

## ACTHAR

### Products Affected

- ACTHAR

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Coverage is not provided for diagnostic procedure.
<b>Required Medical Information</b>	Diagnosis, prescriber or consulting physician specialty, previous medications tried and response
<b>Age Restrictions</b>	Infantile spasms- less than 2yo. Acute MS exac-adult
<b>Prescriber Restrictions</b>	Infantile spasms, prescr/consult w/neurolo/epileptologist.MS exacerbation, prescr/consult w/neuro/phys specializes MS.RA, JIA/JRA, AS, PsA, SLE, Systemic Dermatomyositis, prescr/consult w/rheum.Severe Erythema Multiforme, prescr/consult w/derm.Serum Sickness,prescr/consult w/allergist.Severe acute/chronic allergic/inflamm processes of eye and its adnexa, prescr/consult w/ ophthalmologist.Symptomatic Sarcoidosis, prescr/consult w/pulm/cardio.Nephrotic Syndrome, prescr/consult w/nephrologist.
<b>Coverage Duration</b>	All diagnoses-1 month
<b>Other Criteria</b>	For acute MS exacerbation, approve if Acthar is NOT being used as pulse therapy on a monthly basis. For all other FDA approved diagnoses (other than Infantile spasms or MS exacerbation), approve if the patient has tried a systemic corticosteroid for the current condition and patient has experienced a severe adverse effect or treatment failure with the corticosteroid (e.g., a psychotic reaction).
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# ACTIMMUNE

---

## Products Affected

- ACTIMMUNE

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	N/A
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# ADEMPAS

---

## Products Affected

- ADEMPAS

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	PAH and CTEPH- must be prescribed by or in consultation with a cardiologist or a pulmonologist.
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	For PAH - must have PAH (WHO Group 1) and had a right heart catheterization to confirm the diagnosis of PAH (WHO Group 1).
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# AIMOVIG

---

## Products Affected

- AIMOVIG AUTOINJECTOR

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Combination therapy with Ajoovy, Vyepti or Emgality
<b>Required Medical Information</b>	Diagnosis, number of migraine headaches per month, prior therapies tried
<b>Age Restrictions</b>	18 years and older
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	Approve if the patient meets the following criteria (A and B): A) Patient has greater than or equal to 4 migraine headache days per month (prior to initiating a migraine-preventative medication), AND B) Patient has tried at least two standard prophylactic pharmacologic therapies, at least one drug each from a different pharmacologic class (e.g., anticonvulsant, beta-blocker), and has had inadequate responses to those therapies or the patient has a contraindication to other prophylactic pharmacologic therapies according to the prescribing physician.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# ALDURAZYME

---

## Products Affected

- ALDURAZYME

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis, genetic and lab test results
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a geneticist, endocrinologist, a metabolic disorder sub-specialist, or a physician who specializes in the treatment of lysosomal storage disorders
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	Approve if the patient has a laboratory test demonstrating deficient alpha-L-iduronidase activity in leukocytes, fibroblasts, plasma, or serum OR has a molecular genetic test demonstrating alpha-L-iduronidase gene mutation
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# ALOSETRON

---

## Products Affected

- *alosetron*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Alosetron will not be approved for use in men, as safety and efficacy in men has not been established.
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Alosetron is considered medically necessary for the treatment of severe IBS-D. At least one of the following must be present for diarrhea to be considered severe: frequent and severe abdominal pain or discomfort, frequent bowel urgency or fecal incontinence, and disability or restriction of daily activities due to IBS.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# AMPYRA

---

## Products Affected

- *dalfampridine*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	MS. If prescribed by, or in consultation with, a neurologist or MS specialist.
<b>Coverage Duration</b>	Authorization will be for 1 year.
<b>Other Criteria</b>	N/A
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# ANABOLIC STEROIDS

---

## Products Affected

- ANADROL-50
- *oxandrolone oral tablet 10 mg, 2.5 mg*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Authorization will be for 12 months.
<b>Other Criteria</b>	N/A
<b>Indications</b>	All FDA-approved Indications, Some Medically-accepted Indications.
<b>Off-Label Uses</b>	Patients w/Turner's Syndrome or Ullrich-Turner Syndrome (oxandrolone only), management of protein catabolism w/burns or burn injury (oxandrolone only), AIDS wasting and cachexia

# ANTIBIOTICS (INJECTABLE)

---

## Products Affected

- *amikacin injection solution 1,000 mg/4 ml, 500 mg/2 ml*
- *ampicillin sodium*
- *ampicillin-sulbactam*
- *azithromycin intravenous*
- *aztreonam*
- BICILLIN L-A
- *cefazolin in dextrose (iso-os) intravenous piggyback 1 gram/50 ml*
- *cefazolin injection recon soln 100 gram, 300 g*
- *cefazolin intravenous*
- CEFEPIME IN DEXTROSE 5 %
- *cefepime in dextrose, iso-osm*
- *cefotaxime injection recon soln 1 gram*
- CEFOTETAN IN DEXTROSE, ISO-OSM
- *cefotetan injection*
- *cefoxitin*
- *cefoxitin in dextrose, iso-osm*
- *ceftazidime*
- CEFTAZIDIME IN D5W
- *ceftriaxone in dextrose, iso-os*
- CEFTRIAZONE INJECTION RECON SOLN 100 GRAM
- *ceftriaxone intravenous*
- *cefuroxime sodium injection recon soln 750 mg*
- *cefuroxime sodium intravenous*
- *ciprofloxacin in 5 % dextrose*
- CLINDAMYCIN IN 0.9 % SOD CHLOR
- *clindamycin in 5 % dextrose*
- *clindamycin phosphate injection*
- *clindamycin phosphate intravenous solution 600 mg/4 ml*
- COLISTIN (COLISTIMETHATE NA)
- *doxy-100*
- *doxycycline hyclate intravenous*
- ERYTHROCIN INTRAVENOUS RECON SOLN 500 MG
- *gentamicin in nacl (iso-osm) intravenous piggyback 100 mg/100 ml, 60 mg/50 ml, 80 mg/100 ml, 80 mg/50 ml*
- GENTAMICIN IN NAACL (ISO-OSM) INTRAVENOUS PIGGYBACK 100 MG/50 ML, 120 MG/100 ML
- *gentamicin injection solution 40 mg/ml*
- *gentamicin sulfate (ped) (pf)*
- *levofloxacin in d5w*
- *levofloxacin intravenous*
- *lincomycin*
- *linezolid in dextrose 5%*
- *linezolid-0.9% sodium chloride*
- *metro i.v.*
- *metronidazole in nacl (iso-os)*
- MOXIFLOXACIN-SOD.ACE,SUL-WATER
- *moxifloxacin-sod.chloride(iso)*
- *nafcillin*
- *nafcillin in dextrose iso-osm*
- NUZYRA INTRAVENOUS
- ORBACTIV
- *oxacillin injection*
- *penicillin g potassium*
- *pfizerpen-g*
- PIPERACILLIN-TAZOBACTAM INTRAVENOUS RECON SOLN 13.5 GRAM
- *polymyxin b sulfate*
- SIVEXTRO INTRAVENOUS
- STREPTOMYCIN
- *sulfamethoxazole-trimethoprim intravenous*
- SYNERCID
- *tazicef*
- TEFLARO
- TIGECYCLINE
- *tobramycin sulfate*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	3 months
<b>Other Criteria</b>	N/A
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

## ANTIFUNGALS (IV)

---

### Products Affected

- *caspofungin*
- *voriconazole intravenous*
- *fluconazole in nacl (iso-osm) intravenous piggyback 200 mg/100 ml, 400 mg/200 ml*

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 months
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

# ANTIFUNGALS, POLYENE

---

## Products Affected

- ABELCET
- AMBISOME
- *amphotericin b*

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	6 months
Other Criteria	B vs D coverage determination
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

# ANTINEOPLASTICS, MONOCLONAL ANTIBODIES

---

## Products Affected

- ABRAXANE
- ALIMTA
- ALIQOPA
- BAVENCIO
- BESPONSA
- BORTEZOMIB
- CYRAMZA
- DARZALEX
- ELZONRIS
- EMLICITI
- ENHERTU
- EVOMELA
- GAZYVA
- IMFINZI
- KADCYLA
- KANJINTI
- KEYTRUDA INTRAVENOUS SOLUTION
- LIBTAYO
- LUMOXITI
- MVASI
- MYLOTARG
- OGIVRI
- ONIVYDE
- OPDIVO
- PADCEV
- PERJETA
- POLIVY
- POTELIGEO
- RUXIENCE
- SARCLISA
- TECENTRIQ INTRAVENOUS SOLUTION 1,200 MG/20 ML (60 MG/ML), 840 MG/14 ML (60 MG/ML)
- *thiotepa*
- TRAZIMERA
- TRUXIMA
- UNITUXIN
- VECTIBIX
- VELCADE
- YERVOY INTRAVENOUS SOLUTION 200 MG/40 ML (5 MG/ML), 50 MG/10 ML (5 MG/ML)
- YONDELIS
- ZIRABEV

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Other Criteria</b>	B vs D coverage determination
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# APOKYN

---

## Products Affected

- APOKYN

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Concurrent use with a serotonin 5-HT3 Antagonist
<b>Required Medical Information</b>	Diagnosis, other therapies
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a neurologist
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	Parkinson's disease (PD)-approve if the patient has advanced PD, is experiencing off episodes such as muscle stiffness, slow movements, or difficulty starting movements, is currently receiving carbidopa/levodopa and has previously tried two other treatments for off episodes.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# ARANESP

## Products Affected

- ARANESP (IN POLYSORBATE) INJECTION SOLUTION 100 MCG/ML, 200 MCG/ML, 25 MCG/ML, 300 MCG/ML, 40 MCG/ML, 60 MCG/ML
- ARANESP (IN POLYSORBATE) INJECTION SYRINGE

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Anemia w/CRF not on dialysis. A hemoglobin (Hb) of less than 10.0 g/dL for adults and less than or equal to 11 g/dL for children required for start, Hb has to be less than or equal to 11.5 g/dL adults or less than or equal to 12 g/dL in children if previously receiving epoetin alfa (EA), Mircera or Aranesp. Anemia due to myelosuppressive chemotx, Hb is 10.0 g/dL or less to start or less than or equal to 12.0 g/dL if previously on EA or Aranesp AND currently receiving myelosuppressive chemo. MDS, approve tx if Hb is 10 g/dL or less or serum erythropoietin level is 500 mU/mL or less to start. If the pt has previously been receiving Aranesp or EA, approve only if Hb is 12.0 g/dL or less. All conds, deny if Hb exceeds 12.0 g/dL.
<b>Age Restrictions</b>	MDS anemia = 18 years of age and older.
<b>Prescriber Restrictions</b>	MDS anemia, prescribed by or in consultation with, a hematologist or oncologist.
<b>Coverage Duration</b>	Anemia w/myelosupp=6 mos, Anemia CKD(dialysis)-3 years, no dialysis, MDS-1 year, Other=6 mos.
<b>Other Criteria</b>	N/A
<b>Indications</b>	All FDA-approved Indications, Some Medically-accepted Indications.
<b>Off-Label Uses</b>	Anemia due to myelodysplastic syndrome (MDS)

# ARCALYST

---

## Products Affected

- ARCALYST

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Concurrent biologic therapy
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	Initial tx CAPS-Greater than or equal to 12 years of age.
<b>Prescriber Restrictions</b>	Initial tx CAPS-prescribed by, or in consultation with, a rheumatologist, geneticist, allergist/immunologist, or dermatologist.
<b>Coverage Duration</b>	3 mos initial, 3 years cont
<b>Other Criteria</b>	CAPS renewal - approve if the patient has had a response as determined by the prescriber.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# ARIKAYCE

---

## Products Affected

- ARIKAYCE

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis, previous medication history
<b>Age Restrictions</b>	MAC-18 years and older
<b>Prescriber Restrictions</b>	MAC-Prescribed by a pulmonologist, infectious disease physician or a physician who specializes in the treatment of MAC lung infections. Cystic fibrosis-prescribed by or in consultation with a pulmonologist or physician who specializes in the treatment of cystic fibrosis
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	MAC Lung disease-approve if the patient has NOT achieved negative sputum cultures for Mycobacterium avium complex after a background multidrug regimen AND Arikayce will be used in conjunction to a background multidrug regimen. Note-a multidrug regimen typically includes a macrolide (azithromycin or clarithromycin), ethambutol and a rifamycin (rifampin or rifabutin). Cystic fibrosis-patient has pseudomonas aeruginosa in culture of the airway.
<b>Indications</b>	All FDA-approved Indications, Some Medically-accepted Indications.
<b>Off-Label Uses</b>	Cystic fibrosis pseudomonas aeruginosa infection

# ATYPICAL ANTIPSYCHOTIC

---

## Products Affected

- FANAPT ORAL TABLET
- FANAPT ORAL TABLETS,DOSE PACK
- *paliperidone oral tablet extended release*  
24hr 1.5 mg, 3 mg, 6 mg, 9 mg
- VRAYLAR ORAL CAPSULE
- VRAYLAR ORAL CAPSULE,DOSE PACK

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	Approve if the patient has tried two of the following: olanzapine, quetiapine fumarate, risperidone, ziprasidone. Approve requests for paliperidone ER in Schizoaffective Disorder without the trial of other treatment.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

# AUBAGIO

---

## Products Affected

- AUBAGIO

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Concurrent use of Aubagio with other disease-modifying agents used for multiple sclerosis (MS)
<b>Required Medical Information</b>	Relapsing form of MS
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a neurologist or MS specialist.
<b>Coverage Duration</b>	Authorization will be for 1 year.
<b>Other Criteria</b>	N/A
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# AURYXIA

---

## Products Affected

- AURYXIA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	N/A
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# AUSTEDO

---

## Products Affected

- AUSTEDO ORAL TABLET 12 MG, 6 MG, 9 MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a neurologist or a psychiatrist
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	N/A
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# AVONEX

---

## Products Affected

- AVONEX INTRAMUSCULAR PEN INJECTOR KIT
- AVONEX INTRAMUSCULAR SYRINGE KIT

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Concurrent use of other disease-modifying agent used for multiple sclerosis
<b>Required Medical Information</b>	Relapsing form of Multiple Sclerosis (MS) diagnosis
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or after consultation with a neurologist or an MS specialist.
<b>Coverage Duration</b>	Authorization will be for 3 years.
<b>Other Criteria</b>	N/A
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# BENLYSTA

## Products Affected

- BENLYSTA INTRAVENOUS RECON SOLN 120 MG, 400 MG
- BENLYSTA SUBCUTANEOUS

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Concurrent use with other biologics or with cyclophosphamide intravenous (IV)
<b>Required Medical Information</b>	Diagnosis, medications that will be used in combination, autoantibody status
<b>Age Restrictions</b>	18 years and older (initial).
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a rheumatologist, clinical immunologist, nephrologist, neurologist or dermatologist (initial and continuation)
<b>Coverage Duration</b>	Initial-4 months, cont-3 years
<b>Other Criteria</b>	Initial-The patient has autoantibody-positive SLE (i.e., positive for antinuclear antibodies [ANA] and/or anti-double-stranded DNA antibody [anti-dsDNA]) AND Benlysta is being used concurrently with at least one other standard therapy (i.e., antimalarials [e.g., hydroxychloroquine], a systemic corticosteroid [e.g., prednisone], and/or other immunosuppressants [e.g., azathioprine, mycophenolate mofetil, methotrexate]) unless the patient is determined to be intolerant due to a significant toxicity, as determined by the prescribing physician. Continuation-Benlysta is being used concurrently with at least one other standard therapy (i.e., antimalarials [e.g., hydroxychloroquine], a systemic corticosteroid [e.g., prednisone], and/or other immunosuppressants [e.g., azathioprine, mycophenolate mofetil, methotrexate]) unless the patient is determined to be intolerant due to a significant toxicity, as determined by the prescribing physician AND The patient has responded to Benlysta as determined by the prescriber.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# BETASERON

---

## Products Affected

- BETASERON SUBCUTANEOUS KIT

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Concurrent use with other disease-modifying agent used for multiple sclerosis
<b>Required Medical Information</b>	Relapsing form of Multiple Sclerosis (MS) diagnosis
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or after consultation with a neurologist or an MS specialist.
<b>Coverage Duration</b>	Authorization will be for 3 years.
<b>Other Criteria</b>	N/A
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# BOTOX

---

## Products Affected

- BOTOX

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	cosmetic uses (eg, facial rhytides, frown lines, glabellar wrinkling, horizontal neck rhytides, mid and lower face and neck rejuvenation, platysmal bands, rejuvenation of the peri-orbital region)
<b>Required Medical Information</b>	None
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	Migraine headache prophylaxis in patients with chronic migraine if prescribed by, or after consultation with, a neurologist or HA specialist
<b>Coverage Duration</b>	Authorization will be for 12 months
<b>Other Criteria</b>	<ul style="list-style-type: none"> <li>•Blepharospasm Associated with Dystonia or Strabismus-approve</li> <li>•Cervical Dystonia (spasmodic torticollis)-approve</li> <li>•Hyperhidrosis, primary axillary-approve</li> <li>•Chronic low back pain after trial with at least 2 other pharmacologic therapies (eg, NSAID, antispasmodics, muscle relaxants, opioids, antidepressants) and if being used as part of a multimodal therapeutic pain management program.</li> <li>•Essential tremor after a trial with at least 1 other pharmacologic therapy (eg, primidone, propranolol, benzodiazepines, gabapentin, topiramate).</li> <li>•Migraine Headache Prophylaxis in patients with Chronic migraine -must have 15 or more migraine headache days per month with headache lasting 4 hours per day or longer (prior to initiation of Botox therapy) AND have tried at least two other prophylactic pharmacologic therapies, each from a different pharmacologic class (e.g., beta-blocker, anticonvulsant, tricyclic antidepressant).</li> <li>•Urinary incontinence associated with a neurological condition (e.g., spinal cord injury, multiple sclerosis) approve after a trial with at least one other pharmacologic therapy (e.g., anticholinergic medication).</li> <li>•Overactive Bladder with symptoms of Urge Urinary Incontinence,</li> </ul>

<b>PA Criteria</b>	<b>Criteria Details</b>
	Urgency and Frequence-approve if the patient has tried at least one other pharmacologic therapy <ul style="list-style-type: none"> <li>•Spasticity, lower limb-approve</li> <li>•Spasticity, upper limb-approve</li> </ul>
<b>Indications</b>	All FDA-approved Indications, Some Medically-accepted Indications.
<b>Off-Label Uses</b>	Achalasia, Anal Fissure (anal sphincter), Chronic facial pain/pain associated with TMJ dysfunction, Chronic low back pain, Hyperhidrosis (Palmar/Plantar, facial), Myofascial pain, Sialorrhea (chronic), Spasticity (other than lower and upper limb (eg, due to cerebral palsy, stroke, brain injury, spinal cord injury, MS, hemifacial spasm)), Essential tremor, Dystonia other than cervical (eg, focal dystonias, tardive dystonia, anismus, laryngeal dystonia/spasmodic dysphonia), Frey's syndrome (gustatory sweating), Ophthalmic disorders (other than blepharospasm or Strabismus (eg, esotropia, exotropia, nystagmus, facial nerve paresis))

# C1 ESTERASE INHIBITORS

---

## Products Affected

- HAEGARDA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	prescribed by or in consultation with an allergist/immunologist or a physician that specializes in the treatment of HAE or related disorders
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	N/A
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# CAPLYTA

---

## Products Affected

- CAPLYTA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	Approve if the patient has tried two of the following: olanzapine, quetiapine fumarate, risperidone, ziprasidone.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# CARBAGLU

---

## Products Affected

- CARBAGLU

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a metabolic disease specialist or a specialist who focuses in the treatment of metabolic diseases
<b>Coverage Duration</b>	Pt meets criteria with no genetic test - 3 mo approval. Pt had genetic test - 12 mo approval
<b>Other Criteria</b>	Approve if genetic testing confirmed a mutation leading to N-acetylglutamate synthase deficiency (NAGS) or if the patient has hyperammonemia.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# CAYSTON

---

## Products Affected

- CAYSTON

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a pulmonologist or a physician who specializes in the treatment of cystic fibrosis.
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	Approve if the patient has <i>Pseudomonas aeruginosa</i> in culture of the airway (e.g., sputum culture, oropharyngeal culture, bronchoalveolar lavage culture).
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# CEREZYME

---

## Products Affected

- CEREZYME INTRAVENOUS RECON SOLN 400 UNIT

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis, genetic tests and lab results
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a geneticist, endocrinologist, a metabolic disorder sub-specialist, or a physician who specializes in the treatment of lysosomal storage disorder
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	Gaucher Disease, Type 1-approve if there is demonstration of deficient beta-glucocerebrosidase activity in leukocytes or fibroblasts OR molecular genetic testing documenting glucocerebrosidase gene mutation
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# CHEMET

---

## Products Affected

- CHEMET

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Blood lead level
<b>Age Restrictions</b>	Approve in patients between the age of 12 months and 18 years
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a professional experienced in the use of chelation therapy (eg, a medical toxicologist or a poison control center specialist)
<b>Coverage Duration</b>	Approve for 2 months
<b>Other Criteria</b>	Approve if Chemet is being used to treat acute lead poisoning (not as prophylaxis) and prior to starting Chemet therapy the patient's blood lead level was greater than 45 mcg/dL.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# CHORIONIC GONADOTROPINS

---

## Products Affected

- CHORIONIC GONADOTROPIN,  
HUMAN INTRAMUSCULAR
- NOVAREL
- PREGNYL

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Authorization will be for 12 months
<b>Other Criteria</b>	N/A
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# CIALIS

---

## Products Affected

- CIALIS ORAL TABLET 2.5 MG, 5 MG
- *tadalafil oral tablet 2.5 mg, 5 mg*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Cialis (tadalafil) 2.5mg and 5mg are only covered under Part D for the treatment of benign prostatic hyperplasia (BPH). Cialis (tadalafil) can be approved with a non-D authorization for the indication of erectile dysfunction if the EGWP customer has the lifestyle buy-up
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# CIMZIA

## Products Affected

- CIMZIA
- CIMZIA POWDER FOR RECONST
- CIMZIA STARTER KIT

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Concurrent use with biologic therapy or targeted synthetic DMARD
<b>Required Medical Information</b>	Diagnosis, concurrent medications, previous therapies tried.
<b>Age Restrictions</b>	18 years and older for CD and PP (initial therapy).
<b>Prescriber Restrictions</b>	All dx initial therapy only-RA/AS, prescribed by or in consultation with a rheumatologist. Crohn's disease, prescribed by or in consultation with a gastroenterologist. PsA prescribed by or in consultation with a rheumatologist or dermatologist. PP, prescribed by or in consultation with a dermatologist. nr-axSpA-prescribed by or in consultation with a rheumatologist
<b>Coverage Duration</b>	3 months initial, 3 years cont.
<b>Other Criteria</b>	AS, approve if the patient has tried one of the following: Enbrel or Humira. RA, approve if the patient has tried two of the following: Enbrel, Humira, Rinvoq. PsA, approve if the patient has tried two of the following: Enbrel, Humira, Stelara. PP, approve if the patient has tried two of the following: Enbrel, Humira, Skyrizi, or Stelara. CD, approve if patient has previously tried both Humira or Stelara. Non-radiographic axial spondylitis (nr-axSpA)-approve if the patient has objective signs of inflammation, defined as at least one of the following: C-reactive protein (CRP) elevated beyond the upper limit of normal for the reporting laboratory OR sacroiliitis reported on MRI. Continuation-approve if the patient has had a response as determined by the prescriber.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# CLOBAZAM

---

## Products Affected

- *clobazam oral suspension*
- *clobazam oral tablet*
- SYMPAZAN

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis, other medications tried
<b>Age Restrictions</b>	2 years and older (initial therapy)
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a neurologist (initial therapy)
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	Lennox-Gastaut Syndrome, initial therapy-patient has tried one of the following: lamotrigine, topiramate, rufinamide, felbamate, or Epidiolex. Treatment refractory seizures/epilepsy, initial therapy-patient has tried and/or is concomitantly receiving at least two other antiepileptic drugs (e.g., valproic acid, lamotrigine, topiramate, clonazepam, levetiracetam, zonisamide, felbamate). Continuation-prescriber confirms patient is responding to therapy.
<b>Indications</b>	All FDA-approved Indications, Some Medically-accepted Indications.
<b>Off-Label Uses</b>	Dravet Syndrome and treatment-refractory seizures/epilepsy

# COPAXONE

---

## Products Affected

- COPAXONE SUBCUTANEOUS  
SYRINGE 20 MG/ML, 40 MG/ML

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Concurrent use with other disease-modifying agent used for multiple sclerosis
<b>Required Medical Information</b>	Relapsing form of Multiple Sclerosis (MS) diagnosis
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or after consultation with a neurologist or an MS specialist.
<b>Coverage Duration</b>	Authorization will be for 1 year.
<b>Other Criteria</b>	N/A
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# CORLANOR

---

## Products Affected

- CORLANOR ORAL TABLET

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Previous use of a Beta-blocker, LVEF
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Chronic HF, adults- must have LVEF of less than or equal 35 percent (currently or prior to initiation of Corlanor therapy) AND tried or is currently receiving a Beta-blocker for HF (e.g., metoprolol succinate sustained-release, carvedilol, bisoprolol, carvedilol ER) unless the patient has a contraindication to the use of beta blocker therapy (e.g., bronchospastic disease such as COPD and asthma, severe hypotension or bradycardia). Heart failure due to dilated cardiomyopathy, children-approve.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# CRINONE

---

## Products Affected

- CRINONE VAGINAL GEL 8 %

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Crinone can be approved with a non-D authorization for the indication of infertility if the EGWP customer has the fertility buy-up
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# CYSTARAN

---

## Products Affected

- CYSTARAN

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an ophthalmologist or a metabolic disease specialist or specialist who focuses in the treatment of metabolic diseases
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	Approve if the patient has corneal cysteine crystal deposits confirmed by slit-lamp examination
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# DERMATOLOGICAL WOUND CARE AGENTS

---

## Products Affected

- REGRANEX

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	N/A
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# DIFICID

---

## Products Affected

- DIFICID

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 month
<b>Other Criteria</b>	N/A
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# DUAVEE

---

## Products Affected

- DUAVEE

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	For the prevention of postmenopausal osteoporosis, trial, failure, or intolerance of raloxifene is required prior to the use of Duavee.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# DUPIXENT

## Products Affected

- DUPIXENT SYRINGE

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Concurrent use with Xolair or another Anti-interleukin (IL) Monoclonal Antibody.
<b>Required Medical Information</b>	Diagnosis, prescriber specialty, other medications tried and length of trials
<b>Age Restrictions</b>	asthma/AD-12 years of age and older. Chronic Rhinosinusitis-18 years of age and older
<b>Prescriber Restrictions</b>	Atopic Dermatitis-Prescribed by or in consultation with an allergist, immunologist or dermatologist, asthma-prescribed by or in consultation with an allergist, immunologist or pulmonologist. Rhinosinusitis-prescribed by or in consultation with an allergist, immunologist or otolaryngologist.
<b>Coverage Duration</b>	AD-Initial-4 months, Cont-1 year, asthma/Rhinosinusitis-initial-6 months, continuation 1 year
<b>Other Criteria</b>	Atopic Dermatitis-Initial-meets both a and b: a.has used at least one medium, medium-high, high, and/or super-high-potency prescription topical corticosteroid OR has atopic dermatitis affecting ONLY the face, eyes/eyelids, skin folds, and/or genitalia and has tried tacrolimus ointment AND b.Inadequate efficacy was demonstrated with these previously tried topical prescription therapies, according to the prescribing physician.Continuation-Approve if the pt has responded to Dupixent therapy as determined by the prescribing physician. Asthma-Initial-approve if pt meets the following criteria (i, ii, and iii):i.Pt meets ONE of the following criteria (a or b):a)has a blood eosinophil level of greater than or equal to 150 cells per microliter within the previous 6 weeks or within 6 weeks prior to treatment with any anti-interleukin (IL) therapy or Xolair OR b)has oral corticosteroid-dependent asthma, per the prescriber AND ii.has received combination therapy with BOTH of the following (a and b): a)An inhaled corticosteroid (ICS) AND b)At least one additional asthma controller/maintenance medication (NOTE:An exception to the requirement for a trial of one additional asthma controller/maintenance medication can be made if the patient has already received anti-IL-5 therapy or Xolair used concomitantly with an ICS. Use of a combination

<b>PA Criteria</b>	<b>Criteria Details</b>
	<p>inhaler containing both an ICS and a LABA would fulfil the requirement for both criteria a and b) AND iii.asthma is uncontrolled or was uncontrolled prior to starting any anti-IL therapy or Xolair as defined by ONE of the following (a, b, c, d or e): a)experienced two or more asthma exacerbations requiring treatment with systemic corticosteroids in the previous year OR b)experienced one or more asthma exacerbation requiring hospitalization or an Emergency Department visit in the previous year OR c)has a forced expiratory volume in 1 second (FEV1) less than 80% predicted OR d)has an FEV1/forced vital capacity (FVC) less than 0.80 OR e)The patient's asthma worsens upon tapering of oral corticosteroid therapy. Continuation-Approve if meets the following criteria (i and ii): i.continues to receive therapy with one inhaled corticosteroid (ICS) or one ICS-containing combination inhaler AND ii.has responded to Dupixent therapy as determined by the prescribing physician. Chronic rhinosinusitis with Nasal Polyposis-Initial-pt is currently receiving therapy with an intranasal corticosteroid AND is experiencing significant rhinosinusitis symptoms such as nasal obstruction, rhinorrhea, or reduction/loss of smell according to the prescriber AND meets ONE of the following (a or b): a)has received treatment with a systemic corticosteroid within the previous 2 years or has a contraindication to systemic corticosteroid therapy OR b)has had prior surgery for nasal polyps. Continuation-approve if the pt continues to receive therapy with an intranasal corticosteroid AND pt has responded to Dupixent therapy as determined by the prescriber.</p>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# ELAPRASE

---

## Products Affected

- ELAPRASE

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis, genetic and lab test results
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a geneticist, endocrinologist, a metabolic disorder sub-specialist, or a physician who specializes in the treatment of lysosomal storage disorders
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	Approve if the patient has laboratory test demonstrating deficient iduronate-2-sulfatase activity in leukocytes, fibroblasts, or plasma OR a molecular genetic test demonstrating iduronate-2-sulfatase gene mutation
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# ENBREL

## Products Affected

- ENBREL MINI
- ENBREL SUBCUTANEOUS RECON SOLN
- ENBREL SUBCUTANEOUS SYRINGE
- ENBREL SURECLICK

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Concurrent use with biologic therapy or targeted synthetic DMARD
<b>Required Medical Information</b>	Diagnosis, concurrent medications, previous therapies tried.
<b>Age Restrictions</b>	PP-4 years and older (initial therapy)
<b>Prescriber Restrictions</b>	Initial only-RA/AS/JIA/JRA,prescribed by or in consult w/ rheum. PsA, prescribed by or in consultation w/ rheumatologist or dermatologist.PP, prescribed by or in consult w/ dermatologist.GVHD,prescribed by or in consult w/ oncologist,hematologist,or physician affiliated w/ transplant center. Uveitis, prescribed by or in consultation with an ophthalmologist.
<b>Coverage Duration</b>	FDA dx-3 mo init, 3 yrs cont, uveitis init-3 mo, cont-12 mo.GVHD-1 mo init/3 mo cont.
<b>Other Criteria</b>	RA/PsA initial, patient has tried one conventional synthetic DMARD for at least 3 months (note: patients who have already had a 3-month trial of a biologic for RA are not required to step back and try a conventional synthetic DMARD). JIA/JRA initial, patient has tried another agent (e.g MTX, sulfasalazine, leflunomide, NSAID, or biologic DMARD (eg, etanercept, abatacept, infliximab, anakinra, tocilizumab) or will be starting on Enbrel concurrently with MTX, sulfasalazine, or leflunomide. Approve without trying another agent if pt has absolute contraindication to MTX, sulfasalazine, or leflunomide or if pt has aggressive disease. PP initial, approve if the patient meets one of the following criteria: 1) pt has tried at least one traditional systemic agent (eg, MTX, cyclosporine, acitretin, PUVA) for at least 3 months, unless intolerant (note: pts who have already tried a biologic for psoriasis are not required to step back and try a traditional agent first) OR 2) pt has a contraindication to MTX as determined by the prescribing physician. Uveitis initial, tried one of the following: periocular, intraocular, or systemic corticosteroid, immunosuppressives or other biologic therapy. GVHD, tried or currently is receiving with etanercept 1 conventional GVHD tx (high-dose systemic

<b>PA Criteria</b>	<b>Criteria Details</b>
	corticosteroid, CSA, tacrolimus, MM, thalidomide, antithymocyte globulin, etc.). Continuation-approve if the patient has had a response as determined by the prescriber. Clinical criteria incorporated into the Enbrel 25 mg quantity limit edit, approve additional quantity (to allow for 50 mg twice weekly dosing) if one of the following is met: 1) Patient has plaque psoriasis, OR 2) Patient has RA/JIA/PsA/AS and is started and stabilized on 50 mg twice weekly dosing, OR 3) Patient has RA and the dose is being increased to 50 mg twice weekly and patient has taken MTX in combination with Enbrel 50 mg once weekly for at least 2 months, unless MTX is contraindicated or intolerant, OR 4) Patient has JIA/PsA/AS and the dose is being increased to 50 mg twice weekly after taking 50 mg once weekly for at least 2 months.
<b>Indications</b>	All FDA-approved Indications, Some Medically-accepted Indications.
<b>Off-Label Uses</b>	Graft versus host disease (GVHD), Uveitis

# EPCLUSA

---

## Products Affected

- EPCLUSA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Combination use with other direct acting antivirals, excluding ribavirin.
<b>Required Medical Information</b>	Genotype, prescriber specialty, other medications tried or used in combination with requested medication
<b>Age Restrictions</b>	6 years or older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a gastroenterologist, hepatologist, infectious diseases physician, or a liver transplant physician
<b>Coverage Duration</b>	Will be c/w AASLD guidance and inclusive of treatment already received for the requested drug
<b>Other Criteria</b>	Criteria will be applied consistent with current AASLD/IDSA guidance.
<b>Indications</b>	All FDA-approved Indications, Some Medically-accepted Indications.
<b>Off-Label Uses</b>	Indications consistent with current AASLD/IDSA guidance

# EPIDIOLEX

---

## Products Affected

- EPIDIOLEX

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis, previous therapies
<b>Age Restrictions</b>	Patients 2 years and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a neurologist
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	N/A
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# EPOETIN ALFA

## Products Affected

- EPOGEN INJECTION SOLUTION                      20,000 UNIT/2 ML, 20,000 UNIT/ML, 10,000 UNIT/ML, 2,000 UNIT/ML, 3,000 UNIT/ML, 4,000 UNIT/ML, 20,000 UNIT/2 ML, 20,000 UNIT/ML, 3,000 UNIT/ML, 4,000 UNIT/ML
- PROCRIT INJECTION SOLUTION                      10,000 UNIT/ML, 2,000 UNIT/ML,
- RETACRIT

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	CRF anemia in patients not on dialysis.Hemoglobin (Hb) of less than 10.0 g/dL for adults or less than or equal to 11 g/dL for children to start.Hb less than or equal to 11.5 g/dL for adults or 12 g/dL or less for children if previously on epoetin alfa, Mircerca or Aranesp. Anemia w/myelosuppressive chemotx.pt must be currently receiving myelosuppressive chemo and Hb 10.0 g/dL or less to start.Hb less than or equal to 12.0 g/dL if previously on epoetin alfa or Aranesp.MDS, approve if Hb is 10 g/dL or less or serum erythropoietin level is 500 mU/mL or less to start.Previously receiving Aranesp or EA, approve if Hb is 12.0 g/dL or less. Anemia in HIV with zidovudine, Hb is 10.0 g/dL or less or endogenous erythropoietin levels are 500 mU/mL or less at tx start.Previously on EA approve if Hb is 12.0 g/dL or less. Surgical pts to reduce RBC transfusions - Hgb is less than or equal to 13, surgery is elective, nonvascular and non-cardiac and pt is unwilling or unable to donate autologous blood prior to surgery
<b>Age Restrictions</b>	MDS anemia = 18 years of age and older.
<b>Prescriber Restrictions</b>	MDS anemia, myelofibrosis-prescribed by or in consultation with, a hematologist or oncologist.
<b>Coverage Duration</b>	Chemo-6m,Transfus-1m, CKD(dialysis)-3yrs, Myelofibrosis-init-3 mo, cont-1 yr, all others-1 yr
<b>Other Criteria</b>	Myelofibrosis-Initial-patient has a Hb less than 10 or serum erythropoietin less than or equal to 500 Mu/mL. Cont-patient has a Hgb less than or equal to 12 and according to the prescriber the patient has had a response defined as Hb greater than or equal to 10 or an increase of greater than or equal to 2 g/dL.
<b>Indications</b>	All FDA-approved Indications, Some Medically-accepted Indications.

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off-Label Uses</b>	Anemia due to myelodysplastic syndrome (MDS), myelofibrosis

# ERIVEDGE

---

## Products Affected

- ERIVEDGE

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	BCC (La or Met) - must not have had disease progression while on Odomzo.
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Authorization will be for 3 years
<b>Other Criteria</b>	Locally advanced basal cell carcinoma (LABCC), approve if 1. the patient's BCC has recurred following surgery or radiation, OR 2. the patient is not a candidate for surgery and radiation therapy. Central nervous system cancer (this includes brain and spinal cord tumors)-approve if the patient has tried at least one chemotherapy agent and according to the prescriber, the patient has a mutation of the sonic hedgehog pathway.
<b>Indications</b>	All FDA-approved Indications, Some Medically-accepted Indications.
<b>Off-Label Uses</b>	Central nervous System Cancer

# ERLEADA

---

## Products Affected

- ERLEADA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	3 years
<b>Other Criteria</b>	Prostate cancer-non-metastatic, castration resistant and prostate cancer-metastatic, castration sensitive-approve if the requested medication will be used in combination with a gonadotropin-releasing hormone (GnRH) analog or if the patient has had a bilateral orchiectomy.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# ESBRIET

---

## Products Affected

- ESBRIET ORAL CAPSULE
- ESBRIET ORAL TABLET 267 MG, 801 MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Combination use with nintedanib
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a pulmonologist
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	IPF - must have FVC greater than or equal to 40 percent of the predicted value AND IPF must be diagnosed with either findings on high-resolution computed tomography (HRCT) indicating usual interstitial pneumonia (UIP) or surgical lung biopsy demonstrating UIP.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# EXTAVIA

---

## Products Affected

- EXTAVIA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Concurrent use with other disease-modifying agent used for multiple sclerosis
<b>Required Medical Information</b>	Relapsing form of Multiple Sclerosis (MS) diagnosis
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or after consultation with a neurologist or an MS specialist.
<b>Coverage Duration</b>	Authorization will be for 3 years.
<b>Other Criteria</b>	N/A
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# EYLEA

---

## Products Affected

- EYLEA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Administered by or under the supervision of an ophthalmologist
<b>Coverage Duration</b>	3 years
<b>Other Criteria</b>	N/A
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# FERRIPROX

---

## Products Affected

- FERRIPROX

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Serum ferritin level
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a hematologist
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	Initial therapy - approve if prior to starting therapy the serum ferritin level was greater than 2,500 mcg/L. Continuation therapy - approve if the patient is benefiting from therapy as confirmed by the prescribing physician.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# FIRAZYR

---

## Products Affected

- *icatibant*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Patient must have a confirmed diagnosis of HAE.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	N/A
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# FIRDAPSE

---

## Products Affected

- FIRDAPSE

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	History of seizures (initial therapy)
<b>Required Medical Information</b>	Diagnosis, seizure history, lab and test results
<b>Age Restrictions</b>	18 years and older (initial therapy)
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a neurologist or a neuromuscular specialist (initial therapy)
<b>Coverage Duration</b>	Initial-3 months, Cont-1 year
<b>Other Criteria</b>	Initial therapy-Diagnosis confirmed by at least one electrodiagnostic study (e.g., repetitive nerve stimulation) OR anti-P/Q-type voltage-gated calcium channels (VGCC) antibody testing according to the prescribing physician. Continuation-patient continues to derive benefit (e.g., improved muscle strength, improvements in mobility) from Firdapse, according to the prescribing physician.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# FORTEO

---

## Products Affected

- FORTEO

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Concomitant use with other medications for osteoporosis (eg, denosumab [Prolia], bisphosphonates, raloxifene, calcitonin nasal spray [Fortical], abaloparatide), except calcium and Vitamin D.
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Auth will be for 2 years of total therapy between Tymlos/Bonsity/teriparatide over pt's lifetime
<b>Other Criteria</b>	Treatment of PMO, approve if pt has tried one oral bisphosphonate OR pt cannot take an oral bisphosphonate because the pt cannot swallow or has difficulty swallowing or the pt cannot remain in an upright position post oral bisphosphonate administration or pt has a pre-existing GI medical condition (eg, patient with esophageal lesions, esophageal ulcers, or abnormalities of the esophagus that delay esophageal emptying [stricture, achalasia]), OR pt has tried an IV bisphosphonate (ibandronate or zoledronic acid), OR pt has severe renal impairment (creatinine clearance less than 35 mL/min) or CKD or pt has had an osteoporotic fracture or fragility fracture. Increase bone mass in men (a man is defined as an individual with the biological traits of a man, regardless of the individual's gender identity or gender expression) with primary or hypogondal osteoporosis/Treatment of GIO, approve if pt tried one oral bisphosphonate OR pt cannot take an oral bisphosphonate because the patient cannot swallow or has difficulty swallowing or the patient cannot remain in an upright position post oral bisphosphonate administration or has a pre-existing GI medical condition (eg, patient with esophageal lesions, esophageal ulcers, or abnormalities of the esophagus that delay esophageal emptying [stricture, achalasia]), OR pt has tried zoledronic acid (Reclast), OR pt has severe renal impairment (CrCL less than 35 mL/min) or has CKD or has had an osteoporotic fracture or fragility fracture.

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# GATTEX

---

## Products Affected

- GATTEX 30-VIAL
- GATTEX ONE-VIAL

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis
<b>Age Restrictions</b>	1 year and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a gastroenterologist (initial and continuation)
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	Initial-approve if the patient is currently receiving parenteral nutrition on 3 or more days per week or according to the prescriber, the patient is unable to receive adequate total parenteral nutrition required for caloric needs. Continuation-approve if the patient has experienced at least a 20 percent decrease from baseline in the weekly volume of parenteral nutrition.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# GILENYA

---

## Products Affected

- GILENYA ORAL CAPSULE 0.5 MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Concurrent use of Gilenya with other disease-modifying agents used for multiple sclerosis (MS).
<b>Required Medical Information</b>	For use in MS, patient has a relapsing form of MS.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by, or in consultation with, a neurologist or an MS specialist.
<b>Coverage Duration</b>	Authorization will be for 1 year.
<b>Other Criteria</b>	N/A
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# GONADOTROPIN-RELEASING HORMONE AGONISTS - INJECTABLE LONG ACTING

---

## Products Affected

- ELIGARD
- ELIGARD (3 MONTH)
- ELIGARD (4 MONTH)
- ELIGARD (6 MONTH)
- *leuprolide subcutaneous kit*
- LUPRON DEPOT
- LUPRON DEPOT (3 MONTH)
- LUPRON DEPOT (4 MONTH)
- LUPRON DEPOT (6 MONTH)
- LUPRON DEPOT-PED (3 MONTH) INTRAMUSCULAR SYRINGE KIT 11.25 MG, 30 MG
- LUPRON DEPOT-PED INTRAMUSCULAR KIT 11.25 MG, 15 MG, 7.5 MG (PED)
- TRIPTODUR

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	For the treatment of cancer diagnosis must be prescribed by or in consultation with an oncologist.
Coverage Duration	For abnormal uterine bleeding, uterine leiomyomata 6 mo. All other=12 mo
Other Criteria	N/A
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Ovarian cancer, breast cancer, prophylaxis or treatment of uterine bleeding in patients with hematologic malignancy or undergoing cancer treatment or prior to bone marrow/stem cell transplantation, head and neck cancer-salivary gland tumors

# GROWTH HORMONES - GENOTROPIN

## Products Affected

- GENOTROPIN
- GENOTROPIN MINIQUICK

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	GHD in Children/Adolescents. Pt meets one of the following-1-had 2 GH stim tests with the following-levodopa, insulin-induced hypoglycemia, arginine, clonidine, or glucagon and both are inadequate as defined by a peak GH response which is below the normal reference range of the testing laboratory OR had at least 1 GH test and results show inadequate response and has at least one risk factor for GHD (e.g., ht for age curve deviated down across 2 major height percentiles [e.g., from above the 25 percentile to below the 10 percentile], growth rate is less than the expected normal growth rate based on age and gender, low IGF-1 and/or IGFBP-3 levels). 2.brain radiation or tumor resection and pt has 1 GH stim test and results is inadequate response or has def in at least 1 other pituitary hormone (that is, ACTH, TSH, gonadotropin deficiency [LH and/or FSH] are counted as 1 def], or prolactin).3. congenital hypopituitarism and has one GH stim test with inadequate response OR def in at least one other pituitary hormone and/or the patient has the imaging triad of ectopic posterior pituitary and pituitary hypoplasia with abnormal pituitary stalk 4.pt has panhypopituitarism and has pituitary stalk agenesis, empty sella, sellar or supra-sellar mass lesion, or ectopic posterior pituitary bright spot on MRI or CT or pt has 3 or more pituitary hormone deficiencies or pt has had one GH test and results were inadequate 5.pt had a hypophysectomy. Cont-pt responding to therapy
<b>Age Restrictions</b>	ISS 5 y/o or older, SGA 2 y/o or older, SBS 18 y/o or older
<b>Prescriber Restrictions</b>	GHD (Initial tx children or adolescents w/o hypophysectomy), GHD adults or transitional adolescents, Noonan (initial), Prader Willi (initial for child/adult and cont tx in adults), SHOX (initial), SGA (initial) - prescribed by or in consultation with an endocrinologist. CKD (initial) endocrinologist or nephrologist.
<b>Coverage Duration</b>	ISS - 6 mos intial, 12 months cont tx, SBS-1 month, others 12 mos
<b>Other Criteria</b>	GHD initial in adults and adolescents 1. endocrine must certify not being prescribed for anti-aging or to enhance athletic performance, 2. has either

PA Criteria	Criteria Details
	<p>childhood onset or adult onset resulting from GHD alone, multiple hormone deficiency from pituitary dx, hypothalamic dz, pituitary surgery, cranial radiation tx, tumor treatment, TBI or subarachnoid hemorrhage, AND 3. meets one of the following - A. has known mutations, embryonic lesions, congenital or genetic defects or structural hypothalamic pituitary defects, B. 3 or more pituitary hormone def (ACTH, TSH, LH/FSH, or prolactin, IGF1 less than 84 mcg/L (Esoterix RIA), AND other causes of low serum IGF-1 have been excluded, C. Neg response to ONE preferred GH stim test (insulin peak response less than or equal to 5 mcg/L, Glucagon peak less than or equal to 3 mcg/L (BMI is less than or equal to 25), less than or equal to 3 and BMI is greater than or equal to 25 and less than or equal to 30 with a high pretest probability of GH deficiency, less than or equal to 1 and BMI is greater than or equal to 25 and less than or equal to 30 with a low pretest probability of GH deficiency or less than or equal to 1 mcg/L (BMI is greater than 30), if insulin and glucagon contraindicated then Arginine alone test with peak of less than or equal to 0.4 mcg/L, or Macrilen peak less than 2.8 ng/ml AND BMI is less than or equal to 40 AND if a transitional adolescent must be off tx for at least one month before retesting. ISS initial - baseline ht less than the 1.2 percentile or a standard deviation score (SDS) less than -2.25 for age and gender, open epiphyses, does not have CDGP and height velocity is either growth rate (GR) is a. less than 4 cm/yr for pts greater than or equal to 5 or b. growth velocity is less than 10th percentile for age/gender. CKD initial - CKD defined by abnormal CrCl. Noonan initial - baseline height less than 5th percentile. SHOX initial - SHOX def by chromo analysis, open epiphyses, height less than 3rd percentile for age/gender. SGA initial - baseline ht less than 5th percentile for age/gender and born SGA (birth weight/length that is more than 2 SD below mean for gestational age/gender and didn't have sufficient catch up growth by 2-4 y/o). SBS initial pt receiving specialized nutritional support. Continuation of tx- approve if the patient has experienced improvement, according to the prescribing physician.</p>
<b>Indications</b>	All FDA-approved Indications, Some Medically-accepted Indications.
<b>Off-Label Uses</b>	SHOX, SBS, CKD

# HALAVEN

---

## Products Affected

- HALAVEN

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	For metastatic breast cancer, documentation of prior treatment with an anthracycline and a taxane. For unresectable or metastatic liposarcoma, documentation of prior treatment with an anthracycline-containing regimen.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	For metastatic breast cancer, patients must have previously received at least two chemotherapeutic regimens for the treatment of metastatic disease. B vs D coverage determination.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# HARVONI

---

## Products Affected

- HARVONI ORAL PELLETS IN PACKET 33.75-150 MG, 45-200 MG
- HARVONI ORAL TABLET 45-200 MG, 90-400 MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Combination use with other direct acting antivirals, excluding ribavirin
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	3 years or older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation w/ GI, hepatologist, ID, or a liver transplant MD
<b>Coverage Duration</b>	Will be c/w AASLD guidance and inclusive of treatment already received for the requested drug
<b>Other Criteria</b>	Criteria will be applied consistent with current AASLD/IDSA guidance.
<b>Indications</b>	All FDA-approved Indications, Some Medically-accepted Indications.
<b>Off-Label Uses</b>	Indications consistent with current AASLD/IDSA guidance

# HETLIOZ

---

## Products Affected

- HETLIOZ

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	patient is totally blind with no perception of light
<b>Age Restrictions</b>	18 years or older
<b>Prescriber Restrictions</b>	prescribed by, or in consultation with, a neurologist or a physician who specializes in the treatment of sleep disorders
<b>Coverage Duration</b>	6 mos initial, 12 mos cont
<b>Other Criteria</b>	Initial - dx of Non-24 is confirmed by either assessment of one physiologic circadian phase marker (e.g., measurement of urinary melatonin levels, dim light melatonin onset, assessment of core body temperature), or if assessment of physiologic circadian phase marker cannot be done, the diagnosis must be confirmed by actigraphy plus evaluation of sleep logs. Cont - Approve if pt has achieved adequate results with HetlioZ therapy according to the prescribing physician (e.g., entrainment, clinically meaningful or significant increases in nighttime sleep, clinically meaningful or significant decreases in daytime sleep).
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

## HIGH RISK MEDICATIONS - BENZTROPINE

---

### Products Affected

- *benztropine oral*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	Patients aged less than 65 years, approve. Patients aged 65 years and older, other criteria apply
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	For all medically-accepted indications, approve if the prescriber confirms he/she has assessed risk versus benefit in prescribing benztropine for the patient and he/she would still like to initiate/continue therapy.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# HIGH RISK MEDICATIONS - CARISOPRODOL

---

## Products Affected

- *carisoprodol*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	The physician has documented the indication for the continued use of the HRM (high risk med) with an explanation of the specific benefit established with the medication and how that benefit outweighs the potential risk, AND the physician will continue to monitor for side effects. For patients concurrently taking multiple anticholinergic medications, the physician has assessed the risk.
<b>Age Restrictions</b>	Automatic approval if member is less than 65 years of age. Prior authorization required for age 65 or older.
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	N/A
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# HIGH RISK MEDICATIONS - CYCLOBENZAPRINE

---

## Products Affected

- *cyclobenzaprine oral tablet 10 mg, 5 mg*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	Patients aged less than 65 years, approve.
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Authorization will be for 12 months.
<b>Other Criteria</b>	The physician has assessed risk versus benefit in using this High Risk Medication (HRM) in this patient and has confirmed that he/she would still like to initiate/continue therapy.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# HIGH RISK MEDICATIONS - FIRST GENERATION ANTIHISTAMINES

## Products Affected

- *promethazine oral*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	Patients aged less than 65 years, approve. Patients aged 65 years and older, other criteria apply.
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Authorization will be for 12 months.
<b>Other Criteria</b>	For promethazine, authorize use without a previous drug trial for all FDA-approved indications other than emesis, including cancer/chemo-related emesis. For hydroxyzine hydrochloride, authorize use without a previous drug trial for all FDA-approved indications other than anxiety. For the treatment of non-cancer/chemo related emesis, approve promethazine hydrochloride if the patient has tried a prescription oral anti-emetic agent (ondansetron, granisetron, dolasetron, aprepitant) for the current condition. Approve hydroxyzine hydrochloride if the patient has tried at least two other FDA-approved products for the management of anxiety. Prior to approval of promethazine and hydroxyzine, approve if the physician must have assessed risk versus benefit in prescribing the requested HRM for the patient and must confirm that he/she would still like to initiate/continue therapy.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# HIGH RISK MEDICATIONS - PHENOBARBITAL

---

## Products Affected

- *phenobarbital oral elixir*
- *phenobarbital oral tablet*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Coverage is not provided for use in sedation/insomnia.
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	Patients aged less than 65 years, approve. Patients aged 65 years and older, other criteria apply.
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	For the treatment of seizures, approve only if the patient is currently taking phenobarbital.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# HRM - ANTIDEMENTIA AGENTS

---

## Products Affected

- *ergoloid*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	The physician has documented the indication for the continued use of the HRM (high risk med) with an explanation of the specific benefit established with the medication and how that benefit outweighs the potential risk, AND the physician will continue to monitor for side effects, AND the physician has documented that the patient has tried and failed two (2) safer formulary alternatives or provided clinical rationale why two safer formulary alternatives are not appropriate for the patient.
<b>Age Restrictions</b>	Automatic approval if member is less than 65 years of age. Prior authorization required for age 65 or older.
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Safer alternatives are: donepezil, galantamine and rivastigmine.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# HRM - BUTALBITAL COMBINATIONS

---

## Products Affected

- *ascomp with codeine*
- *bupap oral tablet 50-300 mg*
- *butalbital compound w/codeine*
- *butalbital-acetaminop-caf-cod*
- *butalbital-acetaminophen oral tablet 50-300 mg, 50-325 mg*
- *butalbital-acetaminophen-caff oral capsule*
- *butalbital-acetaminophen-caff oral tablet 50-325-40 mg*
- *butalbital-aspirin-caffeine oral capsule*
- *codeine-butalbital-asa-caff*
- *tencon oral tablet 50-325 mg*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	The physician has documented the indication for the continued use of the HRM (high risk med) with an explanation of the specific benefit established with the medication and how that benefit outweighs the potential risk, AND the physician will continue to monitor for side effects, AND the physician has documented that the patient has tried and failed two (2) safer formulary alternatives or provided clinical rationale why two safer formulary alternatives are not appropriate for the patient.
<b>Age Restrictions</b>	Automatic approval if member is less than 65 years of age. Prior authorization required for age 65 or older.
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Safer alternatives are: naproxen sodium and ibuprofen.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# HRM - GLYBURIDE

---

## Products Affected

- *glyburide*
- *glyburide micronized*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	The physician has documented the indication for the continued use of the HRM (high risk med) with an explanation of the specific benefit established with the medication and how that benefit outweighs the potential risk, AND the physician will continue to monitor for side effects, AND the physician has documented that the patient has tried and failed glipizide or provided clinical rationale as to why that safer formulary alternative is not appropriate for the patient.
<b>Age Restrictions</b>	Automatic approval if member is less than 65 years of age. Prior authorization required for age 65 or older.
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	N/A
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# HRM - GLYBURIDE/METFORMIN

---

## Products Affected

- *glyburide-metformin*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	The physician has documented the indication for the continued use of the HRM (high risk med) with an explanation of the specific benefit established with the medication and how that benefit outweighs the potential risk, AND the physician will continue to monitor for side effects, AND the physician has documented that the patient has tried and failed glipizide-metformin or provided clinical rationale why that safer formulary alternative is not appropriate for the patient.
<b>Age Restrictions</b>	Automatic approval if member is less than 65 years of age. Prior authorization required for age 65 or older.
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	N/A
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# HRM - SKELETAL MUSCLE RELAXANTS

---

## Products Affected

- *carisoprodol-aspirin*
- *carisoprodol-aspirin-codeine*
- *chlorzoxazone oral tablet 500 mg*
- *cyclobenzaprine oral tablet 7.5 mg*
- *metaxalone*
- *methocarbamol oral*
- *orphenadrine citrate oral*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	The physician has documented the indication for the continued use of the HRM (high risk med) with an explanation of the specific benefit established with the medication and how that benefit outweighs the potential risk, AND the physician will continue to monitor for side effects. For patients concurrently taking multiple anticholinergic medications, the physician has assessed the risk.
<b>Age Restrictions</b>	Automatic approval if member is less than 65 years of age. Prior authorization required for age 65 or older.
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	N/A
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# HRM - TRIHEXYPHENIDYL

---

## Products Affected

- *trihexyphenidyl*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	The physician has documented the indication for the continued use of the HRM (high risk med) with an explanation of the specific benefit established with the medication and how that benefit outweighs the potential risk, AND the physician will continue to monitor for side effects. For patients concurrently taking multiple anticholinergic medications, the physician has assessed the risk.
<b>Age Restrictions</b>	Automatic approval if member is less than 65 years of age. Prior authorization required for age 65 or older.
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	N/A
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# HUMIRA

## Products Affected

- HUMIRA PEN KIT 80 MG/0.8 ML, 80 MG/0.8 ML-40 MG/0.4 ML
- HUMIRA PEN CROHNS-UC-HS START
- HUMIRA PEN PSOR-UVEITS-ADOL HS
- HUMIRA SUBCUTANEOUS SYRINGE KIT 10 MG/0.2 ML, 20 MG/0.4 ML, 40 MG/0.8 ML
- HUMIRA(CF) PEDI CROHNS STARTER SUBCUTANEOUS SYRINGE
- HUMIRA(CF) PEN CROHNS-UC-HS
- HUMIRA(CF) PEN PSOR-UV-ADOL HS
- HUMIRA(CF) PEN SUBCUTANEOUS INJECTOR KIT 40 MG/0.4 ML
- HUMIRA(CF) SUBCUTANEOUS SYRINGE KIT 10 MG/0.1 ML, 20 MG/0.2 ML, 40 MG/0.4 ML

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Concurrent use with biologic therapy or targeted synthetic DMARD
<b>Required Medical Information</b>	Diagnosis, concurrent medications, previous therapies tried
<b>Age Restrictions</b>	Crohn's disease (CD), 6 or older (initial therapy only). Ulcerative colitis (UC), 18 or older (initial therapy only)
<b>Prescriber Restrictions</b>	Initial therapy only all dx-RA/JIA/JRA/Ankylosing spondylitis, prescribed by or in consultation with rheumatologist. Psoriatic arthritis (PsA), prescribed by or in consultation with a rheumatologist or dermatologist. Plaque psoriasis (PP), prescribed by or in consultation with a dermatologist. UC/ CD, prescribed by or in consultation with a gastroenterologist. HS - dermatologist.UV-ophthalmologist
<b>Coverage Duration</b>	initial 3 mo, cont tx 3 years.
<b>Other Criteria</b>	RA/PsA initial, patient has tried one conventional synthetic DMARD for at least 3 months (note: patients who have already had a 3-month trial of a biologic for RA are not required to step back and try a conventional synthetic DMARD). JIA/JRA initial, patient has tried another agent (e.g MTX, sulfasalazine, leflunomide, NSAID, or biologic DMARD (eg, etanercept, abatacept, infliximab, anakinra, tocilizumab) or will be starting on Humira concurrently with MTX, sulfasalazine, or leflunomide. Approve without trying another agent if pt has absolute contraindication to MTX, sulfasalazine, or leflunomide or if pt has aggressive disease. PP initial,

<b>PA Criteria</b>	<b>Criteria Details</b>
	<p>approve if the patient meets one of the following criteria: 1) pt has tried at least one traditional systemic agent (eg, MTX, cyclosporine, acitretin, PUVA) for at least 3 months, unless intolerant (note: pts who have already tried a biologic for psoriasis are not required to step back and try a traditional agent first) OR 2) pt has a contraindication to MTX as determined by the prescribing physician. CD initial, approve if the patient meets ONE of the following criteria: 1) patient has tried or is currently taking corticosteroids, or corticosteroids are contraindicated, OR 2) patient has tried one other agent for CD. UC initial, approve if the patient has had a trial of one systemic agent for UC. Uveitis initial, tried one of the following: periocular, intraocular, or systemic corticosteroid, immunosuppressives or other biologic therapy. HS initial, tried ONE other therapy (e.g., intralesional or oral corticosteroids, systemic antibiotics, isotretinoin). Continuation-approve if the patient has had a response as determined by the prescriber. Clinical criteria incorporated into the Humira 40 mg quantity limit edit allow for approval of additional quantities to accommodate induction dosing. The allowable quantity is dependent upon the induction dosing regimen for the applicable FDA-labeled indications as outlined in product labeling.</p>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# IMMUNE SUPPRESSANTS - TRANSPLANT RELATED

## Products Affected

- ASTAGRAF XL
- ATGAM
- AZASAN
- *azathioprine*
- *azathioprine sodium*
- CELLCEPT
- *cyclosporine intravenous*
- *cyclosporine modified*
- *cyclosporine oral capsule*
- ENVARSUS XR
- *everolimus (immunosuppressive) oral tablet 0.25 mg, 0.5 mg, 0.75 mg*
- *engraf oral capsule 100 mg, 25 mg*
- *engraf oral solution*
- *mycophenolate mofetil*
- *mycophenolate mofetil (hcl)*
- *mycophenolate sodium*
- MYFORTIC
- NEORAL
- PROGRAF
- RAPAMUNE
- SANDIMMUNE ORAL SOLUTION
- *sirolimus*
- *tacrolimus oral*
- ZORTRESS ORAL TABLET 1 MG

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	B vs D coverage determination
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

# INCRELEX

---

## Products Affected

- INCRELEX

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis
<b>Age Restrictions</b>	Patients 2 years of age or older
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	N/A
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# INFLIXIMAB

## Products Affected

- RENFLEXIS

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Concurrent use with Biologic DMARD or Targeted Synthetic.
<b>Required Medical Information</b>	Diagnosis, concurrent medication, previous medications tried
<b>Age Restrictions</b>	CD and UC- Pts aged 6 years or more (initial therapy). PP-18 years and older (initial therapy)
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with: RA/Ankylosing spondylitis/Still's disease/JIA/JRA-rheumatologist (initial therapy); Plaque Psoriasis/Pyoderma gangrenosum/Hidradenitis suppurativa-dermatologist (initial therapy), Psoriatic Arthritis-rheumatologist or dermatologist (initial therapy), Crohn's Disease/UC-gastroenterologist (initial therapy), Uveitis ophthalmologist (initial therapy), GVHD-a physician affiliated with a transplant center, oncologist, or hematologist (initial therapy), Behcet's Disease- rheumatologist, dermatologist, ophthalmologist, gastroenterologist, or neurologist (initial therapy), Sarcoidosis-pulmonol, ophthalmol, or dermatol (initial therapy).
<b>Coverage Duration</b>	FDA ind initial - 3 mos, cont 1 year, GVHD initial-1 month, cont-3 months, Pyoderma Gangrenosum-initial 4 months, cont 1 year, all others-initial 3 months, cont-12 mo
<b>Other Criteria</b>	<ul style="list-style-type: none"> <li>•RA initial, patient has tried ONE conventional synthetic DMARD for at least 3 months (note: patients who have already had a 3-month trial of a biologic for RA are not required to step back and try a conventional synthetic DMARD).</li> <li>•CD approve if the pt has tried corticosteroid (CS) or if CSs contraindicated or if currently on CS or if the patient has tried one other conventional systemic therapy for CD OR the patient has enterocutaneous (perianal or abdominal) or rectovaginal fistulas OR the patient has had ileocolonic resection. Note-a previous trial of a biologic also counts as a trial of one other agent for Crohn's disease.</li> <li>•Ulcerative colitis (UC).Tried one systemic agent or was intolerant to one of these agents OR the patient has pouchitis AND has tried therapy with an</li> </ul>

PA Criteria	Criteria Details
	<p>antibiotic, probiotic, corticosteroid enema, or mesalamine enema. Note-a previous trial of a biologic also counts as a trial of one systemic agent for UC.</p> <ul style="list-style-type: none"> <li>•Behcet's. Pt has tried at least one conventional tx (eg, systemic CSs, immunosuppressants [e.g., AZA, MTX, MM, CSA, tacrolimus, chlorambucil, cyclophosphamide] or interferon alfa). NOTE: An exception to the requirement for a trial of one conventional therapy can be made if the patient has already had a trial of at least one tumor necrosis factor for Behcet's disease. These patients are not required to "step back" and try a conventional therapy) OR has ophthalmic manifestations.</li> <li>•SD.Tried CS AND 1 conventional synthetic DMARD (eg, MTX) for 2 mos, or was intolerant.</li> <li>•UV.Approve if the patient has tried one of the following therapies- periocular/intraocular CS, systemic CS or immunosuppressant (eg, MTX, MM, CSA, AZA, CPM)An exception can be made if the patient has already had a trial of an etanercept or adalimumab product.</li> <li>•Sarcoidosis.Tried CS and immunosuppressant (eg, MTX, AZA, CSA, chlorambucil), or chloroquine, or thalidomide).</li> <li>•Pyoderma gangrenosum (PG).Tried one systemic CS or immunosuppressant (eg, mycophenolate, CSA) for 2 mos or was intolerant to one of these agents.</li> <li>•Hidradenitis suppurativa (HS).Tried 1 one other therapy(eg, intralesional/oral CS, systemic antibiotic, isotretinoin).</li> <li>•GVHD.Tried 1 at least one conventional systemic treatment (eg, high-dose CS, antithymocyte globulin, CSA, thalidomide, tacrolimus, MM, etc.)</li> <li>•JIA/JRA (regardless of type of onset) Note-this includes patients with juvenile spondyloarthritis/active sacroiliac arthritis-approve if pt has tried 1 other medication for this condition (eg, MTX, sulfasalazine, or leflunomide, an NSAID, or one biologic DMARD or the pt has aggressive disease.</li> <li>•PP- approve if the patient has tried at least at least one traditional systemic agent for psoriasis for at least 3 months, unless intolerant or the patient has a contraindication to methotrexate (MTX), as determined by the prescriber. Note-A previous trial of a biologic also counts as a trial of a systemic agent.</li> <li>•cont tx - approve if patient has had a response, as determined by the prescriber.</li> </ul>
<b>Indications</b>	All FDA-approved Indications, Some Medically-accepted Indications.

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off-Label Uses</b>	Patients already started on infliximab for a covered use, Behcet's disease, Still's disease, Uveitis, Pyoderma gangrenosum, Hidradenitis suppurativa,, Graft-versus-host disease, Juvenile Idiopathic Arthritis (JIA)/JRA, Sarcoidosis

# INTRAROSA

---

## Products Affected

- INTRAROSA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	N/A
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# KALYDECO

---

## Products Affected

- KALYDECO ORAL GRANULES IN PACKET
- KALYDECO ORAL TABLET

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Combination use with Orkambi, Trikafta or Symdeko
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	6 months of age and older
<b>Prescriber Restrictions</b>	prescribed by or in consultation with a pulmonologist or a physician who specializes in CF
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	CF - must have one of the following mutations in the cystic fibrosis transmembrane conductance regulator (CFTR) gene: E56K, P67L, R74W, D110E, D110H, R117C, E193K, L206W, R347H, R352Q, A455E, D579G, S945L, S977F, F1052V, K1060T, A1067T, G1069R, R1070Q, R1070W, F1074L, D1152H, D1270N, G551D, G178R, S549N, S549R, G551S, G1244E, S1251N, S1255P, G1349D, 2789+5G A, 3272-26A G, 3849+10kbC T, 711+3A G, E831X OR R117H AND must NOT be Homozygous for the F508del Mutation in the CFTR Gene or have unknown CFTR gene mutations.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# KINERET

---

## Products Affected

- KINERET

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Concurrent use with another biologic DMARD or targeted synthetic DMARD
<b>Required Medical Information</b>	Diagnosis, concurrent medications, previous drugs tried.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	RA and Still's disease, prescribed by or in consultation with a rheumatologist. CAPS (Neonatal-Onset Multisystem Inflammatory Disease or Chronic Infantile Neurological Cutaneous and Articular [CINCA] syndrome), prescribed by or in consultation with a pediatrician, rheumatologist, geneticist, or dermatologist.
<b>Coverage Duration</b>	RA/CAPS initial 3 mos, cont 3 years. Stills 12 mos
<b>Other Criteria</b>	RA, approve if the patient has tried one of the following: Enbrel, Humira, Rinvoq. Still's Disease, approve if patient has tried a corticosteroid and has had an inadequate response to 1 conventional synthetic DMARD (eg, methotrexate) for at least 2 months or was intolerant to this therapy. Continuation-approve if the patient has had a response as determined by the prescriber.
<b>Indications</b>	All FDA-approved Indications, Some Medically-accepted Indications.
<b>Off-Label Uses</b>	Still's disease (SD). Juvenile Rheumatoid Arthritis.

# KISQALI

---

## Products Affected

- KISQALI FEMARA CO-PACK ORAL TABLET 200 MG/DAY(200 MG X 1)-2.5 MG, 400 MG/DAY(200 MG X 2)-2.5 MG, 600 MG/DAY(200 MG X 3)-2.5 MG
- KISQALI ORAL TABLET 200 MG/DAY (200 MG X 1), 400 MG/DAY (200 MG X 2), 600 MG/DAY (200 MG X 3)

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	For use with an aromatase inhibitor in postmenopausal women or men as initial endocrine-based therapy, approve if the patient has tried Ibrance. For use with fulvestrant in patients with disease progression following endocrine therapy, approve if the patient has tried Ibrance.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# KORLYM

---

## Products Affected

- KORLYM

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis, prior surgeries
<b>Age Restrictions</b>	18 years and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an endocrinologist or a physician who specializes in the treatment of Cushing's syndrome
<b>Coverage Duration</b>	Endogenous Cushing's Syndrome-1 year. Pt awaiting surgery or response after radiotherapy-4 months
<b>Other Criteria</b>	Endogenous Cushing's Syndrome-Approve if, according to the prescribing physician, the patient is not a candidate for surgery or surgery has not been curative AND if Korlym is being used to control hyperglycemia secondary to hypercortisolism in patients who have type 2 diabetes mellitus or glucose intolerance.
<b>Indications</b>	All FDA-approved Indications, Some Medically-accepted Indications.
<b>Off-Label Uses</b>	Patients with Endogenous Cushing's Syndrome, awaiting surgery, Patients with Endogenous Cushing's syndrome, awaiting a response after radiotherapy

# KUVAN

---

## Products Affected

- KUVAN

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Concurrent use with Palynziq
<b>Required Medical Information</b>	Diagnosis, Phe concentration
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a specialist who focuses in the treatment of metabolic diseases (initial therapy)
<b>Coverage Duration</b>	Initial-12 weeks, Continuation-1 year
<b>Other Criteria</b>	Initial - approve. Continuation - approve if the patient has had a clinical response (e.g., cognitive and/or behavioral improvements) as determined by the prescribing physician OR patient had a 20% or greater reduction in blood Phe concentration from baseline.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# LETAIRIS

---

## Products Affected

- *ambrisentan*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Pulmonary arterial hypertension (PAH) WHO Group 1-results of right heart cath
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	For treatment of pulmonary arterial hypertension, ambrisentan must be prescribed by or in consultation with a cardiologist or a pulmonologist.
<b>Coverage Duration</b>	Authorization will be for 1 year.
<b>Other Criteria</b>	Pulmonary arterial hypertension (PAH) WHO Group 1, are required to have had a right-heart catheterization to confirm diagnosis of PAH to ensure appropriate medical assessment.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# LUMIZYME

---

## Products Affected

- LUMIZYME

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis, genetic and lab test results
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a geneticist, neurologist, a metabolic disorder sub-specialist, or a physician who specializes in the treatment of lysosomal storage disorders
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	Approve if the patient has a laboratory test demonstrating deficient acid alpha-glucosidase activity in blood, fibroblasts, or muscle tissue OR patient has a molecular genetic test demonstrating acid alpha-glucosidase gene mutation
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# MAVYRET

---

## Products Affected

- MAVYRET

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Genotype, prescriber specialty, other medications tried or used in combination with requested medication
<b>Age Restrictions</b>	12 years or older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a gastroenterologist, hepatologist, infectious diseases physician, or a liver transplant physician
<b>Coverage Duration</b>	Criteria will be applied consistent with current AASLD/IDSA guidance.
<b>Other Criteria</b>	Criteria will be applied consistent with current AASLD/IDSA guidance.
<b>Indications</b>	All FDA-approved Indications, Some Medically-accepted Indications.
<b>Off-Label Uses</b>	Indications consistent with current AASLD/IDSA guidance

# MEGACE

---

## Products Affected

- *megestrol oral suspension 400 mg/10 ml (10 ml), 400 mg/10 ml (40 mg/ml), 625 mg/5 ml (125 mg/ml)*
- *megestrol oral tablet*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Coverage is not provided for weight gain for cosmetic reasons.
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	N/A
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# METHAMPHETAMINE HCL

---

## Products Affected

- *methamphetamine*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Patient must have failure, contraindication or intolerance to one formulary alternative such as dextroamphetamine, amphetamine/dextroamphetamine, methylphenidate or dexmethylphenidate before methamphetamine hcl is authorized.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# MOLECULAR TARGET INHIBITORS

---

## Products Affected

- *abiraterone*
- AFINITOR DISPERZ ORAL TABLET FOR SUSPENSION 2 MG, 3 MG, 5 MG
- AFINITOR ORAL TABLET 10 MG, 2.5 MG, 5 MG, 7.5 MG
- ALECENSA
- ALUNBRIG ORAL TABLET 180 MG, 30 MG, 90 MG
- ALUNBRIG ORAL TABLETS, DOSE PACK
- AYVAKIT
- BALVERSA
- BOSULIF
- BRAFTOVI ORAL CAPSULE 75 MG
- BRUKINSA
- CABOMETYX ORAL TABLET 20 MG, 40 MG, 60 MG
- CALQUENCE
- CAPRELSA ORAL TABLET 100 MG, 300 MG
- COMETRIQ ORAL CAPSULE 100 MG/DAY(80 MG X1-20 MG X1), 140 MG/DAY(80 MG X1-20 MG X3), 60 MG/DAY (20 MG X 3/DAY)
- COPIKTRA
- COTELLIC
- DAURISMO ORAL TABLET 100 MG, 25 MG
- *erlotinib oral tablet 100 mg, 150 mg, 25 mg*
- *everolimus (antineoplastic)*
- FARYDAK
- GILOTRIF
- IBRANCE
- ICLUSIG ORAL TABLET 15 MG, 45 MG
- IDHIFA
- *imatinib oral tablet 100 mg, 400 mg*
- IMBRUVICA ORAL CAPSULE 140 MG, 70 MG
- IMBRUVICA ORAL TABLET
- INLYTA ORAL TABLET 1 MG, 5 MG
- INREBIC
- IRESSA
- JAKAFI
- LENVIMA ORAL CAPSULE 10 MG/DAY (10 MG X 1), 12 MG/DAY (4 MG X 3), 14 MG/DAY(10 MG X 1-4 MG X 1), 18 MG/DAY (10 MG X 1-4 MG X2), 20 MG/DAY (10 MG X 2), 24 MG/DAY(10 MG X 2-4 MG X 1), 4 MG, 8 MG/DAY (4 MG X 2)
- LONSURF ORAL TABLET 15-6.14 MG, 20-8.19 MG
- LORBRENA ORAL TABLET 100 MG, 25 MG
- LYNPARZA ORAL TABLET
- MEKINIST ORAL TABLET 0.5 MG, 2 MG
- MEKTOVI
- NERLYNX
- NEXAVAR
- NINLARO
- PEMAZYRE
- PIQRAY
- POMALYST
- QINLOCK
- RETEVMO
- RUBRACA
- RYDAPT
- SPRYCEL ORAL TABLET 100 MG, 140 MG, 20 MG, 50 MG, 70 MG, 80 MG
- STIVARGA
- SUTENT
- SYNRIPO
- TABRECTA
- TAFINLAR
- TAGRISSO
- TALZENNA ORAL CAPSULE 0.25 MG, 1 MG
- TASIGNA ORAL CAPSULE 150 MG, 200 MG, 50 MG
- TAZVERIK
- TIBSOVO

- TUKYSA ORAL TABLET 150 MG, 50 MG
- TYKERB
- VENCLEXTA ORAL TABLET 10 MG, 100 MG, 50 MG
- VENCLEXTA STARTING PACK
- VIZIMPRO
- VOTRIENT
- XALKORI
- XOSPATA
- XPOVIO ORAL TABLET 100 MG/WEEK (20 MG X 5), 60 MG/WEEK (20 MG X 3), 80 MG/WEEK (20 MG X 4), 80MG TWICE WEEK (160 MG/WEEK)
- XTANDI
- ZEJULA
- ZELBORAF
- ZYDELIG
- ZYKADIA ORAL TABLET

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	N/A
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# NAGLAZYME

---

## Products Affected

- NAGLAZYME

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis, genetic and lab test results
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a geneticist, endocrinologist, a metabolic disorder sub-specialist, or a physician who specializes in the treatment of lysosomal storage disorders
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	Approve if the patient has a laboratory test demonstrating deficient N-acetylgalactosamine 4-sulfatase (arylsulfatase B) activity in leukocytes or fibroblasts OR has a molecular genetic test demonstrating arylsulfatase B gene mutation.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# NATPARA

---

## Products Affected

- NATPARA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an endocrinologist.
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	Chronic hypoparathyroidism, initial therapy - approve if before starting Natpara, serum calcium concentration is greater than 7.5 mg/dL and 25-hydroxyvitamin D stores are sufficient per the prescribing physician. Chronic hypoparathyroidism, continuing therapy - approve if during Natpara therapy, the patient's 25-hydroxyvitamin D stores are sufficient per the prescribing physician, AND patient is responding to Natpara therapy, as determined by the prescriber.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# NAYZILAM

---

## Products Affected

- NAYZILAM

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis, other medications used at the same time
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a neurologist
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	Intermittent Episodes of Frequent Seizure Activity (i.e., seizure clusters, acute repetitive seizures)-approve if the patient is currently receiving maintenance antiepileptic medication(s).
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# NMDA RECEPTOR ANTAGONIST

---

## Products Affected

- *memantine oral capsule, sprinkle, er 24hr*
- *memantine oral solution*
- *memantine oral tablet 10 mg, 5 mg*
- *memantine oral tablets, dose pack*
- NAMENDA ORAL TABLET 10 MG, 5 MG
- NAMENDA TITRATION PAK
- NAMENDA XR ORAL CAP, SPRINKLE, ER 24HR DOSE PACK
- NAMENDA XR ORAL CAPSULE, SPRINKLE, ER 24HR
- NAMZARIC

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	Automatic approval if member is greater than 26 years of age. Prior Authorization is required for age 26 or younger.
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	N/A
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# NORTHERA

---

## Products Affected

- NORTHERA ORAL CAPSULE 100 MG, 200 MG, 300 MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Medication history
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a cardiologist or a neurologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	NOH, approve if the patient meets ALL of the following criteria: a) Patient has been diagnosed with symptomatic NOH due to primary autonomic failure (Parkinson's disease, multiple system atrophy, pure autonomic failure), dopamine beta-hydroxylase deficiency, or non-diabetic autonomic neuropathy, AND b) Patient has tried midodrine.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# NUBEQA

---

## Products Affected

- NUBEQA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	3 years
<b>Other Criteria</b>	Prostate cancer - non-metastatic, castration resistant-approve if the requested medication will be used concurrently with a gonadotropin-releasing hormone (GnRH) agonist or if the patient has had a bilateral orchiectomy.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# NUEDEXTA

---

## Products Affected

- NUEDEXTA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	N/A
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# NULOJIX

---

## Products Affected

- NULOJIX

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Documentation of Epstein-Barr virus serology and current medication regimen.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Documentation of use in combination with basiliximab induction, mycophenolate mofetil, and corticosteroids. B vs D coverage determination.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# NUPLAZID

---

## Products Affected

- NUPLAZID ORAL CAPSULE
- NUPLAZID ORAL TABLET 10 MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a neurologist
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	N/A
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# NUVIGIL/PROVIGIL

## Products Affected

- *armodafinil*
- *modafinil oral tablet 100 mg, 200 mg*
- PROVIGIL ORAL TABLET 100 MG, 200 MG

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	18 years and older
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Authorization will be for 12 months.
<b>Other Criteria</b>	Excessive sleepiness associated with Shift Work Sleep Disorder (SWSD) - approve if the patient is working at least 5 overnight shifts per month. Adjunctive/augmentation treatment for depression in adults (modafinil only) if the patient is concurrently receiving other medication therapy for depression. Excessive daytime sleepiness associated with obstructive sleep apnea/hypoapnea syndrome-approve. Excessive daytime sleepiness associated with Narcolepsy-approve if narcolepsy has been confirmed with polysomnography and a multiple sleep latency test (MSLT).
<b>Indications</b>	All FDA-approved Indications, Some Medically-accepted Indications.
<b>Off-Label Uses</b>	Excessive daytime sleepiness (EDS) associated with myotonic dystrophy - modafinil only. Adjunctive/augmentation for treatment of depression in adults - modafinil only.

# OCALIVA

## Products Affected

- OCALIVA

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Prescriber specialty, lab values, prior medications used for diagnosis and length of trials
<b>Age Restrictions</b>	18 years and older (initial therapy)
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a gastroenterologist, hepatologist, or liver transplant physician (initial therapy)
<b>Coverage Duration</b>	6 months initial, 1 year continuation
<b>Other Criteria</b>	Initial treatment of PBC-Patient must meet both 1 and 2-1. Patient has a diagnosis of PBC as defined by TWO of the following:a)Alkaline phosphatase (ALP) elevated above the upper limit of normal as defined by normal laboratory reference values b)Positive anti-mitochondrial antibodies (AMAs) or other PBC-specific auto-antibodies, including sp100 or gp210, if AMA is negative c)Histologic evidence of primary biliary cholangitis (PBC) from a liver biopsy 2. Patient meets ONE of the following: a) Patient has been receiving ursodiol therapy for greater than or equal to 1 year and has had an inadequate response. b) Patient is unable to tolerate ursodiol therapy. Cont tx - approve if the patient has responded to Ocaliva therapy as determined by the prescribing physician (e.g., improved biochemical markers of PBC (e.g., alkaline phosphatase [ALP], bilirubin, gamma-glutamyl transpeptidase [GGT], aspartate aminotransferase [AST], alanine aminotransferase [ALT] levels)).
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# OCREVUS

---

## Products Affected

- OCREVUS

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Concurrent use with other Disease-Modifying Agents used for MS
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by, or in consultation with, a physician who specializes in the treatment of MS and/or a neurologist
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	N/A
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# OCTREOTIDE

---

## Products Affected

- *octreotide acetate*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	N/A
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# ODOMZO

---

## Products Affected

- ODOMZO

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	BCC - Must not have had disease progression while on Erivedge (vismodegib).
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	3 years
<b>Other Criteria</b>	Locally advanced BCC approve if the BCC has recurred following surgery/radiation therapy or if the patient is not a candidate for surgery AND the patient is not a candidate for radiation therapy, according to the prescribing physician. Metastatic BCC - approve.
<b>Indications</b>	All FDA-approved Indications, Some Medically-accepted Indications.
<b>Off-Label Uses</b>	Metastatic BCC

# OFEV

## Products Affected

- OFEV

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Combination use with pirfenidone
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	IPF-Prescribed by or in consultation with a pulmonologist. Interstitial lung disease associated with systemic sclerosis-prescribed by or in consultation with a pulmonologist or rheumatologist.
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	IPF - must have FVC greater than or equal to 40 percent of the predicted value AND IPF must be diagnosed with either findings on high-resolution computed tomography (HRCT) indicating usual interstitial pneumonia (UIP) or surgical lung biopsy demonstrating UIP. Interstitial lung disease associated with systemic sclerosis-approve if the FVC is greater than or equal to 40 percent of the predicted value and the diagnosis is confirmed by high-resolution computed tomography. Chronic fibrosing interstitial lung disease-approve if the forced vital capacity is greater than or equal to 45% of the predicted value AND according to the prescriber the patient has fibrosing lung disease impacting more than 10% of lung volume on high-resolution computed tomography AND according to the prescriber the patient has clinical signs of progression.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# OPSUMIT

---

## Products Affected

- OPSUMIT

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	PAH WHO group, right heart catheterization
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	PAH - must be prescribed by or in consultation with a cardiologist or a pulmonologist.
<b>Coverage Duration</b>	Authorization will be for 3 years.
<b>Other Criteria</b>	Pulmonary arterial hypertension (PAH) WHO Group 1 patients are required to have had a right-heart catheterization to confirm the diagnosis of PAH to ensure appropriate medical assessment.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# ORENCIA

---

## Products Affected

- ORENCIA CLICKJECT
- ORENCIA SUBCUTANEOUS SYRINGE 125 MG/ML, 50 MG/0.4 ML, 87.5 MG/0.7 ML

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Concurrent use with a Biologic DMARD or Targeted Synthetic DMARD.
<b>Required Medical Information</b>	Diagnosis, concurrent medications, previous therapies tried.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Initial therapy only-RA and JIA/JRA prescribed by or in consultation with a rheumatologist. PsA-prescribed by or in consultation with a rheumatologist or dermatologist.
<b>Coverage Duration</b>	3 months initial, 3 years cont.
<b>Other Criteria</b>	RA, approve if the patient has tried one of the following: Enbrel, Humira, Rinvoq, Xeljanz. PsA, approve if the patient has tried one of the following: Enbrel, Humira, Stelara, Xeljanz. JIA/JRA, approve if the patient has tried one of the following: Enbrel, Humira. Continuation-approve if the patient has had a response as determined by the prescriber.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# ORKAMBI

---

## Products Affected

- ORKAMBI ORAL GRANULES IN PACKET
- ORKAMBI ORAL TABLET

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Combination use with Kalydeco, Trikafta or Symdeko.
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	2 years of age and older
<b>Prescriber Restrictions</b>	prescribed by or in consultation with a pulmonologist or a physician who specializes in CF
<b>Coverage Duration</b>	3 years
<b>Other Criteria</b>	CF - homozygous for the Phe508del (F508del) mutation in the CFTR gene (meaning the patient has two copies of the Phe508del mutation)
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# OSPHEANA

---

## Products Affected

- OSPHENA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	N/A
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# PHENYLBUTYRATE

---

## Products Affected

- *sodium phenylbutyrate*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Concomitant use of Ravicti and Buphenyl
<b>Required Medical Information</b>	Diagnosis, genetic tests and lab results
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a metabolic disease specialist (or specialist who focuses in the treatment of metabolic diseases)
<b>Coverage Duration</b>	Pt meets criteria with no genetic test - 3 mo approval. Pt had genetic test - 12 mo approval
<b>Other Criteria</b>	Urea cycle disorders-approve if genetic testing confirmed a mutation resulting in a urea cycle disorder or if the patient has hyperammonemia.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# PHEOCHROMOCYTOMA

---

## Products Affected

- DEMSER

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis, prior medication trials
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an endocrinologist or a physician who specializes in the management of pheochromocytoma (initial therapy for phenoxybenzamine, initial and continuation therapy for Demser)
<b>Coverage Duration</b>	Authorization will be for 1 year
<b>Other Criteria</b>	If the requested drug is Demser for initial therapy, approve if the patient has tried a selective alpha blocker (e.g., doxazosin, terazosin or prazosin) AND the patient has tried phenoxybenzamine (brand or generic). If the requested drug is Demser for continuation therapy, approve if the patient is currently receiving Demser or has received Demser in the past.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# PHOSPHODIESTERASE-5 INHIBITORS FOR PAH

---

## Products Affected

- *alyq*
- *sildenafil (pulmonary arterial hypertension) oral tablet*
- *tadalafil (pulmonary arterial hypertension) oral tablet 20 mg*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis, right heart cath results
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	For PAH, if prescribed by, or in consultation with, a cardiologist or a pulmonologist.
<b>Coverage Duration</b>	Authorization will be for 1 year.
<b>Other Criteria</b>	Pulmonary arterial hypertension (PAH) WHO Group 1, are required to have had a right-heart catheterization to confirm diagnosis of PAH to ensure appropriate medical assessment. Clinical criteria incorporated into the quantity limit edits for sildenafil 20 mg tablets and suspension require confirmation that the indication is PAH (ie, FDA labeled use) prior to reviewing for quantity exception.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# PROLASTIN-C

---

## Products Affected

- PROLASTIN-C

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis, pretreatment AAT serum concentration
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	Alpha1-Antitrypsin (AAT) Deficiency with Emphysema (or COPD) - approve in patients with baseline (pretreatment) AAT serum concentration of less than 80 mg/dL (11 micromol/L).
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# PROMACTA

## Products Affected

- PROMACTA ORAL POWDER IN PACKET 12.5 MG, 25 MG
- PROMACTA ORAL TABLET 12.5 MG, 25 MG, 50 MG, 75 MG

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Cause of thrombocytopenia. Thrombocytopenia due to HCV-related cirrhosis, platelet counts. Severe aplastic anemia, platelet counts and prior therapy. MDS-platelet counts.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Thrombocytopenia due to chronic ITP or Aplastic Anemia, approve if prescribed by, or after consultation with, a hematologist (initial therapy). Thrombocytopenia in pt with chronic Hep C, approve if prescribed by, or after consultation with, a gastroenterologist, hematologist, hepatologist, or a physician who specializes in infectious disease (initial therapy). MDS-presc or after consult with heme/onc (initial therapy).
<b>Coverage Duration</b>	Chronic ITP/MDS initial-3 mo, cont 1yr, AA-initial-4 mo, cont-1 yr, Thrombo/Hep C-1 yr
<b>Other Criteria</b>	Thrombocytopenia in patients with chronic immune (idiopathic) thrombocytopenia purpura, initial-approve if the patient has a platelet count less than 30, 000 microliters or less than 50, 000 microliters and the patient is at an increased risk for bleeding AND the patient has tried ONE other therapy or has undergone a splenectomy. Cont-approve if the patient demonstrates a beneficial clinical response and remains at risk for bleeding complications. Treatment of thrombocytopenia in patients with Chronic Hepatitis C initial-approve if the patient will be receiving interferon-based therapy for chronic hepatitis C AND to allow for initiation of antiviral therapy if the patient has low platelet counts at baseline (eg, less than 75,000 microliters). Aplastic anemia initial - approve if the patient has low platelet counts at baseline/pretreatment (e.g., less than 30,000 microliters) AND tried one immunosuppressant therapy (e.g., cyclosporine, mycophenolate mofetil, sirolimus) OR patient will be using Promacta in combination with standard immunosuppressive therapy. Cont-approve if the patient demonstrates a beneficial clinical response. MDS initial-approve if patient has low- to intermediate-risk MDS AND the patient has a platelet count less than 30, 000 microliters or less than 50, 000 microliters

<b>PA Criteria</b>	<b>Criteria Details</b>
	and is at an increased risk for bleeding. Cont-approve if the patient demonstrates a beneficial clinical response and remains at risk for bleeding complications.
<b>Indications</b>	All FDA-approved Indications, Some Medically-accepted Indications.
<b>Off-Label Uses</b>	Thrombocytopenia in Myelodysplastic Syndrome (MDS)

# PYRIMETHAMINE

---

## Products Affected

- *pyrimethamine*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Patient's immune status
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Toxoplasma gondii Encephalitis, Chronic Maintenance and Prophylaxis (Primary)-prescribed by or in consultation with an infectious diseases specialist. Toxoplasmosis Treatment-prescribed by or in consultation with an infectious diseases specialist, a maternal-fetal medicine specialist, or an ophthalmologist.
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Toxoplasma gondii Encephalitis, Chronic Maintenance, approve if the patient is immunosuppressed. Toxoplasma gondii Encephalitis Prophylaxis (Primary), approve if the patient is immunosuppressed.
<b>Indications</b>	All FDA-approved Indications, Some Medically-accepted Indications.
<b>Off-Label Uses</b>	Chronic maintenance and prophylaxis of Toxoplasma Gondii encephalitis

# REBIF

---

## Products Affected

- REBIF (WITH ALBUMIN) MCG/0.5 ML, 8.8MCG/0.2ML-22
- REBIF REBIDOSE SUBCUTANEOUS MCG/0.5ML (6)
- PEN INJECTOR 22 MCG/0.5 ML, 44
- REBIF TITRATION PACK

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Concurrent use with other disease-modifying agent used for multiple sclerosis
<b>Required Medical Information</b>	Relapsing form of Multiple Sclerosis (MS) diagnosis
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or after consultation with a neurologist or an MS specialist.
<b>Coverage Duration</b>	Authorization will be for 1 year.
<b>Other Criteria</b>	For patients requesting Rebif, approve if the patient has tried two of the following: Avonex, Betaseron, Copaxone, Gilenya and Tecfidera.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# RELISTOR INJECTION

---

## Products Affected

- RELISTOR SUBCUTANEOUS SOLUTION
- RELISTOR SUBCUTANEOUS SYRINGE

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis
<b>Age Restrictions</b>	Patients 18 years of age or older
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	N/A
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# REPATHA

## Products Affected

- REPATHA
- REPATHA SURECLICK
- REPATHA PUSHTRONEX

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Concurrent use of Juxtapid or Praluent.
<b>Required Medical Information</b>	LDL-C and response to other agents, prior therapies tried, medication adverse event history, medical history
<b>Age Restrictions</b>	ASCVD/HeFH/Primary Hyperlipidemia - 18 yo and older, HoFH 13 yo and older.
<b>Prescriber Restrictions</b>	Prescribed by, or in consultation with, a cardiologist, endocrinologist, or a physician who focuses in the treatment of CV risk management and/or lipid disorders
<b>Coverage Duration</b>	Approve for 3 years for ASCVD/HeFH/HoFH. Approve for 1 year for primary hyperlipidemia.
<b>Other Criteria</b>	Hyperlipidemia with HeFH - approve if: 1) diagnosis of HeFH AND 2) tried ONE high intensity statin (i.e. atorvastatin greater than or equal to 40 mg daily or Crestor greater than or equal to 20 mg daily) and LDL remains 70 mg/dL or higher unless pt is statin intolerant defined by experiencing statin related rhabdomyolysis or skeletal-related muscle symptoms while receiving separate trials of atorvastatin and Crestor and during both trials the symptoms resolved upon discontinuation. Hyperlipidemia with ASCVD -approve if: 1) has one of the following conditions: prior MI, h/o ACS, diagnosis of angina, h/o CVA or TIA, PAD, undergone a coronary or other arterial revascularization procedure, AND 2) tried ONE high intensity statin (defined above) and LDL remains 70 mg/dL or higher unless pt is statin intolerant (defined above). HoFH - approve if: 1) has one of the following: a) genetic confirmation of two mutant alleles at the LDLR, APOB, PCSK9, or LDLRAP1 gene locus, OR b) untreated LDL greater than 500 mg/dL (prior to treatment), OR c) treated LDL greater than or equal to 300 mg/dL (after treatment but prior to agents such as Repatha, Kynamro or Juxtapid), OR d) has clinical manifestations of HoFH (e.g., cutaneous xanthomas, tendon xanthomas, arcus cornea, tuberous xanthomas or xanthelasma), AND 2) tried ONE high intensity statin (defined above) for 8 weeks or longer and LDL remains 70 mg/dL or

<b>PA Criteria</b>	<b>Criteria Details</b>
	higher unless statin intolerant (defined above). Primary hyperlipidemia (not associated with ASCVD, HeFH, or HoFH)-approve if the patient has tried one high-intensity statin therapy (defined above) and ezetimibe for 8 weeks or longer and LDL remains 100 mg/dL or higher unless statin intolerant (defined above).
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# REVLIMID

## Products Affected

- REVLIMID

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis and previous therapies or drug regimens tried.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Authorization will be for 3 years.
<b>Other Criteria</b>	Follicular lymphoma-approve if the patient is using Revlimid in combination with rituximab or has tried at least on prior therapy. MCL-approve. MZL-approve. Multiple myeloma-approve. MDS-approve if the patient meets one of the following: 1) Pt has symptomatic anemia, OR 2) Pt has transfusion-dependent anemia, OR 3) Pt has anemia that is not controlled with an erythroid stimulating agent (eg, Procrit [epoetin alfa injection], Aranesp [darbepoetin alfa injection]). Diffuse, Large B Cell Lymphoma (Non-Hodgkin's Lymphoma)-approve if the pt has tried at least one prior therapy. Myelofibrosis-approve if according to the prescriber the patient has anemia and the pt has serum erythropoietin levels greater than or equal to 500 mU/mL. Peripheral T-Cell Lymphoma or T-Cell Leukemia/Lymphoma-approve if the pt has tried at least one other therapy or regimen. CNS cancers (primary)-approve if according to the prescriber the patient has relapsed or refractory disease. Hodgkin lymphoma, classical-approve if the patient has relapsed or refractory disease. Castleman's disease-approve if the patient has relapsed/refractory or progressive disease. AIDS Related Kaposi's Sarcoma-approve if the patient has tried at least one regimen or therapy and the patient has relapsed or refractory disease.
<b>Indications</b>	All FDA-approved Indications, Some Medically-accepted Indications.
<b>Off-Label Uses</b>	Systemic Amyloidosis Light Chain, Diffuse Large B Cell Lymphoma

<b>PA Criteria</b>	<b>Criteria Details</b>
	(Non-Hodgkin's Lymphoma), Myelofibrosis, Castleman's Disease, Hodgkin lymphoma (Classical), Peripheral T-Cell Lymphoma, T-Cell Leukemia/Lymphoma, Central nervous system cancer (primary), Acquired immune deficiency syndrome (AIDS)-related Kaposi's sarcoma.

# RINVOQ

---

## Products Affected

- RINVOQ

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Concurrent use with biologic therapy or targeted synthetic DMARD
<b>Required Medical Information</b>	Diagnosis, concurrent medications, previous drugs tried.
<b>Age Restrictions</b>	18 years and older
<b>Prescriber Restrictions</b>	RA, prescribed by or in consultation with a rheumatologist.
<b>Coverage Duration</b>	Authorization will be for 3 months initial, 3 years cont.
<b>Other Criteria</b>	RA initial, patient has tried one conventional synthetic DMARD for at least 3 months (note: patients who have already had a 3-month trial of a biologic for RA are not required to step back and try a conventional synthetic DMARD).
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# ROZLYTREK

---

## Products Affected

- ROZLYTREK ORAL CAPSULE 100 MG, 200 MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis
<b>Age Restrictions</b>	Solid Tumors-12 years and older
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	3 years
<b>Other Criteria</b>	Solid Tumors-Approve if the patient meets the following criteria (A, B, and C): A) The patient has locally advanced or metastatic solid tumor AND B) The patient's tumor has neurotrophic receptor tyrosine kinase (NTRK) gene fusion AND C) The patient meets one of the following criteria (i or ii): i. The patient has progressed on prior therapies OR ii. There are no acceptable standard therapies and the medication is used as initial therapy. Non-Small Cell Lung Cancer-Approve if the patient has ROS1-positive metastatic disease.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# SAMSCA

---

## Products Affected

- SAMSCA ORAL TABLET 15 MG, 30 MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Concurrent use with Jynarque.
<b>Required Medical Information</b>	Serum sodium less than 125 mEq/L at baseline or less marked hyponatremia, defined as serum sodium less than 135 mEq/L at baseline, that is symptomatic (eg, nausea, vomiting, headache, lethargy, confusion).
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Authorization will be for 30 days
<b>Other Criteria</b>	Hyponatremia - Pt must meet ONE of the following: 1. serum sodium less than 125 mEq/L at baseline, OR 2. marked hyponatremia, defined as less than 135 mEq/L at baseline, that is symptomatic (eg, nausea, vomiting, headache, lethargy, confusion), OR 3. patient has already been started on Samsca and has received less than 30 days of therapy.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# SANDOSTATIN

## Products Affected

- SANDOSTATIN LAR DEPOT INTRAMUSCULAR SUSPENSION, EXTENDED REL RECON

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis, previous treatments/therapies
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Acromegaly-prescribed by or in consultation with an endocrinologist. All neuroendocrine tumors-prescribed by or in consultation with an oncologist, endocrinologist, or gastroenterologist. Pheochromocytoma/paraganglioma-prescribed by or in consultation with an endo/onc/neuro. Meningioma-prescribed by or in consultation with an oncologist, radiologist or neurosurgeon. Thymoma/Thymic carcinoma-prescribed by or in consultation with an oncologist
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	Acromegaly-approve if the patient has (or had) a pre-treatment (baseline) insulin-like growth factor-1 (IGF-1) level above the upper limit of normal based on age and gender for the reporting laboratory AND the patient meets i., ii., or iii: i. has had an inadequate response to surgery and/or radiotherapy or ii. is not an appropriate candidate for surgery and/or radiotherapy or iii. the patient is experiencing negative effects due to tumor size (e.g., optic nerve compression). Neuroendocrine Tumor(s) [NETs] of the Gastrointestinal Tract, Lung, Thymus (Carcinoid Tumors), and Pancreas (including glucagonomas, gastrinomas, vasoactive intestinal peptides-secreting tumors [VIPomas], insulinomas)-approve.
<b>Indications</b>	All FDA-approved Indications, Some Medically-accepted Indications.
<b>Off-Label Uses</b>	Pheochromocytoma/paraganglioma, Meningioma, Thyoma and thymic carcinoma

# SIGNIFOR

---

## Products Affected

- SIGNIFOR

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	18 years and older (initial therapy)
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an endocrinologist or a physician or specializes in the treatment of Cushing's syndrome (initial therapy)
<b>Coverage Duration</b>	Cushing's-Initial-4 mo, Cont therapy - 1 yr. Pt awaiting surgery/response after radiotherapy-4 mo
<b>Other Criteria</b>	Cushing's disease, initial therapy - approve if, according to the prescribing physician, the patient is not a candidate for surgery, or surgery has not been curative. Cushing's disease, continuation therapy - approve if the patient has already been started on Signifor/Signifor LAR and, according to the prescribing physician, the patient has had a response and continuation of therapy is needed to maintain response.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# SIMPONI

## Products Affected

- SIMPONI SUBCUTANEOUS PEN INJECTOR 100 MG/ML, 50 MG/0.5 ML
- SIMPONI SUBCUTANEOUS SYRINGE 100 MG/ML, 50 MG/0.5 ML

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Concurrent use with biologic therapy or targeted synthetic DMARD
<b>Required Medical Information</b>	Diagnosis, concurrent medications, previous therapies tried.
<b>Age Restrictions</b>	UC-18 years and older (initial therapy)
<b>Prescriber Restrictions</b>	All dx-initial only-RA/Ankylosing spondylitis, prescribed by or in consultation with a rheumatologist. Psoriatic arthritis, prescribed by or in consultation with a rheumatologist or dermatologist. UC-prescribed by or in consultation with a gastroenterologist
<b>Coverage Duration</b>	3 months initial, 3 years cont.
<b>Other Criteria</b>	AS, approve if the patient has tried one of the following: Enbrel or Humira. RA, approve if the patient has tried two of the following: Enbrel, Humira, Rinvoq. PsA, approve if the patient has tried two of the following: Enbrel, Humira, Stelara. UC, approve if the patient has tried two of the following: Humira, Stelara. Continuation-approve if the patient has had a response as determined by the prescriber.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# SIRTURO

---

## Products Affected

- SIRTURO ORAL TABLET 100 MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Patients weighing less than 30 kg
<b>Required Medical Information</b>	Diagnosis, concomitant therapy
<b>Age Restrictions</b>	Patients 12 years of age or older
<b>Prescriber Restrictions</b>	Prescribed by, or in consultation with an infectious diseases specialist
<b>Coverage Duration</b>	9 months
<b>Other Criteria</b>	Tuberculosis, Pulmonary Multidrug-resistant or extensively drug resistant-prescribed as part of a combination regimen with other anti-tuberculosis agents
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# SKYRIZI

---

## Products Affected

- SKYRIZI SUBCUTANEOUS SYRINGE KIT

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Concurrent use with biologic therapy or targeted synthetic DMARD
<b>Required Medical Information</b>	Diagnosis, Previous medication use
<b>Age Restrictions</b>	18 years of age and older (initial therapy)
<b>Prescriber Restrictions</b>	PP-Prescribed by or in consultation with a dermatologist (initial therapy)
<b>Coverage Duration</b>	3 mos initial, 3 years cont
<b>Other Criteria</b>	PP initial, approve if the patient meets one of the following criteria: 1) pt has tried at least one traditional systemic agent (eg, MTX, cyclosporine, acitretin, PUVA) for at least 3 months, unless intolerant (note: pts who have already tried a biologic for psoriasis are not required to step back and try a traditional agent first) OR 2) pt has a contraindication to MTX as determined by the prescribing physician. Continuation-approve if the patient has had a response as determined by the prescriber.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# SOMATULINE

## Products Affected

- SOMATULINE DEPOT

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis, previous treatments/therapies
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Acromegaly-prescribed by or in consultation with an endocrinologist. Carcinoid syndrome-prescribed by or in consultation with an oncologist, endocrinologist or gastroenterologist. All neuroendocrine tumors-prescribed by or in consultation with an oncologist, endocrinologist, or gastroenterologist. Pheochromocytoma/paraganglioma-prescribed by or in consultation with an endo/onc/neuro.
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	Acromegaly-approve if the patient has a pre-treatment (baseline) insulin-like growth factor-1 (IGF-1) level above the upper limit of normal based on age and gender for the reporting laboratory AND the patient meets i., ii., or iii: i. has had an inadequate response to surgery and/or radiotherapy or ii. is not an appropriate candidate for surgery and/or radiotherapy or iii. the patient is experiencing negative effects due to tumor size (e.g., optic nerve compression). Neuroendocrine Tumor(s) [NETs] of the Gastrointestinal Tract, Lung, Thymus (Carcinoid Tumors), and Pancreas (including glucagonomas, gastrinomas, vasoactive intestinal peptide-secreting tumors [VIPomas], insulinomas)-approve. Carcinoid Syndrome-approve.
<b>Indications</b>	All FDA-approved Indications, Some Medically-accepted Indications.
<b>Off-Label Uses</b>	Pheochromocytoma/paraganglioma

# SOMAVERT

---

## Products Affected

- SOMAVERT

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis, previous therapy, concomitant therapy
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an endocrinologist
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	Acromegaly-approve if patient meets ONE of the following (i, ii, or iii): i. patient has had an inadequate response to surgery and/or radiotherapy OR ii. The patient is NOT an appropriate candidate for surgery and/or radiotherapy OR iii. The patient is experiencing negative effects due to tumor size (e.g., optic nerve compression) AND patient has (or had) a pre-treatment (baseline) insulin-like growth factor-1 (IGF-1) level above the upper limit of normal (ULN) based on age and gender for the reporting laboratory.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# STELARA

## Products Affected

- STELARA INTRAVENOUS
- STELARA SUBCUTANEOUS SOLUTION
- STELARA SUBCUTANEOUS SYRINGE 45 MG/0.5 ML, 90 MG/ML

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Concurrent use with biologic therapy or targeted synthetic DMARD
<b>Required Medical Information</b>	Diagnosis, concurrent medications, previous drugs tried.
<b>Age Restrictions</b>	18 years and older CD/UC (initial therapy). PP-12 years and older (initial therapy).
<b>Prescriber Restrictions</b>	PP-Prescr/consult w/derm.PsA-prescr/consult w/rheum or derm.CD/UC-prescr/consult w/gastro.
<b>Coverage Duration</b>	PP/PsA Init-3mo,CD/UC load-approve 1 dose IV,CD/UC post IV load-SC 3 mo,cont tx-SC 3 yr
<b>Other Criteria</b>	PsA initial, patient has tried one conventional synthetic DMARD for at least 3 months (note: patients who have already had a 3-month trial of a biologic for RA are not required to step back and try a conventional synthetic DMARD). PP initial, approve if the patient meets one of the following criteria: 1) pt has tried at least one traditional systemic agent (eg, MTX, cyclosporine, acitretin, PUVA) for at least 3 months, unless intolerant (note: pts who have already tried a biologic for psoriasis are not required to step back and try a traditional agent first) OR 2) pt has a contraindication to MTX as determined by the prescribing physician. CD initial, approve if the patient meets ONE of the following criteria: 1) patient has tried or is currently taking corticosteroids, or corticosteroids are contraindicated, OR 2) patient has tried one other agent for CD. UC initial, approve if the patient has had a trial of one systemic agent for UC.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# SYLATRON

---

## Products Affected

- SYLATRON SUBCUTANEOUS KIT  
200 MCG, 300 MCG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	Melanoma-approve if the patient has microscopic or gross nodal involvement and has had a complete lymphadenectomy within the past 84 days. Systemic mastocytosis-approve if the patient has aggressive systemic mastocytosis OR systemic mastocytosis with an associated hematologic malignancy OR osteopenia/osteoporosis with refractory bone pain and/or decreasing bone mineral density on bisphosphonate therapy. Myeloproliferative neoplasms-approve if the patient has symptomatic low-risk myelofibrosis or polycythemia vera or essential thrombocythemia.
<b>Indications</b>	All FDA-approved Indications, Some Medically-accepted Indications.
<b>Off-Label Uses</b>	Systemic mastocytosis, myeloproliferative neoplasms

# SYMDEKO

---

## Products Affected

- SYMDEKO

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Patients with unknown CFTR gene mutations, Combination therapy with Orkambi, Kalydeco or Trikafta
<b>Required Medical Information</b>	Diagnosis, specific CFTR gene mutations
<b>Age Restrictions</b>	Six years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a pulmonologist or a physician who specializes in CF
<b>Coverage Duration</b>	3 years
<b>Other Criteria</b>	CF - must have at least one of the following mutations in the cystic fibrosis transmembrane conductance regulator (CFTR) gene: E56K, P67L, R74W, D110E, D110H, R117C, E193K, L206W, R347H, R352Q, A455E, D579G, 711+3A G, S945L, S977F, F1052V, E831X, K1060T, A1067T, R1070W, F1074L, D1152H, D1270N, 2789+5G A, 3272-26A G, or 3849 + 10kbC T OR the patient has two copies of the F508del mutation
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# SYMLIN

---

## Products Affected

- SYMLINPEN 120
- SYMLINPEN 60

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Authorization will be for 3 years.
<b>Other Criteria</b>	N/A
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# SYNAGIS

---

## Products Affected

- SYNAGIS

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Documentation of diagnosis.
<b>Age Restrictions</b>	24 months or younger
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	6 months
<b>Other Criteria</b>	N/A
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# TALTZ

---

## Products Affected

- TALTZ SYRINGE

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Concurrent use with a Biologic DMARD or Targeted Synthetic DMARD.
<b>Required Medical Information</b>	Diagnosis, Previous medication use
<b>Age Restrictions</b>	PP-6 years and older (initial therapy), all other dx-18 years of age and older (initial therapy)
<b>Prescriber Restrictions</b>	All dx initial therapy only-PP-Prescribed by or in consultation with a dermatologist. PsA prescribed by or in consultation with a rheumatologist or a dermatologist. AS-prescribed by or in consultation with a rheum.
<b>Coverage Duration</b>	Initial authorization will be for 3 months, 3 years continuation.
<b>Other Criteria</b>	PP, approve if the patient has tried two of the following: Enbrel, Humira, Skyrizi, or Stelara. PsA, approve if the patient has tried two of the following: Enbrel, Humira, Stelara. AS, approve if the patient has tried one of the following: Enbrel or Humira. Non-radiographic Axial Spondyloarthritis, approve if the patient has objective signs of inflammation. Continuation-approve if the patient has had a response as determined by the prescriber.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# TARGRETIN ORAL

---

## Products Affected

- *bexarotene*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis, previous therapies tried
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist or dermatologist (initial and continuation)
<b>Coverage Duration</b>	3 years
<b>Other Criteria</b>	N/A
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# TARGRETIN TOPICAL

---

## Products Affected

- TARGRETIN TOPICAL

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis, previous therapies tried
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist or dermatologist (initial and continuation)
<b>Coverage Duration</b>	3 years
<b>Other Criteria</b>	N/A
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# TECFIDERA

---

## Products Affected

- TECFIDERA ORAL  
CAPSULE, DELAYED

RELEASE(DR/EC) 120 MG, 120 MG  
(14)- 240 MG (46), 240 MG

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Concurrent use with other disease-modifying agents used for multiple sclerosis (MS)
<b>Required Medical Information</b>	MS, patient must have a relapsing form of MS
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a neurologist or MS specialist.
<b>Coverage Duration</b>	Authorization will be for 1 year.
<b>Other Criteria</b>	N/A
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# TERIPARATIDE

---

## Products Affected

- TERIPARATIDE

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Concomitant use with other medications for osteoporosis (eg, denosumab [Prolia], bisphosphonates, raloxifene, calcitonin nasal spray [Fortical], abaloparatide), except calcium and Vitamin D.
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Auth will be for 2 years of total therapy between Tymlos/teriparatide over pt's lifetime
<b>Other Criteria</b>	Treatment of PMO, approve if pt has tried one oral bisphosphonate OR pt cannot take an oral bisphosphonate because the pt cannot swallow or has difficulty swallowing or the pt cannot remain in an upright position post oral bisphosphonate administration or pt has a pre-existing GI medical condition (eg, patient with esophageal lesions, esophageal ulcers, or abnormalities of the esophagus that delay esophageal emptying [stricture, achalasia]), OR pt has tried an IV bisphosphonate (ibandronate or zoledronic acid), OR pt has severe renal impairment (creatinine clearance less than 35 mL/min) or CKD or pt has had an osteoporotic fracture or fragility fracture. Increase bone mass in men (a man is defined as an individual with the biological traits of a man, regardless of the individual's gender identity or gender expression) with primary or hypogondal osteoporosis/Treatment of GIO, approve if pt tried one oral bisphosphonate OR pt cannot take an oral bisphosphonate because the patient cannot swallow or has difficulty swallowing or the patient cannot remain in an upright position post oral bisphosphonate administration or has a pre-existing GI medical condition (eg, patient with esophageal lesions, esophageal ulcers, or abnormalities of the esophagus that delay esophageal emptying [stricture, achalasia]), OR pt has tried zoledronic acid (Reclast), OR pt has severe renal impairment (CrCL less than 35 mL/min) or has CKD or has had an osteoporotic fracture or fragility fracture.

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# THALOMID

## Products Affected

- THALOMID ORAL CAPSULE 100 MG, 150 MG, 200 MG, 50 MG

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 3 years.
Other Criteria	Erythem Nodosum Leprosum-approve. Multiple Myeloma-approve. Discoid lupus erythematosus or cutaneous lupus erythematosus, approve if the patient has tried at least two other therapies (eg, corticosteroids [oral, topical, intralesional], hydroxychloroquine, tacrolimus [Protopic], methotrexate, dapsone, acitretin [Soriatane]). Myelofibrosis, approve if according to the prescriber the patient has anemia and has serum erythropoietin levels greater than or equal to 500 mU/mL. Prurigo nodularis, approve. Recurrent aphthous ulcers or aphthous stomatitis, approve if the patient has tried at least two other therapies (eg, topical or intralesional corticosteroids, systemic corticosteroids, topical anesthetics/analgesics [eg, benzocaine lozenges], antimicrobial mouthwashes [eg, tetracycline], acyclovir, colchicine). AIDS Related Kaposi's Sarcoma-approve if the patient has tried at least one regimen or therapy and has relapsed or refractory disease. Castleman's disease-approve if the patient has multicentric Castleman's disease, is negative for the human immunodeficiency virus (HIV) and human herpesvirus-8 (HHV-8) and has hyaline vascular histology.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Discoid lupus erythematosus or cutaneous lupus erythematosus, Myelofibrosis, Prurigo nodularis, Recurrent aphthous ulcers or aphthous

<b>PA Criteria</b>	<b>Criteria Details</b>
	stomatitis, AIDS related Kaposi's Sarcoma, Castleman's Disease.

# TOPICAL AGENTS FOR ATOPIC DERMATITIS

---

## Products Affected

- *tacrolimus topical*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Authorization will be for 12 months.
<b>Other Criteria</b>	Authorize use in patients who have tried a prescription strength topical corticosteroid (brand or generic) for the current condition. Dermatologic condition on or around the eyes, eyelids, axilla, or genitalia, authorize use without a trial of a prescription strength topical corticosteroid.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# TOPICAL RETINOID PRODUCTS

---

## Products Affected

- AVITA
- *tretinoin microspheres*
- *tretinoin topical*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Coverage is not provided for cosmetic use.
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Authorization will be for 12 months
<b>Other Criteria</b>	N/A
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# TOPIRAMATE/ZONISAMIDE

---

## Products Affected

- TOPAMAX
- *topiramate oral capsule, sprinkle*
- *topiramate oral tablet*
- TROKENDI XR
- *zonisamide*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Coverage is not provided for weight loss or smoking cessation.
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Authorization will be for 1 year.
<b>Other Criteria</b>	N/A
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# TRACLEER

---

## Products Affected

- *bosentan*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Pulmonary arterial hypertension (PAH) WHO Group 1, results of right heart cath
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	For treatment of pulmonary arterial hypertension, ambrisentan or bosentan must be prescribed by or in consultation with a cardiologist or a pulmonologist. CTEPH-prescribed by or in consultation with a cardiologist or pulmonologist
<b>Coverage Duration</b>	Authorization will be for 1 year.
<b>Other Criteria</b>	CTEPH - pt must have tried Adempas, has a contraindication to Adempas, or is currently receiving bosentan for CTEPH. Pulmonary arterial hypertension (PAH) WHO Group 1, are required to have had a right-heart catheterization to confirm diagnosis of PAH to ensure appropriate medical assessment.
<b>Indications</b>	All FDA-approved Indications, Some Medically-accepted Indications.
<b>Off-Label Uses</b>	Chronic thromboembolic pulmonary hypertension (CTEPH) (bosentan)

# TRANSMUCOSAL FENTANYL DRUGS

---

## Products Affected

- *fentanyl citrate buccal lozenge on a handle*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Authorization will be for 12 months.
<b>Other Criteria</b>	For breakthrough pain in patients with cancer if patient is unable to swallow, has dysphagia, esophagitis, mucositis, or uncontrollable nausea/vomiting OR patient is unable to take 2 other short-acting narcotics (eg, oxycodone, morphine sulfate, hydromorphone, etc) secondary to allergy or severe adverse events AND patient is on or will be on a long-acting narcotic (eg, Duragesic), or the patient is on intravenous, subcutaneous, or spinal (intrathecal, epidural) narcotics (eg, morphine sulfate, hydromorphone, fentanyl citrate). Clinical criteria incorporated into the quantity limit edits for all transmucosal fentanyl drugs require confirmation that the indication is breakthrough cancer pain (ie, FDA labeled use) prior to reviewing for quantity exception.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# TRELSTAR

---

## Products Affected

- TRELSTAR INTRAMUSCULAR  
SUSPENSION FOR RECONSTITUTION

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	N/A
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# TRIENTINE

---

## Products Affected

- *trientine*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis, medication history, pregnancy status, disease manifestations
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a gastroenterologist, hepatologist, or liver transplant physician.
<b>Coverage Duration</b>	Authorization will be for 3 years.
<b>Other Criteria</b>	For Wilson's Disease, approve if the patient meets ONE of the following: 1) Patient has tried a penicillamine product and per the prescribing physician the patient is intolerant to penicillamine therapy, OR 2) Per the prescribing physician, the patient has clinical features indicating the potential for intolerance to penicillamine therapy (ie, history of any renal disease, congestive splenomegaly causing severe thrombocytopenia, autoimmune tendency), OR 3) Per the prescribing physician, the patient has a contraindication to penicillamine therapy, OR 4) The patient has neurologic manifestations of Wilson's disease, OR 5) The patient is pregnant.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# TURALIO

---

## Products Affected

- TURALIO

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	3 years
<b>Other Criteria</b>	Tenosynovial Giant Cell Tumor (Pigmented Villonodular Synovitis)- approve if, according to the prescriber, the tumor is not amenable to improvement with surgery.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# TYMLOS

---

## Products Affected

- TYMLOS

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Concomitant use with other medications for osteoporosis (eg, denosumab [Prolia], bisphosphonates, calcitonin nasal spray [Fortical], Forteo), Evenity except calcium and Vitamin D. Previous use of Tymlos and/or teriparatide for a combined total no greater than 2 years duration during a patient's lifetime.
<b>Required Medical Information</b>	Previous medications tried, renal function
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Authorization will be for 2 yrs of total therapy between Tymlos/teriparatide over a pt's lifetime.
<b>Other Criteria</b>	Treatment of PMO, approve if the patient meets ONE of the following criteria: patient has tried one oral bisphosphonate or cannot take an oral bisphosphonate because the patient cannot swallow or has difficulty swallowing or patient cannot remain in an upright position post oral bisphosphonate administration or patient has a pre-existing GI medical condition (eg, patient with esophageal lesions, esophageal ulcers, or abnormalities of the esophagus that delay esophageal emptying [stricture, achalasia]), OR patient has tried an IV bisphosphonate (ibandronate or zoledronic acid), OR patient has severe renal impairment or CKD, OR patient has had an osteoporotic fracture or fragility fracture.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# TYSABRI

## Products Affected

- TYSABRI

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Concurrent use of other disease-modifying agents used for MS. Concurrent use with immunosuppressants (eg, 6-mercaptopurine, azathioprine, cyclosporine, methotrexate) in Crohn's disease (CD) patient
<b>Required Medical Information</b>	Diagnosis
<b>Age Restrictions</b>	18 and older (initial and continuation)
<b>Prescriber Restrictions</b>	MS: prescribed by, or in consultation with, a neurologist or a physician who specializes in the treatment of MS. (initial and continuation) CD: prescribed by, or in consultation with, a gastroenterologist (initial and continuation)
<b>Coverage Duration</b>	MS-Authorization will be for 1 year.CD, initial-3 mo. CD, cont therapy-1 year.
<b>Other Criteria</b>	Adults with a relapsing form of MS-initial. Patient has had an inadequate response to, or is unable to tolerate, one disease modifying agent used for MS: (eg, interferon beta-1a (Avonex, Rebif), interferon beta-1b (Betaseron, Extavia), glatiramer acetate (Copaxone/Glatopa), Plegridy, fingolimod (Gilenya), Tecfidera, Lemtrada, daclizumab (Zinbryta), Aubagio, Mavenclad, Mayzent, Vumerity, Lemtrada, Ocrevus) OR the patient has highly active or aggressive disease according to the prescribing physician by meeting one of the following-the patient has demonstrated rapidly-advancing deterioration(s) in physical functioning (e.g., loss of mobility/or lower levels of ambulation, severe changes in strength or coordination OR disabling relapse(s) with suboptimal response to systemic corticosteroids OR magnetic resonance imaging (MRI) findings suggest highly-active or aggressive multiple sclerosis (e.g., new, enlarging, or a high burden of T2 lesions or gadolinium lesions) OR manifestation of multiple sclerosis-related cognitive impairment. Adults with CD, initial. Patient has moderately to severely active CD and patient has tried two biologics for CD. CD, continuation therapy. Patient has had a response to Tysabri, as determined by the prescribing physician.
<b>Indications</b>	All FDA-approved Indications, Some Medically-accepted Indications.

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off-Label Uses</b>	Patients already started on Tysabri for a Covered Use.

# UPTRAVI

---

## Products Affected

- UPTRAVI

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Confirmation of right heart catheterization, medication history.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	PAH must be prescribed by, or in consultation with, a cardiologist or a pulmonologist.
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	Must have PAH (WHO Group 1) and had a right heart catheterization to confirm the diagnosis of PAH (WHO Group 1). Patient new to Uptravi therapy must meet a) OR b): a) tried TWO or is currently taking TWO oral therapies for PAH (either alone or in combination) each for 30 days, unless patient has experienced treatment failure, intolerance, or oral therapy is contraindicated: PDE5 inhibitor (eg, sildenafil, Revatio), endothelin receptor antagonist (ERA) [eg, Tracleer, Letairis or Opsumit], or Adempas, OR b) receiving or has received in the past one prostacyclin therapy for PAH (eg, Orenitram, Ventavis, or epoprostenol injection).
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# VALTOCO

---

## Products Affected

- VALTOCO

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis, other medications used at the same time
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a neurologist
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	Intermittent Episodes of Frequent Seizure Activity (i.e., seizure clusters, acute repetitive seizures)-approve if the patient is currently receiving maintenance antiepileptic medication(s).
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# VANCOMYCIN

---

## Products Affected

- *vancomycin oral capsule 125 mg, 250 mg*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	2 weeks
<b>Other Criteria</b>	N/A
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# VENTAVIS

---

## Products Affected

- VENTAVIS

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	B vs D coverage determination
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# VERZENIO

---

## Products Affected

- VERZENIO

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	For use with an aromatase inhibitor in postmenopausal women or men as initial endocrine-based therapy, approve if the patient has tried Ibrance. For use with fulvestrant in patients with disease progression following endocrine therapy, approve if the patient has tried Ibrance.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# VIBERZI

---

## Products Affected

- VIBERZI

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis of irritable bowel syndrome with diarrhea.
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	The patient must have a history of failure, contraindication or intolerance to one antidiarrheal drug.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# VITRAKVI

---

## Products Affected

- VITRAKVI ORAL CAPSULE 100 MG, 25 MG
- VITRAKVI ORAL SOLUTION

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis, NTRK gene fusion status
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	3 years
<b>Other Criteria</b>	Solid tumors - approve if the tumor has a neurotrophic receptor tyrosine kinase (NTRK) gene fusion without a known acquired resistance mutation AND the tumor is metastatic or surgical resection of tumor will likely result in severe morbidity AND there are no satisfactory alternative treatments or the patient has disease progression following treatment.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# VOSEVI

---

## Products Affected

- VOSEVI

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Genotype, prescriber specialty, other medications tried or used in combination with requested medication
<b>Age Restrictions</b>	18 years or older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a gastroenterologist, hepatologist, infectious diseases physician, or a liver transplant physician
<b>Coverage Duration</b>	Will be c/w AASLD guidance and inclusive of treatment already received for the requested drug
<b>Other Criteria</b>	Criteria will be applied consistent with current AASLD/IDSA guidance.
<b>Indications</b>	All FDA-approved Indications, Some Medically-accepted Indications.
<b>Off-Label Uses</b>	Indications consistent with current AASLD/IDSA guidance

# XATMEP

---

## Products Affected

- XATMEP

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	N/A
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# XCOPRI

---

## Products Affected

- XCOPRI
- XCOPRI MAINTENANCE PACK
- XCOPRI TITRATION PACK

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve if the patient has tried one other anticonvulsant therapy (eg, carbamazepine, divalproex sodium, lamotrigine, levetiracetam, oxcarbazepine, phenytoin, topiramate, valproic acid).
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

# XELJANZ

---

## Products Affected

- XELJANZ
- XELJANZ XR

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Concurrent use with biologic therapy or targeted synthetic DMARD
<b>Required Medical Information</b>	Diagnosis, concurrent medications, previous drugs tried.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	RA, prescribed by or in consultation with a rheumatologist. PsA-prescribed by or in consultation with a rheumatologist or a dermatologist. UC-prescribed by or in consultation with a gastroenterologist.
<b>Coverage Duration</b>	PsA/RA-3 months initial, UC-16 weeks initial, All diagnoses-3 years cont.
<b>Other Criteria</b>	RA/PsA initial, patient has tried one conventional synthetic DMARD for at least 3 months (note: patients who have already had a 3-month trial of a biologic for RA are not required to step back and try a conventional synthetic DMARD). UC initial, approve if the patient has had a trial of one systemic agent for UC.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# XENAZINE

---

## Products Affected

- *tetrabenazine oral tablet 12.5 mg, 25 mg*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	For treatment of chorea associated with Huntington's disease, Tourette syndrome or related tic disorders, hyperkinetic dystonia, or hemiballism, must be prescribed by or after consultation with a neurologist. For TD, must be prescribed by or after consultation with a neurologist or psychiatrist.
<b>Coverage Duration</b>	Authorization will be for 1 year.
<b>Other Criteria</b>	N/A
<b>Indications</b>	All FDA-approved Indications, Some Medically-accepted Indications.
<b>Off-Label Uses</b>	Tardive dyskinesia (TD). Tourette syndrome and related tic disorders. Hyperkinetic dystonia. Hemiballism.

# XGEVA

---

## Products Affected

- XGEVA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	For initial therapy in the treatment of hypercalcemia of malignancy: trial and failure, contraindication, or intolerance to one intravenous bisphosphonate (e.g. pamidronate, zoledronic acid) is required. For continuation of therapy in the treatment of hypercalcemia of malignancy, approve if patient has already been started on Xgeva. For other medically accepted indication, no trial of alternatives is required.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# XIAFLEX

## Products Affected

- XIAFLEX

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Retreatment (i.e., treatment beyond three injections per affected cord for those with Dupuytren's Contracture or beyond eight injections for Peyronie's Disease).
<b>Required Medical Information</b>	Diagnosis
<b>Age Restrictions</b>	18 years and older
<b>Prescriber Restrictions</b>	Dupuytren's Contracture-administered by a healthcare provider experienced in injection procedures of the hand and in the treatment of Dupuytren's contracture. Peyronie's Disease -administered by a healthcare provider experienced in the treatment of male urological diseases.
<b>Coverage Duration</b>	Dupuytren's Contracture-3 months, Peyronie's Disease-6 months
<b>Other Criteria</b>	Dupuytren's Contracture-at baseline (prior to initial injection of Xiaflex), the patient had contracture of a metacarpophalangeal (MP) or proximal interphalangeal (PIP) joint of at least 20 degrees AND the patient will not be treated with more than a total of three injections (maximum) per affected cord. Peyronie's Disease-the patient meets ONE of the following (i or ii): i. at baseline (prior to use of Xiaflex), the patient has a penile curvature deformity of at least 30 degrees OR in a patient who has received prior treatment with Xiaflex, the patient has a penile curvature deformity of at least 15 degrees AND the patient has not previously been treated with a complete course (8 injections) of Xiaflex for Peyronie's disease.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# XIFAXAN

---

## Products Affected

- XIFAXAN ORAL TABLET 200 MG, 550 MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	N/A
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# XOLAIR

## Products Affected

- XOLAIR SUBCUTANEOUS RECON SOLN
- XOLAIR SUBCUTANEOUS SYRINGE 150 MG/ML, 75 MG/0.5 ML

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Concurrent use with an Interleukin (IL) Antagonist Monoclonal Antibody
<b>Required Medical Information</b>	Moderate to severe persistent asthma, baseline IgE level of at least 30 IU/mL. For asthma, patient has a baseline positive skin test or in vitro testing (ie, a blood test for allergen-specific IgE antibodies such as an enzyme-linked immunoabsorbant assay (eg, immunoCAP, ELISA) or the RAST) for 1 or more perennial aeroallergens (eg, house dust mite, animal dander [dog, cat], cockroach, feathers, mold spores) and/or for 1 or more seasonal aeroallergens (grass, pollen, weeds).
<b>Age Restrictions</b>	Moderate to severe persistent asthma-6 years and older. All other diagnoses-12 years and older
<b>Prescriber Restrictions</b>	Moderate to severe persistent asthma if prescribed by, or in consultation with an allergist, immunologist, or pulmonologist. CIU if prescribed by or in consultation with an allergist, immunologist, or dermatologist.
<b>Coverage Duration</b>	Initial tx 4 months, continued tx 12 months
<b>Other Criteria</b>	Moderate to severe persistent asthma approve if pt meets criteria 1 and 2: 1) pt has received at least 3 months of combination therapy with an inhaled corticosteroid and at least one the following: long-acting beta-agonist (LABA), long-acting muscarinic antagonist (LAMA), leukotriene receptor antagonist, or theophylline, and 2) patient's asthma is uncontrolled or was uncontrolled prior to receiving any Xolair or anti-IL-4/13 therapy (Dupixent) therapy as defined by ONE of the following (a, b, c, d, or e): a) The patient experienced two or more asthma exacerbations requiring treatment with systemic corticosteroids in the previous year OR b) The patient experienced one or more asthma exacerbation requiring hospitalization or an Emergency Department (ED) visit in the previous year OR c) Patient has a forced expiratory volume in 1 second (FEV1) less than 80% predicted OR d) Patient has an FEV1/forced vital capacity (FVC) less than 0.80 OR e) The patient's asthma worsens upon tapering of oral corticosteroid therapy NOTE: An exception to the requirement for a trial of one additional asthma controller/maintenance medication can be made if

<b>PA Criteria</b>	<b>Criteria Details</b>
	<p>the patient has already received anti-IL-4/13 therapy (Dupixent) used concomitantly with an ICS for at least 3 consecutive months. For continued Tx for asthma - patient has responded to therapy as determined by the prescribing physician and continues to receive therapy with one inhaled corticosteroid or inhaled corticosteroid containing combination product. For CIU cont tx - must have responded to therapy as determined by the prescribing physician.</p>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# XYREM

---

## Products Affected

- XYREM

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Medication history
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by a sleep specialist physician or a Neurologist
<b>Coverage Duration</b>	12 months.
<b>Other Criteria</b>	For Excessive daytime sleepiness (EDS) in patients with narcolepsy - approve if the patient has tried two CNS stimulants (e.g., methylphenidate, dexamethylphenidate, dextroamphetamine), modafinil, or armodafinil and narcolepsy has been confirmed with polysomnography and a multiple sleep latency test (MSLT). Cataplexy treatment in patients with narcolepsy- approve if narcolepsy has been confirmed with polysomnography and a multiple sleep latency test (MSLT).
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# ZOLINZA

---

## Products Affected

- ZOLINZA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	3 years
<b>Other Criteria</b>	Cutaneous T-Cell Lymphoma including Mycosis Fungoides/Sezary Syndrome-approve.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# ZYPREXA RELPREVV

---

## Products Affected

- ZYPREXA RELPREVV RECONSTITUTION 210 MG, 300 MG,  
INTRAMUSCULAR SUSPENSION FOR 405 MG

PA Criteria	Criteria Details
Exclusion Criteria	Dementia-related psychosis
Required Medical Information	N/A
Age Restrictions	Patients aged less than 65 years, approve. Patients aged 65 years and older, other criteria apply.
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

## PART B VERSUS PART D

---

### Products Affected

- *acetylcysteine solution 100 mg/ml (10 %), 200 mg/ml (20 %)*
- *acyclovir sodium intravenous solution 50 mg/ml*
- *adriamycin intravenous recon soln 10 mg*
- ADRIAMYCIN INTRAVENOUS RECON SOLN 50 MG
- *adriamycin intravenous solution 10 mg/5 ml, 2 mg/ml, 20 mg/10 ml, 50 mg/25 ml*
- *adrucil intravenous solution 2.5 gram/50 ml*
- *albuterol sulfate inhalation solution for nebulization 0.63 mg/3 ml, 1.25 mg/3 ml, 2.5 mg /3 ml (0.083 %), 2.5 mg/0.5 ml, 5 mg/ml*
- AMINOSYN II 10 % INTRAVENOUS PARENTERAL SOLUTION 10 %
- AMINOSYN II 15 % INTRAVENOUS PARENTERAL SOLUTION 15 %
- AMINOSYN-PF 10 % INTRAVENOUS PARENTERAL SOLUTION 10 %
- AMINOSYN-PF 7 % (SULFITE-FREE) INTRAVENOUS PARENTERAL SOLUTION 7 %
- *aprepitant oral capsule 125 mg, 40 mg, 80 mg*
- *aprepitant oral capsule, dose pack 125 mg (1)- 80 mg (2)*
- ARRANON INTRAVENOUS SOLUTION 250 MG/50 ML
- ARSENIC TRIOXIDE INTRAVENOUS SOLUTION 1 MG/ML
- *arsenic trioxide intravenous solution 2 mg/ml*
- ARZERRA INTRAVENOUS SOLUTION 1,000 MG/50 ML, 100 MG/5 ML
- *azacitidine injection recon soln 100 mg*
- BELEODAQ INTRAVENOUS RECON SOLN 500 MG
- BENDEKA INTRAVENOUS SOLUTION 25 MG/ML
- BIVIGAM INTRAVENOUS SOLUTION 10 %
- *bleomycin injection recon soln 15 unit, 30 unit*
- BLINCYTO INTRAVENOUS KIT 35 MCG
- BROVANA INHALATION SOLUTION FOR NEBULIZATION 15 MCG/2 ML
- *budesonide inhalation suspension for nebulization 0.25 mg/2 ml, 0.5 mg/2 ml, 1 mg/2 ml*
- *busulfan intravenous solution 60 mg/10 ml*
- BUSULFEX INTRAVENOUS SOLUTION 60 MG/10 ML
- *carboplatin intravenous solution 10 mg/ml*
- *carmustine intravenous recon soln 100 mg*
- *cisplatin intravenous solution 1 mg/ml*
- *cladribine intravenous solution 10 mg/10 ml*
- CLINIMIX 5%/D15W SULFITE FREE INTRAVENOUS PARENTERAL SOLUTION 5 %
- CLINIMIX 4.25%/D10W SULF FREE INTRAVENOUS PARENTERAL SOLUTION 4.25 %
- CLINIMIX 4.25%/D5W SULFIT FREE INTRAVENOUS PARENTERAL SOLUTION 4.25 %
- CLINIMIX 5%-D20W(SULFITE-FREE) INTRAVENOUS PARENTERAL SOLUTION 5 %
- CLINIMIX E 4.25%/D10W SUL FREE INTRAVENOUS PARENTERAL SOLUTION 4.25 %
- CLINISOL SF 15 % INTRAVENOUS PARENTERAL SOLUTION 15 %
- *clofarabine intravenous solution 20 mg/20 ml*
- COSMEGEN INTRAVENOUS RECON SOLN 0.5 MG
- *cromolyn inhalation solution for nebulization 20 mg/2 ml*

- *cyclophosphamide intravenous recon soln 1 gram, 2 gram, 500 mg*
- *cyclophosphamide oral capsule 25 mg, 50 mg*
- *cytarabine (pf) injection solution 100 mg/5 ml (20 mg/ml), 2 gram/20 ml (100 mg/ml), 20 mg/ml*
- *cytarabine injection solution 20 mg/ml*
- *dacarbazine intravenous recon soln 100 mg, 200 mg*
- *dactinomycin intravenous recon soln 0.5 mg*
- DARZALEX FASPRO SUBCUTANEOUS SOLUTION 1,800 MG-30,000 UNIT/15 ML
- *daunorubicin intravenous solution 5 mg/ml*
- *decitabine intravenous recon soln 50 mg*
- *docetaxel intravenous solution 160 mg/16 ml (10 mg/ml), 160 mg/8 ml (20 mg/ml), 20 mg/2 ml (10 mg/ml), 20 mg/ml (1 ml), 80 mg/4 ml (20 mg/ml), 80 mg/8 ml (10 mg/ml)*
- *doxorubicin intravenous recon soln 50 mg*
- *doxorubicin intravenous solution 10 mg/5 ml, 2 mg/ml, 20 mg/10 ml, 50 mg/25 ml*
- *doxorubicin, peg-liposomal intravenous suspension 2 mg/ml*
- *dronabinol oral capsule 10 mg, 2.5 mg, 5 mg*
- ELLENCE INTRAVENOUS SOLUTION 200 MG/100 ML, 50 MG/25 ML
- EMEND ORAL SUSPENSION FOR RECONSTITUTION 125 MG (25 MG/ML FINAL CONC.)
- ENGERIX-B (PF) INTRAMUSCULAR SYRINGE 20 MCG/ML
- ENGERIX-B PEDIATRIC (PF) INTRAMUSCULAR SYRINGE 10 MCG/0.5 ML
- *epirubicin intravenous solution 200 mg/100 ml, 50 mg/25 ml*
- ERBITUX INTRAVENOUS SOLUTION 100 MG/50 ML, 200 MG/100 ML
- ERWINAZE INJECTION RECON SOLN 10,000 UNIT
- ETOPOPHOS INTRAVENOUS RECON SOLN 100 MG
- *etoposide intravenous solution 20 mg/ml*
- FIRMAGON KIT W DILUENT SYRINGE SUBCUTANEOUS RECON SOLN 120 MG, 80 MG
- FLEBOGAMMA DIF INTRAVENOUS SOLUTION 10 %
- *floxuridine injection recon soln 0.5 gram*
- *fludarabine intravenous recon soln 50 mg*
- *fludarabine intravenous solution 50 mg/2 ml*
- *fluorouracil intravenous solution 1 gram/20 ml, 2.5 gram/50 ml, 5 gram/100 ml, 500 mg/10 ml*
- FOLOTYN INTRAVENOUS SOLUTION 20 MG/ML (1 ML), 40 MG/2 ML (20 MG/ML)
- FREAMINE HBC 6.9 % INTRAVENOUS PARENTERAL SOLUTION 6.9 %
- *freamine iii 10 % intravenous parenteral solution 10 %*
- *fulvestrant intramuscular syringe 250 mg/5 ml*
- GAMMAGARD LIQUID INJECTION SOLUTION 10 %
- GAMMAGARD S-D (IGA < 1 MCG/ML) INTRAVENOUS RECON SOLN 10 GRAM, 5 GRAM
- GAMMAKED INJECTION SOLUTION 1 GRAM/10 ML (10 %), 10 GRAM/100 ML (10 %), 20 GRAM/200 ML (10 %), 5 GRAM/50 ML (10 %)
- GAMMAPLEX (WITH SORBITOL) INTRAVENOUS SOLUTION 5 %
- GAMUNEX-C INJECTION SOLUTION 1 GRAM/10 ML (10 %), 10 GRAM/100 ML (10 %), 2.5 GRAM/25 ML (10 %), 20 GRAM/200 ML (10 %), 40 GRAM/400 ML (10 %), 5 GRAM/50 ML (10 %)
- *gemcitabine intravenous recon soln 1 gram, 2 gram, 200 mg*
- *gemcitabine intravenous solution 1 gram/26.3 ml (38 mg/ml), 2 gram/52.6 ml (38 mg/ml), 200 mg/5.26 ml (38 mg/ml)*

- GEMCITABINE INTRAVENOUS SOLUTION 100 MG/ML
- *granisetron (pf) intravenous solution 1 mg/ml (1 ml)*
- *granisetron hcl intravenous solution 1 mg/ml (1 ml)*
- *granisetron hcl oral tablet 1 mg*
- HEPATAMINE 8% INTRAVENOUS PARENTERAL SOLUTION 8 %
- HIZENTRA SUBCUTANEOUS SOLUTION 1 GRAM/5 ML (20 %), 10 GRAM/50 ML (20 %), 2 GRAM/10 ML (20 %), 4 GRAM/20 ML (20 %)
- *idarubicin intravenous solution 1 mg/ml*
- *ifosfamide intravenous recon soln 1 gram, 3 gram*
- *ifosfamide intravenous solution 1 gram/20 ml, 3 gram/60 ml*
- INFUGEM INTRAVENOUS PIGGYBACK 1,200 MG/120 ML (10 MG/ML), 1,300 MG/130 ML (10 MG/ML), 1,400 MG/140 ML (10 MG/ML), 1,500 MG/150 ML (10 MG/ML), 1,600 MG/160 ML (10 MG/ML), 1,700 MG/170 ML (10 MG/ML), 1,800 MG/180 ML (10 MG/ML), 1,900 MG/190 ML (10 MG/ML), 2,000 MG/200 ML (10 MG/ML), 2,200 MG/220 ML (10 MG/ML)
- INTRALIPID INTRAVENOUS EMULSION 20 %, 30 %
- *ipratropium bromide inhalation solution 0.02 %*
- *ipratropium-albuterol inhalation solution for nebulization 0.5 mg-3 mg(2.5 mg base)/3 ml*
- *irinotecan intravenous solution 100 mg/5 ml, 300 mg/15 ml, 40 mg/2 ml, 500 mg/25 ml*
- IXEMPRA INTRAVENOUS RECON SOLN 15 MG, 45 MG
- JEVTANA INTRAVENOUS SOLUTION 10 MG/ML (FIRST DILUTION)
- KABIVEN INTRAVENOUS EMULSION 3.31-9.8-3.9 %
- KYPROLIS INTRAVENOUS RECON SOLN 10 MG, 30 MG, 60 MG
- *levalbuterol hcl inhalation solution for nebulization 0.31 mg/3 ml, 0.63 mg/3 ml, 1.25 mg/0.5 ml, 1.25 mg/3 ml*
- MARQIBO INTRAVENOUS KIT 5 MG/31 ML(0.16 MG/ML) FINAL
- *melphalan hcl intravenous recon soln 50 mg*
- *melphalan oral tablet 2 mg*
- *mesna intravenous solution 100 mg/ml*
- *mitomycin intravenous recon soln 20 mg, 40 mg, 5 mg*
- *mitoxantrone intravenous concentrate 2 mg/ml*
- MORPHINE INTRAVENOUS SYRINGE 10 MG/ML
- NEBUPENT INHALATION RECON SOLN 300 MG
- NEPHRAMINE 5.4 % INTRAVENOUS PARENTERAL SOLUTION 5.4 %
- NIPENT INTRAVENOUS RECON SOLN 10 MG
- NUTRILIPID INTRAVENOUS EMULSION 20 %
- OCTAGAM INTRAVENOUS SOLUTION 10 %, 5 %
- ONCASPAR INJECTION SOLUTION 750 UNIT/ML
- *ondansetron hcl oral solution 4 mg/5 ml*
- *ondansetron hcl oral tablet 24 mg, 4 mg, 8 mg*
- *ondansetron oral tablet, disintegrating 4 mg, 8 mg*
- *oxaliplatin intravenous recon soln 100 mg, 50 mg*
- *oxaliplatin intravenous solution 100 mg/20 ml, 50 mg/10 ml (5 mg/ml)*
- *paclitaxel intravenous concentrate 6 mg/ml*
- *palonosetron intravenous solution 0.25 mg/5 ml*
- *pentamidine inhalation recon soln 300 mg*
- PERFORMIST INHALATION SOLUTION FOR NEBULIZATION 20 MCG/2 ML

- PERIKABIVEN INTRAVENOUS EMULSION 2.36-6.8-3.5 %
- PLENAMINE INTRAVENOUS PARENTERAL SOLUTION 15 %
- PORTRAZZA INTRAVENOUS SOLUTION 800 MG/50 ML (16 MG/ML)
- *potassium chloride-d5-0.3%nacl intravenous parenteral solution 20 meq/l*
- PREMASOL 10 % INTRAVENOUS PARENTERAL SOLUTION 10 %
- PRIVIGEN INTRAVENOUS SOLUTION 10 %
- PROCALAMINE 3% INTRAVENOUS PARENTERAL SOLUTION 3 %
- PROLEUKIN INTRAVENOUS RECON SOLN 22 MILLION UNIT
- PROSOL 20 % INTRAVENOUS PARENTERAL SOLUTION
- PULMICORT INHALATION SUSPENSION FOR NEBULIZATION 0.25 MG/2 ML, 0.5 MG/2 ML, 1 MG/2 ML
- PULMOZYME INHALATION SOLUTION 1 MG/ML
- RECOMBIVAX HB (PF) INTRAMUSCULAR SUSPENSION 10 MCG/ML, 40 MCG/ML, 5 MCG/0.5 ML
- RECOMBIVAX HB (PF) INTRAMUSCULAR SYRINGE 10 MCG/ML, 5 MCG/0.5 ML
- SIMPONI ARIA INTRAVENOUS SOLUTION 12.5 MG/ML
- SIMULECT INTRAVENOUS RECON SOLN 10 MG, 20 MG
- TEMODAR INTRAVENOUS RECON SOLN 100 MG
- *temsirolimus intravenous recon soln 30 mg/3 ml (10 mg/ml) (first)*
- *tobramycin in 0.225 % nacl inhalation solution for nebulization 300 mg/5 ml*
- *toposar intravenous solution 20 mg/ml*
- *topotecan intravenous solution 4 mg/4 ml (1 mg/ml)*
- TRAVASOL 10 % INTRAVENOUS PARENTERAL SOLUTION 10 %
- TREANDA INTRAVENOUS RECON SOLN 100 MG, 25 MG
- TRODELVY INTRAVENOUS RECON SOLN 180 MG
- TROPHAMINE 10 % INTRAVENOUS PARENTERAL SOLUTION 10 %
- TYVASO INHALATION SOLUTION FOR NEBULIZATION 1.74 MG/2.9 ML (0.6 MG/ML)
- TYVASO INSTITUTIONAL START KIT INHALATION SOLUTION FOR NEBULIZATION 1.74 MG/2.9 ML
- TYVASO REFILL KIT INHALATION SOLUTION FOR NEBULIZATION 1.74 MG/2.9 ML (0.6 MG/ML)
- TYVASO STARTER KIT INHALATION SOLUTION FOR NEBULIZATION 1.74 MG/2.9 ML
- *valrubicin intravesical solution 40 mg/ml*
- *vinblastine intravenous solution 1 mg/ml*
- *vincasar pfs intravenous solution 1 mg/ml, 2 mg/2 ml*
- *vincristine intravenous solution 1 mg/ml, 2 mg/2 ml*
- *vinorelbine intravenous solution 10 mg/ml, 50 mg/5 ml*
- VYXEOS INTRAVENOUS RECON SOLN 44-100 MG
- XOPENEX CONCENTRATE INHALATION SOLUTION FOR NEBULIZATION 1.25 MG/0.5 ML
- XOPENEX INHALATION SOLUTION FOR NEBULIZATION 0.31 MG/3 ML, 0.63 MG/3 ML, 1.25 MG/3 ML
- YUPELRI INHALATION SOLUTION FOR NEBULIZATION 175 MCG/3 ML
- ZALTRAP INTRAVENOUS SOLUTION 100 MG/4 ML (25 MG/ML), 200 MG/8 ML (25 MG/ML)
- ZANOSAR INTRAVENOUS RECON SOLN 1 GRAM
- ZOLADEX SUBCUTANEOUS IMPLANT 10.8 MG, 3.6 MG
- *zoledronic acid intravenous solution 4 mg/5 ml*

- *zoledronic acid-mannitol-water*  
*intravenous piggyback 5 mg/100 ml*

- ZOLEDRONIC AC-MANNITOL-  
0.9NACL INTRAVENOUS  
PIGGYBACK 4 MG/100 ML

### **Details**

This drug 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 drug to make the determination.

## Index

### A

- ABELCET..... 12
- abiraterone..... 101, 102
- ABRAXANE ..... 13, 14
- acetylcysteine solution 100 mg/ml (10 %),  
200 mg/ml (20 %)..... 189
- ACTHAR..... 1
- ACTIMMUNE..... 2
- acyclovir sodium intravenous solution 50  
mg/ml ..... 189
- ADEMPAS ..... 3
- adriamycin intravenous recon soln 10 mg  
..... 189
- ADRIAMYCIN INTRAVENOUS RECON  
SOLN 50 MG..... 189
- adriamycin intravenous solution 10 mg/5 ml,  
2 mg/ml, 20 mg/10 ml, 50 mg/25 ml .. 189
- adrucil intravenous solution 2.5 gram/50 ml  
..... 189
- AFINITOR DISPERZ ORAL TABLET  
FOR SUSPENSION 2 MG, 3 MG, 5 MG  
..... 101, 102
- AFINITOR ORAL TABLET 10 MG, 2.5  
MG, 5 MG, 7.5 MG ..... 101, 102
- AIMOVIG AUTOINJECTOR..... 4
- albuterol sulfate inhalation solution for  
nebulization 0.63 mg/3 ml, 1.25 mg/3 ml,  
2.5 mg /3 ml (0.083 %), 2.5 mg/0.5 ml, 5  
mg/ml ..... 189
- ALDURAZYME..... 5
- ALECENSA..... 101, 102
- ALIMTA..... 13, 14
- ALIQOPA ..... 13, 14
- alosetron..... 6
- ALUNBRIG ORAL TABLET 180 MG, 30  
MG, 90 MG..... 101, 102
- ALUNBRIG ORAL TABLETS,DOSE  
PACK..... 101, 102
- alyq..... 124
- AMBISOME ..... 12
- ambrisentan ..... 96
- amikacin injection solution 1,000 mg/4 ml,  
500 mg/2 ml ..... 9, 10
- AMINOSYN II 10 % INTRAVENOUS  
PARENTERAL SOLUTION 10 % .... 189
- AMINOSYN II 15 % INTRAVENOUS  
PARENTERAL SOLUTION 15 % .... 189
- AMINOSYN-PF 10 % INTRAVENOUS  
PARENTERAL SOLUTION 10 % .... 189
- AMINOSYN-PF 7 % (SULFITE-FREE)  
INTRAVENOUS PARENTERAL  
SOLUTION 7 % ..... 189
- amphotericin b ..... 12
- ampicillin sodium..... 9, 10
- ampicillin-sulbactam..... 9, 10
- ANADROL-50..... 8
- APOKYN..... 15
- aprepitant oral capsule 125 mg, 40 mg, 80  
mg ..... 189
- aprepitant oral capsule,dose pack 125 mg  
(1)- 80 mg (2)..... 189
- ARANESP (IN POLYSORBATE)  
INJECTION SOLUTION 100 MCG/ML,  
200 MCG/ML, 25 MCG/ML, 300  
MCG/ML, 40 MCG/ML, 60 MCG/ML 16
- ARANESP (IN POLYSORBATE)  
INJECTION SYRINGE..... 16
- ARCALYST ..... 17
- ARIKAYCE..... 18
- armodafinil..... 112
- ARRANON INTRAVENOUS SOLUTION  
250 MG/50 ML ..... 189
- ARSENIC TRIOXIDE INTRAVENOUS  
SOLUTION 1 MG/ML..... 189
- arsenic trioxide intravenous solution 2  
mg/ml ..... 189
- ARZERRA INTRAVENOUS SOLUTION  
1,000 MG/50 ML, 100 MG/5 ML ..... 189
- ascomp with codeine..... 78
- ASTAGRAF XL ..... 85
- ATGAM..... 85
- AUBAGIO ..... 20
- AURYXIA ..... 21
- AUSTEDO ORAL TABLET 12 MG, 6 MG,  
9 MG ..... 22
- AVITA ..... 159
- AVONEX INTRAMUSCULAR PEN  
INJECTOR KIT ..... 23
- AVONEX INTRAMUSCULAR SYRINGE  
KIT ..... 23

AYVAKIT .....	101, 102	butalbital compound w/codeine .....	78
azacitidine injection recon soln 100 mg..	189	butalbital-acetaminop-caf-cod .....	78
AZASAN .....	85	butalbital-acetaminophen oral tablet 50-300	
azathioprine.....	85	mg, 50-325 mg.....	78
azathioprine sodium.....	85	butalbital-acetaminophen-caff oral capsule	
azithromycin intravenous.....	9, 10	.....	78
aztreonam.....	9, 10	butalbital-acetaminophen-caff oral tablet 50-	
<b>B</b>		325-40 mg .....	78
BALVERSA .....	101, 102	butalbital-aspirin-caffeine oral capsule.....	78
BAVENCIO.....	13, 14	<b>C</b>	
BELEODAQ INTRAVENOUS RECON		CABOMETYX ORAL TABLET 20 MG, 40	
SOLN 500 MG.....	189	MG, 60 MG.....	101, 102
BENDEKA INTRAVENOUS SOLUTION		CALQUENCE .....	101, 102
25 MG/ML.....	189	CAPLYTA .....	29
BENLYSTA INTRAVENOUS RECON		CAPRELSA ORAL TABLET 100 MG, 300	
SOLN 120 MG, 400 MG .....	24	MG .....	101, 102
BENLYSTA SUBCUTANEOUS.....	24	CARBAGLU.....	30
benztropine oral .....	72	carboplatin intravenous solution 10 mg/ml	
BESPONSA .....	13, 14	.....	189
BETASERON SUBCUTANEOUS KIT ..	25	carisoprodol.....	73
bexarotene .....	151	carisoprodol-aspirin .....	81
BICILLIN L-A.....	9, 10	carisoprodol-aspirin-codeine.....	81
BIVIGAM INTRAVENOUS SOLUTION		carmustine intravenous recon soln 100 mg	
10 % .....	189	.....	189
bleomycin injection recon soln 15 unit, 30		casprofungin.....	11
unit .....	189	CAYSTON.....	31
BLINCYTO INTRAVENOUS KIT 35		cefazolin in dextrose (iso-os) intravenous	
MCG .....	189	piggyback 1 gram/50 ml .....	9, 10
BORTEZOMIB.....	13, 14	cefazolin injection recon soln 100 gram, 300	
bosentan .....	161	g.....	9, 10
BOSULIF .....	101, 102	cefazolin intravenous .....	9, 10
BOTOX.....	26, 27	CEFEPIME IN DEXTROSE 5 %.....	9, 10
BRAFTOVI ORAL CAPSULE 75 MG	101,	cefepime in dextrose,iso-osm.....	9, 10
102		cefotaxime injection recon soln 1 gram	9, 10
BROVANA INHALATION SOLUTION		CEFOTETAN IN DEXTROSE, ISO-OSM9,	
FOR NEBULIZATION 15 MCG/2 ML		10	
.....	189	cefotetan injection.....	9, 10
BRUKINSA .....	101, 102	cefoxitin .....	9, 10
budesonide inhalation suspension for		cefoxitin in dextrose, iso-osm.....	9, 10
nebulization 0.25 mg/2 ml, 0.5 mg/2 ml, 1		ceftazidime.....	9, 10
mg/2 ml .....	189	CEFTAZIDIME IN D5W .....	9, 10
bupap oral tablet 50-300 mg .....	78	ceftriaxone in dextrose,iso-os .....	9, 10
busulfan intravenous solution 60 mg/10 ml		CEFTRIAZONE INJECTION RECON	
.....	189	SOLN 100 GRAM .....	9, 10
BUSULFEX INTRAVENOUS SOLUTION		ceftriaxone intravenous.....	9, 10
60 MG/10 ML.....	189		

cefuroxime sodium injection recon soln 750 mg .....	9, 10	COLISTIN (COLISTIMETHATE NA) 9, 10	
cefuroxime sodium intravenous.....	9, 10	COMETRIQ ORAL CAPSULE 100	
CELLCEPT.....	85	MG/DAY(80 MG X1-20 MG X1), 140	
CEREZYME INTRAVENOUS RECON		MG/DAY(80 MG X1-20 MG X3), 60	
SOLN 400 UNIT.....	32	MG/DAY (20 MG X 3/DAY).....	101, 102
CHEMET .....	33	COPAXONE SUBCUTANEOUS	
chlorzoxazone oral tablet 500 mg.....	81	SYRINGE 20 MG/ML, 40 MG/ML .....	38
CHORIONIC GONADOTROPIN,		COPIKTRA.....	101, 102
HUMAN INTRAMUSCULAR.....	34	CORLANOR ORAL TABLET .....	39
CIALIS ORAL TABLET 2.5 MG, 5 MG.	35	COSMEGEN INTRAVENOUS RECON	
CIMZIA .....	36	SOLN 0.5 MG.....	189
CIMZIA POWDER FOR RECONST .....	36	COTELLIC .....	101, 102
CIMZIA STARTER KIT .....	36	CRINONE VAGINAL GEL 8 % .....	40
ciprofloxacin in 5 % dextrose .....	9, 10	cromolyn inhalation solution for	
cisplatin intravenous solution 1 mg/ml...	189	nebulization 20 mg/2 ml .....	189
cladribine intravenous solution 10 mg/10 ml .....	189	cyclobenzaprine oral tablet 10 mg, 5 mg..	74
CLINDAMYCIN IN 0.9 % SOD CHLOR 9, 10		cyclobenzaprine oral tablet 7.5 mg.....	81
clindamycin in 5 % dextrose.....	9, 10	cyclophosphamide intravenous recon soln 1 gram, 2 gram, 500 mg .....	190
clindamycin phosphate injection.....	9, 10	cyclophosphamide oral capsule 25 mg, 50 mg .....	190
clindamycin phosphate intravenous solution 600 mg/4 ml.....	9, 10	cyclosporine intravenous .....	85
CLINIMIX 5%/D15W SULFITE FREE INTRAVENOUS PARENTERAL SOLUTION 5 % .....	189	cyclosporine modified.....	85
CLINIMIX 4.25%/D10W SULF FREE INTRAVENOUS PARENTERAL SOLUTION 4.25 % .....	189	cyclosporine oral capsule.....	85
CLINIMIX 4.25%/D5W SULFIT FREE INTRAVENOUS PARENTERAL SOLUTION 4.25 % .....	189	CYRAMZA.....	13, 14
CLINIMIX 5%-D20W(SULFITE-FREE) INTRAVENOUS PARENTERAL SOLUTION 5 % .....	189	CYSTARAN .....	41
CLINIMIX E 4.25%/D10W SUL FREE INTRAVENOUS PARENTERAL SOLUTION 4.25 % .....	189	cytarabine (pf) injection solution 100 mg/5 ml (20 mg/ml), 2 gram/20 ml (100 mg/ml), 20 mg/ml .....	190
CLINISOL SF 15 % INTRAVENOUS PARENTERAL SOLUTION 15 % ....	189	cytarabine injection solution 20 mg/ml..	190
clobazam oral suspension .....	37	<b>D</b>	
clobazam oral tablet.....	37	dacarbazine intravenous recon soln 100 mg, 200 mg .....	190
clofarabine intravenous solution 20 mg/20 ml .....	189	dactinomycin intravenous recon soln 0.5 mg .....	190
codeine-butalbital-asa-caff.....	78	dalfampridine .....	7
		DARZALEX.....	13, 14
		DARZALEX FASPRO SUBCUTANEOUS SOLUTION 1,800 MG-30,000 UNIT/15 ML.....	190
		daunorubicin intravenous solution 5 mg/ml .....	190
		DAURISMO ORAL TABLET 100 MG, 25 MG .....	101, 102
		decitabine intravenous recon soln 50 mg	190
		DEMSEER .....	123

DIFICID.....	43	EPIDIOLEX.....	51
docetaxel intravenous solution 160 mg/16 ml (10 mg/ml), 160 mg/8 ml (20 mg/ml), 20 mg/2 ml (10 mg/ml), 20 mg/ml (1 ml), 80 mg/4 ml (20 mg/ml), 80 mg/8 ml (10 mg/ml).....	190	epirubicin intravenous solution 200 mg/100 ml, 50 mg/25 ml.....	190
doxorubicin intravenous recon soln 50 mg .....	190	EPOGEN INJECTION SOLUTION 10,000 UNIT/ML, 2,000 UNIT/ML, 20,000 UNIT/2 ML, 20,000 UNIT/ML, 3,000 UNIT/ML, 4,000 UNIT/ML .....	52, 53
doxorubicin intravenous solution 10 mg/5 ml, 2 mg/ml, 20 mg/10 ml, 50 mg/25 ml .....	190	ERBITUX INTRAVENOUS SOLUTION 100 MG/50 ML, 200 MG/100 ML .....	190
doxorubicin, peg-liposomal intravenous suspension 2 mg/ml.....	190	ergoloid .....	77
doxy-100 .....	9, 10	ERIVEDGE.....	54
doxycycline hyclate intravenous.....	9, 10	ERLEADA.....	55
dronabinol oral capsule 10 mg, 2.5 mg, 5 mg .....	190	erlotinib oral tablet 100 mg, 150 mg, 25 mg .....	101, 102
DUAVEE .....	44	ERWINAZE INJECTION RECON SOLN 10,000 UNIT .....	190
DUPIXENT SYRINGE .....	45, 46	ERYTHROCIN INTRAVENOUS RECON SOLN 500 MG.....	9, 10
<b>E</b>		ESBRIET ORAL CAPSULE.....	56
ELAPRASE .....	47	ESBRIET ORAL TABLET 267 MG, 801 MG .....	56
ELIGARD .....	66	ETOPOPHOS INTRAVENOUS RECON SOLN 100 MG.....	190
ELIGARD (3 MONTH).....	66	etoposide intravenous solution 20 mg/ml	190
ELIGARD (4 MONTH).....	66	everolimus (antineoplastic).....	101, 102
ELIGARD (6 MONTH).....	66	everolimus (immunosuppressive) oral tablet 0.25 mg, 0.5 mg, 0.75 mg .....	85
ELLENCEN INTRAVENOUS SOLUTION 200 MG/100 ML, 50 MG/25 ML .....	190	EVOMELA .....	13, 14
ELZONRIS .....	13, 14	EXTAVIA.....	57
EMEND ORAL SUSPENSION FOR RECONSTITUTION 125 MG (25 MG/ML FINAL CONC.) .....	190	EYLEA .....	58
EMPLICITI.....	13, 14	<b>F</b>	
ENBREL MINI.....	48, 49	FANAPT ORAL TABLET.....	19
ENBREL SUBCUTANEOUS RECON SOLN .....	48, 49	FANAPT ORAL TABLETS,DOSE PACK .....	19
ENBREL SUBCUTANEOUS SYRINGE.....	48, 49	FARYDAK .....	101, 102
ENBREL SURECLICK.....	48, 49	fentanyl citrate buccal lozenge on a handle .....	162
ENGERIX-B (PF) INTRAMUSCULAR SYRINGE 20 MCG/ML .....	190	FERRIPROX.....	59
ENGERIX-B PEDIATRIC (PF) INTRAMUSCULAR SYRINGE 10 MCG/0.5 ML .....	190	FIRDAPSE.....	61
ENHERTU .....	13, 14	FIRMAGON KIT W DILUENT SYRINGE SUBCUTANEOUS RECON SOLN 120 MG, 80 MG.....	190
ENVARUSUS XR.....	85	FLEBOGAMMA DIF INTRAVENOUS SOLUTION 10 % .....	190
EPCLUSA.....	50	floxuridine injection recon soln 0.5 gram	190

fluconazole in nacl (iso-osm) intravenous  
 piggyback 200 mg/100 ml, 400 mg/200  
 ml ..... 11  
 fludarabine intravenous recon soln 50 mg  
 ..... 190  
 fludarabine intravenous solution 50 mg/2 ml  
 ..... 190  
 fluorouracil intravenous solution 1 gram/20  
 ml, 2.5 gram/50 ml, 5 gram/100 ml, 500  
 mg/10 ml ..... 190  
**FOLOTYN INTRAVENOUS SOLUTION**  
 20 MG/ML (1 ML), 40 MG/2 ML (20  
 MG/ML)..... 190  
**FORTEO**..... 62, 63  
**FREAMINE HBC 6.9 % INTRAVENOUS**  
**PARENTERAL SOLUTION 6.9 % ...** 190  
 freamine iii 10 % intravenous parenteral  
 solution 10 % ..... 190  
 fulvestrant intramuscular syringe 250 mg/5  
 ml ..... 190  
**G**  
**GAMMAGARD LIQUID INJECTION**  
**SOLUTION 10 %** ..... 190  
**GAMMAGARD S-D (IGA < 1 MCG/ML)**  
**INTRAVENOUS RECON SOLN 10**  
**GRAM, 5 GRAM**..... 190  
**GAMMAKED INJECTION SOLUTION 1**  
**GRAM/10 ML (10 %), 10 GRAM/100**  
**ML (10 %), 20 GRAM/200 ML (10 %), 5**  
**GRAM/50 ML (10 %)** ..... 190  
**GAMMAPLEX (WITH SORBITOL)**  
**INTRAVENOUS SOLUTION 5 %....** 190  
**GAMUNEX-C INJECTION SOLUTION 1**  
**GRAM/10 ML (10 %), 10 GRAM/100**  
**ML (10 %), 2.5 GRAM/25 ML (10 %),**  
**20 GRAM/200 ML (10 %), 40**  
**GRAM/400 ML (10 %), 5 GRAM/50 ML**  
**(10 %)**..... 190  
**GATTEX 30-VIAL**..... 64  
**GATTEX ONE-VIAL** ..... 64  
**GAZYVA**..... 13, 14  
 gemcitabine intravenous recon soln 1 gram,  
 2 gram, 200 mg ..... 190  
 gemcitabine intravenous solution 1  
 gram/26.3 ml (38 mg/ml), 2 gram/52.6 ml

(38 mg/ml), 200 mg/5.26 ml (38 mg/ml)  
 ..... 190  
**GEMCITABINE INTRAVENOUS**  
**SOLUTION 100 MG/ML** ..... 191  
 gengraf oral capsule 100 mg, 25 mg ..... 85  
 gengraf oral solution ..... 85  
**GENOTROPIN** ..... 67, 68  
**GENOTROPIN MINIQUICK** ..... 67, 68  
 gentamicin in nacl (iso-osm) intravenous  
 piggyback 100 mg/100 ml, 60 mg/50 ml,  
 80 mg/100 ml, 80 mg/50 ml..... 9, 10  
**GENTAMICIN IN NAACL (ISO-OSM)**  
**INTRAVENOUS PIGGYBACK 100**  
**MG/50 ML, 120 MG/100 ML** ..... 9, 10  
 gentamicin injection solution 40 mg/ml 9, 10  
 gentamicin sulfate (ped) (pf)..... 9, 10  
**GILENYA ORAL CAPSULE 0.5 MG**..... 65  
**GILOTRIF** ..... 101, 102  
 glyburide ..... 79  
 glyburide micronized ..... 79  
 glyburide-metformin ..... 80  
 granisetron (pf) intravenous solution 1  
 mg/ml (1 ml) ..... 191  
 granisetron hcl intravenous solution 1 mg/ml  
 (1 ml)..... 191  
 granisetron hcl oral tablet 1 mg ..... 191  
**H**  
**HAEGARDA** ..... 28  
**HALAVEN** ..... 69  
**HARVONI ORAL PELLETS IN PACKET**  
**33.75-150 MG, 45-200 MG** ..... 70  
**HARVONI ORAL TABLET 45-200 MG,**  
**90-400 MG**..... 70  
**HEPATAMINE 8% INTRAVENOUS**  
**PARENTERAL SOLUTION 8 %** ..... 191  
**HETLIOZ**..... 71  
**HIZENTRA SUBCUTANEOUS**  
**SOLUTION 1 GRAM/5 ML (20 %), 10**  
**GRAM/50 ML (20 %), 2 GRAM/10 ML**  
**(20 %), 4 GRAM/20 ML (20 %)** ..... 191  
**HUMIRA PEN**..... 83, 84  
**HUMIRA PEN CROHNS-UC-HS START**  
 ..... 83, 84  
**HUMIRA PEN PSOR-UVEITS-ADOL HS**  
 ..... 83, 84

HUMIRA SUBCUTANEOUS SYRINGE  
 KIT 10 MG/0.2 ML, 20 MG/0.4 ML, 40  
 MG/0.8 ML ..... 83, 84  
 HUMIRA(CF) PEDI CROHNS STARTER  
 SUBCUTANEOUS SYRINGE KIT 80  
 MG/0.8 ML, 80 MG/0.8 ML-40 MG/0.4  
 ML..... 83, 84  
 HUMIRA(CF) PEN CROHNS-UC-HS... 83,  
 84  
 HUMIRA(CF) PEN PSOR-UV-ADOL HS  
 ..... 83, 84  
 HUMIRA(CF) PEN SUBCUTANEOUS  
 PEN INJECTOR KIT 40 MG/0.4 ML. 83,  
 84  
 HUMIRA(CF) SUBCUTANEOUS  
 SYRINGE KIT 10 MG/0.1 ML, 20  
 MG/0.2 ML, 40 MG/0.4 ML ..... 83, 84

**I**  
 IBRANCE..... 101, 102  
 icatibant..... 60  
 ICLUSIG ORAL TABLET 15 MG, 45 MG  
 ..... 101, 102  
 idarubicin intravenous solution 1 mg/ml 191  
 IDHIFA..... 101, 102  
 ifosfamide intravenous recon soln 1 gram, 3  
 gram ..... 191  
 ifosfamide intravenous solution 1 gram/20  
 ml, 3 gram/60 ml..... 191  
 imatinib oral tablet 100 mg, 400 mg 101, 102  
 IMBRUVICA ORAL CAPSULE 140 MG,  
 70 MG ..... 101, 102  
 IMBRUVICA ORAL TABLET ..... 101, 102  
 IMFINZI ..... 13, 14  
 INCRELEX..... 86  
 INFUGEM INTRAVENOUS  
 PIGGYBACK 1,200 MG/120 ML (10  
 MG/ML), 1,300 MG/130 ML (10  
 MG/ML), 1,400 MG/140 ML (10  
 MG/ML), 1,500 MG/150 ML (10  
 MG/ML), 1,600 MG/160 ML (10  
 MG/ML), 1,700 MG/170 ML (10  
 MG/ML), 1,800 MG/180 ML (10  
 MG/ML), 1,900 MG/190 ML (10  
 MG/ML), 2,000 MG/200 ML (10  
 MG/ML), 2,200 MG/220 ML (10  
 MG/ML)..... 191

INLYTA ORAL TABLET 1 MG, 5 MG 101,  
 102  
 INREBIC..... 101, 102  
 INTRALIPID INTRAVENOUS  
 EMULSION 20 %, 30 % ..... 191  
 INTRAROSA..... 90  
 ipratropium bromide inhalation solution  
 0.02 % ..... 191  
 ipratropium-albuterol inhalation solution for  
 nebulization 0.5 mg-3 mg(2.5 mg base)/3  
 ml ..... 191  
 IRESSA..... 101, 102  
 irinotecan intravenous solution 100 mg/5 ml,  
 300 mg/15 ml, 40 mg/2 ml, 500 mg/25 ml  
 ..... 191  
 IXEMPRA INTRAVENOUS RECON  
 SOLN 15 MG, 45 MG ..... 191

**J**  
 JAKAFI..... 101, 102  
 JEVTANA INTRAVENOUS SOLUTION  
 10 MG/ML (FIRST DILUTION) ..... 191

**K**  
 KABIVEN INTRAVENOUS EMULSION  
 3.31-9.8-3.9 %..... 191  
 KADCYLA..... 13, 14  
 KALYDECO ORAL GRANULES IN  
 PACKET ..... 91  
 KALYDECO ORAL TABLET ..... 91  
 KANJINTI ..... 13, 14  
 KEYTRUDA INTRAVENOUS  
 SOLUTION..... 13, 14  
 KINERET ..... 92  
 KISQALI FEMARA CO-PACK ORAL  
 TABLET 200 MG/DAY(200 MG X 1)-  
 2.5 MG, 400 MG/DAY(200 MG X 2)-2.5  
 MG, 600 MG/DAY(200 MG X 3)-2.5  
 MG ..... 93  
 KISQALI ORAL TABLET 200 MG/DAY  
 (200 MG X 1), 400 MG/DAY (200 MG X  
 2), 600 MG/DAY (200 MG X 3) ..... 93  
 KORLYM ..... 94  
 KUVAN ..... 95  
 KYPROLIS INTRAVENOUS RECON  
 SOLN 10 MG, 30 MG, 60 MG..... 191

**L**

LENVIMA ORAL CAPSULE 10 MG/DAY (10 MG X 1), 12 MG/DAY (4 MG X 3), 14 MG/DAY(10 MG X 1-4 MG X 1), 18 MG/DAY (10 MG X 1-4 MG X2), 20 MG/DAY (10 MG X 2), 24 MG/DAY(10 MG X 2-4 MG X 1), 4 MG, 8 MG/DAY (4 MG X 2).....	101, 102
leuprolide subcutaneous kit.....	66
levalbuterol hcl inhalation solution for nebulization 0.31 mg/3 ml, 0.63 mg/3 ml, 1.25 mg/0.5 ml, 1.25 mg/3 ml.....	191
levofloxacin in d5w.....	9, 10
levofloxacin intravenous.....	9, 10
LIBTAYO.....	13, 14
lincomycin.....	9, 10
linezolid in dextrose 5%.....	9, 10
linezolid-0.9% sodium chloride.....	9, 10
LONSURF ORAL TABLET 15-6.14 MG, 20-8.19 MG.....	101, 102
LORBRENA ORAL TABLET 100 MG, 25 MG.....	101, 102
LUMIZYME.....	97
LUMOXITI.....	13, 14
LUPRON DEPOT.....	66
LUPRON DEPOT (3 MONTH).....	66
LUPRON DEPOT (4 MONTH).....	66
LUPRON DEPOT (6 MONTH).....	66
LUPRON DEPOT-PED (3 MONTH) INTRAMUSCULAR SYRINGE KIT 11.25 MG, 30 MG.....	66
LUPRON DEPOT-PED INTRAMUSCULAR KIT 11.25 MG, 15 MG, 7.5 MG (PED).....	66
LYNPARZA ORAL TABLET.....	101, 102

**M**

MARQIBO INTRAVENOUS KIT 5 MG/31 ML(0.16 MG/ML) FINAL.....	191
MAVYRET.....	98
megestrol oral suspension 400 mg/10 ml (10 ml), 400 mg/10 ml (40 mg/ml), 625 mg/5 ml (125 mg/ml).....	99
megestrol oral tablet.....	99
MEKINIST ORAL TABLET 0.5 MG, 2 MG.....	101, 102
MEKTOVI.....	101, 102

melphalan hcl intravenous recon soln 50 mg .....	191
melphalan oral tablet 2 mg.....	191
memantine oral capsule,sprinkle,er 24hr	106
memantine oral solution.....	106
memantine oral tablet 10 mg, 5 mg.....	106
memantine oral tablets,dose pack.....	106
mesna intravenous solution 100 mg/ml ..	191
metaxalone.....	81
methamphetamine.....	100
methocarbamol oral.....	81
metro i.v.....	9, 10
metronidazole in nacl (iso-os).....	9, 10
mitomycin intravenous recon soln 20 mg, 40 mg, 5 mg.....	191
mitoxantrone intravenous concentrate 2 mg/ml.....	191
modafinil oral tablet 100 mg, 200 mg.....	112
MORPHINE INTRAVENOUS SYRINGE 10 MG/ML.....	191
MOXIFLOXACIN-SOD.ACE,SUL- WATER.....	9, 10
moxifloxacin-sod.chloride(iso).....	9, 10
MVASI.....	13, 14
mycophenolate mofetil.....	85
mycophenolate mofetil (hcl).....	85
mycophenolate sodium.....	85
MYFORTIC.....	85
MYLOTARG.....	13, 14

**N**

nafcillin.....	9, 10
nafcillin in dextrose iso-osm.....	9, 10
NAGLAZYME.....	103
NAMENDA ORAL TABLET 10 MG, 5 MG.....	106
NAMENDA TITRATION PAK.....	106
NAMENDA XR ORAL CAP,SPRINKLE,ER 24HR DOSE PACK .....	106
NAMENDA XR ORAL CAPSULE,SPRINKLE,ER 24HR.....	106
NAMZARIC.....	106
NATPARA.....	104
NAYZILAM.....	105
NEBUPENT INHALATION RECON SOLN 300 MG.....	191

NEORAL .....	85	orphenadrine citrate oral .....	81
NEPHRAMINE 5.4 % INTRAVENOUS		OSPHERA .....	121
PARENTERAL SOLUTION 5.4 % ...	191	oxacillin injection.....	9, 10
NERLYNX .....	101, 102	oxaliplatin intravenous recon soln 100 mg,	
NEXAVAR.....	101, 102	50 mg .....	191
NINLARO.....	101, 102	oxaliplatin intravenous solution 100 mg/20	
NIPENT INTRAVENOUS RECON SOLN		ml, 50 mg/10 ml (5 mg/ml).....	191
10 MG .....	191	oxandrolone oral tablet 10 mg, 2.5 mg .....	8
NORTHERA ORAL CAPSULE 100 MG,		<b>P</b>	
200 MG, 300 MG.....	107	paclitaxel intravenous concentrate 6 mg/ml	
NOVAREL .....	34	.....	191
NUBEQA.....	108	PADCEV.....	13, 14
NUEDEXTA.....	109	paliperidone oral tablet extended release	
NULOJIX.....	110	24hr 1.5 mg, 3 mg, 6 mg, 9 mg.....	19
NUPLAZID ORAL CAPSULE.....	111	palonosetron intravenous solution 0.25 mg/5	
NUPLAZID ORAL TABLET 10 MG....	111	ml .....	191
NUTRILIPID INTRAVENOUS		PEMAZYRE .....	101, 102
EMULSION 20 %.....	191	penicillin g potassium .....	9, 10
NUZYRA INTRAVENOUS .....	9, 10	pentamidine inhalation recon soln 300 mg	
<b>O</b>		.....	191
OCALIVA.....	113	PERFORMIST INHALATION	
OCREVUS.....	114	SOLUTION FOR NEBULIZATION 20	
OCTAGAM INTRAVENOUS SOLUTION		MCG/2 ML .....	191
10 %, 5 %.....	191	PERIKABIVEN INTRAVENOUS	
octreotide acetate .....	115	EMULSION 2.36-6.8-3.5 %.....	192
ODOMZO .....	116	PERJETA.....	13, 14
OFEV .....	117	pfizerpen-g.....	9, 10
OGIVRI.....	13, 14	phenobarbital oral elixir.....	76
ONCASPAR INJECTION SOLUTION 750		phenobarbital oral tablet .....	76
UNIT/ML.....	191	PIPERACILLIN-TAZOBACTAM	
ondansetron hcl oral solution 4 mg/5 ml.	191	INTRAVENOUS RECON SOLN 13.5	
ondansetron hcl oral tablet 24 mg, 4 mg,		GRAM.....	9, 10
mg .....	191	PIQRAY.....	101, 102
ondansetron oral tablet, disintegrating 4 mg,		PLENAMINE INTRAVENOUS	
8 mg .....	191	PARENTERAL SOLUTION 15 % ....	192
ONIVYDE .....	13, 14	POLIVY .....	13, 14
OPDIVO .....	13, 14	polymyxin b sulfate.....	9, 10
OPSUMIT .....	118	POMALYST .....	101, 102
ORBACTIV .....	9, 10	PORTRAZZA INTRAVENOUS	
ORENCIA CLICKJECT.....	119	SOLUTION 800 MG/50 ML (16	
ORENCIA SUBCUTANEOUS SYRINGE		MG/ML).....	192
125 MG/ML, 50 MG/0.4 ML, 87.5		potassium chloride-d5-0.3%nacl intravenous	
MG/0.7 ML .....	119	parenteral solution 20 meq/l.....	192
ORKAMBI ORAL GRANULES IN		POTELIGEO.....	13, 14
PACKET.....	120	PREGNYL .....	34
ORKAMBI ORAL TABLET .....	120		

PREMASOL 10 % INTRAVENOUS	
PARENTERAL SOLUTION 10 % ....	192
PRIVIGEN INTRAVENOUS SOLUTION	
10 % .....	192
PROCALAMINE 3% INTRAVENOUS	
PARENTERAL SOLUTION 3 % .....	192
PROCRIT INJECTION SOLUTION 10,000	
UNIT/ML, 2,000 UNIT/ML, 20,000	
UNIT/2 ML, 20,000 UNIT/ML, 3,000	
UNIT/ML, 4,000 UNIT/ML, 40,000	
UNIT/ML .....	52, 53
PROGRAF .....	85
PROLASTIN-C.....	125
PROLEUKIN INTRAVENOUS RECON	
SOLN 22 MILLION UNIT.....	192
PROMACTA ORAL POWDER IN	
PACKET 12.5 MG, 25 MG .....	126, 127
PROMACTA ORAL TABLET 12.5 MG, 25	
MG, 50 MG, 75 MG .....	126, 127
promethazine oral.....	75
PROSOL 20 % INTRAVENOUS	
PARENTERAL SOLUTION.....	192
PROVIGIL ORAL TABLET 100 MG, 200	
MG .....	112
PULMICORT INHALATION	
SUSPENSION FOR NEBULIZATION	
0.25 MG/2 ML, 0.5 MG/2 ML, 1 MG/2	
ML.....	192
PULMOZYME INHALATION	
SOLUTION 1 MG/ML .....	192
pyrimethamine .....	128
<b>Q</b>	
QINLOCK.....	101, 102
<b>R</b>	
RAPAMUNE .....	85
REBIF (WITH ALBUMIN) .....	129
REBIF REBIDOSE SUBCUTANEOUS	
PEN INJECTOR 22 MCG/0.5 ML, 44	
MCG/0.5 ML, 8.8MCG/0.2ML-22	
MCG/0.5ML (6).....	129
REBIF TITRATION PACK .....	129
RECOMBIVAX HB (PF)	
INTRAMUSCULAR SUSPENSION 10	
MCG/ML, 40 MCG/ML, 5 MCG/0.5 ML	
.....	192
RECOMBIVAX HB (PF)	
INTRAMUSCULAR SYRINGE 10	
MCG/ML, 5 MCG/0.5 ML .....	192
REGRANEX.....	42
RELISTOR SUBCUTANEOUS	
SOLUTION.....	130
RELISTOR SUBCUTANEOUS SYRINGE	
.....	130
RENFLEXIS .....	87, 88, 89
REPATHA .....	131, 132
REPATHA PUSHTRONEX.....	131, 132
REPATHA SURECLICK.....	131, 132
RETACRIT .....	52, 53
RETEVMO .....	101, 102
REVLIMID.....	133
RINVOQ.....	135
ROZLYTREK ORAL CAPSULE 100 MG,	
200 MG .....	136
RUBRACA .....	101, 102
RUXIENCE .....	13, 14
RYDAPT.....	101, 102
<b>S</b>	
SAMSCA ORAL TABLET 15 MG, 30 MG	
.....	137
SANDIMMUNE ORAL SOLUTION .....	85
SANDOSTATIN LAR DEPOT	
INTRAMUSCULAR	
SUSPENSION,EXTENDED REL	
RECON.....	138
SARCLISA .....	13, 14
SIGNIFOR .....	139
sildenafil (pulmonary arterial hypertension)	
oral tablet .....	124
SIMPONI ARIA INTRAVENOUS	
SOLUTION 12.5 MG/ML .....	192
SIMPONI SUBCUTANEOUS PEN	
INJECTOR 100 MG/ML, 50 MG/0.5 ML	
.....	140
SIMPONI SUBCUTANEOUS SYRINGE	
100 MG/ML, 50 MG/0.5 ML .....	140
SIMULECT INTRAVENOUS RECON	
SOLN 10 MG, 20 MG .....	192
sirolimus.....	85
SIRTURO ORAL TABLET 100 MG.....	141
SIVEXTRO INTRAVENOUS .....	9, 10

SKYRIZI SUBCUTANEOUS SYRINGE KIT.....	142	MG/ML), 840 MG/14 ML (60 MG/ML) .....	13, 14
sodium phenylbutyrate.....	122	TECFIDERA ORAL CAPSULE,DELAYED	
SOMATULINE DEPOT.....	143	RELEASE(DR/EC) 120 MG, 120 MG (14)- 240 MG (46), 240 MG.....	153
SOMAVERT.....	144	TEFLARO.....	9, 10
SPRYCEL ORAL TABLET 100 MG, 140 MG, 20 MG, 50 MG, 70 MG, 80 MG 101, 102		TEMODAR INTRAVENOUS RECON SOLN 100 MG.....	192
STELARA INTRAVENOUS.....	145	temsirolimus intravenous recon soln 30 mg/3 ml (10 mg/ml) (first).....	192
STELARA SUBCUTANEOUS SOLUTION.....	145	tencon oral tablet 50-325 mg .....	78
STELARA SUBCUTANEOUS SYRINGE 45 MG/0.5 ML, 90 MG/ML .....	145	TERIPARATIDE .....	154, 155
STIVARGA .....	101, 102	tetrabenazine oral tablet 12.5 mg, 25 mg	180
STREPTOMYCIN.....	9, 10	THALOMID ORAL CAPSULE 100 MG, 150 MG, 200 MG, 50 MG .....	156
sulfamethoxazole-trimethoprim intravenous .....	9, 10	thiotepa.....	13, 14
SUTENT .....	101, 102	TIBSOVO .....	101, 102
SYLATRON SUBCUTANEOUS KIT 200 MCG, 300 MCG .....	146	TIGECYCLINE .....	9, 10
SYMDEKO.....	147	tobramycin in 0.225 % nacl inhalation solution for nebulization 300 mg/5 ml	192
SYMLINPEN 120.....	148	tobramycin sulfate.....	9, 10
SYMLINPEN 60.....	148	TOPAMAX.....	160
SYMPAZAN.....	37	topiramate oral capsule, sprinkle .....	160
SYNAGIS .....	149	topiramate oral tablet .....	160
SYNERCID.....	9, 10	toposar intravenous solution 20 mg/ml...	192
SYNRIBO .....	101, 102	topotecan intravenous solution 4 mg/4 ml (1 mg/ml).....	192
<b>T</b>		TRAVASOL 10 % INTRAVENOUS PARENTERAL SOLUTION 10 % ....	192
TABRECTA .....	101, 102	TRAZIMERA .....	13, 14
tacrolimus oral .....	85	TREANDA INTRAVENOUS RECON SOLN 100 MG, 25 MG .....	192
tacrolimus topical.....	158	TRELSTAR INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION .....	163
tadalafil (pulm. hypertension).....	124	tretinoin microspheres.....	159
tadalafil oral tablet 2.5 mg, 5 mg .....	35	tretinoin topical .....	159
TAFINLAR.....	101, 102	trientine .....	164
TAGRISO .....	101, 102	trihexyphenidyl .....	82
TALTZ SYRINGE.....	150	TRIPTODUR .....	66
TALZENNA ORAL CAPSULE 0.25 MG, 1 MG .....	101, 102	TRODELVY INTRAVENOUS RECON SOLN 180 MG.....	192
TARGRETIN TOPICAL .....	152	TROKENDI XR.....	160
TASIGNA ORAL CAPSULE 150 MG, 200 MG, 50 MG.....	101, 102	TROPHAMINE 10 % INTRAVENOUS PARENTERAL SOLUTION 10 % ....	192
tazicef.....	9, 10		
TAZVERIK.....	101, 102		
TECENTRIQ INTRAVENOUS SOLUTION 1,200 MG/20 ML (60			

TRUXIMA .....	13, 14	voriconazole intravenous .....	11
TUKYSA ORAL TABLET 150 MG, 50		VOSEVI.....	176
MG .....	102	VOTRIENT.....	102
TURALIO.....	165	VRAYLAR ORAL CAPSULE.....	19
TYKERB.....	102	VRAYLAR ORAL CAPSULE,DOSE	
TYMLOS .....	166	PACK.....	19
TYSABRI .....	167, 168	VYXEOS INTRAVENOUS RECON SOLN	
TYVASO INHALATION SOLUTION FOR		44-100 MG.....	192
NEBULIZATION 1.74 MG/2.9 ML (0.6		<b>X</b>	
MG/ML).....	192	XALKORI.....	102
TYVASO INSTITUTIONAL START KIT		XATMEP .....	177
INHALATION SOLUTION FOR		XCOPRI.....	178
NEBULIZATION 1.74 MG/2.9 ML ..	192	XCOPRI MAINTENANCE PACK.....	178
TYVASO REFILL KIT INHALATION		XCOPRI TITRATION PACK.....	178
SOLUTION FOR NEBULIZATION 1.74		XELJANZ.....	179
MG/2.9 ML (0.6 MG/ML).....	192	XELJANZ XR .....	179
TYVASO STARTER KIT INHALATION		XGEVA.....	181
SOLUTION FOR NEBULIZATION 1.74		XIAFLEX .....	182
MG/2.9 ML.....	192	XIFAXAN ORAL TABLET 200 MG, 550	
<b>U</b>		MG .....	183
UNITUXIN.....	13, 14	XOLAIR SUBCUTANEOUS RECON	
UPTRAVI.....	169	SOLN .....	184, 185
<b>V</b>		XOLAIR SUBCUTANEOUS SYRINGE	
valrubicin intravesical solution 40 mg/ml	192	150 MG/ML, 75 MG/0.5 ML .....	184, 185
VALTOCO .....	170	XOPENEX CONCENTRATE	
vancomycin oral capsule 125 mg, 250 mg		INHALATION SOLUTION FOR	
.....	171	NEBULIZATION 1.25 MG/0.5 ML ..	192
VECTIBIX.....	13, 14	XOPENEX INHALATION SOLUTION	
VELCADE.....	13, 14	FOR NEBULIZATION 0.31 MG/3 ML,	
VENCLEXTA ORAL TABLET 10 MG,		0.63 MG/3 ML, 1.25 MG/3 ML .....	192
100 MG, 50 MG.....	102	XOSPATA .....	102
VENCLEXTA STARTING PACK.....	102	XPROVIO ORAL TABLET 100 MG/WEEK	
VENTAVIS.....	172	(20 MG X 5), 60 MG/WEEK (20 MG X	
VERZENIO.....	173	3), 80 MG/WEEK (20 MG X 4), 80MG	
VIBERZI.....	174	TWICE WEEK (160 MG/WEEK).....	102
vinblastine intravenous solution 1 mg/ml	192	XTANDI .....	102
vincasar pfs intravenous solution 1 mg/ml, 2		XYREM .....	186
mg/2 ml .....	192	<b>Y</b>	
vincristine intravenous solution 1 mg/ml, 2		YERVOY INTRAVENOUS SOLUTION	
mg/2 ml .....	192	200 MG/40 ML (5 MG/ML), 50 MG/10	
vinorelbine intravenous solution 10 mg/ml,		ML (5 MG/ML) .....	13, 14
50 mg/5 ml .....	192	YONDELIS.....	13, 14
VITRAKVI ORAL CAPSULE 100 MG, 25		YUPELRI INHALATION SOLUTION	
MG .....	175	FOR NEBULIZATION 175 MCG/3 ML	
VITRAKVI ORAL SOLUTION .....	175	.....	192
VIZIMPRO .....	102		

**Z**

ZALTRAP INTRAVENOUS SOLUTION 100 MG/4 ML (25 MG/ML), 200 MG/8 ML (25 MG/ML) .....	192
ZANOSAR INTRAVENOUS RECON SOLN 1 GRAM .....	192
ZEJULA .....	102
ZELBORAF .....	102
ZIRABEV .....	13, 14
ZOLADEX SUBCUTANEOUS IMPLANT 10.8 MG, 3.6 MG.....	192
zoledronic acid intravenous solution 4 mg/5 ml .....	192

zoledronic acid-mannitol-water intravenous piggyback 5 mg/100 ml .....	193
ZOLEDRONIC AC-MANNITOL-0.9NACL INTRAVENOUS PIGGYBACK 4 MG/100 ML .....	193
ZOLINZA .....	187
zonisamide .....	160
ZORTRESS ORAL TABLET 1 MG.....	85
ZYDELIG .....	102
ZYKADIA ORAL TABLET .....	102
ZYPREXA RELPREVV INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION 210 MG, 300 MG, 405 MG.....	188