ABALOPARATIDE (TYMLOS)

MEDICATION(S)
TYMLOS

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

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

REQUIRED MEDICAL INFORMATION
Osteoporosis: one of the following: patient has a history of a broken bone not due to trauma (non-traumatic fracture) or T-score lower than -2.5 or T-score between -1.0 and -2.5 and is at high risk for fracture AND one of the following: trial of a bisphosphonate or a formulary denosumab product, or side effect to bisphosphonate therapy or a formulary denosumab product that supports discontinuation, or initiating or continuing long-term glucocorticoid treatment, 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 a formulary denosumab product, or patient has experienced a recent fracture (within the past 12 months), or history of multiple fractures, or patient experienced a fracture while on long-term glucocorticoid therapy, or T-score less than -3.0, or patient is at high risk for falls, or 10-year hip fracture probability greater than 4.5% based on FRAX score, or 10-year major osteoporosis-related fracture probability greater than 30% based on FRAX score.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

ABEMACICLIB (VERZENIO)

MEDICATION(S)
VERZENIO

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

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

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

ABIRATERONE

MEDICATION(S)
ABIRATERONE ACETATE, ABIRTEGA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

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

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

ACALABRUTINIB (CALQUENCE)

MEDICATION(S)
CALQUENCE

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

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

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

ACETAMINOPHEN/BUTALBITAL

MEDICATION(S)
BUTALBITAL-ACETAMINOPHEN 50-300 MG CAP, BUTALBITAL-ACETAMINOPHEN 50-325 MG TAB, TENCON

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

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

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

ACETAMINOPHEN/BUTALBITAL/CAFFEINE

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

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

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

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

ACETAMINOPHEN/BUTALBITAL/CAFFEINE/CODEINE

MEDICATION(S)
BUTALBITAL-APAP-CAFF-COD 50-325-40-30 MG CAP

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

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

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

ACYCLOVIR CREAM (ZOVIRAX)

MEDICATION(S)
ACYCLOVIR 5 % 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
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

ACYCLOVIR OINTMENT (ZOVIRAX)

MEDICATION(S)
ACYCLOVIR 5 % OINTMENT

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Trial of or has a medical reason for not trying a herpes antiviral drug you take by mouth.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

ADAGRASIB (KRAZATI)

MEDICATION(S)
KRAZATI

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

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

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

ADALIMUMAB (HADLIMA)

MEDICATION(S)
HADLIMA, HADLIMA PUSHTOUCH

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Being used with another targeted immunotherapy drug.

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

AGE RESTRICTION
Age is consistent with the FDA approved indication

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

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

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

ADALIMUMAB RYVK (SIMLANDI)

MEDICATION(S)
SIMLANDI (1 PEN), SIMLANDI (1 SYRINGE), SIMLANDI (2 PEN), SIMLANDI (2 SYRINGE)

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Being used with another targeted immunotherapy drug.

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

AGE RESTRICTION
Age is consistent with the FDA approved indication

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

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

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

ADAPALENE (DIFFERIN)

MEDICATION(S)
ADAPALENE 0.1 % CREAM, ADAPALENE 0.3 % GEL

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

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

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

AFATINIB DIMALEATE (GILOTRIF)

MEDICATION(S)
GILOTRIF

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

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

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan Year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

ALECTINIB (ALECENSA)

MEDICATION(S)
ALECENSA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

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

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan Year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

ALITRETINOIN (PANRETIN)

MEDICATION(S)
PANRETIN

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

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

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
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 tried and failed or had a side effect with a conventional therapy (e.g. anti-diarrheal drug, tricyclic antidepressant, antispasmodic) OR medical reason that conventional therapy cannot be used. Ongoing use: IBS symptoms improved with alosetron and patient does not have constipation problems.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Initial: 2 months
Ongoing use: plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

ALPELISIB (PIQRAY)

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

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

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

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
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).

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

AMIKACIN INHALATION (ARIKAYCE)

MEDICATION(S)
ARIKAYCE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
MAC (mycobactium avium complex) lung infection: being used as part of a multidrug antibacterial regimen (e.g., macrolide, rifamycin, or ethambutol) AND sputum culture is still positive despite 6 months or more of multidrug antibiotic therapy.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

ANAKINRA (KINERET)

MEDICATION(S)
KINERET

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
RA: Not being used in combination with another targeted immunomodulator

REQUIRED MEDICAL INFORMATION
Rheumatoid Arthritis (RA), initial use: Treatment failure or side effect to two of the following: adalimumab (Hadlima, Simlandi), Enbrel, and Rinvoq OR medical reason why all cannot be used.
Ongoing use for all diagnoses: Responding to therapy.

AGE RESTRICTION
Age is consistent with the FDA approved indication

PRESCRIBER RESTRICTION
RA: rheumatologist

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

APALUTAMIDE (ERLEADA)

MEDICATION(S)
ERLEADA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

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

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

APOMORPHINE (APOKYN)

MEDICATION(S)
APOMORPHINE HCL

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Loss of control of body movements due to advanced Parkinson's disease (hypomobility): Treatment failure to a Dopamine agonist, COMT inhibitor, or MAO-B inhibitor.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Neurologist

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

APREMILAST (OTEZLA)

MEDICATION(S)
OTEZLA, OTEZLA/OTEZLA XR INITIATION PK, OTEZLA 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
Plaque Psoriasis (PsO), initial use: treatment failure or side effect with one of the following: a DMARD, a topical corticosteroid, a calcineurin inhibitor, or calcipotriene OR has a medical reason why methotrexate, cyclosporine, acitretin, and topical agents cannot be used.
Behcet's: being used to treat oral ulcers.
Ongoing use for PsA and Behcet's: responding to therapy.
Ongoing use for PsO: PASI or BSA improved from baseline or a decrease in disease severity.

AGE RESTRICTION
Age is consistent with the FDA approved indication

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

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

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 prior to surgery because of history of treatment failure or side effects and dose will be given within 3 hours of surgery.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
PONV: once per surgery.

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

ARIPIPRAZOLE (OPIPZA)

MEDICATION(S)
OPIPZA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Medical reason why oral generic aripiprazole cannot be used.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

ARMODAFINIL (NUVIGIL)

MEDICATION(S)
ARMODAFINIL

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

OFF LABEL USES
Bipolar disorder

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Narcolepsy: patient has positive sleep study (polysomnography) for narcolepsy. Trial and failure or side effect with modafinil or there is a medical reason why modafinil cannot be used.
Obstructive sleep apnea/hypopnea syndrome (OSAHS): patient has a positive sleep study for OSAHS, Trial and failure or side effect with modafinil or there is a medical reason why modafinil cannot be used.
Shift work sleep disorder: Trial and failure or side effect with modafinil or there is a medical reason why modafinil cannot be used.
Bipolar Disorder: being added to current treatment regimen AND Trial and failure or side effect with modafinil or there is a medical reason why modafinil cannot be used.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Bipolar Disorder: Psychiatrist

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

ASCIMINIB (SCEMBLIX)

MEDICATION(S)
SCEMBLIX

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

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

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

ASENAPINE (SAPHRIS)

MEDICATION(S)
ASENAPINE MALEATE

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Trial and failure or side effect to one generic atypical antipsychotic drug or there is a medical reason why all the generic atypical antipsychotics cannot be used.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

ASENAPINE (SECUADO)

MEDICATION(S)
SECUADO

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

ASPIRIN/BUTALBITAL/CAFFEINE

MEDICATION(S)
BUTALBITAL-ASPIRIN-CAFFEINE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

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

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

ASPIRIN/BUTALBITAL/CAFFEINE/CODEINE

MEDICATION(S)
ASCOMP-CODEINE, BUTALBITAL-ASA-CAFF-CODEINE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

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

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

ATOVAQUONE (MEPRON)

MEDICATION(S)
ATOVAQUONE

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

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

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

AVAPRITINIB (AYVAKIT)

MEDICATION(S)
AYVAKIT

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

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

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

AVUTOMETINIB AND DEFACTINIB (AVMAPKI-FAKZYNJA CO-PACK)

MEDICATION(S)
AVMAPKI FAKZYNJA CO-PACK

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

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

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

AXITINIB (INLYTA)

MEDICATION(S)
INLYTA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

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

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

AZACITIDINE (ONUREG)

MEDICATION(S)
ONUREG

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

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

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

AZTREONAM LYSINE (CAYSTON)

MEDICATION(S)
CAYSTON

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Being used for acute treatment of an infection.

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
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
Initial: Diabetic ulcer has not responded to standard therapy for wound management.
Ongoing: Ulcer decreased in size by 30% and has not achieve complete response

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Initial: 3 months
Ongoing: 2 months

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

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
Age is consistent with the FDA approved indication

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
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 Lupkynis, Gazyva, Rituxan, other biologics.

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

AGE RESTRICTION
Age is consistent with the FDA approved indication

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

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

BELZUTIFAN (WELIREG)

MEDICATION(S)
WELIREG

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

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

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

BEXAROTENE CAPSULE (TARGRETIN)

MEDICATION(S)
BEXAROTENE 75 MG CAP

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

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

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

BEXAROTENE (TARGRETIN TOPICAL GEL)

MEDICATION(S)
BEXAROTENE 1 % GEL

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

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

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

BINIMETINIB (MEKTOVI)

MEDICATION(S)
MEKTOVI

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

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

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

BOSENTAN (TRACLEER)

MEDICATION(S)
BOSENTAN

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).

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

BOSUTINIB (BOSULIF)

MEDICATION(S)
BOSULIF 100 MG CAP, BOSULIF 100 MG TAB, BOSULIF 500 MG TAB, BOSULIF 50 MG CAP, BOSUTINIB

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

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

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

BREXPIPRAZOLE (REXULTI)

MEDICATION(S)
REXULTI

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
MDD: being used as a single agent

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

BRIGATINIB (ALUNBRIG)

MEDICATION(S)
ALUNBRIG

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

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

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

BUDESONIDE DELAYED RELEASE (TARPEYO)

MEDICATION(S)
TARPEYO

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Being used in combination with another therapy for IgAN (e.g. Fabhalta, Vanrafia, Voyxact)

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
nephrologist

COVERAGE DURATION
9 months

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

BUDESONIDE ER TABLET (UCERIS)

MEDICATION(S)
BUDESONIDE ER

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

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

EXCLUSION CRITERIA
Microscopic colititis: Used for maintenance

REQUIRED MEDICAL INFORMATION
Ulcerative colitis (UC): being used to start remission of active UC, and patient has tried or has a medical reason for not trying one drug from the mesalamine class, and for moderate disease, medical reason why patient cannot use a generic corticosteroid drug that is taken by mouth.
Autoimmune hepatitis: being used with azathioprine and has a medical reason not to use prednisone or prednisolone or had severe side effect to prednisone or prednisolone that is not also seen with budesonide and dose is not more than 9 mg per day.
Microscopic colitis: being used to start remission of symptoms and dose is not more than 9 mg per day.

AGE RESTRICTION
N/A

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

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

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

BUPRENORPHINE PATCH (BUTRANS)

MEDICATION(S)
BUPRENORPHINE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

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

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Cancer pain: Oncologist or Pain Specialist.

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

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

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.

REQUIRED MEDICAL INFORMATION
Prevention: chart documentation or labs that confirms HAE, and prescriber states that patient has symptomatic disease. Ongoing use: responding to therapy

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

CABOZANTINIB (CABOMETYX)

MEDICATION(S)
CABOMETYX

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

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

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

CABOZANTINIB S-MALATE (COMETRIQ)

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

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

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

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

CALCIPOTRIENE-BETAMETHASONE OINTMENT (TACLONEX)

MEDICATION(S)
CALCIPOTRIENE-BETAMETH DIPROP 0.005-0.064 % OINTMENT

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Trial and failure of either calcipotriene or a topical steroid from the high or very high potency class.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

CANNABIDIOL (CBD) EXTRACT (EPIDIOLEX)

MEDICATION(S)
EPIDIOLEX

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

CAPIVASERTIB (TRUQAP)

MEDICATION(S)
TRUQAP

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

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

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

CAPMATINIB (TABRECTA)

MEDICATION(S)
TABRECTA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

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

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

CARGLUMIC ACID (CARBAGLU)

MEDICATION(S)
CARGLUMIC ACID

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

CARIPRAZINE HYDROCHLORIDE (VRAYLAR)

MEDICATION(S)
VRAYLAR

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

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

REQUIRED MEDICAL INFORMATION
Trial and failure or side effect to one generic atypical antipsychotic drug or there is a medical reason why all the generic atypical antipsychotics cannot be used.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

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
Patient tried and failed or had a side effect with two formulary partial seizure drugs OR medical reason that formulary partial seizure drugs cannot be used.

AGE RESTRICTION
Age is consistent with the FDA approved indication

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

CERITINIB (ZYKADIA)

MEDICATION(S)
ZYKADIA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

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

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

CLOBAZAM (ONFI)

MEDICATION(S)
CLOBAZAM 10 MG TAB, CLOBAZAM 20 MG TAB, CLOBAZAM 2.5 MG/ML SUSPENSION

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

CLOBAZAM ORAL FILM (SYMPAZAN)

MEDICATION(S)
SYMPAZAN

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

CLOZAPINE SUSPENSION (VERSACLOZ)

MEDICATION(S)
VERSACLOZ

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

OFF LABEL USES
Parkinson's psychosis disorder

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

COBIMETINIB (COTELLIC)

MEDICATION(S)
COTELLIC

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

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

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

CRISABOROLE (EUCRISA)

MEDICATION(S)
EUCRISA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Patient is at least 3 months old but less than 2 years old OR patient is at least 2 years old and one of the following: Inadequate response or intolerable side effect to ONE prescription-strength topical corticosteroid agent, or contraindication to the use of ALL prescription-strength topical corticosteroid therapy OR inadequate response, intolerable side effect, or contraindication to a topical calcineurin inhibitor. Ongoing use: responding to therapy

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

CRIZOTINIB (XALKORI)

MEDICATION(S)
XALKORI

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

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

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

CYSTEAMINE (CYSTAGON)

MEDICATION(S)
CYSTAGON

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

DABRAFENIB (TAFINLAR)

MEDICATION(S)
TAFINLAR

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

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

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

DACOMITINIB (VIZIMPRO)

MEDICATION(S)
VIZIMPRO

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

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

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

DALFAMPRIDINE EXTENDED-RELEASE TABLET (AMPYRA)

MEDICATION(S)
DALFAMPRIDINE ER

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Neurologist or Multiple Sclerosis specialist

COVERAGE DURATION
Initial use: 6 months. Ongoing use: plan year.

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

DAPSONE GEL (ACZONE)

MEDICATION(S)
DAPSONE 5 % GEL, DAPSONE 7.5 % GEL

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Initial: Trial and failure or side effect to a topical retinoin agent AND either a topical benzoyl peroxide containing agent or a topical anti-infective agent for acne. Ongoing use: responding to therapy

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Initial: 12 weeks
Reauthorization: Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

DARBEPOETIN ALFA (ARANESP)

MEDICATION(S)
ARANESP (ALBUMIN FREE)

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

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

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

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

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

DAROLUTAMIDE (NUBEQA)

MEDICATION(S)
NUBEQA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

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

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

DASATINIB (SPRYCEL)

MEDICATION(S)
DASATINIB

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

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

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

DECITABINE-CEDAZURIDINE (INQOVI)

MEDICATION(S)
INQOVI

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

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

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

DENOSUMAB (BILDYOS)

MEDICATION(S)
BILDYOS

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Being used with other osteoporosis drugs.

REQUIRED MEDICAL INFORMATION
Treatment or prevention of postmenopausal osteoporosis in women OR to increase bone mass in men: one of the following: trial of a bisphosphonate, 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 and either has history of a non-traumatic fracture or is at high risk for fracture.
Prostate Cancer: Patient is currently taking androgen deprivation therapy.
Breast Cancer: Patient is currently taking an aromatase inhibitor.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

DENOSUMAB (BILPREVDA)

MEDICATION(S)
BILPREVDA

PA INDICATION INDICATOR
3 - All Medically-Accepted 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 within the last 30 days but did not respond well enough or had a side effect.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

DENOSUMAB (ENOBY)

MEDICATION(S)
ENOBY

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Being used with other osteoporosis drugs.

REQUIRED MEDICAL INFORMATION
Treatment or prevention of postmenopausal osteoporosis in women OR to increase bone mass in men: one of the following: trial of a bisphosphonate, 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 and either has history of a non-traumatic fracture or is at high risk for fracture.
Prostate Cancer: Patient is currently taking androgen deprivation therapy.
Breast Cancer: Patient is currently taking an aromatase inhibitor.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

DENOSUMAB (JUBBONTI)

MEDICATION(S)
JUBBONTI

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Being used with other osteoporosis drugs.

REQUIRED MEDICAL INFORMATION
Treatment or prevention of postmenopausal osteoporosis in women OR to increase bone mass in men: one of the following: trial of a bisphosphonate, 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 and either has history of a non-traumatic fracture or is at high risk for fracture.
Prostate Cancer: Patient is currently taking androgen deprivation therapy.
Breast Cancer: Patient is currently taking an aromatase inhibitor.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

DENOSUMAB (WYOST)

MEDICATION(S)
WYOST

PA INDICATION INDICATOR
3 - All Medically-Accepted 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 within the last 30 days but did not respond well enough or had a side effect.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

DENOSUMAB (XTRENBO)

MEDICATION(S)
XTRENBO

PA INDICATION INDICATOR
3 - All Medically-Accepted 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 within the last 30 days but did not respond well enough or had a side effect.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

DEUTETRABENAZINE (AUSTEDO, AUSTEDO XR)

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

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Neurologist or Psychiatrist

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

DEXTROMETHORPHAN HBR- BUPROPION HCL ER (AUVELITY)

MEDICATION(S)
AUVELITY, AUVELITY TITRATION PACK

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Treatment failure or side effect with at least two generic antidepressants.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

DEXTROMETHORPHAN HBR-QUINIDINE SULFATE (NUEDEXTA)

MEDICATION(S)
DEXTROMETHORPHAN-QUINIDINE, NUEDEXTA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Pseudobulbar affect is secondary to one of the following neurologic conditions: Amyotrophic lateral sclerosis (ALS), Alzheimer's disease, Multiple Sclerosis, Parkinson's disease, Stroke, or traumatic brain injury.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

DICLOFENAC TOPICAL GEL (SOLARAZE)

MEDICATION(S)
DICLOFENAC SODIUM 3 % GEL

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Patient tried and failed or had a side effect with fluorouracil or imiquimod OR medical reason that fluorouracil and imiquimod cannot be used.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
90 days

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

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 triptans or has a medical reason for not using triptans.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

DIMETHYL FUMARATE (TECFIDERA)

MEDICATION(S)
DIMETHYL FUMARATE, DIMETHYL FUMARATE STARTER PACK

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

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

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

DORDAVIPRONE (MODEYSO)

MEDICATION(S)
MODEYSO

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

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

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

DOXYCYCLINE MONOHYDRATE (ORACEA)

MEDICATION(S)
DOXYCYCLINE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Patient has tried and failed or had a side effect to any two of the following: a topical sulfacetamide sodium product, a topical metronidazole product, and topical azelaic acid OR there is a medical reason why patient cannot use all of these drugs.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

DRONABINOL

MEDICATION(S)
DRONABINOL 10 MG CAP, DRONABINOL 2.5 MG CAP, DRONABINOL 5 MG CAP

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

DROXIDOPA (NORTHERA)

MEDICATION(S)
DROXIDOPA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Orthostatic hypotension is caused by primary anatomic failure such as Parkinson's disease, multiple system neuropathy or pure autonomic failure, dopamine beta-hydroxylase deficiency, or non-diabetic autonomic neuropathy. For ongoing use: patient has had clinical improvement in symptoms or daily living activities.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Cardiologist or Neurologist

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

DULAGLUTIDE (TRULICITY)

MEDICATION(S)
TRULICITY

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Being used with another GLP-1 agent. Being used for weight loss only.

REQUIRED MEDICAL INFORMATION
Confirmation of Type 2 diabetes

AGE RESTRICTION
Age is consistent with the FDA approved indication

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

DULOXETINE (DRIZALMA SPRINKLE)

MEDICATION(S)
DRIZALMA SPRINKLE

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

DUPILUMAB (DUPIXENT)

MEDICATION(S)
DUPIXENT

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

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

REQUIRED MEDICAL INFORMATION
Asthma, initial use: Treatment failure with recent use of high-dose inhaled corticosteroid along with long-acting beta agonist or leukotriene receptor antagonists, AND patient has had 1 of the following within the past year: 1 or more asthma-related ER or inpatient visits, or 2 or more asthma exacerbations that require oral corticosteroids, AND one of the following: eosinophil blood count is 150 cells/mL or more, or patient on maximally-tolerated oral corticosteroids.
Atopic Dermatitis (AD) initial use: disease is moderate to severe AND ONE of the following: patient has tried a medium to very high potency topical corticosteroid and a topical calcineurin inhibitor OR has a medical reason why these topical therapies cannot be used.
Eosinophilic Esophagitis (EOE) initial use: treatment failure or side effect with a proton pump inhibitor (PPI) or inhaled fluticasone or budesonide OR has a medical reason why PPIs and inhaled fluticasone and budesonide cannot be used.
Chronic rhinosinusitis with nasal polyps (CRSwNP): Being used as add-on maintenance therapy AND treatment failure with an intranasal corticosteroid or medical reason why intranasal corticosteroids cannot be used. COPD: initial use: moderate to severe disease with an eosinophilic phenotype and ONE of the following: being used as an add-on therapy in combo with a long-acting beta agonist (LABA), long-acting muscarinic antagonist (LAMA), and inhaled corticosteroid (ICS) OR in combo with a LABA and LAMA in those who has tried and failed or had a side effect to ICS or has a medical reason why ICS cannot be used.
CSU, Bullous Pemphigoid, AFRS: see Other Criteria.

AGE RESTRICTION
Age is consistent with the FDA approved indication

PRESCRIBER RESTRICTION
EoE: Allergist, Immunologist, or Gastroenterologist. CRSwNP, AFRS: Allergist, Immunologist, or Otolaryngologist. Prurigo Nodularis (PN), Bullous Pemphigoid: Dermatologist. COPD: Pulmonologist.

COVERAGE DURATION
Plan year

OTHER CRITERIA
Chronic Spontaneous Urticaria (CSU): Inadequate response or intolerance after titration up to the maximally tolerated dose of a second-generation antihistamine (up to 4 times FDA approved dose), or contraindication to second-generation antihistamines.
Bullous Pemphigoid: treatment failure or side effect to ONE of the following, or contraindication to ALL of the following: High or very high potency topical steroid, Systemic corticosteroid, Tetracycline antibiotic AND initiated in combination with a tapering course of oral corticosteroids, unless contraindicated.
Allergic Fungal Rhinosinusitis (AFRS): Patient has had sino-nasal surgery for the treatment of AFRS.
Ongoing use for all diagnosis: symptoms improved and/or controlled while on Dupixent.

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

DUVELISIB (COPIKTRA)

MEDICATION(S)
COPIKTRA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

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

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

EFLORNITHINE HYDROCHLORIDE (IWILFIN)

MEDICATION(S)
IWILFIN

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

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

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

ELACESTRANT (ORSERDU)

MEDICATION(S)
ORSERDU

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

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

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

ELAPEGADEMASE-LVLR (REVCOVI)

MEDICATION(S)
REVCOVI

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Intial: Patient has a diagnosis of adenosine deaminase severe combined immune deficiency (ADA-SCID) confirmed by ONE of the following: Molecular genetic confirmation of mutations in both alleles of the ADA1 gene OR Deficiency or absence of ADA in lysed erythrocytes, fibroblasts (cultured from amniotic fluid), or chorionic villus OR Positive screening by T cell receptor excision circles (TRECs) OR Increase in deoxyadenosine triphosphate (dATP) levels in erythrocyte lysates over the testing laboratory's upper limit of the normal range
Reauthorization: Patient has had clinical benefit with the requested drug

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED

N/A

ELEXACAFTOR-TEZACAFTOR-IVACAFTOR (TRIKAFTA)

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

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

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

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

AGE RESTRICTION
Age is consistent with the FDA approved indication

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

ELTROMBOPAG OLAMINE (PROMACTA)

MEDICATION(S)
ELTROMBOPAG OLAMINE

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

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

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

REQUIRED MEDICAL INFORMATION
Chronic Hepatitis C: on interferon-based therapy and platelet count is less than or equal to 75,000/mcl prior to therapy or falls to less than or equal to 50,000/mcl during therapy.Chronic or Persistent 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, and splenectomy OR has a medical reason not to use (contraindication) corticosteroids or IVIG. Aplastic anemia: Platelet count is less than 50,000 cells/mcl and for first-line treatment: being used with cyclosporine and antithymocyte globulin (ATG) therapy. Thrombocytopenia due to MDS: treatment failure or side effect to at least one supported first line therapy for low risk MDS (e.g. decitabine, cyclosporine, ATG, lenalidomide) Or used in combination with ATG or by itself as initial therapy. Immunotherapy-Related Thrombocytopenia: immunotherapy-related Grade 3 (platelet count 50,000 cells/mcl-25,000 cells/mcl) or Grade 4 (platelet count less than 25,000 cells/mcl) thrombocytopenia AND no response to at least 1 week of corticosteroids. Ongoing use: platelet count has improved since starting medication but is not more than 400,000 and for MDS only disease has not progressed to acute leukemia. Thrombocytopenia post-HSCT: prolonged low platelet count (thrombocytopenia) after allogenic transplant and poor graft function.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

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

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

ENASIDENIB MESYLATE (IDHIFA)

MEDICATION(S)
IDHIFA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

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

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

ENCORAFENIB (BRAFTOVI)

MEDICATION(S)
BRAFTOVI

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

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

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

ENSARTINIB (ENSACOVE)

MEDICATION(S)
ENSACOVE

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

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

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

ENTRECTINIB (ROZLYTREK)

MEDICATION(S)
ROZLYTREK

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

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

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

ENZALUTAMIDE (XTANDI)

MEDICATION(S)
XTANDI

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

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

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

EPOETIN ALFA-EPBX (RETACRIT)

MEDICATION(S)
RETACRIT

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

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

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

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

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

ERDAFITINIB (BALVERSA)

MEDICATION(S)
BALVERSA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

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

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

ERENUMAB-AOOE (AIMOVIG)

MEDICATION(S)
AIMOVIG

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
use in combination with another CGRP antagonist

REQUIRED MEDICAL INFORMATION
Migraine headache prevention, Initial: documentation of 4 or more headache days per month. Ongoing: responding to therapy

AGE RESTRICTION
Age is consistent with the FDA approved indication

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

ERLOTINIB (TARCEVA)

MEDICATION(S)
ERLOTINIB HCL

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

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

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

ETANERCEPT (ENBREL)

MEDICATION(S)
ENBREL, ENBREL MINI, ENBREL SURECLICK

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

OFF LABEL USES
graft vs host disease (GVHD)

EXCLUSION CRITERIA
Being used with another targeted immunotherapy drug.

REQUIRED MEDICAL INFORMATION
Plaque Psoriasis (PsO), initial use: patient tried and failed or had a side effect to one DMARD or has a medical reason why methotrexate, 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 from baseline or a decrease in disease severity.
Rheumatoid Arthritis (RA): patient has tried and failed, had a side effect, or a medical reason why a DMARD cannot be used.
Polyarticular Juvenile Idiopathic Arthritis (pJIA): patient has tried and failed or had a side effect to one DMARD or has a medical reason why methotrexate cannot be used.
GVHD: treatment failure or side effect to one drug for GVHD.
For Ankylosing spondylitis (AS), Psoriatic arthritis (PsA), PsO, RA, and pJIA: Adult patient has tried and failed or had a side effect with adalimumab or has a medical reason not to use adalimumab.
Ongoing use for AS, GVHD, pJIAm PsA, RA: responding to therapy.

AGE RESTRICTION
Age is consistent with the FDA approved indication

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

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

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

ETRASIMOD ARGININE (VELSIPITY)

MEDICATION(S)
VELSIPITY

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
Treatment failure or side effect to two of the following: adalimumab (Hadlima, Simlandi), ustekinumab (Yesintek), Rinvoq, Skyrizi, or Tremfya OR medical reason why all cannnot be used.
Ongoing use for all diagnoses: Responding to therapy.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

EVEROLIMUS (AFINITOR)

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

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

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

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

EVEROLIMUS (AFINITOR DISPERZ)

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

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

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

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

EVOLOCUMAB (REPATHA)

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

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Hypercholesterolemia, Heterozygous Familial Hypercholesterolemia (HeFH), Reduce Risk of Major Adverse Cardiovascular Disease: 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) AND one of the following: at least 8 weeks of treatment with a high-intensity statin, or FDA approved package insert supported contraindication to all statins, or intolerance to statin as defined by one of the following: statin-related rhabdomyolysis, or statin-related skeletal muscle symptoms, or statin-related elevated hepatic transaminase.
Homozygous Familial Hypercholesterolemia (HoFH): a positive genetic test for LDL-R genetic mutations OR clinical evidence that confirms HoFH.

AGE RESTRICTION
Age is consistent with the FDA approved indication

PRESCRIBER RESTRICTION
HoFH: Cardiologist or Endocrinologist

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

FECAL MICROBIOTA SPORES, LIVE-BRPK (VOWST)

MEDICATION(S)
VOWST

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Patient had 3 or more episodes of C.difficile infection and has completed antibiotic treatment before starting Vowst.

AGE RESTRICTION
Age is consistent with the FDA approved indication

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
one course (3 days)

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

FEDRATINIB (INREBIC)

MEDICATION(S)
INREBIC

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Being used with another agent that treats myelofibrosis.

REQUIRED MEDICAL INFORMATION
Myelofibrosis: platelet count of at least 50,000 cells/mcl

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

FENFLURAMINE (FINTEPLA)

MEDICATION(S)
FINTEPLA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

FEZOLINETANT (VEOZAH)

MEDICATION(S)
VEOZAH

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Moderate to severe vasomotor symptoms: trial and failure of one non-hormonal therapy (e.g. venlafaxine, desvenlafaxine, paroxetine, citalopram, escitalopram, and gabapentin) AND one estrogen-based therapy unless not appropriate.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

FIDAXOMICIN (DIFICID)

MEDICATION(S)
DIFICID 40 MG/ML RECON SUSP, FIDAXOMICIN

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Clostridium difficile: evidence of current infection.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
10 days

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

FILGRASTIM-AAFI (NIVESTYM)

MEDICATION(S)
NIVESTYM

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

OFF LABEL USES
HIV/AIDS patients on myelosuppressive therapy, drug-induced neutropenia, Myelodysplastic syndrome (MDS), agranulocytosis, febrile neutropenia, Neutropenia due to radiation

EXCLUSION CRITERIA
chemo-induced febrile neutropenia: Being used along with another G-CSF (granulocyte colony stimulating factor) drug.

REQUIRED MEDICAL INFORMATION
Agranulocytosis, neutropenia (congenital, cyclic, or idiopathic): neutropenia is recurring or does not go away and ONE of the following: history of recurring infections or patient had 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: 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 AND for febrile neutropenia: patient has not used pegfilgrastim in the past 14 days. MDS: ONE of the following: ANC is less than 800/mm3, or ANC is less than 1000/mm3 with neutropenia expected to last more than 5 days, or being used with an erythropoiesis-stimulating agent to improve symptoms of anemia and all of the following: Hgb less than 10 and EPO level less than or equal to 500 mU/mL.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
see other criteria

OTHER CRITERIA
Excluded under Part D if covered by Part B. Dose and duration is not more than the FDA labeled maximum.
Coverage duration: Febrile neutropenia: 2 months.Peripheral blood cell collection: 3 months. Congenital, cyclic, idiopathic neutropenia, agranulocytosis, MDS: plan year. Neutropenia due to cancer drug therapy and AML: duration of cancer drug therapy. Neutropenia due to radiation: duration of radiation therapy. Drug induced neutropenia, HIV/AIDs neutropenia: duration of drug therapy. Bone Marrow Transplantation: 6 months.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

FILGRASTIM-SNDZ (ZARXIO)

MEDICATION(S)
ZARXIO

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

OFF LABEL USES
HIV/AIDS patients on myelosuppressive therapy, drug-induced neutropenia, Myelodysplastic syndrome (MDS), agranulocytosis, febrile neutropenia

EXCLUSION CRITERIA
chemo-induced febrile neutropenia: Being used along with another G-CSF (granulocyte colony stimulating factor) drug.

REQUIRED MEDICAL INFORMATION
Agranulocytosis, neutropenia (congenital, cyclic, or idiopathic): neutropenia is recurring or does not go away and ONE of the following: history of recurring infections or patient had 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: 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 AND for febrile neutropenia: patient has not used pegfilgrastim in the past 14 days.
MDS: ONE of the following: ANC is less than 800/mm3, or ANC is less than 1000/mm3 with neutropenia expected to last more than 5 days, or being used with an erythropoiesis-stimulating agent to improve symptoms of anemia and all of the following: Hgb less than 10 and EPO level less than or equal to 500 mU/mL.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
see other criteria

OTHER CRITERIA
Excluded under Part D if covered by Part B. Dose and duration is not more than the FDA labeled maximum.
Coverage duration: Febrile neutropenia: 2 months.Peripheral blood cell collection: 3 months. Congenital, cyclic, idiopathic neutropenia, agranulocytosis, MDS: plan year. Neutropenia due to cancer drug therapy and AML: duration of cancer drug therapy. Neutropenia due to radiation: duration of radiation therapy. Drug induced neutropenia, HIV/AIDs neutropenia: duration of drug therapy. Bone Marrow Transplantation: 6 months.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

FINERENONE (KERENDIA)

MEDICATION(S)
KERENDIA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
CKD associated with T2D: History of and will continue on, or has a contraindication to an angiotensin converting enzyme inhibitor (ACE-i) or an angiotensin receptor blocker (ARB). HF with mildly reduced or preserved LVEF: Diagnosis of heart failure (New York Heart Association [NYHA] class II-IV) with documented left ventricular ejection fraction (LVEF) greater than or equal to 40%, and treatment failure or side effect to SGLT-2 inhibitor or there is a medical reason why SGLT-2 inhibitor cannot be used.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

FINGOLIMOD HCL (GILENYA)

MEDICATION(S)
FINGOLIMOD HCL

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

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

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

FRUQUINTINIB (FRUZAQLA)

MEDICATION(S)
FRUZAQLA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

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

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

FUTIBATINIB (LYTGOBI)

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

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

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

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

GALCANEZUMAB-GNLM (EMGALITY)

MEDICATION(S)
EMGALITY, EMGALITY (300 MG DOSE)

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Migraine HA prevention: use in combination with another CGRP antagonist

REQUIRED MEDICAL INFORMATION
Cluster HA: Trial and failure or side effect to ONE standard of care preventive drug for cluster headaches or patient has a medical reason why all standard of care preventive drugs for cluster headaches cannot be used.
Migraine HA prevention, Initial: documentation of 4 or more headache days per month.
Ongoing for all diagnosis: responding to therapy

AGE RESTRICTION
Age is consistent with the FDA approved indication

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

GANAXOLONE (ZTALMY)

MEDICATION(S)
ZTALMY

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
Age is consistent with the FDA approved indication

PRESCRIBER RESTRICTION
Neurologist

COVERAGE DURATION
plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

GEFITINIB (IRESSA)

MEDICATION(S)
GEFITINIB

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

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

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

GEPIRONE (EXXUA)

MEDICATION(S)
EXXUA, EXXUA TITRATION PACK

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Patient tried and failed or had a side effect with two formulary drugs that treats depression OR medical reason that depression drugs cannot be used.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

GILTERITINIB FUMARATE (XOSPATA)

MEDICATION(S)
XOSPATA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

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

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

GLASDEGIB MALEATE (DAURISMO)

MEDICATION(S)
DAURISMO

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

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

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

GLATIRAMER ACETATE (COPAXONE, GLATOPA)

MEDICATION(S)
GLATIRAMER ACETATE, GLATOPA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

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

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
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
Age is consistent with the FDA approved indication

PRESCRIBER RESTRICTION
Hepatologist, Gastroenterologist, or Infectious Disease.

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

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

GLUTAMINE (ENDARI)

MEDICATION(S)
L-GLUTAMINE 5 GM PACKET

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
Age is consistent with the FDA approved indication

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

GLYCOPYRROLATE ORAL SOLUTION (CUVPOSA)

MEDICATION(S)
GLYCOPYRROLATE 1 MG/5ML SOLUTION

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
Age is consistent with the FDA approved indication

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

GUSELKUMAB IV (TREMFYA IV)

MEDICATION(S)
TREMFYA 200 MG/20ML SOLUTION

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Being used with another targeted immunotherapy drug.

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
Age is consistent with the FDA approved indication

PRESCRIBER RESTRICTION
CD, UC: gastroenterologist

COVERAGE DURATION
one time induction course (8 weeks)

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

GUSELKUMAB SQ (TREMFYA SQ)

MEDICATION(S)
TREMFYA 100 MG/ML SOLN PRSYR, TREMFYA 200 MG/2ML SOLN PRSYR, TREMFYA-CD/UC INDUCTION, TREMFYA ONE-PRESS, TREMFYA PEN

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Being used with another targeted immunotherapy drug.

REQUIRED MEDICAL INFORMATION
Plaque Psoriasis (PsO), initial use: patient tried and failed or had a side effect with one DMARD or medical reason why methotrexate, 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: Ongoing use: PASI or BSA improved from baseline or a decrease in disease severity. Psoriatic arthritis (PsA), Crohn's Disease (CD), Ulcerative colitis (UC), ongoing use: Patient is responding to therapy.

AGE RESTRICTION
Age is consistent with the FDA approved indication

PRESCRIBER RESTRICTION
PsA: Rheumatologist. PsO: Rheumatologist or Dermatologist. CD, UC: gastroenterologist

COVERAGE DURATION
PsO initial: 24 weeks. PsO ongoing and all other indications: plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

HIGH RISK MEDICATION (AMITRIPTYLINE)

MEDICATION(S)
AMITRIPTYLINE HCL

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

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

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
YES

PREREQUISITE THERAPY REQUIRED
N/A

HIGH RISK MEDICATION (AMITRIPTYLINE/PERPHENAZINE)

MEDICATION(S)
PERPHENAZINE-AMITRIPTYLINE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

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

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan Year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

HIGH RISK MEDICATION (CLOMIPRAMINE)

MEDICATION(S)
CLOMIPRAMINE HCL

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

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

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
YES

PREREQUISITE THERAPY REQUIRED
N/A

HIGH RISK MEDICATION (CYPROHEPTADINE)

MEDICATION(S)
CYPROHEPTADINE HCL 4 MG TAB

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

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

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
YES

PREREQUISITE THERAPY REQUIRED
N/A

HIGH RISK MEDICATION (DICYCLOMINE)

MEDICATION(S)
DICYCLOMINE HCL 10 MG/5ML SOLUTION, DICYCLOMINE HCL 10 MG CAP, DICYCLOMINE HCL 20 MG TAB

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

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

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
YES

PREREQUISITE THERAPY REQUIRED
N/A

HIGH RISK MEDICATION (DOXEPIN)

MEDICATION(S)
DOXEPIN HCL 100 MG CAP, DOXEPIN HCL 10 MG CAP, DOXEPIN HCL 10 MG/ML CONC, DOXEPIN HCL 150 MG CAP, DOXEPIN HCL 25 MG CAP, DOXEPIN HCL 50 MG CAP, DOXEPIN HCL 75 MG CAP

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

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

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
YES

PREREQUISITE THERAPY REQUIRED
N/A

HIGH RISK MEDICATION (HYDROXYZINE)

MEDICATION(S)
HYDROXYZINE HCL 10 MG/5ML SYRUP, HYDROXYZINE HCL 10 MG TAB, HYDROXYZINE HCL 25 MG TAB, HYDROXYZINE HCL 50 MG/25ML SYRUP, HYDROXYZINE HCL 50 MG TAB, HYDROXYZINE PAMOATE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

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

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
YES

PREREQUISITE THERAPY REQUIRED
N/A

HIGH RISK MEDICATION (IMIPRAMINE)

MEDICATION(S)
IMIPRAMINE HCL

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

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

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
YES

PREREQUISITE THERAPY REQUIRED
N/A

HIGH RISK MEDICATION (PHENOBARBITAL)

MEDICATION(S)
PHENOBARBITAL

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

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

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
YES

PREREQUISITE THERAPY REQUIRED
N/A

HIGH RISK MEDICATION (PHENYLEPHRINE/PROMETHAZINE)

MEDICATION(S)
PROMETHAZINE-PHENYLEPHRINE, PROMETHAZINE VC

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

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

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan Year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

HIGH RISK MEDICATION (PROMETHAZINE)

MEDICATION(S)
PROMETHAZINE HCL 12.5 MG/10ML SOLUTION, PROMETHAZINE HCL 12.5 MG SUPPOS, PROMETHAZINE HCL 12.5 MG TAB, PROMETHAZINE HCL 25 MG SUPPOS, PROMETHAZINE HCL 25 MG TAB, PROMETHAZINE HCL 50 MG TAB, PROMETHAZINE HCL 6.25 MG/5ML SOLUTION, PROMETHEGAN 12.5 MG SUPPOS, PROMETHEGAN 25 MG SUPPOS

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

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

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
YES

PREREQUISITE THERAPY REQUIRED
N/A

HIGH RISK MEDICATION (PROMETHAZINE/DM)

MEDICATION(S)
PROMETHAZINE-DM

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

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

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan Year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

HIGH RISK MEDICATION (PROMETHAZINE/PHENYLEPHRINE/CODEINE)

MEDICATION(S)
PROMETHAZINE-PHENYLEPH-CODEINE, PROMETHAZINE VC/CODEINE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

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

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan Year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

HIGH RISK MEDICATION (PROMETHAZINE W/CODEINE)

MEDICATION(S)
PROMETHAZINE-CODEINE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

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

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan Year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

HIGH RISK MEDICATION (THIORIDAZINE)

MEDICATION(S)
THIORIDAZINE HCL

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

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

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
YES

PREREQUISITE THERAPY REQUIRED
N/A

HIGH RISK MEDICATION (TRIMIPRAMINE)

MEDICATION(S)
TRIMIPRAMINE MALEATE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

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

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
YES

PREREQUISITE THERAPY REQUIRED
N/A

IBRUTINIB (IMBRUVICA)

MEDICATION(S)
IMBRUVICA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

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

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

ICATIBANT (FIRAZYR)

MEDICATION(S)
ICATIBANT ACETATE, SAJAZIR

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

IDELALISIB (ZYDELIG)

MEDICATION(S)
ZYDELIG

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

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

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

ILOPERIDONE (FANAPT)

MEDICATION(S)
FANAPT, FANAPT TITRATION PACK A, FANAPT TITRATION PACK B, FANAPT TITRATION PACK C

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Trial and failure or side effect to one generic atypical antipsychotic drug or there is a medical reason why all the generic atypical antipsychotics cannot be used.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

IMATINIB MESYLATE (GLEEVEC)

MEDICATION(S)
IMATINIB MESYLATE

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

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

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

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

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

IMATINIB ORAL SOLUTION (IMKELDI)

MEDICATION(S)
IMKELDI

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
Medical reason why imatinib tablet cannot be used.

AGE RESTRICTION
N/A

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

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

IMLUNESTRANT (INLURIYO)

MEDICATION(S)
INLURIYO

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

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

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

IMMUNE GLOBULIN (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, Multiple myeloma, Polymyositis and dermatomyositis, Solid organ transplants, Bone marrow transplants, Hemopoietic stem cell transplant, Small lymphocytic leukemia, Multifocal Motor Neuropathy (MMN), Myasthenia Gravis (MG)

EXCLUSION CRITERIA
AMBD: being used with another immunomodulator

REQUIRED MEDICAL INFORMATION
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.
Typical chronic inflammatory demyelinating polyneuropathy (CIDP), multifocal variant of CIDP (multifocal acquired demyelinating sensor and motor neuropathy of MADSAM), multifocal motor neuropathy (MMN) aka Pure Motor CIDP, and pure sensory chronic inflammatory demyelinating polyneuropathy: IV administration, CIDP confirmed by electrodiagnostic testing (nerve conduction studies) OR nerve conduction studies show possible CIDP and 2 of the following to confirm the diagnosis: CSF examination, nerve biopsy, MRI, ultrasound.
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 and an oral or IV corticosteroid or has a medical reason not to use these types of drugs.
Autoimmune hemolytic anemia, Polymyositis, or Dermatomyositis: IV administration, trial and failure of high dose corticosteroids.
Bone marrow transplant or HSCT: IV administration, being used to prevent bacterial infections and one of the following: within 100 days post-transplant, immunoglobulin G (IgG) level is less than 400 mg/dl, IgG is below normal and chronic graft vs host disease (GVHD) on steroids or GVHD with lung infection, or has cytomegalovirus (CMV).
Chronic lymphocytic leukemia/small lymphocytic leukemia: history of hypogammaglobulinemia (IgG below 500 mg/dl) or recurrent bacterial infections.
Excluded under Part D if covered by Part B.
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

IMMUNE GLOBULIN SQ (HIZENTRA)

MEDICATION(S)
HIZENTRA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Typical chronic inflammatory demyelinating polyneuropathy (CIDP), multifocal variant of CIDP (multifocal acquired demyelinating sensor and motor neuropathy of MADSAM), multifocal motor neuropathy (MMN) aka Pure Motor CIDP, and pure sensory chronic inflammatory demyelinating polyneuropathy: diagnosis confirmed by electrodiagnostic criteria (nerve conduction studies), and patient has been started on IVIG and is switching to Hizentra for ongoing therapy.
Primary Immunodeficiency Disorder (PIDD): current IgG is less than 200mg/dL or ALL of the following: history of recurrent bacterial infections, and failure to respond to antigenic challenge test with diphtheria and tetanus toxoids or pneumococcal polysaccharide vaccine, and history of IgG less than 500mg/dL documented on two occasions or diagnosed by an allergist or immunologist.

AGE RESTRICTION
N/A

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

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

INAVOLISIB (ITOVEBI)

MEDICATION(S)
ITOVEBI

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

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

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

INFLIXIMAB-DYYB (ZYMFENTRA)

MEDICATION(S)
ZYMFENTRA (1 PEN), ZYMFENTRA (2 PEN), ZYMFENTRA (2 SYRINGE)

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
Disease is moderate to severe AND SQ formulation will be started after initial IV infliximab doses.
Ongoing use for all diagnoses: Responding to therapy.

AGE RESTRICTION
Age is consistent with the FDA approved indication

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

INTERFERON BETA-1B (BETASERON)

MEDICATION(S)
BETASERON

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

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

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

INTERFERON GAMMA-1B (ACTIMMUNE)

MEDICATION(S)
ACTIMMUNE

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

ISAVUCONAZONIUM (CRESEMBA)

MEDICATION(S)
CRESEMBA 186 MG CAP, CRESEMBA 74.5 MG CAP

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

OFF LABEL USES
Esophageal candidiasis

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 or being prescribed by infectious disease specialist. Esophageal candidiasis: patient has HIV infection AND patient has a medical reason for not using oral fluconazole.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
3 months

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

ITRACONAZOLE ORAL SOLUTION (SPORANOX)

MEDICATION(S)
ITRACONAZOLE 10 MG/ML SOLUTION

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

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

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

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

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

IVABRADINE (CORLANOR)

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

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
Age is consistent with the FDA approved indication

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

IVACAFTOR (KALYDECO)

MEDICATION(S)
KALYDECO

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Being used with another CFTR modulator agent

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

IVOSIDENIB (TIBSOVO)

MEDICATION(S)
TIBSOVO

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

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

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

IXAZOMIB CITRATE (NINLARO)

MEDICATION(S)
NINLARO

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

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

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

LAMOTRIGINE SUSPENSION (SUBVENITE)

MEDICATION(S)
SUBVENITE 10 MG/ML SUSPENSION

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 lamotrigine tablet.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

LAPATINIB DITOSYLATE (TYKERB)

MEDICATION(S)
LAPATINIB DITOSYLATE

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

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

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

LAROTRECTINIB SULFATE (VITRAKVI)

MEDICATION(S)
VITRAKVI

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

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

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

LAZERTINIB (LAZCLUZE)

MEDICATION(S)
LAZCLUZE

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

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

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

LECANEMAB (LEQEMBI IQLIK)

MEDICATION(S)
LEQEMBI IQLIK, LEQEMBI IQLIK (500 MG DOSE)

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
History of transient ischemic attack, stroke, or seizure in the past 12 months, combination with other Anti-beta amyloid antibody products for Alzheimer's disease, currently receiving anticoagulant therapy except for aspirin at a prophylactic dose or less, MRI scan with pre-existing amyloid-related imaging abnormalities (ARIA) or other irregular findings (e.g. cerebral contusions, encephalomalacia, aneurysms, vascular malformations, infective lesions, multiple lacunar infarcts or stroke involving a major vascular territory)

REQUIRED MEDICAL INFORMATION
Initial use: Patient has a diagnosis of mild cognitive impairment (MCI) or mild dementia due to Alzheimer's Disease (AD) determined by ONE of the following: Clinical Dementia Rating Global Score (CDR-GS) 0.5-1, Montreal Cognitive Assessment (MoCA) greater than or equal to 16, or Mini Mental State Exam (MMSE) score 22-30 AND ONE of the following: positive beta amyloid pathology based on PET scan or lumbar puncture results confirming the presence of elevated P-tau or T-tau protein, and reduced beta amyloid-42, or a low AB42-AB40 ratio as determined by lab assay detected in cerebral spinal fluid (CSF) AND prescriber confirms enrollment in CMS National Patient Registry or another CMS approved study.
Ongoing use: Patient has not progressed beyond MCI or mild dementia related to Alzheimer's disease as determined by ONE of the following: CDR-GS greater than 1, or MoCA less than 16, or MMSE less than or equal to 21 AND patient does not have any of the following based on MRI scans: Moderate to severe ARIA-E symptoms, any ARIA-H symptoms, asymptomatic but moderate to severe radiographic findings of ARIA-E or ARIA-H, or intracerebral hemorrhage greater than 1 cm in diameter AND prescriber confirms enrollment in CMS National Patient Registry or another CMS approved study.

AGE RESTRICTION
Age is consistent with the FDA approved indication

PRESCRIBER RESTRICTION
neurologist, geriatrician, or relevant specialist

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

LENALIDOMIDE (REVLIMID)

MEDICATION(S)
LENALIDOMIDE

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

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

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

LENVATINIB (LENVIMA)

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

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

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

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

LEVALBUTEROL SOLUTION (XOPENEX)

MEDICATION(S)
LEVALBUTEROL HCL

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

LEVETIRACETAM (SPRITAM)

MEDICATION(S)
SPRITAM

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

LEVOMILNACIPRAN HCL (FETZIMA)

MEDICATION(S)
FETZIMA, FETZIMA TITRATION

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Treatment failure or side effect with at least two generic antidepressants.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

LIDOCAINE PATCH (LIDODERM)

MEDICATION(S)
LIDOCAINE 5 % PATCH, LIDOCAN

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

LINEZOLID (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 oral drugs noted on the C&S to work on the bacteria causing the infection or medical reason why those drugs cannot be used. Empiric therapy for suspected MRSA infection: prescribed or recommended by an ID specialist OR trial of one oral antibiotic supported for MRSA including clindamycin, doxycycline, or minocycline, and double strength trimethoprim/sulfamethoxazole, OR medical reason why all oral antibiotics supported for MRSA empiric therapy cannot be used. Infection of the bone or joint OR infective endocarditis: culture and sensitivity report confirm VRE, MRSA, or VISA/VRSA and prescribed or recommended by ID specialist. Multidrug-resistant tuberculosis infection (MDR-TB): Being used as part of a combination regimen.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

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

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

LONG-ACTING NARCOTIC DRUGS (FENTANYL)

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

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

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

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Cancer pain: Oncologist or Pain Specialist.

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

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

LONG-ACTING NARCOTIC DRUGS (HYDROMORPHONE ER)

MEDICATION(S)
HYDROMORPHONE HCL ER

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

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

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Cancer pain: Oncologist or Pain Specialist.

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

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

LONG-ACTING NARCOTIC DRUGS (METHADONE)

MEDICATION(S)
METHADONE HCL 10 MG/5ML SOLUTION, METHADONE HCL 10 MG/ML CONC, METHADONE HCL 10 MG/ML SOLUTION, METHADONE HCL 10 MG TAB, METHADONE HCL 5 MG/5ML SOLUTION, METHADONE HCL 5 MG TAB, METHADONE HCL INTENSOL

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

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

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Cancer pain: Oncologist or Pain Specialist.

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

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

LONG-ACTING NARCOTIC DRUGS (OXYMORPHONE ER)

MEDICATION(S)
OXYMORPHONE HCL ER

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

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

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Cancer pain: Oncologist or Pain Specialist.

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

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

LORLATINIB (LORBRENA)

MEDICATION(S)
LORBRENA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

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

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

LOTILANER (XDEMVY)

MEDICATION(S)
XDEMVY

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
Ophthalmologist or Optometrist

COVERAGE DURATION
6 weeks

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

LUMATEPERONE (CAPLYTA)

MEDICATION(S)
CAPLYTA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

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

REQUIRED MEDICAL INFORMATION
Trial and failure or side effect to one generic atypical antipsychotic drug or there is a medical reason why all the generic atypical antipsychotics cannot be used.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

MACITENTAN (OPSUMIT)

MEDICATION(S)
MACITENTAN

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).

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

MARIBAVIR (LIVTENCITY)

MEDICATION(S)
LIVTENCITY

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
being used with ganciclovir or valganciclovir

REQUIRED MEDICAL INFORMATION
CMV (cytomegalovirus) treatment: undergone a solid organ transplant or hematopoietic stem cell transplant (HSCT) AND treatment failure with one of the following: ganciclovir, valganciclovir, cidofovir, or foscarnet.

AGE RESTRICTION
Age is consistent with the FDA approved indication

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

MECASERMIN (INCRELEX)

MEDICATION(S)
INCRELEX

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

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

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

AGE RESTRICTION
Age is consistent with the FDA approved indication

PRESCRIBER RESTRICTION
Endocrinologist

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

MECHLORETHAMINE (VALCHLOR)

MEDICATION(S)
VALCHLOR

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

MEGESTROL ACETATE ES (MEGACE ES)

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

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

MEGESTROL ACETATE (MEGACE)

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

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

MEPOLIZUMAB (NUCALA)

MEDICATION(S)
NUCALA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Asthma, EGPA, COPD, CRSwNP, HES: combination with other targeted immunomodulators

REQUIRED MEDICAL INFORMATION
Eosinophilic asthma, initial use: eosinophil blood count is 150 cells/microliter or more, and documented treatment failure with recent use of high-dose inhaled corticosteroid along with long-acting beta agonist or leukotriene receptor antagonists, and patient has had at least one of the following within the past year: one or more acute asthma-related ER visit(s), one or more acute inpatient visits where asthma was the diagnosis, or two or more acute asthma exacerbations that require oral corticosteroids, or use of chronic systemic steroids due to severe asthma.
Eosinophilic granulomatosis with polyangiitis (EGPA): patients condition did not improve or has relapsed despite treatment with an oral corticosteroid and/or immunosuppressive therapy.
Hypereosinophilic syndrome (HES): patient is negative for FIP1-like 1-platelet derived growth factor receptor (FIP1L1-PDGFR) mutation and patient had an inadequate response to oral corticosteroids or cytotoxic/immunosuppressive therapy.
Chronic rhinosinusitis with nasal polyps (CRSwNP): Being used as add-on maintenance therapy AND treatment failure with an intranasal corticosteroid or medical reason why intranasal corticosteroids cannot be used.
Chronic Obstructive Pulmonary Disease (COPD): moderate to severe disease with an eosinophilic phenotype and ONE of the following: being used as an add-on therapy in combo with a long-acting beta agonist (LABA), long-acting muscarinic antagonist (LAMA), and inhaled corticosteroid (ICS) OR in combo with a LABA and LAMA in those who has tried and failed or had a side effect to ICS or has a medical reason why ICS cannot be used.
Ongoing use for all diagnoses: responding to therapy.

AGE RESTRICTION
Age is consistent with the FDA approved indication

PRESCRIBER RESTRICTION
EGPA: immunologist, rheumatologist, or pulmonologist. HES: Immunologist, Allergist, Hematologist. CRSwNP: allergist, immunologist, or otolaryngologist. COPD: Pulmonologist

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

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

MERCAPTOPURINE (PURIXAN)

MEDICATION(S)
MERCAPTOPURINE 2000 MG/100ML SUSPENSION

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

METHOTREXATE ORAL SOLUTION (XATMEP)

MEDICATION(S)
XATMEP

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

METHYLTESTOSTERONE (ANDROID, TESTRED)

MEDICATION(S)
METHYLTESTOSTERONE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

MIDOSTAURIN (RYDAPT)

MEDICATION(S)
RYDAPT

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

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

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

MIFEPRISTONE (KORLYM)

MEDICATION(S)
MIFEPRISTONE 300 MG TAB

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

MILSAPERIDONE (BYSANTI)

MEDICATION(S)
BYSANTI, BYSANTI TITRATION PACK A, BYSANTI TITRATION PACK B, BYSANTI TITRATION PACK C

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Trial and failure or side effect to one generic atypical antipsychotic drug or there is a medical reason why all the generic atypical antipsychotics cannot be used.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

MILTEFOSINE (IMPAVIDO)

MEDICATION(S)
IMPAVIDO

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

OFF LABEL USES
Infections caused by one of the following: Acanthamoeba OR Balamuthia mandrillaris OR Naegleria fowleri

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
One of the following: Visceral leishmaniasis due to Leishmania donovani, Cutaneous leishmaniasis due to Leishmania braziliensis, Leishmania guyanensis, or Leishmania panamensis, OR Mucosal leishmaniasis due to Leishmania braziliensis AND age and weight are consistent with the FDA-approved indication

AGE RESTRICTION
Age is consistent with the FDA approved indication

PRESCRIBER RESTRICTION
Infectious disease

COVERAGE DURATION
1 course (28 days)

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

MIRDAMETINIB (GOMEKLI)

MEDICATION(S)
GOMEKLI

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

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

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

MODAFINIL (PROVIGIL)

MEDICATION(S)
MODAFINIL

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Narcolepsy: sleep study (polysomnography) confirms narcolepsy.
Obstructive Sleep Apnea/Hypopnea Syndrome (OSAHS): sleep study (polysomnography) confirms OSAHS.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

MOMELOTINIB (OJJAARA)

MEDICATION(S)
OJJAARA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

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

REQUIRED MEDICAL INFORMATION
Myelofibrosis (MF): Not being used with another agent for myelofibrosis.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

NERATINIB (NERLYNX)

MEDICATION(S)
NERLYNX

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

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

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

NILOTINIB (CAVHANZA)

MEDICATION(S)
CAVHANZA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

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

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

NILOTINIB (TASIGNA)

MEDICATION(S)
NILOTINIB HCL

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

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

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

NINTEDANIB (OFEV)

MEDICATION(S)
NINTEDANIB ESYLATE, OFEV

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
For Brand Ofev: Patient tried and failed or had a side effect with generic nintedanib OR medical reason that generic nintedanib cannot be used

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

NIRAPARIB-ABIRATERONE (AKEEGA)

MEDICATION(S)
AKEEGA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

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

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

NIRAPARIB (ZEJULA)

MEDICATION(S)
ZEJULA 100 MG TAB, ZEJULA 200 MG TAB, ZEJULA 300 MG TAB

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

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

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

NIROGACESTAT (OGSIVEO)

MEDICATION(S)
OGSIVEO

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

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

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

NITAZOXANIDE (ALINIA)

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

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

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

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
All medically accepted conditions: stool culture results confirm diagnosis.
Giardiasis: treatment failure or side effect with tinidazole or metronidazole OR medical reason for not using tinidazole or metronidazole (contraindication).
Clostridium difficle colitis: treatment failure or side effect with vancomycin OR medical reason for not using vancomycin (contraindication).

AGE RESTRICTION
Age is consistent with the FDA approved indication

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
One course (see other criteria)

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

NITISINONE (ORFADIN)

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

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan Year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

NON-PREFERRED DOXYCYCLINE PRODUCTS

MEDICATION(S)
DOXYCYCLINE HYCLATE 100 MG TAB DR, DOXYCYCLINE HYCLATE 150 MG TAB, DOXYCYCLINE HYCLATE 150 MG TAB DR, DOXYCYCLINE HYCLATE 200 MG TAB DR, DOXYCYCLINE HYCLATE 50 MG TAB DR, DOXYCYCLINE HYCLATE 75 MG TAB DR

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Side effect with preferred doxycycline that does not occur with the use of the non-preferred doxycycline product.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

OCTREOTIDE ACETATE (SANDOSTATIN)

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

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

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

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Acromegaly: Endocrinologist

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

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

OLANZAPINE-SAMIDORPHAN (LYBALVI)

MEDICATION(S)
LYBALVI

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Trial and failure or side effect to one generic atypical antipsychotic drug or there is a medical reason why all the generic atypical antipsychotics cannot be used.

AGE RESTRICTION
Age is consistent with the FDA approved indication

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

OLAPARIB (LYNPARZA)

MEDICATION(S)
LYNPARZA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

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

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

OLSALAZINE SODIUM (DIPENTUM)

MEDICATION(S)
DIPENTUM

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

OLUTASIDENIB (REZLIDHIA)

MEDICATION(S)
REZLIDHIA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

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

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

OMALIZUMAB (XOLAIR)

MEDICATION(S)
XOLAIR 150 MG/ML SOLN A-INJ, XOLAIR 150 MG/ML SOLN PRSYR, XOLAIR 300 MG/2ML SOLN A-INJ, XOLAIR 300 MG/2ML SOLN PRSYR, XOLAIR 75 MG/0.5ML SOLN A-INJ, XOLAIR 75 MG/0.5ML SOLN PRSYR

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

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

EXCLUSION CRITERIA
Allergic asthma: being used with other targeted therapies for asthma treatment. IgE-mediated food allergy: being used with food allergen. CSU, Nasal polyps: Being used with another targeted immunotherapy drug.

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

AGE RESTRICTION
Age is consistent with the FDA approved indication

PRESCRIBER RESTRICTION
IgE-mediated food allergy: Allergist or Immunologist. Nasal polyps: allergist, immunologist, or otolaryngologist. Immunotherapy-related severe pruritus: dermatologist, allergist, hematologist, oncologist, or immunologist.

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

OSIMERTINIB (TAGRISSO)

MEDICATION(S)
TAGRISSO

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

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

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

OSPEMIFENE (OSPHENA)

MEDICATION(S)
OSPHENA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Painful sex (dyspareunia) due to menopause: patient has tried Premarin Vaginal cream. Vaginal dryness due to menopause: patient has tried at least two of the following: Premarin vaginal cream, estradiol vaginal cream, estradiol vaginal tablet, Yuvafem, or Estring.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

OXYMORPHONE IMMEDIATE-RELEASE (OPANA)

MEDICATION(S)
OXYMORPHONE HCL

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Being used with other short-acting opioid narcotics.

REQUIRED MEDICAL INFORMATION
Moderate to severe pain, initial use: trial of at least two formulary short-acting narcotic drugs, and total dose across all narcotics is not more than 90 MME/day or if more than 90 MME/day the prescriber states the total dose is medically necessary to treat the pain. Ongoing use (more than 90 days of narcotic therapy): evaluation by pain specialist, and a patient-specific treatment plan exists for evaluating ongoing need for narcotic pain relief, monitoring side effects and misuse and to taper down narcotics, AND total dose across all narcotics is not more than 90 MME/day or if more than 90 MME/day the prescriber states the total dose is medically necessary to treat the pain.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
30 days

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

PACRITINIB (VONJO)

MEDICATION(S)
VONJO

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Being used along with another agent for myelofibrosis

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

PALBOCICLIB (IBRANCE)

MEDICATION(S)
IBRANCE

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

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

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

PALIPERIDONE ER (INVEGA)

MEDICATION(S)
PALIPERIDONE ER

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

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

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

MEDICATION(S)

ABELCET, ABILIFY MAINTENA, ACETYLCYSTEINE 10 % SOLUTION, ACETYLCYSTEINE 20 % SOLUTION, ACYCLOVIR SODIUM, 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, ALBUTEROL SULFATE (2.5 MG/3ML) 0.083% NEBU SOLN, ALBUTEROL SULFATE (5 MG/ML) 0.5% NEBU SOLN, ALDURAZYME, AMINOSYN II 10 % SOLUTION, AMINOSYN-PF, AMPHOTERICIN B, AMPHOTERICIN B LIPOSOME, APREPITANT 125 MG CAP, APREPITANT 80 & 125 MG CAP THPK, APREPITANT 80 MG CAP, ARALAST NP, ARFORMOTEROL TARTRATE, AZASAN, AZATHIOPRINE, AZATHIOPRINE SODIUM, BUDESONIDE 0.25 MG/2ML SUSPENSION, BUDESONIDE 0.5 MG/2ML SUSPENSION, BUDESONIDE 1 MG/2ML SUSPENSION, CABENUVA, CALCITRIOL 1 MCG/ML SOLUTION, CALCIUM ACETATE (PHOS BINDER) 667 MG CAP, 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, DOXERCALCIFEROL, ELAPRASE, ENGERIX-B, ERZOFRI, EVEROLIMUS 0.25 MG TAB, EVEROLIMUS 0.5 MG TAB, EVEROLIMUS 0.75 MG TAB, EVEROLIMUS 1 MG TAB, FORMOTEROL FUMARATE, GENGRAF, GRANISETRON HCL 1 MG TAB, HEPARIN SODIUM (PORCINE) 10000 UNIT/ML SOLUTION, HEPARIN SODIUM (PORCINE) 1000 UNIT/ML SOLUTION, HEPARIN SODIUM (PORCINE) 20000 UNIT/ML SOLUTION, HEPARIN SODIUM (PORCINE) 5000 UNIT/ML SOLUTION, HEPARIN SODIUM (PORCINE) PF 1000 UNIT/ML SOLUTION, HEPLISAV-B, HUMULIN R U-500 (CONCENTRATED), IBANDRONATE SODIUM 3 MG/3ML SOLUTION, INTRALIPID, INVEGA HAFYERA, INVEGA SUSTENNA, INVEGA TRINZA, IPRATROPIUM-ALBUTEROL, IPRATROPIUM BROMIDE 0.02 % SOLUTION, LACOSAMIDE 200 MG/20ML SOLUTION, MELPHALAN, METHOTREXATE SODIUM 250 MG/10ML SOLUTION, METHOTREXATE SODIUM 50 MG/2ML SOLUTION, METHOTREXATE SODIUM (PF), METHYLPREDNISOLONE SODIUM SUCC 125 MG RECON SOLN, MOXIFLOXACIN HCL 400 MG/250ML SOLUTION, MOXIFLOXACIN HCL IN NACL, MYCOPHENOLATE MOFETIL, MYCOPHENOLATE MOFETIL HCL, MYCOPHENOLATE SODIUM, MYCOPHENOLIC ACID, NAGLAZYME, NUTRILIPID, ONDANSETRON 4 MG TAB DISP, ONDANSETRON 8 MG TAB DISP, ONDANSETRON HCL 24 MG TAB, ONDANSETRON HCL 4 MG/5ML SOLUTION, ONDANSETRON HCL 4 MG TAB, ONDANSETRON HCL 8 MG TAB, PARICALCITOL, PENTAMIDINE ISETHIONATE, PERSERIS, PREMASOL, PULMOZYME, RECOMBIVAX HB, RIBAVIRIN 6 GM RECON SOLN, RISPERIDONE MICROSPHERES ER, SANDIMMUNE 100 MG/ML SOLUTION, SEVELAMER CARBONATE 800 MG TAB, SIROLIMUS, SMOFLIPID, SUNLENCA 463.5 MG/1.5ML SOLUTION, SYNRIBO, TACROLIMUS 0.5 MG CAP, TACROLIMUS 1 MG CAP, TACROLIMUS 5 MG CAP, TPN ELECTROLYTES, VANCOMYCIN HCL 5 GM RECON SOLN, VORICONAZOLE 200 MG RECON SOLN, ZOLEDRONIC ACID, ZYPREXA RELPREVV

DETAILS

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

PASIREOTIDE (SIGNIFOR)

MEDICATION(S)
SIGNIFOR

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

PAZOPANIB HCL (VOTRIENT)

MEDICATION(S)
PAZOPANIB HCL

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

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

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

PEGFILGRASTIM-CBQV (UDENYCA)

MEDICATION(S)
UDENYCA

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

OFF LABEL USES
Hematopoietic Cell Transplantation (HCT)

EXCLUSION CRITERIA
Prophylaxis of chemo-induced febrile neutropenia: Being used along with another G-CSF (granulocyte colony stimulating factor) drug.

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
HCT: one dose. Febrile neutropenia: duration of chemo. Acute Radiation Syndrome: 2 doses (one week).

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

PEGFILGRASTIM-JMDB (FULPHILA)

MEDICATION(S)
FULPHILA

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

OFF LABEL USES
Hematopoietic Cell Transplantation (HCT)

EXCLUSION CRITERIA
Prophylaxis of chemo-induced febrile neutropenia: Being used along with another G-CSF (granulocyte colony stimulating factor) drug.

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
HCT: one dose. Febrile neutropenia: duration of chemo. Acute Radiation Syndrome: 2 doses (one week).

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

PEGINTERFERON ALFA-2A (PEGASYS)

MEDICATION(S)
PEGASYS

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

OFF LABEL USES
myelofibrosis, polycythemia vera, essential thrombocythemia, systemic mastocytosis, Chronic Myeloid Leukemia (CML), Hairy cell leukemia, Mycosis fungoides/Sezary syndrome, Primary cutaneous anaplastic large cell lymphoma (ALCL), T-cell leukemia/lymphoma, Erdheim-Chester disease histiocytic neoplasm.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Chronic hepatitis C viral infection: criteria will be applied consistent with FDA labeling. Polycythemia vera or Essential thrombocythemia: trial and failure or side effect to hydroxyurea or medical reason why hydroxyurea cannot be used. Myelofibrosis, systemic mastocytosis, Chronic Myeloid Leukemia (CML), Hairy cell leukemia, Mycosis fungoides/Sezary syndrome, Primary cutaneous anaplastic large cell lymphoma (ALCL), T-cell leukemia/lymphoma, Erdheim-Chester disease histiocytic neoplasm: criteria will be applied consistent with current National Comprehensive Cancer Network (NCCN) guidelines.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Hep B: 48 weeks. Hep C: up to 48 weeks. CML: length of pregnancy. All other Dx: plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

PEGVISOMANT (SOMAVERT)

MEDICATION(S)
SOMAVERT

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Endocrinologist

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

PEMIGATINIB (PEMAZYRE)

MEDICATION(S)
PEMAZYRE

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

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

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

PENCICLOVIR (DENAVIR)

MEDICATION(S)
PENCICLOVIR

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
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: treatment failure or side effect to two of the following: methotrexate, sulfasalazine, hydroxychloroquine, or leflunomide, OR has a medical reason why methotrexate, hydroxychloroquine, sulfasalazine, and leflunomide cannot be used.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

PEXIDARTINIB (TURALIO)

MEDICATION(S)
TURALIO 125 MG CAP

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

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

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
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
Symptoms of hallucinations (seeing, hearing, or experiencing things that others don't) and delusions (believing things that arent true) due to Parkinsons disease.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Neurologist or Psychiatrist

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

PIRFENIDONE (ESBRIET)

MEDICATION(S)
PIRFENIDONE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

PIRTOBRUTINIB (JAYPIRCA)

MEDICATION(S)
JAYPIRCA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

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

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

POMALIDOMIDE (POMALYST)

MEDICATION(S)
POMALIDOMIDE, POMALYST

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

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

REQUIRED MEDICAL INFORMATION
For Brand Pomalyst: Patient tried and failed or had a side effect with generic pomalidomide OR medical reason that generic pomalidomide cannot be used

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

PONATINIB (ICLUSIG)

MEDICATION(S)
ICLUSIG

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

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

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

POSACONAZOLE (NOXAFIL)

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

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

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

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Prevention of aspergillus or candida infection when there is high risk for developing these type of infections. Aspergillosis, fusariosis, histoplasmosis, phaeohyphomycosis within the body that is confirmed by a positive culture test. Treatment of candida infection of the esophagus: trial of fluconazole or there is a medical reason not to use fluconazole. Oropharyngeal candidiasis (suspension only): trial of fluconazole or there is a medical reason not to use fluconazole. Treatment of candida infection within the body that is confirmed by a positive culture and failure of fluconazole or other anti-fungal shown by culture results to treat the infection. ABPA: use after trial of itraconazole or there is a medical reason not to use itraconazole.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

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

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

PRALSETINIB (GAVRETO)

MEDICATION(S)
GAVRETO

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

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

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

PYRIMETHAMINE (DARAPRIM)

MEDICATION(S)
PYRIMETHAMINE

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

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

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Primary pevention of toxoplasmosis: treatment failure or side effect with trimethoprim-sulfamethoxazole (TMP-SMX) or has a medical reason for not using TMP-SMX and patient is immunocompromised.
Chronic maintenance (secondary prophylaxis) of toxoplasmosis: follows initial treatment in HIV-infected patients.
Prevention of Pneumocystis jiroveci (formerly Pneumocystis carinii) Pneumonia (PCP): treatment failure or side effect with trimethoprim-sulfamethoxazole (TMP-SMX) or has a medical reason for not using TMP-SMX AND patient is immunocompromised.
Treatment of cystoisospora belli (formerly Isospora Belli): Patient is immunocompromised AND treatment failure or side effect with trimethoprim-sulfamethoxazole (TMP-SMX) or has a medical reason for not using TMP-SMX.
Chronic manintenance (secondary prophylaxis) of cystoisospora belli (formerly Isospora Belli): follows initial treatment in immunocompromised patients AND treatment failure or side effect with trimethoprim-sulfamethoxazole (TMP-SMX) or has a medical reason for not using TMP-SMX

AGE RESTRICTION
N/A

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

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

QUIZARTINIB (VANFLYTA)

MEDICATION(S)
VANFLYTA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

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

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

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

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED

N/A

REGORAFENIB (STIVARGA)

MEDICATION(S)
STIVARGA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

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

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

RELACORILANT (LIFYORLI)

MEDICATION(S)
LIFYORLI (125 MG DOSE), LIFYORLI (150 MG DOSE)

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

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

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

RELUGOLIX (ORGOVYX)

MEDICATION(S)
ORGOVYX

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

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

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
Age is consistent with the FDA approved indication

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

REPOTRECTINIB (AUGTYRO)

MEDICATION(S)
AUGTYRO

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

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

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

RESMETIROM (REZDIFFRA)

MEDICATION(S)
REZDIFFRA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Decompensated cirrhosis , Moderate to severe hepatic impairment (Child-Pugh class B or C), Other liver diseases (e.g., Wilson's disease, hepatocellular carcinoma, hepatitis B or C), being used in combination with another GLP-1 receptor agonist.

REQUIRED MEDICAL INFORMATION
MASH/NASH, Initial use: Documentation of diagnosis of MASH/NASH with moderate to advanced liver fibrosis (consistent with stages F2 to F3 fibrosis) confirmed by ONE of the following: liver biopsy, Vibration-controlled transient elastography (VCTE), Enhanced liver fibrosis (ELF) score, Magnetic resonance elastography (MRE) AND treatment failure or had a side effect with Wegovy OR medical reason that Wegovy cannot be used. Ongoing use: Patient is responding to therapy.

AGE RESTRICTION
Age is consistent with the FDA approved indication

PRESCRIBER RESTRICTION
gastroenterologist or hepatologist

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

REVUMENIB (REVUFORJ)

MEDICATION(S)
REVUFORJ

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

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

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

RIBOCICLIB (KISQALI)

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

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

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

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

RIBOCICLIB-LETROZOLE (KISQALI FEMARA)

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

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

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

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

RIFAXIMIN (XIFAXAN)

MEDICATION(S)
XIFAXAN

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

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

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Travelers diarrhea: patient has tried azithromycin or a fluoroquinolone like ciprofloxacin or has a medical reason why ciprofloxacin and azithromycin cannot be used.
Hepatic Encephalopathy: patient has tried lactulose.
Irritable bowel syndrome with diarrhea (IBS-D): tried and failed or had a side effect with a conventional therapy (e.g. anti-diarrheal drug, tricyclic antidepressant, antispasmodic) OR medical reason that conventional therapy cannot be used.
Crohn's Disease: patient has tried metronidazole or ciprofloxacin or has a medical reason why metronidazole and ciprofloxacin cannot be used.
SIBO: Confirmation by a current positive breath test AND patient has tried and failed or had side effects with two of the following antibiotics: metronidazole (Flagyl), and ciprofloxacin (Cipro), amoxicillin-clavulanic acid (Augmentin), doxycycline, tetracycline, and trimethoprim-sulfamethoxazole (Bactrim, Septra) or there is a medical reason why all the other antibiotics cannot be tried first.

AGE RESTRICTION
Age is consistent with the FDA approved indication

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
One course (see other criteria)

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

RILONACEPT (ARCALYST)

MEDICATION(S)
ARCALYST

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
Age is consistent with the FDA approved indication

PRESCRIBER RESTRICTION
Recurrent Pericarditis: Cardiologist

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

RIMEGEPANT (NURTEC)

MEDICATION(S)
NURTEC

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Migraine Tx: use in combination with other acute migraine therapies. Migraine HA prevention: use in combination with another CGRP antagonist

REQUIRED MEDICAL INFORMATION
Migraine Tx, Initial: Trial of at least ONE triptan or has a medical reason (contraindication) for not using triptans.
Migraine HA prevention, Initial: documentation of 4 or more headache days per month.
Ongoing for all diagnosis: responding to therapy

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

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) AND patient has tried an endothelin-receptor antagonist and a phosphodiesterase type 5 (PDE-5) inhibitor.
Confirmation of Chronic Thromboembolic Pulmonary Hypertension (CTEPH) by a right heart catheterization or V/Q scan AND patient has been treated with surgery or cannot be treated surgery.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

RIPRETINIB (QINLOCK)

MEDICATION(S)
QINLOCK

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

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

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

RISANKIZUMAB-RZAA IV (SKYRIZI IV)

MEDICATION(S)
SKYRIZI 600 MG/10ML SOLUTION

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Being used with another targeted immunotherapy drug.

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
Age is consistent with the FDA approved indication

PRESCRIBER RESTRICTION
UC, CD: gastroenterologist

COVERAGE DURATION
one time induction course (8 weeks)

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

RISANKIZUMAB-RZAA SQ (SKYRIZI SQ)

MEDICATION(S)
SKYRIZI 150 MG/ML SOLN PRSYR, SKYRIZI 180 MG/1.2ML SOLN CART, SKYRIZI 360 MG/2.4ML SOLN CART, SKYRIZI 55 MG/0.37ML SOLN PRSYR, SKYRIZI (150 MG DOSE), SKYRIZI PEN

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Being used with another targeted immunotherapy drug.

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

AGE RESTRICTION
Age is consistent with the FDA approved indication

PRESCRIBER RESTRICTION
PsO: Dermatologist or Rheumatologist. PsA: Rheumatologist. UC, CD: gastroenterologist

COVERAGE DURATION
PsO initial use: 24 weeks. PsO ongoing use: plan year. PsA, Crohn's, and UC: plan year,

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

ROPEGINTERFERON ALFA-2B (BESREMI)

MEDICATION(S)
BESREMI, BESREMI PEN

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Polycythemia Vera (PV): treatment failure or side effect with hydroxyurea OR medical reason for not using hydroxyurea OR being used as initial treatment for symptomatic low-risk PV.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

RUCAPARIB (RUBRACA)

MEDICATION(S)
RUBRACA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

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

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

RUXOLITINIB (JAKAFI)

MEDICATION(S)
JAKAFI, JAKAFI XR

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

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

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

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

SAPROPTERIN DIHYDROCHLORIDE (KUVAN)

MEDICATION(S)
SAPROPTERIN DIHYDROCHLORIDE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Being used in combination with another medication for PKU

REQUIRED MEDICAL INFORMATION
Phenylketonuria (PKU), initial: chart notes confirm PKU and baseline (just prior to therapy) blood phenylalanine (Phe) levels are given. PKU, ongoing use: continued positive clinical response (e.g. reduction of blood Phe level of at least 30%, blood Phe level less than 360 micromol/L, increase in dietary Phe tolerance, improvement in clinical symptoms)

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

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

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

SARGRAMOSTIM (LEUKINE)

MEDICATION(S)
LEUKINE

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

OFF LABEL USES
HIV/AIDS patients on myelosuppressive therapy, drug-induced neutropenia, Myelodysplastic syndrome (MDS), Aplastic Anemia, febrile neutropenia, Myelodysplastic Syndrome, Neuroblastoma, high risk, Prophylaxis in patients with malignacies who are receiving chemotherapy.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Febrile neutropenia, neutropenia due to HIV/AIDs, neutropenia caused by drugs other than cancer drugs, MDS, or Aplatic Anemia: 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. Neuroblastoma, high-risk: Used in combination with a Unituxin based or Danyelza based regimen AND patient received prior first line therapy OR being used following induction or consolidation therapy. For all indications except Neuroblastoma: intolerance to both Nivestym and Zarxio or medical reason why Nivestym and Zarxio cannot be used.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
see other criteria

OTHER CRITERIA
Excluded under Part D if covered by Part B. Dose and duration is not more than the FDA labeled maximum.
Coverage duration: Febrile neutropenia: 2 months. Peripheral blood cell collection, Aplastic Anemia, MDS: 3 months. MDS: plan year. Neutropenia due to cancer drug therapy and AML: duration of cancer drug therapy. Acute Exposure to Myelosuppressive radiation: duration of radiation therapy. Drug induced neutropenia, HIV/AIDs neutropenia: duration of drug therapy. Bone Marrow Transplantation: 6 months. Neuroblastoma, high risk: plan year.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

SECUKINUMAB (COSENTYX)

MEDICATION(S)
COSENTYX 150 MG/ML SOLN PRSYR, COSENTYX 75 MG/0.5ML SOLN PRSYR, COSENTYX (300 MG DOSE), COSENTYX SENSOREADY (300 MG), COSENTYX SENSOREADY PEN, COSENTYX UNOREADY

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Being used with another targeted immunotherapy drug.

REQUIRED MEDICAL INFORMATION
Ankylosing spondylitis (AS) and non-radiographic axial spondyloarthritis (nr-axSpA): 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.
Hidradenitis suppurativa (HS): patient has Hurley stage II or III HS.
Enthesitis-related arthritis (ERA): patient has tried and failed one NSAID or has a medical reason why all NSAIDs cannot be used.
Plaque Psoriasis (PsO), initial use: patient tried and failed or had a side effect to one DMARD or has a medical reason why methotrexate (MTX), cyclosporine, and acitretin cannot be used AND baseline PASI score 10 or more OR BSA 3% or more OR sensitive areas are involved OR disease affects daily living. Ongoing use: PASI or BSA improved from baseline or a decrease in disease severity.

AGE RESTRICTION
Age is consistent with the FDA approved indication

PRESCRIBER RESTRICTION
PsA, AS, nr-axSpA: Rheumatologist. HS: Dermatologist. PsO: Rheumatologist or Dermatologist.

COVERAGE DURATION
PsO initial: 24 weeks. PsO ongoing and all other indications: plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

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
Patient tried and failed or had a side effect with one formulary drug that treats depression or a medical reason that depression drugs cannot be used.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

SELEXIPAG (UPTRAVI)

MEDICATION(S)
UPTRAVI 1000 MCG TAB, UPTRAVI 100 MCG TAB, UPTRAVI 1200 MCG TAB, UPTRAVI 1400 MCG TAB, UPTRAVI 150 MCG TAB, UPTRAVI 1600 MCG TAB, UPTRAVI 200 & 800 MCG TAB THPK, UPTRAVI 200 MCG TAB, UPTRAVI 400 MCG TAB, UPTRAVI 600 MCG TAB, UPTRAVI 800 MCG TAB

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Diagnosis of Pulmonary Arterial Hypertension (WHO Group 1) and patient has tried or has a side effect to the use of an endothelin receptor antagonist and a phosphodiesterase type 5 (PDE-5) inhibitor.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

SELINEXOR (XPOVIO)

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

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

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

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

SELPERCATINIB (RETEVMO)

MEDICATION(S)
RETEVMO

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

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

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

SELUMETINIB (KOSELUGO)

MEDICATION(S)
KOSELUGO

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

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

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

SEMAGLUTIDE (OZEMPIC)

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

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Being used with another GLP-1 agent. Being used for weight loss only.

REQUIRED MEDICAL INFORMATION
Confirmation of Type 2 diabetes

AGE RESTRICTION
Age is consistent with the FDA approved indication

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

SEMAGLUTIDE (RYBELSUS)

MEDICATION(S)
RYBELSUS

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Being used with another GLP-1 agent. Being used for weight loss only.

REQUIRED MEDICAL INFORMATION
Confirmation of Type 2 diabetes

AGE RESTRICTION
Age is consistent with the FDA approved indication

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

SEMAGLUTIDE SQ (WEGOVY SQ)

MEDICATION(S)
WEGOVY 0.25 MG/0.5ML SOLN A-INJ, WEGOVY 0.5 MG/0.5ML SOLN A-INJ, WEGOVY 1.7 MG/0.75ML SOLN A-INJ, WEGOVY 1 MG/0.5ML SOLN A-INJ, WEGOVY 2.4 MG/0.75ML SOLN A-INJ

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
MASH/NASH: Decompensated cirrhosis , Moderate to severe hepatic impairment (Child-Pugh class B or C), Other liver diseases (e.g., Wilson's disease, hepatocellular carcinoma, hepatitis B or C), combination with another GLP-1 receptor agonist. MACE: combination with another GLP-1 receptor agonist.

REQUIRED MEDICAL INFORMATION
MASH/NASH, Initial: Documentation of diagnosis of MASH/NASH with moderate to advanced liver fibrosis (consistent with stages F2 to F3 fibrosis) confirmed by ONE of the following: liver biopsy or TWO of the following: FIB-4 score, Vibration-controlled transient elastography (VCTE), Enhanced liver fibrosis (ELF) score, Magnetic resonance elastography (MRE). Reauthorization: Patient is responding to therapy.
MACE: initial: Patient has established cardiovascular disease, patient is overweight, patient is currently receiving standard of care treatment for CVD. Reauthorization: Patient is stable on therapy.

AGE RESTRICTION
Age is consistent with the FDA approved indication

PRESCRIBER RESTRICTION
gastroenterologist or hepatologist

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

SEMAGLUTIDE TABLET (WEGOVY)

MEDICATION(S)
WEGOVY 1.5 MG TAB, WEGOVY 25 MG TAB, WEGOVY 4 MG TAB, WEGOVY 9 MG TAB

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
MACE: combination with another GLP-1 receptor agonist.

REQUIRED MEDICAL INFORMATION
MACE, initial: Patient has established cardiovascular disease (CVD), patient is overweight, patient is currently receiving standard of care treatment for CVD. Reauthorization: Patient is stable on therapy.

AGE RESTRICTION
Age is consistent with the FDA approved indication

PRESCRIBER RESTRICTION
gastroenterologist or hepatologist

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

SEVABERTINIB (HYRNUO)

MEDICATION(S)
HYRNUO

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

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

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

SILDENAFIL (REVATIO)

MEDICATION(S)
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.
Raynaud's phenomenon: treatment failure or side effect with a calcium-channel blocker.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

SKELETAL MUSCLE RELAXANTS HRM (CARISOPRODOL)

MEDICATION(S)
CARISOPRODOL 350 MG TAB, VANADOM

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

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

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
3 weeks

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

SKELETAL MUSCLE RELAXANTS HRM (CYCLOBENZAPRINE)

MEDICATION(S)
CYCLOBENZAPRINE HCL 10 MG TAB, CYCLOBENZAPRINE HCL 5 MG TAB

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

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

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
3 weeks

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

PART B PREREQUISITE
YES

PREREQUISITE THERAPY REQUIRED
N/A

SKELETAL MUSCLE RELAXANTS HRM (METAXALONE)

MEDICATION(S)
METAXALONE 400 MG TAB, METAXALONE 800 MG TAB

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

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

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
3 weeks

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

SKELETAL MUSCLE RELAXANTS HRM(METHOCARBAMOL)

MEDICATION(S)
METHOCARBAMOL 500 MG TAB, METHOCARBAMOL 750 MG TAB

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

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

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
3 weeks

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

SODIUM OXYBATE (XYREM)

MEDICATION(S)
SODIUM OXYBATE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Being used with sedative hypnotic drugs or other CNS depressant drugs.

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

SODIUM PHENYLBUTYRATE (BUPHENYL)

MEDICATION(S)
SODIUM PHENYLBUTYRATE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
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
Age is consistent with the FDA approved indication

PRESCRIBER RESTRICTION
Hepatologist, Gastroenterologist, or Infectious Disease.

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

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

SOMATROPIN (OMNITROPE)

MEDICATION(S)
OMNITROPE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Endocrinologist

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

SONIDEGIB (ODOMZO)

MEDICATION(S)
ODOMZO

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

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

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

SORAFENIB (NEXAVAR)

MEDICATION(S)
SORAFENIB TOSYLATE

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

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

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

SOTATERCEPT (WINREVAIR)

MEDICATION(S)
WINREVAIR

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Diagnosis of Pulmonary Arterial Hypertension (WHO Group 1) AND Platelet count is 50,000/mm3 (50 x 109/L) or higher AND Winrevair will be used as add-on treatment to existing dual or triple regimen

AGE RESTRICTION
Age is consistent with the FDA approved indication

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

SOTORASIB (LUMAKRAS)

MEDICATION(S)
LUMAKRAS

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

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

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

SPARSENTAN (FILSPARI)

MEDICATION(S)
FILSPARI

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Primary immunoglobulin A nephropathy (IgAN): Being used in combination with another therapy for IgAN (e.g. Fabhalta, Vanrafia, Voyxact)
Focal segmental glomerulosclerosis (FSGS): Nephrotic syndrome

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
nephrologist

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

STIRIPENTOL (DIACOMIT)

MEDICATION(S)
DIACOMIT

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

SUNITINIB (SUTENT)

MEDICATION(S)
SUNITINIB MALATE

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

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

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

TACROLIMUS (ENVARSUS XR)

MEDICATION(S)
ENVARSUS XR

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

TACROLIMUS FOR ORAL SUSPENSION (PROGRAF PACKET)

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

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

TADALAFIL (ADCIRCA)

MEDICATION(S)
ALYQ, TADALAFIL (PAH)

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

OFF LABEL USES
Raynaud's phenomenon

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
PAH: confirmation of WHO Group I. Raynaud's phenomenon: treatment failure or side effect with a calcium-channel blocker.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

TADALAFIL (CIALIS)

MEDICATION(S)
TADALAFIL 2.5 MG TAB, TADALAFIL 5 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
Raynauds phenomenon: treatment failure or side effect with a calcium-channel blocker. Benign Prostatic Hyperplasia (BPH): treatment failure or side effect with both finasteride and tamsulosin. Dose not to exceed 5 mg per day.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Raynaud's, BPH: plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

TALAZOPARIB (TALZENNA)

MEDICATION(S)
TALZENNA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

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

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

TALETRECTINIB (IBTROZI)

MEDICATION(S)
IBTROZI

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

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

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

TASIMELTEON (HETLIOZ)

MEDICATION(S)
TASIMELTEON

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Non 24 Sleep Wake Cycle, initial use: patient not able to maintain a stable 24-hour sleep-wake pattern synchronized to 24-hr light/dark cycle, Sleep-wake symptoms have been present for at least 12 weeks, patient's symptoms of insomnia cause functional impairment. Non 24 Sleep Wake Cycle, ongoing use: patients total sleep time at night is longer since starting tasimelteon.

AGE RESTRICTION
Age is consistent with the FDA approved indication

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

COVERAGE DURATION
Non 24 Sleep Wake Cycle- initial use: 6 mos. Ongoing: plan year. Smith-Magenis Syndrome: plan year.

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED

N/A

TAZEMETOSTAT (TAZVERIK)

MEDICATION(S)
TAZVERIK

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

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

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

TELOTRISTAT ETHYL (XERMELO)

MEDICATION(S)
XERMELO

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Initial: Treatment failure of octreotide (Sandostatin) AND Being used in combination with octreotide (Sandostatin) Reauthorization: Improvement in diarrheal symptoms from baseline AND Being used in conjunction with octreotide (Sandostatin)

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

TEPOTINIB (TEPMETKO)

MEDICATION(S)
TEPMETKO

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

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

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

TERIFLUNOMIDE (AUBAGIO)

MEDICATION(S)
TERIFLUNOMIDE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

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

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

TERIPARATIDE (FORTEO)

MEDICATION(S)
TERIPARATIDE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Being used with other osteoporosis drugs.

REQUIRED MEDICAL INFORMATION
Osteoporosis: one of the following: patient has a history of a broken bone not due to trauma (non-traumatic fracture) or T-score lower than -2.5 or T-score between -1.0 and -2.5 and is at high risk for fracture AND one of the following: trial of a bisphosphonate or a formulary denosumab product, or side effect to bisphosphonate therapy or a formulary denosumab product that supports discontinuation, or initiating or continuing long-term glucocorticoid treatment, 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 a formulary denosumab product, or patient has experienced a recent fracture (within the past 12 months), or history of multiple fractures, or patient experienced a fracture while on long-term glucocorticoid therapy, or T-score less than -3.0, or patient is at high risk for falls, or 10-year hip fracture probability greater than 4.5% based on FRAX score, or 10-year major osteoporosis-related fracture probability greater than 30% based on FRAX score.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

TETRABENAZINE (XENAZINE)

MEDICATION(S)
TETRABENAZINE

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

OFF LABEL USES
Tardive Dyskinesia, Chronic Tics or Tourette’s Syndrome

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Chronic Tics or Tourette's Syndrome: trial and failure or side effect to two of the following first line therapies: haloperidol (Haldol), pimozide (Orap), clonidine (Catapres), guanfacine (Tenex), risperidone (Risperdal), or aripiprazole (Abilify) or there is a medical reason not to use all first line therapies.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Neurologist or Psychiatrist.

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

THALIDOMIDE (THALOMID)

MEDICATION(S)
THALOMID

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

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

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

TIRZEPATIDE (MOUNJARO)

MEDICATION(S)
MOUNJARO

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Being used with another GLP-1 agent. Being used for weight loss only.

REQUIRED MEDICAL INFORMATION
Confirmation of type 2 diabetes

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

TIVOZANIB (FOTIVDA)

MEDICATION(S)
FOTIVDA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

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

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
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.
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

TOBRAMYCIN (TOBI PODHALER)

MEDICATION(S)
TOBI PODHALER

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

TOCILIZUMAB-AAZG (TYENNE)

MEDICATION(S)
TYENNE 162 MG/0.9ML SOLN A-INJ, TYENNE 162 MG/0.9ML SOLN PRSYR

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

OFF LABEL USES
systemic sclerosis associated interstitial lung disease (SSc-ILD)

EXCLUSION CRITERIA
Being used with another targeted immunotherapy drug.

REQUIRED MEDICAL INFORMATION
Giant Cell Arteritis (CGA): Patient is currently taking steroids.
Polyarticular Juvenile Idiopathic Arthritis (pJIA) and Rheumatoid Arthritis (RA): Initial-Treatment failure or side effect to two of the following: Enbrel, adalimumab, and Rinvoq OR medical reason why all cannnot be used.
Systemic Sclerosis associated interstitial lung disease (SSc-ILD): Patient has systemic sclerosis AND treatment failure or side effect to mycophenolate or cyclophosphamide, OR medical reason why they cannot be used.
Ongoing use for all diagnosis: Patient is responding to Tyenne therapy.

AGE RESTRICTION
Age is consistent with the FDA approved indication

PRESCRIBER RESTRICTION
pJIA, RA, SJIA/Still's Disease: rheumatologist. SSc-ILD: rheumatologist or pulmonologist.

COVERAGE DURATION
pJIA: initial-16 weeks . SJIA: initial-12 weeks. Reauth-plan year All other DX: plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED

N/A

TOLVAPTAN (JYNARQUE)

MEDICATION(S)
TOLVAPTAN

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Patient is currently receiving dialysis treatment

REQUIRED MEDICAL INFORMATION
Patient is at risk of developing rapidly progressing ADPKD

AGE RESTRICTION
Age is consistent with the FDA approved indication

PRESCRIBER RESTRICTION
Nephrologist

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

TOPICAL TESTOSTERONE PRODUCTS

MEDICATION(S)
TESTOSTERONE 10 MG/ACT (2%) GEL, TESTOSTERONE 12.5 MG/ACT (1%) GEL, TESTOSTERONE 1.62 % GEL, TESTOSTERONE 20.25 MG/1.25GM (1.62%) GEL, TESTOSTERONE 20.25 MG/ACT (1.62%) GEL, TESTOSTERONE 25 MG/2.5GM (1%) GEL, TESTOSTERONE 30 MG/ACT SOLUTION, TESTOSTERONE 40.5 MG/2.5GM (1.62%) GEL, TESTOSTERONE 50 MG/5GM (1%) GEL

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

OFF LABEL USES
transgender, gender dysphoria

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

TOPIRAMATE EXTENDED RELEASE (QUDEXY XR)

MEDICATION(S)
TOPIRAMATE ER 100 MG CP24 SPRNK, TOPIRAMATE ER 150 MG CP24 SPRNK, TOPIRAMATE ER 200 MG CP24 SPRNK, TOPIRAMATE ER 25 MG CP24 SPRNK, TOPIRAMATE ER 50 MG CP24 SPRNK

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Patient has tried immediate-release topiramate or has a medical reason why patient cannot use immediate-release topiramate.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

TOPIRAMATE ORAL SOLUTION (EPRONTIA)

MEDICATION(S)
TOPIRAMATE 25 MG/ML SOLUTION

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Medical reason why patient cannot use topiramate tablet or sprinkle capsules

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

TOVORAFENIB (OJEMDA)

MEDICATION(S)
OJEMDA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

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

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

TRAMADOL ER

MEDICATION(S)
TRAMADOL HCL ER 100 MG TAB ER 24H, TRAMADOL HCL ER 200 MG TAB ER 24H, TRAMADOL HCL ER 300 MG TAB ER 24H

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

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

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Cancer pain: Oncologist or Pain Specialist.

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

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

TRAMETINIB (MEKINIST)

MEDICATION(S)
MEKINIST

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

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

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

TRAZODONE ORAL SOLUTION (RALDESY)

MEDICATION(S)
RALDESY

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

TRETINOIN PRODUCTS (AVITA, RETIN-A, ATRALIN)

MEDICATION(S)
TRETINOIN 0.01 % GEL, TRETINOIN 0.025 % CREAM, TRETINOIN 0.025 % GEL, TRETINOIN 0.05 % CREAM, TRETINOIN 0.05 % GEL, 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 required for less than 40 years old.

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

TRIENTINE HCL (SYPRINE)

MEDICATION(S)
TRIENTINE HCL

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Side effect to penicillamine.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

TRIFLURIDINE-TIPIRACIL (LONSURF)

MEDICATION(S)
LONSURF

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

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

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

TUCATINIB (TUKYSA)

MEDICATION(S)
TUKYSA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

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

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

UPADACITINIB (RINVOQ)

MEDICATION(S)
RINVOQ, RINVOQ LQ

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Being used with another targeted immunotherapy drug.

REQUIRED MEDICAL INFORMATION
Rheumatoid Arthritis: patient tried and failed or had a side effect with one DMARD OR medical reason that DMARD cannot be used AND treatment failure or side effect to one or more TNF blockers.
Psoriatic arthritis (PsA): treatment failure or side effect to one or more TNF blockers.
Atopic Dermatitis: disease is moderate to severe AND ONE of the following: patient has tried a medium to very high potency topical corticosteroid and a topical calcineurin inhibitor OR has a medical reason why these topical therapies cannot be used.
Crohn's Disease (CD), Ulcerative Colitis (UC): treatment failure or side effect to one or more TNF blockers. If TNF blocker are clinically inadvisable, prior use of one approved systemic therapy.
Spondyloarthritis (SpA): non-radiographic axial SpA OR treatment failure or side effect to one or more TNF blockers.
Polyarticular juvenile idiopathic arthritis (pJIA): treatment failure or side effect with one DMARD drug or medical reason why methotrexate cannot be used AND treatment failure or side effect to one or more TNF blockers.
Giant cell arteritis (GCA): currently taking steroids.
Ongoing use for all diagnosis: responding to therapy.

AGE RESTRICTION
Age is consistent with the FDA approved indication

PRESCRIBER RESTRICTION
RA, PsA, SpA, pJIA: Rheumatologist. CD, UC: gastroenterologist

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

USTEKINUMAB IV (YESINTEK IV)

MEDICATION(S)
YESINTEK 130 MG/26ML SOLUTION

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Being used with another targeted immunotherapy drug.

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
Age is consistent with the FDA approved indication

PRESCRIBER RESTRICTION
UC, CD: gastroenterologist

COVERAGE DURATION
one time induction infusion

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

USTEKINUMAB SQ (YESINTEK SQ)

MEDICATION(S)
YESINTEK 45 MG/0.5ML SOLN PRSYR, YESINTEK 45 MG/0.5ML SOLUTION, YESINTEK 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 from baseline or a decrease in disease severity.
Crohn's Disease (CD), initial use: SQ formulation will be started after initial IV dose.
Ulcerative colitis (UC), initial use: disease is moderate to severe AND SQ formulation will be started after initial IV dose.
Ongoing use for CD, UC, Psoriatic arthritis (PsA): Responding to therapy.

AGE RESTRICTION
Age is consistent with the FDA approved indication

PRESCRIBER RESTRICTION
PsO: Dermatologist or Rheumatologist. PsA: Rheumatologist. UC, CD: gastroenterologist

COVERAGE DURATION
PsO and PsA: refer to other criteria. CD and UC: plan year.

OTHER CRITERIA
Dose and duration is not more than the FDA labeled maximum.
PsO and PsA initial: one loading dose and 2 maintenance doses (28 weeks total). PsO and PsA onging maintenance use: plan year.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

VANCOMYCIN ORAL SOLUTION (FIRVANQ)

MEDICATION(S)
VANCOMYCIN HCL 250 MG/5ML RECON SOLN, VANCOMYCIN HCL 25 MG/ML RECON SOLN, VANCOMYCIN HCL 50 MG/ML RECON SOLN

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Clostridium difficile: evidence of current infection.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
10 days

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

VANDETANIB (CAPRELSA)

MEDICATION(S)
CAPRELSA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

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

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

VARDENAFIL

MEDICATION(S)
VARDENAFIL HCL

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

OFF LABEL USES
Benign Prostatic Hyperplasia, Raynaud's phenomenon

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Raynaud's phenomenon: treatment failure or side effect with a calcium-channel blocker and treatment failure or side effect with sildenafil (Viagra) and tadalafil (Cialis).
BPH: treatment failure or side effect with both finasteride and tamsulosin AND teatment failure or side effect with tadalafil (Cialis).
ED: due to a drug or medical condition that has been reported in the medical literature to cause ED and treatment failure or side effect with sildenafil (Viagra) and tadalafil (Cialis).

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
ED: limited to 8 tablets per month.
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

VEDOLIZUMAB SC (ENTYVIO SC)

MEDICATION(S)
ENTYVIO PEN

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Being used with another targeted immunotherapy drug.

REQUIRED MEDICAL INFORMATION
Disease is moderate to severe AND SQ formulation will be started after initial IV doses.
Ongoing use for all diagnoses: Responding to therapy.

AGE RESTRICTION
Age is consistent with the FDA approved indication

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

VEMURAFENIB (ZELBORAF)

MEDICATION(S)
ZELBORAF

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

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

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

VENETOCLAX (VENCLEXTA)

MEDICATION(S)
VENCLEXTA, VENCLEXTA STARTING PACK

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

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

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

VEPDEGESTRANT (VEPPANU)

MEDICATION(S)
VEPPANU

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

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

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

VERICIGUAT (VERQUVO)

MEDICATION(S)
VERQUVO

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Left heart ventricular ejection fraction (LVEF) less than or equal to 45% AND patient is on the highest tolerated dose of guideline supported therapies including a renin-angiotensin inhibitor drug and beta-blocker drug unless there is a medical reason for not using (contraindication) the supported therapies.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

VIGABATRIN (SABRIL)

MEDICATION(S)
VIGABATRIN, VIGADRONE, VIGPODER

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Infantile spasm: diagnosis of infantile spasm is confirmed by EEG.
Complex partial seizures: patient has tried two formulary partial seizure drugs.

AGE RESTRICTION
Age is consistent with the FDA approved indication

PRESCRIBER RESTRICTION
Infantile spasms: Neurologist

COVERAGE DURATION
Seizures: annual
Infantile spasms: 6 months

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

VIGABATRIN (VIGAFYDE)

MEDICATION(S)
VIGAFYDE

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Infantile spasm: diagnosis of infantile spasm is confirmed by EEG.

AGE RESTRICTION
Age is consistent with the FDA approved indication

PRESCRIBER RESTRICTION
Neurologist

COVERAGE DURATION
6 months

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

VIMSELTINIB (ROMVIMZA)

MEDICATION(S)
ROMVIMZA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

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

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

VISMODEGIB (ERIVEDGE)

MEDICATION(S)
ERIVEDGE

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

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

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

VONOPRAZAN-AMOXICILLIN-CLARITHROMYCIN (VOQUEZNA TRIPLE PAK)

MEDICATION(S)
VOQUEZNA TRIPLE PAK

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Patient has confirmed H. pylori infection

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
14 days

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

VONOPRAZAN-AMOXICILLIN (VOQUEZNA DUAL PAK)

MEDICATION(S)
VOQUEZNA DUAL PAK

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Patient has confirmed H. pylori infection

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
14 days

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

VORASIDENIB (VORANIGO)

MEDICATION(S)
VORANIGO

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

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

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

VORICONAZOLE ORAL (VFEND)

MEDICATION(S)
VORICONAZOLE 200 MG TAB, VORICONAZOLE 40 MG/ML RECON SUSP, VORICONAZOLE 50 MG TAB

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

OFF LABEL USES
Prophylaxis of Disseminated Candidiasis, Candida Endopthalmitis, Oropharyngeal Candidiasis, Allergic bronchopulmonary aspergillosis, maintenance treatment of talaromycosis (Talaromyces marneffei -formerly Penicillium marneffei) in HIV-positive patients, treatment of Lomentospora (formerly Scedosporium) prolificans infection, treatment of pulmonary aspergillosis, chronic (cavitary or necrotizing), prophylaxis of Invasive Aspergillosis in high-risk patients.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Systemic fungal infection treatment: culture test confirms Aspergillosis, candidemia, deep-tissue candida infection, blastomycosis, scedosporium apiospermum, fusarium species.
Candida infection of the esophagus, throat, mouth (esophageal or oropharyngeal candidiasis) after trial of fluconazole or there is a medical reason not to use fluconazole.
Prophylaxis of asperillosis or candidiasis after a bone marrow or lung transplant.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
BMT: 6mo Lung tx:3mo Esophageal candida:1mo Candidemia/deep-tissue:1mo Other ind in other criteria

OTHER CRITERIA
coverage duration:
ABPA: 4 month.
systemic treatment: plan year.
Dose and duration is not more than the FDA labeled maximum.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

VORINOSTAT (ZOLINZA)

MEDICATION(S)
ZOLINZA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

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

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

XANOMELINE-TROSPIUM (COBENFY)

MEDICATION(S)
COBENFY, COBENFY STARTER PACK

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Being used with another antipsychotic agent

REQUIRED MEDICAL INFORMATION
Trial and failure or side effect to one generic atypical antipsychotic drug or there is a medical reason why all the generic atypical antipsychotics cannot be used.

AGE RESTRICTION
Age is consistent with the FDA approved indication

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

ZANUBRUTINIB (BRUKINSA)

MEDICATION(S)
BRUKINSA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

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

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

ZIFTOMENIB (KOMZIFTI)

MEDICATION(S)
KOMZIFTI

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

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

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

ZONGERTINIB (HERNEXEOS)

MEDICATION(S)
HERNEXEOS

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

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

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

ZURANOLONE (ZURZUVAE)

MEDICATION(S)
ZURZUVAE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Postpartum depression confirmed by DSM-5 (Diagnostic and Statistical Manual of Mental Disorders-5) criteria.

AGE RESTRICTION
Age is consistent with the FDA approved indication

PRESCRIBER RESTRICTION
Psychiatrist or Obstetrician

COVERAGE DURATION
one course per pregnancy (14 days)

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

Part B vs D drugs

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

Medication(s)

MEDICATION NAME	ROUTE	DOSE FORM
ABELCET 5 MG/ML SUSPENSION	IV	SUSPENSION
ABILIFY ASIMTUFII 720 MG/2.4ML PRSYR	IM	PRSYR
ABILIFY ASIMTUFII 960 MG/3.2ML PRSYR	IM	PRSYR
ABILIFY MAINTENA 300 MG PRSYR	IM	PRSYR
ABILIFY MAINTENA 300 MG SRER	IM	
ABILIFY MAINTENA 300 MG SRER	IM	
ABILIFY MAINTENA 400 MG PRSYR	IM	PRSYR
ABILIFY MAINTENA 400 MG SRER	IM	
ABILIFY MAINTENA 400 MG SRER	IM	
ABRAXANE 100 MG RECON SUSP	IV	RECON SUSP
ACETADOTE 200 MG/ML SOLUTION	IV	SOLUTION
ACETAMINOPHEN 10 MG/ML SOLUTION	IV	SOLUTION
ACETYLCYSTEINE 10 % SOLUTION	IN	SOLUTION
ACETYLCYSTEINE 200 MG/ML SOLUTION	IV	SOLUTION
ACETYLCYSTEINE 20 % SOLUTION	IN	SOLUTION
ACTEMRA 200 MG/10ML SOLUTION	IV	SOLUTION
ACTEMRA 400 MG/20ML SOLUTION	IV	SOLUTION
ACTEMRA 80 MG/4ML SOLUTION	IV	SOLUTION
ACYCLOVIR SODIUM 50 MG/ML SOLUTION	IV	SOLUTION
ACYCLOVIR SODIUM-NACL 200-0.9 MG/100ML-% SOLUTION	IV	SOLUTION
ADCETRIS 50 MG RECON SOLN	IV	RECON SOLN
ADRIAMYCIN 50 MG RECON SOLN	IV	RECON SOLN
ADZYNMA 1500 UNIT KIT	IV	KIT
ADZYNMA 500 UNIT KIT	IV	KIT
AKYNZEO 235-0.25 MG/20ML SOLUTION	IV	SOLUTION
AKYNZEO 235-0.25 MG RECON SOLN	IV	RECON SOLN
AKYNZEO 300-0.5 MG CAP	PO	CAP
AKYNZEO (READY-TO-USE) 235-0.25 MG/20ML SOLUTION	IV	SOLUTION
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
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
ALDURAZYME 2.9 MG/5ML SOLUTION	IV	SOLUTION

MEDICATION NAME	ROUTE	DOSE FORM
ALFERON N 5000000 UNIT/ML SOLUTION	IJ	SOLUTION
ALIMTA 100 MG RECON SOLN	IV	RECON SOLN
ALIMTA 500 MG RECON SOLN	IV	RECON SOLN
ALIQOPA 60 MG RECON SOLN	IV	RECON SOLN
ALKERAN 2 MG TAB	PO	TAB
ALKERAN 50 MG RECON SOLN	IV	RECON SOLN
ALLOPURINOL SODIUM 500 MG RECON SOLN	IV	RECON SOLN
ALOPRIM 500 MG RECON SOLN	IV	RECON SOLN
ALYGLO 10 GM/100ML SOLUTION	IV	SOLUTION
ALYGLO 20 GM/200ML SOLUTION	IV	SOLUTION
ALYGLO 5 GM/50ML SOLUTION	IV	SOLUTION
ALYMSYS 100 MG/4ML SOLUTION	IV	SOLUTION
ALYMSYS 400 MG/16ML SOLUTION	IV	SOLUTION
AMBISOME 50 MG RECON SUSP	IV	RECON SUSP
AMINO ACID 5 % SOLUTION	IV	SOLUTION
AMINOPHYLLINE 25 MG/ML SOLUTION	IV	SOLUTION
AMINOPROTECT 5 % SOLUTION	IV	SOLUTION
AMINOSYN II 10 % SOLUTION	IV	SOLUTION
AMINOSYN II 15 % SOLUTION	IV	SOLUTION
AMINOSYN-PF 10 % SOLUTION	IV	SOLUTION
AMINOSYN-PF 7% 7 % SOLUTION	IV	SOLUTION
AMIODARONE HCL 150 MG/3ML SOLUTION	IV	SOLUTION
AMIODARONE HCL 450 MG/9ML SOLUTION	IV	SOLUTION
AMIODARONE HCL 900 MG/18ML SOLUTION	IV	SOLUTION
AMPHOTERICIN B 50 MG RECON SOLN	IV	RECON SOLN
AMPHOTERICIN B LIPOSOME 50 MG RECON SUSP	IV	RECON SUSP
AMVUTTRA 25 MG/0.5ML SOLN PRSYR	SC	SOLN PRSYR
ANZEMET 50 MG TAB	PO	TAB
APREPITANT 125 MG CAP	PO	CAP
APREPITANT 80 & 125 MG CAP THPK	PO	CAP THPK
APREPITANT 80 MG CAP	PO	CAP
ARALAST NP 1000 MG RECON SOLN	IV	RECON SOLN
ARALAST NP 500 MG RECON SOLN	IV	RECON SOLN
ARFORMOTEROL TARTRATE 15 MCG/2ML NEBU SOLN	IN	NEBU SOLN
ARGATROBAN 250 MG/2.5ML SOLUTION	IV	SOLUTION
ARGATROBAN 50 MG/50ML SOLUTION	IV	SOLUTION
ARISTADA 1064 MG/3.9ML PRSYR	IM	PRSYR
ARISTADA 441 MG/1.6ML PRSYR	IM	PRSYR
ARISTADA 662 MG/2.4ML PRSYR	IM	PRSYR
ARISTADA 882 MG/3.2ML PRSYR	IM	PRSYR
ARISTADA INITIO 675 MG/2.4ML PRSYR	IM	PRSYR
ARMLUPEG 6 MG/0.6ML SOLN PRSYR	SC	SOLN PRSYR
ARRANON 5 MG/ML SOLUTION	IV	SOLUTION

MEDICATION NAME	ROUTE	DOSE FORM
ARSENIC TRIOXIDE 10 MG/10ML SOLUTION	IV	SOLUTION
ARSENIC TRIOXIDE 12 MG/6ML SOLUTION	IV	SOLUTION
ARZERRA 1000 MG/50ML CONC	IV	CONC
ARZERRA 100 MG/5ML CONC	IV	CONC
ASCENIV 5 GM/50ML SOLUTION	IV	SOLUTION
ASPARLAS 3750 UNIT/5ML SOLUTION	IV	SOLUTION
ASTAGRAF XL 0.5 MG CAP ER 24H	PO	CAP ER 24H
ASTAGRAF XL 1 MG CAP ER 24H	PO	CAP ER 24H
ASTAGRAF XL 5 MG CAP ER 24H	PO	CAP ER 24H
ATGAM 50 MG/ML SOLUTION	IV	SOLUTION
ATIVAN 2 MG/ML SOLUTION	IJ	SOLUTION
ATIVAN 4 MG/ML SOLUTION	IJ	SOLUTION
AUKELSO 120 MG/1.7ML SOLUTION	SC	SOLUTION
AVASTIN 100 MG/4ML SOLUTION	IV	SOLUTION
AVASTIN 400 MG/16ML SOLUTION	IV	SOLUTION
AVEED 750 MG/3ML SOLUTION	IM	SOLUTION
AVGEMSI 1 GM/26.3ML SOLUTION	IV	SOLUTION
AVGEMSI 2 GM/52.6ML SOLUTION	IV	SOLUTION
AVLAYAH 150 MG RECON SOLN	IV	RECON SOLN
AVOPEF 100 MG/5ML SOLUTION	IV	SOLUTION
AVOPEF 500 MG/25ML SOLUTION	IV	SOLUTION
AVSOLA 100 MG RECON SOLN	IV	RECON SOLN
AVTOZMA 200 MG/10ML SOLUTION	IV	SOLUTION
AVTOZMA 400 MG/20ML SOLUTION	IV	SOLUTION
AVTOZMA 80 MG/4ML SOLUTION	IV	SOLUTION
AVYCAZ 2.5 (2-0.5) GM RECON SOLN	IV	RECON SOLN
AXTLE 100 MG RECON SOLN	IV	RECON SOLN
AXTLE 500 MG RECON SOLN	IV	RECON SOLN
AZACITIDINE 100 MG RECON SUSP	IJ	RECON SUSP
AZASAN 100 MG TAB	PO	TAB
AZASAN 75 MG TAB	PO	TAB
AZATHIOPRINE 100 MG TAB	PO	TAB
AZATHIOPRINE 50 MG TAB	PO	TAB
AZATHIOPRINE 75 MG TAB	PO	TAB
AZATHIOPRINE SODIUM 100 MG RECON SOLN	IJ	RECON SOLN
AZMIRO 200 MG/ML SOLN PRSYR	IM	SOLN PRSYR
BACLOFEN 20000 MCG/20ML SOLUTION	IT	SOLUTION
BACLOFEN 40000 MCG/20ML SOLUTION	IT	SOLUTION
BACLOFEN 40 MG/20ML SOLUTION	IT	SOLUTION
BACLOFEN 50 MCG/ML SOLN PRSYR	IT	SOLN PRSYR
BAVENCIO 200 MG/10ML SOLUTION	IV	SOLUTION
BEIZRAY 2 X 80 MG/4ML & 25%(50 ML) SOLUTION	IV	SOLUTION
BEIZRAY 80 MG/4ML & 25%(50 ML) SOLUTION	IV	SOLUTION
BELEODAQ 500 MG RECON SOLN	IV	RECON SOLN

MEDICATION NAME	ROUTE	DOSE FORM
BELRAPZO 100 MG/4ML SOLUTION	IV	SOLUTION
BENDAMUSTINE HCL 100 MG/4ML SOLUTION	IV	SOLUTION
BENDAMUSTINE HCL 100 MG RECON SOLN	IV	RECON SOLN
BENDAMUSTINE HCL 25 MG RECON SOLN	IV	RECON SOLN
BENDEKA 100 MG/4ML SOLUTION	IV	SOLUTION
BENLYSTA 120 MG RECON SOLN	IV	RECON SOLN
BENLYSTA 400 MG RECON SOLN	IV	RECON SOLN
BENTYL 10 MG/ML SOLUTION	IM	SOLUTION
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
BIVIGAM 10 GM/100ML SOLUTION	IV	SOLUTION
BIVIGAM 5 GM/50ML SOLUTION	IV	SOLUTION
BIZENGRI (750 MG DOSE) 375 MG/18.75ML SOLN THPK	IV	SOLN THPK
BKEMV 300 MG/30ML SOLUTION	IV	SOLUTION
BLENREP 100 MG RECON SOLN	IV	RECON SOLN
BLENREP 70 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
BOMYNTRA 120 MG/1.7ML SOLN PRSYR	SC	SOLN PRSYR
BOMYNTRA 120 MG/1.7ML SOLUTION	SC	SOLUTION
BORUZU 3.5 MG/1.4ML SOLUTION	IJ	SOLUTION
BOSAYA 60 MG/ML SOLN PRSYR	SC	SOLN PRSYR
BOTOX 100 UNIT RECON SOLN	IJ	RECON SOLN
BOTOX 200 UNIT RECON SOLN	IJ	RECON SOLN
BRIUMVI 150 MG/6ML SOLUTION	IV	SOLUTION
BRIVARACETAM 50 MG/5ML SOLUTION	IV	SOLUTION
BRIVIACT 50 MG/5ML SOLUTION	IV	SOLUTION
BROVANA 15 MCG/2ML NEBU SOLN	IN	NEBU SOLN
BUDESONIDE 0.25 MG/2ML SUSPENSION	IN	SUSPENSION
BUDESONIDE 0.5 MG/2ML SUSPENSION	IN	SUSPENSION
BUDESONIDE 1 MG/2ML SUSPENSION	IN	SUSPENSION
BUPRENEX 0.3 MG/ML SOLUTION	IJ	SOLUTION
BUPRENORPHINE HCL 0.3 MG/ML SOLUTION	IJ	SOLUTION
BUSULFAN 6 MG/ML SOLUTION	IV	SOLUTION
BUSULFEX 6 MG/ML SOLUTION	IV	SOLUTION
BUTORPHANOL TARTRATE 1 MG/ML SOLUTION	IJ	SOLUTION
BUTORPHANOL TARTRATE 2 MG/ML SOLUTION	IJ	SOLUTION

MEDICATION NAME	ROUTE	DOSE FORM
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 1 MCG/ML SOLUTION	IV	SOLUTION
CALCIUM ACETATE 667 MG TAB	PO	TAB
CALCIUM ACETATE (PHOS BINDER) 667 MG CAP	PO	CAP
CALCIUM ACETATE (PHOS BINDER) 667 MG TAB	PO	TAB
CALCIUM GLUCONATE 10 % SOLUTION	IV	SOLUTION
CALDOLOR 800 MG/200ML SOLUTION	IV	SOLUTION
CALDOLOR 800 MG/8ML SOLUTION	IV	SOLUTION
CAMCEVI 42 MG PRSYR	SC	PRSYR
CAMPTOSAR 100 MG/5ML SOLUTION	IV	SOLUTION
CAMPTOSAR 300 MG/15ML SOLUTION	IV	SOLUTION
CAMPTOSAR 40 MG/2ML SOLUTION	IV	SOLUTION
CANCIDAS 50 MG RECON SOLN	IV	RECON SOLN
CANCIDAS 70 MG RECON SOLN	IV	RECON SOLN
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 2.5 MG/ML SOLUTION	IV	SOLUTION
CARMUSTINE 100 MG RECON SOLN	IV	RECON SOLN
CARMUSTINE 300 MG RECON SOLN	IV	RECON SOLN
CARMUSTINE 50 MG RECON SOLN	IV	RECON SOLN
CARNITOR 200 MG/ML SOLUTION	IV	SOLUTION
CASPOFUNGIN ACETATE 50 MG RECON SOLN	IV	RECON SOLN
CASPOFUNGIN ACETATE 70 MG RECON SOLN	IV	RECON SOLN
CEFAZOLIN IN SODIUM CHLORIDE 2-0.9 GM/100ML-% SOLUTION	IV	SOLUTION
CEFAZOLIN IN SODIUM CHLORIDE 3-0.9 GM/100ML-% SOLUTION	IV	SOLUTION
CEFAZOLIN SODIUM-DEXTROSE 1-4 GM-%(50ML) RECON SOLN	IV	RECON SOLN
CEFAZOLIN SODIUM-DEXTROSE 1-4 GM/50ML-% SOLUTION	IV	SOLUTION
CEFAZOLIN SODIUM-DEXTROSE 2-3 GM-%(50ML) RECON SOLN	IV	RECON SOLN
CEFAZOLIN SODIUM-DEXTROSE 2-4 GM/100ML-% SOLUTION	IV	SOLUTION
CEFAZOLIN SODIUM-DEXTROSE 2-5 GM/100ML-% SOLUTION	IV	SOLUTION
CEFAZOLIN SODIUM-DEXTROSE 3-2 GM-%(50ML) RECON SOLN	IV	RECON SOLN
CEFAZOLIN SODIUM-DEXTROSE 3-4 GM/150ML-% SOLUTION	IV	SOLUTION

MEDICATION NAME	ROUTE	DOSE FORM
CEFEPIME-DEXTROSE 1-5 GM-%(50ML) RECON SOLN	IV	RECON SOLN
CEFEPIME-DEXTROSE 2-5 GM-%(50ML) RECON SOLN	IV	RECON SOLN
CEFEPIME HCL 100 GM 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-DEXTROSE 1-3.74 GM-%(50ML) RECON SOLN	IV	RECON SOLN
CEFTRIAXONE SODIUM-DEXTROSE 2-2.22 GM-%(50ML) RECON SOLN	IV	RECON SOLN
CEFTRIAXONE SODIUM IN DEXTROSE 20 MG/ML SOLUTION	IV	SOLUTION
CEFTRIAXONE SODIUM IN DEXTROSE 40 MG/ML SOLUTION	IV	SOLUTION
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
CEREZYME 400 UNIT RECON SOLN	IV	RECON SOLN
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
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/50ML SOLUTION	IV	SOLUTION
CISPLATIN 50 MG RECON SOLN	IV	RECON SOLN
CLADRIBINE 10 MG/10ML SOLUTION	IV	SOLUTION
CLINIMIX/DEXTROSE (4.25/10) 4.25 % SOLUTION	IV	SOLUTION
CLINIMIX/DEXTROSE (4.25/5) 4.25 % SOLUTION	IV	SOLUTION
CLINIMIX/DEXTROSE (5/15) 5 % SOLUTION	IV	SOLUTION

MEDICATION NAME	ROUTE	DOSE FORM
CLINIMIX/DEXTROSE (5/20) 5 % SOLUTION	IV	SOLUTION
CLINIMIX/DEXTROSE (6/5) 6 % SOLUTION	IV	SOLUTION
CLINIMIX/DEXTROSE (8/10) 8 % SOLUTION	IV	SOLUTION
CLINIMIX/DEXTROSE (8/14) 8 % SOLUTION	IV	SOLUTION
CLINIMIX E/DEXTROSE (2.75/5) 2.75 % SOLUTION	IV	SOLUTION
CLINIMIX E/DEXTROSE (4.25/10) 4.25 % SOLUTION	IV	SOLUTION
CLINIMIX E/DEXTROSE (4.25/5) 4.25 % SOLUTION	IV	SOLUTION
CLINIMIX E/DEXTROSE (5/15) 5 % SOLUTION	IV	SOLUTION
CLINIMIX E/DEXTROSE (5/20) 5 % SOLUTION	IV	SOLUTION
CLINIMIX E/DEXTROSE (8/10) 8 % SOLUTION	IV	SOLUTION
CLINIMIX E/DEXTROSE (8/14) 8 % SOLUTION	IV	SOLUTION
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
COCAINE HCL 40 MG/ML SOLUTION	NA	SOLUTION
COLUMVI 10 MG/10ML SOLUTION	IV	SOLUTION
COLUMVI 2.5 MG/2.5ML SOLUTION	IV	SOLUTION
CONEXXENCE 60 MG/ML SOLN PRSYR	SC	SOLN PRSYR
COSELA 300 MG RECON SOLN	IV	RECON SOLN
COSENTYX 125 MG/5ML SOLUTION	IV	SOLUTION
COSMEGEN 0.5 MG RECON SOLN	IV	RECON SOLN
CROMOLYN SODIUM 20 MG/2ML NEBU SOLN	IN	NEBU SOLN
CRYSVITA 10 MG/ML SOLUTION	SC	SOLUTION
CRYSVITA 20 MG/ML SOLUTION	SC	SOLUTION
CRYSVITA 30 MG/ML SOLUTION	SC	SOLUTION
CUPRIC CHLORIDE 0.4 MG/ML SOLUTION	IV	SOLUTION
CUTAQUIG 1.65 GM/10ML SOLUTION	SC	SOLUTION
CUTAQUIG 1 GM/6ML SOLUTION	SC	SOLUTION
CUTAQUIG 2 GM/12ML SOLUTION	SC	SOLUTION
CUTAQUIG 3.3 GM/20ML SOLUTION	SC	SOLUTION
CUTAQUIG 4 GM/24ML SOLUTION	SC	SOLUTION
CUTAQUIG 8 GM/48ML SOLUTION	SC	SOLUTION
CUVITRU 10 GM/50ML SOLUTION	SC	SOLUTION
CUVITRU 1 GM/5ML 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 1000 MG/10ML SOLUTION	IV	SOLUTION
CYCLOPHOSPHAMIDE 1 GM/2ML SOLUTION	IV	SOLUTION
CYCLOPHOSPHAMIDE 1 GM/5ML SOLUTION	IV	SOLUTION
CYCLOPHOSPHAMIDE 1 GM RECON SOLN	IJ	RECON SOLN

MEDICATION NAME	ROUTE	DOSE FORM
CYCLOPHOSPHAMIDE 2000 MG/20ML SOLUTION	IV	SOLUTION
CYCLOPHOSPHAMIDE 25 MG CAP	PO	CAP
CYCLOPHOSPHAMIDE 25 MG TAB	PO	TAB
CYCLOPHOSPHAMIDE 2 GM/10ML SOLUTION	IV	SOLUTION
CYCLOPHOSPHAMIDE 2 GM/4ML SOLUTION	IV	SOLUTION
CYCLOPHOSPHAMIDE 2 GM RECON SOLN	IJ	RECON SOLN
CYCLOPHOSPHAMIDE 500 MG/2.5ML SOLUTION	IV	SOLUTION
CYCLOPHOSPHAMIDE 500 MG/5ML SOLUTION	IV	SOLUTION
CYCLOPHOSPHAMIDE 500 MG/ML SOLUTION	IV	SOLUTION
CYCLOPHOSPHAMIDE 500 MG RECON SOLN	IJ	RECON SOLN
CYCLOPHOSPHAMIDE 50 MG CAP	PO	CAP
CYCLOPHOSPHAMIDE 50 MG TAB	PO	TAB
CYCLOSPORINE 100 MG CAP	PO	CAP
CYCLOSPORINE 25 MG CAP	PO	CAP
CYCLOSPORINE 50 MG/ML SOLUTION	IV	SOLUTION
CYCLOSPORINE MODIFIED 100 MG CAP	PO	CAP
CYCLOSPORINE MODIFIED 100 MG/ML SOLUTION	PO	SOLUTION
CYCLOSPORINE MODIFIED 25 MG CAP	PO	CAP
CYCLOSPORINE MODIFIED 50 MG CAP	PO	CAP
CYKLOKAPRON 1000 MG/10ML SOLUTION	IV	SOLUTION
CYRAMZA 100 MG/10ML SOLUTION	IV	SOLUTION
CYRAMZA 500 MG/50ML SOLUTION	IV	SOLUTION
CYTARABINE 20 MG/ML SOLUTION	IJ	SOLUTION
CYTARABINE (PF) 100 MG/ML SOLUTION	IJ	SOLUTION
CYTARABINE (PF) 20 MG/ML SOLUTION	IJ	SOLUTION
CYTOGAM 50 MG/ML SOLUTION	IV	SOLUTION
DACARBAZINE 100 MG RECON SOLN	IV	RECON SOLN
DACARBAZINE 200 MG RECON SOLN	IV	RECON SOLN
DACOGEN 50 MG RECON SOLN	IV	RECON SOLN
DACTINOMYCIN 0.5 MG RECON SOLN	IV	RECON SOLN
DALBAVANCIN HCL 500 MG RECON SOLN	IV	RECON SOLN
DALVANCE 500 MG RECON SOLN	IV	RECON SOLN
DANYELZA 40 MG/10ML SOLUTION	IV	SOLUTION
DAPTOMYCIN-SODIUM CHLORIDE 1000-0.9 MG/100ML-% SOLUTION	IV	SOLUTION
DAPTOMYCIN-SODIUM CHLORIDE 350-0.9 MG/50ML-% SOLUTION	IV	SOLUTION
DAPTOMYCIN-SODIUM CHLORIDE 500-0.9 MG/50ML-% SOLUTION	IV	SOLUTION
DAPTOMYCIN-SODIUM CHLORIDE 700-0.9 MG/100ML-% SOLUTION	IV	SOLUTION
DARZALEX 100 MG/5ML SOLUTION	IV	SOLUTION
DARZALEX 400 MG/20ML SOLUTION	IV	SOLUTION
DARZALEX FASPRO 1800-30000 MG-UT/15ML SOLUTION	SC	SOLUTION

MEDICATION NAME	ROUTE	DOSE FORM
DATROWAY 100 MG RECON SOLN	IV	RECON SOLN
DAUNORUBICIN HCL 20 MG/4ML SOLUTION	IV	SOLUTION
DAUNORUBICIN HCL 50 MG/10ML SOLUTION	IV	SOLUTION
DECITABINE 50 MG RECON SOLN	IV	RECON SOLN
DECNUPAZ 2 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/ML SOLUTION	IJ	SOLUTION
DEMEROL 25 MG/ML SOLUTION	IJ	SOLUTION
DEMEROL 50 MG/ML SOLUTION	IJ	SOLUTION
DEMEROL 75 MG/ML SOLUTION	IJ	SOLUTION
DEPO-MEDROL 20 MG/ML SUSPENSION	IJ	SUSPENSION
DESFERAL 500 MG RECON SOLN	IJ	RECON SOLN
DEXAMETHASONE SODIUM PHOSPHATE 100 MG/10ML SOLUTION	IJ	SOLUTION
DEXAMETHASONE SODIUM PHOSPHATE 10 MG/ML SOLUTION	IJ	SOLUTION
DEXAMETHASONE SODIUM PHOSPHATE 120 MG/30ML SOLUTION	IJ	SOLUTION
DEXAMETHASONE SODIUM PHOSPHATE 20 MG/5ML SOLUTION	IJ	SOLUTION
DEXAMETHASONE SODIUM PHOSPHATE 4 MG/ML SOLUTION	IJ	SOLUTION
DEXAMETHASONE SOD PHOS (PF) 10 MG/ML SOLN PRSYR	IJ	SOLN PRSYR
DEXAMETHASONE SOD PHOSPHATE PF 10 MG/ML SOLUTION	IJ	SOLUTION
DEXAMETH SOD PHOS (PF) +RFID 10 MG/ML SOLN PRSYR	IJ	SOLN PRSYR
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 50 % SOLUTION	IV	SOLUTION
DEXTROSE 5%/ELECTROLYTE #48 SOLUTION	IV	SOLUTION
DEXTROSE 70 % SOLUTION	IV	SOLUTION
DEXYCU 9 % SUSPENSION	IO	SUSPENSION
DIAZEPAM 10 MG/2ML SOLUTION	IJ	SOLUTION
DIAZEPAM 5 MG/ML SOLUTION	IJ	SOLUTION
DICYCLOMINE HCL 10 MG/ML SOLUTION	IM	SOLUTION
DIGOXIN 0.25 MG/ML SOLUTION	IJ	SOLUTION
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

MEDICATION NAME	ROUTE	DOSE FORM
DILTIAZEM HCL 50 MG/10ML SOLUTION	IV	SOLUTION
DOBUTAMINE-DEXTROSE 1-5 MG/ML-% SOLUTION	IV	SOLUTION
DOBUTAMINE-DEXTROSE 2-5 MG/ML-% SOLUTION	IV	SOLUTION
DOBUTAMINE-DEXTROSE 4-5 MG/ML-% SOLUTION	IV	SOLUTION
DOBUTAMINE HCL 12.5 MG/ML SOLUTION	IV	SOLUTION
DOCETAXEL 160 MG/16ML SOLUTION	IV	SOLUTION
DOCETAXEL 160 MG/8ML CONC	IV	CONC
DOCETAXEL 20 MG/2ML SOLUTION	IV	SOLUTION
DOCETAXEL 20 MG/ML CONC	IV	CONC
DOCETAXEL 80 MG/4ML CONC	IV	CONC
DOCETAXEL 80 MG/8ML SOLUTION	IV	SOLUTION
DOCIVYX 160 MG/16ML SOLUTION	IV	SOLUTION
DOCIVYX 20 MG/2ML SOLUTION	IV	SOLUTION
DOCIVYX 80 MG/8ML SOLUTION	IV	SOLUTION
DOPAMINE-DEXTROSE 1.6-5 MG/ML-% SOLUTION	IV	SOLUTION
DOPAMINE-DEXTROSE 3.2-5 MG/ML-% SOLUTION	IV	SOLUTION
DOPAMINE HCL 40 MG/ML SOLUTION	IV	SOLUTION
DOPAMINE IN D5W 0.8-5 MG/ML-% SOLUTION	IV	SOLUTION
DOPAMINE IN D5W 1.6-5 MG/ML-% SOLUTION	IV	SOLUTION
DOPAMINE IN D5W 3.2-5 MG/ML-% SOLUTION	IV	SOLUTION
DOXERCALCIFEROL 0.5 MCG CAP	PO	CAP
DOXERCALCIFEROL 1 MCG CAP	PO	CAP
DOXERCALCIFEROL 2.5 MCG CAP	PO	CAP
DOXERCALCIFEROL 4 MCG/2ML SOLUTION	IV	SOLUTION
DOXIL 2 MG/ML SUSPENSION	IV	SUSPENSION
DOXORUBICIN HCL 10 MG RECON SOLN	IV	RECON SOLN
DOXORUBICIN HCL 2 MG/ML SOLUTION	IV	SOLUTION
DOXORUBICIN HCL 50 MG RECON SOLN	IV	RECON SOLN
DOXORUBICIN HCL LIPOSOMAL 2 MG/ML SUSPENSION	IV	SUSPENSION
DRONABINOL 5 MG/ML SOLUTION	PO	SOLUTION
DUOPA 4.63-20 MG/ML SUSPENSION	EN	SUSPENSION
DURACLON 100 MCG/ML SOLUTION	EP	SOLUTION
DURAMORPH 0.5 MG/ML SOLUTION	IJ	SOLUTION
DURAMORPH 1 MG/ML SOLUTION	IJ	SOLUTION
DURYSTA 10 MCG IMPLANT	IO	IMPLANT
DYSPORT 300 UNIT RECON SOLN	IM	RECON SOLN
DYSPORT 500 UNIT RECON SOLN	IM	RECON SOLN
EDARAVONE 30 MG/100ML SOLUTION	IV	SOLUTION
EDARAVONE 60 MG/100ML SOLUTION	IV	SOLUTION
ELAHERE 100 MG/20ML SOLUTION	IV	SOLUTION
ELAPRASE 6 MG/3ML SOLUTION	IV	SOLUTION
ELCYS 50 MG/ML SOLUTION	IV	SOLUTION
ELELYSO 200 UNIT RECON SOLN	IV	RECON SOLN

MEDICATION NAME	ROUTE	DOSE FORM
ELFABRIO 20 MG/10ML SOLUTION	IV	SOLUTION
ELFABRIO 5 MG/2.5ML SOLUTION	IV	SOLUTION
ELLENCE 200 MG/100ML SOLUTION	IV	SOLUTION
ELLENCE 50 MG/25ML SOLUTION	IV	SOLUTION
ELLIOTTS B SOLUTION	IT	SOLUTION
ELREXFIO 44 MG/1.1ML SOLUTION	SC	SOLUTION
ELREXFIO 76 MG/1.9ML SOLUTION	SC	SOLUTION
EMEND 125 MG/5ML RECON SUSP	PO	RECON SUSP
EMEND 150 MG RECON SOLN	IV	RECON SOLN
EMEND BIPACK 80 MG CAP	PO	CAP
EMEND TRIPACK 80 & 125 MG CAP THPK	PO	CAP THPK
EMPAVELI 1080 MG/20ML SOLUTION	SC	SOLUTION
EMPLICITI 300 MG RECON SOLN	IV	RECON SOLN
EMPLICITI 400 MG RECON SOLN	IV	RECON SOLN
EMRELIS 100 MG RECON SOLN	IV	RECON SOLN
EMRELIS 20 MG RECON SOLN	IV	RECON SOLN
ENALAPRILAT 1.25 MG/ML SOLUTION	IV	SOLUTION
ENGERIX-B 10 MCG/0.5ML SUSP PRSYR	IJ	SUSP PRSYR
ENGERIX-B 20 MCG/ML SUSPENSION	IJ	SUSPENSION
ENGERIX-B 20 MCG/ML SUSP PRSYR	IJ	SUSP PRSYR
ENHERTU 100 MG RECON SOLN	IV	RECON SOLN
ENJAYMO 1100 MG/22ML SOLUTION	IV	SOLUTION
ENTYVIO 300 MG RECON SOLN	IV	RECON SOLN
EPKINLY 48 MG/0.8ML SOLUTION	SC	SOLUTION
EPKINLY 4 MG/0.8ML SOLUTION	SC	SOLUTION
EPOGEN 10000 UNIT/ML SOLUTION	IJ	SOLUTION
EPOGEN 20000 UNIT/ML SOLUTION	IJ	SOLUTION
EPOGEN 2000 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
EPYSQLI 300 MG/30ML SOLUTION	IV	SOLUTION
ERBITUX 100 MG/50ML SOLUTION	IV	SOLUTION
ERBITUX 200 MG/100ML SOLUTION	IV	SOLUTION
ERIBULIN MESYLATE 1 MG/2ML SOLUTION	IV	SOLUTION
ERZOFRI 117 MG/0.75ML SUSP PRSYR	IM	SUSP PRSYR
ERZOFRI 156 MG/ML SUSP PRSYR	IM	SUSP PRSYR
ERZOFRI 234 MG/1.5ML SUSP PRSYR	IM	SUSP PRSYR
ERZOFRI 351 MG/2.25ML SUSP PRSYR	IM	SUSP PRSYR
ERZOFRI 39 MG/0.25ML SUSP PRSYR	IM	SUSP PRSYR
ERZOFRI 78 MG/0.5ML SUSP PRSYR	IM	SUSP PRSYR
ETHACRYNATE SODIUM 50 MG RECON SOLN	IV	RECON SOLN
ETHYOL 500 MG RECON SOLN	IV	RECON SOLN

MEDICATION NAME	ROUTE	DOSE FORM
ETOPOPHOS 100 MG RECON SOLN	IV	RECON SOLN
ETOPOSIDE 100 MG/5ML SOLUTION	IV	SOLUTION
ETOPOSIDE 1 GM/50ML SOLUTION	IV	SOLUTION
ETOPOSIDE 500 MG/25ML SOLUTION	IV	SOLUTION
EVDI 1 MG/20ML SOLUTION	IV	SOLUTION
EVENITY 105 MG/1.17ML SOLN PRSYR	SC	SOLN PRSYR
EVEROLIMUS 0.25 MG TAB	PO	TAB
EVEROLIMUS 0.5 MG TAB	PO	TAB
EVEROLIMUS 0.75 MG TAB	PO	TAB
EVEROLIMUS 1 MG TAB	PO	TAB
EVKEEZA 1200 MG/8ML SOLUTION	IV	SOLUTION
EVKEEZA 345 MG/2.3ML SOLUTION	IV	SOLUTION
EVOMELA 50 MG RECON SOLN	IV	RECON SOLN
EXDENSUR 100 MG/ML SOLN PRSYR	SC	SOLN PRSYR
FABRAZYME 35 MG RECON SOLN	IV	RECON SOLN
FABRAZYME 5 MG RECON SOLN	IV	RECON SOLN
FAMOTIDINE 200 MG/20ML SOLUTION	IV	SOLUTION
FAMOTIDINE 200 MG/50ML SOLUTION	IV	SOLUTION
FAMOTIDINE 20 MG/5ML SOLUTION	IV	SOLUTION
FAMOTIDINE 40 MG/10ML SOLUTION	IV	SOLUTION
FAMOTIDINE 40 MG/4ML SOLUTION	IV	SOLUTION
FAMOTIDINE (PF) 20 MG/2ML SOLUTION	IV	SOLUTION
FASENRA 10 MG/0.5ML SOLN PRSYR	SC	SOLN PRSYR
FASENRA 30 MG/ML SOLN PRSYR	SC	SOLN PRSYR
FAVLYXA 250 MG/10ML SOLUTION	IV	SOLUTION
FAVLYXA 2.5 GM/100ML SOLUTION	IV	SOLUTION
FENSOLVI (6 MONTH) 45 MG KIT	SC	KIT
FILKRI 300 MCG/0.5ML SOLN PRSYR	IJ	SOLN PRSYR
FILKRI 480 MCG/0.8ML SOLN PRSYR	IJ	SOLN PRSYR
FLEBOGAMMA DIF 10 GM/100ML SOLUTION	IV	SOLUTION
FLEBOGAMMA DIF 10 GM/200ML SOLUTION	IV	SOLUTION
FLEBOGAMMA DIF 20 GM/200ML SOLUTION	IV	SOLUTION
FLEBOGAMMA DIF 20 GM/400ML SOLUTION	IV	SOLUTION
FLEBOGAMMA DIF 2.5 GM/50ML SOLUTION	IV	SOLUTION
FLEBOGAMMA DIF 5 GM/100ML SOLUTION	IV	SOLUTION
FLEBOGAMMA DIF 5 GM/50ML SOLUTION	IV	SOLUTION
FLOLAN 0.5 MG RECON SOLN	IV	RECON SOLN
FLOLAN 1.5 MG RECON SOLN	IV	RECON SOLN
FLOXURIDINE 0.5 GM RECON SOLN	IJ	RECON SOLN
FLUDARABINE PHOSPHATE 25 MG/ML SOLUTION	IV	SOLUTION
FLUDARABINE PHOSPHATE 50 MG/2ML SOLUTION	IV	SOLUTION
FLUDARABINE PHOSPHATE 50 MG RECON SOLN	IV	RECON SOLN
FLUOROURACIL 1 GM/20ML SOLUTION	IV	SOLUTION
FLUOROURACIL 2.5 GM/50ML SOLUTION	IV	SOLUTION

MEDICATION NAME	ROUTE	DOSE FORM
FLUOROURACIL 500 MG/10ML SOLUTION	IV	SOLUTION
FLUOROURACIL 5 GM/100ML SOLUTION	IV	SOLUTION
FOCINVEZ 150 MG/50ML SOLUTION	IV	SOLUTION
FOLOTYN 20 MG/ML SOLUTION	IV	SOLUTION
FOLOTYN 40 MG/2ML SOLUTION	IV	SOLUTION
FORMOTEROL FUMARATE 20 MCG/2ML NEBU SOLN	IN	NEBU SOLN
FOSAPREPITANT DIMEGLUMINE 150 MG RECON SOLN	IV	RECON SOLN
FOSPHENYTOIN SODIUM 100 MG PE/2ML SOLUTION	IJ	SOLUTION
FOSPHENYTOIN SODIUM 500 MG PE/10ML SOLUTION	IJ	SOLUTION
FOSRENOL 1000 MG CHEW TAB	PO	CHEW TAB
FOSRENOL 1000 MG PACKET	PO	PACKET
FOSRENOL 500 MG CHEW TAB	PO	CHEW TAB
FOSRENOL 750 MG CHEW TAB	PO	CHEW TAB
FOSRENOL 750 MG PACKET	PO	PACKET
FRINDOVYX 1 GM/2ML SOLUTION	IV	SOLUTION
FRINDOVYX 2 GM/4ML SOLUTION	IV	SOLUTION
FRINDOVYX 500 MG/ML SOLUTION	IV	SOLUTION
FYARRO 100 MG RECON SUSP	IV	RECON SUSP
FYLNETRA 6 MG/0.6ML SOLN PRSYR	SC	SOLN PRSYR
GABLOFEN 10000 MCG/20ML SOLN PRSYR	IT	SOLN PRSYR
GABLOFEN 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 SOLUTION	IM	SOLUTION
GAMMAGARD 10 GM/100ML SOLUTION	IJ	SOLUTION
GAMMAGARD 1 GM/10ML SOLUTION	IJ	SOLUTION
GAMMAGARD 20 GM/200ML SOLUTION	IJ	SOLUTION
GAMMAGARD 2.5 GM/25ML SOLUTION	IJ	SOLUTION
GAMMAGARD 30 GM/300ML SOLUTION	IJ	SOLUTION
GAMMAGARD 5 GM/50ML SOLUTION	IJ	SOLUTION
GAMMAGARD ERC 10 GM/100ML SOLUTION	IJ	SOLUTION
GAMMAGARD ERC 5 GM/50ML SOLUTION	IJ	SOLUTION
GAMMAGARD S/D LESS IGA 10 GM RECON SOLN	IV	RECON SOLN
GAMMAGARD S/D LESS IGA 5 GM RECON SOLN	IV	RECON SOLN
GAMMAKED 10 GM/100ML SOLUTION	IJ	SOLUTION
GAMMAKED 1 GM/10ML SOLUTION	IJ	SOLUTION
GAMMAKED 20 GM/200ML SOLUTION	IJ	SOLUTION
GAMMAKED 5 GM/50ML SOLUTION	IJ	SOLUTION
GAMMAPLEX 10 GM/100ML SOLUTION	IV	SOLUTION
GAMMAPLEX 10 GM/200ML SOLUTION	IV	SOLUTION

MEDICATION NAME	ROUTE	DOSE FORM
GAMMAPLEX 20 GM/200ML SOLUTION	IV	SOLUTION
GAMMAPLEX 20 GM/400ML SOLUTION	IV	SOLUTION
GAMMAPLEX 5 GM/100ML SOLUTION	IV	SOLUTION
GAMMAPLEX 5 GM/50ML SOLUTION	IV	SOLUTION
GANCICLOVIR 500 MG/250ML SOLUTION	IV	SOLUTION
GANCICLOVIR SODIUM 500 MG/10ML SOLUTION	IV	SOLUTION
GANCICLOVIR SODIUM 500 MG RECON SOLN	IV	RECON SOLN
GAZYVA 1000 MG/40ML SOLUTION	IV	SOLUTION
GEMCITABINE HCL 1.5 GM/15ML SOLUTION	IV	SOLUTION
GEMCITABINE HCL 1 GM/10ML SOLUTION	IV	SOLUTION
GEMCITABINE HCL 1 GM/26.3ML SOLUTION	IV	SOLUTION
GEMCITABINE HCL 1 GM RECON SOLN	IV	RECON SOLN
GEMCITABINE HCL 200 MG/2ML SOLUTION	IV	SOLUTION
GEMCITABINE HCL 200 MG/5.26ML SOLUTION	IV	SOLUTION
GEMCITABINE HCL 200 MG RECON SOLN	IV	RECON SOLN
GEMCITABINE HCL 2 GM/20ML SOLUTION	IV	SOLUTION
GEMCITABINE HCL 2 GM/52.6ML SOLUTION	IV	SOLUTION
GEMCITABINE HCL 2 GM RECON SOLN	IV	RECON SOLN
GENGRAF 100 MG CAP	PO	CAP
GENGRAF 100 MG/ML SOLUTION	PO	SOLUTION
GENGRAF 25 MG CAP	PO	CAP
GENTAMICIN IN SALINE 0.8-0.9 MG/ML-% SOLUTION	IV	SOLUTION
GENTAMICIN IN SALINE 1-0.9 MG/ML-% SOLUTION	IV	SOLUTION
GENTAMICIN IN SALINE 1.2-0.9 MG/ML-% SOLUTION	IV	SOLUTION
GENTAMICIN IN SALINE 1.6-0.9 MG/ML-% SOLUTION	IV	SOLUTION
GENTAMICIN IN SALINE 2-0.9 MG/ML-% SOLUTION	IV	SOLUTION
GIVLAARI 189 MG/ML SOLUTION	SC	SOLUTION
GLASSIA 1000 MG/50ML SOLUTION	IV	SOLUTION
GLASSIA 4 GM/200ML SOLUTION	IV	SOLUTION
GLASSIA 5 GM/250ML SOLUTION	IV	SOLUTION
GLUCOSE (DEXTROSE) 50 % SOLUTION	IV	SOLUTION
GLYCOPHOS 1 MMOLE/ML SOLUTION	IV	SOLUTION
GRAFAPEX 1 GM RECON SOLN	IV	RECON SOLN
GRAFAPEX 5 GM RECON SOLN	IV	RECON SOLN
GRANISETRON HCL 1 MG/ML SOLUTION	IV	SOLUTION
GRANISETRON HCL 1 MG TAB	PO	TAB
GRANISETRON HCL 4 MG/4ML SOLUTION	IV	SOLUTION
GRANISOL 2 MG/10ML SOLUTION	PO	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 4 MCG/2ML SOLUTION	IV	SOLUTION

MEDICATION NAME	ROUTE	DOSE FORM
HEPAGAM B 312 UNIT/ML SOLUTION	IJ	SOLUTION
HEPARIN (PORCINE) IN NACL 1000-0.9 UT/500ML-% SOLUTION	IV	SOLUTION
HEPARIN (PORCINE) IN NACL 12500-0.45 UT/250ML-% SOLUTION	IV	SOLUTION
HEPARIN (PORCINE) IN NACL 2000-0.9 UNIT/L-% SOLUTION	IV	SOLUTION
HEPARIN (PORCINE) IN NACL 25000-0.45 UT/250ML-% SOLUTION	IV	SOLUTION
HEPARIN (PORCINE) IN NACL 25000-0.45 UT/500ML-% SOLUTION	IV	SOLUTION
HEPARIN (PORCINE) IN NACL 2500-0.9 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 5000-0.9 UNIT/L-% SOLUTION	IV	SOLUTION
HEPARIN (PORCINE) IN NACL 5000-0.9 UT/500ML-% SOLUTION	IV	SOLUTION
HEPARIN (PORCINE) IN NACL 500-0.9 UT/500ML-% SOLUTION	IV	SOLUTION
HEPARIN SODIUM (PORCINE) 10000 UNIT/ML SOLUTION	IJ	SOLUTION
HEPARIN SODIUM (PORCINE) 1000 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 1000 UNIT/ML SOLUTION	IJ	SOLUTION
HEPARIN SODIUM (PORCINE) PF 5000 UNIT/0.5ML SOLUTION	IJ	SOLUTION
HEPARIN SODIUM (PORCINE) PF 5000 UNIT/ML SOLUTION	IJ	SOLUTION
HEPARIN SODIUM (PORCINE) +RFID 1000 UNIT/ML SOLUTION	IJ	SOLUTION
HEPARIN SOD (PORCINE) IN D5W 100 UNIT/ML SOLUTION	IV	SOLUTION
HEPARIN SOD (PORCINE) IN D5W 25000-5 UT/500ML-% SOLUTION	IV	SOLUTION
HEPARIN SOD (PORCINE) IN D5W 40-5 UNIT/ML-% SOLUTION	IV	SOLUTION
HEPLISAV-B 20 MCG/0.5ML SOLN PRSYR	IM	SOLN PRSYR
HERCEPTIN 150 MG RECON SOLN	IV	RECON SOLN

MEDICATION NAME	ROUTE	DOSE FORM
HERCEPTIN HYLECTA 600-10000 MG-UNT/5ML SOLUTION	SC	SOLUTION
HERCESSI 150 MG RECON SOLN	IV	RECON SOLN
HERCESSI 420 MG RECON SOLN	IV	RECON SOLN
HERZUMA 150 MG RECON SOLN	IV	RECON SOLN
HERZUMA 420 MG RECON SOLN	IV	RECON SOLN
HUMULIN R U-500 (CONCENTRATED) 500 UNIT/ML SOLUTION	SC	SOLUTION
HYCAMTIN 4 MG RECON SOLN	IV	RECON SOLN
HYDROCORTISONE SOD SUC (PF) 100 MG RECON SOLN	IJ	RECON SOLN
HYDROMORPHONE HCL PF 10 MG/ML SOLUTION	IJ	SOLUTION
HYDROMORPHONE HCL PF 500 MG/50ML SOLUTION	IJ	SOLUTION
HYDROMORPHONE HCL PF 50 MG/5ML SOLUTION	IJ	SOLUTION
HYDROXYZINE HCL 25 MG/ML SOLUTION	IM	SOLUTION
HYDROXYZINE HCL 50 MG/ML SOLUTION	IM	SOLUTION
HYOSCYAMINE SULFATE 0.5 MG/ML SOLUTION	IJ	SOLUTION
HYPERHEP B 110 UNIT/0.5ML SOLN PRSYR	IM	SOLN PRSYR
HYPERHEP B 220 UNIT/ML 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
HYQVIA 10 GM/100ML KIT	SC	KIT
HYQVIA 20 GM/200ML KIT	SC	KIT
HYQVIA 2.5 GM/25ML KIT	SC	KIT
HYQVIA 30 GM/300ML KIT	SC	KIT
HYQVIA 5 GM/50ML KIT	SC	KIT
IBANDRONATE SODIUM 3 MG/3ML SOLUTION	IV	SOLUTION
IDAMYCIN PFS 10 MG/10ML SOLUTION	IV	SOLUTION
IDAMYCIN PFS 20 MG/20ML SOLUTION	IV	SOLUTION
IDAMYCIN PFS 5 MG/5ML SOLUTION	IV	SOLUTION
IDARUBICIN HCL 10 MG/10ML SOLUTION	IV	SOLUTION
IDARUBICIN HCL 20 MG/20ML SOLUTION	IV	SOLUTION
IDARUBICIN HCL 5 MG/5ML SOLUTION	IV	SOLUTION
IFEX 1 GM RECON SOLN	IV	RECON SOLN
IFEX 3 GM RECON SOLN	IV	RECON SOLN
IFOSFAMIDE 1 GM/20ML SOLUTION	IV	SOLUTION
IFOSFAMIDE 1 GM RECON SOLN	IV	RECON SOLN
IFOSFAMIDE 3 GM/60ML SOLUTION	IV	SOLUTION
IFOSFAMIDE 3 GM RECON SOLN	IV	RECON SOLN
IMAAVY 1200 MG/6.5ML SOLUTION	IV	SOLUTION
IMAAVY 300 MG/1.62ML SOLUTION	IV	SOLUTION
IMDELLTRA 10 MG RECON SOLN	IV	RECON SOLN

MEDICATION NAME	ROUTE	DOSE FORM
IMDELLTRA 1 MG RECON SOLN	IV	RECON SOLN
IMFINZI 120 MG/2.4ML SOLUTION	IV	SOLUTION
IMFINZI 500 MG/10ML SOLUTION	IV	SOLUTION
IMLYGIC 100000000 UNIT/ML SUSPENSION	LS	SUSPENSION
IMLYGIC 1000000 UNIT/ML SUSPENSION	LS	SUSPENSION
IMOGAM RABIES-HT 300 UNIT/2ML SOLUTION	IJ	SOLUTION
IMULDOSA 130 MG/26ML SOLUTION	IV	SOLUTION
IMURAN 50 MG TAB	PO	TAB
INFLECTRA 100 MG RECON SOLN	IV	RECON SOLN
INFLIXIMAB 100 MG RECON SOLN	IV	RECON SOLN
INFUGEM 1200-0.9 MG/120ML-% SOLUTION	IV	SOLUTION
INFUGEM 1300-0.9 MG/130ML-% SOLUTION	IV	SOLUTION
INFUGEM 1400-0.9 MG/140ML-% SOLUTION	IV	SOLUTION
INFUGEM 1500-0.9 MG/150ML-% SOLUTION	IV	SOLUTION
INFUGEM 1600-0.9 MG/160ML-% SOLUTION	IV	SOLUTION
INFUGEM 1700-0.9 MG/170ML-% SOLUTION	IV	SOLUTION
INFUGEM 1800-0.9 MG/180ML-% SOLUTION	IV	SOLUTION
INFUGEM 1900-0.9 MG/190ML-% SOLUTION	IV	SOLUTION
INFUGEM 2000-0.9 MG/200ML-% SOLUTION	IV	SOLUTION
INFUGEM 2200-0.9 MG/220ML-% SOLUTION	IV	SOLUTION
INFUMORPH 200 200 MG/20ML (10 MG/ML) SOLUTION	IJ	SOLUTION
INFUMORPH 500 500 MG/20ML (25 MG/ML) SOLUTION	IJ	SOLUTION
INTRALIPID 20 % EMULSION	IV	EMULSION
INTRALIPID 30 % EMULSION	IV	EMULSION
INVEGA HAFYERA 1092 MG/3.5ML SUSP PRSYR	IM	SUSP PRSYR
INVEGA HAFYERA 1560 MG/5ML SUSP PRSYR	IM	SUSP PRSYR
INVEGA SUSTENNA 117 MG/0.75ML SUSP PRSYR	IM	SUSP PRSYR
INVEGA SUSTENNA 156 MG/ML SUSP PRSYR	IM	SUSP PRSYR
INVEGA SUSTENNA 234 MG/1.5ML SUSP PRSYR	IM	SUSP PRSYR
INVEGA SUSTENNA 39 MG/0.25ML SUSP PRSYR	IM	SUSP PRSYR
INVEGA SUSTENNA 78 MG/0.5ML SUSP PRSYR	IM	SUSP PRSYR
INVEGA TRINZA 273 MG/0.88ML SUSP PRSYR	IM	SUSP PRSYR
INVEGA TRINZA 410 MG/1.32ML SUSP PRSYR	IM	SUSP PRSYR
INVEGA TRINZA 546 MG/1.75ML SUSP PRSYR	IM	SUSP PRSYR
INVEGA TRINZA 819 MG/2.63ML SUSP PRSYR	IM	SUSP PRSYR
IONOSOL-MB IN D5W SOLUTION	IV	SOLUTION
IPRATROPIUM-ALBUTEROL 0.5-2.5 (3) MG/3ML SOLUTION	IN	SOLUTION
IPRATROPIUM BROMIDE 0.02 % 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

MEDICATION NAME	ROUTE	DOSE FORM
IRINOTECAN HCL 500 MG/25ML SOLUTION	IV	SOLUTION
ISOLYTE-P IN D5W SOLUTION	IV	SOLUTION
ISOLYTE-S PH 7.4 SOLUTION	IV	SOLUTION
ISOLYTE-S SOLUTION	IV	SOLUTION
ISTODAX 10 MG RECON SOLN	IV	RECON SOLN
IVRA 90 MG/ML SOLUTION	IV	SOLUTION
IXEMPRA KIT 15 MG RECON SOLN	IV	RECON SOLN
IXEMPRA KIT 45 MG RECON SOLN	IV	RECON SOLN
JEMPERLI 500 MG/10ML SOLUTION	IV	SOLUTION
JOBEVNE 100 MG/4ML SOLUTION	IV	SOLUTION
JOBEVNE 400 MG/16ML SOLUTION	IV	SOLUTION
JUBEREQ 120 MG/1.7ML SOLUTION	SC	SOLUTION
KABIVEN 3.3-10.8-3.9 % EMULSION	IV	EMULSION
KADCYLA 100 MG RECON SOLN	IV	RECON SOLN
KADCYLA 160 MG RECON SOLN	IV	RECON SOLN
KANJINTI 150 MG RECON SOLN	IV	RECON SOLN
KANJINTI 420 MG RECON SOLN	IV	RECON SOLN
KANUMA 20 MG/10ML SOLUTION	IV	SOLUTION
KCL (0.149%) IN NACL 20-0.45 MEQ/L-% SOLUTION	IV	SOLUTION
KCL IN 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 NACL 0.9%) 40 MEQ/500ML SOLUTION	IV	SOLUTION
KEDRAB 1500 UNIT/10ML SOLUTION	IJ	SOLUTION
KEDRAB 300 UNIT/2ML SOLUTION	IJ	SOLUTION
KEMOPLAT 50 MG/50ML SOLUTION	IV	SOLUTION
KENALOG-10 10 MG/ML SUSPENSION	IJ	SUSPENSION
KENALOG-40 40 MG/ML SUSPENSION	IJ	SUSPENSION
KENALOG-80 80 MG/ML SUSPENSION	IJ	SUSPENSION
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
KEYTRUDA QLEX 395-4800 MG -UNT/2.4ML SOLUTION	SC	SOLUTION
KEYTRUDA QLEX 790-9600 MG -UNT/4.8ML SOLUTION	SC	SOLUTION
KHAPZORY 175 MG RECON SOLN	IV	RECON SOLN
KHAPZORY 300 MG RECON SOLN	IV	RECON SOLN
KIMMTRAK 100 MCG/0.5ML SOLUTION	IV	SOLUTION

MEDICATION NAME	ROUTE	DOSE FORM
KIMYRSA 1200 MG RECON SOLN	IV	RECON SOLN
KITABIS PAK 300 MG/5ML NEBU SOLN	IN	NEBU SOLN
KRYSTEXXA 8 MG/50ML SOLUTION	IV	SOLUTION
KRYSTEXXA 8 MG/ML SOLUTION	IV	SOLUTION
KYLEENA 19.5 MG IUD	IU	IUD
KYPROLIS 10 MG RECON SOLN	IV	RECON SOLN
KYPROLIS 30 MG RECON SOLN	IV	RECON SOLN
KYPROLIS 60 MG RECON SOLN	IV	RECON SOLN
KYXATA 500 MG/50ML SOLUTION	IV	SOLUTION
KYXATA 80 MG/8ML SOLUTION	IV	SOLUTION
LACOSAMIDE 200 MG/20ML SOLUTION	IV	SOLUTION
LAMZEDE 10 MG RECON SOLN	IV	RECON SOLN
LANOXIN 0.25 MG/ML SOLUTION	IJ	SOLUTION
LANOXIN PEDIATRIC 0.1 MG/ML SOLUTION	IJ	SOLUTION
LANREOTIDE ACETATE 120 MG/0.5ML SOLUTION	SC	SOLUTION
LANTHANUM CARBONATE 1000 MG CHEW TAB	PO	CHEW TAB
LANTHANUM CARBONATE 500 MG CHEW TAB	PO	CHEW TAB
LANTHANUM CARBONATE 750 MG CHEW TAB	PO	CHEW TAB
LEMTRADA 12 MG/1.2ML SOLUTION	IV	SOLUTION
LEQVIO 284 MG/1.5ML SOLN PRSYR	SC	SOLN PRSYR
LEUCOVORIN CALCIUM 500 MG/50ML SOLUTION	IJ	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 250 MG/50ML SOLUTION	IV	SOLUTION
LEVETIRACETAM IN NACL 500 MG/100ML SOLUTION	IV	SOLUTION
LEVOCARNITINE 200 MG/ML SOLUTION	IV	SOLUTION
LEVOFLOXACIN IN D5W 250 MG/50ML SOLUTION	IV	SOLUTION
LEVOLEUCOVORIN CALCIUM 50 MG RECON SOLN	IV	RECON SOLN
LEVOLEUCOVORIN CALCIUM PF 175 MG/17.5ML SOLUTION	IV	SOLUTION
LEVOLEUCOVORIN CALCIUM PF 250 MG/25ML SOLUTION	IV	SOLUTION
LEVOTHYROXINE SODIUM 100 MCG/5ML SOLUTION	IV	SOLUTION
LEVOTHYROXINE SODIUM 100 MCG/ML SOLUTION	IV	SOLUTION
LEVOTHYROXINE SODIUM 100 MCG RECON SOLN	IV	RECON SOLN
LEVOTHYROXINE SODIUM 200 MCG/5ML SOLUTION	IV	SOLUTION
LEVOTHYROXINE SODIUM 200 MCG RECON SOLN	IV	RECON SOLN
LEVOTHYROXINE SODIUM 500 MCG/5ML SOLUTION	IV	SOLUTION
LEVOTHYROXINE SODIUM 500 MCG RECON SOLN	IV	RECON SOLN
LEVSIN 0.5 MG/ML SOLUTION	IJ	SOLUTION
LEVULAN KERASTICK 20 % RECON SOLN	EX	RECON SOLN

MEDICATION NAME	ROUTE	DOSE FORM
LIBTAYO 350 MG/7ML SOLUTION	IV	SOLUTION
LIDOCAINE-EPINEPHRINE 0.5 %-1:200000 SOLUTION	IJ	SOLUTION
LIDOCAINE-EPINEPHRINE 1 %-1:100000 SOLUTION	IJ	SOLUTION
LIDOCAINE-EPINEPHRINE 2 %-1:100000 SOLUTION	IJ	SOLUTION
LIDOCAINE-EPINEPHRINE 2 %-1:200000 SOLUTION	IJ	SOLUTION
LIDOCAINE-EPINEPHRINE (PF) 1.5 %-1:200000 SOLUTION	IJ	SOLUTION
LIDOCAINE-EPINEPHRINE (PF) 2 %-1:200000 SOLUTION	IJ	SOLUTION
LIDOCAINE HCL (CARDIAC) PF 100 MG/5ML SOLUTION	IV	SOLUTION
LIORESAL 0.05 MG/ML 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
LOARGYS 2 MG/0.4ML SOLUTION	IJ	SOLUTION
LOQTORZI 240 MG/6ML SOLUTION	IV	SOLUTION
LORAZEPAM 2 MG/ML SOLUTION	IJ	SOLUTION
LORAZEPAM 4 MG/ML SOLUTION	IJ	SOLUTION
LUMIZYME 50 MG RECON SOLN	IV	RECON SOLN
LUMOXITI 1 MG RECON SOLN	IV	RECON SOLN
LUMVOA 500 MG/10ML SOLUTION	IV	SOLUTION
LUNSUMIO 1 MG/ML SOLUTION	IV	SOLUTION
LUNSUMIO 30 MG/30ML SOLUTION	IV	SOLUTION
LUNSUMIO VELO 45 MG/ML SOLUTION	SC	SOLUTION
LUNSUMIO VELO 5 MG/0.5ML SOLUTION	SC	SOLUTION
LUPRON DEPOT-PED (1-MONTH) 11.25 MG KIT	IM	KIT
LUPRON DEPOT-PED (1-MONTH) 15 MG KIT	IM	KIT
LUPRON DEPOT-PED (1-MONTH) 7.5 MG KIT	IM	KIT
LUPRON DEPOT-PED (3-MONTH) 11.25 MG (PED) KIT	IM	KIT
LUPRON DEPOT-PED (3-MONTH) 30 MG KIT	IM	KIT
LUPRON DEPOT-PED (6-MONTH) 45 MG KIT	IM	KIT
LYMPHIR 300 MCG RECON SOLN	IV	RECON SOLN
LYNOZYFIC 200 MG/10ML SOLUTION	IV	SOLUTION
LYNOZYFIC 5 MG/2.5ML SOLUTION	IV	SOLUTION
MAGNESIUM SULFATE 20 GM/500ML SOLUTION	IV	SOLUTION
MAGNESIUM SULFATE 2 GM/50ML SOLUTION	IV	SOLUTION
MAGNESIUM SULFATE 3 GM/100ML SOLUTION	IV	SOLUTION
MAGNESIUM SULFATE 40 GM/1000ML SOLUTION	IV	SOLUTION
MAGNESIUM SULFATE 4 GM/100ML SOLUTION	IV	SOLUTION
MAGNESIUM SULFATE 4 GM/50ML SOLUTION	IV	SOLUTION
MAGNESIUM SULFATE IN D5W 1-5 GM/100ML-% SOLUTION	IV	SOLUTION
MAGNESIUM SULFATE-NACL 2-0.9 GM/50ML-% SOLUTION	IV	SOLUTION

MEDICATION NAME	ROUTE	DOSE FORM
MANGANESE CHLORIDE 0.1 MG/ML SOLUTION	IV	SOLUTION
MANNITOL 20 % SOLUTION	IV	SOLUTION
MANNITOL 25 % SOLUTION	IV	SOLUTION
MARGENZA 250 MG/10ML SOLUTION	IV	SOLUTION
MARINOL 10 MG CAP	PO	CAP
MARINOL 2.5 MG CAP	PO	CAP
MARINOL 5 MG CAP	PO	CAP
MELPHALAN 2 MG TAB	PO	TAB
MELPHALAN HCL 50 MG RECON SOLN	IV	RECON SOLN
MEPERIDINE HCL 100 MG/ML SOLUTION	IJ	SOLUTION
MEPERIDINE HCL 25 MG/ML SOLUTION	IJ	SOLUTION
MEPERIDINE HCL 50 MG/ML SOLUTION	IJ	SOLUTION
MEPSEVII 10 MG/5ML SOLUTION	IV	SOLUTION
METHOCARBAMOL 1000 MG/10ML SOLUTION	IJ	SOLUTION
METHOTREXATE SODIUM 250 MG/10ML SOLUTION	IJ	SOLUTION
METHOTREXATE SODIUM 50 MG/2ML SOLUTION	IJ	SOLUTION
METHOTREXATE SODIUM (PF) 1000 MG/40ML 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
METHYLPREDNISOLONE ACETATE 50 MG/ML SUSPENSION	IJ	SUSPENSION
METHYLPREDNISOLONE SODIUM SUCC 1000 MG RECON SOLN	IJ	RECON SOLN
METHYLPREDNISOLONE SODIUM SUCC 125 MG RECON SOLN	IJ	RECON SOLN
METHYLPREDNISOLONE SODIUM SUCC 500 MG RECON SOLN	IJ	RECON SOLN
METOPROLOL TARTRATE 5 MG/5ML SOLUTION	IV	SOLUTION
MIACALCIN 200 UNIT/ML SOLUTION	IJ	SOLUTION
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
MIRCERA 100 MCG/0.3ML SOLN PRSYR	IJ	SOLN PRSYR
MIRCERA 120 MCG/0.3ML SOLN PRSYR	IJ	SOLN PRSYR
MIRCERA 150 MCG/0.3ML SOLN PRSYR	IJ	SOLN PRSYR
MIRCERA 200 MCG/0.3ML SOLN PRSYR	IJ	SOLN PRSYR

MEDICATION NAME	ROUTE	DOSE FORM
MIRCERA 30 MCG/0.3ML SOLN PRSYR	IJ	SOLN PRSYR
MIRCERA 50 MCG/0.3ML SOLN PRSYR	IJ	SOLN PRSYR
MIRCERA 75 MCG/0.3ML SOLN PRSYR	IJ	SOLN PRSYR
MIRENA (52 MG) 21 MCG/DAY IUD	IU	IUD
MITIGO 200 MG/20ML (10 MG/ML) SOLUTION	IJ	SOLUTION
MITIGO 500 MG/20ML (25 MG/ML) SOLUTION	IJ	SOLUTION
MITOMYCIN 20 MG RECON SOLN	IV	RECON SOLN
MITOMYCIN 40 MG RECON SOLN	IV	RECON SOLN
MITOMYCIN 5 MG RECON SOLN	IV	RECON SOLN
MITOXANTRONE HCL 20 MG/10ML CONC	IV	CONC
MITOXANTRONE HCL 25 MG/12.5ML CONC	IV	CONC
MITOXANTRONE HCL 30 MG/15ML CONC	IV	CONC
MIUDELLA IUD	IU	IUD
MONJUVI 200 MG RECON SOLN	IV	RECON SOLN
MORPHINE SULFATE 1 MG/ML SOLUTION	IJ	SOLUTION
MORPHINE SULFATE 2 MG/ML SOLUTION	IJ	SOLUTION
MORPHINE SULFATE 4 MG/ML SOLUTION	IJ	SOLUTION
MORPHINE SULFATE (PF) 0.5 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) 1 MG/ML SOLUTION	IJ	SOLUTION
MORPHINE SULFATE (PF) 1 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
MOXIFLOXACIN HCL 400 MG/250ML SOLUTION	IV	SOLUTION
MOXIFLOXACIN HCL IN NACL 400 MG/250ML SOLUTION	IV	SOLUTION
MULTIPLE ELECTRO TYPE 1 PH 5.5 SOLUTION	IV	SOLUTION
MULTIPLE ELECTRO TYPE 1 PH 7.4 SOLUTION	IV	SOLUTION
MUTAMYCIN 20 MG RECON SOLN	IV	RECON SOLN
MUTAMYCIN 40 MG RECON SOLN	IV	RECON SOLN
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

MEDICATION NAME	ROUTE	DOSE FORM
MYCOPHENOLATE MOFETIL HCL 500 MG RECON SOLN	IV	RECON SOLN
MYCOPHENOLATE SODIUM 180 MG TAB DR	PO	TAB DR
MYCOPHENOLATE SODIUM 360 MG TAB DR	PO	TAB DR
MYCOPHENOLIC ACID 180 MG TAB DR	PO	TAB DR
MYCOPHENOLIC ACID 360 MG TAB DR	PO	TAB DR
MYFORTIC 180 MG TAB DR	PO	TAB DR
MYFORTIC 360 MG TAB DR	PO	TAB DR
MYHIBBIN 200 MG/ML SUSPENSION	PO	SUSPENSION
MYLOTARG 4.5 MG RECON SOLN	IV	RECON SOLN
MYOBLOC 10000 UNIT/2ML SOLUTION	IM	SOLUTION
MYOBLOC 2500 UNIT/0.5ML SOLUTION	IM	SOLUTION
MYOBLOC 5000 UNIT/ML SOLUTION	IM	SOLUTION
NABI-HB 312 UNIT/ML SOLUTION	IM	SOLUTION
NAFCILLIN SODIUM IN DEXTROSE 1 GM/50ML SOLUTION	IV	SOLUTION
NAFCILLIN SODIUM IN DEXTROSE 2 GM/100ML SOLUTION	IV	SOLUTION
NAGLAZYME 1 MG/ML SOLUTION	IV	SOLUTION
NALBUPHINE HCL 10 MG/ML SOLUTION	IJ	SOLUTION
NALBUPHINE HCL 20 MG/ML SOLUTION	IJ	SOLUTION
NAVITRUX 150 MG RECON SOLN	IV	RECON SOLN
NEBUPENT 300 MG RECON SOLN	IN	RECON SOLN
NELARABINE 5 MG/ML SOLUTION	IV	SOLUTION
NEORAL 100 MG CAP	PO	CAP
NEORAL 100 MG/ML SOLUTION	PO	SOLUTION
NEORAL 25 MG CAP	PO	CAP
NEULASTA 4 MG/0.4ML SOLUTION	SC	SOLUTION
NEULASTA 6 MG/0.6ML SOLN PRSYR	SC	SOLN PRSYR
NEULASTA ONPRO 6 MG/0.6ML SOLN PRSYR	SC	SOLN PRSYR
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
NEXVIAZYME 100 MG RECON SOLN	IV	RECON SOLN
NICARDIPINE HCL 2.5 MG/ML SOLUTION	IV	SOLUTION
NIKTIMVO 22 MG/0.44ML SOLUTION	IV	SOLUTION
NIKTIMVO 22 MG/2.2ML SOLUTION	IV	SOLUTION
NIKTIMVO 9 MG/0.18ML SOLUTION	IV	SOLUTION
NIKTIMVO 9 MG/0.9ML 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

MEDICATION NAME	ROUTE	DOSE FORM
NITROGLYCERIN IN D5W 200-5 MCG/ML-% SOLUTION	IV	SOLUTION
NITROGLYCERIN IN D5W 400-5 MCG/ML-% SOLUTION	IV	SOLUTION
NORMOSOL-R IN D5W SOLUTION	IV	SOLUTION
NORMOSOL-R PH 7.4 SOLUTION	IV	SOLUTION
NORMOSOL-R SOLUTION	IV	SOLUTION
NOVAREL 5000 UNIT RECON SOLN	IM	RECON SOLN
NOXAFIL 300 MG/16.7ML SOLUTION	IV	SOLUTION
NPLATE 125 MCG RECON SOLN	SC	RECON SOLN
NPLATE 250 MCG RECON SOLN	SC	RECON SOLN
NPLATE 500 MCG RECON SOLN	SC	RECON SOLN
NULIBRY 9.5 MG RECON SOLN	IV	RECON SOLN
NULOJIX 250 MG RECON SOLN	IV	RECON SOLN
NUMBRINO 40 MG/ML SOLUTION	NA	SOLUTION
NUTRILIPID 20 % EMULSION	IV	EMULSION
NUZYRA 100 MG RECON SOLN	IV	RECON SOLN
NYPOZI 300 MCG/0.5ML SOLN PRSYR	IJ	SOLN PRSYR
NYPOZI 480 MCG/0.8ML SOLN PRSYR	IJ	SOLN PRSYR
NYVEPRIA 6 MG/0.6ML SOLN PRSYR	SC	SOLN PRSYR
OCREVUS 300 MG/10ML SOLUTION	IV	SOLUTION
OCREVUS ZUNOVO 920-23000 MG-UT/23ML SOLUTION	SC	SOLUTION
OCTAGAM 10 GM/100ML SOLUTION	IV	SOLUTION
OCTAGAM 10 GM/200ML SOLUTION	IV	SOLUTION
OCTAGAM 1 GM/20ML SOLUTION	IV	SOLUTION
OCTAGAM 20 GM/200ML SOLUTION	IV	SOLUTION
OCTAGAM 25 GM/500ML SOLUTION	IV	SOLUTION
OCTAGAM 2.5 GM/50ML SOLUTION	IV	SOLUTION
OCTAGAM 2 GM/20ML SOLUTION	IV	SOLUTION
OCTAGAM 30 GM/300ML SOLUTION	IV	SOLUTION
OCTAGAM 5 GM/100ML SOLUTION	IV	SOLUTION
OCTAGAM 5 GM/50ML SOLUTION	IV	SOLUTION
OCTREOTIDE ACETATE 20 MG KIT	IM	KIT
OCTREOTIDE ACETATE 30 MG KIT	IM	KIT
OGIVRI 150 MG RECON SOLN	IV	RECON SOLN
OGIVRI 420 MG RECON SOLN	IV	RECON SOLN
OHTUVAYRE 3 MG/2.5ML SUSPENSION	IN	SUSPENSION
OMEGAVEN 10 GM/100ML EMULSION	IV	EMULSION
OMEGAVEN 5 GM/50ML EMULSION	IV	EMULSION
OMVOH 300 MG/15ML SOLUTION	IV	SOLUTION
ONAPGO 98 MG/20ML SOLN CART	SC	SOLN CART
ONCASPAR 750 UNIT/ML SOLUTION	IJ	SOLUTION
ONDANSETRON 4 MG TAB DISP	PO	TAB DISP

MEDICATION NAME	ROUTE	DOSE FORM
ONDANSETRON 8 MG TAB DISP	PO	TAB DISP
ONDANSETRON HCL 24 MG TAB	PO	TAB
ONDANSETRON HCL 2 MG/2.5ML SOLUTION	PO	SOLUTION
ONDANSETRON HCL 40 MG/20ML SOLUTION	IJ	SOLUTION
ONDANSETRON HCL 4 MG/2ML SOLN PRSYR	IJ	SOLN PRSYR
ONDANSETRON HCL 4 MG/2ML SOLUTION	IJ	SOLUTION
ONDANSETRON HCL 4 MG/5ML SOLUTION	PO	SOLUTION
ONDANSETRON HCL 4 MG TAB	PO	TAB
ONDANSETRON HCL 8 MG TAB	PO	TAB
ONIVYDE 43 MG/10ML SUSPENSION	IV	SUSPENSION
ONPATTRO 10 MG/5ML SOLUTION	IV	SOLUTION
ONTRUZANT 150 MG RECON SOLN	IV	RECON SOLN
ONTRUZANT 420 MG RECON SOLN	IV	RECON SOLN
OPDIVO 100 MG/10ML SOLUTION	IV	SOLUTION
OPDIVO 120 MG/12ML SOLUTION	IV	SOLUTION
OPDIVO 240 MG/24ML SOLUTION	IV	SOLUTION
OPDIVO 40 MG/4ML SOLUTION	IV	SOLUTION
OPDIVO QVANTIG 300-5000 MG -UT/2.5ML SOLUTION	SC	SOLUTION
OPDIVO QVANTIG 600-10000 MG-UT/5ML SOLUTION	SC	SOLUTION
OPDUALAG 240-80 MG/20ML SOLUTION	IV	SOLUTION
ORBACTIV 400 MG RECON SOLN	IV	RECON SOLN
ORPHENADRINE CITRATE 30 MG/ML SOLUTION	IJ	SOLUTION
OSENVELT 120 MG/1.7ML SOLUTION	SC	SOLUTION
OSMITROL 10 % SOLUTION	IV	SOLUTION
OSMITROL 20 % SOLUTION	IV	SOLUTION
OSPOMYV 60 MG/ML SOLN PRSYR	SC	SOLN PRSYR
OSVYRTI 60 MG/ML SOLN PRSYR	SC	SOLN PRSYR
OTULFI 130 MG/26ML SOLUTION	IV	SOLUTION
OXACILLIN SODIUM 10 GM RECON SOLN	IV	RECON SOLN
OXACILLIN SODIUM 1 GM RECON SOLN	IJ	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/20ML SOLUTION	IV	SOLUTION
OXALIPLATIN 100 MG RECON SOLN	IV	RECON SOLN
OXALIPLATIN 200 MG/40ML SOLUTION	IV	SOLUTION
OXALIPLATIN 50 MG/10ML SOLUTION	IV	SOLUTION
OXALIPLATIN 50 MG RECON SOLN	IV	RECON SOLN
OXLUMO 94.5 MG/0.5ML SOLUTION	SC	SOLUTION
PACLITAXEL 100 MG/16.7ML CONC	IV	CONC
PACLITAXEL 150 MG/25ML CONC	IV	CONC

MEDICATION NAME	ROUTE	DOSE FORM
PACLITAXEL 300 MG/50ML CONC	IV	CONC
PACLITAXEL 30 MG/5ML CONC	IV	CONC
PACLITAXEL PROTEIN-BOUND PART 100 MG RECON SUSP	IV	RECON SUSP
PADCEV 20 MG RECON SOLN	IV	RECON SOLN
PADCEV 30 MG RECON SOLN	IV	RECON SOLN
PALONOSETRON HCL 0.25 MG/2ML SOLUTION	IV	SOLUTION
PALONOSETRON HCL 0.25 MG/5ML SOLN PRSYR	IV	SOLN PRSYR
PALONOSETRON HCL 0.25 MG/5ML SOLUTION	IV	SOLUTION
PAMIDRONATE DISODIUM 6 MG/ML SOLUTION	IV	SOLUTION
PAMIDRONATE DISODIUM 90 MG/10ML SOLUTION	IV	SOLUTION
PANTOPRAZOLE SODIUM-NACL 40-0.9 MG/100ML-% SOLUTION	IV	SOLUTION
PANTOPRAZOLE SODIUM-NACL 40-0.9 MG/50ML-% SOLUTION	IV	SOLUTION
PANTOPRAZOLE SODIUM-NACL 80-0.9 MG/100ML-% SOLUTION	IV	SOLUTION
PANZYGA 10 GM/100ML SOLUTION	IV	SOLUTION
PANZYGA 1 GM/10ML SOLUTION	IV	SOLUTION
PANZYGA 20 GM/200ML SOLUTION	IV	SOLUTION
PANZYGA 2.5 GM/25ML SOLUTION	IV	SOLUTION
PANZYGA 30 GM/300ML SOLUTION	IV	SOLUTION
PANZYGA 5 GM/50ML SOLUTION	IV	SOLUTION
PARAGARD INTRAUTERINE COPPER IUD	IU	IUD
PARAPLATIN 1000 MG/100ML SOLUTION	IV	SOLUTION
PARAPLATIN 150 MG/15ML SOLUTION	IV	SOLUTION
PARAPLATIN 450 MG/45ML SOLUTION	IV	SOLUTION
PARAPLATIN 50 MG/5ML SOLUTION	IV	SOLUTION
PARAPLATIN 600 MG/60ML SOLUTION	IV	SOLUTION
PARICALCITOL 1 MCG CAP	PO	CAP
PARICALCITOL 2 MCG CAP	PO	CAP
PARICALCITOL 2 MCG/ML SOLUTION	IV	SOLUTION
PARICALCITOL 4 MCG CAP	PO	CAP
PARICALCITOL 5 MCG/ML SOLUTION	IV	SOLUTION
PEDMARK 12.5 % SOLUTION	IV	SOLUTION
PEMETREXED DISODIUM 1000 MG RECON SOLN	IV	RECON SOLN
PEMETREXED DISODIUM 100 MG/4ML SOLUTION	IV	SOLUTION
PEMETREXED DISODIUM 100 MG RECON SOLN	IV	RECON SOLN
PEMETREXED DISODIUM 1 GM/40ML SOLUTION	IV	SOLUTION
PEMETREXED DISODIUM 500 MG/20ML SOLUTION	IV	SOLUTION
PEMETREXED DISODIUM 500 MG RECON SOLN	IV	RECON SOLN
PEMETREXED DISODIUM 750 MG RECON SOLN	IV	RECON SOLN
PEMETREXED DISODIUM 850 MG/34ML SOLUTION	IV	SOLUTION
PEMETREXED DITROMETHAMINE 100 MG RECON SOLN	IV	RECON SOLN

MEDICATION NAME	ROUTE	DOSE FORM
PEMETREXED DITROMETHAMINE 500 MG RECON SOLN	IV	RECON SOLN
PEMRYDI RTU 100 MG/10ML SOLUTION	IV	SOLUTION
PEMRYDI RTU 500 MG/50ML SOLUTION	IV	SOLUTION
PENICILLIN G POT IN DEXTROSE 20000 UNIT/ML SOLUTION	IV	SOLUTION
PENICILLIN G POT IN DEXTROSE 40000 UNIT/ML SOLUTION	IV	SOLUTION
PENICILLIN G POT IN DEXTROSE 60000 UNIT/ML SOLUTION	IV	SOLUTION
PENICILLIN G PROCAINE 600000 UNIT/ML SUSPENSION	IM	SUSPENSION
PENTAMIDINE ISETHIONATE 300 MG RECON SOLN	IN	RECON SOLN
PERFOROMIST 20 MCG/2ML NEBU SOLN	IN	NEBU SOLN
PERIKABIVEN 2.4-6.8-3.5-0.5 % EMULSION	IV	EMULSION
PERJETA 420 MG/14ML SOLUTION	IV	SOLUTION
PERSERIS 120 MG PRSYR	SC	PRSYR
PERSERIS 90 MG PRSYR	SC	PRSYR
PHENERGAN 25 MG/ML SOLUTION	IJ	SOLUTION
PHENERGAN 50 MG/ML SOLUTION	IJ	SOLUTION
PHENYTOIN SODIUM 50 MG/ML SOLUTION	IJ	SOLUTION
PHESGO 60-60-2000 MG-MG-U/ML SOLUTION	SC	SOLUTION
PHESGO 80-40-2000 MG-MG-U/ML SOLUTION	SC	SOLUTION
PIASKY 340 MG/2ML SOLUTION	IJ	SOLUTION
PIPERACILLIN-TAZOBACTAM-NACL 2-0.25 GM/50ML RECON SOLN	IV	RECON SOLN
PIPERACILLIN-TAZOBACTAM-NACL 3-0.375 GM/50ML RECON SOLN	IV	RECON SOLN
PIPERACILLIN-TAZOBACTAM-NACL 4-0.5 GM/100ML RECON SOLN	IV	RECON SOLN
PLASMA-LYTE 148 SOLUTION	IV	SOLUTION
PLASMA-LYTE A SOLUTION	IV	SOLUTION
PLENAMINE 15 % SOLUTION	IV	SOLUTION
POLIVY 140 MG RECON SOLN	IV	RECON SOLN
POLIVY 30 MG RECON SOLN	IV	RECON SOLN
POMBILITI 105 MG RECON SOLN	IV	RECON SOLN
PORTRAZZA 800 MG/50ML SOLUTION	IV	SOLUTION
POSACONAZOLE 300 MG/16.7ML SOLUTION	IV	SOLUTION
POSFREA 0.25 MG/5ML SOLUTION	IV	SOLUTION
POTASSIUM ACETATE 2 MEQ/ML SOLUTION	IV	SOLUTION
POTASSIUM CHLORIDE 10 MEQ/50ML SOLUTION	IV	SOLUTION
POTASSIUM CHLORIDE 20 MEQ/50ML SOLUTION	IV	SOLUTION
POTASSIUM CHLORIDE IN DEXTROSE 10-5 MEQ/L-% SOLUTION	IV	SOLUTION
POTASSIUM CHLORIDE IN NACL 20-0.45 MEQ/L-% SOLUTION	IV	SOLUTION

MEDICATION NAME	ROUTE	DOSE FORM
POTASSIUM CHLORIDE IN NACL 20 MEQ/250ML SOLUTION	IV	SOLUTION
POTASSIUM PHOSPHATES 150 MMOLE/50ML SOLUTION	IV	SOLUTION
POTASSIUM PHOSPHATES 15 MMOLE/5ML SOLUTION	IV	SOLUTION
POTASSIUM PHOSPHATES 45 MMOLE/15ML SOLUTION	IV	SOLUTION
POTASSIUM PHOSPHATES(66 MEQ K) 45 MMOLE/15ML SOLUTION	IV	SOLUTION
POTASSIUM PHOSPHATES(71 MEQ K) 45 MMOLE/15ML SOLUTION	IV	SOLUTION
POTASSIUM PHOSPHATES-NACL 15 MMOL/100ML SOLUTION	IV	SOLUTION
POTASSIUM PHOSPHATES-NACL 15 MMOL/250ML SOLUTION	IV	SOLUTION
POTASSIUM PHOSPHATES-NACL 30 MMOL/500ML SOLUTION	IV	SOLUTION
POTELIGEO 20 MG/5ML SOLUTION	IV	SOLUTION
PRALATREXATE 20 MG/ML SOLUTION	IV	SOLUTION
PRALATREXATE 40 MG/2ML SOLUTION	IV	SOLUTION
PREGNYL 10000 UNIT RECON SOLN	IM	RECON SOLN
PREHEVBRIO 10 MCG/ML SUSPENSION	IM	SUSPENSION
PREMASOL 10 % SOLUTION	IV	SOLUTION
PREVYMIS 240 MG/12ML SOLUTION	IV	SOLUTION
PREVYMIS 480 MG/24ML SOLUTION	IV	SOLUTION
PRIALT 100 MCG/ML SOLUTION	IT	SOLUTION
PRIALT 500 MCG/20ML SOLUTION	IT	SOLUTION
PRIALT 500 MCG/5ML SOLUTION	IT	SOLUTION
PRIVIGEN 10 GM/100ML SOLUTION	IV	SOLUTION
PRIVIGEN 20 GM/200ML SOLUTION	IV	SOLUTION
PRIVIGEN 40 GM/400ML SOLUTION	IV	SOLUTION
PRIVIGEN 5 GM/50ML SOLUTION	IV	SOLUTION
PROCAINAMIDE HCL 100 MG/ML SOLUTION	IJ	SOLUTION
PROCAINAMIDE HCL 500 MG/ML SOLUTION	IJ	SOLUTION
PROCHLORPERAZINE EDISYLATE 10 MG/2ML SOLUTION	IJ	SOLUTION
PROCRIT 10000 UNIT/ML SOLUTION	IJ	SOLUTION
PROCRIT 20000 UNIT/ML SOLUTION	IJ	SOLUTION
PROCRIT 2000 UNIT/ML SOLUTION	IJ	SOLUTION
PROCRIT 3000 UNIT/ML SOLUTION	IJ	SOLUTION
PROCRIT 40000 UNIT/ML SOLUTION	IJ	SOLUTION
PROCRIT 4000 UNIT/ML SOLUTION	IJ	SOLUTION
PROGRAF 0.5 MG CAP	PO	CAP
PROGRAF 1 MG CAP	PO	CAP
PROGRAF 5 MG CAP	PO	CAP

MEDICATION NAME	ROUTE	DOSE FORM
PROGRAF 5 MG/ML SOLUTION	IV	SOLUTION
PROLASTIN-C 1000 MG/20ML SOLUTION	IV	SOLUTION
PROLEUKIN 22000000 UNIT RECON SOLN	IV	RECON SOLN
PROLIA 60 MG/ML SOLN PRSYR	SC	SOLN PRSYR
PROMETHAZINE HCL 25 MG/ML SOLUTION	IJ	SOLUTION
PROMETHAZINE HCL 50 MG/ML SOLUTION	IJ	SOLUTION
PROPRANOLOL HCL 1 MG/ML SOLUTION	IV	SOLUTION
PROSOL 20 % SOLUTION	IV	SOLUTION
PULMICORT 0.25 MG/2ML SUSPENSION	IN	SUSPENSION
PULMICORT 0.5 MG/2ML SUSPENSION	IN	SUSPENSION
PULMICORT 1 MG/2ML SUSPENSION	IN	SUSPENSION
PULMOZYME 2.5 MG/2.5ML SOLUTION	IN	SOLUTION
PYZCHIVA 130 MG/26ML SOLUTION	IV	SOLUTION
QIVIGY 10 GM/100ML SOLUTION	IV	SOLUTION
QIVIGY 5 GM/50ML SOLUTION	IV	SOLUTION
RADICAVA 30 MG/100ML SOLUTION	IV	SOLUTION
RAPAMUNE 0.5 MG TAB	PO	TAB
RAPAMUNE 1 MG/ML SOLUTION	PO	SOLUTION
RAPAMUNE 1 MG TAB	PO	TAB
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
RECOMBIVAX HB 10 MCG/ML SUSPENSION	IJ	SUSPENSION
RECOMBIVAX HB 10 MCG/ML SUSP PRSYR	IJ	SUSP PRSYR
RECOMBIVAX HB 40 MCG/ML SUSPENSION	IJ	SUSPENSION
RECOMBIVAX HB 5 MCG/0.5ML SUSPENSION	IJ	SUSPENSION
RECOMBIVAX HB 5 MCG/0.5ML SUSP PRSYR	IJ	SUSP PRSYR
REGONOL 10 MG/2ML SOLUTION	IV	SOLUTION
RELEUKO 300 MCG/0.5ML SOLN PRSYR	SC	SOLN PRSYR
RELEUKO 300 MCG/ML SOLUTION	IJ	SOLUTION
RELEUKO 480 MCG/0.8ML SOLN PRSYR	SC	SOLN PRSYR
RELEUKO 480 MCG/1.6ML SOLUTION	IJ	SOLUTION
REMICADE 100 MG RECON SOLN	IV	RECON SOLN
REMODULIN 100 MG/20ML SOLUTION	IJ	SOLUTION
REMODULIN 200 MG/20ML SOLUTION	IJ	SOLUTION
REMODULIN 20 MG/20ML SOLUTION	IJ	SOLUTION
REMODULIN 50 MG/20ML SOLUTION	IJ	SOLUTION
REMODULIN 8 MG/20ML SOLUTION	IJ	SOLUTION
RENFLEXIS 100 MG RECON SOLN	IV	RECON SOLN
REVATIO 10 MG/12.5ML SOLUTION	IV	SOLUTION
REVTORPYK 180 MG RECON SOLN	IV	RECON SOLN
REZZAYO 200 MG RECON SOLN	IV	RECON SOLN
RIABNI 100 MG/10ML SOLUTION	IV	SOLUTION

MEDICATION NAME	ROUTE	DOSE FORM
RIABNI 500 MG/50ML SOLUTION	IV	SOLUTION
RIBAVIRIN 6 GM RECON SOLN	IN	RECON SOLN
RISPERDAL CONSTA 12.5 MG SRER	IM	
RISPERDAL CONSTA 25 MG SRER	IM	
RISPERDAL CONSTA 37.5 MG SRER	IM	
RISPERDAL CONSTA 50 MG SRER	IM	
RISPERIDONE MICROSPHERES ER 12.5 MG SRER	IM	
RISPERIDONE MICROSPHERES ER 25 MG SRER	IM	
RISPERIDONE MICROSPHERES ER 37.5 MG SRER	IM	
RISPERIDONE MICROSPHERES ER 50 MG SRER	IM	
RITUXAN 100 MG/10ML SOLUTION	IV	SOLUTION
RITUXAN 500 MG/50ML SOLUTION	IV	SOLUTION
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
ROLVEDON 13.2 MG/0.6ML SOLN PRSYR	SC	SOLN PRSYR
ROMIDEPSIN 10 MG RECON SOLN	IV	RECON SOLN
ROMIDEPSIN 27.5 MG/5.5ML SOLUTION	IV	SOLUTION
RUXIENCE 100 MG/10ML SOLUTION	IV	SOLUTION
RUXIENCE 500 MG/50ML SOLUTION	IV	SOLUTION
RYBREVANT 350 MG/7ML SOLUTION	IV	SOLUTION
RYBREVANT FASPRO 1600-20000 MG-UT/10ML SOLUTION	SC	SOLUTION
RYBREVANT FASPRO 2240-28000 MG-UT/14ML SOLUTION	SC	SOLUTION
RYBREVANT FASPRO 2400-30000 MG-UT/15ML SOLUTION	SC	SOLUTION
RYBREVANT FASPRO 3520-44000 MG-UT/22ML SOLUTION	SC	SOLUTION
RYKINDO 25 MG SRER	IM	
RYKINDO 37.5 MG SRER	IM	
RYKINDO 50 MG SRER	IM	
RYLAZE 10 MG/0.5ML SOLUTION	IM	SOLUTION
RYSTIGGO 280 MG/2ML SOLUTION	SC	SOLUTION
RYSTIGGO 420 MG/3ML SOLUTION	SC	SOLUTION
RYSTIGGO 560 MG/4ML SOLUTION	SC	SOLUTION
RYSTIGGO 840 MG/6ML SOLUTION	SC	SOLUTION
RYTELO 188 MG RECON SOLN	IV	RECON SOLN
RYTELO 47 MG RECON SOLN	IV	RECON SOLN
RYZNEUTA 20 MG/ML SOLN PRSYR	SC	SOLN PRSYR
SANDIMMUNE 100 MG CAP	PO	CAP
SANDIMMUNE 100 MG/ML SOLUTION	PO	SOLUTION
SANDIMMUNE 25 MG CAP	PO	CAP

MEDICATION NAME	ROUTE	DOSE FORM
SANDIMMUNE 50 MG/ML SOLUTION	IV	SOLUTION
SANDOSTATIN LAR DEPOT 10 MG KIT	IM	KIT
SANDOSTATIN LAR DEPOT 20 MG KIT	IM	KIT
SANDOSTATIN LAR DEPOT 30 MG KIT	IM	KIT
SAPHNELO 300 MG/2ML SOLUTION	IV	SOLUTION
SARCLISA 100 MG/5ML SOLUTION	IV	SOLUTION
SARCLISA 500 MG/25ML SOLUTION	IV	SOLUTION
SARCLISA ESCENA 1400 MG/10ML SOLUTION	SC	SOLUTION
SELARSDI 130 MG/26ML SOLUTION	IV	SOLUTION
SENSIPAR 30 MG TAB	PO	TAB
SENSIPAR 60 MG TAB	PO	TAB
SENSIPAR 90 MG TAB	PO	TAB
SEVELAMER CARBONATE 0.8 GM PACKET	PO	PACKET
SEVELAMER CARBONATE 2.4 GM PACKET	PO	PACKET
SEVELAMER CARBONATE 800 MG TAB	PO	TAB
SEVELAMER HCL 400 MG TAB	PO	TAB
SEVELAMER HCL 800 MG TAB	PO	TAB
SEZABY 100 MG RECON SOLN	IV	RECON SOLN
SILDENAFIL CITRATE 10 MG/12.5ML SOLUTION	IV	SOLUTION
SIMPONI ARIA 50 MG/4ML SOLUTION	IV	SOLUTION
SIMULECT 10 MG RECON SOLN	IV	RECON SOLN
SIMULECT 20 MG RECON SOLN	IV	RECON SOLN
SIROLIMUS 0.5 MG TAB	PO	TAB
SIROLIMUS 1 MG/ML SOLUTION	PO	SOLUTION
SIROLIMUS 1 MG TAB	PO	TAB
SIROLIMUS 2 MG TAB	PO	TAB
SIVEXTRO 200 MG RECON SOLN	IV	RECON SOLN
SKYLA 13.5 MG IUD	IU	IUD
SMOFLIPID 20 % EMULSION	IV	EMULSION
SODIUM ACETATE 2 MEQ/ML SOLUTION	IV	SOLUTION
SODIUM ACETATE 4 MEQ/ML SOLUTION	IV	SOLUTION
SODIUM BICARBONATE 4.2 % SOLUTION	IV	SOLUTION
SODIUM BICARBONATE 7.5 % SOLUTION	IV	SOLUTION
SODIUM BICARBONATE 8.4 % SOLUTION	IV	SOLUTION
SODIUM CHLORIDE 0.9 % SOLUTION	IJ	SOLUTION
SODIUM CHLORIDE 4 MEQ/ML SOLUTION	IV	SOLUTION
SODIUM DIURIL 500 MG RECON SOLN	IV	RECON SOLN
SODIUM EDECRIN 50 MG RECON SOLN	IV	RECON SOLN
SODIUM PHOSPHATES 150 MMOLE/50ML SOLUTION	IV	SOLUTION
SODIUM PHOSPHATES 15 MMOLE/5ML SOLUTION	IV	SOLUTION
SODIUM PHOSPHATES 45 MMOLE/15ML SOLUTION	IV	SOLUTION
SOLIRIS 300 MG/30ML SOLUTION	IV	SOLUTION
SOLU-CORTEF 1000 MG RECON SOLN	IJ	RECON SOLN
SOLU-CORTEF 100 MG RECON SOLN	IJ	RECON SOLN

MEDICATION NAME	ROUTE	DOSE FORM
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 2 GM RECON SOLN	IJ	RECON SOLN
SOLU-MEDROL 500 MG RECON SOLN	IJ	RECON SOLN
SOLU-MEDROL (PF) 1000 MG RECON SOLN	IJ	RECON SOLN
SOLU-MEDROL (PF) 125 MG RECON SOLN	IJ	RECON SOLN
SOLU-MEDROL (PF) 40 MG RECON SOLN	IJ	RECON SOLN
SOLU-MEDROL (PF) 500 MG RECON SOLN	IJ	RECON SOLN
SOMATULINE DEPOT 120 MG/0.5ML SOLUTION	SC	SOLUTION
SOMATULINE DEPOT 60 MG/0.2ML SOLUTION	SC	SOLUTION
SOMATULINE DEPOT 90 MG/0.3ML SOLUTION	SC	SOLUTION
SPEVIGO 450 MG/7.5ML SOLUTION	IV	SOLUTION
STARJEMZA 130 MG/26ML SOLUTION	IV	SOLUTION
STELARA 130 MG/26ML SOLUTION	IV	SOLUTION
STEQEYMA 130 MG/26ML SOLUTION	IV	SOLUTION
STIMUFEND 6 MG/0.6ML SOLN PRSYR	SC	SOLN PRSYR
STOBOCLO 60 MG/ML SOLN PRSYR	SC	SOLN PRSYR
SUNLENCA 463.5 MG/1.5ML SOLUTION	SC	SOLUTION
SUSTOL 10 MG/0.4ML PRSYR	SC	PRSYR
SYLVANT 100 MG RECON SOLN	IV	RECON SOLN
SYLVANT 400 MG RECON SOLN	IV	RECON SOLN
SYNAGIS 100 MG/ML SOLUTION	IM	SOLUTION
SYNAGIS 50 MG/0.5ML SOLUTION	IM	SOLUTION
SYNDROS 5 MG/ML SOLUTION	PO	SOLUTION
SYNRIBO 3.5 MG RECON SOLN	SC	RECON SOLN
TACROLIMUS 0.5 MG CAP	PO	CAP
TACROLIMUS 1 MG CAP	PO	CAP
TACROLIMUS 5 MG CAP	PO	CAP
TACROLIMUS 5 MG/ML SOLUTION	IV	SOLUTION
TACROLIMUS ER 0.5 MG CAP ER 24H	PO	CAP ER 24H
TACROLIMUS ER 1 MG CAP ER 24H	PO	CAP ER 24H
TACROLIMUS ER 5 MG CAP ER 24H	PO	CAP ER 24H
TALVEY 3 MG/1.5ML SOLUTION	SC	SOLUTION
TALVEY 40 MG/ML SOLUTION	SC	SOLUTION
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
TEPADINA 200 MG/200ML RECON SOLN	IV	RECON SOLN
TEPADINA 400 MG/400ML RECON SOLN	IV	RECON SOLN
TEPEZZA 500 MG RECON SOLN	IV	RECON SOLN
TEPYLUTE 100 MG/10ML SOLUTION	IV	SOLUTION

MEDICATION NAME	ROUTE	DOSE FORM
TEPYLUTE 15 MG/1.5ML SOLUTION	IV	SOLUTION
TEVIMBRA 100 MG/10ML SOLUTION	IV	SOLUTION
TEVIMBRA 150 MG/15ML SOLUTION	IV	SOLUTION
TEZSPIRE 210 MG/1.91ML SOLN A-INJ	SC	SOLN A-INJ
TEZSPIRE 210 MG/1.91ML SOLN PRSYR	SC	SOLN PRSYR
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
TOFIDENCE 200 MG/10ML SOLUTION	IV	SOLUTION
TOFIDENCE 400 MG/20ML SOLUTION	IV	SOLUTION
TOFIDENCE 80 MG/4ML SOLUTION	IV	SOLUTION
TOPOSAR 100 MG/5ML SOLUTION	IV	SOLUTION
TOPOSAR 1 GM/50ML SOLUTION	IV	SOLUTION
TOPOSAR 500 MG/25ML SOLUTION	IV	SOLUTION
TOPOTECAN HCL 4 MG/4ML SOLUTION	IV	SOLUTION
TOPOTECAN HCL 4 MG RECON SOLN	IV	RECON SOLN
TORISEL 25 MG/ML SOLUTION	IV	SOLUTION
TOTECT 500 MG RECON SOLN	IV	RECON SOLN
TPN ELECTROLYTES CONC	IV	CONC
TRANEXAMIC ACID 1000 MG/10ML SOLUTION	IV	SOLUTION
TRAVASOL 10 % SOLUTION	IV	SOLUTION
TRAZIMERA 150 MG RECON SOLN	IV	RECON SOLN
TRAZIMERA 420 MG RECON SOLN	IV	RECON SOLN
TREANDA 100 MG RECON SOLN	IV	RECON SOLN
TREANDA 25 MG RECON SOLN	IV	RECON SOLN
TRELSTAR MIXJECT 11.25 MG RECON SUSP	IM	RECON SUSP
TRELSTAR MIXJECT 22.5 MG RECON SUSP	IM	RECON SUSP
TRELSTAR MIXJECT 3.75 MG RECON SUSP	IM	RECON SUSP
TREPROSTINIL 100 MG/20ML SOLUTION	IJ	SOLUTION
TREPROSTINIL 200 MG/20ML SOLUTION	IJ	SOLUTION
TREPROSTINIL 20 MG/20ML SOLUTION	IJ	SOLUTION
TREPROSTINIL 50 MG/20ML SOLUTION	IJ	SOLUTION
TRIAMCINOLONE ACETONIDE 10 MG/ML SUSPENSION	IJ	SUSPENSION
TRIAMCINOLONE ACETONIDE 40 MG/ML SUSPENSION	IJ	SUSPENSION
TRIAMCINOLONE ACETONIDE 50 MG/ML SUSPENSION	IJ	SUSPENSION
TRIAMCINOLONE ACETONIDE 80 MG/ML SUSPENSION	IJ	SUSPENSION
TRIESENCE 40 MG/ML SUSPENSION	IO	SUSPENSION
TRIOSTAT 10 MCG/ML SOLUTION	IV	SOLUTION
TRIPTODUR 22.5 MG SRER	IM	
TRISENOX 12 MG/6ML SOLUTION	IV	SOLUTION

MEDICATION NAME	ROUTE	DOSE FORM
TRODELVY 180 MG RECON SOLN	IV	RECON SOLN
TROPHAMINE 10 % SOLUTION	IV	SOLUTION
TRUXIMA 100 MG/10ML SOLUTION	IV	SOLUTION
TRUXIMA 500 MG/50ML SOLUTION	IV	SOLUTION
TYENNE 200 MG/10ML SOLUTION	IV	SOLUTION
TYENNE 400 MG/20ML SOLUTION	IV	SOLUTION
TYENNE 80 MG/4ML SOLUTION	IV	SOLUTION
TYRUKO 300 MG/15ML CONC	IV	CONC
TYSABRI 300 MG/15ML CONC	IV	CONC
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
TYZAVAN 1000 MG/200ML SOLUTION	IV	SOLUTION
TYZAVAN 1250 MG/250ML SOLUTION	IV	SOLUTION
TYZAVAN 1500 MG/300ML SOLUTION	IV	SOLUTION
TYZAVAN 1750 MG/350ML SOLUTION	IV	SOLUTION
TYZAVAN 2000 MG/400ML SOLUTION	IV	SOLUTION
TYZAVAN 500 MG/100ML SOLUTION	IV	SOLUTION
TYZAVAN 750 MG/150ML SOLUTION	IV	SOLUTION
UDENYCA ONBODY 6 MG/0.6ML SOLN PRSYR	SC	SOLN PRSYR
ULTOMIRIS 1100 MG/11ML SOLUTION	IV	SOLUTION
ULTOMIRIS 300 MG/3ML SOLUTION	IV	SOLUTION
UNITUXIN 17.5 MG/5ML SOLUTION	IV	SOLUTION
UNLOXCYT 300 MG/5ML SOLUTION	IV	SOLUTION
UPLIZNA 100 MG/10ML SOLUTION	IV	SOLUTION
UPTRAVI 1800 MCG RECON SOLN	IV	RECON SOLN
USTEKINUMAB 130 MG/26ML SOLUTION	IV	SOLUTION
USTEKINUMAB-TTWE 130 MG/26ML SOLUTION	IV	SOLUTION
UVADEX 20 MCG/ML SOLUTION	EC	SOLUTION
UZEDY 100 MG/0.28ML SUSP PRSYR	SC	SUSP PRSYR
UZEDY 125 MG/0.35ML SUSP PRSYR	SC	SUSP PRSYR
UZEDY 150 MG/0.42ML SUSP PRSYR	SC	SUSP PRSYR
UZEDY 200 MG/0.56ML SUSP PRSYR	SC	SUSP PRSYR
UZEDY 250 MG/0.7ML SUSP PRSYR	SC	SUSP PRSYR
UZEDY 50 MG/0.14ML SUSP PRSYR	SC	SUSP PRSYR
UZEDY 75 MG/0.21ML SUSP PRSYR	SC	SUSP PRSYR
VABOMERE 2 (1-1) GM RECON SOLN	IV	RECON SOLN
VALRUBICIN 40 MG/ML SOLUTION	IS	SOLUTION
VALSTAR 40 MG/ML SOLUTION	IS	SOLUTION
VANCOMYCIN HCL 1000 MG/200ML SOLUTION	IV	SOLUTION
VANCOMYCIN HCL 1250 MG/250ML SOLUTION	IV	SOLUTION
VANCOMYCIN HCL 1500 MG/300ML SOLUTION	IV	SOLUTION
VANCOMYCIN HCL 1750 MG/350ML SOLUTION	IV	SOLUTION
VANCOMYCIN HCL 2000 MG/400ML SOLUTION	IV	SOLUTION

MEDICATION NAME	ROUTE	DOSE FORM
VANCOMYCIN HCL 500 MG/100ML SOLUTION	IV	SOLUTION
VANCOMYCIN HCL 5 GM RECON SOLN	IV	RECON SOLN
VANCOMYCIN HCL 750 MG/150ML 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 GM/200ML-% SOLUTION	IV	SOLUTION
VANCOMYCIN HCL IN DEXTROSE 500-5 MG/100ML-% SOLUTION	IV	SOLUTION
VANCOMYCIN HCL IN DEXTROSE 750-5 MG/150ML-% SOLUTION	IV	SOLUTION
VANCOMYCIN HCL IN NACL 1-0.9 GM/200ML-% SOLUTION	IV	SOLUTION
VANCOMYCIN HCL IN NACL 1-0.9 GM/250ML-% SOLUTION	IV	SOLUTION
VANCOMYCIN HCL IN NACL 1.25-0.9 GM/250ML-% SOLUTION	IV	SOLUTION
VANCOMYCIN HCL IN NACL 1.5-0.9 GM/250ML-% SOLUTION	IV	SOLUTION
VANCOMYCIN HCL IN NACL 1.5-0.9 GM/500ML-% SOLUTION	IV	SOLUTION
VANCOMYCIN HCL IN NACL 1.75-0.9 GM/250ML-% SOLUTION	IV	SOLUTION
VANCOMYCIN HCL IN NACL 1.75-0.9 GM/500ML-% SOLUTION	IV	SOLUTION
VANCOMYCIN HCL IN NACL 2-0.9 GM/500ML-% SOLUTION	IV	SOLUTION
VANCOMYCIN HCL IN NACL 500-0.9 MG/100ML-% SOLUTION	IV	SOLUTION
VANCOMYCIN HCL IN NACL 750-0.9 MG/150ML-% SOLUTION	IV	SOLUTION
VANCOMYCIN HCL IN NACL 750-0.9 MG/250ML-% SOLUTION	IV	SOLUTION
VARUBI (180 MG DOSE) 2 X 90 MG TAB THPK	PO	TAB THPK
VECTIBIX 100 MG/5ML SOLUTION	IV	SOLUTION
VECTIBIX 400 MG/20ML SOLUTION	IV	SOLUTION
VEGZELMA 100 MG/4ML SOLUTION	IV	SOLUTION
VEGZELMA 400 MG/16ML SOLUTION	IV	SOLUTION
VELETRI 0.5 MG RECON SOLN	IV	RECON SOLN
VELETRI 1.5 MG RECON SOLN	IV	RECON SOLN
VELPHORO 500 MG CHEW TAB	PO	CHEW TAB
VENTAVIS 10 MCG/ML SOLUTION	IN	SOLUTION
VENTAVIS 20 MCG/ML SOLUTION	IN	SOLUTION
VEOPOZ 400 MG/2ML SOLUTION	IJ	SOLUTION

MEDICATION NAME	ROUTE	DOSE FORM
VERAPAMIL HCL 2.5 MG/ML SOLUTION	IV	SOLUTION
VFEND IV 200 MG RECON SOLN	IV	RECON SOLN
VIBATIV 750 MG RECON SOLN	IV	RECON SOLN
VIDAZA 100 MG RECON SUSP	IJ	RECON SUSP
VIMIZIM 5 MG/5ML SOLUTION	IV	SOLUTION
VIMPAT 200 MG/20ML SOLUTION	IV	SOLUTION
VINBLASTINE SULFATE 1 MG/ML SOLUTION	IV	SOLUTION
VINCASAR PFS 1 MG/ML SOLUTION	IV	SOLUTION
VINCRISTINE SULFATE 1 MG/ML SOLUTION	IV	SOLUTION
VINCRISTINE SULFATE 2 MG/2ML SOLUTION	IV	SOLUTION
VINORELBINE TARTRATE 10 MG/ML SOLUTION	IV	SOLUTION
VINORELBINE TARTRATE 50 MG/5ML SOLUTION	IV	SOLUTION
VIRAZOLE 6 GM RECON SOLN	IN	RECON SOLN
VIVIMUSTA 100 MG/4ML SOLUTION	IV	SOLUTION
VIVITROL 380 MG RECON SUSP	IM	RECON SUSP
VORICONAZOLE 200 MG/20ML SOLUTION	IV	SOLUTION
VORICONAZOLE 200 MG RECON SOLN	IV	RECON SOLN
VPRIV 400 UNIT RECON SOLN	IV	RECON SOLN
VYEPTI 100 MG/ML SOLUTION	IV	SOLUTION
VYKOURA 350 MG/35ML SOLUTION	IJ	SOLUTION
VYKOURA 500 MG/50ML SOLUTION	IJ	SOLUTION
VYKOURA 50 MG/5ML SOLUTION	IJ	SOLUTION
VYVGART 400 MG/20ML SOLUTION	IV	SOLUTION
VYVGART HYTRULO 180-2000 MG-UNIT/ML SOLUTION	SC	SOLUTION
VYXEOS 44-100 MG RECON SUSP	IV	RECON SUSP
WAINUA 45 MG/0.8ML SOLN PRSYR	SC	SOLN PRSYR
WEZLANA 130 MG/26ML SOLUTION	IV	SOLUTION
WINRHO SDF 15000 UNIT/13ML SOLUTION	IJ	SOLUTION
WINRHO SDF 1500 UNIT/1.3ML SOLUTION	IJ	SOLUTION
WINRHO SDF 2500 UNIT/2.2ML SOLUTION	IJ	SOLUTION
WINRHO SDF 5000 UNIT/4.4ML SOLUTION	IJ	SOLUTION
XEMBIFY 10 GM/50ML SOLUTION	SC	SOLUTION
XEMBIFY 1 GM/5ML SOLUTION	SC	SOLUTION
XEMBIFY 2 GM/10ML SOLUTION	SC	SOLUTION
XEMBIFY 4 GM/20ML SOLUTION	SC	SOLUTION
XENLETA 150 MG/15ML SOLUTION	IV	SOLUTION
XENPOZYME 20 MG RECON SOLN	IV	RECON SOLN
XENPOZYME 4 MG RECON SOLN	IV	RECON SOLN
XEOMIN 100 UNIT RECON SOLN	IM	RECON SOLN
XEOMIN 200 UNIT RECON SOLN	IM	RECON SOLN
XEOMIN 50 UNIT RECON SOLN	IM	RECON SOLN
XERAVA 100 MG RECON SOLN	IV	RECON SOLN
XERAVA 50 MG RECON SOLN	IV	RECON SOLN

MEDICATION NAME	ROUTE	DOSE FORM
XGEVA 120 MG/1.7ML SOLUTION	SC	SOLUTION
XIPERE 40 MG/ML SUSPENSION	IO	SUSPENSION
XOLAIR 150 MG RECON SOLN	SC	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
XYLOCAINE/EPINEPHRINE 0.5 %-1:200000 SOLUTION	IJ	SOLUTION
XYLOCAINE/EPINEPHRINE 1 %-1:100000 SOLUTION	IJ	SOLUTION
XYLOCAINE/EPINEPHRINE 2 %-1:100000 SOLUTION	IJ	SOLUTION
XYLOCAINE-MPF/EPINEPHRINE 1 %-1:200000 SOLUTION	IJ	SOLUTION
XYLOCAINE-MPF/EPINEPHRINE 1.5 %-1:200000 SOLUTION	IJ	SOLUTION
XYLOCAINE-MPF/EPINEPHRINE 2 %-1:200000 SOLUTION	IJ	SOLUTION
YARTEMLEA 370 MG/2ML SOLUTION	IV	SOLUTION
YERVOY 200 MG/40ML SOLUTION	IV	SOLUTION
YERVOY 50 MG/10ML SOLUTION	IV	SOLUTION
YIMMUGO 10 GM/100ML SOLUTION	IV	SOLUTION
YIMMUGO 20 GM/200ML SOLUTION	IV	SOLUTION
YIMMUGO 5 GM/50ML SOLUTION	IV	SOLUTION
YONDELIS 1 MG RECON SOLN	IV	RECON SOLN
YUPELRI 175 MCG/3ML NEBU SOLN	IN	NEBU SOLN
ZALTRAP 100 MG/4ML SOLUTION	IV	SOLUTION
ZALTRAP 200 MG/8ML SOLUTION	IV	SOLUTION
ZANOSAR 1 GM RECON SOLN	IV	RECON SOLN
ZEMAIRA 1000 MG RECON SOLN	IV	RECON SOLN
ZEMAIRA 4000 MG RECON SOLN	IV	RECON SOLN
ZEMAIRA 5000 MG RECON SOLN	IV	RECON SOLN
ZEMDRI 500 MG/10ML SOLUTION	IV	SOLUTION
ZEMPLAR 1 MCG CAP	PO	CAP
ZEMPLAR 2 MCG CAP	PO	CAP
ZEMPLAR 2 MCG/ML SOLUTION	IV	SOLUTION
ZEMPLAR 5 MCG/ML SOLUTION	IV	SOLUTION
ZEPZELCA 4 MG RECON SOLN	IV	RECON SOLN
ZERBAXA 1.5 (1-0.5) GM RECON SOLN	IV	RECON SOLN
ZEVALIN Y-90 3.2 MG/2ML KIT	IV	KIT
ZIEXTENZO 6 MG/0.6ML SOLN PRSYR	SC	SOLN PRSYR
ZILRETTA 32 MG SRER	IX	
ZINPLAVA 1000 MG/40ML SOLUTION	IV	SOLUTION
ZIRABEV 100 MG/4ML SOLUTION	IV	SOLUTION
ZIRABEV 400 MG/16ML SOLUTION	IV	SOLUTION
ZOLADEX 10.8 MG IMPLANT	SC	IMPLANT

MEDICATION NAME	ROUTE	DOSE FORM
ZOLADEX 3.6 MG IMPLANT	SC	IMPLANT
ZOLEDRONIC ACID 4 MG/100ML SOLUTION	IV	SOLUTION
ZOLEDRONIC ACID 4 MG/5ML CONC	IV	CONC
ZOLEDRONIC ACID 5 MG/100ML SOLUTION	IV	SOLUTION
ZORTRESS 0.25 MG TAB	PO	TAB
ZORTRESS 0.5 MG TAB	PO	TAB
ZORTRESS 0.75 MG TAB	PO	TAB
ZORTRESS 1 MG TAB	PO	TAB
ZULRESSO 100 MG/20ML SOLUTION	IV	SOLUTION
ZUPLENZ 4 MG FILM	PO	FILM
ZYNLONTA 10 MG RECON SOLN	IV	RECON SOLN
ZYNYZ 500 MG/20ML SOLUTION	IV	SOLUTION
ZYPREXA RELPREVV 210 MG RECON SUSP	IM	RECON SUSP
ZYPREXA RELPREVV 300 MG RECON SUSP	IM	RECON SUSP
ZYPREXA RELPREVV 405 MG RECON SUSP	IM	RECON SUSP