOUCH INSULIN SYRINGE 1 ML 29 GAUGE X 5/16..... 590, 606
CARETOUCH INSULIN SYRINGE 1 ML 30 GAUGE X 5/16..... 590, 606
CARETOUCH INSULIN SYRINGE 1 ML 31 GAUGE X 5/16..... 590, 606
CARETOUCH PEN NEEDLE 29 GAUGE X 1/2..... 590, 606
CARETOUCH PEN NEEDLE 31 GAUGE X 1/4..... 590, 606

Please refer to our Evidence of Coverage for 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.

CARETOUCH PEN NEEDLE 31 GAUGE X 3/16..... 590, 606
CARETOUCH PEN NEEDLE 31 GAUGE X 5/16..... 590, 606
CARETOUCH PEN NEEDLE 32 GAUGE X 3/16..... 590, 606
CARETOUCH PEN NEEDLE 32 GAUGE X 5/32..... 590, 606
CLICKFINE PEN NEEDLE 31 GAUGE X 1/4 ..... 590, 606
CLICKFINE PEN NEEDLE 32 GAUGE X 5/32 ..... 590, 606
clozapine 100 mg disintegrating tablet ... 583
clozapine 12.5 mg disintegrating tablet .. 583
clozapine 150 mg disintegrating tablet ... 583
clozapine 200 mg disintegrating tablet ... 583
clozapine 25 mg disintegrating tablet 583
COBENFY 100 MG-20 MG CAPSULE 619
COBENFY 125 MG-30 MG CAPSULE 619
COBENFY 50 MG-20 MG CAPSULE.. 619
COBENFY STARTER PACK 50 MG-20 MG/100 MG-20 MG CAPSULES IN A DOSE PACK 619
COMFORT EZ INSULIN SYRINGE 0.3 ML 29 GAUGE X 1/2..... 590, 606
COMFORT EZ INSULIN SYRINGE 0.3 ML 30 GAUGE X 1/2..... 591, 606
COMFORT EZ INSULIN SYRINGE 0.3 ML 30 GAUGE X 5/16..... 591, 606
COMFORT EZ INSULIN SYRINGE 0.3 ML 31 GAUGE X 15/64..... 591, 606
COMFORT EZ INSULIN SYRINGE 0.3 ML 31 GAUGE X 5/16..... 591, 606
COMFORT EZ INSULIN SYRINGE 0.5 ML 29 GAUGE X 1/2..... 591, 606
COMFORT EZ INSULIN SYRINGE 0.5 ML 30 GAUGE X 1/2..... 591, 606
COMFORT EZ INSULIN SYRINGE 0.5 ML 30 GAUGE X 5/16..... 591, 606
COMFORT EZ INSULIN SYRINGE 0.5 ML 31 GAUGE X 5/16..... 591, 606
COMFORT EZ INSULIN SYRINGE 1 ML 27 GAUGE X 1/2..... 591, 606
COMFORT EZ INSULIN SYRINGE 1 ML 28 GAUGE X 1/2..... 591, 606
COMFORT EZ INSULIN SYRINGE 1 ML 29 GAUGE X 1/2..... 591, 606
COMFORT EZ INSULIN SYRINGE 1 ML 30 GAUGE X 1/2..... 591, 606
COMFORT EZ INSULIN SYRINGE 1 ML 30 GAUGE X 5/16..... 591, 606
COMFORT EZ INSULIN SYRINGE 1 ML 31 GAUGE X 15/64..... 591, 606
COMFORT EZ INSULIN SYRINGE 1 ML 31 GAUGE X 5/16..... 591, 606
COMFORT EZ INSULIN SYRINGE 1/2 ML 28 GAUGE X 1/2..... 591, 606
COMFORT EZ INSULIN SYRINGE 1/2 ML 31 GAUGE X 15/64..... 591, 606
COMFORT EZ PEN NEEDLES 29 GAUGE X 1/2..... 591, 606
COMFORT EZ PEN NEEDLES 31 GAUGE X 1/4..... 591, 606
COMFORT EZ PEN NEEDLES 31 GAUGE X 3/16..... 591, 606
COMFORT EZ PEN NEEDLES 31 GAUGE X 5/16..... 591, 606
COMFORT EZ PEN NEEDLES 32 GAUGE X 1/4..... 591, 606
COMFORT EZ PEN NEEDLES 32 GAUGE X 3/16..... 591, 606
COMFORT EZ PEN NEEDLES 32 GAUGE X 5/16..... 591, 606
COMFORT EZ PEN NEEDLES 32 GAUGE X 5/32..... 591, 606
COMFORT EZ PEN NEEDLES 33 GAUGE X 1/4..... 591, 606
COMFORT EZ PEN NEEDLES 33 GAUGE X 3/16..... 591, 606
COMFORT EZ PEN NEEDLES 33 GAUGE X 5/16..... 591, 606
COMFORT EZ PEN NEEDLES 33 GAUGE X 5/32..... 591, 606
COMFORT EZ PRO SAFETY PEN NEEDLE 30 GAUGE X 5/16..... 591, 606
COMFORT EZ PRO SAFETY PEN NEEDLE 31 GAUGE X 3/16..... 591, 606

Please refer to our Evidence of Coverage for 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.

COMFORT EZ PRO SAFETY PEN NEEDLE 31 GAUGE X 5/32 ..... 591, 606
COMFORT TOUCH PEN NEEDLE 31 GAUGE X 1/4..... 591, 606
COMFORT TOUCH PEN NEEDLE 31 GAUGE X 3/16..... 591, 606
COMFORT TOUCH PEN NEEDLE 31 GAUGE X 5/16..... 591, 606
COMFORT TOUCH PEN NEEDLE 31 GAUGE X 5/32..... 591, 606
COMFORT TOUCH PEN NEEDLE 32 GAUGE X 1/4..... 591, 606
COMFORT TOUCH PEN NEEDLE 32 GAUGE X 3/16..... 591, 606
COMFORT TOUCH PEN NEEDLE 32 GAUGE X 5/16..... 591, 606
COMFORT TOUCH PEN NEEDLE 32 GAUGE X 5/32..... 591, 606
COMFORT TOUCH PEN NEEDLE 33 GAUGE X 1/4..... 591, 606
COMFORT TOUCH PEN NEEDLE 33 GAUGE X 3/16..... 591, 606
COMFORT TOUCH PEN NEEDLE 33 GAUGE X 5/32..... 591, 606
CURITY ALCOHOL SWABS..... 591, 606
CURITY GAUZE 2 ..... 591, 592, 606
cyclophosphamide 25 mg capsule 582
cyclophosphamide 25 mg tablet..... 582
cyclophosphamide 50 mg capsule 582
cyclophosphamide 50 mg tablet..... 582
D
DERMACEA 2 ..... 592, 606
DERMACEA NON-WOVEN 2 ..... 592, 606
DRIZALMA SPRINKLE 20 MG CAPSULE,DELAYED RELEASE 584
DRIZALMA SPRINKLE 30 MG CAPSULE,DELAYED RELEASE 584
DRIZALMA SPRINKLE 40 MG CAPSULE,DELAYED RELEASE 584
DRIZALMA SPRINKLE 60 MG CAPSULE,DELAYED RELEASE 584
DROPLET INSULIN SYRINGE (HALF UNIT) 0.3 ML 29 GAUGE X 1/2592, 606
DROPLET INSULIN SYRINGE (HALF UNIT) 0.3 ML 30 GAUGE X 1/2592, 606
DROPLET INSULIN SYRINGE (HALF UNIT) 0.3 ML 30 GAUGE X 5/16.... 592, 606
DROPLET INSULIN SYRINGE (HALF UNIT) 0.3 ML 31 GAUGE X 15/64.. 592, 606
DROPLET INSULIN SYRINGE (HALF UNIT) 0.3 ML 31 GAUGE X 5/16.... 592, 606
DROPLET INSULIN SYRINGE (HALF UNIT) 0.5 ML 29 GAUGE X 1/2592, 606
DROPLET INSULIN SYRINGE (HALF UNIT) 0.5 ML 30 GAUGE X 1/2592, 606
DROPLET INSULIN SYRINGE (HALF UNIT) 0.5 ML 30 GAUGE X 15/64.. 592, 606
DROPLET INSULIN SYRINGE (HALF UNIT) 0.5 ML 30 GAUGE X 5/16.... 592, 606
DROPLET INSULIN SYRINGE (HALF UNIT) 0.5 ML 31 GAUGE X 15/64.. 592, 606
DROPLET INSULIN SYRINGE (HALF UNIT) 0.5 ML 31 GAUGE X 5/16.... 592, 606
DROPLET INSULIN SYRINGE 0.3 ML 29 GAUGE X 1/2..... 592, 606
DROPLET INSULIN SYRINGE 0.3 ML 30 GAUGE X 1/2..... 592, 606
DROPLET INSULIN SYRINGE 0.3 ML 30 GAUGE X 15/64..... 592, 606
DROPLET INSULIN SYRINGE 0.3 ML 30 GAUGE X 5/16..... 592, 606
DROPLET INSULIN SYRINGE 0.3 ML 31 GAUGE X 15/64..... 592, 606
DROPLET INSULIN SYRINGE 0.3 ML 31 GAUGE X 5/16..... 592, 606
DROPLET INSULIN SYRINGE 0.5 ML 29 GAUGE X 1/2..... 592, 606
DROPLET INSULIN SYRINGE 0.5 ML 30 GAUGE X 1/2..... 592, 606

Please refer to our Evidence of Coverage for 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.

DROPLET INSULIN SYRINGE 0.5 ML 30 GAUGE X 5/16..... 592, 606
DROPLET INSULIN SYRINGE 0.5 ML 31 GAUGE X 5/16..... 592, 606
DROPLET INSULIN SYRINGE 1 ML 29 GAUGE X 1/2..... 592, 606
DROPLET INSULIN SYRINGE 1 ML 30 GAUGE X 1/2..... 592, 606
DROPLET INSULIN SYRINGE 1 ML 30 GAUGE X 15/64..... 592, 606
DROPLET INSULIN SYRINGE 1 ML 30 GAUGE X 5/16..... 592, 606
DROPLET INSULIN SYRINGE 1 ML 31 GAUGE X 15/64..... 592, 606
DROPLET INSULIN SYRINGE 1 ML 31 GAUGE X 5/16..... 592, 606
DROPLET INSULIN SYRINGE 1/2 ML 31 GAUGE X 15/64..... 592, 606
DROPLET MICRON PEN NEEDLE 34 GAUGE X 9/64..... 592, 606
DROPLET PEN NEEDLE 29 GAUGE X 1/2 ..... 592, 606
DROPLET PEN NEEDLE 29 GAUGE X 3/8 ..... 592, 606
DROPLET PEN NEEDLE 30 GAUGE X 5/16 ..... 592, 606
DROPLET PEN NEEDLE 31 GAUGE X 1/4 ..... 592, 606
DROPLET PEN NEEDLE 31 GAUGE X 3/16 ..... 592, 606
DROPLET PEN NEEDLE 31 GAUGE X 5/16 ..... 592, 606
DROPLET PEN NEEDLE 32 GAUGE X 1/4 ..... 592, 606
DROPLET PEN NEEDLE 32 GAUGE X 3/16 ..... 592, 606
DROPLET PEN NEEDLE 32 GAUGE X 5/16 ..... 592, 606
DROPLET PEN NEEDLE 32 GAUGE X 5/32 ..... 592, 606
DROPSAFE ALCOHOL PREP PADS . 592, 606
DROPSAFE INSULIN SYRINGE 0.3 ML 31 GAUGE X 15/64..... 592, 606
DROPSAFE INSULIN SYRINGE 0.3 ML 31 GAUGE X 5/16..... 593, 606
DROPSAFE INSULIN SYRINGE 0.5 ML 31 GAUGE X 15/64..... 593, 606
DROPSAFE INSULIN SYRINGE 0.5 ML 31 GAUGE X 5/16..... 593, 606
DROPSAFE INSULIN SYRINGE 1 ML 29 GAUGE X 1/2..... 593, 606
DROPSAFE INSULIN SYRINGE 1 ML 31 GAUGE X 15/64..... 593, 606
DROPSAFE INSULIN SYRINGE 1 ML 31 GAUGE X 5/16..... 593, 606
DROPSAFE PEN NEEDLE 31 GAUGE X 1/4 ..... 593, 606
DROPSAFE PEN NEEDLE 31 GAUGE X 3/16 ..... 593, 606
DROPSAFE PEN NEEDLE 31 GAUGE X 5/16 ..... 593, 606
DROPSAFE PEN NEEDLE 31 GAUGE X 5/32 ..... 593, 606

E

EASY COMFORT ALCOHOL PAD TOPICAL PADS 593, 606
EASY COMFORT INSULIN SYRINGE 0.3 ML 31 GAUGE X 5/16..... 593, 606
EASY COMFORT INSULIN SYRINGE 0.3 ML 31 X 1/2..... 593, 606
EASY COMFORT INSULIN SYRINGE 0.5 ML 30 GAUGE X 1/2..... 593, 606
EASY COMFORT INSULIN SYRINGE 0.5 ML 30 GAUGE X 5/16..... 593, 606
EASY COMFORT INSULIN SYRINGE 0.5 ML 31 GAUGE X 5/16..... 593, 606
EASY COMFORT INSULIN SYRINGE 1 ML 29 GAUGE X 5/16..... 593, 606
EASY COMFORT INSULIN SYRINGE 1 ML 30 GAUGE X 1/2..... 593, 606
EASY COMFORT INSULIN SYRINGE 1 ML 30 GAUGE X 5/16..... 593, 606
EASY COMFORT INSULIN SYRINGE 1 ML 31 GAUGE X 5/16..... 593, 606
EASY COMFORT INSULIN SYRINGE 1 ML 32 GAUGE X 5/16..... 593, 606

Please refer to our Evidence of Coverage for 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.

EASY COMFORT INSULIN SYRINGE 1/2 ML 29 X 5/16 ..... 593, 606
EASY COMFORT INSULIN SYRINGE 1/2 ML 32 GAUGE X 5/16 ..... 593, 606
EASY COMFORT PEN NEEDLES 29 GAUGE X 3/16..... 593, 606
EASY COMFORT PEN NEEDLES 29 GAUGE X 5/32..... 593, 606
EASY COMFORT PEN NEEDLES 31 GAUGE X 1/4..... 593, 606
EASY COMFORT PEN NEEDLES 31 GAUGE X 3/16..... 593, 606
EASY COMFORT PEN NEEDLES 31 GAUGE X 5/16..... 593, 606
EASY COMFORT PEN NEEDLES 32 GAUGE X 5/32..... 593, 606
EASY COMFORT PEN NEEDLES 33 GAUGE X 1/4..... 593, 606
EASY COMFORT PEN NEEDLES 33 GAUGE X 3/16..... 593, 606
EASY COMFORT PEN NEEDLES 33 GAUGE X 5/32..... 593, 606
EASY COMFORT SAFETY PEN NEEDLE 31 GAUGE X 1/4 ..... 593, 606
EASY COMFORT SAFETY PEN NEEDLE 31 GAUGE X 3/16 ..... 593, 606
EASY COMFORT SAFETY PEN NEEDLE 32 GAUGE X 5/32 ..... 593, 606
EASY GLIDE INSULIN SYRINGE 0.3 ML 31 GAUGE X 15/64..... 593, 606
EASY GLIDE INSULIN SYRINGE 1 ML 31 GAUGE X 15/64..... 593, 606
EASY GLIDE INSULIN SYRINGE 1/2 ML 31 GAUGE X 15/64..... 593, 606
EASY GLIDE PEN NEEDLE 33 GAUGE X 5/32..... 593, 606
EASY TOUCH 29 GAUGE X 1/2 . 593, 606
EASY TOUCH 31 GAUGE X 1/4 . 593, 606
EASY TOUCH 31 GAUGE X 3/16 593, 606
EASY TOUCH 31 GAUGE X 5/16 593, 606
EASY TOUCH 32 GAUGE X 1/4 . 593, 606
EASY TOUCH 32 GAUGE X 3/16 594, 606
EASY TOUCH 32 GAUGE X 5/32 594, 606
EASY TOUCH ALCOHOL PREP PADS 594, 606
EASY TOUCH AUTORETRACT SYRINGE 0.5 ML 30 GAUGE X 1/4 594, 606
EASY TOUCH AUTORETRACT SYRINGE 0.5 ML 30 GAUGE X 5/16 ..... 594, 606
EASY TOUCH AUTORETRACT SYRINGE 1 ML 30 GAUGE X 1/4 .. 594, 606
EASY TOUCH AUTORETRACT SYRINGE 1 ML 30 GAUGE X 5/16 594, 606
EASY TOUCH FLIPLOCK INSULIN 1 ML 29 GAUGE X 1/2..... 594, 606
EASY TOUCH FLIPLOCK INSULIN 1 ML 31 GAUGE X 5/16..... 594, 606
EASY TOUCH FLIPLOCK INSULIN SYRINGE 1 ML 30 GAUGE X 1/2 .. 594, 606
EASY TOUCH FLIPLOCK INSULIN SYRINGE 1 ML 30 GAUGE X 5/16 594, 606
EASY TOUCH FLIPLOCK SYRINGE 1 ML 27 GAUGE X 1/2..... 594, 606
EASY TOUCH INSULIN SAFETY SYRINGE 0.5 ML 29 GAUGE X 1/2 594, 606
EASY TOUCH INSULIN SAFETY SYRINGE 0.5 ML 30 GAUGE X 5/16 ..... 594, 606
EASY TOUCH INSULIN SAFETY SYRINGE 1 ML 29 GAUGE X 1/2 .. 594, 606
EASY TOUCH INSULIN SAFETY SYRINGE 1 ML 30 GAUGE X 1/2 .. 594, 606
EASY TOUCH INSULIN SYRINGE (HALF UNIT) 0.3 ML 30 GAUGE X 5/16 ..... 594, 606
EASY TOUCH INSULIN SYRINGE (HALF UNIT) 0.3 ML 31 GAUGE X 1/4 ..... 594, 606

Please refer to our Evidence of Coverage for 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.

EASY TOUCH INSULIN SYRINGE (HALF UNIT) 0.3 ML 31 GAUGE X 5/16 ..... 594, 606
EASY TOUCH INSULIN SYRINGE 0.3 ML 30 GAUGE X 1/2..... 594, 606
EASY TOUCH INSULIN SYRINGE 0.3 ML 30 GAUGE X 5/16..... 594, 606
EASY TOUCH INSULIN SYRINGE 0.3 ML 31 GAUGE X 5/16..... 594, 606
EASY TOUCH INSULIN SYRINGE 0.5 ML 29 GAUGE X 1/2..... 594, 606
EASY TOUCH INSULIN SYRINGE 0.5 ML 30 GAUGE X 1/2..... 594, 606
EASY TOUCH INSULIN SYRINGE 0.5 ML 30 GAUGE X 5/16..... 594, 606
EASY TOUCH INSULIN SYRINGE 0.5 ML 31 GAUGE X 5/16..... 594, 606
EASY TOUCH INSULIN SYRINGE 1 ML 27 GAUGE X 1/2..... 594, 606
EASY TOUCH INSULIN SYRINGE 1 ML 27 GAUGE X 5/8..... 594, 606
EASY TOUCH INSULIN SYRINGE 1 ML 28 GAUGE X 1/2..... 594, 606
EASY TOUCH INSULIN SYRINGE 1 ML 29 GAUGE X 1/2..... 594, 606
EASY TOUCH INSULIN SYRINGE 1 ML 30 GAUGE X 1/2..... 594, 606
EASY TOUCH INSULIN SYRINGE 1 ML 30 GAUGE X 5/16..... 594, 606
EASY TOUCH INSULIN SYRINGE 1 ML 31 GAUGE X 1/4..... 594, 606
EASY TOUCH INSULIN SYRINGE 1 ML 31 GAUGE X 5/16..... 594, 606
EASY TOUCH INSULIN SYRINGE 1/2 ML 27 GAUGE X 1/2..... 594, 606
EASY TOUCH INSULIN SYRINGE 1/2 ML 28 GAUGE X 1/2..... 594, 606
EASY TOUCH INSULIN SYRINGE 1/2 ML 31 GAUGE X 1/4..... 594, 606
EASY TOUCH LUER LOCK INSULIN 1 ML SYRINGE 594, 606
EASY TOUCH PEN NEEDLE 30 GAUGE X 5/16..... 594, 606
EASY TOUCH SAFETY PEN NEEDLE 29 GAUGE X 3/16..... 594, 606
EASY TOUCH SAFETY PEN NEEDLE 29 GAUGE X 5/16..... 594, 606
EASY TOUCH SAFETY PEN NEEDLE 30 GAUGE X 1/4..... 594, 606
EASY TOUCH SAFETY PEN NEEDLE 30 GAUGE X 3/16..... 594, 606
EASY TOUCH SAFETY PEN NEEDLE 30 GAUGE X 5/16..... 595, 606
EASY TOUCH SHEATHLOCK INSULIN 1 ML 29 GAUGE X 1/2..... 595, 606
EASY TOUCH SHEATHLOCK INSULIN 1 ML 30 GAUGE X 5/16..... 595, 606
EASY TOUCH SHEATHLOCK INSULIN 1 ML 31 GAUGE X 5/16..... 595, 606
EASY TOUCH SHEATHLOCK INSULIN SYRINGE 1 ML 30 GAUGE X 1/2 .. 595, 606
EASY TOUCH UNI-SLIP 1 ML SYRINGE 595, 606
EASYLIFE ALCOHOL PADS 595, 606
EASYLIFE INSULIN PEN NEEDLE 29 GAUGE X 1/2..... 595, 606
EASYLIFE INSULIN PEN NEEDLE 31 GAUGE X 1/4..... 595, 606
EASYLIFE INSULIN PEN NEEDLE 31 GAUGE X 3/16..... 595, 606
EASYLIFE INSULIN PEN NEEDLE 31 GAUGE X 5/16..... 595, 606
EASYLIFE INSULIN PEN NEEDLE 31 GAUGE X 5/32..... 595, 606
EASYLIFE INSULIN PEN NEEDLE 32 GAUGE X 1/4..... 595, 606
EASYLIFE INSULIN PEN NEEDLE 32 GAUGE X 3/16..... 595, 606
EASYLIFE INSULIN PEN NEEDLE 32 GAUGE X 5/16..... 595, 606
EASYLIFE INSULIN PEN NEEDLE 32 GAUGE X 5/32..... 595, 606
EASYLIFE INSULIN PEN NEEDLE 33 GAUGE X 1/4..... 595, 606
EASYLIFE INSULIN PEN NEEDLE 33 GAUGE X 3/16..... 595, 606

Please refer to our Evidence of Coverage for 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.

EASYLIFE INSULIN PEN NEEDLE 33 GAUGE X 5/16..... 595, 606
EASYLIFE INSULIN PEN NEEDLE 33 GAUGE X 5/32..... 595, 606
EASYLIFE INSULIN SYRINGE 0.5 ML 30 GAUGE X 5/16..... 595, 606
EASYLIFE INSULIN SYRINGE 1 ML 30 GAUGE X 1/2..... 595, 606
EASYLIFE INSULIN SYRINGE 1 ML 30 GAUGE X 5/16..... 595, 606
EASYLIFE INSULIN SYRINGE 1 ML 31 GAUGE X 5/16..... 595, 606
EASYLIFE SAFETY PEN NEEDLE 31 GAUGE X 3/16..... 595, 606
EASYLIFE SAFETY PEN NEEDLE 31 GAUGE X 5/32..... 595, 606
EMBRACE PEN NEEDLE 29 GAUGE X 1/2 ..... 595, 606
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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.

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

2027 Formulary

List of Covered Drugs
Formulary ID#: 27383

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

This formulary was updated on 10/7/2026. For more recent information or other questions, please contact Pharmacy Member Service at 1-888-274-1750 (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.