

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
Prerequisite Therapy Required	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: ALL INDICATIONS: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR THE SAME INDICATION. RA: TRIAL OF OR CONTRAINDICATION TO 3 MONTHS OF TREATMENT WITH ONE CONVENTIONAL SYNTHETIC 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, PJIA, PSA: 1) CONTINUES TO BENEFIT FROM THE MEDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR THE SAME INDICATION.
Indications	All FDA-approved Indications.
Off Label Uses	

Formulary ID: 26376

Effective: 01/01/2026

H9306_26_DRS_037_OE_C

PA Criteria	Criteria Details
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

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 CONVENTIONAL SYNTHETIC DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG) - IF A PATIENT TRIED METHOTREXATE, THEN TRIAL AT A DOSE OF AT LEAST 20 MG PER WEEK OR MAXIMALLY TOLERATED DOSE IS REQUIRED. INITIAL/RENEWAL: ALL INDICATIONS: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR THE SAME INDICATION. RENEWAL: RA, PJIA, PSA: CONTINUES TO BENEFIT FROM THE MEDICATION.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 26376
Effective: 01/01/2026
H9306_26_DRS_037_OE_C

PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

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
Prerequisite Therapy Required	No

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
Prerequisite Therapy Required	No

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
Prerequisite Therapy Required	No

Formulary ID: 26376
Effective: 01/01/2026
H9306_26_DRS_037_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
Prerequisite Therapy Required	No

Formulary ID: 26376
Effective: 01/01/2026
H9306_26_DRS_037_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
Prerequisite Therapy Required	No

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.
Other Criteria	INITIAL: RHEUMATOID ARTHRITIS (RA): TRIAL OF OR CONTRAINDICATION TO 3 MONTHS OF TREATMENT WITH ONE

Formulary ID: 26376

Effective: 01/01/2026

H9306_26_DRS_037_OE_C

PA Criteria	Criteria Details
	CONVENTIONAL SYNTHETIC DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG) - IF PATIENT TRIED METHOTREXATE, THEN TRIAL AT A DOSE OF AT LEAST 20 MG PER WEEK OR MAXIMALLY TOLERATED DOSE IS REQUIRED. AS: TRIAL OF OR CONTRAINDICATION TO AN NSAID. PSO: 1) AT LEAST A 3 MONTH TRIAL OF ONE ORAL IMMUNOSUPPRESSANT (CYCLOSPORINE, METHOTREXATE, TACROLIMUS) OR PUVA (PHOTOTHERAPY), 2) CONTRAINDICATION OR INTOLERANCE TO BOTH IMMUNOSUPPRESSANT AND PUVA, OR 3) PATIENT IS SWITCHING FROM A DIFFERENT BIOLOGIC, PDE-4 INHIBITOR, OR JAK INHIBITOR FOR THE SAME INDICATION. UVEITIS: DOES NOT HAVE ISOLATED ANTERIOR UVEITIS. INITIAL/RENEWAL: ALL INDICATIONS: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR THE SAME INDICATION. RENEWAL: RA, POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS (PJIA), PSA, AS, PSO, HS, UVEITIS: CONTINUES TO BENEFIT FROM THE MEDICATION.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

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, PJA, 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, PJA, 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 CONVENTIONAL SYNTHETIC DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG) - IF PATIENT TRIED METHOTREXATE, THEN TRIAL AT A DOSE OF AT LEAST 20 MG PER WEEK OR MAXIMALLY TOLERATED DOSE IS REQUIRED. AS: TRIAL OF OR CONTRAINDICATION TO AN NSAID. PSO: 1) AT LEAST A 3 MONTH TRIAL OF ONE ORAL IMMUNOSUPPRESSANT (CYCLOSPORINE, METHOTREXATE, TACROLIMUS) OR PUVA (PHOTOTHERAPY), 2) CONTRAINDICATION OR INTOLERANCE TO BOTH IMMUNOSUPPRESSANT AND PUVA, OR 3) PATIENT IS SWITCHING FROM A DIFFERENT BIOLOGIC, PDE-4 INHIBITOR,

Formulary ID: 26376

Effective: 01/01/2026

H9306_26_DRS_037_OE_C

PA Criteria	Criteria Details
	OR JAK INHIBITOR FOR THE SAME INDICATION. UVEITIS: DOES NOT HAVE ISOLATED ANTERIOR UVEITIS. INITIAL/RENEWAL: ALL INDICATIONS: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR THE SAME INDICATION. RENEWAL: RA, POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS (PJIA), PSA, AS, PSO, HS, UVEITIS: CONTINUES TO BENEFIT FROM THE MEDICATION.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

ADALIMUMAB-ADBM

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 CONVENTIONAL SYNTHETIC DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG) - IF PATIENT TRIED METHOTREXATE, THEN TRIAL AT A DOSE OF AT LEAST 20 MG PER WEEK OR MAXIMALLY TOLERATED DOSE IS REQUIRED. AS: TRIAL OF OR CONTRAINDICATION TO AN NSAID. PSO: 1) AT LEAST A 3 MONTH TRIAL OF ONE ORAL IMMUNOSUPPRESSANT (CYCLOSPORINE, METHOTREXATE, TACROLIMUS) OR PUVA (PHOTOTHERAPY), 2) CONTRAINDICATION OR INTOLERANCE TO BOTH IMMUNOSUPPRESSANT AND PUVA, OR 3) PATIENT IS

Formulary ID: 26376

Effective: 01/01/2026

H9306_26_DRS_037_OE_C

PA Criteria	Criteria Details
	SWITCHING FROM A DIFFERENT BIOLOGIC, PDE-4 INHIBITOR, OR JAK INHIBITOR FOR THE SAME INDICATION. UVEITIS: DOES NOT HAVE ISOLATED ANTERIOR UVEITIS. INITIAL/RENEWAL: ALL INDICATIONS: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR THE SAME INDICATION. RENEWAL: RA, POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS (PJIA), PSA, AS, PSO, HS, UVEITIS: CONTINUES TO BENEFIT FROM THE MEDICATION.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

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
Prerequisite Therapy Required	No

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
Prerequisite Therapy Required	No

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
Prerequisite Therapy Required	No

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
Prerequisite Therapy Required	No

Formulary ID: 26376
Effective: 01/01/2026
H9306_26_DRS_037_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	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

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: ALL INDICATIONS: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR THE SAME INDICATION. RA: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA/CYLTEZO/YUFLYMA, XELJANZ, RINVOQ, ORENCIA. RENEWAL: RA: 1) CONTINUES TO BENEFIT FROM THE

Formulary ID: 26376

Effective: 01/01/2026

H9306_26_DRS_037_OE_C

PA Criteria	Criteria Details
	MEDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR THE SAME INDICATION.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

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: 26376
Effective: 01/01/2026
H9306_26_DRS_037_OE_C

PA Criteria	Criteria Details
Prerequisite Therapy Required	No

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

Formulary ID: 26376
Effective: 01/01/2026
H9306_26_DRS_037_OE_C

PA Criteria	Criteria Details
Prerequisite Therapy Required	No

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
Prerequisite Therapy Required	No

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: MILD PSO: TRIAL OF OR CONTRAINDICATION TO ONE CONVENTIONAL SYSTEMIC THERAPY (E.G., METHOTREXATE, ACITRETIN, CYCLOSPORINE) OR ONE CONVENTIONAL TOPICAL THERAPY (E.G., TOPICAL CORTICOSTEROIDS). MODERATE TO SEVERE PSO: 1) AT LEAST A 3 MONTH TRIAL OF ONE ORAL IMMUNOSUPPRESSANT (CYCLOSPORINE, METHOTREXATE, TACROLIMUS) OR PUVA (PHOTOTHERAPY), 2) CONTRAINDICATION OR INTOLERANCE TO BOTH IMMUNOSUPPRESSANT AND PUVA, OR 3) PATIENT IS SWITCHING FROM A DIFFERENT BIOLOGIC, PDE-4 INHIBITOR, OR JAK INHIBITOR FOR THE SAME INDICATION. BEHCETS DISEASE: 1) HAS ORAL ULCERS OR A HISTORY OF RECURRENT

Formulary ID: 26376

Effective: 01/01/2026

H9306_26_DRS_037_OE_C

PA Criteria	Criteria Details
	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). INITIAL/RENEWAL: ALL INDICATIONS: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR THE SAME INDICATION. RENEWAL: ALL INDICATIONS: CONTINUES TO BENEFIT FROM THE MEDICATION.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

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
Prerequisite Therapy Required	No

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
Prerequisite Therapy Required	No

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 AGE OR YOUNGER AT ONSET OF HPP, AND 2) POSITIVE FOR A

Formulary ID: 26376

Effective: 01/01/2026

H9306_26_DRS_037_OE_C

PA Criteria	Criteria Details
	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	Yes

Formulary ID: 26376
Effective: 01/01/2026
H9306_26_DRS_037_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
Prerequisite Therapy Required	No

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
Prerequisite Therapy Required	No

AVUTOMETINIB-DEFACTINIB

Products Affected

- AVMAPKI FAKZYNJA CO-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
Prerequisite Therapy Required	No

AXATILIMAB-CSFR

Products Affected

- NIKTIMVO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	CHRONIC GRAFT VS HOST DISEASE (CGVHD): 1) FAILURE OF AT LEAST TWO LINES OF SYSTEMIC THERAPY, ONE OF WHICH MUST BE A TRIAL OF OR CONTRAINDICATION TO JAKAFI, AND 2) NO CONCURRENT USE WITH JAKAFI, REZUROCK, OR IMBRUVICA.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

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
Prerequisite Therapy Required	No

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
Prerequisite Therapy Required	No

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
Prerequisite Therapy Required	No

BEDAQUILINE

Products Affected

- SIRTURO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	24 WEEKS
Other Criteria	PULMONARY TUBERCULOSIS (TB): USE IN COMBINATION WITH 3 OTHER ANTIBIOTICS
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Formulary ID: 26376
Effective: 01/01/2026
H9306_26_DRS_037_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
Prerequisite Therapy Required	No

Formulary ID: 26376
Effective: 01/01/2026
H9306_26_DRS_037_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	CHRONIC GRAFT VS HOST DISEASE (CGVHD): 1) FAILURE OF AT LEAST TWO LINES OF SYSTEMIC THERAPY, ONE OF WHICH MUST BE A TRIAL OF OR CONTRAINDICATION TO JAKAFI, AND 2) NO CONCURRENT USE WITH JAKAFI, NIKTIMVO, OR IMBRUVICA.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Formulary ID: 26376
Effective: 01/01/2026
H9306_26_DRS_037_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
Prerequisite Therapy Required	No

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
Prerequisite Therapy Required	No

BENRALIZUMAB

Products Affected

- FASENRA
- FASENRA PEN

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 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, AND 2) ONE ASTHMA EXACERBATION REQUIRING SYSTEMIC CORTICOSTEROID BURST LASTING AT LEAST 3 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. INITIAL/RENEWAL: ALL INDICATIONS: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR THE SAME INDICATION. RENEWAL: ASTHMA: 1) CONTINUED USE OF ICS AND ONE OTHER MAINTENANCE MEDICATION, AND 2) CLINICAL

Formulary ID: 26376

Effective: 01/01/2026

H9306_26_DRS_037_OE_C

PA Criteria	Criteria Details
	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. EOSINOPHILIC GRANULOMATOSIS WITH POLYANGIITIS (EGPA): REDUCTION IN EGPA SYMPTOMS COMPARED TO BASELINE OR ABILITY TO REDUCE/ELIMINATE CORTICOSTEROID USE.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	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
Prerequisite Therapy Required	No

BEVACIZUMAB-BVZR

Products Affected

- ZIRABEV

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
Prerequisite Therapy Required	No

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
Prerequisite Therapy Required	No

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
Prerequisite Therapy Required	No

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	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

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
Prerequisite Therapy Required	No

Formulary ID: 26376
Effective: 01/01/2026
H9306_26_DRS_037_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
Prerequisite Therapy Required	No

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
Prerequisite Therapy Required	No

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 TESTS: C1-INH 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
Prerequisite Therapy Required	No

Formulary ID: 26376

Effective: 01/01/2026

H9306_26_DRS_037_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
Prerequisite Therapy Required	No

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
Prerequisite Therapy Required	No

CANNABIDIOL

Products Affected

- EPIDIOLEX

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	INITIAL: 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: 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
Prerequisite Therapy Required	Yes

Formulary ID: 26376
Effective: 01/01/2026
H9306_26_DRS_037_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
Prerequisite Therapy Required	No

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
Prerequisite Therapy Required	No

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
Prerequisite Therapy Required	No

Formulary ID: 26376
Effective: 01/01/2026
H9306_26_DRS_037_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
Prerequisite Therapy Required	No

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: HUMIRA/CYLTEZO/YUFLYMA, XELJANZ, RINVOQ, ORENCIA. PSA: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: COSENTYX, HUMIRA/CYLTEZO/YUFLYMA, SELARSDI/YESINTEK, XELJANZ, RINVOQ, SKYRIZI, TREMFYA, ORENCIA, OTEZLA. AS: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: COSENTYX,

Formulary ID: 26376

Effective: 01/01/2026

H9306_26_DRS_037_OE_C

PA Criteria	Criteria Details
	HUMIRA/CYLTEZO/YUFLYMA, XELJANZ, RINVOQ. CD: TRIAL OF OR CONTRAINDICATION TO ONE OF THE FOLLOWING PREFERRED AGENTS: SELARSDI/YESINTEK, HUMIRA/CYLTEZO/YUFLYMA, RINVOQ, SKYRIZI, TREMFYA. PSO: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: COSENTYX, HUMIRA/CYLTEZO/YUFLYMA, SELARSDI/YESINTEK, SKYRIZI, TREMFYA, OTEZLA. NR-AXSPA: TRIAL OF OR CONTRAINDICATION TO AN NSAID. PJIA: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: 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: ALL INDICATIONS: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR THE SAME INDICATION. RENEWAL FOR RA, PSA, AS, PSO, NR-AXSPA, PJIA: CONTINUES TO BENEFIT FROM THE MEDICATION.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

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
Prerequisite Therapy Required	No

Formulary ID: 26376
Effective: 01/01/2026
H9306_26_DRS_037_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
Prerequisite Therapy Required	No

Formulary ID: 26376
Effective: 01/01/2026
H9306_26_DRS_037_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
Prerequisite Therapy Required	Yes

Formulary ID: 26376
Effective: 01/01/2026
H9306_26_DRS_037_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
Prerequisite Therapy Required	No

CORTICOTROPIN

Products Affected

- 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	
Part B Prerequisite	Yes

Formulary ID: 26376
Effective: 01/01/2026
H9306_26_DRS_037_OE_C

PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

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
Prerequisite Therapy Required	No

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
Prerequisite Therapy Required	No

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
Prerequisite Therapy Required	No

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
Prerequisite Therapy Required	No

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
Prerequisite Therapy Required	No

Formulary ID: 26376
Effective: 01/01/2026
H9306_26_DRS_037_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 (E.G., MILD TO MODERATE BILATERAL LOWER EXTREMITY WEAKNESS, 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
Prerequisite Therapy Required	No

Formulary ID: 26376
Effective: 01/01/2026
H9306_26_DRS_037_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: 26376
Effective: 01/01/2026
H9306_26_DRS_037_OE_C

PA Criteria	Criteria Details
Prerequisite Therapy Required	No

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
Prerequisite Therapy Required	No

Formulary ID: 26376
Effective: 01/01/2026
H9306_26_DRS_037_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
Prerequisite Therapy Required	No

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
Prerequisite Therapy Required	No

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 LIVER DRY 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 LIVER DRY WEIGHT OR GREATER.
Age Restrictions	
Prescriber Restrictions	INITIAL: CHRONIC IRON OVERLOAD DUE TO BLOOD TRANSFUSIONS OR NTDT: 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 DUE TO BLOOD TRANSFUSIONS OR NTDT: DEFERASIROX SPRINKLE PACKETS: TRIAL OF OR CONTRAINDICATION TO GENERIC DEFERASIROX ORAL TABLET OR TABLET FOR ORAL SUSPENSION.
Indications	All FDA-approved Indications.

Formulary ID: 26376
Effective: 01/01/2026
H9306_26_DRS_037_OE_C

PA Criteria	Criteria Details
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

DENOSUMAB-BMWO - OSENVELT

Products Affected

- OSENVELT

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
Prerequisite Therapy Required	No

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
Prerequisite Therapy Required	No

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
Prerequisite Therapy Required	No

Formulary ID: 26376
Effective: 01/01/2026
H9306_26_DRS_037_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
Prerequisite Therapy Required	Yes

Formulary ID: 26376
Effective: 01/01/2026
H9306_26_DRS_037_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
Prerequisite Therapy Required	No

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
Prerequisite Therapy Required	No

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
Prerequisite Therapy Required	No

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
Prerequisite Therapy Required	No

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.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Formulary ID: 26376
Effective: 01/01/2026
H9306_26_DRS_037_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
Prerequisite Therapy Required	No

Formulary ID: 26376
Effective: 01/01/2026
H9306_26_DRS_037_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	AD, PN, CSU: PRESCRIBED OR IN CONSULTATION WITH DERMATOLOGIST, ALLERGIST OR IMMUNOLOGIST. ASTHMA: PRESCRIBED OR IN CONSULTATION WITH ALLERGIST OR PULMONOLOGIST. CRSWNP: PRESCRIBED OR IN CONSULTATION WITH OTOLARYNGOLOGIST, ALLERGIST OR IMMUNOLOGIST. EOE: PRESCRIBED OR IN CONSULTATION WITH GASTROENTEROLOGIST, ALLERGIST, OR IMMUNOLOGIST. EOSINOPHILIC COPD: PRESCRIBED OR IN CONSULTATION WITH PULMONOLOGIST. RENEWAL: CSU: PRESCRIBED OR IN CONSULTATION WITH ALLERGIST, DERMATOLOGIST, OR IMMUNOLOGIST.
Coverage Duration	INITIAL: AD, CRSWNP, EOE, PN, CSU: 6 MOS, ASTHMA, COPD: 12 MOS. RENEWAL: ALL INDICATIONS: 12 MOS.
Other Criteria	INITIAL/RENEWAL: AD: NO CONCURRENT USE WITH OTHER SYSTEMIC BIOLOGICS OR JAK INHIBITORS FOR AD. ASTHMA: NO CONCURRENT USE WITH XOLAIR, TEZSPIRE, OR OTHER ANTI-IL5 BIOLOGICS WHEN USED FOR ASTHMA. CRSWNP: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4

Formulary ID: 26376

Effective: 01/01/2026

H9306_26_DRS_037_OE_C

PA Criteria	Criteria Details
	INHIBITOR) FOR AN AUTOIMMUNE INDICATION. EOSINOPHILIC COPD: NO CONCURRENT USE WITH OTHER SYSTEMIC BIOLOGICS OR JAK-I FOR SAME INDICATION. INITIAL: AD: 1) INTRACTABLE PRURITUS OR CRACKING/OOZING/BLEEDING OF AFFECTED SKIN, AND 2) TRIAL OF OR CONTRAINDICATION TO ONE TOPICAL (CORTICOSTEROID, CALCINEURIN INHIBITOR, PDE4 INHIBITOR, OR JAK INHIBITOR). ASTHMA: 1) CONCURRENT THERAPY WITH A MEDIUM, HIGH-DOSE OR MAXIMALLY-TOLERATED DOSE OF AN INHALED CORTICOSTEROID (ICS) AND ONE OTHER MAINTENANCE MEDICATION, AND 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. CHRONIC RHINOSINUSITIS WITH NASAL POLYPS (CRSWNP): A 56 DAY TRIAL OF ONE TOPICAL NASAL CORTICOSTEROID. PRURIGO NODULARIS (PN): 1) CHRONIC PRURITUS (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: USED IN COMBINATION WITH A LAMA/LABA/ICS. CHRONIC SPONTANEOUS URTICARIA (CSU): 1) TRIAL OF AND MAINTAINED ON, OR CONTRAINDICATION TO A SECOND GENERATION H1 ANTI-HISTAMINE AND 2) STILL EXPERIENCES HIVES OR ANGIOEDEMA MOST DAYS OF THE WEEK FOR AT LEAST 6 WEEKS. RENEWAL: AD, CRSWNP, EOE: IMPROVEMENT WHILE ON THERAPY. ASTHMA: 1) CONTINUED USE OF ICS AND ONE OTHER MAINTENANCE MEDICATION, AND 2) 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-

Formulary ID: 26376

Effective: 01/01/2026

H9306_26_DRS_037_OE_C

PA Criteria	Criteria Details
	RELATED SYMPTOMS. PN: IMPROVEMENT OR REDUCTION OF PRURITUS OR PRURIGINOUS LESIONS. EOSINOPHILIC COPD: 1) USED IN COMBINATION WITH A LAMA/LABA/ICS, AND 2) 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. CSU: MAINTAINED ON OR CONTRAINDICATION TO A SECOND GENERATION H1 ANTI-HISTAMINE.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

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
Prerequisite Therapy Required	No

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
Prerequisite Therapy Required	No

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
Prerequisite Therapy Required	No

Formulary ID: 26376
Effective: 01/01/2026
H9306_26_DRS_037_OE_C

ELAGOLIX

Products Affected

- ORILISSA 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: 26376
Effective: 01/01/2026
H9306_26_DRS_037_OE_C

PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

ELAPEGADEMASE-LVLR

Products Affected

- REVCOVI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	ADENOSINE DEAMINASE SEVERE COMBINED IMMUNE DEFICIENCY (ADA-SCID): INITIAL: ADA-SCID AS MANIFESTED BY: 1) CONFIRMATORY GENETIC TEST, OR 2) SUGGESTIVE LABORATORY FINDINGS (E.G., ELEVATED DEOXYADENOSINE NUCLEOTIDE [DAXP] LEVELS, LYMPHOPENIA) AND HALLMARK SIGNS/SYMPTOMS (E.G., RECURRENT INFECTIONS, FAILURE TO THRIVE, PERSISTENT DIARRHEA).
Age Restrictions	
Prescriber Restrictions	ADA-SCID: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH IMMUNOLOGIST, HEMATOLOGIST/ONCOLOGIST, OR PHYSICIAN SPECIALIZING IN INHERITED METABOLIC DISORDERS.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	ADA-SCID: RENEWAL: 1) IMPROVEMENT OR MAINTENANCE OF IMMUNE FUNCTION FROM BASELINE, AND 2) HAS NOT RECEIVED SUCCESSFUL HCT OR GENE THERAPY.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Formulary ID: 26376
Effective: 01/01/2026
H9306_26_DRS_037_OE_C

ELEXACFTOR-TEZACFTOR-IVACFTOR

Products Affected

- TRIKAFTA ORAL TABLET THERAPY • TRIKAFTA ORAL THERAPY PACK PACK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	CYSTIC FIBROSIS (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 CYSTIC FIBROSIS TRANSMEMBRANE CONDUCTANCE REGULATOR (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
Prerequisite Therapy Required	No

Formulary ID: 26376
Effective: 01/01/2026
H9306_26_DRS_037_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
Prerequisite Therapy Required	No

Formulary ID: 26376
Effective: 01/01/2026
H9306_26_DRS_037_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: 26376
Effective: 01/01/2026
H9306_26_DRS_037_OE_C

PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

ELTROMBOPAG - PROMACTA

Products Affected

- *eltrombopag olamine oral packet 12.5 mg, 25 mg*
- *eltrombopag olamine 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: PROMACTA ORAL SUSPENSION PACKETS: TRIAL OF PROMACTA TABLET OR PATIENT IS UNABLE TO 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	
Part B Prerequisite	No

Formulary ID: 26376

Effective: 01/01/2026

H9306_26_DRS_037_OE_C

PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

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
Prerequisite Therapy Required	No

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
Prerequisite Therapy Required	No

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
Prerequisite Therapy Required	No

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
Prerequisite Therapy Required	Yes

Formulary ID: 26376
Effective: 01/01/2026
H9306_26_DRS_037_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	

Formulary ID: 26376
Effective: 01/01/2026
H9306_26_DRS_037_OE_C

PA Criteria	Criteria Details
Part B Prerequisite	No
Prerequisite Therapy Required	No

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
Prerequisite Therapy Required	No

Formulary ID: 26376
Effective: 01/01/2026
H9306_26_DRS_037_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 COVERED UNDER MEDICARE D DEPENDING UPON THE CIRCUMSTANCES.

Formulary ID: 26376

Effective: 01/01/2026

H9306_26_DRS_037_OE_C

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

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
Prerequisite Therapy Required	No

ERENUMAB-AOOE

Products Affected

- AIMOVIG

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
Prerequisite Therapy Required	Yes

Formulary ID: 26376
Effective: 01/01/2026
H9306_26_DRS_037_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
Prerequisite Therapy Required	No

Formulary ID: 26376
Effective: 01/01/2026
H9306_26_DRS_037_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
Prerequisite Therapy Required	No

ETANERCEPT

Products Affected

- ENBREL MINI
- ENBREL SUBCUTANEOUS SOLUTION 25 MG/0.5ML
- ENBREL SUBCUTANEOUS SOLUTION PREFILLED SYRINGE
- 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 CONVENTIONAL SYNTHETIC DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG) - IF PATIENT TRIED METHOTREXATE, THEN TRIAL AT A DOSE OF AT LEAST 20 MG PER WEEK OR MAXIMALLY TOLERATED DOSE IS REQUIRED. AS: TRIAL OF OR CONTRAINDICATION TO AN NSAID. PSO: 1) AT LEAST A 3 MONTH TRIAL OF ONE ORAL IMMUNOSUPPRESSANT (CYCLOSPORINE, METHOTREXATE, TACROLIMUS) OR PUVA (PHOTOTHERAPY), 2) CONTRAINDICATION OR INTOLERANCE TO BOTH IMMUNOSUPPRESSANT AND PUVA, OR 3) PATIENT IS SWITCHING FROM A DIFFERENT BIOLOGIC, PDE-4 INHIBITOR,

Formulary ID: 26376

Effective: 01/01/2026

H9306_26_DRS_037_OE_C

PA Criteria	Criteria Details
	OR JAK INHIBITOR FOR THE SAME INDICATION. INITIAL/RENEWAL: ALL INDICATIONS: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR THE SAME INDICATION. RENEWAL: ALL INDICATIONS: CONTINUES TO BENEFIT FROM THE MEDICATION.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

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
Prerequisite Therapy Required	No

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
Prerequisite Therapy Required	No

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	CLOSTRIDIODES 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
Prerequisite Therapy Required	No

Formulary ID: 26376
Effective: 01/01/2026
H9306_26_DRS_037_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
Prerequisite Therapy Required	Yes

Formulary ID: 26376
Effective: 01/01/2026
H9306_26_DRS_037_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
Prerequisite Therapy Required	Yes

Formulary ID: 26376
Effective: 01/01/2026
H9306_26_DRS_037_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
Prerequisite Therapy Required	Yes

Formulary ID: 26376
Effective: 01/01/2026
H9306_26_DRS_037_OE_C

FEZOLINETANT

Products Affected

- VEOZAH

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL/RENEWAL: 12 MONTHS
Other Criteria	MENOPAUSAL VASOMOTOR SYMPTOMS (VMS): INITIAL: 1) EXPERIENCES 7 OR MORE HOT FLASHES PER DAY, 2) TRIAL OF OR CONTRAINDICATION TO HORMONAL THERAPY (E.G., ESTRADIOL TRANSDERMAL PATCH, ORAL CONJUGATED ESTROGENS), 3) LABORATORY TESTING TO ESTABLISH BASELINE HEPATIC FUNCTION AND CONTINUED MONITORING OF THESE VALUES IN ACCORDANCE WITH THE FDA CURRENT LABEL RECOMMENDATION, AND 4) NO CONCURRENT USE WITH ANOTHER HORMONAL (E.G., PREMPRO) OR NON-HORMONAL (E.G., BRISDELLE) AGENT FOR VMS. RENEWAL: 1) CONTINUED NEED FOR VMS TREATMENT (PERSISTENT HOT FLASHES), 2) REDUCTION IN VMS FREQUENCY OR SEVERITY DUE TO VEOZAH TREATMENT, AND 3) NO NEW SYMPTOMS OF LIVER INJURY AND/OR WORSENING LAB VALUES.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 26376
Effective: 01/01/2026
H9306_26_DRS_037_OE_C

PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

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
Prerequisite Therapy Required	No

FINERENONE

Products Affected

- KERENDIA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL/RENEWAL:12 MONTHS
Other Criteria	CHRONIC KIDNEY DISEASE (CKD) ASSOCIATED WITH TYPE 2 DIABETES (T2D): INITIAL: HISTORY OF AND WILL CONTINUE ON, OR HAS A CONTRAINDICATION TO, AN ANGIOTENSIN CONVERTING ENZYME INHIBITOR (ACE-I) OR AN ANGIOTENSIN RECEPTOR BLOCKER (ARB).
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Formulary ID: 26376
Effective: 01/01/2026
H9306_26_DRS_037_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
Prerequisite Therapy Required	No

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, 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), AND 4) ONE OF THE FOLLOWING: (A) UNABLE TO SWALLOW EXTENDED-RELEASE (ER) TABLETS OR ADMINISTER ER CAPSULES VIA A FEEDING TUBE, OR (B) FAILURE TO ADHERE OR TOLERATE VIA A FEEDING TUBE AN ORAL CARBIDOPA/LEVODOPA REGIMEN. RENEWAL: IMPROVEMENT IN MOTOR SYMPTOMS WHILE ON THERAPY.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 26376
Effective: 01/01/2026
H9306_26_DRS_037_OE_C

PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

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
Prerequisite Therapy Required	No

Formulary ID: 26376
Effective: 01/01/2026
H9306_26_DRS_037_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
Prerequisite Therapy Required	No

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: 26376
Effective: 01/01/2026
H9306_26_DRS_037_OE_C

PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

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
Prerequisite Therapy Required	No

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
Prerequisite Therapy Required	No

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
Prerequisite Therapy Required	No

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
Prerequisite Therapy Required	No

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
Prerequisite Therapy Required	No

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
Prerequisite Therapy Required	No

Formulary ID: 26376
Effective: 01/01/2026
H9306_26_DRS_037_OE_C

GLP1-SEMAGLUTIDE

Products Affected

- OZEMPIC (0.25 OR 0.5 MG/DOSE)
- OZEMPIC (1 MG/DOSE)
- SUBCUTANEOUS SOLUTION PEN-INJECTOR 4 MG/3ML
- 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
Prerequisite Therapy Required	No

Formulary ID: 26376
Effective: 01/01/2026
H9306_26_DRS_037_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
Prerequisite Therapy Required	No

Formulary ID: 26376
Effective: 01/01/2026
H9306_26_DRS_037_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
Prerequisite Therapy Required	Yes

Formulary ID: 26376
Effective: 01/01/2026
H9306_26_DRS_037_OE_C

GUSELKUMAB

Products Affected

- TREMFYA CROHNS INDUCTION
- 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: PSO: 1) AT LEAST A 3 MONTH TRIAL OF ONE ORAL IMMUNOSUPPRESSANT (CYCLOSPORINE, METHOTREXATE, TACROLIMUS) OR PUVA (PHOTOTHERAPY), 2) CONTRAINDICATION OR INTOLERANCE TO BOTH IMMUNOSUPPRESSANT AND PUVA, OR 3) PATIENT IS SWITCHING FROM A DIFFERENT BIOLOGIC, PDE-4 INHIBITOR, OR JAK INHIBITOR FOR THE SAME INDICATION. INITIAL/RENEWAL: ALL INDICATIONS: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR THE SAME INDICATION. RENEWAL: PSO, PSA: CONTINUES TO BENEFIT FROM THE MEDICATION.

Formulary ID: 26376
Effective: 01/01/2026
H9306_26_DRS_037_OE_C

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

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
Prerequisite Therapy Required	No

Formulary ID: 26376

Effective: 01/01/2026

H9306_26_DRS_037_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	CHRONIC GRAFT VS HOST DISEASE (CGVHD): NO CONCURRENT USE WITH JAKAFI, NIKTIMVO, OR REZUROCK.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Formulary ID: 26376
Effective: 01/01/2026
H9306_26_DRS_037_OE_C

ICATIBANT

Products Affected

- *icatibant acetate*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	HEREDITARY ANGIOEDEMA (HAE): INITIAL: DIAGNOSIS CONFIRMED BY ONE OF THE FOLLOWING COMPLEMENT TESTS: C1-INH PROTEIN LEVELS, C4 PROTEIN LEVELS, C1-INH FUNCTIONAL LEVELS, C1Q.
Age Restrictions	
Prescriber Restrictions	HAE: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH AN ALLERGIST, IMMUNOLOGIST, HEMATOLOGIST OR PULMONOLOGIST.
Coverage Duration	INITIAL/RENEWAL: 12 MONTHS
Other Criteria	HAE: INITIAL/RENEWAL: NO CONCURRENT USE WITH OTHER MEDICATIONS FOR THE TREATMENT OF ACUTE HAE ATTACKS. RENEWAL: REDUCTION IN SEVERITY OR DURATION OF ATTACKS.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Formulary ID: 26376
Effective: 01/01/2026
H9306_26_DRS_037_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
Prerequisite Therapy Required	No

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
Prerequisite Therapy Required	No

Formulary ID: 26376
Effective: 01/01/2026
H9306_26_DRS_037_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
Prerequisite Therapy Required	No

Formulary ID: 26376
Effective: 01/01/2026
H9306_26_DRS_037_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
Prerequisite Therapy Required	No

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
Prerequisite Therapy Required	No

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: HUMIRA/CYLTEZO/YUFLYMA, XELJANZ, RINVOQ, ORENCIA. PSA: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: COSENTYX, HUMIRA/CYLTEZO/YUFLYMA, SELARSDI/YESINTEK, XELJANZ, RINVOQ, SKYRIZI, TREMFYA, ORENCIA, OTEZLA. PSO: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: COSENTYX, HUMIRA/CYLTEZO/YUFLYMA, SELARSDI/YESINTEK, SKYRIZI, TREMFYA, OTEZLA. AS: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: COSENTYX, HUMIRA/CYLTEZO/YUFLYMA, XELJANZ, RINVOQ. MODERATE TO SEVERE CD: TRIAL OF OR CONTRAINDICATION TO TWO OF

Formulary ID: 26376

Effective: 01/01/2026

H9306_26_DRS_037_OE_C

PA Criteria	Criteria Details
	THE FOLLOWING PREFERRED AGENTS, WHERE AGES ALIGN: SELARSDI/YESINTEK, HUMIRA/CYLTEZO/YUFLYMA, RINVOQ, SKYRIZI, TREMFYA. UC: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS, WHERE AGES ALIGN: SELARSDI/YESINTEK, XELJANZ, HUMIRA/CYLTEZO/YUFLYMA, RINVOQ, SKYRIZI, TREMFYA. INITIAL/RENEWAL: RA, PSA, AS, PSO, MODERATE TO SEVERE CD, UC: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR THE SAME INDICATION. RENEWAL: RA, PSA, AS, PSO: CONTINUES TO BENEFIT FROM THE MEDICATION.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

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 PADS
- 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 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
- AUM MINI INSULIN PEN NEEDLE 33G X 5 MM
- AUM MINI INSULIN PEN NEEDLE 33G X 6 MM

Formulary ID: 26376

Effective: 01/01/2026

H9306_26_DRS_037_OE_C

- 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 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" 1 ML (OTC)
- BD INSULIN SYRINGE MICROFINE 28G X 1/2" 1 ML (RX)
- BD INSULIN SYRINGE U-100 1 ML
- 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 30G X 1/2" 0.3 ML
- BD INSULIN SYRINGE ULTRAFINE 30G X 1/2" 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 ULTRAFINE 32G X 4 MM
- BD PEN NEEDLE ORIG ULTRAFINE 29G X 12.7MM
- BD PEN NEEDLE SHORT ULTRAFINE 31G X 8 MM
- 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 SWABS SINGLE USE BUTTERFLY PAD
- BD VEO INSULIN SYR U/F 1/2UNIT 31G X 15/64" 0.3 ML

Formulary ID: 26376

Effective: 01/01/2026

H9306_26_DRS_037_OE_C

- 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
- 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 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

Formulary ID: 26376

Effective: 01/01/2026

H9306_26_DRS_037_OE_C

- 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
- 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 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

Formulary ID: 26376

Effective: 01/01/2026

H9306_26_DRS_037_OE_C

- | | |
|---|---|
| <ul style="list-style-type: none">• 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 | <ul style="list-style-type: none">• 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• 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 |
|---|---|

Formulary ID: 26376

Effective: 01/01/2026

H9306 26 DRS 037 OE C

- 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
- DRUG MART UNIFINE PENTIPS 31G X 5 MM
- 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
- 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 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

Formulary ID: 26376

Effective: 01/01/2026

H9306_26_DRS_037_OE_C

- 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 1/2" 1 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
- 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 INSULIN SYRINGE U-500
- 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

Formulary ID: 26376

Effective: 01/01/2026

H9306_26_DRS_037_OE_C

- 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 29G X 1/2" 0.5 ML
- EQL INSULIN SYRINGE 30G X 5/16" 0.5 ML
- EXEL COMFORT POINT PEN NEEDLE 29G X 12MM
- 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
- 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 30G X 1/2" 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 CLICKFINE PEN NEEDLES 31G X 6 MM
- GNP CLICKFINE PEN NEEDLES 31G X 8 MM
- GNP INSULIN SYRINGE 28G X 1/2" 1 ML
- GNP INSULIN SYRINGE 29G X 1/2" 1 ML
- GNP INSULIN SYRINGE 30G X 5/16" 0.3 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" 0.5 ML
- GNP ULTRA COM INSULIN SYRINGE 30G X 5/16" 1 ML
- GOODSENSE ALCOHOL SWABS PAD 70 %
- GOODSENSE CLICKFINE PEN NEEDLE 31G X 5 MM
- GOODSENSE PEN NEEDLE PENFINE 31G X 5 MM

Formulary ID: 26376

Effective: 01/01/2026

H9306_26_DRS_037_OE_C

- GOODSENSE PEN NEEDLE PENFINE 31G X 8 MM
- GOODSENSE PEN NEEDLE PENFINE 32G X 4 MM
- GOODSENSE PEN NEEDLE PENFINE 32G X 6 MM
- 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
- 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 ALCOHOL PREP PAD
- 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" 0.3 ML
- 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 (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

Formulary ID: 26376

Effective: 01/01/2026

H9306_26_DRS_037_OE_C

- 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 31G X 8 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
- INSUPEN32G EXTR3ME 32G X 6 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 INSULIN SYRINGE 30G X 5/16" 0.5 ML
- KROGER PEN NEEDLES 29G X 12MM
- KROGER PEN NEEDLES 31G X 6 MM
- LEADER INSULIN SYRINGE 28G X 1/2" 0.5 ML
- LEADER INSULIN SYRINGE 28G X 1/2" 1 ML
- 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

Formulary ID: 26376

Effective: 01/01/2026

H9306_26_DRS_037_OE_C

- 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
- MICRODOT PEN NEEDLE 33G X 4 MM
- MIRASORB SPONGES 2"X2"
- MM PEN NEEDLES 31G X 6 MM
- 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)
- MS INSULIN SYRINGE 30G X 5/16" 0.3 ML
- MS INSULIN SYRINGE 31G X 5/16" 0.3 ML
- MS INSULIN SYRINGE 31G X 5/16" 0.5 ML
- MS INSULIN SYRINGE 31G X 5/16" 1 ML

Formulary ID: 26376

Effective: 01/01/2026

H9306_26_DRS_037_OE_C

- 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 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 30G X 5/16" 0.3 ML
- PREFERRED PLUS INSULIN SYRINGE 28G X 1/2" 0.5 ML
- PREFERRED PLUS INSULIN SYRINGE 29G X 1/2" 0.5 ML
- PREFERRED PLUS INSULIN SYRINGE 29G X 1/2" 1 ML
- PREFERRED PLUS INSULIN SYRINGE 30G X 5/16" 1 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

Formulary ID: 26376
Effective: 01/01/2026
H9306_26_DRS_037_OE_C

- 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 29G X 12.7MM
- QUICK TOUCH INSULIN PEN NEEDLE 31G X 4 MM
- QUICK TOUCH INSULIN PEN NEEDLE 31G X 5 MM
- QUICK TOUCH INSULIN PEN NEEDLE 31G X 6 MM
- QUICK TOUCH INSULIN PEN NEEDLE 31G X 8 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
- 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 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 29G X 12MM
- 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

Formulary ID: 26376

Effective: 01/01/2026

H9306_26_DRS_037_OE_C

- 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 %
- 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

Formulary ID: 26376

Effective: 01/01/2026

H9306_26_DRS_037_OE_C

- 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 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
- 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
- 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

Formulary ID: 26376
Effective: 01/01/2026
H9306_26_DRS_037_OE_C

- 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
- 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)

Formulary ID: 26376

Effective: 01/01/2026

H9306_26_DRS_037_OE_C

- 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
- ULTICARE SHORT PEN NEEDLES 31G X 8 MM (OTC)
- ULTICARE SHORT PEN NEEDLES 31G X 8 MM (RX)
- ULTIGUARD SAFEPACK PEN NEEDLE 29G X 12.7MM
- ULTIGUARD SAFEPACK PEN NEEDLE 31G X 5 MM
- ULTIGUARD SAFEPACK PEN NEEDLE 31G X 6 MM
- ULTIGUARD SAFEPACK PEN NEEDLE 31G X 8 MM
- ULTIGUARD SAFEPACK PEN NEEDLE 32G X 4 MM
- ULTIGUARD SAFEPACK PEN NEEDLE 32G X 6 MM
- ULTIGUARD SAFEPACK SYR/NEEDLE 30G X 1/2" 0.3 ML
- ULTIGUARD SAFEPACK SYR/NEEDLE 30G X 1/2" 0.5 ML
- ULTIGUARD SAFEPACK SYR/NEEDLE 30G X 1/2" 1 ML
- ULTIGUARD SAFEPACK SYR/NEEDLE 31G X 5/16" 0.3 ML
- ULTIGUARD SAFEPACK SYR/NEEDLE 31G X 5/16" 0.5 ML
- ULTIGUARD SAFEPACK SYR/NEEDLE 31G X 5/16" 1 ML
- ULTILET ALCOHOL SWABS PAD
- 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
- 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

Formulary ID: 26376

Effective: 01/01/2026

H9306_26_DRS_037_OE_C

- 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
- 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 32G X 4 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

Formulary ID: 26376

Effective: 01/01/2026

H9306_26_DRS_037_OE_C

- 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 %

PA Criteria	Criteria Details
Exclusion Criteria	ONLY COVERED UNDER PART D WHEN USED CONCURRENTLY WITH INSULIN.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	

Formulary ID: 26376
Effective: 01/01/2026
H9306_26_DRS_037_OE_C

PA Criteria	Criteria Details
Coverage Duration	LIFETIME
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

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
Prerequisite Therapy Required	No

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
Prerequisite Therapy Required	No

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
Prerequisite Therapy Required	No

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
Prerequisite Therapy Required	No

Formulary ID: 26376
Effective: 01/01/2026
H9306_26_DRS_037_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
Prerequisite Therapy Required	No

Formulary ID: 26376
Effective: 01/01/2026
H9306_26_DRS_037_OE_C

ISAVUCONAZONIUM

Products Affected

- CRESEMBA ORAL

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	INVASIVE ASPERGILLOSIS, INVASIVE MUCORMYCOSIS: PRESCRIBED BY OR IN CONSULTATION WITH AN INFECTIOUS DISEASE SPECIALIST.
Coverage Duration	6 MONTHS
Other Criteria	INVASIVE ASPERGILLOSIS: TRIAL OF OR CONTRAINDICATION TO VORICONAZOLE. CONTINUATION OF THERAPY AFTER HOSPITAL DISCHARGE REQUIRES NO EXTRA CRITERIA.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Formulary ID: 26376
Effective: 01/01/2026
H9306_26_DRS_037_OE_C

IVACAFTOR

Products Affected

- KALYDECO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	CYSTIC FIBROSIS (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: 1) NOT HOMOZYGOUS FOR F508DEL MUTATION IN THE CYSTIC FIBROSIS TRANSMEMBRANE CONDUCTANCE REGULATOR (CFTR) GENE, AND 2) 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
Prerequisite Therapy Required	No

Formulary ID: 26376
Effective: 01/01/2026
H9306_26_DRS_037_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
Prerequisite Therapy Required	No

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
Prerequisite Therapy Required	No

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
Prerequisite Therapy Required	Yes

Formulary ID: 26376
Effective: 01/01/2026
H9306_26_DRS_037_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
Prerequisite Therapy Required	No

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
Prerequisite Therapy Required	Yes

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
Prerequisite Therapy Required	No

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
Prerequisite Therapy Required	No

Formulary ID: 26376
Effective: 01/01/2026
H9306_26_DRS_037_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
Prerequisite Therapy Required	No

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
Prerequisite Therapy Required	No

Formulary ID: 26376
Effective: 01/01/2026
H9306_26_DRS_037_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
Prerequisite Therapy Required	No

Formulary ID: 26376
Effective: 01/01/2026
H9306_26_DRS_037_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
Prerequisite Therapy Required	No

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
Prerequisite Therapy Required	No

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
Prerequisite Therapy Required	No

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.
Off Label Uses	

Formulary ID: 26376

Effective: 01/01/2026

H9306_26_DRS_037_OE_C

PA Criteria	Criteria Details
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

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: 26376
Effective: 01/01/2026
H9306_26_DRS_037_OE_C

PA Criteria	Criteria Details
Part B Prerequisite	No
Prerequisite Therapy Required	No

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
Prerequisite Therapy Required	No

Formulary ID: 26376
Effective: 01/01/2026
H9306_26_DRS_037_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	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

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
Prerequisite Therapy Required	No

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	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

LINVOSELTAMAB-GCPT

Products Affected

- LYNOZYFIC INTRAVENOUS
SOLUTION 200 MG/10ML, 5 MG/2.5ML

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
Prerequisite Therapy Required	No

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
Prerequisite Therapy Required	No

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
Prerequisite Therapy Required	No

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
Prerequisite Therapy Required	No

LUMACFTOR-IVACFTOR

Products Affected

- ORKAMBI ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	CYSTIC FIBROSIS (CF): INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A PULMONOLOGIST OR CF EXPERT.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: LIFETIME.
Other Criteria	CF: INITIAL: NO CONCURRENT USE WITH ANOTHER CYSTIC FIBROSIS TRANSMEMBRANE CONDUCTANCE REGULATOR (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
Prerequisite Therapy Required	No

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
Prerequisite Therapy Required	Yes

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
Prerequisite Therapy Required	No

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
Prerequisite Therapy Required	No

MAVACAMTEN

Products Affected

- CAMZYOS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	OBSTRUCTIVE HYPERTROPHIC CARDIOMYOPATHY(HCM): INITIAL: LEFT VENTRICULAR OUTFLOW TRACK (LVOT) GRADIENT OF 50 MMHG OR HIGHER
Age Restrictions	
Prescriber Restrictions	OBSTRUCTIVE HCM: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A CARDIOLOGIST
Coverage Duration	INITIAL: 4 MONTHS, RENEWAL: 12 MONTHS.
Other Criteria	OBSTRUCTIVE HCM: INITIAL: TRIAL OF OR CONTRAINDICATION TO A BETA-BLOCKER OR A NON-DIHYDROPYRIDINE CALCIUM CHANNEL BLOCKER. RENEWAL: CONTINUED CLINICAL BENEFIT (E.G., REDUCTION OF SYMPTOMS, NYHA CLASSIFICATION IMPROVEMENT)
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Formulary ID: 26376
Effective: 01/01/2026
H9306_26_DRS_037_OE_C

MECASERMIN

Products Affected

- INCRELEX

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

Formulary ID: 26376
Effective: 01/01/2026
H9306_26_DRS_037_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
Prerequisite Therapy Required	No

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: CRSWNP: 6 MO. OTHERS: 12 MO. RENEWAL: CRSWNP, ASTHMA, EGPA: 12 MO.
Other Criteria	INITIAL: ALL INDICATIONS: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR SAME 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, AND 2) ONE OF THE FOLLOWING: (A) AT LEAST ONE ASTHMA EXACERBATION REQUIRING SYSTEMIC CORTICOSTEROID BURST LASTING AT LEAST 3 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

Formulary ID: 26376

Effective: 01/01/2026

H9306_26_DRS_037_OE_C

PA Criteria	Criteria Details
	THAN TWICE/WEEK, ANY NIGHT WAKING DUE TO ASTHMA, SABA RELIEVER FOR SYMPTOMS MORE THAN TWICE/WEEK, ANY ACTIVITY LIMITATION DUE TO ASTHMA. CHRONIC RHINOSINUSITIS WITH NASAL POLYPS (CRSWNP): 1) A 56 DAY TRIAL OF ONE TOPICAL NASAL CORTICOSTEROID, 2) EVIDENCE OF NASAL POLYPS BY DIRECT EXAMINATION, ENDOSCOPY, OR SINUS CT SCAN, AND 3) INADEQUATELY CONTROLLED DISEASE. RENEWAL: ASTHMA: 1) CONTINUED USE OF ICS AND AT LEAST ONE OTHER MAINTENANCE MEDICATION, 2) 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, AND 3) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR SAME INDICATION. CRSWNP: 1) CLINICAL BENEFIT COMPARED TO BASELINE, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR SAME INDICATION. EOSINOPHILIC GRANULOMATOSIS WITH POLYANGIITIS (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 SAME INDICATION.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

METYROSION

Products Affected

- *metirosine*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	PHEOCHROMOCYTOMA: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH AN ENDOCRINOLOGIST, ENDOCRINE SURGEON, OR HEMATOLOGIST-ONCOLOGIST.
Coverage Duration	PREOPERATIVE PREPARATION FOR SURGERY: 30 DAYS. MALIGNANT PHEOCHROMOCYTOMA: INITIAL/RENEWAL:12 MOS.
Other Criteria	PHEOCHROMOCYTOMA: INITIAL: HAS NON-METASTATIC PHEOCHROMOCYTOMA. PREOPERATIVE PREPARATION FOR SURGERY: USE IN COMBINATION WITH AN ALPHA-ADRENERGIC RECEPTOR BLOCKER. RENEWAL: MALIGNANT PHEOCHROMOCYTOMA: STABLE OR CLINICAL IMPROVEMENT WHILE ON THERAPY.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Formulary ID: 26376
Effective: 01/01/2026
H9306_26_DRS_037_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
Prerequisite Therapy Required	No

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 (AT LEAST 2 TESTS TO CONFIRM), 2) OVERNIGHT 1MG DEXAMETHASONE TEST, OR 3) LATE NIGHT SALIVARY CORTISOL (AT LEAST 2 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), 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
Prerequisite Therapy Required	No

Formulary ID: 26376
Effective: 01/01/2026
H9306_26_DRS_037_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
Prerequisite Therapy Required	No

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
Prerequisite Therapy Required	No

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	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

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
Prerequisite Therapy Required	No

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
Prerequisite Therapy Required	No

Formulary ID: 26376
Effective: 01/01/2026
H9306_26_DRS_037_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
Prerequisite Therapy Required	No

NAXITAMAB-GQ GK

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
Prerequisite Therapy Required	No

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
Prerequisite Therapy Required	No

Formulary ID: 26376
Effective: 01/01/2026
H9306_26_DRS_037_OE_C

NILOTINIB - TASIGNA

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 MEDICATION 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
Prerequisite Therapy Required	No

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
Prerequisite Therapy Required	No

Formulary ID: 26376
Effective: 01/01/2026
H9306_26_DRS_037_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: DOES NOT HAVE OTHER KNOWN CAUSES OF INTERSTITIAL LUNG DISEASE (E.G., HEART FAILURE/FLUID OVERLOAD, DRUG-INDUCED LUNG TOXICITY, RECURRENT ASPIRATION). PF-ILD: LUNG FUNCTION

Formulary ID: 26376

Effective: 01/01/2026

H9306_26_DRS_037_OE_C

PA Criteria	Criteria Details
	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
Prerequisite Therapy Required	Yes

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
Prerequisite Therapy Required	No

Formulary ID: 26376
Effective: 01/01/2026
H9306_26_DRS_037_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
Prerequisite Therapy Required	No

Formulary ID: 26376
Effective: 01/01/2026
H9306_26_DRS_037_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
Prerequisite Therapy Required	No

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
Prerequisite Therapy Required	Yes

Formulary ID: 26376
Effective: 01/01/2026
H9306_26_DRS_037_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
Prerequisite Therapy Required	No

Formulary ID: 26376
Effective: 01/01/2026
H9306_26_DRS_037_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	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

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
Prerequisite Therapy Required	No

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
Prerequisite Therapy Required	No

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
Prerequisite Therapy Required	No

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
Prerequisite Therapy Required	No

Formulary ID: 26376
Effective: 01/01/2026
H9306_26_DRS_037_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
Prerequisite Therapy Required	No

OMACETAXINE

Products Affected

- SYNRIBO

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
Prerequisite Therapy Required	No

Formulary ID: 26376
Effective: 01/01/2026
H9306_26_DRS_037_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, 2) STILL EXPERIENCES HIVES OR ANGIOEDEMA ON MOST DAYS OF THE WEEK FOR AT LEAST 6 WEEKS, AND 3) TRIAL OF OR CONTRAINDICATION TO THE PREFERRED AGENT: DUPIXENT. CRSWNP: 1) A 56 DAY TRIAL OF ONE TOPICAL NASAL CORTICOSTEROID, 2) TRIAL OF OR CONTRAINDICATION TO ONE OF THE FOLLOWING PREFERRED

Formulary ID: 26376

Effective: 01/01/2026

H9306_26_DRS_037_OE_C

PA Criteria	Criteria Details
	AGENTS: NUCALA, DUPIXENT, 3) EVIDENCE OF NASAL POLYPS BY DIRECT EXAMINATION, ENDOSCOPY, OR SINUS CT SCAN, AND 4) INADEQUATELY CONTROLLED DISEASE. 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, AND 2) ONE OF THE FOLLOWING: (A) AT LEAST ONE ASTHMA EXACERBATION REQUIRING SYSTEMIC CORTICOSTEROID BURST LASTING AT LEAST 3 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. FOOD ALLERGY: CONCURRENT USE WITH AN ACTIVE PRESCRIPTION FOR EPINEPHRINE AUTO-INJECTOR/INJECTION . INITIAL/RENEWAL: ALL INDICATIONS: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR THE SAME INDICATION. RENEWAL: CSU: MAINTAINED ON OR CONTRAINDICATION TO A SECOND GENERATION H1 ANTI-HISTAMINE. CRSWNP: CLINICAL BENEFIT COMPARED TO BASELINE. ASTHMA: 1) CONTINUED USE OF ICS AND AT LEAST ONE OTHER MAINTENANCE MEDICATION, AND 2) 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, AND 2) CONCURRENT USE WITH AN ACTIVE PRESCRIPTION FOR EPINEPHRINE AUTO-INJECTOR/INJECTION.
Indications	All FDA-approved Indications.
Off Label Uses	

Formulary ID: 26376
Effective: 01/01/2026
H9306_26_DRS_037_OE_C

PA Criteria	Criteria Details
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

OSIMERTINIB

Products Affected

- TAGRISSO

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
Prerequisite Therapy Required	No

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
Prerequisite Therapy Required	No

Formulary ID: 26376
Effective: 01/01/2026
H9306_26_DRS_037_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
Prerequisite Therapy Required	No

Formulary ID: 26376
Effective: 01/01/2026
H9306_26_DRS_037_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
Prerequisite Therapy Required	Yes

Formulary ID: 26376
Effective: 01/01/2026
H9306_26_DRS_037_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
Prerequisite Therapy Required	No

Formulary ID: 26376
Effective: 01/01/2026
H9306_26_DRS_037_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
Prerequisite Therapy Required	No

Formulary ID: 26376
Effective: 01/01/2026
H9306_26_DRS_037_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
Prerequisite Therapy Required	No

PEGFILGRASTIM - CBQV

Products Affected

- UDENYCA ONBODY

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	NON MYELOID MALIGNANCY: UDENYCA: TRIAL OF OR CONTRAINDICATION TO THE PREFERRED AGENT NYVEPRIA. UDENYCA ONBODY: 1) TRIAL OF OR CONTRAINDICATION TO THE PREFERRED AGENT NYVEPRIA, OR 2) BARRIER TO ACCESS (E.G., TRAVEL BARRIERS, UNABLE TO RETURN TO CLINIC FOR INJECTIONS).
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Formulary ID: 26376
Effective: 01/01/2026
H9306_26_DRS_037_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
Prerequisite Therapy Required	No

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
Prerequisite Therapy Required	No

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
Prerequisite Therapy Required	No

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
Prerequisite Therapy Required	No

Formulary ID: 26376
Effective: 01/01/2026
H9306_26_DRS_037_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.
Indications	All FDA-approved Indications.

Formulary ID: 26376

Effective: 01/01/2026

H9306_26_DRS_037_OE_C

PA Criteria	Criteria Details
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

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
Prerequisite Therapy Required	No

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
Prerequisite Therapy Required	No

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: 26376
Effective: 01/01/2026
H9306_26_DRS_037_OE_C

PA Criteria	Criteria Details
Prerequisite Therapy Required	No

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
Prerequisite Therapy Required	No

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
Prerequisite Therapy Required	No

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
Prerequisite Therapy Required	No

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
Prerequisite Therapy Required	No

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
Prerequisite Therapy Required	No

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
Prerequisite Therapy Required	No

Formulary ID: 26376
Effective: 01/01/2026
H9306_26_DRS_037_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
Prerequisite Therapy Required	No

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
Prerequisite Therapy Required	No

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
Prerequisite Therapy Required	No

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
Prerequisite Therapy Required	No

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
Prerequisite Therapy Required	No

RESMETIROM

Products Affected

- REZDIFFRA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	NONALCOHOLIC STEATOHEPATITIS (NASH): INITIAL: DIAGNOSIS CONFIRMED BY BIOPSY OR NONINVASIVE TESTING, OBTAINED IN THE PAST 12 MONTHS, DEMONSTRATING: 1) LIVER FIBROSIS STAGE 2 OR 3, OR 2) NONALCOHOLIC FATTY LIVER DISEASE (NAFLD) ACTIVITY SCORE OF 4 OR MORE.
Age Restrictions	
Prescriber Restrictions	NASH: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A HEPATOLOGIST OR GASTROENTEROLOGIST
Coverage Duration	INITIAL/RENEWAL: 12 MONTHS
Other Criteria	NASH: INITIAL: ENROLLED IN OR HAS COMPLETED A LIFESTYLE INTERVENTION (E.G., DIETARY, EXERCISE). RENEWAL: DOES NOT MEET ANY OF THE FOLLOWING: 1) A NON-RESPONDER (DEFINED AS NAFLD ACTIVITY SCORE NOT DECREASING BY AT LEAST 2 POINTS FROM BASELINE AND NO REDUCTION IN LIVER FIBROSIS STAGE), OR 2) EXPERIENCED NASH RESOLUTION (DEFINED AS NAFLD ACTIVITY SCORE OF LESS THAN OR EQUAL TO 3 AND LIVER FIBROSIS STAGE 0 TO 1).
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 26376
Effective: 01/01/2026
H9306_26_DRS_037_OE_C

PA Criteria	Criteria Details
Prerequisite Therapy Required	No

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
Prerequisite Therapy Required	No

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
Prerequisite Therapy Required	No

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
Prerequisite Therapy Required	No

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
Prerequisite Therapy Required	No

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
Prerequisite Therapy Required	Yes

Formulary ID: 26376
Effective: 01/01/2026
H9306_26_DRS_037_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 ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR CAPS. DIRA: 1) NO

Formulary ID: 26376

Effective: 01/01/2026

H9306_26_DRS_037_OE_C

PA Criteria	Criteria Details
	CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR DIRA, 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 ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR RP.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

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, MIGRAINE SEVERITY, OR MIGRAINE DURATION WITH THERAPY.

Formulary ID: 26376

Effective: 01/01/2026

H9306_26_DRS_037_OE_C

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

RIOCIGUAT

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: 26376

Effective: 01/01/2026

H9306_26_DRS_037_OE_C

PA Criteria	Criteria Details
Part B Prerequisite	No
Prerequisite Therapy Required	No

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
Prerequisite Therapy Required	No

RISANKIZUMAB-RZAA

Products Affected

- SKYRIZI
- 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) AT LEAST A 3 MONTH TRIAL OF ONE ORAL IMMUNOSUPPRESSANT (CYCLOSPORINE, METHOTREXATE, TACROLIMUS) OR PUVA (PHOTOTHERAPY), 2) CONTRAINDICATION OR INTOLERANCE TO BOTH IMMUNOSUPPRESSANT AND PUVA, OR 3) PATIENT IS SWITCHING FROM A DIFFERENT BIOLOGIC, PDE-4 INHIBITOR, OR JAK INHIBITOR FOR THE SAME INDICATION. INITIAL/RENEWAL: ALL INDICATIONS: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR THE SAME INDICATION. RENEWAL: PSO, PSA: CONTINUES TO BENEFIT FROM THE MEDICATION.
Indications	All FDA-approved Indications.
Off Label Uses	

Formulary ID: 26376
Effective: 01/01/2026
H9306_26_DRS_037_OE_C

PA Criteria	Criteria Details
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

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): 1) HAS RECEIVED OR WILL RECEIVE AT LEAST ONE FULL DOSE OF A RITUXIMAB PRODUCT BY INTRAVENOUS INFUSION PRIOR TO INITIATION OF RITUXIMAB AND HYALURONIDASE, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR THE SAME INDICATION.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Formulary ID: 26376
Effective: 01/01/2026
H9306_26_DRS_037_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, PV: 12 MO. CLL: 6 MO.
Other Criteria	INITIAL: ALL INDICATIONS: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR THE SAME INDICATION. RA: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA/CYLTEZO/YUFLYMA, XELJANZ, RINVOQ, ORENCIA. RENEWAL: RA: 1) CONTINUES TO BENEFIT FROM THE MEDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR THE SAME INDICATION.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 26376
Effective: 01/01/2026
H9306_26_DRS_037_OE_C

PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

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
Prerequisite Therapy Required	No

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: 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
Prerequisite Therapy Required	No

Formulary ID: 26376
Effective: 01/01/2026
H9306_26_DRS_037_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	INITIAL: CHRONIC GRAFT VS HOST DISEASE (CGVHD): NO CONCURRENT USE WITH REZUROCK, NIKTIMVO, OR IMBRUVICA. RENEWAL: MYELOFIBROSIS: CONTINUES TO BENEFIT FROM THE MEDICATION. CGVHD: NO CONCURRENT USE WITH REZUROCK, NIKTIMVO, OR IMBRUVICA.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Formulary ID: 26376
Effective: 01/01/2026
H9306_26_DRS_037_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
Prerequisite Therapy Required	No

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) AT LEAST A 3 MONTH TRIAL OF ONE ORAL IMMUNOSUPPRESSANT (CYCLOSPORINE, METHOTREXATE, TACROLIMUS) OR PUVA (PHOTOTHERAPY), 2) CONTRAINDICATION OR INTOLERANCE TO BOTH IMMUNOSUPPRESSANT AND PUVA, OR 3) PATIENT IS SWITCHING FROM A DIFFERENT BIOLOGIC, PDE-4 INHIBITOR, OR JAK INHIBITOR FOR THE SAME INDICATION. AS, NR-AXSPA: TRIAL OF OR CONTRAINDICATION TO AN NSAID. ERA: TRIAL OF OR CONTRAINDICATION TO ONE NSAID,

Formulary ID: 26376

Effective: 01/01/2026

H9306_26_DRS_037_OE_C

PA Criteria	Criteria Details
	SULFASALAZINE, OR METHOTREXATE. INITIAL/RENEWAL: ALL INDICATIONS: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR THE SAME INDICATION. RENEWAL: ALL INDICATIONS: CONTINUES TO BENEFIT FROM THE MEDICATION.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

SELEXIPAG

Products Affected

- 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
Prerequisite Therapy Required	Yes

Formulary ID: 26376
Effective: 01/01/2026
H9306_26_DRS_037_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
Prerequisite Therapy Required	No

Formulary ID: 26376
Effective: 01/01/2026
H9306_26_DRS_037_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
Prerequisite Therapy Required	No

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
Prerequisite Therapy Required	No

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: 26376
Effective: 01/01/2026
H9306_26_DRS_037_OE_C

PA Criteria	Criteria Details
Prerequisite Therapy Required	No

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
Prerequisite Therapy Required	No

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
Prerequisite Therapy Required	No

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	
Part B Prerequisite	No

Formulary ID: 26376

Effective: 01/01/2026

H9306_26_DRS_037_OE_C

PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

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
Prerequisite Therapy Required	No

Formulary ID: 26376

Effective: 01/01/2026

H9306_26_DRS_037_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: 26376

Effective: 01/01/2026

H9306_26_DRS_037_OE_C

PA Criteria	Criteria Details
Prerequisite Therapy Required	No

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), NOONAN SYNDROME: HEIGHT AT LEAST 2 STANDARD DEVIATIONS BELOW THE MEAN HEIGHT FOR CHILDREN OF THE SAME AGE AND GENDER. TURNER SYNDROME (TS): CONFIRMED BY CHROMOSOMAL ANALYSIS (KARYOTYPING). PRADER WILLI SYNDROME (PWS): CONFIRMED GENETIC DIAGNOSIS OF PWS. ADULT GHD: 1) HAS A CONGENITAL, GENETIC, OR ORGANIC DISEASE (E.G., CRANIOPHARYNGIOMA, PITUITARY HYPOPLASIA, ECTOPIC POSTERIOR PITUITARY, PREVIOUS CRANIAL IRRADIATION), OR 2) GHD CONFIRMED BY ONE OF THE FOLLOWING GROWTH HORMONE (GH) STIMULATION TESTS: (A) INSULIN TOLERANCE TEST (PEAK GH OF 5 NG/ML OR LESS), (B) GLUCAGON-STIMULATION TEST (ONE OF THE FOLLOWING: (I) PEAK RESPONSE OF 3 NG/ML OR LESS AND BMI LESS THAN 25 KG/M2, (II) PEAK RESPONSE OF 3 NG/ML OR LESS AND BMI IS BETWEEN 25 - 30 KG/M2 WITH A PRE-TEST PROBABILITY, (III) PEAK RESPONSE OF 1 NG/ML OR LESS AND BMI IS BETWEEN 25 - 30 KG/M2 WITH LOW TEST PROBABILITY, OR (IV) PEAK RESPONSE OF 1 NG/ML OR LESS AND BMI IS GREATER THAN 30 KG/M2), OR (C) MACIMORELIN TEST (PEAK GH OF 2.8 NG/ML OR LESS).
Age Restrictions	SGA: 2 YEARS OF AGE OR OLDER.
Prescriber Restrictions	INITIAL/RENEWAL: ALL INDICATIONS: PRESCRIBED BY OR IN CONSULTATION WITH AN ENDOCRINOLOGIST.
Coverage Duration	INITIAL/RENEWAL: 12 MONTHS.

Formulary ID: 26376

Effective: 01/01/2026

H9306_26_DRS_037_OE_C

PA Criteria	Criteria Details
Other Criteria	INITIAL: PEDIATRIC GHD, ISS, SGA, TS, NOONAN SYNDROME: OPEN EPIPHYSES AS CONFIRMED BY RADIOGRAPH OF THE WRIST AND HAND. INITIAL/RENEWAL: ADULT GHD, PEDIATRIC GHD, SGA, TS, PWS, NOONAN SYNDROME: NO CONCURRENT USE WITH INCRELEX. RENEWAL: ISS: 1) IMPROVEMENT WHILE ON THERAPY (INCREASED HEIGHT OR INCREASED GROWTH VELOCITY), AND 2) OPEN EPIPHYSES AS CONFIRMED BY RADIOGRAPH OF THE WRIST AND HAND. PEDIATRIC GHD, SGA, TS, NOONAN SYNDROME: 1) IMPROVEMENT WHILE ON THERAPY (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. PWS: IMPROVEMENT IN BODY COMPOSITION.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

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: 3 MONTHS. RENEWAL: 9 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	
Part B Prerequisite	No

Formulary ID: 26376

Effective: 01/01/2026

H9306_26_DRS_037_OE_C

PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

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
Prerequisite Therapy Required	No

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
Prerequisite Therapy Required	No

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: 26376
Effective: 01/01/2026
H9306_26_DRS_037_OE_C

PA Criteria	Criteria Details
Prerequisite Therapy Required	No

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
Prerequisite Therapy Required	No

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
Prerequisite Therapy Required	No

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.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

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
Prerequisite Therapy Required	No

Formulary ID: 26376
Effective: 01/01/2026
H9306_26_DRS_037_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
Prerequisite Therapy Required	Yes

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
Prerequisite Therapy Required	Yes

Formulary ID: 26376

Effective: 01/01/2026

H9306_26_DRS_037_OE_C

TALETRECTINIB

Products Affected

- IBTROZI

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
Prerequisite Therapy Required	No

TALQUETAMAB-TGVS

Products Affected

- TALVEY

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
Prerequisite Therapy Required	No

TARLATAMAB-DLLE

Products Affected

- IMDELLTRA

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
Prerequisite Therapy Required	No

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
Prerequisite Therapy Required	No

TEBENTAFUSP-TEBN

Products Affected

- KIMMTRAK

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
Prerequisite Therapy Required	No

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
Prerequisite Therapy Required	No

TELISOTUZUMAB VEDOTIN-TLLV

Products Affected

- EMRELIS

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
Prerequisite Therapy Required	No

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
Prerequisite Therapy Required	No

Formulary ID: 26376
Effective: 01/01/2026
H9306_26_DRS_037_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
Prerequisite Therapy Required	No

TERIPARATIDE

Products Affected

- TERIPARATIDE SUBCUTANEOUS
SOLUTION PEN-INJECTOR 560
MCG/2.24ML

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
Prerequisite Therapy Required	No

Formulary ID: 26376
Effective: 01/01/2026
H9306_26_DRS_037_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
Prerequisite Therapy Required	No

Formulary ID: 26376
Effective: 01/01/2026
H9306_26_DRS_037_OE_C

TESTOSTERONE CYPIONATE - DEPO

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
Prerequisite Therapy Required	No

Formulary ID: 26376
Effective: 01/01/2026
H9306_26_DRS_037_OE_C

TESTOSTERONE ENANTHATE

Products Affected

- *testosterone enanthate intramuscular solution*

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
Prerequisite Therapy Required	No

Formulary ID: 26376

Effective: 01/01/2026

H9306_26_DRS_037_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
Prerequisite Therapy Required	No

Formulary ID: 26376
Effective: 01/01/2026
H9306_26_DRS_037_OE_C

THALIDOMIDE

Products Affected

- THALOMID ORAL CAPSULE 100 MG, 150 MG, 200 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
Prerequisite Therapy Required	No

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
Prerequisite Therapy Required	No

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
Prerequisite Therapy Required	No

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
Prerequisite Therapy Required	No

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 MONTHS. CRS: 1 MONTH. RENEWAL: RA, PJIA, SJIA, GCA: 12 MONTHS.
Other Criteria	INITIAL: ALL INDICATIONS: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR THE SAME INDICATION. RA: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA/CYLTEZO/YUFLYMA, XELJANZ, RINVOQ, ORENCIA. GIANT CELL ARTERITIS (GCA): 1) HAS COMPLETED, STARTED, OR WILL SOON START A TAPERING COURSE OF GLUCOCORTICIDS, AND 2) TRIAL OF OR CONTRAINDICATION TO THE PREFERRED AGENT: RINVOQ. PJIA: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA/CYLTEZO/YUFLYMA, XELJANZ IR, ORENCIA, RINVOQ. RENEWAL: RA, PJIA, SJIA: 1) CONTINUES TO BENEFIT FROM THE MEDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR THE SAME INDICATION. GCA: NO CONCURRENT USE WITH ANOTHER SYSTEMIC

Formulary ID: 26376

Effective: 01/01/2026

H9306_26_DRS_037_OE_C

PA Criteria	Criteria Details
	BIOLOGIC OR TARGETED SMALL MOLECULES FOR THE SAME INDICATION.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

TOCILIZUMAB-AAZG SQ

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: HUMIRA/CYLTEZO/YUFLYMA, XELJANZ, RINVOQ, ORENCIA. GIANT CELL ARTERITIS (GCA): 1) HAS COMPLETED, STARTED, OR WILL SOON START A TAPERING COURSE OF GLUCOCORTICOID, AND 2) TRIAL OF OR CONTRAINDICATION TO THE PREFERRED AGENT: RINVOQ. PJIA: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA/CYLTEZO/YUFLYMA, XELJANZ IR, ORENCIA, RINVOQ. INITIAL/RENEWAL: ALL INDICATIONS: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR THE SAME INDICATION. RENEWAL: RA, PJIA, SJIA: CONTINUES TO BENEFIT FROM THE MEDICATION.
Indications	All FDA-approved Indications.
Off Label Uses	

Formulary ID: 26376

Effective: 01/01/2026

H9306_26_DRS_037_OE_C

PA Criteria	Criteria Details
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

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 CONVENTIONAL SYNTHETIC DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG) - IF A PATIENT TRIED METHOTREXATE, THEN TRIAL AT A DOSE OF AT LEAST 20 MG PER WEEK OR MAXIMALLY TOLERATED DOSE IS REQUIRED. AS: TRIAL OF OR CONTRAINDICATION TO AN NSAID. INITIAL/RENEWAL: ALL INDICATIONS: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR THE SAME INDICATION. RENEWAL: RA, PSA, AS, PCJIA: CONTINUES TO BENEFIT FROM THE MEDICATION.
Indications	All FDA-approved Indications.
Off Label Uses	

Formulary ID: 26376
Effective: 01/01/2026
H9306_26_DRS_037_OE_C

PA Criteria	Criteria Details
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

TOLVAPTAN

Products Affected

- JYNARQUE ORAL TABLET
- tolvaptan oral tablet therapy pack*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	AUTOSOMAL DOMINANT POLYCYSTIC KIDNEY DISEASE (ADPKD): INITIAL: 1) CONFIRMED POLYCYSTIC KIDNEY DISEASE VIA CT, MRI, OR ULTRASOUND, AND 2) GENETIC TESTING FOR CAUSATIVE MUTATIONS OR FAMILY HISTORY OF CONFIRMED POLYCYSTIC KIDNEY DISEASE IN ONE OR BOTH PARENTS.
Age Restrictions	
Prescriber Restrictions	ADPKD: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A NEPHROLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	ADPKD: INITIAL: DOES NOT HAVE ESRD (I.E., RECEIVING DIALYSIS OR HAS UNDERGONE RENAL TRANSPLANT). RENEWAL: HAS NOT PROGRESSED TO ESRD/DIALYSIS OR TRANSPLANT.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Formulary ID: 26376
Effective: 01/01/2026
H9306_26_DRS_037_OE_C

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
Prerequisite Therapy Required	Yes

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
Prerequisite Therapy Required	No

Formulary ID: 26376
Effective: 01/01/2026
H9306_26_DRS_037_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
Prerequisite Therapy Required	No

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
Prerequisite Therapy Required	No

Formulary ID: 26376
Effective: 01/01/2026
H9306_26_DRS_037_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
Prerequisite Therapy Required	No

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
Prerequisite Therapy Required	No

Formulary ID: 26376
Effective: 01/01/2026
H9306_26_DRS_037_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
Prerequisite Therapy Required	Yes

Formulary ID: 26376
Effective: 01/01/2026
H9306_26_DRS_037_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
Prerequisite Therapy Required	No

Formulary ID: 26376
Effective: 01/01/2026
H9306_26_DRS_037_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
Prerequisite Therapy Required	No

Formulary ID: 26376
Effective: 01/01/2026
H9306_26_DRS_037_OE_C

TRIENTINE CAPSULE

Products Affected

- *trientine hcl oral capsule 250 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	WILSONS DISEASE: INITIAL: LEIPZIG SCORE OF 4 OR GREATER.
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: 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
Prerequisite Therapy Required	Yes

Formulary ID: 26376
Effective: 01/01/2026
H9306_26_DRS_037_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
Prerequisite Therapy Required	No

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
Prerequisite Therapy Required	No

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
Prerequisite Therapy Required	No

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
Prerequisite Therapy Required	Yes

Formulary ID: 26376
Effective: 01/01/2026
H9306_26_DRS_037_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 (PSA): 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: 26376
Effective: 01/01/2026
H9306_26_DRS_037_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. GIANT CELL ARTERITIS (GCA): HAS COMPLETED, STARTED, OR WILL SOON START A TAPERING COURSE OF GLUCOCORTICOID. 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: 26376

Effective: 01/01/2026

H9306_26_DRS_037_OE_C

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

USTEKINUMAB IV

Products Affected

- STELARA INTRAVENOUS

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/RENEWAL: ALL INDICATIONS: 1) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR THE SAME INDICATION, AND 2) TRIAL OF OR CONTRAINDICATION TO ONE OF THE FOLLOWING PREFERRED AGENTS: SELARSDI, YESINTEK. RENEWAL: PSA, PSO: CONTINUES TO BENEFIT FROM THE MEDICATION.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 26376
Effective: 01/01/2026
H9306_26_DRS_037_OE_C

PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

USTEKINUMAB SQ

Products Affected

- STELARA SUBCUTANEOUS SOLUTION 45 MG/0.5ML
- STELARA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE
- *ustekinumab subcutaneous*

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/RENEWAL: ALL INDICATIONS: 1) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR THE SAME INDICATION, AND 2) TRIAL OF OR CONTRAINDICATION TO ONE OF THE FOLLOWING PREFERRED AGENTS: SELARSDI, YESINTEK. RENEWAL: PSA, PSO: CONTINUES TO BENEFIT FROM THE MEDICATION.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 26376
Effective: 01/01/2026
H9306_26_DRS_037_OE_C

PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

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: PSO: 1) AT LEAST A 3 MONTH TRIAL OF ONE ORAL IMMUNOSUPPRESSANT (CYCLOSPORINE, METHOTREXATE, TACROLIMUS) OR PUVA (PHOTOTHERAPY), 2) CONTRAINDICATION OR INTOLERANCE TO BOTH IMMUNOSUPPRESSANT AND PUVA, OR 3) PATIENT IS SWITCHING FROM A DIFFERENT BIOLOGIC, PDE-4 INHIBITOR, OR JAK INHIBITOR FOR THE SAME INDICATION. INITIAL/RENEWAL: ALL INDICATIONS: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR THE SAME INDICATION. RENEWAL: PSA, PSO: CONTINUES TO BENEFIT FROM THE MEDICATION.
Indications	All FDA-approved Indications.
Off Label Uses	

Formulary ID: 26376

Effective: 01/01/2026

H9306_26_DRS_037_OE_C

PA Criteria	Criteria Details
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

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: PSO: 1) AT LEAST A 3 MONTH TRIAL OF ONE ORAL IMMUNOSUPPRESSANT (CYCLOSPORINE, METHOTREXATE, TACROLIMUS) OR PUVA (PHOTOTHERAPY), 2) CONTRAINDICATION OR INTOLERANCE TO BOTH IMMUNOSUPPRESSANT AND PUVA, OR 3) PATIENT IS SWITCHING FROM A DIFFERENT BIOLOGIC, PDE-4 INHIBITOR, OR JAK INHIBITOR FOR THE SAME INDICATION. INITIAL/RENEWAL: ALL INDICATIONS: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR THE SAME INDICATION. RENEWAL: PSA, PSO: CONTINUES TO BENEFIT FROM THE MEDICATION.
Indications	All FDA-approved Indications.
Off Label Uses	

Formulary ID: 26376

Effective: 01/01/2026

H9306_26_DRS_037_OE_C

PA Criteria	Criteria Details
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

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: PSO: 1) AT LEAST A 3 MONTH TRIAL OF ONE ORAL IMMUNOSUPPRESSANT (CYCLOSPORINE, METHOTREXATE, TACROLIMUS) OR PUVA (PHOTOTHERAPY), 2) CONTRAINDICATION OR INTOLERANCE TO BOTH IMMUNOSUPPRESSANT AND PUVA, OR 3) PATIENT IS SWITCHING FROM A DIFFERENT BIOLOGIC, PDE-4 INHIBITOR, OR JAK INHIBITOR FOR THE SAME INDICATION. INITIAL/RENEWAL: ALL INDICATIONS: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR THE SAME INDICATION. RENEWAL: PSA, PSO: CONTINUES TO BENEFIT FROM THE MEDICATION.
Indications	All FDA-approved Indications.
Off Label Uses	

Formulary ID: 26376

Effective: 01/01/2026

H9306_26_DRS_037_OE_C

PA Criteria	Criteria Details
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

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: PSO: 1) AT LEAST A 3 MONTH TRIAL OF ONE ORAL IMMUNOSUPPRESSANT (CYCLOSPORINE, METHOTREXATE, TACROLIMUS) OR PUVA (PHOTOTHERAPY), 2) CONTRAINDICATION OR INTOLERANCE TO BOTH IMMUNOSUPPRESSANT AND PUVA, OR 3) PATIENT IS SWITCHING FROM A DIFFERENT BIOLOGIC, PDE-4 INHIBITOR, OR JAK INHIBITOR FOR THE SAME INDICATION. INITIAL/RENEWAL: ALL INDICATIONS: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR THE SAME INDICATION. RENEWAL: PSA, PSO: CONTINUES TO BENEFIT FROM THE MEDICATION.
Indications	All FDA-approved Indications.
Off Label Uses	

Formulary ID: 26376

Effective: 01/01/2026

H9306_26_DRS_037_OE_C

PA Criteria	Criteria Details
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

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
Prerequisite Therapy Required	No

Formulary ID: 26376
Effective: 01/01/2026
H9306_26_DRS_037_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
Prerequisite Therapy Required	No

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
Prerequisite Therapy Required	No

Formulary ID: 26376
Effective: 01/01/2026
H9306_26_DRS_037_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
Prerequisite Therapy Required	No

Formulary ID: 26376
Effective: 01/01/2026
H9306_26_DRS_037_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
Prerequisite Therapy Required	No

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

Formulary ID: 26376
Effective: 01/01/2026
H9306_26_DRS_037_OE_C

PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

VIGABATRIN

Products Affected

- *vigabatrín*
- *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
Prerequisite Therapy Required	Yes

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
Prerequisite Therapy Required	No

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
Prerequisite Therapy Required	No

Formulary ID: 26376
Effective: 01/01/2026
H9306_26_DRS_037_OE_C

VONOPRAZAN

Products Affected

- VOQUEZNA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: EROSIVE ESOPHAGITIS (EE): DIAGNOSIS CONFIRMED BY ENDOSCOPY (E.G., LOS ANGELES CLASSIFICATION OF REFLUX ESOPHAGITIS GRADE A-D). NON-EROSIVE GASTROESOPHAGEAL REFLUX DISEASE (NERD): DIAGNOSIS CONFIRMED BY ENDOSCOPY AND DOES NOT HAVE PRESENCE OF VISIBLE EROSION (E.G., DOES NOT HAVE LOS ANGELES CLASSIFICATION OF REFLUX ESOPHAGITIS GRADE A-D).
Age Restrictions	
Prescriber Restrictions	INITIAL: EE, NERD: PRESCRIBED BY OR IN CONSULTATION WITH A GASTROENTEROLOGIST.
Coverage Duration	INITIAL: H PYLORI: 30 DAYS. EE: 8 WEEKS. NERD: 4 WEEKS. RENEWAL: EE: 24 WEEKS.
Other Criteria	INITIAL: EE: TRIAL OF OR CONTRAINDICATION TO TWO PROTON PUMP INHIBITORS AT MAXIMUM DOSE FOR 8 WEEKS EACH. NERD: 1) NO PREVIOUS TREATMENT FAILURE WITH VOQUEZNA IN THE LAST 12 MONTHS, AND 2) TRIAL OF OR CONTRAINDICATION TO TWO PROTON PUMP INHIBITORS AT MAXIMUM DOSE FOR 8 WEEKS EACH. RENEWAL: EE: MAINTAINED A CLINICAL RESPONSE ON VOQUEZNA
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Formulary ID: 26376

Effective: 01/01/2026

H9306_26_DRS_037_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
Prerequisite Therapy Required	No

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: CONTRAINDICATION TO OR UNABLE TO SWALLOW FLUCONAZOLE 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
Prerequisite Therapy Required	Yes

Formulary ID: 26376
Effective: 01/01/2026
H9306_26_DRS_037_OE_C

ZANIDATAMAB-HR11

Products Affected

- ZIIHERA

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
Prerequisite Therapy Required	No

ZANUBRUTINIB

Products Affected

- BRUKINSA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	INTOLERANCE TO CALQUENCE OR IMBRUVICA, WHERE INDICATIONS ALIGN.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Formulary ID: 26376
Effective: 01/01/2026
H9306_26_DRS_037_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	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Formulary ID: 26376
Effective: 01/01/2026
H9306_26_DRS_037_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
Prerequisite Therapy Required	No

Formulary ID: 26376
Effective: 01/01/2026
H9306_26_DRS_037_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
Prerequisite Therapy Required	No

Formulary ID: 26376
Effective: 01/01/2026
H9306_26_DRS_037_OE_C

INDEX

A

abiraterone acetate	7
abirtega.....	7
ABOUTTIME PEN NEEDLE 30G X 8 MM	165, 183, 184
ABOUTTIME PEN NEEDLE 31G X 5 MM	165, 183, 184
ABOUTTIME PEN NEEDLE 31G X 8 MM	165, 183, 184
ABOUTTIME PEN NEEDLE 32G X 4 MM	165, 183, 184
ACTIMMUNE.....	188
ADEMPAS	296, 297
ADVOCATE INSULIN PEN NEEDLE 32G X 4 MM.....	165, 183, 184
ADVOCATE INSULIN PEN NEEDLES 29G X 12.7MM.....	165, 183, 184
ADVOCATE INSULIN PEN NEEDLES 31G X 5 MM.....	165, 183, 184
ADVOCATE INSULIN PEN NEEDLES 31G X 8 MM.....	165, 183, 184
ADVOCATE INSULIN PEN NEEDLES 33G X 4 MM.....	165, 183, 184
ADVOCATE INSULIN SYRINGE 29G X 1/2	165, 183, 184
ADVOCATE INSULIN SYRINGE 30G X 5/16	165, 183, 184
ADVOCATE INSULIN SYRINGE 31G X 5/16	165, 183, 184
AIMOVIG.....	122
AKEEGA	242
ALCOHOL PADS	165, 183, 184
ALCOHOL PREP PAD.....	165, 183, 184
ALCOHOL PREP PAD 70 %. 165, 183, 184	
ALCOHOL PREP PADS PAD 70 %	165, 183, 184
ALCOHOL SWABS PAD.....	165, 183, 184
ALCOHOL SWABS PAD 70 % ...	165, 183, 184
ALECENSA.....	18
ALTRENO	362
ALUNBRIG ORAL TABLET 180 MG, 30 MG, 90 MG.....	57
ALUNBRIG ORAL TABLET THERAPY PACK.....	57
ALVAIZ.....	108, 109
ALYFTREK ORAL TABLET 10-50-125 MG, 4-20-50 MG	393
alyq.....	334
ANKTIVA	248
AQ INSULIN SYRINGE 31G X 5/16... 165, 183, 184	
AQINJECT PEN NEEDLE 31G X 5 MM	165, 183, 184
AQINJECT PEN NEEDLE 32G X 4 MM	165, 183, 184
ARCALYST	292, 293
ARIKAYCE.....	20
armodafinil.....	234
ASSURE ID DUO PRO PEN NEEDLES 31G X 5 MM.....	165, 183, 184
ASSURE ID INSULIN SAFETY SYR 29G X 1/2.....	165, 183, 184
ASSURE ID INSULIN SAFETY SYR 31G X 15/64.....	165, 183, 184
ASSURE ID PRO PEN NEEDLES 30G X 5 MM	165, 183, 184
AUGTYRO ORAL CAPSULE 160 MG, 40 MG	284
AUM ALCOHOL PREP PADS PAD 70 %	165, 183, 184
AUM INSULIN SAFETY PEN NEEDLE 31G X 4 MM.....	165, 183, 184
AUM INSULIN SAFETY PEN NEEDLE 31G X 5 MM.....	165, 183, 184
AUM MINI INSULIN PEN NEEDLE 32G X 4 MM.....	165, 183, 184
AUM MINI INSULIN PEN NEEDLE 32G X 5 MM.....	165, 183, 184
AUM MINI INSULIN PEN NEEDLE 32G X 6 MM.....	165, 183, 184
AUM MINI INSULIN PEN NEEDLE 32G X 8 MM.....	165, 183, 184

Formulary ID: 26376

Effective: 01/01/2026

H9306_26_DRS_037_OE_C

AUM MINI INSULIN PEN NEEDLE 33G
X 4 MM..... 165, 183, 184
AUM MINI INSULIN PEN NEEDLE 33G
X 5 MM..... 165, 183, 184
AUM MINI INSULIN PEN NEEDLE 33G
X 6 MM..... 165, 183, 184
AUM PEN NEEDLE 32G X 4 MM 166,
183, 184
AUM PEN NEEDLE 32G X 5 MM 166,
183, 184
AUM PEN NEEDLE 32G X 6 MM 166,
183, 184
AUM PEN NEEDLE 33G X 4 MM 166,
183, 184
AUM PEN NEEDLE 33G X 5 MM 166,
183, 184
AUM PEN NEEDLE 33G X 6 MM 166,
183, 184
AUM READYGARD DUO PEN NEEDLE
32G X 4 MM..... 166, 183, 184
AUM SAFETY PEN NEEDLE 31G X 4
MM 166, 183, 184
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
AVMAPKI FAKZYNJA CO-PACK..... 38
AVONEX PEN INTRAMUSCULAR
AUTO-INJECTOR KIT..... 185
AVONEX PREFILLED
INTRAMUSCULAR PREFILLED
SYRINGE KIT..... 185
AYVAKIT 37
B
BALVERSA ORAL TABLET 3 MG, 4
MG, 5 MG..... 121
BD AUTOSHIELD DUO 30G X 5 MM 166,
183, 184
BD ECLIPSE SYRINGE 30G X 1/2 166,
183, 184

BD INSULIN SYR ULTRAFINE II 31G X
5/16 166, 183, 184
BD INSULIN SYRINGE 25G X 1 166, 183,
184
BD INSULIN SYRINGE 25G X 5/8..... 166,
183, 184
BD INSULIN SYRINGE 26G X 1/2..... 166,
183, 184
BD INSULIN SYRINGE 27.5G X 5/8.. 166,
183, 184
BD INSULIN SYRINGE 27G X 1/2..... 166,
183, 184
BD INSULIN SYRINGE 29G X 1/2..... 166,
183, 184
BD INSULIN SYRINGE HALF-UNIT 31G
X 5/16..... 166, 183, 184
BD INSULIN SYRINGE MICROFINE 27G
X 5/8..... 166, 183, 184
BD INSULIN SYRINGE MICROFINE 28G
X 1/2..... 166, 183, 184
BD INSULIN SYRINGE U-100 1 ML . 166,
183, 184
BD INSULIN SYRINGE ULTRAFINE 29G
X 1/2..... 166, 183, 184
BD INSULIN SYRINGE ULTRAFINE 30G
X 1/2..... 166, 183, 184
BD PEN NEEDLE MICRO ULTRAFINE
32G X 6 MM..... 166, 183, 184
BD PEN NEEDLE MINI U/F 31G X 5 MM
..... 166, 183, 184
BD PEN NEEDLE MINI ULTRAFINE 31G
X 5 MM..... 166, 183, 184
BD PEN NEEDLE NANO 2ND GEN 32G
X 4 MM..... 166, 183, 184
BD PEN NEEDLE NANO ULTRAFINE
32G X 4 MM..... 166, 183, 184
BD PEN NEEDLE ORIG ULTRAFINE
29G X 12.7MM..... 166, 183, 184
BD PEN NEEDLE SHORT ULTRAFINE
31G X 8 MM..... 166, 183, 184
BD SAFETYGLIDE INSULIN SYRINGE
29G X 1/2..... 166, 183, 184
BD SAFETYGLIDE INSULIN SYRINGE
30G X 5/16..... 166, 183, 184

Formulary ID: 26376
Effective: 01/01/2026
H9306_26_DRS_037_OE_C

BD SAFETYGLIDE INSULIN SYRINGE
31G X 15/64..... 166, 183, 184
BD SAFETYGLIDE INSULIN SYRINGE
31G X 5/16..... 166, 183, 184
BD SAFETYGLIDE SYRINGE/NEEDLE
27G X 5/8..... 166, 183, 184
BD SWABS SINGLE USE BUTTERFLY
PAD..... 166, 183, 184
BD VEO INSULIN SYR U/F 1/2UNIT 31G
X 15/64..... 166, 183, 184
BD VEO INSULIN SYR ULTRAFINE 31G
X 15/64..... 167, 183, 184
BD VEO INSULIN SYRINGE U/F 31G X
15/64 167, 183, 184
BENDAMUSTINE HCL INTRAVENOUS
SOLUTION..... 47
bendamustine hcl intravenous solution
reconstituted..... 47
BENDEKA 47
BENLYSTA SUBCUTANEOUS..... 44
BESREMI 304
betaine 50
BETASERON SUBCUTANEOUS KIT 186
bexarotene 52
BIZENGRI (750 MG DOSE) 406
bortezomib injection 54
BORUZU 54
bosentan 55
BOSULIF ORAL CAPSULE 100 MG, 50
MG 56
BOSULIF ORAL TABLET 100 MG, 400
MG, 500 MG..... 56
BRAFTOVI ORAL CAPSULE 75 MG . 113
BRUKINSA 405
C
CABOMETYX ORAL TABLET 20 MG, 40
MG, 60 MG..... 60
CALQUENCE 9
CAMZYOS 221
CAPRELSA ORAL TABLET 100 MG, 300
MG 392
CAREFINE PEN NEEDLES 29G X 12MM
..... 167, 183, 184

CAREFINE PEN NEEDLES 30G X 8 MM
..... 167, 183, 184
CAREFINE PEN NEEDLES 31G X 6 MM
..... 167, 183, 184
CAREFINE PEN NEEDLES 31G X 8 MM
..... 167, 183, 184
CAREFINE PEN NEEDLES 32G X 4 MM
..... 167, 183, 184
CAREFINE PEN NEEDLES 32G X 5 MM
..... 167, 183, 184
CAREFINE PEN NEEDLES 32G X 6 MM
..... 167, 183, 184
CAREONE INSULIN SYRINGE 30G X
1/2 167, 183, 184
CAREONE INSULIN SYRINGE 31G X
5/16 167, 183, 184
CARETOUCH ALCOHOL PREP PAD 70
% 167, 183, 184
CARETOUCH INSULIN SYRINGE 28G X
5/16 167, 183, 184
CARETOUCH INSULIN SYRINGE 29G X
5/16 167, 183, 184
CARETOUCH INSULIN SYRINGE 30G X
5/16 167, 183, 184
CARETOUCH INSULIN SYRINGE 31G X
5/16 167, 183, 184
CARETOUCH PEN NEEDLES 29G X
12MM 167, 183, 184
CARETOUCH PEN NEEDLES 31G X 5
MM 167, 183, 184
CARETOUCH PEN NEEDLES 31G X 6
MM 167, 183, 184
CARETOUCH PEN NEEDLES 31G X 8
MM 167, 183, 184
CARETOUCH PEN NEEDLES 32G X 4
MM 167, 183, 184
CARETOUCH PEN NEEDLES 32G X 5
MM 167, 183, 184
CARETOUCH PEN NEEDLES 33G X 4
MM 167, 183, 184
carglumic acid oral tablet soluble 64
CAYSTON..... 42
CIMZIA (2 SYRINGE) 66, 67

CIMZIA SUBCUTANEOUS KIT 2 X 200
MG 66, 67
CLEVER CHOICE COMFORT EZ 29G X
12MM 167, 183, 184
CLEVER CHOICE COMFORT EZ 33G X
4 MM 167, 183, 184
CLICKFINE PEN NEEDLES 31G X 8 MM
..... 167, 183, 184
CLICKFINE PEN NEEDLES 32G X 4 MM
..... 167, 183, 184
COMETRIQ (100 MG DAILY DOSE)
ORAL KIT 80 & 20 MG 59
COMETRIQ (140 MG DAILY DOSE)
ORAL KIT 3 X 20 MG & 80 MG 59
COMETRIQ (60 MG DAILY DOSE)..... 59
COMFORT ASSIST INSULIN SYRINGE
29G X 1/2..... 167, 183, 184
COMFORT ASSIST INSULIN SYRINGE
31G X 5/16..... 167, 183, 184
COMFORT EZ INSULIN SYRINGE 28G
X 1/2..... 167, 183, 184
COMFORT EZ INSULIN SYRINGE 29G
X 1/2..... 167, 168, 183, 184
COMFORT EZ INSULIN SYRINGE 30G
X 1/2..... 168, 183, 184
COMFORT EZ INSULIN SYRINGE 30G
X 5/16..... 168, 183, 184
COMFORT EZ INSULIN SYRINGE 31G
X 15/64..... 168, 183, 184
COMFORT EZ INSULIN SYRINGE 31G
X 5/16..... 168, 183, 184
COMFORT EZ PEN NEEDLES 31G X 5
MM 168, 183, 184
COMFORT EZ PEN NEEDLES 31G X 6
MM 168, 183, 184
COMFORT EZ PEN NEEDLES 31G X 8
MM 168, 183, 184
COMFORT EZ PEN NEEDLES 32G X 4
MM 168, 183, 184
COMFORT EZ PEN NEEDLES 32G X 5
MM 168, 183, 184
COMFORT EZ PEN NEEDLES 32G X 6
MM 168, 183, 184

COMFORT EZ PEN NEEDLES 32G X 8
MM 168, 183, 184
COMFORT EZ PEN NEEDLES 33G X 4
MM 168, 183, 184
COMFORT EZ PEN NEEDLES 33G X 5
MM 168, 183, 184
COMFORT EZ PEN NEEDLES 33G X 6
MM 168, 183, 184
COMFORT EZ PEN NEEDLES 33G X 8
MM 168, 183, 184
COMFORT EZ PRO PEN NEEDLES 30G
X 8 MM..... 168, 183, 184
COMFORT EZ PRO PEN NEEDLES 31G
X 4 MM..... 168, 183, 184
COMFORT EZ PRO PEN NEEDLES 31G
X 5 MM..... 168, 183, 184
COMFORT TOUCH INSULIN PEN NEED
31G X 4 MM..... 168, 183, 184
COMFORT TOUCH INSULIN PEN NEED
31G X 5 MM..... 168, 183, 184
COMFORT TOUCH INSULIN PEN NEED
31G X 6 MM..... 168, 183, 184
COMFORT TOUCH INSULIN PEN NEED
31G X 8 MM..... 168, 183, 184
COMFORT TOUCH INSULIN PEN NEED
32G X 4 MM..... 168, 183, 184
COMFORT TOUCH INSULIN PEN NEED
32G X 5 MM..... 168, 183, 184
COMFORT TOUCH INSULIN PEN NEED
32G X 6 MM..... 168, 183, 184
COMFORT TOUCH INSULIN PEN NEED
32G X 8 MM..... 168, 183, 184
COPIKTRA..... 100
CORTROPHIN 72, 73
COSENTYX (300 MG DOSE)..... 308, 309
COSENTYX SENSOREADY (300 MG)
..... 308, 309
COSENTYX SUBCUTANEOUS
SOLUTION PREFILLED SYRINGE 75
MG/0.5ML 308, 309
COSENTYX UNOREADY 308, 309
COTELLIC 71
CRESEMBA ORAL 190

CURITY ALL PURPOSE SPONGES PAD
2..... 168, 183, 184
CURITY GAUZE PAD 2 168, 183, 184
CURITY GAUZE SPONGE PAD 2..... 168,
183, 184
CURITY SPONGES PAD 2... 168, 183, 184
CVS GAUZE PAD 2 168, 183, 184
CVS GAUZE STERILE PAD 2 168, 183,
184
CYLTEZO (2 PEN) 15, 16
CYLTEZO (2 SYRINGE) 15, 16
CYLTEZO-CD/UC/HS STARTER.... 15, 16
CYLTEZO-PSORIASIS/UV STARTER 15,
16
D
dalfampridine er 79
DANYELZA 235
DANZITEN 238
dasatinib oral tablet 100 mg, 140 mg, 20 mg,
50 mg, 70 mg, 80 mg 82
DATROWAY 83
DAURISMO ORAL TABLET 100 MG, 25
MG 147
deferasirox granules 85, 86
deferasirox oral tablet 85, 86
DERMACEA GAUZE SPONGE PAD 2
..... 168, 183, 184
DERMACEA IV DRAIN SPONGES PAD
2..... 168, 183, 184
DERMACEA NON-WOVEN SPONGES
PAD 2..... 168, 183, 184
DERMACEA TYPE VII GAUZE PAD 2
..... 168, 183, 184
DIACOMIT ORAL CAPSULE 250 MG,
500 MG 332
DIACOMIT ORAL PACKET 250 MG, 500
MG 332
DIATHRIVE PEN NEEDLE 31G X 5 MM
..... 168, 183, 184
DIATHRIVE PEN NEEDLE 31G X 6 MM
..... 169, 183, 184
DIATHRIVE PEN NEEDLE 31G X 8 MM
..... 169, 183, 184

DIATHRIVE PEN NEEDLE 32G X 4 MM
..... 169, 183, 184
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
..... 169, 183, 184
DROPLET INSULIN SYRINGE 30G X 1/2
..... 169, 183, 184
DROPLET INSULIN SYRINGE 30G X
15/64 169, 183, 184
DROPLET INSULIN SYRINGE 30G X
5/16 169, 183, 184
DROPLET INSULIN SYRINGE 31G X 1/4
..... 169, 183, 184
DROPLET INSULIN SYRINGE 31G X
15/64 169, 183, 184
DROPLET INSULIN SYRINGE 31G X
5/16 169, 183, 184
DROPLET MICRON 34G X 3.5 MM... 169,
183, 184
DROPLET PEN NEEDLES 29G X 10MM
..... 169, 183, 184
DROPLET PEN NEEDLES 29G X 12MM
..... 169, 183, 184
DROPLET PEN NEEDLES 30G X 8 MM
..... 169, 183, 184
DROPLET PEN NEEDLES 31G X 5 MM
..... 169, 183, 184
DROPLET PEN NEEDLES 31G X 6 MM
..... 169, 183, 184
DROPLET PEN NEEDLES 31G X 8 MM
..... 169, 183, 184
DROPLET PEN NEEDLES 32G X 4 MM
..... 169, 183, 184
DROPLET PEN NEEDLES 32G X 5 MM
..... 169, 183, 184
DROPLET PEN NEEDLES 32G X 6 MM
..... 169, 183, 184

DROPLET PEN NEEDLES 32G X 8 MM
..... 169, 183, 184
DROPSAFE ALCOHOL PREP PAD 70 %
..... 169, 183, 184
DROPSAFE SAFETY PEN NEEDLES 31G
X 5 MM..... 169, 183, 184
DROPSAFE SAFETY PEN NEEDLES 31G
X 6 MM..... 169, 183, 184
DROPSAFE SAFETY PEN NEEDLES 31G
X 8 MM..... 169, 183, 184
DROPSAFE SAFETY SYRINGE/NEEDLE
29G X 1/2..... 169, 183, 184
DROPSAFE SAFETY SYRINGE/NEEDLE
31G X 15/64..... 169, 183, 184
DROPSAFE SAFETY SYRINGE/NEEDLE
31G X 5/16..... 169, 183, 184
doxidopa 96
DRUG MART ULTRA COMFORT SYR
29G X 1/2..... 169, 170, 183, 184
DRUG MART ULTRA COMFORT SYR
30G X 5/16..... 170, 183, 184
DRUG MART UNIFINE PENTIPS 31G X
5 MM 170, 183, 184
DUPIXENT SUBCUTANEOUS
SOLUTION AUTO-INJECTOR 97, 99
DUPIXENT SUBCUTANEOUS
SOLUTION PREFILLED SYRINGE . 97,
99

E

EASY COMFORT ALCOHOL PADS PAD
..... 170, 183, 184
EASY COMFORT INSULIN SYRINGE
29G X 5/16..... 170, 183, 184
EASY COMFORT INSULIN SYRINGE
30G X 1/2..... 170, 183, 184
EASY COMFORT INSULIN SYRINGE
30G X 5/16..... 170, 183, 184
EASY COMFORT INSULIN SYRINGE
31G X 1/2..... 170, 183, 184
EASY COMFORT INSULIN SYRINGE
31G X 5/16..... 170, 183, 184
EASY COMFORT INSULIN SYRINGE
32G X 5/16..... 170, 183, 184

EASY COMFORT PEN NEEDLES 29G X
4MM 170, 183, 184
EASY COMFORT PEN NEEDLES 29G X
5MM 170, 183, 184
EASY COMFORT PEN NEEDLES 31G X
5 MM 170, 183, 184
EASY COMFORT PEN NEEDLES 31G X
6 MM 170, 183, 184
EASY COMFORT PEN NEEDLES 31G X
8 MM 170, 183, 184
EASY COMFORT PEN NEEDLES 32G X
4 MM 170, 183, 184
EASY COMFORT PEN NEEDLES 33G X
4 MM 170, 183, 184
EASY COMFORT PEN NEEDLES 33G X
5 MM 170, 183, 184
EASY COMFORT PEN NEEDLES 33G X
6 MM 170, 183, 184
EASY GLIDE PEN NEEDLES 33G X 4
MM 170, 183, 184
EASY TOUCH FLIPLOCK INSULIN SY
29G X 1/2..... 170, 183, 184
EASY TOUCH FLIPLOCK INSULIN SY
30G X 1/2..... 170, 183, 184
EASY TOUCH FLIPLOCK INSULIN SY
30G X 5/16..... 170, 183, 184
EASY TOUCH FLIPLOCK INSULIN SY
31G X 5/16..... 170, 183, 184
EASY TOUCH FLIPLOCK SAFETY SYR
27G X 1/2..... 170, 183, 184
EASY TOUCH INSULIN BARRELS U-
100 1 ML..... 170, 183, 184
EASY TOUCH INSULIN SAFETY SYR
29G X 1/2..... 170, 183, 184
EASY TOUCH INSULIN SAFETY SYR
30G X 1/2..... 170, 183, 184
EASY TOUCH INSULIN SAFETY SYR
30G X 5/16..... 170, 183, 184
EASY TOUCH INSULIN SYRINGE 27G
X 1/2..... 170, 183, 184
EASY TOUCH INSULIN SYRINGE 27G
X 5/8..... 170, 183, 184
EASY TOUCH INSULIN SYRINGE 28G
X 1/2..... 170, 183, 184

Formulary ID: 26376
Effective: 01/01/2026
H9306_26_DRS_037_OE_C

EASY TOUCH INSULIN SYRINGE 29G
X 1/2..... 170, 183, 184
EASY TOUCH INSULIN SYRINGE 30G
X 1/2..... 171, 183, 184
EASY TOUCH INSULIN SYRINGE 30G
X 5/16..... 171, 183, 184
EASY TOUCH INSULIN SYRINGE 31G
X 5/16..... 171, 183, 184
EASY TOUCH PEN NEEDLES 29G X
12MM 171, 183, 184
EASY TOUCH PEN NEEDLES 30G X 5
MM 171, 183, 184
EASY TOUCH PEN NEEDLES 30G X 6
MM 171, 183, 184
EASY TOUCH PEN NEEDLES 30G X 8
MM 171, 183, 184
EASY TOUCH PEN NEEDLES 31G X 5
MM 171, 183, 184
EASY TOUCH PEN NEEDLES 31G X 6
MM 171, 183, 184
EASY TOUCH PEN NEEDLES 31G X 8
MM 171, 183, 184
EASY TOUCH PEN NEEDLES 32G X 4
MM 171, 183, 184
EASY TOUCH PEN NEEDLES 32G X 5
MM 171, 183, 184
EASY TOUCH PEN NEEDLES 32G X 6
MM 171, 183, 184
EASY TOUCH SAFETY PEN NEEDLES
29G X 5MM..... 171, 183, 184
EASY TOUCH SAFETY PEN NEEDLES
29G X 8MM..... 171, 183, 184
EASY TOUCH SAFETY PEN NEEDLES
30G X 8 MM..... 171, 183, 184
EASY TOUCH SHEATHLOCK SYRINGE
29G X 1/2..... 171, 183, 184
EASY TOUCH SHEATHLOCK SYRINGE
30G X 1/2..... 171, 183, 184
EASY TOUCH SHEATHLOCK SYRINGE
30G X 5/16..... 171, 183, 184
EASY TOUCH SHEATHLOCK SYRINGE
31G X 5/16..... 171, 183, 184
ELAHERE 231
ELIGARD 204

ELREXFIO SUBCUTANEOUS
SOLUTION 44 MG/1.1ML, 76
MG/1.9ML 107
eltrombopag olamine oral packet 12.5 mg,
25 mg 110, 111
eltrombopag olamine oral tablet 12.5 mg, 25
mg, 50 mg, 75 mg 110, 111
EMBECTA AUTOSHIELD DUO 30G X 5
MM 171, 183, 184
EMBECTA INS SYR U/F 1/2 UNIT 31G X
15/64 171, 183, 184
EMBECTA INS SYR U/F 1/2 UNIT 31G X
5/16 171, 183, 184
EMBECTA INSULIN SYR ULTRAFINE
30G X 1/2..... 171, 183, 184
EMBECTA INSULIN SYR ULTRAFINE
31G X 5/16..... 171, 183, 184
EMBECTA INSULIN SYRINGE 28G X
1/2 171, 183, 184
EMBECTA INSULIN SYRINGE U-100
27G X 5/8..... 171, 183, 184
EMBECTA INSULIN SYRINGE U-100
28G X 1/2..... 171, 183, 184
EMBECTA INSULIN SYRINGE U-500
..... 171, 183, 184
EMBECTA PEN NEEDLE NANO 2 GEN
32G X 4 MM..... 171, 183, 184
EMBECTA PEN NEEDLE ULTRAFINE
29G X 12.7MM..... 171, 183, 184
EMBECTA PEN NEEDLE ULTRAFINE
32G X 6 MM..... 171, 183, 184
EMBRACE PEN NEEDLES 29G X 12MM
..... 171, 183, 184
EMBRACE PEN NEEDLES 30G X 5 MM
..... 171, 183, 184
EMBRACE PEN NEEDLES 30G X 8 MM
..... 171, 183, 184
EMBRACE PEN NEEDLES 31G X 5 MM
..... 172, 183, 184
EMBRACE PEN NEEDLES 31G X 6 MM
..... 172, 183, 184
EMBRACE PEN NEEDLES 31G X 8 MM
..... 172, 183, 184

Formulary ID: 26376
Effective: 01/01/2026
H9306_26_DRS_037_OE_C

EMBRACE PEN NEEDLES 32G X 4 MM
..... 172, 183, 184
EMGALITY 142, 143
EMGALITY (300 MG DOSE) 142, 143
EMRELIS 343
ENBREL MINI 125, 126
ENBREL SUBCUTANEOUS SOLUTION
25 MG/0.5ML 125, 126
ENBREL SUBCUTANEOUS SOLUTION
PREFILLED SYRINGE 125, 126
ENBREL SURECLICK SUBCUTANEOUS
SOLUTION AUTO-INJECTOR 125, 126
EPCLUSA ORAL PACKET 150-37.5 MG,
200-50 MG 320
EPCLUSA ORAL TABLET 320
EPIDIOLEX 61
EPKINLY 118
EQL ALCOHOL SWABS PAD 70 %... 172,
183, 184
EQL GAUZE PAD 2 172, 183, 184
EQL INSULIN SYRINGE 29G X 1/2... 172,
183, 184
EQL INSULIN SYRINGE 30G X 5/16. 172,
183, 184
ERBITUX 68
ERIVEDGE 400
ERLEADA ORAL TABLET 240 MG, 60
MG 24, 25
erlotinib hcl oral tablet 100 mg, 150 mg, 25
mg 123
everolimus oral tablet 10 mg, 2.5 mg, 5 mg,
7.5 mg 127
everolimus oral tablet soluble 128
EXEL COMFORT POINT PEN NEEDLE
29G X 12MM 172, 183, 184
F
FASENRA 48, 49
FASENRA PEN 48, 49
fentanyl citrate buccal lozenge on a handle
..... 132
fingolimod hcl 137
FINTEPLA 131
FOTIVDA 354

FRUZAQLA ORAL CAPSULE 1 MG, 5
MG 140
FYARRO 317
G
GAUZE PADS PAD 2 172, 183, 184
GAUZE TYPE VII MEDI-PAK PAD 2 172,
183, 184
GAVRETO 278
gefitinib 145
GILOTRIF 17
glatiramer acetate subcutaneous solution
prefilled syringe 20 mg/ml, 40 mg/ml 148
glatopa subcutaneous solution prefilled
syringe 20 mg/ml, 40 mg/ml 148
GLOBAL ALCOHOL PREP EASE 172,
183, 184
GLOBAL EASE INJECT PEN NEEDLES
29G X 12MM 172, 183, 184
GLOBAL EASE INJECT PEN NEEDLES
31G X 5 MM 172, 183, 184
GLOBAL EASE INJECT PEN NEEDLES
31G X 8 MM 172, 183, 184
GLOBAL EASE INJECT PEN NEEDLES
32G X 4 MM 172, 183, 184
GLOBAL EASY GLIDE INSULIN SYR
31G X 15/64 172, 183, 184
GLOBAL INJECT EASE INSULIN SYR
30G X 1/2 172, 183, 184
GLUCOPRO INSULIN SYRINGE 30G X
1/2 172, 183, 184
GLUCOPRO INSULIN SYRINGE 30G X
5/16 172, 183, 184
GLUCOPRO INSULIN SYRINGE 31G X
5/16 172, 183, 184
GNP CLICKFINE PEN NEEDLES 31G X 6
MM 172, 183, 184
GNP CLICKFINE PEN NEEDLES 31G X 8
MM 172, 183, 184
GNP INSULIN SYRINGE 28G X 1/2 .. 172,
183, 184
GNP INSULIN SYRINGE 29G X 1/2 .. 172,
183, 184
GNP INSULIN SYRINGE 30G X 5/16 172,
183, 184

Formulary ID: 26376
Effective: 01/01/2026
H9306_26_DRS_037_OE_C

GNP INSULIN SYRINGES 29GX1/2.. 172,
183, 184
GNP INSULIN SYRINGES 30G X 5/16
..... 172, 183, 184
GNP INSULIN SYRINGES 30GX5/16 172,
183, 184
GNP INSULIN SYRINGES 31GX5/16 172,
183, 184
GNP STERILE GAUZE PAD 2.... 172, 183,
184
GNP ULTRA COM INSULIN SYRINGE
29G X 1/2..... 172, 183, 184
GNP ULTRA COM INSULIN SYRINGE
30G X 5/16..... 172, 183, 184
GOMEKLI ORAL CAPSULE 1 MG, 2 MG
..... 230
GOMEKLI ORAL TABLET SOLUBLE230
GOODSENSE ALCOHOL SWABS PAD
70 % 172, 183, 184
GOODSENSE CLICKFINE PEN NEEDLE
31G X 5 MM..... 172, 183, 184
GOODSENSE PEN NEEDLE PENFINE
31G X 5 MM..... 172, 183, 184
GOODSENSE PEN NEEDLE PENFINE
31G X 8 MM..... 173, 183, 184
GOODSENSE PEN NEEDLE PENFINE
32G X 4 MM..... 173, 183, 184
GOODSENSE PEN NEEDLE PENFINE
32G X 6 MM..... 173, 183, 184
H
HAEGARDA SUBCUTANEOUS
SOLUTION RECONSTITUTED 2000
UNIT, 3000 UNIT 58
HARVONI ORAL PACKET 33.75-150
MG, 45-200 MG 198
HARVONI ORAL TABLET 198
HEALTHWISE INSULIN SYR/NEEDLE
30G X 5/16..... 173, 183, 184
HEALTHWISE INSULIN SYR/NEEDLE
31G X 5/16..... 173, 183, 184
HEALTHWISE MICRON PEN NEEDLES
32G X 4 MM..... 173, 183, 184
HEALTHWISE SHORT PEN NEEDLES
31G X 5 MM..... 173, 183, 184

HEALTHWISE SHORT PEN NEEDLES
31G X 8 MM..... 173, 183, 184
HEALTHY ACCENTS UNIFINE PENTIP
29G X 12MM..... 173, 183, 184
HEALTHY ACCENTS UNIFINE PENTIP
31G X 5 MM..... 173, 183, 184
HEALTHY ACCENTS UNIFINE PENTIP
31G X 6 MM..... 173, 183, 184
HEALTHY ACCENTS UNIFINE PENTIP
31G X 8 MM..... 173, 183, 184
HEALTHY ACCENTS UNIFINE PENTIP
32G X 4 MM..... 173, 183, 184
H-E-B INCONTROL ALCOHOL PAD 173,
183, 184
H-E-B INCONTROL PEN NEEDLES 29G
X 12MM..... 173, 183, 184
H-E-B INCONTROL PEN NEEDLES 31G
X 5 MM..... 173, 183, 184
H-E-B INCONTROL PEN NEEDLES 31G
X 6 MM..... 173, 183, 184
H-E-B INCONTROL PEN NEEDLES 31G
X 8 MM..... 173, 183, 184
H-E-B INCONTROL PEN NEEDLES 32G
X 4 MM..... 173, 183, 184
HERCEPTIN HYLECTA..... 368
HM STERILE ALCOHOL PREP PAD 173,
183, 184
HM STERILE PADS PAD 2.. 173, 183, 184
HM ULTICARE INSULIN SYRINGE 30G
X 1/2..... 173, 183, 184
HM ULTICARE INSULIN SYRINGE 31G
X 5/16..... 173, 183, 184
HM ULTICARE SHORT PEN NEEDLES
31G X 8 MM..... 173, 183, 184
HUMIRA (2 PEN) SUBCUTANEOUS
AUTO-INJECTOR KIT..... 11, 12
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
HUMIRA-CD/UC/HS STARTER
SUBCUTANEOUS AUTO-INJECTOR
KIT 11, 12

Formulary ID: 26376
Effective: 01/01/2026
H9306_26_DRS_037_OE_C

HUMIRA-PED<40KG CROHNS STARTER.....	11, 12
HUMIRA-PED>=40KG CROHNS START	11, 12
HUMIRA-PED>=40KG UC STARTER SUBCUTANEOUS AUTO-INJECTOR KIT.....	11, 12
HUMIRA-PS/UV/ADOL HS STARTER SUBCUTANEOUS AUTO-INJECTOR KIT.....	11, 12
HUMIRA-PSORIASIS/UVEIT STARTER SUBCUTANEOUS AUTO-INJECTOR KIT.....	11, 12
I	
IBRANCE.....	259
IBTROZI.....	337
icatibant acetate.....	157
ICLUSIG.....	276
IDHIFA.....	112
imatinib mesylate oral tablet 100 mg, 400 mg	159
IMBRUVICA ORAL CAPSULE 140 MG, 70 MG	156
IMBRUVICA ORAL SUSPENSION....	156
IMBRUVICA ORAL TABLET	156
IMDELLTRA	339
IMJUDO	370
IMKELDI.....	160
IMPAVIDO.....	229
INCONTROL ULTICARE PEN NEEDLES 31G X 6 MM.....	173, 183, 184
INCONTROL ULTICARE PEN NEEDLES 31G X 8 MM.....	173, 183, 184
INCONTROL ULTICARE PEN NEEDLES 32G X 4 MM.....	173, 183, 184
INCRELEX.....	222
infliximab.....	163, 164
INGREZZA ORAL CAPSULE.....	391
INGREZZA ORAL CAPSULE SPRINKLE	391
INGREZZA ORAL CAPSULE THERAPY PACK.....	391
INLYTA ORAL TABLET 1 MG, 5 MG..	40
INQOVI	84

INREBIC.....	130
INSULIN SYRINGE 29G X 1/2 ...	173, 183, 184
INSULIN SYRINGE 30G X 5/16 .	173, 183, 184
INSULIN SYRINGE 31G X 5/16 .	173, 183, 184
INSULIN SYRINGE/NEEDLE 27G X 1/2	173, 183, 184
INSULIN SYRINGE/NEEDLE 28G X 1/2	174, 183, 184
INSULIN SYRINGE-NEEDLE U-100 27G X 1/2.....	173, 183, 184
INSULIN SYRINGE-NEEDLE U-100 28G X 1/2.....	173, 183, 184
INSULIN SYRINGE-NEEDLE U-100 30G X 5/16.....	173, 183, 184
INSULIN SYRINGE-NEEDLE U-100 31G X 1/4.....	173, 183, 184
INSULIN SYRINGE-NEEDLE U-100 31G X 5/16.....	173, 183, 184
INSUPEN PEN NEEDLES 31G X 5 MM	174, 183, 184
INSUPEN PEN NEEDLES 31G X 8 MM	174, 183, 184
INSUPEN PEN NEEDLES 32G X 4 MM	174, 183, 184
INSUPEN PEN NEEDLES 33G X 4 MM	174, 183, 184
INSUPEN SENSITIVE 32G X 6 MM ..	174, 183, 184
INSUPEN SENSITIVE 32G X 8 MM ..	174, 183, 184
INSUPEN ULTRAFIN 29G X 12MM..	174, 183, 184
INSUPEN ULTRAFIN 30G X 8 MM...	174, 183, 184
INSUPEN ULTRAFIN 31G X 6 MM...	174, 183, 184
INSUPEN ULTRAFIN 31G X 8 MM...	174, 183, 184
INSUPEN32G EXTR3ME 32G X 6 MM	174, 183, 184

ITOVEBI ORAL TABLET 3 MG, 9 MG	162
IWILFIN	101
J	
J & J GAUZE PAD 2	174, 183, 184
JAKAFI	306
javygtor oral tablet	307
JAYPIRCA ORAL TABLET 100 MG, 50 MG	274
JEMPERLI	94
JYNARQUE ORAL TABLET	361
K	
KALYDECO	191
KENDALL HYDROPHILIC FOAM DRESS PAD 2	174, 183, 184
KENDALL HYDROPHILIC FOAM PLUS PAD 2	174, 183, 184
KERENDIA	136
KESIMPTA	249
KEYTRUDA INTRAVENOUS SOLUTION	266
KIMMTRAK	341
KINERET SUBCUTANEOUS SOLUTION PREFILLED SYRINGE	22, 23
KINRAY INSULIN SYRINGE 29G X 1/2	174, 183, 184
KISQALI (200 MG DOSE)	289
KISQALI (400 MG DOSE)	289
KISQALI (600 MG DOSE)	289
KISQALI FEMARA (200 MG DOSE) ..	290
KISQALI FEMARA (400 MG DOSE) ..	290
KISQALI FEMARA (600 MG DOSE) ..	290
KMART VALU INSULIN SYRINGE 29G U-100 1 ML	174, 183, 184
KMART VALU INSULIN SYRINGE 30G U-100 0.3 ML	174, 183, 184
KMART VALU INSULIN SYRINGE 30G U-100 1 ML	174, 183, 184
KOSELUGO ORAL CAPSULE 10 MG, 25 MG	313
KRAZATI	10
KROGER INSULIN SYRINGE 30G X 5/16	174, 183, 184

KROGER PEN NEEDLES 29G X 12MM	174, 183, 184
KROGER PEN NEEDLES 31G X 6 MM	174, 183, 184
KYNMOBI	28
KYNMOBI TITRATION KIT	28
L	
LANREOTIDE ACETATE	194
lapatinib ditosylate	195
LAZCLUZE ORAL TABLET 240 MG, 80 MG	197
LEADER INSULIN SYRINGE 28G X 1/2	174, 183, 184
LEADER UNIFINE PENTIPS 31G X 5 MM	174, 183, 184
LEADER UNIFINE PENTIPS 32G X 4 MM	174, 183, 184
LEADER UNIFINE PENTIPS PLUS 31G X 5 MM	174, 183, 184
LEADER UNIFINE PENTIPS PLUS 31G X 8 MM	174, 183, 184
lenalidomide	199
LENVIMA (10 MG DAILY DOSE)	200
LENVIMA (12 MG DAILY DOSE)	200
LENVIMA (14 MG DAILY DOSE)	200
LENVIMA (18 MG DAILY DOSE)	200
LENVIMA (20 MG DAILY DOSE)	200
LENVIMA (24 MG DAILY DOSE)	200
LENVIMA (4 MG DAILY DOSE)	200
LENVIMA (8 MG DAILY DOSE)	200
LEUPROLIDE ACETATE (3 MONTH)	203
leuprolide acetate injection	202
l-glutamine oral packet	209
lidocaine external ointment 5 %	210
lidocaine external patch 5 %	211
lidocaine-prilocaine external cream	212
lidocan	211
LITETOUCH INSULIN SYRINGE 28G X 1/2	174, 183, 184
LITETOUCH INSULIN SYRINGE 29G X 1/2	174, 183, 184
LITETOUCH INSULIN SYRINGE 30G X 5/16	174, 183, 184

LITETOUCH INSULIN SYRINGE 31G X 5/16 174, 183, 184
LITETOUCH PEN NEEDLES 29G X 12.7MM 174, 183, 184
LITETOUCH PEN NEEDLES 31G X 5 MM 174, 183, 184
LITETOUCH PEN NEEDLES 31G X 6 MM 174, 183, 184
LITETOUCH PEN NEEDLES 31G X 8 MM 174, 183, 184
LITETOUCH PEN NEEDLES 32G X 4 MM 174, 183, 184
LIVTENCITY 220
LONSURF ORAL TABLET 15-6.14 MG, 20-8.19 MG..... 372
LOQTORZI..... 363
LORBRENA ORAL TABLET 100 MG, 25 MG 215
LUMAKRAS ORAL TABLET 120 MG, 240 MG, 320 MG..... 331
LUNSUMIO 233
LUPRON DEPOT (1-MONTH) 205, 206
LUPRON DEPOT (3-MONTH) 205, 206
LUPRON DEPOT (4-MONTH) 205, 206
LUPRON DEPOT (6-MONTH) 205, 206
LUPRON DEPOT-PED (3-MONTH) ... 207, 208
LUPRON DEPOT-PED (6-MONTH) ... 207, 208
LUTRATE DEPOT 203
LYNOZYFIC INTRAVENOUS SOLUTION 200 MG/10ML, 5 MG/2.5ML 213
LYNPARZA ORAL TABLET 250
LYTGOBI (12 MG DAILY DOSE) 141
LYTGOBI (16 MG DAILY DOSE) 141
LYTGOBI (20 MG DAILY DOSE) 141
M
MAGELLAN INSULIN SAFETY SYR 29G X 1/2..... 174, 183, 184
MAGELLAN INSULIN SAFETY SYR 30G X 5/16..... 174, 183, 184
MARGENZA 219
MAVENCLAD (10 TABS) 69

MAVENCLAD (4 TABS) 69
MAVENCLAD (5 TABS) 69
MAVENCLAD (6 TABS) 69
MAVENCLAD (7 TABS) 69
MAVENCLAD (8 TABS) 69
MAVENCLAD (9 TABS) 69
MAXICOMFORT II PEN NEEDLE 31G X 6 MM 175, 183, 184
MAXI-COMFORT INSULIN SYRINGE 28G X 1/2..... 175, 183, 184
MAXI-COMFORT SAFETY PEN NEEDLE 29G X 5MM 175, 183, 184
MAXI-COMFORT SAFETY PEN NEEDLE 29G X 8MM 175, 183, 184
MAXICOMFORT SYR 27G X 1/2 175, 183, 184
MAYZENT ORAL TABLET 0.25 MG, 1 MG, 2 MG..... 316
MAYZENT STARTER PACK..... 316
MEDIC INSULIN SYRINGE 30G X 5/16 175, 183, 184
MEDICINE SHOPPE PEN NEEDLES 29G X 12MM..... 175, 183, 184
MEDICINE SHOPPE PEN NEEDLES 31G X 8 MM..... 175, 183, 184
MEDPURA ALCOHOL PADS 70 % EXTERNAL 175, 183, 184
MEIJER ALCOHOL SWABS PAD 70 % 175, 183, 184
MEIJER PEN NEEDLES 29G X 12MM 175, 183, 184
MEIJER PEN NEEDLES 31G X 6 MM 175, 183, 184
MEIJER PEN NEEDLES 31G X 8 MM 175, 183, 184
MEKINIST ORAL SOLUTION RECONSTITUTED 365
MEKINIST ORAL TABLET 0.5 MG, 2 MG 366
MEKTOVI 53
metyrosine..... 226
MICRODOT PEN NEEDLE 31G X 6 MM 175, 183, 184

Formulary ID: 26376
Effective: 01/01/2026
H9306_26_DRS_037_OE_C

MICRODOT PEN NEEDLE 32G X 4 MM	175, 183, 184
MICRODOT PEN NEEDLE 33G X 4 MM	175, 183, 184
mifepristone oral tablet 300 mg	228
MIPLYFFA	31
MIRASORB SPONGES 2	175, 183, 184
MM PEN NEEDLES 31G X 6 MM	175, 183, 184
MM PEN NEEDLES 32G X 4 MM	175, 183, 184
modafinil oral tablet 100 mg, 200 mg	234
MONOJECT INSULIN SYRINGE 25G X 5/8	175, 183, 184
MONOJECT INSULIN SYRINGE 27G X 1/2	175, 183, 184
MONOJECT INSULIN SYRINGE 28G X 1/2	175, 183, 184
MONOJECT INSULIN SYRINGE 29G X 1/2	175, 183, 184
MONOJECT INSULIN SYRINGE 30G X 5/16	175, 183, 184
MONOJECT INSULIN SYRINGE 31G X 5/16	175, 183, 184
MONOJECT INSULIN SYRINGE U-100 1 ML	175, 183, 184
MONOJECT ULTRA COMFORT SYRINGE 28G X 1/2	175, 183, 184
MONOJECT ULTRA COMFORT SYRINGE 29G X 1/2	175, 183, 184
MONOJECT ULTRA COMFORT SYRINGE 30G X 5/16	175, 183, 184
morphine sulfate (concentrate) oral solution 100 mg/5ml	155
MOUNJARO SUBCUTANEOUS SOLUTION AUTO-INJECTOR	151
MS INSULIN SYRINGE 30G X 5/16	175, 183, 184
MS INSULIN SYRINGE 31G X 5/16	175, 183, 184
N	
NERLYNX	236
NIKTIMVO	39
NINLARO	193

nitisinone	244
NIVESTYM	135
NORDITROPIN FLEXPRO SUBCUTANEOUS SOLUTION PEN-INJECTOR	323, 324
NOVOFINE AUTOCOVER 30G X 8 MM	176, 183, 184
NOVOFINE PEN NEEDLE 32G X 6 MM	176, 183, 184
NOVOFINE PLUS PEN NEEDLE 32G X 4 MM	176, 183, 184
NOVOTWIST PEN NEEDLE 32G X 5 MM	176, 183, 184
NUBEQA	80, 81
NUCALA SUBCUTANEOUS SOLUTION AUTO-INJECTOR	224, 225
NUCALA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML, 40 MG/0.4ML	224, 225
NUCALA SUBCUTANEOUS SOLUTION RECONSTITUTED	224, 225
NUPLAZID ORAL CAPSULE	271
NUPLAZID ORAL TABLET 10 MG	271
NURTEC	294, 295
NYVEPRIA	262
O	
ODOMZO	327
OFEV	239, 240
OGIVRI	367
OGSIVEO ORAL TABLET 100 MG, 150 MG, 50 MG	243
OJEMDA ORAL SUSPENSION RECONSTITUTED	364
OJEMDA ORAL TABLET	364
OJJAARA	232
ONAPGO	26, 27
ONUREG	41
OPDIVO	245
OPDIVO QVANTIG	246
OPDUALAG	247
OPSUMIT	218
ORENCIA CLICKJECT	4, 5
ORENCIA INTRAVENOUS	2, 3

Formulary ID: 26376
Effective: 01/01/2026
H9306_26_DRS_037_OE_C

ORENCIA SUBCUTANEOUS SOLUTION
 PREFILLED SYRINGE 4, 5
 ORFADIN ORAL SUSPENSION..... 244
 ORGOVYX..... 283
 ORLISSA ORAL TABLET 150 MG, 200
 MG 103, 104
 ORKAMBI ORAL TABLET 217
 ORSERDU ORAL TABLET 345 MG, 86
 MG 102
 OSENVET 87
 OTEZLA 29, 30
 oxandrolone oral 257
 OZEMPIC (0.25 OR 0.5 MG/DOSE)..... 150
 OZEMPIC (1 MG/DOSE)
 SUBCUTANEOUS SOLUTION PEN-
 INJECTOR 4 MG/3ML 150
 OZEMPIC (2 MG/DOSE) 150
P
 pazopanib hcl 261
 PC UNIFINE PENTIPS 31G X 5 MM.. 176,
 183, 184
 PC UNIFINE PENTIPS 31G X 6 MM.. 176,
 183, 184
 PC UNIFINE PENTIPS 31G X 8 MM.. 176,
 183, 184
 PEGASYS SUBCUTANEOUS SOLUTION
 180 MCG/ML 264
 PEGASYS SUBCUTANEOUS SOLUTION
 PREFILLED SYRINGE 264
 PEMAZYRE 267
 PEN NEEDLE/5-BEVEL TIP 32G X 4 MM
 176, 183, 184
 PEN NEEDLES 30G X 5 MM (OTC)... 176,
 183, 184
 PEN NEEDLES 30G X 8 MM 176, 183, 184
 PEN NEEDLES 32G X 5 MM 176, 183, 184
 penicillamine oral tablet..... 268, 269
 PENTIPS 29G X 12MM (RX) 176, 183, 184
 PENTIPS 31G X 5 MM (RX). 176, 183, 184
 PENTIPS 31G X 8 MM (RX). 176, 183, 184
 PENTIPS 32G X 4 MM (RX). 176, 183, 184
 PENTIPS GENERIC PEN NEEDLES 29G
 X 12MM..... 176, 183, 184

PENTIPS GENERIC PEN NEEDLES 31G
 X 6 MM..... 176, 183, 184
 PENTIPS GENERIC PEN NEEDLES 32G
 X 6 MM..... 176, 183, 184
 PIP PEN NEEDLES 31G X 5MM 31G X 5
 MM 176, 183, 184
 PIP PEN NEEDLES 32G X 4MM 32G X 4
 MM 176, 183, 184
 PIQRAY (200 MG DAILY DOSE)..... 19
 PIQRAY (250 MG DAILY DOSE)..... 19
 PIQRAY (300 MG DAILY DOSE)..... 19
 pirfenidone oral capsule..... 272, 273
 pirfenidone oral tablet 267 mg, 534 mg, 801
 mg 272, 273
 PLEGRIDY STARTER PACK
 SUBCUTANEOUS SOLUTION AUTO-
 INJECTOR..... 187
 PLEGRIDY STARTER PACK
 SUBCUTANEOUS SOLUTION
 PREFILLED SYRINGE 187
 PLEGRIDY SUBCUTANEOUS
 SOLUTION AUTO-INJECTOR 187
 PLEGRIDY SUBCUTANEOUS
 SOLUTION PREFILLED SYRINGE 187
 POMALYST 275
 posaconazole oral tablet delayed release 277
 PRECISION SURE-DOSE SYRINGE 30G
 X 5/16..... 176, 183, 184
 PREFERRED PLUS INSULIN SYRINGE
 28G X 1/2..... 176, 183, 184
 PREFERRED PLUS INSULIN SYRINGE
 29G X 1/2..... 176, 183, 184
 PREFERRED PLUS INSULIN SYRINGE
 30G X 5/16..... 176, 183, 184
 PREFERRED PLUS UNIFINE PENTIPS
 29G X 12MM..... 176, 183, 184
 PREVENT DROPSAFE PEN NEEDLES
 31G X 6 MM..... 176, 183, 184
 PREVENT DROPSAFE PEN NEEDLES
 31G X 8 MM..... 176, 183, 184
 PREVENT SAFETY PEN NEEDLES 31G
 X 6 MM..... 176, 183, 184
 PREVENT SAFETY PEN NEEDLES 31G
 X 8 MM..... 176, 183, 184

Formulary ID: 26376
 Effective: 01/01/2026
 H9306_26_DRS_037_OE_C

PREVYMIS ORAL TABLET	201
PRO COMFORT ALCOHOL PAD 70 %	176, 183, 184
PRO COMFORT INSULIN SYRINGE 30G X 1/2.....	176, 183, 184
PRO COMFORT INSULIN SYRINGE 30G X 5/16.....	176, 183, 184
PRO COMFORT INSULIN SYRINGE 31G X 5/16.....	176, 183, 184
PRO COMFORT PEN NEEDLES 31G X 8 MM	176, 183, 184
PRO COMFORT PEN NEEDLES 32G X 4 MM	176, 183, 184
PRO COMFORT PEN NEEDLES 32G X 5 MM	176, 183, 184
PRO COMFORT PEN NEEDLES 32G X 6 MM	176, 183, 184
PRODIGY INSULIN SYRINGE 28G X 1/2	176, 183, 184
PRODIGY INSULIN SYRINGE 31G X 5/16	176, 183, 184
PURE COMFORT ALCOHOL PREP PAD	176, 183, 184
PURE COMFORT PEN NEEDLE 32G X 4 MM	176, 183, 184
PURE COMFORT PEN NEEDLE 32G X 5 MM	176, 183, 184
PURE COMFORT PEN NEEDLE 32G X 6 MM	176, 183, 184
PURE COMFORT PEN NEEDLE 32G X 8 MM	176, 183, 184
PURE COMFORT SAFETY PEN NEEDLE 31G X 5 MM.....	177, 183, 184
PURE COMFORT SAFETY PEN NEEDLE 31G X 6 MM.....	177, 183, 184
PURE COMFORT SAFETY PEN NEEDLE 32G X 4 MM.....	177, 183, 184
PX SHORTLENGTH PEN NEEDLES 31G X 8 MM.....	177, 183, 184
pyrimethamine oral	279
Q	
QC ALCOHOL.....	177, 183, 184
QC ALCOHOL SWABS PAD 70 %.....	177, 183, 184

QC BORDER ISLAND GAUZE PAD 2	177, 183, 184
QINLOCK.....	298
QUICK TOUCH INSULIN PEN NEEDLE 29G X 12.7MM.....	177, 183, 184
QUICK TOUCH INSULIN PEN NEEDLE 31G X 4 MM.....	177, 183, 184
QUICK TOUCH INSULIN PEN NEEDLE 31G X 5 MM.....	177, 183, 184
QUICK TOUCH INSULIN PEN NEEDLE 31G X 6 MM.....	177, 183, 184
QUICK TOUCH INSULIN PEN NEEDLE 31G X 8 MM.....	177, 183, 184
QUICK TOUCH INSULIN PEN NEEDLE 32G X 4 MM.....	177, 183, 184
QUICK TOUCH INSULIN PEN NEEDLE 32G X 5 MM.....	177, 183, 184
QUICK TOUCH INSULIN PEN NEEDLE 32G X 6 MM.....	177, 183, 184
QUICK TOUCH INSULIN PEN NEEDLE 32G X 8 MM.....	177, 183, 184
QUICK TOUCH INSULIN PEN NEEDLE 33G X 4 MM.....	177, 183, 184
QUICK TOUCH INSULIN PEN NEEDLE 33G X 5 MM.....	177, 183, 184
QUICK TOUCH INSULIN PEN NEEDLE 33G X 6 MM.....	177, 183, 184
QUICK TOUCH INSULIN PEN NEEDLE 33G X 8 MM.....	177, 183, 184
quinine sulfate oral.....	280
QULIPTA	35
R	
RA ALCOHOL SWABS PAD 70 %.....	177, 183, 184
RA INSULIN SYRINGE 29G X 1/2.....	177, 183, 184
RA INSULIN SYRINGE 30G X 5/16...	177, 183, 184
ra isopropyl alcohol wipes	177, 183, 184
RA PEN NEEDLES 31G X 5 MM	177, 183, 184
RA PEN NEEDLES 31G X 8 MM	177, 183, 184
RA STERILE PAD 2	177, 183, 184

RALDESY	369	REZDIFFRA.....	285, 286
RAYA SURE PEN NEEDLE 29G X 12MM		REZLIDHIA	251
.....	177, 183, 184	REZUROCK.....	45
RAYA SURE PEN NEEDLE 31G X 4 MM		RINVOQ.....	376, 378
.....	177, 183, 184	RINVOQ LQ.....	376, 378
RAYA SURE PEN NEEDLE 31G X 5 MM		RITUXAN HYCELA	301
.....	177, 183, 184	ROMVIMZA	399
RAYA SURE PEN NEEDLE 31G X 6 MM		ROZLYTREK ORAL CAPSULE 100 MG,	
.....	177, 183, 184	200 MG	114
REALITY INSULIN SYRINGE 28G X 1/2		ROZLYTREK ORAL PACKET	115
.....	177, 183, 184	RUBRACA	305
REALITY INSULIN SYRINGE 29G X 1/2		RYBELSUS	150
.....	177, 183, 184	RYBELSUS (FORMULATION R2).....	150
REALITY SWABS PAD.....	177, 183, 184	RYBREVANT	21
RELION ALCOHOL SWABS PAD.....	177,	RYDAPT.....	227
183, 184		RYTELO.....	161
RELI-ON INSULIN SYRINGE 29G 0.3		S	
ML.....	177, 183, 184	SAFETY INSULIN SYRINGES 29G X 1/2	
RELI-ON INSULIN SYRINGE 29G X 1/2			177, 178, 183, 184
.....	177, 183, 184	SAFETY INSULIN SYRINGES 30G X 1/2	
RELION INSULIN SYRINGE 31G X 15/64			178, 183, 184
.....	177, 183, 184	SAFETY INSULIN SYRINGES 30G X	
RELION MINI PEN NEEDLES 31G X 6		5/16	178, 183, 184
MM	177, 183, 184	SAFETY PEN NEEDLES 30G X 5 MM	
RELION PEN NEEDLES 29G X 12MM			178, 183, 184
.....	177, 183, 184	SAFETY PEN NEEDLES 30G X 8 MM	
RELION PEN NEEDLES 31G X 6 MM	177,		178, 183, 184
183, 184		sapropterin dihydrochloride oral tablet...	307
RELION PEN NEEDLES 31G X 8 MM	177,	SB ALCOHOL PREP PAD 70 %..	178, 183,
183, 184		184	
RESTORE CONTACT LAYER PAD 2	177,	SB INSULIN SYRINGE 29G X 1/2	178,
183, 184		183, 184	
RETACRIT INJECTION SOLUTION		SB INSULIN SYRINGE 30G X 5/16 ...	178,
10000 UNIT/ML, 10000		183, 184	
UNIT/ML(1ML), 2000 UNIT/ML, 20000		SB INSULIN SYRINGE 31G X 5/16 ...	178,
UNIT/ML, 3000 UNIT/ML, 4000		183, 184	
UNIT/ML, 40000 UNIT/ML	119, 120	SCEMBLIX ORAL TABLET 100 MG, 20	
RETEVMO ORAL CAPSULE 40 MG, 80		MG, 40 MG.....	32
MG	312	SECURESAFE INSULIN SYRINGE 29G	
RETEVMO ORAL TABLET 120 MG, 160		X 1/2.....	178, 183, 184
MG, 40 MG, 80 MG	312	SECURESAFE SAFETY PEN NEEDLES	
REVCovi.....	105	30G X 8 MM.....	178, 183, 184
REVUFORJ ORAL TABLET 110 MG, 160		SELARSDI	383, 384, 385, 386
MG, 25 MG.....	288		

Formulary ID: 26376

Effective: 01/01/2026

H9306_26_DRS_037_OE_C

SEROSTIM SUBCUTANEOUS
SOLUTION RECONSTITUTED 4 MG,
5 MG, 6 MG..... 325, 326
SIGNIFOR 260
sildenafil citrate oral tablet 20 mg .. 314, 315
SIRTURO 43
SKYRIZI..... 299, 300
SKYRIZI PEN 299, 300
SM ALCOHOL PREP PAD ... 178, 183, 184
SM ALCOHOL PREP PAD 6-70 %
EXTERNAL 178, 183, 184
SM ALCOHOL PREP PAD 70 %. 178, 183,
184
SM GAUZE PAD 2 178, 183, 184
sodium oxybate 318, 319
SOMATULINE DEPOT
SUBCUTANEOUS SOLUTION 60
MG/0.2ML, 90 MG/0.3ML 194
SOMAVERT..... 265
sorafenib tosylate 328
SPRAVATO (56 MG DOSE)..... 124
SPRAVATO (84 MG DOSE)..... 124
STELARA INTRAVENOUS 379, 380
STELARA SUBCUTANEOUS
SOLUTION 45 MG/0.5ML 381, 382
STELARA SUBCUTANEOUS
SOLUTION PREFILLED SYRINGE 381,
382
STERILE GAUZE PAD 2 178, 183, 184
STERILE PAD 2..... 178, 183, 184
STIVARGA 282
STRENSIQ 33, 34
sunitinib malate 333
SURE COMFORT ALCOHOL PREP PAD
70 % 178, 183, 184
SURE COMFORT INSULIN SYRINGE
28G X 1/2..... 178, 183, 184
SURE COMFORT INSULIN SYRINGE
29G X 1/2..... 178, 183, 184
SURE COMFORT INSULIN SYRINGE
30G X 1/2..... 178, 183, 184
SURE COMFORT INSULIN SYRINGE
30G X 5/16..... 178, 183, 184

SURE COMFORT INSULIN SYRINGE
31G X 1/4..... 178, 183, 184
SURE COMFORT INSULIN SYRINGE
31G X 5/16..... 178, 183, 184
SURE COMFORT PEN NEEDLES 29G X
12.7MM 178, 183, 184
SURE COMFORT PEN NEEDLES 30G X
8 MM 178, 183, 184
SURE COMFORT PEN NEEDLES 31G X
5 MM 178, 183, 184
SURE COMFORT PEN NEEDLES 31G X
6 MM 178, 183, 184
SURE COMFORT PEN NEEDLES 31G X
8 MM 178, 183, 184
SURE COMFORT PEN NEEDLES 32G X
4 MM (OTC)..... 178, 183, 184
SURE COMFORT PEN NEEDLES 32G X
4 MM (RX)..... 178, 183, 184
SURE COMFORT PEN NEEDLES 32G X
6 MM 178, 183, 184
SURE-JECT INSULIN SYRINGE 31G X
5/16 178, 179, 183, 184
SURE-PREP ALCOHOL PREP PAD 70 %
..... 179, 183, 184
SURGICAL GAUZE SPONGE PAD 2 179,
183, 184
SYMPAZAN..... 70
SYNRIBO 252
T
TABRECTA 63
tadalafil oral tablet 2.5 mg, 5 mg 335
TAFINLAR ORAL CAPSULE 76
TAFINLAR ORAL TABLET SOLUBLE 77
TAGRISSO 256
TALVEY..... 338
TALZENNA 336
TASIGNA ORAL CAPSULE 150 MG, 200
MG, 50 MG..... 237
TAVNEOS 36
TAZVERIK..... 340
TECHLITE INSULIN SYRINGE 29G X
1/2 179, 183, 184
TECHLITE PEN NEEDLES 32G X 4 MM
..... 179, 183, 184

Formulary ID: 26376
Effective: 01/01/2026
H9306_26_DRS_037_OE_C

TECVAYLI.....	342	TREMFYA ONE-PRESS	153, 154
TEPMETKO	345	TREMFYA PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 200 MG/2ML	153, 154
TERIPARATIDE SUBCUTANEOUS SOLUTION PEN-INJECTOR 560 MCG/2.24ML	346	TREMFYA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE	153, 154
TERUMO INSULIN SYRINGE 29G X 1/2	179, 183, 184	tretinoin external cream	362
testosterone cypionate intramuscular solution 100 mg/ml, 200 mg/ml, 200 mg/ml (1 ml)	348	trientine hcl oral capsule 250 mg.....	371
testosterone enanthate intramuscular solution.....	349	TRIKAFTA ORAL TABLET THERAPY PACK.....	106
testosterone gel 1.62 % transdermal	347	TRIKAFTA ORAL THERAPY PACK..	106
testosterone transdermal gel 12.5 mg/act (1%), 20.25 mg/act (1.62%), 25 mg/2.5gm (1%), 50 mg/5gm (1%).....	347	TRUE COMFORT ALCOHOL PREP PADS PAD 70 %.....	179, 183, 184
tetrabenazine	350	TRUE COMFORT INSULIN SYRINGE 30G X 1/2.....	179, 183, 184
TEVIMBRA.....	352	TRUE COMFORT INSULIN SYRINGE 30G X 5/16.....	179, 183, 184
THALOMID ORAL CAPSULE 100 MG, 150 MG, 200 MG, 50 MG	351	TRUE COMFORT INSULIN SYRINGE 31G X 5/16.....	179, 183, 184
THERAGAUZE PAD 2.....	179, 183, 184	TRUE COMFORT INSULIN SYRINGE 32G X 5/16.....	179, 183, 184
TIBSOVO	192	TRUE COMFORT PEN NEEDLES 31G X 5 MM	179, 183, 184
TIVDAK	353	TRUE COMFORT PEN NEEDLES 31G X 6 MM	179, 183, 184
TODAYS HEALTH PEN NEEDLES 29G X 12MM.....	179, 183, 184	TRUE COMFORT PEN NEEDLES 32G X 4 MM	179, 183, 184
TODAYS HEALTH SHORT PEN NEEDLE 31G X 8 MM	179, 183, 184	TRUE COMFORT PRO ALCOHOL PREP PAD 70 %	179, 183, 184
tolvaptan oral tablet therapy pack	361	TRUE COMFORT PRO INSULIN SYR 30G X 1/2.....	179, 183, 184
TOPCARE CLICKFINE PEN NEEDLES 31G X 6 MM.....	179, 183, 184	TRUE COMFORT PRO INSULIN SYR 30G X 5/16.....	179, 183, 184
TOPCARE CLICKFINE PEN NEEDLES 31G X 8 MM.....	179, 183, 184	TRUE COMFORT PRO INSULIN SYR 31G X 5/16.....	179, 183, 184
TOPCARE ULTRA COMFORT INS SYR 29G X 1/2.....	179, 183, 184	TRUE COMFORT PRO INSULIN SYR 32G X 5/16.....	179, 183, 184
TOPCARE ULTRA COMFORT INS SYR 30G X 5/16.....	179, 183, 184	TRUE COMFORT PRO PEN NEEDLES 31G X 5 MM.....	179, 183, 184
TOPCARE ULTRA COMFORT INS SYR 31G X 5/16.....	179, 183, 184	TRUE COMFORT PRO PEN NEEDLES 31G X 6 MM.....	179, 183, 184
torpenz oral tablet 10 mg, 2.5 mg, 5 mg, 7.5 mg	127	TRUE COMFORT PRO PEN NEEDLES 31G X 8 MM.....	179, 183, 184
TRELSTAR MIXJECT	373		
TREMFYA CROHNS INDUCTION	153, 154		
TREMFYA INTRAVENOUS	153, 154		

Formulary ID: 26376
Effective: 01/01/2026
H9306_26_DRS_037_OE_C

TRUE COMFORT PRO PEN NEEDLES 32G X 4 MM.....	179, 183, 184	TRUQAP TABLET THERAPY PACK 160 MG ORAL	62
TRUE COMFORT PRO PEN NEEDLES 32G X 5 MM.....	180, 183, 184	TRUXIMA.....	302, 303
TRUE COMFORT PRO PEN NEEDLES 32G X 6 MM.....	180, 183, 184	TUKYSA ORAL TABLET 150 MG, 50 MG	374
TRUE COMFORT PRO PEN NEEDLES 33G X 4 MM.....	180, 183, 184	TURALIO	270
TRUE COMFORT PRO PEN NEEDLES 33G X 5 MM.....	180, 183, 184	TYENNE.....	355, 356, 357, 358
TRUE COMFORT PRO PEN NEEDLES 33G X 6 MM.....	180, 183, 184	TYMLOS	1
TRUEPLUS 5-BEVEL PEN NEEDLES 29G X 12.7MM.....	180, 183, 184	U	
TRUEPLUS 5-BEVEL PEN NEEDLES 31G X 5 MM.....	180, 183, 184	UBRELVY	375
TRUEPLUS 5-BEVEL PEN NEEDLES 31G X 6 MM.....	180, 183, 184	UDENYCA ONBODY	263
TRUEPLUS 5-BEVEL PEN NEEDLES 31G X 8 MM.....	180, 183, 184	ULTICARE INSULIN SAFETY SYR 29G X 1/2.....	180, 183, 184
TRUEPLUS 5-BEVEL PEN NEEDLES 32G X 4 MM.....	180, 183, 184	ULTICARE INSULIN SYRINGE 28G X 1/2	180, 183, 184
TRUEPLUS INSULIN SYRINGE 28G X 1/2	180, 183, 184	ULTICARE INSULIN SYRINGE 29G X 1/2	180, 183, 184
TRUEPLUS INSULIN SYRINGE 29G X 1/2	180, 183, 184	ULTICARE INSULIN SYRINGE 30G X 1/2	180, 183, 184
TRUEPLUS INSULIN SYRINGE 30G X 5/16	180, 183, 184	ULTICARE INSULIN SYRINGE 30G X 5/16	180, 183, 184
TRUEPLUS INSULIN SYRINGE 31G X 5/16	180, 183, 184	ULTICARE INSULIN SYRINGE 31G X 1/4	180, 183, 184
TRUEPLUS PEN NEEDLES 29G X 12MM	180, 183, 184	ULTICARE INSULIN SYRINGE 31G X 5/16	180, 181, 183, 184
TRUEPLUS PEN NEEDLES 31G X 5 MM	180, 183, 184	ULTICARE MICRO PEN NEEDLES 32G X 4 MM.....	181, 183, 184
TRUEPLUS PEN NEEDLES 31G X 6 MM	180, 183, 184	ULTICARE MINI PEN NEEDLES 30G X 5 MM	181, 183, 184
TRUEPLUS PEN NEEDLES 31G X 8 MM	180, 183, 184	ULTICARE MINI PEN NEEDLES 31G X 6 MM	181, 183, 184
TRUEPLUS PEN NEEDLES 32G X 4 MM	180, 183, 184	ULTICARE MINI PEN NEEDLES 32G X 6 MM	181, 183, 184
TRULICITY SUBCUTANEOUS SOLUTION AUTO-INJECTOR	149	ULTICARE PEN NEEDLES 29G X 12.7MM (OTC).....	181, 183, 184
TRUQAP ORAL TABLET	62	ULTICARE PEN NEEDLES 29G X 12.7MM (RX)	181, 183, 184
		ULTICARE PEN NEEDLES 31G X 5 MM	181, 183, 184
		ULTICARE SHORT PEN NEEDLES 30G X 8 MM.....	181, 183, 184
		ULTICARE SHORT PEN NEEDLES 31G X 8 MM (OTC).....	181, 183, 184

Formulary ID: 26376
Effective: 01/01/2026
H9306_26_DRS_037_OE_C

ULTICARE SHORT PEN NEEDLES 31G
X 8 MM (RX) 181, 183, 184
ULTIGUARD SAFEPAK PEN NEEDLE
29G X 12.7MM..... 181, 183, 184
ULTIGUARD SAFEPAK PEN NEEDLE
31G X 5 MM..... 181, 183, 184
ULTIGUARD SAFEPAK PEN NEEDLE
31G X 6 MM..... 181, 183, 184
ULTIGUARD SAFEPAK PEN NEEDLE
31G X 8 MM..... 181, 183, 184
ULTIGUARD SAFEPAK PEN NEEDLE
32G X 4 MM..... 181, 183, 184
ULTIGUARD SAFEPAK PEN NEEDLE
32G X 6 MM..... 181, 183, 184
ULTIGUARD SAFEPAK SYR/NEEDLE
30G X 1/2..... 181, 183, 184
ULTIGUARD SAFEPAK SYR/NEEDLE
31G X 5/16..... 181, 183, 184
ULTILET ALCOHOL SWABS PAD ... 181,
183, 184
ULTILET PEN NEEDLE 29G X 12.7MM
..... 181, 183, 184
ULTILET PEN NEEDLE 31G X 5 MM 181,
183, 184
ULTILET PEN NEEDLE 31G X 8 MM 181,
183, 184
ULTILET PEN NEEDLE 32G X 4 MM 181,
183, 184
ULTRA COMFORT INSULIN SYRINGE
30G X 5/16..... 181, 183, 184
ULTRA FLO INSULIN PEN NEEDLES
29G X 12MM..... 181, 183, 184
ULTRA FLO INSULIN PEN NEEDLES
31G X 8 MM..... 181, 183, 184
ULTRA FLO INSULIN PEN NEEDLES
32G X 4 MM..... 181, 183, 184
ULTRA FLO INSULIN PEN NEEDLES
33G X 4 MM..... 181, 183, 184
ULTRA FLO INSULIN SYR 1/2 UNIT
30G X 1/2..... 181, 183, 184
ULTRA FLO INSULIN SYR 1/2 UNIT
30G X 5/16..... 181, 183, 184
ULTRA FLO INSULIN SYR 1/2 UNIT
31G X 5/16..... 181, 183, 184

ULTRA FLO INSULIN SYRINGE 29G X
1/2 181, 183, 184
ULTRA FLO INSULIN SYRINGE 30G X
1/2 181, 183, 184
ULTRA FLO INSULIN SYRINGE 30G X
5/16 181, 182, 183, 184
ULTRA FLO INSULIN SYRINGE 31G X
5/16 182, 183, 184
ULTRA THIN PEN NEEDLES 32G X 4
MM 182, 183, 184
ULTRACARE INSULIN SYRINGE 30G X
1/2 182, 183, 184
ULTRACARE INSULIN SYRINGE 30G X
5/16 182, 183, 184
ULTRACARE INSULIN SYRINGE 31G X
5/16 182, 183, 184
ULTRACARE PEN NEEDLES 31G X 5
MM 182, 183, 184
ULTRACARE PEN NEEDLES 31G X 6
MM 182, 183, 184
ULTRACARE PEN NEEDLES 31G X 8
MM 182, 183, 184
ULTRACARE PEN NEEDLES 32G X 4
MM 182, 183, 184
ULTRACARE PEN NEEDLES 32G X 5
MM 182, 183, 184
ULTRACARE PEN NEEDLES 32G X 6
MM 182, 183, 184
ULTRACARE PEN NEEDLES 33G X 4
MM 182, 183, 184
ULTRA-COMFORT INSULIN SYRINGE
29G X 1/2..... 182, 183, 184
ULTRA-THIN II INS SYR SHORT 30G X
5/16 182, 183, 184
ULTRA-THIN II INS SYR SHORT 31G X
5/16 182, 183, 184
ULTRA-THIN II INSULIN SYRINGE 29G
X 1/2..... 182, 183, 184
ULTRA-THIN II MINI PEN NEEDLE 31G
X 5 MM..... 182, 183, 184
ULTRA-THIN II PEN NEEDLE SHORT
31G X 8 MM..... 182, 183, 184
ULTRA-THIN II PEN NEEDLES 29G X
12.7MM 182, 183, 184

Formulary ID: 26376
Effective: 01/01/2026
H9306_26_DRS_037_OE_C

UNIFINE OTC PEN NEEDLES 31G X 5
MM 182, 183, 184
UNIFINE OTC PEN NEEDLES 32G X 4
MM 182, 183, 184
UNIFINE PEN NEEDLES 32G X 4 MM
..... 182, 183, 184
UNIFINE PENTIPS 29G X 12MM 182, 183,
184
UNIFINE PENTIPS 31G X 6 MM 182, 183,
184
UNIFINE PENTIPS 31G X 8 MM 182, 183,
184
UNIFINE PENTIPS 32G X 4 MM 182, 183,
184
UNIFINE PENTIPS PLUS 29G X 12MM
..... 182, 183, 184
UNIFINE PENTIPS PLUS 31G X 6 MM
..... 182, 183, 184
UNIFINE PENTIPS PLUS 32G X 4 MM
..... 182, 183, 184
UNIFINE PROTECT PEN NEEDLE 30G X
5 MM 182, 183, 184
UNIFINE PROTECT PEN NEEDLE 30G X
8 MM 182, 183, 184
UNIFINE PROTECT PEN NEEDLE 32G X
4 MM 182, 183, 184
UNIFINE SAFECONTROL PEN NEEDLE
30G X 5 MM..... 182, 183, 184
UNIFINE SAFECONTROL PEN NEEDLE
30G X 8 MM..... 182, 183, 184
UNIFINE SAFECONTROL PEN NEEDLE
31G X 5 MM..... 183, 184
UNIFINE SAFECONTROL PEN NEEDLE
31G X 6 MM..... 183, 184
UNIFINE SAFECONTROL PEN NEEDLE
31G X 8 MM..... 183, 184
UNIFINE SAFECONTROL PEN NEEDLE
32G X 4 MM..... 183, 184
UNIFINE ULTRA PEN NEEDLE 31G X 5
MM 183, 184
UNIFINE ULTRA PEN NEEDLE 31G X 6
MM 183, 184
UNIFINE ULTRA PEN NEEDLE 31G X 8
MM 183, 184

UNIFINE ULTRA PEN NEEDLE 32G X 4
MM 183, 184
UPTRAVI ORAL TABLET 1000 MCG,
1200 MCG, 1400 MCG, 1600 MCG, 200
MCG, 400 MCG, 600 MCG, 800 MCG
..... 310
UPTRAVI TITRATION 310
ustekinumab subcutaneous..... 381, 382
V
VALCHLOR..... 223
VALUE HEALTH INSULIN SYRINGE
29G X 1/2..... 183, 184
VANFLYTA 281
VANISHPOINT INSULIN SYRINGE 29G
X 5/16..... 183, 184
VANISHPOINT INSULIN SYRINGE 30G
X 3/16..... 183, 184
VANISHPOINT INSULIN SYRINGE 30G
X 5/16..... 183, 184
VENCLEXTA ORAL TABLET 10 MG,
100 MG, 50 MG..... 395
VENCLEXTA STARTING PACK 395
VEOZAH 133, 134
VERIFINE INSULIN PEN NEEDLE 29G
X 12MM..... 183, 184
VERIFINE INSULIN PEN NEEDLE 31G
X 5 MM..... 183, 184
VERIFINE INSULIN PEN NEEDLE 32G
X 6 MM..... 183, 184
VERIFINE INSULIN SYRINGE 29G X 1/2
..... 183, 184
VERIFINE INSULIN SYRINGE 31G X
5/16 183, 184
VERIFINE PLUS PEN NEEDLE 31G X 5
MM 183, 184
VERIFINE PLUS PEN NEEDLE 31G X 8
MM 183, 184
VERIFINE PLUS PEN NEEDLE 32G X 4
MM 183, 184
VERQUVO 396, 397
VERZENIO..... 6
vigabatrin 398
vigadrone..... 398
vigpoder 398

Formulary ID: 26376
Effective: 01/01/2026
H9306_26_DRS_037_OE_C

VITRAKVI ORAL CAPSULE 100 MG, 25 MG	196
VITRAKVI ORAL SOLUTION	196
VIVIMUSTA	47
VIZIMPRO	78
VONJO	258
VOQUEZNA	401
VORANIGO	402
voriconazole oral suspension reconstituted	403
VOSEVI.....	321, 322
VOWST	129
VP INSULIN SYRINGE 29G X 1/2	183, 184
VUMERITY	93
VYALEV SUBCUTANEOUS SOLUTION 12-240 MG/ML.....	138, 139
VYLOY.....	407
W	
WEBCOL ALCOHOL PREP LARGE PAD 70 %	183, 184
WEGMANS UNIFINE PENTIPS PLUS 31G X 8 MM.....	183, 184
WELIREG.....	46
WINREVAIR.....	329, 330
X	
XALKORI ORAL CAPSULE.....	74
XALKORI ORAL CAPSULE SPRINKLE 150 MG, 20 MG, 50 MG	75
XDEMVEY	216
XELJANZ	359, 360
XELJANZ XR	359, 360
XERMELO	344
XGEVA.....	88
XIFAXAN ORAL TABLET 200 MG, 550 MG	291
XOLAIR	253, 254, 255
XOSPATA	146
XPOVIO (100 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 50 MG	311

XPOVIO (40 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 10 MG, 40 MG	311
XPOVIO (40 MG TWICE WEEKLY) ORAL TABLET THERAPY PACK 40 MG	311
XPOVIO (60 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 60 MG..	311
XPOVIO (60 MG TWICE WEEKLY)...	311
XPOVIO (80 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 40 MG..	311
XPOVIO (80 MG TWICE WEEKLY)...	311
XTANDI ORAL CAPSULE.....	116, 117
XTANDI ORAL TABLET 40 MG, 80 MG	116, 117
Y	
YERVOY	189
YESINTEK.....	387, 388, 389, 390
YONSA.....	8
YUFLYMA (1 PEN).....	13, 14
YUFLYMA (2 SYRINGE).....	13, 14
YUFLYMA-CD/UC/HS STARTER ..	13, 14
Z	
ZEJULA ORAL CAPSULE	241
ZEJULA ORAL TABLET.....	241
ZELBORAF	394
ZEVRX STERILE ALCOHOL PREP PAD PAD 70 %	183, 184
ZIIHERA.....	404
ZIRABEV	51
ZOLADEX.....	152
ZTALMY	144
ZTLIDO	211
ZURZUVAE ORAL CAPSULE 20 MG, 25 MG, 30 MG.....	408
ZYDELIG	158
ZYKADIA ORAL TABLET	65
ZYNLONTA.....	214
ZYNYZ.....	287