

# 2025 Priority Health Medicare Prior Authorization Criteria

An alphabetical index by drug name appears after the drug criteria listings.

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# abiraterone acetate

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## Products Affected

- *abiraterone acetate oral tablet 250 mg, 500 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

# ACTHAR

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## Products Affected

- ACTHAR
- ACTHAR GEL

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Acthar Gel is only covered for the treatment of infantile spasms.
<b>Required Medical Information</b>	Documentation of prior therapies and responses to treatment.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	6 weeks
<b>Other Criteria</b>	Covered for infantile spasms after trial and failure (defined as an intolerance or inability to improve the condition) with Cortrophin.
<b>Indications</b>	Some FDA-approved Indications Only.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# ACTIMMUNE

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## Products Affected

- ACTIMMUNE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient's body surface area (BSA)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

# ADALIMUMAB-ADAZ

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## Products Affected

- *adalimumab-adaz*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Must not be used in combination with other biologic drugs, Otezla, or Janus Kinase Inhibitor (JAKis).
<b>Required Medical Information</b>	Documentation of prior therapies and responses to treatment. For approvals of shortened-interval dosing in Crohn's disease and ulcerative colitis, documentation of the following: (1) Two of the following: symptoms, imaging showing active disease, fecal calprotectin greater than 120, CRP greater than or equal to 300, and (2) inadequate drug trough levels, and (3) initial response to therapy.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Prescriber is a specialist or has consulted with a specialist for the condition being treated.
<b>Coverage Duration</b>	Two years. Dosing must follow the FDA-approved labeling.

PA Criteria	Criteria Details
<b>Other Criteria</b>	<p>For RA: Must try and fail (defined as an intolerance or inability to improve symptoms) one traditional non-biologic immunomodulator drug (e.g., methotrexate, leflunomide, hydroxychloroquine, sulfasalazine). For PsA: Must try and fail (defined above) one traditional non-biologic immunomodulator drug (e.g., methotrexate, leflunomide, sulfasalazine). For UC: Must try and fail (defined above) one traditional non-biologic immunomodulator drug (e.g., 6-mercaptopurine, azathioprine, cyclosporine) or a steroid (e.g., prednisone). For ankylosing spondylitis: Must try and fail (defined above) one nonsteroidal anti-inflammatory drug (NSAID). For psoriasis: Must try and fail (defined above) one traditional non-biologic immunomodulator drug (e.g., methotrexate, cyclosporine, acitretin). For Crohn's disease: Must try and fail (defined above) one traditional non-biologic immunomodulator drug (e.g., 6-mercaptopurine, azathioprine, methotrexate) or a steroid (e.g., prednisone). For hidradenitis suppurativa: Must try and fail (defined above) one other drug for the condition (e.g., prednisone, clindamycin, erythromycin). For uveitis: Must try and fail (defined above) one other drug for the condition (e.g., intraocular or systemic steroids, immunomodulator drugs). For Juvenile Idiopathic Arthritis: Must try and fail (defined above) one other drug for the condition (e.g., methotrexate, sulfasalazine, NSAID) - or - the patient will be starting adalimumab concurrently with methotrexate, sulfasalazine, or leflunomide - or - the patient has aggressive disease, as determined by the prescribing physician.</p>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# ADEMPAS

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## Products Affected

- ADEMPAS

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	For pulmonary arterial hypertension (PAH), confirmed diagnosis of World Health Organization (WHO) Group 1 by right heart catheterization and medical record documentation. Documentation of prior therapies and responses to treatment.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Two years
<b>Other Criteria</b>	For PAH, trial and failure (defined as an inability to improve the condition) with sildenafil or tadalafil. For chronic thromboembolic pulmonary hypertension (CTEPH), must be in WHO Group 4 - and - must be classified as inoperable or as persistent/recurrent after pulmonary endarterectomy.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# AIMOVIG

## Products Affected

- AIMOVIG

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Must not be used in combination with other CGRP antagonist therapy.
<b>Required Medical Information</b>	For migraine prevention initial requests: (1) Must have at least four migraine days per month, AND (2) Must try and fail (defined as an intolerance or inability to improve the condition) two of the following generic migraine prevention drugs, each from a different class and each used for at least 28 days: amitriptyline, nortriptyline, venlafaxine, propranolol, metoprolol, timolol, valproic acid, divalproex, or topiramate, AND (3) Patient has been evaluated for and does not have Medication overuse headache (MOH).
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Initial: 1 year. Reauth: 2 years. Dosing must align with FDA labeling.
<b>Other Criteria</b>	For migraine prevention reauthorization requests: Must provide documentation of a decrease in migraine days per month with use of Aimovig.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No



# AKEEGA

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## Products Affected

- AKEEGA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

# ALECENSA

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## Products Affected

- ALECENSA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

# ALUNBRIG

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## Products Affected

- ALUNBRIG ORAL TABLET 180 MG, 30 MG, 90 MG
- ALUNBRIG ORAL TABLET THERAPY PACK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

# ambrisentan

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## Products Affected

- *ambrisentan*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Confirmed diagnosis of Pulmonary Arterial Hypertension (PAH), World Health Organization Group 1 by right heart catheterization and medical record documentation.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Two years
<b>Other Criteria</b>	
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# AMVUTTRA

## Products Affected

- AMVUTTRA

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Must not be used in combination with TTR stabilizers (e.g., tafamidis) or TTR-lowering agents (e.g. Onpattro).
<b>Required Medical Information</b>	Medical records supporting the request must be provided - AND - must have documentation of a transthyretin (TTR) mutation (e.g., V30M) - AND - must have documentation of a baseline polyneuropathy disability (PND) score less than or equal to IIIb and/or baseline FAP Stage 1 or 2.
<b>Age Restrictions</b>	Must be at least 18 years of age.
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year initial. 2 years reauthorization. Dose must align with the FDA-approved labeling.
<b>Other Criteria</b>	Must have documentation of clinical signs and symptoms of the condition (e.g., motor disability, peripheral/autonomic neuropathy, etc.) - AND - Patient has not had a liver transplant - AND - For reauthorization, must have a positive clinical response to Amvuttra compared to baseline (e.g., improved neuropathy symptoms, motor function, quality of life, slowing of disease progression).
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# aprepitant

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## Products Affected

- *aprepitant oral capsule*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Aprepitant is not covered in the following situations: (1) treatment of established nausea and vomiting, and (2) for chronic continuous use.
<b>Required Medical Information</b>	For post-op nausea/vomiting: Provide date of surgery.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Plan year authorization with limit of one 30-day fill for post-op nausea/vomiting
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# APTIOM

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## Products Affected

- APTIOM ORAL TABLET 200 MG, 400 MG, 600 MG, 800 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Must have documentation supporting a trial and failure (defined as inadequate seizure control) with at least 2 generic anticonvulsants for the condition.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

# ARALAST

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## Products Affected

- ARALAST NP INTRAVENOUS SOLUTION  
RECONSTITUTED 1000 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient must have an FEV1 less than 80 percent predicted - AND - a serum AAT level less than 11 micromoles per liter (80 milligrams per deciliter if measured by radial immunodiffusion or 50 milligrams per deciliter if measure by nephelometry).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



# ARCALYST

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## Products Affected

- ARCALYST

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	For the treatment of recurrent pericarditis: Must have documentation supporting a trial and failure (defined as inadequate response) with an NSAID in combination with colchicine.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	One year
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# ARIKAYCE

## Products Affected

- ARIKAYCE

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	For initial review, sputum culture supporting the diagnosis of Mycobacterium avium complex (MAC) lung disease must be submitted.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Must be prescribed by or in consultation with an infectious disease specialist.
<b>Coverage Duration</b>	Initial approval for 6 months. Reauthorization for 12 months.
<b>Other Criteria</b>	For initial review, documentation of failure to obtain negative sputum cultures after a minimum of 6 months of a multidrug background regimen therapy for MAC lung disease must be provided. For reauthorization, documentation of a negative sputum culture obtained within the last 30 days must be provided. Criteria will be applied consistent with current ATS/IDSA guidelines.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# aripiprazole odt

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## Products Affected

- *aripiprazole oral tablet dispersible*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Patient has had prior trial with AND has a documented contraindication (e.g., dysphagia) to BOTH generic aripiprazole TABLET and generic aripiprazole oral SOLUTION.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	One year initial and reauthorization.
<b>Other Criteria</b>	
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# armodafinil

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## Products Affected

- *armodafinil*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

# asenapine

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## Products Affected

- *asenapine maleate*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Must have documentation supporting a trial and failure (defined as an inadequate response) with two of the following generic drugs used for at least 28 days each: aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone, or lurasidone.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Two years
<b>Other Criteria</b>	
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# AUGTYRO

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## Products Affected

- AUGTYRO ORAL CAPSULE 160 MG, 40 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

# AUSTEDO

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## Products Affected

- AUSTEDO ORAL TABLET 12 MG, 6 MG, 9 MG
- AUSTEDO XR ORAL TABLET EXTENDED RELEASE 24 HOUR 12 MG, 18 MG, 24 MG, 30 MG, 36 MG, 42 MG, 48 MG, 6 MG
- AUSTEDO XR PATIENT TITRATION ORAL TABLET EXTENDED RELEASE THERAPY PACK 12 & 18 & 24 & 30 MG, 6 & 12 & 24

MG

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Must not be used in combination with tetrabenazine or Ingrezza.
<b>Required Medical Information</b>	For tardive dyskinesia initial requests, the following documentation is required: (1) The patient's baseline Abnormal Involuntary Movement Scale (AIMS) score with date of baseline score (baseline is defined as prior to treatment with Austedo), AND (2) Trial and failure with tetrabenazine (defined as an intolerance or inadequate symptom improvement), AND either (3) the patient is using Austedo for TD that is not associated with dopamine receptor blocking, OR (4) the patient is using Austedo for TD associated with the use of dopamine receptor blocking agents and symptoms persist despite stopping or reducing the dose of the dopamine blocking agent or discontinuation or reduction of the dose of the dopamine blocking agent is not possible. For chorea associated with Huntington's disease initial requests: (1) Must provide documentation supporting a trial and failure with tetrabenazine (defined as an intolerance or inadequate symptom improvement).
<b>Age Restrictions</b>	Must be age 18 or older.
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Initial: 1 year. Reauth: 2 years.
<b>Other Criteria</b>	For tardive dyskinesia (TD) reauthorization requests: (1) Must provide documentation of improvement in the patient's AIMS score compared to baseline. For chorea associated with Huntington's disease reauthorization requests: (1) Must provide documentation of improvement in chorea symptoms compared to baseline.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No



# AUVELITY

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## Products Affected

- AUVELITY

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of prior therapies and responses to treatment.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Two years. Dosing must follow the FDA-approved labeling.
<b>Other Criteria</b>	Must try and fail (defined as an inability to improve depressive symptoms after at least 4 weeks of treatment) with an SSRI or SNRI and 1 atypical antidepressant (e.g., bupropion, mirtazapine).
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# AVEED

## Products Affected

- AVEED

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Not covered in males with late-onset (age-related) hypogonadism.
<b>Required Medical Information</b>	For primary and hypogonadotropic hypogonadism: Documentation of the following is required (1) Two pre-treatment serum total testosterone levels, each taken in the morning on separate days, that are less than 300 ng/dL or that are low as defined by the laboratory reference values, AND (2) Patient is male, AND (3) Pre-treatment clinical signs or symptoms of low testosterone other than erectile dysfunction and decreased libido (such as depressed mood, decreased energy, progressive decrease in muscle mass, osteoporosis), AND (4) patient has tried and failed (defined as an intolerance or an inability to improve symptoms or testosterone levels) with a generic injectable testosterone product - and - a generic topical testosterone therapy. For gender dysphoria: Documentation of the following is required: (1) patient has tried and failed (defined as an intolerance or an inability to improve symptoms or testosterone levels) with a generic injectable testosterone product - and - a generic topical testosterone therapy.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Two years
<b>Other Criteria</b>	Approved if the following are met: 1) Patient is male AND 2) has pre-treatment clinical signs or symptoms of low testosterone other than erectile dysfunction or decreased libido (e.g., depressed mood, decreased energy, progressive decrease in muscle mass, osteoporosis), AND 3) has been screened for prostate cancer according to current guidelines, AND 4) has a documented trial and failure (defined as an inability to improve symptoms or condition) with a generic injectable - AND - generic topical testosterone therapy.
<b>Indications</b>	All Medically-accepted Indications.

PA Criteria	Criteria Details
Off Label Uses	
Part B Prerequisite	Yes

# AVONEX

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## Products Affected

- AVONEX PEN INTRAMUSCULAR AUTO-INJECTOR KIT
- AVONEX PREFILLED INTRAMUSCULAR PREFILLED SYRINGE KIT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

# AYVAKIT

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## Products Affected

- AYVAKIT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

# BALVERSA

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## Products Affected

- BALVERSA ORAL TABLET 3 MG, 4 MG, 5 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

# BENLYSTA

## Products Affected

- BENLYSTA SUBCUTANEOUS

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Must not be used with another biologic drug or Lupkynis.
<b>Required Medical Information</b>	For SLE initial requests: Must have a SELENA-SLEDAI score of 6 or more before starting Benlysta AND either an anti-dsDNA antibody greater than 30 IU/ml or ANA greater than 1:80. For LN initial requests: Must have a confirmed diagnosis of SLE AND a kidney biopsy confirming class 3, 4, and/or 5 disease.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Prescriber must be a specialist in treating the condition or have consulted with a specialist.
<b>Coverage Duration</b>	1 year initial. 2 years reauthorization.
<b>Other Criteria</b>	For SLE initial requests: Must be taking two of the following drugs together for at least 12 weeks each: a steroid, immunosuppressant, and/or hydroxychloroquine - AND - For SLE reauthorization: Must have evidence of clinical improvement with Benlysta. For lupus nephritis (LN) initial requests: Must be receiving standard therapy for LN (e.g., mycophenolate or azathioprine plus a steroid) - AND - For LN reauthorization: Must have evidence of clinical improvement with Benlysta, including improved or stable eGFR.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# BESREMI

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## Products Affected

- BESREMI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years. Dosing must follow the FDA-approved labeling.
Other Criteria	Must trial and fail hydroxyurea (defined as an intolerance and/or persistence or recurrence of disease).
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No



# BETASERON

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## Products Affected

- BETASERON SUBCUTANEOUS KIT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

# bexarotene

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## Products Affected

- *bexarotene oral*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

# BEXAROTENE GEL

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## Products Affected

- *bexarotene external*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	Must first try tazarotene.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

# bosentan

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## Products Affected

- *bosentan*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Confirmed diagnosis of Pulmonary Arterial Hypertension (PAH), World Health Organization Group 1 by right heart catheterization and medical record documentation.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Two years
<b>Other Criteria</b>	
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# BOSULIF

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## Products Affected

- BOSULIF ORAL CAPSULE 100 MG, 50 MG
- BOSULIF ORAL TABLET 100 MG, 400 MG, 500 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

# BRAFTOVI

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## Products Affected

- BRAFTOVI ORAL CAPSULE 75 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient must have documentation of BRAF V600 mutation status.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

# BRIVIACT

## Products Affected

- BRIVIACT ORAL SOLUTION
- BRIVIACT ORAL TABLET

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Must have documentation supporting a trial and failure (defined as inadequate seizure control) with generic levetiracetam and at least 1 other generic anticonvulsant for the condition.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Two years
<b>Other Criteria</b>	
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# BRUKINSA

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## Products Affected

- BRUKINSA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	UNDER CMS REVIEW
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No



# CABOMETYX

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## Products Affected

- CABOMETYX

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

# calcipotriene/betamethasone suspension

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## Products Affected

- *calcipotriene-betameth diprop external suspension*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Must have documentation supporting a trial and failure with a generic topical steroid for the scalp (such as fluocinonide solution, clobetasol solution, clobetasol shampoo) in combination with generic calcipotriene solution. Failure is defined as an inadequate response in treating the condition.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Two years
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# CALQUENCE

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## Products Affected

- CALQUENCE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

# CAMZYOS

## Products Affected

- CAMZYOS

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	For initial coverage, must have (1) a diagnosis of symptomatic NYHA class II or III obstructive hypertrophic cardiomyopathy - AND - (2) a LVEF of 55% or more - AND - (3) previous trial and failure (an inability to improve symptoms), contraindication, or intolerance to beta blockers (such as metoprolol) and non-dihydropyridine calcium channel blockers (verapamil or diltiazem) at doses appropriate for obstructive hypertrophic cardiomyopathy. For reauthorization, must have (1) a LVEF of 50% or more - AND - (2) clinically significant improvement of symptoms (such as improvement in NT-proBNP, decreased shortness of breath, or an improvement in patient reported outcomes assessment).
<b>Age Restrictions</b>	Patient is at least 18 years of age or older.
<b>Prescriber Restrictions</b>	Must be prescribed by or in consultation with a cardiologist.
<b>Coverage Duration</b>	Initial: 1 year. Reauthorization: 2 years.
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# CAPLYTA

## Products Affected

- CAPLYTA

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of prior therapies and responses to treatment must be provided.
<b>Age Restrictions</b>	Must be age 18 or older.
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Two years
<b>Other Criteria</b>	For schizophrenia: Patient must have tried and failed (defined as taking the medication as prescribed without an adequate response or with intolerance) two of the following generic atypical antipsychotics: aripiprazole, ziprasidone, olanzapine, risperidone, quetiapine. For depressive episodes associated with bipolar 1 disorder: Patient must have tried and failed (defined above) one of the following generic products: quetiapine or olanzapine (with fluoxetine) - AND - Patient must have tried and failed (defined above) generic lurasidone. For depressive episodes associated with bipolar 2 disorder: Patient must have tried and failed (defined above) quetiapine.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# CAPRELSA

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## Products Affected

- CAPRELSA ORAL TABLET 100 MG, 300 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

# CARGLUMIC ACID

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## Products Affected

- *carglumic acid oral tablet soluble*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

# CAYSTON

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## Products Affected

- CAYSTON

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



# CERDELGA

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## Products Affected

- CERDELGA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

# CHOLBAM

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## Products Affected

- CHOLBAM

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year initial. Two years reauthorization.
Other Criteria	For reauthorization, must have clinical benefit from use of the drug as determined by the provider.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

# clobazam

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## Products Affected

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

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Two years
<b>Other Criteria</b>	Patient must first try one generic anticonvulsant. Clobazam suspension may only be used in patients where tablets are contraindicated (e.g., dysphagia).
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# COBENFY

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## Products Affected

- COBENFY
- COBENFY STARTER PACK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Must have documentation supporting a trial and failure (defined as an inadequate response) with two generic atypical antipsychotics used for at least 28 days each.
Age Restrictions	Must be age 18 or older.
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

# colistimethate sodium

## Products Affected

- *colistimethate sodium (cba)*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	(1) The drug is being used intravenously (IV) or intramuscularly (IM). Administration through nebulization is not covered (CMS-approved compendia do not support inhalation/nebulization of colistimethate), AND (2) the infection is proven, or strongly suspected, to be caused by susceptible bacteria based on the following required documentation: 1) culture and susceptibility information, OR 2) local epidemiology and susceptibility patterns.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Must be prescribed by or in consultation with an infectious disease specialist.
<b>Coverage Duration</b>	One year.
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# COMETRIQ

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## Products Affected

- COMETRIQ (100 MG DAILY DOSE) ORAL KIT 80 & 20 MG
- COMETRIQ (140 MG DAILY DOSE) ORAL KIT 3 X 20 MG & 80 MG
- COMETRIQ (60 MG DAILY DOSE)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

# COPIKTRA

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## Products Affected

- COPIKTRA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

# CORLANOR

## Products Affected

- CORLANOR ORAL SOLUTION

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	For heart failure in adults, documentation of the following is required: (1) Patient has stable, symptomatic chronic heart failure, AND (2) Patient has an ejection fraction of 35% or less, AND (3) Patient is in sinus rhythm with a resting heart rate of at least 70 beats per minute, AND (4) Patient is currently on maximally tolerated beta-blocker therapy OR has a contraindication to beta-blocker therapy (i.e., allergy, severe COPD limiting beta blocker usage). For heart failure in children, documentation of the following is required: (1) patient has stable, symptomatic chronic heart failure due to dilated cardiomyopathy, AND (2) patient is in sinus rhythm with an elevated heart rate, AND (3) baseline heart rate (defined as prior to the use of Corlanor) has been provided.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year initial, 2 years reauth
<b>Other Criteria</b>	For reauthorization requests (adult and children), the patient is continuing to have clinical benefit from Corlanor as defined by maintenance of a decreased heart rate compared to baseline.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No



# CORTROPHIN

## Products Affected

- CORTROPHIN

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Initial-in accordance with FDA label or max of 3 mos. if unspecified in label. Reauth-1 year.
<b>Other Criteria</b>	Not covered for FDA-approved indications of acute gouty arthritis, severe psoriasis, and atopic dermatitis. For all covered FDA-approved indications except infantile spasms, must have a therapeutic trial of parenteral glucocorticoid. Supporting documentation for all drug trials is required demonstrating inadequate response, intolerance, or FDA labeled contraindication to therapy. For acute exacerbations of multiple sclerosis: one month trial of oral glucocorticoid. For nephrotic syndrome associated with lupus erythematosus, systemic lupus erythematosus, and inflammatory ocular disorders: one month trial of an immunosuppressant (e.g. cyclophosphamide, tacrolimus, mycophenolate mofetil, methotrexate, azathioprine). For adjunctive therapy for short-term administration rheumatic disease: 12-week trial of one biologic drug. For systemic dermatomyositis (polymyositis): one 12-week trial with rituximab. Reauthorization of previously authorized therapy requires demonstrated clinical benefit. Quantity limited to dosage as supported by the FDA-approved label.
<b>Indications</b>	Some FDA-approved Indications Only.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	Yes

# COSENTYX

## Products Affected

- COSENTYX (300 MG DOSE)
- COSENTYX SENSOREADY (300 MG)
- COSENTYX SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 75 MG/0.5ML
- COSENTYX UNOREADY

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Must not be used in combination with other biologic drugs, Otezla, or Janus Kinase Inhibitor (JAKis).
<b>Required Medical Information</b>	Documentation of prior therapies and responses to treatment must be provided.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Prescriber is a specialist or has consulted with a specialist for the condition being treated.
<b>Coverage Duration</b>	Two years. Dosing must follow the FDA-approved labeling.
<b>Other Criteria</b>	For PsA: Must try and fail (defined above) one traditional non-biologic immunomodulator drug (e.g., methotrexate, leflunomide, sulfasalazine). For ankylosing spondylitis and non-radiographic axial spondyloarthritis (NRAS): Must try and fail (defined above) one nonsteroidal anti-inflammatory drug (NSAID). For psoriasis: Must try and fail (defined above) one traditional non-biologic immunomodulator drug (e.g., methotrexate, cyclosporine, acitretin). For ERA: Must try and fail (defined above) one other drug for the condition (e.g., methotrexate, sulfasalazine, NSAID) - or - have aggressive disease that necessitates initial biologic therapy. For hidradenitis suppurativa: Must try and fail (defined above) one other drug for the condition (e.g., prednisone, clindamycin, erythromycin).
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# COTELLIC

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## Products Affected

- COTELLIC

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

# CYSTADROPS

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## Products Affected

- CYSTADROPS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

# CYSTARAN

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## Products Affected

- CYSTARAN

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

# DALFAMPRIDINE ER

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## Products Affected

- *dalfampridine er*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Patient must not have history of seizure and creatinine clearance must be greater than 50 ml per min.
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Initial approval for 12 weeks, reauthorization required every 12 months thereafter
<b>Other Criteria</b>	Baseline timed 25-foot walk (T25FW), patient must be currently ambulatory. Reauthorization requires documentation of stability and/or improvement in walking speed.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# DASATINIB

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## Products Affected

- *dasatinib oral tablet 100 mg, 140 mg, 20 mg, 50 mg, 70 mg, 80 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

# DAURISMO

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**Products Affected**

- DAURISMO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No



# DAYBUE

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## Products Affected

- DAYBUE

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Patient does not have atypical or variant Rett syndrome.
<b>Required Medical Information</b>	Must have documentation of the following: (1) Patient's current weight, (2) diagnosis of classic/typical Rett Syndrome (RTT), AND (3) a documented mutation in the MECP2 gene.
<b>Age Restrictions</b>	Must be at least 2 years old.
<b>Prescriber Restrictions</b>	Must be prescribed by or in consultation with a neurologist.
<b>Coverage Duration</b>	One year initial and reauthorization.
<b>Other Criteria</b>	Initial: Must provide documentation of current Rett Syndrome Behavior Questionnaire (RSBQ) score -AND- current Clinical Global Impression-Severity score. For reauthorization: Must provide documentation confirming a positive response to therapy based on the patient's baseline RSBQ and CGIS scores.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# Diabetic Supplies

## Products Affected

- *assure id insulin safety syr 29g x 1/2" 1 ml*
- BD AUTOSHIELD DUO
- BD PEN NEEDLE MICRO U/F
- BD PEN NEEDLE MINI U/F
- BD PEN NEEDLE NANO 2ND GEN
- BD PEN NEEDLE NANO U/F
- BD PEN NEEDLE ORIGINAL U/F
- BD PEN NEEDLE SHORT U/F
- *comfort assist insulin syringe 29g x 1/2" 1 ml*
- *cvs gauze sterile pad 2"x2"*
- *exel comfort point pen needle 29g x 12mm*
- *global alcohol prep ease*
- NOVOFINE PEN NEEDLE
- NOVOFINE PLUS PEN NEEDLE
- NOVOTWIST PEN NEEDLE
- *preferred plus insulin syringe 28g x 1/2" 0.5 ml*
- *reli-on insulin syringe 29g 0.3 ml*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Approve if the prescriber confirms that the medical supply is being requested for a use that is directly associated with delivering insulin to the body.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# DIACOMIT

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## Products Affected

- DIACOMIT

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	(1) Patient has a diagnosis of seizures associated with Dravet syndrome AND (2) Patient is not currently controlled on current therapy (defined as experiencing generalized tonic clonic or clonic seizures within the past 28 days) AND (3) Patient taking concomitant clobazam therapy.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Must be prescribed by or in consultation with a specialist (i.e. neurologist, epileptologist).
<b>Coverage Duration</b>	Two years
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# DICHLORPHENAMIDE

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## Products Affected

- *dichlorphenamide*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

# dihydroergotamine nasal spray

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## Products Affected

- *dihydroergotamine mesylate nasal*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Must have documentation to support (1) a trial and failure (defined as inability to improve symptoms or condition) of one non-oral triptan drug (e.g., sumatriptan nasal spray or injection) AND (2) a trial and failure (defined above) of Nurtec ODT.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Two years
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# dimethyl fumarate

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## Products Affected

- *dimethyl fumarate oral*
- *dimethyl fumarate starter pack*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

# DOJOLVI

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## Products Affected

- DOJOLVI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Must provide documentation supporting the diagnosis (e.g., medical records).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months initial and reauthorization.
Other Criteria	Patient must not have pancreatic insufficiency. For reauthorization, patient must have clinically significant benefit compared to baseline (e.g., reduced hospitalizations, myopathy, cardiac symptoms, muscle weakness, etc.).
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

# DRIZALMA

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## Products Affected

- DRIZALMA SPRINKLE

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Must have documentation of a trial and failure (defined as an inability to improve the condition) with two antidepressants, one of which is duloxetine (generic Cymbalta).
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Two years
<b>Other Criteria</b>	
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No



# droxidopa

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## Products Affected

- *droxidopa*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	One year initial and reauthorization.
<b>Other Criteria</b>	Patient must first try midodrine. For reauthorization: Must have documentation of a positive clinical response (e.g., sustained decrease in dizziness).
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# DUPIXENT

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## Products Affected

- DUPIXENT SUBCUTANEOUS SOLUTION AUTO-INJECTOR 200 MG/1.14ML, 300 MG/2ML
- DUPIXENT SUBCUTANEOUS SOLUTION PEN-INJECTOR 200 MG/1.14ML, 300 MG/2ML
- DUPIXENT SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/0.67ML, 200

MG/1.14ML, 300 MG/2ML

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Must not be used in combination with other biologic drugs or Janus Kinase Inhibitor (JAKis).
<b>Required Medical Information</b>	<p>For initial coverage of asthma, documentation of the following is required: (1) Oral corticosteroid-dependent asthma - or - Eosinophilic asthma with an elevated blood eosinophil count of 150 cells per microliter or more within 6 weeks (prior to the immediate start of treatment with Dupixent) or 300 cells per microliter or more in the previous 12 months, AND (2) Trial and failure of 1 ICS/LABA inhaler in the past 6 months (failure is defined as an inability to improve the condition on the required therapy for at least 4 weeks). For reauthorization of asthma: (1) Must have documentation of clinical benefit with Dupixent compared to baseline (e.g., decrease in exacerbations, improvement in symptoms, decrease in oral steroid use).</p> <p>For initial coverage of eosinophilic esophagitis, documentation of the following is required: (1) Confirmation of diagnosis by esophageal biopsy defined by having at least 15 eosinophils per high power field (HPF), AND (2) Patient's current weight is at least 15 kg, AND (3) Patient has symptoms of esophageal dysfunction, AND (4) Trial and failure (defined as an inability to achieve and maintain remission of low or mild disease activity) with one proton pump inhibitor for at least 2 months, AND (5) Trial and failure (defined above) with one topical steroid (e.g., fluticasone, budesonide) for at least 2 months. For reauthorization of eosinophilic esophagitis: (1) Must have documentation of a reduction in eosinophil count on endoscopic biopsy or a reduction in symptoms (e.g., less dysphagia).</p>
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Prescriber is a specialist or has consulted with a specialist for the condition being treated.
<b>Coverage Duration</b>	1 year initial and 2 years reauth. Dose must follow the FDA-approved labeling.

PA Criteria	Criteria Details
<b>Other Criteria</b>	<p>For initial coverage of prurigo nodularis, documentation of the following is required: (1) Moderate to severe disease defined as a score of at least 7 on the Worst Itching Intensity Numerical Rating Scale (WI-NRS) and at least 20 nodular lesions, AND (2) Trial and failure (defined as inability to improve the condition) with one oral antihistamine, AND (3) Trial and failure (defined above) with a medium or higher potency topical steroid. For reauthorization of prurigo nodularis: (1) Must have documentation of a reduction in nodular lesion count or lesion size and/or a reduction in pruritis. For initial coverage of atopic dermatitis, documentation of the following is required: (1) Confirmation of moderate to severe atopic dermatitis, AND (2) Trial and failure (defined as an inadequate response) to one medium or higher potency topical steroid (e.g., clobetasol) - or - one topical calcineurin inhibitor (e.g., pimecrolimus, tacrolimus). For reauthorization of atopic dermatitis: (1) Must have documented clinical benefit (e.g. less exacerbations, improved symptoms, less steroid use). For initial coverage of chronic rhinosinusitis with nasal polyp, documentation of the following is required: (1) Patient has experienced 2 or more of the following symptoms for at least 12 weeks despite management: nasal congestion or obstruction, nasal drainage, reduction or loss of smell, AND (2) Patient has tried and failed (defined as an inability to improve symptoms for at least 4 weeks) an intranasal steroid, AND (3) Patient will continue to use an intranasal steroid along with Dupixent. For reauthorization of chronic rhinosinusitis with nasal polyp: (1) The patient will continue to use an intranasal steroid along with Dupixent, AND (2) Must have documentation of clinical benefit with Dupixent compared to baseline (e.g., decrease in exacerbations, improvement in symptoms, decrease in oral steroid use).</p>
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# EMGALITY

## Products Affected

- EMGALITY
- EMGALITY (300 MG DOSE)

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Must not be used in combination with other CGRP antagonist therapy.
<b>Required Medical Information</b>	For migraine prevention initial requests: (1) Must have at least four migraine days per month, AND (2) Must try and fail (defined as an intolerance or inability to improve the condition) two of the following generic migraine prevention drugs, each from a different class and each used for at least 28 days: amitriptyline, nortriptyline, venlafaxine, propranolol, metoprolol, timolol, valproic acid, divalproex, or topiramate, AND (3) Patient has been evaluated for and does not have Medication overuse headache (MOH). For cluster headache initial requests: (1) Must try and fail verapamil (fail is defined above), AND (2) Patient has been evaluated for and does not have Medication overuse headache (MOH).
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year. Cluster reauth: 1 year. Migraine reauth: 2 years. Dosing must align with FDA labeling.
<b>Other Criteria</b>	For migraine prevention reauthorization requests: Must provide documentation of a decrease in migraine days per month with use of Emgality. For cluster headache reauthorization requests: Must provide documentation of a decrease in the frequency or intensity of cluster headaches with Emgality.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# EMSAM

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## Products Affected

- EMSAM

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation supporting the trial and failure (defined as an inadequate improvement in depressive symptoms) with two of the following generic antidepressants is required: SNRIs, SSRIs, mirtazapine, or bupropion.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

# ENBREL

## Products Affected

- ENBREL SUBCUTANEOUS SOLUTION 25 MG/0.5ML
- ENBREL SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 25 MG/0.5ML, 50
- ENBREL SURECLICK SUBCUTANEOUS SOLUTION AUTO-INJECTOR

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Must not be used in combination with other biologic drugs, Otezla, or Janus Kinase Inhibitor (JAKis).
<b>Required Medical Information</b>	Documentation of prior therapies and responses to treatment must be provided.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Prescriber is a specialist or has consulted with a specialist for the condition being treated.
<b>Coverage Duration</b>	Two years. Dosing must follow the FDA-approved labeling.
<b>Other Criteria</b>	For RA: Must try and fail (defined as an intolerance or inability to improve symptoms) one traditional non-biologic immunomodulator drug (e.g., methotrexate, leflunomide, hydroxychloroquine, sulfasalazine). For PsA: Must try and fail (defined above) one traditional non-biologic immunomodulator drug (e.g., methotrexate, leflunomide, sulfasalazine). For ankylosing spondylitis: Must try and fail (defined above) one nonsteroidal anti-inflammatory drug (NSAID). For psoriasis: Must try and fail (defined above) one traditional non-biologic immunomodulator drug (e.g., methotrexate, cyclosporine, acitretin). For hidradenitis suppurativa: Must try and fail (defined above) one other drug for the condition (e.g., prednisone, clindamycin, erythromycin). For Juvenile Idiopathic Arthritis: Must try and fail (defined above) one other drug for the condition (e.g., methotrexate, sulfasalazine, NSAID) - or - the patient will be starting Enbrel concurrently with methotrexate, sulfasalazine, or leflunomide - or - the patient has aggressive disease, as determined by the prescribing physician.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# ENBREL MINI

## Products Affected

- ENBREL MINI

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Must not be used in combination with other biologic drugs, Otezla, or Janus Kinase Inhibitor (JAKis).
<b>Required Medical Information</b>	Documentation of prior therapies and responses to treatment must be provided.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Prescriber is a specialist or has consulted with a specialist for the condition being treated.
<b>Coverage Duration</b>	Two years. Dosing must follow the FDA-approved labeling.
<b>Other Criteria</b>	For RA: Must try and fail (defined as an intolerance or inability to improve symptoms) one traditional non-biologic immunomodulator drug (e.g., methotrexate, leflunomide, hydroxychloroquine, sulfasalazine). For PsA: Must try and fail (defined above) one traditional non-biologic immunomodulator drug (e.g., methotrexate, leflunomide, sulfasalazine). For ankylosing spondylitis: Must try and fail (defined above) one nonsteroidal anti-inflammatory drug (NSAID). For psoriasis: Must try and fail (defined above) one traditional non-biologic immunomodulator drug (e.g., methotrexate, cyclosporine, acitretin). For hidradenitis suppurativa: Must try and fail (defined above) one other drug for the condition (e.g., prednisone, clindamycin, erythromycin). For Juvenile Idiopathic Arthritis: Must try and fail (defined above) one other drug for the condition (e.g., methotrexate, sulfasalazine, NSAID) - or - the patient will be starting Enbrel concurrently with methotrexate, sulfasalazine, or leflunomide - or - the patient has aggressive disease, as determined by the prescribing physician.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No



# ENDARI

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## Products Affected

- ENDARI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	Must try and fail hydroxyurea. Fail is defined as continuing to have pain episodes despite appropriately dosed hydroxyurea or having any intolerance to hydroxyurea.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

# ENSPRYNG

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## Products Affected

- ENSPRYNG

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	For NMOSD, must provide documentation of anti-aquaporin-4 (AQP4) antibody positive status in chart notes or medical records.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Must be prescribed by or in consultation with a neurologist.
<b>Coverage Duration</b>	Two years - 3 syringes in month one, 1 syringe per month thereafter
<b>Other Criteria</b>	Patient must have had at least one attack requiring rescue therapy in the last year or two attacks requiring rescue therapy in the last 2 years.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# ENTADFI

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## Products Affected

- ENTADFI

PA Criteria	Criteria Details
Exclusion Criteria	use of concomitant generic tadalafil
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	26 weeks
Other Criteria	Patient must have tried and failed either 6 months of finasteride or 3 months of dutasteride and must have tried and failed 28 days of alfuzosin, doxazosin, tamsulosin, or terazosin.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

# EOHILIA

## Products Affected

- EOHILIA

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	(1) Diagnosis of EOE confirmed by esophageal biopsy, defined as at least 15 eosinophils per high power field (HPF) - and - (2) Must have continued symptoms of EOE despite trial of a proton pump inhibitor for at least 2 months - and (3) - Trial with one topical generic corticosteroid (i.e., fluticasone, budesonide) for at least 2 months with continued symptoms.
<b>Age Restrictions</b>	Must be age 11 years or older.
<b>Prescriber Restrictions</b>	Prescriber is a specialist or has consulted with a specialist for the condition being treated (gastroenterologist, allergist)
<b>Coverage Duration</b>	1 year authorization with a limit of 12 weeks of treatment.
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# EPIDIOLEX

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## Products Affected

- EPIDIOLEX

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

# EPRONTIA

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## Products Affected

- EPRONTIA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Must have documentation supporting a trial and failure (defined as inadequate seizure control) with generic topiramate sprinkles and at least 1 other generic anticonvulsant for the condition.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

# ERIVEDGE

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## Products Affected

- ERIVEDGE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

# ERLEADA

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## Products Affected

- ERLEADA ORAL TABLET 240 MG, 60 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No



# erlotinib

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## Products Affected

- *erlotinib hcl oral tablet 100 mg, 150 mg, 25 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

# EVENITY

## Products Affected

- EVENITY

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Cumulative use of Evenity of more than 12 months is not covered.
<b>Required Medical Information</b>	Must provide documentation of prior therapies and responses to treatment - AND - documentation confirming diagnosis such as T-score.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Must be prescribed by endocrinologist.
<b>Coverage Duration</b>	12 months total therapy
<b>Other Criteria</b>	Must try and fail alendronate, risedronate, or ibandronate - AND - either zoledronic acid or Prolia. Failure is defined as intolerance, decrease in BMD in comparison to previous DEXA scan, new fracture while on therapy OR a contraindication to therapy (e.g., creatinine clearance less than 35 mL/min, inability to sit upright for 30 minutes, esophageal stricture).
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# everolimus

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## Products Affected

- *everolimus oral tablet 10 mg, 2.5 mg, 5 mg, 7.5 mg*
- *everolimus oral tablet soluble*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

# EVRYSDI

## Products Affected

- EVRYSDI

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	For spinal muscular atrophy (SMA), documentation of the genetic test confirming the diagnosis must be provided.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Must be prescribed by a neurologist or in consultation with a neurologist with experience treating SMA.
<b>Coverage Duration</b>	Initial - 12 months, reauthorization - 12 months
<b>Other Criteria</b>	Patient must not be receiving concurrent Spinraza or have previously received or be planning to receive gene therapy for SMA (Zolgensma). For reauthorization, must provide documentation showing a clinically significant improvement in SMA symptoms (e.g., progression, stabilization, decreased decline in motor function) compared to the predicted and natural trajectory of the disease.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# FABHALTA

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## Products Affected

- FABHALTA

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Fabhalta is not covered in combination with other complement drug therapy including Soliris, Ultomiris, Empaveli. (Fabhalta has not been studied and there is no data to support use in combination with other medications used for PHN.)
<b>Required Medical Information</b>	UNDER CMS REVIEW
<b>Age Restrictions</b>	Patient is 18 years of age or older.
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	One year initial and reauthorization.
<b>Other Criteria</b>	UNDER CMS REVIEW
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# FANAPT

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## Products Affected

- FANAPT
- FANAPT TITRATION PACK

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Must have documentation supporting a trial and failure (defined as an inadequate response) with two of the following generic drugs that have support for the requested condition and each used for at least 28 days: aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone, or lurasidone.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Two years
<b>Other Criteria</b>	
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# FASENRA

## Products Affected

- FASENRA PEN
- FASENRA SUBCUTANEOUS SOLUTION  
 PREFILLED SYRINGE 10 MG/0.5ML, 30  
 MG/ML

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Must not be used in combination with other biologic drugs.
<b>Required Medical Information</b>	For initial coverage of severe eosinophilic asthma, documentation of the following is required: (1) An elevated blood eosinophil count of greater than or equal to 150 cells per microliter within 6 weeks (prior to the immediate start of treatment with Fasenra) - OR - greater than or equal to 300 cells per microliter in the previous 12 months, AND (2) Trial with failure of 1 ICS/LABA inhaler in the past 6 months (failure is defined as an inability to improve the condition on the required therapy for at least 4 weeks). For reauthorization of severe eosinophilic asthma: (1) Must have documentation of clinical benefit with Fasenra compared to baseline (e.g., decrease in exacerbations, improvement in symptoms, decrease in oral steroid use).
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Prescriber is a specialist or has consulted with a specialist for the condition being treated.
<b>Coverage Duration</b>	1 year initial and 2 years reauth. Dosing must follow the FDA-approved labeling.
<b>Other Criteria</b>	Diagnosis and administration information will be reviewed to determine if coverage is available as a Medicare Part B or Part D benefit.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# fentanyl citrate transmucosal

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## Products Affected

- *fentanyl citrate buccal lozenge on a handle*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Patient must be age 16 or over
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	Patient must first try two short-acting oral opioids (e.g., oxycodone, morphine sulfate, hydromorphone).
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



# FILSPARI

## Products Affected

- *filspari*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	For all requests: Medical records supporting the request must be provided, including documentation of a covered diagnosis, prior therapies, and responses to treatment. For IgAN initial requests: Must also provide (1) documentation confirming biopsy-verified primary immunoglobulin A nephropathy (IgAN) - AND - (2) documentation of a urine protein-to-creatinine ratio (UPCR) greater than or equal to 1.5 g/g - AND - (3) documentation of an eGFR greater than or equal to 30 mL/min/1.73 m2.
<b>Age Restrictions</b>	Must be age 18 or older
<b>Prescriber Restrictions</b>	Must be prescribed by or in consultation with a nephrologist.
<b>Coverage Duration</b>	One year initial and reauthorization.
<b>Other Criteria</b>	For IgAN initial requests: (1) Patient must try and fail (defined as an intolerance or an inadequate response after a minimum of 3 months) with a maximally tolerated dose of an ACE inhibitor or ARB - AND - (2) Patient must try and fail (defined above) one other drug for the condition (e.g., mycophenolate, steroids, SGLT2 inhibitor, etc.) - AND (3) Patient must not be currently receiving dialysis - AND - (4) Patient has not undergone kidney transplant. For IgAN reauthorization requests: (1) Must have documentation of a reduced proteinuria - AND - no decline in eGFR compared to baseline.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# FILSUVEZ

## Products Affected

- FILSUVEZ

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Must not be used in combination with Vyjuvek.
<b>Required Medical Information</b>	For epidermolysis bullosa initial requests: (1) Must have a diagnosis of recessive dystrophic epidermolysis bullosa (RDEB) with genetic testing confirming mutation(s), AND (2) Must have presence of open, partial thickness skin wounds, AND (3) Application is limited to open, partial thickness skin wounds only during dressing change. For epidermolysis bullosa reauthorization requests: (1) Must have presence of open, partial thickness skin wounds, AND (2) Application is limited to open, partial thickness skin wounds only during dressing change, AND (3) documentation confirming Filsuvez is providing clinical benefit must be provided (e.g. complete wound closure, decrease in wound size, reduced body surface area affected by wounds, increase in granulation tissue, decrease in pain and/or infection).
<b>Age Restrictions</b>	Patient must be 6 months of age or older.
<b>Prescriber Restrictions</b>	Must be prescribed by, or in consultation with, a dermatologist or another board-certified prescriber with qualifications to treat dystrophic epidermolysis bullosa.
<b>Coverage Duration</b>	3 months initial and 6 months reauthorization
<b>Other Criteria</b>	
<b>Indications</b>	Some FDA-approved Indications Only.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# FINGOLIMOD

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## Products Affected

- *fingolimod hcl*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

# FINTEPLA

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## Products Affected

- FINTEPLA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Must have documentation supporting a trial and failure (defined as inadequate seizure control) with two of the following: clobazam, valproic acid, topiramate.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

# Firdapse

## Products Affected

- FIRDAPSE

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Patient must have clinical symptoms of LEMS (i.e., proximal extremity weakness) that interfere with daily activities. Must provide a baseline disease severity score using the Quantitative Myasthenia Gravis (QMG) or the Triple-Timed Up-And-Go (3TUG) test.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Initial approval: 1 year. Reauthorization: 2 years.
<b>Other Criteria</b>	The following criteria must be met for initial coverage: (1) If the patient has cancer associated with LEMS, cancer must have been appropriately treated - AND - (2) patient must not have history of seizures, or an increased risk of seizures due to a condition (e.g., brain metastases) and/or medication (e.g., bupropion) - AND - (3) - for adults only, patient must have documented trial and failure (defined as an intolerance or inability to improve symptoms) to pyridostigmine. For reauthorization: Must have documentation showing improvement or stabilization in condition using the QMG or 3TUG test.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# FOTIVDA

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## Products Affected

- FOTIVDA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

# FRUZAQLA

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## Products Affected

- FRUZAQLA ORAL CAPSULE 1 MG, 5 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

# FYCOMPA

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## Products Affected

- FYCOMPA ORAL SUSPENSION
- FYCOMPA ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Must have documentation supporting a trial and failure (defined as inadequate seizure control) with at least 2 generic anticonvulsants for the condition.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No



# GALAFOLD

## Products Affected

- GALAFOLD

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	For initial requests: (1) Patient must have a confirmed diagnosis of Fabry disease and documentation of an amenable galactosidase alpha gene variant based on in vitro assay data, AND (2) Must have an eGFR of 30 or more.
<b>Age Restrictions</b>	Must be at least 18 years of age.
<b>Prescriber Restrictions</b>	Must be prescribed by, or in consultation with, a specialist for the condition.
<b>Coverage Duration</b>	Two years
<b>Other Criteria</b>	For reauthorization: (1) Must have an eGFR of 30 or more, AND (2) Must have documentation supporting a continued response to Galafold therapy.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# GATTEX

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## Products Affected

- GATTEX

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of dependence on parenteral support for at least 12 months must be provided.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Initial approval is 6 months. Reauthorization: 1 year.
<b>Other Criteria</b>	For reauthorization: Documentation that the patient has had a sustained decreased in parenteral support from baseline as documented by an actual change in volume must be provided.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# GAVRETO

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## Products Affected

- GAVRETO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

# GEFITINIB

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## Products Affected

- *gefitinib*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

# GILOTRIF

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## Products Affected

- GILOTRIF

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

# glatiramer

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## Products Affected

- *glatiramer acetate subcutaneous solution  
prefilled syringe 20 mg/ml, 40 mg/ml*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

# GLATOPA

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## Products Affected

- GLATOPA SUBCUTANEOUS SOLUTION  
 PREFILLED SYRINGE 20 MG/ML, 40  
 MG/ML

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

# GROWTH HORMONE

## Products Affected

- NORDITROPIN FLEXPRO SUBCUTANEOUS SOLUTION PEN-INJECTOR
- OMNITROPE SUBCUTANEOUS SOLUTION CARTRIDGE
- OMNITROPE SUBCUTANEOUS SOLUTION RECONSTITUTED

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	FOR CHILDREN: must submit an untreated growth velocity curve with a minimum of 1 year of growth data showing a growth velocity of less than 10th % for bone age and gender, growth plates must be open, bone age must be a minimum of 1 year behind chronological age (unless GHD is related to pituitary surgery, radiation therapy, or with precocious puberty), must have a documented GH deficiency via 2 growth hormone stimulation tests below 10ng/ml or GH stimulation test level less than 15 ng/ml + IGF-1 and IGF-PB3 levels below normal for bone age and sex, decreased muscle tone by exam. FOR ADULTS with a diagnosis of GHD: Must have confirmation of GHD by meeting one of the following: (1) A suboptimal response using an appropriate GH-stimulation test, (2) Child-onset GHD with confirmed persistent GHD, or (3) patient has all the following: (a) documented pituitary or hypothalamic disease (e.g., brain tumor with previous brain irradiation), (b) greater than or equal to 3 pituitary hormone deficiencies (thyroid-stimulating hormone (TSH), corticotropin (ACTH), and gonadotropins), and (c) low insulin-like growth factor-1 (IGF-1). If IGF-1 value is indeterminate, a suboptimal response on an appropriate GH-stimulation test required.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Must be prescribed by an endocrinologist, gastroenterologist, or nephrologist.
<b>Coverage Duration</b>	One year



PA Criteria	Criteria Details
<b>Other Criteria</b>	FOR CHILDREN: Diagnosis of Growth Hormone Deficiency-height must be less than the 5th% fir age/sex. Diagnosis of Turner's syndrome-height must be less than 10th%. Diagnosis of Pre-transplant chronic renal insufficiency-height must be less than 5th% for age/sex and patient must be receiving weekly dialysis or SCR less than 2 mg/dL. FOR CHILDREN: must not have constitutional growth delay, or acute or chronic catabolic illness. FOR ADULTS, the following conditions are not covered: treatment of reduced growth hormone related to aging, Turner's syndrome or cystinosis. For reauthorization in adults and children: Above normal IGF-1 level requires provider attestation that dose will be decreased and therapy will be managed to obtain a level within normal range.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# HADLIMA

## Products Affected

- HADLIMA PUSHTOUCH SUBCUTANEOUS SOLUTION AUTO-INJECTOR 40 MG/0.4ML, 40 MG/0.8ML, 40 MG/0.8ML
- HADLIMA SUBCUTANEOUS SOLUTION

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Must not be used in combination with other biologic drugs, Otezla, or Janus Kinase Inhibitor (JAKis).
<b>Required Medical Information</b>	Documentation of prior therapies and responses to treatment. For approvals of shortened-interval dosing in Crohn's disease and ulcerative colitis, documentation of the following: (1) Two of the following: symptoms, imaging showing active disease, fecal calprotectin greater than 120, CRP greater than or equal to 300, and (2) inadequate drug trough levels, and (3) initial response to therapy.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Prescriber is a specialist or has consulted with a specialist for the condition being treated.
<b>Coverage Duration</b>	Two years. Dosing must follow the FDA-approved labeling.

PA Criteria	Criteria Details
<b>Other Criteria</b>	<p>For RA: Must try and fail (defined as an intolerance or inability to improve symptoms) one traditional non-biologic immunomodulator drug (e.g., methotrexate, leflunomide, hydroxychloroquine, sulfasalazine). For PsA: Must try and fail (defined above) one traditional non-biologic immunomodulator drug (e.g., methotrexate, leflunomide, sulfasalazine). For UC: Must try and fail (defined above) one traditional non-biologic immunomodulator drug (e.g., 6-mercaptopurine, azathioprine, cyclosporine) or a steroid (e.g., prednisone). For ankylosing spondylitis: Must try and fail (defined above) one nonsteroidal anti-inflammatory drug (NSAID). For psoriasis: Must try and fail (defined above) one traditional non-biologic immunomodulator drug (e.g., methotrexate, cyclosporine, acitretin). For Crohn's disease: Must try and fail (defined above) one traditional non-biologic immunomodulator drug (e.g., 6-mercaptopurine, azathioprine, methotrexate) or a steroid (e.g., prednisone). For hidradenitis suppurativa: Must try and fail (defined above) one other drug for the condition (e.g., prednisone, clindamycin, erythromycin). For uveitis: Must try and fail (defined above) one other drug for the condition (e.g., intraocular or systemic steroids, immunomodulator drugs). For Juvenile Idiopathic Arthritis: Must try and fail (defined above) one other drug for the condition (e.g., methotrexate, sulfasalazine, NSAID) - or - the patient will be starting adalimumab concurrently with methotrexate, sulfasalazine, or leflunomide - or - the patient has aggressive disease, as determined by the prescribing physician.</p>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# Haegarda

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## Products Affected

- HAEGARDA

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Haegarda is not covered if any of the following are met: (1) use in combination with an angiotensin-converting enzyme inhibitor (ACEI), (2) use in combination with other preventative therapies for HAE (e.g., Orladeyo, Takhyzro), and/or (3) used for the treatment of acute attacks.
<b>Required Medical Information</b>	Requires submission of C4, C1-INH protein, and C1-INH function lab results confirming diagnosis.
<b>Age Restrictions</b>	Must be age 6 or older.
<b>Prescriber Restrictions</b>	Prescriber is an allergist, immunologist, hematologist, or other specialist experienced in treating HAE.
<b>Coverage Duration</b>	1 year initial and reauth
<b>Other Criteria</b>	For reauthorization: Must also have documentation showing a decrease in the frequency of attacks.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# HEMADY

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## Products Affected

- HEMADY

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	Patient must try and fail dexamethasone oral tablet (generic Decadron) for current multiple myeloma treatment. Fail is defined as having an intolerance to an inability to improve the condition.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

# HUMIRA

## Products Affected

- HUMIRA (2 PEN)
- HUMIRA (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 10 MG/0.1ML, 20 MG/0.2ML, 40 MG/0.4ML, 40 MG/0.8ML
- HUMIRA PEN SUBCUTANEOUS PEN-INJECTOR KIT
- HUMIRA SUBCUTANEOUS PREFILLED SYRINGE KIT 40 MG/0.8ML
- HUMIRA-CD/UC/HS STARTER
- HUMIRA-PED $\geq$ 40KG UC STARTER
- HUMIRA-PSORIASIS/UEVIT STARTER

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Must not be used in combination with other biologic drugs, Otezla, or Janus Kinase Inhibitor (JAKis).
<b>Required Medical Information</b>	Documentation of prior therapies and responses to treatment. For approvals of shortened-interval dosing in Crohn's disease and ulcerative colitis, documentation of the following: (1) Two of the following: symptoms, imaging showing active disease, fecal calprotectin greater than 120, CRP greater than or equal to 300, and (2) inadequate drug trough levels, and (3) initial response to therapy.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Prescriber is a specialist or has consulted with a specialist for the condition being treated.
<b>Coverage Duration</b>	Two years. Dosing must follow the FDA-approved labeling.

PA Criteria	Criteria Details
<b>Other Criteria</b>	<p>For RA: Must try and fail (defined as an intolerance or inability to improve symptoms) one traditional non-biologic immunomodulator drug (e.g., methotrexate, leflunomide, hydroxychloroquine, sulfasalazine). For PsA: Must try and fail (defined above) one traditional non-biologic immunomodulator drug (e.g., methotrexate, leflunomide, sulfasalazine). For UC: Must try and fail (defined above) one traditional non-biologic immunomodulator drug (e.g., 6-mercaptopurine, azathioprine, cyclosporine) or a steroid (e.g., prednisone). For ankylosing spondylitis: Must try and fail (defined above) one nonsteroidal anti-inflammatory drug (NSAID). For psoriasis: Must try and fail (defined above) one traditional non-biologic immunomodulator drug (e.g., methotrexate, cyclosporine, acitretin). For Crohn's disease: Must try and fail (defined above) one traditional non-biologic immunomodulator drug (e.g., 6-mercaptopurine, azathioprine, methotrexate) or a steroid (e.g., prednisone). For hidradenitis suppurativa: Must try and fail (defined above) one other drug for the condition (e.g., prednisone, clindamycin, erythromycin). For uveitis: Must try and fail (defined above) one other drug for the condition (e.g., intraocular or systemic steroids, immunomodulator drugs). For Juvenile Idiopathic Arthritis: Must try and fail (defined above) one other drug for the condition (e.g., methotrexate, sulfasalazine, NSAID) - or - the patient will be starting adalimumab concurrently with methotrexate, sulfasalazine, or leflunomide - or - the patient has aggressive disease, as determined by the prescribing physician.</p>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# HYFTOR

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## Products Affected

- HYFTOR

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Must not be receiving systemic mTOR inhibitor therapy (e.g., everolimus).
<b>Required Medical Information</b>	Medical records supporting the request must be provided. Must have 3 or more facial angiofibromas.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Must be prescribed by, or in consultation with, a dermatologist, neurologist, or geneticist.
<b>Coverage Duration</b>	Initial coverage: 3 months. Reauthorization: 1 year.
<b>Other Criteria</b>	Must not be a candidate for laser therapy or surgery. Reauthorization: Must have evidence of improvement in facial angiofibromas compared to baseline.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No



# IBRANCE

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## Products Affected

- IBRANCE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

# icatibant acetate

## Products Affected

- *icatibant acetate subcutaneous solution prefilled syringe*
- SAJAZIR SUBCUTANEOUS SOLUTION PREFILLED SYRINGE

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Concurrent use of an angiotensin-converting enzyme inhibitor (ACEI) is not covered.
<b>Required Medical Information</b>	Documentation of C4, C1-INH protein, and C1-INH function lab results confirming diagnosis.
<b>Age Restrictions</b>	Must be age 18 or older.
<b>Prescriber Restrictions</b>	Prescriber is an allergist, immunologist, hematologist, or other specialist experienced in treating HAE.
<b>Coverage Duration</b>	6 months, initial and reauthorization.
<b>Other Criteria</b>	For reauthorization: Must have documentation showing use of previously approved syringes AND a favorable clinical response (decrease in the duration of attacks, quick onset of symptom relief, resolution of symptoms, decrease in attack frequency or severity).
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# ICLUSIG

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## Products Affected

- ICLUSIG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

# ICOSAPENT ETHYL

## Products Affected

- *icosapent ethyl*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	For severe hypertriglyceridemia, laboratory confirmation of a baseline triglyceride level of at least 500 mg/dL prior to starting icosapent ethyl. For reducing the risk of myocardial infarction (MI), stroke, coronary revascularization, and unstable angina requiring hospitalization, laboratory confirmation of a baseline triglyceride level of at least 150mg/dL prior to starting icosapent ethyl.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Two years
<b>Other Criteria</b>	For cardiovascular (CV) risk reduction, must have either established CV disease (e.g., coronary artery disease, heart attack, stroke) OR diabetes mellitus with 2 or more additional risk factors for CV disease (e.g., smoking, hypertension, elevated CRP) - AND - one of the following: (1) Documented trial with ezetimibe AND one high intensity statin (e.g., atorvastatin or rosuvastatin) or, if a high-intensity statin is not tolerated, one statin at the maximally tolerated dose - OR - (2) ezetimibe trial with documented statin intolerance defined as experiencing statin-related muscle symptoms during separate trials of two different statins with symptoms resolving upon discontinuation of the statin during each trial. For hypertriglyceridemia: must have tried fenofibrate for at least 12 weeks with an inability to lower triglycerides below 150mg/dL.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# IDHIFA

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## Products Affected

- IDHIFA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of IDH2 (isocitrate dehydrogenase-2) mutation must be submitted.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

# imatinib mesylate

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## Products Affected

- *imatinib mesylate oral tablet 100 mg, 400 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

# IMBRUVICA

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## Products Affected

- IMBRUVICA ORAL CAPSULE
- IMBRUVICA ORAL SUSPENSION
- IMBRUVICA ORAL TABLET 140 MG, 280 MG, 420 MG

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Two years. Dosing must follow the FDA-approved labeling.
<b>Other Criteria</b>	Criteria will be applied consistent with current NCCN guidance. Reauthorization for GVHD: Must have documentation of clinical benefit.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# IMPAVIDO

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## Products Affected

- IMPAVIDO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One month
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No



# INCRELEX

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## Products Affected

- INCRELEX

PA Criteria	Criteria Details
Exclusion Criteria	Increlex is not covered in patients with closed epiphyses.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

# INLYTA

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## Products Affected

- INLYTA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

# INQOVI

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## Products Affected

- INQOVI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	Patient must first try IV decitabine.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	Yes

# INREBIC

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## Products Affected

- INREBIC

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	Must have tried and failed (defined as an intolerance or inability to improve the condition) Jakafi.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

# insulin aspart

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## Products Affected

- *insulin aspart flexpen*
- *insulin aspart injection*
- *insulin aspart penfill*
- *insulin aspart prot & aspart*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Must have documentation supporting a trial and failure (defined as inability to control blood glucose levels) with one of the following: Humalog, Humalog Mix, Lyumjev, or insulin lispro vials.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Two years
<b>Other Criteria</b>	
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# ISTURISA

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## Products Affected

- ISTURISA ORAL TABLET 1 MG, 5 MG

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Patient must have failed pituitary surgery or have a contraindication to pituitary surgery.
<b>Age Restrictions</b>	Must be 18 years of age or older.
<b>Prescriber Restrictions</b>	Must be prescribed by an endocrinologist
<b>Coverage Duration</b>	Two years
<b>Other Criteria</b>	Patient must have tried and failed two of the following: ketoconazole, Lysodren, cabergoline, and/or Signifor/LAR.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# ivabradine

## Products Affected

- *ivabradine hcl*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	For heart failure in adults, documentation of the following is required: (1) Patient has stable, symptomatic chronic heart failure, AND (2) Patient has an ejection fraction of 35% or less, AND (3) Patient is in sinus rhythm with a resting heart rate of at least 70 beats per minute, AND (4) Patient is currently on maximally tolerated beta-blocker therapy OR has a contraindication to beta-blocker therapy (i.e., allergy, severe COPD limiting beta blocker usage). For heart failure in children, documentation of the following is required: (1) patient has stable, symptomatic chronic heart failure due to dilated cardiomyopathy, AND (2) patient is in sinus rhythm with an elevated heart rate, AND (3) baseline heart rate (defined as prior to the use of ivabradine) has been provided
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	One year initial. Two years reauthorization.
<b>Other Criteria</b>	For reauthorization requests (adult and children), the patient is continuing to have clinical benefit from ivabradine as defined by maintenance of a decreased heart rate compared to baseline.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# IVIG

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## Products Affected

- GAMMAGARD INJECTION SOLUTION 2.5 GM/25ML
- GAMMAGARD S/D LESS IGA
- GAMUNEX-C

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Must provide current weight and requested dose.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Two years
<b>Other Criteria</b>	Dosing must follow FDA-approved labeling or have documentation supporting the dose follows accepted standards of medical practice. Diagnosis and administration information will be reviewed to determine if coverage is available as a Medicare Part B or Part D benefit.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No



# IWILFIN

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## Products Affected

- IWILFIN

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

# JAKAFI

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## Products Affected

- JAKAFI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	Criteria will be applied consistent with current NCCN guidance. Reauthorization for GVHD: Must have documentation of clinical benefit.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

# JAYPIRCA

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## Products Affected

- JAYPIRCA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Medical records supporting that the use of Jaypirca follows current NCCN recommendations must be provided.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	Use of Jaypirca must follow current NCCN recommendations.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

# JOENJA

## Products Affected

- JOENJA

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Must not use in combination with immunosuppressive medications.
<b>Required Medical Information</b>	Documentation of activated phosphoinositide 3-kinase delta syndrome (APDS) with PIK3CD or PIK3R1 mutation confirmed by genetic testing.
<b>Age Restrictions</b>	Must be at least 12 years old.
<b>Prescriber Restrictions</b>	Must be prescribed by or in consultation with a provider who specializes in the management of APDS.
<b>Coverage Duration</b>	One year initial and reauthorization.
<b>Other Criteria</b>	Patient must have nodal and/or extranodal lymphoproliferation, history of repeated oto-sino-pulmonary infections and/or organ dysfunction (e.g. lung, liver) - AND - for reauthorization, must provide documentation confirming a positive response to therapy.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# JYLAMVO

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## Products Affected

- JYLAMVO

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Two years
<b>Other Criteria</b>	Must have documentation to support a trial and failure (defined as an intolerance or inability to improve the condition) with generic methotrexate. Diagnosis will be reviewed to determine if coverage is available as a Medicare Part B or Part D benefit.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# KALYDECO

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## Products Affected

- KALYDECO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient must have laboratory confirmation of ivacaftor-responsive mutation in the CFTR gene.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

# KERENDIA

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## Products Affected

- KERENDIA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For initial treatment, eGFR greater than or equal to 25ml/min/1.73m <sup>2</sup> .
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	Must try and fail (defined as an inability to improve symptoms) or intolerance to a SGLT2i (e.g., Farxiga or Jardiance) AND must be on maximally tolerated ACEI or ARB.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

# KISQALI

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## Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No



# KISQALI FEMARA

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## Products Affected

- KISQALI FEMARA (200 MG DOSE)
- KISQALI FEMARA (400 MG DOSE)
- KISQALI FEMARA (600 MG DOSE)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

# KOSELUGO

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## Products Affected

- KOSELUGO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

# KRAZATI

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## Products Affected

- *krazati*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Medical records supporting that the use of Krazati follows current NCCN recommendations must be provided.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Two years
<b>Other Criteria</b>	Use of Krazati must follow current NCCN recommendations.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# lapatinib

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## Products Affected

- *lapatinib ditosylate*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

# LAZCLUZE

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## Products Affected

- LAZCLUZE ORAL TABLET 240 MG, 80 MG

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

# ledipasvir-sofosbuvir

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## Products Affected

- *ledipasvir-sofosbuvir*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Must have chronic hepatitis C infection.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Prescriber must be a gastroenterologist, hepatologist, or infectious disease specialist.
<b>Coverage Duration</b>	Duration of therapy will be applied consistent with current AASLD/IDSA guidance.
<b>Other Criteria</b>	Must have documentation to support that the use of ledipasvir-sofosbuvir is consistent with current AASLD/IDSA guidance.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# LENALIDOMIDE

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## Products Affected

- *lenalidomide*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

# LENVIMA

## Products Affected

- LENVIMA (10 MG DAILY DOSE)
- LENVIMA (12 MG DAILY DOSE)
- LENVIMA (14 MG DAILY DOSE)
- LENVIMA (18 MG DAILY DOSE)
- LENVIMA (20 MG DAILY DOSE)
- LENVIMA (24 MG DAILY DOSE)
- LENVIMA (4 MG DAILY DOSE)
- LENVIMA (8 MG DAILY DOSE)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No



# LEQVIO

## Products Affected

- LEQVIO

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Must not be used in combination with a PCSK9 inhibitor (e.g., Repatha), Nexletol, or Nexlizet.
<b>Required Medical Information</b>	Must submit most recent LDL-C level. Must submit documentation of prior therapies and responses to treatment.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Must be prescribed by, or in consultation with, a cardiologist, endocrinologist, or board-certified lipidologist.
<b>Coverage Duration</b>	Two years. Limited to 3 syringes year one and 1 syringe every 6 months thereafter.
<b>Other Criteria</b>	Patient must meet the following: (1) Patient has tried a PCSK9 inhibitor (e.g., Repatha) and LDL-C remains greater than or equal to 70mg/dL - and - (2) Patient has tried one high-intensity statin (i.e., atorvastatin greater than or equal to 40 mg daily, rosuvastatin greater than or equal to 20 mg daily) and LDL-C remains greater than or equal to 70mg/dL - or - (3) Patient is statin intolerant demonstrated by experiencing statin-associated rhabdomyolysis to one statin OR failing to achieve LDL-C goal because of skeletal-muscle related symptoms that have continued despite both lowering the statin strength and attempting a different statin. For reauthorization, must also have improved and maintained an improved LDL compared to baseline.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# LIBERVANT

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## Products Affected

- LIBERVANT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

# LIDOCAINE PATCH

## Products Affected

- *lidocaine external patch 5 %*
- LIDOCAN
- LIDOCAN III

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Two years
<b>Other Criteria</b>	Medically accepted indications for lidocaine 5% patch include relief of pain associated with postherpetic neuralgia (PHN), diabetic neuropathy, and cancer-related neuropathic pain.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# LIVTENCITY

## Products Affected

- LIVTENCITY

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Baseline CMV DNA level confirming diagnosis.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	8 weeks
<b>Other Criteria</b>	Must not be used concomitantly with other CMV antivirals (e.g., ganciclovir, valganciclovir). Dosing must follow FDA-approved labeling. Must have documented trial and failure with ganciclovir, valganciclovir, cidofovir or foscarnet. For reauthorization, documentation of response (e.g., CMV DNA level) must be provided.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# LONSURF

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## Products Affected

- LONSURF

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

# LORBRENA

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## Products Affected

- LORBRENA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

# LUMAKRAS

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## Products Affected

- LUMAKRAS ORAL TABLET 120 MG, 320 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

# LUPRON DEPOT

## Products Affected

- LUPRON DEPOT (1-MONTH)  
INTRAMUSCULAR KIT 3.75 MG
- LUPRON DEPOT (3-MONTH)  
INTRAMUSCULAR KIT 11.25 MG
- LUPRON DEPOT-PED (1-MONTH)
- LUPRON DEPOT-PED (3-MONTH)
- LUPRON DEPOT-PED (6-MONTH)

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Two years
<b>Other Criteria</b>	
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No



# LYNPARZA

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## Products Affected

- LYNPARZA ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

# LYTGOBI

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## Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

# MARPLAN

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## Products Affected

- MARPLAN

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation supporting the trial and failure (defined as an inadequate improvement in depressive symptoms) with two of the following generic antidepressants is required: SNRIs, SSRIs, mirtazapine, or bupropion.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

# MATULANE

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## Products Affected

- MATULANE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

# MAVYRET

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## Products Affected

- MAVYRET ORAL PACKET
- MAVYRET ORAL TABLET

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Must have chronic hepatitis C infection.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Prescriber must be a gastroenterologist, hepatologist, or infectious disease specialist.
<b>Coverage Duration</b>	Duration of therapy will be applied consistent with current AASLD/IDSA guidance.
<b>Other Criteria</b>	Must have documentation to support that the use of Mavyret is consistent with current AASLD/IDSA guidance.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# MEKINIST

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## Products Affected

- MEKINIST ORAL TABLET 0.5 MG, 2 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

# MEKINIST ORAL SOLUTION

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## Products Affected

- MEKINIST ORAL SOLUTION RECONSTITUTED

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Coverage requires that the patient is unable to swallow the tablet formulation.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

# MEKTOVI

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## Products Affected

- MEKTOVI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient must have documentation of BRAF V600 mutation status
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No



# METHYLTESTOSTERONE

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## Products Affected

- *methyltestosterone oral*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

# MIFEPRISTONE

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## Products Affected

- *mifepristone oral tablet 300 mg*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Must be prescribed by an endocrinologist.
<b>Coverage Duration</b>	One year.
<b>Other Criteria</b>	For reauthorization of previously approved requests: Must provide documentation of improvement in hyperglycemia control with mifepristone.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# modafinil

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## Products Affected

- *modafinil oral*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

# MOUNJARO

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## Products Affected

- MOUNJARO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	Only covered for the treatment of Type 2 Diabetes Mellitus.
Indications	Some FDA-approved Indications Only.
Off Label Uses	
Part B Prerequisite	No

# MYALEPT

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## Products Affected

- MYALEPT

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Laboratory confirmed leptin deficiency. Must have one of the following: triglyceride level more than 200mg/dL or diabetes mellitus.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Two years
<b>Other Criteria</b>	Patient must not have HIV, infectious liver disease, or acquired lipodystrophy with hematologic abnormalities
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# NAYZILAM

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## Products Affected

- NAYZILAM NASAL SOLUTION 5 MG/0.1ML

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

# NERLYNX

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## Products Affected

- NERLYNX

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months total therapy
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

# NEXLETOL

## Products Affected

- NEXLETOL

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Must not be used along with PCSK9 inhibitors (e.g., Repatha), Juxtapid.
<b>Required Medical Information</b>	Must submit most recent LDL-C level. Must submit documentation of prior therapies and responses to treatment.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Must be prescribed by, or in consultation with, a cardiologist, endocrinologist, or board-certified lipidologist.
<b>Coverage Duration</b>	Two years
<b>Other Criteria</b>	Patient must meet the following: (1) Patient has tried one high-intensity statin (i.e., atorvastatin greater than or equal to 40 mg daily, rosuvastatin greater than or equal to 20 mg daily) plus ezetimibe concomitantly for a minimum of 8 weeks and LDL-C remains greater than or equal to 70mg/dL or (2) Patient has tried ezetimibe and is statin intolerant demonstrated by experiencing statin-associated rhabdomyolysis to one statin OR failing to achieve LDL-C goal because of skeletal-muscle related symptoms that have continued despite both lowering the statin strength and attempting a different statin.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No



# NEXLIZET

## Products Affected

- NEXLIZET

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Must not be used along with PCSK9 inhibitors (e.g., Repatha), Juxtapid.
<b>Required Medical Information</b>	Must submit most recent LDL-C level. Must submit documentation of prior therapies and responses to treatment.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Must be prescribed by, or in consultation with, a cardiologist, endocrinologist, or board-certified lipidologist.
<b>Coverage Duration</b>	Two years
<b>Other Criteria</b>	Patient must meet the following: (1) Patient has tried one high-intensity statin (i.e., atorvastatin greater than or equal to 40 mg daily, rosuvastatin greater than or equal to 20 mg daily) plus ezetimibe concomitantly for a minimum of 8 weeks and LDL-C remains greater than or equal to 70mg/dL or (2) Patient has tried ezetimibe and is statin intolerant demonstrated by experiencing statin-associated rhabdomyolysis to one statin OR failing to achieve LDL-C goal because of skeletal-muscle related symptoms that have continued despite both lowering the statin strength and attempting a different statin.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# NINLARO

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## Products Affected

- NINLARO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

# nitisinone

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## Products Affected

- *nitisinone*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

# NIVESTYM

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## Products Affected

- NIVESTYM INJECTION SOLUTION  
 PREFILLED SYRINGE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

# NUBEQA

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## Products Affected

- NUBEQA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

# NUCALA

## Products Affected

- NUCALA SUBCUTANEOUS SOLUTION AUTO-INJECTOR
  - NUCALA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML, 40
  - NUCALA SUBCUTANEOUS SOLUTION RECONSTITUTED
- MG/0.4ML

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Must not be used in combination with other biologic drugs.
<b>Required Medical Information</b>	<p>Diagnosis and administration information will be reviewed to determine if coverage is available as a Medicare Part B or Part D benefit. For initial coverage of severe eosinophilic asthma, documentation of the following is required: (1) An elevated blood eosinophil count of greater than or equal to 150 cells per microliter within 6 weeks (prior to the immediate start of treatment with Nucala) - OR - greater than or equal to 300 cells per microliter in the previous 12 months, AND (2) Trial with failure of 1 ICS/LABA inhaler in combination with 1 other asthma controller drug in the past 6 months (failure is defined as an inability to improve the condition on required therapy for at least 4 weeks). For reauthorization of severe eosinophilic asthma: (1) Must have documentation of clinical benefit with Nucala compared to baseline (e.g., decrease in exacerbations, improvement in symptoms, decrease in oral steroid use). For initial coverage of chronic rhinosinusitis with nasal polyp, documentation of the following is required: (1) Patient has experienced 2 or more of the following symptoms for at least 12 weeks despite management: nasal congestion or obstruction, nasal drainage, reduction or loss of smell, AND (2) Patient has tried and failed (defined as an inability to improve symptoms for least 4 weeks) an intranasal steroid, AND (3) Patient will continue to use an intranasal steroid along with Nucala. For reauthorization of chronic rhinosinusitis with nasal polyp: (1) The patient will continue to use an intranasal steroid along with Nucala, AND (2) Must have documentation of clinical benefit with Nucala compared to baseline (e.g., decrease in exacerbations, improvement in symptoms, decrease in oral steroid use).</p>
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Prescriber is a specialist or has consulted with a specialist for the condition being treated.
<b>Coverage Duration</b>	1 year initial and 2 years reauth. Dosing must follow the FDA-approved labeling.

PA Criteria	Criteria Details
<b>Other Criteria</b>	<p>For initial coverage of eosinophilic granulomatosis with polyangiitis (EGPA), documentation of the following is required: (1) Patient has non-severe disease defined as absence of life or organ-threatening manifestations, AND (2) Patient has tried and failed (defined as an intolerance or inability to improve symptoms) one traditional, non-biologic immunomodulator (e.g., azathioprine, methotrexate, mycophenolate). For reauthorization of EGPA: (1) Must have documentation of clinical benefit with Nucala compared to baseline (e.g., decrease in exacerbations, improvement in symptoms, decrease in oral steroid use). For initial coverage of Hypereosinophilic Syndrome (HES), documentation of the following is required: (1) Patient has had HES for at least 6 months, AND (2) Patient has a blood eosinophil count of at least 1,000 cells per microliter, AND (3) Patient has had at least 2 HES flares in the past year defined as having symptoms requiring a steroid or an increase in a current steroid, AND (4) the provider attests that there is NO identifiable non-hematologic secondary cause of HES, AND (5) Patient has tried and failed (defined as an inability to improve symptoms) a generic steroid-sparing drug (e.g., hydroxyurea). For reauthorization of Hypereosinophilic Syndrome (HES): (1) Must have documentation of clinical benefit with Nucala compared to baseline (e.g., decrease in exacerbations, improvement in symptoms, decrease in oral steroid use).</p>
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# NUEDEXTA

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## Products Affected

- NUEDEXTA

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Medical records supporting the request, including documentation of the diagnosis, must be provided.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Must be prescribed by a neurologist.
<b>Coverage Duration</b>	Two years
<b>Other Criteria</b>	Coverage requires a diagnosis of pseudobulbar affect caused by an underlying neurological condition (ex. amyotrophic lateral sclerosis, multiple sclerosis, stroke). For reauthorization, documentation that Nuedexta caused a decrease in the number of episodes of laughing or crying compared to baseline must be provided.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No



# NULIBRY

## Products Affected

- NULIBRY

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Confirmed diagnosis of MoCD Type A by genetic testing. Documentation of genetic testing results must be submitted.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Must be prescribed by, or in consultation with a physician who specializes in the treatment of inherited metabolic disorders.
<b>Coverage Duration</b>	Initial 1 year. Reauthorization 2 years
<b>Other Criteria</b>	For reauthorization requests, must also provide documentation demonstrating a beneficial response to therapy compared to pretreatment baseline in one or more of the following: neurological function, gross motor function, and/or developmental milestones.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# NUPLAZID

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## Products Affected

- NUPLAZID ORAL CAPSULE
- NUPLAZID ORAL TABLET 10 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

# NURTEC

## Products Affected

- NURTEC ORAL TABLET DISPERSIBLE 75 MG

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Must not be used in combination with other CGRP antagonist therapy.
<b>Required Medical Information</b>	For migraine prevention initial requests: (1) Must have at least four migraine days per month, AND (2) Must try and fail (defined as an intolerance or inability to improve the condition) two of the following generic migraine prevention drugs, each from a different class and each used for at least 28 days: amitriptyline, nortriptyline, venlafaxine, propranolol, metoprolol, timolol, valproic acid, divalproex, or topiramate, AND (3) Patient has been evaluated for and does not have Medication overuse headache (MOH). For treatment of acute migraine requests: Unless contraindicated per the FDA label, must try and fail (defined as inability to improve symptoms) two different triptan medications.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Initial: 1 year. Reauth: 2 years. Dosing must align with FDA labeling.
<b>Other Criteria</b>	For migraine prevention reauthorization requests: (1) Must provide documentation of a decrease in migraine days per month with use of Nurtec ODT.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# OCALIVA

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## Products Affected

- OCALIVA

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Must have one of the following: alkaline phosphatase level greater than or equal to 1.67 times the upper limit of normal, or total bilirubin greater than or equal to 1 times the upper limit of normal but less than 2 times the upper limit of normal.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Two years
<b>Other Criteria</b>	Patient must have received 12 months of ursodiol therapy and have had an inadequate response or be intolerant to ursodiol.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# ODOMZO

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## Products Affected

- ODOMZO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

# OFEV

## Products Affected

- OFEV

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	For all indications, must have documentation of High Resolution Computed Tomography (HRCT) confirming diagnosis.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Prescriber is or has consulted with a pulmonologist.
<b>Coverage Duration</b>	One year initial. Two years reauth. Dosing must follow the FDA-approved labeling.
<b>Other Criteria</b>	For idiopathic pulmonary fibrosis (IPF): Prescriber must rule out other known causes of interstitial lung disease - and - must have presence of a UIP pattern on HRCT in patients not subjected to surgical lung biopsy. For chronic fibrosing interstitial lung disease with progressive phenotype: Lung fibrosis must be at least 10% - and - Forced Vital Capacity (FVC) decline must be at least 10% - OR - at least 5% with one of the following: worsening respiratory symptoms OR worsening fibrosis on imaging. For systemic sclerosis- related interstitial lung disease (SSc-ILD): Lung fibrosis must be at least 10% - and - patient must try and fail (defined as an intolerance or inability to improve the condition) mycophenolate or cyclophosphamide at maximally tolerated doses - and - provider must attest that the patient is being adequately treated for any complications of SSc (e.g., pulmonary hypertension) and comorbid disease (e.g., chronic obstructive pulmonary disease). For reauthorization of all indications: must have documentation of improvement in condition.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# OGSIVEO

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## Products Affected

- OGSIVEO ORAL TABLET 100 MG, 150 MG, 50 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

# OJEMDA

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## Products Affected

- OJEMDA ORAL SUSPENSION RECONSTITUTED
- OJEMDA ORAL TABLET 100 MG, 100 MG (16 PACK), 100 MG (24 PACK)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For oral suspension, coverage requires that patient is unable to swallow the tablet formulation.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year. Limited to 1 box per 28 days, based on requested strength.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No



# OJJAARA

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## Products Affected

- *ojjaara*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	Criteria will be applied consistent with current NCCN guidance.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

# ONUREG

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## Products Affected

- ONUREG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

# OPSUMIT

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## Products Affected

- OPSUMIT

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Confirmed diagnosis of Pulmonary Arterial Hypertension (PAH), World Health Organization Group 1 by right heart catheterization and medical record documentation. Documentation of prior therapies and responses to treatment.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Two years
<b>Other Criteria</b>	Trial and failure (defined as an inability to improve the condition) with ambrisentan or bosentan.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# OPSYNVI

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## Products Affected

- OPSYNVI

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Confirmed diagnosis of Pulmonary Arterial Hypertension (PAH), World Health Organization Group 1 by right heart catheterization and medical record documentation. Documentation of prior therapies and responses to treatment.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Two years
<b>Other Criteria</b>	Trial and failure (defined as an inability to improve the condition) with ambrisentan or bosentan.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# ORENITRAM

## Products Affected

- ORENITRAM
- ORENITRAM MONTH 1
- ORENITRAM MONTH 2
- ORENITRAM MONTH 3

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Confirmed diagnosis of Pulmonary Arterial Hypertension (PAH), World Health Organization Group 1 by right heart catheterization and medical record documentation. Documentation of prior therapies and responses to treatment.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Two years
<b>Other Criteria</b>	Trial and failure (defined as an inability to improve the condition) of dual therapy with a phosphodiesterase inhibitor (e.g., sildenafil or tadalafil) AND an endothelin receptor antagonist (e.g., ambrisentan or bosentan).
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# ORGOVYX

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## Products Affected

- ORGOVYX

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Must have documentation supporting a trial and failure (defined as an intolerance or inadequate response) with Firmagon (degarelix).
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	One year
<b>Other Criteria</b>	
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	Yes

# ORKAMBI

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## Products Affected

- ORKAMBI ORAL PACKET
- ORKAMBI ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient must have laboratory confirmation of homozygous F508del mutation in the cystic fibrosis transmembrane regulator (CFTR) gene
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

# ORSERDU

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## Products Affected

- ORSERDU ORAL TABLET 345 MG, 86 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Medical records supporting that the use of Orserdu follows current NCCN recommendations must be provided.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	Use of Orserdu must follow current NCCN recommendations.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No



# OTEZLA

## Products Affected

- OTEZLA ORAL TABLET
- OTEZLA ORAL TABLET THERAPY PACK

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Must not be used in combination with other biologic drugs or Janus Kinase Inhibitor (JAKis).
<b>Required Medical Information</b>	Documentation of prior therapies and responses to treatment must be provided.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Prescriber is a specialist or has consulted with a specialist for the condition being treated.
<b>Coverage Duration</b>	Two years. Dosing must follow the FDA-approved labeling.
<b>Other Criteria</b>	For PsO: Must try and fail (defined as an intolerance or inability to improve symptoms) one traditional non-biologic immunomodulator drug (e.g. methotrexate, cyclosporine, acitretin). For PsA: Must try and fail (defined above) one traditional non-biologic immunomodulator drug (e.g., methotrexate, leflunomide, sulfasalazine). For oral ulcers associated with Behcet's disease: Must try and fail (defined above) one other systemic therapy (e.g., colchicine, thalidomide, interferon alpha, tumor necrosis factor inhibitors) for the condition.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# OXERVATE

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## Products Affected

- OXERVATE

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	More than 8-weeks of treatment per lifetime will not be covered.
<b>Required Medical Information</b>	Documentation confirming diagnosis of Stage 2 (persistent epithelial defect) or stage 3 (corneal ulcer) neurotrophic keratitis such as through slit lamp examination.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Must be prescribed by, or in consultation with, an ophthalmologist.
<b>Coverage Duration</b>	8 weeks total treatment. Dosing must follow the FDA-approved labeling.
<b>Other Criteria</b>	
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# OZEMPIC

## Products Affected

- OZEMPIC (0.25 OR 0.5 MG/DOSE) SUBCUTANEOUS SOLUTION PEN-INJECTOR 2 MG/3ML
- OZEMPIC (1 MG/DOSE) SUBCUTANEOUS SOLUTION PEN-INJECTOR 4 MG/3ML
- OZEMPIC (2 MG/DOSE)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	Only covered for the treatment of Type 2 Diabetes Mellitus.
Indications	Some FDA-approved Indications Only.
Off Label Uses	
Part B Prerequisite	No

# PANRETIN

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## Products Affected

- PANRETIN

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	Must first try and fail (defined as an intolerance or inability to improve the condition) with imiquimod 5% cream.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

# PAZOPANIB

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## Products Affected

- *pazopanib hcl*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

# PEMAZYRE

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## Products Affected

- PEMAZYRE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

# penicillamine

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## Products Affected

- *penicillamine oral tablet*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Two years
<b>Other Criteria</b>	For cystinuria, documentation that treatment with conservative measures (e.g. high fluid intake, sodium and protein restriction, urinary alkalization) were ineffective, not tolerated, or contraindicated. Quantity limited to dosage as supported by the FDA-approved label.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# PHENOBARBITAL

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## Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No



# PIQRAY

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## Products Affected

- PIQRAY (200 MG DAILY DOSE)
- PIQRAY (250 MG DAILY DOSE)
- PIQRAY (300 MG DAILY DOSE)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

# PIRFENIDONE

## Products Affected

- *pirfenidone oral capsule*
- *pirfenidone oral tablet 267 mg, 801 mg*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	For all indications, must have documentation of High Resolution Computed Tomography (HRCT) confirming diagnosis.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Prescriber is or has consulted with a pulmonologist.
<b>Coverage Duration</b>	Two years
<b>Other Criteria</b>	For idiopathic pulmonary fibrosis (IPF): (1) The patient's diagnosis must be confirmed by a surgical lung biopsy or by the presence of a UIP pattern on a HRCT, and (2) the prescriber must rule out other known causes of interstitial lung disease. For reauthorization requests: Documentation of improvement in condition with use of pirfenidone must be provided.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# PLEGRIDY

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## Products Affected

- PLEGRIDY
- PLEGRIDY STARTER PACK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

# POMALYST

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## Products Affected

- POMALYST

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

# PRETOMANID

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## Products Affected

- PRETOMANID

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	26 weeks
Other Criteria	Must be used in combination with linezolid and Sirturo.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

# PREVYMIS

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## Products Affected

- PREVYMIS ORAL

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	200 days
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

# PROLASTIN-C

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## Products Affected

- PROLASTIN-C

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Patient must have an FEV1 less than 80 percent predicted - AND - a serum AAT level less than 11 micromoles per liter (80 milligrams per deciliter if measured by radial immunodiffusion or 50 milligrams per deciliter if measure by nephelometry).
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Two years
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# PROLIA

## Products Affected

- PROLIA SUBCUTANEOUS SOLUTION  
PREFILLED SYRINGE

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of prior therapies and responses to treatment.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Two years
<b>Other Criteria</b>	Must first try and fail (defined as a decrease in BMD or new fracture while on therapy) an oral bisphosphonate or zoledronic acid. If intolerant or contraindicated to an oral bisphosphonate, zoledronic acid is required. Coverage is also provided if the patient has a creatinine clearance less than 35 mL/min. Diagnosis and administration information will be reviewed to determine if coverage is available as a Medicare Part B or Part D benefit.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	Yes



# PROMACTA

## Products Affected

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

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Use of Promacta to normalize platelet counts is not covered.
<b>Required Medical Information</b>	Current platelet count must be provided. For ITP, initial requests: Patient has a platelet count less than 30,000/mcL - OR - less than 50,000/mcL with bleeding or one of the following risk factor(s) for bleeding: History of clinically significant bleeding at a higher platelet count, concurrent peptic ulcer disease or liver disease that increase bleeding risk, history of falling, or need for concurrent anticoagulation or anti-platelet therapy
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	3 months
<b>Other Criteria</b>	For thrombocytopenia from hepatitis C infection, initial request: The degree of thrombocytopenia is preventing the initiation of interferon therapy OR limits the ability to maintain optimal interferon based therapy. For thrombocytopenia from hepatitis C infection, reauthorization: current platelet count is less than 400 x 10 <sup>9</sup> /L - and - patient is responding to therapy as evidenced by increased platelet counts - and - patient continues to receive interferon based therapy. For aplastic anemia, initial requests: Must be used with standard immunosuppressive therapy (antithymocyte globulin and cyclosporine) for first-line treatment or must have had an insufficient response to cyclosporine or cyclosporine modified for second-line or subsequent treatment. For aplastic anemia, reauthorization: current platelet count is less than 400 x 10 <sup>9</sup> /L - and - patient is responding to therapy as evidenced by increased platelet counts. For ITP, initial requests: Must have inadequate response or intolerance to steroids or immunoglobulins - AND - either rituximab or splenectomy. For ITP, reauthorization: current platelet count is less than 400 x 10 <sup>9</sup> /L - and - patient is responding to therapy as evidenced by increased platelet counts - and - patient remains at risk for bleeding complications.

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	Yes

# protriptyline

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## Products Affected

- *protriptyline hcl*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Must have documentation supporting a trial and failure (defined as inadequate response) with 2 of the following generic antidepressants: SSRIs, SNRIs, bupropion, mirtazapine, or trazodone.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	One year
<b>Other Criteria</b>	
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# PURIXAN

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## Products Affected

- PURIXAN

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Must have documentation to support a trial and failure with generic mercaptopurine tablet or documentation to support the patient's current inability to swallow tablets.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	One year
<b>Other Criteria</b>	
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# PYRUKYND

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## Products Affected

- PYRUKYND
- PYRUKYND TAPER PACK

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Not covered for a patient with any of the following: Homozygous for R479H mutation, 2 non-missense variants in PKLR gene, not regularly transfused.
<b>Required Medical Information</b>	Genetic testing confirming diagnosis - AND - Current hemoglobin less than or equal to 10mg/dL.
<b>Age Restrictions</b>	Must be 18 years of age or older.
<b>Prescriber Restrictions</b>	Must be prescribed by or in consultation with a hematologist.
<b>Coverage Duration</b>	Initial: 3 months, Reauthorization: 12 months
<b>Other Criteria</b>	For reauthorization: Must have documentation of a positive clinical response as determined by the prescriber.
<b>Indications</b>	Some FDA-approved Indications Only.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# QINLOCK

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## Products Affected

- QINLOCK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

# RADICAVA ORS

## Products Affected

- RADICAVA ORS
- RADICAVA ORS STARTER KIT

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months. Limited to 70 mLs the first 28 days and 50 mLs every 28 days thereafter.
<b>Other Criteria</b>	For initial requests, documentation of the following is required: (1) A diagnosis of definite or probable amyotrophic lateral sclerosis (ALS) as defined by the revised El Escorial/Arlie House criteria, AND (2) a diagnosis of ALS for 2 years or less (please provide date of diagnosis), AND (3) retention of most activities of daily living defined as having a baseline score of at least 2 points on each of the 12 items of the revised ALS Functional Rating Scale (ALSFRS-R) (i.e., a minimum score of 24), AND (4) normal respiratory function defined as a percent-predicted forced vital capacity (% FVC) greater than or equal to 80%. For reauthorization requests, documentation of the following is required: (1) Radicava is slowing the progression of ALS as determined by an improved or stable ALFRS-R score or other supporting clinical documentation.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# REBIF

## Products Affected

- REBIF REBIDOSE SUBCUTANEOUS SOLUTION AUTO-INJECTOR
- REBIF REBIDOSE TITRATION PACK SUBCUTANEOUS SOLUTION AUTO-INJECTOR
- REBIF SUBCUTANEOUS SOLUTION PREFILLED SYRINGE
- REBIF TITRATION PACK SUBCUTANEOUS SOLUTION PREFILLED SYRINGE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No



# RELISTOR

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## Products Affected

- RELISTOR ORAL
- RELISTOR SUBCUTANEOUS SOLUTION

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Patient must not have mechanical gastrointestinal obstruction.
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	4 months
<b>Other Criteria</b>	Must try and fail (defined as an inadequate response or intolerance) to lactulose.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# REPATHA

## Products Affected

- REPATHA
- REPATHA PUSHTRONEX SYSTEM
- REPATHA SURECLICK

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Must submit most recent LDL-C level.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Two years
<b>Other Criteria</b>	Patient must meet one of the following: (1) Patient has tried one high-intensity statin (i.e., atorvastatin greater than or equal to 40 mg daily, rosuvastatin greater than or equal to 20 mg daily) plus ezetimibe concomitantly for a minimum of 8 weeks, and LDL-C remains greater than or equal to 70mg/dL - OR - (2) Patient is statin intolerant as demonstrated by experiencing statin-associated rhabdomyolysis to one statin OR has tried both rosuvastatin and atorvastatin and has experienced skeletal-muscle related symptoms on both agents which also resolved upon discontinuation.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# RETEVMO

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## Products Affected

- RETEVMO ORAL CAPSULE 40 MG, 80 MG
- RETEVMO ORAL TABLET 120 MG, 160 MG, 40 MG, 80 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

# REVCOVI

## Products Affected

- REVCOVI

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Must provide trough plasma ADA activity and trough dAXP levels. Must provide patient's current weight and requested dose.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year initial and continuation
<b>Other Criteria</b>	Provider attestation that treatment will follow FDA-approved labeling with dose adjusted to maintain trough ADA activity over 30 mmol/hr/L, trough dAXP level under 0.02 mmol/L, and/or to maintain adequate immune reconstitution based on clinical assessment of the patient.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# REVLIMID

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## Products Affected

- REVLIMID

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

# REXULTI

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## Products Affected

- REXULTI

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	For agitation in Alzheimer's disease requests: (1) Must have documentation supporting a trial and failure (defined as an inadequate response) with one generic atypical antipsychotic used for at least 28 days. For all other medically-accepted indications: (1) Must have documentation supporting a trial and failure (defined above) with two generic atypical antipsychotic drugs, used for at least 28 days each.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Two years
<b>Other Criteria</b>	
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# REZDIFFRA

## Products Affected

- REZDIFFRA

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	For initial requests, documentation supporting the following is required: (1) A diagnosis of metabolic dysfunction-associated steatohepatitis (MASH) or nonalcoholic steatohepatitis (NASH), AND (2) a fibrosis stage of F2 or F3 confirmed by biopsy or NITs, AND (3) an NAFLD Activity Score (NAS) of at least 4, AND (4) current weight, AND (5) a provider attestation that Rezdiffra will be used in conjunction with diet and exercise as per its FDA labeling.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Must be prescribed by, or in consultation, with a gastroenterologist or hepatologist.
<b>Coverage Duration</b>	One year initial and reauthorization.
<b>Other Criteria</b>	For reauthorization, documentation of the following is required: (1) fibrosis stage of F2 or F3 confirmed by biopsy or NITs, AND (2) documentation supporting improvement or stabilization in steatohepatitis evidenced by fibrosis score or NAFLD Activity (NAS) score.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# REZLIDHIA

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## Products Affected

- REZLIDHIA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No



# REZUROCK

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## Products Affected

- REZUROCK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year initial and continuation.
Other Criteria	Other criteria will be applied consistent with current NCCN guidance. Reauthorization for GVHD: Must have documentation of clinical benefit.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

# RINVOQ

## Products Affected

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

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Must not be used in combination with other biologic drugs, Otezla, or Janus Kinase Inhibitor (JAKis).
<b>Required Medical Information</b>	Documentation of prior therapies and responses to treatment must be provided.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Prescriber is a specialist or has consulted with a specialist for the condition being treated.
<b>Coverage Duration</b>	1 year initial (AD). 2 year initial (others). 2 year reauth (all). Dose must follow FDA labeling
<b>Other Criteria</b>	For RA: Must try and fail (defined as an intolerance or inability to improve symptoms) one traditional non-biologic immunomodulator drug (e.g., methotrexate, leflunomide, hydroxychloroquine, sulfasalazine). For PsA: Must try and fail (defined above) one traditional non-biologic immunomodulator drug (e.g., methotrexate, leflunomide, sulfasalazine). For UC: Must try and fail (defined above) one traditional non-biologic immunomodulator drug (e.g., 6-mercaptopurine, azathioprine, cyclosporine) or a steroid (e.g., prednisone). For ankylosing spondylitis and non-radiographic axial spondyloarthritis (NRAS): Must try and fail (defined above) one nonsteroidal anti-inflammatory drug (NSAID). For Crohn's disease: Must try and fail (defined above) one traditional non-biologic immunomodulator drug (e.g., 6-mercaptopurine, azathioprine, methotrexate) or a steroid (e.g., prednisone). For initial coverage of atopic dermatitis: documentation of the following is required (1) Confirmation of moderate to severe atopic dermatitis, AND (2) Trial and failure (defined as an inadequate response) to one medium or higher potency topical steroid (e.g., clobetasol) - or - one topical calcineurin inhibitor (e.g., pimecrolimus, tacrolimus). For reauthorization of atopic dermatitis: (1) Must have documented clinical benefit (e.g. less exacerbations, improved symptoms, less steroid use).
<b>Indications</b>	All FDA-approved Indications.

PA Criteria	Criteria Details
Off Label Uses	
Part B Prerequisite	No

# RIVFLOZA

## Products Affected

- RIVFLOZA SUBCUTANEOUS SOLUTION
- RIVFLOZA SUBCUTANEOUS SOLUTION  
 PREFILLED SYRINGE 128 MG/0.8ML, 160  
 MG/ML

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Coverage will not be provided in the following situations: (1) Patient has a history of kidney or liver transplant, AND (2) Patient will be using in combination with Oxlumo.
<b>Required Medical Information</b>	(1) Medical records supporting the request must be provided, AND (2) Must have a diagnosis of primary hyperoxaluria type 1 (PH1) confirmed by genetic testing of the AGXT mutation or by liver enzyme analysis, AND (3) must have preserved kidney function with an estimated glomerular filtrate rate (eGFR) of 30 mL/min/1.73m <sup>2</sup> or more, AND (4) for reauthorization requests, must have documented clinical benefit with Rivfloza compared to baseline.
<b>Age Restrictions</b>	Must be 9 years of age or older.
<b>Prescriber Restrictions</b>	Must be prescribed by or in consultation with a nephrologist or urologist.
<b>Coverage Duration</b>	Initial: 1 year. Reauth: 2 years. Dosing must follow the FDA-approved labeling.
<b>Other Criteria</b>	Rivfloza vials are only covered for children 9 to 11 years old weighing less than 50 kilograms per the FDA-approved labeling.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# ROFLUMILAST

## Products Affected

- *roflumilast*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Patient must have an FEV1 less than 50%. Patient must have had more than one COPD exacerbation in the past year.
<b>Age Restrictions</b>	Must be age 18 or older
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Two years
<b>Other Criteria</b>	Patient must have tried and failed triple therapy with an inhaled corticosteroid (ICS), long-acting beta agonist (LABA), and a long-acting antimuscarinic (LAMA) in the past 6 months (failure is defined as no improvement, a worsening of the condition, or an intolerance after trying triple therapy at the maximum dosages for at least 4 weeks consistently). For reauthorization, documentation must be provided showing a reduction in COPD exacerbations.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# ROZLYTREK

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## Products Affected

- ROZLYTREK ORAL CAPSULE 100 MG, 200 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

# ROZLYTREK PELLETT PACK

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## Products Affected

- ROZLYTREK ORAL PACKET

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	The patient has had prior trial with AND is unable to use Rozlytrek oral capsule formulation.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

# RUBRACA

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## Products Affected

- RUBRACA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Must have documentation supporting a trial and failure (defined as an intolerance or inadequate response) with Lynparza.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No



# RUFINAMIDE

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## Products Affected

- *rufinamide*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

# RYBELSUS

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## Products Affected

- RYBELSUS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	Only covered for the treatment of Type 2 Diabetes Mellitus.
Indications	Some FDA-approved Indications Only.
Off Label Uses	
Part B Prerequisite	No

# RYDAPT

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## Products Affected

- RYDAPT

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	For diagnosis of acute myeloid leukemia (AML), patient must have FLT3 mutation-positive disease as detected by an FDA-approved test.
<b>Age Restrictions</b>	Must be age 18 or older
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	One year.
<b>Other Criteria</b>	For diagnosis of AML, patient must be using Rydapt in combination with standard cytarabine and daunorubicin induction and cytarabine consolidation chemotherapy.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# SCEMBLIX

## Products Affected

- SCEMBLIX ORAL TABLET 100 MG, 20 MG, 40 MG

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	For all indications, Eastern Cooperative Oncology Group (ECOG) performance status of 0 or 1. For PH+ CML-CP with T315I mutation, documentation confirming mutation must be provided.
<b>Age Restrictions</b>	Must be 18 years of age or older.
<b>Prescriber Restrictions</b>	Must be prescribed by or in consultation with an oncologist or hematologist.
<b>Coverage Duration</b>	1 year. 20 mg limit to 60 tabs per 30 days. 40 mg limit to 300 tabs per 30 days.
<b>Other Criteria</b>	For PH+ CML-CP with T315I mutation, must submit documentation of a trial & failure (defined as disease progression, inadequate response or intolerance) of Iclusig.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# SECUADO

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## Products Affected

- SECUADO

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Must have documentation supporting a trial and failure (defined as an inadequate response) with two of the following generic drugs used for at least 28 days each: aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone, or lurasidone.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Two years
<b>Other Criteria</b>	
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# SEROSTIM

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## Products Affected

- SEROSTIM SUBCUTANEOUS SOLUTION  
RECONSTITUTED 4 MG, 5 MG, 6 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

# SIGNIFOR

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## Products Affected

- SIGNIFOR

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Two years
<b>Other Criteria</b>	Patient must be too ill for pituitary surgery or patient must have had surgery that failed to completely removed the tumor. Patient must have a documented trial with ketoconazole to reduce cortisol secretion.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# SILDENAFIL CITRATE

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## Products Affected

- *sildenafil citrate oral tablet 20 mg*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Confirmed diagnosis of Pulmonary Arterial Hypertension (PAH), World Health Organization Group 1 by right heart catheterization and medical record documentation.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Two years
<b>Other Criteria</b>	
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No



# SIRTURO

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## Products Affected

- SIRTURO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	24 weeks
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

# SKYCLARYS

## Products Affected

- SKYCLARYS

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of genetically confirmed diagnosis - AND - Baseline modified Friedreich's Ataxia Rating Scale (mFARS) score between 20 to 80.
<b>Age Restrictions</b>	Must be age 16 years or older.
<b>Prescriber Restrictions</b>	Must be prescribed by or in consultation with a neurologist.
<b>Coverage Duration</b>	One year initial and reauthorization
<b>Other Criteria</b>	Patient must be ambulatory. For reauthorization, documentation that medication is providing clinical benefit based on the patient's baseline mFARS score.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# SKYRIZI

## Products Affected

- SKYRIZI PEN
- SKYRIZI SUBCUTANEOUS SOLUTION CARTRIDGE 180 MG/1.2ML, 360 MG/2.4ML
- SKYRIZI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Must not be used in combination with other biologic drugs, Otezla, or Janus Kinase Inhibitor (JAKis).
<b>Required Medical Information</b>	Documentation of prior therapies and responses to treatment must be provided.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Prescriber is a specialist or has consulted with a specialist for the condition being treated.
<b>Coverage Duration</b>	Two years. Dosing must follow the FDA-approved labeling.
<b>Other Criteria</b>	For Crohns disease: Must try and fail (defined as an intolerance or inability to improve symptoms) one traditional non-biologic immunomodulator drug (e.g., 6-mercaptopurine, azathioprine, methotrexate) or a steroid (e.g., prednisone). For PsA: Must try and fail (defined above) one traditional non-biologic immunomodulator drug (e.g., methotrexate, leflunomide, sulfasalazine). For psoriasis: Must try and fail (defined above) one traditional non-biologic immunomodulator drug (e.g., methotrexate, cyclosporine, acitretin).
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# SODIUM OXYBATE

## Products Affected

- SODIUM OXYBATE

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Patient must not be receiving sedative hypnotics with sodium oxybate. Patient must not suffer from succinic semialdehyde dehydrogenase deficiency.
<b>Required Medical Information</b>	Documentation of prior therapies and responses to treatment. Documentation of MSLT and polysomnography confirming diagnosis of narcolepsy.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Prescriber must be a sleep specialist or neurologist.
<b>Coverage Duration</b>	Two years
<b>Other Criteria</b>	For narcolepsy with excessive daytime sleepiness, must first try and fail (defined as an intolerance or inability to improve the condition) amphetamine salts, dextroamphetamine or methylphenidate - AND - either modafinil or armodafinil. For reauthorization requests, must provide documentation demonstrating a decrease in excessive daytime sleepiness with narcolepsy or a decrease in cataplexy episodes.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# sofosbuvir-velpatasvir

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## Products Affected

- *sofosbuvir-velpatasvir*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Must have chronic hepatitis C infection.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Prescriber must be a gastroenterologist, hepatologist, or infectious disease specialist.
<b>Coverage Duration</b>	Duration of therapy will be applied consistent with current AASLD/IDSA guidance.
<b>Other Criteria</b>	Must have documentation to support that the use of sofosbuvir/velpatasvir is consistent with current AASLD/IDSA guidance.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# SOMAVERT

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## Products Affected

- SOMAVERT

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

# SORAFENIB

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## Products Affected

- *sorafenib tosylate*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

# SPRITAM

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## Products Affected

- SPRITAM ORAL TABLET  
DISINTEGRATING SOLUBLE 1000 MG,  
250 MG, 500 MG, 750 MG

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Must have documentation supporting a trial and failure (defined as inadequate seizure control) with generic levetiracetam and at least 1 other generic anticonvulsant for the condition.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Two years
<b>Other Criteria</b>	
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No



# SPRYCEL

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## Products Affected

- SPRYCEL ORAL TABLET 100 MG, 140 MG, 20 MG, 50 MG, 70 MG, 80 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

# STELARA

## Products Affected

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

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Must not be used in combination with other biologic drugs, Otezla, or Janus Kinase Inhibitor (JAKis).
<b>Required Medical Information</b>	Documentation of prior therapies and responses to treatment must be provided.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Prescriber is a specialist or has consulted with a specialist for the condition being treated.
<b>Coverage Duration</b>	Two years. Dosing must follow the FDA-approved labeling.
<b>Other Criteria</b>	For PsA in adults: Must try and fail (defined above) one traditional non-biologic immunomodulator drug (e.g., methotrexate, leflunomide, sulfasalazine). For UC: Must try and fail (defined above) one traditional non-biologic immunomodulator drug (e.g., 6-mercaptopurine, azathioprine, cyclosporine) or a steroid (e.g., prednisone). For psoriasis: Must try and fail (defined above) one traditional non-biologic immunomodulator drug (e.g., methotrexate, cyclosporine, acitretin). For Crohn's disease: Must try and fail (defined above) one traditional non-biologic immunomodulator drug (e.g., 6-mercaptopurine, azathioprine, methotrexate) or a steroid (e.g., prednisone).
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# STIVARGA

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## Products Affected

- STIVARGA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

# SUCRAID

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## Products Affected

- SUCRAID

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

# SUNITINIB MALATE

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## Products Affected

- *sunitinib malate*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

# SYMDEKO

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## Products Affected

- SYMDEKO

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Patient must have laboratory confirmation of homozygous F508del mutation or have at least one tezacaftor/ivacaftor-responsive mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene.
<b>Age Restrictions</b>	Must be age 6 or older.
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Two years
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# SYMPAZAN

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## Products Affected

- SYMPAZAN

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	The patient has had prior trial with AND has a documented contraindication (e.g. dysphagia) to BOTH generic clobazam tablet AND clobazam oral suspension.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year initial and reauthorization.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

# TABRECTA

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## Products Affected

- TABRECTA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No



# tadalafil 2.5mg and 5mg (Cialis)

## Products Affected

- *tadalafil oral tablet 2.5 mg, 5 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	Patient must have tried and failed either 6 months of finasteride or 3 months of dutasteride and must have tried and failed 28 days of alfuzosin, doxazosin, tamsulosin, or terazosin.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

# tadalafil 20mg (Adcirca)

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## Products Affected

- *tadalafil (pah)*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Confirmed diagnosis of Pulmonary Arterial Hypertension (PAH), World Health Organization Group 1 by right heart catheterization and medical record documentation.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Two years
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# TAFINLAR

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## Products Affected

- TAFINLAR ORAL CAPSULE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

# TAFINLAR TABLET FOR ORAL SUPENSION

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## Products Affected

- TAFINLAR ORAL TABLET SOLUBLE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Coverage requires that the patient is unable to swallow the tablet formulation.
Age Restrictions	Must be less than 18 years old.
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

# TAGRISSE

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## Products Affected

- TAGRISSE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

# TALZENNA

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## Products Affected

- TALZENNA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

# TASIGNA

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## Products Affected

- TASIGNA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

# TASIMELTEON

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## Products Affected

- *tasimelteon*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Must be prescribed by a sleep specialist or a neurologist.
<b>Coverage Duration</b>	Two years
<b>Other Criteria</b>	Patient must be totally blind. For reauthorization: must have documented benefit from use of tasimelteon. Not covered for a diagnosis of Smith-Magenis Syndrome (SMS).
<b>Indications</b>	Some FDA-approved Indications Only.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No



# TAVNEOS

## Products Affected

- TAVNEOS

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of the following to support the diagnosis must be provided: (1) eGFR greater than or equal to 15 mL/min/1.72 m <sup>2</sup> , (2) at least 1 major item, 3 non-major items, or 2 renal items of proteinuria and hematuria on the Birmingham Vasculitis Activity Score (BVAS) - AND - (3) positive test for either anti-PR3 or anti-MPO.
<b>Age Restrictions</b>	Must be 18 years of age or older.
<b>Prescriber Restrictions</b>	Must be prescribed by or in consultation with a neurologist or rheumatologist.
<b>Coverage Duration</b>	Initial 6 months. Reauthorization 12 months.
<b>Other Criteria</b>	Tavneos must be used as an add-on to standard therapy including cyclophosphamide, rituximab, and steroids (such as methylprednisolone or prednisone) - AND - patient must have a medical need to reduce steroid use if not previously relapsed (ie. infection, osteoporosis) - AND - patient does not currently require dialysis, have kidney transplant, or have received plasma exchange in the past 12 weeks. For reauthorization: Must have a reduction in the Birmingham Vasculitis Activity Score (BVAS) - AND - steroid dose.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# tazarotene cream

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## Products Affected

- *tazarotene external cream 0.1 %*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

# TAZVERIK

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## Products Affected

- TAZVERIK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

# TEPMETKO

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## Products Affected

- TEPMETKO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

# TERIFLUNOMIDE

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## Products Affected

- *teriflunomide*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

# TERIPARATIDE

## Products Affected

- TERIPARATIDE SUBCUTANEOUS SOLUTION PEN-INJECTOR 620 MCG/2.48ML

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Cumulative use of teriparatide and other parathyroid hormone analogs (e.g., Tymlos) of more than 2 years is not covered.
<b>Required Medical Information</b>	Must provide documentation of prior therapies and responses to treatment - AND - documentation confirming diagnosis such as T-score.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Must be prescribed by endocrinologist.
<b>Coverage Duration</b>	Two years. Dosing must follow FDA-approved labeling.
<b>Other Criteria</b>	Must try and fail alendronate, risedronate, or ibandronate - AND - either zoledronic acid or Prolia. Failure is defined as intolerance, decrease in BMD in comparison to previous DEXA scan, new fracture while on therapy OR a contraindication to therapy (e.g., creatinine clearance less than 35 mL/min, inability to sit upright for 30 minutes, esophageal stricture).
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# testosterone gel

## Products Affected

- testosterone transdermal gel 1.62 %, 10 mg/act (2%), 12.5 mg/act (1%), 20.25 mg/1.25gm (1.62%), 20.25 mg/act (1.62%), 25 mg/2.5gm (1%), 40.5 mg/2.5gm (1.62%), 50 mg/5gm (1%)

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Not covered in males with late-onset (age-related) hypogonadism.
<b>Required Medical Information</b>	For primary and hypogonadotropic hypogonadism: Documentation of the following is required (1) Two pre-treatment serum total testosterone levels, each taken in the morning on separate days, that are less than 300 ng/dL or that are low as defined by the laboratory reference values, AND (2) Patient is male, AND (3) Pre-treatment clinical signs or symptoms of low testosterone other than erectile dysfunction and decreased libido (such as depressed mood, decreased energy, progressive decrease in muscle mass, osteoporosis), AND (4) patient has tried and failed (defined as an intolerance or an inability to improve symptoms or testosterone levels) with a generic injectable testosterone product. For gender dysphoria: Documentation of the following is required: (1) patient has tried and failed (defined as an intolerance or an inability to improve symptoms or testosterone levels) with a generic injectable testosterone product.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Two years
<b>Other Criteria</b>	
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	Yes

# testosterone solution

## Products Affected

- *testosterone transdermal solution*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Not covered in males with late-onset (age-related) hypogonadism.
<b>Required Medical Information</b>	For primary and hypogonadotropic hypogonadism: Documentation of the following is required (1) Two pre-treatment serum total testosterone levels, each taken in the morning on separate days, that are less than 300 ng/dL or that are low as defined by the laboratory reference values, AND (2) Patient is male, AND (3) Pre-treatment clinical signs or symptoms of low testosterone other than erectile dysfunction and decreased libido (such as depressed mood, decreased energy, progressive decrease in muscle mass, osteoporosis), AND (4) patient has tried and failed (defined as an intolerance or an inability to improve symptoms or testosterone levels) with a generic injectable testosterone product. For gender dysphoria: Documentation of the following is required: (1) patient has tried and failed (defined as an intolerance or an inability to improve symptoms or testosterone levels) with a generic injectable testosterone product.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Two years
<b>Other Criteria</b>	
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	Yes



# tetrabenazine

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## Products Affected

- *tetrabenazine oral tablet 12.5 mg, 25 mg*

PA Criteria	Criteria Details
Exclusion Criteria	Must not be used in combination with Austedo or Ingrezza.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	CYP2D6 genotype must be provided for doses greater than 50mg/day.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

# THALOMID

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## Products Affected

- THALOMID

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

# TIBSOVO

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## Products Affected

- TIBSOVO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient must have documentation of IDH1 mutation status
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

# TIOPRONIN

## Products Affected

- *tiopronin oral tablet*
- *tiopronin oral tablet delayed release*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	For approval: (1) Patient weighs at least 20 kg, (2) Patient has a diagnosis of severe homozygous cystinuria that has not responded to the conservative measures of high fluid intake, alkalinizing therapy, and diet modification including salt and protein restriction alone - and - (3) Patient will be using tiopronin in combination with the above conservative measures.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	One year initial and reauthorization.
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# tolvaptan

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## Products Affected

- *tolvaptan*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	30 days
Other Criteria	Treatment must be initiated in an inpatient setting.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

# TRELSTAR

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## Products Affected

- TRELSTAR MIXJECT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Must have documentation supporting a trial and failure (defined as inadequate response) with Eligard or leuprolide 22.5 mg depot.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

# TRETINOIN CAPSULES

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## Products Affected

- *tretinoin oral*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

# TRIKAFTA

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## Products Affected

- TRIKAFTA ORAL TABLET THERAPY PACK
- TRIKAFTA ORAL THERAPY PACK

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	For diagnosis of cystic fibrosis, must provide documentation of a F508del mutation or at least one mutation responsive to Trikafta.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Two years
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No



# trimipramine maleate

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## Products Affected

- *trimipramine maleate oral*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Must have documentation supporting a trial and failure (defined as inadequate response) with 2 of the following generic antidepressants: SSRIs, SNRIs, bupropion, mirtazapine, or trazodone.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	One year
<b>Other Criteria</b>	
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# TRULICITY

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## Products Affected

- TRULICITY

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	Only covered for the treatment of Type 2 Diabetes Mellitus.
Indications	Some FDA-approved Indications Only.
Off Label Uses	
Part B Prerequisite	No

# TRUQAP

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## Products Affected

- TRUQAP ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	For PIK3CA mutations, must first try Piqray.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

# TUKYSA

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## Products Affected

- TUKYSA ORAL TABLET 150 MG, 50 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

# TURALIO

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## Products Affected

- TURALIO ORAL CAPSULE 125 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

# TYENNE

## Products Affected

- TYENNE SUBCUTANEOUS

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Must not be used in combination with other biologic drugs, Otezla, Janus Kinase Inhibitor (JAKis), or Ofev.
<b>Required Medical Information</b>	Documentation of prior therapies and responses to treatment must be provided. For systemic sclerosis- related interstitial lung disease (SSc-ILD) , must also have documentation of High Resolution Computed Tomography (HRCT) confirming diagnosis.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Prescriber is a specialist or has consulted with a specialist for the condition being treated.
<b>Coverage Duration</b>	Two years. Dosing must follow FDA-approved labeling.
<b>Other Criteria</b>	For RA and JIA: Must have documentation supporting a trial and failure of (defined as an intolerance or inability to improve symptoms) two of the following: a preferred adalimumab product, Rinvoq, Xeljanz/Xeljanz XR, or Enbrel. For systemic sclerosis- related interstitial lung disease (SSc-ILD): Lung fibrosis must be at least 10% - and - patient must try and fail (defined as an intolerance or inability to improve the condition) mycophenolate or cyclophosphamide at maximally tolerated doses - and - provider must attest that the patient is being adequately treated for any complications of SSc (e.g.,pulmonary hypertension) and comorbid disease (e.g., chronic obstructive pulmonary disease) - and - for reauthorization, must have documentation of improvement in condition.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# TYMLOS

## Products Affected

- TYMLOS

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Cumulative use of Tymlos and other parathyroid hormone analogs (e.g., teriparatide) of more than 2 years is not covered.
<b>Required Medical Information</b>	Must provide documentation of prior therapies and responses to treatment - AND - documentation confirming diagnosis such as T-score.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Must be prescribed by endocrinologist.
<b>Coverage Duration</b>	Two years total (inclusive of all parathyroid hormone analogs)
<b>Other Criteria</b>	Must try and fail alendronate, risedronate, or ibandronate - AND - either zoledronic acid or Prolia. Failure is defined as intolerance, decrease in BMD in comparison to previous DEXA scan, new fracture while on therapy OR a contraindication to therapy (e.g., creatinine clearance less than 35 mL/min, inability to sit upright for 30 minutes, esophageal stricture).
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# TYVASO

## Products Affected

- TYVASO
- TYVASO REFILL KIT
- TYVASO STARTER KIT

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	For PAH (WHO Group 1), the following are required: (1) Documentation confirming the diagnosis by right heart catheterization, AND (2) Medical records supporting the request, AND (3) documentation supporting a trial and failure (defined as an inability to improve the condition or an intolerance) of dual therapy with a phosphodiesterase inhibitor (e.g., sildenafil or tadalafil) AND an endothelin receptor antagonist (e.g., ambrisentan or bosentan). For reauthorization of PAH: Documentation supporting the patient has had a positive clinical response to Tyvaso compared to baseline must be provided. For PH-ILD, the following are required: (1) Documentation confirming the diagnosis by right heart catheterization, AND (2) Medical records supporting the request, AND (3) Provider attestation that the underlying condition has been treated per the condition's current standard of care, and further treatment is medically necessary, AND (4) the patient's PH-ILD is associated with IPF, CTD, or combined IPF and emphysema (CPFE) (PH associated with other phenotypes such as COPD is not covered based on the current 2022 ESC/ERS Guidelines). For reauthorization of PH-ILD: (1) Documentation supporting that patient has had a positive clinical response that includes an improved 6MWT compared to baseline must be provided.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Must be prescribed by or in consultation with a specialist for the condition.
<b>Coverage Duration</b>	Two years
<b>Other Criteria</b>	Diagnosis and administration information will be reviewed to determine if coverage is available as a Medicare Part B or Part D benefit.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	



PA Criteria	Criteria Details
<b>Part B Prerequisite</b>	No

# TYVASO DPI

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## Products Affected

- TYVASO DPI MAINTENANCE KIT
- TYVASO DPI TITRATION KIT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	UNDER CMS REVIEW
Age Restrictions	
Prescriber Restrictions	Must be prescribed by or in consultation with a specialist for the condition.
Coverage Duration	Two years
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

# UPTRAVI

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## Products Affected

- UPTRAVI
- UPTRAVI TITRATION

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Confirmed diagnosis of Pulmonary Arterial Hypertension (PAH), World Health Organization Group 1 by right heart catheterization and medical record documentation. Documentation of prior therapies and responses to treatment.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Two years
<b>Other Criteria</b>	Trial and failure (defined as an inability to improve the condition) of dual therapy with a phosphodiesterase inhibitor (e.g., sildenafil or tadalafil) AND an endothelin receptor antagonist (e.g., ambrisentan or bosentan).
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# VALCHLOR

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## Products Affected

- VALCHLOR

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	One year
<b>Other Criteria</b>	For limited/localized skin involvement, must have tried topical steroids and either topical tazarotene or topical imiquimod. For generalized skin involvement, must have tried topical steroids.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# VALTOCO

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## Products Affected

- VALTOCO 10 MG DOSE
- VALTOCO 15 MG DOSE
- VALTOCO 20 MG DOSE
- VALTOCO 5 MG DOSE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

# VANFLYTA

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## Products Affected

- VANFLYTA

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

# VENCLEXTA

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## Products Affected

- VENCLEXTA
- VENCLEXTA STARTING PACK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

# VENTAVIS

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## Products Affected

- VENTAVIS INHALATION SOLUTION 10 MCG/ML, 20 MCG/ML

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Confirmed diagnosis of Pulmonary Arterial Hypertension (PAH), World Health Organization Group 1 by right heart catheterization and medical record documentation. Documentation of prior therapies and responses to treatment.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Two years
<b>Other Criteria</b>	Trial and failure (defined as an inability to improve the condition) of dual therapy with a phosphodiesterase inhibitor (e.g., sildenafil or tadalafil) AND an endothelin receptor antagonist (e.g., ambrisentan or bosentan). Diagnosis and administration information will be reviewed to determine if coverage is available as a Medicare Part B or Part D benefit.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No



# VERQUVO

## Products Affected

- VERQUVO

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of prior therapies and responses to treatment must be provided. Documentation of an ejection fraction less than 45% assessed within the past 12 months must be provided.
<b>Age Restrictions</b>	Must be at least 18 years old.
<b>Prescriber Restrictions</b>	Must be prescribed by, or in consultation with, a cardiologist.
<b>Coverage Duration</b>	Two years
<b>Other Criteria</b>	Patient has symptomatic worsening chronic heart failure (NYHA class 2 to 4) - AND - has been hospitalized for heart failure in the past 6 months or treated with outpatient IV diuretic therapy for heart failure in the past 3 months AND - has tried and failed (defined as an intolerance or inability to improve symptoms) maximally tolerated doses of the following medications in combination: an ACEI, ARB, or ARNi (such as enalapril or Entresto) - AND - bisoprolol, carvedilol or metoprolol ER - AND - spironolactone or other diuretic.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# VERSACLOZ

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## Products Affected

- VERSACLOZ

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	The patient has had prior trial with AND has a documented contraindication (e.g. dysphagia) to BOTH generic clozapine tablet AND generic clozapine orally disintegrating tablet (ODT).
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Two years.
<b>Other Criteria</b>	
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# VERZENIO

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## Products Affected

- VERZENIO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

# vigabatrin

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## Products Affected

- *vigabatrin*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	For refractory complex partial seizures: Must have documentation supporting a trial and failure (defined as inadequate seizure control) with at least 2 other generic anticonvulsants for the condition.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Two years
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# vigadrone

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## Products Affected

- *vigadrone*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	For refractory complex partial seizures: Must have documentation supporting a trial and failure (defined as inadequate seizure control) with at least 2 other generic anticonvulsants for the condition.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Two years
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# VIGAFYDE

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## Products Affected

- VIGAFYDE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Must be 2 years of age or younger (max age 2 years).
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

# vigpoder

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## Products Affected

- VIGPODER

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For refractory complex partial seizures: Must have documentation supporting a trial and failure (defined as inadequate seizure control) with at least 2 other generic anticonvulsants for the condition.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

# VIJOICE

## Products Affected

- VIJOICE

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	All the following must be met: (1) Patient has a physician-confirmed and documented diagnosis of PROS including evidence of a mutation in the PIK3CA gene, and (2) Patient has at least one target lesion identified on imaging, and (3) Patient's baseline measurable target lesion volume is documented.
<b>Age Restrictions</b>	Must be at least 2 years old.
<b>Prescriber Restrictions</b>	Must be prescribed by or in consultation with a neurologist, vascular specialist, or geneticist.
<b>Coverage Duration</b>	Initial: 6 months, Reauthorization: 1 year.
<b>Other Criteria</b>	All the following must be met: (1) Patient's condition is severe or life-threatening and systemic treatment is deemed necessary by the treating physician, and (2) for reauthorization of previously approved requests, documentation of a positive response to therapy as determined by the provider.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No



# VITRAKVI

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## Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

# VIZIMPRO

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## Products Affected

- VIZIMPRO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

# VONJO

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## Products Affected

- VONJO

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Two years
<b>Other Criteria</b>	Criteria will be applied consistent with current NCCN guidance.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# voriconazole

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## Products Affected

- *voriconazole intravenous*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

# VOWST

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## Products Affected

- VOWST

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of at least 2 recurrent episodes of CDI (3 or more total CDI episodes) after failure of appropriate antibiotic treatments.
<b>Age Restrictions</b>	Patient must be 18 years of age or older.
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year. Limited to 1 treatment course (12 capsules over 3 days).
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# VOXZOGO

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## Products Affected

- VOXZOGO

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Patient's current weight. Documentation of current annualized growth velocity (AGV). Recent documentation of open epiphyses. Documentation of achondroplasias confirmed by genetic testing.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Must be prescribed by or in consultation with a board-certified geneticist, endocrinologist, neurologist, orthopedic surgeon, or specialist with experience in treating achondroplasia.
<b>Coverage Duration</b>	One year
<b>Other Criteria</b>	For reauthorization: Must have documentation of a positive clinical response as determined by the prescriber.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# VOYDEYA

## Products Affected

- VOYDEYA

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Voydeya is not covered in combination with Fabhalta or Empaveli.
<b>Required Medical Information</b>	For initial requests: (1) Must have diagnosis of PNH confirmed by flow cytometry, (2) must be actively receiving treatment with Ultomiris/Soliris and considered stable (defined as treatment for at least 6 months) -AND- (3) Must have symptomatic extravascular hemolysis defined as: Fatigue or dyspnea - AND - Hgb less than 9.5g/dL - OR - Absolute Reticulocyte Count greater than 120 x 10 <sup>9</sup> /L.
<b>Age Restrictions</b>	Must be 18 years of age or older.
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	One year initial and reauthorization.
<b>Other Criteria</b>	For reauthorization: (1) must be actively receiving treatment with Ultomiris/Soliris, AND (2) must have documentation of improvement in EVH symptoms (e.g., fatigue, dyspnea), AND (3) must have a sustained increase in hemoglobin levels, improvement in hemolysis, or reduced transfusions compared to baseline.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# VRAYLAR

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## Products Affected

- VRAYLAR ORAL CAPSULE

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Must have documentation supporting a trial and failure (defined as an inadequate response) with two of the following generic drugs that have support for the requested condition and each used for at least 28 days: aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone, or lurasidone.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Two years
<b>Other Criteria</b>	
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No



# VYNDAMAX

## Products Affected

- VYNDAMAX

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Must not be used in combination with TTR-lowering agents (e.g., Amvuttra, Onpattro).
<b>Required Medical Information</b>	Coverage requires documentation of the following: (1) New York Heart Association (NYHA) class 1, 2, or 3 heart failure, AND (2) an echocardiogram (ECHO) or cardiac magnetic resonance (CMR) imaging demonstrating cardiac involvement (i.e., increased left ventricular wall thickness), AND (3) a diagnosis of transthyretin amyloid cardiomyopathy (ATTR-CM) confirmed by tissue biopsy, genetic testing, or radionuclide imaging (99mTc-PYP, 99mTc-DPD, or 99mTc-HMDP scan), AND (4) if the diagnosis was confirmed by radionuclide imaging, coverage also requires documentation of Grade 2 or 3 cardiac uptake.
<b>Age Restrictions</b>	Must be age 18 or older
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	One year initial. Two years reauthorization.
<b>Other Criteria</b>	Vyndamax will not be approved if the patient has primary (light-chain) amyloidosis. For reauthorization requests, coverage requires documentation of a positive clinical response to Vyndamax compared to baseline (e.g., reduced cardiovascular-related hospitalizations, improved function, improved quality of life).
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# VYNDAQEL

## Products Affected

- VYNDAQEL

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Must not be used in combination with TTR-lowering agents (e.g., Amvuttra, Onpattro).
<b>Required Medical Information</b>	Coverage requires documentation of the following: (1) New York Heart Association (NYHA) class 1, 2, or 3 heart failure, AND (2) an echocardiogram (ECHO) or cardiac magnetic resonance (CMR) imaging demonstrating cardiac involvement (i.e., increased left ventricular wall thickness, AND (3) a diagnosis of transthyretin amyloid cardiomyopathy (ATTR-CM) confirmed by tissue biopsy, genetic testing, or radionuclide imaging (99mTc-PYP, 99mTc-DPD, or 99mTc-HMDP scan), AND (4) if the diagnosis was confirmed by radionuclide imaging, coverage also requires documentation of Grade 2 or 3 cardiac uptake.
<b>Age Restrictions</b>	Must be age 18 or older.
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	One year initial. Two years reauthorization.
<b>Other Criteria</b>	VynDAQel will not be approved if the patient has primary (light-chain) amyloidosis. For reauthorization requests, coverage requires documentation of a positive clinical response to VynDAQel compared to baseline (e.g., reduced cardiovascular-related hospitalizations, improved function, improved quality of life).
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# WAINUA

## Products Affected

- WAINUA

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Must not be used in combination with tafamidis (Vyndaqel, Vyndamax), or other TTR-lowering agents (Tegsedi, Onpattro, Amvuttra).
<b>Required Medical Information</b>	For hereditary transthyretin-mediated amyloidosis (hATTR) with polyneuropathy, must have (1) confirmation of a transthyretin (TTR) mutation on genetic test, (2) presence of clinical signs and symptoms of the condition (e.g., motor disability, peripheral/autonomic neuropathy, etc.), and (3) documentation of a baseline FAP Stage 1 or 2.
<b>Age Restrictions</b>	Must be 18 years of age or older.
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	One year initial and reauthorization. Dosing must align with FDA-approved labeling.
<b>Other Criteria</b>	Patient must not have had a liver transplant. For reauthorization, must also have documentation of a positive clinical response to Wainua compared to baseline (e.g., improved neuropathy symptoms, motor function, quality of life, slowing of disease progression).
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# WELIREG

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## Products Affected

- WELIREG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

# WINREVAIR

## Products Affected

- WINREVAIR

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	For initial requests, documentation of the following is required: (1) Must have a confirmed diagnosis of Pulmonary Arterial Hypertension (PAH), World Health Organization Group 1, by right heart catheterization, AND (2) Must have WHO functional class II or III symptoms, AND (3) Must have tried and failed (defined as an inability to improve the condition) of dual therapy with a phosphodiesterase inhibitor (e.g., sildenafil or tadalafil) AND an endothelin receptor antagonist (e.g., ambrisentan or bosentan), AND (4) Winrevair will be initiated as add on therapy to at least 2 other PAH agents (e.g. ERA, PDE5i, Prostaglandins).
<b>Age Restrictions</b>	Must be 18 years of age or older.
<b>Prescriber Restrictions</b>	Must be prescribed by or in consultation with a specialist for the condition.
<b>Coverage Duration</b>	One year initial. Two years reauthorization.
<b>Other Criteria</b>	For reauthorization requests: Documentation must be provided demonstrating that the patient has had a beneficial response to Winrevair compared to pretreatment baseline in one or more of the following: improvement in WHO functional class, risk status, or 6MWD.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# XALKORI

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## Products Affected

- XALKORI ORAL CAPSULE
- XALKORI ORAL CAPSULE SPRINKLE 150 MG, 20 MG, 50 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

# XATMEP

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## Products Affected

- XATMEP

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	Must try and fail (defined as an intolerance or inability to improve the condition) generic methotrexate.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

# XCOPRI

## Products Affected

- XCOPRI (250 MG DAILY DOSE) ORAL TABLET THERAPY PACK 100 & 150 MG
- XCOPRI (350 MG DAILY DOSE)
- XCOPRI ORAL TABLET 100 MG, 150 MG, 200 MG, 25 MG, 50 MG
- XCOPRI ORAL TABLET THERAPY PACK

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Must have documentation supporting a trial and failure (defined as inadequate seizure control) with at least 2 generic anticonvulsants for the condition.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Two years
<b>Other Criteria</b>	
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No



# XDEMZY

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## Products Affected

- XDEMZY

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Diagnosis of Demodex blepharitis confirmed by the presence of mites on examination by light microscopy or presence of collarettes on slit lamp examination.
<b>Age Restrictions</b>	Must be at least 18 years of age.
<b>Prescriber Restrictions</b>	Must be prescribed by or in consultation with an optometrist or ophthalmologist.
<b>Coverage Duration</b>	One year.
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# XELJANZ

## Products Affected

- XELJANZ ORAL TABLET

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Must not be used in combination with other biologic drugs, Otezla, or Janus Kinase Inhibitor (JAKis).
<b>Required Medical Information</b>	Documentation of prior therapies and responses to treatment must be provided.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Prescriber is a specialist or has consulted with a specialist for the condition being treated.
<b>Coverage Duration</b>	Two years. Dosing must follow the FDA-approved labeling.
<b>Other Criteria</b>	For RA: Must try and fail (defined as an intolerance or inability to improve symptoms) one traditional non-biologic immunomodulator drug (e.g., methotrexate, leflunomide, hydroxychloroquine, sulfasalazine). For PsA: Must try and fail (defined above) one traditional non-biologic immunomodulator drug (e.g., methotrexate, leflunomide, sulfasalazine). For UC: Must try and fail (defined above) one traditional non-biologic immunomodulator drug (e.g., 6-mercaptopurine, azathioprine, cyclosporine) or a steroid (e.g., prednisone). For ankylosing spondylitis: Must try and fail (defined above) one nonsteroidal anti-inflammatory drug (NSAID). For Juvenile Idiopathic Arthritis: Must try and fail (defined above) one other drug for the condition (e.g., methotrexate, sulfasalazine, NSAID) - or - the patient will be starting Xeljanz concurrently with methotrexate, sulfasalazine, or leflunomide - or - the patient has aggressive disease, as determined by the prescribing physician.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# XELJANZ SOLUTION

## Products Affected

- XELJANZ ORAL SOLUTION

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Must not be used in combination with other biologic drugs, Otezla, or Janus Kinase Inhibitor (JAKis).
<b>Required Medical Information</b>	Documentation of prior therapies and responses to treatment must be provided.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Prescriber is a specialist or has consulted with a specialist for the condition being treated.
<b>Coverage Duration</b>	Two years. Dosing must follow the FDA-approved labeling.
<b>Other Criteria</b>	For RA: Must try and fail (defined as an intolerance or inability to improve symptoms) one traditional non-biologic immunomodulator drug (e.g., methotrexate, leflunomide, hydroxychloroquine, sulfasalazine). For PsA: Must try and fail (defined above) one traditional non-biologic immunomodulator drug (e.g., methotrexate, leflunomide, sulfasalazine). For UC: Must try and fail (defined above) one traditional non-biologic immunomodulator drug (e.g., 6-mercaptopurine, azathioprine, cyclosporine) or a steroid (e.g., prednisone). For ankylosing spondylitis: Must try and fail (defined above) one nonsteroidal anti-inflammatory drug (NSAID). For Juvenile Idiopathic Arthritis: Must try and fail (defined above) one other drug for the condition (e.g., methotrexate, sulfasalazine, NSAID) - or - the patient will be starting Xeljanz concurrently with methotrexate, sulfasalazine, or leflunomide - or - the patient has aggressive disease, as determined by the prescribing physician.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# XELJANZ XR

## Products Affected

- XELJANZ XR

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Must not be used in combination with other biologic drugs, Otezla, or Janus Kinase Inhibitor (JAKis).
<b>Required Medical Information</b>	Documentation of prior therapies and responses to treatment must be provided.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Prescriber is a specialist or has consulted with a specialist for the condition being treated.
<b>Coverage Duration</b>	Two years. Dosing must follow the FDA-approved labeling.
<b>Other Criteria</b>	For RA: Must try and fail (defined as an intolerance or inability to improve symptoms) one traditional non-biologic immunomodulator drug (e.g., methotrexate, leflunomide, hydroxychloroquine, sulfasalazine). For PsA: Must try and fail (defined above) one traditional non-biologic immunomodulator drug (e.g., methotrexate, leflunomide, sulfasalazine). For UC: Must try and fail (defined above) one traditional non-biologic immunomodulator drug (e.g., 6-mercaptopurine, azathioprine, cyclosporine) or a steroid (e.g., prednisone). For ankylosing spondylitis: Must try and fail (defined above) one nonsteroidal anti-inflammatory drug (NSAID). For Juvenile Idiopathic Arthritis: Must try and fail (defined above) one other drug for the condition (e.g., methotrexate, sulfasalazine, NSAID) - or - the patient will be starting Xeljanz XR concurrently with methotrexate, sulfasalazine, or leflunomide - or - the patient has aggressive disease, as determined by the prescribing physician.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# XERMELO

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## Products Affected

- XERMELO

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Patient must be experiencing 4 or more bowel movements per day.
<b>Age Restrictions</b>	Must be 18 years of age or older.
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Two years
<b>Other Criteria</b>	Patient must have been receiving stable dose SSA therapy (either long-acting release (LAR), depot, or infusion pump) for at least 3 months.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# XGEVA

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## Products Affected

- XGEVA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	For all medically-accepted indications (except for Giant Cell Tumor of the bone, and for bone metastases from breast, prostate, and lung cancer), must first try zoledronic acid. Diagnosis and administration information will be reviewed to determine if coverage is available as a Medicare Part B or Part D benefit.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	Yes

# XIFAXAN

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## Products Affected

- XIFAXAN ORAL TABLET 200 MG, 550 MG

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	For IBS-D, no more than a total of three, 14-day treatment courses are covered. Xifaxan COVERAGE FOR SMALL INTESTINAL BACTERIAL OVER-GROWTH (SIBO) IS NOT PROVIDED.
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	End of plan year (all). IBS-D limited to three, 14-day treatment courses. TD limited to three days.
<b>Other Criteria</b>	For travelers diarrhea (TD): Coverage requires a trial and failure (defined as an intolerance or inability to improve the condition) with azithromycin. For hepatic encephalopathy: Coverage requires a trial and failure (defined above) with lactulose.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# XOLAIR

## Products Affected

- XOLAIR

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Must not be used in combination with other biologic drugs.
<b>Required Medical Information</b>	Diagnosis and administration information will be reviewed to determine if coverage is available as a Medicare Part B or Part D benefit. For initial coverage of asthma requests, documentation of the following is required: (1) A baseline IgE level of at least 30 IU/mL (baseline is defined as before treatment with Xolair or another therapy that lowers IgE levels), AND (2) a baseline (defined above) positive skin test or in vitro reactivity to a perennial aeroallergen, AND (3) Patient's current weight, AND (4) Trial and failure of 1 ICS/LABA inhaler in the past 6 months (failure is defined as an inability to improve the condition on the required therapy for at least 4 weeks). For asthma reauthorization requests: (1) Must have documentation of clinical benefit with Xolair compared to baseline (e.g., decrease in exacerbations, improvement in symptoms, decrease in oral steroid use), AND (2) the patient's current weight and baseline IgE level must be provided.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Prescriber is a specialist or has consulted with a specialist for the condition being treated.
<b>Coverage Duration</b>	1 year initial and 2 years reauth. Dosing must follow the FDA-approved labeling.



PA Criteria	Criteria Details
<b>Other Criteria</b>	<p>For initial coverage of food allergy requests, documentation of the following is required: (1) Patient has a diagnosis of an IgE-mediated food allergy confirmed by both a positive in vitro test for IgE to the specified foods AND a positive skin prick test to the specified foods, AND (2) Patient has a clinical history of a significant allergic reaction to the specified foods, AND (3) Patient has a baseline IgE level of at least 30 IU/mL (baseline is defined as before treatment with Xolair or another therapy that lowers IgE levels), AND (4) Xolair will be used in conjunction with a food allergen-avoidant diet, AND (5) Patient's current weight, AND (6) Patient is at least 1 year of age. For food allergy reauthorization requests: (1) Xolair must continue to be used in conjunction with a food allergen-avoidant diet, AND (2) the patient's current weight and baseline IgE level must be provided. For initial coverage of chronic urticaria requests, documentation of the following is required: (1) Patient has a confirmed diagnosis of chronic urticaria defined as urticaria occurring for more than 6 weeks, AND (2) Trial and failure (defined as an inability to improve symptoms) with one H1 antihistamine (such as levocetirizine or desloratadine). For chronic urticaria reauthorization requests: (1) Must have documentation of clinical benefit with Xolair compared to baseline (e.g., decrease in exacerbations, improvement in symptoms, decrease in oral steroid use). For initial coverage of nasal polyp requests, documentation of the following is required: (1) Patient has a baseline IgE level of at least 30 IU/mL (baseline is defined as before treatment with Xolair or another therapy that lowers IgE levels), AND (2) Patient's current weight, AND (3) trial and failure (defined as an inability to improve symptoms for least 4 weeks) with an intranasal steroid, AND (4) Patient will continue to use an intranasal steroid along with Xolair. For nasal polyp reauthorization requests: (1) The patient will continue to use an intranasal steroid along with Xolair, AND (2) Must have documentation of clinical benefit with Xolair compared to baseline (e.g., decrease in exacerbations, improvement in symptoms, decrease in oral steroid use), AND (3) the patient's current weight and baseline IgE level must be provided.</p>
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# XOSPATA

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## Products Affected

- XOSPATA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

# XPOVIO

## Products Affected

- XPOVIO (100 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 50 MG
- XPOVIO (40 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 40 MG
- XPOVIO (40 MG TWICE WEEKLY) ORAL TABLET THERAPY PACK 40 MG
- XPOVIO (60 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 60 MG
- XPOVIO (60 MG TWICE WEEKLY)
- XPOVIO (80 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 40 MG
- XPOVIO (80 MG TWICE WEEKLY)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

# XTANDI

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## Products Affected

- XTANDI ORAL CAPSULE
- XTANDI ORAL TABLET 40 MG, 80 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	For metastatic castration resistant prostate cancer (CRPC) AND metastatic castration-sensitive prostate cancer (CSPC): Documentation supporting a trial and failure (defined as an inadequate response or intolerance) to generic abiraterone is required.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

# ZEJULA

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## Products Affected

- ZEJULA ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

# ZELBORAF

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## Products Affected

- ZELBORAF

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

# ZEMAIRA

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## Products Affected

- ZEMAIRA

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Patient must have an FEV1 less than 80 percent predicted - AND - a serum AAT level less than 11 micromoles per liter (80 milligrams per deciliter if measured by radial immunodiffusion or 50 milligrams per deciliter if measure by nephelometry).
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Two years
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# ZILBRYSQ

## Products Affected

- ZILBRYSQ SUBCUTANEOUS SOLUTION  
 PREFILLED SYRINGE 16.6 MG/0.416ML,  
 23 MG/0.574ML, 32.4 MG/0.81ML

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Must not be used in combination with similar therapies for myasthenia gravis including immune globulins, Soliris, Ultomiris, Vyvgart/Vygart Hytrulo, or Rystiggo. (Zilbrysq has not been studied and there is no data to support use in combination with other medications used to treat MG).
<b>Required Medical Information</b>	For initial requests, must have: (1) Confirmed generalized myasthenia gravis that is anti-acetylcholine receptor antibody (AChR-Ab) positive - AND - (2)baseline Myasthenia Gravis Activities of Daily Living (MG-ADL) of 6 or more - AND - (3) trial and failure (defined as an intolerance or inability to improve the condition) of Vyvgart or Rystiggo - AND - (4) trial and failure (defined above) of Ultomiris. For initial and reauthorization: Medical records supporting the request must be provided.
<b>Age Restrictions</b>	Must be 18 years of age or older.
<b>Prescriber Restrictions</b>	Must be prescribed by or in consultation with a neurologist.
<b>Coverage Duration</b>	12 weeks initial. 1 year reauthorization.
<b>Other Criteria</b>	For reauthorization: Must have a documented response to therapy evidenced by a stable or improved MG-ADL total score from baseline.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	Yes



# ZOLINZA

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## Products Affected

- ZOLINZA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

# ZONISADE

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## Products Affected

- ZONISADE

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	For doses above 400 mg per day, documentation confirming need for further seizure reduction is required.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Two years
<b>Other Criteria</b>	Must have tried generic zonisamide capsules with inability to swallow capsule - AND - must have tried and failed (defined as an inability to improve the condition) one other generic antiseizure medication.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# ZTALMY

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## Products Affected

- ZTALMY

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	(1) Must provide confirmation of CDKL5 deficiency based on genetic testing, (2) Must provide patient's current weight.
<b>Age Restrictions</b>	Must be 2 years of age or older.
<b>Prescriber Restrictions</b>	Must be prescribed by a neurologist.
<b>Coverage Duration</b>	Two years
<b>Other Criteria</b>	Must provide documentation of a trial with failure (defined as inadequate seizure control) of at least 2 previous antiepileptic drugs.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# ZURZUVAE

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## Products Affected

- ZURZUVAE ORAL CAPSULE 20 MG, 25 MG, 30 MG

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Confirmation of diagnosis of postpartum depression.
<b>Age Restrictions</b>	Must be 18 years of age or older.
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	One year. Limited to one treatment course per year.
<b>Other Criteria</b>	Must follow current ACOG recommendations which require the patient to be in the postpartum period (ie, within 12 months postpartum) for depression that has onset in the third trimester or within 4 weeks postpartum.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# ZYDELIG

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## Products Affected

- ZYDELIG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

# ZYKADIA

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## Products Affected

- ZYKADIA ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No



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