ABALOPARATIDE (TYMLOS)

MEDICATION(S)
TYMLOS

PENDING CMS APPROVAL

ABEMACICLIB (VERZENIO)

MEDICATION(S)
VERZENIO

PENDING CMS APPROVAL

ABIRATERONE

MEDICATION(S)
ABIRATERONE ACETATE, ABIRTEGA

PENDING CMS APPROVAL

ACALABRUTINIB (CALQUENCE)

MEDICATION(S)
CALQUENCE 100 MG TAB

PENDING CMS APPROVAL

ACETAMINOPHEN/BUTALBITAL

MEDICATION(S)

BUTALBITAL-ACETAMINOPHEN 50-300 MG CAP, BUTALBITAL-ACETAMINOPHEN 50-325 MG TAB, TENCON

PENDING CMS APPROVAL

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

PENDING CMS APPROVAL

ACETAMINOPHEN/BUTALBITAL/CAFFEINE/CODEINE

MEDICATION(S)

BUTALBITAL-APAP-CAFF-COD 50-325-40-30 MG CAP

PENDING CMS APPROVAL

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

PENDING CMS APPROVAL

ADAGRASIB (KRAZATI)

MEDICATION(S)
KRAZATI

PENDING CMS APPROVAL

ADALIMUMAB (HADLIMA)

MEDICATION(S)
HADLIMA, HADLIMA PUSHTOUCH

PENDING CMS APPROVAL

ADALIMUMAB RYVK (SIMLANDI)

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

PENDING CMS APPROVAL

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

PENDING CMS APPROVAL

ALECTINIB (ALECENSA)

MEDICATION(S)
ALECENSA

PENDING CMS APPROVAL

ALITRETINOIN (PANRETIN)

MEDICATION(S)
PANRETIN

PENDING CMS APPROVAL

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)

PENDING CMS APPROVAL

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

PENDING CMS APPROVAL

APALUTAMIDE (ERLEADA)

MEDICATION(S)
ERLEADA

PENDING CMS APPROVAL

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

PENDING CMS APPROVAL

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

PENDING CMS APPROVAL

ARMODAFINIL (NUVIGIL)

MEDICATION(S)
ARMODAFINIL

PENDING CMS APPROVAL

ASCIMINIB (SCEMBLIX)

MEDICATION(S)
SCEMBLIX

PENDING CMS APPROVAL

ASENAPINE (SAPHRIS)

MEDICATION(S)
ASENAPINE MALEATE

PENDING CMS APPROVAL

ASENAPINE (SECUADO)

MEDICATION(S)
SECUADO

PENDING CMS APPROVAL

ASPIRIN/BUTALBITAL/CAFFEINE

MEDICATION(S)
BUTALBITAL-ASPIRIN-CAFFEINE

PENDING CMS APPROVAL

ASPIRIN/BUTALBITAL/CAFFEINE/CODEINE

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

PENDING CMS APPROVAL

ATOVAQUONE (MEPRON)

MEDICATION(S)
ATOVAQUONE

PENDING CMS APPROVAL

AVAPRITINIB (AYVAKIT)

MEDICATION(S)
AYVAKIT

PENDING CMS APPROVAL

AVUTOMETINIB AND DEFACTINIB (AVMAPKI-FAKZYNJA CO-PACK)

MEDICATION(S)
AVMAPKI FAKZYNJA CO-PACK

PENDING CMS APPROVAL

AXITINIB (INLYTA)

MEDICATION(S)
INLYTA

PENDING CMS APPROVAL

AZACITIDINE (ONUREG)

MEDICATION(S)
ONUREG

PENDING CMS APPROVAL

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

PENDING CMS APPROVAL

BELZUTIFAN (WELIREG)

MEDICATION(S)
WELIREG

PENDING CMS APPROVAL

BEXAROTENE CAPSULE (TARGRETIN)

MEDICATION(S)
BEXAROTENE 75 MG CAP

PENDING CMS APPROVAL

BEXAROTENE (TARGRETIN TOPICAL GEL)

MEDICATION(S)
BEXAROTENE 1 % GEL

PENDING CMS APPROVAL

BINIMETINIB (MEKTOVI)

MEDICATION(S)
MEKTOVI

PENDING CMS APPROVAL

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

PENDING CMS APPROVAL

BREXPIPRAZOLE (REXULTI)

MEDICATION(S)
REXULTI

PENDING CMS APPROVAL

BRIGATINIB (ALUNBRIG)

MEDICATION(S)
ALUNBRIG

PENDING CMS APPROVAL

BUDESONIDE DELAYED RELEASE (TARPEYO)

MEDICATION(S)
TARPEYO

PENDING CMS APPROVAL

BUDESONIDE ER TABLET (UCERIS)

MEDICATION(S)
BUDESONIDE ER

PENDING CMS APPROVAL

BUPRENORPHINE PATCH (BUTRANS)

MEDICATION(S)
BUPRENORPHINE

PENDING CMS APPROVAL

C1 ESTERASE INHIBITOR (HAEGARDA)

MEDICATION(S)
HAEGARDA

PENDING CMS APPROVAL

CABOZANTINIB (CABOMETYX)

MEDICATION(S)
CABOMETYX

PENDING CMS APPROVAL

CABOZANTINIB S-MALATE (COMETRIQ)

MEDICATION(S)

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

PENDING CMS APPROVAL

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

PENDING CMS APPROVAL

CAPIVASERTIB (TRUQAP)

MEDICATION(S)
TRUQAP

PENDING CMS APPROVAL

CAPMATINIB (TABRECTA)

MEDICATION(S)
TABRECTA

PENDING CMS APPROVAL

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 0.5 MG CAP, VRAYLAR 0.75 MG CAP, VRAYLAR 1.5 MG CAP, VRAYLAR 3 MG CAP, VRAYLAR 4.5 MG CAP, VRAYLAR 6 MG CAP

PENDING CMS APPROVAL

CENOBAMATE (XCOPRI)

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

PENDING CMS APPROVAL

CERITINIB (ZYKADIA)

MEDICATION(S)
ZYKADIA

PENDING CMS APPROVAL

CLOBAZAM (ONFI)

MEDICATION(S)

CLOBAZAM 10 MG TAB, CLOBAZAM 20 MG TAB, CLOBAZAM 2.5 MG/ML SUSPENSION

PENDING CMS APPROVAL

CLOBAZAM ORAL FILM (SYMPAZAN)

MEDICATION(S)
SYMPAZAN

PENDING CMS APPROVAL

CLOZAPINE SUSPENSION (VERSACLOZ)

MEDICATION(S)
VERSACLOZ

PENDING CMS APPROVAL

COBIMETINIB (COTELLIC)

MEDICATION(S)
COTELLIC

PENDING CMS APPROVAL

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

PENDING CMS APPROVAL

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

PENDING CMS APPROVAL

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 CMS compendia supported maximum.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

DALFAMPRIDINE EXTENDED-RELEASE TABLET (AMPYRA)

MEDICATION(S)
DALFAMPRIDINE ER

PENDING CMS APPROVAL

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)

PENDING CMS APPROVAL

DAROLUTAMIDE (NUBEQA)

MEDICATION(S)
NUBEQA

PENDING CMS APPROVAL

DASATINIB (SPRYCEL)

MEDICATION(S)
DASATINIB

PENDING CMS APPROVAL

DECITABINE-CEDAZURIDINE (INQOVI)

MEDICATION(S)
INQOVI

PENDING CMS APPROVAL

DENOSUMAB (BILDYOS)

MEDICATION(S)
BILDYOS

PENDING CMS APPROVAL

DENOSUMAB (BILPREVDA)

MEDICATION(S)
BILPREVDA

PENDING CMS APPROVAL

DENOSUMAB (ENOBY)

MEDICATION(S)
ENOBY

PENDING CMS APPROVAL

DENOSUMAB (JUBBONTI)

MEDICATION(S)
JUBBONTI

PENDING CMS APPROVAL

DENOSUMAB (WYOST)

MEDICATION(S)
WYOST

PENDING CMS APPROVAL

DENOSUMAB (XTRENBO)

MEDICATION(S)
XTRENBO

PENDING CMS APPROVAL

DEUTETRABENAZINE (AUSTEDO, AUSTEDO XR)

MEDICATION(S)
AUSTEDO, AUSTEDO XR, AUSTEDO XR PATIENT TITRATION 12 & 18 & 24 & 30 MG TBER THPK

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 45-105 MG TAB ER, AUVELITY TITRATION PACK

PENDING CMS APPROVAL

DEXTROMETHORPHAN HBR-QUINIDINE SULFATE (NUEDEXTA)

MEDICATION(S)
DEXTROMETHORPHAN-QUINIDINE

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

PENDING CMS APPROVAL

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

PENDING CMS APPROVAL

DUPILUMAB (DUPIXENT)

MEDICATION(S)

DUPIXENT 200 MG/1.14ML SOLN A-INJ, DUPIXENT 200 MG/1.14ML SOLN PRSYR, DUPIXENT 300 MG/2ML SOLN A-INJ, DUPIXENT 300 MG/2ML SOLN PRSYR

PENDING CMS APPROVAL

DUVELISIB (COPIKTRA)

MEDICATION(S)
COPIKTRA

PENDING CMS APPROVAL

EFLORNITHINE HYDROCHLORIDE (IWILFIN)

MEDICATION(S)
IWILFIN

PENDING CMS APPROVAL

ELACESTRANT (ORSERDU)

MEDICATION(S)
ORSERDU

PENDING CMS APPROVAL

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

PENDING CMS APPROVAL

ELTROMBOPAG OLAMINE (PROMACTA)

MEDICATION(S)
ELTROMBOPAG OLAMINE

PENDING CMS APPROVAL

ENASIDENIB MESYLATE (IDHIFA)

MEDICATION(S)
IDHIFA

PENDING CMS APPROVAL

ENCORAFENIB (BRAFTOVI)

MEDICATION(S)
BRAFTOVI

PENDING CMS APPROVAL

ENSARTINIB (ENSACOVE)

MEDICATION(S)
ENSACOVE

PENDING CMS APPROVAL

ENTRECTINIB (ROZLYTREK)

MEDICATION(S)
ROZLYTREK

PENDING CMS APPROVAL

ENZALUTAMIDE (XTANDI)

MEDICATION(S)
XTANDI

PENDING CMS APPROVAL

EPOETIN ALFA-EPBX (RETACRIT)

MEDICATION(S)
RETACRIT

PENDING CMS APPROVAL

ERDAFITINIB (BALVERSA)

MEDICATION(S)
BALVERSA

PENDING CMS APPROVAL

ERENUMAB-AOOE (AIMOVIG)

MEDICATION(S)
AIMOVIG

PENDING CMS APPROVAL

ERLOTINIB (TARCEVA)

MEDICATION(S)
ERLOTINIB HCL

PENDING CMS APPROVAL

ETANERCEPT (ENBREL)

MEDICATION(S)

ENBREL 25 MG/0.5ML SOLN PRSYR, ENBREL 25 MG/0.5ML SOLUTION, ENBREL 50 MG/ML SOLN PRSYR, ENBREL MINI, ENBREL SURECLICK

PENDING CMS APPROVAL

ETRASIMOD ARGININE (VELSIPITY)

MEDICATION(S)
VELSIPITY

PENDING CMS APPROVAL

EVEROLIMUS (AFINITOR)

MEDICATION(S)

EVEROLIMUS 10 MG TAB, EVEROLIMUS 2.5 MG TAB, EVEROLIMUS 5 MG TAB, EVEROLIMUS 7.5 MG TAB

PENDING CMS APPROVAL

EVEROLIMUS (AFINITOR DISPERZ)

MEDICATION(S)

EVEROLIMUS 2 MG TAB SOL, EVEROLIMUS 3 MG TAB SOL, EVEROLIMUS 5 MG TAB SOL

PENDING CMS APPROVAL

EVOLOCUMAB (REPATHA)

MEDICATION(S)

REPATHA, REPATHA PUSHTRONEX SYSTEM, REPATHA SURECLICK

PENDING CMS APPROVAL

FECAL MICROBIOTA SPORES, LIVE-BRPK (VOWST)

MEDICATION(S)
VOWST

PENDING CMS APPROVAL

FEDRATINIB (INREBIC)

MEDICATION(S)
INREBIC

PENDING CMS APPROVAL

FENFLURAMINE (FINTEPLA)

MEDICATION(S)
FINTEPLA

PENDING CMS APPROVAL

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

PENDING CMS APPROVAL

FILGRASTIM-SNDZ (ZARXIO)

MEDICATION(S)
ZARXIO

PENDING CMS APPROVAL

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

PENDING CMS APPROVAL

FUTIBATINIB (LYTGOBI)

MEDICATION(S)

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

PENDING CMS APPROVAL

GALCANEZUMAB-GNLM (EMGALITY)

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

PENDING CMS APPROVAL

GANAXOLONE (ZTALMY)

MEDICATION(S)
ZTALMY

PENDING CMS APPROVAL

GEFITINIB (IRESSA)

MEDICATION(S)
GEFITINIB

PENDING CMS APPROVAL

GEPIRONE (EXXUA)

MEDICATION(S)
EXXUA, EXXUA TITRATION PACK

PENDING CMS APPROVAL

GILTERITINIB FUMARATE (XOSPATA)

MEDICATION(S)
XOSPATA

PENDING CMS APPROVAL

GLASDEGIB MALEATE (DAURISMO)

MEDICATION(S)
DAURISMO

PENDING CMS APPROVAL

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

PENDING CMS APPROVAL

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

PENDING CMS APPROVAL

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 100 MG TAB, PHENOBARBITAL 15 MG TAB, PHENOBARBITAL 16.2 MG TAB, PHENOBARBITAL 20 MG/5ML ELIXIR, PHENOBARBITAL 30 MG/7.5ML ELIXIR, PHENOBARBITAL 30 MG TAB, PHENOBARBITAL 32.4 MG TAB, PHENOBARBITAL 60 MG/15ML ELIXIR, PHENOBARBITAL 60 MG TAB, PHENOBARBITAL 64.8 MG TAB, PHENOBARBITAL 97.2 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 (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

IBERDOMIDE (ZENBEXUS)

MEDICATION(S)
ZENBEXUS

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Exclusion criteria will be based on current 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

IBRUTINIB (IMBRUVICA)

MEDICATION(S)

IMBRUVICA 140 MG CAP, IMBRUVICA 140 MG TAB, IMBRUVICA 280 MG TAB, IMBRUVICA 420 MG TAB, IMBRUVICA 70 MG CAP, IMBRUVICA 70 MG/ML SUSPENSION

PENDING CMS APPROVAL

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 CMS compendia supported 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

PENDING CMS APPROVAL

IMATINIB MESYLATE (GLEEVEC)

MEDICATION(S)
IMATINIB MESYLATE

PENDING CMS APPROVAL

IMATINIB ORAL SOLUTION (IMKELDI)

MEDICATION(S)
IMKELDI

PENDING CMS APPROVAL

IMLUNESTRANT (INLURIYO)

MEDICATION(S)
INLURIYO

PENDING CMS APPROVAL

IMMUNE GLOBULIN (GAMUNEX-C)

MEDICATION(S)
GAMUNEX-C

PENDING CMS APPROVAL

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

PENDING CMS APPROVAL

INFLIXIMAB-DYYB (ZYMFENTRA)

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

PENDING CMS APPROVAL

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

PENDING CMS APPROVAL

ISAVUCONAZONIUM (CRESEMBA)

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

PENDING CMS APPROVAL

ITRACONAZOLE ORAL SOLUTION (SPORANOX)

MEDICATION(S)
ITRACONAZOLE 10 MG/ML SOLUTION

PENDING CMS APPROVAL

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

PENDING CMS APPROVAL

IVOSIDENIB (TIBSOVO)

MEDICATION(S)
TIBSOVO

PENDING CMS APPROVAL

IXAZOMIB CITRATE (NINLARO)

MEDICATION(S)
NINLARO

PENDING CMS APPROVAL

LAMOTRIGINE SUSPENSION (SUBVENITE)

MEDICATION(S)
SUBVENITE 10 MG/ML SUSPENSION

PENDING CMS APPROVAL

LAPATINIB DITOSYLATE (TYKERB)

MEDICATION(S)
LAPATINIB DITOSYLATE

PENDING CMS APPROVAL

LAROTRECTINIB SULFATE (VITRAKVI)

MEDICATION(S)
VITRAKVI

PENDING CMS APPROVAL

LAZERTINIB (LAZCLUZE)

MEDICATION(S)
LAZCLUZE

PENDING CMS APPROVAL

LECANEMAB (LEQEMBI IQLIK)

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

PENDING CMS APPROVAL

LENALIDOMIDE (REVLIMID)

MEDICATION(S)
LENALIDOMIDE

PENDING CMS APPROVAL

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)

PENDING CMS APPROVAL

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

PENDING CMS APPROVAL

LEVOMILNACIPRAN HCL (FETZIMA)

MEDICATION(S)
FETZIMA, FETZIMA TITRATION

PENDING CMS APPROVAL

LIDOCAINE PATCH (LIDODERM)

MEDICATION(S)
LIDOCAINE 5 % PATCH, LIDOCAN

PENDING CMS APPROVAL

LINEZOLID (ZYVOX)

MEDICATION(S)

LINEZOLID 100 MG/5ML RECON SUSP, LINEZOLID 600 MG TAB

PENDING CMS APPROVAL

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

PENDING CMS APPROVAL

LONG-ACTING NARCOTIC DRUGS (HYDROMORPHONE ER)

MEDICATION(S)
HYDROMORPHONE HCL ER

PENDING CMS APPROVAL

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

PENDING CMS APPROVAL

LONG-ACTING NARCOTIC DRUGS (OXYMORPHONE ER)

MEDICATION(S)
OXYMORPHONE HCL ER

PENDING CMS APPROVAL

LORLATINIB (LORBRENA)

MEDICATION(S)
LORBRENA

PENDING CMS APPROVAL

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

PENDING CMS APPROVAL

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

PENDING CMS APPROVAL

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

PENDING CMS APPROVAL

MERCAPTOPURINE (PURIXAN)

MEDICATION(S)

MERCAPTOPURINE 2000 MG/100ML SUSPENSION

PENDING CMS APPROVAL

METHOTREXATE ORAL SOLUTION (XATMEP)

MEDICATION(S)
XATMEP

PENDING CMS APPROVAL

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

PENDING CMS APPROVAL

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

PENDING CMS APPROVAL

MODAFINIL (PROVIGIL)

MEDICATION(S)
MODAFINIL

PENDING CMS APPROVAL

MOMELOTINIB (OJJAARA)

MEDICATION(S)
OJJAARA

PENDING CMS APPROVAL

NERATINIB (NERLYNX)

MEDICATION(S)
NERLYNX

PENDING CMS APPROVAL

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

PENDING CMS APPROVAL

NINTEDANIB (OFEV)

MEDICATION(S)
NINTEDANIB ESYLATE, OFEV

PENDING CMS APPROVAL

NIRAPARIB-ABIRATERONE (AKEEGA)

MEDICATION(S)
AKEEGA

PENDING CMS APPROVAL

NIRAPARIB (ZEJULA)

MEDICATION(S)

ZEJULA 100 MG TAB, ZEJULA 200 MG TAB, ZEJULA 300 MG TAB

PENDING CMS APPROVAL

NIROGACESTAT (OGSIVEO)

MEDICATION(S)
OGSIVEO

PENDING CMS APPROVAL

NITAZOXANIDE (ALINIA)

MEDICATION(S)
NITAZOXANIDE

PENDING CMS APPROVAL

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

PENDING CMS APPROVAL

OLANZAPINE-SAMIDORPHAN (LYBALVI)

MEDICATION(S)
LYBALVI

PENDING CMS APPROVAL

OLAPARIB (LYNPARZA)

MEDICATION(S)
LYNPARZA

PENDING CMS APPROVAL

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

PENDING CMS APPROVAL

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

PENDING CMS APPROVAL

OSIMERTINIB (TAGRISSO)

MEDICATION(S)
TAGRISSO

PENDING CMS APPROVAL

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

PENDING CMS APPROVAL

PALBOCICLIB (IBRANCE)

MEDICATION(S)
IBRANCE

PENDING CMS APPROVAL

PALIPERIDONE ER (INVEGA)

MEDICATION(S)
PALIPERIDONE ER

PENDING CMS APPROVAL

PART D VS PART B

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 100 MG CAP, CYCLOSPORINE 25 MG CAP, 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, SEVELAMER CARBONATE 800 MG TAB, SIROLIMUS, SMOFLIPID, SUNLENCA 463.5 MG/1.5ML SOLUTION, 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

PENDING CMS APPROVAL

PEGFILGRASTIM-CBQV (UDENYCA)

MEDICATION(S)
UDENYCA

PENDING CMS APPROVAL

PEGFILGRASTIM-JMDB (FULPHILA)

MEDICATION(S)
FULPHILA

PENDING CMS APPROVAL

PEGINTERFERON ALFA-2A (PEGASYS)

MEDICATION(S)
PEGASYS

PENDING CMS APPROVAL

PEGVISOMANT (SOMAVERT)

MEDICATION(S)
SOMAVERT

PENDING CMS APPROVAL

PEMIGATINIB (PEMAZYRE)

MEDICATION(S)
PEMAZYRE

PENDING CMS APPROVAL

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

PENDING CMS APPROVAL

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

PENDING CMS APPROVAL

POMALIDOMIDE (POMALYST)

MEDICATION(S)
POMALIDOMIDE, POMALYST

PENDING CMS APPROVAL

PONATINIB (ICLUSIG)

MEDICATION(S)
ICLUSIG

PENDING CMS APPROVAL

POSACONAZOLE (NOXAFIL)

MEDICATION(S)

POSACONAZOLE 100 MG TAB DR, POSACONAZOLE 40 MG/ML SUSPENSION

PENDING CMS APPROVAL

PRALSETINIB (GAVRETO)

MEDICATION(S)
GAVRETO

PENDING CMS APPROVAL

PYRIMETHAMINE (DARAPRIM)

MEDICATION(S)
PYRIMETHAMINE

PENDING CMS APPROVAL

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

PENDING CMS APPROVAL

RELACORILANT (LIFYORLI)

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

PENDING CMS APPROVAL

RELUGOLIX (ORGOVYX)

MEDICATION(S)
ORGOVYX

PENDING CMS APPROVAL

REPOTRECTINIB (AUGTYRO)

MEDICATION(S)
AUGTYRO

PENDING CMS APPROVAL

RESMETIROM (REZDIFFRA)

MEDICATION(S)
REZDIFFRA

PENDING CMS APPROVAL

REVUMENIB (REVUFORJ)

MEDICATION(S)
REVUFORJ

PENDING CMS APPROVAL

RIBOCICLIB (KISQALI)

MEDICATION(S)

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

PENDING CMS APPROVAL

RIFAXIMIN (XIFAXAN)

MEDICATION(S)
XIFAXAN

PENDING CMS APPROVAL

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

PENDING CMS APPROVAL

RIOCIGUAT (ADEMPAS)

MEDICATION(S)
ADEMPAS, RIOCIGUAT

PENDING CMS APPROVAL

RIPRETINIB (QINLOCK)

MEDICATION(S)
QINLOCK

PENDING CMS APPROVAL

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 PEN

PENDING CMS APPROVAL

ROPEGINTERFERON ALFA-2B (BESREMI)

MEDICATION(S)
BESREMI, BESREMI PEN

PENDING CMS APPROVAL

RUCAPARIB (RUBRACA)

MEDICATION(S)
RUBRACA

PENDING CMS APPROVAL

RUXOLITINIB (JAKAFI)

MEDICATION(S)
JAKAFI, JAKAFI XR

PENDING CMS APPROVAL

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

PENDING CMS APPROVAL

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

PENDING CMS APPROVAL

SELEGILINE TRANSDERMAL (EMSAM)

MEDICATION(S)
EMSAM

PENDING CMS APPROVAL

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

PENDING CMS APPROVAL

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)

PENDING CMS APPROVAL

SELPERCATINIB (RETEVMO)

MEDICATION(S)

RETEVMO 120 MG TAB, RETEVMO 160 MG TAB, RETEVMO 40 MG TAB, RETEVMO 80 MG TAB

PENDING CMS APPROVAL

SELUMETINIB (KOSELUGO)

MEDICATION(S)
KOSELUGO

PENDING CMS APPROVAL

SEMAGLUTIDE (OZEMPIC)

MEDICATION(S)
OZEMPIC, OZEMPIC (0.25 OR 0.5 MG/DOSE) 2 MG/3ML SOLN PEN, 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

PENDING CMS APPROVAL

SEMAGLUTIDE TABLET (WEGOVY)

MEDICATION(S)

WEGOVY 1.5 MG TAB, WEGOVY 25 MG TAB, WEGOVY 4 MG TAB, WEGOVY 9 MG TAB

PENDING CMS APPROVAL

SEVABERTINIB (HYRNUO)

MEDICATION(S)
HYRNUO

PENDING CMS APPROVAL

SILDENAFIL (REVATIO)

MEDICATION(S)

SILDENAFIL CITRATE 20 MG TAB

PENDING CMS APPROVAL

SKELETAL MUSCLE RELAXANTS HRM (CARISOPRODOL)

MEDICATION(S)
CARISOPRODOL 350 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 (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

PENDING CMS APPROVAL

SOMATROPIN (OMNITROPE)

MEDICATION(S)
OMNITROPE

PENDING CMS APPROVAL

SONIDEGIB (ODOMZO)

MEDICATION(S)
ODOMZO

PENDING CMS APPROVAL

SORAFENIB (NEXAVAR)

MEDICATION(S)
SORAFENIB TOSYLATE

PENDING CMS APPROVAL

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

PENDING CMS APPROVAL

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

PENDING CMS APPROVAL

SUNITINIB (SUTENT)

MEDICATION(S)
SUNITINIB MALATE

PENDING CMS APPROVAL

TACROLIMUS (ENVARSUS XR)

MEDICATION(S)
ENVARSUS XR

PENDING CMS APPROVAL

TACROLIMUS FOR ORAL SUSPENSION (PROGRAF PACKET)

MEDICATION(S)

PROGRAF 0.2 MG PACKET, PROGRAF 1 MG PACKET

PENDING CMS APPROVAL

TADALAFIL (ADCIRCA)

MEDICATION(S)
ALYQ, TADALAFIL (PAH)

PENDING CMS APPROVAL

TADALAFIL (CIALIS)

MEDICATION(S)

TADALAFIL 2.5 MG TAB, TADALAFIL 5 MG TAB

PENDING CMS APPROVAL

TALAZOPARIB (TALZENNA)

MEDICATION(S)
TALZENNA

PENDING CMS APPROVAL

TALETRECTINIB (IBTROZI)

MEDICATION(S)
IBTROZI

PENDING CMS APPROVAL

TASIMELTEON (HETLIOZ)

MEDICATION(S)
TASIMELTEON

PENDING CMS APPROVAL

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

PENDING CMS APPROVAL

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

PENDING CMS APPROVAL

TETRABENAZINE (XENAZINE)

MEDICATION(S)
TETRABENAZINE

PENDING CMS APPROVAL

THALIDOMIDE (THALOMID)

MEDICATION(S)

THALOMID 100 MG CAP, THALOMID 50 MG CAP

PENDING CMS APPROVAL

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

PENDING CMS APPROVAL

TOBRAMYCIN INHALATION AGENTS

MEDICATION(S)

TOBRAMYCIN 300 MG/4ML NEBU SOLN, TOBRAMYCIN 300 MG/5ML NEBU SOLN

PENDING CMS APPROVAL

TOBRAMYCIN (TOBI PODHALER)

MEDICATION(S)
TOBI PODHALER

PENDING CMS APPROVAL

TOCILIZUMAB-AAZG (TYENNE)

MEDICATION(S)

TYENNE 162 MG/0.9ML SOLN A-INJ, TYENNE 162 MG/0.9ML SOLN PRSYR

PENDING CMS APPROVAL

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 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

PENDING CMS APPROVAL

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

PENDING CMS APPROVAL

TOPIRAMATE ORAL SOLUTION (EPRONTIA)

MEDICATION(S)
TOPIRAMATE 25 MG/ML SOLUTION

PENDING CMS APPROVAL

TOVORAFENIB (OJEMDA)

MEDICATION(S)
OJEMDA

PENDING CMS APPROVAL

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

PENDING CMS APPROVAL

TRAMETINIB (MEKINIST)

MEDICATION(S)
MEKINIST

PENDING CMS APPROVAL

TRAZODONE ORAL SOLUTION (RALDESY)

MEDICATION(S)
RALDESY

PENDING CMS APPROVAL

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

PENDING CMS APPROVAL

TUCATINIB (TUKYSA)

MEDICATION(S)
TUKYSA

PENDING CMS APPROVAL

UPADACITINIB (RINVOQ)

MEDICATION(S)
RINVOQ, RINVOQ LQ

PENDING CMS APPROVAL

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

PENDING CMS APPROVAL

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

PENDING CMS APPROVAL

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

PENDING CMS APPROVAL

VEMURAFENIB (ZELBORAF)

MEDICATION(S)
ZELBORAF

PENDING CMS APPROVAL

VENETOCLAX (VENCLEXTA)

MEDICATION(S)
VENCLEXTA, VENCLEXTA STARTING PACK

PENDING CMS APPROVAL

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

PENDING CMS APPROVAL

VIGABATRIN (VIGAFYDE)

MEDICATION(S)
VIGAFYDE

PENDING CMS APPROVAL

VIMSELTINIB (ROMVIMZA)

MEDICATION(S)
ROMVIMZA

PENDING CMS APPROVAL

VISMODEGIB (ERIVEDGE)

MEDICATION(S)
ERIVEDGE

PENDING CMS APPROVAL

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

PENDING CMS APPROVAL

VORICONAZOLE ORAL (VFEND)

MEDICATION(S)

VORICONAZOLE 200 MG TAB, VORICONAZOLE 40 MG/ML RECON SUSP, VORICONAZOLE 50 MG TAB

PENDING CMS APPROVAL

VORINOSTAT (ZOLINZA)

MEDICATION(S)
ZOLINZA

PENDING CMS APPROVAL

XANOMELINE-TROSPIUM (COBENFY)

MEDICATION(S)
COBENFY, COBENFY STARTER PACK

PENDING CMS APPROVAL

ZANUBRUTINIB (BRUKINSA)

MEDICATION(S)
BRUKINSA

PENDING CMS APPROVAL

ZIDESAMTINIB (JIDEYTRO)

MEDICATION(S)
JIDEYTRO

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Exclusion criteria will be based on current 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

PENDING CMS APPROVAL

ZONGERTINIB (HERNEXEOS)

MEDICATION(S)
HERNEXEOS

PENDING CMS APPROVAL

ZURANOLONE (ZURZUVAE)

MEDICATION(S)
ZURZUVAE

PENDING CMS APPROVAL

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
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
DATROWAY 100 MG RECON SOLN	IV	RECON SOLN

MEDICATION NAME	ROUTE	DOSE FORM
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
DILTIAZEM HCL 50 MG/10ML SOLUTION	IV	SOLUTION

MEDICATION NAME	ROUTE	DOSE FORM
DIPHENHYDRAMINE HCL 50 MG/ML SOLUTION	IJ	SOLUTION
DIPHENHYDRAMINE HCL +RFID 50 MG/ML SOLUTION	IJ	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

MEDICATION NAME	ROUTE	DOSE FORM
ELCYS 50 MG/ML SOLUTION	IV	SOLUTION
ELELYSO 200 UNIT RECON SOLN	IV	RECON SOLN
ELFABRIO 20 MG/10ML SOLUTION	IV	SOLUTION
ELFABRIO 5 MG/2.5ML SOLUTION	IV	SOLUTION
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

MEDICATION NAME	ROUTE	DOSE FORM
ETHACRYNATE SODIUM 50 MG RECON SOLN	IV	RECON SOLN
ETHYOL 500 MG RECON SOLN	IV	RECON SOLN
ETOPOPHOS 100 MG RECON SOLN	IV	RECON SOLN
ETOPOSIDE 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

MEDICATION NAME	ROUTE	DOSE FORM
FLUOROURACIL 1 GM/20ML SOLUTION	IV	SOLUTION
FLUOROURACIL 2.5 GM/50ML SOLUTION	IV	SOLUTION
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

MEDICATION NAME	ROUTE	DOSE FORM
GAMMAPLEX 10 GM/100ML SOLUTION	IV	SOLUTION
GAMMAPLEX 10 GM/200ML SOLUTION	IV	SOLUTION
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
GOPRELTO 40 MG/ML SOLUTION	NA	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

MEDICATION NAME	ROUTE	DOSE FORM
GRANIX 480 MCG/1.6ML SOLUTION	SC	SOLUTION
HALAVEN 1 MG/2ML SOLUTION	IV	SOLUTION
HECTOROL 4 MCG/2ML SOLUTION	IV	SOLUTION
HEPAGAM B 312 UNIT/ML SOLUTION	IJ	SOLUTION
HEPARIN (PORCINE) IN NACL 1000-0.9 UT/500ML-% SOLUTION	IV	SOLUTION
HEPARIN (PORCINE) IN NACL 12500-0.45 UT/250ML-% SOLUTION	IV	SOLUTION
HEPARIN (PORCINE) IN NACL 2000-0.9 UNIT/L-% SOLUTION	IV	SOLUTION
HEPARIN (PORCINE) IN NACL 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

MEDICATION NAME	ROUTE	DOSE FORM
HEPLISAV-B 20 MCG/0.5ML SOLN PRSYR	IM	SOLN PRSYR
HERCEPTIN 150 MG RECON SOLN	IV	RECON SOLN
HERCEPTIN HYLECTA 600-10000 MG-UNT/5ML SOLUTION	SC	SOLUTION
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

MEDICATION NAME	ROUTE	DOSE FORM
IMAAVY 300 MG/1.62ML SOLUTION	IV	SOLUTION
IMDELLTRA 10 MG RECON SOLN	IV	RECON SOLN
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

MEDICATION NAME	ROUTE	DOSE FORM
IRINOTECAN HCL 300 MG/15ML SOLUTION	IV	SOLUTION
IRINOTECAN HCL 40 MG/2ML SOLUTION	IV	SOLUTION
IRINOTECAN HCL 500 MG/25ML SOLUTION	IV	SOLUTION
ISEMBYLD 150 MG/3ML 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

MEDICATION NAME	ROUTE	DOSE FORM
KHAPZORY 175 MG RECON SOLN	IV	RECON SOLN
KHAPZORY 300 MG RECON SOLN	IV	RECON SOLN
KIMMTRAK 100 MCG/0.5ML SOLUTION	IV	SOLUTION
KIMYRSA 1200 MG RECON SOLN	IV	RECON SOLN
KITABIS PAK 300 MG/5ML NEBU SOLN	IN	NEBU SOLN
KRYSTEXXA 8 MG/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

MEDICATION NAME	ROUTE	DOSE FORM
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
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

MEDICATION NAME	ROUTE	DOSE FORM
MAGNESIUM SULFATE IN D5W 1-5 GM/100ML-% SOLUTION	IV	SOLUTION
MAGNESIUM SULFATE-NACL 2-0.9 GM/50ML-% SOLUTION	IV	SOLUTION
MANGANESE CHLORIDE 0.1 MG/ML SOLUTION	IV	SOLUTION
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

MEDICATION NAME	ROUTE	DOSE FORM
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
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

MEDICATION NAME	ROUTE	DOSE FORM
MYCOPHENOLATE MOFETIL 250 MG CAP	PO	CAP
MYCOPHENOLATE MOFETIL 500 MG RECON SOLN	IV	RECON SOLN
MYCOPHENOLATE MOFETIL 500 MG TAB	PO	TAB
MYCOPHENOLATE MOFETIL HCL 500 MG RECON SOLN	IV	RECON SOLN
MYCOPHENOLATE SODIUM 180 MG TAB DR	PO	TAB DR
MYCOPHENOLATE SODIUM 360 MG TAB DR	PO	TAB DR
MYCOPHENOLIC ACID 180 MG TAB DR	PO	TAB DR
MYCOPHENOLIC ACID 360 MG TAB DR	PO	TAB DR
MYFORTIC 180 MG TAB DR	PO	TAB DR
MYFORTIC 360 MG TAB DR	PO	TAB DR
MYHIBBIN 200 MG/ML SUSPENSION	PO	SUSPENSION
MYLOTARG 4.5 MG RECON SOLN	IV	RECON SOLN
MYOBLOC 10000 UNIT/2ML SOLUTION	IM	SOLUTION
MYOBLOC 2500 UNIT/0.5ML SOLUTION	IM	SOLUTION
MYOBLOC 5000 UNIT/ML SOLUTION	IM	SOLUTION
NABI-HB 312 UNIT/ML SOLUTION	IM	SOLUTION
NAFCILLIN SODIUM IN DEXTROSE 1 GM/50ML SOLUTION	IV	SOLUTION
NAFCILLIN SODIUM IN DEXTROSE 2 GM/100ML SOLUTION	IV	SOLUTION
NAGLAZYME 1 MG/ML SOLUTION	IV	SOLUTION
NALBUPHINE HCL 10 MG/ML SOLUTION	IJ	SOLUTION
NALBUPHINE HCL 20 MG/ML SOLUTION	IJ	SOLUTION
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

MEDICATION NAME	ROUTE	DOSE FORM
NITROGLYCERIN 5 MG/ML SOLUTION	IV	SOLUTION
NITROGLYCERIN IN D5W 100-5 MCG/ML-% SOLUTION	IV	SOLUTION
NITROGLYCERIN IN D5W 200-5 MCG/ML-% SOLUTION	IV	SOLUTION
NITROGLYCERIN IN D5W 400-5 MCG/ML-% SOLUTION	IV	SOLUTION
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

MEDICATION NAME	ROUTE	DOSE FORM
ONCASPAR 750 UNIT/ML SOLUTION	IJ	SOLUTION
ONDANSETRON 4 MG TAB DISP	PO	TAB DISP
ONDANSETRON 8 MG TAB DISP	PO	TAB DISP
ONDANSETRON HCL 24 MG TAB	PO	TAB
ONDANSETRON HCL 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

MEDICATION NAME	ROUTE	DOSE FORM
PACLITAXEL 100 MG/16.7ML CONC	IV	CONC
PACLITAXEL 150 MG/25ML CONC	IV	CONC
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
PASATRU 300 MG/5ML 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

MEDICATION NAME	ROUTE	DOSE FORM
PEMETREXED DISODIUM 850 MG/34ML SOLUTION	IV	SOLUTION
PEMETREXED DITROMETHAMINE 100 MG RECON SOLN	IV	RECON SOLN
PEMETREXED DITROMETHAMINE 500 MG RECON SOLN	IV	RECON SOLN
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

MEDICATION NAME	ROUTE	DOSE FORM
POTASSIUM CHLORIDE IN DEXTROSE 10-5 MEQ/L-% SOLUTION	IV	SOLUTION
POTASSIUM CHLORIDE IN NACL 20-0.45 MEQ/L-% SOLUTION	IV	SOLUTION
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

MEDICATION NAME	ROUTE	DOSE FORM
PROGRAF 0.5 MG CAP	PO	CAP
PROGRAF 1 MG CAP	PO	CAP
PROGRAF 5 MG CAP	PO	CAP
PROGRAF 5 MG/ML SOLUTION	IV	SOLUTION
PROLASTIN-C 1000 MG/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

MEDICATION NAME	ROUTE	DOSE FORM
REVTORPYK 180 MG RECON SOLN	IV	RECON SOLN
REZZAYO 200 MG RECON SOLN	IV	RECON SOLN
RIABNI 100 MG/10ML SOLUTION	IV	SOLUTION
RIABNI 500 MG/50ML SOLUTION	IV	SOLUTION
RIBAVIRIN 6 GM RECON SOLN	IN	RECON SOLN
RISPERDAL CONSTA 12.5 MG SRER	IM	
RISPERDAL CONSTA 25 MG SRER	IM	
RISPERDAL CONSTA 37.5 MG SRER	IM	
RISPERDAL CONSTA 50 MG SRER	IM	
RISPERIDONE MICROSPHERES ER 12.5 MG SRER	IM	
RISPERIDONE MICROSPHERES ER 25 MG SRER	IM	
RISPERIDONE MICROSPHERES ER 37.5 MG SRER	IM	
RISPERIDONE MICROSPHERES ER 50 MG SRER	IM	
RITUXAN 100 MG/10ML SOLUTION	IV	SOLUTION
RITUXAN 500 MG/50ML SOLUTION	IV	SOLUTION
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

MEDICATION NAME	ROUTE	DOSE FORM
SANDIMMUNE 100 MG CAP	PO	CAP
SANDIMMUNE 100 MG/ML SOLUTION	PO	SOLUTION
SANDIMMUNE 25 MG CAP	PO	CAP
SANDIMMUNE 50 MG/ML SOLUTION	IV	SOLUTION
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

MEDICATION NAME	ROUTE	DOSE FORM
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
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

MEDICATION NAME	ROUTE	DOSE FORM
TEPADINA 400 MG/400ML RECON SOLN	IV	RECON SOLN
TEPEZZA 500 MG RECON SOLN	IV	RECON SOLN
TEPYLUTE 100 MG/10ML SOLUTION	IV	SOLUTION
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

MEDICATION NAME	ROUTE	DOSE FORM
TRIOSTAT 10 MCG/ML SOLUTION	IV	SOLUTION
TRIPTODUR 22.5 MG SRER	IM	
TRISENOX 12 MG/6ML SOLUTION	IV	SOLUTION
TRODELVY 180 MG RECON SOLN	IV	RECON SOLN
TROPHAMINE 10 % SOLUTION	IV	SOLUTION
TRUXIMA 100 MG/10ML SOLUTION	IV	SOLUTION
TRUXIMA 500 MG/50ML SOLUTION	IV	SOLUTION
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

MEDICATION NAME	ROUTE	DOSE FORM
VANCOMYCIN HCL 1500 MG/300ML SOLUTION	IV	SOLUTION
VANCOMYCIN HCL 1750 MG/350ML SOLUTION	IV	SOLUTION
VANCOMYCIN HCL 2000 MG/400ML SOLUTION	IV	SOLUTION
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

MEDICATION NAME	ROUTE	DOSE FORM
VENTAVIS 10 MCG/ML SOLUTION	IN	SOLUTION
VENTAVIS 20 MCG/ML SOLUTION	IN	SOLUTION
VEOPOZ 400 MG/2ML SOLUTION	IJ	SOLUTION
VERAPAMIL HCL 2.5 MG/ML SOLUTION	IV	SOLUTION
VFEND IV 200 MG RECON SOLN	IV	RECON SOLN
VIBATIV 750 MG RECON SOLN	IV	RECON SOLN
VIDAZA 100 MG RECON SUSP	IJ	RECON SUSP
VIMIZIM 5 MG/5ML SOLUTION	IV	SOLUTION
VIMPAT 200 MG/20ML SOLUTION	IV	SOLUTION
VINBLASTINE SULFATE 1 MG/ML SOLUTION	IV	SOLUTION
VINCASAR PFS 1 MG/ML SOLUTION	IV	SOLUTION
VINCRISTINE SULFATE 1 MG/ML SOLUTION	IV	SOLUTION
VINCRISTINE SULFATE 2 MG/2ML SOLUTION	IV	SOLUTION
VINORELBINE TARTRATE 10 MG/ML SOLUTION	IV	SOLUTION
VINORELBINE TARTRATE 50 MG/5ML SOLUTION	IV	SOLUTION
VIRAZOLE 6 GM RECON SOLN	IN	RECON SOLN
VIVIMUSTA 100 MG/4ML SOLUTION	IV	SOLUTION
VIVITROL 380 MG RECON SUSP	IM	RECON SUSP
VORICONAZOLE 200 MG/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

MEDICATION NAME	ROUTE	DOSE FORM
XEOMIN 50 UNIT RECON SOLN	IM	RECON SOLN
XERAVA 100 MG RECON SOLN	IV	RECON SOLN
XERAVA 50 MG RECON SOLN	IV	RECON SOLN
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

MEDICATION NAME	ROUTE	DOSE FORM
ZIRABEV 100 MG/4ML SOLUTION	IV	SOLUTION
ZIRABEV 400 MG/16ML SOLUTION	IV	SOLUTION
ZOLADEX 10.8 MG IMPLANT	SC	IMPLANT
ZOLADEX 3.6 MG IMPLANT	SC	IMPLANT
ZOLEDRONIC ACID 4 MG/100ML SOLUTION	IV	SOLUTION
ZOLEDRONIC ACID 4 MG/5ML CONC	IV	CONC
ZOLEDRONIC ACID 5 MG/100ML SOLUTION	IV	SOLUTION
ZORTRESS 0.25 MG TAB	PO	TAB
ZORTRESS 0.5 MG TAB	PO	TAB
ZORTRESS 0.75 MG TAB	PO	TAB
ZORTRESS 1 MG TAB	PO	TAB
ZULRESSO 100 MG/20ML SOLUTION	IV	SOLUTION
ZUPLENZ 4 MG FILM	PO	FILM
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