

ABALOPARATIDE

Products Affected

- TYMLOS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	24 MONTHS
Other Criteria	OSTEOPOROSIS: HAS NOT RECEIVED A TOTAL OF 24 MONTHS CUMULATIVE TREATMENT WITH ANY PARATHYROID HORMONE THERAPY.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

ABATACEPT IV

Products Affected

- ORENCIA INTRAVENOUS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	INITIAL: RHEUMATOID ARTHRITIS (RA), POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS (PJIA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST. PSORIATIC ARTHRITIS (PSA): PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST OR RHEUMATOLOGIST.
Coverage Duration	RA, PJIA, PSA: INITIAL: 6 MOS, RENEWAL: 12 MOS. ACUTE GRAFT VERSUS HOST DISEASE (AGVHD): 1 MO.
Other Criteria	INITIAL: RA: TRIAL OF OR CONTRAINDICATION TO 3 MONTHS OF TREATMENT WITH ONE DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG) - IF PATIENT TRIED METHOTREXATE, THEN TRIAL AT A DOSE GREATER THAN OR EQUAL TO 20 MG PER WEEK OR MAXIMALLY TOLERATED DOSE IS REQUIRED. PJIA: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR PJIA. PSA: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR PSA. RENEWAL: RA: CONTINUES TO BENEFIT FROM THE MEDICATION. PJIA: 1) CONTINUES TO BENEFIT FROM THE MEDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR PJIA. PSA: 1) CONTINUES TO BENEFIT FROM THE MEDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR PSA.

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PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

ABATACEPT SQ

Products Affected

- ORENCIA CLICKJECT
- ORENCIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	INITIAL: RHEUMATOID ARTHRITIS (RA), POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS (PJIA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST. PSORIATIC ARTHRITIS (PSA): PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST OR RHEUMATOLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	INITIAL: RA: TRIAL OF OR CONTRAINDICATION TO 3 MONTHS OF TREATMENT WITH ONE DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG) - IF PATIENT TRIED METHOTREXATE, THEN TRIAL AT A DOSE GREATER THAN OR EQUAL TO 20 MG PER WEEK OR MAXIMALLY TOLERATED DOSE IS REQUIRED. PJIA: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR PJIA. PSA: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR PSA. RENEWAL: RA: CONTINUES TO BENEFIT FROM THE MEDICATION. PJIA: 1) CONTINUES TO BENEFIT FROM THE MEDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR PJIA. PSA: 1) CONTINUES TO BENEFIT FROM THE MEDICATION, AND 2) NO CONCURRENT USE WITH

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H9306_25_DRS_001_002_OE_C

PA Criteria	Criteria Details
	ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR PSA.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

ABEMACICLIB

Products Affected

- VERZENIO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

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H9306_25_DRS_001_002_OE_C

ABIRATERONE

Products Affected

- *abiraterone acetate*
- *abirtega*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	METASTATIC HIGH-RISK CASTRATION-SENSITIVE PROSTATE CANCER (MCSPC), METASTATIC CASTRATION-RESISTANT PROSTATE CANCER (MCRPC): 1) RECEIVED A BILATERAL ORCHIECTOMY, 2) CASTRATE LEVEL OF TESTOSTERONE (I.E., LESS THAN 50 NG/DL), OR 3) CONCURRENT USE WITH A GONADOTROPIN RELEASING HORMONE (GNRH) ANALOG
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
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H9306_25_DRS_001_002_OE_C

ABIRATERONE SUBMICRONIZED

Products Affected

- YONSA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	METASTATIC CASTRATION-RESISTANT PROSTATE CANCER (MCRPC): 1) RECEIVED A BILATERAL ORCHIECTOMY, 2) CASTRATE LEVEL OF TESTOSTERONE (I.E., LESS THAN 50 NG/DL), OR 3) CONCURRENT USE WITH A GONADOTROPIN RELEASING HORMONE (GNRH) ANALOG.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
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H9306_25_DRS_001_002_OE_C

ACALABRUTINIB

Products Affected

- CALQUENCE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	PREVIOUSLY TREATED MANTLE CELL LYMPHOMA: INTOLERANCE TO BRUKINSA.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

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H9306_25_DRS_001_002_OE_C

ADAGRASIB

Products Affected

- KRAZATI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
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H9306_25_DRS_001_002_OE_C

ADALIMUMAB

Products Affected

- HUMIRA (2 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT
- HUMIRA (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 10 MG/0.1ML, 20 MG/0.2ML, 40 MG/0.4ML, 40 MG/0.8ML
- HUMIRA-CD/UC/HS STARTER SUBCUTANEOUS AUTO-INJECTOR KIT
- HUMIRA-PED<40KG CROHNS STARTER
- HUMIRA-PED>=40KG CROHNS START
- HUMIRA-PED>=40KG UC STARTER SUBCUTANEOUS AUTO-INJECTOR KIT
- HUMIRA-PS/UV/ADOL HS STARTER SUBCUTANEOUS AUTO-INJECTOR KIT
- HUMIRA-PSORIASIS/UVEIT STARTER SUBCUTANEOUS AUTO-INJECTOR KIT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: PLAQUE PSORIASIS (PSO): PSORIASIS COVERING 3 PERCENT OR MORE OF BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, FACE, SCALP, OR GENITAL AREA.
Age Restrictions	
Prescriber Restrictions	INITIAL: RA, PJIA, ANKYLOSING SPONDYLITIS (AS): PRESCRIBED BY OR IN CONSULTATION WITH RHEUMATOLOGIST. PSORIATIC ARTHRITIS (PSA): PRESCRIBED BY OR IN CONSULTATION WITH DERMATOLOGIST OR RHEUMATOLOGIST. PSO, HIDRADENITIS SUPPURATIVA (HS): PRESCRIBED BY OR IN CONSULTATION WITH DERMATOLOGIST. CROHNS DISEASE (CD), ULCERATIVE COLITIS (UC): PRESCRIBED BY OR IN CONSULTATION WITH GASTROENTEROLOGIST. UVEITIS: PRESCRIBED BY OR IN CONSULTATION WITH OPHTHALMOLOGIST
Coverage Duration	INITIAL: RA, PSO, PJIA, AS, PSA, CD, UC, UVEITIS: 6 MONTHS, HS: 12 MONTHS. RENEWAL: 12 MONTHS.

Formulary ID: 25489
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H9306_25_DRS_001_002_OE_C

PA Criteria	Criteria Details
Other Criteria	INITIAL: RHEUMATOID ARTHRITIS (RA): TRIAL OF OR CONTRAINDICATION TO 3 MONTHS OF TREATMENT WITH ONE DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG) - IF PATIENT TRIED METHOTREXATE, THEN TRIAL AT A DOSE GREATER THAN OR EQUAL TO 20 MG PER WEEK OR MAXIMALLY TOLERATED DOSE IS REQUIRED. POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS (PJIA): NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR PJIA. PSA: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR PSA. AS: 1) TRIAL OF OR CONTRAINDICATION TO AN NSAID AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR AS. PSO: 1) ONE OF THE FOLLOWING: (A) AT LEAST A 3 MONTH TRIAL OF ONE ORAL IMMUNOSUPPRESSANT (CYCLOSPORINE, METHOTREXATE, TACROLIMUS) OR PUVA (PHOTOTHERAPY) FOR THE TREATMENT OF PSO, (B) CONTRAINDICATION OR INTOLERANCE TO BOTH IMMUNOSUPPRESSANT AND PUVA FOR THE TREATMENT OF PSO, OR (C) PATIENT IS SWITCHING FROM A DIFFERENT BIOLOGIC, PDE-4 INHIBITOR, OR JAK INHIBITOR FOR THE SAME INDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR PSO. CD: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR CD. UC: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR UC. HS: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR HS. UVEITIS: NO ISOLATED ANTERIOR UVEITIS. RENEWAL: RA, HS, UVEITIS: CONTINUES TO BENEFIT FROM THE MEDICATION. PJIA: 1) CONTINUES TO BENEFIT FROM MEDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR PJIA. PSA: 1) CONTINUES TO BENEFIT FROM MEDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR PSA. AS: 1) CONTINUES TO BENEFIT FROM MEDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR AS. PSO: 1)

Formulary ID: 25489

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H9306_25_DRS_001_002_OE_C

PA Criteria	Criteria Details
	CONTINUES TO BENEFIT FROM THE MEDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR PSO. CD: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR CD. UC: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR UC.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

ADALIMUMAB-AATY

Products Affected

- YUFLYMA (1 PEN)
- YUFLYMA (2 SYRINGE)
- YUFLYMA-CD/UC/HS STARTER

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: PLAQUE PSORIASIS (PSO): PSORIASIS COVERING 3 PERCENT OR MORE OF BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, FACE, SCALP, OR GENITAL AREA.
Age Restrictions	
Prescriber Restrictions	INITIAL: RA, PJIA, ANKYLOSING SPONDYLITIS (AS): PRESCRIBED BY OR IN CONSULTATION WITH RHEUMATOLOGIST. PSORIATIC ARTHRITIS (PSA): PRESCRIBED BY OR IN CONSULTATION WITH DERMATOLOGIST OR RHEUMATOLOGIST. PSO, HIDRADENITIS SUPPURATIVA (HS): PRESCRIBED BY OR IN CONSULTATION WITH DERMATOLOGIST. CROHNS DISEASE (CD), ULCERATIVE COLITIS (UC): PRESCRIBED BY OR IN CONSULTATION WITH GASTROENTEROLOGIST. UVEITIS: PRESCRIBED BY OR IN CONSULTATION WITH OPHTHALMOLOGIST
Coverage Duration	INITIAL: RA, PSO, PJIA, AS, PSA, CD, UC, UVEITIS: 6 MONTHS, HS: 12 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	INITIAL: RHEUMATOID ARTHRITIS (RA): TRIAL OF OR CONTRAINDICATION TO 3 MONTHS OF TREATMENT WITH ONE DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG) - IF PATIENT TRIED METHOTREXATE, THEN TRIAL AT A DOSE GREATER THAN OR EQUAL TO 20 MG PER WEEK OR MAXIMALLY TOLERATED DOSE IS REQUIRED. POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS (PJIA): NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR PJIA. PSA: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL

Formulary ID: 25489

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H9306_25_DRS_001_002_OE_C

PA Criteria	Criteria Details
	MOLECULES FOR PSA. AS: 1) TRIAL OF OR CONTRAINDICATION TO AN NSAID AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR AS. PSO: 1) ONE OF THE FOLLOWING: (A) AT LEAST A 3 MONTH TRIAL OF ONE ORAL IMMUNOSUPPRESSANT (CYCLOSPORINE, METHOTREXATE, TACROLIMUS) OR PUVA (PHOTOTHERAPY) FOR THE TREATMENT OF PSO, (B) CONTRAINDICATION OR INTOLERANCE TO BOTH IMMUNOSUPPRESSANT AND PUVA FOR THE TREATMENT OF PSO, OR (C) PATIENT IS SWITCHING FROM A DIFFERENT BIOLOGIC, PDE-4 INHIBITOR, OR JAK INHIBITOR FOR THE SAME INDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR PSO. CD: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR CD. UC: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR UC. HS: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR HS. UVEITIS: NO ISOLATED ANTERIOR UVEITIS. RENEWAL: RA, HS, UVEITIS: CONTINUES TO BENEFIT FROM MEDICATION. PJIA: 1) CONTINUES TO BENEFIT FROM MEDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR PJIA. PSA: 1) CONTINUES TO BENEFIT FROM MEDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR PSA. AS: 1) CONTINUES TO BENEFIT FROM MEDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR AS. PSO: 1) CONTINUES TO BENEFIT FROM MEDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR PSO. CD: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR CD. UC: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR UC.
Indications	All FDA-approved Indications.
Off Label Uses	

Formulary ID: 25489
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H9306_25_DRS_001_002_OE_C

PA Criteria	Criteria Details
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
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H9306_25_DRS_001_002_OE_C

ADALIMUMAB-ADBIM

Products Affected

- CYLTEZO (2 PEN)
- CYLTEZO (2 SYRINGE)
- CYLTEZO-CD/UC/HS STARTER
- CYLTEZO-PSORIASIS/UV STARTER

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: PLAQUE PSORIASIS (PSO): PSORIASIS COVERING 3 PERCENT OR MORE OF BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, FACE, SCALP, OR GENITAL AREA.
Age Restrictions	
Prescriber Restrictions	INITIAL: RA, PJIA, ANKYLOSING SPONDYLITIS (AS): PRESCRIBED BY OR IN CONSULTATION WITH RHEUMATOLOGIST. PSORIATIC ARTHRITIS (PSA): PRESCRIBED BY OR IN CONSULTATION WITH DERMATOLOGIST OR RHEUMATOLOGIST. PSO, HIDRADENITIS SUPPURATIVA (HS): PRESCRIBED BY OR IN CONSULTATION WITH DERMATOLOGIST. CROHNS DISEASE (CD), ULCERATIVE COLITIS (UC): PRESCRIBED BY OR IN CONSULTATION WITH GASTROENTEROLOGIST. UVEITIS: PRESCRIBED BY OR IN CONSULTATION WITH OPHTHALMOLOGIST
Coverage Duration	INITIAL: RA, PSO, PJIA, AS, PSA, CD, UC, UVEITIS: 6 MONTHS, HS: 12 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	INITIAL: RHEUMATOID ARTHRITIS (RA): TRIAL OF OR CONTRAINDICATION TO 3 MONTHS OF TREATMENT WITH ONE DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG) - IF PATIENT TRIED METHOTREXATE, THEN TRIAL AT A DOSE GREATER THAN OR EQUAL TO 20 MG PER WEEK OR MAXIMALLY TOLERATED DOSE IS REQUIRED. POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS (PJIA): NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR PJIA. PSA: NO CONCURRENT USE WITH

Formulary ID: 25489

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H9306_25_DRS_001_002_OE_C

PA Criteria	Criteria Details
	ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR PSA. AS: 1) TRIAL OF OR CONTRAINDICATION TO AN NSAID AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR AS. PSO: 1) ONE OF THE FOLLOWING: (A) AT LEAST A 3 MONTH TRIAL OF ONE ORAL IMMUNOSUPPRESSANT (CYCLOSPORINE, METHOTREXATE, TACROLIMUS) OR PUVA (PHOTOTHERAPY) FOR THE TREATMENT OF PSO, (B) CONTRAINDICATION OR INTOLERANCE TO BOTH IMMUNOSUPPRESSANT AND PUVA FOR THE TREATMENT OF PSO, OR (C) PATIENT IS SWITCHING FROM A DIFFERENT BIOLOGIC, PDE-4 INHIBITOR, OR JAK INHIBITOR FOR THE SAME INDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR PSO. CD: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR CD. UC: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR UC. HS: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR HS. UVEITIS: NO ISOLATED ANTERIOR UVEITIS. RENEWAL: RA, HS, UVEITIS: CONTINUES TO BENEFIT FROM MEDICATION. PJIA: 1) CONTINUES TO BENEFIT FROM MEDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR PJIA. PSA: 1) CONTINUES TO BENEFIT FROM MEDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR PSA. AS: 1) CONTINUES TO BENEFIT FROM MEDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR AS. PSO: 1) CONTINUES TO BENEFIT FROM MEDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR PSO. CD: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR CD. UC: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR UC.
Indications	All FDA-approved Indications.

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

PA Criteria	Criteria Details
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
 Last Updated: 05/27/2025
 Effective: 06/01/2025
 H9306_25_DRS_001_002_OE_C

AFATINIB

Products Affected

- GILOTRIF

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	METASTATIC NON-SMALL CELL LUNG CANCER (NSCLC) WITH EGFR MUTATION; NOT ON CONCURRENT THERAPY WITH AN EGFR TYROSINE KINASE INHIBITOR.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

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Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

ALECTINIB

Products Affected

- ALECENSA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
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H9306_25_DRS_001_002_OE_C

ALPELISIB-PIQRAY

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	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

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Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

AMIKACIN LIPOSOMAL INH

Products Affected

- ARIKAYCE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	MYCOBACTERIUM AVIUM COMPLEX (MAC) LUNG DISEASE: RENEWAL: 1) NO POSITIVE MAC SPUTUM CULTURE AFTER CONSECUTIVE NEGATIVE CULTURES, AND 2) IMPROVEMENT IN SYMPTOMS. ADDITIONALLY, FOR FIRST RENEWAL, APPROVAL REQUIRES AT LEAST ONE NEGATIVE SPUTUM CULTURE FOR MAC BY SIX MONTHS OF ARIKAYCE TREATMENT. FOR SECOND AND SUBSEQUENT RENEWALS, APPROVAL REQUIRES AT LEAST THREE NEGATIVE SPUTUM CULTURES FOR MAC BY 12 MONTHS OF ARIKAYCE TREATMENT.
Age Restrictions	
Prescriber Restrictions	MAC LUNG DISEASE: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A PULMONOLOGIST OR INFECTIOUS DISEASE SPECIALIST.
Coverage Duration	INITIAL/RENEWAL: 6 MONTHS.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

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H9306_25_DRS_001_002_OE_C

AMIVANTAMAB-VMJW

Products Affected

- RYBREVANT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

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 Effective: 06/01/2025
 H9306_25_DRS_001_002_OE_C

ANAKINRA

Products Affected

- KINERET SUBCUTANEOUS
SOLUTION PREFILLED SYRINGE

PA Criteria	Criteria Details
Exclusion Criteria	CORONAVIRUS DISEASE 2019 (COVID-19) IN HOSPITALIZED ADULTS.
Required Medical Information	INITIAL: CRYOPYRIN-ASSOCIATED PERIODIC SYNDROMES (CAPS): 1) ONE OF THE FOLLOWING: (A) GENETIC TEST FOR GAIN-OF-FUNCTION MUTATIONS IN THE NLRP3 GENE, OR (B) HAS INFLAMMATORY MARKERS (I.E., ELEVATED CRP, ESR, SERUM AMYLOID A PROTEIN (SAA) OR S100 PROTEINS), AND 2) TWO OF THE FOLLOWING: URTICARIAL-LIKE RASH (NEUTROPHILIC DERMATITIS), COLD-TRIGGERED EPISODES, SENSORINEURAL HEARING LOSS, MUSCULOSKELETAL SYMPTOMS, CHRONIC ASEPTIC MENINGITIS, SKELETAL ABNORMALITIES. DEFICIENCY OF INTERLEUKIN-1 RECEPTOR ANTAGONIST (DIRA): 1) ONE OF THE FOLLOWING: (A) GENETIC TEST FOR GAIN-OF-FUNCTION MUTATIONS IN THE IL1RN GENE, OR (B) HAS INFLAMMATORY MARKERS (I.E., ELEVATED CRP, ESR), AND 2) ONE OF THE FOLLOWING: PUSTULAR PSORIASIS-LIKE RASHES, OSTEOMYELITIS, ABSENCE OF BACTERIAL OSTEOMYELITIS, ONYCHOMADESIS.
Age Restrictions	
Prescriber Restrictions	INITIAL: RHEUMATOID ARTHRITIS (RA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST.
Coverage Duration	RA: INITIAL: 6 MONTHS, RENEWAL: 12 MONTHS. CAPS, DIRA: LIFETIME.
Other Criteria	INITIAL: RA: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: ENBREL, HUMIRA/CYLTEZO/YUFLYMA, XELJANZ, RINVOQ, ORENCIA. CAPS, DIRA: NO CONCURRENT USE WITH OTHER IL-1 INHIBITORS. RENEWAL: RA: CONTINUES TO BENEFIT FROM THE MEDICATION.

Formulary ID: 25489

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H9306_25_DRS_001_002_OE_C

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
 Last Updated: 05/27/2025
 Effective: 06/01/2025
 H9306_25_DRS_001_002_OE_C

APALUTAMIDE

Products Affected

- ERLEADA ORAL TABLET 240 MG, 60 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL/RENEWAL: 12 MONTHS.
Other Criteria	INITIAL: NON-METASTATIC CASTRATION-RESISTANT PROSTATE CANCER (NMCRPC): HIGH RISK PROSTATE CANCER (I.E., RAPIDLY INCREASING PROSTATE SPECIFIC ANTIGEN [PSA] LEVELS). NMCRPC, METASTATIC CASTRATION-SENSITIVE PROSTATE CANCER (MCSPC): 1) RECEIVED A BILATERAL ORCHIECTOMY, 2) CASTRATE LEVEL OF TESTOSTERONE (I.E., LESS THAN 50 NG/DL), OR 3) CONCURRENT USE WITH A GONADOTROPIN RELEASING HORMONE (GNRH) ANALOG. RENEWAL: NMCRPC, MCSPC: 1) RECEIVED A BILATERAL ORCHIECTOMY, 2) CASTRATE LEVEL OF TESTOSTERONE (I.E., LESS THAN 50 NG/DL), OR 3) CONCURRENT USE WITH A GNRH ANALOG.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

APOMORPHINE - ONAPGO

Products Affected

- ONAPGO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	PARKINSONS DISEASE (PD): INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST.
Coverage Duration	INITIAL: 3 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	PD: INITIAL: 1) RESPONSIVE TO LEVODOPA, 2) CURRENT MEDICATION REGIMEN, INCLUDING LEVODOPA, HAS BEEN AT A STABLE DOSE FOR AT LEAST 28 DAYS, 3) MOTOR SYMPTOMS ARE CURRENTLY UNCONTROLLED (DEFINED AS AN AVERAGE OFF TIME OF AT LEAST 3 HOURS/DAY, FOR AT LEAST 2 HOURS EACH DAY), AND 4) DOES NOT HAVE ANY OF THE FOLLOWING: ORTHOSTATIC HYPOTENSION, HISTORY OF PROLONGED QTC (GREATER THAN 450 MSEC FOR MALE OR GREATER THAN 470 MSEC FOR FEMALE), ACTIVE OR UNCONTROLLED PSYCHOSIS, ACTIVE OR UNCONTROLLED DEPRESSION. RENEWAL: IMPROVEMENT IN MOTOR SYMPTOMS WHILE ON THERAPY. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489

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H9306_25_DRS_001_002_OE_C

APOMORPHINE - SL

Products Affected

- KYNMOBI
- KYNMOBI TITRATION KIT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	PARKINSONS DISEASE (PD): INITIAL: 18 YEARS OF AGE OR OLDER.
Prescriber Restrictions	PD: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS
Other Criteria	PD: RENEWAL: IMPROVEMENT WITH MOTOR FLUCTUATIONS DURING OFF EPISODES WITH THE USE OF THERAPY.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

APREMILAST

Products Affected

- OTEZLA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: MILD PLAQUE PSORIASIS (PSO): 1) PSORIASIS COVERING 2 PERCENT OF BODY SURFACE AREA (BSA), 2) STATIC PHYSICIAN GLOBAL ASSESSMENT (SPGA) SCORE OF 2, OR 3) PSORIASIS AREA AND SEVERITY INDEX (PASI) SCORE OF 2 TO 9. MODERATE TO SEVERE PSO: PSORIASIS COVERING 3 PERCENT OR MORE OF BSA, OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, FACE, SCALP, OR GENITAL AREA.
Age Restrictions	
Prescriber Restrictions	INITIAL: PSORIATIC ARTHRITIS (PSA): PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST OR RHEUMATOLOGIST. PSO: PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST. BEHCETS DISEASE: PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	INITIAL: PSA: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR PSA. MILD PSO: TRIAL OF OR CONTRAINDICATION TO ONE CONVENTIONAL SYSTEMIC THERAPY (E.G., METHOTREXATE, ACITRETIN, CYCLOSPORINE) OR ONE CONVENTIONAL TOPICAL THERAPY (E.G., PUVA [PHOTOTHERAPY], UVB [ULTRAVIOLET LIGHT B], TOPICAL CORTICOSTEROIDS). MODERATE TO SEVERE PSO: 1) ONE OF THE FOLLOWING: (A) AT LEAST A 3 MONTH TRIAL OF ONE ORAL IMMUNOSUPPRESSANT (CYCLOSPORINE, METHOTREXATE, TACROLIMUS) OR PUVA (PHOTOTHERAPY)

Formulary ID: 25489

Last Updated: 05/27/2025

Effective: 06/01/2025

H9306_25_DRS_001_002_OE_C

PA Criteria	Criteria Details
	FOR THE TREATMENT OF PSO, (B) CONTRAINDICATION OR INTOLERANCE TO BOTH IMMUNOSUPPRESSANT AND PUVA FOR THE TREATMENT OF PSO, OR (C) PATIENT IS SWITCHING FROM A DIFFERENT BIOLOGIC, PDE-4 INHIBITOR, OR JAK INHIBITOR FOR THE SAME INDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR MODERATE TO SEVERE PSO. BEHCETS DISEASE: 1) HAS ORAL ULCERS OR A HISTORY OF RECURRENT ORAL ULCERS BASED ON CLINICAL SYMPTOMS, AND 2) TRIAL OF OR CONTRAINDICATION TO ONE OR MORE CONSERVATIVE TREATMENTS (E.G., COLCHICINE, TOPICAL CORTICOSTEROID, ORAL CORTICOSTEROID). RENEWAL: MILD PSO, BEHCETS DISEASE: CONTINUES TO BENEFIT FROM THE MEDICATION. PSA: 1) CONTINUES TO BENEFIT FROM THE MEDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR PSA. MODERATE TO SEVERE PSO: 1) CONTINUES TO BENEFIT FROM THE MEDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR MODERATE TO SEVERE PSO.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
 Last Updated: 05/27/2025
 Effective: 06/01/2025
 H9306_25_DRS_001_002_OE_C

ARIMOCLOMOL

Products Affected

- MIPLYFFA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	NIEMANN-PICK DISEASE TYPE C (NPC): INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH NEUROLOGIST OR GENETICIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	NPC: RENEWAL: IMPROVEMENT OR SLOWING OF DISEASE PROGRESSION.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

ASCIMINIB

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	PREVIOUSLY TREATED OR T315I MUTATION PHILADELPHIA CHROMOSOME-POSITIVE CHRONIC MYELOID LEUKEMIA (Ph+ CML); MUTATIONAL ANALYSIS PRIOR TO INITIATION AND SCEMBLIX IS APPROPRIATE PER NCCN GUIDELINE TABLE FOR TREATMENT RECOMMENDATIONS BASED ON BCR-ABL1 MUTATION PROFILE.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

ASFOTASE ALFA

Products Affected

- STRENSIQ

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	HYPOPHOSPHATASIA (HPP): INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH AN ENDOCRINOLOGIST, GENETICIST, OR METABOLIC SPECIALIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	INITIAL: PERINATAL/INFANTILE-ONSET HPP: 1) 6 MONTHS OF AGE OR YOUNGER AT ONSET OF HPP, AND 2) POSITIVE FOR A TISSUE NON-SPECIFIC ALKALINE PHOSPHATASE (TNSALP) (ALPL) GENE MUTATION AS CONFIRMED BY GENETIC TESTING OR TWO OF THE FOLLOWING: (A) SERUM ALKALINE PHOSPHATASE (ALP) LEVEL BELOW THAT OF NORMAL RANGE FOR PATIENT AGE, (B) ELEVATED SERUM PYRIDOXAL-5'-PHOSPHATE (PLP) LEVELS AND NO VITAMIN B6 SUPPLEMENTATION IN THE PREVIOUS WEEK, (C) URINE PHOSPHOETHANOLAMINE (PEA) LEVEL ABOVE THAT OF NORMAL RANGE FOR PATIENT AGE, (D) RADIOGRAPHIC EVIDENCE OF HPP, (E) AT LEAST TWO OF THE FOLLOWING: (I) RACHITIC CHEST DEFORMITY, (II) CRANIOSYNOSTOSIS, (III) DELAY IN SKELETAL GROWTH RESULTING IN DELAY OF MOTOR DEVELOPMENT, (IV) HISTORY OF VITAMIN B6 DEPENDENT SEIZURES, (V) NEPHROCALCINOSIS OR HISTORY OF ELEVATED SERUM CALCIUM, (VI) HISTORY OR PRESENCE OF NON-TRAUMATIC POSTNATAL FRACTURE AND DELAYED FRACTURE HEALING. JUVENILE-ONSET HPP: 1) 18 YEARS OF

Formulary ID: 25489

Last Updated: 05/27/2025

Effective: 06/01/2025

H9306_25_DRS_001_002_OE_C

PA Criteria	Criteria Details
	AGE OR YOUNGER AT ONSET OF HPP, AND 2) POSITIVE FOR A TNSALP ALPL GENE MUTATION AS CONFIRMED BY GENETIC TESTING OR TWO OF THE FOLLOWING: (A) SERUM ALP LEVEL BELOW THAT OF NORMAL RANGE FOR PATIENT AGE, (B) ELEVATED SERUM PLP LEVELS AND NO VITAMIN B6 SUPPLEMENTATION IN THE PREVIOUS WEEK, (C) URINE PEA LEVEL ABOVE THAT OF NORMAL RANGE FOR PATIENT AGE, (D) RADIOGRAPHIC EVIDENCE OF HPP, (E) AT LEAST TWO OF THE FOLLOWING: (I) RACHITIC DEFORMITIES, (II) PREMATURE LOSS OF PRIMARY TEETH PRIOR TO 5 YEARS OF AGE, (III) DELAY IN SKELETAL GROWTH RESULTING IN DELAY OF MOTOR DEVELOPMENT, (IV) HISTORY OR PRESENCE OF NON-TRAUMATIC FRACTURES OR DELAYED FRACTURE HEALING. ALL INDICATIONS: 1) NOT CURRENTLY RECEIVING TREATMENT WITH A BISPHOSPHONATE, 2) CALCIUM OR PHOSPHATE LEVELS ARE NOT BELOW THE NORMAL RANGE, 3) NOT HAVE A TREATABLE FORM OF RICKETS. RENEWAL: ALL INDICATIONS: 1) IMPROVEMENT IN THE SKELETAL CHARACTERISTICS OF HPP, AND 2) NOT CURRENTLY RECEIVING TREATMENT WITH A BISPHOSPHONATE.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

ATOGEPANT

Products Affected

- QULIPTA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	MIGRAINE PREVENTION: INITIAL: 1) TRIAL OF OR CONTRAINDICATION TO ONE OF THE FOLLOWING PREVENTIVE MIGRAINE TREATMENTS: DIVALPROEX SODIUM, TOPIRAMATE, PROPRANOLOL, TIMOLOL, AND 2) NO CONCURRENT USE WITH OTHER CGRP INHIBITORS FOR MIGRAINE PREVENTION. RENEWAL: 1) REDUCTION IN MIGRAINE OR HEADACHE FREQUENCY, MIGRAINE SEVERITY, OR MIGRAINE DURATION WITH THERAPY, AND 2) NO CONCURRENT USE WITH OTHER CGRP INHIBITORS FOR MIGRAINE PREVENTION.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

AVACOPAN

Products Affected

- TAVNEOS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	ANTI-NEUTROPHIL CYTOPLASMIC AUTOANTIBODY (ANCA)-ASSOCIATED VASCULITIS: INITIAL: ANCA SEROPOSITIVE (ANTI-PR3 OR ANTI-MPO).
Age Restrictions	
Prescriber Restrictions	ANCA-ASSOCIATED VASCULITIS: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST OR NEPHROLOGIST.
Coverage Duration	INITIAL/RENEWAL: 6 MONTHS.
Other Criteria	ANCA-ASSOCIATED VASCULITIS: RENEWAL: CONTINUES TO BENEFIT FROM THERAPY.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

AVAPRITINIB

Products Affected

- AYVAKIT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

AXATILIMAB-CSFR

Products Affected

- NIKTIMVO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

AXITINIB

Products Affected

- INLYTA ORAL TABLET 1 MG, 5 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

AZACITIDINE

Products Affected

- ONUREG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

AZTREONAM INHALED

Products Affected

- CAYSTON

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	7 YEARS OF AGE OR OLDER
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

BEDAQUILINE

Products Affected

- SIRTURO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	24 WEEKS
Other Criteria	PULMONARY MULTI-DRUG RESISTANT TUBERCULOSIS (MDR-TB); SIRTURO USED IN COMBINATION WITH AT LEAST 3 OTHER ANTIBIOTICS FOR THE TREATMENT OF PULMONARY MDR-TB.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

BELIMUMAB

Products Affected

- BENLYSTA SUBCUTANEOUS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	INITIAL: SYSTEMIC LUPUS ERYTHEMATOSUS (SLE): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST. LUPUS NEPHRITIS (LN): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST OR NEPHROLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS
Other Criteria	INITIAL: SLE: CURRENTLY TAKING CORTICOSTEROIDS, ANTIMALARIALS, NSAIDS, OR IMMUNOSUPPRESSIVE AGENTS. RENEWAL: SLE: PATIENT HAD CLINICAL IMPROVEMENT. LN: IMPROVEMENT IN RENAL RESPONSE FROM BASELINE LABORATORY VALUES (I.E., EGFR OR PROTEINURIA) AND/OR CLINICAL PARAMETERS.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

BELUMOSUDIL

Products Affected

- REZUROCK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

BELZUTIFAN

Products Affected

- WELIREG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

BENDAMUSTINE

Products Affected

- BENDAMUSTINE HCL
INTRAVENOUS SOLUTION
- *bendamustine hcl intravenous solution
reconstituted*
- BENDEKA
- VIVIMUSTA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

BENRALIZUMAB

Products Affected

- FASENRA
- FASENRA PEN

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	ASTHMA: INITIAL: BLOOD EOSINOPHIL LEVEL OF AT LEAST 150 CELLS/MCL WITHIN THE PAST 12 MONTHS.
Age Restrictions	
Prescriber Restrictions	ASTHMA: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A PHYSICIAN SPECIALIZING IN ALLERGY OR PULMONARY MEDICINE.
Coverage Duration	INITIAL/RENEWAL: 12 MONTHS.
Other Criteria	INITIAL: ASTHMA: 1) CONCURRENT THERAPY WITH A MEDIUM, HIGH-DOSE, OR MAXIMALLY TOLERATED DOSE OF AN INHALED CORTICOSTEROID (ICS) AND ONE OTHER MAINTENANCE MEDICATION, 2) ONE ASTHMA EXACERBATION REQUIRING SYSTEMIC CORTICOSTEROID BURST LASTING 3 OR MORE DAYS WITHIN THE PAST 12 MONTHS, OR AT LEAST ONE SERIOUS EXACERBATION REQUIRING HOSPITALIZATION OR ER VISIT WITHIN THE PAST 12 MONTHS, OR POOR SYMPTOM CONTROL DESPITE CURRENT THERAPY AS EVIDENCED BY AT LEAST THREE OF THE FOLLOWING WITHIN THE PAST 4 WEEKS: (A) DAYTIME ASTHMA SYMPTOMS MORE THAN TWICE/WEEK, (B) ANY NIGHT WAKING DUE TO ASTHMA, (C) SABA RELIEVER FOR SYMPTOMS MORE THAN TWICE/WEEK, (D) ANY ACTIVITY LIMITATION DUE TO ASTHMA, AND 3) NO CONCURRENT USE WITH XOLAIR, DUPIXENT, TEZSPIRE, OR OTHER ANTI-IL5 BIOLOGICS WHEN USED FOR ASTHMA. EOSINOPHILIC GRANULOMATOSIS WITH POLYANGIITIS (EGPA): NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR

Formulary ID: 25489

Last Updated: 05/27/2025

Effective: 06/01/2025

H9306_25_DRS_001_002_OE_C

PA Criteria	Criteria Details
	TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-2 INHIBITOR) FOR EGPA. RENEWAL: ASTHMA: 1) NO CONCURRENT USE WITH XOLAIR, DUPIXENT, TEZSPIRE, OR OTHER ANTI-IL5 BIOLOGICS WHEN USED FOR ASTHMA, 2) CONTINUED USE OF ICS AND ONE OTHER MAINTENANCE MEDICATION, AND 3) CLINICAL RESPONSE AS EVIDENCED BY: (A) REDUCTION IN ASTHMA EXACERBATIONS FROM BASELINE, (B) DECREASED UTILIZATION OF RESCUE MEDICATIONS, (C) INCREASE IN PERCENT PREDICTED FEV1 FROM PRETREATMENT BASELINE, OR (D) REDUCTION IN SEVERITY OR FREQUENCY OF ASTHMA-RELATED SYMPTOMS. EGPA: 1) REDUCTION IN EGPA SYMPTOMS COMPARED TO BASELINE OR ABILITY TO REDUCE/ELIMINATE CORTICOSTEROID USE, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR EGPA
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

BETAINE

Products Affected

- *betaine*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

BEVACIZUMAB-ADCD

Products Affected

- VEGZELMA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
 Last Updated: 05/27/2025
 Effective: 06/01/2025
 H9306_25_DRS_001_002_OE_C

BEVACIZUMAB-AWWB

Products Affected

- MVASI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
 Last Updated: 05/27/2025
 Effective: 06/01/2025
 H9306_25_DRS_001_002_OE_C

BEVACIZUMAB-BVZR

Products Affected

- ZIRABEV

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
 Last Updated: 05/27/2025
 Effective: 06/01/2025
 H9306_25_DRS_001_002_OE_C

BEXAROTENE

Products Affected

- bexarotene*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

BINIMETINIB

Products Affected

- MEKTOVI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
 Last Updated: 05/27/2025
 Effective: 06/01/2025
 H9306_25_DRS_001_002_OE_C

BORTEZOMIB

Products Affected

- bortezomib injection*
- BORUZU

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
 Last Updated: 05/27/2025
 Effective: 06/01/2025
 H9306_25_DRS_001_002_OE_C

BOSENTAN

Products Affected

- bosentan*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	PULMONARY ARTERIAL HYPERTENSION (PAH): INITIAL: DIAGNOSIS CONFIRMED BY RIGHT HEART CATHETERIZATION WITH THE FOLLOWING PARAMETERS: 1) MEAN PULMONARY ARTERY PRESSURE (PAP) GREATER THAN 20 MMHG, 2) PULMONARY CAPILLARY WEDGE PRESSURE (PCWP) OF 15 MMHG OR LESS, AND 3) PULMONARY VASCULAR RESISTANCE (PVR) GREATER THAN 2 WOOD UNITS.
Age Restrictions	
Prescriber Restrictions	PAH: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A CARDIOLOGIST OR PULMONOLOGIST.
Coverage Duration	INITIAL/RENEWAL: 12 MONTHS.
Other Criteria	PAH: INITIAL: 1) DOES NOT HAVE ELEVATED LIVER ENZYMES (ALT, AST) MORE THAN 3 TIMES UPPER LIMIT OF NORMAL (ULN) OR INCREASE IN BILIRUBIN BY 2 OR MORE TIMES ULN, AND 2) NO CONCURRENT USE WITH CYCLOSPORINE A OR GLYBURIDE. RENEWAL: NO CONCURRENT USE WITH CYCLOSPORINE A OR GLYBURIDE.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

BOSUTINIB

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	PREVIOUSLY TREATED PHILADELPHIA CHROMOSOME-POSITIVE CHRONIC MYELOID LEUKEMIA (Ph+ CML): MUTATIONAL ANALYSIS PRIOR TO INITIATION AND BOSULIF IS APPROPRIATE PER NCCN GUIDELINE TABLE FOR TREATMENT RECOMMENDATIONS BASED ON BCR-ABL1 MUTATION PROFILE.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

BRIGATINIB

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	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

C1 ESTERASE INHIBITOR-HAEGARDA

Products Affected

- HAEGARDA SUBCUTANEOUS
SOLUTION RECONSTITUTED 2000
UNIT, 3000 UNIT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	HEREDITARY ANGIOEDEMA (HAE): INITIAL: DIAGNOSIS CONFIRMED BY ONE OF THE FOLLOWING COMPLEMENT TESTING: C1INH PROTEIN LEVELS, C4 PROTEIN LEVELS, C1-INH FUNCTIONAL LEVELS, C1Q.
Age Restrictions	
Prescriber Restrictions	HAE: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A HEMATOLOGIST, IMMUNOLOGIST, ALLERGIST OR PULMONOLOGIST.
Coverage Duration	INITIAL/RENEWAL: 12 MONTHS.
Other Criteria	HAE: INITIAL: NOT ON CONCURRENT TREATMENT WITH ALTERNATIVE PROPHYLACTIC AGENT FOR HAE ATTACKS. RENEWAL: 1) IMPROVEMENT COMPARED TO BASELINE IN HAE ATTACKS (I.E., REDUCTIONS IN ATTACK FREQUENCY OR ATTACK SEVERITY), AND 2) NOT ON CONCURRENT TREATMENT WITH ALTERNATIVE PROPHYLACTIC AGENT FOR HAE ATTACKS.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

CABOZANTINIB CAPSULE

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	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

CABOZANTINIB TABLET

Products Affected

- CABOMETYX ORAL TABLET 20 MG, 40 MG, 60 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

CANNABIDIOL

Products Affected

- EPIDIOLEX

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	DRAVET SYNDROME (DS), LENNOX-GASTAUT SYNDROME (LGS), TUBEROUS SCLEROSIS COMPLEX (TSC): PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST.
Coverage Duration	INITIAL/RENEWAL: 12 MONTHS.
Other Criteria	INITIAL: LENNOX-GASTAUT SYNDROME (LGS): TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING ANTIEPILEPTIC MEDICATIONS: RUFINAMIDE, FELBAMATE, CLOBAZAM, TOPIRAMATE, LAMOTRIGINE, CLONAZEPAM.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

CAPIVASERTIB

Products Affected

- TRUQAP ORAL TABLET
- TRUQAP TABLET THERAPY PACK 160 MG ORAL

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

CAPMATINIB

Products Affected

- TABRECTA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

CARGLUMIC ACID

Products Affected

- carglumic acid oral tablet soluble*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: ACUTE OR CHRONIC HYPERAMMONEMIA (HA) DUE TO N ACETYLGLUTAMATE SYNTHASE (NAGS) DEFICIENCY: NAGS GENE MUTATION IS CONFIRMED BY BIOCHEMICAL OR GENETIC TESTING. ACUTE HA DUE TO PROPIONIC ACIDEMIA (PA): 1) CONFIRMED BY ELEVATED METHYLCITRIC ACID AND NORMAL METHYLMALONIC ACID, OR 2) GENETIC TESTING CONFIRMS MUTATION IN THE PCCA OR PCCB GENE. ACUTE HA DUE TO METHYLMALONIC ACIDEMIA (MMA): 1) CONFIRMED BY ELEVATED METHYLMALONIC ACID, METHYLCITRIC ACID, OR 2) GENETIC TESTING CONFIRMS MUTATION IN THE MMUT, MMA, MMAB OR MMADHC GENES.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	ACUTE HA DUE TO NAGS/PA/MMA: 7 DAYS. CHRONIC HA DUE TO NAGS: INITIAL: 6 MOS, RENEWAL: 12 MOS.
Other Criteria	RENEWAL: CHRONIC HA DUE TO NAGS: PATIENT HAS SHOWN CLINICAL IMPROVEMENT.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

CERITINIB

Products Affected

- ZYKADIA ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

CERTOLIZUMAB PEGOL

Products Affected

- CIMZIA (2 SYRINGE)
- CIMZIA SUBCUTANEOUS KIT 2 X 200 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: PLAQUE PSORIASIS (PSO): PSORIASIS COVERING 3 PERCENT OR MORE OF BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, FACE, SCALP, OR GENITAL AREA. NON-RADIOGRAPHIC AXIAL SPONDYLOARTHRITIS (NR-AXSPA): 1) C-REACTIVE PROTEIN (CRP) LEVELS ABOVE THE UPPER LIMIT OF NORMAL, OR 2) SACROILIITIS ON MAGNETIC RESONANCE IMAGING (MRI).
Age Restrictions	
Prescriber Restrictions	INITIAL: RHEUMATOID ARTHRITIS (RA), ANKYLOSING SPONDYLITIS (AS), NR-AXSPA, POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS (PJIA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST. PSORIATIC ARTHRITIS (PSA): PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST OR RHEUMATOLOGIST. CROHNS DISEASE (CD): PRESCRIBED BY OR IN CONSULTATION WITH A GASTROENTEROLOGIST. PSO: PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	INITIAL: RA: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: ENBREL, HUMIRA/CYLTEZO/YUFLYMA, XELJANZ, RINVOQ, ORENCIA. PSA: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: COSENTYX, ENBREL, HUMIRA/CYLTEZO/YUFLYMA, STELARA/SELARSDI/YESINTEK, XELJANZ, RINVOQ, SKYRIZI, TREMFYA, ORENCIA, OTEZLA. PSO: TRIAL OF OR CONTRAINDICATION TO TWO OF THE

Formulary ID: 25489

Last Updated: 05/27/2025

Effective: 06/01/2025

H9306_25_DRS_001_002_OE_C

PA Criteria	Criteria Details
	FOLLOWING PREFERRED AGENTS: COSENTYX, ENBREL, HUMIRA/CYLTEZO/YUFLYMA, STELARA/SELARSDI/YESINTEK, SKYRIZI, TREMFYA, OTEZLA. AS: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: COSENTYX, ENBREL, HUMIRA/CYLTEZO/YUFLYMA, XELJANZ, RINVOQ. CD: TRIAL OF OR CONTRAINDICATION TO ONE OF THE FOLLOWING PREFERRED AGENTS: STELARA/SELARSDI/YESINTEK, HUMIRA/CYLTEZO/YUFLYMA, RINVOQ, SKYRIZI, TREMFYA. NR-AXSPA: TRIAL OF OR CONTRAINDICATION TO AN NSAID. PJIA: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: ENBREL, HUMIRA/CYLTEZO/YUFLYMA, XELJANZ IR, ORENCIA, RINVOQ. INITIAL FOR RA, PSA, PSO, AS, CD, PJIA: TRIAL OF OR CONTRAINDICATION TO THE STEP AGENTS IS NOT REQUIRED IF THE PATIENT IS PREGNANT, BREASTFEEDING, OR TRYING TO BECOME PREGNANT. INITIAL/RENEWAL FOR PSA, PSO, AS, CD, NR-AXSPA, PJIA: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR SAME INDICATION. RENEWAL FOR RA, PSA, AS, PSO, NR-AXSPA, PJIA: CONTINUES TO BENEFIT FROM MEDICATION.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
 Last Updated: 05/27/2025
 Effective: 06/01/2025
 H9306_25_DRS_001_002_OE_C

CETUXIMAB

Products Affected

- ERBITUX

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
 Last Updated: 05/27/2025
 Effective: 06/01/2025
 H9306_25_DRS_001_002_OE_C

CLADRIBINE

Products Affected

- MAVENCLAD (10 TABS)
- MAVENCLAD (4 TABS)
- MAVENCLAD (5 TABS)
- MAVENCLAD (6 TABS)
- MAVENCLAD (7 TABS)
- MAVENCLAD (8 TABS)
- MAVENCLAD (9 TABS)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	48 WEEKS.
Other Criteria	RELAPSING FORM OF MULTIPLE SCLEROSIS (MS): HAS NOT RECEIVED A TOTAL OF TWO YEARS OF MAVENCLAD TREATMENT (I.E., TWO YEARLY TREATMENT COURSES OF TWO CYCLES IN EACH).
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

CLOBAZAM-SYMPAZAN

Products Affected

- SYMPAZAN

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	LENNOX-GASTAUT SYNDROME (LGS): THERAPY IS PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST.
Coverage Duration	12 MONTHS
Other Criteria	LGS: 1) UNABLE TO TAKE TABLETS OR SUSPENSIONS, AND 2) TRIAL OF OR CONTRAINDICATION TO A FORMULARY VERSION OF CLOBAZAM.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

COBIMETINIB

Products Affected

- COTELLIC

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

CORTICOTROPIN

Products Affected

- ACTHAR
- ACTHAR GEL SUBCUTANEOUS PEN-INJECTOR 40 UNIT/0.5ML, 80 UNIT/ML
- CORTROPHIN

PA Criteria	Criteria Details
Exclusion Criteria	INITIAL: NOT APPROVED FOR DIAGNOSTIC PURPOSES.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	INITIAL: ALL FDA APPROVED INDICATIONS EXCEPT INFANTILE SPASMS AND MULTIPLE SCLEROSIS (MS): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST, DERMATOLOGIST, ALLERGIST/IMMUNOLOGIST, OPHTHALMOLOGIST, PULMONOLOGIST OR NEPHROLOGIST.
Coverage Duration	INFANTILE SPASMS AND MS: 28 DAYS. ALL OTHER FDA APPROVED INDICATIONS: INITIAL/RENEWAL: 12 MONTHS.
Other Criteria	INITIAL: ALL FDA APPROVED INDICATIONS EXCEPT INFANTILE SPASMS: TRIAL OF OR CONTRAINDICATION TO INTRAVENOUS (IV) CORTICOSTEROIDS. RENEWAL: ALL FDA APPROVED INDICATIONS EXCEPT INFANTILE SPASMS AND MS: DEMONSTRATED CLINICAL BENEFIT WHILE ON THERAPY AS INDICATED BY SYMPTOM RESOLUTION AND/OR NORMALIZATION OF LABORATORY TESTS. PART B BEFORE PART D STEP THERAPY, APPLIES ONLY TO BENEFICIARIES IN AN MA-PD PLAN.
Indications	All FDA-approved Indications.
Off Label Uses	

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

PA Criteria	Criteria Details
Part B Prerequisite	Yes

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

CRIZOTINIB CAPSULE

Products Affected

- XALKORI ORAL CAPSULE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

CRIZOTINIB PELLETS

Products Affected

- 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	12 MONTHS
Other Criteria	NON-SMALL CELL LUNG CANCER (NSCLC), ANAPLASTIC LARGE CELL LYMPHOMA (ALCL), INFLAMMATORY MYOFIBROBLASTIC TUMOR (IMT); UNABLE TO SWALLOW CAPSULES.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

DABRAFENIB CAPSULES

Products Affected

- TAFINLAR ORAL CAPSULE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

DABRAFENIB SUSPENSION

Products Affected

- TAFINLAR ORAL TABLET SOLUBLE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	UNABLE TO SWALLOW TAFINLAR CAPSULES.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

DACOMITINIB

Products Affected

- VIZIMPRO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	METASTATIC NON-SMALL CELL LUNG CANCER (NSCLC): NOT ON CONCURRENT THERAPY WITH AN EGFR TYROSINE KINASE-INHIBITOR.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

DALFAMPRIDINE

Products Affected

- dalfampridine er*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	MULTIPLE SCLEROSIS (MS): INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST.
Coverage Duration	INITIAL: 3 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	MS: INITIAL: HAS SYMPTOMS OF A WALKING DISABILITY SUCH AS MILD TO MODERATE BILATERAL LOWER EXTREMITY WEAKNESS OR UNILATERAL WEAKNESS PLUS LOWER EXTREMITY OR TRUNCAL ATAXIA. RENEWAL: IMPROVEMENT IN WALKING ABILITY.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

DAROLUTAMIDE

Products Affected

- NUBEQA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL/RENEWAL: 12 MONTHS
Other Criteria	INITIAL: NON-METASTATIC CASTRATION-RESISTANT PROSTATE CANCER (NMCRPC): HIGH RISK PROSTATE CANCER (I.E., RAPIDLY INCREASING PROSTATE SPECIFIC ANTIGEN [PSA] LEVELS). NMCRPC, METASTATIC HORMONE-SENSITIVE PROSTATE CANCER (MHSPC): 1) RECEIVED A BILATERAL ORCHIECTOMY, 2) CASTRATE LEVEL OF TESTOSTERONE (I.E., LESS THAN 50 NG/DL), OR 3) CONCURRENT USE WITH A GONADOTROPIN RELEASING HORMONE (GNRH) ANALOG. RENEWAL: NMCRPC, MHSPC: 1) RECEIVED A BILATERAL ORCHIECTOMY, 2) CASTRATE LEVEL OF TESTOSTERONE (I.E., LESS THAN 50 NG/DL), OR 3) CONCURRENT USE WITH A GNRH ANALOG.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

DASATINIB

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	PREVIOUSLY TREATED PHILADELPHIA CHROMOSOME-POSITIVE CHRONIC MYELOID LEUKEMIA (Ph+ CML): MUTATIONAL ANALYSIS PRIOR TO INITIATION AND DASATINIB IS APPROPRIATE PER NCCN GUIDELINE TABLE FOR TREATMENT RECOMMENDATIONS BASED ON BCR-ABL1 MUTATION PROFILE.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

DATOPOTAMAB DERUXTECAN-DLNK

Products Affected

- DATROWAY

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
 Last Updated: 05/27/2025
 Effective: 06/01/2025
 H9306_25_DRS_001_002_OE_C

DECITABINE/CEDAZURIDINE

Products Affected

- INQOVI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
 Last Updated: 05/27/2025
 Effective: 06/01/2025
 H9306_25_DRS_001_002_OE_C

DEFERASIROX

Products Affected

- *deferasirox granules*
- *deferasirox oral tablet*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: CHRONIC IRON OVERLOAD DUE TO BLOOD TRANSFUSIONS: SERUM FERRITIN LEVEL CONSISTENTLY ABOVE 1000 MCG/L (AT LEAST TWO LAB VALUES IN THE PREVIOUS THREE MONTHS). CHRONIC IRON OVERLOAD IN NON-TRANSFUSION DEPENDENT THALASSEMIA (NTDT): 1) SERUM FERRITIN LEVEL CONSISTENTLY ABOVE 300 MCG/L (AT LEAST TWO LAB VALUES IN THE PREVIOUS THREE MONTHS), AND 2) LIVER IRON CONCENTRATION (LIC) OF 5 MG FE/G OF DRY LIVER WEIGHT OR GREATER. RENEWAL: CHRONIC IRON OVERLOAD DUE TO BLOOD TRANSFUSIONS: SERUM FERRITIN LEVEL CONSISTENTLY ABOVE 500 MCG/L (AT LEAST TWO LAB VALUES IN THE PREVIOUS THREE MONTHS). NTDT: 1) SERUM FERRITIN LEVEL CONSISTENTLY ABOVE 300 MCG/L (AT LEAST TWO LAB VALUES IN THE PREVIOUS THREE MONTHS) OR 2) LIC OF 3 MG FE/G OF DRY LIVER WEIGHT OR GREATER.
Age Restrictions	
Prescriber Restrictions	INITIAL (CHRONIC IRON OVERLOAD): PRESCRIBED BY OR IN CONSULTATION WITH A HEMATOLOGIST OR HEMATOLOGIST/ONCOLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	INITIAL (CHRONIC IRON OVERLOAD): DEFERASIROX SPRINKLE PACKETS: TRIAL OF OR CONTRAINDICATION TO GENERIC DEFERASIROX ORAL TABLET OR TABLET FOR ORAL SUSPENSION.
Indications	All FDA-approved Indications.

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H9306_25_DRS_001_002_OE_C

PA Criteria	Criteria Details
Off Label Uses	
Part B Prerequisite	No

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H9306_25_DRS_001_002_OE_C

DENOSUMAB-XGEVA

Products Affected

- XGEVA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

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 H9306_25_DRS_001_002_OE_C

DEUTETRABENAZINE

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	HUNTINGTON DISEASE: PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST OR MOVEMENT DISORDER SPECIALIST. TARDIVE DYSKINESIA: PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST, PSYCHIATRIST, OR MOVEMENT DISORDER SPECIALIST.
Coverage Duration	12 MONTHS
Other Criteria	TARDIVE DYSKINESIA: HISTORY OF USING AGENTS THAT CAUSE TARDIVE DYSKINESIA.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

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H9306_25_DRS_001_002_OE_C

DICLOFENAC TOPICAL SOLUTION

Products Affected

- *diclofenac sodium external solution 2 %*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 MONTHS
Other Criteria	OSTEOARTHRITIS OF THE KNEE: TRIAL OF OR CONTRAINDICATION TO A FORMULARY VERSION OF DICLOFENAC SODIUM 1% TOPICAL GEL AND A FORMULARY VERSION OF DICLOFENAC SODIUM 1.5% TOPICAL DROPS.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

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 H9306_25_DRS_001_002_OE_C

DICLOFENAC-FLECTOR

Products Affected

- *diclofenac epolamine external*

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

Formulary ID: 25489
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H9306_25_DRS_001_002_OE_C

DIMETHYL FUMARATE

Products Affected

- *dimethyl fumarate oral capsule delayed release 120 mg, 240 mg*
- *dimethyl fumarate starter pack oral capsule delayed release therapy pack*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
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H9306_25_DRS_001_002_OE_C

DIROXIMEL FUMARATE

Products Affected

- VUMERITY

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

DOSTARLIMAB-GXLY

Products Affected

- JEMPERLI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
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H9306_25_DRS_001_002_OE_C

DRONABINOL CAPSULE

Products Affected

- dronabinol*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 MONTHS
Other Criteria	NAUSEA AND VOMITING ASSOCIATED WITH CANCER CHEMOTHERAPY: TRIAL OF OR CONTRAINDICATION TO ONE ANTIEMETIC THERAPY. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D FOR THE INDICATION OF NAUSEA AND VOMITING ASSOCIATED WITH CANCER CHEMOTHERAPY.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
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H9306_25_DRS_001_002_OE_C

DROXIDOPA

Products Affected

- droxidopa*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	NEUROGENIC ORTHOSTATIC HYPOTENSION (NOH): INITIAL: 1) BASELINE BLOOD PRESSURE READINGS WHILE THE PATIENT IS SITTING AND ALSO WITHIN 3 MINUTES OF STANDING FROM A SUPINE POSITION. 2) A DECREASE OF AT LEAST 20 MMHG IN SYSTOLIC BLOOD PRESSURE OR 10 MMHG DIASTOLIC BLOOD PRESSURE WITHIN THREE MINUTES AFTER STANDING FROM A SITTING POSITION.
Age Restrictions	
Prescriber Restrictions	NOH: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST OR CARDIOLOGIST.
Coverage Duration	INITIAL: 3 MONTHS RENEWAL: 12 MONTHS
Other Criteria	NOH: RENEWAL: CONTINUES TO BENEFIT FROM THE MEDICATION.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
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H9306_25_DRS_001_002_OE_C

DUPILUMAB

Products Affected

- DUPIXENT SUBCUTANEOUS SOLUTION AUTO-INJECTOR
- DUPIXENT SUBCUTANEOUS SOLUTION PREFILLED SYRINGE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: EOSINOPHILIC ASTHMA: BLOOD EOSINOPHIL LEVEL OF 150 TO 1500 CELLS/MCL WITHIN THE PAST 12 MONTHS. EOSINOPHILIC ESOPHAGITIS (EOE): DIAGNOSIS CONFIRMED BY ESOPHAGOGASTRODUODENOSCOPY (EGD) WITH BIOPSY. ATOPIC DERMATITIS (AD): AD COVERING AT LEAST 10 PERCENT OF BODY SURFACE AREA OR AD AFFECTING THE FACE, HEAD, NECK, HANDS, FEET, GROIN, OR INTERTRIGINOUS AREAS.
Age Restrictions	
Prescriber Restrictions	INITIAL: AD, PRURIGO NODULARIS (PN): PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST, ALLERGIST OR IMMUNOLOGIST. ASTHMA: PRESCRIBED BY OR IN CONSULTATION WITH A PHYSICIAN SPECIALIZING IN ALLERGY OR PULMONARY MEDICINE. CRSWNP: PRESCRIBED BY OR IN CONSULTATION WITH AN OTOLARYNGOLOGIST, ALLERGIST OR IMMUNOLOGIST. EOE: PRESCRIBED BY OR IN CONSULTATION WITH A GASTROENTEROLOGIST, ALLERGIST, OR IMMUNOLOGIST. EOSINOPHILIC COPD: PRESCRIBED BY OR IN CONSULTATION WITH A PULMONOLOGIST.
Coverage Duration	INITIAL: AD, CRSWNP, EOE, PN: 6 MOS, ASTHMA, COPD: 12 MOS. RENEWAL: ALL INDICATIONS: 12 MOS.
Other Criteria	INITIAL: AD: 1) INTRACTABLE PRURITUS OR CRACKING/OOZING/BLEEDING OF AFFECTED SKIN, 2) TRIAL OF OR CONTRAINDICATION TO ONE TOPICAL (CORTICOSTEROID, CALCINEURIN INHIBITOR, PDE4 INHIBITOR, OR JAK INHIBITOR), AND 3) NO CONCURRENT USE WITH OTHER SYSTEMIC BIOLOGICS OR JAK INHIBITORS FOR

Formulary ID: 25489

Last Updated: 05/27/2025

Effective: 06/01/2025

H9306_25_DRS_001_002_OE_C

PA Criteria	Criteria Details
	AD. ASTHMA: 1) CONCURRENT THERAPY WITH A MEDIUM, HIGH-DOSE OR MAXIMALLY-TOLERATED DOSE OF AN INHALED CORTICOSTEROID (ICS) AND ONE OTHER MAINTENANCE MEDICATION, 2) ONE ASTHMA EXACERBATION REQUIRING SYSTEMIC CORTICOSTEROID BURST LASTING 3 OR MORE DAYS WITHIN THE PAST 12 MONTHS, OR ONE SERIOUS EXACERBATION REQUIRING HOSPITALIZATION OR ER VISIT WITHIN THE PAST 12 MONTHS, OR POOR SYMPTOM CONTROL DESPITE CURRENT THERAPY AS EVIDENCED BY AT LEAST THREE OF THE FOLLOWING WITHIN THE PAST 4 WEEKS: (A) DAYTIME ASTHMA SYMPTOMS MORE THAN TWICE/WEEK, (B) ANY NIGHT WAKING DUE TO ASTHMA, (C) SABA RELIEVER FOR SYMPTOMS MORE THAN TWICE/WEEK, (D) ANY ACTIVITY LIMITATION DUE TO ASTHMA, AND 3) NO CONCURRENT USE WITH XOLAIR, TEZSPIRE, OR OTHER ANTI-IL5 BIOLOGICS WHEN USED FOR ASTHMA. CHRONIC RHINOSINUSITIS WITH NASAL POLYPS (CRSWNP): 1) A 56 DAY TRIAL OF ONE TOPICAL NASAL CORTICOSTEROID, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR AN AUTOIMMUNE INDICATION. PN: 1) CHRONIC PRURITIS (ITCH MORE THAN 6 WEEKS), MULTIPLE PRURIGINOUS LESIONS, AND HISTORY OR SIGN OF A PROLONGED SCRATCHING BEHAVIOR, AND 2) TRIAL OF OR CONTRAINDICATION TO ONE TOPICAL (CORTICOSTEROID OR CALCIPOTRIOL). EOSINOPHILIC COPD: 1) USED IN COMBINATION WITH A LAMA/LABA/ICS, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR EOSINOPHILIC COPD. RENEWAL: AD: 1) IMPROVEMENT WHILE ON THERAPY, AND 2) NO CONCURRENT USE WITH OTHER SYSTEMIC BIOLOGICS OR JAK INHIBITORS FOR AD. EOE: IMPROVEMENT WHILE ON THERAPY. CRSWNP: 1) IMPROVEMENT WHILE ON THERAPY, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR AN AUTOIMMUNE INDICATION. ASTHMA: 1) NO CONCURRENT USE WITH XOLAIR, TEZSPIRE, OR OTHER ANTI-IL5 BIOLOGICS FOR ASTHMA, 2) CONTINUED USE OF ICS AND ONE OTHER MAINTENANCE MEDICATION, AND 3) CLINICAL RESPONSE AS EVIDENCED BY: (A) REDUCTION IN ASTHMA EXACERBATIONS

Formulary ID: 25489

Last Updated: 05/27/2025

Effective: 06/01/2025

H9306_25_DRS_001_002_OE_C

PA Criteria	Criteria Details
	FROM BASELINE, (B) DECREASED UTILIZATION OF RESCUE MEDICATIONS, (C) INCREASE IN PERCENT PREDICTED FEV1 FROM PRETREATMENT BASELINE, OR (D) REDUCTION IN SEVERITY OR FREQUENCY OF ASTHMA-RELATED SYMPTOMS. PN: IMPROVEMENT OR REDUCTION OF PRURITIS OR PRURIGINOUS LESIONS. EOSINOPHILIC COPD: 1) USED IN COMBINATION WITH A LAMA/LABA/ICS, 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR EOSINOPHILIC COPD, AND 3) CLINICAL RESPONSE AS EVIDENCED BY (A) REDUCTION IN COPD EXACERBATIONS FROM BASELINE, (B) REDUCTION IN SEVERITY OR FREQUENCY OF COPD-RELATED SYMPTOMS, OR (C) INCREASE IN FEV1 OF AT LEAST 5 PERCENT FROM PRETREATMENT BASELINE.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

DUVELISIB

Products Affected

- COPIKTRA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
 Last Updated: 05/27/2025
 Effective: 06/01/2025
 H9306_25_DRS_001_002_OE_C

EFLORNITHINE

Products Affected

- IWILFIN

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

Formulary ID: 25489
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 H9306_25_DRS_001_002_OE_C

ELACESTRANT

Products Affected

- ORSERDU ORAL TABLET 345 MG, 86 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
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Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

ELAGOLIX

Products Affected

- ORLISSA ORAL TABLET 150 MG, 200 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	MODERATE TO SEVERE PAIN ASSOCIATED WITH ENDOMETRIOSIS: INITIAL: DIAGNOSIS IS CONFIRMED VIA SURGICAL OR DIRECT VISUALIZATION (E.G., PELVIC ULTRASOUND) OR HISTOPATHOLOGICAL CONFIRMATION (E.G., LAPAROSCOPY OR LAPAROTOMY) IN THE LAST 10 YEARS.
Age Restrictions	MODERATE TO SEVERE PAIN ASSOCIATED WITH ENDOMETRIOSIS: INITIAL: 18 YEARS OF AGE OR OLDER.
Prescriber Restrictions	MODERATE TO SEVERE PAIN ASSOCIATED WITH ENDOMETRIOSIS: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH AN OBSTETRICIAN/GYNECOLOGIST.
Coverage Duration	INITIAL: 6 MONTHS, RENEWAL: 12 MONTHS
Other Criteria	MODERATE TO SEVERE PAIN ASSOCIATED WITH ENDOMETRIOSIS: INITIAL: 1) NO CONCURRENT USE WITH ANOTHER GNRH-MODULATING AGENT, AND 2) TRIAL OF OR CONTRAINDICATION TO AN NSAID AND A PROGESTIN-CONTAINING PREPARATION. RENEWAL: 1) IMPROVEMENT IN PAIN ASSOCIATED WITH ENDOMETRIOSIS WHILE ON THERAPY, AND 2) NO CONCURRENT USE WITH ANOTHER GNRH-MODULATING AGENT
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489

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H9306_25_DRS_001_002_OE_C

ELRANATAMAB-BCMM

Products Affected

- ELREXFIO SUBCUTANEOUS SOLUTION 44 MG/1.1ML, 76 MG/1.9ML

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	RELAPSED OR REFRACTORY MULTIPLE MYELOMA: RENEWAL: 1) HAS RECEIVED AT LEAST 24 WEEKS OF TREATMENT WITH ELREXFIO, AND 2) HAS RESPONDED TO TREATMENT (PARTIAL RESPONSE OR BETTER), AND HAS MAINTAINED THIS RESPONSE FOR AT LEAST 2 MONTHS. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

ELTROMBOPAG - ALVAIZ

Products Affected

- ALVAIZ

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	PERSISTENT OR CHRONIC IMMUNE THROMBOCYTOPENIA (ITP): INITIAL: 1) PLATELET COUNT IS LESS THAN $30 \times 10^9/L$ FROM AT LEAST 2 SEPARATE LABS IN THE LAST 3 MONTHS, OR 2) PLATELET COUNT IS LESS THAN $50 \times 10^9/L$ FROM AT LEAST 2 SEPARATE LABS IN THE LAST 3 MONTHS AND HAD A PRIOR BLEEDING EVENT.
Age Restrictions	
Prescriber Restrictions	INITIAL: ITP: PRESCRIBED BY OR IN CONSULTATION WITH A HEMATOLOGIST OR IMMUNOLOGIST.
Coverage Duration	ITP: INITIAL: 6 MO, RENEWAL: 12 MO. HEPATITIS C, SEVERE APLASTIC ANEMIA: 12 MO.
Other Criteria	INITIAL: ITP: 1) TRIAL OF OR CONTRAINDICATION TO ONE CORTICOSTEROID OR IMMUNOGLOBULIN, OR AN INSUFFICIENT RESPONSE TO SPLENECTOMY, AND 2) NO CONCURRENT USE WITH OTHER THROMBOPOIETIN RECEPTOR AGONISTS (TPO-RAS) OR SPLEEN TYROSINE KINASE (SYK) INHIBITOR. RENEWAL: ITP: 1) IMPROVEMENT IN PLATELET COUNT FROM BASELINE OR REDUCTION IN BLEEDING EVENTS, AND 2) NO CONCURRENT USE WITH OTHER TPO-RAS OR SYK INHIBITOR.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

ELTROMBOPAG - 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
Exclusion Criteria	
Required Medical Information	PERSISTENT OR CHRONIC IMMUNE THROMBOCYTOPENIA (ITP): INITIAL: 1) PLATELET COUNT OF LESS THAN $30 \times 10^9/L$ FROM AT LEAST 2 SEPARATE LAB TESTS IN THE LAST 3 MONTHS, OR 2) PLATELET COUNT OF LESS THAN $50 \times 10^9/L$ FROM AT LEAST 2 SEPARATE LAB TESTS IN THE LAST 3 MONTHS AND A PRIOR BLEEDING EVENT.
Age Restrictions	
Prescriber Restrictions	INITIAL: ITP: PRESCRIBED BY OR IN CONSULTATION WITH A HEMATOLOGIST OR IMMUNOLOGIST.
Coverage Duration	ITP: INITIAL: 6 MO, RENEWAL: 12 MO. HEPATITIS C, SEVERE APLASTIC ANEMIA: 12 MO.
Other Criteria	INITIAL: ITP: 1) TRIAL OF OR CONTRAINDICATION TO ONE CORTICOSTEROID OR IMMUNOGLOBULIN, OR HAD AN INSUFFICIENT RESPONSE TO SPLENECTOMY, AND 2) NO CONCURRENT USE WITH OTHER THROMBOPOIETIN RECEPTOR AGONISTS (TPO-RAS) OR SPLEEN TYROSINE KINASE (SYK) INHIBITOR. ALL INDICATIONS: APPROVAL FOR PROMACTA ORAL SUSPENSION PACKETS REQUIRES A TRIAL OF PROMACTA TABLET OR PATIENT IS UNABLE TOLERATE TABLET FORMULATION. RENEWAL: ITP: 1) IMPROVEMENT IN PLATELET COUNTS FROM BASELINE OR REDUCTION IN BLEEDING EVENTS, AND 2) NO CONCURRENT USE WITH OTHER TPO-RAS OR SYK INHIBITOR.
Indications	All FDA-approved Indications.
Off Label Uses	

Formulary ID: 25489

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H9306_25_DRS_001_002_OE_C

PA Criteria	Criteria Details
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

ENASIDENIB

Products Affected

- IDHIFA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
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Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

ENCORAFENIB

Products Affected

- BRAFTOVI ORAL CAPSULE 75 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
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H9306_25_DRS_001_002_OE_C

ENTRECTINIB CAPSULES

Products Affected

- ROZLYTREK ORAL CAPSULE 100 MG, 200 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
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H9306_25_DRS_001_002_OE_C

ENTRECTINIB PELLETS

Products Affected

- ROZLYTREK ORAL PACKET

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	METASTATIC NON-SMALL CELL LUNG CANCER (NSCLC), SOLID TUMORS: 1) TRIAL OF OR CONTRAINDICATION TO ROZLYTREK CAPSULES MADE INTO AN ORAL SUSPENSION, AND 2) DIFFICULTY OR UNABLE TO SWALLOW CAPSULES.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

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H9306_25_DRS_001_002_OE_C

ENZALUTAMIDE

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	INITIAL: ALL INDICATIONS: 12 MONTHS. RENEWAL: MCRPC, NMCRPC, MCSPC: 12 MONTHS.
Other Criteria	INITIAL: NON-METASTATIC CASTRATION-RESISTANT PROSTATE CANCER (NMCRPC): HIGH RISK PROSTATE CANCER (I.E. RAPIDLY INCREASING PROSTATE SPECIFIC ANTIGEN [PSA] LEVELS). NON-METASTATIC CASTRATION-SENSITIVE PROSTATE CANCER (NMCSPC): HIGH RISK FOR METASTASIS (I.E. PSA DOUBLING TIME OF 9 MONTHS OR LESS). METASTATIC CRPC (MCRPC), NMCRPC, METASTATIC CSPC (MCSPC), NMCSPC : 1) RECEIVED A BILATERAL ORCHIECTOMY, 2) CASTRATE LEVEL OF TESTOSTERONE (I.E., LESS THAN 50 NG/DL), OR 3) CONCURRENT USE WITH A GONADOTROPIN RELEASING HORMONE (GNRH) ANALOG. RENEWAL: MCRPC, NMCRPC, MCSPC: 1) RECEIVED A BILATERAL ORCHIECTOMY, 2) CASTRATE LEVEL OF TESTOSTERONE (I.E., LESS THAN 50 NG/DL), OR 3) CONCURRENT USE WITH A GNRH ANALOG.
Indications	All FDA-approved Indications.
Off Label Uses	

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H9306_25_DRS_001_002_OE_C

PA Criteria	Criteria Details
Part B Prerequisite	No

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H9306_25_DRS_001_002_OE_C

EPCORITAMAB-BYSP

Products Affected

- EPKINLY

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
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 H9306_25_DRS_001_002_OE_C

EPOETIN ALFA-EPBX

Products Affected

- RETACRIT INJECTION SOLUTION UNIT/ML, 4000 UNIT/ML, 40000
10000 UNIT/ML, 10000 UNIT/ML(1ML), UNIT/ML
2000 UNIT/ML, 20000 UNIT/ML, 3000

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: CHRONIC KIDNEY DISEASE (CKD), ANEMIA RELATED TO ZIDOVUDINE, OR CANCER CHEMOTHERAPY: HEMOGLOBIN LEVEL IS LESS THAN 10G/DL. ELECTIVE, NON-CARDIAC, NON-VASCULAR SURGERY: HEMOGLOBIN LEVEL IS LESS THAN 13G/DL. RENEWAL: 1) CKD IN ADULTS NOT ON DIALYSIS: (A) HEMOGLOBIN LEVEL IS LESS THAN 10G/DL, OR (B) HEMOGLOBIN LEVEL HAS REACHED 10G/DL AND THE DOSE IS BEING OR HAS BEEN REDUCED/INTERRUPTED TO DECREASE THE NEED FOR BLOOD TRANSFUSIONS. 2) CKD IN PEDIATRIC PATIENTS: (A) HEMOGLOBIN LEVEL IS LESS THAN 10G/DL, OR (B) HEMOGLOBIN LEVEL HAS APPROACHED OR EXCEEDS 12G/DL AND THE DOSE IS BEING OR HAS BEEN REDUCED/INTERRUPTED TO DECREASE THE NEED FOR BLOOD TRANSFUSIONS. 3) ANEMIA RELATED TO ZIDOVUDINE: HEMOGLOBIN LEVEL BETWEEN 10G/DL AND 12G/DL. 4) CANCER CHEMOTHERAPY: (A) HEMOGLOBIN LEVEL IS LESS THAN 10 G/DL, OR (B) HEMOGLOBIN LEVEL DOES NOT EXCEED A LEVEL NEEDED TO AVOID RBC TRANSFUSION.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	ANEMIA FROM CHEMO/CKD WITHOUT DIALYSIS/ZIDOVUDINE: INITIAL/RENEWAL: 12 MONTHS. SURGERY: 1 MONTH.
Other Criteria	RENEWAL: CKD: NOT RECEIVING DIALYSIS TREATMENT. THIS DRUG MAY BE EITHER BUNDLED WITH AND COVERED UNDER END STAGE RENAL DISEASE DIALYSIS RELATED SERVICES OR

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

PA Criteria	Criteria Details
	COVERED UNDER MEDICARE D DEPENDING UPON THE CIRCUMSTANCES.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

ERDAFITINIB

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	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

ERENUMAB-AOOE

Products Affected

- AIMOVIG

PA Criteria	Criteria Details
Exclusion Criteria	PA Criteria: Pending CMS Approval
Required Medical Information	PA Criteria: Pending CMS Approval
Age Restrictions	PA Criteria: Pending CMS Approval
Prescriber Restrictions	PA Criteria: Pending CMS Approval
Coverage Duration	PA Criteria: Pending CMS Approval
Other Criteria	PA Criteria: Pending CMS Approval
Indications	PA Criteria: Pending CMS Approval
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

ERLOTINIB

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	12 MONTHS
Other Criteria	METASTATIC NON-SMALL CELL LUNG CANCER (NSCLC) WITH EGFR MUTATION: NOT ON CONCURRENT THERAPY WITH AN EGFR TYROSINE KINASE INHIBITOR.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

ESKETAMINE

Products Affected

- SPRAVATO (56 MG DOSE)
- SPRAVATO (84 MG DOSE)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	INITIAL: TREATMENT-RESISTANT DEPRESSION (TRD), MAJOR DEPRESSIVE DISORDER (MDD): PRESCRIBED BY OR IN CONSULTATION WITH A PSYCHIATRIST.
Coverage Duration	INITIAL: TRD: 3 MONTHS. MDD: 4 WEEKS. RENEWAL: TRD, MDD: 12 MONTHS.
Other Criteria	INITIAL: TRD, MDD: 1) NON-PSYCHOTIC, UNIPOLAR DEPRESSION, AND 2) NO ACTIVE SUBSTANCE ABUSE. RENEWAL: TRD, MDD: DEMONSTRATED CLINICAL BENEFIT (IMPROVEMENT IN DEPRESSION) COMPARED TO BASELINE.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

ETANERCEPT

Products Affected

- ENBREL MINI
- ENBREL SUBCUTANEOUS SOLUTION 25 MG/0.5ML
- ENBREL SUBCUTANEOUS SOLUTION PREFILLED SYRINGE
- ENBREL SUBCUTANEOUS SOLUTION RECONSTITUTED
- ENBREL SURECLICK SUBCUTANEOUS SOLUTION AUTO-INJECTOR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: PLAQUE PSORIASIS (PSO): PSORIASIS COVERING 3 PERCENT OR MORE OF BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, FACE, SCALP, OR GENITAL AREA.
Age Restrictions	
Prescriber Restrictions	INITIAL: RHEUMATOID ARTHRITIS (RA), POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS (PJIA), ANKYLOSING SPONDYLITIS (AS): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST. PSORIATIC ARTHRITIS (PSA): PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST OR RHEUMATOLOGIST. PSO: PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST.
Coverage Duration	INITIAL: 6 MONTHS, RENEWAL: 12 MONTHS.
Other Criteria	INITIAL: RA: TRIAL OF OR CONTRAINDICATION TO 3 MONTHS OF TREATMENT WITH ONE DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG) - IF PATIENT TRIED METHOTREXATE, THEN TRIAL AT A DOSE GREATER THAN OR EQUAL TO 20 MG PER WEEK OR MAXIMALLY TOLERATED DOSE IS REQUIRED. PJIA: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR PJIA. PSA: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR PSA. AS: 1) TRIAL OF OR

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

PA Criteria	Criteria Details
	CONTRAINDICATION TO AN NSAID, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR AS. PSO: 1) ONE OF THE FOLLOWING: (A) AT LEAST A 3 MONTH TRIAL OF ONE ORAL IMMUNOSUPPRESSANT (CYCLOSPORINE, METHOTREXATE, TACROLIMUS) OR PUVA (PHOTOTHERAPY) FOR THE TREATMENT OF PSO, (B) CONTRAINDICATION OR INTOLERANCE TO BOTH IMMUNOSUPPRESSANT AND PUVA FOR THE TREATMENT OF PSO, OR (C) PATIENT IS SWITCHING FROM A DIFFERENT BIOLOGIC, PDE-4 INHIBITOR, OR JAK INHIBITOR FOR THE SAME INDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR PSO. RENEWAL: RA: CONTINUES TO BENEFIT FROM THE MEDICATION. PJIA: 1) CONTINUES TO BENEFIT FROM THE MEDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR PJIA. PSA: 1) CONTINUES TO BENEFIT FROM THE MEDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR PSA. AS: 1) CONTINUES TO BENEFIT FROM THE MEDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR AS. PSO: 1) CONTINUES TO BENEFIT FROM THE MEDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR PSO.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

EVEROLIMUS-AFINITOR

Products Affected

- everolimus oral tablet 10 mg, 2.5 mg, 5 mg, 7.5 mg
- torpenz oral tablet 10 mg, 2.5 mg, 5 mg, 7.5 mg

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

EVEROLIMUS-AFINITOR DISPERZ

Products Affected

- *everolimus oral tablet soluble*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

FECAL MICROBIOTA CAPSULE

Products Affected

- VOWST

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	30 DAYS
Other Criteria	CLOSTRIDIoidES DIFFICILE INFECTION (CDI): 1) HAS NOT PREVIOUSLY RECEIVED VOWST: COMPLETION OF ANTIBIOTIC TREATMENT FOR RECURRENT CDI (AT LEAST 3 CDI EPISODES), OR 2) PREVIOUSLY RECEIVED VOWST: (A) TREATMENT FAILURE (DEFINED AS THE PRESENCE OF CDI DIARRHEA WITHIN 8 WEEKS OF FIRST DOSE OF VOWST AND A POSITIVE STOOL TEST FOR C. DIFFICILE), AND (B) HAS NOT RECEIVED MORE THAN ONE TREATMENT COURSE OF VOWST WHICH WAS AT LEAST 12 DAYS AND NOT MORE THAN 8 WEEKS PRIOR.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

FEDRATINIB

Products Affected

- INREBIC

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS
Other Criteria	MYELOFIBROSIS: INITIAL: TRIAL OF OR CONTRAINDICATION TO JAKAFI (RUXOLITINIB). RENEWAL: CONTINUES TO BENEFIT FROM THE MEDICATION.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

FENFLURAMINE

Products Affected

- FINTEPLA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	INITIAL: DRAVET SYNDROME, LENNOX-GASTAUT SYNDROME (LGS): PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST.
Coverage Duration	DRAVET SYNDROME: INITIAL/RENEWAL: 12 MONTHS. LGS: 12 MONTHS.
Other Criteria	INITIAL: LGS: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING ANTIEPILEPTIC MEDICATIONS: RUFINAMIDE, FELBAMATE, CLOBAZAM, TOPIRAMATE, LAMOTRIGINE, CLONAZEPAM. RENEWAL: DRAVET SYNDROME: PATIENT HAS SHOWN CONTINUED CLINICAL BENEFIT (E.G. REDUCTION OF SEIZURES, REDUCED LENGTH OF SEIZURES, SEIZURE CONTROL MAINTAINED).
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

FENTANYL CITRATE

Products Affected

- *fentanyl citrate buccal lozenge on a handle*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	CANCER RELATED PAIN: 1) CURRENTLY ON A MAINTENANCE DOSE OF CONTROLLED-RELEASE OPIOID PAIN MEDICATION, AND 2) TRIAL OF OR CONTRAINDICATION TO AT LEAST ONE IMMEDIATE-RELEASE ORAL OPIOID PAIN AGENT OR PATIENT HAS DIFFICULTY SWALLOWING TABLETS/CAPSULES.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

FEZOLINETANT

Products Affected

- VEOZAH

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	MENOPAUSAL VASOMOTOR SYMPTOMS (VMS): INITIAL: 1) EXPERIENCES 7 OR MORE HOT FLASHES PER DAY, AND 2) TRIAL OF OR CONTRAINDICATION TO HORMONAL THERAPY (E.G., ESTRADIOL TRANSDERMAL PATCH, ORAL CONJUGATED ESTROGENS). RENEWAL: 1) CONTINUED NEED FOR VMS TREATMENT (I.E., PERSISTENT HOT FLASHES), AND 2) REDUCTION IN VMS FREQUENCY OR SEVERITY DUE TO VEOZAH TREATMENT.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

FILGRASTIM-AAFI

Products Affected

- NIVESTYM

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR IN CONSULTATION WITH A HEMATOLOGIST OR ONCOLOGIST.
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

FINERENONE

Products Affected

- KERENDIA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

FINGOLIMOD

Products Affected

- *fingolimod hcl*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

FOSCARBIDOPA-FOSLEVODOPA

Products Affected

- VYALEV SUBCUTANEOUS
SOLUTION 12-240 MG/ML

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	PARKINSONS DISEASE (PD): INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST.
Coverage Duration	INITIAL: 3 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	PD: INITIAL: 1) RESPONSIVE TO LEVODOPA, 2) CURRENT REGIMEN INCLUDES AT LEAST 400 MG/DAY OF LEVODOPA, AND 3) MOTOR SYMPTOMS ARE CURRENTLY UNCONTROLLED (DEFINED AS AN AVERAGE OFF TIME OF AT LEAST 2.5 HOURS/DAY OVER 3 CONSECUTIVE DAYS WITH A MINIMUM OF 2 HOURS EACH DAY). RENEWAL: IMPROVEMENT IN MOTOR SYMPTOMS WHILE ON THERAPY.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

FREMANEZUMAB-VFRM

Products Affected

- AJOVY

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL: 6 MONTHS, RENEWAL: 12 MONTHS.
Other Criteria	MIGRAINE PREVENTION: INITIAL: 1) TRIAL OF OR CONTRAINDICATION TO ONE OF THE FOLLOWING PREVENTIVE MIGRAINE TREATMENTS: DIVALPROEX SODIUM, TOPIRAMATE, PROPRANOLOL, TIMOLOL, AND 2) NO CONCURRENT USE WITH OTHER CGRP INHIBITORS FOR MIGRAINE PREVENTION. RENEWAL: 1) REDUCTION IN MIGRAINE OR HEADACHE FREQUENCY, MIGRAINE SEVERITY, OR MIGRAINE DURATION WITH THERAPY, AND 2) NO CONCURRENT USE WITH OTHER CGRP INHIBITORS FOR MIGRAINE PREVENTION.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

FRUQUINTINIB

Products Affected

- FRUZAQLA ORAL CAPSULE 1 MG, 5 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

FUTIBATINIB

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	INTRAHEPATIC CHOLANGIOCARCINOMA (ICCA): COMPLETE A COMPREHENSIVE OPHTHALMOLOGICAL EXAMINATION, INCLUDING OPTICAL COHERENCE TOMOGRAPHY (OCT), PRIOR TO THE INITIATION OF THERAPY AND AT THE RECOMMENDED SCHEDULED INTERVALS.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

GALCANEZUMAB-GNLM

Products Affected

- EMGALITY
- EMGALITY (300 MG DOSE)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL: MIGRAINE PREVENTION: 6 MOS. EPISODIC CLUSTER HEADACHE: 3 MOS. RENEWAL (ALL): 12 MOS.
Other Criteria	INITIAL: MIGRAINE PREVENTION: 1) NO CONCURRENT USE WITH OTHER CGRP INHIBITORS FOR MIGRAINE PREVENTION, AND 2) TRIAL OF OR CONTRAINDICATION TO ONE OF THE FOLLOWING PREVENTIVE MIGRAINE TREATMENTS: DIVALPROEX SODIUM, TOPIRAMATE, PROPRANOLOL, TIMOLOL. RENEWAL: MIGRAINE PREVENTION: 1) REDUCTION IN MIGRAINE OR HEADACHE FREQUENCY, MIGRAINE SEVERITY, OR MIGRAINE DURATION WITH THERAPY, AND 2) NO CONCURRENT USE WITH OTHER CGRP INHIBITORS FOR MIGRAINE PREVENTION. EPISODIC CLUSTER HEADACHE: IMPROVEMENT IN EPISODIC CLUSTER HEADACHE FREQUENCY AS COMPARED TO BASELINE.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

GANAXOLONE

Products Affected

- ZTALMY

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
 Last Updated: 05/27/2025
 Effective: 06/01/2025
 H9306_25_DRS_001_002_OE_C

GEFITINIB

Products Affected

- *gefitinib*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	METASTATIC NON-SMALL CELL LUNG CANCER (NSCLC) WITH EGFR MUTATION; NOT ON CONCURRENT THERAPY WITH AN EGFR TYROSINE KINASE INHIBITOR.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

GILTERITINIB

Products Affected

- XOSPATA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

GLASDEGIB

Products Affected

- DAURISMO ORAL TABLET 100 MG,
25 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

GLATIRAMER

Products Affected

- *glatiramer acetate subcutaneous solution prefilled syringe 20 mg/ml, 40 mg/ml*
- *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	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
 Last Updated: 05/27/2025
 Effective: 06/01/2025
 H9306_25_DRS_001_002_OE_C

GLP1-DULAGLUTIDE

Products Affected

- TRULICITY SUBCUTANEOUS
SOLUTION AUTO-INJECTOR

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

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

GLP1-SEMAGLUTIDE

Products Affected

- OZEMPIC (0.25 OR 0.5 MG/DOSE)
- OZEMPIC (1 MG/DOSE)
- OZEMPIC (2 MG/DOSE)
- RYBELSUS
- RYBELSUS (FORMULATION R2)

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

Formulary ID: 25489
 Last Updated: 05/27/2025
 Effective: 06/01/2025
 H9306_25_DRS_001_002_OE_C

GLP1-TIRZEPATIDE

Products Affected

- MOUNJARO SUBCUTANEOUS
SOLUTION AUTO-INJECTOR

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

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

GOSERELIN

Products Affected

- ZOLADEX

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	ENDOMETRIOSIS: DIAGNOSIS IS CONFIRMED VIA SURGICAL OR DIRECT VISUALIZATION (E.G., PELVIC ULTRASOUND) OR HISTOPATHOLOGICAL CONFIRMATION (E.G., LAPAROSCOPY OR LAPAROTOMY) IN THE LAST 10 YEARS.
Age Restrictions	
Prescriber Restrictions	ENDOMETRIOSIS: PRESCRIBED BY OR IN CONSULTATION WITH AN OBSTETRICIAN/GYNECOLOGIST.
Coverage Duration	STAGE B2-C PROSTATIC CARCINOMA: 4 MOS. ENDOMETRIOSIS: 6 MOS PER LIFETIME. ALL OTHERS: 12 MONTHS.
Other Criteria	ENDOMETRIOSIS: 1) NO CONCURRENT USE WITH ANOTHER GNRH-MODULATING AGENT, 2) TRIAL OF OR CONTRAINDICATION TO NSAID AND PROGESTIN-CONTAINING PREPARATION, AND 3) HAS NOT RECEIVED A TOTAL OF 6 MONTHS OF TREATMENT PER LIFETIME. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

GUSELKUMAB

Products Affected

- TREMFYA INTRAVENOUS
- TREMFYA ONE-PRESS
- TREMFYA PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 200 MG/2ML
- TREMFYA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: PLAQUE PSORIASIS (PSO): PSORIASIS COVERING 3 PERCENT OR MORE OF BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, FACE, SCALP, OR GENITAL AREA.
Age Restrictions	
Prescriber Restrictions	INITIAL: PSO: PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST. PSORIATIC ARTHRITIS (PSA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST OR DERMATOLOGIST. ULCERATIVE COLITIS (UC), CROHNS DISEASE (CD): PRESCRIBED BY OR IN CONSULTATION WITH A GASTROENTEROLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS
Other Criteria	INITIAL: PSA: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR PSA. PSO: 1) ONE OF THE FOLLOWING: (A) AT LEAST A 3 MONTH TRIAL OF ONE ORAL IMMUNOSUPPRESSANT (CYCLOSPORINE, METHOTREXATE, TACROLIMUS) OR PUVA (PHOTOTHERAPY) FOR THE TREATMENT OF PSO, (B) CONTRAINDICATION OR INTOLERANCE TO BOTH IMMUNOSUPPRESSANT AND PUVA FOR THE TREATMENT OF PSO, OR (C) PATIENT IS SWITCHING FROM A DIFFERENT BIOLOGIC, PDE-4 INHIBITOR, OR JAK INHIBITOR FOR THE SAME INDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

PA Criteria	Criteria Details
	TARGETED SMALL MOLECULES FOR PSO. UC: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR UC. CD: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR CD. RENEWAL: PSA: 1) CONTINUES TO BENEFIT FROM THE MEDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR PSA. PSO: 1) CONTINUES TO BENEFIT FROM THE MEDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR PSO. UC: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR UC. CD: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR CD.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

HIGH CONCENTRATION ORAL OPIOID SOLUTIONS

Products Affected

- *morphine sulfate (concentrate) oral solution 100 mg/5ml*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	OPIOID TOLERANT: 12 MONTHS. HOSPICE, PALLIATIVE CARE OR END OF LIFE CARE: LIFETIME.
Other Criteria	1) OPIOID TOLERANT (I.E. PREVIOUS USE OF 60 MG ORAL MORPHINE PER DAY, 25 MCG TRANSDERMAL FENTANYL PER HOUR, 30 MG ORAL OXYCODONE PER DAY, 8 MG ORAL HYDROMORPHONE PER DAY, 25 MG ORAL OXYMORPHONE PER DAY, 60 MG ORAL HYDROCODONE PER DAY, OR AN EQUIANALGESIC DOSE OF ANOTHER OPIOID) AND HAS TROUBLE SWALLOWING OPIOID TABLETS, CAPSULES, OR LARGE VOLUMES OF LIQUID, OR 2) ENROLLED IN HOSPICE OR PALLIATIVE CARE OR END OF LIFE CARE.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

IBRUTINIB

Products Affected

- IMBRUVICA ORAL CAPSULE 140 MG, 70 MG
- IMBRUVICA ORAL SUSPENSION
- IMBRUVICA ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

ICATIBANT

Products Affected

- *icatibant acetate*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	HEREDITARY ANGIOEDEMA (HAE): DIAGNOSIS CONFIRMED BY COMPLEMENT TESTING.
Age Restrictions	
Prescriber Restrictions	HAE: PRESCRIBED BY OR IN CONSULTATION WITH AN ALLERGIST, IMMUNOLOGIST, OR HEMATOLOGIST.
Coverage Duration	12 MONTHS
Other Criteria	HAE: NO CONCURRENT USE WITH OTHER MEDICATIONS FOR TREATMENT OF ACUTE HAE ATTACKS.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

IDEALISIB

Products Affected

- ZYDELIG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

IMATINIB

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	ADJUVANT GASTROINTESTINAL STROMAL TUMOR TREATMENT: 36 MONTHS. ALL OTHER DIAGNOSES: 12 MONTHS.
Other Criteria	PHILADELPHIA CHROMOSOME POSITIVE CHRONIC MYELOID LEUKEMIA: PATIENT HAS NOT RECEIVED A PREVIOUS TREATMENT WITH ANOTHER TYROSINE KINASE INHIBITOR.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

IMATINIB SOLUTION

Products Affected

- IMKELDI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	ADJUVANT GASTROINTESTINAL STROMAL TUMOR TREATMENT: 36 MONTHS. ALL OTHER DIAGNOSES: 12 MONTHS.
Other Criteria	PHILADELPHIA CHROMOSOME POSITIVE CHRONIC MYELOID LEUKEMIA: PATIENT HAS NOT RECEIVED A PREVIOUS TREATMENT WITH ANOTHER TYROSINE KINASE INHIBITOR. ALL INDICATIONS: UNABLE TO SWALLOW GENERIC IMATINIB TABLETS.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

IMETELSTAT

Products Affected

- RYTELO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

INAVOLISIB

Products Affected

- ITOVEBI ORAL TABLET 3 MG, 9 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

INFLIXIMAB

Products Affected

- infliximab*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: PLAQUE PSORIASIS (PSO): PSORIASIS COVERING 3 PERCENT OR MORE OF BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, GENITAL AREA, SCALP, OR FACE.
Age Restrictions	
Prescriber Restrictions	INITIAL: RHEUMATOID ARTHRITIS (RA), ANKYLOSING SPONDYLITIS (AS): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST. PSORIATIC ARTHRITIS (PSA): PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST OR RHEUMATOLOGIST. PSO: PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST. CROHNS DISEASE (CD), ULCERATIVE COLITIS (UC): PRESCRIBED BY OR IN CONSULTATION WITH A GASTROENTEROLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	INITIAL: RA: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: ENBREL, HUMIRA/CYLTEZO/YUFLYMA, XELJANZ, RINVOQ, ORENCIA. PSA: 1) TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: COSENTYX, ENBREL, HUMIRA/CYLTEZO/YUFLYMA, STELARA/SELARSDI/YESINTEK, XELJANZ, RINVOQ, SKYRIZI, TREMFYA, ORENCIA, OTEZLA, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR PSA. PSO: 1) TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: COSENTYX, ENBREL, HUMIRA/CYLTEZO/YUFLYMA, STELARA/SELARSDI/YESINTEK,

Formulary ID: 25489

Last Updated: 05/27/2025

Effective: 06/01/2025

H9306_25_DRS_001_002_OE_C

PA Criteria	Criteria Details
	SKYRIZI, TREMFYA, OTEZLA, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR PSO. AS: 1) TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: COSENTYX, ENBREL, HUMIRA/CYLTEZO/YUFLYMA, XELJANZ, RINVOQ, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR AS. MODERATE TO SEVERE CD: 1) TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS, WHERE AGES ALIGN: STELARA/SELARSDI/YESINTEK, HUMIRA/CYLTEZO/YUFLYMA, RINVOQ, SKYRIZI, TREMFYA, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR CD. UC: 1) TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS, WHERE AGES ALIGN: STELARA/SELARSDI/YESINTEK, XELJANZ, HUMIRA/CYLTEZO/YUFLYMA, RINVOQ, SKYRIZI, TREMFYA, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR UC. RENEWAL: RA: CONTINUES TO BENEFIT FROM THE MEDICATION. PSA: 1) CONTINUES TO BENEFIT FROM THE MEDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR PSA. PSO: 1) CONTINUES TO BENEFIT FROM THE MEDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR PSO. AS: 1) CONTINUES TO BENEFIT FROM THE MEDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR AS. MODERATE TO SEVERE CD: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR CD. UC: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR UC. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

PA Criteria	Criteria Details
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

INSULIN SUPPLIES PAYMENT DETERMINATION

Products Affected

- ABOUTTIME PEN NEEDLE 30G X 8 MM
- ABOUTTIME PEN NEEDLE 31G X 5 MM
- ABOUTTIME PEN NEEDLE 31G X 8 MM
- ABOUTTIME PEN NEEDLE 32G X 4 MM
- ADVOCATE INSULIN PEN NEEDLE 32G X 4 MM
- ADVOCATE INSULIN PEN NEEDLES 29G X 12.7MM
- ADVOCATE INSULIN PEN NEEDLES 31G X 5 MM
- ADVOCATE INSULIN PEN NEEDLES 31G X 8 MM
- ADVOCATE INSULIN PEN NEEDLES 33G X 4 MM
- ADVOCATE INSULIN SYRINGE 29G X 1/2" 0.3 ML
- ADVOCATE INSULIN SYRINGE 29G X 1/2" 0.5 ML
- ADVOCATE INSULIN SYRINGE 29G X 1/2" 1 ML
- ADVOCATE INSULIN SYRINGE 30G X 5/16" 0.3 ML
- ADVOCATE INSULIN SYRINGE 30G X 5/16" 0.5 ML
- ADVOCATE INSULIN SYRINGE 30G X 5/16" 1 ML
- ADVOCATE INSULIN SYRINGE 31G X 5/16" 0.3 ML
- ADVOCATE INSULIN SYRINGE 31G X 5/16" 0.5 ML
- ADVOCATE INSULIN SYRINGE 31G X 5/16" 1 ML
- ALCOHOL PREP PAD
- ALCOHOL PREP PAD 70 %
- ALCOHOL PREP PADS PAD 70 %
- ALCOHOL SWABS PAD
- ALCOHOL SWABS PAD 70 %
- AQ INSULIN SYRINGE 31G X 5/16" 1 ML
- AQINJECT PEN NEEDLE 31G X 5 MM
- AQINJECT PEN NEEDLE 32G X 4 MM
- ASSURE ID DUO PRO PEN NEEDLES 31G X 5 MM
- ASSURE ID INSULIN SAFETY SYR 29G X 1/2" 1 ML
- ASSURE ID INSULIN SAFETY SYR 29G X 1/2" 0.5 ML (OTC)
- ASSURE ID INSULIN SAFETY SYR 31G X 15/64" 0.5 ML
- ASSURE ID INSULIN SAFETY SYR 31G X 15/64" 1 ML
- ASSURE ID PRO PEN NEEDLES 30G X 5 MM
- AUM ALCOHOL PREP PADS PAD 70 %
- AUM INSULIN SAFETY PEN NEEDLE 31G X 4 MM
- AUM INSULIN SAFETY PEN NEEDLE 31G X 5 MM
- AUM MINI INSULIN PEN NEEDLE 32G X 4 MM
- AUM MINI INSULIN PEN NEEDLE 32G X 5 MM
- AUM MINI INSULIN PEN NEEDLE 32G X 6 MM
- AUM MINI INSULIN PEN NEEDLE 32G X 8 MM
- AUM MINI INSULIN PEN NEEDLE 33G X 4 MM

Formulary ID: 25489

Last Updated: 05/27/2025

Effective: 06/01/2025

H9306_25_DRS_001_002_OE_C

- AUM MINI INSULIN PEN NEEDLE 33G X 5 MM
- AUM MINI INSULIN PEN NEEDLE 33G X 6 MM
- AUM PEN NEEDLE 32G X 4 MM
- AUM PEN NEEDLE 32G X 5 MM
- AUM PEN NEEDLE 32G X 6 MM
- AUM PEN NEEDLE 33G X 4 MM
- AUM PEN NEEDLE 33G X 5 MM
- AUM PEN NEEDLE 33G X 6 MM
- AUM READYGARD DUO PEN NEEDLE 32G X 4 MM
- AUM SAFETY PEN NEEDLE 31G X 4 MM
- BD AUTOSHIELD 29G X 5MM
- BD AUTOSHIELD 29G X 8MM
- BD AUTOSHIELD DUO 30G X 5 MM
- BD ECLIPSE SYRINGE 30G X 1/2" 1 ML
- BD INSULIN SYR ULTRAFINE II 31G X 5/16" 0.3 ML
- BD INSULIN SYR ULTRAFINE II 31G X 5/16" 0.5 ML
- BD INSULIN SYR ULTRAFINE II 31G X 5/16" 1 ML
- BD INSULIN SYRINGE 27.5G X 5/8" 2 ML
- BD INSULIN SYRINGE 25G X 1" 1 ML
- BD INSULIN SYRINGE 25G X 5/8" 1 ML
- BD INSULIN SYRINGE 26G X 1/2" 1 ML
- BD INSULIN SYRINGE 27G X 1/2" 1 ML
- BD INSULIN SYRINGE 29G X 1/2" 0.5 ML (OTC)
- BD INSULIN SYRINGE 29G X 1/2" 0.5 ML (RX)
- BD INSULIN SYRINGE 29G X 1/2" 1 ML (OTC)
- BD INSULIN SYRINGE 29G X 1/2" 1 ML (RX)
- BD INSULIN SYRINGE HALF-UNIT 31G X 5/16" 0.3 ML
- BD INSULIN SYRINGE MICROFINE 27G X 5/8" 1 ML
- BD INSULIN SYRINGE MICROFINE 28G X 1/2" 0.5 ML
- BD INSULIN SYRINGE MICROFINE 28G X 1/2" 1 ML (OTC)
- BD INSULIN SYRINGE MICROFINE 28G X 1/2" 1 ML (RX)
- BD INSULIN SYRINGE U-100 1 ML
- BD INSULIN SYRINGE U-500
- BD INSULIN SYRINGE ULTRAFINE 29G X 1/2" 0.3 ML
- BD INSULIN SYRINGE ULTRAFINE 29G X 1/2" 0.5 ML
- BD INSULIN SYRINGE ULTRAFINE 29G X 1/2" 1 ML
- BD INSULIN SYRINGE ULTRAFINE 30G X 1/2" 0.3 ML
- BD INSULIN SYRINGE ULTRAFINE 30G X 1/2" 0.5 ML
- BD INSULIN SYRINGE ULTRAFINE 30G X 1/2" 1 ML
- BD INSULIN SYRINGE ULTRAFINE 31G X 5/16" 0.3 ML
- BD INSULIN SYRINGE ULTRAFINE 31G X 5/16" 0.5 ML
- BD PEN NEEDLE MICRO ULTRAFINE 32G X 6 MM
- BD PEN NEEDLE MINI U/F 31G X 5 MM
- BD PEN NEEDLE MINI ULTRAFINE 31G X 5 MM
- BD PEN NEEDLE NANO 2ND GEN 32G X 4 MM
- BD PEN NEEDLE NANO U/F 32G X 4 MM
- BD PEN NEEDLE NANO ULTRAFINE 32G X 4 MM
- BD PEN NEEDLE ORIG ULTRAFINE 29G X 12.7MM

Formulary ID: 25489

Last Updated: 05/27/2025

Effective: 06/01/2025

H9306_25_DRS_001_002_OE_C

- BD PEN NEEDLE SHORT ULTRAFINE 31G X 8 MM
- BD SAFETY-LOK INSULIN SYRINGE 29G X 1/2" 1 ML
- BD SAFETYGLIDE INSULIN SYRINGE 29G X 1/2" 0.3 ML
- BD SAFETYGLIDE INSULIN SYRINGE 29G X 1/2" 0.5 ML
- BD SAFETYGLIDE INSULIN SYRINGE 30G X 5/16" 0.5 ML
- BD SAFETYGLIDE INSULIN SYRINGE 31G X 15/64" 0.3 ML
- BD SAFETYGLIDE INSULIN SYRINGE 31G X 15/64" 0.5 ML
- BD SAFETYGLIDE INSULIN SYRINGE 31G X 15/64" 1 ML
- BD SAFETYGLIDE INSULIN SYRINGE 31G X 5/16" 0.3 ML
- BD SAFETYGLIDE SYRINGE/NEEDLE 27G X 5/8" 1 ML
- BD SWAB SINGLE USE REGULAR PAD
- BD SWABS SINGLE USE BUTTERFLY PAD
- BD VEO INSULIN SYR U/F 1/2UNIT 31G X 15/64" 0.3 ML
- BD VEO INSULIN SYR ULTRAFINE 31G X 15/64" 0.3 ML
- BD VEO INSULIN SYR ULTRAFINE 31G X 15/64" 0.5 ML
- BD VEO INSULIN SYR ULTRAFINE 31G X 15/64" 1 ML
- BD VEO INSULIN SYRINGE U/F 31G X 15/64" 0.3 ML
- BD VEO INSULIN SYRINGE U/F 31G X 15/64" 0.5 ML
- BD VEO INSULIN SYRINGE U/F 31G X 15/64" 1 ML
- CAREFINE PEN NEEDLES 29G X 12MM
- CAREFINE PEN NEEDLES 30G X 8 MM
- CAREFINE PEN NEEDLES 31G X 6 MM
- CAREFINE PEN NEEDLES 31G X 8 MM
- CAREFINE PEN NEEDLES 32G X 4 MM
- CAREFINE PEN NEEDLES 32G X 5 MM
- CAREFINE PEN NEEDLES 32G X 6 MM
- CAREONE INSULIN SYRINGE 30G X 1/2" 0.3 ML
- CAREONE INSULIN SYRINGE 30G X 1/2" 0.5 ML
- CAREONE INSULIN SYRINGE 30G X 1/2" 1 ML
- CAREONE INSULIN SYRINGE 31G X 5/16" 0.3 ML
- CAREONE INSULIN SYRINGE 31G X 5/16" 0.5 ML
- CAREONE INSULIN SYRINGE 31G X 5/16" 1 ML
- CARETOUCH ALCOHOL PREP PAD 70 %
- CARETOUCH INSULIN SYRINGE 28G X 5/16" 1 ML
- CARETOUCH INSULIN SYRINGE 29G X 5/16" 1 ML
- CARETOUCH INSULIN SYRINGE 30G X 5/16" 0.5 ML
- CARETOUCH INSULIN SYRINGE 30G X 5/16" 1 ML
- CARETOUCH INSULIN SYRINGE 31G X 5/16" 0.3 ML
- CARETOUCH INSULIN SYRINGE 31G X 5/16" 0.5 ML
- CARETOUCH INSULIN SYRINGE 31G X 5/16" 1 ML
- CARETOUCH PEN NEEDLES 29G X 12MM
- CARETOUCH PEN NEEDLES 31G X 5 MM

Formulary ID: 25489

Last Updated: 05/27/2025

Effective: 06/01/2025

H9306_25_DRS_001_002_OE_C

- CARETOUCH PEN NEEDLES 31G X 6 MM
- CARETOUCH PEN NEEDLES 31G X 8 MM
- CARETOUCH PEN NEEDLES 32G X 4 MM
- CARETOUCH PEN NEEDLES 32G X 5 MM
- CARETOUCH PEN NEEDLES 33G X 4 MM
- CLEVER CHOICE COMFORT EZ 29G X 12MM
- CLEVER CHOICE COMFORT EZ 33G X 4 MM
- CLICKFINE PEN NEEDLES 31G X 6 MM
- CLICKFINE PEN NEEDLES 31G X 8 MM
- CLICKFINE PEN NEEDLES 32G X 4 MM
- COMFORT ASSIST INSULIN SYRINGE 29G X 1/2" 1 ML
- COMFORT ASSIST INSULIN SYRINGE 31G X 5/16" 0.3 ML
- COMFORT EZ INSULIN SYRINGE 28G X 1/2" 0.5 ML
- COMFORT EZ INSULIN SYRINGE 28G X 1/2" 1 ML
- COMFORT EZ INSULIN SYRINGE 29G X 1/2" 0.3 ML
- COMFORT EZ INSULIN SYRINGE 29G X 1/2" 0.5 ML
- COMFORT EZ INSULIN SYRINGE 29G X 1/2" 1 ML
- COMFORT EZ INSULIN SYRINGE 30G X 1/2" 0.3 ML
- COMFORT EZ INSULIN SYRINGE 30G X 1/2" 0.5 ML
- COMFORT EZ INSULIN SYRINGE 30G X 1/2" 1 ML
- COMFORT EZ INSULIN SYRINGE 30G X 5/16" 0.3 ML
- COMFORT EZ INSULIN SYRINGE 30G X 5/16" 0.5 ML
- COMFORT EZ INSULIN SYRINGE 30G X 5/16" 1 ML
- COMFORT EZ INSULIN SYRINGE 31G X 15/64" 0.3 ML
- COMFORT EZ INSULIN SYRINGE 31G X 15/64" 0.5 ML
- COMFORT EZ INSULIN SYRINGE 31G X 15/64" 1 ML
- COMFORT EZ INSULIN SYRINGE 31G X 5/16" 0.3 ML
- COMFORT EZ INSULIN SYRINGE 31G X 5/16" 0.5 ML
- COMFORT EZ INSULIN SYRINGE 31G X 5/16" 1 ML
- COMFORT EZ PEN NEEDLES 31G X 5 MM
- COMFORT EZ PEN NEEDLES 31G X 6 MM
- COMFORT EZ PEN NEEDLES 31G X 8 MM
- COMFORT EZ PEN NEEDLES 32G X 4 MM
- COMFORT EZ PEN NEEDLES 32G X 5 MM
- COMFORT EZ PEN NEEDLES 32G X 6 MM
- COMFORT EZ PEN NEEDLES 32G X 8 MM
- COMFORT EZ PEN NEEDLES 33G X 4 MM
- COMFORT EZ PEN NEEDLES 33G X 5 MM
- COMFORT EZ PEN NEEDLES 33G X 6 MM
- COMFORT EZ PEN NEEDLES 33G X 8 MM
- COMFORT EZ PRO PEN NEEDLES 30G X 8 MM
- COMFORT EZ PRO PEN NEEDLES 31G X 4 MM

Formulary ID: 25489

Last Updated: 05/27/2025

Effective: 06/01/2025

H9306_25_DRS_001_002_OE_C

- COMFORT EZ PRO PEN NEEDLES 31G X 5 MM
- COMFORT TOUCH INSULIN PEN NEED 31G X 4 MM
- COMFORT TOUCH INSULIN PEN NEED 31G X 5 MM
- COMFORT TOUCH INSULIN PEN NEED 31G X 6 MM
- COMFORT TOUCH INSULIN PEN NEED 31G X 8 MM
- COMFORT TOUCH INSULIN PEN NEED 32G X 4 MM
- COMFORT TOUCH INSULIN PEN NEED 32G X 5 MM
- COMFORT TOUCH INSULIN PEN NEED 32G X 6 MM
- COMFORT TOUCH INSULIN PEN NEED 32G X 8 MM
- CURITY ALCOHOL PREPS PAD 70 %
- CURITY ALL PURPOSE SPONGES PAD 2"X2"
- CURITY GAUZE PAD 2"X2"
- CURITY GAUZE SPONGE PAD 2"X2"
- CURITY SPONGES PAD 2"X2"
- CVS GAUZE PAD 2"X2"
- CVS GAUZE STERILE PAD 2"X2"
- DERMACEA GAUZE SPONGE PAD 2"X2"
- DERMACEA IV DRAIN SPONGES PAD 2"X2"
- DERMACEA NON-WOVEN SPONGES PAD 2"X2"
- DERMACEA TYPE VII GAUZE PAD 2"X2"
- DIATHRIVE PEN NEEDLE 31G X 5 MM
- DIATHRIVE PEN NEEDLE 31G X 6 MM
- DIATHRIVE PEN NEEDLE 31G X 8 MM
- DIATHRIVE PEN NEEDLE 32G X 4 MM
- DROPLET INSULIN SYRINGE 29G X 1/2" 0.3 ML
- DROPLET INSULIN SYRINGE 29G X 1/2" 0.5 ML
- DROPLET INSULIN SYRINGE 29G X 1/2" 1 ML
- DROPLET INSULIN SYRINGE 30G X 1/2" 0.3 ML
- DROPLET INSULIN SYRINGE 30G X 1/2" 0.5 ML
- DROPLET INSULIN SYRINGE 30G X 1/2" 1 ML
- DROPLET INSULIN SYRINGE 30G X 15/64" 0.3 ML
- DROPLET INSULIN SYRINGE 30G X 15/64" 0.5 ML
- DROPLET INSULIN SYRINGE 30G X 15/64" 1 ML
- DROPLET INSULIN SYRINGE 30G X 5/16" 0.3 ML
- DROPLET INSULIN SYRINGE 30G X 5/16" 0.5 ML
- DROPLET INSULIN SYRINGE 30G X 5/16" 1 ML
- DROPLET INSULIN SYRINGE 31G X 1/4" 0.3 ML
- DROPLET INSULIN SYRINGE 31G X 1/4" 0.5 ML
- DROPLET INSULIN SYRINGE 31G X 1/4" 1 ML
- DROPLET INSULIN SYRINGE 31G X 15/64" 0.3 ML
- DROPLET INSULIN SYRINGE 31G X 15/64" 0.5 ML
- DROPLET INSULIN SYRINGE 31G X 15/64" 1 ML
- DROPLET INSULIN SYRINGE 31G X 5/16" 0.3 ML
- DROPLET INSULIN SYRINGE 31G X 5/16" 0.5 ML
- DROPLET INSULIN SYRINGE 31G X 5/16" 1 ML
- DROPLET MICRON 34G X 3.5 MM

Formulary ID: 25489

Last Updated: 05/27/2025

Effective: 06/01/2025

H9306_25_DRS_001_002_OE_C

- DROPLET PEN NEEDLES 29G X 10MM
- DROPLET PEN NEEDLES 29G X 12MM
- DROPLET PEN NEEDLES 30G X 8 MM
- DROPLET PEN NEEDLES 31G X 5 MM
- DROPLET PEN NEEDLES 31G X 6 MM
- DROPLET PEN NEEDLES 31G X 8 MM
- DROPLET PEN NEEDLES 32G X 4 MM
- DROPLET PEN NEEDLES 32G X 5 MM
- DROPLET PEN NEEDLES 32G X 6 MM
- DROPLET PEN NEEDLES 32G X 8 MM
- DROPSAFE ALCOHOL PREP PAD 70 %
- DROPSAFE SAFETY PEN NEEDLES 31G X 5 MM
- DROPSAFE SAFETY PEN NEEDLES 31G X 6 MM
- DROPSAFE SAFETY PEN NEEDLES 31G X 8 MM
- DROPSAFE SAFETY SYRINGE/NEEDLE 29G X 1/2" 1 ML
- DROPSAFE SAFETY SYRINGE/NEEDLE 31G X 15/64" 0.3 ML
- DROPSAFE SAFETY SYRINGE/NEEDLE 31G X 15/64" 0.5 ML
- DROPSAFE SAFETY SYRINGE/NEEDLE 31G X 15/64" 1 ML
- DROPSAFE SAFETY SYRINGE/NEEDLE 31G X 5/16" 0.3 ML
- DROPSAFE SAFETY SYRINGE/NEEDLE 31G X 5/16" 0.5 ML
- DROPSAFE SAFETY SYRINGE/NEEDLE 31G X 5/16" 1 ML
- DRUG MART ULTRA COMFORT SYR 29G X 1/2" 0.3 ML
- DRUG MART ULTRA COMFORT SYR 29G X 1/2" 1 ML
- DRUG MART ULTRA COMFORT SYR 30G X 5/16" 0.5 ML
- DRUG MART ULTRA COMFORT SYR 30G X 5/16" 1 ML
- EASY COMFORT ALCOHOL PADS PAD
- EASY COMFORT INSULIN SYRINGE 29G X 5/16" 0.5 ML
- EASY COMFORT INSULIN SYRINGE 29G X 5/16" 1 ML
- EASY COMFORT INSULIN SYRINGE 30G X 1/2" 0.5 ML
- EASY COMFORT INSULIN SYRINGE 30G X 1/2" 1 ML
- EASY COMFORT INSULIN SYRINGE 30G X 5/16" 0.5 ML
- EASY COMFORT INSULIN SYRINGE 30G X 5/16" 1 ML
- EASY COMFORT INSULIN SYRINGE 31G X 1/2" 0.3 ML
- EASY COMFORT INSULIN SYRINGE 31G X 5/16" 0.3 ML
- EASY COMFORT INSULIN SYRINGE 31G X 5/16" 0.5 ML
- EASY COMFORT INSULIN SYRINGE 31G X 5/16" 1 ML
- EASY COMFORT INSULIN SYRINGE 32G X 5/16" 0.5 ML
- EASY COMFORT INSULIN SYRINGE 32G X 5/16" 1 ML
- EASY COMFORT PEN NEEDLES 29G X 4MM
- EASY COMFORT PEN NEEDLES 29G X 5MM
- EASY COMFORT PEN NEEDLES 31G X 5 MM
- EASY COMFORT PEN NEEDLES 31G X 6 MM
- EASY COMFORT PEN NEEDLES 31G X 8 MM
- EASY COMFORT PEN NEEDLES 32G X 4 MM

Formulary ID: 25489

Last Updated: 05/27/2025

Effective: 06/01/2025

H9306_25_DRS_001_002_OE_C

- EASY COMFORT PEN NEEDLES 33G X 4 MM
- EASY COMFORT PEN NEEDLES 33G X 5 MM
- EASY COMFORT PEN NEEDLES 33G X 6 MM
- EASY GLIDE PEN NEEDLES 33G X 4 MM
- EASY TOUCH ALCOHOL PREP MEDIUM PAD 70 %
- EASY TOUCH FLIPLOCK INSULIN SY 29G X 1/2" 1 ML
- EASY TOUCH FLIPLOCK INSULIN SY 30G X 1/2" 1 ML
- EASY TOUCH FLIPLOCK INSULIN SY 30G X 5/16" 1 ML
- EASY TOUCH FLIPLOCK INSULIN SY 31G X 5/16" 1 ML
- EASY TOUCH FLIPLOCK SAFETY SYR 27G X 1/2" 1 ML
- EASY TOUCH INSULIN BARRELS U-100 1 ML
- EASY TOUCH INSULIN SAFETY SYR 29G X 1/2" 0.5 ML
- EASY TOUCH INSULIN SAFETY SYR 29G X 1/2" 1 ML
- EASY TOUCH INSULIN SAFETY SYR 30G X 1/2" 1 ML
- EASY TOUCH INSULIN SAFETY SYR 30G X 5/16" 0.5 ML
- EASY TOUCH INSULIN SYRINGE 27G X 1/2" 0.5 ML
- EASY TOUCH INSULIN SYRINGE 27G X 1/2" 1 ML
- EASY TOUCH INSULIN SYRINGE 27G X 5/8" 1 ML
- EASY TOUCH INSULIN SYRINGE 28G X 1/2" 0.5 ML
- EASY TOUCH INSULIN SYRINGE 28G X 1/2" 1 ML
- EASY TOUCH INSULIN SYRINGE 29G X 1/2" 0.5 ML
- EASY TOUCH INSULIN SYRINGE 29G X 1/2" 1 ML
- EASY TOUCH INSULIN SYRINGE 30G X 1/2" 0.3 ML
- EASY TOUCH INSULIN SYRINGE 30G X 1/2" 0.5 ML
- EASY TOUCH INSULIN SYRINGE 30G X 5/16" 0.3 ML
- EASY TOUCH INSULIN SYRINGE 30G X 5/16" 0.5 ML
- EASY TOUCH INSULIN SYRINGE 30G X 5/16" 1 ML
- EASY TOUCH INSULIN SYRINGE 31G X 5/16" 0.3 ML
- EASY TOUCH INSULIN SYRINGE 31G X 5/16" 0.5 ML
- EASY TOUCH INSULIN SYRINGE 31G X 5/16" 1 ML
- EASY TOUCH PEN NEEDLES 29G X 12MM
- EASY TOUCH PEN NEEDLES 30G X 5 MM
- EASY TOUCH PEN NEEDLES 30G X 6 MM
- EASY TOUCH PEN NEEDLES 30G X 8 MM
- EASY TOUCH PEN NEEDLES 31G X 5 MM
- EASY TOUCH PEN NEEDLES 31G X 6 MM
- EASY TOUCH PEN NEEDLES 31G X 8 MM
- EASY TOUCH PEN NEEDLES 32G X 4 MM
- EASY TOUCH PEN NEEDLES 32G X 5 MM
- EASY TOUCH PEN NEEDLES 32G X 6 MM
- EASY TOUCH SAFETY PEN NEEDLES 29G X 5MM

Formulary ID: 25489

Last Updated: 05/27/2025

Effective: 06/01/2025

H9306_25_DRS_001_002_OE_C

- EASY TOUCH SAFETY PEN NEEDLES 29G X 8MM
- EASY TOUCH SAFETY PEN NEEDLES 30G X 8 MM
- EASY TOUCH SHEATHLOCK SYRINGE 29G X 1/2" 1 ML
- EASY TOUCH SHEATHLOCK SYRINGE 30G X 1/2" 1 ML
- EASY TOUCH SHEATHLOCK SYRINGE 30G X 5/16" 1 ML
- EASY TOUCH SHEATHLOCK SYRINGE 31G X 5/16" 1 ML
- EMBECTA AUTOSHIELD DUO 30G X 5 MM
- EMBECTA INS SYR U/F 1/2 UNIT 31G X 15/64" 0.3 ML
- EMBECTA INS SYR U/F 1/2 UNIT 31G X 5/16" 0.3 ML
- EMBECTA INSULIN SYR ULTRAFINE 30G X 1/2" 0.3 ML
- EMBECTA INSULIN SYR ULTRAFINE 30G X 1/2" 0.5 ML
- EMBECTA INSULIN SYR ULTRAFINE 30G X 1/2" 1 ML
- EMBECTA INSULIN SYR ULTRAFINE 31G X 5/16" 0.5 ML
- EMBECTA INSULIN SYR ULTRAFINE 31G X 5/16" 1 ML
- EMBECTA INSULIN SYRINGE 28G X 1/2" 0.5 ML
- EMBECTA INSULIN SYRINGE U-100 27G X 5/8" 1 ML
- EMBECTA INSULIN SYRINGE U-100 28G X 1/2" 1 ML
- EMBECTA PEN NEEDLE NANO 2 GEN 32G X 4 MM
- EMBECTA PEN NEEDLE ULTRAFINE 29G X 12.7MM
- EMBECTA PEN NEEDLE ULTRAFINE 32G X 6 MM
- EMBRACE PEN NEEDLES 29G X 12MM
- EMBRACE PEN NEEDLES 30G X 5 MM
- EMBRACE PEN NEEDLES 30G X 8 MM
- EMBRACE PEN NEEDLES 31G X 5 MM
- EMBRACE PEN NEEDLES 31G X 6 MM
- EMBRACE PEN NEEDLES 31G X 8 MM
- EMBRACE PEN NEEDLES 32G X 4 MM
- EQL ALCOHOL SWABS PAD 70 %
- EQL GAUZE PAD 2"X2"
- EQL INSULIN SYRINGE 30G X 5/16" 0.3 ML
- EQL INSULIN SYRINGE 30G X 5/16" 0.5 ML
- EQL INSULIN SYRINGE 30G X 5/16" 1 ML
- EXEL COMFORT POINT PEN NEEDLE 29G X 12MM
- FIFTY50 PEN NEEDLES 32G X 6 MM
- FREESTYLE PRECISION INS SYR 30G X 5/16" 0.5 ML
- FREESTYLE PRECISION INS SYR 30G X 5/16" 1 ML
- FREESTYLE PRECISION INS SYR 31G X 5/16" 0.5 ML
- FREESTYLE PRECISION INS SYR 31G X 5/16" 1 ML
- GAUZE PADS PAD 2"X2"
- GAUZE TYPE VII MEDI-PAK PAD 2"X2"
- GLOBAL ALCOHOL PREP EASE
- GLOBAL EASE INJECT PEN NEEDLES 29G X 12MM
- GLOBAL EASE INJECT PEN NEEDLES 31G X 5 MM
- GLOBAL EASE INJECT PEN NEEDLES 31G X 8 MM
- GLOBAL EASE INJECT PEN NEEDLES 32G X 4 MM

Formulary ID: 25489

Last Updated: 05/27/2025

Effective: 06/01/2025

H9306_25_DRS_001_002_OE_C

- GLOBAL EASY GLIDE INSULIN SYR 31G X 15/64" 0.3 ML
- GLOBAL EASY GLIDE INSULIN SYR 31G X 15/64" 0.5 ML
- GLOBAL EASY GLIDE INSULIN SYR 31G X 15/64" 1 ML
- GLOBAL INJECT EASE INSULIN SYR 28G X 1/2" 0.5 ML
- GLOBAL INJECT EASE INSULIN SYR 28G X 1/2" 1 ML
- GLOBAL INJECT EASE INSULIN SYR 29G X 1/2" 0.5 ML
- GLOBAL INJECT EASE INSULIN SYR 29G X 1/2" 1 ML
- GLOBAL INJECT EASE INSULIN SYR 30G X 5/16" 0.5 ML
- GLOBAL INJECT EASE INSULIN SYR 30G X 5/16" 1 ML
- GLUCOPRO INSULIN SYRINGE 30G X 1/2" 0.3 ML
- GLUCOPRO INSULIN SYRINGE 30G X 1/2" 0.5 ML
- GLUCOPRO INSULIN SYRINGE 30G X 1/2" 1 ML
- GLUCOPRO INSULIN SYRINGE 30G X 5/16" 0.3 ML
- GLUCOPRO INSULIN SYRINGE 30G X 5/16" 0.5 ML
- GLUCOPRO INSULIN SYRINGE 30G X 5/16" 1 ML
- GLUCOPRO INSULIN SYRINGE 31G X 5/16" 0.3 ML
- GLUCOPRO INSULIN SYRINGE 31G X 5/16" 0.5 ML
- GLUCOPRO INSULIN SYRINGE 31G X 5/16" 1 ML
- GNP ALCOHOL SWABS PAD
- GNP INSULIN SYRINGE 28G X 1/2" 1 ML
- GNP INSULIN SYRINGE 29G X 1/2" 0.5 ML
- GNP INSULIN SYRINGE 29G X 1/2" 1 ML
- GNP INSULIN SYRINGE 30G X 5/16" 0.5 ML
- GNP INSULIN SYRINGES 29GX1/2" 29G X 1/2" 0.5 ML
- GNP INSULIN SYRINGES 29GX1/2" 29G X 1/2" 1 ML
- GNP INSULIN SYRINGES 30G X 5/16" 1 ML
- GNP INSULIN SYRINGES 30GX5/16" 30G X 5/16" 0.3 ML
- GNP INSULIN SYRINGES 31GX5/16" 31G X 5/16" 0.3 ML
- GNP STERILE GAUZE PAD 2"X2"
- GNP ULTRA COM INSULIN SYRINGE 29G X 1/2" 0.3 ML
- GNP ULTRA COM INSULIN SYRINGE 30G X 5/16" 0.3 ML
- GOODSENSE ALCOHOL SWABS PAD 70 %
- H-E-B INCONTROL ALCOHOL PAD
- H-E-B INCONTROL PEN NEEDLES 29G X 12MM
- H-E-B INCONTROL PEN NEEDLES 31G X 5 MM
- H-E-B INCONTROL PEN NEEDLES 31G X 6 MM
- H-E-B INCONTROL PEN NEEDLES 31G X 8 MM
- H-E-B INCONTROL PEN NEEDLES 32G X 4 MM
- HEALTHWISE INSULIN SYR/NEEDLE 30G X 5/16" 0.3 ML
- HEALTHWISE INSULIN SYR/NEEDLE 30G X 5/16" 0.5 ML
- HEALTHWISE INSULIN SYR/NEEDLE 30G X 5/16" 1 ML
- HEALTHWISE INSULIN SYR/NEEDLE 31G X 5/16" 0.3 ML
- HEALTHWISE INSULIN SYR/NEEDLE 31G X 5/16" 0.5 ML

Formulary ID: 25489

Last Updated: 05/27/2025

Effective: 06/01/2025

H9306_25_DRS_001_002_OE_C

- HEALTHWISE INSULIN SYR/NEEDLE 31G X 5/16" 1 ML
- HEALTHWISE MICRON PEN NEEDLES 32G X 4 MM
- HEALTHWISE SHORT PEN NEEDLES 31G X 5 MM
- HEALTHWISE SHORT PEN NEEDLES 31G X 8 MM
- HEALTHY ACCENTS UNIFINE PENTIP 29G X 12MM
- HEALTHY ACCENTS UNIFINE PENTIP 31G X 5 MM
- HEALTHY ACCENTS UNIFINE PENTIP 31G X 6 MM
- HEALTHY ACCENTS UNIFINE PENTIP 31G X 8 MM
- HEALTHY ACCENTS UNIFINE PENTIP 32G X 4 MM
- HM STERILE PADS PAD 2"X2"
- HM ULTICARE INSULIN SYRINGE 30G X 1/2" 1 ML
- HM ULTICARE INSULIN SYRINGE 31G X 5/16" 0.3 ML
- HM ULTICARE SHORT PEN NEEDLES 31G X 8 MM
- INCONTROL ULTICARE PEN NEEDLES 31G X 6 MM
- INCONTROL ULTICARE PEN NEEDLES 31G X 8 MM
- INCONTROL ULTICARE PEN NEEDLES 32G X 4 MM
- INSULIN SYRINGE 29G X 1/2" 1 ML
- INSULIN SYRINGE 30G X 5/16" 1 ML
- INSULIN SYRINGE 31G X 5/16" 0.3 ML
- INSULIN SYRINGE 31G X 5/16" 0.5 ML
- INSULIN SYRINGE-NEEDLE U-100 27G X 1/2" 0.5 ML (OTC)
- INSULIN SYRINGE-NEEDLE U-100 27G X 1/2" 0.5 ML (RX)
- INSULIN SYRINGE-NEEDLE U-100 27G X 1/2" 1 ML (RX)
- INSULIN SYRINGE-NEEDLE U-100 28G X 1/2" 0.5 ML (RX)
- INSULIN SYRINGE-NEEDLE U-100 28G X 1/2" 1 ML (RX)
- INSULIN SYRINGE-NEEDLE U-100 30G X 5/16" 1 ML
- INSULIN SYRINGE-NEEDLE U-100 31G X 1/4" 0.3 ML
- INSULIN SYRINGE-NEEDLE U-100 31G X 1/4" 0.5 ML
- INSULIN SYRINGE-NEEDLE U-100 31G X 1/4" 1 ML
- INSULIN SYRINGE-NEEDLE U-100 31G X 5/16" 0.5 ML (OTC)
- INSULIN SYRINGE/NEEDLE 27G X 1/2" 0.5 ML
- INSULIN SYRINGE/NEEDLE 28G X 1/2" 0.5 ML
- INSULIN SYRINGE/NEEDLE 28G X 1/2" 1 ML
- INSUPEN PEN NEEDLES 31G X 5 MM
- INSUPEN PEN NEEDLES 32G X 4 MM
- INSUPEN PEN NEEDLES 33G X 4 MM
- INSUPEN SENSITIVE 32G X 6 MM
- INSUPEN SENSITIVE 32G X 8 MM
- INSUPEN ULTRAFIN 29G X 12MM
- INSUPEN ULTRAFIN 30G X 8 MM
- INSUPEN ULTRAFIN 31G X 6 MM
- INSUPEN ULTRAFIN 31G X 8 MM
- J & J GAUZE PAD 2"X2"
- KENDALL HYDROPHILIC FOAM DRESS PAD 2"X2"
- KENDALL HYDROPHILIC FOAM PLUS PAD 2"X2"
- KINRAY INSULIN SYRINGE 29G X 1/2" 0.5 ML
- KMART VALU INSULIN SYRINGE 29G U-100 1 ML
- KMART VALU INSULIN SYRINGE 30G U-100 0.3 ML
- KMART VALU INSULIN SYRINGE 30G U-100 1 ML
- KROGER PEN NEEDLES 29G X 12MM

Formulary ID: 25489

Last Updated: 05/27/2025

Effective: 06/01/2025

H9306_25_DRS_001_002_OE_C

- KROGER PEN NEEDLES 31G X 8 MM
- LEADER UNIFINE PENTIPS 31G X 5 MM
- LEADER UNIFINE PENTIPS 32G X 4 MM
- LEADER UNIFINE PENTIPS PLUS 31G X 5 MM
- LEADER UNIFINE PENTIPS PLUS 31G X 8 MM
- LITETOUCH INSULIN SYRINGE 28G X 1/2" 0.5 ML
- LITETOUCH INSULIN SYRINGE 28G X 1/2" 1 ML
- LITETOUCH INSULIN SYRINGE 29G X 1/2" 0.3 ML
- LITETOUCH INSULIN SYRINGE 29G X 1/2" 0.5 ML
- LITETOUCH INSULIN SYRINGE 29G X 1/2" 1 ML
- LITETOUCH INSULIN SYRINGE 30G X 5/16" 0.3 ML
- LITETOUCH INSULIN SYRINGE 30G X 5/16" 0.5 ML
- LITETOUCH INSULIN SYRINGE 30G X 5/16" 1 ML
- LITETOUCH INSULIN SYRINGE 31G X 5/16" 0.3 ML
- LITETOUCH INSULIN SYRINGE 31G X 5/16" 0.5 ML
- LITETOUCH INSULIN SYRINGE 31G X 5/16" 1 ML
- LITETOUCH PEN NEEDLES 29G X 12.7MM
- LITETOUCH PEN NEEDLES 31G X 5 MM
- LITETOUCH PEN NEEDLES 31G X 6 MM
- LITETOUCH PEN NEEDLES 31G X 8 MM
- LITETOUCH PEN NEEDLES 32G X 4 MM
- MAGELLAN INSULIN SAFETY SYR 29G X 1/2" 0.3 ML
- MAGELLAN INSULIN SAFETY SYR 29G X 1/2" 0.5 ML
- MAGELLAN INSULIN SAFETY SYR 29G X 1/2" 1 ML
- MAGELLAN INSULIN SAFETY SYR 30G X 5/16" 0.3 ML
- MAGELLAN INSULIN SAFETY SYR 30G X 5/16" 0.5 ML
- MAGELLAN INSULIN SAFETY SYR 30G X 5/16" 1 ML
- MAXI-COMFORT INSULIN SYRINGE 28G X 1/2" 0.5 ML
- MAXI-COMFORT INSULIN SYRINGE 28G X 1/2" 1 ML
- MAXI-COMFORT SAFETY PEN NEEDLE 29G X 5MM
- MAXI-COMFORT SAFETY PEN NEEDLE 29G X 8MM
- MAXICOMFORT II PEN NEEDLE 31G X 6 MM
- MAXICOMFORT SYR 27G X 1/2" 27G X 1/2" 0.5 ML
- MAXICOMFORT SYR 27G X 1/2" 27G X 1/2" 1 ML
- MEDIC INSULIN SYRINGE 30G X 5/16" 0.3 ML
- MEDIC INSULIN SYRINGE 30G X 5/16" 0.5 ML
- MEDICINE SHOPPE PEN NEEDLES 29G X 12MM
- MEDICINE SHOPPE PEN NEEDLES 31G X 8 MM
- MEDPURA ALCOHOL PADS 70 % EXTERNAL
- MEIJER ALCOHOL SWABS PAD 70 %
- MEIJER PEN NEEDLES 29G X 12MM
- MEIJER PEN NEEDLES 31G X 6 MM
- MEIJER PEN NEEDLES 31G X 8 MM
- MICRODOT PEN NEEDLE 31G X 6 MM
- MICRODOT PEN NEEDLE 32G X 4 MM

Formulary ID: 25489

Last Updated: 05/27/2025

Effective: 06/01/2025

H9306_25_DRS_001_002_OE_C

- MICRODOT PEN NEEDLE 33G X 4 MM
- MIRASORB SPONGES 2"X2"
- MM PEN NEEDLES 32G X 4 MM
- MONOJECT INSULIN SYRINGE 25G X 5/8" 1 ML
- MONOJECT INSULIN SYRINGE 27G X 1/2" 1 ML (OTC)
- MONOJECT INSULIN SYRINGE 28G X 1/2" 0.5 ML (RX)
- MONOJECT INSULIN SYRINGE 28G X 1/2" 1 ML (OTC)
- MONOJECT INSULIN SYRINGE 28G X 1/2" 1 ML (RX)
- MONOJECT INSULIN SYRINGE 29G X 1/2" 0.3 ML
- MONOJECT INSULIN SYRINGE 29G X 1/2" 0.5 ML
- MONOJECT INSULIN SYRINGE 29G X 1/2" 1 ML (RX)
- MONOJECT INSULIN SYRINGE 30G X 5/16" 0.3 ML
- MONOJECT INSULIN SYRINGE 30G X 5/16" 0.5 ML (RX)
- MONOJECT INSULIN SYRINGE 30G X 5/16" 1 ML (RX)
- MONOJECT INSULIN SYRINGE 31G X 5/16" 1 ML
- MONOJECT INSULIN SYRINGE U-100 1 ML
- MONOJECT ULTRA COMFORT SYRINGE 28G X 1/2" 0.5 ML (OTC)
- MONOJECT ULTRA COMFORT SYRINGE 28G X 1/2" 0.5 ML (RX)
- MONOJECT ULTRA COMFORT SYRINGE 28G X 1/2" 1 ML (OTC)
- MONOJECT ULTRA COMFORT SYRINGE 29G X 1/2" 0.5 ML
- MONOJECT ULTRA COMFORT SYRINGE 29G X 1/2" 1 ML
- MONOJECT ULTRA COMFORT SYRINGE 30G X 5/16" 0.3 ML (OTC)
- MONOJECT ULTRA COMFORT SYRINGE 30G X 5/16" 0.3 ML (RX)
- MONOJECT ULTRA COMFORT SYRINGE 30G X 5/16" 0.5 ML (RX)
- NOVOFINE AUTOCOVER 30G X 8 MM
- NOVOFINE PEN NEEDLE 32G X 6 MM
- NOVOFINE PLUS PEN NEEDLE 32G X 4 MM
- NOVOTWIST PEN NEEDLE 32G X 5 MM
- PC UNIFINE PENTIPS 31G X 5 MM
- PC UNIFINE PENTIPS 31G X 6 MM
- PC UNIFINE PENTIPS 31G X 8 MM
- PEN NEEDLE/5-BEVEL TIP 32G X 4 MM
- PEN NEEDLES 30G X 5 MM (OTC)
- PEN NEEDLES 30G X 8 MM
- PEN NEEDLES 32G X 4 MM (OTC)
- PEN NEEDLES 32G X 5 MM
- PENTIPS 29G X 12MM (RX)
- PENTIPS 31G X 5 MM (RX)
- PENTIPS 31G X 8 MM (RX)
- PENTIPS 32G X 4 MM (RX)
- PENTIPS GENERIC PEN NEEDLES 29G X 12MM
- PENTIPS GENERIC PEN NEEDLES 31G X 6 MM
- PENTIPS GENERIC PEN NEEDLES 32G X 6 MM
- PIP PEN NEEDLES 31G X 5MM 31G X 5 MM
- PIP PEN NEEDLES 32G X 4MM 32G X 4 MM
- PRECISION SURE-DOSE SYRINGE 28G X 1/2" 0.5 ML
- PRECISION SURE-DOSE SYRINGE 28G X 1/2" 1 ML
- PRECISION SURE-DOSE SYRINGE 29G X 1/2" 0.5 ML
- PRECISION SURE-DOSE SYRINGE 30G X 3/8" 0.5 ML

Formulary ID: 25489

Last Updated: 05/27/2025

Effective: 06/01/2025

H9306_25_DRS_001_002_OE_C

- PRECISION SURE-DOSE SYRINGE 30G X 5/16" 0.3 ML
- PRECISION SUREDOSE PLUS SYR 29G X 1/2" 0.3 ML
- PRECISION SUREDOSE PLUS SYR 29G X 1/2" 1 ML
- PREFERRED PLUS INSULIN SYRINGE 28G X 1/2" 0.5 ML
- PREFERRED PLUS UNIFINE PENTIPS 29G X 12MM
- PREVENT DROPSAFE PEN NEEDLES 31G X 6 MM
- PREVENT DROPSAFE PEN NEEDLES 31G X 8 MM
- PREVENT SAFETY PEN NEEDLES 31G X 6 MM
- PREVENT SAFETY PEN NEEDLES 31G X 8 MM
- PRO COMFORT ALCOHOL PAD 70 %
- PRO COMFORT INSULIN SYRINGE 30G X 1/2" 0.5 ML
- PRO COMFORT INSULIN SYRINGE 30G X 1/2" 1 ML
- PRO COMFORT INSULIN SYRINGE 30G X 5/16" 0.5 ML
- PRO COMFORT INSULIN SYRINGE 30G X 5/16" 1 ML
- PRO COMFORT INSULIN SYRINGE 31G X 5/16" 0.5 ML
- PRO COMFORT INSULIN SYRINGE 31G X 5/16" 1 ML
- PRO COMFORT PEN NEEDLES 31G X 8 MM
- PRO COMFORT PEN NEEDLES 32G X 4 MM
- PRO COMFORT PEN NEEDLES 32G X 5 MM
- PRO COMFORT PEN NEEDLES 32G X 6 MM
- PRODIGY INSULIN SYRINGE 28G X 1/2" 1 ML
- PRODIGY INSULIN SYRINGE 31G X 5/16" 0.3 ML
- PRODIGY INSULIN SYRINGE 31G X 5/16" 0.5 ML
- PURE COMFORT ALCOHOL PREP PAD
- PURE COMFORT PEN NEEDLE 32G X 4 MM
- PURE COMFORT PEN NEEDLE 32G X 5 MM
- PURE COMFORT PEN NEEDLE 32G X 6 MM
- PURE COMFORT PEN NEEDLE 32G X 8 MM
- PURE COMFORT SAFETY PEN NEEDLE 31G X 5 MM
- PURE COMFORT SAFETY PEN NEEDLE 31G X 6 MM
- PURE COMFORT SAFETY PEN NEEDLE 32G X 4 MM
- PX SHORTLENGTH PEN NEEDLES 31G X 8 MM
- QC ALCOHOL
- QC ALCOHOL SWABS PAD 70 %
- QC BORDER ISLAND GAUZE PAD 2"X2"
- QUICK TOUCH INSULIN PEN NEEDLE 31G X 4 MM
- QUICK TOUCH INSULIN PEN NEEDLE 31G X 5 MM
- QUICK TOUCH INSULIN PEN NEEDLE 32G X 4 MM
- QUICK TOUCH INSULIN PEN NEEDLE 32G X 5 MM
- QUICK TOUCH INSULIN PEN NEEDLE 32G X 6 MM
- QUICK TOUCH INSULIN PEN NEEDLE 32G X 8 MM
- QUICK TOUCH INSULIN PEN NEEDLE 33G X 4 MM
- QUICK TOUCH INSULIN PEN NEEDLE 33G X 5 MM
- QUICK TOUCH INSULIN PEN NEEDLE 33G X 6 MM

Formulary ID: 25489

Last Updated: 05/27/2025

Effective: 06/01/2025

H9306_25_DRS_001_002_OE_C

- QUICK TOUCH INSULIN PEN NEEDLE 33G X 8 MM
- RA ALCOHOL SWABS PAD 70 %
- RA INSULIN SYRINGE 29G X 1/2" 1 ML
- RA INSULIN SYRINGE 30G X 5/16" 0.5 ML
- RA INSULIN SYRINGE 30G X 5/16" 1 ML
- *ra isopropyl alcohol wipes*
- RA PEN NEEDLES 31G X 5 MM
- RA PEN NEEDLES 31G X 8 MM
- RA STERILE PAD 2"X2"
- RAYA SURE PEN NEEDLE 29G X 12MM
- RAYA SURE PEN NEEDLE 31G X 4 MM
- RAYA SURE PEN NEEDLE 31G X 5 MM
- RAYA SURE PEN NEEDLE 31G X 6 MM
- REALITY INSULIN SYRINGE 28G X 1/2" 0.5 ML
- REALITY INSULIN SYRINGE 28G X 1/2" 1 ML
- REALITY INSULIN SYRINGE 29G X 1/2" 0.5 ML
- REALITY INSULIN SYRINGE 29G X 1/2" 1 ML
- REALITY SWABS PAD
- RELI-ON INSULIN SYRINGE 29G 0.3 ML
- RELI-ON INSULIN SYRINGE 29G 0.5 ML
- RELI-ON INSULIN SYRINGE 29G X 1/2" 1 ML
- RELION ALCOHOL SWABS PAD
- RELION INSULIN SYRINGE 31G X 15/64" 0.3 ML
- RELION INSULIN SYRINGE 31G X 15/64" 0.5 ML
- RELION INSULIN SYRINGE 31G X 15/64" 1 ML
- RELION MINI PEN NEEDLES 31G X 6 MM
- RELION PEN NEEDLES 31G X 6 MM
- RELION PEN NEEDLES 31G X 8 MM
- RESTORE CONTACT LAYER PAD 2"X2"
- SAFETY INSULIN SYRINGES 29G X 1/2" 0.5 ML
- SAFETY INSULIN SYRINGES 29G X 1/2" 1 ML
- SAFETY INSULIN SYRINGES 30G X 1/2" 1 ML
- SAFETY INSULIN SYRINGES 30G X 5/16" 0.5 ML
- SAFETY PEN NEEDLES 30G X 5 MM
- SAFETY PEN NEEDLES 30G X 8 MM
- SB ALCOHOL PREP PAD 70 %
- SB INSULIN SYRINGE 29G X 1/2" 0.5 ML
- SB INSULIN SYRINGE 29G X 1/2" 1 ML
- SB INSULIN SYRINGE 30G X 5/16" 0.5 ML
- SB INSULIN SYRINGE 30G X 5/16" 1 ML
- SB INSULIN SYRINGE 31G X 5/16" 1 ML
- SECURESAFE INSULIN SYRINGE 29G X 1/2" 0.5 ML
- SECURESAFE INSULIN SYRINGE 29G X 1/2" 1 ML
- SECURESAFE SAFETY PEN NEEDLES 30G X 8 MM
- SM ALCOHOL PREP PAD
- SM ALCOHOL PREP PAD 6-70 % EXTERNAL
- SM ALCOHOL PREP PAD 70 %
- SM GAUZE PAD 2"X2"
- STERILE GAUZE PAD 2"X2"
- STERILE PAD 2"X2"
- SURE COMFORT ALCOHOL PREP PAD 70 %

Formulary ID: 25489

Last Updated: 05/27/2025

Effective: 06/01/2025

H9306_25_DRS_001_002_OE_C

- SURE COMFORT INSULIN SYRINGE 28G X 1/2" 0.5 ML
- SURE COMFORT INSULIN SYRINGE 28G X 1/2" 1 ML
- SURE COMFORT INSULIN SYRINGE 29G X 1/2" 0.3 ML
- SURE COMFORT INSULIN SYRINGE 29G X 1/2" 0.5 ML
- SURE COMFORT INSULIN SYRINGE 29G X 1/2" 1 ML
- SURE COMFORT INSULIN SYRINGE 30G X 1/2" 0.3 ML
- SURE COMFORT INSULIN SYRINGE 30G X 1/2" 0.5 ML
- SURE COMFORT INSULIN SYRINGE 30G X 1/2" 1 ML
- SURE COMFORT INSULIN SYRINGE 30G X 5/16" 0.3 ML
- SURE COMFORT INSULIN SYRINGE 30G X 5/16" 0.5 ML
- SURE COMFORT INSULIN SYRINGE 30G X 5/16" 1 ML
- SURE COMFORT INSULIN SYRINGE 31G X 1/4" 0.3 ML
- SURE COMFORT INSULIN SYRINGE 31G X 1/4" 0.5 ML
- SURE COMFORT INSULIN SYRINGE 31G X 1/4" 1 ML
- SURE COMFORT INSULIN SYRINGE 31G X 5/16" 0.3 ML
- SURE COMFORT INSULIN SYRINGE 31G X 5/16" 0.5 ML
- SURE COMFORT INSULIN SYRINGE 31G X 5/16" 1 ML
- SURE COMFORT PEN NEEDLES 29G X 12.7MM
- SURE COMFORT PEN NEEDLES 30G X 8 MM
- SURE COMFORT PEN NEEDLES 31G X 5 MM
- SURE COMFORT PEN NEEDLES 31G X 6 MM
- SURE COMFORT PEN NEEDLES 31G X 8 MM
- SURE COMFORT PEN NEEDLES 32G X 4 MM (OTC)
- SURE COMFORT PEN NEEDLES 32G X 4 MM (RX)
- SURE COMFORT PEN NEEDLES 32G X 6 MM
- SURE-JECT INSULIN SYRINGE 31G X 5/16" 0.3 ML
- SURE-JECT INSULIN SYRINGE 31G X 5/16" 0.5 ML
- SURE-JECT INSULIN SYRINGE 31G X 5/16" 1 ML
- SURE-PREP ALCOHOL PREP PAD 70 %
- SURGICAL GAUZE SPONGE PAD 2"X2"
- TECHLITE INSULIN SYRINGE 29G X 1/2" 0.5 ML
- TECHLITE PLUS PEN NEEDLES 32G X 4 MM
- TERUMO INSULIN SYRINGE 29G X 1/2" 0.3 ML
- THERAGAUZE PAD 2"X2"
- TODAYS HEALTH PEN NEEDLES 29G X 12MM
- TODAYS HEALTH SHORT PEN NEEDLE 31G X 8 MM
- TOPCARE CLICKFINE PEN NEEDLES 31G X 6 MM
- TOPCARE CLICKFINE PEN NEEDLES 31G X 8 MM
- TOPCARE ULTRA COMFORT INS SYR 29G X 1/2" 0.3 ML
- TOPCARE ULTRA COMFORT INS SYR 29G X 1/2" 0.5 ML
- TOPCARE ULTRA COMFORT INS SYR 29G X 1/2" 1 ML
- TOPCARE ULTRA COMFORT INS SYR 30G X 5/16" 0.3 ML
- TOPCARE ULTRA COMFORT INS SYR 30G X 5/16" 0.5 ML

Formulary ID: 25489

Last Updated: 05/27/2025

Effective: 06/01/2025

H9306_25_DRS_001_002_OE_C

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|--|---|
| <ul style="list-style-type: none"> • TOPCARE ULTRA COMFORT INS SYR 30G X 5/16" 1 ML • TOPCARE ULTRA COMFORT INS SYR 31G X 5/16" 0.3 ML • TOPCARE ULTRA COMFORT INS SYR 31G X 5/16" 0.5 ML • TOPCARE ULTRA COMFORT INS SYR 31G X 5/16" 1 ML • TRUE COMFORT ALCOHOL PREP PADS PAD 70 % • TRUE COMFORT INSULIN SYRINGE 30G X 1/2" 0.5 ML • TRUE COMFORT INSULIN SYRINGE 30G X 1/2" 1 ML • TRUE COMFORT INSULIN SYRINGE 30G X 5/16" 0.5 ML • TRUE COMFORT INSULIN SYRINGE 30G X 5/16" 1 ML • TRUE COMFORT INSULIN SYRINGE 31G X 5/16" 0.5 ML • TRUE COMFORT INSULIN SYRINGE 31G X 5/16" 1 ML • TRUE COMFORT INSULIN SYRINGE 32G X 5/16" 1 ML • TRUE COMFORT PEN NEEDLES 31G X 5 MM • TRUE COMFORT PEN NEEDLES 31G X 6 MM • TRUE COMFORT PEN NEEDLES 32G X 4 MM • TRUE COMFORT PRO ALCOHOL PREP PAD 70 % • TRUE COMFORT PRO INSULIN SYR 30G X 1/2" 0.5 ML • TRUE COMFORT PRO INSULIN SYR 30G X 1/2" 1 ML • TRUE COMFORT PRO INSULIN SYR 30G X 5/16" 0.5 ML • TRUE COMFORT PRO INSULIN SYR 30G X 5/16" 1 ML • TRUE COMFORT PRO INSULIN SYR 31G X 5/16" 0.5 ML | <ul style="list-style-type: none"> • TRUE COMFORT PRO INSULIN SYR 31G X 5/16" 1 ML • TRUE COMFORT PRO INSULIN SYR 32G X 5/16" 0.5 ML • TRUE COMFORT PRO INSULIN SYR 32G X 5/16" 1 ML • TRUE COMFORT PRO PEN NEEDLES 31G X 5 MM • TRUE COMFORT PRO PEN NEEDLES 31G X 6 MM • TRUE COMFORT PRO PEN NEEDLES 31G X 8 MM • TRUE COMFORT PRO PEN NEEDLES 32G X 4 MM • TRUE COMFORT PRO PEN NEEDLES 32G X 5 MM • TRUE COMFORT PRO PEN NEEDLES 32G X 6 MM • TRUE COMFORT PRO PEN NEEDLES 33G X 4 MM • TRUE COMFORT PRO PEN NEEDLES 33G X 5 MM • TRUE COMFORT PRO PEN NEEDLES 33G X 6 MM • TRUEPLUS 5-BEVEL PEN NEEDLES 29G X 12.7MM • TRUEPLUS 5-BEVEL PEN NEEDLES 31G X 5 MM • TRUEPLUS 5-BEVEL PEN NEEDLES 31G X 6 MM • TRUEPLUS 5-BEVEL PEN NEEDLES 31G X 8 MM • TRUEPLUS 5-BEVEL PEN NEEDLES 32G X 4 MM • TRUEPLUS INSULIN SYRINGE 28G X 1/2" 0.5 ML • TRUEPLUS INSULIN SYRINGE 28G X 1/2" 1 ML • TRUEPLUS INSULIN SYRINGE 29G X 1/2" 0.3 ML • TRUEPLUS INSULIN SYRINGE 29G X 1/2" 0.5 ML |
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Formulary ID: 25489

Last Updated: 05/27/2025

Effective: 06/01/2025

H9306 25 DRS 001 002 OE C

- TRUEPLUS INSULIN SYRINGE 29G X 1/2" 1 ML
- TRUEPLUS INSULIN SYRINGE 30G X 5/16" 0.3 ML
- TRUEPLUS INSULIN SYRINGE 30G X 5/16" 0.5 ML
- TRUEPLUS INSULIN SYRINGE 30G X 5/16" 1 ML
- TRUEPLUS INSULIN SYRINGE 31G X 5/16" 0.3 ML
- TRUEPLUS INSULIN SYRINGE 31G X 5/16" 0.5 ML
- TRUEPLUS INSULIN SYRINGE 31G X 5/16" 1 ML
- TRUEPLUS PEN NEEDLES 29G X 12MM
- TRUEPLUS PEN NEEDLES 31G X 5 MM
- TRUEPLUS PEN NEEDLES 31G X 6 MM
- TRUEPLUS PEN NEEDLES 31G X 8 MM
- TRUEPLUS PEN NEEDLES 32G X 4 MM
- ULTICARE INSULIN SAFETY SYR 29G X 1/2" 0.5 ML
- ULTICARE INSULIN SAFETY SYR 29G X 1/2" 1 ML
- ULTICARE INSULIN SYRINGE 28G X 1/2" 0.5 ML
- ULTICARE INSULIN SYRINGE 28G X 1/2" 1 ML
- ULTICARE INSULIN SYRINGE 29G X 1/2" 0.3 ML
- ULTICARE INSULIN SYRINGE 29G X 1/2" 0.5 ML
- ULTICARE INSULIN SYRINGE 29G X 1/2" 1 ML
- ULTICARE INSULIN SYRINGE 30G X 1/2" 0.3 ML
- ULTICARE INSULIN SYRINGE 30G X 1/2" 0.5 ML
- ULTICARE INSULIN SYRINGE 30G X 1/2" 1 ML
- ULTICARE INSULIN SYRINGE 30G X 5/16" 0.3 ML
- ULTICARE INSULIN SYRINGE 30G X 5/16" 0.5 ML (OTC)
- ULTICARE INSULIN SYRINGE 30G X 5/16" 0.5 ML (RX)
- ULTICARE INSULIN SYRINGE 30G X 5/16" 1 ML
- ULTICARE INSULIN SYRINGE 31G X 1/4" 0.3 ML
- ULTICARE INSULIN SYRINGE 31G X 1/4" 0.5 ML
- ULTICARE INSULIN SYRINGE 31G X 1/4" 1 ML
- ULTICARE INSULIN SYRINGE 31G X 5/16" 0.3 ML (OTC)
- ULTICARE INSULIN SYRINGE 31G X 5/16" 0.3 ML (RX)
- ULTICARE INSULIN SYRINGE 31G X 5/16" 0.5 ML (OTC)
- ULTICARE INSULIN SYRINGE 31G X 5/16" 0.5 ML (RX)
- ULTICARE INSULIN SYRINGE 31G X 5/16" 1 ML
- ULTICARE MICRO PEN NEEDLES 32G X 4 MM
- ULTICARE MINI PEN NEEDLES 30G X 5 MM
- ULTICARE MINI PEN NEEDLES 31G X 6 MM
- ULTICARE MINI PEN NEEDLES 32G X 6 MM
- ULTICARE PEN NEEDLES 29G X 12.7MM (OTC)
- ULTICARE PEN NEEDLES 29G X 12.7MM (RX)
- ULTICARE PEN NEEDLES 31G X 5 MM
- ULTICARE SHORT PEN NEEDLES 30G X 8 MM

Formulary ID: 25489

Last Updated: 05/27/2025

Effective: 06/01/2025

H9306_25_DRS_001_002_OE_C

- ULTICARE SHORT PEN NEEDLES 31G X 8 MM (OTC)
- ULTICARE SHORT PEN NEEDLES 31G X 8 MM (RX)
- ULTIGUARD SAFEPAK PEN NEEDLE 29G X 12.7MM
- ULTIGUARD SAFEPAK PEN NEEDLE 31G X 5 MM
- ULTIGUARD SAFEPAK PEN NEEDLE 31G X 6 MM
- ULTIGUARD SAFEPAK PEN NEEDLE 31G X 8 MM
- ULTIGUARD SAFEPAK PEN NEEDLE 32G X 4 MM
- ULTIGUARD SAFEPAK PEN NEEDLE 32G X 6 MM
- ULTIGUARD SAFEPAK SYR/NEEDLE 30G X 1/2" 0.3 ML
- ULTIGUARD SAFEPAK SYR/NEEDLE 30G X 1/2" 0.5 ML
- ULTIGUARD SAFEPAK SYR/NEEDLE 30G X 1/2" 1 ML
- ULTIGUARD SAFEPAK SYR/NEEDLE 31G X 5/16" 0.3 ML
- ULTIGUARD SAFEPAK SYR/NEEDLE 31G X 5/16" 0.5 ML
- ULTIGUARD SAFEPAK SYR/NEEDLE 31G X 5/16" 1 ML
- ULTILET ALCOHOL SWABS PAD
- ULTILET INSULIN SYRINGE 30G X 1/2" 0.5 ML
- ULTILET INSULIN SYRINGE 30G X 1/2" 1 ML
- ULTILET INSULIN SYRINGE 30G X 5/16" 0.3 ML
- ULTILET INSULIN SYRINGE 30G X 5/16" 0.5 ML
- ULTILET INSULIN SYRINGE 30G X 5/16" 1 ML
- ULTILET INSULIN SYRINGE 31G X 1/4" 0.3 ML
- ULTILET INSULIN SYRINGE 31G X 1/4" 1 ML
- ULTILET INSULIN SYRINGE 31G X 15/64" 0.3 ML (OTC)
- ULTILET INSULIN SYRINGE 31G X 15/64" 0.3 ML (RX)
- ULTILET INSULIN SYRINGE 31G X 15/64" 0.5 ML
- ULTILET INSULIN SYRINGE 31G X 5/16" 0.3 ML
- ULTILET INSULIN SYRINGE 31G X 5/16" 1 ML
- ULTILET INSULIN SYRINGE SHORT 30G X 1/2" 0.3 ML
- ULTILET INSULIN SYRINGE SHORT 30G X 5/16" 0.3 ML
- ULTILET INSULIN SYRINGE SHORT 30G X 5/16" 0.5 ML
- ULTILET INSULIN SYRINGE SHORT 30G X 5/16" 1 ML
- ULTILET INSULIN SYRINGE SHORT 31G X 5/16" 0.3 ML
- ULTILET INSULIN SYRINGE SHORT 31G X 5/16" 0.5 ML
- ULTILET INSULIN SYRINGE SHORT 31G X 5/16" 1 ML
- ULTILET PEN NEEDLE 29G X 12.7MM
- ULTILET PEN NEEDLE 31G X 5 MM
- ULTILET PEN NEEDLE 31G X 8 MM
- ULTILET PEN NEEDLE 32G X 4 MM
- ULTRA COMFORT INSULIN SYRINGE 30G X 5/16" 0.3 ML
- ULTRA FLO INSULIN PEN NEEDLES 29G X 12MM
- ULTRA FLO INSULIN PEN NEEDLES 31G X 8 MM
- ULTRA FLO INSULIN PEN NEEDLES 32G X 4 MM
- ULTRA FLO INSULIN PEN NEEDLES 33G X 4 MM
- ULTRA FLO INSULIN SYR 1/2 UNIT 30G X 1/2" 0.3 ML
- ULTRA FLO INSULIN SYR 1/2 UNIT 30G X 5/16" 0.3 ML

Formulary ID: 25489

Last Updated: 05/27/2025

Effective: 06/01/2025

H9306_25_DRS_001_002_OE_C

- ULTRA FLO INSULIN SYR 1/2 UNIT 31G X 5/16" 0.3 ML
- ULTRA FLO INSULIN SYRINGE 29G X 1/2" 0.3 ML
- ULTRA FLO INSULIN SYRINGE 29G X 1/2" 0.5 ML
- ULTRA FLO INSULIN SYRINGE 29G X 1/2" 1 ML
- ULTRA FLO INSULIN SYRINGE 30G X 1/2" 0.3 ML
- ULTRA FLO INSULIN SYRINGE 30G X 1/2" 0.5 ML
- ULTRA FLO INSULIN SYRINGE 30G X 1/2" 1 ML
- ULTRA FLO INSULIN SYRINGE 30G X 5/16" 0.3 ML
- ULTRA FLO INSULIN SYRINGE 30G X 5/16" 0.5 ML
- ULTRA FLO INSULIN SYRINGE 30G X 5/16" 1 ML
- ULTRA FLO INSULIN SYRINGE 31G X 5/16" 0.3 ML
- ULTRA FLO INSULIN SYRINGE 31G X 5/16" 0.5 ML
- ULTRA FLO INSULIN SYRINGE 31G X 5/16" 1 ML
- ULTRA THIN PEN NEEDLES 32G X 4 MM
- ULTRA-COMFORT INSULIN SYRINGE 29G X 1/2" 0.5 ML
- ULTRA-THIN II INS SYR SHORT 30G X 5/16" 0.3 ML
- ULTRA-THIN II INS SYR SHORT 30G X 5/16" 0.5 ML
- ULTRA-THIN II INS SYR SHORT 30G X 5/16" 1 ML
- ULTRA-THIN II INS SYR SHORT 31G X 5/16" 0.3 ML
- ULTRA-THIN II INS SYR SHORT 31G X 5/16" 0.5 ML
- ULTRA-THIN II INS SYR SHORT 31G X 5/16" 1 ML
- ULTRA-THIN II INSULIN SYRINGE 29G X 1/2" 0.5 ML
- ULTRA-THIN II INSULIN SYRINGE 29G X 1/2" 1 ML
- ULTRA-THIN II MINI PEN NEEDLE 31G X 5 MM
- ULTRA-THIN II PEN NEEDLE SHORT 31G X 8 MM
- ULTRA-THIN II PEN NEEDLES 29G X 12.7MM
- ULTRACARE INSULIN SYRINGE 30G X 1/2" 0.5 ML
- ULTRACARE INSULIN SYRINGE 30G X 1/2" 1 ML
- ULTRACARE INSULIN SYRINGE 30G X 5/16" 0.3 ML
- ULTRACARE INSULIN SYRINGE 30G X 5/16" 0.5 ML
- ULTRACARE INSULIN SYRINGE 30G X 5/16" 1 ML
- ULTRACARE INSULIN SYRINGE 31G X 5/16" 0.3 ML
- ULTRACARE INSULIN SYRINGE 31G X 5/16" 0.5 ML
- ULTRACARE INSULIN SYRINGE 31G X 5/16" 1 ML
- ULTRACARE PEN NEEDLES 31G X 5 MM
- ULTRACARE PEN NEEDLES 31G X 6 MM
- ULTRACARE PEN NEEDLES 31G X 8 MM
- ULTRACARE PEN NEEDLES 32G X 4 MM
- ULTRACARE PEN NEEDLES 32G X 5 MM
- ULTRACARE PEN NEEDLES 32G X 6 MM
- ULTRACARE PEN NEEDLES 33G X 4 MM
- UNIFINE OTC PEN NEEDLES 31G X 5 MM

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

- UNIFINE OTC PEN NEEDLES 32G X 4 MM
- UNIFINE PEN NEEDLES 32G X 4 MM
- UNIFINE PENTIPS 29G X 12MM
- UNIFINE PENTIPS 31G X 6 MM
- UNIFINE PENTIPS 31G X 8 MM
- UNIFINE PENTIPS PLUS 29G X 12MM
- UNIFINE PENTIPS PLUS 31G X 6 MM
- UNIFINE PENTIPS PLUS 32G X 4 MM
- UNIFINE PROTECT PEN NEEDLE 30G X 5 MM
- UNIFINE PROTECT PEN NEEDLE 30G X 8 MM
- UNIFINE PROTECT PEN NEEDLE 32G X 4 MM
- UNIFINE SAFECONTROL PEN NEEDLE 30G X 5 MM
- UNIFINE SAFECONTROL PEN NEEDLE 30G X 8 MM
- UNIFINE SAFECONTROL PEN NEEDLE 31G X 5 MM
- UNIFINE SAFECONTROL PEN NEEDLE 31G X 6 MM
- UNIFINE SAFECONTROL PEN NEEDLE 31G X 8 MM
- UNIFINE SAFECONTROL PEN NEEDLE 32G X 4 MM
- UNIFINE ULTRA PEN NEEDLE 31G X 5 MM
- UNIFINE ULTRA PEN NEEDLE 31G X 6 MM
- UNIFINE ULTRA PEN NEEDLE 31G X 8 MM
- UNIFINE ULTRA PEN NEEDLE 32G X 4 MM
- VALUE HEALTH INSULIN SYRINGE 29G X 1/2" 0.5 ML
- VALUE HEALTH INSULIN SYRINGE 29G X 1/2" 1 ML
- VANISHPOINT INSULIN SYRINGE 29G X 5/16" 1 ML
- VANISHPOINT INSULIN SYRINGE 30G X 3/16" 0.5 ML
- VANISHPOINT INSULIN SYRINGE 30G X 3/16" 1 ML
- VANISHPOINT INSULIN SYRINGE 30G X 5/16" 0.5 ML
- VANISHPOINT INSULIN SYRINGE 30G X 5/16" 1 ML
- VERIFINE INSULIN PEN NEEDLE 29G X 12MM
- VERIFINE INSULIN PEN NEEDLE 31G X 5 MM
- VERIFINE INSULIN PEN NEEDLE 32G X 6 MM
- VERIFINE INSULIN SYRINGE 29G X 1/2" 0.5 ML
- VERIFINE INSULIN SYRINGE 29G X 1/2" 1 ML
- VERIFINE INSULIN SYRINGE 31G X 5/16" 0.3 ML
- VERIFINE INSULIN SYRINGE 31G X 5/16" 0.5 ML
- VERIFINE INSULIN SYRINGE 31G X 5/16" 1 ML
- VERIFINE PLUS PEN NEEDLE 31G X 5 MM
- VERIFINE PLUS PEN NEEDLE 31G X 8 MM
- VERIFINE PLUS PEN NEEDLE 32G X 4 MM
- VP INSULIN SYRINGE 29G X 1/2" 0.3 ML
- WEBCOL ALCOHOL PREP LARGE PAD 70 %
- WEGMANS UNIFINE PENTIPS PLUS 31G X 8 MM
- ZEVRX STERILE ALCOHOL PREP PAD PAD 70 %

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	LIFETIME
Other Criteria	ONLY COVERED UNDER PART D WHEN USED CONCURRENTLY WITH INSULIN.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
 Last Updated: 05/27/2025
 Effective: 06/01/2025
 H9306_25_DRS_001_002_OE_C

INTERFERON FOR MS-AVONEX

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	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
 Last Updated: 05/27/2025
 Effective: 06/01/2025
 H9306_25_DRS_001_002_OE_C

INTERFERON FOR MS-BETASERON

Products Affected

- BETASERON SUBCUTANEOUS KIT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

INTERFERON FOR MS-PLEGRIDY

Products Affected

- PLEGRIDY STARTER PACK SUBCUTANEOUS SOLUTION AUTO-INJECTOR
- PLEGRIDY STARTER PACK SUBCUTANEOUS SOLUTION PREFILLED SYRINGE
- PLEGRIDY SUBCUTANEOUS SOLUTION AUTO-INJECTOR
- PLEGRIDY SUBCUTANEOUS SOLUTION PREFILLED SYRINGE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

INTERFERON GAMMA-1B

Products Affected

- ACTIMMUNE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	INITIAL: CHRONIC GRANULOMATOUS DISEASE (CGD): PRESCRIBED BY OR IN CONSULTATION WITH A HEMATOLOGIST, INFECTIOUS DISEASE SPECIALIST, OR IMMUNOLOGIST. SEVERE MALIGNANT OSTEOPETROSIS (SMO): PRESCRIBED BY OR IN CONSULTATION WITH AN ENDOCRINOLOGIST OR HEMATOLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS
Other Criteria	RENEWAL: CGD, SMO: 1) DEMONSTRATED CLINICAL BENEFIT COMPARED TO BASELINE, AND 2) HAS NOT RECEIVED HEMATOPOIETIC CELL TRANSPLANTATION.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

IPILIMUMAB

Products Affected

- YERVOY

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL: UNRESECT/MET MEL: 4MO, RCC/CRC/HCC: 3MO, ALL OTHERS: 12MO. INITIAL/RENEWAL: CUTAN MEL: 6MO
Other Criteria	RENEWAL: ADJUVANT CUTANEOUS MELANOMA: NO EVIDENCE OF DISEASE RECURRENCE (DEFINED AS THE APPEARANCE OF ONE OR MORE NEW MELANOMA LESIONS: LOCAL, REGIONAL OR DISTANT METASTASIS). THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

IVACAFTOR

Products Affected

- KALYDECO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	CYSTIC FIBROSIS (CF): INITIAL: CONFIRMED MUTATION IN CFTR GENE ACCEPTABLE FOR THE TREATMENT OF CYSTIC FIBROSIS
Age Restrictions	
Prescriber Restrictions	CF: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A PULMONOLOGIST OR CYSTIC FIBROSIS EXPERT
Coverage Duration	INITIAL: 12 MONTHS. RENEWAL: LIFETIME
Other Criteria	CF: INITIAL: NOT HOMOZYGOUS FOR F508DEL MUTATION IN CFTR GENE. RENEWAL: IMPROVEMENT IN CLINICAL STATUS.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

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H9306_25_DRS_001_002_OE_C

IVOSIDENIB

Products Affected

- TIBSOVO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

IXAZOMIB

Products Affected

- NINLARO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

LANREOTIDE

Products Affected

- LANREOTIDE ACETATE
- SOMATULINE DEPOT
SUBCUTANEOUS SOLUTION 60
MG/0.2ML, 90 MG/0.3ML

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	ACROMEGALY: INITIAL: THERAPY IS PRESCRIBED BY OR IN CONSULTATION WITH AN ENDOCRINOLOGIST.
Coverage Duration	ACROMEGALY: INITIAL: 3 MOS, RENEWAL: 12 MOS.GEP-NETS, CARCINOID SYNDROME: 12 MOS.
Other Criteria	ACROMEGALY: INITIAL: TRIAL OF OR CONTRAINDICATION TO ONE GENERIC OCTREOTIDE INJECTION. RENEWAL: 1) REDUCTION, NORMALIZATION, OR MAINTENANCE OF IGF-1 LEVELS BASED ON AGE AND GENDER, AND 2) IMPROVEMENT OR SUSTAINED REMISSION OF CLINICAL SYMPTOMS.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

LAPATINIB

Products Affected

- *lapatinib ditosylate*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

LAROTRECTINIB

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	12 MONTHS
Other Criteria	VITRAKVI ORAL SOLUTION: 1) TRIAL OF VITRAKVI CAPSULES, OR 2) UNABLE TO TAKE CAPSULE FORMULATION.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

LAZERTINIB

Products Affected

- LAZCLUZE ORAL TABLET 240 MG,
80 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

LEDIPASVIR-SOFOSBUVIR

Products Affected

- HARVONI ORAL PACKET 33.75-150 MG, 45-200 MG
- HARVONI ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	HCV RNA LEVEL WITHIN PAST 6 MONTHS.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE.
Other Criteria	1) CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE, AND 2) NOT CONCURRENTLY TAKING ANY OF THE FOLLOWING: CARBAMAZEPINE, PHENYTOIN, PHENOBARBITAL, OXCARBAZEPINE, RIFAMPIN, RIFABUTIN, RIFAPENTINE, ROSUVASTATIN, TIPRANAVIR/RITONAVIR, SOFOSBUVIR (AS A SINGLE AGENT), EPCLUSA, ZEPATIER, MAVYRET, OR VOSEVI. REQUESTS FOR HARVONI 45MG-200MG PELLETS: PATIENT IS UNABLE TO SWALLOW TABLETS.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
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 Effective: 06/01/2025
 H9306_25_DRS_001_002_OE_C

LENALIDOMIDE

Products Affected

- *lenalidomide*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

LENVATINIB

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	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

LETERMOVIR

Products Affected

- PREVYMIS ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	HSCT: NOT AT RISK FOR LATE CMV: 4 MOS, AT RISK FOR LATE CMV: 7 MOS. KIDNEY TRANSPLANT: 7 MOS.
Other Criteria	HEMATOPOIETIC STEM CELL TRANSPLANT (HSCT): 1) THERAPY WILL BE INITIATED BETWEEN DAY 0 AND DAY 28 POST TRANSPLANT, AND 2) WILL NOT RECEIVE THE MEDICATION BEYOND 100 DAYS POST TRANSPLANT IF NOT AT RISK FOR LATE CYTOMEGALOVIRUS (CMV) INFECTION AND DISEASE, OR BEYOND 200 DAYS POST TRANSPLANT IF AT RISK FOR LATE CMV INFECTION AND DISEASE. KIDNEY TRANSPLANT: 1) THERAPY WILL BE INITIATED BETWEEN DAY 0 AND DAY 7 POST TRANSPLANT, AND 2) WILL NOT RECEIVE THE MEDICATION BEYOND 200 DAYS POST TRANSPLANT.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

LEUPROLIDE

Products Affected

- *leuprolide acetate injection*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PROSTATE CANCER: 12 MONTHS.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

LEUPROLIDE DEPOT

Products Affected

- LEUPROLIDE ACETATE (3 MONTH)
- LUTRATE DEPOT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
 Last Updated: 05/27/2025
 Effective: 06/01/2025
 H9306_25_DRS_001_002_OE_C

LEUPROLIDE-ELIGARD

Products Affected

- ELIGARD

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

LEUPROLIDE-LUPRON DEPOT

Products Affected

- LUPRON DEPOT (1-MONTH)
- LUPRON DEPOT (3-MONTH)
- LUPRON DEPOT (4-MONTH)
- LUPRON DEPOT (6-MONTH)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: ENDOMETRIOSIS: DIAGNOSIS IS CONFIRMED VIA SURGICAL OR DIRECT VISUALIZATION (E.G., PELVIC ULTRASOUND) OR HISTOPATHOLOGICAL CONFIRMATION (E.G., LAPAROSCOPY OR LAPAROTOMY) IN THE LAST 10 YEARS.
Age Restrictions	
Prescriber Restrictions	INITIAL: ENDOMETRIOSIS: PRESCRIBED BY OR IN CONSULTATION WITH AN OBSTETRICIAN/GYNECOLOGIST.
Coverage Duration	PROSTATE CA: 12 MOS. UTERINE FIBROIDS: 3 MOS. ENDOMETRIOSIS: INITIAL/RENEWAL: 6 MOS.
Other Criteria	INITIAL: ENDOMETRIOSIS: 1) NO CONCURRENT USE WITH ANOTHER GNRH-MODULATING AGENT, 2) TRIAL OF OR CONTRAINDICATION TO NSAID AND PROGESTIN-CONTAINING PREPARATION, AND 3) HAS NOT RECEIVED A TOTAL OF 12 MONTHS OF TREATMENT PER LIFETIME. RENEWAL: ENDOMETRIOSIS: 1) IMPROVEMENT OF PAIN RELATED TO ENDOMETRIOSIS WHILE ON THERAPY, 2) RECEIVING CONCOMITANT ADD-BACK THERAPY (I.E., COMBINATION ESTROGEN-PROGESTIN OR PROGESTIN-ONLY CONTRACEPTIVE PREPARATION), 3) NO CONCURRENT USE WITH ANOTHER GNRH-MODULATING AGENT, AND 4) HAS NOT RECEIVED A TOTAL OF 12 MONTHS OF TREATMENT PER LIFETIME. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.

Formulary ID: 25489

Last Updated: 05/27/2025

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H9306_25_DRS_001_002_OE_C

PA Criteria	Criteria Details
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

LEUPROLIDE-LUPRON DEPOT-PED

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	CENTRAL PRECOCIOUS PUBERTY (CPP): INITIAL: FEMALES: ELEVATED LEVELS OF FOLLICLE-STIMULATING HORMONE (FSH) GREATER THAN 4.0 MIU/ML AND LUTEINIZING HORMONE (LH) LEVEL GREATER THAN 0.2 TO 0.3 MIU/ML AT DIAGNOSIS. MALES: ELEVATED LEVELS OF FSH GREATER THAN 5.0 MIU/ML AND LH LEVEL GREATER THAN 0.2 TO 0.3 MIU/ML AT DIAGNOSIS.
Age Restrictions	
Prescriber Restrictions	CPP: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH AN ENDOCRINOLOGIST.
Coverage Duration	INITIAL/RENEWAL: 12 MONTHS.
Other Criteria	CPP: INITIAL: FEMALES: 1) YOUNGER THAN 8 YEARS OF AGE AT ONSET OF CPP, AND 2) AT TANNER STAGE 2 OR ABOVE FOR BREAST DEVELOPMENT AND PUBIC HAIR GROWTH. MALES: 1) YOUNGER THAN 9 YEARS OF AGE AT ONSET OF CPP, AND 2) AT TANNER STAGE 2 OR ABOVE FOR GENITAL DEVELOPMENT AND PUBIC HAIR GROWTH. RENEWAL: 1) TANNER STAGING AT INITIAL DIAGNOSIS HAS STABILIZED OR REGRESSED DURING THREE SEPARATE MEDICAL VISITS IN THE PREVIOUS YEAR, AND 2) HAS NOT REACHED ACTUAL AGE WHICH CORRESPONDS TO CURRENT PUBERTAL AGE. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	

Formulary ID: 25489

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Effective: 06/01/2025

H9306_25_DRS_001_002_OE_C

PA Criteria	Criteria Details
Part B Prerequisite	No

Formulary ID: 25489
 Last Updated: 05/27/2025
 Effective: 06/01/2025
 H9306_25_DRS_001_002_OE_C

L-GLUTAMINE

Products Affected

- l-glutamine oral packet*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	SICKLE CELL DISEASE(SCD): INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A HEMATOLOGIST
Coverage Duration	INITIAL: 12 MONTHS. RENEWAL: LIFETIME.
Other Criteria	SCD: INITIAL: AGES 18 YEARS OR OLDER: 1) AT LEAST 2 SICKLE CELL CRISES IN THE PAST YEAR, 2) SICKLE-CELL ASSOCIATED SYMPTOMS WHICH ARE INTERFERING WITH ACTIVITIES OF DAILY LIVING, OR 3) HISTORY OF OR HAS RECURRENT ACUTE CHEST SYNDROME. AGES 5 TO 17 YEARS: APPROVED WITHOUT ADDITIONAL CRITERIA. RENEWAL: MAINTAINED OR EXPERIENCED A REDUCTION IN ACUTE COMPLICATIONS OF SCD.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

LIDOCAINE OINTMENT

Products Affected

- *lidocaine external ointment 5 %*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	THIS DRUG MAY BE EITHER BUNDLED WITH AND COVERED UNDER END STAGE RENAL DISEASE DIALYSIS RELATED SERVICES OR COVERED UNDER MEDICARE D DEPENDING UPON THE CIRCUMSTANCES.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
 Last Updated: 05/27/2025
 Effective: 06/01/2025
 H9306_25_DRS_001_002_OE_C

LIDOCAINE PATCH

Products Affected

- *lidocaine external patch 5 %*
- *lidocan*
- ZTLIDO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	1) PAIN ASSOCIATED WITH POST-HERPETIC NEURALGIA, 2) NEUROPATHY DUE TO DIABETES MELLITUS, 3) CHRONIC BACK PAIN, OR 4) OSTEOARTHRITIS OF THE KNEE OR HIP.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

LIDOCAINE PRILOCAINE

Products Affected

- *lidocaine-prilocaine external cream*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	THIS DRUG MAY BE EITHER BUNDLED WITH AND COVERED UNDER END STAGE RENAL DISEASE DIALYSIS RELATED SERVICES OR COVERED UNDER MEDICARE D DEPENDING UPON THE CIRCUMSTANCES. INFORMATION MAY NEED TO BE SUBMITTED DESCRIBING THE USE AND SETTING OF THE DRUG TO MAKE THE DETERMINATION.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
 Last Updated: 05/27/2025
 Effective: 06/01/2025
 H9306_25_DRS_001_002_OE_C

LONCASTUXIMAB TESIRINE-LPYL

Products Affected

- ZYNLONTA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
 Last Updated: 05/27/2025
 Effective: 06/01/2025
 H9306_25_DRS_001_002_OE_C

LORLATINIB

Products Affected

- LORBRENA ORAL TABLET 100 MG,
25 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

LOTILANER

Products Affected

- XDEM VY

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	DEMODEX BLEPHARITIS: 18 YEARS OF AGE OR OLDER
Prescriber Restrictions	
Coverage Duration	6 WEEKS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

LUMACAFITOR-IVACAFITOR

Products Affected

- ORKAMBI ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: CYSTIC FIBROSIS (CF); CONFIRMED MUTATION IN CFTR GENE ACCEPTABLE FOR THE TREATMENT OF CF.
Age Restrictions	
Prescriber Restrictions	CF: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A PULMONOLOGIST OR CF EXPERT.
Coverage Duration	INITIAL: 6 MONTHS, RENEWAL: LIFETIME.
Other Criteria	CF: RENEWAL: IMPROVEMENT IN CLINICAL STATUS.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

MACITENTAN

Products Affected

- OPSUMIT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	PULMONARY ARTERIAL HYPERTENSION (PAH): INITIAL: DIAGNOSIS CONFIRMED BY RIGHT HEART CATHETERIZATION WITH THE FOLLOWING PARAMETERS: 1) MEAN PULMONARY ARTERY PRESSURE (PAP) GREATER THAN 20 MMHG, 2) PULMONARY CAPILLARY WEDGE PRESSURE (PCWP) OF 15 MMHG OR LESS, AND 3) PULMONARY VASCULAR RESISTANCE (PVR) GREATER THAN 2 WOOD UNITS.
Age Restrictions	
Prescriber Restrictions	PAH: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A CARDIOLOGIST OR PULMONOLOGIST.
Coverage Duration	INITIAL/RENEWAL: 12 MONTHS.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

MARGETUXIMAB-CMKB

Products Affected

- MARGENZA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

MARIBAVIR

Products Affected

- LIVTENCITY

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

MECASERMIN

Products Affected

- INCRELEX

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH AN ENDOCRINOLOGIST OR NEPHROLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	INITIAL: OPEN EPIPHYSES AS CONFIRMED BY RADIOGRAPH OF WRIST AND HAND. RENEWAL: IMPROVEMENT WHILE ON THERAPY (I.E., INCREASE IN HEIGHT OR INCREASE IN HEIGHT VELOCITY).
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

MECHLORETHAMINE

Products Affected

- VALCHLOR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

MEPOLIZUMAB

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: ASTHMA: BLOOD EOSINOPHIL LEVEL OF AT LEAST 150 CELLS/MCL WITHIN THE PAST 12 MONTHS.
Age Restrictions	
Prescriber Restrictions	INITIAL: ASTHMA: PRESCRIBED BY OR IN CONSULTATION WITH A PHYSICIAN SPECIALIZING IN PULMONARY OR ALLERGY MEDICINE. CRSWNP: PRESCRIBED BY OR IN CONSULTATION WITH AN OTOLARYNGOLOGIST, ALLERGIST OR IMMUNOLOGIST.
Coverage Duration	INITIAL: ASTHMA: 12 MO. CRSWNP: 6 MO. OTHERS: 12 MO. RENEWAL: CRSWNP, ASTHMA: 12 MO.
Other Criteria	INITIAL: ASTHMA: 1) CONCURRENT THERAPY WITH A MEDIUM, HIGH-DOSE OR MAXIMALLY TOLERATED DOSE OF AN INHALED CORTICOSTEROID (ICS) AND AT LEAST ONE OTHER MAINTENANCE MEDICATION, 2) ONE OF THE FOLLOWING: (A) AT LEAST ONE ASTHMA EXACERBATION REQUIRING SYSTEMIC CORTICOSTEROID BURST LASTING 3 OR MORE DAYS WITHIN THE PAST 12 MONTHS OR AT LEAST ONE SERIOUS EXACERBATION REQUIRING HOSPITALIZATION OR ER VISIT WITHIN THE PAST 12 MONTHS, OR (B) POOR SYMPTOM CONTROL DESPITE CURRENT THERAPY AS EVIDENCED BY AT LEAST THREE OF THE FOLLOWING WITHIN THE PAST 4 WEEKS: DAYTIME ASTHMA SYMPTOMS MORE THAN TWICE/WEEK, ANY NIGHT WAKING DUE TO ASTHMA, SABA RELIEVER FOR SYMPTOMS MORE THAN TWICE/WEEK,

Formulary ID: 25489

Last Updated: 05/27/2025

Effective: 06/01/2025

H9306_25_DRS_001_002_OE_C

PA Criteria	Criteria Details
	ANY ACTIVITY LIMITATION DUE TO ASTHMA, AND 3) NO CONCURRENT USE WITH XOLAIR, DUPIXENT, TEZSPIRE, OR OTHER ANTI-IL5 BIOLOGICS WHEN USED FOR ASTHMA. CRSWNP: 1) A 56 DAY TRIAL OF ONE TOPICAL NASAL CORTICOSTEROID, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR AN AUTOIMMUNE INDICATION. RENEWAL: ASTHMA: 1) NO CONCURRENT USE WITH XOLAIR, DUPIXENT, TEZSPIRE, OR OTHER ANTI-IL5 BIOLOGICS WHEN USED FOR ASTHMA, 2) CONTINUED USE OF ICS AND AT LEAST ONE OTHER MAINTENANCE MEDICATION, AND 3) CLINICAL RESPONSE AS EVIDENCED BY: (A) REDUCTION IN ASTHMA EXACERBATIONS FROM BASELINE, (B) DECREASED UTILIZATION OF RESCUE MEDICATIONS, (C) REDUCTION IN SEVERITY OR FREQUENCY OF ASTHMA-RELATED SYMPTOMS, OR (D) INCREASE IN PERCENT PREDICTED FEV1 FROM PRETREATMENT BASELINE. CRSWNP: 1) CLINICAL BENEFIT COMPARED TO BASELINE, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR AN AUTOIMMUNE INDICATION.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
 Last Updated: 05/27/2025
 Effective: 06/01/2025
 H9306_25_DRS_001_002_OE_C

MIDOSTAURIN

Products Affected

- RYDAPT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	ACUTE MYELOID LEUKEMIA: 6 MONTHS. ADVANCED SYSTEMIC MASTOCYTOSIS: 12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

MIFEPRISTONE

Products Affected

- *mifepristone oral tablet 300 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	CUSHINGS SYNDROME (CS): INITIAL: DIAGNOSIS CONFIRMED BY: 1) 24-HR URINE FREE CORTISOL (2 OR MORE TESTS TO CONFIRM), 2) OVERNIGHT 1MG DEXAMETHASONE TEST, OR 3) LATE NIGHT SALIVARY CORTISOL (2 OR MORE TESTS TO CONFIRM).
Age Restrictions	
Prescriber Restrictions	CS: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH AN ENDOCRINOLOGIST.
Coverage Duration	INITIAL/RENEWAL: 12 MONTHS
Other Criteria	CS: INITIAL: HYPERCORTISOLISM IS NOT A RESULT OF CHRONIC GLUCOCORTICOIDS. RENEWAL: 1) CONTINUES TO HAVE IMPROVEMENT OF GLUCOSE TOLERANCE OR STABLE GLUCOSE TOLERANCE (E.G., REDUCED A1C, IMPROVED FASTING GLUCOSE, ETC.), 2) CONTINUES TO HAVE TOLERABILITY TO THERAPY, AND 3) CONTINUES TO NOT BE A CANDIDATE FOR SURGICAL TREATMENT OR HAS FAILED SURGERY.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

MILTEFOSINE

Products Affected

- IMPAVIDO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

MIRDAMETINIB

Products Affected

- GOMEKLI ORAL CAPSULE 1 MG, 2 MG
- GOMEKLI ORAL TABLET SOLUBLE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
 Last Updated: 05/27/2025
 Effective: 06/01/2025
 H9306_25_DRS_001_002_OE_C

MIRVETUXIMAB SORAVTANSINE-GYNX

Products Affected

- ELAHERE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	EPITHELIAL OVARIAN, FALLOPIAN TUBE, OR PRIMARY PERITONEAL CANCER: AN OPHTHALMIC EXAM, INCLUDING VISUAL ACUITY AND SLIT LAMP EXAM, WILL BE COMPLETED PRIOR TO THE INITIATION OF THERAPY AND AT THE RECOMMENDED SCHEDULED INTERVALS.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

MOMELOTINIB

Products Affected

- OJJAARA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
 Last Updated: 05/27/2025
 Effective: 06/01/2025
 H9306_25_DRS_001_002_OE_C

MOSUNETUZUMAB-AXGB

Products Affected

- LUNSUMIO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	RELAPSED OR REFRACTORY FOLLICULAR LYMPHOMA: INITIAL: 6 MONTHS. RENEWAL: 7 MONTHS.
Other Criteria	RELAPSED OR REFRACTORY FOLLICULAR LYMPHOMA: RENEWAL: 1) HAS ACHIEVED A PARTIAL RESPONSE TO TREATMENT, AND 2) HAS NOT PREVIOUSLY RECEIVED MORE THAN 17 CYCLES OF TREATMENT. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

NARCOLEPSY AGENTS

Products Affected

- *armodafinil*
- *modafinil oral tablet 100 mg, 200 mg*

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

Formulary ID: 25489
 Last Updated: 05/27/2025
 Effective: 06/01/2025
 H9306_25_DRS_001_002_OE_C

NAXITAMAB-GQGK

Products Affected

- DANYELZA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

NERATINIB

Products Affected

- NERLYNX

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	EARLY-STAGE (STAGE I-III) BREAST CANCER: MEDICATION IS BEING REQUESTED WITHIN 2 YEARS OF COMPLETING THE LAST TRASTUZUMAB DOSE. ALL OTHER FDA APPROVED INDICATIONS ARE COVERED WITHOUT ADDITIONAL CRITERIA, EXCEPT THOSE CRITERIA IN THE FDA APPROVED LABEL.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
 Last Updated: 05/27/2025
 Effective: 06/01/2025
 H9306_25_DRS_001_002_OE_C

NILOTINIB

Products Affected

- TASIGNA ORAL CAPSULE 150 MG, 200 MG, 50 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	PREVIOUSLY TREATED PHILADELPHIA CHROMOSOME-POSITIVE CHRONIC MYELOID LEUKEMIA (Ph+ CML): MUTATIONAL ANALYSIS PRIOR TO INITIATION AND TASIGNA IS APPROPRIATE PER NCCN GUIDELINE TABLE FOR TREATMENT RECOMMENDATIONS BASED ON BCR-ABL1 MUTATION PROFILE.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

NILOTINIB-DANZITEN

Products Affected

- DANZITEN

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	PREVIOUSLY TREATED PHILADELPHIA CHROMOSOME-POSITIVE CHRONIC MYELOID LEUKEMIA (Ph+ CML): 1) PERFORMED MUTATIONAL ANALYSIS PRIOR TO INITIATION OF THERAPY, AND 2) THERAPY IS APPROPRIATE PER NCCN GUIDELINE TABLE FOR TREATMENT RECOMMENDATIONS BASED ON BCR-ABL1 MUTATION PROFILE.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

NINTEDANIB

Products Affected

- OFEV

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: IDIOPATHIC PULMONARY FIBROSIS (IPF): 1) A USUAL INTERSTITIAL PNEUMONIA (UIP) PATTERN AS EVIDENCED BY HIGH-RESOLUTION COMPUTED TOMOGRAPHY (HRCT) ALONE OR VIA A COMBINATION OF SURGICAL LUNG BIOPSY AND HRCT, AND 2) BASELINE FORCED VITAL CAPACITY (FVC) AT LEAST 50% OF PREDICTED VALUE. SYSTEMIC SCLEROSIS-ASSOCIATED INTERSTITIAL LUNG DISEASE (SSC-ILD): 1) AT LEAST 10% FIBROSIS ON A CHEST HRCT, AND 2) BASELINE FVC AT LEAST 40% OF PREDICTED VALUE. CHRONIC FIBROSING INTERSTITIAL LUNG DISEASE WITH A PROGRESSIVE PHENOTYPE (PF-ILD): 1) AT LEAST 10% FIBROSIS ON A CHEST HRCT, AND 2) BASELINE FVC AT LEAST 45% OF PREDICTED VALUE.
Age Restrictions	
Prescriber Restrictions	INITIAL: IPF: PRESCRIBED BY OR IN CONSULTATION WITH A PULMONOLOGIST. SSC-ILD, PF-ILD: PRESCRIBED BY OR IN CONSULTATION WITH A PULMONOLOGIST OR RHEUMATOLOGIST.
Coverage Duration	INITIAL: SSC-ILD: 6 MOS. IPF, PF-ILD: 12 MOS. RENEWAL (ALL INDICATIONS): 12 MOS.
Other Criteria	INITIAL: IPF: 1) DOES NOT HAVE OTHER KNOWN CAUSES OF INTERSTITIAL LUNG DISEASE (E.G., CONNECTIVE TISSUE DISEASE, DRUG TOXICITY, ASBESTOS OR BERYLLIUM EXPOSURE, HYPERSENSITIVITY PNEUMONITIS), AND 2) TRIAL OF OR CONTRAINDICATION TO THE PREFERRED AGENT: ESBRIET (PIRFENIDONE). SSC-ILD: 1) DOES NOT HAVE OTHER KNOWN CAUSES OF INTERSTITIAL LUNG DISEASE (E.G., HEART FAILURE/FLUID OVERLOAD, DRUG-INDUCED LUNG

Formulary ID: 25489

Last Updated: 05/27/2025

Effective: 06/01/2025

H9306_25_DRS_001_002_OE_C

PA Criteria	Criteria Details
	TOXICITY, RECURRENT ASPIRATION), AND 2) TRIAL OF OR CONTRAINDICATION TO THE PREFERRED AGENT: ACTEMRA SUBQ. PF-ILD: LUNG FUNCTION AND RESPIRATORY SYMPTOMS OR CHEST IMAGING HAVE WORSENERD/PROGRESSED DESPITE TREATMENT WITH MEDICATIONS USED IN CLINICAL PRACTICE FOR ILD (NOT ATTRIBUTABLE TO COMORBIDITIES SUCH AS INFECTION, HEART FAILURE). RENEWAL: IPF, SSC-ILD, PF-ILD: CLINICAL MEANINGFUL IMPROVEMENT OR MAINTENANCE IN ANNUAL RATE OF DECLINE.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

NIRAPARIB

Products Affected

- ZEJULA ORAL CAPSULE
- ZEJULA ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	RECURRENT EPITHELIAL OVARIAN, FALLOPIAN TUBE, OR PRIMARY PERITONEAL CANCER: 1) ZEJULA WILL BE USED AS MONOTHERAPY, AND 2) ZEJULA IS STARTED NO LATER THAN 8 WEEKS AFTER THE MOST RECENT PLATINUM-CONTAINING REGIMEN.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
 Last Updated: 05/27/2025
 Effective: 06/01/2025
 H9306_25_DRS_001_002_OE_C

NIRAPARIB-ABIRATERONE

Products Affected

- AKEEGA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	METASTATIC CASTRATION-RESISTANT PROSTATE CANCER (MCRPC): 1) RECEIVED A BILATERAL ORCHIECTOMY, 2) CASTRATE LEVEL OF TESTOSTERONE (I.E., LESS THAN 50 NG/DL), OR 3) CONCURRENT USE WITH A GONADOTROPIN RELEASING HORMONE (GNRH) ANALOG.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

NIROGACESTAT

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	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

NITISINONE

Products Affected

- nitisinone*
- ORFADIN ORAL SUSPENSION

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	HEREDITARY TYROSINEMIA TYPE 1 (HT-1): INITIAL: DIAGNOSIS CONFIRMED BY ELEVATED URINARY OR PLASMA SUCCINYLACETONE LEVELS OR A MUTATION IN THE FUMARYLACETOACETATE HYDROLASE GENE. RENEWAL: URINARY OR PLASMA SUCCINYLACETONE LEVELS HAVE DECREASED FROM BASELINE WHILE ON TREATMENT WITH NITISINONE.
Age Restrictions	
Prescriber Restrictions	HT-1: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A PRESCRIBER SPECIALIZING IN INHERITED METABOLIC DISEASES.
Coverage Duration	INITIAL: 6 MONTHS, RENEWAL: 12 MONTHS.
Other Criteria	HT-1: INITIAL: ORFADIN SUSPENSION: TRIAL OF OR CONTRAINDICATION TO PREFERRED NITISINONE TABLETS OR CAPSULES.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

NIVOLUMAB

Products Affected

- OPDIVO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	UNRESECTABLE OR METASTATIC MELANOMA: NO CONCURRENT USE WITH TARGETED THERAPY (I.E., BRAF INHIBITORS, MEK INHIBITORS, AND NTRK INHIBITORS).
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

NIVOLUMAB-HYALURONIDASE-NVHY

Products Affected

- OPDIVO QVANTIG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
 Last Updated: 05/27/2025
 Effective: 06/01/2025
 H9306_25_DRS_001_002_OE_C

NIVOLUMAB-RELATLIMAB-RMBW

Products Affected

- OPDUALAG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

NOGAPENDEKIN ALFA

Products Affected

- ANKTIVA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	40 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
 Last Updated: 05/27/2025
 Effective: 06/01/2025
 H9306_25_DRS_001_002_OE_C

OCRELIZUMAB

Products Affected

- OCREVUS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	RELAPSING FORM OF MULTIPLE SCLEROSIS (MS): TRIAL OF TWO AGENTS INDICATED FOR THE TREATMENT OF RELAPSING FORMS OF MS. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

OCRELIZUMAB-HYALURONIDASE-OCSQ

Products Affected

- OCREVUS ZUNOVO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	RELAPSING FORM OF MULTIPLE SCLEROSIS (MS): TRIAL OF TWO AGENTS INDICATED FOR THE TREATMENT OF RELAPSING FORMS OF MS. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

OFATUMUMAB-SQ

Products Affected

- KESIMPTA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
 Last Updated: 05/27/2025
 Effective: 06/01/2025
 H9306_25_DRS_001_002_OE_C

OLANZAPINE/SAMIDORPHAN

Products Affected

- LYBALVI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	SCHIZOPHRENIA, BIPOLAR I: PRESCRIBED BY OR IN CONSULTATION WITH A PSYCHIATRIST
Coverage Duration	12 MONTHS
Other Criteria	SCHIZOPHRENIA: 1) AT HIGH RISK FOR WEIGHT GAIN, AND 2) TRIAL OF OR CONTRAINDICATION TO A FORMULARY VERSION OF LURASIDONE OR ONE OF THE FOLLOWING ORAL ANTIPSYCHOTICS: RISPERIDONE, CLOZAPINE TABLET, OLANZAPINE, IMMEDIATE RELEASE QUETIAPINE FUMARATE, ZIPRASIDONE, ARIPIPRAZOLE. BIPOLAR I: 1) AT HIGH RISK FOR WEIGHT GAIN, AND 2) TRIAL OF OR CONTRAINDICATION TO ONE OF THE FOLLOWING ORAL ANTIPSYCHOTICS: RISPERIDONE, OLANZAPINE, IMMEDIATE RELEASE QUETIAPINE FUMARATE, ZIPRASIDONE, ARIPIPRAZOLE.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

OLAPARIB

Products Affected

- LYNPARZA ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	RECURRENT EPITHELIAL OVARIAN, FALLOPIAN TUBE OR PRIMARY PERITONEAL CANCER: MEDICATION WILL BE USED AS MONOTHERAPY. METASTATIC CASTRATION-RESISTANT PROSTATE CANCER: 1) RECEIVED A BILATERAL ORCHIECTOMY, 2) CASTRATE LEVEL OF TESTOSTERONE (I.E., LESS THAN 50 NG/DL), OR 3) CONCURRENT USE WITH A GONADOTROPIN RELEASING HORMONE (GNRH) ANALOG. ALL OTHER FDA APPROVED INDICATIONS ARE COVERED WITHOUT ADDITIONAL CRITERIA, EXCEPT THOSE CRITERIA IN THE FDA APPROVED LABEL.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

OLUTASIDENIB

Products Affected

- REZLIDHIA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

OMACETAXINE

Products Affected

- SYNRIPO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

OMALIZUMAB

Products Affected

- XOLAIR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: ASTHMA: POSITIVE SKIN PRICK OR BLOOD TEST (E.G., ELISA, FEIA) TO A PERENNIAL AEROALLERGEN AND A BASELINE IGE SERUM LEVEL OF AT LEAST 30 IU/ML. FOOD ALLERGY: 1) IGE SERUM LEVEL OF AT LEAST 30 IU/ML, AND 2) ALLERGEN SPECIFIC IGE SERUM LEVEL OF AT LEAST 6 KUA/L TO AT LEAST ONE FOOD, OR POSITIVE SKIN PRICK TEST TO AT LEAST ONE FOOD, OR POSITIVE MEDICALLY MONITORED FOOD CHALLENGE TO AT LEAST ONE FOOD.
Age Restrictions	
Prescriber Restrictions	INITIAL/RENEWAL: CHRONIC SPONTANEOUS URTICARIA (CSU): PRESCRIBED BY OR IN CONSULTATION WITH AN ALLERGIST, DERMATOLOGIST, OR IMMUNOLOGIST. INITIAL: CHRONIC RHINOSINUSITIS WITH NASAL POLYPS (CRSWNP): PRESCRIBED BY OR IN CONSULTATION WITH AN OTOLARYNGOLOGIST, ALLERGIST OR IMMUNOLOGIST. ASTHMA: PRESCRIBED BY OR IN CONSULTATION WITH A PHYSICIAN SPECIALIZING IN ALLERGY OR PULMONARY MEDICINE. FOOD ALLERGY: PRESCRIBED BY OR IN CONSULTATION WITH ALLERGIST OR IMMUNOLOGIST.
Coverage Duration	INITIAL/RENEWAL: ASTHMA 12 MO/12 MO, CSU 6 MO/12 MO, CRSWNP 6 MO/12 MO, FOOD ALLERGY 12 MO/24 MO
Other Criteria	INITIAL: CSU: 1) TRIAL OF AND MAINTAINED ON, OR CONTRAINDICATION TO A SECOND GENERATION H1 ANTI-HISTAMINE AND 2) STILL EXPERIENCES HIVES OR ANGIOEDEMA ON MOST DAYS OF THE WEEK FOR AT LEAST 6 WEEKS. CRSWNP: 1) A 56 DAY TRIAL OF ONE TOPICAL NASAL CORTICOSTEROID, 2) TRIAL OF OR CONTRAINDICATION TO ONE PREFERRED AGENT: NUCALA, DUPIXENT, AND 3) NO

Formulary ID: 25489

Last Updated: 05/27/2025

Effective: 06/01/2025

H9306_25_DRS_001_002_OE_C

PA Criteria	Criteria Details
	CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR AN AUTOIMMUNE INDICATION. ASTHMA: 1) CONCURRENT THERAPY WITH A MEDIUM, HIGH-DOSE OR MAXIMALLY TOLERATED DOSE OF AN INHALED CORTICOSTEROID (ICS) AND AT LEAST ONE OTHER MAINTENANCE MEDICATION, 2) ONE OF THE FOLLOWING: (A) AT LEAST ONE ASTHMA EXACERBATION REQUIRING SYSTEMIC CORTICOSTEROID BURST LASTING 3 OR MORE DAYS WITHIN THE PAST 12 MONTHS OR AT LEAST ONE SERIOUS EXACERBATION REQUIRING HOSPITALIZATION OR ER VISIT WITHIN THE PAST 12 MONTHS, OR (B) POOR SYMPTOM CONTROL DESPITE CURRENT THERAPY AS EVIDENCED BY AT LEAST THREE OF THE FOLLOWING WITHIN THE PAST 4 WEEKS: DAYTIME ASTHMA SYMPTOMS MORE THAN TWICE/WEEK, ANY NIGHT WAKING DUE TO ASTHMA, SABA RELIEVER FOR SYMPTOMS MORE THAN TWICE/WEEK, ANY ACTIVITY LIMITATION DUE TO ASTHMA, AND 3) NO CONCURRENT USE WITH DUPIXENT, TEZSPIRE, OR ANTI-IL5 BIOLOGICS WHEN USED FOR ASTHMA. FOOD ALLERGY: 1) CONCURRENT USE WITH AN ACTIVE PRESCRIPTION FOR EPINEPHRINE AUTO-INJECTOR/INJECTION, AND 2) NO CONCURRENT USE WITH PEANUT-SPECIFIC IMMUNOTHERAPY. RENEWAL: CSU: MAINTAINED ON OR CONTRAINDICATION TO A SECOND GENERATION H1 ANTI-HISTAMINE. CRSWNP: 1) CLINICAL BENEFIT COMPARED TO BASELINE, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR AN AUTOIMMUNE INDICATION. ASTHMA: 1) NO CONCURRENT USE WITH DUPIXENT, TEZSPIRE, OR ANTI-IL5 BIOLOGICS WHEN USED FOR ASTHMA, 2) CONTINUED USE OF ICS AND AT LEAST ONE OTHER MAINTENANCE MEDICATION, AND 3) CLINICAL RESPONSE AS EVIDENCED BY ONE OF THE FOLLOWING: (A) REDUCTION IN ASTHMA EXACERBATIONS FROM BASELINE, (B) DECREASED UTILIZATION OF RESCUE MEDICATIONS, (C) REDUCTION IN SEVERITY OR FREQUENCY OF ASTHMA-RELATED SYMPTOMS, OR (D) INCREASE IN PERCENT PREDICTED FEV1 FROM PRETREATMENT BASELINE. FOOD ALLERGY: 1) PERSISTENT IGE-MEDIATED FOOD ALLERGY, 2) CONCURRENT USE WITH AN ACTIVE PRESCRIPTION FOR

Formulary ID: 25489

Last Updated: 05/27/2025

Effective: 06/01/2025

H9306_25_DRS_001_002_OE_C

PA Criteria	Criteria Details
	EPINEPHRINE AUTO-INJECTOR/INJECTION, AND 3) NO CONCURRENT USE WITH PEANUT-SPECIFIC IMMUNOTHERAPY.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

OSIMERTINIB

Products Affected

- TAGRISSE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

OXANDROLONE

Products Affected

- *oxandrolone oral*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 MONTHS
Other Criteria	PROTEIN CATABOLISM, BONE PAIN: 1) MONITORED FOR PELIOSIS HEPATIS, LIVER CELL TUMORS, AND BLOOD LIPID CHANGES, 2) DOES NOT HAVE KNOWN OR SUSPECTED: CARCINOMA OF THE PROSTATE OR BREAST IN MALE PATIENTS, CARCINOMA OF THE BREAST IN FEMALES WITH HYPERCALCEMIA, NEPHROSIS (THE NEPHROTIC PHASE OF NEPHRITIS), OR HYPERCALCEMIA, AND 3) DOES NOT HAVE SEVERE HEPATIC DYSFUNCTION.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

PACRITINIB

Products Affected

- VONJO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS
Other Criteria	MYELOFIBROSIS; RENEWAL: CONTINUES TO BENEFIT FROM THE MEDICATION
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

PALBOCICLIB

Products Affected

- IBRANCE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	ADVANCED OR METASTATIC BREAST CANCER: TRIAL OF OR CONTRAINDICATION TO ONE OF THE PREFERRED AGENTS, WHERE INDICATIONS ALIGN: KISQALI, VERZENIO.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

PARATHYROID HORMONE

Products Affected

- NATPARA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	HYPOCALCEMIA SECONDARY TO HYPOPARATHYROIDISM: PRESCRIBED BY OR IN CONSULTATION WITH AN ENDOCRINOLOGIST.
Coverage Duration	12 MONTHS
Other Criteria	HYPOCALCEMIA SECONDARY TO HYPOPARATHYROIDISM: 1) TRIAL OF OR CONTRAINDICATION TO CALCITRIOL, 2) HYPOPARATHYROIDISM IS NOT DUE TO A CALCIUM SENSING RECEPTOR (CSR) MUTATION, AND 3) HYPOPARATHYROIDISM IS NOT CONSIDERED ACUTE POST-SURGICAL HYPOPARATHYROIDISM.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

PASIREOTIDE DIASPARTATE

Products Affected

- SIGNIFOR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	CUSHINGS DISEASE (CD): INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH AN ENDOCRINOLOGIST.
Coverage Duration	INITIAL: 6 MONTHS, RENEWAL: 12 MONTHS.
Other Criteria	CD: RENEWAL: 1) CONTINUED IMPROVEMENT OF CUSHINGS DISEASE, AND 2) MAINTAINED TOLERABILITY TO SIGNIFOR.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

PAZOPANIB

Products Affected

- pazopanib hcl*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	ADVANCED SOFT TISSUE SARCOMA (STS): NOT USED FOR ADIPOCYTIC STS OR GASTROINTESTINAL STROMAL TUMORS (GIST)
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
 Last Updated: 05/27/2025
 Effective: 06/01/2025
 H9306_25_DRS_001_002_OE_C

PEGFILGRASTIM - APGF

Products Affected

- NYVEPRIA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR IN CONSULTATION WITH A HEMATOLOGIST OR ONCOLOGIST.
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

PEGFILGRASTIM-NEULASTA ONPRO

Products Affected

- NEULASTA ONPRO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR IN CONSULTATION WITH A HEMATOLOGIST OR ONCOLOGIST.
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

PEGINTERFERON ALFA-2A

Products Affected

- PEGASYS SUBCUTANEOUS SOLUTION 180 MCG/ML
- PEGASYS SUBCUTANEOUS SOLUTION PREFILLED SYRINGE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	HEPATITIS B: PRESCRIBED BY OR IN CONSULTATION WITH A GASTROENTEROLOGIST, INFECTIOUS DISEASE SPECIALIST, OR PHYSICIAN SPECIALIZING IN THE TREATMENT OF HEPATITIS (E.G., HEPATOLOGIST).
Coverage Duration	HEP B/HEP C: 48 WEEKS.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

PEGVISOMANT

Products Affected

- SOMAVERT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

PEMBROLIZUMAB

Products Affected

- KEYTRUDA INTRAVENOUS SOLUTION

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	UNRESECTABLE OR METASTATIC MELANOMA: NO CONCURRENT USE WITH TARGETED THERAPY (I.E., BRAF INHIBITORS, MEK INHIBITORS, AND NTRK INHIBITORS).
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

PEMIGATINIB

Products Affected

- PEMAZYRE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	CHOLANGIOCARCINOMA, MYELOID/LYMPHOID NEOPLASMS: COMPREHENSIVE OPHTHALMOLOGICAL EXAMINATION, INCLUDING OPTICAL COHERENCE TOMOGRAPHY (OCT), WILL BE COMPLETED PRIOR TO INITIATION OF THERAPY AND AT THE RECOMMENDED SCHEDULED INTERVALS.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

PENICILLAMINE TABLET

Products Affected

- *penicillamine oral tablet*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: CYSTINURIA: HAS NEPHROLITHIASIS AND ONE OF THE FOLLOWING: 1) STONE ANALYSIS SHOWING PRESENCE OF CYSTINE, 2) PRESENCE OF PATHOGNOMONIC HEXAGONAL CYSTINE CRYSTALS ON URINALYSIS, OR 3) FAMILY HISTORY OF CYSTINURIA AND POSITIVE CYANIDE-NITROPRUSSIDE SCREENING.
Age Restrictions	
Prescriber Restrictions	INITIAL: WILSONS DISEASE: PRESCRIBED BY OR IN CONSULTATION WITH A HEPATOLOGIST OR GASTROENTEROLOGIST. CYSTINURIA: PRESCRIBED BY OR IN CONSULTATION WITH A NEPHROLOGIST. RHEUMATOID ARTHRITIS (RA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST.
Coverage Duration	INITIAL: 12 MONTHS, RENEWAL: LIFETIME.
Other Criteria	INITIAL: WILSONS DISEASE: 1) LEIPZIG SCORE OF 4 OR GREATER. RA: 1) NO HISTORY OR OTHER EVIDENCE OF RENAL INSUFFICIENCY, AND 2) TRIAL OF OR CONTRAINDICATION TO 3 MONTHS OF TREATMENT WITH ONE DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG) - IF PATIENT TRIED METHOTREXATE, THEN TRIAL AT A DOSE GREATER THAN OR EQUAL TO 20 MG PER WEEK OR MAXIMALLY TOLERATED DOSE IS REQUIRED. RENEWAL: RA: 1) NO HISTORY OR OTHER EVIDENCE OF RENAL INSUFFICIENCY, AND 2) EXPERIENCED OR MAINTAINED IMPROVEMENT IN TENDER JOINT COUNT OR SWOLLEN JOINT COUNT COMPARED TO BASELINE. WILSONS DISEASE, CYSTINURIA: CONTINUES TO BENEFIT FROM THE MEDICATION.

Formulary ID: 25489

Last Updated: 05/27/2025

Effective: 06/01/2025

H9306_25_DRS_001_002_OE_C

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

PEXIDARTINIB

Products Affected

- TURALIO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

PIMAVANSERIN

Products Affected

- NUPLAZID ORAL CAPSULE
- NUPLAZID ORAL TABLET 10 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	PSYCHOSIS IN PARKINSONS DISEASE (PD): INITIAL: 18 YEARS OR OLDER
Prescriber Restrictions	PSYCHOSIS IN PD: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST, GERIATRICIAN, OR A BEHAVIORAL HEALTH SPECIALIST (E.G., PSYCHIATRIST).
Coverage Duration	INITIAL/RENEWAL: 12 MONTHS.
Other Criteria	PSYCHOSIS IN PD: RENEWAL: IMPROVEMENT IN PSYCHOSIS SYMPTOMS FROM BASELINE AND DEMONSTRATES A CONTINUED NEED FOR TREATMENT.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

PIRFENIDONE

Products Affected

- *pirfenidone oral capsule*
- *pirfenidone oral tablet 267 mg, 534 mg, 801 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	IDIOPATHIC PULMONARY FIBROSIS (IPF): INITIAL: 1) A USUAL INTERSTITIAL PNEUMONIA (UIP) PATTERN AS EVIDENCED BY HIGH-RESOLUTION COMPUTED TOMOGRAPHY (HRCT) ALONE OR VIA A COMBINATION OF SURGICAL LUNG BIOPSY AND HRCT, AND 2) PREDICTED FORCED VITAL CAPACITY (FVC) OF AT LEAST 50% AT BASELINE.
Age Restrictions	IPF: INITIAL: 18 YEARS OR OLDER.
Prescriber Restrictions	IPF: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A PULMONOLOGIST.
Coverage Duration	INITIAL/RENEWAL: 12 MONTHS.
Other Criteria	IPF: INITIAL: 1) DOES NOT HAVE OTHER KNOWN CAUSES OF INTERSTITIAL LUNG DISEASE (E.G., CONNECTIVE TISSUE DISEASE, DRUG TOXICITY, ASBESTOS OR BERYLLIUM EXPOSURE, HYPERSENSITIVITY PNEUMONITIS, SYSTEMIC SCLEROSIS, RHEUMATOID ARTHRITIS, RADIATION, SARCOIDOSIS, BRONCHIOLITIS OBLITERANS ORGANIZING PNEUMONIA, HUMAN IMMUNODEFICIENCY VIRUS (HIV) INFECTION, VIRAL HEPATITIS, OR CANCER). RENEWAL: CLINICAL MEANINGFUL IMPROVEMENT OR MAINTENANCE IN ANNUAL RATE OF DECLINE.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489

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H9306_25_DRS_001_002_OE_C

PIRTOBRUTINIB

Products Affected

- JAYPIRCA ORAL TABLET 100 MG, 50 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

POMALIDOMIDE

Products Affected

- POMALYST

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

PONATINIB

Products Affected

- ICLUSIG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	CHRONIC MYELOID LEUKEMIA (CML): MUTATIONAL ANALYSIS PRIOR TO INITIATION AND ICLUSIG IS APPROPRIATE PER NCCN GUIDELINE TABLE FOR TREATMENT RECOMMENDATIONS BASED ON BCR-ABL1 MUTATION PROFILE.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
 Last Updated: 05/27/2025
 Effective: 06/01/2025
 H9306_25_DRS_001_002_OE_C

POSACONAZOLE TABLET

Products Affected

- *posaconazole oral tablet delayed release*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	CONTINUATION OF THERAPY AFTER HOSPITAL DISCHARGE, PROPHYLAXIS: 6 MONTHS. TREATMENT: 12 WEEKS.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

PRALSETINIB

Products Affected

- GAVRETO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
 Last Updated: 05/27/2025
 Effective: 06/01/2025
 H9306_25_DRS_001_002_OE_C

PYRIMETHAMINE

Products Affected

- pyrimethamine oral

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	TOXOPLASMOSIS: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH AN INFECTIOUS DISEASE SPECIALIST.
Coverage Duration	TOXOPLASMOSIS: INITIAL: 8 WEEKS, RENEWAL: 6 MOS.
Other Criteria	TOXOPLASMOSIS: RENEWAL: ONE OF THE FOLLOWING: (1) PERSISTENT CLINICAL DISEASE (HEADACHE, NEUROLOGICAL SYMPTOMS, OR FEVER) AND PERSISTENT RADIOGRAPHIC DISEASE (ONE OR MORE MASS LESIONS ON BRAIN IMAGING), OR (2) CD4 COUNT LESS THAN 200 CELLS/MM3 AND CURRENTLY TAKING AN ANTI-RETROVIRAL THERAPY IF HIV POSITIVE.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

QUININE

Products Affected

- *quinine sulfate oral*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

QUIZARTINIB

Products Affected

- VANFLYTA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

REGORAFENIB

Products Affected

- STIVARGA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
 Last Updated: 05/27/2025
 Effective: 06/01/2025
 H9306_25_DRS_001_002_OE_C

RELUGOLIX

Products Affected

- ORGOVYX

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

REPOTRECTINIB

Products Affected

- AUGTYRO ORAL CAPSULE 160 MG, 40 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

RESLIZUMAB

Products Affected

- CINQAIR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	ASTHMA: INITIAL: BLOOD EOSINOPHIL LEVEL OF AT LEAST 150 CELLS/MCL WITHIN THE PAST 12 MONTHS.
Age Restrictions	
Prescriber Restrictions	ASTHMA: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A PHYSICIAN SPECIALIZING IN ALLERGY OR PULMONARY MEDICINE.
Coverage Duration	INITIAL/RENEWAL: 12 MONTHS.
Other Criteria	ASTHMA: INITIAL: 1) CONCURRENT THERAPY WITH A MEDIUM, HIGH-DOSE OR MAXIMALLY TOLERATED DOSE OF AN INHALED CORTICOSTEROID (ICS) AND ONE OTHER MAINTENANCE MEDICATION, 2) ONE ASTHMA EXACERBATION REQUIRING SYSTEMIC CORTICOSTEROID BURST LASTING 3 OR MORE DAYS WITHIN THE PAST 12 MONTHS, OR AT LEAST ONE SERIOUS EXACERBATION REQUIRING HOSPITALIZATION OR ER VISIT WITHIN THE PAST 12 MONTHS, OR POOR SYMPTOM CONTROL DESPITE CURRENT THERAPY AS EVIDENCED BY AT LEAST THREE OF THE FOLLOWING WITHIN THE PAST 4 WEEKS: (A) DAYTIME ASTHMA SYMPTOMS MORE THAN TWICE/WEEK, (B) ANY NIGHT WAKING DUE TO ASTHMA, (C) SABA RELIEVER FOR SYMPTOMS MORE THAN TWICE/WEEK, (D) ANY ACTIVITY LIMITATION DUE TO ASTHMA, 3) TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: FASENRA, NUCALA, DUPIXENT, AND 4) NO CONCURRENT USE WITH XOLAIR, DUPIXENT, TEZSPIRE, OR OTHER ANTI-IL5 BIOLOGICS WHEN USED FOR ASTHMA.

Formulary ID: 25489

Last Updated: 05/27/2025

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H9306_25_DRS_001_002_OE_C

PA Criteria	Criteria Details
	RENEWAL: 1) NO CONCURRENT USE WITH XOLAIR, DUPIXENT, TEZSPIRE, OR OTHER ANTI-IL5 BIOLOGICS WHEN USED FOR ASTHMA, 2) CONTINUED USE OF ICS AND ONE OTHER MAINTENANCE MEDICATION, AND 3) CLINICAL RESPONSE AS EVIDENCED BY: (A) REDUCTION IN ASTHMA EXACERBATIONS FROM BASELINE, (B) DECREASED UTILIZATION OF RESCUE MEDICATIONS, (C) REDUCTION IN SEVERITY OR FREQUENCY OF ASTHMA-RELATED SYMPTOMS, OR (D) INCREASE IN PERCENT PREDICTED FEV1 FROM PRETREATMENT BASELINE. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

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H9306_25_DRS_001_002_OE_C

RETIFANLIMAB-DLWR

Products Affected

- ZYNYZ

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
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H9306_25_DRS_001_002_OE_C

REVUMENIB

Products Affected

- REVUFORJ ORAL TABLET 110 MG, 160 MG, 25 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
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H9306_25_DRS_001_002_OE_C

RIBOCICLIB

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	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

RIBOCICLIB-LETROZOLE

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	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
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Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

RIFAXIMIN

Products Affected

- XIFAXAN ORAL TABLET 200 MG, 550 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	TRAVELERS DIARRHEA, HEPATIC ENCEPHALOPATHY (HE): 12 MOS. IBS-D: 8 WKS.
Other Criteria	HE: TRIAL OF OR CONTRAINDICATION TO LACTULOSE OR CONCURRENT LACTULOSE THERAPY.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

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H9306_25_DRS_001_002_OE_C

RILONACEPT

Products Affected

- ARCALYST

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	CRYOPYRIN-ASSOCIATED PERIODIC SYNDROMES (CAPS): 1) ONE OF THE FOLLOWING: (A) GENETIC TEST FOR GAIN-OF-FUNCTION MUTATIONS IN THE NLRP3 GENE, OR (B) HAS INFLAMMATORY MARKERS (I.E., ELEVATED CRP, ESR, SERUM AMYLOID A PROTEIN (SAA) OR S100 PROTEINS), AND 2) TWO OF THE FOLLOWING: URTICARIAL-LIKE RASH (NEUTROPHILIC DERMATITIS), COLD-TRIGGERED EPISODES, SENSORINEURAL HEARING LOSS, MUSCULOSKELETAL SYMPTOMS, CHRONIC ASEPTIC MENINGITIS, SKELETAL ABNORMALITIES. DEFICIENCY OF INTERLEUKIN-1 RECEPTOR ANTAGONIST (DIRA): 1) ONE OF THE FOLLOWING: (A) GENETIC TEST FOR GAIN-OF-FUNCTION MUTATIONS IN THE IL1RN GENE, OR (B) HAS INFLAMMATORY MARKERS (I.E., ELEVATED CRP, ESR), AND 2) ONE OF THE FOLLOWING: PUSTULAR PSORIASIS-LIKE RASHES, OSTEOMYELITIS, ABSENCE OF BACTERIAL OSTEOMYELITIS, ONYCHOMADESIS. RECURRENT PERICARDITIS (RP): TWO OF THE FOLLOWING: CHEST PAIN CONSISTENT WITH PERICARDITIS, PERICARDIAL FRICTION RUB, ECG SHOWING DIFFUSE ST-SEGMENT ELEVATION OR PR-SEGMENT DEPRESSION, NEW OR WORSENING PERICARDIAL EFFUSION.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	CAPS, DIRA: LIFETIME. RP: 12 MONTHS.
Other Criteria	CAPS: NO CONCURRENT USE WITH OTHER IL-1 INHIBITORS. DIRA: 1) NO CONCURRENT USE WITH OTHER IL-1 INHIBITORS,

Formulary ID: 25489

Last Updated: 05/27/2025

Effective: 06/01/2025

H9306_25_DRS_001_002_OE_C

PA Criteria	Criteria Details
	AND 2) TRIAL OF THE PREFERRED AGENT: KINERET. RP: 1) HAD AN EPISODE OF ACUTE PERICARDITIS, 2) SYMPTOM-FREE FOR 4 TO 6 WEEKS, AND 3) NO CONCURRENT USE WITH OTHER IL-1 INHIBITORS.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

RIMEGEPANT

Products Affected

- NURTEC

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	INITIAL: ACUTE MIGRAINE TREATMENT: 1) TRIAL OF OR CONTRAINDICATION TO ONE TRIPTAN (E.G., SUMATRIPTAN, RIZATRIPTAN), AND 2) NO CONCURRENT USE WITH OTHER CGRP INHIBITORS FOR ACUTE MIGRAINE TREATMENT. EPISODIC MIGRAINE PREVENTION: 1) NO CONCURRENT USE WITH OTHER CGRP INHIBITORS FOR MIGRAINE PREVENTION, AND 2) TRIAL OF OR CONTRAINDICATION TO ONE OF THE FOLLOWING PREVENTIVE MIGRAINE TREATMENTS: DIVALPROEX SODIUM, TOPIRAMATE, PROPRANOLOL, TIMOLOL. RENEWAL: ACUTE MIGRAINE TREATMENT: 1) NO CONCURRENT USE WITH OTHER CGRP INHIBITORS FOR ACUTE MIGRAINE TREATMENT, AND 2) ONE OF THE FOLLOWING: (A) IMPROVEMENT FROM BASELINE IN A VALIDATED ACUTE TREATMENT PATIENT-REPORTED OUTCOME QUESTIONNAIRE, OR (B) THERAPY WORKS CONSISTENTLY IN MAJORITY OF MIGRAINE ATTACKS. EPISODIC MIGRAINE PREVENTION: 1) NO CONCURRENT USE WITH OTHER CGRP INHIBITORS FOR MIGRAINE PREVENTION, AND 2) REDUCTION IN MIGRAINE OR HEADACHE FREQUENCY,

Formulary ID: 25489

Last Updated: 05/27/2025

Effective: 06/01/2025

H9306_25_DRS_001_002_OE_C

PA Criteria	Criteria Details
	MIGRAINE SEVERITY, OR MIGRAINE DURATION WITH THERAPY.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

RIOCIQUAT

Products Affected

- ADEMPAS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: PULMONARY ARTERIAL HYPERTENSION (PAH): DIAGNOSIS CONFIRMED BY RIGHT HEART CATHETERIZATION WITH THE FOLLOWING PARAMETERS: 1) MEAN PULMONARY ARTERY PRESSURE (PAP) GREATER THAN 20 MMHG, 2) PULMONARY CAPILLARY WEDGE PRESSURE (PCWP) OF 15 MMHG OR LESS, AND 3) PULMONARY VASCULAR RESISTANCE (PVR) GREATER THAN 2 WOOD UNITS. PERSISTENT/RECURRENT CHRONIC THROMBOEMBOLIC PULMONARY HYPERTENSION (CTEPH) (WHO GROUP 4): WHO FUNCTIONAL CLASS II-IV SYMPTOMS.
Age Restrictions	
Prescriber Restrictions	INITIAL: PAH, CTEPH: PRESCRIBED BY OR IN CONSULTATION WITH A CARDIOLOGIST OR PULMONOLOGIST.
Coverage Duration	INITIAL/RENEWAL: 12 MONTHS.
Other Criteria	INITIAL: PAH: NO CONCURRENT USE WITH NITRATES, NITRIC OXIDE DONORS, PHOSPHODIESTERASE (PDE) INHIBITORS, OR NON-SPECIFIC PDE INHIBITORS. CTEPH: 1) NO CONCURRENT USE WITH NITRATES, NITRIC OXIDE DONORS, PDE INHIBITORS, OR NON-SPECIFIC PDE INHIBITORS, AND 2) NOT A CANDIDATE FOR SURGERY OR HAS INOPERABLE CTEPH OR HAS PERSISTENT OR RECURRENT DISEASE AFTER SURGICAL TREATMENT. RENEWAL: PAH, CTEPH: NO CONCURRENT USE WITH NITRATES, NITRIC OXIDE DONORS, PDE INHIBITORS, OR NON-SPECIFIC PDE INHIBITORS.
Indications	All FDA-approved Indications.
Off Label Uses	

Formulary ID: 25489

Last Updated: 05/27/2025

Effective: 06/01/2025

H9306_25_DRS_001_002_OE_C

PA Criteria	Criteria Details
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

RIPRETINIB

Products Affected

- QINLOCK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
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Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

RISANKIZUMAB-RZAA

Products Affected

- SKYRIZI
- SKYRIZI (150 MG DOSE)
- SKYRIZI PEN

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: PLAQUE PSORIASIS (PSO): PLAQUE PSORIASIS COVERING 3 PERCENT OR MORE OF BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, FACE, SCALP, OR GENITAL AREA.
Age Restrictions	
Prescriber Restrictions	INITIAL: PSO: PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST. PSORIATIC ARTHRITIS (PSA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST OR DERMATOLOGIST. CROHNS DISEASE (CD), ULCERATIVE COLITIS (UC): PRESCRIBED BY OR IN CONSULTATION WITH A GASTROENTEROLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS
Other Criteria	INITIAL: PSO: 1) ONE OF THE FOLLOWING: (A) AT LEAST A 3 MONTH TRIAL OF ONE ORAL IMMUNOSUPPRESSANT (CYCLOSPORINE, METHOTREXATE, TACROLIMUS) OR PUVA (PHOTOTHERAPY) FOR THE TREATMENT OF PSO, (B) CONTRAINDICATION OR INTOLERANCE TO BOTH IMMUNOSUPPRESSANT AND PUVA FOR THE TREATMENT OF PSO, OR (C) PATIENT IS SWITCHING FROM A DIFFERENT BIOLOGIC, PDE-4 INHIBITOR, OR JAK INHIBITOR FOR THE SAME INDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR PSO. PSA: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR PSA. CD: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR CD. UC: NO

Formulary ID: 25489

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H9306_25_DRS_001_002_OE_C

PA Criteria	Criteria Details
	CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR UC. RENEWAL: PSO: 1) CONTINUES TO BENEFIT FROM THE MEDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR PSO. PSA: 1) CONTINUES TO BENEFIT FROM THE MEDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR PSA. CD: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR CD. UC: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR UC.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

RITUXIMAB AND HYALURONIDASE HUMAN-SQ

Products Affected

- RITUXAN HYCELA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	FOLLICULAR LYMPHOMA (FL), DIFFUSE LARGE B-CELL LYMPHOMA (DLBCL), CHRONIC LYMPHOCYTIC LEUKEMIA (CLL): HAS RECEIVED OR WILL RECEIVE AT LEAST ONE FULL DOSE OF A RITUXIMAB PRODUCT BY INTRAVENOUS INFUSION PRIOR TO INITIATION OF RITUXIMAB AND HYALURONIDASE. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

RITUXIMAB-ABBS

Products Affected

- TRUXIMA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	INITIAL: RHEUMATOID ARTHRITIS (RA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST. NON-HODGKINS LYMPHOMA (NHL), CHRONIC LYMPHOCYTIC LEUKEMIA (CLL): PRESCRIBED BY OR IN CONSULTATION WITH AN ONCOLOGIST.
Coverage Duration	RA: INITIAL: 6 MO, RENEWAL: 12 MO. NHL, GPA, MPA: 12 MO. CLL: 6 MO.
Other Criteria	RA: INITIAL: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: ENBREL, HUMIRA/CYLTEZO/YUFLYMA, XELJANZ, RINVOQ, ORENCIA. RENEWAL: CONTINUES TO BENEFIT FROM THE MEDICATION. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

RITUXIMAB-ARRX

Products Affected

- RIABNI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	RHEUMATOID ARTHRITIS (RA): INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST. NON-HODGKINS LYMPHOMA (NHL), CHRONIC LYMPHOCYTIC LEUKEMIA (CLL): PRESCRIBED BY OR IN CONSULTATION WITH AN ONCOLOGIST.
Coverage Duration	RA: INITIAL: 6 MO, RENEWAL: 12 MO. NHL, GPA, MPA: 12 MO. CLL: 6 MO.
Other Criteria	RA: INITIAL: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: ENBREL, HUMIRA/CYLTEZO/YUFLYMA, XELJANZ, RINVOQ, ORENCIA. RENEWAL: CONTINUES TO BENEFIT FROM THE MEDICATION. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

RITUXIMAB-PVVR

Products Affected

- RUXIENCE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	RA: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST. NON-HODGKINS LYMPHOMA (NHL), CHRONIC LYMPHOCYTIC LEUKEMIA (CLL): PRESCRIBED BY OR IN CONSULTATION WITH AN ONCOLOGIST.
Coverage Duration	RA: INITIAL: 6 MO, RENEWAL: 12 MO. NHL, GPA, MPA: 12 MO. CLL: 6 MO.
Other Criteria	RA: INITIAL: TRIAL OF OR CONTRAINDICATION TO TWO PREFERRED AGENTS: ENBREL, HUMIRA/CYLTEZO/YUFLYMA, XELJANZ, RINVOQ, ORENCIA. RENEWAL: CONTINUES TO BENEFIT FROM THE MEDICATION. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

ROPEGINTERFERON ALFA-2B-NJFT

Products Affected

- BESREMI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
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 Effective: 06/01/2025
 H9306_25_DRS_001_002_OE_C

RUCAPARIB

Products Affected

- RUBRACA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	METASTATIC CASTRATION-RESISTANT PROSTATE CANCER: ONE OF THE FOLLOWING: 1) RECEIVED A BILATERAL ORCHIECTOMY, 2) CASTRATE LEVEL OF TESTOSTERONE (I.E., LESS THAN 50 NG/DL), OR 3) CONCURRENT USE WITH A GONADOTROPIN RELEASING HORMONE (GNRH) ANALOG.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

RUXOLITINIB

Products Affected

- JAKAFI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	MYELOFIBROSIS: INITIAL: 6 MONTHS, RENEWAL: 12 MONTHS. POLYCYTHEMIA VERA, GVHD: 12 MONTHS.
Other Criteria	MYELOFIBROSIS: RENEWAL: CONTINUES TO BENEFIT FROM THE MEDICATION.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

SAPROPTERIN

Products Affected

- javygtor oral tablet
- sapropterin dihydrochloride oral tablet

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL: 2 MONTHS, RENEWAL 12 MONTHS.
Other Criteria	HYPERPHENYLALANINEMIA (HPA): INITIAL: NO CONCURRENT USE WITH PALYNZIQ. RENEWAL: 1) CONTINUES TO BENEFIT FROM TREATMENT, AND 2) NO CONCURRENT USE WITH PALYNZIQ.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

SECUKINUMAB IV

Products Affected

- COSENTYX INTRAVENOUS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: NON-RADIOGRAPHIC AXIAL SPONDYLOARTHRITIS (NR-AXSPA): 1) C-REACTIVE PROTEIN (CRP) LEVELS ABOVE THE UPPER LIMIT OF NORMAL, OR 2) SACROILIITIS ON MAGNETIC RESONANCE IMAGING (MRI).
Age Restrictions	
Prescriber Restrictions	INITIAL: PSORIATIC ARTHRITIS (PSA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST OR A DERMATOLOGIST. ANKYLOSING SPONDYLITIS (AS), NR-AXSPA: PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS
Other Criteria	INITIAL: PSA: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR PSA. AS: 1) TRIAL OF OR CONTRAINDICATION TO AN NSAID, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR AS. NR-AXSPA: 1) TRIAL OF OR CONTRAINDICATION TO AN NSAID, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR NR-AXSPA. RENEWAL: PSA: 1) CONTINUES TO BENEFIT FROM THE MEDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR PSA. AS: 1) CONTINUES TO BENEFIT FROM THE MEDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR AS. NR-AXSPA: 1) CONTINUES TO BENEFIT FROM THE MEDICATION, AND 2) NO

Formulary ID: 25489

Last Updated: 05/27/2025

Effective: 06/01/2025

H9306_25_DRS_001_002_OE_C

PA Criteria	Criteria Details
	CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR NR-AXSPA. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

SECUKINUMAB SQ

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
Exclusion Criteria	
Required Medical Information	INITIAL: PLAQUE PSORIASIS (PSO): PSORIASIS COVERING 3 PERCENT OR MORE OF BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, GENITAL AREA, SCALP, OR FACE. NON-RADIOGRAPHIC AXIAL SPONDYLOARTHRITIS (NR-AXSPA): 1) C-REACTIVE PROTEIN (CRP) LEVELS ABOVE THE UPPER LIMIT OF NORMAL, OR 2) SACROILIITIS ON MAGNETIC RESONANCE IMAGING (MRI).
Age Restrictions	
Prescriber Restrictions	INITIAL: PSO, HIDRADENITIS SUPPURATIVA (HS): PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST. PSORIATIC ARTHRITIS (PSA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST OR A DERMATOLOGIST. ANKYLOSING SPONDYLITIS (AS), NR-AXSPA, ENTHESITIS-RELATED ARTHRITIS (ERA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST.
Coverage Duration	INITIAL: HS: 12 MONTHS, ALL OTHER INDICATIONS: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	INITIAL: PSO: 1) ONE OF THE FOLLOWING: (A) AT LEAST A 3 MONTH TRIAL OF ONE ORAL IMMUNOSUPPRESSANT (CYCLOSPORINE, METHOTREXATE, TACROLIMUS) OR PUVA (PHOTOTHERAPY) FOR THE TREATMENT OF PSO, (B) CONTRAINDICATION OR INTOLERANCE TO BOTH IMMUNOSUPPRESSANT AND PUVA FOR THE TREATMENT OF PSO, OR (C) PATIENT IS SWITCHING FROM A DIFFERENT BIOLOGIC, PDE-4 INHIBITOR, OR JAK INHIBITOR FOR THE

Formulary ID: 25489

Last Updated: 05/27/2025

Effective: 06/01/2025

H9306_25_DRS_001_002_OE_C

PA Criteria	Criteria Details
	SAME INDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR PSO. PSA: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR PSA. AS: 1) TRIAL OF OR CONTRAINDICATION TO AN NSAID, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR AS. NR-AXSPA: 1) TRIAL OF OR CONTRAINDICATION TO AN NSAID, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR NR-AXSPA. ERA: TRIAL OF OR CONTRAINDICATION TO ONE NSAID, SULFASALAZINE, OR METHOTREXATE. HS: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR HS. RENEWAL: PSO: 1) CONTINUES TO BENEFIT FROM THE MEDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR PSO. PSA: 1) CONTINUES TO BENEFIT FROM THE MEDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR PSA. AS: 1) CONTINUES TO BENEFIT FROM THE MEDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR AS. NR-AXSPA: 1) CONTINUES TO BENEFIT FROM THE MEDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR NR-AXSPA. ERA, HS: CONTINUES TO BENEFIT FROM THE MEDICATION.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

SELEXIPAG

Products Affected

- UPTRAVI INTRAVENOUS
- UPTRAVI ORAL TABLET 1000 MCG, 1200 MCG, 1400 MCG, 1600 MCG, 200 MCG, 400 MCG, 600 MCG, 800 MCG
- UPTRAVI TITRATION

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	PULMONARY ARTERIAL HYPERTENSION (PAH): INITIAL: DIAGNOSIS CONFIRMED BY RIGHT HEART CATHETERIZATION WITH THE FOLLOWING PARAMETERS: 1) MEAN PULMONARY ARTERY PRESSURE (PAP) GREATER THAN 20 MMHG, 2) PULMONARY CAPILLARY WEDGE PRESSURE (PCWP) OF 15 MMHG OR LESS, AND 3) PULMONARY VASCULAR RESISTANCE (PVR) GREATER THAN 2 WOOD UNITS.
Age Restrictions	
Prescriber Restrictions	PAH: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A CARDIOLOGIST OR PULMONOLOGIST.
Coverage Duration	INITIAL/RENEWAL: 12 MONTHS
Other Criteria	PAH: INITIAL: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING AGENTS FROM DIFFERENT DRUG CLASSES: 1) FORMULARY VERSION OF AN ORAL ENDOTHELIN RECEPTOR ANTAGONIST, 2) FORMULARY VERSION OF AN ORAL PHOSPHODIESTERASE TYPE-5 INHIBITOR FOR PAH, 3) FORMULARY VERSION OF AN ORAL CGMP STIMULATOR.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

SELINEXOR

Products Affected

- XPOVIO (100 MG ONCE WEEKLY)
ORAL TABLET THERAPY PACK 50
MG
- XPOVIO (40 MG ONCE WEEKLY)
ORAL TABLET THERAPY PACK 10
MG, 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	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

SELPERCATINIB

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	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

SELUMETINIB

Products Affected

- KOSELUGO ORAL CAPSULE 10 MG,
25 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

SILDENAFIL TABLET

Products Affected

- sildenafil citrate oral tablet 20 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	PULMONARY ARTERIAL HYPERTENSION (PAH): INITIAL: AGES 18 YEARS OR OLDER: DIAGNOSIS CONFIRMED BY RIGHT HEART CATHETERIZATION WITH THE FOLLOWING PARAMETERS: 1) MEAN PULMONARY ARTERY PRESSURE (PAP) GREATER THAN 20 MMHG, 2) PULMONARY CAPILLARY WEDGE PRESSURE (PCWP) OF 15 MMHG OR LESS, AND 3) PULMONARY VASCULAR RESISTANCE (PVR) GREATER THAN 2 WOOD UNITS. AGES 1 TO 17 YEARS: DIAGNOSIS CONFIRMED BY RIGHT HEART CATHETERIZATION WITH THE FOLLOWING PARAMETERS: 1) MEAN PAP GREATER THAN 20 MMHG, 2) PCWP OF 15 MMHG OR LESS, AND 3) PVR OF 3 WOOD UNITS OR GREATER.
Age Restrictions	
Prescriber Restrictions	PAH: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A CARDIOLOGIST OR PULMONOLOGIST.
Coverage Duration	INITIAL/RENEWAL: 12 MONTHS.
Other Criteria	PAH: INITIAL/RENEWAL: 1) NOT CONCURRENTLY OR INTERMITTENTLY TAKING ORAL ERECTILE DYSFUNCTION AGENTS (E.G. CIALIS, VIAGRA) OR ANY ORGANIC NITRATES IN ANY FORM AND 2) NO CONCURRENT USE WITH GUANYLATE CYCLASE STIMULATORS.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489

Last Updated: 05/27/2025

Effective: 06/01/2025

H9306_25_DRS_001_002_OE_C

SIPONIMOD

Products Affected

- MAYZENT ORAL TABLET 0.25 MG, 1 MG, 2 MG
- MAYZENT STARTER PACK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
 Last Updated: 05/27/2025
 Effective: 06/01/2025
 H9306_25_DRS_001_002_OE_C

SIROLIMUS PROTEIN-BOUND

Products Affected

- FYARRO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
 Last Updated: 05/27/2025
 Effective: 06/01/2025
 H9306_25_DRS_001_002_OE_C

SODIUM OXYBATE-XYREM

Products Affected

- sodium oxybate*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	INITIAL: CATAPLEXY IN NARCOLEPSY, EXCESSIVE DAYTIME SLEEPINESS (EDS) IN NARCOLEPSY: PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST, PSYCHIATRIST, OR SPECIALIST IN SLEEP MEDICINE
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS
Other Criteria	INITIAL: EDS IN NARCOLEPSY: 1) NO CONCURRENT USE WITH A SEDATIVE HYPNOTIC AGENT, 2) AGES 18 YEARS OR OLDER: TRIAL, FAILURE OF, OR CONTRAINDICATION TO A FORMULARY VERSION OF MODAFINIL, ARMODAFINIL, OR SUNOSI AND ONE GENERIC STIMULANT INDICATED FOR EDS IN NARCOLEPSY, AND 3) AGES 7 TO 17 YEARS: TRIAL, FAILURE OF, OR CONTRAINDICATION TO ONE GENERIC STIMULANT INDICATED FOR EDS IN NARCOLEPSY. CATAPLEXY IN NARCOLEPSY: NO CONCURRENT USE WITH A SEDATIVE HYPNOTIC AGENT. RENEWAL: CATAPLEXY IN NARCOLEPSY, EDS IN NARCOLEPSY: 1) SUSTAINED IMPROVEMENT OF SYMPTOMS COMPARED TO BASELINE, AND 2) NO CONCURRENT USE WITH A SEDATIVE HYPNOTIC AGENT.
Indications	All FDA-approved Indications.
Off Label Uses	

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

PA Criteria	Criteria Details
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

SOFOSBUVIR/VELPATASVIR

Products Affected

- EPCLUSA ORAL PACKET 150-37.5 MG, 200-50 MG
- EPCLUSA ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	HCV RNA LEVEL WITHIN PAST 6 MONTHS.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE.
Other Criteria	1) CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE, 2) NOT CONCURRENTLY TAKING ANY OF THE FOLLOWING MEDICATIONS: AMIODARONE, CARBAMAZEPINE, PHENYTOIN, PHENOBARBITAL, OXCARBAZEPINE, RIFAMPIN, RIFABUTIN, RIFAPENTINE, HIV REGIMEN THAT CONTAINS EFAVIRENZ, ROSUVASTATIN AT DOSES ABOVE 10MG, TIPRANA VIR/RITONAVIR, TOPOTECAN, SOVALDI (AS A SINGLE AGENT), HARVONI, ZEPATIER, MAVYRET, OR VOSEVI, AND 3) PATIENTS WITH DECOMPENSATED CIRRHOSIS REQUIRE CONCURRENT RIBAVIRIN UNLESS RIBAVIRIN INELIGIBLE.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

SOFOSBUVIR/VELPATASVIR/VOXILAPREVIR

Products Affected

- VOSEVI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	HCV RNA LEVEL WITHIN PAST 6 MONTHS
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE.
Other Criteria	1) CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE, 2) NOT CONCURRENTLY TAKING ANY OF THE FOLLOWING MEDICATIONS: AMIODARONE, CARBAMAZEPINE, PHENYTOIN, PHENOBARBITAL, OXCARBAZEPINE, RIFAMPIN, RIFABUTIN, RIFAPENTINE, CYCLOSPORINE, PITAVASTATIN, PRAVASTATIN (DOSES ABOVE 40MG), ROSUVASTATIN, METHOTREXATE, MITOXANTRONE, IMATINIB, IRINOTECAN, LAPATINIB, SULFASALAZINE, TOPOTECAN, OR HIV REGIMEN THAT CONTAINS EFAVIRENZ, ATAZANAVIR, LOPINAVIR, TIPRANAVIR/RITONAVIR, SOVALDI (AS A SINGLE AGENT), EPCLUSA, HARVONI, ZEPATIER, OR MAVYRET, AND 3) DOES NOT HAVE MODERATE OR SEVERE HEPATIC IMPAIRMENT (CHILD-PUGH B OR C).
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489

Last Updated: 05/27/2025

Effective: 06/01/2025

H9306_25_DRS_001_002_OE_C

SOMATROPIN - NORDITROPIN

Products Affected

- NORDITROPIN FLEXPRO
SUBCUTANEOUS SOLUTION PEN-
INJECTOR

PA Criteria	Criteria Details
Exclusion Criteria	INITIAL/RENEWAL: ATHLETIC ENHANCEMENT, ANTI-AGING PURPOSES.
Required Medical Information	INITIAL: PEDIATRIC GROWTH HORMONE DEFICIENCY (GHD), IDIOPATHIC SHORT STATURE (ISS), SMALL FOR GESTATIONAL AGE (SGA), TURNER SYNDROME (TS), NOONAN SYNDROME: HEIGHT AT LEAST 2 STANDARD DEVIATIONS BELOW THE MEAN HEIGHT FOR CHILDREN OF THE SAME AGE AND GENDER. PRADER WILLI SYNDROME (PWS): CONFIRMED GENETIC DIAGNOSIS.
Age Restrictions	
Prescriber Restrictions	INITIAL/RENEWAL: ALL INDICATIONS: PRESCRIBED BY OR IN CONSULTATION WITH AN ENDOCRINOLOGIST.
Coverage Duration	INITIAL/RENEWAL: 12 MONTHS.
Other Criteria	INITIAL: ADULT GHD: GHD ALONE OR ASSOCIATED WITH MULTIPLE HORMONE DEFICIENCIES (HYPOPITUITARISM), AS A RESULT OF PITUITARY DISEASE, HYPOTHALAMIC DISEASE, SURGERY, RADIATION THERAPY, OR TRAUMA, OR FOR CONTINUATION OF THERAPY FROM CHILDHOOD ONSET GHD. PEDIATRIC GHD, ISS, SGA, TS, NOONAN SYNDROME: OPEN EPIPHYSES AS CONFIRMED BY RADIOGRAPH OF THE WRIST AND HAND. RENEWAL: PEDIATRIC GHD: 1) IMPROVEMENT WHILE ON THERAPY (I.E., INCREASED HEIGHT OR INCREASED GROWTH VELOCITY), AND 2) OPEN EPIPHYSES AS CONFIRMED BY RADIOGRAPH OF THE WRIST AND HAND OR HAS NOT COMPLETED PREPUBERTAL GROWTH. ISS, SGA, TS, NOONAN SYNDROME: 1) IMPROVEMENT WHILE ON THERAPY (I.E., INCREASED HEIGHT OR INCREASED GROWTH VELOCITY),

Formulary ID: 25489

Last Updated: 05/27/2025

Effective: 06/01/2025

H9306_25_DRS_001_002_OE_C

PA Criteria	Criteria Details
	AND 2) OPEN EPIPHYSES AS CONFIRMED BY RADIOGRAPH OF THE WRIST AND HAND. PWS: IMPROVEMENT IN BODY COMPOSITION.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
 Last Updated: 05/27/2025
 Effective: 06/01/2025
 H9306_25_DRS_001_002_OE_C

SOMATROPIN - SEROSTIM

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	INITIAL/RENEWAL: ATHLETIC ENHANCEMENT, ANTI-AGING PURPOSES
Required Medical Information	INITIAL: HIV/WASTING: ONE OF THE FOLLOWING FOR WEIGHT LOSS: 1) 10% UNINTENTIONAL WEIGHT LOSS OVER 12 MONTHS, 2) 7.5% UNINTENTIONAL WEIGHT LOSS OVER 6 MONTHS, 3) 5% BODY CELL MASS (BCM) LOSS WITHIN 6 MONTHS, 4) BCM LESS THAN 35% (MEN) OF TOTAL BODY WEIGHT AND BODY MASS INDEX (BMI) LESS THAN 27 KG PER METER SQUARED, 5) BCM LESS THAN 23% (WOMEN) OF TOTAL BODY WEIGHT AND BMI LESS THAN 27 KG PER METER SQUARED, OR 6) BMI LESS THAN 18.5 KG PER METER SQUARED.
Age Restrictions	
Prescriber Restrictions	HIV/WASTING: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A GASTROENTEROLOGIST, NUTRITIONAL SUPPORT SPECIALIST, OR INFECTIOUS DISEASE SPECIALIST.
Coverage Duration	INITIAL/RENEWAL: 3 MONTHS.
Other Criteria	HIV/WASTING: INITIAL: 1) INADEQUATE RESPONSE TO ONE PREVIOUS THERAPY (E.G., MEGACE, APPETITE STIMULANTS, ANABOLIC STEROIDS). RENEWAL: 1) CLINICAL BENEFIT IN MUSCLE MASS AND WEIGHT.
Indications	All FDA-approved Indications.
Off Label Uses	

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

PA Criteria	Criteria Details
Part B Prerequisite	No

Formulary ID: 25489
 Last Updated: 05/27/2025
 Effective: 06/01/2025
 H9306_25_DRS_001_002_OE_C

SONIDEGIB

Products Affected

- ODOMZO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	LOCALLY ADVANCED BASAL CELL CARCINOMA (BCC): BASELINE SERUM CREATINE KINASE (CK) AND SERUM CREATININE LEVELS
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

SORAFENIB

Products Affected

- sorafenib tosylate*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

SOTATERCEPT-CSRK

Products Affected

- WINREVAIR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	PULMONARY ARTERIAL HYPERTENSION (PAH): INITIAL: DIAGNOSIS CONFIRMED BY RIGHT HEART CATHETERIZATION WITH THE FOLLOWING PARAMETERS: 1) MEAN PULMONARY ARTERY PRESSURE (PAP) GREATER THAN 20 MMHG, 2) PULMONARY CAPILLARY WEDGE PRESSURE (PCWP) OF 15 MMHG OR LESS, AND 3) PULMONARY VASCULAR RESISTANCE (PVR) GREATER THAN 2 WOOD UNITS.
Age Restrictions	
Prescriber Restrictions	PAH: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A CARDIOLOGIST OR PULMONOLOGIST.
Coverage Duration	INITIAL/RENEWAL: 12 MONTHS.
Other Criteria	PAH: INITIAL: 1) ON BACKGROUND PAH THERAPY (FOR AT LEAST 3 MONTHS) WITH AT LEAST TWO OF THE FOLLOWING AGENTS FROM DIFFERENT DRUG CLASSES: A) ORAL ENDOTHELIN RECEPTOR ANTAGONIST, B) ORAL PHOSPHODIESTERASE TYPE-5 INHIBITOR FOR PAH, C) ORAL CGMP STIMULATOR, D) IV/SQ PROSTACYCLIN, OR 2) ON ONE AGENT FROM ONE OF THE ABOVE DRUG CLASSES, AND HAS A CONTRAINDICATION OR INTOLERANCE TO ALL OF THE OTHER DRUG CLASSES.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489

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Effective: 06/01/2025

H9306_25_DRS_001_002_OE_C

SOTORASIB

Products Affected

- LUMAKRAS ORAL TABLET 120 MG, 240 MG, 320 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

STIRIPENTOL

Products Affected

- DIACOMIT ORAL CAPSULE 250 MG, 500 MG
- DIACOMIT ORAL PACKET 250 MG, 500 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	DRAVET SYNDROME: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST.
Coverage Duration	INITIAL/RENEWAL: 12 MONTHS.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

SUNITINIB

Products Affected

- sunitinib malate*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	GASTROINTESTINAL STROMAL TUMORS (GIST): TRIAL OF OR CONTRAINDICATION TO IMATINIB (GLEEVEC).
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

TADALAFIL - ADCIRCA, ALYQ

Products Affected

- *alyq*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	PULMONARY ARTERIAL HYPERTENSION (PAH): INITIAL: DIAGNOSIS CONFIRMED BY RIGHT HEART CATHETERIZATION WITH THE FOLLOWING PARAMETERS: 1) MEAN PULMONARY ARTERY PRESSURE (PAP) GREATER THAN 20 MMHG, 2) PULMONARY CAPILLARY WEDGE PRESSURE (PCWP) OF 15 MMHG OR LESS, AND 3) PULMONARY VASCULAR RESISTANCE (PVR) GREATER THAN 2 WOOD UNITS.
Age Restrictions	
Prescriber Restrictions	PAH: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A CARDIOLOGIST OR PULMONOLOGIST.
Coverage Duration	INITIAL/RENEWAL: 12 MONTHS.
Other Criteria	PAH: INITIAL/RENEWAL: 1) NOT CONCURRENTLY OR INTERMITTENTLY TAKING ORAL ERECTILE DYSFUNCTION AGENTS (E.G. CIALIS, VIAGRA) OR ANY ORGANIC NITRATES IN ANY FORM, AND 2) NO CONCURRENT USE WITH GUANYLATE CYCLASE STIMULATORS.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

TADALAFIL-CIALIS

Products Affected

- tadalafil oral tablet 2.5 mg, 5 mg

PA Criteria	Criteria Details
Exclusion Criteria	ERECTILE DYSFUNCTION WITHOUT DIAGNOSIS OF BENIGN PROSTATIC HYPERPLASIA (BPH).
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	BPH: 1) TRIAL OF ONE ALPHA BLOCKER (E.G., DOXAZOSIN, TERAZOSIN, TAMSULOSIN, ALFUZOSIN), AND 2) TRIAL OF ONE 5-ALPHA-REDUCTASE INHIBITOR (E.G., FINASTERIDE, DUTASTERIDE). APPLIES TO 2.5MG AND 5MG STRENGTHS ONLY.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

TALAZOPARIB

Products Affected

- TALZENNA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	ADVANCED OR METASTATIC BREAST CANCER: 1) HAS BEEN TREATED WITH CHEMOTHERAPY IN THE NEOADJUVANT, ADJUVANT, OR METASTATIC SETTING, AND 2) IF HORMONE RECEPTOR (HR)-POSITIVE BREAST CANCER, RECEIVED PRIOR TREATMENT WITH ENDOCRINE THERAPY OR IS CONSIDERED INAPPROPRIATE FOR ENDOCRINE THERAPY. METASTATIC CASTRATION-RESISTANT PROSTATE CANCER: 1) RECEIVED A BILATERAL ORCHIECTOMY, 2) CASTRATE LEVEL OF TESTOSTERONE (I.E., LESS THAN 50 NG/DL), OR 3) CONCURRENT USE WITH A GONADOTROPIN RELEASING HORMONE (GNRH) ANALOG.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

TALQUETAMAB-TGVS

Products Affected

- TALVEY

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

TARLATAMAB-DLLE

Products Affected

- IMDELLTRA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
 Last Updated: 05/27/2025
 Effective: 06/01/2025
 H9306_25_DRS_001_002_OE_C

TAZEMETOSTAT

Products Affected

- TAZVERIK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

TEBENTAFUSP-TEBN

Products Affected

- KIMMTRAK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

TECLISTAMAB-CQYV

Products Affected

- TECVAYLI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

TELOTRISTAT

Products Affected

- XERMELO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	CARCINOID SYNDROME DIARRHEA: PRESCRIBED BY OR IN CONSULTATION WITH AN ONCOLOGIST OR GASTROENTEROLOGIST
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

TEPOTINIB

Products Affected

- TEPMETKO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

TERIPARATIDE

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	24 MONTHS
Other Criteria	OSTEOPOROSIS: HAS NOT RECEIVED A TOTAL OF 24 MONTHS CUMULATIVE TREATMENT WITH ANY PARATHYROID HORMONE THERAPY, UNLESS REMAINS AT OR HAS RETURNED TO HAVING A HIGH RISK FOR FRACTURE.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

TESTOSTERONE

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	MALE HYPOGONADISM: INITIAL: CONFIRMED BY: 1) AT LEAST TWO TOTAL SERUM TESTOSTERONE LEVELS OF LESS THAN 300 NG/DL TAKEN ON SEPARATE OCCASIONS, OR 2) FREE SERUM TESTOSTERONE LEVEL OF LESS THAN 5 NG/DL.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL/RENEWAL: 12 MONTHS
Other Criteria	MALE HYPOGONADISM: INITIAL: 1) 40 YEARS OR OLDER: PROSTATE SPECIFIC ANTIGEN (PSA) HAS BEEN EVALUATED FOR PROSTATE CANCER SCREENING. RENEWAL: 1) 40 YEARS OR OLDER: PSA HAS BEEN EVALUATED FOR PROSTATE CANCER SCREENING, AND 2) IMPROVED SYMPTOMS COMPARED TO BASELINE AND TOLERANCE TO TREATMENT.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

TESTOSTERONE CYPIONATE

Products Affected

- testosterone cypionate intramuscular solution 100 mg/ml, 200 mg/ml, 200 mg/ml (1 ml)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	MALE HYPOGONADISM: INITIAL: CONFIRMED BY: 1) AT LEAST TWO TOTAL SERUM TESTOSTERONE LEVELS OF LESS THAN 300 NG/DL TAKEN ON SEPARATE OCCASIONS, OR 2) FREE SERUM TESTOSTERONE LEVEL OF LESS THAN 5 NG/DL.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL/RENEWAL: 12 MONTHS
Other Criteria	MALE HYPOGONADISM: INITIAL: 1) 40 YEARS OR OLDER: PROSTATE SPECIFIC ANTIGEN (PSA) HAS BEEN EVALUATED FOR PROSTATE CANCER SCREENING. RENEWAL: 1) 40 YEARS OR OLDER: PSA HAS BEEN EVALUATED FOR PROSTATE CANCER SCREENING, AND 2) IMPROVED SYMPTOMS COMPARED TO BASELINE AND TOLERANCE TO TREATMENT.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

TESTOSTERONE ENANTHATE

Products Affected

- testosterone enanthate intramuscular solution
- XYOSTED

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	MALE HYPOGONADISM: INITIAL: CONFIRMED BY: 1) AT LEAST TWO TOTAL SERUM TESTOSTERONE LEVELS OF LESS THAN 300 NG/DL TAKEN ON SEPARATE OCCASIONS, OR 2) FREE SERUM TESTOSTERONE LEVEL OF LESS THAN 5 NG/DL.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL/RENEWAL: MALE DELAYED PUBERTY: 6MO, MALE HYPOGONADISM: 12 MO. OTHER INDICATIONS: 12 MO.
Other Criteria	INITIAL: MALE HYPOGONADISM: 1) 40 YEARS OR OLDER: PROSTATE SPECIFIC ANTIGEN (PSA) HAS BEEN EVALUATED FOR PROSTATE CANCER SCREENING. RENEWAL: MALE HYPOGONADISM: 1) 40 YEARS OR OLDER: PSA HAS BEEN EVALUATED FOR PROSTATE CANCER SCREENING, AND 2) IMPROVED SYMPTOMS COMPARED TO BASELINE AND TOLERANCE TO TREATMENT. MALE DELAYED PUBERTY: HAS NOT RECEIVED MORE THAN TWO 6-MONTH COURSES OF TESTOSTERONE REPLACEMENT THERAPY
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

TETRABENAZINE

Products Affected

- tetrabenazine*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	HUNTINGTONS DISEASE: PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST OR MOVEMENT DISORDER SPECIALIST
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

THALIDOMIDE

Products Affected

- THALOMID

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

TISLELIZUMAB-JSGR

Products Affected

- TEVIMBRA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
 Last Updated: 05/27/2025
 Effective: 06/01/2025
 H9306_25_DRS_001_002_OE_C

TISOTUMAB VEDOTIN-TFTV

Products Affected

- TIVDAK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

TIVOZANIB

Products Affected

- FOTIVDA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

TOCILIZUMAB IV

Products Affected

- ACTEMRA

PA Criteria	Criteria Details
Exclusion Criteria	CORONAVIRUS DISEASE 2019 (COVID-19) IN HOSPITALIZED ADULTS
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	INITIAL: RHEUMATOID ARTHRITIS (RA), POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS (PJIA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST. SYSTEMIC JUVENILE IDIOPATHIC ARTHRITIS (SJIA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST, DERMATOLOGIST, OR IMMUNOLOGIST.
Coverage Duration	INITIAL: RA, PJIA, SJIA, GCA: 6 MONTHS. CRS: 1 MONTH. RENEWAL: RA, PJIA, SJIA, GCA: 12 MONTHS.
Other Criteria	INITIAL: RA: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: ENBREL, HUMIRA/CYLTEZO/YUFLYMA, XELJANZ, RINVOQ, ORENCIA. PJIA: 1) TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: ENBREL, HUMIRA/CYLTEZO/YUFLYMA, XELJANZ IR, RINVOQ, ORENCIA, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR PJIA. SJIA: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR SJIA. RENEWAL: RA: CONTINUES TO BENEFIT FROM THE MEDICATION. PJIA: 1) CONTINUES TO BENEFIT FROM THE MEDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR PJIA. SJIA: 1) CONTINUES TO BENEFIT FROM THE MEDICATION, AND 2) NO

Formulary ID: 25489

Last Updated: 05/27/2025

Effective: 06/01/2025

H9306_25_DRS_001_002_OE_C

PA Criteria	Criteria Details
	CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR SJIA.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

TOCILIZUMAB SQ

Products Affected

- ACTEMRA
- ACTEMRA ACTPEN

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	INITIAL: RHEUMATOID ARTHRITIS (RA), POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS (PJIA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST. SYSTEMIC JUVENILE IDIOPATHIC ARTHRITIS (SJIA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST, DERMATOLOGIST, OR IMMUNOLOGIST. SYSTEMIC SCLEROSIS-ASSOCIATED INTERSTITIAL LUNG DISEASE (SSC-ILD): PRESCRIBED BY OR IN CONSULTATION WITH A PULMONOLOGIST OR RHEUMATOLOGIST.
Coverage Duration	INITIAL: 6 MONTHS, RENEWAL: 12 MONTHS.
Other Criteria	INITIAL: RA: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: ENBREL, HUMIRA/CYLTEZO/YUFLYMA, XELJANZ, RINVOQ, ORENCIA. PJIA: 1) TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: ENBREL, HUMIRA/CYLTEZO/YUFLYMA, XELJANZ IR, RINVOQ, ORENCIA, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR PJIA. SJIA: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR SJIA. SSC-ILD: DOES NOT HAVE OTHER KNOWN CAUSES OF INTERSTITIAL LUNG DISEASE (E.G., CONNECTIVE TISSUE DISEASE, DRUG

Formulary ID: 25489

Last Updated: 05/27/2025

Effective: 06/01/2025

H9306_25_DRS_001_002_OE_C

PA Criteria	Criteria Details
	TOXICITY, ASBESTOS OR BERYLLIUM EXPOSURE, HYPERSENSITIVITY PNEUMONITIS). RENEWAL: RA: CONTINUES TO BENEFIT FROM THE MEDICATION. PJIA: 1) CONTINUES TO BENEFIT FROM THE MEDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR PJIA. SJIA: 1) CONTINUES TO BENEFIT FROM THE MEDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR SJIA. SSC-ILD: CLINICAL MEANINGFUL IMPROVEMENT OR MAINTENANCE IN ANNUAL RATE OF DECLINE.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

TOCILIZUMAB-AAZG

Products Affected

- TYENNE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	INITIAL: RHEUMATOID ARTHRITIS (RA), POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS (PJIA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST. SYSTEMIC JUVENILE IDIOPATHIC ARTHRITIS (SJIA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST, DERMATOLOGIST, OR IMMUNOLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	INITIAL: RA: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: ENBREL, HUMIRA/CYLTEZO/YUFLYMA, XELJANZ, RINVOQ, ORENCIA. PJIA: 1) TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: ENBREL, HUMIRA/CYLTEZO/YUFLYMA, XELJANZ IR, ORENCIA, RINVOQ, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR PJIA. SJIA: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR SJIA. RENEWAL: RA: CONTINUES TO BENEFIT FROM THE MEDICATION. PJIA: 1) CONTINUES TO BENEFIT FROM THE MEDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR PJIA. SJIA: 1) CONTINUES TO BENEFIT FROM THE MEDICATION, AND 2) NO

Formulary ID: 25489

Last Updated: 05/27/2025

Effective: 06/01/2025

H9306_25_DRS_001_002_OE_C

PA Criteria	Criteria Details
	CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR SJIA.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

TOCILIZUMAB-AAZG IV

Products Affected

- TYENNE

PA Criteria	Criteria Details
Exclusion Criteria	CORONAVIRUS DISEASE 2019 (COVID-19) IN HOSPITALIZED ADULTS
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	INITIAL: RHEUMATOID ARTHRITIS (RA), POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS (PJIA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST. SYSTEMIC JUVENILE IDIOPATHIC ARTHRITIS (SJIA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST, DERMATOLOGIST, OR IMMUNOLOGIST.
Coverage Duration	INITIAL: RA, PJIA, SJIA, GCA: 6 MOS. CRS: 1 MO. RENEWAL: RA, PJIA, SJIA, GCA: 12 MOS.
Other Criteria	INITIAL: RA: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: ENBREL, HUMIRA/CYLTEZO/YUFLYMA, XELJANZ, RINVOQ, ORENCIA. PJIA: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: ENBREL, HUMIRA/CYLTEZO/YUFLYMA, XELJANZ IR, ORENCIA, RINVOQ. CYTOKINE RELEASE SYNDROME (CRS): NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR CRS. INITIAL/RENEWAL FOR PJIA, SJIA: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR SAME INDICATION. RENEWAL FOR RA, PJIA, SJIA: CONTINUES TO BENEFIT FROM MEDICATION.
Indications	All FDA-approved Indications.
Off Label Uses	

Formulary ID: 25489

Last Updated: 05/27/2025

Effective: 06/01/2025

H9306_25_DRS_001_002_OE_C

PA Criteria	Criteria Details
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

TOFACITINIB

Products Affected

- XELJANZ
- XELJANZ XR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	INITIAL: RHEUMATOID ARTHRITIS (RA), ANKYLOSING SPONDYLITIS (AS), POLYARTICULAR COURSE JUVENILE IDIOPATHIC ARTHRITIS (PCJIA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST. PSORIATIC ARTHRITIS (PSA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST OR DERMATOLOGIST. ULCERATIVE COLITIS (UC): PRESCRIBED BY OR IN CONSULTATION WITH A GASTROENTEROLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	INITIAL: RA: TRIAL OF OR CONTRAINDICATION TO 3 MONTHS OF TREATMENT WITH ONE DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG) - IF A PATIENT TRIED METHOTREXATE, THEN TRIAL AT A DOSE GREATER THAN OR EQUAL TO 20 MG PER WEEK OR MAXIMALLY TOLERATED DOSE IS REQUIRED. PSA: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR PSA. PCJIA: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR PCJIA. AS: 1) TRIAL OF OR CONTRAINDICATION TO AN NSAID, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR AS. UC: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED

Formulary ID: 25489

Last Updated: 05/27/2025

Effective: 06/01/2025

H9306_25_DRS_001_002_OE_C

PA Criteria	Criteria Details
	SMALL MOLECULES FOR UC. RENEWAL: RA: CONTINUES TO BENEFIT FROM THE MEDICATION. PSA: 1) CONTINUES TO BENEFIT FROM THE MEDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR PSA. AS: 1) CONTINUES TO BENEFIT FROM THE MEDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR AS. PCJIA: 1) CONTINUES TO BENEFIT FROM THE MEDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR PCJIA. UC: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR UC.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

TOPICAL TRETINOIN

Products Affected

- ALTRENO
- tretinoin external cream*

PA Criteria	Criteria Details
Exclusion Criteria	COSMETIC INDICATIONS SUCH AS WRINKLES, PHOTOAGING, MELASMA.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	ACNE VULGARIS: BRAND TOPICAL TRETINOIN REQUIRES TRIAL OF OR CONTRAINDICATION TO A GENERIC TOPICAL TRETINOIN PRODUCT.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
 Last Updated: 05/27/2025
 Effective: 06/01/2025
 H9306_25_DRS_001_002_OE_C

TORIPALIMAB-TPZI

Products Affected

- LOQTORZI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	NASOPHARYNGEAL CARCINOMA (NPC): FIRST LINE TREATMENT: 24 MOS, PREVIOUSLY TREATED: LIFETIME.
Other Criteria	THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

TOVORAFENIB

Products Affected

- OJEMDA ORAL SUSPENSION RECONSTITUTED
- OJEMDA ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

TRAMETINIB SOLUTION

Products Affected

- MEKINIST ORAL SOLUTION
RECONSTITUTED

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	UNRESECTABLE OR METASTATIC MELANOMA, MELANOMA, METASTATIC NON-SMALL CELL LUNG CANCER (NSCLC), LOCALLY ADVANCED OR METASTATIC ANAPLASTIC THYROID CANCER (ATC), UNRESECTABLE OR METASTATIC SOLID TUMOR, LOW-GRADE GLIOMA (LGG): UNABLE TO SWALLOW MEKINIST TABLETS.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

TRAMETINIB TABLET

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	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

TRASTUZUMAB-DKST

Products Affected

- OGIVRI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

TRASTUZUMAB-DTTB

Products Affected

- ONTRUZANT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
 Last Updated: 05/27/2025
 Effective: 06/01/2025
 H9306_25_DRS_001_002_OE_C

TRASTUZUMAB-HYALURONIDASE-OYSK

Products Affected

- HERCEPTIN HYLECTA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	ADJUVANT BREAST CANCER, METASTATIC BREAST CANCER: TRIAL OF OR CONTRAINDICATION TO ONE OF THE FOLLOWING PREFERRED AGENTS: HERZUMA, OGIVRI, ONTRUZANT, TRAZIMERA.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

TRASTUZUMAB-PKRB

Products Affected

- HERZUMA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
 Last Updated: 05/27/2025
 Effective: 06/01/2025
 H9306_25_DRS_001_002_OE_C

TRASTUZUMAB-QYYP

Products Affected

- TRAZIMERA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

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 H9306_25_DRS_001_002_OE_C

TRAZODONE

Products Affected

- RALDESY

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	MAJOR DEPRESSIVE DISORDER (MDD): CONTRAINDICATION TO OR UNABLE TO SWALLOW TRAZODONE TABLETS.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
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 Effective: 06/01/2025
 H9306_25_DRS_001_002_OE_C

TREMELIMUMAB-ACTL

Products Affected

- IMJUDO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	UHCC: 30 DAYS. METASTATIC NON-SMALL CELL LUNG CANCER (NSCLC): 5 MONTHS.
Other Criteria	UNRESECTABLE HEPATOCELLULAR CARCINOMA (UHCC): HAS NOT RECEIVED PRIOR TREATMENT WITH IMJUDO. NSCLC: HAS NOT RECEIVED A TOTAL OF 5 DOSES OF IMJUDO.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
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H9306_25_DRS_001_002_OE_C

TRIENTINE CAPSULE

Products Affected

- *trientine hcl oral capsule 250 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	WILSONS DISEASE: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A HEPATOLOGIST OR GASTROENTEROLOGIST.
Coverage Duration	INITIAL: 12 MONTHS, RENEWAL: LIFETIME.
Other Criteria	WILSONS DISEASE: INITIAL: 1) LEIPZIG SCORE OF 4 OR GREATER, AND 2) TRIAL OF OR CONTRAINDICATION TO FORMULARY VERSION OF PENICILLAMINE TABLET. RENEWAL: CONTINUES TO BENEFIT FROM THE MEDICATION.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

TRIFLURIDINE/TIPIRACIL

Products Affected

- LONSURF ORAL TABLET 15-6.14 MG,
20-8.19 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

TRIPTORELIN-TRELSTAR

Products Affected

- TRELSTAR MIXJECT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS.
Other Criteria	THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

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 H9306_25_DRS_001_002_OE_C

TUCATINIB

Products Affected

- TUKYSA ORAL TABLET 150 MG, 50 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

UBROGEPANT

Products Affected

- UBRELVY

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	ACUTE MIGRAINE TREATMENT: INITIAL: 1) TRIAL OF OR CONTRAINDICATION TO ONE TRIPTAN (E.G., SUMATRIPTAN, RIZATRIPTAN), AND 2) NO CONCURRENT USE WITH OTHER CGRP INHIBITORS FOR ACUTE MIGRAINE TREATMENT. RENEWAL: 1) NO CONCURRENT USE WITH OTHER CGRP INHIBITORS FOR ACUTE MIGRAINE TREATMENT, AND 2) ONE OF THE FOLLOWING: (A) IMPROVEMENT FROM BASELINE IN A VALIDATED ACUTE TREATMENT PATIENT-REPORTED OUTCOME QUESTIONNAIRE, OR (B) THERAPY WORKS CONSISTENTLY IN MAJORITY OF MIGRAINE ATTACKS.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
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Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

UPADACITINIB

Products Affected

- RINVOQ
- RINVOQ LQ

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: NON-RADIOGRAPHIC AXIAL SPONDYLOARTHRITIS (NR-AXSPA): 1) C-REACTIVE PROTEIN LEVELS ABOVE THE UPPER LIMIT OF NORMAL, OR 2) SACROILIITIS ON MAGNETIC RESONANCE IMAGING (MRI). ATOPIC DERMATITIS (AD): ATOPIC DERMATITIS COVERING AT LEAST 10 PERCENT OF BODY SURFACE AREA OR ATOPIC DERMATITIS AFFECTING THE FACE, HEAD, NECK, HANDS, FEET, GROIN, OR INTERTRIGINOUS AREAS
Age Restrictions	
Prescriber Restrictions	INITIAL: RHEUMATOID ARTHRITIS (RA), ANKYLOSING SPONDYLITIS (AS), NR-AXSPA, POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS (PJIA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST. PSORIATIC ARTHRITIS: PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST OR DERMATOLOGIST. AD: PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST, ALLERGIST, OR IMMUNOLOGIST. ULCERATIVE COLITIS (UC), CROHNS DISEASE (CD): PRESCRIBED BY OR IN CONSULTATION WITH A GASTROENTEROLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	INITIAL: RA: TRIAL OF OR CONTRAINDICATION TO 3 MONTHS OF TREATMENT WITH ONE DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG) - IF A PATIENT TRIED METHOTREXATE, THEN TRIAL AT A DOSE GREATER THAN OR EQUAL TO 20 MG PER WEEK OR MAXIMALLY TOLERATED DOSE IS REQUIRED. PSA: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

PA Criteria	Criteria Details
	MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR PSA. PJIA: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR PJIA. AD: 1) INTRACTABLE PRURITUS OR CRACKING/OOZING/BLEEDING OF AFFECTED SKIN, 2) TRIAL OF OR CONTRAINDICATION TO A TOPICAL CORTICOSTEROID, TOPICAL CALCINEURIN INHIBITOR, TOPICAL PDE4 INHIBITOR, OR TOPICAL JAK INHIBITOR, AND 3) NO CONCURRENT USE WITH OTHER SYSTEMIC BIOLOGICS FOR ATOPIC DERMATITIS OR OTHER JAK INHIBITORS FOR ANY INDICATION. UC: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR UC. CD: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR CD. AS: 1) TRIAL OF OR CONTRAINDICATION TO AN NSAID (NON-STEROIDAL ANTI-INFLAMMATORY DRUG), AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR AS. NR-AXSPA: 1) TRIAL OF OR CONTRAINDICATION TO AN NSAID, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR NR-AXSPA. RENEWAL: RA: CONTINUES TO BENEFIT FROM THE MEDICATION. AD: 1) IMPROVEMENT WHILE ON THERAPY, AND 2) NO CONCURRENT USE WITH OTHER SYSTEMIC BIOLOGICS FOR ATOPIC DERMATITIS OR OTHER JAK INHIBITOR FOR ANY INDICATION. PSA: 1) CONTINUES TO BENEFIT FROM MEDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR PSA. AS: 1) CONTINUES TO BENEFIT MEDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR AS. NR-AXSPA: 1) CONTINUES TO BENEFIT FROM MEDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR NR-AXSPA. PJIA: 1) CONTINUES TO BENEFIT FROM MEDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR PJIA. UC: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR UC. CD: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR CD.

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

USTEKINUMAB

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: PLAQUE PSORIASIS (PSO): PSORIASIS COVERING 3 PERCENT OR MORE OF BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, GENITAL AREA, SCALP OR FACE.
Age Restrictions	
Prescriber Restrictions	INITIAL: PSORIATIC ARTHRITIS (PSA): PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST OR RHEUMATOLOGIST. PSO: PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST. CROHNS DISEASE (CD), ULCERATIVE COLITIS (UC): PRESCRIBED BY OR IN CONSULTATION WITH A GASTROENTEROLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	INITIAL: PSA: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR PSA. PSO: 1) ONE OF THE FOLLOWING: (A) AT LEAST A 3 MONTH TRIAL OF ONE ORAL IMMUNOSUPPRESSANT (CYCLOSPORINE, METHOTREXATE, TACROLIMUS) OR PUVA (PHOTOTHERAPY) FOR THE TREATMENT OF PSO, (B) CONTRAINDICATION OR INTOLERANCE TO BOTH IMMUNOSUPPRESSANT AND PUVA FOR THE TREATMENT OF PSO, OR (C) PATIENT IS SWITCHING FROM A DIFFERENT BIOLOGIC, PDE-4 INHIBITOR, OR JAK INHIBITOR FOR THE SAME INDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR PSO. CD: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR

Formulary ID: 25489

Last Updated: 05/27/2025

Effective: 06/01/2025

H9306_25_DRS_001_002_OE_C

PA Criteria	Criteria Details
	TARGETED SMALL MOLECULES FOR CD. UC: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR UC. RENEWAL: PSA: 1) CONTINUES TO BENEFIT FROM THE MEDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR PSA. PSO: 1) CONTINUES TO BENEFIT FROM THE MEDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR PSO. CD: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR CD. UC: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR UC.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

USTEKINUMAB IV

Products Affected

- STELARA INTRAVENOUS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	CROHNS DISEASE (CD), ULCERATIVE COLITIS (UC): PRESCRIBED BY OR IN CONSULTATION WITH A GASTROENTEROLOGIST.
Coverage Duration	2 MONTHS
Other Criteria	CD: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR CD. UC: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR UC. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
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H9306_25_DRS_001_002_OE_C

USTEKINUMAB-AEKN IV

Products Affected

- SELARSDI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: PLAQUE PSORIASIS (PSO): PSORIASIS COVERING 3 PERCENT OR MORE OF BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, GENITAL AREA, SCALP OR FACE.
Age Restrictions	
Prescriber Restrictions	INITIAL: PSORIATIC ARTHRITIS (PSA): PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST OR RHEUMATOLOGIST. PSO: PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST. CROHNS DISEASE (CD), ULCERATIVE COLITIS (UC): PRESCRIBED BY OR IN CONSULTATION WITH A GASTROENTEROLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	INITIAL: PSA: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR PSA. PSO: 1) ONE OF THE FOLLOWING: (A) AT LEAST A 3 MONTH TRIAL OF ONE ORAL IMMUNOSUPPRESSANT (CYCLOSPORINE, METHOTREXATE, TACROLIMUS) OR PUVA (PHOTOTHERAPY) FOR THE TREATMENT OF PSO, (B) CONTRAINDICATION OR INTOLERANCE TO BOTH IMMUNOSUPPRESSANT AND PUVA FOR THE TREATMENT OF PSO, OR (C) PATIENT IS SWITCHING FROM A DIFFERENT BIOLOGIC, PDE-4 INHIBITOR, OR JAK INHIBITOR FOR THE SAME INDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR PSO. CD: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR CD. UC: NO CONCURRENT

Formulary ID: 25489

Last Updated: 05/27/2025

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H9306_25_DRS_001_002_OE_C

PA Criteria	Criteria Details
	USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR UC. RENEWAL: PSA: 1) CONTINUES TO BENEFIT FROM THE MEDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR PSA. PSO: 1) CONTINUES TO BENEFIT FROM THE MEDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR PSO. CD: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR CD. UC: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR UC.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

USTEKINUMAB-AEKN SQ

Products Affected

- SELARSDI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: PLAQUE PSORIASIS (PSO): PSORIASIS COVERING 3 PERCENT OR MORE OF BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, GENITAL AREA, SCALP OR FACE.
Age Restrictions	
Prescriber Restrictions	INITIAL: PSORIATIC ARTHRITIS (PSA): PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST OR RHEUMATOLOGIST. PSO: PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST. CROHNS DISEASE (CD), ULCERATIVE COLITIS (UC): PRESCRIBED BY OR IN CONSULTATION WITH A GASTROENTEROLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	INITIAL: PSA: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR PSA. PSO: 1) ONE OF THE FOLLOWING: (A) AT LEAST A 3 MONTH TRIAL OF ONE ORAL IMMUNOSUPPRESSANT (CYCLOSPORINE, METHOTREXATE, TACROLIMUS) OR PUVA (PHOTOTHERAPY) FOR THE TREATMENT OF PSO, (B) CONTRAINDICATION OR INTOLERANCE TO BOTH IMMUNOSUPPRESSANT AND PUVA FOR THE TREATMENT OF PSO, OR (C) PATIENT IS SWITCHING FROM A DIFFERENT BIOLOGIC, PDE-4 INHIBITOR, OR JAK INHIBITOR FOR THE SAME INDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR PSO. CD: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR CD. UC: NO CONCURRENT

Formulary ID: 25489

Last Updated: 05/27/2025

Effective: 06/01/2025

H9306_25_DRS_001_002_OE_C

PA Criteria	Criteria Details
	USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR UC. RENEWAL: PSA: 1) CONTINUES TO BENEFIT FROM THE MEDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR PSA. PSO: 1) CONTINUES TO BENEFIT FROM THE MEDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR PSO. CD: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR CD. UC: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR UC.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

USTEKINUMAB-KFCE IV

Products Affected

- YESINTEK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: PLAQUE PSORIASIS (PSO): PSORIASIS COVERING 3 PERCENT OR MORE OF BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, GENITAL AREA, SCALP OR FACE.
Age Restrictions	
Prescriber Restrictions	INITIAL: PSORIATIC ARTHRITIS (PSA): PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST OR RHEUMATOLOGIST. PSO: PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST. CROHNS DISEASE (CD), ULCERATIVE COLITIS (UC): PRESCRIBED BY OR IN CONSULTATION WITH A GASTROENTEROLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	INITIAL: PSA: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR PSA. PSO: 1) ONE OF THE FOLLOWING: (A) AT LEAST A 3 MONTH TRIAL OF ONE ORAL IMMUNOSUPPRESSANT (CYCLOSPORINE, METHOTREXATE, TACROLIMUS) OR PUVA (PHOTOTHERAPY) FOR THE TREATMENT OF PSO, (B) CONTRAINDICATION OR INTOLERANCE TO BOTH IMMUNOSUPPRESSANT AND PUVA FOR THE TREATMENT OF PSO, OR (C) PATIENT IS SWITCHING FROM A DIFFERENT BIOLOGIC, PDE-4 INHIBITOR, OR JAK INHIBITOR FOR THE SAME INDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR PSO. CD: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR CD. UC: NO CONCURRENT

Formulary ID: 25489

Last Updated: 05/27/2025

Effective: 06/01/2025

H9306_25_DRS_001_002_OE_C

PA Criteria	Criteria Details
	USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR UC. RENEWAL: PSA: 1) CONTINUES TO BENEFIT FROM THE MEDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR PSA. PSO: 1) CONTINUES TO BENEFIT FROM THE MEDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR PSO. CD: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR CD. UC: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR UC.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

USTEKINUMAB-KFCE SQ

Products Affected

- YESINTEK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: PLAQUE PSORIASIS (PSO): PSORIASIS COVERING 3 PERCENT OR MORE OF BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, GENITAL AREA, SCALP OR FACE.
Age Restrictions	
Prescriber Restrictions	INITIAL: PSORIATIC ARTHRITIS (PSA): PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST OR RHEUMATOLOGIST. PSO: PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST. CROHNS DISEASE (CD), ULCERATIVE COLITIS (UC): PRESCRIBED BY OR IN CONSULTATION WITH A GASTROENTEROLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	INITIAL: PSA: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR PSA. PSO: 1) ONE OF THE FOLLOWING: (A) AT LEAST A 3 MONTH TRIAL OF ONE ORAL IMMUNOSUPPRESSANT (CYCLOSPORINE, METHOTREXATE, TACROLIMUS) OR PUVA (PHOTOTHERAPY) FOR THE TREATMENT OF PSO, (B) CONTRAINDICATION OR INTOLERANCE TO BOTH IMMUNOSUPPRESSANT AND PUVA FOR THE TREATMENT OF PSO, OR (C) PATIENT IS SWITCHING FROM A DIFFERENT BIOLOGIC, PDE-4 INHIBITOR, OR JAK INHIBITOR FOR THE SAME INDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR PSO. CD: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR CD. UC: NO CONCURRENT

Formulary ID: 25489

Last Updated: 05/27/2025

Effective: 06/01/2025

H9306_25_DRS_001_002_OE_C

PA Criteria	Criteria Details
	USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR UC. RENEWAL: PSA: 1) CONTINUES TO BENEFIT FROM THE MEDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR PSA. PSO: 1) CONTINUES TO BENEFIT FROM THE MEDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR PSO. CD: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR CD. UC: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR UC.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

VALBENAZINE

Products Affected

- INGREZZA ORAL CAPSULE
- INGREZZA ORAL CAPSULE SPRINKLE
- INGREZZA ORAL CAPSULE THERAPY PACK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	TARDIVE DYSKINESIA (TD): PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST, PSYCHIATRIST, OR MOVEMENT DISORDER SPECIALIST. CHOREA ASSOCIATED WITH HUNTINGTONS DISEASE: PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST OR MOVEMENT DISORDER SPECIALIST.
Coverage Duration	12 MONTHS
Other Criteria	TD: HISTORY OF USING AGENTS THAT CAUSE TARDIVE DYSKINESIA.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

VANDETANIB

Products Affected

- CAPRELSA ORAL TABLET 100 MG, 300 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	CURRENTLY STABLE ON CAPRELSA REQUIRES NO EXTRA CRITERIA.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

VANZACAFTOR-TEZACAFTOR- DEUTIVACAFTOR

Products Affected

- ALYFTREK ORAL TABLET 10-50-125
MG, 4-20-50 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	CF: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A PULMONOLOGIST OR CYSTIC FIBROSIS EXPERT.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: LIFETIME.
Other Criteria	CF: INITIAL: NO CONCURRENT USE WITH ANOTHER CFTR MODULATOR. RENEWAL: 1) IMPROVEMENT IN CLINICAL STATUS, AND 2) NO CONCURRENT USE WITH ANOTHER CFTR MODULATOR.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

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Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

VEMURAFENIB

Products Affected

- ZELBORAF

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	MELANOMA: ZELBORAF WILL BE USED ALONE OR IN COMBINATION WITH COTELLIC
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

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H9306_25_DRS_001_002_OE_C

VENETOCLAX

Products Affected

- VENCLEXTA ORAL TABLET 10 MG, 100 MG, 50 MG
- VENCLEXTA STARTING PACK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

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 H9306_25_DRS_001_002_OE_C

VERICIGUAT

Products Affected

- VERQUVO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL/RENEWAL:12 MONTHS.
Other Criteria	HEART FAILURE (HF): INITIAL: 1) NO CONCURRENT USE WITH LONG-ACTING NITRATES OR NITRIC OXIDE DONORS, RIOCIGUAT, OR PDE-5 INHIBITORS, 2) TRIAL OF OR CONTRAINDICATION TO ONE PREFERRED SGLT-2 INHIBITOR, AND 3) TRIAL OF OR CONTRAINDICATION TO ONE AGENT FROM ANY OF THE FOLLOWING STANDARD OF CARE CLASSES: (A) ACE INHIBITOR, ARB, OR ARNI, (B) BETA BLOCKER (I.E., BISOPROLOL, CARVEDILOL, METOPROLOL SUCCINATE), OR (C) ALDOSTERONE ANTAGONIST (I.E., SPIRONOLACTONE, EPLERENONE). RENEWAL: NO CONCURRENT USE WITH LONG-ACTING NITRATES OR NITRIC OXIDE DONORS, RIOCIGUAT, OR PDE-5 INHIBITORS.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

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Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

VIGABATRIN

Products Affected

- *vigabatin*
- *vigadrone*
- *vigpoder*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	REFRACTORY COMPLEX PARTIAL SEIZURES (CPS), INFANTILE SPASMS: PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST.
Coverage Duration	12 MONTHS
Other Criteria	CPS: TRIAL OF OR CONTRAINDICATION TO TWO ANTIEPILEPTIC AGENTS.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

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H9306_25_DRS_001_002_OE_C

VIMSELTINIB

Products Affected

- ROMVIMZA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
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Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

VISMODEGIB

Products Affected

- ERIVEDGE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

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 Effective: 06/01/2025
 H9306_25_DRS_001_002_OE_C

VORASIDENIB

Products Affected

- VORANIGO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

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Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

VORICONAZOLE SUSPENSION

Products Affected

- *voriconazole oral suspension reconstituted*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	CANDIDA INFECTIONS: 3 MOS. CONTINUATION OF THERAPY, ALL OTHER INDICATIONS: 6 MOS.
Other Criteria	CANDIDA INFECTIONS: 1) TRIAL OF OR CONTRAINDICATION TO FLUCONAZOLE, AND 2) UNABLE TO SWALLOW TABLETS. ALL INDICATIONS EXCEPT ESOPHAGEAL CANDIDIASIS: UNABLE TO SWALLOW TABLETS. CONTINUATION OF THERAPY AFTER HOSPITAL DISCHARGE REQUIRES NO EXTRA CRITERIA.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

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Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

ZANIDATAMAB-HRII

Products Affected

- ZIIHERA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

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 Last Updated: 05/27/2025
 Effective: 06/01/2025
 H9306_25_DRS_001_002_OE_C

ZANUBRUTINIB

Products Affected

- BRUKINSA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

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Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

ZENOCUTUZUMAB-ZBCO

Products Affected

- BIZENGRI (750 MG DOSE)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

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 Effective: 06/01/2025
 H9306_25_DRS_001_002_OE_C

ZOLBETUXIMAB-CLZB

Products Affected

- VYLOY

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

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 Last Updated: 05/27/2025
 Effective: 06/01/2025
 H9306_25_DRS_001_002_OE_C

ZURANOLONE

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	14 DAYS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

INDEX

A

abiraterone acetate	7
abirtega.....	7
ABOUTTIME PEN NEEDLE 30G X 8 MM	160, 180
ABOUTTIME PEN NEEDLE 31G X 5 MM	160, 180
ABOUTTIME PEN NEEDLE 31G X 8 MM	160, 180
ABOUTTIME PEN NEEDLE 32G X 4 MM	160, 180
ACTEMRA.....	348, 349, 350, 351
ACTEMRA ACTPEN	350, 351
ACTHAR	74, 75
ACTHAR GEL SUBCUTANEOUS PEN-INJECTOR 40 UNIT/0.5ML, 80 UNIT/ML	74, 75
ACTIMMUNE.....	184
ADEMPAS	291, 292
ADVOCATE INSULIN PEN NEEDLE 32G X 4 MM.....	160, 180
ADVOCATE INSULIN PEN NEEDLES 29G X 12.7MM.....	160, 180
ADVOCATE INSULIN PEN NEEDLES 31G X 5 MM.....	160, 180
ADVOCATE INSULIN PEN NEEDLES 31G X 8 MM.....	160, 180
ADVOCATE INSULIN PEN NEEDLES 33G X 4 MM.....	160, 180
ADVOCATE INSULIN SYRINGE 29G X 1/2	160, 180
ADVOCATE INSULIN SYRINGE 30G X 5/16	160, 180
ADVOCATE INSULIN SYRINGE 31G X 5/16	160, 180
AIMOVIG.....	118
AJOVY	134
AKEEGA	234
ALCOHOL PREP PAD.....	160, 180
ALCOHOL PREP PAD 70 %.....	160, 180
ALCOHOL PREP PADS PAD 70 %	160, 180
ALCOHOL SWABS PAD.....	160, 180
ALCOHOL SWABS PAD 70 %	160, 180
ALECENSA.....	21
ALTRENO.....	358
ALUNBRIG ORAL TABLET 180 MG, 30 MG, 90 MG.....	59
ALUNBRIG ORAL TABLET THERAPY PACK.....	59
ALVAIZ.....	105
ALYFTREK ORAL TABLET 10-50-125 MG, 4-20-50 MG	391
alyq.....	329
ANKTIVA	240
AQ INSULIN SYRINGE 31G X 5/16... 180	
AQINJECT PEN NEEDLE 31G X 5 MM	160, 180
AQINJECT PEN NEEDLE 32G X 4 MM	160, 180
ARCALYST	287, 288
ARIKAYCE.....	23
armodafinil.....	226
ASSURE ID DUO PRO PEN NEEDLES 31G X 5 MM.....	160, 180
ASSURE ID INSULIN SAFETY SYR 29G X 1/2.....	160, 180
ASSURE ID INSULIN SAFETY SYR 31G X 15/64.....	160, 180
ASSURE ID PRO PEN NEEDLES 30G X 5 MM	160, 180
AUGTYRO ORAL CAPSULE 160 MG, 40 MG	279
AUM ALCOHOL PREP PADS PAD 70 %	160, 180
AUM INSULIN SAFETY PEN NEEDLE 31G X 4 MM.....	160, 180
AUM INSULIN SAFETY PEN NEEDLE 31G X 5 MM.....	160, 180
AUM MINI INSULIN PEN NEEDLE 32G X 4 MM.....	160, 180
AUM MINI INSULIN PEN NEEDLE 32G X 5 MM.....	160, 180

Formulary ID: 25489

Last Updated: 05/27/2025

Effective: 06/01/2025

H9306_25_DRS_001_002_OE_C

AUM MINI INSULIN PEN NEEDLE 32G
X 6 MM..... 160, 180
AUM MINI INSULIN PEN NEEDLE 32G
X 8 MM..... 160, 180
AUM MINI INSULIN PEN NEEDLE 33G
X 4 MM..... 160, 180
AUM MINI INSULIN PEN NEEDLE 33G
X 5 MM..... 161, 180
AUM MINI INSULIN PEN NEEDLE 33G
X 6 MM..... 161, 180
AUM PEN NEEDLE 32G X 4 MM 161, 180
AUM PEN NEEDLE 32G X 5 MM 161, 180
AUM PEN NEEDLE 32G X 6 MM 161, 180
AUM PEN NEEDLE 33G X 4 MM 161, 180
AUM PEN NEEDLE 33G X 5 MM 161, 180
AUM PEN NEEDLE 33G X 6 MM 161, 180
AUM READYGARD DUO PEN NEEDLE
32G X 4 MM..... 161, 180
AUM SAFETY PEN NEEDLE 31G X 4
MM 161, 180
AUSTEDO ORAL TABLET 12 MG, 6 MG,
9 MG 89
AUSTEDO XR ORAL TABLET
EXTENDED RELEASE 24 HOUR 12
MG, 18 MG, 24 MG, 30 MG, 36 MG, 42
MG, 48 MG, 6 MG 89
AUSTEDO XR PATIENT TITRATION . 89
AVONEX PEN INTRAMUSCULAR
AUTO-INJECTOR KIT..... 181
AVONEX PREFILLED
INTRAMUSCULAR PREFILLED
SYRINGE KIT..... 181
AYVAKIT 38
B
BALVERSA ORAL TABLET 3 MG, 4
MG, 5 MG..... 117
BD AUTOSHIELD 29G X 5MM... 161, 180
BD AUTOSHIELD 29G X 8MM... 161, 180
BD AUTOSHIELD DUO 30G X 5 MM 161,
180
BD ECLIPSE SYRINGE 30G X 1/2 161,
180
BD INSULIN SYR ULTRAFINE II 31G X
5/16 161, 180

BD INSULIN SYRINGE 25G X 1. 161, 180
BD INSULIN SYRINGE 25G X 5/8..... 161,
180
BD INSULIN SYRINGE 26G X 1/2..... 161,
180
BD INSULIN SYRINGE 27.5G X 5/8.. 161,
180
BD INSULIN SYRINGE 27G X 1/2..... 161,
180
BD INSULIN SYRINGE 29G X 1/2..... 161,
180
BD INSULIN SYRINGE HALF-UNIT 31G
X 5/16..... 161, 180
BD INSULIN SYRINGE MICROFINE 27G
X 5/8..... 161, 180
BD INSULIN SYRINGE MICROFINE 28G
X 1/2..... 161, 180
BD INSULIN SYRINGE U-100 1 ML . 161,
180
BD INSULIN SYRINGE U-500 161, 180
BD INSULIN SYRINGE ULTRAFINE 29G
X 1/2..... 161, 180
BD INSULIN SYRINGE ULTRAFINE 30G
X 1/2..... 161, 180
BD INSULIN SYRINGE ULTRAFINE 31G
X 5/16..... 161, 180
BD PEN NEEDLE MICRO ULTRAFINE
32G X 6 MM..... 161, 180
BD PEN NEEDLE MINI U/F 31G X 5 MM
..... 161, 180
BD PEN NEEDLE MINI ULTRAFINE 31G
X 5 MM..... 161, 180
BD PEN NEEDLE NANO 2ND GEN 32G
X 4 MM..... 161, 180
BD PEN NEEDLE NANO U/F 32G X 4
MM 161, 180
BD PEN NEEDLE NANO ULTRAFINE
32G X 4 MM..... 161, 180
BD PEN NEEDLE ORIG ULTRAFINE
29G X 12.7MM..... 161, 180
BD PEN NEEDLE SHORT ULTRAFINE
31G X 8 MM..... 162, 180
BD SAFETYGLIDE INSULIN SYRINGE
29G X 1/2..... 162, 180

BD SAFETYGLIDE INSULIN SYRINGE
30G X 5/16..... 162, 180
BD SAFETYGLIDE INSULIN SYRINGE
31G X 15/64..... 162, 180
BD SAFETYGLIDE INSULIN SYRINGE
31G X 5/16..... 162, 180
BD SAFETYGLIDE SYRINGE/NEEDLE
27G X 5/8..... 162, 180
BD SAFETY-LOK INSULIN SYRINGE
29G X 1/2..... 162, 180
BD SWAB SINGLE USE REGULAR PAD
..... 162, 180
BD SWABS SINGLE USE BUTTERFLY
PAD..... 162, 180
BD VEO INSULIN SYR U/F 1/2UNIT 31G
X 15/64..... 162, 180
BD VEO INSULIN SYR ULTRAFINE 31G
X 15/64..... 162, 180
BD VEO INSULIN SYRINGE U/F 31G X
15/64 162, 180
BENDAMUSTINE HCL INTRAVENOUS
SOLUTION..... 47
bendamustine hcl intravenous solution
reconstituted..... 47
BENDEKA 47
BENLYSTA SUBCUTANEOUS..... 44
BESREMI 300
betaine 50
BETASERON SUBCUTANEOUS KIT 182
bexarotene 54
BIZENGRI (750 MG DOSE) 402
bortezomib injection 56
BORUZU 56
bosentan 57
BOSULIF ORAL CAPSULE 100 MG, 50
MG 58
BOSULIF ORAL TABLET 100 MG, 400
MG, 500 MG..... 58
BRAFTOVI ORAL CAPSULE 75 MG . 109
BRUKINSA 401
C
CABOMETYX ORAL TABLET 20 MG, 40
MG, 60 MG..... 62
CALQUENCE 9

CAPRELSA ORAL TABLET 100 MG, 300
MG 390
CAREFINE PEN NEEDLES 29G X 12MM
..... 162, 180
CAREFINE PEN NEEDLES 30G X 8 MM
..... 162, 180
CAREFINE PEN NEEDLES 31G X 6 MM
..... 162, 180
CAREFINE PEN NEEDLES 31G X 8 MM
..... 162, 180
CAREFINE PEN NEEDLES 32G X 4 MM
..... 162, 180
CAREFINE PEN NEEDLES 32G X 5 MM
..... 162, 180
CAREFINE PEN NEEDLES 32G X 6 MM
..... 162, 180
CAREONE INSULIN SYRINGE 30G X
1/2 162, 180
CAREONE INSULIN SYRINGE 31G X
5/16 162, 180
CARETOUCH ALCOHOL PREP PAD 70
% 162, 180
CARETOUCH INSULIN SYRINGE 28G X
5/16 162, 180
CARETOUCH INSULIN SYRINGE 29G X
5/16 162, 180
CARETOUCH INSULIN SYRINGE 30G X
5/16 162, 180
CARETOUCH INSULIN SYRINGE 31G X
5/16 162, 180
CARETOUCH PEN NEEDLES 29G X
12MM 162, 180
CARETOUCH PEN NEEDLES 31G X 5
MM 162, 180
CARETOUCH PEN NEEDLES 31G X 6
MM 163, 180
CARETOUCH PEN NEEDLES 31G X 8
MM 163, 180
CARETOUCH PEN NEEDLES 32G X 4
MM 163, 180
CARETOUCH PEN NEEDLES 32G X 5
MM 163, 180
CARETOUCH PEN NEEDLES 33G X 4
MM 163, 180

carglumic acid oral tablet soluble	66	COMFORT EZ PEN NEEDLES 32G X 4	
CAYSTON.....	42	MM	163, 180
CIMZIA (2 SYRINGE)	68, 69	COMFORT EZ PEN NEEDLES 32G X 5	
CIMZIA SUBCUTANEOUS KIT 2 X 200		MM	163, 180
MG	68, 69	COMFORT EZ PEN NEEDLES 32G X 6	
CINQAIR.....	280, 281	MM	163, 180
CLEVER CHOICE COMFORT EZ 29G X		COMFORT EZ PEN NEEDLES 32G X 8	
12MM	163, 180	MM	163, 180
CLEVER CHOICE COMFORT EZ 33G X		COMFORT EZ PEN NEEDLES 33G X 4	
4 MM	163, 180	MM	163, 180
CLICKFINE PEN NEEDLES 31G X 6 MM		COMFORT EZ PEN NEEDLES 33G X 5	
.....	163, 180	MM	163, 180
CLICKFINE PEN NEEDLES 31G X 8 MM		COMFORT EZ PEN NEEDLES 33G X 6	
.....	163, 180	MM	163, 180
CLICKFINE PEN NEEDLES 32G X 4 MM		COMFORT EZ PEN NEEDLES 33G X 8	
.....	163, 180	MM	163, 180
COMETRIQ (100 MG DAILY DOSE)		COMFORT EZ PRO PEN NEEDLES 30G	
ORAL KIT 80 & 20 MG	61	X 8 MM.....	163, 180
COMETRIQ (140 MG DAILY DOSE)		COMFORT EZ PRO PEN NEEDLES 31G	
ORAL KIT 3 X 20 MG & 80 MG	61	X 4 MM.....	163, 180
COMETRIQ (60 MG DAILY DOSE).....	61	COMFORT EZ PRO PEN NEEDLES 31G	
COMFORT ASSIST INSULIN SYRINGE		X 5 MM.....	164, 180
29G X 1/2.....	163, 180	COMFORT TOUCH INSULIN PEN NEED	
COMFORT ASSIST INSULIN SYRINGE		31G X 4 MM.....	164, 180
31G X 5/16.....	163, 180	COMFORT TOUCH INSULIN PEN NEED	
COMFORT EZ INSULIN SYRINGE 28G		31G X 5 MM.....	164, 180
X 1/2.....	163, 180	COMFORT TOUCH INSULIN PEN NEED	
COMFORT EZ INSULIN SYRINGE 29G		31G X 6 MM.....	164, 180
X 1/2.....	163, 180	COMFORT TOUCH INSULIN PEN NEED	
COMFORT EZ INSULIN SYRINGE 30G		31G X 8 MM.....	164, 180
X 1/2.....	163, 180	COMFORT TOUCH INSULIN PEN NEED	
COMFORT EZ INSULIN SYRINGE 30G		32G X 4 MM.....	164, 180
X 5/16.....	163, 180	COMFORT TOUCH INSULIN PEN NEED	
COMFORT EZ INSULIN SYRINGE 31G		32G X 5 MM.....	164, 180
X 15/64.....	163, 180	COMFORT TOUCH INSULIN PEN NEED	
COMFORT EZ INSULIN SYRINGE 31G		32G X 6 MM.....	164, 180
X 5/16.....	163, 180	COMFORT TOUCH INSULIN PEN NEED	
COMFORT EZ PEN NEEDLES 31G X 5		32G X 8 MM.....	164, 180
MM	163, 180	COPIKTRA.....	100
COMFORT EZ PEN NEEDLES 31G X 6		CORTROPHIN	74, 75
MM	163, 180	COSENTYX (300 MG DOSE).....	306, 307
COMFORT EZ PEN NEEDLES 31G X 8		COSENTYX INTRAVENOUS.....	304, 305
MM	163, 180	COSENTYX SENSOREADY (300 MG)	
			306, 307

COSENTYX SUBCUTANEOUS
SOLUTION PREFILLED SYRINGE 75
MG/0.5ML 306, 307
COSENTYX UNOREADY 306, 307
COTELLIC 73
CURITY ALCOHOL PREPS PAD 70 %
..... 164, 180
CURITY ALL PURPOSE SPONGES PAD
2..... 164, 180
CURITY GAUZE PAD 2 164, 180
CURITY GAUZE SPONGE PAD 2..... 164,
180
CURITY SPONGES PAD 2 164, 180
CVS GAUZE PAD 2 164, 180
CVS GAUZE STERILE PAD 2 164, 180
CYLTEZO (2 PEN) 17, 18, 19
CYLTEZO (2 SYRINGE) 17, 18, 19
CYLTEZO-CD/UC/HS STARTER... 17, 18,
19
CYLTEZO-PSORIASIS/UV STARTER 17,
18, 19
D
dalfampridine er 81
DANYELZA 227
DANZITEN 230
dasatinib oral tablet 100 mg, 140 mg, 20 mg,
50 mg, 70 mg, 80 mg 83
DATROWAY 84
DAURISMO ORAL TABLET 100 MG, 25
MG 141
deferasirox granules 86, 87
deferasirox oral tablet 86, 87
DERMACEA GAUZE SPONGE PAD 2
..... 164, 180
DERMACEA IV DRAIN SPONGES PAD
2..... 164, 180
DERMACEA NON-WOVEN SPONGES
PAD 2..... 164, 180
DERMACEA TYPE VII GAUZE PAD 2
..... 164, 180
DIACOMIT ORAL CAPSULE 250 MG,
500 MG 327
DIACOMIT ORAL PACKET 250 MG, 500
MG 327

DIATHRIVE PEN NEEDLE 31G X 5 MM
..... 164, 180
DIATHRIVE PEN NEEDLE 31G X 6 MM
..... 164, 180
DIATHRIVE PEN NEEDLE 31G X 8 MM
..... 164, 180
DIATHRIVE PEN NEEDLE 32G X 4 MM
..... 164, 180
diclofenac epolamine external 91
diclofenac sodium external solution 2 %.. 90
dimethyl fumarate oral capsule delayed
release 120 mg, 240 mg 92
dimethyl fumarate starter pack oral capsule
delayed release therapy pack 92
dronabinol 95
DROPLET INSULIN SYRINGE 29G X 1/2
..... 164, 180
DROPLET INSULIN SYRINGE 30G X 1/2
..... 164, 180
DROPLET INSULIN SYRINGE 30G X
15/64 164, 180
DROPLET INSULIN SYRINGE 30G X
5/16 164, 180
DROPLET INSULIN SYRINGE 31G X 1/4
..... 164, 180
DROPLET INSULIN SYRINGE 31G X
15/64 164, 180
DROPLET INSULIN SYRINGE 31G X
5/16 164, 180
DROPLET MICRON 34G X 3.5 MM... 164,
180
DROPLET PEN NEEDLES 29G X 10MM
..... 165, 180
DROPLET PEN NEEDLES 29G X 12MM
..... 165, 180
DROPLET PEN NEEDLES 30G X 8 MM
..... 165, 180
DROPLET PEN NEEDLES 31G X 5 MM
..... 165, 180
DROPLET PEN NEEDLES 31G X 6 MM
..... 165, 180
DROPLET PEN NEEDLES 31G X 8 MM
..... 165, 180

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

DROPLET PEN NEEDLES 32G X 4 MM
..... 165, 180
DROPLET PEN NEEDLES 32G X 5 MM
..... 165, 180
DROPLET PEN NEEDLES 32G X 6 MM
..... 165, 180
DROPLET PEN NEEDLES 32G X 8 MM
..... 165, 180
DROPSAFE ALCOHOL PREP PAD 70 %
..... 165, 180
DROPSAFE SAFETY PEN NEEDLES 31G
X 5 MM..... 165, 180
DROPSAFE SAFETY PEN NEEDLES 31G
X 6 MM..... 165, 180
DROPSAFE SAFETY PEN NEEDLES 31G
X 8 MM..... 165, 180
DROPSAFE SAFETY SYRINGE/NEEDLE
29G X 1/2..... 165, 180
DROPSAFE SAFETY SYRINGE/NEEDLE
31G X 15/64..... 165, 180
DROPSAFE SAFETY SYRINGE/NEEDLE
31G X 5/16..... 165, 180
droxidopa 96
DRUG MART ULTRA COMFORT SYR
29G X 1/2..... 165, 180
DRUG MART ULTRA COMFORT SYR
30G X 5/16..... 165, 180
DRUG MART UNIFINE PENTIPS 31G X
5 MM 165, 180
DUPIXENT SUBCUTANEOUS
SOLUTION AUTO-INJECTOR 97, 99
DUPIXENT SUBCUTANEOUS
SOLUTION PREFILLED SYRINGE . 97,
99

E

EASY COMFORT ALCOHOL PADS PAD
..... 165, 180
EASY COMFORT INSULIN SYRINGE
29G X 5/16..... 165, 180
EASY COMFORT INSULIN SYRINGE
30G X 1/2..... 165, 180
EASY COMFORT INSULIN SYRINGE
30G X 5/16..... 165, 180

EASY COMFORT INSULIN SYRINGE
31G X 1/2..... 165, 180
EASY COMFORT INSULIN SYRINGE
31G X 5/16..... 165, 180
EASY COMFORT INSULIN SYRINGE
32G X 5/16..... 165, 180
EASY COMFORT PEN NEEDLES 29G X
4MM 165, 180
EASY COMFORT PEN NEEDLES 29G X
5MM 165, 180
EASY COMFORT PEN NEEDLES 31G X
5 MM 165, 180
EASY COMFORT PEN NEEDLES 31G X
6 MM 165, 180
EASY COMFORT PEN NEEDLES 31G X
8 MM 165, 180
EASY COMFORT PEN NEEDLES 32G X
4 MM 165, 180
EASY COMFORT PEN NEEDLES 33G X
4 MM 166, 180
EASY COMFORT PEN NEEDLES 33G X
5 MM 166, 180
EASY COMFORT PEN NEEDLES 33G X
6 MM 166, 180
EASY GLIDE PEN NEEDLES 33G X 4
MM 166, 180
EASY TOUCH ALCOHOL PREP
MEDIUM PAD 70 %..... 166, 180
EASY TOUCH FLIPLOCK INSULIN SY
29G X 1/2..... 166, 180
EASY TOUCH FLIPLOCK INSULIN SY
30G X 1/2..... 166, 180
EASY TOUCH FLIPLOCK INSULIN SY
30G X 5/16..... 166, 180
EASY TOUCH FLIPLOCK INSULIN SY
31G X 5/16..... 166, 180
EASY TOUCH FLIPLOCK SAFETY SYR
27G X 1/2..... 166, 180
EASY TOUCH INSULIN BARRELS U-
100 1 ML..... 166, 180
EASY TOUCH INSULIN SAFETY SYR
29G X 1/2..... 166, 180
EASY TOUCH INSULIN SAFETY SYR
30G X 1/2..... 166, 180

Formulary ID: 25489

Last Updated: 05/27/2025

Effective: 06/01/2025

H9306_25_DRS_001_002_OE_C

EASY TOUCH INSULIN SAFETY SYR
30G X 5/16..... 166, 180
EASY TOUCH INSULIN SYRINGE 27G
X 1/2..... 166, 180
EASY TOUCH INSULIN SYRINGE 27G
X 5/8..... 166, 180
EASY TOUCH INSULIN SYRINGE 28G
X 1/2..... 166, 180
EASY TOUCH INSULIN SYRINGE 29G
X 1/2..... 166, 180
EASY TOUCH INSULIN SYRINGE 30G
X 1/2..... 166, 180
EASY TOUCH INSULIN SYRINGE 30G
X 5/16..... 166, 180
EASY TOUCH INSULIN SYRINGE 31G
X 5/16..... 166, 180
EASY TOUCH PEN NEEDLES 29G X
12MM 166, 180
EASY TOUCH PEN NEEDLES 30G X 5
MM 166, 180
EASY TOUCH PEN NEEDLES 30G X 6
MM 166, 180
EASY TOUCH PEN NEEDLES 30G X 8
MM 166, 180
EASY TOUCH PEN NEEDLES 31G X 5
MM 166, 180
EASY TOUCH PEN NEEDLES 31G X 6
MM 166, 180
EASY TOUCH PEN NEEDLES 31G X 8
MM 166, 180
EASY TOUCH PEN NEEDLES 32G X 4
MM 166, 180
EASY TOUCH PEN NEEDLES 32G X 5
MM 166, 180
EASY TOUCH PEN NEEDLES 32G X 6
MM 166, 180
EASY TOUCH SAFETY PEN NEEDLES
29G X 5MM..... 166, 180
EASY TOUCH SAFETY PEN NEEDLES
29G X 8MM..... 167, 180
EASY TOUCH SAFETY PEN NEEDLES
30G X 8 MM..... 167, 180
EASY TOUCH SHEATHLOCK SYRINGE
29G X 1/2..... 167, 180

EASY TOUCH SHEATHLOCK SYRINGE
30G X 1/2..... 167, 180
EASY TOUCH SHEATHLOCK SYRINGE
30G X 5/16..... 167, 180
EASY TOUCH SHEATHLOCK SYRINGE
31G X 5/16..... 167, 180
ELAHERE 223
ELIGARD..... 199
ELREXFIO SUBCUTANEOUS
SOLUTION 44 MG/1.1ML, 76
MG/1.9ML 104
EMBECTA AUTOSHIELD DUO 30G X 5
MM 167, 180
EMBECTA INS SYR U/F 1/2 UNIT 31G X
15/64 167, 180
EMBECTA INS SYR U/F 1/2 UNIT 31G X
5/16 167, 180
EMBECTA INSULIN SYR ULTRAFINE
30G X 1/2..... 167, 180
EMBECTA INSULIN SYR ULTRAFINE
31G X 5/16..... 167, 180
EMBECTA INSULIN SYRINGE 28G X
1/2 167, 180
EMBECTA INSULIN SYRINGE U-100
27G X 5/8..... 167, 180
EMBECTA INSULIN SYRINGE U-100
28G X 1/2..... 167, 180
EMBECTA PEN NEEDLE NANO 2 GEN
32G X 4 MM..... 167, 180
EMBECTA PEN NEEDLE ULTRAFINE
29G X 12.7MM..... 167, 180
EMBECTA PEN NEEDLE ULTRAFINE
32G X 6 MM..... 167, 180
EMBRACE PEN NEEDLES 29G X 12MM
..... 167, 180
EMBRACE PEN NEEDLES 30G X 5 MM
..... 167, 180
EMBRACE PEN NEEDLES 30G X 8 MM
..... 167, 180
EMBRACE PEN NEEDLES 31G X 5 MM
..... 167, 180
EMBRACE PEN NEEDLES 31G X 6 MM
..... 167, 180

Formulary ID: 25489
Last Updated: 05/27/2025
Effective: 06/01/2025
H9306_25_DRS_001_002_OE_C

EMBRACE PEN NEEDLES 31G X 8 MM 167, 180
EMBRACE PEN NEEDLES 32G X 4 MM 167, 180
EMGALITY 137
EMGALITY (300 MG DOSE) 137
ENBREL MINI 121, 122
ENBREL SUBCUTANEOUS SOLUTION 25 MG/0.5ML 121, 122
ENBREL SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 121, 122
ENBREL SUBCUTANEOUS SOLUTION RECONSTITUTED 121, 122
ENBREL SURECLICK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 121, 122
EPCLUSA ORAL PACKET 150-37.5 MG, 200-50 MG 317
EPCLUSA ORAL TABLET 317
EPIDIOLEX 63
EPKINLY 114
EQL ALCOHOL SWABS PAD 70 %... 167, 180
EQL GAUZE PAD 2 167, 180
EQL INSULIN SYRINGE 30G X 5/16. 167, 180
ERBITUX 70
ERIVEDGE 397
ERLEADA ORAL TABLET 240 MG, 60 MG 27
erlotinib hcl oral tablet 100 mg, 150 mg, 25 mg 119
everolimus oral tablet 10 mg, 2.5 mg, 5 mg, 7.5 mg 123
everolimus oral tablet soluble 124
EXEL COMFORT POINT PEN NEEDLE 29G X 12MM 167, 180
F
FASENRA 48, 49
FASENRA PEN 48, 49
fentanyl citrate buccal lozenge on a handle 128
FIFTY50 PEN NEEDLES 32G X 6 MM 167, 180
fingolimod hcl 132

FINTEPLA 127
FOTIVDA 347
FREESTYLE PRECISION INS SYR 30G X 5/16 167, 180
FREESTYLE PRECISION INS SYR 31G X 5/16 167, 180
FRUZAQLA ORAL CAPSULE 1 MG, 5 MG 135
FYARRO 314
G
GAUZE PADS PAD 2 167, 180
GAUZE TYPE VII MEDI-PAK PAD 2 167, 180
GAVRETO 273
gefitinib 139
GILOTRIF 20
glatiramer acetate subcutaneous solution prefilled syringe 20 mg/ml, 40 mg/ml 142
glatopa subcutaneous solution prefilled syringe 20 mg/ml, 40 mg/ml 142
GLOBAL ALCOHOL PREP EASE 167, 180
GLOBAL EASE INJECT PEN NEEDLES 29G X 12MM 167, 180
GLOBAL EASE INJECT PEN NEEDLES 31G X 5 MM 167, 180
GLOBAL EASE INJECT PEN NEEDLES 31G X 8 MM 167, 180
GLOBAL EASE INJECT PEN NEEDLES 32G X 4 MM 167, 180
GLOBAL EASY GLIDE INSULIN SYR 31G X 15/64 168, 180
GLOBAL INJECT EASE INSULIN SYR 28G X 1/2 168, 180
GLOBAL INJECT EASE INSULIN SYR 29G X 1/2 168, 180
GLOBAL INJECT EASE INSULIN SYR 30G X 5/16 168, 180
GLUCOPRO INSULIN SYRINGE 30G X 1/2 168, 180
GLUCOPRO INSULIN SYRINGE 30G X 5/16 168, 180
GLUCOPRO INSULIN SYRINGE 31G X 5/16 168, 180
GNP ALCOHOL SWABS PAD 168, 180

GNP INSULIN SYRINGE 28G X 1/2 .. 168,
180
GNP INSULIN SYRINGE 29G X 1/2 .. 168,
180
GNP INSULIN SYRINGE 30G X 5/16 168,
180
GNP INSULIN SYRINGES 29GX1/2 .. 168,
180
GNP INSULIN SYRINGES 30G X 5/16
..... 168, 180
GNP INSULIN SYRINGES 30GX5/16 168,
180
GNP INSULIN SYRINGES 31GX5/16 168,
180
GNP STERILE GAUZE PAD 2..... 168, 180
GNP ULTRA COM INSULIN SYRINGE
29G X 1/2..... 168, 180
GNP ULTRA COM INSULIN SYRINGE
30G X 5/16..... 168, 180
GOMEKLI ORAL CAPSULE 1 MG, 2 MG
..... 222
GOMEKLI ORAL TABLET SOLUBLE 222
GOODSENSE ALCOHOL SWABS PAD
70 % 168, 180
H
HAEGARDA SUBCUTANEOUS
SOLUTION RECONSTITUTED 2000
UNIT, 3000 UNIT 60
HARVONI ORAL PACKET 33.75-150
MG, 45-200 MG 193
HARVONI ORAL TABLET 193
HEALTHWISE INSULIN SYR/NEEDLE
30G X 5/16..... 168, 180
HEALTHWISE INSULIN SYR/NEEDLE
31G X 5/16..... 168, 169, 180
HEALTHWISE MICRON PEN NEEDLES
32G X 4 MM..... 169, 180
HEALTHWISE SHORT PEN NEEDLES
31G X 5 MM..... 169, 180
HEALTHWISE SHORT PEN NEEDLES
31G X 8 MM..... 169, 180
HEALTHY ACCENTS UNIFINE PENTIP
29G X 12MM..... 169, 180

HEALTHY ACCENTS UNIFINE PENTIP
31G X 5 MM..... 169, 180
HEALTHY ACCENTS UNIFINE PENTIP
31G X 6 MM..... 169, 180
HEALTHY ACCENTS UNIFINE PENTIP
31G X 8 MM..... 169, 180
HEALTHY ACCENTS UNIFINE PENTIP
32G X 4 MM..... 169, 180
H-E-B INCONTROL ALCOHOL PAD 168,
180
H-E-B INCONTROL PEN NEEDLES 29G
X 12MM..... 168, 180
H-E-B INCONTROL PEN NEEDLES 31G
X 5 MM..... 168, 180
H-E-B INCONTROL PEN NEEDLES 31G
X 6 MM..... 168, 180
H-E-B INCONTROL PEN NEEDLES 31G
X 8 MM..... 168, 180
H-E-B INCONTROL PEN NEEDLES 32G
X 4 MM..... 168, 180
HERCEPTIN HYLECTA..... 365
HERZUMA..... 366
HM STERILE PADS PAD 2..... 169, 180
HM ULTICARE INSULIN SYRINGE 30G
X 1/2..... 169, 180
HM ULTICARE INSULIN SYRINGE 31G
X 5/16..... 169, 180
HM ULTICARE SHORT PEN NEEDLES
31G X 8 MM..... 169, 180
HUMIRA (2 PEN) SUBCUTANEOUS
AUTO-INJECTOR KIT..... 11, 12, 13
HUMIRA (2 SYRINGE)
SUBCUTANEOUS PREFILLED
SYRINGE KIT 10 MG/0.1ML, 20
MG/0.2ML, 40 MG/0.4ML, 40
MG/0.8ML 11, 12, 13
HUMIRA-CD/UC/HS STARTER
SUBCUTANEOUS AUTO-INJECTOR
KIT 11, 12, 13
HUMIRA-PED<40KG CROHNS
STARTER..... 11, 12, 13
HUMIRA-PED>=40KG CROHNS START
..... 11, 12, 13

HUMIRA-PED>=40KG UC STARTER SUBCUTANEOUS AUTO-INJECTOR KIT	11, 12, 13
HUMIRA-PS/UV/ADOL HS STARTER SUBCUTANEOUS AUTO-INJECTOR KIT	11, 12, 13
HUMIRA-PSORIASIS/UEVIT STARTER SUBCUTANEOUS AUTO-INJECTOR KIT	11, 12, 13
I	
IBRANCE	254
icatibant acetate	151
ICLUSIG	271
IDHIFA	108
imatinib mesylate oral tablet 100 mg, 400 mg	153
IMBRUVICA ORAL CAPSULE 140 MG, 70 MG	150
IMBRUVICA ORAL SUSPENSION.....	150
IMBRUVICA ORAL TABLET	150
IMDELLTRA	333
IMJUDO	369
IMKELDI.....	154
IMPAVIDO.....	221
INCONTROL ULTICARE PEN NEEDLES 31G X 6 MM.....	169, 180
INCONTROL ULTICARE PEN NEEDLES 31G X 8 MM.....	169, 180
INCONTROL ULTICARE PEN NEEDLES 32G X 4 MM.....	169, 180
INCRELEX.....	215
infliximab.....	157, 158, 159
INGREZZA ORAL CAPSULE	389
INGREZZA ORAL CAPSULE SPRINKLE	389
INGREZZA ORAL CAPSULE THERAPY PACK.....	389
INLYTA ORAL TABLET 1 MG, 5 MG..	40
INQOVI	85
INREBIC.....	126
INSULIN SYRINGE 29G X 1/2	169, 180
INSULIN SYRINGE 30G X 5/16 ..	169, 180
INSULIN SYRINGE 31G X 5/16 ..	169, 180

INSULIN SYRINGE/NEEDLE 27G X 1/2	169, 180
INSULIN SYRINGE/NEEDLE 28G X 1/2	169, 180
INSULIN SYRINGE-NEEDLE U-100 27G X 1/2.....	169, 180
INSULIN SYRINGE-NEEDLE U-100 28G X 1/2.....	169, 180
INSULIN SYRINGE-NEEDLE U-100 30G X 5/16.....	169, 180
INSULIN SYRINGE-NEEDLE U-100 31G X 1/4.....	169, 180
INSULIN SYRINGE-NEEDLE U-100 31G X 5/16.....	169, 180
INSUPEN PEN NEEDLES 31G X 5 MM	169, 180
INSUPEN PEN NEEDLES 32G X 4 MM	169, 180
INSUPEN PEN NEEDLES 33G X 4 MM	169, 180
INSUPEN SENSITIVE 32G X 6 MM ..	169, 180
INSUPEN SENSITIVE 32G X 8 MM ..	169, 180
INSUPEN ULTRAFIN 29G X 12MM..	169, 180
INSUPEN ULTRAFIN 30G X 8 MM...	169, 180
INSUPEN ULTRAFIN 31G X 6 MM...	169, 180
INSUPEN ULTRAFIN 31G X 8 MM...	169, 180
ITOVEBI ORAL TABLET 3 MG, 9 MG	156
IWILFIN	101
J	
J & J GAUZE PAD 2.....	169, 180
JAKAFI.....	302
javygtor oral tablet	303
JAYPIRCA ORAL TABLET 100 MG, 50 MG	269
JEMPERLI.....	94
K	
KALYDECO.....	186

KENDALL HYDROPHILIC FOAM	
DRESS PAD 2	169, 180
KENDALL HYDROPHILIC FOAM PLUS	
PAD 2.....	169, 180
KERENDIA	131
KESIMPTA.....	243
KEYTRUDA INTRAVENOUS	
SOLUTION.....	262
KIMMTRAK	335
KINERET SUBCUTANEOUS SOLUTION	
PREFILLED SYRINGE	25, 26
KINRAY INSULIN SYRINGE 29G X 1/2	
.....	169, 180
KISQALI (200 MG DOSE)	284
KISQALI (400 MG DOSE)	284
KISQALI (600 MG DOSE)	284
KISQALI FEMARA (200 MG DOSE) ..	285
KISQALI FEMARA (400 MG DOSE) ..	285
KISQALI FEMARA (600 MG DOSE) ..	285
KMART VALU INSULIN SYRINGE 29G	
U-100 1 ML	169, 180
KMART VALU INSULIN SYRINGE 30G	
U-100 0.3 ML	169, 180
KMART VALU INSULIN SYRINGE 30G	
U-100 1 ML	169, 180
KOSELUGO ORAL CAPSULE 10 MG, 25	
MG	311
KRAZATI.....	10
KROGER PEN NEEDLES 29G X 12MM	
.....	169, 180
KROGER PEN NEEDLES 31G X 8 MM	
.....	170, 180
KYNMOBI	29
KYNMOBI TITRATION KIT	29
L	
LANREOTIDE ACETATE	189
lapatinib ditosylate	190
LAZCLUZE ORAL TABLET 240 MG, 80	
MG	192
LEADER UNIFINE PENTIPS 31G X 5	
MM	170, 180
LEADER UNIFINE PENTIPS 32G X 4	
MM	170, 180

LEADER UNIFINE PENTIPS PLUS 31G	
X 5 MM.....	170, 180
LEADER UNIFINE PENTIPS PLUS 31G	
X 8 MM.....	170, 180
lenalidomide.....	194
LENVIMA (10 MG DAILY DOSE)	195
LENVIMA (12 MG DAILY DOSE)	195
LENVIMA (14 MG DAILY DOSE)	195
LENVIMA (18 MG DAILY DOSE)	195
LENVIMA (20 MG DAILY DOSE)	195
LENVIMA (24 MG DAILY DOSE)	195
LENVIMA (4 MG DAILY DOSE)	195
LENVIMA (8 MG DAILY DOSE)	195
LEUPROLIDE ACETATE (3 MONTH) 198	
leuprolide acetate injection	197
l-glutamine oral packet	204
lidocaine external ointment 5 %	205
lidocaine external patch 5 %	206
lidocaine-prilocaine external cream.....	207
lidocan.....	206
LITETOUCH INSULIN SYRINGE 28G X	
1/2	170, 180
LITETOUCH INSULIN SYRINGE 29G X	
1/2	170, 180
LITETOUCH INSULIN SYRINGE 30G X	
5/16	170, 180
LITETOUCH INSULIN SYRINGE 31G X	
5/16	170, 180
LITETOUCH PEN NEEDLES 29G X	
12.7MM	170, 180
LITETOUCH PEN NEEDLES 31G X 5	
MM	170, 180
LITETOUCH PEN NEEDLES 31G X 6	
MM	170, 180
LITETOUCH PEN NEEDLES 31G X 8	
MM	170, 180
LITETOUCH PEN NEEDLES 32G X 4	
MM	170, 180
LIVTENCITY	214
LONSURF ORAL TABLET 15-6.14 MG,	
20-8.19 MG.....	371
LOQTORZI.....	359
LORBRENA ORAL TABLET 100 MG, 25	
MG	209

LUMAKRAS ORAL TABLET 120 MG,
240 MG, 320 MG..... 326
LUNSUMIO 225
LUPRON DEPOT (1-MONTH) 200, 201
LUPRON DEPOT (3-MONTH) 200, 201
LUPRON DEPOT (4-MONTH) 200, 201
LUPRON DEPOT (6-MONTH) 200, 201
LUPRON DEPOT-PED (3-MONTH) ... 202,
203
LUPRON DEPOT-PED (6-MONTH) ... 202,
203
LUTRATE DEPOT 198
LYBALVI 244
LYNPARZA ORAL TABLET 245
LYTGOBI (12 MG DAILY DOSE) 136
LYTGOBI (16 MG DAILY DOSE) 136
LYTGOBI (20 MG DAILY DOSE) 136
M
MAGELLAN INSULIN SAFETY SYR
29G X 1/2..... 170, 180
MAGELLAN INSULIN SAFETY SYR
30G X 5/16..... 170, 180
MARGENZA 213
MAVENCLAD (10 TABS) 71
MAVENCLAD (4 TABS) 71
MAVENCLAD (5 TABS) 71
MAVENCLAD (6 TABS) 71
MAVENCLAD (7 TABS) 71
MAVENCLAD (8 TABS) 71
MAVENCLAD (9 TABS) 71
MAXICOMFORT II PEN NEEDLE 31G X
6 MM 170, 180
MAXI-COMFORT INSULIN SYRINGE
28G X 1/2..... 170, 180
MAXI-COMFORT SAFETY PEN
NEEDLE 29G X 5MM 170, 180
MAXI-COMFORT SAFETY PEN
NEEDLE 29G X 8MM 170, 180
MAXICOMFORT SYR 27G X 1/2 170, 180
MAYZENT ORAL TABLET 0.25 MG, 1
MG, 2 MG..... 313
MAYZENT STARTER PACK..... 313
MEDIC INSULIN SYRINGE 30G X 5/16
..... 170, 180

MEDICINE SHOPPE PEN NEEDLES 29G
X 12MM..... 170, 180
MEDICINE SHOPPE PEN NEEDLES 31G
X 8 MM..... 170, 180
MEDPURA ALCOHOL PADS 70 %
EXTERNAL 170, 180
MEIJER ALCOHOL SWABS PAD 70 %
..... 170, 180
MEIJER PEN NEEDLES 29G X 12MM
..... 170, 180
MEIJER PEN NEEDLES 31G X 6 MM 170,
180
MEIJER PEN NEEDLES 31G X 8 MM 170,
180
MEKINIST ORAL SOLUTION
RECONSTITUTED 361
MEKINIST ORAL TABLET 0.5 MG, 2
MG 362
MEKTOVI 55
MICRODOT PEN NEEDLE 31G X 6 MM
..... 170, 180
MICRODOT PEN NEEDLE 32G X 4 MM
..... 170, 180
MICRODOT PEN NEEDLE 33G X 4 MM
..... 171, 180
mifepristone oral tablet 300 mg 220
MIPLYFFA..... 32
MIRASORB SPONGES 2 171, 180
MM PEN NEEDLES 32G X 4 MM 171, 180
modafinil oral tablet 100 mg, 200 mg..... 226
MONOJECT INSULIN SYRINGE 25G X
5/8 171, 180
MONOJECT INSULIN SYRINGE 27G X
1/2 171, 180
MONOJECT INSULIN SYRINGE 28G X
1/2 171, 180
MONOJECT INSULIN SYRINGE 29G X
1/2 171, 180
MONOJECT INSULIN SYRINGE 30G X
5/16 171, 180
MONOJECT INSULIN SYRINGE 31G X
5/16 171, 180
MONOJECT INSULIN SYRINGE U-100 1
ML..... 171, 180

MONOJECT ULTRA COMFORT	
SYRINGE 28G X 1/2	171, 180
MONOJECT ULTRA COMFORT	
SYRINGE 29G X 1/2	171, 180
MONOJECT ULTRA COMFORT	
SYRINGE 30G X 5/16	171, 180
morphine sulfate (concentrate) oral solution	
100 mg/5ml	149
MOUNJARO SUBCUTANEOUS	
SOLUTION AUTO-INJECTOR	145
MVASI.....	52
N	
NATPARA.....	255
NERLYNX	228
NEULASTA ONPRO.....	259
NIKTIMVO	39
NINLARO.....	188
nitisinone.....	236
NIVESTYM.....	130
NORDITROPIN FLEXPPO	
SUBCUTANEOUS SOLUTION PEN-	
INJECTOR.....	319, 320
NOVOFINE AUTOCOVER 30G X 8 MM	
.....	171, 180
NOVOFINE PEN NEEDLE 32G X 6 MM	
.....	171, 180
NOVOFINE PLUS PEN NEEDLE 32G X 4	
MM	171, 180
NOVOTWIST PEN NEEDLE 32G X 5 MM	
.....	171, 180
NUBEQA.....	82
NUCALA SUBCUTANEOUS SOLUTION	
AUTO-INJECTOR	217, 218
NUCALA SUBCUTANEOUS SOLUTION	
REFILLED SYRINGE 100 MG/ML, 40	
MG/0.4ML	217, 218
NUCALA SUBCUTANEOUS SOLUTION	
RECONSTITUTED.....	217, 218
NUPLAZID ORAL CAPSULE.....	267
NUPLAZID ORAL TABLET 10 MG....	267
NURTEC.....	289, 290
NYVEPRIA	258
O	
OCREVUS.....	241

OCREVUS ZUNOVO.....	242
ODOMZO	323
OFEV	231, 232
OGIVRI.....	363
OGSIVEO ORAL TABLET 100 MG, 150	
MG, 50 MG.....	235
OJEMDA ORAL SUSPENSION	
RECONSTITUTED.....	360
OJEMDA ORAL TABLET	360
OJJAARA	224
ONAPGO.....	28
ONTRUZANT	364
ONUREG.....	41
OPDIVO	237
OPDIVO QVANTIG	238
OPDUALAG.....	239
OPSUMIT	212
ORENCIA CLICKJECT.....	4, 5
ORENCIA INTRAVENOUS	2, 3
ORENCIA SUBCUTANEOUS SOLUTION	
REFILLED SYRINGE	4, 5
ORFADIN ORAL SUSPENSION.....	236
ORGOVYX.....	278
ORILISSA ORAL TABLET 150 MG, 200	
MG	103
ORKAMBI ORAL TABLET	211
ORSERDU ORAL TABLET 345 MG, 86	
MG	102
OTEZLA	30, 31
oxandrolone oral	252
OZEMPIC (0.25 OR 0.5 MG/DOSE).....	144
OZEMPIC (1 MG/DOSE)	144
OZEMPIC (2 MG/DOSE)	144
P	
pazopanib hcl	257
PC UNIFINE PENTIPS 31G X 5 MM..	171,
180	
PC UNIFINE PENTIPS 31G X 6 MM..	171,
180	
PC UNIFINE PENTIPS 31G X 8 MM..	171,
180	
PEGASYS SUBCUTANEOUS SOLUTION	
180 MCG/ML	260

PEGASYS SUBCUTANEOUS SOLUTION
 PREFILLED SYRINGE 260
 PEMAZYRE 263
 PEN NEEDLE/5-BEVEL TIP 32G X 4 MM
 171, 180
 PEN NEEDLES 30G X 5 MM (OTC)... 171,
 180
 PEN NEEDLES 30G X 8 MM 171, 180
 PEN NEEDLES 32G X 4 MM (OTC)... 171,
 180
 PEN NEEDLES 32G X 5 MM 171, 180
 penicillamine oral tablet..... 264, 265
 PENTIPS 29G X 12MM (RX)..... 171, 180
 PENTIPS 31G X 5 MM (RX)..... 171, 180
 PENTIPS 31G X 8 MM (RX)..... 171, 180
 PENTIPS 32G X 4 MM (RX)..... 171, 180
 PENTIPS GENERIC PEN NEEDLES 29G
 X 12MM..... 171, 180
 PENTIPS GENERIC PEN NEEDLES 31G
 X 6 MM..... 171, 180
 PENTIPS GENERIC PEN NEEDLES 32G
 X 6 MM..... 171, 180
 PIP PEN NEEDLES 31G X 5MM 31G X 5
 MM 171, 180
 PIP PEN NEEDLES 32G X 4MM 32G X 4
 MM 171, 180
 PIQRAY (200 MG DAILY DOSE)..... 22
 PIQRAY (250 MG DAILY DOSE)..... 22
 PIQRAY (300 MG DAILY DOSE)..... 22
 pirfenidone oral capsule..... 268
 pirfenidone oral tablet 267 mg, 534 mg, 801
 mg 268
 PLEGRIDY STARTER PACK
 SUBCUTANEOUS SOLUTION AUTO-
 INJECTOR..... 183
 PLEGRIDY STARTER PACK
 SUBCUTANEOUS SOLUTION
 PREFILLED SYRINGE 183
 PLEGRIDY SUBCUTANEOUS
 SOLUTION AUTO-INJECTOR 183
 PLEGRIDY SUBCUTANEOUS
 SOLUTION PREFILLED SYRINGE 183
 POMALYST 270
 posaconazole oral tablet delayed release 272

PRECISION SUREDOSE PLUS SYR 29G
 X 1/2..... 172, 180
 PRECISION SURE-DOSE SYRINGE 28G
 X 1/2..... 171, 180
 PRECISION SURE-DOSE SYRINGE 29G
 X 1/2..... 171, 180
 PRECISION SURE-DOSE SYRINGE 30G
 X 3/8..... 171, 180
 PRECISION SURE-DOSE SYRINGE 30G
 X 5/16..... 172, 180
 PREFERRED PLUS INSULIN SYRINGE
 28G X 1/2..... 172, 180
 PREFERRED PLUS UNIFINE PENTIPS
 29G X 12MM..... 172, 180
 PREVENT DROPSAFE PEN NEEDLES
 31G X 6 MM..... 172, 180
 PREVENT DROPSAFE PEN NEEDLES
 31G X 8 MM..... 172, 180
 PREVENT SAFETY PEN NEEDLES 31G
 X 6 MM..... 172, 180
 PREVENT SAFETY PEN NEEDLES 31G
 X 8 MM..... 172, 180
 PREVYMIS ORAL TABLET 196
 PRO COMFORT ALCOHOL PAD 70 %
 172, 180
 PRO COMFORT INSULIN SYRINGE 30G
 X 1/2..... 172, 180
 PRO COMFORT INSULIN SYRINGE 30G
 X 5/16..... 172, 180
 PRO COMFORT INSULIN SYRINGE 31G
 X 5/16..... 172, 180
 PRO COMFORT PEN NEEDLES 31G X 8
 MM 172, 180
 PRO COMFORT PEN NEEDLES 32G X 4
 MM 172, 180
 PRO COMFORT PEN NEEDLES 32G X 5
 MM 172, 180
 PRO COMFORT PEN NEEDLES 32G X 6
 MM 172, 180
 PRODIGY INSULIN SYRINGE 28G X 1/2
 172, 180
 PRODIGY INSULIN SYRINGE 31G X
 5/16 172, 180

PROMACTA ORAL PACKET 12.5 MG,
25 MG 106, 107
PROMACTA ORAL TABLET 12.5 MG, 25
MG, 50 MG, 75 MG 106, 107
PURE COMFORT ALCOHOL PREP PAD
..... 172, 180
PURE COMFORT PEN NEEDLE 32G X 4
MM 172, 180
PURE COMFORT PEN NEEDLE 32G X 5
MM 172, 180
PURE COMFORT PEN NEEDLE 32G X 6
MM 172, 180
PURE COMFORT PEN NEEDLE 32G X 8
MM 172, 180
PURE COMFORT SAFETY PEN NEEDLE
31G X 5 MM..... 172, 180
PURE COMFORT SAFETY PEN NEEDLE
31G X 6 MM..... 172, 180
PURE COMFORT SAFETY PEN NEEDLE
32G X 4 MM..... 172, 180
PX SHORTLENGTH PEN NEEDLES 31G
X 8 MM..... 172, 180
pyrimethamine oral 274
Q
QC ALCOHOL 172, 180
QC ALCOHOL SWABS PAD 70 %..... 172,
180
QC BORDER ISLAND GAUZE PAD 2
..... 172, 180
QINLOCK..... 293
QUICK TOUCH INSULIN PEN NEEDLE
31G X 4 MM..... 172, 180
QUICK TOUCH INSULIN PEN NEEDLE
31G X 5 MM..... 172, 180
QUICK TOUCH INSULIN PEN NEEDLE
32G X 4 MM..... 172, 180
QUICK TOUCH INSULIN PEN NEEDLE
32G X 5 MM..... 172, 180
QUICK TOUCH INSULIN PEN NEEDLE
32G X 6 MM..... 172, 180
QUICK TOUCH INSULIN PEN NEEDLE
32G X 8 MM..... 172, 180
QUICK TOUCH INSULIN PEN NEEDLE
33G X 4 MM..... 172, 180

QUICK TOUCH INSULIN PEN NEEDLE
33G X 5 MM..... 172, 180
QUICK TOUCH INSULIN PEN NEEDLE
33G X 6 MM..... 172, 180
QUICK TOUCH INSULIN PEN NEEDLE
33G X 8 MM..... 173, 180
quinine sulfate oral..... 275
QULIPTA 36
R
RA ALCOHOL SWABS PAD 70 %..... 173,
180
RA INSULIN SYRINGE 29G X 1/2..... 173,
180
RA INSULIN SYRINGE 30G X 5/16... 173,
180
ra isopropyl alcohol wipes 173, 180
RA PEN NEEDLES 31G X 5 MM. 173, 180
RA PEN NEEDLES 31G X 8 MM. 173, 180
RA STERILE PAD 2 173, 180
RALDESY 368
RAYA SURE PEN NEEDLE 29G X 12MM
..... 173, 180
RAYA SURE PEN NEEDLE 31G X 4 MM
..... 173, 180
RAYA SURE PEN NEEDLE 31G X 5 MM
..... 173, 180
RAYA SURE PEN NEEDLE 31G X 6 MM
..... 173, 180
REALITY INSULIN SYRINGE 28G X 1/2
..... 173, 180
REALITY INSULIN SYRINGE 29G X 1/2
..... 173, 180
REALITY SWABS PAD..... 173, 180
RELION ALCOHOL SWABS PAD 173,
180
RELI-ON INSULIN SYRINGE 29G 0.3
ML..... 173, 180
RELI-ON INSULIN SYRINGE 29G 0.5
ML..... 173, 180
RELI-ON INSULIN SYRINGE 29G X 1/2
..... 173, 180
RELION INSULIN SYRINGE 31G X 15/64
..... 173, 180

RELION MINI PEN NEEDLES 31G X 6
MM 173, 180
RELION PEN NEEDLES 31G X 6 MM 173,
180
RELION PEN NEEDLES 31G X 8 MM 173,
180
RESTORE CONTACT LAYER PAD 2 173,
180
RETACRIT INJECTION SOLUTION
10000 UNIT/ML, 10000
UNIT/ML(1ML), 2000 UNIT/ML, 20000
UNIT/ML, 3000 UNIT/ML, 4000
UNIT/ML, 40000 UNIT/ML 115, 116
RETEVMO ORAL CAPSULE 40 MG, 80
MG 310
RETEVMO ORAL TABLET 120 MG, 160
MG, 40 MG, 80 MG 310
REVUFORJ ORAL TABLET 110 MG, 160
MG, 25 MG 283
REZLIDHIA 246
REZUROCK 45
RIABNI 298
RINVOQ 375, 377
RINVOQ LQ 375, 377
RITUXAN HYCELA 296
ROMVIMZA 396
ROZLYTREK ORAL CAPSULE 100 MG,
200 MG 110
ROZLYTREK ORAL PACKET 111
RUBRACA 301
RUXIENCE 299
RYBELSUS 144
RYBELSUS (FORMULATION R2)..... 144
RYBREVANT 24
RYDAPT 219
RYTELO 155
S
SAFETY INSULIN SYRINGES 29G X 1/2
..... 173, 180
SAFETY INSULIN SYRINGES 30G X 1/2
..... 173, 180
SAFETY INSULIN SYRINGES 30G X
5/16 173, 180

SAFETY PEN NEEDLES 30G X 5 MM
..... 173, 180
SAFETY PEN NEEDLES 30G X 8 MM
..... 173, 180
sapropterin dihydrochloride oral tablet... 303
SB ALCOHOL PREP PAD 70 %... 173, 180
SB INSULIN SYRINGE 29G X 1/2 173,
180
SB INSULIN SYRINGE 30G X 5/16 ... 173,
180
SB INSULIN SYRINGE 31G X 5/16 ... 173,
180
SCEMBLIX ORAL TABLET 100 MG, 20
MG, 40 MG 33
SECURESAFE INSULIN SYRINGE 29G
X 1/2 173, 180
SECURESAFE SAFETY PEN NEEDLES
30G X 8 MM 173, 180
SELARSDI 381, 382, 383, 384
SEROSTIM SUBCUTANEOUS
SOLUTION RECONSTITUTED 4 MG,
5 MG, 6 MG 321, 322
SIGNIFOR 256
sildenafil citrate oral tablet 20 mg 312
SIRTURO 43
SKYRIZI 294, 295
SKYRIZI (150 MG DOSE) 294, 295
SKYRIZI PEN 294, 295
SM ALCOHOL PREP PAD 173, 180
SM ALCOHOL PREP PAD 6-70 %
EXTERNAL 173, 180
SM ALCOHOL PREP PAD 70 %.. 173, 180
SM GAUZE PAD 2 173, 180
sodium oxybate 315, 316
SOMATULINE DEPOT
SUBCUTANEOUS SOLUTION 60
MG/0.2ML, 90 MG/0.3ML 189
SOMAVERT 261
sorafenib tosylate 324
SPRAVATO (56 MG DOSE) 120
SPRAVATO (84 MG DOSE) 120
STELARA INTRAVENOUS 380
STELARA SUBCUTANEOUS
SOLUTION 45 MG/0.5ML 378, 379

STELARA SUBCUTANEOUS	
SOLUTION PREFILLED SYRINGE 378,	
379	
STERILE GAUZE PAD 2	173, 180
STERILE PAD 2.....	173, 180
STIVARGA	277
STRENSIQ	34, 35
sunitinib malate.....	328
SURE COMFORT ALCOHOL PREP PAD	
70 %	173, 180
SURE COMFORT INSULIN SYRINGE	
28G X 1/2.....	174, 180
SURE COMFORT INSULIN SYRINGE	
29G X 1/2.....	174, 180
SURE COMFORT INSULIN SYRINGE	
30G X 1/2.....	174, 180
SURE COMFORT INSULIN SYRINGE	
30G X 5/16.....	174, 180
SURE COMFORT INSULIN SYRINGE	
31G X 1/4.....	174, 180
SURE COMFORT INSULIN SYRINGE	
31G X 5/16.....	174, 180
SURE COMFORT PEN NEEDLES 29G X	
12.7MM	174, 180
SURE COMFORT PEN NEEDLES 30G X	
8 MM	174, 180
SURE COMFORT PEN NEEDLES 31G X	
5 MM	174, 180
SURE COMFORT PEN NEEDLES 31G X	
6 MM	174, 180
SURE COMFORT PEN NEEDLES 31G X	
8 MM	174, 180
SURE COMFORT PEN NEEDLES 32G X	
4 MM (OTC).....	174, 180
SURE COMFORT PEN NEEDLES 32G X	
4 MM (RX)	174, 180
SURE COMFORT PEN NEEDLES 32G X	
6 MM	174, 180
SURE-JECT INSULIN SYRINGE 31G X	
5/16	174, 180
SURE-PREP ALCOHOL PREP PAD 70 %	
.....	174, 180
SURGICAL GAUZE SPONGE PAD 2	174,
180	

SYMPAZAN.....	72
SYNRIBO	247
T	
TABRECTA	65
tadalafil oral tablet 2.5 mg, 5 mg.....	330
TAFINLAR ORAL CAPSULE	78
TAFINLAR ORAL TABLET SOLUBLE	79
TAGRISSO	251
TALVEY.....	332
TALZENNA	331
TASIGNA ORAL CAPSULE 150 MG, 200	
MG, 50 MG.....	229
TAVNEOS.....	37
TAZVERIK.....	334
TECHLITE INSULIN SYRINGE 29G X	
1/2	174, 180
TECHLITE PLUS PEN NEEDLES 32G X 4	
MM	174, 180
TECVAYLI.....	336
TEPMETKO	338
TERIPARATIDE SUBCUTANEOUS	
SOLUTION PEN-INJECTOR 620	
MCG/2.48ML	339
TERUMO INSULIN SYRINGE 29G X 1/2	
.....	174, 180
testosterone cypionate intramuscular	
solution 100 mg/ml, 200 mg/ml, 200	
mg/ml (1 ml)	341
testosterone enanthate intramuscular	
solution.....	342
testosterone gel 1.62 % transdermal	340
testosterone transdermal gel 12.5 mg/act	
(1%), 20.25 mg/act (1.62%), 25	
mg/2.5gm (1%), 50 mg/5gm (1%).....	340
tetrabenazine	343
TEVIMBRA.....	345
THALOMID	344
THERAGAUZE PAD 2.....	174, 180
TIBSOVO	187
TIVDAK	346
TODAYS HEALTH PEN NEEDLES 29G	
X 12MM.....	174, 180
TODAYS HEALTH SHORT PEN	
NEEDLE 31G X 8 MM	174, 180

TOPCARE CLICKFINE PEN NEEDLES
31G X 6 MM..... 174, 180
TOPCARE CLICKFINE PEN NEEDLES
31G X 8 MM..... 174, 180
TOPCARE ULTRA COMFORT INS SYR
29G X 1/2..... 174, 180
TOPCARE ULTRA COMFORT INS SYR
30G X 5/16..... 174, 175, 180
TOPCARE ULTRA COMFORT INS SYR
31G X 5/16..... 175, 180
torpenz oral tablet 10 mg, 2.5 mg, 5 mg, 7.5
mg 123
TRAZIMERA 367
TRELSTAR MIXJECT 372
TREMIFYA INTRAVENOUS 147, 148
TREMIFYA ONE-PRESS 147, 148
TREMIFYA PEN SUBCUTANEOUS
SOLUTION AUTO-INJECTOR 200
MG/2ML 147, 148
TREMIFYA SUBCUTANEOUS
SOLUTION PREFILLED SYRINGE 147,
148
tretinoin external cream 358
trientine hcl oral capsule 250 mg 370
TRUE COMFORT ALCOHOL PREP
PADS PAD 70 % 175, 180
TRUE COMFORT INSULIN SYRINGE
30G X 1/2..... 175, 180
TRUE COMFORT INSULIN SYRINGE
30G X 5/16..... 175, 180
TRUE COMFORT INSULIN SYRINGE
31G X 5/16..... 175, 180
TRUE COMFORT INSULIN SYRINGE
32G X 5/16..... 175, 180
TRUE COMFORT PEN NEEDLES 31G X
5 MM 175, 180
TRUE COMFORT PEN NEEDLES 31G X
6 MM 175, 180
TRUE COMFORT PEN NEEDLES 32G X
4 MM 175, 180
TRUE COMFORT PRO ALCOHOL PREP
PAD 70 % 175, 180
TRUE COMFORT PRO INSULIN SYR
30G X 1/2..... 175, 180

TRUE COMFORT PRO INSULIN SYR
30G X 5/16..... 175, 180
TRUE COMFORT PRO INSULIN SYR
31G X 5/16..... 175, 180
TRUE COMFORT PRO INSULIN SYR
32G X 5/16..... 175, 180
TRUE COMFORT PRO PEN NEEDLES
31G X 5 MM..... 175, 180
TRUE COMFORT PRO PEN NEEDLES
31G X 6 MM..... 175, 180
TRUE COMFORT PRO PEN NEEDLES
31G X 8 MM..... 175, 180
TRUE COMFORT PRO PEN NEEDLES
32G X 4 MM..... 175, 180
TRUE COMFORT PRO PEN NEEDLES
32G X 5 MM..... 175, 180
TRUE COMFORT PRO PEN NEEDLES
32G X 6 MM..... 175, 180
TRUE COMFORT PRO PEN NEEDLES
33G X 4 MM..... 175, 180
TRUE COMFORT PRO PEN NEEDLES
33G X 5 MM..... 175, 180
TRUE COMFORT PRO PEN NEEDLES
33G X 6 MM..... 175, 180
TRUEPLUS 5-BEVEL PEN NEEDLES
29G X 12.7MM..... 175, 180
TRUEPLUS 5-BEVEL PEN NEEDLES
31G X 5 MM..... 175, 180
TRUEPLUS 5-BEVEL PEN NEEDLES
31G X 6 MM..... 175, 180
TRUEPLUS 5-BEVEL PEN NEEDLES
31G X 8 MM..... 175, 180
TRUEPLUS 5-BEVEL PEN NEEDLES
32G X 4 MM..... 175, 180
TRUEPLUS INSULIN SYRINGE 28G X
1/2 175, 180
TRUEPLUS INSULIN SYRINGE 29G X
1/2 175, 176, 180
TRUEPLUS INSULIN SYRINGE 30G X
5/16 176, 180
TRUEPLUS INSULIN SYRINGE 31G X
5/16 176, 180
TRUEPLUS PEN NEEDLES 29G X 12MM
..... 176, 180

TRUEPLUS PEN NEEDLES 31G X 5 MM
..... 176, 180
TRUEPLUS PEN NEEDLES 31G X 6 MM
..... 176, 180
TRUEPLUS PEN NEEDLES 31G X 8 MM
..... 176, 180
TRUEPLUS PEN NEEDLES 32G X 4 MM
..... 176, 180
TRULICITY SUBCUTANEOUS
SOLUTION AUTO-INJECTOR 143
TRUQAP ORAL TABLET 64
TRUQAP TABLET THERAPY PACK 160
MG ORAL 64
TRUXIMA 297
TUKYSA ORAL TABLET 150 MG, 50
MG 373
TURALIO 266
TYENNE 352, 353, 354, 355
TYMLOS 1
U
UBRELVY 374
ULTICARE INSULIN SAFETY SYR 29G
X 1/2 176, 180
ULTICARE INSULIN SYRINGE 28G X
1/2 176, 180
ULTICARE INSULIN SYRINGE 29G X
1/2 176, 180
ULTICARE INSULIN SYRINGE 30G X
1/2 176, 180
ULTICARE INSULIN SYRINGE 30G X
5/16 176, 180
ULTICARE INSULIN SYRINGE 31G X
1/4 176, 180
ULTICARE INSULIN SYRINGE 31G X
5/16 176, 180
ULTICARE MICRO PEN NEEDLES 32G
X 4 MM 176, 180
ULTICARE MINI PEN NEEDLES 30G X 5
MM 176, 180
ULTICARE MINI PEN NEEDLES 31G X 6
MM 176, 180
ULTICARE MINI PEN NEEDLES 32G X 6
MM 176, 180

ULTICARE PEN NEEDLES 29G X
12.7MM (OTC) 176, 180
ULTICARE PEN NEEDLES 29G X
12.7MM (RX) 176, 180
ULTICARE PEN NEEDLES 31G X 5 MM
..... 176, 180
ULTICARE SHORT PEN NEEDLES 30G
X 8 MM 176, 180
ULTICARE SHORT PEN NEEDLES 31G
X 8 MM (OTC) 177, 180
ULTICARE SHORT PEN NEEDLES 31G
X 8 MM (RX) 177, 180
ULTIGUARD SAFEPAK PEN NEEDLE
29G X 12.7MM 177, 180
ULTIGUARD SAFEPAK PEN NEEDLE
31G X 5 MM 177, 180
ULTIGUARD SAFEPAK PEN NEEDLE
31G X 6 MM 177, 180
ULTIGUARD SAFEPAK PEN NEEDLE
31G X 8 MM 177, 180
ULTIGUARD SAFEPAK PEN NEEDLE
32G X 4 MM 177, 180
ULTIGUARD SAFEPAK PEN NEEDLE
32G X 6 MM 177, 180
ULTIGUARD SAFEPAK SYR/NEEDLE
30G X 1/2 177, 180
ULTIGUARD SAFEPAK SYR/NEEDLE
31G X 5/16 177, 180
ULTILET ALCOHOL SWABS PAD ... 177,
180
ULTILET INSULIN SYRINGE 30G X 1/2
..... 177, 180
ULTILET INSULIN SYRINGE 30G X 5/16
..... 177, 180
ULTILET INSULIN SYRINGE 31G X 1/4
..... 177, 180
ULTILET INSULIN SYRINGE 31G X
15/64 177, 180
ULTILET INSULIN SYRINGE 31G X 5/16
..... 177, 180
ULTILET INSULIN SYRINGE SHORT
30G X 1/2 177, 180
ULTILET INSULIN SYRINGE SHORT
30G X 5/16 177, 180

ULTILET INSULIN SYRINGE SHORT
31G X 5/16..... 177, 180
ULTILET PEN NEEDLE 29G X 12.7MM
..... 177, 180
ULTILET PEN NEEDLE 31G X 5 MM 177,
180
ULTILET PEN NEEDLE 31G X 8 MM 177,
180
ULTILET PEN NEEDLE 32G X 4 MM 177,
180
ULTRA COMFORT INSULIN SYRINGE
30G X 5/16..... 177, 180
ULTRA FLO INSULIN PEN NEEDLES
29G X 12MM..... 177, 180
ULTRA FLO INSULIN PEN NEEDLES
31G X 8 MM..... 177, 180
ULTRA FLO INSULIN PEN NEEDLES
32G X 4 MM..... 177, 180
ULTRA FLO INSULIN PEN NEEDLES
33G X 4 MM..... 177, 180
ULTRA FLO INSULIN SYR 1/2 UNIT
30G X 1/2..... 177, 180
ULTRA FLO INSULIN SYR 1/2 UNIT
30G X 5/16..... 177, 180
ULTRA FLO INSULIN SYR 1/2 UNIT
31G X 5/16..... 178, 180
ULTRA FLO INSULIN SYRINGE 29G X
1/2 178, 180
ULTRA FLO INSULIN SYRINGE 30G X
1/2 178, 180
ULTRA FLO INSULIN SYRINGE 30G X
5/16 178, 180
ULTRA FLO INSULIN SYRINGE 31G X
5/16 178, 180
ULTRA THIN PEN NEEDLES 32G X 4
MM 178, 180
ULTRACARE INSULIN SYRINGE 30G X
1/2 178, 180
ULTRACARE INSULIN SYRINGE 30G X
5/16 178, 180
ULTRACARE INSULIN SYRINGE 31G X
5/16 178, 180
ULTRACARE PEN NEEDLES 31G X 5
MM 178, 180

ULTRACARE PEN NEEDLES 31G X 6
MM 178, 180
ULTRACARE PEN NEEDLES 31G X 8
MM 178, 180
ULTRACARE PEN NEEDLES 32G X 4
MM 178, 180
ULTRACARE PEN NEEDLES 32G X 5
MM 178, 180
ULTRACARE PEN NEEDLES 32G X 6
MM 178, 180
ULTRACARE PEN NEEDLES 33G X 4
MM 178, 180
ULTRA-COMFORT INSULIN SYRINGE
29G X 1/2..... 178, 180
ULTRA-THIN II INS SYR SHORT 30G X
5/16 178, 180
ULTRA-THIN II INS SYR SHORT 31G X
5/16 178, 180
ULTRA-THIN II INSULIN SYRINGE 29G
X 1/2..... 178, 180
ULTRA-THIN II MINI PEN NEEDLE 31G
X 5 MM..... 178, 180
ULTRA-THIN II PEN NEEDLE SHORT
31G X 8 MM..... 178, 180
ULTRA-THIN II PEN NEEDLES 29G X
12.7MM 178, 180
UNIFINE OTC PEN NEEDLES 31G X 5
MM 178, 180
UNIFINE OTC PEN NEEDLES 32G X 4
MM 179, 180
UNIFINE PEN NEEDLES 32G X 4 MM
..... 179, 180
UNIFINE PENTIPS 29G X 12MM 179, 180
UNIFINE PENTIPS 31G X 6 MM. 179, 180
UNIFINE PENTIPS 31G X 8 MM. 179, 180
UNIFINE PENTIPS PLUS 29G X 12MM
..... 179, 180
UNIFINE PENTIPS PLUS 31G X 6 MM
..... 179, 180
UNIFINE PENTIPS PLUS 32G X 4 MM
..... 179, 180
UNIFINE PROTECT PEN NEEDLE 30G X
5 MM 179, 180

UNIFINE PROTECT PEN NEEDLE 30G X 8 MM	179, 180
UNIFINE PROTECT PEN NEEDLE 32G X 4 MM	179, 180
UNIFINE SAFECONTROL PEN NEEDLE 30G X 5 MM.....	179, 180
UNIFINE SAFECONTROL PEN NEEDLE 30G X 8 MM.....	179, 180
UNIFINE SAFECONTROL PEN NEEDLE 31G X 5 MM.....	179, 180
UNIFINE SAFECONTROL PEN NEEDLE 31G X 6 MM.....	179, 180
UNIFINE SAFECONTROL PEN NEEDLE 31G X 8 MM.....	179, 180
UNIFINE SAFECONTROL PEN NEEDLE 32G X 4 MM.....	179, 180
UNIFINE ULTRA PEN NEEDLE 31G X 5 MM	179, 180
UNIFINE ULTRA PEN NEEDLE 31G X 6 MM	179, 180
UNIFINE ULTRA PEN NEEDLE 31G X 8 MM	179, 180
UNIFINE ULTRA PEN NEEDLE 32G X 4 MM	179, 180
UPTRAVI INTRAVENOUS.....	308
UPTRAVI ORAL TABLET 1000 MCG, 1200 MCG, 1400 MCG, 1600 MCG, 200 MCG, 400 MCG, 600 MCG, 800 MCG	308
UPTRAVI TITRATION.....	308
V	
VALCHLOR.....	216
VALUE HEALTH INSULIN SYRINGE 29G X 1/2.....	179, 180
VANFLYTA.....	276
VANISHPOINT INSULIN SYRINGE 29G X 5/16.....	179, 180
VANISHPOINT INSULIN SYRINGE 30G X 3/16.....	179, 180
VANISHPOINT INSULIN SYRINGE 30G X 5/16.....	179, 180
VEGZELMA.....	51
VENCLEXTA ORAL TABLET 10 MG, 100 MG, 50 MG.....	393

VENCLEXTA STARTING PACK	393
VEOZAH	129
VERIFINE INSULIN PEN NEEDLE 29G X 12MM.....	179, 180
VERIFINE INSULIN PEN NEEDLE 31G X 5 MM.....	179, 180
VERIFINE INSULIN PEN NEEDLE 32G X 6 MM.....	179, 180
VERIFINE INSULIN SYRINGE 29G X 1/2	179, 180
VERIFINE INSULIN SYRINGE 31G X 5/16	179, 180
VERIFINE PLUS PEN NEEDLE 31G X 5 MM	179, 180
VERIFINE PLUS PEN NEEDLE 31G X 8 MM	179, 180
VERIFINE PLUS PEN NEEDLE 32G X 4 MM	179, 180
VERQUVO	394
VERZENIO.....	6
vigabatrin	395
vigadrone.....	395
vigpoder	395
VITRAKVI ORAL CAPSULE 100 MG, 25 MG	191
VITRAKVI ORAL SOLUTION	191
VIVIMUSTA	47
VIZIMPRO	80
VONJO	253
VORANIGO	398
voriconazole oral suspension reconstituted	399
VOSEVI.....	318
VOWST	125
VP INSULIN SYRINGE 29G X 1/2	179, 180
VUMERITY	93
VYALEV SUBCUTANEOUS SOLUTION 12-240 MG/ML.....	133
VYLOY.....	403
W	
WEBCOL ALCOHOL PREP LARGE PAD 70 %	179, 180

WEGMANS UNIFINE PENTIPS PLUS
31G X 8 MM..... 179, 180
WELIREG..... 46
WINREVAIR..... 325
X
XALKORI ORAL CAPSULE..... 76
XALKORI ORAL CAPSULE SPRINKLE
150 MG, 20 MG, 50 MG 77
XDEMVEY 210
XELJANZ 356, 357
XELJANZ XR 356, 357
XERMELO 337
XGEVA..... 88
XIFAXAN ORAL TABLET 200 MG, 550
MG 286
XOLAIR 248, 250
XOSPATA 140
XPOVIO (100 MG ONCE WEEKLY)
ORAL TABLET THERAPY PACK 50
MG 309
XPOVIO (40 MG ONCE WEEKLY) ORAL
TABLET THERAPY PACK 10 MG, 40
MG 309
XPOVIO (40 MG TWICE WEEKLY)
ORAL TABLET THERAPY PACK 40
MG 309
XPOVIO (60 MG ONCE WEEKLY) ORAL
TABLET THERAPY PACK 60 MG.. 309
XPOVIO (60 MG TWICE WEEKLY)... 309
XPOVIO (80 MG ONCE WEEKLY) ORAL
TABLET THERAPY PACK 40 MG.. 309

XPOVIO (80 MG TWICE WEEKLY)... 309
XTANDI ORAL CAPSULE..... 112, 113
XTANDI ORAL TABLET 40 MG, 80 MG
..... 112, 113
XYOSTED..... 342
Y
YERVOY 185
YESINTEK..... 385, 386, 387, 388
YONSA..... 8
YUFLYMA (1 PEN)..... 14, 15, 16
YUFLYMA (2 SYRINGE)..... 14, 15, 16
YUFLYMA-CD/UC/HS STARTER . 14, 15,
16
Z
ZEJULA ORAL CAPSULE 233
ZEJULA ORAL TABLET..... 233
ZELBORAF..... 392
ZEVX STERILE ALCOHOL PREP PAD
PAD 70 % 179, 180
ZIIHERA..... 400
ZIRABEV 53
ZOLADEX..... 146
ZTALMY 138
ZTLIDO 206
ZURZUVAE ORAL CAPSULE 20 MG, 25
MG, 30 MG..... 404
ZYDELIG 152
ZYKADIA ORAL TABLET 67
ZYNLONTA..... 208
ZYNZY 282