

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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

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: 26375

Last Updated: 04/01/2026

Effective: 04/01/2026

H9306_26_DRS_039_OE_C

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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

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: 26375

Last Updated: 04/01/2026

Effective: 04/01/2026

H9306_26_DRS_039_OE_C

PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

Formulary ID: 26375
Last Updated: 04/01/2026
Effective: 04/01/2026
H9306_26_DRS_039_OE_C

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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

ABIRATERONE

Products Affected

- *abiraterone acetate*
- *abirtega*

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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

ABIRATERONE SUBMICRONIZED

Products Affected

- ABIRATERONE ACETATE MICRONIZED
- 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: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_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	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

ACORAMIDIS

Products Affected

- ATTRUBY

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	CARDIOMYOPATHY OF WILD TYPE OR VARIANT TRANSTHYRETIN-MEDIATED AMYLOIDOSIS (ATTR-CM): INITIAL: 1) NEW YORK HEART ASSOCIATION (NYHA) CLASS I, II, OR III HEART FAILURE, AND 2) DIAGNOSIS CONFIRMED BY (A) BONE SCAN (SCINTIGRAPHY) STRONGLY POSITIVE FOR MYOCARDIAL UPTAKE OF TC-99M-PYP, OR (B) BIOPSY OF TISSUE OF AFFECTED ORGAN(S) (CARDIAC AND POSSIBLY NON-CARDIAC SITES) TO CONFIRM AMYLOID PRESENCE AND CHEMICAL TYPING TO CONFIRM PRESENCE OF TRANSTHYRETIN (TTR) PROTEIN.
Age Restrictions	
Prescriber Restrictions	ATTR-CM: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A CARDIOLOGIST, ATTR SPECIALIST, OR MEDICAL GENETICIST.
Coverage Duration	INITIAL/RENEWAL: 12 MONTHS.
Other Criteria	ATTR-CM: INITIAL/RENEWAL: NO CONCURRENT USE WITH OTHER ATTR-CM TTR STABILIZERS (E.G., TAFAMIDIS).
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Formulary ID: 26375

Last Updated: 04/01/2026

Effective: 04/01/2026

H9306_26_DRS_039_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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

ADALIMUMAB

Products Affected

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

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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

PA Criteria	Criteria Details
Other Criteria	<p>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, 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.</p>
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

ADALIMUMAB-AATY

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: PLAQUE PSORIASIS (PSO): PSORIASIS COVERING 3 PERCENT OR MORE OF BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, FACE, SCALP, OR GENITAL AREA.
Age Restrictions	
Prescriber Restrictions	INITIAL: RA, PJIA, ANKYLOSING SPONDYLITIS (AS): PRESCRIBED BY OR IN CONSULTATION WITH RHEUMATOLOGIST. PSORIATIC ARTHRITIS (PSA): PRESCRIBED BY OR IN CONSULTATION WITH DERMATOLOGIST OR RHEUMATOLOGIST. PSO, HIDRADENITIS SUPPURATIVA (HS): PRESCRIBED BY OR IN CONSULTATION WITH DERMATOLOGIST. CROHNS DISEASE (CD), ULCERATIVE COLITIS (UC): PRESCRIBED BY OR IN CONSULTATION WITH GASTROENTEROLOGIST. UVEITIS: PRESCRIBED BY OR IN CONSULTATION WITH OPHTHALMOLOGIST.
Coverage Duration	INITIAL: RA, PSO, PJIA, AS, PSA, CD, UC, UVEITIS: 6 MONTHS, HS: 12 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	INITIAL: RHEUMATOID ARTHRITIS (RA): TRIAL OF OR CONTRAINDICATION TO 3 MONTHS OF TREATMENT WITH ONE 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: 26375

Last Updated: 04/01/2026

Effective: 04/01/2026

H9306_26_DRS_039_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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

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

Formulary ID: 26375

Last Updated: 04/01/2026

Effective: 04/01/2026

H9306_26_DRS_039_OE_C

PA Criteria	Criteria Details
	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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

AFATINIB

Products Affected

- GILOTRIF

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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

ALECTINIB

Products Affected

- ALECENSA

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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

ALPELISIB-PIQRAY

Products Affected

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

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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

AMIKACIN LIPOSOMAL INH

Products Affected

- ARIKAYCE

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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

AMIVANTAMAB-HYALURONIDASE-LPUJ

Products Affected

- RYBREVANT FASPRO

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: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

ANAKINRA

Products Affected

- KINERET SUBCUTANEOUS SOLUTION PREFILLED SYRINGE

PA Criteria	Criteria Details
Exclusion Criteria	CORONAVIRUS DISEASE 2019 (COVID-19) IN HOSPITALIZED ADULTS.
Required Medical Information	INITIAL: CRYOPYRIN-ASSOCIATED PERIODIC SYNDROMES (CAPS): 1) ONE OF THE FOLLOWING: (A) GENETIC TEST FOR GAIN-OF-FUNCTION MUTATIONS IN THE NLRP3 GENE, OR (B) HAS INFLAMMATORY MARKERS (I.E., ELEVATED CRP, ESR, SERUM AMYLOID A PROTEIN (SAA) OR S100 PROTEINS), AND 2) TWO OF THE FOLLOWING: URTICARIAL-LIKE RASH (NEUTROPHILIC DERMATITIS), COLD-TRIGGERED EPISODES, SENSORINEURAL HEARING LOSS, MUSCULOSKELETAL SYMPTOMS, CHRONIC ASEPTIC MENINGITIS, SKELETAL ABNORMALITIES. DEFICIENCY OF INTERLEUKIN-1 RECEPTOR ANTAGONIST (DIRA): 1) ONE OF THE FOLLOWING: (A) GENETIC TEST FOR GAIN-OF-FUNCTION MUTATIONS IN THE IL1RN GENE, OR (B) HAS INFLAMMATORY MARKERS (I.E., ELEVATED CRP, ESR), AND 2) ONE OF THE FOLLOWING: PUSTULAR PSORIASIS-LIKE RASHES, OSTEOMYELITIS, ABSENCE OF BACTERIAL OSTEOMYELITIS, ONYCHOMADESIS.
Age Restrictions	
Prescriber Restrictions	INITIAL: RHEUMATOID ARTHRITIS (RA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST.
Coverage Duration	RA: INITIAL: 6 MONTHS, RENEWAL: 12 MONTHS. CAPS, DIRA: LIFETIME.
Other Criteria	INITIAL: 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.

Formulary ID: 26375

Last Updated: 04/01/2026

Effective: 04/01/2026

H9306_26_DRS_039_OE_C

PA Criteria	Criteria Details
	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
Prerequisite Therapy Required	Yes

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

APALUTAMIDE

Products Affected

- ERLEADA ORAL TABLET 240 MG, 60 MG

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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

APOMORPHINE - ONAPGO

Products Affected

- ONAPGO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	PARKINSONS DISEASE (PD): INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST.
Coverage Duration	INITIAL/RENEWAL: 12 MONTHS.
Other Criteria	PD: RENEWAL: IMPROVEMENT IN MOTOR SYMPTOMS WHILE ON THERAPY.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

APOMORPHINE - SL

Products Affected

- KYNMOBI
- KYNMOBI TITRATION KIT

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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

APREMILAST

Products Affected

- OTEZLA
- OTEZLA XR
- OTEZLA/OTEZLA XR INITIATION PK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: MILD PLAQUE PSORIASIS (PSO): 1) PSORIASIS COVERING LESS THAN 3 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

Formulary ID: 26375

Last Updated: 04/01/2026

Effective: 04/01/2026

H9306_26_DRS_039_OE_C

PA Criteria	Criteria Details
	DISEASE: 1) HAS ORAL ULCERS OR A HISTORY OF RECURRENT ORAL ULCERS BASED ON CLINICAL SYMPTOMS, AND 2) TRIAL OF OR CONTRAINDICATION TO ONE OR MORE CONSERVATIVE TREATMENTS (E.G., COLCHICINE, TOPICAL CORTICOSTEROID, ORAL CORTICOSTEROID). 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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

ARIMOCLOMOL

Products Affected

- MIPLYFFA

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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

ASCIMINIB

Products Affected

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

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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

ASFOTASE ALFA

Products Affected

- STRENSIQ

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

Formulary ID: 26375

Last Updated: 04/01/2026

Effective: 04/01/2026

H9306_26_DRS_039_OE_C

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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

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/RENEWAL: NO CONCURRENT USE WITH OTHER CGRP INHIBITORS FOR MIGRAINE PREVENTION. RENEWAL: REDUCTION IN MIGRAINE OR HEADACHE FREQUENCY, MIGRAINE SEVERITY, OR MIGRAINE DURATION WITH THERAPY.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

AVAPRITINIB

Products Affected

- AYVAKIT

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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

AXATILIMAB-CSFR

Products Affected

- NIKTIMVO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

AXITINIB

Products Affected

- INLYTA ORAL TABLET 1 MG, 5 MG

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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

AZACITIDINE

Products Affected

- ONUREG

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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

AZTREONAM INHALED

Products Affected

- CAYSTON

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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

BEDAQUILINE

Products Affected

- SIRTURO

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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_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: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_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: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

BENDAMUSTINE

Products Affected

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

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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

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

Formulary ID: 26375

Last Updated: 04/01/2026

Effective: 04/01/2026

H9306_26_DRS_039_OE_C

PA Criteria	Criteria Details
	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-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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

BEVACIZUMAB-BVZR

Products Affected

- ZIRABEV

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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

BEXAROTENE

Products Affected

- *bexarotene*

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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

BINIMETINIB

Products Affected

- MEKTOVI

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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

BORTEZOMIB

Products Affected

- BORTEZOMIB INJECTION SOLUTION RECONSTITUTED 1 MG, 2.5 MG
- *bortezomib injection solution reconstituted 3.5 mg*
- 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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

BOSENTAN

Products Affected

- *bosentan oral tablet*

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: 26375

Last Updated: 04/01/2026

Effective: 04/01/2026

H9306_26_DRS_039_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	Yes

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

BRIGATINIB

Products Affected

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

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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

C1 ESTERASE INHIBITOR-HAEGARDA

Products Affected

- HAEGARDA SUBCUTANEOUS SOLUTION RECONSTITUTED 2000 UNIT, 3000 UNIT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	HEREDITARY ANGIOEDEMA (HAE): INITIAL: 1) TYPE III HAE, OR 2) TYPE I OR II HAE 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/RENEWAL: 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: 26375
Last Updated: 04/01/2026
Effective: 04/01/2026
H9306_26_DRS_039_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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

CABOZANTINIB TABLET

Products Affected

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

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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

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: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

CAPMATINIB

Products Affected

- TABRECTA

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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

CARGLUMIC ACID

Products Affected

- *carglumic acid oral tablet soluble*

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

Formulary ID: 26375

Last Updated: 04/01/2026

Effective: 04/01/2026

H9306_26_DRS_039_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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

CERTOLIZUMAB PEGOL

Products Affected

- CIMZIA (1 SYRINGE) PREFILLED SYRINGE KIT 200 MG/ML SUBCUTANEOUS
- CIMZIA (2 SYRINGE)
- CIMZIA SUBCUTANEOUS KIT 2 X 200 MG
- CIMZIA-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. 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

Formulary ID: 26375

Last Updated: 04/01/2026

Effective: 04/01/2026

H9306_26_DRS_039_OE_C

PA Criteria	Criteria Details
	<p>OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: COSENTYX, 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.</p>
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

CETUXIMAB

Products Affected

- ERBITUX

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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_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: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

CLOBAZAM-SYMPAZAN

Products Affected

- SYMPAZAN

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	INITIAL: LENNOX-GASTAUT SYNDROME (LGS): THERAPY IS PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST.
Coverage Duration	INITIAL/RENEWAL: 12 MONTHS
Other Criteria	LGS: INITIAL: CONTRAINDICATION TO OR UNABLE TO SWALLOW CLOBAZAM TABLETS OR SUSPENSION.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

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: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

Formulary ID: 26375
Last Updated: 04/01/2026
Effective: 04/01/2026
H9306_26_DRS_039_OE_C

CRIZOTINIB CAPSULE

Products Affected

- XALKORI ORAL CAPSULE

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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

CRIZOTINIB PELLETS

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	NON-SMALL CELL LUNG CANCER (NSCLC), ANAPLASTIC LARGE CELL LYMPHOMA (ALCL), INFLAMMATORY MYOFIBROBLASTIC TUMOR (IMT): UNABLE TO SWALLOW CAPSULES.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

DABRAFENIB CAPSULES

Products Affected

- TAFINLAR ORAL CAPSULE

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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

DABRAFENIB SUSPENSION

Products Affected

- TAFINLAR ORAL TABLET SOLUBLE

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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

DACOMITINIB

Products Affected

- VIZIMPRO

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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_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/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: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

DAROLUTAMIDE

Products Affected

- NUBEQA

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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

DASATINIB

Products Affected

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

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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

DECITABINE/CEDAZURIDINE

Products Affected

- INQOVI

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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

DEFERASIROX

Products Affected

- *deferasirox granules*
- *deferasirox oral tablet*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: CHRONIC IRON OVERLOAD DUE TO BLOOD TRANSFUSIONS: SERUM FERRITIN LEVEL CONSISTENTLY ABOVE 1000 MCG/L. 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. 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.
Off Label Uses	

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

DEUTETRABENAZINE

Products Affected

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

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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_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 1.5% TOPICAL DROPS.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

DIMETHYL FUMARATE

Products Affected

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

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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

DIROXIMEL FUMARATE

Products Affected

- VUMERITY

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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

DORDAVIPRONE

Products Affected

- MODEYSO

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: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

DOSTARLIMAB-GXLY

Products Affected

- JEMPERLI

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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

DRONABINOL CAPSULE

Products Affected

- *dronabinol*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 MONTHS
Other Criteria	NAUSEA AND VOMITING ASSOCIATED WITH CANCER CHEMOTHERAPY: TRIAL OF OR CONTRAINDICATION TO ONE ANTIEMETIC THERAPY.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_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: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_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.
Age Restrictions	
Prescriber Restrictions	INITIAL: AD, PN, CSU: PRESCRIBED OR IN CONSULTATION WITH A 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. COPD: PRESCRIBED OR IN CONSULTATION WITH PULMONOLOGIST. RENEWAL: CSU: PRESCRIBED OR IN CONSULTATION WITH ALLERGIST, DERMATOLOGIST, OR IMMUNOLOGIST.
Coverage Duration	BP: 12 MO. AD/CRSWNP/EOE/PN/CSU: INITIAL/RENEWAL: 6 MO/12 MO. ASTHMA/COPD: INITIAL/RENEWAL: 12 MO.
Other Criteria	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

Formulary ID: 26375

Last Updated: 04/01/2026

Effective: 04/01/2026

H9306_26_DRS_039_OE_C

PA Criteria	Criteria Details
	<p>CORTICOSTEROID BURST LASTING AT LEAST 3 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): 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. PRURIGO NODULARIS (PN): CHRONIC PRURITUS (ITCH MORE THAN 6 WEEKS), MULTIPLE PRURIGINOUS LESIONS, AND HISTORY OR SIGN OF A PROLONGED SCRATCHING BEHAVIOR. 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. INITIAL/RENEWAL : ALL INDICATIONS EXCEPT BULLOUS PEMPHIGOID (BP): NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR THE SAME INDICATION. 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-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</p>

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

PA Criteria	Criteria Details
	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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

EFLORNITHINE

Products Affected

- IWILFIN

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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

ELACESTRANT

Products Affected

- ORSERDU ORAL TABLET 345 MG, 86 MG

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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_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: 26375

Last Updated: 04/01/2026

Effective: 04/01/2026

H9306_26_DRS_039_OE_C

PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

Formulary ID: 26375
Last Updated: 04/01/2026
Effective: 04/01/2026
H9306_26_DRS_039_OE_C

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: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_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: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_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.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Formulary ID: 26375
Last Updated: 04/01/2026
Effective: 04/01/2026
H9306_26_DRS_039_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 $30 \times 10^9/L$, OR 2) PLATELET COUNT IS LESS THAN $50 \times 10^9/L$ 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). RENEWAL: ITP: 1) IMPROVEMENT IN PLATELET COUNT FROM BASELINE OR REDUCTION IN BLEEDING EVENTS, AND 2) NO CONCURRENT USE WITH OTHER TPO-RAS.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Formulary ID: 26375

Last Updated: 04/01/2026

Effective: 04/01/2026

H9306_26_DRS_039_OE_C

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 $30 \times 10^9/L$, OR 2) PLATELET COUNT OF LESS THAN $50 \times 10^9/L$ 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). ALL INDICATIONS: ELTROMBOPAG ORAL SUSPENSION PACKETS: TRIAL OF A FORMULARY VERSION OF ELTROMBOPAG 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.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

Formulary ID: 26375
Last Updated: 04/01/2026
Effective: 04/01/2026
H9306_26_DRS_039_OE_C

ENASIDENIB

Products Affected

- IDHIFA

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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

ENCORAFENIB

Products Affected

- BRAFTOVI ORAL CAPSULE 75 MG

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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

ENSARTINIB

Products Affected

- ENSACOVE ORAL CAPSULE 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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

ENTRECTINIB CAPSULES

Products Affected

- ROZLYTREK ORAL CAPSULE 100 MG, 200 MG

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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

ENTRECTINIB PELLETS

Products Affected

- ROZLYTREK ORAL PACKET

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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_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	12 MONTHS
Other Criteria	NON-METASTATIC CASTRATION-SENSITIVE PROSTATE CANCER (NMCSPC): HIGH RISK FOR METASTASIS (I.E. PSA DOUBLING TIME OF 9 MONTHS OR LESS). METASTATIC CASTRATION-RESISTANT PROSTATE CANCER (MCRPC), NON-METASTATIC CRPC (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.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Formulary ID: 26375

Last Updated: 04/01/2026

Effective: 04/01/2026

H9306_26_DRS_039_OE_C

EPCORITAMAB-BYSP

Products Affected

- EPKINLY

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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_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 13G/DL OR LESS. RENEWAL: 1) CKD IN ADULTS NOT ON DIALYSIS: (A) HEMOGLOBIN LEVEL IS LESS THAN 10G/DL, OR (B) HEMOGLOBIN LEVEL HAS REACHED 10G/DL AND THE DOSE IS BEING OR HAS BEEN REDUCED/INTERRUPTED TO DECREASE THE NEED FOR BLOOD TRANSFUSIONS. 2) CKD IN PEDIATRIC PATIENTS: (A) HEMOGLOBIN LEVEL IS LESS THAN 10G/DL, OR (B) HEMOGLOBIN LEVEL HAS APPROACHED OR EXCEEDS 12G/DL AND THE DOSE IS BEING OR HAS BEEN REDUCED/INTERRUPTED TO DECREASE THE NEED FOR BLOOD TRANSFUSIONS. 3) ANEMIA RELATED TO ZIDOVUDINE: HEMOGLOBIN LEVEL BETWEEN 10G/DL AND 12G/DL. 4) CANCER CHEMOTHERAPY: (A) HEMOGLOBIN LEVEL IS LESS THAN 10 G/DL, OR (B) HEMOGLOBIN LEVEL DOES NOT EXCEED A LEVEL NEEDED TO AVOID RBC TRANSFUSION.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	ANEMIA FROM CHEMO/CKD WITHOUT DIALYSIS/ZIDOVUDINE: INITIAL/RENEWAL: 12 MONTHS. SURGERY: 1 MONTH.
Other Criteria	RENEWAL: CKD: NOT RECEIVING DIALYSIS TREATMENT. THIS DRUG MAY BE EITHER BUNDLED WITH AND COVERED UNDER END STAGE RENAL DISEASE DIALYSIS RELATED SERVICES OR

Formulary ID: 26375
Last Updated: 04/01/2026
Effective: 04/01/2026
H9306_26_DRS_039_OE_C

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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

ERDAFITINIB

Products Affected

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

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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

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/RENEWAL: NO CONCURRENT USE WITH OTHER CGRP INHIBITORS FOR MIGRAINE PREVENTION. RENEWAL: REDUCTION IN MIGRAINE OR HEADACHE FREQUENCY, MIGRAINE SEVERITY, OR MIGRAINE DURATION WITH THERAPY.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_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: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_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 OR OTHER REMS-CERTIFIED PROVIDER.
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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

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

Formulary ID: 26375

Last Updated: 04/01/2026

Effective: 04/01/2026

H9306_26_DRS_039_OE_C

PA Criteria	Criteria Details
	<p>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: ALL INDICATIONS: CONTINUES TO BENEFIT FROM THE MEDICATION.</p>
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

EVEROLIMUS-AFINITOR DISPERZ

Products Affected

- *everolimus oral tablet soluble*

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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

FECAL MICROBIOTA CAPSULE

Products Affected

- VOWST

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	30 DAYS
Other Criteria	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: 26375

Last Updated: 04/01/2026

Effective: 04/01/2026

H9306_26_DRS_039_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: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_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	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: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_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: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_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) TRIAL OF OR CONTRAINDICATION TO HORMONAL THERAPY (E.G., ESTRADIOL TRANSDERMAL PATCH, ORAL CONJUGATED ESTROGENS), 2) LABORATORY TESTING TO ESTABLISH BASELINE HEPATIC FUNCTION AND CONTINUED MONITORING OF THESE VALUES IN ACCORDANCE WITH THE FDA CURRENT LABEL RECOMMENDATION, AND 3) 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 (E.G., ALT, AST, TOTAL BILIRUBIN).
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 26375

Last Updated: 04/01/2026

Effective: 04/01/2026

H9306_26_DRS_039_OE_C

PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

Formulary ID: 26375
Last Updated: 04/01/2026
Effective: 04/01/2026
H9306_26_DRS_039_OE_C

FILGRASTIM-AAFI

Products Affected

- NIVESTYM

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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

FINERENONE

Products Affected

- KERENDIA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: HEART FAILURE (HF): 1) NEW YORK HEART ASSOCIATION (NYHA) CLASS II-IV, AND 2) LEFT VENTRICULAR EJECTION FRACTION OF AT LEAST 40 PERCENT NOT DUE TO AN UNDERLYING CAUSE (E.G., INFILTRATIVE CARDIOMYOPATHY, HYPERTROPHIC CARDIOMYOPATHY, VALVULAR DISEASE, PERICARDIAL DISEASE, HIGH-OUTPUT HEART FAILURE).
Age Restrictions	
Prescriber Restrictions	INITIAL: HF: PRESCRIBED BY OR IN CONSULTATION WITH A CARDIOLOGIST.
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, HAS A CONTRAINDICATION, OR INTOLERANCE TO AN ANGIOTENSIN CONVERTING ENZYME INHIBITOR (ACE-I) OR AN ANGIOTENSIN RECEPTOR BLOCKER (ARB). HF: INITIAL/RENEWAL: NO CONCURRENT USE WITH ANOTHER MINERALOCORTICOID (ALDOSTERONE) RECEPTOR ANTAGONIST.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

Formulary ID: 26375
Last Updated: 04/01/2026
Effective: 04/01/2026
H9306_26_DRS_039_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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

FOSCARBIDOPA-FOSLEVODOPA

Products Affected

- VYALEV SUBCUTANEOUS SOLUTION 12-240 MG/ML

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	PARKINSONS DISEASE (PD): INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST.
Coverage Duration	INITIAL: 12 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	PD: INITIAL: ONE OF THE FOLLOWING: 1) UNABLE TO SWALLOW EXTENDED-RELEASE (ER) TABLETS OR ADMINISTER ER CAPSULES VIA A FEEDING TUBE, OR 2) 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
Prerequisite Therapy Required	Yes

Formulary ID: 26375
Last Updated: 04/01/2026
Effective: 04/01/2026
H9306_26_DRS_039_OE_C

FRUQUINTINIB

Products Affected

- FRUZAQLA ORAL CAPSULE 1 MG, 5 MG

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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

GALCANEZUMAB-GNLM

Products Affected

- EMGALITY
- EMGALITY (300 MG DOSE)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL: MIGRAINE PREVENTION: 6 MOS. EPISODIC CLUSTER HEADACHE: 3 MOS. RENEWAL (ALL): 12 MOS.
Other Criteria	MIGRAINE PREVENTION: INITIAL/RENEWAL: NO CONCURRENT USE WITH OTHER CGRP INHIBITORS FOR MIGRAINE PREVENTION. RENEWAL: REDUCTION IN MIGRAINE OR HEADACHE FREQUENCY, MIGRAINE SEVERITY, OR MIGRAINE DURATION WITH THERAPY. EPISODIC CLUSTER HEADACHE: RENEWAL: IMPROVEMENT IN EPISODIC CLUSTER HEADACHE FREQUENCY AS COMPARED TO BASELINE.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

GANAXOLONE

Products Affected

- ZTALMY

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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

GEFITINIB

Products Affected

- *gefitinib*

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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

GEPHIRONE

Products Affected

- EXXUA
- EXXUA TITRATION PACK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL/RENEWAL: 12 MONTHS.
Other Criteria	MAJOR DEPRESSIVE DISORDER: INITIAL: TRIAL OF OR CONTRAINDICATION TO THE PREFERRED AGENTS: TRINTELLIX AND ONE GENERIC ANTIDEPRESSANT. INITIAL/RENEWAL: NO CONCURRENT USE WITH ANOTHER 5-HT1A RECEPTOR AGONIST (E.G., BUSPIRONE). RENEWAL: RESPONSE TO OR REMISSION OF DEPRESSIVE SYMPTOMS WITH THERAPY.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

GILTERITINIB

Products Affected

- XOSPATA

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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

GLASDEGIB

Products Affected

- DAURISMO ORAL TABLET 100 MG, 25 MG

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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

GLATIRAMER

Products Affected

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

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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

GLP1-DULAGLUTIDE

Products Affected

- TRULICITY SUBCUTANEOUS SOLUTION AUTO-INJECTOR

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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_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: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_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: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_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.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Formulary ID: 26375
Last Updated: 04/01/2026
Effective: 04/01/2026
H9306_26_DRS_039_OE_C

GUSELKUMAB

Products Affected

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

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

Formulary ID: 26375
Last Updated: 04/01/2026
Effective: 04/01/2026
H9306_26_DRS_039_OE_C

PA Criteria	Criteria Details
	SAME INDICATION. RENEWAL: PSO, PSA: CONTINUES TO BENEFIT FROM THE MEDICATION.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

HIGH CONCENTRATION ORAL OPIOID SOLUTIONS

Products Affected

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

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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

Formulary ID: 26375
Last Updated: 04/01/2026
Effective: 04/01/2026
H9306_26_DRS_039_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: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

ICATIBANT

Products Affected

- *icatibant acetate*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	HEREDITARY ANGIOEDEMA (HAE): INITIAL: 1) TYPE III HAE, OR 2) TYPE I OR II HAE 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.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

IDELALISIB

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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

IMATINIB

Products Affected

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

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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_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: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

IMLUNESTRANT

Products Affected

- INLURIYO

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: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

INAVOLISIB

Products Affected

- ITOVEBI ORAL TABLET 3 MG, 9 MG

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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

INFLIXIMAB

Products Affected

- infliximab*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: PLAQUE PSORIASIS (PSO): PSORIASIS COVERING 3 PERCENT OR MORE OF BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, GENITAL AREA, SCALP, OR FACE.
Age Restrictions	
Prescriber Restrictions	INITIAL: RHEUMATOID ARTHRITIS (RA), ANKYLOSING SPONDYLITIS (AS): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST. PSORIATIC ARTHRITIS (PSA): PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST OR RHEUMATOLOGIST. PSO: PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST. CROHNS DISEASE (CD), ULCERATIVE COLITIS (UC): PRESCRIBED BY OR IN CONSULTATION WITH A GASTROENTEROLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	INITIAL: RA: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: 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

Formulary ID: 26375

Last Updated: 04/01/2026

Effective: 04/01/2026

H9306_26_DRS_039_OE_C

PA Criteria	Criteria Details
	<p>TO SEVERE CD: TRIAL OF OR CONTRAINDICATION TO TWO OF 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.</p>
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

INSULIN SUPPLIES PAYMENT DETERMINATION

Products Affected

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

Formulary ID: 26375

Last Updated: 04/01/2026

Effective: 04/01/2026

H9306_26_DRS_039_OE_C

- AUM MINI INSULIN PEN NEEDLE 33G X 5 MM
- AUM MINI INSULIN PEN NEEDLE 33G X 6 MM
- AUM PEN NEEDLE 32G X 4 MM
- AUM PEN NEEDLE 32G X 5 MM
- AUM PEN NEEDLE 32G X 6 MM
- AUM PEN NEEDLE 33G X 4 MM
- AUM PEN NEEDLE 33G X 5 MM
- AUM PEN NEEDLE 33G X 6 MM
- AUM READYGARD DUO PEN NEEDLE 32G X 4 MM
- AUM SAFETY PEN NEEDLE 31G X 4 MM
- BD AUTOSHIELD 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 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 30G X 5/16" 0.5 ML
- BD SAFETYGLIDE INSULIN SYRINGE 31G X 15/64" 0.3 ML
- BD SAFETYGLIDE INSULIN SYRINGE 31G X 15/64" 0.5 ML
- BD SAFETYGLIDE INSULIN SYRINGE 31G X 15/64" 1 ML
- BD SAFETYGLIDE INSULIN SYRINGE 31G X 5/16" 0.3 ML
- BD SAFETYGLIDE SYRINGE/NEEDLE 27G X 5/8" 1 ML
- BD SWAB SINGLE USE REGULAR PAD
- BD SWABS SINGLE USE BUTTERFLY PAD
- BD VEO INSULIN SYR U/F 1/2UNIT 31G X 15/64" 0.3 ML

Formulary ID: 26375

Last Updated: 04/01/2026

Effective: 04/01/2026

H9306_26_DRS_039_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 27G X 1/2" 1 ML
- COMFORT EZ INSULIN SYRINGE 28G X 1/2" 0.5 ML

Formulary ID: 26375

Last Updated: 04/01/2026

Effective: 04/01/2026

H9306_26_DRS_039_OE_C

- COMFORT EZ INSULIN SYRINGE 28G X 1/2" 1 ML
- COMFORT EZ INSULIN SYRINGE 29G X 1/2" 0.3 ML
- COMFORT EZ INSULIN SYRINGE 29G X 1/2" 0.5 ML
- COMFORT EZ INSULIN SYRINGE 29G X 1/2" 1 ML
- COMFORT EZ INSULIN SYRINGE 30G X 1/2" 0.3 ML
- COMFORT EZ INSULIN SYRINGE 30G X 1/2" 0.5 ML
- COMFORT EZ INSULIN SYRINGE 30G X 1/2" 1 ML
- COMFORT EZ INSULIN SYRINGE 30G X 5/16" 0.3 ML
- COMFORT EZ INSULIN SYRINGE 30G X 5/16" 0.5 ML
- COMFORT EZ INSULIN SYRINGE 30G X 5/16" 1 ML
- COMFORT EZ INSULIN SYRINGE 31G X 15/64" 0.3 ML
- COMFORT EZ INSULIN SYRINGE 31G X 15/64" 0.5 ML
- COMFORT EZ INSULIN SYRINGE 31G X 15/64" 1 ML
- COMFORT EZ INSULIN SYRINGE 31G X 5/16" 0.3 ML
- COMFORT EZ INSULIN SYRINGE 31G X 5/16" 0.5 ML
- COMFORT EZ INSULIN SYRINGE 31G X 5/16" 1 ML
- COMFORT EZ PEN NEEDLES 31G X 5 MM
- COMFORT EZ PEN NEEDLES 31G X 6 MM
- COMFORT EZ PEN NEEDLES 31G X 8 MM
- COMFORT EZ PEN NEEDLES 32G X 4 MM
- COMFORT EZ PEN NEEDLES 32G X 5 MM
- COMFORT EZ PEN NEEDLES 32G X 6 MM
- COMFORT EZ PEN NEEDLES 32G X 8 MM
- COMFORT EZ 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 ALCOHOL PREPS PAD 70 %
- CURITY ALL PURPOSE SPONGES PAD 2"X2"
- CURITY GAUZE PAD 2"X2"
- CURITY GAUZE SPONGE PAD 2"X2"
- CURITY SPONGES PAD 2"X2"
- CVS GAUZE PAD 2"X2"
- CVS GAUZE STERILE PAD 2"X2"
- CVS ISOPROPYL ALCOHOL WIPES

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

- DERMACEA GAUZE SPONGE PAD 2"X2"
- DERMACEA IV DRAIN SPONGES PAD 2"X2"
- DERMACEA NON-WOVEN SPONGES PAD 2"X2"
- DERMACEA TYPE VII GAUZE PAD 2"X2"
- DIATHRIVE PEN NEEDLE 31G X 5 MM
- DIATHRIVE PEN NEEDLE 31G X 6 MM
- DIATHRIVE PEN NEEDLE 31G X 8 MM
- DIATHRIVE PEN NEEDLE 32G X 4 MM
- DROPLET INSULIN SYRINGE 29G X 1/2" 0.3 ML
- DROPLET INSULIN SYRINGE 29G X 1/2" 0.5 ML
- DROPLET INSULIN SYRINGE 29G X 1/2" 1 ML
- DROPLET INSULIN SYRINGE 30G X 1/2" 0.3 ML
- DROPLET INSULIN SYRINGE 30G X 1/2" 0.5 ML
- DROPLET INSULIN SYRINGE 30G X 1/2" 1 ML
- DROPLET INSULIN SYRINGE 30G X 15/64" 0.3 ML
- DROPLET INSULIN SYRINGE 30G X 15/64" 0.5 ML
- DROPLET INSULIN SYRINGE 30G X 15/64" 1 ML
- DROPLET INSULIN SYRINGE 30G X 5/16" 0.3 ML
- DROPLET INSULIN SYRINGE 30G X 5/16" 0.5 ML
- DROPLET INSULIN SYRINGE 30G X 5/16" 1 ML
- DROPLET INSULIN SYRINGE 31G X 15/64" 0.3 ML
- DROPLET INSULIN SYRINGE 31G X 15/64" 0.5 ML
- DROPLET INSULIN SYRINGE 31G X 5/16" 0.3 ML
- DROPLET INSULIN SYRINGE 31G X 5/16" 0.5 ML
- DROPLET INSULIN SYRINGE 31G X 5/16" 1 ML
- DROPLET MICRON 34G X 3.5 MM
- 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 AUTOPROTECT DUO 31G X 4 MM
- DROPSAFE AUTOPROTECT DUO 31G X 8 MM
- DROPSAFE SAFETY PEN NEEDLES 31G X 5 MM
- DROPSAFE SAFETY PEN NEEDLES 31G X 6 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

Formulary ID: 26375

Last Updated: 04/01/2026

Effective: 04/01/2026

H9306_26_DRS_039_OE_C

- DROPSAFE SAFETY SYRINGE/NEEDLE 31G X 5/16" 0.3 ML
- DROPSAFE SAFETY SYRINGE/NEEDLE 31G X 5/16" 0.5 ML
- DROPSAFE SAFETY SYRINGE/NEEDLE 31G X 5/16" 1 ML
- DRUG MART ULTRA COMFORT SYR 29G X 1/2" 0.3 ML
- DRUG MART ULTRA COMFORT SYR 29G X 1/2" 1 ML
- DRUG MART ULTRA COMFORT SYR 30G X 5/16" 0.5 ML
- DRUG MART ULTRA COMFORT SYR 30G X 5/16" 1 ML
- 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 ALCOHOL PREP MEDIUM PAD 70 %
- EASY TOUCH FLIPLOCK INSULIN SY 29G X 1/2" 1 ML
- EASY TOUCH FLIPLOCK INSULIN SY 30G X 1/2" 1 ML
- EASY TOUCH FLIPLOCK INSULIN SY 30G X 5/16" 1 ML
- EASY TOUCH FLIPLOCK INSULIN SY 31G X 5/16" 1 ML
- EASY TOUCH FLIPLOCK SAFETY SYR 27G X 1/2" 1 ML
- EASY TOUCH INSULIN BARRELS U-100 1 ML
- EASY TOUCH INSULIN SAFETY SYR 29G X 1/2" 0.5 ML
- EASY TOUCH INSULIN SAFETY SYR 29G X 1/2" 1 ML
- EASY TOUCH INSULIN SAFETY SYR 30G X 1/2" 1 ML
- EASY TOUCH INSULIN SAFETY SYR 30G X 5/16" 0.5 ML

Formulary ID: 26375
Last Updated: 04/01/2026
Effective: 04/01/2026
H9306_26_DRS_039_OE_C

- EASY TOUCH INSULIN SYRINGE 27G X 1/2" 0.5 ML
- EASY TOUCH INSULIN SYRINGE 27G X 1/2" 1 ML
- EASY TOUCH INSULIN SYRINGE 27G X 5/8" 1 ML
- EASY TOUCH INSULIN SYRINGE 28G X 1/2" 0.5 ML
- EASY TOUCH INSULIN SYRINGE 28G X 1/2" 1 ML
- EASY TOUCH INSULIN SYRINGE 29G X 1/2" 0.5 ML
- EASY TOUCH INSULIN SYRINGE 29G X 1/2" 1 ML
- EASY TOUCH INSULIN SYRINGE 30G X 1/2" 0.3 ML
- EASY TOUCH INSULIN SYRINGE 30G X 1/2" 0.5 ML
- EASY TOUCH INSULIN SYRINGE 30G X 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 15/64" 0.5 ML
- EMBECTA INSULIN SYR ULTRAFINE 31G X 15/64" 1 ML
- EMBECTA INSULIN SYR ULTRAFINE 31G X 5/16" 0.5 ML

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

- EMBECTA INSULIN SYR ULTRAFINE 31G X 5/16" 1 ML
- EMBECTA INSULIN SYRINGE 28G X 1/2" 0.5 ML
- EMBECTA INSULIN SYRINGE 28G X 1/2" 1 ML (OTC)
- EMBECTA INSULIN SYRINGE U-100 27G X 5/8" 1 ML
- EMBECTA INSULIN SYRINGE U-500
- EMBECTA PEN NEEDLE NANO 2 GEN 32G X 4 MM
- EMBECTA PEN NEEDLE NANO 32G X 4 MM
- EMBECTA PEN NEEDLE ULTRAFINE 29G X 12.7MM
- EMBECTA PEN NEEDLE ULTRAFINE 31G X 5 MM
- EMBECTA PEN NEEDLE ULTRAFINE 31G X 8 MM
- EMBECTA PEN NEEDLE ULTRAFINE 32G X 6 MM
- EMBRACE PEN NEEDLES 29G X 12MM
- EMBRACE PEN NEEDLES 30G X 5 MM
- EMBRACE PEN NEEDLES 30G X 8 MM
- EMBRACE PEN NEEDLES 31G X 5 MM
- EMBRACE PEN NEEDLES 31G X 6 MM
- EMBRACE PEN NEEDLES 31G X 8 MM
- EMBRACE PEN NEEDLES 32G X 4 MM
- EQL ALCOHOL SWABS PAD 70 %
- EQL GAUZE PAD 2"X2"
- EQL INSULIN SYRINGE 29G X 1/2" 0.3 ML
- EQL INSULIN SYRINGE 29G X 1/2" 0.5 ML
- EQL INSULIN SYRINGE 30G X 5/16" 0.5 ML
- EQL INSULIN SYRINGE 30G X 5/16" 1 ML
- EXEL COMFORT POINT INSULIN SYR 29G X 1/2" 0.3 ML
- EXEL COMFORT POINT INSULIN SYR 30G X 5/16" 0.3 ML
- EXEL COMFORT POINT PEN NEEDLE 29G X 12MM
- FIFTY50 PEN NEEDLES 31G X 5 MM
- FIFTY50 PEN NEEDLES 31G X 8 MM
- FIFTY50 PEN NEEDLES 32G X 4 MM
- FIFTY50 PEN NEEDLES 32G X 6 MM
- 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

Formulary ID: 26375

Last Updated: 04/01/2026

Effective: 04/01/2026

H9306_26_DRS_039_OE_C

- GLUCOPRO INSULIN SYRINGE 30G X 5/16" 1 ML
- GLUCOPRO INSULIN SYRINGE 31G X 5/16" 0.3 ML
- GLUCOPRO INSULIN SYRINGE 31G X 5/16" 0.5 ML
- GLUCOPRO INSULIN SYRINGE 31G X 5/16" 1 ML
- GNP ALCOHOL SWABS PAD
- GNP 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 PEN NEEDLES 31G X 5 MM
- GNP PEN NEEDLES 32G X 4 MM
- GNP PEN NEEDLES 32G X 6 MM
- 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 8 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"

Formulary ID: 26375

Last Updated: 04/01/2026

Effective: 04/01/2026

H9306_26_DRS_039_OE_C

- 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" 0.5 ML
- INSULIN SYRINGE 29G X 1/2" 1 ML
- INSULIN SYRINGE 30G X 5/16" 0.3 ML
- INSULIN SYRINGE 30G X 5/16" 0.5 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 31G X 5/16" 1 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
- 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

Formulary ID: 26375

Last Updated: 04/01/2026

Effective: 04/01/2026

H9306_26_DRS_039_OE_C

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

Formulary ID: 26375

Last Updated: 04/01/2026

Effective: 04/01/2026

H9306_26_DRS_039_OE_C

- 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
- 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 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
- PHARMACIST CHOICE ALCOHOL PAD
- 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

Formulary ID: 26375

Last Updated: 04/01/2026

Effective: 04/01/2026

H9306_26_DRS_039_OE_C

- 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 32G X 4 MM
- PRO COMFORT PEN NEEDLES 32G X 5 MM
- PRO COMFORT PEN NEEDLES 32G X 6 MM
- PRO COMFORT PEN NEEDLES 32G X 8 MM
- PRODIGY INSULIN SYRINGE 28G X 1/2" 1 ML
- PRODIGY INSULIN SYRINGE 31G X 5/16" 0.3 ML
- PRODIGY INSULIN SYRINGE 31G X 5/16" 0.5 ML
- PURE COMFORT ALCOHOL PREP PAD
- PURE COMFORT PEN NEEDLE 32G X 4 MM
- PURE COMFORT PEN NEEDLE 32G X 5 MM
- PURE COMFORT PEN NEEDLE 32G X 6 MM
- PURE COMFORT PEN NEEDLE 32G X 8 MM
- PURE COMFORT SAFETY PEN NEEDLE 31G X 5 MM
- PURE COMFORT SAFETY PEN NEEDLE 31G X 6 MM
- PURE COMFORT SAFETY PEN NEEDLE 32G X 4 MM
- PX SHORTLENGTH PEN NEEDLES 31G X 8 MM
- QC ALCOHOL
- QC ALCOHOL SWABS PAD 70 %
- QC BORDER ISLAND GAUZE PAD 2"X2"
- QUICK TOUCH INSULIN PEN NEEDLE 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

Formulary ID: 26375

Last Updated: 04/01/2026

Effective: 04/01/2026

H9306_26_DRS_039_OE_C

- 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" 0.5 ML
- 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
- 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
- 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"

Formulary ID: 26375

Last Updated: 04/01/2026

Effective: 04/01/2026

H9306_26_DRS_039_OE_C

- 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
- SURGICAL GAUZE SPONGE PAD 2"X2"
- TECHLITE INSULIN SYRINGE 29G X 1/2" 0.5 ML
- TECHLITE PEN NEEDLES 32G X 4 MM
- THERAGA UZE 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

Formulary ID: 26375

Last Updated: 04/01/2026

Effective: 04/01/2026

H9306_26_DRS_039_OE_C

- 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
- 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

Formulary ID: 26375
Last Updated: 04/01/2026
Effective: 04/01/2026
H9306_26_DRS_039_OE_C

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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

- 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
- 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

Formulary ID: 26375

Last Updated: 04/01/2026

Effective: 04/01/2026

H9306_26_DRS_039_OE_C

- 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
- 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

Formulary ID: 26375

Last Updated: 04/01/2026

Effective: 04/01/2026

H9306_26_DRS_039_OE_C

- 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 28G X 1/2" 1 ML
- VERIFINE INSULIN SYRINGE 29G X 1/2" 0.5 ML
- VERIFINE INSULIN SYRINGE 29G X 1/2" 1 ML
- VERIFINE INSULIN SYRINGE 30G X 1/2" 1 ML
- VERIFINE INSULIN SYRINGE 30G X 5/16" 0.5 ML
- VERIFINE INSULIN SYRINGE 30G X 5/16" 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	
Coverage Duration	LIFETIME
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

INTERFERON FOR MS-AVONEX

Products Affected

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

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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

INTERFERON FOR MS-BETASERON

Products Affected

- BETASERON SUBCUTANEOUS KIT

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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

INTERFERON FOR MS-PLEGRIDY

Products Affected

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

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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

INTERFERON GAMMA-1B

Products Affected

- ACTIMMUNE

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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_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).
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_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: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_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: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

IXAZOMIB

Products Affected

- NINLARO

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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

LAMOTRIGINE

Products Affected

- SUBVENITE ORAL SUSPENSION

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	ALL INDICATIONS: CONTRAINDICATION TO OR UNABLE TO SWALLOW LAMOTRIGINE TABLETS.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

LANREOTIDE

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	ACROMEGALY: INITIAL: THERAPY IS PRESCRIBED BY OR IN CONSULTATION WITH AN ENDOCRINOLOGIST.
Coverage Duration	ACROMEGALY: INITIAL/RENEWAL: 12 MOS. GEP-NETS, CARCINOID SYNDROME: 12 MOS.
Other Criteria	ACROMEGALY: 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: 26375
Last Updated: 04/01/2026
Effective: 04/01/2026
H9306_26_DRS_039_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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

LAROTRECTINIB

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	VITRAKVI ORAL SOLUTION: 1) TRIAL OF VITRAKVI CAPSULES, OR 2) UNABLE TO TAKE CAPSULE FORMULATION.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

LAZERTINIB

Products Affected

- LAZCLUZE ORAL TABLET 240 MG, 80 MG

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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

LEDIPASVIR-SOFOSBUVIR

Products Affected

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

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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

LENVATINIB

Products Affected

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

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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_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: 26375

Last Updated: 04/01/2026

Effective: 04/01/2026

H9306_26_DRS_039_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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

LEUPROLIDE DEPOT

Products Affected

- LEUPROLIDE ACETATE (3 MONTH)
- LUTRATE DEPOT

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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

LEUPROLIDE MESYLATE

Products Affected

- CAMCEVI

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: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

LEUPROLIDE-ELIGARD

Products Affected

- ELIGARD

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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

LEUPROLIDE-LUPRON DEPOT

Products Affected

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

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

Formulary ID: 26375

Last Updated: 04/01/2026

Effective: 04/01/2026

H9306_26_DRS_039_OE_C

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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

LEUPROLIDE-LUPRON DEPOT-PED

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	CENTRAL PRECOCIOUS PUBERTY (CPP): INITIAL: FEMALES: ELEVATED LEVEL OF LUTEINIZING HORMONE (LH) LEVEL GREATER THAN 0.2 TO 0.3 MIU/ML AT DIAGNOSIS. MALES: ELEVATED LEVEL OF 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.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

PA Criteria	Criteria Details
Prerequisite Therapy Required	No

Formulary ID: 26375
Last Updated: 04/01/2026
Effective: 04/01/2026
H9306_26_DRS_039_OE_C

L-GLUTAMINE

Products Affected

- *l-glutamine oral packet*

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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

LIDOCAINE PATCH

Products Affected

- *lidocaine external patch 5 %*
- *lidocan*
- *tridacaine ii*
- 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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

LIDOCAINE PRILOCAINE

Products Affected

- *lidocaine-prilocaine external cream*

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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

LONCASTUXIMAB TESIRINE-LPYL

Products Affected

- ZYNLONTA

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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

LORLATINIB

Products Affected

- LORBRENA ORAL TABLET 100 MG, 25 MG

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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

LOTILANER

Products Affected

- XDEM VY

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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

LUMACAFTOR-IVACAFTOR

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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

MACITENTAN

Products Affected

- OPSUMIT

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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

MARGETUXIMAB-CMKB

Products Affected

- MARGENZA

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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

MARIBAVIR

Products Affected

- LIVTENCITY

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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

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/RENEWAL: 12 MONTHS.
Other Criteria	OBSTRUCTIVE HCM: INITIAL: TRIAL OF, CONTRAINDICATION, OR INTOLERANCE 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: 26375
Last Updated: 04/01/2026
Effective: 04/01/2026
H9306_26_DRS_039_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: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

MEPOLIZUMAB

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: ASTHMA: BLOOD EOSINOPHIL LEVEL OF AT LEAST 150 CELLS/MCL WITHIN THE PAST 12 MONTHS.
Age Restrictions	
Prescriber Restrictions	INITIAL: ASTHMA: PRESCRIBED BY OR IN CONSULTATION WITH A PHYSICIAN SPECIALIZING IN PULMONARY OR ALLERGY MEDICINE. CRSWNP: PRESCRIBED BY OR IN CONSULTATION WITH AN OTOLARYNGOLOGIST, ALLERGIST OR IMMUNOLOGIST. EOSINOPHILIC COPD: PRESCRIBED BY OR IN CONSULTATION WITH A PULMONOLOGIST.
Coverage Duration	INITIAL: CRSWNP: 6 MO. OTHERS: 12 MO. RENEWAL: CRSWNP, ASTHMA, COPD, EGPA, HES: 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 THE 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

Formulary ID: 26375

Last Updated: 04/01/2026

Effective: 04/01/2026

H9306_26_DRS_039_OE_C

PA Criteria	Criteria Details
	<p>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. 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. EOSINOPHILIC COPD: USED IN COMBINATION WITH A LAMA/LABA/ICS. 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 THE SAME INDICATION. CRSWNP: 1) CLINICAL BENEFIT COMPARED TO BASELINE, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR THE 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 THE SAME INDICATION. EOSINOPHILIC COPD: 1) USED IN COMBINATION WITH A LAMA/LABA/ICS, 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR THE SAME INDICATION, AND 3) CLINICAL RESPONSE AS EVIDENCED BY (A) REDUCTION IN COPD EXACERBATIONS FROM BASELINE, (B) REDUCTION IN SEVERITY OR FREQUENCY OF COPD-RELATED SYMPTOMS, OR (C) INCREASE IN FEV1 OF AT LEAST 5 PERCENT FROM PRETREATMENT BASELINE.</p>
Indications	All FDA-approved Indications.

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

METYROSINE

Products Affected

- *metyrosine*

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: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

MIFEPRISTONE

Products Affected

- *mifepristone oral tablet 300 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	CUSHINGS SYNDROME (CS): INITIAL: DIAGNOSIS CONFIRMED BY: 1) 24-HR URINE FREE CORTISOL (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 GLUCOCORTICOID. 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: 26375

Last Updated: 04/01/2026

Effective: 04/01/2026

H9306_26_DRS_039_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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

MIRDAMETINIB

Products Affected

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

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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

MIRVETUXIMAB SORAVTANSINE-GYNX

Products Affected

- ELAHERE

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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

MOMELOTINIB

Products Affected

- OJJAARA

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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

MOSUNETUZUMAB-AXGB

Products Affected

- LUNSUMIO
- LUNSUMIO VELO

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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

NAXITAMAB-GQGK

Products Affected

- DANYELZA

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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

NERATINIB

Products Affected

- NERLYNX

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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_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

Formulary ID: 26375
Last Updated: 04/01/2026
Effective: 04/01/2026
H9306_26_DRS_039_OE_C

NILOTINIB-DANZITEN

Products Affected

- DANZITEN

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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

NINTEDANIB

Products Affected

- OFEV

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: IDIOPATHIC PULMONARY FIBROSIS (IPF): 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. 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): AT LEAST 10% FIBROSIS ON A CHEST HRCT.
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 AND RESPIRATORY SYMPTOMS OR CHEST IMAGING HAVE WORSENERD/PROGRESSED DESPITE TREATMENT WITH

Formulary ID: 26375

Last Updated: 04/01/2026

Effective: 04/01/2026

H9306_26_DRS_039_OE_C

PA Criteria	Criteria Details
	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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

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	Yes

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_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), 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.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

NITISINONE

Products Affected

- *nitisinone*
- ORFADIN ORAL SUSPENSION

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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_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: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

NIVOLUMAB-RELATLIMAB-RMBW

Products Affected

- OPDUALAG

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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

NOGAPENDEKIN ALFA

Products Affected

- ANKTIVA

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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

OFATUMUMAB SQ

Products Affected

- KESIMPTA

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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

OLAPARIB

Products Affected

- LYNPARZA ORAL TABLET

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

Formulary ID: 26375

Last Updated: 04/01/2026

Effective: 04/01/2026

H9306_26_DRS_039_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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

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: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_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) 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: 26375

Last Updated: 04/01/2026

Effective: 04/01/2026

H9306_26_DRS_039_OE_C

PA Criteria	Criteria Details
	<p>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 .</p> <p>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.</p>
Indications	All FDA-approved Indications.

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

OXANDROLONE

Products Affected

- oxandrolone oral*

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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_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: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_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	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_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/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: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

PAZOPANIB

Products Affected

- *pazopanib hcl oral tablet 200 mg, 400 mg*

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: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

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: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

PEGVISOMANT

Products Affected

- SOMAVERT

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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

PEMBROLIZUMAB

Products Affected

- KEYTRUDA INTRAVENOUS SOLUTION

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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

PEMBROLIZUMAB-BERAHYALURONIDASE ALFA-PMPH

Products Affected

- KEYTRUDA QLEX

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: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

PEMIGATINIB

Products Affected

- PEMAZYRE

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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

PENICILLAMINE TABLET

Products Affected

- *penicillamine oral tablet*

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

Formulary ID: 26375

Last Updated: 04/01/2026

Effective: 04/01/2026

H9306_26_DRS_039_OE_C

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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

PEXIDARTINIB

Products Affected

- TURALIO

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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

PIMAVANSERIN

Products Affected

- NUPLAZID ORAL CAPSULE
- NUPLAZID ORAL TABLET 10 MG

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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

PIRFENIDONE

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	IDIOPATHIC PULMONARY FIBROSIS (IPF): INITIAL: 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.
Age Restrictions	
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: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

PA Criteria	Criteria Details
Prerequisite Therapy Required	No

Formulary ID: 26375
Last Updated: 04/01/2026
Effective: 04/01/2026
H9306_26_DRS_039_OE_C

PIRTOBRUTINIB

Products Affected

- JAYPIRCA ORAL TABLET 100 MG, 50 MG

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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

POMALIDOMIDE

Products Affected

- *pomalidomide*
- 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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

PONATINIB

Products Affected

- ICLUSIG

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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

POSACONAZOLE TABLET

Products Affected

- *posaconazole oral tablet delayed release*

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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

PRALSETINIB

Products Affected

- GAVRETO

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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

PYRIMETHAMINE

Products Affected

- *pyrimethamine oral*

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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

QUIZARTINIB

Products Affected

- VANFLYTA

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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

REGORAFENIB

Products Affected

- STIVARGA

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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

RELUGOLIX

Products Affected

- ORGOVYX

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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

REPOTRECTINIB

Products Affected

- AUGTYRO ORAL CAPSULE 160 MG, 40 MG

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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

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, GASTROENTEROLOGIST, OR ENDOCRINOLOGIST.
Coverage Duration	INITIAL/RENEWAL: 12 MONTHS
Other Criteria	NASH: RENEWAL: CONTINUES TO HAVE NONCIRRHOTIC NASH WITH MODERATE TO ADVANCED LIVER FIBROSIS (CONSISTENT WITH STAGES F2 TO F3 FIBROSIS).
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

RETIFANLIMAB-DLWR

Products Affected

- ZYNYZ

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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

REVUMENIB

Products Affected

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

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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

RIBOCICLIB

Products Affected

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

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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

RIBOCICLIB-LETROZOLE

Products Affected

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

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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

RIFAXIMIN

Products Affected

- XIFAXAN ORAL TABLET 200 MG, 550 MG

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

Formulary ID: 26375
Last Updated: 04/01/2026
Effective: 04/01/2026
H9306_26_DRS_039_OE_C

RILONACEPT

Products Affected

- ARCALYST

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	<p>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.</p> <p>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.</p>
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

Formulary ID: 26375

Last Updated: 04/01/2026

Effective: 04/01/2026

H9306_26_DRS_039_OE_C

PA Criteria	Criteria Details
	INHIBITOR, PDE-4 INHIBITOR) FOR CAPS. DIRA: 1) NO 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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

RIMEGEPANT

Products Affected

- NURTEC

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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

Formulary ID: 26375
Last Updated: 04/01/2026
Effective: 04/01/2026
H9306_26_DRS_039_OE_C

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.

Formulary ID: 26375

Last Updated: 04/01/2026

Effective: 04/01/2026

H9306_26_DRS_039_OE_C

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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

RIPRETINIB

Products Affected

- QINLOCK

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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

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.

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

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: 26375

Last Updated: 04/01/2026

Effective: 04/01/2026

H9306_26_DRS_039_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: 26375

Last Updated: 04/01/2026

Effective: 04/01/2026

H9306_26_DRS_039_OE_C

PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

Formulary ID: 26375
Last Updated: 04/01/2026
Effective: 04/01/2026
H9306_26_DRS_039_OE_C

ROPEGINTERFERON ALFA-2B-NJFT

Products Affected

- BESREMI

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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

RUCAPARIB

Products Affected

- RUBRACA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	METASTATIC CASTRATION-RESISTANT PROSTATE CANCER: 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: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_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: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

SECUKINUMAB SQ

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: PLAQUE PSORIASIS (PSO): PSORIASIS COVERING 3 PERCENT OR MORE OF BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, GENITAL AREA, SCALP, OR FACE. NON-RADIOGRAPHIC AXIAL SPONDYLOARTHRITIS (NR-AXSPA): 1) C-REACTIVE PROTEIN (CRP) LEVELS ABOVE THE UPPER LIMIT OF NORMAL, OR 2) SACROILIITIS ON MAGNETIC RESONANCE IMAGING (MRI).
Age Restrictions	
Prescriber Restrictions	INITIAL: PSO, HIDRADENITIS SUPPURATIVA (HS): PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST. PSORIATIC ARTHRITIS (PSA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST OR A DERMATOLOGIST. ANKYLOSING SPONDYLITIS (AS), NR-AXSPA, ENTHESITIS-RELATED ARTHRITIS (ERA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST.
Coverage Duration	INITIAL: HS: 12 MONTHS, ALL OTHER INDICATIONS: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	INITIAL: PSO: 1) 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:

Formulary ID: 26375

Last Updated: 04/01/2026

Effective: 04/01/2026

H9306_26_DRS_039_OE_C

PA Criteria	Criteria Details
	TRIAL OF OR CONTRAINDICATION TO ONE NSAID, 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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

Formulary ID: 26375
Last Updated: 04/01/2026
Effective: 04/01/2026
H9306_26_DRS_039_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, 80 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: 26375
Last Updated: 04/01/2026
Effective: 04/01/2026
H9306_26_DRS_039_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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

SELUMETINIB

Products Affected

- KOSELUGO ORAL CAPSULE 10 MG, 25 MG
- KOSELUGO ORAL CAPSULE SPRINKLE 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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

SEVABERTINIB

Products Affected

- HYRNUO

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: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

SILDENAFIL TABLET

Products Affected

- sildenafil citrate oral tablet 20 mg*

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

Formulary ID: 26375

Last Updated: 04/01/2026

Effective: 04/01/2026

H9306_26_DRS_039_OE_C

PA Criteria	Criteria Details
Prerequisite Therapy Required	No

Formulary ID: 26375
Last Updated: 04/01/2026
Effective: 04/01/2026
H9306_26_DRS_039_OE_C

SIPONIMOD

Products Affected

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

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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

SIROLIMUS PROTEIN-BOUND

Products Affected

- FYARRO

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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

SODIUM OXYBATE-XYREM

Products Affected

- *sodium oxybate*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	INITIAL: CATAPLEXY IN NARCOLEPSY, EXCESSIVE DAYTIME SLEEPINESS (EDS) IN NARCOLEPSY: PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST, PSYCHIATRIST, OR SPECIALIST IN SLEEP MEDICINE
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS
Other Criteria	INITIAL: EDS IN NARCOLEPSY: 1) NO CONCURRENT USE WITH A SEDATIVE HYPNOTIC AGENT, AND 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. 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: 26375

Last Updated: 04/01/2026

Effective: 04/01/2026

H9306_26_DRS_039_OE_C

PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

Formulary ID: 26375
Last Updated: 04/01/2026
Effective: 04/01/2026
H9306_26_DRS_039_OE_C

SOFOSBUVIR/VELPATASVIR

Products Affected

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

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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

PA Criteria	Criteria Details
Prerequisite Therapy Required	No

Formulary ID: 26375
Last Updated: 04/01/2026
Effective: 04/01/2026
H9306_26_DRS_039_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: 26375

Last Updated: 04/01/2026

Effective: 04/01/2026

H9306_26_DRS_039_OE_C

PA Criteria	Criteria Details
Prerequisite Therapy Required	No

Formulary ID: 26375
Last Updated: 04/01/2026
Effective: 04/01/2026
H9306_26_DRS_039_OE_C

SOMATROPIN - NORDITROPIN

Products Affected

- NORDITROPIN FLEXPRO
SUBCUTANEOUS SOLUTION PEN-
INJECTOR

PA Criteria	Criteria Details
Exclusion Criteria	INITIAL/RENEWAL: ATHLETIC ENHANCEMENT, ANTI-AGING PURPOSES.
Required Medical Information	INITIAL: PEDIATRIC GROWTH HORMONE DEFICIENCY (GHD), IDIOPATHIC SHORT STATURE (ISS), SMALL FOR GESTATIONAL AGE (SGA), 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.

Formulary ID: 26375

Last Updated: 04/01/2026

Effective: 04/01/2026

H9306_26_DRS_039_OE_C

PA Criteria	Criteria Details
Coverage Duration	INITIAL/RENEWAL: 12 MONTHS.
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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

SOMATROPIN - SEROSTIM

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	INITIAL/RENEWAL: ATHLETIC ENHANCEMENT, ANTI-AGING PURPOSES
Required Medical Information	INITIAL: HIV/WASTING: ONE OF THE FOLLOWING FOR WEIGHT LOSS: 1) 10% UNINTENTIONAL WEIGHT LOSS OVER 12 MONTHS OR 5% WEIGHT LOSS OVER 6 MONTHS, 2) 5% BODY CELL MASS (BCM) LOSS WITHIN 6 MONTHS, 3) BCM LESS THAN 35% (MEN) OF TOTAL BODY WEIGHT AND BODY MASS INDEX (BMI) LESS THAN 27 KG PER METER SQUARED, 4) BCM LESS THAN 23% (WOMEN) OF TOTAL BODY WEIGHT AND BMI LESS THAN 27 KG PER METER SQUARED, OR 5) BMI LESS THAN 20 KG PER METER SQUARED.
Age Restrictions	
Prescriber Restrictions	HIV/WASTING: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A GASTROENTEROLOGIST, NUTRITIONAL SUPPORT SPECIALIST, OR INFECTIOUS DISEASE SPECIALIST.
Coverage Duration	INITIAL/RENEWAL: 9 MONTHS.
Other Criteria	HIV/WASTING: RENEWAL: 1) CLINICAL BENEFIT IN MUSCLE MASS AND WEIGHT.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 26375
Last Updated: 04/01/2026
Effective: 04/01/2026
H9306_26_DRS_039_OE_C

PA Criteria	Criteria Details
Prerequisite Therapy Required	No

Formulary ID: 26375
Last Updated: 04/01/2026
Effective: 04/01/2026
H9306_26_DRS_039_OE_C

SONIDEGIB

Products Affected

- ODOMZO

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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

SORAFENIB

Products Affected

- *sorafenib tosylate*

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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

SOTATERCEPT-CSRK

Products Affected

- WINREVAIR

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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

Formulary ID: 26375
Last Updated: 04/01/2026
Effective: 04/01/2026
H9306_26_DRS_039_OE_C

SOTORASIB

Products Affected

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

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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

STIRIPENTOL

Products Affected

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

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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

SUNITINIB

Products Affected

- *sunitinib malate*

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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

TADALAFIL - ADCIRCA, ALYQ

Products Affected

- *alyq*

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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

TAFAMIDIS

Products Affected

- VYNDAMAX

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	CARDIOMYOPATHY ASSOCIATED WITH WILD TYPE OR HEREDITARY TRANSTHYRETIN-MEDIATED AMYLOIDOSIS (ATTR-CM): INITIAL: 1) NEW YORK HEART ASSOCIATION (NYHA) CLASS I, II, OR III HEART FAILURE, AND 2) DIAGNOSIS CONFIRMED BY (A) BONE SCAN (SCINTIGRAPHY) STRONGLY POSITIVE FOR MYOCARDIAL UPTAKE OF TC-99M-PYP, OR (B) BIOPSY OF TISSUE OF AFFECTED ORGAN(S) (CARDIAC AND POSSIBLY NON-CARDIAC SITES) TO CONFIRM AMYLOID PRESENCE AND CHEMICAL TYPING TO CONFIRM PRESENCE OF TRANSTHYRETIN (TTR) PROTEIN.
Age Restrictions	
Prescriber Restrictions	ATTR-CM: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A CARDIOLOGIST, ATTR SPECIALIST, OR MEDICAL GENETICIST.
Coverage Duration	INITIAL/RENEWAL: 12 MONTHS
Other Criteria	ATTR-CM: INITIAL/RENEWAL: NO CONCURRENT USE WITH OTHER ATTR-CM TTR STABILIZERS (E.G., ACORAMIDIS)
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Formulary ID: 26375

Last Updated: 04/01/2026

Effective: 04/01/2026

H9306_26_DRS_039_OE_C

TALAZOPARIB

Products Affected

- TALZENNA

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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

Formulary ID: 26375
Last Updated: 04/01/2026
Effective: 04/01/2026
H9306_26_DRS_039_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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

TALQUETAMAB-TGVS

Products Affected

- TALVEY

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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

TARLATAMAB-DLLE

Products Affected

- IMDELLTRA

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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

TAZEMETOSTAT

Products Affected

- TAZVERIK

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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

TEBENTAFUSP-TEBN

Products Affected

- KIMMTRAK

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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

TECLISTAMAB-CQYV

Products Affected

- TECVAYLI

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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

TELOTRISTAT

Products Affected

- XERMELO

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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

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: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_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: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_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: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

PA Criteria	Criteria Details
Prerequisite Therapy Required	No

Formulary ID: 26375
Last Updated: 04/01/2026
Effective: 04/01/2026
H9306_26_DRS_039_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: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

TISLELIZUMAB-JSGR

Products Affected

- TEVIMBRA

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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

TISOTUMAB VEDOTIN-TFTV

Products Affected

- TIVDAK

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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

TIVOZANIB

Products Affected

- FOTIVDA

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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

TOCILIZUMAB-AAZG IV

Products Affected

- TYENNE

PA Criteria	Criteria Details
Exclusion Criteria	CORONAVIRUS DISEASE 2019 (COVID-19) IN HOSPITALIZED ADULTS
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	INITIAL: RHEUMATOID ARTHRITIS (RA), POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS (PJIA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST. SYSTEMIC JUVENILE IDIOPATHIC ARTHRITIS (SJIA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST, DERMATOLOGIST, OR IMMUNOLOGIST.
Coverage Duration	INITIAL: RA, PJIA, SJIA, GCA: 6 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.

Formulary ID: 26375

Last Updated: 04/01/2026

Effective: 04/01/2026

H9306_26_DRS_039_OE_C

PA Criteria	Criteria Details
	GCA: 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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

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.

Formulary ID: 26375

Last Updated: 04/01/2026

Effective: 04/01/2026

H9306_26_DRS_039_OE_C

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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

TOFACITINIB

Products Affected

- XELJANZ
- XELJANZ XR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	INITIAL: RHEUMATOID ARTHRITIS (RA), ANKYLOSING SPONDYLITIS (AS), POLYARTICULAR COURSE JUVENILE IDIOPATHIC ARTHRITIS (PCJIA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST. PSORIATIC ARTHRITIS (PSA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST OR DERMATOLOGIST. ULCERATIVE COLITIS (UC): PRESCRIBED BY OR IN CONSULTATION WITH A GASTROENTEROLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	INITIAL: RA: TRIAL OF OR CONTRAINDICATION TO 3 MONTHS OF TREATMENT WITH ONE 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.

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

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: CONFIRMED POLYCYSTIC KIDNEY DISEASE VIA CT, MRI, OR ULTRASOUND.
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). RENEWAL: HAS NOT PROGRESSED TO ESRD/DIALYSIS.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

TORIPALIMAB-TPZI

Products Affected

- LOQTORZI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	NASOPHARYNGEAL CARCINOMA (NPC): FIRST LINE TREATMENT: 24 MOS, PREVIOUSLY TREATED: LIFETIME.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

TRAMETINIB SOLUTION

Products Affected

- MEKINIST ORAL SOLUTION RECONSTITUTED

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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

TRASTUZUMAB-DKST

Products Affected

- OGIVRI

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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_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: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_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: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_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: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_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: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

TRIPTORELIN-TRELSTAR

Products Affected

- TRELSTAR MIXJECT

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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

TUCATINIB

Products Affected

- TUKYSA ORAL TABLET 150 MG, 50 MG

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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

UBROGEPANT

Products Affected

- UBRELVY

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

Formulary ID: 26375

Last Updated: 04/01/2026

Effective: 04/01/2026

H9306_26_DRS_039_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).
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 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. AD: 1) INTRACTABLE PRURITUS OR CRACKING/OOZING/BLEEDING OF AFFECTED SKIN, AND 2) TRIAL OF OR CONTRAINDICATION TO A TOPICAL CORTICOSTEROID, TOPICAL CALCINEURIN INHIBITOR, TOPICAL PDE4 INHIBITOR, OR TOPICAL JAK INHIBITOR. AS,

Formulary ID: 26375

Last Updated: 04/01/2026

Effective: 04/01/2026

H9306_26_DRS_039_OE_C

PA Criteria	Criteria Details
	<p>NR-AXSPA: TRIAL OF OR CONTRAINDICATION TO AN NSAID (NON-STEROIDAL ANTI-INFLAMMATORY DRUG). GIANT CELL ARTERITIS (GCA): HAS COMPLETED, STARTED, OR WILL SOON START A TAPERING COURSE OF GLUCOCORTICOIDS.</p> <p>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, NR-AXSPA, PJIA: CONTINUES TO BENEFIT FROM THE MEDICATION. AD: IMPROVEMENT WHILE ON THERAPY.</p>
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

USTEKINUMAB-AAUZ SQ

Products Affected

- *ustekinumab-aauz*

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.

Formulary ID: 26375

Last Updated: 04/01/2026

Effective: 04/01/2026

H9306_26_DRS_039_OE_C

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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

USTEKINUMAB-AEKN IV

Products Affected

- SELARSDI

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

Formulary ID: 26375

Last Updated: 04/01/2026

Effective: 04/01/2026

H9306_26_DRS_039_OE_C

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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

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.

Formulary ID: 26375

Last Updated: 04/01/2026

Effective: 04/01/2026

H9306_26_DRS_039_OE_C

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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

USTEKINUMAB-KFCE IV

Products Affected

- YESINTEK

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

Formulary ID: 26375

Last Updated: 04/01/2026

Effective: 04/01/2026

H9306_26_DRS_039_OE_C

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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

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.

Formulary ID: 26375

Last Updated: 04/01/2026

Effective: 04/01/2026

H9306_26_DRS_039_OE_C

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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

VALBENZAZINE

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: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

VANZACAFTOR-TEZACAFTOR- DEUTIVACAFTOR

Products Affected

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

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

Formulary ID: 26375
Last Updated: 04/01/2026
Effective: 04/01/2026
H9306_26_DRS_039_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: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

VERICIGUAT

Products Affected

- VERQUVO

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

Formulary ID: 26375

Last Updated: 04/01/2026

Effective: 04/01/2026

H9306_26_DRS_039_OE_C

VIGABATRIN

Products Affected

- *vigabatrin*
- *vigadrone*
- *vigpoder*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	INITIAL: REFRACTORY COMPLEX PARTIAL SEIZURES (CPS), INFANTILE SPASMS: PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST.
Coverage Duration	INITIAL/RENEWAL: 12 MONTHS
Other Criteria	INITIAL: 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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

VIMSELTINIB

Products Affected

- ROMVIMZA

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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

VISMODEGIB

Products Affected

- ERIVEDGE

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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

VONOPRAZAN

Products Affected

- VOQUEZNA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL: H PYLORI: 30 DAYS. EE: 8 WEEKS. NERD: 4 WEEKS. RENEWAL: EE: 24 WEEKS.
Other Criteria	INITIAL: EROSIIVE ESOPHAGITIS (EE): TRIAL OF OR CONTRAINDICATION TO TWO PROTON PUMP INHIBITORS AT MAXIMUM DOSE FOR 8 WEEKS EACH. NON-EROSIVE GASTROESOPHAGEAL REFLUX DISEASE (NERD): 1) NO PREVIOUS TREATMENT FAILURE WITH VOQUEZNA IN THE LAST 12 MONTHS, AND 2) TRIAL OF OR CONTRAINDICATION TO ONE PROTON PUMP INHIBITOR AT MAXIMUM DOSE FOR 8 WEEKS. 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: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

VORICONAZOLE SUSPENSION

Products Affected

- voriconazole oral suspension reconstituted

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	CANDIDA INFECTIONS: 3 MOS. CONTINUATION OF THERAPY, ALL OTHER INDICATIONS: 6 MOS.
Other Criteria	CANDIDA INFECTIONS: 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: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

ZANIDATAMAB-HRII

Products Affected

- ZIIHERA

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

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

ZANUBRUTINIB

Products Affected

- BRUKINSA ORAL CAPSULE
- BRUKINSA ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	MANTLE CELL LYMPHOMA: INTOLERANCE TO CALQUENCE. CHRONIC LYMPHOCYTIC LEUKEMIA, SMALL LYMPHOCYTIC LYMPHOMA: INTOLERANCE TO CALQUENCE OR IMBRUVICA. WALDENSTROMS MACROGLOBULINEMIA: NO STEP REQUIRED.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_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: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

ZIFTOMENIB

Products Affected

- KOMZIFTI

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: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_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: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

ZONGERTINIB

Products Affected

- HERNEXEOS

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: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_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: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

INDEX

A

abiraterone acetate 7
 ABIRATERONE ACETATE
 MICRONIZED 8
 abirtega..... 7
 ABOUTTIME PEN NEEDLE 30G X 8 MM
 165, 184, 185
 ABOUTTIME PEN NEEDLE 31G X 5 MM
 165, 184, 185
 ABOUTTIME PEN NEEDLE 31G X 8 MM
 165, 184, 185
 ABOUTTIME PEN NEEDLE 32G X 4 MM
 165, 184, 185
 ACTIMMUNE..... 189
 ADEMPAS 300, 301
 ADVOCATE INSULIN PEN NEEDLE 32G
 X 4 MM..... 165, 184, 185
 ADVOCATE INSULIN PEN NEEDLES
 29G X 12.7MM..... 165, 184, 185
 ADVOCATE INSULIN PEN NEEDLES
 31G X 5 MM..... 165, 184, 185
 ADVOCATE INSULIN PEN NEEDLES
 31G X 8 MM..... 165, 184, 185
 ADVOCATE INSULIN PEN NEEDLES
 33G X 4 MM..... 165, 184, 185
 ADVOCATE INSULIN SYRINGE 29G X
 1/2 165, 184, 185
 ADVOCATE INSULIN SYRINGE 30G X
 5/16 165, 184, 185
 ADVOCATE INSULIN SYRINGE 31G X
 5/16 165, 184, 185
 AIMOVIG..... 120
 AKEEGA 246
 ALCOHOL PREP PAD..... 165, 184, 185
 ALCOHOL PREP PAD 70 %. 165, 184, 185
 ALCOHOL PREP PADS PAD 70 % 165,
 184, 185
 ALCOHOL SWABS PAD..... 165, 184, 185
 ALCOHOL SWABS PAD 70 % ... 165, 184,
 185
 ALECENSA..... 19

ALTRENO..... 372
 ALUNBRIG ORAL TABLET 180 MG, 30
 MG, 90 MG..... 57
 ALUNBRIG ORAL TABLET THERAPY
 PACK..... 57
 ALVAIZ..... 107
 ALYFTREK ORAL TABLET 10-50-125
 MG, 4-20-50 MG 400
 alyq..... 341
 ANKTIVA 252
 AQ INSULIN SYRINGE 31G X 5/16... 165,
 184, 185
 AQINJECT PEN NEEDLE 31G X 5 MM
 165, 184, 185
 AQINJECT PEN NEEDLE 32G X 4 MM
 165, 184, 185
 ARCALYST 296, 297
 ARIKAYCE..... 21
 armodafinil..... 238
 ASSURE ID DUO PRO PEN NEEDLES
 31G X 5 MM..... 165, 184, 185
 ASSURE ID INSULIN SAFETY SYR 29G
 X 1/2..... 165, 184, 185
 ASSURE ID INSULIN SAFETY SYR 31G
 X 15/64..... 165, 184, 185
 ASSURE ID PRO PEN NEEDLES 30G X 5
 MM 165, 184, 185
 ATTRUBY..... 10
 AUGTYRO ORAL CAPSULE 160 MG, 40
 MG 289
 AUM ALCOHOL PREP PADS PAD 70 %
 165, 184, 185
 AUM INSULIN SAFETY PEN NEEDLE
 31G X 4 MM..... 165, 184, 185
 AUM INSULIN SAFETY PEN NEEDLE
 31G X 5 MM..... 165, 184, 185
 AUM MINI INSULIN PEN NEEDLE 32G
 X 4 MM..... 165, 184, 185
 AUM MINI INSULIN PEN NEEDLE 32G
 X 5 MM..... 165, 184, 185

Formulary ID: 26375

Last Updated: 04/01/2026

Effective: 04/01/2026

H9306_26_DRS_039_OE_C

AUM MINI INSULIN PEN NEEDLE 32G X 6 MM..... 165, 184, 185
 AUM MINI INSULIN PEN NEEDLE 32G X 8 MM..... 165, 184, 185
 AUM MINI INSULIN PEN NEEDLE 33G X 4 MM..... 165, 184, 185
 AUM MINI INSULIN PEN NEEDLE 33G X 5 MM..... 166, 184, 185
 AUM MINI INSULIN PEN NEEDLE 33G X 6 MM..... 166, 184, 185
 AUM PEN NEEDLE 32G X 4 MM 166, 184, 185
 AUM PEN NEEDLE 32G X 5 MM 166, 184, 185
 AUM PEN NEEDLE 32G X 6 MM 166, 184, 185
 AUM PEN NEEDLE 33G X 4 MM 166, 184, 185
 AUM PEN NEEDLE 33G X 5 MM 166, 184, 185
 AUM PEN NEEDLE 33G X 6 MM 166, 184, 185
 AUM READYGARD DUO PEN NEEDLE 32G X 4 MM..... 166, 184, 185
 AUM SAFETY PEN NEEDLE 31G X 4 MM 166, 184, 185
 AUSTEDO ORAL TABLET 12 MG, 6 MG, 9 MG 87
 AUSTEDO XR ORAL TABLET EXTENDED RELEASE 24 HOUR 12 MG, 18 MG, 24 MG, 30 MG, 36 MG, 42 MG, 48 MG, 6 MG 87
 AUSTEDO XR PATIENT TITRATION . 87
 AVMAPKI FAKZYNJA CO-PACK..... 38
 AVONEX PEN INTRAMUSCULAR AUTO-INJECTOR KIT..... 186
 AVONEX PREFILLED INTRAMUSCULAR PREFILLED SYRINGE KIT..... 186
 AYVAKIT 37
B
 BALVERSA ORAL TABLET 3 MG, 4 MG, 5 MG..... 119

BD AUTOSHIELD DUO 30G X 5 MM 166, 184, 185
 BD ECLIPSE SYRINGE 30G X 1/2 166, 184, 185
 BD INSULIN SYR ULTRAFINE II 31G X 5/16 166, 184, 185
 BD INSULIN SYRINGE 27.5G X 5/8.. 166, 184, 185
 BD INSULIN SYRINGE 27G X 1/2..... 166, 184, 185
 BD INSULIN SYRINGE 29G X 1/2..... 166, 184, 185
 BD INSULIN SYRINGE HALF-UNIT 31G X 5/16..... 166, 184, 185
 BD INSULIN SYRINGE MICROFINE 27G X 5/8..... 166, 184, 185
 BD INSULIN SYRINGE MICROFINE 28G X 1/2..... 166, 184, 185
 BD INSULIN SYRINGE U-100 1 ML . 166, 184, 185
 BD INSULIN SYRINGE ULTRAFINE 29G X 1/2..... 166, 184, 185
 BD INSULIN SYRINGE ULTRAFINE 30G X 1/2..... 166, 184, 185
 BD PEN NEEDLE MICRO ULTRAFINE 32G X 6 MM..... 166, 184, 185
 BD PEN NEEDLE MINI U/F 31G X 5 MM 166, 184, 185
 BD PEN NEEDLE MINI ULTRAFINE 31G X 5 MM..... 166, 184, 185
 BD PEN NEEDLE NANO 2ND GEN 32G X 4 MM..... 166, 184, 185
 BD PEN NEEDLE NANO ULTRAFINE 32G X 4 MM..... 166, 184, 185
 BD PEN NEEDLE ORIG ULTRAFINE 29G X 12.7MM..... 166, 184, 185
 BD PEN NEEDLE SHORT ULTRAFINE 31G X 8 MM..... 166, 184, 185
 BD SAFETYGLIDE INSULIN SYRINGE 29G X 1/2..... 166, 184, 185
 BD SAFETYGLIDE INSULIN SYRINGE 30G X 5/16..... 166, 184, 185
 BD SAFETYGLIDE INSULIN SYRINGE 31G X 15/64..... 166, 184, 185

BD SAFETYGLIDE INSULIN SYRINGE 31G X 5/16.....	166, 184, 185	CAPRELSA ORAL TABLET 100 MG, 300 MG	399
BD SAFETYGLIDE SYRINGE/NEEDLE 27G X 5/8.....	166, 184, 185	CAREFINE PEN NEEDLES 29G X 12MM	167, 184, 185
BD SWAB SINGLE USE REGULAR PAD	166, 184, 185	CAREFINE PEN NEEDLES 30G X 8 MM	167, 184, 185
BD SWABS SINGLE USE BUTTERFLY PAD.....	166, 184, 185	CAREFINE PEN NEEDLES 31G X 6 MM	167, 184, 185
BD VEO INSULIN SYR U/F 1/2UNIT 31G X 15/64.....	166, 184, 185	CAREFINE PEN NEEDLES 31G X 8 MM	167, 184, 185
BD VEO INSULIN SYR ULTRAFINE 31G X 15/64.....	167, 184, 185	CAREFINE PEN NEEDLES 32G X 4 MM	167, 184, 185
BD VEO INSULIN SYRINGE U/F 31G X 15/64	167, 184, 185	CAREFINE PEN NEEDLES 32G X 5 MM	167, 184, 185
BENDAMUSTINE HCL INTRAVENOUS SOLUTION.....	47	CAREFINE PEN NEEDLES 32G X 6 MM	167, 184, 185
bendamustine hcl intravenous solution reconstituted.....	47	CAREONE INSULIN SYRINGE 30G X 1/2	167, 184, 185
BENDEKA	47	CAREONE INSULIN SYRINGE 31G X 5/16	167, 184, 185
BENLYSTA SUBCUTANEOUS.....	44	CARETOUCH ALCOHOL PREP PAD 70 %	167, 184, 185
BESREMI	308	CARETOUCH INSULIN SYRINGE 28G X 5/16	167, 184, 185
betaine	50	CARETOUCH INSULIN SYRINGE 29G X 5/16	167, 184, 185
BETASERON SUBCUTANEOUS KIT	187	CARETOUCH INSULIN SYRINGE 30G X 5/16	167, 184, 185
bexarotene	52	CARETOUCH INSULIN SYRINGE 31G X 5/16	167, 184, 185
BIZENGRI (750 MG DOSE)	412	CARETOUCH PEN NEEDLES 29G X 12MM	167, 184, 185
BORTEZOMIB INJECTION SOLUTION RECONSTITUTED 1 MG, 2.5 MG	54	CARETOUCH PEN NEEDLES 31G X 5 MM	167, 184, 185
bortezomib injection solution reconstituted 3.5 mg	54	CARETOUCH PEN NEEDLES 31G X 6 MM	167, 184, 185
BORUZU	54	CARETOUCH PEN NEEDLES 31G X 8 MM	167, 184, 185
bosentan oral tablet	55	CARETOUCH PEN NEEDLES 32G X 4 MM	167, 184, 185
BOSULIF ORAL CAPSULE 100 MG, 50 MG	56	CARETOUCH PEN NEEDLES 32G X 5 MM	167, 184, 185
BOSULIF ORAL TABLET 100 MG, 400 MG, 500 MG.....	56	CARETOUCH PEN NEEDLES 33G X 4 MM	167, 184, 185
BRAFTOVI ORAL CAPSULE 75 MG .	111		
BRUKINSA ORAL CAPSULE	411		
BRUKINSA ORAL TABLET	411		
C			
CABOMETYX ORAL TABLET 20 MG, 40 MG, 60 MG.....	60		
CALQUENCE	9		
CAMCEVI	206		
CAMZYOS	224		

Formulary ID: 26375

Last Updated: 04/01/2026

Effective: 04/01/2026

H9306_26_DRS_039_OE_C

carglumic acid oral tablet soluble 64
 CAYSTON..... 42
 CIMZIA (1 SYRINGE) PREFILLED
 SYRINGE KIT 200 MG/ML
 SUBCUTANEOUS..... 66, 67
 CIMZIA (2 SYRINGE) 66, 67
 CIMZIA SUBCUTANEOUS KIT 2 X 200
 MG 66, 67
 CIMZIA-STARTER 66, 67
 CLEVER CHOICE COMFORT EZ 29G X
 12MM 167, 184, 185
 CLEVER CHOICE COMFORT EZ 33G X
 4 MM 167, 184, 185
 CLICKFINE PEN NEEDLES 31G X 8 MM
 167, 184, 185
 CLICKFINE PEN NEEDLES 32G X 4 MM
 167, 184, 185
 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, 184, 185
 COMFORT ASSIST INSULIN SYRINGE
 31G X 5/16..... 167, 184, 185
 COMFORT EZ INSULIN SYRINGE 27G
 X 1/2..... 167, 184, 185
 COMFORT EZ INSULIN SYRINGE 28G
 X 1/2..... 167, 168, 184, 185
 COMFORT EZ INSULIN SYRINGE 29G
 X 1/2..... 168, 184, 185
 COMFORT EZ INSULIN SYRINGE 30G
 X 1/2..... 168, 184, 185
 COMFORT EZ INSULIN SYRINGE 30G
 X 5/16..... 168, 184, 185
 COMFORT EZ INSULIN SYRINGE 31G
 X 15/64..... 168, 184, 185
 COMFORT EZ INSULIN SYRINGE 31G
 X 5/16..... 168, 184, 185
 COMFORT EZ PEN NEEDLES 31G X 5
 MM 168, 184, 185
 COMFORT EZ PEN NEEDLES 31G X 6
 MM 168, 184, 185

COMFORT EZ PEN NEEDLES 31G X 8
 MM 168, 184, 185
 COMFORT EZ PEN NEEDLES 32G X 4
 MM 168, 184, 185
 COMFORT EZ PEN NEEDLES 32G X 5
 MM 168, 184, 185
 COMFORT EZ PEN NEEDLES 32G X 6
 MM 168, 184, 185
 COMFORT EZ PEN NEEDLES 32G X 8
 MM 168, 184, 185
 COMFORT EZ PEN NEEDLES 33G X 4
 MM 168, 184, 185
 COMFORT EZ PEN NEEDLES 33G X 5
 MM 168, 184, 185
 COMFORT EZ PEN NEEDLES 33G X 6
 MM 168, 184, 185
 COMFORT EZ PEN NEEDLES 33G X 8
 MM 168, 184, 185
 COMFORT EZ PRO PEN NEEDLES 30G
 X 8 MM..... 168, 184, 185
 COMFORT EZ PRO PEN NEEDLES 31G
 X 4 MM..... 168, 184, 185
 COMFORT EZ PRO PEN NEEDLES 31G
 X 5 MM..... 168, 184, 185
 COMFORT TOUCH INSULIN PEN NEED
 31G X 4 MM..... 168, 184, 185
 COMFORT TOUCH INSULIN PEN NEED
 31G X 5 MM..... 168, 184, 185
 COMFORT TOUCH INSULIN PEN NEED
 31G X 6 MM..... 168, 184, 185
 COMFORT TOUCH INSULIN PEN NEED
 31G X 8 MM..... 168, 184, 185
 COMFORT TOUCH INSULIN PEN NEED
 32G X 4 MM..... 168, 184, 185
 COMFORT TOUCH INSULIN PEN NEED
 32G X 5 MM..... 168, 184, 185
 COMFORT TOUCH INSULIN PEN NEED
 32G X 6 MM..... 168, 184, 185
 COMFORT TOUCH INSULIN PEN NEED
 32G X 8 MM..... 168, 184, 185
 COPIKTRA..... 99
 CORTROPHIN 72, 73
 COSENTYX (300 MG DOSE)..... 312, 313

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

COSENTYX SENSOREADY (300 MG)	312, 313
COSENTYX SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 75 MG/0.5ML	312, 313
COSENTYX UNOREADY	312, 313
COTELLIC	71
CRESEMBA ORAL	191
CURITY ALCOHOL PREPS PAD 70 %	168, 184, 185
CURITY ALL PURPOSE SPONGES PAD 2	168, 184, 185
CURITY GAUZE PAD 2	168, 184, 185
CURITY GAUZE SPONGE PAD 2	168, 184, 185
CURITY SPONGES PAD 2	168, 184, 185
CVS GAUZE PAD 2	168, 184, 185
CVS GAUZE STERILE PAD 2	168, 184, 185
CVS ISOPROPYL ALCOHOL WIPES	168, 184, 185
CYLTEZO (2 PEN)	16, 17
CYLTEZO (2 SYRINGE)	16, 17
CYLTEZO-CD/UC/HS STARTER	16, 17
CYLTEZO-PSORIASIS/UV STARTER	16, 17
D	
dalfampridine er	79
DANYELZA	239
DANZITEN	242
dasatinib oral tablet 100 mg, 140 mg, 20 mg, 50 mg, 70 mg, 80 mg	81
DATROWAY	82
DAURISMO ORAL TABLET 100 MG, 25 MG	145
deferasirox granules	84, 85
deferasirox oral tablet	84, 85
DERMACEA GAUZE SPONGE PAD 2	169, 184, 185
DERMACEA IV DRAIN SPONGES PAD 2	169, 184, 185
DERMACEA NON-WOVEN SPONGES PAD 2	169, 184, 185
DERMACEA TYPE VII GAUZE PAD 2	169, 184, 185
DIACOMIT ORAL CAPSULE 250 MG, 500 MG	339
DIACOMIT ORAL PACKET 250 MG, 500 MG	339
DIATHRIVE PEN NEEDLE 31G X 5 MM	169, 184, 185
DIATHRIVE PEN NEEDLE 31G X 6 MM	169, 184, 185
DIATHRIVE PEN NEEDLE 31G X 8 MM	169, 184, 185
DIATHRIVE PEN NEEDLE 32G X 4 MM	169, 184, 185
diclofenac epolamine external	89
diclofenac sodium external solution 2 %	88
dimethyl fumarate oral capsule delayed release 120 mg, 240 mg	90
dimethyl fumarate starter pack oral capsule delayed release therapy pack	90
dronabinol	94
DROPLET INSULIN SYRINGE 29G X 1/2	169, 184, 185
DROPLET INSULIN SYRINGE 30G X 1/2	169, 184, 185
DROPLET INSULIN SYRINGE 30G X 15/64	169, 184, 185
DROPLET INSULIN SYRINGE 30G X 5/16	169, 184, 185
DROPLET INSULIN SYRINGE 31G X 15/64	169, 184, 185
DROPLET INSULIN SYRINGE 31G X 5/16	169, 184, 185
DROPLET MICRON 34G X 3.5 MM	169, 184, 185
DROPLET PEN NEEDLES 29G X 10MM	169, 184, 185
DROPLET PEN NEEDLES 29G X 12MM	169, 184, 185
DROPLET PEN NEEDLES 30G X 8 MM	169, 184, 185
DROPLET PEN NEEDLES 31G X 5 MM	169, 184, 185

DROPLET PEN NEEDLES 31G X 6 MM 169, 184, 185
 DROPLET PEN NEEDLES 31G X 8 MM 169, 184, 185
 DROPLET PEN NEEDLES 32G X 4 MM 169, 184, 185
 DROPLET PEN NEEDLES 32G X 5 MM 169, 184, 185
 DROPLET PEN NEEDLES 32G X 6 MM 169, 184, 185
 DROPLET PEN NEEDLES 32G X 8 MM 169, 184, 185
 DROPSAFE ALCOHOL PREP PAD 70 % 169, 184, 185
 DROPSAFE AUTOPROTECT DUO 31G X 4 MM 169, 184, 185
 DROPSAFE AUTOPROTECT DUO 31G X 8 MM 169, 184, 185
 DROPSAFE SAFETY PEN NEEDLES 31G X 5 MM..... 169, 184, 185
 DROPSAFE SAFETY PEN NEEDLES 31G X 6 MM..... 169, 184, 185
 DROPSAFE SAFETY SYRINGE/NEEDLE 29G X 1/2..... 169, 184, 185
 DROPSAFE SAFETY SYRINGE/NEEDLE 31G X 15/64..... 169, 184, 185
 DROPSAFE SAFETY SYRINGE/NEEDLE 31G X 5/16..... 170, 184, 185
 droxidopa 95
 DRUG MART ULTRA COMFORT SYR 29G X 1/2..... 170, 184, 185
 DRUG MART ULTRA COMFORT SYR 30G X 5/16..... 170, 184, 185
 DRUG MART UNIFINE PENTIPS 31G X 5 MM 170, 184, 185
 DUPIXENT SUBCUTANEOUS SOLUTION AUTO-INJECTOR 96, 98
 DUPIXENT SUBCUTANEOUS SOLUTION PREFILLED SYRINGE . 96, 98

E

EASY COMFORT ALCOHOL PADS PAD 170, 184, 185

EASY COMFORT INSULIN SYRINGE 29G X 5/16..... 170, 184, 185
 EASY COMFORT INSULIN SYRINGE 30G X 1/2..... 170, 184, 185
 EASY COMFORT INSULIN SYRINGE 30G X 5/16..... 170, 184, 185
 EASY COMFORT INSULIN SYRINGE 31G X 1/2..... 170, 184, 185
 EASY COMFORT INSULIN SYRINGE 31G X 5/16..... 170, 184, 185
 EASY COMFORT INSULIN SYRINGE 32G X 5/16..... 170, 184, 185
 EASY COMFORT PEN NEEDLES 29G X 4MM 170, 184, 185
 EASY COMFORT PEN NEEDLES 29G X 5MM 170, 184, 185
 EASY COMFORT PEN NEEDLES 31G X 5 MM 170, 184, 185
 EASY COMFORT PEN NEEDLES 31G X 6 MM 170, 184, 185
 EASY COMFORT PEN NEEDLES 31G X 8 MM 170, 184, 185
 EASY COMFORT PEN NEEDLES 32G X 4 MM 170, 184, 185
 EASY COMFORT PEN NEEDLES 33G X 4 MM 170, 184, 185
 EASY COMFORT PEN NEEDLES 33G X 5 MM 170, 184, 185
 EASY COMFORT PEN NEEDLES 33G X 6 MM 170, 184, 185
 EASY GLIDE PEN NEEDLES 33G X 4 MM 170, 184, 185
 EASY TOUCH ALCOHOL PREP MEDIUM PAD 70 %..... 170, 184, 185
 EASY TOUCH FLIPLOCK INSULIN SY 29G X 1/2..... 170, 184, 185
 EASY TOUCH FLIPLOCK INSULIN SY 30G X 1/2..... 170, 184, 185
 EASY TOUCH FLIPLOCK INSULIN SY 30G X 5/16..... 170, 184, 185
 EASY TOUCH FLIPLOCK INSULIN SY 31G X 5/16..... 170, 184, 185
 EASY TOUCH FLIPLOCK SAFETY SYR 27G X 1/2..... 170, 184, 185

EASY TOUCH INSULIN BARRELS U-100 1 ML.....	170, 184, 185	EASY TOUCH SAFETY PEN NEEDLES 29G X 8MM.....	171, 184, 185
EASY TOUCH INSULIN SAFETY SYR 29G X 1/2.....	170, 184, 185	EASY TOUCH SAFETY PEN NEEDLES 30G X 8 MM.....	171, 184, 185
EASY TOUCH INSULIN SAFETY SYR 30G X 1/2.....	170, 184, 185	EASY TOUCH SHEATHLOCK SYRINGE 29G X 1/2.....	171, 184, 185
EASY TOUCH INSULIN SAFETY SYR 30G X 5/16.....	170, 184, 185	EASY TOUCH SHEATHLOCK SYRINGE 30G X 1/2.....	171, 184, 185
EASY TOUCH INSULIN SYRINGE 27G X 1/2.....	171, 184, 185	EASY TOUCH SHEATHLOCK SYRINGE 30G X 5/16.....	171, 184, 185
EASY TOUCH INSULIN SYRINGE 27G X 5/8.....	171, 184, 185	EASY TOUCH SHEATHLOCK SYRINGE 31G X 5/16.....	171, 184, 185
EASY TOUCH INSULIN SYRINGE 28G X 1/2.....	171, 184, 185	ELAHERE	235
EASY TOUCH INSULIN SYRINGE 29G X 1/2.....	171, 184, 185	ELIGARD	207
EASY TOUCH INSULIN SYRINGE 30G X 1/2.....	171, 184, 185	ELREXFIO SUBCUTANEOUS SOLUTION 44 MG/1.1ML, 76 MG/1.9ML	106
EASY TOUCH INSULIN SYRINGE 30G X 5/16.....	171, 184, 185	eltrombopag olamine oral packet 12.5 mg, 25 mg	108, 109
EASY TOUCH INSULIN SYRINGE 31G X 5/16.....	171, 184, 185	eltrombopag olamine oral tablet 12.5 mg, 25 mg, 50 mg, 75 mg	108, 109
EASY TOUCH PEN NEEDLES 29G X 12MM	171, 184, 185	EMBECTA AUTOSHIELD DUO 30G X 5 MM	171, 184, 185
EASY TOUCH PEN NEEDLES 30G X 5 MM	171, 184, 185	EMBECTA INS SYR U/F 1/2 UNIT 31G X 15/64	171, 184, 185
EASY TOUCH PEN NEEDLES 30G X 6 MM	171, 184, 185	EMBECTA INS SYR U/F 1/2 UNIT 31G X 5/16	171, 184, 185
EASY TOUCH PEN NEEDLES 30G X 8 MM	171, 184, 185	EMBECTA INSULIN SYR ULTRAFINE 30G X 1/2.....	171, 184, 185
EASY TOUCH PEN NEEDLES 31G X 5 MM	171, 184, 185	EMBECTA INSULIN SYR ULTRAFINE 31G X 15/64.....	171, 184, 185
EASY TOUCH PEN NEEDLES 31G X 6 MM	171, 184, 185	EMBECTA INSULIN SYR ULTRAFINE 31G X 5/16.....	171, 172, 184, 185
EASY TOUCH PEN NEEDLES 31G X 8 MM	171, 184, 185	EMBECTA INSULIN SYRINGE 28G X 1/2	172, 184, 185
EASY TOUCH PEN NEEDLES 32G X 4 MM	171, 184, 185	EMBECTA INSULIN SYRINGE U-100 27G X 5/8.....	172, 184, 185
EASY TOUCH PEN NEEDLES 32G X 5 MM	171, 184, 185	EMBECTA INSULIN SYRINGE U-500	172, 184, 185
EASY TOUCH PEN NEEDLES 32G X 6 MM	171, 184, 185	EMBECTA PEN NEEDLE NANO 2 GEN 32G X 4 MM.....	172, 184, 185
EASY TOUCH SAFETY PEN NEEDLES 29G X 5MM.....	171, 184, 185	EMBECTA PEN NEEDLE NANO 32G X 4 MM	172, 184, 185

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

EMBECTA PEN NEEDLE ULTRAFINE 29G X 12.7MM.....	172, 184, 185	EQL INSULIN SYRINGE 30G X 5/16.	172, 184, 185
EMBECTA PEN NEEDLE ULTRAFINE 31G X 5 MM.....	172, 184, 185	ERBITUX	68
EMBECTA PEN NEEDLE ULTRAFINE 31G X 8 MM.....	172, 184, 185	ERIVEDGE.....	406
EMBECTA PEN NEEDLE ULTRAFINE 32G X 6 MM.....	172, 184, 185	ERLEADA ORAL TABLET 240 MG, 60 MG	26
EMBRACE PEN NEEDLES 29G X 12MM	172, 184, 185	erlotinib hcl oral tablet 100 mg, 150 mg, 25 mg	121
EMBRACE PEN NEEDLES 30G X 5 MM	172, 184, 185	everolimus oral tablet 10 mg, 2.5 mg, 5 mg, 7.5 mg	125
EMBRACE PEN NEEDLES 30G X 8 MM	172, 184, 185	everolimus oral tablet soluble	126
EMBRACE PEN NEEDLES 31G X 5 MM	172, 184, 185	EXEL COMFORT POINT INSULIN SYR 29G X 1/2.....	172, 184, 185
EMBRACE PEN NEEDLES 31G X 6 MM	172, 184, 185	EXEL COMFORT POINT INSULIN SYR 30G X 5/16.....	172, 184, 185
EMBRACE PEN NEEDLES 31G X 8 MM	172, 184, 185	EXEL COMFORT POINT PEN NEEDLE 29G X 12MM.....	172, 184, 185
EMBRACE PEN NEEDLES 32G X 4 MM	172, 184, 185	EXXUA.....	143
EMGALITY	140	EXXUA TITRATION PACK.....	143
EMGALITY (300 MG DOSE)	140	F	
EMRELIS	352	FASENRA	48, 49
ENBREL MINI.....	123, 124	FASENRA PEN.....	48, 49
ENBREL SUBCUTANEOUS SOLUTION 25 MG/0.5ML	123, 124	fentanyl citrate buccal lozenge on a handle	130
ENBREL SUBCUTANEOUS SOLUTION PREFILLED SYRINGE	123, 124	FIFTY50 PEN NEEDLES 31G X 5 MM	172, 184, 185
ENBREL SURECLICK SUBCUTANEOUS SOLUTION AUTO-INJECTOR	123, 124	FIFTY50 PEN NEEDLES 31G X 8 MM	172, 184, 185
ENSACOVE ORAL CAPSULE 100 MG, 25 MG	112	FIFTY50 PEN NEEDLES 32G X 4 MM	172, 184, 185
EPCLUSA ORAL PACKET 150-37.5 MG, 200-50 MG.....	326, 327	FIFTY50 PEN NEEDLES 32G X 6 MM	172, 184, 185
EPCLUSA ORAL TABLET.....	326, 327	fingolimod hcl.....	136
EPIDIOLEX.....	61	FINTEPLA.....	129
EPKINLY	116	FOTIVDA.....	364
EQL ALCOHOL SWABS PAD 70 %... 172, 184, 185		FRUZAQLA ORAL CAPSULE 1 MG, 5 MG	138
EQL GAUZE PAD 2	172, 184, 185	FYARRO	323
EQL INSULIN SYRINGE 29G X 1/2... 172, 184, 185		G	
		GAUZE PADS PAD 2.....	172, 184, 185
		GAUZE TYPE VII MEDI-PAK PAD 2	172, 184, 185
		GAVRETO	283
		gefitinib	142

Formulary ID: 26375

Last Updated: 04/01/2026

Effective: 04/01/2026

H9306_26_DRS_039_OE_C

GILOTRIF	18	GNP INSULIN SYRINGES 31GX5/16	173, 184, 185
glatiramer acetate subcutaneous solution		GNP PEN NEEDLES 31G X 5 MM	173, 184, 185
prefilled syringe 20 mg/ml, 40 mg/ml	146	GNP PEN NEEDLES 32G X 4 MM	173, 184, 185
glatopa subcutaneous solution prefilled		GNP PEN NEEDLES 32G X 6 MM	173, 184, 185
syringe 20 mg/ml, 40 mg/ml.....	146	GNP STERILE GAUZE PAD 2....	173, 184, 185
GLOBAL ALCOHOL PREP EASE.....	172, 184, 185	GNP ULTRA COM INSULIN SYRINGE	
GLOBAL EASE INJECT PEN NEEDLES		29G X 1/2.....	173, 184, 185
29G X 12MM.....	172, 184, 185	GNP ULTRA COM INSULIN SYRINGE	
GLOBAL EASE INJECT PEN NEEDLES		30G X 5/16.....	173, 184, 185
31G X 5 MM.....	172, 184, 185	GOMEKLI ORAL CAPSULE 1 MG, 2 MG 234
GLOBAL EASE INJECT PEN NEEDLES		GOMEKLI ORAL TABLET SOLUBLE	234
31G X 8 MM.....	172, 184, 185	GOODSENSE ALCOHOL SWABS PAD	
GLOBAL EASE INJECT PEN NEEDLES		70 %	173, 184, 185
32G X 4 MM.....	172, 184, 185	GOODSENSE CLICKFINE PEN NEEDLE	
GLOBAL EASY GLIDE INSULIN SYR		31G X 5 MM.....	173, 184, 185
31G X 15/64.....	172, 184, 185	GOODSENSE PEN NEEDLE PENFINE	
GLOBAL INJECT EASE INSULIN SYR		31G X 8 MM.....	173, 184, 185
30G X 1/2.....	172, 184, 185	H	
GLUCOPRO INSULIN SYRINGE 30G X		HAEGARDA SUBCUTANEOUS	
1/2	172, 184, 185	SOLUTION RECONSTITUTED 2000	
GLUCOPRO INSULIN SYRINGE 30G X		UNIT, 3000 UNIT	58
5/16	172, 173, 184, 185	HARVONI ORAL PACKET 33.75-150	
GLUCOPRO INSULIN SYRINGE 31G X		MG, 45-200 MG	200
5/16	173, 184, 185	HARVONI ORAL TABLET	200
GNP ALCOHOL SWABS PAD....	173, 184, 185	HEALTHWISE INSULIN SYR/NEEDLE	
GNP CLICKFINE PEN NEEDLES 31G X 6		30G X 5/16.....	173, 184, 185
MM	173, 184, 185	HEALTHWISE INSULIN SYR/NEEDLE	
GNP CLICKFINE PEN NEEDLES 31G X 8		31G X 5/16.....	173, 184, 185
MM	173, 184, 185	HEALTHWISE MICRON PEN NEEDLES	
GNP INSULIN SYRINGE 28G X 1/2 ..	173, 184, 185	32G X 4 MM.....	173, 184, 185
GNP INSULIN SYRINGE 29G X 1/2 ..	173, 184, 185	HEALTHWISE SHORT PEN NEEDLES	
GNP INSULIN SYRINGE 30G X 5/16	173, 184, 185	31G X 5 MM.....	173, 184, 185
GNP INSULIN SYRINGES 29GX1/2 ..	173, 184, 185	HEALTHWISE SHORT PEN NEEDLES	
GNP INSULIN SYRINGES 30G X 5/16 173, 184, 185	31G X 8 MM.....	173, 184, 185
GNP INSULIN SYRINGES 30GX5/16	173, 184, 185	HEALTHY ACCENTS UNIFINE PENTIP	
		29G X 12MM.....	173, 184, 185
		HEALTHY ACCENTS UNIFINE PENTIP	
		31G X 5 MM.....	173, 184, 185

Formulary ID: 26375
Last Updated: 04/01/2026
Effective: 04/01/2026
H9306_26_DRS_039_OE_C

HEALTHY ACCENTS UNIFINE PENTIP
31G X 6 MM..... 173, 184, 185
HEALTHY ACCENTS UNIFINE PENTIP
31G X 8 MM..... 173, 184, 185
HEALTHY ACCENTS UNIFINE PENTIP
32G X 4 MM..... 173, 184, 185
H-E-B INCONTROL ALCOHOL PAD 173,
184, 185
H-E-B INCONTROL PEN NEEDLES 29G
X 12MM..... 173, 184, 185
H-E-B INCONTROL PEN NEEDLES 31G
X 5 MM..... 173, 184, 185
H-E-B INCONTROL PEN NEEDLES 31G
X 6 MM..... 173, 184, 185
H-E-B INCONTROL PEN NEEDLES 31G
X 8 MM..... 173, 184, 185
H-E-B INCONTROL PEN NEEDLES 32G
X 4 MM..... 173, 184, 185
HERCEPTIN HYLECTA..... 378
HERNEXEOS..... 415
HM STERILE ALCOHOL PREP PAD 173,
184, 185
HM STERILE PADS PAD 2.. 173, 184, 185
HM ULTICARE INSULIN SYRINGE 30G
X 1/2..... 174, 184, 185
HM ULTICARE INSULIN SYRINGE 31G
X 5/16..... 174, 184, 185
HM ULTICARE SHORT PEN NEEDLES
31G X 8 MM..... 174, 184, 185
HUMIRA (2 PEN) SUBCUTANEOUS
AUTO-INJECTOR KIT..... 12, 13
HUMIRA (2 SYRINGE)
SUBCUTANEOUS PREFILLED
SYRINGE KIT 10 MG/0.1ML, 20
MG/0.2ML, 40 MG/0.4ML, 40
MG/0.8ML 12, 13
HUMIRA-CD/UC/HS STARTER
SUBCUTANEOUS AUTO-INJECTOR
KIT 12, 13
HUMIRA-PED<40KG CROHNS
STARTER..... 12, 13
HUMIRA-PED>=40KG CROHNS START
..... 12, 13

HUMIRA-PED>=40KG UC STARTER
SUBCUTANEOUS AUTO-INJECTOR
KIT 12, 13
HUMIRA-PS/UV/ADOL HS STARTER
SUBCUTANEOUS AUTO-INJECTOR
KIT 12, 13
HUMIRA-PSORIASIS/UEVIT STARTER
SUBCUTANEOUS AUTO-INJECTOR
KIT 12, 13
HYRNUO 319
I
IBRANCE..... 263
IBTROZI..... 346
icatibant acetate..... 156
ICLUSIG..... 281
IDHIFA 110
imatinib mesylate oral tablet 100 mg, 400
mg 158
IMBRUVICA ORAL CAPSULE 140 MG,
70 MG 155
IMBRUVICA ORAL SUSPENSION.... 155
IMBRUVICA ORAL TABLET 155
IMDELLTRA 348
IMJUDO 380
IMKELDI..... 159
IMPAVIDO..... 233
INCONTROL ULTICARE PEN NEEDLES
31G X 6 MM..... 174, 184, 185
INCONTROL ULTICARE PEN NEEDLES
31G X 8 MM..... 174, 184, 185
INCONTROL ULTICARE PEN NEEDLES
32G X 4 MM..... 174, 184, 185
INCRELEX..... 225
infliximab..... 163, 164
INGREZZA ORAL CAPSULE..... 398
INGREZZA ORAL CAPSULE SPRINKLE
..... 398
INGREZZA ORAL CAPSULE THERAPY
PACK..... 398
INLURIYO 161
INLYTA ORAL TABLET 1 MG, 5 MG.. 40
INQOVI 83
INREBIC..... 128

INSULIN SYRINGE 29G X 1/2 ... 174, 184, 185
 INSULIN SYRINGE 30G X 5/16 . 174, 184, 185
 INSULIN SYRINGE 31G X 5/16 . 174, 184, 185
 INSULIN SYRINGE/NEEDLE 27G X 1/2 174, 184, 185
 INSULIN SYRINGE/NEEDLE 28G X 1/2 174, 184, 185
 INSULIN SYRINGE-NEEDLE U-100 27G X 1/2..... 174, 184, 185
 INSULIN SYRINGE-NEEDLE U-100 28G X 1/2..... 174, 184, 185
 INSULIN SYRINGE-NEEDLE U-100 30G X 5/16..... 174, 184, 185
 INSULIN SYRINGE-NEEDLE U-100 31G X 1/4..... 174, 184, 185
 INSULIN SYRINGE-NEEDLE U-100 31G X 5/16..... 174, 184, 185
 INSUPEN PEN NEEDLES 31G X 5 MM 174, 184, 185
 INSUPEN PEN NEEDLES 31G X 8 MM 174, 184, 185
 INSUPEN PEN NEEDLES 32G X 4 MM 174, 184, 185
 INSUPEN PEN NEEDLES 33G X 4 MM 174, 184, 185
 INSUPEN SENSITIVE 32G X 6 MM... 174, 184, 185
 INSUPEN SENSITIVE 32G X 8 MM... 174, 184, 185
 INSUPEN ULTRAFIN 29G X 12MM.. 174, 184, 185
 INSUPEN ULTRAFIN 30G X 8 MM... 174, 184, 185
 INSUPEN ULTRAFIN 31G X 6 MM... 174, 184, 185
 INSUPEN ULTRAFIN 31G X 8 MM... 174, 184, 185
 INSUPEN32G EXTR3ME 32G X 6 MM 174, 184, 185
 ITOVEBI ORAL TABLET 3 MG, 9 MG 162

IWILFIN 100
J
 J & J GAUZE PAD 2..... 174, 184, 185
 JAKAFI..... 310
 javygtor oral tablet 311
 JAYPIRCA ORAL TABLET 100 MG, 50 MG 279
 JEMPERLI..... 93
 JYNARQUE ORAL TABLET 371
K
 KALYDECO..... 192
 KENDALL HYDROPHILIC FOAM DRESS PAD 2 174, 184, 185
 KENDALL HYDROPHILIC FOAM PLUS PAD 2..... 174, 184, 185
 KERENDIA 134, 135
 KESIMPTA..... 253
 KEYTRUDA INTRAVENOUS SOLUTION..... 270
 KEYTRUDA QLEX..... 271
 KIMMTRAK 350
 KINERET SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 24, 25
 KINRAY INSULIN SYRINGE 29G X 1/2 174, 184, 185
 KISQALI (200 MG DOSE)..... 293
 KISQALI (400 MG DOSE)..... 293
 KISQALI (600 MG DOSE)..... 293
 KISQALI FEMARA (200 MG DOSE) .. 294
 KISQALI FEMARA (400 MG DOSE) .. 294
 KISQALI FEMARA (600 MG DOSE) .. 294
 KMART VALU INSULIN SYRINGE 29G U-100 1 ML 174, 184, 185
 KMART VALU INSULIN SYRINGE 30G U-100 0.3 ML 174, 184, 185
 KMART VALU INSULIN SYRINGE 30G U-100 1 ML 174, 184, 185
 KOMZIFTI 413
 KOSELUGO ORAL CAPSULE 10 MG, 25 MG 318
 KOSELUGO ORAL CAPSULE SPRINKLE 5 MG, 7.5 MG..... 318
 KRAZATI..... 11

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

KROGER INSULIN SYRINGE 30G X 5/16	LITETOUCH INSULIN SYRINGE 30G X
..... 174, 184, 185	5/16 175, 184, 185
KROGER PEN NEEDLES 29G X 12MM	LITETOUCH INSULIN SYRINGE 31G X
..... 174, 184, 185	5/16 175, 184, 185
KROGER PEN NEEDLES 31G X 6 MM	LITETOUCH PEN NEEDLES 29G X
..... 174, 184, 185	12.7MM 175, 184, 185
KYNMOBI 28	LITETOUCH PEN NEEDLES 31G X 5
KYNMOBI TITRATION KIT 28	MM 175, 184, 185
L	LITETOUCH PEN NEEDLES 31G X 6
LANREOTIDE ACETATE 196	MM 175, 184, 185
lapatinib ditosylate 197	LITETOUCH PEN NEEDLES 31G X 8
LAZCLUZE ORAL TABLET 240 MG, 80	MM 175, 184, 185
MG 199	LITETOUCH PEN NEEDLES 32G X 4
LEADER INSULIN SYRINGE 28G X 1/2	MM 175, 184, 185
..... 174, 184, 185	LIVTENCITY 223
LEADER UNIFINE PENTIPS 31G X 5	LONSURF ORAL TABLET 15-6.14 MG,
MM 174, 184, 185	20-8.19 MG 382
LEADER UNIFINE PENTIPS 32G X 4	LOQTORZI 373
MM 174, 184, 185	LORBRENA ORAL TABLET 100 MG, 25
LEADER UNIFINE PENTIPS PLUS 31G	MG 218
X 5 MM 175, 184, 185	LUMAKRAS ORAL TABLET 120 MG,
LEADER UNIFINE PENTIPS PLUS 31G	240 MG, 320 MG 338
X 8 MM 175, 184, 185	LUNSUMIO 237
lenalidomide 201	LUNSUMIO VELO 237
LENVIMA (10 MG DAILY DOSE) 202	LUPRON DEPOT (1-MONTH) 208, 209
LENVIMA (12 MG DAILY DOSE) 202	LUPRON DEPOT (3-MONTH) 208, 209
LENVIMA (14 MG DAILY DOSE) 202	LUPRON DEPOT (4-MONTH) 208, 209
LENVIMA (18 MG DAILY DOSE) 202	LUPRON DEPOT (6-MONTH) 208, 209
LENVIMA (20 MG DAILY DOSE) 202	LUPRON DEPOT-PED (3-MONTH) ... 210,
LENVIMA (24 MG DAILY DOSE) 202	211
LENVIMA (4 MG DAILY DOSE) 202	LUPRON DEPOT-PED (6-MONTH) ... 210,
LENVIMA (8 MG DAILY DOSE) 202	211
LEUPROLIDE ACETATE (3 MONTH) 205	LUTRATE DEPOT 205
leuprolide acetate injection 204	LYNOZYFIC INTRAVENOUS
l-glutamine oral packet 212	SOLUTION 200 MG/10ML, 5
lidocaine external ointment 5 % 213	MG/2.5ML 216
lidocaine external patch 5 % 214	LYNPARZA ORAL TABLET 254
lidocaine-prilocaine external cream 215	LYTGObI (12 MG DAILY DOSE) 139
lidocan 214	LYTGObI (16 MG DAILY DOSE) 139
LITETOUCH INSULIN SYRINGE 28G X	LYTGObI (20 MG DAILY DOSE) 139
1/2 175, 184, 185	M
LITETOUCH INSULIN SYRINGE 29G X	MAGELLAN INSULIN SAFETY SYR
1/2 175, 184, 185	29G X 1/2 175, 184, 185

Formulary ID: 26375
Last Updated: 04/01/2026
Effective: 04/01/2026
H9306_26_DRS_039_OE_C

MAGELLAN INSULIN SAFETY SYR 30G X 5/16.....	175, 184, 185	metirosine.....	230
MARGENZA.....	222	MICRODOT PEN NEEDLE 31G X 6 MM	175, 184, 185
MAVENCLAD (10 TABS).....	69	MICRODOT PEN NEEDLE 32G X 4 MM	175, 184, 185
MAVENCLAD (4 TABS).....	69	MICRODOT PEN NEEDLE 33G X 4 MM	175, 184, 185
MAVENCLAD (5 TABS).....	69	mifepristone oral tablet 300 mg.....	232
MAVENCLAD (6 TABS).....	69	MIPLYFFA.....	31
MAVENCLAD (7 TABS).....	69	MIRASORB SPONGES 2.....	175, 184, 185
MAVENCLAD (8 TABS).....	69	MM PEN NEEDLES 31G X 6 MM.....	175, 184, 185
MAVENCLAD (9 TABS).....	69	MM PEN NEEDLES 32G X 4 MM.....	175, 184, 185
MAXICOMFORT II PEN NEEDLE 31G X 6 MM.....	175, 184, 185	modafinil oral tablet 100 mg, 200 mg.....	238
MAXI-COMFORT INSULIN SYRINGE 28G X 1/2.....	175, 184, 185	MODEYSO.....	92
MAXI-COMFORT SAFETY PEN NEEDLE 29G X 5MM.....	175, 184, 185	MONOJECT INSULIN SYRINGE 25G X 5/8.....	176, 184, 185
MAXI-COMFORT SAFETY PEN NEEDLE 29G X 8MM.....	175, 184, 185	MONOJECT INSULIN SYRINGE 27G X 1/2.....	176, 184, 185
MAXICOMFORT SYR 27G X 1/2.....	175, 184, 185	MONOJECT INSULIN SYRINGE 28G X 1/2.....	176, 184, 185
MAYZENT ORAL TABLET 0.25 MG, 1 MG, 2 MG.....	322	MONOJECT INSULIN SYRINGE 29G X 1/2.....	176, 184, 185
MAYZENT STARTER PACK.....	322	MONOJECT INSULIN SYRINGE 30G X 5/16.....	176, 184, 185
MEDIC INSULIN SYRINGE 30G X 5/16	175, 184, 185	MONOJECT INSULIN SYRINGE 31G X 5/16.....	176, 184, 185
MEDICINE SHOPPE PEN NEEDLES 29G X 12MM.....	175, 184, 185	MONOJECT INSULIN SYRINGE U-100 1 ML.....	176, 184, 185
MEDICINE SHOPPE PEN NEEDLES 31G X 8 MM.....	175, 184, 185	MONOJECT ULTRA COMFORT SYRINGE 28G X 1/2.....	176, 184, 185
MEDPURA ALCOHOL PADS 70 % EXTERNAL.....	175, 184, 185	MONOJECT ULTRA COMFORT SYRINGE 29G X 1/2.....	176, 184, 185
MEIJER ALCOHOL SWABS PAD 70 %	175, 184, 185	MONOJECT ULTRA COMFORT SYRINGE 30G X 5/16.....	176, 184, 185
MEIJER PEN NEEDLES 29G X 12MM	175, 184, 185	morphine sulfate (concentrate) oral solution 100 mg/5ml.....	153, 154
MEIJER PEN NEEDLES 31G X 6 MM.....	175, 184, 185	MOUNJARO SUBCUTANEOUS SOLUTION AUTO-INJECTOR.....	149
MEIJER PEN NEEDLES 31G X 8 MM.....	175, 184, 185	MS INSULIN SYRINGE 30G X 5/16... ..	176, 184, 185
MEKINIST ORAL SOLUTION RECONSTITUTED.....	375	MS INSULIN SYRINGE 31G X 5/16... ..	176, 184, 185
MEKINIST ORAL TABLET 0.5 MG, 2 MG.....	376		
MEKTOVI.....	53		

Formulary ID: 26375
Last Updated: 04/01/2026
Effective: 04/01/2026
H9306_26_DRS_039_OE_C

N

NERLYNX 240

NIKTIMVO 39

NINLARO..... 194

nitisinone..... 248

NIVESTYM..... 133

NORDITROPIN FLEXPRO
SUBCUTANEOUS SOLUTION PEN-
INJECTOR..... 330, 331

NOVOFINE AUTOCOVER 30G X 8 MM
..... 176, 184, 185

NOVOFINE PEN NEEDLE 32G X 6 MM
..... 176, 184, 185

NOVOFINE PLUS PEN NEEDLE 32G X 4
MM 176, 184, 185

NOVOTWIST PEN NEEDLE 32G X 5 MM
..... 176, 184, 185

NUBEQA..... 80

NUCALA SUBCUTANEOUS SOLUTION
AUTO-INJECTOR 227, 228, 229

NUCALA SUBCUTANEOUS SOLUTION
PREFILLED SYRINGE 100 MG/ML, 40
MG/0.4ML 227, 228, 229

NUCALA SUBCUTANEOUS SOLUTION
RECONSTITUTED 227, 228, 229

NUPLAZID ORAL CAPSULE..... 276

NUPLAZID ORAL TABLET 10 MG.... 276

NURTEC..... 298, 299

NYVEPRIA 266

O

ODOMZO 334

OFEV 243, 244

OGIVRI..... 377

OGSIVEO ORAL TABLET 100 MG, 150
MG, 50 MG..... 247

OJEMDA ORAL SUSPENSION
RECONSTITUTED 374

OJEMDA ORAL TABLET 374

OJJAARA 236

ONAPGO..... 27

ONUREG 41

OPDIVO 249

OPDIVO QVANTIG 250

OPDUALAG..... 251

OPSUMIT 221

ORENCIA CLICKJECT..... 4, 5

ORENCIA INTRAVENOUS 2, 3

ORENCIA SUBCUTANEOUS SOLUTION
PREFILLED SYRINGE 4, 5

ORFADIN ORAL SUSPENSION..... 248

ORGOVYX..... 288

ORLISSA ORAL TABLET 150 MG, 200
MG 102, 103

ORKAMBI ORAL TABLET 220

ORSERDU ORAL TABLET 345 MG, 86
MG 101

OSEVELT 86

OTEZLA 29, 30

OTEZLA XR 29, 30

OTEZLA/OTEZLA XR INITIATION PK
..... 29, 30

oxandrolone oral 261

OZEMPIC (0.25 OR 0.5 MG/DOSE)..... 148

OZEMPIC (1 MG/DOSE)
SUBCUTANEOUS SOLUTION PEN-
INJECTOR 4 MG/3ML 148

OZEMPIC (2 MG/DOSE) 148

P

pazopanib hcl oral tablet 200 mg, 400 mg
..... 265

PC UNIFINE PENTIPS 31G X 5 MM.. 176,
184, 185

PC UNIFINE PENTIPS 31G X 6 MM.. 176,
184, 185

PC UNIFINE PENTIPS 31G X 8 MM.. 176,
184, 185

PEGASYS SUBCUTANEOUS SOLUTION
180 MCG/ML 268

PEGASYS SUBCUTANEOUS SOLUTION
PREFILLED SYRINGE 268

PEMAZYRE 272

PEN NEEDLE/5-BEVEL TIP 31G X 8 MM
..... 176, 184, 185

PEN NEEDLE/5-BEVEL TIP 32G X 4 MM
..... 176, 184, 185

PEN NEEDLES 30G X 5 MM (OTC)... 176,
184, 185

PEN NEEDLES 30G X 8 MM 176, 184, 185

Formulary ID: 26375

Last Updated: 04/01/2026

Effective: 04/01/2026

H9306_26_DRS_039_OE_C

PEN NEEDLES 32G X 5 MM 176, 184, 185
 penicillamine oral tablet..... 273, 274
 PENTIPS 29G X 12MM (RX) 176, 184, 185
 PENTIPS 31G X 5 MM (RX). 176, 184, 185
 PENTIPS 31G X 8 MM (RX). 176, 184, 185
 PENTIPS 32G X 4 MM (RX). 176, 184, 185
 PENTIPS GENERIC PEN NEEDLES 29G
 X 12MM..... 176, 184, 185
 PENTIPS GENERIC PEN NEEDLES 31G
 X 6 MM..... 176, 184, 185
 PENTIPS GENERIC PEN NEEDLES 32G
 X 6 MM..... 176, 184, 185
 PHARMACIST CHOICE ALCOHOL PAD
 176, 184, 185
 PIP PEN NEEDLES 31G X 5MM 31G X 5
 MM 176, 184, 185
 PIP PEN NEEDLES 32G X 4MM 32G X 4
 MM 176, 184, 185
 PIQRAY (200 MG DAILY DOSE)..... 20
 PIQRAY (250 MG DAILY DOSE)..... 20
 PIQRAY (300 MG DAILY DOSE)..... 20
 pirfenidone oral capsule 277, 278
 pirfenidone oral tablet 267 mg, 534 mg, 801
 mg 277, 278
 PLEGRIDY STARTER PACK
 SUBCUTANEOUS SOLUTION AUTO-
 INJECTOR..... 188
 PLEGRIDY STARTER PACK
 SUBCUTANEOUS SOLUTION
 PREFILLED SYRINGE 188
 PLEGRIDY SUBCUTANEOUS
 SOLUTION AUTO-INJECTOR 188
 PLEGRIDY SUBCUTANEOUS
 SOLUTION PREFILLED SYRINGE 188
 pomalidomide 280
 POMALYST 280
 posaconazole oral tablet delayed release 282
 PRECISION SURE-DOSE SYRINGE 30G
 X 5/16..... 176, 184, 185
 PREFERRED PLUS INSULIN SYRINGE
 28G X 1/2..... 177, 184, 185
 PREFERRED PLUS INSULIN SYRINGE
 29G X 1/2..... 177, 184, 185

PREFERRED PLUS INSULIN SYRINGE
 30G X 5/16..... 177, 184, 185
 PREFERRED PLUS UNIFINE PENTIPS
 29G X 12MM..... 177, 184, 185
 PREVENT DROPSAFE PEN NEEDLES
 31G X 6 MM..... 177, 184, 185
 PREVENT DROPSAFE PEN NEEDLES
 31G X 8 MM..... 177, 184, 185
 PREVENT SAFETY PEN NEEDLES 31G
 X 6 MM..... 177, 184, 185
 PREVENT SAFETY PEN NEEDLES 31G
 X 8 MM..... 177, 184, 185
 PREVYMIS ORAL TABLET 203
 PRO COMFORT ALCOHOL PAD 70 %
 177, 184, 185
 PRO COMFORT INSULIN SYRINGE 30G
 X 1/2..... 177, 184, 185
 PRO COMFORT INSULIN SYRINGE 30G
 X 5/16..... 177, 184, 185
 PRO COMFORT INSULIN SYRINGE 31G
 X 5/16..... 177, 184, 185
 PRO COMFORT PEN NEEDLES 32G X 4
 MM 177, 184, 185
 PRO COMFORT PEN NEEDLES 32G X 5
 MM 177, 184, 185
 PRO COMFORT PEN NEEDLES 32G X 6
 MM 177, 184, 185
 PRO COMFORT PEN NEEDLES 32G X 8
 MM 177, 184, 185
 PRODIGY INSULIN SYRINGE 28G X 1/2
 177, 184, 185
 PRODIGY INSULIN SYRINGE 31G X
 5/16 177, 184, 185
 PURE COMFORT ALCOHOL PREP PAD
 177, 184, 185
 PURE COMFORT PEN NEEDLE 32G X 4
 MM 177, 184, 185
 PURE COMFORT PEN NEEDLE 32G X 5
 MM 177, 184, 185
 PURE COMFORT PEN NEEDLE 32G X 6
 MM 177, 184, 185
 PURE COMFORT PEN NEEDLE 32G X 8
 MM 177, 184, 185

PURE COMFORT SAFETY PEN NEEDLE
31G X 5 MM..... 177, 184, 185
 PURE COMFORT SAFETY PEN NEEDLE
31G X 6 MM..... 177, 184, 185
 PURE COMFORT SAFETY PEN NEEDLE
32G X 4 MM..... 177, 184, 185
 PX SHORTLENGTH PEN NEEDLES 31G
X 8 MM..... 177, 184, 185
 pyrimethamine oral 284
Q
 QC ALCOHOL 177, 184, 185
 QC ALCOHOL SWABS PAD 70 %..... 177,
184, 185
 QC BORDER ISLAND GAUZE PAD 2
..... 177, 184, 185
 QINLOCK..... 302
 QUICK TOUCH INSULIN PEN NEEDLE
29G X 12.7MM..... 177, 184, 185
 QUICK TOUCH INSULIN PEN NEEDLE
31G X 4 MM..... 177, 184, 185
 QUICK TOUCH INSULIN PEN NEEDLE
31G X 5 MM..... 177, 184, 185
 QUICK TOUCH INSULIN PEN NEEDLE
31G X 6 MM..... 177, 184, 185
 QUICK TOUCH INSULIN PEN NEEDLE
31G X 8 MM..... 177, 184, 185
 QUICK TOUCH INSULIN PEN NEEDLE
32G X 4 MM..... 177, 184, 185
 QUICK TOUCH INSULIN PEN NEEDLE
32G X 5 MM..... 177, 184, 185
 QUICK TOUCH INSULIN PEN NEEDLE
32G X 6 MM..... 177, 184, 185
 QUICK TOUCH INSULIN PEN NEEDLE
32G X 8 MM..... 177, 184, 185
 QUICK TOUCH INSULIN PEN NEEDLE
33G X 4 MM..... 178, 184, 185
 QUICK TOUCH INSULIN PEN NEEDLE
33G X 5 MM..... 178, 184, 185
 QUICK TOUCH INSULIN PEN NEEDLE
33G X 6 MM..... 178, 184, 185
 QUICK TOUCH INSULIN PEN NEEDLE
33G X 8 MM..... 178, 184, 185
 quinine sulfate oral..... 285
 QULIPTA 35

R
 RA ALCOHOL SWABS PAD 70 %..... 178,
184, 185
 RA INSULIN SYRINGE 29G X 1/2..... 178,
184, 185
 RA INSULIN SYRINGE 30G X 5/16... 178,
184, 185
 ra isopropyl alcohol wipes 178, 184, 185
 RA PEN NEEDLES 31G X 5 MM 178, 184,
185
 RA PEN NEEDLES 31G X 8 MM 178, 184,
185
 RA STERILE PAD 2 178, 184, 185
 RALDESY 379
 RAYA SURE PEN NEEDLE 29G X 12MM
..... 178, 184, 185
 RAYA SURE PEN NEEDLE 31G X 4 MM
..... 178, 184, 185
 RAYA SURE PEN NEEDLE 31G X 5 MM
..... 178, 184, 185
 RAYA SURE PEN NEEDLE 31G X 6 MM
..... 178, 184, 185
 REALITY INSULIN SYRINGE 28G X 1/2
..... 178, 184, 185
 REALITY INSULIN SYRINGE 29G X 1/2
..... 178, 184, 185
 REALITY SWABS PAD..... 178, 184, 185
 RELION ALCOHOL SWABS PAD 178,
184, 185
 RELI-ON INSULIN SYRINGE 29G 0.3
ML..... 178, 184, 185
 RELION INSULIN SYRINGE 31G X 15/64
..... 178, 184, 185
 RELION MINI PEN NEEDLES 31G X 6
MM 178, 184, 185
 RELION PEN NEEDLES 29G X 12MM
..... 178, 184, 185
 RELION PEN NEEDLES 31G X 6 MM178,
184, 185
 RELION PEN NEEDLES 31G X 8 MM178,
184, 185
 RESTORE CONTACT LAYER PAD 2 178,
184, 185

Formulary ID: 26375
 Last Updated: 04/01/2026
 Effective: 04/01/2026
 H9306_26_DRS_039_OE_C

RETACRIT INJECTION SOLUTION	
10000 UNIT/ML, 10000	
UNIT/ML(1ML), 2000 UNIT/ML, 20000	
UNIT/ML, 3000 UNIT/ML, 4000	
UNIT/ML, 40000 UNIT/ML	117, 118
RETEVMO ORAL CAPSULE 40 MG, 80	
MG	317
RETEVMO ORAL TABLET 120 MG, 160	
MG, 40 MG, 80 MG	317
REVCOVI.....	104
REVUFORJ ORAL TABLET 110 MG, 160	
MG, 25 MG.....	292
REZDIFFRA.....	290
REZLIDHIA	255
REZUROCK.....	45
RINVOQ.....	386, 387
RINVOQ LQ.....	386, 387
RITUXAN HYCELA	305
ROMVIMZA	405
ROZLYTREK ORAL CAPSULE 100 MG,	
200 MG	113
ROZLYTREK ORAL PACKET	114
RUBRACA	309
RYBELSUS	148
RYBELSUS (FORMULATION R2).....	148
RYBREVANT	23
RYBREVANT FASPRO	22
RYDAPT.....	231
RYTELO.....	160
S	
SAFETY INSULIN SYRINGES 29G X 1/2	
.....	178, 184, 185
SAFETY INSULIN SYRINGES 30G X 1/2	
.....	178, 184, 185
SAFETY INSULIN SYRINGES 30G X	
5/16	178, 184, 185
SAFETY PEN NEEDLES 30G X 5 MM	
.....	178, 184, 185
SAFETY PEN NEEDLES 30G X 8 MM	
.....	178, 184, 185
sapropterin dihydrochloride oral tablet...	311
SB ALCOHOL PREP PAD 70 %..	178, 184,
185	
SB INSULIN SYRINGE 29G X 1/2	178,
184, 185	
SB INSULIN SYRINGE 30G X 5/16 ...	178,
184, 185	
SB INSULIN SYRINGE 31G X 5/16 ...	178,
184, 185	
SCEMBLIX ORAL TABLET 100 MG, 20	
MG, 40 MG.....	32
SECURESAFE INSULIN SYRINGE 29G	
X 1/2.....	178, 184, 185
SECURESAFE SAFETY PEN NEEDLES	
30G X 8 MM.....	178, 184, 185
SELARSDI	390, 391, 392, 393
SEROSTIM SUBCUTANEOUS	
SOLUTION RECONSTITUTED 4 MG,	
5 MG, 6 MG.....	332, 333
SIGNIFOR	264
sildenafil citrate oral tablet 20 mg ..	320, 321
SIRTURO	43
SKYRIZI.....	303, 304
SKYRIZI PEN	303, 304
SM ALCOHOL PREP PAD ...	178, 184, 185
SM ALCOHOL PREP PAD 6-70 %	
EXTERNAL	178, 184, 185
SM ALCOHOL PREP PAD 70 %.	178, 184,
185	
SM GAUZE PAD 2	178, 184, 185
sodium oxybate	324, 325
SOMATULINE DEPOT	
SUBCUTANEOUS SOLUTION 60	
MG/0.2ML, 90 MG/0.3ML	196
SOMAVERT.....	269
sorafenib tosylate	335
SPRAVATO (56 MG DOSE).....	122
SPRAVATO (84 MG DOSE).....	122
STERILE GAUZE PAD 2	179, 184, 185
STERILE PAD 2.....	179, 184, 185
STIVARGA	287
STRENSIQ	33, 34
SUBVENITE ORAL SUSPENSION	195
sunitinib malate.....	340
SURE COMFORT ALCOHOL PREP PAD	
70 %	179, 184, 185

SURE COMFORT INSULIN SYRINGE 28G X 1/2.....	179, 184, 185	TECHLITE INSULIN SYRINGE 29G X 1/2	179, 184, 185
SURE COMFORT INSULIN SYRINGE 29G X 1/2.....	179, 184, 185	TECHLITE PEN NEEDLES 32G X 4 MM	179, 184, 185
SURE COMFORT INSULIN SYRINGE 30G X 1/2.....	179, 184, 185	TECVAYLI.....	351
SURE COMFORT INSULIN SYRINGE 30G X 5/16.....	179, 184, 185	TEPMETKO	354
SURE COMFORT INSULIN SYRINGE 31G X 1/4.....	179, 184, 185	TERIPARATIDE SUBCUTANEOUS SOLUTION PEN-INJECTOR 560 MCG/2.24ML	355
SURE COMFORT INSULIN SYRINGE 31G X 5/16.....	179, 184, 185	testosterone cypionate intramuscular solution 100 mg/ml, 200 mg/ml, 200 mg/ml (1 ml).....	357
SURE COMFORT PEN NEEDLES 29G X 12.7MM	179, 184, 185	testosterone enanthate intramuscular solution.....	358, 359
SURE COMFORT PEN NEEDLES 30G X 8 MM	179, 184, 185	testosterone gel 1.62 % transdermal	356
SURE COMFORT PEN NEEDLES 31G X 5 MM	179, 184, 185	testosterone transdermal gel 12.5 mg/act (1%), 20.25 mg/act (1.62%), 25 mg/2.5gm (1%), 50 mg/5gm (1%).....	356
SURE COMFORT PEN NEEDLES 31G X 6 MM	179, 184, 185	tetrabenazine	360
SURE COMFORT PEN NEEDLES 31G X 8 MM	179, 184, 185	TEVIMBRA.....	362
SURE COMFORT PEN NEEDLES 32G X 4 MM (OTC).....	179, 184, 185	THALOMID ORAL CAPSULE 100 MG, 150 MG, 200 MG, 50 MG	361
SURE COMFORT PEN NEEDLES 32G X 4 MM (RX).....	179, 184, 185	THERAGAUZE PAD 2.....	179, 184, 185
SURE COMFORT PEN NEEDLES 32G X 6 MM	179, 184, 185	TIBSOVO	193
SURGICAL GAUZE SPONGE PAD 2	179, 184, 185	TIVDAK	363
SYMPAZAN.....	70	TODAYS HEALTH PEN NEEDLES 29G X 12MM.....	179, 184, 185
SYNRIBO.....	256	TODAYS HEALTH SHORT PEN NEEDLE 31G X 8 MM	179, 184, 185
T		tolvaptan oral tablet therapy pack.....	371
TABRECTA	63	TOPCARE CLICKFINE PEN NEEDLES 31G X 6 MM.....	179, 184, 185
tadalafil oral tablet 2.5 mg, 5 mg	342	TOPCARE CLICKFINE PEN NEEDLES 31G X 8 MM.....	179, 184, 185
TAFINLAR ORAL CAPSULE	76	TOPCARE ULTRA COMFORT INS SYR 29G X 1/2.....	179, 184, 185
TAFINLAR ORAL TABLET SOLUBLE	77	TOPCARE ULTRA COMFORT INS SYR 30G X 5/16.....	179, 184, 185
TAGRISSE	260	TOPCARE ULTRA COMFORT INS SYR 31G X 5/16.....	179, 180, 184, 185
TALVEY.....	347	torpenz oral tablet 10 mg, 2.5 mg, 5 mg, 7.5 mg	125
TALZENNA	344, 345	TRELSTAR MIXJECT	383
TASIGNA ORAL CAPSULE 150 MG, 200 MG, 50 MG.....	241	TREMFYA INTRAVENOUS	151, 152
TAVNEOS.....	36		
TAZVERIK.....	349		

Formulary ID: 26375

Last Updated: 04/01/2026

Effective: 04/01/2026

H9306_26_DRS_039_OE_C

TREMFYA ONE-PRESS
SUBCUTANEOUS SOLUTION PEN-
INJECTOR..... 151, 152
TREMFYA PEN SUBCUTANEOUS
SOLUTION AUTO-INJECTOR 200
MG/2ML 151, 152
TREMFYA SUBCUTANEOUS
SOLUTION PREFILLED SYRINGE 151,
152
TREMFYA-CD/UC INDUCTION. 151, 152
tretinoin external cream 372
tridacaine ii..... 214
trientine hcl oral capsule 250 mg 381
TRIKAFTA ORAL TABLET THERAPY
PACK..... 105
TRIKAFTA ORAL THERAPY PACK.. 105
TRUE COMFORT ALCOHOL PREP
PADS PAD 70 %..... 180, 184, 185
TRUE COMFORT INSULIN SYRINGE
30G X 1/2..... 180, 184, 185
TRUE COMFORT INSULIN SYRINGE
30G X 5/16..... 180, 184, 185
TRUE COMFORT INSULIN SYRINGE
31G X 5/16..... 180, 184, 185
TRUE COMFORT INSULIN SYRINGE
32G X 5/16..... 180, 184, 185
TRUE COMFORT PEN NEEDLES 31G X
5 MM 180, 184, 185
TRUE COMFORT PEN NEEDLES 31G X
6 MM 180, 184, 185
TRUE COMFORT PEN NEEDLES 32G X
4 MM 180, 184, 185
TRUE COMFORT PRO ALCOHOL PREP
PAD 70 % 180, 184, 185
TRUE COMFORT PRO INSULIN SYR
30G X 1/2..... 180, 184, 185
TRUE COMFORT PRO INSULIN SYR
30G X 5/16..... 180, 184, 185
TRUE COMFORT PRO INSULIN SYR
31G X 5/16..... 180, 184, 185
TRUE COMFORT PRO INSULIN SYR
32G X 5/16..... 180, 184, 185
TRUE COMFORT PRO PEN NEEDLES
31G X 5 MM..... 180, 184, 185

TRUE COMFORT PRO PEN NEEDLES
31G X 6 MM..... 180, 184, 185
TRUE COMFORT PRO PEN NEEDLES
31G X 8 MM..... 180, 184, 185
TRUE COMFORT PRO PEN NEEDLES
32G X 4 MM..... 180, 184, 185
TRUE COMFORT PRO PEN NEEDLES
32G X 5 MM..... 180, 184, 185
TRUE COMFORT PRO PEN NEEDLES
32G X 6 MM..... 180, 184, 185
TRUE COMFORT PRO PEN NEEDLES
33G X 4 MM..... 180, 184, 185
TRUE COMFORT PRO PEN NEEDLES
33G X 5 MM..... 180, 184, 185
TRUE COMFORT PRO PEN NEEDLES
33G X 6 MM..... 180, 184, 185
TRUEPLUS 5-BEVEL PEN NEEDLES
29G X 12.7MM..... 180, 184, 185
TRUEPLUS 5-BEVEL PEN NEEDLES
31G X 5 MM..... 180, 184, 185
TRUEPLUS 5-BEVEL PEN NEEDLES
31G X 6 MM..... 180, 184, 185
TRUEPLUS 5-BEVEL PEN NEEDLES
31G X 8 MM..... 180, 184, 185
TRUEPLUS 5-BEVEL PEN NEEDLES
32G X 4 MM..... 180, 184, 185
TRUEPLUS INSULIN SYRINGE 28G X
1/2 180, 184, 185
TRUEPLUS INSULIN SYRINGE 29G X
1/2 180, 184, 185
TRUEPLUS INSULIN SYRINGE 30G X
5/16 180, 181, 184, 185
TRUEPLUS INSULIN SYRINGE 31G X
5/16 181, 184, 185
TRUEPLUS PEN NEEDLES 29G X 12MM
..... 181, 184, 185
TRUEPLUS PEN NEEDLES 31G X 5 MM
..... 181, 184, 185
TRUEPLUS PEN NEEDLES 31G X 6 MM
..... 181, 184, 185
TRUEPLUS PEN NEEDLES 31G X 8 MM
..... 181, 184, 185
TRUEPLUS PEN NEEDLES 32G X 4 MM
..... 181, 184, 185

Formulary ID: 26375
Last Updated: 04/01/2026
Effective: 04/01/2026
H9306_26_DRS_039_OE_C

TRULICITY SUBCUTANEOUS
SOLUTION AUTO-INJECTOR 147
TRUQAP ORAL TABLET 62
TRUQAP TABLET THERAPY PACK 160
MG ORAL 62
TRUXIMA 306, 307
TUKYSA ORAL TABLET 150 MG, 50
MG 384
TURALIO 275
TYENNE..... 365, 366, 367, 368
TYMLOS 1
U
UBRELVY 385
UDENYCA ONBODY 267
ULTICARE INSULIN SAFETY SYR 29G
X 1/2..... 181, 184, 185
ULTICARE INSULIN SYRINGE 28G X
1/2 181, 184, 185
ULTICARE INSULIN SYRINGE 29G X
1/2 181, 184, 185
ULTICARE INSULIN SYRINGE 30G X
1/2 181, 184, 185
ULTICARE INSULIN SYRINGE 30G X
5/16 181, 184, 185
ULTICARE INSULIN SYRINGE 31G X
1/4 181, 184, 185
ULTICARE INSULIN SYRINGE 31G X
5/16 181, 184, 185
ULTICARE MICRO PEN NEEDLES 32G
X 4 MM..... 181, 184, 185
ULTICARE MINI PEN NEEDLES 30G X 5
MM 181, 184, 185
ULTICARE MINI PEN NEEDLES 31G X 6
MM 181, 184, 185
ULTICARE MINI PEN NEEDLES 32G X 6
MM 181, 184, 185
ULTICARE PEN NEEDLES 29G X
12.7MM (OTC)..... 181, 184, 185
ULTICARE PEN NEEDLES 29G X
12.7MM (RX)..... 181, 184, 185
ULTICARE PEN NEEDLES 31G X 5 MM
..... 181, 184, 185
ULTICARE SHORT PEN NEEDLES 30G
X 8 MM..... 181, 184, 185

ULTICARE SHORT PEN NEEDLES 31G
X 8 MM (OTC)..... 181, 184, 185
ULTICARE SHORT PEN NEEDLES 31G
X 8 MM (RX) 181, 184, 185
ULTIGUARD SAFEPACK PEN NEEDLE
29G X 12.7MM..... 181, 184, 185
ULTIGUARD SAFEPACK PEN NEEDLE
31G X 5 MM..... 182, 184, 185
ULTIGUARD SAFEPACK PEN NEEDLE
31G X 6 MM..... 182, 184, 185
ULTIGUARD SAFEPACK PEN NEEDLE
31G X 8 MM..... 182, 184, 185
ULTIGUARD SAFEPACK PEN NEEDLE
32G X 4 MM..... 182, 184, 185
ULTIGUARD SAFEPACK PEN NEEDLE
32G X 6 MM..... 182, 184, 185
ULTIGUARD SAFEPACK SYR/NEEDLE
30G X 1/2..... 182, 184, 185
ULTIGUARD SAFEPACK SYR/NEEDLE
31G X 5/16..... 182, 184, 185
ULTILET ALCOHOL SWABS PAD ... 182,
184, 185
ULTILET PEN NEEDLE 29G X 12.7MM
..... 182, 184, 185
ULTILET PEN NEEDLE 31G X 5 MM 182,
184, 185
ULTILET PEN NEEDLE 31G X 8 MM 182,
184, 185
ULTILET PEN NEEDLE 32G X 4 MM 182,
184, 185
ULTRA COMFORT INSULIN SYRINGE
30G X 5/16..... 182, 184, 185
ULTRA FLO INSULIN PEN NEEDLES
29G X 12MM..... 182, 184, 185
ULTRA FLO INSULIN PEN NEEDLES
31G X 8 MM..... 182, 184, 185
ULTRA FLO INSULIN PEN NEEDLES
32G X 4 MM..... 182, 184, 185
ULTRA FLO INSULIN PEN NEEDLES
33G X 4 MM..... 182, 184, 185
ULTRA FLO INSULIN SYR 1/2 UNIT
30G X 1/2..... 182, 184, 185
ULTRA FLO INSULIN SYR 1/2 UNIT
30G X 5/16..... 182, 184, 185

Formulary ID: 26375
Last Updated: 04/01/2026
Effective: 04/01/2026
H9306_26_DRS_039_OE_C

ULTRA FLO INSULIN SYR 1/2 UNIT
31G X 5/16..... 182, 184, 185
ULTRA FLO INSULIN SYRINGE 29G X
1/2 182, 184, 185
ULTRA FLO INSULIN SYRINGE 30G X
1/2 182, 184, 185
ULTRA FLO INSULIN SYRINGE 30G X
5/16 182, 184, 185
ULTRA FLO INSULIN SYRINGE 31G X
5/16 182, 184, 185
ULTRA THIN PEN NEEDLES 32G X 4
MM 182, 184, 185
ULTRACARE INSULIN SYRINGE 30G X
1/2 183, 184, 185
ULTRACARE INSULIN SYRINGE 30G X
5/16 183, 184, 185
ULTRACARE INSULIN SYRINGE 31G X
5/16 183, 184, 185
ULTRACARE PEN NEEDLES 31G X 5
MM 183, 184, 185
ULTRACARE PEN NEEDLES 31G X 6
MM 183, 184, 185
ULTRACARE PEN NEEDLES 31G X 8
MM 183, 184, 185
ULTRACARE PEN NEEDLES 32G X 4
MM 183, 184, 185
ULTRACARE PEN NEEDLES 32G X 5
MM 183, 184, 185
ULTRACARE PEN NEEDLES 32G X 6
MM 183, 184, 185
ULTRACARE PEN NEEDLES 33G X 4
MM 183, 184, 185
ULTRA-COMFORT INSULIN SYRINGE
29G X 1/2..... 182, 184, 185
ULTRA-THIN II INS SYR SHORT 30G X
5/16 182, 184, 185
ULTRA-THIN II INS SYR SHORT 31G X
5/16 182, 184, 185
ULTRA-THIN II INSULIN SYRINGE 29G
X 1/2..... 182, 183, 184, 185
ULTRA-THIN II MINI PEN NEEDLE 31G
X 5 MM..... 183, 184, 185
ULTRA-THIN II PEN NEEDLE SHORT
31G X 8 MM..... 183, 184, 185

ULTRA-THIN II PEN NEEDLES 29G X
12.7MM 183, 184, 185
UNIFINE OTC PEN NEEDLES 31G X 5
MM 183, 184, 185
UNIFINE OTC PEN NEEDLES 32G X 4
MM 183, 184, 185
UNIFINE PEN NEEDLES 32G X 4 MM
..... 183, 184, 185
UNIFINE PENTIPS 29G X 12MM 183, 184,
185
UNIFINE PENTIPS 31G X 6 MM 183, 184,
185
UNIFINE PENTIPS 31G X 8 MM 183, 184,
185
UNIFINE PENTIPS 32G X 4 MM 183, 184,
185
UNIFINE PENTIPS PLUS 29G X 12MM
..... 183, 184, 185
UNIFINE PENTIPS PLUS 31G X 6 MM
..... 183, 184, 185
UNIFINE PENTIPS PLUS 32G X 4 MM
..... 183, 184, 185
UNIFINE PROTECT PEN NEEDLE 30G X
5 MM 183, 184, 185
UNIFINE PROTECT PEN NEEDLE 30G X
8 MM 183, 184, 185
UNIFINE PROTECT PEN NEEDLE 32G X
4 MM 183, 184, 185
UNIFINE SAFECONTROL PEN NEEDLE
30G X 5 MM..... 183, 184, 185
UNIFINE SAFECONTROL PEN NEEDLE
30G X 8 MM..... 183, 184, 185
UNIFINE SAFECONTROL PEN NEEDLE
31G X 5 MM..... 183, 184, 185
UNIFINE SAFECONTROL PEN NEEDLE
31G X 6 MM..... 183, 184, 185
UNIFINE SAFECONTROL PEN NEEDLE
31G X 8 MM..... 183, 184, 185
UNIFINE SAFECONTROL PEN NEEDLE
32G X 4 MM..... 183, 184, 185
UNIFINE ULTRA PEN NEEDLE 31G X 5
MM 183, 184, 185
UNIFINE ULTRA PEN NEEDLE 31G X 6
MM 183, 184, 185

Formulary ID: 26375
Last Updated: 04/01/2026
Effective: 04/01/2026
H9306_26_DRS_039_OE_C

UNIFINE ULTRA PEN NEEDLE 31G X 8
MM 183, 184, 185

UNIFINE ULTRA PEN NEEDLE 32G X 4
MM 183, 184, 185

UPTRAVI ORAL TABLET 1000 MCG,
1200 MCG, 1400 MCG, 1600 MCG, 200
MCG, 400 MCG, 600 MCG, 800 MCG
..... 314, 315

UPTRAVI TITRATION..... 314, 315

ustekinumab-aauz 388, 389

V

VALCHLOR..... 226

VALUE HEALTH INSULIN SYRINGE
29G X 1/2..... 183, 184, 185

VANFLYTA..... 286

VANISHPOINT INSULIN SYRINGE 29G
X 5/16..... 183, 184, 185

VANISHPOINT INSULIN SYRINGE 30G
X 3/16..... 183, 184, 185

VANISHPOINT INSULIN SYRINGE 30G
X 5/16..... 184, 185

VENCLEXTA ORAL TABLET 10 MG,
100 MG, 50 MG..... 402

VENCLEXTA STARTING PACK..... 402

VEOZAH 131, 132

VERIFINE INSULIN PEN NEEDLE 29G
X 12MM..... 184, 185

VERIFINE INSULIN PEN NEEDLE 31G
X 5 MM..... 184, 185

VERIFINE INSULIN PEN NEEDLE 32G
X 6 MM..... 184, 185

VERIFINE INSULIN SYRINGE 28G X 1/2
..... 184, 185

VERIFINE INSULIN SYRINGE 29G X 1/2
..... 184, 185

VERIFINE INSULIN SYRINGE 30G X 1/2
..... 184, 185

VERIFINE INSULIN SYRINGE 30G X
5/16 184, 185

VERIFINE INSULIN SYRINGE 31G X
5/16 184, 185

VERIFINE PLUS PEN NEEDLE 31G X 5
MM 184, 185

VERIFINE PLUS PEN NEEDLE 31G X 8
MM 184, 185

VERIFINE PLUS PEN NEEDLE 32G X 4
MM 184, 185

VERQUVO..... 403

VERZENIO..... 6

vigabatrin 404

vigadrone..... 404

vigpoder 404

VITRAKVI ORAL CAPSULE 100 MG, 25
MG 198

VITRAKVI ORAL SOLUTION 198

VIVIMUSTA 47

VIZIMPRO 78

VONJO 262

VOQUEZNA 407

VORANIGO 408

voriconazole oral suspension reconstituted
..... 409

VOSEVI..... 328, 329

VOWST 127

VP INSULIN SYRINGE 29G X 1/2 184,
185

VUMERITY 91

VYALEV SUBCUTANEOUS SOLUTION
12-240 MG/ML..... 137

VYLOY..... 414

VYNDAMAX..... 343

W

WEBCOL ALCOHOL PREP LARGE PAD
70 % 184, 185

WEGMANS UNIFINE PENTIPS PLUS
31G X 8 MM..... 184, 185

WELIREG..... 46

WINREVAIR..... 336, 337

X

XALKORI ORAL CAPSULE..... 74

XALKORI ORAL CAPSULE SPRINKLE
150 MG, 20 MG, 50 MG 75

XDEMVY..... 219

XELJANZ..... 369, 370

XELJANZ XR 369, 370

XERMELO 353

XIFAXAN ORAL TABLET 200 MG, 550
MG 295
XOLAIR 257, 258, 259
XOSPATA 144
XPOVIO (100 MG ONCE WEEKLY)
ORAL TABLET THERAPY PACK 50
MG 316
XPOVIO (40 MG ONCE WEEKLY) ORAL
TABLET THERAPY PACK 10 MG, 40
MG 316
XPOVIO (40 MG TWICE WEEKLY)
ORAL TABLET THERAPY PACK 40
MG 316
XPOVIO (60 MG ONCE WEEKLY) ORAL
TABLET THERAPY PACK 60 MG.. 316
XPOVIO (60 MG TWICE WEEKLY)... 316
XPOVIO (80 MG ONCE WEEKLY) ORAL
TABLET THERAPY PACK 40 MG, 80
MG 316
XPOVIO (80 MG TWICE WEEKLY)... 316
XTANDI ORAL CAPSULE..... 115
XTANDI ORAL TABLET 40 MG, 80 MG
..... 115

Y
YERVOY 190
YESINTEK..... 394, 395, 396, 397
YONSA..... 8
YUFLYMA (1 PEN)..... 14, 15
YUFLYMA (2 SYRINGE)..... 14, 15
YUFLYMA-CD/UC/HS STARTER .. 14, 15

Z
ZEJULA ORAL CAPSULE 245
ZEJULA ORAL TABLET..... 245
ZELBORAF 401
ZEVRX STERILE ALCOHOL PREP PAD
PAD 70 %..... 184, 185
ZIIHERA..... 410
ZIRABEV 51
ZOLADEX..... 150
ZTALMY 141
ZTLIDO 214
ZURZUVAE ORAL CAPSULE 20 MG, 25
MG, 30 MG..... 416
ZYDELIG 157
ZYKADIA ORAL TABLET 65
ZYNLONTA..... 217
ZYNYZ..... 291