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.

REQUIRED MEDICAL INFORMATION
Postmenopausal 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: documented worsening BMD, following at least two years of therapy with 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, 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

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
N/A

ABIRATERONE (ZYTIGA)

MEDICATION(S)
ABIRATERONE ACETATE

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Being used with androgen receptor inhibitor (e.g. Erleada, Xtandi). Prior failure of other abiraterone formulation (e.g. Yonsa).

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
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
N/A

ADALIMUMAB (HUMIRA)

MEDICATION(S)
HUMIRA, HUMIRA PEDIATRIC CROHNS START, HUMIRA PEN, HUMIRA PEN-CD/UC/HS STARTER, HUMIRA PEN-PEDIATRIC UC START, HUMIRA PEN-PS/UV/ADOL HS START, HUMIRA PEN-PSOR/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.
Juvenile Idiopathic Arthritis (JIA): patient has tried one DMARD or has a medical reason why MTX cannot be used.
Psoriatic Arthritis (PsA): patient has tried one DMARD or has a medical reason why MTX, leflunomide, and sulfasalazine cannot be used.
Rheumatoid Arthritis (RA): patient has tried one DMARD or has medical reason why MTX, hydroxychloroquine, and sulfasalazine cannot be used.
Ulcerative Colitis (UC): patient has tried a corticosteroid (e.g. prednisone) or an immunomodulator (e.g. azathioprine) or has a medical reason why a corticosteroid cannot be used.

AGE RESTRICTION

Plaque Psoriasis: 18 years of age or older. JIA: 2 years of age or older.

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

N/A

ADAPALENE (DIFFERIN)

MEDICATION(S)
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. Approved without prior authorization if less than 40 years of age.

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
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
Length of therapy will be based on FDA labeling and current NCCN guidelines.

OTHER CRITERIA
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
18 years of age or older.

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Length of therapy will be based on FDA labeling and current NCCN guidelines.

OTHER CRITERIA
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 ACE inhibitor (e.g. lisinopril) and one of the following drug classes: ARB (e.g. losartan), 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
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
Required medical information will be aligned with FDA labeling and current NCCN guidelines.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
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 condition did not get better with use of an antispasmodic or antidiarrheal drug. 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
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
Being used by itself or with another drug that is not fulvestrant.

REQUIRED MEDICAL INFORMATION
Postmenopausal woman or man with hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative breast cancer that has come back or spread to other areas while on or after hormone therapy and has tested positive for an abnormal PIK3CA gene.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
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
18 years of age or older.

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
N/A

AMIFAMPRIDINE (RUZURGI)

MEDICATION(S)
RUZURGI

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Being used with another aminopyridine drug (e.g. dalfampridine, Firdapse). History of seizures. Allergy to aminopyridine.

REQUIRED MEDICAL INFORMATION
Diagnosis confirmed by proximal muscle weakness and one of the following tests: positive anti-P/Q-type voltage-gated calcium channel (VGCC) antibody test OR compound muscle action potential (CMAP).

AGE RESTRICTION
6 years of age or older.

PRESCRIBER RESTRICTION
Neurologist

COVERAGE DURATION
Plan year

OTHER CRITERIA
N/A

AMIFAMPRIDINE PHOSPHATE (FIRDAPSE)

MEDICATION(S)
FIRDAPSE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Being used with another aminopyridine drug (e.g. dalfampridine, Ruzurgi).
History of seizures.
Allergy to aminopyridine.

REQUIRED MEDICAL INFORMATION
Medical reason for not using Ruzurgi and diagnosis confirmed by proximal muscle weakness and one of the following tests: positive anti-P/Q-type voltage-gated calcium channel (VGCC) antibody test OR compound muscle action potential (CMAP).

AGE RESTRICTION
18 years of age or older.

PRESCRIBER RESTRICTION
Neurologist

COVERAGE DURATION
Plan year

OTHER CRITERIA
N/A

APALUTAMIDE (ERLEADA)

MEDICATION(S)
ERLEADA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Being used with androgen receptor inhibitor (e.g. Xtandi, Zytiga).

REQUIRED MEDICAL INFORMATION
Prostate cancer, castration-sensitive: disease has spread to other areas of the body (metastatic) and being used with a gonadotropin-releasing hormone (GnRH) analog (e.g. Zoladex, leuprolide) if no prior removal of the testes (bilateral orchiectomy). Prostate cancer, castration-resistant: prior GnRH analog therapy or bilateral orchiectomy AND non-metastatic disease with rising PSA levels despite androgen deprivation therapy (ADT).

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
N/A

APOMORPHINE (APOKYN)

MEDICATION(S)
APOKYN

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Being used with a 5HT3 antagonist drug (e.g. ondansetron, alosetron).

REQUIRED MEDICAL INFORMATION
Loss of control of body movements due to advanced Parkinson's disease (hypomobility): using at least two antiparkinsonian drugs, one of which is levodopa/carbidopa and being used with an anti-emetic drug (e.g. trimethobenzamide).

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Neurologist

COVERAGE DURATION
Plan year

OTHER CRITERIA
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
N/A

ARIPIPRAZOLE (ABILIFY MAINTENA ER)

MEDICATION(S)
ABILIFY MAINTENA

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
Treatment failure with at least one oral atypical antipsychotic (risperidone, ziprasidone, quetiapine, olanzapine, aripiprazole).

AGE RESTRICTION
18 years of age or older.

PRESCRIBER RESTRICTION
Psychiatrist

COVERAGE DURATION
Plan year

OTHER CRITERIA
Excluded under Part D if covered by Part B.

ARIPIPRAZOLE LAUROXIL (ARISTADA AND ARISTADA INITIO)

MEDICATION(S)
ARISTADA, ARISTADA INITIO

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
Treatment failure with at least one oral atypical antipsychotic (risperidone, ziprasidone, quetiapine, olanzapine, aripiprazole).

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Schizophrenia: Psychiatrist

COVERAGE DURATION
Aristada: plan year
Aristada Initio: one time to start/restart Aristada treatment

OTHER CRITERIA
Aristada Initio: single use along with oral aripiprazole

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
Psychiatrist

COVERAGE DURATION
Plan year

OTHER CRITERIA
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
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
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
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
PCP or Toxoplasmosis prevention or treatment: patient is immunocompromised or at high risk of infection and 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: 7days, PCP/Toxo prevention: plan year

OTHER CRITERIA
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
18 years of age or older.

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
N/A

AXITINIB (INLYTA)

MEDICATION(S)
INLYTA

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
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
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
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
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
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: seropositive disease with ANA titer of 1:80 or more OR positive anti-Smith antibody OR Anti-dsDNA antibody of 30 IU/mL or more OR positive ANA Direct and anti-dsDNA antibody of 9 or more and patient is currently taking one or more of the following: prednisone, methylprednisolone, azathioprine, methotrexate, mycophenolate, chloroquine, hydroxychloroquine. Ongoing use requires prescriber statement to show patients clinical status has not worsened and patient has benefited from treatment as evidenced by one or more of the following: less number or severity of SLE flares, daily steroid dose has been lowered, or improvement in physician global assessment.
Lupus Nephritis: being added to standard SLE therapy (e.g. corticosteroids, immunomodulators).

AGE RESTRICTION
Lupus Nephritis: 18 years of age or older.
SLE: 5 years of age or older

PRESCRIBER RESTRICTION
SLE: Rheumatologist
Lupus Nephritis: Rheumatologist or Nephrologist

COVERAGE DURATION
plan year

OTHER CRITERIA

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
12 years of age or older

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
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
N/A

BEXAROTENE (TARGRETIN TOPICAL GEL)

MEDICATION(S)
TARGRETIN 1 % GEL

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
N/A

BEXAROTENE CAPSULE (TARGRETIN)

MEDICATION(S)
BEXAROTENE

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
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
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
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
Required medical information will be aligned with FDA labeling and current NCCN guidelines and for first line therapy for CML and ALL medical reason why imatinib cannot be used.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
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 of aripiprazole or medical reason for not using aripiprazole.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Psychiatrist

COVERAGE DURATION
Plan year

OTHER CRITERIA
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
18 years of age or older.

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
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. Autoimmune hepatitis: gastroenterologist, hepatologist, or infectious disease specialist.

COVERAGE DURATION
CD initial: adults 8 weeks. CD maintenance: 3 months. Autoimmune hepatitis: plan year

OTHER CRITERIA

Coverage duration: Microscopic colitis – initial: 8 weeks, ongoing use: plan year

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
Autoimmune hepatitis: patient has liver cirrhosis.

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, microscopic colitis: Gastroenterologist. Autoimmune hepatitis: Gastroenterologist, Hepatologist or Infectious Disease.

COVERAGE DURATION
UC, microscopic colitis: 8 weeks. Autoimmune hepatitis: 6 months.

OTHER CRITERIA
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
6 months or older.

PRESCRIBER RESTRICTION
Endocrinologist

COVERAGE DURATION
Plan year

OTHER CRITERIA
Excluded under part D if covered by part B.

BUTALBITAL CONTAINING PRODUCTS

MEDICATION(S)
BAC, BUTALBITAL-APAP-CAFFEINE 50-325-40 MG TAB, BUTALBITAL-ASPIRIN-CAFFEINE 50-325-40 MG TAB

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 and if 65 years of age and older, prescriber confirms the benefits of the drug outweigh any risks and will monitor for side effects.

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
N/A

C1 ESTERASE INHIBITOR (BERINERT)

MEDICATION(S)
BERINERT

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
N/A

C1 ESTERASE INHIBITOR (CINRYZE)

MEDICATION(S)
CINRYZE

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, Haegarda).

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
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
N/A

C1 ESTERASE INHIBITOR (RUCONEST)

MEDICATION(S)
RUCONEST

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
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
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
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: Rheumatologist

COVERAGE DURATION
Plan year

OTHER CRITERIA
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 of two of the following anti-seizure drugs: valproic acid, topiramate, levetiracetam, and clobazam.
Lennox-Gastaut syndrome: trial of two of the following anti-seizure drugs: clonazepam, felbamate, lamotrigine, topiramate, and valproic acid.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
N/A

CAPLACIZUMAB-YHDP (CABLIVI)

MEDICATION(S)
CABLIVI

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Continuation from inpatient hospital Cablivi treatment.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
58 days for inpatient or 103 days for outpatient plasma exchange

OTHER CRITERIA
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
N/A

CARGLUMIC ACID (CARBAGLU)

MEDICATION(S)
CARBAGLU

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
N/A

CARIPRAZINE HYDROCHLORIDE (VRAYLAR)

MEDICATION(S)
VRAYLAR

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 to one preferred atypical antipsychotic agent (e.g. aripiprazole, clozapine, olanzapine, quetiapine, risperidone, ziprasidone).

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Psychiatrist

COVERAGE DURATION
Plan year

OTHER CRITERIA
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.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
2 months

OTHER CRITERIA
Ongoing use: continued neutropenia, culture remains positive, or ongoing symptoms.

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
18 years of age or older.

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
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
18 years of age or older.

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
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
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 of valproic acid.
Lennox-Gastaut syndrome: trial of two of the following anti-seizure drugs: clonazepam, felbamate, lamotrigine, topiramate, and valproic acid.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
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 valproate and side effect to preferred clobazam (Onfi) that is not seen with Sympazan.
Lennox-Gastaut Syndrome: side effect to preferred clobazam (Onfi) that is not seen with Sympazan.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
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
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
18 years of age or older.

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
N/A

CORTICOTROPIN (H.P. ACTHAR GEL)

MEDICATION(S)
ACTHAR

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

AGE RESTRICTION
Infantile spasms: patient is under 2 years of age

PRESCRIBER RESTRICTION
Infantile spasms: pediatric 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
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
18 years of age or older.

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
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
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
N/A

CYSTEAMINE DELAYED RELEASE (PROCYSBI)

MEDICATION(S)
PROCYSBI

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
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
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
Oncologist

COVERAGE DURATION
Plan year

OTHER CRITERIA
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: scored between 8-45 seconds on a 25-foot walking test. 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
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)

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Chronic kidney disease (CKD), initial: anemia confirmed by a hemoglobin (Hgb) is 10g/dL or less or a Hct of 30% or less AND 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. Ongoing use: Hgb level of less than or equal to 11g/dl or a Hct of 33% or less.

Myelosuppressive chemo related anemia, initial: patient is on chemo or completed last dose within last 8 wks for solid tumor, lymphoma, or lymphocytic leukemia or patient has multiple myeloma (MM) on Revlimid tx, Hgb is less than 10g/dl or a Hct 30% or less AND one of the following: target Hgb level has not been met or maintained with at least 8 weeks of max dose Retacrit OR patient has a contraindication to 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. Ongoing use: patient is on chemo OR on Revlimid tx for MM OR final dose of chemo was within the last 8wks and Hgb is less than or equal to 12g/dl or Hct is 36% or less before the next Aranesp dose.

MDS, initial: Hgb is less than or equal to 10g/dL or HCT is 30% or less (symptomatic anemia), EPO level is less than or equal to 500U/ml, AND one of the following: target Hgb level has not been met or maintained with at least 8 weeks of max dose Retacrit OR patient has a contraindication to 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. Ongoing use: current Hgb is less than or equal to 12g/dl or Hct is 36% or less, and Hgb rose at least 1.5g/dl or reduced number of blood transfusions.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
MDS, CKD: 6 months

Anemia due to chemo: 12 weeks no more than 8 weeks after last dose of chemo

OTHER CRITERIA
Excluded under Part D if covered by Part B.

DAROLUTAMIDE (NUBEQA)

MEDICATION(S)
NUBEQA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Being used with androgen receptor inhibitor (e.g. Erleada, Xtandi).

REQUIRED MEDICAL INFORMATION
Prostate cancer: cancer has not spread to other parts of the body and no confirmed by rising PSA levels despite medical or surgical treatment that lowers testosterone (castration resistant disease) and being used with a gonadotropin-releasing hormone (GnRH) analog if no prior removal of the testes (bilateral orchiectomy).

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
N/A

DASATINIB (SPRYCEL)

MEDICATION(S)
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
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
Required medical information will be aligned with FDA labeling and current NCCN guidelines.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
N/A

DEFERIPRONE (FERRIPROX)

MEDICATION(S)
DEFERIPRONE, FERRIPROX 100 MG/ML SOLUTION, FERRIPROX 1000 MG TAB, FERRIPROX TWICE-A-DAY

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 deferasirox.

AGE RESTRICTION
18 years of age or older.

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
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: documented worsening BMD, following at least two years of therapy with a bisphosphonate (e.g. alendronate, ibandronate, 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

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
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
Medical reason why patient cannot use preferred dexamethasone tablet.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
N/A

DIGOXIN (LANOXIN – HIGH RISK MEDICATION)

MEDICATION(S)
DIGITEK 250 MCG TAB, DIGOX 250 MCG TAB, DIGOXIN 250 MCG TAB

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Prescriber is aware that doses of 250 mcg/day can be potentially harmful in older adults 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
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
Cluster Headache: Neurologist or headache specialist.

COVERAGE DURATION
Plan year

OTHER CRITERIA

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, 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.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
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
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.

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
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
Documentation to confirm a swallowing defect that does not allow for the use duloxetine delayed-release capsule.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
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
N/A

ELEXACAFTOR/TEZACAFTOR/IVACAFTOR (TRIKAFTA)

MEDICATION(S)
TRIKAFTA

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 copy of F508del mutation in the CFTR gene.

AGE RESTRICTION
6 years of age or older.

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
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 Gaucher's disease.
Patient is an ultra-rapid CYP2D6 metabolizer.

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
18 years of age or older.

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
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

EXCLUSION CRITERIA
Chronic immune thrombocytopenia (ITP): being used with another thrombopoietin receptor agonist (TPO-RA) or fostamatinib (Tavalisse).
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).
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.

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

N/A

ENASIDENIB MESYLATE (IDHIFA)

MEDICATION(S)
IDHIFA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
AML: 18 years of age or older

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
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
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
NSCLC: 18 years of age or older.
Solid Tumors: 12 years of age or older.

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
N/A

ENZALUTAMIDE (XTANDI)

MEDICATION(S)
XTANDI

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Being used with androgen receptor inhibitor (e.g. Erleada, Zytiga).

REQUIRED MEDICAL INFORMATION
Prostate cancer, castration-sensitive: disease has spread to other areas of the body (metastatic) and being used with a gonadotropin-releasing hormone (GnRH) analog (e.g. Zoladex, leuprolide) if no prior removal of the testes (bilateral orchiectomy). Prostate cancer, castration-resistant: prior GnRH analog therapy or bilateral orchiectomy AND metastatic disease or non-metastatic disease with rising PSA levels despite androgen deprivation therapy (ADT).

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
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)
anemia due to rheumatoid arthritis (RA)
anemia due to ribavirin therapy

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Chronic kidney disease (CKD), initial use: anemia confirmed by a hemoglobin level of 10g/dL or less or a Hct of 30% or less. Ongoing use: Hgb level of less than or equal to 11g/dl or a Hct less than or equal to 33%. Anemia due to cancer drug therapy (myelosuppressive chemotherapy), initial use: patient is on chemo or completed last dose within last 8 wks for solid tumor, lymphoma, or lymphocytic leukemia or patient has multiple myeloma (MM) on Revlimid tx, Hgb is less than 10g/dl or Hct is less than or equal to 30%. Ongoing use: patient is receiving chemo OR currently on Revlimid tx for MM OR final dose of chemo was within the last 8wks and Hgb is less than or equal to 12g/dl or Hct is less than or equal to 36% before the next Retacrit dose. MDS, initial use: Hgb is less than or equal to 10g/dL or HCT is less than or equal to 30% (symptomatic anemia), and EPO level is less than or equal to 500U/ml. Ongoing use: current Hgb is less than or equal to 12g/dl or Hct is less than or equal to 36%, and Hgb rose at least 1.5g/dl or reduced number of blood transfusions since starting Retacrit. HIV: currently on zidovudine and Hgb is less than or equal to 10g/dl or Hct is less than or equal to 30%. Anemia prior to a planned surgery: Hgb is less than 13g/dl and patient is likely to have significant blood loss and need of blood transfusions during surgery.
Anemia due to RA, initial: current Hgb less than or equal to 10 g/dL or HCT less than or equal to 30%, and anemia is not acute or caused by correctable etiology (e.g. occult blood loss due to gastritis). Ongoing use: current Hgb is 12 g/dL or less or Hct is 36% or lower.
Hepatitis C on ribavirin therapy: at least a 3 g/dL drop in Hgb within one month on ribavirin, or Hgb is 12 g/dL or less or Hct is 36% or lower.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
MDS, CKD: 6 months
Anemia due to zidovudine: 12 weeks

OTHER CRITERIA
Coverage duration for anemia due to chemo: 12 weeks and no more than 8 weeks after last dose of chemo. Coverage duration for planned surgery: 1 month; RA: 6months; anemia due to ribavirin: duration of ribavirin therapy.

Excluded under Part D if covered by Part B.

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
18 years of age or older.

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
N/A

ERENUMAB-AOOE (AIMOVIG)

MEDICATION(S)
AIMOVIG, AIMOVIG (140 MG DOSE)

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
18 years of age or older.

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
N/A

ERLOTINIB (TARCEVA)

MEDICATION(S)
ERLOTINIB HCL

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
N/A

ESTROGEN PRODUCTS (HIGH RISK MEDICATION)

MEDICATION(S)
DOTTI, ESTRADIOL 0.025 MG/24HR PATCH TW, ESTRADIOL 0.025 MG/24HR PATCH WK, ESTRADIOL 0.0375 MG/24HR PATCH TW, ESTRADIOL 0.0375 MG/24HR PATCH WK, ESTRADIOL 0.05 MG/24HR PATCH TW, ESTRADIOL 0.05 MG/24HR PATCH WK, ESTRADIOL 0.06 MG/24HR PATCH WK, ESTRADIOL 0.075 MG/24HR PATCH TW, ESTRADIOL 0.075 MG/24HR PATCH WK, ESTRADIOL 0.1 MG/24HR PATCH TW, ESTRADIOL 0.1 MG/24HR PATCH WK, ESTRADIOL 0.5 MG TAB, ESTRADIOL 1 MG TAB, ESTRADIOL 2 MG TAB, FYAVOLV, JEVANTIQUE LO, JINTELI, LYLLANA, MENEST, NORETHINDRONE-ETH ESTRADIOL

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
To help with symptoms of dryness, discomfort, pain in the vaginal area due to menopause: patient has tried the safer drugs estradiol vaginal cream and estradiol vaginal ring (Estring), and prescriber confirms the benefits of the drug outweigh any risks and will monitor for side effects. Other FDA indications: 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
N/A

ETANERCEPT (ENBREL – KIT, SYRINGE, SURECLICK)

MEDICATION(S)
ENBREL, 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. polyarticular Juvenile Idiopathic Arthritis (pJIA): patient has tried one DMARD or has a medical reason why methotrexate (MTX) cannot be used. 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): patient has tried one DMARD or has medical reason why MTX, hydroxychloroquine, and sulfasalazine 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
PsO: 4 years of age or older. pJIA: 2 years of age or older.

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

COVERAGE DURATION

PsO: initial 12 weeks, ongoing plan year. HS: 6 months. Other indications: plan year

OTHER CRITERIA

Coverage Duration: all other indications: plan year

EVEROLIMUS (AFINITOR DISPERZ)

MEDICATION(S)
AFINITOR DISPERZ, 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
N/A

EVEROLIMUS (AFINITOR)

MEDICATION(S)
AFINITOR 10 MG TAB, 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
N/A

EVEROLIMUS (ZORTRESS)

MEDICATION(S)
EVEROLIMUS 0.25 MG TAB, EVEROLIMUS 0.5 MG TAB, EVEROLIMUS 0.75 MG TAB, ZORTRESS 1 MG TAB

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Trial of or medical reason for not using mycophenolate and tacrolimus.

AGE RESTRICTION
18 years of age or older.

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Excluded under part D if covered by part B.

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
Hyperlipidemia: 18 years of age or older. HoFH: 13 years of age or older.

PRESCRIBER RESTRICTION
HoFH: Cardiologist or Endocrinologist

COVERAGE DURATION
Plan year

OTHER CRITERIA
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
18 years of age or older.

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
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
Trial of two of the following anti-seizure drugs: valproic acid, topiramate, levetiracetam, and clobazam.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
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.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
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: 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 mo. HIV: plan year

OTHER CRITERIA

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
Excluded under Part D if covered by Part B.

FINGOLIMOD HCL (GILENYA)

MEDICATION(S)
GILENYA 0.5 MG CAP

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
N/A

FOSTAMATINIB (TAVALISSE)

MEDICATION(S)
TAVALISSE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Being used with another thrombopoietin receptor agonists (TPO-RA).

REQUIRED MEDICAL INFORMATION
Chronic immune thrombocytopenia (ITP), initial use: platelet count is less than 30,000 cells/mcl, and patient has tried one of the following treatments: corticosteroids (e.g. prednisone), IVIG, anti-D, and splenectomy or has a medical reason not to use (contraindication) corticosteroids, IVIG, and anti-D. Ongoing use: patient's platelet count has increased from baseline.

AGE RESTRICTION
18 years of age or older.

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
N/A

GEFITINIB (IRESSA)

MEDICATION(S)
IRESSA

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
N/A

GILTERITINIB FUMARATE (XOSPATA)

MEDICATION(S)
XOSPATA

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
N/A

GLASDEGIB MALEATE (DAURISMO)

MEDICATION(S)
DAURISMO

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
N/A

GLATIRAMER (COPAXONE)

MEDICATION(S)
COPAXONE 40 MG/ML SOLN PRSYR

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
N/A

GLATIRAMER (COPAXONE, GLATOPA)

MEDICATION(S)
COPAXONE 20 MG/ML SOLN PRSYR

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
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
12 years of age or older.

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
N/A

GLYCEROL PHENYLBUTYRATE (RAVICTI)

MEDICATION(S)
RAVICTI

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
N/A

HALOBETASOL/TAZAROTENE FOAM (DUOBRII)

MEDICATION(S)
DUOBRII

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Trial of either topical tazarotene or a topical corticosteroid in the very high potency group.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
N/A

MEDICATION(S)

AMITRIPTYLINE HCL, CHLORDIAZEPOXIDE HCL, CLOMIPRAMINE HCL, CYCLOBENZAPRINE HCL 10 MG TAB, CYCLOBENZAPRINE HCL 5 MG TAB, CYPROHEPTADINE HCL 4 MG TAB, DICYCLOMINE HCL 10 MG CAP, 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, IMIPRAMINE HCL, INDOMETHACIN 25 MG CAP, INDOMETHACIN 50 MG CAP, MEPROBAMATE, METHOCARBAMOL 500 MG TAB, METHOCARBAMOL 750 MG TAB, PHENOBARBITAL, PROMETHAZINE HCL 12.5 MG TAB, PROMETHAZINE HCL 25 MG TAB, PROMETHAZINE HCL 25 MG/ML SOLUTION, PROMETHAZINE HCL 50 MG TAB, PROMETHAZINE HCL 50 MG/ML SOLUTION, SCOPOLAMINE, 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

N/A

IBANDRONATE VIAL (BONIVA IV)

MEDICATION(S)
IBANDRONATE SODIUM 3 MG/3ML SOLUTION

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Postmenopausal osteoporosis: T-score of ?2.5 or lower or history of non-traumatic fracture AND one of the following: documented worsening BMD on an oral bisphosphonate, or documented non-traumatic fracture on an oral bisphosphonate, or patient is not able to take an oral bisphosphonate or had a GI side effect to a monthly oral bisphosphonate that caused discontinuation.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Excluded under part D if covered by part B.

IBRUTINIB (IMBRUVICA)

MEDICATION(S)
IMBRUVICA 140 MG CAP, IMBRUVICA 280 MG TAB, IMBRUVICA 420 MG TAB, IMBRUVICA 560 MG TAB, IMBRUVICA 70 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
N/A

ICATIBANT (FIRAZYR)

MEDICATION(S)
ICATIBANT ACETATE

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
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
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
Patient has tried one preferred atypical antipsychotic drug (e.g. aripiprazole, clozapine, olanzapine, quetiapine, risperidone, ziprasidone) or has a medical reason not to use preferred atypical antipsychotic drugs.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Psychiatrist

COVERAGE DURATION
Plan year

OTHER CRITERIA
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
Tenosynovial giant cell tumor (TGCT): Orthopedic surgeon or Oncologist

COVERAGE DURATION
Plan year

OTHER CRITERIA
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.

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.

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.

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.

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.

INFIGRANTINIB (TRUSELTIQ)

MEDICATION(S)
TRUSELTIQ (100MG DAILY DOSE), TRUSELTIQ (125MG DAILY DOSE), TRUSELTIQ (50MG DAILY DOSE), TRUSELTIQ (75MG 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
18 years of age or older

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
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
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
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

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.

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
N/A

ITRACONAZOLE (SPORANOX)

MEDICATION(S)
ITRACONAZOLE 100 MG CAP

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) or coccidiomycosis, 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)

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Blastomycosis, Histoplasmosis, Sporotrichosis, 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, oral terbinafine, or oral fluconazole, 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. Candidiasis, cryptococcosis, or coccidioidomycosis prevention: patient is immunosuppressed/compromised, and patient has tried or has a medical reason for not using fluconazole. Prophylaxis (primary or secondary) or maintenance treatment of talaromycosis (Talaromyces marneffei: Patient with HIV infection.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION

Tinea Versicolor:1wk Tinea Capitas:1mo Onyc:3mo All other tinea:2wk ABPA:4mo All other dx: plan year

OTHER CRITERIA

N/A

IVABRADINE (CORLANOR)

MEDICATION(S)
CORLANOR

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
N/A

IVACAFTOR (KALYDECO)

MEDICATION(S)
KALYDECO

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
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
18 years of age or older.

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
N/A

IXAZOMIB CITRATE (NINLARO)

MEDICATION(S)
NINLARO

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
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
PSO: 6 years of age or older.
PsA, SpA: 18 years of age or older.

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

COVERAGE DURATION
PsO, initial: 12 weeks - ongoing use: plan year
All other indications: plan year

OTHER CRITERIA

N/A

LACOSAMIDE (VIMPAT IV)

MEDICATION(S)
VIMPAT 200 MG/20ML SOLUTION

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Patient has tried two anti-seizure drugs and has a medical reason for not using oral form of Vimpat.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
N/A

LANREOTIDE ACETATE (SOMATULINE DEPOT)

MEDICATION(S)
SOMATULINE DEPOT

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.

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
N/A

LAROTRECTINIB SULFATE (VITRAKVI)

MEDICATION(S)
VITRAKVI

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
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
3 years of age or older.

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
N/A

LENALIDOMIDE (REVLIMID)

MEDICATION(S)
REVLIMID

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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
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
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.

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
N/A

LEVOLEUCOVORIN CALCIUM (FUSILEV)

MEDICATION(S)
LEVOLEUCOVORIN CALCIUM 50 MG RECON SOLN, LEVOLEUCOVORIN CALCIUM PF

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Side effect with the use of leucovorin that would not happen with the use of Fusilev.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Excluded under Part D if covered by Part B.

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 formulary drugs that treat major depressive disorder (MDD).

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
N/A

LIDOCAINE PATCH (LIDODERM)

MEDICATION(S)
LIDOCAINE 5 % PATCH

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
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 Infectious Disease 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

N/A

LOMITAPIDE MESYLATE (JUXTAPID)

MEDICATION(S)
JUXTAPID

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Homozygous Familial Hypercholesterolemia (HoFH), initial use: diagnosis confirmed by a genetic test confirming LDL-R genetic mutations or clinical evidence supporting HoFH, AND patient has tried a combination of lipid-lowering drugs containing a maximally tolerated statin and a non-statin lipid lowering drug or has documented statin intolerance and patient's condition did not respond well enough to a non-statin lipid lowering drug, AND being used with a standard lipid lowering regimen containing a maximally tolerated statin and a non-statin lipid lowering drug or a non-statin lipid lowering drug for patient with documented statin intolerance.

AGE RESTRICTION
18 years of age or older.

PRESCRIBER RESTRICTION
Cardiologist or Endocrinologist

COVERAGE DURATION
Plan year

OTHER CRITERIA
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 long-acting narcotic, 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

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
18 years of age or older.

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
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
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).

AGE RESTRICTION
18 years of age or older.

PRESCRIBER RESTRICTION
Psychiatrist

COVERAGE DURATION
Plan year

OTHER CRITERIA
N/A

LURASIDONE (LATUDA)

MEDICATION(S)
LATUDA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Patient has tried one preferred atypical antipsychotic drug such as aripiprazole, olanzapine, quetiapine, risperidone, or ziprasidone.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Schizophrenia: Psychiatrist

COVERAGE DURATION
Plan year

OTHER CRITERIA
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 AND patient has tried Letairis.

AGE RESTRICTION
18 years of age or older.

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
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 confirmed by an increase in growth velocity of more than 2 cm in the past year and evidence of delayed bone age.

AGE RESTRICTION
Patient is between 2 to 18 years of age.

PRESCRIBER RESTRICTION
Endocrinologist

COVERAGE DURATION
Plan year

OTHER CRITERIA
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
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

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
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
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 (e.g. Xolair, Cinqair, Dupixent, Fasenra). Eosinophilic asthma: being used as a single agent.

REQUIRED MEDICAL INFORMATION
Eosinophilic asthma, initial use: eosinophil blood count is 150 cells/microliter or more within last six weeks documented treatment failure with recent use of high-dose inhaled corticosteroid along with long-acting beta agonist, 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. 1st reauth: improvement in asthma symptoms confirmed by fewer asthma attacks, a decrease in the dose or how often you use your oral or inhaled steroids, or a reduction in your asthma symptoms (e.g. fewer sick days, less use of a rescue inhaler). 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 inadquate response to oral corticosteroids or hydroxyurea

AGE RESTRICTION
Eosinophilic asthma: 6 years of age or older. EGPA: 18 years of age or older.

PRESCRIBER RESTRICTION
Eosinophilic asthma: Immunologist, Pulmonologist, or Allergist. EGPA: Immunologist, Rheumatologist. HES: Immunologist, Allergist, Hematologist

COVERAGE DURATION
Eosinophilic asthma initial use: 6 mo, ongoing use: plan year EGPA, HES: plan year

OTHER CRITERIA
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
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
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 Amitiza or Movantik.

AGE RESTRICTION
18 years of age or older.

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
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, obesity not associated with generalized Lipodystrophy, partial Lipodystrophy, or non-alcoholic Steatohepatitis (NASH).

REQUIRED MEDICAL INFORMATION
Generalized Lipodystrophy: low leptin level (male under 3.3ng/mL, female under 4ng/mL) and patient needs high doses of insulin (at least 200 Units/day or at least 2 Units/kg/day or using concentrated U-500 insulin) to treat diabetes mellitus, has high triglycerides that has not responded to drug therapy (TG at least 250 mg/dL), or has history of pancreatitis due to high triglycerides.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Endocrinologist

COVERAGE DURATION
Plan year

OTHER CRITERIA
N/A

MIDOSTAURIN (RYDAPT)

MEDICATION(S)
RYDAPT

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
AML and Mastocytosis: plan year

OTHER CRITERIA
N/A

MIFEPRISTONE (KORYLYM)

MEDICATION(S)
KORLYM

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
N/A

MIGLUSTAT (ZAVESCA)

MEDICATION(S)
MIGLUSTAT

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
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
18 years of age or older.

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
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
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 did not respond to corticosteroids or is on corticosteroids and 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.

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
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
Required medical information will be aligned with FDA labeling and current NCCN guidelines and for first line therapy for CML and ALL medical reason why imatinib cannot be used.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
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 or severe disease where FVC is under 50% or DLCO is under 30%

REQUIRED MEDICAL INFORMATION
IPF, initial use: patient has mild to moderate disease confirmed by 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, patient continues to have mild to moderate IPF disease confirmed by the following pulmonary function tests: FVC equal or above 50% and DLCO is equal or over 30%.
Systemic sclerosis-associated or chronic fibrosing interstitial lung disease: pulmonary function tests show FVC equal or over 40% and DLCO equal or over 30% of predicted normal.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Pulmonologist.
SSc-ILD: rheumatologist or pulmonologist.

COVERAGE DURATION
Plan year

OTHER CRITERIA
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
N/A

NITAZOXANIDE (ALINIA)

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

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Stool culture results confirms diagnosis, and for Giardiasis: treatment failure or side effect with metronidazole OR medical reason for not using metronidazole (contraindication).

AGE RESTRICTION
12 years of age or older.

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
3 days (one course)

OTHER CRITERIA
N/A

NITISINONE (ORFADIN)

MEDICATION(S)
NITISINONE

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
N/A

NITISINONE (NITYR)

MEDICATION(S)
NITYR

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
N/A

NITROGLYCERIN RECTAL (RECTIV)

MEDICATION(S)
RECTIV

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
18 years of age or older.

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
one time for 21 days

OTHER CRITERIA
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, Intestinal obstruction, Neuroendocrine Tumor of the lung, Pituitary adenoma, Prevention of postoperative complications of pancreatic surgery, Pancreatic tumors (gastrinoma, glucagonoma, insulinoma), Radiation-induced diarrhea, Recurrent Meningioma, 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 other causes (i.e. infection, underlying GI disease, malabsorption) have been ruled out, and treatment failure or side effect with diphenoxylate/atropine or loperamide.
Intestinal obstruction: intestinal obstruction is due to cancer.
Thymus cancer (thymoma): treatment failure with prior cancer drug therapy.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Acromegaly: Endocrinologist

COVERAGE DURATION
Acromegaly: plan year
Other conditions: 6 months

OTHER CRITERIA
Excluded under Part D if covered by Part B.

OCTREOTIDE ACETATE (SANDOSTATIN)

MEDICATION(S)
OCTREOTIDE ACETATE

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, Intestinal obstruction, 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, Recurrent Meningioma, 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. Intestinal obstruction: intestinal obstruction is due to cancer. Thymus cancer (thymoma): treatment failure with prior cancer drug therapy. Pheochromocytoma and paraganglioma: cancer cannot be removed by surgery or has spread to other areas of the body, and somatostatin receptor positive, and symptomatic (e.g. high blood pressure, headaches, sweating, and/or heart palpitations).

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Acromegaly: Endocrinologist

COVERAGE DURATION
Acromegaly: plan year Other conditions: 6 months

OTHER CRITERIA

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
N/A

OLANZAPINE PAMOATE (ZYPREXA RELPREVV)

MEDICATION(S)
ZYPREXA RELPREVV

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
Treatment failure with at least one oral atypical antipsychotic (e.g. risperidone, ziprasidone) and medical reason why injectable risperidone (Risperdal Consta) cannot be used.

AGE RESTRICTION
18 years of age or older.

PRESCRIBER RESTRICTION
Psychiatrist

COVERAGE DURATION
Plan year

OTHER CRITERIA
Excluded under Part D if covered by Part B.

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
Patient has tried at least one oral atypical antipsychotic (i.e. risperidone, ziprasidone, quetiapine, olanzapine, aripiprazole) or there is a medical reason why all oral atypical antipsychotics cannot be used.

AGE RESTRICTION
18 years of age or older.

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
N/A

OLAPARIB (LYNPARZA)

MEDICATION(S)
LYNPARZA 100 MG TAB, LYNPARZA 150 MG TAB

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
N/A

OMALIZUMAB (XOLAIR)

MEDICATION(S)
XOLAIR

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Allergic asthma: being used with other targeted therapies (e.g. Nucala, Cinqair, Dupixent, Fasenra). Allergic asthma: being used as a single agent.

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, 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. Ongoing use: improvement in asthma symptoms confirmed by one or more of the following: fewer asthma attacks, a decrease in the dose or how often you use your oral or inhaled steroids, or a reduction in your asthma symptoms (e.g. fewer sick days, less use of a rescue inhaler).
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)

AGE RESTRICTION
Allergic asthma: 6 years of age or older. CIU: 12 years of age or older. Polyps: 18 years of age or older

PRESCRIBER RESTRICTION
CIU: Allergist or Immunologist Allergic asthma: Pulmonologist or Immunologist
Nasal polyps: allergist, immunologist, or otolaryngologist.

COVERAGE DURATION

Allergic asthma, initial 6 months, ongoing use: plan year
CIU, nasal polyps: plan year

OTHER CRITERIA

N/A

ORITAVANCIN DIPHOSPHATE (ORBACTIV)

MEDICATION(S)
ORBACTIV

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Medical reason why oral antibiotics cannot be used AND culture and sensitivity report confirm vancomycin-resistant staphylococcus aureus (VRSA), vancomycin-insensitive staphylococcus aureus (VISA), or methicillin-resistant staphylococcus aureus (MRSA) and patient has an allergy or contraindication to vancomycin.

AGE RESTRICTION
18 years of age or older.

PRESCRIBER RESTRICTION
Infectious Disease Specialist

COVERAGE DURATION
One treatment course.

OTHER CRITERIA
N/A

OSIMERTINIB (TAGRISSO)

MEDICATION(S)
TAGRISSO

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
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
N/A

OXANDROLONE (OXANDRIN)

MEDICATION(S)
OXANDROLONE

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

OFF LABEL USES
AIDS wasting and cachexia associated with chronic disease, Turner Syndrome, Severe Burn add on therapy, Alcohol Hepatitis

EXCLUSION CRITERIA
Will be used with Serostim or nandrolone.

REQUIRED MEDICAL INFORMATION
AIDS wasting or cachexia associated with chronic disease, initial use: patient meets one of the following: weighs less than 90% ideal body weight, or has lost 10% or more of usual body weight, or has a baseline BIA or total body DEXA showing body cell mass below 40% in males and 35% in females. Ongoing use: body weight or body cell mass (BCM) has improved or stabilized on oxandrolone.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

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

OTHER CRITERIA
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
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 of risperidone and one other preferred atypical antipsychotic such as aripiprazole, ziprasidone, quetiapine, or olanzapine.

AGE RESTRICTION
Schizophrenia: 12 years of age or older. Schizoaffective disorder: 18 years of age or older.

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
N/A

PALIPERIDONE PALMITATE (INVEGA HAFYERA)

MEDICATION(S)
INVEGA HAFYERA

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
Use of a once-a-month paliperidone palmitate ER injection (e.g., INVEGA SUSTENNA) for at least 4 months OR an every-three-month paliperidone palmitate extended release injectable suspension (e.g., INVEGA TRINZA) for at least one three-month cycle.

AGE RESTRICTION
18 years of age or older.

PRESCRIBER RESTRICTION
Psychiatrist

COVERAGE DURATION
Plan year

OTHER CRITERIA
Excluded under Part D if covered by Part B.

PALIPERIDONE PALMITATE (INVEGA SUSTENNA)

MEDICATION(S)
INVEGA SUSTENNA

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
Treatment failure with at least one oral atypical antipsychotic (risperidone, ziprasidone, quetiapine, olanzapine, aripiprazole).

AGE RESTRICTION
18 years of age or older.

PRESCRIBER RESTRICTION
Psychiatrist

COVERAGE DURATION
Plan year

OTHER CRITERIA
Excluded under Part D if covered by Part B.

PALIPERIDONE PALMITATE (INVEGA TRINZA)

MEDICATION(S)
INVEGA TRINZA

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
Treatment failure with at least one oral atypical antipsychotic (risperidone, ziprasidone, quetiapine, olanzapine, aripiprazole) and use of Invega Sustenna for at least 4 months.

AGE RESTRICTION
18 years of age or older.

PRESCRIBER RESTRICTION
Psychiatrist

COVERAGE DURATION
Plan year

OTHER CRITERIA
Excluded under Part D if covered by Part B.

PANOBINOSTAT LACTATE (FARYDAK)

MEDICATION(S)
FARYDAK

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
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
18 years of age or older.

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N/A

PART D VS PART B

MEDICATION(S)

ABELCET, ACETYLCYSTEINE 10 % SOLUTION, ACETYLCYSTEINE 20 % SOLUTION, ACYCLOVIR SODIUM 50 MG/ML SOLUTION, 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, AMBISOME, AMINOSYN 10 % SOLUTION, AMINOSYN II 10 % SOLUTION, AMINOSYN II 15 % SOLUTION, AMINOSYN II/ELECTROLYTES, AMINOSYN-HBC, AMINOSYN-PF, AMINOSYN-RF, AMINOSYN/ELECTROLYTES, AMPHOTERICIN B, APREPITANT 125 MG CAP, APREPITANT 80 & 125 MG CAP, APREPITANT 80 & 125 MG MISC, APREPITANT 80 MG CAP, ARALAST NP, 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, 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, ENGERIX-B, FABRAZYME 35 MG RECON SOLN, 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, HEPATAMINE, INTRALIPID, IPRATROPIUM BROMIDE 0.02 % SOLUTION, IPRATROPIUM-ALBUTEROL, KEPIVANCE, LUMIZYME, METHOTREXATE SODIUM 1 GM RECON SOLN, METHOTREXATE SODIUM 250 MG/10ML SOLUTION, METHOTREXATE SODIUM 50 MG/2ML SOLUTION, METHOTREXATE SODIUM (PF), MYCOPHENOLATE MOFETIL, MYCOPHENOLATE MOFETIL HCL, MYCOPHENOLATE SODIUM, NAGLAZYME, NUTRILIPID, ONDANSETRON, ONDANSETRON HCL 24 MG TAB, ONDANSETRON HCL 4 MG TAB, ONDANSETRON HCL 4 MG/5ML SOLUTION, ONDANSETRON HCL 8 MG TAB, PARICALCITOL, PENTAMIDINE ISETHIONATE, PLENAMINE, PREMASOL, PROLASTIN-C, PULMOZYME, RECOMBIVAX HB, RIBAVIRIN 6 GM RECON SOLN, SANDIMMUNE 100 MG/ML SOLUTION, SIROLIMUS, SMOFLIPID, SYNRIBO, TACROLIMUS 0.5 MG CAP, TACROLIMUS 1 MG CAP, TACROLIMUS 5 MG CAP, TPN ELECTROLYTES, TWINRIX, VENTAVIS, ZOLEDRONIC ACID

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, initial use: pituitary surgery is not an option or has not been curative. Ongoing use: patient responded to initial treatment confirmed by a decrease in the mean 24-hour urinary free cortisol (UFC).

AGE RESTRICTION
18 years of age or older.

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Initial: 3 months
Reauth: 1 year

OTHER CRITERIA
N/A

PAZOPANIB HCL (VOTRIENT)

MEDICATION(S)
VOTRIENT

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
N/A

PEGFILGRASTIM (NEULASTA)

MEDICATION(S)
NEULASTA, NEULASTA ONPRO

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Being used concurrently with filgrastim.

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Chemo-induced: duration of chemo
Radiation-induced: duration of radiation

OTHER CRITERIA
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
N/A

PEGLOTICASE (KRYSTEXXA)

MEDICATION(S)
KRYSTEXXA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Initial use: one of the following to confirm chronic gout not controlled with the use of allopurinol: more than three gout flares in the past 18 months, one or more tophi (lumps of uric acid crystals under the skin), or chronic gouty arthritis. Ongoing use: uric acid level is lower than 6 mg/dL with the use of Krystexxa.

AGE RESTRICTION
18 years of age or older.

PRESCRIBER RESTRICTION
Rheumatologist

COVERAGE DURATION
6 months

OTHER CRITERIA
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
Patient failed or is not a candidate for radiation or 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
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
18 years of age or older

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
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
N/A

PEXIDARTINIB (TURALIO)

MEDICATION(S)
TURALIO

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Not being used with imatinib

REQUIRED MEDICAL INFORMATION
Tenosynovial giant cell tumor (TGCT): surgery is not an option.

AGE RESTRICTION
18 years of age or older.

PRESCRIBER RESTRICTION
Orthopedic surgeon or Oncologist

COVERAGE DURATION
Plan year

OTHER CRITERIA
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
N/A

PIRFENIDONE (ESBRIET)

MEDICATION(S)
ESBRIET

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Being used with another IPF drug.
Being used for severe IPF disease where FVC is under 50% or DLCO is under 30%.

REQUIRED MEDICAL INFORMATION
Idiopathic Pulmonary Fibrosis (IPF), initial use: patient has mild to moderate disease confirmed by 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, patient continues to have mild to moderate IPF disease confirmed by the following pulmonary function tests: FVC equal or above 50% and DLCO is equal or over 30%.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Pulmonologist

COVERAGE DURATION
Plan year

OTHER CRITERIA
N/A

PLERIXAFOR (MOZOBIL)

MEDICATION(S)
MOZOBIL

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
one time

OTHER CRITERIA
N/A

POMALIDOMIDE (POMALYST)

MEDICATION(S)
POMALYST

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
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
Required medical information will be aligned with FDA labeling and current NCCN guidelines and for first line therapy for ALL medical reason why imatinib cannot be used.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
N/A

POSACONAZOLE (NOXAFIL)

MEDICATION(S)
POSACONAZOLE

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

OFF LABEL USES
Esophageal candidiasis treatment, Oropharyngeal candidiasis treatment, Invasive aspergillosis, candidiasis, cryptococcosis, 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, cryptococcosis, 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

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
N/A

PRAMLINTIDE ACETATE (SYMLIN)

MEDICATION(S)
SYMLINPEN 120, SYMLINPEN 60

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
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), PCP prevention, 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 manintenance (secondary prophylaxis) of toxoplasmosis: follows initial treatment in HIV-infected patients

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Toxoplasmosis: infectious disease specialist, ophthalmologist, or gynecologist. PCP prevention and Isosopra Belli: infectious disease specialist.

COVERAGE DURATION
Plan year

OTHER CRITERIA
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
N/A

RANOLAZINE (RANEXA ER)

MEDICATION(S)
RANOLAZINE ER

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Tried and failed at least two drugs from the nitrate, calcium-channel blocker, and beta-blocker drug classes OR has a medical reason for not using these drug classes.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
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
N/A

RELUGOLIX (ORGOVYX)

MEDICATION(S)
ORGOVYX

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
18 years of age or older

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
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
N/A

RIBOCICLIB SUCCINATE/LETROZOLE (KISQALI FEMARA)

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

RIFAXIMIN (XIFAXAN)

MEDICATION(S)
XIFAXAN

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Travelers diarrhea: patient has tried azithromycin or a fluoroquinolone like ciprofloxacin or has a medical reason not to use ciprofloxacin and azithromycin. 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.

AGE RESTRICTION
Travelers diarrhea: 12 years of age or older. Hepatic Encephalopathy & IBS-D: 18 years of age or older.

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Travelers diarrhea: 3 days
Hepatic encephalopathy: plan year
IBS-D: 14 days

OTHER CRITERIA
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 antiinflammatory drug (NSAID) or contraindication to colchicine in combination with oral NSAID OR patient did not respond to corticosteroids or is on corticosteroids

AGE RESTRICTION
12 years of age or older.

PRESCRIBER RESTRICTION
Recurrent Pericarditis: Cardiologist

COVERAGE DURATION
Plan year

OTHER CRITERIA
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
18 years of age or older.

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
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
N/A

RISPERIDONE (PERSERIS ER)

MEDICATION(S)
PERSERIS

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
Treatment failure with at least one oral atypical antipsychotic (e.g. risperidone, ziprasidone) and medical reason why injectable risperidone (Risperdal Consta) cannot be used.

AGE RESTRICTION
18 years of age or older.

PRESCRIBER RESTRICTION
Psychiatrist

COVERAGE DURATION
Plan year

OTHER CRITERIA
Excluded under Part D if covered by Part B.

ROFLUMILAST (DALIRESP)

MEDICATION(S)
DALIRESP

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
N/A

RUCAPARIB CAMSYLATE (RUBRACA)

MEDICATION(S)
RUBRACA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Being used as part of a multi-cancer drug regimen.

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
N/A

RUXOLITINIB (JAKAFI)

MEDICATION(S)
JAKAFI

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Myelofibrosis (MF): not being used along with another agent for myelofibrosis

REQUIRED MEDICAL INFORMATION
MF: patient has enlarged spleen and platelet count is equal to or more than 50,000 cells/mcl.
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 or side effect with systemic corticosteroids (e.g. prednisone, methylprednisolone).

AGE RESTRICTION
All other conditions: 18 years of age or older.
GvHD: 12 years of age or older.

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
N/A

SAPROPTERIN DIHYDROCHLORIDE (KUVAN)

MEDICATION(S)
SAPROPTERIN DIHYDROCHLORIDE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Phenylketonuria (PKU), initial: chart notes confirm PKU, dose does not exceed 10mg/kg per day, and baseline (just prior to therapy) and target blood phenylalanine (Phe) levels are given. PKU, dose increases: phenylalanine level is not at target range or there is less than a 20% lowering of Phe level at a dose that is less than 20mg/kg/day. PKU, ongoing use: recent phenylalanine level is at target range or there is at least a 20% lowering in Phe level.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

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

OTHER CRITERIA
N/A

SARGRAMOSTIM (LEUKINE)

MEDICATION(S)
LEUKINE

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
Chemo initial: 14 days ongoing: length of chemo Other FDA uses: 30 days

OTHER CRITERIA
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
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
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
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
2 years of age or older

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
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. Raynauds phenomenon: treatment failure or side effect with a calcium-channel blocker (e.g. nifedipine).

AGE RESTRICTION
18 years of age or older.

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
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: patient has tried methylphenidate, amphetamine, or dextroamphetamine, and did not respond or had a side effect to modafinil or armodafinil, OR has a medical reason not to use methylphenidates, amphetamines, dextroamphetamines, modafinil and armodafinil.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
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
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
6 years of age or older.

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
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
18 years of age or older.

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
N/A

SOMATROPIN (NORDITROPIN)

MEDICATION(S)
NORDITROPIN FLEXPRO

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Growth hormone deficiency (GHD) with pituitary disease: ADULTS – evidence of pituitary disease and failed one standard growth hormone stim test within one year of starting growth hormone. PEDS - evidence of pituitary disease, growth velocity decline, and failed one standard growth hormone stim test.
GHD without pituitary disease: ADULTS - there is at least one documented pituitary hormone defect, IGF-I is below mean of reference range (below 50th percentile) and has failed one GH stim test OR there are three or more documented pituitary hormone defects and IGF-1 is outside of reference range for sex/age. PEDS - height is less than 3rd percentile for age/sex, height velocity is less than 10th percentile of normal for age/sex tracked over at least one year, and either failed two standard growth hormone stim tests or failed one standard growth hormone stim test and has low IGF-1.
GHD continuing from childhood, initial: evidence of pituitary disease OR patient failed one standard growth hormone stim test after the age of 18 and within one year of starting growth hormone therapy. For ongoing use: prescriber states patient responded to therapy.
Small for Gestational Age (SGA): patient's length at birth or birth weight are two or more standard deviations below the mean (less than the 3rd percentile) for gestational age (adjusted for prematurity) and patient's height is two or more standard deviations below the mean.
Ongoing use in SGA or PED GHD: growth velocity improved while on GH.
Ongoing use for pediatrics with growth failure due to chronic kidney disease: patient did not have a kidney transplant within the past year.
Ongoing use for Turners or Prader-Willi syndrome: prescriber has determined that benefits outweigh risk and continuation is necessary.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Adult GHD: Endocrinologist
Turners Syndrome, Prader-Willi Syndrome, ped GHD, SGA: pediatric Endocrinologist

COVERAGE DURATION
Plan year

OTHER CRITERIA
N/A

SOMATROPIN (SEROSTIM)

MEDICATION(S)
SEROSTIM

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
HIV-associated wasting or cachexia, initial use: patient weighs less than 90% ideal body weight OR has lost greater than or equal to 10% of usual body weight OR has a baseline BIA or total body DEXA showing body cell mass below 40% in males and 35% in females. Ongoing use: improvement in the body weight or body cell mass (BCM) compared to baseline.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 weeks

OTHER CRITERIA
N/A

SONIDEGIB (ODOMZO)

MEDICATION(S)
ODOMZO

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Patient has used a hedgehog inhibitor (e.g. Erivedge).
Being used as part of a multi-drug chemotherapy regimen.

REQUIRED MEDICAL INFORMATION
Initial use: patient still has disease despite surgery or radiation therapy and patient is not a candidate for further surgery or radiation therapy.
For ongoing use: disease has not worsened since starting Odomzo.

AGE RESTRICTION
18 years of age or older.

PRESCRIBER RESTRICTION
Oncologist

COVERAGE DURATION
Initial: 6 months
Ongoing use: plan year

OTHER CRITERIA
N/A

SORAFENIB (NEXAVAR)

MEDICATION(S)
NEXAVAR

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
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
18 years of age or older

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
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 and treatment failure or side effect with valproate or has a medical reason not to use valproate.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
N/A

SULFONYLUREAS, LONG ACTING (HIGH RISK MEDICATION)

MEDICATION(S)
GLYBURIDE, GLYBURIDE MICRONIZED, GLYBURIDE-METFORMIN

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Patient has tried glipizide or glipizide/metformin and 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
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
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.

TADALAFIL (ADCIRCA)

MEDICATION(S)
ALYQ, TADALAFIL (PAH)

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

AGE RESTRICTION
18 years of age or older.

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
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
18 years of age or older.

PRESCRIBER RESTRICTION
Cardiologist

COVERAGE DURATION
Plan year

OTHER CRITERIA
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
18 years of age or older.

PRESCRIBER RESTRICTION
Cardiologist

COVERAGE DURATION
Plan year

OTHER CRITERIA
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
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
N/A

TASIMELTEON (HETLIOZ)

MEDICATION(S)
HETLIOZ

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Non-24 hour sleep wake cycle Initial use: patient is not able to maintain a stable 24-hour sleep-wake pattern synchronized to 24-hr light/dark cycle. Non-24 hour sleep wake cycle ongoing use: patients total sleep time at night is longer and has less day time sleep since starting Hetlioz. Smith-Magenis syndrome: patient has nighttime sleep disturbances

AGE RESTRICTION
Non-24 hour sleep wake cycle: 18 years of age or older.
Smith-Magenis syndrome: 16 years of age or older.

PRESCRIBER RESTRICTION
N/A

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

OTHER CRITERIA
N/A

TAZEMETOSTAT (TAZVERIK)

MEDICATION(S)
TAZVERIK

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Being used as part of a multi-drug regimen.

REQUIRED MEDICAL INFORMATION
Documentation to confirm patient is not a candidate to have the cancer removed by surgery.

AGE RESTRICTION
16 years of age or older.

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
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
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
18 years of age or older.

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
N/A

TERIFLUNOMIDE (AUBAGIO)

MEDICATION(S)
AUBAGIO

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
N/A

TESAMORELIN ACETATE (EGRIFTA)

MEDICATION(S)
EGRIFTA, EGRIFTA SV

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Patient has a current malignancy.

REQUIRED MEDICAL INFORMATION
Initial use: prescriber states patient has an intact hypothalamic-pituitary-adrenal axis AND CT scan results confirm excess visceral fat accumulation OR 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
18 years of age or older.

PRESCRIBER RESTRICTION
Endocrinologist or HIV Specialist

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

OTHER CRITERIA
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
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
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
N/A

AGE RESTRICTION
6 years of age or older.

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
N/A

THALIDOMIDE (THALOMID)

MEDICATION(S)
THALOMID

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
N/A

TIAGABINE (GABITRIL)

MEDICATION(S)
TIAGABINE HCL

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 to two of the following drugs: carbamazepine, divalproex, ethosuximide, gabapentin, lamotrigine, levetiracetam, phenytoin, primidone, valproic acid, zonisamide.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
N/A

TIOPRONIN (THIOLA)

MEDICATION(S)
THIOLA EC

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
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
18 years of age or older.

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
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
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
Excluded under Part D if covered by Part B.

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: treatment failure or side effect with methotrexate. 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), initial use: trial and failure or side effect with either an oral corticosteroid (e.g. prednisone, prednisolone) or an immunomodulator drug (e.g. azathioprine or mercaptopurine) or has a medical reason why oral corticosteroid and immunomodulator drugs cannot be used. Polyarticular Juvenile Idiopathic Arthritis (pJIA): treatment failure or side effect with one DMARD drug or medical reason why methotrexate cannot be used.

AGE RESTRICTION
RA, PsA, UC: 18 years of age or older. pJIA: 2 years of age or older

PRESCRIBER RESTRICTION
RA, PsA, pJIA: Rheumatologist. UC: Gastroenterologist.

COVERAGE DURATION
RA, PsA, PJIA: plan year
UC initial: 16 weeks, ongoing use: plan year

OTHER CRITERIA
N/A

TOPICAL TESTOSTERONE PRODUCTS

MEDICATION(S)
TESTOSTERONE 12.5 MG/ACT (1%) GEL, TESTOSTERONE 25 MG/2.5GM (1%) 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
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
N/A

TRANSMUCOSAL FENTANYL PRODUCTS

MEDICATION(S)
FENTANYL CITRATE 100 MCG TAB, FENTANYL CITRATE 1200 MCG LOZ HANDLE, FENTANYL CITRATE 1600 MCG LOZ HANDLE, FENTANYL CITRATE 200 MCG LOZ HANDLE, FENTANYL CITRATE 200 MCG TAB, FENTANYL CITRATE 400 MCG LOZ HANDLE, FENTANYL CITRATE 400 MCG TAB, FENTANYL CITRATE 600 MCG LOZ HANDLE, FENTANYL CITRATE 600 MCG TAB, FENTANYL CITRATE 800 MCG LOZ HANDLE, FENTANYL CITRATE 800 MCG TAB

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
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
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
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
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
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
18 years of age or older.

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
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
18 years of age or older.

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
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: trial and failure or side effect with an oral corticosteroid (e.g. prednisone, budesonide EC) or has a medical reason why oral corticosteroids cannot be used AND 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 treatment failure or side effect with oral corticosteroids or immunomodulator drugs (e.g. azathioprine or mercaptopurine) or has a medical reason why these drugs cannot be used AND SQ formulation will be started after initial IV dose.
UC, ongoing use: symptom improvement with use of Stelara.

AGE RESTRICTION
PsO: 6 years of age or older. PsA, CD, UC: 18 years of age or older.

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

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
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
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
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
N/A

VIGADRONE AND VIGABATRIN (SABRIL)

MEDICATION(S)
VIGABATRIN, VIGADRONE

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
For 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 other drugs that stop seizures and will be used with another anti-seizure drug.

AGE RESTRICTION
Complex partial seizures: 2 years of age or older. Infantile spasms: 2 years of age or less.

PRESCRIBER RESTRICTION
Infantile spasms: Neurologist

COVERAGE DURATION
Seizures: annual
Infantile spasms: 6 months

OTHER CRITERIA
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
18 years of age or older.

PRESCRIBER RESTRICTION
Skin Cancer (BCC), locally advanced: Dermatologist or Oncologist Metastatic: Oncologist

COVERAGE DURATION
Plan year

OTHER CRITERIA
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 infection, treatment of pulmonary aspergillosis, chronic (cavitary, prophylaxis of Invasive Aspergillosis in high-risk patients or necrotizing)

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 Invasive Aspergillosis in high-risk patients: patient has a weakened defense system (immunocompromised).

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

VORINOSTAT (ZOLINZA)

MEDICATION(S)
ZOLINZA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
18 years of age or older.

PRESCRIBER RESTRICTION
Oncologist

COVERAGE DURATION
Plan year

OTHER CRITERIA
N/A

VOXELOTOR (OXBRYTA)

MEDICATION(S)
OXBRYTA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Trial of or medical reason not to use hydroxyurea OR being added to current hydroxyurea therapy.

AGE RESTRICTION
12 years of age or older.

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
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
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
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
Acyclovir Sodium 50 MG/ML SOLUTION	IV	SOLUTION
Acyclovir Sodium 500 MG RECON SOLN	IV	RECON SOLN
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
Adrucil 5 GM/100ML SOLUTION	IV	SOLUTION
Adrucil 500 MG/10ML SOLUTION	IV	SOLUTION
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
Albuterol Sulfate 2.5 MG/0.5ML NEBU SOLN	IN	NEBU SOLN
Aldurazyme 2.9 MG/5ML SOLUTION	IV	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
AmBisome 50 MG RECON SUSP	IV	RECON SUSP
Amino Acid 10 % SOLUTION	IV	SOLUTION
Amino Acid 5 % SOLUTION	IV	SOLUTION

MEDICATION NAME	ROUTE	DOSE FORM
Aminophylline 25 MG/ML SOLUTION	IV	SOLUTION
AminoProtect 5 % SOLUTION	IV	SOLUTION
Aminosyn 10 % SOLUTION	IV	SOLUTION
Aminosyn 8.5 % SOLUTION	IV	SOLUTION
Aminosyn II 10 % SOLUTION	IV	SOLUTION
Aminosyn II 15 % SOLUTION	IV	SOLUTION
Aminosyn II 8.5 % SOLUTION	IV	SOLUTION
Aminosyn II/Electrolytes 8.5 % SOLUTION	IV	SOLUTION
Aminosyn M 3.5 % SOLUTION	IV	SOLUTION
Aminosyn-HBC 7 % SOLUTION	IV	SOLUTION
Aminosyn-PF 10 % SOLUTION	IV	SOLUTION
Aminosyn-PF 7 % SOLUTION	IV	SOLUTION
Aminosyn-RF 5.2 % SOLUTION	IV	SOLUTION
Aminosyn/Electrolytes 7 % SOLUTION	IV	SOLUTION
Aminosyn/Electrolytes 8.5 % 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
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
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
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 INJECTABLE	IV	INJECTABLE
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

MEDICATION NAME	ROUTE	DOSE FORM
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
Azactam in Dextrose 1 GM/50ML SOLUTION	IV	SOLUTION
Azactam in Dextrose 2 GM/50ML SOLUTION	IV	SOLUTION
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
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/4ML SOLUTION	IV	SOLUTION
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
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 3.5 MG RECON SOLN	IV	RECON SOLN
Botox 100 UNIT RECON SOLN	IJ	RECON SOLN
Botox 200 UNIT RECON SOLN	IJ	RECON SOLN
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

MEDICATION NAME	ROUTE	DOSE FORM
Buprenorphine HCl 0.3 MG/ML SOLUTION	IJ	SOLUTION
Busulfan 6 MG/ML SOLUTION	IV	SOLUTION
Busulfex 6 MG/ML SOLUTION	IV	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
Campath 30 MG/ML SOLUTION	IV	SOLUTION
Camptosar 100 MG/5ML SOLUTION	IV	SOLUTION
Camptosar 300 MG/15ML SOLUTION	IV	SOLUTION
Camptosar 40 MG/2ML SOLUTION	IV	SOLUTION
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
Cardene IV 40-5 MG/200ML-% SOLUTION	IV	SOLUTION
Carmustine 100 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 2-0.9 GM/50ML-% 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 2-5 GM/50ML-% SOLUTION	IV	SOLUTION

MEDICATION NAME	ROUTE	DOSE FORM
CeFAZolin Sodium-Dextrose 3-5 GM/100ML-% 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
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
Cesamet 1 MG CAP	PO	CAP
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
Cipro in D5W 400 MG/200ML SOLUTION	IV	SOLUTION
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

MEDICATION NAME	ROUTE	DOSE FORM
CISplatin 50 MG/50ML SOLUTION	IV	SOLUTION
Cladribine 10 MG/10ML SOLUTION	IV	SOLUTION
Cleviprex 50 MG/100ML EMULSION	IV	EMULSION
Clinimix E/Dextrose (2.75/10) 2.75 % 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 (4.25/25) 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 (5/25) 5 % SOLUTION	IV	SOLUTION
Clinimix E/Dextrose (8/10) 8 % SOLUTION	IV	SOLUTION
Clinimix E/Dextrose (8/14) 8 % SOLUTION	IV	SOLUTION
Clinimix N14G30E 4.25 % SOLUTION	IV	SOLUTION
Clinimix N9G15E 2.75 % SOLUTION	IV	SOLUTION
Clinimix N9G20E 2.75 % SOLUTION	IV	SOLUTION
Clinimix/Dextrose (2.75/5) 2.75 % SOLUTION	IV	SOLUTION
Clinimix/Dextrose (4.25/10) 4.25 % SOLUTION	IV	SOLUTION
Clinimix/Dextrose (4.25/20) 4.25 % SOLUTION	IV	SOLUTION
Clinimix/Dextrose (4.25/25) 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 (5/25) 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
CloNIDine HCl (Analgesia) 500 MCG/ML SOLUTION	EP	SOLUTION
Cocaine HCl 40 MG/ML SOLUTION	NA	SOLUTION
Cosela 300 MG RECON SOLN	IV	RECON SOLN
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

MEDICATION NAME	ROUTE	DOSE FORM
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/5ML SOLUTION	IV	SOLUTION
Cyclophosphamide 2 GM RECON SOLN	IJ	RECON SOLN
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
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
Cyramza 100 MG/10ML SOLUTION	IV	SOLUTION
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 INJECTABLE	IV	INJECTABLE
Cytovene 500 MG RECON SOLN	IV	RECON SOLN
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
Danyelza 40 MG/10ML 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

MEDICATION NAME	ROUTE	DOSE FORM
Demerol 100 MG/ML SOLUTION	IJ	SOLUTION
Demerol 25 MG/0.5ML SOLUTION	IJ	SOLUTION
Demerol 25 MG/ML SOLUTION	IJ	SOLUTION
Demerol 50 MG/ML SOLUTION	IJ	SOLUTION
Demerol 75 MG/1.5ML 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 HCl 250 MG RECON SOLN	IV	RECON SOLN
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
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
Dilaudid 4 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 250 MG/20ML SOLUTION	IV	SOLUTION
DOBUTamine HCl 500 MG/40ML SOLUTION	IV	SOLUTION
DOBUTamine in D5W 1-5 MG/ML-% SOLUTION	IV	SOLUTION
DOBUTamine in D5W 2 MG/ML SOLUTION	IV	SOLUTION
DOBUTamine in D5W 4-5 MG/ML-% SOLUTION	IV	SOLUTION
DOCEtaxel (Non-Alcohol) 160 MG/8ML SOLUTION	IV	SOLUTION
DOCEtaxel (Non-Alcohol) 20 MG/ML SOLUTION	IV	SOLUTION
DOCEtaxel (Non-Alcohol) 80 MG/4ML SOLUTION	IV	SOLUTION
DOCEtaxel 160 MG/16ML SOLUTION	IV	SOLUTION

MEDICATION NAME	ROUTE	DOSE FORM
DOCEtaxel 160 MG/8ML CONC	IV	CONC
DOCEtaxel 20 MG/0.5ML CONC	IV	CONC
DOCEtaxel 20 MG/2ML SOLUTION	IV	SOLUTION
DOCEtaxel 20 MG/ML CONC	IV	CONC
DOCEtaxel 200 MG/10ML CONC	IV	CONC
DOCEtaxel 80 MG/2ML CONC	IV	CONC
DOCEtaxel 80 MG/4ML CONC	IV	CONC
DOCEtaxel 80 MG/8ML SOLUTION	IV	SOLUTION
DOPamine HCl 160 MG/ML SOLUTION	IV	SOLUTION
DOPamine HCl 40 MG/ML SOLUTION	IV	SOLUTION
DOPamine HCl 80 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
Doribax 250 MG RECON SOLN	IV	RECON SOLN
Doripenem 250 MG RECON SOLN	IV	RECON SOLN
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 INJECTABLE	IV	INJECTABLE
DOXOrubicin HCl 10 MG RECON SOLN	IV	RECON SOLN
DOXOrubicin HCl 2 MG/ML SOLUTION	IV	SOLUTION
DOXOrubicin HCl 50 MG RECON SOLN	IV	RECON SOLN
DOXOrubicin HCl Liposomal 2 MG/ML INJECTABLE	IV	INJECTABLE
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
Dysport 300 UNIT RECON SOLN	IM	RECON SOLN
Dysport 500 UNIT RECON SOLN	IM	RECON SOLN
Elaprase 6 MG/3ML SOLUTION	IV	SOLUTION
Elcys 50 MG/ML SOLUTION	IV	SOLUTION
Elelyso 200 UNIT RECON SOLN	IV	RECON SOLN
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
Emend 125 MG CAP	PO	CAP
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

MEDICATION NAME	ROUTE	DOSE FORM
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 INJECTABLE	IV	INJECTABLE
Engerix-B 10 MCG/0.5ML INJECTABLE	IM	INJECTABLE
Engerix-B 10 MCG/0.5ML SUSPENSION	IJ	SUSPENSION
Engerix-B 20 MCG/ML INJECTABLE	IM	INJECTABLE
Engerix-B 20 MCG/ML SUSPENSION	IJ	SUSPENSION
Enhertu 100 MG RECON SOLN	IV	RECON SOLN
Entyvio 300 MG RECON SOLN	IV	RECON SOLN
Envarsus XR 0.75 MG TAB ER 24H	PO	TAB ER 24H
Envarsus XR 1 MG TAB ER 24H	PO	TAB ER 24H
Envarsus XR 4 MG TAB ER 24H	PO	TAB ER 24H
EpiRUBicin HCl 200 MG/100ML SOLUTION	IV	SOLUTION
EpiRUBicin HCl 50 MG/25ML SOLUTION	IV	SOLUTION
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
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
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
Fensolvi (6 Month) 45 MG (Ped) 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

MEDICATION NAME	ROUTE	DOSE FORM
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
Fludarabine Phosphate 50 MG RECON SOLN	IV	RECON SOLN
Fludarabine Phosphate 50 MG/2ML SOLUTION	IV	SOLUTION
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
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
Fusilev 50 MG RECON SOLN	IV	RECON SOLN
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
Gamifant 10 MG/2ML SOLUTION	IV	SOLUTION
Gamifant 100 MG/20ML SOLUTION	IV	SOLUTION
Gamifant 50 MG/10ML SOLUTION	IV	SOLUTION
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

MEDICATION NAME	ROUTE	DOSE FORM
Gemzar 1 GM RECON SOLN	IV	RECON SOLN
Gemzar 200 MG RECON SOLN	IV	RECON SOLN
Gengraf 100 MG CAP	PO	CAP
Gengraf 100 MG/ML SOLUTION	PO	SOLUTION
Gengraf 25 MG CAP	PO	CAP
Gengraf 50 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
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
Glycophos 1 MMOLE/ML SOLUTION	IV	SOLUTION
Goprelto 40 MG/ML SOLUTION	NA	SOLUTION
Granisetron HCl 0.1 MG/ML SOLUTION	IV	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 0.5 MCG CAP	PO	CAP
Hectorol 1 MCG CAP	PO	CAP
Hectorol 2 MCG/ML SOLUTION	IV	SOLUTION
Hectorol 2.5 MCG CAP	PO	CAP
Hectorol 4 MCG/2ML SOLUTION	IV	SOLUTION
HepaGam B SOLUTION	IJ	SOLUTION
Heparin (Porcine) in NaCl 100-0.45 UT/100ML-% SOLUTION	IV	SOLUTION
Heparin (Porcine) in NaCl 100-0.9 UT/100ML-% SOLUTION	IV	SOLUTION
Heparin (Porcine) in NaCl 1000-0.9 UNIT/L-% SOLUTION	IV	SOLUTION
Heparin (Porcine) in NaCl 1000-0.9 UT/100ML-% SOLUTION	IV	SOLUTION
Heparin (Porcine) in NaCl 1000-0.9 UT/250ML-% SOLUTION	IV	SOLUTION
Heparin (Porcine) in NaCl 1000-0.9 UT/500ML-% SOLUTION	IV	SOLUTION
Heparin (Porcine) in NaCl 10000-0.9 UNIT/L-% SOLUTION	IV	SOLUTION
Heparin (Porcine) in NaCl 10000-0.9 UT/100ML-% SOLUTION	IV	SOLUTION

MEDICATION NAME	ROUTE	DOSE FORM
Heparin (Porcine) in NaCl 10000-0.9 UT/500ML-% SOLUTION	IV	SOLUTION
Heparin (Porcine) in NaCl 1250-0.9 UT/250ML-% SOLUTION	IV	SOLUTION
Heparin (Porcine) in NaCl 12500-0.45 UT/250ML-% SOLUTION	IV	SOLUTION
Heparin (Porcine) in NaCl 150-0.45 UT/150ML-% SOLUTION	IV	SOLUTION
Heparin (Porcine) in NaCl 1500-0.9 UT/150ML-% SOLUTION	IV	SOLUTION
Heparin (Porcine) in NaCl 1500-0.9 UT/250ML-% SOLUTION	IV	SOLUTION
Heparin (Porcine) in NaCl 15000-0.9 UT/500ML-% SOLUTION	IV	SOLUTION
Heparin (Porcine) in NaCl 2000-0.9 UNIT/L-% SOLUTION	IV	SOLUTION
Heparin (Porcine) in NaCl 2000-0.9 UT/500ML-% SOLUTION	IV	SOLUTION
Heparin (Porcine) in NaCl 20000-0.9 UNIT/L-% SOLUTION	IV	SOLUTION
Heparin (Porcine) in NaCl 250-0.45 UT/250ML-% SOLUTION	IV	SOLUTION
Heparin (Porcine) in NaCl 250-0.9 UT/250ML-% SOLUTION	IV	SOLUTION
Heparin (Porcine) in NaCl 2500-0.9 UT/250ML-% 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 25000-0.9 UT/250ML-% SOLUTION	IV	SOLUTION
Heparin (Porcine) in NaCl 25000-0.9 UT/500ML-% SOLUTION	IV	SOLUTION
Heparin (Porcine) in NaCl 3000-0.9 UNIT/L-% SOLUTION	IV	SOLUTION
Heparin (Porcine) in NaCl 3000-0.9 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 4000-0.9 UT/500ML-% SOLUTION	IV	SOLUTION
Heparin (Porcine) in NaCl 40000-0.45 UNIT/L-% SOLUTION	IV	SOLUTION
Heparin (Porcine) in NaCl 500-0.45 UT/250ML-% SOLUTION	IV	SOLUTION

MEDICATION NAME	ROUTE	DOSE FORM
Heparin (Porcine) in NaCl 500-0.45 UT/500ML-% SOLUTION	IV	SOLUTION
Heparin (Porcine) in NaCl 500-0.9 UT/500ML-% SOLUTION	IV	SOLUTION
Heparin (Porcine) in NaCl 5000-0.45 UNIT/L-% 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 (Porcine) in NaCl 6000-0.9 UNIT/L-% SOLUTION	IV	SOLUTION
Heparin (Porcine) in NaCl 8000-0.9 UNIT/L-% SOLUTION	IV	SOLUTION
Heparin Sod (Porcine) in D5W 100 UNIT/ML SOLUTION	IV	SOLUTION
Heparin Sod (Porcine) in D5W 10000-5 UT/100ML-% SOLUTION	IV	SOLUTION
Heparin Sod (Porcine) in D5W 12500-5 UT/250ML-% 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
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 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
Heplisav-B 20 MCG/0.5ML SOLUTION	IM	SOLUTION
Herceptin 150 MG RECON SOLN	IV	RECON SOLN
Herceptin 440 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
Hycamtin 4 MG RECON SOLN	IV	RECON SOLN
HYDROmorphone HCl 0.2 MG/ML SOLUTION	IJ	SOLUTION
HYDROmorphone HCl 1 MG/ML SOLUTION	IJ	SOLUTION

MEDICATION NAME	ROUTE	DOSE FORM
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
HYDROmorphone HCl-NaCl 10-0.9 MG/50ML-% SOLUTION	IV	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
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
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
Imfinzi 120 MG/2.4ML SOLUTION	IV	SOLUTION
Imfinzi 500 MG/10ML SOLUTION	IV	SOLUTION
Imlygic 1000000 UNIT/ML SUSPENSION	LS	SUSPENSION
Imlygic 100000000 UNIT/ML SUSPENSION	LS	SUSPENSION
Imogam Rabies-HT 1500 UNIT/10ML SOLUTION	IJ	SOLUTION
Imogam Rabies-HT 300 UNIT/2ML SOLUTION	IJ	SOLUTION

MEDICATION NAME	ROUTE	DOSE FORM
Imuran 50 MG TAB	PO	TAB
Inflectra 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
Intralipid 20 % EMULSION	IV	EMULSION
Intralipid 30 % EMULSION	IV	EMULSION
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 (Overfill) 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 3.3-9.8-3.9-0.7 % 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 (in NaCl 0.9%) 10 MEQ/100ML SOLUTION	IV	SOLUTION
KCl (in NaCl 0.9%) 10 MEQ/500ML SOLUTION	IV	SOLUTION
KCl (in NaCl 0.9%) 20 MEQ/250ML SOLUTION	IV	SOLUTION
KCl (in NaCl 0.9%) 40 MEQ/250ML SOLUTION	IV	SOLUTION

MEDICATION NAME	ROUTE	DOSE FORM
KCl (in NaCl 0.9%) 40 MEQ/500ML SOLUTION	IV	SOLUTION
KCl in D5W Lactated Ringers 40 MEQ/L 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
KCl in Lactated Ringers 20 MEQ/L SOLUTION	IV	SOLUTION
KCl-Lidocaine in NaCl 20-10 MEQ-MG /100ML SOLUTION	IV	SOLUTION
Kedrab 1500 UNIT/10ML SOLUTION	IJ	SOLUTION
Kedrab 300 UNIT/2ML SOLUTION	IJ	SOLUTION
Kenalog 10 MG/ML SUSPENSION	IJ	SUSPENSION
Kenalog 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
Kimyrsa 1200 MG RECON SOLN	IV	RECON SOLN
Kitabis Pak 300 MG/5ML NEBU SOLN	IN	NEBU SOLN
Kyprolis 10 MG RECON SOLN	IV	RECON SOLN
Kyprolis 30 MG RECON SOLN	IV	RECON SOLN
Kyprolis 60 MG RECON SOLN	IV	RECON SOLN
L-Cysteine HCl 50 MG/ML SOLUTION	IV	SOLUTION
Labetalol HCl 5 MG/ML SOLUTION	IV	SOLUTION
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
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 500 MG/100ML SOLUTION	IV	SOLUTION
LevoFLOXacin in D5W 250 MG/50ML SOLUTION	IV	SOLUTION
LEVOleucovorin Calcium 175 MG RECON SOLN	IV	RECON SOLN
Levothyroxine Sodium 100 MCG RECON SOLN	IV	RECON SOLN
Levothyroxine Sodium 100 MCG/5ML SOLUTION	IV	SOLUTION
Levothyroxine Sodium 200 MCG RECON SOLN	IV	RECON SOLN

MEDICATION NAME	ROUTE	DOSE FORM
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
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
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
Lipodox 50 2 MG/ML INJECTABLE	IV	INJECTABLE
LORazepam 2 MG/ML SOLUTION	IJ	SOLUTION
LORazepam 4 MG/ML SOLUTION	IJ	SOLUTION
Lucentis 0.3 MG/0.05ML SOLN PRSYR	IZ	SOLN PRSYR
Lucentis 0.3 MG/0.05ML SOLUTION	IZ	SOLUTION
Lucentis 0.5 MG/0.05ML SOLN PRSYR	IZ	SOLN PRSYR
Lucentis 0.5 MG/0.05ML SOLUTION	IZ	SOLUTION
Lumizyme 50 MG RECON SOLN	IV	RECON SOLN
Lumoxiti 1 MG RECON SOLN	IV	RECON SOLN
Magnesium Sulfate 2 GM/50ML SOLUTION	IV	SOLUTION
Magnesium Sulfate 20 GM/500ML SOLUTION	IV	SOLUTION
Magnesium Sulfate 4 GM/100ML SOLUTION	IV	SOLUTION
Magnesium Sulfate 4 GM/50ML SOLUTION	IV	SOLUTION
Magnesium Sulfate 40 GM/1000ML SOLUTION	IV	SOLUTION
Magnesium Sulfate 50 % SOLUTION	IJ	SOLUTION
Magnesium Sulfate in D5W 1-5 GM/100ML-% SOLUTION	IV	SOLUTION
Magnesium Sulfate-NaCl 2-0.9 GM/50ML-% SOLUTION	IV	SOLUTION
Magnesium Sulfate-NaCl 20-0.9 GM/250ML-% SOLUTION	IV	SOLUTION
Magnesium Sulfate-NaCl 3-0.9 GM/150ML-% SOLUTION	IV	SOLUTION
Magnesium Sulfate-NaCl 40-0.9 GM/500ML-% 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

MEDICATION NAME	ROUTE	DOSE FORM
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 10 MG/ML SOLUTION	IJ	SOLUTION
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 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 500 MG RECON SOLN	IJ	RECON SOLN
Metoprolol Tartrate 5 MG/5ML SOLN CART	IV	SOLN CART
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
Midazolam 2 MG/2ML SOLN PRSYR	IJ	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
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
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 40 MG RECON SOLN	IV	RECON SOLN
MitoMYcin 5 MG RECON SOLN	IV	RECON SOLN

MEDICATION NAME	ROUTE	DOSE FORM
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) 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/0.7ML DEVICE	IM	DEVICE
Morphine Sulfate 10 MG/ML SOLUTION	IJ	SOLUTION
Morphine Sulfate 150 MG/30ML SOLUTION	IV	SOLUTION
Morphine Sulfate 2 MG/ML SOLUTION	IJ	SOLUTION
Morphine Sulfate 25 MG/ML SOLUTION	IV	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	IJ	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
Mustargen 10 MG RECON SOLN	IJ	RECON SOLN
Mutamycin 20 MG RECON SOLN	IV	RECON SOLN
Mutamycin 40 MG RECON SOLN	IV	RECON SOLN
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

MEDICATION NAME	ROUTE	DOSE FORM
Myfortic 180 MG TAB DR	PO	TAB DR
Myfortic 360 MG TAB DR	PO	TAB DR
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
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
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
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 pH 7.4 SOLUTION	IV	SOLUTION

MEDICATION NAME	ROUTE	DOSE FORM
Novarel 10000 UNIT RECON SOLN	IM	RECON SOLN
Novarel 5000 UNIT RECON SOLN	IM	RECON SOLN
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
Nutrilyte CONC	IV	CONC
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
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
Ofirmev 10 MG/ML SOLUTION	IV	SOLUTION
Ogivri 150 MG RECON SOLN	IV	RECON SOLN
Ogivri 420 MG RECON SOLN	IV	RECON SOLN
Olinvyk 1 MG/ML SOLUTION	IV	SOLUTION
Olinvyk 2 MG/2ML SOLUTION	IV	SOLUTION
Olinvyk 30 MG/30ML SOLUTION	IV	SOLUTION
Omegaven 10 GM/100ML EMULSION	IV	EMULSION
Omegaven 5 GM/50ML EMULSION	IV	EMULSION
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 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
Ondansetron HCl-Dextrose 8-5 MG/50ML-% SOLUTION	IV	SOLUTION
Onivyde 43 MG/10ML INJECTABLE	IV	INJECTABLE
Onpattro 10 MG/5ML SOLUTION	IV	SOLUTION

MEDICATION NAME	ROUTE	DOSE FORM
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
Orphenadrine Citrate 30 MG/ML SOLUTION	IJ	SOLUTION
Osmitrol 10 % SOLUTION	IV	SOLUTION
Osmitrol 15 % SOLUTION	IV	SOLUTION
Osmitrol 20 % SOLUTION	IV	SOLUTION
Osmitrol 5 % 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/16.67ML CONC	IV	CONC
PACLitaxel 100 MG/16.7ML CONC	IV	CONC
PACLitaxel 150 MG/25ML CONC	IV	CONC
PACLitaxel 30 MG/5ML CONC	IV	CONC
PACLitaxel 300 MG/50ML CONC	IV	CONC
Padcev 20 MG RECON SOLN	IV	RECON SOLN
Padcev 30 MG RECON SOLN	IV	RECON SOLN
Palforzia Initial Escalation 0.5 & 1 & 1.5 & 3 & 6 MG CSPK	PO	
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
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

MEDICATION NAME	ROUTE	DOSE FORM
Panzyga 5 GM/50ML SOLUTION	IV	SOLUTION
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
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
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
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
Portrazza 800 MG/50ML SOLUTION	IV	SOLUTION
Potassium Acetate 2 MEQ/ML SOLUTION	IV	SOLUTION
Potassium Acetate-NaCl 10 MEQ/100ML SOLUTION	IV	SOLUTION
Potassium Chloride 0.4 MEQ/ML SOLUTION	IV	SOLUTION
Potassium Chloride 10 MEQ/50ML SOLUTION	IV	SOLUTION
Potassium Chloride 20 MEQ/50ML SOLUTION	IV	SOLUTION
Potassium Chloride in D5W 10 MEQ/500ML SOLUTION	IV	SOLUTION
Potassium Chloride in D5W 20 MEQ/250ML SOLUTION	IV	SOLUTION
Potassium Chloride in D5W 40 MEQ/250ML SOLUTION	IV	SOLUTION
Potassium Chloride in D5W 40 MEQ/500ML SOLUTION	IV	SOLUTION

MEDICATION NAME	ROUTE	DOSE FORM
Potassium Chloride in NaCl 10-0.9 MEQ/L-% SOLUTION	IV	SOLUTION
Potassium Chloride in NaCl 20-0.45 MEQ/L-% SOLUTION	IV	SOLUTION
Potassium Phosphate-NaCl 15 MMOL/100ML SOLUTION	IV	SOLUTION
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-Dextrose 15 MMOL/250ML SOLUTION	IV	SOLUTION
Potassium Phosphates-Dextrose 30 MMOL/500ML SOLUTION	IV	SOLUTION
Potassium Phosphates-Dextrose 7.5 MMOL/100ML SOLUTION	IV	SOLUTION
Potassium Phosphates-Dextrose 9 MMOL/50ML SOLUTION	IV	SOLUTION
Potassium Phosphates-NaCl 10 MMOL/100ML SOLUTION	IV	SOLUTION
Potassium Phosphates-NaCl 10 MMOL/250ML SOLUTION	IV	SOLUTION
Potassium Phosphates-NaCl 15 MMOL/150ML SOLUTION	IV	SOLUTION
Potassium Phosphates-NaCl 15 MMOL/250ML SOLUTION	IV	SOLUTION
Potassium Phosphates-NaCl 20 MMOL/100ML SOLUTION	IV	SOLUTION
Potassium Phosphates-NaCl 22 MMOL/500ML SOLUTION	IV	SOLUTION
Potassium Phosphates-NaCl 30 MMOL/250ML SOLUTION	IV	SOLUTION
Potassium Phosphates-NaCl 40 MMOL/250ML SOLUTION	IV	SOLUTION
Potassium Phosphates-NaCl 5 MMOL/250ML SOLUTION	IV	SOLUTION
Potassium Phosphates-NaCl 7 MMOL/100ML SOLUTION	IV	SOLUTION
Potassium Phosphates-NaCl 7.5 MMOL/100ML SOLUTION	IV	SOLUTION
Potassium Phosphates-NaCl 9 MMOL/100ML SOLUTION	IV	SOLUTION
Poteligeo 20 MG/5ML SOLUTION	IV	SOLUTION
Pregnyl 10000 UNIT RECON SOLN	IM	RECON SOLN
Premasol 10 % SOLUTION	IV	SOLUTION
Premasol 6 % SOLUTION	IV	SOLUTION

MEDICATION NAME	ROUTE	DOSE FORM
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 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
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
Pulmicort 1 MG/2ML SUSPENSION	IN	SUSPENSION
Pulmozyme 2.5 MG/2.5ML SOLUTION	IN	SOLUTION
QuiNIDine Gluconate 80 MG/ML SOLUTION	IJ	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 SUSPENSION	IJ	SUSPENSION
Recombivax HB 40 MCG/ML SUSPENSION	IJ	SUSPENSION
Recombivax HB 5 MCG/0.5ML SUSPENSION	IJ	SUSPENSION
Recothrom 20000 UNIT RECON SOLN	EX	RECON SOLN
Recothrom 5000 UNIT RECON SOLN	EX	RECON SOLN
Recothrom Spray Kit 20000 UNIT RECON SOLN	EX	RECON SOLN

MEDICATION NAME	ROUTE	DOSE FORM
Regonol 10 MG/2ML SOLUTION	IV	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
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
Rituxan 100 MG/10ML SOLUTION	IV	SOLUTION
Rituxan 500 MG/50ML SOLUTION	IV	SOLUTION
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
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
Rylaze 10 MG/0.5ML SOLUTION	IM	SOLUTION
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
Seconal 100 MG CAP	PO	CAP
Sensipar 30 MG TAB	PO	TAB
Sensipar 60 MG TAB	PO	TAB
Sensipar 90 MG TAB	PO	TAB
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

MEDICATION NAME	ROUTE	DOSE FORM
Sirolimus 1 MG/ML SOLUTION	PO	SOLUTION
Sirolimus 2 MG TAB	PO	TAB
Sivextro 200 MG RECON SOLN	IV	RECON SOLN
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 0.9 % SOLUTION	IJ	SOLUTION
Sodium Chloride 23.4 % 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 Phosphate-NaCl 10 MMOL/100ML SOLUTION	IV	SOLUTION
Sodium Phosphate-NaCl 15 MMOL/100ML SOLUTION	IV	SOLUTION
Sodium Phosphate-NaCl 15 MMOL/250ML SOLUTION	IV	SOLUTION
Sodium Phosphate-NaCl 30 MMOL/250ML SOLUTION	IV	SOLUTION
Sodium Phosphate-NaCl 40 MMOL/250ML SOLUTION	IV	SOLUTION
Sodium Phosphate-NaCl 7.5 MMOL/100ML SOLUTION	IV	SOLUTION
Sodium Phosphate-NaCl 9 MMOL/50ML SOLUTION	IV	SOLUTION
Sodium Phosphates 15 MMOLE/5ML SOLUTION	IV	SOLUTION
Sodium Phosphates 45 MMOLE/15ML SOLUTION	IV	SOLUTION
Sodium Phosphates-Dextrose 15 MMOL/100ML SOLUTION	IV	SOLUTION
Sodium Phosphates-Dextrose 15 MMOL/250ML 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 1000 MG RECON SOLN	IJ	RECON SOLN
SOLU-medrol 125 MG RECON SOLN	IJ	RECON SOLN
SOLU-medrol 2 GM RECON SOLN	IJ	RECON SOLN
SOLU-medrol 40 MG RECON SOLN	IJ	RECON SOLN
SOLU-medrol 500 MG RECON SOLN	IJ	RECON SOLN
Spravato (56 MG Dose) 28 MG/DEVICE SOLN THPK	NA	SOLN THPK
Spravato (84 MG Dose) 28 MG/DEVICE SOLN THPK	NA	SOLN THPK
Sublocade 100 MG/0.5ML SOLN PRSYR	SC	SOLN PRSYR
Sublocade 300 MG/1.5ML SOLN PRSYR	SC	SOLN PRSYR

MEDICATION NAME	ROUTE	DOSE FORM
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
Syndros 5 MG/ML SOLUTION	PO	SOLUTION
Synribo 3.5 MG RECON SOLN	SC	RECON SOLN
Synthamin 17 10 % SOLUTION	IV	SOLUTION
Tacrolimus 0.5 MG CAP	PO	CAP
Tacrolimus 1 MG CAP	PO	CAP
Tacrolimus 5 MG CAP	PO	CAP
Taxotere 20 MG/ML CONC	IV	CONC
Taxotere 80 MG/4ML CONC	IV	CONC
Tazicef 1 GM/50ML SOLUTION	IV	SOLUTION
Tecentriq 1200 MG/20ML SOLUTION	IV	SOLUTION
Tecentriq 840 MG/14ML SOLUTION	IV	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
Teriparatide (Recombinant) 620 MCG/2.48ML SOLN PEN	SC	SOLN PEN
Theophylline in D5W 0.8-5 MG/ML-% SOLUTION	IV	SOLUTION
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
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
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

MEDICATION NAME	ROUTE	DOSE FORM
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
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
Triostat 10 MCG/ML SOLUTION	IV	SOLUTION
Triptodur 22.5 MG SRER	IM	
Trisenox 10 MG/10ML SOLUTION	IV	SOLUTION
Trisenox 12 MG/6ML SOLUTION	IV	SOLUTION
Trodelvy 180 MG RECON SOLN	IV	RECON SOLN
TrophAmine 10 % SOLUTION	IV	SOLUTION
Trophamine 6 % 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
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 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
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/10ML SOLUTION	IV	SOLUTION
Vancomycin HCl 1000 MG/200ML SOLUTION	IV	SOLUTION
Vancomycin HCl 1250 MG/12.5ML SOLUTION	IV	SOLUTION
Vancomycin HCl 1250 MG/250ML SOLUTION	IV	SOLUTION
Vancomycin HCl 1500 MG/15ML SOLUTION	IV	SOLUTION
Vancomycin HCl 1500 MG/300ML SOLUTION	IV	SOLUTION
Vancomycin HCl 1750 MG/17.5ML SOLUTION	IV	SOLUTION
Vancomycin HCl 1750 MG/350ML SOLUTION	IV	SOLUTION
Vancomycin HCl 2000 MG/20ML 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

MEDICATION NAME	ROUTE	DOSE FORM
Vancomycin HCl 750 MG/150ML SOLUTION	IV	SOLUTION
Vancomycin HCl 750 MG/7.5ML SOLUTION	IV	SOLUTION
Vancomycin HCl in Dextrose 1-5 GM/100ML-% SOLUTION	IV	SOLUTION
Vancomycin HCl in Dextrose 1-5 GM/200ML-% SOLUTION	IV	SOLUTION
Vancomycin HCl in Dextrose 1-5 GM/250ML-% 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 1.5-5 GM/500ML-% SOLUTION	IV	SOLUTION
Vancomycin HCl in Dextrose 1.75-5 GM/500ML-% SOLUTION	IV	SOLUTION
Vancomycin HCl in Dextrose 2-5 GM/500ML-% 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/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/150ML-% 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/150ML-% 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/300ML-% 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/300ML-% SOLUTION	IV	SOLUTION
Vancomycin HCl in NaCl 1.75-0.9 GM/500ML-% SOLUTION	IV	SOLUTION
Vancomycin HCl in NaCl 2-0.9 GM/250ML-% SOLUTION	IV	SOLUTION

MEDICATION NAME	ROUTE	DOSE FORM
Vancomycin HCl in NaCl 2-0.9 GM/500ML-% SOLUTION	IV	SOLUTION
Vancomycin HCl in NaCl 2.5-0.9 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
Vasostrict 20 UNIT/ML SOLUTION	IV	SOLUTION
Vectibix 100 MG/5ML SOLUTION	IV	SOLUTION
Vectibix 400 MG/20ML 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
Verapamil HCl 2.5 MG/ML SOLUTION	IV	SOLUTION
Vibativ 750 MG RECON SOLN	IV	RECON SOLN
Vidaza 100 MG RECON SUSP	IJ	RECON SUSP
Vimizim 5 MG/5ML 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
Vinorelbine Tartrate 10 MG/ML SOLUTION	IV	SOLUTION
Vinorelbine Tartrate 50 MG/5ML SOLUTION	IV	SOLUTION
Virazole 6 GM RECON SOLN	IN	RECON SOLN
Vyepti 100 MG/ML SOLUTION	IV	SOLUTION
Vyxeos 44-100 MG RECON SUSP	IV	RECON SUSP
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
Xeomin 100 UNIT RECON SOLN	IM	RECON SOLN
Xeomin 200 UNIT RECON SOLN	IM	RECON SOLN
Xeomin 50 UNIT RECON SOLN	IM	RECON SOLN
Xerava 100 MG RECON SOLN	IV	RECON SOLN

MEDICATION NAME	ROUTE	DOSE FORM
Xerava 50 MG RECON SOLN	IV	RECON SOLN
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
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
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
Zinc Sulfate 1 MG/ML SOLUTION	IV	SOLUTION
Zinc Sulfate 3 MG/ML SOLUTION	IV	SOLUTION
Zinc Sulfate 5 MG/ML SOLUTION	IV	SOLUTION
Zinecard 250 MG RECON SOLN	IV	RECON SOLN
Zinecard 500 MG RECON SOLN	IV	RECON SOLN
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
Zofran 4 MG/5ML SOLUTION	PO	SOLUTION
Zofran 8 MG TAB	PO	TAB
Zofran ODT 4 MG TAB DISP	PO	TAB DISP
Zofran ODT 8 MG TAB DISP	PO	TAB DISP
Zoladex 10.8 MG IMPLANT	SC	IMPLANT
Zoladex 3.6 MG IMPLANT	SC	IMPLANT
Zoledronic Acid 4 MG RECON SOLN	IV	RECON SOLN
Zoledronic Acid 4 MG/100ML SOLUTION	IV	SOLUTION
Zoledronic Acid 4 MG/5ML CONC	IV	CONC
Zoledronic Acid 5 MG/100ML SOLUTION	IV	SOLUTION
Zometa 4 MG/100ML SOLUTION	IV	SOLUTION
Zometa 4 MG/5ML CONC	IV	CONC
Zortress 0.25 MG TAB	PO	TAB

MEDICATION NAME	ROUTE	DOSE FORM
Zortress 0.5 MG TAB	PO	TAB
Zortress 0.75 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