



2027 Medicare Part D Prior Authorization Grid

Please Note:

1. Drugs not reflected on this authorization grid do not require authorization.
2. All services must be medically necessary, subject to CMS regulations.
3. Payment is based on benefits in effect at the time of service, member eligibility and medical necessity.
4. Members require a prior authorization for ALL non-formulary drugs.
5. Retroactive requests (services already rendered) need to be submitted as a claim.
6. Codes may not be categorized in an area that you are familiar, please search the entire document.

ABALOPARATIDE

Products Affected

- TYMLOS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
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

ABEMACICLIB

Products Affected

- VERZENIO

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

ABIRATERONE

Products Affected

- *abiraterone oral tablet 250 mg*
- *abirtega*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
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	Yes

ABIRATERONE SUBMICRONIZED

Products Affected

- YONSA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
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	Yes

ACALABRUTINIB

Products Affected

- CALQUENCE (ACALABRUTINIB MAL)

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

ADAGRASIB

Products Affected

- KRAZATI

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

ADALIMUMAB

Products Affected

- HUMIRA PEN
- HUMIRA SUBCUTANEOUS SYRINGE KIT 40 MG/0.8 ML
- HUMIRA(CF)
- HUMIRA(CF) PEN
- HUMIRA(CF) PEN CROHNS-UC-HS
- HUMIRA(CF) PEN PEDIATRIC UC
- HUMIRA(CF) PEN PSOR-UV-ADOL HS

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/RENEWAL: PLAN YEAR.

PA Criteria	Criteria Details
Other Criteria	INITIAL: RHEUMATOID ARTHRITIS (RA): TRIAL OF OR CONTRAINDICATION TO 3 MONTHS OF TREATMENT WITH ONE CLINICAL STANDARD OF CARE AGENT: A 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 ONE CLINICAL STANDARD OF CARE AGENT: AN NSAID. PSO: 1) AT LEAST A 3 MONTH TRIAL OF ONE OF THE FOLLOWING CLINICAL STANDARD OF CARE AGENTS: AN ORAL IMMUNOSUPPRESSANT (CYCLOSPORINE, METHOTREXATE, TACROLIMUS), PUVA (PHOTOTHERAPY), 2) CONTRAINDICATION OR INTOLERANCE TO BOTH OF THE FOLLOWING CLINICAL STANDARD OF CARE AGENTS: AN IMMUNOSUPPRESSANT, PUVA, OR 3) PATIENT IS SWITCHING FROM A DIFFERENT BIOLOGIC, PDE-4 INHIBITOR, OR JAK INHIBITOR FOR THE SAME INDICATION. UVEITIS: 1) DOES NOT HAVE ISOLATED ANTERIOR UVEITIS, AND 2) FOR POSTERIOR UVEITIS, TRIAL OF OR CONTRAINDICATION TO ONE CLINICAL STANDARD OF CARE AGENT: A 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, 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

ADALIMUMAB-AATY

Products Affected

- *adalimumab-aaty*
- *adalimumab-aaty(cf) ai crohns*

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/RENEWAL: PLAN YEAR.

PA Criteria	Criteria Details
Other Criteria	INITIAL: RHEUMATOID ARTHRITIS (RA): TRIAL OF OR CONTRAINDICATION TO 3 MONTHS OF TREATMENT WITH ONE CLINICAL STANDARD OF CARE AGENT: A 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 ONE CLINICAL STANDARD OF CARE AGENT: AN NSAID. PSO: 1) AT LEAST A 3 MONTH TRIAL OF ONE OF THE FOLLOWING CLINICAL STANDARD OF CARE AGENTS: AN ORAL IMMUNOSUPPRESSANT (CYCLOSPORINE, METHOTREXATE, TACROLIMUS), PUVA (PHOTOTHERAPY), 2) CONTRAINDICATION OR INTOLERANCE TO BOTH OF THE FOLLOWING CLINICAL STANDARD OF CARE AGENTS: AN IMMUNOSUPPRESSANT, PUVA, OR 3) PATIENT IS SWITCHING FROM A DIFFERENT BIOLOGIC, PDE-4 INHIBITOR, OR JAK INHIBITOR FOR THE SAME INDICATION. UVEITIS: 1) DOES NOT HAVE ISOLATED ANTERIOR UVEITIS, AND 2) FOR POSTERIOR UVEITIS, TRIAL OF OR CONTRAINDICATION TO ONE CLINICAL STANDARD OF CARE AGENT: A 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, 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

ADALIMUMAB-BWWD

Products Affected

- HADLIMA
- HADLIMA PUSHTOUCH
- HADLIMA(CF)
- HADLIMA(CF) 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, 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/RENEWAL: PLAN YEAR.

PA Criteria	Criteria Details
Other Criteria	INITIAL: RHEUMATOID ARTHRITIS (RA): TRIAL OF OR CONTRAINDICATION TO 3 MONTHS OF TREATMENT WITH ONE CLINICAL STANDARD OF CARE AGENT: A 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 ONE CLINICAL STANDARD OF CARE AGENT: AN NSAID. PSO: 1) AT LEAST A 3 MONTH TRIAL OF ONE OF THE FOLLOWING CLINICAL STANDARD OF CARE AGENTS: AN ORAL IMMUNOSUPPRESSANT (CYCLOSPORINE, METHOTREXATE, TACROLIMUS), PUVA (PHOTOTHERAPY), 2) CONTRAINDICATION OR INTOLERANCE TO BOTH OF THE FOLLOWING CLINICAL STANDARD OF CARE AGENTS: AN IMMUNOSUPPRESSANT, PUVA, OR 3) PATIENT IS SWITCHING FROM A DIFFERENT BIOLOGIC, PDE-4 INHIBITOR, OR JAK INHIBITOR FOR THE SAME INDICATION. UVEITIS: 1) DOES NOT HAVE ISOLATED ANTERIOR UVEITIS, AND 2) FOR POSTERIOR UVEITIS, TRIAL OF OR CONTRAINDICATION TO ONE CLINICAL STANDARD OF CARE AGENT: A 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, 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

AFATINIB

Products Affected

- GILOTRIF

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
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

ALECTINIB

Products Affected

- ALECENSA

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

ALPELISIB-PIQRAY

Products Affected

- PIQRAY ORAL TABLET 200 MG/DAY (200 MG X 1), 250 MG/DAY (200 MG X1-50 MG X1), 300 MG/DAY (150 MG X 2)

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

AMBRISENTAN

Products Affected

- *ambrisentan*

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: PLAN YEAR.
Other Criteria	PAH: INITIAL: DOES NOT HAVE IDIOPATHIC PULMONARY FIBROSIS.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

AMIKACIN LIPOSOMAL INH

Products Affected

- ARIKAYCE

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

AMIVANTAMAB-HYALURONIDASE-LPUJ

Products Affected

- RYBREVANT FASPRO

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

AMIVANTAMAB-VMJW

Products Affected

- RYBREVANT

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

ANAKINRA

Products Affected

- KINERET

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	INITIAL/RENEWAL: PLAN YEAR.

PA Criteria	Criteria Details
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/ADALIMUMAB-AATY/HADLIMA, XELJANZ, RINVOQ. 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

ANIFROLUMAB-FNIA

Products Affected

- SAPHNELO PEN

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	SYSTEMIC LUPUS ERYTHEMATOSUS (SLE): INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST.
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
Other Criteria	SLE: INITIAL: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR SLE. RENEWAL: 1) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR SLE, 2) CLINICAL IMPROVEMENT WHILE ON THERAPY.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

APALUTAMIDE

Products Affected

- ERLEADA ORAL TABLET 240 MG, 60 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
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	Yes

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: PLAN YEAR.
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

APREMILAST

Products Affected

- OTEZLA
- OTEZLA STARTER
- OTEZLA XR
- OTEZLA XR INITIATION

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/RENEWAL: PLAN YEAR.

PA Criteria	Criteria Details
Other Criteria	INITIAL: MILD PSO: TRIAL OF OR CONTRAINDICATION TO ONE OF THE FOLLOWING CLINICAL STANDARD OF CARE AGENTS: A CONVENTIONAL SYSTEMIC THERAPY (E.G., METHOTREXATE, ACITRETIN, CYCLOSPORINE), A CONVENTIONAL TOPICAL THERAPY (E.G., TOPICAL CORTICOSTEROIDS). MODERATE TO SEVERE PSO: 1) AT LEAST A 3 MONTH TRIAL OF ONE OF THE FOLLOWING CLINICAL STANDARD OF CARE AGENTS: AN ORAL IMMUNOSUPPRESSANT (CYCLOSPORINE, METHOTREXATE, TACROLIMUS), PUVA (PHOTOTHERAPY), 2) CONTRAINDICATION OR INTOLERANCE TO BOTH OF THE FOLLOWING CLINICAL STANDARD OF CARE AGENTS: IMMUNOSUPPRESSANT, PUVA, OR 3) PATIENT IS SWITCHING FROM A DIFFERENT BIOLOGIC, PDE-4 INHIBITOR, OR JAK INHIBITOR FOR THE SAME INDICATION. BEHCETS DISEASE: 1) HAS ORAL ULCERS OR A HISTORY OF RECURRENT ORAL ULCERS BASED ON CLINICAL SYMPTOMS, AND 2) TRIAL OF OR CONTRAINDICATION TO ONE OR MORE CONSERVATIVE TREATMENTS (E.G., COLCHICINE, TOPICAL CORTICOSTEROID, ORAL CORTICOSTEROID). 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

ARMODAFINIL

Products Affected

- *armodafinil*

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

ASCIMINIB

Products Affected

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

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

ASFOTASE ALFA

Products Affected

- STRENSIQ SUBCUTANEOUS
SOLUTION 28 MG/0.7 ML, 40 MG/ML, 80
MG/0.8 ML

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	HYPOPHOSPHATASIA (HPP): INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH AN ENDOCRINOLOGIST, GENETICIST, OR METABOLIC SPECIALIST.
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.

PA Criteria	Criteria Details
Other Criteria	INITIAL: PERINATAL/INFANTILE-ONSET HPP: 1) 6 MONTHS OF AGE OR YOUNGER AT ONSET OF HPP, AND 2) POSITIVE FOR A TISSUE NON-SPECIFIC ALKALINE PHOSPHATASE (TNSALP) (ALPL) GENE MUTATION AS CONFIRMED BY GENETIC TESTING OR TWO OF THE FOLLOWING: (A) SERUM ALKALINE PHOSPHATASE (ALP) LEVEL BELOW THAT OF NORMAL RANGE FOR PATIENT AGE, (B) ELEVATED SERUM PYRIDOXAL-5'-PHOSPHATE (PLP) LEVELS AND NO VITAMIN B6 SUPPLEMENTATION IN THE PREVIOUS WEEK, (C) URINE PHOSPHOETHANOLAMINE (PEA) LEVEL ABOVE THAT OF NORMAL RANGE FOR PATIENT AGE, (D) RADIOGRAPHIC EVIDENCE OF HPP, (E) AT LEAST TWO OF THE FOLLOWING: (I) RACHITIC CHEST DEFORMITY, (II) CRANIOSYNOSTOSIS, (III) DELAY IN SKELETAL GROWTH RESULTING IN DELAY OF MOTOR DEVELOPMENT, (IV) HISTORY OF VITAMIN B6 DEPENDENT SEIZURES, (V) NEPHROCALCINOSIS OR HISTORY OF ELEVATED SERUM CALCIUM, (VI) HISTORY OR PRESENCE OF NON-TRAUMATIC POSTNATAL FRACTURE AND DELAYED FRACTURE HEALING. JUVENILE-ONSET HPP: 1) 18 YEARS OF AGE OR YOUNGER AT ONSET OF HPP, AND 2) POSITIVE FOR A TNSALP ALPL GENE MUTATION AS CONFIRMED BY GENETIC TESTING OR TWO OF THE FOLLOWING: (A) SERUM ALP LEVEL BELOW THAT OF NORMAL RANGE FOR PATIENT AGE, (B) ELEVATED SERUM PLP LEVELS AND NO VITAMIN B6 SUPPLEMENTATION IN THE PREVIOUS WEEK, (C) URINE PEA LEVEL ABOVE THAT OF NORMAL RANGE FOR PATIENT AGE, (D) RADIOGRAPHIC EVIDENCE OF HPP, (E) AT LEAST TWO OF THE FOLLOWING: (I) RACHITIC DEFORMITIES, (II) PREMATURE LOSS OF PRIMARY TEETH PRIOR TO 5 YEARS OF AGE, (III) DELAY IN SKELETAL GROWTH RESULTING IN DELAY OF MOTOR DEVELOPMENT, (IV) HISTORY OR PRESENCE OF NON-TRAUMATIC FRACTURES OR DELAYED FRACTURE HEALING. ALL INDICATIONS: 1) NOT CURRENTLY RECEIVING TREATMENT WITH A BISPHOSPHONATE, 2) CALCIUM OR PHOSPHATE LEVELS ARE NOT BELOW THE NORMAL RANGE, 3)
	NOT HAVE A TREATABLE FORM OF RICKETS. RENEWAL: ALL INDICATIONS: 1) IMPROVEMENT IN THE SKELETAL CHARACTERISTICS OF HPP, AND 2) NOT CURRENTLY RECEIVING TREATMENT WITH A BISPHOSPHONATE.
Indications	All FDA-approved Indications.
Off Label Uses	

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

ATOGEPANT

Products Affected

- QULIPTA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
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

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: PLAN YEAR.
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

AVAPRITINIB

Products Affected

- AYVAKIT

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

AVUTOMETINIB-DEFACTINIB

Products Affected

- AVMAPKI
- AVMAPKI-FAKZYNJA

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

AXITINIB

Products Affected

- INLYTA ORAL TABLET 1 MG, 5 MG

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

AZACITIDINE

Products Affected

- ONUREG

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

AZTREONAM INHALED

Products Affected

- CAYSTON

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

BEDAQUILINE

Products Affected

- SIRTURO

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

BELIMUMAB

Products Affected

- BENLYSTA SUBCUTANEOUS

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

PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

BELUMOSUDIL

Products Affected

- REZUROCK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
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

BELZUTIFAN

Products Affected

- WELIREG

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

BENDAMUSTINE

Products Affected

- *bendamustine intravenous recon soln 25 mg*

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

BENRALIZUMAB

Products Affected

- FASENRA
- FASENRA PEN

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: ASTHMA: BLOOD EOSINOPHIL LEVEL OF AT LEAST 150 CELLS/MCL WITHIN THE PAST 12 MONTHS.
Age Restrictions	
Prescriber Restrictions	INITIAL: ASTHMA: PRESCRIBED BY OR IN CONSULTATION WITH A PHYSICIAN SPECIALIZING IN ALLERGY OR PULMONARY MEDICINE.
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.

PA Criteria	Criteria Details
Other Criteria	INITIAL: ASTHMA: 1) CONCURRENT THERAPY WITH A MEDIUM, HIGH-DOSE, OR MAXIMALLY TOLERATED DOSE OF AN INHALED CORTICOSTEROID (ICS) AND ONE OTHER MAINTENANCE MEDICATION, AND 2) ONE ASTHMA EXACERBATION REQUIRING SYSTEMIC CORTICOSTEROID BURST LASTING AT LEAST 3 DAYS WITHIN THE PAST 12 MONTHS, OR AT LEAST ONE SERIOUS EXACERBATION REQUIRING HOSPITALIZATION OR ER VISIT WITHIN THE PAST 12 MONTHS, OR POOR SYMPTOM CONTROL DESPITE CURRENT THERAPY AS EVIDENCED BY AT LEAST THREE OF THE FOLLOWING WITHIN THE PAST 4 WEEKS: (A) DAYTIME ASTHMA SYMPTOMS MORE THAN TWICE/WEEK, (B) ANY NIGHT WAKING DUE TO ASTHMA, (C) SABA RELIEVER FOR SYMPTOMS MORE THAN TWICE/WEEK, (D) ANY ACTIVITY LIMITATION DUE TO ASTHMA. INITIAL/RENEWAL: ALL INDICATIONS: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR THE SAME INDICATION. RENEWAL: ASTHMA: 1) CONTINUED USE OF ICS AND ONE OTHER MAINTENANCE MEDICATION, AND 2) CLINICAL RESPONSE AS EVIDENCED BY: (A) REDUCTION IN ASTHMA EXACERBATIONS FROM BASELINE, (B) DECREASED UTILIZATION OF RESCUE MEDICATIONS, (C) INCREASE IN PERCENT PREDICTED FEV1 FROM PRETREATMENT BASELINE, OR (D) REDUCTION IN SEVERITY OR FREQUENCY OF ASTHMA-RELATED SYMPTOMS. EOSINOPHILIC GRANULOMATOSIS WITH POLYANGIITIS (EGPA): REDUCTION IN EGPA SYMPTOMS COMPARED TO BASELINE OR ABILITY TO REDUCE/ELIMINATE CORTICOSTEROID USE.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

BETAINE

Products Affected

- *betaine*

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

BEXAROTENE

Products Affected

- *bexarotene*

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

BINIMETINIB

Products Affected

- MEKTOVI

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

BORTEZOMIB

Products Affected

- *bortezomib injection*

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

BOSUTINIB

Products Affected

- BOSULIF ORAL CAPSULE 100 MG, 50 MG
- BOSULIF ORAL TABLET 100 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	PLAN YEAR
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

BRIGATINIB

Products Affected

- ALUNBRIG ORAL TABLET 180 MG, 30 MG, 90 MG
- ALUNBRIG ORAL TABLETS,DOSE PACK

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

BUDESONIDE-TARPEYO

Products Affected

- TARPEYO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	PRIMARY IMMUNOGLOBULIN A NEPHROPATHY (IGAN): INITIAL: 1) DIAGNOSIS IS CONFIRMED BY A RENAL BIOPSY, 2) EGFR OF AT LEAST 35 ML/MIN/1.73 M2, AND 3) PROGRESSIVELY DECLINING GLOMERULAR FILTRATION RATE AND/OR WORSENING PROTEINURIA.
Age Restrictions	
Prescriber Restrictions	PRIMARY IGAN: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A NEPHROLOGIST.
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
Other Criteria	PRIMARY IGAN: INITIAL: 1) TRIAL AND CONTINUATION OF AN ACE INHIBITOR OR AN ARB AT MAXIMUM TOLERATED DOSE FOR AT LEAST 3 MONTHS OR CONTRAINDICATION TO BOTH CLASSES, AND 2) TRIAL AND CONTINUATION OF OR CONTRAINDICATION TO SGLT2 INHIBITOR. RENEWAL: 1) IMPROVED OR STABLE KIDNEY FUNCTION COMPARED TO BASELINE, OR 2) REDUCTION IN PROTEINURIA.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

C1 ESTERASE INHIBITOR-HAEGARDA

Products Affected

- HAEGARDA SUBCUTANEOUS RECON
SOLN 2,000 UNIT, 3,000 UNIT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	HEREDITARY ANGIOEDEMA (HAE): INITIAL: 1) 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, OR 2) TYPE III HAE CONFIRMED BY: (A) RECURRENT, NON-URTICARIAL ANGIOEDEMA INVOLVING THE SKIN, GASTROINTESTINAL TRACT, OR AIRWAY, CONSISTENT WITH BRADYKININ-MEDIATED HAE AND ATTACKS NOT EXPLAINED BY HISTAMINERGIC/URTICARIAL ANGIOEDEMA, AND (B) OTHER CAUSES OF ANGIOEDEMA HAVE BEEN EXCLUDED, INCLUDING ACE-INHIBITOR/ARB-ASSOCIATED ANGIOEDEMA, ACQUIRED C1-INH DEFICIENCY, AND MAST-CELL/HISTAMINERGIC ANGIOEDEMA.
Age Restrictions	
Prescriber Restrictions	HAE: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A HEMATOLOGIST, IMMUNOLOGIST, ALLERGIST OR PULMONOLOGIST.
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
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

PA Criteria	Criteria Details
Prerequisite Therapy Required	No

CABOZANTINIB CAPSULE

Products Affected

- COMETRIQ ORAL CAPSULE 100 MG/DAY(80 MG X1-20 MG X1), 140 MG/DAY(80 MG X1-20 MG X3), 60 MG/DAY (20 MG X 3/DAY)

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

CABOZANTINIB TABLET

Products Affected

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

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

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: PLAN YEAR.
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

CAPIVASERTIB

Products Affected

- TRUQAP

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

CAPMATINIB

Products Affected

- TABRECTA

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

CARGLUMIC ACID

Products Affected

- *carglumic acid*

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/RENEWAL: PLAN YEAR.
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

CERITINIB

Products Affected

- ZYKADIA

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

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: PLAN YEAR.
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

COBIMETINIB

Products Affected

- COTELLIC

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

CORTICOTROPIN-CORTROPHIN

Products Affected

- CORTROPHIN GEL INJECTION

PA Criteria	Criteria Details
Exclusion Criteria	INITIAL: NOT APPROVED FOR DIAGNOSTIC PURPOSES.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	INITIAL: ALL FDA APPROVED INDICATIONS EXCEPT INFANTILE SPASMS AND MULTIPLE SCLEROSIS (MS): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST, DERMATOLOGIST, ALLERGIST/IMMUNOLOGIST, OPHTHALMOLOGIST, PULMONOLOGIST OR NEPHROLOGIST.
Coverage Duration	INFANTILE SPASMS AND MS: 28 DAYS. ALL OTHER FDA APPROVED INDICATIONS: INITIAL/RENEWAL: PLAN YEAR.
Other Criteria	INITIAL: ALL FDA APPROVED INDICATIONS EXCEPT INFANTILE SPASMS: TRIAL OF OR CONTRAINDICATION TO THE CLINICAL STANDARD OF CARE AGENT: INTRAVENOUS (IV) CORTICOSTEROIDS. RENEWAL: ALL FDA APPROVED INDICATIONS EXCEPT INFANTILE SPASMS AND MS: DEMONSTRATED CLINICAL BENEFIT WHILE ON THERAPY AS INDICATED BY SYMPTOM RESOLUTION AND/OR NORMALIZATION OF LABORATORY TESTS. PART B BEFORE PART D STEP THERAPY, APPLIES ONLY TO BENEFICIARIES IN AN MA-PD PLAN.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	Yes

PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

CRIZOTINIB CAPSULE

Products Affected

- XALKORI ORAL CAPSULE

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

CRIZOTINIB PELLETS

Products Affected

- XALKORI ORAL PELLET 150 MG, 20 MG, 50 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
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

DABRAFENIB CAPSULES

Products Affected

- TAFINLAR ORAL CAPSULE

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

DABRAFENIB SUSPENSION

Products Affected

- TAFINLAR ORAL TABLET FOR SUSPENSION

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

DACOMITINIB

Products Affected

- VIZIMPRO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
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

DALFAMPRIDINE

Products Affected

- *dalfampridine*

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: PLAN YEAR.
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

DAROLUTAMIDE

Products Affected

- NUBEQA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
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	Yes

DASATINIB-SPRYCEL

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	PLAN YEAR
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

DECITABINE/CEDAZURIDINE

Products Affected

- INQOVI

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

DEFERASIROX

Products Affected

- *deferasirox oral granules in packet*
- *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/RENEWAL: PLAN YEAR.
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	

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

DENOSUMAB-BMWO - OSENVELT

Products Affected

- OSENVELT

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

DEUTETRABENAZINE

Products Affected

- AUSTEDO ORAL TABLET 12 MG, 6 MG, 9 MG
- AUSTEDO XR ORAL TABLET EXTENDED RELEASE 24 HR 12 MG, 18 MG, 24 MG, 30 MG, 36 MG, 42 MG, 48 MG, 6 MG
- AUSTEDO XR TITRATION KT(WK1-4)

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	PLAN YEAR
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

DIAZEPAM

Products Affected

- VALTOCO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	EPILEPSY: AGES 12 YEARS OR OLDER: TRIAL OF OR CONTRAINDICATION TO THE PREFERRED AGENT: NAYZILAM.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

DICLOFENAC TOPICAL SOLUTION

Products Affected

- *diclofenac sodium topical solution in metered-dose pump*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
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

DIHYDROERGOTAMINE - NASAL

Products Affected

- *dihydroergotamine nasal*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	ACUTE MIGRAINE TREATMENT: 1) NO CONCURRENT USE WITH ANY OTHER DIHYDROERGOTAMINE OR ERGOTAMINE MEDICATIONS, AND 2) TRIAL OF OR CONTRAINDICATION TO BOTH OF THE FOLLOWING PREFERRED AGENTS: TRIPTAN (E.G., SUMATRIPTAN, RIZATRIPTAN), CGRP INHIBITOR FOR ACUTE MIGRAINE TREATMENT (NURTEC ODT, UBRELVY).
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

DIMETHYL FUMARATE

Products Affected

- *dimethyl fumarate oral capsule, delayed release(dr/ec) 120 mg, 120 mg (14)- 240 mg (46), 240 mg*

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

DIROXIMEL FUMARATE

Products Affected

- VUMERITY

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

DORDAVIPRONE

Products Affected

- MODEYSO

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

DRONABINOL CAPSULE

Products Affected

- *dronabinol oral capsule*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
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

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: PLAN YEAR.
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

DUPILUMAB

Products Affected

- DUPIXENT PEN
- DUPIXENT SYRINGE SUBCUTANEOUS
SYRINGE 200 MG/1.14 ML, 300 MG/2 ML

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. EOSINOPHILIC CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD): BLOOD EOSINOPHIL LEVEL OF AT LEAST 300 CELLS/MCL.
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,AFRS: 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	INITIAL/RENEWAL: PLAN YEAR.

PA Criteria	Criteria Details
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 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 CLINICAL STANDARD OF CARE AGENT: A 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, FOUR TIMES THE MAXIMALLY LABELED DOSE OF A SECOND GENERATION H1 ANTI-HISTAMINE, AND 2) STILL EXPERIENCES HIVES OR ANGIOEDEMA MOST DAYS OF THE WEEK FOR AT LEAST 6 WEEKS. ALLERGIC FUNGAL RHINOSINUSITIS (AFRS): 1) INADEQUATELY CONTROLLED

PA Criteria	Criteria Details
	DISEASE POST ENDOSCOPIC SINUS SURGERY, AND 2) A 56 DAY TRIAL OF ONE CLINICAL STANDARD OF CARE AGENT: A TOPICAL NASAL CORTICOSTEROID. INITIAL/RENEWAL: ALL INDICATIONS EXCEPT BULLOUS PEMPHIGOID (BP) AND AFRS: 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-RELATED SYMPTOMS. CSU: MAINTAINED ON OR CONTRAINDICATION TO A SECOND GENERATION H1 ANTI-HISTAMINE. AFRS: CONTINUES TO BENEFIT FROM THE MEDICATION.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

DUVELISIB

Products Affected

- COPIKTRA

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

EFLORNITHINE

Products Affected

- IWILFIN

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

ELACESTRANT

Products Affected

- ORSERDU ORAL TABLET 345 MG, 86 MG

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

ELAGOLIX

Products Affected

- ORILISSA ORAL TABLET 150 MG, 200 MG

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

PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

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/RENEWAL: PLAN YEAR.
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

ELEXACFTOR-TEZACFTOR-IVACFTOR

Products Affected

- TRIKAFTA ORAL GRANULES IN PACKET, SEQUENTIAL
- TRIKAFTA ORAL TABLETS, SEQUENTIAL

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/RENEWAL: PLAN YEAR.
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

ELTROMBOPAG - PROMACTA

Products Affected

- *eltrombopag olamine oral powder in 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/RENEWAL: PLAN YEAR. HEPATITIS C, SEVERE APLASTIC ANEMIA: PLAN YEAR.
Other Criteria	INITIAL: ITP: 1) INSUFFICIENT RESPONSE TO SPLENECTOMY, OR TRIAL OF OR CONTRAINDICATION TO ONE OF THE FOLLOWING CLINICAL STANDARD OF CARE AGENTS: CORTICOSTEROID, INTRAVENOUS IMMUNOGLOBULIN (IVIG). ALL INDICATIONS: REQUESTS FOR BRAND PROMACTA REQUIRE A TRIAL OF OR CONTRAINDICATION TO THE PREFERRED AGENT: GENERIC ELTROMBOPAG OLAMINE. INITIAL/RENEWAL: ITP: NO CONCURRENT USE WITH OTHER THROMBOPOIETIN RECEPTOR AGONISTS (TPO-RAS). RENEWAL: ITP: IMPROVEMENT IN PLATELET COUNTS FROM BASELINE OR REDUCTION IN BLEEDING EVENTS.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

ENASIDENIB

Products Affected

- IDHIFA

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

ENCORAFENIB

Products Affected

- BRAFTOVI

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

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	PLAN YEAR
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

ENTRECTINIB CAPSULES

Products Affected

- ROZLYTREK ORAL CAPSULE 100 MG, 200 MG

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

ENTRECTINIB PELLETS

Products Affected

- ROZLYTREK ORAL PELLETS IN PACKET

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
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

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	PLAN YEAR
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	Yes

EPOETIN ALFA-EPBX

Products Affected

- RETACRIT INJECTION SOLUTION
10,000 UNIT/ML, 2,000 UNIT/ML, 20,000
UNIT/2 ML, 20,000 UNIT/ML, 3,000
UNIT/ML, 4,000 UNIT/ML, 40,000
UNIT/ML

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: ANEMIA DUE TO CHRONIC KIDNEY DISEASE (CKD), ZIDOVUDINE OR CANCER CHEMOTHERAPY: HEMOGLOBIN (HGB) LEVEL IS LESS THAN 10G/DL. ELECTIVE, NON-CARDIAC, NON-VASCULAR SURGERY: HGB LEVEL IS 13G/DL OR LESS. RENEWAL: ANEMIA DUE TO CKD: 1) ADULTS: (A) HGB LEVEL IS LESS THAN 10G/DL, OR (B) HGB LEVEL HAS REACHED 10G/DL AND THE DOSE IS BEING OR HAS BEEN REDUCED/INTERRUPTED TO DECREASE THE NEED FOR BLOOD TRANSFUSIONS, OR 2) PEDIATRICS: (A) HGB LEVEL IS LESS THAN 10G/DL, OR (B) HGB LEVEL HAS APPROACHED OR EXCEEDS 12G/DL AND THE DOSE IS BEING OR HAS BEEN REDUCED/INTERRUPTED TO DECREASE THE NEED FOR BLOOD TRANSFUSIONS. ANEMIA RELATED TO ZIDOVUDINE: HGB LEVEL IS BETWEEN 10G/DL AND 12G/DL. ANEMIA DUE TO CHEMO: 1) HGB LEVEL IS LESS THAN 10G/DL, OR 2) HGB LEVEL DOES NOT EXCEED A LEVEL NEEDED TO AVOID RED BLOOD CELL (RBC) TRANSFUSION.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	ANEMIA FROM CHEMO/CKD WITHOUT DIALYSIS/ZIDOVUDINE: INITIAL/RENEWAL: PLAN YEAR. SURGERY: 1 MONTH.

PA Criteria	Criteria Details
Other Criteria	INITIAL: SURGERY: NO CONCURRENT USE WITH ANOTHER ERYTHROPOIESIS-STIMULATING AGENT (ESA) OR A HYPOXIA-INDUCIBLE FACTOR PROLYL HYDROXYLASE INHIBITOR (HIF-PHI). INITIAL/RENEWAL: ANEMIA DUE TO CKD/ZIDOVUDINE/CHEMO: NO CONCURRENT USE WITH ANOTHER ESA OR A HIF-PHI. RENEWAL: ANEMIA DUE TO CKD: NOT RECEIVING DIALYSIS TREATMENT.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

ERDAFITINIB

Products Affected

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

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

ERENUMAB-AOOE

Products Affected

- AIMOVIG AUTOINJECTOR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
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

ERLOTINIB

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
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

ETANERCEPT

Products Affected

- ENBREL MINI
- ENBREL SUBCUTANEOUS SOLUTION
- ENBREL SUBCUTANEOUS SYRINGE
- ENBREL SURECLICK

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/RENEWAL: PLAN YEAR.

PA Criteria	Criteria Details
Other Criteria	INITIAL: RA: 1) TRIAL OF OR CONTRAINDICATION TO 3 MONTHS OF TREATMENT WITH ONE CLINICAL STANDARD OF CARE AGENT: A 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, AND 2) TRIAL OF OR CONTRAINDICATION TO ONE OF THE FOLLOWING PREFERRED AGENTS: ADALIMUMAB-AATY, HADLIMA. PJIA: TRIAL OF OR CONTRAINDICATION TO ONE OF THE FOLLOWING PREFERRED AGENTS: ADALIMUMAB-AATY, HADLIMA. PSA: TRIAL OF OR CONTRAINDICATION TO ONE OF THE FOLLOWING PREFERRED AGENTS, WHERE AGES ALIGN: ADALIMUMAB-AATY, HADLIMA. AS: 1) TRIAL OF OR CONTRAINDICATION TO ONE CLINICAL STANDARD OF CARE AGENT: AN NSAID, AND 2) TRIAL OF OR CONTRAINDICATION TO ONE OF THE FOLLOWING PREFERRED AGENTS: ADALIMUMAB-AATY, HADLIMA. PSO: 1) ONE OF THE FOLLOWING: (A) AT LEAST A 3 MONTH TRIAL OF ONE OF THE FOLLOWING CLINICAL STANDARD OF CARE AGENTS: AN ORAL IMMUNOSUPPRESSANT (CYCLOSPORINE, METHOTREXATE, TACROLIMUS), PUVA (PHOTOTHERAPY), (B) CONTRAINDICATION OR INTOLERANCE TO BOTH OF THE FOLLOWING CLINICAL STANDARD OF CARE AGENTS: AN IMMUNOSUPPRESSANT, PUVA, OR (C) PATIENT IS SWITCHING FROM A DIFFERENT BIOLOGIC, PDE-4 INHIBITOR, OR JAK INHIBITOR FOR THE SAME INDICATION, AND 2) TRIAL OF OR CONTRAINDICATION TO ONE OF THE FOLLOWING PREFERRED AGENTS, WHERE AGES ALIGN: ADALIMUMAB-AATY, HADLIMA. 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

ETRASIMOD

Products Affected

- VELSIPITY

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	ULCERATIVE COLITIS (UC): INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A GASTROENTEROLOGIST.
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
Other Criteria	UC: INITIAL: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: SELARSDI/YESINTEK/OTULFI, XELJANZ, HUMIRA/ADALIMUMAB-AATY/HADLIMA, RINVOQ, SKYRIZI, TREMFYA. INITIAL/RENEWAL: 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	Yes

EVEROLIMUS-AFINITOR

Products Affected

- *everolimus (antineoplastic) 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	PLAN YEAR
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

EVEROLIMUS-AFINITOR DISPERZ

Products Affected

- *everolimus (antineoplastic) oral tablet for suspension*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	TUBEROUS SCLEROSIS COMPLEX (TSC) ASSOCIATED PARTIAL-ONSET SEIZURES: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST.
Coverage Duration	PLAN YEAR
Other Criteria	TSC ASSOCIATED PARTIAL-ONSET SEIZURES: INITIAL: TRIAL OF OR CONTRAINDICATION TO THE PREFERRED AGENTS: 1) EPIDIOLEX, AND 2) ONE OTHER ANTIEPILEPTIC AGENT.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

FECAL MICROBIOTA CAPSULE

Products Affected

- VOWST

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	CLOSTRIDIODES DIFFICILE INFECTION (CDI): PRESCRIBED BY OR IN CONSULTATION WITH GASTROENTEROLOGIST OR INFECTIOUS DISEASE SPECIALIST.
Coverage Duration	30 DAYS
Other Criteria	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	Yes

FEDRATINIB

Products Affected

- INREBIC

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
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

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: PLAN YEAR.
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

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	PLAN YEAR
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

FEZOLINETANT

Products Affected

- VEOZAH

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
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

PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

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	PLAN YEAR
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

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: PLAN YEAR.
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

PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

FINGOLIMOD

Products Affected

- *fingolimod*

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

FOSCARBIDOPA-FOSLEVODOPA

Products Affected

- VYALEV

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: PLAN YEAR.
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	No

FRUQUINTINIB

Products Affected

- FRUZAQLA ORAL CAPSULE 1 MG, 5 MG

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

FUTIBATINIB

Products Affected

- LYTGOBI

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	PLAN YEAR
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

GALCANEZUMAB-GNLM

Products Affected

- EMGALITY PEN
- EMGALITY SYRINGE SUBCUTANEOUS
SYRINGE 120 MG/ML, 300 MG/3 ML (100
MG/ML X 3)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL: MIGRAINE PREVENTION: PLAN YEAR. EPISODIC CLUSTER HEADACHE: 3 MOS. RENEWAL (ALL): PLAN YEAR.
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: INITIAL: SYMPTOMS WERE NOT ADEQUATELY MANAGED WITH ABORTIVE THERAPIES (E.G., IMITREX, ZOMIG). 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	Yes

GANAXOLONE

Products Affected

- ZTALMY

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

GEFITINIB

Products Affected

- *gefitinib*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
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

GEPIRONE

Products Affected

- EXXUA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
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

GILTERITINIB

Products Affected

- XOSPATA

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

GLASDEGIB

Products Affected

- DAURISMO ORAL TABLET 100 MG, 25 MG

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

GLATIRAMER

Products Affected

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

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

GLP1-DULAGLUTIDE

Products Affected

- TRULICITY

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

GLP1-SEMAGLUTIDE

Products Affected

- OZEMPIC ORAL
- OZEMPIC SUBCUTANEOUS
- RYBELSUS

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

GLP1-TIRZEPATIDE

Products Affected

- MOUNJARO

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

GUSELKUMAB

Products Affected

- TREMFYA INTRAVENOUS INJECTOR 200 MG/2 ML
- TREMFYA ONE-PRESS • TREMFYA SUBCUTANEOUS SYRINGE
- TREMFYA PEN INDUCTION PK(2PEN)
- TREMFYA PEN SUBCUTANEOUS PEN

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/RENEWAL: PLAN YEAR.
Other Criteria	INITIAL: PSO: 1) AT LEAST A 3 MONTH TRIAL OF ONE OF THE FOLLOWING CLINICAL STANDARD OF CARE AGENTS: AN ORAL IMMUNOSUPPRESSANT (CYCLOSPORINE, METHOTREXATE, TACROLIMUS), PUVA (PHOTOTHERAPY), 2) CONTRAINDICATION OR INTOLERANCE TO BOTH OF THE FOLLOWING CLINICAL STANDARD OF CARE AGENTS: AN IMMUNOSUPPRESSANT, 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.

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

HIGH RISK DRUGS IN THE ELDERLY - BUTALBITAL/APAP/CAF

Products Affected

- *butalbital-acetaminophen-caff 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	PLAN YEAR
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

HIGH RISK DRUGS IN THE ELDERLY - BUTALBITAL/APAP/CAF/COD

Products Affected

- *butalbital-acetaminop-caf-cod oral capsule*
50-325-40-30 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	PLAN YEAR
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

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	PLAN YEAR
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

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	PLAN YEAR
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

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	PLAN YEAR
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

HIGH RISK DRUGS IN THE ELDERLY - GLYBURIDE

Products Affected

- *glyburide*
- *glyburide micronized*

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	PLAN YEAR
Other Criteria	TYPE 2 DIABETES MELLITUS (DM): 1) TRIAL OF OR CONTRAINDICATION TO ONE OF THE FOLLOWING CLINICAL STANDARD OF CARE AGENTS: GLIMEPIRIDE, 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	No

HIGH RISK DRUGS IN THE ELDERLY - GLYBURIDE/METFORMIN

Products Affected

- *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	PLAN YEAR
Other Criteria	TYPE 2 DIABETES MELLITUS (DM): 1) TRIAL OF OR CONTRAINDICATION TO ONE OF THE FOLLOWING CLINICAL STANDARD OF CARE AGENTS: GLIMEPIRIDE, 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	No

HIGH RISK DRUGS IN THE ELDERLY - KETOROLAC

Products Affected

- *ketorolac 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	30 days
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

HIGH RISK DRUGS IN THE ELDERLY - PHENOBARBITAL

Products Affected

- *phenobarbital*

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	PLAN YEAR
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

HIGH RISK DRUGS IN THE ELDERLY - PROMETHAZINE

Products Affected

- *promethazine 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	PLAN YEAR
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.
Off Label Uses	

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

HIGH RISK DRUGS IN THE ELDERLY - SCOPOLAMINE

Products Affected

- *scopolamine base*

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	PLAN YEAR
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

HIGH RISK DRUGS IN THE ELDERLY- DIPHENOXYLATE-ATROPINE

Products Affected

- *diphenoxylate-atropine 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	PLAN YEAR
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

HIGH RISK DRUGS IN THE ELDERLY- INDOMETHACIN

Products Affected

- *indomethacin oral capsule*

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	PLAN YEAR
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

HIGH RISK DRUGS IN THE ELDERLY- MEGESTROL

Products Affected

- *megestrol 400 mg/10 ml susp cup outer*
- *megestrol oral suspension 400 mg/10 ml (40 mg/ml), 625 mg/5 ml (125 mg/ml)*
- *megestrol 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	PLAN YEAR
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

HIGH RISK DRUGS IN THE ELDERLY- PAROXETINE

Products Affected

- *paroxetine hcl*

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	PLAN YEAR
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

IBRUTINIB

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
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

ICATIBANT

Products Affected

- *icatibant*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	HEREDITARY ANGIOEDEMA (HAE): INITIAL: 1) 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, OR 2) TYPE III HAE CONFIRMED BY: (A) RECURRENT, NON-URTICARIAL ANGIOEDEMA INVOLVING THE SKIN, GASTROINTESTINAL TRACT, OR AIRWAY, CONSISTENT WITH BRADYKININ-MEDIATED HAE AND ATTACKS NOT EXPLAINED BY HISTAMINERGIC/URTICARIAL ANGIOEDEMA, AND (B) OTHER CAUSES OF ANGIOEDEMA HAVE BEEN EXCLUDED, INCLUDING ACE-INHIBITOR/ARB-ASSOCIATED ANGIOEDEMA, ACQUIRED C1-INH DEFICIENCY, AND MAST-CELL/HISTAMINERGIC ANGIOEDEMA.
Age Restrictions	
Prescriber Restrictions	HAE: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH AN ALLERGIST, IMMUNOLOGIST, HEMATOLOGIST OR PULMONOLOGIST.
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
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

PA Criteria	Criteria Details
Prerequisite Therapy Required	No

IDEALALISIB

Products Affected

- ZYDELIG

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

IMATINIB

Products Affected

- *imatinib oral tablet 100 mg, 400 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
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

IMATINIB SOLUTION

Products Affected

- IMKELDI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
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

IMLUNESTRANT

Products Affected

- INLURIYO

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

INAVOLISIB

Products Affected

- ITOVEBI ORAL TABLET 3 MG, 9 MG

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

INFLIXIMAB

Products Affected

- *infliximab*

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

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

INFLIXIMAB-DYYB SQ

Products Affected

- ZYMFENTRA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	INITIAL: ULCERATIVE COLITIS (UC), CROHNS DISEASE (CD): PRESCRIBED BY OR IN CONSULTATION WITH A GASTROENTEROLOGIST.
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
Other Criteria	INITIAL: UC: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: SELARSDI/YESINTEK/OTULFI, XELJANZ, HUMIRA/ADALIMUMAB-AATY/HADLIMA, RINVOQ, SKYRIZI, TREMFYA. CD: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: SELARSDI/YESINTEK/OTULFI, HUMIRA/ADALIMUMAB-AATY/HADLIMA, RINVOQ, SKYRIZI, TREMFYA. 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.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

INSULIN SUPPLIES PAYMENT DETERMINATION

Products Affected

- 1ST TIER UNIFINE PENTP 5MM 31G
- 1ST TIER UNIFINE PNTIP 4MM 32G
- 1ST TIER UNIFINE PNTIP 6MM 31G
- 1ST TIER UNIFINE PNTIP 8MM 31G STRL,SINGLE-USE,SHRT
- 1ST TIER UNIFINE PNTTP 29GX1/2"
- 1ST TIER UNIFINE PNTTP 31GX3/16
- 1ST TIER UNIFINE PNTTP 32GX5/32
- ADVOCATE INS 0.3 ML 30GX5/16"
- ADVOCATE INS 0.3 ML 31GX5/16"
- ADVOCATE INS 0.5 ML 30GX5/16"
- ADVOCATE INS 0.5 ML 31GX5/16"
- ADVOCATE INS 1 ML 31GX5/16"
- ADVOCATE INS SYR 1 ML 30GX5/16
- ADVOCATE PEN NEEDLE 32G 4MM
- ADVOCATE PEN NEEDLE 4MM 33G
- ADVOCATE PEN NEEDLES 5MM 31G
- ADVOCATE PEN NEEDLES 8MM 31G
- ALCOHOL PADS
- AQINJECT PEN NEEDLE 31G 5MM
- AQINJECT PEN NEEDLE 32G 4MM
- ASSURE ID DUO PRO NDL 31G 5MM
- ASSURE ID DUO-SHIELD 30GX3/16"
- ASSURE ID DUO-SHIELD 30GX5/16"
- ASSURE ID INSULIN SAFETY SYRINGE 1 ML 29 GAUGE X 1/2"
- ASSURE ID PEN NEEDLE 30GX5/16"
- ASSURE ID PRO PEN NDL 30G 5MM
- ASSURE ID SYR 0.5 ML 31GX15/64"
- ASSURE ID SYR 1 ML 31GX15/64"
- BD AUTOSHIELD DUO NDL 5MMX30G
- BD ECLIPSE 30GX1/2" SYRINGE
- BD INS SYR 0.3 ML 8MMX31G(1/2)
- BD INS SYR UF 0.3 ML 12.7MMX30G
- BD INS SYR UF 0.5 ML 12.7MMX30G NOT FOR RETAIL SALE
- BD INSULIN SYR 1 ML 27GX12.7MM
- BD INSULIN SYR 1 ML 27GX5/8" MICRO-FINE
- BD SAFETYGLD INS 0.3 ML 29G 13MM
- BD SAFETYGLD INS 0.3 ML 31G 8MM
- BD SAFETYGLD INS 0.5 ML 30G 8MM
- BD SAFETYGLD INS 1 ML 29G 13MM
- BD SAFETYGLID INS 1 ML 6MMX31G
- BD SAFETYGLIDE SYRINGE 27GX5/8
- BD SAFTYGLD INS 0.3 ML 6MMX31G
- BD SAFTYGLD INS 0.5 ML 29G 13MM
- BD SAFTYGLD INS 0.5 ML 6MMX31G
- BD SINGLE USE SWAB
- BD UF MICRO PEN NEEDLE 6MMX32G
- BD UF MINI PEN NEEDLE 5MMX31G
- BD UF NANO PEN NEEDLE 4MMX32G
- BD UF ORIG PEN NDL 12.7MMX29G
- BD UF SHORT PEN NEEDLE 8MMX31G
- BD VEO INS 0.3 ML 6MMX31G (1/2)
- BD VEO INS SYRING 1 ML 6MMX31G
- BD VEO INS SYRN 0.3 ML 6MMX31G
- BD VEO INS SYRN 0.5 ML 6MMX31G
- BORDERED GAUZE 2"X2"
- CAREFINE PEN NEEDLE 12.7MM 29G HRI
- CAREFINE PEN NEEDLE 4MM 32G
- CAREFINE PEN NEEDLE 5MM 32G
- CAREFINE PEN NEEDLE 6MM 31G HRI
- CAREFINE PEN NEEDLE 8MM 30G HRI
- CAREFINE PEN NEEDLES 6MM 32G
- CAREFINE PEN NEEDLES 8MM 31G
- CARETOUCH ALCOHOL 70% PREP PAD
- CARETOUCH PEN NEEDLE 29G 12MM
- CARETOUCH PEN NEEDLE 31GX1/4"
- CARETOUCH PEN NEEDLE 31GX3/16"
- CARETOUCH PEN NEEDLE 31GX5/16"
- CARETOUCH PEN NEEDLE 32GX3/16"
- CARETOUCH PEN NEEDLE 32GX5/32"
- CARETOUCH SYR 0.3 ML 31GX5/16"
- CARETOUCH SYR 0.5 ML 30GX5/16"
- CARETOUCH SYR 0.5 ML 31GX5/16"
- CARETOUCH SYR 1 ML 28GX5/16"
- CARETOUCH SYR 1 ML 29GX5/16"
- CARETOUCH SYR 1 ML 30GX5/16"
- CARETOUCH SYR 1 ML 31GX5/16"
- CLICKFINE PEN NEEDLE 32GX5/32"

- 32GX4MM, STERILE
- CLICKFINE UNIVERSAL 31G X 1/4" 6MM, STORE BRAND
- COMFORT EZ 0.3 ML 31G 15/64"
- COMFORT EZ 0.5 ML 31G 15/64"
- COMFORT EZ INS 0.3 ML 30GX1/2"
- COMFORT EZ INS 0.3 ML 30GX5/16"
- COMFORT EZ INS 1 ML 31G 15/64"
- COMFORT EZ INS 1 ML 31GX5/16"
- COMFORT EZ INSULIN SYR 0.3 ML
- COMFORT EZ INSULIN SYR 0.5 ML
- COMFORT EZ PEN NEEDLE 12MM 29G
- COMFORT EZ PEN NEEDLES 4MM 32G SINGLE USE, MICRO
- COMFORT EZ PEN NEEDLES 4MM 33G
- COMFORT EZ PEN NEEDLES 5MM 31G MINI
- COMFORT EZ PEN NEEDLES 5MM 32G SINGLE USE,MINI,HRI
- COMFORT EZ PEN NEEDLES 5MM 33G
- COMFORT EZ PEN NEEDLES 6MM 31G
- COMFORT EZ PEN NEEDLES 6MM 32G
- COMFORT EZ PEN NEEDLES 6MM 33G
- COMFORT EZ PEN NEEDLES 8MM 31G SHORT
- COMFORT EZ PEN NEEDLES 8MM 32G
- COMFORT EZ PEN NEEDLES 8MM 33G
- COMFORT EZ PRO PEN NDL 30G 8MM
- COMFORT EZ PRO PEN NDL 31G 4MM
- COMFORT EZ PRO PEN NDL 31G 5MM
- COMFORT EZ SYR 0.3 ML 29GX1/2"
- COMFORT EZ SYR 0.5 ML 28GX1/2"
- COMFORT EZ SYR 0.5 ML 29GX1/2"
- COMFORT EZ SYR 0.5 ML 30GX1/2"
- COMFORT EZ SYR 1 ML 27G 12.7MM
- COMFORT EZ SYR 1 ML 28GX1/2"
- COMFORT EZ SYR 1 ML 29GX1/2"
- COMFORT EZ SYR 1 ML 30GX1/2"
- COMFORT EZ SYR 1 ML 30GX5/16"
- COMFORT POINT PEN NDL 31GX1/3"
- COMFORT POINT PEN NDL 31GX1/6"
- COMFORT TOUCH PEN NDL 31G 4MM
- COMFORT TOUCH PEN NDL 31G 5MM
- COMFORT TOUCH PEN NDL 31G 6MM
- COMFORT TOUCH PEN NDL 31G 8MM
- COMFORT TOUCH PEN NDL 32G 4MM
- COMFORT TOUCH PEN NDL 32G 5MM
- COMFORT TOUCH PEN NDL 32G 6MM
- COMFORT TOUCH PEN NDL 32G 8MM
- COMFORT TOUCH PEN NDL 33G 4MM
- COMFORT TOUCH PEN NDL 33G 6MM
- COMFORT TOUCH PEN NDL 33GX5MM
- CURITY ALCOHOL PREPS 2 PLY,MEDIUM
- CURITY GAUZE PADS
- CURITY GAUZE SPONGES (12 PLY)-200/BAG
- DERMACEA 2"X2" GAUZE 12 PLY, USP TYPE VII
- DERMACEA GAUZE 2"X2" SPONGE 8 PLY
- DERMACEA NON-WOVEN 2"X2" SPNGE
- DROPLET 0.3 ML 29G 12.7MM(1/2) OUTER
- DROPLET 0.3 ML 30G 12.7MM(1/2) OUTER
- DROPLET 0.5 ML 29GX12.5MM(1/2)
- DROPLET 0.5 ML 30GX12.5MM(1/2)
- DROPLET INS 0.3 ML 29GX12.5MM
- DROPLET INS 0.3 ML 30G 8MM(1/2) OUTER
- DROPLET INS 0.3 ML 30GX12.5MM
- DROPLET INS 0.3 ML 31G 6MM(1/2) OUTER
- DROPLET INS 0.3 ML 31G 8MM(1/2) OUTER
- DROPLET INS 0.5 ML 29G 12.7MM OUTER
- DROPLET INS 0.5 ML 30G 12.7MM OUTER
- DROPLET INS 0.5 ML 30GX6MM(1/2)
- DROPLET INS 0.5 ML 30GX8MM(1/2)
- DROPLET INS 0.5 ML 31GX6MM(1/2)
- DROPLET INS 0.5 ML 31GX8MM(1/2)
- DROPLET INS SYR 0.3 ML 30GX6MM
- DROPLET INS SYR 0.3 ML 30GX8MM
- DROPLET INS SYR 0.3 ML 31GX6MM
- DROPLET INS SYR 0.3 ML 31GX8MM
- DROPLET INS SYR 0.5 ML 30G 8MM OUTER
- DROPLET INS SYR 0.5 ML 31G 6MM OUTER
- DROPLET INS SYR 0.5 ML 31G 8MM

- OUTER
- DROPLET INS SYR 1 ML 29G 12.7MM
- OUTER
- DROPLET INS SYR 1 ML 30G 12.5MM
- DROPLET INS SYR 1 ML 30G 6MM
- DROPLET INS SYR 1 ML 30G 8MM
- OUTER
- DROPLET INS SYR 1 ML 31G 6MM
- OUTER
- DROPLET INS SYR 1 ML 31G 8MM
- DROPLET MICRON 34G X 9/64"
- DROPLET PEN NEEDLE 29G 10MM
- DROPLET PEN NEEDLE 29G 12MM
- DROPLET PEN NEEDLE 30G 8MM
- DROPLET PEN NEEDLE 31G 5MM
- DROPLET PEN NEEDLE 31G 6MM
- DROPLET PEN NEEDLE 31G 8MM
- DROPLET PEN NEEDLE 32G 4MM
- DROPLET PEN NEEDLE 32G 5MM
- DROPLET PEN NEEDLE 32G 6MM
- DROPLET PEN NEEDLE 32G 8MM
- DROPSAFE ALCOHOL 70% PREP PADS
- DROPSAFE INS SYR 0.3 ML 31G 6MM
- DROPSAFE INS SYR 0.3 ML 31G 8MM
- DROPSAFE INS SYR 0.5 ML 31G 6MM
- DROPSAFE INS SYR 0.5 ML 31G 8MM
- DROPSAFE INSUL SYR 1 ML 31G 6MM
- DROPSAFE INSUL SYR 1 ML 31G 8MM
- DROPSAFE INSULN 1 ML 29G 12.5MM
- DROPSAFE PEN NEEDLE 31G 4MM
- DROPSAFE PEN NEEDLE 31G 5MM
- DROPSAFE PEN NEEDLE 31G 8MM
- DROPSAFE PEN NEEDLE 31GX1/4"
- EASY CMFT SFTY PEN NDL 31G 5MM
- EASY CMFT SFTY PEN NDL 31G 6MM
- EASY CMFT SFTY PEN NDL 32G 4MM
- EASY COMFORT 0.3 ML 31G 1/2"
- EASY COMFORT 0.3 ML 31G 5/16"
- EASY COMFORT 0.5 ML 30GX1/2"
- EASY COMFORT 0.5 ML 31GX5/16"
- EASY COMFORT 0.5 ML 32GX5/16"
- EASY COMFORT 0.5 ML SYRINGE
- EASY COMFORT 1 ML 31GX5/16"
- EASY COMFORT 1 ML 32GX5/16"
- EASY COMFORT ALCOHOL 70% PAD
- EASY COMFORT INSULIN 1 ML SYR
- EASY COMFORT PEN NDL 29G 4MM
- EASY COMFORT PEN NDL 29G 5MM
- EASY COMFORT PEN NDL 31GX1/4"
- EASY COMFORT PEN NDL 31GX3/16"
- EASY COMFORT PEN NDL 31GX5/16"
- EASY COMFORT PEN NDL 32GX5/32"
- EASY COMFORT PEN NDL 33G 4MM
- EASY COMFORT PEN NDL 33G 5MM
- EASY COMFORT PEN NDL 33G 6MM
- EASY COMFORT SYR 0.5 ML 29G 8MM
- EASY COMFORT SYR 1 ML 29G 8MM
- EASY COMFORT SYR 1 ML 30GX1/2"
- EASY GLIDE INS 0.3 ML 31GX6MM
- EASY GLIDE INS 0.5 ML 31GX6MM
- EASY GLIDE INS 1 ML 31GX6MM
- EASY GLIDE PEN NEEDLE 4MM 33G
- EASY TOUCH 0.3 ML 30G 8MM(1/2)
- EASY TOUCH 0.3 ML 31G 6MM(1/2)
- EASY TOUCH 0.3 ML 31G 8MM(1/2)
- EASY TOUCH 0.3 ML SYR 30GX1/2"
- EASY TOUCH 0.5 ML SYR 27GX1/2"
- EASY TOUCH 0.5 ML SYR 29GX1/2"
- EASY TOUCH 0.5 ML SYR 30GX1/2"
- EASY TOUCH 0.5 ML SYR 30GX5/16
- EASY TOUCH 1 ML SYR 29GX1/2"
- EASY TOUCH 1 ML SYR 30GX1/2"
- EASY TOUCH ALCOHOL 70% PADS
- GAMMA-STERILIZED
- EASY TOUCH AUTO 0.5 ML 30G 6MM
- EASY TOUCH AUTO 0.5 ML 30G 8MM
- EASY TOUCH AUTORET 1 ML 30G 6MM
- EASY TOUCH AUTORET 1 ML 30G 8MM
- EASY TOUCH FLIPLOK 1 ML 27GX0.5
- EASY TOUCH INS 0.3 ML 30G 8MM
- EASY TOUCH INS 0.3 ML 31G 8MM
- EASY TOUCH INS 0.5 ML 30G 8MM
- EASY TOUCH INS 0.5 ML 31G 6MM
- EASY TOUCH INS 0.5 ML 31G 8MM
- EASY TOUCH INS 1 ML 27G 1/2"
- EASY TOUCH INS 1 ML 28G 12.7MM
- EASY TOUCH INS SYR 1 ML 30G 8MM
- EASY TOUCH INS SYR 1 ML 31G 6MM
- EASY TOUCH INS SYR 1 ML 31G 8MM
- EASY TOUCH INSULIN 1 ML 29GX1/2
- EASY TOUCH INSULIN 1 ML 30GX1/2
- EASY TOUCH INSULIN SYR 1 ML
- EASY TOUCH INSULIN SYR 1 ML
- RETRACTABLE

- EASY TOUCH INSULN 1 ML 29GX1/2"
- EASY TOUCH INSULN 1 ML 30GX1/2"
- EASY TOUCH INSULN 1 ML 30GX5/16
- EASY TOUCH INSULN 1 ML 31GX5/16
- EASY TOUCH LUER LOK INSUL 1 ML
- EASY TOUCH PEN NEEDLE 29GX1/2"
- EASY TOUCH PEN NEEDLE 30GX5/16
- EASY TOUCH PEN NEEDLE 31GX1/4"
- EASY TOUCH PEN NEEDLE 31GX3/16
- EASY TOUCH PEN NEEDLE 31GX5/16
- EASY TOUCH PEN NEEDLE 32GX1/4"
- EASY TOUCH PEN NEEDLE 32GX3/16
- EASY TOUCH PEN NEEDLE 32GX5/32
- EASY TOUCH SAF PEN NDL 29G 5MM
- EASY TOUCH SAF PEN NDL 29G 8MM
- EASY TOUCH SAF PEN NDL 30G 5MM
- EASY TOUCH SAF PEN NDL 30G 8MM
- EASY TOUCH SYR 0.5 ML 28G 12.7MM
- EASY TOUCH SYR 0.5 ML 29G 12.7MM
- EASY TOUCH SYR 1 ML 27G 16MM
- EASY TOUCH UNI-SLIP SYR 1 ML
- EASYLIFE ALCOHOL 70% PADS
- EASYLIFE INS PEN NDL 29G 12MM
- EASYLIFE INS PEN NDL 31G 4MM
- EASYLIFE INS PEN NDL 31G 5MM
- EASYLIFE INS PEN NDL 31G 6MM
- EASYLIFE INS PEN NDL 31G 8MM
- EASYLIFE INS PEN NDL 32G 4MM
- EASYLIFE INS PEN NDL 32G 5MM
- EASYLIFE INS PEN NDL 32G 6MM
- EASYLIFE INS PEN NDL 32G 8MM
- EASYLIFE INS PEN NDL 33G 4MM
- EASYLIFE INS PEN NDL 33G 5MM
- EASYLIFE INS PEN NDL 33G 6MM
- EASYLIFE INS PEN NDL 33G 8MM
- EASYLIFE INS SYR 0.5 ML 30G 8MM
- EASYLIFE INS SYR 1 ML 30G 8MM
- EASYLIFE INS SYR 1 ML 31G 8MM
- EASYLIFE SAFTY PEN NDL 31G 4MM
- EASYLIFE SAFTY PEN NDL 31G 5MM
- EASYLIFE SYR 1 ML 30G 12.7MM
- EASYTOUCH SAF PEN NDL 30G 6MM
- EMBRACE PEN NEEDLE 29G 12MM
- EMBRACE PEN NEEDLE 30G 5MM
- EMBRACE PEN NEEDLE 30G 8MM
- EMBRACE PEN NEEDLE 31G 5MM
- EMBRACE PEN NEEDLE 31G 6MM
- EMBRACE PEN NEEDLE 31G 8MM
- EMBRACE PEN NEEDLE 32G 4MM
- EXEL U100 0.3 ML 29GX1/2"
- EXEL U100 0.3 ML 30GX5/16"
- FT STERILE PADS 2" X 2"
- GAUZE PAD TOPICAL BANDAGE 2 X 2"
- GNP ALCOHOL SWAB STERILE, TWO PLY
- GNP PEN NEEDLE 31G 5MM
- GNP PEN NEEDLE 32G 6MM
- GNP SIMPLI PEN NEEDLE 32G 4MM
- GNP ULT C 0.3 ML 29GX1/2" (1/2) 1/2 UNIT
- GNP ULT CMFRT 0.5 ML 29GX1/2"
- GNP ULTR CMFRT 0.5 ML 30GX5/16
- GNP ULTRA COMFORT 1 ML SYRINGE
- GNP ULTRA COMFORT 3/10 ML SYR
- GS PEN NEEDLE 31G X 8MM
- HEALTHWISE INS 0.3 ML 30GX5/16"
- HEALTHWISE INS 0.3 ML 31GX5/16"
- HEALTHWISE INS 0.5 ML 30GX5/16"
- HEALTHWISE INS 0.5 ML 31GX5/16"
- HEALTHWISE INS 1 ML 30GX5/16"
- HEALTHWISE INS 1 ML 31GX5/16"
- HEALTHWISE PEN NEEDLE 31G 5MM
- HEALTHWISE PEN NEEDLE 31G 8MM
- HEALTHWISE PEN NEEDLE 32G 4MM
- HEALTHY ACCENTS PENTIP 5MM 31G
- HEALTHY ACCENTS PENTIP 6MM 31G
- HEALTHY ACCENTS PENTIP 8MM 31G
- HEALTHY ACCENTS PENTIP 12MM 29G
- HEB INCONTROL ALCOHOL 70% PADS
- INCONTROL PEN NEEDLE 12MM 29G
- INCONTROL PEN NEEDLE 4MM 32G
- INCONTROL PEN NEEDLE 5MM 31G
- INCONTROL PEN NEEDLE 6MM 31G
- INCONTROL PEN NEEDLE 8MM 31G
- INSULIN 1 ML SYRINGE
- INSULIN 1/2 ML SYRINGE
- INSULIN 3/10 ML SYRINGE
- INSULIN SYR 0.3 ML 31GX1/4(1/2)
- INSULIN SYRIN 0.5 ML 28GX1/2" (OTC)
- INSULIN SYRIN 0.5 ML 29GX1/2" (OTC)
- INSULIN SYRIN 0.5 ML 30GX1/2" (RX)
- INSULIN SYRIN 0.5 ML 30GX5/16" SHORT NEEDLE (OTC)

- INSULIN SYRINGE 0.5 ML 27G 1/2" INNER
- INSULIN SYRINGE 0.3 ML
- INSULIN SYRINGE 0.3 ML 31GX1/4
- INSULIN SYRINGE 0.5 ML
- INSULIN SYRINGE 0.5 ML 31GX1/4
- INSULIN SYRINGE 1 ML
- INSULIN SYRINGE 1 ML 27G 1/2" INNER
- INSULIN SYRINGE 1 ML 28GX1/2" (OTC)
- INSULIN SYRINGE 1 ML 30GX1/2" SHORT NEEDLE (OTC)
- INSULIN SYRINGE 1 ML 30GX5/16" SHORT NEEDLE (OTC)
- INSULIN SYRINGE 1 ML 31GX1/4"
- INSULIN SYRINGE 1 ML 31GX5/16" SHORT NEEDLE, THIN II (OTC)
- INSULIN SYRINGE-NEEDLE U-100 SYRINGE 0.3 ML 29 GAUGE, 1 ML 29 GAUGE X 1/2", 1/2 ML 28 GAUGE
- INSULIN U-500 SYRINGE-NEEDLE
- INSUPEN PEN NEEDLE 29GX1/2"
- INSUPEN PEN NEEDLE 31G 8MM
- INSUPEN PEN NEEDLE 31GX3/16"
- INSUPEN PEN NEEDLE 32G 4MM
- INSUPEN PEN NEEDLE 32G 6MM (RX)
- IV ANTISEPTIC WIPES
- KENDALL ALCOHOL 70% PREP PAD
- LISCO SPONGES 100/BAG
- MAGELLAN INSUL SYRINGE 0.3 ML
- MAGELLAN INSUL SYRINGE 0.5 ML
- MAGELLAN INSULIN SYR 0.3 ML
- MAGELLAN INSULIN SYR 0.5 ML
- MAGELLAN INSULIN SYRINGE 1 ML
- MAXI-COMFORT INS 0.5 ML 28G
- MAXI-COMFORT INS 1 ML 28GX1/2"
- MAXICOMFORT II PEN NDL 31GX6MM
- MAXICOMFORT INS 0.5 ML 27GX1/2"
- MAXICOMFORT INS 1 ML 27GX1/2"
- MAXICOMFORT PEN NDL 29G X 5MM
- MAXICOMFORT PEN NDL 29G X 8MM
- MICRODOT PEN NEEDLE 31GX6MM
- MICRODOT PEN NEEDLE 32GX4MM
- MICRODOT PEN NEEDLE 33GX4MM
- MICRODOT READYGARD NDL 31G 5MM OUTER
- MINI PEN NEEDLE 32G 5MM
- MINI PEN NEEDLE 32G 8MM
- MINI PEN NEEDLE 33G 5MM
- MINI PEN NEEDLE 33G 6MM
- MINI ULTRA-THIN II PEN NDL 31G STERILE
- MONOJECT 0.5 ML SYRN 28GX1/2"
- MONOJECT 1 ML SYRN 27X1/2"
- MONOJECT 1 ML SYRN 28GX1/2" (OTC)
- MONOJECT INSUL SYR U100 (OTC)
- MONOJECT INSUL SYR U100 .5ML, 29GX1/2" (OTC)
- MONOJECT INSUL SYR U100 0.5 ML CONVERTS TO 29G (OTC)
- MONOJECT INSUL SYR U100 1 ML
- MONOJECT INSUL SYR U100 1 ML 3'S, 29GX1/2" (OTC)
- MONOJECT INSUL SYR U100 1 ML W/O NEEDLE (OTC)
- MONOJECT INSULIN SYR 0.3 ML
- MONOJECT INSULIN SYR 0.3 ML (OTC)
- MONOJECT INSULIN SYR 0.5 ML
- MONOJECT INSULIN SYR 0.5 ML (OTC)
- MONOJECT INSULIN SYR 1 ML 3'S (OTC)
- MONOJECT INSULIN SYR U-100
- MONOJECT SYRINGE 0.3 ML
- MONOJECT SYRINGE 0.5 ML
- MONOJECT SYRINGE 1 ML
- NANO 2 GEN PEN NEEDLE 32G 4MM
- NANO PEN NEEDLE 32G 4MM
- NOVOFINE 32G NEEDLES
- NOVOFINE AUTOCOVER 30G NEEDLE
- NOVOFINE PLUS PEN NDL 32GX1/6"
- PEN NEEDLE 30G 5MM OUTER
- PEN NEEDLE 30G 8MM INNER
- PEN NEEDLE 30G X 5/16"
- PEN NEEDLE 31G X 1/4" HRI
- PEN NEEDLE 33G 4MM
- PEN NEEDLE, DIABETIC NEEDLE 29 GAUGE X 1/2"
- PEN NEEDLES 12MM 29G 29GX12MM, STRL
- PEN NEEDLES 4MM 32G
- PEN NEEDLES 5MM 31G 31GX5MM, STRL, MINI (OTC)
- PEN NEEDLES 8MM 31G

- 31GX8MM,STRL,SHORT (OTC)
- PENTIPS PEN NEEDLE 29G 1/2"
- PENTIPS PEN NEEDLE 31G 1/4"
- PENTIPS PEN NEEDLE 31GX3/16" MINI, 5MM
- PENTIPS PEN NEEDLE 31GX5/16" SHORT, 8MM
- PENTIPS PEN NEEDLE 32G 1/4"
- PENTIPS PEN NEEDLE 32GX5/32"
- PIP PEN NEEDLE 31G X 5MM
- PIP PEN NEEDLE 32G X 4MM
- PREVENT PEN NEEDLE 31GX1/4"
- PREVENT PEN NEEDLE 31GX5/16"
- PRO COMFORT 0.5 ML 30GX1/2"
- PRO COMFORT 0.5 ML 30GX5/16"
- PRO COMFORT 0.5 ML 31GX5/16"
- PRO COMFORT 1 ML 30GX1/2"
- PRO COMFORT 1 ML 30GX5/16"
- PRO COMFORT 1 ML 31GX5/16"
- PRO COMFORT ALCOHOL 70% PADS
- PRO COMFORT PEN NDL 32G 8MM
- PRO COMFORT PEN NDL 32G X 1/4"
- PRO COMFORT PEN NDL 4MM 32G
- PRO COMFORT PEN NDL 5MM 32G
- PRO-COMFORT ALCOHOL 70% PADS
- PRODIGY INS SYR 1 ML 28GX1/2"
- PRODIGY SYRNG 0.5 ML 31GX5/16"
- PRODIGY SYRNGE 0.3 ML 31GX5/16"
- PURE CMFT SFTY PEN NDL 31G 5MM
- PURE CMFT SFTY PEN NDL 31G 6MM
- PURE CMFT SFTY PEN NDL 32G 4MM
- PURE COMFORT ALCOHOL 70% PADS
- PURE COMFORT PEN NDL 32G 4MM
- PURE COMFORT PEN NDL 32G 5MM
- PURE COMFORT PEN NDL 32G 6MM
- PURE COMFORT PEN NDL 32G 8MM
- RA ISOPROPYL ALCOHOL 70% WIPES
- RA STERILE PADS 2"X 2"
- RAYA SURE PEN NEEDLE 29G 12MM
- RAYA SURE PEN NEEDLE 31G 4MM
- RAYA SURE PEN NEEDLE 31G 5MM
- RAYA SURE PEN NEEDLE 31G 6MM
- RELION INS SYR 0.3 ML 31GX6MM
- RELION INS SYR 0.5 ML 31GX6MM
- RELION INS SYR 1 ML 31GX15/64"
- RELION PEN NEEDLE 32GX5/32"
- RELION SYRING 0.3 ML 31GX5/16"
- INNER
- RELION SYRING 0.5 ML 31GX5/16" INNER (OTC)
- SAFESNAP INS SYR UNITS-100 0.3 ML 30GX5/16",10X10
- SAFESNAP INS SYR UNITS-100 0.5 ML 29GX1/2",10X10
- SAFESNAP INS SYR UNITS-100 0.5 ML 30GX5/16",10X10
- SAFESNAP INS SYR UNITS-100 1 ML 28GX1/2",10X10
- SAFESNAP INS SYR UNITS-100 1 ML 29GX1/2",10X10
- SAFETY PEN NEEDLE 31G 4MM
- SAFETY PEN NEEDLE 5MM X 31G
- SAFETY SYRINGE 0.5 ML 30G 1/2"
- SECURESAFE PEN NDL 30GX5/16" OUTER
- SECURESAFE PEN NEEDLE 31G 5MM OUTER
- SECURESAFE SYR 0.5 ML 29G 1/2" OUTER
- SECURESAFE SYRNG 1 ML 29G 1/2" OUTER
- SKY SAFETY PEN NEEDLE 30G 5MM
- SKY SAFETY PEN NEEDLE 30G 8MM
- SURE CMFT SFTY PEN NDL 31G 6MM
- SURE CMFT SFTY PEN NDL 32G 4MM
- SURE COMFORT 0.5 ML SYRINGE
- SURE COMFORT 1 ML SYRINGE
- SURE COMFORT 3/10 ML SYRINGE
- SURE COMFORT 3/10 ML SYRINGE INSULIN SYRINGE
- SURE COMFORT 30G PEN NEEDLE
- SURE COMFORT ALCOHOL PREP PADS
- SURE COMFORT INS 0.3 ML 31GX1/4
- SURE COMFORT INS 0.5 ML 31GX1/4
- SURE COMFORT INS 1 ML 31GX1/4"
- SURE COMFORT PEN NDL 29GX1/2" 12.7MM
- SURE COMFORT PEN NDL 31G 5MM
- SURE COMFORT PEN NDL 31G 8MM
- SURE COMFORT PEN NDL 32G 4MM
- SURE COMFORT PEN NDL 32G 6MM
- SURE-FINE PEN NEEDLES 12.7MM
- SURE-FINE PEN NEEDLES 5MM
- SURE-FINE PEN NEEDLES 8MM

- SURE-JECT INSU SYR U100 0.3 ML
- SURE-JECT INSU SYR U100 0.5 ML
- SURE-JECT INSU SYR U100 1 ML
- SURE-JECT INSUL SYR U100 1 ML
- SURE-JECT INSULIN SYRINGE 1 ML
- SURE-PREP ALCOHOL PREP PADS
- TECHLITE 0.3 ML 29GX12MM (1/2)
- TECHLITE 0.3 ML 30GX8MM (1/2)
- TECHLITE 0.3 ML 31GX6MM (1/2)
- TECHLITE 0.3 ML 31GX8MM (1/2)
- TECHLITE 0.5 ML 30GX12MM (1/2)
- TECHLITE 0.5 ML 30GX8MM (1/2)
- TECHLITE 0.5 ML 31GX6MM (1/2)
- TECHLITE 0.5 ML 31GX8MM (1/2)
- TECHLITE INS SYR 1 ML 29GX12MM
- TECHLITE INS SYR 1 ML 30GX12MM
- TECHLITE INS SYR 1 ML 31GX6MM
- TECHLITE INS SYR 1 ML 31GX8MM
- TECHLITE PEN NEEDLE 29GX1/2"
- TECHLITE PEN NEEDLE 29GX3/8"
- TECHLITE PEN NEEDLE 31GX1/4"
- TECHLITE PEN NEEDLE 31GX3/16"
- TECHLITE PEN NEEDLE 31GX5/16"
- TECHLITE PEN NEEDLE 32GX1/4"
- TECHLITE PEN NEEDLE 32GX5/16"
- TECHLITE PEN NEEDLE 32GX5/32"
- TECHLITE PLUS PEN NDL 32G 4MM
- TERUMO INS SYRINGE U100-1 ML
- TERUMO INS SYRINGE U100-1/2 ML
- TERUMO INS SYRINGE U100-1/3 ML
- TERUMO INS SYRNG U100-1/2 ML
- THINPRO INS SYRIN U100-0.3 ML
- THINPRO INS SYRIN U100-0.5 ML
- THINPRO INS SYRIN U100-1 ML
- TOPFINE INSULN PEN NDL 32G 4MM
- TRUE CMFRT PRO 0.5 ML 30G 5/16"
- TRUE CMFRT PRO 0.5 ML 31G 5/16"
- TRUE CMFRT PRO 0.5 ML 32G 5/16"
- TRUE CMFT SFTY PEN NDL 31G 5MM
- TRUE CMFT SFTY PEN NDL 31G 6MM
- TRUE CMFT SFTY PEN NDL 32G 4MM
- TRUE COMFORT 0.5 ML 30G 1/2"
- TRUE COMFORT 0.5 ML 30G 5/16"
- TRUE COMFORT 0.5 ML 31G 5/16"
- TRUE COMFORT 0.5 ML 31GX5/16"
- TRUE COMFORT 1 ML 31GX5/16"
- TRUE COMFORT ALCOHOL 70% PADS
- TRUE COMFORT PEN NDL 31G 8MM
- TRUE COMFORT PEN NDL 31GX5MM
- TRUE COMFORT PEN NDL 31GX6MM
- TRUE COMFORT PEN NDL 32G 5MM
- TRUE COMFORT PEN NDL 32G 6MM
- TRUE COMFORT PEN NDL 32GX4MM
- TRUE COMFORT PEN NDL 33G 4MM
- TRUE COMFORT PEN NDL 33G 5MM
- TRUE COMFORT PEN NDL 33G 6MM
- TRUE COMFORT PRO 1 ML 30G 1/2"
- TRUE COMFORT PRO 1 ML 30G 5/16"
- TRUE COMFORT PRO 1 ML 31G 5/16"
- TRUE COMFORT PRO 1 ML 32G 5/16"
- TRUE COMFORT PRO ALCOHOL PADS
- TRUE COMFORT SFTY 1 ML 30G 1/2"
- TRUE COMFRT PRO 0.5 ML 30G 1/2"
- TRUE COMFRT SFTY 1 ML 30G 5/16"
- TRUE COMFRT SFTY 1 ML 31G 5/16"
- TRUE COMFRT SFTY 1 ML 32G 5/16"
- TRUE-CMFRT PRO PEN NDL 31G 5MM
- TRUE-CMFRT PRO PEN NDL 31G 6MM
- TRUE-CMFRT PRO PEN NDL 31G 8MM
- TRUE-CMFRT PRO PEN NDL 32G 4MM
- TRUEPLUS PEN NEEDLE 29GX1/2"
- TRUEPLUS PEN NEEDLE 31G X 1/4"
- TRUEPLUS PEN NEEDLE 31GX3/16"
- TRUEPLUS PEN NEEDLE 31GX5/16"
- TRUEPLUS PEN NEEDLE 32GX5/32"
- TRUEPLUS SYR 0.3 ML 29GX1/2"
- TRUEPLUS SYR 0.3 ML 30GX5/16"
- TRUEPLUS SYR 0.3 ML 31GX5/16"
- TRUEPLUS SYR 0.5 ML 28GX1/2"
- TRUEPLUS SYR 0.5 ML 29GX1/2"
- TRUEPLUS SYR 0.5 ML 30GX5/16"
- TRUEPLUS SYR 0.5 ML 31GX5/16"
- TRUEPLUS SYR 1 ML 28GX1/2"
- TRUEPLUS SYR 1 ML 29GX1/2"
- TRUEPLUS SYR 1 ML 30GX5/16"
- TRUEPLUS SYR 1 ML 31GX5/16"
- ULT CFT 0.3 ML 31GX5/16" (1/2) 1/2 UNIT
- ULTICAR INS 0.3 ML 31GX1/4(1/2)
- ULTICARE INS 0.3 ML 31GX1/4"
- ULTICARE INS 0.5 ML 31GX1/4"
- ULTICARE INS 1 ML 31GX1/4"
- ULTICARE INS SYR 1 ML 30GX1/2"
- ULTICARE PEN NEEDLE 31GX3/16"

- ULTICARE PEN NEEDLE 6MM 31G
- ULTICARE PEN NEEDLE 8MM 31G
- ULTICARE PEN NEEDLES 12MM 29G
- ULTICARE PEN NEEDLES 4MM 32G MICRO, 32GX4MM
- ULTICARE PEN NEEDLES 6MM 32G
- ULTICARE SAFE PEN NDL 30G 8MM
- ULTICARE SAFE PEN NDL 5MM 30G
- ULTICARE SYR 0.3 ML 30GX1/2"
- ULTICARE SYR 0.3 ML 31GX5/16" SHORT NDL
- ULTICARE SYR 0.5 ML 30GX1/2"
- ULTICARE SYR 0.5 ML 31GX5/16" SHORT NDL
- ULTICARE SYR 1 ML 31GX5/16"
- ULTIGUARD SAFE 1 ML 30G 12.7MM
- ULTIGUARD SAFE0.3 ML 30G 12.7MM
- ULTIGUARD SAFE0.5 ML 30G 12.7MM
- ULTIGUARD SAFEPACK 1 ML 31G 8MM
- ULTIGUARD SAFEPACK 29G 12.7MM
- ULTIGUARD SAFEPACK 31G 5MM
- ULTIGUARD SAFEPACK 31G 6MM
- ULTIGUARD SAFEPACK 31G 8MM
- ULTIGUARD SAFEPACK 32G 4MM
- ULTIGUARD SAFEPACK 32G 6MM
- ULTIGUARD SAFEPK 0.3 ML 31G 8MM
- ULTIGUARD SAFEPK 0.5 ML 31G 8MM
- ULTILET ALCOHOL STERL SWAB
- ULTILET INSULIN SYRINGE 0.3 ML
- ULTILET INSULIN SYRINGE 0.5 ML
- ULTILET INSULIN SYRINGE 1 ML
- ULTILET PEN NEEDLE
- ULTILET PEN NEEDLE 4MM 32G
- ULTRA COMFORT 0.3 ML 29GX1/2"
- ULTRA COMFORT 0.3 ML SYRINGE
- ULTRA COMFORT 0.5 ML 28GX1/2" CONVERTS TO 29G
- ULTRA COMFORT 0.5 ML 29GX1/2"
- ULTRA COMFORT 0.5 ML 31GX5/16"
- ULTRA COMFORT 0.5 ML SYRINGE
- ULTRA COMFORT 1 ML 29GX1/2"
- ULTRA COMFORT 1 ML 30GX5/16"
- ULTRA COMFORT 1 ML 31GX5/16"
- ULTRA COMFORT 1 ML SYRINGE
- ULTRA FLO 0.3 ML 30G 1/2" (1/2)
- ULTRA FLO 0.3 ML 30G 5/16"(1/2)
- ULTRA FLO 0.3 ML 31G 5/16"(1/2)
- ULTRA FLO PEN NEEDLE 31G 5MM
- ULTRA FLO PEN NEEDLE 31G 8MM
- ULTRA FLO PEN NEEDLE 32G 4MM
- ULTRA FLO PEN NEEDLE 33G 4MM
- ULTRA FLO PEN NEEDLES 12MM 29G
- ULTRA FLO SYR 0.3 ML 29GX1/2"
- ULTRA FLO SYR 0.3 ML 30G 5/16"
- ULTRA FLO SYR 0.3 ML 31G 5/16"
- ULTRA FLO SYR 0.5 ML 29G 1/2"
- ULTRA THIN PEN NDL 32G X 4MM
- ULTRA-FINE 0.3 ML 30G 12.7MM
- ULTRA-FINE 0.3 ML 31G 6MM (1/2)
- ULTRA-FINE 0.3 ML 31G 8MM (1/2)
- ULTRA-FINE 0.5 ML 30G 12.7MM
- ULTRA-FINE INS SYR 1 ML 31G 6MM
- ULTRA-FINE INS SYR 1 ML 31G 8MM
- ULTRA-FINE PEN NDL 29G 12.7MM
- ULTRA-FINE PEN NEEDLE 31G 5MM
- ULTRA-FINE PEN NEEDLE 31G 8MM
- ULTRA-FINE PEN NEEDLE 32G 6MM
- ULTRA-FINE SYR 0.3 ML 31G 6MM
- ULTRA-FINE SYR 0.3 ML 31G 8MM
- ULTRA-FINE SYR 0.5 ML 31G 6MM
- ULTRA-FINE SYR 0.5 ML 31G 8MM
- ULTRA-FINE SYR 1 ML 30G 12.7MM
- ULTRA-THIN II 1 ML 31GX5/16"
- ULTRA-THIN II INS 0.3 ML 30G
- ULTRA-THIN II INS 0.3 ML 31G
- ULTRA-THIN II INS 0.5 ML 29G
- ULTRA-THIN II INS 0.5 ML 30G
- ULTRA-THIN II INS 0.5 ML 31G
- ULTRA-THIN II INS SYR 1 ML 29G
- ULTRA-THIN II INS SYR 1 ML 30G
- ULTRA-THIN II PEN NDL 29GX1/2"
- ULTRA-THIN II PEN NDL 31GX5/16"
- ULTRACARE INS 0.3 ML 30GX5/16"
- ULTRACARE INS 0.3 ML 31GX5/16"
- ULTRACARE INS 0.5 ML 30GX1/2"
- ULTRACARE INS 0.5 ML 30GX5/16"
- ULTRACARE INS 0.5 ML 31GX5/16"
- ULTRACARE INS 1 ML 30G X 5/16"
- ULTRACARE INS 1 ML 30GX1/2"
- ULTRACARE INS 1 ML 31G X 5/16"
- ULTRACARE PEN NEEDLE 31GX1/4"
- ULTRACARE PEN NEEDLE 31GX3/16"
- ULTRACARE PEN NEEDLE 31GX5/16"
- ULTRACARE PEN NEEDLE 32GX1/4"

- ULTRACARE PEN NEEDLE 32GX3/16"
- ULTRACARE PEN NEEDLE 32GX5/32"
- ULTRACARE PEN NEEDLE 33GX5/32"
- UNIFINE OTC PEN NEEDLE 31G 5MM
- UNIFINE OTC PEN NEEDLE 32G 4MM
- UNIFINE PENTIPS 12MM 29G
29GX12MM, STRL
- UNIFINE PENTIPS 31GX3/16"
31GX5MM,STRL,MINI
- UNIFINE PENTIPS 32G 4MM
- UNIFINE PENTIPS 32GX1/4"
- UNIFINE PENTIPS 33GX5/32"
- UNIFINE PENTIPS 6MM 31G
- UNIFINE PENTIPS 8MM 31G 31GX8MM,
SHORT, STRL
- UNIFINE PENTIPS MAX 30GX3/16"
- UNIFINE PENTIPS PLUS 29GX1/2"
12MM
- UNIFINE PENTIPS PLUS 30GX3/16"
- UNIFINE PENTIPS PLUS 31G 5MM
- UNIFINE PENTIPS PLUS 31GX1/4"
ULTRA SHORT, 6MM
- UNIFINE PENTIPS PLUS 32GX5/32"
- UNIFINE PENTIPS PLUS 33GX5/32"
- UNIFINE PROTECT 30G 5MM
- UNIFINE PROTECT 30G 8MM
- UNIFINE PROTECT 32G 4MM
- UNIFINE SAFECONTROL 30G 5MM
- UNIFINE SAFECONTROL 30G 8MM
- UNIFINE SAFECONTROL 31G 5MM
- UNIFINE SAFECONTROL 31G 6MM
- UNIFINE SAFECONTROL 31G 8MM
- UNIFINE SAFECONTROL 32G 4MM
- UNIFINE ULTR PEN NDL 34G 3.5MM
- UNIFINE ULTRA PEN NDL 29G 12MM
- UNIFINE ULTRA PEN NDL 31G 5MM
- UNIFINE ULTRA PEN NDL 31G 6MM
- UNIFINE ULTRA PEN NDL 31G 8MM
- UNIFINE ULTRA PEN NDL 32G 4MM
- UNIFINE ULTRA PEN NDL 32G 6MM
- VANISHPOINT 0.5 ML 30GX1/2" SY
OUTER
- VANISHPOINT INS 0.5 ML 30G 8MM
OUTER
- VANISHPOINT INS 1 ML 30GX3/16"
- VANISHPOINT U-100 29X1/2 SYR
- VERIFINE INS SYR 1 ML 29G 1/2"
- VERIFINE PEN NEEDLE 29G 12MM
- VERIFINE PEN NEEDLE 31G 5MM
- VERIFINE PEN NEEDLE 31G X 6MM
- VERIFINE PEN NEEDLE 31G X 8MM
- VERIFINE PEN NEEDLE 32G 6MM
- VERIFINE PEN NEEDLE 32G X 4MM
- VERIFINE PEN NEEDLE 32G X 5MM
- VERIFINE PLUS PEN NDL 31G 5MM
- VERIFINE PLUS PEN NDL 31G 8MM
- VERIFINE PLUS PEN NDL 32G 4MM
- VERIFINE PLUS PEN NDL 32G 4MM-
SHARPS CONTAINER
- VERIFINE SYRING 0.5 ML 29G 1/2"
- VERIFINE SYRING 1 ML 31G 5/16"
- VERIFINE SYRNG 0.3 ML 31G 5/16"
- VERIFINE SYRNG 0.5 ML 31G 5/16"
- VERSALON ALL PURPOSE SPONGE
25'S,N-STERILE,3PLY
- WEBCOL ALCOHOL PREPS 20'S,LARGE
- WM UNIFINE PENTIP PLUS 8MM 31G
W/ SAFETY CLICK

PA Criteria	Criteria Details
Exclusion Criteria	ONLY COVERED UNDER PART D WHEN USED CONCURRENTLY WITH INSULIN.
Required Medical Information	
Age Restrictions	

PA Criteria	Criteria Details
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

INTERFERON FOR MS-AVONEX

Products Affected

- AVONEX INTRAMUSCULAR PEN INJECTOR KIT
- AVONEX INTRAMUSCULAR SYRINGE KIT

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

INTERFERON FOR MS-BETASERON

Products Affected

- BETASERON SUBCUTANEOUS KIT

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

INTERFERON FOR MS-PLEGRIDY

Products Affected

- PLEGRIDY SUBCUTANEOUS PEN INJECTOR 125 MCG/0.5 ML, 63 MCG/0.5 ML- 94 MCG/0.5 ML
- PLEGRIDY SUBCUTANEOUS SYRINGE

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

INTERFERON GAMMA-1B

Products Affected

- ACTIMMUNE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	INITIAL: CHRONIC GRANULOMATOUS DISEASE (CGD): PRESCRIBED BY OR IN CONSULTATION WITH A HEMATOLOGIST, INFECTIOUS DISEASE SPECIALIST, OR IMMUNOLOGIST. SEVERE MALIGNANT OSTEOPETROSIS (SMO): PRESCRIBED BY OR IN CONSULTATION WITH AN ENDOCRINOLOGIST OR HEMATOLOGIST.
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
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

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	PLAN YEAR
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

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/RENEWAL: PLAN YEAR.
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

IVOSIDENIB

Products Affected

- TIBSOVO

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

IXAZOMIB

Products Affected

- NINLARO

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

LAMOTRIGINE

Products Affected

- SUBVENITE ORAL SUSPENSION

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
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

LANREOTIDE

Products Affected

- *lanreotide subcutaneous syringe 120 mg/0.5 ml*
- SOMATULINE DEPOT SUBCUTANEOUS SYRINGE 60 MG/0.2 ML, 90 MG/0.3 ML

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: PLAN YEAR. GEP-NETS, CARCINOID SYNDROME: PLAN YEAR.
Other Criteria	ACROMEGALY: INITIAL: SERUM INSULIN-LIKE GROWTH FACTOR 1 (IGF-1) LEVEL (ADJUSTED FOR AGE) IS ELEVATED OR UNEQUIVOCAL WITH INADEQUATE SUPPRESSION OF GROWTH HORMONE AFTER A GLUCOSE LOAD. 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

LAPATINIB

Products Affected

- *lapatinib*

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

LAROTRECTINIB

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
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

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	PLAN YEAR
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

LECANEMAB-IRMB

Products Affected

- LEQEMBI IQLIK SUBCUTANEOUS
AUTO-INJECTOR 360 MG/1.8 ML

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	ALZHEIMERS DISEASE: INITIAL: 1) CLINICAL DEMENTIA RATING GLOBAL SCORE OF 0.5 OR 1.0, OR 2) MINI MENTAL STATUS EXAM SCORE OF 22-30.
Age Restrictions	
Prescriber Restrictions	ALZHEIMERS DISEASE: INITIAL: THERAPY IS PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST, GERIATRICIAN, OR PSYCHIATRIST.
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
Other Criteria	ALZHEIMERS DISEASE: INITIAL: 1) PRESENCE OF AMYLOID-BETA PLAQUES, 2) BASELINE BRAIN MRI WITHIN ONE YEAR PRIOR TO TREATMENT, 3) NO HISTORY OF A CLOTTING DISORDER, AND 4) NO CONCURRENT USE WITH ANY ANTICOAGULANT OR ANTIPLATELET THERAPY EXCEPT FOR ASPIRIN AT 81MG DAILY OR LESS. RENEWAL: 1) COGNITIVE DECLINE HAS SLOWED OR STOPPED, 2) NOT EXPERIENCING ANY SEVERE, UNSTABLE, OR SYMPTOMATIC AMYLOID-RELATED IMAGING ABNORMALITIES, AND 3) NO CONCURRENT USE WITH ANY ANTICOAGULANT OR ANTIPLATELET THERAPY EXCEPT FOR ASPIRIN AT 81MG DAILY OR LESS.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

PA Criteria	Criteria Details
Prerequisite Therapy Required	No

LENALIDOMIDE

Products Affected

- *lenalidomide*

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

LENVATINIB

Products Affected

- LENVIMA

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

LETERMOVIR

Products Affected

- PREVYMIS ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	CYTOMEGALOVIRUS (CMV) PROPHYLAXIS: PRESCRIBED BY OR IN CONSULTATION WITH A TRANSPLANT SPECIALIST OR INFECTIOUS DISEASE SPECIALIST.
Coverage Duration	CMV PROPHYLAXIS: 7 MONTHS
Other Criteria	CMV PROPHYLAXIS FOR HSCT: 1) THERAPY WILL BE INITIATED BETWEEN DAY 0 AND DAY 28 POST TRANSPLANT, AND 2) WILL NOT RECEIVE THE MEDICATION BEYOND 200 DAYS POST TRANSPLANT. CMV PROPHYLAXIS FOR 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

LEUPROLIDE

Products Affected

- *leuprolide subcutaneous kit*

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

LEUPROLIDE DEPOT

Products Affected

- *leuprolide acetate (3 month)*
- LUTRATE DEPOT (3 MONTH)

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

LEUPROLIDE MESYLATE

Products Affected

- CAMCEVI (6 MONTH)

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

LEUPROLIDE-ELIGARD

Products Affected

- ELIGARD
- ELIGARD (3 MONTH)
- ELIGARD (4 MONTH)
- ELIGARD (6 MONTH)

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

LEUPROLIDE-LUPRON DEPOT

Products Affected

- LUPRON DEPOT
- 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, UTERINE FIBROIDS: PRESCRIBED BY OR IN CONSULTATION WITH AN OBSTETRICIAN/GYNECOLOGIST.
Coverage Duration	PROSTATE CA: PLAN YEAR. UTERINE FIBROIDS: 3 MOS. ENDOMETRIOSIS: INITIAL/RENEWAL: PLAN YEAR.
Other Criteria	INITIAL: ENDOMETRIOSIS, UTERINE FIBROIDS: NO CONCURRENT USE WITH ANOTHER GNRH-MODULATING AGENT. ENDOMETRIOSIS: 1) TRIAL OF OR CONTRAINDICATION TO BOTH OF THE FOLLOWING CLINICAL STANDARD OF CARE AGENTS: AN NSAID, A PROGESTIN-CONTAINING PREPARATION, AND 2) 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.

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

LEUPROLIDE-LUPRON DEPOT-PED

Products Affected

- LUPRON DEPOT-PED (3 MONTH)
- LUPRON DEPOT-PED
INTRAMUSCULAR SYRINGE KIT

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: PLAN YEAR.
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

PA Criteria	Criteria Details
Prerequisite Therapy Required	No

L-GLUTAMINE

Products Affected

- *glutamine (sickle cell)*

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/RENEWAL: PLAN YEAR.
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

LIDOCAINE OINTMENT

Products Affected

- *lidocaine topical ointment*

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

LIDOCAINE PATCH

Products Affected

- *dermacinrx lidocan 5% patch outer*
- *lidocaine topical adhesive patch,medicated 5 %*
- *lidocan 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	PLAN YEAR
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

LIDOCAINE PRILOCAINE

Products Affected

- *lidocaine-prilocaine topical cream*

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

LORLATINIB

Products Affected

- LORBRENA ORAL TABLET 100 MG, 25 MG

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

LOTILANER

Products Affected

- XDEMVY

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	DEMODEX BLEPHARITIS: PRESENCE OF DEMODEX MITES CONFIRMED BY LIGHT MICROSCOPY OR SLIT LAMP EXAMINATION.
Age Restrictions	DEMODEX BLEPHARITIS: 18 YEARS OF AGE OR OLDER
Prescriber Restrictions	DEMODEX BLEPHARITIS: PRESCRIBED BY OR IN CONSULTATION WITH AN OPHTHALMOLOGIST OR OPTOMETRIST.
Coverage Duration	6 WEEKS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

LUMACAFTOR-IVACAFTOR

Products Affected

- ORKAMBI ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	CYSTIC FIBROSIS (CF): INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A PULMONOLOGIST OR CF EXPERT.
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
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

MACITENTAN

Products Affected

- *macitentan*

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: PLAN YEAR.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

MARIBAVIR

Products Affected

- LIVTENCITY

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	CYTOMEGALOVIRUS (CMV): PRESCRIBED BY OR IN CONSULTATION WITH A TRANSPLANT SPECIALIST OR INFECTIOUS DISEASE SPECIALIST.
Coverage Duration	8 WEEKS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

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: PLAN YEAR.
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

MECHLORETHAMINE

Products Affected

- VALCHLOR

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

MEPOLIZUMAB

Products Affected

- NUCALA SUBCUTANEOUS AUTO-INJECTOR
- NUCALA SUBCUTANEOUS RECON SOLN
- NUCALA SUBCUTANEOUS SYRINGE 100 MG/ML, 40 MG/0.4 ML

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. EOSINOPHILIC CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD): BLOOD EOSINOPHIL LEVEL OF AT LEAST 150 CELLS/MCL AT SCREENING (I.E., WITHIN THE PAST 3 MONTHS) OR AT LEAST 300 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/RENEWAL: PLAN YEAR.

PA Criteria	Criteria Details
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 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

PA Criteria	Criteria Details
	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 ONE OF THE FOLLOWING: (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	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

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	PHEOCHROMOCYTOMA: PRE-OP SURGERY: 30 DAYS, TREATMENT: PLAN YEAR.
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	Yes

MIDAZOLAM

Products Affected

- NAYZILAM

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

MIDOSTAURIN

Products Affected

- RYDAPT

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

MIFEPRISTONE

Products Affected

- *mifepristone oral tablet 300 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	CUSHINGS SYNDROME (CS): INITIAL: DIAGNOSIS CONFIRMED BY: 1) 24-HR URINE FREE CORTISOL (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: PLAN YEAR.
Other Criteria	CS: INITIAL: HYPERCORTISOLISM IS NOT A RESULT OF CHRONIC GLUCOCORTICOID. INITIAL/RENEWAL: NO CONCURRENT USE WITH OTHER AGENTS USED TO LOWER CORTISOL LEVELS FOR CS. 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

PA Criteria	Criteria Details
Prerequisite Therapy Required	No

MILTEFOSINE

Products Affected

- IMPAVIDO

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

MIRDAMETINIB

Products Affected

- GOMEKLI ORAL CAPSULE 1 MG, 2 MG
- GOMEKLI ORAL TABLET FOR SUSPENSION

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

MODAFINIL

Products Affected

- *modafinil oral tablet 100 mg, 200 mg*

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

MOMELOTINIB

Products Affected

- OJJAARA

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

MORPHINE SOLUTION

Products Affected

- *morphine concentrate oral solution*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	OPIOID TOLERANT: PLAN YEAR. 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
Prerequisite Therapy Required	Yes

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: PLAN YEAR.

PA Criteria	Criteria Details
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 WORSENEDED/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 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

NERATINIB

Products Affected

- NERLYNX

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
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

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	PLAN YEAR
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

NILOTINIB-DANZITEN

Products Affected

- DANZITEN

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

NINTEDANIB

Products Affected

- *nintedanib*
- OFEV

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: IDIOPATHIC PULMONARY FIBROSIS (IPF): A USUAL INTERSTITIAL PNEUMONIA (UIP) PATTERN AS EVIDENCED BY HIGH-RESOLUTION COMPUTED TOMOGRAPHY (HRCT) ALONE OR VIA A COMBINATION OF SURGICAL LUNG BIOPSY AND HRCT. SYSTEMIC SCLEROSIS-ASSOCIATED INTERSTITIAL LUNG DISEASE (SSC-ILD): 1) AT LEAST 10% FIBROSIS ON A CHEST HRCT, AND 2) BASELINE FVC AT LEAST 40% OF PREDICTED VALUE. CHRONIC FIBROSING INTERSTITIAL LUNG DISEASE WITH A PROGRESSIVE PHENOTYPE (PF-ILD): AT LEAST 10% FIBROSIS ON A CHEST HRCT.
Age Restrictions	
Prescriber Restrictions	INITIAL: IPF: PRESCRIBED BY OR IN CONSULTATION WITH A PULMONOLOGIST. SSC-ILD, PF-ILD: PRESCRIBED BY OR IN CONSULTATION WITH A PULMONOLOGIST OR RHEUMATOLOGIST.
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.

PA Criteria	Criteria Details
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 MEDICATIONS USED IN CLINICAL PRACTICE FOR ILD (NOT ATTRIBUTABLE TO COMORBIDITIES SUCH AS INFECTION, HEART FAILURE). INITIAL/RENEWAL: IPF, PF-ILD: NO CONCURRENT USE WITH ESBRIET. 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

NIRAPARIB

Products Affected

- ZEJULA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
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

NIRAPARIB-ABIRATERONE

Products Affected

- AKEEGA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
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	Yes

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	PLAN YEAR
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

NITISINONE

Products Affected

- *nitisinone*
- ORFADIN ORAL SUSPENSION

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

NIVOLUMAB

Products Affected

- OPDIVO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
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

NIVOLUMAB-HYALURONIDASE-NVHY

Products Affected

- OPDIVO QVANTIG

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

OFATUMUMAB SQ

Products Affected

- KESIMPTA PEN

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

OLAPARIB

Products Affected

- LYNPARZA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
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	Yes

OLEZARSEN

Products Affected

- TRYNGOLZA

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

OLUTASIDENIB

Products Affected

- REZLIDHIA

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

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: PLAN YEAR.

PA Criteria	Criteria Details
Other Criteria	INITIAL: CSU: 1) TRIAL OF AND MAINTAINED ON, OR CONTRAINDICATION TO, FOUR TIMES THE MAXIMALLY LABELED DOSE OF 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 CLINICAL STANDARD OF CARE AGENT: A TOPICAL NASAL CORTICOSTEROID, 2) TRIAL OF OR CONTRAINDICATION TO ONE OF THE FOLLOWING PREFERRED 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-

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

OSILODROSTAT

Products Affected

- ISTURISA ORAL TABLET 1 MG, 5 MG

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

OSIMERTINIB

Products Affected

- TAGRISSO

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

PACRITINIB

Products Affected

- VONJO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
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

PALBOCICLIB

Products Affected

- IBRANCE

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

PASIREOTIDE DIASPARTATE

Products Affected

- SIGNIFOR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	CUSHINGS DISEASE (CD): INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH AN ENDOCRINOLOGIST.
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
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

PAZOPANIB

Products Affected

- *pazopanib oral tablet 200 mg, 400 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
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

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	PLAN YEAR
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

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	PLAN YEAR
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

PEGINTERFERON ALFA-2A

Products Affected

- PEGASYS

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	PLAN YEAR
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

PEGVISOMANT

Products Affected

- SOMAVERT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	ACROMEGALY: PRESCRIBED BY OR IN CONSULTATION WITH AN ENDOCRINOLOGIST.
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
Other Criteria	ACROMEGALY: INITIAL: SERUM INSULIN-LIKE GROWTH FACTOR 1 (IGF-1) LEVEL (ADJUSTED FOR AGE) IS ELEVATED OR UNEQUIVOCAL WITH INADEQUATE SUPPRESSION OF GROWTH HORMONE AFTER A GLUCOSE LOAD. 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	No

PEMBROLIZUMAB

Products Affected

- KEYTRUDA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
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

PEMBROLIZUMAB-BERAHYALURONIDASE ALFA-PMPH

Products Affected

- KEYTRUDA QLEX

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

PEMIGATINIB

Products Affected

- PEMAZYRE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
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

PENICILLAMINE TABLET

Products Affected

- *penicillamine oral tablet*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	WILSONS DISEASE: 1) GENETIC TESTING CONFIRMING AN ATP7B MUTATION, 2) 24-HOUR URINARY COPPER EXCRETION (GREATER THAN 40 MICROGRAMS/24 HOURS), 3) LIVER BIOPSY WITH COPPER DRY WEIGHT GREATER THAN 75 MICROGRAMS/GRAM, OR 4) SERUM CERULOPLASMIN LEVEL OF LESS THAN 20 MG/DL. 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	WILSONS DISEASE: PRESCRIBED BY OR IN CONSULTATION WITH A HEPATOLOGIST OR GASTROENTEROLOGIST. INITIAL: CYSTINURIA: PRESCRIBED BY OR IN CONSULTATION WITH A NEPHROLOGIST. RHEUMATOID ARTHRITIS (RA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST.
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.

PA Criteria	Criteria Details
Other Criteria	INITIAL: 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 OF AT LEAST 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. CYSTINURIA: CONTINUES TO BENEFIT FROM THE MEDICATION.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

PEXIDARTINIB

Products Affected

- TURALIO

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

PIMAVANSERIN

Products Affected

- NUPLAZID

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: PLAN YEAR.
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

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: PLAN YEAR.
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). INITIAL/RENEWAL: NO CONCURRENT USE WITH OFEV. RENEWAL: CLINICAL MEANINGFUL IMPROVEMENT OR MAINTENANCE IN ANNUAL RATE OF DECLINE.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

PA Criteria	Criteria Details
Prerequisite Therapy Required	No

PIRTOBRUTINIB

Products Affected

- JAYPIRCA ORAL TABLET 100 MG, 50 MG

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

POMALIDOMIDE

Products Affected

- *pomalidomide*
- POMALYST

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

PONATINIB

Products Affected

- ICLUSIG

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

POSACONAZOLE TABLET

Products Affected

- *posaconazole oral tablet, delayed release (dr/ec)*

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

PRALSETINIB

Products Affected

- GAVRETO

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

PYRIMETHAMINE

Products Affected

- *pyrimethamine*

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	Yes

QUININE

Products Affected

- *quinine sulfate*

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

QUIZARTINIB

Products Affected

- VANFLYTA

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

REGORAFENIB

Products Affected

- STIVARGA

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

RELACORILANT

Products Affected

- LIFYORLI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
Other Criteria	RENEWAL: 1) CLINICAL BENEFIT WHILE ON THERAPY, AND 2) CONTINUATION OF NAB-PACLITAXEL THERAPY.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

RELUGOLIX

Products Affected

- ORGOVYX

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

REPOTRECTINIB

Products Affected

- AUGTYRO ORAL CAPSULE 160 MG, 40 MG

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

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 ONE OF THE FOLLOWING: 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: PLAN YEAR.
Other Criteria	NASH: INITIAL: TRIAL OF OR CONTRAINDICATION TO THE PREFERRED AGENT: WEGOVY. RENEWAL: CONTINUES TO HAVE NONCIRRHOTIC NASH WITH MODERATE TO ADVANCED LIVER FIBROSIS (CONSISTENT WITH STAGES F2 TO F3 FIBROSIS). INITIAL/RENEWAL: NO CONCURRENT USE WITH WEGOVY FOR THE TREATMENT OF NASH.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

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	PLAN YEAR
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

RIBOCICLIB

Products Affected

- KISQALI ORAL TABLET 200 MG/DAY (200 MG X 1), 400 MG/DAY (200 MG X 2), 600 MG/DAY (200 MG X 3)

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

RIBOCICLIB-LETROZOLE

Products Affected

- KISQALI FEMARA CO-PACK ORAL
TABLET 200 MG/DAY(200 MG X 1)-2.5
MG, 400 MG/DAY(200 MG X 2)-2.5 MG,
600 MG/DAY(200 MG X 3)-2.5 MG

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

RIFAXIMIN

Products Affected

- XIFAXAN ORAL TABLET 200 MG, 550 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	TRAVELERS DIARRHEA, HEPATIC ENCEPHALOPATHY (HE): PLAN YEAR. IBS-D: 8 WKS.
Other Criteria	HE: TRIAL OF THE CLINICAL STANDARD OF CARE AGENT: LACTULOSE OR CURRENTLY ON LACTULOSE MONOTHERAPY. IRRITABLE BOWEL SYNDROME WITH DIARRHEA (IBS-D): TRIAL OF OR CONTRAINDICATION TO THE CLINICAL STANDARD OF CARE AGENT: DICYCLOMINE. TRAVELERS DIARRHEA (TD): TRIAL OF OR CONTRAINDICATION TO ONE OF THE FOLLOWING CLINICAL STANDARD OF CARE AGENTS: GENERIC ORAL CIPROFLOXACIN, AZITHROMYCIN, OFLOXACIN, LEVOFLOXACIN.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

RILONACEPT

Products Affected

- ARCALYST

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: CRYOPYRIN-ASSOCIATED PERIODIC SYNDROMES (CAPS): 1) GENETIC TEST FOR GAIN-OF-FUNCTION MUTATIONS IN THE NLRP3 GENE, OR 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) GENETIC TEST FOR GAIN-OF-FUNCTION MUTATIONS IN THE IL1RN GENE, OR HAS INFLAMMATORY MARKERS (I.E., ELEVATED CRP, ESR), AND 2) HAS PUSTULAR PSORIASIS-LIKE RASHES, OSTEOMYELITIS, ABSENCE OF BACTERIAL OSTEOMYELITIS, OR 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	INITIAL/RENEWAL: PLAN YEAR.

PA Criteria	Criteria Details
Other Criteria	INITIAL: CAPS: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK 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, AND 2) SYMPTOM-FREE FOR 4 TO 6 WEEKS. INITIAL/RENEWAL: RP: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR RP. RENEWAL: RP: REDUCTION OF PERICARDITIS RECURRENCE OR IMPROVEMENT IN SYMPTOMS.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

RIMEGEPANT

Products Affected

- NURTEC ODT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
Other Criteria	ACUTE MIGRAINE TREATMENT: 1) TRIAL OF OR CONTRAINDICATION TO ONE CLINICAL STANDARD OF CARE AGENT: A TRIPTAN (E.G., SUMATRIPTAN, RIZATRIPTAN) AND 2) NO CONCURRENT USE WITH OTHER CGRP INHIBITORS FOR ACUTE MIGRAINE TREATMENT. 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
Prerequisite Therapy Required	Yes

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: PLAN YEAR.
Other Criteria	INITIAL: PAH: NO CONCURRENT USE WITH NITRATES, NITRIC OXIDE DONORS, PHOSPHODIESTERASE (PDE) INHIBITORS, OR NON-SPECIFIC PDE INHIBITORS. CTEPH: 1) NO CONCURRENT USE WITH NITRATES, NITRIC OXIDE DONORS, PDE INHIBITORS, OR NON-SPECIFIC PDE INHIBITORS, AND 2) NOT A CANDIDATE FOR SURGERY OR HAS INOPERABLE CTEPH OR HAS PERSISTENT OR RECURRENT DISEASE AFTER SURGICAL TREATMENT. RENEWAL: PAH, CTEPH: NO CONCURRENT USE WITH NITRATES, NITRIC OXIDE DONORS, PDE INHIBITORS, OR NON-SPECIFIC PDE INHIBITORS.
Indications	All FDA-approved Indications.
Off Label Uses	

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

RIPRETINIB

Products Affected

- QINLOCK

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

RISANKIZUMAB-RZAA

Products Affected

- SKYRIZI

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/RENEWAL: PLAN YEAR.
Other Criteria	INITIAL: PSO: 1) AT LEAST A 3 MONTH TRIAL OF ONE OF THE FOLLOWING CLINICAL STANDARD OF CARE AGENTS: AN ORAL IMMUNOSUPPRESSANT (CYCLOSPORINE, METHOTREXATE, TACROLIMUS), PUVA (PHOTOTHERAPY), 2) CONTRAINDICATION OR INTOLERANCE TO BOTH OF THE FOLLOWING CLINICAL STANDARD OF CARE AGENTS: AN IMMUNOSUPPRESSANT, 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.

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

ROPEGINTERFERON ALFA-2B-NJFT

Products Affected

- BESREMI
- BESREMI PEN

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

RUCAPARIB

Products Affected

- RUBRACA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
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	Yes

RUXOLITINIB

Products Affected

- JAKAFI
- JAKAFI XR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
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

SAPROPTERIN

Products Affected

- *javygtor oral tablet, soluble*
- *sapropterin oral tablet, soluble*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	HYPERPHENYLALANINEMIA (HPA) WITH PHENYLKETONURIA (PKU): INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A METABOLIC OR GENETIC DISEASE SPECIALIST.
Coverage Duration	INITIAL: 2 MONTHS. RENEWAL: PLAN YEAR.
Other Criteria	HPA WITH PKU: INITIAL/RENEWAL: NO CONCURRENT USE WITH ANOTHER AGENT INDICATED FOR THE TREATMENT OF PKU. RENEWAL: CONTINUES TO BENEFIT FROM TREATMENT.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

SARGRAMOSTIM

Products Affected

- LEUKINE INJECTION RECON SOLN

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

SARILUMAB

Products Affected

- KEVZARA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	RHEUMATOID ARTHRITIS (RA), POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS (PJIA): INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST.
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
Other Criteria	INITIAL: RA: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA/ADALIMUMAB-AATY/HADLIMA, XELJANZ, RINVOQ. PJIA: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA/ADALIMUMAB-AATY/HADLIMA, XELJANZ IR, RINVOQ. PMR: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR PMR. INITIAL/RENEWAL: RA, PJIA: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR THE SAME INDICATION. RENEWAL: RA, PJIA: CONTINUES TO BENEFIT FROM THE MEDICATION.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

SECUKINUMAB SQ

Products Affected

- COSENTYX (2 SYRINGES)
- COSENTYX PEN (2 PENS)
- COSENTYX SUBCUTANEOUS SYRINGE 75 MG/0.5 ML
- COSENTYX UNOREADY PEN

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/RENEWAL: PLAN YEAR.

PA Criteria	Criteria Details
Other Criteria	INITIAL: PSO: 1) AT LEAST A 3 MONTH TRIAL OF ONE OF THE FOLLOWING CLINICAL STANDARD OF CARE AGENTS: AN ORAL IMMUNOSUPPRESSANT (CYCLOSPORINE, METHOTREXATE, TACROLIMUS), PUVA (PHOTOTHERAPY), 2) CONTRAINDICATION OR INTOLERANCE TO BOTH OF THE FOLLOWING CLINICAL STANDARD OF CARE AGENTS: IMMUNOSUPPRESSANT, 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 ONE CLINICAL STANDARD OF CARE AGENT: AN NSAID. ERA: TRIAL OF OR CONTRAINDICATION TO ONE OF THE FOLLOWING CLINICAL STANDARD OF CARE AGENTS: AN NSAID, SULFASALAZINE, 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

SELEXIPAG

Products Affected

- UPTRAVI ORAL TABLET 1,000 MCG, 1,200 MCG, 1,400 MCG, 1,600 MCG, 200 MCG, 400 MCG, 600 MCG, 800 MCG
- UPTRAVI ORAL TABLETS,DOSE PACK

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: PLAN YEAR.
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

SELINEXOR

Products Affected

- XPOVIO ORAL TABLET 100 MG/WEEK (50 MG X 2), 40 MG/WEEK (10 MG X 4), 40 MG/WEEK (40 MG X 1), 40MG TWICE WEEK (40 MG X 2), 60 MG/WEEK (60 MG X 1), 60MG TWICE WEEK (120 MG/WEEK), 80 MG/WEEK (40 MG X 2), 80 MG/WEEK (80 MG X 1), 80MG TWICE WEEK (160 MG/WEEK)

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

SELPERCATINIB

Products Affected

- 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	PLAN YEAR
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

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	PLAN YEAR
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

SEMAGLUTIDE - WEGOVY

Products Affected

- WEGOVY ORAL MG/0.75 ML
- WEGOVY SUBCUTANEOUS PEN INJECTOR 0.25 MG/0.5 ML, 0.5 MG/0.5 ML, 1 MG/0.5 ML, 1.7 MG/0.75 ML, 2.4

PA Criteria	Criteria Details
Exclusion Criteria	TREATMENT OF OBESITY
Required Medical Information	INITIAL: MAJOR ADVERSE CARDIOVASCULAR EVENTS (MACE): 1) BODY MASS INDEX (BMI) OF AT LEAST 27 KG/M(2), OR 2) BMI OF AT LEAST 25 KG/M(2) IF ASIAN. NONCIRRHOTIC METABOLIC DYSFUNCTION ASSOCIATED STEATOHEPATITIS (MASH): HAD A BIOPSY OR NON-INVASIVE TEST OBTAINED IN THE PAST 12 MONTHS DEMONSTRATING LIVER FIBROSIS OF STAGE 2 OR 3.
Age Restrictions	
Prescriber Restrictions	INITIAL: MASH: PRESCRIBED BY OR IN CONSULTATION WITH A HEPATOLOGIST, GASTROENTEROLOGIST, OR ENDOCRINOLOGIST.
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
Other Criteria	MACE: INITIAL/RENEWAL: 1) NO CONCURRENT USE WITH ANOTHER GLP-1 OR GLP-1/GIP RECEPTOR AGONIST, AND 2) HAS A HISTORY OF AND WILL CONTINUE ON, OR HAS A CONTRAINDICATION TO ALL OF THE FOLLOWING CLINICAL STANDARD OF CARE TREATMENTS: (A) AN ANTIPLATELET MEDICATION (REQUIREMENT DOES NOT APPLY TO PATIENTS WITH A HISTORY OF A HEMORRHAGIC STROKE), (B) A HMG-COA REDUCTASE INHIBITOR, AND (C) A BLOOD PRESSURE MEDICATION. MASH: INITIAL: NO CONCURRENT USE WITH REZDIFFRA, ANOTHER GLP-1 OR GLP-1/GIP RECEPTOR AGONIST. RENEWAL: 1) HAS DISEASE STABILITY OR IMPROVEMENT FROM BASELINE, AND 2) NO CONCURRENT USE WITH REZDIFFRA, ANOTHER GLP-1 OR GLP-1/GIP RECEPTOR AGONIST.
Indications	All FDA-approved Indications.

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

SEVABERTINIB

Products Affected

- HYRNUO

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

SILDENAFIL TABLET

Products Affected

- *sildenafil (pulm.hypertension) oral tablet*

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: PLAN YEAR.
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

PA Criteria	Criteria Details
Prerequisite Therapy Required	No

SODIUM OXYBATE-XYREM

Products Affected

- *sodium oxybate*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	INITIAL: CATAPLEXY IN NARCOLEPSY, EXCESSIVE DAYTIME SLEEPINESS (EDS) IN NARCOLEPSY: PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST, PSYCHIATRIST, OR SPECIALIST IN SLEEP MEDICINE
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
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

PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

SOFOSBUVIR/VELPATASVIR

Products Affected

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

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

PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

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

PA Criteria	Criteria Details
Prerequisite Therapy Required	No

SOMATROPIN - NORDITROPIN

Products Affected

- NORDITROPIN FLEXPRO

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.
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.

PA Criteria	Criteria Details
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

SOMATROPIN - SEROSTIM

Products Affected

- SEROSTIM SUBCUTANEOUS RECON
SOLN 4 MG, 5 MG, 6 MG

PA Criteria	Criteria Details
Exclusion Criteria	INITIAL/RENEWAL: ATHLETIC ENHANCEMENT, ANTI-AGING PURPOSES
Required Medical Information	HIV/WASTING: INITIAL: 1) FOR NON-SUPPRESSED HIV VIREMIA (VIRAL LOAD GREATER THAN 200 COPIES/ML), ONE OF THE FOLLOWING: (A) GREATER THAN 10% LOSS OF BASELINE BODY WEIGHT AND HAS CHRONIC DIARRHEA, CHRONIC WEAKNESS OR A FEVER FOR AT LEAST 30 DAYS, (B) 90% IDEAL BODY WEIGHT OR BODY MASS INDEX (BMI) LESS THAN 18.5 KG/M2 AND A GREATER THAN 10% WEIGHT LOSS FROM PREMORBID MAXIMUM OVER A 12-MONTH PERIOD, OR (C) 90% IDEAL BODY WEIGHT OR BMI LESS THAN 18.5 KG/M2 AND A GREATER THAN 5% WEIGHT LOSS IN THE PREVIOUS 6 MONTHS, OR 2) FOR SUPPRESSED HIV VIREMIA (VIRAL LOAD LESS THAN 200 COPIES/ML), ONE OF THE FOLLOWING: (A) GREATER THAN 5% LOSS OF PREMORBID BODY WEIGHT OVER 6 MONTHS, (B) GREATER THAN 10% LOSS OF PREMORBID BODY WEIGHT OVER 12 MONTHS, (C) LOW BMI (LESS THAN 20 KG/M2) IF OBJECTIVE WEIGHT LOSS IS NOT AVAILABLE.
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: PLAN YEAR.
Other Criteria	HIV/WASTING: INITIAL/RENEWAL: PATIENT IS ON OPTIMIZED HIV ANTI-RETROVIRAL THERAPY. RENEWAL: POSITIVE RESPONSE TO TREATMENT (E.G., IMPROVEMENT IN BMI OR WEIGHT, PHYSICAL IMPROVEMENTS SUCH AS TIMED WALK OR CHAIR RISE).

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

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	PLAN YEAR
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

SORAFENIB

Products Affected

- *sorafenib*

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

SOTATERCEPT-CSRK

Products Affected

- WINREVAIR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	PULMONARY ARTERIAL HYPERTENSION (PAH): INITIAL: DIAGNOSIS CONFIRMED BY RIGHT HEART CATHETERIZATION WITH THE FOLLOWING PARAMETERS: 1) MEAN PULMONARY ARTERY PRESSURE (PAP) GREATER THAN 20 MMHG, 2) PULMONARY CAPILLARY WEDGE PRESSURE (PCWP) OF 15 MMHG OR LESS, AND 3) PULMONARY VASCULAR RESISTANCE (PVR) GREATER THAN 2 WOOD UNITS.
Age Restrictions	
Prescriber Restrictions	PAH: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A CARDIOLOGIST OR PULMONOLOGIST.
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
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

PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

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	PLAN YEAR
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

SPARSENTAN

Products Affected

- FILSPARI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	PRIMARY IMMUNOGLOBULIN A NEPHROPATHY (IGAN): INITIAL: 1) DIAGNOSIS CONFIRMED BY BIOPSY, 2) PROTEINURIA OF AT LEAST 0.5G/DAY, AND 3) EGFR OF AT LEAST 30ML/MIN/1.73M2.
Age Restrictions	
Prescriber Restrictions	PRIMARY IGAN: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A NEPHROLOGIST.
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
Other Criteria	INITIAL: PRIMARY IGAN: 1) TRIED AND WILL CONTINUE TO USE AN SGLT2 INHIBITOR, OR HAS A CONTRAINDICATION TO AN SGLT2 INHIBITOR, AND 2) NO CONCURRENT USE WITH AN ACE INHIBITOR, ARB, ENDOTHELIN RECEPTOR ANTAGONIST, ALISKIREN, FABHALTA, VANRAFIA, OR VOYXACT. FSGS: 1) TRIAL OF OR CONTRAINDICATION TO AT LEAST 3 MONTHS OF TREATMENT WITH ONE OF THE FOLLOWING CLINICAL STANDARD OF CARE AGENTS: AN ACE INHIBITOR OR AN ARB, AND 2) NO CONCURRENT USE WITH AN ACE INHIBITOR OR AN ARB. RENEWAL: PRIMARY IGAN: 1) NO CONCURRENT USE WITH AN ACE INHIBITOR, ARB, ENDOTHELIN RECEPTOR ANTAGONIST, ALISKIREN, FABHALTA, VANRAFIA, OR VOYXACT, AND 2) REDUCTION IN PROTEINURIA, OR IMPROVED OR STABLE KIDNEY FUNCTION COMPARED TO BASELINE. FSGS: 1) REDUCTION IN PROTEINURIA FROM BASELINE, 2) REDUCTION IN UPCR, AND 3) NO CONCURRENT USE WITH AN ACE INHIBITOR OR AN ARB.
Indications	All FDA-approved Indications.

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

STIRIPENTOL

Products Affected

- DIACOMIT ORAL CAPSULE 250 MG, 500 MG
- DIACOMIT ORAL POWDER IN 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: PLAN YEAR.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

SUNITINIB

Products Affected

- *sunitinib malate*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
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

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: PLAN YEAR.
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

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	PLAN YEAR
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

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: PLAN YEAR.
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

TALAZOPARIB

Products Affected

- TALZENNA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
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

PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

TALETRECTINIB

Products Affected

- IBTROZI

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

TELOTRISTAT

Products Affected

- XERMELO

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

TEPOTINIB

Products Affected

- TEPMETKO

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

TERIPARATIDE

Products Affected

- *teriparatide subcutaneous pen injector 20 mcg/dose (560mcg/2.24ml)*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
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

TESTOSTERONE

Products Affected

- *testosterone transdermal gel in metered-dose pump 12.5 mg/ 1.25 gram (1 %), 20.25 mg/1.25 gram (1.62 %)* (25 mg/2.5gram), 1 % (50 mg/5 gram)
- *testosterone transdermal gel in packet 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: PLAN YEAR.
Other Criteria	MALE HYPOGONADISM: INITIAL/RENEWAL: 40 YEARS OR OLDER: PROSTATE SPECIFIC ANTIGEN (PSA) HAS BEEN EVALUATED WITHIN THE PAST 12 MONTHS, AND 1) PSA LEVEL IS LESS THAN OR EQUAL TO 4 NG/ML, OR 2) PSA LEVEL IS GREATER THAN 4 NG/ML AND THE BENEFITS OF ONGOING THERAPY OUTWEIGH THE RISKS OF ELEVATED PSA. RENEWAL: 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

TESTOSTERONE CYPIONATE - DEPO

Products Affected

- *testosterone cypionate*

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: PLAN YEAR.
Other Criteria	MALE HYPOGONADISM: INITIAL/RENEWAL: 40 YEARS OR OLDER: PROSTATE SPECIFIC ANTIGEN (PSA) HAS BEEN EVALUATED WITHIN THE PAST 12 MONTHS, AND 1) PSA LEVEL IS LESS THAN OR EQUAL TO 4 NG/ML, OR 2) PSA LEVEL IS GREATER THAN 4 NG/ML AND THE BENEFITS OF ONGOING THERAPY OUTWEIGH THE RISKS OF ELEVATED PSA. RENEWAL: 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

TESTOSTERONE ENANTHATE

Products Affected

- *testosterone enanthate*

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 HYPOGONADISM/ MALE DELAYED PUBERTY: PLAN YEAR. OTHER INDICATIONS: PLAN YEAR.
Other Criteria	INITIAL/RENEWAL: MALE HYPOGONADISM: 40 YEARS OR OLDER: PROSTATE SPECIFIC ANTIGEN (PSA) HAS BEEN EVALUATED WITHIN THE PAST 12 MONTHS, AND 1) PSA LEVEL IS LESS THAN OR EQUAL TO 4 NG/ML, OR 2) PSA LEVEL IS GREATER THAN 4 NG/ML AND THE BENEFITS OF ONGOING THERAPY OUTWEIGH THE RISKS OF ELEVATED PSA. RENEWAL: MALE HYPOGONADISM: 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

PA Criteria	Criteria Details
Prerequisite Therapy Required	No

TETRABENAZINE

Products Affected

- *tetrabenazine*

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

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	PLAN YEAR
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

TIVOZANIB

Products Affected

- FOTIVDA

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

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/RENEWAL: RA, PJIA, SJIA, GCA: PLAN YEAR. CRS: 1 MONTH.

PA Criteria	Criteria Details
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/ADALIMUMAB-AATY/HADLIMA, XELJANZ, RINVOQ. 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/ADALIMUMAB-AATY/HADLIMA, XELJANZ IR, 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. 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

TOCILIZUMAB-AAZG SQ

Products Affected

- TYENNE
- TYENNE AUTOINJECTOR

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/RENEWAL: PLAN YEAR.
Other Criteria	INITIAL: RA: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA/ADALIMUMAB-AATY/HADLIMA, XELJANZ, RINVOQ. GIANT CELL ARTERITIS (GCA): 1) HAS COMPLETED, STARTED, OR WILL SOON START A TAPERING COURSE OF GLUCOCORTICIDS, AND 2) TRIAL OF OR CONTRAINDICATION TO THE PREFERRED AGENT: RINVOQ. PJIA: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA/ADALIMUMAB-AATY/HADLIMA, XELJANZ IR, 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.

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

TOFACITINIB

Products Affected

- *tofacitinib*

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/RENEWAL: PLAN YEAR.
Other Criteria	INITIAL: RA: TRIAL OF OR CONTRAINDICATION TO 3 MONTHS OF TREATMENT WITH ONE CLINICAL STANDARD OF CARE AGENT: A 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 ONE CLINICAL STANDARD OF CARE AGENT: 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.

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

TOLVAPTAN

Products Affected

- *tolvaptan (polycys kidney dis) oral tablet*
- *tolvaptan (polycys kidney dis) oral tablets, sequential*

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/RENEWAL: PLAN YEAR.
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

TOPICAL TRETINOIN

Products Affected

- ALTRENO
- *tretinoin topical cream*

PA Criteria	Criteria Details
Exclusion Criteria	COSMETIC INDICATIONS SUCH AS WRINKLES, PHOTOAGING, MELASMA.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
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

TOVORAFENIB

Products Affected

- OJEMDA ORAL SUSPENSION FOR RECONSTITUTION
- OJEMDA ORAL TABLET

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

TRAMETINIB SOLUTION

Products Affected

- MEKINIST ORAL RECON SOLN

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
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

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	PLAN YEAR
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

TRASTUZUMAB-DKST

Products Affected

- OGIVRI

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

TRASTUZUMAB-HYALURONIDASE-OYSK

Products Affected

- HERCEPTIN HYLECTA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
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

TRAZODONE

Products Affected

- RALDESY

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
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	Yes

TREPROSTINIL-YUTREPIA

Products Affected

- YUTREPIA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: PULMONARY ARTERIAL HYPERTENSION (PAH), PULMONARY HYPERTENSION-INTERSTITIAL LUNG DISEASE (PH-ILD): DIAGNOSIS CONFIRMED BY RIGHT HEART CATHETERIZATION WITH THE FOLLOWING PARAMETERS: 1) MEAN PULMONARY ARTERY PRESSURE (PAP) GREATER THAN 20 MMHG, 2) PULMONARY CAPILLARY WEDGE PRESSURE (PCWP) OF 15 MMHG OR LESS, AND 3) PULMONARY VASCULAR RESISTANCE (PVR) GREATER THAN 2 WOOD UNITS.
Age Restrictions	
Prescriber Restrictions	INITIAL: PAH, PH-ILD: PRESCRIBED BY OR IN CONSULTATION WITH A CARDIOLOGIST OR PULMONOLOGIST.
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
Other Criteria	INITIAL: PAH: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING AGENTS FROM DIFFERENT DRUG CLASSES: 1) ORAL ENDOTHELIN RECEPTOR ANTAGONIST, 2) ORAL PHOSPHODIESTERASE TYPE-5 INHIBITOR FOR PAH, 3) ORAL CGMP STIMULATOR, 4) IV/SQ PROSTACYCLIN.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

TRIENTINE CAPSULE

Products Affected

- *trientine oral capsule 250 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	WILSONS DISEASE: 1) GENETIC TESTING CONFIRMING AN ATP7B MUTATION, 2) 24-HOUR URINARY COPPER EXCRETION (GREATER THAN 40 MICROGRAMS/24 HOURS), 3) LIVER BIOPSY WITH COPPER DRY WEIGHT GREATER THAN 75 MICROGRAMS/GRAM, OR 4) SERUM CERULOPLASMIN LEVEL OF LESS THAN 20 MG/DL.
Age Restrictions	
Prescriber Restrictions	WILSONS DISEASE: PRESCRIBED BY OR IN CONSULTATION WITH A HEPATOLOGIST OR GASTROENTEROLOGIST.
Coverage Duration	PLAN YEAR
Other Criteria	WILSONS DISEASE: TRIAL OF OR CONTRAINDICATION TO THE PREFERRED AGENT: PENICILLAMINE TABLET.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

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	PLAN YEAR
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

TUCATINIB

Products Affected

- TUKYSA ORAL TABLET 150 MG, 50 MG

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

UBROGEPANT

Products Affected

- UBRELVY

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
Other Criteria	ACUTE MIGRAINE TREATMENT: 1) TRIAL OF OR CONTRAINDICATION TO ONE PREFERRED AGENT: A TRIPTAN (E.G., SUMATRIPTAN, RIZATRIPTAN), AND 2) NO CONCURRENT USE WITH OTHER CGRP INHIBITORS FOR ACUTE MIGRAINE TREATMENT.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

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. ATOPIC DERMATITIS (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/RENEWAL: PLAN YEAR.

PA Criteria	Criteria Details
Other Criteria	INITIAL: RA: TRIAL OF OR CONTRAINDICATION TO 3 MONTHS OF TREATMENT WITH ONE CLINICAL STANDARD OF CARE AGENT: A 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. AD: 1) INTRACTABLE PRURITUS OR CRACKING/OOZING/BLEEDING OF AFFECTED SKIN, AND 2) TRIAL OF OR CONTRAINDICATION TO ONE OF THE FOLLOWING CLINICAL STANDARD OF CARE AGENTS: A TOPICAL CORTICOSTEROID, TOPICAL CALCINEURIN INHIBITOR, TOPICAL PDE4 INHIBITOR, OR TOPICAL JAK INHIBITOR. AS, NR-AXSPA: TRIAL OF OR CONTRAINDICATION TO ONE CLINICAL STANDARD OF CARE AGENT: 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

USTEKINUMAB-AAUZ IV

Products Affected

- OTULFI

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/RENEWAL: PLAN YEAR.
Other Criteria	INITIAL: PSO: 1) AT LEAST A 3 MONTH TRIAL OF ONE OF THE FOLLOWING CLINICAL STANDARD OF CARE AGENTS: AN ORAL IMMUNOSUPPRESSANT (CYCLOSPORINE, METHOTREXATE, TACROLIMUS), PUVA (PHOTOTHERAPY), 2) CONTRAINDICATION OR INTOLERANCE TO BOTH OF THE FOLLOWING CLINICAL STANDARD OF CARE AGENTS: AN IMMUNOSUPPRESSANT, 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.

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

USTEKINUMAB-AAUZ SQ

Products Affected

- OTULFI

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/RENEWAL: PLAN YEAR.
Other Criteria	INITIAL: PSO: 1) AT LEAST A 3 MONTH TRIAL OF ONE OF THE FOLLOWING CLINICAL STANDARD OF CARE AGENTS: AN ORAL IMMUNOSUPPRESSANT (CYCLOSPORINE, METHOTREXATE, TACROLIMUS), PUVA (PHOTOTHERAPY), 2) CONTRAINDICATION OR INTOLERANCE TO BOTH OF THE FOLLOWING CLINICAL STANDARD OF CARE AGENTS: AN IMMUNOSUPPRESSANT, 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.

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

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/RENEWAL: PLAN YEAR.
Other Criteria	INITIAL: PSO: 1) AT LEAST A 3 MONTH TRIAL OF ONE OF THE FOLLOWING CLINICAL STANDARD OF CARE AGENTS: AN ORAL IMMUNOSUPPRESSANT (CYCLOSPORINE, METHOTREXATE, TACROLIMUS), PUVA (PHOTOTHERAPY), 2) CONTRAINDICATION OR INTOLERANCE TO BOTH OF THE FOLLOWING CLINICAL STANDARD OF CARE AGENTS: AN IMMUNOSUPPRESSANT, 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.

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

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/RENEWAL: PLAN YEAR.
Other Criteria	INITIAL: PSO: 1) AT LEAST A 3 MONTH TRIAL OF ONE OF THE FOLLOWING CLINICAL STANDARD OF CARE AGENTS: AN ORAL IMMUNOSUPPRESSANT (CYCLOSPORINE, METHOTREXATE, TACROLIMUS), PUVA (PHOTOTHERAPY), 2) CONTRAINDICATION OR INTOLERANCE TO BOTH OF THE FOLLOWING CLINICAL STANDARD OF CARE AGENTS: AN IMMUNOSUPPRESSANT, 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.

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

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/RENEWAL: PLAN YEAR.
Other Criteria	INITIAL: PSO: 1) AT LEAST A 3 MONTH TRIAL OF ONE OF THE FOLLOWING CLINICAL STANDARD OF CARE AGENTS: AN ORAL IMMUNOSUPPRESSANT (CYCLOSPORINE, METHOTREXATE, TACROLIMUS), PUVA (PHOTOTHERAPY), 2) CONTRAINDICATION OR INTOLERANCE TO BOTH OF THE FOLLOWING CLINICAL STANDARD OF CARE AGENTS: AN IMMUNOSUPPRESSANT, 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.

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

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/RENEWAL: PLAN YEAR.
Other Criteria	INITIAL: PSO: 1) AT LEAST A 3 MONTH TRIAL OF ONE OF THE FOLLOWING CLINICAL STANDARD OF CARE AGENTS: AN ORAL IMMUNOSUPPRESSANT (CYCLOSPORINE, METHOTREXATE, TACROLIMUS), PUVA (PHOTOTHERAPY), 2) CONTRAINDICATION OR INTOLERANCE TO BOTH OF THE FOLLOWING CLINICAL STANDARD OF CARE AGENTS: AN IMMUNOSUPPRESSANT, 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.

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

VALBENAZINE

Products Affected

- INGREZZA
- INGREZZA INITIATION PK(TARDIV)
- INGREZZA SPRINKLE

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	PLAN YEAR
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

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	PLAN YEAR
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

VEDOLIZUMAB

Products Affected

- ENTYVIO
- ENTYVIO PEN

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	INITIAL: CROHNS DISEASE (CD), ULCERATIVE COLITIS (UC): PRESCRIBED BY OR IN CONSULTATION WITH A GASTROENTEROLOGIST.
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
Other Criteria	INITIAL: CD: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: SELARSDI/YESINTEK/OTULFI, HUMIRA/ADALIMUMAB-AATY/HADLIMA, RINVOQ, SKYRIZI, TREMFYA. UC: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: SELARSDI/YESINTEK/OTULFI, XELJANZ, HUMIRA/ADALIMUMAB-AATY/HADLIMA, RINVOQ, SKYRIZI, TREMFYA. 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.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

VEMURAFENIB

Products Affected

- ZELBORAF

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
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	Yes

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	PLAN YEAR
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

VERICIGUAT

Products Affected

- VERQUVO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	HEART FAILURE (HF): INITIAL/RENEWAL: PRESCRIBED BY OR IN CONSULTATION WITH A CARDIOLOGIST.
Coverage Duration	INITIAL/RENEWAL: PLAN YEAR.
Other Criteria	HF: INITIAL: HIGH-RISK WITH WORSENING HF AS EVIDENCED BY HOSPITALIZATION FOR HF OR NEED FOR INTRAVENOUS DIURETICS. INITIAL/RENEWAL: 1) NO CONCURRENT USE WITH RIOICIGUAT OR PDE-5 INHIBITORS, AND 2) HISTORY OF AND CONTINUATION OF, OR CONTRAINDICATION OR INTOLERANCE TO, ONE AGENT FROM ANY OF THE FOLLOWING GUIDELINE-DIRECTED MEDICAL THERAPY (GDMT) MEDICATION CLASSES: (A) ACE INHIBITOR, ARB, OR ARNI, (B) BETA BLOCKER, (C) ALDOSTERONE ANTAGONIST, (D) SGLT-2 INHIBITOR.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

VIGABATRIN

Products Affected

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

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

VIMSELTINIB

Products Affected

- ROMVIMZA

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

VISMODEGIB

Products Affected

- ERIVEDGE

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

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: PLAN YEAR.
Other Criteria	INITIAL: EROSION ESOPHAGITIS (EE): TRIAL OF OR CONTRAINDICATION TO THE CLINICAL STANDARD OF CARE AGENTS: 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 THE CLINICAL STANDARD OF CARE AGENT: 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

VORASIDENIB

Products Affected

- VORANIGO

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

VORICONAZOLE SUSPENSION

Products Affected

- *voriconazole oral suspension for reconstitution*

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: PLAN YEAR.
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

ZANUBRUTINIB

Products Affected

- BRUKINSA ORAL CAPSULE
- BRUKINSA ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
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

ZIFTOMENIB

Products Affected

- KOMZIFTI

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

ZONGERTINIB

Products Affected

- HERNEXEOS

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

ZURANOLONE

Products Affected

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

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

INDEX

1ST TIER UNIFINE PENTP 5MM 31G...	169	ASSURE ID INSULIN SAFETY	
1ST TIER UNIFINE PNTIP 4MM 32G.....	169	SYRINGE 1 ML 29 GAUGE X 1/2"	169
1ST TIER UNIFINE PNTIP 6MM 31G.....	169	ASSURE ID PEN NEEDLE 30GX5/16"...	169
1ST TIER UNIFINE PNTIP 8MM 31G		ASSURE ID PRO PEN NDL 30G 5MM...	169
STRL,SINGLE-USE,SHRT	169	ASSURE ID SYR 0.5 ML 31GX15/64"	169
1ST TIER UNIFINE PNTIP 29GX1/2"	169	ASSURE ID SYR 1 ML 31GX15/64"	169
1ST TIER UNIFINE PNTIP 31GX3/16.....	169	AUGTYRO ORAL CAPSULE 160 MG,	
1ST TIER UNIFINE PNTIP 32GX5/32.....	169	40 MG.....	279
<i>abigale</i>	144	AUSTEDO ORAL TABLET 12 MG, 6	
<i>abiraterone oral tablet 250 mg</i>	3	MG, 9 MG.....	79
<i>abirtega</i>	3	AUSTEDO XR ORAL TABLET	
ACTIMMUNE.....	182	EXTENDED RELEASE 24 HR 12 MG, 18	
<i>adalimumab-aaty</i>	9	MG, 24 MG, 30 MG, 36 MG, 42 MG, 48	
<i>adalimumab-aaty(cf) ai crohns</i>	9	MG, 6 MG	79
ADEMPAS.....	288	AUSTEDO XR TITRATION KT(WK1-4)..	79
ADVOCATE INS 0.3 ML 30GX5/16"	169	AVMAPKI.....	35
ADVOCATE INS 0.3 ML 31GX5/16"	169	AVMAPKI-FAKZYNJA.....	35
ADVOCATE INS 0.5 ML 30GX5/16"	169	AVONEX INTRAMUSCULAR PEN	
ADVOCATE INS 0.5 ML 31GX5/16"	169	INJECTOR KIT	179
ADVOCATE INS 1 ML 31GX5/16".....	169	AVONEX INTRAMUSCULAR	
ADVOCATE INS SYR 1 ML 30GX5/16..	169	SYRINGE KIT.....	179
ADVOCATE PEN NEEDLE 32G 4MM...	169	AYVAKIT	34
ADVOCATE PEN NEEDLE 4MM 33G...	169	BALVERSA ORAL TABLET 3 MG, 4	
ADVOCATE PEN NEEDLES 5MM 31G.	169	MG, 5 MG.....	108
ADVOCATE PEN NEEDLES 8MM 31G.	169	BD AUTOSHIELD DUO NDL	
AIMOVIG AUTOINJECTOR.....	109	5MMX30G.....	169
AKEEGA	237	BD ECLIPSE 30GX1/2" SYRINGE.....	169
ALCOHOL PADS	169	BD INS SYR 0.3 ML 8MMX31G(1/2).....	169
ALECENSA.....	14	BD INS SYR UF 0.3 ML 12.7MMX30G..	169
ALTRENO.....	353	BD INS SYR UF 0.5 ML 12.7MMX30G	
ALUNBRIG ORAL TABLET 180 MG, 30		NOT FOR RETAIL SALE.....	169
MG, 90 MG.....	52	BD INSULIN SYR 1 ML 27GX12.7MM..	169
ALUNBRIG ORAL TABLETS,DOSE		BD INSULIN SYR 1 ML 27GX5/8"	
PACK.....	52	MICRO-FINE.....	169
<i>alyq</i>	330	BD SAFETGLD INS 0.3 ML 29G 13MM.	169
<i>ambrisentan</i>	16	BD SAFETYGLD INS 0.3 ML 31G 8MM	169
AQINJECT PEN NEEDLE 31G 5MM.....	169	BD SAFETYGLD INS 0.5 ML 30G 8MM	169
AQINJECT PEN NEEDLE 32G 4MM.....	169	BD SAFETYGLD INS 1 ML 29G 13MM.	169
ARCALYST.....	285	BD SAFETYGLID INS 1 ML 6MMX31G	169
ARIKAYCE.....	17	BD SAFETYGLIDE SYRINGE 27GX5/8	169
<i>armodafinil</i>	27	BD SAFTYGLD INS 0.3 ML 6MMX31G	169
ASSURE ID DUO PRO NDL 31G 5MM..	169	BD SAFTYGLD INS 0.5 ML 29G 13MM	169
ASSURE ID DUO-SHIELD 30GX3/16"...	169	BD SAFTYGLD INS 0.5 ML 6MMX31G	169
ASSURE ID DUO-SHIELD 30GX5/16"...	169	BD SINGLE USE SWAB.....	169

BD UF MICRO PEN NEEDLE 6MMX32G.....	169	CAREFINE PEN NEEDLE 8MM 30G HRI.....	169
BD UF MINI PEN NEEDLE 5MMX31G..	169	CAREFINE PEN NEEDLES 6MM 32G...	169
BD UF NANO PEN NEEDLE 4MMX32G	169	CAREFINE PEN NEEDLES 8MM 31G...	169
BD UF ORIG PEN NDL 12.7MMX29G...	169	CARETOUCH ALCOHOL 70% PREP PAD.....	169
BD UF SHORT PEN NEEDLE 8MMX31G.....	169	CARETOUCH PEN NEEDLE 29G 12MM	169
BD VEO INS 0.3 ML 6MMX31G (1/2)...	169	CARETOUCH PEN NEEDLE 31GX1/4" .	169
BD VEO INS SYRING 1 ML 6MMX31G	169	CARETOUCH PEN NEEDLE 31GX3/16"	169
BD VEO INS SYRN 0.3 ML 6MMX31G.	169	CARETOUCH PEN NEEDLE 31GX5/16"	169
BD VEO INS SYRN 0.5 ML 6MMX31G.	169	CARETOUCH PEN NEEDLE 32GX3/16"	169
<i>bendamustine intravenous recon soln 25 mg.....</i>	44	CARETOUCH PEN NEEDLE 32GX5/32"	169
BENLYSTA SUBCUTANEOUS.....	40	CARETOUCH SYR 0.3 ML 31GX5/16"..	169
BESREMI.....	293	CARETOUCH SYR 0.5 ML 30GX5/16"..	169
BESREMI PEN.....	293	CARETOUCH SYR 0.5 ML 31GX5/16"..	169
<i>betaine.....</i>	47	CARETOUCH SYR 1 ML 28GX5/16".....	169
BETASERON SUBCUTANEOUS KIT	180	CARETOUCH SYR 1 ML 29GX5/16".....	169
<i>bexarotene.....</i>	48	CARETOUCH SYR 1 ML 30GX5/16".....	169
BORDERED GAUZE 2"X2".....	169	CARETOUCH SYR 1 ML 31GX5/16".....	169
<i>bortezomib injection.....</i>	50	<i>carglumic acid.....</i>	61
BOSULIF ORAL CAPSULE 100 MG, 50 MG.....	51	CAYSTON.....	38
BOSULIF ORAL TABLET 100 MG, 500 MG.....	51	CLICKFINE PEN NEEDLE 32GX5/32" 32GX4MM, STERILE.....	169
<i>bosutinib oral tablet 100 mg, 400 mg, 500 mg.....</i>	51	CLICKFINE UNIVERSAL 31G X 1/4" 6MM, STORE BRAND.....	169
BRAFTOVI.....	101	COMETRIQ ORAL CAPSULE 100 MG/DAY(80 MG X1-20 MG X1), 140 MG/DAY(80 MG X1-20 MG X3), 60 MG/DAY (20 MG X 3/DAY).....	56
BRUKINSA ORAL CAPSULE.....	392	COMFORT EZ 0.3 ML 31G 15/64".....	169
BRUKINSA ORAL TABLET.....	392	COMFORT EZ 0.5 ML 31G 15/64".....	169
<i>butalbital-acetaminop-caf-cod oral capsule 50-325-40-30 mg.....</i>	142	COMFORT EZ INS 0.3 ML 30GX1/2".....	169
<i>butalbital-acetaminophen-caff oral tablet..</i>	141	COMFORT EZ INS 0.3 ML 30GX5/16"...	169
CABOMETYX ORAL TABLET 20 MG, 40 MG, 60 MG.....	57	COMFORT EZ INS 1 ML 31G 15/64".....	169
CALQUENCE (ACALABRUTINIB MAL).....	5	COMFORT EZ INS 1 ML 31GX5/16".....	169
CAMCEVI (6 MONTH).....	199	COMFORT EZ INSULIN SYR 0.3 ML....	169
CAPRELSA ORAL TABLET 100 MG, 300 MG.....	380	COMFORT EZ INSULIN SYR 0.5 ML....	169
CAREFINE PEN NEEDLE 12.7MM 29G HRI.....	169	COMFORT EZ PEN NEEDLE 12MM 29G.....	169
CAREFINE PEN NEEDLE 4MM 32G.....	169	COMFORT EZ PEN NEEDLES 4MM 32G SINGLE USE, MICRO.....	169
CAREFINE PEN NEEDLE 5MM 32G.....	169		
CAREFINE PEN NEEDLE 6MM 31G HRI.....	169		

COMFORT EZ PEN NEEDLES 4MM 33G.....	169	COMFORT TOUCH PEN NDL 32G 4MM	169
COMFORT EZ PEN NEEDLES 5MM 31G MINI.....	169	COMFORT TOUCH PEN NDL 32G 5MM	169
COMFORT EZ PEN NEEDLES 5MM 32G SINGLE USE,MINI,HRI.....	169	COMFORT TOUCH PEN NDL 32G 6MM	169
COMFORT EZ PEN NEEDLES 5MM 33G.....	169	COMFORT TOUCH PEN NDL 32G 8MM	169
COMFORT EZ PEN NEEDLES 6MM 31G.....	169	COMFORT TOUCH PEN NDL 33G 4MM	169
COMFORT EZ PEN NEEDLES 6MM 32G.....	169	COMFORT TOUCH PEN NDL 33G 6MM	169
COMFORT EZ PEN NEEDLES 6MM 33G.....	169	COMFORT TOUCH PEN NDL 33GX5MM.....	169
COMFORT EZ PEN NEEDLES 8MM 31G SHORT.....	169	COPIKTRA.....	91
COMFORT EZ PEN NEEDLES 8MM 32G.....	169	CORTROPHIN GEL INJECTION.....	65
COMFORT EZ PEN NEEDLES 8MM 33G.....	169	COSENTYX (2 SYRINGES).....	300
COMFORT EZ PRO PEN NDL 30G 8MM	169	COSENTYX PEN (2 PENS).....	300
COMFORT EZ PRO PEN NDL 31G 4MM	169	COSENTYX SUBCUTANEOUS SYRINGE 75 MG/0.5 ML.....	300
COMFORT EZ PRO PEN NDL 31G 5MM	169	COSENTYX UNOREADY PEN.....	300
COMFORT EZ SYR 0.3 ML 29GX1/2"	169	COTELLIC.....	64
COMFORT EZ SYR 0.5 ML 28GX1/2"	169	CRESEMBA ORAL.....	183
COMFORT EZ SYR 0.5 ML 29GX1/2"	169	CURITY ALCOHOL PREPS 2 PLY,MEDIUM.....	169
COMFORT EZ SYR 0.5 ML 30GX1/2"	169	CURITY GAUZE PADS.....	169
COMFORT EZ SYR 1 ML 27G 12.7MM.....	169	CURITY GAUZE SPONGES (12 PLY)- 200/BAG.....	169
COMFORT EZ SYR 1 ML 28GX1/2"	169	<i>dalfampridine</i>	72
COMFORT EZ SYR 1 ML 29GX1/2"	169	DANZITEN.....	233
COMFORT EZ SYR 1 ML 30GX1/2"	169	<i>dasatinib oral tablet 100 mg, 140 mg, 20 mg, 50 mg, 70 mg, 80 mg</i>	74
COMFORT EZ SYR 1 ML 30GX5/16"	169	DAURISMO ORAL TABLET 100 MG, 25 MG.....	134
COMFORT POINT PEN NDL 31GX1/3".....	169	<i>deferasirox oral granules in packet</i>	76
COMFORT POINT PEN NDL 31GX1/6".....	169	<i>deferasirox oral tablet</i>	76
COMFORT TOUCH PEN NDL 31G 4MM	169	DERMACEA 2"X2" GAUZE 12 PLY, USP TYPE VII.....	169
COMFORT TOUCH PEN NDL 31G 5MM	169	DERMACEA GAUZE 2"X2" SPONGE 8 PLY.....	169
COMFORT TOUCH PEN NDL 31G 6MM	169	DERMACEA NON-WOVEN 2"X2" SPNGE.....	169
COMFORT TOUCH PEN NDL 31G 8MM	169	<i>dermacinrx lidocan 5% patch outer</i>	207
		DIACOMIT ORAL CAPSULE 250 MG, 500 MG.....	328
		DIACOMIT ORAL POWDER IN PACKET 250 MG, 500 MG.....	328

<i>diclofenac sodium topical solution in metered-dose pump</i>	81	DROPLET INS SYR 1 ML 31G 6MM OUTER.....	169
<i>dihydroergotamine nasal</i>	82	DROPLET INS SYR 1 ML 31G 8MM.....	169
<i>dimethyl fumarate oral capsule, delayed release(dr/ec) 120 mg, 120 mg (14)- 240 mg (46), 240 mg</i>	83	DROPLET MICRON 34G X 9/64".....	169
<i>diphenoxylate-atropine oral tablet</i>	153	DROPLET PEN NEEDLE 29G 10MM.....	169
<i>dipyridamole oral</i>	143	DROPLET PEN NEEDLE 29G 12MM.....	169
<i>dronabinol oral capsule</i>	86	DROPLET PEN NEEDLE 30G 8MM.....	169
DROPLET 0.3 ML 29G 12.7MM(1/2) OUTER.....	169	DROPLET PEN NEEDLE 31G 5MM.....	169
DROPLET 0.3 ML 30G 12.7MM(1/2) OUTER.....	169	DROPLET PEN NEEDLE 31G 6MM.....	169
DROPLET 0.5 ML 29GX12.5MM(1/2).....	169	DROPLET PEN NEEDLE 31G 8MM.....	169
DROPLET 0.5 ML 30GX12.5MM(1/2).....	169	DROPLET PEN NEEDLE 32G 4MM.....	169
DROPLET INS 0.3 ML 29GX12.5MM.....	169	DROPLET PEN NEEDLE 32G 5MM.....	169
DROPLET INS 0.3 ML 30G 8MM(1/2) OUTER.....	169	DROPLET PEN NEEDLE 32G 6MM.....	169
DROPLET INS 0.3 ML 30GX12.5MM.....	169	DROPLET PEN NEEDLE 32G 8MM.....	169
DROPLET INS 0.3 ML 31G 6MM(1/2) OUTER.....	169	DROPSAFE ALCOHOL 70% PREP PADS.....	169
DROPLET INS 0.3 ML 31G 8MM(1/2) OUTER.....	169	DROPSAFE INS SYR 0.3 ML 31G 6MM	169
DROPLET INS 0.5 ML 29G 12.7MM OUTER.....	169	DROPSAFE INS SYR 0.3 ML 31G 8MM	169
DROPLET INS 0.5 ML 30G 12.7MM OUTER.....	169	DROPSAFE INS SYR 0.5 ML 31G 6MM	169
DROPLET INS 0.5 ML 30GX6MM(1/2)..	169	DROPSAFE INS SYR 0.5 ML 31G 8MM	169
DROPLET INS 0.5 ML 30GX8MM(1/2)..	169	DROPSAFE INSUL SYR 1 ML 31G 6MM.....	169
DROPLET INS 0.5 ML 31GX6MM(1/2)..	169	DROPSAFE INSUL SYR 1 ML 31G 8MM.....	169
DROPLET INS 0.5 ML 31GX8MM(1/2)..	169	DROPSAFE INSULN 1 ML 29G 12.5MM.....	169
DROPLET INS SYR 0.3 ML 30GX6MM.	169	DROPSAFE PEN NEEDLE 31G 4MM.....	169
DROPLET INS SYR 0.3 ML 30GX8MM.	169	DROPSAFE PEN NEEDLE 31G 5MM.....	169
DROPLET INS SYR 0.3 ML 31GX6MM.	169	DROPSAFE PEN NEEDLE 31G 8MM.....	169
DROPLET INS SYR 0.3 ML 31GX8MM.	169	DROPSAFE PEN NEEDLE 31GX1/4".....	169
DROPLET INS SYR 0.5 ML 30G 8MM OUTER.....	169	<i>droxidopa</i>	87
DROPLET INS SYR 0.5 ML 31G 6MM OUTER.....	169	DUPIXENT PEN.....	88
DROPLET INS SYR 0.5 ML 31G 8MM OUTER.....	169	DUPIXENT SYRINGE	
DROPLET INS SYR 1 ML 29G 12.7MM OUTER.....	169	SUBCUTANEOUS SYRINGE 200	
DROPLET INS SYR 1 ML 30G 12.5MM.	169	MG/1.14 ML, 300 MG/2 ML.....	88
DROPLET INS SYR 1 ML 30G 6MM.....	169	EASY CMFT SFTY PEN NDL 31G 5MM	169
DROPLET INS SYR 1 ML 30G 8MM OUTER.....	169	EASY CMFT SFTY PEN NDL 31G 6MM	169
		EASY CMFT SFTY PEN NDL 32G 4MM	169
		EASY COMFORT 0.3 ML 31G 1/2".....	169
		EASY COMFORT 0.3 ML 31G 5/16".....	169
		EASY COMFORT 0.5 ML 30GX1/2".....	169
		EASY COMFORT 0.5 ML 31GX5/16".....	169
		EASY COMFORT 0.5 ML 32GX5/16".....	169
		EASY COMFORT 0.5 ML SYRINGE.....	169
		EASY COMFORT 1 ML 31GX5/16".....	169
		EASY COMFORT 1 ML 32GX5/16".....	169
		EASY COMFORT ALCOHOL 70% PAD	169

EASY COMFORT INSULIN 1 ML SYR..169	EASY TOUCH INS SYR 1 ML 31G 6MM
EASY COMFORT PEN NDL 29G 4MM..169	 169
EASY COMFORT PEN NDL 29G 5MM..169	EASY TOUCH INS SYR 1 ML 31G 8MM
EASY COMFORT PEN NDL 31GX1/4" .. 169	 169
EASY COMFORT PEN NDL 31GX3/16" 169	EASY TOUCH INSULIN 1 ML 29GX1/2 169
EASY COMFORT PEN NDL 31GX5/16" 169	EASY TOUCH INSULIN 1 ML 30GX1/2 169
EASY COMFORT PEN NDL 32GX5/32" 169	EASY TOUCH INSULIN SYR 1 ML..... 169
EASY COMFORT PEN NDL 33G 4MM..169	EASY TOUCH INSULIN SYR 1 ML
EASY COMFORT PEN NDL 33G 5MM..169	RETRACTABLE..... 169
EASY COMFORT PEN NDL 33G 6MM..169	EASY TOUCH INSULN 1 ML 29GX1/2" 169
EASY COMFORT SYR 0.5 ML 29G	EASY TOUCH INSULN 1 ML 30GX1/2" 169
8MM..... 169	EASY TOUCH INSULN 1 ML 30GX5/16 169
EASY COMFORT SYR 1 ML 29G 8MM.169	EASY TOUCH INSULN 1 ML 31GX5/16 169
EASY COMFORT SYR 1 ML 30GX1/2". 169	EASY TOUCH LUER LOK INSUL 1 ML 169
EASY GLIDE INS 0.3 ML 31GX6MM.... 169	EASY TOUCH PEN NEEDLE 29GX1/2" 169
EASY GLIDE INS 0.5 ML 31GX6MM.... 169	EASY TOUCH PEN NEEDLE 30GX5/16 169
EASY GLIDE INS 1 ML 31GX6MM..... 169	EASY TOUCH PEN NEEDLE 31GX1/4" 169
EASY GLIDE PEN NEEDLE 4MM 33G..169	EASY TOUCH PEN NEEDLE 31GX3/16 169
EASY TOUCH 0.3 ML 30G 8MM(1/2).... 169	EASY TOUCH PEN NEEDLE 31GX5/16 169
EASY TOUCH 0.3 ML 31G 6MM(1/2).... 169	EASY TOUCH PEN NEEDLE 32GX1/4" 169
EASY TOUCH 0.3 ML 31G 8MM(1/2).... 169	EASY TOUCH PEN NEEDLE 32GX3/16 169
EASY TOUCH 0.3 ML SYR 30GX1/2" 169	EASY TOUCH PEN NEEDLE 32GX5/32 169
EASY TOUCH 0.5 ML SYR 27GX1/2" 169	EASY TOUCH SAF PEN NDL 29G 5MM
EASY TOUCH 0.5 ML SYR 29GX1/2" 169	 169
EASY TOUCH 0.5 ML SYR 30GX1/2" 169	EASY TOUCH SAF PEN NDL 29G 8MM
EASY TOUCH 0.5 ML SYR 30GX5/16... 169	 169
EASY TOUCH 1 ML SYR 29GX1/2" 169	EASY TOUCH SAF PEN NDL 30G 5MM
EASY TOUCH 1 ML SYR 30GX1/2" 169	 169
EASY TOUCH ALCOHOL 70% PADS	EASY TOUCH SAF PEN NDL 30G 8MM
GAMMA-STERILIZED..... 169	 169
EASY TOUCH AUTO 0.5 ML 30G 6MM 169	EASY TOUCH SYR 0.5 ML 28G
EASY TOUCH AUTO 0.5 ML 30G 8MM 169	12.7MM..... 169
EASY TOUCH AUTORET 1 ML 30G	EASY TOUCH SYR 0.5 ML 29G
6MM..... 169	12.7MM..... 169
EASY TOUCH AUTORET 1 ML 30G	EASY TOUCH SYR 1 ML 27G 16MM.... 169
8MM..... 169	EASY TOUCH UNI-SLIP SYR 1 ML..... 169
EASY TOUCH FLIPLOK 1 ML 27GX0.5 169	EASYLIFE ALCOHOL 70% PADS..... 169
EASY TOUCH INS 0.3 ML 30G 8MM.... 169	EASYLIFE INS PEN NDL 29G 12MM.... 169
EASY TOUCH INS 0.3 ML 31G 8MM.... 169	EASYLIFE INS PEN NDL 31G 4MM..... 169
EASY TOUCH INS 0.5 ML 30G 8MM.... 169	EASYLIFE INS PEN NDL 31G 5MM..... 169
EASY TOUCH INS 0.5 ML 31G 6MM.... 169	EASYLIFE INS PEN NDL 31G 6MM..... 169
EASY TOUCH INS 0.5 ML 31G 8MM.... 169	EASYLIFE INS PEN NDL 31G 8MM..... 169
EASY TOUCH INS 1 ML 27G 1/2" 169	EASYLIFE INS PEN NDL 32G 4MM..... 169
EASY TOUCH INS 1 ML 28G 12.7MM... 169	EASYLIFE INS PEN NDL 32G 5MM..... 169
EASY TOUCH INS SYR 1 ML 30G 8MM	EASYLIFE INS PEN NDL 32G 6MM..... 169
..... 169	EASYLIFE INS PEN NDL 32G 8MM..... 169
	EASYLIFE INS PEN NDL 33G 4MM..... 169

EASYLIFE INS PEN NDL 33G 5MM.....	169	<i>erlotinib oral tablet 100 mg, 150 mg, 25</i>	
EASYLIFE INS PEN NDL 33G 6MM.....	169	<i>mg</i>	110
EASYLIFE INS PEN NDL 33G 8MM.....	169	<i>estradiol-norethindrone acet</i>	144
EASYLIFE INS SYR 0.5 ML 30G 8MM..	169	<i>everolimus (antineoplastic) oral tablet 10</i>	
EASYLIFE INS SYR 1 ML 30G 8MM.....	169	<i>mg, 2.5 mg, 5 mg, 7.5 mg</i>	114
EASYLIFE INS SYR 1 ML 31G 8MM.....	169	<i>everolimus (antineoplastic) oral tablet for</i>	
EASYLIFE SAFTY PEN NDL 31G 4MM	169	<i>suspension</i>	115
EASYLIFE SAFTY PEN NDL 31G 5MM	169	EXEL U100 0.3 ML 29GX1/2".....	169
EASYLIFE SYR 1 ML 30G 12.7MM.....	169	EXEL U100 0.3 ML 30GX5/16".....	169
EASYTOUCH SAF PEN NDL 30G 6MM	169	EXXUA.....	132
ELIGARD.....	200	FASENRA.....	45
ELIGARD (3 MONTH).....	200	FASENRA PEN.....	45
ELIGARD (4 MONTH).....	200	<i>fentanyl citrate buccal lozenge on a handle</i>	
ELIGARD (6 MONTH).....	200		119
<i>eltrombopag olamine oral powder in</i>		FILSPARI.....	326
<i>packet 12.5 mg, 25 mg</i>	98	<i> fingolimod</i>	125
<i>eltrombopag olamine oral tablet 12.5 mg,</i>		FINTEPLA.....	118
<i>25 mg, 50 mg, 75 mg</i>	98	FOTIVDA.....	345
EMBRACE PEN NEEDLE 29G 12MM....	169	FRUZAQLA ORAL CAPSULE 1 MG, 5	
EMBRACE PEN NEEDLE 30G 5MM.....	169	MG.....	127
EMBRACE PEN NEEDLE 30G 8MM.....	169	FT STERILE PADS 2" X 2".....	169
EMBRACE PEN NEEDLE 31G 5MM.....	169	GAUZE PAD TOPICAL BANDAGE 2 X	
EMBRACE PEN NEEDLE 31G 6MM.....	169	2 ".....	169
EMBRACE PEN NEEDLE 31G 8MM.....	169	GAVRETO.....	272
EMBRACE PEN NEEDLE 32G 4MM.....	169	<i>gefitinib</i>	131
EMGALITY PEN.....	129	GILOTRIF.....	13
EMGALITY SYRINGE		<i>glatiramer subcutaneous syringe 20 mg/ml,</i>	
SUBCUTANEOUS SYRINGE 120		<i>40 mg/ml</i>	135
MG/ML, 300 MG/3 ML (100 MG/ML X		<i>glatopa subcutaneous syringe 20 mg/ml, 40</i>	
3).....	129	<i>mg/ml</i>	135
ENBREL MINI.....	111	<i>glutamine (sickle cell)</i>	205
ENBREL SUBCUTANEOUS SOLUTION		<i>glyburide</i>	146
.....	111	<i>glyburide micronized</i>	146
ENBREL SUBCUTANEOUS SYRINGE.	111	<i>glyburide-metformin</i>	147
ENBREL SURECLICK.....	111	GNP ALCOHOL SWAB STERILE, TWO	
ENSACOVE ORAL CAPSULE 100 MG,		PLY.....	169
25 MG.....	102	GNP PEN NEEDLE 31G 5MM.....	169
ENTYVIO.....	381	GNP PEN NEEDLE 32G 6MM.....	169
ENTYVIO PEN.....	381	GNP SIMPLI PEN NEEDLE 32G 4MM...	169
EPCLUSA ORAL PELLETS IN PACKET		GNP ULT C 0.3 ML 29GX1/2" (1/2) 1/2	
150-37.5 MG, 200-50 MG.....	313	UNIT.....	169
EPCLUSA ORAL TABLET.....	313	GNP ULT CMFRT 0.5 ML 29GX1/2".....	169
EPIDIOLEX.....	58	GNP ULTR CMFRT 0.5 ML 30GX5/16...	169
ERIVEDGE.....	388	GNP ULTRA COMFORT 1 ML	
ERLEADA ORAL TABLET 240 MG, 60		SYRINGE.....	169
MG.....	23	GNP ULTRA COMFORT 3/10 ML SYR..	169

GOMEKLI ORAL CAPSULE 1 MG, 2 MG.....	225	IMBRUVICA ORAL CAPSULE 140 MG, 70 MG.....	157
GOMEKLI ORAL TABLET FOR SUSPENSION.....	225	IMBRUVICA ORAL SUSPENSION.....	157
GS PEN NEEDLE 31G X 8MM.....	169	IMBRUVICA ORAL TABLET.....	157
HADLIMA.....	11	IMKELDI.....	162
HADLIMA PUSHTOUCH.....	11	IMPAVIDO.....	224
HADLIMA(CF).....	11	INCONTROL PEN NEEDLE 12MM 29G.....	169
HADLIMA(CF) PUSHTOUCH.....	11	INCONTROL PEN NEEDLE 4MM 32G..	169
HAEGARDA SUBCUTANEOUS RECON SOLN 2,000 UNIT, 3,000 UNIT.....	54	INCONTROL PEN NEEDLE 5MM 31G..	169
HEALTHWISE INS 0.3 ML 30GX5/16"..	169	INCONTROL PEN NEEDLE 6MM 31G..	169
HEALTHWISE INS 0.3 ML 31GX5/16"..	169	INCONTROL PEN NEEDLE 8MM 31G..	169
HEALTHWISE INS 0.5 ML 30GX5/16"..	169	INCRELEX.....	214
HEALTHWISE INS 0.5 ML 31GX5/16"..	169	<i>indomethacin oral capsule</i>	154
HEALTHWISE INS 1 ML 30GX5/16".....	169	<i>infliximab</i>	165
HEALTHWISE INS 1 ML 31GX5/16".....	169	INGREZZA.....	379
HEALTHWISE PEN NEEDLE 31G 5MM.....	169	INGREZZA INITIATION PK(TARDIV)..	379
HEALTHWISE PEN NEEDLE 31G 8MM.....	169	INGREZZA SPRINKLE.....	379
HEALTHWISE PEN NEEDLE 32G 4MM.....	169	INLURIYO.....	163
HEALTHY ACCENTS PENTIP 5MM 31G.....	169	INLYTA ORAL TABLET 1 MG, 5 MG.....	36
HEALTHY ACCENTS PENTIP 6MM 31G.....	169	INQOVI.....	75
HEALTHY ACCENTS PENTIP 8MM 31G.....	169	INREBIC.....	117
HEALTHY ACCENTS PENTIP 12MM 29G.....	169	INSULIN 1 ML SYRINGE.....	169
HEB INCONTROL ALCOHOL 70% PADS.....	169	INSULIN 1/2 ML SYRINGE.....	169
HERCEPTIN HYLECTA.....	358	INSULIN 3/10 ML SYRINGE.....	169
HERNEXEOS.....	394	INSULIN SYR 0.3 ML 31GX1/4(1/2).....	169
HUMIRA PEN.....	7	INSULIN SYRIN 0.5 ML 28GX1/2" (OTC).....	169
HUMIRA SUBCUTANEOUS SYRINGE KIT 40 MG/0.8 ML.....	7	INSULIN SYRIN 0.5 ML 29GX1/2" (OTC).....	169
HUMIRA(CF).....	7	INSULIN SYRIN 0.5 ML 30GX1/2" (RX).....	169
HUMIRA(CF) PEN.....	7	INSULIN SYRIN 0.5 ML 30GX5/16".....	169
HUMIRA(CF) PEN CROHNS-UC-HS.....	7	SHORT NEEDLE (OTC).....	169
HUMIRA(CF) PEN PEDIATRIC UC.....	7	INSULIN SYRING 0.5 ML 27G 1/2".....	169
HUMIRA(CF) PEN PSOR-UV-ADOL HS... ..	7	INNER.....	169
HYRNUO.....	308	INSULIN SYRINGE 0.3 ML.....	169
IBRANCE.....	252	INSULIN SYRINGE 0.3 ML 31GX1/4.....	169
IBTROZI.....	335	INSULIN SYRINGE 0.5 ML.....	169
<i>icatibant</i>	158	INSULIN SYRINGE 0.5 ML 31GX1/4.....	169
ICLUSIG.....	270	INSULIN SYRINGE 1 ML.....	169
IDHIFA.....	100	INSULIN SYRINGE 1 ML 27G 1/2".....	169
<i>imatinib oral tablet 100 mg, 400 mg</i>	161	INNER.....	169
		INSULIN SYRINGE 1 ML 28GX1/2" (OTC).....	169
		INSULIN SYRINGE 1 ML 30GX1/2".....	169
		SHORT NEEDLE (OTC).....	169
		INSULIN SYRINGE 1 ML 30GX5/16".....	169
		SHORT NEEDLE (OTC).....	169

INSULIN SYRINGE 1 ML 31GX1/4"	169	<i>lapatinib</i>	189
INSULIN SYRINGE 1 ML 31GX5/16"		LAZCLUZE ORAL TABLET 240 MG, 80	
SHORT NEEDLE, THIN II (OTC)	169	MG	191
INSULIN SYRINGE-NEEDLE U-100		<i>lenalidomide</i>	194
SYRINGE 0.3 ML 29 GAUGE, 1 ML 29		LENVIMA	195
GAUGE X 1/2", 1/2 ML 28 GAUGE	169	LEQEMBI IQLIK SUBCUTANEOUS	
INSULIN U-500 SYRINGE-NEEDLE	169	AUTO-INJECTOR 360 MG/1.8 ML	192
INSUPEN PEN NEEDLE 29GX1/2"	169	LEUKINE INJECTION RECON SOLN ...	297
INSUPEN PEN NEEDLE 31G 8MM	169	<i>leuprolide acetate (3 month)</i>	198
INSUPEN PEN NEEDLE 31GX3/16"	169	<i>leuprolide subcutaneous kit</i>	197
INSUPEN PEN NEEDLE 32G 4MM	169	<i>lidocaine topical adhesive patch, medicated</i>	
INSUPEN PEN NEEDLE 32G 6MM (RX)		5 %	207
.....	169	<i>lidocaine topical ointment</i>	206
ISTURISA ORAL TABLET 1 MG, 5 MG	249	<i>lidocaine-prilocaine topical cream</i>	208
ITOVEBI ORAL TABLET 3 MG, 9 MG ..	164	<i>lidocan iii</i>	207
IV ANTISEPTIC WIPES	169	LIFYORLI	277
IWILFIN	92	LISCO SPONGES 100/BAG	169
JAKAFI	295	LIVTENCITY	213
JAKAFI XR	295	LONSURF ORAL TABLET 15-6.14 MG,	
JASCAYD	229	20-8.19 MG	362
<i>javygtor oral tablet, soluble</i>	296	LORBRENA ORAL TABLET 100 MG,	
JAYPIRCA ORAL TABLET 100 MG, 50		25 MG	209
MG	268	LUMAKRAS ORAL TABLET 120 MG,	
KALYDECO	184	240 MG, 320 MG	325
KENDALL ALCOHOL 70% PREP PAD ..	169	LUPRON DEPOT	201
KERENDIA	123	LUPRON DEPOT (3 MONTH)	201
KESIMPTA PEN	242	LUPRON DEPOT (4 MONTH)	201
<i>ketorolac oral</i>	148	LUPRON DEPOT (6 MONTH)	201
KEVZARA	298	LUPRON DEPOT-PED (3 MONTH)	203
KEYTRUDA	259	LUPRON DEPOT-PED	
KEYTRUDA QLEX	260	INTRAMUSCULAR SYRINGE KIT	203
KINERET	20	LUTRATE DEPOT (3 MONTH)	198
KISQALI FEMARA CO-PACK ORAL		LYNPARZA	243
TABLET 200 MG/DAY(200 MG X 1)-2.5		LYTGABI	128
MG, 400 MG/DAY(200 MG X 2)-2.5 MG,		<i>macitentan</i>	212
600 MG/DAY(200 MG X 3)-2.5 MG	283	MAGELLAN INSUL SYRINGE 0.3 ML ..	169
KISQALI ORAL TABLET 200 MG/DAY		MAGELLAN INSUL SYRINGE 0.5 ML ..	169
(200 MG X 1), 400 MG/DAY (200 MG X		MAGELLAN INSULIN SYR 0.3 ML	169
2), 600 MG/DAY (200 MG X 3)	282	MAGELLAN INSULIN SYR 0.5 ML	169
KOMZIFTI	393	MAGELLAN INSULIN SYRINGE 1 ML	169
KOSELUGO ORAL CAPSULE 10 MG,		MAXICOMFORT II PEN NDL	
25 MG	305	31GX6MM	169
KOSELUGO ORAL CAPSULE,		MAXICOMFORT INS 0.5 ML 27GX1/2" ..	169
SPRINKLE 5 MG, 7.5 MG	305	MAXI-COMFORT INS 0.5 ML 28G	169
KRAZATI	6	MAXICOMFORT INS 1 ML 27GX1/2" ...	169
<i>lanreotide subcutaneous syringe 120</i>		MAXI-COMFORT INS 1 ML 28GX1/2" ..	169
<i>mg/0.5 ml</i>	188		

MAXICOMFORT PEN NDL 29G X 5MM	MONOJECT INSULIN SYR 0.5 ML
..... 169	(OTC).....169
MAXICOMFORT PEN NDL 29G X 8MM	MONOJECT INSULIN SYR 1 ML 3'S
..... 169	(OTC).....169
<i>megestrol 400 mg/10 ml susp cup outer</i> 155	MONOJECT INSULIN SYR U-100..... 169
<i>megestrol oral suspension 400 mg/10 ml</i>	MONOJECT SYRINGE 0.3 ML.....169
<i>(40 mg/ml), 625 mg/5 ml (125 mg/ml)</i> 155	MONOJECT SYRINGE 0.5 ML.....169
<i>megestrol oral tablet</i> 155	MONOJECT SYRINGE 1 ML.....169
MEKINIST ORAL RECON SOLN..... 355	<i>morphine concentrate oral solution</i> 228
MEKINIST ORAL TABLET 0.5 MG, 2	MOUNJARO 138
MG.....356	NANO 2 GEN PEN NEEDLE 32G 4MM. 169
MEKTOVI.....49	NANO PEN NEEDLE 32G 4MM.....169
<i>metirosine</i> 219	NAYZILAM.....220
MICRODOT PEN NEEDLE 31GX6MM..169	NERLYNX.....231
MICRODOT PEN NEEDLE 32GX4MM..169	<i>nilotinib hcl oral capsule 150 mg, 200 mg,</i>
MICRODOT PEN NEEDLE 33GX4MM..169	<i>50 mg</i> 232
MICRODOT READYGARD NDL 31G	NINLARO 186
5MM OUTER.....169	<i>nintedanib</i> 234
<i>mifepristone oral tablet 300 mg</i> 222	<i>nitisinone</i> 239
<i>mimvey</i> 144	NIVESTYM.....122
MINI PEN NEEDLE 32G 5MM.....169	NORDITROPIN FLEXPOR..... 317
MINI PEN NEEDLE 32G 8MM.....169	NOVOFINE 32G NEEDLES..... 169
MINI PEN NEEDLE 33G 5MM.....169	NOVOFINE AUTOCOVER 30G
MINI PEN NEEDLE 33G 6MM.....169	NEEDLE.....169
MINI ULTRA-THIN II PEN NDL 31G	NOVOFINE PLUS PEN NDL 32GX1/6"..169
STERILE..... 169	NUBEQA.....73
<i>modafinil oral tablet 100 mg, 200 mg</i> 226	NUCALA SUBCUTANEOUS AUTO-
MODEYSO..... 85	INJECTOR..... 216
MONOJECT 0.5 ML SYRN 28GX1/2".....169	NUCALA SUBCUTANEOUS RECON
MONOJECT 1 ML SYRN 27X1/2".....169	SOLN.....216
MONOJECT 1 ML SYRN 28GX1/2"	NUCALA SUBCUTANEOUS SYRINGE
(OTC).....169	100 MG/ML, 40 MG/0.4 ML..... 216
MONOJECT INSUL SYR U100 (OTC)....169	NUPLAZID.....265
MONOJECT INSUL SYR U100	NURTEC ODT.....287
.5ML,29GX1/2" (OTC)..... 169	NYVEPRIA.....255
MONOJECT INSUL SYR U100 0.5 ML	ODOMZO.....321
CONVERTS TO 29G (OTC)..... 169	OFEV.....234
MONOJECT INSUL SYR U100 1 ML.... 169	OGIVRI.....357
MONOJECT INSUL SYR U100 1 ML 3'S,	OGSIVEO ORAL TABLET 100 MG, 150
29GX1/2" (OTC)..... 169	MG, 50 MG..... 238
MONOJECT INSUL SYR U100 1 ML	OJEMDA ORAL SUSPENSION FOR
W/O NEEDLE (OTC)..... 169	RECONSTITUTION.....354
MONOJECT INSULIN SYR 0.3 ML..... 169	OJEMDA ORAL TABLET.....354
MONOJECT INSULIN SYR 0.3 ML	OJJAARA 227
(OTC).....169	ONAPGO.....24
MONOJECT INSULIN SYR 0.5 ML..... 169	ONUREG.....37
	OPDIVO.....240

OPDIVO QVANTIG.....	241	PIQRAY ORAL TABLET 200 MG/DAY	
ORFADIN ORAL SUSPENSION.....	239	(200 MG X 1), 250 MG/DAY (200 MG	
ORGOVYX.....	278	X1-50 MG X1), 300 MG/DAY (150 MG X	
ORILISSA ORAL TABLET 150 MG, 200		2).....	15
MG.....	94	<i>pirfenidone oral capsule</i>	266
ORKAMBI ORAL TABLET.....	211	<i>pirfenidone oral tablet 267 mg, 534 mg,</i>	
ORSERDU ORAL TABLET 345 MG, 86		<i>801 mg</i>	266
MG.....	93	PLEGRIDY SUBCUTANEOUS PEN	
OSENVLT.....	78	INJECTOR 125 MCG/0.5 ML, 63	
OTEZLA.....	25	MCG/0.5 ML- 94 MCG/0.5 ML.....	181
OTEZLA STARTER.....	25	PLEGRIDY SUBCUTANEOUS	
OTEZLA XR.....	25	SYRINGE 125 MCG/0.5 ML, 63 MCG/0.5	
OTEZLA XR INITIATION.....	25	ML- 94 MCG/0.5 ML.....	181
OTULFI.....	367, 369	<i>pomalidomide</i>	269
OZEMPIC ORAL.....	137	POMALYST.....	269
OZEMPIC SUBCUTANEOUS.....	137	<i>posaconazole oral tablet, delayed release</i>	
<i>paroxetine hcl</i>	156	(<i>dr/ec</i>).....	271
<i>pazopanib oral tablet 200 mg, 400 mg</i>	254	PREMPHASE.....	145
PEGASYS.....	257	PREMPRO.....	145
PEMAZYRE.....	261	PREVENT PEN NEEDLE 31GX1/4".....	169
PEN NEEDLE 30G 5MM OUTER.....	169	PREVENT PEN NEEDLE 31GX5/16".....	169
PEN NEEDLE 30G 8MM INNER.....	169	PREVYMIS ORAL TABLET.....	196
PEN NEEDLE 30G X 5/16".....	169	PRO COMFORT 0.5 ML 30GX1/2".....	169
PEN NEEDLE 31G X 1/4" HRI.....	169	PRO COMFORT 0.5 ML 30GX5/16".....	169
PEN NEEDLE 33G 4MM.....	169	PRO COMFORT 0.5 ML 31GX5/16".....	169
PEN NEEDLE, DIABETIC NEEDLE 29		PRO COMFORT 1 ML 30GX1/2".....	169
GAUGE X 1/2".....	169	PRO COMFORT 1 ML 30GX5/16".....	169
PEN NEEDLES 12MM 29G		PRO COMFORT 1 ML 31GX5/16".....	169
29GX12MM,STRL.....	169	PRO COMFORT ALCOHOL 70% PADS.....	169
PEN NEEDLES 4MM 32G.....	169	PRO COMFORT PEN NDL 32G 8MM....	169
PEN NEEDLES 5MM 31G		PRO COMFORT PEN NDL 32G X 1/4"....	169
31GX5MM,STRL,MINI (OTC).....	169	PRO COMFORT PEN NDL 4MM 32G....	169
PEN NEEDLES 8MM 31G		PRO COMFORT PEN NDL 5MM 32G....	169
31GX8MM,STRL,SHORT (OTC).....	169	PRO-COMFORT ALCOHOL 70% PADS.....	169
<i>penicillamine oral tablet</i>	262	PRODIGY INS SYR 1 ML 28GX1/2".....	169
PENTIPS PEN NEEDLE 29G 1/2".....	169	PRODIGY SYRNG 0.5 ML 31GX5/16"....	169
PENTIPS PEN NEEDLE 31G 1/4".....	169	PRODIGY SYRNGE 0.3 ML 31GX5/16"....	169
PENTIPS PEN NEEDLE 31GX3/16"		<i>promethazine oral tablet</i>	150
MINI, 5MM.....	169	PURE CMFT SFTY PEN NDL 31G 5MM.....	169
PENTIPS PEN NEEDLE 31GX5/16"		PURE CMFT SFTY PEN NDL 31G 6MM.....	169
SHORT, 8MM.....	169	PURE CMFT SFTY PEN NDL 32G 4MM.....	169
PENTIPS PEN NEEDLE 32G 1/4".....	169	PURE COMFORT ALCOHOL 70%	
PENTIPS PEN NEEDLE 32GX5/32".....	169	PADS.....	169
<i>phenobarbital</i>	149	PURE COMFORT PEN NDL 32G 4MM..	169
PIP PEN NEEDLE 31G X 5MM.....	169	PURE COMFORT PEN NDL 32G 5MM..	169
PIP PEN NEEDLE 32G X 4MM.....	169	PURE COMFORT PEN NDL 32G 6MM..	169
		PURE COMFORT PEN NDL 32G 8MM..	169

<i>pyrimethamine</i>	273	SAFESNAP INS SYR UNITS-100 0.5 ML	
QINLOCK.....	290	29GX1/2",10X10.....	169
<i>quinine sulfate</i>	274	SAFESNAP INS SYR UNITS-100 0.5 ML	
QULIPTA.....	32	30GX5/16",10X10.....	169
RA ISOPROPYL ALCOHOL 70% WIPES		SAFESNAP INS SYR UNITS-100 1 ML	
.....	169	28GX1/2",10X10.....	169
RA STERILE PADS 2"X 2".....	169	SAFESNAP INS SYR UNITS-100 1 ML	
RALDESY.....	359	29GX1/2",10X10.....	169
RAYA SURE PEN NEEDLE 29G 12MM.....	169	SAFETY PEN NEEDLE 31G 4MM.....	169
RAYA SURE PEN NEEDLE 31G 4MM.....	169	SAFETY PEN NEEDLE 5MM X 31G.....	169
RAYA SURE PEN NEEDLE 31G 5MM.....	169	SAFETY SYRINGE 0.5 ML 30G 1/2".....	169
RAYA SURE PEN NEEDLE 31G 6MM.....	169	SAPHNELO PEN.....	22
RELION INS SYR 0.3 ML 31GX6MM....	169	<i>sapropterin oral tablet,soluble</i>	296
RELION INS SYR 0.5 ML 31GX6MM....	169	SCEMBLIX ORAL TABLET 100 MG, 20	
RELION INS SYR 1 ML 31GX15/64".....	169	MG, 40 MG.....	28
RELION PEN NEEDLE 32GX5/32".....	169	<i>scopolamine base</i>	152
RELION SYRING 0.3 ML 31GX5/16"		SECURESAFE PEN NDL 30GX5/16"	
INNER.....	169	OUTER.....	169
RELION SYRING 0.5 ML 31GX5/16"		SECURESAFE PEN NEEDLE 31G 5MM	
INNER (OTC).....	169	OUTER.....	169
RETACRIT INJECTION SOLUTION		SECURESAFE SYR 0.5 ML 29G 1/2"	
10,000 UNIT/ML, 2,000 UNIT/ML,		OUTER.....	169
20,000 UNIT/2 ML, 20,000 UNIT/ML,		SECURESAFE SYRNG 1 ML 29G 1/2"	
3,000 UNIT/ML, 4,000 UNIT/ML, 40,000		OUTER.....	169
UNIT/ML.....	106	SELARSDI.....	371, 373
RETEVMO ORAL TABLET 120 MG, 160		SEROSTIM SUBCUTANEOUS RECON	
MG, 40 MG, 80 MG.....	304	SOLN 4 MG, 5 MG, 6 MG.....	319
REVCovi.....	96	SIGNIFOR.....	253
REVUFORJ ORAL TABLET 110 MG,		<i>sildenafil (pulm.hypertension) oral tablet..</i>	309
160 MG, 25 MG.....	281	SIRTURO.....	39
REZDIFFRA.....	280	SKY SAFETY PEN NEEDLE 30G 5MM.....	169
REZLIDHIA.....	245	SKY SAFETY PEN NEEDLE 30G 8MM.....	169
REZUROCK.....	42	SKYRIZI.....	291
RINVOQ.....	365	<i>sodium oxybate</i>	311
RINVOQ LQ.....	365	SOMATULINE DEPOT	
ROMVIMZA.....	387	SUBCUTANEOUS SYRINGE 60 MG/0.2	
ROZLYTREK ORAL CAPSULE 100 MG,		ML, 90 MG/0.3 ML.....	188
200 MG.....	103	SOMAVERT.....	258
ROZLYTREK ORAL PELLETS IN		<i>sorafenib</i>	322
PACKET.....	104	STIVARGA.....	276
RUBRACA.....	294	STRENSIQ SUBCUTANEOUS	
RYBELSUS.....	137	SOLUTION 28 MG/0.7 ML, 40 MG/ML,	
RYBREVANT.....	19	80 MG/0.8 ML.....	29
RYBREVANT FASPRO.....	18	SUBVENITE ORAL SUSPENSION.....	187
RYDAPT.....	221	<i>sunitinib malate</i>	329
SAFESNAP INS SYR UNITS-100 0.3 ML		SURE CMFT SFTY PEN NDL 31G 6MM.....	169
30GX5/16",10X10.....	169	SURE CMFT SFTY PEN NDL 32G 4MM.....	169

SURE COMFORT 0.5 ML SYRINGE.....	169	TECHLITE INS SYR 1 ML 31GX8MM...	169
SURE COMFORT 1 ML SYRINGE.....	169	TECHLITE PEN NEEDLE 29GX1/2"	169
SURE COMFORT 3/10 ML SYRINGE....	169	TECHLITE PEN NEEDLE 29GX3/8"	169
SURE COMFORT 3/10 ML SYRINGE		TECHLITE PEN NEEDLE 31GX1/4"	169
INSULIN SYRINGE.....	169	TECHLITE PEN NEEDLE 31GX3/16"	169
SURE COMFORT 30G PEN NEEDLE	169	TECHLITE PEN NEEDLE 31GX5/16"	169
SURE COMFORT ALCOHOL PREP		TECHLITE PEN NEEDLE 32GX1/4"	169
PADS.....	169	TECHLITE PEN NEEDLE 32GX5/16"	169
SURE COMFORT INS 0.3 ML 31GX1/4.	169	TECHLITE PEN NEEDLE 32GX5/32"	169
SURE COMFORT INS 0.5 ML 31GX1/4.	169	TECHLITE PLUS PEN NDL 32G 4MM...	169
SURE COMFORT INS 1 ML 31GX1/4" ...	169	TEPMETKO.....	337
SURE COMFORT PEN NDL 29GX1/2"		<i>teriparatide subcutaneous pen injector 20</i>	
12.7MM.....	169	<i>mcg/dose (560mcg/2.24ml)</i>	338
SURE COMFORT PEN NDL 31G 5MM..	169	TERUMO INS SYRINGE U100-1 ML.....	169
SURE COMFORT PEN NDL 31G 8MM..	169	TERUMO INS SYRINGE U100-1/2 ML..	169
SURE COMFORT PEN NDL 32G 4MM..	169	TERUMO INS SYRINGE U100-1/3 ML..	169
SURE COMFORT PEN NDL 32G 6MM..	169	TERUMO INS SYRNG U100-1/2 ML.....	169
SURE-FINE PEN NEEDLES 12.7MM.....	169	<i>testosterone cypionate</i>	340
SURE-FINE PEN NEEDLES 5MM.....	169	<i>testosterone enanthate</i>	341
SURE-FINE PEN NEEDLES 8MM.....	169	<i>testosterone transdermal gel in metered-</i>	
SURE-JECT INSU SYR U100 0.3 ML.....	169	<i>dose pump 12.5 mg/ 1.25 gram (1 %),</i>	
SURE-JECT INSU SYR U100 0.5 ML.....	169	<i>20.25 mg/1.25 gram (1.62 %)</i>	339
SURE-JECT INSU SYR U100 1 ML.....	169	<i>testosterone transdermal gel in packet 1 %</i>	
SURE-JECT INSUL SYR U100 1 ML.....	169	<i>(25 mg/2.5gram), 1 % (50 mg/5 gram)</i>	339
SURE-JECT INSULIN SYRINGE 1 ML..	169	<i>tetrabenazine.....</i>	343
SURE-PREP ALCOHOL PREP PADS.....	169	THALOMID ORAL CAPSULE 100 MG,	
SYMPAZAN.....	63	150 MG, 200 MG, 50 MG	344
TABRECTA.....	60	THINPRO INS SYRIN U100-0.3 ML.....	169
<i>tadalafil oral tablet 2.5 mg, 5 mg.....</i>	331	THINPRO INS SYRIN U100-0.5 ML.....	169
TAFINLAR ORAL CAPSULE.....	69	THINPRO INS SYRIN U100-1 ML.....	169
TAFINLAR ORAL TABLET FOR		TIBSOVO.....	185
SUSPENSION.....	70	<i>tofacitinib.....</i>	350
TAGRISSO.....	250	<i>tolvaptan (polycys kidney dis) oral tablet...</i>	352
TALZENNA.....	333	<i>tolvaptan (polycys kidney dis) oral tablets,</i>	
TARPEYO.....	53	<i>sequential.....</i>	352
TAVNEOS.....	33	TOPFINE INSULN PEN NDL 32G 4MM	169
TECHLITE 0.3 ML 29GX12MM (1/2)....	169	<i>torpenz oral tablet 10 mg, 2.5 mg, 5 mg,</i>	
TECHLITE 0.3 ML 30GX8MM (1/2)....	169	<i>7.5 mg.....</i>	114
TECHLITE 0.3 ML 31GX6MM (1/2)....	169	TREMFYA INTRAVENOUS.....	139
TECHLITE 0.3 ML 31GX8MM (1/2)....	169	TREMFYA ONE-PRESS.....	139
TECHLITE 0.5 ML 30GX12MM (1/2)....	169	TREMFYA PEN INDUCTION PK(2PEN)	
TECHLITE 0.5 ML 30GX8MM (1/2)....	169		139
TECHLITE 0.5 ML 31GX6MM (1/2)....	169	TREMFYA PEN SUBCUTANEOUS PEN	
TECHLITE 0.5 ML 31GX8MM (1/2)....	169	INJECTOR 200 MG/2 ML.....	139
TECHLITE INS SYR 1 ML 29GX12MM.	169	TREMFYA SUBCUTANEOUS	
TECHLITE INS SYR 1 ML 30GX12MM.	169	SYRINGE.....	139
TECHLITE INS SYR 1 ML 31GX6MM...	169	<i>tretinoin topical cream.....</i>	353

<i>trientine oral capsule 250 mg</i>	361	TRUEPLUS PEN NEEDLE 31G X 1/4" ...	169
TRIKAFTA ORAL GRANULES IN		TRUEPLUS PEN NEEDLE 31GX3/16" ...	169
PACKET, SEQUENTIAL.....	97	TRUEPLUS PEN NEEDLE 31GX5/16" ...	169
TRIKAFTA ORAL TABLETS,		TRUEPLUS PEN NEEDLE 32GX5/32" ...	169
SEQUENTIAL.....	97	TRUEPLUS SYR 0.3 ML 29GX1/2"	169
TRUE CMFRT PRO 0.5 ML 30G 5/16"	169	TRUEPLUS SYR 0.3 ML 30GX5/16"	169
TRUE CMFRT PRO 0.5 ML 31G 5/16"	169	TRUEPLUS SYR 0.3 ML 31GX5/16"	169
TRUE CMFRT PRO 0.5 ML 32G 5/16"	169	TRUEPLUS SYR 0.5 ML 28GX1/2"	169
TRUE CMFT SFTY PEN NDL 31G 5MM	169	TRUEPLUS SYR 0.5 ML 29GX1/2"	169
TRUE CMFT SFTY PEN NDL 31G 6MM	169	TRUEPLUS SYR 0.5 ML 30GX5/16"	169
TRUE CMFT SFTY PEN NDL 32G 4MM	169	TRUEPLUS SYR 0.5 ML 31GX5/16"	169
TRUE COMFORT 0.5 ML 30G 1/2"	169	TRUEPLUS SYR 1 ML 28GX1/2"	169
TRUE COMFORT 0.5 ML 30G 5/16"	169	TRUEPLUS SYR 1 ML 29GX1/2"	169
TRUE COMFORT 0.5 ML 31G 5/16"	169	TRUEPLUS SYR 1 ML 30GX5/16"	169
TRUE COMFORT 0.5 ML 31GX5/16"	169	TRUEPLUS SYR 1 ML 31GX5/16"	169
TRUE COMFORT 1 ML 31GX5/16"	169	TRULICITY	136
TRUE COMFORT ALCOHOL 70%		TRUQAP	59
PADS.....	169	TRYNGOLZA	244
TRUE COMFORT PEN NDL 31G 8MM..	169	TUKYSA ORAL TABLET 150 MG, 50	
TRUE COMFORT PEN NDL 31GX5MM	169	MG	363
TRUE COMFORT PEN NDL 31GX6MM	169	TURALIO	264
TRUE COMFORT PEN NDL 32G 5MM..	169	TYENNE.....	346, 348
TRUE COMFORT PEN NDL 32G 6MM..	169	TYENNE AUTOINJECTOR.....	348
TRUE COMFORT PEN NDL 32GX4MM	169	TYMLOS.....	1
TRUE COMFORT PEN NDL 33G 4MM..	169	UBRELVY	364
TRUE COMFORT PEN NDL 33G 5MM..	169	UDENYCA ONBODY	256
TRUE COMFORT PEN NDL 33G 6MM..	169	ULT CFT 0.3 ML 31GX5/16" (1/2) 1/2	
TRUE COMFORT PRO 1 ML 30G 1/2" ...	169	UNIT	169
TRUE COMFORT PRO 1 ML 30G 5/16" .	169	ULTICAR INS 0.3 ML 31GX1/4(1/2).....	169
TRUE COMFORT PRO 1 ML 31G 5/16" .	169	ULTICARE INS 0.3 ML 31GX1/4"	169
TRUE COMFORT PRO 1 ML 32G 5/16" .	169	ULTICARE INS 0.5 ML 31GX1/4"	169
TRUE COMFORT PRO ALCOHOL		ULTICARE INS 1 ML 31GX1/4"	169
PADS.....	169	ULTICARE INS SYR 1 ML 30GX1/2"	169
TRUE COMFORT SFTY 1 ML 30G 1/2" .	169	ULTICARE PEN NEEDLE 31GX3/16"	169
TRUE COMFRT PRO 0.5 ML 30G 1/2" ...	169	ULTICARE PEN NEEDLE 6MM 31G.....	169
TRUE COMFRT SFTY 1 ML 30G 5/16" ..	169	ULTICARE PEN NEEDLE 8MM 31G.....	169
TRUE COMFRT SFTY 1 ML 31G 5/16" ..	169	ULTICARE PEN NEEDLES 12MM 29G.	169
TRUE COMFRT SFTY 1 ML 32G 5/16" ..	169	ULTICARE PEN NEEDLES 4MM 32G	
TRUE-CMFRT PRO PEN NDL 31G 5MM		MICRO, 32GX4MM.....	169
.....	169	ULTICARE PEN NEEDLES 6MM 32G...	169
TRUE-CMFRT PRO PEN NDL 31G 6MM		ULTICARE SAFE PEN NDL 30G 8MM..	169
.....	169	ULTICARE SAFE PEN NDL 5MM 30G..	169
TRUE-CMFRT PRO PEN NDL 31G 8MM		ULTICARE SYR 0.3 ML 30GX1/2"	169
.....	169	ULTICARE SYR 0.3 ML 31GX5/16"	
TRUE-CMFRT PRO PEN NDL 32G 4MM		SHORT NDL.....	169
.....	169	ULTICARE SYR 0.5 ML 30GX1/2"	169
TRUEPLUS PEN NEEDLE 29GX1/2"	169		

ULTICARE SYR 0.5 ML 31GX5/16"	169	ULTRA FLO SYR 0.3 ML 30G 5/16"	169
SHORT NDL	169	ULTRA FLO SYR 0.3 ML 31G 5/16"	169
ULTICARE SYR 1 ML 31GX5/16"	169	ULTRA FLO SYR 0.5 ML 29G 1/2"	169
ULTIGUARD SAFE 1 ML 30G 12.7MM.	169	ULTRA THIN PEN NDL 32G X 4MM	169
ULTIGUARD SAFE0.3 ML 30G 12.7MM	169	ULTRACARE INS 0.3 ML 30GX5/16"	169
.....	169	ULTRACARE INS 0.3 ML 31GX5/16"	169
ULTIGUARD SAFE0.5 ML 30G 12.7MM	169	ULTRACARE INS 0.5 ML 30GX1/2"	169
.....	169	ULTRACARE INS 0.5 ML 30GX5/16"	169
ULTIGUARD SAFEPACK 1 ML 31G	169	ULTRACARE INS 0.5 ML 31GX5/16"	169
8MM.....	169	ULTRACARE INS 1 ML 30G X 5/16"	169
ULTIGUARD SAFEPACK 29G 12.7MM	169	ULTRACARE INS 1 ML 30GX1/2"	169
ULTIGUARD SAFEPACK 31G 5MM.....	169	ULTRACARE INS 1 ML 31G X 5/16"	169
ULTIGUARD SAFEPACK 31G 6MM.....	169	ULTRACARE PEN NEEDLE 31GX1/4"	169
ULTIGUARD SAFEPACK 31G 8MM.....	169	ULTRACARE PEN NEEDLE 31GX3/16"	169
ULTIGUARD SAFEPACK 32G 4MM.....	169	ULTRACARE PEN NEEDLE 31GX5/16"	169
ULTIGUARD SAFEPACK 32G 6MM.....	169	ULTRACARE PEN NEEDLE 32GX1/4"	169
ULTIGUARD SAFEPK 0.3 ML 31G	169	ULTRACARE PEN NEEDLE 32GX3/16"	169
8MM.....	169	ULTRACARE PEN NEEDLE 32GX5/32"	169
ULTIGUARD SAFEPK 0.5 ML 31G	169	ULTRACARE PEN NEEDLE 33GX5/32"	169
8MM.....	169	ULTRA-FINE 0.3 ML 30G 12.7MM.....	169
ULTILET ALCOHOL STERL SWAB	169	ULTRA-FINE 0.3 ML 31G 6MM (1/2).....	169
ULTILET INSULIN SYRINGE 0.3 ML...	169	ULTRA-FINE 0.3 ML 31G 8MM (1/2).....	169
ULTILET INSULIN SYRINGE 0.5 ML...	169	ULTRA-FINE 0.5 ML 30G 12.7MM.....	169
ULTILET INSULIN SYRINGE 1 ML	169	ULTRA-FINE INS SYR 1 ML 31G 6MM	169
ULTILET PEN NEEDLE	169	ULTRA-FINE INS SYR 1 ML 31G 8MM	169
ULTILET PEN NEEDLE 4MM 32G	169	ULTRA-FINE PEN NDL 29G 12.7MM.....	169
ULTRA COMFORT 0.3 ML 29GX1/2"	169	ULTRA-FINE PEN NEEDLE 31G 5MM.....	169
ULTRA COMFORT 0.3 ML SYRINGE...	169	ULTRA-FINE PEN NEEDLE 31G 8MM.....	169
ULTRA COMFORT 0.5 ML 28GX1/2"	169	ULTRA-FINE PEN NEEDLE 32G 6MM.....	169
CONVERTS TO 29G.....	169	ULTRA-FINE SYR 0.3 ML 31G 6MM.....	169
ULTRA COMFORT 0.5 ML 29GX1/2"	169	ULTRA-FINE SYR 0.3 ML 31G 8MM.....	169
ULTRA COMFORT 0.5 ML 31GX5/16" ..	169	ULTRA-FINE SYR 0.5 ML 31G 6MM.....	169
ULTRA COMFORT 0.5 ML SYRINGE...	169	ULTRA-FINE SYR 0.5 ML 31G 8MM.....	169
ULTRA COMFORT 1 ML 29GX1/2"	169	ULTRA-FINE SYR 1 ML 30G 12.7MM...	169
ULTRA COMFORT 1 ML 30GX5/16"	169	ULTRA-THIN II 1 ML 31GX5/16"	169
ULTRA COMFORT 1 ML 31GX5/16"	169	ULTRA-THIN II INS 0.3 ML 30G	169
ULTRA COMFORT 1 ML SYRINGE.....	169	ULTRA-THIN II INS 0.3 ML 31G	169
ULTRA FLO 0.3 ML 30G 1/2" (1/2).....	169	ULTRA-THIN II INS 0.5 ML 29G	169
ULTRA FLO 0.3 ML 30G 5/16"(1/2).....	169	ULTRA-THIN II INS 0.5 ML 30G	169
ULTRA FLO 0.3 ML 31G 5/16"(1/2).....	169	ULTRA-THIN II INS 0.5 ML 31G	169
ULTRA FLO PEN NEEDLE 31G 5MM...	169	ULTRA-THIN II INS SYR 1 ML 29G	169
ULTRA FLO PEN NEEDLE 31G 8MM...	169	ULTRA-THIN II INS SYR 1 ML 30G	169
ULTRA FLO PEN NEEDLE 32G 4MM...	169	ULTRA-THIN II PEN NDL 29GX1/2"	169
ULTRA FLO PEN NEEDLE 33G 4MM...	169	ULTRA-THIN II PEN NDL 31GX5/16.....	169
ULTRA FLO PEN NEEDLES 12MM 29G	169	UNIFINE OTC PEN NEEDLE 31G 5MM	169
.....	169	UNIFINE OTC PEN NEEDLE 32G 4MM	169
ULTRA FLO SYR 0.3 ML 29GX1/2"	169		

UNIFINE PENTIPS 12MM 29G		VANISHPOINT INS 1 ML 30GX3/16"	169
29GX12MM, STRL.....	169	VANISHPOINT U-100 29X1/2 SYR.....	169
UNIFINE PENTIPS 31GX3/16"		VELSIPITY	113
31GX5MM,STRL,MINI.....	169	VENCLEXTA ORAL TABLET 10 MG,	
UNIFINE PENTIPS 32G 4MM.....	169	100 MG, 50 MG.....	384
UNIFINE PENTIPS 32GX1/4"	169	VENCLEXTA STARTING PACK.....	384
UNIFINE PENTIPS 33GX5/32"	169	VEOZAH.....	120
UNIFINE PENTIPS 6MM 31G.....	169	VERIFINE INS SYR 1 ML 29G 1/2"	169
UNIFINE PENTIPS 8MM 31G		VERIFINE PEN NEEDLE 29G 12MM.....	169
31GX8MM, SHORT, STRL.....	169	VERIFINE PEN NEEDLE 31G 5MM.....	169
UNIFINE PENTIPS MAX 30GX3/16"	169	VERIFINE PEN NEEDLE 31G X 6MM...	169
UNIFINE PENTIPS PLUS 29GX1/2"		VERIFINE PEN NEEDLE 31G X 8MM...	169
12MM.....	169	VERIFINE PEN NEEDLE 32G 6MM.....	169
UNIFINE PENTIPS PLUS 30GX3/16"	169	VERIFINE PEN NEEDLE 32G X 4MM...	169
UNIFINE PENTIPS PLUS 31G 5MM.....	169	VERIFINE PEN NEEDLE 32G X 5MM...	169
UNIFINE PENTIPS PLUS 31GX1/4"		VERIFINE PLUS PEN NDL 31G 5MM...	169
ULTRA SHORT, 6MM.....	169	VERIFINE PLUS PEN NDL 31G 8MM...	169
UNIFINE PENTIPS PLUS 32GX5/32"	169	VERIFINE PLUS PEN NDL 32G 4MM...	169
UNIFINE PENTIPS PLUS 33GX5/32"	169	VERIFINE PLUS PEN NDL 32G 4MM-	
UNIFINE PROTECT 30G 5MM.....	169	SHARPS CONTAINER.....	169
UNIFINE PROTECT 30G 8MM.....	169	VERIFINE SYRING 0.5 ML 29G 1/2"	169
UNIFINE PROTECT 32G 4MM.....	169	VERIFINE SYRING 1 ML 31G 5/16"	169
UNIFINE SAFECONTROL 30G 5MM.....	169	VERIFINE SYRNG 0.3 ML 31G 5/16"	169
UNIFINE SAFECONTROL 30G 8MM.....	169	VERIFINE SYRNG 0.5 ML 31G 5/16"	169
UNIFINE SAFECONTROL 31G 5MM.....	169	VERQUVO.....	385
UNIFINE SAFECONTROL 31G 6MM.....	169	VERSALON ALL PURPOSE SPONGE	
UNIFINE SAFECONTROL 31G 8MM.....	169	25'S,N-STERILE,3PLY	169
UNIFINE SAFECONTROL 32G 4MM.....	169	VERZENIO.....	2
UNIFINE ULTRA PEN NDL 34G 3.5MM..	169	<i>vigabatrin</i>	386
UNIFINE ULTRA PEN NDL 29G 12MM	169	<i>vigadrone</i>	386
UNIFINE ULTRA PEN NDL 31G 5MM..	169	<i>vigpoder</i>	386
UNIFINE ULTRA PEN NDL 31G 6MM..	169	VITRAKVI ORAL CAPSULE 100 MG,	
UNIFINE ULTRA PEN NDL 31G 8MM..	169	25 MG.....	190
UNIFINE ULTRA PEN NDL 32G 4MM..	169	VITRAKVI ORAL SOLUTION	190
UNIFINE ULTRA PEN NDL 32G 6MM..	169	VIZIMPRO.....	71
UPTRAVI ORAL TABLET 1,000 MCG,		VONJO.....	251
1,200 MCG, 1,400 MCG, 1,600 MCG, 200		VOQUEZNA.....	389
MCG, 400 MCG, 600 MCG, 800 MCG	302	VORANIGO.....	390
UPTRAVI ORAL TABLETS,DOSE		<i>voriconazole oral suspension for</i>	
PACK.....	302	<i>reconstitution</i>	391
VALCHLOR.....	215	VOSEVI.....	315
VALTOCO.....	80	VOWST.....	116
VANFLYTA.....	275	VUMERITY.....	84
VANISHPOINT 0.5 ML 30GX1/2" SY		VYALEV.....	126
OUTER.....	169	VYNDAMAX.....	332
VANISHPOINT INS 0.5 ML 30G 8MM		WEBCOL ALCOHOL PREPS	
OUTER.....	169	20'S,LARGE.....	169

WEGOVY ORAL.....	306
WEGOVY SUBCUTANEOUS PEN INJECTOR 0.25 MG/0.5 ML, 0.5 MG/0.5 ML, 1 MG/0.5 ML, 1.7 MG/0.75 ML, 2.4 MG/0.75 ML.....	306
WELIREG.....	43
WINREVAIR.....	323
WM UNIFINE PENTIP PLUS 8MM 31G W/ SAFETY CLICK.....	169
XALKORI ORAL CAPSULE.....	67
XALKORI ORAL PELLETT 150 MG, 20 MG, 50 MG.....	68
XDEMVIY.....	210
XERMELO.....	336
XIFAXAN ORAL TABLET 200 MG, 550 MG.....	284
XOLAIR.....	246
XOSPATA.....	133
XPOVIO ORAL TABLET 100 MG/WEEK (50 MG X 2), 40 MG/WEEK (10 MG X 4), 40 MG/WEEK (40 MG X 1), 40MG TWICE WEEK (40 MG X 2), 60 MG/WEEK (60 MG X 1), 60MG TWICE WEEK (120 MG/WEEK), 80 MG/WEEK (40 MG X 2), 80 MG/WEEK (80 MG X 1), 80MG TWICE WEEK (160 MG/WEEK).....	303
XTANDI ORAL CAPSULE.....	105
XTANDI ORAL TABLET 40 MG, 80 MG	105
YESINTEK.....	375, 377
YONSA.....	4
<i>yulithira oral tablet 10 mg, 2.5 mg, 5 mg, 7.5 mg.....</i>	114
YUTREPIA.....	360
ZEJULA.....	236
ZELBORAF.....	383
ZTALMY.....	130
ZURZUVAE ORAL CAPSULE 20 MG, 25 MG, 30 MG.....	395
ZYDELIG.....	160
ZYKADIA.....	62
ZYMFENTRA.....	167

Step Therapy

ARIPIPRAZOLE FILM

Products Affected

Step 2:

- OPIPZA 10 MG ORAL FILM
- OPIPZA 2 MG ORAL FILM
- OPIPZA 5 MG ORAL FILM

Details

Criteria	TRIAL OF GENERIC ARIPIPRAZOLE TABLETS IN THE PAST 120 DAYS
----------	--

ARIPIPIRAZOLE ODT

Products Affected

Step 2:

- *aripiprazole 10 mg disintegrating tablet*
- *aripiprazole 15 mg disintegrating tablet*

Details

Criteria	PRIOR CLAIM FOR ONE FORMULARY ORAL ANTIPSYCHOTIC: RISPERIDONE, CLOZAPINE TABLET, OLANZAPINE, IMMEDIATE RELEASE QUETIAPINE FUMARATE, ZIPRASIDONE, ARIPIPIRAZOLE (TAB, FILM, SOLN) ASENAPINE, PALIPERIDONE, LURASIDONE WITHIN THE PAST 120 DAYS.
----------	--

ASENAPINE PATCH

Products Affected

Step 2:

- SECUADO 3.8 MG/24 HOUR TRANSDERMAL 24 HOUR PATCH
- SECUADO 5.7 MG/24 HOUR TRANSDERMAL 24 HOUR PATCH
- SECUADO 7.6 MG/24 HOUR TRANSDERMAL 24 HOUR PATCH

Details

Criteria	CLAIM FOR 2 FORMULARY ORAL GENERIC ANTIPSYCHOTICS: LURASIDONE, RISPERIDONE, CLOZAPINE TAB, OLANZAPINE, IR QUETIAPINE FUMARATE, ZIPRASIDONE, ARIPIPRAZOLE, ASENAPINE, PALIPERIDONE WITHIN PAST 365 DAYS
----------	--

B VERSUS D ADMINISTRATIVE STEP

Products Affected

Step 2:

- *cyclophosphamide 25 mg capsule*
- *cyclophosphamide 25 mg tablet*
- *cyclophosphamide 50 mg capsule*
- *cyclophosphamide 50 mg tablet*
- JYLAMVO 2 MG/ML ORAL SOLUTION
- *methotrexate sodium 2.5 mg tablet*
- XATMEP 2.5 MG/ML ORAL SOLUTION

Details

Criteria	IN ORDER TO ASSIST IN A PART B VS. D PAYMENT DETERMINATION, A PRIOR CLAIM SEEN FOR A RHEUMATOID ARTHRITIS, PSORIASIS OR ACTIVE POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS DRUG WITHIN THE PAST 120 DAYS WILL QUALIFY FOR PART D PAYMENT. ALL OTHER INDICATIONS WILL HAVE A PART B VS. D PAYMENT DETERMINATION MADE THROUGH THE FORMULARY EXCEPTION PROCESS PRIOR TO THE APPROVAL OF THE DRUG.
----------	--

CLOZAPINE

Products Affected

Step 2:

- *clozapine 100 mg disintegrating tablet*
- *clozapine 12.5 mg disintegrating tablet*
- *clozapine 150 mg disintegrating tablet*
- *clozapine 200 mg disintegrating tablet*
- *clozapine 25 mg disintegrating tablet*
- VERSACLOZ 50 MG/ML ORAL SUSPENSION

Details

Criteria	PRIOR CLAIM FOR ONE FORMULARY ORAL ANTIPSYCHOTIC: RISPERIDONE, CLOZAPINE TABLET, OLANZAPINE, IMMEDIATE RELEASE QUETIAPINE FUMARATE, ZIPRASIDONE, ARIPIRAZOLE, ASENAPINE, PALIPERIDONE, LURASIDONE WITHIN THE PAST 120 DAYS.
----------	---

DRIZALMA SPRINKLE

Products Affected

Step 2:

- DRIZALMA SPRINKLE 20 MG CAPSULE,DELAYED RELEASE
- DRIZALMA SPRINKLE 30 MG CAPSULE,DELAYED RELEASE
- DRIZALMA SPRINKLE 40 MG CAPSULE,DELAYED RELEASE
- DRIZALMA SPRINKLE 60 MG CAPSULE,DELAYED RELEASE

Details

Criteria	PRIOR CLAIM FOR FORMULARY GENERIC DULOXETINE CAPSULE WITHIN THE PAST 120 DAYS.
----------	--

ESLICARBAZEPINE ACETATE

Products Affected

Step 2:

- *eslicarbazepine 200 mg tablet*
- *eslicarbazepine 400 mg tablet*
- *eslicarbazepine 600 mg tablet*
- *eslicarbazepine 800 mg tablet*

Details

Criteria	PRIOR CLAIM FOR 2 GENERIC ANTICONVULSANT AGENTS (CARBAMAZEPINE, DIVALPROEX SODIUM, GABAPENTIN, LAMOTRIGINE, LEVETIRACETAM, OXCARBAZEPINE, TIAGABINE, TOPIRAMATE, VALPROIC ACID, ZONISAMIDE OR LACOSAMIDE), WITHIN THE PAST 365 DAYS.
-----------------	--

FIBRATES

Products Affected

Step 2:

- *omega-3 acid ethyl esters 1 gram capsule*

Details

Criteria	PRIOR CLAIM FOR GENERIC FENOFIBRATE IN THE LAST 120 DAY
----------	---

HIGH INTENSITY STATIN

Products Affected

Step 2:

- NEXLETOL 180 MG TABLET
- NEXLIZET 180 MG-10 MG TABLET
- REPATHA PUSHTRONEX 420 MG/3.5 ML SUBCUTANEOUS WEARABLE INJECTOR
- REPATHA SURECLICK 140 MG/ML SUBCUTANEOUS PEN INJECTOR
- REPATHA SYRINGE 140 MG/ML SUBCUTANEOUS SYRINGE

Details

Criteria	PRIOR 25 DAY TRIAL OF GENERIC HIGH INTENSITY STATIN: FORMULARY VERSION OF ATORVASTATIN (40 MG or 80 MG) OR ROSUVASTATIN (20 MG or 40 MG) WITHIN THE PAST 120 DAYS. OTHERWISE, A STEP EXCEPTION REQUEST IS REQUIRED IF PATIENT CANNOT TOLERATE A STATIN.
----------	---

ILOPERIDONE

Products Affected

Step 2:

- FANAPT 1 MG TABLET
- FANAPT 10 MG TABLET
- FANAPT 12 MG TABLET
- FANAPT 2 MG TABLET
- FANAPT 4 MG TABLET
- FANAPT 6 MG TABLET
- FANAPT 8 MG TABLET
- FANAPT TITRATION PACK A 1 MG (2)-2 MG (2)-4 MG (2)-6 MG (2) TABLETS
- FANAPT TITRATION PACK B 1 MG (6)-2 MG (2)-6 MG (2)-8 MG (2) TABLETS
- FANAPT TITRATION PACK C 1 MG (4)-2 MG (2)-6 MG (2) TABLETS

Details

Criteria	CLAIM FOR 2 FORMULARY ORAL GENERIC ANTIPSYCHOTICS: LURASIDONE, RISPERIDONE, CLOZAPINE TAB, OLANZAPINE, IR QUETIAPINE FUMARATE, ZIPRASIDONE, ARIPIRAZOLE, ASENAPINE, PALIPERIDONE WITHIN THE PAST 365 DAYS.
----------	--

INSULIN SUPPLY PAYMENT DETERMINATION ST

Products Affected

Step 2:

- 1ST TIER UNIFINE PENTIPS 31 GAUGE X 1/4" NEEDLE
- 1ST TIER UNIFINE PENTIPS 31 GAUGE X 3/16" NEEDLE
- 1ST TIER UNIFINE PENTIPS 31 GAUGE X 5/16" NEEDLE
- 1ST TIER UNIFINE PENTIPS 32 GAUGE X 5/32" NEEDLE
- 1ST TIER UNIFINE PENTIPS PLUS 29 GAUGE X 1/2" NEEDLE
- 1ST TIER UNIFINE PENTIPS PLUS 31 GAUGE X 3/16" NEEDLE
- 1ST TIER UNIFINE PENTIPS PLUS 32 GAUGE X 5/32" NEEDLE
- ADVOCATE PEN NEEDLE 31 GAUGE X 3/16"
- ADVOCATE PEN NEEDLE 31 GAUGE X 5/16"
- ADVOCATE PEN NEEDLE 32 GAUGE X 5/32"
- ADVOCATE PEN NEEDLE 33 GAUGE X 5/32"
- ADVOCATE SYRINGES 0.3 ML 30 GAUGE X 5/16"
- ADVOCATE SYRINGES 0.3 ML 31 GAUGE X 5/16"
- ADVOCATE SYRINGES 0.5 ML 30 GAUGE X 5/16"
- ADVOCATE SYRINGES 0.5 ML 31 GAUGE X 5/16"
- ADVOCATE SYRINGES 1 ML 30 GAUGE X 5/16"
- ADVOCATE SYRINGES 1 ML 31 GAUGE X 5/16"
- ALCOHOL PADS
- ALCOHOL PREP PADS
- ALCOHOL SWABS
- ALCOHOL WIPES
- AQINJECT PEN NEEDLE 31 GAUGE X 3/16"
- AQINJECT PEN NEEDLE 32 GAUGE X 5/32"
- ASSURE ID DUO PRO SAFETY PEN NEEDLE 31 GAUGE X 3/16"
- ASSURE ID DUO-SHIELD 30 GAUGE X 3/16" NEEDLE
- ASSURE ID DUO-SHIELD 30 GAUGE X 5/16" NEEDLE
- ASSURE ID INSULIN SAFETY 0.5 ML 31 GAUGE X 15/64" SYRINGE
- ASSURE ID INSULIN SAFETY 1 ML 29 GAUGE X 1/2" SYRINGE
- ASSURE ID INSULIN SAFETY 1 ML 31 GAUGE X 15/64" SYRINGE
- ASSURE ID PEN NEEDLE 30 GAUGE X 5/16"
- ASSURE ID PRO PEN NEEDLE 30 GAUGE X 3/16"
- BD ALCOHOL SWABS
- BD AUTOSHIELD DUO PEN NEEDLE 30 GAUGE X 3/16"
- BD ECLIPSE LUER-LOK 1 ML 30 GAUGE X 1/2" SYRINGE
- BD INSULIN SYRINGE 1 ML 27 GAUGE X 1/2"
- BD INSULIN SYRINGE ULTRA-FINE (HALF UNIT) 0.3 ML 31 GAUGE X 5/16"
- BD INSULIN SYRINGE ULTRA-FINE 0.3 ML 30 GAUGE X 1/2"
- BD INSULIN SYRINGE ULTRA-FINE 0.5 ML 30 GAUGE X 1/2"
- BD SAFETYGLIDE INSULIN SYRINGE 0.3 ML 29 GAUGE X 1/2"
- BD SAFETYGLIDE INSULIN SYRINGE 0.3 ML 31 GAUGE X 15/64"
- BD SAFETYGLIDE INSULIN SYRINGE 0.3 ML 31 GAUGE X 5/16"
- BD SAFETYGLIDE INSULIN SYRINGE 0.5 ML 29 GAUGE X 1/2"
- BD SAFETYGLIDE INSULIN SYRINGE

- 0.5 ML 30 GAUGE X 5/16"
- BD SAFETYGLIDE INSULIN SYRINGE 0.5 ML 31 GAUGE X 15/64"
- BD SAFETYGLIDE INSULIN SYRINGE 1 ML 29 GAUGE X 1/2"
- BD SAFETYGLIDE INSULIN SYRINGE 1 ML 31 GAUGE X 15/64"
- BD SAFETYGLIDE SYRINGE 1 ML 27 GAUGE X 5/8"
- BD ULTRA-FINE MICRO PEN NEEDLE 32 GAUGE X 1/4"
- BD ULTRA-FINE MINI PEN NEEDLE 31 GAUGE X 3/16"
- BD ULTRA-FINE NANO PEN NEEDLE 32 GAUGE X 5/32"
- BD ULTRA-FINE ORIGINAL PEN NEEDLE 29 GAUGE X 1/2"
- BD ULTRA-FINE SHORT PEN NEEDLE 31 GAUGE X 5/16"
- BD VEO INSULIN SYRINGE ULTRA-FINE (HALF UNIT) 0.3 ML 31 GAUGE X 15/64"
- BD VEO INSULIN SYRINGE ULTRA-FINE 0.3 ML 31 GAUGE X 15/64"
- BD VEO INSULIN SYRINGE ULTRA-FINE 1 ML 31 GAUGE X 15/64"
- BD VEO INSULIN SYRINGE ULTRA-FINE 1/2 ML 31 GAUGE X 15/64"
- BORDERED GAUZE 2" X 2" BANDAGE
- CAREFINE PEN NEEDLE 29 GAUGE X 1/2"
- CAREFINE PEN NEEDLE 30 GAUGE X 5/16"
- CAREFINE PEN NEEDLE 31 GAUGE X 1/4"
- CAREFINE PEN NEEDLE 31 GAUGE X 5/16"
- CAREFINE PEN NEEDLE 32 GAUGE X 1/4"
- CAREFINE PEN NEEDLE 32 GAUGE X 3/16"
- CAREFINE PEN NEEDLE 32 GAUGE X 5/32"
- CARETOUCH ALCOHOL PREP PAD TOPICAL PADS
- CARETOUCH INSULIN SYRINGE 0.3 ML 31 GAUGE X 5/16"
- CARETOUCH INSULIN SYRINGE 0.5 ML 30 GAUGE X 5/16"
- CARETOUCH INSULIN SYRINGE 0.5 ML 31 GAUGE X 5/16"
- CARETOUCH INSULIN SYRINGE 1 ML 28 GAUGE X 5/16"
- CARETOUCH INSULIN SYRINGE 1 ML 29 GAUGE X 5/16"
- CARETOUCH INSULIN SYRINGE 1 ML 30 GAUGE X 5/16"
- CARETOUCH INSULIN SYRINGE 1 ML 31 GAUGE X 5/16"
- CARETOUCH PEN NEEDLE 29 GAUGE X 1/2"
- CARETOUCH PEN NEEDLE 31 GAUGE X 1/4"
- CARETOUCH PEN NEEDLE 31 GAUGE X 3/16"
- CARETOUCH PEN NEEDLE 31 GAUGE X 5/16"
- CARETOUCH PEN NEEDLE 32 GAUGE X 3/16"
- CARETOUCH PEN NEEDLE 32 GAUGE X 5/32"
- CLICKFINE PEN NEEDLE 31 GAUGE X 1/4"
- CLICKFINE PEN NEEDLE 32 GAUGE X 5/32"
- COMFORT EZ INSULIN SYRINGE 0.3 ML 29 GAUGE X 1/2"
- COMFORT EZ INSULIN SYRINGE 0.3 ML 30 GAUGE X 1/2"
- COMFORT EZ INSULIN SYRINGE 0.3 ML 30 GAUGE X 5/16"
- COMFORT EZ INSULIN SYRINGE 0.3 ML 31 GAUGE X 15/64"
- COMFORT EZ INSULIN SYRINGE 0.3 ML 31 GAUGE X 5/16"
- COMFORT EZ INSULIN SYRINGE 0.5 ML 29 GAUGE X 1/2"
- COMFORT EZ INSULIN SYRINGE 0.5 ML 30 GAUGE X 1/2"
- COMFORT EZ INSULIN SYRINGE 0.5 ML 30 GAUGE X 5/16"
- COMFORT EZ INSULIN SYRINGE 0.5 ML 31 GAUGE X 5/16"
- COMFORT EZ INSULIN SYRINGE 1 ML

- 27 GAUGE X 1/2"
- COMFORT EZ INSULIN SYRINGE 1 ML 28 GAUGE X 1/2"
- COMFORT EZ INSULIN SYRINGE 1 ML 29 GAUGE X 1/2"
- COMFORT EZ INSULIN SYRINGE 1 ML 30 GAUGE X 1/2"
- COMFORT EZ INSULIN SYRINGE 1 ML 30 GAUGE X 5/16"
- COMFORT EZ INSULIN SYRINGE 1 ML 31 GAUGE X 15/64"
- COMFORT EZ INSULIN SYRINGE 1 ML 31 GAUGE X 5/16"
- COMFORT EZ INSULIN SYRINGE 1/2 ML 28 GAUGE X 1/2"
- COMFORT EZ INSULIN SYRINGE 1/2 ML 31 GAUGE X 15/64"
- COMFORT EZ PEN NEEDLES 29 GAUGE X 1/2"
- COMFORT EZ PEN NEEDLES 31 GAUGE X 1/4"
- COMFORT EZ PEN NEEDLES 31 GAUGE X 3/16"
- COMFORT EZ PEN NEEDLES 31 GAUGE X 5/16"
- COMFORT EZ PEN NEEDLES 32 GAUGE X 1/4"
- COMFORT EZ PEN NEEDLES 32 GAUGE X 3/16"
- COMFORT EZ PEN NEEDLES 32 GAUGE X 5/16"
- COMFORT EZ PEN NEEDLES 32 GAUGE X 5/32"
- COMFORT EZ PEN NEEDLES 33 GAUGE X 1/4"
- COMFORT EZ PEN NEEDLES 33 GAUGE X 3/16"
- COMFORT EZ PEN NEEDLES 33 GAUGE X 5/16"
- COMFORT EZ PEN NEEDLES 33 GAUGE X 5/32"
- COMFORT EZ PRO SAFETY PEN NEEDLE 30 GAUGE X 5/16"
- COMFORT EZ PRO SAFETY PEN NEEDLE 31 GAUGE X 3/16"
- COMFORT EZ PRO SAFETY PEN NEEDLE 31 GAUGE X 5/32"
- COMFORT TOUCH PEN NEEDLE 31 GAUGE X 1/4"
- COMFORT TOUCH PEN NEEDLE 31 GAUGE X 3/16"
- COMFORT TOUCH PEN NEEDLE 31 GAUGE X 5/16"
- COMFORT TOUCH PEN NEEDLE 31 GAUGE X 5/32"
- COMFORT TOUCH PEN NEEDLE 32 GAUGE X 1/4"
- COMFORT TOUCH PEN NEEDLE 32 GAUGE X 3/16"
- COMFORT TOUCH PEN NEEDLE 32 GAUGE X 5/16"
- COMFORT TOUCH PEN NEEDLE 32 GAUGE X 5/32"
- COMFORT TOUCH PEN NEEDLE 33 GAUGE X 1/4"
- COMFORT TOUCH PEN NEEDLE 33 GAUGE X 3/16"
- COMFORT TOUCH PEN NEEDLE 33 GAUGE X 5/32"
- CURITY ALCOHOL SWABS
- CURITY GAUZE 2" X 2" BANDAGE
- CURITY GAUZE 2" X 2" SPONGE
- DERMACEA 2" X 2" BANDAGE
- DERMACEA 2" X 2" SPONGE
- DERMACEA NON-WOVEN 2" X 2" SPONGE
- DROPLET INSULIN SYRINGE (HALF UNIT) 0.3 ML 29 GAUGE X 1/2"
- DROPLET INSULIN SYRINGE (HALF UNIT) 0.3 ML 30 GAUGE X 1/2"
- DROPLET INSULIN SYRINGE (HALF UNIT) 0.3 ML 30 GAUGE X 5/16"
- DROPLET INSULIN SYRINGE (HALF UNIT) 0.3 ML 31 GAUGE X 15/64"
- DROPLET INSULIN SYRINGE (HALF UNIT) 0.3 ML 31 GAUGE X 5/16"
- DROPLET INSULIN SYRINGE (HALF UNIT) 0.5 ML 29 GAUGE X 1/2"
- DROPLET INSULIN SYRINGE (HALF UNIT) 0.5 ML 30 GAUGE X 1/2"
- DROPLET INSULIN SYRINGE (HALF UNIT) 0.5 ML 30 GAUGE X 15/64"
- DROPLET INSULIN SYRINGE (HALF UNIT) 0.5 ML 30 GAUGE X 5/16"

- DROPLET INSULIN SYRINGE (HALF UNIT) 0.5 ML 31 GAUGE X 15/64"
- DROPLET INSULIN SYRINGE (HALF UNIT) 0.5 ML 31 GAUGE X 5/16"
- DROPLET INSULIN SYRINGE 0.3 ML 29 GAUGE X 1/2"
- DROPLET INSULIN SYRINGE 0.3 ML 30 GAUGE X 1/2"
- DROPLET INSULIN SYRINGE 0.3 ML 30 GAUGE X 15/64"
- DROPLET INSULIN SYRINGE 0.3 ML 30 GAUGE X 5/16"
- DROPLET INSULIN SYRINGE 0.3 ML 31 GAUGE X 15/64"
- DROPLET INSULIN SYRINGE 0.3 ML 31 GAUGE X 5/16"
- DROPLET INSULIN SYRINGE 0.5 ML 29 GAUGE X 1/2"
- DROPLET INSULIN SYRINGE 0.5 ML 30 GAUGE X 1/2"
- DROPLET INSULIN SYRINGE 0.5 ML 30 GAUGE X 5/16"
- DROPLET INSULIN SYRINGE 0.5 ML 31 GAUGE X 5/16"
- DROPLET INSULIN SYRINGE 1 ML 29 GAUGE X 1/2"
- DROPLET INSULIN SYRINGE 1 ML 30 GAUGE X 1/2"
- DROPLET INSULIN SYRINGE 1 ML 30 GAUGE X 15/64"
- DROPLET INSULIN SYRINGE 1 ML 30 GAUGE X 5/16"
- DROPLET INSULIN SYRINGE 1 ML 31 GAUGE X 15/64"
- DROPLET INSULIN SYRINGE 1 ML 31 GAUGE X 5/16"
- DROPLET INSULIN SYRINGE 1/2 ML 31 GAUGE X 15/64"
- DROPLET MICRON PEN NEEDLE 34 GAUGE X 9/64"
- DROPLET PEN NEEDLE 29 GAUGE X 1/2"
- DROPLET PEN NEEDLE 29 GAUGE X 3/8"
- DROPLET PEN NEEDLE 30 GAUGE X 5/16"
- DROPLET PEN NEEDLE 31 GAUGE X 1/4"
- DROPLET PEN NEEDLE 31 GAUGE X 3/16"
- DROPLET PEN NEEDLE 31 GAUGE X 5/16"
- DROPLET PEN NEEDLE 32 GAUGE X 1/4"
- DROPLET PEN NEEDLE 32 GAUGE X 3/16"
- DROPLET PEN NEEDLE 32 GAUGE X 5/16"
- DROPLET PEN NEEDLE 32 GAUGE X 5/32"
- DROPSAFE ALCOHOL PREP PADS
- DROPSAFE INSULIN SYRINGE 0.3 ML 31 GAUGE X 15/64"
- DROPSAFE INSULIN SYRINGE 0.3 ML 31 GAUGE X 5/16"
- DROPSAFE INSULIN SYRINGE 0.5 ML 31 GAUGE X 15/64"
- DROPSAFE INSULIN SYRINGE 0.5 ML 31 GAUGE X 5/16"
- DROPSAFE INSULIN SYRINGE 1 ML 29 GAUGE X 1/2"
- DROPSAFE INSULIN SYRINGE 1 ML 31 GAUGE X 15/64"
- DROPSAFE INSULIN SYRINGE 1 ML 31 GAUGE X 5/16"
- DROPSAFE PEN NEEDLE 31 GAUGE X 1/4"
- DROPSAFE PEN NEEDLE 31 GAUGE X 3/16"
- DROPSAFE PEN NEEDLE 31 GAUGE X 5/16"
- DROPSAFE PEN NEEDLE 31 GAUGE X 5/32"
- EASY COMFORT ALCOHOL PAD TOPICAL PADS
- EASY COMFORT INSULIN SYRINGE 0.3 ML 31 GAUGE X 5/16"
- EASY COMFORT INSULIN SYRINGE 0.3 ML 31 X 1/2"
- EASY COMFORT INSULIN SYRINGE 0.5 ML 30 GAUGE X 1/2"
- EASY COMFORT INSULIN SYRINGE 0.5 ML 30 GAUGE X 5/16"
- EASY COMFORT INSULIN SYRINGE 0.5

- ML 31 GAUGE X 5/16"
- EASY COMFORT INSULIN SYRINGE 1 ML 29 GAUGE X 5/16"
- EASY COMFORT INSULIN SYRINGE 1 ML 30 GAUGE X 1/2"
- EASY COMFORT INSULIN SYRINGE 1 ML 30 GAUGE X 5/16"
- EASY COMFORT INSULIN SYRINGE 1 ML 31 GAUGE X 5/16"
- EASY COMFORT INSULIN SYRINGE 1 ML 32 GAUGE X 5/16"
- EASY COMFORT INSULIN SYRINGE 1/2 ML 29 X 5/16"
- EASY COMFORT INSULIN SYRINGE 1/2 ML 32 GAUGE X 5/16"
- EASY COMFORT PEN NEEDLES 29 GAUGE X 3/16"
- EASY COMFORT PEN NEEDLES 29 GAUGE X 5/32"
- EASY COMFORT PEN NEEDLES 31 GAUGE X 1/4"
- EASY COMFORT PEN NEEDLES 31 GAUGE X 3/16"
- EASY COMFORT PEN NEEDLES 31 GAUGE X 5/16"
- EASY COMFORT PEN NEEDLES 32 GAUGE X 5/32"
- EASY COMFORT PEN NEEDLES 33 GAUGE X 1/4"
- EASY COMFORT PEN NEEDLES 33 GAUGE X 3/16"
- EASY COMFORT PEN NEEDLES 33 GAUGE X 5/32"
- EASY COMFORT SAFETY PEN NEEDLE 31 GAUGE X 1/4"
- EASY COMFORT SAFETY PEN NEEDLE 31 GAUGE X 3/16"
- EASY COMFORT SAFETY PEN NEEDLE 32 GAUGE X 5/32"
- EASY GLIDE INSULIN SYRINGE 0.3 ML 31 GAUGE X 15/64"
- EASY GLIDE INSULIN SYRINGE 1 ML 31 GAUGE X 15/64"
- EASY GLIDE INSULIN SYRINGE 1/2 ML 31 GAUGE X 15/64"
- EASY GLIDE PEN NEEDLE 33 GAUGE X 5/32"
- EASY TOUCH 29 GAUGE X 1/2" NEEDLE
- EASY TOUCH 31 GAUGE X 1/4" NEEDLE
- EASY TOUCH 31 GAUGE X 3/16" NEEDLE
- EASY TOUCH 31 GAUGE X 5/16" NEEDLE
- EASY TOUCH 32 GAUGE X 1/4" NEEDLE
- EASY TOUCH 32 GAUGE X 3/16" NEEDLE
- EASY TOUCH 32 GAUGE X 5/32" NEEDLE
- EASY TOUCH ALCOHOL PREP PADS
- EASY TOUCH AUTORETRACT SYRINGE 0.5 ML 30 GAUGE X 1/4"
- EASY TOUCH AUTORETRACT SYRINGE 0.5 ML 30 GAUGE X 5/16"
- EASY TOUCH AUTORETRACT SYRINGE 1 ML 30 GAUGE X 1/4"
- EASY TOUCH AUTORETRACT SYRINGE 1 ML 30 GAUGE X 5/16"
- EASY TOUCH FLIPLOCK INSULIN 1 ML 29 GAUGE X 1/2" SYRINGE
- EASY TOUCH FLIPLOCK INSULIN 1 ML 31 GAUGE X 5/16" SYRINGE
- EASY TOUCH FLIPLOCK INSULIN SYRINGE 1 ML 30 GAUGE X 1/2"
- EASY TOUCH FLIPLOCK INSULIN SYRINGE 1 ML 30 GAUGE X 5/16"
- EASY TOUCH FLIPLOCK SYRINGE 1 ML 27 GAUGE X 1/2"
- EASY TOUCH INSULIN SAFETY SYRINGE 0.5 ML 29 GAUGE X 1/2"
- EASY TOUCH INSULIN SAFETY SYRINGE 0.5 ML 30 GAUGE X 5/16"
- EASY TOUCH INSULIN SAFETY SYRINGE 1 ML 29 GAUGE X 1/2"
- EASY TOUCH INSULIN SAFETY SYRINGE 1 ML 30 GAUGE X 1/2"
- EASY TOUCH INSULIN SYRINGE (HALF UNIT) 0.3 ML 30 GAUGE X 5/16"
- EASY TOUCH INSULIN SYRINGE (HALF UNIT) 0.3 ML 31 GAUGE X 1/4"
- EASY TOUCH INSULIN SYRINGE (HALF UNIT) 0.3 ML 31 GAUGE X 5/16"

- EASY TOUCH INSULIN SYRINGE 0.3 ML 30 GAUGE X 1/2"
- EASY TOUCH INSULIN SYRINGE 0.3 ML 30 GAUGE X 5/16"
- EASY TOUCH INSULIN SYRINGE 0.3 ML 31 GAUGE X 5/16"
- EASY TOUCH INSULIN SYRINGE 0.5 ML 29 GAUGE X 1/2"
- EASY TOUCH INSULIN SYRINGE 0.5 ML 30 GAUGE X 1/2"
- EASY TOUCH INSULIN SYRINGE 0.5 ML 30 GAUGE X 5/16"
- EASY TOUCH INSULIN SYRINGE 0.5 ML 31 GAUGE X 5/16"
- EASY TOUCH INSULIN SYRINGE 1 ML 27 GAUGE X 1/2"
- EASY TOUCH INSULIN SYRINGE 1 ML 27 GAUGE X 5/8"
- EASY TOUCH INSULIN SYRINGE 1 ML 28 GAUGE X 1/2"
- EASY TOUCH INSULIN SYRINGE 1 ML 29 GAUGE X 1/2"
- EASY TOUCH INSULIN SYRINGE 1 ML 30 GAUGE X 1/2"
- EASY TOUCH INSULIN SYRINGE 1 ML 30 GAUGE X 5/16"
- EASY TOUCH INSULIN SYRINGE 1 ML 31 GAUGE X 1/4"
- EASY TOUCH INSULIN SYRINGE 1 ML 31 GAUGE X 5/16"
- EASY TOUCH INSULIN SYRINGE 1/2 ML 27 GAUGE X 1/2"
- EASY TOUCH INSULIN SYRINGE 1/2 ML 28 GAUGE X 1/2"
- EASY TOUCH INSULIN SYRINGE 1/2 ML 31 GAUGE X 1/4"
- EASY TOUCH LUER LOCK INSULIN 1 ML SYRINGE
- EASY TOUCH PEN NEEDLE 30 GAUGE X 5/16"
- EASY TOUCH SAFETY PEN NEEDLE 29 GAUGE X 3/16"
- EASY TOUCH SAFETY PEN NEEDLE 29 GAUGE X 5/16"
- EASY TOUCH SAFETY PEN NEEDLE 30 GAUGE X 1/4"
- EASY TOUCH SAFETY PEN NEEDLE 30 GAUGE X 3/16"
- EASY TOUCH SAFETY PEN NEEDLE 30 GAUGE X 5/16"
- EASY TOUCH SHEATHLOCK INSULIN 1 ML 29 GAUGE X 1/2" SYRINGE
- EASY TOUCH SHEATHLOCK INSULIN 1 ML 30 GAUGE X 5/16" SYRINGE
- EASY TOUCH SHEATHLOCK INSULIN 1 ML 31 GAUGE X 5/16" SYRINGE
- EASY TOUCH SHEATHLOCK INSULIN SYRINGE 1 ML 30 GAUGE X 1/2"
- EASY TOUCH UNI-SLIP 1 ML SYRINGE
- EASYLIFE ALCOHOL PADS
- EASYLIFE INSULIN PEN NEEDLE 29 GAUGE X 1/2"
- EASYLIFE INSULIN PEN NEEDLE 31 GAUGE X 1/4"
- EASYLIFE INSULIN PEN NEEDLE 31 GAUGE X 3/16"
- EASYLIFE INSULIN PEN NEEDLE 31 GAUGE X 5/16"
- EASYLIFE INSULIN PEN NEEDLE 31 GAUGE X 5/32"
- EASYLIFE INSULIN PEN NEEDLE 32 GAUGE X 1/4"
- EASYLIFE INSULIN PEN NEEDLE 32 GAUGE X 3/16"
- EASYLIFE INSULIN PEN NEEDLE 32 GAUGE X 5/16"
- EASYLIFE INSULIN PEN NEEDLE 32 GAUGE X 5/32"
- EASYLIFE INSULIN PEN NEEDLE 33 GAUGE X 1/4"
- EASYLIFE INSULIN PEN NEEDLE 33 GAUGE X 3/16"
- EASYLIFE INSULIN PEN NEEDLE 33 GAUGE X 5/16"
- EASYLIFE INSULIN PEN NEEDLE 33 GAUGE X 5/32"
- EASYLIFE INSULIN SYRINGE 0.5 ML 30 GAUGE X 5/16"
- EASYLIFE INSULIN SYRINGE 1 ML 30 GAUGE X 1/2"
- EASYLIFE INSULIN SYRINGE 1 ML 30 GAUGE X 5/16"
- EASYLIFE INSULIN SYRINGE 1 ML 31 GAUGE X 5/16"

- EASYLIFE SAFETY PEN NEEDLE 31 GAUGE X 3/16"
- EASYLIFE SAFETY PEN NEEDLE 31 GAUGE X 5/32"
- EMBRACE PEN NEEDLE 29 GAUGE X 1/2"
- EMBRACE PEN NEEDLE 30 GAUGE X 3/16"
- EMBRACE PEN NEEDLE 30 GAUGE X 5/16"
- EMBRACE PEN NEEDLE 31 GAUGE X 1/4"
- EMBRACE PEN NEEDLE 31 GAUGE X 3/16"
- EMBRACE PEN NEEDLE 31 GAUGE X 5/16"
- EMBRACE PEN NEEDLE 32 GAUGE X 5/32"
- EXEL INSULIN 0.3 ML 29 GAUGE X 1/2" SYRINGE
- GAUZE BANDAGE 2" X 2"
- GAUZE PAD 2" X 2" BANDAGE
- HEALTHWISE INSULIN SYRINGE 0.3 ML 30 GAUGE X 5/16"
- HEALTHWISE INSULIN SYRINGE 0.3 ML 31 GAUGE X 5/16"
- HEALTHWISE INSULIN SYRINGE 0.5 ML 30 GAUGE X 5/16"
- HEALTHWISE INSULIN SYRINGE 0.5 ML 31 GAUGE X 5/16"
- HEALTHWISE INSULIN SYRINGE 1 ML 30 GAUGE X 5/16"
- HEALTHWISE INSULIN SYRINGE 1 ML 31 GAUGE X 5/16"
- HEALTHWISE PEN NEEDLE 31 GAUGE X 3/16"
- HEALTHWISE PEN NEEDLE 31 GAUGE X 5/16"
- HEALTHWISE PEN NEEDLE 32 GAUGE X 5/32"
- HEALTHY ACCENTS UNIFINE PENTIP 29 GAUGE X 1/2" NEEDLE
- HEALTHY ACCENTS UNIFINE PENTIP 31 GAUGE X 1/4" NEEDLE
- HEALTHY ACCENTS UNIFINE PENTIP 31 GAUGE X 3/16" NEEDLE
- HEALTHY ACCENTS UNIFINE PENTIP 31 GAUGE X 5/16" NEEDLE
- INCONTROL ALCOHOL PADS
- INCONTROL PEN NEEDLE 29 GAUGE X 1/2"
- INCONTROL PEN NEEDLE 31 GAUGE X 1/4"
- INCONTROL PEN NEEDLE 31 GAUGE X 3/16"
- INCONTROL PEN NEEDLE 31 GAUGE X 5/16"
- INCONTROL PEN NEEDLE 32 GAUGE X 5/32"
- INSULIN SYRINGE MICROFINE 1 ML 27 GAUGE X 5/8"
- INSULIN SYRINGE U-100 WITH NEEDLE 0.3 ML 29 GAUGE
- INSULIN SYRINGE U-100 WITH NEEDLE 0.3 ML 30
- INSULIN SYRINGE U-100 WITH NEEDLE 0.3 ML 30 GAUGE X 5/16"
- INSULIN SYRINGE U-100 WITH NEEDLE 0.3 ML 31 GAUGE X 1/4"
- INSULIN SYRINGE U-100 WITH NEEDLE 0.3 ML 31 GAUGE X 15/64"
- INSULIN SYRINGE U-100 WITH NEEDLE 0.3 ML 31 GAUGE X 5/16"
- INSULIN SYRINGE U-100 WITH NEEDLE 0.5 ML 29 GAUGE X 1/2"
- INSULIN SYRINGE U-100 WITH NEEDLE 0.5 ML 30 GAUGE X 1/2"
- INSULIN SYRINGE U-100 WITH NEEDLE 0.5 ML 30 GAUGE X 5/16"
- INSULIN SYRINGE U-100 WITH NEEDLE 0.5 ML 31 GAUGE X 5/16"
- INSULIN SYRINGE U-100 WITH NEEDLE 1 ML 27 GAUGE X 1/2"
- INSULIN SYRINGE U-100 WITH NEEDLE 1 ML 28 GAUGE X 1/2"
- INSULIN SYRINGE U-100 WITH NEEDLE 1 ML 29 GAUGE X 1/2"
- INSULIN SYRINGE U-100 WITH NEEDLE 1 ML 29 GAUGE X 7/16"
- INSULIN SYRINGE U-100 WITH NEEDLE 1 ML 30 GAUGE X 1/2"
- INSULIN SYRINGE U-100 WITH NEEDLE 1 ML 30 GAUGE X 3/8"
- INSULIN SYRINGE U-100 WITH

- NEEDLE 1 ML 30 GAUGE X 5/16"
- INSULIN SYRINGE U-100 WITH NEEDLE 1 ML 30 GAUGE X 7/16"
- INSULIN SYRINGE U-100 WITH NEEDLE 1 ML 31 GAUGE X 1/4"
- INSULIN SYRINGE U-100 WITH NEEDLE 1 ML 31 GAUGE X 15/64"
- INSULIN SYRINGE U-100 WITH NEEDLE 1 ML 31 GAUGE X 5/16"
- INSULIN SYRINGE U-100 WITH NEEDLE 1/2 ML 27 GAUGE X 1/2"
- INSULIN SYRINGE U-100 WITH NEEDLE 1/2 ML 28 GAUGE
- INSULIN SYRINGE U-100 WITH NEEDLE 1/2 ML 28 GAUGE X 1/2"
- INSULIN SYRINGE U-100 WITH NEEDLE 1/2 ML 29
- INSULIN SYRINGE U-100 WITH NEEDLE 1/2 ML 30 GAUGE
- INSULIN SYRINGE U-100 WITH NEEDLE 1/2 ML 31 GAUGE X 1/4"
- INSULIN SYRINGE U-100 WITH NEEDLE 1/2 ML 31 GAUGE X 15/64"
- INSULIN SYRINGE-NEEDLE U-100 HALF UNIT MARKING 0.3 ML 31 GAUGE X 1/4"
- INSULIN U-500 SYRINGE-NEEDLE 1/2 ML 31 GAUGE X 15/64"
- INSUPEN PEN NEEDLE 29 GAUGE X 1/2"
- INSUPEN PEN NEEDLE 31 GAUGE X 3/16"
- INSUPEN PEN NEEDLE 31 GAUGE X 5/16"
- INSUPEN PEN NEEDLE 32 GAUGE X 1/4"
- INSUPEN PEN NEEDLE 32 GAUGE X 5/32"
- IV PREP WIPES MEDICATED
- LISCO 2" X 2" SPONGE
- MAGELLAN INSULIN SAFETY SYRINGE 0.3 ML 29 GAUGE X 1/2"
- MAGELLAN INSULIN SAFETY SYRINGE 0.5 ML 29 GAUGE X 1/2"
- MAGELLAN INSULIN SAFETY SYRINGE 1 ML 29 GAUGE X 1/2"
- MAGELLAN INSULIN SAFETY SYRINGE 1 ML 30 GAUGE X 5/16"
- MAGELLAN SYRINGE 0.3 ML 30 X 5/16"
- MAGELLAN SYRINGE 0.5 ML 30 GAUGE X 5/16"
- MAXICOMFORT II PEN NEEDLE 31 GAUGE X 1/4"
- MAXICOMFORT INSULIN SYRINGE 1 ML 27 GAUGE X 1/2"
- MAXI-COMFORT INSULIN SYRINGE 1 ML 28 GAUGE X 1/2"
- MAXICOMFORT INSULIN SYRINGE 1/2 ML 27 GAUGE X 1/2"
- MAXI-COMFORT INSULIN SYRINGE 1/2 ML 28 GAUGE X 1/2"
- MAXICOMFORT SAFETY PEN NEEDLE 29 GAUGE X 3/16"
- MAXICOMFORT SAFETY PEN NEEDLE 29 GAUGE X 5/16"
- MICRODOT INSULIN PEN NEEDLE 31 GAUGE X 1/4"
- MICRODOT INSULIN PEN NEEDLE 32 GAUGE X 5/32"
- MICRODOT INSULIN PEN NEEDLE 33 GAUGE X 5/32"
- MICRODOT READYGARD PEN NEEDLE 31 GAUGE X 3/16"
- MINI ULTRA-THIN II 31 GAUGE X 3/16" NEEDLE
- MONOJECT INSULIN SAFETY SYRINGE 0.3 ML 30 GAUGE X 5/16"
- MONOJECT INSULIN SAFETY SYRINGE 0.5 ML 29 GAUGE X 1/2"
- MONOJECT INSULIN SAFETY SYRINGE 0.5 ML 30 GAUGE X 5/16"
- MONOJECT INSULIN SAFETY SYRINGE 1 ML 29 GAUGE X 1/2"
- MONOJECT INSULIN SYRINGE 0.3 ML 29 GAUGE X 1/2"
- MONOJECT INSULIN SYRINGE 0.3 ML 30 GAUGE X 5/16"
- MONOJECT INSULIN SYRINGE 0.3 ML 31 GAUGE X 5/16"
- MONOJECT INSULIN SYRINGE 0.5 ML 29 GAUGE X 1/2"
- MONOJECT INSULIN SYRINGE 0.5 ML 30 GAUGE X 5/16"
- MONOJECT INSULIN SYRINGE 0.5 ML

- 31 GAUGE X 5/16"
- MONOJECT INSULIN SYRINGE 1 ML
- MONOJECT INSULIN SYRINGE 1 ML 25 GAUGE X 5/8"
- MONOJECT INSULIN SYRINGE 1 ML 27 GAUGE X 1/2"
- MONOJECT INSULIN SYRINGE 1 ML 28 GAUGE X 1/2"
- MONOJECT INSULIN SYRINGE 1 ML 29 GAUGE X 1/2"
- MONOJECT INSULIN SYRINGE 1 ML 30 GAUGE X 5/16"
- MONOJECT INSULIN SYRINGE 1 ML 31 GAUGE X 5/16"
- MONOJECT INSULIN SYRINGE 1/2 ML 28 GAUGE X 1/2"
- MONOJECT SYRINGE 1/2 ML 28 GAUGE
- MONOJECT ULTRA COMFORT INSULIN 1/2 ML 28 GAUGE SYRINGE
- NANO 2ND GEN PEN NEEDLE 32 GAUGE X 5/32"
- NANO PEN NEEDLE 32 GAUGE X 5/32"
- NOVOFINE 32 32 GAUGE X 1/4" NEEDLE
- NOVOFINE AUTOCOVER 30 GAUGE X 1/3" NEEDLE
- NOVOFINE PLUS 32 GAUGE X 1/6" NEEDLE
- PEN NEEDLE 29 GAUGE X 1/2"
- PEN NEEDLE 30 GAUGE X 5/16"
- PEN NEEDLE 31 GAUGE X 3/16"
- PEN NEEDLE 31 GAUGE X 5/16"
- PEN NEEDLE 32 GAUGE X 5/32"
- PEN NEEDLE, DIABETIC 29 GAUGE X 1/2"
- PEN NEEDLE, DIABETIC 29 GAUGE X 15/32"
- PEN NEEDLE, DIABETIC 30 GAUGE X 3/16"
- PEN NEEDLE, DIABETIC 30 GAUGE X 5/16"
- PEN NEEDLE, DIABETIC 31 GAUGE X 1/3"
- PEN NEEDLE, DIABETIC 31 GAUGE X 1/4"
- PEN NEEDLE, DIABETIC 31 GAUGE X 1/6"
- PEN NEEDLE, DIABETIC 31 GAUGE X 13/64"
- PEN NEEDLE, DIABETIC 31 GAUGE X 15/64"
- PEN NEEDLE, DIABETIC 31 GAUGE X 3/16"
- PEN NEEDLE, DIABETIC 31 GAUGE X 5/16"
- PEN NEEDLE, DIABETIC 31 GAUGE X 5/32"
- PEN NEEDLE, DIABETIC 32 GAUGE X 1/4"
- PEN NEEDLE, DIABETIC 32 GAUGE X 3/16"
- PEN NEEDLE, DIABETIC 32 GAUGE X 5/16"
- PEN NEEDLE, DIABETIC 32 GAUGE X 5/32"
- PEN NEEDLE, DIABETIC 33 GAUGE X 1/4"
- PEN NEEDLE, DIABETIC 33 GAUGE X 3/16"
- PEN NEEDLE, DIABETIC 33 GAUGE X 5/32"
- PEN NEEDLE, DIABETIC, SAFETY 31 GAUGE X 5/32"
- PENTIPS PEN NEEDLE 29 GAUGE X 1/2"
- PENTIPS PEN NEEDLE 31 GAUGE X 1/4"
- PENTIPS PEN NEEDLE 31 GAUGE X 3/16"
- PENTIPS PEN NEEDLE 31 GAUGE X 5/16"
- PENTIPS PEN NEEDLE 32 GAUGE X 1/4"
- PENTIPS PEN NEEDLE 32 GAUGE X 5/32"
- PIP PEN NEEDLE 31 GAUGE X 3/16"
- PIP PEN NEEDLE 32 GAUGE X 5/32"
- PREVENT DROPSAFE PEN NEEDLE 31 GAUGE X 1/4"
- PREVENT DROPSAFE PEN NEEDLE 31 GAUGE X 5/16"
- PRO COMFORT ALCOHOL PADS
- PRO COMFORT INSULIN SYRINGE 0.5 ML 30 GAUGE X 1/2"
- PRO COMFORT INSULIN SYRINGE 0.5 ML 30 GAUGE X 5/16"
- PRO COMFORT INSULIN SYRINGE 0.5

- ML 31 GAUGE X 5/16"
- PRO COMFORT INSULIN SYRINGE 1 ML 30 GAUGE X 1/2"
- PRO COMFORT INSULIN SYRINGE 1 ML 30 GAUGE X 5/16"
- PRO COMFORT INSULIN SYRINGE 1 ML 31 GAUGE X 5/16"
- PRO COMFORT PEN NEEDLE 32 GAUGE X 1/4"
- PRO COMFORT PEN NEEDLE 32 GAUGE X 3/16"
- PRO COMFORT PEN NEEDLE 32 GAUGE X 5/16"
- PRO COMFORT PEN NEEDLE 32 GAUGE X 5/32"
- PRO-COMFORT ALCOHOL PADS
- PRODIGY INSULIN SYRINGE 0.3 ML 31 GAUGE X 5/16"
- PRODIGY INSULIN SYRINGE 0.5 ML 31 GAUGE X 5/16"
- PRODIGY INSULIN SYRINGE 1 ML 28 GAUGE X 1/2"
- PURE COMFORT ALCOHOL PADS
- PURE COMFORT PEN NEEDLE 32 GAUGE X 1/4"
- PURE COMFORT PEN NEEDLE 32 GAUGE X 3/16"
- PURE COMFORT PEN NEEDLE 32 GAUGE X 5/16"
- PURE COMFORT PEN NEEDLE 32 GAUGE X 5/32"
- PURE COMFORT SAFETY PEN NEEDLE 31 GAUGE X 1/4"
- PURE COMFORT SAFETY PEN NEEDLE 31 GAUGE X 3/16"
- PURE COMFORT SAFETY PEN NEEDLE 32 GAUGE X 5/32"
- SAFESNAP INSULIN SYRINGE 0.3 ML 30 GAUGE X 5/16"
- SAFESNAP INSULIN SYRINGE 0.5 ML 29 GAUGE X 1/2"
- SAFESNAP INSULIN SYRINGE 0.5 ML 30 GAUGE X 5/16"
- SAFESNAP INSULIN SYRINGE 1 ML 28 GAUGE X 1/2"
- SAFESNAP INSULIN SYRINGE 1 ML 29 GAUGE X 1/2"
- SAFETY PEN NEEDLE 31 GAUGE X 3/16"
- SECURESAFE INSULIN SYRINGE 0.5 ML 29 GAUGE X 1/2"
- SECURESAFE INSULIN SYRINGE 1 ML 29 GAUGE X 1/2"
- SECURESAFE PEN NEEDLE 30 GAUGE X 5/16"
- SECURESAFE PEN NEEDLE 31 GAUGE X 3/16"
- SIMPLI PEN NEEDLE 32 GAUGE X 5/32"
- SKY SAFETY PEN NEEDLE 30 GAUGE X 3/16"
- SKY SAFETY PEN NEEDLE 30 GAUGE X 5/16"
- STERILE PADS 2" X 2" BANDAGE
- SURE COMFORT ALCOHOL PREP PADS
- SURE COMFORT INSULIN SYRINGE 0.3 ML 29 GAUGE X 1/2"
- SURE COMFORT INSULIN SYRINGE 0.3 ML 30 GAUGE X 1/2"
- SURE COMFORT INSULIN SYRINGE 0.3 ML 30 GAUGE X 5/16"
- SURE COMFORT INSULIN SYRINGE 0.3 ML 31 GAUGE X 1/4"
- SURE COMFORT INSULIN SYRINGE 0.3 ML 31 GAUGE X 5/16"
- SURE COMFORT INSULIN SYRINGE 0.5 ML 30 GAUGE X 1/2"
- SURE COMFORT INSULIN SYRINGE 0.5 ML 30 GAUGE X 5/16"
- SURE COMFORT INSULIN SYRINGE 0.5 ML 31 GAUGE X 5/16"
- SURE COMFORT INSULIN SYRINGE 1 ML 28 GAUGE X 1/2"
- SURE COMFORT INSULIN SYRINGE 1 ML 29 GAUGE X 1/2"
- SURE COMFORT INSULIN SYRINGE 1 ML 30 GAUGE X 1/2"
- SURE COMFORT INSULIN SYRINGE 1 ML 30 GAUGE X 5/16"
- SURE COMFORT INSULIN SYRINGE 1 ML 31 GAUGE X 1/4"
- SURE COMFORT INSULIN SYRINGE 1 ML 31 GAUGE X 5/16"
- SURE COMFORT INSULIN SYRINGE 1/2 ML 28 GAUGE X 1/2"

- SURE COMFORT INSULIN SYRINGE 1/2 ML 31 GAUGE X 1/4"
- SURE COMFORT INSULIN SYRINGE U-100 0.5 ML 29 GAUGE X 1/2"
- SURE COMFORT PEN NEEDLE 29 GAUGE X 1/2"
- SURE COMFORT PEN NEEDLE 30 GAUGE X 5/16"
- SURE COMFORT PEN NEEDLE 31 GAUGE X 3/16"
- SURE COMFORT PEN NEEDLE 31 GAUGE X 5/16"
- SURE COMFORT PEN NEEDLE 32 GAUGE X 1/4"
- SURE COMFORT PEN NEEDLE 32 GAUGE X 5/32"
- SURE COMFORT SAFETY PEN NEEDLE 31 GAUGE X 1/4"
- SURE COMFORT SAFETY PEN NEEDLE 32 GAUGE X 5/32"
- SURE-FINE PEN NEEDLES 29 GAUGE X 1/2"
- SURE-FINE PEN NEEDLES 31 GAUGE X 3/16"
- SURE-FINE PEN NEEDLES 31 GAUGE X 5/16"
- SURE-JECT INSULIN SYRINGE 0.3 ML 29 GAUGE X 1/2"
- SURE-JECT INSULIN SYRINGE 0.3 ML 30 GAUGE X 5/16"
- SURE-JECT INSULIN SYRINGE 0.5 ML 29 GAUGE X 1/2"
- SURE-JECT INSULIN SYRINGE 0.5 ML 30 GAUGE X 5/16"
- SURE-JECT INSULIN SYRINGE 1 ML 28 GAUGE X 1/2"
- SURE-JECT INSULIN SYRINGE 1 ML 29 GAUGE X 1/2"
- SURE-JECT INSULIN SYRINGE 1 ML 30 GAUGE X 5/16"
- SURE-JECT INSULIN SYRINGE 1 ML 31 GAUGE X 5/16"
- SURE-JECT INSULIN SYRINGE 1/2 ML 28 GAUGE X 1/2"
- SURE-PREP ALCOHOL PREP PADS
- SYRINGE WITH NEEDLE, SAFETY 0.5 ML 30 GAUGE X 1/2"
- TECHLITE INSULIN SYRINGE (HALF UNIT) 0.3 ML 29 GAUGE X 1/2"
- TECHLITE INSULIN SYRINGE (HALF UNIT) 0.3 ML 30 GAUGE X 5/16"
- TECHLITE INSULIN SYRINGE (HALF UNIT) 0.3 ML 31 GAUGE X 15/64"
- TECHLITE INSULIN SYRINGE (HALF UNIT) 0.3 ML 31 GAUGE X 5/16"
- TECHLITE INSULIN SYRINGE (HALF UNIT) 0.5 ML 30 GAUGE X 1/2"
- TECHLITE INSULIN SYRINGE (HALF UNIT) 0.5 ML 30 GAUGE X 5/16"
- TECHLITE INSULIN SYRINGE (HALF UNIT) 0.5 ML 31 GAUGE X 15/64"
- TECHLITE INSULIN SYRINGE (HALF UNIT) 0.5 ML 31 GAUGE X 5/16"
- TECHLITE INSULIN SYRINGE 1 ML 29 GAUGE X 1/2"
- TECHLITE INSULIN SYRINGE 1 ML 30 GAUGE X 1/2"
- TECHLITE INSULIN SYRINGE 1 ML 31 GAUGE X 15/64"
- TECHLITE INSULIN SYRINGE 1 ML 31 GAUGE X 5/16"
- TECHLITE PEN NEEDLE 29 GAUGE X 1/2"
- TECHLITE PEN NEEDLE 29 GAUGE X 3/8"
- TECHLITE PEN NEEDLE 31 GAUGE X 1/4"
- TECHLITE PEN NEEDLE 31 GAUGE X 3/16"
- TECHLITE PEN NEEDLE 31 GAUGE X 5/16"
- TECHLITE PEN NEEDLE 32 GAUGE X 1/4"
- TECHLITE PEN NEEDLE 32 GAUGE X 5/16"
- TECHLITE PEN NEEDLE 32 GAUGE X 5/32"
- TECHLITE PLUS PEN NEEDLE 32 GAUGE X 5/32"
- TERUMO INSULIN SYRINGE 0.3 ML 30 X 3/8"
- TERUMO INSULIN SYRINGE 0.5 ML 29 GAUGE X 1/2"
- TERUMO INSULIN SYRINGE 1 ML 27

- GAUGE X 1/2"
- TERUMO INSULIN SYRINGE 1 ML 28 GAUGE X 1/2"
- TERUMO INSULIN SYRINGE 1 ML 29 GAUGE X 1/2"
- TERUMO INSULIN SYRINGE 1/2 ML 27 GAUGE X 1/2"
- TERUMO INSULIN SYRINGE 1/2 ML 28 GAUGE X 1/2"
- TERUMO INSULIN SYRINGE 1/2 ML 30 X 3/8"
- THINPRO INSULIN SYRINGE 0.3 ML 29 GAUGE X 1/2"
- THINPRO INSULIN SYRINGE 0.3 ML 30 X 3/8"
- THINPRO INSULIN SYRINGE 0.3 ML 31 X 3/8"
- THINPRO INSULIN SYRINGE 0.5 ML 29 GAUGE X 1/2"
- THINPRO INSULIN SYRINGE 0.5 ML 31 X 3/8"
- THINPRO INSULIN SYRINGE 1 ML 28 GAUGE X 1/2"
- THINPRO INSULIN SYRINGE 1 ML 29 GAUGE X 1/2"
- THINPRO INSULIN SYRINGE 1 ML 30 GAUGE X 3/8"
- THINPRO INSULIN SYRINGE 1 ML 31 X 3/8"
- THINPRO INSULIN SYRINGE 1/2 ML 28 GAUGE X 1/2"
- THINPRO INSULIN SYRINGE 1/2 ML 30 X 3/8"
- TOPFINE INSULIN PEN NEEDLE 32 GAUGE X 5/32"
- TRUE COMFORT ALCOHOL PADS
- TRUE COMFORT INSULIN SYRINGE 0.5 ML 31 GAUGE X 5/16"
- TRUE COMFORT INSULIN SYRINGE 1 ML 31 GAUGE X 5/16"
- TRUE COMFORT PEN NEEDLE 31 GAUGE X 1/4"
- TRUE COMFORT PEN NEEDLE 31 GAUGE X 3/16"
- TRUE COMFORT PEN NEEDLE 31 GAUGE X 5/16"
- TRUE COMFORT PEN NEEDLE 32 GAUGE X 1/4"
- TRUE COMFORT PEN NEEDLE 32 GAUGE X 3/16"
- TRUE COMFORT PEN NEEDLE 32 GAUGE X 5/32"
- TRUE COMFORT PEN NEEDLE 33 GAUGE X 1/4"
- TRUE COMFORT PEN NEEDLE 33 GAUGE X 3/16"
- TRUE COMFORT PEN NEEDLE 33 GAUGE X 5/32"
- TRUE COMFORT PRO ALCOHOL PADS
- TRUE COMFORT PRO INS SYRINGE 0.5 ML 30 GAUGE X 1/2"
- TRUE COMFORT PRO INS SYRINGE 0.5 ML 30 GAUGE X 5/16"
- TRUE COMFORT PRO INS SYRINGE 0.5 ML 31 GAUGE X 5/16"
- TRUE COMFORT PRO INS SYRINGE 1 ML 30 GAUGE X 1/2"
- TRUE COMFORT PRO INS SYRINGE 1 ML 30 GAUGE X 5/16"
- TRUE COMFORT PRO INS SYRINGE 1 ML 31 GAUGE X 5/16"
- TRUE COMFORT PRO INS SYRINGE 1 ML 32 GAUGE X 5/16"
- TRUE COMFORT PRO INS SYRINGE 1/2 ML 32 GAUGE X 5/16"
- TRUE COMFORT SAFETY INSULIN SYRINGE 0.5 ML 30 GAUGE X 1/2"
- TRUE COMFORT SAFETY INSULIN SYRINGE 0.5 ML 30 GAUGE X 5/16"
- TRUE COMFORT SAFETY INSULIN SYRINGE 0.5 ML 31 GAUGE X 5/16"
- TRUE COMFORT SAFETY INSULIN SYRINGE 1 ML 30 GAUGE X 1/2"
- TRUE COMFORT SAFETY INSULIN SYRINGE 1 ML 30 GAUGE X 5/16"
- TRUE COMFORT SAFETY INSULIN SYRINGE 1 ML 31 GAUGE X 5/16"
- TRUE COMFORT SAFETY INSULIN SYRINGE 1 ML 32 GAUGE X 5/16"
- TRUE COMFORT SAFETY PEN NEEDLE 31 GAUGE X 1/4"
- TRUE COMFORT SAFETY PEN NEEDLE 31 GAUGE X 3/16"
- TRUE COMFORT SAFETY PEN NEEDLE

- 32 GAUGE X 5/32"
- TRUE-COMFORT PRO PEN NEEDLE 31 GAUGE X 15/64"
- TRUE-COMFORT PRO PEN NEEDLE 31 GAUGE X 3/16"
- TRUE-COMFORT PRO PEN NEEDLE 31 GAUGE X 5/16"
- TRUE-COMFORT PRO PEN NEEDLE 32 GAUGE X 5/32"
- TRUEPLUS INSULIN 0.3 ML 29 GAUGE X 1/2" SYRINGE
- TRUEPLUS INSULIN 0.3 ML 30 GAUGE X 5/16" SYRINGE
- TRUEPLUS INSULIN 0.3 ML 31 GAUGE X 5/16" SYRINGE
- TRUEPLUS INSULIN 0.5 ML 29 GAUGE X 1/2" SYRINGE
- TRUEPLUS INSULIN 0.5 ML 30 GAUGE X 5/16" SYRINGE
- TRUEPLUS INSULIN 0.5 ML 31 GAUGE X 5/16" SYRINGE
- TRUEPLUS INSULIN 1 ML 28 GAUGE X 1/2" SYRINGE
- TRUEPLUS INSULIN 1 ML 29 GAUGE X 1/2" SYRINGE
- TRUEPLUS INSULIN 1 ML 30 GAUGE X 5/16" SYRINGE
- TRUEPLUS INSULIN 1 ML 31 GAUGE X 5/16" SYRINGE
- TRUEPLUS INSULIN 1/2 ML 28 GAUGE X 1/2" SYRINGE
- TRUEPLUS PEN NEEDLE 29 GAUGE X 1/2"
- TRUEPLUS PEN NEEDLE 31 GAUGE X 1/4"
- TRUEPLUS PEN NEEDLE 31 GAUGE X 3/16"
- TRUEPLUS PEN NEEDLE 31 GAUGE X 5/16"
- TRUEPLUS PEN NEEDLE 32 GAUGE X 5/32"
- ULTICARE 0.3 ML 30 GAUGE X 1/2" SYRINGE
- ULTICARE 0.3 ML 31 GAUGE X 5/16" SYRINGE
- ULTICARE 0.5 ML 30 GAUGE X 1/2" SYRINGE
- ULTICARE 0.5 ML 31 GAUGE X 5/16" SYRINGE
- ULTICARE 1 ML 30 GAUGE X 1/2" SYRINGE
- ULTICARE 1 ML 31 GAUGE X 5/16" SYRINGE
- ULTICARE INSULIN SYRINGE (HALF UNIT) 0.3 ML 31 GAUGE X 1/4"
- ULTICARE INSULIN SYRINGE 0.3 ML 31 GAUGE X 1/4"
- ULTICARE INSULIN SYRINGE 1 ML 31 GAUGE X 1/4"
- ULTICARE INSULIN SYRINGE 1/2 ML 31 GAUGE X 1/4"
- ULTICARE PEN NEEDLE 29 GAUGE X 1/2"
- ULTICARE PEN NEEDLE 31 GAUGE X 1/4"
- ULTICARE PEN NEEDLE 31 GAUGE X 3/16"
- ULTICARE PEN NEEDLE 31 GAUGE X 5/16"
- ULTICARE PEN NEEDLE 32 GAUGE X 1/4"
- ULTICARE PEN NEEDLE 32 GAUGE X 5/32"
- ULTICARE SAFETY PEN NEEDLE 30 GAUGE X 3/16"
- ULTICARE SAFETY PEN NEEDLE 30 GAUGE X 5/16"
- ULTIGUARD SAFEPACK-INSULIN SYRINGE 0.3 ML 30 X 1/2"
- ULTIGUARD SAFEPACK-INSULIN SYRINGE 0.3 ML 31 X 5/16"
- ULTIGUARD SAFEPACK-INSULIN SYRINGE 1 ML 30 X 1/2"
- ULTIGUARD SAFEPACK-INSULIN SYRINGE 1 ML 31 X 5/16"
- ULTIGUARD SAFEPACK-INSULIN SYRINGE 1/2 ML 30 X 1/2"
- ULTIGUARD SAFEPACK-INSULIN SYRINGE 1/2 ML 31 X 5/16"
- ULTIGUARD SAFEPACK-PEN NEEDLE 29 GAUGE X 1/2"
- ULTIGUARD SAFEPACK-PEN NEEDLE 31 GAUGE X 1/4"
- ULTIGUARD SAFEPACK-PEN NEEDLE

- 31 GAUGE X 3/16"
- ULTIGUARD SAFEPAK-PEN NEEDLE 31 GAUGE X 5/16"
- ULTIGUARD SAFEPAK-PEN NEEDLE 32 GAUGE X 1/4"
- ULTIGUARD SAFEPAK-PEN NEEDLE 32 GAUGE X 5/32"
- ULTILET ALCOHOL SWAB
- ULTILET INSULIN SYRINGE 0.3 ML 29 GAUGE
- ULTILET INSULIN SYRINGE 0.3 ML 29 GAUGE X 1/2"
- ULTILET INSULIN SYRINGE 0.3 ML 30 GAUGE X 5/16"
- ULTILET INSULIN SYRINGE 0.3 ML 31 GAUGE X 5/16"
- ULTILET INSULIN SYRINGE 0.5 ML 29 GAUGE X 1/2"
- ULTILET INSULIN SYRINGE 0.5 ML 30 GAUGE X 5/16"
- ULTILET INSULIN SYRINGE 0.5 ML 31 GAUGE X 5/16"
- ULTILET INSULIN SYRINGE 1 ML 29 GAUGE
- ULTILET INSULIN SYRINGE 1 ML 29 GAUGE X 1/2"
- ULTILET INSULIN SYRINGE 1 ML 30 GAUGE X 5/16"
- ULTILET INSULIN SYRINGE 1 ML 31 GAUGE X 5/16"
- ULTILET INSULIN SYRINGE 1/2 ML 29 GAUGE
- ULTILET PEN NEEDLE 29 GAUGE
- ULTILET PEN NEEDLE 32 GAUGE X 5/32"
- ULTRA COMFORT INSULIN SYRINGE (HALF UNIT) 0.3 ML 29 GAUGE X 1/2"
- ULTRA COMFORT INSULIN SYRINGE (HALF UNIT) 0.3 ML 31 GAUGE X 5/16"
- ULTRA COMFORT INSULIN SYRINGE 0.3 ML 29 GAUGE X 1/2"
- ULTRA COMFORT INSULIN SYRINGE 0.3 ML 30
- ULTRA COMFORT INSULIN SYRINGE 0.3 ML 30 GAUGE X 5/16"
- ULTRA COMFORT INSULIN SYRINGE 0.5 ML 29 GAUGE X 1/2"
- ULTRA COMFORT INSULIN SYRINGE 0.5 ML 30 GAUGE X 5/16"
- ULTRA COMFORT INSULIN SYRINGE 1 ML 28 GAUGE X 1/2"
- ULTRA COMFORT INSULIN SYRINGE 1 ML 29 GAUGE X 1/2"
- ULTRA COMFORT INSULIN SYRINGE 1 ML 30 GAUGE X 5/16"
- ULTRA COMFORT INSULIN SYRINGE 1 ML 30 GAUGE X 7/16"
- ULTRA COMFORT INSULIN SYRINGE 1 ML 31 GAUGE X 5/16"
- ULTRA COMFORT INSULIN SYRINGE 1/2 ML 28 GAUGE X 1/2"
- ULTRA COMFORT INSULIN SYRINGE 1/2 ML 29
- ULTRA COMFORT INSULIN SYRINGE 1/2 ML 30 GAUGE
- ULTRA FLO INSULIN SYRINGE (HALF UNIT) 0.3 ML 30 GAUGE X 1/2"
- ULTRA FLO INSULIN SYRINGE (HALF UNIT) 0.3 ML 30 GAUGE X 5/16"
- ULTRA FLO INSULIN SYRINGE (HALF UNIT) 0.3 ML 31 GAUGE X 5/16"
- ULTRA FLO INSULIN SYRINGE 0.3 ML 29 GAUGE X 1/2"
- ULTRA FLO INSULIN SYRINGE 0.3 ML 30 GAUGE X 5/16"
- ULTRA FLO INSULIN SYRINGE 0.3 ML 31 GAUGE X 5/16"
- ULTRA FLO INSULIN SYRINGE 0.5 ML 29 GAUGE X 1/2"
- ULTRA FLO PEN NEEDLE 29 GAUGE X 1/2"
- ULTRA FLO PEN NEEDLE 31 GAUGE X 3/16"
- ULTRA FLO PEN NEEDLE 31 GAUGE X 5/16"
- ULTRA FLO PEN NEEDLE 32 GAUGE X 5/32"
- ULTRA FLO PEN NEEDLE 33 GAUGE X 5/32"
- ULTRA THIN PEN NEEDLE 32 GAUGE X 5/32"
- ULTRACARE INSULIN SYRINGE 0.3 ML 30 GAUGE X 5/16"

- ULTRACARE INSULIN SYRINGE 0.3 ML 31 GAUGE X 5/16"
- ULTRACARE INSULIN SYRINGE 0.5 ML 30 GAUGE X 1/2"
- ULTRACARE INSULIN SYRINGE 0.5 ML 30 GAUGE X 5/16"
- ULTRACARE INSULIN SYRINGE 0.5 ML 31 GAUGE X 5/16"
- ULTRACARE INSULIN SYRINGE 1 ML 30 GAUGE X 1/2"
- ULTRACARE INSULIN SYRINGE 1 ML 30 GAUGE X 5/16"
- ULTRACARE INSULIN SYRINGE 1 ML 31 GAUGE X 5/16"
- ULTRACARE PEN NEEDLE 31 GAUGE X 1/4"
- ULTRACARE PEN NEEDLE 31 GAUGE X 3/16"
- ULTRACARE PEN NEEDLE 31 GAUGE X 5/16"
- ULTRACARE PEN NEEDLE 32 GAUGE X 1/4"
- ULTRACARE PEN NEEDLE 32 GAUGE X 3/16"
- ULTRACARE PEN NEEDLE 32 GAUGE X 5/32"
- ULTRACARE PEN NEEDLE 33 GAUGE X 5/32"
- ULTRA-FINE INSULIN SYRINGE (HALF UNIT) 0.3 ML 31 GAUGE X 15/64"
- ULTRA-FINE INSULIN SYRINGE (HALF UNIT) 0.3 ML 31 GAUGE X 5/16"
- ULTRA-FINE INSULIN SYRINGE 0.3 ML 30 GAUGE X 1/2"
- ULTRA-FINE INSULIN SYRINGE 0.3 ML 31 GAUGE X 15/64"
- ULTRA-FINE INSULIN SYRINGE 0.3 ML 31 GAUGE X 5/16"
- ULTRA-FINE INSULIN SYRINGE 0.5 ML 30 GAUGE X 1/2"
- ULTRA-FINE INSULIN SYRINGE 0.5 ML 31 GAUGE X 5/16"
- ULTRA-FINE INSULIN SYRINGE 1 ML 30 GAUGE X 1/2"
- ULTRA-FINE INSULIN SYRINGE 1 ML 31 GAUGE X 15/64"
- ULTRA-FINE INSULIN SYRINGE 1 ML 31 GAUGE X 5/16"
- ULTRA-FINE INSULIN SYRINGE 1/2 ML 31 GAUGE X 15/64"
- ULTRA-FINE PEN NEEDLE 29 GAUGE X 1/2"
- ULTRA-FINE PEN NEEDLE 31 GAUGE X 3/16"
- ULTRA-FINE PEN NEEDLE 31 GAUGE X 5/16"
- ULTRA-FINE PEN NEEDLE 32 GAUGE X 1/4"
- ULTRA-THIN II (SHORT) INSULIN SYRINGE 0.3 ML 30 GAUGE X 5/16"
- ULTRA-THIN II (SHORT) INSULIN SYRINGE 0.3 ML 31 GAUGE X 5/16"
- ULTRA-THIN II (SHORT) INSULIN SYRINGE 0.5 ML 30 GAUGE X 5/16"
- ULTRA-THIN II (SHORT) INSULIN SYRINGE 0.5 ML 31 GAUGE X 5/16"
- ULTRA-THIN II (SHORT) INSULIN SYRINGE 1 ML 30 GAUGE X 5/16"
- ULTRA-THIN II (SHORT) INSULIN SYRINGE 1 ML 31 GAUGE X 5/16"
- ULTRA-THIN II (SHORT) PEN NDL 31 GAUGE X 5/16" NEEDLE
- ULTRA-THIN II INSULIN PEN NEEDLES 29 GAUGE X 1/2"
- ULTRA-THIN II INSULIN SYRINGE 0.5 ML 29 GAUGE X 1/2"
- ULTRA-THIN II INSULIN SYRINGE 1 ML 29 GAUGE X 1/2"
- UNIFINE OTC PEN NEEDLE 31 GAUGE X 3/16"
- UNIFINE OTC PEN NEEDLE 32 GAUGE X 5/32"
- UNIFINE PENTIPS 29 GAUGE X 1/2" NEEDLE
- UNIFINE PENTIPS 31 GAUGE X 1/4" NEEDLE
- UNIFINE PENTIPS 31 GAUGE X 3/16" NEEDLE
- UNIFINE PENTIPS 31 GAUGE X 5/16" NEEDLE
- UNIFINE PENTIPS 32 GAUGE X 1/4" NEEDLE
- UNIFINE PENTIPS 32 GAUGE X 5/32" NEEDLE

- UNIFINE PENTIPS 33 GAUGE X 5/32" NEEDLE
- UNIFINE PENTIPS MAXFLOW 30 GAUGE X 3/16" NEEDLE
- UNIFINE PENTIPS PLUS 29 GAUGE X 1/2" NEEDLE
- UNIFINE PENTIPS PLUS 31 GAUGE X 1/4" NEEDLE
- UNIFINE PENTIPS PLUS 31 GAUGE X 3/16" NEEDLE
- UNIFINE PENTIPS PLUS 31 GAUGE X 5/16" NEEDLE
- UNIFINE PENTIPS PLUS 32 GAUGE X 5/32" NEEDLE
- UNIFINE PENTIPS PLUS 33 GAUGE X 5/32" NEEDLE
- UNIFINE PENTIPS PLUS MAXFLOW 30 GAUGE X 3/16" NEEDLE
- UNIFINE PROTECT 30 GAUGE X 3/16" NEEDLE
- UNIFINE PROTECT 30 GAUGE X 5/16" NEEDLE
- UNIFINE PROTECT 32 GAUGE X 5/32" NEEDLE
- UNIFINE SAFECONTROL PEN NEEDLE 30 GAUGE X 3/16"
- UNIFINE SAFECONTROL PEN NEEDLE 30 GAUGE X 5/16"
- UNIFINE SAFECONTROL PEN NEEDLE 31 GAUGE X 1/4"
- UNIFINE SAFECONTROL PEN NEEDLE 31 GAUGE X 3/16"
- UNIFINE SAFECONTROL PEN NEEDLE 31 GAUGE X 5/16"
- UNIFINE SAFECONTROL PEN NEEDLE 32 GAUGE X 5/32"
- UNIFINE ULTRA PEN NEEDLE 29 GAUGE X 1/2"
- UNIFINE ULTRA PEN NEEDLE 31 GAUGE X 1/4"
- UNIFINE ULTRA PEN NEEDLE 31 GAUGE X 3/16"
- UNIFINE ULTRA PEN NEEDLE 31 GAUGE X 5/16"
- UNIFINE ULTRA PEN NEEDLE 32 GAUGE X 1/4"
- UNIFINE ULTRA PEN NEEDLE 32 GAUGE X 5/32"
- UNIFINE ULTRA PEN NEEDLE 34 GAUGE X 9/64"
- VANISHPOINT INSULIN SYRINGE 0.5 ML 30 GAUGE X 5/16"
- VANISHPOINT INSULIN SYRINGE 1 ML 30 GAUGE X 3/16"
- VANISHPOINT SYRINGE 0.5 ML 30 GAUGE X 1/2"
- VANISHPOINT SYRINGE 1 ML 29 GAUGE X 1/2"
- VERIFINE INSULIN SYRINGE 0.3 ML 31 GAUGE X 5/16"
- VERIFINE INSULIN SYRINGE 0.5 ML 29 GAUGE X 1/2"
- VERIFINE INSULIN SYRINGE 0.5 ML 31 GAUGE X 5/16"
- VERIFINE INSULIN SYRINGE 1 ML 29 GAUGE X 1/2"
- VERIFINE INSULIN SYRINGE 1 ML 31 GAUGE X 5/16"
- VERIFINE PEN NEEDLE 29 GAUGE X 1/2"
- VERIFINE PEN NEEDLE 31 GAUGE X 1/4"
- VERIFINE PEN NEEDLE 31 GAUGE X 3/16"
- VERIFINE PEN NEEDLE 31 GAUGE X 5/16"
- VERIFINE PEN NEEDLE 32 GAUGE X 1/4"
- VERIFINE PEN NEEDLE 32 GAUGE X 3/16"
- VERIFINE PEN NEEDLE 32 GAUGE X 5/32"
- VERIFINE PLUS PEN NEEDLE 31 GAUGE X 3/16"
- VERIFINE PLUS PEN NEEDLE 31 GAUGE X 5/16"
- VERIFINE PLUS PEN NEEDLE 32 GAUGE X 5/32"
- VERIFINE PLUS PEN NEEDLE-SHARPS CONTAINER 32 GAUGE X 5/32"
- VERSALON 2" X 2" SPONGE
- WEBCOL TOPICAL PADS

Details

Criteria	IN ORDER TO ASSIST IN PAYMENT DETERMINATION, A PRIOR CLAIM SEEN FOR AN INJECTABLE INSULIN WITHIN THE PAST 120 DAYS WILL QUALIFY FOR PART D PAYMENT.
----------	---

IVABRADINE

Products Affected

Step 2:

- *ivabradine 5 mg tablet*
- *ivabradine 7.5 mg tablet*

Details

Criteria	PRIOR CLAIM FOR GENERIC FORMULARY VERSION OF BISOPROLOL, CARVEDILOL, OR METOPROLOL SUCCINATE WITHIN THE PAST 120 DAYS.
----------	--

KLISYRI

Products Affected

Step 2:

- KLISYRI 1 % (250 MG) TOPICAL OINTMENT IN PACKET

Details

Criteria	PRIOR CLAIM FOR GENERIC TOPICAL FLUOROURACIL IN THE LAST 120 DAYS.
----------	--

LEVOMILNACIPRAN

Products Affected

Step 2:

- FETZIMA 120 MG CAPSULE,EXTENDED RELEASE
- FETZIMA 20 MG (2)-40 MG (26) CAPSULE,EXTENDED RELEASE,24 HR,DOSE PACK
- FETZIMA 20 MG CAPSULE,EXTENDED RELEASE
- FETZIMA 40 MG CAPSULE,EXTENDED RELEASE
- FETZIMA 80 MG CAPSULE,EXTENDED RELEASE

Details

Criteria	PRIOR CLAIM FOR TRINTELLIX AND 1 GENERIC ANTIDEPRESSANT: BUPROPION, CITALOPRAM, ESCITALOPRAM, FLUOXETINE, MIRTAZAPINE, PAROXETINE, SERTRALINE, VENLAFAXINE, or VILAZODONE IN THE PAST 365 DAYS
----------	--

LUMATEPERONE TOSYLATE

Products Affected

Step 2:

- CAPLYTA 10.5 MG CAPSULE
- CAPLYTA 21 MG CAPSULE
- CAPLYTA 42 MG CAPSULE

Details

Criteria	CLAIM FOR 2 FORMULARY ORAL GENERIC ANTIPSYCHOTICS: LURASIDONE, RISPERIDONE, OLANZAPINE, IMMEDIATE RELEASE QUETIAPINE FUMARATE, ZIPRASIDONE, ARIPRAZOLE, ASENAPINE WITHIN THE PAST 365 DAYS
----------	---

MEMANTINE ER

Products Affected

Step 2:

- *memantine 14 mg capsule sprinkle, extended release 24hr*
- *memantine 21 mg capsule sprinkle, extended release 24hr*
- *memantine 28 mg capsule sprinkle, extended release 24hr*
- *memantine 7 mg capsule sprinkle, extended release 24hr*

Details

Criteria	PRIOR CLAIM FOR FORMULARY VERSION OF MEMANTINE IR WITHIN THE PAST 120 DAYS
----------	---

MILSAPERIDONE

Products Affected

Step 2:

- BYSANTI 1 MG TABLET
- BYSANTI 10 MG TABLET
- BYSANTI 12 MG TABLET
- BYSANTI 2 MG TABLET
- BYSANTI 4 MG TABLET
- BYSANTI 6 MG TABLET
- BYSANTI 8 MG TABLET
- BYSANTI TITRATION PACK A 1MG(2)-2 MG(2)-4MG(2)-6 MG(2) TABLET PK
- BYSANTI TITRATION PACK B 1MG(6)-2MG(2)-6MG(2)-8MG(2) TABLET PK
- BYSANTI TITRATION PACK C 1 MG (4)-2 MG (2)-6 MG (2) TABLET PK

Details

Criteria	CLAIM FOR 1 GEN ATYPICAL ANTIPSYCHOTIC (LURASIDONE, RISPERIDONE, OLANZAPINE, QUETIAPINE FUMARATE IR, ZIPRASIDONE, ARIPIPRAZOLE, ASENAPINE) AND 1 PREF AGENT: VRAYLAR, REXULTI, OR LYBALVI IN LAST 365 D
----------	---

NICOTINE OTC

Products Affected

Step 2:

- NICOTROL NS 10 MG/ML NASAL SPRAY

Details

Criteria	PRIOR CLAIMS FOR OTC NICOTINE GUM OR LOZENGE AND OTC NICOTINE PATCHES IN THE PAST 365 DAYS
----------	--

OPHTHALMIC ALLERGY - OTC

Products Affected

Step 2:

- *loteprednol etabonate 0.2 % eye drops,suspension*

Details

Criteria	PRIOR CLAIM FOR ONE OF THE FOLLOWING: OTC LORATADINE, OTC LORATADINE D, OTC CETIRIZINE, OTC CETIRIZINE D, OTC FEXOFENADINE, OTC FEXOFENADINE D, OTC LEVOCETIRIZINE, OTC OLOPATADINE, OTC GENERIC KETOTIFEN EYE DROPS 0.025%, LEVOCETIRIZINE, CROMOLYN SODIUM, OR EPINASTINE WITHIN THE PAST 120 DAYS.
----------	---

PERAMPANEL

Products Affected

Step 2:

- *perampanel 0.5 mg/ml oral suspension*
- *perampanel 10 mg tablet*
- *perampanel 12 mg tablet*
- *perampanel 2 mg tablet*
- *perampanel 4 mg tablet*
- *perampanel 6 mg tablet*
- *perampanel 8 mg tablet*

Details

Criteria	PRIOR CLAIM FOR 2 GENERIC ANTICONVULSANT AGENTS (CARBAMAZEPINE, DIVALPROEX SODIUM, GABAPENTIN, LAMOTRIGINE, LEVETIRACETAM, OXCARBAZEPINE, TIAGABINE, TOPIRAMATE, VALPROIC ACID, ZONISAMIDE OR LACOSAMIDE), WITHIN THE PAST 365 DAYS.
----------	--

RUFINAMIDE

Products Affected

Step 2:

- *rufinamide 200 mg tablet*
- *rufinamide 40 mg/ml oral suspension*
- *rufinamide 400 mg tablet*

Details

Criteria	PRIOR CLAIM FOR GENERIC ANTICONVULSANT AGENT (CARBAMAZEPINE, DIVALPROEX SODIUM, GABAPENTIN, LAMOTRIGINE, LEVETIRACETAM, OXCARBAZEPINE, TIAGABINE, TOPIRAMATE, VALPROIC ACID, OR ZONISAMIDE), WITHIN THE PAST 120 DAYS.
----------	--

SELEGILINE PATCH

Products Affected

Step 2:

- EMSAM 12 MG/24 HR TRANSDERMAL 24 HOUR PATCH
- EMSAM 6 MG/24 HR TRANSDERMAL 24 HOUR PATCH
- EMSAM 9 MG/24 HR TRANSDERMAL 24 HOUR PATCH

Details

Criteria	PRIOR CLAIM OF FORMULARY ORAL VERSION OF SSRI (CITALOPRAM, ESCITALOPRAM, FLUOXETINE, PAROXETINE OR SERTRALINE), SNRI (DESVENLAFAXINE, DULOXETINE OR VENLAFAXINE), MIRTAZAPINE, OR BUPROPION IR/SR/XL IN THE PAST 120 DAYS
----------	---

SPRITAM

Products Affected

Step 2:

- *levetiracetam 250 mg tablet for oral suspension*
- *levetiracetam 500 mg tablet for oral suspension*
- SPRITAM 1,000 MG TABLET FOR ORAL SUSPENSION
- SPRITAM 750 MG TABLET FOR ORAL SUSPENSION

Details

Criteria	PRIOR CLAIM FOR GENERIC LEVETIRACETAM SOLUTION IN THE PAST 120 DAYS
----------	---

TOPIRAMATE SOLUTION

Products Affected

Step 2:

- *topiramate 25 mg/ml oral solution*

Details

Criteria	PRIOR CLAIM FOR GENERIC TOPIRAMATE (TABLETS OR CAPSULES) WITHIN THE PAST 120 DAYS.
----------	--

XANOMELINE/TROSPIUM

Products Affected

Step 2:

- COBENFY 100 MG-20 MG CAPSULE
- COBENFY 125 MG-30 MG CAPSULE
- COBENFY 50 MG-20 MG CAPSULE
- COBENFY STARTER PACK 50 MG-20 MG/100 MG-20 MG CAPSULES IN A DOSE PACK

Details

Criteria	CLAIM FOR ONE FORMULARY ORAL ANTIPSYCHOTIC: LURASIDONE, RISPERIDONE, CLOZAPINE TAB, OLANZAPINE, IR QUETIAPINE FUMARATE, ZIPRASIDONE, ARIPIPRAZOLE, ASENAPINE, PALIPERIDONE WITHIN THE PAST 120 DAYS
----------	--

INDEX

1ST TIER UNIFINE PENTIPS 31 GAUGE X 1/4" NEEDLE.....	11	ASSURE ID DUO-SHIELD 30 GAUGE X 3/16" NEEDLE.....	11
1ST TIER UNIFINE PENTIPS 31 GAUGE X 3/16" NEEDLE.....	11	ASSURE ID DUO-SHIELD 30 GAUGE X 5/16" NEEDLE.....	11
1ST TIER UNIFINE PENTIPS 31 GAUGE X 5/16" NEEDLE.....	11	ASSURE ID INSULIN SAFETY 0.5 ML 31 GAUGE X 15/64" SYRINGE.....	11
1ST TIER UNIFINE PENTIPS 32 GAUGE X 5/32" NEEDLE.....	11	ASSURE ID INSULIN SAFETY 1 ML 29 GAUGE X 1/2" SYRINGE.....	11
1ST TIER UNIFINE PENTIPS PLUS 29 GAUGE X 1/2" NEEDLE.....	11	ASSURE ID INSULIN SAFETY 1 ML 31 GAUGE X 15/64" SYRINGE.....	11
1ST TIER UNIFINE PENTIPS PLUS 31 GAUGE X 3/16" NEEDLE.....	11	ASSURE ID PEN NEEDLE 30 GAUGE X 5/16".....	11
1ST TIER UNIFINE PENTIPS PLUS 32 GAUGE X 5/32" NEEDLE.....	11	ASSURE ID PRO PEN NEEDLE 30 GAUGE X 3/16".....	11
ADVOCATE PEN NEEDLE 31 GAUGE X 3/16".....	11	BD ALCOHOL SWABS.....	11
ADVOCATE PEN NEEDLE 31 GAUGE X 5/16".....	11	BD AUTOSHIELD DUO PEN NEEDLE 30 GAUGE X 3/16".....	11
ADVOCATE PEN NEEDLE 32 GAUGE X 5/32".....	11	BD ECLIPSE LUER-LOK 1 ML 30 GAUGE X 1/2" SYRINGE.....	11
ADVOCATE PEN NEEDLE 33 GAUGE X 5/32".....	11	BD INSULIN SYRINGE 1 ML 27 GAUGE X 1/2".....	11
ADVOCATE SYRINGES 0.3 ML 30 GAUGE X 5/16".....	11	BD INSULIN SYRINGE ULTRA-FINE (HALF UNIT) 0.3 ML 31 GAUGE X 5/16".....	11
ADVOCATE SYRINGES 0.3 ML 31 GAUGE X 5/16".....	11	BD INSULIN SYRINGE ULTRA-FINE 0.3 ML 30 GAUGE X 1/2".....	11
ADVOCATE SYRINGES 0.5 ML 30 GAUGE X 5/16".....	11	BD INSULIN SYRINGE ULTRA-FINE 0.5 ML 30 GAUGE X 1/2".....	11
ADVOCATE SYRINGES 0.5 ML 31 GAUGE X 5/16".....	11	BD SAFETYGLIDE INSULIN SYRINGE 0.3 ML 29 GAUGE X 1/2".....	11
ADVOCATE SYRINGES 1 ML 30 GAUGE X 5/16".....	11	BD SAFETYGLIDE INSULIN SYRINGE 0.3 ML 31 GAUGE X 15/64".....	11
ADVOCATE SYRINGES 1 ML 31 GAUGE X 5/16".....	11	BD SAFETYGLIDE INSULIN SYRINGE 0.3 ML 31 GAUGE X 5/16".....	11
ALCOHOL PADS.....	11	BD SAFETYGLIDE INSULIN SYRINGE 0.5 ML 29 GAUGE X 1/2".....	11
ALCOHOL PREP PADS.....	11	BD SAFETYGLIDE INSULIN SYRINGE 0.5 ML 30 GAUGE X 5/16".....	11
ALCOHOL SWABS.....	11	BD SAFETYGLIDE INSULIN SYRINGE 0.5 ML 31 GAUGE X 15/64".....	11
ALCOHOL WIPES.....	11	BD SAFETYGLIDE INSULIN SYRINGE 1 ML 29 GAUGE X 1/2".....	11
AQINJECT PEN NEEDLE 31 GAUGE X 3/16".....	11	BD SAFETYGLIDE INSULIN SYRINGE 1 ML 31 GAUGE X 15/64".....	11
AQINJECT PEN NEEDLE 32 GAUGE X 5/32".....	11	BD SAFETYGLIDE SYRINGE 1 ML 27 GAUGE X 5/8".....	11
<i>aripiprazole 10 mg disintegrating tablet.....</i>	<i>2</i>		
<i>aripiprazole 15 mg disintegrating tablet.....</i>	<i>2</i>		
ASSURE ID DUO PRO SAFETY PEN NEEDLE 31 GAUGE X 3/16".....	11		

BD ULTRA-FINE MICRO PEN NEEDLE 32 GAUGE X 1/4"	11	CAREFINE PEN NEEDLE 32 GAUGE X 1/4"	11
BD ULTRA-FINE MINI PEN NEEDLE 31 GAUGE X 3/16"	11	CAREFINE PEN NEEDLE 32 GAUGE X 3/16"	11
BD ULTRA-FINE NANO PEN NEEDLE 32 GAUGE X 5/32"	11	CAREFINE PEN NEEDLE 32 GAUGE X 5/32"	11
BD ULTRA-FINE ORIGINAL PEN NEEDLE 29 GAUGE X 1/2"	11	CARETOUCH ALCOHOL PREP PAD TOPICAL PADS	11
BD ULTRA-FINE SHORT PEN NEEDLE 31 GAUGE X 5/16"	11	CARETOUCH INSULIN SYRINGE 0.3 ML 31 GAUGE X 5/16"	11
BD VEO INSULIN SYRINGE ULTRA- FINE (HALF UNIT) 0.3 ML 31 GAUGE X 15/64"	11	CARETOUCH INSULIN SYRINGE 0.5 ML 30 GAUGE X 5/16"	11
BD VEO INSULIN SYRINGE ULTRA- FINE 0.3 ML 31 GAUGE X 15/64"	11	CARETOUCH INSULIN SYRINGE 0.5 ML 31 GAUGE X 5/16"	11
BD VEO INSULIN SYRINGE ULTRA- FINE 1 ML 31 GAUGE X 15/64"	11	CARETOUCH INSULIN SYRINGE 1 ML 28 GAUGE X 5/16"	11
BD VEO INSULIN SYRINGE ULTRA- FINE 1/2 ML 31 GAUGE X 15/64"	11	CARETOUCH INSULIN SYRINGE 1 ML 29 GAUGE X 5/16"	11
BORDERED GAUZE 2" X 2" BANDAGE	11	CARETOUCH INSULIN SYRINGE 1 ML 30 GAUGE X 5/16"	11
BYSANTI 1 MG TABLET	33	CARETOUCH INSULIN SYRINGE 1 ML 31 GAUGE X 5/16"	11
BYSANTI 10 MG TABLET	33	CARETOUCH PEN NEEDLE 29 GAUGE X 1/2"	11
BYSANTI 12 MG TABLET	33	CARETOUCH PEN NEEDLE 31 GAUGE X 1/4"	11
BYSANTI 2 MG TABLET	33	CARETOUCH PEN NEEDLE 31 GAUGE X 3/16"	11
BYSANTI 4 MG TABLET	33	CARETOUCH PEN NEEDLE 31 GAUGE X 5/16"	11
BYSANTI 6 MG TABLET	33	CARETOUCH PEN NEEDLE 32 GAUGE X 3/16"	11
BYSANTI 8 MG TABLET	33	CARETOUCH PEN NEEDLE 32 GAUGE X 5/32"	11
BYSANTI TITRATION PACK A 1MG(2)-2 MG(2)-4MG(2)-6 MG(2) TABLET PK	33	CLICKFINE PEN NEEDLE 31 GAUGE X 1/4"	11
BYSANTI TITRATION PACK B 1MG(6)-2MG(2)-6MG(2)-8MG(2) TABLET PK	33	CLICKFINE PEN NEEDLE 32 GAUGE X 5/32"	11
BYSANTI TITRATION PACK C 1 MG (4)-2 MG (2)-6 MG (2) TABLET PK	33	<i>clozapine 100 mg disintegrating tablet</i>	5
CAPLYTA 10.5 MG CAPSULE	31	<i>clozapine 12.5 mg disintegrating tablet</i>	5
CAPLYTA 21 MG CAPSULE	31	<i>clozapine 150 mg disintegrating tablet</i>	5
CAPLYTA 42 MG CAPSULE	31	<i>clozapine 200 mg disintegrating tablet</i>	5
CAREFINE PEN NEEDLE 29 GAUGE X 1/2"	11	<i>clozapine 25 mg disintegrating tablet</i>	5
CAREFINE PEN NEEDLE 30 GAUGE X 5/16"	11	COBENFY 100 MG-20 MG CAPSULE	41
CAREFINE PEN NEEDLE 31 GAUGE X 1/4"	11	COBENFY 125 MG-30 MG CAPSULE	41
CAREFINE PEN NEEDLE 31 GAUGE X 5/16"	11	COBENFY 50 MG-20 MG CAPSULE	41

COBENFY STARTER PACK 50 MG-20 MG/100 MG-20 MG CAPSULES IN A DOSE PACK.....	41	COMFORT EZ PEN NEEDLES 32 GAUGE X 1/4"	11
COMFORT EZ INSULIN SYRINGE 0.3 ML 29 GAUGE X 1/2"	11	COMFORT EZ PEN NEEDLES 32 GAUGE X 3/16"	11
COMFORT EZ INSULIN SYRINGE 0.3 ML 30 GAUGE X 1/2"	11	COMFORT EZ PEN NEEDLES 32 GAUGE X 5/16"	11
COMFORT EZ INSULIN SYRINGE 0.3 ML 30 GAUGE X 5/16"	11	COMFORT EZ PEN NEEDLES 32 GAUGE X 5/32"	11
COMFORT EZ INSULIN SYRINGE 0.3 ML 31 GAUGE X 15/64"	11	COMFORT EZ PEN NEEDLES 33 GAUGE X 1/4"	11
COMFORT EZ INSULIN SYRINGE 0.3 ML 31 GAUGE X 5/16"	11	COMFORT EZ PEN NEEDLES 33 GAUGE X 3/16"	11
COMFORT EZ INSULIN SYRINGE 0.5 ML 29 GAUGE X 1/2"	11	COMFORT EZ PEN NEEDLES 33 GAUGE X 5/16"	11
COMFORT EZ INSULIN SYRINGE 0.5 ML 30 GAUGE X 1/2"	11	COMFORT EZ PEN NEEDLES 33 GAUGE X 5/32"	11
COMFORT EZ INSULIN SYRINGE 0.5 ML 30 GAUGE X 5/16"	11	COMFORT EZ PRO SAFETY PEN NEEDLE 30 GAUGE X 5/16"	11
COMFORT EZ INSULIN SYRINGE 0.5 ML 31 GAUGE X 5/16"	11	COMFORT EZ PRO SAFETY PEN NEEDLE 31 GAUGE X 3/16"	11
COMFORT EZ INSULIN SYRINGE 1 ML 27 GAUGE X 1/2"	11	COMFORT EZ PRO SAFETY PEN NEEDLE 31 GAUGE X 5/32"	11
COMFORT EZ INSULIN SYRINGE 1 ML 28 GAUGE X 1/2"	11	COMFORT TOUCH PEN NEEDLE 31 GAUGE X 1/4"	11
COMFORT EZ INSULIN SYRINGE 1 ML 29 GAUGE X 1/2"	11	COMFORT TOUCH PEN NEEDLE 31 GAUGE X 3/16"	11
COMFORT EZ INSULIN SYRINGE 1 ML 30 GAUGE X 1/2"	11	COMFORT TOUCH PEN NEEDLE 31 GAUGE X 5/16"	11
COMFORT EZ INSULIN SYRINGE 1 ML 30 GAUGE X 5/16"	11	COMFORT TOUCH PEN NEEDLE 31 GAUGE X 5/32"	11
COMFORT EZ INSULIN SYRINGE 1 ML 31 GAUGE X 15/64"	11	COMFORT TOUCH PEN NEEDLE 32 GAUGE X 1/4"	11
COMFORT EZ INSULIN SYRINGE 1 ML 31 GAUGE X 5/16"	11	COMFORT TOUCH PEN NEEDLE 32 GAUGE X 3/16"	11
COMFORT EZ INSULIN SYRINGE 1/2 ML 28 GAUGE X 1/2"	11	COMFORT TOUCH PEN NEEDLE 32 GAUGE X 5/16"	11
COMFORT EZ INSULIN SYRINGE 1/2 ML 31 GAUGE X 15/64"	11	COMFORT TOUCH PEN NEEDLE 32 GAUGE X 5/32"	11
COMFORT EZ PEN NEEDLES 29 GAUGE X 1/2"	11	COMFORT TOUCH PEN NEEDLE 33 GAUGE X 1/4"	11
COMFORT EZ PEN NEEDLES 31 GAUGE X 1/4"	11	COMFORT TOUCH PEN NEEDLE 33 GAUGE X 3/16"	11
COMFORT EZ PEN NEEDLES 31 GAUGE X 3/16"	11	COMFORT TOUCH PEN NEEDLE 33 GAUGE X 5/32"	11
COMFORT EZ PEN NEEDLES 31 GAUGE X 5/16"	11	CURITY ALCOHOL SWABS.....	11
		CURITY GAUZE 2" X 2" BANDAGE.....	11
		CURITY GAUZE 2" X 2" SPONGE.....	11

<i>cyclophosphamide 25 mg capsule</i>	4	DROPLET INSULIN SYRINGE 0.3 ML	
<i>cyclophosphamide 25 mg tablet</i>	4	31 GAUGE X 15/64".....	11
<i>cyclophosphamide 50 mg capsule</i>	4	DROPLET INSULIN SYRINGE 0.3 ML	
<i>cyclophosphamide 50 mg tablet</i>	4	31 GAUGE X 5/16".....	11
DERMACEA 2" X 2" BANDAGE.....	11	DROPLET INSULIN SYRINGE 0.5 ML	
DERMACEA 2" X 2" SPONGE.....	11	29 GAUGE X 1/2".....	11
DERMACEA NON-WOVEN 2" X 2"		DROPLET INSULIN SYRINGE 0.5 ML	
SPONGE.....	11	30 GAUGE X 1/2".....	11
DRIZALMA SPRINKLE 20 MG		DROPLET INSULIN SYRINGE 0.5 ML	
CAPSULE,DELAYED RELEASE.....	6	30 GAUGE X 5/16".....	11
DRIZALMA SPRINKLE 30 MG		DROPLET INSULIN SYRINGE 0.5 ML	
CAPSULE,DELAYED RELEASE.....	6	31 GAUGE X 5/16".....	11
DRIZALMA SPRINKLE 40 MG		DROPLET INSULIN SYRINGE 1 ML 29	
CAPSULE,DELAYED RELEASE.....	6	GAUGE X 1/2".....	11
DRIZALMA SPRINKLE 60 MG		DROPLET INSULIN SYRINGE 1 ML 30	
CAPSULE,DELAYED RELEASE.....	6	GAUGE X 1/2".....	11
DROPLET INSULIN SYRINGE (HALF		DROPLET INSULIN SYRINGE 1 ML 30	
UNIT) 0.3 ML 29 GAUGE X 1/2".....	11	GAUGE X 15/64".....	11
DROPLET INSULIN SYRINGE (HALF		DROPLET INSULIN SYRINGE 1 ML 30	
UNIT) 0.3 ML 30 GAUGE X 1/2".....	11	GAUGE X 5/16".....	11
DROPLET INSULIN SYRINGE (HALF		DROPLET INSULIN SYRINGE 1 ML 31	
UNIT) 0.3 ML 30 GAUGE X 5/16".....	11	GAUGE X 15/64".....	11
DROPLET INSULIN SYRINGE (HALF		DROPLET INSULIN SYRINGE 1 ML 31	
UNIT) 0.3 ML 31 GAUGE X 15/64".....	11	GAUGE X 5/16".....	11
DROPLET INSULIN SYRINGE (HALF		DROPLET INSULIN SYRINGE 1/2 ML	
UNIT) 0.3 ML 31 GAUGE X 5/16".....	11	31 GAUGE X 15/64".....	11
DROPLET INSULIN SYRINGE (HALF		DROPLET MICRON PEN NEEDLE 34	
UNIT) 0.5 ML 29 GAUGE X 1/2".....	11	GAUGE X 9/64".....	11
DROPLET INSULIN SYRINGE (HALF		DROPLET PEN NEEDLE 29 GAUGE X	
UNIT) 0.5 ML 30 GAUGE X 1/2".....	11	1/2".....	11
DROPLET INSULIN SYRINGE (HALF		DROPLET PEN NEEDLE 29 GAUGE X	
UNIT) 0.5 ML 30 GAUGE X 15/64".....	11	3/8".....	11
DROPLET INSULIN SYRINGE (HALF		DROPLET PEN NEEDLE 30 GAUGE X	
UNIT) 0.5 ML 30 GAUGE X 5/16".....	11	5/16".....	11
DROPLET INSULIN SYRINGE (HALF		DROPLET PEN NEEDLE 31 GAUGE X	
UNIT) 0.5 ML 31 GAUGE X 15/64".....	11	1/4".....	11
DROPLET INSULIN SYRINGE (HALF		DROPLET PEN NEEDLE 31 GAUGE X	
UNIT) 0.5 ML 31 GAUGE X 5/16".....	11	3/16".....	11
DROPLET INSULIN SYRINGE 0.3 ML		DROPLET PEN NEEDLE 31 GAUGE X	
29 GAUGE X 1/2".....	11	5/16".....	11
DROPLET INSULIN SYRINGE 0.3 ML		DROPLET PEN NEEDLE 32 GAUGE X	
30 GAUGE X 1/2".....	11	1/4".....	11
DROPLET INSULIN SYRINGE 0.3 ML		DROPLET PEN NEEDLE 32 GAUGE X	
30 GAUGE X 15/64".....	11	3/16".....	11
DROPLET INSULIN SYRINGE 0.3 ML		DROPLET PEN NEEDLE 32 GAUGE X	
30 GAUGE X 5/16".....	11	5/16".....	11

DROPLET PEN NEEDLE 32 GAUGE X 5/32"	11	EASY COMFORT INSULIN SYRINGE 1/2 ML 29 X 5/16"	11
DROPSAFE ALCOHOL PREP PADS	11	EASY COMFORT INSULIN SYRINGE 1/2 ML 32 GAUGE X 5/16"	11
DROPSAFE INSULIN SYRINGE 0.3 ML 31 GAUGE X 15/64"	11	EASY COMFORT PEN NEEDLES 29 GAUGE X 3/16"	11
DROPSAFE INSULIN SYRINGE 0.3 ML 31 GAUGE X 5/16"	11	EASY COMFORT PEN NEEDLES 29 GAUGE X 5/32"	11
DROPSAFE INSULIN SYRINGE 0.5 ML 31 GAUGE X 15/64"	11	EASY COMFORT PEN NEEDLES 31 GAUGE X 1/4"	11
DROPSAFE INSULIN SYRINGE 0.5 ML 31 GAUGE X 5/16"	11	EASY COMFORT PEN NEEDLES 31 GAUGE X 3/16"	11
DROPSAFE INSULIN SYRINGE 1 ML 29 GAUGE X 1/2"	11	EASY COMFORT PEN NEEDLES 31 GAUGE X 5/16"	11
DROPSAFE INSULIN SYRINGE 1 ML 31 GAUGE X 15/64"	11	EASY COMFORT PEN NEEDLES 32 GAUGE X 5/32"	11
DROPSAFE INSULIN SYRINGE 1 ML 31 GAUGE X 5/16"	11	EASY COMFORT PEN NEEDLES 33 GAUGE X 1/4"	11
DROPSAFE PEN NEEDLE 31 GAUGE X 1/4"	11	EASY COMFORT PEN NEEDLES 33 GAUGE X 3/16"	11
DROPSAFE PEN NEEDLE 31 GAUGE X 3/16"	11	EASY COMFORT PEN NEEDLES 33 GAUGE X 5/32"	11
DROPSAFE PEN NEEDLE 31 GAUGE X 5/16"	11	EASY COMFORT SAFETY PEN NEEDLE 31 GAUGE X 1/4"	11
DROPSAFE PEN NEEDLE 31 GAUGE X 5/32"	11	EASY COMFORT SAFETY PEN NEEDLE 31 GAUGE X 3/16"	11
EASY COMFORT ALCOHOL PAD TOPICAL PADS	11	EASY COMFORT SAFETY PEN NEEDLE 32 GAUGE X 5/32"	11
EASY COMFORT INSULIN SYRINGE 0.3 ML 31 GAUGE X 5/16"	11	EASY GLIDE INSULIN SYRINGE 0.3 ML 31 GAUGE X 15/64"	11
EASY COMFORT INSULIN SYRINGE 0.3 ML 31 X 1/2"	11	EASY GLIDE INSULIN SYRINGE 1 ML 31 GAUGE X 15/64"	11
EASY COMFORT INSULIN SYRINGE 0.5 ML 30 GAUGE X 1/2"	11	EASY GLIDE INSULIN SYRINGE 1/2 ML 31 GAUGE X 15/64"	11
EASY COMFORT INSULIN SYRINGE 0.5 ML 30 GAUGE X 5/16"	11	EASY GLIDE PEN NEEDLE 33 GAUGE X 5/32"	11
EASY COMFORT INSULIN SYRINGE 0.5 ML 31 GAUGE X 5/16"	11	EASY TOUCH 29 GAUGE X 1/2" NEEDLE	11
EASY COMFORT INSULIN SYRINGE 1 ML 29 GAUGE X 5/16"	11	EASY TOUCH 31 GAUGE X 1/4" NEEDLE	11
EASY COMFORT INSULIN SYRINGE 1 ML 30 GAUGE X 1/2"	11	EASY TOUCH 31 GAUGE X 3/16" NEEDLE	11
EASY COMFORT INSULIN SYRINGE 1 ML 30 GAUGE X 5/16"	11	EASY TOUCH 31 GAUGE X 5/16" NEEDLE	11
EASY COMFORT INSULIN SYRINGE 1 ML 31 GAUGE X 5/16"	11	EASY TOUCH 32 GAUGE X 1/4" NEEDLE	11
EASY COMFORT INSULIN SYRINGE 1 ML 32 GAUGE X 5/16"	11		

EASY TOUCH 32 GAUGE X 3/16" NEEDLE.....	11	EASY TOUCH INSULIN SYRINGE 0.5 ML 30 GAUGE X 1/2"	11
EASY TOUCH 32 GAUGE X 5/32" NEEDLE.....	11	EASY TOUCH INSULIN SYRINGE 0.5 ML 30 GAUGE X 5/16"	11
EASY TOUCH ALCOHOL PREP PADS...	11	EASY TOUCH INSULIN SYRINGE 0.5 ML 31 GAUGE X 5/16"	11
EASY TOUCH AUTORETRACT SYRINGE 0.5 ML 30 GAUGE X 1/4"	11	EASY TOUCH INSULIN SYRINGE 1 ML 27 GAUGE X 1/2"	11
EASY TOUCH AUTORETRACT SYRINGE 0.5 ML 30 GAUGE X 5/16"	11	EASY TOUCH INSULIN SYRINGE 1 ML 27 GAUGE X 5/8"	11
EASY TOUCH AUTORETRACT SYRINGE 1 ML 30 GAUGE X 1/4"	11	EASY TOUCH INSULIN SYRINGE 1 ML 28 GAUGE X 1/2"	11
EASY TOUCH AUTORETRACT SYRINGE 1 ML 30 GAUGE X 5/16"	11	EASY TOUCH INSULIN SYRINGE 1 ML 29 GAUGE X 1/2"	11
EASY TOUCH FLIPLOCK INSULIN 1 ML 29 GAUGE X 1/2" SYRINGE.....	11	EASY TOUCH INSULIN SYRINGE 1 ML 30 GAUGE X 1/2"	11
EASY TOUCH FLIPLOCK INSULIN 1 ML 31 GAUGE X 5/16" SYRINGE.....	11	EASY TOUCH INSULIN SYRINGE 1 ML 30 GAUGE X 5/16"	11
EASY TOUCH FLIPLOCK INSULIN SYRINGE 1 ML 30 GAUGE X 1/2"	11	EASY TOUCH INSULIN SYRINGE 1 ML 31 GAUGE X 1/4"	11
EASY TOUCH FLIPLOCK INSULIN SYRINGE 1 ML 30 GAUGE X 5/16"	11	EASY TOUCH INSULIN SYRINGE 1 ML 31 GAUGE X 5/16"	11
EASY TOUCH FLIPLOCK SYRINGE 1 ML 27 GAUGE X 1/2"	11	EASY TOUCH INSULIN SYRINGE 1/2 ML 27 GAUGE X 1/2"	11
EASY TOUCH INSULIN SAFETY SYRINGE 0.5 ML 29 GAUGE X 1/2"	11	EASY TOUCH INSULIN SYRINGE 1/2 ML 28 GAUGE X 1/2"	11
EASY TOUCH INSULIN SAFETY SYRINGE 0.5 ML 30 GAUGE X 5/16"	11	EASY TOUCH INSULIN SYRINGE 1/2 ML 31 GAUGE X 1/4"	11
EASY TOUCH INSULIN SAFETY SYRINGE 1 ML 29 GAUGE X 1/2"	11	EASY TOUCH LUER LOCK INSULIN 1 ML SYRINGE.....	11
EASY TOUCH INSULIN SAFETY SYRINGE 1 ML 30 GAUGE X 1/2"	11	EASY TOUCH PEN NEEDLE 30 GAUGE X 5/16"	11
EASY TOUCH INSULIN SYRINGE (HALF UNIT) 0.3 ML 30 GAUGE X 5/16"	11	EASY TOUCH SAFETY PEN NEEDLE 29 GAUGE X 3/16"	11
EASY TOUCH INSULIN SYRINGE (HALF UNIT) 0.3 ML 31 GAUGE X 1/4" ..	11	EASY TOUCH SAFETY PEN NEEDLE 29 GAUGE X 5/16"	11
EASY TOUCH INSULIN SYRINGE (HALF UNIT) 0.3 ML 31 GAUGE X 5/16"	11	EASY TOUCH SAFETY PEN NEEDLE 30 GAUGE X 1/4"	11
EASY TOUCH INSULIN SYRINGE 0.3 ML 30 GAUGE X 1/2"	11	EASY TOUCH SAFETY PEN NEEDLE 30 GAUGE X 3/16"	11
EASY TOUCH INSULIN SYRINGE 0.3 ML 30 GAUGE X 5/16"	11	EASY TOUCH SAFETY PEN NEEDLE 30 GAUGE X 5/16"	11
EASY TOUCH INSULIN SYRINGE 0.3 ML 31 GAUGE X 5/16"	11	EASY TOUCH SHEATHLOCK INSULIN 1 ML 29 GAUGE X 1/2" SYRINGE.....	11
EASY TOUCH INSULIN SYRINGE 0.5 ML 29 GAUGE X 1/2"	11	EASY TOUCH SHEATHLOCK INSULIN 1 ML 30 GAUGE X 5/16" SYRINGE.....	11

EASY TOUCH SHEATHLOCK INSULIN 1 ML 31 GAUGE X 5/16" SYRINGE.....	11	EMBRACE PEN NEEDLE 30 GAUGE X 3/16"	11
EASY TOUCH SHEATHLOCK INSULIN SYRINGE 1 ML 30 GAUGE X 1/2"	11	EMBRACE PEN NEEDLE 30 GAUGE X 5/16"	11
EASY TOUCH UNI-SLIP 1 ML SYRINGE.....	11	EMBRACE PEN NEEDLE 31 GAUGE X 1/4"	11
EASYLIFE ALCOHOL PADS	11	EMBRACE PEN NEEDLE 31 GAUGE X 3/16"	11
EASYLIFE INSULIN PEN NEEDLE 29 GAUGE X 1/2"	11	EMBRACE PEN NEEDLE 31 GAUGE X 5/16"	11
EASYLIFE INSULIN PEN NEEDLE 31 GAUGE X 1/4"	11	EMBRACE PEN NEEDLE 32 GAUGE X 5/32"	11
EASYLIFE INSULIN PEN NEEDLE 31 GAUGE X 3/16"	11	EMSAM 12 MG/24 HR TRANSDERMAL 24 HOUR PATCH.....	38
EASYLIFE INSULIN PEN NEEDLE 31 GAUGE X 5/16"	11	EMSAM 6 MG/24 HR TRANSDERMAL 24 HOUR PATCH.....	38
EASYLIFE INSULIN PEN NEEDLE 31 GAUGE X 5/32"	11	EMSAM 9 MG/24 HR TRANSDERMAL 24 HOUR PATCH.....	38
EASYLIFE INSULIN PEN NEEDLE 32 GAUGE X 1/4"	11	<i>eslicarbazepine 200 mg tablet</i>	7
EASYLIFE INSULIN PEN NEEDLE 32 GAUGE X 3/16"	11	<i>eslicarbazepine 400 mg tablet</i>	7
EASYLIFE INSULIN PEN NEEDLE 32 GAUGE X 5/16"	11	<i>eslicarbazepine 600 mg tablet</i>	7
EASYLIFE INSULIN PEN NEEDLE 32 GAUGE X 5/32"	11	<i>eslicarbazepine 800 mg tablet</i>	7
EASYLIFE INSULIN PEN NEEDLE 33 GAUGE X 1/4"	11	EXEL INSULIN 0.3 ML 29 GAUGE X 1/2" SYRINGE.....	11
EASYLIFE INSULIN PEN NEEDLE 33 GAUGE X 3/16"	11	FANAPT 1 MG TABLET	10
EASYLIFE INSULIN PEN NEEDLE 33 GAUGE X 5/16"	11	FANAPT 10 MG TABLET	10
EASYLIFE INSULIN PEN NEEDLE 33 GAUGE X 5/32"	11	FANAPT 12 MG TABLET	10
EASYLIFE INSULIN SYRINGE 0.5 ML 30 GAUGE X 5/16"	11	FANAPT 2 MG TABLET	10
EASYLIFE INSULIN SYRINGE 1 ML 30 GAUGE X 1/2"	11	FANAPT 4 MG TABLET	10
EASYLIFE INSULIN SYRINGE 1 ML 30 GAUGE X 5/16"	11	FANAPT 6 MG TABLET	10
EASYLIFE INSULIN SYRINGE 1 ML 31 GAUGE X 5/16"	11	FANAPT 8 MG TABLET	10
EASYLIFE SAFETY PEN NEEDLE 31 GAUGE X 3/16"	11	FANAPT TITRATION PACK A 1 MG (2)-2 MG (2)-4 MG (2)-6 MG (2) TABLETS	10
EASYLIFE SAFETY PEN NEEDLE 31 GAUGE X 5/32"	11	FANAPT TITRATION PACK B 1 MG (6)-2 MG (2)-6 MG (2)-8 MG (2) TABLETS	10
EMBRACE PEN NEEDLE 29 GAUGE X 1/2"	11	FANAPT TITRATION PACK C 1 MG (4)-2 MG (2)-6 MG (2) TABLETS.....	10
		FETZIMA 120 MG CAPSULE,EXTENDED RELEASE	30
		FETZIMA 20 MG (2)-40 MG (26) CAPSULE,EXTENDED RELEASE,24 HR,DOSE PACK.....	30
		FETZIMA 20 MG CAPSULE,EXTENDED RELEASE	30

FETZIMA 40 MG CAPSULE,EXTENDED RELEASE.....	30	INSULIN SYRINGE U-100 WITH NEEDLE 0.3 ML 30.....	11
FETZIMA 80 MG CAPSULE,EXTENDED RELEASE.....	30	INSULIN SYRINGE U-100 WITH NEEDLE 0.3 ML 30 GAUGE X 5/16".....	11
GAUZE BANDAGE 2" X 2".....	11	INSULIN SYRINGE U-100 WITH NEEDLE 0.3 ML 31 GAUGE X 1/4".....	11
GAUZE PAD 2" X 2" BANDAGE.....	11	INSULIN SYRINGE U-100 WITH NEEDLE 0.3 ML 31 GAUGE X 15/64".....	11
HEALTHWISE INSULIN SYRINGE 0.3 ML 30 GAUGE X 5/16".....	11	INSULIN SYRINGE U-100 WITH NEEDLE 0.3 ML 31 GAUGE X 5/16".....	11
HEALTHWISE INSULIN SYRINGE 0.3 ML 31 GAUGE X 5/16".....	11	INSULIN SYRINGE U-100 WITH NEEDLE 0.5 ML 29 GAUGE X 1/2".....	11
HEALTHWISE INSULIN SYRINGE 0.5 ML 30 GAUGE X 5/16".....	11	INSULIN SYRINGE U-100 WITH NEEDLE 0.5 ML 30 GAUGE X 1/2".....	11
HEALTHWISE INSULIN SYRINGE 0.5 ML 31 GAUGE X 5/16".....	11	INSULIN SYRINGE U-100 WITH NEEDLE 0.5 ML 30 GAUGE X 5/16".....	11
HEALTHWISE INSULIN SYRINGE 1 ML 30 GAUGE X 5/16".....	11	INSULIN SYRINGE U-100 WITH NEEDLE 0.5 ML 31 GAUGE X 5/16".....	11
HEALTHWISE INSULIN SYRINGE 1 ML 31 GAUGE X 5/16".....	11	INSULIN SYRINGE U-100 WITH NEEDLE 1 ML 27 GAUGE X 1/2".....	11
HEALTHWISE PEN NEEDLE 31 GAUGE X 3/16".....	11	INSULIN SYRINGE U-100 WITH NEEDLE 1 ML 28 GAUGE X 1/2".....	11
HEALTHWISE PEN NEEDLE 31 GAUGE X 5/16".....	11	INSULIN SYRINGE U-100 WITH NEEDLE 1 ML 29 GAUGE X 1/2".....	11
HEALTHWISE PEN NEEDLE 32 GAUGE X 5/32".....	11	INSULIN SYRINGE U-100 WITH NEEDLE 1 ML 29 GAUGE X 7/16".....	11
HEALTHY ACCENTS UNIFINE PENTIP 29 GAUGE X 1/2" NEEDLE.....	11	INSULIN SYRINGE U-100 WITH NEEDLE 1 ML 30 GAUGE X 1/2".....	11
HEALTHY ACCENTS UNIFINE PENTIP 31 GAUGE X 1/4" NEEDLE.....	11	INSULIN SYRINGE U-100 WITH NEEDLE 1 ML 30 GAUGE X 3/8".....	11
HEALTHY ACCENTS UNIFINE PENTIP 31 GAUGE X 3/16" NEEDLE.....	11	INSULIN SYRINGE U-100 WITH NEEDLE 1 ML 30 GAUGE X 5/16".....	11
HEALTHY ACCENTS UNIFINE PENTIP 31 GAUGE X 5/16" NEEDLE.....	11	INSULIN SYRINGE U-100 WITH NEEDLE 1 ML 30 GAUGE X 7/16".....	11
INCONTROL ALCOHOL PADS.....	11	INSULIN SYRINGE U-100 WITH NEEDLE 1 ML 31 GAUGE X 1/4".....	11
INCONTROL PEN NEEDLE 29 GAUGE X 1/2".....	11	INSULIN SYRINGE U-100 WITH NEEDLE 1 ML 31 GAUGE X 15/64".....	11
INCONTROL PEN NEEDLE 31 GAUGE X 1/4".....	11	INSULIN SYRINGE U-100 WITH NEEDLE 1 ML 31 GAUGE X 5/16".....	11
INCONTROL PEN NEEDLE 31 GAUGE X 3/16".....	11	INSULIN SYRINGE U-100 WITH NEEDLE 1/2 ML 27 GAUGE X 1/2".....	11
INCONTROL PEN NEEDLE 31 GAUGE X 5/16".....	11	INSULIN SYRINGE U-100 WITH NEEDLE 1/2 ML 28 GAUGE.....	11
INCONTROL PEN NEEDLE 32 GAUGE X 5/32".....	11	INSULIN SYRINGE U-100 WITH NEEDLE 1/2 ML 28 GAUGE X 1/2".....	11
INSULIN SYRINGE MICROFINE 1 ML 27 GAUGE X 5/8".....	11		
INSULIN SYRINGE U-100 WITH NEEDLE 0.3 ML 29 GAUGE.....	11		

INSULIN SYRINGE U-100 WITH NEEDLE 1/2 ML 29	11	MAGELLAN SYRINGE 0.5 ML 30 GAUGE X 5/16"	11
INSULIN SYRINGE U-100 WITH NEEDLE 1/2 ML 30 GAUGE	11	MAXICOMFORT II PEN NEEDLE 31 GAUGE X 1/4"	11
INSULIN SYRINGE U-100 WITH NEEDLE 1/2 ML 31 GAUGE X 1/4"	11	MAXICOMFORT INSULIN SYRINGE 1 ML 27 GAUGE X 1/2"	11
INSULIN SYRINGE U-100 WITH NEEDLE 1/2 ML 31 GAUGE X 15/64"	11	MAXI-COMFORT INSULIN SYRINGE 1 ML 28 GAUGE X 1/2"	11
INSULIN SYRINGE-NEEDLE U-100 HALF UNIT MARKING 0.3 ML 31 GAUGE X 1/4"	11	MAXICOMFORT INSULIN SYRINGE 1/2 ML 27 GAUGE X 1/2"	11
INSULIN U-500 SYRINGE-NEEDLE 1/2 ML 31 GAUGE X 15/64"	11	MAXI-COMFORT INSULIN SYRINGE 1/2 ML 28 GAUGE X 1/2"	11
INSUPEN PEN NEEDLE 29 GAUGE X 1/2"	11	MAXICOMFORT SAFETY PEN NEEDLE 29 GAUGE X 3/16"	11
INSUPEN PEN NEEDLE 31 GAUGE X 3/16"	11	MAXICOMFORT SAFETY PEN NEEDLE 29 GAUGE X 5/16"	11
INSUPEN PEN NEEDLE 31 GAUGE X 5/16"	11	<i>memantine 14 mg capsule sprinkle,extended release 24hr</i>	32
INSUPEN PEN NEEDLE 32 GAUGE X 1/4"	11	<i>memantine 21 mg capsule sprinkle,extended release 24hr</i>	32
INSUPEN PEN NEEDLE 32 GAUGE X 5/32"	11	<i>memantine 28 mg capsule sprinkle,extended release 24hr</i>	32
IV PREP WIPES MEDICATED	11	<i>memantine 7 mg capsule sprinkle,extended release 24hr</i>	32
<i>ivabradine 5 mg tablet</i>	28	<i>methotrexate sodium 2.5 mg tablet</i>	4
<i>ivabradine 7.5 mg tablet</i>	28	MICRODOT INSULIN PEN NEEDLE 31 GAUGE X 1/4"	11
JYLAMVO 2 MG/ML ORAL SOLUTION ...	4	MICRODOT INSULIN PEN NEEDLE 32 GAUGE X 5/32"	11
KLISYRI 1 % (250 MG) TOPICAL OINTMENT IN PACKET	29	MICRODOT INSULIN PEN NEEDLE 33 GAUGE X 5/32"	11
<i>levetiracetam 250 mg tablet for oral suspension</i>	39	MICRODOT READYGARD PEN NEEDLE 31 GAUGE X 3/16"	11
<i>levetiracetam 500 mg tablet for oral suspension</i>	39	MINI ULTRA-THIN II 31 GAUGE X 3/16" NEEDLE	11
LISCO 2" X 2" SPONGE	11	MONOJECT INSULIN SAFETY SYRINGE 0.3 ML 30 GAUGE X 5/16"	11
<i>loteprednol etabonate 0.2 % eye drops,suspension</i>	35	MONOJECT INSULIN SAFETY SYRINGE 0.5 ML 29 GAUGE X 1/2"	11
MAGELLAN INSULIN SAFETY SYRINGE 0.3 ML 29 GAUGE X 1/2"	11	MONOJECT INSULIN SAFETY SYRINGE 0.5 ML 30 GAUGE X 5/16"	11
MAGELLAN INSULIN SAFETY SYRINGE 0.5 ML 29 GAUGE X 1/2"	11	MONOJECT INSULIN SAFETY SYRINGE 1 ML 29 GAUGE X 1/2"	11
MAGELLAN INSULIN SAFETY SYRINGE 1 ML 29 GAUGE X 1/2"	11	MONOJECT INSULIN SYRINGE 0.3 ML 29 GAUGE X 1/2"	11
MAGELLAN INSULIN SAFETY SYRINGE 1 ML 30 GAUGE X 5/16"	11	MONOJECT INSULIN SYRINGE 0.3 ML 30 GAUGE X 5/16"	11
MAGELLAN SYRINGE 0.3 ML 30 X 5/16"	11		

MONOJECT INSULIN SYRINGE 0.3 ML 31 GAUGE X 5/16"	11	PEN NEEDLE 31 GAUGE X 3/16"	11
MONOJECT INSULIN SYRINGE 0.5 ML 29 GAUGE X 1/2"	11	PEN NEEDLE 31 GAUGE X 5/16"	11
MONOJECT INSULIN SYRINGE 0.5 ML 30 GAUGE X 5/16"	11	PEN NEEDLE 32 GAUGE X 5/32"	11
MONOJECT INSULIN SYRINGE 0.5 ML 31 GAUGE X 5/16"	11	PEN NEEDLE, DIABETIC 29 GAUGE X 1/2"	11
MONOJECT INSULIN SYRINGE 1 ML.....	11	PEN NEEDLE, DIABETIC 29 GAUGE X 15/32"	11
MONOJECT INSULIN SYRINGE 1 ML 25 GAUGE X 5/8"	11	PEN NEEDLE, DIABETIC 30 GAUGE X 3/16"	11
MONOJECT INSULIN SYRINGE 1 ML 27 GAUGE X 1/2"	11	PEN NEEDLE, DIABETIC 30 GAUGE X 5/16"	11
MONOJECT INSULIN SYRINGE 1 ML 28 GAUGE X 1/2"	11	PEN NEEDLE, DIABETIC 31 GAUGE X 1/3"	11
MONOJECT INSULIN SYRINGE 1 ML 29 GAUGE X 1/2"	11	PEN NEEDLE, DIABETIC 31 GAUGE X 1/4"	11
MONOJECT INSULIN SYRINGE 1 ML 30 GAUGE X 5/16"	11	PEN NEEDLE, DIABETIC 31 GAUGE X 1/6"	11
MONOJECT INSULIN SYRINGE 1 ML 31 GAUGE X 5/16"	11	PEN NEEDLE, DIABETIC 31 GAUGE X 13/64"	11
MONOJECT INSULIN SYRINGE 1/2 ML 28 GAUGE X 1/2"	11	PEN NEEDLE, DIABETIC 31 GAUGE X 15/64"	11
MONOJECT SYRINGE 1/2 ML 28 GAUGE.....	11	PEN NEEDLE, DIABETIC 31 GAUGE X 3/16"	11
MONOJECT ULTRA COMFORT INSULIN 1/2 ML 28 GAUGE SYRINGE ...	11	PEN NEEDLE, DIABETIC 31 GAUGE X 5/16"	11
NANO 2ND GEN PEN NEEDLE 32 GAUGE X 5/32"	11	PEN NEEDLE, DIABETIC 31 GAUGE X 5/32"	11
NANO PEN NEEDLE 32 GAUGE X 5/32"	11	PEN NEEDLE, DIABETIC 32 GAUGE X 1/4"	11
NEXLETOL 180 MG TABLET.....	9	PEN NEEDLE, DIABETIC 32 GAUGE X 3/16"	11
NEXLIZET 180 MG-10 MG TABLET.....	9	PEN NEEDLE, DIABETIC 32 GAUGE X 5/16"	11
NICOTROL NS 10 MG/ML NASAL SPRAY	34	PEN NEEDLE, DIABETIC 32 GAUGE X 5/32"	11
NOVOFINE 32 32 GAUGE X 1/4" NEEDLE	11	PEN NEEDLE, DIABETIC 33 GAUGE X 1/4"	11
NOVOFINE AUTOCOVER 30 GAUGE X 1/3" NEEDLE.....	11	PEN NEEDLE, DIABETIC 33 GAUGE X 3/16"	11
NOVOFINE PLUS 32 GAUGE X 1/6" NEEDLE	11	PEN NEEDLE, DIABETIC 33 GAUGE X 5/32"	11
<i>omega-3 acid ethyl esters 1 gram capsule</i>	8	PEN NEEDLE, DIABETIC, SAFETY 31 GAUGE X 5/32"	11
OPIPZA 10 MG ORAL FILM.....	1	PENTIPS PEN NEEDLE 29 GAUGE X 1/2"	11
OPIPZA 2 MG ORAL FILM.....	1	PENTIPS PEN NEEDLE 31 GAUGE X 1/4"	11
OPIPZA 5 MG ORAL FILM.....	1		
PEN NEEDLE 29 GAUGE X 1/2"	11		
PEN NEEDLE 30 GAUGE X 5/16"	11		

PENTIPS PEN NEEDLE 31 GAUGE X 3/16"	11	PRODIGY INSULIN SYRINGE 1 ML 28 GAUGE X 1/2"	11
PENTIPS PEN NEEDLE 31 GAUGE X 5/16"	11	PURE COMFORT ALCOHOL PADS	11
PENTIPS PEN NEEDLE 32 GAUGE X 1/4"	11	PURE COMFORT PEN NEEDLE 32 GAUGE X 1/4"	11
PENTIPS PEN NEEDLE 32 GAUGE X 5/32"	11	PURE COMFORT PEN NEEDLE 32 GAUGE X 3/16"	11
<i>perampanel 0.5 mg/ml oral suspension</i>	36	PURE COMFORT PEN NEEDLE 32 GAUGE X 5/16"	11
<i>perampanel 10 mg tablet</i>	36	PURE COMFORT PEN NEEDLE 32 GAUGE X 5/32"	11
<i>perampanel 12 mg tablet</i>	36	PURE COMFORT SAFETY PEN NEEDLE 31 GAUGE X 1/4"	11
<i>perampanel 2 mg tablet</i>	36	PURE COMFORT SAFETY PEN NEEDLE 31 GAUGE X 3/16"	11
<i>perampanel 4 mg tablet</i>	36	PURE COMFORT SAFETY PEN NEEDLE 32 GAUGE X 5/32"	11
<i>perampanel 6 mg tablet</i>	36	REPATHA PUSHTRONEX 420 MG/3.5 ML SUBCUTANEOUS WEARABLE INJECTOR	9
<i>perampanel 8 mg tablet</i>	36	REPATHA SURECLICK 140 MG/ML SUBCUTANEOUS PEN INJECTOR	9
PIP PEN NEEDLE 31 GAUGE X 3/16"	11	REPATHA SYRINGE 140 MG/ML SUBCUTANEOUS SYRINGE	9
PIP PEN NEEDLE 32 GAUGE X 5/32"	11	<i>rufinamide 200 mg tablet</i>	37
PREVENT DROPSAFE PEN NEEDLE 31 GAUGE X 1/4"	11	<i>rufinamide 40 mg/ml oral suspension</i>	37
PREVENT DROPSAFE PEN NEEDLE 31 GAUGE X 5/16"	11	<i>rufinamide 400 mg tablet</i>	37
PRO COMFORT ALCOHOL PADS	11	SAFESNAP INSULIN SYRINGE 0.3 ML 30 GAUGE X 5/16"	11
PRO COMFORT INSULIN SYRINGE 0.5 ML 30 GAUGE X 1/2"	11	SAFESNAP INSULIN SYRINGE 0.5 ML 29 GAUGE X 1/2"	11
PRO COMFORT INSULIN SYRINGE 0.5 ML 30 GAUGE X 5/16"	11	SAFESNAP INSULIN SYRINGE 0.5 ML 30 GAUGE X 5/16"	11
PRO COMFORT INSULIN SYRINGE 0.5 ML 31 GAUGE X 5/16"	11	SAFESNAP INSULIN SYRINGE 1 ML 28 GAUGE X 1/2"	11
PRO COMFORT INSULIN SYRINGE 1 ML 30 GAUGE X 1/2"	11	SAFESNAP INSULIN SYRINGE 1 ML 29 GAUGE X 1/2"	11
PRO COMFORT INSULIN SYRINGE 1 ML 30 GAUGE X 5/16"	11	SAFETY PEN NEEDLE 31 GAUGE X 3/16"	11
PRO COMFORT INSULIN SYRINGE 1 ML 31 GAUGE X 5/16"	11	SECUADO 3.8 MG/24 HOUR TRANSDERMAL 24 HOUR PATCH	3
PRO COMFORT PEN NEEDLE 32 GAUGE X 1/4"	11	SECUADO 5.7 MG/24 HOUR TRANSDERMAL 24 HOUR PATCH	3
PRO COMFORT PEN NEEDLE 32 GAUGE X 3/16"	11	SECUADO 7.6 MG/24 HOUR TRANSDERMAL 24 HOUR PATCH	3
PRO COMFORT PEN NEEDLE 32 GAUGE X 5/16"	11	SECURESAFE INSULIN SYRINGE 0.5 ML 29 GAUGE X 1/2"	11
PRO COMFORT PEN NEEDLE 32 GAUGE X 5/32"	11		
PRO-COMFORT ALCOHOL PADS	11		
PRODIGY INSULIN SYRINGE 0.3 ML 31 GAUGE X 5/16"	11		
PRODIGY INSULIN SYRINGE 0.5 ML 31 GAUGE X 5/16"	11		

SECURES SAFE INSULIN SYRINGE 1 ML 29 GAUGE X 1/2"	11	SURE COMFORT INSULIN SYRINGE 1/2 ML 28 GAUGE X 1/2"	11
SECURES SAFE PEN NEEDLE 30 GAUGE X 5/16"	11	SURE COMFORT INSULIN SYRINGE 1/2 ML 31 GAUGE X 1/4"	11
SECURES SAFE PEN NEEDLE 31 GAUGE X 3/16"	11	SURE COMFORT INSULIN SYRINGE U-100 0.5 ML 29 GAUGE X 1/2"	11
SIMPLI PEN NEEDLE 32 GAUGE X 5/32"	11	SURE COMFORT PEN NEEDLE 29 GAUGE X 1/2"	11
SKY SAFETY PEN NEEDLE 30 GAUGE X 3/16"	11	SURE COMFORT PEN NEEDLE 30 GAUGE X 5/16"	11
SKY SAFETY PEN NEEDLE 30 GAUGE X 5/16"	11	SURE COMFORT PEN NEEDLE 31 GAUGE X 3/16"	11
SPRITAM 1,000 MG TABLET FOR ORAL SUSPENSION	39	SURE COMFORT PEN NEEDLE 31 GAUGE X 5/16"	11
SPRITAM 750 MG TABLET FOR ORAL SUSPENSION	39	SURE COMFORT PEN NEEDLE 32 GAUGE X 1/4"	11
STERILE PADS 2" X 2" BANDAGE	11	SURE COMFORT PEN NEEDLE 32 GAUGE X 5/32"	11
SURE COMFORT ALCOHOL PREP PADS	11	SURE COMFORT SAFETY PEN NEEDLE 31 GAUGE X 1/4"	11
SURE COMFORT INSULIN SYRINGE 0.3 ML 29 GAUGE X 1/2"	11	SURE COMFORT SAFETY PEN NEEDLE 32 GAUGE X 5/32"	11
SURE COMFORT INSULIN SYRINGE 0.3 ML 30 GAUGE X 1/2"	11	SURE-FINE PEN NEEDLES 29 GAUGE X 1/2"	11
SURE COMFORT INSULIN SYRINGE 0.3 ML 30 GAUGE X 5/16"	11	SURE-FINE PEN NEEDLES 31 GAUGE X 3/16"	11
SURE COMFORT INSULIN SYRINGE 0.3 ML 31 GAUGE X 1/4"	11	SURE-FINE PEN NEEDLES 31 GAUGE X 5/16"	11
SURE COMFORT INSULIN SYRINGE 0.3 ML 31 GAUGE X 5/16"	11	SURE-JECT INSULIN SYRINGE 0.3 ML 29 GAUGE X 1/2"	11
SURE COMFORT INSULIN SYRINGE 0.5 ML 30 GAUGE X 1/2"	11	SURE-JECT INSULIN SYRINGE 0.3 ML 30 GAUGE X 5/16"	11
SURE COMFORT INSULIN SYRINGE 0.5 ML 30 GAUGE X 5/16"	11	SURE-JECT INSULIN SYRINGE 0.5 ML 29 GAUGE X 1/2"	11
SURE COMFORT INSULIN SYRINGE 0.5 ML 31 GAUGE X 5/16"	11	SURE-JECT INSULIN SYRINGE 0.5 ML 30 GAUGE X 5/16"	11
SURE COMFORT INSULIN SYRINGE 1 ML 28 GAUGE X 1/2"	11	SURE-JECT INSULIN SYRINGE 1 ML 28 GAUGE X 1/2"	11
SURE COMFORT INSULIN SYRINGE 1 ML 29 GAUGE X 1/2"	11	SURE-JECT INSULIN SYRINGE 1 ML 29 GAUGE X 1/2"	11
SURE COMFORT INSULIN SYRINGE 1 ML 30 GAUGE X 1/2"	11	SURE-JECT INSULIN SYRINGE 1 ML 30 GAUGE X 5/16"	11
SURE COMFORT INSULIN SYRINGE 1 ML 30 GAUGE X 5/16"	11	SURE-JECT INSULIN SYRINGE 1 ML 31 GAUGE X 5/16"	11
SURE COMFORT INSULIN SYRINGE 1 ML 31 GAUGE X 1/4"	11	SURE-JECT INSULIN SYRINGE 1/2 ML 28 GAUGE X 1/2"	11
SURE COMFORT INSULIN SYRINGE 1 ML 31 GAUGE X 5/16"	11	SURE-PREP ALCOHOL PREP PADS	11

SYRINGE WITH NEEDLE, SAFETY 0.5 ML 30 GAUGE X 1/2"	11	TERUMO INSULIN SYRINGE 0.5 ML 29 GAUGE X 1/2"	11
TECHLITE INSULIN SYRINGE (HALF UNIT) 0.3 ML 29 GAUGE X 1/2"	11	TERUMO INSULIN SYRINGE 1 ML 27 GAUGE X 1/2"	11
TECHLITE INSULIN SYRINGE (HALF UNIT) 0.3 ML 30 GAUGE X 5/16"	11	TERUMO INSULIN SYRINGE 1 ML 28 GAUGE X 1/2"	11
TECHLITE INSULIN SYRINGE (HALF UNIT) 0.3 ML 31 GAUGE X 15/64"	11	TERUMO INSULIN SYRINGE 1 ML 29 GAUGE X 1/2"	11
TECHLITE INSULIN SYRINGE (HALF UNIT) 0.3 ML 31 GAUGE X 5/16"	11	TERUMO INSULIN SYRINGE 1/2 ML 27 GAUGE X 1/2"	11
TECHLITE INSULIN SYRINGE (HALF UNIT) 0.5 ML 30 GAUGE X 1/2"	11	TERUMO INSULIN SYRINGE 1/2 ML 28 GAUGE X 1/2"	11
TECHLITE INSULIN SYRINGE (HALF UNIT) 0.5 ML 30 GAUGE X 5/16"	11	TERUMO INSULIN SYRINGE 1/2 ML 30 X 3/8"	11
TECHLITE INSULIN SYRINGE (HALF UNIT) 0.5 ML 31 GAUGE X 15/64"	11	THINPRO INSULIN SYRINGE 0.3 ML 29 GAUGE X 1/2"	11
TECHLITE INSULIN SYRINGE (HALF UNIT) 0.5 ML 31 GAUGE X 5/16"	11	THINPRO INSULIN SYRINGE 0.3 ML 30 X 3/8"	11
TECHLITE INSULIN SYRINGE 1 ML 29 GAUGE X 1/2"	11	THINPRO INSULIN SYRINGE 0.3 ML 31 X 3/8"	11
TECHLITE INSULIN SYRINGE 1 ML 30 GAUGE X 1/2"	11	THINPRO INSULIN SYRINGE 0.5 ML 29 GAUGE X 1/2"	11
TECHLITE INSULIN SYRINGE 1 ML 31 GAUGE X 15/64"	11	THINPRO INSULIN SYRINGE 0.5 ML 31 X 3/8"	11
TECHLITE INSULIN SYRINGE 1 ML 31 GAUGE X 5/16"	11	THINPRO INSULIN SYRINGE 1 ML 28 GAUGE X 1/2"	11
TECHLITE PEN NEEDLE 29 GAUGE X 1/2"	11	THINPRO INSULIN SYRINGE 1 ML 29 GAUGE X 1/2"	11
TECHLITE PEN NEEDLE 29 GAUGE X 3/8"	11	THINPRO INSULIN SYRINGE 1 ML 30 GAUGE X 3/8"	11
TECHLITE PEN NEEDLE 31 GAUGE X 1/4"	11	THINPRO INSULIN SYRINGE 1 ML 31 X 3/8"	11
TECHLITE PEN NEEDLE 31 GAUGE X 3/16"	11	THINPRO INSULIN SYRINGE 1/2 ML 28 GAUGE X 1/2"	11
TECHLITE PEN NEEDLE 31 GAUGE X 5/16"	11	THINPRO INSULIN SYRINGE 1/2 ML 30 X 3/8"	11
TECHLITE PEN NEEDLE 32 GAUGE X 1/4"	11	TOPFINE INSULIN PEN NEEDLE 32 GAUGE X 5/32"	11
TECHLITE PEN NEEDLE 32 GAUGE X 5/16"	11	<i>topiramate 25 mg/ml oral solution</i>	40
TECHLITE PEN NEEDLE 32 GAUGE X 5/32"	11	TRUE COMFORT ALCOHOL PADS	11
TECHLITE PLUS PEN NEEDLE 32 GAUGE X 5/32"	11	TRUE COMFORT INSULIN SYRINGE 0.5 ML 31 GAUGE X 5/16"	11
TERUMO INSULIN SYRINGE 0.3 ML 30 X 3/8"	11	TRUE COMFORT INSULIN SYRINGE 1 ML 31 GAUGE X 5/16"	11
		TRUE COMFORT PEN NEEDLE 31 GAUGE X 1/4"	11

TRUE COMFORT PEN NEEDLE 31	TRUE COMFORT SAFETY INSULIN
GAUGE X 3/16" 11	SYRINGE 1 ML 32 GAUGE X 5/16" 11
TRUE COMFORT PEN NEEDLE 31	TRUE COMFORT SAFETY PEN
GAUGE X 5/16" 11	NEEDLE 31 GAUGE X 1/4" 11
TRUE COMFORT PEN NEEDLE 32	TRUE COMFORT SAFETY PEN
GAUGE X 1/4" 11	NEEDLE 31 GAUGE X 3/16" 11
TRUE COMFORT PEN NEEDLE 32	TRUE COMFORT SAFETY PEN
GAUGE X 3/16" 11	NEEDLE 32 GAUGE X 5/32" 11
TRUE COMFORT PEN NEEDLE 32	TRUE-COMFORT PRO PEN NEEDLE
GAUGE X 5/32" 11	31 GAUGE X 15/64" 11
TRUE COMFORT PEN NEEDLE 33	TRUE-COMFORT PRO PEN NEEDLE
GAUGE X 1/4" 11	31 GAUGE X 3/16" 11
TRUE COMFORT PEN NEEDLE 33	TRUE-COMFORT PRO PEN NEEDLE
GAUGE X 3/16" 11	31 GAUGE X 5/16" 11
TRUE COMFORT PEN NEEDLE 33	TRUE-COMFORT PRO PEN NEEDLE
GAUGE X 5/32" 11	32 GAUGE X 5/32" 11
TRUE COMFORT PRO ALCOHOL	TRUEPLUS INSULIN 0.3 ML 29
PADS..... 11	GAUGE X 1/2" SYRINGE..... 11
TRUE COMFORT PRO INS SYRINGE	TRUEPLUS INSULIN 0.3 ML 30
0.5 ML 30 GAUGE X 1/2" 11	GAUGE X 5/16" SYRINGE..... 11
TRUE COMFORT PRO INS SYRINGE	TRUEPLUS INSULIN 0.3 ML 31
0.5 ML 30 GAUGE X 5/16" 11	GAUGE X 5/16" SYRINGE..... 11
TRUE COMFORT PRO INS SYRINGE	TRUEPLUS INSULIN 0.5 ML 29
0.5 ML 31 GAUGE X 5/16" 11	GAUGE X 1/2" SYRINGE..... 11
TRUE COMFORT PRO INS SYRINGE 1	TRUEPLUS INSULIN 0.5 ML 30
ML 30 GAUGE X 1/2" 11	GAUGE X 5/16" SYRINGE..... 11
TRUE COMFORT PRO INS SYRINGE 1	TRUEPLUS INSULIN 0.5 ML 31
ML 30 GAUGE X 5/16" 11	GAUGE X 5/16" SYRINGE..... 11
TRUE COMFORT PRO INS SYRINGE 1	TRUEPLUS INSULIN 1 ML 28 GAUGE
ML 31 GAUGE X 5/16" 11	X 1/2" SYRINGE..... 11
TRUE COMFORT PRO INS SYRINGE 1	TRUEPLUS INSULIN 1 ML 29 GAUGE
ML 32 GAUGE X 5/16" 11	X 1/2" SYRINGE..... 11
TRUE COMFORT PRO INS SYRINGE	TRUEPLUS INSULIN 1 ML 30 GAUGE
1/2 ML 32 GAUGE X 5/16" 11	X 5/16" SYRINGE..... 11
TRUE COMFORT SAFETY INSULIN	TRUEPLUS INSULIN 1 ML 31 GAUGE
SYRINGE 0.5 ML 30 GAUGE X 1/2" 11	X 5/16" SYRINGE..... 11
TRUE COMFORT SAFETY INSULIN	TRUEPLUS INSULIN 1/2 ML 28
SYRINGE 0.5 ML 30 GAUGE X 5/16" 11	GAUGE X 1/2" SYRINGE..... 11
TRUE COMFORT SAFETY INSULIN	TRUEPLUS PEN NEEDLE 29 GAUGE X
SYRINGE 0.5 ML 31 GAUGE X 5/16" 11	1/2" 11
TRUE COMFORT SAFETY INSULIN	TRUEPLUS PEN NEEDLE 31 GAUGE X
SYRINGE 1 ML 30 GAUGE X 1/2" 11	1/4" 11
TRUE COMFORT SAFETY INSULIN	TRUEPLUS PEN NEEDLE 31 GAUGE X
SYRINGE 1 ML 30 GAUGE X 5/16" 11	3/16" 11
TRUE COMFORT SAFETY INSULIN	TRUEPLUS PEN NEEDLE 31 GAUGE X
SYRINGE 1 ML 31 GAUGE X 5/16" 11	5/16" 11

TRUEPLUS PEN NEEDLE 32 GAUGE X 5/32"	11	ULTIGUARD SAFEPAK-INSULIN SYRINGE 1/2 ML 30 X 1/2"	11
ULTICARE 0.3 ML 30 GAUGE X 1/2" SYRINGE	11	ULTIGUARD SAFEPAK-INSULIN SYRINGE 1/2 ML 31 X 5/16"	11
ULTICARE 0.3 ML 31 GAUGE X 5/16" SYRINGE	11	ULTIGUARD SAFEPAK-PEN NEEDLE 29 GAUGE X 1/2"	11
ULTICARE 0.5 ML 30 GAUGE X 1/2" SYRINGE	11	ULTIGUARD SAFEPAK-PEN NEEDLE 31 GAUGE X 1/4"	11
ULTICARE 0.5 ML 31 GAUGE X 5/16" SYRINGE	11	ULTIGUARD SAFEPAK-PEN NEEDLE 31 GAUGE X 3/16"	11
ULTICARE 1 ML 30 GAUGE X 1/2" SYRINGE	11	ULTIGUARD SAFEPAK-PEN NEEDLE 31 GAUGE X 5/16"	11
ULTICARE 1 ML 31 GAUGE X 5/16" SYRINGE	11	ULTIGUARD SAFEPAK-PEN NEEDLE 32 GAUGE X 1/4"	11
ULTICARE INSULIN SYRINGE (HALF UNIT) 0.3 ML 31 GAUGE X 1/4"	11	ULTIGUARD SAFEPAK-PEN NEEDLE 32 GAUGE X 5/32"	11
ULTICARE INSULIN SYRINGE 0.3 ML 31 GAUGE X 1/4"	11	ULTILET ALCOHOL SWAB	11
ULTICARE INSULIN SYRINGE 1 ML 31 GAUGE X 1/4"	11	ULTILET INSULIN SYRINGE 0.3 ML 29 GAUGE	11
ULTICARE INSULIN SYRINGE 1/2 ML 31 GAUGE X 1/4"	11	ULTILET INSULIN SYRINGE 0.3 ML 29 GAUGE X 1/2"	11
ULTICARE PEN NEEDLE 29 GAUGE X 1/2"	11	ULTILET INSULIN SYRINGE 0.3 ML 30 GAUGE X 5/16"	11
ULTICARE PEN NEEDLE 31 GAUGE X 1/4"	11	ULTILET INSULIN SYRINGE 0.3 ML 31 GAUGE X 5/16"	11
ULTICARE PEN NEEDLE 31 GAUGE X 3/16"	11	ULTILET INSULIN SYRINGE 0.5 ML 29 GAUGE X 1/2"	11
ULTICARE PEN NEEDLE 31 GAUGE X 5/16"	11	ULTILET INSULIN SYRINGE 0.5 ML 30 GAUGE X 5/16"	11
ULTICARE PEN NEEDLE 32 GAUGE X 1/4"	11	ULTILET INSULIN SYRINGE 0.5 ML 31 GAUGE X 5/16"	11
ULTICARE PEN NEEDLE 32 GAUGE X 5/32"	11	ULTILET INSULIN SYRINGE 1 ML 29 GAUGE	11
ULTICARE SAFETY PEN NEEDLE 30 GAUGE X 3/16"	11	ULTILET INSULIN SYRINGE 1 ML 29 GAUGE X 1/2"	11
ULTICARE SAFETY PEN NEEDLE 30 GAUGE X 5/16"	11	ULTILET INSULIN SYRINGE 1 ML 30 GAUGE X 5/16"	11
ULTIGUARD SAFEPAK-INSULIN SYRINGE 0.3 ML 30 X 1/2"	11	ULTILET INSULIN SYRINGE 1 ML 31 GAUGE X 5/16"	11
ULTIGUARD SAFEPAK-INSULIN SYRINGE 0.3 ML 31 X 5/16"	11	ULTILET INSULIN SYRINGE 1/2 ML 29	11
ULTIGUARD SAFEPAK-INSULIN SYRINGE 1 ML 30 X 1/2"	11	ULTILET PEN NEEDLE 29 GAUGE	11
ULTIGUARD SAFEPAK-INSULIN SYRINGE 1 ML 31 X 5/16"	11	ULTILET PEN NEEDLE 32 GAUGE X 5/32"	11
		ULTRA COMFORT INSULIN SYRINGE (HALF UNIT) 0.3 ML 29 GAUGE X 1/2" ..	11

ULTRA COMFORT INSULIN SYRINGE (HALF UNIT) 0.3 ML 31 GAUGE X 5/16"	11	ULTRA FLO PEN NEEDLE 31 GAUGE X 3/16"	11
ULTRA COMFORT INSULIN SYRINGE 0.3 ML 29 GAUGE X 1/2"	11	ULTRA FLO PEN NEEDLE 31 GAUGE X 5/16"	11
ULTRA COMFORT INSULIN SYRINGE 0.3 ML 30	11	ULTRA FLO PEN NEEDLE 32 GAUGE X 5/32"	11
ULTRA COMFORT INSULIN SYRINGE 0.3 ML 30 GAUGE X 5/16"	11	ULTRA FLO PEN NEEDLE 33 GAUGE X 5/32"	11
ULTRA COMFORT INSULIN SYRINGE 0.5 ML 29 GAUGE X 1/2"	11	ULTRA THIN PEN NEEDLE 32 GAUGE X 5/32"	11
ULTRA COMFORT INSULIN SYRINGE 0.5 ML 30 GAUGE X 5/16"	11	ULTRACARE INSULIN SYRINGE 0.3 ML 30 GAUGE X 5/16"	11
ULTRA COMFORT INSULIN SYRINGE 0.5 ML 31 GAUGE X 5/16"	11	ULTRACARE INSULIN SYRINGE 0.3 ML 31 GAUGE X 5/16"	11
ULTRA COMFORT INSULIN SYRINGE 1 ML 28 GAUGE X 1/2"	11	ULTRACARE INSULIN SYRINGE 0.5 ML 30 GAUGE X 1/2"	11
ULTRA COMFORT INSULIN SYRINGE 1 ML 29 GAUGE X 1/2"	11	ULTRACARE INSULIN SYRINGE 0.5 ML 30 GAUGE X 5/16"	11
ULTRA COMFORT INSULIN SYRINGE 1 ML 30 GAUGE X 5/16"	11	ULTRACARE INSULIN SYRINGE 0.5 ML 31 GAUGE X 5/16"	11
ULTRA COMFORT INSULIN SYRINGE 1 ML 30 GAUGE X 7/16"	11	ULTRACARE INSULIN SYRINGE 1 ML 30 GAUGE X 1/2"	11
ULTRA COMFORT INSULIN SYRINGE 1 ML 31 GAUGE X 5/16"	11	ULTRACARE INSULIN SYRINGE 1 ML 30 GAUGE X 5/16"	11
ULTRA COMFORT INSULIN SYRINGE 1/2 ML 28 GAUGE X 1/2"	11	ULTRACARE INSULIN SYRINGE 1 ML 31 GAUGE X 5/16"	11
ULTRA COMFORT INSULIN SYRINGE 1/2 ML 29	11	ULTRACARE PEN NEEDLE 31 GAUGE X 1/4"	11
ULTRA COMFORT INSULIN SYRINGE 1/2 ML 30 GAUGE	11	ULTRACARE PEN NEEDLE 31 GAUGE X 3/16"	11
ULTRA FLO INSULIN SYRINGE (HALF UNIT) 0.3 ML 30 GAUGE X 1/2"	11	ULTRACARE PEN NEEDLE 31 GAUGE X 5/16"	11
ULTRA FLO INSULIN SYRINGE (HALF UNIT) 0.3 ML 30 GAUGE X 5/16"	11	ULTRACARE PEN NEEDLE 32 GAUGE X 1/4"	11
ULTRA FLO INSULIN SYRINGE (HALF UNIT) 0.3 ML 31 GAUGE X 5/16"	11	ULTRACARE PEN NEEDLE 32 GAUGE X 3/16"	11
ULTRA FLO INSULIN SYRINGE 0.3 ML 29 GAUGE X 1/2"	11	ULTRACARE PEN NEEDLE 32 GAUGE X 5/32"	11
ULTRA FLO INSULIN SYRINGE 0.3 ML 30 GAUGE X 5/16"	11	ULTRACARE PEN NEEDLE 33 GAUGE X 5/32"	11
ULTRA FLO INSULIN SYRINGE 0.3 ML 31 GAUGE X 5/16"	11	ULTRA-FINE INSULIN SYRINGE (HALF UNIT) 0.3 ML 31 GAUGE X 15/64"	11
ULTRA FLO INSULIN SYRINGE 0.5 ML 29 GAUGE X 1/2"	11	ULTRA-FINE INSULIN SYRINGE (HALF UNIT) 0.3 ML 31 GAUGE X 5/16"	11
ULTRA FLO PEN NEEDLE 29 GAUGE X 1/2"	11		

ULTRA-FINE INSULIN SYRINGE 0.3 ML 30 GAUGE X 1/2"	11	UNIFINE OTC PEN NEEDLE 31 GAUGE X 3/16"	11
ULTRA-FINE INSULIN SYRINGE 0.3 ML 31 GAUGE X 15/64"	11	UNIFINE OTC PEN NEEDLE 32 GAUGE X 5/32"	11
ULTRA-FINE INSULIN SYRINGE 0.3 ML 31 GAUGE X 5/16"	11	UNIFINE PENTIPS 29 GAUGE X 1/2" NEEDLE	11
ULTRA-FINE INSULIN SYRINGE 0.5 ML 30 GAUGE X 1/2"	11	UNIFINE PENTIPS 31 GAUGE X 1/4" NEEDLE	11
ULTRA-FINE INSULIN SYRINGE 0.5 ML 31 GAUGE X 5/16"	11	UNIFINE PENTIPS 31 GAUGE X 3/16" NEEDLE	11
ULTRA-FINE INSULIN SYRINGE 1 ML 30 GAUGE X 1/2"	11	UNIFINE PENTIPS 31 GAUGE X 5/16" NEEDLE	11
ULTRA-FINE INSULIN SYRINGE 1 ML 31 GAUGE X 15/64"	11	UNIFINE PENTIPS 32 GAUGE X 1/4" NEEDLE	11
ULTRA-FINE INSULIN SYRINGE 1 ML 31 GAUGE X 5/16"	11	UNIFINE PENTIPS 32 GAUGE X 5/32" NEEDLE	11
ULTRA-FINE INSULIN SYRINGE 1/2 ML 31 GAUGE X 15/64"	11	UNIFINE PENTIPS 33 GAUGE X 5/32" NEEDLE	11
ULTRA-FINE PEN NEEDLE 29 GAUGE X 1/2"	11	UNIFINE PENTIPS MAXFLOW 30 GAUGE X 3/16" NEEDLE	11
ULTRA-FINE PEN NEEDLE 31 GAUGE X 3/16"	11	UNIFINE PENTIPS PLUS 29 GAUGE X 1/2" NEEDLE	11
ULTRA-FINE PEN NEEDLE 31 GAUGE X 5/16"	11	UNIFINE PENTIPS PLUS 31 GAUGE X 1/4" NEEDLE	11
ULTRA-FINE PEN NEEDLE 32 GAUGE X 1/4"	11	UNIFINE PENTIPS PLUS 31 GAUGE X 3/16" NEEDLE	11
ULTRA-THIN II (SHORT) INSULIN SYRINGE 0.3 ML 30 GAUGE X 5/16"	11	UNIFINE PENTIPS PLUS 31 GAUGE X 5/16" NEEDLE	11
ULTRA-THIN II (SHORT) INSULIN SYRINGE 0.3 ML 31 GAUGE X 5/16"	11	UNIFINE PENTIPS PLUS 32 GAUGE X 5/32" NEEDLE	11
ULTRA-THIN II (SHORT) INSULIN SYRINGE 0.5 ML 30 GAUGE X 5/16"	11	UNIFINE PENTIPS PLUS 33 GAUGE X 5/32" NEEDLE	11
ULTRA-THIN II (SHORT) INSULIN SYRINGE 0.5 ML 31 GAUGE X 5/16"	11	UNIFINE PENTIPS PLUS MAXFLOW 30 GAUGE X 3/16" NEEDLE	11
ULTRA-THIN II (SHORT) INSULIN SYRINGE 1 ML 30 GAUGE X 5/16"	11	UNIFINE PROTECT 30 GAUGE X 3/16" NEEDLE	11
ULTRA-THIN II (SHORT) INSULIN SYRINGE 1 ML 31 GAUGE X 5/16"	11	UNIFINE PROTECT 30 GAUGE X 5/16" NEEDLE	11
ULTRA-THIN II (SHORT) PEN NDL 31 GAUGE X 5/16" NEEDLE	11	UNIFINE PROTECT 32 GAUGE X 5/32" NEEDLE	11
ULTRA-THIN II INSULIN PEN NEEDLES 29 GAUGE X 1/2"	11	UNIFINE SAFECONTROL PEN NEEDLE 30 GAUGE X 3/16"	11
ULTRA-THIN II INSULIN SYRINGE 0.5 ML 29 GAUGE X 1/2"	11	UNIFINE SAFECONTROL PEN NEEDLE 30 GAUGE X 5/16"	11
ULTRA-THIN II INSULIN SYRINGE 1 ML 29 GAUGE X 1/2"	11	UNIFINE SAFECONTROL PEN NEEDLE 31 GAUGE X 1/4"	11

UNIFINE SAFECONTROL PEN NEEDLE 31 GAUGE X 3/16"	11	VERIFINE PEN NEEDLE 32 GAUGE X 1/4"	11
UNIFINE SAFECONTROL PEN NEEDLE 31 GAUGE X 5/16"	11	VERIFINE PEN NEEDLE 32 GAUGE X 3/16"	11
UNIFINE SAFECONTROL PEN NEEDLE 32 GAUGE X 5/32"	11	VERIFINE PEN NEEDLE 32 GAUGE X 5/32"	11
UNIFINE ULTRA PEN NEEDLE 29 GAUGE X 1/2"	11	VERIFINE PLUS PEN NEEDLE 31 GAUGE X 3/16"	11
UNIFINE ULTRA PEN NEEDLE 31 GAUGE X 1/4"	11	VERIFINE PLUS PEN NEEDLE 31 GAUGE X 5/16"	11
UNIFINE ULTRA PEN NEEDLE 31 GAUGE X 3/16"	11	VERIFINE PLUS PEN NEEDLE 32 GAUGE X 5/32"	11
UNIFINE ULTRA PEN NEEDLE 31 GAUGE X 5/16"	11	VERIFINE PLUS PEN NEEDLE- SHARPS CONTAINER 32 GAUGE X 5/32"	11
UNIFINE ULTRA PEN NEEDLE 32 GAUGE X 1/4"	11	VERSACLOZ 50 MG/ML ORAL SUSPENSION	5
UNIFINE ULTRA PEN NEEDLE 32 GAUGE X 5/32"	11	VERSALON 2" X 2" SPONGE	11
UNIFINE ULTRA PEN NEEDLE 34 GAUGE X 9/64"	11	WEBCOL TOPICAL PADS	11
VANISHPOINT INSULIN SYRINGE 0.5 ML 30 GAUGE X 5/16"	11	XATMEP 2.5 MG/ML ORAL SOLUTION ..	4
VANISHPOINT INSULIN SYRINGE 1 ML 30 GAUGE X 3/16"	11		
VANISHPOINT SYRINGE 0.5 ML 30 GAUGE X 1/2"	11		
VANISHPOINT SYRINGE 1 ML 29 GAUGE X 1/2"	11		
VERIFINE INSULIN SYRINGE 0.3 ML 31 GAUGE X 5/16"	11		
VERIFINE INSULIN SYRINGE 0.5 ML 29 GAUGE X 1/2"	11		
VERIFINE INSULIN SYRINGE 0.5 ML 31 GAUGE X 5/16"	11		
VERIFINE INSULIN SYRINGE 1 ML 29 GAUGE X 1/2"	11		
VERIFINE INSULIN SYRINGE 1 ML 31 GAUGE X 5/16"	11		
VERIFINE PEN NEEDLE 29 GAUGE X 1/2"	11		
VERIFINE PEN NEEDLE 31 GAUGE X 1/4"	11		
VERIFINE PEN NEEDLE 31 GAUGE X 3/16"	11		
VERIFINE PEN NEEDLE 31 GAUGE X 5/16"	11		