

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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374

Last Updated: 06/01/2026

Effective: 06/01/2026

H9306_26_DRS_041_OE_C

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

ABATACEPT SQ

Products Affected

- ORENCIA CLICKJECT
- ORENCIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	INITIAL: RHEUMATOID ARTHRITIS (RA), POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS (PJIA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST. PSORIATIC ARTHRITIS (PSA): PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST OR RHEUMATOLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	INITIAL: RA: TRIAL OF OR CONTRAINDICATION TO 3 MONTHS OF TREATMENT WITH ONE CONVENTIONAL SYNTHETIC DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG) - IF A PATIENT TRIED METHOTREXATE, THEN TRIAL AT A DOSE OF AT LEAST 20 MG PER WEEK OR MAXIMALLY TOLERATED DOSE IS REQUIRED. INITIAL/RENEWAL: ALL INDICATIONS: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR THE SAME INDICATION. RENEWAL: RA, PJIA, PSA: CONTINUES TO BENEFIT FROM THE MEDICATION.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 26374

Last Updated: 06/01/2026

Effective: 06/01/2026

H9306_26_DRS_041_OE_C

PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

Formulary ID: 26374
Last Updated: 06/01/2026
Effective: 06/01/2026
H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374

Last Updated: 06/01/2026

Effective: 06/01/2026

H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_OE_C

ADALIMUMAB-AATY

Products Affected

- *adalimumab-aaty (1 pen) auto-injector kit 40 mg/0.4ml subcutaneous*
- *adalimumab-aaty (1 pen) subcutaneous auto-injector kit 80 mg/0.8ml*
- *adalimumab-aaty (2 pen)*
- *adalimumab-aaty (2 syringe)*
- *adalimumab-aaty cd/uc/hs start*
- 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

Formulary ID: 26374

Last Updated: 06/01/2026

Effective: 06/01/2026

H9306_26_DRS_041_OE_C

PA Criteria	Criteria Details
	<p>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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_OE_C

ADALIMUMAB-ADBIM

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: PLAQUE PSORIASIS (PSO): PSORIASIS COVERING 3 PERCENT OR MORE OF BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, FACE, SCALP, OR GENITAL AREA.
Age Restrictions	
Prescriber Restrictions	INITIAL: RA, PJA, ANKYLOSING SPONDYLITIS (AS): PRESCRIBED BY OR IN CONSULTATION WITH RHEUMATOLOGIST. PSORIATIC ARTHRITIS (PSA): PRESCRIBED BY OR IN CONSULTATION WITH DERMATOLOGIST OR RHEUMATOLOGIST. PSO, HIDRADENITIS SUPPURATIVA (HS): PRESCRIBED BY OR IN CONSULTATION WITH DERMATOLOGIST. CROHNS DISEASE (CD), ULCERATIVE COLITIS (UC): PRESCRIBED BY OR IN CONSULTATION WITH GASTROENTEROLOGIST. UVEITIS: PRESCRIBED BY OR IN CONSULTATION WITH OPHTHALMOLOGIST.
Coverage Duration	INITIAL: RA, PSO, PJA, AS, PSA, CD, UC, UVEITIS: 6 MONTHS, HS: 12 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	INITIAL: RHEUMATOID ARTHRITIS (RA): TRIAL OF OR CONTRAINDICATION TO 3 MONTHS OF TREATMENT WITH ONE CONVENTIONAL SYNTHETIC DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG) - IF PATIENT TRIED METHOTREXATE, THEN TRIAL AT A DOSE OF AT LEAST 20 MG PER WEEK OR MAXIMALLY TOLERATED DOSE IS REQUIRED. AS: TRIAL OF OR CONTRAINDICATION TO AN NSAID. PSO: 1) AT LEAST A 3 MONTH TRIAL OF ONE ORAL IMMUNOSUPPRESSANT (CYCLOSPORINE, METHOTREXATE, TACROLIMUS) OR PUVA (PHOTOTHERAPY), 2) CONTRAINDICATION OR INTOLERANCE

Formulary ID: 26374

Last Updated: 06/01/2026

Effective: 06/01/2026

H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_OE_C

ADALIMUMAB-BWWD

Products Affected

- HADLIMA
- HADLIMA PUSH TOUCH

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 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: 26374

Last Updated: 06/01/2026

Effective: 06/01/2026

H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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/HADLIMA, XELJANZ, RINVOQ,

Formulary ID: 26374

Last Updated: 06/01/2026

Effective: 06/01/2026

H9306_26_DRS_041_OE_C

PA Criteria	Criteria Details
	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
Prerequisite Therapy Required	Yes

Formulary ID: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_OE_C

APOMORPHINE - SL

Products Affected

- KYNMOBI

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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374

Last Updated: 06/01/2026

Effective: 06/01/2026

H9306_26_DRS_041_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

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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374

Last Updated: 06/01/2026

Effective: 06/01/2026

H9306_26_DRS_041_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 BISPHOSPHONATE, 2) CALCIUM OR PHOSPHATE LEVELS ARE NOT BELOW THE NORMAL RANGE, 3) NOT HAVE A TREATABLE FORM OF RICKETS. RENEWAL: ALL INDICATIONS: 1) IMPROVEMENT IN THE SKELETAL CHARACTERISTICS OF HPP, AND 2) NOT CURRENTLY RECEIVING TREATMENT WITH A BISPHOSPHONATE.</p>
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Formulary ID: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374

Last Updated: 06/01/2026

Effective: 06/01/2026

H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374

Last Updated: 06/01/2026

Effective: 06/01/2026

H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
Last Updated: 06/01/2026
Effective: 06/01/2026
H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_OE_C

CAPIVASERTIB

Products Affected

- TRUQAP ORAL TABLET 200 MG
- TRUQAP ORAL TABLET THERAPY PACK 160 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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374

Last Updated: 06/01/2026

Effective: 06/01/2026

H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_OE_C

CERTOLIZUMAB PEGOL

Products Affected

- CIMZIA (1 SYRINGE)
- 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 SPONDYLOARTHRTIS (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/HADLIMA, XELJANZ, RINVOQ, ORENCIA. PSA: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: COSENTYX, HUMIRA/CYLTEZO/YUFLYMA/HADLIMA, SELARSDI/YESINTEK/USTEKINUMAB-AAUZ, XELJANZ,

Formulary ID: 26374

Last Updated: 06/01/2026

Effective: 06/01/2026

H9306_26_DRS_041_OE_C

PA Criteria	Criteria Details
	<p>RINVOQ, SKYRIZI, TREMFYA, ORENCIA, OTEZLA. AS: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: COSENTYX, HUMIRA/CYLTEZO/YUFLYMA/HADLIMA, XELJANZ, RINVOQ. CD: TRIAL OF OR CONTRAINDICATION TO ONE OF THE FOLLOWING PREFERRED AGENTS: SELARSDI/YESINTEK/USTEKINUMAB-AAUZ, HUMIRA/CYLTEZO/YUFLYMA/HADLIMA, RINVOQ, SKYRIZI, TREMFYA. PSO: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: COSENTYX, HUMIRA/CYLTEZO/YUFLYMA/HADLIMA, SELARSDI/YESINTEK/USTEKINUMAB-AAUZ, 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/HADLIMA, 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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_OE_C

PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

Formulary ID: 26374
Last Updated: 06/01/2026
Effective: 06/01/2026
H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_OE_C

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

Formulary ID: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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, AFRS: 12 MO. AD/CRSWNP/EOE/PN/CSU: INITIAL/RENEWAL: 6 MO/12 MO. ASTHMA/COPD: INIT/RENEW: 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: 26374

Last Updated: 06/01/2026

Effective: 06/01/2026

H9306_26_DRS_041_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 ONE OF THE FOLLOWING: (A) REDUCTION IN COPD EXACERBATIONS FROM BASELINE, OR</p>

Formulary ID: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_OE_C

PA Criteria	Criteria Details
	(B) REDUCTION IN SEVERITY OR FREQUENCY OF COPD-RELATED SYMPTOMS. 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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_OE_C

ELAGOLIX

Products Affected

- ORLISSA ORAL TABLET 150 MG, 200 MG

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

Formulary ID: 26374

Last Updated: 06/01/2026

Effective: 06/01/2026

H9306_26_DRS_041_OE_C

PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

Formulary ID: 26374
Last Updated: 06/01/2026
Effective: 06/01/2026
H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
Last Updated: 06/01/2026
Effective: 06/01/2026
H9306_26_DRS_041_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: 26374

Last Updated: 06/01/2026

Effective: 06/01/2026

H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_OE_C

PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

Formulary ID: 26374
Last Updated: 06/01/2026
Effective: 06/01/2026
H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374

Last Updated: 06/01/2026

Effective: 06/01/2026

H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
Last Updated: 06/01/2026
Effective: 06/01/2026
H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_OE_C

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

Formulary ID: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374

Last Updated: 06/01/2026

Effective: 06/01/2026

H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374

Last Updated: 06/01/2026

Effective: 06/01/2026

H9306_26_DRS_041_OE_C

PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

Formulary ID: 26374
Last Updated: 06/01/2026
Effective: 06/01/2026
H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_OE_C

PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

Formulary ID: 26374
Last Updated: 06/01/2026
Effective: 06/01/2026
H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
Last Updated: 06/01/2026
Effective: 06/01/2026
H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_OE_C

GEPIRONE

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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_OE_C

GLP1-SEMAGLUTIDE

Products Affected

- OZEMPIC
- 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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374

Last Updated: 06/01/2026

Effective: 06/01/2026

H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_OE_C

PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

Formulary ID: 26374
Last Updated: 06/01/2026
Effective: 06/01/2026
H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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/HADLIMA, XELJANZ, RINVOQ, ORENCIA. PSA: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: COSENTYX, HUMIRA/CYLTEZO/YUFLYMA/HADLIMA, SELARSDI/YESINTEK/USTEKINUMAB-AAUZ, XELJANZ, RINVOQ, SKYRIZI, TREMFYA, ORENCIA, OTEZLA. PSO: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: COSENTYX, HUMIRA/CYLTEZO/YUFLYMA/HADLIMA, SELARSDI/YESINTEK/USTEKINUMAB-AAUZ, SKYRIZI, TREMFYA, OTEZLA. AS: TRIAL OF OR CONTRAINDICATION TO

Formulary ID: 26374

Last Updated: 06/01/2026

Effective: 06/01/2026

H9306_26_DRS_041_OE_C

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

Formulary ID: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374

Last Updated: 06/01/2026

Effective: 06/01/2026

H9306_26_DRS_041_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
- AURORA PEN NEEDLES 29G X 12MM
- AURORA PEN NEEDLES 31G X 6 MM
- AURORA PEN NEEDLES 31G X 8 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

Formulary ID: 26374

Last Updated: 06/01/2026

Effective: 06/01/2026

H9306_26_DRS_041_OE_C

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

Formulary ID: 26374
Last Updated: 06/01/2026
Effective: 06/01/2026
H9306_26_DRS_041_OE_C

- COMFORT EZ INSULIN SYRINGE 27G X 1/2" 1 ML
- COMFORT EZ INSULIN SYRINGE 28G X 1/2" 0.5 ML
- COMFORT EZ INSULIN SYRINGE 28G X 1/2" 1 ML
- COMFORT EZ INSULIN SYRINGE 29G X 1/2" 0.3 ML
- COMFORT EZ INSULIN SYRINGE 29G X 1/2" 0.5 ML
- COMFORT EZ INSULIN SYRINGE 29G X 1/2" 1 ML
- COMFORT EZ INSULIN SYRINGE 30G X 1/2" 0.3 ML
- COMFORT EZ INSULIN SYRINGE 30G X 1/2" 0.5 ML
- COMFORT EZ INSULIN SYRINGE 30G X 1/2" 1 ML
- COMFORT EZ INSULIN SYRINGE 30G X 5/16" 0.3 ML
- COMFORT EZ INSULIN SYRINGE 30G X 5/16" 0.5 ML
- COMFORT EZ INSULIN SYRINGE 30G X 5/16" 1 ML
- COMFORT EZ INSULIN SYRINGE 31G X 15/64" 0.3 ML
- COMFORT EZ INSULIN SYRINGE 31G X 15/64" 0.5 ML
- COMFORT EZ INSULIN SYRINGE 31G X 15/64" 1 ML
- COMFORT EZ INSULIN SYRINGE 31G X 5/16" 0.3 ML
- COMFORT EZ INSULIN SYRINGE 31G X 5/16" 0.5 ML
- COMFORT EZ INSULIN SYRINGE 31G X 5/16" 1 ML
- COMFORT EZ INSULIN SYRINGE 31G X 5/16" 1 ML
- COMFORT EZ PEN NEEDLES 31G X 5 MM
- COMFORT EZ PEN NEEDLES 31G X 6 MM
- COMFORT EZ PEN NEEDLES 31G X 8 MM
- COMFORT EZ PEN NEEDLES 32G X 4 MM
- COMFORT EZ PEN NEEDLES 32G X 5 MM
- COMFORT EZ PEN NEEDLES 32G X 6 MM
- COMFORT EZ PEN NEEDLES 32G X 8 MM
- COMFORT EZ PEN NEEDLES 33G X 4 MM
- COMFORT EZ PEN NEEDLES 33G X 5 MM
- COMFORT EZ PEN NEEDLES 33G X 6 MM
- COMFORT EZ PEN NEEDLES 33G X 8 MM
- COMFORT EZ PRO PEN NEEDLES 30G X 8 MM
- COMFORT EZ PRO PEN NEEDLES 31G X 4 MM
- COMFORT EZ PRO PEN NEEDLES 31G X 5 MM
- COMFORT TOUCH INSULIN PEN NEED 31G X 4 MM
- COMFORT TOUCH INSULIN PEN NEED 31G X 5 MM
- COMFORT TOUCH INSULIN PEN NEED 31G X 6 MM
- COMFORT TOUCH INSULIN PEN NEED 31G X 8 MM
- COMFORT TOUCH INSULIN PEN NEED 32G X 4 MM
- COMFORT TOUCH INSULIN PEN NEED 32G X 5 MM
- COMFORT TOUCH INSULIN PEN NEED 32G X 6 MM
- COMFORT TOUCH INSULIN PEN NEED 32G X 8 MM
- CURITY ALCOHOL PREPS PAD 70 %
- CURITY ALL PURPOSE SPONGES PAD 2"X2"
- CURITY GAUZE PAD 2"X2"
- CURITY GAUZE SPONGE PAD 2"X2"

Formulary ID: 26374
Last Updated: 06/01/2026
Effective: 06/01/2026
H9306_26_DRS_041_OE_C

- CURITY SPONGES PAD 2"X2"
- CVS ALCOHOL PREP PADS PAD 70 %
- CVS GAUZE PAD 2"X2"
- CVS GAUZE STERILE PAD 2"X2"
- *cvs isopropyl alcohol wipes*
- CVS PREP PAD 70 %
- 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 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 INSULIN SYRINGE 31G X 5/16" 1 ML
- DROPLET INSULIN SYRINGE 31G X 5/16" 0.3 ML
- DROPLET INSULIN SYRINGE 31G X 5/16" 0.5 ML
- DROPLET INSULIN SYRINGE 31G X 5/16" 1 ML
- DROPLET 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

Formulary ID: 26374
Last Updated: 06/01/2026
Effective: 06/01/2026
H9306_26_DRS_041_OE_C

- DROPSAFE SAFETY SYRINGE/NEEDLE 31G X 15/64" 0.3 ML
- DROPSAFE SAFETY SYRINGE/NEEDLE 31G X 15/64" 0.5 ML
- DROPSAFE SAFETY SYRINGE/NEEDLE 31G X 15/64" 1 ML
- DROPSAFE SAFETY SYRINGE/NEEDLE 31G X 5/16" 0.3 ML
- DROPSAFE SAFETY SYRINGE/NEEDLE 31G X 5/16" 0.5 ML
- DROPSAFE SAFETY SYRINGE/NEEDLE 31G X 5/16" 1 ML
- DRUG MART ULTRA COMFORT SYR 29G X 1/2" 0.3 ML
- DRUG MART ULTRA COMFORT SYR 29G X 1/2" 1 ML
- DRUG MART ULTRA COMFORT SYR 30G X 5/16" 0.5 ML
- DRUG MART ULTRA COMFORT SYR 30G X 5/16" 1 ML
- 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 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

Formulary ID: 26374
Last Updated: 06/01/2026
Effective: 06/01/2026
H9306_26_DRS_041_OE_C

- EASY TOUCH INSULIN SAFETY SYR 29G X 1/2" 0.5 ML
- EASY TOUCH INSULIN SAFETY SYR 29G X 1/2" 1 ML
- EASY TOUCH INSULIN SAFETY SYR 30G X 1/2" 1 ML
- EASY TOUCH INSULIN SAFETY SYR 30G X 5/16" 0.5 ML
- EASY TOUCH INSULIN SYRINGE 27G X 1/2" 0.5 ML
- EASY TOUCH INSULIN SYRINGE 27G X 1/2" 1 ML
- EASY TOUCH INSULIN SYRINGE 27G X 5/8" 1 ML
- EASY TOUCH INSULIN SYRINGE 28G X 1/2" 0.5 ML
- EASY TOUCH INSULIN SYRINGE 28G X 1/2" 1 ML
- EASY TOUCH INSULIN SYRINGE 29G X 1/2" 0.5 ML
- EASY TOUCH INSULIN SYRINGE 29G X 1/2" 1 ML
- EASY TOUCH INSULIN SYRINGE 30G X 1/2" 0.3 ML
- EASY TOUCH INSULIN SYRINGE 30G X 1/2" 0.5 ML
- EASY TOUCH INSULIN SYRINGE 30G X 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

Formulary ID: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_OE_C

- 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
- 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 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

Formulary ID: 26374

Last Updated: 06/01/2026

Effective: 06/01/2026

H9306_26_DRS_041_OE_C

- GLUCOPRO INSULIN SYRINGE 30G X 5/16" 0.5 ML
- GLUCOPRO INSULIN SYRINGE 30G X 5/16" 1 ML
- GLUCOPRO INSULIN SYRINGE 31G X 5/16" 0.3 ML
- GLUCOPRO INSULIN SYRINGE 31G X 5/16" 0.5 ML
- GLUCOPRO INSULIN SYRINGE 31G X 5/16" 1 ML
- GNP ALCOHOL SWABS PAD
- GNP 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

Formulary ID: 26374

Last Updated: 06/01/2026

Effective: 06/01/2026

H9306_26_DRS_041_OE_C

- HM STERILE ALCOHOL PREP PAD
- HM STERILE PADS PAD 2"X2"
- HM ULTICARE INSULIN SYRINGE 30G X 1/2" 1 ML
- HM ULTICARE INSULIN SYRINGE 31G X 5/16" 0.3 ML
- HM ULTICARE SHORT PEN NEEDLES 31G X 8 MM
- INCONTROL ULTICARE PEN NEEDLES 31G X 6 MM
- INCONTROL ULTICARE PEN NEEDLES 31G X 8 MM
- INCONTROL ULTICARE PEN NEEDLES 32G X 4 MM
- INSULIN SYRINGE 29G X 1/2" 0.3 ML
- INSULIN SYRINGE 29G X 1/2" 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 29G X 12MM
- 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 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

Formulary ID: 26374

Last Updated: 06/01/2026

Effective: 06/01/2026

H9306_26_DRS_041_OE_C

- LEADER UNIFINE PENTIPS 32G X 4 MM
- LEADER UNIFINE PENTIPS PLUS 31G X 5 MM
- LEADER UNIFINE PENTIPS PLUS 31G X 8 MM
- LITETOUCH INSULIN SYRINGE 28G X 1/2" 0.5 ML
- LITETOUCH INSULIN SYRINGE 28G X 1/2" 1 ML
- LITETOUCH INSULIN SYRINGE 29G X 1/2" 0.3 ML
- LITETOUCH INSULIN SYRINGE 29G X 1/2" 0.5 ML
- LITETOUCH INSULIN SYRINGE 29G X 1/2" 1 ML
- LITETOUCH INSULIN SYRINGE 30G X 5/16" 0.3 ML
- LITETOUCH INSULIN SYRINGE 30G X 5/16" 0.5 ML
- LITETOUCH INSULIN SYRINGE 30G X 5/16" 1 ML
- LITETOUCH INSULIN SYRINGE 31G X 5/16" 0.3 ML
- LITETOUCH INSULIN SYRINGE 31G X 5/16" 0.5 ML
- LITETOUCH INSULIN SYRINGE 31G X 5/16" 1 ML
- LITETOUCH PEN NEEDLES 29G X 12.7MM
- LITETOUCH PEN NEEDLES 31G X 5 MM
- LITETOUCH PEN NEEDLES 31G X 6 MM
- LITETOUCH PEN NEEDLES 31G X 8 MM
- LITETOUCH PEN NEEDLES 32G X 4 MM
- MAGELLAN INSULIN SAFETY SYR 29G X 1/2" 0.3 ML
- MAGELLAN INSULIN SAFETY SYR 29G X 1/2" 0.5 ML
- MAGELLAN INSULIN SAFETY SYR 30G X 5/16" 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"

Formulary ID: 26374

Last Updated: 06/01/2026

Effective: 06/01/2026

H9306_26_DRS_041_OE_C

- MM PEN NEEDLES 31G X 6 MM
- MM PEN NEEDLES 32G X 4 MM
- MONOJECT INSULIN SYRINGE 25G X 5/8" 1 ML
- MONOJECT INSULIN SYRINGE 27G X 1/2" 1 ML (OTC)
- MONOJECT INSULIN SYRINGE 28G X 1/2" 0.5 ML (RX)
- MONOJECT INSULIN SYRINGE 28G X 1/2" 1 ML (OTC)
- MONOJECT INSULIN SYRINGE 28G X 1/2" 1 ML (RX)
- MONOJECT INSULIN SYRINGE 29G X 1/2" 0.3 ML
- MONOJECT INSULIN SYRINGE 29G X 1/2" 0.5 ML
- MONOJECT INSULIN SYRINGE 29G X 1/2" 1 ML (RX)
- MONOJECT INSULIN SYRINGE 30G X 5/16" 0.3 ML
- MONOJECT INSULIN SYRINGE 30G X 5/16" 0.5 ML (RX)
- MONOJECT INSULIN SYRINGE 30G X 5/16" 1 ML (RX)
- MONOJECT INSULIN SYRINGE 31G X 5/16" 1 ML
- MONOJECT INSULIN SYRINGE U-100 1 ML
- MONOJECT ULTRA COMFORT SYRINGE 28G X 1/2" 0.5 ML (OTC)
- MONOJECT ULTRA COMFORT SYRINGE 28G X 1/2" 0.5 ML (RX)
- MONOJECT ULTRA COMFORT SYRINGE 28G X 1/2" 1 ML (OTC)
- MONOJECT ULTRA COMFORT SYRINGE 29G X 1/2" 0.5 ML
- MONOJECT ULTRA COMFORT SYRINGE 29G X 1/2" 1 ML
- MONOJECT ULTRA COMFORT SYRINGE 30G X 5/16" 0.3 ML (OTC)
- MONOJECT ULTRA COMFORT SYRINGE 30G X 5/16" 0.3 ML (RX)
- MONOJECT ULTRA COMFORT SYRINGE 30G X 5/16" 0.5 ML (RX)
- MS INSULIN SYRINGE 31G X 5/16" 0.3 ML
- MS INSULIN SYRINGE 31G X 5/16" 0.5 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 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
- PREFERRED PLUS INSULIN SYRINGE 28G X 1/2" 0.5 ML
- PREFERRED PLUS INSULIN SYRINGE 29G X 1/2" 0.5 ML

Formulary ID: 26374

Last Updated: 06/01/2026

Effective: 06/01/2026

H9306_26_DRS_041_OE_C

- 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
- QUICK TOUCH INSULIN PEN NEEDLE 33G X 4 MM
- QUICK TOUCH INSULIN PEN NEEDLE 33G X 5 MM

Formulary ID: 26374

Last Updated: 06/01/2026

Effective: 06/01/2026

H9306_26_DRS_041_OE_C

- 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
- RAYA SURE PEN NEEDLE 31G X 8 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 ALCOHOL SWABS PAD 70 %
- 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: 26374
Last Updated: 06/01/2026
Effective: 06/01/2026
H9306_26_DRS_041_OE_C

- STERILE GAUZE 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 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
- THERAGAUZE PAD 2"X2"
- TODAYS HEALTH PEN NEEDLES 29G X 12MM
- TODAYS HEALTH SHORT PEN NEEDLE 31G X 8 MM
- TOPCARE CLICKFINE PEN NEEDLES 31G X 6 MM
- TOPCARE CLICKFINE PEN NEEDLES 31G X 8 MM
- TOPCARE ULTRA COMFORT INS SYR 29G X 1/2" 0.3 ML
- TOPCARE ULTRA COMFORT INS SYR 29G X 1/2" 0.5 ML
- TOPCARE ULTRA COMFORT INS SYR 29G X 1/2" 1 ML
- TOPCARE ULTRA COMFORT INS SYR 30G X 5/16" 0.3 ML
- TOPCARE ULTRA COMFORT INS SYR 30G X 5/16" 0.5 ML
- TOPCARE ULTRA COMFORT INS SYR 30G X 5/16" 1 ML
- TOPCARE ULTRA COMFORT INS SYR 31G X 5/16" 0.3 ML
- TOPCARE ULTRA COMFORT INS SYR 31G X 5/16" 0.5 ML
- TOPCARE ULTRA COMFORT INS SYR 31G X 5/16" 1 ML
- TRUE COMFORT ALCOHOL PREP PADS PAD 70 %

Formulary ID: 26374

Last Updated: 06/01/2026

Effective: 06/01/2026

H9306_26_DRS_041_OE_C

- 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
- TRUEPLUS INSULIN SYRINGE 30G X 5/16" 1 ML
- TRUEPLUS INSULIN SYRINGE 31G X 5/16" 0.3 ML

Formulary ID: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_OE_C

- 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
- ULTIGUARD SAFEPACK PEN NEEDLE 31G X 5 MM
- ULTIGUARD SAFEPACK PEN NEEDLE 31G X 6 MM

Formulary ID: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_OE_C

- 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
- ULTRA-THIN II INSULIN SYRINGE 29G X 1/2" 1 ML
- ULTRA-THIN II MINI PEN NEEDLE 31G X 5 MM

Formulary ID: 26374

Last Updated: 06/01/2026

Effective: 06/01/2026

H9306_26_DRS_041_OE_C

- 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
- VANISHPOINT INSULIN SYRINGE 30G X 5/16" 0.5 ML
- VANISHPOINT INSULIN SYRINGE 30G X 5/16" 1 ML

Formulary ID: 26374

Last Updated: 06/01/2026

Effective: 06/01/2026

H9306_26_DRS_041_OE_C

- 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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_OE_C

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

Formulary ID: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_OE_C

INTERFERON FOR MS-PLEGRIDY

Products Affected

- PLEGRIDY STARTER PACK SUBCUTANEOUS SOLUTION AUTO-INJECTOR
- PLEGRIDY SUBCUTANEOUS SOLUTION AUTO-INJECTOR
- PLEGRIDY STARTER PACK SUBCUTANEOUS SOLUTION PREFILLED SYRINGE
- 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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
Last Updated: 06/01/2026
Effective: 06/01/2026
H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
Last Updated: 06/01/2026
Effective: 06/01/2026
H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_OE_C

LETERMОВIR

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: 26374

Last Updated: 06/01/2026

Effective: 06/01/2026

H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_OE_C

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

Formulary ID: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_OE_C

PA Criteria	Criteria Details
Prerequisite Therapy Required	No

Formulary ID: 26374
Last Updated: 06/01/2026
Effective: 06/01/2026
H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
Last Updated: 06/01/2026
Effective: 06/01/2026
H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374

Last Updated: 06/01/2026

Effective: 06/01/2026

H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_OE_C

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

Formulary ID: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
Last Updated: 06/01/2026
Effective: 06/01/2026
H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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 GLUCOCORTICOIDS. RENEWAL: 1) CONTINUES TO HAVE IMPROVEMENT OF GLUCOSE TOLERANCE OR STABLE GLUCOSE TOLERANCE (E.G., REDUCED A1C, IMPROVED FASTING GLUCOSE), 2) CONTINUES TO HAVE TOLERABILITY TO THERAPY, AND 3) CONTINUES TO NOT BE A CANDIDATE FOR SURGICAL TREATMENT OR HAS FAILED SURGERY.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Formulary ID: 26374

Last Updated: 06/01/2026

Effective: 06/01/2026

H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_OE_C

MIRDAMETINIB

Products Affected

- GOMEKLI ORAL CAPSULE 1 MG, 2 MG
- GOMEKLI ORAL TABLET SOLUBLE 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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_OE_C

NERANDOMILAST

Products Affected

- JASCAYD

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. PROGRESSIVE PULMONARY FIBROSIS (PPF): 1) AT LEAST 10% FIBROSIS ON A CHEST HRCT, AND 2) INTERSTITIAL LUNG DISEASE WITH A PROGRESSIVE PHENOTYPE (PF-ILD).
Age Restrictions	
Prescriber Restrictions	INITIAL: IPF: PRESCRIBED BY OR IN CONSULTATION WITH A PULMONOLOGIST. PPF: PRESCRIBED BY OR IN CONSULTATION WITH A PULMONOLOGIST OR RHEUMATOLOGIST.
Coverage Duration	INITIAL/RENEWAL: 12 MONTHS.
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, SYSTEMIC SCLEROSIS, RHEUMATOID ARTHRITIS, RADIATION, SARCOIDOSIS, BRONCHIOLITIS OBLITERANS ORGANIZING PNEUMONIA, HUMAN IMMUNODEFICIENCY VIRUS (HIV) INFECTION, VIRAL HEPATITIS, CANCER), AND 2) TRIAL OF OR CONTRAINDICATION TO ONE OF THE FOLLOWING PREFERRED AGENTS: OFEV, PIRFENIDONE. PPF: 1) LUNG FUNCTION AND RESPIRATORY SYMPTOMS OR CHEST IMAGING HAVE WORSENERD/PROGRESSED DESPITE TREATMENT WITH MEDICATIONS USED IN CLINICAL PRACTICE FOR ILD (NOT ATTRIBUTABLE TO COMORBIDITIES SUCH AS INFECTION, HEART FAILURE), AND 2) TRIAL OF OR CONTRAINDICATION

Formulary ID: 26374

Last Updated: 06/01/2026

Effective: 06/01/2026

H9306_26_DRS_041_OE_C

PA Criteria	Criteria Details
	TO THE PREFERRED AGENT: OFEV (NINTEDANIB). RENEWAL: IPF, PPF: 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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_OE_C

NILOTINIB - TASIGNA

Products Affected

- *nilotinib hcl oral capsule 150 mg, 200 mg, 50 mg*
- 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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_OE_C

NINTEDANIB

Products Affected

- *nintedanib esylate*
- 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: 26374

Last Updated: 06/01/2026

Effective: 06/01/2026

H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374

Last Updated: 06/01/2026

Effective: 06/01/2026

H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_OE_C

OMACETAXINE

Products Affected

- SYNRIPO

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

Formulary ID: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374

Last Updated: 06/01/2026

Effective: 06/01/2026

H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_OE_C

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

Formulary ID: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374

Last Updated: 06/01/2026

Effective: 06/01/2026

H9306_26_DRS_041_OE_C

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

Formulary ID: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_OE_C

PA Criteria	Criteria Details
Prerequisite Therapy Required	No

Formulary ID: 26374
Last Updated: 06/01/2026
Effective: 06/01/2026
H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
Last Updated: 06/01/2026
Effective: 06/01/2026
H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
Last Updated: 06/01/2026
Effective: 06/01/2026
H9306_26_DRS_041_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: 26374

Last Updated: 06/01/2026

Effective: 06/01/2026

H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_OE_C

PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

Formulary ID: 26374
Last Updated: 06/01/2026
Effective: 06/01/2026
H9306_26_DRS_041_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: 26374

Last Updated: 06/01/2026

Effective: 06/01/2026

H9306_26_DRS_041_OE_C

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

Formulary ID: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
Last Updated: 06/01/2026
Effective: 06/01/2026
H9306_26_DRS_041_OE_C

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

Formulary ID: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374

Last Updated: 06/01/2026

Effective: 06/01/2026

H9306_26_DRS_041_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/HADLIMA, 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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_OE_C

PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

Formulary ID: 26374
Last Updated: 06/01/2026
Effective: 06/01/2026
H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374

Last Updated: 06/01/2026

Effective: 06/01/2026

H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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 ONE OF THE FOLLOWING AGENTS: 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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_OE_C

PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

Formulary ID: 26374
Last Updated: 06/01/2026
Effective: 06/01/2026
H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374

Last Updated: 06/01/2026

Effective: 06/01/2026

H9306_26_DRS_041_OE_C

PA Criteria	Criteria Details
Prerequisite Therapy Required	No

Formulary ID: 26374
Last Updated: 06/01/2026
Effective: 06/01/2026
H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374

Last Updated: 06/01/2026

Effective: 06/01/2026

H9306_26_DRS_041_OE_C

PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

Formulary ID: 26374
Last Updated: 06/01/2026
Effective: 06/01/2026
H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_OE_C

PA Criteria	Criteria Details
Prerequisite Therapy Required	No

Formulary ID: 26374
Last Updated: 06/01/2026
Effective: 06/01/2026
H9306_26_DRS_041_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: 26374

Last Updated: 06/01/2026

Effective: 06/01/2026

H9306_26_DRS_041_OE_C

PA Criteria	Criteria Details
Prerequisite Therapy Required	No

Formulary ID: 26374
Last Updated: 06/01/2026
Effective: 06/01/2026
H9306_26_DRS_041_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: 26374
Last Updated: 06/01/2026
Effective: 06/01/2026
H9306_26_DRS_041_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: 26374
Last Updated: 06/01/2026
Effective: 06/01/2026
H9306_26_DRS_041_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: 26374
Last Updated: 06/01/2026
Effective: 06/01/2026
H9306_26_DRS_041_OE_C

PA Criteria	Criteria Details
Prerequisite Therapy Required	No

Formulary ID: 26374
Last Updated: 06/01/2026
Effective: 06/01/2026
H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_OE_C

PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

Formulary ID: 26374
Last Updated: 06/01/2026
Effective: 06/01/2026
H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374

Last Updated: 06/01/2026

Effective: 06/01/2026

H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_OE_C

PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

Formulary ID: 26374
Last Updated: 06/01/2026
Effective: 06/01/2026
H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
Last Updated: 06/01/2026
Effective: 06/01/2026
H9306_26_DRS_041_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: 26374
Last Updated: 06/01/2026
Effective: 06/01/2026
H9306_26_DRS_041_OE_C

PA Criteria	Criteria Details
Prerequisite Therapy Required	No

Formulary ID: 26374
Last Updated: 06/01/2026
Effective: 06/01/2026
H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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/HADLIMA, 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/HADLIMA, 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: 26374

Last Updated: 06/01/2026

Effective: 06/01/2026

H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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/HADLIMA, 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/HADLIMA, 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.

Formulary ID: 26374

Last Updated: 06/01/2026

Effective: 06/01/2026

H9306_26_DRS_041_OE_C

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

Formulary ID: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_OE_C

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

Formulary ID: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_OE_C

TREPROSTINIL-YUTREPIA

Products Affected

- YUTREPIA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: PULMONARY ARTERIAL HYPERTENSION (PAH), PULMONARY HYPERTENSION-INTERSTITIAL LUNG DISEASE (PH-ILD): 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	INITIAL: PAH, PH-ILD: PRESCRIBED BY OR IN CONSULTATION WITH A CARDIOLOGIST OR PULMONOLOGIST.
Coverage Duration	INITIAL/RENEWAL: 12 MONTHS.
Other Criteria	INITIAL: PAH: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING AGENTS FROM DIFFERENT DRUG CLASSES: 1) ORAL ENDOTHELIN RECEPTOR ANTAGONIST, 2) ORAL PHOSPHODIESTERASE TYPE-5 INHIBITOR FOR PAH, 3) ORAL CGMP STIMULATOR, 4) IV/SQ PROSTACYCLIN.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Formulary ID: 26374

Last Updated: 06/01/2026

Effective: 06/01/2026

H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
Last Updated: 06/01/2026
Effective: 06/01/2026
H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374

Last Updated: 06/01/2026

Effective: 06/01/2026

H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374

Last Updated: 06/01/2026

Effective: 06/01/2026

H9306_26_DRS_041_OE_C

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

Formulary ID: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374

Last Updated: 06/01/2026

Effective: 06/01/2026

H9306_26_DRS_041_OE_C

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

Formulary ID: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374

Last Updated: 06/01/2026

Effective: 06/01/2026

H9306_26_DRS_041_OE_C

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

Formulary ID: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374

Last Updated: 06/01/2026

Effective: 06/01/2026

H9306_26_DRS_041_OE_C

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

Formulary ID: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374

Last Updated: 06/01/2026

Effective: 06/01/2026

H9306_26_DRS_041_OE_C

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

Formulary ID: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
Last Updated: 06/01/2026
Effective: 06/01/2026
H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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 RIOICIGUAT OR PDE-5 INHIBITORS.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Formulary ID: 26374

Last Updated: 06/01/2026

Effective: 06/01/2026

H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
Last Updated: 06/01/2026
Effective: 06/01/2026
H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
Last Updated: 06/01/2026
Effective: 06/01/2026
H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_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: 26374
 Last Updated: 06/01/2026
 Effective: 06/01/2026
 H9306_26_DRS_041_OE_C

INDEX

A

abiraterone acetate	7	ALCOHOL PREP PAD 70 %.	167, 186, 187
ABIRATERONE ACETATE		ALCOHOL PREP PADS PAD 70 %	167, 186, 187
MICRONIZED	8	ALCOHOL SWABS PAD.....	167, 186, 187
abirtega.....	7	ALCOHOL SWABS PAD 70 % ...	167, 186, 187
ABOUTTIME PEN NEEDLE 30G X 8 MM		ALECENSA.....	21
.....	167, 186, 187	ALTRENO	376
ABOUTTIME PEN NEEDLE 31G X 5 MM		ALUNBRIG ORAL TABLET 180 MG, 30	
.....	167, 186, 187	MG, 90 MG.....	59
ABOUTTIME PEN NEEDLE 31G X 8 MM		ALUNBRIG ORAL TABLET THERAPY	
.....	167, 186, 187	PACK.....	59
ABOUTTIME PEN NEEDLE 32G X 4 MM		ALVAIZ.....	109
.....	167, 186, 187	ALYFTREK ORAL TABLET 10-50-125	
ACTIMMUNE.....	191	MG, 4-20-50 MG	405
adalimumab-aaty (1 pen) auto-injector kit 40		alyq.....	345
mg/0.4ml subcutaneous.....	14, 15	ANKTIVA	256
adalimumab-aaty (1 pen) subcutaneous auto-		AQ INSULIN SYRINGE 31G X 5/16...	167, 186, 187
injector kit 80 mg/0.8ml.....	14, 15	
adalimumab-aaty (2 pen)	14, 15	AQINJECT PEN NEEDLE 31G X 5 MM	
adalimumab-aaty (2 syringe)	14, 15	167, 186, 187
adalimumab-aaty cd/uc/hs start.....	14, 15	AQINJECT PEN NEEDLE 32G X 4 MM	
ADEMPAS	304, 305	167, 186, 187
ADVOCATE INSULIN PEN NEEDLE 32G		ARCALYST	300, 301
X 4 MM.....	167, 186, 187	ARIKAYCE.....	23
ADVOCATE INSULIN PEN NEEDLES		armodafinil.....	240
29G X 12.7MM.....	167, 186, 187	ASSURE ID DUO PRO PEN NEEDLES	
ADVOCATE INSULIN PEN NEEDLES		31G X 5 MM.....	167, 186, 187
31G X 5 MM.....	167, 186, 187	ASSURE ID INSULIN SAFETY SYR 29G	
ADVOCATE INSULIN PEN NEEDLES		X 1/2.....	167, 186, 187
31G X 8 MM.....	167, 186, 187	ASSURE ID INSULIN SAFETY SYR 31G	
ADVOCATE INSULIN PEN NEEDLES		X 15/64.....	167, 186, 187
33G X 4 MM.....	167, 186, 187	ASSURE ID PRO PEN NEEDLES 30G X 5	
ADVOCATE INSULIN SYRINGE 29G X		MM	167, 186, 187
1/2	167, 186, 187	ATTRUBY.....	10
ADVOCATE INSULIN SYRINGE 30G X		AUGTYRO ORAL CAPSULE 160 MG, 40	
5/16	167, 186, 187	MG	293
ADVOCATE INSULIN SYRINGE 31G X		AUM ALCOHOL PREP PADS PAD 70 %	
5/16	167, 186, 187	167, 186, 187
AIMOVIG.....	122	AUM INSULIN SAFETY PEN NEEDLE	
AKEEGA	250	31G X 4 MM.....	167, 186, 187
ALCOHOL PREP PAD.....	167, 186, 187		

AUM INSULIN SAFETY PEN NEEDLE 31G X 5 MM.....	167, 186, 187	MG, 18 MG, 24 MG, 30 MG, 36 MG, 42 MG, 48 MG, 6 MG	89
AUM MINI INSULIN PEN NEEDLE 32G X 4 MM.....	167, 186, 187	AUSTEDO XR PATIENT TITRATION .	89
AUM MINI INSULIN PEN NEEDLE 32G X 5 MM.....	167, 186, 187	AVMAPKI FAKZYNJA CO-PACK.....	40
AUM MINI INSULIN PEN NEEDLE 32G X 6 MM.....	167, 186, 187	AVONEX PEN INTRAMUSCULAR AUTO-INJECTOR KIT.....	188
AUM MINI INSULIN PEN NEEDLE 32G X 8 MM.....	167, 186, 187	AVONEX PREFILLED INTRAMUSCULAR PREFILLED SYRINGE KIT.....	188
AUM MINI INSULIN PEN NEEDLE 33G X 4 MM.....	167, 186, 187	AYVAKIT	39
AUM MINI INSULIN PEN NEEDLE 33G X 5 MM.....	168, 186, 187	B	
AUM MINI INSULIN PEN NEEDLE 33G X 6 MM.....	168, 186, 187	BALVERSA ORAL TABLET 3 MG, 4 MG, 5 MG.....	121
AUM PEN NEEDLE 32G X 4 MM	168, 186, 187	BD AUTOSHIELD DUO 30G X 5 MM	168, 186, 187
AUM PEN NEEDLE 32G X 5 MM	168, 186, 187	BD ECLIPSE SYRINGE 30G X 1/2	168, 186, 187
AUM PEN NEEDLE 32G X 6 MM	168, 186, 187	BD INSULIN SYR ULTRAFINE II 31G X 5/16	168, 186, 187
AUM PEN NEEDLE 33G X 4 MM	168, 186, 187	BD INSULIN SYRINGE 27.5G X 5/8..	168, 186, 187
AUM PEN NEEDLE 33G X 5 MM	168, 186, 187	BD INSULIN SYRINGE 27G X 1/2.....	168, 186, 187
AUM PEN NEEDLE 33G X 6 MM	168, 186, 187	BD INSULIN SYRINGE 29G X 1/2.....	168, 186, 187
AUM READYGARD DUO PEN NEEDLE 32G X 4 MM.....	168, 186, 187	BD INSULIN SYRINGE HALF-UNIT 31G X 5/16.....	168, 186, 187
AUM SAFETY PEN NEEDLE 31G X 4 MM	168, 186, 187	BD INSULIN SYRINGE MICROFINE 27G X 5/8.....	168, 186, 187
AURORA PEN NEEDLES 29G X 12MM	168, 186, 187	BD INSULIN SYRINGE MICROFINE 28G X 1/2.....	168, 186, 187
AURORA PEN NEEDLES 31G X 6 MM	168, 186, 187	BD INSULIN SYRINGE U-100 1 ML .	168, 186, 187
AURORA PEN NEEDLES 31G X 8 MM	168, 186, 187	BD INSULIN SYRINGE ULTRAFINE 29G X 1/2.....	168, 186, 187
AUSTEDO ORAL TABLET 12 MG, 6 MG, 9 MG	89	BD INSULIN SYRINGE ULTRAFINE 30G X 1/2.....	168, 186, 187
AUSTEDO XR ORAL TABLET EXTENDED RELEASE 24 HOUR 12		BD PEN NEEDLE MICRO ULTRAFINE 32G X 6 MM.....	168, 186, 187
		BD PEN NEEDLE MINI U/F 31G X 5 MM	168, 186, 187
		BD PEN NEEDLE MINI ULTRAFINE 31G X 5 MM.....	168, 186, 187

BD PEN NEEDLE NANO 2ND GEN 32G X 4 MM.....	168, 186, 187	BORUZU	56
BD PEN NEEDLE NANO ULTRAFINE 32G X 4 MM.....	168, 186, 187	bosentan oral tablet	57
BD PEN NEEDLE ORIG ULTRAFINE 29G X 12.7MM.....	168, 186, 187	BOSULIF ORAL CAPSULE 100 MG, 50 MG	58
BD PEN NEEDLE SHORT ULTRAFINE 31G X 8 MM.....	168, 186, 187	BOSULIF ORAL TABLET 100 MG, 400 MG, 500 MG.....	58
BD SAFETYGLIDE INSULIN SYRINGE 29G X 1/2.....	168, 186, 187	BRAFTOVI ORAL CAPSULE 75 MG .	113
BD SAFETYGLIDE INSULIN SYRINGE 30G X 5/16.....	168, 186, 187	BRUKINSA ORAL CAPSULE	416
BD SAFETYGLIDE INSULIN SYRINGE 31G X 15/64.....	168, 186, 187	BRUKINSA ORAL TABLET	416
BD SAFETYGLIDE INSULIN SYRINGE 31G X 5/16.....	168, 186, 187	C	
BD SAFETYGLIDE SYRINGE/NEEDLE 27G X 5/8.....	168, 186, 187	CABOMETYX ORAL TABLET 20 MG, 40 MG, 60 MG.....	62
BD SWAB SINGLE USE REGULAR PAD	168, 186, 187	CALQUENCE	9
BD SWABS SINGLE USE BUTTERFLY PAD.....	169, 186, 187	CAMCEVI	208
BD VEO INSULIN SYR U/F 1/2UNIT 31G X 15/64.....	169, 186, 187	CAMZYOS	226
BD VEO INSULIN SYR ULTRAFINE 31G X 15/64.....	169, 186, 187	CAPRELSA ORAL TABLET 100 MG, 300 MG	404
BD VEO INSULIN SYRINGE U/F 31G X 15/64	169, 186, 187	CAREFINE PEN NEEDLES 29G X 12MM	169, 186, 187
BENDAMUSTINE HCL INTRAVENOUS SOLUTION.....	49	CAREFINE PEN NEEDLES 30G X 8 MM	169, 186, 187
bendamustine hcl intravenous solution reconstituted.....	49	CAREFINE PEN NEEDLES 31G X 6 MM	169, 186, 187
BENDEKA	49	CAREFINE PEN NEEDLES 31G X 8 MM	169, 186, 187
BENLYSTA SUBCUTANEOUS.....	46	CAREFINE PEN NEEDLES 32G X 4 MM	169, 186, 187
BESREMI	312	CAREFINE PEN NEEDLES 32G X 5 MM	169, 186, 187
betaine	52	CAREFINE PEN NEEDLES 32G X 6 MM	169, 186, 187
BETASERON SUBCUTANEOUS KIT	189	CAREONE INSULIN SYRINGE 30G X 1/2	169, 186, 187
bexarotene	54	CAREONE INSULIN SYRINGE 31G X 5/16	169, 186, 187
BIZENGRI (750 MG DOSE)	417	CARETOUCH ALCOHOL PREP PAD 70 %	169, 186, 187
BORTEZOMIB INJECTION SOLUTION RECONSTITUTED 1 MG, 2.5 MG.....	56	CARETOUCH INSULIN SYRINGE 28G X 5/16	169, 186, 187
bortezomib injection solution reconstituted 3.5 mg	56	CARETOUCH INSULIN SYRINGE 29G X 5/16	169, 186, 187
		CARETOUCH INSULIN SYRINGE 30G X 5/16	169, 186, 187

CARETOUCH INSULIN SYRINGE 31G X 5/16	169, 186, 187	COMFORT EZ INSULIN SYRINGE 28G X 1/2.....	170, 186, 187
CARETOUCH PEN NEEDLES 29G X 12MM	169, 186, 187	COMFORT EZ INSULIN SYRINGE 29G X 1/2.....	170, 186, 187
CARETOUCH PEN NEEDLES 31G X 5 MM	169, 186, 187	COMFORT EZ INSULIN SYRINGE 30G X 1/2.....	170, 186, 187
CARETOUCH PEN NEEDLES 31G X 6 MM	169, 186, 187	COMFORT EZ INSULIN SYRINGE 30G X 5/16.....	170, 186, 187
CARETOUCH PEN NEEDLES 31G X 8 MM	169, 186, 187	COMFORT EZ INSULIN SYRINGE 31G X 15/64.....	170, 186, 187
CARETOUCH PEN NEEDLES 32G X 4 MM	169, 186, 187	COMFORT EZ INSULIN SYRINGE 31G X 5/16.....	170, 186, 187
CARETOUCH PEN NEEDLES 32G X 5 MM	169, 186, 187	COMFORT EZ PEN NEEDLES 31G X 5 MM	170, 186, 187
CARETOUCH PEN NEEDLES 33G X 4 MM	169, 186, 187	COMFORT EZ PEN NEEDLES 31G X 6 MM	170, 186, 187
carglumic acid oral tablet soluble	66	COMFORT EZ PEN NEEDLES 31G X 8 MM	170, 186, 187
CAYSTON.....	44	COMFORT EZ PEN NEEDLES 32G X 4 MM	170, 186, 187
CIMZIA (1 SYRINGE)	68, 69	COMFORT EZ PEN NEEDLES 32G X 5 MM	170, 186, 187
CIMZIA (2 SYRINGE)	68, 69	COMFORT EZ PEN NEEDLES 32G X 6 MM	170, 186, 187
CIMZIA SUBCUTANEOUS KIT 2 X 200 MG	68, 69	COMFORT EZ PEN NEEDLES 32G X 8 MM	170, 186, 187
CIMZIA-STARTER	68, 69	COMFORT EZ PEN NEEDLES 33G X 4 MM	170, 186, 187
CLEVER CHOICE COMFORT EZ 29G X 12MM	169, 186, 187	COMFORT EZ PEN NEEDLES 33G X 5 MM	170, 186, 187
CLEVER CHOICE COMFORT EZ 33G X 4 MM	169, 186, 187	COMFORT EZ PEN NEEDLES 33G X 6 MM	170, 186, 187
CLICKFINE PEN NEEDLES 31G X 8 MM	169, 186, 187	COMFORT EZ PRO PEN NEEDLES 30G X 8 MM.....	170, 186, 187
CLICKFINE PEN NEEDLES 32G X 4 MM	169, 186, 187	COMFORT EZ PRO PEN NEEDLES 31G X 4 MM.....	170, 186, 187
COMETRIQ (100 MG DAILY DOSE) ORAL KIT 80 & 20 MG	61	COMFORT EZ PRO PEN NEEDLES 31G X 5 MM.....	170, 186, 187
COMETRIQ (140 MG DAILY DOSE) ORAL KIT 3 X 20 MG & 80 MG	61	COMFORT TOUCH INSULIN PEN NEED 31G X 4 MM.....	170, 186, 187
COMETRIQ (60 MG DAILY DOSE).....	61		
COMFORT ASSIST INSULIN SYRINGE 29G X 1/2.....	169, 186, 187		
COMFORT ASSIST INSULIN SYRINGE 31G X 5/16.....	169, 186, 187		
COMFORT EZ INSULIN SYRINGE 27G X 1/2.....	170, 186, 187		

COMFORT TOUCH INSULIN PEN NEED
31G X 5 MM..... 170, 186, 187
COMFORT TOUCH INSULIN PEN NEED
31G X 6 MM..... 170, 186, 187
COMFORT TOUCH INSULIN PEN NEED
31G X 8 MM..... 170, 186, 187
COMFORT TOUCH INSULIN PEN NEED
32G X 4 MM..... 170, 186, 187
COMFORT TOUCH INSULIN PEN NEED
32G X 5 MM..... 170, 186, 187
COMFORT TOUCH INSULIN PEN NEED
32G X 6 MM..... 170, 186, 187
COMFORT TOUCH INSULIN PEN NEED
32G X 8 MM..... 170, 186, 187
COPIKTRA..... 101
CORTROPHIN..... 74, 75
COSENTYX (300 MG DOSE)..... 316, 317
COSENTYX SENSOREADY (300 MG)
..... 316, 317
COSENTYX SUBCUTANEOUS
SOLUTION PREFILLED SYRINGE 75
MG/0.5ML..... 316, 317
COSENTYX UNOREADY..... 316, 317
COTELLIC..... 73
CRESEMBA ORAL..... 193
CURITY ALCOHOL PREPS PAD 70 %
..... 170, 186, 187
CURITY ALL PURPOSE SPONGES PAD
2..... 170, 186, 187
CURITY GAUZE PAD 2..... 170, 186, 187
CURITY GAUZE SPONGE PAD 2..... 170,
186, 187
CURITY SPONGES PAD 2... 171, 186, 187
CVS ALCOHOL PREP PADS PAD 70 %
..... 171, 186, 187
CVS GAUZE PAD 2..... 171, 186, 187
CVS GAUZE STERILE PAD 2 171, 186,
187
cvs isopropyl alcohol wipes 171, 186, 187
CVS PREP PAD 70 %..... 171, 186, 187
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..... 81
DANYELZA..... 241
DANZITEN 246
dasatinib oral tablet 100 mg, 140 mg, 20 mg,
50 mg, 70 mg, 80 mg 83
DATROWAY 84
DAURISMO ORAL TABLET 100 MG, 25
MG 147
deferasirox granules..... 86, 87
deferasirox oral tablet 86, 87
DERMACEA GAUZE SPONGE PAD 2
..... 171, 186, 187
DERMACEA IV DRAIN SPONGES PAD
2..... 171, 186, 187
DERMACEA NON-WOVEN SPONGES
PAD 2..... 171, 186, 187
DERMACEA TYPE VII GAUZE PAD 2
..... 171, 186, 187
DIACOMIT ORAL CAPSULE 250 MG,
500 MG..... 343
DIACOMIT ORAL PACKET 250 MG, 500
MG..... 343
DIATHRIVE PEN NEEDLE 31G X 5 MM
..... 171, 186, 187
DIATHRIVE PEN NEEDLE 31G X 6 MM
..... 171, 186, 187
DIATHRIVE PEN NEEDLE 31G X 8 MM
..... 171, 186, 187
DIATHRIVE PEN NEEDLE 32G X 4 MM
..... 171, 186, 187
diclofenac epolamine external 91
diclofenac sodium external solution 2 %.. 90
dimethyl fumarate oral capsule delayed
release 120 mg, 240 mg 92
dimethyl fumarate starter pack oral capsule
delayed release therapy pack 92
dronabinol 96
DROPLET INSULIN SYRINGE 29G X 1/2
..... 171, 186, 187

DROPLET INSULIN SYRINGE 30G X 1/2
..... 171, 186, 187
DROPLET INSULIN SYRINGE 30G X
15/64 171, 186, 187
DROPLET INSULIN SYRINGE 30G X
5/16 171, 186, 187
DROPLET INSULIN SYRINGE 31G X
15/64 171, 186, 187
DROPLET INSULIN SYRINGE 31G X
5/16 171, 186, 187
DROPLET MICRON 34G X 3.5 MM... 171,
186, 187
DROPLET PEN NEEDLES 29G X 10MM
..... 171, 186, 187
DROPLET PEN NEEDLES 29G X 12MM
..... 171, 186, 187
DROPLET PEN NEEDLES 30G X 8 MM
..... 171, 186, 187
DROPLET PEN NEEDLES 31G X 5 MM
..... 171, 186, 187
DROPLET PEN NEEDLES 31G X 6 MM
..... 171, 186, 187
DROPLET PEN NEEDLES 31G X 8 MM
..... 171, 186, 187
DROPLET PEN NEEDLES 32G X 4 MM
..... 171, 186, 187
DROPLET PEN NEEDLES 32G X 5 MM
..... 171, 186, 187
DROPLET PEN NEEDLES 32G X 6 MM
..... 171, 186, 187
DROPLET PEN NEEDLES 32G X 8 MM
..... 171, 186, 187
DROPSAFE ALCOHOL PREP PAD 70 %
..... 171, 186, 187
DROPSAFE AUTOPROTECT DUO 31G X
4 MM 171, 186, 187
DROPSAFE AUTOPROTECT DUO 31G X
8 MM 171, 186, 187
DROPSAFE SAFETY PEN NEEDLES 31G
X 5 MM..... 171, 186, 187
DROPSAFE SAFETY PEN NEEDLES 31G
X 6 MM..... 171, 186, 187

DROPSAFE SAFETY SYRINGE/NEEDLE
29G X 1/2..... 171, 186, 187
DROPSAFE SAFETY SYRINGE/NEEDLE
31G X 15/64..... 172, 186, 187
DROPSAFE SAFETY SYRINGE/NEEDLE
31G X 5/16..... 172, 186, 187
droxidopa 97
DRUG MART ULTRA COMFORT SYR
29G X 1/2..... 172, 186, 187
DRUG MART ULTRA COMFORT SYR
30G X 5/16..... 172, 186, 187
DRUG MART UNIFINE PENTIPS 31G X
5 MM 172, 186, 187
DUPIXENT SUBCUTANEOUS
SOLUTION AUTO-INJECTOR .. 98, 100
DUPIXENT SUBCUTANEOUS
SOLUTION PREFILLED SYRINGE . 98,
100

E

EASY COMFORT ALCOHOL PADS PAD
..... 172, 186, 187
EASY COMFORT INSULIN SYRINGE
29G X 5/16..... 172, 186, 187
EASY COMFORT INSULIN SYRINGE
30G X 1/2..... 172, 186, 187
EASY COMFORT INSULIN SYRINGE
30G X 5/16..... 172, 186, 187
EASY COMFORT INSULIN SYRINGE
31G X 1/2..... 172, 186, 187
EASY COMFORT INSULIN SYRINGE
31G X 5/16..... 172, 186, 187
EASY COMFORT INSULIN SYRINGE
32G X 5/16..... 172, 186, 187
EASY COMFORT PEN NEEDLES 29G X
4MM 172, 186, 187
EASY COMFORT PEN NEEDLES 29G X
5MM 172, 186, 187
EASY COMFORT PEN NEEDLES 31G X
5 MM 172, 186, 187
EASY COMFORT PEN NEEDLES 31G X
6 MM 172, 186, 187
EASY COMFORT PEN NEEDLES 31G X
8 MM 172, 186, 187

EASY COMFORT PEN NEEDLES 32G X 4 MM	172, 186, 187	EASY TOUCH INSULIN SYRINGE 31G X 5/16.....	173, 186, 187
EASY COMFORT PEN NEEDLES 33G X 4 MM	172, 186, 187	EASY TOUCH PEN NEEDLES 29G X 12MM	173, 186, 187
EASY COMFORT PEN NEEDLES 33G X 5 MM	172, 186, 187	EASY TOUCH PEN NEEDLES 30G X 5 MM	173, 186, 187
EASY COMFORT PEN NEEDLES 33G X 6 MM	172, 186, 187	EASY TOUCH PEN NEEDLES 30G X 6 MM	173, 186, 187
EASY GLIDE PEN NEEDLES 33G X 4 MM	172, 186, 187	EASY TOUCH PEN NEEDLES 30G X 8 MM	173, 186, 187
EASY TOUCH ALCOHOL PREP MEDIUM PAD 70 %.....	172, 186, 187	EASY TOUCH PEN NEEDLES 31G X 5 MM	173, 186, 187
EASY TOUCH FLIPLOCK INSULIN SY 29G X 1/2.....	172, 186, 187	EASY TOUCH PEN NEEDLES 31G X 6 MM	173, 186, 187
EASY TOUCH FLIPLOCK INSULIN SY 30G X 1/2.....	172, 186, 187	EASY TOUCH PEN NEEDLES 31G X 8 MM	173, 186, 187
EASY TOUCH FLIPLOCK INSULIN SY 30G X 5/16.....	172, 186, 187	EASY TOUCH PEN NEEDLES 32G X 4 MM	173, 186, 187
EASY TOUCH FLIPLOCK INSULIN SY 31G X 5/16.....	172, 186, 187	EASY TOUCH PEN NEEDLES 32G X 5 MM	173, 186, 187
EASY TOUCH FLIPLOCK SAFETY SYR 27G X 1/2.....	172, 186, 187	EASY TOUCH PEN NEEDLES 32G X 6 MM	173, 186, 187
EASY TOUCH INSULIN BARRELS U- 100 1 ML.....	172, 186, 187	EASY TOUCH SAFETY PEN NEEDLES 29G X 5MM.....	173, 186, 187
EASY TOUCH INSULIN SAFETY SYR 29G X 1/2.....	173, 186, 187	EASY TOUCH SAFETY PEN NEEDLES 29G X 8MM.....	173, 186, 187
EASY TOUCH INSULIN SAFETY SYR 30G X 1/2.....	173, 186, 187	EASY TOUCH SAFETY PEN NEEDLES 30G X 8 MM.....	173, 186, 187
EASY TOUCH INSULIN SAFETY SYR 30G X 5/16.....	173, 186, 187	EASY TOUCH SHEATHLOCK SYRINGE 29G X 1/2.....	173, 186, 187
EASY TOUCH INSULIN SYRINGE 27G X 1/2.....	173, 186, 187	EASY TOUCH SHEATHLOCK SYRINGE 30G X 1/2.....	173, 186, 187
EASY TOUCH INSULIN SYRINGE 27G X 5/8.....	173, 186, 187	EASY TOUCH SHEATHLOCK SYRINGE 30G X 5/16.....	173, 186, 187
EASY TOUCH INSULIN SYRINGE 28G X 1/2.....	173, 186, 187	EASY TOUCH SHEATHLOCK SYRINGE 31G X 5/16.....	173, 186, 187
EASY TOUCH INSULIN SYRINGE 29G X 1/2.....	173, 186, 187	ELAHERE	237
EASY TOUCH INSULIN SYRINGE 30G X 1/2.....	173, 186, 187	ELIGARD	209
EASY TOUCH INSULIN SYRINGE 30G X 5/16.....	173, 186, 187	ELREXFIO SUBCUTANEOUS SOLUTION 44 MG/1.1ML, 76 MG/1.9ML	108
		eltrombopag olamine oral packet 12.5 mg, 25 mg	110, 111

eltrombopag olamine oral tablet 12.5 mg, 25 mg, 50 mg, 75 mg	110, 111	EMBRACE PEN NEEDLES 31G X 8 MM	174, 186, 187
EMBECTA AUTOSHIELD DUO 30G X 5 MM	173, 186, 187	EMBRACE PEN NEEDLES 32G X 4 MM	174, 186, 187
EMBECTA INS SYR U/F 1/2 UNIT 31G X 15/64	173, 186, 187	EMGALITY	142
EMBECTA INS SYR U/F 1/2 UNIT 31G X 5/16	173, 186, 187	EMGALITY (300 MG DOSE)	142
EMBECTA INSULIN SYR ULTRAFINE 30G X 1/2.....	173, 174, 186, 187	EMRELIS	356
EMBECTA INSULIN SYR ULTRAFINE 31G X 15/64.....	174, 186, 187	ENBREL MINI.....	125, 126
EMBECTA INSULIN SYR ULTRAFINE 31G X 5/16.....	174, 186, 187	ENBREL SUBCUTANEOUS SOLUTION 25 MG/0.5ML.....	125, 126
EMBECTA INSULIN SYRINGE 28G X 1/2	174, 186, 187	ENBREL SUBCUTANEOUS SOLUTION PREFILLED SYRINGE	125, 126
EMBECTA INSULIN SYRINGE U-100 27G X 5/8.....	174, 186, 187	ENBREL SURECLICK SUBCUTANEOUS SOLUTION AUTO-INJECTOR	125, 126
EMBECTA INSULIN SYRINGE U-500	174, 186, 187	ENSACOVE ORAL CAPSULE 100 MG, 25 MG	114
EMBECTA PEN NEEDLE NANO 2 GEN 32G X 4 MM.....	174, 186, 187	EPCLUSA ORAL PACKET 150-37.5 MG, 200-50 MG.....	330, 331
EMBECTA PEN NEEDLE NANO 32G X 4 MM	174, 186, 187	EPCLUSA ORAL TABLET.....	330, 331
EMBECTA PEN NEEDLE ULTRAFINE 29G X 12.7MM.....	174, 186, 187	EPIDIOLEX.....	63
EMBECTA PEN NEEDLE ULTRAFINE 31G X 5 MM.....	174, 186, 187	EPKINLY	118
EMBECTA PEN NEEDLE ULTRAFINE 31G X 8 MM.....	174, 186, 187	EQL ALCOHOL SWABS PAD 70 %... 174, 186, 187	
EMBECTA PEN NEEDLE ULTRAFINE 32G X 6 MM.....	174, 186, 187	EQL GAUZE PAD 2	174, 186, 187
EMBRACE PEN NEEDLES 29G X 12MM	174, 186, 187	EQL INSULIN SYRINGE 30G X 5/16. 174, 186, 187	
EMBRACE PEN NEEDLES 30G X 5 MM	174, 186, 187	ERBITUX	70
EMBRACE PEN NEEDLES 30G X 8 MM	174, 186, 187	ERIVEDGE.....	411
EMBRACE PEN NEEDLES 31G X 5 MM	174, 186, 187	ERLEADA ORAL TABLET 240 MG, 60 MG	28
EMBRACE PEN NEEDLES 31G X 6 MM	174, 186, 187	erlotinib hcl oral tablet 100 mg, 150 mg, 25 mg	123
		everolimus oral tablet 10 mg, 2.5 mg, 5 mg, 7.5 mg	127
		everolimus oral tablet soluble	128
		EXEL COMFORT POINT INSULIN SYR 29G X 1/2.....	174, 186, 187
		EXEL COMFORT POINT INSULIN SYR 30G X 5/16.....	174, 186, 187
		EXEL COMFORT POINT PEN NEEDLE 29G X 12MM.....	174, 186, 187
		EXXUA.....	145
		EXXUA TITRATION PACK.....	145

F

FASENRA 50, 51
 FASENRA PEN..... 50, 51
 fentanyl citrate buccal lozenge on a handle
 132
 FIFTY50 PEN NEEDLES 31G X 5 MM
 174, 186, 187
 FIFTY50 PEN NEEDLES 31G X 8 MM
 174, 186, 187
 FIFTY50 PEN NEEDLES 32G X 4 MM
 174, 186, 187
 FIFTY50 PEN NEEDLES 32G X 6 MM
 174, 186, 187
 fingolimod hcl..... 138
 FINTEPLA..... 131
 FOTIVDA..... 368
 FRUZAQLA ORAL CAPSULE 1 MG, 5
 MG 140
 FYARRO 327

G

GAUZE PADS PAD 2..... 174, 186, 187
 GAUZE TYPE VII MEDI-PAK PAD 2 174,
 186, 187
 GAVRETO 287
 gefitinib..... 144
 GILOTRIF 20
 glatiramer acetate subcutaneous solution
 prefilled syringe 20 mg/ml, 40 mg/ml 148
 glatopa subcutaneous solution prefilled
 syringe 20 mg/ml, 40 mg/ml..... 148
 GLOBAL ALCOHOL PREP EASE..... 174,
 186, 187
 GLOBAL EASE INJECT PEN NEEDLES
 29G X 12MM..... 174, 186, 187
 GLOBAL EASE INJECT PEN NEEDLES
 31G X 5 MM..... 174, 186, 187
 GLOBAL EASE INJECT PEN NEEDLES
 31G X 8 MM..... 174, 186, 187
 GLOBAL EASE INJECT PEN NEEDLES
 32G X 4 MM..... 174, 186, 187
 GLOBAL EASY GLIDE INSULIN SYR
 31G X 15/64..... 174, 186, 187

GLOBAL INJECT EASE INSULIN SYR
 30G X 1/2..... 174, 186, 187
 GLUCOPRO INSULIN SYRINGE 30G X
 1/2 174, 186, 187
 GLUCOPRO INSULIN SYRINGE 30G X
 5/16 174, 175, 186, 187
 GLUCOPRO INSULIN SYRINGE 31G X
 5/16 175, 186, 187
 GNP ALCOHOL SWABS PAD.... 175, 186,
 187
 GNP CLICKFINE PEN NEEDLES 31G X 6
 MM 175, 186, 187
 GNP CLICKFINE PEN NEEDLES 31G X 8
 MM 175, 186, 187
 GNP INSULIN SYRINGE 28G X 1/2 .. 175,
 186, 187
 GNP INSULIN SYRINGE 29G X 1/2 .. 175,
 186, 187
 GNP INSULIN SYRINGE 30G X 5/16 175,
 186, 187
 GNP INSULIN SYRINGES 29GX1/2.. 175,
 186, 187
 GNP INSULIN SYRINGES 30G X 5/16
 175, 186, 187
 GNP INSULIN SYRINGES 30GX5/16 175,
 186, 187
 GNP INSULIN SYRINGES 31GX5/16 175,
 186, 187
 GNP PEN NEEDLES 31G X 5 MM 175,
 186, 187
 GNP PEN NEEDLES 32G X 4 MM 175,
 186, 187
 GNP PEN NEEDLES 32G X 6 MM 175,
 186, 187
 GNP STERILE GAUZE PAD 2 175, 186,
 187
 GNP ULTRA COM INSULIN SYRINGE
 29G X 1/2..... 175, 186, 187
 GNP ULTRA COM INSULIN SYRINGE
 30G X 5/16..... 175, 186, 187
 GOMEKLI ORAL CAPSULE 1 MG, 2 MG
 236
 GOMEKLI ORAL TABLET SOLUBLE236

GOODSENSE ALCOHOL SWABS PAD
70 % 175, 186, 187
GOODSENSE CLICKFINE PEN NEEDLE
31G X 5 MM..... 175, 186, 187
GOODSENSE PEN NEEDLE PENFINE
31G X 8 MM..... 175, 186, 187
H
HADLIMA..... 18, 19
HADLIMA PUSH TOUCH..... 18, 19
HAEGARDA SUBCUTANEOUS
SOLUTION RECONSTITUTED 2000
UNIT, 3000 UNIT 60
HARVONI ORAL PACKET 33.75-150
MG, 45-200 MG 202
HARVONI ORAL TABLET 202
HEALTHWISE INSULIN SYR/NEEDLE
30G X 5/16..... 175, 186, 187
HEALTHWISE INSULIN SYR/NEEDLE
31G X 5/16..... 175, 186, 187
HEALTHWISE MICRON PEN NEEDLES
32G X 4 MM..... 175, 186, 187
HEALTHWISE SHORT PEN NEEDLES
31G X 5 MM..... 175, 186, 187
HEALTHWISE SHORT PEN NEEDLES
31G X 8 MM..... 175, 186, 187
HEALTHY ACCENTS UNIFINE PENTIP
29G X 12MM..... 175, 186, 187
HEALTHY ACCENTS UNIFINE PENTIP
31G X 5 MM..... 175, 186, 187
HEALTHY ACCENTS UNIFINE PENTIP
31G X 6 MM..... 175, 186, 187
HEALTHY ACCENTS UNIFINE PENTIP
31G X 8 MM..... 175, 186, 187
HEALTHY ACCENTS UNIFINE PENTIP
32G X 4 MM..... 175, 186, 187
H-E-B INCONTROL ALCOHOL PAD 175,
186, 187
H-E-B INCONTROL PEN NEEDLES 29G
X 12MM..... 175, 186, 187
H-E-B INCONTROL PEN NEEDLES 31G
X 5 MM..... 175, 186, 187
H-E-B INCONTROL PEN NEEDLES 31G
X 6 MM..... 175, 186, 187

H-E-B INCONTROL PEN NEEDLES 31G
X 8 MM..... 175, 186, 187
H-E-B INCONTROL PEN NEEDLES 32G
X 4 MM..... 175, 186, 187
HERCEPTIN HYLECTA..... 382
HERNEXEOS..... 420
HM STERILE ALCOHOL PREP PAD 176,
186, 187
HM STERILE PADS PAD 2.. 176, 186, 187
HM ULTICARE INSULIN SYRINGE 30G
X 1/2..... 176, 186, 187
HM ULTICARE INSULIN SYRINGE 31G
X 5/16..... 176, 186, 187
HM ULTICARE SHORT PEN NEEDLES
31G X 8 MM..... 176, 186, 187
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/UEVEIT STARTER
SUBCUTANEOUS AUTO-INJECTOR
KIT 12, 13
HYRNUO 323
I
IBRANCE 267
IBTROZI..... 350
icatibant acetate..... 158

ICLUSIG.....	285	INSULIN SYRINGE-NEEDLE U-100 30G X 5/16.....	176, 186, 187
IDHIFA.....	112	INSULIN SYRINGE-NEEDLE U-100 31G X 1/4.....	176, 186, 187
imatinib mesylate oral tablet 100 mg, 400 mg	160	INSULIN SYRINGE-NEEDLE U-100 31G X 5/16.....	176, 186, 187
IMBRUVICA ORAL CAPSULE 140 MG, 70 MG	157	INSUPEN PEN NEEDLES 29G X 12MM	176, 186, 187
IMBRUVICA ORAL SUSPENSION.....	157	INSUPEN PEN NEEDLES 31G X 5 MM	176, 186, 187
IMBRUVICA ORAL TABLET	157	INSUPEN PEN NEEDLES 31G X 8 MM	176, 186, 187
IMDELLTRA	352	INSUPEN PEN NEEDLES 32G X 4 MM	176, 186, 187
IMJUDO	384	INSUPEN PEN NEEDLES 33G X 4 MM	176, 186, 187
IMKELDI.....	161	INSUPEN SENSITIVE 32G X 6 MM ..	176, 186, 187
IMPAVIDO.....	235	INSUPEN SENSITIVE 32G X 8 MM ..	176, 186, 187
INCONTROL ULTICARE PEN NEEDLES 31G X 6 MM.....	176, 186, 187	INSUPEN ULTRAFIN 30G X 8 MM...	176, 186, 187
INCONTROL ULTICARE PEN NEEDLES 31G X 8 MM.....	176, 186, 187	INSUPEN ULTRAFIN 31G X 6 MM...	176, 186, 187
INCONTROL ULTICARE PEN NEEDLES 32G X 4 MM.....	176, 186, 187	INSUPEN ULTRAFIN 31G X 8 MM...	176, 186, 187
INCRELEX.....	227	INSUPEN32G EXTR3ME 32G X 6 MM	176, 186, 187
infliximab.....	165, 166	ITOVEBI ORAL TABLET 3 MG, 9 MG	164
INGREZZA ORAL CAPSULE.....	403	IWILFIN	102
INGREZZA ORAL CAPSULE SPRINKLE	403	J	
INGREZZA ORAL CAPSULE THERAPY PACK.....	403	J & J GAUZE PAD 2.....	176, 186, 187
INLURIYO	163	JAKAFI.....	314
INLYTA ORAL TABLET 1 MG, 5 MG..	42	JASCAYD.....	242, 243
INQOVI	85	javygtor oral tablet	315
INREBIC.....	130	JAYPIRCA ORAL TABLET 100 MG, 50 MG	283
INSULIN SYRINGE 29G X 1/2 ...	176, 186, 187	JEMPERLI.....	95
INSULIN SYRINGE 30G X 5/16 .	176, 186, 187	JYNARQUE ORAL TABLET	375
INSULIN SYRINGE 31G X 5/16 .	176, 186, 187	K	
INSULIN SYRINGE/NEEDLE 27G X 1/2	176, 186, 187	KALYDECO.....	194
INSULIN SYRINGE/NEEDLE 28G X 1/2	176, 186, 187		
INSULIN SYRINGE-NEEDLE U-100 27G X 1/2.....	176, 186, 187		
INSULIN SYRINGE-NEEDLE U-100 28G X 1/2.....	176, 186, 187		

KENDALL HYDROPHILIC FOAM DRESS PAD 2	176, 186, 187	LAZCLUZE ORAL TABLET 240 MG, 80 MG	201
KENDALL HYDROPHILIC FOAM PLUS PAD 2.....	176, 186, 187	LEADER INSULIN SYRINGE 28G X 1/2	176, 186, 187
KERENDIA	136, 137	LEADER UNIFINE PENTIPS 31G X 5 MM	176, 186, 187
KESIMPTA.....	257	LEADER UNIFINE PENTIPS 32G X 4 MM	177, 186, 187
KEYTRUDA INTRAVENOUS SOLUTION.....	274	LEADER UNIFINE PENTIPS PLUS 31G X 5 MM.....	177, 186, 187
KEYTRUDA QLEX.....	275	LEADER UNIFINE PENTIPS PLUS 31G X 8 MM.....	177, 186, 187
KIMMTRAK	354	lenalidomide.....	203
KINERET SUBCUTANEOUS SOLUTION PREFILLED SYRINGE	26, 27	LENVIMA (10 MG DAILY DOSE)	204
KINRAY INSULIN SYRINGE 29G X 1/2	176, 186, 187	LENVIMA (12 MG DAILY DOSE)	204
KISQALI (200 MG DOSE)	297	LENVIMA (14 MG DAILY DOSE)	204
KISQALI (400 MG DOSE)	297	LENVIMA (18 MG DAILY DOSE)	204
KISQALI (600 MG DOSE)	297	LENVIMA (20 MG DAILY DOSE)	204
KISQALI FEMARA (200 MG DOSE) ..	298	LENVIMA (24 MG DAILY DOSE)	204
KISQALI FEMARA (400 MG DOSE) ..	298	LENVIMA (4 MG DAILY DOSE)	204
KISQALI FEMARA (600 MG DOSE) ..	298	LENVIMA (8 MG DAILY DOSE)	204
KMART VALU INSULIN SYRINGE 29G U-100 1 ML	176, 186, 187	LEUPROLIDE ACETATE (3 MONTH) 207 leuprolide acetate injection	206
KMART VALU INSULIN SYRINGE 30G U-100 0.3 ML	176, 186, 187	l-glutamine oral packet	214
KMART VALU INSULIN SYRINGE 30G U-100 1 ML	176, 186, 187	lidocaine external ointment 5 %	215
KOMZIFTI	418	lidocaine external patch 5 %.....	216
KOSELUGO ORAL CAPSULE 10 MG, 25 MG	322	lidocaine-prilocaine external cream.....	217
KOSELUGO ORAL CAPSULE SPRINKLE 5 MG, 7.5 MG.....	322	lidocan.....	216
KRAZATI.....	11	LITETOUCH INSULIN SYRINGE 28G X 1/2	177, 186, 187
KROGER INSULIN SYRINGE 30G X 5/16	176, 186, 187	LITETOUCH INSULIN SYRINGE 29G X 1/2	177, 186, 187
KROGER PEN NEEDLES 29G X 12MM	176, 186, 187	LITETOUCH INSULIN SYRINGE 30G X 5/16	177, 186, 187
KROGER PEN NEEDLES 31G X 6 MM	176, 186, 187	LITETOUCH INSULIN SYRINGE 31G X 5/16	177, 186, 187
KYNMOBI	30	LITETOUCH PEN NEEDLES 29G X 12.7MM	177, 186, 187
L		LITETOUCH PEN NEEDLES 31G X 5 MM	177, 186, 187
LANREOTIDE ACETATE	198	LITETOUCH PEN NEEDLES 31G X 6 MM	177, 186, 187
lapatinib ditosylate	199		

LITETOUCH PEN NEEDLES 31G X 8 MM	177, 186, 187	MAXICOMFORT II PEN NEEDLE 31G X 6 MM	177, 186, 187
LITETOUCH PEN NEEDLES 32G X 4 MM	177, 186, 187	MAXI-COMFORT INSULIN SYRINGE 28G X 1/2.....	177, 186, 187
LIVTENCITY.....	225	MAXI-COMFORT SAFETY PEN NEEDLE 29G X 5MM.....	177, 186, 187
LONSURF ORAL TABLET 15-6.14 MG, 20-8.19 MG.....	387	MAXI-COMFORT SAFETY PEN NEEDLE 29G X 8MM.....	177, 186, 187
LOQTORZI.....	377	MAXICOMFORT SYR 27G X 1/2.....	177, 186, 187
LORBRENA ORAL TABLET 100 MG, 25 MG.....	220	MAYZENT ORAL TABLET 0.25 MG, 1 MG, 2 MG.....	326
LUMAKRAS ORAL TABLET 120 MG, 240 MG, 320 MG.....	342	MAYZENT STARTER PACK.....	326
LUNSUMIO	239	MEDIC INSULIN SYRINGE 30G X 5/16	177, 186, 187
LUNSUMIO VELO.....	239	MEDICINE SHOPPE PEN NEEDLES 29G X 12MM.....	177, 186, 187
LUPRON DEPOT (1-MONTH).....	210, 211	MEDICINE SHOPPE PEN NEEDLES 31G X 8 MM.....	177, 186, 187
LUPRON DEPOT (3-MONTH).....	210, 211	MEDPURA ALCOHOL PADS 70 % EXTERNAL	177, 186, 187
LUPRON DEPOT (4-MONTH).....	210, 211	MEIJER ALCOHOL SWABS PAD 70 %	177, 186, 187
LUPRON DEPOT (6-MONTH).....	210, 211	MEIJER PEN NEEDLES 29G X 12MM	177, 186, 187
LUPRON DEPOT-PED (3-MONTH) ...	212, 213	MEIJER PEN NEEDLES 31G X 6 MM	177, 186, 187
LUPRON DEPOT-PED (6-MONTH) ...	212, 213	MEIJER PEN NEEDLES 31G X 8 MM	177, 186, 187
LUTRATE DEPOT	207	MEKINIST ORAL SOLUTION RECONSTITUTED	379
LYNOZYFIC INTRAVENOUS SOLUTION 200 MG/10ML, 5 MG/2.5ML	218	MEKINIST ORAL TABLET 0.5 MG, 2 MG	380
LYNPARZA ORAL TABLET	258	MEKTOVI	55
LYTGObI (12 MG DAILY DOSE).....	141	metyrosine.....	232
LYTGObI (16 MG DAILY DOSE).....	141	MICRODOT PEN NEEDLE 31G X 6 MM	177, 186, 187
LYTGObI (20 MG DAILY DOSE).....	141	MICRODOT PEN NEEDLE 32G X 4 MM	177, 186, 187
M		MICRODOT PEN NEEDLE 33G X 4 MM	177, 186, 187
MAGELLAN INSULIN SAFETY SYR 29G X 1/2.....	177, 186, 187	mifepristone oral tablet 300 mg	234
MAGELLAN INSULIN SAFETY SYR 30G X 5/16.....	177, 186, 187	MIPLYFFA.....	33
MARGENZA	224		
MAVENCLAD (10 TABS).....	71		
MAVENCLAD (4 TABS).....	71		
MAVENCLAD (5 TABS).....	71		
MAVENCLAD (6 TABS).....	71		
MAVENCLAD (7 TABS).....	71		
MAVENCLAD (8 TABS).....	71		
MAVENCLAD (9 TABS).....	71		

MIRASORB SPONGES 2..... 177, 186, 187
MM PEN NEEDLES 31G X 6 MM 178,
186, 187
MM PEN NEEDLES 32G X 4 MM 178,
186, 187
modafinil oral tablet 100 mg, 200 mg..... 240
MODEYSO..... 94
MONOJECT INSULIN SYRINGE 25G X
5/8 178, 186, 187
MONOJECT INSULIN SYRINGE 27G X
1/2 178, 186, 187
MONOJECT INSULIN SYRINGE 28G X
1/2 178, 186, 187
MONOJECT INSULIN SYRINGE 29G X
1/2 178, 186, 187
MONOJECT INSULIN SYRINGE 30G X
5/16 178, 186, 187
MONOJECT INSULIN SYRINGE 31G X
5/16 178, 186, 187
MONOJECT INSULIN SYRINGE U-100 1
ML..... 178, 186, 187
MONOJECT ULTRA COMFORT
SYRINGE 28G X 1/2 178, 186, 187
MONOJECT ULTRA COMFORT
SYRINGE 29G X 1/2 178, 186, 187
MONOJECT ULTRA COMFORT
SYRINGE 30G X 5/16 178, 186, 187
morphine sulfate (concentrate) oral solution
100 mg/5ml..... 155, 156
MOUNJARO SUBCUTANEOUS
SOLUTION AUTO-INJECTOR 151
MS INSULIN SYRINGE 31G X 5/16... 178,
186, 187
N
NERLYNX 244
NIKTIMVO 41
nilotinib hcl oral capsule 150 mg, 200 mg,
50 mg 245
NINLARO..... 196
nintedanib esylate..... 247, 248
nitisinone..... 252
NIVESTYM..... 135

NORDITROPIN FLEXPRO
SUBCUTANEOUS SOLUTION PEN-
INJECTOR..... 334, 335
NOVOFINE AUTOCOVER 30G X 8 MM
..... 178, 186, 187
NOVOFINE PEN NEEDLE 32G X 6 MM
..... 178, 186, 187
NOVOFINE PLUS PEN NEEDLE 32G X 4
MM 178, 186, 187
NOVOTWIST PEN NEEDLE 32G X 5 MM
..... 178, 186, 187
NUBEQA..... 82
NUCALA SUBCUTANEOUS SOLUTION
AUTO-INJECTOR 229, 230, 231
NUCALA SUBCUTANEOUS SOLUTION
PREFILLED SYRINGE 100 MG/ML, 40
MG/0.4ML..... 229, 230, 231
NUCALA SUBCUTANEOUS SOLUTION
RECONSTITUTED..... 229, 230, 231
NUPLAZID ORAL CAPSULE..... 280
NUPLAZID ORAL TABLET 10 MG.... 280
NURTEC..... 302, 303
NYVEPRIA 270
O
ODOMZO..... 338
OFEV 247, 248
OGIVRI..... 381
OGSIVEO ORAL TABLET 100 MG, 150
MG, 50 MG..... 251
OJEMDA ORAL SUSPENSION
RECONSTITUTED..... 378
OJEMDA ORAL TABLET 378
OJJAARA 238
ONAPGO..... 29
ONUREG..... 43
OPDIVO 253
OPDIVO QVANTIG 254
OPDUALAG..... 255
OPSUMIT 223
ORENCIA CLICKJECT..... 4, 5
ORENCIA INTRAVENOUS 2, 3
ORENCIA SUBCUTANEOUS SOLUTION
PREFILLED SYRINGE 4, 5

ORFADIN ORAL SUSPENSION.....	252	PENTIPS 32G X 4 MM (RX).	178, 186, 187
ORGOVYX.....	292	PENTIPS GENERIC PEN NEEDLES 29G	
ORLISSA ORAL TABLET 150 MG, 200		X 12MM.....	178, 186, 187
MG	104, 105	PENTIPS GENERIC PEN NEEDLES 31G	
ORKAMBI ORAL TABLET	222	X 6 MM.....	178, 186, 187
ORSERDU ORAL TABLET 345 MG, 86		PENTIPS GENERIC PEN NEEDLES 32G	
MG	103	X 6 MM.....	178, 186, 187
OSEVELT	88	PHARMACIST CHOICE ALCOHOL PAD	
OTEZLA	31, 32	178, 186, 187
OTEZLA XR	31, 32	PIP PEN NEEDLES 31G X 5MM 31G X 5	
OTEZLA/OTEZLA XR INITIATION PK		MM	178, 186, 187
.....	31, 32	PIP PEN NEEDLES 32G X 4MM 32G X 4	
oxandrolone oral	265	MM	178, 186, 187
OZEMPIC	150	PIQRAY (200 MG DAILY DOSE).....	22
OZEMPIC (0.25 OR 0.5 MG/DOSE).....	150	PIQRAY (250 MG DAILY DOSE).....	22
OZEMPIC (1 MG/DOSE)		PIQRAY (300 MG DAILY DOSE).....	22
SUBCUTANEOUS SOLUTION PEN-		pirfenidone oral capsule.....	281, 282
INJECTOR 4 MG/3ML	150	pirfenidone oral tablet 267 mg, 534 mg, 801	
OZEMPIC (2 MG/DOSE)	150	mg	281, 282
P		PLEGRIDY STARTER PACK	
pazopanib hcl oral tablet 200 mg, 400 mg		SUBCUTANEOUS SOLUTION AUTO-	
.....	269	INJECTOR.....	190
PC UNIFINE PENTIPS 31G X 5 MM..	178,	PLEGRIDY STARTER PACK	
186, 187		SUBCUTANEOUS SOLUTION	
PC UNIFINE PENTIPS 31G X 6 MM..	178,	PREFILLED SYRINGE	190
186, 187		PLEGRIDY SUBCUTANEOUS	
PC UNIFINE PENTIPS 31G X 8 MM..	178,	SOLUTION AUTO-INJECTOR	190
186, 187		PLEGRIDY SUBCUTANEOUS	
PEGASYS SUBCUTANEOUS SOLUTION		SOLUTION PREFILLED SYRINGE	190
180 MCG/ML	272	pomalidomide	284
PEGASYS SUBCUTANEOUS SOLUTION		POMALYST	284
PREFILLED SYRINGE	272	posaconazole oral tablet delayed release	286
PEMAZYRE.....	276	PRECISION SURE-DOSE SYRINGE 30G	
PEN NEEDLE/5-BEVEL TIP 31G X 8 MM		X 5/16.....	178, 186, 187
.....	178, 186, 187	PREFERRED PLUS INSULIN SYRINGE	
PEN NEEDLES 30G X 5 MM (OTC)...	178,	28G X 1/2.....	178, 186, 187
186, 187		PREFERRED PLUS INSULIN SYRINGE	
PEN NEEDLES 30G X 8 MM	178, 186, 187	29G X 1/2.....	178, 179, 186, 187
PEN NEEDLES 32G X 5 MM	178, 186, 187	PREFERRED PLUS INSULIN SYRINGE	
penicillamine oral tablet.....	277, 278	30G X 5/16.....	179, 186, 187
PENTIPS 29G X 12MM (RX)	178, 186, 187	PREFERRED PLUS UNIFINE PENTIPS	
PENTIPS 31G X 5 MM (RX).	178, 186, 187	29G X 12MM.....	179, 186, 187
PENTIPS 31G X 8 MM (RX).	178, 186, 187		

PREVENT DROPSAFE PEN NEEDLES 31G X 6 MM.....	179, 186, 187	PURE COMFORT SAFETY PEN NEEDLE 32G X 4 MM.....	179, 186, 187
PREVENT DROPSAFE PEN NEEDLES 31G X 8 MM.....	179, 186, 187	PX SHORTLENGTH PEN NEEDLES 31G X 8 MM.....	179, 186, 187
PREVENT SAFETY PEN NEEDLES 31G X 6 MM.....	179, 186, 187	pyrimethamine oral	288
PREVENT SAFETY PEN NEEDLES 31G X 8 MM.....	179, 186, 187	Q	
PREVYMIS ORAL TABLET	205	QC ALCOHOL.....	179, 186, 187
PRO COMFORT ALCOHOL PAD 70 %	179, 186, 187	QC ALCOHOL SWABS PAD 70 %.....	179, 186, 187
PRO COMFORT INSULIN SYRINGE 30G X 1/2.....	179, 186, 187	QC BORDER ISLAND GAUZE PAD 2	179, 186, 187
PRO COMFORT INSULIN SYRINGE 30G X 5/16.....	179, 186, 187	QINLOCK.....	306
PRO COMFORT INSULIN SYRINGE 31G X 5/16.....	179, 186, 187	QUICK TOUCH INSULIN PEN NEEDLE 29G X 12.7MM.....	179, 186, 187
PRO COMFORT PEN NEEDLES 32G X 4 MM	179, 186, 187	QUICK TOUCH INSULIN PEN NEEDLE 31G X 4 MM.....	179, 186, 187
PRO COMFORT PEN NEEDLES 32G X 5 MM	179, 186, 187	QUICK TOUCH INSULIN PEN NEEDLE 31G X 5 MM.....	179, 186, 187
PRO COMFORT PEN NEEDLES 32G X 6 MM	179, 186, 187	QUICK TOUCH INSULIN PEN NEEDLE 31G X 6 MM.....	179, 186, 187
PRO COMFORT PEN NEEDLES 32G X 8 MM	179, 186, 187	QUICK TOUCH INSULIN PEN NEEDLE 31G X 8 MM.....	179, 186, 187
PRODIGY INSULIN SYRINGE 28G X 1/2	179, 186, 187	QUICK TOUCH INSULIN PEN NEEDLE 32G X 4 MM.....	179, 186, 187
PRODIGY INSULIN SYRINGE 31G X 5/16	179, 186, 187	QUICK TOUCH INSULIN PEN NEEDLE 32G X 5 MM.....	179, 186, 187
PURE COMFORT ALCOHOL PREP PAD	179, 186, 187	QUICK TOUCH INSULIN PEN NEEDLE 32G X 6 MM.....	179, 186, 187
PURE COMFORT PEN NEEDLE 32G X 4 MM	179, 186, 187	QUICK TOUCH INSULIN PEN NEEDLE 32G X 8 MM.....	179, 186, 187
PURE COMFORT PEN NEEDLE 32G X 5 MM	179, 186, 187	QUICK TOUCH INSULIN PEN NEEDLE 33G X 4 MM.....	179, 186, 187
PURE COMFORT PEN NEEDLE 32G X 6 MM	179, 186, 187	QUICK TOUCH INSULIN PEN NEEDLE 33G X 5 MM.....	179, 186, 187
PURE COMFORT PEN NEEDLE 32G X 8 MM	179, 186, 187	QUICK TOUCH INSULIN PEN NEEDLE 33G X 6 MM.....	180, 186, 187
PURE COMFORT SAFETY PEN NEEDLE 31G X 5 MM.....	179, 186, 187	QUICK TOUCH INSULIN PEN NEEDLE 33G X 8 MM.....	180, 186, 187
PURE COMFORT SAFETY PEN NEEDLE 31G X 6 MM.....	179, 186, 187	quinine sulfate oral.....	289
		QULIPTA	37
		R	
		RA ALCOHOL SWABS PAD 70 %.....	180, 186, 187

RA INSULIN SYRINGE 29G X 1/2..... 180, 186, 187
 RA INSULIN SYRINGE 30G X 5/16... 180, 186, 187
 ra isopropyl alcohol wipes 180, 186, 187
 RA PEN NEEDLES 31G X 5 MM 180, 186, 187
 RA PEN NEEDLES 31G X 8 MM 180, 186, 187
 RA STERILE PAD 2 180, 186, 187
 RALDESY 383
 RAYA SURE PEN NEEDLE 29G X 12MM 180, 186, 187
 RAYA SURE PEN NEEDLE 31G X 4 MM 180, 186, 187
 RAYA SURE PEN NEEDLE 31G X 5 MM 180, 186, 187
 RAYA SURE PEN NEEDLE 31G X 6 MM 180, 186, 187
 RAYA SURE PEN NEEDLE 31G X 8 MM 180, 186, 187
 REALITY INSULIN SYRINGE 28G X 1/2 180, 186, 187
 REALITY INSULIN SYRINGE 29G X 1/2 180, 186, 187
 REALITY SWABS PAD..... 180, 186, 187
 RELION ALCOHOL SWABS PAD 180, 186, 187
 RELION ALCOHOL SWABS PAD 70 % 180, 186, 187
 RELI-ON INSULIN SYRINGE 29G 0.3 ML..... 180, 186, 187
 RELION INSULIN SYRINGE 31G X 15/64 180, 186, 187
 RELION MINI PEN NEEDLES 31G X 6 MM 180, 186, 187
 RELION PEN NEEDLES 29G X 12MM 180, 186, 187
 RELION PEN NEEDLES 31G X 6 MM180, 186, 187
 RELION PEN NEEDLES 31G X 8 MM180, 186, 187

RESTORE CONTACT LAYER PAD 2 180, 186, 187
 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 119, 120
 RETEVMO ORAL CAPSULE 40 MG, 80 MG 321
 RETEVMO ORAL TABLET 120 MG, 160 MG, 40 MG, 80 MG 321
 REVCIVI..... 106
 REVUFORJ ORAL TABLET 110 MG, 160 MG, 25 MG..... 296
 REZDIFFRA..... 294
 REZLIDHIA 259
 REZUROCK..... 47
 RINVOQ 391, 392
 RINVOQ LQ..... 391, 392
 RITUXAN HYCELA 309
 ROMVIMZA 410
 ROZLYTREK ORAL CAPSULE 100 MG, 200 MG 115
 ROZLYTREK ORAL PACKET 116
 RUBRACA 313
 RYBELSUS 150
 RYBELSUS (FORMULATION R2)..... 150
 RYBREVANT 25
 RYBREVANT FASPRO 24
 RYDAPT..... 233
 RYTELO..... 162
S
 SAFETY INSULIN SYRINGES 29G X 1/2 180, 186, 187
 SAFETY INSULIN SYRINGES 30G X 1/2 180, 186, 187
 SAFETY INSULIN SYRINGES 30G X 5/16 180, 186, 187
 SAFETY PEN NEEDLES 30G X 5 MM 180, 186, 187
 SAFETY PEN NEEDLES 30G X 8 MM 180, 186, 187
 sapropterin dihydrochloride oral tablet... 315

SB ALCOHOL PREP PAD 70 %..	180, 186, 187	SURE COMFORT ALCOHOL PREP PAD 70 %	181, 186, 187
SB INSULIN SYRINGE 29G X 1/2	180, 186, 187	SURE COMFORT INSULIN SYRINGE 28G X 1/2.....	181, 186, 187
SB INSULIN SYRINGE 30G X 5/16 ...	180, 186, 187	SURE COMFORT INSULIN SYRINGE 29G X 1/2.....	181, 186, 187
SB INSULIN SYRINGE 31G X 5/16 ...	180, 186, 187	SURE COMFORT INSULIN SYRINGE 30G X 1/2.....	181, 186, 187
SCEMBLIX ORAL TABLET 100 MG, 20 MG, 40 MG.....	34	SURE COMFORT INSULIN SYRINGE 30G X 5/16.....	181, 186, 187
SECURESAFE INSULIN SYRINGE 29G X 1/2.....	180, 186, 187	SURE COMFORT INSULIN SYRINGE 31G X 1/4.....	181, 186, 187
SECURESAFE SAFETY PEN NEEDLES 30G X 8 MM.....	180, 186, 187	SURE COMFORT INSULIN SYRINGE 31G X 5/16.....	181, 186, 187
SELARSDI	395, 396, 397, 398	SURE COMFORT PEN NEEDLES 29G X 12.7MM	181, 186, 187
SEROSTIM SUBCUTANEOUS SOLUTION RECONSTITUTED 4 MG, 5 MG, 6 MG.....	336, 337	SURE COMFORT PEN NEEDLES 30G X 8 MM	181, 186, 187
SIGNIFOR	268	SURE COMFORT PEN NEEDLES 31G X 5 MM	181, 186, 187
sildenafil citrate oral tablet 20 mg ..	324, 325	SURE COMFORT PEN NEEDLES 31G X 6 MM	181, 186, 187
SIRTURO	45	SURE COMFORT PEN NEEDLES 31G X 8 MM	181, 186, 187
SKYRIZI.....	307, 308	SURE COMFORT PEN NEEDLES 32G X 4 MM (OTC).....	181, 186, 187
SKYRIZI PEN	307, 308	SURE COMFORT PEN NEEDLES 32G X 4 MM (RX).....	181, 186, 187
SM ALCOHOL PREP PAD ...	180, 186, 187	SURE COMFORT PEN NEEDLES 32G X 6 MM	181, 186, 187
SM ALCOHOL PREP PAD 6-70 % EXTERNAL	180, 186, 187	SURGICAL GAUZE SPONGE PAD 2	181, 186, 187
SM ALCOHOL PREP PAD 70 %.	180, 186, 187	SYMPAZAN.....	72
SM GAUZE PAD 2	180, 186, 187	SYNRIBO	260
sodium oxybate	328, 329	T	
SOMATULINE DEPOT SUBCUTANEOUS SOLUTION 60 MG/0.2ML, 90 MG/0.3ML	198	TABRECTA	65
SOMAVERT.....	273	tadalafil oral tablet 2.5 mg, 5 mg	346
sorafenib tosylate	339	TAFINLAR ORAL CAPSULE	78
SPRAVATO (56 MG DOSE).....	124	TAFINLAR ORAL TABLET SOLUBLE	79
SPRAVATO (84 MG DOSE).....	124	TAGRISSE	264
STERILE GAUZE PAD 2	181, 186, 187	TALVEY.....	351
STIVARGA	291	TALZENNA	348, 349
STRENSIQ	35, 36		
SUBVENITE ORAL SUSPENSION	197		
sunitinib malate.....	344		

TASIGNA ORAL CAPSULE 150 MG, 200 MG, 50 MG.....	245	TRELSTAR MIXJECT	388
TAVNEOS.....	38	TREMFYA INTRAVENOUS	153, 154
TAZVERIK.....	353	TREMFYA ONE-PRESS	
TECHLITE INSULIN SYRINGE 29G X 1/2	181, 186, 187	SUBCUTANEOUS SOLUTION PEN-INJECTOR.....	153, 154
TECVAYLI.....	355	TREMFYA PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 200 MG/2ML	153, 154
TEPMETKO	358	TREMFYA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE	153, 154
teriparatide subcutaneous solution pen-injector 560 mcg/2.24ml	359	TREMFYA-CD/UC INDUCTION.	153, 154
testosterone cypionate intramuscular solution 100 mg/ml, 200 mg/ml, 200 mg/ml (1 ml)	361	tretinoin external cream	376
testosterone enanthate intramuscular solution.....	362, 363	tridacaine ii.....	216
testosterone gel 1.62 % transdermal	360	trientine hcl oral capsule 250 mg	386
testosterone transdermal gel 12.5 mg/act (1%), 20.25 mg/act (1.62%), 25 mg/2.5gm (1%), 50 mg/5gm (1%).....	360	TRIKAFTA ORAL TABLET THERAPY PACK.....	107
tetrabenazine	364	TRIKAFTA ORAL THERAPY PACK..	107
TEVIMBRA.....	366	TRUE COMFORT ALCOHOL PREP PADS PAD 70 %.....	181, 186, 187
THALOMID ORAL CAPSULE 100 MG, 150 MG, 200 MG, 50 MG	365	TRUE COMFORT INSULIN SYRINGE 30G X 1/2.....	182, 186, 187
THERAGAUZE PAD 2.....	181, 186, 187	TRUE COMFORT INSULIN SYRINGE 30G X 5/16.....	182, 186, 187
TIBSOVO	195	TRUE COMFORT INSULIN SYRINGE 31G X 5/16.....	182, 186, 187
TIVDAK	367	TRUE COMFORT INSULIN SYRINGE 32G X 5/16.....	182, 186, 187
TODAYS HEALTH PEN NEEDLES 29G X 12MM.....	181, 186, 187	TRUE COMFORT PEN NEEDLES 31G X 5 MM	182, 186, 187
TODAYS HEALTH SHORT PEN NEEDLE 31G X 8 MM	181, 186, 187	TRUE COMFORT PEN NEEDLES 31G X 6 MM	182, 186, 187
tolvaptan oral tablet therapy pack.....	375	TRUE COMFORT PEN NEEDLES 32G X 4 MM	182, 186, 187
TOPCARE CLICKFINE PEN NEEDLES 31G X 6 MM.....	181, 186, 187	TRUE COMFORT PRO ALCOHOL PREP PAD 70 %.....	182, 186, 187
TOPCARE CLICKFINE PEN NEEDLES 31G X 8 MM.....	181, 186, 187	TRUE COMFORT PRO INSULIN SYR 30G X 1/2.....	182, 186, 187
TOPCARE ULTRA COMFORT INS SYR 29G X 1/2.....	181, 186, 187	TRUE COMFORT PRO INSULIN SYR 30G X 5/16.....	182, 186, 187
TOPCARE ULTRA COMFORT INS SYR 30G X 5/16.....	181, 186, 187	TRUE COMFORT PRO INSULIN SYR 31G X 5/16.....	182, 186, 187
TOPCARE ULTRA COMFORT INS SYR 31G X 5/16.....	181, 186, 187		
torpenz oral tablet 10 mg, 2.5 mg, 5 mg, 7.5 mg	127		

TRUE COMFORT PRO INSULIN SYR 32G X 5/16.....	182, 186, 187	TRUEPLUS PEN NEEDLES 31G X 6 MM	183, 186, 187
TRUE COMFORT PRO PEN NEEDLES 31G X 5 MM.....	182, 186, 187	TRUEPLUS PEN NEEDLES 31G X 8 MM	183, 186, 187
TRUE COMFORT PRO PEN NEEDLES 31G X 6 MM.....	182, 186, 187	TRUEPLUS PEN NEEDLES 32G X 4 MM	183, 186, 187
TRUE COMFORT PRO PEN NEEDLES 31G X 8 MM.....	182, 186, 187	TRULICITY SUBCUTANEOUS SOLUTION AUTO-INJECTOR	149
TRUE COMFORT PRO PEN NEEDLES 32G X 4 MM.....	182, 186, 187	TRUQAP ORAL TABLET 200 MG.....	64
TRUE COMFORT PRO PEN NEEDLES 32G X 5 MM.....	182, 186, 187	TRUQAP ORAL TABLET THERAPY PACK 160 MG	64
TRUE COMFORT PRO PEN NEEDLES 32G X 6 MM.....	182, 186, 187	TRUXIMA.....	310, 311
TRUE COMFORT PRO PEN NEEDLES 33G X 4 MM.....	182, 186, 187	TUKYSA ORAL TABLET 150 MG, 50 MG	389
TRUE COMFORT PRO PEN NEEDLES 33G X 5 MM.....	182, 186, 187	TURALIO.....	279
TRUE COMFORT PRO PEN NEEDLES 33G X 6 MM.....	182, 186, 187	TYENNE.....	369, 370, 371, 372
TRUEPLUS 5-BEVEL PEN NEEDLES 29G X 12.7MM.....	182, 186, 187	TYMLOS	1
TRUEPLUS 5-BEVEL PEN NEEDLES 31G X 5 MM.....	182, 186, 187	U	
TRUEPLUS 5-BEVEL PEN NEEDLES 31G X 6 MM.....	182, 186, 187	UBRELVY.....	390
TRUEPLUS 5-BEVEL PEN NEEDLES 31G X 8 MM.....	182, 186, 187	UDENYCA ONBODY.....	271
TRUEPLUS 5-BEVEL PEN NEEDLES 32G X 4 MM.....	182, 186, 187	ULTICARE INSULIN SAFETY SYR 29G X 1/2.....	183, 186, 187
TRUEPLUS INSULIN SYRINGE 28G X 1/2	182, 186, 187	ULTICARE INSULIN SYRINGE 28G X 1/2	183, 186, 187
TRUEPLUS INSULIN SYRINGE 29G X 1/2	182, 186, 187	ULTICARE INSULIN SYRINGE 29G X 1/2	183, 186, 187
TRUEPLUS INSULIN SYRINGE 30G X 5/16	182, 186, 187	ULTICARE INSULIN SYRINGE 30G X 1/2	183, 186, 187
TRUEPLUS INSULIN SYRINGE 31G X 5/16	182, 183, 186, 187	ULTICARE INSULIN SYRINGE 30G X 5/16	183, 186, 187
TRUEPLUS PEN NEEDLES 29G X 12MM	183, 186, 187	ULTICARE INSULIN SYRINGE 31G X 1/4	183, 186, 187
TRUEPLUS PEN NEEDLES 31G X 5 MM	183, 186, 187	ULTICARE INSULIN SYRINGE 31G X 5/16	183, 186, 187
		ULTICARE MICRO PEN NEEDLES 32G X 4 MM.....	183, 186, 187
		ULTICARE MINI PEN NEEDLES 30G X 5 MM	183, 186, 187
		ULTICARE MINI PEN NEEDLES 31G X 6 MM	183, 186, 187
		ULTICARE MINI PEN NEEDLES 32G X 6 MM	183, 186, 187

ULTICARE PEN NEEDLES 29G X 12.7MM (OTC).....	183, 186, 187	ULTRA FLO INSULIN PEN NEEDLES 31G X 8 MM.....	184, 186, 187
ULTICARE PEN NEEDLES 29G X 12.7MM (RX).....	183, 186, 187	ULTRA FLO INSULIN PEN NEEDLES 32G X 4 MM.....	184, 186, 187
ULTICARE PEN NEEDLES 31G X 5 MM.....	183, 186, 187	ULTRA FLO INSULIN PEN NEEDLES 33G X 4 MM.....	184, 186, 187
ULTICARE SHORT PEN NEEDLES 30G X 8 MM.....	183, 186, 187	ULTRA FLO INSULIN SYR 1/2 UNIT 30G X 1/2.....	184, 186, 187
ULTICARE SHORT PEN NEEDLES 31G X 8 MM (OTC).....	183, 186, 187	ULTRA FLO INSULIN SYR 1/2 UNIT 30G X 5/16.....	184, 186, 187
ULTICARE SHORT PEN NEEDLES 31G X 8 MM (RX).....	183, 186, 187	ULTRA FLO INSULIN SYR 1/2 UNIT 31G X 5/16.....	184, 186, 187
ULTIGUARD SAFEPACK PEN NEEDLE 29G X 12.7MM.....	183, 186, 187	ULTRA FLO INSULIN SYRINGE 29G X 1/2.....	184, 186, 187
ULTIGUARD SAFEPACK PEN NEEDLE 31G X 5 MM.....	183, 186, 187	ULTRA FLO INSULIN SYRINGE 30G X 1/2.....	184, 186, 187
ULTIGUARD SAFEPACK PEN NEEDLE 31G X 6 MM.....	183, 186, 187	ULTRA FLO INSULIN SYRINGE 30G X 5/16.....	184, 186, 187
ULTIGUARD SAFEPACK PEN NEEDLE 31G X 8 MM.....	184, 186, 187	ULTRA FLO INSULIN SYRINGE 31G X 5/16.....	184, 186, 187
ULTIGUARD SAFEPACK PEN NEEDLE 32G X 4 MM.....	184, 186, 187	ULTRA THIN PEN NEEDLES 32G X 4 MM.....	184, 186, 187
ULTIGUARD SAFEPACK PEN NEEDLE 32G X 6 MM.....	184, 186, 187	ULTRACARE INSULIN SYRINGE 30G X 1/2.....	185, 186, 187
ULTIGUARD SAFEPACK SYR/NEEDLE 30G X 1/2.....	184, 186, 187	ULTRACARE INSULIN SYRINGE 30G X 5/16.....	185, 186, 187
ULTIGUARD SAFEPACK SYR/NEEDLE 31G X 5/16.....	184, 186, 187	ULTRACARE INSULIN SYRINGE 31G X 5/16.....	185, 186, 187
ULTILET ALCOHOL SWABS PAD ...	184, 186, 187	ULTRACARE PEN NEEDLES 31G X 5 MM.....	185, 186, 187
ULTILET PEN NEEDLE 29G X 12.7MM.....	184, 186, 187	ULTRACARE PEN NEEDLES 31G X 6 MM.....	185, 186, 187
ULTILET PEN NEEDLE 31G X 5 MM	184, 187	ULTRACARE PEN NEEDLES 31G X 8 MM.....	185, 186, 187
ULTILET PEN NEEDLE 31G X 8 MM	184, 187	ULTRACARE PEN NEEDLES 32G X 4 MM.....	185, 186, 187
ULTILET PEN NEEDLE 32G X 4 MM	184, 187	ULTRACARE PEN NEEDLES 32G X 5 MM.....	185, 186, 187
ULTRA COMFORT INSULIN SYRINGE 30G X 5/16.....	184, 186, 187	ULTRACARE PEN NEEDLES 32G X 6 MM.....	185, 186, 187
ULTRA FLO INSULIN PEN NEEDLES 29G X 12MM.....	184, 186, 187	ULTRACARE PEN NEEDLES 33G X 4 MM.....	185, 186, 187

ULTRA-COMFORT INSULIN SYRINGE 29G X 1/2.....	184, 186, 187	UNIFINE SAFECONTROL PEN NEEDLE 30G X 8 MM.....	185, 186, 187
ULTRA-THIN II INS SYR SHORT 30G X 5/16	184, 186, 187	UNIFINE SAFECONTROL PEN NEEDLE 31G X 5 MM.....	185, 186, 187
ULTRA-THIN II INS SYR SHORT 31G X 5/16	184, 186, 187	UNIFINE SAFECONTROL PEN NEEDLE 31G X 6 MM.....	185, 186, 187
ULTRA-THIN II INSULIN SYRINGE 29G X 1/2.....	184, 186, 187	UNIFINE SAFECONTROL PEN NEEDLE 31G X 8 MM.....	185, 186, 187
ULTRA-THIN II MINI PEN NEEDLE 31G X 5 MM.....	184, 186, 187	UNIFINE SAFECONTROL PEN NEEDLE 32G X 4 MM.....	185, 186, 187
ULTRA-THIN II PEN NEEDLE SHORT 31G X 8 MM.....	185, 186, 187	UNIFINE ULTRA PEN NEEDLE 31G X 5 MM	185, 186, 187
ULTRA-THIN II PEN NEEDLES 29G X 12.7MM	185, 186, 187	UNIFINE ULTRA PEN NEEDLE 31G X 6 MM	185, 186, 187
UNIFINE OTC PEN NEEDLES 31G X 5 MM	185, 186, 187	UNIFINE ULTRA PEN NEEDLE 31G X 8 MM	185, 186, 187
UNIFINE OTC PEN NEEDLES 32G X 4 MM	185, 186, 187	UNIFINE ULTRA PEN NEEDLE 32G X 4 MM	185, 186, 187
UNIFINE PEN NEEDLES 32G X 4 MM	185, 186, 187	UPTRAVI ORAL TABLET 1000 MCG, 1200 MCG, 1400 MCG, 1600 MCG, 200 MCG, 400 MCG, 600 MCG, 800 MCG	318, 319
UNIFINE PENTIPS 29G X 12MM	185, 186, 187	UPTRAVI TITRATION.....	318, 319
UNIFINE PENTIPS 31G X 6 MM	185, 186, 187	ustekinumab-aaaz	393, 394
UNIFINE PENTIPS 31G X 8 MM	185, 186, 187	V	
UNIFINE PENTIPS 32G X 4 MM	185, 186, 187	VALCHLOR.....	228
UNIFINE PENTIPS PLUS 29G X 12MM	185, 186, 187	VALUE HEALTH INSULIN SYRINGE 29G X 1/2.....	185, 186, 187
UNIFINE PENTIPS PLUS 31G X 6 MM	185, 186, 187	VANFLYTA.....	290
UNIFINE PENTIPS PLUS 32G X 4 MM	185, 186, 187	VANISHPOINT INSULIN SYRINGE 29G X 5/16.....	185, 186, 187
UNIFINE PROTECT PEN NEEDLE 30G X 5 MM	185, 186, 187	VANISHPOINT INSULIN SYRINGE 30G X 3/16.....	185, 186, 187
UNIFINE PROTECT PEN NEEDLE 30G X 8 MM	185, 186, 187	VANISHPOINT INSULIN SYRINGE 30G X 5/16.....	185, 186, 187
UNIFINE PROTECT PEN NEEDLE 32G X 4 MM	185, 186, 187	VENCLEXTA ORAL TABLET 10 MG, 100 MG, 50 MG.....	407
UNIFINE SAFECONTROL PEN NEEDLE 30G X 5 MM.....	185, 186, 187	VENCLEXTA STARTING PACK	407
		VEOZAH	133, 134
		VERIFINE INSULIN PEN NEEDLE 29G X 12MM.....	186, 187
		VERIFINE INSULIN PEN NEEDLE 31G X 5 MM.....	186, 187

VERIFINE INSULIN PEN NEEDLE 32G X 6 MM..... 186, 187
 VERIFINE INSULIN SYRINGE 28G X 1/2 186, 187
 VERIFINE INSULIN SYRINGE 29G X 1/2 186, 187
 VERIFINE INSULIN SYRINGE 30G X 1/2 186, 187
 VERIFINE INSULIN SYRINGE 30G X 5/16 186, 187
 VERIFINE INSULIN SYRINGE 31G X 5 MM 186, 187
 VERIFINE PLUS PEN NEEDLE 31G X 8 MM 186, 187
 VERIFINE PLUS PEN NEEDLE 32G X 4 MM 186, 187
 VERQUVO 408
 VERZENIO..... 6
 vigabatrin 409
 vigadrone..... 409
 vigpoder 409
 VITRAKVI ORAL CAPSULE 100 MG, 25 MG 200
 VITRAKVI ORAL SOLUTION 200
 VIVIMUSTA 49
 VIZIMPRO 80
 VONJO 266
 VOQUEZNA 412
 VORANIGO 413
 voriconazole oral suspension reconstituted 414
 VOSEVI..... 332, 333
 VOWST 129
 VP INSULIN SYRINGE 29G X 1/2 186, 187
 VUMERITY 93
 VYALEV SUBCUTANEOUS SOLUTION 12-240 MG/ML..... 139
 VYLOY..... 419
 VYNDAMAX..... 347

W
 WEBCOL ALCOHOL PREP LARGE PAD 70 % 186, 187
 WEGMANS UNIFINE PENTIPS PLUS 31G X 8 MM..... 186, 187
 WELIREG..... 48
 WINREVAIR..... 340, 341

X
 XALKORI ORAL CAPSULE 76
 XALKORI ORAL CAPSULE SPRINKLE 150 MG, 20 MG, 50 MG 77
 XDEMVY 221
 XELJANZ 373, 374
 XELJANZ XR 373, 374
 XERMELO 357
 XIFAXAN ORAL TABLET 200 MG, 550 MG 299
 XOLAIR 261, 262, 263
 XOSPATA 146
 XPOVIO (100 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 50 MG 320
 XPOVIO (40 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 10 MG, 40 MG 320
 XPOVIO (40 MG TWICE WEEKLY) ORAL TABLET THERAPY PACK 40 MG 320
 XPOVIO (60 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 60 MG.. 320
 XPOVIO (60 MG TWICE WEEKLY)... 320
 XPOVIO (80 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 40 MG, 80 MG 320
 XPOVIO (80 MG TWICE WEEKLY)... 320
 XTANDI ORAL CAPSULE..... 117
 XTANDI ORAL TABLET 40 MG, 80 MG 117

Y
 YERVOY 192
 YESINTEK..... 399, 400, 401, 402
 YONSA..... 8
 YUFLYMA (1 PEN)..... 14, 15

YUFLYMA (2 SYRINGE)..... 14, 15
 YUFLYMA-CD/UC/HS STARTER .. 14, 15
 YUTREPIA..... 385
Z
 ZEJULA ORAL CAPSULE 249
 ZEJULA ORAL TABLET..... 249
 ZELBORAF..... 406
 ZEVRX STERILE ALCOHOL PREP PAD
 PAD 70 %..... 186, 187
 ZIIHERA..... 415

ZIRABEV 53
 ZOLADEX..... 152
 ZTALMY 143
 ZTLIDO 216
 ZURZUVAE ORAL CAPSULE 20 MG, 25
 MG, 30 MG..... 421
 ZYDELIG 159
 ZYKADIA ORAL TABLET 67
 ZYNLONTA..... 219
 ZYNYZ..... 295