# ABALOPARATIDE (TYMLOS)

## MEDICATION(S)
TYMLOS

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
Total parathyroid hormone analog therapy has exceeded 2 years.

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

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA

N/A

# ABEMACICLIB (VERZENIO)

## MEDICATION(S)
VERZENIO

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

## OFF LABEL USES
N/A

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

## REQUIRED MEDICAL INFORMATION
N/A

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# ABIRATERONE (ZYTIGA)

## MEDICATION(S)
ABIRATERONE ACETATE

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

## OFF LABEL USES
N/A

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

## REQUIRED MEDICAL INFORMATION
N/A

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# ACALABRUTINIB (CALQUENCE)

## MEDICATION(S)
CALQUENCE

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

## OFF LABEL USES
N/A

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

## REQUIRED MEDICAL INFORMATION
N/A

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# ACETAMINOPHEN/CAFFEINE/DIHYDROCODEINE

## MEDICATION(S)
APAP-CAFF-DIHYDROCODEINE, DVORAH

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
Being used with other short-acting opioids.

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

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
30 days

## OTHER CRITERIA
N/A

# ACYCLOVIR CREAM (ZOVIRAX)

## MEDICATION(S)
ACYCLOVIR 5 % CREAM

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
N/A

## REQUIRED MEDICAL INFORMATION
Medical reason why oral antiviral drugs such as valacyclovir, acyclovir, and famciclovir cannot be tried.

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# ACYCLOVIR OINTMENT (ZOVIRAX)

## MEDICATION(S)
ACYCLOVIR 5 % OINTMENT

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
N/A

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

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# ADALIMUMAB (HUMIRA)

## MEDICATION(S)
HUMIRA, HUMIRA PEDIATRIC CROHNS START, HUMIRA PEN, HUMIRA PEN-CD/UC/HS STARTER, HUMIRA PEN-PEDIATRIC UC START, HUMIRA PEN-PS/UV/ADOL HS START, HUMIRA PEN-PSOR/UVEIT STARTER

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

## OFF LABEL USES
N/A

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

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

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

## PRESCRIBER RESTRICTION

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

## COVERAGE DURATION

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

## OTHER CRITERIA

N/A

# ADAPALENE (DIFFERIN)

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

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
N/A

## REQUIRED MEDICAL INFORMATION
N/A

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

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# ADAPALENE SWAB (PLIXDA)

## MEDICATION(S)
ADAPALENE 0.1 % PAD

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
N/A

## REQUIRED MEDICAL INFORMATION
Medical reason why the patient cannot not use adapalene 1% cream, gel, and lotion.

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# ADAPALENE TOPICAL SOLUTION (DIFFERIN)

## MEDICATION(S)
ADAPALENE 0.1 % SOLUTION

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
N/A

## REQUIRED MEDICAL INFORMATION
Medical reason why the patient cannot not use adapalene 1% cream, gel, and lotion.

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# AFATINIB DIMALEATE (GILOTRIF)

## MEDICATION(S)
GILOTRIF

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

## OFF LABEL USES
N/A

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

## REQUIRED MEDICAL INFORMATION
N/A

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

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

## OTHER CRITERIA
N/A

# ALECTINIB (ALECENSA)

## MEDICATION(S)
ALECENSA

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

## OFF LABEL USES
N/A

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

## REQUIRED MEDICAL INFORMATION
N/A

## AGE RESTRICTION
18 years of age or older.

## PRESCRIBER RESTRICTION
N/A

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

## OTHER CRITERIA
N/A

# ALISKIREN (TEKTURNA)

## MEDICATION(S)
ALISKIREN FUMARATE

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
N/A

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

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# ALITRETINOIN (PANRETIN)

## MEDICATION(S)
PANRETIN

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

## OFF LABEL USES
N/A

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

## REQUIRED MEDICAL INFORMATION
N/A

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# ALOGLIPTIN TABLET (NESINA)

## MEDICATION(S)
ALOGLIPTIN BENZOATE

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
N/A

## REQUIRED MEDICAL INFORMATION
Type-2 diabetes: patient has tried or has a medical reason for not trying metformin.

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# ALOGLIPTIN/METFORMIN TABLET (KAZANO)

## MEDICATION(S)
ALOGLIPTIN-METFORMIN HCL

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
N/A

## REQUIRED MEDICAL INFORMATION
Type-2 diabetes did not get better with use of metformin by itself.

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# ALOGLIPTIN/PIOGLITAZONE TABLET (OSENI)

## MEDICATION(S)
ALOGLIPTIN-PIOGLITAZONE

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
N/A

## REQUIRED MEDICAL INFORMATION
Type-2 diabetes: patient has tried or has a medical reason for not trying metformin.

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# ALOSETRON (LOTRONEX)

## MEDICATION(S)
ALOSETRON HCL

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
N/A

## REQUIRED MEDICAL INFORMATION
Irritable bowel syndrome with diarrhea (IBS-D), initial use: patient is female, and condition did not get better with use of an antispasmodic or antidiarrheal drug. Ongoing use: IBS symptoms improved with alosetron and patient does not have constipation problems.

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

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

## OTHER CRITERIA
N/A

# ALPELISIB (PIQRAY)

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

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

## OFF LABEL USES
N/A

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

## REQUIRED MEDICAL INFORMATION
N/A

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# ALPROSTADIL (MUSE)

## MEDICATION(S)
MUSE

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
Being used with another ED drug.

## REQUIRED MEDICAL INFORMATION
Erectile dysfunction (ED) is caused by a drug that has been reported in the medical literature to cause erectile dysfunction or erectile dysfunction is caused by an underlying medical condition.

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
Limited to 6 tablets per month.

# AMBRISENTAN (LETAIRIS)

## MEDICATION(S)
AMBRISENTAN

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
N/A

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

## AGE RESTRICTION
18 years of age or older.

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# AMIFAMPRIDINE (RUZURGI)

## MEDICATION(S)
RUZURGI

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

## OFF LABEL USES
N/A

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

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

## AGE RESTRICTION
6 years of age or older.

## PRESCRIBER RESTRICTION
Neurologist

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# AMIFAMPRIDINE PHOSPHATE (FIRDAPSE)

## MEDICATION(S)
FIRDAPSE

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

## OFF LABEL USES
N/A

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

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

## AGE RESTRICTION
18 years of age or older.

## PRESCRIBER RESTRICTION
Neurologist

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# APALUTAMIDE (ERLEADA)

## MEDICATION(S)
ERLEADA

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

## OFF LABEL USES
N/A

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

## REQUIRED MEDICAL INFORMATION
N/A

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# APOMORPHINE (APOKYN)

## MEDICATION(S)
APOMORPHINE HCL

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
N/A

## REQUIRED MEDICAL INFORMATION
Loss of control of body movements due to advanced Parkinson's disease (hypomobility): using at least two antiparkinsonian drugs, one of which is levodopa/carbidopa.

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
Neurologist

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# APREMILAST (OTEZLA)

## MEDICATION(S)
OTEZLA

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

## OFF LABEL USES
N/A

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

## REQUIRED MEDICAL INFORMATION
Behcet's Disease: treatment failure or side effect with one of the following: triamcinolone dental paste (Kenalog, Oralone) or colchicine. 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. Psoriatic arthritis (PsA): treatment failure or side effect with one DMARD drug or medical reason why methotrexate, leflunomide, and sulfasalazine cannot be used.

## AGE RESTRICTION
18 years of age or older.

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

## COVERAGE DURATION
PsO initial use: 16 weeks. PsO ongoing use, Behcet's Disease, PsA: plan year.

## OTHER CRITERIA
N/A

# APREPITANT 40MG CAPSULE (EMEND)

## MEDICATION(S)
APREPITANT 40 MG CAP

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
N/A

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

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
PONV: once per surgery.

## OTHER CRITERIA
N/A

# ARIPIPRAZOLE (ABILIFY MAINTENA ER)

## MEDICATION(S)
ABILIFY MAINTENA

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

## OFF LABEL USES
N/A

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

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

## AGE RESTRICTION
18 years of age or older.

## PRESCRIBER RESTRICTION
Psychiatrist

## COVERAGE DURATION
Plan year

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

# ARIPIPRAZOLE LAUROXIL (ARISTADA AND ARISTADA INITIO)

## MEDICATION(S)
ARISTADA, ARISTADA INITIO

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

## OFF LABEL USES
N/A

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

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

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
Schizophrenia: Psychiatrist

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

## OTHER CRITERIA
Aristada Initio: single use along with oral aripiprazole

# 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. Obstructive sleep apnea/hypopnea syndrome (OSAHS): patient has a positive sleep study for OSAHS, and Epworth Sleepiness Scale score of at least 10. Shift work sleep disorder: patient is a night shift worker working between 11pm and 7am OR patient is an early morning shift worker with starting hours between 4am and 7am OR patient is a rotating shift worker with night shifts. Bipolar Disorder: being added to current treatment regimen.

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
Bipolar Disorder: Psychiatrist

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# ASCIMINIB (SCEMBLIX)

## MEDICATION(S)
SCEMBLIX

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

## OFF LABEL USES
N/A

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

## REQUIRED MEDICAL INFORMATION
N/A

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# ASENAPINE (SAPHRIS)

## MEDICATION(S)
ASENAPINE MALEATE

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
N/A

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

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# ASENAPINE (SECUADO)

## MEDICATION(S)
SECUADO

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
N/A

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

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# ASFOTASE ALFA (STRENSIQ)

## MEDICATION(S)
STRENSIQ

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

## OFF LABEL USES
N/A

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

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

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
HPP: Endocrinologist, Geneticist, or Pediatric Specialist

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# ATOVAQUONE (MEPRON)

## MEDICATION(S)
ATOVAQUONE

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
N/A

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

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
PCP: 21days, Toxo: 6wks, Babesiosis: 7days, PCP/Toxo prevention: plan year

## OTHER CRITERIA
N/A

# AVAPRITINIB (AYVAKIT)

## MEDICATION(S)
AYVAKIT

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

## OFF LABEL USES
N/A

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

## REQUIRED MEDICAL INFORMATION
N/A

## AGE RESTRICTION
18 years of age or older.

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# AXITINIB (INLYTA)

## MEDICATION(S)
INLYTA

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

## OFF LABEL USES
N/A

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

## REQUIRED MEDICAL INFORMATION
N/A

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# AZACITIDINE (ONUREG)

## MEDICATION(S)
ONUREG

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

## OFF LABEL USES
N/A

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

## REQUIRED MEDICAL INFORMATION
N/A

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# AZTREONAM LYSINE (CAYSTON)

## MEDICATION(S)
CAYSTON

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

## OFF LABEL USES
N/A

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

## REQUIRED MEDICAL INFORMATION
N/A

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# BECAPLERMIN (REGRANEX)

## MEDICATION(S)
REGRANEX

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
Treating pressure ulcers or venous stasis ulcers.

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

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
3 months

## OTHER CRITERIA
N/A

# BEDAQUILINE (SIRTURO)

## MEDICATION(S)
SIRTURO

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
N/A

## REQUIRED MEDICAL INFORMATION
N/A

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
PLAN YEAR

## OTHER CRITERIA
N/A

# BELIMUMAB (BENLYSTA)

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

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

## OFF LABEL USES
N/A

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

## REQUIRED MEDICAL INFORMATION
Systemic Lupus Erythematous (SLE) initial use: patient is currently taking one or more of the following: prednisone, methylprednisolone, azathioprine, methotrexate, mycophenolate, chloroquine, hydroxychloroquine. Ongoing use requires prescriber statement to show patients clinical status has not worsened and patient has benefited from treatment as evidenced by one or more of the following: less number or severity of SLE flares, daily steroid dose has been lowered, or improvement in physician global assessment. Lupus Nephritis: being added to standard SLE therapy (e.g. corticosteroids, immunomodulators).

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

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

## COVERAGE DURATION
plan year

## OTHER CRITERIA
N/A

## BELUMOSUDIL (REZUROCK)

### MEDICATION(S)
REZUROCK

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

### OFF LABEL USES
N/A

### EXCLUSION CRITERIA
N/A

### REQUIRED MEDICAL INFORMATION
N/A

### AGE RESTRICTION
N/A

### PRESCRIBER RESTRICTION
N/A

### COVERAGE DURATION
plan year

### OTHER CRITERIA
N/A

# BELZUTIFAN (WELIREG)

## MEDICATION(S)
WELIREG

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

## OFF LABEL USES
N/A

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

## REQUIRED MEDICAL INFORMATION
N/A

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan Year

## OTHER CRITERIA
N/A

# BEXAROTENE (TARGRETIN TOPICAL GEL)

## MEDICATION(S)
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
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
N/A

# BINIMETINIB (MEKTOVI)

## MEDICATION(S)
MEKTOVI

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

## OFF LABEL USES
N/A

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

## REQUIRED MEDICAL INFORMATION
N/A

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# BOSENTAN (TRACLEER)

## MEDICATION(S)
BOSENTAN, TRACLEER 32 MG TAB SOL

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
N/A

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

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# BOSUTINIB (BOSULIF)

## MEDICATION(S)
BOSULIF

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

## OFF LABEL USES
N/A

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

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

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# BREXPIPRAZOLE (REXULTI)

## MEDICATION(S)
REXULTI

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
Depression: being used as a single agent

## REQUIRED MEDICAL INFORMATION
Trial of aripiprazole or medical reason for not using aripiprazole.

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# BRIGATINIB (ALUNBRIG)

## MEDICATION(S)
ALUNBRIG

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

## OFF LABEL USES
N/A

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

## REQUIRED MEDICAL INFORMATION
N/A

## AGE RESTRICTION
18 years of age or older.

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# BUDESONIDE (ENTOCORT EC)

## MEDICATION(S)
BUDESONIDE 3 MG CP DR PART

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

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

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

## REQUIRED MEDICAL INFORMATION
CD, initial use: budesonide will be used to induce remission.
CD, ongoing use: prescriber states patient responded to initial therapy and needs to continue therapy to maintain remission and there is a medical reason why guideline supported therapies (e.g. infliximab, mesalamine, azathioprine) for maintaining CD remission cannot be used.
Autoimmune hepatitis: being used with azathioprine and has a medical reason not to use prednisone or prednisolone or had severe side effect to prednisone or prednisolone that is not also seen with budesonide and initial dose is not more than 9 mg per day.
Microscopic colitis: initial dose is not more than 9 mg per day. For ongoing use: responded to initial therapy but symptoms returned after therapy was completed and dose is not more than 6 mg per day.

## AGE RESTRICTION
N/A

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

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

## OTHER CRITERIA

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

# BUDESONIDE ER TABLET (UCERIS)

## MEDICATION(S)
BUDESONIDE ER

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

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

## EXCLUSION CRITERIA
Autoimmune hepatitis: patient has liver cirrhosis.

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

## AGE RESTRICTION
N/A

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

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

## OTHER CRITERIA
N/A

# BUPRENORPHINE PATCH (BUTRANS) – NARCOTIC SAFETY INITIATIVE

## MEDICATION(S)
BUPRENORPHINE

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

## OFF LABEL USES
N/A

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

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

## AGE RESTRICTION
N/A

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

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

## OTHER CRITERIA

N/A

# BUPROPION XL (FORFIVO XL)

## MEDICATION(S)
BUPROPION HCL ER (XL) 450 MG TAB ER 24H

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
N/A

## REQUIRED MEDICAL INFORMATION
Patient currently on buproprion XL (generic Wellbutrin XL) and want to lower pill burden.

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# BUROSUMAB-TWZA (CRYSVITA SQ)

## MEDICATION(S)
CRYSVITA

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
N/A

## REQUIRED MEDICAL INFORMATION
Adult patients (18 years and older), initial use: patient has osteomalacia-related symptoms [e.g. spontaneous or unhealed bone breaks (fractures), elevated serum bone ALP] or skeletal pain that affects daily activities and not controlled with non-narcotic pain medication.
Ongoing use: improvement in patients symptoms (e.g. healing of rickets, correction of leg deformities, or increase in height for children, healing of existing fractures or lower number of new fractures, less pain with daily activities, better mobility, or ALP is lower than prior lab result).

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
XLH: Endocrinologist
TIO: Endocrinologist or oncologist

## COVERAGE DURATION
Plan year

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

# BUTALBITAL CONTAINING PRODUCTS

## MEDICATION(S)
ASCOMP-CODEINE, BAC, BUPAP, BUTALBITAL-ACETAMINOPHEN 50-300 MG CAP, BUTALBITAL-ACETAMINOPHEN 50-300 MG TAB, BUTALBITAL-ACETAMINOPHEN 50-325 MG TAB, BUTALBITAL-APAP, BUTALBITAL-APAP-CAFF-COD, BUTALBITAL-APAP-CAFFEINE, BUTALBITAL-ASA-CAFF-CODEINE, BUTALBITAL-ASPIRIN-CAFFEINE, ESGIC 50-325-40 MG CAP, FIORICET, PHRENILIN FORTE, ZEBUTAL

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
N/A

## REQUIRED MEDICAL INFORMATION
Tension Headache: trial of two prescription strength non-steroidal anti-inflammatory drugs (NSAIDs) and amount requested does not exceed the amount needed to treat the number of headache days per month and if 65 years of age and older, prescriber confirms the benefits of the drug outweigh any risks and will monitor for side effects.

## AGE RESTRICTION
N/A

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

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# BUTALBITAL/CAFFEINE/ACETAMINOPHEN ORAL SOLUTION

## MEDICATION(S)
VANATOL LQ, VANATOL S, VTOL LQ

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
N/A

## REQUIRED MEDICAL INFORMATION
Tension headaches: trial of two prescription strength non-steroidal anti-inflammatory drugs (NSAIDs) and amount requested does not exceed the amount needed to treat the number of headache days per month and medical condition that prevents using a tablet or capsule form of butalbital with caffeine and acetaminophen and if 65 years of age and older, prescriber confirms the benefits of the drug outweigh any risks and will monitor for side effects.

## AGE RESTRICTION
N/A

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

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# C1 ESTERASE INHIBITOR (BERINERT)

## MEDICATION(S)
BERINERT

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
N/A

## REQUIRED MEDICAL INFORMATION
N/A

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# C1 ESTERASE INHIBITOR (CINRYZE)

## MEDICATION(S)
CINRYZE

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

## OFF LABEL USES
N/A

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

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

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# C1 ESTERASE INHIBITOR (HAEGARDA)

## MEDICATION(S)
HAEGARDA

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

## OFF LABEL USES
N/A

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

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

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# C1 ESTERASE INHIBITOR (RUCONEST)

## MEDICATION(S)
RUCONEST

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
N/A

## REQUIRED MEDICAL INFORMATION
N/A

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# CABOZANTINIB (CABOMETYX)

## MEDICATION(S)
CABOMETYX

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

## OFF LABEL USES
N/A

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

## REQUIRED MEDICAL INFORMATION
N/A

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# CABOZANTINIB S-MALATE (COMETRIQ)

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

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

## OFF LABEL USES
N/A

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

## REQUIRED MEDICAL INFORMATION
N/A

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# CALCIPOTRIENE/BETAMETHASONE OINTMENT (TACLONEX)

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

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
N/A

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

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# CALCIPOTRIENE/BETAMETHASONE SUSPENSION (TACLONEX)

## MEDICATION(S)
CALCIPOTRIENE-BETAMETH DIPROP 0.005-0.064 % SUSPENSION

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
N/A

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

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# CANAKINUMAB (ILARIS)

## MEDICATION(S)
ILARIS

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
N/A

## REQUIRED MEDICAL INFORMATION
N/A

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
SJIA and AOSD: Rheumatologist

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# CANNABIDIOL (CBD) EXTRACT (EPIDIOLEX)

## MEDICATION(S)
EPIDIOLEX

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
N/A

## REQUIRED MEDICAL INFORMATION
Dravet syndrome: trial of two of the following anti-seizure drugs: valproic acid, topiramate, levetiracetam, and clobazam.
Lennox-Gastaut syndrome: trial of two of the following anti-seizure drugs: clonazepam, felbamate, lamotrigine, topiramate, and valproic acid.

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# CAPLACIZUMAB-YHDP (CABLIVI)

## MEDICATION(S)
CABLIVI

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
N/A

## REQUIRED MEDICAL INFORMATION
Continuation from inpatient hospital Cablivi treatment.

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

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

## OTHER CRITERIA
N/A

# CAPMATINIB (TABRECTA)

## MEDICATION(S)
TABRECTA

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

## OFF LABEL USES
N/A

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

## REQUIRED MEDICAL INFORMATION
N/A

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# CARGLUMIC ACID (CARBAGLU)

## MEDICATION(S)
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
N/A

# CARIPRAZINE HYDROCHLORIDE (VRAYLAR)

## MEDICATION(S)
VRAYLAR

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
N/A

## REQUIRED MEDICAL INFORMATION
Treatment failure or side effect to one preferred atypical antipsychotic agent (e.g. aripiprazole, clozapine, olanzapine, quetiapine, risperidone, ziprasidone).

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# CASPOFUNGIN (CANCIDAS)

## MEDICATION(S)
CASPOFUNGIN ACETATE

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
N/A

## REQUIRED MEDICAL INFORMATION
Oropharyngeal or Esophageal Candidiasis: patient has tried fluconazole OR fungal culture confirms infection is resistant to azole antifungals.
Invasive Aspergillosis: patient has tried an oral or IV azole antifungal or fungal culture confirms infection is resistant to azole antifungals.
Antifungal prophylaxis in cancer patients at high risk of febrile neutropenia [e.g. due to chemotherapy regimen, AML/MDS patient, undergoing HCST]: patient has tried fluconazole, voriconazole, or posaconazole or has a medical reason (contraindications) to azole antifungals.
Pulmonary Aspergillosis: patient has tried itraconazole or voriconazole.

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
2 months

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

# CENOBAMATE (XCOPRI)

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

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
N/A

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

## AGE RESTRICTION
18 years of age or older.

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# CERITINIB (ZYKADIA)

## MEDICATION(S)
ZYKADIA

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

## OFF LABEL USES
N/A

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

## REQUIRED MEDICAL INFORMATION
N/A

## AGE RESTRICTION
18 years of age or older.

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# CHOLIC ACID (CHOLBAM)

## MEDICATION(S)
CHOLBAM

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
N/A

## REQUIRED MEDICAL INFORMATION
N/A

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# CLOBAZAM (ONFI)

## MEDICATION(S)
CLOBAZAM

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
N/A

## REQUIRED MEDICAL INFORMATION
Dravet syndrome: trial of valproic acid.
Lennox-Gastaut syndrome: trial of two of the following anti-seizure drugs: clonazepam, felbamate, lamotrigine, topiramate, and valproic acid.

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# CLOBAZAM ORAL FILM (SYMPAZAN)

## MEDICATION(S)
SYMPAZAN

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
N/A

## REQUIRED MEDICAL INFORMATION
Seizures due to Dravet Syndrome: Trial and failure or side effect with valproate and side effect to preferred clobazam (Onfi) that is not seen with Sympazan.
Lennox-Gastaut Syndrome: side effect to preferred clobazam (Onfi) that is not seen with Sympazan.

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# CLOBETASOL FOAM (OLUX, OLUX-E)

## MEDICATION(S)
CLOBETASOL PROPIONATE 0.05 % FOAM, CLOBETASOL PROPIONATE EMULSION, TOVET 0.05 % FOAM

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
N/A

## REQUIRED MEDICAL INFORMATION
Patient has tried clobetasol 0.05% topical solution.

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# CLOZAPINE SUSPENSION (VERSACLOZ)

## MEDICATION(S)
VERSACLOZ

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

## OFF LABEL USES
Parkinson's psychosis disorder

## EXCLUSION CRITERIA
N/A

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

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# COBIMETINIB (COTELLIC)

## MEDICATION(S)
COTELLIC

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

## OFF LABEL USES
N/A

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

## REQUIRED MEDICAL INFORMATION
N/A

## AGE RESTRICTION
18 years of age or older.

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# CORTICOTROPIN (CORTROPHIN)

## MEDICATION(S)
CORTROPHIN

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
N/A

## REQUIRED MEDICAL INFORMATION
Ongoing use for treating infantile spasm: medical records show continued diagnosis (e.g. EEG confirms ongoing spasm). Multiple Sclerosis (MS): patient is on a maintenance drug for MS (e.g. Tecfidera, Betaseron, glatiramer, Gilenya, Aubagio) but has an acute flare up and has had a side effect or contraindication to corticosteroids that is not seen with the use of Cortrophin. Idiopathic or lupus erythematosus associated nephrotic syndrome, first use: patient's condition has not gotten better while using at least one immunosuppressive drug (cyclophosphamide, cyclosporine, and mycophenolate), and patient's condition responded to corticosteroid therapy but has had a side effect with the therapy that would not be seen with the use of Cortrophin. Ongoing use requires prescriber statement that patient's condition has gotten better while using Cortrophin. All other FDA approved indications, first use: patient has not seen improvement of symptoms despite trying at least one different FDA approved drug for the condition other than corticosteroids, and has had a side effect to corticosteroids that is not seen with the use of Cortrophin. Ongoing use requires prescriber statement that patient's condition has gotten better while using Cortrophin.

## AGE RESTRICTION
N/A

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

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

## OTHER CRITERIA
N/A

# CORTICOTROPIN (H.P. ACTHAR GEL)

## MEDICATION(S)
ACTHAR

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
N/A

## REQUIRED MEDICAL INFORMATION
Ongoing use for treating infantile spasm: medical records show continued diagnosis (e.g. EEG confirms ongoing spasm). Multiple Sclerosis (MS): patient is on a maintenance drug for MS (e.g. Tecfidera, Betaseron, glatiramer, Gilenya, Aubagio) but has an acute flare up and has had a side effect or contraindication to corticosteroids that is not seen with the use of Acthar H.P. Idiopathic or lupus erythematosus associated nephrotic syndrome, first use: patients condition has not gotten better while using at least one immunosuppressive drug (cyclophosphamide, cyclosporine, and mycophenolate), and patients condition responded to corticosteroid therapy but has had a side effect with the therapy that would not be seen with the use of Acthar H.P. Ongoing use requires prescriber statement that patients condition has gotten better while using Acthar H.P. All other FDA approved indications, first use: patient has not seen improvement of symptoms despite trying at least one different FDA approved drug for the condition other than corticosteroids, and has had a side effect to corticosteroids that is not seen with the use of Acthar H.P. Ongoing use requires prescriber statement that patients condition has gotten better while using Acthar H.P.

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

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

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

## OTHER CRITERIA
N/A

# CRIZOTINIB (XALKORI)

## MEDICATION(S)
XALKORI

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

## OFF LABEL USES
N/A

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

## REQUIRED MEDICAL INFORMATION
N/A

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# CYSTEAMINE (CYSTAGON)

## MEDICATION(S)
CYSTAGON

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
N/A

## REQUIRED MEDICAL INFORMATION
N/A

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# CYSTEAMINE (CYSTARAN)

## MEDICATION(S)
CYSTARAN

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
N/A

## REQUIRED MEDICAL INFORMATION
N/A

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# CYSTEAMINE DELAYED RELEASE (PROCYSBI)

## MEDICATION(S)
PROCYSBI

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
N/A

## REQUIRED MEDICAL INFORMATION
N/A

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# DABRAFENIB (TAFINLAR)

## MEDICATION(S)
TAFINLAR

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

## OFF LABEL USES
N/A

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

## REQUIRED MEDICAL INFORMATION
N/A

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# DACOMITINIB (VIZIMPRO)

## MEDICATION(S)
VIZIMPRO

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

## OFF LABEL USES
N/A

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

## REQUIRED MEDICAL INFORMATION
N/A

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
Oncologist

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# DALFAMPRIDINE EXTENDED-RELEASE TABLET (AMPYRA)

## MEDICATION(S)
DALFAMPRIDINE ER

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
N/A

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

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
Neurologist or Multiple Sclerosis specialist

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

## OTHER CRITERIA
N/A

# DAPSONE GEL (ACZONE)

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

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
N/A

## REQUIRED MEDICAL INFORMATION
Patient has tried at least two preferred acne agents including: topical benzoyl peroxide containing agents, oral antibiotics (e.g. azithromycin, clindamycin, minocycline), topical anti-infectives (e.g. clindamycin), topical retinoids (e.g. adapalene, tretinoin).

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# DARBEPOETIN ALFA (ARANESP)

## MEDICATION(S)
ARANESP (ALBUMIN FREE)

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

## OFF LABEL USES
low red blood cells (anemia) due to Myelodysplastic Syndrome (MDS)

## EXCLUSION CRITERIA
N/A

## REQUIRED MEDICAL INFORMATION
Chronic kidney disease (CKD), initial: anemia confirmed by a hemoglobin (Hgb) is 10g/dL or less or a Hct of 30% or less AND target Hgb level has not been met or maintained with at least 8 weeks of max dose Retacrit OR patient has a medical reason (contraindication) not to use Retacrit OR had a side effect with Retacrit that is not seen with Aranesp OR patient has a religious belief that does not allow treatment with drugs that contain human albumin. Ongoing use: Hgb level of less than or equal to 11g/dl or a Hct of 33% or less.

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

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

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
MDS, CKD: 6 months

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

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

# DAROLUTAMIDE (NUBEQA)

## MEDICATION(S)
NUBEQA

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

## OFF LABEL USES
N/A

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

## REQUIRED MEDICAL INFORMATION
N/A

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# DASATINIB (SPRYCEL)

## MEDICATION(S)
SPRYCEL

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

## OFF LABEL USES
N/A

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

## REQUIRED MEDICAL INFORMATION
N/A

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# DECITABINE/CEDAZURIDINE (INQOVI)

## MEDICATION(S)
INQOVI

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

## OFF LABEL USES
N/A

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

## REQUIRED MEDICAL INFORMATION
N/A

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# DEFERIPRONE (FERRIPROX)

## MEDICATION(S)
DEFERIPRONE, FERRIPROX 100 MG/ML SOLUTION

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
N/A

## REQUIRED MEDICAL INFORMATION
Treatment failure or side effect with deferasirox.

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# DENOSUMAB (PROLIA)

## MEDICATION(S)
PROLIA

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
Being used with other osteoporosis drugs.

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

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA

N/A

# DENOSUMAB (XGEVA)

## MEDICATION(S)
XGEVA

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
N/A

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

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# DESONIDE 0.05% GEL (DESONATE)

## MEDICATION(S)
DESONIDE 0.05 % GEL, DESRX

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
N/A

## REQUIRED MEDICAL INFORMATION
Trial of desonide 0.05% cream, lotion, or ointment

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# DEUTETRABENAZINE (AUSTEDO)

## MEDICATION(S)
AUSTEDO

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
N/A

## REQUIRED MEDICAL INFORMATION
N/A

## AGE RESTRICTION
18 years of age or older.

## PRESCRIBER RESTRICTION
Tardive Dyskinesia: Neurologist or Psychiatrist
Huntington's Chorea: Neurologist

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# DEXAMETHASONE DOSE PACK

## MEDICATION(S)
DEXABLISS

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
N/A

## REQUIRED MEDICAL INFORMATION
Medical reason why patient cannot use preferred dexamethasone formulations.

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# DEXAMETHASONE TABLET (HEMADY)

## MEDICATION(S)
HEMADY

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
N/A

## REQUIRED MEDICAL INFORMATION
Medical reason why patient cannot use preferred dexamethasone tablet.

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# DEXTROMETHORPHAN HBR- BUPROPION HCL ER (AUVELITY)

## MEDICATION(S)
AUVELITY

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
N/A

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

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
plan year

## OTHER CRITERIA
N/A

# DEXTROMETHORPHAN HYDROBROMIDE/QUINIDINE SULFATE (NUEDEXTA)

## MEDICATION(S)
NUEDEXTA

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
N/A

## REQUIRED MEDICAL INFORMATION
N/A

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# DICLOFENAC TOPICAL GEL (SOLARAZE)

## MEDICATION(S)
DICLOFENAC SODIUM 3 % GEL

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
N/A

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

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
90 days

## OTHER CRITERIA
N/A

# DICLOFENAC TOPICAL PATCH (FLECTOR)

## MEDICATION(S)
DICLOFENAC EPOLAMINE

## 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
2 months

## OTHER CRITERIA
N/A

# DIGOXIN (LANOXIN – HIGH RISK MEDICATION)

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

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
N/A

## REQUIRED MEDICAL INFORMATION
Prescriber is aware that doses of 250 mcg/day can be potentially harmful in older adults and will monitor for side effects.

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

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# DIHYDROERGOTAMINE INJECTION (D.H.E. 45)

## MEDICATION(S)
DIHYDROERGOTAMINE MESYLATE 1 MG/ML SOLUTION

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

## OFF LABEL USES
N/A

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

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

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
Cluster Headache: Neurologist or headache specialist.

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# DIHYDROERGOTAMINE MESYLATE (MIGRANAL NASAL SPRAY)

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

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

## OFF LABEL USES
N/A

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

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

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# DIMETHYL FUMARATE (TECFIDERA)

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

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

## OFF LABEL USES
N/A

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

## REQUIRED MEDICAL INFORMATION
N/A

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# DOXYCYCLINE MONOHYDRATE (ORACEA)

## MEDICATION(S)
DOXYCYCLINE

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
N/A

## REQUIRED MEDICAL INFORMATION
Acne Rosacea: patient has tried or has a medical reason for not using a topical sulfacetamide sodium/sulfur product and a topical metronidazole product.

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# DOXYLAMINE/PYRIDOXINE TABLET (DICLEGIS DR)

## MEDICATION(S)
DOXYLAMINE-PYRIDOXINE

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
N/A

## REQUIRED MEDICAL INFORMATION
Nausea and vomiting due to pregnancy

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# DRONABINOL

## MEDICATION(S)
DRONABINOL

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
N/A

## REQUIRED MEDICAL INFORMATION
N/A

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

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

# DROXIDOPA (NORTHERA)

## MEDICATION(S)
DROXIDOPA

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
N/A

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

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
Cardiologist or Neurologist

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# DULOXETINE (DRIZALMA SPRINKLE)

## MEDICATION(S)
DRIZALMA SPRINKLE

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
N/A

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

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# DUTASTERIDE/TAMSULOSIN HCL (JALYN)

## MEDICATION(S)
DUTASTERIDE-TAMSULOSIN HCL

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
N/A

## REQUIRED MEDICAL INFORMATION
Patient tried dutasteride by itself and would like dutasteride/tamsulosin to lower pill burden, OR patient tried finasteride along with one of the following alpha blocker drugs: tamsulosin, doxazosin, prazosin, or terazosin.

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# DUVELISIB (COPIKTRA)

## MEDICATION(S)
COPIKTRA

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

## OFF LABEL USES
N/A

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

## REQUIRED MEDICAL INFORMATION
N/A

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# ELEXACAFTOR/TEZACAFTOR/IVACAFTOR (TRIKAFTA)

## MEDICATION(S)
TRIKAFTA

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

## OFF LABEL USES
N/A

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

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

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# ELIGLUSTAT (CERDELGA)

## MEDICATION(S)
CERDELGA

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

## OFF LABEL USES
N/A

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

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

## AGE RESTRICTION
18 years of age or older.

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# ELTROMBOPAG OLAMINE (PROMACTA)

## MEDICATION(S)
PROMACTA

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

## OFF LABEL USES
Myelodysplastic syndrome (MDS)-related thrombocytopenia

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

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

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

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

## OTHER CRITERIA

N/A

# ENASIDENIB MESYLATE (IDHIFA)

## MEDICATION(S)
IDHIFA

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

## OFF LABEL USES
N/A

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

## REQUIRED MEDICAL INFORMATION
N/A

## AGE RESTRICTION
AML: 18 years of age or older

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# ENCORAFENIB (BRAFTOVI)

## MEDICATION(S)
BRAFTOVI

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

## OFF LABEL USES
N/A

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

## REQUIRED MEDICAL INFORMATION
N/A

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# ENTRECTINIB (ROZLYTREK)

## MEDICATION(S)
ROZLYTREK

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

## OFF LABEL USES
N/A

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

## REQUIRED MEDICAL INFORMATION
N/A

## AGE RESTRICTION
NSCLC: 18 years of age or older. Solid Tumors: 12 years of age or older.

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# ENZALUTAMIDE (XTANDI)

## MEDICATION(S)
XTANDI

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

## OFF LABEL USES
N/A

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

## REQUIRED MEDICAL INFORMATION
N/A

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# EPOETIN ALFA-EPBX (RETACRIT)

## MEDICATION(S)
RETACRIT

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

## OFF LABEL USES
low red blood cells (anemia) due to Myelodysplastic Syndrome (MDS), anemia due to rheumatoid arthritis (RA), anemia due to ribavirin therapy

## EXCLUSION CRITERIA
N/A

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

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

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

## OTHER CRITERIA
Coverage duration for anemia due to chemo: 12 weeks and no more than 8 weeks after last dose of chemo. Coverage duration for planned surgery: 1 month, RA: 6months, anemia due to ribavirin: duration of ribavirin therapy. Excluded under Part D if covered by Part B.

# ERDAFITINIB (BALVERSA)

## MEDICATION(S)
BALVERSA

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

## OFF LABEL USES
N/A

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

## REQUIRED MEDICAL INFORMATION
N/A

## AGE RESTRICTION
18 years of age or older.

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# ERENUMAB-AOOE (AIMOVIG)

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

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
N/A

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

## AGE RESTRICTION
18 years of age or older.

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# ERGOLOID MESYLATE (HIGH RISK MEDICATION)

## MEDICATION(S)
ERGOLOID MESYLATES

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
N/A

## REQUIRED MEDICAL INFORMATION
Alzheimer's disease or vascular dementia: prescriber confirms the benefits of the drug outweigh any risks and will monitor for side effects, and patient has tried two safer drugs including donepezil, galantamine, and rivastigmine or has a medical reason for not using the safer drugs.

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

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# 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
N/A

# ESOMEPRAZOLE PACKET FOR ORAL SUSPENSION (NEXIUM)

## MEDICATION(S)
ESOMEPRAZOLE MAGNESIUM 10 MG PACKET, ESOMEPRAZOLE MAGNESIUM 20 MG PACKET, ESOMEPRAZOLE MAGNESIUM 40 MG PACKET

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
N/A

## REQUIRED MEDICAL INFORMATION
Trial of omeprazole and lansoprazole capsules.

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# ESTROGEN PRODUCTS (HIGH RISK MEDICATION)

## MEDICATION(S)
AMABELZ, CLIMARA PRO, DOTTI, DUAVEE, ESTRADIOL 0.025 MG/24HR PATCH TW, ESTRADIOL 0.025 MG/24HR PATCH WK, ESTRADIOL 0.0375 MG/24HR PATCH TW, ESTRADIOL 0.0375 MG/24HR PATCH WK, ESTRADIOL 0.05 MG/24HR PATCH TW, ESTRADIOL 0.05 MG/24HR PATCH WK, ESTRADIOL 0.06 MG/24HR PATCH WK, ESTRADIOL 0.075 MG/24HR PATCH TW, ESTRADIOL 0.075 MG/24HR PATCH WK, ESTRADIOL 0.1 MG/24HR PATCH TW, ESTRADIOL 0.1 MG/24HR PATCH WK, ESTRADIOL 0.25 MG/0.25GM GEL, ESTRADIOL 0.5 MG TAB, ESTRADIOL 0.5 MG/0.5GM GEL, ESTRADIOL 0.75 MG/0.75GM GEL, ESTRADIOL 1 MG TAB, ESTRADIOL 1 MG/GM GEL, ESTRADIOL 1.25 MG/1.25GM GEL, ESTRADIOL 2 MG TAB, ESTRADIOL-NORETHINDRONE ACET, FYAVOLV, JEVANTIQUE LO, JINTELI, LOPREEZA, LYLLANA, MENEST, MIMVEY, MIMVEY LO, NORETHINDRONE-ETH ESTRADIOL, PREMARIN 0.3 MG TAB, PREMARIN 0.45 MG TAB, PREMARIN 0.625 MG TAB, PREMARIN 0.9 MG TAB, PREMARIN 1.25 MG TAB, PREMPHASE, PREMPRO

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
N/A

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

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

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan Year

## OTHER CRITERIA
N/A

# ETANERCEPT (ENBREL – KIT, SYRINGE, SURECLICK)

## MEDICATION(S)
ENBREL, ENBREL SURECLICK

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

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

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

## REQUIRED MEDICAL INFORMATION
Spondyloarthritis (SpA): patient is not able to use NSAIDs due to history of GI bleed or ulcer OR patient has tried one RX strength NSAID in combination with a PPI and had GI side effects OR patient's condition did not respond to a trial of two different RX strength NSAIDs. polyarticular Juvenile Idiopathic Arthritis (pJIA): patient has tried one DMARD or has a medical reason why methotrexate (MTX) cannot be used. Plaque Psoriasis (PsO), initial use: patient has tried one DMARD or has a medical reason why MTX, cyclosporine, and acitretin cannot be used AND baseline PASI score 10 or more OR BSA 3% or more OR sensitive areas are involved OR disease affects daily living. PsO, ongoing use: PASI or BSA improved on Enbrel. Psoriatic Arthritis (PsA): patient has tried one DMARD or has a medical reason why MTX, leflunomide, and sulfasalazine cannot be used. Rheumatoid Arthritis (RA): patient has tried one DMARD or has medical reason why MTX, hydroxychloroquine, and sulfasalazine cannot be used. Hidradenitis suppurativa (HS): Hurley stage II or III HS and failed or had a side effect with Humira failed or has a medical reason not to use Humira. For ongoing use: clinical response seen with use of Enbrel. GVHD: treatment failure or side effect to injectable or oral corticosteroids (e.g. prednisone, methylprednisolone).

## AGE RESTRICTION
PsO: 4 years of age or older. pJIA: 2 years of age or older.

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

## COVERAGE DURATION

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

## OTHER CRITERIA

N/A

# ETHACRYNIC ACID (EDECRIN)

## MEDICATION(S)
ETHACRYNIC ACID

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
N/A

## REQUIRED MEDICAL INFORMATION
Edema, heart failure, ascites: medical reason why patient is not able to use at least one preferred generically available loop diuretic agent (e.g. bumetanide tablet, furosemide tablet, torsemide.

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
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
N/A

# EVEROLIMUS (AFINITOR)

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

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

## OFF LABEL USES
N/A

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

## REQUIRED MEDICAL INFORMATION
N/A

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# EVEROLIMUS (ZORTRESS)

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

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
N/A

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

## AGE RESTRICTION
18 years of age or older.

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

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

# EVOLOCUMAB (REPATHA)

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

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
N/A

## REQUIRED MEDICAL INFORMATION
Primary Hyperlipidemia [including Heterozygous Familial Hypercholesterolemia (HeFH) or reduction of death due to Cardiovascular Disease (CVD)]: current LDL cholesterol (LDL-C) is at or above 70mg/dl (or at or above 55mg/dl if prescriber states extreme risk for heart disease) on lipid lowering therapy (such as statins and/or ezetimibe), and being used with a high-intensity statin like atorvastatin 40-80mg or rosuvastatin 20-40mg unless patient cannot use statins due to a medical reason (contraindication) or is intolerant to statins as defined by statin related rhabdomyolysis or has had skeletal-related muscle symptoms with the use of two different statins.
Homozygous Familial Hypercholesterolemia (HoFH): a positive genetic test for LDL-R genetic mutations OR clinical evidence that confirms HoFH, current lipid-lowering regimen has not worked well enough and being used with other lipid lowering therapies (e.g. statins, ezetimibe, LDL apheresis).

## AGE RESTRICTION
Hyperlipidemia: 18 years of age or older. HoFH: 13 years of age or older.

## PRESCRIBER RESTRICTION
HoFH: Cardiologist or Endocrinologist

## COVERAGE DURATION
Plan year

## OTHER CRITERIA

N/A

# FEDRATINIB (INREBIC)

## MEDICATION(S)
INREBIC

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

## OFF LABEL USES
N/A

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

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

## AGE RESTRICTION
18 years of age or older.

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# FENFLURAMINE (FINTEPLA)

## MEDICATION(S)
FINTEPLA

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
N/A

## REQUIRED MEDICAL INFORMATION
Dravet Syndrome: Trial of two of the following anti-seizure drugs: valproic acid, topiramate, levetiracetam, and clobazam.
Lennox-Gastaut syndrome: trial of two of the following anti-seizure drugs: clonazepam, felbamate, lamotrigine, and topiramate.

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# FENOPROFEN PRODUCTS

## MEDICATION(S)
FENOPROFEN CALCIUM 400 MG CAP, FENOPROFEN CALCIUM 600 MG TAB

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
N/A

## REQUIRED MEDICAL INFORMATION
Tried two preferred NSAIDS OR has a contraindication to all preferred NSAIDs that is not seen with fenoprofen.

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# FERRIC CITRATE (AURYXIA)

## MEDICATION(S)
AURYXIA

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
N/A

## REQUIRED MEDICAL INFORMATION
Patient has high blood phosphate levels and is on dialysis due to CKD.

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# FILGRASTIM-SNDZ (ZARXIO)

## MEDICATION(S)
ZARXIO

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

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

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

## REQUIRED MEDICAL INFORMATION
Agranulocytosis, congenital neutropenia, cyclic neutropenia, or idiopathic neutropenia: neutropenia is recurring or does not go away and there is a history of recurring infections (e.g. multiple episodes of infections requiring antibiotics) or at least one hospitalization for an infection within the past year. Febrile neutropenia, neutropenia due to HIV/AIDs, or neutropenia caused by drugs other than cancer drugs: no use of pegfilgrastim within the past 14 days and absolute neutrophil count (ANC) is less than 800/mm3 or ANC is less than 1000/mm3 with neutropenia expected to last more than 5 days. Neutropenia due to cancer drug therapy: not being used with pegfilgrastim. Neutropenia due to radiation therapy: not being used with pegfilgrastim. Acute myeloid leukemia (AML): being used to prevent or reduce neutropenia due to use of cancer drug therapy. MDS: ANC is less than 800/mm3 or ANC is less than 1000/mm3 with neutropenia expected to last more than 5 days or being used with epoetin (e.g. Retacrit) to improve symptoms of low red blood cells (anemia).

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION

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

## OTHER CRITERIA

Coverage duration:
Congenital, cyclic, idiopathic neutropenia and agranulocytosis: plan year Neutropenia due to cancer drug therapy and AML: duration of cancer drug therapy
Neutropenia due to radiation: duration of radiation therapy
MDS: 3 months
Excluded under Part D if covered by Part B.

# FINGOLIMOD HCL (GILENYA)

## MEDICATION(S)
GILENYA 0.5 MG CAP

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

## OFF LABEL USES
N/A

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

## REQUIRED MEDICAL INFORMATION
N/A

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan Year

## OTHER CRITERIA
N/A

# FLUOROURACIL (CARAC)

## MEDICATION(S)
FLUOROURACIL 0.5 % CREAM

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
N/A

## REQUIRED MEDICAL INFORMATION
Patient has tried at least one preferred topical Actinic Keratosis agent (e.g. fluorouracil cream or solution (Efudex), imiquimod cream) OR has a medical reason not to use (contraindication) all preferred topical Actinic Keratosis agents.

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# FLURANDRENOLIDE CREAM, LOTION, OINTMENT (CORDRAN, NOLIX)

## MEDICATION(S)
FLURANDRENOLIDE, NOLIX

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
N/A

## REQUIRED MEDICAL INFORMATION
Patient has tried two generically available topical corticosteroids in the same or higher potency class.

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# FOSTAMATINIB (TAVALISSE)

## MEDICATION(S)
TAVALISSE

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
N/A

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

## AGE RESTRICTION
18 years of age or older.

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# GANAXOLONE SUSPENSION (ZTALMY)

## MEDICATION(S)
ZTALMY

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
N/A

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

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
Neurologist

## COVERAGE DURATION
plan year

## OTHER CRITERIA
N/A

# GEFITINIB (IRESSA)

## MEDICATION(S)
IRESSA

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

## OFF LABEL USES
N/A

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

## REQUIRED MEDICAL INFORMATION
N/A

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# 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
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
N/A

# GLATIRAMER (COPAXONE)

## MEDICATION(S)
COPAXONE

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

## OFF LABEL USES
N/A

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

## REQUIRED MEDICAL INFORMATION
N/A

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# GLECAPREVIR/PIBRENTASVIR (MAVYRET)

## MEDICATION(S)
MAVYRET

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

## OFF LABEL USES
N/A

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

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

## AGE RESTRICTION
N/A

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

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

## OTHER CRITERIA
N/A

# GLYCEROL PHENYLBUTYRATE (RAVICTI)

## MEDICATION(S)
RAVICTI

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
N/A

## REQUIRED MEDICAL INFORMATION
N/A

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# GLYCOPYRROLATE 1.5 MG TABLET (GLYCATE)

## MEDICATION(S)
GLYCATE, GLYCOPYRROLATE 1.5 MG TAB

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
N/A

## REQUIRED MEDICAL INFORMATION
Medical reason why patient is not able to use generic glycopyrrolate 1mg and 2mg strengths.

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# GLYCOPYRROLATE SOLUTION (CUVPOSA)

## MEDICATION(S)
GLYCOPYRROLATE 1 MG/5ML SOLUTION

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
N/A

## REQUIRED MEDICAL INFORMATION
N/A

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
plan year

## OTHER CRITERIA
N/A

# GUAIFENESIN HYDROCODONE BITARTRATE ORAL SOLUTION (OBREDON)

## MEDICATION(S)
HYDROCODONE-GUAIFENESIN

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
Patient is 12 years of age or younger.

## REQUIRED MEDICAL INFORMATION
Cough suppression: patient had a side effect with guaifenesin/codeine syrup that is not also seen with the use of guaifenesin/hydrocodone oral solution, and dose is not more than the FDA label maximum, and for patients 12 to 18 years old: prescriber is aware this medication can be potentially harmful and has a plan to monitor the patient for side effects.

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# HALCINONIDE 1% CREAM (HALOG)

## MEDICATION(S)
HALCINONIDE

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
N/A

## REQUIRED MEDICAL INFORMATION
Trial and failure or side effect with two generic topical steroids in the high or very high potency group.

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

## MEDICATION(S)

AMITRIPTYLINE HCL, ARMOUR THYROID, CARBINOXAMINE MALEATE, CARISOPRODOL, CARISOPRODOL-ASPIRIN, CARISOPRODOL-ASPIRIN-CODEINE, CHLORDIAZEPOXIDE HCL, CHLORDIAZEPOXIDE-AMITRIPTYLINE, CHLORDIAZEPOXIDE-CLIDINIUM, CHLORPROPAMIDE, CHLORZOXAZONE, CLEMASTINE FUMARATE, CLOMIPRAMINE HCL, CYCLOBENZAPRINE HCL, CYCLOBENZAPRINE HCL ER, CYPROHEPTADINE HCL, DEXCHLORPHENIRAMINE MALEATE, DICYCLOMINE HCL 10 MG CAP, DICYCLOMINE HCL 10 MG/5ML SOLUTION, DICYCLOMINE HCL 20 MG TAB, DIPYRIDAMOLE 25 MG TAB, DIPYRIDAMOLE 50 MG TAB, DIPYRIDAMOLE 75 MG TAB, DOXEPIN HCL 10 MG CAP, DOXEPIN HCL 10 MG/ML CONC, DOXEPIN HCL 100 MG CAP, DOXEPIN HCL 150 MG CAP, DOXEPIN HCL 25 MG CAP, DOXEPIN HCL 50 MG CAP, DOXEPIN HCL 75 MG CAP, FEXMID, HYDROXYZINE HCL 10 MG TAB, HYDROXYZINE HCL 10 MG/5ML SYRUP, HYDROXYZINE HCL 25 MG TAB, HYDROXYZINE HCL 50 MG TAB, HYDROXYZINE PAMOATE, IMIPRAMINE HCL, IMIPRAMINE PAMOATE, INDOMETHACIN 25 MG CAP, INDOMETHACIN 50 MG CAP, INDOMETHACIN ER, KETOROLAC TROMETHAMINE 10 MG TAB, MEPERIDINE HCL 100 MG TAB, MEPERIDINE HCL 50 MG TAB, MEPERIDINE HCL 50 MG/5ML SOLUTION, MEPROBAMATE, METAXALL, METAXALONE, METHOCARBAMOL 500 MG TAB, METHOCARBAMOL 750 MG TAB, NP THYROID, ORPHENADRINE CITRATE ER, ORPHENADRINE-ASA-CAFFEINE, ORPHENADRINE-ASPIRIN-CAFFEINE 50-770-60 MG TAB, ORPHENGESIC FORTE, PB-HYOSCY-ATROPINE-SCOPOLAMINE 16.2 MG/5ML ELIXIR, PENTAZOCINE-NALOXONE HCL, PERPHENAZINE-AMITRIPTYLINE, PHENADOZ, PHENOBARBITAL, PHENOBARBITAL-BELLADONNA ALK 16.2 MG/5ML ELIXIR, PHENOHYTRO 16.2 MG/5ML ELIXIR, PROMETHAZINE HCL, PROMETHAZINE VC, PROMETHAZINE VC/CODEINE, PROMETHAZINE-CODEINE, PROMETHAZINE-DM, PROMETHAZINE-PHENYLEPH-CODEINE, PROMETHAZINE-PHENYLEPHRINE, PROMETHEGAN, PROPANTHELINE BROMIDE, QUAZEPAM, RYCLORA, SCOPOLAMINE, THIORIDAZINE HCL, THYROID, TRIMETHOBENZAMIDE HCL, TRIMIPRAMINE MALEATE, 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
Plan Year

## OTHER CRITERIA
N/A

# IBANDRONATE VIAL (BONIVA IV)

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

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
N/A

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

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

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

# IBRUTINIB (IMBRUVICA)

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

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

## OFF LABEL USES
N/A

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

## REQUIRED MEDICAL INFORMATION
N/A

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# IBUPROFEN-FAMOTIDINE (DUEXIS)

## MEDICATION(S)
IBUPROFEN-FAMOTIDINE

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
N/A

## REQUIRED MEDICAL INFORMATION
Medical reason why trial of ibuprofen along with famotidine cannot be used.

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
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
N/A

# IDELALISIB (ZYDELIG)

## MEDICATION(S)
ZYDELIG

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

## OFF LABEL USES
N/A

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

## REQUIRED MEDICAL INFORMATION
N/A

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# ILOPERIDONE (FANAPT)

## MEDICATION(S)
FANAPT, FANAPT TITRATION PACK

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
N/A

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

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# IMATINIB MESYLATE (GLEEVEC)

## MEDICATION(S)
IMATINIB MESYLATE

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

## OFF LABEL USES
N/A

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

## REQUIRED MEDICAL INFORMATION
N/A

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
Tenosynovial giant cell tumor (TGCT): Orthopedic surgeon or Oncologist.
Hypereosinophilic syndrome (HES): Allergist, Immunologist, or Hematologist.

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# IMIGLUCERASE (CEREZYME)

## MEDICATION(S)
CEREZYME

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

## OFF LABEL USES
N/A

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

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

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

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

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

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

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

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

## EXCLUSION CRITERIA
AMBD: being used with another immunomodulator

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

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
CIDP, MMN, MG: Neurologist

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

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

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

## MEDICATION(S)
HIZENTRA

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
N/A

## REQUIRED MEDICAL INFORMATION
Chronic Inflammatory Demyelinating Polyneuropathy (CIDP), Multifocal Acquired Demyelinating Polyneuropathy, or pure sensory Chronic Inflammatory Demyelinating Polyneuropathy (CIDP): diagnosis confirmed by electrodiagnostic criteria (nerve conduction studies), and patient has been started on IVIG and is switching to Hizentra for ongoing therapy.
Primary Immunodeficiency Disorder (PIDD): current IgG is less than 200mg/dL or ALL of the following: history of recurrent bacterial infections, and failure to respond to antigenic challenge test with diphtheria and tetanus toxoids or pneumococcal polysaccharide vaccine, and history of IgG less than 500mg/dL documented on two occasions or diagnosed by an allergist or immunologist.

## AGE RESTRICTION
N/A

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

## COVERAGE DURATION
Plan year

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

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

## MEDICATION(S)
GAMMAKED

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

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

## EXCLUSION CRITERIA
AMBD: being used with another immunomodulator

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

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
CIDP, MMN, MG: Neurologist

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

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

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

## MEDICATION(S)
GAMUNEX-C

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

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

## EXCLUSION CRITERIA
AMBD: being used with another immunomodulator

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

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
CIDP, MMN, MG: Neurologist

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

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

# INFIGRANTINIB (TRUSELTIQ)

## MEDICATION(S)
TRUSELTIQ (100MG DAILY DOSE), TRUSELTIQ (125MG DAILY DOSE), TRUSELTIQ (50MG DAILY DOSE), TRUSELTIQ (75MG DAILY DOSE)

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

## OFF LABEL USES
N/A

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

## REQUIRED MEDICAL INFORMATION
N/A

## AGE RESTRICTION
18 years of age or older

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# INTERFERON BETA-1B (BETASERON)

## MEDICATION(S)
BETASERON

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

## OFF LABEL USES
N/A

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

## REQUIRED MEDICAL INFORMATION
N/A

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# INTERFERON GAMMA-1B (ACTIMMUNE)

## MEDICATION(S)
ACTIMMUNE

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
N/A

## REQUIRED MEDICAL INFORMATION
N/A

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# INTRAVENOUS IMMUNE GLOBULIN (IVIG)

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

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

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

## EXCLUSION CRITERIA
AMBD: being used with another immunomodulator

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

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
CIDP, MMN, MG: Neurologist

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

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

Excluded under Part D if covered by Part B.

# ISAVUCONAZONIUM (CRESEMBA)

## MEDICATION(S)
CRESEMBA

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
N/A

## REQUIRED MEDICAL INFORMATION
Invasive aspergillosis: blood or tissue culture positive for Aspergillus, and patient has a medical reason for not using voriconazole.
Invasive mucormycosis: culture is positive for mucormyocosis pathogens (e.g. Rhizopus, Rhizomucor, Lichtheimia, Mucormycetes) or being prescribed by infectious disease specialist.
Esophageal candidiasis: patient has HIV infection and patient has a medical reason for not using oral fluconazole.

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
3 months

## OTHER CRITERIA
N/A

# ITRACONAZOLE (SPORANOX)

## MEDICATION(S)
ITRACONAZOLE

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

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

## EXCLUSION CRITERIA
N/A

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

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION

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

## OTHER CRITERIA

N/A

# IVABRADINE (CORLANOR)

## MEDICATION(S)
CORLANOR

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
N/A

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

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# IVACAFTOR (KALYDECO)

## MEDICATION(S)
KALYDECO

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
N/A

## REQUIRED MEDICAL INFORMATION
N/A

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# IVOSIDENIB (TIBSOVO)

## MEDICATION(S)
TIBSOVO

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

## OFF LABEL USES
N/A

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

## REQUIRED MEDICAL INFORMATION
N/A

## AGE RESTRICTION
18 years of age or older.

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# IXAZOMIB CITRATE (NINLARO)

## MEDICATION(S)
NINLARO

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

## OFF LABEL USES
N/A

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

## REQUIRED MEDICAL INFORMATION
N/A

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# IXEKIZUMAB (TALTZ)

## MEDICATION(S)
TALTZ

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

## OFF LABEL USES
N/A

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

## REQUIRED MEDICAL INFORMATION
Spondyloarthritis (SpA): patient is not able to take NSAIDs due to history of GI bleed or ulcer OR patient has tried one RX strength NSAID in combination with a PPI and had GI side effects OR patient's condition did not respond to a trial of two different RX strength NSAIDs. Plaque Psoriasis (PsO), initial use: patient has tried one DMARD or has a medical reason why methotrexate (MTX), cyclosporine, and acitretin cannot be used AND baseline PASI score 10 or more OR BSA 3% or more OR sensitive areas are involved OR disease affects daily living. PSO, ongoing use: PASI or BSA improved on Taltz. Psoriatic Arthritis (PsA): patient has tried one DMARD or has a medical reason why MTX, leflunomide, and sulfasalazine cannot be used.

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

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

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

## OTHER CRITERIA
N/A

# LANREOTIDE ACETATE (SOMATULINE DEPOT)

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

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
N/A

## REQUIRED MEDICAL INFORMATION
N/A

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
Acromegaly: Endocrinologist

## COVERAGE DURATION
Plan year

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

# LAPATINIB DITOSYLATE (TYKERB)

## MEDICATION(S)
LAPATINIB DITOSYLATE

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

## OFF LABEL USES
N/A

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

## REQUIRED MEDICAL INFORMATION
N/A

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# LAROTRECTINIB SULFATE (VITRAKVI)

## MEDICATION(S)
VITRAKVI

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

## OFF LABEL USES
N/A

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

## REQUIRED MEDICAL INFORMATION
N/A

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# LEDIPASVIR/SOFOSBUVIR (HARVONI)

## MEDICATION(S)
HARVONI, LEDIPASVIR-SOFOSBUVIR

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

## OFF LABEL USES
N/A

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

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

## AGE RESTRICTION
3 years of age or older.

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

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

## OTHER CRITERIA
N/A

# LENALIDOMIDE (REVLIMID)

## MEDICATION(S)
LENALIDOMIDE, REVLIMID 2.5 MG CAP, REVLIMID 20 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
MDS: transfusion dependent or hemoglobin less than 10 g/dL confirming anemia associated disease.

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# LENVATINIB (LENVIMA)

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

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

## OFF LABEL USES
N/A

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

## REQUIRED MEDICAL INFORMATION
N/A

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# LEVALBUTEROL SOLUTION (XOPENEX)

## MEDICATION(S)
LEVALBUTEROL HCL

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
N/A

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

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

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

# LEVETIRACETAM (SPRITAM)

## MEDICATION(S)
SPRITAM

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
N/A

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

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# LEVOMILNACIPRAN HCL (FETZIMA)

## MEDICATION(S)
FETZIMA, FETZIMA TITRATION

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
N/A

## REQUIRED MEDICAL INFORMATION
Treatment failure or side effect with at least two formulary drugs that treat major depressive disorder (MDD).

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# LIDOCAINE PATCH (LIDODERM)

## MEDICATION(S)
LIDOCAINE 5 % PATCH

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
N/A

## REQUIRED MEDICAL INFORMATION
N/A

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# LINEZOLID ORAL (ZYVOX)

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

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
N/A

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

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

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

## OTHER CRITERIA

N/A

# LOMITAPIDE MESYLATE (JUXTAPID)

## MEDICATION(S)
JUXTAPID

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
N/A

## REQUIRED MEDICAL INFORMATION
Homozygous Familial Hypercholesterolemia (HoFH): diagnosis confirmed by a genetic test confirming LDL-R genetic mutations or clinical evidence supporting HoFH, AND being used with a standard lipid lowering regimen (i.e.. a maximally tolerated statin, a non-statin lipid lowering drug for patient with documented statin intolerance) AND patient has tried and failed or has a medical reason for not using Repatha.

## AGE RESTRICTION
18 years of age or older.

## PRESCRIBER RESTRICTION
Cardiologist or Endocrinologist

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

## 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, HYDROCODONE BITARTRATE ER, HYDROMORPHONE HCL ER, LEVORPHANOL TARTRATE, METHADONE HCL 10 MG TAB, METHADONE HCL 10 MG/5ML SOLUTION, METHADONE HCL 10 MG/ML CONC, METHADONE HCL 10 MG/ML SOLUTION, METHADONE HCL 5 MG TAB, METHADONE HCL 5 MG/5ML SOLUTION, METHADONE HCL INTENSOL, MORPHINE SULFATE ER 10 MG CAP ER 24H, MORPHINE SULFATE ER 100 MG CAP ER 24H, MORPHINE SULFATE ER 20 MG CAP ER 24H, MORPHINE SULFATE ER 30 MG CAP ER 24H, MORPHINE SULFATE ER 40 MG CAP ER 24H, MORPHINE SULFATE ER 50 MG CAP ER 24H, MORPHINE SULFATE ER 60 MG CAP ER 24H, MORPHINE SULFATE ER 80 MG CAP ER 24H, MORPHINE SULFATE ER BEADS, OXYCODONE HCL ER, OXYMORPHONE HCL ER

## PA INDICATION INDICATOR

1 - All FDA-Approved Indications

## OFF LABEL USES

N/A

## EXCLUSION CRITERIA

Being used with other long-acting narcotic drugs.

## REQUIRED MEDICAL INFORMATION

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

## AGE RESTRICTION
N/A

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

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

## OTHER CRITERIA
N/A

# LORLATINIB (LORBRENA)

## MEDICATION(S)
LORBRENA

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

## OFF LABEL USES
N/A

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

## REQUIRED MEDICAL INFORMATION
N/A

## AGE RESTRICTION
18 years of age or older.

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# LUMATEPERONE (CAPLYTA)

## MEDICATION(S)
CAPLYTA

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
N/A

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

## AGE RESTRICTION
18 years of age or older.

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# LURASIDONE (LATUDA)

## MEDICATION(S)
LATUDA

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
N/A

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

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# MACITENTAN (OPSUMIT)

## MEDICATION(S)
OPSUMIT

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
N/A

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

## AGE RESTRICTION
18 years of age or older.

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# MECASERMIN (INCRELEX)

## MEDICATION(S)
INCRELEX

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

## OFF LABEL USES
N/A

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

## REQUIRED MEDICAL INFORMATION
Initial use: height is at or more than 3.0 standard deviations below standard range for sex and age, and basal IGF-1 is at or more than 3.0 standard deviations below standard range for sex and age, and evidence of delayed bone age, and for severe IGF-1 deficiency growth hormone level is normal or higher for sex and age.
Ongoing use: response to therapy confirmed by an increase in growth velocity of more than 2 cm in the past year and evidence of delayed bone age.

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

## PRESCRIBER RESTRICTION
Endocrinologist

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# MECHLORETHAMINE (VALCHLOR)

## MEDICATION(S)
VALCHLOR

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
N/A

## REQUIRED MEDICAL INFORMATION
N/A

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# MEGESTROL ACETATE (MEGACE)

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

# MEGESTROL ACETATE ES (MEGACE ES)

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

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
N/A

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

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# MELOXICAM CAPSULE (VIVLODEX)

## MEDICATION(S)
MELOXICAM 10 MG CAP, MELOXICAM 5 MG CAP

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
N/A

## REQUIRED MEDICAL INFORMATION
Osteoarthritis: intolerance or contraindication to meloxicam tablet (Mobic) not expected with meloxicam micronized capsule

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# MEPOLIZUMAB (NUCALA)

## MEDICATION(S)
NUCALA

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

## OFF LABEL USES
N/A

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

## REQUIRED MEDICAL INFORMATION
Eosinophilic asthma, initial use: eosinophil blood count is 150 cells/microliter or more within last six weeks documented treatment failure with recent use of high-dose inhaled corticosteroid along with long-acting beta agonist, and patient has had at least one of the following within the past year: one or more acute asthma-related ER visit(s), one or more acute inpatient visits where asthma was the diagnosis, or two or more acute asthma exacerbations that require oral corticosteroids. 1st reauth: improvement in asthma symptoms confirmed by fewer asthma attacks, a decrease in the dose or how often you use your oral or inhaled steroids, or a reduction in your asthma symptoms (e.g. fewer sick days, less use of a rescue inhaler). eosinophilic granulomatosis with polyangiitis (EGPA): patients condition did not improve or has relapsed despite treatment with an oral corticosteroid and/or immunosuppressive therapy (e.g. azathioprine, methotrexate, mycophenolic acid). Hypereosinophilic syndrome (HES): patient is negative for FIP1-like 1-platelet derived growth factor receptor (FIP1L1-PDGFR) mutation and patient had an inadequate response to oral corticosteroids or hydroxyurea. Chronic rhinosinusitis with nasal polyps (CRSwNP): Treatment failure with an intranasal corticosteroid or medical rationale why intranasal corticosteroids cannot be used.

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

## PRESCRIBER RESTRICTION

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

## COVERAGE DURATION

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

## OTHER CRITERIA

N/A

# MERCAPTOPURINE MONOHYDRATE (PURIXAN)

## MEDICATION(S)
PURIXAN

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
N/A

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

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# METFORMIN ER MODIFIED RELEASE TABLET (GLUMETZA)

## MEDICATION(S)
METFORMIN HCL ER (MOD)

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
N/A

## REQUIRED MEDICAL INFORMATION
Side effect with metformin er tablet (generic Glucophage XR) that does not occur with metformin er modified release tablet (generic Glumetza)

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# METFORMIN ER OSMOTIC TABLET (FORTAMET)

## MEDICATION(S)
METFORMIN HCL ER (OSM)

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
N/A

## REQUIRED MEDICAL INFORMATION
Side effect with metformin er tablet (generic Glucophage XR) that does not occur with the use of metformin er osmotic tablet.

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# METHAMPHETAMINE TABLET (DESOXYN)

## MEDICATION(S)
METHAMPHETAMINE HCL

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
N/A

## REQUIRED MEDICAL INFORMATION
Treatment failure or side effect with one preferred short-acting stimulant drug (e.g. methylphenidate)

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# METHOTREXATE ORAL SOLUTION (XATMEP)

## MEDICATION(S)
XATMEP

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
N/A

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

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# METHYLNALTREXONE (RELISTOR SQ)

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

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
N/A

## REQUIRED MEDICAL INFORMATION
Constipation due to ongoing use of opioids for non-cancer pain: patient has tried Amitiza or Movantik.

## AGE RESTRICTION
18 years of age or older.

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# METHYLPHENIDATE EXTENDED-RELEASE

## MEDICATION(S)
METHYLPHENIDATE HCL ER 72 MG TAB ER, RELEXXII 72 MG TAB ER

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
N/A

## REQUIRED MEDICAL INFORMATION
Attention Deficit Hyperactivity Disorder (ADHD) was confirmed with DSM-V criteria and medical reason why patient cannot use two methylphenidate er 36mg tablets.

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
Psychiatrist

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# METHYLTESTOSTERONE (ANDROID, METHITEST, TESTRED)

## MEDICATION(S)
METHYLTESTOSTERONE

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
N/A

## REQUIRED MEDICAL INFORMATION
N/A

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# METOCLOPRAMIDE ODT (METOZOLV ODT)

## MEDICATION(S)
METOCLOPRAMIDE HCL 10 MG TAB DISP, METOCLOPRAMIDE HCL 5 MG TAB DISP

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
N/A

## REQUIRED MEDICAL INFORMATION
Medical condition that prevents swallowing a tablet.

## AGE RESTRICTION
18 years of age or older.

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# METRELEPTIN (MYALEPT)

## MEDICATION(S)
MYALEPT

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

## OFF LABEL USES
N/A

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

## REQUIRED MEDICAL INFORMATION
Generalized Lipodystrophy: Patient has one of the following: diabetes mellitus (HbA1c greater than 7% or FPG values 126 mg/dL or greater), or hypertriglyceridemia (TG 250mg/dL or greater), or history of pancreatitis associated with hypertriglyceridemia, or increased fasting insulin (greater than 25mIU/L), or Non-alcoholic steatohepatitis in non-obese individual, or early onset cardiomyopathy, or polycystic ovary syndrome (PCOS)

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# MIDOSTAURIN (RYDAPT)

## MEDICATION(S)
RYDAPT

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

## OFF LABEL USES
N/A

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

## REQUIRED MEDICAL INFORMATION
N/A

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
AML and Mastocytosis: plan year

## OTHER CRITERIA
N/A

# MIFEPRISTONE (KORLYM)

## MEDICATION(S)
KORLYM

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
N/A

## REQUIRED MEDICAL INFORMATION
N/A

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# MIGLUSTAT (ZAVESCA)

## MEDICATION(S)
MIGLUSTAT

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

## OFF LABEL USES
N/A

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

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

## AGE RESTRICTION
18 years of age or older.

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# MINOCYCLINE HCL (SOLODYN ER)

## MEDICATION(S)
COREMINO, MINOCYCLINE HCL ER 105 MG TAB ER 24H, MINOCYCLINE HCL ER 115 MG TAB ER 24H, MINOCYCLINE HCL ER 135 MG TAB ER 24H, MINOCYCLINE HCL ER 45 MG TAB ER 24H, MINOCYCLINE HCL ER 55 MG TAB ER 24H, MINOCYCLINE HCL ER 65 MG TAB ER 24H, MINOCYCLINE HCL ER 80 MG TAB ER 24H, MINOCYCLINE HCL ER 90 MG TAB ER 24H

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
N/A

## REQUIRED MEDICAL INFORMATION
Acne Vulgaris: treatment failure or side effect with doxycycline and side effect with the use of short-acting minocycline that does not occur with the use of minocycline er (Solodyn).

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# MOBOCERTINIB (EXKIVITY)

## MEDICATION(S)
EXKIVITY

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

## OFF LABEL USES
N/A

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

## REQUIRED MEDICAL INFORMATION
N/A

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# MUPIROCIN CREAM (BACTROBAN)

## MEDICATION(S)
MUPIROCIN CALCIUM

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
N/A

## REQUIRED MEDICAL INFORMATION
N/A

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# NALOXONE AUTO-INJECTOR (EVZIO)

## MEDICATION(S)
NALOXONE HCL 2 MG/0.4ML SOLN A-INJ

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
N/A

## REQUIRED MEDICAL INFORMATION
Side effect or contraindication to naloxone prefilled syringe and nasal spray that is not also seen with naloxone auto-injector.

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# NAPROXEN-ESOMEPRAZOLE (VIMOVO)

## MEDICATION(S)
NAPROXEN-ESOMEPRAZOLE MG

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
N/A

## REQUIRED MEDICAL INFORMATION
Patient is currently taking naproxen along with esomeprazole and would like to lower pill burden

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# NATALIZUMAB (TYSABRI)

## MEDICATION(S)
TYSABRI

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

## OFF LABEL USES
N/A

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

## REQUIRED MEDICAL INFORMATION
Relapsing forms of Multiple Sclerosis: patient has tried at least one of the following therapies: Betaseron, glatiramer 20mg, Copaxone, Aubagio, Gilenya, Tecfidera.
Crohn's Disease, initial use: patient did not respond to corticosteroids or is on corticosteroids and has a medical reason why TNF-blockers (e.g. Humira) cannot be used.
Ongoing use: patient's condition has improved while on Tysabri.

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
MS: plan year
Crohn's Disease: initial use: 3 months, ongoing use: plan year

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

# NERATINIB (NERLYNX)

## MEDICATION(S)
NERLYNX

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

## OFF LABEL USES
N/A

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

## REQUIRED MEDICAL INFORMATION
N/A

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# NILOTINIB (TASIGNA)

## MEDICATION(S)
TASIGNA

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

## OFF LABEL USES
N/A

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

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

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# NINTEDANIB ESYLATE (OFEV)

## MEDICATION(S)
OFEV

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
Idiopathic Pulmonary Fibrosis (IPF): being used with another IPF drug or severe disease where FVC is under 50% or DLCO is under 30%

## REQUIRED MEDICAL INFORMATION
IPF, initial use: patient has mild to moderate disease confirmed by the following pulmonary function tests: forced vital capacity (FVC) equal or over 50%, and diffusing capacity of carbon monoxide (DLCO) equal or over 30%.
Ongoing use: patient has not received a lung transplant, patient continues to have mild to moderate IPF disease confirmed by the following pulmonary function tests: FVC equal or above 50% and DLCO is equal or over 30%.
ssILD (Systemic sclerosis interstitial lung disease): trial of at least one guideline supported therapy (i.e. cyclophosphamide, mycophenolate, azathioprine, or systemic glucocorticoids ) or medical reason why they cannot be used.

## AGE RESTRICTION
N/A

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

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# NIRAPARIB TOSYLATE (ZEJULA)

## MEDICATION(S)
ZEJULA

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

## OFF LABEL USES
N/A

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

## REQUIRED MEDICAL INFORMATION
N/A

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# NITAZOXANIDE (ALINIA)

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

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

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

## EXCLUSION CRITERIA
N/A

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

## AGE RESTRICTION
12 years of age or older.

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
one course (see other criteria)

## OTHER CRITERIA
Giardiasis: 3 days
Cryptosporidiosis: 3 days unless HIV+ then 14 days
Clostridium difficile colitis: 10 days
viral gastroenteritis: 3 days amebiasis (Entamoeba histolytica): 3 days
liver fluke infection (Fasciola hepatica): 7 days
Cestode (tapeworm): 3 days

# NITISINONE (ORFADIN)

## MEDICATION(S)
NITISINONE

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
N/A

## REQUIRED MEDICAL INFORMATION
N/A

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan Year

## OTHER CRITERIA
N/A

# NITISINONE (NITYR)

## MEDICATION(S)
NITYR

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
N/A

## REQUIRED MEDICAL INFORMATION
N/A

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# NON-FORMULARY HIGH RISK MEDICATION

## MEDICATION(S)
ESGIC 50-325-40 MG CAP

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
N/A

## REQUIRED MEDICAL INFORMATION
Prescriber's supporting statement states the drug is medically necessary because all covered drugs on the formulary would not be as effective or would cause side effects.

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# NON-PREFERRED DOXYCYCLINE PRODUCTS

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

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
N/A

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

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# NON-PREFERRED HYDROCODONE-ACETAMINOPHEN PRODUCTS

## MEDICATION(S)
HYDROCODONE-ACETAMINOPHEN 10-300 MG TAB, HYDROCODONE-ACETAMINOPHEN 10-325 MG/15ML SOLUTION, HYDROCODONE-ACETAMINOPHEN 5-300 MG TAB, HYDROCODONE-ACETAMINOPHEN 7.5-300 MG TAB, VICODIN HP

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

## OFF LABEL USES
N/A

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

## REQUIRED MEDICAL INFORMATION
Moderate to severe pain, initial use: side effect to the preferred hydrocodone-acetaminophen product that would not occur with the non-preferred hydrocodone-acetaminophen product and total dose across all narcotics is not more than 90 MME/day or if more than 90 MME/day the prescriber states the total dose is medically necessary to treat the pain. Ongoing use (more than 90 days of narcotic therapy): evaluation by pain specialist, documented patient-specific treatment plan for evaluating ongoing need for narcotic pain relief, potential misuse, and monitoring plan for adverse side effects, and total dose across all narcotics is not more than 90 MME/day or if more than 90 MME/day the prescriber states the total dose is medically necessary to treat the pain.

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
30 days

## OTHER CRITERIA
N/A

# NON-PREFERRED NON-STEROIDAL ANTI-INFLAMMATORY DRUGS

## MEDICATION(S)
KETOPROFEN ER, MEFENAMIC ACID, NAPROXEN 125 MG/5ML SUSPENSION, NAPROXEN SODIUM ER 375 MG TAB ER 24H, NAPROXEN SODIUM ER 500 MG TAB ER 24H, TOLMETIN SODIUM

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
N/A

## REQUIRED MEDICAL INFORMATION
Trial of two preferred NSAIDS OR there is a contraindication to all preferred NSAIDs that is not seen with the non-preferred NSAID.

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# NON-PREFERRED OXYCODONE-ACETAMINOPHEN PRODUCTS

## MEDICATION(S)
NALOCET, OXYCODONE-ACETAMINOPHEN 10-300 MG TAB, OXYCODONE-ACETAMINOPHEN 2.5-300 MG TAB, OXYCODONE-ACETAMINOPHEN 5-300 MG TAB, OXYCODONE-ACETAMINOPHEN 7.5-300 MG TAB, PRIMLEV, PROLATE 10-300 MG TAB, PROLATE 5-300 MG TAB, PROLATE 7.5-300 MG TAB

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

## OFF LABEL USES
N/A

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

## REQUIRED MEDICAL INFORMATION
Moderate to severe pain, initial use: side effect to the preferred oxycodone-acetaminophen product that would not occur with the non-preferred oxycodone-acetaminophen product and total dose across all narcotics is not more than 90 MME/day or if more than 90 MME/day the prescriber states the total dose is medically necessary to treat the pain. Ongoing use (more than 90 days of narcotic therapy): evaluation by pain specialist, documented patient-specific treatment plan for evaluating ongoing need for narcotic pain relief, potential misuse, and monitoring plan for adverse side effects, and total dose across all narcotics is not more than 90 MME/day or if more than 90 MME/day the prescriber states the total dose is medically necessary to treat the pain.

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
30 days

## OTHER CRITERIA

N/A

# OCTREOTIDE ACETATE (SANDOSTATIN LAR DEPOT)

## MEDICATION(S)
SANDOSTATIN LAR DEPOT

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

## OFF LABEL USES
AIDS-associated diarrhea, Bleeding esophageal varices, Chemotherapy-induced diarrhea, Intestinal obstruction, Neuroendocrine Tumor of the lung, Pituitary adenoma, Prevention of postoperative complications of pancreatic surgery, Pancreatic tumors (gastrinoma, glucagonoma, insulinoma), Radiation-induced diarrhea, Recurrent Meningioma, Thymoma, Zollinger-Ellison syndrome

## EXCLUSION CRITERIA
N/A

## REQUIRED MEDICAL INFORMATION
Diarrhea due to HIV: patient has been on anti-retroviral therapy (ART) for at least one month, and other causes (i.e. infection, underlying GI disease, malabsorption) have been ruled out, and treatment failure or side effect with diphenoxylate/atropine or loperamide.
Intestinal obstruction: intestinal obstruction is due to cancer.
Thymus cancer (thymoma): treatment failure with prior cancer drug therapy.

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
Acromegaly: Endocrinologist

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

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

# OCTREOTIDE ACETATE (SANDOSTATIN)

## MEDICATION(S)
OCTREOTIDE ACETATE

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

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

## EXCLUSION CRITERIA
N/A

## REQUIRED MEDICAL INFORMATION
Diarrhea due to HIV: patient has been on anti-retroviral therapy (ART) for at least one month, and prescriber states other causes (i.e. infection, underlying GI disease, malabsorption) have been ruled out, and patient has tried diphenoxylate/atropine or loperamide. Intestinal obstruction: intestinal obstruction is due to cancer. Thymus cancer (thymoma): treatment failure with prior cancer drug therapy. Pheochromocytoma and paraganglioma: cancer cannot be removed by surgery or has spread to other areas of the body, and somatostatin receptor positive, and symptomatic (e.g. high blood pressure, headaches, sweating, and/or heart palpitations).

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
Acromegaly: Endocrinologist

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

## OTHER CRITERIA

N/A

# ODEVIXIBAT (BYLVAY)

## MEDICATION(S)
BYLVAY, BYLVAY (PELLETS)

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
N/A

## REQUIRED MEDICAL INFORMATION
N/A

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
Gastroenterologist or Hepatologist

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# OLANZAPINE PAMOATE (ZYPREXA RELPREVV)

## MEDICATION(S)
ZYPREXA RELPREVV

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

## OFF LABEL USES
N/A

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

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

## AGE RESTRICTION
18 years of age or older.

## PRESCRIBER RESTRICTION
Psychiatrist

## COVERAGE DURATION
Plan year

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

# OLANZAPINE-SAMIDORPHAN (LYBALVI)

## MEDICATION(S)
LYBALVI

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
N/A

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

## AGE RESTRICTION
18 years of age or older.

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# OLAPARIB (LYNPARZA)

## MEDICATION(S)
LYNPARZA

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

## OFF LABEL USES
N/A

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

## REQUIRED MEDICAL INFORMATION
N/A

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# OLSALAZINE SODIUM (DIPENTUM)

## MEDICATION(S)
DIPENTUM

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
N/A

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

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# OMALIZUMAB (XOLAIR)

## MEDICATION(S)
XOLAIR

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

## OFF LABEL USES
N/A

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

## REQUIRED MEDICAL INFORMATION
Allergic Asthma, initial use: recent total serum IgE level is more than 30IU/ml, documented treatment failure with recent use of high-dose inhaled corticosteroid along with long-acting beta agonist, and patient has had at least one of the following within the past year: one or more acute asthma-related ER visit(s), one or more acute inpatient visits where asthma was the diagnosis, or two or more acute asthma exacerbations that require oral corticosteroids. Ongoing use: improvement in asthma symptoms confirmed by one or more of the following: fewer asthma attacks, a decrease in the dose or how often you use your oral or inhaled steroids, or a reduction in your asthma symptoms (e.g. fewer sick days, less use of a rescue inhaler).
Chronic Idiopathic Urticaria (CIU): failure to respond to hydroxyzine, doxepin, or high dose second-generation antihistamines OR has a medical reason not to use (contraindication) or had a side effect to hydroxyzine, doxepin, and second-generation antihistamines.
Nasal polyps: treatment failure or side effect with a nasal corticosteroid (e.g. fluticasone)

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

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

## COVERAGE DURATION

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

## OTHER CRITERIA

N/A

# OMEPRAZOLE-BICARBONATE PACKET (ZEGERID)

## MEDICATION(S)
OMEPRAZOLE-SODIUM BICARBONATE 20-1680 MG PACKET, OMEPRAZOLE-SODIUM BICARBONATE 40-1680 MG 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 omeprazole and lansoprazole capsule OR being used to lower risk of GI bleed in the critically ill.

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# ORITAVANCIN DIPHOSPHATE (ORBACTIV)

## MEDICATION(S)
ORBACTIV

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
N/A

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

## AGE RESTRICTION
18 years of age or older.

## PRESCRIBER RESTRICTION
Infectious Disease Specialist

## COVERAGE DURATION
One treatment course.

## OTHER CRITERIA
N/A

# OSIMERTINIB (TAGRISSO)

## MEDICATION(S)
TAGRISSO

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

## OFF LABEL USES
N/A

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

## REQUIRED MEDICAL INFORMATION
N/A

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# OSPEMIFENE (OSPHENA)

## MEDICATION(S)
OSPHENA

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
N/A

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

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# OXYMORPHONE IMMEDIATE-RELEASE (OPANA)

## MEDICATION(S)
OXYMORPHONE HCL

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

## OFF LABEL USES
N/A

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

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

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
30 days

## OTHER CRITERIA
N/A

# PACRITINIB (VONJO)

## MEDICATION(S)
VONJO

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

## OFF LABEL USES
N/A

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

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

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# PALBOCICLIB (IBRANCE)

## MEDICATION(S)
IBRANCE

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

## OFF LABEL USES
N/A

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

## REQUIRED MEDICAL INFORMATION
N/A

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# PALIPERIDONE ER (INVEGA)

## MEDICATION(S)
PALIPERIDONE ER

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

## OFF LABEL USES
N/A

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

## REQUIRED MEDICAL INFORMATION
Trial of risperidone and one other preferred atypical antipsychotic such as aripiprazole, ziprasidone, quetiapine, or olanzapine.

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

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# PALIPERIDONE PALMITATE (INVEGA HAFYERA)

## MEDICATION(S)
INVEGA HAFYERA

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

## OFF LABEL USES
N/A

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

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

## AGE RESTRICTION
18 years of age or older.

## PRESCRIBER RESTRICTION
Psychiatrist

## COVERAGE DURATION
Plan year

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

# PALIPERIDONE PALMITATE (INVEGA SUSTENNA)

## MEDICATION(S)
INVEGA SUSTENNA

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

## OFF LABEL USES
N/A

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

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

## AGE RESTRICTION
18 years of age or older.

## PRESCRIBER RESTRICTION
Psychiatrist

## COVERAGE DURATION
Plan year

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

# PALIPERIDONE PALMITATE (INVEGA TRINZA)

## MEDICATION(S)
INVEGA TRINZA

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

## OFF LABEL USES
N/A

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

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

## AGE RESTRICTION
18 years of age or older.

## PRESCRIBER RESTRICTION
Psychiatrist

## COVERAGE DURATION
Plan year

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

# PANOBINOSTAT LACTATE (FARYDAK)

## MEDICATION(S)
FARYDAK

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

## OFF LABEL USES
N/A

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

## REQUIRED MEDICAL INFORMATION
N/A

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# PARATHYROID HORMONE (NATPARA)

## MEDICATION(S)
NATPARA

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
N/A

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

## AGE RESTRICTION
18 years of age or older.

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan Year

## OTHER CRITERIA
N/A

MEDICATION(S)

ABELCET, ACETYLCYSTEINE 10 % SOLUTION, ACETYLCYSTEINE 20 % SOLUTION, ACYCLOVIR SODIUM 50 MG/ML SOLUTION, ALBUTEROL SULFATE (2.5 MG/3ML) 0.083% NEBU SOLN, ALBUTEROL SULFATE (5 MG/ML) 0.5% NEBU SOLN, ALBUTEROL SULFATE 0.63 MG/3ML NEBU SOLN, ALBUTEROL SULFATE 1.25 MG/3ML NEBU SOLN, ALBUTEROL SULFATE 2.5 MG/0.5ML NEBU SOLN, ALDURAZYME, AMBISOME, AMINOSYN, AMINOSYN II, AMINOSYN II/ELECTROLYTES, AMINOSYN-HBC, AMINOSYN-PF, AMINOSYN-RF, AMINOSYN/ELECTROLYTES, AMPHOTERICIN B, AMPHOTERICIN B LIPOSOME, APREPITANT 125 MG CAP, APREPITANT 80 & 125 MG CAP, APREPITANT 80 & 125 MG MISC, APREPITANT 80 MG CAP, APRETUDE, ARALAST NP, ARFORMOTEROL TARTRATE, AZASAN, AZATHIOPRINE, AZATHIOPRINE SODIUM, BUDESONIDE 0.25 MG/2ML SUSPENSION, BUDESONIDE 0.5 MG/2ML SUSPENSION, BUDESONIDE 1 MG/2ML SUSPENSION, CABENUVA, CALCITONIN (SALMON) 200 UNIT/ML SOLUTION, CALCITRIOL 0.25 MCG CAP, CALCITRIOL 0.5 MCG CAP, CALCITRIOL 1 MCG/ML SOLUTION, CINACALCET HCL, CLINISOL SF, CROMOLYN SODIUM 20 MG/2ML NEBU SOLN, CYCLOPHOSPHAMIDE 25 MG CAP, CYCLOPHOSPHAMIDE 25 MG TAB, CYCLOPHOSPHAMIDE 50 MG CAP, CYCLOPHOSPHAMIDE 50 MG TAB, CYCLOSPORINE 100 MG CAP, CYCLOSPORINE 25 MG CAP, CYCLOSPORINE 50 MG/ML SOLUTION, CYCLOSPORINE MODIFIED, DEXAMETHASONE SOD PHOSPHATE PF 10 MG/ML SOLUTION, DEXAMETHASONE SODIUM PHOSPHATE 10 MG/ML SOLUTION, DEXAMETHASONE SODIUM PHOSPHATE 100 MG/10ML SOLUTION, DOXERCALCIFEROL, ELAPRASE, ENGERIX-B, FABRAZYME, FORMOTEROL FUMARATE, GENGRAF, GRANISETRON HCL, HEPARIN SODIUM (PORCINE) 1000 UNIT/ML SOLUTION, HEPARIN SODIUM (PORCINE) 10000 UNIT/ML SOLUTION, HEPARIN SODIUM (PORCINE) 20000 UNIT/ML SOLUTION, HEPARIN SODIUM (PORCINE) 5000 UNIT/ML SOLUTION, HEPATAMINE, INTRALIPID, IPRATROPIUM BROMIDE 0.02 % SOLUTION, IPRATROPIUM-ALBUTEROL, KEPIVANCE, LACOSAMIDE 200 MG/20ML SOLUTION, MELPHALAN, METHOTREXATE SODIUM 1 GM RECON SOLN, METHOTREXATE SODIUM 250 MG/10ML SOLUTION, METHOTREXATE SODIUM 50 MG/2ML SOLUTION, METHOTREXATE SODIUM (PF), MYCOPHENOLATE MOFETIL, MYCOPHENOLATE MOFETIL HCL, MYCOPHENOLATE SODIUM, NAGLAZYME, NUTRILIPID, ONDANSETRON, ONDANSETRON HCL 24 MG TAB, ONDANSETRON HCL 4 MG TAB, ONDANSETRON HCL 4 MG/5ML SOLUTION, ONDANSETRON HCL 8 MG TAB, PARICALCITOL, PENTAMIDINE ISETHIONATE, PLENAMINE, PREHEVBRIO, PREMASOL, PROLASTIN-C, PULMOZYME, RECOMBIVAX HB, RIBAVIRIN 6 GM RECON SOLN, SANDIMMUNE 100 MG/ML SOLUTION, SIROLIMUS, SMOFLIPID, SYNRIBO, TACROLIMUS 0.5 MG CAP, TACROLIMUS 1 MG CAP, TACROLIMUS 5 MG CAP, THIOTEPA, TPN ELECTROLYTES, TRELSTAR MIXJECT, TWINRIX, VENTAVIS, VORICONAZOLE 200 MG RECON SOLN, ZOLEDRONIC ACID

## DETAILS

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

# PASIREOTIDE (SIGNIFOR)

## MEDICATION(S)
SIGNIFOR

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
N/A

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

## AGE RESTRICTION
18 years of age or older.

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Initial: 3 months
Reauth: 1 year

## OTHER CRITERIA
N/A

# PAZOPANIB HCL (VOTRIENT)

## MEDICATION(S)
VOTRIENT

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

## OFF LABEL USES
N/A

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

## REQUIRED MEDICAL INFORMATION
N/A

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# PEGINTERFERON ALFA-2A (PEGASYS)

## MEDICATION(S)
PEGASYS, PEGASYS PROCLICK

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

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

## EXCLUSION CRITERIA
N/A

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

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Hepatitis B: 48 weeks
Hepatitis C: based on AASLD-IDSA guidance

## OTHER CRITERIA
N/A

# PEGLOTICASE (KRYSTEXXA)

## MEDICATION(S)
KRYSTEXXA

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
N/A

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

## AGE RESTRICTION
18 years of age or older.

## PRESCRIBER RESTRICTION
Rheumatologist

## COVERAGE DURATION
6 months

## OTHER CRITERIA
N/A

# PEGVISOMANT (SOMAVERT)

## MEDICATION(S)
SOMAVERT

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
N/A

## REQUIRED MEDICAL INFORMATION
Patient failed or is not a candidate for radiation or surgery AND failed treatment or had a side effect with octreotide or Somatuline.

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
Endocrinologist

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# PEMIGATINIB (PEMAZYRE)

## MEDICATION(S)
PEMAZYRE

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

## OFF LABEL USES
N/A

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

## REQUIRED MEDICAL INFORMATION
N/A

## AGE RESTRICTION
18 years of age or older.

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# PENCICLOVIR (DENAVIR)

## MEDICATION(S)
DENAVIR

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
N/A

## REQUIRED MEDICAL INFORMATION
Medical reason why oral antiviral drugs such as valacyclovir, acyclovir, and famciclovir cannot be tried.

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# PENICILLAMINE (DEPEN)

## MEDICATION(S)
PENICILLAMINE 250 MG TAB

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
N/A

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

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# PEXIDARTINIB (TURALIO)

## MEDICATION(S)
TURALIO

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

## OFF LABEL USES
N/A

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

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

## AGE RESTRICTION
18 years of age or older.

## PRESCRIBER RESTRICTION
Orthopedic surgeon or Oncologist

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# PIMAVANSERIN (NUPLAZID)

## MEDICATION(S)
NUPLAZID

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
Being used for dementia-related psychosis.

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

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
Neurologist or Psychiatrist

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# PIRFENIDONE (ESBRIET)

## MEDICATION(S)
ESBRIET 267 MG CAP, PIRFENIDONE

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

## OFF LABEL USES
N/A

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

## REQUIRED MEDICAL INFORMATION
Idiopathic Pulmonary Fibrosis (IPF), initial use: patient has mild to moderate disease confirmed by the following pulmonary function tests: forced vital capacity (FVC) equal or over 50%, and diffusing capacity of carbon monoxide (DLCO) equal or over 30%.
Ongoing use: patient has not received a lung transplant, patient continues to have mild to moderate IPF disease confirmed by the following pulmonary function tests: FVC equal or above 50% and DLCO is equal or over 30%.

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
Pulmonologist

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# PLERIXAFOR (MOZOBIL)

MEDICATION(S)
MOZOBIL

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
one time

OTHER CRITERIA
N/A

# POMALIDOMIDE (POMALYST)

## MEDICATION(S)
POMALYST

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

## OFF LABEL USES
N/A

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

## REQUIRED MEDICAL INFORMATION
N/A

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# 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
First line therapy for ALL: medical reason why imatinib cannot be used.

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# POSACONAZOLE (NOXAFIL)

## MEDICATION(S)
NOXAFIL 40 MG/ML SUSPENSION, POSACONAZOLE

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

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

## EXCLUSION CRITERIA
N/A

## REQUIRED MEDICAL INFORMATION
Prevention of aspergillus or candida infection when there is high risk for developing these type of infections (e.g. weakened defense system due to cancer drug therapy, HIV, GVHD)
Aspergillosis, cryptococcosis, fusariosis, histoplasmosis, phaeohyphomycosis within the body that is confirmed by a positive culture test.
Treatment of candida infection of the esophagus, throat, mouth (esophageal or oropharyngeal candidiasis) after trial of fluconazole or there is a medical reason not to use fluconazole.
Treatment of candida infection within the body that is confirmed by a positive culture and failure of fluconazole or other anti-fungal shown by culture results to treat the infection.
ABPA: current use of chronic oral corticosteroid use after trial of itraconazole or there is a medical reason not to use itraconazole.

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

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

## OTHER CRITERIA

N/A

# PRALSETINIB (GAVRETO)

## MEDICATION(S)
GAVRETO

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

## OFF LABEL USES
N/A

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

## REQUIRED MEDICAL INFORMATION
N/A

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# PREDNISOLONE ODT (ORAPRED ODT)

## MEDICATION(S)
PREDNISOLONE SODIUM PHOSPHATE 10 MG TAB DISP, PREDNISOLONE SODIUM PHOSPHATE 15 MG TAB DISP, PREDNISOLONE SODIUM PHOSPHATE 30 MG TAB DISP

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
N/A

## REQUIRED MEDICAL INFORMATION
Medical reason why preferred prednisolone (tablet, syrup) and prednisone (solution, tablet) cannot be used (contraindication).

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# PREGABALIN ER (LYRICA CR)

## MEDICATION(S)
PREGABALIN ER

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
N/A

## REQUIRED MEDICAL INFORMATION
Patient has tried immediate-release (IR) pregabalin or has a medical reason for not using IR pregabalin.

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# PYRIMETHAMINE (DARAPRIM)

## MEDICATION(S)
PYRIMETHAMINE

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

## OFF LABEL USES
Toxoplasmosis prevention, Toxoplasmosis chronic manintenance (secondary prophylaxis), PCP prevention, Isospora Belli treatment or secondary prevention.

## EXCLUSION CRITERIA
N/A

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

## AGE RESTRICTION
N/A

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

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# REGORAFENIB (STIVARGA)

## MEDICATION(S)
STIVARGA

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

## OFF LABEL USES
N/A

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

## REQUIRED MEDICAL INFORMATION
N/A

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# RELUGOLIX (ORGOVYX)

## MEDICATION(S)
ORGOVYX

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

## OFF LABEL USES
N/A

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

## REQUIRED MEDICAL INFORMATION
N/A

## AGE RESTRICTION
18 years of age or older.

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# RIBOCICLIB (KISQALI)

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

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

## OFF LABEL USES
N/A

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

## REQUIRED MEDICAL INFORMATION
N/A

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# RIBOCICLIB SUCCINATE/LETROZOLE (KISQALI FEMARA)

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

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

## OFF LABEL USES
N/A

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

## REQUIRED MEDICAL INFORMATION
N/A

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# RIFAXIMIN (XIFAXAN)

## MEDICATION(S)
XIFAXAN

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

## OFF LABEL USES
Clostridium difficile associated diarrhea (CDAD), Crohn's Disease

## EXCLUSION CRITERIA
N/A

## REQUIRED MEDICAL INFORMATION
Travelers diarrhea: patient has tried azithromycin or a fluoroquinolone like ciprofloxacin or has a medical reason why ciprofloxacin and azithromycin cannot be used. Hepatic Encephalopathy: patient has tried lactulose. Irritable bowel syndrome with diarrhea (IBS-D): patient has tried an anti-diarrheal drug (diphenoxylate/atropine, loperamide) OR has a medical reason not to use (contraindication) anti-diarrheal therapies. Clostridium difficile associated diarrhea (CDAD): patient has tried vancomycin. Crohn's Disease: patient has tried metronidazole or ciprofloxacin or has a medical reason why metronidazole and ciprofloxacin cannot be used.

## AGE RESTRICTION
Travelers diarrhea: 12 years of age or older. Hepatic Encephalopathy, IBS-D,Clostridium difficile associated diarrhea (CDAD), Crohn's Disease: 18 years of age or older.

## 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

# RILONACEPT (ARCALYST)

## MEDICATION(S)
ARCALYST

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
N/A

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

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
Recurrent Pericarditis: Cardiologist

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# RIOCIGUAT (ADEMPAS)

## MEDICATION(S)
ADEMPAS

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
N/A

## REQUIRED MEDICAL INFORMATION
Confirmation of Pulmonary Arterial Hypertension (WHO Group I) by right heart catheterization test AND patient has tried an endothelin-receptor antagonist (e.g. Tracleer) and a phosphodiesterase type 5 (PDE-5) inhibitor (e.g. sildenafil). Confirmation of Chronic Thromboembolic Pulmonary Hypertension (CTEPH) by a right heart catheterization or V/Q scan AND patient has been treated with surgery or cannot be treated surgery.

## AGE RESTRICTION
18 years of age or older.

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# RIPRETINIB (QINLOCK)

## MEDICATION(S)
QINLOCK

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

## OFF LABEL USES
N/A

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

## REQUIRED MEDICAL INFORMATION
N/A

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# RISANKIZUMAB-RZAA (SKYRIZI)

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

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

## OFF LABEL USES
N/A

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

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

## AGE RESTRICTION
18 years of age or older.

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

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

## OTHER CRITERIA
N/A

# RISANKIZUMAB-RZAA IV (SKYRIZI IV)

## MEDICATION(S)
SKYRIZI 600 MG/10ML SOLUTION

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

## OFF LABEL USES
N/A

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

## REQUIRED MEDICAL INFORMATION
N/A

## AGE RESTRICTION
18 years of age or older.

## PRESCRIBER RESTRICTION
N/A

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

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

# RISPERIDONE (PERSERIS ER)

## MEDICATION(S)
PERSERIS

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

## OFF LABEL USES
N/A

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

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

## AGE RESTRICTION
18 years of age or older.

## PRESCRIBER RESTRICTION
Psychiatrist

## COVERAGE DURATION
Plan year

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

# ROFLUMILAST (DALIRESP)

## MEDICATION(S)
DALIRESP, ROFLUMILAST

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
N/A

## REQUIRED MEDICAL INFORMATION
N/A

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# ROPEGINTERFERON ALFA-2B (BESREMI)

## MEDICATION(S)
BESREMI

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
N/A

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

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# RUCAPARIB CAMSYLATE (RUBRACA)

## MEDICATION(S)
RUBRACA

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

## OFF LABEL USES
N/A

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

## REQUIRED MEDICAL INFORMATION
N/A

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# RUXOLITINIB (JAKAFI)

## MEDICATION(S)
JAKAFI

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

## OFF LABEL USES
N/A

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

## REQUIRED MEDICAL INFORMATION
MF: patient has enlarged spleen and platelet count is equal to or more than 50,000 cells/mcl.
Polycythemia Vera (PV): treatment failure or side effect with hydroxyurea OR medical reason for not using hydroxyurea and hematocrit of at least 40%.
Graft vs Host Disease (GvHD): treatment failure or side effect with systemic corticosteroids (e.g. prednisone, methylprednisolone).

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

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# SACROSIDASE (SUCRAID)

## MEDICATION(S)
SUCRAID

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
N/A

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

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
Gastroenterologist, Geneticist, or Metabolic Specialist.

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# SAPROPTERIN DIHYDROCHLORIDE (KUVAN)

## MEDICATION(S)
JAVYGTOR 100 MG PACKET, JAVYGTOR 100 MG TAB, SAPROPTERIN DIHYDROCHLORIDE

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
N/A

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

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

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

## OTHER CRITERIA
N/A

# SELEGILINE TRANSDERMAL (EMSAM)

## MEDICATION(S)
EMSAM

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
N/A

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

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# SELINEXOR (XPOVIO)

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

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

## OFF LABEL USES
N/A

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

## REQUIRED MEDICAL INFORMATION
N/A

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# SELPERCATINIB (RETEVMO)

## MEDICATION(S)
RETEVMO

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

## OFF LABEL USES
N/A

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

## REQUIRED MEDICAL INFORMATION
N/A

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# SELUMETINIB (KOSELUGO)

## MEDICATION(S)
KOSELUGO

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

## OFF LABEL USES
N/A

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

## REQUIRED MEDICAL INFORMATION
N/A

## AGE RESTRICTION
2 years of age or older

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# SILDENAFIL (REVATIO)

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

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

## OFF LABEL USES
Raynauds phenomenon

## EXCLUSION CRITERIA
N/A

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

## AGE RESTRICTION
18 years of age or older.

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# SILDENAFIL (VIAGRA)

## MEDICATION(S)
SILDENAFIL CITRATE 100 MG TAB, SILDENAFIL CITRATE 25 MG TAB, SILDENAFIL CITRATE 50 MG TAB

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

## OFF LABEL USES
Penile rehabilitation, Raynaud's phenomenon

## EXCLUSION CRITERIA
N/A

## REQUIRED MEDICAL INFORMATION
ED: due to a drug or medical condition that has been reported in the medical literature to cause ED.
Penile rehabilitation: prostate removed by surgery (radical prostatectomy) within the past 6 months.
Raynaud's phenomenon: treatment failure or side effect with a calcium-channel blocker (e.g. nifedipine).

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Penile rehab: 6 months
ED and Raynaud's: plan year

## OTHER CRITERIA
ED: limited to 6 tablets per month

# SODIUM OXYBATE (XYREM)

## MEDICATION(S)
XYREM

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

## OFF LABEL USES
N/A

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

## REQUIRED MEDICAL INFORMATION
Narcolepsy is confirmed by sleep study and patient has brief losses of muscle tone (cataplexy).
Excessive daytime sleepiness due to narcolepsy: patient has tried methylphenidate, amphetamine, or dextroamphetamine, and did not respond or had a side effect to modafinil or armodafinil, OR has a medical reason not to use methylphenidates, amphetamines, dextroamphetamines, modafinil and armodafinil.

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# SODIUM PHENYLBUTYRATE (BUPHENYL)

## MEDICATION(S)
SODIUM PHENYLBUTYRATE

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
N/A

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

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# SOFOSBUVIR/VELPATASVIR (EPCLUSA)

## MEDICATION(S)
EPCLUSA, SOFOSBUVIR-VELPATASVIR

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

## OFF LABEL USES
N/A

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

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

## AGE RESTRICTION
N/A

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

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

## OTHER CRITERIA
N/A

# SOFOSBUVIR/VELPATASVIR/VOXILAPREVIR (VOSEVI)

## MEDICATION(S)
VOSEVI

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

## OFF LABEL USES
N/A

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

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

## AGE RESTRICTION
18 years of age or older.

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

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

## OTHER CRITERIA
N/A

# SOMATROPIN (NORDITROPIN)

## MEDICATION(S)
NORDITROPIN FLEXPRO

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
N/A

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

## AGE RESTRICTION
N/A

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

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# SOMATROPIN (SEROSTIM)

## MEDICATION(S)
SEROSTIM

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
N/A

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

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
12 weeks

## OTHER CRITERIA
N/A

# SONIDEGIB (ODOMZO)

## MEDICATION(S)
ODOMZO

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

## OFF LABEL USES
N/A

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

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

## AGE RESTRICTION
18 years of age or older.

## PRESCRIBER RESTRICTION
Oncologist

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

## OTHER CRITERIA
N/A

# SORAFENIB (NEXAVAR)

## MEDICATION(S)
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
N/A

# SOTORASIB (LUMAKRAS)

## MEDICATION(S)
LUMAKRAS

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

## OFF LABEL USES
N/A

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

## REQUIRED MEDICAL INFORMATION
N/A

## AGE RESTRICTION
18 years of age or older

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# STIRIPENTOL (DIACOMIT)

## MEDICATION(S)
DIACOMIT

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
N/A

## REQUIRED MEDICAL INFORMATION
Seizures due to Dravet syndrome: being used with clobazam and treatment failure or side effect with valproate or has a medical reason not to use valproate.

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# SULFONYLUREAS, LONG ACTING (HIGH RISK MEDICATION)

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

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
N/A

## REQUIRED MEDICAL INFORMATION
Patient has tried glipizide or glipizide/metformin and prescriber confirms the benefits of the drug outweigh any risks and will monitor for side effects.

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

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan Year

## OTHER CRITERIA
N/A

# SUMATRIPTAN 85MG-NAPROXEN 500MG TABLET (TREXIMET)

## MEDICATION(S)
SUMATRIPTAN-NAPROXEN SODIUM

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
N/A

## REQUIRED MEDICAL INFORMATION
Acute migraines or cluster headaches: total number of doses is not more than the amount needed to treat the number of headache days per month, and headache did not get better with sumatriptan 50mg tablet along with naproxen 500mg tablet, and patient had a side effect with sumatriptan 100mg tablet along with naproxen 500mg tablet that does not occur with the use of sumatriptan 85 mg/naproxen 500 mg tablets.

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# SUNITINIB MALATE (SUTENT)

## MEDICATION(S)
SUNITINIB MALATE

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

## OFF LABEL USES
N/A

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

## REQUIRED MEDICAL INFORMATION
N/A

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# TACROLIMUS (ENVARSUS XR)

## MEDICATION(S)
ENVARSUS XR

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
N/A

## REQUIRED MEDICAL INFORMATION
Patient has tried immediate-release (IR) tacrolimus or has a medical reason for not using IR tacrolimus.

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

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

# TACROLIMUS FOR ORAL SUSPENSION (PROGRAF GRANULES)

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

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
N/A

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

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

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

# TADALAFIL (ADCIRCA)

## MEDICATION(S)
ALYQ, TADALAFIL (PAH)

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

## OFF LABEL USES
Raynauds phenomenon

## EXCLUSION CRITERIA
N/A

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

## AGE RESTRICTION
18 years of age or older.

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# TADALAFIL (CIALIS ED)

## MEDICATION(S)
TADALAFIL 10 MG TAB, TADALAFIL 20 MG TAB

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

## OFF LABEL USES
Raynaud's phenomenon, Penile rehabilitation

## EXCLUSION CRITERIA
N/A

## REQUIRED MEDICAL INFORMATION
Raynauds phenomenon: treatment failure or side effect with a calcium-channel blocker (e.g. nifedipine) and sildenafil (Viagra). Benign Prostatic Hyperplasia (BPH): treatment failure or side effect with both finasteride and tamsulosin.
ED: due to a drug or medical condition that has been reported in the medical literature to cause ED.
Penile rehabilitation: prostate removed by surgery (radical prostatectomy) within the past 6 months.

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Penile rehab: 6 months
ED and Raynaud's: plan year

## OTHER CRITERIA
ED: limited to 6 tablets per month

# 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 (e.g. nifedipine) and sildenafil (Viagra). Benign Prostatic Hyperplasia (BPH): treatment failure or side effect with both finasteride and tamsulosin.

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# TAFAMIDIS (VYNDAMAX)

## MEDICATION(S)
VYNDAMAX

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

## OFF LABEL USES
N/A

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

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

## AGE RESTRICTION
18 years of age or older.

## PRESCRIBER RESTRICTION
Cardiologist

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# TAFAMIDIS MEGLUMINE (VYNDAQEL)

## MEDICATION(S)
VYNDAQEL

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

## OFF LABEL USES
N/A

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

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

## AGE RESTRICTION
18 years of age or older.

## PRESCRIBER RESTRICTION
Cardiologist

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# TALAZOPARIB TOSYLATE (TALZENNA)

## MEDICATION(S)
TALZENNA

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

## OFF LABEL USES
N/A

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

## REQUIRED MEDICAL INFORMATION
N/A

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# TASIMELTEON (HETLIOZ)

## MEDICATION(S)
HETLIOZ

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
N/A

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

## AGE RESTRICTION
Non 24 Sleep Wake Cycle: 18 years of age or older. Smith-Magenis Syndrome: 16 years of age or older.

## PRESCRIBER RESTRICTION
N/A

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

## OTHER CRITERIA
N/A

# TAVABOROLE (KERYDIN)

## MEDICATION(S)
TAVABOROLE

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
N/A

## REQUIRED MEDICAL INFORMATION
Trial and failure to either oral terbinafine or oral itraconazole OR contraindication to both oral terbinafine and oral itraconazole

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
48 weeks

## OTHER CRITERIA
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
Documentation to confirm patient is not a candidate to have the cancer removed by surgery.

## AGE RESTRICTION
16 years of age or older.

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# TEDUGLUTIDE (GATTEX)

## MEDICATION(S)
GATTEX

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
N/A

## REQUIRED MEDICAL INFORMATION
Initial use: patient has been dependent on parenteral nutrition for at least 3 months
Ongoing use: patient is still receiving parenteral nutrition (e.g. TPN or PPN) and has had a reduction in weekly parenteral nutrition volume since starting Gattex.

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
6 months

## OTHER CRITERIA
N/A

# TELOTRISTAT ETHYL (XERMELO)

## MEDICATION(S)
XERMELO

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
N/A

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

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# TEPOTINIB (TEPMETKO)

## MEDICATION(S)
TEPMETKO

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

## OFF LABEL USES
N/A

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

## REQUIRED MEDICAL INFORMATION
N/A

## AGE RESTRICTION
18 years of age or older.

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# TERIFLUNOMIDE (AUBAGIO)

## MEDICATION(S)
AUBAGIO

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

## OFF LABEL USES
N/A

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

## REQUIRED MEDICAL INFORMATION
N/A

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# TERIPARATIDE (FORTEO)

## MEDICATION(S)
FORTEO

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
Being used with other osteoporosis drugs.

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

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA

N/A

# TESAMORELIN ACETATE (EGRIFTA)

## MEDICATION(S)
EGRIFTA, EGRIFTA SV

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
Patient has a current malignancy.

## REQUIRED MEDICAL INFORMATION
Initial use: prescriber states patient has an intact hypothalamic-pituitary-adrenal axis AND CT scan results confirm excess visceral fat accumulation OR for men: having a waist circumference greater than 37.4 inches (97 cm) and a waist to hip ratio greater than or equal to 0.94 or for women: having a waist circumference greater than 37 inches (94 cm) and a waist to hip ratio greater than or equal to 0.88.
Ongoing use: patient has had or maintained improvement in waist circumference.

## AGE RESTRICTION
18 years of age or older.

## PRESCRIBER RESTRICTION
Endocrinologist or HIV Specialist

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

## OTHER CRITERIA
N/A

# TETRABENAZINE (XENAZINE)

## MEDICATION(S)
TETRABENAZINE

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
N/A

## REQUIRED MEDICAL INFORMATION
N/A

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# TEZACAFTOR-IVACAFTOR (SYMDEKO)

## MEDICATION(S)
SYMDEKO

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

## OFF LABEL USES
N/A

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

## REQUIRED MEDICAL INFORMATION
N/A

## AGE RESTRICTION
6 years of age or older.

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# THALIDOMIDE (THALOMID)

## MEDICATION(S)
THALOMID

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

## OFF LABEL USES
N/A

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

## REQUIRED MEDICAL INFORMATION
N/A

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# TIOPRONIN (THIOLA)

## MEDICATION(S)
THIOLA EC, TIOPRONIN

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
N/A

## REQUIRED MEDICAL INFORMATION
N/A

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# TIVOZANIB (FOTIVDA)

## MEDICATION(S)
FOTIVDA

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

## OFF LABEL USES
N/A

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

## REQUIRED MEDICAL INFORMATION
N/A

## AGE RESTRICTION
18 years of age or older.

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# TOBRAMYCIN (TOBI PODHALER)

## MEDICATION(S)
TOBI PODHALER

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

## OFF LABEL USES
bronchiectasis

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

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

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# TOBRAMYCIN INHALATION AGENTS

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

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

## OFF LABEL USES
bronchiectasis

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

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

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

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

# TOFACITINIB (XELJANZ, XELJANZ XR)

## MEDICATION(S)
XELJANZ, XELJANZ XR

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

## OFF LABEL USES
N/A

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

## REQUIRED MEDICAL INFORMATION
Rheumatoid Arthritis: treatment failure or side effect with methotrexate. Psoriatic arthritis (PsA): treatment failure or side effect with one DMARD drug or medical reason why methotrexate, leflunomide, and sulfasalazine cannot be used. Polyarticular Juvenile Idiopathic Arthritis (pJIA): treatment failure or side effect with one DMARD drug or medical reason why methotrexate cannot be used. For oral solution for all indications: patient is unable to swallow a tablet. Spondyloarthritis (SpA): patient is not able to take NSAIDs due to history of GI bleed or ulcer OR patient has tried one RX strength NSAID in combination with a PPI and had GI side effects OR patient's condition did not respond to a trial of two different RX strength NSAIDs AND treatment failure or side effect to a TNF inhibitor (i.e., Humira) or medical reason why a TNF inhibitor cannot be used.

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

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

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

## OTHER CRITERIA
N/A

# TOPICAL DOXEPIN (ZONALON)

## MEDICATION(S)
DOXEPIN HCL 5 % CREAM

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
N/A

## REQUIRED MEDICAL INFORMATION
Trial of two topical steroids in the medium, high, or very high potency class or there is a medical reason why topical steroids cannot be used (contraindication).

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
8 days

## OTHER CRITERIA
N/A

# TOPICAL TESTOSTERONE PRODUCTS

## MEDICATION(S)
TESTOSTERONE 1.62 % GEL, TESTOSTERONE 10 MG/ACT (2%) GEL, TESTOSTERONE 12.5 MG/ACT (1%) GEL, TESTOSTERONE 20.25 MG/1.25GM (1.62%) GEL, TESTOSTERONE 20.25 MG/ACT (1.62%) GEL, TESTOSTERONE 25 MG/2.5GM (1%) GEL, TESTOSTERONE 30 MG/ACT SOLUTION, TESTOSTERONE 40.5 MG/2.5GM (1.62%) GEL, TESTOSTERONE 50 MG/5GM (1%) GEL

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

## OFF LABEL USES
transgender, gender dysphoria

## EXCLUSION CRITERIA
N/A

## REQUIRED MEDICAL INFORMATION
N/A

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# TOPIRAMATE EXTENDED RELEASE (QUDEXY XR)

## MEDICATION(S)
TOPIRAMATE ER

## 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 immediate-release topiramate.

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# TOPIRAMATE ORAL SOLUTION (EPRONTIA)

## MEDICATION(S)
EPRONTIA

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
N/A

## REQUIRED MEDICAL INFORMATION
Medical reason why patient cannot use topiramate tablet or sprinkle capsules

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# TRAMADOL ER (CONZIP, RYZOLT) – NARCOTIC SAFETY INITIATIVE

## MEDICATION(S)
TRAMADOL HCL ER 100 MG CAP ER 24H, TRAMADOL HCL ER 150 MG CAP ER 24H, TRAMADOL HCL ER 200 MG CAP ER 24H, TRAMADOL HCL ER 300 MG CAP ER 24H, TRAMADOL HCL ER (BIPHASIC)

## 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 tramadol immediate-release and intolerable side effect to the preferred tramadol extended release (generic Ultram ER), and chart notes document pain history including baseline pain intensity score and functional interference score, a plan for monitoring side effects and misuse, and a plan to taper down narcotics.
Non-cancer pain, reauth: total daily dose across all narcotic drugs is less than 90 MME per day, and dose has been consolidated to the least number of higher strength forms, and chart notes document current pain intensity score, functional interference score, any side effects and/or misuse with current pain treatment regimen, and plan to taper narcotic use.

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
Cancer Pain: Oncologist or Pain Specialist.

## COVERAGE DURATION

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

## OTHER CRITERIA

N/A

# TRAMADOL ER (ULTRAM ER) – NARCOTIC SAFETY INITIATIVE

## MEDICATION(S)
TRAMADOL HCL ER 100 MG TAB ER 24H, TRAMADOL HCL ER 200 MG TAB ER 24H, TRAMADOL HCL ER 300 MG TAB ER 24H

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

## OFF LABEL USES
N/A

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

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

## AGE RESTRICTION
N/A

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

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

## OTHER CRITERIA

N/A

# TRAMETINIB (MEKINIST)

## MEDICATION(S)
MEKINIST

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

## OFF LABEL USES
N/A

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

## REQUIRED MEDICAL INFORMATION
N/A

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# TRANSMUCOSAL FENTANYL PRODUCTS

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

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
N/A

## REQUIRED MEDICAL INFORMATION
Documentation of pain due to cancer.

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
Oncologist or Pain Management Specialist

## COVERAGE DURATION
6 months

## OTHER CRITERIA
N/A

# TRETINOIN MICROSPHERE (RETIN-A MICRO)

## MEDICATION(S)
TRETINOIN MICROSPHERE, TRETINOIN MICROSPHERE PUMP

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
N/A

## REQUIRED MEDICAL INFORMATION
Treatment failure to two generic retinoid products (e.g. tretinoin 0.25% cream, adapalene cream).

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

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# TRETINOIN PRODUCTS (AVITA, RETIN-A, ATRALIN)

## MEDICATION(S)
AVITA, TRETINOIN 0.01 % GEL, TRETINOIN 0.025 % CREAM, TRETINOIN 0.025 % GEL, TRETINOIN 0.05 % CREAM, TRETINOIN 0.05 % GEL, TRETINOIN 0.1 % CREAM

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
N/A

## REQUIRED MEDICAL INFORMATION
N/A

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

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# TRIAMCINOLONE TOPICAL SPRAY (KENALOG)

## MEDICATION(S)
TRIAMCINOLONE ACETONIDE 0.147 MG/GM AERO SOLN

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
N/A

## REQUIRED MEDICAL INFORMATION
Trial  of triamcinolone cream, ointment, or lotion AND one other topical steroid in the same or higher potency (strength) class.

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# TRIENTINE HCL (SYPRINE)

## MEDICATION(S)
CLOVIQUE, TRIENTINE HCL

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
N/A

## REQUIRED MEDICAL INFORMATION
N/A

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# TRIFLURIDINE/TIPIRACIL HCL (LONSURF)

## MEDICATION(S)
LONSURF

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

## OFF LABEL USES
N/A

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

## REQUIRED MEDICAL INFORMATION
N/A

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# TUCATINIB (TUKYSA)

## MEDICATION(S)
TUKYSA

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

## OFF LABEL USES
N/A

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

## REQUIRED MEDICAL INFORMATION
N/A

## AGE RESTRICTION
18 years of age or older.

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# UBROGEPANT (UBRELVY)

## MEDICATION(S)
UBRELVY

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
N/A

## REQUIRED MEDICAL INFORMATION
Trial of at least two triptans (e.g., sumatriptan, rizatriptian, naratriptan) or has a medical reason (contraindication) for not using triptans.

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# UMBRALISIB TOSYLATE (UKONIQ)

## MEDICATION(S)
UKONIQ

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

## OFF LABEL USES
N/A

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

## REQUIRED MEDICAL INFORMATION
N/A

## AGE RESTRICTION
18 years of age or older.

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

MEDICATION(S)
LACTULOSE 10 GM PACKET

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Medical reason why patient is not able to use the bulk formulation.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
N/A

# UPADACITINIB (RINVOQ)

## MEDICATION(S)
RINVOQ

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

## OFF LABEL USES
N/A

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

## REQUIRED MEDICAL INFORMATION
Rheumatoid Arthritis: treatment failure or side effect with methotrexate. Psoriatic arthritis (PsA): treatment failure or side effect with one DMARD drug or medical reason why methotrexate, leflunomide, and sulfasalazine cannot be used AND treatment failure or side effect to a TNF inhibitor (i.e., Humira) or medical reason why a TNF inhibitor cannot be used.
Atopic Dermatitis: moderate to severe disease confirmed by Investigators Global Assessment (IGA) score of 3-4, Eczema Area and Severity Index (EASI) score of at least 16, Body surface area of at least 10%, or Severity Scoring of Atopic Dermatitis Index (SCORAD) score of at least 25 AND treatment failure or side effect with a topical calcineurin inhibitor (i.e., tacrolimus ointment) AND any of the following systemic therapies: methotrexate, corticosteroids, azathioprine, mycophenolate mofetil OR has a medical reason why these topical and systemic therapies cannot be used.
Ulcerative Colitis (UC): Trial of  a TNF inhibitor (i.e., Humira).
Spondyloarthritis (SpA): One of the following: 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 AND trial of a TNF inhibitor (i.e., Humira).

## AGE RESTRICTION
RA, PsA, UC, SpA: 18 years of age or older. Atopic Dermatitis: 12 years of age or older

## PRESCRIBER RESTRICTION
RA, PsA, SpA: Rheumatologist.
Atopic Dermatitis: Dermatologist, Allergist, or Immunologist

## COVERAGE DURATION
RA, PsA, Atopic Dermatitis, UC, SpA: Plan year

## OTHER CRITERIA
N/A

# USTEKINUMAB IV (STELARA IV)

## MEDICATION(S)
STELARA 130 MG/26ML SOLUTION

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

## OFF LABEL USES
N/A

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

## REQUIRED MEDICAL INFORMATION
N/A

## AGE RESTRICTION
18 years of age or older.

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
one time induction infusion

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

# USTEKINUMAB SQ (STELARA)

## MEDICATION(S)
STELARA 45 MG/0.5ML SOLN PRSYR, STELARA 45 MG/0.5ML SOLUTION, STELARA 90 MG/ML SOLN PRSYR

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

## OFF LABEL USES
N/A

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

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

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

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

## COVERAGE DURATION
PsO initial use: 28 weeks. PsO ongoing use, CD, UC, and PsA: plan year.

## OTHER CRITERIA

N/A

# VALBENAZINE (INGREZZA)

## MEDICATION(S)
INGREZZA

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
N/A

## REQUIRED MEDICAL INFORMATION
N/A

## AGE RESTRICTION
18 years of age or older.

## PRESCRIBER RESTRICTION
Tardive Dyskinesia: Neurologist or Psychiatrist.

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# VANCOMYCIN ORAL SOLUTION (FIRVANQ)

## MEDICATION(S)
VANCOMYCIN HCL 250 MG/5ML RECON SOLN

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
N/A

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

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
10 days

## OTHER CRITERIA
N/A

# VANDETANIB (CAPRELSA)

## MEDICATION(S)
CAPRELSA

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

## OFF LABEL USES
N/A

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

## REQUIRED MEDICAL INFORMATION
N/A

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# VARDENAFIL (LEVITRA, STAXYN)

## MEDICATION(S)
VARDENAFIL HCL

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

## OFF LABEL USES
Benign Prostatic Hyperplasia, Raynaud's phenomenon

## EXCLUSION CRITERIA
N/A

## REQUIRED MEDICAL INFORMATION
Raynaud's phenomenon: treatment failure or side effect with a calcium-channel blocker (e.g. nifedipine) and treatment failure or side effect with sildenafil (Viagra).
BPH: trial of both finasteride and tamsulosin.
ED: due to a drug or medical condition that has been reported in the medical literature to cause ED and treatment failure or side effect with sildenafil (Viagra) and tadalafil (Cialis).

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
ED: limited to 6 tablets per month.

# VEMURAFENIB (ZELBORAF)

## MEDICATION(S)
ZELBORAF

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

## OFF LABEL USES
N/A

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

## REQUIRED MEDICAL INFORMATION
N/A

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# VENETOCLAX (VENCLEXTA)

## MEDICATION(S)
VENCLEXTA, VENCLEXTA STARTING PACK

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

## OFF LABEL USES
N/A

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

## REQUIRED MEDICAL INFORMATION
N/A

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# VIGADRONE AND VIGABATRIN (SABRIL)

## MEDICATION(S)
VIGABATRIN, VIGADRONE

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
N/A

## REQUIRED MEDICAL INFORMATION
For continued use: ongoing diagnosis of infantile spasm is confirmed by EEG OR prescriber provides medical reason for continued use. Complex partial seizures: patient has tried two other drugs that stop seizures

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

## PRESCRIBER RESTRICTION
Infantile spasms: Neurologist

## COVERAGE DURATION
Seizures: annual Infantile spasms: 6 months

## OTHER CRITERIA
N/A

# VISMODEGIB (ERIVEDGE)

## MEDICATION(S)
ERIVEDGE

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

## OFF LABEL USES
N/A

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

## REQUIRED MEDICAL INFORMATION
N/A

## AGE RESTRICTION
18 years of age or older.

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

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# VORICONAZOLE ORAL (VFEND)

## MEDICATION(S)
VORICONAZOLE 200 MG TAB, VORICONAZOLE 40 MG/ML RECON SUSP, VORICONAZOLE 50 MG TAB

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

## OFF LABEL USES
Prophylaxis of Disseminated Candidiasis, Candida Endopthalmitis, Oropharyngeal Candidiasis, Allergic bronchopulmonary aspergillosis, 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 and has a weakened defense system (immunosuppressed).

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
BMT:6mo Lung tx:3mo Esophageal candida:1mo Candidemia/deep-tissue:1mo Other ind in other criteria

## OTHER CRITERIA
coverage duration: ABPA: 4 month systemic treatment: plan year

# VORINOSTAT (ZOLINZA)

## MEDICATION(S)
ZOLINZA

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

## OFF LABEL USES
N/A

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

## REQUIRED MEDICAL INFORMATION
N/A

## AGE RESTRICTION
18 years of age or older.

## PRESCRIBER RESTRICTION
Oncologist

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# VOXELOTOR (OXBRYTA)

## MEDICATION(S)
OXBRYTA

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
N/A

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

## AGE RESTRICTION
4 years of age or older.

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# ZANUBRUTINIB (BRUKINSA)

## MEDICATION(S)
BRUKINSA

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

## OFF LABEL USES
N/A

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

## REQUIRED MEDICAL INFORMATION
N/A

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

# ZILEUTON EXTENDED RELEASE (ZYFLO CR)

## MEDICATION(S)
ZILEUTON ER

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

## OFF LABEL USES
N/A

## EXCLUSION CRITERIA
N/A

## REQUIRED MEDICAL INFORMATION
Asthma: patient has tried both montelukast and zafirlukast.

## AGE RESTRICTION
N/A

## PRESCRIBER RESTRICTION
N/A

## COVERAGE DURATION
Plan year

## OTHER CRITERIA
N/A

## Part B vs D drugs

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

Medication(s)

| MEDICATION NAME | ROUTE | DOSE FORM |
|---|---|---|
| Abelcet 5 MG/ML SUSPENSION | IV | SUSPENSION |
| Abraxane 100 MG RECON SUSP | IV | RECON SUSP |
| Acetadote 200 MG/ML SOLUTION | IV | SOLUTION |
| Acetaminophen 10 MG/ML SOLUTION | IV | SOLUTION |
| Acetaminophen 1000 MG/100ML SOLUTION | IV | SOLUTION |
| Acetylcysteine 10 % SOLUTION | IN | SOLUTION |
| Acetylcysteine 20 % SOLUTION | IN | SOLUTION |
| Acetylcysteine 200 MG/ML SOLUTION | IV | SOLUTION |
| Acyclovir Sodium 50 MG/ML SOLUTION | IV | SOLUTION |
| Acyclovir Sodium 500 MG RECON SOLN | IV | RECON SOLN |
| Adcetris 50 MG RECON SOLN | IV | RECON SOLN |
| Adriamycin 10 MG RECON SOLN | IV | RECON SOLN |
| Adriamycin 2 MG/ML SOLUTION | IV | SOLUTION |
| Adriamycin 50 MG RECON SOLN | IV | RECON SOLN |
| Adrucil 2.5 GM/50ML SOLUTION | IV | SOLUTION |
| Adrucil 5 GM/100ML SOLUTION | IV | SOLUTION |
| Adrucil 500 MG/10ML SOLUTION | IV | SOLUTION |
| Akynzeo 235-0.25 MG RECON SOLN | IV | RECON SOLN |
| Akynzeo 235-0.25 MG/20ML SOLUTION | IV | SOLUTION |
| Akynzeo 300-0.5 MG CAP | PO | CAP |
| Albuterol Sulfate (2.5 MG/3ML) 0.083% NEBU SOLN | IN | NEBU SOLN |
| Albuterol Sulfate (5 MG/ML) 0.5% NEBU SOLN | IN | NEBU SOLN |
| Albuterol Sulfate 0.63 MG/3ML NEBU SOLN | IN | NEBU SOLN |
| Albuterol Sulfate 1.25 MG/3ML NEBU SOLN | IN | NEBU SOLN |
| Albuterol Sulfate 2.5 MG/0.5ML NEBU SOLN | IN | NEBU SOLN |
| Aldurazyme 2.9 MG/5ML SOLUTION | IV | SOLUTION |
| Alimta 100 MG RECON SOLN | IV | RECON SOLN |
| Alimta 500 MG RECON SOLN | IV | RECON SOLN |
| Aliqopa 60 MG RECON SOLN | IV | RECON SOLN |
| Alkeran 2 MG TAB | PO | TAB |
| Alkeran 50 MG RECON SOLN | IV | RECON SOLN |
| Allopurinol Sodium 500 MG RECON SOLN | IV | RECON SOLN |
| Aloprim 500 MG RECON SOLN | IV | RECON SOLN |
| Aloxi 0.25 MG/5ML SOLUTION | IV | SOLUTION |
| Alymsys 100 MG/4ML SOLUTION | IV | SOLUTION |
| Alymsys 400 MG/16ML SOLUTION | IV | SOLUTION |

| MEDICATION NAME | ROUTE | DOSE FORM |
|---|---|---|
| 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 10 % SOLUTION | IV | SOLUTION |
| Aminosyn 8.5 % SOLUTION | IV | SOLUTION |
| Aminosyn II 10 % SOLUTION | IV | SOLUTION |
| Aminosyn II 15 % SOLUTION | IV | SOLUTION |
| Aminosyn II 8.5 % SOLUTION | IV | SOLUTION |
| Aminosyn II/Electrolytes 8.5 % SOLUTION | IV | SOLUTION |
| Aminosyn M 3.5 % SOLUTION | IV | SOLUTION |
| Aminosyn-HBC 7 % SOLUTION | IV | SOLUTION |
| Aminosyn-PF 10 % SOLUTION | IV | SOLUTION |
| Aminosyn-PF 7 % SOLUTION | IV | SOLUTION |
| Aminosyn-RF 5.2 % SOLUTION | IV | SOLUTION |
| Aminosyn/Electrolytes 7 % SOLUTION | IV | SOLUTION |
| Aminosyn/Electrolytes 8.5 % SOLUTION | IV | SOLUTION |
| Amiodarone HCl 150 MG/3ML SOLUTION | IV | SOLUTION |
| Amiodarone HCl 450 MG/9ML SOLUTION | IV | SOLUTION |
| Amiodarone HCl 900 MG/18ML SOLUTION | IV | SOLUTION |
| Amphotericin B 50 MG RECON SOLN | IV | RECON SOLN |
| Amphotericin B Liposome 50 MG RECON SUSP | IV | RECON SUSP |
| Amvuttra 25 MG/0.5ML SOLN PRSYR | SC | SOLN PRSYR |
| Anzemet 100 MG TAB | PO | TAB |
| Anzemet 50 MG TAB | PO | TAB |
| Aprepitant 125 MG CAP | PO | CAP |
| Aprepitant 80 & 125 MG CAP | PO | CAP |
| Aprepitant 80 & 125 MG MISC | PO | MISC |
| Aprepitant 80 MG CAP | PO | CAP |
| Apretude 600 MG/3ML SUSP | IM | SUSP |
| Aralast NP 1000 MG RECON SOLN | IV | RECON SOLN |
| Aralast NP 500 MG RECON SOLN | IV | RECON SOLN |
| Arformoterol Tartrate 15 MCG/2ML NEBU SOLN | IN | NEBU SOLN |
| Argatroban 250 MG/2.5ML SOLUTION | IV | SOLUTION |
| Argatroban 50 MG/50ML SOLUTION | IV | SOLUTION |
| Arranon 5 MG/ML SOLUTION | IV | SOLUTION |
| Arsenic Trioxide 10 MG/10ML SOLUTION | IV | SOLUTION |
| Arsenic Trioxide 12 MG/6ML SOLUTION | IV | SOLUTION |
| Arzerra 100 MG/5ML CONC | IV | CONC |
| Arzerra 1000 MG/50ML CONC | IV | CONC |
| Asceniv 5 GM/50ML SOLUTION | IV | SOLUTION |
| Astagraf XL 0.5 MG CAP ER 24H | PO | CAP ER 24H |
| Astagraf XL 1 MG CAP ER 24H | PO | CAP ER 24H |
| Astagraf XL 5 MG CAP ER 24H | PO | CAP ER 24H |

| MEDICATION NAME | ROUTE | DOSE FORM |
|---|---|---|
| Atgam 50 MG/ML INJECTABLE | IV | INJECTABLE |
| Ativan 2 MG/ML SOLUTION | IJ | SOLUTION |
| Ativan 4 MG/ML SOLUTION | IJ | SOLUTION |
| Avastin 100 MG/4ML SOLUTION | IV | SOLUTION |
| Avastin 400 MG/16ML SOLUTION | IV | SOLUTION |
| Aveed 750 MG/3ML SOLUTION | IM | SOLUTION |
| Avelox 400 MG/250ML SOLUTION | IV | SOLUTION |
| Avsola 100 MG RECON SOLN | IV | RECON SOLN |
| Avycaz 2.5 (2-0.5) GM RECON SOLN | IV | RECON SOLN |
| AzaCITIDine 100 MG RECON SUSP | IJ | RECON SUSP |
| Azactam in Dextrose 1 GM/50ML SOLUTION | IV | SOLUTION |
| Azactam in Dextrose 2 GM/50ML SOLUTION | IV | SOLUTION |
| Azasan 100 MG TAB | PO | TAB |
| Azasan 75 MG TAB | PO | TAB |
| azaTHIOprine 100 MG TAB | PO | TAB |
| AzaTHIOprine 50 MG TAB | PO | TAB |
| azaTHIOprine 75 MG TAB | PO | TAB |
| AzaTHIOprine Sodium 100 MG RECON SOLN | IJ | RECON SOLN |
| Baclofen 10 MG/20ML SOLUTION | IT | SOLUTION |
| Baclofen 20000 MCG/20ML SOLUTION | IT | SOLUTION |
| Baclofen 40 MG/20ML SOLUTION | IT | SOLUTION |
| Bavencio 200 MG/10ML SOLUTION | IV | SOLUTION |
| Beleodaq 500 MG RECON SOLN | IV | RECON SOLN |
| Belrapzo 100 MG/4ML SOLUTION | IV | SOLUTION |
| Bendamustine HCl 100 MG/4ML SOLUTION | IV | SOLUTION |
| Bendeka 100 MG/4ML SOLUTION | IV | SOLUTION |
| Benlysta 120 MG RECON SOLN | IV | RECON SOLN |
| Benlysta 400 MG RECON SOLN | IV | RECON SOLN |
| Bentyl 10 MG/ML SOLUTION | IM | SOLUTION |
| Beovu 6 MG/0.05ML SOLN PRSYR | IZ | SOLN PRSYR |
| Beovu 6 MG/0.05ML SOLUTION | IZ | SOLUTION |
| Besponsa 0.9 MG RECON SOLN | IV | RECON SOLN |
| Betamethasone Combo 6 (3-3) MG/ML SUSPENSION | IJ | SUSPENSION |
| Betamethasone Sod Phos & Acet 6 (3-3) MG/ML SUSPENSION | IJ | SUSPENSION |
| Bethkis 300 MG/4ML NEBU SOLN | IN | NEBU SOLN |
| BiCNU 100 MG RECON SOLN | IV | RECON SOLN |
| Blenrep 100 MG RECON SOLN | IV | RECON SOLN |
| Bleomycin Sulfate 15 UNIT RECON SOLN | IJ | RECON SOLN |
| Bleomycin Sulfate 30 UNIT RECON SOLN | IJ | RECON SOLN |
| Blincyto 35 MCG RECON SOLN | IV | RECON SOLN |
| Boniva 3 MG/3ML SOLUTION | IV | SOLUTION |
| Bortezomib 1 MG RECON SOLN | IJ | RECON SOLN |

| MEDICATION NAME | ROUTE | DOSE FORM |
|---|---|---|
| Bortezomib 2.5 MG RECON SOLN | IJ | RECON SOLN |
| Bortezomib 3.5 MG RECON SOLN | IJ | RECON SOLN |
| Bortezomib 3.5 MG RECON SOLN | IV | RECON SOLN |
| Bortezomib 3.5 MG/1.4ML SOLUTION | IJ | SOLUTION |
| Botox 100 UNIT RECON SOLN | IJ | RECON SOLN |
| Botox 200 UNIT RECON SOLN | IJ | RECON SOLN |
| Brovana 15 MCG/2ML NEBU SOLN | IN | NEBU SOLN |
| Budesonide 0.25 MG/2ML SUSPENSION | IN | SUSPENSION |
| Budesonide 0.5 MG/2ML SUSPENSION | IN | SUSPENSION |
| Budesonide 1 MG/2ML SUSPENSION | IN | SUSPENSION |
| Buprenex 0.3 MG/ML SOLUTION | IJ | SOLUTION |
| Buprenorphine HCl 0.3 MG/ML SOLUTION | IJ | SOLUTION |
| Busulfan 6 MG/ML SOLUTION | IV | SOLUTION |
| Busulfex 6 MG/ML SOLUTION | IV | SOLUTION |
| Byooviz 0.5 MG/0.05ML SOLUTION | IZ | SOLUTION |
| Cabenuva 400 & 600 MG/2ML SUSP | IM | SUSP |
| Cabenuva 600 & 900 MG/3ML SUSP | IM | SUSP |
| Calcitonin (Salmon) 200 UNIT/ML SOLUTION | IJ | SOLUTION |
| Calcitriol 0.25 MCG CAP | PO | CAP |
| Calcitriol 0.5 MCG CAP | PO | CAP |
| Calcitriol 1 MCG/ML SOLUTION | IV | SOLUTION |
| Calcitriol 1 MCG/ML SOLUTION | PO | SOLUTION |
| Calcium Gluconate 10 % SOLUTION | IV | SOLUTION |
| Caldolor 800 MG/200ML SOLUTION | IV | SOLUTION |
| Caldolor 800 MG/8ML SOLUTION | IV | SOLUTION |
| Camcevi 42 MG PRSYR | SC | PRSYR |
| Campath 30 MG/ML SOLUTION | IV | SOLUTION |
| Camptosar 100 MG/5ML SOLUTION | IV | SOLUTION |
| Camptosar 300 MG/15ML SOLUTION | IV | SOLUTION |
| Camptosar 40 MG/2ML SOLUTION | IV | SOLUTION |
| CARBOplatin 150 MG/15ML SOLUTION | IV | SOLUTION |
| CARBOplatin 450 MG/45ML SOLUTION | IV | SOLUTION |
| CARBOplatin 50 MG/5ML SOLUTION | IV | SOLUTION |
| CARBOplatin 600 MG/60ML SOLUTION | IV | SOLUTION |
| Cardene IV 20-0.86 MG/200ML-% SOLUTION | IV | SOLUTION |
| Cardene IV 20-4.8 MG/200ML-% SOLUTION | IV | SOLUTION |
| Cardene IV 40-0.83 MG/200ML-% SOLUTION | IV | SOLUTION |
| Carmustine 100 MG RECON SOLN | IV | RECON SOLN |
| Carmustine 300 MG RECON SOLN | IV | RECON SOLN |
| Carmustine 50 MG RECON SOLN | IV | RECON SOLN |
| Carnitor 200 MG/ML SOLUTION | IV | SOLUTION |
| ceFAZolin in Sodium Chloride 2-0.9 GM/100ML-% SOLUTION | IV | SOLUTION |

| MEDICATION NAME | ROUTE | DOSE FORM |
|---|---|---|
| CeFAZolin in Sodium Chloride 2-0.9 GM/50ML-% SOLUTION | IV | SOLUTION |
| CeFAZolin in Sodium Chloride 3-0.9 GM/100ML-% SOLUTION | IV | SOLUTION |
| CeFAZolin Sodium-Dextrose 1-4 GM-%(50ML) RECON SOLN | IV | RECON SOLN |
| CeFAZolin Sodium-Dextrose 1-4 GM/50ML-% SOLUTION | IV | SOLUTION |
| CeFAZolin Sodium-Dextrose 2-3 GM-%(50ML) RECON SOLN | IV | RECON SOLN |
| CeFAZolin Sodium-Dextrose 2-4 GM/100ML-% SOLUTION | IV | SOLUTION |
| CeFAZolin Sodium-Dextrose 2-5 GM/100ML-% SOLUTION | IV | SOLUTION |
| CeFAZolin Sodium-Dextrose 2-5 GM/50ML-% SOLUTION | IV | SOLUTION |
| CeFAZolin Sodium-Dextrose 3-5 GM/100ML-% SOLUTION | IV | SOLUTION |
| Cefepime HCl 100 GM RECON SOLN | IV | RECON SOLN |
| Cefepime-Dextrose 1-5 GM-%(50ML) RECON SOLN | IV | RECON SOLN |
| Cefepime-Dextrose 2-5 GM-%(50ML) RECON SOLN | IV | RECON SOLN |
| CefoTEtan Disodium-Dextrose 1-3.58 GM-%(50ML) RECON SOLN | IV | RECON SOLN |
| CefoTEtan Disodium-Dextrose 2-2.08 GM-%(50ML) RECON SOLN | IV | RECON SOLN |
| CefOXitin Sodium-Dextrose 1-4 GM-%(50ML) RECON SOLN | IV | RECON SOLN |
| CefOXitin Sodium-Dextrose 2-2.2 GM-%(50ML) RECON SOLN | IV | RECON SOLN |
| CefTAZidime and Dextrose 1-5 GM-%(50ML) RECON SOLN | IV | RECON SOLN |
| CefTAZidime and Dextrose 2-5 GM-%(50ML) RECON SOLN | IV | RECON SOLN |
| CefTRIAXone Sodium 100 GM RECON SOLN | IJ | RECON SOLN |
| CefTRIAXone Sodium in Dextrose 20 MG/ML SOLUTION | IV | SOLUTION |
| CefTRIAXone Sodium in Dextrose 40 MG/ML SOLUTION | IV | SOLUTION |
| CefTRIAXone Sodium-Dextrose 1-3.74 GM-%(50ML) RECON SOLN | IV | RECON SOLN |
| CefTRIAXone Sodium-Dextrose 2-2.22 GM-%(50ML) RECON SOLN | IV | RECON SOLN |
| Celestone Soluspan 6 (3-3) MG/ML SUSPENSION | IJ | SUSPENSION |
| CellCept 200 MG/ML RECON SUSP | PO | RECON SUSP |
| CellCept 250 MG CAP | PO | CAP |
| CellCept 500 MG TAB | PO | TAB |
| CellCept Intravenous 500 MG RECON SOLN | IV | RECON SOLN |
| Cerebyx 100 MG PE/2ML SOLUTION | IJ | SOLUTION |
| Cerebyx 500 MG PE/10ML SOLUTION | IJ | SOLUTION |

| MEDICATION NAME | ROUTE | DOSE FORM |
|---|---|---|
| Cesamet 1 MG CAP | PO | CAP |
| Chlorothiazide Sodium 500 MG RECON SOLN | IV | RECON SOLN |
| Chorionic Gonadotropin 10000 UNIT RECON SOLN | IM | RECON SOLN |
| Cidofovir 75 MG/ML SOLUTION | IV | SOLUTION |
| Cimerli 0.3 MG/0.05ML SOLUTION | IZ | SOLUTION |
| Cimerli 0.5 MG/0.05ML SOLUTION | IZ | SOLUTION |
| Cinacalcet HCl 30 MG TAB | PO | TAB |
| Cinacalcet HCl 60 MG TAB | PO | TAB |
| Cinacalcet HCl 90 MG TAB | PO | TAB |
| Cinqair 100 MG/10ML SOLUTION | IV | SOLUTION |
| Cinvanti 130 MG/18ML EMULSION | IV | EMULSION |
| Cipro in D5W 400 MG/200ML SOLUTION | IV | SOLUTION |
| Ciprofloxacin in D5W 400 MG/200ML SOLUTION | IV | SOLUTION |
| CISplatin 100 MG/100ML SOLUTION | IV | SOLUTION |
| CISplatin 200 MG/200ML SOLUTION | IV | SOLUTION |
| CISplatin 50 MG RECON SOLN | IV | RECON SOLN |
| CISplatin 50 MG/50ML SOLUTION | IV | SOLUTION |
| Cladribine 10 MG/10ML SOLUTION | IV | SOLUTION |
| Cleviprex 50 MG/100ML EMULSION | IV | EMULSION |
| Clinimix E/Dextrose (2.75/10) 2.75 % SOLUTION | IV | SOLUTION |
| Clinimix E/Dextrose (2.75/5) 2.75 % SOLUTION | IV | SOLUTION |
| Clinimix E/Dextrose (4.25/10) 4.25 % SOLUTION | IV | SOLUTION |
| Clinimix E/Dextrose (4.25/25) 4.25 % SOLUTION | IV | SOLUTION |
| Clinimix E/Dextrose (4.25/5) 4.25 % SOLUTION | IV | SOLUTION |
| Clinimix E/Dextrose (5/15) 5 % SOLUTION | IV | SOLUTION |
| Clinimix E/Dextrose (5/20) 5 % SOLUTION | IV | SOLUTION |
| Clinimix E/Dextrose (5/25) 5 % SOLUTION | IV | SOLUTION |
| Clinimix E/Dextrose (8/10) 8 % SOLUTION | IV | SOLUTION |
| Clinimix E/Dextrose (8/14) 8 % SOLUTION | IV | SOLUTION |
| Clinimix N14G30E 4.25 % SOLUTION | IV | SOLUTION |
| Clinimix N9G15E 2.75 % SOLUTION | IV | SOLUTION |
| Clinimix N9G20E 2.75 % SOLUTION | IV | SOLUTION |
| Clinimix/Dextrose (4.25/10) 4.25 % SOLUTION | IV | SOLUTION |
| Clinimix/Dextrose (4.25/25) 4.25 % SOLUTION | IV | SOLUTION |
| Clinimix/Dextrose (4.25/5) 4.25 % SOLUTION | IV | SOLUTION |
| Clinimix/Dextrose (5/15) 5 % SOLUTION | IV | SOLUTION |
| Clinimix/Dextrose (5/20) 5 % SOLUTION | IV | SOLUTION |
| Clinimix/Dextrose (5/25) 5 % SOLUTION | IV | SOLUTION |
| Clinimix/Dextrose (6/5) 6 % SOLUTION | IV | SOLUTION |
| Clinimix/Dextrose (8/10) 8 % SOLUTION | IV | SOLUTION |
| Clinimix/Dextrose (8/14) 8 % SOLUTION | IV | SOLUTION |
| Clinisol SF 15 % SOLUTION | IV | SOLUTION |
| Clinolipid 20 % EMULSION | IV | EMULSION |
| Clofarabine 1 MG/ML SOLUTION | IV | SOLUTION |

| MEDICATION NAME | ROUTE | DOSE FORM |
|---|---|---|
| Clolar 1 MG/ML SOLUTION | IV | SOLUTION |
| CloNIDine HCl (Analgesia) 100 MCG/ML SOLUTION | EP | SOLUTION |
| CloNIDine HCl (Analgesia) 500 MCG/ML SOLUTION | EP | SOLUTION |
| Cocaine HCl 40 MG/ML SOLUTION | NA | SOLUTION |
| Cosela 300 MG RECON SOLN | IV | RECON SOLN |
| Cosmegen 0.5 MG RECON SOLN | IV | RECON SOLN |
| Cromolyn Sodium 20 MG/2ML NEBU SOLN | IN | NEBU SOLN |
| Cupric Chloride 0.4 MG/ML SOLUTION | IV | SOLUTION |
| Cutaquig 1 GM/6ML SOLUTION | SC | SOLUTION |
| Cutaquig 1.65 GM/10ML SOLUTION | SC | SOLUTION |
| Cutaquig 2 GM/12ML SOLUTION | SC | SOLUTION |
| Cutaquig 3.3 GM/20ML SOLUTION | SC | SOLUTION |
| Cutaquig 4 GM/24ML SOLUTION | SC | SOLUTION |
| Cutaquig 8 GM/48ML SOLUTION | SC | SOLUTION |
| Cuvitru 1 GM/5ML SOLUTION | SC | SOLUTION |
| Cuvitru 10 GM/50ML SOLUTION | SC | SOLUTION |
| Cuvitru 2 GM/10ML SOLUTION | SC | SOLUTION |
| Cuvitru 4 GM/20ML SOLUTION | SC | SOLUTION |
| Cuvitru 8 GM/40ML SOLUTION | SC | SOLUTION |
| Cyclophosphamide 1 GM RECON SOLN | IJ | RECON SOLN |
| Cyclophosphamide 1 GM/5ML SOLUTION | IV | SOLUTION |
| Cyclophosphamide 2 GM RECON SOLN | IJ | RECON SOLN |
| Cyclophosphamide 2 GM/10ML SOLUTION | IV | SOLUTION |
| Cyclophosphamide 25 MG CAP | PO | CAP |
| Cyclophosphamide 25 MG TAB | PO | TAB |
| Cyclophosphamide 50 MG CAP | PO | CAP |
| Cyclophosphamide 50 MG TAB | PO | TAB |
| Cyclophosphamide 500 MG RECON SOLN | IJ | RECON SOLN |
| Cyclophosphamide 500 MG/2.5ML SOLUTION | IV | SOLUTION |
| CycloSPORINE 100 MG CAP | PO | CAP |
| CycloSPORINE 25 MG CAP | PO | CAP |
| CycloSPORINE 50 MG/ML SOLUTION | IV | SOLUTION |
| CycloSPORINE Modified 100 MG CAP | PO | CAP |
| CycloSPORINE Modified 100 MG/ML SOLUTION | PO | SOLUTION |
| CycloSPORINE Modified 25 MG CAP | PO | CAP |
| CycloSPORINE Modified 50 MG CAP | PO | CAP |
| Cyramza 100 MG/10ML SOLUTION | IV | SOLUTION |
| Cyramza 500 MG/50ML SOLUTION | IV | SOLUTION |
| Cytarabine (PF) 100 MG/ML SOLUTION | IJ | SOLUTION |
| Cytarabine (PF) 20 MG/ML SOLUTION | IJ | SOLUTION |
| Cytarabine 20 MG/ML SOLUTION | IJ | SOLUTION |
| Cytogam 50 MG/ML INJECTABLE | IV | INJECTABLE |
| Cytovene 500 MG RECON SOLN | IV | RECON SOLN |
| Dacarbazine 100 MG RECON SOLN | IV | RECON SOLN |

| MEDICATION NAME | ROUTE | DOSE FORM |
|---|---|---|
| Dacarbazine 200 MG RECON SOLN | IV | RECON SOLN |
| Dacogen 50 MG RECON SOLN | IV | RECON SOLN |
| DACTINomycin 0.5 MG RECON SOLN | IV | RECON SOLN |
| Danyelza 40 MG/10ML SOLUTION | IV | SOLUTION |
| Darzalex 100 MG/5ML SOLUTION | IV | SOLUTION |
| Darzalex 400 MG/20ML SOLUTION | IV | SOLUTION |
| Darzalex Faspro 1800-30000 MG-UT/15ML SOLUTION | SC | SOLUTION |
| DAUNOrubicin HCl 20 MG/4ML SOLUTION | IV | SOLUTION |
| DAUNOrubicin HCl 50 MG/10ML SOLUTION | IV | SOLUTION |
| Decitabine 50 MG RECON SOLN | IV | RECON SOLN |
| Deferoxamine Mesylate 2 GM RECON SOLN | IJ | RECON SOLN |
| Deferoxamine Mesylate 500 MG RECON SOLN | IJ | RECON SOLN |
| Defitelio 200 MG/2.5ML SOLUTION | IV | SOLUTION |
| Demerol 100 MG/2ML SOLUTION | IJ | SOLUTION |
| Demerol 100 MG/ML SOLUTION | IJ | SOLUTION |
| Demerol 25 MG/0.5ML SOLUTION | IJ | SOLUTION |
| Demerol 25 MG/ML SOLUTION | IJ | SOLUTION |
| Demerol 50 MG/ML SOLUTION | IJ | SOLUTION |
| Demerol 75 MG/1.5ML SOLUTION | IJ | SOLUTION |
| Demerol 75 MG/ML SOLUTION | IJ | SOLUTION |
| DEPO-Medrol 20 MG/ML SUSPENSION | IJ | SUSPENSION |
| Desferal 500 MG RECON SOLN | IJ | RECON SOLN |
| Dexamethasone Sod Phosphate PF 10 MG/ML SOLN PRSYR | IJ | SOLN PRSYR |
| Dexamethasone Sod Phosphate PF 10 MG/ML SOLUTION | IJ | SOLUTION |
| Dexamethasone Sodium Phosphate 10 MG/ML SOLUTION | IJ | SOLUTION |
| Dexamethasone Sodium Phosphate 100 MG/10ML SOLUTION | IJ | SOLUTION |
| Dexrazoxane HCl 250 MG RECON SOLN | IV | RECON SOLN |
| Dexrazoxane HCl 500 MG RECON SOLN | IV | RECON SOLN |
| Dextrose 20 % SOLUTION | IV | SOLUTION |
| Dextrose 250 MG/ML SOLUTION | IV | SOLUTION |
| Dextrose 30 % SOLUTION | IV | SOLUTION |
| Dextrose 40 % SOLUTION | IV | SOLUTION |
| Dextrose 5%/Electrolyte #48 SOLUTION | IV | SOLUTION |
| Dextrose 50 % SOLUTION | IV | SOLUTION |
| Dextrose 70 % SOLUTION | IV | SOLUTION |
| DiazePAM 5 MG/ML SOLUTION | IJ | SOLUTION |
| Dicyclomine HCl 10 MG/ML SOLUTION | IM | SOLUTION |
| Digoxin 0.25 MG/ML SOLUTION | IJ | SOLUTION |
| Dilaudid 0.2 MG/ML SOLUTION | IJ | SOLUTION |
| Dilaudid 1 MG/ML SOLUTION | IJ | SOLUTION |

| MEDICATION NAME | ROUTE | DOSE FORM |
|---|---|---|
| Dilaudid 2 MG/ML SOLUTION | IJ | SOLUTION |
| Dilaudid 4 MG/ML SOLUTION | IJ | SOLUTION |
| DilTIAZem HCl 100 MG RECON SOLN | IV | RECON SOLN |
| DilTIAZem HCl 125 MG/25ML SOLUTION | IV | SOLUTION |
| DilTIAZem HCl 25 MG/5ML SOLUTION | IV | SOLUTION |
| DilTIAZem HCl 50 MG/10ML SOLUTION | IV | SOLUTION |
| DOBUTamine HCl 250 MG/20ML SOLUTION | IV | SOLUTION |
| DOBUTamine in D5W 1-5 MG/ML-% SOLUTION | IV | SOLUTION |
| DOBUTamine in D5W 2 MG/ML SOLUTION | IV | SOLUTION |
| DOBUTamine in D5W 4-5 MG/ML-% SOLUTION | IV | SOLUTION |
| DOCEtaxel (Non-Alcohol) 160 MG/8ML SOLUTION | IV | SOLUTION |
| DOCEtaxel (Non-Alcohol) 20 MG/ML SOLUTION | IV | SOLUTION |
| DOCEtaxel (Non-Alcohol) 80 MG/4ML SOLUTION | IV | SOLUTION |
| DOCEtaxel 160 MG/16ML SOLUTION | IV | SOLUTION |
| DOCEtaxel 160 MG/8ML CONC | IV | CONC |
| DOCEtaxel 20 MG/2ML SOLUTION | IV | SOLUTION |
| DOCEtaxel 20 MG/ML CONC | IV | CONC |
| DOCEtaxel 200 MG/10ML CONC | IV | CONC |
| DOCEtaxel 80 MG/4ML CONC | IV | CONC |
| DOCEtaxel 80 MG/8ML SOLUTION | IV | SOLUTION |
| DOPamine HCl 160 MG/ML SOLUTION | IV | SOLUTION |
| DOPamine HCl 40 MG/ML SOLUTION | IV | SOLUTION |
| DOPamine HCl 80 MG/ML SOLUTION | IV | SOLUTION |
| DOPamine in D5W 0.8-5 MG/ML-% SOLUTION | IV | SOLUTION |
| DOPamine in D5W 1.6-5 MG/ML-% SOLUTION | IV | SOLUTION |
| DOPamine in D5W 3.2-5 MG/ML-% SOLUTION | IV | SOLUTION |
| Doripenem 250 MG RECON SOLN | IV | RECON SOLN |
| Doxercalciferol 0.5 MCG CAP | PO | CAP |
| Doxercalciferol 1 MCG CAP | PO | CAP |
| Doxercalciferol 2.5 MCG CAP | PO | CAP |
| Doxercalciferol 4 MCG/2ML SOLUTION | IV | SOLUTION |
| Doxil 2 MG/ML INJECTABLE | IV | INJECTABLE |
| DOXOrubicin HCl 10 MG RECON SOLN | IV | RECON SOLN |
| DOXOrubicin HCl 2 MG/ML SOLUTION | IV | SOLUTION |
| DOXOrubicin HCl 50 MG RECON SOLN | IV | RECON SOLN |
| DOXOrubicin HCl Liposomal 2 MG/ML INJECTABLE | IV | INJECTABLE |
| Duopa 4.63-20 MG/ML SUSPENSION | EN | SUSPENSION |
| Duraclon 100 MCG/ML SOLUTION | EP | SOLUTION |
| Duramorph 0.5 MG/ML SOLUTION | IJ | SOLUTION |
| Duramorph 1 MG/ML SOLUTION | IJ | SOLUTION |
| Dysport 300 UNIT RECON SOLN | IM | RECON SOLN |
| Dysport 500 UNIT RECON SOLN | IM | RECON SOLN |
| Elaprase 6 MG/3ML SOLUTION | IV | SOLUTION |
| Elcys 50 MG/ML SOLUTION | IV | SOLUTION |

| MEDICATION NAME | ROUTE | DOSE FORM |
|---|---|---|
| Elelyso 200 UNIT RECON SOLN | IV | RECON SOLN |
| Elitek 1.5 MG RECON SOLN | IV | RECON SOLN |
| Elitek 7.5 MG RECON SOLN | IV | RECON SOLN |
| Ellence 200 MG/100ML SOLUTION | IV | SOLUTION |
| Ellence 50 MG/25ML SOLUTION | IV | SOLUTION |
| Elliotts B SOLUTION | IT | SOLUTION |
| Emend 125 MG CAP | PO | CAP |
| Emend 125 MG/5ML RECON SUSP | PO | RECON SUSP |
| Emend 150 MG RECON SOLN | IV | RECON SOLN |
| Emend 80 MG CAP | PO | CAP |
| Emend Tri-Pack 80 & 125 MG CAP | PO | CAP |
| Empaveli 1080 MG/20ML SOLUTION | SC | SOLUTION |
| Empliciti 300 MG RECON SOLN | IV | RECON SOLN |
| Empliciti 400 MG RECON SOLN | IV | RECON SOLN |
| Enalaprilat 1.25 MG/ML INJECTABLE | IV | INJECTABLE |
| Engerix-B 10 MCG/0.5ML SUSP PRSYR | IJ | SUSP PRSYR |
| Engerix-B 20 MCG/ML SUSP PRSYR | IJ | SUSP PRSYR |
| Engerix-B 20 MCG/ML SUSPENSION | IJ | SUSPENSION |
| Enhertu 100 MG RECON SOLN | IV | RECON SOLN |
| Enjaymo 1100 MG/22ML SOLUTION | IV | SOLUTION |
| Entyvio 300 MG RECON SOLN | IV | RECON SOLN |
| EpiRUBicin HCl 200 MG/100ML SOLUTION | IV | SOLUTION |
| EpiRUBicin HCl 50 MG/25ML SOLUTION | IV | SOLUTION |
| Epogen 10000 UNIT/ML SOLUTION | IJ | SOLUTION |
| Epogen 2000 UNIT/ML SOLUTION | IJ | SOLUTION |
| Epogen 20000 UNIT/ML SOLUTION | IJ | SOLUTION |
| Epogen 3000 UNIT/ML SOLUTION | IJ | SOLUTION |
| Epogen 4000 UNIT/ML SOLUTION | IJ | SOLUTION |
| Epoprostenol Sodium 0.5 MG RECON SOLN | IV | RECON SOLN |
| Epoprostenol Sodium 1.5 MG RECON SOLN | IV | RECON SOLN |
| Erbitux 100 MG/50ML SOLUTION | IV | SOLUTION |
| Erbitux 200 MG/100ML SOLUTION | IV | SOLUTION |
| Erwinase 10000 UNIT RECON SOLN | IJ | RECON SOLN |
| Erwinaze 10000 UNIT RECON SOLN | IJ | RECON SOLN |
| Ethacrynate Sodium 50 MG RECON SOLN | IV | RECON SOLN |
| Ethyol 500 MG RECON SOLN | IV | RECON SOLN |
| Etopophos 100 MG RECON SOLN | IV | RECON SOLN |
| Etoposide 1 GM/50ML SOLUTION | IV | SOLUTION |
| Etoposide 100 MG/5ML SOLUTION | IV | SOLUTION |
| Etoposide 500 MG/25ML SOLUTION | IV | SOLUTION |
| Evenity 105 MG/1.17ML SOLN PRSYR | SC | SOLN PRSYR |
| Evkeeza 1200 MG/8ML SOLUTION | IV | SOLUTION |
| Evkeeza 345 MG/2.3ML SOLUTION | IV | SOLUTION |
| Evomela 50 MG RECON SOLN | IV | RECON SOLN |

| MEDICATION NAME | ROUTE | DOSE FORM |
|---|---|---|
| Eylea 2 MG/0.05ML SOLN PRSYR | IZ | SOLN PRSYR |
| Eylea 2 MG/0.05ML SOLUTION | IZ | SOLUTION |
| Fabrazyme 35 MG RECON SOLN | IV | RECON SOLN |
| Fabrazyme 5 MG RECON SOLN | IV | RECON SOLN |
| Fensolvi (6 Month) 45 MG KIT | SC | KIT |
| FentaNYL Citrate (PF) 100 MCG/2ML SOLN CART | IJ | SOLN CART |
| FentaNYL Citrate (PF) 100 MCG/2ML SOLUTION | IJ | SOLUTION |
| FentaNYL Citrate (PF) 1000 MCG/20ML SOLUTION | IJ | SOLUTION |
| FentaNYL Citrate (PF) 250 MCG/5ML SOLUTION | IJ | SOLUTION |
| FentaNYL Citrate (PF) 2500 MCG/50ML SOLUTION | IJ | SOLUTION |
| fentaNYL Citrate (PF) 50 MCG/ML SOLUTION | IJ | SOLUTION |
| FentaNYL Citrate (PF) 500 MCG/10ML SOLUTION | IJ | SOLUTION |
| Flolan 0.5 MG RECON SOLN | IV | RECON SOLN |
| Flolan 1.5 MG RECON SOLN | IV | RECON SOLN |
| Fludarabine Phosphate 25 MG/ML SOLUTION | IV | SOLUTION |
| Fludarabine Phosphate 50 MG RECON SOLN | IV | RECON SOLN |
| Fludarabine Phosphate 50 MG/2ML SOLUTION | IV | SOLUTION |
| Fluorouracil 1 GM/20ML SOLUTION | IV | SOLUTION |
| Fluorouracil 2.5 GM/50ML SOLUTION | IV | SOLUTION |
| Fluorouracil 5 GM/100ML SOLUTION | IV | SOLUTION |
| Fluorouracil 500 MG/10ML SOLUTION | IV | SOLUTION |
| Folotyn 20 MG/ML SOLUTION | IV | SOLUTION |
| Folotyn 40 MG/2ML SOLUTION | IV | SOLUTION |
| Formoterol Fumarate 20 MCG/2ML NEBU SOLN | IN | NEBU SOLN |
| Fosaprepitant Dimeglumine 150 MG RECON SOLN | IV | RECON SOLN |
| Fosphenytoin Sodium 100 MG PE/2ML SOLUTION | IJ | SOLUTION |
| Fosphenytoin Sodium 500 MG PE/10ML SOLUTION | IJ | SOLUTION |
| FreAmine HBC 6.9 % SOLUTION | IV | SOLUTION |
| FreAmine III 10 % SOLUTION | IV | SOLUTION |
| Fulphila 6 MG/0.6ML SOLN PRSYR | SC | SOLN PRSYR |
| Fusilev 50 MG RECON SOLN | IV | RECON SOLN |
| Fyarro 100 MG RECON SUSP | IV | RECON SUSP |
| Fylnetra 6 MG/0.6ML SOLN PRSYR | SC | SOLN PRSYR |
| Gablofen 10000 MCG/20ML SOLN PRSYR | IT | SOLN PRSYR |
| Gablofen 10000 MCG/20ML SOLUTION | IT | SOLUTION |
| Gablofen 20000 MCG/20ML SOLN PRSYR | IT | SOLN PRSYR |
| Gablofen 20000 MCG/20ML SOLUTION | IT | SOLUTION |
| Gablofen 40000 MCG/20ML SOLN PRSYR | IT | SOLN PRSYR |
| Gablofen 40000 MCG/20ML SOLUTION | IT | SOLUTION |
| Gablofen 50 MCG/ML SOLN PRSYR | IT | SOLN PRSYR |
| Gamifant 10 MG/2ML SOLUTION | IV | SOLUTION |
| Gamifant 100 MG/20ML SOLUTION | IV | SOLUTION |
| Gamifant 50 MG/10ML SOLUTION | IV | SOLUTION |
| Ganciclovir 500 MG/250ML SOLUTION | IV | SOLUTION |

| MEDICATION NAME | ROUTE | DOSE FORM |
|---|---|---|
| Ganciclovir Sodium 500 MG RECON SOLN | IV | RECON SOLN |
| Ganciclovir Sodium 500 MG/10ML SOLUTION | IV | SOLUTION |
| Gazyva 1000 MG/40ML SOLUTION | IV | SOLUTION |
| Gemcitabine HCl 1 GM RECON SOLN | IV | RECON SOLN |
| Gemcitabine HCl 1 GM/10ML SOLUTION | IV | SOLUTION |
| Gemcitabine HCl 1 GM/26.3ML SOLUTION | IV | SOLUTION |
| Gemcitabine HCl 1.5 GM/15ML SOLUTION | IV | SOLUTION |
| Gemcitabine HCl 2 GM RECON SOLN | IV | RECON SOLN |
| Gemcitabine HCl 2 GM/20ML SOLUTION | IV | SOLUTION |
| Gemcitabine HCl 2 GM/52.6ML SOLUTION | IV | SOLUTION |
| Gemcitabine HCl 200 MG RECON SOLN | IV | RECON SOLN |
| Gemcitabine HCl 200 MG/2ML SOLUTION | IV | SOLUTION |
| Gemcitabine HCl 200 MG/5.26ML SOLUTION | IV | SOLUTION |
| Gemzar 1 GM RECON SOLN | IV | RECON SOLN |
| Gemzar 200 MG RECON SOLN | IV | RECON SOLN |
| Gengraf 100 MG CAP | PO | CAP |
| Gengraf 100 MG/ML SOLUTION | PO | SOLUTION |
| Gengraf 25 MG CAP | PO | CAP |
| Gentamicin in Saline 0.8-0.9 MG/ML-% SOLUTION | IV | SOLUTION |
| Gentamicin in Saline 1-0.9 MG/ML-% SOLUTION | IV | SOLUTION |
| Gentamicin in Saline 1.2-0.9 MG/ML-% SOLUTION | IV | SOLUTION |
| Gentamicin in Saline 1.6-0.9 MG/ML-% SOLUTION | IV | SOLUTION |
| Gentamicin in Saline 2-0.9 MG/ML-% SOLUTION | IV | SOLUTION |
| Givlaari 189 MG/ML SOLUTION | SC | SOLUTION |
| Glycophos 1 MMOLE/ML SOLUTION | IV | SOLUTION |
| Goprelto 40 MG/ML SOLUTION | NA | SOLUTION |
| Granisetron HCl 0.1 MG/ML SOLUTION | IV | SOLUTION |
| Granisetron HCl 1 MG TAB | PO | TAB |
| Granisetron HCl 1 MG/ML SOLUTION | IV | SOLUTION |
| Granisetron HCl 4 MG/4ML SOLUTION | IV | SOLUTION |
| Granix 300 MCG/0.5ML SOLN PRSYR | SC | SOLN PRSYR |
| Granix 300 MCG/ML SOLUTION | SC | SOLUTION |
| Granix 480 MCG/0.8ML SOLN PRSYR | SC | SOLN PRSYR |
| Granix 480 MCG/1.6ML SOLUTION | SC | SOLUTION |
| Halaven 1 MG/2ML SOLUTION | IV | SOLUTION |
| Hectorol 2 MCG/ML SOLUTION | IV | SOLUTION |
| Hectorol 4 MCG/2ML SOLUTION | IV | SOLUTION |
| HepaGam B 312 UNIT/ML SOLUTION | IJ | SOLUTION |
| Heparin (Porcine) in NaCl 100-0.45 UT/100ML-% SOLUTION | IV | SOLUTION |
| Heparin (Porcine) in NaCl 100-0.9 UT/100ML-% SOLUTION | IV | SOLUTION |
| Heparin (Porcine) in NaCl 1000-0.9 UNIT/L-% SOLUTION | IV | SOLUTION |

| MEDICATION NAME | ROUTE | DOSE FORM |
|---|---|---|
| Heparin (Porcine) in NaCl 1000-0.9 UT/100ML-% SOLUTION | IV | SOLUTION |
| Heparin (Porcine) in NaCl 1000-0.9 UT/250ML-% SOLUTION | IV | SOLUTION |
| Heparin (Porcine) in NaCl 1000-0.9 UT/500ML-% SOLUTION | IV | SOLUTION |
| Heparin (Porcine) in NaCl 10000-0.9 UNIT/L-% SOLUTION | IV | SOLUTION |
| Heparin (Porcine) in NaCl 10000-0.9 UT/100ML-% SOLUTION | IV | SOLUTION |
| Heparin (Porcine) in NaCl 10000-0.9 UT/500ML-% SOLUTION | IV | SOLUTION |
| Heparin (Porcine) in NaCl 1250-0.9 UT/250ML-% SOLUTION | IV | SOLUTION |
| Heparin (Porcine) in NaCl 12500-0.45 UT/250ML-% SOLUTION | IV | SOLUTION |
| Heparin (Porcine) in NaCl 150-0.45 UT/150ML-% SOLUTION | IV | SOLUTION |
| Heparin (Porcine) in NaCl 1500-0.9 UT/150ML-% SOLUTION | IV | SOLUTION |
| Heparin (Porcine) in NaCl 1500-0.9 UT/250ML-% SOLUTION | IV | SOLUTION |
| Heparin (Porcine) in NaCl 15000-0.9 UT/500ML-% SOLUTION | IV | SOLUTION |
| Heparin (Porcine) in NaCl 2000-0.9 UNIT/L-% SOLUTION | IV | SOLUTION |
| Heparin (Porcine) in NaCl 2000-0.9 UT/500ML-% SOLUTION | IV | SOLUTION |
| Heparin (Porcine) in NaCl 20000-0.9 UNIT/L-% SOLUTION | IV | SOLUTION |
| Heparin (Porcine) in NaCl 250-0.45 UT/250ML-% SOLUTION | IV | SOLUTION |
| Heparin (Porcine) in NaCl 250-0.9 UT/250ML-% SOLUTION | IV | SOLUTION |
| Heparin (Porcine) in NaCl 2500-0.9 UT/250ML-% SOLUTION | IV | SOLUTION |
| Heparin (Porcine) in NaCl 2500-0.9 UT/500ML-% SOLUTION | IV | SOLUTION |
| Heparin (Porcine) in NaCl 25000-0.45 UT/250ML-% SOLUTION | IV | SOLUTION |
| Heparin (Porcine) in NaCl 25000-0.45 UT/500ML-% SOLUTION | IV | SOLUTION |
| Heparin (Porcine) in NaCl 25000-0.9 UT/250ML-% SOLUTION | IV | SOLUTION |
| Heparin (Porcine) in NaCl 25000-0.9 UT/500ML-% SOLUTION | IV | SOLUTION |
| Heparin (Porcine) in NaCl 3000-0.9 UNIT/L-% SOLUTION | IV | SOLUTION |
| Heparin (Porcine) in NaCl 3000-0.9 UT/500ML-% SOLUTION | IV | SOLUTION |

| MEDICATION NAME | ROUTE | DOSE FORM |
|---|---|---|
| Heparin (Porcine) in NaCl 30000-0.9 UNIT/L-% SOLUTION | IV | SOLUTION |
| Heparin (Porcine) in NaCl 4000-0.9 UNIT/L-% SOLUTION | IV | SOLUTION |
| Heparin (Porcine) in NaCl 4000-0.9 UT/500ML-% SOLUTION | IV | SOLUTION |
| Heparin (Porcine) in NaCl 40000-0.45 UNIT/L-% SOLUTION | IV | SOLUTION |
| Heparin (Porcine) in NaCl 500-0.45 UT/250ML-% SOLUTION | IV | SOLUTION |
| Heparin (Porcine) in NaCl 500-0.45 UT/500ML-% SOLUTION | IV | SOLUTION |
| Heparin (Porcine) in NaCl 500-0.9 UT/500ML-% SOLUTION | IV | SOLUTION |
| Heparin (Porcine) in NaCl 5000-0.45 UNIT/L-% SOLUTION | IV | SOLUTION |
| Heparin (Porcine) in NaCl 5000-0.9 UNIT/L-% SOLUTION | IV | SOLUTION |
| Heparin (Porcine) in NaCl 5000-0.9 UT/500ML-% SOLUTION | IV | SOLUTION |
| Heparin (Porcine) in NaCl 6000-0.9 UNIT/L-% SOLUTION | IV | SOLUTION |
| Heparin (Porcine) in NaCl 8000-0.9 UNIT/L-% SOLUTION | IV | SOLUTION |
| Heparin Sod (Porcine) in D5W 100 UNIT/ML SOLUTION | IV | SOLUTION |
| Heparin Sod (Porcine) in D5W 10000-5 UT/100ML-% SOLUTION | IV | SOLUTION |
| Heparin Sod (Porcine) in D5W 12500-5 UT/250ML-% SOLUTION | IV | SOLUTION |
| Heparin Sod (Porcine) in D5W 25000-5 UT/500ML-% SOLUTION | IV | SOLUTION |
| Heparin Sod (Porcine) in D5W 40-5 UNIT/ML-% SOLUTION | IV | SOLUTION |
| Heparin Sodium (Porcine) 1000 UNIT/ML SOLUTION | IJ | SOLUTION |
| Heparin Sodium (Porcine) 10000 UNIT/ML SOLUTION | IJ | SOLUTION |
| Heparin Sodium (Porcine) 20000 UNIT/ML SOLUTION | IJ | SOLUTION |
| Heparin Sodium (Porcine) 5000 UNIT/0.5ML SOLN PRSYR | IJ | SOLN PRSYR |
| Heparin Sodium (Porcine) 5000 UNIT/ML SOLUTION | IJ | SOLUTION |
| Heparin Sodium (Porcine) PF 5000 UNIT/0.5ML SOLUTION | IJ | SOLUTION |
| Heparin Sodium (Porcine) PF 5000 UNIT/ML SOLUTION | IJ | SOLUTION |
| Hepatamine 8 % SOLUTION | IV | SOLUTION |
| Heplisav-B 20 MCG/0.5ML SOLN PRSYR | IM | SOLN PRSYR |
| Heplisav-B 20 MCG/0.5ML SOLUTION | IM | SOLUTION |
| Herceptin 150 MG RECON SOLN | IV | RECON SOLN |

| MEDICATION NAME | ROUTE | DOSE FORM |
|---|---|---|
| Herceptin 440 MG RECON SOLN | IV | RECON SOLN |
| Herceptin Hylecta 600-10000 MG-UNT/5ML SOLUTION | SC | SOLUTION |
| Herzuma 150 MG RECON SOLN | IV | RECON SOLN |
| Herzuma 420 MG RECON SOLN | IV | RECON SOLN |
| Hycamtin 4 MG RECON SOLN | IV | RECON SOLN |
| HYDROmorphone HCl 0.2 MG/ML SOLUTION | IJ | SOLUTION |
| HYDROmorphone HCl 1 MG/ML SOLUTION | IJ | SOLUTION |
| HYDROmorphone HCl 2 MG/ML SOLUTION | IJ | SOLUTION |
| HYDROmorphone HCl 4 MG/ML SOLUTION | IJ | SOLUTION |
| HYDROmorphone HCl PF 1 MG/ML SOLUTION | IJ | SOLUTION |
| HYDROmorphone HCl PF 10 MG/ML SOLUTION | IJ | SOLUTION |
| HYDROmorphone HCl PF 2 MG/ML SOLUTION | IJ | SOLUTION |
| HYDROmorphone HCl PF 4 MG/ML SOLUTION | IJ | SOLUTION |
| HYDROmorphone HCl PF 50 MG/5ML SOLUTION | IJ | SOLUTION |
| HYDROmorphone HCl PF 500 MG/50ML SOLUTION | IJ | SOLUTION |
| HYDROmorphone HCl-NaCl 10-0.9 MG/50ML-% SOLUTION | IV | SOLUTION |
| HyperHEP B 110 UNIT/0.5ML SOLN PRSYR | IM | SOLN PRSYR |
| HyperHEP B 220 UNIT/ML SOLN PRSYR | IM | SOLN PRSYR |
| HyperHEP B 220 UNIT/ML SOLUTION | IM | SOLUTION |
| Hyperlyte-CR CONC | IV | CONC |
| HyperRAB 1500 UNIT/5ML SOLUTION | IJ | SOLUTION |
| HyperRAB 300 UNIT/ML SOLUTION | IJ | SOLUTION |
| HyperRAB 900 UNIT/3ML SOLUTION | IJ | SOLUTION |
| HyperRAB S/D 1500 UNIT/10ML SOLUTION | IJ | SOLUTION |
| HyperRAB S/D 300 UNIT/2ML SOLUTION | IJ | SOLUTION |
| HyperRHO S/D 1500 UNIT SOLN PRSYR | IM | SOLN PRSYR |
| HyperRHO S/D 250 UNIT SOLN PRSYR | IM | SOLN PRSYR |
| Hyqvia 10 GM/100ML KIT | SC | KIT |
| Hyqvia 2.5 GM/25ML KIT | SC | KIT |
| Hyqvia 20 GM/200ML KIT | SC | KIT |
| Hyqvia 30 GM/300ML KIT | SC | KIT |
| Hyqvia 5 GM/50ML KIT | SC | KIT |
| Idamycin PFS 10 MG/10ML SOLUTION | IV | SOLUTION |
| Idamycin PFS 20 MG/20ML SOLUTION | IV | SOLUTION |
| Idamycin PFS 5 MG/5ML SOLUTION | IV | SOLUTION |
| IDArubicin HCl 10 MG/10ML SOLUTION | IV | SOLUTION |
| IDArubicin HCl 20 MG/20ML SOLUTION | IV | SOLUTION |
| IDArubicin HCl 5 MG/5ML SOLUTION | IV | SOLUTION |
| Ifex 1 GM RECON SOLN | IV | RECON SOLN |
| Ifex 3 GM RECON SOLN | IV | RECON SOLN |
| Ifosfamide 1 GM RECON SOLN | IV | RECON SOLN |
| Ifosfamide 1 GM/20ML SOLUTION | IV | SOLUTION |

| MEDICATION NAME | ROUTE | DOSE FORM |
|---|---|---|
| Ifosfamide 3 GM RECON SOLN | IV | RECON SOLN |
| Ifosfamide 3 GM/60ML SOLUTION | IV | SOLUTION |
| Imfinzi 120 MG/2.4ML SOLUTION | IV | SOLUTION |
| Imfinzi 500 MG/10ML SOLUTION | IV | SOLUTION |
| Imjudo 25 MG/1.25ML SOLUTION | IV | SOLUTION |
| Imjudo 300 MG/15ML SOLUTION | IV | SOLUTION |
| Imlygic 1000000 UNIT/ML SUSPENSION | LS | SUSPENSION |
| Imlygic 100000000 UNIT/ML SUSPENSION | LS | SUSPENSION |
| Imogam Rabies-HT 1500 UNIT/10ML SOLUTION | IJ | SOLUTION |
| Imogam Rabies-HT 300 UNIT/2ML SOLUTION | IJ | SOLUTION |
| Imuran 50 MG TAB | PO | TAB |
| Inflectra 100 MG RECON SOLN | IV | RECON SOLN |
| Infugem 1200-0.9 MG/120ML-% SOLUTION | IV | SOLUTION |
| Infugem 1300-0.9 MG/130ML-% SOLUTION | IV | SOLUTION |
| Infugem 1400-0.9 MG/140ML-% SOLUTION | IV | SOLUTION |
| Infugem 1500-0.9 MG/150ML-% SOLUTION | IV | SOLUTION |
| Infugem 1600-0.9 MG/160ML-% SOLUTION | IV | SOLUTION |
| Infugem 1700-0.9 MG/170ML-% SOLUTION | IV | SOLUTION |
| Infugem 1800-0.9 MG/180ML-% SOLUTION | IV | SOLUTION |
| Infugem 1900-0.9 MG/190ML-% SOLUTION | IV | SOLUTION |
| Infugem 2000-0.9 MG/200ML-% SOLUTION | IV | SOLUTION |
| Infugem 2200-0.9 MG/220ML-% SOLUTION | IV | SOLUTION |
| Infumorph 200 200 MG/20ML (10 MG/ML) SOLUTION | IJ | SOLUTION |
| Infumorph 500 500 MG/20ML (25 MG/ML) SOLUTION | IJ | SOLUTION |
| Intralipid 20 % EMULSION | IV | EMULSION |
| Intralipid 30 % EMULSION | IV | EMULSION |
| Ipratropium Bromide 0.02 % SOLUTION | IN | SOLUTION |
| Ipratropium-Albuterol 0.5-2.5 (3) MG/3ML SOLUTION | IN | SOLUTION |
| Irinotecan HCl 100 MG/5ML SOLUTION | IV | SOLUTION |
| Irinotecan HCl 300 MG/15ML SOLUTION | IV | SOLUTION |
| Irinotecan HCl 40 MG/2ML SOLUTION | IV | SOLUTION |
| Irinotecan HCl 500 MG/25ML SOLUTION | IV | SOLUTION |
| Isolyte-P in D5W SOLUTION | IV | SOLUTION |
| Isolyte-S SOLUTION | IV | SOLUTION |
| Isolyte-S pH 7.4 SOLUTION | IV | SOLUTION |
| Istodax (Overfill) 10 MG RECON SOLN | IV | RECON SOLN |
| Ixempra Kit 15 MG RECON SOLN | IV | RECON SOLN |
| Ixempra Kit 45 MG RECON SOLN | IV | RECON SOLN |
| Jelmyto 80 (2 x 40) MG RECON SOLN | UL | RECON SOLN |
| Jemperli 500 MG/10ML SOLUTION | IV | SOLUTION |
| Jevtana 60 MG/1.5ML SOLUTION | IV | SOLUTION |

| MEDICATION NAME | ROUTE | DOSE FORM |
|---|---|---|
| Kabiven 3.3-9.8-3.9-0.7 % EMULSION | IV | EMULSION |
| Kadcyla 100 MG RECON SOLN | IV | RECON SOLN |
| Kadcyla 160 MG RECON SOLN | IV | RECON SOLN |
| Kanjinti 150 MG RECON SOLN | IV | RECON SOLN |
| Kanjinti 420 MG RECON SOLN | IV | RECON SOLN |
| Kanuma 20 MG/10ML SOLUTION | IV | SOLUTION |
| KCl (in NaCl 0.9%) 10 MEQ/100ML SOLUTION | IV | SOLUTION |
| KCl (in NaCl 0.9%) 10 MEQ/500ML SOLUTION | IV | SOLUTION |
| KCl (in NaCl 0.9%) 20 MEQ/250ML SOLUTION | IV | SOLUTION |
| KCl (in NaCl 0.9%) 40 MEQ/250ML SOLUTION | IV | SOLUTION |
| KCl (in NaCl 0.9%) 40 MEQ/500ML SOLUTION | IV | SOLUTION |
| KCl in D5W Lactated Ringers 40 MEQ/L SOLUTION | IV | SOLUTION |
| KCl in Dextrose-NaCl 10-5-0.45 MEQ/L-%-% SOLUTION | IV | SOLUTION |
| KCl in Dextrose-NaCl 30-5-0.45 MEQ/L-%-% SOLUTION | IV | SOLUTION |
| KCl in Dextrose-NaCl 40-5-0.45 MEQ/L-%-% SOLUTION | IV | SOLUTION |
| KCl in Lactated Ringers 20 MEQ/L SOLUTION | IV | SOLUTION |
| KCl-Lidocaine in NaCl 20-10 MEQ-MG /100ML SOLUTION | IV | SOLUTION |
| Kedrab 1500 UNIT/10ML SOLUTION | IJ | SOLUTION |
| Kedrab 300 UNIT/2ML SOLUTION | IJ | SOLUTION |
| Kenalog 10 MG/ML SUSPENSION | IJ | SUSPENSION |
| Kenalog 40 MG/ML SUSPENSION | IJ | SUSPENSION |
| Kenalog-80 80 MG/ML SUSPENSION | IJ | SUSPENSION |
| Kepivance 6.25 MG RECON SOLN | IV | RECON SOLN |
| Keppra 500 MG/5ML SOLUTION | IV | SOLUTION |
| Ketorolac Tromethamine 15 MG/ML SOLUTION | IJ | SOLUTION |
| Ketorolac Tromethamine 30 MG/ML SOLUTION | IJ | SOLUTION |
| Ketorolac Tromethamine 60 MG/2ML SOLUTION | IM | SOLUTION |
| Keytruda 100 MG/4ML SOLUTION | IV | SOLUTION |
| Khapzory 175 MG RECON SOLN | IV | RECON SOLN |
| Khapzory 300 MG RECON SOLN | IV | RECON SOLN |
| Kimmtrak 100 MCG/0.5ML SOLUTION | IV | SOLUTION |
| Kimyrsa 1200 MG RECON SOLN | IV | RECON SOLN |
| Kitabis Pak 300 MG/5ML NEBU SOLN | IN | NEBU SOLN |
| Kyprolis 10 MG RECON SOLN | IV | RECON SOLN |
| Kyprolis 30 MG RECON SOLN | IV | RECON SOLN |
| Kyprolis 60 MG RECON SOLN | IV | RECON SOLN |
| L-Cysteine HCl 50 MG/ML SOLUTION | IV | SOLUTION |
| Labetalol HCl 5 MG/ML SOLUTION | IV | SOLUTION |
| Lacosamide 200 MG/20ML SOLUTION | IV | SOLUTION |
| Lanoxin 0.25 MG/ML SOLUTION | IJ | SOLUTION |
| Lanoxin Pediatric 0.1 MG/ML SOLUTION | IJ | SOLUTION |

| MEDICATION NAME | ROUTE | DOSE FORM |
|---|---|---|
| Lartruvo 190 MG/19ML SOLUTION | IV | SOLUTION |
| Lartruvo 500 MG/50ML SOLUTION | IV | SOLUTION |
| Lemtrada 12 MG/1.2ML SOLUTION | IV | SOLUTION |
| Leqvio 284 MG/1.5ML SOLN PRSYR | SC | SOLN PRSYR |
| LevETIRAcetam 500 MG/5ML SOLUTION | IV | SOLUTION |
| LevETIRAcetam in NaCl 1000 MG/100ML SOLUTION | IV | SOLUTION |
| LevETIRAcetam in NaCl 1500 MG/100ML SOLUTION | IV | SOLUTION |
| levETIRAcetam in NaCl 250 MG/50ML SOLUTION | IV | SOLUTION |
| LevETIRAcetam in NaCl 500 MG/100ML SOLUTION | IV | SOLUTION |
| LevoFLOXacin in D5W 250 MG/50ML SOLUTION | IV | SOLUTION |
| LEVOleucovorin Calcium 175 MG RECON SOLN | IV | RECON SOLN |
| LEVOleucovorin Calcium 50 MG RECON SOLN | IV | RECON SOLN |
| LEVOleucovorin Calcium PF 175 MG/17.5ML SOLUTION | IV | SOLUTION |
| LEVOleucovorin Calcium PF 250 MG/25ML SOLUTION | IV | SOLUTION |
| Levothyroxine Sodium 100 MCG RECON SOLN | IV | RECON SOLN |
| Levothyroxine Sodium 100 MCG/5ML SOLUTION | IV | SOLUTION |
| Levothyroxine Sodium 200 MCG RECON SOLN | IV | RECON SOLN |
| Levothyroxine Sodium 200 MCG/5ML SOLUTION | IV | SOLUTION |
| Levothyroxine Sodium 500 MCG RECON SOLN | IV | RECON SOLN |
| Levothyroxine Sodium 500 MCG/5ML SOLUTION | IV | SOLUTION |
| Libtayo 350 MG/7ML SOLUTION | IV | SOLUTION |
| Lidocaine HCl (Cardiac) 100 MG/5ML SOLN PRSYR | IV | SOLN PRSYR |
| Lidocaine HCl (Cardiac) 50 MG/5ML SOLN PRSYR | IV | SOLN PRSYR |
| Lidocaine HCl (Cardiac) PF 100 MG/5ML SOLN PRSYR | IV | SOLN PRSYR |
| Lidocaine HCl (Cardiac) PF 100 MG/5ML SOLUTION | IV | SOLUTION |
| Lidocaine HCl (Cardiac) PF 50 MG/5ML SOLN PRSYR | IV | SOLN PRSYR |
| Lidocaine in D5W 4-5 MG/ML-% SOLUTION | IV | SOLUTION |
| Lioresal 0.05 MG/ML SOLUTION | IT | SOLUTION |
| Lioresal 10 MG/20ML SOLUTION | IT | SOLUTION |
| Lioresal 10 MG/5ML SOLUTION | IT | SOLUTION |
| Lioresal 40 MG/20ML SOLUTION | IT | SOLUTION |
| Liothyronine Sodium 10 MCG/ML SOLUTION | IV | SOLUTION |
| Lipodox 50 2 MG/ML INJECTABLE | IV | INJECTABLE |
| LORazepam 2 MG/ML SOLUTION | IJ | SOLUTION |
| LORazepam 4 MG/ML SOLUTION | IJ | SOLUTION |
| Lucentis 0.3 MG/0.05ML SOLN PRSYR | IZ | SOLN PRSYR |
| Lucentis 0.3 MG/0.05ML SOLUTION | IZ | SOLUTION |
| Lucentis 0.5 MG/0.05ML SOLN PRSYR | IZ | SOLN PRSYR |
| Lucentis 0.5 MG/0.05ML SOLUTION | IZ | SOLUTION |
| Lumizyme 50 MG RECON SOLN | IV | RECON SOLN |

| MEDICATION NAME | ROUTE | DOSE FORM |
|---|---|---|
| Lumoxiti 1 MG RECON SOLN | IV | RECON SOLN |
| Magnesium Sulfate 2 GM/50ML SOLUTION | IV | SOLUTION |
| Magnesium Sulfate 20 GM/500ML SOLUTION | IV | SOLUTION |
| Magnesium Sulfate 4 GM/100ML SOLUTION | IV | SOLUTION |
| Magnesium Sulfate 4 GM/50ML SOLUTION | IV | SOLUTION |
| Magnesium Sulfate 40 GM/1000ML SOLUTION | IV | SOLUTION |
| Magnesium Sulfate 50 % SOLUTION | IJ | SOLUTION |
| Magnesium Sulfate in D5W 1-5 GM/100ML-% SOLUTION | IV | SOLUTION |
| Magnesium Sulfate-NaCl 2-0.9 GM/50ML-% SOLUTION | IV | SOLUTION |
| Magnesium Sulfate-NaCl 20-0.9 GM/250ML-% SOLUTION | IV | SOLUTION |
| Magnesium Sulfate-NaCl 3-0.9 GM/150ML-% SOLUTION | IV | SOLUTION |
| Magnesium Sulfate-NaCl 40-0.9 GM/500ML-% SOLUTION | IV | SOLUTION |
| Manganese Chloride 0.1 MG/ML SOLUTION | IV | SOLUTION |
| Manganese Sulfate 0.1 MG/ML SOLUTION | IV | SOLUTION |
| Mannitol 20 % SOLUTION | IV | SOLUTION |
| Mannitol 25 % SOLUTION | IV | SOLUTION |
| Margenza 250 MG/10ML SOLUTION | IV | SOLUTION |
| Marinol 10 MG CAP | PO | CAP |
| Marinol 2.5 MG CAP | PO | CAP |
| Marinol 5 MG CAP | PO | CAP |
| Marqibo 5 MG/31ML SUSPENSION | IV | SUSPENSION |
| Melphalan 2 MG TAB | PO | TAB |
| Melphalan HCl 50 MG RECON SOLN | IV | RECON SOLN |
| Meperidine HCl 10 MG/ML SOLUTION | IJ | SOLUTION |
| Meperidine HCl 100 MG/ML SOLUTION | IJ | SOLUTION |
| Meperidine HCl 25 MG/ML SOLUTION | IJ | SOLUTION |
| Meperidine HCl 50 MG/ML SOLUTION | IJ | SOLUTION |
| Mepsevii 10 MG/5ML SOLUTION | IV | SOLUTION |
| Methocarbamol 1000 MG/10ML SOLUTION | IJ | SOLUTION |
| Methotrexate Sodium (PF) 1 GM/40ML SOLUTION | IJ | SOLUTION |
| Methotrexate Sodium (PF) 250 MG/10ML SOLUTION | IJ | SOLUTION |
| Methotrexate Sodium (PF) 50 MG/2ML SOLUTION | IJ | SOLUTION |
| Methotrexate Sodium 1 GM RECON SOLN | IJ | RECON SOLN |
| Methotrexate Sodium 250 MG/10ML SOLUTION | IJ | SOLUTION |
| Methotrexate Sodium 50 MG/2ML SOLUTION | IJ | SOLUTION |
| MethylPREDNISolone Acetate 50 MG/ML SUSPENSION | IJ | SUSPENSION |
| MethylPREDNISolone Sodium Succ 1000 MG RECON SOLN | IJ | RECON SOLN |

| MEDICATION NAME | ROUTE | DOSE FORM |
|---|---|---|
| methylPREDNISolone Sodium Succ 500 MG RECON SOLN | IJ | RECON SOLN |
| Metoprolol Tartrate 5 MG/5ML SOLN CART | IV | SOLN CART |
| Metoprolol Tartrate 5 MG/5ML SOLUTION | IV | SOLUTION |
| Miacalcin 200 UNIT/ML SOLUTION | IJ | SOLUTION |
| MICRhoGAM Ultra-Filtered Plus 250 UNIT SOLN PRSYR | IM | SOLN PRSYR |
| Midazolam 2 MG/2ML SOLN PRSYR | IJ | SOLN PRSYR |
| Milrinone Lactate 10 MG/10ML SOLUTION | IV | SOLUTION |
| Milrinone Lactate 20 MG/20ML SOLUTION | IV | SOLUTION |
| Milrinone Lactate 50 MG/50ML SOLUTION | IV | SOLUTION |
| Milrinone Lactate in Dextrose 20-5 MG/100ML-% SOLUTION | IV | SOLUTION |
| Milrinone Lactate in Dextrose 40-5 MG/200ML-% SOLUTION | IV | SOLUTION |
| Minocin 100 MG RECON SOLN | IV | RECON SOLN |
| Mitigo 200 MG/20ML (10 MG/ML) SOLUTION | IJ | SOLUTION |
| Mitigo 500 MG/20ML (25 MG/ML) SOLUTION | IJ | SOLUTION |
| MitoMYcin 20 MG RECON SOLN | IV | RECON SOLN |
| MitoMYcin 40 MG RECON SOLN | IV | RECON SOLN |
| MitoMYcin 5 MG RECON SOLN | IV | RECON SOLN |
| MitoXANTRONE HCl 20 MG/10ML CONC | IV | CONC |
| MitoXANTRONE HCl 25 MG/12.5ML CONC | IV | CONC |
| MitoXANTRONE HCl 30 MG/15ML CONC | IV | CONC |
| Monjuvi 200 MG RECON SOLN | IV | RECON SOLN |
| Morphine Sulfate (PF) 0.5 MG/ML SOLUTION | IJ | SOLUTION |
| Morphine Sulfate (PF) 1 MG/ML SOLUTION | IJ | SOLUTION |
| Morphine Sulfate (PF) 10 MG/ML SOLUTION | IJ | SOLUTION |
| Morphine Sulfate (PF) 10 MG/ML SOLUTION | IV | SOLUTION |
| Morphine Sulfate (PF) 2 MG/ML SOLUTION | IJ | SOLUTION |
| Morphine Sulfate (PF) 2 MG/ML SOLUTION | IV | SOLUTION |
| Morphine Sulfate (PF) 4 MG/ML SOLUTION | IJ | SOLUTION |
| Morphine Sulfate (PF) 4 MG/ML SOLUTION | IV | SOLUTION |
| Morphine Sulfate (PF) 5 MG/ML SOLUTION | IJ | SOLUTION |
| Morphine Sulfate (PF) 8 MG/ML SOLUTION | IJ | SOLUTION |
| Morphine Sulfate (PF) 8 MG/ML SOLUTION | IV | SOLUTION |
| Morphine Sulfate 0.5 MG/ML SOLUTION | IV | SOLUTION |
| Morphine Sulfate 1 MG/ML SOLUTION | IJ | SOLUTION |
| Morphine Sulfate 1 MG/ML SOLUTION | IV | SOLUTION |
| Morphine Sulfate 10 MG/0.7ML DEVICE | IM | DEVICE |
| Morphine Sulfate 10 MG/ML SOLUTION | IJ | SOLUTION |
| Morphine Sulfate 10 MG/ML SOLUTION | IV | SOLUTION |
| Morphine Sulfate 150 MG/30ML SOLUTION | IV | SOLUTION |
| Morphine Sulfate 2 MG/ML SOLUTION | IJ | SOLUTION |
| Morphine Sulfate 25 MG/ML SOLUTION | IV | SOLUTION |

| MEDICATION NAME | ROUTE | DOSE FORM |
|---|---|---|
| Morphine Sulfate 4 MG/ML SOLUTION | IJ | SOLUTION |
| Morphine Sulfate 4 MG/ML SOLUTION | IV | SOLUTION |
| Morphine Sulfate 5 MG/ML SOLUTION | IJ | SOLUTION |
| Morphine Sulfate 50 MG/ML SOLUTION | IV | SOLUTION |
| Morphine Sulfate 8 MG/ML SOLUTION | IJ | SOLUTION |
| Morphine Sulfate 8 MG/ML SOLUTION | IV | SOLUTION |
| Moxifloxacin HCl 400 MG/250ML SOLUTION | IV | SOLUTION |
| Moxifloxacin HCl in NaCl 400 MG/250ML SOLUTION | IV | SOLUTION |
| Mustargen 10 MG RECON SOLN | IJ | RECON SOLN |
| Mutamycin 20 MG RECON SOLN | IV | RECON SOLN |
| Mutamycin 40 MG RECON SOLN | IV | RECON SOLN |
| Mutamycin 5 MG RECON SOLN | IV | RECON SOLN |
| Mvasi 100 MG/4ML SOLUTION | IV | SOLUTION |
| Mvasi 400 MG/16ML SOLUTION | IV | SOLUTION |
| Mycophenolate Mofetil 200 MG/ML RECON SUSP | PO | RECON SUSP |
| Mycophenolate Mofetil 250 MG CAP | PO | CAP |
| Mycophenolate Mofetil 500 MG RECON SOLN | IV | RECON SOLN |
| Mycophenolate Mofetil 500 MG TAB | PO | TAB |
| Mycophenolate Mofetil HCl 500 MG RECON SOLN | IV | RECON SOLN |
| Mycophenolate Sodium 180 MG TAB DR | PO | TAB DR |
| Mycophenolate Sodium 360 MG TAB DR | PO | TAB DR |
| Myfortic 180 MG TAB DR | PO | TAB DR |
| Myfortic 360 MG TAB DR | PO | TAB DR |
| Mylotarg 4.5 MG RECON SOLN | IV | RECON SOLN |
| Myobloc 10000 UNIT/2ML SOLUTION | IM | SOLUTION |
| Myobloc 2500 UNIT/0.5ML SOLUTION | IM | SOLUTION |
| Myobloc 5000 UNIT/ML SOLUTION | IM | SOLUTION |
| Nabi-HB 312 UNIT/ML SOLUTION | IM | SOLUTION |
| Nafcillin Sodium in Dextrose 1 GM/50ML SOLUTION | IV | SOLUTION |
| Nafcillin Sodium in Dextrose 2 GM/100ML SOLUTION | IV | SOLUTION |
| Naglazyme 1 MG/ML SOLUTION | IV | SOLUTION |
| Nalbuphine HCl 10 MG/ML SOLUTION | IJ | SOLUTION |
| Nalbuphine HCl 20 MG/ML SOLUTION | IJ | SOLUTION |
| Navelbine 10 MG/ML SOLUTION | IV | SOLUTION |
| Navelbine 50 MG/5ML SOLUTION | IV | SOLUTION |
| Nebupent 300 MG RECON SOLN | IN | RECON SOLN |
| Nelarabine 5 MG/ML SOLUTION | IV | SOLUTION |
| Neoral 100 MG CAP | PO | CAP |
| Neoral 100 MG/ML SOLUTION | PO | SOLUTION |
| Neoral 25 MG CAP | PO | CAP |
| NephrAmine 5.4 % SOLUTION | IV | SOLUTION |
| Neulasta 6 MG/0.6ML SOLN PRSYR | SC | SOLN PRSYR |
| Neulasta Onpro 6 MG/0.6ML PREF SY KT | SC | PREF SY KT |

| MEDICATION NAME | ROUTE | DOSE FORM |
|---|---|---|
| Neupogen 300 MCG/0.5ML SOLN PRSYR | IJ | SOLN PRSYR |
| Neupogen 300 MCG/ML SOLUTION | IJ | SOLUTION |
| Neupogen 480 MCG/0.8ML SOLN PRSYR | IJ | SOLN PRSYR |
| Neupogen 480 MCG/1.6ML SOLUTION | IJ | SOLUTION |
| Nexplanon 68 MG IMPLANT | SC | IMPLANT |
| Nexterone 150-4.21 MG/100ML-% SOLUTION | IV | SOLUTION |
| Nexterone 360-4.14 MG/200ML-% SOLUTION | IV | SOLUTION |
| Nexviazyme 100 MG RECON SOLN | IV | RECON SOLN |
| NiCARdipine HCl 2.5 MG/ML SOLUTION | IV | SOLUTION |
| niCARdipine HCl in NaCl 20-0.9 MG/200ML-% SOLUTION | IV | SOLUTION |
| niCARdipine HCl in NaCl 40-0.9 MG/200ML-% SOLUTION | IV | SOLUTION |
| Nipent 10 MG RECON SOLN | IV | RECON SOLN |
| Nitroglycerin 5 MG/ML SOLUTION | IV | SOLUTION |
| Nitroglycerin in D5W 100-5 MCG/ML-% SOLUTION | IV | SOLUTION |
| Nitroglycerin in D5W 200-5 MCG/ML-% SOLUTION | IV | SOLUTION |
| Nitroglycerin in D5W 400-5 MCG/ML-% SOLUTION | IV | SOLUTION |
| Nivestym 300 MCG/0.5ML SOLN PRSYR | IJ | SOLN PRSYR |
| Nivestym 300 MCG/ML SOLUTION | IJ | SOLUTION |
| Nivestym 480 MCG/0.8ML SOLN PRSYR | IJ | SOLN PRSYR |
| Nivestym 480 MCG/1.6ML SOLUTION | IJ | SOLUTION |
| Normosol-R SOLUTION | IV | SOLUTION |
| Normosol-R pH 7.4 SOLUTION | IV | SOLUTION |
| Novarel 10000 UNIT RECON SOLN | IM | RECON SOLN |
| Novarel 5000 UNIT RECON SOLN | IM | RECON SOLN |
| Nplate 125 MCG RECON SOLN | SC | RECON SOLN |
| Nplate 250 MCG RECON SOLN | SC | RECON SOLN |
| Nplate 500 MCG RECON SOLN | SC | RECON SOLN |
| Nulibry 9.5 MG RECON SOLN | IV | RECON SOLN |
| Nulojix 250 MG RECON SOLN | IV | RECON SOLN |
| Numbrino 40 MG/ML SOLUTION | NA | SOLUTION |
| Nutrilipid 20 % EMULSION | IV | EMULSION |
| Nuzyra 100 MG RECON SOLN | IV | RECON SOLN |
| Nyvepria 6 MG/0.6ML SOLN PRSYR | SC | SOLN PRSYR |
| Ocrevus 300 MG/10ML SOLUTION | IV | SOLUTION |
| Octagam 1 GM/20ML SOLUTION | IV | SOLUTION |
| Octagam 10 GM/100ML SOLUTION | IV | SOLUTION |
| Octagam 10 GM/200ML SOLUTION | IV | SOLUTION |
| Octagam 2 GM/20ML SOLUTION | IV | SOLUTION |
| Octagam 2.5 GM/50ML SOLUTION | IV | SOLUTION |
| Octagam 20 GM/200ML SOLUTION | IV | SOLUTION |
| Octagam 25 GM/500ML SOLUTION | IV | SOLUTION |
| Octagam 30 GM/300ML SOLUTION | IV | SOLUTION |

| MEDICATION NAME | ROUTE | DOSE FORM |
|---|---|---|
| Octagam 5 GM/100ML SOLUTION | IV | SOLUTION |
| Octagam 5 GM/50ML SOLUTION | IV | SOLUTION |
| Ofirmev 10 MG/ML SOLUTION | IV | SOLUTION |
| Ogivri 150 MG RECON SOLN | IV | RECON SOLN |
| Ogivri 420 MG RECON SOLN | IV | RECON SOLN |
| Olinvyk 1 MG/ML SOLUTION | IV | SOLUTION |
| Olinvyk 2 MG/2ML SOLUTION | IV | SOLUTION |
| Olinvyk 30 MG/30ML SOLUTION | IV | SOLUTION |
| Omegaven 10 GM/100ML EMULSION | IV | EMULSION |
| Omegaven 5 GM/50ML EMULSION | IV | EMULSION |
| Oncaspar 750 UNIT/ML SOLUTION | IJ | SOLUTION |
| Ondansetron 4 MG TAB DISP | PO | TAB DISP |
| Ondansetron 8 MG TAB DISP | PO | TAB DISP |
| Ondansetron HCl 24 MG TAB | PO | TAB |
| Ondansetron HCl 4 MG TAB | PO | TAB |
| Ondansetron HCl 4 MG/2ML SOLN PRSYR | IJ | SOLN PRSYR |
| Ondansetron HCl 4 MG/2ML SOLUTION | IJ | SOLUTION |
| Ondansetron HCl 4 MG/5ML SOLUTION | PO | SOLUTION |
| Ondansetron HCl 40 MG/20ML SOLUTION | IJ | SOLUTION |
| Ondansetron HCl 8 MG TAB | PO | TAB |
| Ondansetron HCl-Dextrose 8-5 MG/50ML-% SOLUTION | IV | SOLUTION |
| Onivyde 43 MG/10ML INJECTABLE | IV | INJECTABLE |
| Onpattro 10 MG/5ML SOLUTION | IV | SOLUTION |
| Ontruzant 150 MG RECON SOLN | IV | RECON SOLN |
| Ontruzant 420 MG RECON SOLN | IV | RECON SOLN |
| Opdivo 100 MG/10ML SOLUTION | IV | SOLUTION |
| Opdivo 120 MG/12ML SOLUTION | IV | SOLUTION |
| Opdivo 240 MG/24ML SOLUTION | IV | SOLUTION |
| Opdivo 40 MG/4ML SOLUTION | IV | SOLUTION |
| Opdualag 240-80 MG/20ML SOLUTION | IV | SOLUTION |
| Orphenadrine Citrate 30 MG/ML SOLUTION | IJ | SOLUTION |
| Osmitrol 10 % SOLUTION | IV | SOLUTION |
| Osmitrol 15 % SOLUTION | IV | SOLUTION |
| Osmitrol 20 % SOLUTION | IV | SOLUTION |
| Osmitrol 5 % SOLUTION | IV | SOLUTION |
| Oxacillin Sodium 1 GM RECON SOLN | IJ | RECON SOLN |
| Oxacillin Sodium 10 GM RECON SOLN | IV | RECON SOLN |
| Oxacillin Sodium 2 GM RECON SOLN | IJ | RECON SOLN |
| Oxacillin Sodium in Dextrose 1 GM/50ML SOLUTION | IV | SOLUTION |
| Oxacillin Sodium in Dextrose 2 GM/50ML SOLUTION | IV | SOLUTION |
| Oxaliplatin 100 MG RECON SOLN | IV | RECON SOLN |
| Oxaliplatin 100 MG/20ML SOLUTION | IV | SOLUTION |
| Oxaliplatin 200 MG/40ML SOLUTION | IV | SOLUTION |

| MEDICATION NAME | ROUTE | DOSE FORM |
|---|---|---|
| Oxaliplatin 50 MG RECON SOLN | IV | RECON SOLN |
| Oxaliplatin 50 MG/10ML SOLUTION | IV | SOLUTION |
| Oxlumo 94.5 MG/0.5ML SOLUTION | SC | SOLUTION |
| PACLitaxel 100 MG/16.7ML CONC | IV | CONC |
| PACLitaxel 150 MG/25ML CONC | IV | CONC |
| PACLitaxel 30 MG/5ML CONC | IV | CONC |
| PACLitaxel 300 MG/50ML CONC | IV | CONC |
| PACLitaxel Protein-Bound Part 100 MG RECON SUSP | IV | RECON SUSP |
| Padcev 20 MG RECON SOLN | IV | RECON SOLN |
| Padcev 30 MG RECON SOLN | IV | RECON SOLN |
| Palforzia Initial Escalation 0.5 & 1 & 1.5 & 3 & 6 MG CSPK | PO | |
| Palonosetron HCl 0.25 MG/2ML SOLUTION | IV | SOLUTION |
| Palonosetron HCl 0.25 MG/5ML SOLN PRSYR | IV | SOLN PRSYR |
| Palonosetron HCl 0.25 MG/5ML SOLUTION | IV | SOLUTION |
| Pamidronate Disodium 30 MG RECON SOLN | IV | RECON SOLN |
| Pamidronate Disodium 30 MG/10ML SOLUTION | IV | SOLUTION |
| Pamidronate Disodium 6 MG/ML SOLUTION | IV | SOLUTION |
| Pamidronate Disodium 90 MG RECON SOLN | IV | RECON SOLN |
| Pamidronate Disodium 90 MG/10ML SOLUTION | IV | SOLUTION |
| Panzyga 1 GM/10ML SOLUTION | IV | SOLUTION |
| Panzyga 10 GM/100ML SOLUTION | IV | SOLUTION |
| Panzyga 2.5 GM/25ML SOLUTION | IV | SOLUTION |
| Panzyga 20 GM/200ML SOLUTION | IV | SOLUTION |
| Panzyga 30 GM/300ML SOLUTION | IV | SOLUTION |
| Panzyga 5 GM/50ML SOLUTION | IV | SOLUTION |
| Paraplatin 1000 MG/100ML SOLUTION | IV | SOLUTION |
| Paraplatin 150 MG/15ML SOLUTION | IV | SOLUTION |
| Paraplatin 450 MG/45ML SOLUTION | IV | SOLUTION |
| Paraplatin 50 MG/5ML SOLUTION | IV | SOLUTION |
| Paraplatin 600 MG/60ML SOLUTION | IV | SOLUTION |
| Paricalcitol 1 MCG CAP | PO | CAP |
| Paricalcitol 2 MCG CAP | PO | CAP |
| Paricalcitol 2 MCG/ML SOLUTION | IV | SOLUTION |
| Paricalcitol 4 MCG CAP | PO | CAP |
| Paricalcitol 5 MCG/ML SOLUTION | IV | SOLUTION |
| Pedmark 12.5 % SOLUTION | IV | SOLUTION |
| PEMEtrexed 1 GM/40ML SOLUTION | IV | SOLUTION |
| PEMEtrexed 100 MG/4ML SOLUTION | IV | SOLUTION |
| PEMEtrexed 500 MG/20ML SOLUTION | IV | SOLUTION |
| PEMEtrexed Disodium 1 GM/40ML SOLUTION | IV | SOLUTION |
| PEMEtrexed Disodium 100 MG RECON SOLN | IV | RECON SOLN |
| PEMEtrexed Disodium 100 MG/4ML SOLUTION | IV | SOLUTION |

| MEDICATION NAME | ROUTE | DOSE FORM |
|---|---|---|
| PEMEtrexed Disodium 1000 MG RECON SOLN | IV | RECON SOLN |
| PEMEtrexed Disodium 500 MG RECON SOLN | IV | RECON SOLN |
| PEMEtrexed Disodium 500 MG/20ML SOLUTION | IV | SOLUTION |
| PEMEtrexed Disodium 750 MG RECON SOLN | IV | RECON SOLN |
| PEMEtrexed Disodium 850 MG/34ML SOLUTION | IV | SOLUTION |
| PEMEtrexed Ditromethamine 100 MG RECON SOLN | IV | RECON SOLN |
| PEMEtrexed Ditromethamine 500 MG RECON SOLN | IV | RECON SOLN |
| Pemfexy 500 MG/20ML SOLUTION | IV | SOLUTION |
| Penicillin G Pot in Dextrose 20000 UNIT/ML SOLUTION | IV | SOLUTION |
| Penicillin G Pot in Dextrose 40000 UNIT/ML SOLUTION | IV | SOLUTION |
| Penicillin G Pot in Dextrose 60000 UNIT/ML SOLUTION | IV | SOLUTION |
| Penicillin G Procaine 600000 UNIT/ML SUSPENSION | IM | SUSPENSION |
| Pentamidine Isethionate 300 MG RECON SOLN | IN | RECON SOLN |
| Pepaxto 20 MG RECON SOLN | IV | RECON SOLN |
| Perforomist 20 MCG/2ML NEBU SOLN | IN | NEBU SOLN |
| Perikabiven 2.4-6.8-3.5-0.5 % EMULSION | IV | EMULSION |
| Perjeta 420 MG/14ML SOLUTION | IV | SOLUTION |
| Phenytoin Sodium 50 MG/ML SOLUTION | IJ | SOLUTION |
| Phesgo 60-60-2000 MG-MG-U/ML SOLUTION | SC | SOLUTION |
| Phesgo 80-40-2000 MG-MG-U/ML SOLUTION | SC | SOLUTION |
| Plasma-Lyte 148 SOLUTION | IV | SOLUTION |
| Plasma-Lyte A SOLUTION | IV | SOLUTION |
| Plenamine 15 % SOLUTION | IV | SOLUTION |
| Polivy 140 MG RECON SOLN | IV | RECON SOLN |
| Polivy 30 MG RECON SOLN | IV | RECON SOLN |
| Portrazza 800 MG/50ML SOLUTION | IV | SOLUTION |
| Potassium Acetate 2 MEQ/ML SOLUTION | IV | SOLUTION |
| Potassium Acetate-NaCl 10 MEQ/100ML SOLUTION | IV | SOLUTION |
| Potassium Chloride 0.4 MEQ/ML SOLUTION | IV | SOLUTION |
| Potassium Chloride 10 MEQ/50ML SOLUTION | IV | SOLUTION |
| Potassium Chloride 20 MEQ/50ML SOLUTION | IV | SOLUTION |
| Potassium Chloride in D5W 10 MEQ/500ML SOLUTION | IV | SOLUTION |
| Potassium Chloride in D5W 20 MEQ/250ML SOLUTION | IV | SOLUTION |
| Potassium Chloride in D5W 40 MEQ/250ML SOLUTION | IV | SOLUTION |
| Potassium Chloride in D5W 40 MEQ/500ML SOLUTION | IV | SOLUTION |
| Potassium Chloride in NaCl 10-0.9 MEQ/L-% SOLUTION | IV | SOLUTION |

| MEDICATION NAME | ROUTE | DOSE FORM |
|---|---|---|
| Potassium Chloride in NaCl 20-0.45 MEQ/L-% SOLUTION | IV | SOLUTION |
| Potassium Phosphate-NaCl 15 MMOL/100ML SOLUTION | IV | SOLUTION |
| Potassium Phosphates 15 MMOLE/5ML SOLUTION | IV | SOLUTION |
| Potassium Phosphates 150 MMOLE/50ML SOLUTION | IV | SOLUTION |
| Potassium Phosphates 45 MMOLE/15ML SOLUTION | IV | SOLUTION |
| Potassium Phosphates(66 mEq K) 45 MMOLE/15ML SOLUTION | IV | SOLUTION |
| Potassium Phosphates(71 mEq K) 45 MMOLE/15ML SOLUTION | IV | SOLUTION |
| Potassium Phosphates-Dextrose 15 MMOL/250ML SOLUTION | IV | SOLUTION |
| Potassium Phosphates-Dextrose 30 MMOL/500ML SOLUTION | IV | SOLUTION |
| Potassium Phosphates-Dextrose 7.5 MMOL/100ML SOLUTION | IV | SOLUTION |
| Potassium Phosphates-Dextrose 9 MMOL/50ML SOLUTION | IV | SOLUTION |
| Potassium Phosphates-NaCl 10 MMOL/100ML SOLUTION | IV | SOLUTION |
| Potassium Phosphates-NaCl 10 MMOL/250ML SOLUTION | IV | SOLUTION |
| Potassium Phosphates-NaCl 15 MMOL/150ML SOLUTION | IV | SOLUTION |
| Potassium Phosphates-NaCl 15 MMOL/250ML SOLUTION | IV | SOLUTION |
| Potassium Phosphates-NaCl 20 MMOL/100ML SOLUTION | IV | SOLUTION |
| Potassium Phosphates-NaCl 22 MMOL/500ML SOLUTION | IV | SOLUTION |
| Potassium Phosphates-NaCl 30 MMOL/250ML SOLUTION | IV | SOLUTION |
| Potassium Phosphates-NaCl 40 MMOL/250ML SOLUTION | IV | SOLUTION |
| Potassium Phosphates-NaCl 5 MMOL/250ML SOLUTION | IV | SOLUTION |
| Potassium Phosphates-NaCl 7 MMOL/100ML SOLUTION | IV | SOLUTION |
| Potassium Phosphates-NaCl 7.5 MMOL/100ML SOLUTION | IV | SOLUTION |
| Potassium Phosphates-NaCl 9 MMOL/100ML SOLUTION | IV | SOLUTION |
| Poteligeo 20 MG/5ML SOLUTION | IV | SOLUTION |
| Pregnyl 10000 UNIT RECON SOLN | IM | RECON SOLN |
| PreHevbrio 10 MCG/ML SUSPENSION | IM | SUSPENSION |
| Premasol 10 % SOLUTION | IV | SOLUTION |
| Prevymis 240 MG/12ML SOLUTION | IV | SOLUTION |

| MEDICATION NAME | ROUTE | DOSE FORM |
|---|---|---|
| Prevymis 480 MG/24ML SOLUTION | IV | SOLUTION |
| Prialt 100 MCG/ML SOLUTION | IT | SOLUTION |
| Prialt 500 MCG/20ML SOLUTION | IT | SOLUTION |
| Prialt 500 MCG/5ML SOLUTION | IT | SOLUTION |
| Procainamide HCl 100 MG/ML SOLUTION | IJ | SOLUTION |
| Procainamide HCl 500 MG/ML SOLUTION | IJ | SOLUTION |
| Procalamine 3 % SOLUTION | IV | SOLUTION |
| Prochlorperazine Edisylate 10 MG/2ML SOLUTION | IJ | SOLUTION |
| Prochlorperazine Edisylate 50 MG/10ML SOLUTION | IJ | SOLUTION |
| Procrit 10000 UNIT/ML SOLUTION | IJ | SOLUTION |
| Procrit 2000 UNIT/ML SOLUTION | IJ | SOLUTION |
| Procrit 20000 UNIT/ML SOLUTION | IJ | SOLUTION |
| Procrit 3000 UNIT/ML SOLUTION | IJ | SOLUTION |
| Procrit 4000 UNIT/ML SOLUTION | IJ | SOLUTION |
| Procrit 40000 UNIT/ML SOLUTION | IJ | SOLUTION |
| Prograf 0.5 MG CAP | PO | CAP |
| Prograf 1 MG CAP | PO | CAP |
| Prograf 5 MG CAP | PO | CAP |
| Prograf 5 MG/ML SOLUTION | IV | SOLUTION |
| Prolastin-C 1000 MG RECON SOLN | IV | RECON SOLN |
| Prolastin-C 1000 MG/20ML SOLUTION | IV | SOLUTION |
| Proleukin 22000000 UNIT RECON SOLN | IV | RECON SOLN |
| Propranolol HCl 1 MG/ML SOLUTION | IV | SOLUTION |
| Prosol 20 % SOLUTION | IV | SOLUTION |
| Pulmicort 0.25 MG/2ML SUSPENSION | IN | SUSPENSION |
| Pulmicort 0.5 MG/2ML SUSPENSION | IN | SUSPENSION |
| Pulmicort 1 MG/2ML SUSPENSION | IN | SUSPENSION |
| Pulmozyme 2.5 MG/2.5ML SOLUTION | IN | SOLUTION |
| QuiNIDine Gluconate 80 MG/ML SOLUTION | IJ | SOLUTION |
| Radicava 30 MG/100ML SOLUTION | IV | SOLUTION |
| Rapamune 0.5 MG TAB | PO | TAB |
| Rapamune 1 MG TAB | PO | TAB |
| Rapamune 1 MG/ML SOLUTION | PO | SOLUTION |
| Rapamune 2 MG TAB | PO | TAB |
| Reblozyl 25 MG RECON SOLN | SC | RECON SOLN |
| Reblozyl 75 MG RECON SOLN | SC | RECON SOLN |
| Recarbrio 1.25 GM RECON SOLN | IV | RECON SOLN |
| Reclast 5 MG/100ML SOLUTION | IV | SOLUTION |
| Recombivax HB 10 MCG/ML SUSP PRSYR | IJ | SUSP PRSYR |
| Recombivax HB 10 MCG/ML SUSPENSION | IJ | SUSPENSION |
| Recombivax HB 40 MCG/ML SUSPENSION | IJ | SUSPENSION |
| Recombivax HB 5 MCG/0.5ML SUSP PRSYR | IJ | SUSP PRSYR |
| Recombivax HB 5 MCG/0.5ML SUSPENSION | IJ | SUSPENSION |
| Recothrom 20000 UNIT RECON SOLN | EX | RECON SOLN |

| MEDICATION NAME | ROUTE | DOSE FORM |
|---|---|---|
| Recothrom 5000 UNIT RECON SOLN | EX | RECON SOLN |
| Recothrom Spray Kit 20000 UNIT RECON SOLN | EX | RECON SOLN |
| Regonol 10 MG/2ML SOLUTION | IV | SOLUTION |
| Releuko 300 MCG/0.5ML SOLN PRSYR | SC | SOLN PRSYR |
| Releuko 300 MCG/ML SOLUTION | IJ | SOLUTION |
| Releuko 480 MCG/0.8ML SOLN PRSYR | SC | SOLN PRSYR |
| Releuko 480 MCG/1.6ML SOLUTION | IJ | SOLUTION |
| Remicade 100 MG RECON SOLN | IV | RECON SOLN |
| Remodulin 100 MG/20ML SOLUTION | IJ | SOLUTION |
| Remodulin 20 MG/20ML SOLUTION | IJ | SOLUTION |
| Remodulin 200 MG/20ML SOLUTION | IJ | SOLUTION |
| Remodulin 50 MG/20ML SOLUTION | IJ | SOLUTION |
| Renflexis 100 MG RECON SOLN | IV | RECON SOLN |
| RhoGAM Ultra-Filtered Plus 1500 UNIT SOLN PRSYR | IM | SOLN PRSYR |
| Rhophylac 1500 UNIT/2ML SOLN PRSYR | IJ | SOLN PRSYR |
| Riabni 100 MG/10ML SOLUTION | IV | SOLUTION |
| Riabni 500 MG/50ML SOLUTION | IV | SOLUTION |
| Ribavirin 6 GM RECON SOLN | IN | RECON SOLN |
| Rituxan 100 MG/10ML SOLUTION | IV | SOLUTION |
| Rituxan 500 MG/50ML SOLUTION | IV | SOLUTION |
| Rituxan Hycela 1400-23400 MG -UT/11.7ML SOLUTION | SC | SOLUTION |
| Rituxan Hycela 1600-26800 MG -UT/13.4ML SOLUTION | SC | SOLUTION |
| Robaxin 1000 MG/10ML SOLUTION | IJ | SOLUTION |
| Rocaltrol 0.25 MCG CAP | PO | CAP |
| Rocaltrol 0.5 MCG CAP | PO | CAP |
| Rocaltrol 1 MCG/ML SOLUTION | PO | SOLUTION |
| RomiDEPsin 10 MG RECON SOLN | IV | RECON SOLN |
| romiDEPsin 27.5 MG/5.5ML SOLUTION | IV | SOLUTION |
| Ruxience 100 MG/10ML SOLUTION | IV | SOLUTION |
| Ruxience 500 MG/50ML SOLUTION | IV | SOLUTION |
| Rybrevant 350 MG/7ML SOLUTION | IV | SOLUTION |
| Rylaze 10 MG/0.5ML SOLUTION | IM | SOLUTION |
| SandIMMUNE 100 MG CAP | PO | CAP |
| SandIMMUNE 100 MG/ML SOLUTION | PO | SOLUTION |
| SandIMMUNE 25 MG CAP | PO | CAP |
| SandIMMUNE 50 MG/ML SOLUTION | IV | SOLUTION |
| Saphnelo 300 MG/2ML SOLUTION | IV | SOLUTION |
| Sarclisa 100 MG/5ML SOLUTION | IV | SOLUTION |
| Sarclisa 500 MG/25ML SOLUTION | IV | SOLUTION |
| Seconal 100 MG CAP | PO | CAP |
| Sensipar 30 MG TAB | PO | TAB |
| Sensipar 60 MG TAB | PO | TAB |

| MEDICATION NAME | ROUTE | DOSE FORM |
|---|---|---|
| Sensipar 90 MG TAB | PO | TAB |
| Simponi Aria 50 MG/4ML SOLUTION | IV | SOLUTION |
| Simulect 10 MG RECON SOLN | IV | RECON SOLN |
| Simulect 20 MG RECON SOLN | IV | RECON SOLN |
| Sirolimus 0.5 MG TAB | PO | TAB |
| Sirolimus 1 MG TAB | PO | TAB |
| Sirolimus 1 MG/ML SOLUTION | PO | SOLUTION |
| Sirolimus 2 MG TAB | PO | TAB |
| Sivextro 200 MG RECON SOLN | IV | RECON SOLN |
| SMOFlipid 20 % EMULSION | IV | EMULSION |
| Sodium Acetate 2 MEQ/ML SOLUTION | IV | SOLUTION |
| Sodium Acetate 4 MEQ/ML SOLUTION | IV | SOLUTION |
| Sodium Bicarbonate 4.2 % SOLUTION | IV | SOLUTION |
| Sodium Bicarbonate 7.5 % SOLUTION | IV | SOLUTION |
| Sodium Bicarbonate 8.4 % SOLUTION | IV | SOLUTION |
| Sodium Chloride 0.9 % SOLUTION | IJ | SOLUTION |
| Sodium Chloride 23.4 % SOLUTION | IV | SOLUTION |
| Sodium Chloride 4 MEQ/ML SOLUTION | IV | SOLUTION |
| Sodium Diuril 500 MG RECON SOLN | IV | RECON SOLN |
| Sodium Edecrin 50 MG RECON SOLN | IV | RECON SOLN |
| Sodium Phosphate-NaCl 10 MMOL/100ML SOLUTION | IV | SOLUTION |
| Sodium Phosphate-NaCl 15 MMOL/100ML SOLUTION | IV | SOLUTION |
| Sodium Phosphate-NaCl 15 MMOL/250ML SOLUTION | IV | SOLUTION |
| Sodium Phosphate-NaCl 30 MMOL/250ML SOLUTION | IV | SOLUTION |
| Sodium Phosphate-NaCl 40 MMOL/250ML SOLUTION | IV | SOLUTION |
| Sodium Phosphate-NaCl 7.5 MMOL/100ML SOLUTION | IV | SOLUTION |
| Sodium Phosphate-NaCl 9 MMOL/50ML SOLUTION | IV | SOLUTION |
| Sodium Phosphates 15 MMOLE/5ML SOLUTION | IV | SOLUTION |
| Sodium Phosphates 45 MMOLE/15ML SOLUTION | IV | SOLUTION |
| Sodium Phosphates-Dextrose 15 MMOL/100ML SOLUTION | IV | SOLUTION |
| Sodium Phosphates-Dextrose 15 MMOL/250ML SOLUTION | IV | SOLUTION |
| Soliris 300 MG/30ML SOLUTION | IV | SOLUTION |
| Solu-CORTEF 1000 MG RECON SOLN | IJ | RECON SOLN |
| Solu-CORTEF 250 MG RECON SOLN | IJ | RECON SOLN |
| Solu-CORTEF 500 MG RECON SOLN | IJ | RECON SOLN |
| SOLU-medrol 1000 MG RECON SOLN | IJ | RECON SOLN |
| SOLU-medrol 125 MG RECON SOLN | IJ | RECON SOLN |
| SOLU-medrol 2 GM RECON SOLN | IJ | RECON SOLN |

| MEDICATION NAME | ROUTE | DOSE FORM |
|---|---|---|
| SOLU-medrol 40 MG RECON SOLN | IJ | RECON SOLN |
| SOLU-medrol 500 MG RECON SOLN | IJ | RECON SOLN |
| Somatuline Depot 120 MG/0.5ML SOLUTION | SC | SOLUTION |
| Spevigo 450 MG/7.5ML SOLUTION | IV | SOLUTION |
| Spravato (56 MG Dose) 28 MG/DEVICE SOLN THPK | NA | SOLN THPK |
| Spravato (84 MG Dose) 28 MG/DEVICE SOLN THPK | NA | SOLN THPK |
| Sublocade 100 MG/0.5ML SOLN PRSYR | SC | SOLN PRSYR |
| Sublocade 300 MG/1.5ML SOLN PRSYR | SC | SOLN PRSYR |
| Sustol 10 MG/0.4ML PRSYR | SC | PRSYR |
| Susvimo (Implant 1st Fill) 10 MG/0.1ML SOLUTION | IZ | SOLUTION |
| Susvimo (Implant Refill) 10 MG/0.1ML SOLUTION | IZ | SOLUTION |
| Sylvant 100 MG RECON SOLN | IV | RECON SOLN |
| Sylvant 400 MG RECON SOLN | IV | RECON SOLN |
| Synagis 100 MG/ML SOLUTION | IM | SOLUTION |
| Syndros 5 MG/ML SOLUTION | PO | SOLUTION |
| Synribo 3.5 MG RECON SOLN | SC | RECON SOLN |
| Synthamin 17 10 % SOLUTION | IV | SOLUTION |
| Tacrolimus 0.5 MG CAP | PO | CAP |
| Tacrolimus 1 MG CAP | PO | CAP |
| Tacrolimus 5 MG CAP | PO | CAP |
| Taxotere 20 MG/ML CONC | IV | CONC |
| Taxotere 80 MG/4ML CONC | IV | CONC |
| Tazicef 1 GM/50ML SOLUTION | IV | SOLUTION |
| Tecentriq 1200 MG/20ML SOLUTION | IV | SOLUTION |
| Tecentriq 840 MG/14ML SOLUTION | IV | SOLUTION |
| Temodar 100 MG RECON SOLN | IV | RECON SOLN |
| Temsirolimus 25 MG/ML SOLUTION | IV | SOLUTION |
| Teniposide 10 MG/ML SOLUTION | IV | SOLUTION |
| Tepadina 100 MG RECON SOLN | IJ | RECON SOLN |
| Tepadina 15 MG RECON SOLN | IJ | RECON SOLN |
| Tepezza 500 MG RECON SOLN | IV | RECON SOLN |
| Tezspire 210 MG/1.91ML SOLN PRSYR | SC | SOLN PRSYR |
| Theophylline in D5W 0.8-5 MG/ML-% SOLUTION | IV | SOLUTION |
| Thiotepa 100 MG RECON SOLN | IJ | RECON SOLN |
| Thiotepa 15 MG RECON SOLN | IJ | RECON SOLN |
| Thymoglobulin 25 MG RECON SOLN | IV | RECON SOLN |
| Tice BCG 50 MG RECON SUSP | IS | RECON SUSP |
| Tivdak 40 MG RECON SOLN | IV | RECON SOLN |
| Tobi 300 MG/5ML NEBU SOLN | IN | NEBU SOLN |
| Tobramycin 300 MG/5ML NEBU SOLN | IN | NEBU SOLN |
| Toposar 1 GM/50ML SOLUTION | IV | SOLUTION |
| Toposar 100 MG/5ML SOLUTION | IV | SOLUTION |
| Toposar 500 MG/25ML SOLUTION | IV | SOLUTION |
| Topotecan HCl 4 MG RECON SOLN | IV | RECON SOLN |

| MEDICATION NAME | ROUTE | DOSE FORM |
|---|---|---|
| Topotecan HCl 4 MG/4ML SOLUTION | IV | SOLUTION |
| Torisel 25 MG/ML SOLUTION | IV | SOLUTION |
| Totect 500 MG RECON SOLN | IV | RECON SOLN |
| TPN Electrolytes CONC | IV | CONC |
| Travasol 10 % SOLUTION | IV | SOLUTION |
| Trazimera 150 MG RECON SOLN | IV | RECON SOLN |
| Trazimera 420 MG RECON SOLN | IV | RECON SOLN |
| Treanda 100 MG RECON SOLN | IV | RECON SOLN |
| Treanda 25 MG RECON SOLN | IV | RECON SOLN |
| Trelstar Mixject 11.25 MG RECON SUSP | IM | RECON SUSP |
| Trelstar Mixject 22.5 MG RECON SUSP | IM | RECON SUSP |
| Trelstar Mixject 3.75 MG RECON SUSP | IM | RECON SUSP |
| Treprostinil 100 MG/20ML SOLUTION | IJ | SOLUTION |
| Treprostinil 20 MG/20ML SOLUTION | IJ | SOLUTION |
| Treprostinil 200 MG/20ML SOLUTION | IJ | SOLUTION |
| Treprostinil 50 MG/20ML SOLUTION | IJ | SOLUTION |
| Triamcinolone Acetonide 40 MG/ML SUSPENSION | IJ | SUSPENSION |
| Triamcinolone Acetonide 50 MG/ML SUSPENSION | IJ | SUSPENSION |
| Triostat 10 MCG/ML SOLUTION | IV | SOLUTION |
| Triptodur 22.5 MG SRER | IM | |
| Trisenox 12 MG/6ML SOLUTION | IV | SOLUTION |
| Trodelvy 180 MG RECON SOLN | IV | RECON SOLN |
| TrophAmine 10 % SOLUTION | IV | SOLUTION |
| Trophamine 6 % SOLUTION | IV | SOLUTION |
| Truxima 100 MG/10ML SOLUTION | IV | SOLUTION |
| Truxima 500 MG/50ML SOLUTION | IV | SOLUTION |
| Twinrix 720-20 ELU-MCG/ML SUSP PRSYR | IM | SUSP PRSYR |
| Tyvaso 0.6 MG/ML SOLUTION | IN | SOLUTION |
| Tyvaso Refill 0.6 MG/ML SOLUTION | IN | SOLUTION |
| Tyvaso Starter 0.6 MG/ML SOLUTION | IN | SOLUTION |
| Udenyca 6 MG/0.6ML SOLN PRSYR | SC | SOLN PRSYR |
| Ultomiris 1100 MG/11ML SOLUTION | IV | SOLUTION |
| Ultomiris 300 MG/30ML SOLUTION | IV | SOLUTION |
| Ultomiris 300 MG/3ML SOLUTION | IV | SOLUTION |
| Unituxin 17.5 MG/5ML SOLUTION | IV | SOLUTION |
| Uplizna 100 MG/10ML SOLUTION | IV | SOLUTION |
| Uptravi 1800 MCG RECON SOLN | IV | RECON SOLN |
| Vabomere 2 (1-1) GM RECON SOLN | IV | RECON SOLN |
| Vabysmo 6 MG/0.05ML SOLUTION | IZ | SOLUTION |
| Valrubicin 40 MG/ML SOLUTION | IS | SOLUTION |
| Valstar 40 MG/ML SOLUTION | IS | SOLUTION |
| Vancomycin HCl 1000 MG/10ML SOLUTION | IV | SOLUTION |
| Vancomycin HCl 1000 MG/200ML SOLUTION | IV | SOLUTION |
| Vancomycin HCl 1250 MG/12.5ML SOLUTION | IV | SOLUTION |

| MEDICATION NAME | ROUTE | DOSE FORM |
|---|---|---|
| Vancomycin HCl 1250 MG/250ML SOLUTION | IV | SOLUTION |
| Vancomycin HCl 1500 MG/15ML SOLUTION | IV | SOLUTION |
| Vancomycin HCl 1500 MG/300ML SOLUTION | IV | SOLUTION |
| Vancomycin HCl 1750 MG/17.5ML SOLUTION | IV | SOLUTION |
| Vancomycin HCl 1750 MG/350ML SOLUTION | IV | SOLUTION |
| Vancomycin HCl 2000 MG/20ML SOLUTION | IV | SOLUTION |
| Vancomycin HCl 2000 MG/400ML SOLUTION | IV | SOLUTION |
| Vancomycin HCl 5 GM RECON SOLN | IV | RECON SOLN |
| Vancomycin HCl 500 MG/100ML SOLUTION | IV | SOLUTION |
| Vancomycin HCl 750 MG/150ML SOLUTION | IV | SOLUTION |
| Vancomycin HCl 750 MG/7.5ML SOLUTION | IV | SOLUTION |
| Vancomycin HCl in Dextrose 1-5 GM/100ML-% SOLUTION | IV | SOLUTION |
| Vancomycin HCl in Dextrose 1-5 GM/200ML-% SOLUTION | IV | SOLUTION |
| Vancomycin HCl in Dextrose 1-5 GM/250ML-% SOLUTION | IV | SOLUTION |
| Vancomycin HCl in Dextrose 1.25-5 GM/250ML-% SOLUTION | IV | SOLUTION |
| Vancomycin HCl in Dextrose 1.5-5 GM/250ML-% SOLUTION | IV | SOLUTION |
| Vancomycin HCl in Dextrose 1.5-5 GM/300ML-% SOLUTION | IV | SOLUTION |
| Vancomycin HCl in Dextrose 1.5-5 GM/500ML-% SOLUTION | IV | SOLUTION |
| Vancomycin HCl in Dextrose 1.75-5 GM/500ML-% SOLUTION | IV | SOLUTION |
| Vancomycin HCl in Dextrose 2-5 GM/500ML-% SOLUTION | IV | SOLUTION |
| Vancomycin HCl in Dextrose 500-5 MG/100ML-% SOLUTION | IV | SOLUTION |
| Vancomycin HCl in Dextrose 750-5 MG/150ML-% SOLUTION | IV | SOLUTION |
| Vancomycin HCl in NaCl 1-0.9 GM/150ML-% SOLUTION | IV | SOLUTION |
| Vancomycin HCl in NaCl 1-0.9 GM/200ML-% SOLUTION | IV | SOLUTION |
| Vancomycin HCl in NaCl 1-0.9 GM/250ML-% SOLUTION | IV | SOLUTION |
| Vancomycin HCl in NaCl 1.25-0.9 GM/150ML-% SOLUTION | IV | SOLUTION |
| Vancomycin HCl in NaCl 1.25-0.9 GM/250ML-% SOLUTION | IV | SOLUTION |
| Vancomycin HCl in NaCl 1.5-0.9 GM/150ML-% SOLUTION | IV | SOLUTION |
| Vancomycin HCl in NaCl 1.5-0.9 GM/250ML-% SOLUTION | IV | SOLUTION |
| Vancomycin HCl in NaCl 1.5-0.9 GM/300ML-% SOLUTION | IV | SOLUTION |

| MEDICATION NAME | ROUTE | DOSE FORM |
|---|---|---|
| Vancomycin HCl in NaCl 1.5-0.9 GM/500ML-% SOLUTION | IV | SOLUTION |
| Vancomycin HCl in NaCl 1.75-0.9 GM/250ML-% SOLUTION | IV | SOLUTION |
| Vancomycin HCl in NaCl 1.75-0.9 GM/300ML-% SOLUTION | IV | SOLUTION |
| Vancomycin HCl in NaCl 1.75-0.9 GM/500ML-% SOLUTION | IV | SOLUTION |
| Vancomycin HCl in NaCl 2-0.9 GM/250ML-% SOLUTION | IV | SOLUTION |
| Vancomycin HCl in NaCl 2-0.9 GM/500ML-% SOLUTION | IV | SOLUTION |
| Vancomycin HCl in NaCl 2.5-0.9 GM/500ML-% SOLUTION | IV | SOLUTION |
| Vancomycin HCl in NaCl 500-0.9 MG/100ML-% SOLUTION | IV | SOLUTION |
| Vancomycin HCl in NaCl 750-0.9 MG/150ML-% SOLUTION | IV | SOLUTION |
| Vancomycin HCl in NaCl 750-0.9 MG/250ML-% SOLUTION | IV | SOLUTION |
| Vantas 50 MG KIT | SC | KIT |
| Varubi (180 MG Dose) 2 x 90 MG TAB THPK | PO | TAB THPK |
| Vasopressin 20 UNIT/ML SOLUTION | IV | SOLUTION |
| Vasopressin 5 UNIT/5ML SOLN PRSYR | IV | SOLN PRSYR |
| Vasostrict 0.2 UNIT/ML SOLUTION | IV | SOLUTION |
| Vasostrict 0.4 UNIT/ML SOLUTION | IV | SOLUTION |
| Vasostrict 20 UNIT/ML SOLUTION | IV | SOLUTION |
| Vectibix 100 MG/5ML SOLUTION | IV | SOLUTION |
| Vectibix 400 MG/20ML SOLUTION | IV | SOLUTION |
| Velcade 3.5 MG RECON SOLN | IJ | RECON SOLN |
| Veletri 0.5 MG RECON SOLN | IV | RECON SOLN |
| Veletri 1.5 MG RECON SOLN | IV | RECON SOLN |
| Ventavis 10 MCG/ML SOLUTION | IN | SOLUTION |
| Ventavis 20 MCG/ML SOLUTION | IN | SOLUTION |
| Verapamil HCl 2.5 MG/ML SOLUTION | IV | SOLUTION |
| 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 |
| Vinorelbine Tartrate 10 MG/ML SOLUTION | IV | SOLUTION |
| Vinorelbine Tartrate 50 MG/5ML SOLUTION | IV | SOLUTION |
| Virazole 6 GM RECON SOLN | IN | RECON SOLN |

| MEDICATION NAME | ROUTE | DOSE FORM |
|---|---|---|
| Voriconazole 200 MG RECON SOLN | IV | RECON SOLN |
| Vpriv 400 UNIT RECON SOLN | IV | RECON SOLN |
| Vyepti 100 MG/ML SOLUTION | IV | SOLUTION |
| Vyvgart 400 MG/20ML SOLUTION | IV | SOLUTION |
| Vyxeos 44-100 MG RECON SUSP | IV | RECON SUSP |
| WinRho SDF 1500 UNIT/1.3ML SOLUTION | IJ | SOLUTION |
| WinRho SDF 15000 UNIT/13ML SOLUTION | IJ | SOLUTION |
| WinRho SDF 2500 UNIT/2.2ML SOLUTION | IJ | SOLUTION |
| WinRho SDF 5000 UNIT/4.4ML SOLUTION | IJ | SOLUTION |
| Xembify 1 GM/5ML SOLUTION | SC | SOLUTION |
| Xembify 10 GM/50ML SOLUTION | SC | SOLUTION |
| Xembify 2 GM/10ML SOLUTION | SC | SOLUTION |
| Xembify 4 GM/20ML SOLUTION | SC | SOLUTION |
| Xenleta 150 MG/15ML SOLUTION | IV | SOLUTION |
| Xenpozyme 20 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 |
| Xopenex 0.31 MG/3ML NEBU SOLN | IN | NEBU SOLN |
| Xopenex 0.63 MG/3ML NEBU SOLN | IN | NEBU SOLN |
| Xopenex 1.25 MG/3ML NEBU SOLN | IN | NEBU SOLN |
| Xopenex Concentrate 1.25 MG/0.5ML NEBU SOLN | IN | NEBU SOLN |
| Yervoy 200 MG/40ML SOLUTION | IV | SOLUTION |
| Yervoy 50 MG/10ML SOLUTION | IV | SOLUTION |
| Yondelis 1 MG RECON SOLN | IV | RECON SOLN |
| Yupelri 175 MCG/3ML SOLUTION | IN | SOLUTION |
| Zaltrap 100 MG/4ML SOLUTION | IV | SOLUTION |
| Zaltrap 200 MG/8ML SOLUTION | IV | SOLUTION |
| Zanosar 1 GM RECON SOLN | IV | RECON SOLN |
| Zemaira 1000 MG RECON SOLN | IV | RECON SOLN |
| Zemdri 500 MG/10ML SOLUTION | IV | SOLUTION |
| Zemplar 1 MCG CAP | PO | CAP |
| Zemplar 2 MCG CAP | PO | CAP |
| Zemplar 2 MCG/ML SOLUTION | IV | SOLUTION |
| Zemplar 5 MCG/ML SOLUTION | IV | SOLUTION |
| Zepzelca 4 MG RECON SOLN | IV | RECON SOLN |
| Zerbaxa 1.5 (1-0.5) GM RECON SOLN | IV | RECON SOLN |
| Zevalin Y-90 3.2 MG/2ML KIT | IV | KIT |
| Ziextenzo 6 MG/0.6ML SOLN PRSYR | SC | SOLN PRSYR |
| Zinc Sulfate 1 MG/ML SOLUTION | IV | SOLUTION |
| Zinc Sulfate 3 MG/ML SOLUTION | IV | SOLUTION |
| Zinc Sulfate 5 MG/ML SOLUTION | IV | SOLUTION |

| MEDICATION NAME | ROUTE | DOSE FORM |
|---|---|---|
| Zinecard 250 MG RECON SOLN | IV | RECON SOLN |
| Zinecard 500 MG RECON SOLN | IV | RECON SOLN |
| Zinplava 1000 MG/40ML SOLUTION | IV | SOLUTION |
| Zirabev 100 MG/4ML SOLUTION | IV | SOLUTION |
| Zirabev 400 MG/16ML SOLUTION | IV | SOLUTION |
| Zofran 4 MG TAB | PO | TAB |
| Zofran 4 MG/5ML SOLUTION | PO | SOLUTION |
| Zofran 8 MG TAB | PO | TAB |
| Zoladex 10.8 MG IMPLANT | SC | IMPLANT |
| Zoladex 3.6 MG IMPLANT | SC | IMPLANT |
| Zoledronic Acid 4 MG RECON SOLN | IV | RECON SOLN |
| Zoledronic Acid 4 MG/100ML SOLUTION | IV | SOLUTION |
| Zoledronic Acid 4 MG/5ML CONC | IV | CONC |
| Zoledronic Acid 5 MG/100ML SOLUTION | IV | SOLUTION |
| Zometa 4 MG/100ML SOLUTION | IV | SOLUTION |
| Zometa 4 MG/5ML CONC | IV | CONC |
| Zortress 0.25 MG TAB | PO | TAB |
| Zortress 0.5 MG TAB | PO | TAB |
| Zortress 0.75 MG TAB | PO | TAB |
| Zortress 1 MG TAB | PO | TAB |
| Zulresso 100 MG/20ML SOLUTION | IV | SOLUTION |
| Zuplenz 4 MG FILM | PO | FILM |
| Zuplenz 8 MG FILM | PO | FILM |
| Zynlonta 10 MG RECON SOLN | IV | RECON SOLN |