



**VNS Health EasyCare Plus
(HMO D-SNP)
and
VNS Health Total (HMO D-SNP)
Prior Authorization Requirements
Effective: 11/12/2024**

ABALOPARATIDE

Products Affected

- TYMLOS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	24 MONTHS
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

ABATACEPT IV

Products Affected

- ORENCIA (WITH MALTOSE)

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. PSORIATIC ARTHRITIS (PSA): PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST OR RHEUMATOLOGIST.
Coverage Duration	RA, PJIA, PSA: INITIAL: 6 MOS, RENEWAL: 12 MOS. ACUTE GRAFT VERSUS HOST DISEASE (AGVHD): 1 MO.
Other Criteria	INITIAL: RA: TRIAL OF OR CONTRAINDICATION TO 3 MONTHS OF TREATMENT WITH ONE DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG) - IF PATIENT TRIED METHOTREXATE, THEN TRIAL AT A DOSE GREATER THAN OR EQUAL TO 20 MG PER WEEK OR MAXIMALLY TOLERATED DOSE IS REQUIRED. PJIA, PSA 1): TRIAL OF OR CONTRAINDICATION TO ONE DMARD, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR AN AUTOIMMUNE INDICATION. RENEWAL: RA: CONTINUES TO BENEFIT FROM THE MEDICATION. PJIA, PSA: 1) CONTINUES TO BENEFIT FROM THE MEDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR AN AUTOIMMUNE INDICATION.
Indications	All FDA-approved Indications.

PA Criteria	Criteria Details
Off Label Uses	
Part B Prerequisite	No

ABATACEPT SQ

Products Affected

- ORENCIA
- ORENCIA CLICKJECT

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. PSORIATIC ARTHRITIS (PSA): PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST OR RHEUMATOLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	INITIAL: RA: TRIAL OF OR CONTRAINDICATION TO 3 MONTHS OF TREATMENT WITH ONE DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG) - IF PATIENT TRIED METHOTREXATE, THEN TRIAL AT A DOSE GREATER THAN OR EQUAL TO 20 MG PER WEEK OR MAXIMALLY TOLERATED DOSE IS REQUIRED. PJIA, PSA: 1) TRIAL OF OR CONTRAINDICATION TO ONE DMARD, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR AN AUTOIMMUNE INDICATION. RENEWAL: RA: CONTINUES TO BENEFIT FROM THE MEDICATION. PJIA, PSA: 1) CONTINUES TO BENEFIT FROM THE MEDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR AN AUTOIMMUNE INDICATION.
Indications	All FDA-approved Indications.

PA Criteria	Criteria Details
Off Label Uses	
Part B Prerequisite	No

ABEMACICLIB

Products Affected

- VERZENIO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

ABIRATERONE

Products Affected

- *abiraterone*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
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

ABIRATERONE SUBMICRONIZED

Products Affected

- YONSA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
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

ACALABRUTINIB

Products Affected

- CALQUENCE
- CALQUENCE (ACALABRUTINIB MAL)

PA Criteria	Criteria Details
Exclusion Criteria	PA Criteria: Pending CMS Approval
Required Medical Information	PA Criteria: Pending CMS Approval
Age Restrictions	PA Criteria: Pending CMS Approval
Prescriber Restrictions	PA Criteria: Pending CMS Approval
Coverage Duration	PA Criteria: Pending CMS Approval
Other Criteria	PA Criteria: Pending CMS Approval
Indications	PA Criteria: Pending CMS Approval
Off Label Uses	PA Criteria: Pending CMS Approval
Part B Prerequisite	No

ADAGRASIB

Products Affected

- KRAZATI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

ADALIMUMAB

Products Affected

- HUMIRA PEN
- HUMIRA PEN CROHNS-UC-HS START
- HUMIRA PEN PSOR-UVEITS-ADOL HS
- HUMIRA SUBCUTANEOUS SYRINGE KIT 40 MG/0.8 ML
- HUMIRA(CF)
- HUMIRA(CF) PEDI CROHNS STARTER
- 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, 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: RA, PSO, PJIA, AS, PSA, CD, UC, UVEITIS: 6 MONTHS, HS: 3 MONTHS. RENEWAL: 12 MONTHS.

PA Criteria	Criteria Details
Other Criteria	<p>INITIAL: RHEUMATOID ARTHRITIS (RA): TRIAL OF OR CONTRAINDICATION TO 3 MONTHS OF TREATMENT WITH ONE DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG) - IF PATIENT TRIED METHOTREXATE, THEN TRIAL AT A DOSE GREATER THAN OR EQUAL TO 20 MG PER WEEK OR MAXIMALLY TOLERATED DOSE IS REQUIRED.</p> <p>POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS (PJIA), PSA: 1) TRIAL OF OR CONTRAINDICATION TO ONE DMARD, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR AN AUTOIMMUNE INDICATION. AS: 1) TRIAL OF OR CONTRAINDICATION TO AN NSAID AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR AN AUTOIMMUNE INDICATION. PSO: 1) ONE OF THE FOLLOWING: (A) AT LEAST A 3 MONTH TRIAL OF ONE ORAL IMMUNOSUPPRESSANT (CYCLOSPORINE, METHOTREXATE, TACROLIMUS) OR PUVA (PHOTOTHERAPY) FOR THE TREATMENT OF PSO, (B) CONTRAINDICATION OR INTOLERANCE TO BOTH IMMUNOSUPPRESSANT AND PUVA FOR THE TREATMENT OF PSO, OR (C) PATIENT IS SWITCHING FROM A DIFFERENT BIOLOGIC, PDE-4 INHIBITOR, OR JAK INHIBITOR FOR THE SAME INDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR AN AUTOIMMUNE INDICATION. CD, UC: 1) TRIAL OF OR CONTRAINDICATION TO ONE CONVENTIONAL THERAPY (E.G., CORTICOSTEROID [E.G., BUDESONIDE, METHYLPREDNISOLONE], AZATHIOPRINE, MERCAPTOPYRINE, METHOTREXATE, MESALAMINE), AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR AN AUTOIMMUNE INDICATION. HS: NO CONCURRENT USE WITH OTHER SYSTEMIC BIOLOGICS FOR HS OR TNF</p>

PA Criteria	Criteria Details
	INHIBITORS FOR ANY INDICATION. UVEITIS: NO ISOLATED ANTERIOR UVEITIS. RENEWAL: RA, HS, UVEITIS: CONTINUES TO BENEFIT FROM THE MEDICATION. PJIA, PSA, AS, PSO: 1) CONTINUES TO BENEFIT FROM THE MEDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR AN AUTOIMMUNE INDICATION. CD, UC: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR AN AUTOIMMUNE INDICATION.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

AFATINIB

Products Affected

- GILOTRIF

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
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

ALECTINIB

Products Affected

- ALECENSA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

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	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

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: 12 MONTHS.
Other Criteria	PAH: INITIAL: DOES NOT HAVE IDIOPATHIC PULMONARY FIBROSIS.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

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: 6 MONTHS.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

AMIVANTAMAB-VMJW

Products Affected

- RYBREVANT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

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	RA: INITIAL: 6 MONTHS, RENEWAL: 12 MONTHS. CAPS, DIRA: LIFETIME.
Other Criteria	INITIAL: RA: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: ENBREL, HUMIRA, XELJANZ, RINVOQ, ORENCIA. CAPS, DIRA: NO CONCURRENT USE WITH OTHER IL-1 INHIBITORS. RENEWAL: RA: CONTINUES TO BENEFIT FROM THE MEDICATION.
Indications	All FDA-approved Indications.

PA Criteria	Criteria Details
Off Label Uses	
Part B Prerequisite	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	INITIAL/RENEWAL: 12 MONTHS.
Other Criteria	INITIAL: NON-METASTATIC CASTRATION-RESISTANT PROSTATE CANCER (NMCRPC): HIGH RISK PROSTATE CANCER (I.E., RAPIDLY INCREASING PROSTATE SPECIFIC ANTIGEN [PSA] LEVELS). 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. RENEWAL: NMCRPC, MCSPC: 1) RECEIVED A BILATERAL ORCHIECTOMY, 2) CASTRATE LEVEL OF TESTOSTERONE (I.E., LESS THAN 50 NG/DL), OR 3) CONCURRENT USE WITH A GNRH ANALOG.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

APOMORPHINE

Products Affected

- *apomorphine*

PA Criteria	Criteria Details
Exclusion Criteria	PA Criteria: Pending CMS Approval
Required Medical Information	PA Criteria: Pending CMS Approval
Age Restrictions	PA Criteria: Pending CMS Approval
Prescriber Restrictions	PA Criteria: Pending CMS Approval
Coverage Duration	PA Criteria: Pending CMS Approval
Other Criteria	PA Criteria: Pending CMS Approval
Indications	PA Criteria: Pending CMS Approval
Off Label Uses	PA Criteria: Pending CMS Approval
Part B Prerequisite	No

APOMORPHINE - SL

Products Affected

- KYNMOBI SUBLINGUAL FILM 10 MG, 10-15-20-25-30 MG, 15 MG, 20 MG, 25 MG, 30 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	PARKINSONS DISEASE (PD): INITIAL: 18 YEARS OF AGE OR OLDER.
Prescriber Restrictions	PD: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS
Other Criteria	PD: INITIAL: PHYSICIAN HAS OPTIMIZED DRUG THERAPY FOR PARKINSONS DISEASE. RENEWAL: IMPROVEMENT WITH MOTOR FLUCTUATIONS DURING OFF EPISODES WITH THE USE OF THERAPY.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

APREMILAST

Products Affected

- OTEZLA
- OTEZLA STARTER

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: MILD PLAQUE PSORIASIS (PSO): 1) PSORIASIS COVERING 2 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, 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: 6 MONTHS. RENEWAL: 12 MONTHS.

PA Criteria	Criteria Details
Other Criteria	<p>INITIAL: PSA: 1) TRIAL OF OR CONTRAINDICATION TO ONE DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG), AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR AN AUTOIMMUNE INDICATION. MILD PSO: TRIAL OF OR CONTRAINDICATION TO ONE CONVENTIONAL SYSTEMIC THERAPY (E.G., METHOTREXATE, ACITRETIN, CYCLOSPORINE) OR ONE CONVENTIONAL TOPICAL THERAPY (E.G., PUVA [PHOTOTHERAPY], UVB [ULTRAVIOLET LIGHT B], TOPICAL CORTICOSTEROIDS). MODERATE TO SEVERE PSO: 1) ONE OF THE FOLLOWING: (A) AT LEAST A 3 MONTH TRIAL OF ONE ORAL IMMUNOSUPPRESSANT (CYCLOSPORINE, METHOTREXATE, TACROLIMUS) OR PUVA (PHOTOTHERAPY) FOR THE TREATMENT OF PSO, (B) CONTRAINDICATION OR INTOLERANCE TO BOTH IMMUNOSUPPRESSANT AND PUVA FOR THE TREATMENT OF PSO, OR (C) PATIENT IS SWITCHING FROM A DIFFERENT BIOLOGIC, PDE-4 INHIBITOR, OR JAK INHIBITOR FOR THE SAME INDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR AN AUTOIMMUNE 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). RENEWAL: MILD PSO, BEHCETS DISEASE: CONTINUES TO BENEFIT FROM THE MEDICATION. PSA, MODERATE TO SEVERE PSO: 1) CONTINUES TO BENEFIT FROM THE MEDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR AN AUTOIMMUNE INDICATION.</p>
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

ASCIMINIB

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	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	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

ASFOTASE ALFA

Products Affected

- STRENSIQ

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: 6 MONTHS. RENEWAL: 12 MONTHS.

PA Criteria	Criteria Details
Other Criteria	<p>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 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)</p>
	<p>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.</p>
Indications	All FDA-approved Indications.
Off Label Uses	

PA Criteria	Criteria Details
Part B Prerequisite	No

ATEZOLIZUMAB

Products Affected

- TECENTRIQ

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

ATOGEPANT

Products Affected

- QULIPTA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	MIGRAINE PREVENTION: INITIAL: 1) TRIAL OF OR CONTRAINDICATION TO ONE OF THE FOLLOWING PREVENTIVE MIGRAINE TREATMENTS: DIVALPROEX SODIUM, TOPIRAMATE, PROPRANOLOL, TIMOLOL, AND 2) NO CONCURRENT USE WITH OTHER CGRP INHIBITORS FOR MIGRAINE PREVENTION. RENEWAL: 1) REDUCTION IN MIGRAINE OR HEADACHE FREQUENCY, MIGRAINE SEVERITY, OR MIGRAINE DURATION WITH THERAPY, AND 2) NO CONCURRENT USE WITH OTHER CGRP INHIBITORS FOR MIGRAINE PREVENTION.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	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: 6 MONTHS.
Other Criteria	ANCA-ASSOCIATED VASCULITIS: RENEWAL: CONTINUES TO BENEFIT FROM THERAPY.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

AVAPRITINIB

Products Affected

- AYVAKIT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

AVATROMBOPAG

Products Affected

- DOPTELET (10 TAB PACK)
- DOPTELET (15 TAB PACK)
- DOPTELET (30 TAB PACK)

PA Criteria	Criteria Details
Exclusion Criteria	PA Criteria: Pending CMS Approval
Required Medical Information	PA Criteria: Pending CMS Approval
Age Restrictions	PA Criteria: Pending CMS Approval
Prescriber Restrictions	PA Criteria: Pending CMS Approval
Coverage Duration	PA Criteria: Pending CMS Approval
Other Criteria	PA Criteria: Pending CMS Approval
Indications	PA Criteria: Pending CMS Approval
Off Label Uses	PA Criteria: Pending CMS Approval
Part B Prerequisite	No

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	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

AZACITIDINE

Products Affected

- ONUREG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

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	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

BECAPLERMIN

Products Affected

- REGRANEX

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	DIABETIC NEUROPATHIC ULCERS: PRESCRIBED BY OR IN CONSULTATION WITH A VASCULAR SURGEON, PODIATRIST, ENDOCRINOLOGIST, PHYSICIAN PRACTICING IN A SPECIALTY WOUND CLINIC OR INFECTIOUS DISEASE SPECIALIST.
Coverage Duration	3 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

BEDAQUILINE

Products Affected

- SIRTURO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	24 WEEKS
Other Criteria	PULMONARY MULTI-DRUG RESISTANT TUBERCULOSIS (MDR-TB): SIRTURO USED IN COMBINATION WITH AT LEAST 3 OTHER ANTIBIOTICS FOR THE TREATMENT OF PULMONARY MDR-TB.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

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: 6 MONTHS. RENEWAL: 12 MONTHS
Other Criteria	INITIAL: SLE: CURRENTLY TAKING CORTICOSTEROIDS, ANTIMALARIALS, NSAIDS, OR IMMUNOSUPPRESSIVE AGENTS. RENEWAL: SLE: PATIENT HAD CLINICAL IMPROVEMENT. LN: IMPROVEMENT IN RENAL RESPONSE FROM BASELINE LABORATORY VALUES (I.E., EGFR OR PROTEINURIA) AND/OR CLINICAL PARAMETERS.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

BELUMOSUDIL

Products Affected

- REZUROCK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

BELZUTIFAN

Products Affected

- WELIREG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

BENDAMUSTINE

Products Affected

- *bendamustine intravenous recon soln*
- BENDAMUSTINE INTRAVENOUS SOLUTION
- BENDEKA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

BENRALIZUMAB

Products Affected

- FASENRA
- FASENRA PEN

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	ASTHMA: INITIAL: BLOOD EOSINOPHIL LEVEL OF AT LEAST 150 CELLS/MCL WITHIN THE PAST 12 MONTHS.
Age Restrictions	
Prescriber Restrictions	ASTHMA: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A PHYSICIAN SPECIALIZING IN ALLERGY OR PULMONARY MEDICINE.
Coverage Duration	INITIAL: 4 MONTHS. RENEWAL: 12 MONTHS.

PA Criteria	Criteria Details
Other Criteria	<p>ASTHMA: INITIAL: 1) CONCURRENT THERAPY WITH A MEDIUM, HIGH-DOSE, OR MAXIMALLY TOLERATED DOSE OF AN INHALED CORTICOSTEROID (ICS) AND ONE OTHER MAINTENANCE MEDICATION, 2) ONE ASTHMA EXACERBATION REQUIRING SYSTEMIC CORTICOSTEROID BURST LASTING 3 OR MORE 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, AND 3) NO CONCURRENT USE WITH XOLAIR, DUPIXENT, TEZSPIRE, OR OTHER ANTI-IL5 BIOLOGICS WHEN USED FOR ASTHMA. RENEWAL: 1) NO CONCURRENT USE WITH XOLAIR, DUPIXENT, TEZSPIRE, OR OTHER ANTI-IL5 BIOLOGICS WHEN USED FOR ASTHMA, 2) CONTINUED USE OF ICS AND ONE OTHER MAINTENANCE MEDICATION, AND 3) 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.</p>
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

BETAINE

Products Affected

- *betaine*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

BEVACIZUMAB-ADCD

Products Affected

- VEGZELMA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

BEVACIZUMAB-AWWB

Products Affected

- MVASI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

BEVACIZUMAB-BVZR

Products Affected

- ZIRABEV

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

BEXAROTENE

Products Affected

- *bexarotene*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

BINIMETINIB

Products Affected

- MEKTOVI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

BORTEZOMIB

Products Affected

- *bortezomib injection*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

BOSENTAN

Products Affected

- *bosentan*

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: 12 MONTHS.
Other Criteria	PAH: INITIAL: 1) DOES NOT HAVE ELEVATED LIVER ENZYMES (ALT, AST) MORE THAN 3 TIMES UPPER LIMIT OF NORMAL (ULN) OR INCREASE IN BILIRUBIN BY 2 OR MORE TIMES ULN, AND 2) NO CONCURRENT USE WITH CYCLOSPORINE A OR GLYBURIDE. RENEWAL: NO CONCURRENT USE WITH CYCLOSPORINE A OR GLYBURIDE.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

BOSUTINIB

Products Affected

- BOSULIF ORAL CAPSULE 100 MG, 50 MG
- BOSULIF 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	12 MONTHS
Other Criteria	PREVIOUSLY TREATED (Ph+ CML): MUTATIONAL ANALYSIS PRIOR TO INITIATION AND BOSULIF IS APPROPRIATE PER NCCN GUIDELINE TABLE FOR TREATMENT RECOMMENDATIONS BASED ON BCR-ABL1 MUTATION PROFILE.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

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	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

C1 ESTERASE INHIBITOR-CINRYZE

Products Affected

- CINRYZE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	HEREDITARY ANGIOEDEMA (HAE): INITIAL: DIAGNOSIS CONFIRMED BY COMPLEMENT TESTING.
Age Restrictions	
Prescriber Restrictions	HAE: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A HEMATOLOGIST, IMMUNOLOGIST, OR ALLERGIST.
Coverage Duration	INITIAL/RENEWAL: 12 MONTHS.
Other Criteria	HAE: INITIAL: NOT ON CONCURRENT TREATMENT WITH ALTERNATIVE PROPHYLACTIC AGENT FOR HAE ATTACKS. RENEWAL: 1) IMPROVEMENT COMPARED TO BASELINE IN HAE ATTACKS (I.E., REDUCTIONS IN ATTACK FREQUENCY OR ATTACK SEVERITY), AND 2) NOT ON CONCURRENT TREATMENT WITH ALTERNATIVE PROPHYLACTIC AGENT FOR HAE ATTACKS. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

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: DIAGNOSIS CONFIRMED BY COMPLEMENT TESTING.
Age Restrictions	
Prescriber Restrictions	HAE: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A HEMATOLOGIST, IMMUNOLOGIST, OR ALLERGIST.
Coverage Duration	INITIAL/RENEWAL: 12 MONTHS.
Other Criteria	HAE: INITIAL: NOT ON CONCURRENT TREATMENT WITH ALTERNATIVE PROPHYLACTIC AGENT FOR HAE ATTACKS. RENEWAL: 1) IMPROVEMENT COMPARED TO BASELINE IN HAE ATTACKS (I.E., REDUCTIONS IN ATTACK FREQUENCY OR ATTACK SEVERITY), AND 2) NOT ON CONCURRENT TREATMENT WITH ALTERNATIVE PROPHYLACTIC AGENT FOR HAE ATTACKS.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

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	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	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	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

CANAKINUMAB

Products Affected

- ILARIS (PF)

PA Criteria	Criteria Details
Exclusion Criteria	
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.
Age Restrictions	
Prescriber Restrictions	INITIAL: SYSTEMIC JUVENILE IDIOPATHIC ARTHRITIS (SJIA), ADULT-ONSET STILLS DISEASE (AOSD): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST, DERMATOLOGIST, OR IMMUNOLOGIST. GOUT: PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST. RENEWAL: GOUT: PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST.
Coverage Duration	INITIAL: AOSD/SJIA: 6 MO, CAPS: LIFETIME, ALL OTHER DIAGNOSES: 12 MO. RENEWAL: AOSD/SJIA/GOUT: 12 MO

PA Criteria	Criteria Details
Other Criteria	<p>INITIAL: CAPS: NO CONCURRENT USE WITH OTHER IL-1 INHIBITORS. AOSD, SJIA: 1) TRIAL OF OR CONTRAINDICATION TO ONE DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG), AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR AN AUTOIMMUNE INDICATION. GOUT: NO CONCURRENT USE WITH OTHER IL-1 INHIBITORS. RENEWAL: AOSD, SJIA: 1) CONTINUES TO BENEFIT FROM THE MEDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR AN AUTOIMMUNE INDICATION. GOUT: 1) NO CONCURRENT USE WITH OTHER IL-1 INHIBITORS, AND 2) IMPROVEMENT IN GOUT FLARES.</p>
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

CANNABIDIOL

Products Affected

- EPIDIOLEX

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	DRAVET SYNDROME (DS), LENNOX-GASTAUT SYNDROME (LGS), TUBEROUS SCLEROSIS COMPLEX (TSC): PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST.
Coverage Duration	INITIAL/RENEWAL: 12 MONTHS.
Other Criteria	INITIAL: LENNOX-GASTAUT SYNDROME (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

CAPIVASERTIB

Products Affected

- TRUQAP

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

CAPLACIZUMAB YHDP

Products Affected

- CABLIVI INJECTION KIT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	ACQUIRED THROMBOTIC THROMBOCYTOPENIA PURPURA (ATTP): PRESCRIBED BY OR IN CONSULTATION WITH A HEMATOLOGIST.
Coverage Duration	12 MONTHS
Other Criteria	ATTP: 1) CABLIVI WAS PREVIOUSLY INITIATED AS PART OF AN FDA APPROVED TREATMENT REGIMEN IN COMBINATION WITH PLASMA EXCHANGE AND IMMUNOSUPPRESSIVE THERAPY IN AN INPATIENT SETTING, AND 2) HAS NOT EXPERIENCED MORE THAN TWO RECURRENCES OF ATTP WHILE ON CABLIVI THERAPY (I.E., NEW DROP IN PLATELET COUNT REQUIRING REPEAT PLASMA EXCHANGE DURING 30 DAYS POST-PLASMA EXCHANGE THERAPY [PEX] AND UP TO 28 DAYS OF EXTENDED THERAPY).
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

CAPMATINIB

Products Affected

- TABRECTA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

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: 6 MOS, RENEWAL: 12 MOS.
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

CERITINIB

Products Affected

- ZYKADIA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

CERTOLIZUMAB PEGOL

Products Affected

- CIMZIA POWDER FOR RECONST
- CIMZIA SUBCUTANEOUS SYRINGE KIT 400 MG/2 ML (200 MG/ML X 2)

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, OR GENITAL AREA. 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: RHEUMATOID ARTHRITIS (RA), ANKYLOSING SPONDYLITIS (AS), NR-AXSPA: PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST. PSORIATIC ARTHRITIS (PSA): PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST OR RHEUMATOLOGIST. CROHNS DISEASE (CD): PRESCRIBED BY OR IN CONSULTATION WITH A GASTROENTEROLOGIST. PSO: PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.

PA Criteria	Criteria Details
Other Criteria	<p>INITIAL: RA: 1) PATIENT IS PREGNANT, BREASTFEEDING, OR TRYING TO BECOME PREGNANT, OR 2) TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: ENBREL, HUMIRA, XELJANZ, RINVOQ, ORENCIA. PSA: 1) ONE OF THE FOLLOWING: (A) PATIENT IS PREGNANT, BREASTFEEDING, OR TRYING TO BECOME PREGNANT, OR (B) TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: COSENTYX, ENBREL, HUMIRA, STELARA, XELJANZ, RINVOQ, SKYRIZI, TREMFYA, ORENCIA, OTEZLA, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR AN AUTOIMMUNE INDICATION. PSO: 1) ONE OF THE FOLLOWING: (A) PATIENT IS PREGNANT, BREASTFEEDING, OR TRYING TO BECOME PREGNANT, OR (B) TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: COSENTYX, ENBREL, HUMIRA, STELARA, SKYRIZI, TREMFYA, OTEZLA, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR AN AUTOIMMUNE INDICATION. AS: 1) ONE OF THE FOLLOWING: (A) PATIENT IS PREGNANT, BREASTFEEDING, OR TRYING TO BECOME PREGNANT, OR (B) TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: COSENTYX, ENBREL, HUMIRA, XELJANZ, RINVOQ, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR AN AUTOIMMUNE INDICATION. CD: 1) ONE OF THE FOLLOWING: (A) PATIENT IS PREGNANT, BREASTFEEDING, OR TRYING TO BECOME PREGNANT, OR (B) TRIAL OF OR CONTRAINDICATION TO ONE OF THE FOLLOWING PREFERRED AGENTS: STELARA, HUMIRA, RINVOQ, SKYRIZI, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR AN</p>

PA Criteria	Criteria Details
	<p>AUTOIMMUNE INDICATION. NR-AXSPA: 1) TRIAL OF OR CONTRAINDICATION TO AN NSAID, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR AN AUTOIMMUNE INDICATION. RENEWAL: CD: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR AN AUTOIMMUNE INDICATION. RA: CONTINUES TO BENEFIT FROM THE MEDICATION. PSA, AS, PSO, NR-AXSPA: 1) CONTINUES TO BENEFIT FROM THE MEDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR AN AUTOIMMUNE INDICATION.</p>
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

CETUXIMAB

Products Affected

- ERBITUX

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

CLADRIBINE

Products Affected

- MAVENCLAD (10 TABLET PACK)
- MAVENCLAD (4 TABLET PACK)
- MAVENCLAD (5 TABLET PACK)
- MAVENCLAD (6 TABLET PACK)
- MAVENCLAD (7 TABLET PACK)
- MAVENCLAD (8 TABLET PACK)
- MAVENCLAD (9 TABLET PACK)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL/RENEWAL: 48 WEEKS.
Other Criteria	RELAPSING FORM OF MULTIPLE SCLEROSIS (MS): INITIAL: HAS NOT RECEIVED A TOTAL OF TWO YEARS OF MAVENCLAD TREATMENT (I.E., TWO YEARLY TREATMENT COURSES OF TWO CYCLES IN EACH). RENEWAL: 1) HAS DEMONSTRATED CLINICAL BENEFIT COMPARED TO PRE-TREATMENT BASELINE, 2) DOES NOT HAVE LYMPHOPENIA, AND 3) HAS NOT RECEIVED A TOTAL OF TWO YEARS OF MAVENCLAD TREATMENT (I.E., TWO YEARLY TREATMENT COURSES OF TWO CYCLES IN EACH).
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

CLOBAZAM-SYMPAZAN

Products Affected

- SYMPAZAN

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	LENNOX-GASTAUT SYNDROME (LGS): THERAPY IS PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST.
Coverage Duration	12 MONTHS
Other Criteria	LGS: 1) UNABLE TO TAKE TABLETS OR SUSPENSIONS, AND 2) TRIAL OF OR CONTRAINDICATION TO A FORMULARY VERSION OF CLOBAZAM.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

COBIMETINIB

Products Affected

- COTELLIC

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

CORTICOTROPIN

Products Affected

- ACTHAR
- ACTHAR SELFJECT SUBCUTANEOUS PEN INJECTOR 40 UNIT/0.5 ML, 80 UNIT/ML
- CORTROPHIN GEL

PA Criteria	Criteria Details
Exclusion Criteria	PA Criteria: Pending CMS Approval
Required Medical Information	PA Criteria: Pending CMS Approval
Age Restrictions	PA Criteria: Pending CMS Approval
Prescriber Restrictions	PA Criteria: Pending CMS Approval
Coverage Duration	PA Criteria: Pending CMS Approval
Other Criteria	PA Criteria: Pending CMS Approval
Indications	PA Criteria: Pending CMS Approval
Off Label Uses	PA Criteria: Pending CMS Approval
Part B Prerequisite	Yes

CRIZOTINIB CAPSULE

Products Affected

- XALKORI ORAL CAPSULE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

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	12 MONTHS
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

DABRAFENIB CAPSULES

Products Affected

- TAFINLAR ORAL CAPSULE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

DABRAFENIB SUSPENSION

Products Affected

- TAFINLAR ORAL TABLET FOR SUSPENSION

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	UNABLE TO SWALLOW TAFINLAR CAPSULES.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

DACOMITINIB

Products Affected

- VIZIMPRO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
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

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: 3 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	MS: INITIAL: HAS SYMPTOMS OF A WALKING DISABILITY SUCH AS MILD TO MODERATE BILATERAL LOWER EXTREMITY WEAKNESS OR 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

DARATUMUMAB

Products Affected

- DARZALEX

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

DARATUMUMAB-HYALURONIDASE-FIHJ

Products Affected

- DARZALEX FASPRO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

DAROLUTAMIDE

Products Affected

- NUBEQA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL/RENEWAL: 12 MONTHS
Other Criteria	INITIAL: NON-METASTATIC CASTRATION-RESISTANT PROSTATE CANCER (NMCRPC): HIGH RISK PROSTATE CANCER (I.E., RAPIDLY INCREASING PROSTATE SPECIFIC ANTIGEN [PSA] LEVELS). NMCRPC, METASTATIC HORMONE-SENSITIVE PROSTATE CANCER (MHSPC): 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. RENEWAL: NMCRPC, MHSPC: 1) RECEIVED A BILATERAL ORCHIECTOMY, 2) CASTRATE LEVEL OF TESTOSTERONE (I.E., LESS THAN 50 NG/DL), OR 3) CONCURRENT USE WITH A GNRH ANALOG.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

DASATINIB

Products Affected

- *dasatinib oral tablet 100 mg, 140 mg, 20 mg, 50 mg, 70 mg, 80 mg*
- SPRYCEL 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 SPRYCEL IS APPROPRIATE PER NCCN GUIDELINE TABLE FOR TREATMENT RECOMMENDATIONS BASED ON BCR-ABL1 MUTATION PROFILE.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

DECITABINE/CEDAZURIDINE

Products Affected

- INQOVI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

DEFERASIROX

Products Affected

- *deferasirox*

PA Criteria	Criteria Details
Exclusion Criteria	PA Criteria: Pending CMS Approval
Required Medical Information	PA Criteria: Pending CMS Approval
Age Restrictions	PA Criteria: Pending CMS Approval
Prescriber Restrictions	PA Criteria: Pending CMS Approval
Coverage Duration	PA Criteria: Pending CMS Approval
Other Criteria	PA Criteria: Pending CMS Approval
Indications	PA Criteria: Pending CMS Approval
Off Label Uses	PA Criteria: Pending CMS Approval
Part B Prerequisite	No

DEFERIPRONE

Products Affected

- *deferiprone*
- FERRIPROX ORAL SOLUTION

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	TRANSFUSIONAL IRON OVERLOAD: RENEWAL: SERUM FERRITIN LEVELS CONSISTENTLY ABOVE 500 MCG/L (AT LEAST TWO LAB VALUES IN THE PREVIOUS THREE MONTHS).
Age Restrictions	
Prescriber Restrictions	TRANSFUSIONAL IRON OVERLOAD: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A HEMATOLOGIST OR HEMATOLOGIST/ONCOLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS
Other Criteria	INITIAL: TRANSFUSIONAL IRON OVERLOAD DUE TO THALASSEMIA SYNDROMES: 1) TRIAL OF, CONTRAINDICATION, INTOLERABLE TOXICITIES, OR CLINICALLY SIGNIFICANT ADVERSE EFFECTS TO A FORMULARY VERSION OF DEFERASIROX OR DEFEROXAMINE, OR 2) CURRENT CHELATION THERAPY (I.E., FORMULARY VERSION OF DEFERASIROX OR DEFEROXAMINE) IS INADEQUATE. TRANSFUSIONAL IRON OVERLOAD DUE TO SICKLE CELL DISEASE OR OTHER ANEMIAS: TRIAL OF OR CONTRAINDICATION TO A FORMULARY VERSION OF DEFERASIROX OR DEFEROXAMINE.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

DENOSUMAB-XGEVA

Products Affected

- XGEVA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

DEUTETRABENAZINE

Products Affected

- AUSTEDO ORAL TABLET 12 MG, 6 MG, 9 MG, 24 MG, 30 MG, 36 MG, 42 MG, 48 MG, 6 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	12 MONTHS
Other Criteria	TARDIVE DYSKINESIA: HISTORY OF USING AGENTS THAT CAUSE TARDIVE DYSKINESIA.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

DICLOFENAC TOPICAL GEL

Products Affected

- *diclofenac sodium topical gel 3 %*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

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	6 MONTHS
Other Criteria	OSTEOARTHRITIS OF THE KNEE: TRIAL OF OR CONTRAINDICATION TO A FORMULARY VERSION OF DICLOFENAC SODIUM 1% TOPICAL GEL AND A FORMULARY VERSION OF DICLOFENAC SODIUM 1.5% TOPICAL DROPS.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

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	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

DIROXIMEL FUMARATE

Products Affected

- VUMERITY

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

DOSTARLIMAB-GXLY

Products Affected

- JEMPERLI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

DRONABINOL CAPSULE

Products Affected

- *dronabinol*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 MONTHS
Other Criteria	NAUSEA AND VOMITING ASSOCIATED WITH CANCER CHEMOTHERAPY: TRIAL OF OR CONTRAINDICATION TO ONE ANTIEMETIC THERAPY. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D FOR THE INDICATION OF NAUSEA AND VOMITING ASSOCIATED WITH CANCER CHEMOTHERAPY.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

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: 12 MONTHS
Other Criteria	NOH: RENEWAL: CONTINUES TO BENEFIT FROM THE MEDICATION.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

DUPILUMAB

Products Affected

- DUPIXENT PEN
- DUPIXENT SYRINGE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	<p>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. ATOPIC DERMATITIS (AD): AD COVERING AT LEAST 10 PERCENT OF BODY SURFACE AREA OR AD AFFECTING THE FACE, HEAD, NECK, HANDS, FEET, GROIN, OR INTERTRIGINOUS AREAS.</p>
Age Restrictions	
Prescriber Restrictions	<p>INITIAL: AD, PRURIGO NODULARIS (PN): PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST, ALLERGIST OR IMMUNOLOGIST. ASTHMA: PRESCRIBED BY OR IN CONSULTATION WITH A PHYSICIAN SPECIALIZING IN ALLERGY OR PULMONARY MEDICINE. CHRONIC RHINOSINUSITIS WITH NASAL POLYPOSIS (CRSWNP): PRESCRIBED BY OR IN CONSULTATION WITH AN OTOLARYNGOLOGIST, ALLERGIST OR IMMUNOLOGIST. EOE: PRESCRIBED BY OR IN CONSULTATION WITH A GASTROENTEROLOGIST, ALLERGIST, OR IMMUNOLOGIST.</p>
Coverage Duration	<p>INITIAL: AD, CRSWNP, EOE, PN: 6 MOS, ASTHMA: 4 MOS. RENEWAL: ALL INDICATIONS: 12 MOS.</p>

PA Criteria	Criteria Details
Other Criteria	<p>INITIAL: AD: 1) INTRACTABLE PRURITUS OR CRACKING/OOZING/BLEEDING OF AFFECTED SKIN, 2) TRIAL OF OR CONTRAINDICATION TO ONE TOPICAL (CORTICOSTEROID, CALCINEURIN INHIBITOR, PDE4 INHIBITOR, OR JAK INHIBITOR), AND 3) NO CONCURRENT USE WITH OTHER SYSTEMIC BIOLOGICS OR JAK INHIBITORS FOR AD. ASTHMA: 1) CONCURRENT THERAPY WITH A MEDIUM, HIGH-DOSE OR MAXIMALLY-TOLERATED DOSE OF AN INHALED CORTICOSTEROID (ICS) AND ONE OTHER MAINTENANCE MEDICATION, 2) ONE ASTHMA EXACERBATION REQUIRING SYSTEMIC CORTICOSTEROID BURST LASTING 3 OR MORE 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, AND 3) NO CONCURRENT USE WITH XOLAIR, TEZSPIRE, OR OTHER ANTI-IL5 BIOLOGICS WHEN USED FOR ASTHMA. CRSWNP: 1) EVIDENCE OF NASAL POLYPS BY DIRECT EXAMINATION, ENDOSCOPY OR SINUS CT SCAN, 2) INADEQUATELY CONTROLLED DISEASE AS DETERMINED BY USE OF SYSTEMIC STEROIDS IN THE PAST 2 YEARS OR ENDOSCOPIC SINUS SURGERY, 3) A 56 DAY TRIAL OF ONE TOPICAL NASAL CORTICOSTEROID, AND 4) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR AN AUTOIMMUNE INDICATION. PN: 1) CHRONIC PRURITIS (ITCH MORE THAN 6 WEEKS), MULTIPLE PRURIGINOUS LESIONS, AND HISTORY OR SIGN OF A PROLONGED SCRATCHING BEHAVIOR, AND 2) TRIAL OF OR CONTRAINDICATION TO ONE TOPICAL (CORTICOSTEROID OR</p>

PA Criteria	Criteria Details
	<p>CALCIPOTRIOL). RENEWAL: AD: 1) IMPROVEMENT WHILE ON THERAPY, AND 2) NO CONCURRENT USE WITH OTHER SYSTEMIC BIOLOGICS OR JAK INHIBITORS FOR AD. EOE: IMPROVEMENT WHILE ON THERAPY. CRSWNP: 1) IMPROVEMENT WHILE ON THERAPY, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR AN AUTOIMMUNE INDICATION. ASTHMA: 1) NO CONCURRENT USE WITH XOLAIR, TEZSPIRE, OR OTHER ANTI-IL5 BIOLOGICS FOR ASTHMA, 2) CONTINUED USE OF ICS AND ONE OTHER MAINTENANCE MEDICATION, AND 3) 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. PN: IMPROVEMENT OR REDUCTION OF PRURITIS OR PRURIGINOUS LESIONS.</p>
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

DUVELISIB

Products Affected

- COPIKTRA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

EFLAPEGRASTIM-XNST

Products Affected

- ROLVEDON

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	NON MYELOID MALIGNANCY: PRESCRIBED BY OR IN CONSULTATION WITH A HEMATOLOGIST OR ONCOLOGIST.
Coverage Duration	12 MONTHS
Other Criteria	NON MYELOID MALIGNANCY: TRIAL OF OR CONTRAINDICATION TO THE PREFERRED AGENT: NYVEPRIA.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

EFLORNITHINE

Products Affected

- IWILFIN

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	24 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

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	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

ELAFIBRANOR

Products Affected

- IQIRVO

PA Criteria	Criteria Details
Exclusion Criteria	PA Criteria: Pending CMS Approval
Required Medical Information	PA Criteria: Pending CMS Approval
Age Restrictions	PA Criteria: Pending CMS Approval
Prescriber Restrictions	PA Criteria: Pending CMS Approval
Coverage Duration	PA Criteria: Pending CMS Approval
Other Criteria	PA Criteria: Pending CMS Approval
Indications	PA Criteria: Pending CMS Approval
Off Label Uses	PA Criteria: Pending CMS Approval
Part B Prerequisite	No

ELAGOLIX

Products Affected

- ORLISSA 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: 6 MONTHS, RENEWAL: 12 MONTHS
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

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: 6 MONTHS. RENEWAL: 12 MONTHS.
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

ELEXACAFITOR-TEZACAFITOR-IVACAFITOR

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	CYSTIC FIBROSIS (CF): INITIAL: CONFIRMED MUTATION IN CFTR GENE ACCEPTABLE FOR THE TREATMENT OF CYSTIC FIBROSIS.
Age Restrictions	
Prescriber Restrictions	CF: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A PULMONOLOGIST OR CYSTIC FIBROSIS EXPERT.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: LIFETIME.
Other Criteria	CF: RENEWAL: 1) MAINTAINED, IMPROVED, OR DEMONSTRATED LESS THAN EXPECTED DECLINE IN FEV1 OR BODY MASS INDEX (BMI), OR 2) REDUCTION IN NUMBER OF PULMONARY EXACERBATIONS.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

ELIGLUSTAT

Products Affected

- CERDELGA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

ELRANATAMAB-BCMM

Products Affected

- ELREXFIO 44 MG/1.1 ML VIAL INNER, SUV, P/F
- ELREXFIO SUBCUTANEOUS SOLUTION 40 MG/ML

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	RELAPSED OR REFRACTORY MULTIPLE MYELOMA: RENEWAL: 1) HAS RECEIVED AT LEAST 24 WEEKS OF TREATMENT WITH ELREXFIO, AND 2) HAS RESPONDED TO TREATMENT (PARTIAL RESPONSE OR BETTER), AND HAS MAINTAINED THIS RESPONSE FOR AT LEAST 2 MONTHS. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

ELTROMBOPAG - ALVAIZ

Products Affected

- ALVAIZ

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	PERSISTENT OR CHRONIC IMMUNE THROMBOCYTOPENIA (ITP): INITIAL: 1) PLATELET COUNT IS LESS THAN $30 \times 10^9/L$ FROM AT LEAST 2 SEPARATE LABS IN THE LAST 3 MONTHS, OR 2) PLATELET COUNT IS LESS THAN $50 \times 10^9/L$ FROM AT LEAST 2 SEPARATE LABS IN THE LAST 3 MONTHS AND HAD A PRIOR BLEEDING EVENT.
Age Restrictions	
Prescriber Restrictions	INITIAL: ITP: PRESCRIBED BY OR IN CONSULTATION WITH A HEMATOLOGIST OR IMMUNOLOGIST.
Coverage Duration	ITP: INITIAL: 2 MO, RENEWAL: 12 MO. HEPATITIS C, SEVERE APLASTIC ANEMIA: 12 MO.
Other Criteria	INITIAL: ITP: 1) TRIAL OF OR CONTRAINDICATION TO CORTICOSTEROIDS OR IMMUNOGLOBULINS, OR AN INSUFFICIENT RESPONSE TO SPLENECTOMY, AND 2) NO CONCURRENT USE WITH OTHER THROMBOPOIETIN RECEPTOR AGONISTS (TPO-RAS) OR SPLEEN TYROSINE KINASE (SYK) INHIBITOR. RENEWAL: ITP: 1) IMPROVEMENT IN PLATELET COUNT FROM BASELINE OR REDUCTION IN BLEEDING EVENTS, AND 2) NO CONCURRENT USE WITH OTHER TPO-RAS OR SYK INHIBITOR.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

ELTROMBOPAG - PROMACTA

Products Affected

- PROMACTA ORAL POWDER IN PACKET 12.5 MG, 25 MG
- PROMACTA 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 $30 \times 10^9/L$ FROM AT LEAST 2 SEPARATE LAB TESTS IN THE LAST 3 MONTHS, OR 2) PLATELET COUNT OF LESS THAN $50 \times 10^9/L$ FROM AT LEAST 2 SEPARATE LAB TESTS IN THE LAST 3 MONTHS 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: 2 MO, RENEWAL: 12 MO. HEPATITIS C, SEVERE APLASTIC ANEMIA: 12 MO.
Other Criteria	INITIAL: ITP: 1) TRIAL OF OR CONTRAINDICATION TO CORTICOSTEROIDS OR IMMUNOGLOBULINS, OR HAD AN INSUFFICIENT RESPONSE TO SPLENECTOMY, AND 2) NO CONCURRENT USE WITH OTHER THROMBOPOIETIN RECEPTOR AGONISTS (TPO-RAS) OR SPLEEN TYROSINE KINASE (SYK) INHIBITOR. ALL INDICATIONS: APPROVAL FOR PROMACTA ORAL SUSPENSION PACKETS REQUIRES A TRIAL OF PROMACTA TABLETS OR PATIENT IS UNABLE TOLERATE TABLET FORMULATION. RENEWAL: ITP: 1) IMPROVEMENT IN PLATELET COUNTS FROM BASELINE OR REDUCTION IN BLEEDING EVENTS, AND 2) NO CONCURRENT USE WITH OTHER TPO-RAS OR SYK INHIBITOR.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

ENASIDENIB

Products Affected

- IDHIFA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

ENCORAFENIB

Products Affected

- BRAFTOVI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	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	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

ENTRECTINIB PELLETS

Products Affected

- ROZLYTREK ORAL PELLETS IN PACKET

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
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

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	INITIAL: ALL INDICATIONS: 12 MONTHS. RENEWAL: MCRPC, NMCRPC, MCSPC: 12 MONTHS.
Other Criteria	INITIAL: NON-METASTATIC CASTRATION-RESISTANT PROSTATE CANCER (NMCRPC): HIGH RISK PROSTATE CANCER (I.E. RAPIDLY INCREASING PROSTATE SPECIFIC ANTIGEN [PSA] LEVELS). NON-METASTATIC CASTRATION-SENSITIVE PROSTATE CANCER (NMCSPC): HIGH RISK FOR METASTASIS (I.E. PSA DOUBLING TIME OF 9 MONTHS OR LESS). METASTATIC CRPC (MCRPC), 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. RENEWAL: MCRPC, NMCRPC, MCSPC: 1) RECEIVED A BILATERAL ORCHIECTOMY, 2) CASTRATE LEVEL OF TESTOSTERONE (I.E., LESS THAN 50 NG/DL), OR 3) CONCURRENT USE WITH A GNRH ANALOG.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

EPCORITAMAB-BYSP

Products Affected

- EPKINLY

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

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	<p>INITIAL: CHRONIC KIDNEY DISEASE (CKD), ANEMIA RELATED TO ZIDOVUDINE, OR CANCER CHEMOTHERAPY: HEMOGLOBIN LEVEL IS LESS THAN 10G/DL. ELECTIVE, NON-CARDIAC, NON-VASCULAR SURGERY: HEMOGLOBIN LEVEL IS LESS THAN 13G/DL. RENEWAL: 1) CKD IN ADULTS NOT ON DIALYSIS: (A) HEMOGLOBIN LEVEL IS LESS THAN 10G/DL, OR (B) HEMOGLOBIN LEVEL HAS REACHED 10G/DL AND THE DOSE IS BEING OR HAS BEEN REDUCED/INTERRUPTED TO DECREASE THE NEED FOR BLOOD TRANSFUSIONS. 2) CKD IN PEDIATRIC PATIENTS: (A) HEMOGLOBIN LEVEL IS LESS THAN 10G/DL, OR (B) HEMOGLOBIN LEVEL HAS APPROACHED OR EXCEEDS 12G/DL AND THE DOSE IS BEING OR HAS BEEN REDUCED/INTERRUPTED TO DECREASE THE NEED FOR BLOOD TRANSFUSIONS. 3) ANEMIA RELATED TO ZIDOVUDINE: HEMOGLOBIN LEVEL BETWEEN 10G/DL AND 12G/DL. 4) CANCER CHEMOTHERAPY: (A) HEMOGLOBIN LEVEL IS LESS THAN 10 G/DL, OR (B) HEMOGLOBIN LEVEL DOES NOT EXCEED A LEVEL NEEDED TO AVOID RBC TRANSFUSION.</p>
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	ANEMIA FROM CHEMO/CKD WITHOUT DIALYSIS/ZIDOVUDINE: INITIAL/RENEWAL: 12 MONTHS. SURGERY: 1 MONTH.
Other Criteria	RENEWAL: CKD: NOT RECEIVING DIALYSIS TREATMENT. THIS DRUG MAY BE EITHER BUNDLED WITH AND COVERED UNDER END STAGE RENAL DISEASE DIALYSIS RELATED SERVICES OR COVERED UNDER MEDICARE D DEPENDING UPON THE CIRCUMSTANCES.

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

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	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

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	12 MONTHS
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

ESKETAMINE

Products Affected

- SPRAVATO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	INITIAL: TREATMENT-RESISTANT DEPRESSION (TRD), MAJOR DEPRESSIVE DISORDER (MDD): PRESCRIBED BY OR IN CONSULTATION WITH A PSYCHIATRIST.
Coverage Duration	INITIAL: TRD: 3 MONTHS. MDD: 4 WEEKS. RENEWAL: TRD, MDD: 12 MONTHS.
Other Criteria	INITIAL: TRD: 1) NON-PSYCHOTIC, UNIPOLAR DEPRESSION, 2) NO ACTIVE SUBSTANCE ABUSE, AND 3) ADEQUATE TRIAL (AT LEAST 4 WEEKS) OF AT LEAST TWO ANTIDEPRESSANT AGENTS FROM DIFFERENT CLASSES THAT ARE INDICATED FOR DEPRESSION. MDD: 1) NON-PSYCHOTIC, UNIPOLAR DEPRESSION, AND 2) NO ACTIVE SUBSTANCE ABUSE. RENEWAL: TRD, MDD: DEMONSTRATED CLINICAL BENEFIT (IMPROVEMENT IN DEPRESSION) COMPARED TO BASELINE.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

ETANERCEPT

Products Affected

- ENBREL
- ENBREL MINI
- 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 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: 6 MONTHS, RENEWAL: 12 MONTHS.

PA Criteria	Criteria Details
Other Criteria	<p>INITIAL: RA: TRIAL OF OR CONTRAINDICATION TO 3 MONTHS OF TREATMENT WITH ONE DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG) - IF PATIENT TRIED METHOTREXATE, THEN TRIAL AT A DOSE GREATER THAN OR EQUAL TO 20 MG PER WEEK OR MAXIMALLY TOLERATED DOSE IS REQUIRED. PJIA, PSA: 1) TRIAL OF OR CONTRAINDICATION TO ONE DMARD, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR AN AUTOIMMUNE INDICATION. AS: 1) TRIAL OF OR CONTRAINDICATION TO AN NSAID, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR AN AUTOIMMUNE INDICATION. PSO: 1) ONE OF THE FOLLOWING: (A) AT LEAST A 3 MONTH TRIAL OF ONE ORAL IMMUNOSUPPRESSANT (CYCLOSPORINE, METHOTREXATE, TACROLIMUS) OR PUVA (PHOTOTHERAPY) FOR THE TREATMENT OF PSO, (B) CONTRAINDICATION OR INTOLERANCE TO BOTH IMMUNOSUPPRESSANT AND PUVA FOR THE TREATMENT OF PSO, OR (C) PATIENT IS SWITCHING FROM A DIFFERENT BIOLOGIC, PDE-4 INHIBITOR, OR JAK INHIBITOR FOR THE SAME INDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR AN AUTOIMMUNE INDICATION. RENEWAL: RA: CONTINUES TO BENEFIT FROM THE MEDICATION. PJIA, PSA, AS, PSO: 1) CONTINUES TO BENEFIT FROM THE MEDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR AN AUTOIMMUNE INDICATION.</p>
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

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*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

EVEROLIMUS-AFINITOR DISPERZ

Products Affected

- *everolimus (antineoplastic) oral tablet for suspension*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

FECAL MICROBIOTA CAPSULE

Products Affected

- VOWST

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	30 DAYS
Other Criteria	CLOSTRIDIODES DIFFICILE INFECTION (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

FEDRATINIB

Products Affected

- INREBIC

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS
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

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	DRAVET SYNDROME: INITIAL/RENEWAL: 12 MONTHS. LGS: 12 MONTHS.
Other Criteria	INITIAL: LGS: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING ANTIEPILEPTIC MEDICATIONS: RUFINAMIDE, FELBAMATE, CLOBAZAM, TOPIRAMATE, LAMOTRIGINE, CLONAZEPAM. RENEWAL: DRAVET SYNDROME: PATIENT HAS SHOWN CONTINUED CLINICAL BENEFIT (E.G. REDUCTION OF SEIZURES, REDUCED LENGTH OF SEIZURES, SEIZURE CONTROL MAINTAINED).
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

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	12 MONTHS
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. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

FEZOLINETANT

Products Affected

- VEOZAH

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	MENOPAUSAL VASOMOTOR SYMPTOMS (VMS): INITIAL: 1) EXPERIENCES 7 OR MORE HOT FLASHES PER DAY, AND 2) TRIAL OF OR CONTRAINDICATION TO HORMONAL THERAPY (E.G., ESTRADIOL TRANSDERMAL PATCH, ORAL CONJUGATED ESTROGENS). RENEWAL: 1) CONTINUED NEED FOR VMS TREATMENT (I.E., PERSISTENT HOT FLASHES), AND 2) REDUCTION IN VMS FREQUENCY OR SEVERITY DUE TO VEOZAH TREATMENT.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

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	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

FILGRASTIM-SNDZ

Products Affected

- ZARXIO

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	12 MONTHS
Other Criteria	TRIAL OF OR CONTRAINDICATION TO THE PREFERRED AGENT NIVESTYM, WHERE INDICATIONS ALIGN
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

FINERENONE

Products Affected

- KERENDIA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

FINGOLIMOD

Products Affected

- *fingolimod*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

FOSTAMATINIB

Products Affected

- TAVALISSE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	CHRONIC IMMUNE THROMBOCYTOPENIA (CITP): INITIAL: 1) PLATELET COUNT OF LESS THAN $30 \times 10^9/L$ FROM AT LEAST 2 SEPARATE LAB TESTS IN THE LAST 3 MONTHS, OR 2) PLATELET COUNT OF LESS THAN $50 \times 10^9/L$ FROM AT LEAST 2 SEPARATE LAB TESTS IN THE LAST 3 MONTHS AND A PRIOR BLEEDING EVENT.
Age Restrictions	
Prescriber Restrictions	CITP: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A HEMATOLOGIST OR IMMUNOLOGIST.
Coverage Duration	INITIAL: 3 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	CITP: INITIAL: NO CONCURRENT USE WITH THROMBOPOIETIN RECEPTOR AGONISTS (TPO-RAS). RENEWAL: 1) IMPROVEMENT IN PLATELET COUNTS FROM BASELINE OR REDUCTION IN BLEEDING EVENTS, AND 2) NO CONCURRENT USE WITH TPO-RAS.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

FREMANEZUMAB-VFRM

Products Affected

- AJOVY AUTOINJECTOR
- AJOVY SYRINGE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL: 6 MONTHS, RENEWAL: 12 MONTHS.
Other Criteria	MIGRAINE PREVENTION: INITIAL: 1) TRIAL OF OR CONTRAINDICATION TO ONE OF THE FOLLOWING PREVENTIVE MIGRAINE TREATMENTS: DIVALPROEX SODIUM, TOPIRAMATE, PROPRANOLOL, TIMOLOL, AND 2) NO CONCURRENT USE WITH OTHER CGRP INHIBITORS FOR MIGRAINE PREVENTION. RENEWAL: 1) REDUCTION IN MIGRAINE OR HEADACHE FREQUENCY, MIGRAINE SEVERITY, OR MIGRAINE DURATION WITH THERAPY, AND 2) NO CONCURRENT USE WITH OTHER CGRP INHIBITORS FOR MIGRAINE PREVENTION.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

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	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

FUTIBATINIB

Products Affected

- LYTGOBI ORAL TABLET 12 MG/DAY (4 MG X 3), 16 MG/DAY (4 MG X 4), 20 MG/DAY (4 MG X 5)

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	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

GALCANEZUMAB-GNLM

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL: MIGRAINE PREVENTION: 6 MOS. EPISODIC CLUSTER HEADACHE: 3 MOS. RENEWAL (ALL): 12 MOS.
Other Criteria	INITIAL: MIGRAINE PREVENTION: 1) NO CONCURRENT USE WITH OTHER CGRP INHIBITORS FOR MIGRAINE PREVENTION, AND 2) TRIAL OF OR CONTRAINDICATION TO ONE OF THE FOLLOWING PREVENTIVE MIGRAINE TREATMENTS: DIVALPROEX SODIUM, TOPIRAMATE, PROPRANOLOL, TIMOLOL. RENEWAL: MIGRAINE PREVENTION: 1) REDUCTION IN MIGRAINE OR HEADACHE FREQUENCY, MIGRAINE SEVERITY, OR MIGRAINE DURATION WITH THERAPY, AND 2) NO CONCURRENT USE WITH OTHER CGRP INHIBITORS FOR MIGRAINE PREVENTION. EPISODIC CLUSTER HEADACHE: IMPROVEMENT IN EPISODIC CLUSTER HEADACHE FREQUENCY AS COMPARED TO BASELINE.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

GANAXOLONE

Products Affected

- ZTALMY

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

GEFITINIB

Products Affected

- *gefitinib*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
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

GILTERITINIB

Products Affected

- XOSPATA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

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	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

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	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

GLECAPREVIR/PIBRENTASVIR

Products Affected

- MAVYRET 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) ONE OF THE FOLLOWING, WHEN THESE AGENTS ARE CONSIDERED ACCEPTABLE FOR TREATMENT OF THE SPECIFIC GENOTYPE PER AASLD/IDSA GUIDANCE: (A) SHORT TRIAL OF A PREFERRED FORMULARY AGENT: HARVONI OR EPCLUSA, OR (B) CONTRAINDICATION TO BOTH OF THE PREFERRED FORMULARY AGENTS: HARVONI AND EPCLUSA, 3) NOT CONCURRENTLY TAKING ANY OF THE FOLLOWING MEDICATIONS: CARBAMAZEPINE, RIFAMPIN, ETHINYL ESTRADIOL-CONTAINING MEDICATION, ATAZANAVIR, DARUNAVIR, LOPINAVIR, RITONAVIR, EFAVIRENZ, ATORVASTATIN, LOVASTATIN, SIMVASTATIN, ROSUVASTATIN AT DOSES GREATER THAN 10MG, CYCLOSPORINE AT DOSES GREATER THAN 100MG PER DAY, EPCLUSA, HARVONI, VOSEVI, OR ZEPATIER, 4) PATIENT MUST NOT HAVE PRIOR FAILURE OF A DAA REGIMEN WITH NS5A INHIBITOR AND HCV PROTEASE INHIBITOR, AND 5) DOES NOT HAVE MODERATE OR SEVERE HEPATIC IMPAIRMENT (CHILD PUGH B OR C).
Indications	All FDA-approved Indications.

PA Criteria	Criteria Details
Off Label Uses	
Part B Prerequisite	No

GLP1-DULAGLUTIDE

Products Affected

- TRULICITY

PA Criteria	Criteria Details
Exclusion Criteria	PA Criteria: Pending CMS Approval
Required Medical Information	PA Criteria: Pending CMS Approval
Age Restrictions	PA Criteria: Pending CMS Approval
Prescriber Restrictions	PA Criteria: Pending CMS Approval
Coverage Duration	PA Criteria: Pending CMS Approval
Other Criteria	PA Criteria: Pending CMS Approval
Indications	PA Criteria: Pending CMS Approval
Off Label Uses	PA Criteria: Pending CMS Approval
Part B Prerequisite	No

GLP1-SEMAGLUTIDE

Products Affected

- OZEMPIC
- RYBELSUS

PA Criteria	Criteria Details
Exclusion Criteria	PA Criteria: Pending CMS Approval
Required Medical Information	PA Criteria: Pending CMS Approval
Age Restrictions	PA Criteria: Pending CMS Approval
Prescriber Restrictions	PA Criteria: Pending CMS Approval
Coverage Duration	PA Criteria: Pending CMS Approval
Other Criteria	PA Criteria: Pending CMS Approval
Indications	PA Criteria: Pending CMS Approval
Off Label Uses	PA Criteria: Pending CMS Approval
Part B Prerequisite	No

GLP1-TIRZEPATIDE

Products Affected

- MOUNJARO

PA Criteria	Criteria Details
Exclusion Criteria	PA Criteria: Pending CMS Approval
Required Medical Information	PA Criteria: Pending CMS Approval
Age Restrictions	PA Criteria: Pending CMS Approval
Prescriber Restrictions	PA Criteria: Pending CMS Approval
Coverage Duration	PA Criteria: Pending CMS Approval
Other Criteria	PA Criteria: Pending CMS Approval
Indications	PA Criteria: Pending CMS Approval
Off Label Uses	PA Criteria: Pending CMS Approval
Part B Prerequisite	No

GLYCEROL PHENYL BUTYRATE

Products Affected

- RAVICTI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	UREA CYCLE DISORDER (UCD): INITIAL: DIAGNOSIS IS CONFIRMED BY ENZYMATIC, BIOCHEMICAL OR GENETIC TESTING
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL/RENEWAL: 12 MONTHS
Other Criteria	UCD: INITIAL: TRIAL OF OR CONTRAINDICATION TO SODIUM PHENYL BUTYRATE. RENEWAL: PATIENT HAS CLINICAL BENEFIT FROM BASELINE.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

GOSERELIN

Products Affected

- ZOLADEX

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	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	ENDOMETRIOSIS: PRESCRIBED BY OR IN CONSULTATION WITH AN OBSTETRICIAN/GYNECOLOGIST.
Coverage Duration	STAGE B2-C PROSTATIC CARCINOMA: 4 MOS. ENDOMETRIOSIS: 6 MOS PER LIFETIME. ALL OTHERS: 12 MONTHS.
Other Criteria	ENDOMETRIOSIS: 1) NO CONCURRENT USE WITH ANOTHER GNRH-MODULATING AGENT, 2) TRIAL OF OR CONTRAINDICATION TO NSAID AND PROGESTIN-CONTAINING PREPARATION, AND 3) HAS NOT RECEIVED A TOTAL OF 6 MONTHS OF TREATMENT PER LIFETIME. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

GUSELKUMAB

Products Affected

- TREMFYA SUBCUTANEOUS AUTO-INJECTOR
- TREMFYA SUBCUTANEOUS SYRINGE 100 MG/ML

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 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.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS

PA Criteria	Criteria Details
Other Criteria	<p>INITIAL: PSA: 1) TRIAL OF OR CONTRAINDICATION TO ONE DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG), AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR AN AUTOIMMUNE INDICATION. PSO: 1) ONE OF THE FOLLOWING: (A) AT LEAST A 3 MONTH TRIAL OF ONE ORAL IMMUNOSUPPRESSANT (CYCLOSPORINE, METHOTREXATE, TACROLIMUS) OR PUVA (PHOTOTHERAPY) FOR THE TREATMENT OF PSO, (B) CONTRAINDICATION OR INTOLERANCE TO BOTH IMMUNOSUPPRESSANT AND PUVA FOR THE TREATMENT OF PSO, OR (C) PATIENT IS SWITCHING FROM A DIFFERENT BIOLOGIC, PDE-4 INHIBITOR, OR JAK INHIBITOR FOR THE SAME INDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR AN AUTOIMMUNE INDICATION. RENEWAL: PSO, PSA: 1) CONTINUES TO BENEFIT FROM THE MEDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR AN AUTOIMMUNE INDICATION.</p>
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

HIGH CONCENTRATION ORAL OPIOID SOLUTIONS

Products Affected

- *morphine concentrate oral solution*
- *oxycodone oral concentrate*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	OPIOID TOLERANT: 12 MONTHS. 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

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	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

IBUPROFEN-FAMOTIDINE

Products Affected

- *ibuprofen-famotidine*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	TRIAL OF ONE OF THE FOLLOWING GENERIC, FEDERAL LEGEND HISTAMINE H2-RECEPTOR ANTAGONISTS: FAMOTIDINE, CIMETIDINE, OR NIZATIDINE, AND TRIAL OF GENERIC, FEDERAL LEGEND IBUPROFEN.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

ICATIBANT

Products Affected

- *icatibant*
- *sajazir*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	HEREDITARY ANGIOEDEMA (HAE): DIAGNOSIS CONFIRMED BY COMPLEMENT TESTING.
Age Restrictions	
Prescriber Restrictions	HAE: PRESCRIBED BY OR IN CONSULTATION WITH AN ALLERGIST, IMMUNOLOGIST, OR HEMATOLOGIST.
Coverage Duration	12 MONTHS
Other Criteria	HAE: NO CONCURRENT USE WITH OTHER MEDICATIONS FOR TREATMENT OF ACUTE HAE ATTACKS.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

IDELALISIB

Products Affected

- ZYDELIG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

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	ADJUVANT GASTROINTESTINAL STROMAL TUMOR TREATMENT: 36 MONTHS. ALL OTHER DIAGNOSES: 12 MONTHS.
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

IMETELSTAT

Products Affected

- RYTELO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

INFIGRATINIB

Products Affected

- TRUSELTIQ

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	CHOLANGIOCARCINOMA: COMPREHENSIVE OPHTHALMOLOGICAL EXAMINATION, INCLUDING OPTICAL COHERENCE TOMOGRAPHY (OCT), WILL BE COMPLETED PRIOR TO INITIATION OF THERAPY AND AT THE RECOMMENDED SCHEDULED INTERVALS.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	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, 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: 6 MONTHS. RENEWAL: 12 MONTHS.

PA Criteria	Criteria Details
Other Criteria	<p>INITIAL: RA: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: ENBREL, HUMIRA, XELJANZ, RINVOQ, ORENCIA. PSA: 1) TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: COSENTYX, ENBREL, HUMIRA, STELARA, XELJANZ, RINVOQ, SKYRIZI, TREMFYA, ORENCIA, OTEZLA, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR AN AUTOIMMUNE INDICATION. PSO: 1) TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: COSENTYX, ENBREL, HUMIRA, STELARA, SKYRIZI, TREMFYA, OTEZLA, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR AN AUTOIMMUNE INDICATION. AS: 1) TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: COSENTYX, ENBREL, HUMIRA, XELJANZ, RINVOQ, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR AN AUTOIMMUNE INDICATION. MODERATE TO SEVERE CD: 1) TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS, WHERE AGES ALIGN: STELARA, HUMIRA, RINVOQ, SKYRIZI, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR AN AUTOIMMUNE INDICATION. UC: 1) TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS, WHERE AGES ALIGN: STELARA, XELJANZ, HUMIRA, RINVOQ, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR AN AUTOIMMUNE INDICATION. RENEWAL: RA: CONTINUES TO BENEFIT FROM THE MEDICATION. AS, PSO, PSA: 1) CONTINUES TO BENEFIT FROM THE MEDICATION, AND 2) NO</p>

PA Criteria	Criteria Details
	CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR AN AUTOIMMUNE INDICATION. UC, MODERATE TO SEVERE CD: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR AN AUTOIMMUNE INDICATION. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

INFLIXIMAB-ABDA

Products Affected

- RENFLEXIS

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, 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: 6 MONTHS. RENEWAL: 12 MONTHS.

PA Criteria	Criteria Details
Other Criteria	<p>INITIAL: RA: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: ENBREL, HUMIRA, XELJANZ, RINVOQ, ORENCIA. PSA: 1) TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: COSENTYX, ENBREL, HUMIRA, STELARA, XELJANZ, RINVOQ, SKYRIZI, TREMFYA, ORENCIA, OTEZLA, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR AN AUTOIMMUNE INDICATION. PSO: 1) TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: COSENTYX, ENBREL, HUMIRA, STELARA, SKYRIZI, TREMFYA, OTEZLA, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR AN AUTOIMMUNE INDICATION. AS: 1) TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: COSENTYX, ENBREL, HUMIRA, XELJANZ, RINVOQ, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR AN AUTOIMMUNE INDICATION. MODERATE TO SEVERE CD: 1) TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS, WHERE AGES ALIGN: STELARA, HUMIRA, RINVOQ, SKYRIZI, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR AN AUTOIMMUNE INDICATION. UC: 1) TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS, WHERE AGES ALIGN: STELARA, XELJANZ, HUMIRA, RINVOQ, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR AN AUTOIMMUNE INDICATION. RENEWAL: RA: CONTINUES TO BENEFIT FROM THE MEDICATION. AS, PSO, PSA: 1) CONTINUES TO BENEFIT FROM THE MEDICATION, AND 2) NO</p>

PA Criteria	Criteria Details
	<p>CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR AN AUTOIMMUNE INDICATION. UC, MODERATE TO SEVERE CD: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR AN AUTOIMMUNE INDICATION. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.</p>
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

INFLIXIMAB-AXXQ

Products Affected

- AVSOLA

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, 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: 6 MONTHS. RENEWAL: 12 MONTHS.

PA Criteria	Criteria Details
Other Criteria	<p>INITIAL: RA: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: ENBREL, HUMIRA, XELJANZ, RINVOQ, ORENCIA. PSA: 1) TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: COSENTYX, ENBREL, HUMIRA, STELARA, XELJANZ, RINVOQ, SKYRIZI, TREMFYA, ORENCIA, OTEZLA, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR AN AUTOIMMUNE INDICATION. PSO: 1) TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: COSENTYX, ENBREL, HUMIRA, STELARA, SKYRIZI, TREMFYA, OTEZLA, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR AN AUTOIMMUNE INDICATION. AS: 1) TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: COSENTYX, ENBREL, HUMIRA, XELJANZ, RINVOQ, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR AN AUTOIMMUNE INDICATION. MODERATE TO SEVERE CD: 1) TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS, WHERE AGES ALIGN: STELARA, HUMIRA, RINVOQ, SKYRIZI, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR AN AUTOIMMUNE INDICATION. UC: 1) TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS, WHERE AGES ALIGN: STELARA, XELJANZ, HUMIRA, RINVOQ, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR AN AUTOIMMUNE INDICATION. RENEWAL: RA: CONTINUES TO BENEFIT FROM THE MEDICATION. AS, PSO, PSA: 1) CONTINUES TO BENEFIT FROM THE MEDICATION, AND 2) NO</p>

PA Criteria	Criteria Details
	CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR AN AUTOIMMUNE INDICATION. UC, MODERATE TO SEVERE CD: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR AN AUTOIMMUNE INDICATION. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

INFLIXIMAB-DYYB - IV

Products Affected

- INFLECTRA

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, 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: 6 MONTHS. RENEWAL: 12 MONTHS.

PA Criteria	Criteria Details
Other Criteria	<p>INITIAL: RA: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: ENBREL, HUMIRA, XELJANZ, RINVOQ, ORENCIA. PSA: 1) TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: COSENTYX, ENBREL, HUMIRA, STELARA, XELJANZ, RINVOQ, SKYRIZI, TREMFYA, ORENCIA, OTEZLA, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR AN AUTOIMMUNE INDICATION. PSO: 1) TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: COSENTYX, ENBREL, HUMIRA, STELARA, SKYRIZI, TREMFYA, OTEZLA, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR AN AUTOIMMUNE INDICATION. AS: 1) TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: COSENTYX, ENBREL, HUMIRA, XELJANZ, RINVOQ, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR AN AUTOIMMUNE INDICATION. MODERATE TO SEVERE CD: 1) TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS, WHERE AGES ALIGN: STELARA, HUMIRA, RINVOQ, SKYRIZI, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR AN AUTOIMMUNE INDICATION. UC: 1) TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS, WHERE AGES ALIGN: STELARA, XELJANZ, HUMIRA, RINVOQ, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR AN AUTOIMMUNE INDICATION. RENEWAL: RA: CONTINUES TO BENEFIT FROM THE MEDICATION. AS, PSO, PSA: 1) CONTINUES TO BENEFIT FROM THE MEDICATION, AND 2) NO</p>

PA Criteria	Criteria Details
	CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR AN AUTOIMMUNE INDICATION. UC, MODERATE TO SEVERE CD: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR AN AUTOIMMUNE INDICATION. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

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: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	INITIAL: UC: 1) TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: STELARA, XELJANZ, HUMIRA, RINVOQ, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR AN AUTOIMMUNE INDICATION. CD: 1) TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: STELARA, HUMIRA, RINVOQ, SKYRIZI, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR AN AUTOIMMUNE INDICATION. RENEWAL: UC, CD: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR AN AUTOIMMUNE INDICATION.
Indications	All FDA-approved Indications.
Off Label Uses	

PA Criteria	Criteria Details
Part B Prerequisite	No

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
- ABOUTTIME PEN NEEDLE 30G X 8MM
- ABOUTTIME PEN NEEDLE 31G X 5MM
- ABOUTTIME PEN NEEDLE 31G X 8MM
- ABOUTTIME PEN NEEDLE 32G X 4MM
- 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 0.3 ML 29GX1/2
- ADVOCATE INS SYR 0.5 ML 29GX1/2
- ADVOCATE INS SYR 1 ML 29GX1/2"
- ADVOCATE INS SYR 1 ML 30GX5/16
- ADVOCATE PEN NDL 12.7MM 29G
- ADVOCATE PEN NEEDLE 32G 4MM
- ADVOCATE PEN NEEDLE 4MM 33G
- ADVOCATE PEN NEEDLES 5MM 31G
- ADVOCATE PEN NEEDLES 8MM 31G
- ALCOHOL 70% SWABS
- ALCOHOL PADS
- ALCOHOL PREP SWABS
- ALCOHOL WIPES
- 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 30GX3/16"
- ASSURE ID PEN NEEDLE 30GX5/16"
- ASSURE ID PEN NEEDLE 31GX3/16"
- ASSURE ID PRO PEN NDL 30G 5MM
- ASSURE ID SYR 0.5 ML 29GX1/2" (RX)
- 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 ECLIPSE NEEDLE 30GX1/2" (OTC)
- BD INS SYR 0.3 ML 8MMX31G(1/2)
- BD INS SYRINGE 1/2 ML 6MMX31G (ONLY FOR 500 UNIT/ML INSULIN)
- BD INS SYRN UF 1 ML 12.7MMX30G NOT FOR RETAIL SALE
- BD INSULIN SYR 1 ML 25GX1"
- BD INSULIN SYR 1 ML 25GX5/8"
- BD INSULIN SYR 1 ML 26GX1/2"
- BD INSULIN SYR 1 ML 27GX5/8" MICRO-FINE
- BD INSULIN SYR 1 ML 28GX1/2" (OTC)
- BD INSULIN SYRINGE 1 ML W/O NEEDLE
- BD LUER-LOK SYRINGE 1 ML
- BD NANO 2 GEN PEN NDL 32G 4MM
- BD SAFETGLD INS 0.3 ML 29G 13MM
- BD SAFETGLD INS 0.5 ML 13MMX29G
- 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
- CAREFINE PEN NEEDLE 4MM 32G
- CAREFINE PEN NEEDLE 5MM 32G
- CAREFINE PEN NEEDLE 6MM 31G
- CAREFINE PEN NEEDLE 8MM 30G
- CAREFINE PEN NEEDLES 6MM 32G
- CAREFINE PEN NEEDLES 8MM 31G
- 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 31G X 5/16" NEEDLES 8MM, UNIVERSAL
- 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 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
- 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
- CURAD GAUZE PADS 2" X 2"
- CURITY ALCOHOL PREPS 2 PLY, MEDIUM
- CURITY GAUZE SPONGES (12 PLY)-200/BAG
- CURITY GAUZE PADS 1'S(12 PLY)
- DERMACEA 2"X2" GAUZE 12 PLY, USP TYPE VII
- DERMACEA GAUZE 2"X2" SPONGE 8 PLY
- DERMACEA NON-WOVEN 2"X2" SPNGE
- 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 30GX12.5MM
- 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 1 ML 29GX12.5MM
- DROPLET INS SYR 1 ML 30GX12.5MM
- DROPLET INS SYR 1 ML 30GX6MM
- DROPLET INS SYR 1 ML 30GX8MM
- DROPLET INS SYR 1 ML 31GX6MM
- DROPLET INS SYR 1 ML 31GX8MM
- DROPLET MICRON 34G X 9/64"
- DROPLET PEN NEEDLE 29GX1/2"
- DROPLET PEN NEEDLE 29GX3/8"
- DROPLET PEN NEEDLE 30GX5/16"
- DROPLET PEN NEEDLE 31GX1/4"
- DROPLET PEN NEEDLE 31GX3/16"
- DROPLET PEN NEEDLE 31GX5/16"
- DROPLET PEN NEEDLE 32GX1/4"
- DROPLET PEN NEEDLE 32GX3/16"
- DROPLET PEN NEEDLE 32GX5/16"
- DROPLET PEN NEEDLE 32GX5/32"
- 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 31GX1/4"
- DROPSAFE PEN NEEDLE 31GX3/16"
- DROPSAFE PEN NEEDLE 31GX5/16"
- DRUG MART ULTRA COMFORT SYR
- 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 0.3 ML SYRINGE
- 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 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 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 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 27GX1/2"
- EASY TOUCH 1 ML SYR 29GX1/2"
- EASY TOUCH 1 ML SYR 30GX1/2"
- EASY TOUCH ALCOHOL 70% PADS
GAMMA-STERILIZED
- EASY TOUCH FLIPLOK 1 ML 27GX0.5
- EASY TOUCH INSULIN 1 ML 29GX1/2
- EASY TOUCH INSULIN 1 ML 30GX1/2
- EASY TOUCH INSULIN SYR 0.3 ML
- EASY TOUCH INSULIN SYR 0.5 ML
- 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
- 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 SYR 1 ML 28G 12.7MM
- EASY TOUCH SYR 1 ML 29G 12.7MM
- EASY TOUCH UNI-SLIP SYR 1 ML
- 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
- EQL INSULIN 0.3 ML SYRINGE SHORT NEEDLE
- EQL INSULIN 0.5 ML SYRINGE SHORT NEEDLE
- EQL INSULIN 1 ML SYRINGE SHORT NEEDLE
- EXEL INSULIN SYRINGE 27G-1 ML
- FIFTY50 INS 0.5 ML 31GX5/16" SHORT NEEDLE (OTC)
- FIFTY50 INS SYR 1 ML 31GX5/16" SHORT NEEDLE (OTC)
- FIFTY50 PEN 31G X 3/16" NEEDLE (OTC)
- FP INSULIN 1 ML SYRINGE
- FREESTYLE PREC 0.5 ML 30GX5/16
- FREESTYLE PREC 0.5 ML 31GX5/16
- FREESTYLE PREC 1 ML 30GX5/16"
- FREESTYLE PREC 1 ML 31GX5/16"
- GAUZE PAD TOPICAL BANDAGE 2 X 2 "
- GNP ULT C 0.3 ML 29GX1/2" (1/2) 1/2 UNIT
- GNP ULTRA COMFORT 0.5 ML SYR
- GNP ULTRA COMFORT 1 ML SYRINGE
- GNP ULTRA COMFORT 3/10 ML SYR
- 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 4MM 32G
- HEALTHY ACCENTS PENTIP 5MM 31G
- HEALTHY ACCENTS PENTIP 6MM 31G
- HEALTHY ACCENTS PENTIP 8MM 31G
- HEALTHY ACCENTS PENTIP 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
- INCONTROL PEN NEEDLE 8MM 31G
- INSULIN SYR 0.3 ML 31GX1/4(1/2)
- INSULIN SYRIN 0.3 ML 30GX1/2" SHORT NEEDLE
- INSULIN SYRIN 0.5 ML 28GX1/2" (OTC)
- INSULIN SYRIN 0.5 ML 29GX1/2" (OTC)
- INSULIN SYRIN 0.5 ML 30GX1/2" SHORT NEEDLE (OTC)
- INSULIN SYRIN 0.5 ML 30GX5/16" SHORT NEEDLE (OTC)
- INSULIN SYRING 0.5 ML 27G 1/2" INNER (OTC)
- 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 30GX1/2" (RX)
- INSULIN SYRINGE 1 ML 30GX5/16" SHORT NEEDLE (OTC)
- INSULIN SYRINGE 1 ML 31GX1/4"
- INSULIN SYRINGE-NEEDLE U-100 SYRINGE 0.3 ML 29 GAUGE, 1 ML 29 GAUGE X 1/2", 1/2 ML 28 GAUGE
- INSUPEN 30G ULTRAFIN NEEDLE
- INSUPEN 31G ULTRAFIN NEEDLE
- INSUPEN 32G 6MM PEN NEEDLE
- INSUPEN 32G 8MM PEN NEEDLE
- INSUPEN PEN NEEDLE 29GX12MM
- INSUPEN PEN NEEDLE 31GX3/16"
- INSUPEN PEN NEEDLE 32GX4MM
- INSUPEN PEN NEEDLE 33GX4MM
- IV ANTISEPTIC WIPES
- KENDALL ALCOHOL 70% PREP PAD

- LISCO SPONGES 100/BAG
- LITE TOUCH 31GX1/4" PEN NEEDLE
- LITE TOUCH INSULIN 0.5 ML SYR
- LITE TOUCH INSULIN 1 ML SYR
- LITE TOUCH INSULIN SYR 1 ML
- LITE TOUCH PEN NEEDLE 29G
- LITE TOUCH PEN NEEDLE 31G
- LITETOUCH INS 0.3 ML 29GX1/2"
- LITETOUCH INS 0.3 ML 30GX5/16"
- LITETOUCH INS 0.3 ML 31GX5/16"
- LITETOUCH INS 0.5 ML 31GX5/16"
- LITETOUCH SYR 0.5 ML 28GX1/2"
- LITETOUCH SYR 0.5 ML 29GX1/2"
- LITETOUCH SYR 0.5 ML 30GX5/16"
- LITETOUCH SYRIN 1 ML 28GX1/2"
- LITETOUCH SYRIN 1 ML 29GX1/2"
- LITETOUCH SYRIN 1 ML 30GX5/16"
- 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 4MM
- MINI PEN NEEDLE 32G 5MM
- MINI PEN NEEDLE 32G 6MM
- MINI PEN NEEDLE 32G 8MM
- MINI PEN NEEDLE 33G 4MM
- 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)
- 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
- NOVOFINE 30
- NOVOFINE 32G NEEDLES
- NOVOFINE PLUS PEN NDL 32GX1/6"
- NOVOTWIST NEEDLE 32G 5MM
- PC UNIFINE PENTIPS 8MM NEEDLE SHORT
- PEN NEEDLE 30G 5MM OUTER
- PEN NEEDLE 30G 8MM INNER
- PEN NEEDLE 30G X 5/16"
- PEN NEEDLE, DIABETIC NEEDLE 29 GAUGE X 1/2"
- PEN NEEDLES 12MM 29G 29GX12MM, STRL
- PEN NEEDLES 4MM 32G
- PEN NEEDLES 6MM 31G 31GX6MM, STRL
- 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" 4MM
- 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 31GX5/16"
- PRO COMFORT PEN NDL 32G X 1/4"
- PRO COMFORT PEN NDL 4MM 32G
- PRO COMFORT PEN NDL 5MM 32G
- 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
- RAYA SURE PEN NEEDLE 29G 12MM
- RAYA SURE PEN NEEDLE 31G 4MM
- RAYA SURE PEN NEEDLE 31G 5MM
- RAYA SURE PEN NEEDLE 31G 6MM
- RELI-ON INSULIN 0.5 ML SYR
- RELI-ON INSULIN 1 ML SYR
- RELION INS SYR 0.3 ML 31GX6MM
- RELION INS SYR 0.5 ML 31GX6MM
- RELION INS SYR 1 ML 31GX15/64"
- RELION MINI PEN 31G X 1/4" NDL
- RELION NEEDLES
- RELION PEN NEEDLES
- 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
- 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 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
- SM ULT CFT 0.3 ML 31GX5/16(1/2)
- STERILE PADS 2" X 2"
- 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 30GX12MM (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 29GX12MM (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 30GX8MM
- 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
- TOPCARE CLICKFINE 31G X 1/4"
- TOPCARE CLICKFINE 31G X 5/16"
- TOPCARE ULTRA COMFORT SYRINGE
- 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"
- 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"
- TRUEPLUS PEN NEEDLE 29G 12MM
- TRUEPLUS PEN NEEDLE 31G 5MM
- TRUEPLUS PEN NEEDLE 31G 8MM
- TRUEPLUS PEN NEEDLE 31G X 1/4"
- 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"
- ULTICAR INS 0.3 ML 31GX1/4(1/2)
- ULTICARE INS 1 ML 31GX1/4"
- ULTICARE INS SYR 0.3 ML 30G 8MM
- ULTICARE INS SYR 0.3 ML 31G 6MM
- ULTICARE INS SYR 0.3 ML 31G 8MM
- ULTICARE INS SYR 0.5 ML 31G 6MM
- 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 29G 12.7MM
- ULTICARE SYR 0.3 ML 30GX1/2"
- ULTICARE SYR 0.3 ML 31GX5/16"
- ULTICARE SYR 0.5 ML 30GX1/2"
- 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 SAFE PACK 32G 4MM
- 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 6MM
- ULTIGUARD SAFEPK 0.3 ML 31G 8MM
- 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 SYRINGE
- ULTRA COMFORT 0.5 ML 28GX1/2" CONVERTS TO 29G
- ULTRA COMFORT 0.5 ML 29GX1/2"
- ULTRA COMFORT 0.5 ML SYRINGE
- 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-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 PEN NEEDLE 32G 4MM
- UNIFINE PENTIPS 12MM 29G 29GX12MM, STRL
- UNIFINE PENTIPS 31GX3/16" 31GX5MM,STRL,MINI
- UNIFINE PENTIPS 32GX1/4"
- UNIFINE PENTIPS 32GX5/32" 32GX4MM, STRL, NANO
- UNIFINE PENTIPS 33GX5/32"
- UNIFINE PENTIPS 6MM 31G
- UNIFINE PENTIPS MAX 30GX3/16"
- UNIFINE PENTIPS NEEDLES 29G
- UNIFINE PENTIPS PLUS 29GX1/2" 12MM
- UNIFINE PENTIPS PLUS 30GX3/16"
- UNIFINE PENTIPS PLUS 31GX1/4" ULTRA SHORT, 6MM
- UNIFINE PENTIPS PLUS 31GX3/16" MINI
- UNIFINE PENTIPS PLUS 31GX5/16" SHORT
- UNIFINE PENTIPS PLUS 32GX5/32"
- UNIFINE PENTIPS PLUS 33GX5/32"
- UNIFINE PROTECT 30G 5MM
- UNIFINE PROTECT 30G 8MM
- UNIFINE PROTECT 32G 4MM
- UNIFINE SAFECONTROL 30GX3/16"
- UNIFINE SAFECONTROL 30GX5/16"

- UNIFINE SAFECONTROL 31G 5MM
- UNIFINE SAFECONTROL 31G 6MM
- UNIFINE SAFECONTROL 31G 8MM
- UNIFINE SAFECONTROL 32G 4MM
- UNIFINE ULTRA PEN NDL 31G 5MM
- UNIFINE ULTRA PEN NDL 31G 6MM
- UNIFINE ULTRA PEN NDL 31G 8MM
- UNIFINE ULTRA PEN NDL 32G 4MM
- VANISHPOINT 0.5 ML 30GX1/2" SY 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

PA Criteria	Criteria Details
Exclusion Criteria	PA Criteria: Pending CMS Approval
Required Medical Information	PA Criteria: Pending CMS Approval
Age Restrictions	PA Criteria: Pending CMS Approval
Prescriber Restrictions	PA Criteria: Pending CMS Approval
Coverage Duration	PA Criteria: Pending CMS Approval
Other Criteria	PA Criteria: Pending CMS Approval
Indications	PA Criteria: Pending CMS Approval
Off Label Uses	PA Criteria: Pending CMS Approval
Part B Prerequisite	No

INTERFERON FOR MS-AVONEX

Products Affected

- AVONEX INTRAMUSCULAR PEN INJECTOR KIT
- AVONEX INTRAMUSCULAR SYRINGE KIT
- AVONEX PEN 30 MCG/0.5 ML

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

INTERFERON FOR MS-BETASERON

Products Affected

- BETASERON SUBCUTANEOUS KIT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

INTERFERON GAMMA-1B

Products Affected

- ACTIMMUNE

PA Criteria	Criteria Details
Exclusion Criteria	PA Criteria: Pending CMS Approval
Required Medical Information	PA Criteria: Pending CMS Approval
Age Restrictions	PA Criteria: Pending CMS Approval
Prescriber Restrictions	PA Criteria: Pending CMS Approval
Coverage Duration	PA Criteria: Pending CMS Approval
Other Criteria	PA Criteria: Pending CMS Approval
Indications	PA Criteria: Pending CMS Approval
Off Label Uses	PA Criteria: Pending CMS Approval
Part B Prerequisite	No

IPILIMUMAB

Products Affected

- YERVOY

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL: UNRESECT/MET MEL: 4MO, RCC/CRC/HCC: 3MO, ALL OTHERS: 12MO. INITIAL/RENEWAL: CUTAN MEL: 6MO
Other Criteria	RENEWAL: ADJUVANT CUTANEOUS MELANOMA: NO EVIDENCE OF DISEASE RECURRENCE (DEFINED AS THE APPEARANCE OF ONE OR MORE NEW MELANOMA LESIONS: LOCAL, REGIONAL OR DISTANT METASTASIS). THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

ITRACONAZOLE SOLUTION

Products Affected

- *itraconazole oral solution*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 MONTHS
Other Criteria	ESOPHAGEAL CANDIDIASIS AND OROPHARYNGEAL CANDIDIASIS: TRIAL OF OR CONTRAINDICATION TO FLUCONAZOLE.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

IVACAFTOR

Products Affected

- KALYDECO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	CYSTIC FIBROSIS (CF): INITIAL: CONFIRMED MUTATION IN CFTR GENE ACCEPTABLE FOR THE TREATMENT OF CYSTIC FIBROSIS
Age Restrictions	
Prescriber Restrictions	CF: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A PULMONOLOGIST OR CYSTIC FIBROSIS EXPERT
Coverage Duration	INITIAL: 12 MONTHS. RENEWAL: LIFETIME
Other Criteria	CF: INITIAL: NOT HOMOZYGOUS FOR F508DEL MUTATION IN CFTR GENE. RENEWAL: 1) MAINTAINED, IMPROVED, OR DEMONSTRATED LESS THAN EXPECTED DECLINE IN FEV1 OR BODY MASS INDEX (BMI), OR 2) REDUCTION IN NUMBER OF PULMONARY EXACERBATIONS.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

IVOSIDENIB

Products Affected

- TIBSOVO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

IXAZOMIB

Products Affected

- NINLARO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

LANADELUMAB-FLYO

Products Affected

- TAKHZYRO SUBCUTANEOUS SOLUTION (150 MG/ML)
- TAKHZYRO SUBCUTANEOUS SYRINGE 150 MG/ML, 300 MG/2 ML (150 MG/ML)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	HEREDITARY ANGIOEDEMA (HAE): INITIAL: DIAGNOSIS CONFIRMED BY COMPLEMENT TESTING.
Age Restrictions	
Prescriber Restrictions	HAE: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH AN ALLERGIST, IMMUNOLOGIST, OR HEMATOLOGIST.
Coverage Duration	INITIAL/RENEWAL: 12 MONTHS
Other Criteria	HAE: INITIAL: NOT ON CONCURRENT TREATMENT WITH ALTERNATIVE PROPHYLACTIC AGENT FOR HAE ATTACKS. RENEWAL: 1) IMPROVEMENT COMPARED TO BASELINE IN HAE ATTACKS (I.E., REDUCTIONS IN ATTACK FREQUENCY OR ATTACK SEVERITY), AND 2) NOT ON CONCURRENT TREATMENT WITH ALTERNATIVE PROPHYLACTIC AGENT FOR HAE ATTACKS.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

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: 3 MOS, RENEWAL: 12 MOS.GEP-NETS, CARCINOID SYNDROME: 12 MOS.
Other Criteria	ACROMEGALY: INITIAL: TRIAL OF OR CONTRAINDICATION TO ONE GENERIC OCTREOTIDE INJECTION. 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

LAPATINIB

Products Affected

- *lapatinib*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

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	12 MONTHS
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

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	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

LEDIPASVIR-SOFOSBUVIR

Products Affected

- HARVONI ORAL PELLETS IN PACKET
33.75-150 MG, 45-200 MG
- HARVONI 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, AND 2) NOT CONCURRENTLY TAKING ANY OF THE FOLLOWING: CARBAMAZEPINE, PHENYTOIN, PHENOBARBITAL, OXCARBAZEPINE, RIFAMPIN, RIFABUTIN, RIFAPENTINE, ROSUVASTATIN, TIPRANA VIR/RITONAVIR, SOFOSBUVIR (AS A SINGLE AGENT), EPCLUSA, ZEPATIER, MAVYRET, OR VOSEVI. REQUESTS FOR HARVONI 45MG-200MG PELLETS: PATIENT IS UNABLE TO SWALLOW TABLETS.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

LENALIDOMIDE

Products Affected

- *lenalidomide*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

LENVATINIB

Products Affected

- LENVIMA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

LETERMOVIR

Products Affected

- PREVYMIS ORAL

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	HSCT: NOT AT RISK FOR LATE CMV: 4 MOS, AT RISK FOR LATE CMV: 7 MOS. KIDNEY TRANSPLANT: 7 MOS.
Other Criteria	HEMATOPOIETIC STEM CELL TRANSPLANT (HSCT): 1) THERAPY WILL BE INITIATED BETWEEN DAY 0 AND DAY 28 POST TRANSPLANT, AND 2) WILL NOT RECEIVE THE MEDICATION BEYOND 100 DAYS POST TRANSPLANT IF NOT AT RISK FOR LATE CYTOMEGALOVIRUS (CMV) INFECTION AND DISEASE, OR BEYOND 200 DAYS POST TRANSPLANT IF AT RISK FOR LATE CMV INFECTION AND DISEASE. 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

LEUPROLIDE

Products Affected

- *leuprolide subcutaneous kit*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PROSTATE CANCER: 12 MONTHS.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

LEUPROLIDE DEPOT

Products Affected

- *leuprolide (3 month)*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	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	12 MONTHS.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

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: PRESCRIBED BY OR IN CONSULTATION WITH AN OBSTETRICIAN/GYNECOLOGIST.
Coverage Duration	PROSTATE CA: 12 MOS. UTERINE FIBROIDS: 3 MOS. ENDOMETRIOSIS: INITIAL/RENEWAL: 6 MOS.
Other Criteria	INITIAL: ENDOMETRIOSIS: 1) NO CONCURRENT USE WITH ANOTHER GNRH-MODULATING AGENT, 2) TRIAL OF OR CONTRAINDICATION TO NSAID AND PROGESTIN-CONTAINING PREPARATION, AND 3) 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. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	

PA Criteria	Criteria Details
Part B Prerequisite	No

LEUPROLIDE-LUPRON DEPOT-PED

Products Affected

- LUPRON DEPOT-PED
- LUPRON DEPOT-PED (3 MONTH)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	CENTRAL PRECOCIOUS PUBERTY (CPP): INITIAL: FEMALES: ELEVATED LEVELS OF FOLLICLE-STIMULATING HORMONE (FSH) GREATER THAN 4.0 MIU/ML AND LUTEINIZING HORMONE (LH) LEVEL GREATER THAN 0.2 TO 0.3 MIU/ML AT DIAGNOSIS. MALES: ELEVATED LEVELS OF FSH GREATER THAN 5.0 MIU/ML AND 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: 12 MONTHS.
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. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	

PA Criteria	Criteria Details
Part B Prerequisite	No

LEVODOPA

Products Affected

- INBRIJA INHALATION CAPSULE,
W/INHALATION DEVICE

PA Criteria	Criteria Details
Exclusion Criteria	PA Criteria: Pending CMS Approval
Required Medical Information	PA Criteria: Pending CMS Approval
Age Restrictions	PA Criteria: Pending CMS Approval
Prescriber Restrictions	PA Criteria: Pending CMS Approval
Coverage Duration	PA Criteria: Pending CMS Approval
Other Criteria	PA Criteria: Pending CMS Approval
Indications	PA Criteria: Pending CMS Approval
Off Label Uses	PA Criteria: Pending CMS Approval
Part B Prerequisite	No

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: 12 MONTHS. RENEWAL: LIFETIME.
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

LIDOCAINE OINTMENT

Products Affected

- *lidocaine topical ointment*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION. THIS DRUG MAY BE EITHER BUNDLED WITH AND COVERED UNDER END STAGE RENAL DISEASE DIALYSIS RELATED SERVICES OR COVERED UNDER MEDICARE D DEPENDING UPON THE CIRCUMSTANCES.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

LIDOCAINE PATCH

Products Affected

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

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	12 MONTHS
Other Criteria	THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

LIDOCAINE PRILOCAINE

Products Affected

- *lidocaine-prilocaine topical cream*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	THIS DRUG MAY BE EITHER BUNDLED WITH AND COVERED UNDER END STAGE RENAL DISEASE DIALYSIS RELATED SERVICES OR COVERED UNDER MEDICARE D DEPENDING UPON THE CIRCUMSTANCES. INFORMATION MAY NEED TO BE SUBMITTED DESCRIBING THE USE AND SETTING OF THE DRUG TO MAKE THE DETERMINATION. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

LIDOCAINE SOLUTION

Products Affected

- *lidocaine hcl mucous membrane solution 4 % (40 mg/ml)*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

LOMITAPIDE

Products Affected

- JUXTAPID ORAL CAPSULE 10 MG, 20 MG, 30 MG, 5 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	HOMOZYGOUS FAMILIAL HYPERCHOLESTEROLEMIA (HOFH): 1) DIAGNOSIS DETERMINED BY: (A) DEFINITE SIMON BROOME DIAGNOSTIC CRITERIA, (B) DUTCH LIPID NETWORK CRITERIA SCORE OF AT LEAST 8, OR (C) CLINICAL DIAGNOSIS BASED ON A HISTORY OF AN UNTREATED LDL-C CONCENTRATION GREATER THAN 500 MG/DL TOGETHER WITH EITHER XANTHOMA BEFORE 10 YEARS OF AGE OR EVIDENCE OF HEFH IN BOTH PARENTS, AND 2) LDL-C LEVEL OF AT LEAST 70MG/DL WHILE ON MAXIMALLY TOLERATED DRUG TREATMENT.
Age Restrictions	
Prescriber Restrictions	HOFH: PRESCRIBED BY OR IN CONSULTATION WITH A CARDIOLOGIST, ENDOCRINOLOGIST OR LIPIDOLOGIST.
Coverage Duration	12 MONTHS

PA Criteria	Criteria Details
Other Criteria	HOFH: 1) TRIAL OF REPATHA, UNLESS THE PATIENT HAS NON-FUNCTIONING LDL RECEPTORS, AND 2) ONE OF THE FOLLOWING: (A) TAKING A HIGH-INTENSITY STATIN (I.E., ATORVASTATIN 40-80MG DAILY, ROSUVASTATIN 20-40MG DAILY) FOR A DURATION OF AT LEAST 8 WEEKS, (B) TAKING A MAXIMALLY TOLERATED DOSE OF ANY STATIN FOR A DURATION OF AT LEAST 8 WEEKS GIVEN THAT THE PATIENT CANNOT TOLERATE A HIGH-INTENSITY STATIN, (C) ABSOLUTE CONTRAINDICATION TO STATIN THERAPY (E.G., ACTIVE DECOMPENSATED LIVER DISEASE, NURSING FEMALE, PREGNANCY OR PLANS TO BECOME PREGNANT, HYPERSENSITIVITY REACTIONS), (D) STATIN INTOLERANCE, OR (E) TRIAL OF ROSUVASTATIN, ATORVASTATIN, OR STATIN THERAPY AT ANY DOSE AND HAS EXPERIENCED SKELETAL-MUSCLE RELATED SYMPTOMS (E.G., MYOPATHY).
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

LONCASTUXIMAB TESIRINE-LPYL

Products Affected

- ZYNLONTA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

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	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

LOTILANER

Products Affected

- XDEMZY

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	DEMODEX BLEPHARITIS: 18 YEARS OF AGE OR OLDER
Prescriber Restrictions	
Coverage Duration	6 WEEKS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

LUMACAFITOR-IVACAFITOR

Products Affected

- ORKAMBI ORAL GRANULES IN PACKET
- ORKAMBI ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: CYSTIC FIBROSIS (CF): CONFIRMED MUTATION IN CFTR GENE ACCEPTABLE FOR THE TREATMENT OF CF.
Age Restrictions	
Prescriber Restrictions	CF: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A PULMONOLOGIST OR CF EXPERT.
Coverage Duration	INITIAL: 6 MONTHS, RENEWAL: LIFETIME.
Other Criteria	CF: RENEWAL: 1) MAINTAINED, IMPROVED, OR DEMONSTRATED LESS THAN EXPECTED DECLINE IN FEV1 OR BODY MASS INDEX (BMI), OR 2) REDUCTION IN NUMBER OF PULMONARY EXACERBATIONS.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

MACITENTAN

Products Affected

- OPSUMIT

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: 12 MONTHS.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

MARGETUXIMAB-CMKB

Products Affected

- MARGENZA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

MARIBAVIR

Products Affected

- LIVTENCITY

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

MECASERMIN

Products Affected

- INCRELEX

PA Criteria	Criteria Details
Exclusion Criteria	PA Criteria: Pending CMS Approval
Required Medical Information	PA Criteria: Pending CMS Approval
Age Restrictions	PA Criteria: Pending CMS Approval
Prescriber Restrictions	PA Criteria: Pending CMS Approval
Coverage Duration	PA Criteria: Pending CMS Approval
Other Criteria	PA Criteria: Pending CMS Approval
Indications	PA Criteria: Pending CMS Approval
Off Label Uses	PA Criteria: Pending CMS Approval
Part B Prerequisite	No

MECHLORETHAMINE

Products Affected

- VALCHLOR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

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.
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.
Coverage Duration	INITIAL: ASTHMA: 4 MO. CRSWNP: 6 MO. OTHERS: 12 MO. RENEWAL: CRSWNP, ASTHMA: 12 MO.

PA Criteria	Criteria Details
Other Criteria	<p>INITIAL: 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, 2) ONE OF THE FOLLOWING: (A) AT LEAST ONE ASTHMA EXACERBATION REQUIRING SYSTEMIC CORTICOSTEROID BURST LASTING 3 OR MORE 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, AND 3) NO CONCURRENT USE WITH XOLAIR, DUPIXENT, TEZSPIRE, OR OTHER ANTI-IL5 BIOLOGICS WHEN USED FOR ASTHMA. CRSWNP: 1) A 56 DAY TRIAL OF ONE TOPICAL NASAL CORTICOSTEROID, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR AN AUTOIMMUNE INDICATION. RENEWAL: ASTHMA: 1) NO CONCURRENT USE WITH XOLAIR, DUPIXENT, TEZSPIRE, OR OTHER ANTI-IL5 BIOLOGICS WHEN USED FOR ASTHMA, 2) CONTINUED USE OF ICS AND AT LEAST ONE OTHER MAINTENANCE MEDICATION, AND 3) 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. CRSWNP: 1) CLINICAL BENEFIT COMPARED TO BASELINE, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR AN AUTOIMMUNE INDICATION.</p>
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

METHYLNALTREXONE INJECTABLE

Products Affected

- RELISTOR SUBCUTANEOUS SOLUTION
- RELISTOR SUBCUTANEOUS SYRINGE
12 MG/0.6 ML, 8 MG/0.4 ML

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	ADVANCED ILLNESS: 6 MONTHS. CHRONIC NON-CANCER PAIN: 12 MONTHS.
Other Criteria	CHRONIC NON-CANCER PAIN: 1) HAS BEEN TAKING OPIOIDS FOR AT LEAST 4 WEEKS, AND 2) TRIAL OF OR CONTRAINDICATION TO THE PREFERRED AGENTS: NALOXEGOL (MOVANTIK) AND LUBIPROSTONE (AMITIZA)
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

METHYLNALTREXONE ORAL

Products Affected

- RELISTOR ORAL

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	OPIOID INDUCED CONSTIPATION WITH CHRONIC NON-CANCER PAIN: 1) HAS BEEN TAKING OPIOIDS FOR AT LEAST 4 WEEKS, AND 2) TRIAL OF OR CONTRAINDICATION TO THE PREFERRED AGENTS: NALOXEGOL (MOVANTIK) AND LUBIPROSTONE (AMITIZA)
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

MIDOSTAURIN

Products Affected

- RYDAPT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	ACUTE MYELOID LEUKEMIA: 6 MONTHS. ADVANCED SYSTEMIC MASTOCYTOSIS: 12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

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 (2 OR MORE TESTS TO CONFIRM), 2) OVERNIGHT 1MG DEXAMETHASONE TEST, OR 3) LATE NIGHT SALIVARY CORTISOL (2 OR MORE TESTS TO CONFIRM).
Age Restrictions	
Prescriber Restrictions	CS: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH AN ENDOCRINOLOGIST.
Coverage Duration	INITIAL/RENEWAL: 12 MONTHS
Other Criteria	CS: INITIAL: HYPERCORTISOLISM IS NOT A RESULT OF CHRONIC GLUCOCORTICOIDS. RENEWAL: 1) CONTINUES TO HAVE IMPROVEMENT OF GLUCOSE TOLERANCE OR STABLE GLUCOSE TOLERANCE (E.G., REDUCED A1C, IMPROVED FASTING GLUCOSE, ETC.), 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

MIGALASTAT

Products Affected

- GALAFOLD

PA Criteria	Criteria Details
Exclusion Criteria	PA Criteria: Pending CMS Approval
Required Medical Information	PA Criteria: Pending CMS Approval
Age Restrictions	PA Criteria: Pending CMS Approval
Prescriber Restrictions	PA Criteria: Pending CMS Approval
Coverage Duration	PA Criteria: Pending CMS Approval
Other Criteria	PA Criteria: Pending CMS Approval
Indications	PA Criteria: Pending CMS Approval
Off Label Uses	PA Criteria: Pending CMS Approval
Part B Prerequisite	No

MIGLUSTAT-ZAVESCA

Products Affected

- *miglustat*
- *yargesa*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

MILTEFOSINE

Products Affected

- IMPAVIDO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

MOBOCERTINIB

Products Affected

- EXKIVITY

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

MOMELOTINIB

Products Affected

- OJJAARA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

MOSUNETUZUMAB-AXGB

Products Affected

- LUNSUMIO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	RELAPSED OR REFRACTORY FOLLICULAR LYMPHOMA: INITIAL: 6 MONTHS. RENEWAL: 7 MONTHS.
Other Criteria	RELAPSED OR REFRACTORY FOLLICULAR LYMPHOMA: RENEWAL: 1) HAS ACHIEVED A PARTIAL RESPONSE TO TREATMENT, AND 2) HAS NOT PREVIOUSLY RECEIVED MORE THAN 17 CYCLES OF TREATMENT. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

NAFARELIN

Products Affected

- SYNAREL

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	<p>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. CENTRAL PRECOCIOUS PUBERTY (CPP): FEMALES: ELEVATED LEVELS OF FOLLICLE-STIMULATING HORMONE (FSH) GREATER THAN 4.0 MIU/ML AND LUTEINIZING HORMONE (LH) LEVEL GREATER THAN 0.2 TO 0.3 MIU/ML AT DIAGNOSIS. MALES: ELEVATED LEVELS OF FSH GREATER THAN 5.0 MIU/ML AND LH LEVEL GREATER THAN 0.2 TO 0.3 MIU/ML AT DIAGNOSIS.</p>
Age Restrictions	
Prescriber Restrictions	<p>INITIAL: ENDOMETRIOSIS: PRESCRIBED BY OR IN CONSULTATION WITH AN OBSTETRICIAN/GYNECOLOGIST. CPP: PRESCRIBED BY OR IN CONSULTATION WITH AN ENDOCRINOLOGIST.</p>
Coverage Duration	<p>ENDOMETRIOSIS: 6 MONTHS. CPP: INITIAL/RENEWAL: 12 MONTHS.</p>

PA Criteria	Criteria Details
Other Criteria	<p>INITIAL: ENDOMETRIOSIS: 1) NO CONCURRENT USE WITH ANOTHER GNRH-MODULATING AGENT, 2) TRIAL OF OR CONTRAINDICATION TO NSAID AND PROGESTIN-CONTAINING PREPARATION, AND 3) HAS NOT RECEIVED A TOTAL OF 6 MONTHS OF TREATMENT PER LIFETIME. CPP: 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: CPP: 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.</p>
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

NARCOLEPSY AGENTS

Products Affected

- *armodafinil*
- *modafinil oral tablet 100 mg, 200 mg*

PA Criteria	Criteria Details
Exclusion Criteria	PA Criteria: Pending CMS Approval
Required Medical Information	PA Criteria: Pending CMS Approval
Age Restrictions	PA Criteria: Pending CMS Approval
Prescriber Restrictions	PA Criteria: Pending CMS Approval
Coverage Duration	PA Criteria: Pending CMS Approval
Other Criteria	PA Criteria: Pending CMS Approval
Indications	PA Criteria: Pending CMS Approval
Off Label Uses	PA Criteria: Pending CMS Approval
Part B Prerequisite	No

NAXITAMAB-GQGK

Products Affected

- DANYELZA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

NEDOSIRAN

Products Affected

- RIVFLOZA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

NERATINIB

Products Affected

- NERLYNX

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
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

NILOTINIB

Products Affected

- TASIGNA 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 TASIGNA IS APPROPRIATE PER NCCN GUIDELINE TABLE FOR TREATMENT RECOMMENDATIONS BASED ON BCR-ABL1 MUTATION PROFILE.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

NINTEDANIB

Products Affected

- OFEV

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	<p>INITIAL: IDIOPATHIC PULMONARY FIBROSIS (IPF): 1) 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, AND 2) BASELINE FORCED VITAL CAPACITY (FVC) AT LEAST 50% OF PREDICTED VALUE. 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): 1) AT LEAST 10% FIBROSIS ON A CHEST HRCT, AND 2) BASELINE FVC AT LEAST 45% OF PREDICTED VALUE.</p>
Age Restrictions	
Prescriber Restrictions	<p>INITIAL: IPF: PRESCRIBED BY OR IN CONSULTATION WITH A PULMONOLOGIST. SSC-ILD, PF-ILD: PRESCRIBED BY OR IN CONSULTATION WITH A PULMONOLOGIST OR RHEUMATOLOGIST.</p>
Coverage Duration	<p>INITIAL: SSC-ILD: 6 MOS. IPF, PF-ILD: 12 MOS. RENEWAL (ALL INDICATIONS): 12 MOS.</p>

PA Criteria	Criteria Details
Other Criteria	<p>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: 1) DOES NOT HAVE OTHER KNOWN CAUSES OF INTERSTITIAL LUNG DISEASE (E.G., HEART FAILURE/FLUID OVERLOAD, DRUG-INDUCED LUNG TOXICITY, RECURRENT ASPIRATION), AND 2) TRIAL OF OR CONTRAINDICATION TO THE PREFERRED AGENT: ACTEMRA SUBQ. PF-ILD: LUNG FUNCTION AND RESPIRATORY SYMPTOMS OR CHEST IMAGING HAVE WORSENERD/PROGRESSED DESPITE TREATMENT WITH MEDICATIONS USED IN CLINICAL PRACTICE FOR ILD (NOT ATTRIBUTABLE TO COMORBIDITIES SUCH AS INFECTION, HEART FAILURE). RENEWAL: IPF, SSC-ILD, PF-ILD: CLINICAL MEANINGFUL IMPROVEMENT OR MAINTENANCE IN ANNUAL RATE OF DECLINE.</p>
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

NIRAPARIB

Products Affected

- ZEJULA ORAL CAPSULE
- ZEJULA ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
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

NIRAPARIB-ABIRATERONE

Products Affected

- AKEEGA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
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

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	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

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: 6 MONTHS, RENEWAL: 12 MONTHS.
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

NIVOLUMAB

Products Affected

- OPDIVO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
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

NIVOLUMAB-RELATLIMAB-RMBW

Products Affected

- OPDUALAG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

NOGAPENDEKIN ALFA

Products Affected

- ANKTIVA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	40 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

OBETICHOLIC ACID

Products Affected

- OCALIVA

PA Criteria	Criteria Details
Exclusion Criteria	PRIMARY BILIARY CHOLANGITIS (PBC): INITIAL/RENEWAL: COMPLETE BILIARY OBSTRUCTION.
Required Medical Information	PBC: INITIAL: DIAGNOSIS CONFIRMED BY TWO OF THE FOLLOWING: 1) ELEVATED ALKALINE PHOSPHATASE, 2) PRESENCE OF ANTIMITOCHONDRIAL ANTIBODIES (AMA) OR PBC-SPECIFIC AUTOANTIBODIES, INCLUDING SP100 OR GP210 IF AMA IS NEGATIVE, OR 3) HISTOLOGIC EVIDENCE OF NON-SUPPURATIVE DESTRUCTIVE CHOLANGITIS AND DESTRUCTION OF INTERLOBULAR BILE DUCTS (BY LIVER BIOPSY).
Age Restrictions	
Prescriber Restrictions	PBC: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A GASTROENTEROLOGIST OR HEPATOLOGIST.
Coverage Duration	INITIAL/RENEWAL: 12 MONTHS
Other Criteria	PBC: INITIAL: 1) USED IN COMBINATION WITH URSODIOL IF INADEQUATE RESPONSE AFTER TREATMENT WITH URSODIOL MONOTHERAPY FOR AT LEAST 1 YEAR, OR 2) USED AS MONOTHERAPY IF UNABLE TO TOLERATE URSODIOL. RENEWAL: CONTINUES TO BENEFIT FROM THE MEDICATION.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

OCRELIZUMAB

Products Affected

- OCREVUS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	RELAPSING FORM OF MULTIPLE SCLEROSIS (MS): TRIAL OF TWO AGENTS INDICATED FOR THE TREATMENT OF RELAPSING FORMS OF MS. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

OFATUMUMAB-SQ

Products Affected

- KESIMPTA PEN

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

OLANZAPINE/SAMIDORPHAN

Products Affected

- LYBALVI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	SCHIZOPHRENIA, BIPOLAR I: PRESCRIBED BY OR IN CONSULTATION WITH A PSYCHIATRIST
Coverage Duration	12 MONTHS
Other Criteria	SCHIZOPHRENIA: 1) AT HIGH RISK FOR WEIGHT GAIN, AND 2) TRIAL OF OR CONTRAINDICATION TO A FORMULARY VERSION OF LURASIDONE OR ONE OF THE FOLLOWING ORAL ANTIPSYCHOTICS: RISPERIDONE, CLOZAPINE TABLET, OLANZAPINE, IMMEDIATE RELEASE QUETIAPINE FUMARATE, ZIPRASIDONE, ARIPIPRAZOLE. BIPOLAR I: 1) AT HIGH RISK FOR WEIGHT GAIN, AND 2) TRIAL OF OR CONTRAINDICATION TO ONE OF THE FOLLOWING ORAL ANTIPSYCHOTICS: RISPERIDONE, OLANZAPINE, IMMEDIATE RELEASE QUETIAPINE FUMARATE, ZIPRASIDONE, ARIPIPRAZOLE.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

OLAPARIB

Products Affected

- LYNPARZA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
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

OLUTASIDENIB

Products Affected

- REZLIDHIA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

OMACETAXINE

Products Affected

- SYNRIBO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	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) ALLERGEN SPECIFIC IGE SERUM LEVEL OF AT LEAST 6 KUA/L TO AT LEAST ONE FOOD, OR 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: ASTHMA: 4 MO. CSU, CRSWNP: 6 MO. FOOD ALLERGY: 12 MO. RENEWAL: SEE OTHER CRITERIA

PA Criteria	Criteria Details
Other Criteria	<p>INITIAL: CSU: 1) TRIAL OF AND MAINTAINED ON, OR CONTRAINDICATION TO A SECOND GENERATION H1 ANTI-HISTAMINE AND 2) STILL EXPERIENCES HIVES OR ANGIOEDEMA ON MOST DAYS OF THE WEEK FOR AT LEAST 6 WEEKS. CRSWNP: 1) A 56 DAY TRIAL OF ONE TOPICAL NASAL CORTICOSTEROID, 2) TRIAL OF OR CONTRAINDICATION TO ONE PREFERRED AGENT: NUCALA, DUPIXENT, AND 3) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR AN AUTOIMMUNE 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, 2) ONE OF THE FOLLOWING: (A) AT LEAST ONE ASTHMA EXACERBATION REQUIRING SYSTEMIC CORTICOSTEROID BURST LASTING 3 OR MORE 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, AND 3) NO CONCURRENT USE WITH DUPIXENT, TEZSPIRE, OR ANTI-IL5 BIOLOGICS WHEN USED FOR ASTHMA. FOOD ALLERGY: 1) CONCURRENT USE WITH AN ACTIVE PRESCRIPTION FOR EPINEPHRINE AUTO-INJECTOR/INJECTION, AND 2) NO CONCURRENT USE WITH PEANUT-SPECIFIC IMMUNOTHERAPY. RENEWAL: CSU: 12 MONTHS APPROVAL: MAINTAINED ON OR CONTRAINDICATION TO A SECOND GENERATION H1 ANTI-HISTAMINE. CRSWNP: 12 MONTHS APPROVAL: 1) CLINICAL BENEFIT COMPARED TO BASELINE, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC</p>

PA Criteria	Criteria Details
	<p>BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR AN AUTOIMMUNE INDICATION. ASTHMA: 12 MONTHS APPROVAL: 1) NO CONCURRENT USE WITH DUPIXENT, TEZSPIRE, OR ANTI-IL5 BIOLOGICS WHEN USED FOR ASTHMA, 2) CONTINUED USE OF ICS AND AT LEAST ONE OTHER MAINTENANCE MEDICATION, AND 3) 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: 24 MONTHS APPROVAL: 1) PERSISTENT IGE-MEDIATED FOOD ALLERGY, 2) CONCURRENT USE WITH AN ACTIVE PRESCRIPTION FOR EPINEPHRINE AUTO-INJECTOR/INJECTION, AND 3) NO CONCURRENT USE WITH PEANUT-SPECIFIC IMMUNOTHERAPY.</p>
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

OPICAPONE

Products Affected

- ONGENTYS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	PARKINSONS DISEASE: 18 YEARS OF AGE OR OLDER
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

OSIMERTINIB

Products Affected

- TAGRISSO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	NON-SMALL CELL LUNG CANCER (NSCLC) WITH EGFR EXON 19 DELETIONS OR EXON 21 L858R MUTATIONS, OR EGFR T790M MUTATION: NO CONCURRENT THERAPY WITH AN EGFR TYROSINE KINASE-INHIBITOR.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

OXANDROLONE

Products Affected

- *oxandrolone*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 MONTHS
Other Criteria	PROTEIN CATABOLISM, BONE PAIN: 1) MONITORED FOR PELIOSIS HEPATIS, LIVER CELL TUMORS, AND BLOOD LIPID CHANGES, 2) DOES NOT HAVE KNOWN OR SUSPECTED: CARCINOMA OF THE PROSTATE OR BREAST IN MALE PATIENTS, CARCINOMA OF THE BREAST IN FEMALES WITH HYPERCALCEMIA, NEPHROSIS (THE NEPHROTIC PHASE OF NEPHRITIS), OR HYPERCALCEMIA, AND 3) DOES NOT HAVE SEVERE HEPATIC DYSFUNCTION.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

PACRITINIB

Products Affected

- VONJO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS
Other Criteria	MYELOFIBROSIS: RENEWAL: CONTINUES TO BENEFIT FROM THE MEDICATION
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

PALBOCICLIB

Products Affected

- IBRANCE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	ADVANCED OR METASTATIC BREAST CANCER: TRIAL OF OR CONTRAINDICATION TO ONE OF THE PREFERRED AGENTS, WHERE INDICATIONS ALIGN: KISQALI, VERZENIO.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

PARATHYROID HORMONE

Products Affected

- NATPARA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	HYPOCALCEMIA SECONDARY TO HYPOPARATHYROIDISM: PRESCRIBED BY OR IN CONSULTATION WITH AN ENDOCRINOLOGIST.
Coverage Duration	12 MONTHS
Other Criteria	HYPOCALCEMIA SECONDARY TO HYPOPARATHYROIDISM: 1) TRIAL OF OR CONTRAINDICATION TO CALCITRIOL, 2) HYPOPARATHYROIDISM IS NOT DUE TO A CALCIUM SENSING RECEPTOR (CSR) MUTATION, AND 3) HYPOPARATHYROIDISM IS NOT CONSIDERED ACUTE POST-SURGICAL HYPOPARATHYROIDISM.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

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: 6 MONTHS, RENEWAL: 12 MONTHS.
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

PAZOPANIB

Products Affected

- *pazopanib*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
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

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	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

PEGFILGRASTIM-FPGK

Products Affected

- STIMUFEND

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	12 MONTHS
Other Criteria	TRIAL OF OR CONTRAINDICATION TO THE PREFERRED AGENT NYVEPRIA, WHERE INDICATIONS ALIGN.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

PEGFILGRASTIM-NEULASTA ONPRO

Products Affected

- NEULASTA ONPRO

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	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

PEGFILGRASTIM-PBBK

Products Affected

- FYLNETRA

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	12 MONTHS
Other Criteria	TRIAL OF OR CONTRAINDICATION TO THE PREFERRED AGENT NYVEPRIA, WHERE INDICATIONS ALIGN.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

PEGINTERFERON ALFA-2A

Products Affected

- PEGASYS

PA Criteria	Criteria Details
Exclusion Criteria	PA Criteria: Pending CMS Approval
Required Medical Information	PA Criteria: Pending CMS Approval
Age Restrictions	PA Criteria: Pending CMS Approval
Prescriber Restrictions	PA Criteria: Pending CMS Approval
Coverage Duration	PA Criteria: Pending CMS Approval
Other Criteria	PA Criteria: Pending CMS Approval
Indications	PA Criteria: Pending CMS Approval
Off Label Uses	PA Criteria: Pending CMS Approval
Part B Prerequisite	No

PEGVALIASE-PQPZ

Products Affected

- PALYNZIQ

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	PHENYLKETONURIA (PKU): INITIAL: NO CONCURRENT USE WITH KUVAN. RENEWAL: 1) CONTINUES TO BENEFIT FROM THE MEDICATION, AND 2) NO CONCURRENT USE WITH KUVAN.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

PEGVISOMANT

Products Affected

- SOMAVERT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

PEMBROLIZUMAB

Products Affected

- KEYTRUDA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
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

PEMIGATINIB

Products Affected

- PEMAZYRE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
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

PENICILLAMINE TABLET

Products Affected

- *penicillamine oral tablet*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	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	INITIAL: WILSONS DISEASE: PRESCRIBED BY OR IN CONSULTATION WITH A HEPATOLOGIST OR GASTROENTEROLOGIST. CYSTINURIA: PRESCRIBED BY OR IN CONSULTATION WITH A NEPHROLOGIST. RHEUMATOID ARTHRITIS (RA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST.
Coverage Duration	INITIAL: 12 MONTHS, RENEWAL: LIFETIME.
Other Criteria	INITIAL: WILSONS DISEASE: 1) LEIPZIG SCORE OF 4 OR GREATER. 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 AT A DOSE GREATER THAN OR EQUAL TO 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 COUNT COMPARED TO BASELINE. WILSONS DISEASE, CYSTINURIA: CONTINUES TO BENEFIT FROM THE MEDICATION.

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

PEXIDARTINIB

Products Affected

- TURALIO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	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: 12 MONTHS.
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

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: 1) 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, AND 2) PREDICTED FORCED VITAL CAPACITY (FVC) OF AT LEAST 50% AT BASELINE.
Age Restrictions	IPF: INITIAL: 18 YEARS OR OLDER.
Prescriber Restrictions	IPF: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A PULMONOLOGIST.
Coverage Duration	INITIAL/RENEWAL: 12 MONTHS.
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). RENEWAL: CLINICAL MEANINGFUL IMPROVEMENT OR MAINTENANCE IN ANNUAL RATE OF DECLINE.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

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	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

POMALIDOMIDE

Products Affected

- POMALYST

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

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	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

POSACONAZOLE SUSPENSION

Products Affected

- *posaconazole oral*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	OPC: 3 MONTHS. CONTINUATION OF THERAPY AFTER HOSPITAL DISCHARGE, PROPHYLAXIS: 6 MONTHS.
Other Criteria	OROPHARYNGEAL CANDIDIASIS (OPC): TRIAL OF OR CONTRAINDICATION TO FLUCONAZOLE OR ITRACONAZOLE. PROPHYLAXIS OF INVASIVE ASPERGILLUS AND CANDIDA INFECTION: 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

POSACONAZOLE TABLET

Products Affected

- *posaconazole oral*

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

POSACONAZOLE-POWDERMIX

Products Affected

- NOXAFIL ORAL SUSP,DELAYED
RELEASE FOR RECON

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 MONTHS
Other Criteria	PROPHYLAXIS OF INVASIVE ASPERGILLUS AND CANDIDA INFECTION: INABILITY 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

PRALSETINIB

Products Affected

- GAVRETO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

PRAMLINTIDE

Products Affected

- SYMLINPEN 120
- SYMLINPEN 60

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	TYPE I OR TYPE II DIABETES: REQUIRING INSULIN OR CONTINUOUS INSULIN INFUSION (INSULIN PUMP) FOR GLYCEMIC CONTROL
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

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

QUININE

Products Affected

- *quinine sulfate*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

QUIZARTINIB

Products Affected

- VANFLYTA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

REGORAFENIB

Products Affected

- STIVARGA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

RELUGOLIX

Products Affected

- ORGOVYX

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

REPOTRECTINIB

Products Affected

- AUGTYRO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

RESLIZUMAB

Products Affected

- CINQAIR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	ASTHMA: INITIAL: BLOOD EOSINOPHIL LEVEL OF AT LEAST 150 CELLS/MCL WITHIN THE PAST 12 MONTHS.
Age Restrictions	
Prescriber Restrictions	ASTHMA: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A PHYSICIAN SPECIALIZING IN ALLERGY OR PULMONARY MEDICINE.
Coverage Duration	ASTHMA: INITIAL: 4 MONTHS. RENEWAL: 12 MONTHS

PA Criteria	Criteria Details
Other Criteria	<p>ASTHMA: INITIAL: 1) CONCURRENT THERAPY WITH A MEDIUM, HIGH-DOSE OR MAXIMALLY TOLERATED DOSE OF AN INHALED CORTICOSTEROID (ICS) AND ONE OTHER MAINTENANCE MEDICATION, 2) ONE ASTHMA EXACERBATION REQUIRING SYSTEMIC CORTICOSTEROID BURST LASTING 3 OR MORE 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, 3) TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: FASENRA, NUCALA, DUPIXENT, AND 4) NO CONCURRENT USE WITH XOLAIR, DUPIXENT, TEZSPIRE, OR OTHER ANTI-IL5 BIOLOGICS WHEN USED FOR ASTHMA. RENEWAL: 1) NO CONCURRENT USE WITH XOLAIR, DUPIXENT, TEZSPIRE, OR OTHER ANTI-IL5 BIOLOGICS WHEN USED FOR ASTHMA, 2) CONTINUED USE OF ICS AND ONE OTHER MAINTENANCE MEDICATION, AND 3) 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. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.</p>
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

RETIFANLIMAB-DLWR

Products Affected

- ZYNYZ

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

RIBOCICLIB

Products Affected

- 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	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

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	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

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): 12 MOS. IBS-D: 8 WKS.
Other Criteria	HE: TRIAL OF OR CONTRAINDICATION TO LACTULOSE OR CONCURRENT LACTULOSE THERAPY.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

RILONACEPT

Products Affected

- ARCALYST

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	<p>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.</p> <p>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.</p> <p>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.</p>
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	CAPS, DIRA: LIFETIME. RP: 12 MONTHS.

PA Criteria	Criteria Details
Other Criteria	CAPS: NO CONCURRENT USE WITH OTHER IL-1 INHIBITORS. DIRA: 1) NO CONCURRENT USE WITH OTHER IL-1 INHIBITORS, AND 2) TRIAL OF THE PREFERRED AGENT: KINERET. RP: 1) HAD AN EPISODE OF ACUTE PERICARDITIS, 2) SYMPTOM-FREE FOR 4 TO 6 WEEKS, AND 3) NO CONCURRENT USE WITH OTHER IL-1 INHIBITORS.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

RIMEGEPANT

Products Affected

- NURTEC ODT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	<p>INITIAL: ACUTE MIGRAINE TREATMENT: 1) TRIAL OF OR CONTRAINDICATION TO ONE TRIPTAN (E.G., SUMATRIPTAN, RIZATRIPTAN), AND 2) NO CONCURRENT USE WITH OTHER CGRP INHIBITORS FOR ACUTE MIGRAINE TREATMENT. EPISODIC MIGRAINE PREVENTION: 1) NO CONCURRENT USE WITH OTHER CGRP INHIBITORS FOR MIGRAINE PREVENTION, AND 2) TRIAL OF OR CONTRAINDICATION TO ONE OF THE FOLLOWING PREVENTIVE MIGRAINE TREATMENTS: DIVALPROEX SODIUM, TOPIRAMATE, PROPRANOLOL, TIMOLOL. RENEWAL: ACUTE MIGRAINE TREATMENT: 1) NO CONCURRENT USE WITH OTHER CGRP INHIBITORS FOR ACUTE MIGRAINE TREATMENT, AND 2) ONE OF THE FOLLOWING: (A) IMPROVEMENT FROM BASELINE IN A VALIDATED ACUTE TREATMENT PATIENT-REPORTED OUTCOME QUESTIONNAIRE, OR (B) THERAPY WORKS CONSISTENTLY IN MAJORITY OF MIGRAINE ATTACKS. EPISODIC MIGRAINE PREVENTION: 1) NO CONCURRENT USE WITH OTHER CGRP INHIBITORS FOR MIGRAINE PREVENTION, AND 2) REDUCTION IN MIGRAINE OR HEADACHE FREQUENCY, MIGRAINE SEVERITY, OR MIGRAINE DURATION WITH THERAPY.</p>

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

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: 12 MONTHS.
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.
Off Label Uses	

PA Criteria	Criteria Details
Part B Prerequisite	No

RIPRETINIB

Products Affected

- QINLOCK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

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 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): PRESCRIBED BY OR IN CONSULTATION WITH A GASTROENTEROLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS

PA Criteria	Criteria Details
Other Criteria	<p>INITIAL: PSO: 1) ONE OF THE FOLLOWING: (A) AT LEAST A 3 MONTH TRIAL OF ONE ORAL IMMUNOSUPPRESSANT (CYCLOSPORINE, METHOTREXATE, TACROLIMUS) OR PUVA (PHOTOTHERAPY) FOR THE TREATMENT OF PSO, (B) CONTRAINDICATION OR INTOLERANCE TO BOTH IMMUNOSUPPRESSANT AND PUVA FOR THE TREATMENT OF PSO, OR (C) PATIENT IS SWITCHING FROM A DIFFERENT BIOLOGIC, PDE-4 INHIBITOR, OR JAK INHIBITOR FOR THE SAME INDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR AN AUTOIMMUNE INDICATION. PSA: 1) TRIAL OF OR CONTRAINDICATION TO ONE DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG), AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR AN AUTOIMMUNE INDICATION. CD: 1) TRIAL OF OR CONTRAINDICATION TO ONE CONVENTIONAL THERAPY (E.G., CORTICOSTEROID [E.G., BUDESONIDE, METHYLPREDNISOLONE], AZATHIOPRINE, MERCAPTOPYRINE, METHOTREXATE, MESALAMINE), AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR AN AUTOIMMUNE INDICATION. RENEWAL: PSO, PSA: 1) CONTINUES TO BENEFIT FROM THE MEDICATION 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR AN AUTOIMMUNE INDICATION. CD: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR AN AUTOIMMUNE INDICATION.</p>
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

RISDIPLAM

Products Affected

- EVRYSDI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	SPINAL MUSCULAR ATROPHY (SMA): INITIAL: GENE MUTATION ANALYSIS INDICATING MUTATIONS OR DELETIONS OF BOTH ALLELES OF THE SURVIVAL MOTOR NEURON 1 (SMN1) GENE. FOR PRESYMPTOMATIC PATIENTS: UP TO THREE COPIES OF SURVIVAL MOTOR NEURON 2 (SMN2) BASED ON NEWBORN SCREENING.
Age Restrictions	
Prescriber Restrictions	SMA: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A NEUROMUSCULAR SPECIALIST OR SMA SPECIALIST AT A SMA SPECIALTY CENTER.
Coverage Duration	INITIAL/RENEWAL: 12 MONTHS
Other Criteria	SMA: INITIAL: FOR SYMPTOMATIC PATIENTS: 1) BASELINE MOTOR FUNCTION ASSESSMENT BY A NEUROMUSCULAR SPECIALIST OR SMA SPECIALIST, AND 2) IF PATIENT RECEIVED GENE THERAPY, PATIENT HAD LESS THAN EXPECTED CLINICAL BENEFIT WITH GENE THERAPY. RENEWAL: IMPROVED, MAINTAINED, OR DEMONSTRATED LESS THAN EXPECTED DECLINE IN: 1) MOTOR FUNCTION ASSESSMENTS COMPARED TO BASELINE, OR 2) OTHER MUSCLE FUNCTION.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

RITUXIMAB AND HYALURONIDASE HUMAN-SQ

Products Affected

- RITUXAN HYCELA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	FOLLICULAR LYMPHOMA (FL), DIFFUSE LARGE B-CELL LYMPHOMA (DLBCL), CHRONIC LYMPHOCYTIC LEUKEMIA (CLL): HAS RECEIVED OR WILL RECEIVE AT LEAST ONE FULL DOSE OF A RITUXIMAB PRODUCT BY INTRAVENOUS INFUSION PRIOR TO INITIATION OF RITUXIMAB AND HYALURONIDASE. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

RITUXIMAB-ABBS

Products Affected

- TRUXIMA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	INITIAL: RHEUMATOID ARTHRITIS (RA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST. NON-HODGKINS LYMPHOMA (NHL), CHRONIC LYMPHOCYTIC LEUKEMIA (CLL): PRESCRIBED BY OR IN CONSULTATION WITH AN ONCOLOGIST.
Coverage Duration	RA: INITIAL: 6 MO, RENEWAL: 12 MO. NHL, GPA, MPA: 12 MO. CLL: 6 MO.
Other Criteria	RA: INITIAL: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: ENBREL, HUMIRA, XELJANZ, RINVOQ, ORENCIA. RENEWAL: CONTINUES TO BENEFIT FROM THE MEDICATION. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

RITUXIMAB-ARRX

Products Affected

- RIABNI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	RHEUMATOID ARTHRITIS (RA): INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST. NON-HODGKINS LYMPHOMA (NHL), CHRONIC LYMPHOCYTIC LEUKEMIA (CLL): PRESCRIBED BY OR IN CONSULTATION WITH AN ONCOLOGIST.
Coverage Duration	RA: INITIAL: 6 MO, RENEWAL: 12 MO. NHL, GPA, MPA: 12 MO. CLL: 6 MO.
Other Criteria	RA: INITIAL: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: ENBREL, HUMIRA, XELJANZ, RINVOQ, ORENCIA. RENEWAL: CONTINUES TO BENEFIT FROM THE MEDICATION. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

RITUXIMAB-PVVR

Products Affected

- RUXIENCE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	RA: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST. NON-HODGKINS LYMPHOMA (NHL), CHRONIC LYMPHOCYTIC LEUKEMIA (CLL): PRESCRIBED BY OR IN CONSULTATION WITH AN ONCOLOGIST.
Coverage Duration	RA: INITIAL: 6 MO, RENEWAL: 12 MO. NHL, GPA, MPA: 12 MO. CLL: 6 MO.
Other Criteria	RA: INITIAL: TRIAL OF OR CONTRAINDICATION TO TWO PREFERRED AGENTS: ENBREL, HUMIRA, XELJANZ, RINVOQ, ORENCIA. RENEWAL: CONTINUES TO BENEFIT FROM THE MEDICATION. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

ROPEGINTERFERON ALFA-2B-NJFT

Products Affected

- BESREMI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

RUCAPARIB

Products Affected

- RUBRACA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	METASTATIC CASTRATION-RESISTANT PROSTATE CANCER: ONE OF THE FOLLOWING: 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

RUXOLITINIB

Products Affected

- JAKAFI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	MYELOFIBROSIS: INITIAL: 6 MONTHS, RENEWAL: 12 MONTHS. POLYCYTHEMIA VERA, GVHD: 12 MONTHS
Other Criteria	MYELOFIBROSIS: RENEWAL: CONTINUES TO BENEFIT FROM THE MEDICATION.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

SAPROPTERIN

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	PA Criteria: Pending CMS Approval
Required Medical Information	PA Criteria: Pending CMS Approval
Age Restrictions	PA Criteria: Pending CMS Approval
Prescriber Restrictions	PA Criteria: Pending CMS Approval
Coverage Duration	PA Criteria: Pending CMS Approval
Other Criteria	PA Criteria: Pending CMS Approval
Indications	PA Criteria: Pending CMS Approval
Off Label Uses	PA Criteria: Pending CMS Approval
Part B Prerequisite	No

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	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

SATRALIZUMAB-MWGE

Products Affected

- ENSPRYNG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	NEUROMYELITIS OPTICA SPECTRUM DISORDER (NMOSD): INITIAL: PRESCRIBED BY AN OPHTHALMOLOGIST OR PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST
Coverage Duration	INITIAL/RENEWAL: 12 MONTHS.
Other Criteria	NMOSD: INITIAL: 1) ONE OF THE FOLLOWING CORE CLINICAL CHARACTERISTIC: (A) OPTIC NEURITIS, (B) ACUTE MYELITIS, (C) AREA POSTREMA SYNDROME, (D) ACUTE BRAINSTEM SYNDROME, (E) SYMPTOMATIC NARCOLEPSY OR ACUTE DIENCEPHALIC CLINICAL SYNDROME WITH NMOSD-TYPICAL DIENCEPHALIC MRI LESIONS, OR (F) SYMPTOMATIC CEREBRAL SYNDROME WITH NMOSD-TYPICAL BRAIN LESIONS, AND 2) NO CONCURRENT USE WITH RITUXIMAB, INEBILIZUMAB, OR ECULIZUMAB. RENEWAL: 1) REDUCTION IN RELAPSE FREQUENCY FROM BASELINE, AND 2) NO CONCURRENT USE WITH RITUXIMAB, INEBILIZUMAB, OR ECULIZUMAB.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

SECUKINUMAB IV

Products Affected

- COSENTYX INTRAVENOUS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: 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: PSORIATIC ARTHRITIS (PSA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST OR A DERMATOLOGIST. ANKYLOSING SPONDYLITIS (AS), NR-AXSPA: PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS
Other Criteria	INITIAL: PSA: 1) TRIAL OF OR CONTRAINDICATION TO ONE DMARD (DISEASE-MODIFYING ANTI-RHEUMATIC DRUG), AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR AN AUTOIMMUNE INDICATION. AS, NR-AXSPA: 1) TRIAL OF OR CONTRAINDICATION TO AN NSAID, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR AN AUTOIMMUNE INDICATION. RENEWAL: PSA, AS, NR-AXSPA: 1) CONTINUES TO BENEFIT FROM THE MEDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR AN AUTOIMMUNE INDICATION. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

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, 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: HS: 4 MONTHS, ALL OTHER INDICATIONS: 6 MONTHS. RENEWAL: 12 MONTHS.

PA Criteria	Criteria Details
Other Criteria	<p>INITIAL: PSO: 1) ONE OF THE FOLLOWING: (A) AT LEAST A 3 MONTH TRIAL OF ONE ORAL IMMUNOSUPPRESSANT (CYCLOSPORINE, METHOTREXATE, TACROLIMUS) OR PUVA (PHOTOTHERAPY) FOR THE TREATMENT OF PSO, (B) CONTRAINDICATION OR INTOLERANCE TO BOTH IMMUNOSUPPRESSANT AND PUVA FOR THE TREATMENT OF PSO, OR (C) PATIENT IS SWITCHING FROM A DIFFERENT BIOLOGIC, PDE-4 INHIBITOR, OR JAK INHIBITOR FOR THE SAME INDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR AN AUTOIMMUNE INDICATION. PSA: 1) TRIAL OF OR CONTRAINDICATION TO ONE DMARD (DISEASE-MODIFYING ANTI-RHEUMATIC DRUG), AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR AN AUTOIMMUNE INDICATION. AS, NR-AXSPA: 1) TRIAL OF OR CONTRAINDICATION TO AN NSAID, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR AN AUTOIMMUNE INDICATION. ERA: TRIAL OF OR CONTRAINDICATION TO ONE NSAID, SULFASALAZINE, OR METHOTREXATE. HS: NO CONCURRENT USE WITH OTHER SYSTEMIC BIOLOGICS FOR HS OR OTHER IL-17 INHIBITORS FOR ANY INDICATION. RENEWAL: PSO, PSA, AS, NR-AXSPA: 1) CONTINUES TO BENEFIT FROM THE MEDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR AN AUTOIMMUNE INDICATION. ERA: CONTINUES TO BENEFIT FROM THE MEDICATION. HS: 1) NO CONCURRENT USE WITH OTHER SYSTEMIC BIOLOGICS FOR HS OR OTHER IL-17 INHIBITORS FOR ANY INDICATION, AND 2) CONTINUES TO BENEFIT FROM THE MEDICATION.</p>
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

SELADELPAR

Products Affected

- LIVDELZI

PA Criteria	Criteria Details
Exclusion Criteria	PA Criteria: Pending CMS Approval
Required Medical Information	PA Criteria: Pending CMS Approval
Age Restrictions	PA Criteria: Pending CMS Approval
Prescriber Restrictions	PA Criteria: Pending CMS Approval
Coverage Duration	PA Criteria: Pending CMS Approval
Other Criteria	PA Criteria: Pending CMS Approval
Indications	PA Criteria: Pending CMS Approval
Off Label Uses	PA Criteria: Pending CMS Approval
Part B Prerequisite	No

SELEXIPAG

Products Affected

- UPTRAVI INTRAVENOUS
- 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: 12 MONTHS
Other Criteria	PAH: INITIAL: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING AGENTS FROM DIFFERENT DRUG CLASSES: 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

SELINEXOR

Products Affected

- XPOVIO ORAL TABLET 100 MG/WEEK (50 MG X 2), 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), 80MG TWICE WEEK (160 MG/WEEK)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

SELPERCATINIB

Products Affected

- RETEVMO ORAL CAPSULE 40 MG, 80 MG
- 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	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

SELUMETINIB

Products Affected

- KOSELUGO ORAL CAPSULE 10 MG, 25 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

SILDENAFIL TABLET

Products Affected

- *sildenafil (pulm.hypertension) oral tablet*

PA Criteria	Criteria Details
Exclusion Criteria	PA Criteria: Pending CMS Approval
Required Medical Information	PA Criteria: Pending CMS Approval
Age Restrictions	PA Criteria: Pending CMS Approval
Prescriber Restrictions	PA Criteria: Pending CMS Approval
Coverage Duration	PA Criteria: Pending CMS Approval
Other Criteria	PA Criteria: Pending CMS Approval
Indications	PA Criteria: Pending CMS Approval
Off Label Uses	PA Criteria: Pending CMS Approval
Part B Prerequisite	No

SIPONIMOD

Products Affected

- MAYZENT ORAL TABLET 0.25 MG, 1 MG, 2 MG
- MAYZENT STARTER(FOR 1MG MAINT)
- MAYZENT STARTER(FOR 2MG MAINT)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL/RENEWAL: 12 MONTHS
Other Criteria	RELAPSING FORM OF MULTIPLE SCLEROSIS (MS): RENEWAL: 1) DEMONSTRATED CLINICAL BENEFIT COMPARED TO PRE-TREATMENT BASELINE, AND 2) DOES NOT HAVE LYMPHOPENIA.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

SIROLIMUS PROTEIN-BOUND

Products Affected

- FYARRO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

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: 6 MONTHS. RENEWAL: 12 MONTHS
Other Criteria	INITIAL: EDS IN NARCOLEPSY: 1) NO CONCURRENT USE WITH A SEDATIVE HYPNOTIC AGENT, 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, AND 3) AGES 7 TO 17 YEARS: TRIAL, FAILURE OF, OR CONTRAINDICATION TO 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

SODIUM PHENYLBUTYRATE TABLETS

Products Affected

- *sodium phenylbutyrate oral tablet*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	UREA CYCLE DISORDER (UCD): INITIAL: UCD IS CONFIRMED VIA ENZYMATIC, BIOCHEMICAL OR GENETIC TESTING.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL/RENEWAL: 12 MONTHS.
Other Criteria	UCD: RENEWAL: CLINICAL BENEFIT FROM BASELINE.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

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

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

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), TURNER SYNDROME (TS), NOONAN SYNDROME: HEIGHT AT LEAST 2 STANDARD DEVIATIONS BELOW THE MEAN HEIGHT FOR CHILDREN OF THE SAME AGE AND GENDER. PRADER WILLI SYNDROME (PWS): CONFIRMED GENETIC DIAGNOSIS.
Age Restrictions	
Prescriber Restrictions	INITIAL/RENEWAL: ALL INDICATIONS: PRESCRIBED BY OR IN CONSULTATION WITH AN ENDOCRINOLOGIST.
Coverage Duration	INITIAL/RENEWAL: 12 MONTHS.
Other Criteria	INITIAL: ADULT GHD: GHD ALONE OR ASSOCIATED WITH MULTIPLE HORMONE DEFICIENCIES (HYPOPHYSECTOMY), AS A RESULT OF PITUITARY DISEASE, HYPOTHALAMIC DISEASE, SURGERY, RADIATION THERAPY, OR TRAUMA, OR FOR CONTINUATION OF THERAPY FROM CHILDHOOD ONSET GHD. PEDIATRIC GHD, ISS, SGA, TS, NOONAN SYNDROME: OPEN EPIPHYSES AS CONFIRMED BY RADIOGRAPH OF THE WRIST AND HAND. RENEWAL: PEDIATRIC GHD: 1) IMPROVEMENT WHILE ON THERAPY (I.E., 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. ISS, SGA, TS, NOONAN SYNDROME: 1) IMPROVEMENT WHILE ON THERAPY (I.E., INCREASED HEIGHT OR INCREASED GROWTH VELOCITY), AND 2) OPEN EPIPHYSES AS CONFIRMED BY RADIOGRAPH OF THE WRIST AND HAND. PWS: IMPROVEMENT IN BODY COMPOSITION.

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

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	INITIAL: HIV/WASTING: ONE OF THE FOLLOWING FOR WEIGHT LOSS: 1) 10% UNINTENTIONAL WEIGHT LOSS OVER 12 MONTHS, 2) 7.5% UNINTENTIONAL WEIGHT LOSS OVER 6 MONTHS, 3) 5% BODY CELL MASS (BCM) LOSS WITHIN 6 MONTHS, 4) BCM LESS THAN 35% (MEN) OF TOTAL BODY WEIGHT AND BODY MASS INDEX (BMI) LESS THAN 27 KG PER METER SQUARED, 5) BCM LESS THAN 23% (WOMEN) OF TOTAL BODY WEIGHT AND BMI LESS THAN 27 KG PER METER SQUARED, OR 6) BMI LESS THAN 18.5 KG PER METER SQUARED.
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: 3 MONTHS.
Other Criteria	HIV/WASTING: INITIAL: 1) INADEQUATE RESPONSE TO ONE PREVIOUS THERAPY (E.G., MEGACE, APPETITE STIMULANTS, ANABOLIC STEROIDS). RENEWAL: 1) CLINICAL BENEFIT IN MUSCLE MASS AND WEIGHT.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

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	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

SORAFENIB

Products Affected

- *sorafenib*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

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: 12 MONTHS.
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

SOTORASIB

Products Affected

- LUMAKRAS ORAL TABLET 120 MG, 320 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

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: 12 MONTHS.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

SUNITINIB

Products Affected

- *sunitinib malate*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	GASTROINTESTINAL STROMAL TUMORS (GIST): TRIAL OF OR CONTRAINDICATION TO IMATINIB (GLEEVEC).
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

TADALAFIL - ADCIRCA, ALYQ

Products Affected

- *alyq*

PA Criteria	Criteria Details
Exclusion Criteria	PA Criteria: Pending CMS Approval
Required Medical Information	PA Criteria: Pending CMS Approval
Age Restrictions	PA Criteria: Pending CMS Approval
Prescriber Restrictions	PA Criteria: Pending CMS Approval
Coverage Duration	PA Criteria: Pending CMS Approval
Other Criteria	PA Criteria: Pending CMS Approval
Indications	PA Criteria: Pending CMS Approval
Off Label Uses	PA Criteria: Pending CMS Approval
Part B Prerequisite	No

TADALAFIL-CIALIS

Products Affected

- *tadalafil oral tablet 2.5 mg, 5 mg*

PA Criteria	Criteria Details
Exclusion Criteria	PA Criteria: Pending CMS Approval
Required Medical Information	PA Criteria: Pending CMS Approval
Age Restrictions	PA Criteria: Pending CMS Approval
Prescriber Restrictions	PA Criteria: Pending CMS Approval
Coverage Duration	PA Criteria: Pending CMS Approval
Other Criteria	PA Criteria: Pending CMS Approval
Indications	PA Criteria: Pending CMS Approval
Off Label Uses	PA Criteria: Pending CMS Approval
Part B Prerequisite	No

TALAZOPARIB

Products Affected

- TALZENNA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
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

TALQUETAMAB-TGVS

Products Affected

- TALVEY

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

TARLATAMAB-DLLE

Products Affected

- IMDELLTRA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

TASIMELTEON

Products Affected

- HETLIOZ LQ
- *tasimelteon*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	LIFETIME
Other Criteria	NON-24 HOUR SLEEP-WAKE DISORDER: LIGHT-INSENSITIVE OR HAS TOTAL BLINDNESS.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

TAZEMETOSTAT

Products Affected

- TAZVERIK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

TEBENTAFUSP-TEBN

Products Affected

- KIMMTRAK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

TECLISTAMAB-CQYV

Products Affected

- TECVAYLI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

TEDUGLUTIDE

Products Affected

- GATTEX 30-VIAL

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	SHORT BOWEL SYNDROME (SBS): INITIAL/RENEWAL: PRESCRIBED BY OR IN CONSULTATION WITH A GASTROENTEROLOGIST
Coverage Duration	INITIAL: 6 MONTHS, RENEWAL: 12 MONTHS
Other Criteria	SBS: INITIAL: DEPENDENT ON INTRAVENOUS PARENTERAL NUTRITION DEFINED AS REQUIRING PARENTERAL NUTRITION AT LEAST THREE TIMES PER WEEK. RENEWAL: ACHIEVED OR MAINTAINED A DECREASED NEED FOR PARENTERAL SUPPORT COMPARED TO BASELINE.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

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	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

TEPOTINIB

Products Affected

- TEPMETKO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

TERIFLUNOMIDE

Products Affected

- *teriflunomide*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

TERIPARATIDE

Products Affected

- *teriparatide subcutaneous pen injector 20 mcg/dose (620mcg/2.48ml)*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	24 MONTHS
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

TESAMORELIN

Products Affected

- EGRIFTA SV

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

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 %*
- *testosterone transdermal solution in metered pump w/app (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: 12 MONTHS
Other Criteria	MALE HYPOGONADISM: INITIAL: 1) 40 YEARS OR OLDER: PROSTATE SPECIFIC ANTIGEN (PSA) HAS BEEN EVALUATED FOR PROSTATE CANCER SCREENING. RENEWAL: 1) 40 YEARS OR OLDER: PSA HAS BEEN EVALUATED FOR PROSTATE CANCER SCREENING, AND 2) IMPROVED SYMPTOMS COMPARED TO BASELINE AND TOLERANCE TO TREATMENT.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

TESTOSTERONE CYPIONATE

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: 12 MONTHS
Other Criteria	MALE HYPOGONADISM: INITIAL: 1) 40 YEARS OR OLDER: PROSTATE SPECIFIC ANTIGEN (PSA) HAS BEEN EVALUATED FOR PROSTATE CANCER SCREENING. RENEWAL: 1) 40 YEARS OR OLDER: PSA HAS BEEN EVALUATED FOR PROSTATE CANCER SCREENING, AND 2) IMPROVED SYMPTOMS COMPARED TO BASELINE AND TOLERANCE TO TREATMENT.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

TESTOSTERONE ENANTHATE

Products Affected

- *testosterone enanthate*
- XYOSTED

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 DELAYED PUBERTY: 6MO, MALE HYPOGONADISM: 12 MO. OTHER INDICATIONS: 12 MO.
Other Criteria	INITIAL: MALE HYPOGONADISM: 1) 40 YEARS OR OLDER: PROSTATE SPECIFIC ANTIGEN (PSA) HAS BEEN EVALUATED FOR PROSTATE CANCER SCREENING. RENEWAL: MALE HYPOGONADISM: 1) 40 YEARS OR OLDER: PSA HAS BEEN EVALUATED FOR PROSTATE CANCER SCREENING, AND 2) 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

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	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

TEZACAFTOR/IVACAFTOR

Products Affected

- SYMDEKO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	CYSTIC FIBROSIS (CF): INITIAL: CONFIRMED MUTATION IN CFTR GENE ACCEPTABLE FOR THE TREATMENT OF CYSTIC FIBROSIS.
Age Restrictions	
Prescriber Restrictions	CF: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A PULMONOLOGIST OR CYSTIC FIBROSIS EXPERT
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: LIFETIME
Other Criteria	CF: RENEWAL: 1) MAINTAINED, IMPROVED, OR DEMONSTRATED LESS THAN EXPECTED DECLINE IN FEV1 OR BODY MASS INDEX (BMI), OR 2) REDUCTION IN NUMBER OF PULMONARY EXACERBATIONS.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

THALIDOMIDE

Products Affected

- THALOMID

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

TILDRAKIZUMAB-ASMN

Products Affected

- ILUMYA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	PLAQUE PSORIASIS (PSO): INITIAL: PSORIASIS COVERING 3 PERCENT OR MORE OF BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, GENITAL AREA, OR FACE.
Age Restrictions	
Prescriber Restrictions	PSO: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST.
Coverage Duration	INITIAL: 6 MONTHS, RENEWAL: 12 MONTHS.
Other Criteria	PSO: INITIAL: 1) TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: COSENTYX, ENBREL, HUMIRA, STELARA, SKYRIZI, TREMFYA, OTEZLA, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR AN AUTOIMMUNE INDICATION. RENEWAL: 1) CONTINUES TO BENEFIT FROM THE MEDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR AN AUTOIMMUNE INDICATION.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

TISLELIZUMAB-JSGR

Products Affected

- TEVIMBRA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

TISOTUMAB VEDOTIN-TFTV

Products Affected

- TIVDAK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

TIVOZANIB

Products Affected

- FOTIVDA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

TOCILIZUMAB IV

Products Affected

- ACTEMRA

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: RA, PJIA, SJIA, GCA: 6 MONTHS. CRS: 1 MONTH. RENEWAL: RA, PJIA, SJIA, GCA: 12 MONTHS.

PA Criteria	Criteria Details
Other Criteria	<p>INITIAL: RA: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: ENBREL, HUMIRA, XELJANZ, RINVOQ, ORENCIA. PJIA: 1) TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: ENBREL, HUMIRA, XELJANZ IR, ORENCIA, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR AN AUTOIMMUNE INDICATION. SJIA: 1) TRIAL OF OR CONTRAINDICATION TO ONE DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG), AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR AN AUTOIMMUNE INDICATION. RENEWAL: RA: CONTINUES TO BENEFIT FROM THE MEDICATION. PJIA, SJIA: 1) CONTINUES TO BENEFIT FROM THE MEDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR AN AUTOIMMUNE INDICATION.</p>
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

TOCILIZUMAB SQ

Products Affected

- ACTEMRA
- ACTEMRA ACTPEN

PA Criteria	Criteria Details
Exclusion Criteria	PA Criteria: Pending CMS Approval
Required Medical Information	PA Criteria: Pending CMS Approval
Age Restrictions	PA Criteria: Pending CMS Approval
Prescriber Restrictions	PA Criteria: Pending CMS Approval
Coverage Duration	PA Criteria: Pending CMS Approval
Other Criteria	PA Criteria: Pending CMS Approval
Indications	PA Criteria: Pending CMS Approval
Off Label Uses	PA Criteria: Pending CMS Approval
Part B Prerequisite	No

TOFACITINIB

Products Affected

- XELJANZ
- XELJANZ XR

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: 6 MONTHS. RENEWAL: 12 MONTHS.

PA Criteria	Criteria Details
Other Criteria	<p>INITIAL: RA: TRIAL OF OR CONTRAINDICATION TO 3 MONTHS OF TREATMENT WITH ONE DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG) - IF A PATIENT TRIED METHOTREXATE, THEN TRIAL AT A DOSE GREATER THAN OR EQUAL TO 20 MG PER WEEK OR MAXIMALLY TOLERATED DOSE IS REQUIRED. PSA, PCJIA: 1) TRIAL OF OR CONTRAINDICATION TO ONE DMARD, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR AN AUTOIMMUNE INDICATION. AS: 1) TRIAL OF OR CONTRAINDICATION TO AN NSAID, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR AN AUTOIMMUNE INDICATION. UC: 1) TRIAL OF OR CONTRAINDICATION TO ONE CONVENTIONAL THERAPY (E.G., CORTICOSTEROID [E.G., BUDESONIDE, METHYLPREDNISOLONE], AZATHIOPRINE, MERCAPTOPYRINE, METHOTREXATE, MESALAMINE), AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR AN AUTOIMMUNE INDICATION. RENEWAL: RA: CONTINUES TO BENEFIT FROM THE MEDICATION. PSA, AS, PCJIA: 1) CONTINUES TO BENEFIT FROM THE MEDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR AN AUTOIMMUNE INDICATION. UC: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR AN AUTOIMMUNE INDICATION.</p>
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

TOLVAPTAN

Products Affected

- JYNARQUE ORAL TABLET
- JYNARQUE ORAL TABLETS, SEQUENTIAL

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	AUTOSOMAL DOMINANT POLYCYSTIC KIDNEY DISEASE (ADPKD): INITIAL: 1) CONFIRMED POLYCYSTIC KIDNEY DISEASE VIA CT, MRI, OR ULTRASOUND, AND 2) GENETIC TESTING FOR CAUSATIVE MUTATIONS OR FAMILY HISTORY OF CONFIRMED POLYCYSTIC KIDNEY DISEASE IN ONE OR BOTH PARENTS.
Age Restrictions	
Prescriber Restrictions	ADPKD: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A NEPHROLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	ADPKD: INITIAL: DOES NOT HAVE ESRD (I.E., RECEIVING DIALYSIS OR HAS UNDERGONE RENAL TRANSPLANT). RENEWAL: HAS NOT PROGRESSED TO ESRD/DIALYSIS OR TRANSPLANT.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

TOPICAL TRETINOIN

Products Affected

- ALTRENO
- *tretinoin*

PA Criteria	Criteria Details
Exclusion Criteria	COSMETIC INDICATIONS SUCH AS WRINKLES, PHOTOAGING, MELASMA.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
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

TORIPALIMAB-TPZI

Products Affected

- LOQTORZI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	NASOPHARYNGEAL CARCINOMA (NPC): FIRST LINE TREATMENT: 24 MOS, PREVIOUSLY TREATED: LIFETIME.
Other Criteria	THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

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	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

TRAMETINIB SOLUTION

Products Affected

- MEKINIST ORAL RECON SOLN

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
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

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	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

TRASTUZUMAB-ANNS

Products Affected

- KANJINTI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	ADJUVANT BREAST CANCER, METASTATIC BREAST CANCER: TRIAL OF OR CONTRAINDICATION TO ONE OF THE FOLLOWING PREFERRED AGENTS: HERZUMA, OGIVRI, ONTRUZANT, TRAZIMERA. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

TRASTUZUMAB-DKST

Products Affected

- OGIVRI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

TRASTUZUMAB-DTTB

Products Affected

- ONTRUZANT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

TRASTUZUMAB-HYALURONIDASE-OYSK

Products Affected

- HERCEPTIN HYLECTA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
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

TRASTUZUMAB-PKRB

Products Affected

- HERZUMA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

TRASTUZUMAB-QYYP

Products Affected

- TRAZIMERA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

TREMELIMUMAB-ACTL

Products Affected

- IMJUDO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	UHCC: 30 DAYS. METASTATIC NON-SMALL CELL LUNG CANCER (NSCLC): 5 MONTHS.
Other Criteria	UNRESECTABLE HEPATOCELLULAR CARCINOMA (UHCC): HAS NOT RECEIVED PRIOR TREATMENT WITH IMJUDO. NSCLC: HAS NOT RECEIVED A TOTAL OF 5 DOSES OF IMJUDO.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

TREPROSTINIL INHALED

Products Affected

- TYVASO

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: PAH: 12 MONTHS, PH-ILD: 6 MONTHS. RENEWAL: PAH, PH-ILD: 12 MONTHS.
Other Criteria	INITIAL: PAH: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING AGENTS FROM DIFFERENT DRUG CLASSES: 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, 4) FORMULARY VERSION OF AN IV/SQ PROSTACYCLIN. THIS DRUG MAY BE COVERED UNDER MEDICARE PART B OR D DEPENDING UPON THE CIRCUMSTANCES.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

TREPROSTINIL INJECTABLE

Products Affected

- *treprostinil sodium*

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: 12 MONTHS
Other Criteria	PAH: INITIAL: 1) CONTINUATION OF THERAPY FROM HOSPITAL DISCHARGE, 2) NEW START AND PHYSICIAN INDICATED PATIENT IS INTERMEDIATE OR HIGH RISK, OR 3) NEW START AND TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING AGENTS FROM DIFFERENT DRUG CLASSES: (A) FORMULARY VERSION OF AN ORAL ENDOTHELIN RECEPTOR ANTAGONIST, (B) FORMULARY VERSION OF AN ORAL PHOSPHODIESTERASE TYPE-5 INHIBITOR FOR PAH, (C) FORMULARY VERSION OF AN ORAL CGMP STIMULATOR. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	

PA Criteria	Criteria Details
Part B Prerequisite	No

TRIENTINE CAPSULE

Products Affected

- *trientine oral capsule 250 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	WILSONS DISEASE: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A HEPATOLOGIST OR GASTROENTEROLOGIST.
Coverage Duration	INITIAL: 12 MONTHS, RENEWAL: LIFETIME.
Other Criteria	WILSONS DISEASE: INITIAL: 1) LEIPZIG SCORE OF 4 OR GREATER, AND 2) TRIAL OF OR CONTRAINDICATION TO FORMULARY VERSION OF PENICILLAMINE TABLET. RENEWAL: CONTINUES TO BENEFIT FROM THE MEDICATION.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

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	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

TRIPTORELIN-TRELSTAR

Products Affected

- TRELSTAR INTRAMUSCULAR
SUSPENSION FOR RECONSTITUTION

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS.
Other Criteria	THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

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	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

UBROGEPANT

Products Affected

- UBRELVY

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	ACUTE MIGRAINE TREATMENT: INITIAL: 1) TRIAL OF OR CONTRAINDICATION TO ONE TRIPTAN (E.G., SUMATRIPTAN, RIZATRIPTAN), AND 2) NO CONCURRENT USE WITH OTHER CGRP INHIBITORS FOR ACUTE MIGRAINE TREATMENT. RENEWAL: 1) NO CONCURRENT USE WITH OTHER CGRP INHIBITORS FOR ACUTE MIGRAINE TREATMENT, AND 2) ONE OF THE FOLLOWING: (A) IMPROVEMENT FROM BASELINE IN A VALIDATED ACUTE TREATMENT PATIENT-REPORTED OUTCOME QUESTIONNAIRE, OR (B) THERAPY WORKS CONSISTENTLY IN MAJORITY OF MIGRAINE ATTACKS.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

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). ATOPIC DERMATITIS (AD): ATOPIC DERMATITIS COVERING AT LEAST 10 PERCENT OF BODY SURFACE AREA OR ATOPIC DERMATITIS AFFECTING THE FACE, HEAD, NECK, HANDS, FEET, GROIN, OR INTERTRIGINOUS AREAS
Age Restrictions	
Prescriber Restrictions	INITIAL: RHEUMATOID ARTHRITIS (RA), ANKYLOSING SPONDYLITIS (AS), NR-AXSPA: PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST. PSORIATIC ARTHRITIS: PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST OR DERMATOLOGIST. 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: 6 MONTHS. RENEWAL: 12 MONTHS.

PA Criteria	Criteria Details
Other Criteria	<p>INITIAL: RA: TRIAL OF OR CONTRAINDICATION TO 3 MONTHS OF TREATMENT WITH ONE DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG) - IF A PATIENT TRIED METHOTREXATE, THEN TRIAL AT A DOSE GREATER THAN OR EQUAL TO 20 MG PER WEEK OR MAXIMALLY TOLERATED DOSE IS REQUIRED. PSA: 1) TRIAL OF OR CONTRAINDICATION TO ONE DMARD, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR AN AUTOIMMUNE INDICATION. AD: 1) INTRACTABLE PRURITUS OR CRACKING/OOZING/BLEEDING OF AFFECTED SKIN, 2) TRIAL OF OR CONTRAINDICATION TO A TOPICAL CORTICOSTEROID, TOPICAL CALCINEURIN INHIBITOR, TOPICAL PDE4 INHIBITOR, OR TOPICAL JAK INHIBITOR, AND 3) NO CONCURRENT USE WITH OTHER SYSTEMIC BIOLOGICS FOR ATOPIC DERMATITIS OR OTHER JAK INHIBITORS FOR ANY INDICATION. UC, CD: 1) TRIAL OF OR CONTRAINDICATION TO ONE CONVENTIONAL THERAPY (E.G., CORTICOSTEROID [E.G., BUDESONIDE, METHYLPREDNISOLONE], AZATHIOPRINE, MERCAPTOPYRINE, METHOTREXATE, MESALAMINE), AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR AN AUTOIMMUNE INDICATION. AS, NR-AXSPA: 1) TRIAL OF OR CONTRAINDICATION TO AN NSAID (NON-STEROIDAL ANTI-INFLAMMATORY DRUG), AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR AN AUTOIMMUNE INDICATION. RENEWAL: RA: CONTINUES TO BENEFIT FROM THE MEDICATION. AD: 1) IMPROVEMENT WHILE ON THERAPY, AND 2) NO CONCURRENT USE WITH OTHER SYSTEMIC BIOLOGICS FOR ATOPIC DERMATITIS OR OTHER JAK INHIBITOR FOR ANY INDICATION. PSA, AS, NR-AXSPA: 1) CONTINUES TO BENEFIT FROM THE MEDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC</p>
	<p>BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR AN AUTOIMMUNE INDICATION. UC, CD: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR AN AUTOIMMUNE INDICATION.</p>
Indications	All FDA-approved Indications.

PA Criteria	Criteria Details
Off Label Uses	
Part B Prerequisite	No

USTEKINUMAB

Products Affected

- STELARA

PA Criteria	Criteria Details
Exclusion Criteria	PA Criteria: Pending CMS Approval
Required Medical Information	PA Criteria: Pending CMS Approval
Age Restrictions	PA Criteria: Pending CMS Approval
Prescriber Restrictions	PA Criteria: Pending CMS Approval
Coverage Duration	PA Criteria: Pending CMS Approval
Other Criteria	PA Criteria: Pending CMS Approval
Indications	PA Criteria: Pending CMS Approval
Off Label Uses	PA Criteria: Pending CMS Approval
Part B Prerequisite	No

USTEKINUMAB IV

Products Affected

- STELARA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	CROHNS DISEASE (CD), ULCERATIVE COLITIS (UC): PRESCRIBED BY OR IN CONSULTATION WITH A GASTROENTEROLOGIST.
Coverage Duration	2 MONTHS
Other Criteria	CD, UC: 1) TRIAL OF OR CONTRAINDICATION TO ONE CONVENTIONAL THERAPY (E.G., CORTICOSTEROID [E.G., BUDESONIDE, METHYLPREDNISOLONE], AZATHIOPRINE, MERCAPTOPYRINE, METHOTREXATE, MESALAMINE), AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE- 4 INHIBITOR) FOR AN AUTOIMMUNE INDICATION. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

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	12 MONTHS
Other Criteria	TD: HISTORY OF USING AGENTS THAT CAUSE TARDIVE DYSKINESIA.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

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	12 MONTHS
Other Criteria	CURRENTLY STABLE ON CAPRELSA REQUIRES NO EXTRA CRITERIA.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

VEMURAFENIB

Products Affected

- ZELBORAF

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
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

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	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

VERICIGUAT

Products Affected

- VERQUVO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL/RENEWAL:12 MONTHS.
Other Criteria	HEART FAILURE (HF): INITIAL: 1) NO CONCURRENT USE WITH LONG-ACTING NITRATES OR NITRIC OXIDE DONORS, RIOCIGUAT, OR PDE-5 INHIBITORS, 2) TRIAL OF OR CONTRAINDICATION TO ONE PREFERRED SGLT-2 INHIBITOR, AND 3) TRIAL OF OR CONTRAINDICATION TO ONE AGENT FROM ANY OF THE FOLLOWING STANDARD OF CARE CLASSES: (A) ACE INHIBITOR, ARB, OR ARNI, (B) BETA BLOCKER (I.E., BISOPROLOL, CARVEDILOL, METOPROLOL SUCCINATE), OR (C) ALDOSTERONE ANTAGONIST (I.E., SPIRONOLACTONE, EPLERENONE). RENEWAL: NO CONCURRENT USE WITH LONG-ACTING NITRATES OR NITRIC OXIDE DONORS, RIOCIGUAT, OR PDE-5 INHIBITORS.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

VIGABATRIN

Products Affected

- *vigabatin*
- *vigadrone*
- *vigpoder*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	REFRACTORY COMPLEX PARTIAL SEIZURES (CPS), INFANTILE SPASMS: PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST.
Coverage Duration	12 MONTHS
Other Criteria	CPS: TRIAL OF OR CONTRAINDICATION TO TWO ANTIEPILEPTIC AGENTS.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

VISMODEGIB

Products Affected

- ERIVEDGE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

VORASIDENIB

Products Affected

- VORANIGO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

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: 6 MOS.
Other Criteria	CANDIDA INFECTIONS: 1) TRIAL OF OR CONTRAINDICATION TO FLUCONAZOLE, AND 2) UNABLE TO SWALLOW 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

ZANUBRUTINIB

Products Affected

- BRUKINSA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	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

INDEX

1ST TIER UNIFINE PENTP 5MM 31G... 179	ALCOHOL WIPES..... 179
1ST TIER UNIFINE PNTIP 4MM 32G..... 179	ALECENSA..... 15
1ST TIER UNIFINE PNTIP 6MM 31G..... 179	ALTRENO.....386
1ST TIER UNIFINE PNTIP 8MM 31G	ALUNBRIG ORAL TABLET 180 MG, 30
STRL,SINGLE-USE,SHRT 179	MG, 90 MG..... 56
1ST TIER UNIFINE PNTIP 29GX1/2" 179	ALUNBRIG ORAL TABLETS,DOSE
1ST TIER UNIFINE PNTIP 31GX3/16..... 179	PACK..... 56
1ST TIER UNIFINE PNTIP 32GX5/32 179	ALVAIZ..... 112
<i>abiraterone</i> 7	<i>alyq</i> 355
ABOUTTIME PEN NEEDLE 30G X	<i>ambrisentan</i> 17
8MM..... 179	ANKTIVA.....257
ABOUTTIME PEN NEEDLE 31G X	<i>apomorphine</i>.....23
5MM..... 179	AQINJECT PEN NEEDLE 31G 5MM..... 179
ABOUTTIME PEN NEEDLE 31G X	AQINJECT PEN NEEDLE 32G 4MM..... 179
8MM..... 179	ARCALYST..... 310
ABOUTTIME PEN NEEDLE 32G X	ARIKAYCE.....18
4MM..... 179	<i>armodafinil</i> 244
ACTEMRA.....380, 382	ASSURE ID DUO PRO NDL 31G 5MM.. 179
ACTEMRA ACTPEN..... 382	ASSURE ID DUO-SHIELD 30GX3/16" ... 179
ACTHAR..... 76	ASSURE ID DUO-SHIELD 30GX5/16" ... 179
ACTHAR SELFJECT SUBCUTANEOUS	ASSURE ID INSULIN SAFETY
PEN INJECTOR 40 UNIT/0.5 ML, 80	SYRINGE 1 ML 29 GAUGE X 1/2" 179
UNIT/ML.....76	ASSURE ID PEN NEEDLE 30GX3/16" ... 179
ACTIMMUNE.....191	ASSURE ID PEN NEEDLE 30GX5/16" ... 179
ADEMPAS..... 314	ASSURE ID PEN NEEDLE 31GX3/16" ... 179
ADVOCATE INS 0.3 ML 30GX5/16" 179	ASSURE ID PRO PEN NDL 30G 5MM... 179
ADVOCATE INS 0.3 ML 31GX5/16" 179	ASSURE ID SYR 0.5 ML 29GX1/2" (RX)
ADVOCATE INS 0.5 ML 30GX5/16" 179	..... 179
ADVOCATE INS 0.5 ML 31GX5/16" 179	ASSURE ID SYR 0.5 ML 31GX15/64" 179
ADVOCATE INS 1 ML 31GX5/16"..... 179	ASSURE ID SYR 1 ML 31GX15/64"..... 179
ADVOCATE INS SYR 0.3 ML 29GX1/2. 179	AUGTYRO.....303
ADVOCATE INS SYR 0.5 ML 29GX1/2. 179	AUSTEDO ORAL TABLET 12 MG, 6
ADVOCATE INS SYR 1 ML 29GX1/2".. 179	MG, 9 MG..... 91
ADVOCATE INS SYR 1 ML 30GX5/16.. 179	AUSTEDO XR ORAL TABLET
ADVOCATE PEN NDL 12.7MM 29G..... 179	EXTENDED RELEASE 24 HR 12 MG, 18
ADVOCATE PEN NEEDLE 32G 4MM... 179	MG, 24 MG, 30 MG, 36 MG, 42 MG, 48
ADVOCATE PEN NEEDLE 4MM 33G... 179	MG, 6 MG..... 91
ADVOCATE PEN NEEDLES 5MM 31G. 179	AUSTEDO XR TITRATION KT(WK1-4)..91
ADVOCATE PEN NEEDLES 8MM 31G. 179	AVONEX INTRAMUSCULAR PEN
AJOVY AUTOINJECTOR..... 139	INJECTOR KIT .....188
AJOVY SYRINGE.....139	AVONEX INTRAMUSCULAR
AKEEGA.....252	SYRINGE KIT 188
ALCOHOL 70% SWABS 179	AVONEX PEN 30 MCG/0.5 ML.....188
ALCOHOL PADS..... 179	AVSOLA..... 171
ALCOHOL PREP SWABS..... 179	AYVAKIT 34

BALVERSA ORAL TABLET 3 MG, 4 MG, 5 MG.....	122	BENDAMUSTINE INTRAVENOUS SOLUTION.....	44
BD AUTOSHIELD DUO NDL 5MMX30G.....	179	BENDEKA.....	44
BD ECLIPSE 30GX1/2" SYRINGE.....	179	BENLYSTA SUBCUTANEOUS.....	41
BD ECLIPSE NEEDLE 30GX1/2" (OTC)	179	BESREMI.....	324
BD INS SYR 0.3 ML 8MMX31G(1/2).....	179	<i>betaine</i>	47
BD INS SYRINGE 1/2 ML 6MMX31G (ONLY FOR 500 UNIT/ML INSULIN)....	179	BETASERON SUBCUTANEOUS KIT	189
BD INS SYRN UF 1 ML 12.7MMX30G NOT FOR RETAIL SALE.....	179	<i>bexarotene</i>	51
BD INSULIN SYR 1 ML 25GX1".....	179	BORDERED GAUZE 2"X2".....	179
BD INSULIN SYR 1 ML 25GX5/8".....	179	<i>bortezomib injection</i>	53
BD INSULIN SYR 1 ML 26GX1/2".....	179	<i>bosentan</i>	54
BD INSULIN SYR 1 ML 27GX5/8" MICRO-FINE.....	179	BOSULIF ORAL CAPSULE 100 MG, 50 MG.....	55
BD INSULIN SYR 1 ML 28GX1/2" (OTC).....	179	BOSULIF ORAL TABLET 100 MG, 400 MG, 500 MG.....	55
BD INSULIN SYRINGE 1 ML W/O NEEDLE.....	179	BRAFTOVI.....	115
BD LUER-LOK SYRINGE 1 ML.....	179	BRUKINSA.....	420
BD NANO 2 GEN PEN NDL 32G 4MM..	179	CABLIVI INJECTION KIT.....	65
BD SAFETGLD INS 0.3 ML 29G 13MM.	179	CABOMETYX ORAL TABLET 20 MG, 40 MG, 60 MG.....	60
BD SAFETGLD INS 0.5 ML 13MMX29G.....	179	CALQUENCE.....	9
BD SAFETYGLD INS 0.3 ML 31G 8MM	179	CALQUENCE (ACALABRUTINIB MAL).....	9
BD SAFETYGLD INS 0.5 ML 30G 8MM	179	CAPRELSA ORAL TABLET 100 MG, 300 MG.....	412
BD SAFETYGLD INS 1 ML 29G 13MM.	179	CAREFINE PEN NEEDLE 12.7MM 29G.	179
BD SAFETYGLID INS 1 ML 6MMX31G	179	CAREFINE PEN NEEDLE 4MM 32G.....	179
BD SAFETYGLIDE SYRINGE 27GX5/8	179	CAREFINE PEN NEEDLE 5MM 32G.....	179
BD SAFTYGLD INS 0.3 ML 6MMX31G	179	CAREFINE PEN NEEDLE 6MM 31G.....	179
BD SAFTYGLD INS 0.5 ML 29G 13MM	179	CAREFINE PEN NEEDLE 8MM 30G.....	179
BD SAFTYGLD INS 0.5 ML 6MMX31G	179	CAREFINE PEN NEEDLES 6MM 32G...	179
BD SINGLE USE SWAB.....	179	CAREFINE PEN NEEDLES 8MM 31G...	179
BD UF MICRO PEN NEEDLE 6MMX32G.....	179	CARETOUCH ALCOHOL 70% PREP PAD.....	179
BD UF MINI PEN NEEDLE 5MMX31G.	179	CARETOUCH PEN NEEDLE 29G 12MM.....	179
BD UF NANO PEN NEEDLE 4MMX32G.....	179	CARETOUCH PEN NEEDLE 31GX1/4" .	179
BD UF ORIG PEN NDL 12.7MMX29G...	179	CARETOUCH PEN NEEDLE 31GX3/16".....	179
BD UF SHORT PEN NEEDLE 8MMX31G.....	179	CARETOUCH PEN NEEDLE 31GX5/16".....	179
BD VEO INS 0.3 ML 6MMX31G (1/2)....	179	CARETOUCH PEN NEEDLE 32GX3/16".....	179
BD VEO INS SYRING 1 ML 6MMX31G	179	CARETOUCH PEN NEEDLE 32GX5/32".....	179
BD VEO INS SYRN 0.3 ML 6MMX31G.	179	CARETOUCH SYR 0.3 ML 31GX5/16"..	179
BD VEO INS SYRN 0.5 ML 6MMX31G.	179	CARETOUCH SYR 0.5 ML 30GX5/16"..	179
<i>bendamustine intravenous recon soln</i>	44		

CARETOUCH SYR 0.5 ML 31GX5/16" ..	179	COMFORT EZ PEN NEEDLES 6MM	
CARETOUCH SYR 1 ML 28GX5/16"	179	33G.....	179
CARETOUCH SYR 1 ML 29GX5/16"	179	COMFORT EZ PEN NEEDLES 8MM	
CARETOUCH SYR 1 ML 30GX5/16"	179	31G SHORT	179
CARETOUCH SYR 1 ML 31GX5/16"	179	COMFORT EZ PEN NEEDLES 8MM	
<i>carglumic acid</i>	67	32G.....	179
CAYSTON.....	38	COMFORT EZ PEN NEEDLES 8MM	
CERDELGA.....	110	33G.....	179
CIMZIA POWDER FOR RECONST.....	69	COMFORT EZ PRO PEN NDL 30G 8MM	
CIMZIA SUBCUTANEOUS SYRINGE		.....	179
KIT 400 MG/2 ML (200 MG/ML X 2).....	69	COMFORT EZ PRO PEN NDL 31G 4MM	
CINQAIR.....	304	.....	179
CINRYZE.....	57	COMFORT EZ PRO PEN NDL 31G 5MM	
CLICKFINE 31G X 5/16" NEEDLES		.....	179
8MM, UNIVERSAL.....	179	COMFORT EZ SYR 0.3 ML 29GX1/2"	179
CLICKFINE PEN NEEDLE 32GX5/32"		COMFORT EZ SYR 0.5 ML 28GX1/2"	179
32GX4MM, STERILE.....	179	COMFORT EZ SYR 0.5 ML 29GX1/2"	179
CLICKFINE UNIVERSAL 31G X 1/4"		COMFORT EZ SYR 0.5 ML 30GX1/2"	179
6MM, STORE BRAND.....	179	COMFORT EZ SYR 1 ML 28GX1/2"	179
COMETRIQ ORAL CAPSULE 100		COMFORT EZ SYR 1 ML 29GX1/2"	179
MG/DAY(80 MG X1-20 MG X1), 140		COMFORT EZ SYR 1 ML 30GX1/2"	179
MG/DAY(80 MG X1-20 MG X3), 60		COMFORT EZ SYR 1 ML 30GX5/16"	179
MG/DAY (20 MG X 3/DAY).....	59	COMFORT POINT PEN NDL 31GX1/3" .	179
COMFORT EZ 0.3 ML 31G 15/64"	179	COMFORT POINT PEN NDL 31GX1/6" .	179
COMFORT EZ 0.5 ML 31G 15/64"	179	COMFORT TOUCH PEN NDL 31G 4MM	
COMFORT EZ INS 0.3 ML 30GX1/2"	179	.....	179
COMFORT EZ INS 0.3 ML 30GX5/16" ...	179	COMFORT TOUCH PEN NDL 31G 5MM	
COMFORT EZ INS 1 ML 31G 15/64"	179	.....	179
COMFORT EZ INS 1 ML 31GX5/16"	179	COMFORT TOUCH PEN NDL 31G 6MM	
COMFORT EZ INSULIN SYR 0.3 ML....	179	.....	179
COMFORT EZ INSULIN SYR 0.5 ML....	179	COMFORT TOUCH PEN NDL 31G 8MM	
COMFORT EZ PEN NEEDLE 12MM		.....	179
29G.....	179	COMFORT TOUCH PEN NDL 32G 4MM	
COMFORT EZ PEN NEEDLES 4MM		.....	179
32G SINGLE USE, MICRO.....	179	COMFORT TOUCH PEN NDL 32G 5MM	
COMFORT EZ PEN NEEDLES 4MM		.....	179
33G.....	179	COMFORT TOUCH PEN NDL 32G 6MM	
COMFORT EZ PEN NEEDLES 5MM		.....	179
31G MINI.....	179	COMFORT TOUCH PEN NDL 32G 8MM	
COMFORT EZ PEN NEEDLES 5MM		.....	179
32G SINGLE USE,MINI,HRI.....	179	COMFORT TOUCH PEN NDL 33G 4MM	
COMFORT EZ PEN NEEDLES 5MM		.....	179
33G.....	179	COMFORT TOUCH PEN NDL 33G 6MM	
COMFORT EZ PEN NEEDLES 6MM		.....	179
31G.....	179	COMFORT TOUCH PEN NDL	
COMFORT EZ PEN NEEDLES 6MM		33GX5MM.....	179
32G.....	179	COPIKTRA.....	102

CORTROPHIN GEL.....	76	DROPLET INS 0.3 ML 29GX12.5MM.....	179
COSENTYX (2 SYRINGES).....	332	DROPLET INS 0.3 ML 30GX12.5MM.....	179
COSENTYX INTRAVENOUS.....	330	DROPLET INS 0.5 ML 30GX6MM(1/2)..	179
COSENTYX PEN (2 PENS).....	332	DROPLET INS 0.5 ML 30GX8MM(1/2)..	179
COSENTYX SUBCUTANEOUS		DROPLET INS 0.5 ML 31GX6MM(1/2)..	179
SYRINGE 75 MG/0.5 ML.....	332	DROPLET INS 0.5 ML 31GX8MM(1/2)..	179
COSENTYX UNOREADY PEN.....	332	DROPLET INS SYR 0.3 ML 30GX6MM.	179
COTELLIC.....	75	DROPLET INS SYR 0.3 ML 30GX8MM.	179
CURAD GAUZE PADS 2" X 2".....	179	DROPLET INS SYR 0.3 ML 31GX6MM.	179
CURITY ALCOHOL PREPS 2		DROPLET INS SYR 0.3 ML 31GX8MM.	179
PLY,MEDIUM.....	179	DROPLET INS SYR 1 ML 29GX12.5MM	
CURITY GAUZE SPONGES (12 PLY)-		.....	179
200/BAG.....	179	DROPLET INS SYR 1 ML 30GX12.5MM	
CURITY GAUZE PADS 1'S(12 PLY).....	179	.....	179
<i>dalfampridine</i>	82	DROPLET INS SYR 1 ML 30GX6MM....	179
DANYELZA.....	245	DROPLET INS SYR 1 ML 30GX8MM....	179
DARZALEX.....	83	DROPLET INS SYR 1 ML 31GX6MM....	179
DARZALEX FASPRO.....	84	DROPLET INS SYR 1 ML 31GX8MM....	179
<i>dasatinib oral tablet 100 mg, 140 mg, 20</i>		DROPLET MICRON 34G X 9/64".....	179
<i>mg, 50 mg, 70 mg, 80 mg</i>	86	DROPLET PEN NEEDLE 29GX1/2".....	179
DAURISMO ORAL TABLET 100 MG, 25		DROPLET PEN NEEDLE 29GX3/8".....	179
MG.....	146	DROPLET PEN NEEDLE 30GX5/16".....	179
<i>deferasirox</i>	88	DROPLET PEN NEEDLE 31GX1/4".....	179
<i>deferiprone</i>	89	DROPLET PEN NEEDLE 31GX3/16".....	179
DERMACEA 2"X2" GAUZE 12 PLY,		DROPLET PEN NEEDLE 31GX5/16".....	179
USP TYPE VII.....	179	DROPLET PEN NEEDLE 32GX1/4".....	179
DERMACEA GAUZE 2"X2" SPONGE 8		DROPLET PEN NEEDLE 32GX3/16".....	179
PLY.....	179	DROPLET PEN NEEDLE 32GX5/16".....	179
DERMACEA NON-WOVEN 2"X2"		DROPLET PEN NEEDLE 32GX5/32".....	179
SPNGE.....	179	DROPSAFE ALCOHOL 70% PREP	
<i>dermacinrx lidocan 5% patch outer</i>	216	PADS.....	179
DIACOMIT ORAL CAPSULE 250 MG,		DROPSAFE INS SYR 0.3 ML 31G 6MM	179
500 MG.....	353	DROPSAFE INS SYR 0.3 ML 31G 8MM	179
DIACOMIT ORAL POWDER IN		DROPSAFE INS SYR 0.5 ML 31G 6MM	179
PACKET 250 MG, 500 MG.....	353	DROPSAFE INS SYR 0.5 ML 31G 8MM	179
<i>diclofenac sodium topical gel 3 %</i>	92	DROPSAFE INSUL SYR 1 ML 31G	
<i>diclofenac sodium topical solution in</i>		6MM.....	179
<i>metered-dose pump</i>	93	DROPSAFE INSUL SYR 1 ML 31G	
<i>dimethyl fumarate oral capsule, delayed</i>		8MM.....	179
<i>release(dr/ec) 120 mg, 120 mg (14)- 240</i>		DROPSAFE INSULN 1 ML 29G 12.5MM	
<i>mg (46), 240 mg</i>	94	.....	179
DOPTELET (10 TAB PACK).....	35	DROPSAFE PEN NEEDLE 31GX1/4".....	179
DOPTELET (15 TAB PACK).....	35	DROPSAFE PEN NEEDLE 31GX3/16" ...	179
DOPTELET (30 TAB PACK).....	35	DROPSAFE PEN NEEDLE 31GX5/16" ...	179
<i>dronabinol</i>	97	<i>droxidopa</i>	98
DROPLET 0.5 ML 29GX12.5MM(1/2).....	179	DRUG MART ULTRA COMFORT SYR.	179
DROPLET 0.5 ML 30GX12.5MM(1/2).....	179	DUPIXENT PEN.....	99

DUPIXENT SYRINGE.....	99	EASY TOUCH INSULN 1 ML 30GX5/16	179
EASY CMFT SFTY PEN NDL 31G 5MM	179	EASY TOUCH INSULN 1 ML 31GX5/16	179
EASY CMFT SFTY PEN NDL 31G 6MM	179	EASY TOUCH LUER LOK INSUL 1 ML	179
EASY CMFT SFTY PEN NDL 32G 4MM	179	EASY TOUCH PEN NEEDLE 29GX1/2"	179
EASY COMFORT 0.3 ML 31G 1/2"	179	EASY TOUCH PEN NEEDLE 30GX5/16	179
EASY COMFORT 0.3 ML 31G 5/16"	179	EASY TOUCH PEN NEEDLE 31GX1/4"	179
EASY COMFORT 0.3 ML SYRINGE.....	179	EASY TOUCH PEN NEEDLE 31GX3/16	179
EASY COMFORT 0.5 ML 30GX1/2"	179	EASY TOUCH PEN NEEDLE 31GX5/16	179
EASY COMFORT 0.5 ML 31GX5/16"	179	EASY TOUCH PEN NEEDLE 32GX1/4"	179
EASY COMFORT 0.5 ML 32GX5/16"	179	EASY TOUCH PEN NEEDLE 32GX3/16	179
EASY COMFORT 0.5 ML SYRINGE.....	179	EASY TOUCH PEN NEEDLE 32GX5/32	179
EASY COMFORT 1 ML 31GX5/16"	179	EASY TOUCH SAF PEN NDL 29G 5MM	
EASY COMFORT 1 ML 32GX5/16"	179	.....	179
EASY COMFORT ALCOHOL 70% PAD	179	EASY TOUCH SAF PEN NDL 29G 8MM	
EASY COMFORT INSULIN 1 ML SYR..	179	.....	179
EASY COMFORT PEN NDL 31GX1/4" ..	179	EASY TOUCH SAF PEN NDL 30G 5MM	
EASY COMFORT PEN NDL 31GX3/16"	179	.....	179
EASY COMFORT PEN NDL 31GX5/16"	179	EASY TOUCH SAF PEN NDL 30G 8MM	
EASY COMFORT PEN NDL 32GX5/32"	179	.....	179
EASY COMFORT PEN NDL 33G 4MM..	179	EASY TOUCH SYR 0.5 ML 28G	
EASY COMFORT PEN NDL 33G 5MM..	179	12.7MM.....	179
EASY COMFORT PEN NDL 33G 6MM..	179	EASY TOUCH SYR 0.5 ML 29G	
EASY COMFORT SYR 1 ML 30GX1/2"	179	12.7MM.....	179
EASY GLIDE INS 0.3 ML 31GX6MM....	179	EASY TOUCH SYR 1 ML 27G 16MM....	179
EASY GLIDE INS 0.5 ML 31GX6MM....	179	EASY TOUCH SYR 1 ML 28G 12.7MM.	179
EASY GLIDE INS 1 ML 31GX6MM.....	179	EASY TOUCH SYR 1 ML 29G 12.7MM.	179
EASY GLIDE PEN NEEDLE 4MM 33G..	179	EASY TOUCH UNI-SLIP SYR 1 ML.....	179
EASY TOUCH 0.3 ML SYR 30GX1/2"	179	EASYTOUCH SAF PEN NDL 30G 6MM	179
EASY TOUCH 0.5 ML SYR 27GX1/2"	179	EGRIFTA SV.....	369
EASY TOUCH 0.5 ML SYR 29GX1/2"	179	ELIGARD.....	208
EASY TOUCH 0.5 ML SYR 30GX1/2"	179	ELIGARD (3 MONTH).....	208
EASY TOUCH 0.5 ML SYR 30GX5/16...	179	ELIGARD (4 MONTH).....	208
EASY TOUCH 1 ML SYR 27GX1/2"	179	ELIGARD (6 MONTH).....	208
EASY TOUCH 1 ML SYR 29GX1/2"	179	ELREXFIO 44 MG/1.1 ML VIAL INNER,	
EASY TOUCH 1 ML SYR 30GX1/2"	179	SUV, P/F.....	111
EASY TOUCH ALCOHOL 70% PADS		ELREXFIO SUBCUTANEOUS	
GAMMA-STERILIZED.....	179	SOLUTION 40 MG/ML.....	111
EASY TOUCH FLIPILOK 1 ML 27GX0.5	179	EMBRACE PEN NEEDLE 29G 12MM....	179
EASY TOUCH INSULIN 1 ML 29GX1/2	179	EMBRACE PEN NEEDLE 30G 5MM.....	179
EASY TOUCH INSULIN 1 ML 30GX1/2	179	EMBRACE PEN NEEDLE 30G 8MM.....	179
EASY TOUCH INSULIN SYR 0.3 ML....	179	EMBRACE PEN NEEDLE 31G 5MM.....	179
EASY TOUCH INSULIN SYR 0.5 ML....	179	EMBRACE PEN NEEDLE 31G 6MM.....	179
EASY TOUCH INSULIN SYR 1 ML.....	179	EMBRACE PEN NEEDLE 31G 8MM.....	179
EASY TOUCH INSULIN SYR 1 ML		EMBRACE PEN NEEDLE 32G 4MM.....	179
RETRACTABLE.....	179	EMGALITY PEN.....	142
EASY TOUCH INSULN 1 ML 29GX1/2"	179		
EASY TOUCH INSULN 1 ML 30GX1/2"	179		

EMGALITY SYRINGE	FREESTYLE PREC 0.5 ML 30GX5/16....	179
SUBCUTANEOUS SYRINGE 120	FREESTYLE PREC 0.5 ML 31GX5/16....	179
MG/ML, 300 MG/3 ML (100 MG/ML X	FREESTYLE PREC 1 ML 30GX5/16"	179
3).....	FREESTYLE PREC 1 ML 31GX5/16"	179
ENBREL.....	FRUZAQLA ORAL CAPSULE 1 MG, 5	
ENBREL MINI.....	MG.....	140
ENBREL SURECLICK.....	FYARRO.....	341
ENSPRYNG.....	FYLNTRA.....	279
EPCLUSA ORAL PELLETS IN PACKET	GALAFOLD.....	236
150-37.5 MG, 200-50 MG.....	GATTEX 30-VIAL.....	364
EPCLUSA ORAL TABLET.....	GAUZE PAD TOPICAL BANDAGE 2 X	
EPIDIOLEX.....	2 ".....	179
EPKINLY.....	GAVRETO.....	296
EQL INSULIN 0.3 ML SYRINGE	<i>gefitinib</i>	144
SHORT NEEDLE.....	GILOTRIF.....	14
EQL INSULIN 0.5 ML SYRINGE	<i>glatiramer subcutaneous syringe 20 mg/ml,</i>	
SHORT NEEDLE.....	<i>40 mg/ml</i>	147
EQL INSULIN 1 ML SYRINGE SHORT	<i>glatopa subcutaneous syringe 20 mg/ml, 40</i>	
NEEDLE.....	<i>mg/ml</i>	147
ERBITUX.....	<i>glutamine (sickle cell)</i>	214
ERIVEDGE.....	GNP ULT C 0.3 ML 29GX1/2" (1/2) 1/2	
ERLEADA ORAL TABLET 240 MG, 60	UNIT.....	179
MG.....	GNP ULTRA COMFORT 0.5 ML SYR....	179
<i>erlotinib oral tablet 100 mg, 150 mg, 25</i>	GNP ULTRA COMFORT 1 ML	
<i>mg</i>	SYRINGE.....	179
<i>everolimus (antineoplastic) oral tablet 10</i>	GNP ULTRA COMFORT 3/10 ML SYR..	179
<i>mg, 2.5 mg, 5 mg, 7.5 mg</i>	HAEGARDA SUBCUTANEOUS RECON	
<i>everolimus (antineoplastic) oral tablet for</i>	SOLN 2,000 UNIT, 3,000 UNIT.....	58
<i>suspension</i>	HARVONI ORAL PELLETS IN PACKET	
EVRYSDI.....	33.75-150 MG, 45-200 MG.....	202
EXEL INSULIN SYRINGE 27G-1 ML....	HARVONI ORAL TABLET.....	202
EXKIVITY.....	HEALTHWISE INS 0.3 ML 30GX5/16"..	179
FASENRA.....	HEALTHWISE INS 0.3 ML 31GX5/16"..	179
FASENRA PEN.....	HEALTHWISE INS 0.5 ML 30GX5/16"..	179
<i>fentanyl citrate buccal lozenge on a handle</i>	HEALTHWISE INS 0.5 ML 31GX5/16"..	179
.....	HEALTHWISE INS 1 ML 30GX5/16".....	179
FERRIPROX ORAL SOLUTION.....	HEALTHWISE INS 1 ML 31GX5/16".....	179
FIFTY50 INS 0.5 ML 31GX5/16" SHORT	HEALTHWISE PEN NEEDLE 31G 5MM	179
NEEDLE (OTC).....	HEALTHWISE PEN NEEDLE 31G 8MM	179
FIFTY50 INS SYR 1 ML 31GX5/16"	HEALTHWISE PEN NEEDLE 32G 4MM	179
SHORT NEEDLE (OTC).....	HEALTHY ACCENTS PENTIP 4MM	
FIFTY50 PEN 31G X 3/16" NEEDLE	32G.....	179
(OTC).....	HEALTHY ACCENTS PENTIP 5MM	
<i> fingolimod</i>	31G.....	179
FINTEPLA.....	HEALTHY ACCENTS PENTIP 6MM	
FOTIVDA.....	31G.....	179
FP INSULIN 1 ML SYRINGE.....		

HEALTHY ACCENTS PENTIP 8MM 31G.....	179	INGREZZA SPRINKLE.....	411
HEALTHY ACCENTS PENTP 12MM 29G.....	179	INLYTA ORAL TABLET 1 MG, 5 MG.....	36
HEB INCONTROL ALCOHOL 70% PADS.....	179	INQOVI.....	87
HERCEPTIN HYLECTA.....	394	INREBIC.....	130
HERZUMA.....	395	INSULIN SYR 0.3 ML 31GX1/4(1/2).....	179
HETLIOZ LQ.....	360	INSULIN SYRIN 0.3 ML 30GX1/2" SHORT NEEDLE.....	179
HUMIRA PEN.....	11	INSULIN SYRIN 0.5 ML 28GX1/2" (OTC).....	179
HUMIRA PEN CROHNS-UC-HS START..	11	INSULIN SYRIN 0.5 ML 29GX1/2" (OTC).....	179
HUMIRA PEN PSOR-UEVITS-ADOL HS	11	INSULIN SYRIN 0.5 ML 30GX1/2" SHORT NEEDLE (OTC).....	179
HUMIRA SUBCUTANEOUS SYRINGE KIT 40 MG/0.8 ML.....	11	INSULIN SYRIN 0.5 ML 30GX5/16" SHORT NEEDLE (OTC).....	179
HUMIRA(CF).....	11	INSULIN SYRING 0.5 ML 27G 1/2" INNER (OTC).....	179
HUMIRA(CF) PEDI CROHNS STARTER	11	INSULIN SYRINGE 0.3 ML.....	179
HUMIRA(CF) PEN.....	11	INSULIN SYRINGE 0.3 ML 31GX1/4.....	179
HUMIRA(CF) PEN CROHNS-UC-HS.....	11	INSULIN SYRINGE 0.5 ML.....	179
HUMIRA(CF) PEN PEDIATRIC UC.....	11	INSULIN SYRINGE 0.5 ML 31GX1/4.....	179
HUMIRA(CF) PEN PSOR-UV-ADOL HS..	11	INSULIN SYRINGE 1 ML.....	179
IBRANCE.....	272	INSULIN SYRINGE 1 ML 30GX1/2" (RX).....	179
<i>ibuprofen-famotidine</i>	159	INSULIN SYRINGE 1 ML 30GX5/16" SHORT NEEDLE (OTC).....	179
<i>icatibant</i>	160	INSULIN SYRINGE 1 ML 31GX1/4".....	179
ICLUSIG.....	292	INSULIN SYRINGE-NEEDLE U-100 SYRINGE 0.3 ML 29 GAUGE, 1 ML 29 GAUGE X 1/2", 1/2 ML 28 GAUGE.....	179
IDHIFA.....	114	INSUPEN 30G ULTRAFIN NEEDLE.....	179
ILARIS (PF).....	61	INSUPEN 31G ULTRAFIN NEEDLE.....	179
ILUMYA.....	376	INSUPEN 32G 6MM PEN NEEDLE.....	179
<i>imatinib oral tablet 100 mg, 400 mg</i>	162	INSUPEN 32G 8MM PEN NEEDLE.....	179
IMBRUVICA ORAL CAPSULE 140 MG, 70 MG.....	158	INSUPEN PEN NEEDLE 29GX12MM....	179
IMBRUVICA ORAL SUSPENSION.....	158	INSUPEN PEN NEEDLE 31GX3/16".....	179
IMBRUVICA ORAL TABLET.....	158	INSUPEN PEN NEEDLE 32GX4MM.....	179
IMDELLTRA.....	359	INSUPEN PEN NEEDLE 33GX4MM.....	179
IMJUDO.....	397	IQIRVO.....	106
IMPAVIDO.....	238	<i>itraconazole oral solution</i>	193
INBRIJA INHALATION CAPSULE, W/INHALATION DEVICE.....	213	IV ANTISEPTIC WIPES.....	179
INCONTROL PEN NEEDLE 12MM 29G	179	IWILFIN.....	104
INCONTROL PEN NEEDLE 4MM 32G..	179	JAKAFI.....	326
INCONTROL PEN NEEDLE 5MM 31G..	179	<i>javygtor oral tablet,soluble</i>	327
INCONTROL PEN NEEDLE 6MM 31G..	179	JAYPIRCA ORAL TABLET 100 MG, 50 MG.....	290
INCONTROL PEN NEEDLE 8MM 31G..	179	JEMPERLI.....	96
INCRELEX.....	228		
INFLECTRA.....	174		
<i>infliximab</i>	165		
INGREZZA.....	411		
INGREZZA INITIATION PK(TARDIV)..	411		

JUXTAPID ORAL CAPSULE 10 MG, 20 MG, 30 MG, 5 MG.....	219	LITE TOUCH INSULIN SYR 1 ML.....	179
JYNARQUE ORAL TABLET.....	385	LITE TOUCH PEN NEEDLE 29G.....	179
JYNARQUE ORAL TABLETS, SEQUENTIAL.....	385	LITE TOUCH PEN NEEDLE 31G.....	179
KALYDECO.....	194	LITETOUCH INS 0.3 ML 29GX1/2".....	179
KANJINTI.....	391	LITETOUCH INS 0.3 ML 30GX5/16".....	179
KENDALL ALCOHOL 70% PREP PAD.....	179	LITETOUCH INS 0.3 ML 31GX5/16".....	179
KERENDIA.....	136	LITETOUCH INS 0.5 ML 31GX5/16".....	179
KESIMPTA PEN.....	260	LITETOUCH SYR 0.5 ML 28GX1/2".....	179
KEYTRUDA.....	283	LITETOUCH SYR 0.5 ML 29GX1/2".....	179
KIMMTRAK.....	362	LITETOUCH SYR 0.5 ML 30GX5/16"....	179
KINERET.....	20	LITETOUCH SYRIN 1 ML 28GX1/2".....	179
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.....	308	LITETOUCH SYRIN 1 ML 29GX1/2".....	179
KISQALI ORAL TABLET 200 MG/DAY (200 MG X 1), 400 MG/DAY (200 MG X 2), 600 MG/DAY (200 MG X 3).....	307	LITETOUCH SYRIN 1 ML 30GX5/16" ...	179
KOSELUGO ORAL CAPSULE 10 MG, 25 MG.....	338	LIVDELZI.....	334
KRAZATI.....	10	LIVTENCITY.....	227
KYNMOBI SUBLINGUAL FILM 10 MG, 10-15-20-25-30 MG, 15 MG, 20 MG, 25 MG, 30 MG.....	24	LONSURF ORAL TABLET 15-6.14 MG, 20-8.19 MG.....	402
<i>lanreotide subcutaneous syringe 120 mg/0.5.ml.....</i>	198	LOQTORZI.....	387
<i>lapatinib.....</i>	199	LORBRENA ORAL TABLET 100 MG, 25 MG.....	222
LAZCLUZE ORAL TABLET 240 MG, 80 MG.....	201	LUMAKRAS ORAL TABLET 120 MG, 320 MG.....	352
<i>lenalidomide.....</i>	203	LUNSUMIO.....	241
LENVIMA.....	204	LUPRON DEPOT.....	209
LEUKINE INJECTION RECON SOLN... <i>leuprolide (3 month).....</i>	328 207	LUPRON DEPOT (3 MONTH).....	209
<i>leuprolide subcutaneous kit.....</i>	206	LUPRON DEPOT (4 MONTH).....	209
<i>lidocaine hcl mucous membrane solution 4 % (40 mg/ml).....</i>	218	LUPRON DEPOT (6 MONTH).....	209
<i>lidocaine topical adhesive patch,medicated 5 %.....</i>	216	LUPRON DEPOT-PED.....	211
<i>lidocaine topical ointment.....</i>	215	LUPRON DEPOT-PED (3 MONTH).....	211
<i>lidocaine-prilocaine topical cream.....</i>	217	LYBALVI.....	261
<i>lidocaine iii.....</i>	216	LYNPARZA.....	262
LISCO SPONGES 100/BAG.....	179	LYTGOBI ORAL TABLET 12 MG/DAY (4 MG X 3), 16 MG/DAY (4 MG X 4), 20 MG/DAY (4 MG X 5).....	141
LITE TOUCH 31GX1/4" PEN NEEDLE..	179	MAGELLAN INSUL SYRINGE 0.3 ML..	179
LITE TOUCH INSULIN 0.5 ML SYR.....	179	MAGELLAN INSUL SYRINGE 0.5 ML..	179
LITE TOUCH INSULIN 1 ML SYR.....	179	MAGELLAN INSULIN SYR 0.3 ML.....	179
		MAGELLAN INSULIN SYR 0.5 ML.....	179
		MAGELLAN INSULIN SYRINGE 1 ML	179
		MARGENZA.....	226
		MAVENCLAD (10 TABLET PACK).....	73
		MAVENCLAD (4 TABLET PACK).....	73
		MAVENCLAD (5 TABLET PACK).....	73
		MAVENCLAD (6 TABLET PACK).....	73
		MAVENCLAD (7 TABLET PACK).....	73
		MAVENCLAD (8 TABLET PACK).....	73
		MAVENCLAD (9 TABLET PACK).....	73

MAVYRET ORAL TABLET.....	148	MONOJECT INSUL SYR U100 1 ML.....	179
MAXICOMFORT II PEN NDL 31GX6MM.....	179	MONOJECT INSUL SYR U100 1 ML 3'S, 29GX1/2" (OTC).....	179
MAXICOMFORT INS 0.5 ML 27GX1/2"	179	MONOJECT INSUL SYR U100 1 ML W/O NEEDLE (OTC).....	179
MAXI-COMFORT INS 0.5 ML 28G.....	179	MONOJECT INSULIN SYR 0.3 ML.....	179
MAXICOMFORT INS 1 ML 27GX1/2" ...	179	MONOJECT INSULIN SYR 0.3 ML (OTC).....	179
MAXI-COMFORT INS 1 ML 28GX1/2" ..	179	MONOJECT INSULIN SYR 0.5 ML.....	179
MAXICOMFORT PEN NDL 29G X 5MM	179	MONOJECT INSULIN SYR 0.5 ML (OTC).....	179
MAXICOMFORT PEN NDL 29G X 8MM	179	MONOJECT INSULIN SYR 1 ML 3'S (OTC).....	179
MAYZENT ORAL TABLET 0.25 MG, 1 MG, 2 MG.....	340	MONOJECT INSULIN SYR U-100.....	179
MAYZENT STARTER(FOR 1MG MAINT).....	340	MONOJECT SYRINGE 0.3 ML.....	179
MAYZENT STARTER(FOR 2MG MAINT).....	340	MONOJECT SYRINGE 0.5 ML.....	179
MEKINIST ORAL RECON SOLN.....	389	MONOJECT SYRINGE 1 ML.....	179
MEKINIST ORAL TABLET 0.5 MG, 2 MG.....	390	<i>morphine concentrate oral solution</i>	157
MEKTOVI.....	52	MOUNJARO.....	152
MICRODOT PEN NEEDLE 31GX6MM..	179	MVASI.....	49
MICRODOT PEN NEEDLE 32GX4MM..	179	NATPARA.....	273
MICRODOT PEN NEEDLE 33GX4MM..	179	NERLYNX.....	247
MICRODOT READYGARD NDL 31G 5MM OUTER.....	179	NEULASTA ONPRO.....	278
<i>mifepristone oral tablet 300 mg</i>	235	NINLARO.....	196
<i>miglustat</i>	237	<i>nitisinone</i>	254
MINI PEN NEEDLE 32G 4MM.....	179	NIVESTYM.....	134
MINI PEN NEEDLE 32G 5MM.....	179	NORDITROPIN FLEXPRO.....	346
MINI PEN NEEDLE 32G 6MM.....	179	NOVOFINE 30.....	179
MINI PEN NEEDLE 32G 8MM.....	179	NOVOFINE 32G NEEDLES.....	179
MINI PEN NEEDLE 33G 4MM.....	179	NOVOFINE PLUS PEN NDL 32GX1/6" ..	179
MINI PEN NEEDLE 33G 5MM.....	179	NOVOTWIST NEEDLE 32G 5MM.....	179
MINI PEN NEEDLE 33G 6MM.....	179	NOXAFIL ORAL SUSP,DELAYED RELEASE FOR RECON.....	295
MINI ULTRA-THIN II PEN NDL 31G STERILE.....	179	NUBEQA.....	85
<i>modafinil oral tablet 100 mg, 200 mg</i>	244	NUCALA SUBCUTANEOUS AUTO- INJECTOR.....	230
MONOJECT 0.5 ML SYRN 28GX1/2"	179	NUCALA SUBCUTANEOUS RECON SOLN.....	230
MONOJECT 1 ML SYRN 27X1/2"	179	NUCALA SUBCUTANEOUS SYRINGE 100 MG/ML, 40 MG/0.4 ML.....	230
MONOJECT 1 ML SYRN 28GX1/2" (OTC).....	179	NUPLAZID.....	288
MONOJECT INSUL SYR U100 (OTC)....	179	NURTEC ODT.....	312
MONOJECT INSUL SYR U100 .5ML,29GX1/2" (OTC).....	179	NYVEPRIA.....	276
MONOJECT INSUL SYR U100 0.5 ML CONVERTS TO 29G (OTC).....	179	OCALIVA.....	258
		OCREVUS.....	259
		ODOMZO.....	349
		OFEV.....	249

OGIVRI.....	392	PEN NEEDLES 8MM 31G	
OGSIVEO ORAL TABLET 100 MG, 150		31GX8MM,STRL,SHORT.(OTC).....	179
MG, 50 MG.....	253	<i>penicillamine oral tablet</i>	285
OJEMDA ORAL SUSPENSION FOR		PENTIPS PEN NEEDLE 29G 1/2".....	179
RECONSTITUTION.....	388	PENTIPS PEN NEEDLE 31G 1/4".....	179
OJEMDA ORAL TABLET.....	388	PENTIPS PEN NEEDLE 31GX3/16"	
OJJAARA.....	240	MINI, 5MM.....	179
ONGENTYS.....	268	PENTIPS PEN NEEDLE 31GX5/16"	
ONTRUZANT.....	393	SHORT, 8MM.....	179
ONUREG.....	37	PENTIPS PEN NEEDLE 32G 1/4".....	179
OPDIVO.....	255	PENTIPS PEN NEEDLE 32GX5/32"	
OPDUALAG.....	256	4MM.....	179
OPSUMIT.....	225	PIP PEN NEEDLE 31G X 5MM.....	179
ORENCIA.....	4	PIP PEN NEEDLE 32G X 4MM.....	179
ORENCIA (WITH MALTOSE).....	2	PIQRAY ORAL TABLET 200 MG/DAY	
ORENCIA CLICKJECT.....	4	(200 MG X 1), 250 MG/DAY (200 MG	
ORFADIN ORAL SUSPENSION.....	254	X1-50 MG X1), 300 MG/DAY (150 MG X	
ORGOVYX.....	302	2).....	16
ORLISSA ORAL TABLET 150 MG, 200		<i>pirfenidone oral capsule</i>	289
MG.....	107	<i>pirfenidone oral tablet 267 mg, 534 mg,</i>	
ORKAMBI ORAL GRANULES IN		<i>801 mg</i>	289
PACKET.....	224	PLEGRIDY SUBCUTANEOUS PEN	
ORKAMBI ORAL TABLET.....	224	INJECTOR 125 MCG/0.5 ML, 63	
ORSERDU ORAL TABLET 345 MG, 86		MCG/0.5 ML- 94 MCG/0.5.ML.....	190
MG.....	105	PLEGRIDY SUBCUTANEOUS	
OTEZLA.....	25	SYRINGE 125 MCG/0.5 ML, 63 MCG/0.5	
OTEZLA STARTER.....	25	ML- 94 MCG/0.5 ML.....	190
<i>oxandrolone</i>	270	POMALYST.....	291
<i>oxycodone oral concentrate</i>	157	<i>posaconazole oral</i>	293, 294
OZEMPIC.....	151	PREVENT PEN NEEDLE 31GX1/4".....	179
PALYNZIQ.....	281	PREVENT PEN NEEDLE 31GX5/16".....	179
<i>pazopanib</i>	275	PREVYMIS ORAL.....	205
PC UNIFINE PENTIPS 8MM NEEDLE		PRO COMFORT 0.5 ML 30GX1/2".....	179
SHORT.....	179	PRO COMFORT 0.5 ML 30GX5/16".....	179
PEGASYS.....	280	PRO COMFORT 0.5 ML 31GX5/16".....	179
PEMAZYRE.....	284	PRO COMFORT 1 ML 30GX1/2".....	179
PEN NEEDLE 30G 5MM OUTER.....	179	PRO COMFORT 1 ML 30GX5/16".....	179
PEN NEEDLE 30G 8MM INNER.....	179	PRO COMFORT 1 ML 31GX5/16".....	179
PEN NEEDLE 30G X 5/16".....	179	PRO COMFORT ALCOHOL 70% PADS	179
PEN NEEDLE, DIABETIC NEEDLE 29		PRO COMFORT PEN NDL 31GX5/16"...	179
GAUGE X 1/2".....	179	PRO COMFORT PEN NDL 32G X 1/4"...	179
PEN NEEDLES 12MM 29G		PRO COMFORT PEN NDL 4MM 32G....	179
29GX12MM,STRL.....	179	PRO COMFORT PEN NDL 5MM 32G....	179
PEN NEEDLES 4MM 32G.....	179	PRODIGY INS SYR 1 ML 28GX1/2".....	179
PEN NEEDLES 6MM 31G 31GX6MM,		PRODIGY SYRNG 0.5 ML 31GX5/16"...	179
STRL.....	179	PRODIGY SYRNGE 0.3 ML 31GX5/16".....	179

PROMACTA ORAL POWDER IN PACKET 12.5 MG, 25 MG.....	113	REZLIDHIA.....	263
PROMACTA ORAL TABLET 12.5 MG, 25 MG, 50 MG, 75 MG.....	113	REZUROCK.....	42
PURE CMFT SFTY PEN NDL 31G 5MM	179	RIABNI.....	322
PURE CMFT SFTY PEN NDL 31G 6MM	179	RINVOQ.....	406
PURE CMFT SFTY PEN NDL 32G 4MM	179	RINVOQ LQ.....	406
PURE COMFORT ALCOHOL 70% PADS.....	179	RITUXAN HYCELA.....	320
PURE COMFORT PEN NDL 32G 4MM..	179	RIVFLOZA.....	246
PURE COMFORT PEN NDL 32G 5MM..	179	ROLVEDON.....	103
PURE COMFORT PEN NDL 32G 6MM..	179	ROZLYTREK ORAL CAPSULE 100 MG, 200 MG.....	116
PURE COMFORT PEN NDL 32G 8MM..	179	ROZLYTREK ORAL PELLETS IN PACKET.....	117
<i>pyrimethamine</i>	298	RUBRACA.....	325
QINLOCK.....	316	RUXIENCE.....	323
<i>quinine sulfate</i>	299	RYBELSUS.....	151
QULIPTA.....	32	RYBREVANT.....	19
RAVICTI.....	153	RYDAPT.....	234
RAYA SURE PEN NEEDLE 29G 12MM.	179	RYTELO.....	163
RAYA SURE PEN NEEDLE 31G 4MM..	179	SAFESNAP INS SYR UNITS-100 0.3 ML 30GX5/16",10X10.....	179
RAYA SURE PEN NEEDLE 31G 5MM..	179	SAFESNAP INS SYR UNITS-100 0.5 ML 29GX1/2",10X10.....	179
RAYA SURE PEN NEEDLE 31G 6MM..	179	SAFESNAP INS SYR UNITS-100 0.5 ML 30GX5/16",10X10.....	179
REGRANEX.....	39	SAFESNAP INS SYR UNITS-100 1 ML 28GX1/2",10X10.....	179
RELION INS SYR 0.3 ML 31GX6MM....	179	SAFESNAP INS SYR UNITS-100 1 ML 29GX1/2",10X10.....	179
RELION INS SYR 0.5 ML 31GX6MM....	179	SAFETY PEN NEEDLE 31G 4MM.....	179
RELION INS SYR 1 ML 31GX15/64".....	179	SAFETY PEN NEEDLE 5MM X 31G.....	179
RELI-ON INSULIN 0.5 ML SYR.....	179	SAFETY SYRINGE 0.5 ML 30G 1/2".....	179
RELI-ON INSULIN 1 ML SYR.....	179	<i>sajazir</i>	160
RELION MINI PEN 31G X 1/4" NDL.....	179	<i>sapropterin oral tablet,soluble</i>	327
RELION NEEDLES.....	179	SCEMBLIX ORAL TABLET 100 MG, 20 MG, 40 MG.....	27
RELION PEN NEEDLES.....	179	SECURESAFE PEN NDL 30GX5/16" OUTER.....	179
RELISTOR ORAL.....	233	SECURESAFE SYR 0.5 ML 29G 1/2" OUTER.....	179
RELISTOR SUBCUTANEOUS SOLUTION.....	232	SECURESAFE SYRNG 1 ML 29G 1/2" OUTER.....	179
RELISTOR SUBCUTANEOUS SYRINGE 12 MG/0.6 ML, 8 MG/0.4 ML.	232	SEROSTIM SUBCUTANEOUS RECON SOLN 4 MG, 5 MG, 6 MG.....	348
RENFLEXIS.....	168	SIGNIFOR.....	274
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.....	120	<i>sildenafil (pulm.hypertension) oral tablet..</i>	339
RETEVMO ORAL CAPSULE 40 MG, 80 MG.....	337	SIRTURO.....	40
RETEVMO ORAL TABLET 120 MG, 160 MG, 40 MG, 80 MG.....	337	SKY SAFETY PEN NEEDLE 30G 5MM.	179
REVCIVI.....	108		

SKY SAFETY PEN NEEDLE 30G 8MM..	179	SYMDEKO.....	374
SKYRIZI.....	317	SYMLINPEN 120.....	297
SM ULT CFT 0.3 ML 31GX5/16(1/2).....	179	SYMLINPEN 60.....	297
<i>sodium oxybate</i>	342	SYMPAZAN.....	74
<i>sodium phenylbutyrate oral tablet</i>	343	SYNAREL.....	242
SOMATULINE DEPOT		SYNRIBO.....	264
SUBCUTANEOUS SYRINGE 60 MG/0.2		TABRECTA.....	66
ML, 90 MG/0.3 ML.....	198	<i>tadalafil oral tablet 2.5 mg, 5 mg</i>	356
SOMAVERT.....	282	TAFINLAR ORAL CAPSULE.....	79
<i>sorafenib</i>	350	TAFINLAR ORAL TABLET FOR	
SPRAVATO.....	124	SUSPENSION.....	80
SPRYCEL ORAL TABLET 100 MG, 140		TAGRISSE.....	269
MG, 20 MG, 50 MG, 70 MG, 80 MG.....	86	TAKHZYRO SUBCUTANEOUS	
STELARA.....	409, 410	SOLUTION.....	197
STERILE PADS 2" X 2".....	179	TAKHZYRO SUBCUTANEOUS	
STIMUFEND.....	277	SYRINGE 150 MG/ML, 300 MG/2 ML	
STIVARGA.....	301	(150 MG/ML).....	197
STRENSIQ.....	28	TALVEY.....	358
<i>sunitinib malate</i>	354	TALZENNA.....	357
SURE CMFT SFTY PEN NDL 31G 6MM	179	TASIGNA ORAL CAPSULE 150 MG,	
SURE CMFT SFTY PEN NDL 32G 4MM	179	200 MG, 50 MG.....	248
SURE COMFORT 0.5 ML SYRINGE.....	179	<i>tasimelteon</i>	360
SURE COMFORT 1 ML SYRINGE.....	179	TAVALISSE.....	138
SURE COMFORT 3/10 ML SYRINGE....	179	TAVNEOS.....	33
SURE COMFORT 3/10 ML SYRINGE		TAZVERIK.....	361
INSULIN SYRINGE.....	179	TECENTRIQ.....	31
SURE COMFORT 30G PEN NEEDLE.....	179	TECHLITE 0.3 ML 29GX12MM (1/2)....	179
SURE COMFORT ALCOHOL PREP		TECHLITE 0.3 ML 30GX12MM (1/2)....	179
PADS.....	179	TECHLITE 0.3 ML 30GX8MM (1/2).....	179
SURE COMFORT INS 0.3 ML 31GX1/4.	179	TECHLITE 0.3 ML 31GX6MM (1/2).....	179
SURE COMFORT INS 0.5 ML 31GX1/4.	179	TECHLITE 0.3 ML 31GX8MM (1/2).....	179
SURE COMFORT INS 1 ML 31GX1/4" ...	179	TECHLITE 0.5 ML 29GX12MM (1/2)....	179
SURE COMFORT PEN NDL 29GX1/2"		TECHLITE 0.5 ML 30GX12MM (1/2)....	179
12.7MM.....	179	TECHLITE 0.5 ML 30GX8MM (1/2).....	179
SURE COMFORT PEN NDL 31G 5MM..	179	TECHLITE 0.5 ML 31GX6MM (1/2).....	179
SURE COMFORT PEN NDL 31G 8MM..	179	TECHLITE 0.5 ML 31GX8MM (1/2).....	179
SURE COMFORT PEN NDL 32G 4MM..	179	TECHLITE INS SYR 1 ML 29GX12MM..	179
SURE COMFORT PEN NDL 32G 6MM..	179	TECHLITE INS SYR 1 ML 30GX12MM..	179
SURE-FINE PEN NEEDLES 12.7MM.....	179	TECHLITE INS SYR 1 ML 30GX8MM...	179
SURE-FINE PEN NEEDLES 5MM.....	179	TECHLITE INS SYR 1 ML 31GX6MM...	179
SURE-FINE PEN NEEDLES 8MM.....	179	TECHLITE INS SYR 1 ML 31GX8MM...	179
SURE-JECT INSU SYR U100 0.3 ML.....	179	TECHLITE PEN NEEDLE 29GX1/2".....	179
SURE-JECT INSU SYR U100 0.5 ML.....	179	TECHLITE PEN NEEDLE 29GX3/8".....	179
SURE-JECT INSU SYR U100 1 ML.....	179	TECHLITE PEN NEEDLE 31GX1/4".....	179
SURE-JECT INSUL SYR U100 1 ML.....	179	TECHLITE PEN NEEDLE 31GX3/16"....	179
SURE-JECT INSULIN SYRINGE 1 ML..	179	TECHLITE PEN NEEDLE 31GX5/16"....	179
SURE-PREP ALCOHOL PREP PADS.....	179	TECHLITE PEN NEEDLE 32GX1/4".....	179

TECHLITE PEN NEEDLE 32GX5/16"	179	TRIKAFTA ORAL TABLETS,	
TECHLITE PEN NEEDLE 32GX5/32"	179	SEQUENTIAL	109
TECHLITE PLUS PEN NDL 32G 4MM...	179	TRUE CMFRT PRO 0.5 ML 30G 5/16"	179
TECVAYLI	363	TRUE CMFRT PRO 0.5 ML 31G 5/16"	179
TEPMETKO	366	TRUE CMFRT PRO 0.5 ML 32G 5/16"	179
<i>teriflunomide</i>	367	TRUE CMFT SFTY PEN NDL 31G 5MM	179
<i>teriparatide subcutaneous pen injector 20</i>		TRUE CMFT SFTY PEN NDL 31G 6MM	179
<i>mcg/dose (620mcg/2.48ml)</i>	368	TRUE CMFT SFTY PEN NDL 32G 4MM	179
TERUMO INS SYRINGE U100-1 ML	179	TRUE COMFORT 0.5 ML 30G 1/2"	179
TERUMO INS SYRINGE U100-1/2 ML ..	179	TRUE COMFORT 0.5 ML 30G 5/16"	179
TERUMO INS SYRINGE U100-1/3 ML ..	179	TRUE COMFORT 0.5 ML 31G 5/16"	179
TERUMO INS SYRNG U100-1/2 ML	179	TRUE COMFORT 0.5 ML 31GX5/16"	179
<i>testosterone cypionate</i>	371	TRUE COMFORT 1 ML 31GX5/16"	179
<i>testosterone enanthate</i>	372	TRUE COMFORT ALCOHOL 70%	
<i>testosterone transdermal gel in metered-</i>		PADS	179
<i>dose pump 12.5 mg/ 1.25 gram (1 %),</i>		TRUE COMFORT PEN NDL 31G 8MM..	179
<i>20.25 mg/1.25 gram (1.62 %)</i>	370	TRUE COMFORT PEN NDL 31GX5MM	179
<i>testosterone transdermal gel in packet 1 %</i>		TRUE COMFORT PEN NDL 31GX6MM	179
<i>(25 mg/2.5gram), 1 % (50 mg/5 gram)</i>	370	TRUE COMFORT PEN NDL 32G 5MM..	179
<i>testosterone transdermal solution in</i>		TRUE COMFORT PEN NDL 32G 6MM..	179
<i>metered pump w/app</i>	370	TRUE COMFORT PEN NDL 32GX4MM	179
<i>tetrabenazine</i>	373	TRUE COMFORT PEN NDL 33G 4MM..	179
TEVIMBRA	377	TRUE COMFORT PEN NDL 33G 5MM..	179
THALOMID	375	TRUE COMFORT PEN NDL 33G 6MM..	179
THINPRO INS SYRIN U100-0.3 ML	179	TRUE COMFORT PRO 1 ML 30G 1/2" ...	179
THINPRO INS SYRIN U100-0.5 ML	179	TRUE COMFORT PRO 1 ML 30G 5/16" .	179
THINPRO INS SYRIN U100-1 ML	179	TRUE COMFORT PRO 1 ML 31G 5/16" .	179
TIBSOVO	195	TRUE COMFORT PRO 1 ML 32G 5/16" .	179
TIVDAK	378	TRUE COMFORT PRO ALCOHOL	
TOPCARE CLICKFINE 31G X 1/4"	179	PADS	179
TOPCARE CLICKFINE 31G X 5/16"	179	TRUE COMFORT SFTY 1 ML 30G 1/2" .	179
TOPCARE ULTRA COMFORT		TRUE COMFRT PRO 0.5 ML 30G 1/2" ...	179
SYRINGE	179	TRUE COMFRT SFTY 1 ML 30G 5/16" ..	179
<i>torpenz oral tablet 10 mg, 2.5 mg, 5 mg,</i>		TRUE COMFRT SFTY 1 ML 31G 5/16" ..	179
<i>7.5 mg</i>	127	TRUE COMFRT SFTY 1 ML 32G 5/16" ..	179
TRAZIMERA	396	TRUEPLUS PEN NEEDLE 29G 12MM...	179
TRELSTAR INTRAMUSCULAR		TRUEPLUS PEN NEEDLE 31G 5MM	179
SUSPENSION FOR RECONSTITUTION	403	TRUEPLUS PEN NEEDLE 31G 8MM	179
TREMFYA SUBCUTANEOUS AUTO-		TRUEPLUS PEN NEEDLE 31G X 1/4" ...	179
INJECTOR	155	TRUEPLUS PEN NEEDLE 32GX5/32" ...	179
TREMFYA SUBCUTANEOUS		TRUEPLUS SYR 0.3 ML 29GX1/2"	179
SYRINGE 100 MG/ML	155	TRUEPLUS SYR 0.3 ML 30GX5/16"	179
<i>treprostinil sodium</i>	399	TRUEPLUS SYR 0.3 ML 31GX5/16"	179
<i>tretinoin</i>	386	TRUEPLUS SYR 0.5 ML 28GX1/2"	179
<i>trientine oral capsule 250 mg</i>	401	TRUEPLUS SYR 0.5 ML 29GX1/2"	179
TRIKAFTA ORAL GRANULES IN		TRUEPLUS SYR 0.5 ML 30GX5/16"	179
PACKET, SEQUENTIAL	109	TRUEPLUS SYR 0.5 ML 31GX5/16"	179

TRUEPLUS SYR 1 ML 28GX1/2".....	179	ULTIGUARD SAFE PACK 32G 4MM....	179
TRUEPLUS SYR 1 ML 29GX1/2".....	179	ULTIGUARD SAFE0.3 ML 30G 12.7MM	
TRUEPLUS SYR 1 ML 30GX5/16".....	179	.....	179
TRUEPLUS SYR 1 ML 31GX5/16".....	179	ULTIGUARD SAFE0.5 ML 30G 12.7MM	
TRULICITY.....	150	.....	179
TRUQAP.....	64	ULTIGUARD SAFEPACK 1 ML 31G	
TRUSELTIQ.....	164	8MM.....	179
TRUXIMA.....	321	ULTIGUARD SAFEPK 0.5 ML 31G	
TUKYSA ORAL TABLET 150 MG, 50		8MM.....	179
MG.....	404	ULTILET ALCOHOL STERL SWAB.....	179
TURALIO.....	287	ULTILET INSULIN SYRINGE 0.3 ML...	179
TYMLOS.....	1	ULTILET INSULIN SYRINGE 0.5 ML...	179
TYVASO.....	398	ULTILET INSULIN SYRINGE 1 ML.....	179
UBRELVY.....	405	ULTILET PEN NEEDLE.....	179
ULTICAR INS 0.3 ML 31GX1/4(1/2).....	179	ULTILET PEN NEEDLE 4MM 32G.....	179
ULTICARE INS 1 ML 31GX1/4".....	179	ULTRA COMFORT 0.3 ML SYRINGE...	179
ULTICARE INS SYR 0.3 ML 30G 8MM.	179	ULTRA COMFORT 0.5 ML 28GX1/2"	
ULTICARE INS SYR 0.3 ML 31G 6MM.	179	CONVERTS TO 29G.....	179
ULTICARE INS SYR 0.3 ML 31G 8MM.	179	ULTRA COMFORT 0.5 ML 29GX1/2"....	179
ULTICARE INS SYR 0.5 ML 31G 6MM.	179	ULTRA COMFORT 0.5 ML SYRINGE...	179
ULTICARE INS SYR 1 ML 30GX1/2".....	179	ULTRA COMFORT 1 ML 31GX5/16".....	179
ULTICARE PEN NEEDLE 31GX3/16"....	179	ULTRA COMFORT 1 ML SYRINGE.....	179
ULTICARE PEN NEEDLE 6MM 31G.....	179	ULTRA FLO 0.3 ML 30G 1/2" (1/2).....	179
ULTICARE PEN NEEDLE 8MM 31G.....	179	ULTRA FLO 0.3 ML 30G 5/16"(1/2).....	179
ULTICARE PEN NEEDLES 12MM 29G.	179	ULTRA FLO 0.3 ML 31G 5/16"(1/2).....	179
ULTICARE PEN NEEDLES 4MM 32G		ULTRA FLO PEN NEEDLE 31G 5MM...	179
MICRO, 32GX4MM.....	179	ULTRA FLO PEN NEEDLE 31G 8MM...	179
ULTICARE PEN NEEDLES 6MM 32G...	179	ULTRA FLO PEN NEEDLE 32G 4MM...	179
ULTICARE SAFE PEN NDL 30G 8MM..	179	ULTRA FLO PEN NEEDLE 33G 4MM...	179
ULTICARE SAFE PEN NDL 5MM 30G..	179	ULTRA FLO PEN NEEDLES 12MM 29G	
ULTICARE SYR 0.3 ML 29G 12.7MM....	179	.....	179
ULTICARE SYR 0.3 ML 30GX1/2".....	179	ULTRA FLO SYR 0.3 ML 29GX1/2".....	179
ULTICARE SYR 0.3 ML 31GX5/16"		ULTRA FLO SYR 0.3 ML 30G 5/16".....	179
SHORT NDL.....	179	ULTRA FLO SYR 0.3 ML 31G 5/16".....	179
ULTICARE SYR 0.5 ML 30GX1/2".....	179	ULTRA FLO SYR 0.5 ML 29G 1/2".....	179
ULTICARE SYR 0.5 ML 31GX5/16"		ULTRA THIN PEN NDL 32G X 4MM.....	179
SHORT NDL.....	179	ULTRACARE INS 0.3 ML 30GX5/16"....	179
ULTICARE SYR 1 ML 31GX5/16".....	179	ULTRACARE INS 0.3 ML 31GX5/16"....	179
ULTIGUARD SAFE 1 ML 30G 12.7MM.	179	ULTRACARE INS 0.5 ML 30GX1/2".....	179
ULTIGUARD SAFE PACK 32G 4MM....	179	ULTRACARE INS 0.5 ML 30GX5/16"....	179
ULTIGUARD SAFE0.3 ML 30G 12.7MM		ULTRACARE INS 0.5 ML 31GX5/16"....	179
.....	179	ULTRACARE INS 1 ML 30G X 5/16"....	179
ULTIGUARD SAFE0.5 ML 30G 12.7MM		ULTRACARE INS 1 ML 30GX1/2".....	179
.....	179	ULTRACARE INS 1 ML 31G X 5/16"....	179
ULTIGUARD SAFEPACK 1 ML 31G		ULTRACARE PEN NEEDLE 31GX1/4".....	179
8MM.....	179	ULTRACARE PEN NEEDLE 31GX3/16".....	179
ULTIGUARD SAFEPACK 29G 12.7MM	179	ULTRACARE PEN NEEDLE 31GX5/16".....	179
		ULTRACARE PEN NEEDLE 32GX1/4".....	179

ULTRACARE PEN NEEDLE 32GX3/16" 179	UNIFINE ULTRA PEN NDL 31G 8MM.. 179
ULTRACARE PEN NEEDLE 32GX5/32" 179	UNIFINE ULTRA PEN NDL 32G 4MM.. 179
ULTRACARE PEN NEEDLE 33GX5/32" 179	UPTRAVI INTRAVENOUS..... 335
ULTRA-THIN II 1 ML 31GX5/16" 179	UPTRAVI ORAL TABLET 1,000 MCG,
ULTRA-THIN II INS 0.3 ML 30G 179	1,200 MCG, 1,400 MCG, 1,600 MCG, 200
ULTRA-THIN II INS 0.3 ML 31G 179	MCG, 400 MCG, 600 MCG, 800 MCG..... 335
ULTRA-THIN II INS 0.5 ML 29G 179	UPTRAVI ORAL TABLETS,DOSE
ULTRA-THIN II INS 0.5 ML 30G 179	PACK 335
ULTRA-THIN II INS 0.5 ML 31G 179	VALCHLOR..... 229
ULTRA-THIN II INS SYR 1 ML 29G 179	VANFLYTA 300
ULTRA-THIN II INS SYR 1 ML 30G 179	VANISHPOINT 0.5 ML 30GX1/2" SY
ULTRA-THIN II PEN NDL 29GX1/2" 179	OUTER..... 179
ULTRA-THIN II PEN NDL 31GX5/16..... 179	VANISHPOINT INS 1 ML 30GX3/16" 179
UNIFINE PEN NEEDLE 32G 4MM..... 179	VANISHPOINT U-100 29X1/2 SYR..... 179
UNIFINE PENTIPS 12MM 29G	VEGZELMA..... 48
29GX12MM, STRL..... 179	VENCLEXTA ORAL TABLET 10 MG,
UNIFINE PENTIPS 31GX3/16"	100 MG, 50 MG..... 414
31GX5MM,STRL,MINI..... 179	VENCLEXTA STARTING PACK..... 414
UNIFINE PENTIPS 32GX1/4" 179	VEOZAH..... 133
UNIFINE PENTIPS 32GX5/32"	VERIFINE INS SYR 1 ML 29G 1/2" 179
32GX4MM, STRL, NANO 179	VERIFINE PEN NEEDLE 29G 12MM..... 179
UNIFINE PENTIPS 33GX5/32" 179	VERIFINE PEN NEEDLE 31G 5MM..... 179
UNIFINE PENTIPS 6MM 31G..... 179	VERIFINE PEN NEEDLE 31G X 6MM... 179
UNIFINE PENTIPS MAX 30GX3/16" 179	VERIFINE PEN NEEDLE 31G X 8MM... 179
UNIFINE PENTIPS NEEDLES 29G 179	VERIFINE PEN NEEDLE 32G 6MM..... 179
UNIFINE PENTIPS PLUS 29GX1/2"	VERIFINE PEN NEEDLE 32G X 4MM... 179
12MM..... 179	VERIFINE PEN NEEDLE 32G X 5MM... 179
UNIFINE PENTIPS PLUS 30GX3/16" 179	VERIFINE PLUS PEN NDL 31G 5MM... 179
UNIFINE PENTIPS PLUS 31GX1/4"	VERIFINE PLUS PEN NDL 31G 8MM... 179
ULTRA SHORT, 6MM..... 179	VERIFINE PLUS PEN NDL 32G 4MM... 179
UNIFINE PENTIPS PLUS 31GX3/16"	VERIFINE PLUS PEN NDL 32G 4MM-
MINI..... 179	SHARPS CONTAINER..... 179
UNIFINE PENTIPS PLUS 31GX5/16"	VERIFINE SYRING 0.5 ML 29G 1/2" 179
SHORT..... 179	VERIFINE SYRING 1 ML 31G 5/16" 179
UNIFINE PENTIPS PLUS 32GX5/32" 179	VERIFINE SYRNG 0.3 ML 31G 5/16" 179
UNIFINE PENTIPS PLUS 33GX5/32" 179	VERIFINE SYRNG 0.5 ML 31G 5/16" 179
UNIFINE PROTECT 30G 5MM..... 179	VERQUVO..... 415
UNIFINE PROTECT 30G 8MM..... 179	VERSALON ALL PURPOSE SPONGE
UNIFINE PROTECT 32G 4MM..... 179	25'S,N-STERILE,3PLY 179
UNIFINE SAFECONTROL 30GX3/16" ... 179	VERZENIO..... 6
UNIFINE SAFECONTROL 30GX5/16" ... 179	<i>vigabatrin</i> 416
UNIFINE SAFECONTROL 31G 5MM..... 179	<i>vigadrone</i> 416
UNIFINE SAFECONTROL 31G 6MM..... 179	<i>vigpoder</i> 416
UNIFINE SAFECONTROL 31G 8MM..... 179	VITRAKVI ORAL CAPSULE 100 MG,
UNIFINE SAFECONTROL 32G 4MM..... 179	25 MG..... 200
UNIFINE ULTRA PEN NDL 31G 5MM.. 179	VITRAKVI ORAL SOLUTION 200
UNIFINE ULTRA PEN NDL 31G 6MM.. 179	VIZIMPRO 81

VONJO.....	271	ZYDELIG.....	161
VORANIGO.....	418	ZYKADIA.....	68
<i>voriconazole oral suspension for</i>		ZYMFENTRA.....	177
<i>reconstitution</i>	419	ZYNLONTA.....	221
VOSEVI.....	345	ZYNYZ.....	306
VOWST.....	129		
VUMERITY.....	95		
WEBCOL ALCOHOL PREPS			
20'S,LARGE.....	179		
WELIREG.....	43		
WINREVAIR.....	351		
XALKORI ORAL CAPSULE.....	77		
XALKORI ORAL PELLETT 150 MG, 20			
MG, 50 MG.....	78		
XDEMVI.....	223		
XELJANZ.....	383		
XELJANZ XR.....	383		
XERMELO.....	365		
XGEVA.....	90		
XIFAXAN ORAL TABLET 200 MG, 550			
MG.....	309		
XOLAIR.....	265		
XOSPATA.....	145		
XPOVIO ORAL TABLET 100			
MG/WEEK (50 MG X 2), 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), 80MG			
TWICE WEEK (160 MG/WEEK).....	336		
XTANDI ORAL CAPSULE.....	118		
XTANDI ORAL TABLET 40 MG, 80 MG			
.....	118		
XYOSTED.....	372		
<i>yargesa</i>	237		
YERVOY.....	192		
YONSA.....	8		
ZARXIO.....	135		
ZEJULA ORAL CAPSULE.....	251		
ZEJULA ORAL TABLET.....	251		
ZELBORAF.....	413		
ZIRABEV.....	50		
ZOLADEX.....	154		
ZTALMY.....	143		
ZTLIDO.....	216		
ZURZUVAE ORAL CAPSULE 20 MG,			
25 MG, 30 MG.....	421		