009 ORAL_AND_INTRAVENOUS_ONCOLYTICS

MEDICATION(S)

ABIRATERONE ACETATE 250 MG TAB, AKEEGA, ALECENSA, ALUNBRIG, AUGTYRO, AYVAKIT, BALVERSA, BESREMI, BEXAROTENE 75 MG CAPSULE, BOSULIF 100 MG TABLET, BOSULIF 400 MG TABLET, BOSULIF 500 MG TABLET, BRAFTOVI, BRUKINSA, CABOMETYX, CALQUENCE, CAPECITABINE, CAPRELSA, COMETRIQ, COPIKTRA, COTELLIC, CYCLOPHOSPHAMIDE 25 MG CAPSULE, CYCLOPHOSPHAMIDE 50 MG CAPSULE, DAURISMO, ELIGARD, EMCYT, ERIVEDGE, ERLEADA, ERLOTINIB HCL 100 MG TABLET, ERLOTINIB HCL 150 MG TABLET, ERLOTINIB HCL 25 MG TABLET, EVEROLIMUS 10 MG TABLET, EVEROLIMUS 2 MG TAB FOR SUSP, EVEROLIMUS 2.5 MG TABLET, EVEROLIMUS 3 MG TAB FOR SUSP, EVEROLIMUS 5 MG TAB FOR SUSP, EVEROLIMUS 5 MG TABLET, EVEROLIMUS 7.5 MG TABLET, EXKIVITY, FARYDAK, FOTIVDA, FRUZAQLA, GEFITINIB, GILOTRIF, GLEOSTINE, HYCAMTIN 0.25 MG CAPSULE, HYCAMTIN 1 MG CAPSULE, IBRANCE, ICLUSIG, IDHIFA, IMATINIB MESYLATE, IMBRUVICA 140 MG CAPSULE, IMBRUVICA 140 MG TABLET, IMBRUVICA 280 MG TABLET, IMBRUVICA 420 MG TABLET, IMBRUVICA 560 MG TABLET, IMBRUVICA 70 MG CAPSULE, INLYTA, INQOVI, INREBIC, IWILFIN, JAKAFI, JAYPIRCA, KISQALI, KOSELUGO, KRAZATI, LAPATINIB, LENALIDOMIDE, LENVIMA, LEUKERAN, LEUPROLIDE 2WK 14 MG/2.8 ML KT, LEUPROLIDE 2WK 14 MG/2.8 ML VL, LEUPROLIDE DEPOT, LORBRENA, LUMAKRAS, LUPRON DEPOT, LYNPARZA, LYSODREN, LYTGOBI, MATULANE, MEKINIST 0.5 MG TABLET, MEKINIST 2 MG TABLET, MEKTOVI, MERCAPTOPURINE 50 MG TABLET, METHOTREXATE SODIUM, MYLERAN, NERLYNX, NINLARO, NUBEQA, ODOMZO, OGSIVEO, OJJAARA, ONUREG, ORGOVYX, ORSERDU, PAZOPANIB HCL, PEMAZYRE, PIQRAY, POMALYST, PURIXAN, QINLOCK, RETEVMO, REZLIDHIA, REZUROCK, ROZLYTREK 100 MG CAPSULE, ROZLYTREK 200 MG CAPSULE, RUBRACA, RYDAPT, SCEMBLIX, SOLTAMOX, SORAFENIB, SPRYCEL, STIVARGA, SUNITINIB MALATE, SYNRIBO, TABRECTA, TAFINLAR 50 MG CAPSULE, TAFINLAR 75 MG CAPSULE, TAGRISSO, TALZENNA, TASIGNA, TAZVERIK, TEMOZOLOMIDE, TEPMETKO, TIBSOVO, TOREMIFENE CITRATE, TRETINOIN 10 MG CAPSULE, TRUQAP, TRUSELTIQ, TUKYSA, TURALIO, UKONIQ, VANFLYTA, VENCLEXTA, VENCLEXTA STARTING PACK, VERZENIO, VITRAKVI, VIZIMPRO, VONJO, WELIREG, XALKORI 200 MG CAPSULE, XALKORI 250 MG CAPSULE, XOSPATA, XPOVIO, XTANDI, YONSA, ZEJULA, ZELBORAF, ZOLINZA, ZYDELIG, ZYKADIA

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

N/A

015 RECTIV

MEDICATION(S)

RECTIV

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

N/A

MEDICATION(S)

BUTALB-ACETAMIN-CAFF 50-325-40, BUTALBITAL-ASPIRIN-CAFFEINE TB

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

N/A

018 MIGRAINE_PREVENTION

MEDICATION(S)

AIMOVIG AUTOINJECTOR, EMGALITY PEN, EMGALITY SYRINGE, QULIPTA

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

N/A

MEDICATION(S)

NARATRIPTAN HCL, SUMATRIPTAN 20 MG NASAL SPRAY, SUMATRIPTAN 5 MG NASAL SPRAY

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

N/A

MEDICATION(S)

ACETAMINOP-CODEINE 120-12 MG/5, ACETAMINOPHEN-COD #2 TABLET, ACETAMINOPHEN-COD #3 TABLET, ACETAMINOPHEN-COD #4 TABLET, CODEINE SULFATE, ENDOCET, HYDROCODONE-ACETAMIN 10-325 MG, HYDROCODONE-ACETAMIN 2.5-325, HYDROCODONE-ACETAMIN 5-325 MG, HYDROCODONE-ACETAMIN 7.5-325, HYDROMORPHONE 2 MG TABLET, HYDROMORPHONE 4 MG TABLET, HYDROMORPHONE 8 MG TABLET, MORPHINE SULF 10 MG/5 ML CUP, MORPHINE SULF 10 MG/5 ML SOLN, MORPHINE SULF 100 MG/5 ML CONC, MORPHINE SULF 20 MG/5 ML SOLN, MORPHINE SULFATE IR 15 MG TAB, MORPHINE SULFATE IR 30 MG TAB, OXYCODONE HCL (IR) 10 MG TAB, OXYCODONE HCL (IR) 15 MG TAB, OXYCODONE HCL (IR) 20 MG TAB, OXYCODONE HCL (IR) 30 MG TAB, OXYCODONE HCL (IR) 5 MG TABLET, OXYCODONE HCL 100 MG/5 ML CONC, OXYCODONE HCL 5 MG/5 ML CUP, OXYCODONE HCL 5 MG/5 ML SOLN, OXYCODONE-ACETAMINOPHEN 10-325, OXYCODONE-ACETAMINOPHEN 5-325, OXYCODONE-ACETAMINOPHN 2.5-325, OXYCODONE-ACETAMINOPHN 7.5-325, TRAMADOL HCL 50 MG TABLET, TRAMADOL HCL-ACETAMINOPHEN

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

N/A

MEDICATION(S)

FENTANYL, MORPHINE SULF ER 100 MG TABLET, MORPHINE SULF ER 15 MG TABLET, MORPHINE SULF ER 200 MG TABLET, MORPHINE SULF ER 30 MG TABLET, MORPHINE SULF ER 60 MG TABLET, OXYCODONE HCL ER

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

N/A

025 DIRECT_FACTOR_XA_INHIBITORS

MEDICATION(S)

DABIGATRAN ETEXILATE

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

N/A

MEDICATION(S)

PRALUENT PEN, REPATHA PUSHTRONEX, REPATHA SURECLICK, REPATHA SYRINGE

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

N/A

037 PULMONARY_HYPERTENSION

MEDICATION(S)

ADEMPAS, ALYQ, AMBRISENTAN, SILDENAFIL 20 MG TABLET, TADALAFIL 20 MG TABLET, TREPROSTINIL, TYVASO, TYVASO INSTITUTIONAL START KIT, TYVASO REFILL KIT, TYVASO STARTER KIT, UPTRAVI 1,000 MCG TABLET, UPTRAVI 1,200 MCG TABLET, UPTRAVI 1,400 MCG TABLET, UPTRAVI 1,600 MCG TABLET, UPTRAVI 200 MCG TABLET, UPTRAVI 200-800 TITRATION PACK, UPTRAVI 400 MCG TABLET, UPTRAVI 600 MCG TABLET, UPTRAVI 800 MCG TABLET, VENTAVIS

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

N/A

038 ATOPIC_DERMATITIS_SYSTEMIC

MEDICATION(S)

CIBINQO, DUPIXENT PEN, DUPIXENT SYRINGE

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

N/A

038 TOPICAL_ANTIINFLAMMATORY_MEDICATIONS

MEDICATION(S)

TACROLIMUS 0.03% OINTMENT, TACROLIMUS 0.1% OINTMENT

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

N/A

039 FINACEA_AZELEX

MEDICATION(S)

AZELAIC ACID 15% GEL, AZELEX, FINACEA 15% FOAM

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

N/A

042 ORAL_ISOTRETINOIN

MEDICATION(S)

ACCUTANE, AMNESTEEM, CLARAVIS, ISOTRETINOIN 10 MG CAPSULE, ISOTRETINOIN 20 MG CAPSULE, ISOTRETINOIN 25 MG CAPSULE, ISOTRETINOIN 30 MG CAPSULE, ISOTRETINOIN 35 MG CAPSULE, ISOTRETINOIN 40 MG CAPSULE, MYORISAN, ZENATANE

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

N/A

043 TOPICAL_RETINOIDS

MEDICATION(S)

ADAPALENE 0.3% GEL, TRETINOIN 0.01% GEL, TRETINOIN 0.025% CREAM, TRETINOIN 0.025% GEL, TRETINOIN 0.05% CREAM, TRETINOIN 0.1% CREAM

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

N/A

048 ACITRETIN

MEDICATION(S)
ACITRETIN

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
N/A

049 TOPICAL_STEROIDS

MEDICATION(S)

DESOXIMETASONE 0.25% OINTMENT, HYDROCORTISONE 1% CREAM

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

N/A

050 CHEMET

MEDICATION(S)

CHEMET

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

N/A

051 EXJADE_JADENU

MEDICATION(S)
DEFERASIROX

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
N/A

052 BLOOD_GLUCOSE_TEST_STRIPS

MEDICATION(S)

FREESTYLE LIBRE 14 DAY READER, FREESTYLE LIBRE 14 DAY SENSOR, FREESTYLE LIBRE 2 READER, FREESTYLE LIBRE 2 SENSOR, FREESTYLE LIBRE 3 READER, FREESTYLE LIBRE 3 SENSOR

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

N/A

MEDICATION(S)

ALOGLIPTIN, ALOGLIPTIN-METFORMIN, ALOGLIPTIN-PIOGLITAZONE

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

N/A

055 INCRETIN_MIMETICS

MEDICATION(S)

MOUNJARO, OZEMPIC, RYBELSUS, VICTOZA 2-PAK, VICTOZA 3-PAK

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

N/A

MEDICATION(S)

FARXIGA, GLYXAMBI, JARDIANCE, SYNJARDY, SYNJARDY XR, TRIJARDY XR, XIGDUO XR

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

N/A

057 LONG-ACTING_(BASAL)_INSULINS

MEDICATION(S)

INSULIN DEGLUDEC, INSULIN DEGLUDEC PEN (U-100), INSULIN DEGLUDEC PEN (U-200)

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

N/A

058 TESTOSTERONE_REPLACEMENT

MEDICATION(S)

KYZATREX, TESTOSTERONE 1% (25MG/2.5G) PK, TESTOSTERONE 1% (50 MG/5 G) PK, TESTOSTERONE 1.62% (2.5 G) PKT, TESTOSTERONE 1.62% GEL PUMP, TESTOSTERONE 1.62%(1.25 G) PKT, TESTOSTERONE 12.5 MG/1.25 GRAM, TESTOSTERONE 50 MG/5 GRAM GEL, TESTOSTERONE 50 MG/5 GRAM PKT

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

N/A

063 CINACALCET_(SENSIPAR)

MEDICATION(S)

CINACALCET HCL

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

N/A

MEDICATION(S)

MYCAPSSA, OCTREOTIDE ACETATE, SOMAVERT

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

N/A

067 ANTI-OBESITY_MEDICATIONS

MEDICATION(S)

CONTRAVE, PHENTERMINE 15 MG CAPSULE, PHENTERMINE 30 MG CAPSULE, PHENTERMINE 37.5 MG CAPSULE, PHENTERMINE 37.5 MG TABLET, SAXENDA, WEGOVY, ZEPBOUND

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

N/A

068 PARATHRYOID_HORMONE

MEDICATION(S)

TERIPARATIDE 620 MCG/2.48 ML, TYMLOS

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

N/A

071 GLUCOSYLCERAMIDE SYNTHASE INHIBITOR

MEDICATION(S)

CERDELGA, MIGLUSTAT, OPFOLDA, YARGESA

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

N/A

072 EMFLAZA

MEDICATION(S)

DEFLAZACORT, EMFLAZA 22.75 MG/ML ORAL SUSP

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

N/A

MEDICATION(S)

TOLTERODINE TARTRATE, TOLTERODINE TARTRATE ER, TROSPIUM CHLORIDE, TROSPIUM CHLORIDE ER

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

N/A

076 DRONABINOL_(MARINOL)

MEDICATION(S)
DRONABINOL

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
N/A

MEDICATION(S)

AKYNZEO 300-0.5 MG CAPSULE, APREPITANT, EMEND 125 MG POWDER PACKET

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

N/A

079 SCOPOLAMINE

MEDICATION(S)
SCOPOLAMINE

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
N/A

080 5-HT3_RECEPTOR_ANTAGONISTS

MEDICATION(S)

GRANISETRON HCL 1 MG TABLET, ONDANSETRON 4 MG/5 ML SOLN CUP, ONDANSETRON 4 MG/5 ML SOLUTION

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

N/A

081 CONSTIPATION_AGENTS

MEDICATION(S)

LUBIPROSTONE, MOVANTIK, SYMPROIC

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

N/A

082 IBS-DIARRHEA_PREDOMINANT

MEDICATION(S)

ALOSETRON HCL, VIBERZI

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

N/A

086 OCALIVA

MEDICATION(S)
OCALIVA

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
N/A

087 THROMBOCYTOPENIA

MEDICATION(S)

PROMACTA 12.5 MG TABLET, PROMACTA 25 MG TABLET, PROMACTA 50 MG TABLET, PROMACTA 75 MG TABLET

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

N/A

088 WHITE_BLOOD_CELL_STIMULATORS

MEDICATION(S)

FYLNETRA, PLERIXAFOR, RELEUKO

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

N/A

089 ERYTHROPOIETIN_STIMULATING_AGENTS

MEDICATION(S)

JESDUVROQ, RETACRIT

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

N/A

090 HEREDITARY_ANGIOEDEMA

MEDICATION(S)

ICATIBANT, ORLADEYO, TAKHZYRO 300 MG/2 ML VIAL

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

N/A

091 ORFADIN_NITYR

MEDICATION(S)
NITISINONE

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
N/A

MEDICATION(S)

VORICONAZOLE 200 MG TABLET, VORICONAZOLE 40 MG/ML SUSP, VORICONAZOLE 50 MG TABLET

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

N/A

095 DARAPRIM

MEDICATION(S)

PYRIMETHAMINE 25 MG TABLET

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

N/A

096 NEBUPENT

MEDICATION(S)

PENTAMIDINE 300 MG INHAL POWDR

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

N/A

MEDICATION(S)
IVERMECTIN 3 MG TABLET, MALATHION, SPINOSAD

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
N/A

098 XIFAXAN

MEDICATION(S)

XIFAXAN

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

N/A

099 TOPICAL_ANTIVIRALS

MEDICATION(S)

ACYCLOVIR 5% CREAM, ACYCLOVIR 5% OINTMENT

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

N/A

100 VALGANCICLOVIR

MEDICATION(S)
VALGANCICLOVIR HCL

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
N/A

101 DIFICID

MEDICATION(S)

DIFICID 200 MG TABLET

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

N/A

102 ORAL_FLUOROQUINOLONES

MEDICATION(S)

MOXIFLOXACIN HCL 400 MG TABLET

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

N/A

MEDICATION(S)
VEMLIDY

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
N/A

MEDICATION(S)
MAVYRET, SOFOSBUVIR-VELPATASVIR, VOSEVI

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
N/A

105 FUZEON

MEDICATION(S)
FUZEON

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
N/A

107 ANTITUBERCULAR_ANTIBIOTICS

MEDICATION(S)
PRETOMANID, SIRTURO

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
N/A

MEDICATION(S)

AVONEX PREFILLED SYR 30 MCG KT, AVONEX PEN 30 MCG/0.5 ML KIT, BETASERON, DIMETHYL FUMARATE 30D START PK, DIMETHYL FUMARATE DR 120 MG CP, DIMETHYL FUMARATE DR 240 MG CP, EXTAVIA, FINGOLIMOD, GILENYA 0.25 MG CAPSULE, GLATIRAMER ACETATE, GLATOPA, MAVENCLAD, REBIF, REBIF REBIDOSE

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

N/A

109 DALFAMPRIDINE_(AMPYRA)

MEDICATION(S)
DALFAMPRIDINE ER

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
N/A

111 SLEEP_DISORDER_MEDICATIONS

MEDICATION(S)

ARMODAFINIL, MODAFINIL

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

N/A

MEDICATION(S)

AUSTEDO, INGREZZA, INGREZZA INITIATION PACK, TETRABENAZINE

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

N/A

114 NUEDEXTA

MEDICATION(S)
NUEDEXTA

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
N/A

115 PHOSPHATE_BINDERS

MEDICATION(S)

LANTHANUM CARBONATE, SEVELAMER 0.8 GM POWDER PACKET, SEVELAMER 2.4 GM POWDER PACKET, SEVELAMER HCL

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

N/A

118 ENDARI

MEDICATION(S)
ENDARI

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
N/A

121 ENDOMETRIOSIS_MEDICATIONS

MEDICATION(S)

LUPRON DEPOT 11.25 MG 3MO KIT, LUPRON DEPOT 3.75 MG KIT, ORILISSA

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

N/A

MEDICATION(S)

EPINASTINE HCL, CVS OLOPATADINE 0.1% EYE DROPS, CVS OLOPATADINE 0.2% EYE DROP, GNP OLOPATADINE 0.1% EYE DROPS, GNP OLOPATADINE 0.2% EYE DROP, OLOPATADINE HCL 0.1% EYE DROP, OLOPATADINE HCL 0.1% EYE DROPS, OLOPATADINE HCL 0.2% EYE DROP, QC OLOPATADINE 0.2% EYE DROP, SM OLOPATADINE 0.2% EYE DROP, PATADAY ONCE DAILY 0.7% DROPS

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

N/A

MEDICATION(S)

CYCLOSPORINE 0.05% EYE EMULS

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

N/A

127 IDIOPATHIC_PULMONARY_FIBROSIS

MEDICATION(S)

PIRFENIDONE 267 MG TABLET, PIRFENIDONE 534 MG TABLET, PIRFENIDONE 801 MG TABLET

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

N/A

MEDICATION(S)

CAYSTON, KALYDECO 150 MG TABLET, KALYDECO 25 MG GRANULES PACKET, KALYDECO 50 MG GRANULES PACKET, KALYDECO 75 MG GRANULES PACKET, ORKAMBI 100 MG-125 MG TABLET, ORKAMBI 100-125 MG GRANULE PKT, ORKAMBI 150-188 MG GRANULE PKT, ORKAMBI 200 MG-125 MG TABLET, PULMOZYME, SYMDEKO, TOBRAMYCIN 300 MG/5 ML AMPULE, TRIKAFTA 100-50-75 MG/150 MG

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

N/A

130 DALIRESP

MEDICATION(S)
ROFLUMILAST

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
N/A

135 NICOTINE_REPLACEMENT_THERAPY_(NRT)

MEDICATION(S)
NICOTROL, NICOTROL NS

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
N/A

136 NARCOTIC_WITHDRAWAL_THERAPY_AGENTS

MEDICATION(S)

BUPRENORPHINE-NALOX 12-3MG FLM, BUPRENORPHINE-NALOX 2-0.5MG FM, BUPRENORPHINE-NALOX 4-1MG FILM, BUPRENORPHINE-NALOX 8-2MG FILM, ZUBSOLV

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

N/A

137 INSOMNIA_MEDICATIONS

MEDICATION(S)

DOXEPIN 10 MG CAPSULE, DOXEPIN 100 MG CAPSULE, DOXEPIN 150 MG CAPSULE, DOXEPIN 25 MG CAPSULE, DOXEPIN 50 MG CAPSULE, DOXEPIN 75 MG CAPSULE, ESZOPICLONE 2 MG TABLET, ESZOPICLONE 3 MG TABLET, RAMELTEON, ZOLPIDEM TARTRATE ER

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

N/A

MEDICATION(S)

ACITRETIN, ACTEMRA 162 MG/0.9 ML SYRINGE, ACTEMRA ACTPEN, AMJEVITA(CF) 10MG/0.2ML SYRING, AMJEVITA(CF) 20MG/0.4ML SYRING, AMJEVITA(CF) 40MG/0.8ML SYRING, AMJEVITA(CF) 40MG/0.8ML AUTOIN, CIBINQO, COSENTYX (2 SYRINGES), COSENTYX SENSOREADY (2 PENS), COSENTYX SENSOREADY PEN, COSENTYX SYRINGE, COSENTYX UNOREADY PEN, CYLTEZO(CF), CYLTEZO(CF) PEN, CYLTEZO(CF) PEN CROHN'S-UC-HS, CYLTEZO(CF) PEN PSORIASIS-UV, ENBREL, ENBREL MINI, ENBREL SURECLICK, HUMIRA, HUMIRA PEN, HUMIRA PEN CROHN'S-UC-HS, HUMIRA PEN PSOR-UVEITS-ADOL HS, HUMIRA(CF), HUMIRA(CF) PEDIATRIC CROHN'S, HUMIRA(CF) PEN, HUMIRA(CF) PEN CROHN'S-UC-HS, HUMIRA(CF) PEN PEDIATRIC UC, HUMIRA(CF) PEN PSOR-UV-ADOL HS, OLUMIANT, ORENCIA 125 MG/ML SYRINGE, ORENCIA 50 MG/0.4 ML SYRINGE, ORENCIA 87.5 MG/0.7 ML SYRINGE, ORENCIA CLICKJECT, OTEZLA, STELARA 45 MG/0.5 ML SYRINGE, STELARA 45 MG/0.5 ML VIAL, STELARA 90 MG/ML SYRINGE, XELJANZ 10 MG TABLET, XELJANZ 5 MG TABLET, XELJANZ XR

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

N/A

141 GOUT

MEDICATION(S)
FEBUXOSTAT

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
N/A

142 TAVNEOS

MEDICATION(S)
TAVNEOS

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
N/A

MEDICATION(S)

DUPIXENT PEN, DUPIXENT SYRINGE

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

N/A

147 OXBRYTA

MEDICATION(S)
OXBRYTA 500 MG TABLET

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
N/A

149 ADRENAL STEROID INHIBITORS

MEDICATION(S)
ISTURISA

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
N/A

150 EVRYSDI_(RISDIPLAM)

MEDICATION(S)
EVRYSDI

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
N/A

151 UTERINE FIBROIDS

MEDICATION(S)

LUPRON DEPOT 11.25 MG 3MO KIT, LUPRON DEPOT 3.75 MG KIT, ORIAHNN

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

N/A

152 KERENDIA

MEDICATION(S)
KERENDIA

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
N/A

154 SYMTUZA

MEDICATION(S)
SYMTUZA

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
N/A

155 SKYCLARYS

MEDICATION(S)
SKYCLARYS

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
N/A