# ABALOPARATIDE

## Products Affected

- TYMLOS

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

# ABATACEPT IV

**Products Affected**

- ORENCIA INTRAVENOUS

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

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

# ABATACEPT SQ

**Products Affected**

- ORENCIA CLICKJECT
- ORENCIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE

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

| PA Criteria | Criteria Details |
|---|---|
| | MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR AN AUTOIMMUNE INDICATION. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# ABEMACICLIB

**Products Affected**

- VERZENIO

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

# ABIRATERONE

## Products Affected

- *abiraterone acetate*

| 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 |

# ABIRATERONE SUBMICRONIZED

**Products Affected**

- YONSA

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

# ACALABRUTINIB

**Products Affected**

- CALQUENCE

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 MONTHS |
| **Other Criteria** | MANTLE CELL LYMPHOMA: INTOLERANCE TO BRUKINSA. CHRONIC LYMPHOCYTIC LEUKEMIA OR SMALL LYMPHOCYTIC LYMPHOMA: INTOLERANCE TO BRUKINSA OR IMBRUVICA. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# 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 |

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

# 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 |

# 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 |

# 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 |

# 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 |

# AMIVANTAMAB-VMJW

**Products Affected**

- RYBREVANT

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

# ANAKINRA

**Products Affected**

- KINERET SUBCUTANEOUS SOLUTION PREFILLED SYRINGE

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

| PA Criteria | Criteria Details |
|---|---|
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# APALUTAMIDE

**Products Affected**

- ERLEADA ORAL TABLET 240 MG, 60 MG

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

# APOMORPHINE - SL

**Products Affected**

- KYNMOBI
- KYNMOBI TITRATION KIT

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

# APREMILAST

**Products Affected**

- OTEZLA

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

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

# 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 |

# 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 |

# ASFOTASE ALFA

**Products Affected**

- STRENSIQ

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

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

# ATOGEPANT

**Products Affected**

- QULIPTA

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

# 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 |

# 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 |

# 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 |

# 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 |

# 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 |

# BEDAQUILINE

**Products Affected**

- SIRTURO

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

# 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 |

# BELUMOSUDIL

**Products Affected**

- REZUROCK

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

# 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 |

# BENDAMUSTINE

**Products Affected**

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

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

# BENRALIZUMAB

**Products Affected**

- FASENRA
- FASENRA PEN

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

# BETAINE

## Products Affected

- *betaine*

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

# BEVACIZUMAB-ADCD

**Products Affected**

- VEGZELMA

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

# BEVACIZUMAB-AWWB

**Products Affected**

- MVASI

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

# BEVACIZUMAB-BVZR

**Products Affected**

- ZIRABEV

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

# 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 |

# 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 |

# BORTEZOMIB

**Products Affected**

- *bortezomib injection*
- BORUZU

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

# BOSENTAN

### Products Affected

- *bosentan*

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

# 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 |

# 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 |

# C1 ESTERASE INHIBITOR-HAEGARDA

**Products Affected**

- HAEGARDA SUBCUTANEOUS SOLUTION RECONSTITUTED 2000 UNIT, 3000 UNIT

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

# 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 |

# 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 |

# CANNABIDIOL

**Products Affected**

- EPIDIOLEX

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

# CAPIVASERTIB

**Products Affected**

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

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

# 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 |

# 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 |

# 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 |

# CERTOLIZUMAB PEGOL

**Products Affected**

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

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

| PA Criteria | Criteria Details |
|---|---|
| | TREMFYA, ORENCIA, OTEZLA, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR PSA. PSO: 1) ONE OF THE FOLLOWING: (A) PATIENT IS PREGNANT, BREASTFEEDING, OR TRYING TO BECOME PREGNANT, OR (B) TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: COSENTYX, ENBREL, HUMIRA, STELARA, SKYRIZI, TREMFYA, OTEZLA, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR PSO. AS: 1) ONE OF THE FOLLOWING: (A) PATIENT IS PREGNANT, BREASTFEEDING, OR TRYING TO BECOME PREGNANT, OR (B) TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: COSENTYX, ENBREL, HUMIRA, XELJANZ, RINVOQ, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR AS. CD: 1) ONE OF THE FOLLOWING: (A) PATIENT IS PREGNANT, BREASTFEEDING, OR TRYING TO BECOME PREGNANT, OR (B) TRIAL OF OR CONTRAINDICATION TO ONE OF THE FOLLOWING PREFERRED AGENTS: STELARA, HUMIRA, RINVOQ, SKYRIZI, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR CD. NR-AXSPA: 1) TRIAL OF OR CONTRAINDICATION TO AN NSAID, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR NR-AXSPA. PJIA: 1) ONE OF THE FOLLOWING: (A) PATIENT IS PREGNANT, BREASTFEEDING, OR TRYING TO BECOME PREGNANT, OR (B) TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: ENBREL, HUMIRA, XELJANZ IR, ORENCIA, RINVOQ, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR PJIA. RENEWAL: CD: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR CD. RA: CONTINUES TO BENEFIT FROM MEDICATION. PSA: 1) CONTINUES TO BENEFIT FROM MEDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR PSA. AS: 1) CONTINUES TO BENEFIT FROM MEDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR AS. PSO: 1) CONTINUES TO BENEFIT FROM MEDICATION, AND 2) NO |

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

# CETUXIMAB

**Products Affected**

- ERBITUX

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

# 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** | INITIAL/RENEWAL: 48 WEEKS. |
| **Other Criteria** | RELAPSING FORM OF MULTIPLE SCLEROSIS (MS): INITIAL: HAS NOT RECEIVED A TOTAL OF TWO YEARS OF MAVENCLAD TREATMENT (I.E., TWO YEARLY TREATMENT COURSES OF TWO CYCLES IN EACH). RENEWAL: 1) HAS DEMONSTRATED CLINICAL BENEFIT COMPARED TO PRE-TREATMENT BASELINE, 2) DOES NOT HAVE LYMPHOPENIA, AND 3) 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 |

# CLOBAZAM-SYMPAZAN

**Products Affected**

- SYMPAZAN

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

# 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 |

# CORTICOTROPIN

**Products Affected**

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

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | 23811 |
| **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 |

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# 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 |

# 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 |

# 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 |

# 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 |

# 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 |

# DALFAMPRIDINE

**Products Affected**

- *dalfampridine er*

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

# DAROLUTAMIDE

**Products Affected**

- NUBEQA

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

# 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 |

# 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 |

# DEFERASIROX

**Products Affected**

- *deferasirox granules*
- *deferasirox oral tablet*

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

| PA Criteria | Criteria Details |
|---|---|
| **Part B Prerequisite** | No |

# DENOSUMAB-XGEVA

**Products Affected**

- XGEVA

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

# 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 |

# DICLOFENAC TOPICAL SOLUTION

**Products Affected**

- *diclofenac sodium external solution 2 %*

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

# 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 |

# 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 |

# 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 |

# DRONABINOL CAPSULE

**Products Affected**

- *dronabinol*

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

# 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 |

# DUPILUMAB

**Products Affected**

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

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

# DUVELISIB

## Products Affected

- COPIKTRA

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

# 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 |

# 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 |

# ELAGOLIX

**Products Affected**

- ORILISSA ORAL TABLET 150 MG, 200 MG

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

# ELRANATAMAB-BCMM

**Products Affected**

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

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

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

# ELTROMBOPAG - PROMACTA

**Products Affected**

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

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

| PA Criteria | Criteria Details |
|---|---|
| **Part B Prerequisite** | No |

# 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 |

# 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 |

# 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 |

# 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 |

# ENZALUTAMIDE

**Products Affected**

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

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

| PA Criteria | Criteria Details |
|---|---|
| **Part B Prerequisite** | No |

# EPCORITAMAB-BYSP

**Products Affected**

- EPKINLY

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

# EPOETIN ALFA-EPBX

**Products Affected**

- 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

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

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

# ERDAFITINIB

**Products Affected**

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

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

# 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 |

# ESKETAMINE

**Products Affected**

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

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

# ETANERCEPT

**Products Affected**

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

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | INITIAL: PLAQUE PSORIASIS (PSO): PSORIASIS COVERING 3 PERCENT OR MORE OF BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, FACE, SCALP, OR GENITAL AREA. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | INITIAL: RHEUMATOID ARTHRITIS (RA), POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS (PJIA), ANKYLOSING SPONDYLITIS (AS): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST. PSORIATIC ARTHRITIS (PSA): PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST OR RHEUMATOLOGIST. PSO: PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST. |
| **Coverage Duration** | INITIAL: 6 MONTHS, RENEWAL: 12 MONTHS. |
| **Other Criteria** | INITIAL: RA: TRIAL OF OR CONTRAINDICATION TO 3 MONTHS OF TREATMENT WITH ONE DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG) - IF PATIENT TRIED METHOTREXATE, THEN TRIAL AT A DOSE GREATER THAN OR EQUAL TO 20 MG PER WEEK OR MAXIMALLY TOLERATED DOSE IS REQUIRED. PJIA: 1) TRIAL OF OR CONTRAINDICATION TO ONE DMARD, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR AN AUTOIMMUNE INDICATION. PSA: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., |

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

# 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 |

# 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 |

# FECAL MICROBIOTA CAPSULE

**Products Affected**

- VOWST

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

# 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 |

# FENFLURAMINE

**Products Affected**

- FINTEPLA

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

# 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 |

# FEZOLINETANT

**Products Affected**

- VEOZAH

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

# 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 |

# FINERENONE

## Products Affected

- KERENDIA

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

# 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 |

# FOSCARBIDOPA-FOSLEVODOPA

**Products Affected**

- VYALEV SUBCUTANEOUS SOLUTION 12-240 MG/ML

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

# FREMANEZUMAB-VFRM

**Products Affected**

- AJOVY

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

# 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 |

# 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 |

# GALCANEZUMAB-GNLM

**Products Affected**

- EMGALITY
- EMGALITY (300 MG DOSE)

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

# 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 |

# 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 |

# 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 |

# 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 |

# 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 |

# 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 |

# GLP1-SEMAGLUTIDE

**Products Affected**

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

| 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 |

# 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 |

# GOSERELIN

**Products Affected**

- ZOLADEX

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

# GUSELKUMAB

**Products Affected**

- TREMFYA INTRAVENOUS
- TREMFYA SUBCUTANEOUS SOLUTION AUTO-INJECTOR
- TREMFYA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE

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

| PA Criteria | Criteria Details |
|---|---|
| | MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR AN AUTOIMMUNE INDICATION. RENEWAL: PSO, PSA: 1) CONTINUES TO BENEFIT FROM THE MEDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR AN AUTOIMMUNE INDICATION. UC: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR AN AUTOIMMUNE INDICATION. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# 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 |

# IBRUTINIB

**Products Affected**

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

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

# ICATIBANT

## Products Affected

- *icatibant acetate subcutaneous solution prefilled syringe*

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

# 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 |

# 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 |

# 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 |

# 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 |

# 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 |

# INFIGRATINIB

**Products Affected**

- TRUSELTIQ (100MG DAILY DOSE)
- TRUSELTIQ (125MG DAILY DOSE)
- TRUSELTIQ (50MG DAILY DOSE)
- TRUSELTIQ (75MG DAILY DOSE)

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | CHOLANGIOCARCINOMA: COMPREHENSIVE OPHTHALMOLOGICAL EXAMINATION, INCLUDING OPTICAL COHERENCE TOMOGRAPHY (OCT), WILL BE COMPLETED PRIOR TO 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 |

# INFLIXIMAB

**Products Affected**

- *infliximab*

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

| PA Criteria | Criteria Details |
|---|---|
| | INHIBITOR, PDE-4 INHIBITOR) FOR AN AUTOIMMUNE INDICATION. AS: 1) TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: COSENTYX, ENBREL, HUMIRA, XELJANZ, RINVOQ, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR AN AUTOIMMUNE INDICATION. MODERATE TO SEVERE CD: 1) TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS, WHERE AGES ALIGN: STELARA, HUMIRA, RINVOQ, SKYRIZI, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR AN AUTOIMMUNE INDICATION. UC: 1) TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS, WHERE AGES ALIGN: STELARA, XELJANZ, HUMIRA, RINVOQ, SKYRIZI, TREMFYA, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR AN AUTOIMMUNE INDICATION. RENEWAL: RA: CONTINUES TO BENEFIT FROM THE MEDICATION. AS, PSO, PSA: 1) CONTINUES TO BENEFIT FROM THE MEDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR AN AUTOIMMUNE INDICATION. UC, MODERATE TO SEVERE CD: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR AN AUTOIMMUNE INDICATION. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

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

Formulary ID: 25488
Last Updated: 01/21/2025
Effective: 02/01/2025
H9306_25_DRS_001_001_OE_C

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

- BD SAFETYGLIDE INSULIN SYRINGE 29G X 1/2" 0.5 ML
- BD SAFETYGLIDE INSULIN SYRINGE 30G X 5/16" 0.5 ML
- BD SAFETYGLIDE INSULIN SYRINGE 31G X 15/64" 0.3 ML
- BD SAFETYGLIDE INSULIN SYRINGE 31G X 15/64" 0.5 ML
- BD SAFETYGLIDE INSULIN SYRINGE 31G X 15/64" 1 ML
- BD SAFETYGLIDE INSULIN SYRINGE 31G X 5/16" 0.3 ML
- BD SAFETYGLIDE SYRINGE/NEEDLE 27G X 5/8" 1 ML
- BD SWAB SINGLE USE REGULAR PAD
- BD SWABS SINGLE USE BUTTERFLY PAD
- BD VEO INSULIN SYR U/F 1/2UNIT 31G X 15/64" 0.3 ML
- BD VEO INSULIN SYRINGE U/F 31G X 15/64" 0.3 ML (OTC)
- BD VEO INSULIN SYRINGE U/F 31G X 15/64" 0.3 ML (RX)
- BD VEO INSULIN SYRINGE U/F 31G X 15/64" 0.5 ML (OTC)
- BD VEO INSULIN SYRINGE U/F 31G X 15/64" 0.5 ML (RX)
- BD VEO INSULIN SYRINGE U/F 31G X 15/64" 1 ML (OTC)
- BD VEO INSULIN SYRINGE U/F 31G X 15/64" 1 ML (RX)
- 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 6 MM
- CLICKFINE PEN NEEDLES 31G X 8 MM
- CLICKFINE PEN NEEDLES 32G X 4 MM
- COMFORT ASSIST INSULIN SYRINGE 29G X 1/2" 1 ML
- COMFORT ASSIST INSULIN SYRINGE 31G X 5/16" 0.3 ML
- COMFORT EZ INSULIN SYRINGE 28G X 1/2" 0.5 ML
- COMFORT EZ INSULIN SYRINGE 28G X 1/2" 1 ML
- COMFORT EZ INSULIN SYRINGE 29G X 1/2" 0.3 ML
- COMFORT EZ INSULIN SYRINGE 29G X 1/2" 0.5 ML
- COMFORT EZ INSULIN SYRINGE 29G X 1/2" 1 ML
- COMFORT EZ INSULIN SYRINGE 30G X 1/2" 0.3 ML
- COMFORT EZ INSULIN SYRINGE 30G X 1/2" 0.5 ML
- COMFORT EZ INSULIN SYRINGE 30G X 1/2" 1 ML
- COMFORT EZ INSULIN SYRINGE 30G X 5/16" 0.3 ML
- COMFORT EZ INSULIN SYRINGE 30G X 5/16" 0.5 ML
- COMFORT EZ INSULIN SYRINGE 30G X 5/16" 1 ML
- COMFORT EZ INSULIN SYRINGE 31G X 15/64" 0.3 ML
- COMFORT EZ INSULIN SYRINGE 31G X 15/64" 0.5 ML
- COMFORT EZ INSULIN SYRINGE 31G X 15/64" 1 ML
- COMFORT EZ INSULIN SYRINGE 31G X 5/16" 0.3 ML
- COMFORT EZ INSULIN SYRINGE 31G X 5/16" 0.5 ML
- COMFORT EZ INSULIN SYRINGE 31G X 5/16" 1 ML
- COMFORT EZ PEN NEEDLES 31G X 5 MM
- COMFORT EZ PEN NEEDLES 31G X 6 MM
- COMFORT EZ PEN NEEDLES 31G X 8 MM
- COMFORT EZ PEN NEEDLES 32G X 4 MM
- COMFORT EZ PEN NEEDLES 32G X 5 MM
- COMFORT EZ PEN NEEDLES 32G X 6 MM
- COMFORT EZ PEN NEEDLES 32G X 8 MM
- COMFORT EZ PEN NEEDLES 33G X 4 MM
- COMFORT EZ PEN NEEDLES 33G X 5 MM
- COMFORT EZ PEN NEEDLES 33G X 6 MM
- COMFORT EZ PEN NEEDLES 33G X 8 MM
- COMFORT EZ PRO PEN NEEDLES 30G X 8 MM
- COMFORT EZ PRO PEN NEEDLES 31G X 4 MM
- COMFORT EZ PRO PEN NEEDLES 31G X 5 MM
- COMFORT TOUCH INSULIN PEN NEED 31G X 4 MM
- COMFORT TOUCH INSULIN PEN NEED 31G X 5 MM
- COMFORT TOUCH INSULIN PEN NEED 31G X 6 MM
- COMFORT TOUCH INSULIN PEN NEED 31G X 8 MM
- COMFORT TOUCH INSULIN PEN NEED 32G X 4 MM
- COMFORT TOUCH INSULIN PEN NEED 32G X 5 MM

- COMFORT TOUCH INSULIN PEN NEED 32G X 6 MM
- COMFORT TOUCH INSULIN PEN NEED 32G X 8 MM
- CURITY ALCOHOL PREPS PAD 70 %
- CURITY ALL PURPOSE SPONGES PAD 2"X2"
- CURITY GAUZE PAD 2"X2"
- CURITY GAUZE SPONGE PAD 2"X2"
- CURITY SPONGES PAD 2"X2"
- CVS GAUZE PAD 2"X2"
- CVS GAUZE STERILE PAD 2"X2"
- DERMACEA GAUZE SPONGE PAD 2"X2"
- DERMACEA IV DRAIN SPONGES PAD 2"X2"
- DERMACEA NON-WOVEN SPONGES PAD 2"X2"
- DERMACEA TYPE VII GAUZE PAD 2"X2"
- DIATHRIVE PEN NEEDLE 31G X 5 MM
- DIATHRIVE PEN NEEDLE 31G X 6 MM
- DIATHRIVE PEN NEEDLE 31G X 8 MM
- DIATHRIVE PEN NEEDLE 32G X 4 MM
- DROPLET INSULIN SYRINGE 29G X 1/2" 0.3 ML
- DROPLET INSULIN SYRINGE 29G X 1/2" 0.5 ML
- DROPLET INSULIN SYRINGE 29G X 1/2" 1 ML
- DROPLET INSULIN SYRINGE 30G X 1/2" 0.3 ML
- DROPLET INSULIN SYRINGE 30G X 1/2" 0.5 ML
- DROPLET INSULIN SYRINGE 30G X 1/2" 1 ML
- DROPLET INSULIN SYRINGE 30G X 15/64" 0.3 ML
- DROPLET INSULIN SYRINGE 30G X 15/64" 0.5 ML
- DROPLET INSULIN SYRINGE 30G X 15/64" 1 ML
- DROPLET INSULIN SYRINGE 30G X 5/16" 0.3 ML
- DROPLET INSULIN SYRINGE 30G X 5/16" 0.5 ML
- DROPLET INSULIN SYRINGE 30G X 5/16" 1 ML
- DROPLET INSULIN SYRINGE 31G X 15/64" 0.3 ML
- DROPLET INSULIN SYRINGE 31G X 15/64" 0.5 ML
- DROPLET INSULIN SYRINGE 31G X 15/64" 1 ML
- DROPLET INSULIN SYRINGE 31G X 5/16" 0.3 ML
- DROPLET INSULIN SYRINGE 31G X 5/16" 0.5 ML
- DROPLET INSULIN SYRINGE 31G X 5/16" 1 ML
- DROPLET MICRON 34G X 3.5 MM
- DROPLET PEN NEEDLES 29G X 10MM
- DROPLET PEN NEEDLES 29G X 12MM
- DROPLET PEN NEEDLES 30G X 8 MM
- DROPLET PEN NEEDLES 31G X 5 MM
- DROPLET PEN NEEDLES 31G X 6 MM
- DROPLET PEN NEEDLES 31G X 8 MM
- DROPLET PEN NEEDLES 32G X 4 MM
- DROPLET PEN NEEDLES 32G X 5 MM
- DROPLET PEN NEEDLES 32G X 6 MM
- DROPLET PEN NEEDLES 32G X 8 MM
- DROPSAFE ALCOHOL PREP PAD 70 %
- DROPSAFE SAFETY PEN NEEDLES 31G X 5 MM
- DROPSAFE SAFETY PEN NEEDLES 31G X 6 MM
- DROPSAFE SAFETY PEN NEEDLES 31G X 8 MM
- DROPSAFE SAFETY SYRINGE/NEEDLE 29G X 1/2" 1 ML

- DROPSAFE SAFETY SYRINGE/NEEDLE 31G X 15/64" 0.3 ML
- DROPSAFE SAFETY SYRINGE/NEEDLE 31G X 15/64" 0.5 ML
- DROPSAFE SAFETY SYRINGE/NEEDLE 31G X 15/64" 1 ML
- DROPSAFE SAFETY SYRINGE/NEEDLE 31G X 5/16" 0.3 ML
- DROPSAFE SAFETY SYRINGE/NEEDLE 31G X 5/16" 0.5 ML
- DROPSAFE SAFETY SYRINGE/NEEDLE 31G X 5/16" 1 ML
- DRUG MART ULTRA COMFORT SYR 29G X 1/2" 0.3 ML
- DRUG MART ULTRA COMFORT SYR 29G X 1/2" 1 ML
- DRUG MART ULTRA COMFORT SYR 30G X 5/16" 0.5 ML
- DRUG MART ULTRA COMFORT SYR 30G X 5/16" 1 ML
- DRUG MART UNIFINE PENTIPS 31G X 5 MM
- EASY COMFORT ALCOHOL PADS PAD
- EASY COMFORT INSULIN SYRINGE 30G X 1/2" 0.5 ML
- EASY COMFORT INSULIN SYRINGE 30G X 1/2" 1 ML
- EASY COMFORT INSULIN SYRINGE 30G X 5/16" 0.5 ML
- EASY COMFORT INSULIN SYRINGE 30G X 5/16" 1 ML
- EASY COMFORT INSULIN SYRINGE 31G X 1/2" 0.3 ML
- EASY COMFORT INSULIN SYRINGE 31G X 5/16" 0.3 ML
- EASY COMFORT INSULIN SYRINGE 31G X 5/16" 0.5 ML
- EASY COMFORT INSULIN SYRINGE 31G X 5/16" 1 ML
- EASY COMFORT INSULIN SYRINGE 32G X 5/16" 0.5 ML
- EASY COMFORT INSULIN SYRINGE 32G X 5/16" 1 ML
- EASY COMFORT PEN NEEDLES 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 1ML
- 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
- EMBRACE PEN NEEDLES 29G X 12MM
- EMBRACE PEN NEEDLES 30G X 5 MM
- EMBRACE PEN NEEDLES 30G X 8 MM
- EMBRACE PEN NEEDLES 31G X 5 MM
- EMBRACE PEN NEEDLES 31G X 6 MM
- EMBRACE PEN NEEDLES 31G X 8 MM
- EMBRACE PEN NEEDLES 32G X 4 MM
- EQL ALCOHOL SWABS PAD 70 %
- EQL GAUZE PAD 2"X2"
- EQL INSULIN SYRINGE 30G X 5/16" 0.3 ML
- EQL INSULIN SYRINGE 30G X 5/16" 0.5 ML
- EQL INSULIN SYRINGE 30G X 5/16" 1 ML
- EXEL COMFORT POINT PEN NEEDLE 29G X 12MM
- FIFTY50 PEN NEEDLES 32G X 6 MM

- FREESTYLE PRECISION INS SYR 30G X 5/16" 0.5 ML
- FREESTYLE PRECISION INS SYR 30G X 5/16" 1 ML
- FREESTYLE PRECISION INS SYR 31G X 5/16" 0.5 ML
- FREESTYLE PRECISION INS SYR 31G X 5/16" 1 ML
- GAUZE PADS PAD 2"X2"
- GAUZE TYPE VII MEDI-PAK PAD 2"X2"
- GLOBAL ALCOHOL PREP EASE
- GLOBAL EASE INJECT PEN NEEDLES 29G X 12MM
- GLOBAL EASE INJECT PEN NEEDLES 31G X 5 MM
- GLOBAL EASE INJECT PEN NEEDLES 31G X 8 MM
- GLOBAL EASE INJECT PEN NEEDLES 32G X 4 MM
- GLOBAL EASY GLIDE INSULIN SYR 31G X 15/64" 0.3 ML
- GLOBAL EASY GLIDE INSULIN SYR 31G X 15/64" 0.5 ML
- GLOBAL EASY GLIDE INSULIN SYR 31G X 15/64" 1 ML
- GLOBAL INJECT EASE INSULIN SYR 28G X 1/2" 0.5 ML
- GLOBAL INJECT EASE INSULIN SYR 28G X 1/2" 1 ML
- GLOBAL INJECT EASE INSULIN SYR 29G X 1/2" 0.5 ML
- GLOBAL INJECT EASE INSULIN SYR 29G X 1/2" 1 ML
- GLOBAL INJECT EASE INSULIN SYR 30G X 1/2" 0.3 ML
- GLOBAL INJECT EASE INSULIN SYR 30G X 1/2" 0.5 ML
- GLOBAL INJECT EASE INSULIN SYR 30G X 5/16" 0.5 ML
- GLOBAL INJECT EASE INSULIN SYR 30G X 5/16" 1 ML
- GLUCOPRO INSULIN SYRINGE 30G X 1/2" 0.3 ML
- GLUCOPRO INSULIN SYRINGE 30G X 1/2" 0.5 ML
- GLUCOPRO INSULIN SYRINGE 30G X 1/2" 1 ML
- GLUCOPRO INSULIN SYRINGE 30G X 5/16" 0.3 ML
- GLUCOPRO INSULIN SYRINGE 30G X 5/16" 0.5 ML
- GLUCOPRO INSULIN SYRINGE 30G X 5/16" 1 ML
- GLUCOPRO INSULIN SYRINGE 31G X 5/16" 0.3 ML
- GLUCOPRO INSULIN SYRINGE 31G X 5/16" 0.5 ML
- GLUCOPRO INSULIN SYRINGE 31G X 5/16" 1 ML
- GNP ALCOHOL SWABS PAD
- GNP INSULIN SYRINGE 28G X 1/2" 1 ML
- GNP INSULIN SYRINGE 29G X 1/2" 0.5 ML
- GNP INSULIN SYRINGE 29G X 1/2" 1 ML
- GNP INSULIN SYRINGE 30G X 5/16" 0.5 ML
- GNP INSULIN SYRINGE 30G X 5/16" 1 ML
- GNP INSULIN SYRINGES 29GX1/2" 29G X 1/2" 0.5 ML
- GNP INSULIN SYRINGES 29GX1/2" 29G X 1/2" 1 ML
- GNP INSULIN SYRINGES 30G X 5/16" 1 ML
- GNP INSULIN SYRINGES 30GX5/16" 30G X 5/16" 0.3 ML
- GNP INSULIN SYRINGES 31GX5/16" 31G X 5/16" 0.3 ML
- GNP STERILE GAUZE PAD 2"X2"
- GNP ULTRA COM INSULIN SYRINGE 29G X 1/2" 0.3 ML
- GNP ULTRA COM INSULIN SYRINGE 30G X 5/16" 0.3 ML
- GOODSENSE ALCOHOL SWABS PAD 70 %

- H-E-B INCONTROL ALCOHOL PAD
- H-E-B INCONTROL PEN NEEDLES 29G X 12MM
- H-E-B INCONTROL PEN NEEDLES 31G X 5 MM
- H-E-B INCONTROL PEN NEEDLES 31G X 6 MM
- H-E-B INCONTROL PEN NEEDLES 31G X 8 MM
- H-E-B INCONTROL PEN NEEDLES 32G X 4 MM
- HEALTHWISE INSULIN SYR/NEEDLE 30G X 5/16" 0.3 ML
- HEALTHWISE INSULIN SYR/NEEDLE 30G X 5/16" 0.5 ML
- HEALTHWISE INSULIN SYR/NEEDLE 30G X 5/16" 1 ML
- HEALTHWISE INSULIN SYR/NEEDLE 31G X 5/16" 0.3 ML
- HEALTHWISE INSULIN SYR/NEEDLE 31G X 5/16" 0.5 ML
- HEALTHWISE INSULIN SYR/NEEDLE 31G X 5/16" 1 ML
- HEALTHWISE MICRON PEN NEEDLES 32G X 4 MM
- HEALTHWISE SHORT PEN NEEDLES 31G X 5 MM
- HEALTHWISE SHORT PEN NEEDLES 31G X 8 MM
- HEALTHY ACCENTS UNIFINE PENTIP 29G X 12MM
- HEALTHY ACCENTS UNIFINE PENTIP 31G X 5 MM
- HEALTHY ACCENTS UNIFINE PENTIP 31G X 6 MM
- HEALTHY ACCENTS UNIFINE PENTIP 31G X 8 MM
- HEALTHY ACCENTS UNIFINE PENTIP 32G X 4 MM
- HM STERILE PADS PAD 2"X2"
- HM ULTICARE INSULIN SYRINGE 30G X 1/2" 1 ML
- HM ULTICARE INSULIN SYRINGE 31G X 5/16" 0.3 ML
- HM ULTICARE SHORT PEN NEEDLES 31G X 8 MM
- INCONTROL ULTICARE PEN NEEDLES 31G X 6 MM
- INCONTROL ULTICARE PEN NEEDLES 31G X 8 MM
- INCONTROL ULTICARE PEN NEEDLES 32G X 4 MM
- INSULIN SYRINGE 29G X 1" 0.3 ML
- INSULIN SYRINGE 29G X 1/2" 1 ML
- INSULIN SYRINGE 30G X 1/2" 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-NEEDLE U-100 27G X 1/2" 0.5 ML (OTC)
- INSULIN SYRINGE-NEEDLE U-100 27G X 1/2" 0.5 ML (RX)
- INSULIN SYRINGE-NEEDLE U-100 27G X 1/2" 1 ML (RX)
- INSULIN SYRINGE-NEEDLE U-100 28G X 1/2" 0.5 ML (RX)
- INSULIN SYRINGE-NEEDLE U-100 28G X 1/2" 1 ML (RX)
- INSULIN SYRINGE-NEEDLE U-100 30G X 5/16" 1 ML
- INSULIN SYRINGE-NEEDLE U-100 31G X 1/4" 0.3 ML
- INSULIN SYRINGE-NEEDLE U-100 31G X 1/4" 0.5 ML
- INSULIN SYRINGE-NEEDLE U-100 31G X 1/4" 1 ML
- INSULIN SYRINGE-NEEDLE U-100 31G X 5/16" 0.5 ML (OTC)
- INSULIN SYRINGE/NEEDLE 27G X 1/2" 0.5 ML
- INSULIN SYRINGE/NEEDLE 28G X 1/2" 0.5 ML
- INSULIN SYRINGE/NEEDLE 28G X 1/2" 1 ML
- INSUPEN PEN NEEDLES 31G X 5 MM
- INSUPEN PEN NEEDLES 32G X 4 MM

- INSUPEN PEN NEEDLES 33G X 4 MM
- INSUPEN ULTRAFIN 29G X 12MM
- INSUPEN ULTRAFIN 31G X 8 MM
- J & J GAUZE PAD 2"X2"
- KENDALL HYDROPHILIC FOAM DRESS PAD 2"X2"
- KENDALL HYDROPHILIC FOAM PLUS PAD 2"X2"
- KINRAY INSULIN SYRINGE 29G X 1/2" 0.5 ML
- KMART VALU INSULIN SYRINGE 29G U-100 1 ML
- KMART VALU INSULIN SYRINGE 30G U-100 0.3 ML
- KMART VALU INSULIN SYRINGE 30G U-100 1 ML
- KROGER PEN NEEDLES 29G X 12MM
- KROGER PEN NEEDLES 31G X 8 MM
- LEADER UNIFINE PENTIPS 31G X 5 MM
- LEADER UNIFINE PENTIPS 32G X 4 MM
- LEADER UNIFINE PENTIPS PLUS 31G X 5 MM
- LEADER UNIFINE PENTIPS PLUS 31G X 8 MM
- LITETOUCH INSULIN SYRINGE 28G X 1/2" 0.5 ML
- LITETOUCH INSULIN SYRINGE 28G X 1/2" 1 ML
- LITETOUCH INSULIN SYRINGE 29G X 1/2" 0.3 ML
- LITETOUCH INSULIN SYRINGE 29G X 1/2" 0.5 ML
- LITETOUCH INSULIN SYRINGE 29G X 1/2" 1 ML
- LITETOUCH INSULIN SYRINGE 30G X 5/16" 0.3 ML
- LITETOUCH INSULIN SYRINGE 30G X 5/16" 0.5 ML
- LITETOUCH INSULIN SYRINGE 30G X 5/16" 1 ML
- LITETOUCH INSULIN SYRINGE 31G X 5/16" 0.3 ML
- LITETOUCH INSULIN SYRINGE 31G X 5/16" 0.5 ML
- LITETOUCH INSULIN SYRINGE 31G X 5/16" 1 ML
- LITETOUCH PEN NEEDLES 29G X 12.7MM
- LITETOUCH PEN NEEDLES 31G X 5 MM
- LITETOUCH PEN NEEDLES 31G X 6 MM
- LITETOUCH PEN NEEDLES 31G X 8 MM
- LITETOUCH PEN NEEDLES 32G X 4 MM
- MAGELLAN INSULIN SAFETY SYR 29G X 1/2" 0.3 ML
- MAGELLAN INSULIN SAFETY SYR 29G X 1/2" 0.5 ML
- MAGELLAN INSULIN SAFETY SYR 29G X 1/2" 1 ML
- MAGELLAN INSULIN SAFETY SYR 30G X 5/16" 0.3 ML
- MAGELLAN INSULIN SAFETY SYR 30G X 5/16" 0.5 ML
- MAGELLAN INSULIN SAFETY SYR 30G X 5/16" 1 ML
- MAXI-COMFORT INSULIN SYRINGE 28G X 1/2" 0.5 ML
- MAXI-COMFORT INSULIN SYRINGE 28G X 1/2" 1 ML
- MAXI-COMFORT SAFETY PEN NEEDLE 29G X 5MM
- MAXI-COMFORT SAFETY PEN NEEDLE 29G X 8MM
- MAXICOMFORT II PEN NEEDLE 31G X 6 MM
- MAXICOMFORT SYR 27G X 1/2" 27G X 1/2" 0.5 ML
- MAXICOMFORT SYR 27G X 1/2" 27G X 1/2" 1 ML
- MEDIC INSULIN SYRINGE 30G X 5/16" 0.3 ML
- MEDIC INSULIN SYRINGE 30G X 5/16" 0.5 ML

- MEDICINE SHOPPE PEN NEEDLES 29G X 12MM
- MEDICINE SHOPPE PEN NEEDLES 31G X 8 MM
- MEDPURA ALCOHOL PADS 70 % EXTERNAL
- MEIJER ALCOHOL SWABS PAD 70 %
- MEIJER PEN NEEDLES 29G X 12MM
- MEIJER PEN NEEDLES 31G X 6 MM
- MEIJER PEN NEEDLES 31G X 8 MM
- MICRODOT PEN NEEDLE 31G X 6 MM
- MICRODOT PEN NEEDLE 32G X 4 MM
- MICRODOT PEN NEEDLE 33G X 4 MM
- MIRASORB SPONGES 2"X2"
- MM PEN NEEDLES 32G X 4 MM
- MONOJECT INSULIN SYRINGE 25G X 5/8" 1 ML
- MONOJECT INSULIN SYRINGE 27G X 1/2" 1 ML (OTC)
- MONOJECT INSULIN SYRINGE 28G X 1/2" 0.5 ML (RX)
- MONOJECT INSULIN SYRINGE 28G X 1/2" 1 ML (OTC)
- MONOJECT INSULIN SYRINGE 28G X 1/2" 1 ML (RX)
- MONOJECT INSULIN SYRINGE 29G X 1/2" 0.3 ML
- MONOJECT INSULIN SYRINGE 29G X 1/2" 0.5 ML
- MONOJECT INSULIN SYRINGE 29G X 1/2" 1 ML (RX)
- MONOJECT INSULIN SYRINGE 30G X 5/16" 0.3 ML
- MONOJECT INSULIN SYRINGE 30G X 5/16" 0.5 ML (RX)
- MONOJECT INSULIN SYRINGE 30G X 5/16" 1 ML (RX)
- MONOJECT INSULIN SYRINGE 31G X 5/16" 1 ML
- MONOJECT INSULIN SYRINGE U-100 1 ML
- MONOJECT ULTRA COMFORT SYRINGE 28G X 1/2" 0.5 ML (OTC)
- MONOJECT ULTRA COMFORT SYRINGE 28G X 1/2" 0.5 ML (RX)
- MONOJECT ULTRA COMFORT SYRINGE 28G X 1/2" 1 ML (OTC)
- MONOJECT ULTRA COMFORT SYRINGE 29G X 1/2" 0.5 ML
- MONOJECT ULTRA COMFORT SYRINGE 29G X 1/2" 1 ML
- MONOJECT ULTRA COMFORT SYRINGE 30G X 5/16" 0.3 ML (OTC)
- MONOJECT ULTRA COMFORT SYRINGE 30G X 5/16" 0.3 ML (RX)
- MONOJECT ULTRA COMFORT SYRINGE 30G X 5/16" 0.5 ML (RX)
- NOVOFINE AUTOCOVER 30G X 8 MM
- NOVOFINE PEN NEEDLE 32G X 6 MM
- NOVOFINE PLUS PEN NEEDLE 32G X 4 MM
- NOVOTWIST PEN NEEDLE 32G X 5 MM
- PC UNIFINE PENTIPS 31G X 5 MM
- PC UNIFINE PENTIPS 31G X 6 MM
- PC UNIFINE PENTIPS 31G X 8 MM
- PEN NEEDLES 29G X 12MM
- PEN NEEDLES 30G X 5 MM (OTC)
- PEN NEEDLES 30G X 8 MM
- PEN NEEDLES 31G X 5 MM (OTC)
- PEN NEEDLES 31G X 8 MM (OTC)
- PEN NEEDLES 32G X 4 MM (OTC)
- PEN NEEDLES 32G X 5 MM
- PENTIPS 29G X 12MM (RX)
- PENTIPS 31G X 5 MM (RX)
- PENTIPS 31G X 8 MM (RX)
- PENTIPS 32G X 4 MM (RX)
- PENTIPS GENERIC PEN NEEDLES 29G X 12MM
- PENTIPS GENERIC PEN NEEDLES 31G X 6 MM
- PENTIPS GENERIC PEN NEEDLES 32G X 6 MM

- PIP PEN NEEDLES 31G X 5MM 31G X 5 MM
- PIP PEN NEEDLES 32G X 4MM 32G X 4 MM
- PRECISION SURE-DOSE SYRINGE 28G X 1/2" 0.5 ML
- PRECISION SURE-DOSE SYRINGE 28G X 1/2" 1 ML
- PRECISION SURE-DOSE SYRINGE 29G X 1/2" 0.5 ML
- PRECISION SURE-DOSE SYRINGE 30G X 3/8" 0.5 ML
- PRECISION SURE-DOSE SYRINGE 30G X 5/16" 0.3 ML
- PRECISION SUREDOSE PLUS SYR 29G X 1/2" 0.3 ML
- PRECISION SUREDOSE PLUS SYR 29G X 1/2" 1 ML
- PREFERRED PLUS INSULIN SYRINGE 28G X 1/2" 0.5 ML
- PREFERRED PLUS UNIFINE PENTIPS 29G X 12MM
- PREVENT DROPSAFE PEN NEEDLES 31G X 6 MM
- PREVENT DROPSAFE PEN NEEDLES 31G X 8 MM
- PREVENT SAFETY PEN NEEDLES 31G X 6 MM
- PREVENT SAFETY PEN NEEDLES 31G X 8 MM
- PRO COMFORT ALCOHOL PAD 70 %
- PRO COMFORT INSULIN SYRINGE 30G X 1/2" 0.5 ML
- PRO COMFORT INSULIN SYRINGE 30G X 1/2" 1 ML
- PRO COMFORT INSULIN SYRINGE 30G X 5/16" 0.5 ML
- PRO COMFORT INSULIN SYRINGE 30G X 5/16" 1 ML
- PRO COMFORT INSULIN SYRINGE 31G X 5/16" 0.5 ML
- PRO COMFORT INSULIN SYRINGE 31G X 5/16" 1 ML
- PRO COMFORT PEN NEEDLES 31G X 8 MM
- PRO COMFORT PEN NEEDLES 32G X 4 MM
- PRO COMFORT PEN NEEDLES 32G X 5 MM
- PRO COMFORT PEN NEEDLES 32G X 6 MM
- PRODIGY INSULIN SYRINGE 28G X 1/2" 1 ML
- PRODIGY INSULIN SYRINGE 31G X 5/16" 0.3 ML
- PRODIGY INSULIN SYRINGE 31G X 5/16" 0.5 ML
- PURE COMFORT ALCOHOL PREP PAD
- PURE COMFORT PEN NEEDLE 32G X 4 MM
- PURE COMFORT PEN NEEDLE 32G X 5 MM
- PURE COMFORT PEN NEEDLE 32G X 6 MM
- PURE COMFORT PEN NEEDLE 32G X 8 MM
- PURE COMFORT SAFETY PEN NEEDLE 31G X 5 MM
- PURE COMFORT SAFETY PEN NEEDLE 31G X 6 MM
- PURE COMFORT SAFETY PEN NEEDLE 32G X 4 MM
- PX SHORTLENGTH PEN NEEDLES 31G X 8 MM
- QC ALCOHOL
- QC ALCOHOL SWABS PAD 70 %
- QC BORDER ISLAND GAUZE PAD 2"X2"
- RA ALCOHOL SWABS PAD 70 %
- RA INSULIN SYRINGE 29G X 1/2" 1 ML
- RA INSULIN SYRINGE 30G X 5/16" 0.5 ML
- RA INSULIN SYRINGE 30G X 5/16" 1 ML
- *ra isopropyl alcohol wipes*

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

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

- TRUE COMFORT INSULIN SYRINGE 31G X 5/16" 0.5 ML
- TRUE COMFORT INSULIN SYRINGE 31G X 5/16" 1 ML
- TRUE COMFORT INSULIN SYRINGE 32G X 5/16" 1 ML
- TRUE COMFORT PEN NEEDLES 31G X 5 MM
- TRUE COMFORT PEN NEEDLES 31G X 6 MM
- TRUE COMFORT PEN NEEDLES 32G X 4 MM
- TRUE COMFORT PRO ALCOHOL PREP PAD 70 %
- TRUE COMFORT PRO INSULIN SYR 30G X 1/2" 0.5 ML
- TRUE COMFORT PRO INSULIN SYR 30G X 1/2" 1 ML
- TRUE COMFORT PRO INSULIN SYR 30G X 5/16" 0.5 ML
- TRUE COMFORT PRO INSULIN SYR 30G X 5/16" 1 ML
- TRUE COMFORT PRO INSULIN SYR 31G X 5/16" 0.5 ML
- TRUE COMFORT PRO INSULIN SYR 31G X 5/16" 1 ML
- TRUE COMFORT PRO INSULIN SYR 32G X 5/16" 0.5 ML
- TRUE COMFORT PRO INSULIN SYR 32G X 5/16" 1 ML
- TRUE COMFORT PRO PEN NEEDLES 31G X 5 MM
- TRUE COMFORT PRO PEN NEEDLES 31G X 6 MM
- TRUE COMFORT PRO PEN NEEDLES 31G X 8 MM
- TRUE COMFORT PRO PEN NEEDLES 32G X 4 MM
- 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 INSULIN SYRINGE 28G X 1/2" 0.5 ML
- TRUEPLUS INSULIN SYRINGE 28G X 1/2" 1 ML
- TRUEPLUS INSULIN SYRINGE 29G X 1/2" 0.3 ML
- TRUEPLUS INSULIN SYRINGE 29G X 1/2" 0.5 ML
- TRUEPLUS INSULIN SYRINGE 29G X 1/2" 1 ML
- TRUEPLUS INSULIN SYRINGE 30G X 5/16" 0.3 ML
- TRUEPLUS INSULIN SYRINGE 30G X 5/16" 0.5 ML
- TRUEPLUS INSULIN SYRINGE 30G X 5/16" 1 ML
- TRUEPLUS INSULIN SYRINGE 31G X 5/16" 0.3 ML
- TRUEPLUS INSULIN SYRINGE 31G X 5/16" 0.5 ML
- TRUEPLUS INSULIN SYRINGE 31G X 5/16" 1 ML
- TRUEPLUS PEN NEEDLES 29G X 12MM
- TRUEPLUS PEN NEEDLES 31G X 5 MM
- TRUEPLUS PEN NEEDLES 31G X 6 MM
- TRUEPLUS PEN NEEDLES 31G X 8 MM
- TRUEPLUS PEN NEEDLES 32G X 4 MM
- ULTICARE INSULIN SAFETY SYR 29G X 1/2" 0.5 ML
- ULTICARE INSULIN SAFETY SYR 29G X 1/2" 1 ML
- ULTICARE INSULIN SYRINGE 28G X 1/2" 0.5 ML
- ULTICARE INSULIN SYRINGE 28G X 1/2" 1 ML

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

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

- ULTRA-THIN II INS SYR SHORT 31G X 5/16" 0.5 ML
- ULTRA-THIN II INS SYR SHORT 31G X 5/16" 1 ML
- ULTRA-THIN II INSULIN SYRINGE 29G X 1/2" 0.5 ML
- ULTRA-THIN II INSULIN SYRINGE 29G X 1/2" 1 ML
- ULTRA-THIN II MINI PEN NEEDLE 31G X 5 MM
- ULTRA-THIN II PEN NEEDLE SHORT 31G X 8 MM
- ULTRA-THIN II PEN NEEDLES 29G X 12.7MM
- ULTRACARE INSULIN SYRINGE 30G X 1/2" 0.5 ML
- ULTRACARE INSULIN SYRINGE 30G X 1/2" 1 ML
- ULTRACARE INSULIN SYRINGE 30G X 5/16" 0.3 ML
- ULTRACARE INSULIN SYRINGE 30G X 5/16" 0.5 ML
- ULTRACARE INSULIN SYRINGE 30G X 5/16" 1 ML
- ULTRACARE INSULIN SYRINGE 31G X 5/16" 0.3 ML
- ULTRACARE INSULIN SYRINGE 31G X 5/16" 0.5 ML
- ULTRACARE INSULIN SYRINGE 31G X 5/16" 1 ML
- ULTRACARE PEN NEEDLES 31G X 5 MM
- ULTRACARE PEN NEEDLES 31G X 6 MM
- ULTRACARE PEN NEEDLES 31G X 8 MM
- ULTRACARE PEN NEEDLES 32G X 4 MM
- ULTRACARE PEN NEEDLES 32G X 5 MM
- ULTRACARE PEN NEEDLES 32G X 6 MM
- ULTRACARE PEN NEEDLES 33G X 4 MM
- UNIFINE PEN NEEDLES 32G X 4 MM
- UNIFINE PENTIPS 29G X 12MM
- UNIFINE PENTIPS 31G X 6 MM
- UNIFINE PENTIPS 31G X 8 MM
- UNIFINE PENTIPS PLUS 29G X 12MM
- UNIFINE PENTIPS PLUS 31G X 6 MM
- UNIFINE PENTIPS PLUS 32G X 4 MM
- UNIFINE PROTECT PEN NEEDLE 30G X 5 MM
- UNIFINE PROTECT PEN NEEDLE 30G X 8 MM
- UNIFINE PROTECT PEN NEEDLE 32G X 4 MM
- UNIFINE SAFECONTROL PEN NEEDLE 30G X 5 MM
- UNIFINE SAFECONTROL PEN NEEDLE 30G X 8 MM
- UNIFINE SAFECONTROL PEN NEEDLE 31G X 5 MM
- UNIFINE SAFECONTROL PEN NEEDLE 31G X 6 MM
- UNIFINE SAFECONTROL PEN NEEDLE 31G X 8 MM
- UNIFINE SAFECONTROL PEN NEEDLE 32G X 4 MM
- UNIFINE ULTRA PEN NEEDLE 31G X 5 MM
- UNIFINE ULTRA PEN NEEDLE 31G X 6 MM
- UNIFINE ULTRA PEN NEEDLE 31G X 8 MM
- UNIFINE ULTRA PEN NEEDLE 32G X 4 MM
- VALUE HEALTH INSULIN SYRINGE 29G X 1/2" 0.5 ML
- VALUE HEALTH INSULIN SYRINGE 29G X 1/2" 1 ML
- VANISHPOINT INSULIN SYRINGE 29G X 5/16" 1 ML
- VANISHPOINT INSULIN SYRINGE 30G X 3/16" 0.5 ML
- VANISHPOINT INSULIN SYRINGE 30G X 3/16" 1 ML

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

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

# 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 |

# 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 |

# INTERFERON FOR MS-PLEGRIDY

**Products Affected**

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

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

# 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 |

# IPILIMUMAB

**Products Affected**

- YERVOY

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

# IVACAFTOR

**Products Affected**

- KALYDECO

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | CYSTIC FIBROSIS (CF): INITIAL: CONFIRMED MUTATION IN CFTR GENE ACCEPTABLE FOR THE TREATMENT OF CYSTIC FIBROSIS |
| **Age Restrictions** | |
| **Prescriber Restrictions** | CF: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A PULMONOLOGIST OR CYSTIC FIBROSIS EXPERT |
| **Coverage Duration** | INITIAL: 12 MONTHS. RENEWAL: LIFETIME |
| **Other Criteria** | CF: INITIAL: NOT HOMOZYGOUS FOR F508DEL MUTATION IN CFTR GENE. RENEWAL: 1) MAINTAINED, IMPROVED, OR DEMONSTRATED LESS THAN EXPECTED DECLINE IN FEV1 OR BODY MASS INDEX (BMI), OR 2) REDUCTION IN NUMBER OF PULMONARY EXACERBATIONS. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# 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 |

# 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 |

# LANREOTIDE

**Products Affected**

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

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

# 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 |

# 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 |

# 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 |

# LEDIPASVIR-SOFOSBUVIR

**Products Affected**

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

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

# 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 |

# 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 |

# LETERMOVIR

**Products Affected**

- PREVYMIS ORAL TABLET

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

# 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 |

# LEUPROLIDE DEPOT

**Products Affected**

- LEUPROLIDE ACETATE (3 MONTH)

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

# 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 |

# LEUPROLIDE-LUPRON DEPOT

**Products Affected**

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

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

| PA Criteria | Criteria Details |
|---|---|
| **Part B Prerequisite** | No |

# LEUPROLIDE-LUPRON DEPOT-PED

**Products Affected**

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

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

| PA Criteria | Criteria Details |
|---|---|
| **Part B Prerequisite** | No |

# L-GLUTAMINE

## Products Affected

- *l-glutamine oral packet*

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

# LIDOCAINE OINTMENT

### Products Affected

- *lidocaine external ointment 5 %*

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

# LIDOCAINE PATCH

**Products Affected**

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

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

# LIDOCAINE PRILOCAINE

## Products Affected

- *lidocaine-prilocaine external cream*

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

# 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 |

# 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 |

# LOTILANER

### Products Affected

- XDEMVY

| 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 |

# LUMACAFTOR-IVACAFTOR

**Products Affected**

- ORKAMBI ORAL TABLET

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | INITIAL: CYSTIC FIBROSIS (CF): CONFIRMED MUTATION IN CFTR GENE ACCEPTABLE FOR THE TREATMENT OF CF. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | CF: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A PULMONOLOGIST OR CF EXPERT. |
| **Coverage Duration** | INITIAL: 6 MONTHS, RENEWAL: LIFETIME. |
| **Other Criteria** | CF: RENEWAL: 1) MAINTAINED, IMPROVED, OR DEMONSTRATED LESS THAN EXPECTED DECLINE IN FEV1 OR BODY MASS INDEX (BMI), OR 2) REDUCTION IN NUMBER OF PULMONARY EXACERBATIONS. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# MACITENTAN

**Products Affected**

- OPSUMIT

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

# 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 |

# 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 |

# MECASERMIN

**Products Affected**

- INCRELEX

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

# 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 |

# MEPOLIZUMAB

**Products Affected**

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

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | INITIAL: ASTHMA: BLOOD EOSINOPHIL LEVEL OF AT LEAST 150 CELLS/MCL WITHIN THE PAST 12 MONTHS. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | INITIAL: ASTHMA: PRESCRIBED BY OR IN CONSULTATION WITH A PHYSICIAN SPECIALIZING IN PULMONARY OR ALLERGY MEDICINE. CRSWNP: PRESCRIBED BY OR IN CONSULTATION WITH AN OTOLARYNGOLOGIST, ALLERGIST OR IMMUNOLOGIST. |
| **Coverage Duration** | INITIAL: ASTHMA: 4 MO. CRSWNP: 6 MO. OTHERS: 12 MO. RENEWAL: CRSWNP, ASTHMA: 12 MO. |
| **Other Criteria** | INITIAL: ASTHMA: 1) CONCURRENT THERAPY WITH A MEDIUM, HIGH-DOSE OR MAXIMALLY TOLERATED DOSE OF AN INHALED CORTICOSTEROID (ICS) AND AT LEAST ONE OTHER MAINTENANCE MEDICATION, 2) ONE OF THE FOLLOWING: (A) AT LEAST ONE ASTHMA EXACERBATION REQUIRING SYSTEMIC CORTICOSTEROID BURST LASTING 3 OR MORE DAYS WITHIN THE PAST 12 MONTHS OR AT LEAST ONE SERIOUS EXACERBATION REQUIRING HOSPITALIZATION OR ER VISIT WITHIN THE PAST 12 MONTHS, OR (B) POOR SYMPTOM CONTROL DESPITE CURRENT THERAPY AS EVIDENCED BY AT LEAST THREE OF THE FOLLOWING WITHIN THE PAST 4 WEEKS: DAYTIME ASTHMA SYMPTOMS MORE THAN TWICE/WEEK, ANY NIGHT WAKING DUE TO ASTHMA, SABA RELIEVER FOR SYMPTOMS MORE THAN TWICE/WEEK, ANY ACTIVITY LIMITATION DUE TO ASTHMA, AND 3) NO |

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

# 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 |

# MIFEPRISTONE

## Products Affected

- *mifepristone oral tablet 300 mg*

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

# 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 |

# 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 |

# MOSUNETUZUMAB-AXGB

**Products Affected**

- LUNSUMIO

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

# 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 |

# 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 |

# 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 |

# NILOTINIB

**Products Affected**

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

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

# 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 |

# NINTEDANIB

**Products Affected**

- OFEV

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

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

# NIRAPARIB

**Products Affected**

- ZEJULA ORAL CAPSULE
- ZEJULA ORAL TABLET

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

# NIRAPARIB-ABIRATERONE

**Products Affected**

- AKEEGA

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

# 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 |

# 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 |

# 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 |

# 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 |

# 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 |

# OCRELIZUMAB

**Products Affected**

- OCREVUS

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

# OCRELIZUMAB-HYALURONIDASE-OCSQ

**Products Affected**

- OCREVUS ZUNOVO

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

# 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 |

# OLANZAPINE/SAMIDORPHAN

**Products Affected**

- LYBALVI

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

# 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 |

# 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 |

# OMACETAXINE

**Products Affected**

- SYNRIBO

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

# OMALIZUMAB

**Products Affected**

- XOLAIR

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

# 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 |

# 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 |

# 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 |

# PALBOCICLIB

**Products Affected**

- IBRANCE

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

# PARATHYROID HORMONE

**Products Affected**

- NATPARA

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

# PASIREOTIDE DIASPARTATE

**Products Affected**

- SIGNIFOR

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

# PAZOPANIB

## Products Affected

- *pazopanib hcl*

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

# 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 |

# PEGFILGRASTIM-NEULASTA ONPRO

**Products Affected**

- NEULASTA ONPRO

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

# 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 |

# 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 |

# 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 |

# 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 |

# PENICILLAMINE TABLET

### Products Affected

- *penicillamine oral tablet*

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

| PA Criteria | Criteria Details |
|---|---|
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# 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 |

# 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 |

# PIRFENIDONE

### Products Affected

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

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

# 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 |

# POMALIDOMIDE

**Products Affected**

- POMALYST

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

# 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 |

# 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 |

# 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 |

# 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 |

# 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 |

# 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 |

# 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 |

# 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 |

# 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 |

# RESLIZUMAB

**Products Affected**

- CINQAIR

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

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

# 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 |

# REVUMENIB

## Products Affected

- REVUFORJ ORAL TABLET 110 MG, 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 |

# 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 |

# 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 |

# 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 |

# RILONACEPT

**Products Affected**

- ARCALYST

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

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

# RIMEGEPANT

**Products Affected**

- NURTEC

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

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

# RIOCIGUAT

**Products Affected**

- ADEMPAS

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

| PA Criteria | Criteria Details |
|---|---|
| **Part B Prerequisite** | No |

# RIPRETINIB

## Products Affected

- QINLOCK

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

# RISANKIZUMAB-RZAA

**Products Affected**

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

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

| PA Criteria | Criteria Details |
|---|---|
| | MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR AN AUTOIMMUNE INDICATION. RENEWAL: PSO, PSA: 1) CONTINUES TO BENEFIT FROM THE MEDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR AN AUTOIMMUNE INDICATION. CD, UC: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR AN AUTOIMMUNE INDICATION. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# RITUXIMAB AND HYALURONIDASE HUMAN-SQ

**Products Affected**

- RITUXAN HYCELA

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

# RITUXIMAB-ABBS

**Products Affected**

- TRUXIMA

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

# RITUXIMAB-ARRX

**Products Affected**

- RIABNI

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

# RITUXIMAB-PVVR

**Products Affected**

- RUXIENCE

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

# 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 |

# RUCAPARIB

**Products Affected**

- RUBRACA

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

# RUXOLITINIB

**Products Affected**

- JAKAFI

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

# 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 |

# SECUKINUMAB IV

**Products Affected**

- COSENTYX INTRAVENOUS

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

| PA Criteria | Criteria Details |
|---|---|
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# SECUKINUMAB SQ

**Products Affected**

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

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | INITIAL: PLAQUE PSORIASIS (PSO): PSORIASIS COVERING 3 PERCENT OR MORE OF BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, GENITAL AREA, SCALP, OR FACE. NON-RADIOGRAPHIC AXIAL SPONDYLOARTHRITIS (NR-AXSPA): 1) C-REACTIVE PROTEIN (CRP) LEVELS ABOVE THE UPPER LIMIT OF NORMAL, OR 2) SACROILIITIS ON MAGNETIC RESONANCE IMAGING (MRI). |
| **Age Restrictions** | |
| **Prescriber Restrictions** | INITIAL: PSO, HIDRADENITIS SUPPURATIVA (HS): PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST. PSORIATIC ARTHRITIS (PSA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST OR A DERMATOLOGIST. ANKYLOSING SPONDYLITIS (AS), NR-AXSPA, ENTHESITIS-RELATED ARTHRITIS (ERA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST. |
| **Coverage Duration** | INITIAL: HS: 4 MONTHS, ALL OTHER INDICATIONS: 6 MONTHS. RENEWAL: 12 MONTHS. |
| **Other Criteria** | INITIAL: PSO: 1) ONE OF THE FOLLOWING: (A) AT LEAST A 3 MONTH TRIAL OF ONE ORAL IMMUNOSUPPRESSANT (CYCLOSPORINE, METHOTREXATE, TACROLIMUS) OR PUVA (PHOTOTHERAPY) FOR THE TREATMENT OF PSO, (B) CONTRAINDICATION OR INTOLERANCE TO BOTH IMMUNOSUPPRESSANT AND PUVA FOR THE TREATMENT OF PSO, OR (C) PATIENT IS SWITCHING FROM A DIFFERENT BIOLOGIC, PDE-4 INHIBITOR, OR JAK INHIBITOR FOR THE SAME INDICATION, AND 2) NO CONCURRENT USE WITH |

| PA Criteria | Criteria Details |
|---|---|
| | ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR AN AUTOIMMUNE INDICATION. PSA: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR AN AUTOIMMUNE INDICATION. AS, NR-AXSPA: 1) TRIAL OF OR CONTRAINDICATION TO AN NSAID, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR AN AUTOIMMUNE INDICATION. ERA: TRIAL OF OR CONTRAINDICATION TO ONE NSAID, SULFASALAZINE, OR METHOTREXATE. HS: NO CONCURRENT USE WITH OTHER SYSTEMIC BIOLOGICS FOR HS OR OTHER IL-17 INHIBITORS FOR ANY INDICATION. RENEWAL: PSO, PSA, AS, NR-AXSPA: 1) CONTINUES TO BENEFIT FROM THE MEDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR AN AUTOIMMUNE INDICATION. ERA, HS: CONTINUES TO BENEFIT FROM THE MEDICATION. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# SELEXIPAG

**Products Affected**

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

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

# SELINEXOR

**Products Affected**

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

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

# 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 |

# SELUMETINIB

**Products Affected**

- KOSELUGO ORAL CAPSULE 10 MG, 25 MG

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

# 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 |

# 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** | INITIAL/RENEWAL: 12 MONTHS |
| **Other Criteria** | RELAPSING FORM OF MULTIPLE SCLEROSIS (MS): RENEWAL: DEMONSTRATED CLINICAL BENEFIT COMPARED TO PRE-TREATMENT BASELINE. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# SIROLIMUS PROTEIN-BOUND

**Products Affected**

- FYARRO

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

# SODIUM OXYBATE-XYREM

## Products Affected

- *sodium oxybate*

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

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# 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, TIPRANAVIR/RITONAVIR, TOPOTECAN, SOVALDI (AS A SINGLE AGENT), HARVONI, ZEPATIER, MAVYRET, OR VOSEVI, AND 3) PATIENTS WITH DECOMPENSATED CIRRHOSIS REQUIRE CONCURRENT RIBAVIRIN UNLESS RIBAVIRIN INELIGIBLE. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# 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 |

# SOMATROPIN - NORDITROPIN

**Products Affected**

- NORDITROPIN FLEXPRO SUBCUTANEOUS SOLUTION PEN-INJECTOR

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

| PA Criteria | Criteria Details |
|---|---|
| | THE WRIST AND HAND. PWS: IMPROVEMENT IN BODY COMPOSITION. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# SOMATROPIN - SEROSTIM

**Products Affected**

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

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | INITIAL/RENEWAL: ATHLETIC ENHANCEMENT, ANTI-AGING PURPOSES |
| **Required Medical Information** | INITIAL: HIV/WASTING: ONE OF THE FOLLOWING FOR WEIGHT LOSS: 1) 10% UNINTENTIONAL WEIGHT LOSS OVER 12 MONTHS, 2) 7.5% UNINTENTIONAL WEIGHT LOSS OVER 6 MONTHS, 3) 5% BODY CELL MASS (BCM) LOSS WITHIN 6 MONTHS, 4) BCM LESS THAN 35% (MEN) OF TOTAL BODY WEIGHT AND BODY MASS INDEX (BMI) LESS THAN 27 KG PER METER SQUARED, 5) BCM LESS THAN 23% (WOMEN) OF TOTAL BODY WEIGHT AND BMI LESS THAN 27 KG PER METER SQUARED, OR 6) BMI LESS THAN 18.5 KG PER METER SQUARED. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | HIV/WASTING: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A GASTROENTEROLOGIST, NUTRITIONAL SUPPORT SPECIALIST, OR INFECTIOUS DISEASE SPECIALIST. |
| **Coverage Duration** | INITIAL/RENEWAL: 3 MONTHS. |
| **Other Criteria** | HIV/WASTING: INITIAL: 1) INADEQUATE RESPONSE TO ONE PREVIOUS THERAPY (E.G., MEGACE, APPETITE STIMULANTS, ANABOLIC STEROIDS). RENEWAL: 1) CLINICAL BENEFIT IN MUSCLE MASS AND WEIGHT. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

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# 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 |

# 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 |

# 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 |

# 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 |

# 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 |

# SUNITINIB

## Products Affected

- *sunitinib malate*

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

# 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 |

# 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 |

# 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 |

# TALQUETAMAB-TGVS

**Products Affected**

- TALVEY

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

# TARLATAMAB-DLLE

**Products Affected**

- IMDELLTRA

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

# 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 |

# TEBENTAFUSP-TEBN

**Products Affected**

- KIMMTRAK

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

# 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 |

# 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 |

# 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 |

# TERIPARATIDE

**Products Affected**

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

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

# 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 |

# TESTOSTERONE CYPIONATE

## Products Affected

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

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

# TESTOSTERONE ENANTHATE

**Products Affected**

- *testosterone enanthate intramuscular solution*
- XYOSTED

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

# 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 |

# THALIDOMIDE

**Products Affected**

- THALOMID

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

# 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 |

# 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 |

# 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 |

# TOCILIZUMAB IV

**Products Affected**

- ACTEMRA

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

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

# TOCILIZUMAB SQ

**Products Affected**

- ACTEMRA
- ACTEMRA ACTPEN

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

| PA Criteria | Criteria Details |
|---|---|
| | EXPOSURE, HYPERSENSITIVITY PNEUMONITIS). RENEWAL: RA: CONTINUES TO BENEFIT FROM THE MEDICATION. PJIA, SJIA: 1) CONTINUES TO BENEFIT FROM THE MEDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR AN AUTOIMMUNE INDICATION. SSC-ILD: CLINICAL MEANINGFUL IMPROVEMENT OR MAINTENANCE IN ANNUAL RATE OF DECLINE. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# TOFACITINIB

**Products Affected**

- XELJANZ
- XELJANZ XR

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

| PA Criteria | Criteria Details |
|---|---|
| | TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR AN AUTOIMMUNE INDICATION. UC: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR AN AUTOIMMUNE INDICATION. RENEWAL: RA: CONTINUES TO BENEFIT FROM THE MEDICATION. PSA, AS, PCJIA: 1) CONTINUES TO BENEFIT FROM THE MEDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR AN AUTOIMMUNE INDICATION. UC: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR AN AUTOIMMUNE INDICATION. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# 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 |

# TORIPALIMAB-TPZI

**Products Affected**

- LOQTORZI

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

# 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 |

# 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 |

# 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 |

# TRASTUZUMAB-DKST

**Products Affected**

- OGIVRI

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

# TRASTUZUMAB-DTTB

**Products Affected**

- ONTRUZANT

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

# 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 |

# TRASTUZUMAB-PKRB

**Products Affected**

- HERZUMA

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

# TRASTUZUMAB-QYYP

**Products Affected**

- TRAZIMERA

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

# 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 |

# TRIENTINE CAPSULE

### Products Affected

- *trientine hcl oral capsule 250 mg*

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

# 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 |

# TRIPTORELIN-TRELSTAR

**Products Affected**

- TRELSTAR MIXJECT

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

# 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 |

# 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 |

# UPADACITINIB

**Products Affected**

- RINVOQ
- RINVOQ LQ

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | INITIAL: NON-RADIOGRAPHIC AXIAL SPONDYLOARTHRITIS (NR-AXSPA): 1) C-REACTIVE PROTEIN LEVELS ABOVE THE UPPER LIMIT OF NORMAL, OR 2) SACROILIITIS ON MAGNETIC RESONANCE IMAGING (MRI). ATOPIC DERMATITIS (AD): ATOPIC DERMATITIS COVERING AT LEAST 10 PERCENT OF BODY SURFACE AREA OR ATOPIC DERMATITIS AFFECTING THE FACE, HEAD, NECK, HANDS, FEET, GROIN, OR INTERTRIGINOUS AREAS |
| **Age Restrictions** | |
| **Prescriber Restrictions** | INITIAL: RHEUMATOID ARTHRITIS (RA), ANKYLOSING SPONDYLITIS (AS), NR-AXSPA, POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS (PJIA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST. PSORIATIC ARTHRITIS: PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST OR DERMATOLOGIST. AD: PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST, ALLERGIST, OR IMMUNOLOGIST. ULCERATIVE COLITIS (UC), CROHNS DISEASE (CD): PRESCRIBED BY OR IN CONSULTATION WITH A GASTROENTEROLOGIST. |
| **Coverage Duration** | INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS. |
| **Other Criteria** | INITIAL: RA: TRIAL OF OR CONTRAINDICATION TO 3 MONTHS OF TREATMENT WITH ONE DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG) - IF A PATIENT TRIED METHOTREXATE, THEN TRIAL AT A DOSE GREATER THAN OR EQUAL TO 20 MG PER WEEK OR MAXIMALLY TOLERATED DOSE IS REQUIRED. PSA: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR AN |

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

# USTEKINUMAB

**Products Affected**

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

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

| PA Criteria | Criteria Details |
|---|---|
| | WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR AN AUTOIMMUNE INDICATION. RENEWAL: PSA, PSO: 1) CONTINUES TO BENEFIT FROM THE MEDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR AN AUTOIMMUNE INDICATION. CD, UC: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR AN AUTOIMMUNE INDICATION. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# USTEKINUMAB IV

**Products Affected**

- STELARA INTRAVENOUS

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

# VALBENAZINE

**Products Affected**

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

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

# 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 |

# 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 |

# 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 |

# VERICIGUAT

**Products Affected**

- VERQUVO

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

# VIGABATRIN

**Products Affected**

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

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

# 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 |

# 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 |

# VORICONAZOLE SUSPENSION

## Products Affected

- *voriconazole oral suspension reconstituted*

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

# ZANIDATAMAB-HRII

**Products Affected**

- ZIIHERA

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

# ZANUBRUTINIB

**Products Affected**

- BRUKINSA

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

# 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 |

# 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 |

## INDEX

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