Prior Authorization Criteria
Last Updated: November 15, 2024
Effective Date: January 1, 2025

2025 **Prior Authorizations**

(List of Prior Authorizations)

PLEASE READ CAREFULLY: THIS DOCUMENT CONTAINS INFORMATION ABOUT THE PRIOR AUTHORIZATIONS ON DRUGS THAT WE COVER IN THIS PLAN.

Note to existing members: Beneficiaries must use network pharmacies to access their prescription drug benefit. "Benefits, List of Covered Drugs, pharmacy and provider networks and copayments may change from time to time throughout the year and on January 1 of each year."

IEHP DualChoice (HMO D-SNP) is an HMO Plan with a Medicare contract. Enrollment in IEHP DualChoice (HMO D-SNP) depends on contract renewal.

You can get this document for free in other formats, such as large print, braille, and/or audio. Call IEHP DualChoice Member Services at 1-877-273-IEHP (4347), 8am-8pm (PST), 7 days a week, including holidays. TTY users should call 1-800-718-4347. The call is free.

Puede obtener este documento gratis en otros formatos, como letra grande, Braille y/o audio. Llame a Servicios para Miembros de IEHP DualChoice al 1-877-273-IEHP (4347), 8am a 8pm (Hora del Pacífico), los 7 días de la semana, incluidos los días festivos. Los usuarios de TTY deben llamar al 1-800-718-4347. La llamada es gratuita.

您可以免費索取本文件的其他格式，例如大字版、盲文版和/或音訊版。請致電1-877-273-IEHP (4347) 與IEHP DualChoice會員服務處聯絡。服務時間為上午8點至晚上8點（太平洋標準時間），每週7天，包括節假日。TTY使用者應撥打1-800-718-4347。電話服務免費。

Quý vị có thể tải miễn phí tài liệu này ở các định dạng khác, chẳng hạn như bản in cỡ lớn, chữ nổi Braille và/hoặc tệp âm thanh. Hãy gọi Ban Dịch Vụ Hội Viên IEHP DualChoice theo số 1-877-273-IEHP (4347), 8 giờ sáng - 8 giờ tối (Múi giờ PST), 7 ngày ngày trong tuần, kể cả các ngày lễ. Người dùng TTY vui lòng gọi số 1-800-718-4347. Miễn phí cước gọi.

ABELCET

Products Affected

- ABELCET

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Subject to Part B vs Part D determination. Failure or clinically significant adverse effects to the formulary alternative: conventional Amphotericin B.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

ABILIFY MAINTENA

Products Affected

- ABILIFY ASIMTUFII INTRAMUSCULAR SUSPENSION,EXTENDED REL SYRING 720 MG/2.4 ML, 960 MG/3.2 ML
- ABILIFY MAINTENA INTRAMUSCULAR SUSPENSION,EXTENDED REL RECON 300 MG, 400 MG
- ABILIFY MAINTENA INTRAMUSCULAR SUSPENSION,EXTENDED REL SYRING

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documented history of receiving oral aripiprazole without any clinically significant side effects.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to two of the formulary alternatives: Invega Sustenna, Invega Trinza or Risperdal Consta.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

ACITRETIN

Products Affected

- *acitretin*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Dermatologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to two of the formulary alternatives: calcipotriene, clobetasol, cyclosporine, fluocinonide, methotrexate, or Tazorac.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

ACTIMMUNE

Products Affected

- ACTIMMUNE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Endocrinologist, Hematologist, Infectious Disease specialist, Immunologist, Oncologist, Orthopedist, Rheumatologist
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

ADEFOVIR

Products Affected

- *adefovir*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Gastroenterologist, Hepatologist, Infectious Disease specialist
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

ADHD

Products Affected

- *dexmethylphenidate oral tablet*
- *methylphenidate hcl oral capsule, er biphasic 30-70*
- *methylphenidate hcl oral capsule,er biphasic 50-50*
- *methylphenidate hcl oral solution*
- *methylphenidate hcl oral tablet*
- *methylphenidate hcl oral tablet extended release*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

AIMOVIG

Products Affected

- AIMOVIG AUTOINJECTOR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Neurologist, Headache Specialist, Pain Specialist
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to one of the formulary alternatives: divalproex, valproic acid, or topiramate and failure or clinically significant adverse effects to one of the formulary alternatives: metoprolol, timolol, propranolol.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

ALOSETRON

Products Affected

- *alosetron*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Irritable bowel syndrome with diarrhea: Failure or clinically significant adverse effects to the formulary alternative: loperamide.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

AMBISOME

Products Affected

- AMBISOME
- *amphotericin b liposome*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Subject to Part B vs Part D determination. Failure or clinically significant adverse effects to the formulary alternative: conventional Amphotericin B.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

AMITRIPTYLINE

Products Affected

- *amitriptyline*
- *amitriptyline-chlordiazepoxide oral tablet 12.5-5 mg, 25-10 mg*
- *perphenazine-amitriptyline*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Approve if less than 65 years of age. If aged 65 years and older, prior authorization criteria will apply.
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Depression: Failure or clinically significant adverse effects to two of the formulary alternatives: citalopram, escitalopram, fluoxetine, sertraline, venlafaxine, desvenlafaxine, duloxetine, mirtazapine, or bupropion
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

AMOXAPINE

Products Affected

- *amoxapine*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Approve if less than 65 years of age. If aged 65 years and older, prior authorization criteria will apply.
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to two of the formulary alternatives: citalopram, escitalopram, fluoxetine, sertraline, venlafaxine, desvenlafaxine, duloxetine, mirtazapine, or bupropion
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

AMPHOTERICIN B

Products Affected

- *amphotericin b*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Subject to Part B vs Part D determination.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

ANTICONVULSANTS 1

Products Affected

- APTIOM ORAL TABLET 200 MG, 400 MG, 600 MG, 800 MG
- EPIDIOLEX
- FYCOMPA ORAL SUSPENSION
- FYCOMPA ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Neurologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to one of the formulary alternatives: carbamazepine, clonazepam, divalproex, ethosuximide, felbamate, gabapentin, lamotrigine, levetiracetam, lorazepam, oxcarbazepine, phenytoin, tiagabine, topiramate, valproic acid or zonisamide.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

ANTICONVULSANTS 2

Products Affected

- *clobazam oral suspension*
- *clobazam oral tablet*
- DIACOMIT
- FINTEPLA
- MOTPOLY XR ORAL CAPSULE,EXTENDED RELEASE 24HR 100 MG, 150 MG, 200 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Neurologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Clobazam, Fenfluramine, or Stiripentol: Must be used as adjunctive treatment of seizure. Lacosamide: For partial seizure: Failure or clinically significant adverse effects to two of the following: carbamazepine, divalproex, felbamate, gabapentin, levetiracetam, oxcarbazepine, phenytoin, tiagabine, topiramate, valproic acid or zonisamide. For tonic-clonic seizure: Failure or clinically significant adverse effects to two of the following: lamotrigine, levetiracetam, phenytoin, or topiramate.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

ANTINEOPLASTIC

Products Affected

- *abiraterone oral tablet 250 mg, 500 mg*
- AFINITOR DISPERZ ORAL TABLET FOR SUSPENSION 2 MG
- AKEEGA
- ALECENSA
- ALUNBRIG
- AUGTYRO ORAL CAPSULE 40 MG
- AYVAKIT ORAL TABLET 100 MG, 200 MG, 25 MG, 300 MG, 50 MG
- BALVERSA ORAL TABLET 3 MG, 4 MG, 5 MG
- BESREMI
- BOSULIF
- BRAFTOVI
- BRUKINSA
- CABOMETYX
- CALQUENCE (ACALABRUTINIB MAL)
- CAPRELSA
- COMETRIQ
- COPIKTRA
- COTELLIC
- *dasatinib oral tablet 100 mg, 140 mg, 20 mg, 50 mg, 70 mg, 80 mg*
- DAURISMO ORAL TABLET 100 MG, 25 MG
- ERIVEDGE
- ERLEADA ORAL TABLET 240 MG, 60 MG
- *erlotinib oral tablet 100 mg, 150 mg, 25 mg*
- *everolimus (antineoplastic) oral tablet*
- *everolimus (antineoplastic) oral tablet for suspension 3 mg, 5 mg*
- EXKIVITY
- FOTIVDA
- FRUZAQLA ORAL CAPSULE 1 MG, 5 MG
- GAVRETO
- *gefitinib*
- GILOTRIF
- GLEOSTINE
- IBRANCE
- ICLUSIG ORAL TABLET 10 MG, 15 MG, 30 MG, 45 MG
- IDHIFA
- *imatinib oral tablet 100 mg, 400 mg*
- IMBRUVICA ORAL CAPSULE 140 MG, 70 MG
- IMBRUVICA ORAL SUSPENSION
- IMBRUVICA ORAL TABLET 140 MG, 280 MG, 420 MG
- INLYTA ORAL TABLET 1 MG, 5 MG
- INQOVI
- INREBIC
- IRESSA
- ITOVEBI ORAL TABLET 3 MG, 9 MG
- IWILFIN
- JAKAFI
- JAYPIRCA ORAL TABLET 100 MG, 50 MG
- KISQALI FEMARA CO-PACK
- KISQALI ORAL TABLET 200 MG/DAY (200 MG X 1), 400 MG/DAY (200 MG X 2), 600 MG/DAY (200 MG X 3)
- KOSELUGO ORAL CAPSULE 10 MG, 25 MG
- KRAZATI
- *lapatinib*
- LAZCLUZE ORAL TABLET 240 MG, 80 MG
- *lenalidomide*
- 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
- LORBRENA ORAL TABLET 100 MG, 25 MG
- LUMAKRAS ORAL TABLET 120 MG, 320 MG

- LYNPARZA
- LYTGOBI ORAL TABLET 12 MG/DAY (4 MG X 3), 16 MG/DAY (4 MG X 4), 20 MG/DAY (4 MG X 5)
- MATULANE
- MEKINIST ORAL RECON SOLN
- MEKINIST ORAL TABLET 0.5 MG, 2 MG
- MEKTOVI
- NERLYNX
- NEXAVAR
- NINLARO
- NUBEQA
- ODOMZO
- OGSIVEO ORAL TABLET 100 MG, 150 MG, 50 MG
- OJEMDA ORAL SUSPENSION FOR RECONSTITUTION
- OJEMDA ORAL TABLET
- OJJAARA ORAL TABLET 100 MG, 150 MG, 200 MG
- ONUREG
- ORGOVYX
- ORSERDU ORAL TABLET 345 MG, 86 MG
- PANRETIN
- *pazopanib*
- PEMAZYRE
- PIQRAY ORAL TABLET 200 MG/DAY (200 MG X 1), 250 MG/DAY (200 MG X1-50 MG X1), 300 MG/DAY (150 MG X 2)
- POMALYST
- PURIXAN
- QINLOCK
- RETEVMO ORAL CAPSULE 40 MG, 80 MG
- RETEVMO ORAL TABLET 120 MG, 160 MG, 40 MG, 80 MG
- REVLIMID
- REZLIDHIA
- ROZLYTREK ORAL CAPSULE 100 MG, 200 MG
- ROZLYTREK ORAL PELLETS IN PACKET
- RUBRACA
- RYDAPT
- SCEMBLIX ORAL TABLET 100 MG, 20 MG, 40 MG
- *sorafenib*
- SPRYCEL ORAL TABLET 100 MG, 140 MG, 20 MG, 50 MG, 70 MG, 80 MG
- STIVARGA
- *sunitinib malate*
- SUTENT
- TABLOID
- TABRECTA
- TAFINLAR
- TAGRISSO
- TALZENNA ORAL CAPSULE 0.1 MG, 0.25 MG, 0.35 MG, 0.5 MG, 0.75 MG, 1 MG
- TASIGNA
- TAZVERIK
- TEPMETKO
- THALOMID
- TIBSOVO
- *torpenz*
- TRUQAP
- TUKYSA ORAL TABLET 150 MG, 50 MG
- TURALIO ORAL CAPSULE 125 MG, 200 MG
- VANFLYTA
- VENCLEXTA
- VENCLEXTA STARTING PACK
- VERZENIO
- VITRAKVI ORAL CAPSULE 100 MG, 25 MG
- VITRAKVI ORAL SOLUTION
- VIZIMPRO
- VONJO
- VORANIGO ORAL TABLET 10 MG, 40 MG
- VOTRIENT
- WELIREG
- XALKORI ORAL CAPSULE
- XALKORI ORAL PELLET 150 MG, 20 MG, 50 MG
- XERMELO
- XOSPATA

- XPOVIO ORAL TABLET 100 MG/WEEK (50 MG X 2), 40 MG/WEEK (40 MG X 1), 40MG TWICE WEEK (40 MG X 2), 60 MG/WEEK (60 MG X 1), 60MG TWICE WEEK (120 MG/WEEK), 80 MG/WEEK (40 MG X 2), 80MG TWICE WEEK (160 MG/WEEK)
- XTANDI
- YONSA
- ZEJULA ORAL TABLET 100 MG, 200 MG, 300 MG
- ZELBORAF
- ZOLINZA
- ZYDELIG
- ZYKADIA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

APREPITANT

Products Affected

- *aprepitant*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months.
Other Criteria	Subject to Part B vs Part D determination. Failure or clinically significant adverse effects to one of the formulary 5-HT3 antagonist alternatives: ondansetron or granisetron except when the member is on any chemotherapy.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

ARCALYST

Products Affected

- ARCALYST

PA Criteria	Criteria Details
Exclusion Criteria	Concurrently taking any tumor necrosis factor (TNF)-blocking agents such as Enbrel, Humira, or Remicade.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

ARIKAYCE

Products Affected

- ARIKAYCE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation: positive sputum cultures after a minimum of 6 consecutive months of a multidrug background regimen therapy.
Age Restrictions	
Prescriber Restrictions	Infectious Disease specialist, Pulmonologist
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

ARMODAFINIL

Products Affected

- *armodafinil*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Narcolepsy: Failure or clinically significant adverse effects to all of the formulary alternatives: dextroamphetamine and methylphenidate.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

ATOVAQUONE

Products Affected

- *atovaquone*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Pneumocystic pneumonia: Failure or clinically significant adverse effects to the formulary alternative: trimethoprim/sulfamethoxazole.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

AUBAGIO

Products Affected

- AUBAGIO
- *teriflunomide*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Neurologist
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

AUSTEDO

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	Concurrent use with an MAOI. Untreated or inadequately-treated depression, or current suicidality in patients with Huntington disease.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Neurologist, Psychiatrist
Coverage Duration	Until the end of calendar year.
Other Criteria	Chorea (Huntington's Disease): Failure or clinically significant adverse effects to the formulary alternative: tetrabenazine. Reauthorization only: Documentation of positive response to medication therapy.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

AUVELITY

Products Affected

- AUVELITY

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Depression: Failure or clinically significant adverse effects to two of the formulary alternatives: citalopram, escitalopram, fluoxetine, sertraline, venlafaxine, desvenlafaxine, duloxetine, mirtazapine, or bupropion.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

BRONCHITOL

Products Affected

- BRONCHITOL

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	New: Documentation that patient has passed the BRONCHITOL Tolerance Test (BTT). Reauthorization only: Documentation of positive response to medication therapy (improvement in lung function as determined by change in FEV1).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

CASPOFUNGIN

Products Affected

- *caspofungin*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

CIMZIA

Products Affected

- CIMZIA
- CIMZIA POWDER FOR RECONST

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Rheumatologist, Dermatologist, or Gastroenterologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Rheumatoid Arthritis: Failure or clinically significant adverse effects to two of the formulary alternatives: Enbrel, Humira, Rinvoq, or Xeljanz IR/XR. Crohn's Disease: Failure or clinically significant adverse effects to two of the formulary alternatives: Humira, Stelara, or Skyrizi. Psoriatic arthritis: Failure or clinically significant adverse effects to two of the formulary alternatives: Enbrel, Humira, Stelara, Xeljanz IR/XR, Rinvoq, or Skyrizi. Ankylosing spondylitis: Failure or clinically significant adverse effects to two of the formulary alternatives: Enbrel, Humira, Rinvoq, or Xeljanz IR/XR. Non-radiographic Axial Spondyloarthritis: Failure or clinically significant adverse effects to the formulary alternative: Cosentyx. Plaque psoriasis: Failure or clinically significant adverse effects to two of the formulary alternatives: Humira, Stelara, Enbrel, or Skyrizi.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

CLOMIPRAMINE

Products Affected

- *clomipramine*

PA Criteria	Criteria Details
Exclusion Criteria	Any of the following: Concomitant use of an MAOI, or Use within 14 days of discontinuing an MAOI, or Concomitant use of linezolid, or Concomitant use of intravenous methylene blue, or Use during the acute recovery period after a myocardial infarction.
Required Medical Information	
Age Restrictions	Approve if less than 65 years of age. If aged 65 years and older, prior authorization criteria will apply.
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Obsessive-Compulsive Disorder: Failure or clinically significant adverse effects to two of the formulary alternatives: fluoxetine, fluvoxamine, or sertraline.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

CONSTIPATION AGENTS

Products Affected

- MOVANTIK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to one of the formulary alternatives: lactulose or polyethylene glycol.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

CORLANOR

Products Affected

- CORLANOR ORAL SOLUTION
- CORLANOR ORAL TABLET
- *ivabradine*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Heart failure in adult patients: Documented New York Association (NYHA) class II to IV heart failure with an ejection fraction of less than or equal to 35% and sinus rhythm with a resting heart rate greater than or equal to 70 beats per minute (bpm). Documentation that patient is on maximally tolerated dose of beta blocker or has a history of a documented intolerance, contraindication or a hypersensitivity to beta blocker. Documented concurrent use with an ACE inhibitor or ARB, unless both are not tolerated or contraindicated. Heart failure in pediatric patients: Documented NYHA/Ross class II to IV heart failure with an ejection fraction of less than or equal to 45% and sinus rhythm with a resting heart rate greater than or equal to 105 bpm in the age subset 6-12 months, greater than or equal to 95 bpm in the age subset 1-3 years, greater than or equal to 75 bpm in the age subset 3-5 years, greater than or equal to 70 bpm in the age subset 5-18 years
Age Restrictions	
Prescriber Restrictions	Cardiologist
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

COSENTYX

Products Affected

- COSENTYX (2 SYRINGES)
- COSENTYX PEN (2 PENS)
- COSENTYX SUBCUTANEOUS SYRINGE 75 MG/0.5 ML
- COSENTYX UNOREADY PEN

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Plaque psoriasis: documentation of psoriasis of greater than 3% BSA or affecting crucial body areas such as hands, feet, face or genitals.
Age Restrictions	
Prescriber Restrictions	Dermatologist, Rheumatologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Ankylosing spondylitis: For adults, failure or clinically significant adverse effects to both of the formulary alternatives: Enbrel and Humira. Psoriatic arthritis: For adults, failure or clinically significant adverse effects to both of the formulary alternatives: Enbrel and Humira. Plaque Psoriasis: For adults, failure or clinically significant adverse effects to one of the formulary alternatives: Humira, Enbrel, or Skyrizi. Non-radiographic Axial Spondyloarthritis: Failure or clinically significant adverse effects to a non-steroidal anti-inflammatory drug (NSAID) or has an intolerance or contraindication to NSAID.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

CYCLOBENZAPRINE

Products Affected

- *cyclobenzaprine oral tablet 10 mg, 5 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Approve if less than 65 years of age. If aged 65 years and older, prior authorization criteria will apply.
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Documentation explaining specific benefit established with the medication, and how that benefit outweighs the potential risk
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

DALFAMPRIDINE

Products Affected

- *dalfampridine*

PA Criteria	Criteria Details
Exclusion Criteria	Moderate or severe renal impairment (CrCL 50 mL/min or less).
Required Medical Information	Concurrently on a disease-modifying agent for multiple sclerosis. Documentation of difficulty walking (such as timed 25-foot walk test: Patient must be able to walk 25 feet within 8-45 sec). Reauthorization only: Documentation of positive response to medication therapy.
Age Restrictions	
Prescriber Restrictions	Neurologist
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

DALIRESP

Products Affected

- DALIRESP
- *roflumilast*

PA Criteria	Criteria Details
Exclusion Criteria	Liver impairment, moderate to severe (Child-Pugh B or C).
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to two of the formulary alternatives: either Wixela or Fluticasone/Salmeterol, Anoro Ellipta, Serevent, Spiriva or Tudorza.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

DEFERASIROX

Products Affected

- *deferasirox oral tablet, dispersible*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Hematologist
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

DESIPRAMINE

Products Affected

- *desipramine*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Approve if less than 65 years of age. If aged 65 years and older, prior authorization criteria will apply.
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Depression: Failure or clinically significant adverse effects to two of the formulary alternatives: citalopram, escitalopram, fluoxetine, sertraline, venlafaxine, desvenlafaxine, duloxetine, mirtazapine, or bupropion
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

DIAZEPAM SOLUTION

Products Affected

- *diazepam intensol*
- *diazepam oral solution 5 mg/5 ml (1 mg/ml)*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of difficulty or inability to swallow.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

DIMETHYL FUMARATE

Products Affected

- *dimethyl fumarate*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Neurologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to all of the formulary alternatives: Aubagio and glatiramer.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

DISOPYRAMIDE

Products Affected

- *disopyramide phosphate oral capsule*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Approve if less than 65 years of age. If aged 65 years and older, prior authorization criteria will apply.
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Arrhythmia: Failure or clinically significant adverse effects to two of the formulary alternatives: acebutolol, flecainide, mexiletine, propafenone, quinidine, or sotalol.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

DOXEPIN

Products Affected

- *doxepin oral capsule*
- *doxepin oral concentrate*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Approve if less than 65 years of age. If aged 65 years and older, prior authorization criteria will apply.
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	For the average daily dose of doxepin that is greater than 6 mg: Anxiety: Failure or clinically significant adverse effects to two of the formulary alternatives: buspirone, duloxetine, escitalopram, or venlafaxine. Depression: Failure or clinically significant adverse effects to two of the formulary alternatives: citalopram, escitalopram, fluoxetine, sertraline, venlafaxine, desvenlafaxine, duloxetine, mirtazapine, or bupropion
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

DRIZALMA

Products Affected

- DRIZALMA SPRINKLE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of difficulty or inability to swallow an intact capsule or failure or clinically significant adverse effects to the formulary alternative: duloxetine.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

DRONABINOL

Products Affected

- *dronabinol*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Chemotherapy-induced nausea and vomiting: Failure or clinically significant adverse effects to two of the formulary alternatives: chlorpromazine, granisetron, metoclopramide, ondansetron, or prochlorperazine.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

DROXIDOPA

Products Affected

- *droxidopa*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

DUPIXENT

Products Affected

- DUPIXENT PEN
- DUPIXENT SYRINGE SUBCUTANEOUS SYRINGE 200 MG/1.14 ML, 300 MG/2 ML

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Initial: eosinophilic asthma: blood eosinophil level greater than or equal to 150 cells/mcl within the past 12 months. Eosinophilic Esophagitis: diagnosis confirmed by esophagogastroduodenoscopy with biopsy.
Age Restrictions	
Prescriber Restrictions	Initial: Atopic Dermatitis, Prurigo Nodularis: prescribed by or in consultation with a Dermatologist, Allergist or Immunologist. Asthma: prescribed by or in consultation with a physician specializing in allergy or pulmonary medicine. Chronic Rhinosinusitis with Nasal Polyposis: prescribed by or in consultation with an Otolaryngologist, Allergist or Immunologist. Eosinophilic Esophagitis: prescribed by or in consultation with a Gastroenterologist, Allergist, or Immunologist.
Coverage Duration	Until the end of calendar year.
Other Criteria	Initial: Atopic Dermatitis: 1) Atopic Dermatitis covering at least 10 percent of body surface area or Atopic Dermatitis affecting the face, head, neck, hands, feet, groin, or intertriginous areas, 2) intractable pruritus or cracking/oozing/bleeding of affected skin, 3) trial of or contraindication to one topical (corticosteroid or calcineurin inhibitor), and 4) no concurrent use with other systemic biologic/JAK inhibitor for Atopic Dermatitis. Asthma: 1) concurrent therapy with a medium, high-dose or maximally-tolerated dose of an inhaled corticosteroid (ICS) and one other maintenance medication, 2) one asthma exacerbation requiring systemic corticosteroid burst lasting 3 or more days within the past 12 months, or one serious exacerbation requiring hospitalization or ER visit within the past 12 months, or poor symptom control despite current therapy as evidenced by at least three of the following within the past 4 weeks: daytime asthma symptoms more than twice/week, any night waking due to asthma, Short-Acting Beta Agonist (SABA) reliever for symptoms more than twice/week, any activity limitation due to asthma, and 3) no concurrent use with Xolair or other Anti-IL5 biologics when used for

PA Criteria	Criteria Details
	asthma. Chronic Rhinosinusitis with Nasal Polyposis: 1) evidence of nasal polyps by direct examination, endoscopy or sinus CT scan, 2) inadequately controlled disease as determined by use of systemic steroids in the past 2 years or endoscopic sinus surgery, and 3) trial of one topical nasal corticosteroid. Prurigo Nodularis: 1) chronic pruritis (itch more than 6 weeks), multiple pruriginous lesions, and history or sign of a prolonged scratching behavior, 2) trial of or contraindication to one topical (corticosteroid or calcipotriene). Renewal: Atopic Dermatitis: 1) improvement while on therapy, and 2) no concurrent use with other systemic biologic/JAK inhibitor for Atopic Dermatitis. Chronic Rhinosinusitis with Nasal Polyposis, Eosinophilic Esophagitis: improvement while on therapy. Asthma: 1) no concurrent use with Xolair, or other Anti-IL5 biologics for asthma, 2) continued use of ICS and one other maintenance medication, and 3) clinical response as evidenced by: (a) reduction in asthma exacerbations from baseline, (b) decreased utilization of rescue medications, (c) increase in percent predicted FEV1 from pretreatment baseline, or (d) reduction in severity or frequency of asthma-related symptoms. Prurigo Nodularis: improvement or reduction of pruritis or pruriginous lesions.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

ELIGARD

Products Affected

- ELIGARD
- ELIGARD (3 MONTH)
- ELIGARD (4 MONTH)
- ELIGARD (6 MONTH)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Oncologist, Urologist
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

EMSAM

Products Affected

- EMSAM

PA Criteria	Criteria Details
Exclusion Criteria	Concomitant use with other serotonergic drugs (i.e. SSRIs, SNRIs, TCAs)
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to all of the formulary alternatives: phenelzine and tranylcypromine.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

ENBREL

Products Affected

- ENBREL MINI
- ENBREL SUBCUTANEOUS SOLUTION
- ENBREL SUBCUTANEOUS SYRINGE
- ENBREL SURECLICK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Plaque psoriasis: documentation of psoriasis of greater than 3% BSA or affecting crucial body areas such as hands, feet, face or genitals.
Age Restrictions	
Prescriber Restrictions	Dermatologist, Rheumatologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Rheumatoid Arthritis: Failure or clinically significant adverse effects to one of the formulary alternatives: azathioprine, cyclosporine, hydroxychloroquine, leflunomide, methotrexate, or sulfasalazine. Psoriatic arthritis: Failure or clinically significant adverse effects to the formulary alternative: methotrexate. Ankylosing spondylitis: Failure or clinically significant adverse effects to one of the formulary alternatives: celecoxib, diclofenac, indomethacin, naproxen, or sulindac. Plaque psoriasis: Failure or clinically significant adverse effects to one of the following: acitretin, cyclosporine, methotrexate or phototherapy.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

ENDARI

Products Affected

- ENDARI
- *glutamine (sickle cell)*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Hematologist
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

ESBRIET

Products Affected

- ESBRIET ORAL CAPSULE
- ESBRIET ORAL TABLET 267 MG, 801 MG
- *pirfenidone oral capsule*
- *pirfenidone oral tablet 267 mg, 534 mg, 801 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Initial authorization: Diagnosis of idiopathic pulmonary fibrosis confirmed by the presence of usual interstitial pneumonia on high resolution computed tomography (HRCT) and/or surgical lung biopsy. Documentation of liver function tests, documentation of baseline forced vial capacity (FVC) greater than or equal to 50 percent of the predicted value AND documentation of percent predicted diffusing capacity of the lungs for carbon monoxide (%DLCO) greater than or equal to 30 percent.
Age Restrictions	
Prescriber Restrictions	Pulmonologist
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

ESTROGENS

Products Affected

- DUAVEE
- *estradiol oral*
- *estradiol transdermal patch weekly*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Approve if less than 65 years of age. If aged 65 years and older, prior authorization criteria will apply.
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Postmenopausal osteoporosis prophylaxis: Failure or clinically significant adverse effects all of the formulary alternatives: alendronic acid and risedronate. Vulvar and vaginal atrophy: Failure or clinically significant adverse effects to one of the formulary alternatives: estradiol cream or Premarin Cream.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

FENTANYL LOZENGE

Products Affected

- *fentanyl citrate buccal lozenge on a handle*

PA Criteria	Criteria Details
Exclusion Criteria	Acute, intermittent, or postoperative pain.
Required Medical Information	Documentation of opioid tolerance taking around-the-clock opioid therapy consisting of at least 60mg of oral morphine daily, at least 25mg transdermal fentanyl/hour, at least 30 mg of oral oxycodone daily, at least 8mg oral hydromorphone daily or an equianalgesic dose of another opioid daily for a week or longer for breakthrough pain of cancer. Patients must remain on around-the clock opioids when taking transmucosal immediate release fentanyl.
Age Restrictions	
Prescriber Restrictions	Pain Specialist, Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

FETZIMA

Products Affected

- FETZIMA ORAL CAPSULE,EXT REL 24HR DOSE PACK 20 MG (2)- 40 MG (26)
- FETZIMA ORAL CAPSULE,EXTENDED RELEASE 24 HR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to two of the formulary alternatives: citalopram, escitalopram, fluoxetine, sertraline, venlafaxine, desvenlafaxine, duloxetine, mirtazapine, or bupropion.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

FIRAZYR

Products Affected

- *icatibant*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of hereditary angioedema (HAE), must be confirmed by blood testing.
Age Restrictions	
Prescriber Restrictions	Allergist, Immunologist, Hematologist
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

FIRMAGON

Products Affected

- FIRMAGON KIT W DILUENT SYRINGE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Oncologist, Urologist
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

GENOTROPIN

Products Affected

- GENOTROPIN
- GENOTROPIN MINIQUICK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	AGHD(initial): diagnosis confirmed as a result of past diagnosis of childhood-onset GHD, or adult-onset GHD with documentation of hormone deficiency due to hypothalamic-pituitary disease from organic or known causes (eg: damage from surgery, cranial irradiation, head trauma, subarachnoid hemorrhage) and documentation of one growth-hormone stimulant test (eg: insulin tolerance test, arginine/GHRH,glucagon,arginine) to confirm adult GHD w/corresponding peak GH values ([ITT at or below 5mcg/L],[GHRH+ARG at or below 11mcg/L if BMI less than 25kg/m2, at or below 8mcg/L if BMI at or above 25 and below 30kg/m2, or at or below 4mcg/L if BMI at or above 30kg/m2],[glucagon at or below 3mcg/L],[Arg at or below 0.4mcg/L]) or documentated deficiency of 3 anterior pituitary hormones (prolactin,ACTH,TSH,FSH/LH) and IFG-1/somatomedinC below age and gender adjusted normal range as provided by physicians lab. AGHD(reauthorization): Documentation of positive experience by the patient.
Age Restrictions	
Prescriber Restrictions	Endocrinologist
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

GEODON SOLUTION

Products Affected

- *ziprasidone mesylate*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

GILENYA

Products Affected

- *fingolimod*
- GILENYA

PA Criteria	Criteria Details
Exclusion Criteria	Class III or IV heart failure, decompensated heart failure requiring hospitalization, myocardial infarction, stroke, transient ischemic attack or unstable angina within the last 6 months. Concomitant use of Class Ia or Class III anti-arrhythmic drugs. Mobitz type II second-degree or third-degree atrioventricular block, or sick-sinus syndrome unless the patient has a functional pacemaker. QT interval at baseline 500 ms or greater.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Neurologist
Coverage Duration	Until the end of calendar year.
Other Criteria	For adults: Failure or clinically significant adverse effects to Aubagio and glatiramer.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

GLATIRAMER

Products Affected

- *glatiramer*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Neurologist
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

GLATOPA

Products Affected

- *glatopa*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Neurologist
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

GLP1

Products Affected

- MOUNJARO
- OZEMPIC SUBCUTANEOUS PEN INJECTOR 0.25 MG OR 0.5 MG (2 MG/3 ML), 1 MG/DOSE (4 MG/3 ML), 2 MG/DOSE (8 MG/3 ML)
- RYBELSUS
- TRULICITY

PA Criteria	Criteria Details
Exclusion Criteria	Multiple Endocrine Neoplasia syndrome type 2 (MEN 2) or a personal or family history of medullary thyroid carcinoma (MTC), treatment for obesity or weight loss only, and concurrent use with DPP4 inhibitors.
Required Medical Information	For a diagnosis of Type 2 Diabetes Mellitus the patient has a trial and failure, contraindication or intolerance to metformin or any metformin combination product.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Reauthorization only: Documentation of positive response to medication therapy (reduction in HbA1C or maintenance of HbA1c level).
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

GLYBURIDE

Products Affected

- *glyburide*
- *glyburide micronized*
- *glyburide-metformin oral tablet 1.25-250 mg, 2.5-500 mg, 5-500 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Approve if less than 65 years of age. If aged 65 years and older, prior authorization criteria will apply.
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to formulary alternative: glipizide.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

GUANFACINE

Products Affected

- *guanfacine oral tablet*
- *guanfacine oral tablet extended release 24 hr*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Approve if less than 65 years of age. If aged 65 years and older, prior authorization criteria will apply.
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Hypertension: Failure or clinically significant adverse effects to two of the formulary alternatives: benazepril, fosinopril, hydrochlorothiazide, irbesartan, lisinopril, losartan, losartan/hydrochlorothiazide, lisinopril/hydrochlorothiazide, quinapril/hydrochlorothiazide, quinapril, ramipril, or valsartan/hydrochlorothiazide. ADHD: Failure or clinically significant adverse effects to two of the formulary alternatives: amphetamine/dextroamphetamine, dexmethylphenidate, dextroamphetamine, or methylphenidate.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

HRM ANTIPSYCHOTICS

Products Affected

- *molindone oral tablet 10 mg, 25 mg, 5 mg*
- *thioridazine*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Approve if less than 65 years of age. If aged 65 years and older, prior authorization criteria will apply.
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to two of the formulary alternatives: olanzapine, risperidone, quetiapine, ziprasidone, or aripiprazole.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

HUMIRA

Products Affected

- HUMIRA PEN
- HUMIRA SUBCUTANEOUS SYRINGE KIT 40 MG/0.8 ML
- HUMIRA(CF)
- HUMIRA(CF) PEN
- HUMIRA(CF) PEN CROHNS-UC-HS
- HUMIRA(CF) PEN PSOR-UV-ADOL HS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Plaque psoriasis: documentation of psoriasis involving 3% of BSA or greater, or affecting crucial body areas such as hands, feet, face or genitals.
Age Restrictions	
Prescriber Restrictions	Dermatologist, Gastroenterologist, Ophthalmologist, Rheumatologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Rheumatoid Arthritis: Failure or clinically significant adverse effects to one of the formulary alternatives: azathioprine, cyclosporine, hydroxychloroquine, leflunomide, methotrexate, or sulfasalazine. Psoriatic arthritis: Failure or clinically significant adverse effects to the formulary alternative: methotrexate. Ankylosing spondylitis: Failure or clinically significant adverse effects to one of the formulary alternatives: celecoxib, diclofenac, indomethacin, naproxen, or sulindac. Plaque psoriasis: Failure or clinically significant adverse effects to one of the formulary alternatives: acitretin, cyclosporine, methotrexate or phototherapy. Crohn's disease and Ulcerative colitis: Failure or clinically significant adverse effects to one of the formulary alternatives: budesonide, mesalamine or sulfasalazine.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

HUMIRA PEDIATRIC

Products Affected

- HUMIRA(CF) PEDI CROHNS STARTER
- HUMIRA(CF) PEN PEDIATRIC UC

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

IMIPRAMINE

Products Affected

- *imipramine hcl*
- *imipramine pamoate*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Approve if less than 65 years of age. If aged 65 years and older, prior authorization criteria will apply.
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

IMPAVIDO

Products Affected

- IMPAVIDO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Females of Reproductive Potential: confirm negative pregnancy status.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

INCRELEX

Products Affected

- INCRELEX

PA Criteria	Criteria Details
Exclusion Criteria	Pediatric patients with malignant neoplasm or history of malignancy. Use for growth promotion in patients with closed epiphyses.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Endocrinologist
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

INDOMETHACIN

Products Affected

- *indomethacin oral capsule*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Approve if less than 65 years of age. If aged 65 years and older, prior authorization criteria will apply.
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to two of the formulary alternatives: celecoxib, diclofenac, ibuprofen, meloxicam, nabumetone, naproxen, or sulindac.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

INGREZZA

Products Affected

- INGREZZA
- INGREZZA INITIATION PK(TARDIV)
- INGREZZA SPRINKLE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Neurologist, Psychiatrist
Coverage Duration	Until the end of calendar year.
Other Criteria	Chorea (Huntington's Disease): Failure or clinically significant adverse effects to the formulary alternative: tetrabenazine. Reauthorization only: Documentation of positive response to medication therapy.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

INSULIN SUPPLIES PAYMENT DETERMINATION

Products Affected

- 1ST TIER UNIFINE PENTP 5MM 31G
- 1ST TIER UNIFINE PNTIP 4MM 32G
- 1ST TIER UNIFINE PNTIP 6MM 31G
- 1ST TIER UNIFINE PNTIP 8MM 31G STRL,SINGLE-USE,SHRT
- 1ST TIER UNIFINE PNTP 29GX1/2"
- 1ST TIER UNIFINE PNTP 31GX3/16
- 1ST TIER UNIFINE PNTP 32GX5/32
- ABOUTTIME PEN NEEDLE 30G X 8MM
- ABOUTTIME PEN NEEDLE 31G X 5MM
- ABOUTTIME PEN NEEDLE 31G X 8MM
- ABOUTTIME PEN NEEDLE 32G X 4MM
- ADVOCATE INS 0.3 ML 30GX5/16"
- ADVOCATE INS 0.3 ML 31GX5/16"
- ADVOCATE INS 0.5 ML 30GX5/16"
- ADVOCATE INS 0.5 ML 31GX5/16"
- ADVOCATE INS 1 ML 31GX5/16"
- ADVOCATE INS SYR 0.3 ML 29GX1/2
- ADVOCATE INS SYR 0.5 ML 29GX1/2
- ADVOCATE INS SYR 1 ML 29GX1/2"
- ADVOCATE INS SYR 1 ML 30GX5/16
- ADVOCATE PEN NDL 12.7MM 29G
- ADVOCATE PEN NEEDLE 32G 4MM
- ADVOCATE PEN NEEDLE 4MM 33G
- ADVOCATE PEN NEEDLES 5MM 31G
- ADVOCATE PEN NEEDLES 8MM 31G
- ALCOHOL 70% SWABS
- ALCOHOL PADS
- ALCOHOL PREP SWABS
- ALCOHOL WIPES
- AQINJECT PEN NEEDLE 31G 5MM
- AQINJECT PEN NEEDLE 32G 4MM
- ASSURE ID DUO PRO NDL 31G 5MM
- ASSURE ID DUO-SHIELD 30GX3/16"
- ASSURE ID DUO-SHIELD 30GX5/16"
- ASSURE ID INSULIN SAFETY SYRINGE 1 ML 29 GAUGE X 1/2"
- ASSURE ID PEN NEEDLE 30GX3/16"
- ASSURE ID PEN NEEDLE 30GX5/16"
- ASSURE ID PEN NEEDLE 31GX3/16"
- ASSURE ID PRO PEN NDL 30G 5MM
- ASSURE ID SYR 0.5 ML 29GX1/2" (RX)
- ASSURE ID SYR 0.5 ML 31GX15/64"
- ASSURE ID SYR 1 ML 31GX15/64"
- BD AUTOSHIELD DUO NDL 5MMX30G
- BD ECLIPSE 30GX1/2" SYRINGE
- BD ECLIPSE NEEDLE 30GX1/2" (OTC)
- BD INS SYR 0.3 ML 8MMX31G(1/2)
- BD INS SYRINGE 1/2 ML 6MMX31G (ONLY FOR 500 UNIT/ML INSULIN)
- BD INS SYRN UF 1 ML 12.7MMX30G NOT FOR RETAIL SALE
- BD INSULIN SYR 1 ML 25GX1"
- BD INSULIN SYR 1 ML 25GX5/8"
- BD INSULIN SYR 1 ML 26GX1/2"
- BD INSULIN SYR 1 ML 27GX12.7MM
- BD INSULIN SYR 1 ML 27GX5/8" MICRO-FINE
- BD INSULIN SYRINGE 1 ML W/O NEEDLE
- BD LUER-LOK SYRINGE 1 ML
- BD NANO 2 GEN PEN NDL 32G 4MM
- BD SAFETGLD INS 0.3 ML 29G 13MM
- BD SAFETGLD INS 0.5 ML 13MMX29G
- BD SAFETYGLD INS 0.3 ML 31G 8MM
- BD SAFETYGLD INS 0.5 ML 30G 8MM
- BD SAFETYGLD INS 1 ML 29G 13MM
- BD SAFETYGLID INS 1 ML 6MMX31G
- BD SAFETYGLIDE SYRINGE 27GX5/8
- BD SAFTYGLD INS 0.3 ML 6MMX31G
- BD SAFTYGLD INS 0.5 ML 29G 13MM
- BD SAFTYGLD INS 0.5 ML 6MMX31G

- BD SINGLE USE SWAB
- BD UF MICRO PEN NEEDLE 6MMX32G
- BD UF MINI PEN NEEDLE 5MMX31G
- BD UF NANO PEN NEEDLE 4MMX32G
- BD UF ORIG PEN NDL 12.7MMX29G
- BD UF SHORT PEN NEEDLE 8MMX31G
- BD VEO INS 0.3 ML 6MMX31G (1/2)
- BD VEO INS SYRING 1 ML 6MMX31G
- BD VEO INS SYRN 0.3 ML 6MMX31G
- BD VEO INS SYRN 0.5 ML 6MMX31G
- BORDERED GAUZE 2"X2"
- CAREFINE PEN NEEDLE 12.7MM 29G
- CAREFINE PEN NEEDLE 4MM 32G
- CAREFINE PEN NEEDLE 5MM 32G
- CAREFINE PEN NEEDLE 6MM 31G
- CAREFINE PEN NEEDLE 8MM 30G
- CAREFINE PEN NEEDLES 6MM 32G
- CAREFINE PEN NEEDLES 8MM 31G
- CARETOUCH ALCOHOL 70% PREP PAD
- CARETOUCH PEN NEEDLE 29G 12MM
- CARETOUCH PEN NEEDLE 31GX1/4"
- CARETOUCH PEN NEEDLE 31GX3/16"
- CARETOUCH PEN NEEDLE 31GX5/16"
- CARETOUCH PEN NEEDLE 32GX3/16"
- CARETOUCH PEN NEEDLE 32GX5/32"
- CARETOUCH SYR 0.3 ML 31GX5/16"
- CARETOUCH SYR 0.5 ML 30GX5/16"
- CARETOUCH SYR 0.5 ML 31GX5/16"
- CARETOUCH SYR 1 ML 28GX5/16"
- CARETOUCH SYR 1 ML 29GX5/16"
- CARETOUCH SYR 1 ML 30GX5/16"
- CARETOUCH SYR 1 ML 31GX5/16"
- CLICKFINE 31G X 5/16" NEEDLES 8MM, UNIVERSAL
- CLICKFINE PEN NEEDLE 32GX5/32" 32GX4MM, STERILE
- CLICKFINE UNIVERSAL 31G X 1/4" 6MM, STORE BRAND
- COMFORT EZ 0.3 ML 31G 15/64"
- COMFORT EZ 0.5 ML 31G 15/64"
- COMFORT EZ INS 0.3 ML 30GX1/2"
- COMFORT EZ INS 0.3 ML 30GX5/16"
- COMFORT EZ INS 1 ML 31G 15/64"
- COMFORT EZ INS 1 ML 31GX5/16"
- COMFORT EZ INSULIN SYR 0.3 ML
- COMFORT EZ INSULIN SYR 0.5 ML
- COMFORT EZ PEN NEEDLE 12MM 29G
- COMFORT EZ PEN NEEDLES 4MM 32G SINGLE USE, MICRO
- COMFORT EZ PEN NEEDLES 4MM 33G
- COMFORT EZ PEN NEEDLES 5MM 31G MINI
- COMFORT EZ PEN NEEDLES 5MM 32G SINGLE USE,MINI,HRI
- COMFORT EZ PEN NEEDLES 5MM 33G
- COMFORT EZ PEN NEEDLES 6MM 31G
- COMFORT EZ PEN NEEDLES 6MM 32G
- COMFORT EZ PEN NEEDLES 6MM 33G
- COMFORT EZ PEN NEEDLES 8MM 31G SHORT
- COMFORT EZ PEN NEEDLES 8MM 32G
- COMFORT EZ PEN NEEDLES 8MM 33G
- COMFORT EZ PRO PEN NDL 30G 8MM
- COMFORT EZ PRO PEN NDL 31G 4MM
- COMFORT EZ PRO PEN NDL 31G 5MM
- COMFORT EZ SYR 0.3 ML 29GX1/2"
- COMFORT EZ SYR 0.5 ML 28GX1/2"
- COMFORT EZ SYR 0.5 ML 29GX1/2"
- COMFORT EZ SYR 0.5 ML 30GX1/2"
- COMFORT EZ SYR 1 ML 28GX1/2"
- COMFORT EZ SYR 1 ML 29GX1/2"

- COMFORT EZ SYR 1 ML 30GX1/2"
- COMFORT EZ SYR 1 ML 30GX5/16"
- COMFORT POINT PEN NDL 31GX1/3"
- COMFORT POINT PEN NDL 31GX1/6"
- COMFORT TOUCH PEN NDL 31G 4MM
- COMFORT TOUCH PEN NDL 31G 5MM
- COMFORT TOUCH PEN NDL 31G 6MM
- COMFORT TOUCH PEN NDL 31G 8MM
- COMFORT TOUCH PEN NDL 32G 4MM
- COMFORT TOUCH PEN NDL 32G 5MM
- COMFORT TOUCH PEN NDL 32G 6MM
- COMFORT TOUCH PEN NDL 32G 8MM
- COMFORT TOUCH PEN NDL 33G 4MM
- COMFORT TOUCH PEN NDL 33G 6MM
- COMFORT TOUCH PEN NDL 33GX5MM
- CURAD GAUZE PADS 2" X 2"
- CURITY ALCOHOL PREPS 2 PLY,MEDIUM
- CURITY GAUZE SPONGES (12 PLY)-200/BAG
- CURITY GUAZE PADS 1'S(12 PLY)
- DERMACEA 2"X2" GAUZE 12 PLY, USP TYPE VII
- DERMACEA GAUZE 2"X2" SPONGE 8 PLY
- DERMACEA NON-WOVEN 2"X2" SPNGE
- DROPLET 0.5 ML 29GX12.5MM(1/2)
- DROPLET 0.5 ML 30GX12.5MM(1/2)
- DROPLET INS 0.3 ML 29GX12.5MM
- DROPLET INS 0.3 ML 30GX12.5MM
- DROPLET INS 0.5 ML 30GX6MM(1/2)
- DROPLET INS 0.5 ML 30GX8MM(1/2)
- DROPLET INS 0.5 ML 31GX6MM(1/2)
- DROPLET INS 0.5 ML 31GX8MM(1/2)
- DROPLET INS SYR 0.3 ML 30GX6MM
- DROPLET INS SYR 0.3 ML 30GX8MM
- DROPLET INS SYR 0.3 ML 31GX6MM
- DROPLET INS SYR 0.3 ML 31GX8MM
- DROPLET INS SYR 1 ML 29GX12.5MM
- DROPLET INS SYR 1 ML 30GX12.5MM
- DROPLET INS SYR 1 ML 30GX6MM
- DROPLET INS SYR 1 ML 30GX8MM
- DROPLET INS SYR 1 ML 31GX6MM
- DROPLET INS SYR 1 ML 31GX8MM
- DROPLET MICRON 34G X 9/64"
- DROPLET PEN NEEDLE 29GX1/2"
- DROPLET PEN NEEDLE 29GX3/8"
- DROPLET PEN NEEDLE 30GX5/16"
- DROPLET PEN NEEDLE 31GX1/4"
- DROPLET PEN NEEDLE 31GX3/16"
- DROPLET PEN NEEDLE 31GX5/16"
- DROPLET PEN NEEDLE 32GX1/4"
- DROPLET PEN NEEDLE 32GX3/16"
- DROPLET PEN NEEDLE 32GX5/16"
- DROPLET PEN NEEDLE 32GX5/32"
- DROPSAFE ALCOHOL 70% PREP PADS
- DROPSAFE INS SYR 0.3 ML 31G 6MM
- DROPSAFE INS SYR 0.3 ML 31G 8MM
- DROPSAFE INS SYR 0.5 ML 31G 6MM
- DROPSAFE INS SYR 0.5 ML 31G 8MM
- DROPSAFE INSUL SYR 1 ML 31G 6MM
- DROPSAFE INSUL SYR 1 ML 31G 8MM
- DROPSAFE INSULN 1 ML 29G 12.5MM
- DROPSAFE PEN NEEDLE 31GX1/4"
- DROPSAFE PEN NEEDLE 31GX3/16"
- DROPSAFE PEN NEEDLE 31GX5/16"
- DRUG MART ULTRA COMFORT SYR
- EASY CMFT SFTY PEN NDL 31G 5MM
- EASY CMFT SFTY PEN NDL 31G 6MM
- EASY CMFT SFTY PEN NDL 32G 4MM
- EASY COMFORT 0.3 ML 31G 1/2"

- EASY COMFORT 0.3 ML 31G 5/16"
- EASY COMFORT 0.3 ML SYRINGE
- EASY COMFORT 0.5 ML 30GX1/2"
- EASY COMFORT 0.5 ML 31GX5/16"
- EASY COMFORT 0.5 ML 32GX5/16"
- EASY COMFORT 0.5 ML SYRINGE
- EASY COMFORT 1 ML 31GX5/16"
- EASY COMFORT 1 ML 32GX5/16"
- EASY COMFORT ALCOHOL 70% PAD
- EASY COMFORT INSULIN 1 ML SYR
- EASY COMFORT PEN NDL 31GX1/4"
- EASY COMFORT PEN NDL 31GX3/16"
- EASY COMFORT PEN NDL 31GX5/16"
- EASY COMFORT PEN NDL 32GX5/32"
- EASY COMFORT PEN NDL 33G 4MM
- EASY COMFORT PEN NDL 33G 5MM
- EASY COMFORT PEN NDL 33G 6MM
- EASY COMFORT SYR 1 ML 30GX1/2"
- EASY GLIDE INS 0.3 ML 31GX6MM
- EASY GLIDE INS 0.5 ML 31GX6MM
- EASY GLIDE INS 1 ML 31GX6MM
- EASY GLIDE PEN NEEDLE 4MM 33G
- EASY TOUCH 0.3 ML SYR 30GX1/2"
- EASY TOUCH 0.5 ML SYR 27GX1/2"
- EASY TOUCH 0.5 ML SYR 29GX1/2"
- EASY TOUCH 0.5 ML SYR 30GX1/2"
- EASY TOUCH 0.5 ML SYR 30GX5/16
- EASY TOUCH 1 ML SYR 27GX1/2"
- EASY TOUCH 1 ML SYR 29GX1/2"
- EASY TOUCH 1 ML SYR 30GX1/2"
- EASY TOUCH ALCOHOL 70% PADS GAMMA-STERILIZED
- EASY TOUCH FLIPLOK 1 ML 27GX0.5
- EASY TOUCH INSULIN 1 ML 29GX1/2
- EASY TOUCH INSULIN 1 ML 30GX1/2
- EASY TOUCH INSULIN SYR 0.3 ML
- EASY TOUCH INSULIN SYR 0.5 ML
- EASY TOUCH INSULIN SYR 1 ML
- EASY TOUCH INSULIN SYR 1 ML RETRACTABLE
- EASY TOUCH INSULN 1 ML 29GX1/2"
- EASY TOUCH INSULN 1 ML 30GX1/2"
- EASY TOUCH INSULN 1 ML 30GX5/16
- EASY TOUCH INSULN 1 ML 31GX5/16
- EASY TOUCH LUER LOK INSUL 1 ML
- EASY TOUCH PEN NEEDLE 29GX1/2"
- EASY TOUCH PEN NEEDLE 30GX5/16
- EASY TOUCH PEN NEEDLE 31GX1/4"
- EASY TOUCH PEN NEEDLE 31GX3/16
- EASY TOUCH PEN NEEDLE 31GX5/16
- EASY TOUCH PEN NEEDLE 32GX1/4"
- EASY TOUCH PEN NEEDLE 32GX3/16
- EASY TOUCH PEN NEEDLE 32GX5/32
- EASY TOUCH SAF PEN NDL 29G 5MM
- EASY TOUCH SAF PEN NDL 29G 8MM
- EASY TOUCH SAF PEN NDL 30G 5MM
- EASY TOUCH SAF PEN NDL 30G 8MM
- EASY TOUCH SYR 0.5 ML 28G 12.7MM
- EASY TOUCH SYR 0.5 ML 29G 12.7MM
- EASY TOUCH SYR 1 ML 27G 16MM
- EASY TOUCH SYR 1 ML 28G 12.7MM
- EASY TOUCH SYR 1 ML 29G 12.7MM
- EASY TOUCH UNI-SLIP SYR 1 ML
- EASYTOUCH SAF PEN NDL 30G 6MM
- EMBRACE PEN NEEDLE 29G 12MM
- EMBRACE PEN NEEDLE 30G 5MM
- EMBRACE PEN NEEDLE 30G 8MM
- EMBRACE PEN NEEDLE 31G 5MM
- EMBRACE PEN NEEDLE 31G 6MM
- EMBRACE PEN NEEDLE 31G 8MM
- EMBRACE PEN NEEDLE 32G 4MM
- EQL INSULIN 0.3 ML SYRINGE SHORT NEEDLE
- EQL INSULIN 0.5 ML SYRINGE SHORT NEEDLE
- EQL INSULIN 1 ML SYRINGE SHORT NEEDLE
- FIFTY50 INS 0.5 ML 31GX5/16" SHORT NEEDLE (OTC)
- FIFTY50 INS SYR 1 ML 31GX5/16" SHORT NEEDLE (OTC)
- FIFTY50 PEN 31G X 3/16" NEEDLE (OTC)
- FP INSULIN 1 ML SYRINGE
- FREESTYLE PREC 0.5 ML 30GX5/16
- FREESTYLE PREC 0.5 ML 31GX5/16

- FREESTYLE PREC 1 ML 30GX5/16"
- FREESTYLE PREC 1 ML 31GX5/16"
- GAUZE PAD TOPICAL BANDAGE 2 X 2 "
- GNP ULT C 0.3 ML 29GX1/2" (1/2) 1/2 UNIT
- GNP ULTRA COMFORT 0.5 ML SYR
- GNP ULTRA COMFORT 1 ML SYRINGE
- GNP ULTRA COMFORT 3/10 ML SYR
- HEALTHWISE INS 0.3 ML 30GX5/16"
- HEALTHWISE INS 0.3 ML 31GX5/16"
- HEALTHWISE INS 0.5 ML 30GX5/16"
- HEALTHWISE INS 0.5 ML 31GX5/16"
- HEALTHWISE INS 1 ML 30GX5/16"
- HEALTHWISE INS 1 ML 31GX5/16"
- HEALTHWISE PEN NEEDLE 31G 5MM
- HEALTHWISE PEN NEEDLE 31G 8MM
- HEALTHWISE PEN NEEDLE 32G 4MM
- HEALTHY ACCENTS PENTIP 4MM 32G
- HEALTHY ACCENTS PENTIP 5MM 31G
- HEALTHY ACCENTS PENTIP 6MM 31G
- HEALTHY ACCENTS PENTIP 8MM 31G
- HEALTHY ACCENTS PENTP 12MM 29G
- HEB INCONTROL ALCOHOL 70% PADS
- INCONTROL PEN NEEDLE 12MM 29G
- INCONTROL PEN NEEDLE 4MM 32G
- INCONTROL PEN NEEDLE 5MM 31G
- INCONTROL PEN NEEDLE 6MM 31G
- INCONTROL PEN NEEDLE 8MM 31G
- INSULIN SYR 0.3 ML 31GX1/4(1/2)
- INSULIN SYRIN 0.3 ML 30GX1/2" SHORT NEEDLE
- INSULIN SYRIN 0.5 ML 28GX1/2" (OTC)
- INSULIN SYRIN 0.5 ML 29GX1/2" (OTC)
- INSULIN SYRIN 0.5 ML 30GX1/2" SHORT NEEDLE (OTC)
- INSULIN SYRIN 0.5 ML 30GX5/16" SHORT NEEDLE (OTC)
- INSULIN SYRING 0.5 ML 27G 1/2" INNER (OTC)
- INSULIN SYRINGE 0.3 ML
- INSULIN SYRINGE 0.3 ML 31GX1/4
- INSULIN SYRINGE 0.5 ML
- INSULIN SYRINGE 0.5 ML 31GX1/4
- INSULIN SYRINGE 1 ML
- INSULIN SYRINGE 1 ML 27G 1/2" INNER
- INSULIN SYRINGE 1 ML 28G 1/2" INNER (RX)
- INSULIN SYRINGE 1 ML 30GX1/2" (RX)
- INSULIN SYRINGE 1 ML 30GX5/16" SHORT NEEDLE (OTC)
- INSULIN SYRINGE 1 ML 31GX1/4"
- INSULIN SYRINGE-NEEDLE U-100 SYRINGE 0.3 ML 29 GAUGE, 1 ML 29 GAUGE X 1/2", 1/2 ML 28 GAUGE
- INSUPEN 30G ULTRAFIN NEEDLE
- INSUPEN 31G ULTRAFIN NEEDLE
- INSUPEN 32G 6MM PEN NEEDLE
- INSUPEN 32G 8MM PEN NEEDLE
- INSUPEN PEN NEEDLE 29GX12MM
- INSUPEN PEN NEEDLE 31GX3/16"
- INSUPEN PEN NEEDLE 32GX4MM
- INSUPEN PEN NEEDLE 33GX4MM
- IV ANTISEPTIC WIPES
- KENDALL ALCOHOL 70% PREP PAD
- LISCO SPONGES 100/BAG
- LITE TOUCH 31GX1/4" PEN NEEDLE
- LITE TOUCH INSULIN 0.5 ML SYR
- LITE TOUCH INSULIN 1 ML SYR
- LITE TOUCH INSULIN SYR 1 ML
- LITE TOUCH PEN NEEDLE 29G
- LITE TOUCH PEN NEEDLE 31G
- LITETOUCH INS 0.3 ML 29GX1/2"
- LITETOUCH INS 0.3 ML 30GX5/16"
- LITETOUCH INS 0.3 ML 31GX5/16"
- LITETOUCH INS 0.5 ML 31GX5/16"
- LITETOUCH SYR 0.5 ML 28GX1/2"
- LITETOUCH SYR 0.5 ML 29GX1/2"

- LITETOUCH SYR 0.5 ML 30GX5/16"
- LITETOUCH SYRIN 1 ML 28GX1/2"
- LITETOUCH SYRIN 1 ML 29GX1/2"
- LITETOUCH SYRIN 1 ML 30GX5/16"
- MAGELLAN INSUL SYRINGE 0.3 ML
- MAGELLAN INSUL SYRINGE 0.5 ML
- MAGELLAN INSULIN SYR 0.3 ML
- MAGELLAN INSULIN SYR 0.5 ML
- MAGELLAN INSULIN SYRINGE 1 ML
- MAXI-COMFORT INS 0.5 ML 28G
- MAXI-COMFORT INS 1 ML 28GX1/2"
- MAXICOMFORT II PEN NDL 31GX6MM
- MAXICOMFORT INS 0.5 ML 27GX1/2"
- MAXICOMFORT INS 1 ML 27GX1/2"
- MAXICOMFORT PEN NDL 29G X 5MM
- MAXICOMFORT PEN NDL 29G X 8MM
- MICRODOT PEN NEEDLE 31GX6MM
- MICRODOT PEN NEEDLE 32GX4MM
- MICRODOT PEN NEEDLE 33GX4MM
- MICRODOT READYGARD NDL 31G 5MM OUTER
- MINI PEN NEEDLE 32G 4MM
- MINI PEN NEEDLE 32G 5MM
- MINI PEN NEEDLE 32G 6MM
- MINI PEN NEEDLE 32G 8MM
- MINI PEN NEEDLE 33G 4MM
- MINI PEN NEEDLE 33G 5MM
- MINI PEN NEEDLE 33G 6MM
- MINI ULTRA-THIN II PEN NDL 31G STERILE
- MONOJECT 0.5 ML SYRN 28GX1/2"
- MONOJECT 1 ML SYRN 27X1/2"
- MONOJECT 1 ML SYRN 28GX1/2" (OTC)
- MONOJECT INSUL SYR U100 (OTC)
- MONOJECT INSUL SYR U100 .5ML,29GX1/2" (OTC)
- MONOJECT INSUL SYR U100 0.5 ML CONVERTS TO 29G (OTC)
- MONOJECT INSUL SYR U100 1 ML
- MONOJECT INSUL SYR U100 1 ML 3'S, 29GX1/2" (OTC)
- MONOJECT INSUL SYR U100 1 ML W/O NEEDLE (OTC)
- MONOJECT INSULIN SYR 0.3 ML
- MONOJECT INSULIN SYR 0.3 ML (OTC)
- MONOJECT INSULIN SYR 0.5 ML
- MONOJECT INSULIN SYR 0.5 ML (OTC)
- MONOJECT INSULIN SYR 1 ML 3'S (OTC)
- MONOJECT INSULIN SYR U-100
- MONOJECT SYRINGE 0.3 ML
- MONOJECT SYRINGE 0.5 ML
- MONOJECT SYRINGE 1 ML
- NOVOFINE 30
- NOVOFINE 32G NEEDLES
- NOVOFINE PLUS PEN NDL 32GX1/6"
- NOVOTWIST NEEDLE 32G 5MM
- PC UNIFINE PENTIPS 8MM NEEDLE SHORT
- PEN NEEDLE 30G 5MM OUTER
- PEN NEEDLE 30G 8MM INNER
- PEN NEEDLE 30G X 5/16"
- PEN NEEDLE, DIABETIC NEEDLE 29 GAUGE X 1/2"
- PEN NEEDLES 12MM 29G 29GX12MM,STRL
- PEN NEEDLES 4MM 32G
- PEN NEEDLES 6MM 31G 31GX6MM, STRL
- PEN NEEDLES 8MM 31G 31GX8MM,STRL,SHORT (OTC)
- PENTIPS PEN NEEDLE 29G 1/2"
- PENTIPS PEN NEEDLE 31G 1/4"
- PENTIPS PEN NEEDLE 31GX3/16" MINI, 5MM
- PENTIPS PEN NEEDLE 31GX5/16" SHORT, 8MM
- PENTIPS PEN NEEDLE 32G 1/4"
- PENTIPS PEN NEEDLE 32GX5/32" 4MM
- PIP PEN NEEDLE 31G X 5MM
- PIP PEN NEEDLE 32G X 4MM
- PREVENT PEN NEEDLE 31GX1/4"
- PREVENT PEN NEEDLE 31GX5/16"
- PRO COMFORT 0.5 ML 30GX1/2"

- PRO COMFORT 0.5 ML 30GX5/16"
- PRO COMFORT 0.5 ML 31GX5/16"
- PRO COMFORT 1 ML 30GX1/2"
- PRO COMFORT 1 ML 30GX5/16"
- PRO COMFORT 1 ML 31GX5/16"
- PRO COMFORT ALCOHOL 70% PADS
- PRO COMFORT PEN NDL 31GX5/16"
- PRO COMFORT PEN NDL 32G X 1/4"
- PRO COMFORT PEN NDL 4MM 32G
- PRO COMFORT PEN NDL 5MM 32G
- PRODIGY INS SYR 1 ML 28GX1/2"
- PRODIGY SYRNG 0.5 ML 31GX5/16"
- PRODIGY SYRNGE 0.3 ML 31GX5/16"
- PURE CMFT SFTY PEN NDL 31G 5MM
- PURE CMFT SFTY PEN NDL 31G 6MM
- PURE CMFT SFTY PEN NDL 32G 4MM
- PURE COMFORT ALCOHOL 70% PADS
- PURE COMFORT PEN NDL 32G 4MM
- PURE COMFORT PEN NDL 32G 5MM
- PURE COMFORT PEN NDL 32G 6MM
- PURE COMFORT PEN NDL 32G 8MM
- RAYA SURE PEN NEEDLE 29G 12MM
- RAYA SURE PEN NEEDLE 31G 4MM
- RAYA SURE PEN NEEDLE 31G 5MM
- RAYA SURE PEN NEEDLE 31G 6MM
- RELI-ON INSULIN 0.5 ML SYR
- RELI-ON INSULIN 1 ML SYR
- RELION INS SYR 0.3 ML 31GX6MM
- RELION INS SYR 0.5 ML 31GX6MM
- RELION INS SYR 1 ML 31GX15/64"
- RELION MINI PEN 31G X 1/4" NDL
- RELION NEEDLES
- RELION PEN NEEDLES
- SAFESNAP INS SYR UNITS-100 0.3 ML 30GX5/16",10X10
- SAFESNAP INS SYR UNITS-100 0.5 ML 29GX1/2",10X10
- SAFESNAP INS SYR UNITS-100 0.5 ML 30GX5/16",10X10
- SAFESNAP INS SYR UNITS-100 1 ML 28GX1/2",10X10
- SAFESNAP INS SYR UNITS-100 1 ML 29GX1/2",10X10
- SAFETY PEN NEEDLE 31G 4MM
- SAFETY PEN NEEDLE 5MM X 31G
- SAFETY SYRINGE 0.5 ML 30G 1/2"
- SECURESAFE PEN NDL 30GX5/16" OUTER
- SECURESAFE SYR 0.5 ML 29G 1/2" OUTER
- SECURESAFE SYRNG 1 ML 29G 1/2" OUTER
- SKY SAFETY PEN NEEDLE 30G 5MM
- SKY SAFETY PEN NEEDLE 30G 8MM
- SM ULT CFT 0.3 ML 31GX5/16(1/2)
- STERILE PADS 2" X 2"
- SURE CMFT SFTY PEN NDL 31G 6MM
- SURE CMFT SFTY PEN NDL 32G 4MM
- SURE COMFORT 0.5 ML SYRINGE
- SURE COMFORT 1 ML SYRINGE
- SURE COMFORT 3/10 ML SYRINGE
- SURE COMFORT 3/10 ML SYRINGE INSULIN SYRINGE
- SURE COMFORT 30G PEN NEEDLE
- SURE COMFORT ALCOHOL PREP PADS
- SURE COMFORT INS 0.3 ML 31GX1/4
- SURE COMFORT INS 0.5 ML 31GX1/4
- SURE COMFORT INS 1 ML 31GX1/4"
- SURE COMFORT PEN NDL 29GX1/2" 12.7MM
- SURE COMFORT PEN NDL 31G 5MM
- SURE COMFORT PEN NDL 31G 8MM
- SURE COMFORT PEN NDL 32G 4MM
- SURE COMFORT PEN NDL 32G 6MM
- SURE-FINE PEN NEEDLES 12.7MM
- SURE-FINE PEN NEEDLES 5MM
- SURE-FINE PEN NEEDLES 8MM
- SURE-JECT INSU SYR U100 0.3 ML
- SURE-JECT INSU SYR U100 0.5 ML
- SURE-JECT INSU SYR U100 1 ML
- SURE-JECT INSUL SYR U100 1 ML
- SURE-JECT INSULIN SYRINGE 1 ML
- SURE-PREP ALCOHOL PREP PADS
- TECHLITE 0.3 ML 29GX12MM (1/2)
- TECHLITE 0.3 ML 30GX12MM (1/2)
- TECHLITE 0.3 ML 30GX8MM (1/2)
- TECHLITE 0.3 ML 31GX6MM (1/2)
- TECHLITE 0.3 ML 31GX8MM (1/2)
- TECHLITE 0.5 ML 29GX12MM (1/2)
- TECHLITE 0.5 ML 30GX12MM (1/2)

- TECHLITE 0.5 ML 30GX8MM (1/2)
- TECHLITE 0.5 ML 31GX6MM (1/2)
- TECHLITE 0.5 ML 31GX8MM (1/2)
- TECHLITE INS SYR 1 ML 29GX12MM
- TECHLITE INS SYR 1 ML 30GX12MM
- TECHLITE INS SYR 1 ML 30GX8MM
- TECHLITE INS SYR 1 ML 31GX6MM
- TECHLITE INS SYR 1 ML 31GX8MM
- TECHLITE PEN NEEDLE 29GX1/2"
- TECHLITE PEN NEEDLE 29GX3/8"
- TECHLITE PEN NEEDLE 31GX1/4"
- TECHLITE PEN NEEDLE 31GX3/16"
- TECHLITE PEN NEEDLE 31GX5/16"
- TECHLITE PEN NEEDLE 32GX1/4"
- TECHLITE PEN NEEDLE 32GX5/16"
- TECHLITE PEN NEEDLE 32GX5/32"
- TECHLITE PLUS PEN NDL 32G 4MM
- TERUMO INS SYRINGE U100-1 ML
- TERUMO INS SYRINGE U100-1/2 ML
- TERUMO INS SYRINGE U100-1/3 ML
- TERUMO INS SYRNG U100-1/2 ML
- THINPRO INS SYRIN U100-0.3 ML
- THINPRO INS SYRIN U100-0.5 ML
- THINPRO INS SYRIN U100-1 ML
- TOPCARE CLICKFINE 31G X 1/4"
- TOPCARE CLICKFINE 31G X 5/16"
- TOPCARE ULTRA COMFORT SYRINGE
- TRUE CMFRT PRO 0.5 ML 30G 5/16"
- TRUE CMFRT PRO 0.5 ML 31G 5/16"
- TRUE CMFRT PRO 0.5 ML 32G 5/16"
- TRUE CMFT SFTY PEN NDL 31G 5MM
- TRUE CMFT SFTY PEN NDL 31G 6MM
- TRUE CMFT SFTY PEN NDL 32G 4MM
- TRUE COMFORT 0.5 ML 30G 1/2"
- TRUE COMFORT 0.5 ML 30G 5/16"
- TRUE COMFORT 0.5 ML 31G 5/16"
- TRUE COMFORT 0.5 ML 31GX5/16"
- TRUE COMFORT 1 ML 31GX5/16"
- TRUE COMFORT ALCOHOL 70% PADS
- TRUE COMFORT PEN NDL 31G 8MM
- TRUE COMFORT PEN NDL 31GX5MM
- TRUE COMFORT PEN NDL 31GX6MM
- TRUE COMFORT PEN NDL 32G 5MM
- TRUE COMFORT PEN NDL 32G 6MM
- TRUE COMFORT PEN NDL 32GX4MM
- TRUE COMFORT PEN NDL 33G 4MM
- TRUE COMFORT PEN NDL 33G 5MM
- TRUE COMFORT PEN NDL 33G 6MM
- TRUE COMFORT PRO 1 ML 30G 1/2"
- TRUE COMFORT PRO 1 ML 30G 5/16"
- TRUE COMFORT PRO 1 ML 31G 5/16"
- TRUE COMFORT PRO 1 ML 32G 5/16"
- TRUE COMFORT PRO ALCOHOL PADS
- TRUE COMFORT SFTY 1 ML 30G 1/2"
- TRUE COMFRT PRO 0.5 ML 30G 1/2"
- TRUE COMFRT SFTY 1 ML 30G 5/16"
- TRUE COMFRT SFTY 1 ML 31G 5/16"
- TRUE COMFRT SFTY 1 ML 32G 5/16"
- TRUEPLUS PEN NEEDLE 29G 12MM
- TRUEPLUS PEN NEEDLE 31G 5MM
- TRUEPLUS PEN NEEDLE 31G 8MM
- TRUEPLUS PEN NEEDLE 31G X 1/4"
- TRUEPLUS PEN NEEDLE 32GX5/32"
- TRUEPLUS SYR 0.3 ML 29GX1/2"
- TRUEPLUS SYR 0.3 ML 30GX5/16"
- TRUEPLUS SYR 0.3 ML 31GX5/16"
- TRUEPLUS SYR 0.5 ML 28GX1/2"
- TRUEPLUS SYR 0.5 ML 29GX1/2"
- TRUEPLUS SYR 0.5 ML 30GX5/16"
- TRUEPLUS SYR 0.5 ML 31GX5/16"
- TRUEPLUS SYR 1 ML 28GX1/2"
- TRUEPLUS SYR 1 ML 29GX1/2"
- TRUEPLUS SYR 1 ML 30GX5/16"
- TRUEPLUS SYR 1 ML 31GX5/16"
- ULTICAR INS 0.3 ML 31GX1/4(1/2)
- ULTICARE INS 1 ML 31GX1/4"
- ULTICARE INS SYR 0.3 ML 30G 8MM
- ULTICARE INS SYR 0.3 ML 31G 6MM
- ULTICARE INS SYR 0.3 ML 31G 8MM
- ULTICARE INS SYR 0.5 ML 31G 6MM
- ULTICARE INS SYR 1 ML 30GX1/2"
- ULTICARE PEN NEEDLE 31GX3/16"
- ULTICARE PEN NEEDLE 6MM 31G
- ULTICARE PEN NEEDLE 8MM 31G
- ULTICARE PEN NEEDLES 12MM 29G

- ULTICARE PEN NEEDLES 4MM 32G MICRO, 32GX4MM
- ULTICARE PEN NEEDLES 6MM 32G
- ULTICARE SAFE PEN NDL 30G 8MM
- ULTICARE SAFE PEN NDL 5MM 30G
- ULTICARE SYR 0.3 ML 29G 12.7MM
- ULTICARE SYR 0.3 ML 30GX1/2"
- ULTICARE SYR 0.3 ML 31GX5/16" SHORT NDL
- ULTICARE SYR 0.5 ML 30GX1/2"
- ULTICARE SYR 0.5 ML 31GX5/16" SHORT NDL
- ULTICARE SYR 1 ML 31GX5/16"
- ULTIGUARD SAFE 1 ML 30G 12.7MM
- ULTIGUARD SAFE PACK 32G 4MM
- ULTIGUARD SAFE0.3 ML 30G 12.7MM
- ULTIGUARD SAFE0.5 ML 30G 12.7MM
- ULTIGUARD SAFEPACK 1 ML 31G 8MM
- ULTIGUARD SAFEPACK 29G 12.7MM
- ULTIGUARD SAFEPACK 31G 5MM
- ULTIGUARD SAFEPACK 31G 6MM
- ULTIGUARD SAFEPACK 31G 8MM
- ULTIGUARD SAFEPACK 32G 6MM
- ULTIGUARD SAFEPK 0.3 ML 31G 8MM
- ULTIGUARD SAFEPK 0.5 ML 31G 8MM
- ULTILET ALCOHOL STERL SWAB
- ULTILET INSULIN SYRINGE 0.3 ML
- ULTILET INSULIN SYRINGE 0.5 ML
- ULTILET INSULIN SYRINGE 1 ML
- ULTILET PEN NEEDLE
- ULTILET PEN NEEDLE 4MM 32G
- ULTRA COMFORT 0.3 ML SYRINGE
- ULTRA COMFORT 0.5 ML 28GX1/2" CONVERTS TO 29G
- ULTRA COMFORT 0.5 ML 29GX1/2"
- ULTRA COMFORT 0.5 ML SYRINGE
- ULTRA COMFORT 1 ML 31GX5/16"
- ULTRA COMFORT 1 ML SYRINGE
- ULTRA FLO 0.3 ML 30G 1/2" (1/2)
- ULTRA FLO 0.3 ML 30G 5/16"(1/2)
- ULTRA FLO 0.3 ML 31G 5/16"(1/2)
- ULTRA FLO PEN NEEDLE 31G 5MM
- ULTRA FLO PEN NEEDLE 31G 8MM
- ULTRA FLO PEN NEEDLE 32G 4MM
- ULTRA FLO PEN NEEDLE 33G 4MM
- ULTRA FLO PEN NEEDLES 12MM 29G
- ULTRA FLO SYR 0.3 ML 29GX1/2"
- ULTRA FLO SYR 0.3 ML 30G 5/16"
- ULTRA FLO SYR 0.3 ML 31G 5/16"
- ULTRA FLO SYR 0.5 ML 29G 1/2"
- ULTRA THIN PEN NDL 32G X 4MM
- ULTRA-THIN II 1 ML 31GX5/16"
- ULTRA-THIN II INS 0.3 ML 30G
- ULTRA-THIN II INS 0.3 ML 31G
- ULTRA-THIN II INS 0.5 ML 29G
- ULTRA-THIN II INS 0.5 ML 30G
- ULTRA-THIN II INS 0.5 ML 31G
- ULTRA-THIN II INS SYR 1 ML 29G
- ULTRA-THIN II INS SYR 1 ML 30G
- ULTRA-THIN II PEN NDL 29GX1/2"
- ULTRA-THIN II PEN NDL 31GX5/16
- ULTRACARE INS 0.3 ML 30GX5/16"
- ULTRACARE INS 0.3 ML 31GX5/16"
- ULTRACARE INS 0.5 ML 30GX1/2"
- ULTRACARE INS 0.5 ML 30GX5/16"
- ULTRACARE INS 0.5 ML 31GX5/16"
- ULTRACARE INS 1 ML 30G X 5/16"
- ULTRACARE INS 1 ML 30GX1/2"
- ULTRACARE INS 1 ML 31G X 5/16"
- ULTRACARE PEN NEEDLE 31GX1/4"
- ULTRACARE PEN NEEDLE 31GX3/16"
- ULTRACARE PEN NEEDLE 31GX5/16"
- ULTRACARE PEN NEEDLE 32GX1/4"
- ULTRACARE PEN NEEDLE 32GX3/16"
- ULTRACARE PEN NEEDLE 32GX5/32"
- ULTRACARE PEN NEEDLE 33GX5/32"
- UNIFINE PEN NEEDLE 32G 4MM
- UNIFINE PENTIPS 12MM 29G 29GX12MM, STRL
- UNIFINE PENTIPS 31GX3/16" 31GX5MM,STRL,MINI
- UNIFINE PENTIPS 32GX1/4"
- UNIFINE PENTIPS 32GX5/32" 32GX4MM, STRL, NANO
- UNIFINE PENTIPS 33GX5/32"
- UNIFINE PENTIPS 6MM 31G

- UNIFINE PENTIPS MAX 30GX3/16"
- UNIFINE PENTIPS NEEDLES 29G
- UNIFINE PENTIPS PLUS 29GX1/2" 12MM
- UNIFINE PENTIPS PLUS 30GX3/16"
- UNIFINE PENTIPS PLUS 31GX1/4" ULTRA SHORT, 6MM
- UNIFINE PENTIPS PLUS 31GX3/16" MINI
- UNIFINE PENTIPS PLUS 31GX5/16" SHORT
- UNIFINE PENTIPS PLUS 32GX5/32"
- UNIFINE PENTIPS PLUS 33GX5/32"
- UNIFINE PROTECT 30G 5MM
- UNIFINE PROTECT 30G 8MM
- UNIFINE PROTECT 32G 4MM
- UNIFINE SAFECONTROL 30GX3/16"
- UNIFINE SAFECONTROL 30GX5/16"
- UNIFINE SAFECONTROL 31G 5MM
- UNIFINE SAFECONTROL 31G 6MM
- UNIFINE SAFECONTROL 31G 8MM
- UNIFINE SAFECONTROL 32G 4MM
- UNIFINE ULTRA PEN NDL 31G 5MM
- UNIFINE ULTRA PEN NDL 31G 6MM
- UNIFINE ULTRA PEN NDL 31G 8MM
- UNIFINE ULTRA PEN NDL 32G 4MM
- VANISHPOINT 0.5 ML 30GX1/2" SY OUTER
- VANISHPOINT INS 1 ML 30GX3/16"
- VANISHPOINT U-100 29X1/2 SYR
- VERIFINE INS SYR 1 ML 29G 1/2"
- VERIFINE PEN NEEDLE 29G 12MM
- VERIFINE PEN NEEDLE 31G 5MM
- VERIFINE PEN NEEDLE 31G X 6MM
- VERIFINE PEN NEEDLE 31G X 8MM
- VERIFINE PEN NEEDLE 32G 6MM
- VERIFINE PEN NEEDLE 32G X 4MM
- VERIFINE PEN NEEDLE 32G X 5MM
- VERIFINE PLUS PEN NDL 31G 5MM
- VERIFINE PLUS PEN NDL 31G 8MM
- VERIFINE PLUS PEN NDL 32G 4MM
- VERIFINE PLUS PEN NDL 32G 4MM-SHARPS CONTAINER
- VERIFINE SYRING 0.5 ML 29G 1/2"
- VERIFINE SYRING 1 ML 31G 5/16"
- VERIFINE SYRNG 0.3 ML 31G 5/16"
- VERIFINE SYRNG 0.5 ML 31G 5/16"
- VERSALON ALL PURPOSE SPONGE 25'S,N-STERILE,3PLY
- WEBCOL ALCOHOL PREPS 20'S,LARGE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	ONLY COVERED UNDER PART D WHEN USED CONCURRENTLY WITH INSULIN.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	LIFETIME
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

PA Criteria	Criteria Details
Part B Prerequisite	No

INTERFERON BETA-1A

Products Affected

- PLEGRIDY SUBCUTANEOUS PEN INJECTOR 125 MCG/0.5 ML
- PLEGRIDY SUBCUTANEOUS SYRINGE 125 MCG/0.5 ML
- REBIF (WITH ALBUMIN)
- REBIF REBIDOSE
- REBIF TITRATION PACK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Neurologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to all of the formulary alternatives: Aubagio and glatiramer.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

INVEGA HAFYERA

Products Affected

- INVEGA HAFYERA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to all of the formulary alternatives: oral paliperidone and Invega Sustenna.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

INVEGA SUSTENNA

Products Affected

- INVEGA SUSTENNA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to the formulary alternative: oral paliperidone.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

INVEGA TRINZA

Products Affected

- INVEGA TRINZA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to all of the formulary alternatives: oral paliperidone and Invega Sustenna.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

ITRACONAZOLE

Products Affected

- *itraconazole oral solution*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

JYLAMVO

Products Affected

- JYLAMVO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Oncologist, Dermatologist, Hematologist , Rheumatologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Subject to Part B vs Part D determination.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

KALYDECO

Products Affected

- KALYDECO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of a mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene that is responsive to ivacaftor.
Age Restrictions	
Prescriber Restrictions	Infectious Disease specialist, Pulmonologist
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

KERENDIA

Products Affected

- KERENDIA

PA Criteria	Criteria Details
Exclusion Criteria	Concomitant use with a strong CYP3A4 inhibitor or diagnosis of adrenal insufficiency
Required Medical Information	Labs within the past 30 days documenting serum potassium level of less than or equal to 5.0 mEq/L, estimated glomerular filtration rate of at least 25 mL/min/1.73m2 and urine albumin-to-creatinine ratio (UACR) of at least 30 mg/g (2) Receiving concurrent therapy with angiotensin-converting enzyme inhibitor (ACE inhibitor) or angiotensin receptor blocker (ARB) at maximally tolerated labeled dosage, unless contraindicated (3) medical justification that a sodium-glucose cotransport-2 (SGLT2) inhibitor (Jardiance, Invokana, Farxiga, Steglatro) AND a steroidal mineralocorticoid receptor antagonist (spironolactone, eplerenone) have been tried and failed, are contraindicated, or would not be medically appropriate for the patient.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

KINERET

Products Affected

- KINERET

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Rheumatoid Arthritis: Failure or clinically significant adverse effects to two of the formulary alternatives: Enbrel, Humira, Rinvoq, or Xeljanz IR/XR.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

KORLYM

Products Affected

- KORLYM
- *mifepristone oral tablet 300 mg*

PA Criteria	Criteria Details
Exclusion Criteria	Concomitant use of simvastatin, lovastatin and CYP3A substrates with narrow therapeutic ranges (e.g. cyclosporine, fentanyl, sirolimus, etc.). History of unexplained vaginal bleeding or endometrial hyperplasia with atypia or endometrial carcinoma.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

LEDIPASVIR-SOFOSBUVIR

Products Affected

- *ledipasvir-sofosbuvir*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of chronic hepatitis C infection confirmed by a detectable serum hepatitis C virus RNA through quantitative assay. Documentation of genotype. Documentation of the absence or presence of cirrhosis and if compensated or decompensated. Documentation of any previous treatment. Documentation of liver transplant status. Treatment regimen will be approved based on genotype and previous treatment experience as defined by current AASLD guidelines.
Age Restrictions	
Prescriber Restrictions	Gastroenterologist, Hepatologist, Infectious Disease specialist
Coverage Duration	Duration will be applied consistent with current AASLD/IDSA guidance.
Other Criteria	Hepatitis C: Failure or clinically significant adverse effects to the formulary alternative: sofosbuvir-velpatasvir (generic Epclusa).
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

LEUKINE

Products Affected

- LEUKINE INJECTION RECON SOLN

PA Criteria	Criteria Details
Exclusion Criteria	Excessive leukemia myeloid blasts in the bone marrow or peripheral blood equal to or greater than 10%.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Hematologist, Oncologist
Coverage Duration	3 months.
Other Criteria	Failure or clinically significant adverse effects to formulary alternative: Nivestym and Zarxio.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

LEUPROLIDE ACETATE

Products Affected

- *leuprolide (3 month)*
- *leuprolide subcutaneous kit*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Oncologist, Urologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Subject to Part B vs Part D determination.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

LEVALBUTEROL

Products Affected

- *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*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Subject to Part B vs Part D determination. Failure or clinically significant adverse effects to the formulary alternative: albuterol inhalant solution.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

LIDOCAINE PATCH

Products Affected

- *lidocaine topical adhesive patch,medicated 5 %*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of one of the following: Pain associated with diabetic neuropathy, Pain associated with cancer-related neuropathy, Post-herpetic neuralgia, Chronic back pain, or Osteoarthritis of the knee or hip.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

LIVTENCITY

Products Affected

- LIVTENCITY

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	New: Documentation that patient is refractory to prior therapy with ganciclovir, valganciclovir, cidofovir or foscarnet.
Age Restrictions	
Prescriber Restrictions	Infectious Disease specialist, Oncologist, Transplant specialist
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

LUPRON DEPOT

Products Affected

- LUPRON DEPOT
- LUPRON DEPOT (3 MONTH)
- LUPRON DEPOT (4 MONTH)
- LUPRON DEPOT (6 MONTH)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Endometriosis: Patient has had surgical ablation to prevent recurrence, or history of failure, contraindication, or intolerance to oral contraceptives.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Subject to Part B vs Part D determination.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

LYRICA

Products Affected

- *pregabalin oral capsule 100 mg, 150 mg, 200 mg, 225 mg, 25 mg, 300 mg, 50 mg, 75 mg*
- *pregabalin oral solution*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Postherpetic neuralgia: Failure or clinically significant adverse effects to the formulary alternative: gabapentin. Diabetic neuropathy: Failure or clinically significant adverse effects to all of the formulary alternatives: duloxetine and gabapentin. Fibromyalgia: Failure or clinically significant adverse effects to two of the formulary alternatives: duloxetine, gabapentin or Savella.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

MEGESTROL

Products Affected

- *megestrol oral suspension 400 mg/10 ml (40 mg/ml)*
- *megestrol oral tablet*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Approve if less than 65 years of age. If aged 65 years and older, prior authorization criteria will apply.
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Cachexia associated with AIDS: Failure or clinically significant adverse effects to all of the formulary alternatives: dronabinol and oxandrolone.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

MEPROBAMATE

Products Affected

- *meprobamate*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Approve if less than 65 years of age. If aged 65 years and older, prior authorization criteria will apply.
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to at least two of the formulary alternatives: buspirone, duloxetine, escitalopram, or venlafaxine.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

METHOCARBAMOL

Products Affected

- *methocarbamol oral tablet 500 mg, 750 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Approve if less than 65 years of age. If aged 65 years and older, prior authorization criteria will apply.
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Documentation explaining specific benefit established with the medication, and how that benefit outweighs the potential risk
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

METHYLDOPA/HYDROCHLOROTHIAZIDE

Products Affected

- *methyldopa-hydrochlorothiazide*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Approve if less than 65 years of age. If aged 65 years and older, prior authorization criteria will apply.
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to two of the formulary alternatives: benazepril, fosinopril, hydrochlorothiazide, irbesartan, lisinopril, losartan, losartan/hydrochlorothiazide, lisinopril/hydrochlorothiazide, quinapril/hydrochlorothiazide, quinapril, ramipril, or valsartan/hydrochlorothiazide.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

METYROSINE

Products Affected

- *metyrosine*

PA Criteria	Criteria Details
Exclusion Criteria	Essential hypertension.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

MODAFINIL

Products Affected

- *modafinil*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Narcolepsy: Failure or clinically significant adverse effects to all of the formulary alternatives: dextroamphetamine and methylphenidate.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

NAYZILAM

Products Affected

- LIBERVANT
- NAYZILAM

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Neurologist
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

NIVESTYM

Products Affected

- NIVESTYM INJECTION

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Hematologist, Infectious Disease specialist, Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

NUCALA

Products Affected

- NUCALA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Allergist, Immunologist, Pulmonologist, Rheumatologist, Hematologist, or Otolaryngologist.
Coverage Duration	Until the end of calendar year.
Other Criteria	Asthma: Failure or clinically significant adverse effects to two of the formulary alternatives: 1) budesonide, Flovent, Arnuity Ellipta or Qvar and 2) fluticasone-salmeterol, Wixela, or Breo Ellipta.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

NUEDEXTA

Products Affected

- NUEDEXTA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Neurologist
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

NUPLAZID

Products Affected

- NUPLAZID

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

OCTREOTIDE

Products Affected

- *octreotide acetate injection solution*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

OFEV

Products Affected

- OFEV

PA Criteria	Criteria Details
Exclusion Criteria	Moderate or severe hepatic impairment (Child-Pugh B or C).
Required Medical Information	Initial authorization: Documentation of liver function tests. Reauthorization only: Documentation of positive response to therapy and documentation of liver function tests.
Age Restrictions	
Prescriber Restrictions	Pulmonologist
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

OLANZAPINE ODT

Products Affected

- *olanzapine oral tablet,disintegrating*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of difficulty or inability to swallow or failure or clinically significant adverse effects to the formulary alternative: oral olanzapine.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

OLANZAPINE SOLUTION

Products Affected

- *olanzapine intramuscular*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

OMNITROPE

Products Affected

- OMNITROPE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	AGHD (initial): diagnosis confirmed as a result of past diagnosis of childhood-onset GHD, or adult-onset GHD with documentation of hormone deficiency due to hypothalamic-pituitary disease from organic or known causes (eg: damage from surgery, cranial irradiation, head trauma, subarachnoid hemorrhage) and documentation of one growth-hormone stimulant test (eg: insulin tolerance test, arginine/GHRH, glucagon, arginine) to confirm adult GHD w/corresponding peak GH values ([ITT at or below 5mcg/L],[GHRH+ARG at or below 11mcg/L if BMI less than 25kg/m2, at or below 8mcg/L if BMI at or above 25 and below 30kg/m2, or at or below 4mcg/L if BMI at or above 30kg/m2],[glucagon at or below 3mcg/L],[Arg at or below 0.4mcg/L]) or documented deficiency of 3 anterior pituitary hormones (prolactin, ACTH, TSH, FSH/LH) and IFG-1/somatomedin C below age and gender adjusted normal range as provided by physicians lab. AGHD (reauthorization): Documentation of positive experience by the patient.
Age Restrictions	
Prescriber Restrictions	Endocrinologist
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

ORAL ANTIPSYCHOTICS

Products Affected

- *asenapine maleate*
- CAPLYTA
- COBENFY
- COBENFY STARTER PACK
- FANAPT
- LATUDA ORAL TABLET 120 MG, 20 MG, 40 MG, 60 MG, 80 MG
- *lurasidone oral tablet 120 mg, 20 mg, 40 mg, 60 mg, 80 mg*
- VRAYLAR ORAL CAPSULE
- VRAYLAR ORAL CAPSULE,DOSE PACK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to two of the formulary alternatives: olanzapine, quetiapine, risperidone, ziprasidone or aripiprazole.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

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
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Rheumatologist, transplant specialist
Coverage Duration	Until the end of calendar year.
Other Criteria	Rheumatoid Arthritis: Failure or clinically significant adverse effects to one of the formulary alternatives: azathioprine, cyclosporine, hydroxychloroquine, leflunomide, methotrexate, or sulfasalazine. Psoriatic arthritis: Failure or clinically significant adverse effects to the formulary alternative: methotrexate.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

ORKAMBI

Products Affected

- ORKAMBI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of homozygous F508del mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene.
Age Restrictions	
Prescriber Restrictions	Infectious Disease specialist, Pulmonologist
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

OTEZLA

Products Affected

- OTEZLA
- OTEZLA STARTER

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Plaque psoriasis: documentation of psoriasis with BSA of 2% or greater or affecting crucial body areas such as hands, feet, face or genitals.
Age Restrictions	
Prescriber Restrictions	Dermatologist, Rheumatologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Psoriatic arthritis: Failure or clinically significant adverse effects to the formulary alternative: methotrexate. Plaque psoriasis: Failure or clinically significant adverse effects to one of the formulary alternatives: acitretin, cyclosporine, methotrexate or phototherapy.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

OXBRYTA

Products Affected

- OXBRYTA ORAL TABLET 300 MG, 500 MG
- OXBRYTA ORAL TABLET FOR SUSPENSION

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of at least 1 episode of vaso-occlusive crisis (VOC) in the past 12 months. Hemoglobin (Hgb) greater than or equal to 5.5 and less than or equal to 10.5 g/dL. Re-authorization: Documentation of positive response to therapy.
Age Restrictions	
Prescriber Restrictions	Hematologist
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

OXERVATE

Products Affected

- OXERVATE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of Stage 2 or 3 neurotrophic keratitis.
Age Restrictions	
Prescriber Restrictions	Ophthalmologist
Coverage Duration	8 weeks.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

OXTELLAR

Products Affected

- *oxcarbazepine oral tablet extended release 24 hr 150 mg, 300 mg, 600 mg*
- OXTELLAR XR ORAL TABLET EXTENDED RELEASE 24 HR 150 MG, 300 MG, 600 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Neurologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to oxcarbazepine immediate release.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

PAH

Products Affected

- *ambrisentan*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Cardiologist, Pulmonologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to the formulary alternative: sildenafil or tadalafil. Approve if in combination with tadalafil for treatment naive PAH patients with WHO FC II and III.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

PARATHYROID HORMONE ANALOGS

Products Affected

- *teriparatide subcutaneous pen injector 20 mcg/dose (620mcg/2.48ml)*
- TYMLOS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Bone mineral density (BMD) T score of -3.5 or less based on BMD measurements from lumbar spine (at least two vertebral bodies), hip (femoral neck, total hip), or radius (one-third radius site) OR BMD T-score between -2.5 and -3.5 (BMD T-score greater than -3.5 and less than or equal to -2.5) based on BMD measurements from lumbar spine (at least two vertebral bodies), hip (femoral neck, total hip), or radius (one-third radius site) and a history of fractures.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to one of the formulary alternatives: alendronic acid or risedronate. Medical justification required for treatment duration beyond 24 months.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

PDE5 INHIBITORS

Products Affected

- *alyq*
- *sildenafil (pulm.hypertension) oral tablet*
- *tadalafil (pulm. hypertension)*
- TADLIQ

PA Criteria	Criteria Details
Exclusion Criteria	Concurrent use with nitrates or PDE5 inhibitors.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Cardiologist, Pulmonologist
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

PEGFILGRASTIM

Products Affected

- FULPHILA
- UDENYCA
- UDENYCA AUTOINJECTOR
- UDENYCA ONBODY
- ZIEXTENZO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Hematologist, Infectious Disease specialist, Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to formulary alternative: Nivestym and Zarxio.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

PHENOBARBITAL

Products Affected

- *phenobarbital*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Approve if less than 65 years of age. If aged 65 years and older, prior authorization criteria will apply.
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Anticonvulsant: Failure or clinically significant adverse effects to two of the formulary alternatives: carbamazepine, divalproex, ethosuximide, felbamate, gabapentin, lamotrigine, levetiracetam, oxcarbazepine, phenytoin, tiagabine, topiramate, or zonisamide.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

PIMECROLIMUS

Products Affected

- *pimecrolimus*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to one of the topical formulary alternatives: clobetasol, betamethasone, fluocinolone or fluocinonide and failure or clinically significant adverse effects to the formulary alternative: tacrolimus ointment.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

POSACONAZOLE

Products Affected

- NOXAFIL ORAL SUSPENSION
- *posaconazole oral*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to one of the formulary alternatives: fluconazole, itraconazole, or voriconazole.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

PRADAXA PELLET

Products Affected

- PRADAXA ORAL PELLETS IN PACKET

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Pediatric patients aged 3 months to less than 12 years of age.
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

PREMARIN TABLETS

Products Affected

- PREMARIN ORAL

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Postmenopausal osteoporosis prophylaxis: Failure or clinically significant adverse effects to all of the formulary alternatives: alendronic acid and risedronate. Vulvar and vaginal atrophy: Failure or clinically significant adverse effects to the formulary alternative: estradiol cream. Other indication(s): Failure or clinically significant adverse effects to one of the formulary alternatives: estradiol transdermal patch or estradiol tablet.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

PREMPRO TABLETS

Products Affected

- PREMPRO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Postmenopausal osteoporosis prophylaxis: Failure or clinically significant adverse effects to all of the formulary alternatives: alendronic acid and risedronate. Vulvar and vaginal atrophy: Failure or clinically significant adverse effects to the formulary alternative: estradiol cream. Other indication(s): Failure or clinically significant adverse effects to one of the formulary alternatives: estradiol transdermal patch or estradiol tablet.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

PREVYMIS

Products Affected

- PREVYMIS ORAL

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Infectious Disease specialist, Oncologist, Transplant specialist
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

PROCRIT

Products Affected

- PROCRIT

PA Criteria	Criteria Details
Exclusion Criteria	Uncontrolled hypertension.
Required Medical Information	For anemia due to chronic kidney disease: Hemoglobin (Hgb) is less than 10g/dL and documentation of transferrin saturation greater than or equal to 20% and ferritin greater than or equal to 100ng/mL. For anemia due to chemotherapy: Hemoglobin (Hgb) is less than 10g/dL. For surgical FDA indications: Hemoglobin (Hgb) is 10g/dL-13g/dL and patient is not a candidate for autologous blood donation and significant blood loss is anticipated from elective, non cardiac, or nonvascular surgery. Zidovudine induced: Hemoglobin (Hgb) is less than 11g/dL. Myelodysplastic syndrome: Hemoglobin (Hgb) is less than 11g/dL and erythropoietin is less than or equal to 500 mU/mL.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Subject to Part B vs Part D determination.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

PROLASTIN C

Products Affected

- PROLASTIN-C INTRAVENOUS SOLUTION

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Clinical evidence of emphysema
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year
Other Criteria	Pre-treatment serum levels of alpha-1 antitrypsin (AAT) that is less than 11 micromol/L (80 mg/dl by radial immunodiffusion or 50 mg/dl by nephelometry)
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

PROLIA

Products Affected

- PROLIA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of bone mineral density (BMD) T-score of -3.5 or less based on BMD measurements from lumbar spine (at least two vertebral bodies), hip (femoral neck, total hip), or radius (one-third radius site) OR BMD T-score between -2.5 and -3.5 (greater than -3.5 and less than or equal to -2.5) based on BMD measurements from lumbar spine (at least two vertebral bodies), hip (femoral neck, total hip), or radius (one-third radius site) and a history of fractures.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to all of the formulary alternatives: alendronic acid and risedronate.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

PROMACTA

Products Affected

- PROMACTA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of platelet count. Thrombocytopenia in hepatitis C infection: Documentation of concurrent or planned interferon-based treatment of chronic hepatitis C.
Age Restrictions	
Prescriber Restrictions	Gastroenterologist, Hematologist, Hepatologist, Infectious Disease specialist, Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Chronic immune (idiopathic) thrombocytopenia: Failure or clinically significant adverse effects to one of the formulary alternatives: dexamethasone, methylprednisolone, prednisolone or prednisone.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

PROMETHAZINE

Products Affected

- *promethazine oral*
- *promethazine rectal suppository 12.5 mg, 25 mg*
- *promethegan rectal suppository 25 mg, 50 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Approve if less than 65 years of age. If aged 65 years and older, prior authorization criteria will apply.
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Allergy: Failure or clinically significant adverse effects to one of the formulary alternatives: cetirizine and levocetirizine. Nausea and vomiting: Failure or clinically significant adverse effects to two of the formulary alternatives: chlorpromazine, granisetron, ondansetron, or prochlorperazine.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

PROTRIPTYLINE

Products Affected

- *protriptyline*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Approve if less than 65 years of age. If aged 65 years and older, prior authorization criteria will apply.
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to two of the formulary alternatives: citalopram, escitalopram, fluoxetine, sertraline, venlafaxine, desvenlafaxine, duloxetine, mirtazapine, or bupropion
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

PYRIMETHAMINE

Products Affected

- *pyrimethamine*

PA Criteria	Criteria Details
Exclusion Criteria	Anemia due to folate deficiency
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Hematologist, HIV specialist, Infectious Disease specialist, Oncologist, Transplant specialist
Coverage Duration	Until the end of calendar year.
Other Criteria	Primary prophylaxis of toxoplasmic encephalitis: Failure or clinically significant adverse effects to the formulary alternative: trimethoprim/sulfamethoxazole.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

QUININE

Products Affected

- *quinine sulfate*

PA Criteria	Criteria Details
Exclusion Criteria	Prevention or treatment of nocturnal leg cramps.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	10 days.
Other Criteria	Failure or clinically significant adverse effects to one of the formulary alternatives: chloroquine or hydroxychloroquine.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

REPATHA

Products Affected

- REPATHA PUSHTRONEX
- REPATHA SURECLICK
- REPATHA SYRINGE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Primary hyperlipidemia: Documentation of current LDL levels above 100mg/dL while taking maximally tolerated statin therapy and ezetimibe therapy, unless intolerant or contraindicated to statin or ezetimibe therapy. Secondary prevention of ASCVD: Documentation of at least one high risk feature: recent ACS (within the past 12 months), history of MI, history of ischemic stroke, or symptomatic peripheral arterial disease (history of claudication with ABI greater than 0.85, or previous revascularization or amputation). Heterozygous Familial Hypercholesterolemia (HeFH) or Homozygous Familial Hypercholesterolemia (HoFH): Documentation to confirm diagnosis by genetic testing or by clinical criteria (such as Simon Broome or the Dutch Lipid Clinic Network criteria, or history of untreated LDL-C greater than 180 mg/dL together with xanthoma or cornealis), or evidence of Familial Hypercholesterolemia in first or second-degree relatives.
Age Restrictions	
Prescriber Restrictions	Cardiologist, Endocrinologist, Lipid specialist
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

RETACRIT

Products Affected

- RETACRIT INJECTION SOLUTION 10,000 UNIT/ML, 2,000 UNIT/ML, 20,000 UNIT/ML, 3,000 UNIT/ML, 4,000 UNIT/ML, 40,000 UNIT/ML

PA Criteria	Criteria Details
Exclusion Criteria	Uncontrolled hypertension.
Required Medical Information	For anemia due to chronic kidney disease: Hemoglobin (Hgb) is less than 10g/dL and documentation of transferrin saturation greater than or equal to 20% and ferritin greater than or equal to 100ng/mL. For anemia due to chemotherapy: Hemoglobin (Hgb) is less than 10g/dL. For surgical FDA indications: Hemoglobin (Hgb) is 10g/dL-13g/dL and patient is not a candidate for autologous blood donation and significant blood loss is anticipated from elective, non cardiac, or nonvascular surgery. Zidovudine induced: Hemoglobin (Hgb) is less than 11g/dL. Myelodysplastic syndrome: Hemoglobin (Hgb) is less than 11g/dL and erythropoietin is less than or equal to 500 mU/mL.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Subject to Part B vs Part D determination.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

REXULTI

Products Affected

- REXULTI ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Schizophrenia: Failure or clinically significant adverse effects to two of the formulary alternatives: olanzapine, risperidone, quetiapine, ziprasidone or aripiprazole. Depression: Failure or clinically significant adverse effects to two of the formulary alternatives: citalopram, escitalopram, fluoxetine, mirtazapine, paroxetine, sertraline, or venlafaxine.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

REZUROCK

Products Affected

- REZUROCK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

RINVOQ

Products Affected

- RINVOQ LQ
- RINVOQ ORAL TABLET EXTENDED RELEASE 24 HR 15 MG, 30 MG, 45 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Rheumatologist, dermatologist, gastroenterologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Rheumatoid Arthritis: Failure or clinically significant adverse effects to one of the formulary alternatives: azathioprine, cyclosporine, hydroxychloroquine, leflunomide, methotrexate, or sulfasalazine. Ankylosing spondylitis: Failure or clinically significant adverse effects to one of the formulary alternatives: celecoxib, diclofenac, indomethacin, naproxen, or sulindac. Psoriatic arthritis: Failure or clinically significant adverse effects to the formulary alternative: methotrexate. Non-radiographic Axial Spondyloarthritis: Failure or clinically significant adverse effects to a non-steroidal anti-inflammatory drug (NSAID) or has an intolerance or contraindication to NSAID. Crohn's disease and Ulcerative colitis: Failure or clinically significant adverse effects to one of the formulary alternatives: budesonide, mesalamine or sulfasalazine. Initial Atopic Dermatitis: 1) Atopic Dermatitis covering at least 10 percent of body surface area or Atopic Dermatitis affecting the face, head, neck, hands, feet, groin, or intertriginous areas, 2) intractable pruritus or cracking/oozing/bleeding of affected skin, 3) trial of or contraindication to one topical (corticosteroid or calcineurin inhibitor), and 4) no concurrent use with other systemic biologic for Atopic Dermatitis. Renewal: Atopic Dermatitis: 1) improvement while on therapy, and 2) no concurrent use with other systemic biologic for Atopic Dermatitis.
Indications	All FDA-approved Indications.

PA Criteria	Criteria Details
Off Label Uses	
Part B Prerequisite	No

RISPERDAL CONSTA

Products Affected

- RISPERDAL CONSTA
- UZEDY
- *risperidone microspheres*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to the formulary alternative: oral risperidone.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

RUFINAMIDE

Products Affected

- *rufinamide oral suspension*
- *rufinamide oral tablet*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Failure or clinically significant adverse effects to one of the formulary alternatives: carbamazepine, clonazepam, divalproex, ethosuximide, felbamate, gabapentin, lamotrigine, levetiracetam, lorazepam, oxcarbazepine, phenytoin, tiagabine, topiramate, clobazam or zonisamide. For Rufinamide suspension: Failure or clinically significant adverse effects to one of the formulary alternatives: Rufinamide tablet.
Age Restrictions	
Prescriber Restrictions	Neurologist
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

SAPROPTERIN

Products Affected

- *sapropterin*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

SECUADO

Products Affected

- SECUADO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to two of the formulary alternatives: olanzapine, quetiapine, risperidone, ziprasidone or aripiprazole.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

SIGNIFOR

Products Affected

- SIGNIFOR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

SIRTURO

Products Affected

- SIRTURO ORAL TABLET 100 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Infectious Disease specialist
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

SKYRIZI

Products Affected

- SKYRIZI SUBCUTANEOUS PEN INJECTOR
- SKYRIZI SUBCUTANEOUS SYRINGE 150 MG/ML
- SKYRIZI SUBCUTANEOUS WEARABLE INJECTOR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Plaque psoriasis: documentation of psoriasis of greater than 3% BSA or affecting crucial body areas such as hands, feet, face or genitals.
Age Restrictions	
Prescriber Restrictions	Dermatologist, gastroenterologist, rheumatologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Plaque psoriasis: Failure or clinically significant adverse effects to one of the following: acitretin, cyclosporine, methotrexate or phototherapy.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

SOFOSBUVIR-VELPATASVIR

Products Affected

- *sofosbuvir-velpatasvir*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of chronic hepatitis C infection confirmed by a detectable serum hepatitis C virus RNA through quantitative assay. Documentation of genotype. Documentation of the absence or presence of cirrhosis and if compensated or decompensated. Documentation of any previous treatment. Documentation of liver transplant status. Treatment regimen will be approved based on genotype and previous treatment experience as defined by current AASLD guidelines.
Age Restrictions	
Prescriber Restrictions	Gastroenterologist, Hepatologist, Infectious Disease specialist
Coverage Duration	Duration will be applied consistent with current AASLD/IDSA guidance.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

SOMAVERT

Products Affected

- SOMAVERT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Endocrinologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to the formulary alternative: octreotide.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

SPRITAM

Products Affected

- SPRITAM

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Neurologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to the formulary alternative: levetiracetam oral solution.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

STELARA

Products Affected

- STELARA SUBCUTANEOUS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Plaque psoriasis: documentation of psoriasis of greater than 3% BSA or affecting crucial body areas such as hands, feet, face or genitals.
Age Restrictions	
Prescriber Restrictions	Dermatologist, Gastroenterologist, Rheumatologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Psoriatic arthritis: Failure or clinically significant adverse effects to the formulary alternative: methotrexate. Plaque psoriasis: Failure or clinically significant adverse effects to one of the formulary alternatives: acitretin, cyclosporine, methotrexate or phototherapy. Crohn's disease and Ulcerative colitis: Failure or clinically significant adverse effects to one of the formulary alternatives: budesonide, mesalamine or sulfasalazine.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

SYMPAZAN

Products Affected

- SYMPAZAN

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of difficulty or inability to swallow.
Age Restrictions	
Prescriber Restrictions	Neurologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to two of the formulary alternatives: carbamazepine, clonazepam, divalproex, ethosuximide, felbamate, gabapentin, lamotrigine, levetiracetam, lorazepam, oxcarbazepine, phenytoin, tiagabine, topiramate, valproic acid or zonisamide.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

SYNAREL

Products Affected

- SYNAREL

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

TACROLIMUS OINTMENT

Products Affected

- *tacrolimus topical*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to two of the topical formulary alternatives: clobetasol, betamethasone, fluocinolone, or fluocinonide.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

TADALAFIL

Products Affected

- *tadalafil oral tablet 5 mg*

PA Criteria	Criteria Details
Exclusion Criteria	Erectile Dysfunction without diagnosis of Benign Prostatic Hyperplasia (BPH).
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Benign Prostatic Hyperplasia: 1) trial of one alpha blocker (e.g., doxazosin, terazosin, tamsulosin, alfuzosin), and 2) trial of one 5-alpha-reductase inhibitor (e.g., finasteride, dutasteride).
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

TAKHZYRO

Products Affected

- TAKHZYRO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of hereditary angioedema (HAE), must be confirmed by blood testing.
Age Restrictions	
Prescriber Restrictions	Allergist, Immunologist, Hematologist
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

TALTZ

Products Affected

- TALTZ AUTOINJECTOR
- TALTZ SYRINGE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Plaque psoriasis: documentation of psoriasis of greater than 3% BSA or affecting crucial body areas such as hands, feet, face or genitals.
Age Restrictions	
Prescriber Restrictions	Dermatologist, Rheumatologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Psoriatic arthritis: Failure or clinically significant adverse effects to the formulary alternative: methotrexate. Ankylosing spondylitis: Failure or clinically significant adverse effects to one of the formulary alternatives: celecoxib, diclofenac, indomethacin, naproxen, or sulindac. Plaque psoriasis: Failure or clinically significant adverse effects to one of the formulary alternatives: acitretin, cyclosporine, methotrexate or phototherapy.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

TARGRETIN

Products Affected

- *bexarotene*
- TARGRETIN TOPICAL

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Dermatologist, Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

TAVNEOS

Products Affected

- TAVNEOS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	1) Diagnosis of granulomatosis with polyangiitis (GPA) and microscopic polyangiitis (MPA) variant of anti-neutrophil cytoplasmic autoantibody (ANCA)-associated vasculitis, 2) positive test for either anti-PR3 or anti-MPO, 3) at least 1 major item, 3 non-major items, or 2 renal items of proteinuria and hematuria on the Birmingham Vasculitis Activity Score (BVAS), 4) eGFR greater than or equal to 15 mL/min/1.72 m2, 5) currently receiving standard therapy with cyclophosphamide or rituximab
Age Restrictions	
Prescriber Restrictions	Rheumatologist, Nephrologist
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

TAZORAC

Products Affected

- *tazarotene topical cream*
- *tazarotene topical gel*
- TAZORAC TOPICAL CREAM 0.05 %
- TAZORAC TOPICAL GEL

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Plaque psoriasis: Failure or clinically significant adverse effects to one of the topical formulary alternatives: calcipotriene, clobetasol or fluocinonide. Acne vulgaris: Failure or clinically significant adverse effects to two of the formulary alternatives: benzoyl peroxide/clindamycin topical, benzoyl peroxide/erythromycin topical, clindamycin topical, doxycycline oral, erythromycin topical, minocycline oral, tetracycline oral or tretinoin topical.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

TECFIDERA

Products Affected

- *dimethyl fumarate*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Neurologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to all of the formulary alternatives: Aubagio and glatiramer.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

TESTOSTERONE

Products Affected

- *methyltestosterone oral capsule*
- *testosterone cypionate*
- *testosterone enanthate*
- *testosterone transdermal gel in metered-dose pump*
- *testosterone transdermal gel in packet*
- *testosterone transdermal solution in metered pump w/app*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documented pretreatment serum testosterone levels less than the laboratory's lower reference limit within the recent 3 months.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

TESTOSTERONE PUMP

Products Affected

- *testosterone transdermal gel in metered-dose pump*
- *testosterone transdermal gel in packet*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documented pretreatment serum testosterone levels less than the laboratory's lower reference limit within the recent 3 months.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to two of the formulary alternatives: testosterone cypionate, testosterone enanthate or testosterone transdermal gel or solution.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

TETRABENAZINE

Products Affected

- *tetrabenazine*

PA Criteria	Criteria Details
Exclusion Criteria	Concurrent use with an MAOI. Untreated or inadequately-treated depression, or current suicidality.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Neurologist
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

TIGECYCLINE

Products Affected

- *tigecycline*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Infectious Disease specialist
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

TOBI PODHALER

Products Affected

- TOBI PODHALER

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Infectious Disease specialist, Pulmonologist
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

TOBRAMYCIN SOLUTION

Products Affected

- *tobramycin in 0.225 % nacl*
- *tobramycin inhalation*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Infectious Disease specialist, Pulmonologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Subject to Part B vs Part D determination.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

TOLCAPONE

Products Affected

- *tolcapone*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of concurrent use with levodopa and carbidopa.
Age Restrictions	
Prescriber Restrictions	Neurologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to two of the formulary alternatives: amantadine, bromocriptine, carbidopa/levodopa, entacapone, pramipexole, ropinirole, or selegiline.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

TRELSTAR

Products Affected

- TRELSTAR INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Subject to Part B vs Part D determination.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

TRIENTINE

Products Affected

- *trientine oral capsule 250 mg*

PA Criteria	Criteria Details
Exclusion Criteria	Biliary cirrhosis, rheumatoid arthritis.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to the formulary alternative: penicillamine.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

TRIHEXYPHENIDYL

Products Affected

- *trihexyphenidyl*

PA Criteria	Criteria Details
Exclusion Criteria	Narrow angle glaucoma.
Required Medical Information	
Age Restrictions	Approve if less than 65 years of age. If aged 65 years and older, prior authorization criteria will apply.
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Parkinsonism: Failure or clinically significant adverse effects to one of the formulary alternatives: amantadine, bromocriptine, carbidopa/levodopa, entacapone, pramipexole, ropinirole, or selegiline. Medication-induced movement disorder - extrapyramidal disease: Failure or clinically significant adverse effects to the formulary alternative: amantadine.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

TRIMIPRAMINE

Products Affected

- *trimipramine*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Approve if less than 65 years of age. If aged 65 years and older, prior authorization criteria will apply.
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to two of the formulary alternatives: citalopram, escitalopram, fluoxetine, sertraline, venlafaxine, desvenlafaxine, duloxetine, mirtazapine, or bupropion
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

TRINTELLIX

Products Affected

- TRINTELLIX

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to two of the formulary alternatives: citalopram, escitalopram, fluoxetine, sertraline, venlafaxine, desvenlafaxine, duloxetine, mirtazapine, or bupropion
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

UBRELVY

Products Affected

- UBRELVY

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Medical justification specifying that TWO formulary anti-migraine drugs from different classes have been tried and failed are contraindicated, or would not be medically appropriate. Classes include: (1) Analgesics- aspirin, naproxen, ibuprofen, diclofenac, celecoxib, indomethacin, nabumetone, and (2) Triptans- sumatriptan, rizatriptan/rizatriptan ODT
Age Restrictions	
Prescriber Restrictions	Neurologist, Pain Specialist, Headache Specialist
Coverage Duration	Until the end of calendar year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

VALCHLOR

Products Affected

- VALCHLOR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Dermatologist, Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

VANCOMYCIN CAPSULE

Products Affected

- *vancomycin oral capsule 125 mg, 250 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	C diff diarrhea: Reauthorization: Documentation of C. Difficile positive stool
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 months.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

VEMLIDY

Products Affected

- VEMLIDY

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Hepatologist, Gastroenterologist, Infectious Disease specialist
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

VEOZAH

Products Affected

- VEOZAH

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Menopausal vasomotor symptoms (VMS): initial: 1) experiences 7 or more hot flashes per day, and 2) trial of or contraindication to hormonal therapy (e.g., estradiol transdermal patch, oral conjugated estrogens). Renewal: 1) continued need for VMS treatment (i.e., persistent hot flashes), and 2) reduction in VMS frequency or severity due to Veozah treatment.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

VERQUVO

Products Affected

- VERQUVO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Cardiologist
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

VIBERZI

Products Affected

- VIBERZI

PA Criteria	Criteria Details
Exclusion Criteria	History of gallbladder removal.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to the all of the formulary alternatives: dicyclomine and loperamide.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

VIIBRYD

Products Affected

- VIIBRYD ORAL TABLET
- *vilazodone*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to two of the formulary alternatives: citalopram, escitalopram, fluoxetine, sertraline, venlafaxine, desvenlafaxine, duloxetine, mirtazapine, or bupropion
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

VORICONAZOLE

Products Affected

- *voriconazole intravenous*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

VOWST

Products Affected

- VOWST

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	1) Diagnosis of greater than or equal to 2 recurrent Clostridioides Difficile Infection (CDI), 2) current episode of CDI must be controlled (less than 3 unformed/loose stools/day for 2 consecutive days) following 10 to 21 days of antibiotic therapy, 3) recent positive stool test for C. difficile, and 4) completion of antibiotic treatment
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

WEGOVY

Products Affected

- WEGOVY

PA Criteria	Criteria Details
Exclusion Criteria	Concurrent use with DPP4 inhibitors, history of Type 1 or Type 2 Diabetes Mellitus, and/or history of NYHA Class IV Heart Failure. Use of weight loss only.
Required Medical Information	BMI greater than or equal to 27 kg/m2. Documentation of one of the following: prior MI, prior stroke, symptomatic PAD (evidenced by intermittent claudication with ABI less than 0.85 at rest and/or peripheral arterial revascularization procedure and/or amputation due to ASCVD).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Reauthorization only: Documentation of positive response to medication therapy.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

XATMEP

Products Affected

- XATMEP

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Oncologist, Pediatrician, Rheumatologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Subject to Part B vs Part D determination.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

XDEMVY

Products Affected

- XDEMVY

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

XELJANZ

Products Affected

- XELJANZ ORAL SOLUTION
- XELJANZ ORAL TABLET
- XELJANZ XR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Gastroenterologist, Rheumatologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Rheumatoid Arthritis: Failure or clinically significant adverse effects to one of the formulary alternatives: azathioprine, cyclosporine, hydroxychloroquine, leflunomide, methotrexate, or sulfasalazine. Psoriatic arthritis: Failure or clinically significant adverse effects to the formulary alternative: methotrexate. Ulcerative colitis: Failure or clinically significant adverse effects to formulary alternative: Humira.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

XGEVA

Products Affected

- XGEVA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

XIFAXAN

Products Affected

- XIFAXAN

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Hepatic encephalopathy: Failure or clinically significant adverse effects to the formulary alternative: lactulose. Irritable bowel syndrome with diarrhea: Failure or clinically significant adverse effects to all of the formulary alternative: loperamide. Traveler's diarrhea: Failure or clinically significant adverse effects to one of the formulary alternatives: ciprofloxacin or levofloxacin.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

XOLAIR

Products Affected

- XOLAIR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Asthma (Initial): Forced expiratory volume in one second or peak expiratory flow less than or equal to 80% of predicted level, or measures of asthma control indicate uncontrolled asthma (eg, Asthma Control Test [ACT] score 19 or less). Baseline (pre-Xolair treatment) serum total IgE level greater than or equal to 30 IU/mL. Positive skin test or in vitro reactivity to a perennial aeroallergen.
Age Restrictions	
Prescriber Restrictions	Allergist, Dermatologist, Immunologist, Pulmonologist, Otolaryngologist
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

XYREM

Products Affected

- *sodium oxybate*
- XYREM

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Daytime excessive sleepiness in patients with narcolepsy: Failure or clinically significant adverse effects to two of the formulary alternatives: dextroamphetamine, methylphenidate, and modafinil.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

ZARXIO

Products Affected

- ZARXIO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Hematologist, Infectious Disease specialist, Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

ZEPATIER

Products Affected

- ZEPATIER

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of chronic hepatitis C infection confirmed by a detectable serum hepatitis C virus RNA through quantitative assay. Documentation of genotype. Documentation of the absence or presence of cirrhosis and if compensated or decompensated. Documentation of any previous treatment. Documentation of liver transplant status. Treatment regimen will be approved based on genotype and previous treatment experience as defined by current AASLD guidelines. For genotype 1a: Documentation for NS5A polymorphism testing.
Age Restrictions	
Prescriber Restrictions	Gastroenterologist, Hepatologist, Infectious Disease specialist
Coverage Duration	Duration will be applied consistent with current AASLD/IDSA guidance.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

ZYPREXA RELPREVV

Products Affected

- ZYPREXA RELPREVV INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION 210 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documented history of receiving oral olanzapine without any clinically significant side effects.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to two of the formulary alternatives: Invega Sustenna, Invega Trinza or Risperdal Consta.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

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