# ABALOPARATIDE (TYMLOS)

**MEDICATION(S)**
TYMLOS

**PA INDICATION INDICATOR**
1 - All FDA-Approved Indications

**OFF LABEL USES**
N/A

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

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

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
YES

## ABEMACICLIB (VERZENIO)

**MEDICATION(S)**
VERZENIO

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

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

**REQUIRED MEDICAL INFORMATION**
N/A

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## ABIRATERONE

**MEDICATION(S)**
ABIRATERONE ACETATE, ABIRTEGA

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

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

**REQUIRED MEDICAL INFORMATION**
N/A

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## ACALABRUTINIB (CALQUENCE)

**MEDICATION(S)**
CALQUENCE

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

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

**REQUIRED MEDICAL INFORMATION**
N/A

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## ACETAMINOPHEN/BUTALBITAL/CAFFEINE

**MEDICATION(S)**
BAC (BUTALBITAL-ACETAMIN-CAFF), BUTALBITAL-APAP-CAFFEINE 50-325-40 MG TAB

**PA INDICATION INDICATOR**
1 - All FDA-Approved Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
N/A

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

**AGE RESTRICTION**
N/A

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

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
YES

## ACYCLOVIR OINTMENT (ZOVIRAX)

**MEDICATION(S)**
ACYCLOVIR 5 % OINTMENT

**PA INDICATION INDICATOR**
1 - All FDA-Approved Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
N/A

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

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
YES

## ADAGRASIB (KRAZATI)

**MEDICATION(S)**
KRAZATI

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

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

**REQUIRED MEDICAL INFORMATION**
N/A

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## ADALIMUMAB (HADLIMA)

**MEDICATION(S)**
HADLIMA, HADLIMA PUSHTOUCH

**PA INDICATION INDICATOR**
1 - All FDA-Approved Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
Being used with another targeted immunotherapy drug.

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

**AGE RESTRICTION**
Age is consistent with the FDA approved indication

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

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

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
YES

## ADALIMUMAB RYVK (SIMLANDI)

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

**PA INDICATION INDICATOR**
1 - All FDA-Approved Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
Being used with another targeted immunotherapy drug.

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

**AGE RESTRICTION**
Age is consistent with the FDA approved indication

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

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

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
YES

## AFATINIB DIMALEATE (GILOTRIF)

**MEDICATION(S)**
GILOTRIF

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

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

**REQUIRED MEDICAL INFORMATION**
N/A

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan Year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## ALECTINIB (ALECENSA)

**MEDICATION(S)**
ALECENSA

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

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

**REQUIRED MEDICAL INFORMATION**
N/A

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan Year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## ALITRETINOIN (PANRETIN)

**MEDICATION(S)**
PANRETIN

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

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

**REQUIRED MEDICAL INFORMATION**
N/A

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## ALOSETRON (LOTRONEX)

**MEDICATION(S)**
ALOSETRON HCL

**PA INDICATION INDICATOR**
1 - All FDA-Approved Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
N/A

**REQUIRED MEDICAL INFORMATION**
Irritable bowel syndrome with diarrhea (IBS-D), initial use: patient is female, and tried and failed or had a side effect with a conventional therapy (e.g. anti-diarrheal drug, tricyclic antidepressant, antispasmodic) OR medical reason that conventional therapy cannot be used. Ongoing use: IBS symptoms improved with alosetron and patient does not have constipation problems.

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Initial: 2 months
Ongoing use: plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
YES

## ALPELISIB (PIQRAY)

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

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

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

**REQUIRED MEDICAL INFORMATION**
N/A

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## AMBRISENTAN (LETAIRIS)

**MEDICATION(S)**
AMBRISENTAN

**PA INDICATION INDICATOR**
1 - All FDA-Approved Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
N/A

**REQUIRED MEDICAL INFORMATION**
Confirmation of Pulmonary Arterial Hypertension (WHO Group I).

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## AMIKACIN INHALATION (ARIKAYCE)

**MEDICATION(S)**
ARIKAYCE

**PA INDICATION INDICATOR**
1 - All FDA-Approved Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
N/A

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

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
YES

## ANAKINRA (KINERET)

**MEDICATION(S)**
KINERET

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

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

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

**AGE RESTRICTION**
Age is consistent with the FDA approved indication

**PRESCRIBER RESTRICTION**
RA: rheumatologist

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
YES

## APALUTAMIDE (ERLEADA)

**MEDICATION(S)**
ERLEADA

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

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

**REQUIRED MEDICAL INFORMATION**
N/A

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## APREMILAST (OTEZLA)

**MEDICATION(S)**
OTEZLA, OTEZLA/OTEZLA XR INITIATION PK, OTEZLA XR

**PA INDICATION INDICATOR**
1 - All FDA-Approved Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
Being used with another targeted immunotherapy drug.

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

**AGE RESTRICTION**
Age is consistent with the FDA approved indication

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

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
YES

## APREPITANT 40MG CAPSULE (EMEND)

**MEDICATION(S)**
APREPITANT 40 MG CAP

**PA INDICATION INDICATOR**
1 - All FDA-Approved Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
N/A

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

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
PONV: once per surgery.

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
YES

## ARIPIPRAZOLE (OPIPZA)

**MEDICATION(S)**
OPIPZA

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
N/A

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

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
YES

## ARMODAFINIL (NUVIGIL)

**MEDICATION(S)**
ARMODAFINIL

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

**OFF LABEL USES**
Bipolar disorder

**EXCLUSION CRITERIA**
N/A

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

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
Bipolar Disorder: Psychiatrist

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
YES

## ASCIMINIB (SCEMBLIX)

**MEDICATION(S)**
SCEMBLIX

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

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

**REQUIRED MEDICAL INFORMATION**
N/A

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## ASENAPINE (SAPHRIS)

**MEDICATION(S)**
ASENAPINE MALEATE

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
N/A

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

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
YES

## ASENAPINE (SECUADO)

**MEDICATION(S)**
SECUADO

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
N/A

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

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
YES

## ASPIRIN/BUTALBITAL/CAFFEINE

**MEDICATION(S)**
BUTALBITAL-ASPIRIN-CAFFEINE

**PA INDICATION INDICATOR**
1 - All FDA-Approved Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
N/A

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

**AGE RESTRICTION**
N/A

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

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
YES

## ATOVAQUONE (MEPRON)

**MEDICATION(S)**
ATOVAQUONE

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
N/A

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

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

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

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
YES

## AVAPRITINIB (AYVAKIT)

**MEDICATION(S)**
AYVAKIT

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

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

**REQUIRED MEDICAL INFORMATION**
N/A

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## AVUTOMETINIB AND DEFACTINIB (AVMAPKI-FAKZYNJA CO-PACK)

**MEDICATION(S)**
AVMAPKI FAKZYNJA CO-PACK

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

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

**REQUIRED MEDICAL INFORMATION**
N/A

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## AXITINIB (INLYTA)

**MEDICATION(S)**
INLYTA

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

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

**REQUIRED MEDICAL INFORMATION**
N/A

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## AZACITIDINE (ONUREG)

**MEDICATION(S)**
ONUREG

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

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

**REQUIRED MEDICAL INFORMATION**
N/A

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## AZTREONAM LYSINE (CAYSTON)

**MEDICATION(S)**
CAYSTON

**PA INDICATION INDICATOR**
1 - All FDA-Approved Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
Being used for acute treatment of an infection.

**REQUIRED MEDICAL INFORMATION**
N/A

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## BEDAQUILINE (SIRTURO)

**MEDICATION(S)**
SIRTURO

**PA INDICATION INDICATOR**
1 - All FDA-Approved Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
N/A

**REQUIRED MEDICAL INFORMATION**
N/A

**AGE RESTRICTION**
Age is consistent with the FDA approved indication

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## BELIMUMAB (BENLYSTA)

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

**PA INDICATION INDICATOR**
1 - All FDA-Approved Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
Diagnosis is severe CNS lupus. Benlysta is being used with Lupkynis, Gazyva, Rituxan, other biologics.

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

**AGE RESTRICTION**
Age is consistent with the FDA approved indication

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

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
YES

## BELZUTIFAN (WELIREG)

**MEDICATION(S)**
WELIREG

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

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

**REQUIRED MEDICAL INFORMATION**
N/A

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## BEXAROTENE CAPSULE (TARGRETIN)

**MEDICATION(S)**
BEXAROTENE 75 MG CAP

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

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

**REQUIRED MEDICAL INFORMATION**
N/A

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## BEXAROTENE (TARGRETIN TOPICAL GEL)

**MEDICATION(S)**
BEXAROTENE 1 % GEL

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

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

**REQUIRED MEDICAL INFORMATION**
N/A

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## BINIMETINIB (MEKTOVI)

**MEDICATION(S)**
MEKTOVI

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

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

**REQUIRED MEDICAL INFORMATION**
N/A

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## BOSENTAN (TRACLEER)

**MEDICATION(S)**
BOSENTAN

**PA INDICATION INDICATOR**
1 - All FDA-Approved Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
N/A

**REQUIRED MEDICAL INFORMATION**
Confirmation of Pulmonary Arterial Hypertension (WHO Group I).

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## BOSUTINIB (BOSULIF)

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

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

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

**REQUIRED MEDICAL INFORMATION**
N/A

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## BREXPIPRAZOLE (REXULTI)

**MEDICATION(S)**
REXULTI

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
MDD: being used as a single agent

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

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
YES

## BRIGATINIB (ALUNBRIG)

**MEDICATION(S)**
ALUNBRIG

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

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

**REQUIRED MEDICAL INFORMATION**
N/A

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## BUDESONIDE DELAYED RELEASE (TARPEYO)

**MEDICATION(S)**
TARPEYO

**PA INDICATION INDICATOR**
1 - All FDA-Approved Indications

**OFF LABEL USES**
N/A

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

**REQUIRED MEDICAL INFORMATION**
N/A

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
nephrologist

**COVERAGE DURATION**
9 months

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

# BUDESONIDE ER TABLET (UCERIS)

**MEDICATION(S)**
BUDESONIDE ER

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

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

**EXCLUSION CRITERIA**
Microscopic colititis: Used for maintenance

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

**AGE RESTRICTION**
N/A

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

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

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
YES

## BUPRENORPHINE PATCH (BUTRANS)

**MEDICATION(S)**
BUPRENORPHINE

**PA INDICATION INDICATOR**
1 - All FDA-Approved Indications

**OFF LABEL USES**
N/A

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

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

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
Cancer pain: Oncologist or Pain Specialist.

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

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
YES

## C1 ESTERASE INHIBITOR (HAEGARDA)

**MEDICATION(S)**
HAEGARDA

**PA INDICATION INDICATOR**
1 - All FDA-Approved Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
Being used with other Hereditary Angioedema (HAE) preventive therapies.

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

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## CABOZANTINIB (CABOMETYX)

**MEDICATION(S)**
CABOMETYX

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

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

**REQUIRED MEDICAL INFORMATION**
N/A

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## CABOZANTINIB S-MALATE (COMETRIQ)

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

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

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

**REQUIRED MEDICAL INFORMATION**
N/A

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## CANNABIDIOL (CBD) EXTRACT (EPIDIOLEX)

**MEDICATION(S)**
EPIDIOLEX

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
N/A

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

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
YES

## CAPIVASERTIB (TRUQAP)

**MEDICATION(S)**
TRUQAP

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

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

**REQUIRED MEDICAL INFORMATION**
N/A

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## CAPMATINIB (TABRECTA)

**MEDICATION(S)**
TABRECTA

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

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

**REQUIRED MEDICAL INFORMATION**
N/A

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## CARGLUMIC ACID (CARBAGLU)

**MEDICATION(S)**
CARGLUMIC ACID

**PA INDICATION INDICATOR**
1 - All FDA-Approved Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
N/A

**REQUIRED MEDICAL INFORMATION**
N/A

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## CARIPRAZINE HYDROCHLORIDE (VRAYLAR)

**MEDICATION(S)**
VRAYLAR

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

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

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

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
YES

## CENOBAMATE (XCOPRI)

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

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
N/A

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

**AGE RESTRICTION**
Age is consistent with the FDA approved indication

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
YES

## CERITINIB (ZYKADIA)

**MEDICATION(S)**
ZYKADIA

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

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

**REQUIRED MEDICAL INFORMATION**
N/A

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## CLOBAZAM (ONFI)

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

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
N/A

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

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
YES

## CLOBAZAM ORAL FILM (SYMPAZAN)

**MEDICATION(S)**
SYMPAZAN

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
N/A

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

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
YES

## CLOZAPINE SUSPENSION (VERSACLOZ)

**MEDICATION(S)**
VERSACLOZ

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

**OFF LABEL USES**
Parkinson's psychosis disorder

**EXCLUSION CRITERIA**
N/A

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

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
YES

## COBIMETINIB (COTELLIC)

**MEDICATION(S)**
COTELLIC

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

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

**REQUIRED MEDICAL INFORMATION**
N/A

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## CRISABOROLE (EUCRISA)

**MEDICATION(S)**
EUCRISA

**PA INDICATION INDICATOR**
1 - All FDA-Approved Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
N/A

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

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
YES

## CRIZOTINIB (XALKORI)

**MEDICATION(S)**
XALKORI

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

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

**REQUIRED MEDICAL INFORMATION**
N/A

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## DABRAFENIB (TAFINLAR)

**MEDICATION(S)**
TAFINLAR

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

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

**REQUIRED MEDICAL INFORMATION**
N/A

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## DACOMITINIB (VIZIMPRO)

**MEDICATION(S)**
VIZIMPRO

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

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

**REQUIRED MEDICAL INFORMATION**
N/A

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## DALFAMPRIDINE EXTENDED-RELEASE TABLET (AMPYRA)

**MEDICATION(S)**
DALFAMPRIDINE ER

**PA INDICATION INDICATOR**
1 - All FDA-Approved Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
N/A

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

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
Neurologist or Multiple Sclerosis specialist

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

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## DARBEPOETIN ALFA (ARANESP)

**MEDICATION(S)**
ARANESP (ALBUMIN FREE)

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

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

**EXCLUSION CRITERIA**
N/A

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

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

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

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
YES

## DAROLUTAMIDE (NUBEQA)

**MEDICATION(S)**
NUBEQA

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

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

**REQUIRED MEDICAL INFORMATION**
N/A

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## DASATINIB (SPRYCEL)

**MEDICATION(S)**
DASATINIB

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

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

**REQUIRED MEDICAL INFORMATION**
N/A

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## DECITABINE-CEDAZURIDINE (INQOVI)

**MEDICATION(S)**
INQOVI

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

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

**REQUIRED MEDICAL INFORMATION**
N/A

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## DENOSUMAB (BILDYOS)

**MEDICATION(S)**
BILDYOS

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
Being used with other osteoporosis drugs.

**REQUIRED MEDICAL INFORMATION**
Treatment or prevention of postmenopausal osteoporosis in women OR to increase bone mass in men: one of the following: trial of a bisphosphonate, OR side effect to bisphosphonate therapy that supports discontinuation, OR Patient is at very high risk of fracture by meeting at least one of the following: non-traumatic fracture while on bisphosphonate therapy, patient has experienced a recent fracture (within the past 12 months) or history of multiple fractures, patient experienced a fracture while on long-term glucocorticoid therapy, or T-score less than -3.0, or patient is at high risk for falls, or 10-year hip fracture probability of greater than 4.5% based on FRAX score, or 10-year major osteoporosis-related fracture probability greater than 30% based on FRAX score.
Glucocorticoid-induced osteoporosis: initiating or continuing long-term glucocorticoid treatment and either has history of a non-traumatic fracture or is at high risk for fracture.
Prostate Cancer: Patient is currently taking androgen deprivation therapy.
Breast Cancer: Patient is currently taking an aromatase inhibitor.

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
YES

## DENOSUMAB (BILPREVDA)

**MEDICATION(S)**
BILPREVDA

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
N/A

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

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
YES

## DENOSUMAB (ENOBY)

**MEDICATION(S)**
ENOBY

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
Being used with other osteoporosis drugs.

**REQUIRED MEDICAL INFORMATION**
Treatment or prevention of postmenopausal osteoporosis in women OR to increase bone mass in men: one of the following: trial of a bisphosphonate, OR side effect to bisphosphonate therapy that supports discontinuation, OR Patient is at very high risk of fracture by meeting at least one of the following: non-traumatic fracture while on bisphosphonate therapy, patient has experienced a recent fracture (within the past 12 months) or history of multiple fractures, patient experienced a fracture while on long-term glucocorticoid therapy, or T-score less than -3.0, or patient is at high risk for falls, or 10-year hip fracture probability of greater than 4.5% based on FRAX score, or 10-year major osteoporosis-related fracture probability greater than 30% based on FRAX score.
Glucocorticoid-induced osteoporosis: initiating or continuing long-term glucocorticoid treatment and either has history of a non-traumatic fracture or is at high risk for fracture.
Prostate Cancer:  Patient is currently taking androgen deprivation therapy.
Breast Cancer:  Patient is currently taking an aromatase inhibitor.

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
YES

## DENOSUMAB (JUBBONTI)

**MEDICATION(S)**
JUBBONTI

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
Being used with other osteoporosis drugs.

**REQUIRED MEDICAL INFORMATION**
Treatment or prevention of postmenopausal osteoporosis in women OR to increase bone mass in men: one of the following: trial of a bisphosphonate, OR side effect to bisphosphonate therapy that supports discontinuation, OR Patient is at very high risk of fracture by meeting at least one of the following: non-traumatic fracture while on bisphosphonate therapy, patient has experienced a recent fracture (within the past 12 months) or history of multiple fractures, patient experienced a fracture while on long-term glucocorticoid therapy, or T-score less than -3.0, or patient is at high risk for falls, or 10-year hip fracture probability of greater than 4.5% based on FRAX score, or 10-year major osteoporosis-related fracture probability greater than 30% based on FRAX score.
Glucocorticoid-induced osteoporosis: initiating or continuing long-term glucocorticoid treatment and either has history of a non-traumatic fracture or is at high risk for fracture.
Prostate Cancer:  Patient is currently taking androgen deprivation therapy.
Breast Cancer:  Patient is currently taking an aromatase inhibitor.

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
YES

## DENOSUMAB (WYOST)

**MEDICATION(S)**
WYOST

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
N/A

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

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
YES

## DENOSUMAB (XTRENBO)

**MEDICATION(S)**
XTRENBO

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
N/A

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

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
YES

## DEUTETRABENAZINE (AUSTEDO, AUSTEDO XR)

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

**PA INDICATION INDICATOR**
1 - All FDA-Approved Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
N/A

**REQUIRED MEDICAL INFORMATION**
N/A

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
Neurologist or Psychiatrist

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## DEXTROMETHORPHAN HBR- BUPROPION HCL ER (AUVELITY)

**MEDICATION(S)**
AUVELITY, AUVELITY TITRATION PACK

**PA INDICATION INDICATOR**
1 - All FDA-Approved Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
N/A

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

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
YES

## DICLOFENAC TOPICAL GEL (SOLARAZE)

**MEDICATION(S)**
DICLOFENAC SODIUM 3 % GEL

**PA INDICATION INDICATOR**
1 - All FDA-Approved Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
N/A

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

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
90 days

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
YES

## DIHYDROERGOTAMINE MESYLATE (MIGRANAL NASAL SPRAY)

**MEDICATION(S)**
DIHYDROERGOTAMINE MESYLATE 4 MG/ML SOLUTION

**PA INDICATION INDICATOR**
1 - All FDA-Approved Indications

**OFF LABEL USES**
N/A

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

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

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
YES

## DIMETHYL FUMARATE (TECFIDERA)

**MEDICATION(S)**
DIMETHYL FUMARATE, DIMETHYL FUMARATE STARTER PACK

**PA INDICATION INDICATOR**
1 - All FDA-Approved Indications

**OFF LABEL USES**
N/A

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

**REQUIRED MEDICAL INFORMATION**
N/A

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## DORDAVIPRONE (MODEYSO)

**MEDICATION(S)**
MODEYSO

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

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

**REQUIRED MEDICAL INFORMATION**
N/A

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## DRONABINOL

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

**PA INDICATION INDICATOR**
1 - All FDA-Approved Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
N/A

**REQUIRED MEDICAL INFORMATION**
N/A

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## DROXIDOPA (NORTHERA)

**MEDICATION(S)**
DROXIDOPA

**PA INDICATION INDICATOR**
1 - All FDA-Approved Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
N/A

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

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
Cardiologist or Neurologist

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## DULAGLUTIDE (TRULICITY)

**MEDICATION(S)**
TRULICITY

**PA INDICATION INDICATOR**
1 - All FDA-Approved Indications

**OFF LABEL USES**
N/A

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

**REQUIRED MEDICAL INFORMATION**
Confirmation of Type 2 diabetes

**AGE RESTRICTION**
Age is consistent with the FDA approved indication

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## DULOXETINE (DRIZALMA SPRINKLE)

**MEDICATION(S)**
DRIZALMA SPRINKLE

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
N/A

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

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
YES

## DUPILUMAB (DUPIXENT)

**MEDICATION(S)**
DUPIXENT

**PA INDICATION INDICATOR**
1 - All FDA-Approved Indications

**OFF LABEL USES**
N/A

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

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

**AGE RESTRICTION**
Age is consistent with the FDA approved indication

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

**COVERAGE DURATION**
Plan year

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

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
YES

## DUVELISIB (COPIKTRA)

**MEDICATION(S)**
COPIKTRA

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

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

**REQUIRED MEDICAL INFORMATION**
N/A

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## EFLORNITHINE HYDROCHLORIDE (IWILFIN)

**MEDICATION(S)**
IWILFIN

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

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

**REQUIRED MEDICAL INFORMATION**
N/A

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## ELACESTRANT (ORSERDU)

**MEDICATION(S)**
ORSERDU

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

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

**REQUIRED MEDICAL INFORMATION**
N/A

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## ELAPEGADEMASE-LVLR (REVCOVI)

**MEDICATION(S)**
REVCOVI

**PA INDICATION INDICATOR**
1 - All FDA-Approved Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
N/A

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

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**

N/A

## ELEXACAFTOR-TEZACAFTOR-IVACAFTOR (TRIKAFTA)

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

**PA INDICATION INDICATOR**
1 - All FDA-Approved Indications

**OFF LABEL USES**
N/A

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

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

**AGE RESTRICTION**
Age is consistent with the FDA approved indication

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## ELTROMBOPAG OLAMINE (PROMACTA)

**MEDICATION(S)**
ELTROMBOPAG OLAMINE

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

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

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

**REQUIRED MEDICAL INFORMATION**
Chronic Hepatitis C: on interferon-based therapy and platelet count is less than or equal to 75,000/mcl prior to therapy or falls to less than or equal to 50,000/mcl during therapy.Chronic or Persistent ITP, initial: platelet count is less than 30,000/mcl, and patient had a side effect or did not respond well enough to one of the following treatments: corticosteroids, IVIG, and splenectomy OR has a medical reason not to use (contraindication) corticosteroids or IVIG. Aplastic anemia: Platelet count is less than 50,000 cells/mcl and for first-line treatment: being used with cyclosporine and antithymocyte globulin (ATG) therapy. Thrombocytopenia due to MDS: treatment failure or side effect to at least one supported first line therapy for low risk MDS (e.g. decitabine, cyclosporine, ATG, lenalidomide) Or used in combination with ATG or by itself as initial therapy. Immunotherapy-Related Thrombocytopenia: immunotherapy-related Grade 3 (platelet count 50,000 cells/mcl-25,000 cells/mcl) or Grade 4 (platelet count less than 25,000 cells/mcl) thrombocytopenia AND no response to at least 1 week of corticosteroids. Ongoing use: platelet count has improved since starting medication but is not more than 400,000 and for MDS only disease has not progressed to acute leukemia. Thrombocytopenia post-HSCT: prolonged low platelet count (thrombocytopenia) after allogenic transplant and poor graft function.

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

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

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
YES

## ENASIDENIB MESYLATE (IDHIFA)

**MEDICATION(S)**
IDHIFA

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

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

**REQUIRED MEDICAL INFORMATION**
N/A

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## ENCORAFENIB (BRAFTOVI)

**MEDICATION(S)**
BRAFTOVI

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

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

**REQUIRED MEDICAL INFORMATION**
N/A

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## ENSARTINIB (ENSACOVE)

**MEDICATION(S)**
ENSACOVE

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

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

**REQUIRED MEDICAL INFORMATION**
N/A

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## ENTRECTINIB (ROZLYTREK)

**MEDICATION(S)**
ROZLYTREK

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

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

**REQUIRED MEDICAL INFORMATION**
N/A

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## ENZALUTAMIDE (XTANDI)

**MEDICATION(S)**
XTANDI

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

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

**REQUIRED MEDICAL INFORMATION**
N/A

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## EPOETIN ALFA-EPBX (RETACRIT)

**MEDICATION(S)**
RETACRIT

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

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

**EXCLUSION CRITERIA**
N/A

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

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

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

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## ERDAFITINIB (BALVERSA)

**MEDICATION(S)**
BALVERSA

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

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

**REQUIRED MEDICAL INFORMATION**
N/A

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## ERENUMAB-AOOE (AIMOVIG)

**MEDICATION(S)**
AIMOVIG

**PA INDICATION INDICATOR**
1 - All FDA-Approved Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
use in combination with another CGRP antagonist

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

**AGE RESTRICTION**
Age is consistent with the FDA approved indication

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## ERLOTINIB (TARCEVA)

**MEDICATION(S)**
ERLOTINIB HCL

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

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

**REQUIRED MEDICAL INFORMATION**
N/A

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

# ETANERCEPT (ENBREL)

**MEDICATION(S)**
ENBREL, ENBREL MINI, ENBREL SURECLICK

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

**OFF LABEL USES**
graft vs host disease (GVHD)

**EXCLUSION CRITERIA**
Being used with another targeted immunotherapy drug.

**REQUIRED MEDICAL INFORMATION**
Plaque Psoriasis (PsO), initial use: patient tried and failed or had a side effect to one DMARD or has a medical reason why methotrexate, cyclosporine, and acitretin cannot be used AND baseline PASI score 10 or more OR BSA 3% or more OR sensitive areas are involved OR disease affects daily living. Ongoing use: PASI or BSA improved from baseline or a decrease in disease severity.
Rheumatoid Arthritis (RA): patient has tried and failed, had a side effect, or a medical reason why a DMARD cannot be used.
Polyarticular Juvenile Idiopathic Arthritis (pJIA): patient has tried and failed or had a side effect to one DMARD or has a medical reason why methotrexate cannot be used.
GVHD: treatment failure or side effect to one drug for GVHD.
For Ankylosing spondylitis (AS), Psoriatic arthritis (PsA), PsO, RA, and pJIA: Adult patient has tried and failed or had a side effect with adalimumab or has a medical reason not to use adalimumab.
Ongoing use for AS, GVHD, pJIAm PsA, RA: responding to therapy.

**AGE RESTRICTION**
Age is consistent with the FDA approved indication

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

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

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
YES

## ETRASIMOD ARGININE (VELSIPITY)

**MEDICATION(S)**
VELSIPITY

**PA INDICATION INDICATOR**
1 - All FDA-Approved Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
Being used with another targeted immunotherapy drug.

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

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
YES

## EVEROLIMUS (AFINITOR)

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

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

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

**REQUIRED MEDICAL INFORMATION**
N/A

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## EVEROLIMUS (AFINITOR DISPERZ)

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

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

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

**REQUIRED MEDICAL INFORMATION**
N/A

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## EVOLOCUMAB (REPATHA)

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

**PA INDICATION INDICATOR**
1 - All FDA-Approved Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
N/A

**REQUIRED MEDICAL INFORMATION**
Hypercholesterolemia, Heterozygous Familial Hypercholesterolemia (HeFH), Reduce Risk of Major Adverse Cardiovascular Disease: current LDL cholesterol (LDL-C) is at or above 70mg/dl (or at or above 55mg/dl if prescriber states extreme risk for heart disease) AND one of the following: at least 8 weeks of treatment with a high-intensity statin, or FDA approved package insert supported contraindication to all statins, or intolerance to statin as defined by one of the following: statin-related rhabdomyolysis, or statin-related skeletal muscle symptoms, or statin-related elevated hepatic transaminase.
Homozygous Familial Hypercholesterolemia (HoFH): a positive genetic test for LDL-R genetic mutations OR clinical evidence that confirms HoFH.

**AGE RESTRICTION**
Age is consistent with the FDA approved indication

**PRESCRIBER RESTRICTION**
HoFH: Cardiologist or Endocrinologist

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
YES

## FECAL MICROBIOTA SPORES, LIVE-BRPK (VOWST)

**MEDICATION(S)**
VOWST

**PA INDICATION INDICATOR**
1 - All FDA-Approved Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
N/A

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

**AGE RESTRICTION**
Age is consistent with the FDA approved indication

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
one course (3 days)

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
YES

## FEDRATINIB (INREBIC)

**MEDICATION(S)**
INREBIC

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
Being used with another agent that treats myelofibrosis.

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

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## FENFLURAMINE (FINTEPLA)

**MEDICATION(S)**
FINTEPLA

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
N/A

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

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
YES

## FEZOLINETANT (VEOZAH)

**MEDICATION(S)**
VEOZAH

**PA INDICATION INDICATOR**
1 - All FDA-Approved Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
N/A

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

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
YES

## FIDAXOMICIN (DIFICID)

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

**PA INDICATION INDICATOR**
1 - All FDA-Approved Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
N/A

**REQUIRED MEDICAL INFORMATION**
Clostridium difficile: evidence of current infection.

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
10 days

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## FILGRASTIM-AAFI (NIVESTYM)

**MEDICATION(S)**
NIVESTYM

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

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

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

**REQUIRED MEDICAL INFORMATION**
Agranulocytosis, neutropenia (congenital, cyclic, or idiopathic): neutropenia is recurring or does not go away and ONE of the following: history of recurring infections or patient had one hospitalization for an infection within the past year. Febrile neutropenia, neutropenia due to HIV/AIDs, or neutropenia caused by drugs other than cancer drugs: absolute neutrophil count (ANC) is less than 800/mm3 or ANC is less than 1000/mm3 with neutropenia expected to last more than 5 days AND for febrile neutropenia: patient has not used pegfilgrastim in the past 14 days. MDS: ONE of the following: ANC is less than 800/mm3, or ANC is less than 1000/mm3 with neutropenia expected to last more than 5 days, or being used with an erythropoiesis-stimulating agent to improve symptoms of anemia and all of the following: Hgb less than 10 and EPO level less than or equal to 500 mU/mL.

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
see other criteria

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## FILGRASTIM-SNDZ (ZARXIO)

**MEDICATION(S)**
ZARXIO

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

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

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

**REQUIRED MEDICAL INFORMATION**
Agranulocytosis, neutropenia (congenital, cyclic, or idiopathic): neutropenia is recurring or does not go away and ONE of the following: history of recurring infections or patient had one hospitalization for an infection within the past year.
Febrile neutropenia, neutropenia due to HIV/AIDs, or neutropenia caused by drugs other than cancer drugs: absolute neutrophil count (ANC) is less than 800/mm3 or ANC is less than 1000/mm3 with neutropenia expected to last more than 5 days AND for febrile neutropenia: patient has not used pegfilgrastim in the past 14 days.
MDS: ONE of the following: ANC is less than 800/mm3, or ANC is less than 1000/mm3 with neutropenia expected to last more than 5 days, or being used with an erythropoiesis-stimulating agent to improve symptoms of anemia and all of the following: Hgb less than 10 and EPO level less than or equal to 500 mU/mL.

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
see other criteria

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## FINERENONE (KERENDIA)

**MEDICATION(S)**
KERENDIA

**PA INDICATION INDICATOR**
1 - All FDA-Approved Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
N/A

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

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
YES

## FINGOLIMOD HCL (GILENYA)

**MEDICATION(S)**
FINGOLIMOD HCL

**PA INDICATION INDICATOR**
1 - All FDA-Approved Indications

**OFF LABEL USES**
N/A

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

**REQUIRED MEDICAL INFORMATION**
N/A

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## FRUQUINTINIB (FRUZAQLA)

**MEDICATION(S)**
FRUZAQLA

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

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

**REQUIRED MEDICAL INFORMATION**
N/A

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## FUTIBATINIB (LYTGOBI)

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

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

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

**REQUIRED MEDICAL INFORMATION**
N/A

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## GALCANEZUMAB-GNLM (EMGALITY)

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

**PA INDICATION INDICATOR**
1 - All FDA-Approved Indications

**OFF LABEL USES**
N/A

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

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

**AGE RESTRICTION**
Age is consistent with the FDA approved indication

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
YES

## GANAXOLONE (ZTALMY)

**MEDICATION(S)**
ZTALMY

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
N/A

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

**AGE RESTRICTION**
Age is consistent with the FDA approved indication

**PRESCRIBER RESTRICTION**
Neurologist

**COVERAGE DURATION**
plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## GEFITINIB (IRESSA)

**MEDICATION(S)**
GEFITINIB

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

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

**REQUIRED MEDICAL INFORMATION**
N/A

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## GEPIRONE (EXXUA)

**MEDICATION(S)**
EXXUA, EXXUA TITRATION PACK

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
N/A

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

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
YES

## GILTERITINIB FUMARATE (XOSPATA)

**MEDICATION(S)**
XOSPATA

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

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

**REQUIRED MEDICAL INFORMATION**
N/A

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## GLASDEGIB MALEATE (DAURISMO)

**MEDICATION(S)**
DAURISMO

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

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

**REQUIRED MEDICAL INFORMATION**
N/A

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## GLATIRAMER ACETATE (COPAXONE, GLATOPA)

**MEDICATION(S)**
GLATIRAMER ACETATE, GLATOPA

**PA INDICATION INDICATOR**
1 - All FDA-Approved Indications

**OFF LABEL USES**
N/A

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

**REQUIRED MEDICAL INFORMATION**
N/A

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## GLECAPREVIR-PIBRENTASVIR (MAVYRET)

**MEDICATION(S)**
MAVYRET

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

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

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

**AGE RESTRICTION**
Age is consistent with the FDA approved indication

**PRESCRIBER RESTRICTION**
Hepatologist, Gastroenterologist, or Infectious Disease.

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

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## GLUTAMINE (ENDARI)

**MEDICATION(S)**
L-GLUTAMINE 5 GM PACKET

**PA INDICATION INDICATOR**
1 - All FDA-Approved Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
N/A

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

**AGE RESTRICTION**
Age is consistent with the FDA approved indication

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
YES

## GUSELKUMAB IV (TREMFYA IV)

**MEDICATION(S)**
TREMFYA 200 MG/20ML SOLUTION

**PA INDICATION INDICATOR**
1 - All FDA-Approved Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
Being used with another targeted immunotherapy drug.

**REQUIRED MEDICAL INFORMATION**
N/A

**AGE RESTRICTION**
Age is consistent with the FDA approved indication

**PRESCRIBER RESTRICTION**
CD, UC: gastroenterologist

**COVERAGE DURATION**
one time induction course (8 weeks)

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## GUSELKUMAB SQ (TREMFYA SQ)

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

**PA INDICATION INDICATOR**
1 - All FDA-Approved Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
Being used with another targeted immunotherapy drug.

**REQUIRED MEDICAL INFORMATION**
Plaque Psoriasis (PsO), initial use: patient tried and failed or had a side effect with one DMARD or medical reason why methotrexate, cyclosporine, and acitretin cannot be used AND baseline PASI score 10 or more OR BSA 3% or more OR sensitive areas are involved OR disease affects daily living. PsO, Ongoing use: Ongoing use: PASI or BSA improved from baseline or a decrease in disease severity. Psoriatic arthritis (PsA), Crohn's Disease (CD), Ulcerative colitis (UC), ongoing use: Patient is responding to therapy.

**AGE RESTRICTION**
Age is consistent with the FDA approved indication

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

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

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
YES

## HIGH RISK MEDICATION (AMITRIPTYLINE)

**MEDICATION(S)**
AMITRIPTYLINE HCL

**PA INDICATION INDICATOR**
1 - All FDA-Approved Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
N/A

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

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

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
YES

**PREREQUISITE THERAPY REQUIRED**
N/A

## HIGH RISK MEDICATION (AMITRIPTYLINE/PERPHENAZINE)

**MEDICATION(S)**
PERPHENAZINE-AMITRIPTYLINE

**PA INDICATION INDICATOR**
1 - All FDA-Approved Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
N/A

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

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

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan Year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## HIGH RISK MEDICATION (CLOMIPRAMINE)

**MEDICATION(S)**
CLOMIPRAMINE HCL

**PA INDICATION INDICATOR**
1 - All FDA-Approved Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
N/A

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

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

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
YES

**PREREQUISITE THERAPY REQUIRED**
N/A

## HIGH RISK MEDICATION (CYPROHEPTADINE)

**MEDICATION(S)**
CYPROHEPTADINE HCL 4 MG TAB

**PA INDICATION INDICATOR**
1 - All FDA-Approved Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
N/A

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

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

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
YES

**PREREQUISITE THERAPY REQUIRED**
N/A

## HIGH RISK MEDICATION (DICYCLOMINE)

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

**PA INDICATION INDICATOR**
1 - All FDA-Approved Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
N/A

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

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

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
YES

**PREREQUISITE THERAPY REQUIRED**
N/A

## HIGH RISK MEDICATION (DOXEPIN)

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

**PA INDICATION INDICATOR**
1 - All FDA-Approved Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
N/A

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

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

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
YES

**PREREQUISITE THERAPY REQUIRED**
N/A

## HIGH RISK MEDICATION (HYDROXYZINE)

**MEDICATION(S)**
HYDROXYZINE HCL 10 MG TAB, HYDROXYZINE HCL 25 MG TAB, 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 (PROMETHAZINE)

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

**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 (THIORIDAZINE)

**MEDICATION(S)**
THIORIDAZINE HCL

**PA INDICATION INDICATOR**
1 - All FDA-Approved Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
N/A

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

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

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
YES

**PREREQUISITE THERAPY REQUIRED**
N/A

## HIGH RISK MEDICATION (TRIMIPRAMINE)

**MEDICATION(S)**
TRIMIPRAMINE MALEATE

**PA INDICATION INDICATOR**
1 - All FDA-Approved Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
N/A

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

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

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
YES

**PREREQUISITE THERAPY REQUIRED**
N/A

## IBRUTINIB (IMBRUVICA)

**MEDICATION(S)**
IMBRUVICA

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

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

**REQUIRED MEDICAL INFORMATION**
N/A

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## ICATIBANT (FIRAZYR)

**MEDICATION(S)**
ICATIBANT ACETATE, SAJAZIR

**PA INDICATION INDICATOR**
1 - All FDA-Approved Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
N/A

**REQUIRED MEDICAL INFORMATION**
N/A

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## IDELALISIB (ZYDELIG)

**MEDICATION(S)**
ZYDELIG

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

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

**REQUIRED MEDICAL INFORMATION**
N/A

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## ILOPERIDONE (FANAPT)

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

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
N/A

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

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
YES

## IMATINIB MESYLATE (GLEEVEC)

**MEDICATION(S)**
IMATINIB MESYLATE

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

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

**REQUIRED MEDICAL INFORMATION**
N/A

**AGE RESTRICTION**
N/A

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

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## IMATINIB ORAL SOLUTION (IMKELDI)

**MEDICATION(S)**
IMKELDI

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

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

**REQUIRED MEDICAL INFORMATION**
Medical reason why imatinib tablet cannot be used.

**AGE RESTRICTION**
N/A

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

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
YES

## IMLUNESTRANT (INLURIYO)

**MEDICATION(S)**
INLURIYO

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

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

**REQUIRED MEDICAL INFORMATION**
N/A

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## IMMUNE GLOBULIN (GAMUNEX-C)

**MEDICATION(S)**
GAMUNEX-C

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

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

**EXCLUSION CRITERIA**
AMBD: being used with another immunomodulator

**REQUIRED MEDICAL INFORMATION**
Primary Immunodeficiency Disorder (PIDD), SQ and IV administration: current IgG is less than 200mg/dL or ALL of the following: history of recurrent bacterial infections, and failure to respond to antigenic challenge test with diphtheria and tetanus toxoids or pneumococcal polysaccharide vaccine, and history of IgG less than 500mg/dL documented on two occasions or diagnosed by an allergist or immunologist.
Typical chronic inflammatory demyelinating polyneuropathy (CIDP), multifocal variant of CIDP (multifocal acquired demyelinating sensor and motor neuropathy of MADSAM), multifocal motor neuropathy (MMN) aka Pure Motor CIDP, and pure sensory chronic inflammatory demyelinating polyneuropathy: IV administration, CIDP confirmed by electrodiagnostic testing (nerve conduction studies) OR nerve conduction studies show possible CIDP and 2 of the following to confirm the diagnosis: CSF examination, nerve biopsy, MRI, ultrasound.
Primary immune thrombocytopenia (ITP): IV administration, platelet count is less than 30,000cells/mm3. For ongoing use: continued thrombocytopenia with prior response to IVIG or is scheduled for surgery or invasive procedure.
Myasthenia Gravis (MG): IV administration, treatment failure, side effect, or medical reason for not using one of the following: a corticosteroid, mycophenolate, azathioprine, cyclosporine, or cyclophosphamide.
Multifocal Motor Neuropathy (MMN): IV administration and condition confirmed with nerve conduction studies (electrodiagnostic testing).

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
CIDP, MMN, MG: Neurologist

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

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
YES

## IMMUNE GLOBULIN SQ (HIZENTRA)

**MEDICATION(S)**
HIZENTRA

**PA INDICATION INDICATOR**
1 - All FDA-Approved Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
N/A

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

**AGE RESTRICTION**
N/A

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

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## INAVOLISIB (ITOVEBI)

**MEDICATION(S)**
ITOVEBI

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

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

**REQUIRED MEDICAL INFORMATION**
N/A

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## INFLIXIMAB-DYYB (ZYMFENTRA)

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

**PA INDICATION INDICATOR**
1 - All FDA-Approved Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
Being used with another targeted immunotherapy drug.

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

**AGE RESTRICTION**
Age is consistent with the FDA approved indication

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## INTERFERON BETA-1B (BETASERON)

**MEDICATION(S)**
BETASERON

**PA INDICATION INDICATOR**
1 - All FDA-Approved Indications

**OFF LABEL USES**
N/A

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

**REQUIRED MEDICAL INFORMATION**
N/A

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## INTERFERON GAMMA-1B (ACTIMMUNE)

**MEDICATION(S)**
ACTIMMUNE

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
N/A

**REQUIRED MEDICAL INFORMATION**
N/A

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## ISAVUCONAZONIUM (CRESEMBA)

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

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

**OFF LABEL USES**
Esophageal candidiasis

**EXCLUSION CRITERIA**
N/A

**REQUIRED MEDICAL INFORMATION**
Invasive aspergillosis: blood or tissue culture positive for Aspergillus AND patient has a medical reason for not using voriconazole. Invasive mucormycosis: culture is positive for mucormyocosis pathogens or being prescribed by infectious disease specialist. Esophageal candidiasis: patient has HIV infection AND patient has a medical reason for not using oral fluconazole.

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
3 months

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
YES

## IVABRADINE (CORLANOR)

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

**PA INDICATION INDICATOR**
1 - All FDA-Approved Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
N/A

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

**AGE RESTRICTION**
Age is consistent with the FDA approved indication

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
YES

## IVACAFTOR (KALYDECO)

**MEDICATION(S)**
KALYDECO

**PA INDICATION INDICATOR**
1 - All FDA-Approved Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
Being used with another CFTR modulator agent

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

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## IVOSIDENIB (TIBSOVO)

**MEDICATION(S)**
TIBSOVO

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

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

**REQUIRED MEDICAL INFORMATION**
N/A

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## IXAZOMIB CITRATE (NINLARO)

**MEDICATION(S)**
NINLARO

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

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

**REQUIRED MEDICAL INFORMATION**
N/A

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## LAMOTRIGINE SUSPENSION (SUBVENITE)

**MEDICATION(S)**
SUBVENITE 10 MG/ML SUSPENSION

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
N/A

**REQUIRED MEDICAL INFORMATION**
Patient has a medical reason for not using lamotrigine tablet.

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
YES

## LAPATINIB DITOSYLATE (TYKERB)

**MEDICATION(S)**
LAPATINIB DITOSYLATE

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

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

**REQUIRED MEDICAL INFORMATION**
N/A

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## LAROTRECTINIB SULFATE (VITRAKVI)

**MEDICATION(S)**
VITRAKVI

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

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

**REQUIRED MEDICAL INFORMATION**
N/A

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## LAZERTINIB (LAZCLUZE)

**MEDICATION(S)**
LAZCLUZE

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

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

**REQUIRED MEDICAL INFORMATION**
N/A

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

# LECANEMAB (LEQEMBI IQLIK)

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

**PA INDICATION INDICATOR**
1 - All FDA-Approved Indications

**OFF LABEL USES**
N/A

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

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

**AGE RESTRICTION**
Age is consistent with the FDA approved indication

**PRESCRIBER RESTRICTION**
neurologist, geriatrician, or relevant specialist

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## LENALIDOMIDE (REVLIMID)

**MEDICATION(S)**
LENALIDOMIDE

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

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

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

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## LENVATINIB (LENVIMA)

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

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

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

**REQUIRED MEDICAL INFORMATION**
N/A

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## LEVALBUTEROL SOLUTION (XOPENEX)

**MEDICATION(S)**
LEVALBUTEROL HCL

**PA INDICATION INDICATOR**
1 - All FDA-Approved Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
N/A

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

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
YES

## LEVETIRACETAM (SPRITAM)

**MEDICATION(S)**
SPRITAM

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
N/A

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

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
YES

## LEVOMILNACIPRAN HCL (FETZIMA)

**MEDICATION(S)**
FETZIMA, FETZIMA TITRATION

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
N/A

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

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
YES

## LIDOCAINE PATCH (LIDODERM)

**MEDICATION(S)**
LIDOCAINE 5 % PATCH, LIDOCAN

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
N/A

**REQUIRED MEDICAL INFORMATION**
N/A

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## LINEZOLID (ZYVOX)

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

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
N/A

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

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

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

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
YES

## LONG-ACTING NARCOTIC DRUGS (FENTANYL)

**MEDICATION(S)**
FENTANYL 100 MCG/HR PATCH 72HR, FENTANYL 12 MCG/HR PATCH 72HR, FENTANYL 25 MCG/HR PATCH 72HR, FENTANYL 50 MCG/HR PATCH 72HR, FENTANYL 75 MCG/HR PATCH 72HR

**PA INDICATION INDICATOR**
1 - All FDA-Approved Indications

**OFF LABEL USES**
N/A

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

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

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
Cancer pain: Oncologist or Pain Specialist.

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

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
YES

## LONG-ACTING NARCOTIC DRUGS (METHADONE)

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

**PA INDICATION INDICATOR**
1 - All FDA-Approved Indications

**OFF LABEL USES**
N/A

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

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

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
Cancer pain: Oncologist or Pain Specialist.

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

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
YES

## LORLATINIB (LORBRENA)

**MEDICATION(S)**
LORBRENA

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

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

**REQUIRED MEDICAL INFORMATION**
N/A

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## LOTILANER (XDEMVY)

**MEDICATION(S)**
XDEMVY

**PA INDICATION INDICATOR**
1 - All FDA-Approved Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
N/A

**REQUIRED MEDICAL INFORMATION**
N/A

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
Ophthalmologist or Optometrist

**COVERAGE DURATION**
6 weeks

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## LUMATEPERONE (CAPLYTA)

**MEDICATION(S)**
CAPLYTA

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

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

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

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
YES

## MACITENTAN (OPSUMIT)

**MEDICATION(S)**
MACITENTAN

**PA INDICATION INDICATOR**
1 - All FDA-Approved Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
N/A

**REQUIRED MEDICAL INFORMATION**
Confirmation of Pulmonary Arterial Hypertension (WHO Group I).

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## MARIBAVIR (LIVTENCITY)

**MEDICATION(S)**
LIVTENCITY

**PA INDICATION INDICATOR**
1 - All FDA-Approved Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
being used with ganciclovir or valganciclovir

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

**AGE RESTRICTION**
Age is consistent with the FDA approved indication

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
YES

## MECASERMIN (INCRELEX)

**MEDICATION(S)**
INCRELEX

**PA INDICATION INDICATOR**
1 - All FDA-Approved Indications

**OFF LABEL USES**
N/A

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

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

**AGE RESTRICTION**
Age is consistent with the FDA approved indication

**PRESCRIBER RESTRICTION**
Endocrinologist

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## MECHLORETHAMINE (VALCHLOR)

**MEDICATION(S)**
VALCHLOR

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
N/A

**REQUIRED MEDICAL INFORMATION**
N/A

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## MEGESTROL ACETATE (MEGACE)

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

**PA INDICATION INDICATOR**
1 - All FDA-Approved Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
N/A

**REQUIRED MEDICAL INFORMATION**
N/A

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## MEPOLIZUMAB (NUCALA)

**MEDICATION(S)**
NUCALA

**PA INDICATION INDICATOR**
1 - All FDA-Approved Indications

**OFF LABEL USES**
N/A

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

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

**AGE RESTRICTION**
Age is consistent with the FDA approved indication

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

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

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
YES

## MERCAPTOPURINE (PURIXAN)

**MEDICATION(S)**
MERCAPTOPURINE 2000 MG/100ML SUSPENSION

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
N/A

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

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
YES

## METHOTREXATE ORAL SOLUTION (XATMEP)

**MEDICATION(S)**
XATMEP

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
N/A

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

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
YES

## MIDOSTAURIN (RYDAPT)

**MEDICATION(S)**
RYDAPT

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

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

**REQUIRED MEDICAL INFORMATION**
N/A

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## MIFEPRISTONE (KORLYM)

**MEDICATION(S)**
MIFEPRISTONE 300 MG TAB

**PA INDICATION INDICATOR**
1 - All FDA-Approved Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
N/A

**REQUIRED MEDICAL INFORMATION**
N/A

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## MILSAPERIDONE (BYSANTI)

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

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
N/A

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

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
YES

## MILTEFOSINE (IMPAVIDO)

**MEDICATION(S)**
IMPAVIDO

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

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

**EXCLUSION CRITERIA**
N/A

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

**AGE RESTRICTION**
Age is consistent with the FDA approved indication

**PRESCRIBER RESTRICTION**
Infectious disease

**COVERAGE DURATION**
1 course (28 days)

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## MIRDAMETINIB (GOMEKLI)

**MEDICATION(S)**
GOMEKLI

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

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

**REQUIRED MEDICAL INFORMATION**
N/A

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## MODAFINIL (PROVIGIL)

**MEDICATION(S)**
MODAFINIL

**PA INDICATION INDICATOR**
1 - All FDA-Approved Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
N/A

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

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## MOMELOTINIB (OJJAARA)

**MEDICATION(S)**
OJJAARA

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

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

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

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## NERATINIB (NERLYNX)

**MEDICATION(S)**
NERLYNX

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

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

**REQUIRED MEDICAL INFORMATION**
N/A

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## NILOTINIB (CAVHANZA)

**MEDICATION(S)**
CAVHANZA

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

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

**REQUIRED MEDICAL INFORMATION**
N/A

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## NILOTINIB (TASIGNA)

**MEDICATION(S)**
NILOTINIB HCL

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

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

**REQUIRED MEDICAL INFORMATION**
N/A

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## NINTEDANIB (OFEV)

**MEDICATION(S)**
NINTEDANIB ESYLATE, OFEV

**PA INDICATION INDICATOR**
1 - All FDA-Approved Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
N/A

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

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
YES

## NIRAPARIB-ABIRATERONE (AKEEGA)

**MEDICATION(S)**
AKEEGA

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

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

**REQUIRED MEDICAL INFORMATION**
N/A

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## NIRAPARIB (ZEJULA)

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

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

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

**REQUIRED MEDICAL INFORMATION**
N/A

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## NIROGACESTAT (OGSIVEO)

**MEDICATION(S)**
OGSIVEO

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

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

**REQUIRED MEDICAL INFORMATION**
N/A

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## NITAZOXANIDE (ALINIA)

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

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

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

**EXCLUSION CRITERIA**
N/A

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

**AGE RESTRICTION**
Age is consistent with the FDA approved indication

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
One course (see other criteria)

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
YES

## NITISINONE (ORFADIN)

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

**PA INDICATION INDICATOR**
1 - All FDA-Approved Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
N/A

**REQUIRED MEDICAL INFORMATION**
N/A

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan Year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## OCTREOTIDE ACETATE (SANDOSTATIN)

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

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

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

**EXCLUSION CRITERIA**
N/A

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

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
Acromegaly: Endocrinologist

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

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
YES

## OLANZAPINE-SAMIDORPHAN (LYBALVI)

**MEDICATION(S)**
LYBALVI

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
N/A

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

**AGE RESTRICTION**
Age is consistent with the FDA approved indication

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
YES

## OLAPARIB (LYNPARZA)

**MEDICATION(S)**
LYNPARZA

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

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

**REQUIRED MEDICAL INFORMATION**
N/A

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## OLUTASIDENIB (REZLIDHIA)

**MEDICATION(S)**
REZLIDHIA

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

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

**REQUIRED MEDICAL INFORMATION**
N/A

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## OMALIZUMAB (XOLAIR)

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

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

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

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

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

**AGE RESTRICTION**
Age is consistent with the FDA approved indication

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

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
YES

## OSIMERTINIB (TAGRISSO)

**MEDICATION(S)**
TAGRISSO

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

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

**REQUIRED MEDICAL INFORMATION**
N/A

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## OSPEMIFENE (OSPHENA)

**MEDICATION(S)**
OSPHENA

**PA INDICATION INDICATOR**
1 - All FDA-Approved Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
N/A

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

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
YES

## PACRITINIB (VONJO)

**MEDICATION(S)**
VONJO

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
Being used along with another agent for myelofibrosis

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

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## PALBOCICLIB (IBRANCE)

**MEDICATION(S)**
IBRANCE

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

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

**REQUIRED MEDICAL INFORMATION**
N/A

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## PALIPERIDONE ER (INVEGA)

**MEDICATION(S)**
PALIPERIDONE ER

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

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

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

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
YES

## 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, AZATHIOPRINE 50 MG TAB, AZATHIOPRINE SODIUM, BUDESONIDE 0.25 MG/2ML SUSPENSION, BUDESONIDE 0.5 MG/2ML SUSPENSION, BUDESONIDE 1 MG/2ML SUSPENSION, CABENUVA, CALCITRIOL 1 MCG/ML SOLUTION, CALCIUM ACETATE (PHOS BINDER) 667 MG CAP, CINACALCET HCL, CROMOLYN SODIUM 20 MG/2ML NEBU SOLN, CYCLOPHOSPHAMIDE 25 MG CAP, CYCLOPHOSPHAMIDE 25 MG TAB, CYCLOPHOSPHAMIDE 50 MG CAP, CYCLOPHOSPHAMIDE 50 MG TAB, CYCLOSPORINE, CYCLOSPORINE MODIFIED, DEXAMETHASONE SOD PHOSPHATE PF, DOXERCALCIFEROL 4 MCG/2ML SOLUTION, ELAPRASE, ENGERIX-B, ERZOFRI, EVEROLIMUS 0.25 MG TAB, EVEROLIMUS 0.5 MG TAB, EVEROLIMUS 0.75 MG TAB, EVEROLIMUS 1 MG TAB, 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, METHOTREXATE SODIUM 250 MG/10ML SOLUTION, METHOTREXATE SODIUM 50 MG/2ML SOLUTION, METHOTREXATE SODIUM (PF), METHYLPREDNISOLONE SODIUM SUCC 125 MG RECON SOLN, MOXIFLOXACIN HCL 400 MG/250ML SOLUTION, MOXIFLOXACIN HCL IN NACL, MYCOPHENOLATE MOFETIL, MYCOPHENOLATE MOFETIL HCL, MYCOPHENOLATE SODIUM, MYCOPHENOLIC ACID, NAGLAZYME, NUTRILIPID, ONDANSETRON 4 MG TAB DISP, ONDANSETRON 8 MG TAB DISP, ONDANSETRON HCL 24 MG TAB, ONDANSETRON HCL 4 MG/5ML SOLUTION, ONDANSETRON HCL 4 MG TAB, ONDANSETRON HCL 8 MG TAB, PARICALCITOL, PENTAMIDINE ISETHIONATE, PERSERIS, PREMASOL, PULMOZYME, RECOMBIVAX HB, RIBAVIRIN 6 GM RECON SOLN, RISPERIDONE MICROSPHERES ER, SANDIMMUNE 100 MG/ML SOLUTION, SEVELAMER CARBONATE 800 MG TAB, SIROLIMUS, SMOFLIPID, SUNLENCA 463.5 MG/1.5ML SOLUTION, SYNRIBO, TACROLIMUS 0.5 MG CAP, TACROLIMUS 1 MG CAP, TACROLIMUS 5 MG CAP, TPN ELECTROLYTES, VANCOMYCIN HCL 5 GM RECON SOLN, VORICONAZOLE 200 MG RECON SOLN, ZOLEDRONIC ACID, ZYPREXA RELPREVV

**DETAILS**

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

## PASIREOTIDE (SIGNIFOR)

**MEDICATION(S)**
SIGNIFOR

**PA INDICATION INDICATOR**
1 - All FDA-Approved Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
N/A

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

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## PAZOPANIB HCL (VOTRIENT)

**MEDICATION(S)**
PAZOPANIB HCL

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

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

**REQUIRED MEDICAL INFORMATION**
N/A

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## PEGFILGRASTIM-CBQV (UDENYCA)

**MEDICATION(S)**
UDENYCA

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

**OFF LABEL USES**
Hematopoietic Cell Transplantation (HCT)

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

**REQUIRED MEDICAL INFORMATION**
N/A

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

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

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## PEGFILGRASTIM-JMDB (FULPHILA)

**MEDICATION(S)**
FULPHILA

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

**OFF LABEL USES**
Hematopoietic Cell Transplantation (HCT)

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

**REQUIRED MEDICAL INFORMATION**
N/A

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

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

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## PEGINTERFERON ALFA-2A (PEGASYS)

**MEDICATION(S)**
PEGASYS

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

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

**EXCLUSION CRITERIA**
N/A

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

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

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

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
YES

## PEGVISOMANT (SOMAVERT)

**MEDICATION(S)**
SOMAVERT

**PA INDICATION INDICATOR**
1 - All FDA-Approved Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
N/A

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

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
Endocrinologist

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
YES

## PEMIGATINIB (PEMAZYRE)

**MEDICATION(S)**
PEMAZYRE

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

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

**REQUIRED MEDICAL INFORMATION**
N/A

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## PENICILLAMINE (DEPEN)

**MEDICATION(S)**
PENICILLAMINE 250 MG TAB

**PA INDICATION INDICATOR**
1 - All FDA-Approved Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
N/A

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

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
YES

## PEXIDARTINIB (TURALIO)

**MEDICATION(S)**
TURALIO 125 MG CAP

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

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

**REQUIRED MEDICAL INFORMATION**
N/A

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## PIMAVANSERIN (NUPLAZID)

**MEDICATION(S)**
NUPLAZID

**PA INDICATION INDICATOR**
1 - All FDA-Approved Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
Being used for dementia-related psychosis.

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

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
Neurologist or Psychiatrist

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## PIRFENIDONE (ESBRIET)

**MEDICATION(S)**
PIRFENIDONE

**PA INDICATION INDICATOR**
1 - All FDA-Approved Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
N/A

**REQUIRED MEDICAL INFORMATION**
N/A

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## PIRTOBRUTINIB (JAYPIRCA)

**MEDICATION(S)**
JAYPIRCA

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

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

**REQUIRED MEDICAL INFORMATION**
N/A

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## POMALIDOMIDE (POMALYST)

**MEDICATION(S)**
POMALIDOMIDE, POMALYST

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

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

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

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
YES

## PONATINIB (ICLUSIG)

**MEDICATION(S)**
ICLUSIG

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

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

**REQUIRED MEDICAL INFORMATION**
N/A

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## POSACONAZOLE (NOXAFIL)

**MEDICATION(S)**
POSACONAZOLE 100 MG TAB DR

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

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

**EXCLUSION CRITERIA**
N/A

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

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
esophageal candidiasis: one month. all other conditions: Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
YES

## PRALSETINIB (GAVRETO)

**MEDICATION(S)**
GAVRETO

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

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

**REQUIRED MEDICAL INFORMATION**
N/A

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## PYRIMETHAMINE (DARAPRIM)

**MEDICATION(S)**
PYRIMETHAMINE

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

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

**EXCLUSION CRITERIA**
N/A

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

**AGE RESTRICTION**
N/A

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

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
YES

## QUININE SULFATE 324MG (QUALAQUIN)

**MEDICATION(S)**
QUININE SULFATE

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

**OFF LABEL USES**
Babesiosis

**EXCLUSION CRITERIA**
N/A

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

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

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

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## QUIZARTINIB (VANFLYTA)

**MEDICATION(S)**
VANFLYTA

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

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

**REQUIRED MEDICAL INFORMATION**
N/A

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

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

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**

N/A

## REGORAFENIB (STIVARGA)

**MEDICATION(S)**
STIVARGA

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

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

**REQUIRED MEDICAL INFORMATION**
N/A

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## RELACORILANT (LIFYORLI)

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

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

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

**REQUIRED MEDICAL INFORMATION**
N/A

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## RELUGOLIX (ORGOVYX)

**MEDICATION(S)**
ORGOVYX

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

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

**REQUIRED MEDICAL INFORMATION**
N/A

**AGE RESTRICTION**
Age is consistent with the FDA approved indication

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## REPOTRECTINIB (AUGTYRO)

**MEDICATION(S)**
AUGTYRO

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

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

**REQUIRED MEDICAL INFORMATION**
N/A

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## RESMETIROM (REZDIFFRA)

**MEDICATION(S)**
REZDIFFRA

**PA INDICATION INDICATOR**
1 - All FDA-Approved Indications

**OFF LABEL USES**
N/A

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

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

**AGE RESTRICTION**
Age is consistent with the FDA approved indication

**PRESCRIBER RESTRICTION**
gastroenterologist or hepatologist

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
YES

## REVUMENIB (REVUFORJ)

**MEDICATION(S)**
REVUFORJ

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

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

**REQUIRED MEDICAL INFORMATION**
N/A

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## RIBOCICLIB (KISQALI)

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

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

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

**REQUIRED MEDICAL INFORMATION**
N/A

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## RIBOCICLIB-LETROZOLE (KISQALI FEMARA)

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

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

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

**REQUIRED MEDICAL INFORMATION**
N/A

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## RIFAXIMIN (XIFAXAN)

**MEDICATION(S)**
XIFAXAN

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

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

**EXCLUSION CRITERIA**
N/A

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

**AGE RESTRICTION**
Age is consistent with the FDA approved indication

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
One course (see other criteria)

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
YES

## RILONACEPT (ARCALYST)

**MEDICATION(S)**
ARCALYST

**PA INDICATION INDICATOR**
1 - All FDA-Approved Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
N/A

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

**AGE RESTRICTION**
Age is consistent with the FDA approved indication

**PRESCRIBER RESTRICTION**
Recurrent Pericarditis: Cardiologist

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
YES

## RIMEGEPANT (NURTEC)

**MEDICATION(S)**
NURTEC

**PA INDICATION INDICATOR**
1 - All FDA-Approved Indications

**OFF LABEL USES**
N/A

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

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

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
YES

## RIOCIGUAT (ADEMPAS)

**MEDICATION(S)**
ADEMPAS

**PA INDICATION INDICATOR**
1 - All FDA-Approved Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
N/A

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

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
YES

## RIPRETINIB (QINLOCK)

**MEDICATION(S)**
QINLOCK

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

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

**REQUIRED MEDICAL INFORMATION**
N/A

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## RISANKIZUMAB-RZAA IV (SKYRIZI IV)

**MEDICATION(S)**
SKYRIZI 600 MG/10ML SOLUTION

**PA INDICATION INDICATOR**
1 - All FDA-Approved Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
Being used with another targeted immunotherapy drug.

**REQUIRED MEDICAL INFORMATION**
N/A

**AGE RESTRICTION**
Age is consistent with the FDA approved indication

**PRESCRIBER RESTRICTION**
UC, CD: gastroenterologist

**COVERAGE DURATION**
one time induction course (8 weeks)

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## RISANKIZUMAB-RZAA SQ (SKYRIZI SQ)

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

**PA INDICATION INDICATOR**
1 - All FDA-Approved Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
Being used with another targeted immunotherapy drug.

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

**AGE RESTRICTION**
Age is consistent with the FDA approved indication

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

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

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
YES

## ROPEGINTERFERON ALFA-2B (BESREMI)

**MEDICATION(S)**
BESREMI, BESREMI PEN

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
N/A

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

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
YES

## RUCAPARIB (RUBRACA)

**MEDICATION(S)**
RUBRACA

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

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

**REQUIRED MEDICAL INFORMATION**
N/A

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## RUXOLITINIB (JAKAFI)

**MEDICATION(S)**
JAKAFI, JAKAFI XR

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

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

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

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

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
YES

## SAPROPTERIN DIHYDROCHLORIDE (KUVAN)

**MEDICATION(S)**
SAPROPTERIN DIHYDROCHLORIDE

**PA INDICATION INDICATOR**
1 - All FDA-Approved Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
Being used in combination with another medication for PKU

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

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

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

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## SARGRAMOSTIM (LEUKINE)

**MEDICATION(S)**
LEUKINE

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

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

**EXCLUSION CRITERIA**
N/A

**REQUIRED MEDICAL INFORMATION**
Febrile neutropenia, neutropenia due to HIV/AIDs, neutropenia caused by drugs other than cancer drugs, MDS, or Aplatic Anemia: absolute neutrophil count (ANC) is less than 800/mm3 or ANC is less than 1000/mm3 with neutropenia expected to last more than 5 days. Neuroblastoma, high-risk: Used in combination with a Unituxin based or Danyelza based regimen AND patient received prior first line therapy OR being used following induction or consolidation therapy. For all indications except Neuroblastoma: intolerance to both Nivestym and Zarxio or medical reason why Nivestym and Zarxio cannot be used.

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
see other criteria

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
YES

## SECUKINUMAB (COSENTYX)

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

**PA INDICATION INDICATOR**
1 - All FDA-Approved Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
Being used with another targeted immunotherapy drug.

**REQUIRED MEDICAL INFORMATION**
Ankylosing spondylitis (AS) and non-radiographic axial spondyloarthritis (nr-axSpA): patient is not able to take NSAIDs due to history of GI bleed or ulcer OR patient has tried one RX strength NSAID in combination with a PPI and had GI side effects OR patient's condition did not respond to a trial of two different RX strength NSAIDs.
Hidradenitis suppurativa (HS): patient has Hurley stage II or III HS.
Enthesitis-related arthritis (ERA): patient has tried and failed one NSAID or has a medical reason why all NSAIDs cannot be used.
Plaque Psoriasis (PsO), initial use: patient tried and failed or had a side effect to one DMARD or has a medical reason why methotrexate (MTX), cyclosporine, and acitretin cannot be used AND baseline PASI score 10 or more OR BSA 3% or more OR sensitive areas are involved OR disease affects daily living. Ongoing use: PASI or BSA improved from baseline or a decrease in disease severity.

**AGE RESTRICTION**
Age is consistent with the FDA approved indication

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

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

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
YES

## SELEGILINE TRANSDERMAL (EMSAM)

**MEDICATION(S)**
EMSAM

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
N/A

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

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
YES

## SELEXIPAG (UPTRAVI)

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

**PA INDICATION INDICATOR**
1 - All FDA-Approved Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
N/A

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

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
YES

## SELINEXOR (XPOVIO)

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

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

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

**REQUIRED MEDICAL INFORMATION**
N/A

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## SELPERCATINIB (RETEVMO)

**MEDICATION(S)**
RETEVMO

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

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

**REQUIRED MEDICAL INFORMATION**
N/A

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## SELUMETINIB (KOSELUGO)

**MEDICATION(S)**
KOSELUGO

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

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

**REQUIRED MEDICAL INFORMATION**
N/A

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## SEMAGLUTIDE (OZEMPIC)

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

**PA INDICATION INDICATOR**
1 - All FDA-Approved Indications

**OFF LABEL USES**
N/A

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

**REQUIRED MEDICAL INFORMATION**
Confirmation of Type 2 diabetes

**AGE RESTRICTION**
Age is consistent with the FDA approved indication

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## SEMAGLUTIDE (RYBELSUS)

**MEDICATION(S)**
RYBELSUS

**PA INDICATION INDICATOR**
1 - All FDA-Approved Indications

**OFF LABEL USES**
N/A

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

**REQUIRED MEDICAL INFORMATION**
Confirmation of Type 2 diabetes

**AGE RESTRICTION**
Age is consistent with the FDA approved indication

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## SEMAGLUTIDE SQ (WEGOVY SQ)

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

**PA INDICATION INDICATOR**
1 - All FDA-Approved Indications

**OFF LABEL USES**
N/A

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

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

**AGE RESTRICTION**
Age is consistent with the FDA approved indication

**PRESCRIBER RESTRICTION**
gastroenterologist or hepatologist

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
YES

## SEMAGLUTIDE TABLET (WEGOVY)

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

**PA INDICATION INDICATOR**
1 - All FDA-Approved Indications

**OFF LABEL USES**
N/A

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

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

**AGE RESTRICTION**
Age is consistent with the FDA approved indication

**PRESCRIBER RESTRICTION**
gastroenterologist or hepatologist

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
YES

## SEVABERTINIB (HYRNUO)

**MEDICATION(S)**
HYRNUO

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

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

**REQUIRED MEDICAL INFORMATION**
N/A

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## SILDENAFIL (REVATIO)

**MEDICATION(S)**
SILDENAFIL CITRATE 20 MG TAB

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

**OFF LABEL USES**
Raynauds phenomenon

**EXCLUSION CRITERIA**
N/A

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

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
YES

## SKELETAL MUSCLE RELAXANTS HRM (CARISOPRODOL)

**MEDICATION(S)**
CARISOPRODOL 350 MG TAB, VANADOM

**PA INDICATION INDICATOR**
1 - All FDA-Approved Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
N/A

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

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

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
3 weeks

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## SKELETAL MUSCLE RELAXANTS HRM (CYCLOBENZAPRINE)

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

**PA INDICATION INDICATOR**
1 - All FDA-Approved Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
N/A

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

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

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
3 weeks

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

**PART B PREREQUISITE**
YES

**PREREQUISITE THERAPY REQUIRED**
N/A

## SKELETAL MUSCLE RELAXANTS HRM(METHOCARBAMOL)

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

**PA INDICATION INDICATOR**
1 - All FDA-Approved Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
N/A

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

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

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
3 weeks

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## SODIUM OXYBATE (XYREM)

**MEDICATION(S)**
SODIUM OXYBATE

**PA INDICATION INDICATOR**
1 - All FDA-Approved Indications

**OFF LABEL USES**
N/A

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

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

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
YES

## SODIUM PHENYLBUTYRATE (BUPHENYL)

**MEDICATION(S)**
SODIUM PHENYLBUTYRATE

**PA INDICATION INDICATOR**
1 - All FDA-Approved Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
N/A

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

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## SOFOSBUVIR-VELPATASVIR-VOXILAPREVIR (VOSEVI)

**MEDICATION(S)**
VOSEVI

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

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

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

**AGE RESTRICTION**
Age is consistent with the FDA approved indication

**PRESCRIBER RESTRICTION**
Hepatologist, Gastroenterologist, or Infectious Disease.

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

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## SOMATROPIN (OMNITROPE)

**MEDICATION(S)**
OMNITROPE

**PA INDICATION INDICATOR**
1 - All FDA-Approved Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
N/A

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

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
Endocrinologist

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## SONIDEGIB (ODOMZO)

**MEDICATION(S)**
ODOMZO

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

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

**REQUIRED MEDICAL INFORMATION**
N/A

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## SORAFENIB (NEXAVAR)

**MEDICATION(S)**
SORAFENIB TOSYLATE

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

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

**REQUIRED MEDICAL INFORMATION**
N/A

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## SOTATERCEPT (WINREVAIR)

**MEDICATION(S)**
WINREVAIR

**PA INDICATION INDICATOR**
1 - All FDA-Approved Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
N/A

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

**AGE RESTRICTION**
Age is consistent with the FDA approved indication

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## SOTORASIB (LUMAKRAS)

**MEDICATION(S)**
LUMAKRAS

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

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

**REQUIRED MEDICAL INFORMATION**
N/A

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## SPARSENTAN (FILSPARI)

**MEDICATION(S)**
FILSPARI

**PA INDICATION INDICATOR**
1 - All FDA-Approved Indications

**OFF LABEL USES**
N/A

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

**REQUIRED MEDICAL INFORMATION**
N/A

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
nephrologist

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## STIRIPENTOL (DIACOMIT)

**MEDICATION(S)**
DIACOMIT

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
N/A

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

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
YES

## SUNITINIB (SUTENT)

**MEDICATION(S)**
SUNITINIB MALATE

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

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

**REQUIRED MEDICAL INFORMATION**
N/A

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## TACROLIMUS (ENVARSUS XR)

**MEDICATION(S)**
ENVARSUS XR

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
N/A

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

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
YES

## TACROLIMUS FOR ORAL SUSPENSION (PROGRAF PACKET)

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

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
N/A

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

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
YES

## TADALAFIL (ADCIRCA)

**MEDICATION(S)**
ALYQ, TADALAFIL (PAH)

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

**OFF LABEL USES**
Raynaud's phenomenon

**EXCLUSION CRITERIA**
N/A

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

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
YES

## TADALAFIL (CIALIS)

**MEDICATION(S)**
TADALAFIL 2.5 MG TAB, TADALAFIL 5 MG TAB

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

**OFF LABEL USES**
Raynauds phenomenon

**EXCLUSION CRITERIA**
N/A

**REQUIRED MEDICAL INFORMATION**
Raynauds phenomenon: treatment failure or side effect with a calcium-channel blocker. Benign Prostatic Hyperplasia (BPH): treatment failure or side effect with both finasteride and tamsulosin. Dose not to exceed 5 mg per day.

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Raynaud's, BPH: plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
YES

## TALAZOPARIB (TALZENNA)

**MEDICATION(S)**
TALZENNA

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

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

**REQUIRED MEDICAL INFORMATION**
N/A

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## TALETRECTINIB (IBTROZI)

**MEDICATION(S)**
IBTROZI

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

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

**REQUIRED MEDICAL INFORMATION**
N/A

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## TAMOXIFEN (SOLTAMOX)

**MEDICATION(S)**
SOLTAMOX

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
N/A

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

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
YES

## TASIMELTEON (HETLIOZ)

**MEDICATION(S)**
TASIMELTEON

**PA INDICATION INDICATOR**
1 - All FDA-Approved Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
N/A

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

**AGE RESTRICTION**
Age is consistent with the FDA approved indication

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

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

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**

N/A

## TAZEMETOSTAT (TAZVERIK)

**MEDICATION(S)**
TAZVERIK

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

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

**REQUIRED MEDICAL INFORMATION**
N/A

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## TELOTRISTAT ETHYL (XERMELO)

**MEDICATION(S)**
XERMELO

**PA INDICATION INDICATOR**
1 - All FDA-Approved Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
N/A

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

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
YES

## TEPOTINIB (TEPMETKO)

**MEDICATION(S)**
TEPMETKO

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

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

**REQUIRED MEDICAL INFORMATION**
N/A

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## TERIFLUNOMIDE (AUBAGIO)

**MEDICATION(S)**
TERIFLUNOMIDE

**PA INDICATION INDICATOR**
1 - All FDA-Approved Indications

**OFF LABEL USES**
N/A

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

**REQUIRED MEDICAL INFORMATION**
N/A

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## TERIPARATIDE (FORTEO)

**MEDICATION(S)**
TERIPARATIDE

**PA INDICATION INDICATOR**
1 - All FDA-Approved Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
Being used with other osteoporosis drugs.

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

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
YES

## TETRABENAZINE (XENAZINE)

**MEDICATION(S)**
TETRABENAZINE

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

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

**EXCLUSION CRITERIA**
N/A

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

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
Neurologist or Psychiatrist.

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
YES

## THALIDOMIDE (THALOMID)

**MEDICATION(S)**
THALOMID

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

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

**REQUIRED MEDICAL INFORMATION**
N/A

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## TIRZEPATIDE (MOUNJARO)

**MEDICATION(S)**
MOUNJARO

**PA INDICATION INDICATOR**
1 - All FDA-Approved Indications

**OFF LABEL USES**
N/A

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

**REQUIRED MEDICAL INFORMATION**
Confirmation of type 2 diabetes

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## TIVOZANIB (FOTIVDA)

**MEDICATION(S)**
FOTIVDA

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

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

**REQUIRED MEDICAL INFORMATION**
N/A

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## TOBRAMYCIN INHALATION AGENTS

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

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

**OFF LABEL USES**
bronchiectasis

**EXCLUSION CRITERIA**
Being used for acute treatment of an infection.

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

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## TOBRAMYCIN (TOBI PODHALER)

**MEDICATION(S)**
TOBI PODHALER

**PA INDICATION INDICATOR**
1 - All FDA-Approved Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
Being used for acute treatment of an infection.

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

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## TOCILIZUMAB-AAZG (TYENNE)

**MEDICATION(S)**
TYENNE 162 MG/0.9ML SOLN A-INJ, TYENNE 162 MG/0.9ML SOLN PRSYR

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

**OFF LABEL USES**
systemic sclerosis associated interstitial lung disease (SSc-ILD)

**EXCLUSION CRITERIA**
Being used with another targeted immunotherapy drug.

**REQUIRED MEDICAL INFORMATION**
Giant Cell Arteritis (CGA): Patient is currently taking steroids.
Polyarticular Juvenile Idiopathic Arthritis (pJIA) and Rheumatoid Arthritis (RA): Initial-Treatment failure or side effect to two of the following: Enbrel, adalimumab, and Rinvoq OR medical reason why all cannnot be used.
Systemic Sclerosis associated interstitial lung disease (SSc-ILD): Patient has systemic sclerosis AND treatment failure or side effect to mycophenolate or cyclophosphamide, OR medical reason why they cannot be used.
Ongoing use for all diagnosis: Patient is responding to Tyenne therapy.

**AGE RESTRICTION**
Age is consistent with the FDA approved indication

**PRESCRIBER RESTRICTION**
pJIA, RA, SJIA/Still's Disease: rheumatologist. SSc-ILD: rheumatologist or pulmonologist.

**COVERAGE DURATION**
pJIA: initial-16 weeks . SJIA: initial-12 weeks. Reauth-plan year All other DX: plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**

N/A

## TOLVAPTAN (JYNARQUE)

**MEDICATION(S)**
TOLVAPTAN

**PA INDICATION INDICATOR**
1 - All FDA-Approved Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
Patient is currently receiving dialysis treatment

**REQUIRED MEDICAL INFORMATION**
Patient is at risk of developing rapidly progressing ADPKD

**AGE RESTRICTION**
Age is consistent with the FDA approved indication

**PRESCRIBER RESTRICTION**
Nephrologist

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## TOPICAL TESTOSTERONE PRODUCTS

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

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

**OFF LABEL USES**
transgender, gender dysphoria

**EXCLUSION CRITERIA**
N/A

**REQUIRED MEDICAL INFORMATION**
N/A

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## TOPIRAMATE ORAL SOLUTION (EPRONTIA)

**MEDICATION(S)**
TOPIRAMATE 25 MG/ML SOLUTION

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
N/A

**REQUIRED MEDICAL INFORMATION**
Medical reason why patient cannot use topiramate tablet or sprinkle capsules

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
YES

## TOVORAFENIB (OJEMDA)

**MEDICATION(S)**
OJEMDA

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

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

**REQUIRED MEDICAL INFORMATION**
N/A

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## TRAMADOL ER

**MEDICATION(S)**
TRAMADOL HCL ER 100 MG TAB ER 24H, TRAMADOL HCL ER 200 MG TAB ER 24H, TRAMADOL HCL ER 300 MG TAB ER 24H

**PA INDICATION INDICATOR**
1 - All FDA-Approved Indications

**OFF LABEL USES**
N/A

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

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

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
Cancer pain: Oncologist or Pain Specialist.

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

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
YES

## TRAMETINIB (MEKINIST)

**MEDICATION(S)**
MEKINIST

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

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

**REQUIRED MEDICAL INFORMATION**
N/A

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## TRAZODONE ORAL SOLUTION (RALDESY)

**MEDICATION(S)**
RALDESY

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
N/A

**REQUIRED MEDICAL INFORMATION**
Medical reason why trazodone tablet cannot be used.

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
YES

## TRETINOIN (AVITA, RETIN-A)

**MEDICATION(S)**
TRETINOIN 0.01 % GEL, TRETINOIN 0.025 % CREAM, TRETINOIN 0.025 % GEL, TRETINOIN 0.05 % CREAM, TRETINOIN 0.1 % CREAM

**PA INDICATION INDICATOR**
1 - All FDA-Approved Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
N/A

**REQUIRED MEDICAL INFORMATION**
N/A

**AGE RESTRICTION**
40 years of age or older. No prior authorization needed if less than 40 years of age.

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## TRIENTINE HCL (SYPRINE)

**MEDICATION(S)**
TRIENTINE HCL

**PA INDICATION INDICATOR**
1 - All FDA-Approved Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
N/A

**REQUIRED MEDICAL INFORMATION**
Side effect to penicillamine.

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
YES

## TRIFLURIDINE-TIPIRACIL (LONSURF)

**MEDICATION(S)**
LONSURF

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

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

**REQUIRED MEDICAL INFORMATION**
N/A

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## TUCATINIB (TUKYSA)

**MEDICATION(S)**
TUKYSA

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

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

**REQUIRED MEDICAL INFORMATION**
N/A

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## UPADACITINIB (RINVOQ)

**MEDICATION(S)**
RINVOQ, RINVOQ LQ

**PA INDICATION INDICATOR**
1 - All FDA-Approved Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
Being used with another targeted immunotherapy drug.

**REQUIRED MEDICAL INFORMATION**
Rheumatoid Arthritis: patient tried and failed or had a side effect with one DMARD OR medical reason that DMARD cannot be used AND treatment failure or side effect to one or more TNF blockers.
Psoriatic arthritis (PsA): treatment failure or side effect to one or more TNF blockers.
Atopic Dermatitis: disease is moderate to severe AND ONE of the following: patient has tried a medium to very high potency topical corticosteroid and a topical calcineurin inhibitor OR has a medical reason why these topical therapies cannot be used.
Crohn's Disease (CD), Ulcerative Colitis (UC): treatment failure or side effect to one or more TNF blockers. If TNF blocker are clinically inadvisable, prior use of one approved systemic therapy.
Spondyloarthritis (SpA): non-radiographic axial SpA OR treatment failure or side effect to one or more TNF blockers.
Polyarticular juvenile idiopathic arthritis (pJIA): treatment failure or side effect with one DMARD drug or medical reason why methotrexate cannot be used AND treatment failure or side effect to one or more TNF blockers.
Giant cell arteritis (GCA): currently taking steroids.
Ongoing use for all diagnosis: responding to therapy.

**AGE RESTRICTION**
Age is consistent with the FDA approved indication

**PRESCRIBER RESTRICTION**
RA, PsA, SpA, pJIA: Rheumatologist. CD, UC: gastroenterologist

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
YES

## USTEKINUMAB IV (YESINTEK IV)

**MEDICATION(S)**
YESINTEK 130 MG/26ML SOLUTION

**PA INDICATION INDICATOR**
1 - All FDA-Approved Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
Being used with another targeted immunotherapy drug.

**REQUIRED MEDICAL INFORMATION**
N/A

**AGE RESTRICTION**
Age is consistent with the FDA approved indication

**PRESCRIBER RESTRICTION**
UC, CD: gastroenterologist

**COVERAGE DURATION**
one time induction infusion

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

# USTEKINUMAB SQ (YESINTEK SQ)

**MEDICATION(S)**
YESINTEK 45 MG/0.5ML SOLN PRSYR, YESINTEK 45 MG/0.5ML SOLUTION, YESINTEK 90 MG/ML SOLN PRSYR

**PA INDICATION INDICATOR**
1 - All FDA-Approved Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
Being used with another targeted immunotherapy drug.

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

**AGE RESTRICTION**
Age is consistent with the FDA approved indication

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

**COVERAGE DURATION**
PsO and PsA: refer to other criteria.  CD and UC: plan year.

**OTHER CRITERIA**
Dose and duration is not more than the FDA labeled maximum.
PsO and PsA initial: one loading dose and 2 maintenance doses (28 weeks total). PsO and PsA onging maintenance use: plan year.

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
YES

## VANDETANIB (CAPRELSA)

**MEDICATION(S)**
CAPRELSA

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

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

**REQUIRED MEDICAL INFORMATION**
N/A

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## VEDOLIZUMAB SC (ENTYVIO SC)

**MEDICATION(S)**
ENTYVIO PEN

**PA INDICATION INDICATOR**
1 - All FDA-Approved Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
Being used with another targeted immunotherapy drug.

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

**AGE RESTRICTION**
Age is consistent with the FDA approved indication

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## VEMURAFENIB (ZELBORAF)

**MEDICATION(S)**
ZELBORAF

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

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

**REQUIRED MEDICAL INFORMATION**
N/A

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

# VENETOCLAX (VENCLEXTA)

**MEDICATION(S)**
VENCLEXTA, VENCLEXTA STARTING PACK

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

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

**REQUIRED MEDICAL INFORMATION**
N/A

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## VEPDEGESTRANT (VEPPANU)

**MEDICATION(S)**
VEPPANU

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

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

**REQUIRED MEDICAL INFORMATION**
N/A

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## VERICIGUAT (VERQUVO)

**MEDICATION(S)**
VERQUVO

**PA INDICATION INDICATOR**
1 - All FDA-Approved Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
N/A

**REQUIRED MEDICAL INFORMATION**
Left heart ventricular ejection fraction (LVEF) less than or equal to 45% AND patient is on the highest tolerated dose of guideline supported therapies including a renin-angiotensin inhibitor drug and beta-blocker drug unless there is a medical reason for not using (contraindication) the supported therapies.

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
YES

## VIGABATRIN (SABRIL)

**MEDICATION(S)**
VIGABATRIN, VIGADRONE, VIGPODER

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
N/A

**REQUIRED MEDICAL INFORMATION**
Infantile spasm: diagnosis of infantile spasm is confirmed by EEG.
Complex partial seizures: patient has tried two formulary partial seizure drugs.

**AGE RESTRICTION**
Age is consistent with the FDA approved indication

**PRESCRIBER RESTRICTION**
Infantile spasms: Neurologist

**COVERAGE DURATION**
Seizures: annual
Infantile spasms: 6 months

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
YES

## VIGABATRIN (VIGAFYDE)

**MEDICATION(S)**
VIGAFYDE

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
N/A

**REQUIRED MEDICAL INFORMATION**
Infantile spasm: diagnosis of infantile spasm is confirmed by EEG.

**AGE RESTRICTION**
Age is consistent with the FDA approved indication

**PRESCRIBER RESTRICTION**
Neurologist

**COVERAGE DURATION**
6 months

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## VIMSELTINIB (ROMVIMZA)

**MEDICATION(S)**
ROMVIMZA

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

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

**REQUIRED MEDICAL INFORMATION**
N/A

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## VISMODEGIB (ERIVEDGE)

**MEDICATION(S)**
ERIVEDGE

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

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

**REQUIRED MEDICAL INFORMATION**
N/A

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## VONOPRAZAN-AMOXICILLIN-CLARITHROMYCIN (VOQUEZNA TRIPLE PAK)

**MEDICATION(S)**
VOQUEZNA TRIPLE PAK

**PA INDICATION INDICATOR**
1 - All FDA-Approved Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
N/A

**REQUIRED MEDICAL INFORMATION**
Patient has confirmed H. pylori infection

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
14 days

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## VONOPRAZAN-AMOXICILLIN (VOQUEZNA DUAL PAK)

**MEDICATION(S)**
VOQUEZNA DUAL PAK

**PA INDICATION INDICATOR**
1 - All FDA-Approved Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
N/A

**REQUIRED MEDICAL INFORMATION**
Patient has confirmed H. pylori infection

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
14 days

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## VORASIDENIB (VORANIGO)

**MEDICATION(S)**
VORANIGO

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

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

**REQUIRED MEDICAL INFORMATION**
N/A

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## VORICONAZOLE ORAL (VFEND)

**MEDICATION(S)**
VORICONAZOLE 200 MG TAB, VORICONAZOLE 40 MG/ML RECON SUSP, VORICONAZOLE 50 MG TAB

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

**OFF LABEL USES**
Prophylaxis of Disseminated Candidiasis, Candida Endopthalmitis, Oropharyngeal Candidiasis, Allergic bronchopulmonary aspergillosis, maintenance treatment of talaromycosis (Talaromyces marneffei -formerly Penicillium marneffei) in HIV-positive patients, treatment of Lomentospora (formerly Scedosporium) prolificans infection, treatment of pulmonary aspergillosis, chronic (cavitary or necrotizing), prophylaxis of Invasive Aspergillosis in high-risk patients.

**EXCLUSION CRITERIA**
N/A

**REQUIRED MEDICAL INFORMATION**
Systemic fungal infection treatment: culture test confirms Aspergillosis, candidemia, deep-tissue candida infection, blastomycosis, scedosporium apiospermum, fusarium species.
Candida infection of the esophagus, throat, mouth (esophageal or oropharyngeal candidiasis) after trial of fluconazole or there is a medical reason not to use fluconazole.
Prophylaxis of asperillosis or candidiasis after a bone marrow or lung transplant.

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
BMT: 6mo Lung tx:3mo Esophageal candida:1mo Candidemia/deep-tissue:1mo Other ind in other criteria

**OTHER CRITERIA**
coverage duration:
ABPA: 4 month.
systemic treatment: plan year.
Dose and duration is not more than the FDA labeled maximum.

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
YES

## VORINOSTAT (ZOLINZA)

**MEDICATION(S)**
ZOLINZA

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

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

**REQUIRED MEDICAL INFORMATION**
N/A

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## XANOMELINE-TROSPIUM (COBENFY)

**MEDICATION(S)**
COBENFY, COBENFY STARTER PACK

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
Being used with another antipsychotic agent

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

**AGE RESTRICTION**
Age is consistent with the FDA approved indication

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
YES

## ZANUBRUTINIB (BRUKINSA)

**MEDICATION(S)**
BRUKINSA

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

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

**REQUIRED MEDICAL INFORMATION**
N/A

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## ZIFTOMENIB (KOMZIFTI)

**MEDICATION(S)**
KOMZIFTI

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

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

**REQUIRED MEDICAL INFORMATION**
N/A

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## ZONGERTINIB (HERNEXEOS)

**MEDICATION(S)**
HERNEXEOS

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

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

**REQUIRED MEDICAL INFORMATION**
N/A

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## ZURANOLONE (ZURZUVAE)

**MEDICATION(S)**
ZURZUVAE

**PA INDICATION INDICATOR**
1 - All FDA-Approved Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
N/A

**REQUIRED MEDICAL INFORMATION**
Postpartum depression confirmed by DSM-5 (Diagnostic and Statistical Manual of Mental Disorders-5) criteria.

**AGE RESTRICTION**
Age is consistent with the FDA approved indication

**PRESCRIBER RESTRICTION**
Psychiatrist or Obstetrician

**COVERAGE DURATION**
one course per pregnancy (14 days)

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

**PART B PREREQUISITE**
N/A

**PREREQUISITE THERAPY REQUIRED**
N/A

## Part B vs D drugs

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

Medication(s)

| MEDICATION NAME | ROUTE | DOSE FORM |
|---|---|---|
| ABELCET 5 MG/ML SUSPENSION | IV | SUSPENSION |
| ABILIFY ASIMTUFII 720 MG/2.4ML PRSYR | IM | PRSYR |
| ABILIFY ASIMTUFII 960 MG/3.2ML PRSYR | IM | PRSYR |
| ABILIFY MAINTENA 300 MG PRSYR | IM | PRSYR |
| ABILIFY MAINTENA 300 MG SRER | IM | |
| ABILIFY MAINTENA 300 MG SRER | IM | |
| ABILIFY MAINTENA 400 MG PRSYR | IM | PRSYR |
| ABILIFY MAINTENA 400 MG SRER | IM | |
| ABILIFY MAINTENA 400 MG SRER | IM | |
| ABRAXANE 100 MG RECON SUSP | IV | RECON SUSP |
| ACETADOTE 200 MG/ML SOLUTION | IV | SOLUTION |
| ACETAMINOPHEN 10 MG/ML SOLUTION | IV | SOLUTION |
| ACETYLCYSTEINE 10 % SOLUTION | IN | SOLUTION |
| ACETYLCYSTEINE 200 MG/ML SOLUTION | IV | SOLUTION |
| ACETYLCYSTEINE 20 % SOLUTION | IN | SOLUTION |
| ACTEMRA 200 MG/10ML SOLUTION | IV | SOLUTION |
| ACTEMRA 400 MG/20ML SOLUTION | IV | SOLUTION |
| ACTEMRA 80 MG/4ML SOLUTION | IV | SOLUTION |
| ACYCLOVIR SODIUM 50 MG/ML SOLUTION | IV | SOLUTION |
| ACYCLOVIR SODIUM-NACL 200-0.9 MG/100ML-% SOLUTION | IV | SOLUTION |
| ADCETRIS 50 MG RECON SOLN | IV | RECON SOLN |
| ADRIAMYCIN 50 MG RECON SOLN | IV | RECON SOLN |
| ADZYNMA 1500 UNIT KIT | IV | KIT |
| ADZYNMA 500 UNIT KIT | IV | KIT |
| AKYNZEO 235-0.25 MG/20ML SOLUTION | IV | SOLUTION |
| AKYNZEO 235-0.25 MG RECON SOLN | IV | RECON SOLN |
| AKYNZEO 300-0.5 MG CAP | PO | CAP |
| AKYNZEO (READY-TO-USE) 235-0.25 MG/20ML SOLUTION | IV | SOLUTION |
| ALBUTEROL SULFATE 0.63 MG/3ML NEBU SOLN | IN | NEBU SOLN |
| ALBUTEROL SULFATE 1.25 MG/3ML NEBU SOLN | IN | NEBU SOLN |
| ALBUTEROL SULFATE 2.5 MG/0.5ML NEBU SOLN | IN | NEBU SOLN |
| ALBUTEROL SULFATE (2.5 MG/3ML) 0.083% NEBU SOLN | IN | NEBU SOLN |
| ALBUTEROL SULFATE (5 MG/ML) 0.5% NEBU SOLN | IN | NEBU SOLN |
| ALDURAZYME 2.9 MG/5ML SOLUTION | IV | SOLUTION |

| MEDICATION NAME | ROUTE | DOSE FORM |
|---|---|---|
| ALFERON N 5000000 UNIT/ML SOLUTION | IJ | SOLUTION |
| ALIMTA 100 MG RECON SOLN | IV | RECON SOLN |
| ALIMTA 500 MG RECON SOLN | IV | RECON SOLN |
| ALIQOPA 60 MG RECON SOLN | IV | RECON SOLN |
| ALKERAN 2 MG TAB | PO | TAB |
| ALKERAN 50 MG RECON SOLN | IV | RECON SOLN |
| ALLOPURINOL SODIUM 500 MG RECON SOLN | IV | RECON SOLN |
| ALOPRIM 500 MG RECON SOLN | IV | RECON SOLN |
| ALYGLO 10 GM/100ML SOLUTION | IV | SOLUTION |
| ALYGLO 20 GM/200ML SOLUTION | IV | SOLUTION |
| ALYGLO 5 GM/50ML SOLUTION | IV | SOLUTION |
| ALYMSYS 100 MG/4ML SOLUTION | IV | SOLUTION |
| ALYMSYS 400 MG/16ML SOLUTION | IV | SOLUTION |
| AMBISOME 50 MG RECON SUSP | IV | RECON SUSP |
| AMINO ACID 5 % SOLUTION | IV | SOLUTION |
| AMINOPHYLLINE 25 MG/ML SOLUTION | IV | SOLUTION |
| AMINOPROTECT 5 % SOLUTION | IV | SOLUTION |
| AMINOSYN II 10 % SOLUTION | IV | SOLUTION |
| AMINOSYN II 15 % SOLUTION | IV | SOLUTION |
| AMINOSYN-PF 10 % SOLUTION | IV | SOLUTION |
| AMINOSYN-PF 7% 7 % SOLUTION | IV | SOLUTION |
| AMIODARONE HCL 150 MG/3ML SOLUTION | IV | SOLUTION |
| AMIODARONE HCL 450 MG/9ML SOLUTION | IV | SOLUTION |
| AMIODARONE HCL 900 MG/18ML SOLUTION | IV | SOLUTION |
| AMPHOTERICIN B 50 MG RECON SOLN | IV | RECON SOLN |
| AMPHOTERICIN B LIPOSOME 50 MG RECON SUSP | IV | RECON SUSP |
| AMVUTTRA 25 MG/0.5ML SOLN PRSYR | SC | SOLN PRSYR |
| ANZEMET 50 MG TAB | PO | TAB |
| APREPITANT 125 MG CAP | PO | CAP |
| APREPITANT 80 & 125 MG CAP THPK | PO | CAP THPK |
| APREPITANT 80 MG CAP | PO | CAP |
| ARALAST NP 1000 MG RECON SOLN | IV | RECON SOLN |
| ARALAST NP 500 MG RECON SOLN | IV | RECON SOLN |
| ARFORMOTEROL TARTRATE 15 MCG/2ML NEBU SOLN | IN | NEBU SOLN |
| ARGATROBAN 250 MG/2.5ML SOLUTION | IV | SOLUTION |
| ARGATROBAN 50 MG/50ML SOLUTION | IV | SOLUTION |
| ARISTADA 1064 MG/3.9ML PRSYR | IM | PRSYR |
| ARISTADA 441 MG/1.6ML PRSYR | IM | PRSYR |
| ARISTADA 662 MG/2.4ML PRSYR | IM | PRSYR |
| ARISTADA 882 MG/3.2ML PRSYR | IM | PRSYR |
| ARISTADA INITIO 675 MG/2.4ML PRSYR | IM | PRSYR |
| ARMLUPEG 6 MG/0.6ML SOLN PRSYR | SC | SOLN PRSYR |
| ARRANON 5 MG/ML SOLUTION | IV | SOLUTION |

| MEDICATION NAME | ROUTE | DOSE FORM |
|---|---|---|
| ARSENIC TRIOXIDE 10 MG/10ML SOLUTION | IV | SOLUTION |
| ARSENIC TRIOXIDE 12 MG/6ML SOLUTION | IV | SOLUTION |
| ARZERRA 1000 MG/50ML CONC | IV | CONC |
| ARZERRA 100 MG/5ML CONC | IV | CONC |
| ASCENIV 5 GM/50ML SOLUTION | IV | SOLUTION |
| ASPARLAS 3750 UNIT/5ML SOLUTION | IV | SOLUTION |
| ASTAGRAF XL 0.5 MG CAP ER 24H | PO | CAP ER 24H |
| ASTAGRAF XL 1 MG CAP ER 24H | PO | CAP ER 24H |
| ASTAGRAF XL 5 MG CAP ER 24H | PO | CAP ER 24H |
| ATGAM 50 MG/ML SOLUTION | IV | SOLUTION |
| ATIVAN 2 MG/ML SOLUTION | IJ | SOLUTION |
| ATIVAN 4 MG/ML SOLUTION | IJ | SOLUTION |
| AUKELSO 120 MG/1.7ML SOLUTION | SC | SOLUTION |
| AVASTIN 100 MG/4ML SOLUTION | IV | SOLUTION |
| AVASTIN 400 MG/16ML SOLUTION | IV | SOLUTION |
| AVEED 750 MG/3ML SOLUTION | IM | SOLUTION |
| AVGEMSI 1 GM/26.3ML SOLUTION | IV | SOLUTION |
| AVGEMSI 2 GM/52.6ML SOLUTION | IV | SOLUTION |
| AVLAYAH 150 MG RECON SOLN | IV | RECON SOLN |
| AVOPEF 100 MG/5ML SOLUTION | IV | SOLUTION |
| AVOPEF 500 MG/25ML SOLUTION | IV | SOLUTION |
| AVSOLA 100 MG RECON SOLN | IV | RECON SOLN |
| AVTOZMA 200 MG/10ML SOLUTION | IV | SOLUTION |
| AVTOZMA 400 MG/20ML SOLUTION | IV | SOLUTION |
| AVTOZMA 80 MG/4ML SOLUTION | IV | SOLUTION |
| AVYCAZ 2.5 (2-0.5) GM RECON SOLN | IV | RECON SOLN |
| AXTLE 100 MG RECON SOLN | IV | RECON SOLN |
| AXTLE 500 MG RECON SOLN | IV | RECON SOLN |
| AZACITIDINE 100 MG RECON SUSP | IJ | RECON SUSP |
| AZASAN 100 MG TAB | PO | TAB |
| AZASAN 75 MG TAB | PO | TAB |
| AZATHIOPRINE 100 MG TAB | PO | TAB |
| AZATHIOPRINE 50 MG TAB | PO | TAB |
| AZATHIOPRINE 75 MG TAB | PO | TAB |
| AZATHIOPRINE SODIUM 100 MG RECON SOLN | IJ | RECON SOLN |
| AZMIRO 200 MG/ML SOLN PRSYR | IM | SOLN PRSYR |
| BACLOFEN 20000 MCG/20ML SOLUTION | IT | SOLUTION |
| BACLOFEN 40000 MCG/20ML SOLUTION | IT | SOLUTION |
| BACLOFEN 40 MG/20ML SOLUTION | IT | SOLUTION |
| BACLOFEN 50 MCG/ML SOLN PRSYR | IT | SOLN PRSYR |
| BAVENCIO 200 MG/10ML SOLUTION | IV | SOLUTION |
| BEIZRAY 2 X 80 MG/4ML & 25%(50 ML) SOLUTION | IV | SOLUTION |
| BEIZRAY 80 MG/4ML & 25%(50 ML) SOLUTION | IV | SOLUTION |
| BELEODAQ 500 MG RECON SOLN | IV | RECON SOLN |

| MEDICATION NAME | ROUTE | DOSE FORM |
|---|---|---|
| BELRAPZO 100 MG/4ML SOLUTION | IV | SOLUTION |
| BENDAMUSTINE HCL 100 MG/4ML SOLUTION | IV | SOLUTION |
| BENDAMUSTINE HCL 100 MG RECON SOLN | IV | RECON SOLN |
| BENDAMUSTINE HCL 25 MG RECON SOLN | IV | RECON SOLN |
| BENDEKA 100 MG/4ML SOLUTION | IV | SOLUTION |
| BENLYSTA 120 MG RECON SOLN | IV | RECON SOLN |
| BENLYSTA 400 MG RECON SOLN | IV | RECON SOLN |
| BENTYL 10 MG/ML SOLUTION | IM | SOLUTION |
| BESPONSA 0.9 MG RECON SOLN | IV | RECON SOLN |
| BETAMETHASONE COMBO 6 (3-3) MG/ML SUSPENSION | IJ | SUSPENSION |
| BETAMETHASONE SOD PHOS & ACET 6 (3-3) MG/ML SUSPENSION | IJ | SUSPENSION |
| BETHKIS 300 MG/4ML NEBU SOLN | IN | NEBU SOLN |
| BICNU 100 MG RECON SOLN | IV | RECON SOLN |
| BIVIGAM 10 GM/100ML SOLUTION | IV | SOLUTION |
| BIVIGAM 5 GM/50ML SOLUTION | IV | SOLUTION |
| BIZENGRI (750 MG DOSE) 375 MG/18.75ML SOLN THPK | IV | SOLN THPK |
| BKEMV 300 MG/30ML SOLUTION | IV | SOLUTION |
| BLENREP 100 MG RECON SOLN | IV | RECON SOLN |
| BLENREP 70 MG RECON SOLN | IV | RECON SOLN |
| BLEOMYCIN SULFATE 15 UNIT RECON SOLN | IJ | RECON SOLN |
| BLEOMYCIN SULFATE 30 UNIT RECON SOLN | IJ | RECON SOLN |
| BLINCYTO 35 MCG RECON SOLN | IV | RECON SOLN |
| BOMYNTRA 120 MG/1.7ML SOLN PRSYR | SC | SOLN PRSYR |
| BOMYNTRA 120 MG/1.7ML SOLUTION | SC | SOLUTION |
| BORUZU 3.5 MG/1.4ML SOLUTION | IJ | SOLUTION |
| BOSAYA 60 MG/ML SOLN PRSYR | SC | SOLN PRSYR |
| BOTOX 100 UNIT RECON SOLN | IJ | RECON SOLN |
| BOTOX 200 UNIT RECON SOLN | IJ | RECON SOLN |
| BRIUMVI 150 MG/6ML SOLUTION | IV | SOLUTION |
| BRIVARACETAM 50 MG/5ML SOLUTION | IV | SOLUTION |
| BRIVIACT 50 MG/5ML SOLUTION | IV | SOLUTION |
| BROVANA 15 MCG/2ML NEBU SOLN | IN | NEBU SOLN |
| BUDESONIDE 0.25 MG/2ML SUSPENSION | IN | SUSPENSION |
| BUDESONIDE 0.5 MG/2ML SUSPENSION | IN | SUSPENSION |
| BUDESONIDE 1 MG/2ML SUSPENSION | IN | SUSPENSION |
| BUPRENEX 0.3 MG/ML SOLUTION | IJ | SOLUTION |
| BUPRENORPHINE HCL 0.3 MG/ML SOLUTION | IJ | SOLUTION |
| BUSULFAN 6 MG/ML SOLUTION | IV | SOLUTION |
| BUSULFEX 6 MG/ML SOLUTION | IV | SOLUTION |
| BUTORPHANOL TARTRATE 1 MG/ML SOLUTION | IJ | SOLUTION |
| BUTORPHANOL TARTRATE 2 MG/ML SOLUTION | IJ | SOLUTION |

| MEDICATION NAME | ROUTE | DOSE FORM |
|---|---|---|
| CABENUVA 400 & 600 MG/2ML SUSP | IM | SUSP |
| CABENUVA 600 & 900 MG/3ML SUSP | IM | SUSP |
| CALCITONIN (SALMON) 200 UNIT/ML SOLUTION | IJ | SOLUTION |
| CALCITRIOL 1 MCG/ML SOLUTION | IV | SOLUTION |
| CALCIUM ACETATE 667 MG TAB | PO | TAB |
| CALCIUM ACETATE (PHOS BINDER) 667 MG CAP | PO | CAP |
| CALCIUM ACETATE (PHOS BINDER) 667 MG TAB | PO | TAB |
| CALCIUM GLUCONATE 10 % SOLUTION | IV | SOLUTION |
| CALDOLOR 800 MG/200ML SOLUTION | IV | SOLUTION |
| CALDOLOR 800 MG/8ML SOLUTION | IV | SOLUTION |
| CAMCEVI 42 MG PRSYR | SC | PRSYR |
| CAMPTOSAR 100 MG/5ML SOLUTION | IV | SOLUTION |
| CAMPTOSAR 300 MG/15ML SOLUTION | IV | SOLUTION |
| CAMPTOSAR 40 MG/2ML SOLUTION | IV | SOLUTION |
| CANCIDAS 50 MG RECON SOLN | IV | RECON SOLN |
| CANCIDAS 70 MG RECON SOLN | IV | RECON SOLN |
| CARBOPLATIN 150 MG/15ML SOLUTION | IV | SOLUTION |
| CARBOPLATIN 450 MG/45ML SOLUTION | IV | SOLUTION |
| CARBOPLATIN 50 MG/5ML SOLUTION | IV | SOLUTION |
| CARBOPLATIN 600 MG/60ML SOLUTION | IV | SOLUTION |
| CARDENE IV 2.5 MG/ML SOLUTION | IV | SOLUTION |
| CARMUSTINE 100 MG RECON SOLN | IV | RECON SOLN |
| CARMUSTINE 300 MG RECON SOLN | IV | RECON SOLN |
| CARMUSTINE 50 MG RECON SOLN | IV | RECON SOLN |
| CARNITOR 200 MG/ML SOLUTION | IV | SOLUTION |
| CASPOFUNGIN ACETATE 50 MG RECON SOLN | IV | RECON SOLN |
| CASPOFUNGIN ACETATE 70 MG RECON SOLN | IV | RECON SOLN |
| CEFAZOLIN IN SODIUM CHLORIDE 2-0.9 GM/100ML-% SOLUTION | IV | SOLUTION |
| CEFAZOLIN IN SODIUM CHLORIDE 3-0.9 GM/100ML-% SOLUTION | IV | SOLUTION |
| CEFAZOLIN SODIUM-DEXTROSE 1-4 GM-%(50ML) RECON SOLN | IV | RECON SOLN |
| CEFAZOLIN SODIUM-DEXTROSE 1-4 GM/50ML-% SOLUTION | IV | SOLUTION |
| CEFAZOLIN SODIUM-DEXTROSE 2-3 GM-%(50ML) RECON SOLN | IV | RECON SOLN |
| CEFAZOLIN SODIUM-DEXTROSE 2-4 GM/100ML-% SOLUTION | IV | SOLUTION |
| CEFAZOLIN SODIUM-DEXTROSE 2-5 GM/100ML-% SOLUTION | IV | SOLUTION |
| CEFAZOLIN SODIUM-DEXTROSE 3-2 GM-%(50ML) RECON SOLN | IV | RECON SOLN |
| CEFAZOLIN SODIUM-DEXTROSE 3-4 GM/150ML-% SOLUTION | IV | SOLUTION |

| MEDICATION NAME | ROUTE | DOSE FORM |
|---|---|---|
| CEFEPIME-DEXTROSE 1-5 GM-%(50ML) RECON SOLN | IV | RECON SOLN |
| CEFEPIME-DEXTROSE 2-5 GM-%(50ML) RECON SOLN | IV | RECON SOLN |
| CEFEPIME HCL 100 GM RECON SOLN | IV | RECON SOLN |
| CEFOXITIN SODIUM-DEXTROSE 1-4 GM-%(50ML) RECON SOLN | IV | RECON SOLN |
| CEFOXITIN SODIUM-DEXTROSE 2-2.2 GM-%(50ML) RECON SOLN | IV | RECON SOLN |
| CEFTAZIDIME AND DEXTROSE 1-5 GM-%(50ML) RECON SOLN | IV | RECON SOLN |
| CEFTAZIDIME AND DEXTROSE 2-5 GM-%(50ML) RECON SOLN | IV | RECON SOLN |
| CEFTRIAXONE SODIUM 100 GM RECON SOLN | IJ | RECON SOLN |
| CEFTRIAXONE SODIUM-DEXTROSE 1-3.74 GM-%(50ML) RECON SOLN | IV | RECON SOLN |
| CEFTRIAXONE SODIUM-DEXTROSE 2-2.22 GM-%(50ML) RECON SOLN | IV | RECON SOLN |
| CEFTRIAXONE SODIUM IN DEXTROSE 20 MG/ML SOLUTION | IV | SOLUTION |
| CEFTRIAXONE SODIUM IN DEXTROSE 40 MG/ML SOLUTION | IV | SOLUTION |
| CELESTONE SOLUSPAN 6 (3-3) MG/ML SUSPENSION | IJ | SUSPENSION |
| CELLCEPT 200 MG/ML RECON SUSP | PO | RECON SUSP |
| CELLCEPT 250 MG CAP | PO | CAP |
| CELLCEPT 500 MG TAB | PO | TAB |
| CELLCEPT INTRAVENOUS 500 MG RECON SOLN | IV | RECON SOLN |
| CEREBYX 100 MG PE/2ML SOLUTION | IJ | SOLUTION |
| CEREBYX 500 MG PE/10ML SOLUTION | IJ | SOLUTION |
| CEREZYME 400 UNIT RECON SOLN | IV | RECON SOLN |
| CHLOROTHIAZIDE SODIUM 500 MG RECON SOLN | IV | RECON SOLN |
| CHORIONIC GONADOTROPIN 10000 UNIT RECON SOLN | IM | RECON SOLN |
| CIDOFOVIR 75 MG/ML SOLUTION | IV | SOLUTION |
| CINACALCET HCL 30 MG TAB | PO | TAB |
| CINACALCET HCL 60 MG TAB | PO | TAB |
| CINACALCET HCL 90 MG TAB | PO | TAB |
| CINQAIR 100 MG/10ML SOLUTION | IV | SOLUTION |
| CIPROFLOXACIN IN D5W 400 MG/200ML SOLUTION | IV | SOLUTION |
| CISPLATIN 100 MG/100ML SOLUTION | IV | SOLUTION |
| CISPLATIN 200 MG/200ML SOLUTION | IV | SOLUTION |
| CISPLATIN 50 MG/50ML SOLUTION | IV | SOLUTION |
| CISPLATIN 50 MG RECON SOLN | IV | RECON SOLN |
| CLADRIBINE 10 MG/10ML SOLUTION | IV | SOLUTION |
| CLINIMIX/DEXTROSE (4.25/10) 4.25 % SOLUTION | IV | SOLUTION |
| CLINIMIX/DEXTROSE (4.25/5) 4.25 % SOLUTION | IV | SOLUTION |
| CLINIMIX/DEXTROSE (5/15) 5 % SOLUTION | IV | SOLUTION |

| MEDICATION NAME | ROUTE | DOSE FORM |
|---|---|---|
| CLINIMIX/DEXTROSE (5/20) 5 % SOLUTION | IV | SOLUTION |
| CLINIMIX/DEXTROSE (6/5) 6 % SOLUTION | IV | SOLUTION |
| CLINIMIX/DEXTROSE (8/10) 8 % SOLUTION | IV | SOLUTION |
| CLINIMIX/DEXTROSE (8/14) 8 % SOLUTION | IV | SOLUTION |
| CLINIMIX E/DEXTROSE (2.75/5) 2.75 % SOLUTION | IV | SOLUTION |
| CLINIMIX E/DEXTROSE (4.25/10) 4.25 % SOLUTION | IV | SOLUTION |
| CLINIMIX E/DEXTROSE (4.25/5) 4.25 % SOLUTION | IV | SOLUTION |
| CLINIMIX E/DEXTROSE (5/15) 5 % SOLUTION | IV | SOLUTION |
| CLINIMIX E/DEXTROSE (5/20) 5 % SOLUTION | IV | SOLUTION |
| CLINIMIX E/DEXTROSE (8/10) 8 % SOLUTION | IV | SOLUTION |
| CLINIMIX E/DEXTROSE (8/14) 8 % SOLUTION | IV | SOLUTION |
| CLINISOL SF 15 % SOLUTION | IV | SOLUTION |
| CLINOLIPID 20 % EMULSION | IV | EMULSION |
| CLOFARABINE 1 MG/ML SOLUTION | IV | SOLUTION |
| CLOLAR 1 MG/ML SOLUTION | IV | SOLUTION |
| CLONIDINE HCL (ANALGESIA) 100 MCG/ML SOLUTION | EP | SOLUTION |
| COCAINE HCL 40 MG/ML SOLUTION | NA | SOLUTION |
| COLUMVI 10 MG/10ML SOLUTION | IV | SOLUTION |
| COLUMVI 2.5 MG/2.5ML SOLUTION | IV | SOLUTION |
| CONEXXENCE 60 MG/ML SOLN PRSYR | SC | SOLN PRSYR |
| COSELA 300 MG RECON SOLN | IV | RECON SOLN |
| COSENTYX 125 MG/5ML SOLUTION | IV | SOLUTION |
| COSMEGEN 0.5 MG RECON SOLN | IV | RECON SOLN |
| CROMOLYN SODIUM 20 MG/2ML NEBU SOLN | IN | NEBU SOLN |
| CRYSVITA 10 MG/ML SOLUTION | SC | SOLUTION |
| CRYSVITA 20 MG/ML SOLUTION | SC | SOLUTION |
| CRYSVITA 30 MG/ML SOLUTION | SC | SOLUTION |
| CUPRIC CHLORIDE 0.4 MG/ML SOLUTION | IV | SOLUTION |
| CUTAQUIG 1.65 GM/10ML SOLUTION | SC | SOLUTION |
| CUTAQUIG 1 GM/6ML SOLUTION | SC | SOLUTION |
| CUTAQUIG 2 GM/12ML SOLUTION | SC | SOLUTION |
| CUTAQUIG 3.3 GM/20ML SOLUTION | SC | SOLUTION |
| CUTAQUIG 4 GM/24ML SOLUTION | SC | SOLUTION |
| CUTAQUIG 8 GM/48ML SOLUTION | SC | SOLUTION |
| CUVITRU 10 GM/50ML SOLUTION | SC | SOLUTION |
| CUVITRU 1 GM/5ML SOLUTION | SC | SOLUTION |
| CUVITRU 2 GM/10ML SOLUTION | SC | SOLUTION |
| CUVITRU 4 GM/20ML SOLUTION | SC | SOLUTION |
| CUVITRU 8 GM/40ML SOLUTION | SC | SOLUTION |
| CYCLOPHOSPHAMIDE 1000 MG/10ML SOLUTION | IV | SOLUTION |
| CYCLOPHOSPHAMIDE 1 GM/2ML SOLUTION | IV | SOLUTION |
| CYCLOPHOSPHAMIDE 1 GM/5ML SOLUTION | IV | SOLUTION |
| CYCLOPHOSPHAMIDE 1 GM RECON SOLN | IJ | RECON SOLN |

| MEDICATION NAME | ROUTE | DOSE FORM |
|---|---|---|
| CYCLOPHOSPHAMIDE 2000 MG/20ML SOLUTION | IV | SOLUTION |
| CYCLOPHOSPHAMIDE 25 MG CAP | PO | CAP |
| CYCLOPHOSPHAMIDE 25 MG TAB | PO | TAB |
| CYCLOPHOSPHAMIDE 2 GM/10ML SOLUTION | IV | SOLUTION |
| CYCLOPHOSPHAMIDE 2 GM/4ML SOLUTION | IV | SOLUTION |
| CYCLOPHOSPHAMIDE 2 GM RECON SOLN | IJ | RECON SOLN |
| CYCLOPHOSPHAMIDE 500 MG/2.5ML SOLUTION | IV | SOLUTION |
| CYCLOPHOSPHAMIDE 500 MG/5ML SOLUTION | IV | SOLUTION |
| CYCLOPHOSPHAMIDE 500 MG/ML SOLUTION | IV | SOLUTION |
| CYCLOPHOSPHAMIDE 500 MG RECON SOLN | IJ | RECON SOLN |
| CYCLOPHOSPHAMIDE 50 MG CAP | PO | CAP |
| CYCLOPHOSPHAMIDE 50 MG TAB | PO | TAB |
| CYCLOSPORINE 100 MG CAP | PO | CAP |
| CYCLOSPORINE 25 MG CAP | PO | CAP |
| CYCLOSPORINE 50 MG/ML SOLUTION | IV | SOLUTION |
| CYCLOSPORINE MODIFIED 100 MG CAP | PO | CAP |
| CYCLOSPORINE MODIFIED 100 MG/ML SOLUTION | PO | SOLUTION |
| CYCLOSPORINE MODIFIED 25 MG CAP | PO | CAP |
| CYCLOSPORINE MODIFIED 50 MG CAP | PO | CAP |
| CYKLOKAPRON 1000 MG/10ML SOLUTION | IV | SOLUTION |
| CYRAMZA 100 MG/10ML SOLUTION | IV | SOLUTION |
| CYRAMZA 500 MG/50ML SOLUTION | IV | SOLUTION |
| CYTARABINE 20 MG/ML SOLUTION | IJ | SOLUTION |
| CYTARABINE (PF) 100 MG/ML SOLUTION | IJ | SOLUTION |
| CYTARABINE (PF) 20 MG/ML SOLUTION | IJ | SOLUTION |
| CYTOGAM 50 MG/ML SOLUTION | IV | SOLUTION |
| DACARBAZINE 100 MG RECON SOLN | IV | RECON SOLN |
| DACARBAZINE 200 MG RECON SOLN | IV | RECON SOLN |
| 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 |
|---|---|---|
| DOBUTAMINE-DEXTROSE 1-5 MG/ML-% SOLUTION | IV | SOLUTION |
| DOBUTAMINE-DEXTROSE 2-5 MG/ML-% SOLUTION | IV | SOLUTION |
| DOBUTAMINE-DEXTROSE 4-5 MG/ML-% SOLUTION | IV | SOLUTION |
| DOBUTAMINE HCL 12.5 MG/ML SOLUTION | IV | SOLUTION |
| DOCETAXEL 160 MG/16ML SOLUTION | IV | SOLUTION |
| DOCETAXEL 160 MG/8ML CONC | IV | CONC |
| DOCETAXEL 20 MG/2ML SOLUTION | IV | SOLUTION |
| DOCETAXEL 20 MG/ML CONC | IV | CONC |
| DOCETAXEL 80 MG/4ML CONC | IV | CONC |
| DOCETAXEL 80 MG/8ML SOLUTION | IV | SOLUTION |
| DOCIVYX 160 MG/16ML SOLUTION | IV | SOLUTION |
| DOCIVYX 20 MG/2ML SOLUTION | IV | SOLUTION |
| DOCIVYX 80 MG/8ML SOLUTION | IV | SOLUTION |
| DOPAMINE-DEXTROSE 1.6-5 MG/ML-% SOLUTION | IV | SOLUTION |
| DOPAMINE-DEXTROSE 3.2-5 MG/ML-% SOLUTION | IV | SOLUTION |
| DOPAMINE HCL 40 MG/ML SOLUTION | IV | SOLUTION |
| DOPAMINE IN D5W 0.8-5 MG/ML-% SOLUTION | IV | SOLUTION |
| DOPAMINE IN D5W 1.6-5 MG/ML-% SOLUTION | IV | SOLUTION |
| DOPAMINE IN D5W 3.2-5 MG/ML-% SOLUTION | IV | SOLUTION |
| DOXERCALCIFEROL 0.5 MCG CAP | PO | CAP |
| DOXERCALCIFEROL 1 MCG CAP | PO | CAP |
| DOXERCALCIFEROL 2.5 MCG CAP | PO | CAP |
| DOXERCALCIFEROL 4 MCG/2ML SOLUTION | IV | SOLUTION |
| DOXIL 2 MG/ML SUSPENSION | IV | SUSPENSION |
| DOXORUBICIN HCL 10 MG RECON SOLN | IV | RECON SOLN |
| DOXORUBICIN HCL 2 MG/ML SOLUTION | IV | SOLUTION |
| DOXORUBICIN HCL 50 MG RECON SOLN | IV | RECON SOLN |
| DOXORUBICIN HCL LIPOSOMAL 2 MG/ML SUSPENSION | IV | SUSPENSION |
| DRONABINOL 5 MG/ML SOLUTION | PO | SOLUTION |
| DUOPA 4.63-20 MG/ML SUSPENSION | EN | SUSPENSION |
| DURACLON 100 MCG/ML SOLUTION | EP | SOLUTION |
| DURAMORPH 0.5 MG/ML SOLUTION | IJ | SOLUTION |
| DURAMORPH 1 MG/ML SOLUTION | IJ | SOLUTION |
| DURYSTA 10 MCG IMPLANT | IO | IMPLANT |
| DYSPORT 300 UNIT RECON SOLN | IM | RECON SOLN |
| DYSPORT 500 UNIT RECON SOLN | IM | RECON SOLN |
| EDARAVONE 30 MG/100ML SOLUTION | IV | SOLUTION |
| EDARAVONE 60 MG/100ML SOLUTION | IV | SOLUTION |
| ELAHERE 100 MG/20ML SOLUTION | IV | SOLUTION |
| ELAPRASE 6 MG/3ML SOLUTION | IV | SOLUTION |
| ELCYS 50 MG/ML SOLUTION | IV | SOLUTION |
| ELELYSO 200 UNIT RECON SOLN | IV | RECON SOLN |
| ELFABRIO 20 MG/10ML SOLUTION | IV | SOLUTION |

| MEDICATION NAME | ROUTE | DOSE FORM |
|---|---|---|
| ELFABRIO 5 MG/2.5ML SOLUTION | IV | SOLUTION |
| ELLENCE 200 MG/100ML SOLUTION | IV | SOLUTION |
| ELLENCE 50 MG/25ML SOLUTION | IV | SOLUTION |
| ELLIOTTS B SOLUTION | IT | SOLUTION |
| ELREXFIO 44 MG/1.1ML SOLUTION | SC | SOLUTION |
| ELREXFIO 76 MG/1.9ML SOLUTION | SC | SOLUTION |
| EMEND 125 MG/5ML RECON SUSP | PO | RECON SUSP |
| EMEND 150 MG RECON SOLN | IV | RECON SOLN |
| EMEND BIPACK 80 MG CAP | PO | CAP |
| EMEND TRIPACK 80 & 125 MG CAP THPK | PO | CAP THPK |
| EMPAVELI 1080 MG/20ML SOLUTION | SC | SOLUTION |
| EMPLICITI 300 MG RECON SOLN | IV | RECON SOLN |
| EMPLICITI 400 MG RECON SOLN | IV | RECON SOLN |
| EMRELIS 100 MG RECON SOLN | IV | RECON SOLN |
| EMRELIS 20 MG RECON SOLN | IV | RECON SOLN |
| ENALAPRILAT 1.25 MG/ML SOLUTION | IV | SOLUTION |
| ENGERIX-B 10 MCG/0.5ML SUSP PRSYR | IJ | SUSP PRSYR |
| ENGERIX-B 20 MCG/ML SUSPENSION | IJ | SUSPENSION |
| ENGERIX-B 20 MCG/ML SUSP PRSYR | IJ | SUSP PRSYR |
| ENHERTU 100 MG RECON SOLN | IV | RECON SOLN |
| ENJAYMO 1100 MG/22ML SOLUTION | IV | SOLUTION |
| ENTYVIO 300 MG RECON SOLN | IV | RECON SOLN |
| EPKINLY 48 MG/0.8ML SOLUTION | SC | SOLUTION |
| EPKINLY 4 MG/0.8ML SOLUTION | SC | SOLUTION |
| EPOGEN 10000 UNIT/ML SOLUTION | IJ | SOLUTION |
| EPOGEN 20000 UNIT/ML SOLUTION | IJ | SOLUTION |
| EPOGEN 2000 UNIT/ML SOLUTION | IJ | SOLUTION |
| EPOGEN 3000 UNIT/ML SOLUTION | IJ | SOLUTION |
| EPOGEN 4000 UNIT/ML SOLUTION | IJ | SOLUTION |
| EPOPROSTENOL SODIUM 0.5 MG RECON SOLN | IV | RECON SOLN |
| EPOPROSTENOL SODIUM 1.5 MG RECON SOLN | IV | RECON SOLN |
| EPYSQLI 300 MG/30ML SOLUTION | IV | SOLUTION |
| ERBITUX 100 MG/50ML SOLUTION | IV | SOLUTION |
| ERBITUX 200 MG/100ML SOLUTION | IV | SOLUTION |
| ERIBULIN MESYLATE 1 MG/2ML SOLUTION | IV | SOLUTION |
| ERZOFRI 117 MG/0.75ML SUSP PRSYR | IM | SUSP PRSYR |
| ERZOFRI 156 MG/ML SUSP PRSYR | IM | SUSP PRSYR |
| ERZOFRI 234 MG/1.5ML SUSP PRSYR | IM | SUSP PRSYR |
| ERZOFRI 351 MG/2.25ML SUSP PRSYR | IM | SUSP PRSYR |
| ERZOFRI 39 MG/0.25ML SUSP PRSYR | IM | SUSP PRSYR |
| ERZOFRI 78 MG/0.5ML SUSP PRSYR | IM | SUSP PRSYR |
| ETHACRYNATE SODIUM 50 MG RECON SOLN | IV | RECON SOLN |
| ETHYOL 500 MG RECON SOLN | IV | RECON SOLN |
| ETOPOPHOS 100 MG RECON SOLN | IV | RECON SOLN |

| MEDICATION NAME | ROUTE | DOSE FORM |
|---|---|---|
| ETOPOSIDE 100 MG/5ML SOLUTION | IV | SOLUTION |
| ETOPOSIDE 1 GM/50ML SOLUTION | IV | SOLUTION |
| ETOPOSIDE 500 MG/25ML SOLUTION | IV | SOLUTION |
| EVDI 1 MG/20ML SOLUTION | IV | SOLUTION |
| EVENITY 105 MG/1.17ML SOLN PRSYR | SC | SOLN PRSYR |
| EVEROLIMUS 0.25 MG TAB | PO | TAB |
| EVEROLIMUS 0.5 MG TAB | PO | TAB |
| EVEROLIMUS 0.75 MG TAB | PO | TAB |
| EVEROLIMUS 1 MG TAB | PO | TAB |
| EVKEEZA 1200 MG/8ML SOLUTION | IV | SOLUTION |
| EVKEEZA 345 MG/2.3ML SOLUTION | IV | SOLUTION |
| EVOMELA 50 MG RECON SOLN | IV | RECON SOLN |
| EXDENSUR 100 MG/ML SOLN PRSYR | SC | SOLN PRSYR |
| FABRAZYME 35 MG RECON SOLN | IV | RECON SOLN |
| FABRAZYME 5 MG RECON SOLN | IV | RECON SOLN |
| FAMOTIDINE 200 MG/20ML SOLUTION | IV | SOLUTION |
| FAMOTIDINE 200 MG/50ML SOLUTION | IV | SOLUTION |
| FAMOTIDINE 20 MG/5ML SOLUTION | IV | SOLUTION |
| FAMOTIDINE 40 MG/10ML SOLUTION | IV | SOLUTION |
| FAMOTIDINE 40 MG/4ML SOLUTION | IV | SOLUTION |
| FAMOTIDINE (PF) 20 MG/2ML SOLUTION | IV | SOLUTION |
| FASENRA 10 MG/0.5ML SOLN PRSYR | SC | SOLN PRSYR |
| FASENRA 30 MG/ML SOLN PRSYR | SC | SOLN PRSYR |
| FAVLYXA 250 MG/10ML SOLUTION | IV | SOLUTION |
| FAVLYXA 2.5 GM/100ML SOLUTION | IV | SOLUTION |
| FENSOLVI (6 MONTH) 45 MG KIT | SC | KIT |
| FILKRI 300 MCG/0.5ML SOLN PRSYR | IJ | SOLN PRSYR |
| FILKRI 480 MCG/0.8ML SOLN PRSYR | IJ | SOLN PRSYR |
| FLEBOGAMMA DIF 10 GM/100ML SOLUTION | IV | SOLUTION |
| FLEBOGAMMA DIF 10 GM/200ML SOLUTION | IV | SOLUTION |
| FLEBOGAMMA DIF 20 GM/200ML SOLUTION | IV | SOLUTION |
| FLEBOGAMMA DIF 20 GM/400ML SOLUTION | IV | SOLUTION |
| FLEBOGAMMA DIF 2.5 GM/50ML SOLUTION | IV | SOLUTION |
| FLEBOGAMMA DIF 5 GM/100ML SOLUTION | IV | SOLUTION |
| FLEBOGAMMA DIF 5 GM/50ML SOLUTION | IV | SOLUTION |
| FLOLAN 0.5 MG RECON SOLN | IV | RECON SOLN |
| FLOLAN 1.5 MG RECON SOLN | IV | RECON SOLN |
| FLOXURIDINE 0.5 GM RECON SOLN | IJ | RECON SOLN |
| FLUDARABINE PHOSPHATE 25 MG/ML SOLUTION | IV | SOLUTION |
| FLUDARABINE PHOSPHATE 50 MG/2ML SOLUTION | IV | SOLUTION |
| FLUDARABINE PHOSPHATE 50 MG RECON SOLN | IV | RECON SOLN |
| FLUOROURACIL 1 GM/20ML SOLUTION | IV | SOLUTION |
| FLUOROURACIL 2.5 GM/50ML SOLUTION | IV | SOLUTION |
| FLUOROURACIL 500 MG/10ML SOLUTION | IV | SOLUTION |

| MEDICATION NAME | ROUTE | DOSE FORM |
|---|---|---|
| FLUOROURACIL 5 GM/100ML SOLUTION | IV | SOLUTION |
| FOCINVEZ 150 MG/50ML SOLUTION | IV | SOLUTION |
| FOLOTYN 20 MG/ML SOLUTION | IV | SOLUTION |
| FOLOTYN 40 MG/2ML SOLUTION | IV | SOLUTION |
| FORMOTEROL FUMARATE 20 MCG/2ML NEBU SOLN | IN | NEBU SOLN |
| FOSAPREPITANT DIMEGLUMINE 150 MG RECON SOLN | IV | RECON SOLN |
| FOSPHENYTOIN SODIUM 100 MG PE/2ML SOLUTION | IJ | SOLUTION |
| FOSPHENYTOIN SODIUM 500 MG PE/10ML SOLUTION | IJ | SOLUTION |
| FOSRENOL 1000 MG CHEW TAB | PO | CHEW TAB |
| FOSRENOL 1000 MG PACKET | PO | PACKET |
| FOSRENOL 500 MG CHEW TAB | PO | CHEW TAB |
| FOSRENOL 750 MG CHEW TAB | PO | CHEW TAB |
| FOSRENOL 750 MG PACKET | PO | PACKET |
| FRINDOVYX 1 GM/2ML SOLUTION | IV | SOLUTION |
| FRINDOVYX 2 GM/4ML SOLUTION | IV | SOLUTION |
| FRINDOVYX 500 MG/ML SOLUTION | IV | SOLUTION |
| FYARRO 100 MG RECON SUSP | IV | RECON SUSP |
| FYLNETRA 6 MG/0.6ML SOLN PRSYR | SC | SOLN PRSYR |
| GABLOFEN 10000 MCG/20ML SOLN PRSYR | IT | SOLN PRSYR |
| GABLOFEN 20000 MCG/20ML SOLN PRSYR | IT | SOLN PRSYR |
| GABLOFEN 20000 MCG/20ML SOLUTION | IT | SOLUTION |
| GABLOFEN 40000 MCG/20ML SOLN PRSYR | IT | SOLN PRSYR |
| GABLOFEN 40000 MCG/20ML SOLUTION | IT | SOLUTION |
| GABLOFEN 50 MCG/ML SOLN PRSYR | IT | SOLN PRSYR |
| GAMASTAN SOLUTION | IM | SOLUTION |
| GAMMAGARD 10 GM/100ML SOLUTION | IJ | SOLUTION |
| GAMMAGARD 1 GM/10ML SOLUTION | IJ | SOLUTION |
| GAMMAGARD 20 GM/200ML SOLUTION | IJ | SOLUTION |
| GAMMAGARD 2.5 GM/25ML SOLUTION | IJ | SOLUTION |
| GAMMAGARD 30 GM/300ML SOLUTION | IJ | SOLUTION |
| GAMMAGARD 5 GM/50ML SOLUTION | IJ | SOLUTION |
| GAMMAGARD ERC 10 GM/100ML SOLUTION | IJ | SOLUTION |
| GAMMAGARD ERC 5 GM/50ML SOLUTION | IJ | SOLUTION |
| GAMMAGARD S/D LESS IGA 10 GM RECON SOLN | IV | RECON SOLN |
| GAMMAGARD S/D LESS IGA 5 GM RECON SOLN | IV | RECON SOLN |
| GAMMAKED 10 GM/100ML SOLUTION | IJ | SOLUTION |
| GAMMAKED 1 GM/10ML SOLUTION | IJ | SOLUTION |
| GAMMAKED 20 GM/200ML SOLUTION | IJ | SOLUTION |
| GAMMAKED 5 GM/50ML SOLUTION | IJ | SOLUTION |
| GAMMAPLEX 10 GM/100ML SOLUTION | IV | SOLUTION |
| GAMMAPLEX 10 GM/200ML SOLUTION | IV | SOLUTION |
| GAMMAPLEX 20 GM/200ML SOLUTION | IV | SOLUTION |

| MEDICATION NAME | ROUTE | DOSE FORM |
|---|---|---|
| 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 |
| GRANIX 480 MCG/1.6ML SOLUTION | SC | SOLUTION |
| HALAVEN 1 MG/2ML SOLUTION | IV | SOLUTION |
| HECTOROL 4 MCG/2ML SOLUTION | IV | SOLUTION |

| MEDICATION NAME | ROUTE | DOSE FORM |
|---|---|---|
| HEPAGAM B 312 UNIT/ML SOLUTION | IJ | SOLUTION |
| HEPARIN (PORCINE) IN NACL 1000-0.9 UT/500ML-% SOLUTION | IV | SOLUTION |
| HEPARIN (PORCINE) IN NACL 12500-0.45 UT/250ML-% SOLUTION | IV | SOLUTION |
| HEPARIN (PORCINE) IN NACL 2000-0.9 UNIT/L-% SOLUTION | IV | SOLUTION |
| HEPARIN (PORCINE) IN NACL 25000-0.45 UT/250ML-% SOLUTION | IV | SOLUTION |
| HEPARIN (PORCINE) IN NACL 25000-0.45 UT/500ML-% SOLUTION | IV | SOLUTION |
| HEPARIN (PORCINE) IN NACL 2500-0.9 UT/500ML-% SOLUTION | IV | SOLUTION |
| HEPARIN (PORCINE) IN NACL 30000-0.9 UNIT/L-% SOLUTION | IV | SOLUTION |
| HEPARIN (PORCINE) IN NACL 4000-0.9 UNIT/L-% SOLUTION | IV | SOLUTION |
| HEPARIN (PORCINE) IN NACL 5000-0.9 UNIT/L-% SOLUTION | IV | SOLUTION |
| HEPARIN (PORCINE) IN NACL 5000-0.9 UT/500ML-% SOLUTION | IV | SOLUTION |
| HEPARIN (PORCINE) IN NACL 500-0.9 UT/500ML-% SOLUTION | IV | SOLUTION |
| HEPARIN SODIUM (PORCINE) 10000 UNIT/ML SOLUTION | IJ | SOLUTION |
| HEPARIN SODIUM (PORCINE) 1000 UNIT/ML SOLUTION | IJ | SOLUTION |
| HEPARIN SODIUM (PORCINE) 20000 UNIT/ML SOLUTION | IJ | SOLUTION |
| HEPARIN SODIUM (PORCINE) 5000 UNIT/0.5ML SOLN PRSYR | IJ | SOLN PRSYR |
| HEPARIN SODIUM (PORCINE) 5000 UNIT/ML SOLUTION | IJ | SOLUTION |
| HEPARIN SODIUM (PORCINE) PF 1000 UNIT/ML SOLUTION | IJ | SOLUTION |
| HEPARIN SODIUM (PORCINE) PF 5000 UNIT/0.5ML SOLUTION | IJ | SOLUTION |
| HEPARIN SODIUM (PORCINE) PF 5000 UNIT/ML SOLUTION | IJ | SOLUTION |
| HEPARIN SODIUM (PORCINE) +RFID 1000 UNIT/ML SOLUTION | IJ | SOLUTION |
| HEPARIN SOD (PORCINE) IN D5W 100 UNIT/ML SOLUTION | IV | SOLUTION |
| HEPARIN SOD (PORCINE) IN D5W 25000-5 UT/500ML-% SOLUTION | IV | SOLUTION |
| HEPARIN SOD (PORCINE) IN D5W 40-5 UNIT/ML-% SOLUTION | IV | SOLUTION |
| HEPLISAV-B 20 MCG/0.5ML SOLN PRSYR | IM | SOLN PRSYR |
| HERCEPTIN 150 MG RECON SOLN | IV | RECON SOLN |

| MEDICATION NAME | ROUTE | DOSE FORM |
|---|---|---|
| HERCEPTIN HYLECTA 600-10000 MG-UNT/5ML SOLUTION | SC | SOLUTION |
| HERCESSI 150 MG RECON SOLN | IV | RECON SOLN |
| HERCESSI 420 MG RECON SOLN | IV | RECON SOLN |
| HERZUMA 150 MG RECON SOLN | IV | RECON SOLN |
| HERZUMA 420 MG RECON SOLN | IV | RECON SOLN |
| HUMULIN R U-500 (CONCENTRATED) 500 UNIT/ML SOLUTION | SC | SOLUTION |
| HYCAMTIN 4 MG RECON SOLN | IV | RECON SOLN |
| HYDROCORTISONE SOD SUC (PF) 100 MG RECON SOLN | IJ | RECON SOLN |
| HYDROMORPHONE HCL PF 10 MG/ML SOLUTION | IJ | SOLUTION |
| HYDROMORPHONE HCL PF 500 MG/50ML SOLUTION | IJ | SOLUTION |
| HYDROMORPHONE HCL PF 50 MG/5ML SOLUTION | IJ | SOLUTION |
| HYDROXYZINE HCL 25 MG/ML SOLUTION | IM | SOLUTION |
| HYDROXYZINE HCL 50 MG/ML SOLUTION | IM | SOLUTION |
| HYOSCYAMINE SULFATE 0.5 MG/ML SOLUTION | IJ | SOLUTION |
| HYPERHEP B 110 UNIT/0.5ML SOLN PRSYR | IM | SOLN PRSYR |
| HYPERHEP B 220 UNIT/ML SOLUTION | IM | SOLUTION |
| HYPERLYTE-CR CONC | IV | CONC |
| HYPERRAB 1500 UNIT/5ML SOLUTION | IJ | SOLUTION |
| HYPERRAB 300 UNIT/ML SOLUTION | IJ | SOLUTION |
| HYPERRAB 900 UNIT/3ML SOLUTION | IJ | SOLUTION |
| HYQVIA 10 GM/100ML KIT | SC | KIT |
| HYQVIA 20 GM/200ML KIT | SC | KIT |
| HYQVIA 2.5 GM/25ML KIT | SC | KIT |
| HYQVIA 30 GM/300ML KIT | SC | KIT |
| HYQVIA 5 GM/50ML KIT | SC | KIT |
| IBANDRONATE SODIUM 3 MG/3ML SOLUTION | IV | SOLUTION |
| IDAMYCIN PFS 10 MG/10ML SOLUTION | IV | SOLUTION |
| IDAMYCIN PFS 20 MG/20ML SOLUTION | IV | SOLUTION |
| IDAMYCIN PFS 5 MG/5ML SOLUTION | IV | SOLUTION |
| IDARUBICIN HCL 10 MG/10ML SOLUTION | IV | SOLUTION |
| IDARUBICIN HCL 20 MG/20ML SOLUTION | IV | SOLUTION |
| IDARUBICIN HCL 5 MG/5ML SOLUTION | IV | SOLUTION |
| IFEX 1 GM RECON SOLN | IV | RECON SOLN |
| IFEX 3 GM RECON SOLN | IV | RECON SOLN |
| IFOSFAMIDE 1 GM/20ML SOLUTION | IV | SOLUTION |
| IFOSFAMIDE 1 GM RECON SOLN | IV | RECON SOLN |
| IFOSFAMIDE 3 GM/60ML SOLUTION | IV | SOLUTION |
| IFOSFAMIDE 3 GM RECON SOLN | IV | RECON SOLN |
| IMAAVY 1200 MG/6.5ML SOLUTION | IV | SOLUTION |
| IMAAVY 300 MG/1.62ML SOLUTION | IV | SOLUTION |
| IMDELLTRA 10 MG RECON SOLN | IV | RECON SOLN |

| MEDICATION NAME | ROUTE | DOSE FORM |
|---|---|---|
| IMDELLTRA 1 MG RECON SOLN | IV | RECON SOLN |
| IMFINZI 120 MG/2.4ML SOLUTION | IV | SOLUTION |
| IMFINZI 500 MG/10ML SOLUTION | IV | SOLUTION |
| IMLYGIC 100000000 UNIT/ML SUSPENSION | LS | SUSPENSION |
| IMLYGIC 1000000 UNIT/ML SUSPENSION | LS | SUSPENSION |
| IMOGAM RABIES-HT 300 UNIT/2ML SOLUTION | IJ | SOLUTION |
| IMULDOSA 130 MG/26ML SOLUTION | IV | SOLUTION |
| IMURAN 50 MG TAB | PO | TAB |
| INFLECTRA 100 MG RECON SOLN | IV | RECON SOLN |
| INFLIXIMAB 100 MG RECON SOLN | IV | RECON SOLN |
| INFUGEM 1200-0.9 MG/120ML-% SOLUTION | IV | SOLUTION |
| INFUGEM 1300-0.9 MG/130ML-% SOLUTION | IV | SOLUTION |
| INFUGEM 1400-0.9 MG/140ML-% SOLUTION | IV | SOLUTION |
| INFUGEM 1500-0.9 MG/150ML-% SOLUTION | IV | SOLUTION |
| INFUGEM 1600-0.9 MG/160ML-% SOLUTION | IV | SOLUTION |
| INFUGEM 1700-0.9 MG/170ML-% SOLUTION | IV | SOLUTION |
| INFUGEM 1800-0.9 MG/180ML-% SOLUTION | IV | SOLUTION |
| INFUGEM 1900-0.9 MG/190ML-% SOLUTION | IV | SOLUTION |
| INFUGEM 2000-0.9 MG/200ML-% SOLUTION | IV | SOLUTION |
| INFUGEM 2200-0.9 MG/220ML-% SOLUTION | IV | SOLUTION |
| INFUMORPH 200 200 MG/20ML (10 MG/ML) SOLUTION | IJ | SOLUTION |
| INFUMORPH 500 500 MG/20ML (25 MG/ML) SOLUTION | IJ | SOLUTION |
| INTRALIPID 20 % EMULSION | IV | EMULSION |
| INTRALIPID 30 % EMULSION | IV | EMULSION |
| INVEGA HAFYERA 1092 MG/3.5ML SUSP PRSYR | IM | SUSP PRSYR |
| INVEGA HAFYERA 1560 MG/5ML SUSP PRSYR | IM | SUSP PRSYR |
| INVEGA SUSTENNA 117 MG/0.75ML SUSP PRSYR | IM | SUSP PRSYR |
| INVEGA SUSTENNA 156 MG/ML SUSP PRSYR | IM | SUSP PRSYR |
| INVEGA SUSTENNA 234 MG/1.5ML SUSP PRSYR | IM | SUSP PRSYR |
| INVEGA SUSTENNA 39 MG/0.25ML SUSP PRSYR | IM | SUSP PRSYR |
| INVEGA SUSTENNA 78 MG/0.5ML SUSP PRSYR | IM | SUSP PRSYR |
| INVEGA TRINZA 273 MG/0.88ML SUSP PRSYR | IM | SUSP PRSYR |
| INVEGA TRINZA 410 MG/1.32ML SUSP PRSYR | IM | SUSP PRSYR |
| INVEGA TRINZA 546 MG/1.75ML SUSP PRSYR | IM | SUSP PRSYR |
| INVEGA TRINZA 819 MG/2.63ML SUSP PRSYR | IM | SUSP PRSYR |
| IONOSOL-MB IN D5W SOLUTION | IV | SOLUTION |
| IPRATROPIUM-ALBUTEROL 0.5-2.5 (3) MG/3ML SOLUTION | IN | SOLUTION |
| IPRATROPIUM BROMIDE 0.02 % SOLUTION | IN | SOLUTION |
| IRINOTECAN HCL 100 MG/5ML SOLUTION | IV | SOLUTION |
| IRINOTECAN HCL 300 MG/15ML SOLUTION | IV | SOLUTION |
| IRINOTECAN HCL 40 MG/2ML SOLUTION | IV | SOLUTION |

| MEDICATION NAME | ROUTE | DOSE FORM |
|---|---|---|
| IRINOTECAN HCL 500 MG/25ML SOLUTION | IV | SOLUTION |
| ISOLYTE-P IN D5W SOLUTION | IV | SOLUTION |
| ISOLYTE-S PH 7.4 SOLUTION | IV | SOLUTION |
| ISOLYTE-S SOLUTION | IV | SOLUTION |
| ISTODAX 10 MG RECON SOLN | IV | RECON SOLN |
| IVRA 90 MG/ML SOLUTION | IV | SOLUTION |
| IXEMPRA KIT 15 MG RECON SOLN | IV | RECON SOLN |
| IXEMPRA KIT 45 MG RECON SOLN | IV | RECON SOLN |
| JEMPERLI 500 MG/10ML SOLUTION | IV | SOLUTION |
| JOBEVNE 100 MG/4ML SOLUTION | IV | SOLUTION |
| JOBEVNE 400 MG/16ML SOLUTION | IV | SOLUTION |
| JUBEREQ 120 MG/1.7ML SOLUTION | SC | SOLUTION |
| KABIVEN 3.3-10.8-3.9 % EMULSION | IV | EMULSION |
| KADCYLA 100 MG RECON SOLN | IV | RECON SOLN |
| KADCYLA 160 MG RECON SOLN | IV | RECON SOLN |
| KANJINTI 150 MG RECON SOLN | IV | RECON SOLN |
| KANJINTI 420 MG RECON SOLN | IV | RECON SOLN |
| KANUMA 20 MG/10ML SOLUTION | IV | SOLUTION |
| KCL (0.149%) IN NACL 20-0.45 MEQ/L-% SOLUTION | IV | SOLUTION |
| KCL IN DEXTROSE-NACL 10-5-0.45 MEQ/L-%-% SOLUTION | IV | SOLUTION |
| KCL IN DEXTROSE-NACL 30-5-0.45 MEQ/L-%-% SOLUTION | IV | SOLUTION |
| KCL IN DEXTROSE-NACL 40-5-0.45 MEQ/L-%-% SOLUTION | IV | SOLUTION |
| KCL (IN NACL 0.9%) 40 MEQ/500ML SOLUTION | IV | SOLUTION |
| KEDRAB 1500 UNIT/10ML SOLUTION | IJ | SOLUTION |
| KEDRAB 300 UNIT/2ML SOLUTION | IJ | SOLUTION |
| KEMOPLAT 50 MG/50ML SOLUTION | IV | SOLUTION |
| KENALOG-10 10 MG/ML SUSPENSION | IJ | SUSPENSION |
| KENALOG-40 40 MG/ML SUSPENSION | IJ | SUSPENSION |
| KENALOG-80 80 MG/ML SUSPENSION | IJ | SUSPENSION |
| KEPPRA 500 MG/5ML SOLUTION | IV | SOLUTION |
| KETOROLAC TROMETHAMINE 15 MG/ML SOLUTION | IJ | SOLUTION |
| KETOROLAC TROMETHAMINE 30 MG/ML SOLUTION | IJ | SOLUTION |
| KETOROLAC TROMETHAMINE 60 MG/2ML SOLUTION | IM | SOLUTION |
| KEYTRUDA 100 MG/4ML SOLUTION | IV | SOLUTION |
| KEYTRUDA QLEX 395-4800 MG -UNT/2.4ML SOLUTION | SC | SOLUTION |
| KEYTRUDA QLEX 790-9600 MG -UNT/4.8ML SOLUTION | SC | SOLUTION |
| KHAPZORY 175 MG RECON SOLN | IV | RECON SOLN |
| KHAPZORY 300 MG RECON SOLN | IV | RECON SOLN |
| KIMMTRAK 100 MCG/0.5ML SOLUTION | IV | SOLUTION |

| MEDICATION NAME | ROUTE | DOSE FORM |
|---|---|---|
| KIMYRSA 1200 MG RECON SOLN | IV | RECON SOLN |
| KITABIS PAK 300 MG/5ML NEBU SOLN | IN | NEBU SOLN |
| KRYSTEXXA 8 MG/50ML SOLUTION | IV | SOLUTION |
| KRYSTEXXA 8 MG/ML SOLUTION | IV | SOLUTION |
| KYLEENA 19.5 MG IUD | IU | IUD |
| KYPROLIS 10 MG RECON SOLN | IV | RECON SOLN |
| KYPROLIS 30 MG RECON SOLN | IV | RECON SOLN |
| KYPROLIS 60 MG RECON SOLN | IV | RECON SOLN |
| KYXATA 500 MG/50ML SOLUTION | IV | SOLUTION |
| KYXATA 80 MG/8ML SOLUTION | IV | SOLUTION |
| LACOSAMIDE 200 MG/20ML SOLUTION | IV | SOLUTION |
| LAMZEDE 10 MG RECON SOLN | IV | RECON SOLN |
| LANOXIN 0.25 MG/ML SOLUTION | IJ | SOLUTION |
| LANOXIN PEDIATRIC 0.1 MG/ML SOLUTION | IJ | SOLUTION |
| LANREOTIDE ACETATE 120 MG/0.5ML SOLUTION | SC | SOLUTION |
| LANTHANUM CARBONATE 1000 MG CHEW TAB | PO | CHEW TAB |
| LANTHANUM CARBONATE 500 MG CHEW TAB | PO | CHEW TAB |
| LANTHANUM CARBONATE 750 MG CHEW TAB | PO | CHEW TAB |
| LEMTRADA 12 MG/1.2ML SOLUTION | IV | SOLUTION |
| LEQVIO 284 MG/1.5ML SOLN PRSYR | SC | SOLN PRSYR |
| LEUCOVORIN CALCIUM 500 MG/50ML SOLUTION | IJ | SOLUTION |
| LEVETIRACETAM 500 MG/5ML SOLUTION | IV | SOLUTION |
| LEVETIRACETAM IN NACL 1000 MG/100ML SOLUTION | IV | SOLUTION |
| LEVETIRACETAM IN NACL 1500 MG/100ML SOLUTION | IV | SOLUTION |
| LEVETIRACETAM IN NACL 250 MG/50ML SOLUTION | IV | SOLUTION |
| LEVETIRACETAM IN NACL 500 MG/100ML SOLUTION | IV | SOLUTION |
| LEVOCARNITINE 200 MG/ML SOLUTION | IV | SOLUTION |
| LEVOFLOXACIN IN D5W 250 MG/50ML SOLUTION | IV | SOLUTION |
| LEVOLEUCOVORIN CALCIUM 50 MG RECON SOLN | IV | RECON SOLN |
| LEVOLEUCOVORIN CALCIUM PF 175 MG/17.5ML SOLUTION | IV | SOLUTION |
| LEVOLEUCOVORIN CALCIUM PF 250 MG/25ML SOLUTION | IV | SOLUTION |
| LEVOTHYROXINE SODIUM 100 MCG/5ML SOLUTION | IV | SOLUTION |
| LEVOTHYROXINE SODIUM 100 MCG/ML SOLUTION | IV | SOLUTION |
| LEVOTHYROXINE SODIUM 100 MCG RECON SOLN | IV | RECON SOLN |
| LEVOTHYROXINE SODIUM 200 MCG/5ML SOLUTION | IV | SOLUTION |
| LEVOTHYROXINE SODIUM 200 MCG RECON SOLN | IV | RECON SOLN |
| LEVOTHYROXINE SODIUM 500 MCG/5ML SOLUTION | IV | SOLUTION |
| LEVOTHYROXINE SODIUM 500 MCG RECON SOLN | IV | RECON SOLN |
| LEVSIN 0.5 MG/ML SOLUTION | IJ | SOLUTION |
| LEVULAN KERASTICK 20 % RECON SOLN | EX | RECON SOLN |

| MEDICATION NAME | ROUTE | DOSE FORM |
|---|---|---|
| LIBTAYO 350 MG/7ML SOLUTION | IV | SOLUTION |
| LIDOCAINE-EPINEPHRINE 0.5 %-1:200000 SOLUTION | IJ | SOLUTION |
| LIDOCAINE-EPINEPHRINE 1 %-1:100000 SOLUTION | IJ | SOLUTION |
| LIDOCAINE-EPINEPHRINE 2 %-1:100000 SOLUTION | IJ | SOLUTION |
| LIDOCAINE-EPINEPHRINE 2 %-1:200000 SOLUTION | IJ | SOLUTION |
| LIDOCAINE-EPINEPHRINE (PF) 1.5 %-1:200000 SOLUTION | IJ | SOLUTION |
| LIDOCAINE-EPINEPHRINE (PF) 2 %-1:200000 SOLUTION | IJ | SOLUTION |
| LIDOCAINE HCL (CARDIAC) PF 100 MG/5ML SOLUTION | IV | SOLUTION |
| LIORESAL 0.05 MG/ML SOLUTION | IT | SOLUTION |
| LIORESAL 10 MG/5ML SOLUTION | IT | SOLUTION |
| LIORESAL 40 MG/20ML SOLUTION | IT | SOLUTION |
| LIOTHYRONINE SODIUM 10 MCG/ML SOLUTION | IV | SOLUTION |
| LOARGYS 2 MG/0.4ML SOLUTION | IJ | SOLUTION |
| LOQTORZI 240 MG/6ML SOLUTION | IV | SOLUTION |
| LORAZEPAM 2 MG/ML SOLUTION | IJ | SOLUTION |
| LORAZEPAM 4 MG/ML SOLUTION | IJ | SOLUTION |
| LUMIZYME 50 MG RECON SOLN | IV | RECON SOLN |
| LUMOXITI 1 MG RECON SOLN | IV | RECON SOLN |
| LUMVOA 500 MG/10ML SOLUTION | IV | SOLUTION |
| LUNSUMIO 1 MG/ML SOLUTION | IV | SOLUTION |
| LUNSUMIO 30 MG/30ML SOLUTION | IV | SOLUTION |
| LUNSUMIO VELO 45 MG/ML SOLUTION | SC | SOLUTION |
| LUNSUMIO VELO 5 MG/0.5ML SOLUTION | SC | SOLUTION |
| LUPRON DEPOT-PED (1-MONTH) 11.25 MG KIT | IM | KIT |
| LUPRON DEPOT-PED (1-MONTH) 15 MG KIT | IM | KIT |
| LUPRON DEPOT-PED (1-MONTH) 7.5 MG KIT | IM | KIT |
| LUPRON DEPOT-PED (3-MONTH) 11.25 MG (PED) KIT | IM | KIT |
| LUPRON DEPOT-PED (3-MONTH) 30 MG KIT | IM | KIT |
| LUPRON DEPOT-PED (6-MONTH) 45 MG KIT | IM | KIT |
| LYMPHIR 300 MCG RECON SOLN | IV | RECON SOLN |
| LYNOZYFIC 200 MG/10ML SOLUTION | IV | SOLUTION |
| LYNOZYFIC 5 MG/2.5ML SOLUTION | IV | SOLUTION |
| MAGNESIUM SULFATE 20 GM/500ML SOLUTION | IV | SOLUTION |
| MAGNESIUM SULFATE 2 GM/50ML SOLUTION | IV | SOLUTION |
| MAGNESIUM SULFATE 3 GM/100ML SOLUTION | IV | SOLUTION |
| MAGNESIUM SULFATE 40 GM/1000ML SOLUTION | IV | SOLUTION |
| MAGNESIUM SULFATE 4 GM/100ML SOLUTION | IV | SOLUTION |
| MAGNESIUM SULFATE 4 GM/50ML SOLUTION | IV | SOLUTION |
| MAGNESIUM SULFATE IN D5W 1-5 GM/100ML-% SOLUTION | IV | SOLUTION |
| MAGNESIUM SULFATE-NACL 2-0.9 GM/50ML-% SOLUTION | IV | SOLUTION |

| MEDICATION NAME | ROUTE | DOSE FORM |
|---|---|---|
| MANGANESE CHLORIDE 0.1 MG/ML SOLUTION | IV | SOLUTION |
| MANNITOL 20 % SOLUTION | IV | SOLUTION |
| MANNITOL 25 % SOLUTION | IV | SOLUTION |
| MARGENZA 250 MG/10ML SOLUTION | IV | SOLUTION |
| MARINOL 10 MG CAP | PO | CAP |
| MARINOL 2.5 MG CAP | PO | CAP |
| MARINOL 5 MG CAP | PO | CAP |
| MELPHALAN 2 MG TAB | PO | TAB |
| MELPHALAN HCL 50 MG RECON SOLN | IV | RECON SOLN |
| MEPERIDINE HCL 100 MG/ML SOLUTION | IJ | SOLUTION |
| MEPERIDINE HCL 25 MG/ML SOLUTION | IJ | SOLUTION |
| MEPERIDINE HCL 50 MG/ML SOLUTION | IJ | SOLUTION |
| MEPSEVII 10 MG/5ML SOLUTION | IV | SOLUTION |
| METHOCARBAMOL 1000 MG/10ML SOLUTION | IJ | SOLUTION |
| METHOTREXATE SODIUM 250 MG/10ML SOLUTION | IJ | SOLUTION |
| METHOTREXATE SODIUM 50 MG/2ML SOLUTION | IJ | SOLUTION |
| METHOTREXATE SODIUM (PF) 1000 MG/40ML SOLUTION | IJ | SOLUTION |
| METHOTREXATE SODIUM (PF) 1 GM/40ML SOLUTION | IJ | SOLUTION |
| METHOTREXATE SODIUM (PF) 250 MG/10ML SOLUTION | IJ | SOLUTION |
| METHOTREXATE SODIUM (PF) 50 MG/2ML SOLUTION | IJ | SOLUTION |
| METHYLPREDNISOLONE ACETATE 50 MG/ML SUSPENSION | IJ | SUSPENSION |
| METHYLPREDNISOLONE SODIUM SUCC 1000 MG RECON SOLN | IJ | RECON SOLN |
| METHYLPREDNISOLONE SODIUM SUCC 125 MG RECON SOLN | IJ | RECON SOLN |
| METHYLPREDNISOLONE SODIUM SUCC 500 MG RECON SOLN | IJ | RECON SOLN |
| METOPROLOL TARTRATE 5 MG/5ML SOLUTION | IV | SOLUTION |
| MIACALCIN 200 UNIT/ML SOLUTION | IJ | SOLUTION |
| MILRINONE LACTATE 10 MG/10ML SOLUTION | IV | SOLUTION |
| MILRINONE LACTATE 20 MG/20ML SOLUTION | IV | SOLUTION |
| MILRINONE LACTATE 50 MG/50ML SOLUTION | IV | SOLUTION |
| MILRINONE LACTATE IN DEXTROSE 20-5 MG/100ML-% SOLUTION | IV | SOLUTION |
| MILRINONE LACTATE IN DEXTROSE 40-5 MG/200ML-% SOLUTION | IV | SOLUTION |
| MINOCIN 100 MG RECON SOLN | IV | RECON SOLN |
| MIRCERA 100 MCG/0.3ML SOLN PRSYR | IJ | SOLN PRSYR |
| MIRCERA 120 MCG/0.3ML SOLN PRSYR | IJ | SOLN PRSYR |
| MIRCERA 150 MCG/0.3ML SOLN PRSYR | IJ | SOLN PRSYR |
| MIRCERA 200 MCG/0.3ML SOLN PRSYR | IJ | SOLN PRSYR |

| MEDICATION NAME | ROUTE | DOSE FORM |
|---|---|---|
| MIRCERA 30 MCG/0.3ML SOLN PRSYR | IJ | SOLN PRSYR |
| MIRCERA 50 MCG/0.3ML SOLN PRSYR | IJ | SOLN PRSYR |
| MIRCERA 75 MCG/0.3ML SOLN PRSYR | IJ | SOLN PRSYR |
| MIRENA (52 MG) 21 MCG/DAY IUD | IU | IUD |
| MITIGO 200 MG/20ML (10 MG/ML) SOLUTION | IJ | SOLUTION |
| MITIGO 500 MG/20ML (25 MG/ML) SOLUTION | IJ | SOLUTION |
| MITOMYCIN 20 MG RECON SOLN | IV | RECON SOLN |
| MITOMYCIN 40 MG RECON SOLN | IV | RECON SOLN |
| MITOMYCIN 5 MG RECON SOLN | IV | RECON SOLN |
| MITOXANTRONE HCL 20 MG/10ML CONC | IV | CONC |
| MITOXANTRONE HCL 25 MG/12.5ML CONC | IV | CONC |
| MITOXANTRONE HCL 30 MG/15ML CONC | IV | CONC |
| MIUDELLA IUD | IU | IUD |
| MONJUVI 200 MG RECON SOLN | IV | RECON SOLN |
| MORPHINE SULFATE 1 MG/ML SOLUTION | IJ | SOLUTION |
| MORPHINE SULFATE 2 MG/ML SOLUTION | IJ | SOLUTION |
| MORPHINE SULFATE 4 MG/ML SOLUTION | IJ | SOLUTION |
| MORPHINE SULFATE (PF) 0.5 MG/ML SOLUTION | IJ | SOLUTION |
| MORPHINE SULFATE (PF) 10 MG/ML SOLUTION | IJ | SOLUTION |
| MORPHINE SULFATE (PF) 10 MG/ML SOLUTION | IV | SOLUTION |
| MORPHINE SULFATE (PF) 1 MG/ML SOLUTION | IJ | SOLUTION |
| MORPHINE SULFATE (PF) 1 MG/ML SOLUTION | IV | SOLUTION |
| MORPHINE SULFATE (PF) 2 MG/ML SOLUTION | IJ | SOLUTION |
| MORPHINE SULFATE (PF) 2 MG/ML SOLUTION | IV | SOLUTION |
| MORPHINE SULFATE (PF) 4 MG/ML SOLUTION | IJ | SOLUTION |
| MORPHINE SULFATE (PF) 4 MG/ML SOLUTION | IV | SOLUTION |
| MORPHINE SULFATE (PF) 5 MG/ML SOLUTION | IJ | SOLUTION |
| MORPHINE SULFATE (PF) 8 MG/ML SOLUTION | IJ | SOLUTION |
| MORPHINE SULFATE (PF) 8 MG/ML SOLUTION | IV | SOLUTION |
| MOXIFLOXACIN HCL 400 MG/250ML SOLUTION | IV | SOLUTION |
| MOXIFLOXACIN HCL IN NACL 400 MG/250ML SOLUTION | IV | SOLUTION |
| MULTIPLE ELECTRO TYPE 1 PH 5.5 SOLUTION | IV | SOLUTION |
| MULTIPLE ELECTRO TYPE 1 PH 7.4 SOLUTION | IV | SOLUTION |
| MUTAMYCIN 20 MG RECON SOLN | IV | RECON SOLN |
| MUTAMYCIN 40 MG RECON SOLN | IV | RECON SOLN |
| MUTAMYCIN 5 MG RECON SOLN | IV | RECON SOLN |
| MVASI 100 MG/4ML SOLUTION | IV | SOLUTION |
| MVASI 400 MG/16ML SOLUTION | IV | SOLUTION |
| MYCOPHENOLATE MOFETIL 200 MG/ML RECON SUSP | PO | RECON SUSP |
| MYCOPHENOLATE MOFETIL 250 MG CAP | PO | CAP |
| MYCOPHENOLATE MOFETIL 500 MG RECON SOLN | IV | RECON SOLN |
| MYCOPHENOLATE MOFETIL 500 MG TAB | PO | TAB |

| MEDICATION NAME | ROUTE | DOSE FORM |
|---|---|---|
| MYCOPHENOLATE MOFETIL HCL 500 MG RECON SOLN | IV | RECON SOLN |
| MYCOPHENOLATE SODIUM 180 MG TAB DR | PO | TAB DR |
| MYCOPHENOLATE SODIUM 360 MG TAB DR | PO | TAB DR |
| MYCOPHENOLIC ACID 180 MG TAB DR | PO | TAB DR |
| MYCOPHENOLIC ACID 360 MG TAB DR | PO | TAB DR |
| MYFORTIC 180 MG TAB DR | PO | TAB DR |
| MYFORTIC 360 MG TAB DR | PO | TAB DR |
| MYHIBBIN 200 MG/ML SUSPENSION | PO | SUSPENSION |
| MYLOTARG 4.5 MG RECON SOLN | IV | RECON SOLN |
| MYOBLOC 10000 UNIT/2ML SOLUTION | IM | SOLUTION |
| MYOBLOC 2500 UNIT/0.5ML SOLUTION | IM | SOLUTION |
| MYOBLOC 5000 UNIT/ML SOLUTION | IM | SOLUTION |
| NABI-HB 312 UNIT/ML SOLUTION | IM | SOLUTION |
| NAFCILLIN SODIUM IN DEXTROSE 1 GM/50ML SOLUTION | IV | SOLUTION |
| NAFCILLIN SODIUM IN DEXTROSE 2 GM/100ML SOLUTION | IV | SOLUTION |
| NAGLAZYME 1 MG/ML SOLUTION | IV | SOLUTION |
| NALBUPHINE HCL 10 MG/ML SOLUTION | IJ | SOLUTION |
| NALBUPHINE HCL 20 MG/ML SOLUTION | IJ | SOLUTION |
| NAVITRUX 150 MG RECON SOLN | IV | RECON SOLN |
| NEBUPENT 300 MG RECON SOLN | IN | RECON SOLN |
| NELARABINE 5 MG/ML SOLUTION | IV | SOLUTION |
| NEORAL 100 MG CAP | PO | CAP |
| NEORAL 100 MG/ML SOLUTION | PO | SOLUTION |
| NEORAL 25 MG CAP | PO | CAP |
| NEULASTA 4 MG/0.4ML SOLUTION | SC | SOLUTION |
| NEULASTA 6 MG/0.6ML SOLN PRSYR | SC | SOLN PRSYR |
| NEULASTA ONPRO 6 MG/0.6ML SOLN PRSYR | SC | SOLN PRSYR |
| NEUPOGEN 300 MCG/0.5ML SOLN PRSYR | IJ | SOLN PRSYR |
| NEUPOGEN 300 MCG/ML SOLUTION | IJ | SOLUTION |
| NEUPOGEN 480 MCG/0.8ML SOLN PRSYR | IJ | SOLN PRSYR |
| NEUPOGEN 480 MCG/1.6ML SOLUTION | IJ | SOLUTION |
| NEXVIAZYME 100 MG RECON SOLN | IV | RECON SOLN |
| NICARDIPINE HCL 2.5 MG/ML SOLUTION | IV | SOLUTION |
| NIKTIMVO 22 MG/0.44ML SOLUTION | IV | SOLUTION |
| NIKTIMVO 22 MG/2.2ML SOLUTION | IV | SOLUTION |
| NIKTIMVO 9 MG/0.18ML SOLUTION | IV | SOLUTION |
| NIKTIMVO 9 MG/0.9ML SOLUTION | IV | SOLUTION |
| NIPENT 10 MG RECON SOLN | IV | RECON SOLN |
| NITROGLYCERIN 5 MG/ML SOLUTION | IV | SOLUTION |
| NITROGLYCERIN IN D5W 100-5 MCG/ML-% SOLUTION | IV | SOLUTION |

| MEDICATION NAME | ROUTE | DOSE FORM |
|---|---|---|
| NITROGLYCERIN IN D5W 200-5 MCG/ML-% SOLUTION | IV | SOLUTION |
| NITROGLYCERIN IN D5W 400-5 MCG/ML-% SOLUTION | IV | SOLUTION |
| NORMOSOL-R IN D5W SOLUTION | IV | SOLUTION |
| NORMOSOL-R PH 7.4 SOLUTION | IV | SOLUTION |
| NORMOSOL-R SOLUTION | IV | SOLUTION |
| NOVAREL 5000 UNIT RECON SOLN | IM | RECON SOLN |
| NOXAFIL 300 MG/16.7ML SOLUTION | IV | SOLUTION |
| NPLATE 125 MCG RECON SOLN | SC | RECON SOLN |
| NPLATE 250 MCG RECON SOLN | SC | RECON SOLN |
| NPLATE 500 MCG RECON SOLN | SC | RECON SOLN |
| NULIBRY 9.5 MG RECON SOLN | IV | RECON SOLN |
| NULOJIX 250 MG RECON SOLN | IV | RECON SOLN |
| NUMBRINO 40 MG/ML SOLUTION | NA | SOLUTION |
| NUTRILIPID 20 % EMULSION | IV | EMULSION |
| NUZYRA 100 MG RECON SOLN | IV | RECON SOLN |
| NYPOZI 300 MCG/0.5ML SOLN PRSYR | IJ | SOLN PRSYR |
| NYPOZI 480 MCG/0.8ML SOLN PRSYR | IJ | SOLN PRSYR |
| NYVEPRIA 6 MG/0.6ML SOLN PRSYR | SC | SOLN PRSYR |
| OCREVUS 300 MG/10ML SOLUTION | IV | SOLUTION |
| OCREVUS ZUNOVO 920-23000 MG-UT/23ML SOLUTION | SC | SOLUTION |
| OCTAGAM 10 GM/100ML SOLUTION | IV | SOLUTION |
| OCTAGAM 10 GM/200ML SOLUTION | IV | SOLUTION |
| OCTAGAM 1 GM/20ML SOLUTION | IV | SOLUTION |
| OCTAGAM 20 GM/200ML SOLUTION | IV | SOLUTION |
| OCTAGAM 25 GM/500ML SOLUTION | IV | SOLUTION |
| OCTAGAM 2.5 GM/50ML SOLUTION | IV | SOLUTION |
| OCTAGAM 2 GM/20ML SOLUTION | IV | SOLUTION |
| OCTAGAM 30 GM/300ML SOLUTION | IV | SOLUTION |
| OCTAGAM 5 GM/100ML SOLUTION | IV | SOLUTION |
| OCTAGAM 5 GM/50ML SOLUTION | IV | SOLUTION |
| OCTREOTIDE ACETATE 20 MG KIT | IM | KIT |
| OCTREOTIDE ACETATE 30 MG KIT | IM | KIT |
| OGIVRI 150 MG RECON SOLN | IV | RECON SOLN |
| OGIVRI 420 MG RECON SOLN | IV | RECON SOLN |
| OHTUVAYRE 3 MG/2.5ML SUSPENSION | IN | SUSPENSION |
| OMEGAVEN 10 GM/100ML EMULSION | IV | EMULSION |
| OMEGAVEN 5 GM/50ML EMULSION | IV | EMULSION |
| OMVOH 300 MG/15ML SOLUTION | IV | SOLUTION |
| ONAPGO 98 MG/20ML SOLN CART | SC | SOLN CART |
| ONCASPAR 750 UNIT/ML SOLUTION | IJ | SOLUTION |
| ONDANSETRON 4 MG TAB DISP | PO | TAB DISP |

| MEDICATION NAME | ROUTE | DOSE FORM |
|---|---|---|
| ONDANSETRON 8 MG TAB DISP | PO | TAB DISP |
| ONDANSETRON HCL 24 MG TAB | PO | TAB |
| ONDANSETRON HCL 2 MG/2.5ML SOLUTION | PO | SOLUTION |
| ONDANSETRON HCL 40 MG/20ML SOLUTION | IJ | SOLUTION |
| ONDANSETRON HCL 4 MG/2ML SOLN PRSYR | IJ | SOLN PRSYR |
| ONDANSETRON HCL 4 MG/2ML SOLUTION | IJ | SOLUTION |
| ONDANSETRON HCL 4 MG/5ML SOLUTION | PO | SOLUTION |
| ONDANSETRON HCL 4 MG TAB | PO | TAB |
| ONDANSETRON HCL 8 MG TAB | PO | TAB |
| ONIVYDE 43 MG/10ML SUSPENSION | IV | SUSPENSION |
| ONPATTRO 10 MG/5ML SOLUTION | IV | SOLUTION |
| ONTRUZANT 150 MG RECON SOLN | IV | RECON SOLN |
| ONTRUZANT 420 MG RECON SOLN | IV | RECON SOLN |
| OPDIVO 100 MG/10ML SOLUTION | IV | SOLUTION |
| OPDIVO 120 MG/12ML SOLUTION | IV | SOLUTION |
| OPDIVO 240 MG/24ML SOLUTION | IV | SOLUTION |
| OPDIVO 40 MG/4ML SOLUTION | IV | SOLUTION |
| OPDIVO QVANTIG 300-5000 MG -UT/2.5ML SOLUTION | SC | SOLUTION |
| OPDIVO QVANTIG 600-10000 MG-UT/5ML SOLUTION | SC | SOLUTION |
| OPDUALAG 240-80 MG/20ML SOLUTION | IV | SOLUTION |
| ORBACTIV 400 MG RECON SOLN | IV | RECON SOLN |
| ORPHENADRINE CITRATE 30 MG/ML SOLUTION | IJ | SOLUTION |
| OSENVELT 120 MG/1.7ML SOLUTION | SC | SOLUTION |
| OSMITROL 10 % SOLUTION | IV | SOLUTION |
| OSMITROL 20 % SOLUTION | IV | SOLUTION |
| OSPOMYV 60 MG/ML SOLN PRSYR | SC | SOLN PRSYR |
| OSVYRTI 60 MG/ML SOLN PRSYR | SC | SOLN PRSYR |
| OTULFI 130 MG/26ML SOLUTION | IV | SOLUTION |
| OXACILLIN SODIUM 10 GM RECON SOLN | IV | RECON SOLN |
| OXACILLIN SODIUM 1 GM RECON SOLN | IJ | RECON SOLN |
| OXACILLIN SODIUM 2 GM RECON SOLN | IJ | RECON SOLN |
| OXACILLIN SODIUM IN DEXTROSE 1 GM/50ML SOLUTION | IV | SOLUTION |
| OXACILLIN SODIUM IN DEXTROSE 2 GM/50ML SOLUTION | IV | SOLUTION |
| OXALIPLATIN 100 MG/20ML SOLUTION | IV | SOLUTION |
| OXALIPLATIN 100 MG RECON SOLN | IV | RECON SOLN |
| OXALIPLATIN 200 MG/40ML SOLUTION | IV | SOLUTION |
| OXALIPLATIN 50 MG/10ML SOLUTION | IV | SOLUTION |
| OXALIPLATIN 50 MG RECON SOLN | IV | RECON SOLN |
| OXLUMO 94.5 MG/0.5ML SOLUTION | SC | SOLUTION |
| PACLITAXEL 100 MG/16.7ML CONC | IV | CONC |
| PACLITAXEL 150 MG/25ML CONC | IV | CONC |

| MEDICATION NAME | ROUTE | DOSE FORM |
|---|---|---|
| PACLITAXEL 300 MG/50ML CONC | IV | CONC |
| PACLITAXEL 30 MG/5ML CONC | IV | CONC |
| PACLITAXEL PROTEIN-BOUND PART 100 MG RECON SUSP | IV | RECON SUSP |
| PADCEV 20 MG RECON SOLN | IV | RECON SOLN |
| PADCEV 30 MG RECON SOLN | IV | RECON SOLN |
| PALONOSETRON HCL 0.25 MG/2ML SOLUTION | IV | SOLUTION |
| PALONOSETRON HCL 0.25 MG/5ML SOLN PRSYR | IV | SOLN PRSYR |
| PALONOSETRON HCL 0.25 MG/5ML SOLUTION | IV | SOLUTION |
| PAMIDRONATE DISODIUM 6 MG/ML SOLUTION | IV | SOLUTION |
| PAMIDRONATE DISODIUM 90 MG/10ML SOLUTION | IV | SOLUTION |
| PANTOPRAZOLE SODIUM-NACL 40-0.9 MG/100ML-% SOLUTION | IV | SOLUTION |
| PANTOPRAZOLE SODIUM-NACL 40-0.9 MG/50ML-% SOLUTION | IV | SOLUTION |
| PANTOPRAZOLE SODIUM-NACL 80-0.9 MG/100ML-% SOLUTION | IV | SOLUTION |
| PANZYGA 10 GM/100ML SOLUTION | IV | SOLUTION |
| PANZYGA 1 GM/10ML SOLUTION | IV | SOLUTION |
| PANZYGA 20 GM/200ML SOLUTION | IV | SOLUTION |
| PANZYGA 2.5 GM/25ML SOLUTION | IV | SOLUTION |
| PANZYGA 30 GM/300ML SOLUTION | IV | SOLUTION |
| PANZYGA 5 GM/50ML SOLUTION | IV | SOLUTION |
| PARAGARD INTRAUTERINE COPPER IUD | IU | IUD |
| PARAPLATIN 1000 MG/100ML SOLUTION | IV | SOLUTION |
| PARAPLATIN 150 MG/15ML SOLUTION | IV | SOLUTION |
| PARAPLATIN 450 MG/45ML SOLUTION | IV | SOLUTION |
| PARAPLATIN 50 MG/5ML SOLUTION | IV | SOLUTION |
| PARAPLATIN 600 MG/60ML SOLUTION | IV | SOLUTION |
| PARICALCITOL 1 MCG CAP | PO | CAP |
| PARICALCITOL 2 MCG CAP | PO | CAP |
| PARICALCITOL 2 MCG/ML SOLUTION | IV | SOLUTION |
| PARICALCITOL 4 MCG CAP | PO | CAP |
| PARICALCITOL 5 MCG/ML SOLUTION | IV | SOLUTION |
| PEDMARK 12.5 % SOLUTION | IV | SOLUTION |
| PEMETREXED DISODIUM 1000 MG RECON SOLN | IV | RECON SOLN |
| PEMETREXED DISODIUM 100 MG/4ML SOLUTION | IV | SOLUTION |
| PEMETREXED DISODIUM 100 MG RECON SOLN | IV | RECON SOLN |
| PEMETREXED DISODIUM 1 GM/40ML SOLUTION | IV | SOLUTION |
| PEMETREXED DISODIUM 500 MG/20ML SOLUTION | IV | SOLUTION |
| PEMETREXED DISODIUM 500 MG RECON SOLN | IV | RECON SOLN |
| PEMETREXED DISODIUM 750 MG RECON SOLN | IV | RECON SOLN |
| PEMETREXED DISODIUM 850 MG/34ML SOLUTION | IV | SOLUTION |
| PEMETREXED DITROMETHAMINE 100 MG RECON SOLN | IV | RECON SOLN |

| MEDICATION NAME | ROUTE | DOSE FORM |
|---|---|---|
| PEMETREXED DITROMETHAMINE 500 MG RECON SOLN | IV | RECON SOLN |
| PEMRYDI RTU 100 MG/10ML SOLUTION | IV | SOLUTION |
| PEMRYDI RTU 500 MG/50ML SOLUTION | IV | SOLUTION |
| PENICILLIN G POT IN DEXTROSE 20000 UNIT/ML SOLUTION | IV | SOLUTION |
| PENICILLIN G POT IN DEXTROSE 40000 UNIT/ML SOLUTION | IV | SOLUTION |
| PENICILLIN G POT IN DEXTROSE 60000 UNIT/ML SOLUTION | IV | SOLUTION |
| PENICILLIN G PROCAINE 600000 UNIT/ML SUSPENSION | IM | SUSPENSION |
| PENTAMIDINE ISETHIONATE 300 MG RECON SOLN | IN | RECON SOLN |
| PERFOROMIST 20 MCG/2ML NEBU SOLN | IN | NEBU SOLN |
| PERIKABIVEN 2.4-6.8-3.5-0.5 % EMULSION | IV | EMULSION |
| PERJETA 420 MG/14ML SOLUTION | IV | SOLUTION |
| PERSERIS 120 MG PRSYR | SC | PRSYR |
| PERSERIS 90 MG PRSYR | SC | PRSYR |
| PHENERGAN 25 MG/ML SOLUTION | IJ | SOLUTION |
| PHENERGAN 50 MG/ML SOLUTION | IJ | SOLUTION |
| PHENYTOIN SODIUM 50 MG/ML SOLUTION | IJ | SOLUTION |
| PHESGO 60-60-2000 MG-MG-U/ML SOLUTION | SC | SOLUTION |
| PHESGO 80-40-2000 MG-MG-U/ML SOLUTION | SC | SOLUTION |
| PIASKY 340 MG/2ML SOLUTION | IJ | SOLUTION |
| PIPERACILLIN-TAZOBACTAM-NACL 2-0.25 GM/50ML RECON SOLN | IV | RECON SOLN |
| PIPERACILLIN-TAZOBACTAM-NACL 3-0.375 GM/50ML RECON SOLN | IV | RECON SOLN |
| PIPERACILLIN-TAZOBACTAM-NACL 4-0.5 GM/100ML RECON SOLN | IV | RECON SOLN |
| PLASMA-LYTE 148 SOLUTION | IV | SOLUTION |
| PLASMA-LYTE A SOLUTION | IV | SOLUTION |
| PLENAMINE 15 % SOLUTION | IV | SOLUTION |
| POLIVY 140 MG RECON SOLN | IV | RECON SOLN |
| POLIVY 30 MG RECON SOLN | IV | RECON SOLN |
| POMBILITI 105 MG RECON SOLN | IV | RECON SOLN |
| PORTRAZZA 800 MG/50ML SOLUTION | IV | SOLUTION |
| POSACONAZOLE 300 MG/16.7ML SOLUTION | IV | SOLUTION |
| POSFREA 0.25 MG/5ML SOLUTION | IV | SOLUTION |
| POTASSIUM ACETATE 2 MEQ/ML SOLUTION | IV | SOLUTION |
| POTASSIUM CHLORIDE 10 MEQ/50ML SOLUTION | IV | SOLUTION |
| POTASSIUM CHLORIDE 20 MEQ/50ML SOLUTION | IV | SOLUTION |
| POTASSIUM CHLORIDE IN DEXTROSE 10-5 MEQ/L-% SOLUTION | IV | SOLUTION |
| POTASSIUM CHLORIDE IN NACL 20-0.45 MEQ/L-% SOLUTION | IV | SOLUTION |

| MEDICATION NAME | ROUTE | DOSE FORM |
|---|---|---|
| POTASSIUM CHLORIDE IN NACL 20 MEQ/250ML SOLUTION | IV | SOLUTION |
| POTASSIUM PHOSPHATES 150 MMOLE/50ML SOLUTION | IV | SOLUTION |
| POTASSIUM PHOSPHATES 15 MMOLE/5ML SOLUTION | IV | SOLUTION |
| POTASSIUM PHOSPHATES 45 MMOLE/15ML SOLUTION | IV | SOLUTION |
| POTASSIUM PHOSPHATES(66 MEQ K) 45 MMOLE/15ML SOLUTION | IV | SOLUTION |
| POTASSIUM PHOSPHATES(71 MEQ K) 45 MMOLE/15ML SOLUTION | IV | SOLUTION |
| POTASSIUM PHOSPHATES-NACL 15 MMOL/100ML SOLUTION | IV | SOLUTION |
| POTASSIUM PHOSPHATES-NACL 15 MMOL/250ML SOLUTION | IV | SOLUTION |
| POTASSIUM PHOSPHATES-NACL 30 MMOL/500ML SOLUTION | IV | SOLUTION |
| POTELIGEO 20 MG/5ML SOLUTION | IV | SOLUTION |
| PRALATREXATE 20 MG/ML SOLUTION | IV | SOLUTION |
| PRALATREXATE 40 MG/2ML SOLUTION | IV | SOLUTION |
| PREGNYL 10000 UNIT RECON SOLN | IM | RECON SOLN |
| PREHEVBRIO 10 MCG/ML SUSPENSION | IM | SUSPENSION |
| PREMASOL 10 % SOLUTION | IV | SOLUTION |
| PREVYMIS 240 MG/12ML SOLUTION | IV | SOLUTION |
| PREVYMIS 480 MG/24ML SOLUTION | IV | SOLUTION |
| PRIALT 100 MCG/ML SOLUTION | IT | SOLUTION |
| PRIALT 500 MCG/20ML SOLUTION | IT | SOLUTION |
| PRIALT 500 MCG/5ML SOLUTION | IT | SOLUTION |
| PRIVIGEN 10 GM/100ML SOLUTION | IV | SOLUTION |
| PRIVIGEN 20 GM/200ML SOLUTION | IV | SOLUTION |
| PRIVIGEN 40 GM/400ML SOLUTION | IV | SOLUTION |
| PRIVIGEN 5 GM/50ML SOLUTION | IV | SOLUTION |
| PROCAINAMIDE HCL 100 MG/ML SOLUTION | IJ | SOLUTION |
| PROCAINAMIDE HCL 500 MG/ML SOLUTION | IJ | SOLUTION |
| PROCHLORPERAZINE EDISYLATE 10 MG/2ML SOLUTION | IJ | SOLUTION |
| PROCRIT 10000 UNIT/ML SOLUTION | IJ | SOLUTION |
| PROCRIT 20000 UNIT/ML SOLUTION | IJ | SOLUTION |
| PROCRIT 2000 UNIT/ML SOLUTION | IJ | SOLUTION |
| PROCRIT 3000 UNIT/ML SOLUTION | IJ | SOLUTION |
| PROCRIT 40000 UNIT/ML SOLUTION | IJ | SOLUTION |
| PROCRIT 4000 UNIT/ML SOLUTION | IJ | SOLUTION |
| PROGRAF 0.5 MG CAP | PO | CAP |
| PROGRAF 1 MG CAP | PO | CAP |
| PROGRAF 5 MG CAP | PO | CAP |

| MEDICATION NAME | ROUTE | DOSE FORM |
|---|---|---|
| PROGRAF 5 MG/ML SOLUTION | IV | SOLUTION |
| PROLASTIN-C 1000 MG/20ML SOLUTION | IV | SOLUTION |
| PROLEUKIN 22000000 UNIT RECON SOLN | IV | RECON SOLN |
| PROLIA 60 MG/ML SOLN PRSYR | SC | SOLN PRSYR |
| PROMETHAZINE HCL 25 MG/ML SOLUTION | IJ | SOLUTION |
| PROMETHAZINE HCL 50 MG/ML SOLUTION | IJ | SOLUTION |
| PROPRANOLOL HCL 1 MG/ML SOLUTION | IV | SOLUTION |
| PROSOL 20 % SOLUTION | IV | SOLUTION |
| PULMICORT 0.25 MG/2ML SUSPENSION | IN | SUSPENSION |
| PULMICORT 0.5 MG/2ML SUSPENSION | IN | SUSPENSION |
| PULMICORT 1 MG/2ML SUSPENSION | IN | SUSPENSION |
| PULMOZYME 2.5 MG/2.5ML SOLUTION | IN | SOLUTION |
| PYZCHIVA 130 MG/26ML SOLUTION | IV | SOLUTION |
| QIVIGY 10 GM/100ML SOLUTION | IV | SOLUTION |
| QIVIGY 5 GM/50ML SOLUTION | IV | SOLUTION |
| RADICAVA 30 MG/100ML SOLUTION | IV | SOLUTION |
| RAPAMUNE 0.5 MG TAB | PO | TAB |
| RAPAMUNE 1 MG/ML SOLUTION | PO | SOLUTION |
| RAPAMUNE 1 MG TAB | PO | TAB |
| RAPAMUNE 2 MG TAB | PO | TAB |
| REBLOZYL 25 MG RECON SOLN | SC | RECON SOLN |
| REBLOZYL 75 MG RECON SOLN | SC | RECON SOLN |
| RECARBRIO 1.25 GM RECON SOLN | IV | RECON SOLN |
| RECOMBIVAX HB 10 MCG/ML SUSPENSION | IJ | SUSPENSION |
| RECOMBIVAX HB 10 MCG/ML SUSP PRSYR | IJ | SUSP PRSYR |
| RECOMBIVAX HB 40 MCG/ML SUSPENSION | IJ | SUSPENSION |
| RECOMBIVAX HB 5 MCG/0.5ML SUSPENSION | IJ | SUSPENSION |
| RECOMBIVAX HB 5 MCG/0.5ML SUSP PRSYR | IJ | SUSP PRSYR |
| REGONOL 10 MG/2ML SOLUTION | IV | SOLUTION |
| RELEUKO 300 MCG/0.5ML SOLN PRSYR | SC | SOLN PRSYR |
| RELEUKO 300 MCG/ML SOLUTION | IJ | SOLUTION |
| RELEUKO 480 MCG/0.8ML SOLN PRSYR | SC | SOLN PRSYR |
| RELEUKO 480 MCG/1.6ML SOLUTION | IJ | SOLUTION |
| REMICADE 100 MG RECON SOLN | IV | RECON SOLN |
| REMODULIN 100 MG/20ML SOLUTION | IJ | SOLUTION |
| REMODULIN 200 MG/20ML SOLUTION | IJ | SOLUTION |
| REMODULIN 20 MG/20ML SOLUTION | IJ | SOLUTION |
| REMODULIN 50 MG/20ML SOLUTION | IJ | SOLUTION |
| REMODULIN 8 MG/20ML SOLUTION | IJ | SOLUTION |
| RENFLEXIS 100 MG RECON SOLN | IV | RECON SOLN |
| REVATIO 10 MG/12.5ML SOLUTION | IV | SOLUTION |
| REVTORPYK 180 MG RECON SOLN | IV | RECON SOLN |
| REZZAYO 200 MG RECON SOLN | IV | RECON SOLN |
| RIABNI 100 MG/10ML SOLUTION | IV | SOLUTION |

| MEDICATION NAME | ROUTE | DOSE FORM |
|---|---|---|
| RIABNI 500 MG/50ML SOLUTION | IV | SOLUTION |
| RIBAVIRIN 6 GM RECON SOLN | IN | RECON SOLN |
| RISPERDAL CONSTA 12.5 MG SRER | IM | |
| RISPERDAL CONSTA 25 MG SRER | IM | |
| RISPERDAL CONSTA 37.5 MG SRER | IM | |
| RISPERDAL CONSTA 50 MG SRER | IM | |
| RISPERIDONE MICROSPHERES ER 12.5 MG SRER | IM | |
| RISPERIDONE MICROSPHERES ER 25 MG SRER | IM | |
| RISPERIDONE MICROSPHERES ER 37.5 MG SRER | IM | |
| RISPERIDONE MICROSPHERES ER 50 MG SRER | IM | |
| RITUXAN 100 MG/10ML SOLUTION | IV | SOLUTION |
| RITUXAN 500 MG/50ML SOLUTION | IV | SOLUTION |
| RITUXAN HYCELA 1400-23400 MG -UT/11.7ML SOLUTION | SC | SOLUTION |
| RITUXAN HYCELA 1600-26800 MG -UT/13.4ML SOLUTION | SC | SOLUTION |
| ROBAXIN 1000 MG/10ML SOLUTION | IJ | SOLUTION |
| ROLVEDON 13.2 MG/0.6ML SOLN PRSYR | SC | SOLN PRSYR |
| ROMIDEPSIN 10 MG RECON SOLN | IV | RECON SOLN |
| ROMIDEPSIN 27.5 MG/5.5ML SOLUTION | IV | SOLUTION |
| RUXIENCE 100 MG/10ML SOLUTION | IV | SOLUTION |
| RUXIENCE 500 MG/50ML SOLUTION | IV | SOLUTION |
| RYBREVANT 350 MG/7ML SOLUTION | IV | SOLUTION |
| RYBREVANT FASPRO 1600-20000 MG-UT/10ML SOLUTION | SC | SOLUTION |
| RYBREVANT FASPRO 2240-28000 MG-UT/14ML SOLUTION | SC | SOLUTION |
| RYBREVANT FASPRO 2400-30000 MG-UT/15ML SOLUTION | SC | SOLUTION |
| RYBREVANT FASPRO 3520-44000 MG-UT/22ML SOLUTION | SC | SOLUTION |
| RYKINDO 25 MG SRER | IM | |
| RYKINDO 37.5 MG SRER | IM | |
| RYKINDO 50 MG SRER | IM | |
| RYLAZE 10 MG/0.5ML SOLUTION | IM | SOLUTION |
| RYSTIGGO 280 MG/2ML SOLUTION | SC | SOLUTION |
| RYSTIGGO 420 MG/3ML SOLUTION | SC | SOLUTION |
| RYSTIGGO 560 MG/4ML SOLUTION | SC | SOLUTION |
| RYSTIGGO 840 MG/6ML SOLUTION | SC | SOLUTION |
| RYTELO 188 MG RECON SOLN | IV | RECON SOLN |
| RYTELO 47 MG RECON SOLN | IV | RECON SOLN |
| RYZNEUTA 20 MG/ML SOLN PRSYR | SC | SOLN PRSYR |
| SANDIMMUNE 100 MG CAP | PO | CAP |
| SANDIMMUNE 100 MG/ML SOLUTION | PO | SOLUTION |
| SANDIMMUNE 25 MG CAP | PO | CAP |

| MEDICATION NAME | ROUTE | DOSE FORM |
|---|---|---|
| SANDIMMUNE 50 MG/ML SOLUTION | IV | SOLUTION |
| SANDOSTATIN LAR DEPOT 10 MG KIT | IM | KIT |
| SANDOSTATIN LAR DEPOT 20 MG KIT | IM | KIT |
| SANDOSTATIN LAR DEPOT 30 MG KIT | IM | KIT |
| SAPHNELO 300 MG/2ML SOLUTION | IV | SOLUTION |
| SARCLISA 100 MG/5ML SOLUTION | IV | SOLUTION |
| SARCLISA 500 MG/25ML SOLUTION | IV | SOLUTION |
| SARCLISA ESCENA 1400 MG/10ML SOLUTION | SC | SOLUTION |
| SELARSDI 130 MG/26ML SOLUTION | IV | SOLUTION |
| SENSIPAR 30 MG TAB | PO | TAB |
| SENSIPAR 60 MG TAB | PO | TAB |
| SENSIPAR 90 MG TAB | PO | TAB |
| SEVELAMER CARBONATE 0.8 GM PACKET | PO | PACKET |
| SEVELAMER CARBONATE 2.4 GM PACKET | PO | PACKET |
| SEVELAMER CARBONATE 800 MG TAB | PO | TAB |
| SEVELAMER HCL 400 MG TAB | PO | TAB |
| SEVELAMER HCL 800 MG TAB | PO | TAB |
| SEZABY 100 MG RECON SOLN | IV | RECON SOLN |
| SILDENAFIL CITRATE 10 MG/12.5ML SOLUTION | IV | SOLUTION |
| SIMPONI ARIA 50 MG/4ML SOLUTION | IV | SOLUTION |
| SIMULECT 10 MG RECON SOLN | IV | RECON SOLN |
| SIMULECT 20 MG RECON SOLN | IV | RECON SOLN |
| SIROLIMUS 0.5 MG TAB | PO | TAB |
| SIROLIMUS 1 MG/ML SOLUTION | PO | SOLUTION |
| SIROLIMUS 1 MG TAB | PO | TAB |
| SIROLIMUS 2 MG TAB | PO | TAB |
| SIVEXTRO 200 MG RECON SOLN | IV | RECON SOLN |
| SKYLA 13.5 MG IUD | IU | IUD |
| SMOFLIPID 20 % EMULSION | IV | EMULSION |
| SODIUM ACETATE 2 MEQ/ML SOLUTION | IV | SOLUTION |
| SODIUM ACETATE 4 MEQ/ML SOLUTION | IV | SOLUTION |
| SODIUM BICARBONATE 4.2 % SOLUTION | IV | SOLUTION |
| SODIUM BICARBONATE 7.5 % SOLUTION | IV | SOLUTION |
| SODIUM BICARBONATE 8.4 % SOLUTION | IV | SOLUTION |
| SODIUM CHLORIDE 0.9 % SOLUTION | IJ | SOLUTION |
| SODIUM CHLORIDE 4 MEQ/ML SOLUTION | IV | SOLUTION |
| SODIUM DIURIL 500 MG RECON SOLN | IV | RECON SOLN |
| SODIUM EDECRIN 50 MG RECON SOLN | IV | RECON SOLN |
| SODIUM PHOSPHATES 150 MMOLE/50ML SOLUTION | IV | SOLUTION |
| SODIUM PHOSPHATES 15 MMOLE/5ML SOLUTION | IV | SOLUTION |
| SODIUM PHOSPHATES 45 MMOLE/15ML SOLUTION | IV | SOLUTION |
| SOLIRIS 300 MG/30ML SOLUTION | IV | SOLUTION |
| SOLU-CORTEF 1000 MG RECON SOLN | IJ | RECON SOLN |
| SOLU-CORTEF 100 MG RECON SOLN | IJ | RECON SOLN |

| MEDICATION NAME | ROUTE | DOSE FORM |
|---|---|---|
| SOLU-CORTEF 250 MG RECON SOLN | IJ | RECON SOLN |
| SOLU-CORTEF 500 MG RECON SOLN | IJ | RECON SOLN |
| SOLU-MEDROL 1000 MG RECON SOLN | IJ | RECON SOLN |
| SOLU-MEDROL 2 GM RECON SOLN | IJ | RECON SOLN |
| SOLU-MEDROL 500 MG RECON SOLN | IJ | RECON SOLN |
| SOLU-MEDROL (PF) 1000 MG RECON SOLN | IJ | RECON SOLN |
| SOLU-MEDROL (PF) 125 MG RECON SOLN | IJ | RECON SOLN |
| SOLU-MEDROL (PF) 40 MG RECON SOLN | IJ | RECON SOLN |
| SOLU-MEDROL (PF) 500 MG RECON SOLN | IJ | RECON SOLN |
| SOMATULINE DEPOT 120 MG/0.5ML SOLUTION | SC | SOLUTION |
| SOMATULINE DEPOT 60 MG/0.2ML SOLUTION | SC | SOLUTION |
| SOMATULINE DEPOT 90 MG/0.3ML SOLUTION | SC | SOLUTION |
| SPEVIGO 450 MG/7.5ML SOLUTION | IV | SOLUTION |
| STARJEMZA 130 MG/26ML SOLUTION | IV | SOLUTION |
| STELARA 130 MG/26ML SOLUTION | IV | SOLUTION |
| STEQEYMA 130 MG/26ML SOLUTION | IV | SOLUTION |
| STIMUFEND 6 MG/0.6ML SOLN PRSYR | SC | SOLN PRSYR |
| STOBOCLO 60 MG/ML SOLN PRSYR | SC | SOLN PRSYR |
| SUNLENCA 463.5 MG/1.5ML SOLUTION | SC | SOLUTION |
| SUSTOL 10 MG/0.4ML PRSYR | SC | PRSYR |
| SYLVANT 100 MG RECON SOLN | IV | RECON SOLN |
| SYLVANT 400 MG RECON SOLN | IV | RECON SOLN |
| SYNAGIS 100 MG/ML SOLUTION | IM | SOLUTION |
| SYNAGIS 50 MG/0.5ML SOLUTION | IM | SOLUTION |
| SYNDROS 5 MG/ML SOLUTION | PO | SOLUTION |
| SYNRIBO 3.5 MG RECON SOLN | SC | RECON SOLN |
| TACROLIMUS 0.5 MG CAP | PO | CAP |
| TACROLIMUS 1 MG CAP | PO | CAP |
| TACROLIMUS 5 MG CAP | PO | CAP |
| TACROLIMUS 5 MG/ML SOLUTION | IV | SOLUTION |
| TACROLIMUS ER 0.5 MG CAP ER 24H | PO | CAP ER 24H |
| TACROLIMUS ER 1 MG CAP ER 24H | PO | CAP ER 24H |
| TACROLIMUS ER 5 MG CAP ER 24H | PO | CAP ER 24H |
| TALVEY 3 MG/1.5ML SOLUTION | SC | SOLUTION |
| TALVEY 40 MG/ML SOLUTION | SC | SOLUTION |
| TAZICEF 1 GM/50ML SOLUTION | IV | SOLUTION |
| TECENTRIQ 1200 MG/20ML SOLUTION | IV | SOLUTION |
| TECENTRIQ 840 MG/14ML SOLUTION | IV | SOLUTION |
| TEMODAR 100 MG RECON SOLN | IV | RECON SOLN |
| TEMSIROLIMUS 25 MG/ML SOLUTION | IV | SOLUTION |
| TEPADINA 200 MG/200ML RECON SOLN | IV | RECON SOLN |
| TEPADINA 400 MG/400ML RECON SOLN | IV | RECON SOLN |
| TEPEZZA 500 MG RECON SOLN | IV | RECON SOLN |
| TEPYLUTE 100 MG/10ML SOLUTION | IV | SOLUTION |

| MEDICATION NAME | ROUTE | DOSE FORM |
|---|---|---|
| TEPYLUTE 15 MG/1.5ML SOLUTION | IV | SOLUTION |
| TEVIMBRA 100 MG/10ML SOLUTION | IV | SOLUTION |
| TEVIMBRA 150 MG/15ML SOLUTION | IV | SOLUTION |
| TEZSPIRE 210 MG/1.91ML SOLN A-INJ | SC | SOLN A-INJ |
| TEZSPIRE 210 MG/1.91ML SOLN PRSYR | SC | SOLN PRSYR |
| THYMOGLOBULIN 25 MG RECON SOLN | IV | RECON SOLN |
| TICE BCG 50 MG RECON SUSP | IS | RECON SUSP |
| TIVDAK 40 MG RECON SOLN | IV | RECON SOLN |
| TOBI 300 MG/5ML NEBU SOLN | IN | NEBU SOLN |
| TOFIDENCE 200 MG/10ML SOLUTION | IV | SOLUTION |
| TOFIDENCE 400 MG/20ML SOLUTION | IV | SOLUTION |
| TOFIDENCE 80 MG/4ML SOLUTION | IV | SOLUTION |
| TOPOSAR 100 MG/5ML SOLUTION | IV | SOLUTION |
| TOPOSAR 1 GM/50ML SOLUTION | IV | SOLUTION |
| TOPOSAR 500 MG/25ML SOLUTION | IV | SOLUTION |
| TOPOTECAN HCL 4 MG/4ML SOLUTION | IV | SOLUTION |
| TOPOTECAN HCL 4 MG RECON SOLN | IV | RECON SOLN |
| TORISEL 25 MG/ML SOLUTION | IV | SOLUTION |
| TOTECT 500 MG RECON SOLN | IV | RECON SOLN |
| TPN ELECTROLYTES CONC | IV | CONC |
| TRANEXAMIC ACID 1000 MG/10ML SOLUTION | IV | SOLUTION |
| TRAVASOL 10 % SOLUTION | IV | SOLUTION |
| TRAZIMERA 150 MG RECON SOLN | IV | RECON SOLN |
| TRAZIMERA 420 MG RECON SOLN | IV | RECON SOLN |
| TREANDA 100 MG RECON SOLN | IV | RECON SOLN |
| TREANDA 25 MG RECON SOLN | IV | RECON SOLN |
| TRELSTAR MIXJECT 11.25 MG RECON SUSP | IM | RECON SUSP |
| TRELSTAR MIXJECT 22.5 MG RECON SUSP | IM | RECON SUSP |
| TRELSTAR MIXJECT 3.75 MG RECON SUSP | IM | RECON SUSP |
| TREPROSTINIL 100 MG/20ML SOLUTION | IJ | SOLUTION |
| TREPROSTINIL 200 MG/20ML SOLUTION | IJ | SOLUTION |
| TREPROSTINIL 20 MG/20ML SOLUTION | IJ | SOLUTION |
| TREPROSTINIL 50 MG/20ML SOLUTION | IJ | SOLUTION |
| TRIAMCINOLONE ACETONIDE 10 MG/ML SUSPENSION | IJ | SUSPENSION |
| TRIAMCINOLONE ACETONIDE 40 MG/ML SUSPENSION | IJ | SUSPENSION |
| TRIAMCINOLONE ACETONIDE 50 MG/ML SUSPENSION | IJ | SUSPENSION |
| TRIAMCINOLONE ACETONIDE 80 MG/ML SUSPENSION | IJ | SUSPENSION |
| TRIESENCE 40 MG/ML SUSPENSION | IO | SUSPENSION |
| TRIOSTAT 10 MCG/ML SOLUTION | IV | SOLUTION |
| TRIPTODUR 22.5 MG SRER | IM | |
| TRISENOX 12 MG/6ML SOLUTION | IV | SOLUTION |

| MEDICATION NAME | ROUTE | DOSE FORM |
|---|---|---|
| TRODELVY 180 MG RECON SOLN | IV | RECON SOLN |
| TROPHAMINE 10 % SOLUTION | IV | SOLUTION |
| TRUXIMA 100 MG/10ML SOLUTION | IV | SOLUTION |
| TRUXIMA 500 MG/50ML SOLUTION | IV | SOLUTION |
| TYENNE 200 MG/10ML SOLUTION | IV | SOLUTION |
| TYENNE 400 MG/20ML SOLUTION | IV | SOLUTION |
| TYENNE 80 MG/4ML SOLUTION | IV | SOLUTION |
| TYRUKO 300 MG/15ML CONC | IV | CONC |
| TYSABRI 300 MG/15ML CONC | IV | CONC |
| TYVASO 0.6 MG/ML SOLUTION | IN | SOLUTION |
| TYVASO REFILL 0.6 MG/ML SOLUTION | IN | SOLUTION |
| TYVASO STARTER 0.6 MG/ML SOLUTION | IN | SOLUTION |
| TYZAVAN 1000 MG/200ML SOLUTION | IV | SOLUTION |
| TYZAVAN 1250 MG/250ML SOLUTION | IV | SOLUTION |
| TYZAVAN 1500 MG/300ML SOLUTION | IV | SOLUTION |
| TYZAVAN 1750 MG/350ML SOLUTION | IV | SOLUTION |
| TYZAVAN 2000 MG/400ML SOLUTION | IV | SOLUTION |
| TYZAVAN 500 MG/100ML SOLUTION | IV | SOLUTION |
| TYZAVAN 750 MG/150ML SOLUTION | IV | SOLUTION |
| UDENYCA ONBODY 6 MG/0.6ML SOLN PRSYR | SC | SOLN PRSYR |
| ULTOMIRIS 1100 MG/11ML SOLUTION | IV | SOLUTION |
| ULTOMIRIS 300 MG/3ML SOLUTION | IV | SOLUTION |
| UNITUXIN 17.5 MG/5ML SOLUTION | IV | SOLUTION |
| UNLOXCYT 300 MG/5ML SOLUTION | IV | SOLUTION |
| UPLIZNA 100 MG/10ML SOLUTION | IV | SOLUTION |
| UPTRAVI 1800 MCG RECON SOLN | IV | RECON SOLN |
| USTEKINUMAB 130 MG/26ML SOLUTION | IV | SOLUTION |
| USTEKINUMAB-TTWE 130 MG/26ML SOLUTION | IV | SOLUTION |
| UVADEX 20 MCG/ML SOLUTION | EC | SOLUTION |
| UZEDY 100 MG/0.28ML SUSP PRSYR | SC | SUSP PRSYR |
| UZEDY 125 MG/0.35ML SUSP PRSYR | SC | SUSP PRSYR |
| UZEDY 150 MG/0.42ML SUSP PRSYR | SC | SUSP PRSYR |
| UZEDY 200 MG/0.56ML SUSP PRSYR | SC | SUSP PRSYR |
| UZEDY 250 MG/0.7ML SUSP PRSYR | SC | SUSP PRSYR |
| UZEDY 50 MG/0.14ML SUSP PRSYR | SC | SUSP PRSYR |
| UZEDY 75 MG/0.21ML SUSP PRSYR | SC | SUSP PRSYR |
| VABOMERE 2 (1-1) GM RECON SOLN | IV | RECON SOLN |
| VALRUBICIN 40 MG/ML SOLUTION | IS | SOLUTION |
| VALSTAR 40 MG/ML SOLUTION | IS | SOLUTION |
| VANCOMYCIN HCL 1000 MG/200ML SOLUTION | IV | SOLUTION |
| VANCOMYCIN HCL 1250 MG/250ML SOLUTION | IV | SOLUTION |
| VANCOMYCIN HCL 1500 MG/300ML SOLUTION | IV | SOLUTION |
| VANCOMYCIN HCL 1750 MG/350ML SOLUTION | IV | SOLUTION |
| VANCOMYCIN HCL 2000 MG/400ML SOLUTION | IV | SOLUTION |

| MEDICATION NAME | ROUTE | DOSE FORM |
|---|---|---|
| VANCOMYCIN HCL 500 MG/100ML SOLUTION | IV | SOLUTION |
| VANCOMYCIN HCL 5 GM RECON SOLN | IV | RECON SOLN |
| VANCOMYCIN HCL 750 MG/150ML SOLUTION | IV | SOLUTION |
| VANCOMYCIN HCL IN DEXTROSE 1.25-5 GM/250ML-% SOLUTION | IV | SOLUTION |
| VANCOMYCIN HCL IN DEXTROSE 1.5-5 GM/250ML-% SOLUTION | IV | SOLUTION |
| VANCOMYCIN HCL IN DEXTROSE 1.5-5 GM/300ML-% SOLUTION | IV | SOLUTION |
| VANCOMYCIN HCL IN DEXTROSE 1-5 GM/200ML-% SOLUTION | IV | SOLUTION |
| VANCOMYCIN HCL IN DEXTROSE 500-5 MG/100ML-% SOLUTION | IV | SOLUTION |
| VANCOMYCIN HCL IN DEXTROSE 750-5 MG/150ML-% SOLUTION | IV | SOLUTION |
| VANCOMYCIN HCL IN NACL 1-0.9 GM/200ML-% SOLUTION | IV | SOLUTION |
| VANCOMYCIN HCL IN NACL 1-0.9 GM/250ML-% SOLUTION | IV | SOLUTION |
| VANCOMYCIN HCL IN NACL 1.25-0.9 GM/250ML-% SOLUTION | IV | SOLUTION |
| VANCOMYCIN HCL IN NACL 1.5-0.9 GM/250ML-% SOLUTION | IV | SOLUTION |
| VANCOMYCIN HCL IN NACL 1.5-0.9 GM/500ML-% SOLUTION | IV | SOLUTION |
| VANCOMYCIN HCL IN NACL 1.75-0.9 GM/250ML-% SOLUTION | IV | SOLUTION |
| VANCOMYCIN HCL IN NACL 1.75-0.9 GM/500ML-% SOLUTION | IV | SOLUTION |
| VANCOMYCIN HCL IN NACL 2-0.9 GM/500ML-% SOLUTION | IV | SOLUTION |
| VANCOMYCIN HCL IN NACL 500-0.9 MG/100ML-% SOLUTION | IV | SOLUTION |
| VANCOMYCIN HCL IN NACL 750-0.9 MG/150ML-% SOLUTION | IV | SOLUTION |
| VANCOMYCIN HCL IN NACL 750-0.9 MG/250ML-% SOLUTION | IV | SOLUTION |
| VARUBI (180 MG DOSE) 2 X 90 MG TAB THPK | PO | TAB THPK |
| VECTIBIX 100 MG/5ML SOLUTION | IV | SOLUTION |
| VECTIBIX 400 MG/20ML SOLUTION | IV | SOLUTION |
| VEGZELMA 100 MG/4ML SOLUTION | IV | SOLUTION |
| VEGZELMA 400 MG/16ML SOLUTION | IV | SOLUTION |
| VELETRI 0.5 MG RECON SOLN | IV | RECON SOLN |
| VELETRI 1.5 MG RECON SOLN | IV | RECON SOLN |
| VELPHORO 500 MG CHEW TAB | PO | CHEW TAB |
| VENTAVIS 10 MCG/ML SOLUTION | IN | SOLUTION |
| VENTAVIS 20 MCG/ML SOLUTION | IN | SOLUTION |
| VEOPOZ 400 MG/2ML SOLUTION | IJ | SOLUTION |

| MEDICATION NAME | ROUTE | DOSE FORM |
|---|---|---|
| VERAPAMIL HCL 2.5 MG/ML SOLUTION | IV | SOLUTION |
| VFEND IV 200 MG RECON SOLN | IV | RECON SOLN |
| VIBATIV 750 MG RECON SOLN | IV | RECON SOLN |
| VIDAZA 100 MG RECON SUSP | IJ | RECON SUSP |
| VIMIZIM 5 MG/5ML SOLUTION | IV | SOLUTION |
| VIMPAT 200 MG/20ML SOLUTION | IV | SOLUTION |
| VINBLASTINE SULFATE 1 MG/ML SOLUTION | IV | SOLUTION |
| VINCASAR PFS 1 MG/ML SOLUTION | IV | SOLUTION |
| VINCRISTINE SULFATE 1 MG/ML SOLUTION | IV | SOLUTION |
| VINCRISTINE SULFATE 2 MG/2ML SOLUTION | IV | SOLUTION |
| VINORELBINE TARTRATE 10 MG/ML SOLUTION | IV | SOLUTION |
| VINORELBINE TARTRATE 50 MG/5ML SOLUTION | IV | SOLUTION |
| VIRAZOLE 6 GM RECON SOLN | IN | RECON SOLN |
| VIVIMUSTA 100 MG/4ML SOLUTION | IV | SOLUTION |
| VIVITROL 380 MG RECON SUSP | IM | RECON SUSP |
| VORICONAZOLE 200 MG/20ML SOLUTION | IV | SOLUTION |
| VORICONAZOLE 200 MG RECON SOLN | IV | RECON SOLN |
| VPRIV 400 UNIT RECON SOLN | IV | RECON SOLN |
| VYEPTI 100 MG/ML SOLUTION | IV | SOLUTION |
| VYKOURA 350 MG/35ML SOLUTION | IJ | SOLUTION |
| VYKOURA 500 MG/50ML SOLUTION | IJ | SOLUTION |
| VYKOURA 50 MG/5ML SOLUTION | IJ | SOLUTION |
| VYVGART 400 MG/20ML SOLUTION | IV | SOLUTION |
| VYVGART HYTRULO 180-2000 MG-UNIT/ML SOLUTION | SC | SOLUTION |
| VYXEOS 44-100 MG RECON SUSP | IV | RECON SUSP |
| WAINUA 45 MG/0.8ML SOLN PRSYR | SC | SOLN PRSYR |
| WEZLANA 130 MG/26ML SOLUTION | IV | SOLUTION |
| WINRHO SDF 15000 UNIT/13ML SOLUTION | IJ | SOLUTION |
| WINRHO SDF 1500 UNIT/1.3ML SOLUTION | IJ | SOLUTION |
| WINRHO SDF 2500 UNIT/2.2ML SOLUTION | IJ | SOLUTION |
| WINRHO SDF 5000 UNIT/4.4ML SOLUTION | IJ | SOLUTION |
| XEMBIFY 10 GM/50ML SOLUTION | SC | SOLUTION |
| XEMBIFY 1 GM/5ML SOLUTION | SC | SOLUTION |
| XEMBIFY 2 GM/10ML SOLUTION | SC | SOLUTION |
| XEMBIFY 4 GM/20ML SOLUTION | SC | SOLUTION |
| XENLETA 150 MG/15ML SOLUTION | IV | SOLUTION |
| XENPOZYME 20 MG RECON SOLN | IV | RECON SOLN |
| XENPOZYME 4 MG RECON SOLN | IV | RECON SOLN |
| XEOMIN 100 UNIT RECON SOLN | IM | RECON SOLN |
| XEOMIN 200 UNIT RECON SOLN | IM | RECON SOLN |
| XEOMIN 50 UNIT RECON SOLN | IM | RECON SOLN |
| XERAVA 100 MG RECON SOLN | IV | RECON SOLN |
| XERAVA 50 MG RECON SOLN | IV | RECON SOLN |

| MEDICATION NAME | ROUTE | DOSE FORM |
|---|---|---|
| XGEVA 120 MG/1.7ML SOLUTION | SC | SOLUTION |
| XIPERE 40 MG/ML SUSPENSION | IO | SUSPENSION |
| XOLAIR 150 MG RECON SOLN | SC | RECON SOLN |
| XOPENEX 0.31 MG/3ML NEBU SOLN | IN | NEBU SOLN |
| XOPENEX 0.63 MG/3ML NEBU SOLN | IN | NEBU SOLN |
| XOPENEX 1.25 MG/3ML NEBU SOLN | IN | NEBU SOLN |
| XOPENEX CONCENTRATE 1.25 MG/0.5ML NEBU SOLN | IN | NEBU SOLN |
| XYLOCAINE/EPINEPHRINE 0.5 %-1:200000 SOLUTION | IJ | SOLUTION |
| XYLOCAINE/EPINEPHRINE 1 %-1:100000 SOLUTION | IJ | SOLUTION |
| XYLOCAINE/EPINEPHRINE 2 %-1:100000 SOLUTION | IJ | SOLUTION |
| XYLOCAINE-MPF/EPINEPHRINE 1 %-1:200000 SOLUTION | IJ | SOLUTION |
| XYLOCAINE-MPF/EPINEPHRINE 1.5 %-1:200000 SOLUTION | IJ | SOLUTION |
| XYLOCAINE-MPF/EPINEPHRINE 2 %-1:200000 SOLUTION | IJ | SOLUTION |
| YARTEMLEA 370 MG/2ML SOLUTION | IV | SOLUTION |
| YERVOY 200 MG/40ML SOLUTION | IV | SOLUTION |
| YERVOY 50 MG/10ML SOLUTION | IV | SOLUTION |
| YIMMUGO 10 GM/100ML SOLUTION | IV | SOLUTION |
| YIMMUGO 20 GM/200ML SOLUTION | IV | SOLUTION |
| YIMMUGO 5 GM/50ML SOLUTION | IV | SOLUTION |
| YONDELIS 1 MG RECON SOLN | IV | RECON SOLN |
| YUPELRI 175 MCG/3ML NEBU SOLN | IN | NEBU SOLN |
| ZALTRAP 100 MG/4ML SOLUTION | IV | SOLUTION |
| ZALTRAP 200 MG/8ML SOLUTION | IV | SOLUTION |
| ZANOSAR 1 GM RECON SOLN | IV | RECON SOLN |
| ZEMAIRA 1000 MG RECON SOLN | IV | RECON SOLN |
| ZEMAIRA 4000 MG RECON SOLN | IV | RECON SOLN |
| ZEMAIRA 5000 MG RECON SOLN | IV | RECON SOLN |
| ZEMDRI 500 MG/10ML SOLUTION | IV | SOLUTION |
| ZEMPLAR 1 MCG CAP | PO | CAP |
| ZEMPLAR 2 MCG CAP | PO | CAP |
| ZEMPLAR 2 MCG/ML SOLUTION | IV | SOLUTION |
| ZEMPLAR 5 MCG/ML SOLUTION | IV | SOLUTION |
| ZEPZELCA 4 MG RECON SOLN | IV | RECON SOLN |
| ZERBAXA 1.5 (1-0.5) GM RECON SOLN | IV | RECON SOLN |
| ZEVALIN Y-90 3.2 MG/2ML KIT | IV | KIT |
| ZIEXTENZO 6 MG/0.6ML SOLN PRSYR | SC | SOLN PRSYR |
| ZILRETTA 32 MG SRER | IX | |
| ZINPLAVA 1000 MG/40ML SOLUTION | IV | SOLUTION |
| ZIRABEV 100 MG/4ML SOLUTION | IV | SOLUTION |
| ZIRABEV 400 MG/16ML SOLUTION | IV | SOLUTION |
| ZOLADEX 10.8 MG IMPLANT | SC | IMPLANT |

| MEDICATION NAME | ROUTE | DOSE FORM |
|---|---|---|
| ZOLADEX 3.6 MG IMPLANT | SC | IMPLANT |
| ZOLEDRONIC ACID 4 MG/100ML SOLUTION | IV | SOLUTION |
| ZOLEDRONIC ACID 4 MG/5ML CONC | IV | CONC |
| ZOLEDRONIC ACID 5 MG/100ML SOLUTION | IV | SOLUTION |
| ZORTRESS 0.25 MG TAB | PO | TAB |
| ZORTRESS 0.5 MG TAB | PO | TAB |
| ZORTRESS 0.75 MG TAB | PO | TAB |
| ZORTRESS 1 MG TAB | PO | TAB |
| ZULRESSO 100 MG/20ML SOLUTION | IV | SOLUTION |
| ZUPLENZ 4 MG FILM | PO | FILM |
| ZYNLONTA 10 MG RECON SOLN | IV | RECON SOLN |
| ZYNYZ 500 MG/20ML SOLUTION | IV | SOLUTION |
| ZYPREXA RELPREVV 210 MG RECON SUSP | IM | RECON SUSP |
| ZYPREXA RELPREVV 300 MG RECON SUSP | IM | RECON SUSP |
| ZYPREXA RELPREVV 405 MG RECON SUSP | IM | RECON SUSP |