ABALOPARATIDE (TYMLOS)

MEDICATION(S)
TYMLOS

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Total parathyroid hormone analog therapy has exceeded 2 years. Being used with other osteoporosis drugs.

REQUIRED MEDICAL INFORMATION
Osteoporosis: patient has a history of a broken bone not due to trauma (non-traumatic fracture) or T-score between -1.0 and -2.5 and is at high risk for fracture or T-score lower than -2.5 AND one of the following: trial of a bisphosphonate (e.g. alendronate, ibandronate, risedronate, or zoledronic acid) or Prolia, OR side effect to bisphosphonate therapy or Prolia therapy that supports discontinuation, OR Patient is at very high risk of fracture by meeting at least one of the following: non-traumatic fracture while on bisphosphonate therapy or Prolia, patient has experienced a recent fracture (within the past 12 months) or history of multiple fractures, patient experienced a fracture while on long-term glucocorticoid therapy, or T-score less than -3.0, or patient is at high risk for falls, or 10-year hip fracture probability greater than 4.5% based on FRAX score, or 10-year major osteoporosis-related fracture probability greater than 30% based on FRAX score

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

ABEMACICLIB (VERZENIO)

MEDICATION(S)
VERZENIO

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Exclusion criteria will be based on current National Comprehensive Cancer Network (NCCN) guidelines and FDA labeling.

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

ABIRATERONE (ZYTIGA)

MEDICATION(S)
ABIRATERONE ACETATE

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Exclusion criteria will be based on current National Comprehensive Cancer Network (NCCN) guidelines and FDA labeling.

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

ACALABRUTINIB (CALQUENCE)

MEDICATION(S)
CALQUENCE

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Exclusion criteria will be based on current National Comprehensive Cancer Network (NCCN) guidelines and FDA labeling.

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

ACYCLOVIR OINTMENT (ZOVIRAX)

MEDICATION(S)
ACYCLOVIR 5 % OINTMENT

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Patient has tried or has a medical reason for not trying a herpes antiviral drug you take by mouth (e.g. acyclovir, valacyclovir).

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

ADAGRASIB (KRAZATI)

MEDICATION(S)
KRAZATI

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Exclusion criteria will be based on current National Comprehensive Cancer Network (NCCN) guidelines and FDA labeling.

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

ADALIMUMAB (HADLIMA)

MEDICATION(S)
HADLIMA, HADLIMA PUSHTOUCH

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Being used with another targeted immunotherapy drug.

REQUIRED MEDICAL INFORMATION
Ankylosing spondylitis (AS): patient is not able to take NSAIDs due to history of GI bleed or ulcer OR patient has tried one RX strength NSAID in combination with a PPI and had GI side effects OR patient's condition did not respond to a trial of two different RX strength NSAIDs.
Crohn's Disease (CD) weekly dosing: patient has tried every other week dosing and had a flare or loss in response.
Hidradenitis suppurativa (HS): patient has Hurley stage II or III HS.
Non-infectious uveitis: patient has tried a systemic corticosteroid (e.g. prednisone, dexamethasone, hydrocortisone) or has a medical reason why corticosteroids cannot be used.
Plaque Psoriasis (PsO), initial use: patient tried and failed or had a side effect to one DMARD or has a medical reason why methotrexate (MTX), cyclosporine, and acitretin cannot be used AND baseline PASI score 10 or more OR BSA 3% or more OR sensitive areas are involved OR disease affects daily living. Ongoing use: PASI or BSA improved on Hadlima.
Psoriatic Arthritis (PsA): patient has tried and failed or had a side effect to one DMARD or has a medical reason why MTX, leflunomide, and sulfasalazine cannot be use.
Rheumatoid Arthritis (RA): patient has tried and failed or had a side effect to methotrexate (MTX) or has a medical reason why MTX cannot be used.
Polyarticular Juvenile Idiopathic Arthritis (pJIA): patient has tried and failed or had a side effect to one DMARD or has a medical reason why methotrexate (MTX) cannot be used.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
RA, PsA, pJIA, AS: Rheumatologist. PsO: Rheumatologist or Dermatologist. HS: Dermatologist. Non-infectious uveitis: Ophthalmologist.

COVERAGE DURATION
PsO, initial: 24 weeks - ongoing use: plan year. All other indications: plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

ADALIMUMAB (HUMIRA)

MEDICATION(S)
HUMIRA, HUMIRA (2 PEN), HUMIRA (2 SYRINGE) 40 MG/0.8ML PREF SY KT, HUMIRA-CD/UC/HS STARTER, HUMIRA-PED<40KG CROHNS STARTER, HUMIRA-PED>/=40KG CROHNS START, HUMIRA-PED>/=40KG UC STARTER, HUMIRA-PS/UV/ADOL HS STARTER, HUMIRA-PSORIASIS/UVEIT STARTER

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Being used with another targeted immunotherapy drug.

REQUIRED MEDICAL INFORMATION
Spondyloarthritis (SpA): patient is not able to take NSAIDs due to history of GI bleed or ulcer OR patient has tried one RX strength NSAID in combination with a PPI and had GI side effects OR patient's condition did not respond to a trial of two different RX strength NSAIDs.

Crohn's Disease (CD), weekly dosing: patient has tried every other week dosing and had a flare or loss in response.

Hidradenitis suppurativa (HS): patient has Hurley stage II or III HS.

Non-infectious uveitis: patient has tried a systemic corticosteroid (e.g. prednisone, dexamethasone, hydrocortisone) or has a medical reason why corticosteroids cannot be used.

Plaque Psoriasis (PsO), initial use: patient has tried one DMARD or has a medical reason why methotrexate (MTX), cyclosporine, and acitretin cannot be used AND baseline PASI score 10 or more OR BSA 3% or more OR sensitive areas are involved OR disease affects daily living. Ongoing use: PASI or BSA improved on Humira.

Psoriatic Arthritis (PsA): patient has tried one DMARD or has a medical reason why MTX, leflunomide, and sulfasalazine cannot be used.

Rheumatoid Arthritis (RA) and Juvenile Idiopathic Arthritis (JIA): treatment failure or side effect with methotrexate (MTX) or patient has a medical reason why MTX cannot be used.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
RA, PsA, JIA, AS: Rheumatologist. PsO: Rheumatologist or Dermatologist. HS: Dermatologist. Non-infectious uveitis: Ophthalmologist.

COVERAGE DURATION
PsO, initial: 16 weeks - ongoing use: plan year All other indications: plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

ADAPALENE (DIFFERIN)

MEDICATION(S)
ADAPALENE 0.1 % CREAM, ADAPALENE 0.1 % GEL

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
40 years of age or older. No prior authorization required for less than 40 years old.

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

AFATINIB DIMALEATE (GILOTRIF)

MEDICATION(S)
GILOTRIF

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Exclusion criteria will be based on current National Comprehensive Cancer Network (NCCN) guidelines and FDA labeling.

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan Year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

ALECTINIB (ALECENSA)

MEDICATION(S)
ALECENSA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Exclusion criteria will be based on current National Comprehensive Cancer Network (NCCN) guidelines and FDA labeling.

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan Year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

ALISKIREN (TEKTURNA)

MEDICATION(S)
ALISKIREN FUMARATE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Trial and failure of at least one ARB (e.g. losartan) and one of the following drug classes: ACE inhibitor (e.g. lisinopril), CCB (e.g. diltiazem, amlodipine), thiazide (e.g. hydrochlorothiazide), or beta blocker (e.g. atenolol).

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

ALITRETINOIN (PANRETIN)

MEDICATION(S)
PANRETIN

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Exclusion criteria will be based on current National Comprehensive Cancer Network (NCCN) guidelines and FDA labeling.

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

ALOSETRON (LOTRONEX)

MEDICATION(S)
ALOSETRON HCL

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Irritable bowel syndrome with diarrhea (IBS-D), initial use: patient is female, and trial and failure or side effect to an anti-diarrheal drug (i.e., diphenoxylate-atropine (Lomotil), loperamide) OR has a medical reason not to use (contraindication) anti-diarrheal therapies. Ongoing use: IBS symptoms improved with alosetron and patient does not have constipation problems.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Initial: 2 months

Ongoing use: plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

ALPELISIB (PIQRAY)

MEDICATION(S)
PIQRAY (200 MG DAILY DOSE), PIQRAY (250 MG DAILY DOSE), PIQRAY (300 MG DAILY DOSE)

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Exclusion criteria will be based on current National Comprehensive Cancer Network (NCCN) guidelines and FDA labeling.

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

AMBRISENTAN (LETAIRIS)

MEDICATION(S)
AMBRISENTAN

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Confirmation of Pulmonary Arterial Hypertension (WHO Group I) by right heart catheterization test.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

APALUTAMIDE (ERLEADA)

MEDICATION(S)
ERLEADA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Exclusion criteria will be based on current National Comprehensive Cancer Network (NCCN) guidelines and FDA labeling.

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

APOMORPHINE (APOKYN)

MEDICATION(S)
APOMORPHINE HCL

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Loss of control of body movements due to advanced Parkinson's disease (hypomobility): Treatment failure to at least one antiparkinsonian drug (i.e., pramipexole, entacapone, rasagiline, etc.).

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Neurologist

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

APREMILAST (OTEZLA)

MEDICATION(S)
OTEZLA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Being used with another targeted immunotherapy drug.

REQUIRED MEDICAL INFORMATION
Behcet's Disease.

Plaque Psoriasis (PsO), initial use: treatment failure or side effect with one of the following: a DMARD, a topical corticosteroid (i.e., betamethasone), a calcineurin inhibitor (i.e., tacrolimus ointment), or calcipotriene OR has a medical reason why methotrexate, cyclosporine, acitretin, or topical agents cannot be used.

Psoriatic arthritis (PsA): treatment failure or side effect with one DMARD drug or medical reason why methotrexate, leflunomide, and sulfasalazine cannot be used.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
PsO: Dermatologist or Rheumatologist. PsA: Rheumatologist.

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE

N/A

APREPITANT 40MG CAPSULE (EMEND)

MEDICATION(S)
APREPITANT 40 MG CAP

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Prevention of post-surgery nausea and vomiting (PONV): patient cannot use other antiemetics (e.g. ondansetron, promethazine, transdermal scopolamine) prior to surgery because of history of treatment failure or side effects and dose will be given within 3 hours of surgery.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
PONV: once per surgery.

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

ARMODAFINIL (NUVIGIL)

MEDICATION(S)
ARMODAFINIL

PA INDICATION INDICATOR
4 - All FDA-Approved Indications, Some Medically-Accepted Indications

OFF LABEL USES
Bipolar disorder

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Narcolepsy: patient has positive sleep study (polysomnography) for narcolepsy. Trial and failure or side effect with modafinil or there is a medical reason why modafinil cannot be used.

Obstructive sleep apnea/hypopnea syndrome (OSAHS): patient has a positive sleep study for OSAHS, Trial and failure or side effect with modafinil or there is a medical reason why modafinil cannot be used. Shift work sleep disorder: patient is a night shift worker working between 11pm and 7am OR patient is an early morning shift worker with starting hours between 4am and 7am OR patient is a rotating shift worker with night shifts. Trial and failure or side effect with modafinil or there is a medical reason why modafinil cannot be used.

Bipolar Disorder: being added to current treatment regimen AND Trial and failure or side effect with modafinil or there is a medical reason why modafinil cannot be used.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Bipolar Disorder: Psychiatrist

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

ASCIMINIB (SCEMBLIX)

MEDICATION(S)
SCEMBLIX

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Exclusion criteria will be based on current National Comprehensive Cancer Network (NCCN) guidelines and FDA labeling.

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

ASENAPINE (SAPHRIS)

MEDICATION(S)
ASENAPINE MALEATE

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Trial and failure or side effect with one preferred atypical antipsychotic agent (e.g. aripiprazole, olanzapine) or there is a medical reason why all the preferred agents cannot be used.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

ASENAPINE (SECUADO)

MEDICATION(S)
SECUADO

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Side effect to asenapine tablet (Saphris) not seen with Secuado.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

ASFOTASE ALFA (STRENSIQ)

MEDICATION(S)
STRENSIQ

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Being used for odonto- or pseudo- HPP or adult-onset HPP.

REQUIRED MEDICAL INFORMATION
Documented history of one or more signs of HPP and lab test confirms low alkaline phosphatase (ALP) activity for age and gender.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
HPP: Endocrinologist, Geneticist, or Pediatric Specialist

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

ATOVAQUONE (MEPRON)

MEDICATION(S)
ATOVAQUONE

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Toxoplasmosis prevention or treatment: patient is immunocompromised or at high risk of infection. Toxoplasmosis primary prevention: patient has failed or had a side effect to tmp/smx or has a medical reason (contraindication) for not using tmp/smx. PCP prevention or treatment: patient is immunocompromised or at high risk of infection and patient has failed or had a side effect to tmp/smx or has a medical reason (contraindication) for not using tmp/smx. Babesiosis treatment: active infection confirmed by blood smear test that is positive for Babesia microti parasites, PCR blood sample positive for Babesia microti DNA, or FISH test positive for Babesia microti RNA.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
PCP: 21days, Toxo: 6wks, Babesiosis: 10 days, PCP/Toxo prevention: Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

AVAPRITINIB (AYVAKIT)

MEDICATION(S)
AYVAKIT

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Exclusion criteria will be based on current National Comprehensive Cancer Network (NCCN) guidelines and FDA labeling.

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

AXITINIB (INLYTA)

MEDICATION(S)
INLYTA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Exclusion criteria will be based on current National Comprehensive Cancer Network (NCCN) guidelines and FDA labeling.

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

AZACITIDINE (ONUREG)

MEDICATION(S)
ONUREG

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Exclusion criteria will be based on current National Comprehensive Cancer Network (NCCN) guidelines and FDA labeling.

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

AZTREONAM LYSINE (CAYSTON)

MEDICATION(S)
CAYSTON

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Being used for acute treatment of an infection.

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

BECAPLERMIN (REGRANEX)

MEDICATION(S)
REGRANEX

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Treating pressure ulcers or venous stasis ulcers.

REQUIRED MEDICAL INFORMATION
Diabetic ulcer has not responded to standard therapy for wound management (i.e. debridement, dressing changes, pressure relief).

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
3 months

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

BEDAQUILINE (SIRTURO)

MEDICATION(S)
SIRTURO

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
PLAN YEAR

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

BELIMUMAB (BENLYSTA)

MEDICATION(S)
BENLYSTA 200 MG/ML SOLN A-INJ, BENLYSTA 200 MG/ML SOLN PRSYR

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Diagnosis is severe CNS lupus. Benlysta is being used with Rituxan, other biologics, or IV cyclophosphamide.

REQUIRED MEDICAL INFORMATION
Systemic Lupus Erythematous (SLE) initial use: patient is currently taking one or more of the following: prednisone, methylprednisolone, azathioprine, methotrexate, mycophenolate, chloroquine, hydroxychloroquine.
Lupus Nephritis: being added to standard SLE therapy (e.g. corticosteroids, immunomodulators).

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
SLE: Rheumatologist
Lupus Nephritis: Rheumatologist or Nephrologist.

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

BELUMOSUDIL (REZUROCK)

MEDICATION(S)
REZUROCK

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

BELZUTIFAN (WELIREG)

MEDICATION(S)
WELIREG

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Exclusion criteria will be based on current National Comprehensive Cancer Network (NCCN) guidelines and FDA labeling.

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan Year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

BEXAROTENE (TARGRETIN TOPICAL GEL)

MEDICATION(S)
BEXAROTENE 1 % GEL

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Exclusion criteria will be based on current National Comprehensive Cancer Network (NCCN) guidelines and FDA labeling.

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

BEXAROTENE CAPSULE (TARGRETIN)

MEDICATION(S)
BEXAROTENE 75 MG CAP

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Exclusion criteria will be based on current National Comprehensive Cancer Network (NCCN) guidelines and FDA labeling.

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

BINIMETINIB (MEKTOVI)

MEDICATION(S)
MEKTOVI

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Exclusion criteria will be based on current National Comprehensive Cancer Network (NCCN) guidelines and FDA labeling.

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

BOSENTAN (TRACLEER)

MEDICATION(S)
BOSENTAN, TRACLEER 32 MG TAB SOL

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Confirmation of Pulmonary Arterial Hypertension (WHO Group I) by right heart catheterization test.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

BOSUTINIB (BOSULIF)

MEDICATION(S)
BOSULIF

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Exclusion criteria will be based on current National Comprehensive Cancer Network (NCCN) guidelines and FDA labeling.

REQUIRED MEDICAL INFORMATION
First line therapy for CML: medical reason why imatinib cannot be used.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

BREXPIPRAZOLE (REXULTI)

MEDICATION(S)
REXULTI

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Depression: being used as a single agent

REQUIRED MEDICAL INFORMATION
Trial and failure or side effect with aripiprazole or medical reason why aripiprazole cannot be used.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

BRIGATINIB (ALUNBRIG)

MEDICATION(S)
ALUNBRIG

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Exclusion criteria will be based on current National Comprehensive Cancer Network (NCCN) guidelines and FDA labeling.

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

BUDESONIDE (ENTOCORT EC)

MEDICATION(S)
BUDESONIDE 3 MG CP DR PART

PA INDICATION INDICATOR
4 - All FDA-Approved Indications, Some Medically-Accepted Indications

OFF LABEL USES
Microscopic colitis (aka lymphocytic and collagenous colitis), Autoimmune hepatitis

EXCLUSION CRITERIA
Being used for severe Crohn's disease (CD). Autoimmune hepatitis: patient has liver cirrhosis.

REQUIRED MEDICAL INFORMATION
CD, initial use: budesonide will be used to induce remission.

CD, ongoing use: prescriber states patient responded to initial therapy and needs to continue therapy to maintain remission and there is a medical reason why guideline supported therapies (e.g. infliximab, mesalamine, azathioprine) for maintaining CD remission cannot be used.

Autoimmune hepatitis: being used with azathioprine and has a medical reason not to use prednisone or prednisolone or had severe side effect to prednisone or prednisolone that is not also seen with budesonide and initial dose is not more than 9 mg per day.

Microscopic colitis: initial dose is not more than 9 mg per day. For ongoing use: responded to initial therapy but symptoms returned after therapy was completed and dose is not more than 6 mg per day.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Microscopic colitis: gastroenterologist or infectious disease specialist. Autoimmune hepatitis: gastroenterologist, hepatologist, or infectious disease specialist.

COVERAGE DURATION
Autoimmune hepatitis: plan year. CD and Microscopic colitis: see other criteria.

OTHER CRITERIA

CD and Microscopic colitis initial: 8 weeks. CD maintenance: 3 months.
Microscopic colitis ongoing: plan year.
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE

N/A

BUDESONIDE ER TABLET (UCERIS)

MEDICATION(S)
BUDESONIDE ER

PA INDICATION INDICATOR
4 - All FDA-Approved Indications, Some Medically-Accepted Indications

OFF LABEL USES
Microscopic colitis (aka lymphocytic and collagenous colitis), Autoimmune hepatitis

EXCLUSION CRITERIA
Microscopic colititis: Used for maintenance

REQUIRED MEDICAL INFORMATION
Ulcerative colitis (UC): being used to start remission of active UC, and patient has tried or has a medical reason for not trying one drug from the mesalamine class (e.g. balsalazide, mesalamine), and for moderate disease, medical reason why patient cannot use a generic corticosteroid drug that is taken by mouth (e.g. prednisone, methylprednisolone, hydrocortisone, and dexamethasone).

Autoimmune hepatitis: being used with azathioprine and has a medical reason not to use prednisone or prednisolone or had severe side effect to prednisone or prednisolone that is not also seen with budesonide and dose is not more than 9 mg per day.

Microscopic colitis: being used to start remission of symptoms and dose is not more than 9 mg per day.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
UC: Gastroenterologist. Microscopic colitis: Gastroenterologist, Infectious Disease. Autoimmune hepatitis: Gastroenterologist, Hepatologist or Infectious Disease.

COVERAGE DURATION
UC, Microscopic colitis: 8 weeks. Autoimmune hepatitis: plan year.

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

BUPRENORPHINE PATCH (BUTRANS) – NARCOTIC SAFETY INITIATIVE

MEDICATION(S)
BUPRENORPHINE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Being used with other long-acting narcotic drugs.

REQUIRED MEDICAL INFORMATION
Cancer pain: dose has been consolidated to the least number of higher strength forms.

Non-cancer pain, initial: cause of pain cannot be removed or treated with other treatment options, and pain occurs daily and has lasted for at least 3 months, and pain is severe enough to need daily around-the-clock long-term narcotic use, and total daily dose across all narcotic drugs is less than 90 MME, and dose has been consolidated to the least number of higher strength forms and patient has tried at least one short-acting narcotic drug, and chart notes document pain history including baseline pain intensity score and functional interference score, a plan for monitoring side effects and misuse, and a plan to taper down narcotics.

Non-cancer pain, reauth: total daily dose across all narcotic drugs is less than 90 MME per day, and dose has been consolidated to the least number of higher strength forms, and chart notes document current pain intensity score, functional interference score, any side effects and/or misuse with current pain treatment regimen, and plan to taper narcotic use.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Cancer pain: Oncologist or Pain Specialist.

COVERAGE DURATION
Cancer pain: plan year Non-cancer pain: initial 30 days,1st reauth 3mos, ongoing reauths plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

BUROSUMAB-TWZA (CRYSVITA SQ)

MEDICATION(S)
CRYSVITA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Adult patients (18 years and older), initial use: patient has osteomalacia-related symptoms [e.g. spontaneous or unhealed bone breaks (fractures), elevated serum bone ALP] or skeletal pain that affects daily activities and not controlled with non-narcotic pain medication.

Ongoing use: improvement in patients symptoms (e.g. healing of rickets, correction of leg deformities, or increase in height for children, healing of existing fractures or lower number of new fractures, less pain with daily activities, better mobility, or ALP is lower than prior lab result).

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
XLH: Endocrinologist

TIO: Endocrinologist or oncologist

COVERAGE DURATION
Plan year

OTHER CRITERIA
Excluded under Part D if covered by Part B.
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE

N/A

BUTALBITAL CONTAINING PRODUCTS

MEDICATION(S)
BAC, BUTALBITAL-ACETAMINOPHEN 50-300 MG CAP, BUTALBITAL-APAP-CAFF-COD 50-325-40-30 MG CAP, BUTALBITAL-APAP-CAFFEINE 50-325-40 MG CAP, BUTALBITAL-APAP-CAFFEINE 50-325-40 MG TAB, BUTALBITAL-ASPIRIN-CAFFEINE, ESGIC 50-325-40 MG CAP, ZEBUTAL

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Tension Headache: trial of two prescription strength non-steroidal anti-inflammatory drugs (NSAIDs) and amount requested does not exceed the amount needed to treat the number of headache days per month.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
If more than 8 headache days per month: neurologist or headache or pain specialist

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

C1 ESTERASE INHIBITOR (HAEGARDA)

MEDICATION(S)
HAEGARDA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Being used with other Hereditary Angioedema (HAE) preventive therapies (e.g. danazol, Cinryze).

REQUIRED MEDICAL INFORMATION
Prevention: chart documentation or labs that show C4 and C1-INH (antigenic or functional) levels confirm HAE type I or II, and prescriber states that patient has symptomatic disease.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

CABOZANTINIB (CABOMETYX)

MEDICATION(S)
CABOMETYX

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Exclusion criteria will be based on current National Comprehensive Cancer Network (NCCN) guidelines and FDA labeling.

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

CABOZANTINIB S-MALATE (COMETRIQ)

MEDICATION(S)
COMETRIQ (100 MG DAILY DOSE), COMETRIQ (140 MG DAILY DOSE), COMETRIQ (60 MG DAILY DOSE)

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Exclusion criteria will be based on current National Comprehensive Cancer Network (NCCN) guidelines and FDA labeling.

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

CANAKINUMAB (ILARIS)

MEDICATION(S)
ILARIS

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
SJIA and AOSD: Rheumatologist

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

CANNABIDIOL (CBD) EXTRACT (EPIDIOLEX)

MEDICATION(S)
EPIDIOLEX

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Dravet Syndrome: Trial and failure of valproic acid, divalproex, or clobazam.

Lennox-Gastaut syndrome: trial and failure or side effect to two of the following anti-seizure drugs: clonazepam, felbamate, lamotrigine, and topiramate or there is a medical reason why all these other drugs cannot be used.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

CAPIVASERTIB (TRUQAP)

MEDICATION(S)
TRUQAP

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Exclusion criteria will be based on current National Comprehensive Cancer Network (NCCN) guidelines and FDA labeling.

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

CAPMATINIB (TABRECTA)

MEDICATION(S)
TABRECTA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Exclusion criteria will be based on current National Comprehensive Cancer Network (NCCN) guidelines and FDA labeling.

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

CARGLUMIC ACID (CARBAGLU)

MEDICATION(S)
CARGLUMIC ACID

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

CARIPRAZINE HYDROCHLORIDE (VRAYLAR)

MEDICATION(S)
VRAYLAR

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Major Depressive Disorder: Being used as single agent therapy.

REQUIRED MEDICAL INFORMATION
Trial and failure or side effect to one preferred atypical antipsychotic drug (e.g. aripiprazole, clozapine, olanzapine, quetiapine, risperidone, ziprasidone) or there is a medical reason why all the preferred agents cannot be used.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

CASPOFUNGIN (CANCIDAS)

MEDICATION(S)
CASPOFUNGIN ACETATE

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Oropharyngeal or Esophageal Candidiasis: patient has tried fluconazole OR fungal culture confirms infection is resistant to azole antifungals.

Invasive Aspergillosis: patient has tried an oral or IV azole antifungal or fungal culture confirms infection is resistant to azole antifungals.

Antifungal prophylaxis in cancer patients at high risk of febrile neutropenia [e.g. due to chemotherapy regimen, AML/MDS patient, undergoing HCST]: patient has tried fluconazole, voriconazole, or posaconazole or has a medical reason (contraindications) to azole antifungals.

Pulmonary Aspergillosis: patient has tried itraconazole or voriconazole.

Ongoing use for all conditions: continued neutropenia, culture remains positive, or ongoing symptoms.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
2 months

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

CENOBAMATE (XCOPRI)

MEDICATION(S)
XCOPRI, XCOPRI (250 MG DAILY DOSE), XCOPRI (350 MG DAILY DOSE)

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Treatment failure or side effect with two preferred partial seizure drugs (e.g. carbamazepine, clorazepate, divalproex, felbamate lamotrigine, levetiracetam, oxcarbazepine, phenytoin, topiramate, zonisamide) OR medical reason why the preferred partial seizure drugs cannot be used (contraindication).

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

CERITINIB (ZYKADIA)

MEDICATION(S)
ZYKADIA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Exclusion criteria will be based on current National Comprehensive Cancer Network (NCCN) guidelines and FDA labeling.

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

CHOLIC ACID (CHOLBAM)

MEDICATION(S)
CHOLBAM

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

CLOBAZAM (ONFI)

MEDICATION(S)
CLOBAZAM

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Dravet syndrome: trial and failure or side effect to valproic acid or divalproex.

Lennox-Gastaut syndrome: trial and failure or side effect to two of the following anti-seizure drugs: clonazepam, felbamate, lamotrigine, and topiramate or there is a medical reason why all these other drugs cannot be used.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

CLOBAZAM ORAL FILM (SYMPAZAN)

MEDICATION(S)
SYMPAZAN

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Seizures due to Dravet Syndrome: Trial and failure or side effect with valproic acid or divalproex AND side effect to clobazam (Onfi) tablet and suspension that is not seen with Sympazan.

Lennox-Gastaut Syndrome: side effect to clobazam (Onfi) tablet and suspension that is not seen with Sympazan.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

CLOZAPINE SUSPENSION (VERSACLOZ)

MEDICATION(S)
VERSACLOZ

PA INDICATION INDICATOR
4 - All FDA-Approved Indications, Some Medically-Accepted Indications

OFF LABEL USES
Parkinson's psychosis disorder

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Patient has a medical reason not to use clozapine tablets.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

COBIMETINIB (COTELLIC)

MEDICATION(S)
COTELLIC

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Exclusion criteria will be based on current National Comprehensive Cancer Network (NCCN) guidelines and FDA labeling.

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

CORTICOTROPIN (CORTROPHIN)

MEDICATION(S)
CORTROPHIN

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Ongoing use for treating infantile spasm: medical records show continued diagnosis (e.g. EEG confirms ongoing spasm).

Multiple Sclerosis (MS): patient is on a maintenance drug for MS (e.g. Tecfidera, Betaseron, glatiramer, Gilenya, Aubagio) but has an acute flare up and has had a side effect or contraindication to corticosteroids that is not seen with the use of Cortrophin.

Idiopathic or lupus erythematosus associated nephrotic syndrome, first use: patient's condition has not gotten better while using at least one immunosuppressive drug (cyclophosphamide, cyclosporine, and mycophenolate), and patient's condition responded to corticosteroid therapy but has had a side effect with the therapy that would not be seen with the use of Cortrophin. Ongoing use requires prescriber statement that patient's condition has gotten better while using Cortrophin.

All other FDA approved indications, first use: patient has not seen improvement of symptoms despite trying at least one different FDA approved drug for the condition other than corticosteroids, and has had a side effect to corticosteroids that is not seen with the use of Cortrophin. Ongoing use requires prescriber statement that patient's condition has gotten better while using Cortrophin.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Infantile spasms: Neurologist or Neonatologist MS: Neurologist or MS specialist Idiopathic or lupus erythematosus associated nephrotic syndrome: Nephrologist Rheumatic disorders, Collagen diseases: Rheumatologist Skin Diseases: Dermatologist Eye diseases: Ophthalmologist Symptomatic sarcoidosis: Pulmonologist

COVERAGE DURATION
MS flare: 3 weeks, Other FDA approved uses: 1 month

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

CRIZOTINIB (XALKORI)

MEDICATION(S)
XALKORI

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Exclusion criteria will be based on current National Comprehensive Cancer Network (NCCN) guidelines and FDA labeling.

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

CYSTEAMINE (CYSTAGON)

MEDICATION(S)
CYSTAGON

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

CYSTEAMINE (CYSTARAN)

MEDICATION(S)
CYSTARAN

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

CYSTEAMINE DELAYED RELEASE (PROCYSBI)

MEDICATION(S)
PROCYSBI 25 MG CAP DR, PROCYSBI 75 MG CAP DR

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

DABRAFENIB (TAFINLAR)

MEDICATION(S)
TAFINLAR

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Exclusion criteria will be based on current National Comprehensive Cancer Network (NCCN) guidelines and FDA labeling.

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

DACOMITINIB (VIZIMPRO)

MEDICATION(S)
VIZIMPRO

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Exclusion criteria will be based on current National Comprehensive Cancer Network (NCCN) guidelines and FDA labeling.

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

DALFAMPRIDINE EXTENDED-RELEASE TABLET (AMPYRA)

MEDICATION(S)
DALFAMPRIDINE ER

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Multiple sclerosis, initial use: 25-foot walking test score. Ongoing use: updated timed 25-foot walking test shows improvement from prior or baseline test.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Neurologist or Multiple Sclerosis specialist

COVERAGE DURATION
Initial use: 3 months. Ongoing use: plan year.

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

DARBEPOETIN ALFA (ARANESP)

MEDICATION(S)
ARANESP (ALBUMIN FREE)

PA INDICATION INDICATOR
4 - All FDA-Approved Indications, Some Medically-Accepted Indications

OFF LABEL USES
Low red blood cells (anemia) due to Myelodysplastic Syndrome (MDS), anemia in patients with cancer who are undergoing palliative treatment, Myelofibrosis.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Chronic kidney disease (CKD), initial: Hgb is less than 10g/dL. Ongoing use: Hgb level of less than or equal to 10 g/dl in adults with CKD (not on dialysis), 11g/dL in adults with CKD (on dialysis), or 12 g/dl in children with CKD (not on dialysis). Myelosuppressive chemo related anemia Hgb is less than 10g/dl AND one of the following: patient is on chemo or completed last dose within last 8 wks or patient has multiple myeloma (MM) on Revlimid tx. MDS or Myelofibrosis: Hgb is less than 10g/dL (symptomatic anemia), and EPO level is less than or equal to 500U/ml or for MDS: patient has isolated 5q chromosome deletion [del (5q)]. Anemia in cancer patients undergoing palliative treatment: Hgb is less than or equal to 10g/dL. For all indications: target Hgb level has not been met or maintained with at least 8 weeks of max dose Retacrit OR patient has a medical reason (contraindication) not to use Retacrit OR had a side effect with Retacrit that is not seen with Aranesp OR patient has a religious belief that does not allow treatment with drugs that contain human albumin.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
CKD: 6 months. All other conditions: Plan year

OTHER CRITERIA
Excluded under Part D if covered by Part B.
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

DAROLUTAMIDE (NUBEQA)

MEDICATION(S)
NUBEQA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Exclusion criteria will be based on current National Comprehensive Cancer Network (NCCN) guidelines and FDA labeling.

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

DASATINIB (SPRYCEL)

MEDICATION(S)
DASATINIB, SPRYCEL

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Exclusion criteria will be based on current National Comprehensive Cancer Network (NCCN) guidelines and FDA labeling.

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

DECITABINE/CEDAZURIDINE (INQOVI)

MEDICATION(S)
INQOVI

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Exclusion criteria will be based on current National Comprehensive Cancer Network (NCCN) guidelines and FDA labeling.

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

DENOSUMAB (PROLIA)

MEDICATION(S)
PROLIA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Being used with other osteoporosis drugs.

REQUIRED MEDICAL INFORMATION
Treatment or prevention of postmenopausal osteoporosis in women OR to increase bone mass in men: one of the following: trial of a bisphosphonate (e.g. alendronate, ibandronate, risedronate, or zoledronic acid), OR side effect to bisphosphonate therapy that supports discontinuation, OR Patient is at very high risk of fracture by meeting at least one of the following: non-traumatic fracture while on bisphosphonate therapy, patient has experienced a recent fracture (within the past 12 months) or history of multiple fractures, patient experienced a fracture while on long-term glucocorticoid therapy, or T-score less than -3.0, or patient is at high risk for falls, or 10-year hip fracture probability of greater than 4.5% based on FRAX score, or 10-year major osteoporosis-related fracture probability greater than 30% based on FRAX score.

Glucocorticoid-induced osteoporosis: initiating or continuing long-term glucocorticoid treatment (e.g. prednisone, dexamethasone) and either has history of a non-traumatic fracture or is at high risk for fracture.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

DENOSUMAB (XGEVA)

MEDICATION(S)
XGEVA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Bone metastases from solid tumors or multiple myeloma: documentation of metastatic bone disease by scan or x-ray. Treatment of high calcium due to cancer: patient tried intravenous bisphosphonate therapy (e.g. zoledronic acid, pamidronate) within the last 30 days but did not respond well enough or had a side effect.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

DEUTETRABENAZINE (AUSTEDO)

MEDICATION(S)
AUSTEDO, AUSTEDO XR, AUSTEDO XR PATIENT TITRATION

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Tardive Dyskinesia: Neurologist or Psychiatrist

Huntington's Chorea: Neurologist

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

DEXAMETHASONE TABLET (HEMADY)

MEDICATION(S)
HEMADY

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Patient is using dexamethasone tablet and would like Hemady to lower pill burden.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

DEXTROMETHORPHAN HBR- BUPROPION HCL ER (AUVELITY)

MEDICATION(S)
AUVELITY

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Treatment failure or side effect with at least two generic antidepressants (e.g., fluoxetine, bupropion, duloxetine, sertraline, venlafaxine, etc.).

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

DICLOFENAC TOPICAL GEL (SOLARAZE)

MEDICATION(S)
DICLOFENAC SODIUM 3 % GEL

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Treatment failure or side effect with one preferred topical Actinic Keratosis agent (e.g. fluorouracil cream or solution, imiquimod cream) OR has a medical reason for not using all preferred topical Actinic Keratosis agents.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
90 days

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

DIHYDROERGOTAMINE INJECTION (D.H.E. 45)

MEDICATION(S)
DIHYDROERGOTAMINE MESYLATE 1 MG/ML SOLUTION

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Being used with another triptan or ergot-type drug.

REQUIRED MEDICAL INFORMATION
Migraine Headache: total number of doses matches the amount needed to treat the number of headache days per month, and trial of at least two preferred triptans or has a medical reason (contraindication) for not using triptans, for more than 8 headache days per month: prescribed by a Neurologist or headache specialist and currently taking a migraine prevention drug OR has a contraindication to all of the following migraine prevention drugs: divalproex, valproate, topiramate, amitriptyline, venlafaxine, atenolol, and nadolol. Cluster Headache: total number of doses matches the amount needed to treat the number of headache days per month, and trial of sumatriptan and zolmitriptan, and currently on prophylactic drugs supported for preventing cluster headaches including prednisone, dexamethasone, verapamil, lithium, or topiramate, OR has a contraindication to the supported prophylactic drugs.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE

N/A

DIHYDROERGOTAMINE MESYLATE (MIGRANAL NASAL SPRAY)

MEDICATION(S)
DIHYDROERGOTAMINE MESYLATE 4 MG/ML SOLUTION

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Being used with another triptan or ergot-type drug.

REQUIRED MEDICAL INFORMATION
Migraine Headache: total number of doses matches the amount needed to treat the number of headache days per month, and trial of at least two preferred triptans or has a medical reason (contraindication) for not using triptans.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

DIMETHYL FUMARATE (TECFIDERA)

MEDICATION(S)
DIMETHYL FUMARATE, DIMETHYL FUMARATE STARTER PACK

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Being used with other disease-modifying therapies for relapsing Multiple Sclerosis.

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

DRONABINOL

MEDICATION(S)
DRONABINOL

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Excluded under Part D if covered by Part B.
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

DROXIDOPA (NORTHERA)

MEDICATION(S)
DROXIDOPA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Orthostatic hypotension is caused by primary anatomic failure such as Parkinson's disease, multiple system neuropathy or pure autonomic failure, dopamine beta-hydroxylase deficiency, or non-diabetic autonomic neuropathy. For ongoing use: patient has had clinical improvement in symptoms (i.e. dizziness, lightheadedness, vision, weakness, fatigue, concentration, head/neck discomfort) or daily living activities.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Cardiologist or Neurologist

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

DULAGLUTIDE (TRULICITY)

MEDICATION(S)
TRULICITY

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Being used with another GLP-1 agent

REQUIRED MEDICAL INFORMATION
Type 2 diabetes: Confirmed AND one of the following: trial and failure or side effect with metformin or medical reason why metformin cannot be used, or A1C of 7.5% or greater and being used with another diabetes drug, or patient has heart (cardiovascular) disease. or more than one risk factor for heart (cardiovascular) disease (i.e., high blood pressure, high cholesterol, chronic kidney disease, etc.).

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

DULOXETINE (DRIZALMA SPRINKLE)

MEDICATION(S)
DRIZALMA SPRINKLE

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Medical reason why patient is not able to use duloxetine delayed-release capsule.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

DUPILUMAB (DUPIXENT)

MEDICATION(S)
DUPIXENT

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Asthma: Being used with another targeted immunotherapy drug. Atopic Dermatitis (AD): Being used with a JAK inhibitor or another targeted immunotherapy.

REQUIRED MEDICAL INFORMATION
Asthma, initial use: Treatment failure with recent use of high-dose inhaled corticosteroid along with long-acting beta agonist or leukotriene receptor antagonists, AND patient has had one of the following within the past year: one or more asthma-related ER or inpatient visits, or two or more asthma exacerbations that require oral corticosteroids, AND one of the following: eosinophil blood count is 150 cells/mL or more, or patient on maximally-tolerated oral corticosteroids. Atopic Dermatitis (AD) initial use: moderate to severe disease confirmed by Investigator's Global Assessment (IGA) score of 3-4, Eczema Area and Severity Index (EASI) score of at least 16, Body surface area of at least 10%, or Severity Scoring of Atopic Dermatitis Index (SCORAD) score of at least 25 AND treatment failure or side effect with any two of the following: a medium to very high potency topical corticosteroid, a topical calcineurin inhibitor, or a systemic immunosuppressant (i.e., azathioprine, mycophenolate, or cyclosporine) OR has a medical reason why these topical and systemic therapies cannot be used. Eosinophilic Esophagitis (EOE) initial use: treatment failure or side effect with a proton pump inhibitor (PPI) or inhaled fluticasone or budesonide OR has a medical reason why PPIs and inhaled fluticasone and budesonide cannot be used. Chronic rhinosinusitis with nasal polyps (CRSwNP): Treatment failure with an intranasal corticosteroid or medical reason why intranasal corticosteroids cannot be used. Ongoing use for all Dx: symptoms improved and/or controlled while on Dupixent.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Asthma: Immunologist, Pulmonologist, or Allergist. AD: Dermatologist, Immunologist, Allergist. EoE: Allergist, Immunologist, or Gastroenterologist. CRSwNP: Allergist, Immunologist, or Otolaryngologist. Prurigo Nodularis (PN): Dermatologist.

COVERAGE DURATION
Asthma, AD, EoE initial use: 6 mo, ongoing use: plan year. PN: 6 mo. CRSwNP: plan year.

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

DUVELISIB (COPIKTRA)

MEDICATION(S)
COPIKTRA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Exclusion criteria will be based on current National Comprehensive Cancer Network (NCCN) guidelines and FDA labeling.

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

EFLORNITHINE HYDROCHLORIDE (IWILFIN)

MEDICATION(S)
IWILFIN

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Exclusion criteria will be based on current National Comprehensive Cancer Network (NCCN) guidelines and FDA labeling.

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

ELACESTRANT (ORSERDU)

MEDICATION(S)
ORSERDU

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Exclusion criteria will be based on current National Comprehensive Cancer Network (NCCN) guidelines and FDA labeling.

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

ELEXACAFTOR/TEZACAFTOR/IVACAFTOR (TRIKAFTA)

MEDICATION(S)
TRIKAFTA 100-50-75 & 150 MG TAB THPK, TRIKAFTA 50-25-37.5 & 75 MG TAB THPK

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Being used with another CFTR modulator agent (e.g. Kalydeco, Symdeko, Orkambi)

REQUIRED MEDICAL INFORMATION
Documentation that confirms there is at least one CFTR gene mutation sensitive to Trikafta.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

ELIGLUSTAT (CERDELGA)

MEDICATION(S)
CERDELGA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Being used with another therapy that treats Type-1 Gauchers disease. Patient is an ultra-rapid CYP2D6 metabolizer.

REQUIRED MEDICAL INFORMATION
Patient has at least one of the following: low red blood cell count (anemia) with a low hemoglobin for age and sex, low platelet count (thrombocytopenia) with a platelet count under 100,000 cells/mcl or bleeding episodes documented as being due to thrombocytopenia, evidence of bone disease, enlarged liver (hepatomegaly), enlarged spleen (splenomegaly), or clinical symptoms of abdominal pain, fatigue, impaired physical movements, malnutrition (cachexia), or bone pain.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

ELTROMBOPAG OLAMINE (PROMACTA)

MEDICATION(S)
PROMACTA

PA INDICATION INDICATOR
4 - All FDA-Approved Indications, Some Medically-Accepted Indications

OFF LABEL USES
Myelodysplastic syndrome (MDS)-related thrombocytopenia, Thrombocytopenia post-hematopoietic cell transplant (HSCT)

EXCLUSION CRITERIA
Chronic immune thrombocytopenia (ITP): being used with another thrombopoietin receptor agonist (TPO-RA). MDS: being used in high-risk MDS.

REQUIRED MEDICAL INFORMATION
Chronic Hepatitis C: on interferon-based therapy and platelet count is less than or equal to 75,000/mcl prior to therapy or falls to less than or equal to 50,000/mcl during therapy. Chronic ITP, initial: platelet count is less than 30,000/mcl, and patient had a side effect or did not respond well enough to one of the following treatments: corticosteroids, IVIG, anti-D, and splenectomy OR has a medical reason not to use (contraindication) corticosteroids, IVIG, and anti-D. Aplastic anemia: prior therapy did not work well enough and platelet count is less than 50,000 cells/mcl or being used with cyclosporine and antithymocyte globulin (ATG) therapy for initial treatment. Thrombocytopenia due to MDS: treatment failure or side effect to at least one supported first line therapy for low risk MDS (e.g. decitabine, cyclosporine, ATG, lenalidomide) Or used in combination with ATG or by itself as initial therapy. Ongoing use: platelet count has improved since starting Promacta but is not more than 400,000 and for MDS only disease has not progressed to acute leukemia. Thrombocytopenia post-HSCT: prolonged low platelet count (thrombocytopenia) after allogenic transplant and poor graft function.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
ITP, initial: 3 months all other conditions: 6 months Ongoing use: 6 months

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

ENASIDENIB MESYLATE (IDHIFA)

MEDICATION(S)
IDHIFA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Exclusion criteria will be based on current National Comprehensive Cancer Network (NCCN) guidelines and FDA labeling.

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

ENCORAFENIB (BRAFTOVI)

MEDICATION(S)
BRAFTOVI

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Exclusion criteria will be based on current National Comprehensive Cancer Network (NCCN) guidelines and FDA labeling.

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

ENTRECTINIB (ROZLYTREK)

MEDICATION(S)
ROZLYTREK

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Exclusion criteria will be based on current National Comprehensive Cancer Network (NCCN) guidelines and FDA labeling.

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

ENZALUTAMIDE (XTANDI)

MEDICATION(S)
XTANDI

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Exclusion criteria will be based on current National Comprehensive Cancer Network (NCCN) guidelines and FDA labeling.

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

EPOETIN ALFA-EPBX (RETACRIT)

MEDICATION(S)
RETACRIT

PA INDICATION INDICATOR
4 - All FDA-Approved Indications, Some Medically-Accepted Indications

OFF LABEL USES
Low red blood cells (anemia) due to Myelodysplastic Syndrome (MDS), Myelofibrosis, anemia in patients with cancer who are undergoing palliative treatment.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Chronic kidney disease (CKD), initial use: Hgb is less than 10g/dL. Ongoing use: Hgb level of less than or equal to 10 g/dl in adults with CKD (not on dialysis), 11g/dL in adults with CKD (on dialysis), or 12 g/dl in children with CKD (not on dialysis). Anemia due to cancer drug therapy (myelosuppressive chemotherapy): Hgb is less than 10g/dl AND one of the following: patient is on chemo or completed last dose within last 8 wks or patient has multiple myeloma (MM) on Revlimid tx. MDS or Myelofibrosis: Hgb is less than 10g/dL (symptomatic anemia), and EPO level is less than or equal to 500U/ml or for MDS: patient has isolated 5q chromosome deletion [del (5q)]. HIV: currently on zidovudine and Hgb is less than 10g/dl. Anemia prior to a planned surgery: Hgb is less than or equal to 13g/dl and patient is likely to have significant blood loss and need of blood transfusions during surgery. Anemia in cancer patients undergoing palliative treatment: Hgb is less than or equal to 10g/dL.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
CKD: 6 months. Anemia prior to planned surgery: 1 month. All other conditions: Plan year

OTHER CRITERIA
Excluded under Part D if covered by Part B.
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

ERDAFITINIB (BALVERSA)

MEDICATION(S)
BALVERSA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Exclusion criteria will be based on current National Comprehensive Cancer Network (NCCN) guidelines and FDA labeling.

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

ERENUMAB-AOOE (AIMOVIG)

MEDICATION(S)
AIMOVIG

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Migraine headache prevention: documentation of 4 or more headache days per month, treatment failure or side effects with at least 2 preventive therapies from the following drug classes: beta blockers, antidepressants, anticonvulsants or there is a medical reason why the patient cannot use the AAN level A or B guideline endorsed preventive drugs.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

ERLOTINIB (TARCEVA)

MEDICATION(S)
ERLOTINIB HCL

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Exclusion criteria will be based on current National Comprehensive Cancer Network (NCCN) guidelines and FDA labeling.

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

ETANERCEPT (ENBREL – KIT, SYRINGE, SURECLICK)

MEDICATION(S)
ENBREL, ENBREL MINI, ENBREL SURECLICK

PA INDICATION INDICATOR
4 - All FDA-Approved Indications, Some Medically-Accepted Indications

OFF LABEL USES
hidradenitis suppurativa and graft vs host disease (GVHD)

EXCLUSION CRITERIA
Being used with another targeted immunotherapy drug.

REQUIRED MEDICAL INFORMATION
Spondyloarthritis (SpA): patient is not able to use NSAIDs due to history of GI bleed or ulcer OR patient has tried one RX strength NSAID in combination with a PPI and had GI side effects OR patient's condition did not respond to a trial of two different RX strength NSAIDs.

Plaque Psoriasis (PsO), initial use: patient has tried one DMARD or has a medical reason why MTX, cyclosporine, and acitretin cannot be used AND baseline PASI score 10 or more OR BSA 3% or more OR sensitive areas are involved OR disease affects daily living. PsO, ongoing use: PASI or BSA improved on Enbrel. Psoriatic Arthritis (PsA): patient has tried one DMARD or has a medical reason why MTX, leflunomide, and sulfasalazine cannot be used.

Rheumatoid Arthritis (RA) and Polyarticular Juvenile Idiopathic Arthritis (pJIA): Treatment failure or side effect with methotrexate or patient has a medical reason why MTX cannot be used.

Hidradenitis suppurativa (HS): Hurley stage II or III HS and failed or had a side effect with Humira failed or has a medical reason not to use Humira. For ongoing use: clinical response seen with use of Enbrel.

GVHD: treatment failure or side effect to injectable or oral corticosteroids (e.g. prednisone, methylprednisolone).

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
RA, pJIA, AS: Rheumatologist. PsA: Dermatologist or Rheumatologist. PsO, HS: Dermatologist.

COVERAGE DURATION
PsO: initial 12 weeks, ongoing plan year,

HS: 6 months,

Other indications: plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

EVEROLIMUS (AFINITOR DISPERZ)

MEDICATION(S)
EVEROLIMUS 2 MG TAB SOL, EVEROLIMUS 3 MG TAB SOL, EVEROLIMUS 5 MG TAB SOL

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Exclusion criteria will be based on current National Comprehensive Cancer Network (NCCN) guidelines and FDA labeling.

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

EVEROLIMUS (AFINITOR)

MEDICATION(S)
EVEROLIMUS 10 MG TAB, EVEROLIMUS 2.5 MG TAB, EVEROLIMUS 5 MG TAB, EVEROLIMUS 7.5 MG TAB

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Exclusion criteria will be based on current National Comprehensive Cancer Network (NCCN) guidelines and FDA labeling.

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

EVOLOCUMAB (REPATHA)

MEDICATION(S)
REPATHA, REPATHA PUSHTRONEX SYSTEM, REPATHA SURECLICK

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Primary Hyperlipidemia [including Heterozygous Familial Hypercholesterolemia (HeFH) or reduction of death due to Cardiovascular Disease (CVD)]: current LDL cholesterol (LDL-C) is at or above 70mg/dl (or at or above 55mg/dl if prescriber states extreme risk for heart disease) on lipid lowering therapy (such as statins and/or ezetimibe), and being used with a high-intensity statin like atorvastatin 40-80mg or rosuvastatin 20-40mg unless patient cannot use statins due to a medical reason (contraindication) or is intolerant to statins as defined by statin related rhabdomyolysis or has had skeletal-related muscle symptoms with the use of two different statins.

Homozygous Familial Hypercholesterolemia (HoFH): a positive genetic test for LDL-R genetic mutations OR clinical evidence that confirms HoFH, current lipid-lowering regimen has not worked well enough and being used with other lipid lowering therapies (e.g. statins, ezetimibe, LDL apheresis).

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
HoFH: Cardiologist or Endocrinologist

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

EXENATIDE (BYETTA)

MEDICATION(S)
BYETTA 10 MCG PEN, BYETTA 5 MCG PEN

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Being used with another GLP-1 agent

REQUIRED MEDICAL INFORMATION
Type 2 diabetes: Confirmed AND one of the following: trial and failure or side effect with metformin or medical reason why metformin cannot be used, or A1C of 7.5% or greater and being used with another diabetes drug.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

FEDRATINIB (INREBIC)

MEDICATION(S)
INREBIC

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Not being used with another agent that treats myelofibrosis.

REQUIRED MEDICAL INFORMATION
Myelofibrosis: platelet count of at least 50,000 cells/mcl, trial and failure of Jakafi or has a medical reason for not using Jakafi (contraindication).

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

FENFLURAMINE (FINTEPLA)

MEDICATION(S)
FINTEPLA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Dravet Syndrome: Trial and failure of valproic acid, divalproex, or clobazam. Lennox-Gastaut syndrome: trial and failure or side effect to two of the following anti-seizure drugs: clonazepam, felbamate, lamotrigine, and topiramate or there is a medical reason why all these other drugs cannot be used.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

FERRIC CITRATE (AURYXIA)

MEDICATION(S)
AURYXIA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Patient has high blood phosphate levels and is on dialysis due to CKD AND Trial and failure or side effect to both calcium acetate (PhosLo) and sevelamer carbonate (Renvela), or medical reason why calcium acetate and sevelamer carbonate cannot be used.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

FIDAXOMICIN (DIFICID)

MEDICATION(S)
DIFICID

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Clostridium difficile: evidence of current infection AND trial of oral vancomycin or has a medical reason why oral vancomycin cannot be used.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
10 days

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

FILGRASTIM-SNDZ (ZARXIO)

MEDICATION(S)
ZARXIO

PA INDICATION INDICATOR
4 - All FDA-Approved Indications, Some Medically-Accepted Indications

OFF LABEL USES
Cyclic neutropenia, agranulocytosis, Febrile neutropenia, Drug-Induced neutropenia, Myelodysplastic Syndrome (MDS), AIDS - neutropenia

EXCLUSION CRITERIA
Being used to treat low white bloods called neutrophils (neutropenia) due to autoimmune disorders, burn victims, or chronic infections.

REQUIRED MEDICAL INFORMATION
Agranulocytosis, congenital neutropenia, cyclic neutropenia, or idiopathic neutropenia: neutropenia is recurring or does not go away and there is a history of recurring infections (e.g. multiple episodes of infections requiring antibiotics) or at least one hospitalization for an infection within the past year.

Febrile neutropenia, neutropenia due to HIV/AIDs, or neutropenia caused by drugs other than cancer drugs: no use of pegfilgrastim within the past 14 days and absolute neutrophil count (ANC) is less than 800/mm3 or ANC is less than 1000/mm3 with neutropenia expected to last more than 5 days.

Neutropenia due to cancer drug therapy: not being used with pegfilgrastim.

Neutropenia due to radiation therapy: not being used with pegfilgrastim.

Acute myeloid leukemia (AML): being used to prevent or reduce neutropenia due to use of cancer drug therapy.

MDS: Hgb less than 10 gm/dL AND EPO level less than or equal to 500 mU/mL AND One of the following: ANC is less than 800/mm3 or ANC is less than 1000/mm3 with neutropenia expected to last more than 5 days or being used with epoetin (e.g. Retacrit) to improve symptoms of low red blood cells (anemia).

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Febrile neutropenia, peripheral blood cell collection: 2 mos. HIV: plan year. (see other criteria)

OTHER CRITERIA
Excluded under Part D if covered by Part B. Dose and duration is not more than the FDA labeled maximum.
Coverage duration:
Congenital, cyclic, idiopathic neutropenia and agranulocytosis: plan year. Neutropenia due to cancer drug therapy and AML: duration of cancer drug therapy.
Neutropenia due to radiation: duration of radiation therapy.
MDS: 3 months.

PART B PREREQUISITE
N/A

FINERENONE (KERENDIA)

MEDICATION(S)
KERENDIA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Treatment failure or side effect to Farxiga or there is a medical reason why Farxiga cannot be used.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

FINGOLIMOD HCL (GILENYA)

MEDICATION(S)
FINGOLIMOD HCL

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Being used with other disease-modifying therapies for relapsing Multiple Sclerosis.

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan Year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

FRUQUINTINIB (FRUZAQLA)

MEDICATION(S)
FRUZAQLA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Exclusion criteria will be based on current National Comprehensive Cancer Network (NCCN) guidelines and FDA labeling.

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

FUTIBATINIB (LYTGOBI)

MEDICATION(S)
LYTGOBI (12 MG DAILY DOSE), LYTGOBI (16 MG DAILY DOSE), LYTGOBI (20 MG DAILY DOSE)

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Exclusion criteria will be based on current National Comprehensive Cancer Network (NCCN) guidelines and FDA labeling.

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

GANAXOLONE SUSPENSION (ZTALMY)

MEDICATION(S)
ZTALMY

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
A genetic test confirms CDKL5 (cyclin-dependent kinase-like 5) deficiency disorder

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Neurologist

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

GEFITINIB (IRESSA)

MEDICATION(S)
GEFITINIB

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Exclusion criteria will be based on current National Comprehensive Cancer Network (NCCN) guidelines and FDA labeling.

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

GILTERITINIB FUMARATE (XOSPATA)

MEDICATION(S)
XOSPATA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Exclusion criteria will be based on current National Comprehensive Cancer Network (NCCN) guidelines and FDA labeling.

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

GLASDEGIB MALEATE (DAURISMO)

MEDICATION(S)
DAURISMO

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Exclusion criteria will be based on current National Comprehensive Cancer Network (NCCN) guidelines and FDA labeling.

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

GLATIRAMER (COPAXONE)

MEDICATION(S)
COPAXONE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Being used with other disease-modifying therapies for relapsing Multiple Sclerosis.

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

GLECAPREVIR/PIBRENTASVIR (MAVYRET)

MEDICATION(S)
MAVYRET

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Exclusion criteria will be based on current AASLD/IDSA guidelines.

REQUIRED MEDICAL INFORMATION
Required medical information will be aligned with current AASLD/IDSA guidelines.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Hepatologist, Gastroenterologist, or Infectious Disease.

COVERAGE DURATION
Length of therapy will be based on current AASLD/IDSA guidelines and FDA labeling.

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

GLUTAMINE (ENDARI)

MEDICATION(S)
L-GLUTAMINE 5 GM PACKET

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Treatment failure or side effect with hydroxyurea OR medical reason for not using hydroxyurea.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

HIGH RISK MEDICATION

MEDICATION(S)
AMITRIPTYLINE HCL, CLOMIPRAMINE HCL, CYPROHEPTADINE HCL 4 MG TAB, DICYCLOMINE HCL 10 MG CAP, DICYCLOMINE HCL 10 MG/5ML SOLUTION, DICYCLOMINE HCL 20 MG TAB, DOXEPIN HCL 10 MG CAP, DOXEPIN HCL 10 MG/ML CONC, DOXEPIN HCL 100 MG CAP, DOXEPIN HCL 150 MG CAP, DOXEPIN HCL 25 MG CAP, DOXEPIN HCL 50 MG CAP, DOXEPIN HCL 75 MG CAP, HYDROXYZINE HCL 10 MG TAB, HYDROXYZINE HCL 25 MG TAB, HYDROXYZINE HCL 50 MG TAB, HYDROXYZINE PAMOATE, IMIPRAMINE HCL, PERPHENAZINE-AMITRIPTYLINE, PHENOBARBITAL, PROMETHAZINE HCL 12.5 MG TAB, PROMETHAZINE HCL 25 MG TAB, PROMETHAZINE HCL 50 MG TAB, PROMETHAZINE HCL 6.25 MG/5ML SOLUTION, THIORIDAZINE HCL, TRIMIPRAMINE MALEATE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Prescriber confirms the benefits of the drug outweigh any risks and will monitor for side effects.

AGE RESTRICTION
65 years and older. No prior authorization required for less than 65 years old.

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan Year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE

N/A

IBRUTINIB (IMBRUVICA)

MEDICATION(S)
IMBRUVICA 140 MG CAP, IMBRUVICA 280 MG TAB, IMBRUVICA 420 MG TAB, IMBRUVICA 560 MG TAB, IMBRUVICA 70 MG CAP, IMBRUVICA 70 MG/ML SUSPENSION

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Exclusion criteria will be based on current National Comprehensive Cancer Network (NCCN) guidelines and FDA labeling.

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

ICATIBANT (FIRAZYR)

MEDICATION(S)
ICATIBANT ACETATE, SAJAZIR

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

IDELALISIB (ZYDELIG)

MEDICATION(S)
ZYDELIG

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Exclusion criteria will be based on current National Comprehensive Cancer Network (NCCN) guidelines and FDA labeling.

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

ILOPERIDONE (FANAPT)

MEDICATION(S)
FANAPT, FANAPT TITRATION PACK

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Trial and failure or side effect to one preferred atypical antipsychotic drug (e.g. aripiprazole, clozapine, olanzapine, quetiapine, risperidone, ziprasidone) or there is a medical reason why all the preferred agents cannot be used.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

IMATINIB MESYLATE (GLEEVEC)

MEDICATION(S)
IMATINIB MESYLATE

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Exclusion criteria will be based on current National Comprehensive Cancer Network (NCCN) guidelines and FDA labeling.

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Hypereosinophilic syndrome (HES): Allergist, Immunologist, or Hematologist.

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

IMIGLUCERASE (CEREZYME)

MEDICATION(S)
CEREZYME

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Being used with another therapy that treats Type-1 Gaucher's disease.

REQUIRED MEDICAL INFORMATION
Disease confirmed by either glucocerebrosidase enzyme activity in the white blood cells or skin fibroblasts less or equal to 30% of normal activity or genetic analysis identifying two copies of a mutant glucocerebrosidase encoding allele, AND patient has at least one of the following: low red blood cell count (anemia) with a low hemoglobin for age and sex, low platelet count (thrombocytopenia) with a platelet count under 100,000 cells/mcl or bleeding episodes documented as being due to thrombocytopenia, evidence of bone disease, enlarged liver (hepatomegaly), enlarged spleen (splenomegaly), or clinical symptoms of abdominal pain, fatigue, impaired physical movements, malnutrition (cachexia), or bone pain.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Excluded under Part D if covered by Part B.
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE

N/A

IMMUNE GLOBULIN, GAMM(IGG)/GLYCINE/GLUCOSE/IGA (GAMMAGARD)

MEDICATION(S)
GAMMAGARD, GAMMAGARD S/D LESS IGA

PA INDICATION INDICATOR
4 - All FDA-Approved Indications, Some Medically-Accepted Indications

OFF LABEL USES
Autoimmune mucocutaneous blistering disease (AMBD), Guillian-Barre syndrome, Bone marrow transplant, Autoimmune Hemolytic anemia, Multiple myeloma, Polymyositis and dermatomyositis, Solid organ transplants, Bone marrow transplants, Hemopoietic stem cell transplant, Small lymphocytic leukemia

EXCLUSION CRITERIA
AMBD: being used with another immunomodulator

REQUIRED MEDICAL INFORMATION
Primary Immunodeficiency Disorder (PIDD), SQ and IV administration: current IgG is less than 200mg/dL or ALL of the following: history of recurrent bacterial infections, and failure to respond to antigenic challenge test with diphtheria and tetanus toxoids or pneumococcal polysaccharide vaccine, and history of IgG less than 500mg/dL documented on two occasions or diagnosed by an allergist or immunologist. Chronic Inflammatory Demyelinating Polyneuropathy (CIDP), Multifocal Acquired Demyelinating Polyneuropathy, or pure sensory Chronic Inflammatory Demyelinating Polyneuropathy (CIDP): IV administration, diagnosis confirmed by electrodiagnostic criteria and two of the following criteria: motor or sensory dysfunction in more than one limb lasting at least 2 months, no reflexes (areflexia), nerve biopsy shows evidence of demyelination and remyelination, or CSF cell count is less than 10cells/mm3 (if HIV positive then CSF count less than 50cells/mm-3). Primary immune thrombocytopenia (ITP): IV administration, platelet count is less than 30,000cells/mm3. For ongoing use: continued thrombocytopenia with prior response to IVIG or is scheduled for surgery or invasive procedure. Myasthenia Gravis (MG): IV administration, treatment failure, side effect, or medical reason for not using one of the following: a corticosteroid, mycophenolate, azathioprine, cyclosporine, or cyclophosphamide.

Multifocal Motor Neuropathy (MMN): IV administration and condition confirmed with nerve conduction studies (electrodiagnostic testing).

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
CIDP, MMN, MG: Neurologist

COVERAGE DURATION
MG: 3 months ITP: 6 months GBS: 5 days all other conditions: plan year

OTHER CRITERIA
AMBD (pemphigus, epidermolysis bullosa acquisita): IV administration, condition is confirmed by testing the sore or blister (lesional tissue biopsy or serology) and did not respond to trial of an immunosuppressant drug (e.g. azathioprine, cyclophosphamide) and an oral or IV corticosteroid (e.g. prednisone) or has a medical reason not to use these types of drugs. Autoimmune hemolytic anemia, Polymyositis, or Dermatomyositis: IV administration, trial and failure of high dose corticosteroids. Bone marrow transplant or HSCT: IV administration, being used to prevent bacterial infections and one of the following: within 100 days post-transplant, immunoglobulin G (IgG) level is less than 400 mg/dl, IgG is below normal and chronic graft vs host disease (GVHD) on steroids or GVHD with lung infection, or has cytomegalovirus (CMV). Chronic lymphocytic leukemia/small lymphocytic leukemia: history of hypogammaglobulinemia (IgG below 500 mg/dl) or recurrent bacterial infections. Excluded under Part D if covered by Part B.
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

IMMUNE GLOBULIN, GAMMA (IGG)/PROLINE/IGA (HIZENTRA)

MEDICATION(S)
HIZENTRA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Chronic Inflammatory Demyelinating Polyneuropathy (CIDP), Multifocal Acquired Demyelinating Polyneuropathy, or pure sensory Chronic Inflammatory Demyelinating Polyneuropathy (CIDP): diagnosis confirmed by electrodiagnostic criteria (nerve conduction studies), and patient has been started on IVIG and is switching to Hizentra for ongoing therapy.

Primary Immunodeficiency Disorder (PIDD): current IgG is less than 200mg/dL or ALL of the following: history of recurrent bacterial infections, and failure to respond to antigenic challenge test with diphtheria and tetanus toxoids or pneumococcal polysaccharide vaccine, and history of IgG less than 500mg/dL documented on two occasions or diagnosed by an allergist or immunologist.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
CIDP, Multifocal acquired Demyelinating Polyneuropathy, or pure sensory CIDP: Neurologist

COVERAGE DURATION
Plan year

OTHER CRITERIA
Excluded under Part D if covered by Part B.
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

IMMUNE GLOBULIN, GAMMA(IGG)/GLYCINE/IGA (GAMMAKED)

MEDICATION(S)
GAMMAKED

PA INDICATION INDICATOR
4 - All FDA-Approved Indications, Some Medically-Accepted Indications

OFF LABEL USES
Autoimmune mucocutaneous blistering disease (AMBD), Guillian-Barre syndrome, Bone marrow transplant, Autoimmune Hemolytic anemia, Kawasaki disease, Multiple myeloma, Polymyositis and dermatomyositis, Solid organ transplants, Bone marrow transplants, Chronic lymphocytic leukemia, Small lymphocytic leukemia, Hemopoietic stem cell transplant

EXCLUSION CRITERIA
AMBD: being used with another immunomodulator

REQUIRED MEDICAL INFORMATION
Primary Immunodeficiency Disorder (PIDD), SQ and IV administration: current IgG is less than 200mg/dL or ALL of the following: history of recurrent bacterial infections, and failure to respond to antigenic challenge test with diphtheria and tetanus toxoids or pneumococcal polysaccharide vaccine, and history of IgG less than 500mg/dL documented on two occasions or diagnosed by an allergist or immunologist. Chronic Inflammatory Demyelinating Polyneuropathy (CIDP), Multifocal Acquired Demyelinating Polyneuropathy, or pure sensory Chronic Inflammatory Demyelinating Polyneuropathy (CIDP): IV administration, diagnosis confirmed by electrodiagnostic criteria and two of the following criteria: motor or sensory dysfunction in more than one limb lasting at least 2 months, no reflexes (areflexia), nerve biopsy shows evidence of demyelination and remyelination, or CSF cell count is less than 10cells/mm3 (if HIV positive then CSF count less than 50cells/mm-3). Primary immune thrombocytopenia (ITP): IV administration, platelet count is less than 30,000cells/mm3. For ongoing use: continued thrombocytopenia with prior response to IVIG or is scheduled for surgery or invasive procedure. Myasthenia Gravis (MG): IV administration, treatment failure, side effect, or medical reason for not using one of the following: a corticosteroid, mycophenolate, azathioprine, cyclosporine, or cyclophosphamide.

Multifocal Motor Neuropathy (MMN): IV administration and condition confirmed with nerve conduction studies (electrodiagnostic testing).

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
CIDP, MMN, MG: Neurologist

COVERAGE DURATION
MG: 3 months, ITP: 6 months, GBS: 5 days, all other conditions: plan year

OTHER CRITERIA
AMBD (pemphigus, epidermolysis bullosa acquisita): IV administration, condition is confirmed by testing the sore or blister (lesional tissue biopsy or serology) and did not respond to trial of an immunosuppressant drug (e.g. azathioprine, cyclophosphamide) and an oral or IV corticosteroid (e.g. prednisone) or has a medical reason not to use these types of drugs.
Autoimmune hemolytic anemia, Polymyositis, or Dermatomyositis: IV administration, trial and failure of high dose corticosteroids. Bone marrow transplant or HSCT: IV administration, being used to prevent bacterial infections and one of the following: within 100 days post-transplant, immunoglobulin G (IgG) level is less than 400 mg/dl, IgG is below normal and chronic graft vs host disease (GVHD) on steroids or GVHD with lung infection, or has cytomegalovirus (CMV).
Chronic lymphocytic leukemia/small lymphocytic leukemia: history of hypogammaglobulinemia (IgG below 500 mg/dl) or recurrent bacterial infections. Excluded under Part D if covered by Part B.
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

IMMUNE GLOBULIN, GAMMA(IGG)/GLYCINE/IGA (GAMUNEX-C)

MEDICATION(S)
GAMUNEX-C

PA INDICATION INDICATOR
4 - All FDA-Approved Indications, Some Medically-Accepted Indications

OFF LABEL USES
Autoimmune mucocutaneous blistering disease (AMBD), Guillian-Barre syndrome, Bone marrow transplant, Autoimmune Hemolytic anemia, Kawasaki disease, Multiple myeloma, Polymyositis and dermatomyositis, Solid organ transplants, Bone marrow transplants, Chronic lymphocytic leukemia, Small lymphocytic leukemia, Hemopoietic stem cell transplant

EXCLUSION CRITERIA
AMBD: being used with another immunomodulator

REQUIRED MEDICAL INFORMATION
Primary Immunodeficiency Disorder (PIDD), SQ and IV administration: current IgG is less than 200mg/dL or ALL of the following: history of recurrent bacterial infections, and failure to respond to antigenic challenge test with diphtheria and tetanus toxoids or pneumococcal polysaccharide vaccine, and history of IgG less than 500mg/dL documented on two occasions or diagnosed by an allergist or immunologist.

Chronic Inflammatory Demyelinating Polyneuropathy (CIDP), Multifocal Acquired Demyelinating Polyneuropathy, or pure sensory Chronic Inflammatory Demyelinating Polyneuropathy (CIDP): IV administration, diagnosis confirmed by electrodiagnostic criteria and two of the following criteria: motor or sensory dysfunction in more than one limb lasting at least 2 months, no reflexes (areflexia), nerve biopsy shows evidence of demyelination and remyelination, or CSF cell count is less than 10cells/mm3 (if HIV positive then CSF count less than 50cells/mm-3).

Primary immune thrombocytopenia (ITP): IV administration, platelet count is less than 30,000cells/mm3. For ongoing use: continued thrombocytopenia with prior response to IVIG or is scheduled for surgery or invasive procedure.

Myasthenia Gravis (MG): IV administration, treatment failure, side effect, or medical reason for not using one of the following: a corticosteroid, mycophenolate, azathioprine, cyclosporine, or cyclophosphamide.

Multifocal Motor Neuropathy (MMN): IV administration and condition confirmed with nerve conduction studies (electrodiagnostic testing).

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
CIDP, MMN, MG: Neurologist

COVERAGE DURATION
MG: 3 months ITP: 6 months GBS: 5 days all other conditions: plan year

OTHER CRITERIA

AMBD (pemphigus, epidermolysis bullosa acquisita): IV administration, condition is confirmed by testing the sore or blister (lesional tissue biopsy or serology)and did not respond to trial of an immunosuppressant drug (e.g. azathioprine, cyclophosphamide) and an oral or IV corticosteroid (e.g. prednisone) or has a medical reason not to use these types of drugs.
Autoimmune hemolytic anemia, Polymyositis, or Dermatomyositis: IV administration, trial and failure of high dose corticosteroids.
Bone marrow transplant or HSCT: IV administration, being used to prevent bacterial infections and one of the following: within 100 days post-transplant, immunoglobulin G (IgG) level is less than 400 mg/dl, IgG is below normal and chronic graft vs host disease (GVHD) on steroids or GVHD with lung infection, or has cytomegalovirus (CMV).
Chronic lymphocytic leukemia/small lymphocytic leukemia: history of hypogammaglobulinemia (IgG below 500 mg/dl) or recurrent bacterial infections.
Excluded under Part D if covered by Part B.
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE

N/A

INTERFERON BETA-1B (BETASERON)

MEDICATION(S)
BETASERON

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Being used with other disease-modifying therapies for relapsing Multiple Sclerosis.

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

INTERFERON GAMMA-1B (ACTIMMUNE)

MEDICATION(S)
ACTIMMUNE

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

INTRAVENOUS IMMUNE GLOBULIN (IVIG)

MEDICATION(S)
BIVIGAM, CARIMUNE NF, FLEBOGAMMA DIF, GAMMAPLEX, PRIVIGEN

PA INDICATION INDICATOR
4 - All FDA-Approved Indications, Some Medically-Accepted Indications

OFF LABEL USES
Autoimmune mucocutaneous blistering disease (AMBD), Guillian-Barre syndrome, Bone marrow transplant, Autoimmune Hemolytic anemia, Multiple myeloma, Polymyositis and dermatomyositis, Solid organ transplants, Bone marrow transplants, Hemopoietic stem cell transplant, Small lymphocytic leukemia, Multifocal Motor Neuropathy (MMN), Myasthenia Gravis (MG)

EXCLUSION CRITERIA
AMBD: being used with another immunomodulator

REQUIRED MEDICAL INFORMATION
Chronic Inflammatory Demyelinating Polyneuropathy (CIDP), Multifocal Acquired Demyelinating Polyneuropathy, or pure sensory Chronic Inflammatory Demyelinating Polyneuropathy (CIDP): diagnosis confirmed by electrodiagnostic criteria and two of the following criteria: motor or sensory dysfunction in more than one limb lasting at least 2 months, no reflexes (areflexia), nerve biopsy shows evidence of demyelination and remyelination, or CSF cell count is less than 10cells/mm3 (if HIV positive then CSF count less than 50cells/mm-3).

Primary Immune Thrombocytopenia (ITP): platelet count is less than 30,000cells/mm3. For ongoing use: continued thrombocytopenia with prior response to IVIG or is scheduled for surgery or invasive procedure.

Myasthenia Gravis (MG): treatment failure, side effect, or medical reason for not using one of the following: a corticosteroid, mycophenolate, azathioprine, cyclosporine, or cyclophosphamide.

Primary Immunodeficiency Disorder (PIDD): current IgG is less than 200mg/dL or ALL of the following: history of recurrent bacterial infections, and failure to respond to antigenic challenge test with diphtheria and tetanus toxoids or pneumococcal polysaccharide vaccine, and history of IgG less than 500mg/dL documented on two occasions or diagnosed by an allergist or immunologist.

Multifocal Motor Neuropathy (MMN): condition confirmed by nerve conduction studies (electrodiagnostic testing)

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
CIDP, MMN, MG: Neurologist

COVERAGE DURATION
MG: 3 months ITP: 6 months GBS: 5 days all other conditions: plan year

OTHER CRITERIA

AMBD (pemphigus, epidermolysis bullosa acquisita): condition is confirmed by testing the sore or blister (lesional tissue biopsy or serology) and did not respond to trial of an immunosuppressant drug (e.g. azathioprine, cyclophosphamide) and an oral or IV corticosteroid (e.g. prednisone) or has a medical reason not to use these types of drugs.
Autoimmune hemolytic anemia, Polymyositis, or Dermatomyositis: trial and failure of high dose corticosteroids.
Bone marrow transplant or HSCT: being used to prevent bacterial infections and one of the following: within 100 days post-transplant, immunoglobulin G (IgG) level is less than 400 mg/dl, IgG is below normal and chronic graft vs host disease (GVHD) on steroids or GVHD with lung infection, or has cytomegalovirus (CMV).
Chronic lymphocytic leukemia/small lymphocytic leukemia: history of hypogammaglobulinemia (IgG below 500 mg/dl) or recurrent bacterial infections.
Excluded under Part D if covered by Part B.
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE

N/A

ISAVUCONAZONIUM (CRESEMBA)

MEDICATION(S)
CRESEMBA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Invasive aspergillosis: blood or tissue culture positive for Aspergillus, and patient has a medical reason for not using voriconazole.

Invasive mucormycosis: culture is positive for mucormyocosis pathogens (e.g. Rhizopus, Rhizomucor, Lichtheimia, Mucormycetes) or being prescribed by infectious disease specialist.

Esophageal candidiasis: patient has HIV infection and patient has a medical reason for not using oral fluconazole.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
3 months

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

ITRACONAZOLE SOLUTION (SPORANOX)

MEDICATION(S)
ITRACONAZOLE 10 MG/ML SOLUTION

PA INDICATION INDICATOR
4 - All FDA-Approved Indications, Some Medically-Accepted Indications

OFF LABEL USES
Systemic infections due to sporotrichosis (cutaneous, lymphonodular, osteoarticular, pulmonary, disseminated, or meningeal), coccidiomycosis, cryptococcosis, tinea corporis, cruris, pedis, manuum, capitis, versicolor, and unguium (onychomycosis), allergic bronchopulmonary aspergillosis (ABPA). Prophylaxis (primary or secondary) or maintenance treatment of talaromycosis (Talaromyces marneffei). treatment of pulmonary aspergillosis, chronic (cavitary or necrotizing). Prophylaxis of aspergillosis and histoplasmosis.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Blastomycosis, Histoplasmosis, Sporotrichosis, Cryptococcosis, or Aspergillosis infection: culture confirms infection.
Tinea Capitas: patient has tried or has a medical reason for not using oral terbinafine.
Tinea Corporus, Curis, Pedis or Manuum: patient has tried or has a medical reason for not using topical antifungal or oral terbinafine.
Tinea Versicolor: patient has tried or has a medical reason for not using topical ketoconazole or oral fluconazole.
Onychomycosis: patient has tried or has a medical reason for not using oral terbinafine.
Coccidioidomycosis culture confirms infection, and patient has tried or has a medical reason for not using fluconazole.
Aspergillosis or Histoplasmosis prevention: patient is immunosuppressed/compromised.
Prophylaxis (primary or secondary) or maintenance treatment of talaromycosis (Talaromyces marneffei): Patient with HIV infection.
For treatment other than oropharyngeal or esophageal candidiasis: patient has difficulty swallowing a capsule or tablet.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
T. Vesicolor: 1wk T. Capitas: 8wks Onyc: 3mo Other Tinea: 1mo ABPA: 4mo All other dx: plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

IVABRADINE (CORLANOR)

MEDICATION(S)
CORLANOR 5 MG/5ML SOLUTION, IVABRADINE HCL

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Left heart ventricular ejection fraction (LVEF) less than or equal to 35%, patient is in sinus rhythm with resting heart rate of at least 70 beats per minute, and patient is on the highest tolerated dose of guideline supported therapies including a renin-angiotensin inhibitor drug (e.g. ACE-Inhibitor, ARB agent, Entresto) and beta-blocker drug (e.g. bisoprolol, carvedilol, metoprolol succinate) unless there is a medical reason for not using (contraindication) the supported therapies. Pediatric patients: CHF is due to dilated cardiomyopathy.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

IVACAFTOR (KALYDECO)

MEDICATION(S)
KALYDECO

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Being used with another CFTR modulator agent (i.e., Orkambi, Symdeko, Trikafta)

REQUIRED MEDICAL INFORMATION
Documentation that confirms there is at least one CFTR gene mutation sensitive to Kalydeco.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

IVOSIDENIB (TIBSOVO)

MEDICATION(S)
TIBSOVO

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Exclusion criteria will be based on current National Comprehensive Cancer Network (NCCN) guidelines and FDA labeling.

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

IXAZOMIB CITRATE (NINLARO)

MEDICATION(S)
NINLARO

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Exclusion criteria will be based on current National Comprehensive Cancer Network (NCCN) guidelines and FDA labeling.

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

IXEKIZUMAB (TALTZ)

MEDICATION(S)
TALTZ

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Being used with another targeted immunotherapy drug.

REQUIRED MEDICAL INFORMATION
Spondyloarthritis (SpA): patient is not able to take NSAIDs due to history of GI bleed or ulcer OR patient has tried one RX strength NSAID in combination with a PPI and had GI side effects OR patient's condition did not respond to a trial of two different RX strength NSAIDs.

Plaque Psoriasis (PsO), initial use: patient has tried one DMARD or has a medical reason why methotrexate (MTX), cyclosporine, and acitretin cannot be used AND baseline PASI score 10 or more OR BSA 3% or more OR sensitive areas are involved OR disease affects daily living. PSO, ongoing use: PASI or BSA improved on Taltz.

Psoriatic Arthritis (PsA): patient has tried one DMARD or has a medical reason why MTX, leflunomide, and sulfasalazine cannot be used.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
PsA: Rheumatologist. PsO: Rheumatologist or Dermatologist.

COVERAGE DURATION
PsO initial: 12 weeks, PsO ongoing: plan year, all other indications: plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE

N/A

LANREOTIDE ACETATE (SOMATULINE DEPOT)

MEDICATION(S)
LANREOTIDE ACETATE, SOMATULINE DEPOT 60 MG/0.2ML SOLUTION, SOMATULINE DEPOT 90 MG/0.3ML SOLUTION

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Acromegaly: Endocrinologist

COVERAGE DURATION
Plan year

OTHER CRITERIA
Excluded under Part D if covered by Part B.
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

LAPATINIB DITOSYLATE (TYKERB)

MEDICATION(S)
LAPATINIB DITOSYLATE

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Exclusion criteria will be based on current National Comprehensive Cancer Network (NCCN) guidelines and FDA labeling.

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

LAROTRECTINIB SULFATE (VITRAKVI)

MEDICATION(S)
VITRAKVI

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Exclusion criteria will be based on current National Comprehensive Cancer Network (NCCN) guidelines and FDA labeling.

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

LEDIPASVIR/SOFOSBUVIR (HARVONI)

MEDICATION(S)
HARVONI, LEDIPASVIR-SOFOSBUVIR

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Exclusion criteria will be based on current AASLD/IDSA guidelines.

REQUIRED MEDICAL INFORMATION
Required medical information will be aligned with current AASLD/IDSA guidelines.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Hepatologist, Gastroenterologist, or Infectious Disease.

COVERAGE DURATION
Length of therapy will be based on current AASLD/IDSA guidelines and FDA labeling.

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

LENALIDOMIDE (REVLIMID)

MEDICATION(S)
LENALIDOMIDE, REVLIMID

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Exclusion criteria will be based on current National Comprehensive Cancer Network (NCCN) guidelines and FDA labeling.

REQUIRED MEDICAL INFORMATION
MDS: transfusion dependent or hemoglobin less than 10 g/dL confirming anemia associated disease.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

LENVATINIB (LENVIMA)

MEDICATION(S)
LENVIMA (10 MG DAILY DOSE), LENVIMA (12 MG DAILY DOSE), LENVIMA (14 MG DAILY DOSE), LENVIMA (18 MG DAILY DOSE), LENVIMA (20 MG DAILY DOSE), LENVIMA (24 MG DAILY DOSE), LENVIMA (4 MG DAILY DOSE), LENVIMA (8 MG DAILY DOSE)

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Exclusion criteria will be based on current National Comprehensive Cancer Network (NCCN) guidelines and FDA labeling.

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

LEVALBUTEROL SOLUTION (XOPENEX)

MEDICATION(S)
LEVALBUTEROL HCL

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Patient has had a side effect with albuterol nebulized solution (not MDI or oral syrup) that is not seen with the use of levalbuterol.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Excluded under Part D if covered by Part B.
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

LEVETIRACETAM (SPRITAM)

MEDICATION(S)
SPRITAM

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Medical reason why patient is not able to use generic levetiracetam oral solution and tablet.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

LEVOMILNACIPRAN HCL (FETZIMA)

MEDICATION(S)
FETZIMA, FETZIMA TITRATION

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Treatment failure or side effect with at least two generic antidepressants (e.g., fluoxetine, bupropion, duloxetine, sertraline, venlafaxine, etc.).

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

LIDOCAINE PATCH (LIDODERM)

MEDICATION(S)
LIDOCAINE 5 % PATCH, LIDOCAN

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

LINEZOLID ORAL (ZYVOX)

MEDICATION(S)
LINEZOLID 100 MG/5ML RECON SUSP, LINEZOLID 600 MG TAB

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
VRE, MRSA, or VISA skin or soft tissue infection confirmed by culture and sensitivity (C&S): treatment failure or side effect with one oral drug noted on the C&S to work on the bacteria causing the infection or recommended by an Infectious Disease (ID) specialist. MSSA skin or soft tissue infection: recommended by an ID specialist and treatment failure or side effect with two preferred oral drugs noted on the C&S to work on the bacteria causing the infection or medical reason why the preferred drugs cannot be used. Empiric therapy for suspected MRSA infection: prescribed or recommended by an ID specialist OR trial of one oral antibiotic supported for MRSA including clindamycin, doxycycline, or minocycline, and double strength trimethoprim/sulfamethoxazole, OR medical reason why all oral antibiotics supported for MRSA empiric therapy cannot be used. Infection of the bone or joint OR infective endocarditis: culture and sensitivity report confirm VRE, MRSA, or VISA/VRSA and prescribed or recommended by ID specialist. Multidrug-resistant tuberculosis infection (MDR-TB): being used with pretomanid and bedaquiline.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
VRE 28 days. Osteo 42 days. Endocarditis 56 days. MDR-TB 26 wks. Empiric tx/pneumonia/SSTI 14days.

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

LIRAGLUTIDE (VICTOZA)

MEDICATION(S)
VICTOZA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Being used with another GLP-1 agent

REQUIRED MEDICAL INFORMATION
Type 2 diabetes: Confirmed AND one of the following: trial and failure or side effect with metformin or medical reason why metformin cannot be used, or A1C of 7.5% or greater and being used with another diabetes drug, or patient has heart (cardiovascular) disease.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

LONG-ACTING NARCOTIC DRUGS (NARCOTIC SAFETY INITIATIVE)

MEDICATION(S)
FENTANYL 100 MCG/HR PATCH 72HR, FENTANYL 12 MCG/HR PATCH 72HR, FENTANYL 25 MCG/HR PATCH 72HR, FENTANYL 50 MCG/HR PATCH 72HR, FENTANYL 75 MCG/HR PATCH 72HR, METHADONE HCL 10 MG TAB, METHADONE HCL 10 MG/5ML SOLUTION, METHADONE HCL 10 MG/ML SOLUTION, METHADONE HCL 5 MG TAB, METHADONE HCL 5 MG/5ML SOLUTION

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Being used with other long-acting narcotic drugs.

REQUIRED MEDICAL INFORMATION
Cancer pain: dose has been consolidated to the least number of higher strength forms. Non-cancer pain, initial: cause of pain cannot be removed or treated with other treatment options, and pain occurs daily and has lasted for at least 3 months, and pain is severe enough to need daily around-the-clock long-term narcotic use, and total daily dose across all narcotic drugs is less than 90 MME, and dose has been consolidated to the least number of higher strength forms and trial of at least one short-acting and morphine sulfate ER tablet (MS Contin), and chart notes document pain history including baseline pain intensity score and functional interference score, a plan for monitoring side effects and misuse, and a plan to taper down narcotics. Non-cancer pain, reauth: total daily dose across all narcotic drugs is less than 90 MME per day, and dose has been consolidated to the least number of higher strength forms, and chart notes document current pain intensity score, functional interference score, any side effects and/or misuse with current pain treatment regimen, and plan to taper narcotic use.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Cancer pain: Oncologist or Pain Specialist.

COVERAGE DURATION
Cancer pain: plan year Non-cancer pain: initial 30 days,1st reauth 3mos, ongoing reauths plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

LORLATINIB (LORBRENA)

MEDICATION(S)
LORBRENA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Exclusion criteria will be based on current National Comprehensive Cancer Network (NCCN) guidelines and FDA labeling.

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

LUMATEPERONE (CAPLYTA)

MEDICATION(S)
CAPLYTA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Schizophrenia: Trial and failure or side effect with one of the following preferred atypical antipsychotics: aripiprazole, clozapine, olanzapine, quetiapine, risperidone, ziprasidone OR there is a medical reason for not using the preferred atypical antipsychotics (contraindication).
Bipolar Disorder: Trial and failure or side effect with one of the following preferred atypical antipsychotics: olanzapine, quetiapine, lurasidone OR there is a medical reason for not using the generic atypical antipsychotics (contraindication).

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

MACITENTAN (OPSUMIT)

MEDICATION(S)
OPSUMIT

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Confirmation of Pulmonary Arterial Hypertension (WHO Group I) by right heart catheterization test.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

MECASERMIN (INCRELEX)

MEDICATION(S)
INCRELEX

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Severe primary IGF-1 deficiency: being used with growth hormone therapy.

REQUIRED MEDICAL INFORMATION
Initial use: height is at or more than 3.0 standard deviations below standard range for sex and age, and basal IGF-1 is at or more than 3.0 standard deviations below standard range for sex and age, and evidence of delayed bone age, and for severe IGF-1 deficiency growth hormone level is normal or higher for sex and age. Ongoing use: response to therapy and evidence of delayed bone age.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Endocrinologist

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

MECHLORETHAMINE (VALCHLOR)

MEDICATION(S)
VALCHLOR

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

MEGESTROL ACETATE (MEGACE)

MEDICATION(S)
MEGESTROL ACETATE 20 MG TAB, MEGESTROL ACETATE 40 MG TAB, MEGESTROL ACETATE 40 MG/ML SUSPENSION, MEGESTROL ACETATE 400 MG/10ML SUSPENSION, MEGESTROL ACETATE 800 MG/20ML SUSPENSION

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

MEGESTROL ACETATE ES (MEGACE ES)

MEDICATION(S)
MEGESTROL ACETATE 625 MG/5ML SUSPENSION

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Patient has tried megestrol acetate 200mg/5ml oral suspension.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

MEPOLIZUMAB (NUCALA)

MEDICATION(S)
NUCALA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Eosinophilic asthma: being used with other targeted therapies for asthma treatment (e.g. Xolair, Cinqair, Dupixent, Fasenra).

REQUIRED MEDICAL INFORMATION
Eosinophilic asthma, initial use: eosinophil blood count is 150 cells/microliter or more, and documented treatment failure with recent use of high-dose inhaled corticosteroid along with long-acting beta agonist or leukotriene receptor antagonists (i.e., montelukast), and patient has had at least one of the following within the past year: one or more acute asthma-related ER visit(s), one or more acute inpatient visits where asthma was the diagnosis, or two or more acute asthma exacerbations that require oral corticosteroids, or use of chronic systemic steroids due to severe asthma. Ongoing use: asthma symptoms improved and/or controlled while on Nucala.
Eosinophilic granulomatosis with polyangiitis (EGPA): patients condition did not improve or has relapsed despite treatment with an oral corticosteroid and/or immunosuppressive therapy (e.g. azathioprine, methotrexate, mycophenolic acid).
Hypereosinophilic syndrome (HES): patient is negative for FIP1-like 1-platelet derived growth factor receptor (FIP1L1-PDGFR) mutation and patient had an inadequate response to oral corticosteroids or hydroxyurea.
Chronic rhinosinusitis with nasal polyps (CRSwNP): Treatment failure with an intranasal corticosteroid or medical rationale why intranasal corticosteroids cannot be used.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Eosinophilic asthma: Immunologist, Pulmonologist, or Allergist. EGPA: Immunologist, Rheumatologist, or pulmonologist. HES: Immunologist, Allergist, Hematologist. CRSwNP: allergist, immunologist, or otolaryngologist.

COVERAGE DURATION
Eosinophilic asthma initial use: 6 mo, ongoing use: plan year. All other Dx: plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

MERCAPTOPURINE MONOHYDRATE (PURIXAN)

MEDICATION(S)
PURIXAN

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Medical reason why patient cannot use mercaptopurine tablet.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

METHOTREXATE ORAL SOLUTION (XATMEP)

MEDICATION(S)
XATMEP

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Medical reason why patient cannot take tablet form of methotrexate.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

METHYLNALTREXONE (RELISTOR SQ)

MEDICATION(S)
RELISTOR 12 MG/0.6ML SOLUTION, RELISTOR 8 MG/0.4ML SOLUTION

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Constipation due to ongoing use of opioids for non-cancer pain: patient has tried and failed Movantik or have a medical reason why Movantik cannot be tried.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

METRELEPTIN (MYALEPT)

MEDICATION(S)
MYALEPT

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Being used for HIV-related Lipodystrophy, general obesity not associated with congenital leptin deficiency.

REQUIRED MEDICAL INFORMATION
Generalized Lipodystrophy: Patient has one of the following: diabetes mellitus (HbA1c greater than 7% or FPG values 126 mg/dL or greater), or hypertriglyceridemia (TG 250mg/dL or greater), or history of pancreatitis associated with hypertriglyceridemia, or increased fasting insulin (greater than 25mIU/L)

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

MIDOSTAURIN (RYDAPT)

MEDICATION(S)
RYDAPT

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Exclusion criteria will be based on current National Comprehensive Cancer Network (NCCN) guidelines and FDA labeling.

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

MIFEPRISTONE (KORLYM)

MEDICATION(S)
MIFEPRISTONE 300 MG TAB

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

MIGLUSTAT (ZAVESCA)

MEDICATION(S)
MIGLUSTAT, YARGESA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Being used in with another therapy for Gauchers disease type-1.

REQUIRED MEDICAL INFORMATION
Patient has at least one of the following: low red blood cell count (anemia) with a low hemoglobin for age and sex, low platelet count (thrombocytopenia) with a platelet count under 100,000 cells/mcl or bleeding episodes documented as being due to thrombocytopenia, evidence of bone disease, enlarged liver (hepatomegaly), enlarged spleen (splenomegaly), or clinical symptoms of abdominal pain, fatigue, impaired physical movements, malnutrition (cachexia), or bone pain.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

MOBOCERTINIB (EXKIVITY)

MEDICATION(S)
EXKIVITY

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Exclusion criteria will be based on current National Comprehensive Cancer Network (NCCN) guidelines and FDA labeling.

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

MODAFINIL (PROVIGIL)

MEDICATION(S)
MODAFINIL

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Narcolepsy: sleep study (polysomnography) confirms narcolepsy.

Obstructive Sleep Apnea/Hypopnea Syndrome (OSAHS): sleep study (polysomnography) confirms OSAHS.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

MOMELOTINIB (OJJAARA)

MEDICATION(S)
OJJAARA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Exclusion criteria will be based on current National Comprehensive Cancer Network (NCCN) guidelines and FDA labeling.

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan Year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

NATALIZUMAB (TYSABRI)

MEDICATION(S)
TYSABRI

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
RRMS: Tysabri is being used in combination with another disease-modifying therapy for MS.
Crohns Disease: Tysabri is being used with immunosuppressants, other targeted immunotherapies, or anakinra.

REQUIRED MEDICAL INFORMATION
Relapsing forms of Multiple Sclerosis: patient has tried at least one of the following therapies: Betaseron, glatiramer 20mg, Copaxone, Aubagio, Gilenya, Tecfidera.

Crohn's Disease, initial use: patient tried and failed a TNF-blocker (e.g. Humira) or has a medical reason why TNF-blockers (e.g. Humira) cannot be used. Ongoing use: patient's condition has improved while on Tysabri.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
MS: plan year

Crohn's Disease: initial use: 3 months, ongoing use: plan year

OTHER CRITERIA
Excluded under Part D if covered by Part B.
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE

N/A

NERATINIB (NERLYNX)

MEDICATION(S)
NERLYNX

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Exclusion criteria will be based on current National Comprehensive Cancer Network (NCCN) guidelines and FDA labeling.

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

NILOTINIB (TASIGNA)

MEDICATION(S)
TASIGNA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Exclusion criteria will be based on current National Comprehensive Cancer Network (NCCN) guidelines and FDA labeling.

REQUIRED MEDICAL INFORMATION
First line therapy for CML: medical reason why imatinib cannot be used.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

NINTEDANIB ESYLATE (OFEV)

MEDICATION(S)
OFEV

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Idiopathic Pulmonary Fibrosis (IPF): being used with another IPF drug

REQUIRED MEDICAL INFORMATION
IPF, initial use: patient has the following pulmonary function tests: forced vital capacity (FVC) equal or over 50%, and diffusing capacity of carbon monoxide (DLCO) equal or over 30%. Ongoing use: patient has not received a lung transplant

ssILD (Systemic sclerosis interstitial lung disease): tried and failed or had a side effect to mycophenolate or cyclophosphamide, or medical reason why they cannot be used.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
IPF: Pulmonologist. ILD: Rheumatologist or Pulmonologist.

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

NIRAPARIB TOSYLATE (ZEJULA)

MEDICATION(S)
ZEJULA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Exclusion criteria will be based on current National Comprehensive Cancer Network (NCCN) guidelines and FDA labeling.

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

NIRAPARIB-ABIRATERONE (AKEEGA)

MEDICATION(S)
AKEEGA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Exclusion criteria will be based on current National Comprehensive Cancer Network (NCCN) guidelines and FDA labeling.

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

NIROGACESTAT HYDROBROMIDE (OGSIVEO)

MEDICATION(S)
OGSIVEO

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Exclusion criteria will be based on current National Comprehensive Cancer Network (NCCN) guidelines and FDA labeling.

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

NITAZOXANIDE (ALINIA)

MEDICATION(S)
ALINIA 100 MG/5ML RECON SUSP, NITAZOXANIDE

PA INDICATION INDICATOR
4 - All FDA-Approved Indications, Some Medically-Accepted Indications

OFF LABEL USES
Cryptosporidiosis in HIV+ patients, Clostridium difficile colitis, viral gastroenteritis, amebiasis (Entamoeba histolytica), liver fluke infection (Fasciola hepatica), Cestode (tapeworm)

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
All medically accepted conditions: stool culture results confirm diagnosis.

Giardiasis: treatment failure or side effect with metronidazole OR medical reason for not using metronidazole (contraindication).

Clostridium difficle colitis: treatment failure or side effect with vancomycin OR medical reason for not using vancomycin (contraindication).

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
One course (see other criteria)

OTHER CRITERIA
Giardiasis: 3 days.
Cryptosporidiosis: 3 days unless HIV+ then 14 days.
Clostridium difficle colitis: 10 days.
viral gastroenteritis: 3 days amebiasis (Entamoeba histolytica): 3 days.
liver fluke infection (Fasciola hepatica): 7 days.
Cestode (tapeworm): 3 days.
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

NITISINONE (ORFADIN)

MEDICATION(S)
NITISINONE 10 MG CAP, NITISINONE 2 MG CAP, NITISINONE 5 MG CAP

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan Year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

OCTREOTIDE ACETATE (SANDOSTATIN LAR DEPOT)

MEDICATION(S)
SANDOSTATIN LAR DEPOT

PA INDICATION INDICATOR
4 - All FDA-Approved Indications, Some Medically-Accepted Indications

OFF LABEL USES
AIDS-associated diarrhea, Bleeding esophageal varices, Chemotherapy-induced diarrhea, Neuroendocrine Tumor of the lung, Pituitary adenoma, Prevention of postoperative complications of pancreatic surgery, Pancreatic tumors (gastrinoma, glucagonoma, insulinoma), Radiation-induced diarrhea, Thymoma, Zollinger-Ellison syndrome, central nervous system cancers (meningiomas).

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Diarrhea due to HIV: patient has been on anti-retroviral therapy (ART) for at least one month, and other causes (i.e. infection, underlying GI disease, malabsorption) have been ruled out, and treatment failure or side effect with diphenoxylate/atropine or loperamide. Meningiomas: Being used with everolimus, AND one of the following: disease is worsening or growing (progressive) or surgery is not an option (unresectable).

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Acromegaly: Endocrinologist

COVERAGE DURATION
Acromegaly, Meningioma: plan year
Other conditions: 6 months

OTHER CRITERIA
Excluded under Part D if covered by Part B.
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE

N/A

OCTREOTIDE ACETATE (SANDOSTATIN)

MEDICATION(S)
OCTREOTIDE ACETATE 100 MCG/ML SOLN PRSYR, OCTREOTIDE ACETATE 100 MCG/ML SOLUTION, OCTREOTIDE ACETATE 1000 MCG/ML SOLUTION, OCTREOTIDE ACETATE 200 MCG/ML SOLUTION, OCTREOTIDE ACETATE 50 MCG/ML SOLN PRSYR, OCTREOTIDE ACETATE 50 MCG/ML SOLUTION, OCTREOTIDE ACETATE 500 MCG/ML SOLN PRSYR, OCTREOTIDE ACETATE 500 MCG/ML SOLUTION

PA INDICATION INDICATOR
4 - All FDA-Approved Indications, Some Medically-Accepted Indications

OFF LABEL USES
AIDS-associated diarrhea, Bleeding esophageal varices, Chemotherapy-induced diarrhea, Cryptosporidiosis, Dumping syndrome, Neuroendocrine Tumor of the GI tract, lung, or thymus, Lymphorrhagia, Pancreatitis, necrotizing Pituitary adenoma, Prevention of postoperative complications of pancreatic surgery, Pancreatic tumors (gastrinoma, glucagonoma, insulinoma), paraganglioma, pheochromocytoma, Polycystic Ovary Syndrome (PCOS), Radiation-induced diarrhea, Thymoma, Zollinger-Ellison syndrome.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Diarrhea due to HIV: patient has been on anti-retroviral therapy (ART) for at least one month, and prescriber states other causes (i.e. infection, underlying GI disease, malabsorption) have been ruled out, and patient has tried diphenoxylate/atropine or loperamide.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Acromegaly: Endocrinologist

COVERAGE DURATION
Acromegaly: plan year, Other conditions: 6 months

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

ODEVIXIBAT (BYLVAY)

MEDICATION(S)
BYLVAY, BYLVAY (PELLETS)

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Gastroenterologist or Hepatologist

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

OLANZAPINE-SAMIDORPHAN (LYBALVI)

MEDICATION(S)
LYBALVI

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Trial and failure or side effect to one preferred atypical antipsychotic drug (e.g. aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone) or there is a medical reason why all the preferred agents cannot be used.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

OLAPARIB (LYNPARZA)

MEDICATION(S)
LYNPARZA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Exclusion criteria will be based on current National Comprehensive Cancer Network (NCCN) guidelines and FDA labeling.

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

OLSALAZINE SODIUM (DIPENTUM)

MEDICATION(S)
DIPENTUM

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Trial of one of the following: mesalamine 0.375g long-acting capsule, mesalamine 1.2g long-acting tablet, or balsalazide 750 mg capsule OR medical reason why these drugs cannot be used (contraindication).

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

OLUTASIDENIB (REZLIDHIA)

MEDICATION(S)
REZLIDHIA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Exclusion criteria will be based on current National Comprehensive Cancer Network (NCCN) guidelines and FDA labeling.

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

OMALIZUMAB (XOLAIR)

MEDICATION(S)
XOLAIR

PA INDICATION INDICATOR
4 - All FDA-Approved Indications, Some Medically-Accepted Indications

OFF LABEL USES
Refractory immunotherapy-related severe pruritus, Systemic Mastocytosis

EXCLUSION CRITERIA
Allergic asthma: being used with other targeted therapies for asthma treatment (e.g. Nucala, Cinqair, Dupixent, Fasenra).

REQUIRED MEDICAL INFORMATION
Allergic Asthma, initial use: recent total serum IgE level is more than 30IU/ml, documented treatment failure with recent use of high-dose inhaled corticosteroid along with long-acting beta agonist or leukotriene receptor antagonists (i.e., montelukast), and patient has had at least one of the following within the past year: one or more acute asthma-related ER visit(s), one or more acute inpatient visits where asthma was the diagnosis, or two or more acute asthma exacerbations that require oral corticosteroids, or use of chronic systemic steroids due to severe asthma. Ongoing use:asthma symptoms improved and/or controlled while on Xolair.
Chronic Idiopathic Urticaria (CIU): failure to respond to hydroxyzine, doxepin, or high dose second-generation antihistamines OR has a medical reason not to use (contraindication) or had a side effect to hydroxyzine, doxepin, and second-generation antihistamines.
Nasal polyps: treatment failure or side effect with a nasal corticosteroid (e.g. fluticasone).
IgE-mediated food allergy: diagnosis confirmed by positive skin prick test (SPT), serum IgE level, or food challenge to one or more foods (e.g., peanut, milk, egg, wheat, cashew, hazelnut, walnut).
Systemic Mastocytosis: treatment failure or side effect to an antihistamine and an oral corticosteroid, or has a medical reason why antihistamines and oral corticosteroids can not be used.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
CIU, IgE-mediated food allergy: Allergist or Immunologist. Allergic asthma: Allergist, Pulmonologist or Immunologist. Nasal polyps: allergist, immunologist, or otolaryngologist. Immunotherapy-related severe pruritus: dermatologist, allergist, or immunologist.

COVERAGE DURATION
Allergic asthma, initial 6 months, ongoing use: plan year. All other Dx: plan year.

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

OSIMERTINIB (TAGRISSO)

MEDICATION(S)
TAGRISSO

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Exclusion criteria will be based on current National Comprehensive Cancer Network (NCCN) guidelines and FDA labeling.

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

OSPEMIFENE (OSPHENA)

MEDICATION(S)
OSPHENA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Painful sex (dyspareunia) due to menopause: patient has tried Premarin Vaginal cream.

Vaginal dryness due to menopause: patient has tried at least two of the following: Premarin vaginal cream, estradiol vaginal cream, estradiol vaginal tablet, Yuvafem, or Estring.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

PACRITINIB (VONJO)

MEDICATION(S)
VONJO

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Being used along with another agent for myelofibrosis

REQUIRED MEDICAL INFORMATION
Platelet count is less than 50,000 cells/mcl.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

PALBOCICLIB (IBRANCE)

MEDICATION(S)
IBRANCE

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Exclusion criteria will be based on current National Comprehensive Cancer Network (NCCN) guidelines and FDA labeling.

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

PALIPERIDONE ER (INVEGA)

MEDICATION(S)
PALIPERIDONE ER

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Older adults (65 years and older) with dementia-related psychosis.

REQUIRED MEDICAL INFORMATION
Trial and failure or side effect to risperidone or there is a medical reason why risperidone cannot be tried.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

PARATHYROID HORMONE (NATPARA)

MEDICATION(S)
NATPARA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Hypoparathyroidism: Lab tests confirm low blood calcium (hypocalcemia).

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

PART D VS PART B

MEDICATION(S)

ABELCET, ABILIFY ASIMTUFII, ABILIFY MAINTENA, ACETYLCYSTEINE 10 % SOLUTION, ACETYLCYSTEINE 20 % SOLUTION, ACYCLOVIR SODIUM, ALBUTEROL SULFATE (2.5 MG/3ML) 0.083% NEBU SOLN, ALBUTEROL SULFATE (5 MG/ML) 0.5% NEBU SOLN, ALBUTEROL SULFATE 0.63 MG/3ML NEBU SOLN, ALBUTEROL SULFATE 1.25 MG/3ML NEBU SOLN, ALBUTEROL SULFATE 2.5 MG/0.5ML NEBU SOLN, ALDURAZYME, AMINOSYN II 10 % SOLUTION, AMINOSYN-PF 10 % SOLUTION, AMPHOTERICIN B, AMPHOTERICIN B LIPOSOME, APREPITANT 125 MG CAP, APREPITANT 80 & 125 MG CAP, APREPITANT 80 & 125 MG MISC, APREPITANT 80 MG CAP, ARALAST NP, ARISTADA, ARISTADA INITIO, AZATHIOPRINE 50 MG TAB, AZATHIOPRINE SODIUM, BUDESONIDE 0.25 MG/2ML SUSPENSION, BUDESONIDE 0.5 MG/2ML SUSPENSION, BUDESONIDE 1 MG/2ML SUSPENSION, CABENUVA, CALCITRIOL 0.25 MCG CAP, CALCITRIOL 0.5 MCG CAP, CALCITRIOL 1 MCG/ML SOLUTION, CINACALCET HCL, CROMOLYN SODIUM 20 MG/2ML NEBU SOLN, CYCLOPHOSPHAMIDE 25 MG CAP, CYCLOPHOSPHAMIDE 25 MG TAB, CYCLOPHOSPHAMIDE 50 MG CAP, CYCLOPHOSPHAMIDE 50 MG TAB, CYCLOSPORINE 100 MG CAP, CYCLOSPORINE 25 MG CAP, CYCLOSPORINE 50 MG/ML SOLUTION, CYCLOSPORINE MODIFIED, DEXAMETHASONE SOD PHOSPHATE PF 10 MG/ML SOLUTION, DEXAMETHASONE SODIUM PHOSPHATE 10 MG/ML SOLUTION, DEXAMETHASONE SODIUM PHOSPHATE 100 MG/10ML SOLUTION, DOXERCALCIFEROL, ELAPRASE, ENGERIX-B, EVEROLIMUS 0.25 MG TAB, EVEROLIMUS 0.5 MG TAB, EVEROLIMUS 0.75 MG TAB, EVEROLIMUS 1 MG TAB, GENGRAF, GRANISETRON HCL, HEPARIN SODIUM (PORCINE) 1000 UNIT/ML SOLUTION, HEPARIN SODIUM (PORCINE) 10000 UNIT/ML SOLUTION, HEPARIN SODIUM (PORCINE) 20000 UNIT/ML SOLUTION, HEPARIN SODIUM (PORCINE) 5000 UNIT/ML SOLUTION, HEPARIN SODIUM (PORCINE) PF 1000 UNIT/ML SOLUTION, HEPATAMINE, HEPLISAV-B, HUMULIN R U-500 (CONCENTRATED), IBANDRONATE SODIUM 3 MG/3ML SOLUTION, INTRALIPID, INVEGA HAFYERA, INVEGA SUSTENNA, INVEGA TRINZA, IPRATROPIUM BROMIDE 0.02 % SOLUTION, IPRATROPIUM-ALBUTEROL, KEPIVANCE 6.25 MG RECON SOLN, LACOSAMIDE 200 MG/20ML SOLUTION, METHOTREXATE SODIUM 1 GM RECON SOLN, METHOTREXATE SODIUM 1000 MG/40ML SOLUTION, METHOTREXATE SODIUM 250 MG/10ML SOLUTION, METHOTREXATE SODIUM 50 MG/2ML SOLUTION, METHOTREXATE SODIUM (PF), METHYLPREDNISOLONE SODIUM SUCC 125 MG RECON SOLN, MOXIFLOXACIN HCL 400 MG/250ML SOLUTION, MOXIFLOXACIN HCL IN NACL, MYCOPHENOLATE MOFETIL, MYCOPHENOLATE MOFETIL HCL, MYCOPHENOLATE SODIUM, MYCOPHENOLIC ACID, NAGLAZYME, NUTRILIPID, ONDANSETRON 4 MG TAB DISP, ONDANSETRON 8 MG TAB DISP, ONDANSETRON HCL 24 MG TAB, ONDANSETRON HCL 4 MG TAB, ONDANSETRON HCL 4 MG/5ML SOLUTION, ONDANSETRON HCL 8 MG TAB, PARICALCITOL, PENTAMIDINE ISETHIONATE, PERSERIS, PREHEVBRIO, PREMASOL, PROLASTIN-C, PULMOZYME, RECOMBIVAX HB, RIBAVIRIN 6 GM RECON SOLN, RISPERIDONE MICROSPHERES ER, SANDIMMUNE 100 MG/ML SOLUTION, SIROLIMUS, SMOFLIPID, SUNLENCA 463.5 MG/1.5ML SOLUTION, SYNRIBO, TACROLIMUS 0.5 MG CAP, TACROLIMUS 1 MG CAP, TACROLIMUS 5 MG CAP, THIOTEPA, TPN ELECTROLYTES, TRELSTAR MIXJECT, TWINRIX, VENTAVIS, VORICONAZOLE 200 MG RECON SOLN,

ZOLEDRONIC ACID, ZYPREXA RELPREVV

DETAILS

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

PASIREOTIDE (SIGNIFOR)

MEDICATION(S)
SIGNIFOR

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Cushings disease: pituitary surgery is not an option or has not been curative.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

PAZOPANIB HCL (VOTRIENT)

MEDICATION(S)
PAZOPANIB HCL

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Exclusion criteria will be based on current National Comprehensive Cancer Network (NCCN) guidelines and FDA labeling.

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

PEGINTERFERON ALFA-2A (PEGASYS)

MEDICATION(S)
PEGASYS, PEGASYS PROCLICK

PA INDICATION INDICATOR
4 - All FDA-Approved Indications, Some Medically-Accepted Indications

OFF LABEL USES
myelofibrosis, polycythemia vera, essential thrombocythemia, systemic mastocytosis

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Chronic hepatitis C viral infection: criteria will be applied consistent with current AASLD-IDSA guidance.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Hepatitis B: 48 weeks

Hepatitis C: based on AASLD-IDSA guidance

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

PEGVISOMANT (SOMAVERT)

MEDICATION(S)
SOMAVERT

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Failed radiation or surgery or not a candidate for both radiation and surgery AND failed treatment or had a side effect with octreotide or Somatuline.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Endocrinologist

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

PEMIGATINIB (PEMAZYRE)

MEDICATION(S)
PEMAZYRE

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Exclusion criteria will be based on current National Comprehensive Cancer Network (NCCN) guidelines and FDA labeling.

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

PENICILLAMINE (DEPEN)

MEDICATION(S)
PENICILLAMINE 250 MG TAB

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Rheumatoid Arthritis: patient tried two of the following: methotrexate, sulfasalazine, hydroxychloroquine, or leflunomide, OR has a medical reason why methotrexate, hydroxychloroquine, sulfasalazine, and leflunomide cannot be used.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

PEXIDARTINIB (TURALIO)

MEDICATION(S)
TURALIO

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Exclusion criteria will be based on current National Comprehensive Cancer Network (NCCN) guidelines and FDA labeling.

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

PIMAVANSERIN (NUPLAZID)

MEDICATION(S)
NUPLAZID

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Being used for dementia-related psychosis.

REQUIRED MEDICAL INFORMATION
Evaluation by psychiatrist confirms Parkinson’s disease psychosis (PDP) – symptoms of hallucinations (seeing, hearing, or experiencing things that others don't) and delusions (believing things that aren’t true) due to Parkinson’s disease.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Neurologist or Psychiatrist

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

PIRFENIDONE (ESBRIET)

MEDICATION(S)
PIRFENIDONE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Being used with another IPF drug.

REQUIRED MEDICAL INFORMATION
Idiopathic Pulmonary Fibrosis (IPF), initial use: patient has the following pulmonary function tests: forced vital capacity (FVC) equal or over 50%, and diffusing capacity of carbon monoxide (DLCO) equal or over 30%. Ongoing use: patient has not received a lung transplant.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Pulmonologist

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

PIRTOBRUTINIB (JAYPIRCA)

MEDICATION(S)
JAYPIRCA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Exclusion criteria will be based on current National Comprehensive Cancer Network (NCCN) guidelines and FDA labeling.

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

POMALIDOMIDE (POMALYST)

MEDICATION(S)
POMALYST

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Exclusion criteria will be based on current National Comprehensive Cancer Network (NCCN) guidelines and FDA labeling.

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

PONATINIB (ICLUSIG)

MEDICATION(S)
ICLUSIG

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Exclusion criteria will be based on current National Comprehensive Cancer Network (NCCN) guidelines and FDA labeling.

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

POSACONAZOLE (NOXAFIL)

MEDICATION(S)
POSACONAZOLE 100 MG TAB DR, POSACONAZOLE 40 MG/ML SUSPENSION

PA INDICATION INDICATOR
4 - All FDA-Approved Indications, Some Medically-Accepted Indications

OFF LABEL USES
Esophageal candidiasis treatment, fusariosis, histoplasmosis, phaeohyphomycosis, Allergic Bronchopulmonary Aspergillosis (ABPA), refractory treatment of pulmonary aspergillosis, chronic (cavitary or necrotizing).

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Prevention of aspergillus or candida infection when there is high risk for developing these type of infections (e.g. weakened defense system due to cancer drug therapy, HIV, GVHD).

Aspergillosis, fusariosis, histoplasmosis, phaeohyphomycosis within the body that is confirmed by a positive culture test.

Treatment of candida infection of the esophagus, throat, mouth (esophageal or oropharyngeal candidiasis) after trial of fluconazole or there is a medical reason not to use fluconazole.

Treatment of candida infection within the body that is confirmed by a positive culture and failure of fluconazole or other anti-fungal shown by culture results to treat the infection.

ABPA: use after trial of itraconazole or there is a medical reason not to use itraconazole.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
oral or esophageal candidiasis: one month all other conditions: Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

PRALSETINIB (GAVRETO)

MEDICATION(S)
GAVRETO

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Exclusion criteria will be based on current National Comprehensive Cancer Network (NCCN) guidelines and FDA labeling.

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

PYRIMETHAMINE (DARAPRIM)

MEDICATION(S)
PYRIMETHAMINE

PA INDICATION INDICATOR
4 - All FDA-Approved Indications, Some Medically-Accepted Indications

OFF LABEL USES
Toxoplasmosis prevention, Toxoplasmosis chronic manintenance (secondary prophylaxis), Pneumocystis jiroveci (formerly Pneumocystis carinii) Pneumonia (PCP) prevention, Cystoisospora belli (formerly Isospora Belli) treatment or secondary prevention.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Primary pevention of toxoplasmosis: treatment failure or side effect with trimethoprim-sulfamethoxazole (TMP-SMX) or has a medical reason for not using TMP-SMX and patient is immunocompromised (i.e. cancer, HIV+, post-transplantation).

Chronic maintenance (secondary prophylaxis) of toxoplasmosis: follows initial treatment in HIV-infected patients.

Prevention of Pneumocystis jiroveci (formerly Pneumocystis carinii) Pneumonia (PCP): treatment failure or side effect with trimethoprim-sulfamethoxazole (TMP-SMX) or has a medical reason for not using TMP-SMX AND patient is HIV+.

Treatment of cystoisospora belli (formerly Isospora Belli): Patient is HIV+ AND treatment failure or side effect with trimethoprim-sulfamethoxazole (TMP-SMX) or has a medical reason for not using TMP-SMX.

Chronic manintenance (secondary prophylaxis) of cystoisospora belli (formerly Isospora Belli): follows initial treatment in HIV-infected patients AND treatment failure or side effect with trimethoprim-sulfamethoxazole (TMP-SMX) or has a medical reason for not using TMP-SMX

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Toxoplasmosis: infectious disease specialist, ophthalmologist, or gynecologist. Pneumocystis jiroveci (formerly Pneumocystis carinii) Pneumonia (PCP) prevention and cystoisospora belli (formerly Isospora Belli) treatment or secondary prevention: infectious disease specialist.

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

QUININE SULFATE 324MG (QUALAQUIN)

MEDICATION(S)
QUININE SULFATE

PA INDICATION INDICATOR
4 - All FDA-Approved Indications, Some Medically-Accepted Indications

OFF LABEL USES
Babesiosis

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Babesiosis: current Babesia infection confirmed by one of the following: blood smear positive for Babesia microti parasites, Polymerase Chain Reaction (PCR) blood sample by that is positive for Babesia microti DNA, OR blood sample by FISH is positive for Babesia microti RNA.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Malaria: 7 days. Babesiosis: 10 days.

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

QUIZARTINIB (VANFLYTA)

MEDICATION(S)
VANFLYTA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Exclusion criteria will be based on current National Comprehensive Cancer Network (NCCN) guidelines and FDA labeling.

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Induction: 2 months. Consolidation: 4 months. Maintenance therapy: 36 months. (see other criteria)

OTHER CRITERIA
Treatment course consists of:
a. Up to two cycles for use with standard cytarabine and anthracycline for induction, and
b. Up to four cycles for use with cytarabine for consolidation, and
c. Up to 36 cycles as a single agent for maintenance after consolidation therapy or until disease progression.

PART B PREREQUISITE
N/A

REGORAFENIB (STIVARGA)

MEDICATION(S)
STIVARGA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Exclusion criteria will be based on current National Comprehensive Cancer Network (NCCN) guidelines and FDA labeling.

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

RELUGOLIX (ORGOVYX)

MEDICATION(S)
ORGOVYX

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Exclusion criteria will be based on current National Comprehensive Cancer Network (NCCN) guidelines and FDA labeling.

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

REPOTRECTINIB (AUGTYRO)

MEDICATION(S)
AUGTYRO

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Exclusion criteria will be based on current National Comprehensive Cancer Network (NCCN) guidelines and FDA labeling.

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

RIBOCICLIB (KISQALI)

MEDICATION(S)
KISQALI (200 MG DOSE), KISQALI (400 MG DOSE), KISQALI (600 MG DOSE)

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Exclusion criteria will be based on current National Comprehensive Cancer Network (NCCN) guidelines and FDA labeling.

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

RIBOCICLIB SUCCINATE/LETROZOLE (KISQALI FEMARA)

MEDICATION(S)
KISQALI FEMARA (200 MG DOSE), KISQALI FEMARA (400 MG DOSE), KISQALI FEMARA (600 MG DOSE)

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Exclusion criteria will be based on current National Comprehensive Cancer Network (NCCN) guidelines and FDA labeling.

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

RIFAXIMIN (XIFAXAN)

MEDICATION(S)
XIFAXAN

PA INDICATION INDICATOR
4 - All FDA-Approved Indications, Some Medically-Accepted Indications

OFF LABEL USES
Clostridium difficile associated diarrhea (CDAD), Crohn's Disease, Small bowel bacterial overgrowth syndrome/Small intestinal bacterial overgrowth (SIBO)

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Travelers diarrhea: patient has tried azithromycin or a fluoroquinolone like ciprofloxacin or has a medical reason why ciprofloxacin and azithromycin cannot be used.
Hepatic Encephalopathy: patient has tried lactulose.
Irritable bowel syndrome with diarrhea (IBS-D): patient has tried an anti-diarrheal drug (diphenoxylate/atropine, loperamide) OR has a medical reason not to use (contraindication) anti-diarrheal therapies.
Clostridium difficile associated diarrhea (CDAD): patient has tried vancomycin.
Crohn's Disease: patient has tried metronidazole or ciprofloxacin or has a medical reason why metronidazole and ciprofloxacin cannot be used.
SIBO: Confirmation by a current positive breath test (e.g., lactulose hydrogen or glucose hydrogen) AND patient has tried and failed or had side effects with two of the following antibiotics: metronidazole (Flagyl), and ciprofloxacin (Cipro), amoxicillin-clavulanic acid (Augmentin), doxycycline, tetracycline, and trimethoprim-sulfamethoxazole (Bactrim, Septra) or there is a medical reason why all the other antibiotics cannot be tried first.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
One course (see other criteria)

OTHER CRITERIA

Travelers diarrhea: 3 days. Hepatic encephalopathy: plan year. IBS-D: 2 weeks. CDAD: 20 days. Crohn's Disease: 12 weeks. SIBO: 14 days.

PART B PREREQUISITE

N/A

RILONACEPT (ARCALYST)

MEDICATION(S)
ARCALYST

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Recurrent Pericarditis: trial of colchicine in combination with oral non-steroidal anti-inflammatory drug (NSAID) or contraindication to colchicine in combination with oral NSAID OR patient did not respond to corticosteroids or is on corticosteroids.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Recurrent Pericarditis: Cardiologist

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

RIMEGEPANT (NURTEC)

MEDICATION(S)
NURTEC

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Migraine Tx: Trial of at least two triptans (e.g., sumatriptan, rizatriptan, naratriptan) or has a medical reason (contraindication) for not using triptans.
Migraine HA prevention: documentation of 4 or more headache days per month, treatment failure or side effects with at least 2 preventive therapies from the following drug classes: beta blockers, antidepressants, anticonvulsants or there is a medical reason why the patient cannot use the AAN level A or B guideline endorsed preventive drugs.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

RIOCIGUAT (ADEMPAS)

MEDICATION(S)
ADEMPAS

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Confirmation of Pulmonary Arterial Hypertension (WHO Group I) by right heart catheterization test AND patient has tried an endothelin-receptor antagonist (e.g. Tracleer) and a phosphodiesterase type 5 (PDE-5) inhibitor (e.g. sildenafil).

Confirmation of Chronic Thromboembolic Pulmonary Hypertension (CTEPH) by a right heart catheterization or V/Q scan AND patient has been treated with surgery or cannot be treated surgery.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

RIPRETINIB (QINLOCK)

MEDICATION(S)
QINLOCK

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Exclusion criteria will be based on current National Comprehensive Cancer Network (NCCN) guidelines and FDA labeling.

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

RISANKIZUMAB-RZAA IV (SKYRIZI IV)

MEDICATION(S)
SKYRIZI 600 MG/10ML SOLUTION

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Being used with another targeted immunotherapy drug.

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
18 years of age or older.

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
one time induction course (8 weeks)

OTHER CRITERIA
Excluded under Part D if covered by Part B.
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

RISANKIZUMAB-RZAA SQ (SKYRIZI SQ)

MEDICATION(S)
SKYRIZI 150 MG/ML SOLN PRSYR, SKYRIZI 180 MG/1.2ML SOLN CART, SKYRIZI 360 MG/2.4ML SOLN CART, SKYRIZI (150 MG DOSE), SKYRIZI PEN

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Being used with another targeted immunotherapy drug.

REQUIRED MEDICAL INFORMATION
Plaque Psoriasis (PsO), initial use: treatment failure or side effect with one DMARD or has a medical reason why methotrexate, cyclosporine, and acitretin cannot be used AND moderate to severe disease confirmed by Psoriasis Area and Severity Index (PASI) score of 10 or more OR Body Surface Area (BSA) of at least 3% OR sensitive areas are involved OR disease affects daily living. PsO, ongoing use: PASI or BSA improved with use of Skyrizi.
Psoriatic arthritis (PsA): treatment failure or side effect with one DMARD drug or medical reason why methotrexate, leflunomide, and sulfasalazine cannot be used.
Ulcerative colitis (UC): disease is moderate to severe AND SQ formulation will be started after initial IV dose.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
PsO: Dermatologist or Rheumatologist. PsA: Rheumatologist

COVERAGE DURATION
PsO initial use: 16 weeks. PsO ongoing use: plan year. PsA, Crohn's, UC: plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE

N/A

ROFLUMILAST (DALIRESP)

MEDICATION(S)
ROFLUMILAST

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

ROPEGINTERFERON ALFA-2B (BESREMI)

MEDICATION(S)
BESREMI

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Polycythemia Vera (PV): treatment failure or side effect with hydroxyurea OR medical reason for not using hydroxyurea

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

RUCAPARIB CAMSYLATE (RUBRACA)

MEDICATION(S)
RUBRACA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Exclusion criteria will be based on current National Comprehensive Cancer Network (NCCN) guidelines and FDA labeling.

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

RUXOLITINIB (JAKAFI)

MEDICATION(S)
JAKAFI

PA INDICATION INDICATOR
4 - All FDA-Approved Indications, Some Medically-Accepted Indications

OFF LABEL USES
Myeloid, lymphoid, or mixed phenotype neoplasms with eosinophilia, CAR-T cell related toxicities, Myelodysplastic/ Myeloproliferative overlap neoplasms, Essential thrombocytopenia, T-cell Lymphomas, Pediatric acute lymphoblastic leukemia (ALL).

EXCLUSION CRITERIA
Myelofibrosis (MF): Being used along with another agent for myelofibrosis.

REQUIRED MEDICAL INFORMATION
MF: platelet count is equal to or more than 50,000 cells/mcl or being used in combination with Reblozyl for low blood cells (anemia). Polycythemia Vera (PV): treatment failure or side effect with hydroxyurea OR medical reason for not using hydroxyurea and hematocrit of at least 40%. Graft vs Host Disease (GvHD): treatment failure to at least one prior drug for GVHD (i.e., systemic corticosteroids, cyclophosphamide, cyclosporine, methotrexate, mycophenolate, and tacrolimus). All off-label uses: criteria will be applied consistent with current National Comprehensive Cancer Network (NCCN) guidelines.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE

N/A

SACROSIDASE (SUCRAID)

MEDICATION(S)
SUCRAID

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Initial use: patient has been evaluated to rule out other causes of disaccharidase deficiency.
Ongoing use: patient's gastrointestinal symptoms (i.e. abdominal pain, diarrhea, watery stools, bloating, flatulence) have been reduced.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Gastroenterologist, Geneticist, or Metabolic Specialist.

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

SAPROPTERIN DIHYDROCHLORIDE (KUVAN)

MEDICATION(S)
JAVYGTOR, SAPROPTERIN DIHYDROCHLORIDE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Being used in combination with pegvaliase-pqpz (Palynziq)

REQUIRED MEDICAL INFORMATION
Phenylketonuria (PKU), initial: chart notes confirm PKU and baseline (just prior to therapy) blood phenylalanine (Phe) levels are given. PKU, ongoing use: phenylalanine level improved from baseline

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Initial: 3 months dose increases: 3 months, ongoing use: plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

SELEGILINE TRANSDERMAL (EMSAM)

MEDICATION(S)
EMSAM

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Treatment failure or side effect with at least one preferred drug that treats depression (e.g. bupropion, maprotiline, citalopram, paroxetine, sertraline, venlafaxine, duloxetine).

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

SELINEXOR (XPOVIO)

MEDICATION(S)
XPOVIO (100 MG ONCE WEEKLY), XPOVIO (40 MG ONCE WEEKLY), XPOVIO (40 MG TWICE WEEKLY), XPOVIO (60 MG ONCE WEEKLY), XPOVIO (60 MG TWICE WEEKLY), XPOVIO (80 MG ONCE WEEKLY), XPOVIO (80 MG TWICE WEEKLY)

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Exclusion criteria will be based on current National Comprehensive Cancer Network (NCCN) guidelines and FDA labeling.

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

SELPERCATINIB (RETEVMO)

MEDICATION(S)
RETEVMO

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Exclusion criteria will be based on current National Comprehensive Cancer Network (NCCN) guidelines and FDA labeling.

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

SELUMETINIB (KOSELUGO)

MEDICATION(S)
KOSELUGO

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Exclusion criteria will be based on current National Comprehensive Cancer Network (NCCN) guidelines and FDA labeling.

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

SEMAGLUTIDE (RYBELSUS)

MEDICATION(S)
RYBELSUS

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Being used with another GLP-1 agent

REQUIRED MEDICAL INFORMATION
Type 2 diabetes: Confirmed AND one of the following: trial and failure or side effect with metformin or medical reason why metformin cannot be used, or A1C of 7.5% or greater and being used with another diabetes drug.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

SEMAGLUTIDE SQ (OZEMPIC)

MEDICATION(S)
OZEMPIC (0.25 OR 0.5 MG/DOSE), OZEMPIC (1 MG/DOSE), OZEMPIC (2 MG/DOSE)

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Being used with another GLP-1 agent

REQUIRED MEDICAL INFORMATION
Type 2 diabetes: Confirmed AND one of the following: trial and failure or side effect with metformin or medical reason why metformin cannot be used, or A1C of 7.5% or greater and being used with another diabetes drug, or patient has heart (cardiovascular) disease.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

SILDENAFIL (REVATIO)

MEDICATION(S)
SILDENAFIL CITRATE 10 MG/ML RECON SUSP, SILDENAFIL CITRATE 20 MG TAB

PA INDICATION INDICATOR
4 - All FDA-Approved Indications, Some Medically-Accepted Indications

OFF LABEL USES
Raynauds phenomenon

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
PAH: confirmation of WHO Group I by right heart catheterization test.

Raynaud's phenomenon: treatment failure or side effect with a calcium-channel blocker (e.g. nifedipine).

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

SKELETAL MUSCLE RELAXANTS (HIGH RISK MEDICATION)

MEDICATION(S)
CARISOPRODOL 350 MG TAB, CYCLOBENZAPRINE HCL 10 MG TAB, CYCLOBENZAPRINE HCL 5 MG TAB, METHOCARBAMOL 500 MG TAB, METHOCARBAMOL 750 MG TAB, VANADOM

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Prescriber confirms the benefits of the drug outweigh any risks and will monitor for side effects.

AGE RESTRICTION
65 years and older. No prior authorization required for less than 65 years old.

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
3 weeks

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

SODIUM OXYBATE (XYREM)

MEDICATION(S)
XYREM

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Xyrem is being used with sedative hypnotic drugs or other CNS depressant drugs.

REQUIRED MEDICAL INFORMATION
Narcolepsy is confirmed by sleep study and patient has brief losses of muscle tone (cataplexy). Excessive daytime sleepiness due to narcolepsy: Trial and failure or side effect to modafinil, or has a medical reason not to use modafinil.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

SODIUM PHENYLBUTYRATE (BUPHENYL)

MEDICATION(S)
SODIUM PHENYLBUTYRATE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Chart documentation for inherited Urea Cycle enzyme deficiency.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

SOFOSBUVIR/VELPATASVIR (EPCLUSA)

MEDICATION(S)
EPCLUSA, SOFOSBUVIR-VELPATASVIR

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Exclusion criteria will be based on current AASLD/IDSA guidelines.

REQUIRED MEDICAL INFORMATION
Required medical information will be aligned with current AASLD/IDSA guidelines.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Hepatologist, Gastroenterologist, or Infectious Disease.

COVERAGE DURATION
Length of therapy will be based on current AASLD/IDSA guidelines and FDA labeling.

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

SOFOSBUVIR/VELPATASVIR/VOXILAPREVIR (VOSEVI)

MEDICATION(S)
VOSEVI

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Exclusion criteria will be based on current AASLD/IDSA guidelines.

REQUIRED MEDICAL INFORMATION
Required medical information will be aligned with current AASLD/IDSA guidelines.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Hepatologist, Gastroenterologist, or Infectious Disease.

COVERAGE DURATION
Length of therapy will be based on current AASLD/IDSA guidelines and FDA labeling.

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

SOMATROPIN (GENOTROPIN)

MEDICATION(S)
GENOTROPIN, GENOTROPIN MINIQUICK

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Adult Growth hormone deficiency (GHD): low IGF-1 (below mean of reference range) AND history of hypothalamic-pituitary disease (i.e., structural, trauma, treatment induced), AND one of the following: failed one growth hormone stimulation test or three or more documented pituitary hormone deficiencies. Adult GHD continuing from childhood with prior use of GH: One of the following: growth not complete OR growth complete and low IGF-1 (below mean of reference range) AND for patients with pituitary gland: patient failed one standard growth hormone stimulation test. Pediatric GHD with pituitary disease: One of the following: growth rate (velocity) decline, AND presence of hypothalamic-pituitary disease (i.e., structural, trauma, treatment induced), AND one of the following: failed one growth hormone stimulation test or at least one documented pituitary hormone deficiency OR newborn with congenital pituitary defect or at least one pituitary hormone deficiency and low blood sugar and blood growth hormone level less than 5 ug/L, OR three or more documented pituitary hormone deficiencies. Pediatric GHD without pituitary disease: height is 2 or more standard deviations below mean (less than 3rd percentile) for age and sex, height rate is less than 10th percentile of normal for age and sex within the last year, and failure of two standard growth hormone stimulation tests. Small for Gestational Age (SGA): length at birth or birth weight are two or more standard deviations below the mean (less than the 3rd percentile) for gestational age and height is two or more standard deviations below the mean.

Ongoing use in Adult GHD: responding to GH. Ongoing use in SGA or pediatric GHD: growth rate improved or maintained while on GH. Ongoing use for pediatrics with growth failure due to CKD: patient did not have a kidney transplant within the past year. Ongoing use for Turners or Prader-Willi syndrome: provider has determined that benefits outweigh risk and continuation is necessary.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Endocrinologist

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

SOMATROPIN (OMNITROPE)

MEDICATION(S)
OMNITROPE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Adult Growth hormone deficiency (GHD): low IGF-1 (below mean of reference range) AND history of hypothalamic-pituitary disease (i.e., structural, trauma, treatment induced), AND one of the following: failed one growth hormone stimulation test or three or more documented pituitary hormone deficiencies. Adult GHD continuing from childhood with prior use of GH: One of the following: growth not complete OR growth complete and low IGF-1 (below mean of reference range) AND for patients with pituitary gland: patient failed one standard growth hormone stimulation test. Pediatric GHD with pituitary disease: One of the following: growth rate (velocity) decline, AND presence of hypothalamic-pituitary disease (i.e., structural, trauma, treatment induced), AND one of the following: failed one growth hormone stimulation test or at least one documented pituitary hormone deficiency OR newborn with congenital pituitary defect or at least one pituitary hormone deficiency and low blood sugar and blood growth hormone level less than 5 ug/L, OR three or more documented pituitary hormone deficiencies. Pediatric GHD without pituitary disease: height is 2 or more standard deviations below mean (less than 3rd percentile) for age and sex, height rate is less than 10th percentile of normal for age and sex within the last year, and failure of two standard growth hormone stimulation tests. Small for Gestational Age (SGA): length at birth or birth weight are two or more standard deviations below the mean (less than the 3rd percentile) for gestational age and height is two or more standard deviations below the mean.
Ongoing use in Adult GHD: responding to GH. Ongoing use in SGA or pediatric GHD: growth rate improved or maintained while on GH. Ongoing use for Turners or Prader-Willi syndrome: provider has determined that benefits outweigh risk and continuation is necessary.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Endocrinologist

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

SONIDEGIB (ODOMZO)

MEDICATION(S)
ODOMZO

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Exclusion criteria will be based on current National Comprehensive Cancer Network (NCCN) guidelines and FDA labeling.

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

SORAFENIB (NEXAVAR)

MEDICATION(S)
SORAFENIB TOSYLATE

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Exclusion criteria will be based on current National Comprehensive Cancer Network (NCCN) guidelines and FDA labeling.

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

SOTORASIB (LUMAKRAS)

MEDICATION(S)
LUMAKRAS

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Exclusion criteria will be based on current National Comprehensive Cancer Network (NCCN) guidelines and FDA labeling.

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

STIRIPENTOL (DIACOMIT)

MEDICATION(S)
DIACOMIT

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Seizures due to Dravet syndrome: being used with clobazam.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

SUNITINIB MALATE (SUTENT)

MEDICATION(S)
SUNITINIB MALATE

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Exclusion criteria will be based on current National Comprehensive Cancer Network (NCCN) guidelines and FDA labeling.

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

TACROLIMUS (ENVARSUS XR)

MEDICATION(S)
ENVARSUS XR

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Patient is using immediate-release (IR) tacrolimus and would like Envarsus to lower pill burden.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Excluded under Part D if covered by Part B.
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

TACROLIMUS FOR ORAL SUSPENSION (PROGRAF GRANULES)

MEDICATION(S)
PROGRAF 0.2 MG PACKET, PROGRAF 1 MG PACKET

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Patient has a medical reason for not using tacrolimus capsules.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Excluded under Part D if covered by Part B.
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

TADALAFIL (ADCIRCA)

MEDICATION(S)
ALYQ, TADALAFIL (PAH)

PA INDICATION INDICATOR
4 - All FDA-Approved Indications, Some Medically-Accepted Indications

OFF LABEL USES
Raynaud's phenomenon

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
PAH: confirmation of WHO Group I by right heart catheterization test. Raynaud's phenomenon: treatment failure or side effect with a calcium-channel blocker (e.g. nifedipine).

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

TAFAMIDIS (VYNDAMAX)

MEDICATION(S)
VYNDAMAX

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Being used with a gene silencer like Tegsedi or Onpattro.

REQUIRED MEDICAL INFORMATION
Heart disease (cardiomyopathy) is due to transthyretin-mediated amyloidosis (ATTR) confirmed by clinical features, genetic testing, and biopsy or immunochemistry.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Cardiologist

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

TAFAMIDIS MEGLUMINE (VYNDAQEL)

MEDICATION(S)
VYNDAQEL

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Being used with a gene silencer like Tegsedi or Onpattro.

REQUIRED MEDICAL INFORMATION
Heart disease (cardiomyopathy) is due to transthyretin-mediated amyloidosis (ATTR) confirmed by clinical features, genetic testing, and biopsy or immunochemistry.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Cardiologist

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

TALAZOPARIB TOSYLATE (TALZENNA)

MEDICATION(S)
TALZENNA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Exclusion criteria will be based on current National Comprehensive Cancer Network (NCCN) guidelines and FDA labeling.

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

TAMOXIFEN (SOLTAMOX)

MEDICATION(S)
SOLTAMOX

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Medical reason why tamoxifen tablet cannot be used.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

TASIMELTEON (HETLIOZ)

MEDICATION(S)
TASIMELTEON

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Non 24 Sleep Wake Cycle, initial use: patient not able to maintain a stable 24-hour sleep-wake pattern synchronized to 24-hr light/dark cycle. Non 24 Sleep Wake Cycle, ongoing use: patients total sleep time at night is longer and has less day time sleep since starting tasimelteon.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Non 24 Sleep Wake Cycle: sleep specialist, neurologist

COVERAGE DURATION
Non 24 Sleep Wake Cycle, initial use: 3mos. Ongoing use: plan year Smith-Magenis Syndrome: plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

TAZEMETOSTAT (TAZVERIK)

MEDICATION(S)
TAZVERIK

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Exclusion criteria will be based on current National Comprehensive Cancer Network (NCCN) guidelines and FDA labeling.

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

TEDUGLUTIDE (GATTEX)

MEDICATION(S)
GATTEX

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Initial use: patient has been dependent on parenteral nutrition for at least 3 months

Ongoing use: patient is still receiving parenteral nutrition (e.g. TPN or PPN) and has had a reduction in weekly parenteral nutrition volume since starting Gattex.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
6 months

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

TELOTRISTAT ETHYL (XERMELO)

MEDICATION(S)
XERMELO

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Treatment failure of octreotide (Sandostatin) or lanretotide (Somatuline) AND being used in combination with octreotide (Sandostatin) or lanreotide (Somatuline).

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

TEPOTINIB (TEPMETKO)

MEDICATION(S)
TEPMETKO

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Exclusion criteria will be based on current National Comprehensive Cancer Network (NCCN) guidelines and FDA labeling.

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

TERIFLUNOMIDE (AUBAGIO)

MEDICATION(S)
TERIFLUNOMIDE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Being used with other disease-modifying therapies for relapsing Multiple Sclerosis.

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

TERIPARATIDE (FORTEO)

MEDICATION(S)
FORTEO

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Being used with other osteoporosis drugs.

REQUIRED MEDICAL INFORMATION
Osteoporosis: one of the following: patient has a history of a broken bone not due to trauma (non-traumatic fracture) or T-score between -1.0 and -2.5 and is at high risk for fracture or T-score lower than -2.5 AND trial of a bisphosphonate (e.g. alendronate, ibandronate, or zoledronic acid) or Prolia, OR side effect to bisphosphonate therapy or Prolia therapy that supports discontinuation, OR Patient is at very high risk of fracture by meeting at least one of the following: non-traumatic fracture while on bisphosphonate therapy or Prolia, patient has experienced a recent fracture (within the past 12 months) or history of multiple fractures, or T-score less than -3.0, or patient is at high risk for falls, or 10-year hip fracture probability greater than 4.5% based on FRAX score, or 10-year major osteoporosis-related fracture probability greater than 30% based on FRAX score AND medical reason why Tymlos cannot be used. Glucocorticoid-induced osteoporosis: initiating or continuing long-term glucocorticoid treatment (e.g. prednisone, dexamethasone) and either has history of a non-traumatic fracture or is at high risk for fracture.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

TERIPARATIDE (RECOMBINANT)

MEDICATION(S)
TERIPARATIDE (RECOMBINANT) 620 MCG/2.48ML SOLN PEN

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Being used with other osteoporosis drugs.

REQUIRED MEDICAL INFORMATION
Osteoporosis: one of the following: patient has a history of a broken bone not due to trauma (non-traumatic fracture) or T-score between -1.0 and -2.5 and is at high risk for fracture or T-score lower than -2.5 AND trial of a bisphosphonate (e.g. alendronate, ibandronate, or zoledronic acid) or Prolia, OR side effect to bisphosphonate therapy or Prolia therapy that supports discontinuation, OR Patient is at very high risk of fracture by meeting at least one of the following: non-traumatic fracture while on bisphosphonate therapy or Prolia, patient has experienced a recent fracture (within the past 12 months) or history of multiple fractures, or T-score less than -3.0, or patient is at high risk for falls, or 10-year hip fracture probability greater than 4.5% based on FRAX score, or 10-year major osteoporosis-related fracture probability greater than 30% based on FRAX score.
Glucocorticoid-induced osteoporosis: initiating or continuing long-term glucocorticoid treatment (e.g. prednisone, dexamethasone) and either has history of a non-traumatic fracture or is at high risk for fracture.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

TESAMORELIN ACETATE (EGRIFTA)

MEDICATION(S)
EGRIFTA SV

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Being used in combination with any form of growth hormone (somatropin) or IGF-1 (mecasermin)

REQUIRED MEDICAL INFORMATION
Initial use: for men: having a waist circumference greater than 37.4 inches (97 cm) and a waist to hip ratio greater than or equal to 0.94 or for women: having a waist circumference greater than 37 inches (94 cm) and a waist to hip ratio greater than or equal to 0.88. Ongoing use: patient has had or maintained improvement in waist circumference.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Endocrinologist or HIV Specialist

COVERAGE DURATION
Initial use: 3 months Ongoing use: 6 months

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

TETRABENAZINE (XENAZINE)

MEDICATION(S)
TETRABENAZINE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Neurologist

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

TEZACAFTOR-IVACAFTOR (SYMDEKO)

MEDICATION(S)
SYMDEKO

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Being used with another CFTR potentiator drug (e.g. Orkambi).

REQUIRED MEDICAL INFORMATION
Documentation that confirms there is both (e.g., homozygous) F508 gene muations or at least one CFTR gene mutation sensitive to Symdeko.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

THALIDOMIDE (THALOMID)

MEDICATION(S)
THALOMID

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Exclusion criteria will be based on current National Comprehensive Cancer Network (NCCN) guidelines and FDA labeling.

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

TIOPRONIN (THIOLA)

MEDICATION(S)
TIOPRONIN 100 MG TAB

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

TIRZEPATIDE (MOUNJARO)

MEDICATION(S)
MOUNJARO

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Being used with another GLP-1 agent.

REQUIRED MEDICAL INFORMATION
Confirmation of type 2 diabetes AND one of the following: trial and failure or side effect with metformin or medical reason why metformin cannot be used, OR A1C of 7.5% or greater and being used with another diabetes drug.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

TIVOZANIB (FOTIVDA)

MEDICATION(S)
FOTIVDA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Exclusion criteria will be based on current National Comprehensive Cancer Network (NCCN) guidelines and FDA labeling.

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

TOBRAMYCIN (TOBI PODHALER)

MEDICATION(S)
TOBI PODHALER

PA INDICATION INDICATOR
4 - All FDA-Approved Indications, Some Medically-Accepted Indications

OFF LABEL USES
bronchiectasis

EXCLUSION CRITERIA
Being used for acute treatment of an infection.

REQUIRED MEDICAL INFORMATION
Patient has cystic fibrosis or bronchiectasis and copy of sputum culture positive for Pseudomonas Aeruginosa.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

TOBRAMYCIN INHALATION AGENTS

MEDICATION(S)
TOBRAMYCIN 300 MG/4ML NEBU SOLN, TOBRAMYCIN 300 MG/5ML NEBU SOLN

PA INDICATION INDICATOR
4 - All FDA-Approved Indications, Some Medically-Accepted Indications

OFF LABEL USES
bronchiectasis

EXCLUSION CRITERIA
Being used for acute treatment of an infection.

REQUIRED MEDICAL INFORMATION
Patient has cystic fibrosis or a bronchiectasis and copy of sputum culture is positive for Pseudomonas Aeruginosa.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

TOFACITINIB (XELJANZ, XELJANZ XR)

MEDICATION(S)
XELJANZ, XELJANZ XR

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Being used with another targeted immunotherapy drug.

REQUIRED MEDICAL INFORMATION
Rheumatoid Arthritis and Polyarticular Juvenile Idiopathic Arthritis (pJIA): treatment failure or side effect with methotrexate OR medical reason why methotrexate cannnot be used AND trial of a TNF inhibitor (i.e., Humira). Psoriatic arthritis (PsA): treatment failure or side effect with one DMARD drug or medical reason why methotrexate, leflunomide, and sulfasalazine cannot be used AND trial of a TNF inhibitor (i.e., Humira). Spondyloarthritis (SpA): trial of a TNF inhibitor (i.e., Humira). Ulcerative Colitis (UC): trial of a TNF inhibitor (i.e., Humira). For oral solution for all indications: patient is unable to swallow a tablet.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
RA, PsA, pJIA, SpA: Rheumatologist.

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

TOPICAL TESTOSTERONE PRODUCTS

MEDICATION(S)
TESTOSTERONE 1.62 % GEL, TESTOSTERONE 12.5 MG/ACT (1%) GEL, TESTOSTERONE 20.25 MG/1.25GM (1.62%) GEL, TESTOSTERONE 20.25 MG/ACT (1.62%) GEL, TESTOSTERONE 25 MG/2.5GM (1%) GEL, TESTOSTERONE 40.5 MG/2.5GM (1.62%) GEL, TESTOSTERONE 50 MG/5GM (1%) GEL

PA INDICATION INDICATOR
4 - All FDA-Approved Indications, Some Medically-Accepted Indications

OFF LABEL USES
transgender, gender dysphoria

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

TOPIRAMATE ORAL SOLUTION (EPRONTIA)

MEDICATION(S)
EPRONTIA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Medical reason why patient cannot use topiramate tablet or sprinkle capsules

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

TOVORAFENIB (OJEMDA)

MEDICATION(S)
OJEMDA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Exclusion criteria will be based on current National Comprehensive Cancer Network (NCCN) guidelines and FDA labeling.

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

TRAMADOL ER (ULTRAM ER) – NARCOTIC SAFETY INITIATIVE

MEDICATION(S)
TRAMADOL HCL ER 100 MG TAB ER 24H, TRAMADOL HCL ER 200 MG TAB ER 24H, TRAMADOL HCL ER 300 MG TAB ER 24H

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Being used with other long-acting narcotic drugs.

REQUIRED MEDICAL INFORMATION
Cancer pain: dose has been consolidated to the least number of higher strength forms.

Non-cancer pain, initial: cause of pain cannot be removed or treated with other treatment options, and pain occurs daily and has lasted for at least 3 months, and pain is severe enough to need daily around-the-clock long-term narcotic use, and total daily dose across all narcotic drugs is less than 90 MME, and dose has been consolidated to the least number of higher strength forms and trial of short-acting tramadol, and chart notes document pain history including baseline pain intensity score and functional interference score, a plan for monitoring side effects and misuse, and a plan to taper down narcotics.

Non-cancer pain, reauth: total daily dose across all narcotic drugs is less than 90 MME per day, and dose has been consolidated to the least number of higher strength forms, and chart notes document current pain intensity score, functional interference score, any side effects and/or misuse with current pain treatment regimen, and plan to taper narcotic use.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Cancer pain: Oncologist or Pain Specialist.

COVERAGE DURATION
Cancer pain: plan year Non-cancer pain: initial 30 days,1st reauth 3mos, ongoing reauths plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

TRAMETINIB (MEKINIST)

MEDICATION(S)
MEKINIST

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Exclusion criteria will be based on current National Comprehensive Cancer Network (NCCN) guidelines and FDA labeling.

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

TRANSMUCOSAL FENTANYL PRODUCTS

MEDICATION(S)
FENTANYL CITRATE 1200 MCG LOZ HANDLE, FENTANYL CITRATE 1600 MCG LOZ HANDLE, FENTANYL CITRATE 200 MCG LOZ HANDLE, FENTANYL CITRATE 400 MCG LOZ HANDLE, FENTANYL CITRATE 600 MCG LOZ HANDLE, FENTANYL CITRATE 800 MCG LOZ HANDLE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Documentation of pain due to cancer.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Oncologist or Pain Management Specialist

COVERAGE DURATION
6 months

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

TRETINOIN (AVITA, RETIN-A)

MEDICATION(S)
AVITA, TRETINOIN 0.01 % GEL, TRETINOIN 0.025 % CREAM, TRETINOIN 0.025 % GEL, TRETINOIN 0.05 % CREAM, TRETINOIN 0.1 % CREAM

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
40 years of age or older. No prior authorization needed if less than 40 years of age.

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

TRIENTINE HCL (SYPRINE)

MEDICATION(S)
CLOVIQUE, TRIENTINE HCL

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Side effect to penicillamine.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

TRIFLURIDINE/TIPIRACIL HCL (LONSURF)

MEDICATION(S)
LONSURF

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Exclusion criteria will be based on current National Comprehensive Cancer Network (NCCN) guidelines and FDA labeling.

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

TUCATINIB (TUKYSA)

MEDICATION(S)
TUKYSA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Exclusion criteria will be based on current National Comprehensive Cancer Network (NCCN) guidelines and FDA labeling.

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

UBROGEPANT (UBRELVY)

MEDICATION(S)
UBRELVY

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Trial and failure or side effect to at least two triptans (e.g., sumatriptan, rizatriptan, naratriptan) or has a medical reason (contraindication) for not using triptans.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

UMBRALISIB TOSYLATE (UKONIQ)

MEDICATION(S)
UKONIQ

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Exclusion criteria will be based on current National Comprehensive Cancer Network (NCCN) guidelines and FDA labeling.

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

UPADACITINIB (RINVOQ)

MEDICATION(S)
RINVOQ, RINVOQ LQ

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Being used with another targeted immunotherapy drug.

REQUIRED MEDICAL INFORMATION
Rheumatoid Arthritis: treatment failure or side effect with methotrexate or medical reason why methotrexate cannot be used AND trial of a TNF inhibitor (i.e., Humira). Psoriatic arthritis (PsA): trial of a TNF inhibitor (i.e., Humira). Atopic Dermatitis: moderate to severe disease confirmed by Investigators Global Assessment (IGA) score of 3-4, Eczema Area and Severity Index (EASI) score of at least 16, Body surface area of at least 10%, or Severity Scoring of Atopic Dermatitis Index (SCORAD) score of at least 25 AND treatment failure or side effect with a topical calcineurin inhibitor (i.e., tacrolimus ointment) OR has a medical reason why these topical therapies cannot be used. Ulcerative Colitis (UC) or Crohn's Disease (CD): Trial of a TNF inhibitor (i.e., Humira). Spondyloarthritis (SpA): Trial of a TNF inhibitor (i.e., Humira)

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
RA, PsA, SpA, pJIA: Rheumatologist. Atopic Dermatitis: Dermatologist, Allergist, or Immunologist.

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE

N/A

USTEKINUMAB IV (STELARA IV)

MEDICATION(S)
STELARA 130 MG/26ML SOLUTION

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Being used with another targeted immunotherapy drug.

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
18 years of age or older.

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
one time induction infusion

OTHER CRITERIA
Excluded under Part D if covered by Part B.
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

USTEKINUMAB SQ (STELARA)

MEDICATION(S)
STELARA 45 MG/0.5ML SOLN PRSYR, STELARA 45 MG/0.5ML SOLUTION, STELARA 90 MG/ML SOLN PRSYR

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Being used with another targeted immunotherapy drug.

REQUIRED MEDICAL INFORMATION
Plaque Psoriasis (PsO), initial use: treatment failure or side effect with one DMARD or has a medical reason why methotrexate, cyclosporine, and acitretin cannot be used AND moderate to severe disease confirmed by Psoriasis Area and Severity Index (PASI) score of 10 or more OR Body Surface Area (BSA) of at least 3% OR sensitive areas are involved OR disease affects daily living. PsO, ongoing use: PASI or BSA improved with use of Stelara.

Psoriatic arthritis (PsA): treatment failure or side effect with one DMARD drug or medical reason why methotrexate, leflunomide, and sulfasalazine cannot be used.

Crohn's Disease (CD), initial use: SQ formulation will be started after initial IV dose. CD, ongoing use: symptom improvement with use of Stelara.

Ulcerative colitis (UC), initial use: disease is moderate to severe AND SQ formulation will be started after initial IV dose. UC, ongoing use: symptom improvement with use of Stelara.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
PsO: Dermatologist or Rheumatologist. PsA: Rheumatologist.

COVERAGE DURATION
PsO initial use: 28 weeks. PsO ongoing use, CD, UC, and PsA: plan year.

OTHER CRITERIA

Dose and duration is not more than the FDA labeled maximum.
PsO and PsA initial: one loading dose and 2 maintenance doses (28 weeks total). PsO and PsA onging maintenance use: plan year.

PART B PREREQUISITE

N/A

VALBENAZINE (INGREZZA)

MEDICATION(S)
INGREZZA 40 & 80 MG CAP THPK, INGREZZA 40 MG CAP, INGREZZA 60 MG CAP, INGREZZA 80 MG CAP

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Tardive Dyskinesia: Neurologist or Psychiatrist. Chorea associated with Huntington's disease (HD): Neurologist.

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

VANDETANIB (CAPRELSA)

MEDICATION(S)
CAPRELSA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Exclusion criteria will be based on current National Comprehensive Cancer Network (NCCN) guidelines and FDA labeling.

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

VEMURAFENIB (ZELBORAF)

MEDICATION(S)
ZELBORAF

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Exclusion criteria will be based on current National Comprehensive Cancer Network (NCCN) guidelines and FDA labeling.

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

VENETOCLAX (VENCLEXTA)

MEDICATION(S)
VENCLEXTA, VENCLEXTA STARTING PACK

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Exclusion criteria will be based on current National Comprehensive Cancer Network (NCCN) guidelines and FDA labeling.

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

VERICIGUAT (VERQUVO)

MEDICATION(S)
VERQUVO

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Left heart ventricular ejection fraction (LVEF) less than or equal to 45% AND patient is on the highest tolerated dose of guideline supported therapies including a renin-angiotensin inhibitor drug (e.g. ACE-Inhibitor, ARB agent, Entresto) and beta-blocker drug (e.g. bisoprolol, carvedilol, metoprolol succinate) unless there is a medical reason for not using (contraindication) the supported therapies.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

VIGABATRIN (VIGAFYDE)

MEDICATION(S)
VIGAFYDE

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Diagnosis of infantile spasm is confirmed by EEG.

AGE RESTRICTION
Age consistent with FDA label

PRESCRIBER RESTRICTION
Neurologist

COVERAGE DURATION
Up to plan year (depends on patient's age)

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

VIGADRONE AND VIGABATRIN (SABRIL)

MEDICATION(S)
VIGABATRIN, VIGADRONE, VIGPODER

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Infantile spasm continued use: ongoing diagnosis of infantile spasm is confirmed by EEG OR prescriber provides medical reason for continued use.

Complex partial seizures: patient has tried two preferred partial seizure drugs (e.g. carbamazepine, clorazepate, divalproex, felbamate lamotrigine, levetiracetam, oxcarbazepine, phenytoin, topiramate, zonisamide)

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Infantile spasms: Neurologist

COVERAGE DURATION
Seizures: annual

Infantile spasms: 6 months

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

VISMODEGIB (ERIVEDGE)

MEDICATION(S)
ERIVEDGE

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Exclusion criteria will be based on current National Comprehensive Cancer Network (NCCN) guidelines and FDA labeling.

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

VORICONAZOLE ORAL (VFEND)

MEDICATION(S)
VORICONAZOLE 200 MG TAB, VORICONAZOLE 40 MG/ML RECON SUSP, VORICONAZOLE 50 MG TAB

PA INDICATION INDICATOR
4 - All FDA-Approved Indications, Some Medically-Accepted Indications

OFF LABEL USES
Prophylaxis of Disseminated Candidiasis, Candida Endopthalmitis, Oropharyngeal Candidiasis, Allergic bronchopulmonary aspergillosis, maintenance treatment of talaromycosis (Talaromyces marneffei -formerly Penicillium marneffei) in HIV-positive patients, treatment of Lomentospora (formerly Scedosporium) prolificans infection, treatment of pulmonary aspergillosis, chronic (cavitary or necrotizing), prophylaxis of Invasive Aspergillosis in high-risk patients.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Systemic fungal infection treatment: culture test confirms Aspergillosis, candidemia, deep-tissue candida infection, blastomycosis, scedosporium apiospermum, fusarium species.

Candida infection of the esophagus, throat, mouth (esophageal or oropharyngeal candidiasis) after trial of fluconazole or there is a medical reason not to use fluconazole.

Prophylaxis of asperillosis or candidiasis after a bone marrow or lung transplant.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
BMT:6mo Lung tx:3mo Esophageal candida:1mo Candidemia/deep-tissue:1mo Other ind in other criteria

OTHER CRITERIA
coverage duration:
ABPA: 4 month.
systemic treatment: plan year.
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

VORINOSTAT (ZOLINZA)

MEDICATION(S)
ZOLINZA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Exclusion criteria will be based on current National Comprehensive Cancer Network (NCCN) guidelines and FDA labeling.

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

ZANUBRUTINIB (BRUKINSA)

MEDICATION(S)
BRUKINSA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Exclusion criteria will be based on current National Comprehensive Cancer Network (NCCN) guidelines and FDA labeling.

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

ZURANOLONE (ZURZUVAE)

MEDICATION(S)
ZURZUVAE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Postpartum depression confirmed by DSM-5 (Diagnostic and Statistical Manual of Mental Disorders-5) criteria.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Psychiatrist or Obstetrician

COVERAGE DURATION
One course per pregnancy (14 days)

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

Part B vs D drugs

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

Medication(s)

MEDICATION NAME	ROUTE	DOSE FORM
Abelcet 5 MG/ML SUSPENSION	IV	SUSPENSION
Abilify Asimtufii 720 MG/2.4ML PRSYR	IM	PRSYR
Abilify Asimtufii 960 MG/3.2ML PRSYR	IM	PRSYR
Abilify Maintena 300 MG PRSYR	IM	PRSYR
Abilify Maintena 300 MG SRER	IM	
Abilify Maintena 400 MG PRSYR	IM	PRSYR
Abilify Maintena 400 MG SRER	IM	
Abraxane 100 MG RECON SUSP	IV	RECON SUSP
Acetadote 200 MG/ML SOLUTION	IV	SOLUTION
Acetaminophen 10 MG/ML SOLUTION	IV	SOLUTION
Acetaminophen 1000 MG/100ML SOLUTION	IV	SOLUTION
Acetylcysteine 10 % SOLUTION	IN	SOLUTION
Acetylcysteine 20 % SOLUTION	IN	SOLUTION
Acetylcysteine 200 MG/ML SOLUTION	IV	SOLUTION
Actemra 200 MG/10ML SOLUTION	IV	SOLUTION
Actemra 400 MG/20ML SOLUTION	IV	SOLUTION
Actemra 80 MG/4ML SOLUTION	IV	SOLUTION
Acyclovir Sodium 50 MG/ML SOLUTION	IV	SOLUTION
Acyclovir Sodium-NaCl 200-0.9 MG/100ML-% SOLUTION	IV	SOLUTION
Adcetris 50 MG RECON SOLN	IV	RECON SOLN
Adrenalin 1 MG/ML SOLUTION	IJ	SOLUTION
Adrenalin 30 MG/30ML SOLUTION	IJ	SOLUTION
Adriamycin 10 MG RECON SOLN	IV	RECON SOLN
Adriamycin 2 MG/ML SOLUTION	IV	SOLUTION
Adriamycin 50 MG RECON SOLN	IV	RECON SOLN
Adrucil 2.5 GM/50ML SOLUTION	IV	SOLUTION
Adzynma 1500 UNIT KIT	IV	KIT
Adzynma 500 UNIT KIT	IV	KIT
Akynzeo 235-0.25 MG RECON SOLN	IV	RECON SOLN
Akynzeo 235-0.25 MG/20ML SOLUTION	IV	SOLUTION
Akynzeo 300-0.5 MG CAP	PO	CAP
Albuterol Sulfate (2.5 MG/3ML) 0.083% NEBU SOLN	IN	NEBU SOLN
Albuterol Sulfate (5 MG/ML) 0.5% NEBU SOLN	IN	NEBU SOLN
Albuterol Sulfate 0.63 MG/3ML NEBU SOLN	IN	NEBU SOLN
Albuterol Sulfate 1.25 MG/3ML NEBU SOLN	IN	NEBU SOLN

MEDICATION NAME	ROUTE	DOSE FORM
Albuterol Sulfate 2.5 MG/0.5ML NEBU SOLN	IN	NEBU SOLN
Aldurazyme 2.9 MG/5ML SOLUTION	IV	SOLUTION
Alferon N 5000000 UNIT/ML SOLUTION	IJ	SOLUTION
Alimta 100 MG RECON SOLN	IV	RECON SOLN
Alimta 500 MG RECON SOLN	IV	RECON SOLN
Aliqopa 60 MG RECON SOLN	IV	RECON SOLN
Alkeran 2 MG TAB	PO	TAB
Alkeran 50 MG RECON SOLN	IV	RECON SOLN
Allopurinol Sodium 500 MG RECON SOLN	IV	RECON SOLN
Aloprim 500 MG RECON SOLN	IV	RECON SOLN
Aloxi 0.25 MG/5ML SOLUTION	IV	SOLUTION
Alyglo 10 GM/100ML SOLUTION	IV	SOLUTION
Alyglo 20 GM/200ML SOLUTION	IV	SOLUTION
Alyglo 5 GM/50ML SOLUTION	IV	SOLUTION
Alymsys 100 MG/4ML SOLUTION	IV	SOLUTION
Alymsys 400 MG/16ML SOLUTION	IV	SOLUTION
AmBisome 50 MG RECON SUSP	IV	RECON SUSP
Amino Acid 5 % SOLUTION	IV	SOLUTION
Aminophylline 25 MG/ML SOLUTION	IV	SOLUTION
AminoProtect 5 % SOLUTION	IV	SOLUTION
Aminosyn II 10 % SOLUTION	IV	SOLUTION
Aminosyn II 15 % SOLUTION	IV	SOLUTION
Aminosyn-PF 10 % SOLUTION	IV	SOLUTION
Aminosyn-PF 7 % SOLUTION	IV	SOLUTION
Aminosyn-PF 7% 7 % SOLUTION	IV	SOLUTION
Amiodarone HCl 150 MG/3ML SOLUTION	IV	SOLUTION
Amiodarone HCl 450 MG/9ML SOLUTION	IV	SOLUTION
Amiodarone HCl 900 MG/18ML SOLUTION	IV	SOLUTION
Amphotericin B 50 MG RECON SOLN	IV	RECON SOLN
Amphotericin B Liposome 50 MG RECON SUSP	IV	RECON SUSP
Amvuttra 25 MG/0.5ML SOLN PRSYR	SC	SOLN PRSYR
Anzemet 100 MG TAB	PO	TAB
Anzemet 50 MG TAB	PO	TAB
Aprepitant 125 MG CAP	PO	CAP
Aprepitant 80 & 125 MG CAP	PO	CAP
Aprepitant 80 & 125 MG MISC	PO	MISC
Aprepitant 80 MG CAP	PO	CAP
Aralast NP 1000 MG RECON SOLN	IV	RECON SOLN
Aralast NP 500 MG RECON SOLN	IV	RECON SOLN
Arformoterol Tartrate 15 MCG/2ML NEBU SOLN	IN	NEBU SOLN
Argatroban 250 MG/2.5ML SOLUTION	IV	SOLUTION
Argatroban 50 MG/50ML SOLUTION	IV	SOLUTION
Aristada 1064 MG/3.9ML PRSYR	IM	PRSYR
Aristada 441 MG/1.6ML PRSYR	IM	PRSYR

MEDICATION NAME	ROUTE	DOSE FORM
Aristada 662 MG/2.4ML PRSYR	IM	PRSYR
Aristada 882 MG/3.2ML PRSYR	IM	PRSYR
Aristada Initio 675 MG/2.4ML PRSYR	IM	PRSYR
Arranon 5 MG/ML SOLUTION	IV	SOLUTION
Arsenic Trioxide 10 MG/10ML SOLUTION	IV	SOLUTION
Arsenic Trioxide 12 MG/6ML SOLUTION	IV	SOLUTION
Arzerra 100 MG/5ML CONC	IV	CONC
Arzerra 1000 MG/50ML CONC	IV	CONC
Asceniv 5 GM/50ML SOLUTION	IV	SOLUTION
Asparlas 3750 UNIT/5ML SOLUTION	IV	SOLUTION
Astagraf XL 0.5 MG CAP ER 24H	PO	CAP ER 24H
Astagraf XL 1 MG CAP ER 24H	PO	CAP ER 24H
Astagraf XL 5 MG CAP ER 24H	PO	CAP ER 24H
Atgam 50 MG/ML SOLUTION	IV	SOLUTION
Ativan 2 MG/ML SOLUTION	IJ	SOLUTION
Ativan 4 MG/ML SOLUTION	IJ	SOLUTION
Avastin 100 MG/4ML SOLUTION	IV	SOLUTION
Avastin 400 MG/16ML SOLUTION	IV	SOLUTION
Aveed 750 MG/3ML SOLUTION	IM	SOLUTION
Avelox 400 MG/250ML SOLUTION	IV	SOLUTION
Avsola 100 MG RECON SOLN	IV	RECON SOLN
Avycaz 2.5 (2-0.5) GM RECON SOLN	IV	RECON SOLN
AzaCITIDine 100 MG RECON SUSP	IJ	RECON SUSP
Azasan 100 MG TAB	PO	TAB
Azasan 75 MG TAB	PO	TAB
azaTHIOprine 100 MG TAB	PO	TAB
AzaTHIOprine 50 MG TAB	PO	TAB
azaTHIOprine 75 MG TAB	PO	TAB
AzaTHIOprine Sodium 100 MG RECON SOLN	IJ	RECON SOLN
Baclofen 10 MG/20ML SOLUTION	IT	SOLUTION
Baclofen 20000 MCG/20ML SOLUTION	IT	SOLUTION
Baclofen 40 MG/20ML SOLUTION	IT	SOLUTION
Baclofen 40000 MCG/20ML SOLUTION	IT	SOLUTION
Baclofen 50 MCG/ML SOLN PRSYR	IT	SOLN PRSYR
Bavencio 200 MG/10ML SOLUTION	IV	SOLUTION
Beleodaq 500 MG RECON SOLN	IV	RECON SOLN
Belrapzo 100 MG/4ML SOLUTION	IV	SOLUTION
Bendamustine HCl 100 MG RECON SOLN	IV	RECON SOLN
Bendamustine HCl 100 MG/4ML SOLUTION	IV	SOLUTION
Bendamustine HCl 25 MG RECON SOLN	IV	RECON SOLN
Bendeka 100 MG/4ML SOLUTION	IV	SOLUTION
Benlysta 120 MG RECON SOLN	IV	RECON SOLN
Benlysta 400 MG RECON SOLN	IV	RECON SOLN
Bentyl 10 MG/ML SOLUTION	IM	SOLUTION

MEDICATION NAME	ROUTE	DOSE FORM
Besponsa 0.9 MG RECON SOLN	IV	RECON SOLN
Betamethasone Combo 6 (3-3) MG/ML SUSPENSION	IJ	SUSPENSION
Betamethasone Sod Phos & Acet 6 (3-3) MG/ML SUSPENSION	IJ	SUSPENSION
Bethkis 300 MG/4ML NEBU SOLN	IN	NEBU SOLN
BiCNU 100 MG RECON SOLN	IV	RECON SOLN
Blenrep 100 MG RECON SOLN	IV	RECON SOLN
Bleomycin Sulfate 15 UNIT RECON SOLN	IJ	RECON SOLN
Bleomycin Sulfate 30 UNIT RECON SOLN	IJ	RECON SOLN
Blincyto 35 MCG RECON SOLN	IV	RECON SOLN
Boniva 3 MG/3ML SOLUTION	IV	SOLUTION
Bortezomib 1 MG RECON SOLN	IJ	RECON SOLN
Bortezomib 2.5 MG RECON SOLN	IJ	RECON SOLN
Bortezomib 3.5 MG RECON SOLN	IJ	RECON SOLN
Bortezomib 3.5 MG RECON SOLN	IV	RECON SOLN
Bortezomib 3.5 MG/1.4ML SOLUTION	IV	SOLUTION
Botox 100 UNIT RECON SOLN	IJ	RECON SOLN
Botox 200 UNIT RECON SOLN	IJ	RECON SOLN
Briumvi 150 MG/6ML SOLUTION	IV	SOLUTION
Brovana 15 MCG/2ML NEBU SOLN	IN	NEBU SOLN
Budesonide 0.25 MG/2ML SUSPENSION	IN	SUSPENSION
Budesonide 0.5 MG/2ML SUSPENSION	IN	SUSPENSION
Budesonide 1 MG/2ML SUSPENSION	IN	SUSPENSION
Buprenex 0.3 MG/ML SOLUTION	IJ	SOLUTION
Buprenorphine HCl 0.3 MG/ML SOLUTION	IJ	SOLUTION
Busulfan 6 MG/ML SOLUTION	IV	SOLUTION
Busulfex 6 MG/ML SOLUTION	IV	SOLUTION
Butorphanol Tartrate 1 MG/ML SOLUTION	IJ	SOLUTION
Butorphanol Tartrate 2 MG/ML SOLUTION	IJ	SOLUTION
Cabenuva 400 & 600 MG/2ML SUSP	IM	SUSP
Cabenuva 600 & 900 MG/3ML SUSP	IM	SUSP
Calcitonin (Salmon) 200 UNIT/ML SOLUTION	IJ	SOLUTION
Calcitriol 0.25 MCG CAP	PO	CAP
Calcitriol 0.5 MCG CAP	PO	CAP
Calcitriol 1 MCG/ML SOLUTION	IV	SOLUTION
Calcitriol 1 MCG/ML SOLUTION	PO	SOLUTION
Calcium Gluconate 10 % SOLUTION	IV	SOLUTION
Caldolor 800 MG/200ML SOLUTION	IV	SOLUTION
Caldolor 800 MG/8ML SOLUTION	IV	SOLUTION
Camcevi 42 MG PRSYR	SC	PRSYR
Camptosar 100 MG/5ML SOLUTION	IV	SOLUTION
Camptosar 300 MG/15ML SOLUTION	IV	SOLUTION
Camptosar 40 MG/2ML SOLUTION	IV	SOLUTION

MEDICATION NAME	ROUTE	DOSE FORM
CARBOplatin 150 MG/15ML SOLUTION	IV	SOLUTION
CARBOplatin 450 MG/45ML SOLUTION	IV	SOLUTION
CARBOplatin 50 MG/5ML SOLUTION	IV	SOLUTION
CARBOplatin 600 MG/60ML SOLUTION	IV	SOLUTION
Cardene IV 20-0.86 MG/200ML-% SOLUTION	IV	SOLUTION
Cardene IV 20-4.8 MG/200ML-% SOLUTION	IV	SOLUTION
Cardene IV 40-0.83 MG/200ML-% SOLUTION	IV	SOLUTION
Carmustine 100 MG RECON SOLN	IV	RECON SOLN
Carmustine 300 MG RECON SOLN	IV	RECON SOLN
Carmustine 50 MG RECON SOLN	IV	RECON SOLN
Carnitor 200 MG/ML SOLUTION	IV	SOLUTION
ceFAZolin in Sodium Chloride 2-0.9 GM/100ML-% SOLUTION	IV	SOLUTION
CeFAZolin in Sodium Chloride 3-0.9 GM/100ML-% SOLUTION	IV	SOLUTION
CeFAZolin Sodium-Dextrose 1-4 GM-%(50ML) RECON SOLN	IV	RECON SOLN
CeFAZolin Sodium-Dextrose 1-4 GM/50ML-% SOLUTION	IV	SOLUTION
CeFAZolin Sodium-Dextrose 2-3 GM-%(50ML) RECON SOLN	IV	RECON SOLN
CeFAZolin Sodium-Dextrose 2-4 GM/100ML-% SOLUTION	IV	SOLUTION
ceFAZolin Sodium-Dextrose 2-5 GM/100ML-% SOLUTION	IV	SOLUTION
ceFAZolin Sodium-Dextrose 3-4 GM/150ML-% SOLUTION	IV	SOLUTION
Cefepime HCl 100 GM RECON SOLN	IV	RECON SOLN
Cefepime-Dextrose 1-5 GM-%(50ML) RECON SOLN	IV	RECON SOLN
Cefepime-Dextrose 2-5 GM-%(50ML) RECON SOLN	IV	RECON SOLN
CefoTEtan Disodium-Dextrose 1-3.58 GM-%(50ML) RECON SOLN	IV	RECON SOLN
CefoTEtan Disodium-Dextrose 2-2.08 GM-%(50ML) RECON SOLN	IV	RECON SOLN
CefOXitin Sodium-Dextrose 1-4 GM-%(50ML) RECON SOLN	IV	RECON SOLN
CefOXitin Sodium-Dextrose 2-2.2 GM-%(50ML) RECON SOLN	IV	RECON SOLN
CefTAZidime and Dextrose 1-5 GM-%(50ML) RECON SOLN	IV	RECON SOLN
CefTAZidime and Dextrose 2-5 GM-%(50ML) RECON SOLN	IV	RECON SOLN
CefTRIAXone Sodium 100 GM RECON SOLN	IJ	RECON SOLN
CefTRIAXone Sodium in Dextrose 20 MG/ML SOLUTION	IV	SOLUTION
CefTRIAXone Sodium in Dextrose 40 MG/ML SOLUTION	IV	SOLUTION

MEDICATION NAME	ROUTE	DOSE FORM
CefTRIAXone Sodium-Dextrose 1-3.74 GM-%(50ML) RECON SOLN	IV	RECON SOLN
CefTRIAXone Sodium-Dextrose 2-2.22 GM-%(50ML) RECON SOLN	IV	RECON SOLN
Celestone Soluspan 6 (3-3) MG/ML SUSPENSION	IJ	SUSPENSION
CellCept 200 MG/ML RECON SUSP	PO	RECON SUSP
CellCept 250 MG CAP	PO	CAP
CellCept 500 MG TAB	PO	TAB
CellCept Intravenous 500 MG RECON SOLN	IV	RECON SOLN
Cerebyx 100 MG PE/2ML SOLUTION	IJ	SOLUTION
Cerebyx 500 MG PE/10ML SOLUTION	IJ	SOLUTION
Chlorothiazide Sodium 500 MG RECON SOLN	IV	RECON SOLN
Chorionic Gonadotropin 10000 UNIT RECON SOLN	IM	RECON SOLN
Cidofovir 75 MG/ML SOLUTION	IV	SOLUTION
Cinacalcet HCl 30 MG TAB	PO	TAB
Cinacalcet HCl 60 MG TAB	PO	TAB
Cinacalcet HCl 90 MG TAB	PO	TAB
Cinqair 100 MG/10ML SOLUTION	IV	SOLUTION
Cinvanti 130 MG/18ML EMULSION	IV	EMULSION
Ciprofloxacin in D5W 400 MG/200ML SOLUTION	IV	SOLUTION
CISplatin 100 MG/100ML SOLUTION	IV	SOLUTION
CISplatin 200 MG/200ML SOLUTION	IV	SOLUTION
CISplatin 50 MG RECON SOLN	IV	RECON SOLN
CISplatin 50 MG/50ML SOLUTION	IV	SOLUTION
Cladribine 10 MG/10ML SOLUTION	IV	SOLUTION
Clinimix E/Dextrose (2.75/5) 2.75 % SOLUTION	IV	SOLUTION
Clinimix E/Dextrose (4.25/10) 4.25 % SOLUTION	IV	SOLUTION
Clinimix E/Dextrose (4.25/5) 4.25 % SOLUTION	IV	SOLUTION
Clinimix E/Dextrose (5/15) 5 % SOLUTION	IV	SOLUTION
Clinimix E/Dextrose (5/20) 5 % SOLUTION	IV	SOLUTION
Clinimix E/Dextrose (8/10) 8 % SOLUTION	IV	SOLUTION
Clinimix E/Dextrose (8/14) 8 % SOLUTION	IV	SOLUTION
Clinimix/Dextrose (4.25/10) 4.25 % SOLUTION	IV	SOLUTION
Clinimix/Dextrose (4.25/5) 4.25 % SOLUTION	IV	SOLUTION
Clinimix/Dextrose (5/15) 5 % SOLUTION	IV	SOLUTION
Clinimix/Dextrose (5/20) 5 % SOLUTION	IV	SOLUTION
Clinimix/Dextrose (6/5) 6 % SOLUTION	IV	SOLUTION
Clinimix/Dextrose (8/10) 8 % SOLUTION	IV	SOLUTION
Clinimix/Dextrose (8/14) 8 % SOLUTION	IV	SOLUTION
Clinisol SF 15 % SOLUTION	IV	SOLUTION
Clinolipid 20 % EMULSION	IV	EMULSION
Clofarabine 1 MG/ML SOLUTION	IV	SOLUTION
Clolar 1 MG/ML SOLUTION	IV	SOLUTION
CloNIDine HCl (Analgesia) 100 MCG/ML SOLUTION	EP	SOLUTION

MEDICATION NAME	ROUTE	DOSE FORM
Cocaine HCl 40 MG/ML SOLUTION	NA	SOLUTION
Columvi 10 MG/10ML SOLUTION	IV	SOLUTION
Columvi 2.5 MG/2.5ML SOLUTION	IV	SOLUTION
Cosela 300 MG RECON SOLN	IV	RECON SOLN
Cosentyx 125 MG/5ML SOLUTION	IV	SOLUTION
Cosmegen 0.5 MG RECON SOLN	IV	RECON SOLN
Cromolyn Sodium 20 MG/2ML NEBU SOLN	IN	NEBU SOLN
Cupric Chloride 0.4 MG/ML SOLUTION	IV	SOLUTION
Cutaquig 1 GM/6ML SOLUTION	SC	SOLUTION
Cutaquig 1.65 GM/10ML SOLUTION	SC	SOLUTION
Cutaquig 2 GM/12ML SOLUTION	SC	SOLUTION
Cutaquig 3.3 GM/20ML SOLUTION	SC	SOLUTION
Cutaquig 4 GM/24ML SOLUTION	SC	SOLUTION
Cutaquig 8 GM/48ML SOLUTION	SC	SOLUTION
Cuvitru 1 GM/5ML SOLUTION	SC	SOLUTION
Cuvitru 10 GM/50ML SOLUTION	SC	SOLUTION
Cuvitru 2 GM/10ML SOLUTION	SC	SOLUTION
Cuvitru 4 GM/20ML SOLUTION	SC	SOLUTION
Cuvitru 8 GM/40ML SOLUTION	SC	SOLUTION
Cyclophosphamide 1 GM RECON SOLN	IJ	RECON SOLN
cycloPHOSphamide 1 GM/2ML SOLUTION	IV	SOLUTION
Cyclophosphamide 1 GM/5ML SOLUTION	IV	SOLUTION
cycloPHOSphamide 1000 MG/10ML SOLUTION	IV	SOLUTION
Cyclophosphamide 2 GM RECON SOLN	IJ	RECON SOLN
Cyclophosphamide 2 GM/10ML SOLUTION	IV	SOLUTION
cycloPHOSphamide 2 GM/4ML SOLUTION	IV	SOLUTION
cycloPHOSphamide 2000 MG/20ML SOLUTION	IV	SOLUTION
Cyclophosphamide 25 MG CAP	PO	CAP
Cyclophosphamide 25 MG TAB	PO	TAB
Cyclophosphamide 50 MG CAP	PO	CAP
Cyclophosphamide 50 MG TAB	PO	TAB
Cyclophosphamide 500 MG RECON SOLN	IJ	RECON SOLN
Cyclophosphamide 500 MG/2.5ML SOLUTION	IV	SOLUTION
cycloPHOSphamide 500 MG/5ML SOLUTION	IV	SOLUTION
cycloPHOSphamide 500 MG/ML SOLUTION	IV	SOLUTION
CycloSPORINE 100 MG CAP	PO	CAP
CycloSPORINE 25 MG CAP	PO	CAP
CycloSPORINE 50 MG/ML SOLUTION	IV	SOLUTION
CycloSPORINE Modified 100 MG CAP	PO	CAP
CycloSPORINE Modified 100 MG/ML SOLUTION	PO	SOLUTION
CycloSPORINE Modified 25 MG CAP	PO	CAP
CycloSPORINE Modified 50 MG CAP	PO	CAP
Cyklokapron 1000 MG/10ML SOLUTION	IV	SOLUTION
Cyramza 100 MG/10ML SOLUTION	IV	SOLUTION

MEDICATION NAME	ROUTE	DOSE FORM
Cyramza 500 MG/50ML SOLUTION	IV	SOLUTION
Cytarabine (PF) 100 MG/ML SOLUTION	IJ	SOLUTION
Cytarabine (PF) 20 MG/ML SOLUTION	IJ	SOLUTION
Cytarabine 20 MG/ML SOLUTION	IJ	SOLUTION
Cytogam 50 MG/ML SOLUTION	IV	SOLUTION
Dacarbazine 100 MG RECON SOLN	IV	RECON SOLN
Dacarbazine 200 MG RECON SOLN	IV	RECON SOLN
Dacogen 50 MG RECON SOLN	IV	RECON SOLN
DACTINomycin 0.5 MG RECON SOLN	IV	RECON SOLN
Dalvance 500 MG RECON SOLN	IV	RECON SOLN
Danyelza 40 MG/10ML SOLUTION	IV	SOLUTION
DAPTOmycin-Sodium Chloride 1000-0.9 MG/100ML-% SOLUTION	IV	SOLUTION
DAPTOmycin-Sodium Chloride 350-0.9 MG/50ML-% SOLUTION	IV	SOLUTION
DAPTOmycin-Sodium Chloride 500-0.9 MG/50ML-% SOLUTION	IV	SOLUTION
DAPTOmycin-Sodium Chloride 700-0.9 MG/100ML-% SOLUTION	IV	SOLUTION
Darzalex 100 MG/5ML SOLUTION	IV	SOLUTION
Darzalex 400 MG/20ML SOLUTION	IV	SOLUTION
Darzalex Faspro 1800-30000 MG-UT/15ML SOLUTION	SC	SOLUTION
DAUNOrubicin HCl 20 MG/4ML SOLUTION	IV	SOLUTION
DAUNOrubicin HCl 50 MG/10ML SOLUTION	IV	SOLUTION
Decitabine 50 MG RECON SOLN	IV	RECON SOLN
Deferoxamine Mesylate 2 GM RECON SOLN	IJ	RECON SOLN
Deferoxamine Mesylate 500 MG RECON SOLN	IJ	RECON SOLN
Defitelio 200 MG/2.5ML SOLUTION	IV	SOLUTION
Demerol 100 MG/2ML SOLUTION	IJ	SOLUTION
Demerol 100 MG/ML SOLUTION	IJ	SOLUTION
Demerol 25 MG/ML SOLUTION	IJ	SOLUTION
Demerol 50 MG/ML SOLUTION	IJ	SOLUTION
Demerol 75 MG/ML SOLUTION	IJ	SOLUTION
DEPO-Medrol 20 MG/ML SUSPENSION	IJ	SUSPENSION
Desferal 500 MG RECON SOLN	IJ	RECON SOLN
Dexamethasone Sod Phosphate PF 10 MG/ML SOLN PRSYR	IJ	SOLN PRSYR
Dexamethasone Sod Phosphate PF 10 MG/ML SOLUTION	IJ	SOLUTION
Dexamethasone Sodium Phosphate 10 MG/ML SOLUTION	IJ	SOLUTION
Dexamethasone Sodium Phosphate 100 MG/10ML SOLUTION	IJ	SOLUTION
Dexrazoxane 250 MG RECON SOLN	IV	RECON SOLN
Dexrazoxane HCl 250 MG RECON SOLN	IV	RECON SOLN

MEDICATION NAME	ROUTE	DOSE FORM
Dexrazoxane HCl 500 MG RECON SOLN	IV	RECON SOLN
Dextrose 20 % SOLUTION	IV	SOLUTION
Dextrose 250 MG/ML SOLUTION	IV	SOLUTION
Dextrose 30 % SOLUTION	IV	SOLUTION
Dextrose 40 % SOLUTION	IV	SOLUTION
Dextrose 5%/Electrolyte #48 SOLUTION	IV	SOLUTION
Dextrose 50 % SOLUTION	IV	SOLUTION
Dextrose 70 % SOLUTION	IV	SOLUTION
Dexycu 9 % SUSPENSION	IO	SUSPENSION
diazePAM 10 MG/2ML SOLUTION	IJ	SOLUTION
DiazePAM 5 MG/ML SOLUTION	IJ	SOLUTION
Dicyclomine HCl 10 MG/ML SOLUTION	IM	SOLUTION
Digoxin 0.25 MG/ML SOLUTION	IJ	SOLUTION
Dilaudid 0.2 MG/ML SOLUTION	IJ	SOLUTION
Dilaudid 1 MG/ML SOLUTION	IJ	SOLUTION
Dilaudid 2 MG/ML SOLUTION	IJ	SOLUTION
DilTIAZem HCl 100 MG RECON SOLN	IV	RECON SOLN
DilTIAZem HCl 125 MG/25ML SOLUTION	IV	SOLUTION
DilTIAZem HCl 25 MG/5ML SOLUTION	IV	SOLUTION
DilTIAZem HCl 50 MG/10ML SOLUTION	IV	SOLUTION
DOBUTamine HCl 12.5 MG/ML SOLUTION	IV	SOLUTION
DOBUTamine HCl 250 MG/20ML SOLUTION	IV	SOLUTION
DOBUTamine in D5W 2 MG/ML SOLUTION	IV	SOLUTION
DOBUTamine-Dextrose 1-5 MG/ML-% SOLUTION	IV	SOLUTION
DOBUTamine-Dextrose 4-5 MG/ML-% SOLUTION	IV	SOLUTION
DOCEtaxel 160 MG/16ML SOLUTION	IV	SOLUTION
DOCEtaxel 160 MG/8ML CONC	IV	CONC
DOCEtaxel 20 MG/2ML SOLUTION	IV	SOLUTION
DOCEtaxel 20 MG/ML CONC	IV	CONC
DOCEtaxel 80 MG/4ML CONC	IV	CONC
DOCEtaxel 80 MG/8ML SOLUTION	IV	SOLUTION
Docivyx 160 MG/16ML SOLUTION	IV	SOLUTION
Docivyx 20 MG/2ML SOLUTION	IV	SOLUTION
Docivyx 80 MG/8ML SOLUTION	IV	SOLUTION
DOPamine HCl 40 MG/ML SOLUTION	IV	SOLUTION
DOPamine in D5W 0.8-5 MG/ML-% SOLUTION	IV	SOLUTION
DOPamine in D5W 1.6-5 MG/ML-% SOLUTION	IV	SOLUTION
DOPamine in D5W 3.2-5 MG/ML-% SOLUTION	IV	SOLUTION
Doxercalciferol 0.5 MCG CAP	PO	CAP
Doxercalciferol 1 MCG CAP	PO	CAP
Doxercalciferol 2.5 MCG CAP	PO	CAP
Doxercalciferol 4 MCG/2ML SOLUTION	IV	SOLUTION
Doxil 2 MG/ML SUSPENSION	IV	SUSPENSION
DOXOrubicin HCl 10 MG RECON SOLN	IV	RECON SOLN

MEDICATION NAME	ROUTE	DOSE FORM
DOXOrubicin HCl 2 MG/ML SOLUTION	IV	SOLUTION
DOXOrubicin HCl 50 MG RECON SOLN	IV	RECON SOLN
DOXOrubicin HCl Liposomal 2 MG/ML SUSPENSION	IV	SUSPENSION
Duopa 4.63-20 MG/ML SUSPENSION	EN	SUSPENSION
Duraclon 100 MCG/ML SOLUTION	EP	SOLUTION
Duramorph 0.5 MG/ML SOLUTION	IJ	SOLUTION
Duramorph 1 MG/ML SOLUTION	IJ	SOLUTION
Durysta 10 MCG IMPLANT	IO	IMPLANT
Dysport 300 UNIT RECON SOLN	IM	RECON SOLN
Dysport 500 UNIT RECON SOLN	IM	RECON SOLN
Edaravone 30 MG/100ML SOLUTION	IV	SOLUTION
Elahere 100 MG/20ML SOLUTION	IV	SOLUTION
Elaprase 6 MG/3ML SOLUTION	IV	SOLUTION
Elcys 50 MG/ML SOLUTION	IV	SOLUTION
Elelyso 200 UNIT RECON SOLN	IV	RECON SOLN
Elfabrio 20 MG/10ML SOLUTION	IV	SOLUTION
Elfabrio 5 MG/2.5ML SOLUTION	IV	SOLUTION
Elitek 1.5 MG RECON SOLN	IV	RECON SOLN
Elitek 7.5 MG RECON SOLN	IV	RECON SOLN
Ellence 200 MG/100ML SOLUTION	IV	SOLUTION
Ellence 50 MG/25ML SOLUTION	IV	SOLUTION
Elliotts B SOLUTION	IT	SOLUTION
Elrexfio 44 MG/1.1ML SOLUTION	SC	SOLUTION
Elrexfio 76 MG/1.9ML SOLUTION	SC	SOLUTION
Emend 125 MG/5ML RECON SUSP	PO	RECON SUSP
Emend 150 MG RECON SOLN	IV	RECON SOLN
Emend 80 MG CAP	PO	CAP
Emend Tri-Pack 80 & 125 MG CAP	PO	CAP
Empaveli 1080 MG/20ML SOLUTION	SC	SOLUTION
Empliciti 300 MG RECON SOLN	IV	RECON SOLN
Empliciti 400 MG RECON SOLN	IV	RECON SOLN
Enalaprilat 1.25 MG/ML SOLUTION	IV	SOLUTION
Engerix-B 10 MCG/0.5ML SUSP PRSYR	IJ	SUSP PRSYR
Engerix-B 20 MCG/ML SUSP PRSYR	IJ	SUSP PRSYR
Engerix-B 20 MCG/ML SUSPENSION	IJ	SUSPENSION
Enhertu 100 MG RECON SOLN	IV	RECON SOLN
Enjaymo 1100 MG/22ML SOLUTION	IV	SOLUTION
Entyvio 300 MG RECON SOLN	IV	RECON SOLN
EPINEPHrine (Anaphylaxis) 1 MG/ML SOLUTION	IJ	SOLUTION
EPINEPHrine (Anaphylaxis) 30 MG/30ML SOLUTION	IJ	SOLUTION
EpiRUBicin HCl 200 MG/100ML SOLUTION	IV	SOLUTION
EpiRUBicin HCl 50 MG/25ML SOLUTION	IV	SOLUTION
Epkinly 4 MG/0.8ML SOLUTION	SC	SOLUTION
Epkinly 48 MG/0.8ML SOLUTION	SC	SOLUTION

MEDICATION NAME	ROUTE	DOSE FORM
Epogen 10000 UNIT/ML SOLUTION	IJ	SOLUTION
Epogen 2000 UNIT/ML SOLUTION	IJ	SOLUTION
Epogen 20000 UNIT/ML SOLUTION	IJ	SOLUTION
Epogen 3000 UNIT/ML SOLUTION	IJ	SOLUTION
Epogen 4000 UNIT/ML SOLUTION	IJ	SOLUTION
Epoprostenol Sodium 0.5 MG RECON SOLN	IV	RECON SOLN
Epoprostenol Sodium 1.5 MG RECON SOLN	IV	RECON SOLN
Erbitux 100 MG/50ML SOLUTION	IV	SOLUTION
Erbitux 200 MG/100ML SOLUTION	IV	SOLUTION
eriBULin Mesylate 1 MG/2ML SOLUTION	IV	SOLUTION
Erwinase 10000 UNIT RECON SOLN	IJ	RECON SOLN
Erwinaze 10000 UNIT RECON SOLN	IJ	RECON SOLN
Ethacrynate Sodium 50 MG RECON SOLN	IV	RECON SOLN
Ethyol 500 MG RECON SOLN	IV	RECON SOLN
Etopophos 100 MG RECON SOLN	IV	RECON SOLN
Etoposide 1 GM/50ML SOLUTION	IV	SOLUTION
Etoposide 100 MG/5ML SOLUTION	IV	SOLUTION
Etoposide 500 MG/25ML SOLUTION	IV	SOLUTION
Evenity 105 MG/1.17ML SOLN PRSYR	SC	SOLN PRSYR
Everolimus 0.25 MG TAB	PO	TAB
Everolimus 0.5 MG TAB	PO	TAB
Everolimus 0.75 MG TAB	PO	TAB
Everolimus 1 MG TAB	PO	TAB
Evkeeza 1200 MG/8ML SOLUTION	IV	SOLUTION
Evkeeza 345 MG/2.3ML SOLUTION	IV	SOLUTION
Evomela 50 MG RECON SOLN	IV	RECON SOLN
Fabrazyme 35 MG RECON SOLN	IV	RECON SOLN
Fabrazyme 5 MG RECON SOLN	IV	RECON SOLN
Fasenra 10 MG/0.5ML SOLN PRSYR	SC	SOLN PRSYR
Fasenra 30 MG/ML SOLN PRSYR	SC	SOLN PRSYR
Fensolvi (6 Month) 45 MG KIT	SC	KIT
FentaNYL Citrate (PF) 100 MCG/2ML SOLN CART	IJ	SOLN CART
FentaNYL Citrate (PF) 100 MCG/2ML SOLUTION	IJ	SOLUTION
FentaNYL Citrate (PF) 1000 MCG/20ML SOLUTION	IJ	SOLUTION
FentaNYL Citrate (PF) 250 MCG/5ML SOLUTION	IJ	SOLUTION
FentaNYL Citrate (PF) 2500 MCG/50ML SOLUTION	IJ	SOLUTION
fentaNYL Citrate (PF) 50 MCG/ML SOLUTION	IJ	SOLUTION
FentaNYL Citrate (PF) 500 MCG/10ML SOLUTION	IJ	SOLUTION
Flolan 0.5 MG RECON SOLN	IV	RECON SOLN
Flolan 1.5 MG RECON SOLN	IV	RECON SOLN
Floxuridine 0.5 GM RECON SOLN	IJ	RECON SOLN
Fludarabine Phosphate 25 MG/ML SOLUTION	IV	SOLUTION
Fludarabine Phosphate 50 MG RECON SOLN	IV	RECON SOLN
Fludarabine Phosphate 50 MG/2ML SOLUTION	IV	SOLUTION

MEDICATION NAME	ROUTE	DOSE FORM
Fluorouracil 1 GM/20ML SOLUTION	IV	SOLUTION
Fluorouracil 2.5 GM/50ML SOLUTION	IV	SOLUTION
Fluorouracil 5 GM/100ML SOLUTION	IV	SOLUTION
Fluorouracil 500 MG/10ML SOLUTION	IV	SOLUTION
Focinvez 150 MG/50ML SOLUTION	IV	SOLUTION
Folotyn 20 MG/ML SOLUTION	IV	SOLUTION
Folotyn 40 MG/2ML SOLUTION	IV	SOLUTION
Formoterol Fumarate 20 MCG/2ML NEBU SOLN	IN	NEBU SOLN
Fosaprepitant Dimeglumine 150 MG RECON SOLN	IV	RECON SOLN
Fosphenytoin Sodium 100 MG PE/2ML SOLUTION	IJ	SOLUTION
Fosphenytoin Sodium 500 MG PE/10ML SOLUTION	IJ	SOLUTION
FreAmine HBC 6.9 % SOLUTION	IV	SOLUTION
FreAmine III 10 % SOLUTION	IV	SOLUTION
Fulphila 6 MG/0.6ML SOLN PRSYR	SC	SOLN PRSYR
Fyarro 100 MG RECON SUSP	IV	RECON SUSP
Fylnetra 6 MG/0.6ML SOLN PRSYR	SC	SOLN PRSYR
Gablofen 10000 MCG/20ML SOLN PRSYR	IT	SOLN PRSYR
Gablofen 10000 MCG/20ML SOLUTION	IT	SOLUTION
Gablofen 20000 MCG/20ML SOLN PRSYR	IT	SOLN PRSYR
Gablofen 20000 MCG/20ML SOLUTION	IT	SOLUTION
Gablofen 40000 MCG/20ML SOLN PRSYR	IT	SOLN PRSYR
Gablofen 40000 MCG/20ML SOLUTION	IT	SOLUTION
Gablofen 50 MCG/ML SOLN PRSYR	IT	SOLN PRSYR
GamaSTAN INJECTABLE	IM	INJECTABLE
Ganciclovir 500 MG/250ML SOLUTION	IV	SOLUTION
Ganciclovir Sodium 500 MG RECON SOLN	IV	RECON SOLN
Ganciclovir Sodium 500 MG/10ML SOLUTION	IV	SOLUTION
Gazyva 1000 MG/40ML SOLUTION	IV	SOLUTION
Gemcitabine HCl 1 GM RECON SOLN	IV	RECON SOLN
Gemcitabine HCl 1 GM/10ML SOLUTION	IV	SOLUTION
Gemcitabine HCl 1 GM/26.3ML SOLUTION	IV	SOLUTION
Gemcitabine HCl 1.5 GM/15ML SOLUTION	IV	SOLUTION
Gemcitabine HCl 2 GM RECON SOLN	IV	RECON SOLN
Gemcitabine HCl 2 GM/20ML SOLUTION	IV	SOLUTION
Gemcitabine HCl 2 GM/52.6ML SOLUTION	IV	SOLUTION
Gemcitabine HCl 200 MG RECON SOLN	IV	RECON SOLN
Gemcitabine HCl 200 MG/2ML SOLUTION	IV	SOLUTION
Gemcitabine HCl 200 MG/5.26ML SOLUTION	IV	SOLUTION
Gengraf 100 MG CAP	PO	CAP
Gengraf 100 MG/ML SOLUTION	PO	SOLUTION
Gengraf 25 MG CAP	PO	CAP
Gentamicin in Saline 0.8-0.9 MG/ML-% SOLUTION	IV	SOLUTION
Gentamicin in Saline 1-0.9 MG/ML-% SOLUTION	IV	SOLUTION
Gentamicin in Saline 1.2-0.9 MG/ML-% SOLUTION	IV	SOLUTION

MEDICATION NAME	ROUTE	DOSE FORM
Gentamicin in Saline 1.6-0.9 MG/ML-% SOLUTION	IV	SOLUTION
Gentamicin in Saline 2-0.9 MG/ML-% SOLUTION	IV	SOLUTION
Givlaari 189 MG/ML SOLUTION	SC	SOLUTION
Glassia 1000 MG/50ML SOLUTION	IV	SOLUTION
Glycophos 1 MMOLE/ML SOLUTION	IV	SOLUTION
Goprelto 40 MG/ML SOLUTION	NA	SOLUTION
Granisetron HCl 1 MG TAB	PO	TAB
Granisetron HCl 1 MG/ML SOLUTION	IV	SOLUTION
Granisetron HCl 4 MG/4ML SOLUTION	IV	SOLUTION
Granix 300 MCG/0.5ML SOLN PRSYR	SC	SOLN PRSYR
Granix 300 MCG/ML SOLUTION	SC	SOLUTION
Granix 480 MCG/0.8ML SOLN PRSYR	SC	SOLN PRSYR
Granix 480 MCG/1.6ML SOLUTION	SC	SOLUTION
Halaven 1 MG/2ML SOLUTION	IV	SOLUTION
Hectorol 2 MCG/ML SOLUTION	IV	SOLUTION
Hectorol 4 MCG/2ML SOLUTION	IV	SOLUTION
HepaGam B 312 UNIT/ML SOLUTION	IJ	SOLUTION
Heparin (Porcine) in NaCl 1000-0.9 UT/500ML-% SOLUTION	IV	SOLUTION
Heparin (Porcine) in NaCl 12500-0.45 UT/250ML-% SOLUTION	IV	SOLUTION
Heparin (Porcine) in NaCl 2000-0.9 UNIT/L-% SOLUTION	IV	SOLUTION
Heparin (Porcine) in NaCl 2500-0.9 UT/500ML-% SOLUTION	IV	SOLUTION
Heparin (Porcine) in NaCl 25000-0.45 UT/250ML-% SOLUTION	IV	SOLUTION
Heparin (Porcine) in NaCl 25000-0.45 UT/500ML-% SOLUTION	IV	SOLUTION
Heparin (Porcine) in NaCl 30000-0.9 UNIT/L-% SOLUTION	IV	SOLUTION
Heparin (Porcine) in NaCl 4000-0.9 UNIT/L-% SOLUTION	IV	SOLUTION
Heparin (Porcine) in NaCl 500-0.9 UT/500ML-% SOLUTION	IV	SOLUTION
Heparin (Porcine) in NaCl 5000-0.9 UNIT/L-% SOLUTION	IV	SOLUTION
Heparin (Porcine) in NaCl 5000-0.9 UT/500ML-% SOLUTION	IV	SOLUTION
Heparin Sod (Porcine) in D5W 100 UNIT/ML SOLUTION	IV	SOLUTION
Heparin Sod (Porcine) in D5W 25000-5 UT/500ML-% SOLUTION	IV	SOLUTION
Heparin Sod (Porcine) in D5W 40-5 UNIT/ML-% SOLUTION	IV	SOLUTION
Heparin Sodium (Porcine) 1000 UNIT/ML SOLUTION	IJ	SOLUTION
Heparin Sodium (Porcine) 10000 UNIT/ML SOLUTION	IJ	SOLUTION

MEDICATION NAME	ROUTE	DOSE FORM
Heparin Sodium (Porcine) 20000 UNIT/ML SOLUTION	IJ	SOLUTION
Heparin Sodium (Porcine) 5000 UNIT/0.5ML SOLN PRSYR	IJ	SOLN PRSYR
Heparin Sodium (Porcine) 5000 UNIT/ML SOLUTION	IJ	SOLUTION
Heparin Sodium (Porcine) PF 1000 UNIT/ML SOLUTION	IJ	SOLUTION
Heparin Sodium (Porcine) PF 5000 UNIT/0.5ML SOLUTION	IJ	SOLUTION
Heparin Sodium (Porcine) PF 5000 UNIT/ML SOLUTION	IJ	SOLUTION
Hepatamine 8 % SOLUTION	IV	SOLUTION
Heplisav-B 20 MCG/0.5ML SOLN PRSYR	IM	SOLN PRSYR
Herceptin 150 MG RECON SOLN	IV	RECON SOLN
Herceptin Hylecta 600-10000 MG-UNT/5ML SOLUTION	SC	SOLUTION
Herzuma 150 MG RECON SOLN	IV	RECON SOLN
Herzuma 420 MG RECON SOLN	IV	RECON SOLN
HumuLIN R U-500 (CONCENTRATED) 500 UNIT/ML SOLUTION	SC	SOLUTION
Hycamtin 4 MG RECON SOLN	IV	RECON SOLN
Hydrocortisone Sod Suc (PF) 100 MG RECON SOLN	IJ	RECON SOLN
HYDROmorphone HCl 0.2 MG/ML SOLUTION	IJ	SOLUTION
HYDROmorphone HCl 1 MG/ML SOLUTION	IJ	SOLUTION
HYDROmorphone HCl 2 MG/ML SOLUTION	IJ	SOLUTION
HYDROmorphone HCl 4 MG/ML SOLUTION	IJ	SOLUTION
HYDROmorphone HCl PF 1 MG/ML SOLUTION	IJ	SOLUTION
HYDROmorphone HCl PF 10 MG/ML SOLUTION	IJ	SOLUTION
HYDROmorphone HCl PF 2 MG/ML SOLUTION	IJ	SOLUTION
HYDROmorphone HCl PF 4 MG/ML SOLUTION	IJ	SOLUTION
HYDROmorphone HCl PF 50 MG/5ML SOLUTION	IJ	SOLUTION
HYDROmorphone HCl PF 500 MG/50ML SOLUTION	IJ	SOLUTION
HydrOXYzine HCl 25 MG/ML SOLUTION	IM	SOLUTION
HydrOXYzine HCl 50 MG/ML SOLUTION	IM	SOLUTION
Hyoscyamine Sulfate 0.5 MG/ML SOLUTION	IJ	SOLUTION
HyperHEP B 110 UNIT/0.5ML SOLN PRSYR	IM	SOLN PRSYR
HyperHEP B 220 UNIT/ML SOLN PRSYR	IM	SOLN PRSYR
HyperHEP B 220 UNIT/ML SOLUTION	IM	SOLUTION
Hyperlyte-CR CONC	IV	CONC
HyperRAB 1500 UNIT/5ML SOLUTION	IJ	SOLUTION
HyperRAB 300 UNIT/ML SOLUTION	IJ	SOLUTION
HyperRAB 900 UNIT/3ML SOLUTION	IJ	SOLUTION
HyperRAB S/D 1500 UNIT/10ML SOLUTION	IJ	SOLUTION
HyperRAB S/D 300 UNIT/2ML SOLUTION	IJ	SOLUTION
HyperRHO S/D 1500 UNIT SOLN PRSYR	IM	SOLN PRSYR
HyperRHO S/D 250 UNIT SOLN PRSYR	IM	SOLN PRSYR

MEDICATION NAME	ROUTE	DOSE FORM
Hyqvia 10 GM/100ML KIT	SC	KIT
Hyqvia 2.5 GM/25ML KIT	SC	KIT
Hyqvia 20 GM/200ML KIT	SC	KIT
Hyqvia 30 GM/300ML KIT	SC	KIT
Hyqvia 5 GM/50ML KIT	SC	KIT
Ibandronate Sodium 3 MG/3ML SOLUTION	IV	SOLUTION
Idamycin PFS 10 MG/10ML SOLUTION	IV	SOLUTION
Idamycin PFS 20 MG/20ML SOLUTION	IV	SOLUTION
Idamycin PFS 5 MG/5ML SOLUTION	IV	SOLUTION
IDArubicin HCl 10 MG/10ML SOLUTION	IV	SOLUTION
IDArubicin HCl 20 MG/20ML SOLUTION	IV	SOLUTION
IDArubicin HCl 5 MG/5ML SOLUTION	IV	SOLUTION
Ifex 1 GM RECON SOLN	IV	RECON SOLN
Ifex 3 GM RECON SOLN	IV	RECON SOLN
Ifosfamide 1 GM RECON SOLN	IV	RECON SOLN
Ifosfamide 1 GM/20ML SOLUTION	IV	SOLUTION
Ifosfamide 3 GM RECON SOLN	IV	RECON SOLN
Ifosfamide 3 GM/60ML SOLUTION	IV	SOLUTION
Imdelltra 1 MG RECON SOLN	IV	RECON SOLN
Imdelltra 10 MG RECON SOLN	IV	RECON SOLN
Imfinzi 120 MG/2.4ML SOLUTION	IV	SOLUTION
Imfinzi 500 MG/10ML SOLUTION	IV	SOLUTION
Imjudo 25 MG/1.25ML SOLUTION	IV	SOLUTION
Imjudo 300 MG/15ML SOLUTION	IV	SOLUTION
Imlygic 1000000 UNIT/ML SUSPENSION	LS	SUSPENSION
Imlygic 100000000 UNIT/ML SUSPENSION	LS	SUSPENSION
Imogam Rabies-HT 300 UNIT/2ML SOLUTION	IJ	SOLUTION
Imuran 50 MG TAB	PO	TAB
Inflectra 100 MG RECON SOLN	IV	RECON SOLN
inFLIXimab 100 MG RECON SOLN	IV	RECON SOLN
Infugem 1200-0.9 MG/120ML-% SOLUTION	IV	SOLUTION
Infugem 1300-0.9 MG/130ML-% SOLUTION	IV	SOLUTION
Infugem 1400-0.9 MG/140ML-% SOLUTION	IV	SOLUTION
Infugem 1500-0.9 MG/150ML-% SOLUTION	IV	SOLUTION
Infugem 1600-0.9 MG/160ML-% SOLUTION	IV	SOLUTION
Infugem 1700-0.9 MG/170ML-% SOLUTION	IV	SOLUTION
Infugem 1800-0.9 MG/180ML-% SOLUTION	IV	SOLUTION
Infugem 1900-0.9 MG/190ML-% SOLUTION	IV	SOLUTION
Infugem 2000-0.9 MG/200ML-% SOLUTION	IV	SOLUTION
Infugem 2200-0.9 MG/220ML-% SOLUTION	IV	SOLUTION
Infumorph 200 200 MG/20ML (10 MG/ML) SOLUTION	IJ	SOLUTION
Infumorph 500 500 MG/20ML (25 MG/ML) SOLUTION	IJ	SOLUTION

MEDICATION NAME	ROUTE	DOSE FORM
Intralipid 20 % EMULSION	IV	EMULSION
Intralipid 30 % EMULSION	IV	EMULSION
Invega Hafyera 1092 MG/3.5ML SUSP PRSYR	IM	SUSP PRSYR
Invega Hafyera 1560 MG/5ML SUSP PRSYR	IM	SUSP PRSYR
Invega Sustenna 117 MG/0.75ML SUSP PRSYR	IM	SUSP PRSYR
Invega Sustenna 156 MG/ML SUSP PRSYR	IM	SUSP PRSYR
Invega Sustenna 234 MG/1.5ML SUSP PRSYR	IM	SUSP PRSYR
Invega Sustenna 39 MG/0.25ML SUSP PRSYR	IM	SUSP PRSYR
Invega Sustenna 78 MG/0.5ML SUSP PRSYR	IM	SUSP PRSYR
Invega Trinza 273 MG/0.88ML SUSP PRSYR	IM	SUSP PRSYR
Invega Trinza 410 MG/1.32ML SUSP PRSYR	IM	SUSP PRSYR
Invega Trinza 546 MG/1.75ML SUSP PRSYR	IM	SUSP PRSYR
Invega Trinza 819 MG/2.63ML SUSP PRSYR	IM	SUSP PRSYR
Ionosol-MB in D5W SOLUTION	IV	SOLUTION
Ipratropium Bromide 0.02 % SOLUTION	IN	SOLUTION
Ipratropium-Albuterol 0.5-2.5 (3) MG/3ML SOLUTION	IN	SOLUTION
Irinotecan HCl 100 MG/5ML SOLUTION	IV	SOLUTION
Irinotecan HCl 300 MG/15ML SOLUTION	IV	SOLUTION
Irinotecan HCl 40 MG/2ML SOLUTION	IV	SOLUTION
Irinotecan HCl 500 MG/25ML SOLUTION	IV	SOLUTION
Isolyte-P in D5W SOLUTION	IV	SOLUTION
Isolyte-S SOLUTION	IV	SOLUTION
Isolyte-S pH 7.4 SOLUTION	IV	SOLUTION
Istodax 10 MG RECON SOLN	IV	RECON SOLN
Ixempra Kit 15 MG RECON SOLN	IV	RECON SOLN
Ixempra Kit 45 MG RECON SOLN	IV	RECON SOLN
Jelmyto 80 (2 x 40) MG RECON SOLN	UL	RECON SOLN
Jemperli 500 MG/10ML SOLUTION	IV	SOLUTION
Jevtana 60 MG/1.5ML SOLUTION	IV	SOLUTION
Kabiven 3.3-10.8-3.9 % EMULSION	IV	EMULSION
Kadcyla 100 MG RECON SOLN	IV	RECON SOLN
Kadcyla 160 MG RECON SOLN	IV	RECON SOLN
Kanjinti 150 MG RECON SOLN	IV	RECON SOLN
Kanjinti 420 MG RECON SOLN	IV	RECON SOLN
Kanuma 20 MG/10ML SOLUTION	IV	SOLUTION
KCl (0.149%) in NaCl 20-0.45 MEQ/L-% SOLUTION	IV	SOLUTION
KCl (in NaCl 0.9%) 40 MEQ/500ML SOLUTION	IV	SOLUTION
KCl in Dextrose-NaCl 10-5-0.45 MEQ/L-%-% SOLUTION	IV	SOLUTION
KCl in Dextrose-NaCl 30-5-0.45 MEQ/L-%-% SOLUTION	IV	SOLUTION
KCl in Dextrose-NaCl 40-5-0.45 MEQ/L-%-% SOLUTION	IV	SOLUTION
Kedrab 1500 UNIT/10ML SOLUTION	IJ	SOLUTION

MEDICATION NAME	ROUTE	DOSE FORM
Kedrab 300 UNIT/2ML SOLUTION	IJ	SOLUTION
Kenalog-10 10 MG/ML SUSPENSION	IJ	SUSPENSION
Kenalog-40 40 MG/ML SUSPENSION	IJ	SUSPENSION
Kenalog-80 80 MG/ML SUSPENSION	IJ	SUSPENSION
Kepivance 6.25 MG RECON SOLN	IV	RECON SOLN
Keppra 500 MG/5ML SOLUTION	IV	SOLUTION
Ketorolac Tromethamine 15 MG/ML SOLUTION	IJ	SOLUTION
Ketorolac Tromethamine 30 MG/ML SOLUTION	IJ	SOLUTION
Ketorolac Tromethamine 60 MG/2ML SOLUTION	IM	SOLUTION
Keytruda 100 MG/4ML SOLUTION	IV	SOLUTION
Khapzory 175 MG RECON SOLN	IV	RECON SOLN
Khapzory 300 MG RECON SOLN	IV	RECON SOLN
Kimmtrak 100 MCG/0.5ML SOLUTION	IV	SOLUTION
Kimyrsa 1200 MG RECON SOLN	IV	RECON SOLN
Kitabis Pak 300 MG/5ML NEBU SOLN	IN	NEBU SOLN
Krystexxa 8 MG/ML SOLUTION	IV	SOLUTION
Kyleena 19.5 MG IUD	IU	IUD
Kyprolis 10 MG RECON SOLN	IV	RECON SOLN
Kyprolis 30 MG RECON SOLN	IV	RECON SOLN
Kyprolis 60 MG RECON SOLN	IV	RECON SOLN
Labetalol HCl 5 MG/ML SOLUTION	IV	SOLUTION
Lacosamide 200 MG/20ML SOLUTION	IV	SOLUTION
Lamzede 10 MG RECON SOLN	IV	RECON SOLN
Lanoxin 0.25 MG/ML SOLUTION	IJ	SOLUTION
Lanoxin Pediatric 0.1 MG/ML SOLUTION	IJ	SOLUTION
Lartruvo 190 MG/19ML SOLUTION	IV	SOLUTION
Lartruvo 500 MG/50ML SOLUTION	IV	SOLUTION
Lemtrada 12 MG/1.2ML SOLUTION	IV	SOLUTION
Leqvio 284 MG/1.5ML SOLN PRSYR	SC	SOLN PRSYR
LevETIRAcetam 500 MG/5ML SOLUTION	IV	SOLUTION
LevETIRAcetam in NaCl 1000 MG/100ML SOLUTION	IV	SOLUTION
LevETIRAcetam in NaCl 1500 MG/100ML SOLUTION	IV	SOLUTION
levETIRAcetam in NaCl 250 MG/50ML SOLUTION	IV	SOLUTION
LevETIRAcetam in NaCl 500 MG/100ML SOLUTION	IV	SOLUTION
levOCARNitine 200 MG/ML SOLUTION	IV	SOLUTION
LevoFLOXacin in D5W 250 MG/50ML SOLUTION	IV	SOLUTION
LEVOleucovorin Calcium 50 MG RECON SOLN	IV	RECON SOLN
LEVOleucovorin Calcium PF 175 MG/17.5ML SOLUTION	IV	SOLUTION
LEVOleucovorin Calcium PF 250 MG/25ML SOLUTION	IV	SOLUTION
Levothyroxine Sodium 100 MCG RECON SOLN	IV	RECON SOLN
Levothyroxine Sodium 100 MCG/5ML SOLUTION	IV	SOLUTION
Levothyroxine Sodium 100 MCG/ML SOLUTION	IV	SOLUTION

MEDICATION NAME	ROUTE	DOSE FORM
Levothyroxine Sodium 200 MCG RECON SOLN	IV	RECON SOLN
Levothyroxine Sodium 200 MCG/5ML SOLUTION	IV	SOLUTION
Levothyroxine Sodium 500 MCG RECON SOLN	IV	RECON SOLN
Levothyroxine Sodium 500 MCG/5ML SOLUTION	IV	SOLUTION
Levsin 0.5 MG/ML SOLUTION	IJ	SOLUTION
Levulan Kerastick 20 % RECON SOLN	EX	RECON SOLN
Libtayo 350 MG/7ML SOLUTION	IV	SOLUTION
Lidocaine HCl (Cardiac) 100 MG/5ML SOLN PRSYR	IV	SOLN PRSYR
Lidocaine HCl (Cardiac) 50 MG/5ML SOLN PRSYR	IV	SOLN PRSYR
Lidocaine HCl (Cardiac) PF 100 MG/5ML SOLN PRSYR	IV	SOLN PRSYR
Lidocaine HCl (Cardiac) PF 100 MG/5ML SOLUTION	IV	SOLUTION
Lidocaine HCl (Cardiac) PF 50 MG/5ML SOLN PRSYR	IV	SOLN PRSYR
Lidocaine in D5W 4-5 MG/ML-% SOLUTION	IV	SOLUTION
Lidocaine-EPINEPHrine (PF) 1.5 %-1:200000 SOLUTION	IJ	SOLUTION
Lidocaine-EPINEPHrine (PF) 2 %-1:200000 SOLUTION	IJ	SOLUTION
Lidocaine-Epinephrine 0.5 %-1:200000 SOLUTION	IJ	SOLUTION
Lidocaine-Epinephrine 1 %-1:100000 SOLUTION	IJ	SOLUTION
Lidocaine-Epinephrine 2 %-1:100000 SOLUTION	IJ	SOLUTION
Lidocaine-Epinephrine 2 %-1:50000 SOLUTION	IJ	SOLUTION
Liletta (52 MG) 20.1 MCG/DAY IUD	IU	IUD
Lioresal 0.05 MG/ML SOLUTION	IT	SOLUTION
Lioresal 10 MG/20ML SOLUTION	IT	SOLUTION
Lioresal 10 MG/5ML SOLUTION	IT	SOLUTION
Lioresal 40 MG/20ML SOLUTION	IT	SOLUTION
Liothyronine Sodium 10 MCG/ML SOLUTION	IV	SOLUTION
Loqtorzi 240 MG/6ML SOLUTION	IV	SOLUTION
LORazepam 2 MG/ML SOLUTION	IJ	SOLUTION
LORazepam 4 MG/ML SOLUTION	IJ	SOLUTION
Lumizyme 50 MG RECON SOLN	IV	RECON SOLN
Lumoxiti 1 MG RECON SOLN	IV	RECON SOLN
Lunsumio 1 MG/ML SOLUTION	IV	SOLUTION
Lunsumio 30 MG/30ML SOLUTION	IV	SOLUTION
Lupron Depot-Ped (1-Month) 11.25 MG KIT	IM	KIT
Lupron Depot-Ped (1-Month) 15 MG KIT	IM	KIT
Lupron Depot-Ped (1-Month) 7.5 MG KIT	IM	KIT
Lupron Depot-Ped (3-Month) 11.25 MG (Ped) KIT	IM	KIT
Lupron Depot-Ped (3-Month) 30 MG KIT	IM	KIT
Lupron Depot-Ped (6-Month) 45 MG KIT	IM	KIT
Magnesium Sulfate 2 GM/50ML SOLUTION	IV	SOLUTION
Magnesium Sulfate 20 GM/500ML SOLUTION	IV	SOLUTION
Magnesium Sulfate 4 GM/100ML SOLUTION	IV	SOLUTION

MEDICATION NAME	ROUTE	DOSE FORM
Magnesium Sulfate 4 GM/50ML SOLUTION	IV	SOLUTION
Magnesium Sulfate 40 GM/1000ML SOLUTION	IV	SOLUTION
Magnesium Sulfate in D5W 1-5 GM/100ML-% SOLUTION	IV	SOLUTION
Magnesium Sulfate-NaCl 2-0.9 GM/50ML-% SOLUTION	IV	SOLUTION
Manganese Chloride 0.1 MG/ML SOLUTION	IV	SOLUTION
Manganese Sulfate 0.1 MG/ML SOLUTION	IV	SOLUTION
Mannitol 20 % SOLUTION	IV	SOLUTION
Mannitol 25 % SOLUTION	IV	SOLUTION
Margenza 250 MG/10ML SOLUTION	IV	SOLUTION
Marinol 10 MG CAP	PO	CAP
Marinol 2.5 MG CAP	PO	CAP
Marinol 5 MG CAP	PO	CAP
Marqibo 5 MG/31ML SUSPENSION	IV	SUSPENSION
Melphalan 2 MG TAB	PO	TAB
Melphalan HCl 50 MG RECON SOLN	IV	RECON SOLN
Meperidine HCl 100 MG/ML SOLUTION	IJ	SOLUTION
Meperidine HCl 25 MG/ML SOLUTION	IJ	SOLUTION
Meperidine HCl 50 MG/ML SOLUTION	IJ	SOLUTION
Mepsevii 10 MG/5ML SOLUTION	IV	SOLUTION
Methocarbamol 1000 MG/10ML SOLUTION	IJ	SOLUTION
Methotrexate Sodium (PF) 1 GM/40ML SOLUTION	IJ	SOLUTION
Methotrexate Sodium (PF) 250 MG/10ML SOLUTION	IJ	SOLUTION
Methotrexate Sodium (PF) 50 MG/2ML SOLUTION	IJ	SOLUTION
Methotrexate Sodium 1 GM RECON SOLN	IJ	RECON SOLN
Methotrexate Sodium 1000 MG/40ML SOLUTION	IJ	SOLUTION
Methotrexate Sodium 250 MG/10ML SOLUTION	IJ	SOLUTION
Methotrexate Sodium 50 MG/2ML SOLUTION	IJ	SOLUTION
MethylPREDNISolone Acetate 50 MG/ML SUSPENSION	IJ	SUSPENSION
MethylPREDNISolone Sodium Succ 1000 MG RECON SOLN	IJ	RECON SOLN
MethylPREDNISolone Sodium Succ 125 MG RECON SOLN	IJ	RECON SOLN
methylPREDNISolone Sodium Succ 500 MG RECON SOLN	IJ	RECON SOLN
Metoprolol Tartrate 5 MG/5ML SOLUTION	IV	SOLUTION
Miacalcin 200 UNIT/ML SOLUTION	IJ	SOLUTION
MICRhoGAM Ultra-Filtered Plus 250 UNIT SOLN PRSYR	IM	SOLN PRSYR
Milrinone Lactate 10 MG/10ML SOLUTION	IV	SOLUTION
Milrinone Lactate 20 MG/20ML SOLUTION	IV	SOLUTION
Milrinone Lactate 50 MG/50ML SOLUTION	IV	SOLUTION

MEDICATION NAME	ROUTE	DOSE FORM
Milrinone Lactate in Dextrose 20-5 MG/100ML-% SOLUTION	IV	SOLUTION
Milrinone Lactate in Dextrose 40-5 MG/200ML-% SOLUTION	IV	SOLUTION
Minocin 100 MG RECON SOLN	IV	RECON SOLN
Mirena (52 MG) 20 MCG/DAY IUD	IU	IUD
Mitigo 200 MG/20ML (10 MG/ML) SOLUTION	IJ	SOLUTION
Mitigo 500 MG/20ML (25 MG/ML) SOLUTION	IJ	SOLUTION
MitoMYcin 20 MG RECON SOLN	IV	RECON SOLN
MitoMYcin 20 MG/40ML SOLN PRSYR	IS	SOLN PRSYR
MitoMYcin 40 MG RECON SOLN	IV	RECON SOLN
MitoMYcin 5 MG RECON SOLN	IV	RECON SOLN
MitoXANTRONE HCl 20 MG/10ML CONC	IV	CONC
MitoXANTRONE HCl 25 MG/12.5ML CONC	IV	CONC
MitoXANTRONE HCl 30 MG/15ML CONC	IV	CONC
Monjuvi 200 MG RECON SOLN	IV	RECON SOLN
Morphine Sulfate (PF) 0.5 MG/ML SOLUTION	IJ	SOLUTION
Morphine Sulfate (PF) 1 MG/ML SOLUTION	IJ	SOLUTION
Morphine Sulfate (PF) 1 MG/ML SOLUTION	IV	SOLUTION
Morphine Sulfate (PF) 10 MG/ML SOLUTION	IJ	SOLUTION
Morphine Sulfate (PF) 10 MG/ML SOLUTION	IV	SOLUTION
Morphine Sulfate (PF) 2 MG/ML SOLUTION	IJ	SOLUTION
Morphine Sulfate (PF) 2 MG/ML SOLUTION	IV	SOLUTION
Morphine Sulfate (PF) 4 MG/ML SOLUTION	IJ	SOLUTION
Morphine Sulfate (PF) 4 MG/ML SOLUTION	IV	SOLUTION
Morphine Sulfate (PF) 5 MG/ML SOLUTION	IJ	SOLUTION
Morphine Sulfate (PF) 8 MG/ML SOLUTION	IJ	SOLUTION
Morphine Sulfate (PF) 8 MG/ML SOLUTION	IV	SOLUTION
Morphine Sulfate 0.5 MG/ML SOLUTION	IV	SOLUTION
Morphine Sulfate 1 MG/ML SOLUTION	IJ	SOLUTION
Morphine Sulfate 1 MG/ML SOLUTION	IV	SOLUTION
Morphine Sulfate 10 MG/ML SOLUTION	IV	SOLUTION
Morphine Sulfate 2 MG/ML SOLUTION	IJ	SOLUTION
Morphine Sulfate 4 MG/ML SOLUTION	IJ	SOLUTION
Morphine Sulfate 4 MG/ML SOLUTION	IV	SOLUTION
Morphine Sulfate 5 MG/ML SOLUTION	IJ	SOLUTION
Morphine Sulfate 50 MG/ML SOLUTION	IV	SOLUTION
Morphine Sulfate 8 MG/ML SOLUTION	IV	SOLUTION
Moxifloxacin HCl 400 MG/250ML SOLUTION	IV	SOLUTION
Moxifloxacin HCl in NaCl 400 MG/250ML SOLUTION	IV	SOLUTION
Multiple Electro Type 1 pH 5.5 SOLUTION	IV	SOLUTION
Multiple Electro Type 1 pH 7.4 SOLUTION	IV	SOLUTION
Mutamycin 20 MG RECON SOLN	IV	RECON SOLN
Mutamycin 40 MG RECON SOLN	IV	RECON SOLN

MEDICATION NAME	ROUTE	DOSE FORM
Mutamycin 5 MG RECON SOLN	IV	RECON SOLN
Mvasi 100 MG/4ML SOLUTION	IV	SOLUTION
Mvasi 400 MG/16ML SOLUTION	IV	SOLUTION
Mycophenolate Mofetil 200 MG/ML RECON SUSP	PO	RECON SUSP
Mycophenolate Mofetil 250 MG CAP	PO	CAP
Mycophenolate Mofetil 500 MG RECON SOLN	IV	RECON SOLN
Mycophenolate Mofetil 500 MG TAB	PO	TAB
Mycophenolate Mofetil HCl 500 MG RECON SOLN	IV	RECON SOLN
Mycophenolate Sodium 180 MG TAB DR	PO	TAB DR
Mycophenolate Sodium 360 MG TAB DR	PO	TAB DR
Mycophenolic Acid 180 MG TAB DR	PO	TAB DR
Mycophenolic Acid 360 MG TAB DR	PO	TAB DR
Myfortic 180 MG TAB DR	PO	TAB DR
Myfortic 360 MG TAB DR	PO	TAB DR
Myhibbin 200 MG/ML SUSPENSION	PO	SUSPENSION
Mylotarg 4.5 MG RECON SOLN	IV	RECON SOLN
Myobloc 10000 UNIT/2ML SOLUTION	IM	SOLUTION
Myobloc 2500 UNIT/0.5ML SOLUTION	IM	SOLUTION
Myobloc 5000 UNIT/ML SOLUTION	IM	SOLUTION
Nabi-HB 312 UNIT/ML SOLUTION	IM	SOLUTION
Nafcillin Sodium in Dextrose 1 GM/50ML SOLUTION	IV	SOLUTION
Nafcillin Sodium in Dextrose 2 GM/100ML SOLUTION	IV	SOLUTION
Naglazyme 1 MG/ML SOLUTION	IV	SOLUTION
Nalbuphine HCl 10 MG/ML SOLUTION	IJ	SOLUTION
Nalbuphine HCl 20 MG/ML SOLUTION	IJ	SOLUTION
Navelbine 10 MG/ML SOLUTION	IV	SOLUTION
Navelbine 50 MG/5ML SOLUTION	IV	SOLUTION
Nebupent 300 MG RECON SOLN	IN	RECON SOLN
Nelarabine 5 MG/ML SOLUTION	IV	SOLUTION
Neoral 100 MG CAP	PO	CAP
Neoral 100 MG/ML SOLUTION	PO	SOLUTION
Neoral 25 MG CAP	PO	CAP
NephrAmine 5.4 % SOLUTION	IV	SOLUTION
Neulasta 6 MG/0.6ML SOLN PRSYR	SC	SOLN PRSYR
Neulasta Onpro 6 MG/0.6ML PREF SY KT	SC	PREF SY KT
Neupogen 300 MCG/0.5ML SOLN PRSYR	IJ	SOLN PRSYR
Neupogen 300 MCG/ML SOLUTION	IJ	SOLUTION
Neupogen 480 MCG/0.8ML SOLN PRSYR	IJ	SOLN PRSYR
Neupogen 480 MCG/1.6ML SOLUTION	IJ	SOLUTION
Nexplanon 68 MG IMPLANT	SC	IMPLANT
Nexterone 150-4.21 MG/100ML-% SOLUTION	IV	SOLUTION
Nexterone 360-4.14 MG/200ML-% SOLUTION	IV	SOLUTION
Nexviazyme 100 MG RECON SOLN	IV	RECON SOLN

MEDICATION NAME	ROUTE	DOSE FORM
NiCARdipine HCl 2.5 MG/ML SOLUTION	IV	SOLUTION
niCARdipine HCl in NaCl 20-0.9 MG/200ML-% SOLUTION	IV	SOLUTION
niCARdipine HCl in NaCl 40-0.9 MG/200ML-% SOLUTION	IV	SOLUTION
Nipent 10 MG RECON SOLN	IV	RECON SOLN
Nitroglycerin 5 MG/ML SOLUTION	IV	SOLUTION
Nitroglycerin in D5W 100-5 MCG/ML-% SOLUTION	IV	SOLUTION
Nitroglycerin in D5W 200-5 MCG/ML-% SOLUTION	IV	SOLUTION
Nitroglycerin in D5W 400-5 MCG/ML-% SOLUTION	IV	SOLUTION
Nivestym 300 MCG/0.5ML SOLN PRSYR	IJ	SOLN PRSYR
Nivestym 300 MCG/ML SOLUTION	IJ	SOLUTION
Nivestym 480 MCG/0.8ML SOLN PRSYR	IJ	SOLN PRSYR
Nivestym 480 MCG/1.6ML SOLUTION	IJ	SOLUTION
Normosol-R SOLUTION	IV	SOLUTION
Normosol-R in D5W SOLUTION	IV	SOLUTION
Normosol-R pH 7.4 SOLUTION	IV	SOLUTION
Novarel 10000 UNIT RECON SOLN	IM	RECON SOLN
Novarel 5000 UNIT RECON SOLN	IM	RECON SOLN
Noxafil 300 MG/16.7ML SOLUTION	IV	SOLUTION
Nplate 125 MCG RECON SOLN	SC	RECON SOLN
Nplate 250 MCG RECON SOLN	SC	RECON SOLN
Nplate 500 MCG RECON SOLN	SC	RECON SOLN
Nulibry 9.5 MG RECON SOLN	IV	RECON SOLN
Nulojix 250 MG RECON SOLN	IV	RECON SOLN
Numbrino 40 MG/ML SOLUTION	NA	SOLUTION
Nutrilipid 20 % EMULSION	IV	EMULSION
Nuzyra 100 MG RECON SOLN	IV	RECON SOLN
Nyvepria 6 MG/0.6ML SOLN PRSYR	SC	SOLN PRSYR
Ocrevus 300 MG/10ML SOLUTION	IV	SOLUTION
Ocrevus Zunovo 920-23000 MG-UT/23ML SOLUTION	SC	SOLUTION
Octagam 1 GM/20ML SOLUTION	IV	SOLUTION
Octagam 10 GM/100ML SOLUTION	IV	SOLUTION
Octagam 10 GM/200ML SOLUTION	IV	SOLUTION
Octagam 2 GM/20ML SOLUTION	IV	SOLUTION
Octagam 2.5 GM/50ML SOLUTION	IV	SOLUTION
Octagam 20 GM/200ML SOLUTION	IV	SOLUTION
Octagam 25 GM/500ML SOLUTION	IV	SOLUTION
Octagam 30 GM/300ML SOLUTION	IV	SOLUTION
Octagam 5 GM/100ML SOLUTION	IV	SOLUTION
Octagam 5 GM/50ML SOLUTION	IV	SOLUTION
Octreotide Acetate 20 MG KIT	IM	KIT
Octreotide Acetate 30 MG KIT	IM	KIT
Ofirmev 10 MG/ML SOLUTION	IV	SOLUTION

MEDICATION NAME	ROUTE	DOSE FORM
Ogivri 150 MG RECON SOLN	IV	RECON SOLN
Ogivri 420 MG RECON SOLN	IV	RECON SOLN
Ohtuvayre 3 MG/2.5ML SUSPENSION	IN	SUSPENSION
Omegaven 10 GM/100ML EMULSION	IV	EMULSION
Omegaven 5 GM/50ML EMULSION	IV	EMULSION
Omvoh 300 MG/15ML SOLUTION	IV	SOLUTION
Oncaspar 750 UNIT/ML SOLUTION	IJ	SOLUTION
Ondansetron 4 MG TAB DISP	PO	TAB DISP
Ondansetron 8 MG TAB DISP	PO	TAB DISP
Ondansetron HCl 24 MG TAB	PO	TAB
Ondansetron HCl 4 MG TAB	PO	TAB
Ondansetron HCl 4 MG/2ML SOLN PRSYR	IJ	SOLN PRSYR
Ondansetron HCl 4 MG/2ML SOLUTION	IJ	SOLUTION
Ondansetron HCl 4 MG/5ML SOLUTION	PO	SOLUTION
Ondansetron HCl 40 MG/20ML SOLUTION	IJ	SOLUTION
Ondansetron HCl 8 MG TAB	PO	TAB
Onivyde 43 MG/10ML INJECTABLE	IV	INJECTABLE
Onpattro 10 MG/5ML SOLUTION	IV	SOLUTION
Ontruzant 150 MG RECON SOLN	IV	RECON SOLN
Ontruzant 420 MG RECON SOLN	IV	RECON SOLN
Opdivo 100 MG/10ML SOLUTION	IV	SOLUTION
Opdivo 120 MG/12ML SOLUTION	IV	SOLUTION
Opdivo 240 MG/24ML SOLUTION	IV	SOLUTION
Opdivo 40 MG/4ML SOLUTION	IV	SOLUTION
Opdualag 240-80 MG/20ML SOLUTION	IV	SOLUTION
Orbactiv 400 MG RECON SOLN	IV	RECON SOLN
Orphenadrine Citrate 30 MG/ML SOLUTION	IJ	SOLUTION
Osmitrol 10 % SOLUTION	IV	SOLUTION
Osmitrol 15 % SOLUTION	IV	SOLUTION
Osmitrol 20 % SOLUTION	IV	SOLUTION
Oxacillin Sodium 1 GM RECON SOLN	IJ	RECON SOLN
Oxacillin Sodium 10 GM RECON SOLN	IV	RECON SOLN
Oxacillin Sodium 2 GM RECON SOLN	IJ	RECON SOLN
Oxacillin Sodium in Dextrose 1 GM/50ML SOLUTION	IV	SOLUTION
Oxacillin Sodium in Dextrose 2 GM/50ML SOLUTION	IV	SOLUTION
Oxaliplatin 100 MG RECON SOLN	IV	RECON SOLN
Oxaliplatin 100 MG/20ML SOLUTION	IV	SOLUTION
Oxaliplatin 200 MG/40ML SOLUTION	IV	SOLUTION
Oxaliplatin 50 MG RECON SOLN	IV	RECON SOLN
Oxaliplatin 50 MG/10ML SOLUTION	IV	SOLUTION
Oxlumo 94.5 MG/0.5ML SOLUTION	SC	SOLUTION
PACLitaxel 100 MG/16.7ML CONC	IV	CONC
PACLitaxel 150 MG/25ML CONC	IV	CONC
PACLitaxel 30 MG/5ML CONC	IV	CONC

MEDICATION NAME	ROUTE	DOSE FORM
PACLitaxel 300 MG/50ML CONC	IV	CONC
PACLitaxel Protein-Bound Part 100 MG RECON SUSP	IV	RECON SUSP
Padcev 20 MG RECON SOLN	IV	RECON SOLN
Padcev 30 MG RECON SOLN	IV	RECON SOLN
Palonosetron HCl 0.25 MG/2ML SOLUTION	IV	SOLUTION
Palonosetron HCl 0.25 MG/5ML SOLN PRSYR	IV	SOLN PRSYR
Palonosetron HCl 0.25 MG/5ML SOLUTION	IV	SOLUTION
Pamidronate Disodium 30 MG RECON SOLN	IV	RECON SOLN
Pamidronate Disodium 30 MG/10ML SOLUTION	IV	SOLUTION
Pamidronate Disodium 6 MG/ML SOLUTION	IV	SOLUTION
Pamidronate Disodium 90 MG RECON SOLN	IV	RECON SOLN
Pamidronate Disodium 90 MG/10ML SOLUTION	IV	SOLUTION
Pantoprazole Sodium-NaCl 40-0.9 MG/100ML-% SOLUTION	IV	SOLUTION
Pantoprazole Sodium-NaCl 80-0.9 MG/100ML-% SOLUTION	IV	SOLUTION
Panzyga 1 GM/10ML SOLUTION	IV	SOLUTION
Panzyga 10 GM/100ML SOLUTION	IV	SOLUTION
Panzyga 2.5 GM/25ML SOLUTION	IV	SOLUTION
Panzyga 20 GM/200ML SOLUTION	IV	SOLUTION
Panzyga 30 GM/300ML SOLUTION	IV	SOLUTION
Panzyga 5 GM/50ML SOLUTION	IV	SOLUTION
Paragard Intrauterine Copper IUD	IU	IUD
Paraplatin 1000 MG/100ML SOLUTION	IV	SOLUTION
Paraplatin 150 MG/15ML SOLUTION	IV	SOLUTION
Paraplatin 450 MG/45ML SOLUTION	IV	SOLUTION
Paraplatin 50 MG/5ML SOLUTION	IV	SOLUTION
Paraplatin 600 MG/60ML SOLUTION	IV	SOLUTION
Paricalcitol 1 MCG CAP	PO	CAP
Paricalcitol 2 MCG CAP	PO	CAP
Paricalcitol 2 MCG/ML SOLUTION	IV	SOLUTION
Paricalcitol 4 MCG CAP	PO	CAP
Paricalcitol 5 MCG/ML SOLUTION	IV	SOLUTION
Pedmark 12.5 % SOLUTION	IV	SOLUTION
PEMEtrexed 1 GM/40ML SOLUTION	IV	SOLUTION
PEMEtrexed 100 MG/4ML SOLUTION	IV	SOLUTION
PEMEtrexed 500 MG/20ML SOLUTION	IV	SOLUTION
PEMEtrexed Disodium 1 GM/40ML SOLUTION	IV	SOLUTION
PEMEtrexed Disodium 100 MG RECON SOLN	IV	RECON SOLN
PEMEtrexed Disodium 100 MG/4ML SOLUTION	IV	SOLUTION
PEMEtrexed Disodium 1000 MG RECON SOLN	IV	RECON SOLN
PEMEtrexed Disodium 500 MG RECON SOLN	IV	RECON SOLN
PEMEtrexed Disodium 500 MG/20ML SOLUTION	IV	SOLUTION

MEDICATION NAME	ROUTE	DOSE FORM
PEMEtrexed Disodium 750 MG RECON SOLN	IV	RECON SOLN
PEMEtrexed Disodium 850 MG/34ML SOLUTION	IV	SOLUTION
PEMEtrexed Ditromethamine 100 MG RECON SOLN	IV	RECON SOLN
PEMEtrexed Ditromethamine 500 MG RECON SOLN	IV	RECON SOLN
Pemfexy 500 MG/20ML SOLUTION	IV	SOLUTION
Pemrydi RTU 100 MG/10ML SOLUTION	IV	SOLUTION
Pemrydi RTU 500 MG/50ML SOLUTION	IV	SOLUTION
Penicillin G Pot in Dextrose 20000 UNIT/ML SOLUTION	IV	SOLUTION
Penicillin G Pot in Dextrose 40000 UNIT/ML SOLUTION	IV	SOLUTION
Penicillin G Pot in Dextrose 60000 UNIT/ML SOLUTION	IV	SOLUTION
Penicillin G Procaine 600000 UNIT/ML SUSPENSION	IM	SUSPENSION
Pentamidine Isethionate 300 MG RECON SOLN	IN	RECON SOLN
Pepaxto 20 MG RECON SOLN	IV	RECON SOLN
Perforomist 20 MCG/2ML NEBU SOLN	IN	NEBU SOLN
Perikabiven 2.4-6.8-3.5-0.5 % EMULSION	IV	EMULSION
Perjeta 420 MG/14ML SOLUTION	IV	SOLUTION
Perseris 120 MG PRSYR	SC	PRSYR
Perseris 90 MG PRSYR	SC	PRSYR
Phenergan 25 MG/ML SOLUTION	IJ	SOLUTION
Phenergan 50 MG/ML SOLUTION	IJ	SOLUTION
Phenytoin Sodium 50 MG/ML SOLUTION	IJ	SOLUTION
Phesgo 60-60-2000 MG-MG-U/ML SOLUTION	SC	SOLUTION
Phesgo 80-40-2000 MG-MG-U/ML SOLUTION	SC	SOLUTION
Piasky 340 MG/2ML SOLUTION	IJ	SOLUTION
Plasma-Lyte 148 SOLUTION	IV	SOLUTION
Plasma-Lyte A SOLUTION	IV	SOLUTION
Plenamine 15 % SOLUTION	IV	SOLUTION
Polivy 140 MG RECON SOLN	IV	RECON SOLN
Polivy 30 MG RECON SOLN	IV	RECON SOLN
Pombiliti 105 MG RECON SOLN	IV	RECON SOLN
Portrazza 800 MG/50ML SOLUTION	IV	SOLUTION
Posaconazole 300 MG/16.7ML SOLUTION	IV	SOLUTION
Potassium Acetate 2 MEQ/ML SOLUTION	IV	SOLUTION
Potassium Chloride 10 MEQ/50ML SOLUTION	IV	SOLUTION
Potassium Chloride 20 MEQ/50ML SOLUTION	IV	SOLUTION
Potassium Chloride in Dextrose 10-5 MEQ/L-% SOLUTION	IV	SOLUTION
Potassium Chloride in NaCl 20 MEQ/250ML SOLUTION	IV	SOLUTION
Potassium Chloride in NaCl 20-0.45 MEQ/L-% SOLUTION	IV	SOLUTION

MEDICATION NAME	ROUTE	DOSE FORM
Potassium Phosphates 15 MMOLE/5ML SOLUTION	IV	SOLUTION
Potassium Phosphates 150 MMOLE/50ML SOLUTION	IV	SOLUTION
Potassium Phosphates 45 MMOLE/15ML SOLUTION	IV	SOLUTION
Potassium Phosphates(66 mEq K) 45 MMOLE/15ML SOLUTION	IV	SOLUTION
Potassium Phosphates(71 mEq K) 45 MMOLE/15ML SOLUTION	IV	SOLUTION
Potassium Phosphates-NaCl 15 MMOL/250ML SOLUTION	IV	SOLUTION
Poteligeo 20 MG/5ML SOLUTION	IV	SOLUTION
PRALAtrexate 20 MG/ML SOLUTION	IV	SOLUTION
PRALAtrexate 40 MG/2ML SOLUTION	IV	SOLUTION
Pregnyl 10000 UNIT RECON SOLN	IM	RECON SOLN
PreHevbrio 10 MCG/ML SUSPENSION	IM	SUSPENSION
Premasol 10 % SOLUTION	IV	SOLUTION
Prevymis 240 MG/12ML SOLUTION	IV	SOLUTION
Prevymis 480 MG/24ML SOLUTION	IV	SOLUTION
Prialt 100 MCG/ML SOLUTION	IT	SOLUTION
Prialt 500 MCG/20ML SOLUTION	IT	SOLUTION
Prialt 500 MCG/5ML SOLUTION	IT	SOLUTION
Procainamide HCl 100 MG/ML SOLUTION	IJ	SOLUTION
Procainamide HCl 500 MG/ML SOLUTION	IJ	SOLUTION
Procalamine 3 % SOLUTION	IV	SOLUTION
Prochlorperazine Edisylate 10 MG/2ML SOLUTION	IJ	SOLUTION
Prochlorperazine Edisylate 50 MG/10ML SOLUTION	IJ	SOLUTION
Procrit 10000 UNIT/ML SOLUTION	IJ	SOLUTION
Procrit 2000 UNIT/ML SOLUTION	IJ	SOLUTION
Procrit 20000 UNIT/ML SOLUTION	IJ	SOLUTION
Procrit 3000 UNIT/ML SOLUTION	IJ	SOLUTION
Procrit 4000 UNIT/ML SOLUTION	IJ	SOLUTION
Procrit 40000 UNIT/ML SOLUTION	IJ	SOLUTION
Prograf 0.5 MG CAP	PO	CAP
Prograf 1 MG CAP	PO	CAP
Prograf 5 MG CAP	PO	CAP
Prograf 5 MG/ML SOLUTION	IV	SOLUTION
Prolastin-C 1000 MG RECON SOLN	IV	RECON SOLN
Prolastin-C 1000 MG/20ML SOLUTION	IV	SOLUTION
Proleukin 22000000 UNIT RECON SOLN	IV	RECON SOLN
Promethazine HCl 25 MG/ML SOLUTION	IJ	SOLUTION
Promethazine HCl 50 MG/ML SOLUTION	IJ	SOLUTION
Propranolol HCl 1 MG/ML SOLUTION	IV	SOLUTION
Prosol 20 % SOLUTION	IV	SOLUTION
Pulmicort 0.25 MG/2ML SUSPENSION	IN	SUSPENSION
Pulmicort 0.5 MG/2ML SUSPENSION	IN	SUSPENSION

MEDICATION NAME	ROUTE	DOSE FORM
Pulmicort 1 MG/2ML SUSPENSION	IN	SUSPENSION
Pulmozyme 2.5 MG/2.5ML SOLUTION	IN	SOLUTION
Radicava 30 MG/100ML SOLUTION	IV	SOLUTION
Rapamune 0.5 MG TAB	PO	TAB
Rapamune 1 MG TAB	PO	TAB
Rapamune 1 MG/ML SOLUTION	PO	SOLUTION
Rapamune 2 MG TAB	PO	TAB
Reblozyl 25 MG RECON SOLN	SC	RECON SOLN
Reblozyl 75 MG RECON SOLN	SC	RECON SOLN
Recarbrio 1.25 GM RECON SOLN	IV	RECON SOLN
Reclast 5 MG/100ML SOLUTION	IV	SOLUTION
Recombivax HB 10 MCG/ML SUSP PRSYR	IJ	SUSP PRSYR
Recombivax HB 10 MCG/ML SUSPENSION	IJ	SUSPENSION
Recombivax HB 40 MCG/ML SUSPENSION	IJ	SUSPENSION
Recombivax HB 5 MCG/0.5ML SUSP PRSYR	IJ	SUSP PRSYR
Recombivax HB 5 MCG/0.5ML SUSPENSION	IJ	SUSPENSION
Regonol 10 MG/2ML SOLUTION	IV	SOLUTION
Releuko 300 MCG/0.5ML SOLN PRSYR	SC	SOLN PRSYR
Releuko 300 MCG/ML SOLUTION	IJ	SOLUTION
Releuko 480 MCG/0.8ML SOLN PRSYR	SC	SOLN PRSYR
Releuko 480 MCG/1.6ML SOLUTION	IJ	SOLUTION
Remicade 100 MG RECON SOLN	IV	RECON SOLN
Remodulin 100 MG/20ML SOLUTION	IJ	SOLUTION
Remodulin 20 MG/20ML SOLUTION	IJ	SOLUTION
Remodulin 200 MG/20ML SOLUTION	IJ	SOLUTION
Remodulin 50 MG/20ML SOLUTION	IJ	SOLUTION
Renflexis 100 MG RECON SOLN	IV	RECON SOLN
Revatio 10 MG/12.5ML SOLUTION	IV	SOLUTION
Rezzayo 200 MG RECON SOLN	IV	RECON SOLN
RhoGAM Ultra-Filtered Plus 1500 UNIT SOLN PRSYR	IM	SOLN PRSYR
Rhophylac 1500 UNIT/2ML SOLN PRSYR	IJ	SOLN PRSYR
Riabni 100 MG/10ML SOLUTION	IV	SOLUTION
Riabni 500 MG/50ML SOLUTION	IV	SOLUTION
Ribavirin 6 GM RECON SOLN	IN	RECON SOLN
RisperDAL Consta 12.5 MG SRER	IM	
RisperDAL Consta 25 MG SRER	IM	
RisperDAL Consta 37.5 MG SRER	IM	
RisperDAL Consta 50 MG SRER	IM	
risperiDONE Microspheres ER 12.5 MG SRER	IM	
risperiDONE Microspheres ER 25 MG SRER	IM	
risperiDONE Microspheres ER 37.5 MG SRER	IM	
risperiDONE Microspheres ER 50 MG SRER	IM	
Rituxan 100 MG/10ML SOLUTION	IV	SOLUTION
Rituxan 500 MG/50ML SOLUTION	IV	SOLUTION

MEDICATION NAME	ROUTE	DOSE FORM
Rituxan Hycela 1400-23400 MG -UT/11.7ML SOLUTION	SC	SOLUTION
Rituxan Hycela 1600-26800 MG -UT/13.4ML SOLUTION	SC	SOLUTION
Robaxin 1000 MG/10ML SOLUTION	IJ	SOLUTION
Rocaltrol 0.25 MCG CAP	PO	CAP
Rocaltrol 0.5 MCG CAP	PO	CAP
Rocaltrol 1 MCG/ML SOLUTION	PO	SOLUTION
Rolvedon 13.2 MG/0.6ML SOLN PRSYR	SC	SOLN PRSYR
romiDEPsin 10 MG RECON SOLN	IV	RECON SOLN
romiDEPsin 27.5 MG/5.5ML SOLUTION	IV	SOLUTION
Ruxience 100 MG/10ML SOLUTION	IV	SOLUTION
Ruxience 500 MG/50ML SOLUTION	IV	SOLUTION
Rybrevant 350 MG/7ML SOLUTION	IV	SOLUTION
Rykindo 25 MG SRER	IM	
Rykindo 37.5 MG SRER	IM	
Rykindo 50 MG SRER	IM	
Rylaze 10 MG/0.5ML SOLUTION	IM	SOLUTION
Rystiggo 280 MG/2ML SOLUTION	SC	SOLUTION
Rystiggo 420 MG/3ML SOLUTION	SC	SOLUTION
Rystiggo 560 MG/4ML SOLUTION	SC	SOLUTION
Rystiggo 840 MG/6ML SOLUTION	SC	SOLUTION
Rytelo 188 MG RECON SOLN	IV	RECON SOLN
Rytelo 47 MG RECON SOLN	IV	RECON SOLN
SandIMMUNE 100 MG CAP	PO	CAP
SandIMMUNE 100 MG/ML SOLUTION	PO	SOLUTION
SandIMMUNE 25 MG CAP	PO	CAP
SandIMMUNE 50 MG/ML SOLUTION	IV	SOLUTION
Saphnelo 300 MG/2ML SOLUTION	IV	SOLUTION
Sarclisa 100 MG/5ML SOLUTION	IV	SOLUTION
Sarclisa 500 MG/25ML SOLUTION	IV	SOLUTION
Sensipar 30 MG TAB	PO	TAB
Sensipar 60 MG TAB	PO	TAB
Sensipar 90 MG TAB	PO	TAB
Sezaby 100 MG RECON SOLN	IV	RECON SOLN
Sildenafil Citrate 10 MG/12.5ML SOLUTION	IV	SOLUTION
Simponi Aria 50 MG/4ML SOLUTION	IV	SOLUTION
Simulect 10 MG RECON SOLN	IV	RECON SOLN
Simulect 20 MG RECON SOLN	IV	RECON SOLN
Sirolimus 0.5 MG TAB	PO	TAB
Sirolimus 1 MG TAB	PO	TAB
Sirolimus 1 MG/ML SOLUTION	PO	SOLUTION
Sirolimus 2 MG TAB	PO	TAB
Sivextro 200 MG RECON SOLN	IV	RECON SOLN

MEDICATION NAME	ROUTE	DOSE FORM
Skyla 13.5 MG IUD	IU	IUD
SMOFlipid 20 % EMULSION	IV	EMULSION
Sodium Acetate 2 MEQ/ML SOLUTION	IV	SOLUTION
Sodium Acetate 4 MEQ/ML SOLUTION	IV	SOLUTION
Sodium Bicarbonate 4.2 % SOLUTION	IV	SOLUTION
Sodium Bicarbonate 7.5 % SOLUTION	IV	SOLUTION
Sodium Bicarbonate 8.4 % SOLUTION	IV	SOLUTION
Sodium Chloride 4 MEQ/ML SOLUTION	IV	SOLUTION
Sodium Diuril 500 MG RECON SOLN	IV	RECON SOLN
Sodium Edecrin 50 MG RECON SOLN	IV	RECON SOLN
Sodium Phosphates 15 MMOLE/5ML SOLUTION	IV	SOLUTION
Sodium Phosphates 150 MMOLE/50ML SOLUTION	IV	SOLUTION
Sodium Phosphates 45 MMOLE/15ML SOLUTION	IV	SOLUTION
Soliris 300 MG/30ML SOLUTION	IV	SOLUTION
Solu-CORTEF 1000 MG RECON SOLN	IJ	RECON SOLN
Solu-CORTEF 250 MG RECON SOLN	IJ	RECON SOLN
Solu-CORTEF 500 MG RECON SOLN	IJ	RECON SOLN
SOLU-Medrol (PF) 1000 MG RECON SOLN	IJ	RECON SOLN
SOLU-Medrol (PF) 125 MG RECON SOLN	IJ	RECON SOLN
SOLU-Medrol (PF) 40 MG RECON SOLN	IJ	RECON SOLN
SOLU-Medrol (PF) 500 MG RECON SOLN	IJ	RECON SOLN
SOLU-medrol 1000 MG RECON SOLN	IJ	RECON SOLN
SOLU-Medrol 2 GM RECON SOLN	IJ	RECON SOLN
SOLU-medrol 500 MG RECON SOLN	IJ	RECON SOLN
Somatuline Depot 120 MG/0.5ML SOLUTION	SC	SOLUTION
Spevigo 150 MG/ML SOLN PRSYR	SC	SOLN PRSYR
Spevigo 450 MG/7.5ML SOLUTION	IV	SOLUTION
Spravato (56 MG Dose) 28 MG/DEVICE SOLN THPK	NA	SOLN THPK
Spravato (84 MG Dose) 28 MG/DEVICE SOLN THPK	NA	SOLN THPK
Stimufend 6 MG/0.6ML SOLN PRSYR	SC	SOLN PRSYR
Sublocade 100 MG/0.5ML SOLN PRSYR	SC	SOLN PRSYR
Sublocade 300 MG/1.5ML SOLN PRSYR	SC	SOLN PRSYR
Sunlenca 463.5 MG/1.5ML SOLUTION	SC	SOLUTION
Sustol 10 MG/0.4ML PRSYR	SC	PRSYR
Sylvant 100 MG RECON SOLN	IV	RECON SOLN
Sylvant 400 MG RECON SOLN	IV	RECON SOLN
Synagis 100 MG/ML SOLUTION	IM	SOLUTION
Synagis 50 MG/0.5ML SOLUTION	IM	SOLUTION
Syndros 5 MG/ML SOLUTION	PO	SOLUTION
Synribo 3.5 MG RECON SOLN	SC	RECON SOLN
Tacrolimus 0.5 MG CAP	PO	CAP
Tacrolimus 1 MG CAP	PO	CAP
Tacrolimus 5 MG CAP	PO	CAP
Talvey 3 MG/1.5ML SOLUTION	SC	SOLUTION

MEDICATION NAME	ROUTE	DOSE FORM
Talvey 40 MG/ML SOLUTION	SC	SOLUTION
Taxotere 20 MG/ML CONC	IV	CONC
Tazicef 1 GM/50ML SOLUTION	IV	SOLUTION
Tecentriq 1200 MG/20ML SOLUTION	IV	SOLUTION
Tecentriq 840 MG/14ML SOLUTION	IV	SOLUTION
Tecentriq Hybreza 1875-30000 MG-UT/15ML SOLUTION	SC	SOLUTION
Temodar 100 MG RECON SOLN	IV	RECON SOLN
Temsirolimus 25 MG/ML SOLUTION	IV	SOLUTION
Teniposide 10 MG/ML SOLUTION	IV	SOLUTION
Tepadina 100 MG RECON SOLN	IJ	RECON SOLN
Tepadina 15 MG RECON SOLN	IJ	RECON SOLN
Tepezza 500 MG RECON SOLN	IV	RECON SOLN
Tevimbra 100 MG/10ML SOLUTION	IV	SOLUTION
Tezspire 210 MG/1.91ML SOLN A-INJ	SC	SOLN A-INJ
Tezspire 210 MG/1.91ML SOLN PRSYR	SC	SOLN PRSYR
Thiotepa 100 MG RECON SOLN	IJ	RECON SOLN
Thiotepa 15 MG RECON SOLN	IJ	RECON SOLN
Thymoglobulin 25 MG RECON SOLN	IV	RECON SOLN
Tice BCG 50 MG RECON SUSP	IS	RECON SUSP
Tivdak 40 MG RECON SOLN	IV	RECON SOLN
Tobi 300 MG/5ML NEBU SOLN	IN	NEBU SOLN
Tobramycin 300 MG/5ML NEBU SOLN	IN	NEBU SOLN
Tofidence 200 MG/10ML SOLUTION	IV	SOLUTION
Tofidence 400 MG/20ML SOLUTION	IV	SOLUTION
Tofidence 80 MG/4ML SOLUTION	IV	SOLUTION
Toposar 1 GM/50ML SOLUTION	IV	SOLUTION
Toposar 100 MG/5ML SOLUTION	IV	SOLUTION
Toposar 500 MG/25ML SOLUTION	IV	SOLUTION
Topotecan HCl 4 MG RECON SOLN	IV	RECON SOLN
Topotecan HCl 4 MG/4ML SOLUTION	IV	SOLUTION
Torisel 25 MG/ML SOLUTION	IV	SOLUTION
Totect 500 MG RECON SOLN	IV	RECON SOLN
TPN Electrolytes CONC	IV	CONC
Tranexamic Acid 1000 MG/10ML SOLUTION	IV	SOLUTION
Travasol 10 % SOLUTION	IV	SOLUTION
Trazimera 150 MG RECON SOLN	IV	RECON SOLN
Trazimera 420 MG RECON SOLN	IV	RECON SOLN
Treanda 100 MG RECON SOLN	IV	RECON SOLN
Treanda 25 MG RECON SOLN	IV	RECON SOLN
Trelstar Mixject 11.25 MG RECON SUSP	IM	RECON SUSP
Trelstar Mixject 22.5 MG RECON SUSP	IM	RECON SUSP
Trelstar Mixject 3.75 MG RECON SUSP	IM	RECON SUSP
Tremfya 200 MG/20ML SOLUTION	IV	SOLUTION

MEDICATION NAME	ROUTE	DOSE FORM
Treprostinil 100 MG/20ML SOLUTION	IJ	SOLUTION
Treprostinil 20 MG/20ML SOLUTION	IJ	SOLUTION
Treprostinil 200 MG/20ML SOLUTION	IJ	SOLUTION
Treprostinil 50 MG/20ML SOLUTION	IJ	SOLUTION
Triamcinolone Acetonide 40 MG/ML SUSPENSION	IJ	SUSPENSION
Triamcinolone Acetonide 50 MG/ML SUSPENSION	IJ	SUSPENSION
Triesence 40 MG/ML SUSPENSION	IO	SUSPENSION
Triostat 10 MCG/ML SOLUTION	IV	SOLUTION
Triptodur 22.5 MG SRER	IM	
Trisenox 12 MG/6ML SOLUTION	IV	SOLUTION
Trodelvy 180 MG RECON SOLN	IV	RECON SOLN
TrophAmine 10 % SOLUTION	IV	SOLUTION
Truxima 100 MG/10ML SOLUTION	IV	SOLUTION
Truxima 500 MG/50ML SOLUTION	IV	SOLUTION
Twinrix 720-20 ELU-MCG/ML SUSP PRSYR	IM	SUSP PRSYR
Tyenne 200 MG/10ML SOLUTION	IV	SOLUTION
Tyenne 400 MG/20ML SOLUTION	IV	SOLUTION
Tyenne 80 MG/4ML SOLUTION	IV	SOLUTION
Tyvaso 0.6 MG/ML SOLUTION	IN	SOLUTION
Tyvaso Refill 0.6 MG/ML SOLUTION	IN	SOLUTION
Tyvaso Starter 0.6 MG/ML SOLUTION	IN	SOLUTION
Udenyca 6 MG/0.6ML SOLN A-INJ	SC	SOLN A-INJ
Udenyca 6 MG/0.6ML SOLN PRSYR	SC	SOLN PRSYR
Udenyca Onbody 6 MG/0.6ML SOLN PRSYR	SC	SOLN PRSYR
Ultomiris 1100 MG/11ML SOLUTION	IV	SOLUTION
Ultomiris 300 MG/30ML SOLUTION	IV	SOLUTION
Ultomiris 300 MG/3ML SOLUTION	IV	SOLUTION
Unituxin 17.5 MG/5ML SOLUTION	IV	SOLUTION
Uplizna 100 MG/10ML SOLUTION	IV	SOLUTION
Uptravi 1800 MCG RECON SOLN	IV	RECON SOLN
Uvadex 20 MCG/ML SOLUTION	EC	SOLUTION
Uzedy 100 MG/0.28ML SUSP PRSYR	SC	SUSP PRSYR
Uzedy 125 MG/0.35ML SUSP PRSYR	SC	SUSP PRSYR
Uzedy 150 MG/0.42ML SUSP PRSYR	SC	SUSP PRSYR
Uzedy 200 MG/0.56ML SUSP PRSYR	SC	SUSP PRSYR
Uzedy 250 MG/0.7ML SUSP PRSYR	SC	SUSP PRSYR
Uzedy 50 MG/0.14ML SUSP PRSYR	SC	SUSP PRSYR
Uzedy 75 MG/0.21ML SUSP PRSYR	SC	SUSP PRSYR
Vabomere 2 (1-1) GM RECON SOLN	IV	RECON SOLN
Valrubicin 40 MG/ML SOLUTION	IS	SOLUTION
Valstar 40 MG/ML SOLUTION	IS	SOLUTION
Vancomycin HCl 1000 MG/200ML SOLUTION	IV	SOLUTION
Vancomycin HCl 1250 MG/250ML SOLUTION	IV	SOLUTION
Vancomycin HCl 1500 MG/300ML SOLUTION	IV	SOLUTION

MEDICATION NAME	ROUTE	DOSE FORM
Vancomycin HCl 1750 MG/350ML SOLUTION	IV	SOLUTION
Vancomycin HCl 2000 MG/400ML SOLUTION	IV	SOLUTION
Vancomycin HCl 5 GM RECON SOLN	IV	RECON SOLN
Vancomycin HCl 500 MG/100ML SOLUTION	IV	SOLUTION
Vancomycin HCl 750 MG/150ML SOLUTION	IV	SOLUTION
Vancomycin HCl in Dextrose 1-5 GM/200ML-% SOLUTION	IV	SOLUTION
Vancomycin HCl in Dextrose 1.25-5 GM/250ML-% SOLUTION	IV	SOLUTION
Vancomycin HCl in Dextrose 1.5-5 GM/250ML-% SOLUTION	IV	SOLUTION
Vancomycin HCl in Dextrose 1.5-5 GM/300ML-% SOLUTION	IV	SOLUTION
Vancomycin HCl in Dextrose 500-5 MG/100ML-% SOLUTION	IV	SOLUTION
Vancomycin HCl in Dextrose 750-5 MG/150ML-% SOLUTION	IV	SOLUTION
Vancomycin HCl in NaCl 1-0.9 GM/200ML-% SOLUTION	IV	SOLUTION
Vancomycin HCl in NaCl 1-0.9 GM/250ML-% SOLUTION	IV	SOLUTION
Vancomycin HCl in NaCl 1.25-0.9 GM/250ML-% SOLUTION	IV	SOLUTION
Vancomycin HCl in NaCl 1.5-0.9 GM/250ML-% SOLUTION	IV	SOLUTION
Vancomycin HCl in NaCl 1.5-0.9 GM/500ML-% SOLUTION	IV	SOLUTION
Vancomycin HCl in NaCl 1.75-0.9 GM/250ML-% SOLUTION	IV	SOLUTION
Vancomycin HCl in NaCl 1.75-0.9 GM/500ML-% SOLUTION	IV	SOLUTION
Vancomycin HCl in NaCl 2-0.9 GM/500ML-% SOLUTION	IV	SOLUTION
Vancomycin HCl in NaCl 500-0.9 MG/100ML-% SOLUTION	IV	SOLUTION
Vancomycin HCl in NaCl 750-0.9 MG/150ML-% SOLUTION	IV	SOLUTION
Vancomycin HCl in NaCl 750-0.9 MG/250ML-% SOLUTION	IV	SOLUTION
Vantas 50 MG KIT	SC	KIT
Varubi (180 MG Dose) 2 x 90 MG TAB THPK	PO	TAB THPK
Vasopressin 20 UNIT/ML SOLUTION	IV	SOLUTION
Vasostrict 20 UNIT/ML SOLUTION	IV	SOLUTION
Vasostrict 20-5 UT/100ML-% SOLUTION	IV	SOLUTION
Vasostrict 40-5 UT/100ML-% SOLUTION	IV	SOLUTION
Vectibix 100 MG/5ML SOLUTION	IV	SOLUTION
Vectibix 400 MG/20ML SOLUTION	IV	SOLUTION
Vegzelma 100 MG/4ML SOLUTION	IV	SOLUTION

MEDICATION NAME	ROUTE	DOSE FORM
Vegzelma 400 MG/16ML SOLUTION	IV	SOLUTION
Velcade 3.5 MG RECON SOLN	IJ	RECON SOLN
Veletri 0.5 MG RECON SOLN	IV	RECON SOLN
Veletri 1.5 MG RECON SOLN	IV	RECON SOLN
Ventavis 10 MCG/ML SOLUTION	IN	SOLUTION
Ventavis 20 MCG/ML SOLUTION	IN	SOLUTION
Veopoz 400 MG/2ML SOLUTION	IJ	SOLUTION
Verapamil HCl 2.5 MG/ML SOLUTION	IV	SOLUTION
Vfend IV 200 MG RECON SOLN	IV	RECON SOLN
Vibativ 750 MG RECON SOLN	IV	RECON SOLN
Vidaza 100 MG RECON SUSP	IJ	RECON SUSP
Vimizim 5 MG/5ML SOLUTION	IV	SOLUTION
Vimpat 200 MG/20ML SOLUTION	IV	SOLUTION
VinBLAStine Sulfate 1 MG/ML SOLUTION	IV	SOLUTION
Vincasar PFS 1 MG/ML SOLUTION	IV	SOLUTION
VinCRIStine Sulfate 1 MG/ML SOLUTION	IV	SOLUTION
vinCRIStine Sulfate 2 MG/2ML SOLUTION	IV	SOLUTION
Vinorelbine Tartrate 10 MG/ML SOLUTION	IV	SOLUTION
Vinorelbine Tartrate 50 MG/5ML SOLUTION	IV	SOLUTION
Virazole 6 GM RECON SOLN	IN	RECON SOLN
Vivimusta 100 MG/4ML SOLUTION	IV	SOLUTION
Vivitrol 380 MG RECON SUSP	IM	RECON SUSP
Voriconazole 200 MG RECON SOLN	IV	RECON SOLN
Vpriv 400 UNIT RECON SOLN	IV	RECON SOLN
Vyepti 100 MG/ML SOLUTION	IV	SOLUTION
Vyvgart 400 MG/20ML SOLUTION	IV	SOLUTION
Vyvgart Hytrulo 180-2000 MG-UNIT/ML SOLUTION	SC	SOLUTION
Vyxeos 44-100 MG RECON SUSP	IV	RECON SUSP
Winrevair 2 x 45 MG KIT	SC	KIT
Winrevair 2 x 60 MG KIT	SC	KIT
Winrevair 45 MG KIT	SC	KIT
Winrevair 60 MG KIT	SC	KIT
WinRho SDF 1500 UNIT/1.3ML SOLUTION	IJ	SOLUTION
WinRho SDF 15000 UNIT/13ML SOLUTION	IJ	SOLUTION
WinRho SDF 2500 UNIT/2.2ML SOLUTION	IJ	SOLUTION
WinRho SDF 5000 UNIT/4.4ML SOLUTION	IJ	SOLUTION
Xembify 1 GM/5ML SOLUTION	SC	SOLUTION
Xembify 10 GM/50ML SOLUTION	SC	SOLUTION
Xembify 2 GM/10ML SOLUTION	SC	SOLUTION
Xembify 4 GM/20ML SOLUTION	SC	SOLUTION
Xenleta 150 MG/15ML SOLUTION	IV	SOLUTION
Xenpozyme 20 MG RECON SOLN	IV	RECON SOLN
Xenpozyme 4 MG RECON SOLN	IV	RECON SOLN
Xeomin 100 UNIT RECON SOLN	IM	RECON SOLN

MEDICATION NAME	ROUTE	DOSE FORM
Xeomin 200 UNIT RECON SOLN	IM	RECON SOLN
Xeomin 50 UNIT RECON SOLN	IM	RECON SOLN
Xerava 100 MG RECON SOLN	IV	RECON SOLN
Xerava 50 MG RECON SOLN	IV	RECON SOLN
Xipere 40 MG/ML SUSPENSION	IO	SUSPENSION
Xopenex 0.31 MG/3ML NEBU SOLN	IN	NEBU SOLN
Xopenex 0.63 MG/3ML NEBU SOLN	IN	NEBU SOLN
Xopenex 1.25 MG/3ML NEBU SOLN	IN	NEBU SOLN
Xopenex Concentrate 1.25 MG/0.5ML NEBU SOLN	IN	NEBU SOLN
Xylocaine Dental 2 %-1:100000 SOLUTION	IJ	SOLUTION
Xylocaine Dental 2 %-1:50000 SOLUTION	IJ	SOLUTION
Xylocaine-MPF/Epinephrine 1 %-1:200000 SOLUTION	IJ	SOLUTION
Xylocaine-MPF/Epinephrine 1.5 %-1:200000 SOLUTION	IJ	SOLUTION
Xylocaine-MPF/Epinephrine 2 %-1:200000 SOLUTION	IJ	SOLUTION
Xylocaine/Epinephrine 0.5 %-1:200000 SOLUTION	IJ	SOLUTION
Xylocaine/Epinephrine 1 %-1:100000 SOLUTION	IJ	SOLUTION
Xylocaine/Epinephrine 2 %-1:100000 SOLUTION	IJ	SOLUTION
Yervoy 200 MG/40ML SOLUTION	IV	SOLUTION
Yervoy 50 MG/10ML SOLUTION	IV	SOLUTION
Yondelis 1 MG RECON SOLN	IV	RECON SOLN
Yupelri 175 MCG/3ML SOLUTION	IN	SOLUTION
Zaltrap 100 MG/4ML SOLUTION	IV	SOLUTION
Zaltrap 200 MG/8ML SOLUTION	IV	SOLUTION
Zanosar 1 GM RECON SOLN	IV	RECON SOLN
Zemaira 1000 MG RECON SOLN	IV	RECON SOLN
Zemaira 4000 MG RECON SOLN	IV	RECON SOLN
Zemaira 5000 MG RECON SOLN	IV	RECON SOLN
Zemdri 500 MG/10ML SOLUTION	IV	SOLUTION
Zemplar 1 MCG CAP	PO	CAP
Zemplar 2 MCG CAP	PO	CAP
Zemplar 2 MCG/ML SOLUTION	IV	SOLUTION
Zemplar 5 MCG/ML SOLUTION	IV	SOLUTION
Zepzelca 4 MG RECON SOLN	IV	RECON SOLN
Zerbaxa 1.5 (1-0.5) GM RECON SOLN	IV	RECON SOLN
Zevalin Y-90 3.2 MG/2ML KIT	IV	KIT
Ziextenzo 6 MG/0.6ML SOLN PRSYR	SC	SOLN PRSYR
Zilretta 32 MG SRER	IX	
Zinplava 1000 MG/40ML SOLUTION	IV	SOLUTION
Zirabev 100 MG/4ML SOLUTION	IV	SOLUTION
Zirabev 400 MG/16ML SOLUTION	IV	SOLUTION
Zofran 4 MG TAB	PO	TAB

MEDICATION NAME	ROUTE	DOSE FORM
Zoladex 10.8 MG IMPLANT	SC	IMPLANT
Zoladex 3.6 MG IMPLANT	SC	IMPLANT
Zoledronic Acid 4 MG/100ML SOLUTION	IV	SOLUTION
Zoledronic Acid 4 MG/5ML CONC	IV	CONC
Zoledronic Acid 5 MG/100ML SOLUTION	IV	SOLUTION
Zortress 0.25 MG TAB	PO	TAB
Zortress 0.5 MG TAB	PO	TAB
Zortress 0.75 MG TAB	PO	TAB
Zortress 1 MG TAB	PO	TAB
Zulresso 100 MG/20ML SOLUTION	IV	SOLUTION
Zuplenz 4 MG FILM	PO	FILM
Zuplenz 8 MG FILM	PO	FILM
Zynlonta 10 MG RECON SOLN	IV	RECON SOLN
Zynyz 500 MG/20ML SOLUTION	IV	SOLUTION
ZyPREXA Relprevv 210 MG RECON SUSP	IM	RECON SUSP
ZyPREXA Relprevv 300 MG RECON SUSP	IM	RECON SUSP
ZyPREXA Relprevv 405 MG RECON SUSP	IM	RECON SUSP