



Medicare Advantage Plans

Prior Authorization Criteria

2026

This prior authorization document was updated on 07/21 /2026. To determine if your drug has a prior authorization requirement, use the GlobalHealth's online search covered drug tool specific to your plan at www.GlobalHealth.com. For information on how to request an exception (also called a coverage determination) to the prior authorization criteria for any of these drugs, please contact Customer Care at 1-866-494-3927 (TTY users should call 711), 24 hours a day, seven days a week, or visit www.GlobalHealth.com.

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Este documento de autorización previa fue actualizado el 21/07/2026. Para determinar si su medicamento tiene un requisito de autorización previa, utilice la herramienta de búsqueda de medicamentos cubiertos en línea de GlobalHealth específica para su plan en www.GlobalHealth.com. Para obtener información sobre cómo solicitar una excepción (también llamada determinación de cobertura) a los criterios de terapia escalonada para cualquiera de estos medicamentos, comuníquese con Atención al Cliente al 1-866-494-3927 (los usuarios de TTY deben llamar al 711), las 24 horas del día, los siete días de la semana, o visite www.GlobalHealth.com.

ABALOPARATIDE

Products Affected

- TYMLOS

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

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ABATACEPT IV

Products Affected

- ORENCIA INTRAVENOUS

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

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

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ABATACEPT SQ

Products Affected

- ORENCIA CLICKJECT
- ORENCIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE

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

Formulary ID: 26380

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PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

Formulary ID: 26380
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ABEMACICLIB

Products Affected

- VERZENIO

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

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ABIRATERONE

Products Affected

- *abiraterone acetate*
- *abirtega*

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

Formulary ID: 26380
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 Updated: 07/21/2026

ABIRATERONE SUBMICRONIZED

Products Affected

- ABIRATERONE ACETATE MICRONIZED
- YONSA

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

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ACALABRUTINIB

Products Affected

- CALQUENCE ORAL TABLET

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

Formulary ID: 26380
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Updated: 07/21/2026

ACORAMIDIS

Products Affected

- ATTRUBY

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

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ADAGRASIB

Products Affected

- KRAZATI

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

Formulary ID: 26380
Effective: 08/01/2026
Updated: 07/21/2026

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-PSORIASIS/UVEIT STARTER SUBCUTANEOUS AUTO-INJECTOR KIT

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

Formulary ID: 26380

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Updated: 07/21/2026

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

Formulary ID: 26380
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Updated: 07/21/2026

ADALIMUMAB-AATY

Products Affected

- *adalimumab-aaty (1 pen) auto-injector kit 40 mg/0.4ml subcutaneous*
- *adalimumab-aaty (1 pen) subcutaneous auto-injector kit 80 mg/0.8ml*
- *adalimumab-aaty (2 pen)*
- *adalimumab-aaty (2 syringe)*
- *adalimumab-aaty cd/uc/hs start*
- YUFLYMA (1 PEN)
- YUFLYMA (2 SYRINGE)
- YUFLYMA-CD/UC/HS STARTER

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

Formulary ID: 26380

Effective: 08/01/2026

Updated: 07/21/2026

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

Formulary ID: 26380
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ADALIMUMAB-ADBIM

Products Affected

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

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

Formulary ID: 26380

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Updated: 07/21/2026

PA Criteria	Criteria Details
	TO BOTH IMMUNOSUPPRESSANT AND PUVA, OR 3) PATIENT IS SWITCHING FROM A DIFFERENT BIOLOGIC, PDE-4 INHIBITOR, OR JAK INHIBITOR FOR THE SAME INDICATION. UVEITIS: DOES NOT HAVE ISOLATED ANTERIOR UVEITIS. INITIAL/RENEWAL: ALL INDICATIONS: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR THE SAME INDICATION. RENEWAL: RA, POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS (PJIA), PSA, AS, PSO, HS, UVEITIS: CONTINUES TO BENEFIT FROM THE MEDICATION.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Formulary ID: 26380
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ADALIMUMAB-BWWD

Products Affected

- HADLIMA
- HADLIMA PUSHTOUCH

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

Formulary ID: 26380

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

Formulary ID: 26380
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 Updated: 07/21/2026

AFATINIB

Products Affected

- GILOTRIF

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

Formulary ID: 26380
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Updated: 07/21/2026

ALECTINIB

Products Affected

- ALECENSA

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

Formulary ID: 26380
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Updated: 07/21/2026

ALPELISIB-PIQRAY

Products Affected

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

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

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AMIKACIN LIPOSOMAL INH

Products Affected

- ARIKAYCE

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

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AMIVANTAMAB-HYALURONIDASE-LPUJ

Products Affected

- RYBREVANT FASPRO

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

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AMIVANTAMAB-VMJW

Products Affected

- RYBREVANT

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

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ANAKINRA

Products Affected

- KINERET SUBCUTANEOUS SOLUTION PREFILLED SYRINGE

PA Criteria	Criteria Details
Exclusion Criteria	CORONAVIRUS DISEASE 2019 (COVID-19) IN HOSPITALIZED ADULTS.
Required Medical Information	INITIAL: CRYOPYRIN-ASSOCIATED PERIODIC SYNDROMES (CAPS): 1) ONE OF THE FOLLOWING: (A) GENETIC TEST FOR GAIN-OF-FUNCTION MUTATIONS IN THE NLRP3 GENE, OR (B) HAS INFLAMMATORY MARKERS (I.E., ELEVATED CRP, ESR, SERUM AMYLOID A PROTEIN (SAA) OR S100 PROTEINS), AND 2) TWO OF THE FOLLOWING: URTICARIAL-LIKE RASH (NEUTROPHILIC DERMATITIS), COLD-TRIGGERED EPISODES, SENSORINEURAL HEARING LOSS, MUSCULOSKELETAL SYMPTOMS, CHRONIC ASEPTIC MENINGITIS, SKELETAL ABNORMALITIES. DEFICIENCY OF INTERLEUKIN-1 RECEPTOR ANTAGONIST (DIRA): 1) ONE OF THE FOLLOWING: (A) GENETIC TEST FOR GAIN-OF-FUNCTION MUTATIONS IN THE IL1RN GENE, OR (B) HAS INFLAMMATORY MARKERS (I.E., ELEVATED CRP, ESR), AND 2) ONE OF THE FOLLOWING: PUSTULAR PSORIASIS-LIKE RASHES, OSTEOMYELITIS, ABSENCE OF BACTERIAL OSTEOMYELITIS, ONYCHOMADESIS.
Age Restrictions	
Prescriber Restrictions	INITIAL: RHEUMATOID ARTHRITIS (RA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST.
Coverage Duration	RA: INITIAL: 6 MONTHS, RENEWAL: 12 MONTHS. CAPS, DIRA: LIFETIME.
Other Criteria	INITIAL: ALL INDICATIONS: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR THE SAME INDICATION. RA: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA/CYLTEZO/YUFLYMA/HADLIMA, XELJANZ, RINVOQ,

Formulary ID: 26380

Effective: 08/01/2026

Updated: 07/21/2026

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

Formulary ID: 26380
 Effective: 08/01/2026
 Updated: 07/21/2026

APALUTAMIDE

Products Affected

- ERLEADA ORAL TABLET 240 MG, 60 MG

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

Formulary ID: 26380
 Effective: 08/01/2026
 Updated: 07/21/2026

APOMORPHINE - ONAPGO

Products Affected

- ONAPGO

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

Formulary ID: 26380
 Effective: 08/01/2026
 Updated: 07/21/2026

APREMILAST

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: MILD PLAQUE PSORIASIS (PSO): 1) PSORIASIS COVERING LESS THAN 3 PERCENT OF BODY SURFACE AREA (BSA), 2) STATIC PHYSICIAN GLOBAL ASSESSMENT (SPGA) SCORE OF 2, OR 3) PSORIASIS AREA AND SEVERITY INDEX (PASI) SCORE OF 2 TO 9. MODERATE TO SEVERE PSO: PSORIASIS COVERING 3 PERCENT OR MORE OF BSA, OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, FACE, SCALP, OR GENITAL AREA.
Age Restrictions	
Prescriber Restrictions	INITIAL: PSORIATIC ARTHRITIS (PSA): PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST OR RHEUMATOLOGIST. PSO: PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST. BEHCETS DISEASE: PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	INITIAL: MILD PSO: TRIAL OF OR CONTRAINDICATION TO ONE CONVENTIONAL SYSTEMIC THERAPY (E.G., METHOTREXATE, ACITRETIN, CYCLOSPORINE) OR ONE CONVENTIONAL TOPICAL THERAPY (E.G., TOPICAL CORTICOSTEROIDS). MODERATE TO SEVERE PSO: 1) AT LEAST A 3 MONTH TRIAL OF ONE ORAL IMMUNOSUPPRESSANT (CYCLOSPORINE, METHOTREXATE, TACROLIMUS) OR PUVA (PHOTOTHERAPY), 2) CONTRAINDICATION OR INTOLERANCE TO BOTH IMMUNOSUPPRESSANT AND PUVA, OR 3) PATIENT IS SWITCHING FROM A DIFFERENT BIOLOGIC, PDE-4 INHIBITOR, OR JAK INHIBITOR FOR THE SAME INDICATION. BEHCETS

Formulary ID: 26380

Effective: 08/01/2026

Updated: 07/21/2026

PA Criteria	Criteria Details
	DISEASE: 1) HAS ORAL ULCERS OR A HISTORY OF RECURRENT ORAL ULCERS BASED ON CLINICAL SYMPTOMS, AND 2) TRIAL OF OR CONTRAINDICATION TO ONE OR MORE CONSERVATIVE TREATMENTS (E.G., COLCHICINE, TOPICAL CORTICOSTEROID, ORAL CORTICOSTEROID). INITIAL/RENEWAL: ALL INDICATIONS: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR THE SAME INDICATION. RENEWAL: ALL INDICATIONS: CONTINUES TO BENEFIT FROM THE MEDICATION.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Formulary ID: 26380
 Effective: 08/01/2026
 Updated: 07/21/2026

ARIMOCLOMOL

Products Affected

- MIPLYFFA

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

Formulary ID: 26380
Effective: 08/01/2026
Updated: 07/21/2026

ASCIMINIB

Products Affected

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

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

Formulary ID: 26380
 Effective: 08/01/2026
 Updated: 07/21/2026

ATOGEPANT

Products Affected

- QULIPTA

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

Formulary ID: 26380
 Effective: 08/01/2026
 Updated: 07/21/2026

AVACOPAN

Products Affected

- TAVNEOS

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

Formulary ID: 26380
 Effective: 08/01/2026
 Updated: 07/21/2026

AVAPRITINIB

Products Affected

- AYVAKIT

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

Formulary ID: 26380
Effective: 08/01/2026
Updated: 07/21/2026

AVUTOMETINIB-DEFACTINIB

Products Affected

- AVMAPKI FAKZYNJA CO-PACK

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

Formulary ID: 26380
Effective: 08/01/2026
Updated: 07/21/2026

AXATILIMAB-CSFR

Products Affected

- NIKTIMVO

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

Formulary ID: 26380
 Effective: 08/01/2026
 Updated: 07/21/2026

AXITINIB

Products Affected

- INLYTA ORAL TABLET 1 MG, 5 MG

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

Formulary ID: 26380
Effective: 08/01/2026
Updated: 07/21/2026

AZACITIDINE

Products Affected

- ONUREG

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

Formulary ID: 26380
Effective: 08/01/2026
Updated: 07/21/2026

AZTREONAM INHALED

Products Affected

- CAYSTON

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

Formulary ID: 26380
Effective: 08/01/2026
Updated: 07/21/2026

BEDAQUILINE

Products Affected

- SIRTURO

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

Formulary ID: 26380
Effective: 08/01/2026
Updated: 07/21/2026

BELIMUMAB

Products Affected

- BENLYSTA SUBCUTANEOUS

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

Formulary ID: 26380
Effective: 08/01/2026
Updated: 07/21/2026

BELUMOSUDIL

Products Affected

- REZUROCK

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

Formulary ID: 26380
 Effective: 08/01/2026
 Updated: 07/21/2026

BELZUTIFAN

Products Affected

- WELIREG

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

Formulary ID: 26380
Effective: 08/01/2026
Updated: 07/21/2026

BENDAMUSTINE

Products Affected

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

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

Formulary ID: 26380
Effective: 08/01/2026
Updated: 07/21/2026

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	PA Criteria: Pending CMS Approval
Prerequisite Therapy Required	PA Criteria: Pending CMS Approval

Formulary ID: 26380
Effective: 08/01/2026
Updated: 07/21/2026

BEVACIZUMAB-BVZR

Products Affected

- ZIRABEV

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

Formulary ID: 26380
Effective: 08/01/2026
Updated: 07/21/2026

BEXAROTENE

Products Affected

- *bexarotene*

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

Formulary ID: 26380
Effective: 08/01/2026
Updated: 07/21/2026

BINIMETINIB

Products Affected

- MEKTOVI

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

Formulary ID: 26380
Effective: 08/01/2026
Updated: 07/21/2026

BORTEZOMIB

Products Affected

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

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

Formulary ID: 26380
 Effective: 08/01/2026
 Updated: 07/21/2026

BOSENTAN

Products Affected

- bosentan oral tablet*

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

Formulary ID: 26380

Effective: 08/01/2026

Updated: 07/21/2026

BOSUTINIB

Products Affected

- BOSULIF ORAL CAPSULE 100 MG, 50 MG
- BOSULIF ORAL TABLET 100 MG, 400 MG, 500 MG
- *bosutinib oral tablet 100 mg, 400 mg, 500 mg*

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

Formulary ID: 26380
Effective: 08/01/2026
Updated: 07/21/2026

BRIGATINIB

Products Affected

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

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

Formulary ID: 26380
Effective: 08/01/2026
Updated: 07/21/2026

C1 ESTERASE INHIBITOR-HAEGARDA

Products Affected

- HAEGARDA SUBCUTANEOUS
SOLUTION RECONSTITUTED 2000
UNIT, 3000 UNIT

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

Formulary ID: 26380
Effective: 08/01/2026
Updated: 07/21/2026

CABOZANTINIB CAPSULE

Products Affected

- COMETRIQ (100 MG DAILY DOSE)
ORAL KIT 80 & 20 MG
- COMETRIQ (140 MG DAILY DOSE)
ORAL KIT 3 X 20 MG & 80 MG
- COMETRIQ (60 MG DAILY DOSE)

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

Formulary ID: 26380
Effective: 08/01/2026
Updated: 07/21/2026

CABOZANTINIB TABLET

Products Affected

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

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

Formulary ID: 26380
Effective: 08/01/2026
Updated: 07/21/2026

CANNABIDIOL

Products Affected

- EPIDIOLEX

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

Formulary ID: 26380
 Effective: 08/01/2026
 Updated: 07/21/2026

CAPIVASERTIB

Products Affected

- TRUQAP ORAL TABLET 200 MG
- TRUQAP ORAL TABLET THERAPY PACK 160 MG

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

Formulary ID: 26380
Effective: 08/01/2026
Updated: 07/21/2026

CAPMATINIB

Products Affected

- TABRECTA

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

Formulary ID: 26380
Effective: 08/01/2026
Updated: 07/21/2026

CARGLUMIC ACID

Products Affected

- carglumic acid oral tablet soluble*

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

Formulary ID: 26380

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Updated: 07/21/2026

CERITINIB

Products Affected

- ZYKADIA ORAL TABLET

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

Formulary ID: 26380
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CERTOLIZUMAB PEGOL

Products Affected

- CIMZIA (1 SYRINGE)
- CIMZIA (2 SYRINGE)
- CIMZIA SUBCUTANEOUS KIT 2 X 200 MG
- CIMZIA-STARTER

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

Formulary ID: 26380

Effective: 08/01/2026

Updated: 07/21/2026

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

Formulary ID: 26380
Effective: 08/01/2026
Updated: 07/21/2026

CETUXIMAB

Products Affected

- ERBITUX

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

Formulary ID: 26380
Effective: 08/01/2026
Updated: 07/21/2026

CLOBAZAM-SYMPAZAN

Products Affected

- SYMPAZAN

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

Formulary ID: 26380
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 Updated: 07/21/2026

COBIMETINIB

Products Affected

- COTELLIC

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

Formulary ID: 26380
Effective: 08/01/2026
Updated: 07/21/2026

CRIZOTINIB CAPSULE

Products Affected

- XALKORI ORAL CAPSULE

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

Formulary ID: 26380
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Updated: 07/21/2026

CRIZOTINIB PELLETS

Products Affected

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

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

Formulary ID: 26380
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Updated: 07/21/2026

DABRAFENIB CAPSULES

Products Affected

- TAFINLAR ORAL CAPSULE

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

Formulary ID: 26380
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Updated: 07/21/2026

DABRAFENIB SUSPENSION

Products Affected

- TAFINLAR ORAL TABLET SOLUBLE

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

Formulary ID: 26380
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Updated: 07/21/2026

DACOMITINIB

Products Affected

- VIZIMPRO

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

Formulary ID: 26380
 Effective: 08/01/2026
 Updated: 07/21/2026

DALFAMPRIDINE

Products Affected

- *dalfampridine er*

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

Formulary ID: 26380
 Effective: 08/01/2026
 Updated: 07/21/2026

DAROLUTAMIDE

Products Affected

- NUBEQA

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

Formulary ID: 26380
Effective: 08/01/2026
Updated: 07/21/2026

DASATINIB

Products Affected

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

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

Formulary ID: 26380
 Effective: 08/01/2026
 Updated: 07/21/2026

DATOPOTAMAB DERUXTECAN-DLNK

Products Affected

- DATROWAY

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

Formulary ID: 26380
Effective: 08/01/2026
Updated: 07/21/2026

DECITABINE/CEDAZURIDINE

Products Affected

- INQOVI

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

Formulary ID: 26380
Effective: 08/01/2026
Updated: 07/21/2026

DEFERASIROX

Products Affected

- *deferasirox granules*
- *deferasirox oral tablet*

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

Formulary ID: 26380

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

Formulary ID: 26380
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 Updated: 07/21/2026

DENOSUMAB-BMWO - OSENVELT

Products Affected

- OSENVELT

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

Formulary ID: 26380
Effective: 08/01/2026
Updated: 07/21/2026

DEUTETRABENAZINE

Products Affected

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

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

Formulary ID: 26380
Effective: 08/01/2026
Updated: 07/21/2026

DICLOFENAC TOPICAL SOLUTION

Products Affected

- *diclofenac sodium external solution 2 %*

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

Formulary ID: 26380
Effective: 08/01/2026
Updated: 07/21/2026

DICLOFENAC-FLECTOR

Products Affected

- *diclofenac epolamine external*

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

Formulary ID: 26380
Effective: 08/01/2026
Updated: 07/21/2026

DIMETHYL FUMARATE

Products Affected

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

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

Formulary ID: 26380
Effective: 08/01/2026
Updated: 07/21/2026

DIROXIMEL FUMARATE

Products Affected

- VUMERITY

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

Formulary ID: 26380
Effective: 08/01/2026
Updated: 07/21/2026

DORDAVIPRONE

Products Affected

- MODEYSO

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

Formulary ID: 26380
Effective: 08/01/2026
Updated: 07/21/2026

DOSTARLIMAB-GXLY

Products Affected

- JEMPERLI

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

Formulary ID: 26380
Effective: 08/01/2026
Updated: 07/21/2026

DRONABINOL CAPSULE

Products Affected

- dronabinol oral capsule*

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

Formulary ID: 26380
 Effective: 08/01/2026
 Updated: 07/21/2026

DROXIDOPA

Products Affected

- *droxidopa*

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

Formulary ID: 26380
 Effective: 08/01/2026
 Updated: 07/21/2026

DUPILUMAB

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: EOSINOPHILIC ASTHMA: BLOOD EOSINOPHIL LEVEL OF 150 TO 1500 CELLS/MCL WITHIN THE PAST 12 MONTHS. EOSINOPHILIC ESOPHAGITIS (EOE): DIAGNOSIS CONFIRMED BY ESOPHAGOGASTRODUODENOSCOPY (EGD) WITH BIOPSY.
Age Restrictions	
Prescriber Restrictions	INITIAL: AD, PN, CSU: PRESCRIBED OR IN CONSULTATION WITH A DERMATOLOGIST, ALLERGIST OR IMMUNOLOGIST. ASTHMA: PRESCRIBED OR IN CONSULTATION WITH ALLERGIST OR PULMONOLOGIST. CRSWNP: PRESCRIBED OR IN CONSULTATION WITH OTOLARYNGOLOGIST, ALLERGIST OR IMMUNOLOGIST. EOE: PRESCRIBED OR IN CONSULTATION WITH GASTROENTEROLOGIST, ALLERGIST, OR IMMUNOLOGIST. COPD: PRESCRIBED OR IN CONSULTATION WITH PULMONOLOGIST. RENEWAL: CSU: PRESCRIBED OR IN CONSULTATION WITH ALLERGIST, DERMATOLOGIST, OR IMMUNOLOGIST.
Coverage Duration	BP, AFRS: 12 MO. AD/CRSWNP/EOE/PN/CSU: INITIAL/RENEWAL: 6 MO/12 MO. ASTHMA/COPD: INIT/RENEW: 12 MO.
Other Criteria	INITIAL: AD: 1) INTRACTABLE PRURITUS OR CRACKING/OOZING/BLEEDING OF AFFECTED SKIN, AND 2) TRIAL OF OR CONTRAINDICATION TO ONE TOPICAL (CORTICOSTEROID, CALCINEURIN INHIBITOR, PDE4 INHIBITOR, OR JAK INHIBITOR). ASTHMA: 1) CONCURRENT THERAPY WITH A MEDIUM, HIGH-DOSE OR MAXIMALLY-TOLERATED DOSE OF AN INHALED CORTICOSTEROID (ICS) AND ONE OTHER MAINTENANCE MEDICATION, AND 2) ONE ASTHMA EXACERBATION REQUIRING SYSTEMIC

Formulary ID: 26380

Effective: 08/01/2026

Updated: 07/21/2026

PA Criteria	Criteria Details
	CORTICOSTEROID BURST LASTING AT LEAST 3 DAYS WITHIN THE PAST 12 MONTHS, OR ONE SERIOUS EXACERBATION REQUIRING HOSPITALIZATION OR ER VISIT WITHIN THE PAST 12 MONTHS, OR POOR SYMPTOM CONTROL DESPITE CURRENT THERAPY AS EVIDENCED BY AT LEAST THREE OF THE FOLLOWING WITHIN THE PAST 4 WEEKS: (A) DAYTIME ASTHMA SYMPTOMS MORE THAN TWICE/WEEK, (B) ANY NIGHT WAKING DUE TO ASTHMA, (C) SABA RELIEVER FOR SYMPTOMS MORE THAN TWICE/WEEK, (D) ANY ACTIVITY LIMITATION DUE TO ASTHMA. CHRONIC RHINOSINUSITIS WITH NASAL POLYPS (CRSWNP): 1) A 56 DAY TRIAL OF ONE TOPICAL NASAL CORTICOSTEROID, 2) EVIDENCE OF NASAL POLYPS BY DIRECT EXAMINATION, ENDOSCOPY, OR SINUS CT SCAN, AND 3) INADEQUATELY CONTROLLED DISEASE. PRURIGO NODULARIS (PN): CHRONIC PRURITUS (ITCH MORE THAN 6 WEEKS), MULTIPLE PRURIGINOUS LESIONS, AND HISTORY OR SIGN OF A PROLONGED SCRATCHING BEHAVIOR. EOSINOPHILIC COPD: USED IN COMBINATION WITH A LAMA/LABA/ICS. CHRONIC SPONTANEOUS URTICARIA (CSU): 1) TRIAL OF AND MAINTAINED ON, OR CONTRAINDICATION TO A SECOND GENERATION H1 ANTI-HISTAMINE AND 2) STILL EXPERIENCES HIVES OR ANGIOEDEMA MOST DAYS OF THE WEEK FOR AT LEAST 6 WEEKS. INITIAL/RENEWAL : ALL INDICATIONS EXCEPT BULLOUS PEMPHIGOID (BP): NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR THE SAME INDICATION. RENEWAL: AD, CRSWNP, EOE: IMPROVEMENT WHILE ON THERAPY. ASTHMA: 1) CONTINUED USE OF ICS AND ONE OTHER MAINTENANCE MEDICATION, AND 2) CLINICAL RESPONSE AS EVIDENCED BY: (A) REDUCTION IN ASTHMA EXACERBATIONS FROM BASELINE, (B) DECREASED UTILIZATION OF RESCUE MEDICATIONS, (C) INCREASE IN PERCENT PREDICTED FEV1 FROM PRETREATMENT BASELINE, OR (D) REDUCTION IN SEVERITY OR FREQUENCY OF ASTHMA-RELATED SYMPTOMS. PN: IMPROVEMENT OR REDUCTION OF PRURITUS OR PRURIGINOUS LESIONS. EOSINOPHILIC COPD: 1) USED IN COMBINATION WITH A LAMA/LABA/ICS, AND 2) CLINICAL RESPONSE AS EVIDENCED BY ONE OF THE FOLLOWING: (A) REDUCTION IN COPD EXACERBATIONS FROM BASELINE, OR (B) REDUCTION IN SEVERITY OR FREQUENCY OF COPD-

Formulary ID: 26380
Effective: 08/01/2026
Updated: 07/21/2026

PA Criteria	Criteria Details
	RELATED SYMPTOMS. CSU: MAINTAINED ON OR CONTRAINDICATION TO A SECOND GENERATION H1 ANTI-HISTAMINE.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Formulary ID: 26380
 Effective: 08/01/2026
 Updated: 07/21/2026

DUVELISIB

Products Affected

- COPIKTRA

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

Formulary ID: 26380
Effective: 08/01/2026
Updated: 07/21/2026

EFLORNITHINE

Products Affected

- IWILFIN

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

Formulary ID: 26380
Effective: 08/01/2026
Updated: 07/21/2026

ELACESTRANT

Products Affected

- ORSERDU ORAL TABLET 345 MG, 86 MG

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

Formulary ID: 26380
Effective: 08/01/2026
Updated: 07/21/2026

ELAPEGADEMASE-LVLR

Products Affected

- REVCOVI

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

Formulary ID: 26380

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Updated: 07/21/2026

ELEXACFTOR-TEZACFTOR-IVACFTOR

Products Affected

- TRIKAFTA ORAL TABLET THERAPY • TRIKAFTA ORAL THERAPY PACK PACK

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

Formulary ID: 26380
Effective: 08/01/2026
Updated: 07/21/2026

ELRANATAMAB-BCMM

Products Affected

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

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

Formulary ID: 26380
 Effective: 08/01/2026
 Updated: 07/21/2026

ELTROMBOPAG - ALVAIZ

Products Affected

- ALVAIZ

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

Formulary ID: 26380

Effective: 08/01/2026

Updated: 07/21/2026

ELTROMBOPAG - PROMACTA

Products Affected

- *eltrombopag olamine oral packet 12.5 mg, 25 mg*
- *eltrombopag olamine oral tablet 12.5 mg, 25 mg, 50 mg, 75 mg*

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

Formulary ID: 26380

Effective: 08/01/2026

Updated: 07/21/2026

PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

Formulary ID: 26380
 Effective: 08/01/2026
 Updated: 07/21/2026

ENASIDENIB

Products Affected

- IDHIFA

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

Formulary ID: 26380
Effective: 08/01/2026
Updated: 07/21/2026

ENCORAFENIB

Products Affected

- BRAFTOVI ORAL CAPSULE 75 MG

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

Formulary ID: 26380
Effective: 08/01/2026
Updated: 07/21/2026

ENSARTINIB

Products Affected

- ENSACOVE ORAL CAPSULE 100 MG,
25 MG

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

Formulary ID: 26380
Effective: 08/01/2026
Updated: 07/21/2026

ENTRECTINIB CAPSULES

Products Affected

- ROZLYTREK ORAL CAPSULE 100 MG, 200 MG

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

Formulary ID: 26380
Effective: 08/01/2026
Updated: 07/21/2026

ENTRECTINIB PELLETS

Products Affected

- ROZLYTREK ORAL PACKET

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

Formulary ID: 26380
Effective: 08/01/2026
Updated: 07/21/2026

ENZALUTAMIDE

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	NON-METASTATIC CASTRATION-SENSITIVE PROSTATE CANCER (NMCSPC): HIGH RISK FOR METASTASIS (I.E. PSA DOUBLING TIME OF 9 MONTHS OR LESS). METASTATIC CASTRATION-RESISTANT PROSTATE CANCER (MCRPC), NON-METASTATIC CRPC (NMCRPC), METASTATIC CSPC (MCSPC), NMCSPC: 1) RECEIVED A BILATERAL ORCHIECTOMY, 2) CASTRATE LEVEL OF TESTOSTERONE (I.E., LESS THAN 50 NG/DL), OR 3) CONCURRENT USE WITH A GONADOTROPIN RELEASING HORMONE (GNRH) ANALOG.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Formulary ID: 26380

Effective: 08/01/2026

Updated: 07/21/2026

EPCORITAMAB-BYSP

Products Affected

- EPKINLY

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

Formulary ID: 26380
Effective: 08/01/2026
Updated: 07/21/2026

EPOETIN ALFA-EPBX

Products Affected

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

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

Formulary ID: 26380

Effective: 08/01/2026

Updated: 07/21/2026

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

Formulary ID: 26380
 Effective: 08/01/2026
 Updated: 07/21/2026

ERDAFITINIB

Products Affected

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

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

Formulary ID: 26380
Effective: 08/01/2026
Updated: 07/21/2026

ERENUMAB-AOOE

Products Affected

- AIMOVIG

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

Formulary ID: 26380
Effective: 08/01/2026
Updated: 07/21/2026

ERLOTINIB

Products Affected

- *erlotinib hcl oral tablet 100 mg, 150 mg, 25 mg*

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

Formulary ID: 26380
 Effective: 08/01/2026
 Updated: 07/21/2026

ESKETAMINE

Products Affected

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

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

Formulary ID: 26380
 Effective: 08/01/2026
 Updated: 07/21/2026

ETANERCEPT

Products Affected

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

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

Formulary ID: 26380

Effective: 08/01/2026

Updated: 07/21/2026

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

Formulary ID: 26380
 Effective: 08/01/2026
 Updated: 07/21/2026

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*
- *yulithira oral tablet 10 mg, 2.5 mg, 5 mg, 7.5 mg*

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

Formulary ID: 26380
 Effective: 08/01/2026
 Updated: 07/21/2026

EVEROLIMUS-AFINITOR DISPERZ

Products Affected

- *everolimus oral tablet soluble*

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

Formulary ID: 26380
Effective: 08/01/2026
Updated: 07/21/2026

FECAL MICROBIOTA CAPSULE

Products Affected

- VOWST

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

Formulary ID: 26380

Effective: 08/01/2026

Updated: 07/21/2026

FEDRATINIB

Products Affected

- INREBIC

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

Formulary ID: 26380
 Effective: 08/01/2026
 Updated: 07/21/2026

FENFLURAMINE

Products Affected

- FINTEPLA

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

Formulary ID: 26380
Effective: 08/01/2026
Updated: 07/21/2026

FENTANYL CITRATE

Products Affected

- *fentanyl citrate buccal lozenge on a handle*

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

Formulary ID: 26380
 Effective: 08/01/2026
 Updated: 07/21/2026

FEZOLINETANT

Products Affected

- VEOZAH

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

Formulary ID: 26380

Effective: 08/01/2026

Updated: 07/21/2026

PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

Formulary ID: 26380
 Effective: 08/01/2026
 Updated: 07/21/2026

FILGRASTIM-AAFI

Products Affected

- NIVESTYM

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

Formulary ID: 26380
Effective: 08/01/2026
Updated: 07/21/2026

FINERENONE

Products Affected

- KERENDIA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: HEART FAILURE (HF): 1) NEW YORK HEART ASSOCIATION (NYHA) CLASS II-IV, AND 2) LEFT VENTRICULAR EJECTION FRACTION OF AT LEAST 40 PERCENT NOT DUE TO AN UNDERLYING CAUSE (E.G., INFILTRATIVE CARDIOMYOPATHY, HYPERTROPHIC CARDIOMYOPATHY, VALVULAR DISEASE, PERICARDIAL DISEASE, HIGH-OUTPUT HEART FAILURE).
Age Restrictions	
Prescriber Restrictions	INITIAL: HF: PRESCRIBED BY OR IN CONSULTATION WITH A CARDIOLOGIST.
Coverage Duration	INITIAL/RENEWAL:12 MONTHS
Other Criteria	CHRONIC KIDNEY DISEASE (CKD) ASSOCIATED WITH TYPE 2 DIABETES (T2D): INITIAL: HISTORY OF AND WILL CONTINUE ON, HAS A CONTRAINDICATION, OR INTOLERANCE TO AN ANGIOTENSIN CONVERTING ENZYME INHIBITOR (ACE-I) OR AN ANGIOTENSIN RECEPTOR BLOCKER (ARB). HF: INITIAL/RENEWAL: NO CONCURRENT USE WITH ANOTHER MINERALOCORTICOID (ALDOSTERONE) RECEPTOR ANTAGONIST.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 26380

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Updated: 07/21/2026

PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

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FINGOLIMOD

Products Affected

- *fingolimod hcl*

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

Formulary ID: 26380
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FOSCARBIDOPA-FOSLEVODOPA

Products Affected

- VYALEV SUBCUTANEOUS
SOLUTION 12-240 MG/ML

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	PARKINSONS DISEASE (PD): INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST.
Coverage Duration	INITIAL: 12 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	PD: INITIAL: ONE OF THE FOLLOWING: 1) UNABLE TO SWALLOW EXTENDED-RELEASE (ER) TABLETS OR ADMINISTER ER CAPSULES VIA A FEEDING TUBE, OR 2) FAILURE TO ADHERE OR TOLERATE VIA A FEEDING TUBE AN ORAL CARBIDOPA/LEVODOPA REGIMEN. RENEWAL: IMPROVEMENT IN MOTOR SYMPTOMS WHILE ON THERAPY.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Formulary ID: 26380
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Updated: 07/21/2026

FRUQUINTINIB

Products Affected

- FRUZAQLA ORAL CAPSULE 1 MG, 5 MG

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

Formulary ID: 26380
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Updated: 07/21/2026

FUTIBATINIB

Products Affected

- LYTGOBI (12 MG DAILY DOSE)
- LYTGOBI (16 MG DAILY DOSE)
- LYTGOBI (20 MG DAILY DOSE)

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

Formulary ID: 26380
Effective: 08/01/2026
Updated: 07/21/2026

GALCANEZUMAB-GNLM

Products Affected

- EMGALITY
- EMGALITY (300 MG DOSE)

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

Formulary ID: 26380
Effective: 08/01/2026
Updated: 07/21/2026

GANAXOLONE

Products Affected

- ZTALMY

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

Formulary ID: 26380
Effective: 08/01/2026
Updated: 07/21/2026

GEFITINIB

Products Affected

- *gefitinib*

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

Formulary ID: 26380
 Effective: 08/01/2026
 Updated: 07/21/2026

GEPIRONE

Products Affected

- EXXUA
- EXXUA TITRATION PACK

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

Formulary ID: 26380
 Effective: 08/01/2026
 Updated: 07/21/2026

GILTERITINIB

Products Affected

- XOSPATA

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

Formulary ID: 26380
Effective: 08/01/2026
Updated: 07/21/2026

GLASDEGIB

Products Affected

- DAURISMO ORAL TABLET 100 MG,
25 MG

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

Formulary ID: 26380
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GLATIRAMER

Products Affected

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

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

Formulary ID: 26380
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Updated: 07/21/2026

GLP1-DULAGLUTIDE

Products Affected

- TRULICITY SUBCUTANEOUS
SOLUTION AUTO-INJECTOR

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

Formulary ID: 26380
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GLP1-SEMAGLUTIDE

Products Affected

- OZEMPIC
- OZEMPIC (0.25 OR 0.5 MG/DOSE) SUBCUTANEOUS SOLUTION PEN-INJECTOR 2 MG/3ML
- OZEMPIC (1 MG/DOSE) SUBCUTANEOUS SOLUTION PEN-INJECTOR 4 MG/3ML
- OZEMPIC (2 MG/DOSE)
- RYBELSUS
- RYBELSUS (FORMULATION R2)

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

Formulary ID: 26380
Effective: 08/01/2026
Updated: 07/21/2026

GLP1-TIRZEPATIDE

Products Affected

- MOUNJARO SUBCUTANEOUS
SOLUTION AUTO-INJECTOR

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

Formulary ID: 26380
Effective: 08/01/2026
Updated: 07/21/2026

GOSERELIN

Products Affected

- ZOLADEX

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

Formulary ID: 26380
Effective: 08/01/2026
Updated: 07/21/2026

GUSELKUMAB

Products Affected

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

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

Formulary ID: 26380

Effective: 08/01/2026

Updated: 07/21/2026

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

Formulary ID: 26380
 Effective: 08/01/2026
 Updated: 07/21/2026

HIGH CONCENTRATION ORAL OPIOID SOLUTIONS

Products Affected

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

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

Formulary ID: 26380
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PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

Formulary ID: 26380
 Effective: 08/01/2026
 Updated: 07/21/2026

HIGH RISK DRUGS IN THE ELDERLY - BUTALBITAL-CONTAINING AGENTS

Products Affected

- *butalbital-apap-caff-cod oral capsule 50-325-40-30 mg*
- *butalbital-apap-caffeine oral capsule*
- *butalbital-apap-caffeine oral tablet 50-325-40 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	PRESCRIBER ACKNOWLEDGEMENT/AWARENESS DRUG IS CONSIDERED HIGH RISK FOR PATIENTS 65 YEARS AND OLDER. HOSPICE PATIENTS ARE APPROVED WITHOUT REQUIRING ADDITIONAL CRITERIA.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Formulary ID: 26380
Effective: 08/01/2026
Updated: 07/21/2026

HIGH RISK DRUGS IN THE ELDERLY - DIPYRIDAMOLE

Products Affected

- *dipyridamole oral*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	PREScriBER ACKNOWLEDGEMENT/AWARENESS THAT THE DRUG IS CONSIDERED HIGH RISK FOR PATIENTS 65 YEARS AND OLDER. HOSPICE PATIENTS WILL BE APPROVED WITHOUT REQUIRING ADDITIONAL CRITERIA.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Formulary ID: 26380
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HIGH RISK DRUGS IN THE ELDERLY - ESTRADIOL-NORETHINDRONE

Products Affected

- *abigale*
- *estradiol-norethindrone acet*
- *mimvey*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	VULVAR/VAGINAL ATROPHY, OSTEOPOROSIS, AND VASOMOTOR SYMPTOMS OF MENOPAUSE: PRESCRIBER ACKNOWLEDGEMENT/AWARENESS THAT THE DRUG IS CONSIDERED HIGH RISK FOR PATIENTS 65 YEARS AND OLDER. HYPOESTROGENISM TREATMENT AND HOSPICE PATIENTS WILL BE APPROVED WITHOUT REQUIRING ADDITIONAL CRITERIA.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Formulary ID: 26380

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Updated: 07/21/2026

HIGH RISK DRUGS IN THE ELDERLY - ESTROGEN-MEDROXYPROGESTERONE

Products Affected

- PREMPHASE
- PREMPRO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	PREScriBER ACKNOWLEDGEMENT/AWARENESS THAT THE DRUG IS CONSIDERED HIGH RISK FOR PATIENTS 65 YEARS AND OLDER. HOSPICE PATIENTS WILL BE APPROVED WITHOUT REQUIRING ADDITIONAL CRITERIA.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Formulary ID: 26380
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HIGH RISK DRUGS IN THE ELDERLY - GLYBURIDE FORMULATIONS

Products Affected

- *glyburide micronized*
- *glyburide oral*
- *glyburide-metformin*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	TYPE 2 DIABETES MELLITUS (DM): 1) TRIAL OF OR CONTRAINDICATION TO GLIMEPIRIDE OR GLIPIZIDE, OR 2) PRESCRIBER ACKNOWLEDGEMENT/AWARENESS THAT THE DRUG IS CONSIDERED HIGH RISK FOR PATIENTS 65 YEARS AND OLDER. HOSPICE PATIENTS ARE APPROVED WITHOUT REQUIRING ADDITIONAL CRITERIA.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Formulary ID: 26380
Effective: 08/01/2026
Updated: 07/21/2026

HIGH RISK DRUGS IN THE ELDERLY - PHENOBARBITAL

Products Affected

- *phenobarbital oral elixir 20 mg/5ml*
- *phenobarbital oral tablet*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	EPILEPSY/SEIZURES: PATIENTS WHO ARE NEWLY PRESCRIBED PHENOBARBITAL: 1) HAS NOT RESPONDED TO AT LEAST ONE ANTICONVULSANT, OR 2) PRESCRIBER ACKNOWLEDGEMENT/AWARENESS THAT THE DRUG IS CONSIDERED HIGH RISK FOR PATIENTS 65 YEARS AND OLDER. HOSPICE PATIENTS WILL BE APPROVED WITHOUT REQUIRING ADDITIONAL CRITERIA.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Formulary ID: 26380
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HIGH RISK DRUGS IN THE ELDERLY - PROMETHAZINE

Products Affected

- *promethazine hcl injection solution 25 mg/ml*
- *promethazine hcl oral tablet*
- *promethazine hcl rectal suppository 25 mg*
- *promethegan rectal suppository 12.5 mg, 25 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	PRURITUS/URTICARIA/SEASONAL/PERENNIAL ALLERGY: 1) TRIAL OF OR CONTRAINDICATION TO A NON-SEDATING ANTIHISTAMINE SUCH AS LEVOCETIRIZINE, OR 2) PRESCRIBER ACKNOWLEDGEMENT/AWARENESS THAT THE DRUG IS CONSIDERED HIGH RISK FOR PATIENTS 65 YEARS AND OLDER. NAUSEA AND VOMITING: PRESCRIBER ACKNOWLEDGEMENT/AWARENESS THAT THE DRUG IS CONSIDERED HIGH-RISK FOR PATIENTS 65 YEARS AND OLDER. HOSPICE PATIENTS REQUIRE PHYSICIAN ATTESTATION THAT REQUESTED MEDICATION IS USED TO TREAT A DIAGNOSIS UNRELATED TO THE TERMINAL ILLNESS OR RELATED CONDITION, AND ARE APPROVED WITHOUT TRIAL OF FORMULARY ALTERNATIVES NOR REQUIRING PRESCRIBER ACKNOWLEDGEMENT.
Indications	All FDA-approved Indications.

Formulary ID: 26380

Effective: 08/01/2026

Updated: 07/21/2026

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

Formulary ID: 26380
 Effective: 08/01/2026
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HIGH RISK DRUGS IN THE ELDERLY - SCOPOLAMINE

Products Affected

- *scopolamine*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	PREScriBER ACKNOWLEDGEMENT/AWARENESS THAT THE DRUG IS CONSIDERED HIGH RISK FOR PATIENTS 65 YEARS AND OLDER. HOSPICE PATIENTS REQUIRE PHYSICIAN ATTESTATION THAT REQUESTED MEDICATION IS USED TO TREAT A DIAGNOSIS UNRELATED TO THE TERMINAL ILLNESS OR RELATED CONDITION, AND ARE APPROVED WITHOUT REQUIRING PRESCRIBER ACKNOWLEDGEMENT.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Formulary ID: 26380
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Updated: 07/21/2026

HIGH RISK DRUGS IN THE ELDERLY- DIPHENOXYLATE-ATROPINE

Products Affected

- *diphenoxylate-atropine oral tablet 2.5-0.025 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	PREScriBER ACKNOWLEDGEMENT/AWARENESS THAT THE DRUG IS CONSIDERED HIGH RISK FOR PATIENTS 65 YEARS AND OLDER. HOSPICE PATIENTS WILL BE APPROVED WITHOUT REQUIRING ADDITIONAL CRITERIA.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Formulary ID: 26380
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HIGH RISK DRUGS IN THE ELDERLY- INDOMETHACIN

Products Affected

- *indomethacin oral capsule 25 mg, 50 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	PREScriBER ACKNOWLEDGEMENT/AWARENESS DRUG IS CONSIDERED HIGH RISK FOR PATIENTS 65 YEARS AND OLDER. HOSPICE PATIENTS WILL BE APPROVED WITHOUT REQUIRING ADDITIONAL CRITERIA.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Formulary ID: 26380
Effective: 08/01/2026
Updated: 07/21/2026

HIGH RISK DRUGS IN THE ELDERLY- MEGESTROL

Products Affected

- *megestrol acetate oral suspension 40 mg/ml, 625 mg/5ml*
- *megestrol acetate oral tablet*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	PREScriBER ACKNOWLEDGEMENT/AWARENESS THAT THE DRUG IS CONSIDERED HIGH RISK FOR PATIENTS 65 YEARS AND OLDER. HOSPICE PATIENTS WILL BE APPROVED WITHOUT REQUIRING ADDITIONAL CRITERIA.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Formulary ID: 26380
Effective: 08/01/2026
Updated: 07/21/2026

HIGH RISK DRUGS IN THE ELDERLY- PAROXETINE

Products Affected

- *paroxetine hcl*
- *paroxetine hcl er*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	PREScriBER ACKNOWLEDGEMENT/AWARENESS THAT THE DRUG IS CONSIDERED HIGH RISK FOR PATIENTS 65 YEARS AND OLDER. HOSPICE PATIENTS WILL BE APPROVED WITHOUT REQUIRING ADDITIONAL CRITERIA.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Formulary ID: 26380
Effective: 08/01/2026
Updated: 07/21/2026

IBRUTINIB

Products Affected

- IMBRUVICA ORAL CAPSULE 140 MG, 70 MG
- IMBRUVICA ORAL TABLET 140 MG, 280 MG, 420 MG
- IMBRUVICA ORAL SUSPENSION

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	CHRONIC GRAFT VS HOST DISEASE (CGVHD): NO CONCURRENT USE WITH JAKAFI, NIKTIMVO, OR REZUROCK.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Formulary ID: 26380
 Effective: 08/01/2026
 Updated: 07/21/2026

ICATIBANT

Products Affected

- *icatibant acetate*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	HEREDITARY ANGIOEDEMA (HAE): INITIAL: 1) TYPE III HAE, OR 2) TYPE I OR II HAE CONFIRMED BY ONE OF THE FOLLOWING COMPLEMENT TESTS: C1-INH PROTEIN LEVELS, C4 PROTEIN LEVELS, C1-INH FUNCTIONAL LEVELS, C1Q.
Age Restrictions	
Prescriber Restrictions	HAE: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH AN ALLERGIST, IMMUNOLOGIST, HEMATOLOGIST OR PULMONOLOGIST.
Coverage Duration	INITIAL/RENEWAL: 12 MONTHS
Other Criteria	HAE: INITIAL/RENEWAL: NO CONCURRENT USE WITH OTHER MEDICATIONS FOR THE TREATMENT OF ACUTE HAE ATTACKS.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Formulary ID: 26380
 Effective: 08/01/2026
 Updated: 07/21/2026

IDEALISIB

Products Affected

- ZYDELIG

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

Formulary ID: 26380
Effective: 08/01/2026
Updated: 07/21/2026

IMATINIB

Products Affected

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

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

Formulary ID: 26380
 Effective: 08/01/2026
 Updated: 07/21/2026

IMATINIB SOLUTION

Products Affected

- IMKELDI

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

Formulary ID: 26380
 Effective: 08/01/2026
 Updated: 07/21/2026

IMETELSTAT

Products Affected

- RYTELO

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

Formulary ID: 26380
Effective: 08/01/2026
Updated: 07/21/2026

IMLUNESTRANT

Products Affected

- INLURIYO

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

Formulary ID: 26380
Effective: 08/01/2026
Updated: 07/21/2026

INAVOLISIB

Products Affected

- ITOVEBI ORAL TABLET 3 MG, 9 MG

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

Formulary ID: 26380
Effective: 08/01/2026
Updated: 07/21/2026

INSULIN SUPPLIES PAYMENT DETERMINATION

Products Affected

- 1ST TIER UNIFINE PENTIPS 29G X 12MM
- 1ST TIER UNIFINE PENTIPS 31G X 5 MM
- 1ST TIER UNIFINE PENTIPS 31G X 6 MM
- 1ST TIER UNIFINE PENTIPS 31G X 8 MM
- 1ST TIER UNIFINE PENTIPS 32G X 4 MM
- 1ST TIER UNIFINE PENTIPS 32G X 6 MM
- 1ST TIER UNIFINE PENTIPS 33G X 4 MM
- 1ST TIER UNIFINE PENTIPS PLUS 29G X 12MM
- 1ST TIER UNIFINE PENTIPS PLUS 31G X 5 MM
- 1ST TIER UNIFINE PENTIPS PLUS 31G X 6 MM
- 1ST TIER UNIFINE PENTIPS PLUS 31G X 8 MM
- 1ST TIER UNIFINE PENTIPS PLUS 32G X 4 MM
- 1ST TIER UNIFINE PENTIPS PLUS 33G X 4 MM
- 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 PADS PAD 70 %
- ALCOHOL PREP PAD
- ALCOHOL PREP PAD 70 %
- ALCOHOL PREP PADS PAD 70 %
- ALCOHOL SWABS PAD
- ALCOHOL SWABS PAD 70 %
- AQ INSULIN SYRINGE 29G X 1/2" 1 ML

Formulary ID: 26380

Effective: 08/01/2026

Updated: 07/21/2026

- AQ INSULIN SYRINGE 30G X 5/16" 0.5 ML
- 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 PRO PEN NEEDLES 30G X 5 MM
- ASSURE ID SAFETY PEN NEEDLES 30G X 8 MM
- AUM ALCOHOL PREP PADS PAD 70 %
- AUM INSULIN SAFETY PEN NEEDLE 31G X 4 MM
- AUM INSULIN SAFETY PEN NEEDLE 31G X 5 MM
- AUM MINI INSULIN PEN NEEDLE 32G X 4 MM
- AUM MINI INSULIN PEN NEEDLE 32G X 5 MM
- AUM MINI INSULIN PEN NEEDLE 32G X 6 MM
- AUM MINI INSULIN PEN NEEDLE 32G X 8 MM
- AUM MINI INSULIN PEN NEEDLE 33G X 4 MM
- AUM MINI INSULIN PEN NEEDLE 33G X 5 MM
- AUM MINI INSULIN PEN NEEDLE 33G X 6 MM
- 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
- AUM SAFETY PEN NEEDLE 31G X 5 MM
- AURORA PEN NEEDLES 29G X 12MM
- AURORA PEN NEEDLES 31G X 6 MM
- AURORA PEN NEEDLES 31G X 8 MM
- BD AUTOSHIELD DUO 30G X 5 MM
- BD ECLIPSE SYRINGE 30G X 1/2" 1 ML
- BD INS SYR ULTRAFINE 1/2UNIT 31G X 5/16" 0.3 ML
- BD INSULIN SYR ULTRAFINE II 31G X 5/16" 0.3 ML
- BD INSULIN SYR ULTRAFINE II 31G X 5/16" 0.5 ML
- BD INSULIN SYR ULTRAFINE II 31G X 5/16" 1 ML
- BD INSULIN SYRINGE 27.5G X 5/8" 2 ML
- BD INSULIN SYRINGE 27G X 1/2" 1 ML
- BD INSULIN SYRINGE 29G X 1/2" 0.3 ML
- BD INSULIN SYRINGE 29G X 1/2" 0.5 ML (OTC)
- BD INSULIN SYRINGE 29G X 1/2" 0.5 ML (RX)
- BD INSULIN SYRINGE 29G X 1/2" 1 ML (OTC)
- BD INSULIN SYRINGE 29G X 1/2" 1 ML (RX)
- BD INSULIN SYRINGE HALF-UNIT 31G X 5/16" 0.3 ML
- BD INSULIN SYRINGE MICROFINE 27G X 5/8" 1 ML
- BD INSULIN SYRINGE MICROFINE 28G X 1/2" 0.5 ML
- BD INSULIN SYRINGE MICROFINE 28G X 1/2" 1 ML (OTC)
- BD INSULIN SYRINGE MICROFINE 28G X 1/2" 1 ML (RX)
- BD INSULIN SYRINGE U-100 1 ML

Formulary ID: 26380

Effective: 08/01/2026

Updated: 07/21/2026

- 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 30G X 1/2" 0.3 ML
- BD INSULIN SYRINGE ULTRAFINE 30G X 1/2" 0.5 ML
- BD INSULIN SYRINGE ULTRAFINE 30G X 1/2" 1 ML
- BD INSULIN SYRINGE ULTRAFINE 31G X 5/16" 0.3 ML
- BD INSULIN SYRINGE ULTRAFINE 31G X 5/16" 0.5 ML
- BD INSULIN SYRINGE ULTRAFINE 31G X 5/16" 1 ML
- BD PEN NEEDLE MICRO ULTRAFINE 32G X 6 MM
- BD PEN NEEDLE MINI U/F 31G X 5 MM
- BD PEN NEEDLE MINI ULTRAFINE 31G X 5 MM
- BD PEN NEEDLE NANO 2ND GEN 32G X 4 MM
- BD PEN NEEDLE NANO ULTRAFINE 32G X 4 MM
- BD PEN NEEDLE ORIG ULTRAFINE 29G X 12.7MM
- BD PEN NEEDLE SHORT ULTRAFINE 31G X 8 MM
- BD SAFETYGLIDE INSULIN SYRINGE 29G X 1/2" 0.3 ML
- BD SAFETYGLIDE INSULIN SYRINGE 29G X 1/2" 0.5 ML
- BD SAFETYGLIDE INSULIN SYRINGE 30G X 5/16" 0.5 ML
- BD SAFETYGLIDE INSULIN SYRINGE 31G X 15/64" 0.3 ML
- BD SAFETYGLIDE INSULIN SYRINGE 31G X 15/64" 0.5 ML
- BD SAFETYGLIDE INSULIN SYRINGE 31G X 15/64" 1 ML
- BD SAFETYGLIDE INSULIN SYRINGE 31G X 5/16" 0.3 ML
- BD SAFETYGLIDE SYRINGE/NEEDLE 27G X 5/8" 1 ML
- BD SWAB SINGLE USE REGULAR PAD
- BD VEO INSULIN SYR U/F 1/2UNIT 31G X 15/64" 0.3 ML
- BD VEO INSULIN SYR ULTRAFINE 31G X 15/64" 0.3 ML
- BD VEO INSULIN SYR ULTRAFINE 31G X 15/64" 0.5 ML
- BD VEO INSULIN SYR ULTRAFINE 31G X 15/64" 1 ML
- BD VEO INSULIN SYRINGE U/F 31G X 15/64" 0.3 ML
- BD VEO INSULIN SYRINGE U/F 31G X 15/64" 0.5 ML
- BD VEO INSULIN SYRINGE U/F 31G X 15/64" 1 ML
- CAREFINE PEN NEEDLES 29G X 12MM
- CAREFINE PEN NEEDLES 30G X 8 MM
- CAREFINE PEN NEEDLES 31G X 6 MM
- CAREFINE PEN NEEDLES 31G X 8 MM
- CAREFINE PEN NEEDLES 32G X 4 MM
- CAREFINE PEN NEEDLES 32G X 5 MM
- CAREFINE PEN NEEDLES 32G X 6 MM
- CAREONE INSULIN SYRINGE 30G X 1/2" 0.3 ML
- CAREONE INSULIN SYRINGE 30G X 1/2" 0.5 ML
- CAREONE INSULIN SYRINGE 30G X 1/2" 1 ML

Formulary ID: 26380

Effective: 08/01/2026

Updated: 07/21/2026

- 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
- CAREONE UNIFINE PENTIPS PLUS 29G X 12MM
- CAREONE UNIFINE PENTIPS PLUS 31G X 5 MM
- CAREONE UNIFINE PENTIPS PLUS 31G X 6 MM
- CAREONE UNIFINE PENTIPS PLUS 31G X 8 MM
- CAREONE UNIFINE PENTIPS PLUS 32G X 4 MM
- CAREONE UNIFINE PENTIPS PLUS 33G X 4 MM
- 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 5 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 27G X 1/2" 1 ML
- COMFORT EZ INSULIN SYRINGE 28G X 1/2" 0.5 ML
- COMFORT EZ INSULIN SYRINGE 28G X 1/2" 1 ML
- COMFORT EZ INSULIN SYRINGE 29G X 1/2" 0.3 ML
- COMFORT EZ INSULIN SYRINGE 29G X 1/2" 0.5 ML
- COMFORT EZ INSULIN SYRINGE 29G X 1/2" 1 ML
- COMFORT EZ INSULIN SYRINGE 30G X 1/2" 0.3 ML
- COMFORT EZ INSULIN SYRINGE 30G X 1/2" 0.5 ML
- COMFORT EZ INSULIN SYRINGE 30G X 1/2" 1 ML
- COMFORT EZ INSULIN SYRINGE 30G X 5/16" 0.3 ML

Formulary ID: 26380

Effective: 08/01/2026

Updated: 07/21/2026

- 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 MICRO PEN NEEDLES 32G X 4 MM
- 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 EZ SHORT PEN NEEDLES 31G X 8 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
- COMFORT TOUCH INSULIN PEN NEED 33G X 4 MM
- COMFORT TOUCH INSULIN PEN NEED 33G X 5 MM
- COMFORT TOUCH INSULIN PEN NEED 33G X 6 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 ALCOHOL PREP PADS PAD 70 %
- CVS GAUZE PAD 2"X2"
- CVS GAUZE STERILE PAD 2"X2"
- *cvs isopropyl alcohol wipes*
- CVS PREP PAD 70 %
- DERMACEA GAUZE SPONGE PAD 2"X2"
- DERMACEA IV DRAIN SPONGES PAD 2"X2"

Formulary ID: 26380

Effective: 08/01/2026

Updated: 07/21/2026

- 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 AUTOPROTECT DUO 31G X 4 MM
- DROPSAFE AUTOPROTECT DUO 31G X 5 MM
- DROPSAFE AUTOPROTECT DUO 31G X 8 MM
- DROPSAFE SAFETY PEN NEEDLES 31G X 5 MM
- DROPSAFE SAFETY PEN NEEDLES 31G X 6 MM
- DROPSAFE SAFETY 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

Formulary ID: 26380

Effective: 08/01/2026

Updated: 07/21/2026

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

Formulary ID: 26380

Effective: 08/01/2026

Updated: 07/21/2026

- EASY TOUCH INSULIN SYRINGE 27G X 1/2" 1 ML
- EASY TOUCH INSULIN SYRINGE 27G X 5/8" 1 ML
- EASY TOUCH INSULIN SYRINGE 28G X 1/2" 0.5 ML
- EASY TOUCH INSULIN SYRINGE 28G X 1/2" 1 ML
- EASY TOUCH INSULIN SYRINGE 29G X 1/2" 0.5 ML
- EASY TOUCH INSULIN SYRINGE 29G X 1/2" 1 ML
- EASY TOUCH INSULIN SYRINGE 30G X 1/2" 0.3 ML
- EASY TOUCH INSULIN SYRINGE 30G X 1/2" 0.5 ML
- EASY TOUCH INSULIN SYRINGE 30G X 1/2" 1 ML
- EASY TOUCH INSULIN SYRINGE 30G X 5/16" 0.3 ML
- EASY TOUCH INSULIN SYRINGE 30G X 5/16" 0.5 ML
- EASY TOUCH INSULIN SYRINGE 30G X 5/16" 1 ML
- EASY TOUCH INSULIN SYRINGE 31G X 5/16" 0.3 ML
- EASY TOUCH INSULIN SYRINGE 31G X 5/16" 0.5 ML
- EASY TOUCH INSULIN SYRINGE 31G X 5/16" 1 ML
- EASY TOUCH PEN NEEDLES 29G X 12MM
- EASY TOUCH PEN NEEDLES 30G X 5 MM
- EASY TOUCH PEN NEEDLES 30G X 6 MM
- EASY TOUCH PEN NEEDLES 30G X 8 MM
- EASY TOUCH PEN NEEDLES 31G X 5 MM
- EASY TOUCH PEN NEEDLES 31G X 6 MM
- EASY TOUCH PEN NEEDLES 31G X 8 MM
- EASY TOUCH PEN NEEDLES 32G X 4 MM
- EASY TOUCH PEN NEEDLES 32G X 5 MM
- EASY TOUCH PEN NEEDLES 32G X 6 MM
- EASY TOUCH SAFETY PEN NEEDLES 29G X 5MM
- EASY TOUCH SAFETY PEN NEEDLES 29G X 8MM
- EASY TOUCH SAFETY PEN NEEDLES 30G X 8 MM
- EASY TOUCH SHEATHLOCK SYRINGE 29G X 1/2" 1 ML
- EASY TOUCH SHEATHLOCK SYRINGE 30G X 1/2" 1 ML
- EASY TOUCH SHEATHLOCK SYRINGE 30G X 5/16" 1 ML
- EASY TOUCH SHEATHLOCK SYRINGE 31G X 5/16" 1 ML
- EMBECTA AUTOSHIELD DUO 30G X 5 MM
- EMBECTA INS SYR U/F 1/2 UNIT 31G X 15/64" 0.3 ML
- EMBECTA INS SYR U/F 1/2 UNIT 31G X 5/16" 0.3 ML
- EMBECTA INSULIN SYR ULTRAFINE 30G X 1/2" 0.3 ML
- EMBECTA INSULIN SYR ULTRAFINE 30G X 1/2" 0.5 ML
- EMBECTA INSULIN SYR ULTRAFINE 30G X 1/2" 1 ML
- EMBECTA INSULIN SYR ULTRAFINE 31G X 15/64" 0.3 ML
- EMBECTA INSULIN SYR ULTRAFINE 31G X 15/64" 0.5 ML
- EMBECTA INSULIN SYR ULTRAFINE 31G X 15/64" 1 ML
- EMBECTA INSULIN SYR ULTRAFINE 31G X 5/16" 0.3 ML

Formulary ID: 26380

Effective: 08/01/2026

Updated: 07/21/2026

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

Formulary ID: 26380

Effective: 08/01/2026

Updated: 07/21/2026

- GLOBAL EASY GLIDE INSULIN SYR 31G X 15/64" 0.5 ML
- GLOBAL EASY GLIDE INSULIN SYR 31G X 15/64" 1 ML
- GLOBAL EASY GLIDE INSULIN SYR 31G X 5/16" 0.3 ML
- GLOBAL EASY GLIDE PEN NEEDLES 32G X 4 MM
- 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" 0.3 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 1/2" 1 ML
- GLOBAL INJECT EASE INSULIN SYR 30G X 5/16" 0.3 ML
- GLOBAL INJECT EASE INSULIN SYR 30G X 5/16" 0.5 ML
- GLOBAL INJECT EASE INSULIN SYR 30G X 5/16" 1 ML
- GLOBAL INJECT EASE INSULIN SYR 31G X 5/16" 0.3 ML
- GLOBAL INJECT EASE INSULIN SYR 31G X 5/16" 0.5 ML
- GLOBAL INJECT EASE INSULIN SYR 31G X 5/16" 1 ML
- GLOBAL INSULIN SYRINGES 30G X 1/2" 0.3 ML
- GLOBAL INSULIN SYRINGES 30G X 5/16" 0.3 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 70 %
- GNP CLICKFINE PEN NEEDLES 31G X 6 MM
- GNP CLICKFINE PEN NEEDLES 31G X 8 MM
- GNP INSULIN SYRINGE 28G X 1/2" 0.5 ML
- GNP INSULIN SYRINGE 29G X 1/2" 0.3 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" 0.3 ML
- GNP INSULIN SYRINGE 30G X 5/16" 0.5 ML
- GNP INSULIN SYRINGE 30G X 5/16" 1 ML
- GNP INSULIN SYRINGE 31G X 5/16" 0.3 ML
- GNP INSULIN SYRINGE 31G X 5/16" 0.5 ML
- GNP INSULIN SYRINGE 31G X 5/16" 1 ML
- GNP INSULIN SYRINGES 28GX1/2" 28G X 1/2" 1 ML

Formulary ID: 26380

Effective: 08/01/2026

Updated: 07/21/2026

- GNP INSULIN SYRINGES 29GX1/2" 29G X 1/2" 0.5 ML
- GNP INSULIN SYRINGES 29GX1/2" 29G X 1/2" 1 ML
- GNP INSULIN SYRINGES 30G X 5/16" 1 ML
- GNP INSULIN SYRINGES 30GX5/16" 30G X 5/16" 0.3 ML
- GNP INSULIN SYRINGES 31GX5/16" 31G X 5/16" 0.3 ML
- GNP PEN NEEDLES 31G X 5 MM
- GNP PEN NEEDLES 31G X 8 MM
- GNP PEN NEEDLES 32G X 4 MM
- GNP PEN NEEDLES 32G X 6 MM
- GNP STERILE GAUZE PAD 2"X2"
- GNP ULTICARE PEN NEEDLES 31G X 5 MM
- GNP ULTICARE PEN NEEDLES 31G X 8 MM
- GNP ULTICARE PEN NEEDLES 32G X 4 MM
- GNP ULTICARE PEN NEEDLES 32G X 6 MM
- GNP ULTIGUARD SAFEPAK NEEDLE 31G X 5 MM
- GNP ULTIGUARD SAFEPAK NEEDLE 31G X 8 MM
- GNP ULTIGUARD SAFEPAK NEEDLE 32G X 4 MM
- GNP ULTIGUARD SAFEPAK NEEDLE 32G X 6 MM
- GNP ULTRA COM INSULIN SYRINGE 28G X 1/2" 1 ML
- GOODSENSE ALCOHOL SWABS PAD 70 %
- GOODSENSE CLICKFINE PEN NEEDLE 31G X 5 MM
- GOODSENSE PEN NEEDLE PENFINE 31G X 5 MM
- GOODSENSE PEN NEEDLE PENFINE 31G X 8 MM
- GOODSENSE PEN NEEDLE PENFINE 32G X 4 MM
- GOODSENSE PEN NEEDLE PENFINE 32G X 6 MM
- H-E-B INCONTROL ALCOHOL PAD
- H-E-B INCONTROL PEN NEEDLES 29G X 12MM
- H-E-B INCONTROL PEN NEEDLES 31G X 5 MM
- H-E-B INCONTROL PEN NEEDLES 31G X 6 MM
- H-E-B INCONTROL PEN NEEDLES 31G X 8 MM
- H-E-B INCONTROL PEN NEEDLES 32G X 4 MM
- H-E-B INCONTROL UNIFINE PENTIP 31G X 5 MM
- H-E-B INCONTROL UNIFINE PENTIP 31G X 6 MM
- H-E-B INCONTROL UNIFINE PENTIP 31G X 8 MM
- H-E-B INCONTROL UNIFINE PENTIP 32G X 4 MM
- H-E-B INCONTROL UNIFINE PENTIP 33G 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
- HM STERILE PADS PAD 2"X2"

Formulary ID: 26380

Effective: 08/01/2026

Updated: 07/21/2026

- HM ULTICARE INSULIN SYRINGE 30G X 1/2" 1 ML
- HM ULTICARE INSULIN SYRINGE 31G X 5/16" 0.3 ML
- HM ULTICARE MINI PEN NEEDLES 31G X 5 MM
- 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 28G X 1/2" 0.5 ML
- INSULIN SYRINGE 29G X 1/2" 0.3 ML
- INSULIN SYRINGE 29G X 1/2" 0.5 ML
- INSULIN SYRINGE 29G X 1/2" 1 ML
- INSULIN SYRINGE 30G X 5/16" 0.3 ML
- INSULIN SYRINGE 30G X 5/16" 0.5 ML
- INSULIN SYRINGE 30G X 5/16" 1 ML
- INSULIN SYRINGE 31G X 5/16" 0.3 ML
- INSULIN SYRINGE 31G X 5/16" 0.5 ML
- INSULIN SYRINGE 31G X 5/16" 1 ML
- INSULIN SYRINGE-NEEDLE U-100 27G X 1/2" 0.5 ML (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 (OTC)
- INSULIN SYRINGE-NEEDLE U-100 27G X 1/2" 1 ML (RX)
- INSULIN SYRINGE-NEEDLE U-100 28G X 1/2" 0.5 ML (OTC)
- INSULIN SYRINGE-NEEDLE U-100 28G X 1/2" 0.5 ML (RX)
- INSULIN SYRINGE-NEEDLE U-100 28G X 1/2" 1 ML (OTC)
- INSULIN SYRINGE-NEEDLE U-100 28G X 1/2" 1 ML (RX)
- INSULIN SYRINGE-NEEDLE U-100 29G X 1/2" 0.5 ML (OTC)
- INSULIN SYRINGE-NEEDLE U-100 29G X 1/2" 0.5 ML (RX)
- INSULIN SYRINGE-NEEDLE U-100 29G X 1/2" 1 ML (OTC)
- INSULIN SYRINGE-NEEDLE U-100 29G X 1/2" 1 ML (RX)
- INSULIN SYRINGE-NEEDLE U-100 30G X 1/2" 1 ML (OTC)
- INSULIN SYRINGE-NEEDLE U-100 30G X 1/2" 1 ML (RX)
- INSULIN SYRINGE-NEEDLE U-100 30G X 5/16" 0.3 ML
- INSULIN SYRINGE-NEEDLE U-100 30G X 5/16" 0.5 ML (OTC)
- INSULIN SYRINGE-NEEDLE U-100 30G X 5/16" 0.5 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" 0.3 ML
- INSULIN SYRINGE-NEEDLE U-100 31G X 5/16" 0.5 ML (OTC)
- INSULIN SYRINGE-NEEDLE U-100 31G X 5/16" 0.5 ML (RX)
- INSULIN SYRINGE-NEEDLE U-100 31G X 5/16" 1 ML (OTC)
- INSULIN SYRINGE-NEEDLE U-100 31G X 5/16" 1 ML (RX)
- INSUPEN PEN NEEDLES 29G X 12MM
- INSUPEN PEN NEEDLES 31G X 5 MM
- INSUPEN PEN NEEDLES 31G X 8 MM
- INSUPEN PEN NEEDLES 32G X 4 MM
- INSUPEN PEN NEEDLES 33G X 4 MM

Formulary ID: 26380

Effective: 08/01/2026

Updated: 07/21/2026

- Formulary ID: 26380
Effective: 08/01/2026
Updated: 07/21/2026

- 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
- LONGS INSULIN SYRINGE 31G X 5/16" 0.5 ML
- 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
- MARATHON MEDICAL PENTIPS 29G X 12MM
- MARATHON MEDICAL PENTIPS 31G X 5 MM
- MARATHON MEDICAL PENTIPS 31G X 8 MM
- MARATHON MEDICAL PENTIPS 32G X 4 MM
- 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

Formulary ID: 26380

Effective: 08/01/2026

Updated: 07/21/2026

- Formulary ID: 26380
Effective: 08/01/2026
Updated: 07/21/2026

- NOVOFINE PLUS PEN NEEDLE 32G X 4 MM
- PC UNIFINE PENTIPS 31G X 5 MM
- PC UNIFINE PENTIPS 31G X 6 MM
- PC UNIFINE PENTIPS 31G X 8 MM
- PEN NEEDLE/5-BEVEL TIP 31G X 8 MM
- PEN NEEDLE/5-BEVEL TIP 32G X 4 MM
- PEN NEEDLES 29G X 12MM
- PEN NEEDLES 30G X 5 MM (OTC)
- PEN NEEDLES 30G X 5 MM (RX)
- PEN NEEDLES 30G X 8 MM
- PEN NEEDLES 31G X 5 MM (OTC)
- PEN NEEDLES 31G X 5 MM (RX)
- PEN NEEDLES 31G X 6 MM
- PEN NEEDLES 31G X 8 MM (OTC)
- PEN NEEDLES 31G X 8 MM (RX)
- PEN NEEDLES 32G X 4 MM (OTC)
- PEN NEEDLES 32G X 4 MM (RX)
- PEN NEEDLES 32G X 5 MM
- PEN NEEDLES 32G X 6 MM
- PEN NEEDLES 33G X 4 MM
- PEN NEEDLES 5/16" 31G X 8 MM
- PENTIPS 29G X 12MM (OTC)
- PENTIPS 29G X 12MM (RX)
- PENTIPS 31G X 5 MM (OTC)
- PENTIPS 31G X 5 MM (RX)
- PENTIPS 31G X 6 MM
- PENTIPS 31G X 8 MM (OTC)
- PENTIPS 31G X 8 MM (RX)
- PENTIPS 32G X 4 MM (OTC)
- PENTIPS 32G X 4 MM (RX)
- PENTIPS 32G X 6 MM
- PENTIPS GENERIC PEN NEEDLES 29G X 12MM
- PENTIPS GENERIC PEN NEEDLES 31G X 5 MM
- PENTIPS GENERIC PEN NEEDLES 31G X 6 MM
- PENTIPS GENERIC PEN NEEDLES 31G X 8 MM
- PENTIPS GENERIC PEN NEEDLES 32G X 4 MM
- PENTIPS GENERIC PEN NEEDLES 32G X 6 MM
- PHARMACIST CHOICE ALCOHOL PAD
- PIP PEN NEEDLES 31G X 5MM 31G X 5 MM
- PIP PEN NEEDLES 32G X 4MM 32G X 4 MM
- PRECISION SURE-DOSE SYRINGE 30G X 5/16" 0.3 ML
- PREFERRED PLUS INSULIN SYRINGE 28G X 1/2" 0.5 ML
- PREFERRED PLUS INSULIN SYRINGE 28G X 1/2" 1 ML
- PREFERRED PLUS INSULIN SYRINGE 29G X 1/2" 0.3 ML
- PREFERRED PLUS INSULIN SYRINGE 29G X 1/2" 0.5 ML
- PREFERRED PLUS INSULIN SYRINGE 29G X 1/2" 1 ML
- PREFERRED PLUS INSULIN SYRINGE 30G X 5/16" 0.3 ML
- PREFERRED PLUS INSULIN SYRINGE 30G X 5/16" 0.5 ML
- PREFERRED PLUS INSULIN SYRINGE 30G X 5/16" 1 ML
- PREFERRED PLUS UNIFINE PENTIPS 29G X 12MM
- PREVENT DROPSAFE PEN NEEDLES 31G X 6 MM
- PREVENT DROPSAFE PEN NEEDLES 31G X 8 MM
- PREVENT SAFETY PEN NEEDLES 31G X 6 MM
- PREVENT SAFETY PEN NEEDLES 31G X 8 MM
- PRO COMFORT ALCOHOL PAD 70 %
- PRO COMFORT INSULIN SYRINGE 30G X 1/2" 0.5 ML
- PRO COMFORT INSULIN SYRINGE 30G X 1/2" 1 ML

Formulary ID: 26380

Effective: 08/01/2026

Updated: 07/21/2026

- PRO COMFORT INSULIN SYRINGE 30G X 5/16" 0.5 ML
- PRO COMFORT INSULIN SYRINGE 30G X 5/16" 1 ML
- PRO COMFORT INSULIN SYRINGE 31G X 5/16" 0.5 ML
- PRO COMFORT INSULIN SYRINGE 31G X 5/16" 1 ML
- PRO COMFORT PEN NEEDLES 32G X 4 MM
- PRO COMFORT PEN NEEDLES 32G X 5 MM
- PRO COMFORT PEN NEEDLES 32G X 6 MM
- PRO COMFORT PEN NEEDLES 32G X 8 MM
- PRODIGY INSULIN SYRINGE 28G X 1/2" 1 ML
- PRODIGY INSULIN SYRINGE 31G X 5/16" 0.3 ML
- PRODIGY INSULIN SYRINGE 31G X 5/16" 0.5 ML
- PURE COMFORT ALCOHOL PREP PAD
- PURE COMFORT PEN NEEDLE 32G X 4 MM
- PURE COMFORT PEN NEEDLE 32G X 5 MM
- PURE COMFORT PEN NEEDLE 32G X 6 MM
- PURE COMFORT PEN NEEDLE 32G X 8 MM
- PURE COMFORT SAFETY PEN NEEDLE 31G X 5 MM
- PURE COMFORT SAFETY PEN NEEDLE 31G X 6 MM
- PURE COMFORT SAFETY PEN NEEDLE 32G X 4 MM
- PX EXTRA SHORT PEN NEEDLES 31G X 6 MM
- PX INSULIN SYRINGE 30G X 1/2" 0.5 ML
- PX MINI PEN NEEDLES 31G X 5 MM
- PX PEN NEEDLE 29G X 12MM
- PX PEN NEEDLE 31G X 8 MM
- PX SHORTLENGTH PEN NEEDLES 31G X 8 MM
- QC ALCOHOL
- QC ALCOHOL SWABS PAD 70 %
- QC BORDER ISLAND GAUZE PAD 2"X2"
- QC PEN NEEDLES 29G X 12MM
- QC PEN NEEDLES 31G X 6 MM
- QC PEN NEEDLES 31G X 8 MM
- QC UNIFINE PENTIPS 32G X 4 MM
- QUICK TOUCH INSULIN PEN NEEDLE 29G X 12.7MM
- QUICK TOUCH INSULIN PEN NEEDLE 31G X 4 MM
- QUICK TOUCH INSULIN PEN NEEDLE 31G X 5 MM
- QUICK TOUCH INSULIN PEN NEEDLE 31G X 6 MM
- QUICK TOUCH INSULIN PEN NEEDLE 31G X 8 MM
- QUICK TOUCH INSULIN PEN NEEDLE 32G X 4 MM
- QUICK TOUCH INSULIN PEN NEEDLE 32G X 5 MM
- QUICK TOUCH INSULIN PEN NEEDLE 32G X 6 MM
- QUICK TOUCH INSULIN PEN NEEDLE 32G X 8 MM
- QUICK TOUCH INSULIN PEN NEEDLE 33G X 4 MM
- QUICK TOUCH INSULIN PEN NEEDLE 33G X 5 MM
- QUICK TOUCH INSULIN PEN NEEDLE 33G X 6 MM
- QUICK TOUCH INSULIN PEN NEEDLE 33G X 8 MM
- RA ALCOHOL SWABS PAD 70 %
- RA INSULIN SYRINGE 29G X 1/2" 0.5 ML
- RA INSULIN SYRINGE 29G X 1/2" 1 ML

Formulary ID: 26380

Effective: 08/01/2026

Updated: 07/21/2026

- RA INSULIN SYRINGE 30G X 5/16" 0.5 ML
- RA INSULIN SYRINGE 30G X 5/16" 1 ML
- *ra isopropyl alcohol wipes*
- RA PEN NEEDLES 31G X 5 MM
- RA PEN NEEDLES 31G X 8 MM
- RA STERILE PAD 2"X2"
- RAYA SURE PEN NEEDLE 29G X 12MM
- RAYA SURE PEN NEEDLE 31G X 4 MM
- RAYA SURE PEN NEEDLE 31G X 5 MM
- RAYA SURE PEN NEEDLE 31G X 6 MM
- RAYA SURE PEN NEEDLE 31G X 8 MM
- REALITY INSULIN SYRINGE 28G X 1/2" 0.5 ML
- REALITY INSULIN SYRINGE 28G X 1/2" 1 ML
- REALITY INSULIN SYRINGE 29G X 1/2" 0.5 ML
- REALITY INSULIN SYRINGE 29G X 1/2" 1 ML
- REALITY SWABS PAD
- RELI-ON INSULIN SYRINGE 29G 0.3 ML
- RELION ALCOHOL SWABS PAD
- RELION ALCOHOL SWABS PAD 70 %
- RELION INSULIN SYRINGE 29G X 1/2" 0.5 ML
- 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 INSULIN SYRINGE 31G X 5/16" 0.3 ML
- RELION INSULIN SYRINGE 31G X 5/16" 0.5 ML
- RELION INSULIN SYRINGE 31G X 5/16" 1 ML
- RELION MINI PEN NEEDLES 31G X 6 MM
- RELION PEN NEEDLES 29G X 12MM
- RELION PEN NEEDLES 31G X 6 MM
- RELION PEN NEEDLES 31G X 8 MM
- RELION PEN NEEDLES 32G X 4 MM
- RELION SHORT PEN NEEDLES 31G X 8 MM
- RESTORE CONTACT LAYER PAD 2"X2"
- SAFETY PEN NEEDLES 30G X 5 MM
- SAFETY PEN NEEDLES 30G X 8 MM
- SAPS CARE ALCOHOL PREP PAD 70 %
- SAPS HEALTH ALCOHOL PREP PAD 70 %
- SAPS HEALTH CARE ALCOHOL PREP PAD 70 %
- 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
- SECURESAFE SAFETY PEN NEEDLES 31G X 5 MM
- SM STERILE PAD 2"X2"
- STERILE GAUZE PAD 2"X2"
- STERILE PAD 2"X2"

Formulary ID: 26380

Effective: 08/01/2026

Updated: 07/21/2026

- SURE COMFORT ALCOHOL PREP PAD 70 %
- SURE COMFORT INSULIN SYRINGE 28G X 1/2" 0.5 ML
- SURE COMFORT INSULIN SYRINGE 28G X 1/2" 1 ML
- SURE COMFORT INSULIN SYRINGE 29G X 1/2" 0.3 ML
- SURE COMFORT INSULIN SYRINGE 29G X 1/2" 0.5 ML
- SURE COMFORT INSULIN SYRINGE 29G X 1/2" 1 ML
- SURE COMFORT INSULIN SYRINGE 30G X 1/2" 0.3 ML
- SURE COMFORT INSULIN SYRINGE 30G X 1/2" 0.5 ML
- SURE COMFORT INSULIN SYRINGE 30G X 1/2" 1 ML
- SURE COMFORT INSULIN SYRINGE 30G X 5/16" 0.3 ML
- SURE COMFORT INSULIN SYRINGE 30G X 5/16" 0.5 ML
- SURE COMFORT INSULIN SYRINGE 30G X 5/16" 1 ML
- SURE COMFORT INSULIN SYRINGE 31G X 1/4" 0.3 ML
- SURE COMFORT INSULIN SYRINGE 31G X 1/4" 0.5 ML
- SURE COMFORT INSULIN SYRINGE 31G X 1/4" 1 ML
- SURE COMFORT INSULIN SYRINGE 31G X 5/16" 0.3 ML
- SURE COMFORT INSULIN SYRINGE 31G X 5/16" 0.5 ML
- SURE COMFORT INSULIN SYRINGE 31G X 5/16" 1 ML
- SURE COMFORT PEN NEEDLES 29G X 12.7MM
- SURE COMFORT PEN NEEDLES 30G X 8 MM
- SURE COMFORT PEN NEEDLES 31G X 5 MM
- SURE COMFORT PEN NEEDLES 31G X 6 MM
- SURE COMFORT PEN NEEDLES 31G X 8 MM
- SURE COMFORT PEN NEEDLES 32G X 4 MM (OTC)
- SURE COMFORT PEN NEEDLES 32G X 4 MM (RX)
- SURE COMFORT PEN NEEDLES 32G X 6 MM
- SURGICAL GAUZE SPONGE PAD 2"X2"
- TECHLITE INSULIN SYRINGE 30G X 1/2" 1 ML
- TECHLITE INSULIN SYRINGE 31G X 15/64" 0.3 ML
- TECHLITE INSULIN SYRINGE 31G X 15/64" 0.5 ML
- TECHLITE INSULIN SYRINGE 31G X 15/64" 1 ML
- TECHLITE INSULIN SYRINGE 31G X 5/16" 0.3 ML
- TECHLITE INSULIN SYRINGE 31G X 5/16" 0.5 ML
- TECHLITE INSULIN SYRINGE 31G X 5/16" 1 ML
- TECHLITE PEN NEEDLES 29G X 12MM
- TECHLITE PEN NEEDLES 31G X 5 MM
- TECHLITE PEN NEEDLES 31G X 8 MM
- TECHLITE PEN NEEDLES 32G X 4 MM
- TECHLITE PEN NEEDLES 32G X 6 MM
- TECHLITE PLUS PEN NEEDLES 32G X 4 MM
- TEGADERM FOAM PAD 2"X2"
- THERAGAUZE PAD 2"X2"
- TODAY'S HEALTH PEN NEEDLES 29G X 12MM

Formulary ID: 26380

Effective: 08/01/2026

Updated: 07/21/2026

- 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
- TRUE COMFORT SAFETY PEN NEEDLE 31G X 5 MM

Formulary ID: 26380

Effective: 08/01/2026

Updated: 07/21/2026

- TRUE COMFORT SAFETY PEN NEEDLE 31G X 6 MM
- TRUE COMFORT SAFETY PEN NEEDLE 32G X 4 MM
- TRUEPLUS 5-BEVEL PEN NEEDLES 29G X 12.7MM
- TRUEPLUS 5-BEVEL PEN NEEDLES 31G X 5 MM
- TRUEPLUS 5-BEVEL PEN NEEDLES 31G X 6 MM
- TRUEPLUS 5-BEVEL PEN NEEDLES 31G X 8 MM
- TRUEPLUS 5-BEVEL PEN NEEDLES 32G X 4 MM
- TRUEPLUS INSULIN SYRINGE 28G X 1/2" 0.5 ML
- TRUEPLUS INSULIN SYRINGE 28G X 1/2" 1 ML
- TRUEPLUS INSULIN SYRINGE 29G X 1/2" 0.3 ML
- TRUEPLUS INSULIN SYRINGE 29G X 1/2" 0.5 ML
- TRUEPLUS INSULIN SYRINGE 29G X 1/2" 1 ML
- TRUEPLUS INSULIN SYRINGE 30G X 5/16" 0.3 ML
- TRUEPLUS INSULIN SYRINGE 30G X 5/16" 0.5 ML
- TRUEPLUS INSULIN SYRINGE 30G X 5/16" 1 ML
- TRUEPLUS INSULIN SYRINGE 31G X 5/16" 0.3 ML
- TRUEPLUS INSULIN SYRINGE 31G X 5/16" 0.5 ML
- TRUEPLUS INSULIN SYRINGE 31G X 5/16" 1 ML
- TRUEPLUS PEN NEEDLES 29G X 12MM
- TRUEPLUS PEN NEEDLES 31G X 5 MM
- TRUEPLUS PEN NEEDLES 31G X 6 MM
- TRUEPLUS PEN NEEDLES 31G X 8 MM
- TRUEPLUS PEN NEEDLES 32G X 4 MM
- ULTICARE ALCOHOL SWABS PAD
- ULTICARE ALCOHOL SWABS PAD 70 %
- ULTICARE INSULIN SAFETY SYR 29G X 1/2" 0.5 ML
- ULTICARE INSULIN SAFETY SYR 29G X 1/2" 1 ML
- ULTICARE INSULIN SYR 1/2 UNIT 31G X 1/4" 0.3 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

Formulary ID: 26380

Effective: 08/01/2026

Updated: 07/21/2026

- 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 31G X 6 MM
- ULTICARE MICRO PEN NEEDLES 31G X 8 MM
- 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 SAFEPAK PEN NEEDLE 29G X 12.7MM
- ULTIGUARD SAFEPAK PEN NEEDLE 31G X 5 MM
- ULTIGUARD SAFEPAK PEN NEEDLE 31G X 6 MM
- ULTIGUARD SAFEPAK PEN NEEDLE 31G X 8 MM
- ULTIGUARD SAFEPAK PEN NEEDLE 32G X 4 MM
- ULTIGUARD SAFEPAK SYR/NEEDLE 30G X 1/2" 0.3 ML
- ULTIGUARD SAFEPAK SYR/NEEDLE 30G X 1/2" 0.5 ML
- ULTIGUARD SAFEPAK SYR/NEEDLE 30G X 1/2" 1 ML
- ULTIGUARD SAFEPAK SYR/NEEDLE 31G X 5/16" 0.3 ML
- ULTIGUARD SAFEPAK SYR/NEEDLE 31G X 5/16" 0.5 ML
- ULTIGUARD SAFEPAK SYR/NEEDLE 31G X 5/16" 1 ML
- ULTILET ALCOHOL SWABS PAD
- ULTILET 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 5 MM
- 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

Formulary ID: 26380

Effective: 08/01/2026

Updated: 07/21/2026

- 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-CARE ALCOHOL PREP PADS PAD 70 %
- ULTRA-THIN II INS SYR SHORT 30G X 5/16" 0.3 ML
- ULTRA-THIN II INS SYR SHORT 30G X 5/16" 0.5 ML
- ULTRA-THIN II INS SYR SHORT 30G X 5/16" 1 ML
- ULTRA-THIN II INS SYR SHORT 31G X 5/16" 0.3 ML
- ULTRA-THIN II INS SYR SHORT 31G X 5/16" 0.5 ML
- ULTRA-THIN II INS SYR SHORT 31G X 5/16" 1 ML
- ULTRA-THIN II INSULIN SYRINGE 29G X 1/2" 0.5 ML
- ULTRA-THIN II INSULIN SYRINGE 29G X 1/2" 1 ML
- ULTRA-THIN II MINI PEN NEEDLE 31G X 5 MM
- ULTRA-THIN II PEN NEEDLE SHORT 31G X 8 MM
- ULTRA-THIN II PEN NEEDLES 29G X 12.7MM
- ULTRACARE INSULIN SYRINGE 30G X 1/2" 0.5 ML
- ULTRACARE INSULIN SYRINGE 30G X 1/2" 1 ML
- ULTRACARE INSULIN SYRINGE 30G X 5/16" 0.3 ML
- ULTRACARE INSULIN SYRINGE 30G X 5/16" 0.5 ML
- ULTRACARE INSULIN SYRINGE 30G X 5/16" 1 ML
- ULTRACARE INSULIN SYRINGE 31G X 5/16" 0.3 ML
- ULTRACARE INSULIN SYRINGE 31G X 5/16" 0.5 ML
- ULTRACARE INSULIN SYRINGE 31G X 5/16" 1 ML
- ULTRACARE PEN NEEDLES 31G X 5 MM
- ULTRACARE PEN NEEDLES 31G X 6 MM
- ULTRACARE PEN NEEDLES 31G X 8 MM
- ULTRACARE PEN NEEDLES 32G X 4 MM
- ULTRACARE PEN NEEDLES 32G X 5 MM
- ULTRACARE PEN NEEDLES 32G X 6 MM
- ULTRACARE PEN NEEDLES 33G X 4 MM
- UNIFINE OTC PEN NEEDLES 31G X 5 MM
- UNIFINE OTC PEN NEEDLES 32G X 4 MM
- UNIFINE PENTIPS 29G X 12MM
- UNIFINE PENTIPS 30G X 5 MM
- UNIFINE PENTIPS 31G X 5 MM
- UNIFINE PENTIPS 31G X 6 MM
- UNIFINE PENTIPS 31G X 8 MM

Formulary ID: 26380

Effective: 08/01/2026

Updated: 07/21/2026

- UNIFINE PENTIPS 32G X 4 MM
- UNIFINE PENTIPS 32G X 6 MM
- UNIFINE PENTIPS 33G X 4 MM
- UNIFINE PENTIPS PLUS 29G X 12MM
- UNIFINE PENTIPS PLUS 30G X 5 MM
- UNIFINE PENTIPS PLUS 31G X 5 MM
- UNIFINE PENTIPS PLUS 31G X 6 MM
- UNIFINE PENTIPS PLUS 31G X 8 MM
- UNIFINE PENTIPS PLUS 32G X 4 MM
- UNIFINE PENTIPS PLUS 33G 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 29G X 12MM
- 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
- UNIFINE ULTRA PEN NEEDLE 32G X 6 MM
- UNIFINE ULTRA PEN NEEDLE 34G X 3.5 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 1/2" 1 ML
- VANISHPOINT INSULIN SYRINGE 29G X 5/16" 1 ML
- VANISHPOINT INSULIN SYRINGE 30G X 1/2" 0.5 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 31G X 8 MM
- VERIFINE INSULIN PEN NEEDLE 32G X 4 MM
- VERIFINE INSULIN PEN NEEDLE 32G X 6 MM
- VERIFINE INSULIN SYRINGE 28G X 1/2" 1 ML
- VERIFINE INSULIN SYRINGE 29G X 1/2" 0.5 ML
- VERIFINE INSULIN SYRINGE 29G X 1/2" 1 ML
- VERIFINE INSULIN SYRINGE 30G X 1/2" 1 ML
- VERIFINE INSULIN SYRINGE 30G X 5/16" 0.5 ML
- VERIFINE INSULIN SYRINGE 30G X 5/16" 1 ML
- VERIFINE INSULIN SYRINGE 31G X 5/16" 0.3 ML

Formulary ID: 26380

Effective: 08/01/2026

Updated: 07/21/2026

- 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 %
- WEBCOL ALCOHOL PREP MEDIUM PAD 70 %
- WEGMANS UNIFINE PENTIPS PLUS 31G X 5 MM
- WEGMANS UNIFINE PENTIPS PLUS 31G X 6 MM
- WEGMANS UNIFINE PENTIPS PLUS 31G X 8 MM
- ZEV RX INSULIN SYRINGE 30G X 1/2" 0.5 ML
- ZEV RX INSULIN SYRINGE 30G X 1/2" 1 ML
- ZEV RX INSULIN SYRINGE 30G X 5/16" 0.5 ML
- ZEV RX INSULIN SYRINGE 30G X 5/16" 1 ML
- ZEV RX PEN NEEDLES 31G X 5 MM
- ZEV RX PEN NEEDLES 31G X 6 MM
- ZEV RX PEN NEEDLES 31G X 8 MM
- ZEV RX PEN NEEDLES 32G X 4 MM
- ZEV RX STERILE ALCOHOL PREP PAD 70 %

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

Formulary ID: 26380

Effective: 08/01/2026

Updated: 07/21/2026

PA Criteria	Criteria Details
Prerequisite Therapy Required	No

Formulary ID: 26380
 Effective: 08/01/2026
 Updated: 07/21/2026

INTERFERON FOR MS-AVONEX

Products Affected

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

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

Formulary ID: 26380
Effective: 08/01/2026
Updated: 07/21/2026

INTERFERON FOR MS-BETASERON

Products Affected

- BETASERON SUBCUTANEOUS KIT

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

Formulary ID: 26380
Effective: 08/01/2026
Updated: 07/21/2026

INTERFERON GAMMA-1B

Products Affected

- ACTIMMUNE

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

Formulary ID: 26380
Effective: 08/01/2026
Updated: 07/21/2026

IPILIMUMAB

Products Affected

- YERVOY

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

Formulary ID: 26380
Effective: 08/01/2026
Updated: 07/21/2026

ISAVUCONAZONIUM

Products Affected

- CRESEMBA ORAL

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

Formulary ID: 26380
Effective: 08/01/2026
Updated: 07/21/2026

IVACAFTOR

Products Affected

- KALYDECO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	CYSTIC FIBROSIS (CF): INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A PULMONOLOGIST OR CYSTIC FIBROSIS EXPERT
Coverage Duration	INITIAL: 12 MONTHS. RENEWAL: LIFETIME
Other Criteria	CF: INITIAL: 1) NOT HOMOZYGOUS FOR F508DEL MUTATION IN THE CYSTIC FIBROSIS TRANSMEMBRANE CONDUCTANCE REGULATOR (CFTR) GENE, AND 2) NO CONCURRENT USE WITH ANOTHER CFTR MODULATOR. RENEWAL: 1) IMPROVEMENT IN CLINICAL STATUS, AND 2) NO CONCURRENT USE WITH ANOTHER CFTR MODULATOR.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Formulary ID: 26380
Effective: 08/01/2026
Updated: 07/21/2026

IVOSIDENIB

Products Affected

- TIBSOVO

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

Formulary ID: 26380
Effective: 08/01/2026
Updated: 07/21/2026

IXAZOMIB

Products Affected

- NINLARO

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

Formulary ID: 26380
Effective: 08/01/2026
Updated: 07/21/2026

LAMOTRIGINE

Products Affected

- SUBVENITE ORAL SUSPENSION

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

Formulary ID: 26380
Effective: 08/01/2026
Updated: 07/21/2026

LANREOTIDE

Products Affected

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

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

Formulary ID: 26380
Effective: 08/01/2026
Updated: 07/21/2026

LAPATINIB

Products Affected

- *lapatinib ditosylate*

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

Formulary ID: 26380
Effective: 08/01/2026
Updated: 07/21/2026

LAROTRECTINIB

Products Affected

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

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

Formulary ID: 26380
 Effective: 08/01/2026
 Updated: 07/21/2026

LAZERTINIB

Products Affected

- LAZCLUZE ORAL TABLET 240 MG, 80 MG

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

Formulary ID: 26380
Effective: 08/01/2026
Updated: 07/21/2026

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

Formulary ID: 26380
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Updated: 07/21/2026

LENALIDOMIDE

Products Affected

- *lenalidomide*

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

Formulary ID: 26380
Effective: 08/01/2026
Updated: 07/21/2026

LENVATINIB

Products Affected

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

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

Formulary ID: 26380
 Effective: 08/01/2026
 Updated: 07/21/2026

LETERMOVIR

Products Affected

- PREVYMIS ORAL TABLET

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

Formulary ID: 26380

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Updated: 07/21/2026

LEUPROLIDE

Products Affected

- leuprolide acetate injection*

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

Formulary ID: 26380
Effective: 08/01/2026
Updated: 07/21/2026

LEUPROLIDE DEPOT

Products Affected

- LEUPROLIDE ACETATE (3 MONTH)
- LUTRATE DEPOT

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

Formulary ID: 26380
Effective: 08/01/2026
Updated: 07/21/2026

LEUPROLIDE MESYLATE

Products Affected

- CAMCEVI

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

Formulary ID: 26380
Effective: 08/01/2026
Updated: 07/21/2026

LEUPROLIDE-ELIGARD

Products Affected

- ELIGARD

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

Formulary ID: 26380
Effective: 08/01/2026
Updated: 07/21/2026

LEUPROLIDE-LUPRON DEPOT

Products Affected

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

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

Formulary ID: 26380

Effective: 08/01/2026

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

Formulary ID: 26380
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 Updated: 07/21/2026

LEUPROLIDE-LUPRON DEPOT-PED

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	CENTRAL PRECOCIOUS PUBERTY (CPP): INITIAL: FEMALES: ELEVATED LEVEL OF LUTEINIZING HORMONE (LH) LEVEL GREATER THAN 0.2 TO 0.3 MIU/ML AT DIAGNOSIS. MALES: ELEVATED LEVEL OF LH LEVEL GREATER THAN 0.2 TO 0.3 MIU/ML AT DIAGNOSIS.
Age Restrictions	
Prescriber Restrictions	CPP: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH AN ENDOCRINOLOGIST.
Coverage Duration	INITIAL/RENEWAL: 12 MONTHS.
Other Criteria	CPP: INITIAL: FEMALES: 1) YOUNGER THAN 8 YEARS OF AGE AT ONSET OF CPP, AND 2) AT TANNER STAGE 2 OR ABOVE FOR BREAST DEVELOPMENT AND PUBIC HAIR GROWTH. MALES: 1) YOUNGER THAN 9 YEARS OF AGE AT ONSET OF CPP, AND 2) AT TANNER STAGE 2 OR ABOVE FOR GENITAL DEVELOPMENT AND PUBIC HAIR GROWTH. RENEWAL: 1) TANNER STAGING AT INITIAL DIAGNOSIS HAS STABILIZED OR REGRESSED DURING THREE SEPARATE MEDICAL VISITS IN THE PREVIOUS YEAR, AND 2) HAS NOT REACHED ACTUAL AGE WHICH CORRESPONDS TO CURRENT PUBERTAL AGE.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 26380

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Updated: 07/21/2026

PA Criteria	Criteria Details
Prerequisite Therapy Required	No

Formulary ID: 26380
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 Updated: 07/21/2026

L-GLUTAMINE

Products Affected

- *l-glutamine oral packet*

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

Formulary ID: 26380
Effective: 08/01/2026
Updated: 07/21/2026

LIDOCAINE OINTMENT

Products Affected

- *lidocaine external ointment 5 %*

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

Formulary ID: 26380
Effective: 08/01/2026
Updated: 07/21/2026

LIDOCAINE PATCH

Products Affected

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

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

Formulary ID: 26380
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Updated: 07/21/2026

LIDOCAINE PRILOCAINE

Products Affected

- *lidocaine-prilocaine external cream*

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

Formulary ID: 26380
Effective: 08/01/2026
Updated: 07/21/2026

LINVOSELTAMAB-GCPT

Products Affected

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

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

Formulary ID: 26380
Effective: 08/01/2026
Updated: 07/21/2026

LONCASTUXIMAB TESIRINE-LPYL

Products Affected

- ZYNLONTA

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

Formulary ID: 26380
Effective: 08/01/2026
Updated: 07/21/2026

LORLATINIB

Products Affected

- LORBRENA ORAL TABLET 100 MG,
25 MG

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

Formulary ID: 26380
Effective: 08/01/2026
Updated: 07/21/2026

LOTILANER

Products Affected

- XDEM VY

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

Formulary ID: 26380
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Updated: 07/21/2026

LUMACFTOR-IVACFTOR

Products Affected

- ORKAMBI ORAL TABLET

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

Formulary ID: 26380
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Updated: 07/21/2026

MARGETUXIMAB-CMKB

Products Affected

- MARGENZA

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

Formulary ID: 26380
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Updated: 07/21/2026

MARIBAVIR

Products Affected

- LIVTENCITY

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

Formulary ID: 26380
Effective: 08/01/2026
Updated: 07/21/2026

MAVACAMTEN

Products Affected

- CAMZYOS

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

Formulary ID: 26380
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Updated: 07/21/2026

MECASERMIN

Products Affected

- INCRELEX

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

Formulary ID: 26380
 Effective: 08/01/2026
 Updated: 07/21/2026

MECHLORETHAMINE

Products Affected

- VALCHLOR

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

Formulary ID: 26380
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Updated: 07/21/2026

MEPOLIZUMAB

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: ASTHMA: BLOOD EOSINOPHIL LEVEL OF AT LEAST 150 CELLS/MCL WITHIN THE PAST 12 MONTHS.
Age Restrictions	
Prescriber Restrictions	INITIAL: ASTHMA: PRESCRIBED BY OR IN CONSULTATION WITH A PHYSICIAN SPECIALIZING IN PULMONARY OR ALLERGY MEDICINE. CRSWNP: PRESCRIBED BY OR IN CONSULTATION WITH AN OTOLARYNGOLOGIST, ALLERGIST OR IMMUNOLOGIST. EOSINOPHILIC COPD: PRESCRIBED BY OR IN CONSULTATION WITH A PULMONOLOGIST.
Coverage Duration	INITIAL: CRSWNP: 6 MO. OTHERS: 12 MO. RENEWAL: CRSWNP, ASTHMA, COPD, EGPA, HES: 12 MO.
Other Criteria	INITIAL: ALL INDICATIONS: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR THE SAME INDICATION. ASTHMA: 1) CONCURRENT THERAPY WITH A MEDIUM, HIGH-DOSE OR MAXIMALLY TOLERATED DOSE OF AN INHALED CORTICOSTEROID (ICS) AND AT LEAST ONE OTHER MAINTENANCE MEDICATION, AND 2) ONE OF THE FOLLOWING: (A) AT LEAST ONE ASTHMA EXACERBATION REQUIRING SYSTEMIC CORTICOSTEROID BURST LASTING AT LEAST 3 DAYS WITHIN THE PAST 12 MONTHS OR AT LEAST ONE SERIOUS EXACERBATION REQUIRING HOSPITALIZATION OR ER VISIT WITHIN THE PAST 12 MONTHS, OR (B) POOR SYMPTOM CONTROL DESPITE CURRENT THERAPY AS

Formulary ID: 26380

Effective: 08/01/2026

Updated: 07/21/2026

PA Criteria	Criteria Details
	EVIDENCED BY AT LEAST THREE OF THE FOLLOWING WITHIN THE PAST 4 WEEKS: DAYTIME ASTHMA SYMPTOMS MORE THAN TWICE/WEEK, ANY NIGHT WAKING DUE TO ASTHMA, SABA RELIEVER FOR SYMPTOMS MORE THAN TWICE/WEEK, ANY ACTIVITY LIMITATION DUE TO ASTHMA. CHRONIC RHINOSINUSITIS WITH NASAL POLYPS (CRSWNP): 1) A 56 DAY TRIAL OF ONE TOPICAL NASAL CORTICOSTEROID, 2) EVIDENCE OF NASAL POLYPS BY DIRECT EXAMINATION, ENDOSCOPY, OR SINUS CT SCAN, AND 3) INADEQUATELY CONTROLLED DISEASE. EOSINOPHILIC COPD: USED IN COMBINATION WITH A LAMA/LABA/ICS. RENEWAL: ASTHMA: 1) CONTINUED USE OF ICS AND AT LEAST ONE OTHER MAINTENANCE MEDICATION, 2) CLINICAL RESPONSE AS EVIDENCED BY: (A) REDUCTION IN ASTHMA EXACERBATIONS FROM BASELINE, (B) DECREASED UTILIZATION OF RESCUE MEDICATIONS, (C) REDUCTION IN SEVERITY OR FREQUENCY OF ASTHMA-RELATED SYMPTOMS, OR (D) INCREASE IN PERCENT PREDICTED FEV1 FROM PRETREATMENT BASELINE, AND 3) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR THE SAME INDICATION. CRSWNP: 1) CLINICAL BENEFIT COMPARED TO BASELINE, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR THE SAME INDICATION. EOSINOPHILIC GRANULOMATOSIS WITH POLYANGIITIS (EGPA): 1) REDUCTION IN EGPA SYMPTOMS COMPARED TO BASELINE OR ABILITY TO REDUCE/ELIMINATE CORTICOSTEROID USE, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR THE SAME INDICATION. EOSINOPHILIC COPD: 1) USED IN COMBINATION WITH A LAMA/LABA/ICS, 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR THE SAME INDICATION, AND 3) CLINICAL RESPONSE AS EVIDENCED BY: (A) REDUCTION IN COPD EXACERBATIONS FROM BASELINE, OR (B) REDUCTION IN SEVERITY OR FREQUENCY OF COPD-RELATED SYMPTOMS.
Indications	All FDA-approved Indications.
Off Label Uses	

Formulary ID: 26380
Effective: 08/01/2026
Updated: 07/21/2026

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

Formulary ID: 26380
 Effective: 08/01/2026
 Updated: 07/21/2026

METYROSIONE

Products Affected

- *metirosine*

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

Formulary ID: 26380
Effective: 08/01/2026
Updated: 07/21/2026

MIDOSTAURIN

Products Affected

- RYDAPT

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

Formulary ID: 26380
Effective: 08/01/2026
Updated: 07/21/2026

MIFEPRISTONE

Products Affected

- *mifepristone oral tablet 300 mg*

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

Formulary ID: 26380

Effective: 08/01/2026

Updated: 07/21/2026

MILTEFOSINE

Products Affected

- IMPAVIDO

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

Formulary ID: 26380
Effective: 08/01/2026
Updated: 07/21/2026

MIRDAMETINIB

Products Affected

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

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

Formulary ID: 26380
Effective: 08/01/2026
Updated: 07/21/2026

MIRVETUXIMAB SORAVTANSINE-GYNX

Products Affected

- ELAHERE

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

Formulary ID: 26380
Effective: 08/01/2026
Updated: 07/21/2026

MOMELOTINIB

Products Affected

- OJJAARA

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

Formulary ID: 26380
Effective: 08/01/2026
Updated: 07/21/2026

MOSUNETUZUMAB-AXGB

Products Affected

- LUNSUMIO
- LUNSUMIO VELO

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

Formulary ID: 26380
Effective: 08/01/2026
Updated: 07/21/2026

NARCOLEPSY AGENTS

Products Affected

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

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

Formulary ID: 26380
 Effective: 08/01/2026
 Updated: 07/21/2026

NAXITAMAB-GQGK

Products Affected

- DANYELZA

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

Formulary ID: 26380
Effective: 08/01/2026
Updated: 07/21/2026

NERANDOMILAST

Products Affected

- JASCAYD

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: IDIOPATHIC PULMONARY FIBROSIS (IPF): A USUAL INTERSTITIAL PNEUMONIA (UIP) PATTERN AS EVIDENCED BY HIGH-RESOLUTION COMPUTED TOMOGRAPHY (HRCT) ALONE OR VIA A COMBINATION OF SURGICAL LUNG BIOPSY AND HRCT. PROGRESSIVE PULMONARY FIBROSIS (PPF): 1) AT LEAST 10% FIBROSIS ON A CHEST HRCT, AND 2) INTERSTITIAL LUNG DISEASE WITH A PROGRESSIVE PHENOTYPE (PF-ILD).
Age Restrictions	
Prescriber Restrictions	INITIAL: IPF: PRESCRIBED BY OR IN CONSULTATION WITH A PULMONOLOGIST. PPF: PRESCRIBED BY OR IN CONSULTATION WITH A PULMONOLOGIST OR RHEUMATOLOGIST.
Coverage Duration	INITIAL/RENEWAL: 12 MONTHS.
Other Criteria	INITIAL: IPF: 1) DOES NOT HAVE OTHER KNOWN CAUSES OF INTERSTITIAL LUNG DISEASE (E.G., CONNECTIVE TISSUE DISEASE, DRUG TOXICITY, ASBESTOS OR BERYLLIUM EXPOSURE, HYPERSENSITIVITY PNEUMONITIS, SYSTEMIC SCLEROSIS, RHEUMATOID ARTHRITIS, RADIATION, SARCOIDOSIS, BRONCHIOLITIS OBLITERANS ORGANIZING PNEUMONIA, HUMAN IMMUNODEFICIENCY VIRUS (HIV) INFECTION, VIRAL HEPATITIS, CANCER), AND 2) TRIAL OF OR CONTRAINDICATION TO ONE OF THE FOLLOWING PREFERRED AGENTS: OFEV, PIRFENIDONE. PPF: 1) LUNG FUNCTION AND RESPIRATORY SYMPTOMS OR CHEST IMAGING HAVE WORSENERED/PROGRESSED DESPITE TREATMENT WITH MEDICATIONS USED IN CLINICAL PRACTICE FOR ILD (NOT ATTRIBUTABLE TO COMORBIDITIES SUCH AS INFECTION, HEART FAILURE), AND 2) TRIAL OF OR CONTRAINDICATION

Formulary ID: 26380

Effective: 08/01/2026

Updated: 07/21/2026

PA Criteria	Criteria Details
	TO THE PREFERRED AGENT: OFEV (NINTEDANIB). RENEWAL: IPF, PPF: CLINICAL MEANINGFUL IMPROVEMENT OR MAINTENANCE IN ANNUAL RATE OF DECLINE.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Formulary ID: 26380
 Effective: 08/01/2026
 Updated: 07/21/2026

NERATINIB

Products Affected

- NERLYNX

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

Formulary ID: 26380
 Effective: 08/01/2026
 Updated: 07/21/2026

NILOTINIB - TASIGNA

Products Affected

- nilotinib hcl oral capsule 150 mg, 200 mg, 50 mg*

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

Formulary ID: 26380
Effective: 08/01/2026
Updated: 07/21/2026

NILOTINIB-DANZITEN

Products Affected

- DANZITEN

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

Formulary ID: 26380
Effective: 08/01/2026
Updated: 07/21/2026

NINTEDANIB

Products Affected

- *nintedanib esylate*

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

Formulary ID: 26380

Effective: 08/01/2026

Updated: 07/21/2026

PA Criteria	Criteria Details
	MEDICATIONS USED IN CLINICAL PRACTICE FOR ILD (NOT ATTRIBUTABLE TO COMORBIDITIES SUCH AS INFECTION, HEART FAILURE). RENEWAL: IPF, SSC-ILD, PF-ILD: CLINICAL MEANINGFUL IMPROVEMENT OR MAINTENANCE IN ANNUAL RATE OF DECLINE.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Formulary ID: 26380
 Effective: 08/01/2026
 Updated: 07/21/2026

NIRAPARIB

Products Affected

- ZEJULA ORAL CAPSULE
- ZEJULA ORAL TABLET

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

Formulary ID: 26380
Effective: 08/01/2026
Updated: 07/21/2026

NIRAPARIB-ABIRATERONE

Products Affected

- AKEEGA

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

Formulary ID: 26380
 Effective: 08/01/2026
 Updated: 07/21/2026

NIROGACESTAT

Products Affected

- OGSIVEO ORAL TABLET 100 MG, 150 MG, 50 MG

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

Formulary ID: 26380
Effective: 08/01/2026
Updated: 07/21/2026

NIVOLUMAB

Products Affected

- OPDIVO

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

Formulary ID: 26380
Effective: 08/01/2026
Updated: 07/21/2026

NIVOLUMAB-HYALURONIDASE-NVHY

Products Affected

- OPDIVO QVANTIG

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

Formulary ID: 26380
Effective: 08/01/2026
Updated: 07/21/2026

NIVOLUMAB-RELATLIMAB-RMBW

Products Affected

- OPDUALAG

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

Formulary ID: 26380
Effective: 08/01/2026
Updated: 07/21/2026

NOGAPENDEKIN ALFA

Products Affected

- ANKTIVA

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

Formulary ID: 26380
Effective: 08/01/2026
Updated: 07/21/2026

OLAPARIB

Products Affected

- LYNPARZA ORAL TABLET

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

Formulary ID: 26380

Effective: 08/01/2026

Updated: 07/21/2026

OLUTASIDENIB

Products Affected

- REZLIDHIA

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

Formulary ID: 26380
Effective: 08/01/2026
Updated: 07/21/2026

OMACETAXINE

Products Affected

- SYNRIBO

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

Formulary ID: 26380
Effective: 08/01/2026
Updated: 07/21/2026

OMALIZUMAB

Products Affected

- XOLAIR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: ASTHMA: POSITIVE SKIN PRICK OR BLOOD TEST (E.G., ELISA, FEIA) TO A PERENNIAL AEROALLERGEN AND A BASELINE IGE SERUM LEVEL OF AT LEAST 30 IU/ML. FOOD ALLERGY: 1) IGE SERUM LEVEL OF AT LEAST 30 IU/ML, AND 2) POSITIVE SKIN PRICK TEST TO AT LEAST ONE FOOD, OR POSITIVE MEDICALLY MONITORED FOOD CHALLENGE TO AT LEAST ONE FOOD.
Age Restrictions	
Prescriber Restrictions	INITIAL/RENEWAL: CHRONIC SPONTANEOUS URTICARIA (CSU): PRESCRIBED BY OR IN CONSULTATION WITH AN ALLERGIST, DERMATOLOGIST, OR IMMUNOLOGIST. INITIAL: CHRONIC RHINOSINUSITIS WITH NASAL POLYPS (CRSWNP): PRESCRIBED BY OR IN CONSULTATION WITH AN OTOLARYNGOLOGIST, ALLERGIST OR IMMUNOLOGIST. ASTHMA: PRESCRIBED BY OR IN CONSULTATION WITH A PHYSICIAN SPECIALIZING IN ALLERGY OR PULMONARY MEDICINE. FOOD ALLERGY: PRESCRIBED BY OR IN CONSULTATION WITH ALLERGIST OR IMMUNOLOGIST.
Coverage Duration	INITIAL/RENEWAL: ASTHMA 12 MO/12 MO, CSU 6 MO/12 MO, CRSWNP 6 MO/12 MO, FOOD ALLERGY 12 MO/24 MO
Other Criteria	INITIAL: CSU: 1) TRIAL OF AND MAINTAINED ON, OR CONTRAINDICATION TO A SECOND GENERATION H1 ANTI-HISTAMINE, 2) STILL EXPERIENCES HIVES OR ANGIOEDEMA ON MOST DAYS OF THE WEEK FOR AT LEAST 6 WEEKS, AND 3) TRIAL OF OR CONTRAINDICATION TO THE PREFERRED AGENT: DUPIXENT. CRSWNP: 1) A 56 DAY TRIAL OF ONE TOPICAL NASAL CORTICOSTEROID, 2) TRIAL OF OR CONTRAINDICATION TO ONE OF THE FOLLOWING PREFERRED

Formulary ID: 26380

Effective: 08/01/2026

Updated: 07/21/2026

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

Formulary ID: 26380
Effective: 08/01/2026
Updated: 07/21/2026

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

Formulary ID: 26380
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 Updated: 07/21/2026

OSIMERTINIB

Products Affected

- TAGRISSO

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

Formulary ID: 26380
Effective: 08/01/2026
Updated: 07/21/2026

PACRITINIB

Products Affected

- VONJO

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

Formulary ID: 26380
Effective: 08/01/2026
Updated: 07/21/2026

PALBOCICLIB

Products Affected

- IBRANCE

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

Formulary ID: 26380
Effective: 08/01/2026
Updated: 07/21/2026

PASIREOTIDE DIASPARTATE

Products Affected

- SIGNIFOR

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

Formulary ID: 26380
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Updated: 07/21/2026

PAZOPANIB

Products Affected

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

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

Formulary ID: 26380
Effective: 08/01/2026
Updated: 07/21/2026

PEGFILGRASTIM - APGF

Products Affected

- NYVEPRIA

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

Formulary ID: 26380
Effective: 08/01/2026
Updated: 07/21/2026

PEGFILGRASTIM - CBQV

Products Affected

- UDENYCA ONBODY

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR IN CONSULTATION WITH A HEMATOLOGIST OR ONCOLOGIST.
Coverage Duration	12 MONTHS
Other Criteria	NON MYELOID MALIGNANCY: UDENYCA: TRIAL OF OR CONTRAINDICATION TO THE PREFERRED AGENT NYVEPRIA. UDENYCA ONBODY: 1) TRIAL OF OR CONTRAINDICATION TO THE PREFERRED AGENT NYVEPRIA, OR 2) BARRIER TO ACCESS (E.G., TRAVEL BARRIERS, UNABLE TO RETURN TO CLINIC FOR INJECTIONS).
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Formulary ID: 26380
Effective: 08/01/2026
Updated: 07/21/2026

PEGINTERFERON ALFA-2A

Products Affected

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

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

Formulary ID: 26380
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Updated: 07/21/2026

PEGVISOMANT

Products Affected

- SOMAVERT

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

Formulary ID: 26380
Effective: 08/01/2026
Updated: 07/21/2026

PEMBROLIZUMAB

Products Affected

- KEYTRUDA INTRAVENOUS SOLUTION

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

Formulary ID: 26380
 Effective: 08/01/2026
 Updated: 07/21/2026

PEMBROLIZUMAB-BERAHYALURONIDASE ALFA-PMPH

Products Affected

- KEYTRUDA QLEX

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

Formulary ID: 26380
Effective: 08/01/2026
Updated: 07/21/2026

PEMIGATINIB

Products Affected

- PEMAZYRE

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

Formulary ID: 26380
 Effective: 08/01/2026
 Updated: 07/21/2026

PENICILLAMINE TABLET

Products Affected

- *penicillamine oral tablet*

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

Formulary ID: 26380

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Updated: 07/21/2026

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

Formulary ID: 26380
 Effective: 08/01/2026
 Updated: 07/21/2026

PEXIDARTINIB

Products Affected

- TURALIO ORAL CAPSULE 125 MG

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

Formulary ID: 26380
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Updated: 07/21/2026

PIMAVANSERIN

Products Affected

- NUPLAZID ORAL CAPSULE
- NUPLAZID ORAL TABLET 10 MG

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

Formulary ID: 26380
 Effective: 08/01/2026
 Updated: 07/21/2026

PIRFENIDONE

Products Affected

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

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

Formulary ID: 26380
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 Updated: 07/21/2026

PA Criteria	Criteria Details
Prerequisite Therapy Required	No

Formulary ID: 26380
 Effective: 08/01/2026
 Updated: 07/21/2026

PIRTOBRUTINIB

Products Affected

- JAYPIRCA ORAL TABLET 100 MG, 50 MG

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

Formulary ID: 26380
Effective: 08/01/2026
Updated: 07/21/2026

POMALIDOMIDE

Products Affected

- *pomalidomide*
- POMALYST

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

Formulary ID: 26380
Effective: 08/01/2026
Updated: 07/21/2026

PONATINIB

Products Affected

- ICLUSIG

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

Formulary ID: 26380
Effective: 08/01/2026
Updated: 07/21/2026

POSACONAZOLE TABLET

Products Affected

- *posaconazole oral tablet delayed release*

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

Formulary ID: 26380
Effective: 08/01/2026
Updated: 07/21/2026

PRALSETINIB

Products Affected

- GAVRETO

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

Formulary ID: 26380
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Updated: 07/21/2026

PYRIMETHAMINE

Products Affected

- *pyrimethamine oral*

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

Formulary ID: 26380
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QUININE

Products Affected

- *quinine sulfate oral*

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

Formulary ID: 26380
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Updated: 07/21/2026

QUIZARTINIB

Products Affected

- VANFLYTA

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

Formulary ID: 26380
Effective: 08/01/2026
Updated: 07/21/2026

REGORAFENIB

Products Affected

- STIVARGA

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

Formulary ID: 26380
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Updated: 07/21/2026

RELUGOLIX

Products Affected

- ORGOVYX

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

Formulary ID: 26380
Effective: 08/01/2026
Updated: 07/21/2026

REPOTRECTINIB

Products Affected

- AUGTYRO ORAL CAPSULE 160 MG, 40 MG

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

Formulary ID: 26380
Effective: 08/01/2026
Updated: 07/21/2026

RESMETIROM

Products Affected

- REZDIFFRA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	NONALCOHOLIC STEATOHEPATITIS (NASH): INITIAL: DIAGNOSIS CONFIRMED BY BIOPSY OR NONINVASIVE TESTING, OBTAINED IN THE PAST 12 MONTHS, DEMONSTRATING: 1) LIVER FIBROSIS STAGE 2 OR 3, OR 2) NONALCOHOLIC FATTY LIVER DISEASE (NAFLD) ACTIVITY SCORE OF 4 OR MORE.
Age Restrictions	
Prescriber Restrictions	NASH: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A HEPATOLOGIST, GASTROENTEROLOGIST, OR ENDOCRINOLOGIST.
Coverage Duration	INITIAL/RENEWAL: 12 MONTHS
Other Criteria	NASH: RENEWAL: CONTINUES TO HAVE NONCIRRHOTIC NASH WITH MODERATE TO ADVANCED LIVER FIBROSIS (CONSISTENT WITH STAGES F2 TO F3 FIBROSIS).
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Formulary ID: 26380
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Updated: 07/21/2026

RETIFANLIMAB-DLWR

Products Affected

- ZYNYZ

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

Formulary ID: 26380
Effective: 08/01/2026
Updated: 07/21/2026

REVUMENIB

Products Affected

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

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

Formulary ID: 26380
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Updated: 07/21/2026

RIBOCICLIB

Products Affected

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

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

Formulary ID: 26380
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Updated: 07/21/2026

RIBOCICLIB-LETROZOLE

Products Affected

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

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

Formulary ID: 26380
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Updated: 07/21/2026

RIFAXIMIN

Products Affected

- XIFAXAN ORAL TABLET 200 MG, 550 MG

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

Formulary ID: 26380
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Updated: 07/21/2026

RILONACEPT

Products Affected

- ARCALYST

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

Formulary ID: 26380

Effective: 08/01/2026

Updated: 07/21/2026

PA Criteria	Criteria Details
	INHIBITOR, PDE-4 INHIBITOR) FOR CAPS. DIRA: 1) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR DIRA, AND 2) TRIAL OF THE PREFERRED AGENT: KINERET. RP: 1) HAD AN EPISODE OF ACUTE PERICARDITIS, 2) SYMPTOM-FREE FOR 4 TO 6 WEEKS, AND 3) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR RP.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Formulary ID: 26380
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 Updated: 07/21/2026

RIMEGEPANT

Products Affected

- NURTEC

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

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PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

Formulary ID: 26380
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RIOCIGUAT

Products Affected

- ADEMPAS

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

Formulary ID: 26380

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Updated: 07/21/2026

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

Formulary ID: 26380
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 Updated: 07/21/2026

RIPRETINIB

Products Affected

- QINLOCK

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

Formulary ID: 26380
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Updated: 07/21/2026

RISANKIZUMAB-RZAA

Products Affected

- SKYRIZI INTRAVENOUS
- SKYRIZI PEN
- SKYRIZI SUBCUTANEOUS SOLUTION CARTRIDGE
- SKYRIZI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML

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

Formulary ID: 26380

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Updated: 07/21/2026

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

Formulary ID: 26380
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 Updated: 07/21/2026

RITUXIMAB AND HYALURONIDASE HUMAN-SQ

Products Affected

- RITUXAN HYCELA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	FOLLICULAR LYMPHOMA (FL), DIFFUSE LARGE B-CELL LYMPHOMA (DLBCL), CHRONIC LYMPHOCYTIC LEUKEMIA (CLL): 1) HAS RECEIVED OR WILL RECEIVE AT LEAST ONE FULL DOSE OF A RITUXIMAB PRODUCT BY INTRAVENOUS INFUSION PRIOR TO INITIATION OF RITUXIMAB AND HYALURONIDASE, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR THE SAME INDICATION.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Formulary ID: 26380
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Updated: 07/21/2026

RITUXIMAB-ABBS

Products Affected

- TRUXIMA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	INITIAL: RHEUMATOID ARTHRITIS (RA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST. NON-HODGKINS LYMPHOMA (NHL), CHRONIC LYMPHOCYTIC LEUKEMIA (CLL): PRESCRIBED BY OR IN CONSULTATION WITH AN ONCOLOGIST.
Coverage Duration	RA: INITIAL: 6 MO, RENEWAL: 12 MO. NHL, GPA, MPA, PV: 12 MO. CLL: 6 MO.
Other Criteria	INITIAL: ALL INDICATIONS: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR THE SAME INDICATION. RA: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA/CYLTEZO/YUFLYMA/HADLIMA, XELJANZ, RINVOQ, ORENCIA. RENEWAL: RA: 1) CONTINUES TO BENEFIT FROM THE MEDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR THE SAME INDICATION.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Formulary ID: 26380

Effective: 08/01/2026

Updated: 07/21/2026

PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

Formulary ID: 26380
 Effective: 08/01/2026
 Updated: 07/21/2026

ROPEGINTERFERON ALFA-2B-NJFT

Products Affected

- BESREMI

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

Formulary ID: 26380
Effective: 08/01/2026
Updated: 07/21/2026

RUCAPARIB

Products Affected

- RUBRACA

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

Formulary ID: 26380
 Effective: 08/01/2026
 Updated: 07/21/2026

RUXOLITINIB

Products Affected

- JAKAFI
- JAKAFI XR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	MYELOFIBROSIS: INITIAL: 6 MONTHS, RENEWAL: 12 MONTHS. POLYCYTHEMIA VERA, GVHD: 12 MONTHS.
Other Criteria	INITIAL: CHRONIC GRAFT VS HOST DISEASE (CGVHD): NO CONCURRENT USE WITH REZUROCK, NIKTIMVO, OR IMBRUVICA. RENEWAL: MYELOFIBROSIS: CONTINUES TO BENEFIT FROM THE MEDICATION. CGVHD: NO CONCURRENT USE WITH REZUROCK, NIKTIMVO, OR IMBRUVICA.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Formulary ID: 26380
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Updated: 07/21/2026

SAPROPTERIN

Products Affected

- *javygtor oral tablet*
- *sapropterin dihydrochloride oral tablet*

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

Formulary ID: 26380
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 Updated: 07/21/2026

SECUKINUMAB SQ

Products Affected

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

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

Formulary ID: 26380

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Updated: 07/21/2026

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

Formulary ID: 26380
 Effective: 08/01/2026
 Updated: 07/21/2026

SELEXIPAG

Products Affected

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

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

Formulary ID: 26380

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Updated: 07/21/2026

SELINEXOR

Products Affected

- XPOVIO (100 MG ONCE WEEKLY)
ORAL TABLET THERAPY PACK 50 MG
- XPOVIO (40 MG ONCE WEEKLY)
ORAL TABLET THERAPY PACK 10 MG, 40 MG
- XPOVIO (40 MG TWICE WEEKLY)
ORAL TABLET THERAPY PACK 40 MG
- XPOVIO (60 MG ONCE WEEKLY)
ORAL TABLET THERAPY PACK 60 MG
- XPOVIO (60 MG TWICE WEEKLY)
- XPOVIO (80 MG ONCE WEEKLY)
ORAL TABLET THERAPY PACK 40 MG, 80 MG
- XPOVIO (80 MG TWICE WEEKLY)

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

Formulary ID: 26380
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SELPERCATINIB

Products Affected

- RETEVMO ORAL CAPSULE 40 MG, 80 MG
- RETEVMO ORAL TABLET 120 MG, 160 MG, 40 MG, 80 MG

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

Formulary ID: 26380
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Updated: 07/21/2026

SELUMETINIB

Products Affected

- KOSELUGO ORAL CAPSULE 10 MG, 25 MG
- KOSELUGO ORAL CAPSULE SPRINKLE 5 MG, 7.5 MG

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

Formulary ID: 26380
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SEVABERTINIB

Products Affected

- HYRNUO

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

Formulary ID: 26380
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Updated: 07/21/2026

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

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PA Criteria	Criteria Details
Prerequisite Therapy Required	No

Formulary ID: 26380
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SIROLIMUS PROTEIN-BOUND

Products Affected

- FYARRO

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

Formulary ID: 26380
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Updated: 07/21/2026

SODIUM OXYBATE-XYREM

Products Affected

- sodium oxybate*

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

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PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

Formulary ID: 26380
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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, TIPRANA VIR/RITONAVIR, TOPOTECAN, SOVALDI (AS A SINGLE AGENT), HARVONI, ZEPATIER, MAVYRET, OR VOSEVI, AND 3) PATIENTS WITH DECOMPENSATED CIRRHOSIS REQUIRE CONCURRENT RIBAVIRIN UNLESS RIBAVIRIN INELIGIBLE.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

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PA Criteria	Criteria Details
Prerequisite Therapy Required	No

Formulary ID: 26380
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 Updated: 07/21/2026

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

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PA Criteria	Criteria Details
Prerequisite Therapy Required	No

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SOMATROPIN - NORDITROPIN

Products Affected

- NORDITROPIN FLEXPRO
SUBCUTANEOUS SOLUTION PEN-
INJECTOR

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

Formulary ID: 26380

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PA Criteria	Criteria Details
Coverage Duration	INITIAL/RENEWAL: 12 MONTHS.
Other Criteria	INITIAL: PEDIATRIC GHD, ISS, SGA, TS, NOONAN SYNDROME: OPEN EPIPHYSES AS CONFIRMED BY RADIOGRAPH OF THE WRIST AND HAND. INITIAL/RENEWAL: ADULT GHD, PEDIATRIC GHD, SGA, TS, PWS, NOONAN SYNDROME: NO CONCURRENT USE WITH INCRELEX. RENEWAL: ISS: 1) IMPROVEMENT WHILE ON THERAPY (INCREASED HEIGHT OR INCREASED GROWTH VELOCITY), AND 2) OPEN EPIPHYSES AS CONFIRMED BY RADIOGRAPH OF THE WRIST AND HAND. PEDIATRIC GHD, SGA, TS, NOONAN SYNDROME: 1) IMPROVEMENT WHILE ON THERAPY (INCREASED HEIGHT OR INCREASED GROWTH VELOCITY), AND 2) OPEN EPIPHYSES AS CONFIRMED BY RADIOGRAPH OF THE WRIST AND HAND OR HAS NOT COMPLETED PREPUBERTAL GROWTH. PWS: IMPROVEMENT IN BODY COMPOSITION.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Formulary ID: 26380
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SOMATROPIN - SEROSTIM

Products Affected

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

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

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Updated: 07/21/2026

PA Criteria	Criteria Details
Prerequisite Therapy Required	No

Formulary ID: 26380
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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
Prerequisite Therapy Required	No

Formulary ID: 26380
Effective: 08/01/2026
Updated: 07/21/2026

SORAFENIB

Products Affected

- *sorafenib tosylate*

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

Formulary ID: 26380
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Updated: 07/21/2026

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

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PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

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SOTORASIB

Products Affected

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

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

Formulary ID: 26380
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STIRIPENTOL

Products Affected

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

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

Formulary ID: 26380
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Updated: 07/21/2026

SUNITINIB

Products Affected

- *sunitinib malate*

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

Formulary ID: 26380
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Updated: 07/21/2026

TADALAFIL - ADCIRCA, ALYQ

Products Affected

- *alyq*

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

Formulary ID: 26380

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Updated: 07/21/2026

TADALAFIL-CIALIS

Products Affected

- *tadalafil oral tablet 2.5 mg, 5 mg*

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

Formulary ID: 26380
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 Updated: 07/21/2026

TAFAMIDIS

Products Affected

- VYNDAMAX

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

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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

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PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

Formulary ID: 26380
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 Updated: 07/21/2026

TALETRECTINIB

Products Affected

- IBTROZI

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

Formulary ID: 26380
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TALQUETAMAB-TGVS

Products Affected

- TALVEY

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

Formulary ID: 26380
Effective: 08/01/2026
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TARLATAMAB-DLLE

Products Affected

- IMDELLTRA

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

Formulary ID: 26380
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TEBENTAFUSP-TEBN

Products Affected

- KIMMTRAK

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

Formulary ID: 26380
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TECLISTAMAB-CQYV

Products Affected

- TECVAYLI

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

Formulary ID: 26380
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Updated: 07/21/2026

TELISOTUZUMAB VEDOTIN-TLLV

Products Affected

- EMRELIS

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

Formulary ID: 26380
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Updated: 07/21/2026

TELOTRISTAT

Products Affected

- XERMELO

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

Formulary ID: 26380
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TEPOTINIB

Products Affected

- TEPMETKO

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

Formulary ID: 26380
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TERIPARATIDE

Products Affected

- *teriparatide subcutaneous solution pen-injector 560 mcg/2.24ml*

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

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TESTOSTERONE

Products Affected

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

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

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Updated: 07/21/2026

TESTOSTERONE CYPIONATE - DEPO

Products Affected

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

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

Formulary ID: 26380

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Updated: 07/21/2026

TESTOSTERONE ENANTHATE

Products Affected

- *testosterone enanthate intramuscular solution*

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

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PA Criteria	Criteria Details
Prerequisite Therapy Required	No

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TETRABENAZINE

Products Affected

- tetrabenazine*

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

Formulary ID: 26380
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Updated: 07/21/2026

THALIDOMIDE

Products Affected

- THALOMID ORAL CAPSULE 100 MG, 150 MG, 200 MG, 50 MG

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

Formulary ID: 26380
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TISLELIZUMAB-JSGR

Products Affected

- TEVIMBRA

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

Formulary ID: 26380
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TISOTUMAB VEDOTIN-TFTV

Products Affected

- TIVDAK

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

Formulary ID: 26380
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Updated: 07/21/2026

TIVOZANIB

Products Affected

- FOTIVDA

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

Formulary ID: 26380
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Updated: 07/21/2026

TOCILIZUMAB-AAZG IV

Products Affected

- TYENNE

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

Formulary ID: 26380

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Updated: 07/21/2026

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

Formulary ID: 26380
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 Updated: 07/21/2026

TOCILIZUMAB-AAZG SQ

Products Affected

- TYENNE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	INITIAL: RHEUMATOID ARTHRITIS (RA), POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS (PJIA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST. SYSTEMIC JUVENILE IDIOPATHIC ARTHRITIS (SJIA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST, DERMATOLOGIST, OR IMMUNOLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS
Other Criteria	INITIAL: RA: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA/CYLTEZO/YUFLYMA/HADLIMA, XELJANZ, RINVOQ, ORENCIA. GIANT CELL ARTERITIS (GCA): 1) HAS COMPLETED, STARTED, OR WILL SOON START A TAPERING COURSE OF GLUCOCORTICOID, AND 2) TRIAL OF OR CONTRAINDICATION TO THE PREFERRED AGENT: RINVOQ. PJIA: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA/CYLTEZO/YUFLYMA/HADLIMA, XELJANZ IR, ORENCIA, RINVOQ. INITIAL/RENEWAL: ALL INDICATIONS: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR THE SAME INDICATION. RENEWAL: RA, PJIA, SJIA: CONTINUES TO BENEFIT FROM THE MEDICATION.
Indications	All FDA-approved Indications.

Formulary ID: 26380

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

Formulary ID: 26380
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TOFACITINIB

Products Affected

- *tofacitinib citrate er*
- *tofacitinib citrate oral*
- XELJANZ
- XELJANZ XR

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

Formulary ID: 26380

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

Formulary ID: 26380
 Effective: 08/01/2026
 Updated: 07/21/2026

TOLVAPTAN

Products Affected

- JYNARQUE ORAL TABLET
- tolvaptan oral tablet therapy pack*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	AUTOSOMAL DOMINANT POLYCYSTIC KIDNEY DISEASE (ADPKD): INITIAL: CONFIRMED POLYCYSTIC KIDNEY DISEASE VIA CT, MRI, OR ULTRASOUND.
Age Restrictions	
Prescriber Restrictions	ADPKD: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A NEPHROLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	ADPKD: INITIAL: DOES NOT HAVE ESRD (I.E., RECEIVING DIALYSIS). RENEWAL: HAS NOT PROGRESSED TO ESRD/DIALYSIS.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Formulary ID: 26380
 Effective: 08/01/2026
 Updated: 07/21/2026

TOPICAL TRETINOIN

Products Affected

- ALTRENO
- tretinoin external cream*

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

Formulary ID: 26380
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Updated: 07/21/2026

TORIPALIMAB-TPZI

Products Affected

- LOQTORZI

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

Formulary ID: 26380
Effective: 08/01/2026
Updated: 07/21/2026

TOVORAFENIB

Products Affected

- OJEMDA ORAL SUSPENSION RECONSTITUTED
- OJEMDA ORAL TABLET

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

Formulary ID: 26380
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Updated: 07/21/2026

TRAMETINIB SOLUTION

Products Affected

- MEKINIST ORAL SOLUTION
RECONSTITUTED

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

Formulary ID: 26380
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Updated: 07/21/2026

TRAMETINIB TABLET

Products Affected

- MEKINIST ORAL TABLET 0.5 MG, 2 MG

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

Formulary ID: 26380
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Updated: 07/21/2026

TRASTUZUMAB-DKST

Products Affected

- OGIVRI

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

Formulary ID: 26380
Effective: 08/01/2026
Updated: 07/21/2026

TRASTUZUMAB-HYALURONIDASE-OYSK

Products Affected

- HERCEPTIN HYLECTA

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

Formulary ID: 26380
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Updated: 07/21/2026

TRAZODONE

Products Affected

- RALDESY

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

Formulary ID: 26380
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Updated: 07/21/2026

TREMELIMUMAB-ACTL

Products Affected

- IMJUDO

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

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TRIENTINE CAPSULE

Products Affected

- *trientine hcl oral capsule 250 mg*

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

Formulary ID: 26380
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TRIFLURIDINE/TIPIRACIL

Products Affected

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

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

Formulary ID: 26380
Effective: 08/01/2026
Updated: 07/21/2026

TRIPTORELIN-TRELSTAR

Products Affected

- TRELSTAR MIXJECT

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

Formulary ID: 26380
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Updated: 07/21/2026

TUCATINIB

Products Affected

- TUKYSA ORAL TABLET 150 MG, 50 MG

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

Formulary ID: 26380
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Updated: 07/21/2026

UBROGEPANT

Products Affected

- UBRELVY

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

Formulary ID: 26380

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Updated: 07/21/2026

UPADACITINIB

Products Affected

- RINVOQ
- RINVOQ LQ

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: NON-RADIOGRAPHIC AXIAL SPONDYLOARTHRITIS (NR-AXSPA): 1) C-REACTIVE PROTEIN LEVELS ABOVE THE UPPER LIMIT OF NORMAL, OR 2) SACROILIITIS ON MAGNETIC RESONANCE IMAGING (MRI).
Age Restrictions	
Prescriber Restrictions	INITIAL: RHEUMATOID ARTHRITIS (RA), ANKYLOSING SPONDYLITIS (AS), NR-AXSPA, POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS (PJIA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST. PSORIATIC ARTHRITIS (PSA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST OR DERMATOLOGIST. AD: PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST, ALLERGIST, OR IMMUNOLOGIST. ULCERATIVE COLITIS (UC), CROHNS DISEASE (CD): PRESCRIBED BY OR IN CONSULTATION WITH A GASTROENTEROLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	INITIAL: RA: TRIAL OF OR CONTRAINDICATION TO 3 MONTHS OF TREATMENT WITH ONE CONVENTIONAL SYNTHETIC DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG) - IF A PATIENT TRIED METHOTREXATE, THEN TRIAL AT A DOSE OF AT LEAST 20 MG PER WEEK OR MAXIMALLY TOLERATED DOSE IS REQUIRED. AD: 1) INTRACTABLE PRURITUS OR CRACKING/OOZING/BLEEDING OF AFFECTED SKIN, AND 2) TRIAL OF OR CONTRAINDICATION TO A TOPICAL CORTICOSTEROID, TOPICAL CALCINEURIN INHIBITOR, TOPICAL PDE4 INHIBITOR, OR TOPICAL JAK INHIBITOR. AS,

Formulary ID: 26380

Effective: 08/01/2026

Updated: 07/21/2026

PA Criteria	Criteria Details
	NR-AXSPA: TRIAL OF OR CONTRAINDICATION TO AN NSAID (NON-STEROIDAL ANTI-INFLAMMATORY DRUG). GIANT CELL ARTERITIS (GCA): HAS COMPLETED, STARTED, OR WILL SOON START A TAPERING COURSE OF GLUCOCORTICOID. INITIAL/RENEWAL: ALL INDICATIONS: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR THE SAME INDICATION. RENEWAL: RA, PSA, AS, NR-AXSPA, PJIA: CONTINUES TO BENEFIT FROM THE MEDICATION. AD: IMPROVEMENT WHILE ON THERAPY.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Formulary ID: 26380
Effective: 08/01/2026
Updated: 07/21/2026

USTEKINUMAB-AAUZ SQ

Products Affected

- ustekinumab-aauz*

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

Formulary ID: 26380

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

Formulary ID: 26380
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 Updated: 07/21/2026

USTEKINUMAB-AEKN IV

Products Affected

- SELARSDI

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

Formulary ID: 26380

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Updated: 07/21/2026

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

Formulary ID: 26380
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 Updated: 07/21/2026

USTEKINUMAB-AEKN SQ

Products Affected

- SELARSDI

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

Formulary ID: 26380

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

Formulary ID: 26380
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USTEKINUMAB-KFCE IV

Products Affected

- YESINTEK

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

Formulary ID: 26380

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

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USTEKINUMAB-KFCE SQ

Products Affected

- YESINTEK

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

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

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VALBENAZINE

Products Affected

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

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

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VANDETANIB

Products Affected

- CAPRELSA ORAL TABLET 100 MG, 300 MG

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

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VEMURAFENIB

Products Affected

- ZELBORAF

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

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VENETOCLAX

Products Affected

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

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

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VERICIGUAT

Products Affected

- VERQUVO

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

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VIGABATRIN

Products Affected

- *vigabatrín*
- *vigadrone*
- *vigpoder*

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

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VIMSELTINIB

Products Affected

- ROMVIMZA

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

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VISMODEGIB

Products Affected

- ERIVEDGE

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

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VONOPRAZAN

Products Affected

- VOQUEZNA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL: H PYLORI: 30 DAYS. EE: 8 WEEKS. NERD: 4 WEEKS. RENEWAL: EE: 24 WEEKS.
Other Criteria	INITIAL: EROSION ESOPHAGITIS (EE): TRIAL OF OR CONTRAINDICATION TO TWO PROTON PUMP INHIBITORS AT MAXIMUM DOSE FOR 8 WEEKS EACH. NON-EROSIVE GASTROESOPHAGEAL REFLUX DISEASE (NERD): 1) NO PREVIOUS TREATMENT FAILURE WITH VOQUEZNA IN THE LAST 12 MONTHS, AND 2) TRIAL OF OR CONTRAINDICATION TO ONE PROTON PUMP INHIBITOR AT MAXIMUM DOSE FOR 8 WEEKS. RENEWAL: EE: MAINTAINED A CLINICAL RESPONSE ON VOQUEZNA.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

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VORASIDENIB

Products Affected

- VORANIGO

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

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VORICONAZOLE SUSPENSION

Products Affected

- *voriconazole oral suspension reconstituted*

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

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ZANIDATAMAB-HR11

Products Affected

- Z11HERA

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

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Effective: 08/01/2026
Updated: 07/21/2026

ZANUBRUTINIB

Products Affected

- BRUKINSA ORAL CAPSULE
- BRUKINSA ORAL TABLET

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

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ZENOCUTUZUMAB-ZBCO

Products Affected

- BIZENGRI (750 MG DOSE)

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

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ZIFTOMENIB

Products Affected

- KOMZIFTI

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

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ZOLBETUXIMAB-CLZB

Products Affected

- VYLOY

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

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Updated: 07/21/2026

ZONGERTINIB

Products Affected

- HERNEXEOS

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

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ZURANOLONE

Products Affected

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

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

Formulary ID: 26380
Effective: 08/01/2026
Updated: 07/21/2026

INDEX

1

1ST TIER UNIFINE PENTIPS 29G X
12MM 166, 189
1ST TIER UNIFINE PENTIPS 31G X 5
MM 166, 189
1ST TIER UNIFINE PENTIPS 31G X 6
MM 166, 189
1ST TIER UNIFINE PENTIPS 31G X 8
MM 166, 189
1ST TIER UNIFINE PENTIPS 32G X 4
MM 166, 189
1ST TIER UNIFINE PENTIPS 32G X 6
MM 166, 189
1ST TIER UNIFINE PENTIPS 33G X 4
MM 166, 189
1ST TIER UNIFINE PENTIPS PLUS 29G
X 12MM..... 166, 189
1ST TIER UNIFINE PENTIPS PLUS 31G
X 5 MM..... 166, 189
1ST TIER UNIFINE PENTIPS PLUS 31G
X 6 MM..... 166, 189
1ST TIER UNIFINE PENTIPS PLUS 31G
X 8 MM..... 166, 189
1ST TIER UNIFINE PENTIPS PLUS 32G
X 4 MM..... 166, 189
1ST TIER UNIFINE PENTIPS PLUS 33G
X 4 MM..... 166, 189

A

abigale 147
abiraterone acetate 7
ABIRATERONE ACETATE
MICRONIZED 8
abirtega..... 7
ABOUTTIME PEN NEEDLE 30G X 8 MM
..... 166, 189
ABOUTTIME PEN NEEDLE 31G X 5 MM
..... 166, 189
ABOUTTIME PEN NEEDLE 31G X 8 MM
..... 166, 189
ABOUTTIME PEN NEEDLE 32G X 4 MM
..... 166, 189
ACTIMMUNE..... 192
adalimumab-aaty (1 pen) auto-injector kit 40
mg/0.4ml subcutaneous..... 14, 15

adalimumab-aaty (1 pen) subcutaneous auto-
injector kit 80 mg/0.8ml..... 14, 15
adalimumab-aaty (2 pen) 14, 15
adalimumab-aaty (2 syringe) 14, 15
adalimumab-aaty cd/uc/hs start..... 14, 15
ADEMPAS 300, 301
ADVOCATE ALCOHOL PREP PADS
PAD 70 % 166, 189
ADVOCATE INSULIN PEN NEEDLE 32G
X 4 MM..... 166, 189
ADVOCATE INSULIN PEN NEEDLES
29G X 12.7MM..... 166, 189
ADVOCATE INSULIN PEN NEEDLES
31G X 5 MM..... 166, 189
ADVOCATE INSULIN PEN NEEDLES
31G X 8 MM..... 166, 189
ADVOCATE INSULIN PEN NEEDLES
33G X 4 MM..... 166, 189
ADVOCATE INSULIN SYRINGE 29G X
1/2 166, 189
ADVOCATE INSULIN SYRINGE 30G X
5/16 166, 189
ADVOCATE INSULIN SYRINGE 31G X
5/16 166, 189
AIMOVIG..... 112
AKEEGA 249
ALCOHOL PADS PAD 70 %..... 166, 189
ALCOHOL PREP PAD..... 166, 189
ALCOHOL PREP PAD 70 %..... 166, 189
ALCOHOL PREP PADS PAD 70 % 166,
189
ALCOHOL SWABS PAD..... 166, 189
ALCOHOL SWABS PAD 70 % 166, 189
ALECENSA..... 21
ALTRENO..... 365
ALUNBRIG ORAL TABLET 180 MG, 30
MG, 90 MG..... 54
ALUNBRIG ORAL TABLET THERAPY
PACK..... 54
ALVAIZ..... 99
alyq..... 337
ANKTIVA 254
AQ INSULIN SYRINGE 29G X 1/2..... 166,
189

AQ INSULIN SYRINGE 30G X 5/16... 166, 189
 AQ INSULIN SYRINGE 31G X 5/16... 166, 189
 AQINJECT PEN NEEDLE 31G X 5 MM 166, 189
 AQINJECT PEN NEEDLE 32G X 4 MM 167, 189
 ARCALYST 296, 297
 ARIKAYCE 23
 armodafinil 239
 ASSURE ID DUO PRO PEN NEEDLES 31G X 5 MM 167, 189
 ASSURE ID INSULIN SAFETY SYR 29G X 1/2 167, 189
 ASSURE ID PRO PEN NEEDLES 30G X 5 MM 167, 189
 ASSURE ID SAFETY PEN NEEDLES 30G X 8 MM 167, 189
 ATTRUBY 10
 AUGTYRO ORAL CAPSULE 160 MG, 40 MG 289
 AUM ALCOHOL PREP PADS PAD 70 % 167, 189
 AUM INSULIN SAFETY PEN NEEDLE 31G X 4 MM 167, 189
 AUM INSULIN SAFETY PEN NEEDLE 31G X 5 MM 167, 189
 AUM MINI INSULIN PEN NEEDLE 32G X 4 MM 167, 189
 AUM MINI INSULIN PEN NEEDLE 32G X 5 MM 167, 189
 AUM MINI INSULIN PEN NEEDLE 32G X 6 MM 167, 189
 AUM MINI INSULIN PEN NEEDLE 32G X 8 MM 167, 189
 AUM MINI INSULIN PEN NEEDLE 33G X 4 MM 167, 189
 AUM MINI INSULIN PEN NEEDLE 33G X 5 MM 167, 189
 AUM MINI INSULIN PEN NEEDLE 33G X 6 MM 167, 189
 AUM PEN NEEDLE 32G X 4 MM 167, 189
 AUM PEN NEEDLE 32G X 5 MM 167, 189
 AUM PEN NEEDLE 32G X 6 MM 167, 189
 AUM PEN NEEDLE 33G X 4 MM 167, 189

AUM PEN NEEDLE 33G X 5 MM 167, 189
 AUM PEN NEEDLE 33G X 6 MM 167, 189
 AUM READYGARD DUO PEN NEEDLE 32G X 4 MM 167, 189
 AUM SAFETY PEN NEEDLE 31G X 4 MM 167, 189
 AUM SAFETY PEN NEEDLE 31G X 5 MM 167, 189
 AURORA PEN NEEDLES 29G X 12MM 167, 189
 AURORA PEN NEEDLES 31G X 6 MM 167, 189
 AURORA PEN NEEDLES 31G X 8 MM 167, 189
 AUSTEDO ORAL TABLET 12 MG, 6 MG, 9 MG 81
 AUSTEDO XR ORAL TABLET EXTENDED RELEASE 24 HOUR 12 MG, 18 MG, 24 MG, 30 MG, 36 MG, 42 MG, 48 MG, 6 MG 81
 AUSTEDO XR PATIENT TITRATION . 81
 AVMAPKI FAKZYNJA CO-PACK 37
 AVONEX PEN INTRAMUSCULAR AUTO-INJECTOR KIT 190
 AVONEX PREFILLED INTRAMUSCULAR PREFILLED SYRINGE KIT 190
 AYVAKIT 36
B
 BALVERSA ORAL TABLET 3 MG, 4 MG, 5 MG 111
 BD AUTOSHIELD DUO 30G X 5 MM 167, 189
 BD ECLIPSE SYRINGE 30G X 1/2 167, 189
 BD INS SYR ULTRAFINE 1/2UNIT 31G X 5/16 167, 189
 BD INSULIN SYR ULTRAFINE II 31G X 5/16 167, 189
 BD INSULIN SYRINGE 27.5G X 5/8.. 167, 189
 BD INSULIN SYRINGE 27G X 1/2 167, 189
 BD INSULIN SYRINGE 29G X 1/2 167, 189

BD INSULIN SYRINGE HALF-UNIT 31G
X 5/16..... 167, 189

BD INSULIN SYRINGE MICROFINE 27G
X 5/8..... 167, 189

BD INSULIN SYRINGE MICROFINE 28G
X 1/2..... 167, 189

BD INSULIN SYRINGE U/F 30G X 1/2
..... 167, 189

BD INSULIN SYRINGE U-100 1 ML . 167,
189

BD INSULIN SYRINGE ULTRAFINE 29G
X 1/2..... 167, 189

BD INSULIN SYRINGE ULTRAFINE 30G
X 1/2..... 167, 168, 189

BD INSULIN SYRINGE ULTRAFINE 31G
X 5/16..... 168, 189

BD PEN NEEDLE MICRO ULTRAFINE
32G X 6 MM..... 168, 189

BD PEN NEEDLE MINI U/F 31G X 5 MM
..... 168, 189

BD PEN NEEDLE MINI ULTRAFINE 31G
X 5 MM..... 168, 189

BD PEN NEEDLE NANO 2ND GEN 32G
X 4 MM..... 168, 189

BD PEN NEEDLE NANO ULTRAFINE
32G X 4 MM..... 168, 189

BD PEN NEEDLE ORIG ULTRAFINE
29G X 12.7MM..... 168, 189

BD PEN NEEDLE SHORT ULTRAFINE
31G X 8 MM..... 168, 189

BD SAFETYGLIDE INSULIN SYRINGE
29G X 1/2..... 168, 189

BD SAFETYGLIDE INSULIN SYRINGE
30G X 5/16..... 168, 189

BD SAFETYGLIDE INSULIN SYRINGE
31G X 15/64..... 168, 189

BD SAFETYGLIDE INSULIN SYRINGE
31G X 5/16..... 168, 189

BD SAFETYGLIDE SYRINGE/NEEDLE
27G X 5/8..... 168, 189

BD SWAB SINGLE USE REGULAR PAD
..... 168, 189

BD VEO INSULIN SYR U/F 1/2UNIT 31G
X 15/64..... 168, 189

BD VEO INSULIN SYR ULTRAFINE 31G
X 15/64..... 168, 189

BD VEO INSULIN SYRINGE U/F 31G X
15/64 168, 189

BENDAMUSTINE HCL INTRAVENOUS
SOLUTION..... 46

bendamustine hcl intravenous solution
reconstituted..... 46

BENDEKA 46

BENLYSTA SUBCUTANEOUS..... 43

BESREMI 308

BETASERON SUBCUTANEOUS KIT 191

bexarotene 49

BIZENGRI (750 MG DOSE) 404

BORTEZOMIB INJECTION SOLUTION
RECONSTITUTED 1 MG, 2.5 MG 51

bortezomib injection solution reconstituted
3.5 mg 51

BORUZU 51

bosentan oral tablet 52

BOSULIF ORAL CAPSULE 100 MG, 50
MG 53

BOSULIF ORAL TABLET 100 MG, 400
MG, 500 MG..... 53

bosutinib oral tablet 100 mg, 400 mg, 500
mg 53

BRAFTOVI ORAL CAPSULE 75 MG . 103

BRUKINSA ORAL CAPSULE 403

BRUKINSA ORAL TABLET..... 403

butalbital-apap-caff-cod oral capsule 50-
325-40-30 mg..... 145

butalbital-apap-caffeine oral capsule 145

butalbital-apap-caffeine oral tablet 50-325-
40 mg 145

C

CABOMETYX ORAL TABLET 20 MG, 40
MG, 60 MG..... 57

CALQUENCE ORAL TABLET 9

CAMCEVI 209

CAMZYOS..... 225

CAPRELSA ORAL TABLET 100 MG, 300
MG 392

CAREFINE PEN NEEDLES 29G X 12MM
..... 168, 189

CAREFINE PEN NEEDLES 30G X 8 MM
..... 168, 189

CAREFINE PEN NEEDLES 31G X 6 MM
..... 168, 189

CAREFINE PEN NEEDLES 31G X 8 MM 168, 189

CAREFINE PEN NEEDLES 32G X 4 MM 168, 189

CAREFINE PEN NEEDLES 32G X 5 MM 168, 189

CAREFINE PEN NEEDLES 32G X 6 MM 168, 189

CAREONE INSULIN SYRINGE 30G X 1/2 168, 189

CAREONE INSULIN SYRINGE 31G X 5/16 168, 189

CAREONE UNIFINE PENTIPS PLUS 29G X 12MM..... 168, 189

CAREONE UNIFINE PENTIPS PLUS 31G X 5 MM..... 168, 189

CAREONE UNIFINE PENTIPS PLUS 31G X 6 MM..... 168, 189

CAREONE UNIFINE PENTIPS PLUS 31G X 8 MM..... 168, 189

CAREONE UNIFINE PENTIPS PLUS 32G X 4 MM..... 169, 189

CAREONE UNIFINE PENTIPS PLUS 33G X 4 MM..... 169, 189

CARETOUCH ALCOHOL PREP PAD 70 % 169, 189

CARETOUCH INSULIN SYRINGE 28G X 5/16 169, 189

CARETOUCH INSULIN SYRINGE 29G X 5/16 169, 189

CARETOUCH INSULIN SYRINGE 30G X 5/16 169, 189

CARETOUCH INSULIN SYRINGE 31G X 5/16 169, 189

CARETOUCH PEN NEEDLES 29G X 12MM 169, 189

CARETOUCH PEN NEEDLES 31G X 5 MM 169, 189

CARETOUCH PEN NEEDLES 31G X 6 MM 169, 189

CARETOUCH PEN NEEDLES 31G X 8 MM 169, 189

CARETOUCH PEN NEEDLES 32G X 4 MM 169, 189

CARETOUCH PEN NEEDLES 32G X 5 MM 169, 189

CARETOUCH PEN NEEDLES 33G X 4 MM 169, 189

carglumic acid oral tablet soluble 61

CAYSTON..... 41

CIMZIA (1 SYRINGE) 63, 64

CIMZIA (2 SYRINGE) 63, 64

CIMZIA SUBCUTANEOUS KIT 2 X 200 MG 63, 64

CIMZIA-STARTER 63, 64

CLEVER CHOICE COMFORT EZ 29G X 12MM 169, 189

CLEVER CHOICE COMFORT EZ 33G X 4 MM 169, 189

CLICKFINE PEN NEEDLES 31G X 5 MM 169, 189

CLICKFINE PEN NEEDLES 31G X 6 MM 169, 189

CLICKFINE PEN NEEDLES 31G X 8 MM 169, 189

CLICKFINE PEN NEEDLES 32G X 4 MM 169, 189

COMETRIQ (100 MG DAILY DOSE) ORAL KIT 80 & 20 MG 56

COMETRIQ (140 MG DAILY DOSE) ORAL KIT 3 X 20 MG & 80 MG 56

COMETRIQ (60 MG DAILY DOSE)..... 56

COMFORT ASSIST INSULIN SYRINGE 29G X 1/2..... 169, 189

COMFORT ASSIST INSULIN SYRINGE 31G X 5/16..... 169, 189

COMFORT EZ INSULIN SYRINGE 27G X 1/2..... 169, 189

COMFORT EZ INSULIN SYRINGE 28G X 1/2..... 169, 189

COMFORT EZ INSULIN SYRINGE 29G X 1/2..... 169, 189

COMFORT EZ INSULIN SYRINGE 30G X 1/2..... 169, 189

COMFORT EZ INSULIN SYRINGE 30G X 5/16..... 169, 189

COMFORT EZ INSULIN SYRINGE 31G X 15/64..... 169, 189

COMFORT EZ INSULIN SYRINGE 31G X 5/16..... 169, 189

COMFORT EZ MICRO PEN NEEDLES 32G X 4 MM..... 169, 189

COMFORT EZ PEN NEEDLES 31G X 5
MM 170, 189

COMFORT EZ PEN NEEDLES 31G X 6
MM 170, 189

COMFORT EZ PEN NEEDLES 31G X 8
MM 170, 189

COMFORT EZ PEN NEEDLES 32G X 4
MM 170, 189

COMFORT EZ PEN NEEDLES 32G X 5
MM 170, 189

COMFORT EZ PEN NEEDLES 32G X 6
MM 170, 189

COMFORT EZ PEN NEEDLES 32G X 8
MM 170, 189

COMFORT EZ PEN NEEDLES 33G X 4
MM 170, 189

COMFORT EZ PEN NEEDLES 33G X 5
MM 170, 189

COMFORT EZ PEN NEEDLES 33G X 6
MM 170, 189

COMFORT EZ PEN NEEDLES 33G X 8
MM 170, 189

COMFORT EZ PRO PEN NEEDLES 30G
X 8 MM..... 170, 189

COMFORT EZ PRO PEN NEEDLES 31G
X 4 MM..... 170, 189

COMFORT EZ PRO PEN NEEDLES 31G
X 5 MM..... 170, 189

COMFORT EZ SHORT PEN NEEDLES
31G X 8 MM..... 170, 189

COMFORT TOUCH INSULIN PEN NEED
31G X 4 MM..... 170, 189

COMFORT TOUCH INSULIN PEN NEED
31G X 5 MM..... 170, 189

COMFORT TOUCH INSULIN PEN NEED
31G X 6 MM..... 170, 189

COMFORT TOUCH INSULIN PEN NEED
31G X 8 MM..... 170, 189

COMFORT TOUCH INSULIN PEN NEED
32G X 4 MM..... 170, 189

COMFORT TOUCH INSULIN PEN NEED
32G X 5 MM..... 170, 189

COMFORT TOUCH INSULIN PEN NEED
32G X 6 MM..... 170, 189

COMFORT TOUCH INSULIN PEN NEED
32G X 8 MM..... 170, 189

COMFORT TOUCH INSULIN PEN NEED
33G X 4 MM..... 170, 189

COMFORT TOUCH INSULIN PEN NEED
33G X 5 MM..... 170, 189

COMFORT TOUCH INSULIN PEN NEED
33G X 6 MM..... 170, 189

COPIKTRA..... 93

COSENTYX (300 MG DOSE)..... 312, 313

COSENTYX SENSOREADY (300 MG)
..... 312, 313

COSENTYX SUBCUTANEOUS
SOLUTION PREFILLED SYRINGE 75
MG/0.5ML 312, 313

COSENTYX UNOREADY 312, 313

COTELLIC 67

CRESEMBA ORAL 194

CURITY ALCOHOL PREPS PAD 70 %
..... 170, 189

CURITY ALL PURPOSE SPONGES PAD
2..... 170, 189

CURITY GAUZE PAD 2 170, 189

CURITY GAUZE SPONGE PAD 2..... 170,
189

CURITY SPONGES PAD 2..... 170, 189

CVS ALCOHOL PREP PADS PAD 70 %
..... 170, 189

CVS GAUZE PAD 2 170, 189

CVS GAUZE STERILE PAD 2 170, 189

cvs isopropyl alcohol wipes 170, 189

CVS PREP PAD 70 %..... 170, 189

CYLTEZO (2 PEN) 16, 17

CYLTEZO (2 SYRINGE) 16, 17

CYLTEZO-CD/UC/HS STARTER.... 16, 17

CYLTEZO-PSORIASIS/UV STARTER 16,
17

D

dalfampridine er 73

DANYELZA..... 240

DANZITEN 245

dasatinib oral tablet 100 mg, 140 mg, 20 mg,
50 mg, 70 mg, 80 mg 75

DATROWAY 76

DAURISMO ORAL TABLET 100 MG, 25
MG 136

deferasirox granules 78, 79

deferasirox oral tablet 78, 79

DERMACEA GAUZE SPONGE PAD 2
..... 170, 189

DERMACEA IV DRAIN SPONGES PAD
2..... 170, 189

DERMACEA NON-WOVEN SPONGES
PAD 2..... 170, 189

DERMACEA TYPE VII GAUZE PAD 2
..... 170, 189

DIACOMIT ORAL CAPSULE 250 MG,
500 MG 335

DIACOMIT ORAL PACKET 250 MG, 500
MG 335

DIATHRIVE PEN NEEDLE 31G X 5 MM
..... 170, 189

DIATHRIVE PEN NEEDLE 31G X 6 MM
..... 170, 189

DIATHRIVE PEN NEEDLE 31G X 8 MM
..... 170, 189

DIATHRIVE PEN NEEDLE 32G X 4 MM
..... 170, 189

diclofenac epolamine external 83

diclofenac sodium external solution 2 %.. 82

dimethyl fumarate oral capsule delayed
release 120 mg, 240 mg 84

dimethyl fumarate starter pack oral capsule
delayed release therapy pack 84

diphenoxylate-atropine oral tablet 2.5-0.025
mg 154

dipyridamole oral 146

dronabinol oral capsule 88

DROPLET INSULIN SYRINGE 29G X 1/2
..... 170, 189

DROPLET INSULIN SYRINGE 30G X 1/2
..... 170, 171, 189

DROPLET INSULIN SYRINGE 30G X
15/64 171, 189

DROPLET INSULIN SYRINGE 30G X
5/16 171, 189

DROPLET INSULIN SYRINGE 31G X
15/64 171, 189

DROPLET INSULIN SYRINGE 31G X
5/16 171, 189

DROPLET MICRON 34G X 3.5 MM... 171,
189

DROPLET PEN NEEDLES 29G X 10MM
..... 171, 189

DROPLET PEN NEEDLES 29G X 12MM
..... 171, 189

DROPLET PEN NEEDLES 30G X 8 MM
..... 171, 189

DROPLET PEN NEEDLES 31G X 5 MM
..... 171, 189

DROPLET PEN NEEDLES 31G X 6 MM
..... 171, 189

DROPLET PEN NEEDLES 31G X 8 MM
..... 171, 189

DROPLET PEN NEEDLES 32G X 4 MM
..... 171, 189

DROPLET PEN NEEDLES 32G X 5 MM
..... 171, 189

DROPLET PEN NEEDLES 32G X 6 MM
..... 171, 189

DROPLET PEN NEEDLES 32G X 8 MM
..... 171, 189

DROPSAFE ALCOHOL PREP PAD 70 %
..... 171, 189

DROPSAFE AUTOPROTECT DUO 31G X
4 MM 171, 189

DROPSAFE AUTOPROTECT DUO 31G X
5 MM 171, 189

DROPSAFE AUTOPROTECT DUO 31G X
8 MM 171, 189

DROPSAFE SAFETY PEN NEEDLES 31G
X 5 MM..... 171, 189

DROPSAFE SAFETY PEN NEEDLES 31G
X 6 MM..... 171, 189

DROPSAFE SAFETY PEN NEEDLES 31G
X 8 MM..... 171, 189

DROPSAFE SAFETY SYRINGE/NEEDLE
29G X 1/2..... 171, 189

DROPSAFE SAFETY SYRINGE/NEEDLE
31G X 15/64..... 171, 189

DROPSAFE SAFETY SYRINGE/NEEDLE
31G X 5/16..... 171, 189

droxidopa 89

DRUG MART UNIFINE PENTIPS 29G X
12MM 171, 189

DRUG MART UNIFINE PENTIPS 31G X
6 MM 171, 189

DRUG MART UNIFINE PENTIPS 31G X
8 MM 171, 189

DRUG MART UNIFINE PENTIPS PLUS
 32G X 4 MM..... 171, 189
 DUPIXENT SUBCUTANEOUS
 SOLUTION AUTO-INJECTOR 90, 92
 DUPIXENT SUBCUTANEOUS
 SOLUTION PREFILLED SYRINGE . 90,
 92

E

EASY COMFORT ALCOHOL PADS PAD
 171, 189
 EASY COMFORT INSULIN SYRINGE
 29G X 5/16..... 171, 189
 EASY COMFORT INSULIN SYRINGE
 30G X 1/2..... 171, 189
 EASY COMFORT INSULIN SYRINGE
 30G X 5/16..... 171, 172, 189
 EASY COMFORT INSULIN SYRINGE
 31G X 1/2..... 172, 189
 EASY COMFORT INSULIN SYRINGE
 31G X 5/16..... 172, 189
 EASY COMFORT INSULIN SYRINGE
 32G X 5/16..... 172, 189
 EASY COMFORT PEN NEEDLES 29G X
 4MM 172, 189
 EASY COMFORT PEN NEEDLES 29G X
 5MM 172, 189
 EASY COMFORT PEN NEEDLES 31G X
 5 MM 172, 189
 EASY COMFORT PEN NEEDLES 31G X
 6 MM 172, 189
 EASY COMFORT PEN NEEDLES 31G X
 8 MM 172, 189
 EASY COMFORT PEN NEEDLES 32G X
 4 MM 172, 189
 EASY COMFORT PEN NEEDLES 33G X
 4 MM 172, 189
 EASY COMFORT PEN NEEDLES 33G X
 5 MM 172, 189
 EASY COMFORT PEN NEEDLES 33G X
 6 MM 172, 189
 EASY GLIDE PEN NEEDLES 33G X 4
 MM 172, 189
 EASY TOUCH ALCOHOL PREP
 MEDIUM PAD 70 %..... 172, 189
 EASY TOUCH FLIPLOCK INSULIN SY
 29G X 1/2..... 172, 189

EASY TOUCH FLIPLOCK INSULIN SY
 30G X 1/2..... 172, 189
 EASY TOUCH FLIPLOCK INSULIN SY
 30G X 5/16..... 172, 189
 EASY TOUCH FLIPLOCK INSULIN SY
 31G X 5/16..... 172, 189
 EASY TOUCH FLIPLOCK SAFETY SYR
 27G X 1/2..... 172, 189
 EASY TOUCH INSULIN BARRELS U-
 100 1 ML..... 172, 189
 EASY TOUCH INSULIN SAFETY SYR
 29G X 1/2..... 172, 189
 EASY TOUCH INSULIN SAFETY SYR
 30G X 1/2..... 172, 189
 EASY TOUCH INSULIN SAFETY SYR
 30G X 5/16..... 172, 189
 EASY TOUCH INSULIN SYRINGE 27G
 X 1/2..... 172, 189
 EASY TOUCH INSULIN SYRINGE 27G
 X 5/8..... 172, 189
 EASY TOUCH INSULIN SYRINGE 28G
 X 1/2..... 172, 189
 EASY TOUCH INSULIN SYRINGE 29G
 X 1/2..... 172, 189
 EASY TOUCH INSULIN SYRINGE 30G
 X 1/2..... 172, 189
 EASY TOUCH INSULIN SYRINGE 30G
 X 5/16..... 172, 189
 EASY TOUCH INSULIN SYRINGE 31G
 X 5/16..... 172, 189
 EASY TOUCH PEN NEEDLES 29G X
 12MM 173, 189
 EASY TOUCH PEN NEEDLES 30G X 5
 MM 173, 189
 EASY TOUCH PEN NEEDLES 30G X 6
 MM 173, 189
 EASY TOUCH PEN NEEDLES 30G X 8
 MM 173, 189
 EASY TOUCH PEN NEEDLES 31G X 5
 MM 173, 189
 EASY TOUCH PEN NEEDLES 31G X 6
 MM 173, 189
 EASY TOUCH PEN NEEDLES 31G X 8
 MM 173, 189
 EASY TOUCH PEN NEEDLES 32G X 4
 MM 173, 189

EASY TOUCH PEN NEEDLES 32G X 5
MM 173, 189

EASY TOUCH PEN NEEDLES 32G X 6
MM 173, 189

EASY TOUCH SAFETY PEN NEEDLES
29G X 5MM..... 173, 189

EASY TOUCH SAFETY PEN NEEDLES
29G X 8MM..... 173, 189

EASY TOUCH SAFETY PEN NEEDLES
30G X 8 MM..... 173, 189

EASY TOUCH SHEATHLOCK SYRINGE
29G X 1/2..... 173, 189

EASY TOUCH SHEATHLOCK SYRINGE
30G X 1/2..... 173, 189

EASY TOUCH SHEATHLOCK SYRINGE
30G X 5/16..... 173, 189

EASY TOUCH SHEATHLOCK SYRINGE
31G X 5/16..... 173, 189

ELAHERE 236

ELIGARD 210

ELREXFIO SUBCUTANEOUS
SOLUTION 44 MG/1.1ML, 76
MG/1.9ML 98

eltrombopag olamine oral packet 12.5 mg,
25 mg 100, 101

eltrombopag olamine oral tablet 12.5 mg, 25
mg, 50 mg, 75 mg 100, 101

EMBECTA AUTOSHIELD DUO 30G X 5
MM 173, 189

EMBECTA INS SYR U/F 1/2 UNIT 31G X
15/64 173, 189

EMBECTA INS SYR U/F 1/2 UNIT 31G X
5/16 173, 189

EMBECTA INSULIN SYR ULTRAFINE
30G X 1/2..... 173, 189

EMBECTA INSULIN SYR ULTRAFINE
31G X 15/64..... 173, 189

EMBECTA INSULIN SYR ULTRAFINE
31G X 5/16..... 173, 189

EMBECTA INSULIN SYRINGE 28G X
1/2 173, 189

EMBECTA INSULIN SYRINGE U-100
27G X 5/8..... 173, 189

EMBECTA INSULIN SYRINGE U-500
..... 173, 189

EMBECTA PEN NEEDLE NANO 2 GEN
32G X 4 MM..... 173, 189

EMBECTA PEN NEEDLE NANO 32G X 4
MM 173, 189

EMBECTA PEN NEEDLE ULTRAFINE
29G X 12.7MM..... 173, 189

EMBECTA PEN NEEDLE ULTRAFINE
31G X 5 MM..... 173, 189

EMBECTA PEN NEEDLE ULTRAFINE
31G X 8 MM..... 173, 189

EMBECTA PEN NEEDLE ULTRAFINE
32G X 6 MM..... 173, 189

EMBRACE PEN NEEDLES 29G X 12MM
..... 173, 189

EMBRACE PEN NEEDLES 30G X 5 MM
..... 173, 189

EMBRACE PEN NEEDLES 30G X 8 MM
..... 173, 189

EMBRACE PEN NEEDLES 31G X 5 MM
..... 173, 189

EMBRACE PEN NEEDLES 31G X 6 MM
..... 173, 189

EMBRACE PEN NEEDLES 31G X 8 MM
..... 174, 189

EMBRACE PEN NEEDLES 32G X 4 MM
..... 174, 189

EMGALITY 131

EMGALITY (300 MG DOSE) 131

EMRELIS 346

ENBREL MINI..... 115, 116

ENBREL SUBCUTANEOUS SOLUTION
25 MG/0.5ML 115, 116

ENBREL SUBCUTANEOUS SOLUTION
REFILLED SYRINGE 115, 116

ENBREL SURECLICK SUBCUTANEOUS
SOLUTION AUTO-INJECTOR 115, 116

ENSACOVE ORAL CAPSULE 100 MG,
25 MG 104

EPCLUSA ORAL PACKET 150-37.5 MG,
200-50 MG..... 324

EPCLUSA ORAL TABLET..... 324

EPIDIOLEX..... 58

EPKINLY 108

EQL ALCOHOL SWABS PAD 70 %... 174,
189

EQL GAUZE PAD 2 174, 189

EQL INSULIN SYRINGE 29G X 1/2... 174, 189
 EQL INSULIN SYRINGE 30G X 5/16. 174, 189
 EQL INSULIN SYRINGE 31G X 5/16. 174, 189
 ERBITUX 65
 ERIVEDGE..... 398
 ERLEADA ORAL TABLET 240 MG, 60 MG 28
 erlotinib hcl oral tablet 100 mg, 150 mg, 25 mg 113
 estradiol-norethindrone acet..... 147
 everolimus oral tablet 10 mg, 2.5 mg, 5 mg, 7.5 mg 117
 everolimus oral tablet soluble 118
 EXEL COMFORT POINT PEN NEEDLE 29G X 12MM..... 174, 189
 EXXUA..... 134
 EXXUA TITRATION PACK..... 134
F
 FASENRA 47
 FASENRA PEN..... 47
 fentanyl citrate buccal lozenge on a handle 122
 FIFTY50 ALCOHOL PREP PAD 70 % 174, 189
 FIFTY50 PEN NEEDLES 31G X 5 MM 174, 189
 FIFTY50 PEN NEEDLES 31G X 8 MM 174, 189
 FIFTY50 PEN NEEDLES 32G X 4 MM 174, 189
 FIFTY50 PEN NEEDLES 32G X 6 MM 174, 189
 FIFTY50 SUPERIOR COMFORT SYR 31G X 5/16..... 174, 189
 fingolimod hcl..... 127
 FINTEPLA..... 121
 FOTIVDA 357
 FRUZAQLA ORAL CAPSULE 1 MG, 5 MG 129
 FYARRO 321
G
 GAUZE PADS PAD 2..... 174, 189

GAUZE TYPE VII MEDI-PAK PAD 2 174, 189
 GAVRETO 283
 gefitinib 133
 GILOTRIF 20
 glatiramer acetate subcutaneous solution prefilled syringe 20 mg/ml, 40 mg/ml 137
 glatopa subcutaneous solution prefilled syringe 20 mg/ml, 40 mg/ml 137
 GLOBAL ALCOHOL PREP EASE 174, 189
 GLOBAL EASE INJECT PEN NEEDLES 29G X 12MM..... 174, 189
 GLOBAL EASE INJECT PEN NEEDLES 31G X 5 MM..... 174, 189
 GLOBAL EASE INJECT PEN NEEDLES 31G X 8 MM..... 174, 189
 GLOBAL EASE INJECT PEN NEEDLES 32G X 4 MM..... 174, 189
 GLOBAL EASY GLIDE INSULIN SYR 31G X 15/64..... 174, 189
 GLOBAL EASY GLIDE INSULIN SYR 31G X 5/16..... 174, 189
 GLOBAL EASY GLIDE PEN NEEDLES 32G X 4 MM..... 174, 189
 GLOBAL INJECT EASE INSULIN SYR 28G X 1/2..... 174, 189
 GLOBAL INJECT EASE INSULIN SYR 29G X 1/2..... 174, 189
 GLOBAL INJECT EASE INSULIN SYR 30G X 1/2..... 174, 189
 GLOBAL INJECT EASE INSULIN SYR 30G X 5/16..... 174, 189
 GLOBAL INJECT EASE INSULIN SYR 31G X 5/16..... 174, 189
 GLOBAL INSULIN SYRINGES 30G X 1/2 174, 189
 GLOBAL INSULIN SYRINGES 30G X 5/16 175, 189
 GLUCOPRO INSULIN SYRINGE 30G X 1/2 175, 189
 GLUCOPRO INSULIN SYRINGE 30G X 5/16 175, 189
 GLUCOPRO INSULIN SYRINGE 31G X 5/16 175, 189
 glyburide micronized 149
 glyburide oral 149

glyburide-metformin 149
 GNP ALCOHOL SWABS PAD 70 % .. 175,
 189
 GNP CLICKFINE PEN NEEDLES 31G X 6
 MM 175, 189
 GNP CLICKFINE PEN NEEDLES 31G X 8
 MM 175, 189
 GNP INSULIN SYRINGE 28G X 1/2 .. 175,
 189
 GNP INSULIN SYRINGE 29G X 1/2 .. 175,
 189
 GNP INSULIN SYRINGE 30G X 5/16 175,
 189
 GNP INSULIN SYRINGE 31G X 5/16 175,
 189
 GNP INSULIN SYRINGES 28GX1/2 .. 175,
 189
 GNP INSULIN SYRINGES 29GX1/2 .. 175,
 189
 GNP INSULIN SYRINGES 30G X 5/16
 175, 189
 GNP INSULIN SYRINGES 30GX5/16 175,
 189
 GNP INSULIN SYRINGES 31GX5/16 175,
 189
 GNP PEN NEEDLES 31G X 5 MM 175,
 189
 GNP PEN NEEDLES 31G X 8 MM 175,
 189
 GNP PEN NEEDLES 32G X 4 MM 175,
 189
 GNP PEN NEEDLES 32G X 6 MM 175,
 189
 GNP STERILE GAUZE PAD 2 175, 189
 GNP ULTICARE PEN NEEDLES 31G X 5
 MM 175, 189
 GNP ULTICARE PEN NEEDLES 31G X 8
 MM 175, 189
 GNP ULTICARE PEN NEEDLES 32G X 4
 MM 175, 189
 GNP ULTICARE PEN NEEDLES 32G X 6
 MM 175, 189
 GNP ULTIGUARD SAFEPACK NEEDLE
 31G X 5 MM..... 175, 189
 GNP ULTIGUARD SAFEPACK NEEDLE
 31G X 8 MM..... 175, 189

GNP ULTIGUARD SAFEPACK NEEDLE
 32G X 4 MM..... 175, 189
 GNP ULTIGUARD SAFEPACK NEEDLE
 32G X 6 MM..... 175, 189
 GNP ULTRA COM INSULIN SYRINGE
 28G X 1/2..... 175, 189
 GOMEKLI ORAL CAPSULE 1 MG, 2 MG
 235
 GOMEKLI ORAL TABLET SOLUBLE235
 GOODSENSE ALCOHOL SWABS PAD
 70 % 175, 189
 GOODSENSE CLICKFINE PEN NEEDLE
 31G X 5 MM..... 175, 189
 GOODSENSE PEN NEEDLE PENFINE
 31G X 5 MM..... 175, 189
 GOODSENSE PEN NEEDLE PENFINE
 31G X 8 MM..... 175, 189
 GOODSENSE PEN NEEDLE PENFINE
 32G X 4 MM..... 175, 189
 GOODSENSE PEN NEEDLE PENFINE
 32G X 6 MM..... 176, 189
H
 HADLIMA..... 18, 19
 HADLIMA PUSHTOUCH..... 18, 19
 HAEGARDA SUBCUTANEOUS
 SOLUTION RECONSTITUTED 2000
 UNIT, 3000 UNIT 55
 HARVONI ORAL PACKET 33.75-150
 MG, 45-200 MG 203
 HARVONI ORAL TABLET 203
 HEALTHWISE INSULIN SYR/NEEDLE
 30G X 5/16..... 176, 189
 HEALTHWISE INSULIN SYR/NEEDLE
 31G X 5/16..... 176, 189
 HEALTHWISE MICRON PEN NEEDLES
 32G X 4 MM..... 176, 189
 HEALTHWISE SHORT PEN NEEDLES
 31G X 5 MM..... 176, 189
 HEALTHWISE SHORT PEN NEEDLES
 31G X 8 MM..... 176, 189
 H-E-B INCONTROL ALCOHOL PAD 176,
 189
 H-E-B INCONTROL PEN NEEDLES 29G
 X 12MM..... 176, 189
 H-E-B INCONTROL PEN NEEDLES 31G
 X 5 MM..... 176, 189

H-E-B INCONTROL PEN NEEDLES 31G X 6 MM.....	176, 189
H-E-B INCONTROL PEN NEEDLES 31G X 8 MM.....	176, 189
H-E-B INCONTROL PEN NEEDLES 32G X 4 MM.....	176, 189
H-E-B INCONTROL UNIFINE PENTIP 31G X 5 MM.....	176, 189
H-E-B INCONTROL UNIFINE PENTIP 31G X 6 MM.....	176, 189
H-E-B INCONTROL UNIFINE PENTIP 31G X 8 MM.....	176, 189
H-E-B INCONTROL UNIFINE PENTIP 32G X 4 MM.....	176, 189
H-E-B INCONTROL UNIFINE PENTIP 33G X 4 MM.....	176, 189
HERCEPTIN HYLECTA.....	371
HERNEXEOS.....	407
HM STERILE PADS PAD 2.....	176, 189
HM ULTICARE INSULIN SYRINGE 30G X 1/2.....	176, 189
HM ULTICARE INSULIN SYRINGE 31G X 5/16.....	176, 189
HM ULTICARE MINI PEN NEEDLES 31G X 5 MM.....	176, 189
HM ULTICARE SHORT PEN NEEDLES 31G X 8 MM.....	176, 189
HUMIRA (2 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT.....	12, 13
HUMIRA (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 10 MG/0.1ML, 20 MG/0.2ML, 40 MG/0.4ML, 40 MG/0.8ML	12, 13
HUMIRA-CD/UC/HS STARTER SUBCUTANEOUS AUTO-INJECTOR KIT	12, 13
HUMIRA-PED<40KG CROHNS STARTER.....	12, 13
HUMIRA-PED>=40KG CROHNS START	12, 13
HUMIRA-PED>=40KG UC STARTER SUBCUTANEOUS AUTO-INJECTOR KIT	12, 13
HUMIRA-PSORIASIS/UVEIT STARTER SUBCUTANEOUS AUTO-INJECTOR KIT	12, 13
HYRNUO	318
I	
IBRANCE	263
IBTROZI.....	341
icatibant acetate.....	159
ICLUSIG.....	281
IDHIFA	102
imatinib mesylate oral tablet 100 mg, 400 mg	161
IMBRUVICA ORAL CAPSULE 140 MG, 70 MG	158
IMBRUVICA ORAL SUSPENSION.....	158
IMBRUVICA ORAL TABLET 140 MG, 280 MG, 420 MG.....	158
IMDELLTRA	343
IMJUDO	373
IMKELDI.....	162
IMPAVIDO.....	234
INCONTROL ULTICARE PEN NEEDLES 31G X 6 MM.....	176, 189
INCONTROL ULTICARE PEN NEEDLES 31G X 8 MM.....	176, 189
INCONTROL ULTICARE PEN NEEDLES 32G X 4 MM.....	176, 189
INCRELEX.....	226
indomethacin oral capsule 25 mg, 50 mg	155
INGREZZA ORAL CAPSULE.....	391
INGREZZA ORAL CAPSULE SPRINKLE	391
INGREZZA ORAL CAPSULE THERAPY PACK.....	391
INLURIYO	164
INLYTA ORAL TABLET 1 MG, 5 MG..	39
INQOVI	77
INREBIC.....	120
INSULIN SYRINGE 28G X 1/2	176, 189
INSULIN SYRINGE 29G X 1/2	176, 189
INSULIN SYRINGE 30G X 5/16 ..	176, 189
INSULIN SYRINGE 31G X 5/16 ..	176, 189
INSULIN SYRINGE-NEEDLE U-100 27G X 1/2.....	176, 189
INSULIN SYRINGE-NEEDLE U-100 28G X 1/2.....	176, 189

INSULIN SYRINGE-NEEDLE U-100 29G
 X 1/2..... 176, 177, 189
 INSULIN SYRINGE-NEEDLE U-100 30G
 X 1/2..... 177, 189
 INSULIN SYRINGE-NEEDLE U-100 30G
 X 5/16..... 177, 189
 INSULIN SYRINGE-NEEDLE U-100 31G
 X 1/4..... 177, 189
 INSULIN SYRINGE-NEEDLE U-100 31G
 X 5/16..... 177, 189
 INSUPEN PEN NEEDLES 29G X 12MM
 177, 189
 INSUPEN PEN NEEDLES 31G X 5 MM
 177, 189
 INSUPEN PEN NEEDLES 31G X 8 MM
 177, 189
 INSUPEN PEN NEEDLES 32G X 4 MM
 177, 189
 INSUPEN PEN NEEDLES 33G X 4 MM
 177, 189
 INSUPEN SENSITIVE 32G X 6 MM... 177,
 189
 INSUPEN SENSITIVE 32G X 8 MM... 177,
 189
 INSUPEN ULTRAFIN 30G X 8 MM... 177,
 189
 INSUPEN ULTRAFIN 31G X 6 MM... 177,
 189
 INSUPEN ULTRAFIN 31G X 8 MM... 177,
 189
 INSUPEN32G EXTR3ME 32G X 6 MM
 177, 189
 ITOVEBI ORAL TABLET 3 MG, 9 MG
 165
 IWILFIN 94
J
 J & J GAUZE PAD 2..... 177, 189
 JAKAFI..... 310
 JAKAFI XR 310
 JASCAYD..... 241, 242
 javygtor oral tablet 311
 JAYPIRCA ORAL TABLET 100 MG, 50
 MG 279
 JEMPERLI..... 87
 JYNARQUE ORAL TABLET 364

K
 KALYDECO..... 195
 KENDALL HYDROPHILIC FOAM
 DRESS PAD 2 177, 189
 KENDALL HYDROPHILIC FOAM PLUS
 PAD 2..... 177, 189
 KERENDIA 126
 KEYTRUDA INTRAVENOUS
 SOLUTION..... 270
 KEYTRUDA QLEX..... 271
 KIMMTRAK 344
 KINERET SUBCUTANEOUS SOLUTION
 PREFILLED SYRINGE 26, 27
 KINRAY INSULIN SYRINGE 29G X 1/2
 177, 189
 KINRAY INSULIN SYRINGE 31G X 5/16
 177, 189
 KISQALI (200 MG DOSE)..... 293
 KISQALI (400 MG DOSE)..... 293
 KISQALI (600 MG DOSE)..... 293
 KISQALI FEMARA (200 MG DOSE) .. 294
 KISQALI FEMARA (400 MG DOSE) .. 294
 KISQALI FEMARA (600 MG DOSE) .. 294
 KMART VALU INSULIN SYRINGE 29G
 U-100 0.5 ML 177, 189
 KMART VALU INSULIN SYRINGE 29G
 U-100 1 ML 177, 189
 KMART VALU INSULIN SYRINGE 30G
 U-100 0.3 ML 177, 189
 KMART VALU INSULIN SYRINGE 30G
 U-100 0.5 ML 177, 189
 KMART VALU INSULIN SYRINGE 30G
 U-100 1 ML 177, 189
 KOMZIFTI 405
 KOSELUGO ORAL CAPSULE 10 MG, 25
 MG 317
 KOSELUGO ORAL CAPSULE
 SPRINKLE 5 MG, 7.5 MG..... 317
 KRAZATI..... 11
 KROGER INSULIN SYRINGE 29G X 1/2
 177, 189
 KROGER INSULIN SYRINGE 30G X 5/16
 177, 189
 KROGER INSULIN SYRINGE 31G X 5/16
 177, 189

KROGER PEN NEEDLES 29G X 12MM	177, 189
KROGER PEN NEEDLES 31G X 5 MM	177, 189
KROGER PEN NEEDLES 31G X 6 MM	177, 189
KROGER PEN NEEDLES 31G X 8 MM	177, 189
KROGER PEN NEEDLES 32G X 4 MM	178, 189
KROGER PEN NEEDLES 33G X 4 MM	178, 189
L	
LANREOTIDE ACETATE	199
lapatinib ditosylate	200
LAZCLUZE ORAL TABLET 240 MG, 80 MG	202
LEADER INSULIN SYRINGE 28G X 1/2	178, 189
LEADER INSULIN SYRINGE 29G X 1/2	178, 189
LEADER INSULIN SYRINGE 30G X 5/16	178, 189
LEADER INSULIN SYRINGE 31G X 5/16	178, 189
LEADER UNIFINE PENTIPS 31G X 5 MM	178, 189
LEADER UNIFINE PENTIPS 32G X 4 MM	178, 189
LEADER UNIFINE PENTIPS PLUS 31G X 5 MM	178, 189
LEADER UNIFINE PENTIPS PLUS 31G X 8 MM	178, 189
LEADER UNIFINE PENTIPS PLUS 32G X 4 MM	178, 189
lenalidomide	204
LENVIMA (10 MG DAILY DOSE)	205
LENVIMA (12 MG DAILY DOSE)	205
LENVIMA (14 MG DAILY DOSE)	205
LENVIMA (18 MG DAILY DOSE)	205
LENVIMA (20 MG DAILY DOSE)	205
LENVIMA (24 MG DAILY DOSE)	205
LENVIMA (4 MG DAILY DOSE)	205
LENVIMA (8 MG DAILY DOSE)	205
LEUPROLIDE ACETATE (3 MONTH)	208
leuprolide acetate injection	207

l-glutamine oral packet	214
lidocaine external ointment 5 %	215
lidocaine external patch 5 %	216
lidocaine-prilocaine external cream	217
lidocan	216
LITETOUCH INSULIN SYRINGE 28G X 1/2	178, 189
LITETOUCH INSULIN SYRINGE 29G X 1/2	178, 189
LITETOUCH INSULIN SYRINGE 30G X 5/16	178, 189
LITETOUCH INSULIN SYRINGE 31G X 5/16	178, 189
LITETOUCH PEN NEEDLES 29G X 12.7MM	178, 189
LITETOUCH PEN NEEDLES 31G X 5 MM	178, 189
LITETOUCH PEN NEEDLES 31G X 6 MM	178, 189
LITETOUCH PEN NEEDLES 31G X 8 MM	178, 189
LITETOUCH PEN NEEDLES 32G X 4 MM	178, 189
LIVTENCITY	224
LONGS INSULIN SYRINGE 31G X 5/16	178, 189
LONSURF ORAL TABLET 15-6.14 MG, 20-8.19 MG	375
LOQTORZI	366
LORBRENA ORAL TABLET 100 MG, 25 MG	220
LUMAKRAS ORAL TABLET 120 MG, 240 MG, 320 MG	334
LUNSUMIO	238
LUNSUMIO VELO	238
LUPRON DEPOT (1-MONTH)	211, 212
LUPRON DEPOT (3-MONTH)	211, 212
LUPRON DEPOT (4-MONTH)	211, 212
LUPRON DEPOT (6-MONTH)	211, 212
LUPRON DEPOT-PED (3-MONTH)	213
LUPRON DEPOT-PED (6-MONTH)	213
LUTRATE DEPOT	208
LYNOZYFIC INTRAVENOUS SOLUTION 200 MG/10ML, 5 MG/2.5ML	218
LYNPARZA ORAL TABLET	255

LYTGOBI (12 MG DAILY DOSE) 130
 LYTGOBI (16 MG DAILY DOSE) 130
 LYTGOBI (20 MG DAILY DOSE) 130

M

MAGELLAN INSULIN SAFETY SYR
 29G X 1/2..... 178, 189
 MAGELLAN INSULIN SAFETY SYR
 30G X 5/16..... 178, 189
 MARATHON MEDICAL PENTIPS 29G X
 12MM 178, 189
 MARATHON MEDICAL PENTIPS 31G X
 5 MM 178, 189
 MARATHON MEDICAL PENTIPS 31G X
 8 MM 178, 189
 MARATHON MEDICAL PENTIPS 32G X
 4 MM 178, 189
 MARGENZA 223
 MAXICOMFORT II PEN NEEDLE 31G X
 6 MM 179, 189
 MAXI-COMFORT INSULIN SYRINGE
 28G X 1/2..... 179, 189
 MAXI-COMFORT SAFETY PEN
 NEEDLE 29G X 5MM 179, 189
 MAXI-COMFORT SAFETY PEN
 NEEDLE 29G X 8MM 179, 189
 MAXICOMFORT SYR 27G X 1/2 179, 189
 MEDIC INSULIN SYRINGE 30G X 5/16
 179, 189
 MEDICINE SHOPPE PEN NEEDLES 29G
 X 12MM..... 179, 189
 MEDICINE SHOPPE PEN NEEDLES 31G
 X 8 MM..... 179, 189
 MEDPURA ALCOHOL PADS 70 %
 EXTERNAL 179, 189
 megestrol acetate oral suspension 40 mg/ml,
 625 mg/5ml 156
 megestrol acetate oral tablet..... 156
 MEIJER ALCOHOL SWABS PAD 70 %
 179, 189
 MEIJER PEN NEEDLES 29G X 12MM
 179, 189
 MEIJER PEN NEEDLES 31G X 6 MM 179,
 189
 MEIJER PEN NEEDLES 31G X 8 MM 179,
 189

MEKINIST ORAL SOLUTION
 RECONSTITUTED 368
 MEKINIST ORAL TABLET 0.5 MG, 2
 MG 369
 MEKTOVI 50
 metyrosine 231
 MICRODOT PEN NEEDLE 31G X 6 MM
 179, 189
 MICRODOT PEN NEEDLE 32G X 4 MM
 179, 189
 MICRODOT PEN NEEDLE 33G X 4 MM
 179, 189
 mifepristone oral tablet 300 mg 233
 mimvey 147
 MIPLYFFA..... 32
 MIRASORB SPONGES 2..... 179, 189
 MM INSULIN SYRINGE/NEEDLE 30G X
 5/16 179, 189
 MM INSULIN SYRINGE/NEEDLE 31G X
 5/16 179, 189
 MM PEN NEEDLES 31G X 5 MM 179, 189
 MM PEN NEEDLES 31G X 6 MM 179, 189
 MM PEN NEEDLES 31G X 8 MM 179, 189
 MM PEN NEEDLES 32G X 4 MM 179, 189
 modafinil oral tablet 100 mg, 200 mg..... 239
 MODEYSO..... 86
 MONOJECT INSULIN SYRINGE 25G X
 5/8 179, 189
 MONOJECT INSULIN SYRINGE 27G X
 1/2 179, 189
 MONOJECT INSULIN SYRINGE 28G X
 1/2 179, 189
 MONOJECT INSULIN SYRINGE 29G X
 1/2 179, 189
 MONOJECT INSULIN SYRINGE 30G X
 5/16 179, 189
 MONOJECT INSULIN SYRINGE 31G X
 5/16 179, 189
 MONOJECT INSULIN SYRINGE U-100 1
 ML..... 179, 189
 MONOJECT ULTRA COMFORT
 SYRINGE 28G X 1/2 179, 189
 MONOJECT ULTRA COMFORT
 SYRINGE 29G X 1/2 180, 189
 MONOJECT ULTRA COMFORT
 SYRINGE 30G X 5/16 180, 189

MONOJECT ULTRA COMFORT	
SYRINGE 31G X 5/16	180, 189
morphine sulfate (concentrate) oral solution	
100 mg/5ml	144
MOUNJARO SUBCUTANEOUS	
SOLUTION AUTO-INJECTOR	140
MS INSULIN SYRINGE 31G X 5/16...	180,
189	
N	
NERLYNX	243
NIKTIMVO	38
nilotinib hcl oral capsule 150 mg, 200 mg,	
50 mg	244
NINLARO.....	197
nintedanib esylate.....	246, 247
NIVESTYM.....	125
NORDITROPIN FLEXP	
SUBCUTANEOUS SOLUTION PEN-	
INJECTOR.....	327, 328
NOVOFINE AUTOCOVER PEN NEEDLE	
30G X 8 MM.....	180, 189
NOVOFINE PEN NEEDLE 32G X 6 MM	
.....	180, 189
NOVOFINE PLUS PEN NEEDLE 32G X 4	
MM	180, 189
NUBEQA.....	74
NUCALA SUBCUTANEOUS SOLUTION	
AUTO-INJECTOR	228, 229, 230
NUCALA SUBCUTANEOUS SOLUTION	
REFILLED SYRINGE 100 MG/ML, 40	
MG/0.4ML	228, 229, 230
NUCALA SUBCUTANEOUS SOLUTION	
RECONSTITUTED	228, 229, 230
NUPLAZID ORAL CAPSULE.....	276
NUPLAZID ORAL TABLET 10 MG....	276
NURTEC.....	298, 299
NYVEPRIA	266
O	
ODOMZO	330
OGIVRI.....	370
OGSIVEO ORAL TABLET 100 MG, 150	
MG, 50 MG.....	250
OJEMDA ORAL SUSPENSION	
RECONSTITUTED	367
OJEMDA ORAL TABLET	367
OJJAARA	237
ONAPGO.....	29
ONUREG.....	40
OPDIVO	251
OPDIVO QVANTIG	252
OPDUALAG.....	253
ORENCIA CLICKJECT.....	4, 5
ORENCIA INTRAVENOUS	2, 3
ORENCIA SUBCUTANEOUS SOLUTION	
REFILLED SYRINGE	4, 5
ORGOVYX.....	288
ORKAMBI ORAL TABLET	222
ORSERDU ORAL TABLET 345 MG, 86	
MG	95
OSENVELT.....	80
OTEZLA.....	30, 31
OTEZLA XR	30, 31
OTEZLA/OTEZLA XR INITIATION PK	
.....	30, 31
OZEMPIC	139
OZEMPIC (0.25 OR 0.5 MG/DOSE)	
SUBCUTANEOUS SOLUTION PEN-	
INJECTOR 2 MG/3ML	139
OZEMPIC (1 MG/DOSE)	
SUBCUTANEOUS SOLUTION PEN-	
INJECTOR 4 MG/3ML	139
OZEMPIC (2 MG/DOSE)	139
P	
paroxetine hcl.....	157
paroxetine hcl er.....	157
pazopanib hcl oral tablet 200 mg, 400 mg	
.....	265
PC UNIFINE PENTIPS 31G X 5 MM..	180,
189	
PC UNIFINE PENTIPS 31G X 6 MM..	180,
189	
PC UNIFINE PENTIPS 31G X 8 MM..	180,
189	
PEGASYS SUBCUTANEOUS SOLUTION	
180 MCG/ML	268
PEGASYS SUBCUTANEOUS SOLUTION	
REFILLED SYRINGE	268
PEMAZYRE.....	272
PEN NEEDLE/5-BEVEL TIP 31G X 8 MM	
.....	180, 189
PEN NEEDLE/5-BEVEL TIP 32G X 4 MM	
.....	180, 189

PEN NEEDLES 29G X 12MM 180, 189
 PEN NEEDLES 30G X 5 MM (OTC)... 180, 189
 PEN NEEDLES 30G X 5 MM (RX) 180, 189
 PEN NEEDLES 30G X 8 MM 180, 189
 PEN NEEDLES 31G X 5 MM (OTC)... 180, 189
 PEN NEEDLES 31G X 5 MM (RX) 180, 189
 PEN NEEDLES 31G X 6 MM 180, 189
 PEN NEEDLES 31G X 8 MM (OTC)... 180, 189
 PEN NEEDLES 31G X 8 MM (RX) 180, 189
 PEN NEEDLES 32G X 4 MM (OTC)... 180, 189
 PEN NEEDLES 32G X 4 MM (RX) 180, 189
 PEN NEEDLES 32G X 5 MM 180, 189
 PEN NEEDLES 32G X 6 MM 180, 189
 PEN NEEDLES 33G X 4 MM 180, 189
 PEN NEEDLES 5/16 180, 189
 penicillamine oral tablet..... 273, 274
 PENTIPS 29G X 12MM (OTC) 180, 189
 PENTIPS 29G X 12MM (RX)..... 180, 189
 PENTIPS 31G X 5 MM (OTC) 180, 189
 PENTIPS 31G X 5 MM (RX)..... 180, 189
 PENTIPS 31G X 6 MM..... 180, 189
 PENTIPS 31G X 8 MM (OTC) 180, 189
 PENTIPS 31G X 8 MM (RX)..... 180, 189
 PENTIPS 32G X 4 MM (OTC) 180, 189
 PENTIPS 32G X 4 MM (RX)..... 180, 189
 PENTIPS 32G X 6 MM..... 180, 189
 PENTIPS GENERIC PEN NEEDLES 29G X 12MM..... 180, 189
 PENTIPS GENERIC PEN NEEDLES 31G X 5 MM..... 180, 189
 PENTIPS GENERIC PEN NEEDLES 31G X 6 MM..... 180, 189
 PENTIPS GENERIC PEN NEEDLES 31G X 8 MM..... 180, 189
 PENTIPS GENERIC PEN NEEDLES 32G X 4 MM..... 180, 189
 PENTIPS GENERIC PEN NEEDLES 32G X 6 MM..... 180, 189

PHARMACIST CHOICE ALCOHOL PAD 180, 189
 phenobarbital oral elixir 20 mg/5ml 150
 phenobarbital oral tablet 150
 PIP PEN NEEDLES 31G X 5MM 31G X 5 MM 180, 189
 PIP PEN NEEDLES 32G X 4MM 32G X 4 MM 180, 189
 PIQRAY (200 MG DAILY DOSE)..... 22
 PIQRAY (250 MG DAILY DOSE)..... 22
 PIQRAY (300 MG DAILY DOSE)..... 22
 pirfenidone oral capsule..... 277, 278
 pirfenidone oral tablet 267 mg, 534 mg, 801 mg 277, 278
 pomalidomide 280
 POMALYST 280
 posaconazole oral tablet delayed release 282
 PRECISION SURE-DOSE SYRINGE 30G X 5/16..... 180, 189
 PREFERRED PLUS INSULIN SYRINGE 28G X 1/2..... 180, 189
 PREFERRED PLUS INSULIN SYRINGE 29G X 1/2..... 180, 181, 189
 PREFERRED PLUS INSULIN SYRINGE 30G X 5/16..... 181, 189
 PREFERRED PLUS UNIFINE PENTIPS 29G X 12MM..... 181, 189
 PREMPHASE..... 148
 PREMPRO..... 148
 PREVENT DROPSAFE PEN NEEDLES 31G X 6 MM..... 181, 189
 PREVENT DROPSAFE PEN NEEDLES 31G X 8 MM..... 181, 189
 PREVENT SAFETY PEN NEEDLES 31G X 6 MM..... 181, 189
 PREVENT SAFETY PEN NEEDLES 31G X 8 MM..... 181, 189
 PREVYMIS ORAL TABLET 206
 PRO COMFORT ALCOHOL PAD 70 % 181, 189
 PRO COMFORT INSULIN SYRINGE 30G X 1/2..... 181, 189
 PRO COMFORT INSULIN SYRINGE 30G X 5/16..... 181, 189
 PRO COMFORT INSULIN SYRINGE 31G X 5/16..... 181, 189

PRO COMFORT PEN NEEDLES 32G X 4
 MM 181, 189
 PRO COMFORT PEN NEEDLES 32G X 5
 MM 181, 189
 PRO COMFORT PEN NEEDLES 32G X 6
 MM 181, 189
 PRO COMFORT PEN NEEDLES 32G X 8
 MM 181, 189
 PRODIGY INSULIN SYRINGE 28G X 1/2
 181, 189
 PRODIGY INSULIN SYRINGE 31G X
 5/16 181, 189
 promethazine hcl injection solution 25
 mg/ml 151, 152
 promethazine hcl oral tablet..... 151, 152
 promethazine hcl rectal suppository 25 mg
 151, 152
 promethegan rectal suppository 12.5 mg, 25
 mg 151, 152
 PURE COMFORT ALCOHOL PREP PAD
 181, 189
 PURE COMFORT PEN NEEDLE 32G X 4
 MM 181, 189
 PURE COMFORT PEN NEEDLE 32G X 5
 MM 181, 189
 PURE COMFORT PEN NEEDLE 32G X 6
 MM 181, 189
 PURE COMFORT PEN NEEDLE 32G X 8
 MM 181, 189
 PURE COMFORT SAFETY PEN NEEDLE
 31G X 5 MM..... 181, 189
 PURE COMFORT SAFETY PEN NEEDLE
 31G X 6 MM..... 181, 189
 PURE COMFORT SAFETY PEN NEEDLE
 32G X 4 MM..... 181, 189
 PX EXTRA SHORT PEN NEEDLES 31G
 X 6 MM..... 181, 189
 PX INSULIN SYRINGE 30G X 1/2 181,
 189
 PX MINI PEN NEEDLES 31G X 5 MM
 181, 189
 PX PEN NEEDLE 29G X 12MM .. 181, 189
 PX PEN NEEDLE 31G X 8 MM ... 181, 189
 PX SHORTLENGTH PEN NEEDLES 31G
 X 8 MM..... 181, 189
 pyrimethamine oral 284

Q

QC ALCOHOL..... 181, 189
 QC ALCOHOL SWABS PAD 70 %..... 181,
 189
 QC BORDER ISLAND GAUZE PAD 2
 181, 189
 QC PEN NEEDLES 29G X 12MM 181, 189
 QC PEN NEEDLES 31G X 6 MM. 181, 189
 QC PEN NEEDLES 31G X 8 MM. 181, 189
 QC UNIFINE PENTIPS 32G X 4 MM . 181,
 189
 QINLOCK..... 302
 QUICK TOUCH INSULIN PEN NEEDLE
 29G X 12.7MM..... 181, 189
 QUICK TOUCH INSULIN PEN NEEDLE
 31G X 4 MM..... 181, 189
 QUICK TOUCH INSULIN PEN NEEDLE
 31G X 5 MM..... 181, 189
 QUICK TOUCH INSULIN PEN NEEDLE
 31G X 6 MM..... 181, 189
 QUICK TOUCH INSULIN PEN NEEDLE
 31G X 8 MM..... 181, 189
 QUICK TOUCH INSULIN PEN NEEDLE
 32G X 4 MM..... 181, 189
 QUICK TOUCH INSULIN PEN NEEDLE
 32G X 5 MM..... 182, 189
 QUICK TOUCH INSULIN PEN NEEDLE
 32G X 6 MM..... 182, 189
 QUICK TOUCH INSULIN PEN NEEDLE
 32G X 8 MM..... 182, 189
 QUICK TOUCH INSULIN PEN NEEDLE
 33G X 4 MM..... 182, 189
 QUICK TOUCH INSULIN PEN NEEDLE
 33G X 5 MM..... 182, 189
 QUICK TOUCH INSULIN PEN NEEDLE
 33G X 6 MM..... 182, 189
 QUICK TOUCH INSULIN PEN NEEDLE
 33G X 8 MM..... 182, 189
 quinine sulfate oral..... 285
 QULIPTA 34

R

RA ALCOHOL SWABS PAD 70 %..... 182,
 189
 RA INSULIN SYRINGE 29G X 1/2..... 182,
 189

RA INSULIN SYRINGE 30G X 5/16... 182, 189
 ra isopropyl alcohol wipes 182, 189
 RA PEN NEEDLES 31G X 5 MM. 182, 189
 RA PEN NEEDLES 31G X 8 MM. 182, 189
 RA STERILE PAD 2 182, 189
 RALDESY 372
 RAYA SURE PEN NEEDLE 29G X 12MM 182, 189
 RAYA SURE PEN NEEDLE 31G X 4 MM 182, 189
 RAYA SURE PEN NEEDLE 31G X 5 MM 182, 189
 RAYA SURE PEN NEEDLE 31G X 6 MM 182, 189
 RAYA SURE PEN NEEDLE 31G X 8 MM 182, 189
 REALITY INSULIN SYRINGE 28G X 1/2 182, 189
 REALITY INSULIN SYRINGE 29G X 1/2 182, 189
 REALITY SWABS PAD..... 182, 189
 RELION ALCOHOL SWABS PAD 182, 189
 RELION ALCOHOL SWABS PAD 70 % 182, 189
 RELI-ON INSULIN SYRINGE 29G 0.3 ML..... 182, 189
 RELION INSULIN SYRINGE 29G X 1/2 182, 189
 RELION INSULIN SYRINGE 31G X 15/64 182, 189
 RELION INSULIN SYRINGE 31G X 5/16 182, 189
 RELION MINI PEN NEEDLES 31G X 6 MM 182, 189
 RELION PEN NEEDLES 29G X 12MM 182, 189
 RELION PEN NEEDLES 31G X 6 MM182, 189
 RELION PEN NEEDLES 31G X 8 MM182, 189
 RELION PEN NEEDLES 32G X 4 MM182, 189
 RELION SHORT PEN NEEDLES 31G X 8 MM 182, 189

RESTORE CONTACT LAYER PAD 2 182, 189
 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 109, 110
 RETEVMO ORAL CAPSULE 40 MG, 80 MG 316
 RETEVMO ORAL TABLET 120 MG, 160 MG, 40 MG, 80 MG 316
 REVCovi..... 96
 REVUFORJ ORAL TABLET 110 MG, 160 MG, 25 MG..... 292
 REZDIFFRA..... 290
 REZLIDHIA 256
 REZUROCK..... 44
 RINVOQ 379, 380
 RINVOQ LQ..... 379, 380
 RITUXAN HYCELA 305
 ROMVIMZA 397
 ROZLYTREK ORAL CAPSULE 100 MG, 200 MG 105
 ROZLYTREK ORAL PACKET 106
 RUBRACA 309
 RYBELSUS 139
 RYBELSUS (FORMULATION R2)..... 139
 RYBREVANT 25
 RYBREVANT FASPRO 24
 RYDAPT..... 232
 RYTELO..... 163
S
 SAFETY PEN NEEDLES 30G X 5 MM 182, 189
 SAFETY PEN NEEDLES 30G X 8 MM 182, 189
 sapropterin dihydrochloride oral tablet... 311
 SAPS CARE ALCOHOL PREP PAD 70 % 182, 189
 SAPS HEALTH ALCOHOL PREP PAD 70 % 182, 189
 SAPS HEALTH CARE ALCOHOL PREP PAD 70 % 182, 189
 SB ALCOHOL PREP PAD 70 %... 182, 189
 SB INSULIN SYRINGE 29G X 1/2 182, 189

SB INSULIN SYRINGE 30G X 5/16 ... 182,
183, 189
SB INSULIN SYRINGE 31G X 5/16 ... 183,
189
SCEMBLIX ORAL TABLET 100 MG, 20
MG, 40 MG..... 33
scopolamine 153
SECURESAFE INSULIN SYRINGE 29G
X 1/2..... 183, 189
SECURESAFE SAFETY PEN NEEDLES
30G X 8 MM..... 183, 189
SECURESAFE SAFETY PEN NEEDLES
31G X 5 MM..... 183, 189
SELARSDI 383, 384, 385, 386
SEROSTIM SUBCUTANEOUS
SOLUTION RECONSTITUTED 4 MG,
5 MG, 6 MG..... 329
SIGNIFOR 264
sildenafil citrate oral tablet 20 mg .. 319, 320
SIRTURO 42
SKYRIZI INTRAVENOUS 303, 304
SKYRIZI PEN 303, 304
SKYRIZI SUBCUTANEOUS SOLUTION
CARTRIDGE..... 303, 304
SKYRIZI SUBCUTANEOUS SOLUTION
PREFILLED SYRINGE 150 MG/ML
..... 303, 304
SM STERILE PAD 2..... 183, 189
sodium oxybate 322, 323
SOMATULINE DEPOT
SUBCUTANEOUS SOLUTION 60
MG/0.2ML, 90 MG/0.3ML 199
SOMAVERT..... 269
sorafenib tosylate 331
SPRAVATO (56 MG DOSE)..... 114
SPRAVATO (84 MG DOSE)..... 114
STERILE GAUZE PAD 2 183, 189
STERILE PAD 2..... 183, 189
STIVARGA 287
SUBVENITE ORAL SUSPENSION 198
sunitinib malate..... 336
SURE COMFORT ALCOHOL PREP PAD
70 % 183, 189
SURE COMFORT INSULIN SYRINGE
28G X 1/2..... 183, 189

SURE COMFORT INSULIN SYRINGE
29G X 1/2..... 183, 189
SURE COMFORT INSULIN SYRINGE
30G X 1/2..... 183, 189
SURE COMFORT INSULIN SYRINGE
30G X 5/16..... 183, 189
SURE COMFORT INSULIN SYRINGE
31G X 1/4..... 183, 189
SURE COMFORT INSULIN SYRINGE
31G X 5/16..... 183, 189
SURE COMFORT PEN NEEDLES 29G X
12.7MM 183, 189
SURE COMFORT PEN NEEDLES 30G X
8 MM 183, 189
SURE COMFORT PEN NEEDLES 31G X
5 MM 183, 189
SURE COMFORT PEN NEEDLES 31G X
6 MM 183, 189
SURE COMFORT PEN NEEDLES 31G X
8 MM 183, 189
SURE COMFORT PEN NEEDLES 32G X
4 MM (OTC)..... 183, 189
SURE COMFORT PEN NEEDLES 32G X
4 MM (RX) 183, 189
SURE COMFORT PEN NEEDLES 32G X
6 MM 183, 189
SURGICAL GAUZE SPONGE PAD 2 183,
189
SYMPAZAN..... 66
SYNRIBO 257
T
TABRECTA 60
tadalafil oral tablet 2.5 mg, 5 mg 338
TAFINLAR ORAL CAPSULE 70
TAFINLAR ORAL TABLET SOLUBLE 71
TAGRISSO 261
TALVEY..... 342
TALZENNA 340
TAVNEOS..... 35
TECHLITE INSULIN SYRINGE 30G X
1/2 183, 189
TECHLITE INSULIN SYRINGE 31G X
15/64 183, 189
TECHLITE INSULIN SYRINGE 31G X
5/16 183, 189

TECHLITE PEN NEEDLES 29G X 12MM	183, 189	TOPCARE ULTRA COMFORT INS SYR 30G X 5/16.....	184, 189
TECHLITE PEN NEEDLES 31G X 5 MM	183, 189	TOPCARE ULTRA COMFORT INS SYR 31G X 5/16.....	184, 189
TECHLITE PEN NEEDLES 31G X 8 MM	183, 189	torpenz oral tablet 10 mg, 2.5 mg, 5 mg, 7.5 mg	117
TECHLITE PEN NEEDLES 32G X 4 MM	184, 189	TRELSTAR MIXJECT	376
TECHLITE PEN NEEDLES 32G X 6 MM	184, 189	TREMFYA INTRAVENOUS	142, 143
TECHLITE PLUS PEN NEEDLES 32G X 4 MM	184, 189	TREMFYA ONE-PRESS SUBCUTANEOUS SOLUTION PEN-INJECTOR.....	142, 143
TECVAYLI.....	345	TREMFYA PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 200 MG/2ML	142, 143
TEGADERM FOAM PAD 2.....	184, 189	TREMFYA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE	142, 143
TEPMETKO	348	TREMFYA-CD/UC INDUCTION.	142, 143
teriparatide subcutaneous solution pen-injector 560 mcg/2.24ml	349	tretinoin external cream	365
testosterone cypionate intramuscular solution 100 mg/ml, 200 mg/ml, 200 mg/ml (1 ml)	351	tridacaine iii	216
testosterone enanthate intramuscular solution.....	352	trientine hcl oral capsule 250 mg	374
testosterone gel 1.62 % transdermal	350	TRIKAFTA ORAL TABLET THERAPY PACK.....	97
testosterone transdermal gel 12.5 mg/act (1%), 20.25 mg/act (1.62%), 25 mg/2.5gm (1%), 50 mg/5gm (1%).....	350	TRIKAFTA ORAL THERAPY PACK....	97
tetrabenazine	353	TRUE COMFORT ALCOHOL PREP PADS PAD 70 %.....	184, 189
TEVIMBRA.....	355	TRUE COMFORT INSULIN SYRINGE 30G X 1/2.....	184, 189
THALOMID ORAL CAPSULE 100 MG, 150 MG, 200 MG, 50 MG	354	TRUE COMFORT INSULIN SYRINGE 30G X 5/16.....	184, 189
THERAGAUZE PAD 2.....	184, 189	TRUE COMFORT INSULIN SYRINGE 31G X 5/16.....	184, 189
TIBSOVO	196	TRUE COMFORT INSULIN SYRINGE 32G X 5/16.....	184, 189
TIVDAK	356	TRUE COMFORT PEN NEEDLES 31G X 5 MM	184, 189
TODAYS HEALTH PEN NEEDLES 29G X 12MM.....	184, 189	TRUE COMFORT PEN NEEDLES 31G X 6 MM	184, 189
TODAYS HEALTH SHORT PEN NEEDLE 31G X 8 MM	184, 189	TRUE COMFORT PEN NEEDLES 32G X 4 MM	184, 189
tofacitinib citrate er	362, 363	TRUE COMFORT PRO ALCOHOL PREP PAD 70 %	184, 189
tofacitinib citrate oral.....	362, 363	TRUE COMFORT PRO INSULIN SYR 30G X 1/2.....	184, 189
tolvaptan oral tablet therapy pack	364	TRUE COMFORT PRO INSULIN SYR 30G X 5/16.....	184, 189
TOPCARE CLICKFINE PEN NEEDLES 31G X 6 MM.....	184, 189		
TOPCARE CLICKFINE PEN NEEDLES 31G X 8 MM.....	184, 189		
TOPCARE ULTRA COMFORT INS SYR 29G X 1/2.....	184, 189		

TRUE COMFORT PRO INSULIN SYR 31G X 5/16.....	184, 189
TRUE COMFORT PRO INSULIN SYR 32G X 5/16.....	184, 189
TRUE COMFORT PRO PEN NEEDLES 31G X 5 MM.....	184, 189
TRUE COMFORT PRO PEN NEEDLES 31G X 6 MM.....	184, 189
TRUE COMFORT PRO PEN NEEDLES 31G X 8 MM.....	184, 189
TRUE COMFORT PRO PEN NEEDLES 32G X 4 MM.....	184, 189
TRUE COMFORT PRO PEN NEEDLES 32G X 5 MM.....	184, 189
TRUE COMFORT PRO PEN NEEDLES 32G X 6 MM.....	184, 189
TRUE COMFORT PRO PEN NEEDLES 33G X 4 MM.....	184, 189
TRUE COMFORT PRO PEN NEEDLES 33G X 5 MM.....	185, 189
TRUE COMFORT PRO PEN NEEDLES 33G X 6 MM.....	185, 189
TRUE COMFORT SAFETY PEN NEEDLE 31G X 5 MM	185, 189
TRUE COMFORT SAFETY PEN NEEDLE 31G X 6 MM	185, 189
TRUE COMFORT SAFETY PEN NEEDLE 32G X 4 MM	185, 189
TRUEPLUS 5-BEVEL PEN NEEDLES 29G X 12.7MM.....	185, 189
TRUEPLUS 5-BEVEL PEN NEEDLES 31G X 5 MM.....	185, 189
TRUEPLUS 5-BEVEL PEN NEEDLES 31G X 6 MM.....	185, 189
TRUEPLUS 5-BEVEL PEN NEEDLES 31G X 8 MM.....	185, 189
TRUEPLUS 5-BEVEL PEN NEEDLES 32G X 4 MM.....	185, 189
TRUEPLUS INSULIN SYRINGE 28G X 1/2	185, 189
TRUEPLUS INSULIN SYRINGE 29G X 1/2	185, 189
TRUEPLUS INSULIN SYRINGE 30G X 5/16	185, 189
TRUEPLUS INSULIN SYRINGE 31G X 5/16	185, 189
TRUEPLUS PEN NEEDLES 29G X 12MM	185, 189
TRUEPLUS PEN NEEDLES 31G X 5 MM	185, 189
TRUEPLUS PEN NEEDLES 31G X 6 MM	185, 189
TRUEPLUS PEN NEEDLES 31G X 8 MM	185, 189
TRUEPLUS PEN NEEDLES 32G X 4 MM	185, 189
TRULICITY SUBCUTANEOUS SOLUTION AUTO-INJECTOR	138
TRUQAP ORAL TABLET 200 MG	59
TRUQAP ORAL TABLET THERAPY PACK 160 MG	59
TRUXIMA	306, 307
TUKYSA ORAL TABLET 150 MG, 50 MG	377
TURALIO ORAL CAPSULE 125 MG..	275
TYENNE.....	358, 359, 360, 361
TYMLOS	1
U	
UBRELVY	378
UDENYCA ONBODY	267
ULTICARE ALCOHOL SWABS PAD	185, 189
ULTICARE ALCOHOL SWABS PAD 70 %	185, 189
ULTICARE INSULIN SAFETY SYR 29G X 1/2.....	185, 189
ULTICARE INSULIN SYR 1/2 UNIT 31G X 1/4.....	185, 189
ULTICARE INSULIN SYRINGE 28G X 1/2	185, 189
ULTICARE INSULIN SYRINGE 29G X 1/2	185, 189
ULTICARE INSULIN SYRINGE 30G X 1/2	185, 189
ULTICARE INSULIN SYRINGE 30G X 5/16	185, 189
ULTICARE INSULIN SYRINGE 31G X 1/4	185, 186, 189
ULTICARE INSULIN SYRINGE 31G X 5/16	186, 189
ULTICARE MICRO PEN NEEDLES 31G X 6 MM.....	186, 189

ULTICARE MICRO PEN NEEDLES 31G X 8 MM.....	186, 189	ULTILET PEN NEEDLE 32G X 4 MM	186, 189
ULTICARE MICRO PEN NEEDLES 32G X 4 MM.....	186, 189	ULTRA COMFORT INSULIN SYRINGE 30G X 5/16.....	186, 189
ULTICARE MINI PEN NEEDLES 30G X 5 MM	186, 189	ULTRA FLO INSULIN PEN NEEDLES 29G X 12MM.....	186, 189
ULTICARE MINI PEN NEEDLES 31G X 6 MM	186, 189	ULTRA FLO INSULIN PEN NEEDLES 31G X 5 MM.....	186, 189
ULTICARE MINI PEN NEEDLES 32G X 6 MM	186, 189	ULTRA FLO INSULIN PEN NEEDLES 31G X 8 MM.....	186, 189
ULTICARE PEN NEEDLES 29G X 12.7MM (OTC).....	186, 189	ULTRA FLO INSULIN PEN NEEDLES 32G X 4 MM.....	186, 189
ULTICARE PEN NEEDLES 29G X 12.7MM (RX).....	186, 189	ULTRA FLO INSULIN PEN NEEDLES 33G X 4 MM.....	186, 189
ULTICARE PEN NEEDLES 31G X 5 MM	186, 189	ULTRA FLO INSULIN SYR 1/2 UNIT 30G X 1/2.....	186, 189
ULTICARE SHORT PEN NEEDLES 30G X 8 MM.....	186, 189	ULTRA FLO INSULIN SYR 1/2 UNIT 30G X 5/16.....	186, 189
ULTICARE SHORT PEN NEEDLES 31G X 8 MM (OTC).....	186, 189	ULTRA FLO INSULIN SYR 1/2 UNIT 31G X 5/16.....	186, 189
ULTICARE SHORT PEN NEEDLES 31G X 8 MM (RX)	186, 189	ULTRA FLO INSULIN SYRINGE 29G X 1/2	186, 189
ULTIGUARD SAFEPACK PEN NEEDLE 29G X 12.7MM.....	186, 189	ULTRA FLO INSULIN SYRINGE 30G X 1/2	187, 189
ULTIGUARD SAFEPACK PEN NEEDLE 31G X 5 MM.....	186, 189	ULTRA FLO INSULIN SYRINGE 30G X 5/16	187, 189
ULTIGUARD SAFEPACK PEN NEEDLE 31G X 6 MM.....	186, 189	ULTRA FLO INSULIN SYRINGE 31G X 5/16	187, 189
ULTIGUARD SAFEPACK PEN NEEDLE 31G X 8 MM.....	186, 189	ULTRA THIN PEN NEEDLES 32G X 4 MM	187, 189
ULTIGUARD SAFEPACK PEN NEEDLE 32G X 4 MM.....	186, 189	ULTRA-CARE ALCOHOL PREP PADS PAD 70 %	187, 189
ULTIGUARD SAFEPACK PEN NEEDLE 32G X 6 MM.....	186, 189	ULTRACARE INSULIN SYRINGE 30G X 1/2	187, 189
ULTIGUARD SAFEPACK SYR/NEEDLE 30G X 1/2.....	186, 189	ULTRACARE INSULIN SYRINGE 30G X 5/16	187, 189
ULTIGUARD SAFEPACK SYR/NEEDLE 31G X 5/16.....	186, 189	ULTRACARE INSULIN SYRINGE 31G X 5/16	187, 189
ULTILET ALCOHOL SWABS PAD ...	186, 189	ULTRACARE PEN NEEDLES 31G X 5 MM	187, 189
ULTILET PEN NEEDLE 29G X 12.7MM	186, 189	ULTRACARE PEN NEEDLES 31G X 6 MM	187, 189
ULTILET PEN NEEDLE 31G X 5 MM	186, 189	ULTRACARE PEN NEEDLES 31G X 8 MM	187, 189
ULTILET PEN NEEDLE 31G X 8 MM	186, 189	ULTRACARE PEN NEEDLES 32G X 4 MM	187, 189

ULTRACARE PEN NEEDLES 32G X 5
 MM 187, 189
 ULTRACARE PEN NEEDLES 32G X 6
 MM 187, 189
 ULTRACARE PEN NEEDLES 33G X 4
 MM 187, 189
 ULTRA-THIN II INS SYR SHORT 30G X
 5/16 187, 189
 ULTRA-THIN II INS SYR SHORT 31G X
 5/16 187, 189
 ULTRA-THIN II INSULIN SYRINGE 29G
 X 1/2..... 187, 189
 ULTRA-THIN II MINI PEN NEEDLE 31G
 X 5 MM..... 187, 189
 ULTRA-THIN II PEN NEEDLE SHORT
 31G X 8 MM..... 187, 189
 ULTRA-THIN II PEN NEEDLES 29G X
 12.7MM 187, 189
 UNIFINE OTC PEN NEEDLES 31G X 5
 MM 187, 189
 UNIFINE OTC PEN NEEDLES 32G X 4
 MM 187, 189
 UNIFINE PENTIPS 29G X 12MM 187, 189
 UNIFINE PENTIPS 30G X 5 MM. 187, 189
 UNIFINE PENTIPS 31G X 5 MM. 187, 189
 UNIFINE PENTIPS 31G X 6 MM. 187, 189
 UNIFINE PENTIPS 31G X 8 MM. 187, 189
 UNIFINE PENTIPS 32G X 4 MM. 187, 189
 UNIFINE PENTIPS 32G X 6 MM. 187, 189
 UNIFINE PENTIPS 33G X 4 MM. 187, 189
 UNIFINE PENTIPS PLUS 29G X 12MM
 187, 189
 UNIFINE PENTIPS PLUS 30G X 5 MM
 187, 189
 UNIFINE PENTIPS PLUS 31G X 5 MM
 187, 189
 UNIFINE PENTIPS PLUS 31G X 6 MM
 188, 189
 UNIFINE PENTIPS PLUS 31G X 8 MM
 188, 189
 UNIFINE PENTIPS PLUS 32G X 4 MM
 188, 189
 UNIFINE PENTIPS PLUS 33G X 4 MM
 188, 189
 UNIFINE PROTECT PEN NEEDLE 30G X
 5 MM 188, 189

UNIFINE PROTECT PEN NEEDLE 30G X
 8 MM 188, 189
 UNIFINE PROTECT PEN NEEDLE 32G X
 4 MM 188, 189
 UNIFINE SAFECONTROL PEN NEEDLE
 30G X 5 MM..... 188, 189
 UNIFINE SAFECONTROL PEN NEEDLE
 30G X 8 MM..... 188, 189
 UNIFINE SAFECONTROL PEN NEEDLE
 31G X 5 MM..... 188, 189
 UNIFINE SAFECONTROL PEN NEEDLE
 31G X 6 MM..... 188, 189
 UNIFINE SAFECONTROL PEN NEEDLE
 31G X 8 MM..... 188, 189
 UNIFINE SAFECONTROL PEN NEEDLE
 32G X 4 MM..... 188, 189
 UNIFINE ULTRA PEN NEEDLE 29G X
 12MM 188, 189
 UNIFINE ULTRA PEN NEEDLE 31G X 5
 MM 188, 189
 UNIFINE ULTRA PEN NEEDLE 31G X 6
 MM 188, 189
 UNIFINE ULTRA PEN NEEDLE 31G X 8
 MM 188, 189
 UNIFINE ULTRA PEN NEEDLE 32G X 4
 MM 188, 189
 UNIFINE ULTRA PEN NEEDLE 32G X 6
 MM 188, 189
 UNIFINE ULTRA PEN NEEDLE 34G X
 3.5 MM 188, 189
 UPTRAVI ORAL TABLET 1000 MCG,
 1200 MCG, 1400 MCG, 1600 MCG, 200
 MCG, 400 MCG, 600 MCG, 800 MCG
 314
 UPTRAVI TITRATION..... 314
 ustekinumab-aauz 381, 382
V
 VALCHLOR..... 227
 VALUE HEALTH INSULIN SYRINGE
 29G X 1/2..... 188, 189
 VANFLYTA 286
 VANISHPOINT INSULIN SYRINGE 29G
 X 1/2..... 188, 189
 VANISHPOINT INSULIN SYRINGE 29G
 X 5/16..... 188, 189

VANISHPOINT INSULIN SYRINGE 30G X 1/2.....	188, 189	VONJO	262
VANISHPOINT INSULIN SYRINGE 30G X 3/16.....	188, 189	VOQUEZNA	399
VANISHPOINT INSULIN SYRINGE 30G X 5/16.....	188, 189	VORANIGO	400
VENCLEXTA ORAL TABLET 10 MG, 100 MG, 50 MG.....	394	voriconazole oral suspension reconstituted	401
VENCLEXTA STARTING PACK	394	VOSEVI.....	325, 326
VEOZAH	123, 124	VOWST	119
VERIFINE INSULIN PEN NEEDLE 29G X 12MM.....	188, 189	VP INSULIN SYRINGE 29G X 1/2	189
VERIFINE INSULIN PEN NEEDLE 31G X 5 MM.....	188, 189	VUMERITY	85
VERIFINE INSULIN PEN NEEDLE 31G X 8 MM.....	188, 189	VYALEV SUBCUTANEOUS SOLUTION 12-240 MG/ML.....	128
VERIFINE INSULIN PEN NEEDLE 32G X 4 MM.....	188, 189	VYLOY.....	406
VERIFINE INSULIN PEN NEEDLE 32G X 6 MM.....	188, 189	VYNDAMAX.....	339
VERIFINE INSULIN SYRINGE 28G X 1/2	188, 189	W	
VERIFINE INSULIN SYRINGE 29G X 1/2	188, 189	WEBCOL ALCOHOL PREP LARGE PAD 70 %	189
VERIFINE INSULIN SYRINGE 30G X 1/2	188, 189	WEBCOL ALCOHOL PREP MEDIUM PAD 70 %	189
VERIFINE INSULIN SYRINGE 30G X 5/16	188, 189	WEGMANS UNIFINE PENTIPS PLUS 31G X 5 MM.....	189
VERIFINE INSULIN SYRINGE 31G X 5/16	188, 189	WEGMANS UNIFINE PENTIPS PLUS 31G X 6 MM.....	189
VERIFINE PLUS PEN NEEDLE 31G X 5 MM	188, 189	WEGMANS UNIFINE PENTIPS PLUS 31G X 8 MM.....	189
VERIFINE PLUS PEN NEEDLE 31G X 8 MM	188, 189	WEGMANS UNIFINE PENTIPS PLUS 32G X 4 MM.....	189
VERIFINE PLUS PEN NEEDLE 32G X 4 MM	188, 189	WELIREG.....	45
VERQUVO	395	WINREVAIR.....	332, 333
VERZENIO.....	6	X	
vigabatrin	396	XALKORI ORAL CAPSULE.....	68
vigadrone.....	396	XALKORI ORAL CAPSULE SPRINKLE 150 MG, 20 MG, 50 MG	69
vigpoder	396	XDEMVY	221
VITRAKVI ORAL CAPSULE 100 MG, 25 MG	201	XELJANZ	362, 363
VITRAKVI ORAL SOLUTION	201	XELJANZ XR	362, 363
VIVIMUSTA	46	XERMELO	347
VIZIMPRO	72	XIFAXAN ORAL TABLET 200 MG, 550 MG	295
		XOLAIR	258, 259, 260
		XOSPATA	135
		XPOVIO (100 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 50 MG	315
		XPOVIO (40 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 10 MG, 40 MG	315

XPOVIO (40 MG TWICE WEEKLY) ORAL TABLET THERAPY PACK 40 MG	315
XPOVIO (60 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 60 MG..	315
XPOVIO (60 MG TWICE WEEKLY)...	315
XPOVIO (80 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 40 MG, 80 MG	315
XPOVIO (80 MG TWICE WEEKLY)...	315
XTANDI ORAL CAPSULE.....	107
XTANDI ORAL TABLET 40 MG, 80 MG	107

Y

YERVOY	193
YESINTEK	387, 388, 389, 390
YONSA.....	8
YUFLYMA (1 PEN).....	14, 15
YUFLYMA (2 SYRINGE).....	14, 15
YUFLYMA-CD/UC/HS STARTER ..	14, 15
yulithira oral tablet 10 mg, 2.5 mg, 5 mg, 7.5 mg	117

Z

ZEJULA ORAL CAPSULE	248
---------------------------	-----

ZEJULA ORAL TABLET.....	248
ZELBORAF	393
ZEVRX INSULIN SYRINGE 30G X 1/2	189
ZEVRX INSULIN SYRINGE 30G X 5/16	189
ZEVRX PEN NEEDLES 31G X 5 MM.	189
ZEVRX PEN NEEDLES 31G X 6 MM.	189
ZEVRX PEN NEEDLES 31G X 8 MM.	189
ZEVRX PEN NEEDLES 32G X 4 MM.	189
ZEVRX STERILE ALCOHOL PREP PAD PAD 70 %	189
ZIIHERA.....	402
ZIRABEV	48
ZOLADEX.....	141
ZTALMY	132
ZURZUVAE ORAL CAPSULE 20 MG, 25 MG, 30 MG.....	408
ZYDELIG	160
ZYKADIA ORAL TABLET	62
ZYNLONTA.....	219
ZYNYZ	291