

**Presbyterian Senior Care (HMO) / (HMO-POS)
Presbyterian Dual Plus (HMO D-SNP)
Formulary Prior Authorization Criteria
Effective June 1, 2026**

The formulary may change at any time. You will receive notice when required.

For the most recent list of drugs, information on obtaining a coverage determination or exception, or other questions, please contact the Presbyterian Customer Service Center.

Presbyterian Senior Care:



(505) 923-6060
1-800-797-5343
(TTY 711)



October 1 - March 31:

8 a.m. to 8 p.m., seven days a week
(except holidays)

April 1 - September 30:

8 a.m. to 8 p.m., Monday - Friday
(except holidays)

Presbyterian Dual Plus:



(505) 923-7675
1-855-465-7737
(TTY 711)



www.phs.org/Medicare

Learn more about Presbyterian's Nondiscrimination Notice and Interpreter Services.

Based on a Model of Care review, Presbyterian Dual Plus (HMO D-SNP) has been approved by the National Committee for Quality Assurance (NCQA) to operate a Special Needs Plan (SNP) through 2028.

Abilify MyCite (aripiprazole with sensor)

Products Affected

- Abilify MyCite
- Abilify MyCite Maintenance Kit Oral Tablet Therapy Pack 15 MG, 2 MG, 20 MG, 5 MG
- Abilify MyCite Starter Kit Oral Tablet Therapy Pack 10 MG

PA Criteria	Criteria Details
Exclusion Criteria	Patients with dementia-related psychosis.
Required Medical Information	Chart notes documenting that the patient has tried at least two (2) oral atypical anti-psychotics, one of which must be aripiprazole.
Age Restrictions	Patient is 18 years of age or older
Prescriber Restrictions	
Coverage Duration	Initial: 3 months Renewal: 6 months
Other Criteria	Reauthorization: Documentation that the patient is clinically stable on Abilify MyCite and the prescriber documents that the patient requires the continued use of Abilify MyCite.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Actiq (fentanyl transmucosal)

Products Affected

- fentaNYL Citrate Buccal Lozenge On A
Handle 1200 MCG, 1600 MCG, 400 MCG,
600 MCG, 800 MCG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Trial and failure of an immediate release oral opiate and must be used in combination with a long-acting oral opiate.
Age Restrictions	16 years or older
Prescriber Restrictions	Oncologist or Pain Specialist
Coverage Duration	6 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Adcirca (tadalafil)

Products Affected

- Alyq
- Tadalafil (PAH)

PA Criteria	Criteria Details
Exclusion Criteria	Tadalafil is excluded from coverage for the treatment of Erectile Dysfunction.
Required Medical Information	Documentation of Pulmonary Arterial Hypertension as determined by a right heart catheterization.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Adempas (riociguat)

Products Affected

- Adempas

PA Criteria	Criteria Details
Exclusion Criteria	Must not be used in combination with nitrates, nitric oxide donors, or PDE-5 inhibitors.
Required Medical Information	If using for pulmonary arterial hypertension (PAH), must have tried and failed or have a contraindication to Revatio (sildenafil) or Adcirca (tadalafil).
Age Restrictions	18 years or older
Prescriber Restrictions	Cardiologist or Pulmonologist
Coverage Duration	1 year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Afinitor (everolimus)

Products Affected

- Everolimus Oral Tablet 10 MG, 2.5 MG, 5 MG, 7.5 MG
- Torpenz

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Afinitor Disperz (everolimus)

Products Affected

- Everolimus Oral Tablet Soluble

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Y0055_MPC092560_NSR_C_10022025

Formulary ID 0026395

Version 046

Last Updated: 05/21/2026

Page | 7

Akeega (niraparib and abiraterone)

Products Affected

- Akeega

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Six (6) months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Alecensa (alectinib)

Products Affected

- Alecensa

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Alunbrig (brigantinib)

Products Affected

- Alunbrig

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Amjevita (adalimumab-atto)

Products Affected

- Amjevita Subcutaneous Solution Auto-Injector
- Amjevita Subcutaneous Solution Prefilled Syringe 40 MG/0.4ML, 40 MG/0.8ML
- Amjevita-Ped 10kg to <15kg
- Amjevita-Ped 15kg to <30kg

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	<p>1. Ankylosing Spondylitis (AS): peripheral arthritis must have a trial of sulfasalazine and an NSAID. Patients with axial disease and failure of NSAIDs can be started without a trial of sulfasalazine. 2. Crohn's disease (CD): Documented diagnosis of moderately to severely active CD as evidenced by colonoscopy, CT scan, MRI, or capsule endoscopy. 3. Juvenile Idiopathic Arthritis (JIA): An adequate trial (3 months or more) of one of the following DMARDs: i. Leflunomide ii. Methotrexate iii. Sulfasalazine. 4. Plaque Psoriasis (PsO): a. The patient must have at least 3% of their body surface area (BSA) affected by plaque psoriasis (unless on hands, feet, scalp, face, or genital area). b. The disease is severe as defined by a total Psoriasis Area Severity Index (PASI) of at least 5 or more and/or a Dermatology Life Quality Index (DLQI) of more than 5. c. The patient has failed to adequately respond to, or is intolerant, a 3-month trial of a topical agent (topical corticosteroid, topical calcineurin inhibitor, topical vitamin D analogs, etc.). 5. Psoriatic Arthritis (PsA): Documented diagnosis of PsA. 6. Rheumatoid Arthritis (RA): Moderate to severe RA is defined as: DAS-28 more than 3.2 or CDAI more than 10.1. c. An adequate trial (3 months or more) of one of the following other DMARDs: i. Hydroxychloroquine ii. Leflunomide iii. Methotrexate iv. Sulfasalazine 7. Ulcerative Colitis (UC): Documented diagnosis of moderately to severely active UC as evidenced by colonoscopy, CT scan, MRI, or capsule endoscopy.</p>
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with a rheumatologist, dermatologist, gastroenterologist, or ophthalmologist.

Y0055_MPC092560_NSR_C_10022025

Formulary ID 0026395

Version 046

Last Updated: 05/21/2026

Page | 11

PA Criteria	Criteria Details
Coverage Duration	One (1) year
Other Criteria	8. Hidradenitis Suppurativa (HS): Documented diagnosis of Hurley Stage II or III HS. 9. Uveitis: a. Documented diagnosis of non-infectious intermediate, posterior and panuveitis in adult patients and meets the following: i. documented trial failure, contraindication, or intolerance to at least two (2) drugs from the following: conventional therapy such as ophthalmic or systemic corticosteroids AND immunosuppressive drugs (e.g., azathioprine, cyclosporine, methotrexate, or tacrolimus). For all diagnoses: 1. Current PPD (tuberculosis) negative skin test or negative QuantiFERON-TB Gold test before the initiation of therapy, 2. The appropriate Disease Specific Criteria has been met. CONTINUATION CRITERIA: Documentation of positive response with treatment
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Androderm (testosterone topical)

Products Affected

- Androderm Transdermal Patch 24 Hour

PA Criteria	Criteria Details
Exclusion Criteria	Testosterone replacement will not be covered for the treatment of sexual dysfunction.
Required Medical Information	Trial and failure of Androgel (testosterone gel). If using for primary hypogonadism, the patient must have two low total testosterone levels (drawn on separate days) with elevated luteinizing hormone (LH) and follicular stimulating hormone (FSH) levels. If using for hypogonadotropic hypogonadism, the patient must have two low total testosterone levels (drawn on separate days) with low to low-normal LH and FSH levels.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Androgel 1.62% (testosterone topical)

Products Affected

- Testosterone Transdermal Gel 1.62 %, 10 (1.62%), 25 MG/2.5GM (1%), 40.5 MG/ACT (2%), 12.5 MG/ACT (1%), 20.25 MG/2.5GM (1.62%), 50 MG/5GM (1%) MG/1.25GM (1.62%), 20.25 MG/ACT

PA Criteria	Criteria Details
Exclusion Criteria	Testosterone replacement will not be covered for the treatment of sexual dysfunction.
Required Medical Information	If using for primary hypogonadism, the patient must have two low total testosterone levels (drawn on separate days) with elevated luteinizing hormone (LH) and follicular stimulating hormone (FSH) levels. If using for hypogonadotropic hypogonadism, the patient must have two low total testosterone levels (drawn on separate days) with low to low-normal LH and FSH levels.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Apokyn (apomorphine)

Products Affected

- Apokyn Subcutaneous Solution Cartridge
- Apomorphine HCl Subcutaneous

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Must be used as an adjunct to levodopa and one (1) formulary oral dopamine agonist medication indicated for Parkinson's disease.
Age Restrictions	
Prescriber Restrictions	Neurologist
Coverage Duration	6 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Arcalyst (rilonacept)

Products Affected

- Arcalyst

PA Criteria	Criteria Details
Exclusion Criteria	Will not be used in combination with etanercept, adalimumab, anakinra, abatacept, or infliximab.
Required Medical Information	
Age Restrictions	12 years or older for the indications of Cryopyrin-Associated Periodic Syndromes, including Familial Cold Autoinflammatory Syndrome, and Muckle-Wells Syndrome, recurrent pericarditis. Adults and pediatrics weighing 10 kg or more for the maintenance of remission of Deficiency of Interleukin-1 Receptor Antagonist.
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Augtyro (repotrecitinib)

Products Affected

- Augtyro

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Six (6) months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Austedo (deutetrabenazine)

Products Affected

- Austedo
- Austedo XR
- Austedo Patient Titration Kit
- Austedo XR Patient Titration

PA Criteria	Criteria Details
Exclusion Criteria	Deutetrabenazine is not covered for patients who are actively suicidal, who have untreated or inadequately treated depression, who have impaired hepatic function, or who are currently taking monoamine oxidase inhibitors or reserpine.
Required Medical Information	Documentation that member is being monitored for depression and suicidal ideation. Chorea associated with Huntington disease (HD): Documentation that the patient is ambulatory. Tardive Dyskinesia (TD): Documentation of a baseline Abnormal Involuntary Movement Scale (AIMS) must be provided.
Age Restrictions	
Prescriber Restrictions	Psychiatrists, neurologists, specialty nurse practitioners, specialty physician assistants, or was prescribed in consultation with the aforementioned specialists.
Coverage Duration	Initial: 6 months Renewal: 1 year
Other Criteria	Renewal: Chart notes documenting that the patient's disease has stabilized or improved based on prescriber's assessment while on therapy.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Auvelity (dextromethorphan/bupropion)

Products Affected

- Auvelity

PA Criteria	Criteria Details
Exclusion Criteria	1. Seizure disorder. 2. Current or prior diagnosis of bulimia or anorexia nervosa. 3. Abrupt discontinuation of alcohol, benzodiazepines, barbiturates, and antiepileptic drugs. 4. Use with an MAOI.
Required Medical Information	1. Member has a clinical diagnosis of major depressive disorder (MDD) as defined by DSM-5 criteria and/or appropriate depression rating scale (e.g., MADRS). 2. Member has had previous treatment , contraindication, or intolerance to at least two antidepressants from two different classes (e.g., SSRI, SNRI).
Age Restrictions	18 years of age and over
Prescriber Restrictions	
Coverage Duration	One (1) year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Avmapki-Fakzynja (avutometinib-defactinib)

Products Affected

- Avmapki Fakzynja Co-Pack

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Ayvakit (avapritinib)

Products Affected

- Ayvakit

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Balversa (erdafitinib)

Products Affected

- Balversa

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Benlysta (belimumab)

Products Affected

- Benlysta Subcutaneous

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Must be used in combination with standard therapy.
Age Restrictions	
Prescriber Restrictions	Nephrologist or Rheumatologist
Coverage Duration	Initial: 6 months Renewal: 1 year
Other Criteria	Documentation must be submitted demonstrating a clinical benefit has been established and maintained compared to baseline.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Besremi

Products Affected

- Besremi

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For Non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium or, one of the following: a Class I, Iia, or Iib recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, and some journals.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Bosulif (bosutinib)

Products Affected

- Bosulif

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Braftovi (encorafenib)

Products Affected

- Braftovi

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Bronchitol (mannitol)

Products Affected

- Bronchitol

PA Criteria	Criteria Details
Exclusion Criteria	Failure to pass Bronchitol tolerate test (BTT)
Required Medical Information	1. Diagnosis of cystic fibrosis. 2. Documentation of in adequate response to hypertonic saline and Pulmozyme, unless contraindicated or not tolerated. 3. Documentation that member has successfully complete the Bronchitol tolerance test (BTT).
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with a pulmonologist.
Coverage Duration	One (1) year
Other Criteria	Continuation criteria: positive clinical response to therapy
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Brukinsa (Zanubrutinib)

Products Affected

- Brukinsa

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Buphenyl (sodium phenylbutyrate)

Products Affected

- Sodium Phenylbutyrate Oral Powder 3 GM/TSP
- Sodium Phenylbutyrate Oral Tablet

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Cabometyx (cabozantinib)

Products Affected

- Cabometyx

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Calquence (acalabrutinib)

Products Affected

- Calquence

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Caplyta (lumateperone)

Products Affected

- Caplyta

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	<p>1. Schizophrenia: a. Trial and failure of two (2) atypical antipsychotics for a minimum of 4 weeks (non-responders) or 12 weeks (partial responders) - e.g., aripiprazole, lurasidone, olanzapine, quetiapine, risperidone, ziprasidone, first-generation antipsychotics, OR member has a current diagnosis of metabolic syndrome, pre-metabolic syndrome, or diabetes mellitus and has failed aripiprazole AND ziprasidone, unless there is a documented contraindication or intolerance. 2. Bipolar: a. Monotherapy: Trial and failure of two alternatives from the following: i. lamotrigine, ii. lithium, iii. carbamazepine, iv. valproic acid, v. Atypical Antipsychotics (e.g., aripiprazole, lurasidone, quetiapine). b. adjunct therapy: will be used with either lithium or valproic acid. 3. Major Depressive Disorder (MDD): Major Depressive Disorder (MDD): a. Must be used as adjunctive or add on treatment for MDD, not as monotherapy, AND b. The patient must have a documented trial and failure (minimum of 4 weeks) of at least one (1) drug from the following classes: SSRI, SNRI, bupropion, or mirtazapine, AND c. Trial and failure of aripiprazole or quetiapine in combination with an antidepressant for at least four (4) weeks.</p>
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One (1) year
Other Criteria	Continuation criteria: Documentation of positive clinical response to therapy.
Indications	All FDA-approved Indications.
Off Label Uses	

Y0055_MPC092560_NSR_C_10022025

Formulary ID 0026395

Version 046

Last Updated: 05/21/2026

Page | 32

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

Caprelsa (vandetanib)

Products Affected

- Caprelsa

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Carbaglu (carglumic acid)

Products Affected

- Carglumic Acid

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Cayston (aztreonam lysine)

Products Affected

- Cayston

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	FEV1 must be 25% to 75% of predicted. Patient must have a positive sputum culture for Pseudomonas aeruginosa.
Age Restrictions	7 years or older
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

CGRP Inhibitor

Products Affected

- Aimovig

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of Episodic Migraines (4 to 14 monthly migraine days with at least moderate disability (Migraine Disability Score - MIDAS- of at least 11 or HIT-6 - six-item Headache Impact Test - score greater than 50) or Chronic Migraines (15 or more monthly headache days).
Age Restrictions	18 years or older
Prescriber Restrictions	Prescribed by or in consultation with a Headache Specialist, a Neurologist, or a Pain Specialist.
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Cibinqo (abrocitinib)

Products Affected

- Cibinqo

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	a. Documentation of trial and failure of the following: i. Medium, high, or very high potency topical corticosteroid. ii. Topical calcineurin inhibitor. b. Documentation is provided that a non-corticosteroid systemic immunosuppressant (e.g., cyclosporine, azathioprine, methotrexate, or mycophenolate mofetil) has failed to achieve and maintain remission of disease activity.
Age Restrictions	
Prescriber Restrictions	Dermatologist
Coverage Duration	Initial: 6 months Renewal: 1 year
Other Criteria	Continuation criteria: positive clinical response to therapy.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Cinryze (C1 inhibitor-human)

Products Affected

- Cinryze

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Clovique (trientine)

Products Affected

- Trientine HCl

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documented intolerance to penicillamine
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Cobenfy (xanomeline and trospium chloride)

Products Affected

- Cobenfy
- Cobenfy Starter Pack

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	The patient must have a documented intolerance, side effects or lack of efficacy to at least two (2) other formulary atypical antipsychotics. Medication trials that fail due to lack of efficacy must be attempted for a minimum of 4 weeks if no response, and a minimum of 12 weeks if partial response, unless the patient has a documented intolerance or contraindication to the preferred medication. OR The patient has a current diagnosis of Metabolic Syndrome, Pre-Metabolic Syndrome, or Diabetes Mellitus and has failed ziprasidone or there is clinical documentation why ziprasidone is not clinically appropriate.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Colony Stimulating Factor

Products Affected

- Udenyca Subcutaneous Solution Prefilled Syringe
- Zarxio

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Indications for approval: 1. Cancer patients receiving myelosuppressive therapy. 2. Patients with acute myeloid leukemia receiving induction or consolidation chemotherapy. 3. Cancer patients receiving bone marrow transplant. 4. Patients undergoing peripheral blood progenitor cell collection and therapy. 5. Patients with severe chronic neutropenia (cyclic or idiopathic) that meets one of the following: a) Documented diagnosis of severe chronic neutropenia (idiopathic) with an ANC of less than 500/mm ³ on three separate occasions over the previous 6 months. OR b) Documented diagnosis of severe chronic neutropenia (cyclic) with five consecutive days per cycle with an ANC less than 500/mm ³ for each of 3 regularly spaced cycles over a 6-month period. 6. Patients with severe chronic neutropenia (congenital) that have a documented diagnosis of congenital neutropenia. 7. For the treatment of hematopoietic syndrome of acute radiation symptoms.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 months
Other Criteria	This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.
Indications	All FDA-approved Indications.
Off Label Uses	

Y0055_MPC092560_NSR_C_10022025

Formulary ID 0026395

Version 046

Last Updated: 05/21/2026

Page | 42

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

Cometriq (cabozantinib)

Products Affected

- Cometriq (100 MG Daily Dose)
- Cometriq (140 MG Daily Dose)
- Cometriq (60 MG Daily Dose)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Copiktra (duvelisib)

Products Affected

- Copiktra

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Y0055_MPC092560_NSR_C_10022025

Formulary ID 0026395

Version 046

Last Updated: 05/21/2026

Page | 45

Corlanor (ivabradine)

Products Affected

- Corlanor Oral Solution
- Ivabradine HCl

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Adults: Documented diagnosis of symptomatic chronic heart failure with left ventricular ejection fraction (LVEF) 35% or less, who are in normal sinus rhythm with a resting heart rate of at least 70 beats per minute (documented in the last 60 days) and are on a beta-blocker or have a contraindication or intolerance to beta-blocker use. Documentation that the patient has tried/failed sacubitril/valsartan or has a contraindication or intolerance to sacubitril/valsartan use. Pediatrics: Documented diagnosis of Symptomatic Heart Failure due to Dilated Cardiomyopathy in patients 6 months of age or older.
Age Restrictions	
Prescriber Restrictions	Cardiologist or in consultation with a Cardiologist or a cardiac care specialist
Coverage Duration	1 year
Other Criteria	Continuation: Documentation of successful response to the medication.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Cosentyx (secukinumab)

Products Affected

- Cosentyx (300 MG Dose)
- Cosentyx Sensoready (300 MG)
- Cosentyx Subcutaneous Solution Prefilled Syringe 75 MG/0.5ML
- Cosentyx UnoReady

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	<p>1. Ankylosing Spondylitis: i. The patient has a documented trial and failure with a non-steroidal anti-inflammatory drug (NSAID) or such treatment is contraindicated or not tolerated. ii. Patients with peripheral arthritis must have a documented trial and failure with sulfasalazine or such treatment is contraindicated or not tolerated. iii. Patients with axial disease and a trial and failure of, or a contraindication to, NSAIDs can be started on Cosentyx without a trial of sulfasalazine. iv. Trial and failure, unless contraindicated or not tolerated, to one of the following agents: 1. Amjevita. 2. Enbrel.3. Hadlima. 4. Xeljanz. 2. Plaque Psoriasis: i. The patient must have 3% or more of their body surface area (BSA) affected by plaque psoriasis (or less than 3% if a crucial area of the body is affected. ii. The disease is severe as defined by a total Psoriasis Area Severity Index (PASI) more than 5 and/or a Dermatology Life Quality Index (DLQI) more than 5. iii. The patient has failed to adequately respond to or is intolerant to a 3-month trial of two of the topical agents (topical corticosteroid, topical calcineurin inhibitor, topical vitamin D analog, etc.). iv. Trial and failure, unless contraindicated or not tolerated, of one of the following agents: 1. Amjevita. 2. Enbrel.3. Hadlima. 3. Psoriatic Arthritis: i. An adequate trial (3 months or more) of one of the following DMARDs: 1. Cyclosporine. 2. Leflunomide. 3. Methotrexate. 4. Sulfasalazine. ii. Trial and failure, unless contraindicated or not tolerated, to one of the following agents: 1. Amjevita. 2. Enbrel. 3. Hadlima. 4. Xeljanz, or the patient has been treated with a targeted immunomodulator in past. Please provide date of therapy, duration of therapy, and drug name.</p>
Age Restrictions	

PA Criteria	Criteria Details
Prescriber Restrictions	Rheumatologist or Dermatologist
Coverage Duration	Initial: 6 months Renewal: 1 year
Other Criteria	Non-radiographic axial spondyloarthritis: trial and failure of two non-steroidal anti-inflammatories for at least 4 weeks each at maximally tolerated doses, unless contraindicated or not tolerated. Hidradenitis suppurativa (HS): Documented diagnosis of Hurley Stage II or Stage III HS. Enthesitis-related arthritis: trial and failure of two non-steroidal anti-inflammatories for at least 4 weeks each at maximally tolerated doses, unless contraindicated or not tolerated. Continuation criteria: positive clinical response to therapy.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Cotellic (cobimetinib)

Products Affected

- Cotellic

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Cresemba (isavuconazonium)

Products Affected

- Cresemba Oral

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	One of the following is met: a. the patient has a diagnosis of invasive aspergillosis. b. The patient has a diagnosis of invasive mucormycosis. c. The use of the requested drug is for an indication other than those noted above that is supported by CMS-approved compendia, such as Micromedex and AHFS-Drug Information.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Three (3) months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Cystaran (cysteamine) ophthalmic solution

Products Affected

- Cystaran

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Original diagnosis made by an eye specialist. Individual has medical record documentation of a confirmed diagnosis of cystinosis. Individual has medical record documentation of corneal cystine crystals.
Age Restrictions	
Prescriber Restrictions	Ophthalmologist
Coverage Duration	6 months
Other Criteria	Reauthorization: documentation of positive clinical response to Cystaran therapy.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Danziten (nilotinib)

Products Affected

- Danziten

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Daraprim (pyrimethamine)

Products Affected

- Pyrimethamine Oral

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Toxoplasmosis: documentation that the patient will be using a sulfonamide. Toxoplasmosis prophylaxis.
Age Restrictions	
Prescriber Restrictions	Infectious Disease or in consultation with Infectious Disease
Coverage Duration	8 weeks
Other Criteria	Pyrimethamine is not recommended for the treatment of acute malarial attacks and is not included in the CDC recommendations for the treatment of malaria. Pyrimethamine is not the drug of choice for malaria prophylaxis.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Daurismo (glasdegib)

Products Affected

- Daurismo

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Deferasirox (Jadenu and Exjade)

Products Affected

- Deferasirox Oral Tablet
- Deferasirox Oral Tablet Soluble

PA Criteria	Criteria Details
Exclusion Criteria	eGFR less than 40 ml/min/1.73, patients with poor performance status, patients with high-risk myelodysplastic syndrome (MDS), and patients with advanced malignancies.
Required Medical Information	1. Chronic iron overload due to blood transfusions: The member has received a transfusion of at least 100 mL/kg of packed red blood cells (e.g., at least 20 units of packed red blood cells for a 40 kg person or more than 20 units in an individual weighing more than 40 kg), and serum ferritin is consistently greater than 1,000 mcg/L. 2. Iron overload in non-transfusion-dependent thalassemia syndromes (NTDT): The member has a liver iron concentration (LIC) of at least 5 mg Fe/g of dry weight and a serum ferritin greater than 300 mcg/L. Baseline lab values required for both indications: renal function, serum transaminases and bilirubin, and auditory and ophthalmic examinations.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Initial: 6 months. Continuation: 1 year
Other Criteria	Continuation criteria: 1. Chronic iron overload due to blood transfusions: routine (monthly) blood counts, liver function, renal function, and ferritin. 2. NTDT: LIC every 6 months, routine (monthly) blood counts, liver function, renal function, and ferritin.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Y0055_MPC092560_NSR_C_10022025

Formulary ID 0026395

Version 046

Last Updated: 05/21/2026

Page | 55

PA Criteria	Criteria Details
Prerequisite Therapy Required	No

Depen (penicillamine tablets)

Products Affected

- penicillAMINE Oral Tablet

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Cystinuria: Documented trial and failure or intolerance to Thiola (tiopronin).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	Renewal: Documentation must be submitted demonstrating a successful response to the medication.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Drizalma (duloxetine)

Products Affected

- Drizalma Sprinkle

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Chart notes documenting a trial of, intolerance, or contraindication to duloxetine (Cymbalta) capsule or amitriptyline use in the last 180 days.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One (1) year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Dupixent

Products Affected

- Dupixent

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	<p>1. Atopic Dermatitis a. Diagnosis of moderate to severe atopic dermatitis. b. 6 months of age and older c. Member has had an inadequate response to a 3-month trial of a medium to high potency topical steroid (e.g., mometasone, fluocinilone, fluocinonide) OR a topical calcineurin inhibitor (e.g., tacrolimus). d. IGA score of at least 3 e. EASI score of at least 16 f. Minimum body surface area involvement of ≥10% g. Initial curation: 6 months h. Reauthorization: Documentation of positive clinical response and will not be used in combination with another biologic medication.</p> <p>2. Asthma a. 6 years of age and older b. History of one or more asthma exacerbations that required treatment with systemic corticosteroids or emergency visit or hospitalization for the treatment of asthma within the past year. c. Daily dependence on oral corticosteroids in addition to regular use of high-dose inhaled corticosteroids plus an additional controller. d. Diagnosis of eosinophilic asthma. e. Initial coverage duration: 6 months f. Reauthorization: Documented clinical response to Dupixent demonstrated by 1) reduction in frequency of exacerbations, 2) decreased utilization of rescue medications, 3) reduction in oral corticosteroid requirements: Dupixent will be used in combination with an ICS controller medication: and Dupixent will not be used with another biologic medication.</p> <p>3. Bullous pemphigoid: Trial and failure of a high-potency topical steroid, oral steroid, or doxycycline. BP Disease Area Score of 24 or greater. Weekly average Peak Pruritus NRS score of 4 or greater. Will be used in combination with a tapered course of oral corticosteroids. Continuation: positive clinical response as evidenced by sustained remission and improvement in scores.</p>
Age Restrictions	
Prescriber Restrictions	

PA Criteria	Criteria Details
Coverage Duration	Initial: 6 months Continuation: 1 year
Other Criteria	<p>3. Chronic Rhinosinusitis with Nasal Polyps a. 12 years of age and older b. To be used as add-on maintenance treatment for individuals with: Nasal polyps detected by direct examination, endoscopy, or sinus CT scan Significant rhinosinusitis such as nasal obstruction, rhinorrhea, or reduction or loss of smell as documented by the prescriber. c. Bilateral Nasal Polyp Score (NPS) of at least 5, and NPS of at least 2 in each nostril. d. Documented inadequate response to nasal corticosteroids. e. Patient has received treatment with systemic corticosteroids with the past two years (or has a contraindication) or has had prior surgery for nasal polyps. f. Initial coverage: 6 months g. Reauthorization: Documented positive clinical response: patient will continue to receive Dupixent as add-on maintenance therapy in combination with intranasal corticosteroids, and patient will not use Dupixent with another biologic medication. 4. Eosinophilic Esophagitis: a. Documented trial and failure of a proton pump inhibitor (PPI) or a topical glucocorticoid steroid. b. Diagnosis confirmed by greater than or equal to 15 intraepithelial eosinophils per high-power field (eos/hpf). c. Prescribed by or in consultation with a gastroenterologist or allergist. d. Reauthorization: documented positive clinical response as demonstrated by a decrease in eos/hpf and improvement in baseline Dysphagia Symptom Questionnaire (DSQ) score. 5. Prurigo Nodularis: a. Worst Itch-Numeric Rating Scale (WI-NRS) greater than or equal to 7 and nodular lesions. 6. COPD: FEV1/FVC ratio of less than 0.7 and post-bronchodilator FEV1 of 30%. 7. Chronic Spontaneous Urticaria: Trial and failure of two antihistamines at maximum tolerated doses for at least two weeks each, unless contraindicated or not tolerated. Member has not received prior anti-IgE therapy. Continuation: responded positively as evidenced by a decrease in itch severity, decrease in number of hives, or decrease in size of hives.</p>
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite	Yes

PA Criteria	Criteria Details
Therapy Required	

Emend (aprepitant oral)

Products Affected

- Aprepitant
- Emend Oral Suspension Reconstituted

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Emgality (galcanezumab-gnlm)

Products Affected

- Emgality

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of Episodic Migraines (4 to 14 monthly migraine days with at least moderate disability (Migraine Disability Score - MIDAS- of at least 11 or HIT-6 - six-item Headache Impact Test - score greater than 50), or documented diagnosis of episodic cluster headaches.
Age Restrictions	18 years or older
Prescriber Restrictions	Prescribed by or in consultation with a Headache Specialist, a Neurologist, or a Pain Specialist.
Coverage Duration	6 months
Other Criteria	Continuation: Documentation that the patient has experienced a positive clinical response
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Enbrel (etanercept)

Products Affected

- Enbrel Mini
- Enbrel Subcutaneous Solution 25 MG/0.5ML
- Enbrel Subcutaneous Solution Prefilled Syringe
- Enbrel Subcutaneous Solution Reconstituted
- Enbrel SureClick Subcutaneous Solution Auto-Injector

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	<p>1. Ankylosing Spondylitis (AS): peripheral arthritis must have a trial of sulfasalazine and an NSAID. Patients with axial disease and failure of NSAIDs can be started without a trial of sulfasalazine. 2. Juvenile Idiopathic Arthritis (JIA): An adequate trial (3 months or more) of one of the following DMARDs: leflunomide, methotrexate, sulfasalazine. 3. Plaque Psoriasis (PsO): a. The patient must have at least 3% of their body surface area (BSA) affected by plaque psoriasis (unless on hands, feet, scalp, face, or genital area). b. The disease is severe as defined by a total Psoriasis Area Severity Index (PASI) of at least 5 or more, or a Dermatology Life Quality Index (DLQI) of more than 5. c. The patient has failed to adequately respond to, or is intolerant, a 3-month trial of a topical agent (topical corticosteroid, topical calcineurin inhibitor, topical vitamin D analogs, etc.). 4. Psoriatic Arthritis (PsA): Documented diagnosis of psoriatic arthritis. 5. Rheumatoid Arthritis (RA): Moderate to severe RA is defined as: DAS-28 more than 3.2 or CDAI more than 10.1. An adequate trial (3 months or more) of one of the following other DMARDs: hydroxychloroquine, leflunomide, methotrexate, sulfasalazine.</p>
Age Restrictions	
Prescriber Restrictions	<p>1. AS/JIA/RA - prescribed by or in consultation with a rheumatologist. 3. PsA- prescribed by or in consultation with a dermatologist or rheumatologist 4. PsO- prescribed by or in consultation with a dermatologist.</p>

PA Criteria	Criteria Details
Coverage Duration	1 year
Other Criteria	For all diagnoses: 1. Current PPD (tuberculosis) negative skin test or negative QuantiFERON-TB Gold test before the initiation of therapy. 2. The appropriate Disease Specific Criteria has been met. CONTINUATION CRITERIA: Documentation of positive clinical response to treatment.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Endari (L-glutamine)

Products Affected

- L-Glutamine Oral Packet

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	1. Diagnosis of sickle cell disease. 2. Will be used to reduce acute complications of sickle cell disease. 3. Will be used concurrently with hydroxyurea, unless contraindicated or not tolerated. 4. Member has had two (2) or more painful sickle cell crises within the past 12 months.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One (1) year
Other Criteria	Continuation therapy: positive clinical response to therapy.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Ensacove (ensartinib)

Products Affected

- Ensacove

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Entocort (budesonide capsules)

Products Affected

- Budesonide Oral

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	1. The member has a diagnosis of mild to moderate Crohn's disease. 2. Documented trial and failure of sulfasalazine.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Epclusa (sofosbuvir/velpatasvir)

Products Affected

- Sofosbuvir-Velpatasvir

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Medical records documenting the diagnosis of chronic Hepatitis C, including laboratory documentation of genotype and subtype, detectable HCV RNA levels at baseline, HIV status and liver transplant status.
Age Restrictions	3 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with a infectious disease specialist, hepatologist, or gastroenterologist.
Coverage Duration	Duration as per package insert or Class I or II recommendation by the AASLD/IDSA/IAS-USA guidelines
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Epidiolex (cannabidiol)

Products Affected

- Epidiolex

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Lennox-Gastaut Syndrome: Diagnosis of Lennox-Gastaut Syndrome and seizures have been inadequately controlled by a trial of at least two antiepileptic drugs (e.g. clobazam, valproate, lamotrigine, topiramate, levetiracetam). Dravet Syndrome: Diagnosis of Dravet Syndrome and seizures have been inadequately controlled by a trial of at least two antiepileptic drugs (e.g. clobazam, valproate, lamotrigine, topiramate, levetiracetam).
Age Restrictions	1 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with a Neurologist
Coverage Duration	Initial: 6 months ReAuthorization: 1 year
Other Criteria	AST, ALT and total bilirubin levels will be obtained 1 month, 3 months, and 6 months after initiation, then periodically thereafter or as clinically indicated. ReAuthorization: Patient is tolerating treatment and there continues to be a medical need for the medication and there has been disease stabilization or improvement while on this medication.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Y0055_MPC092560_NSR_C_10022025

Formulary ID 0026395

Version 046

Last Updated: 05/21/2026

Page | 70

Erivedge (vismodegib)

Products Affected

- Erivedge

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Erleada (apalutamide)

Products Affected

- Erleada

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Erythropoietin Stimulating Agents

Products Affected

- Retacrit Injection Solution 10000 UNIT/ML, 3000 UNIT/ML, 4000 UNIT/ML, 10000 UNIT/ML(1ML), 2000 UNIT/ML, 40000 UNIT/ML

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Erzofri (paliperidone)

Products Affected

- Erzofri

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation that the patient has tried and failed oral paliperidone or risperidone.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One (1) year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Esbriet (pirfenidone)

Products Affected

- Pirfenidone Oral Capsule
- Pirfenidone Oral Tablet 267 MG, 801 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	1. Diagnosis confirmed by high-resolution computed tomography (HRCT). 2. Exclusion of other known causes, such as domestic and occupational environmental exposures, connective tissue disease, and drug toxicity. 3. Baseline Forced Vital Capacity (FVC) greater than or equal to 50% (pulmonary function tests - PFTs - within the past 60 days).
Age Restrictions	18 years or older
Prescriber Restrictions	Pulmonologist
Coverage Duration	1 year
Other Criteria	Baseline Liver Function test
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Fanapt (iloperidone)

Products Affected

- Fanapt
- Fanapt Titration Pack
- Fanapt Titration Pack A

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	1. Schizophrenia: a. Trial and failure of two (2) atypical antipsychotics for a minimum of 4 weeks (non-responders) or 12 weeks (partial responders) - e.g., aripiprazole, lurasidone, olanzapine, quetiapine, risperidone, ziprasidone, first-generation antipsychotics, OR member has a current diagnosis of metabolic syndrome, pre-metabolic syndrome, or diabetes mellitus and has failed aripiprazole AND ziprasidone, unless there is a documented contraindication or intolerance. 2. Bipolar: a. Monotherapy: Trial and failure of two alternatives from the following: i. lamotrigine, ii. lithium, iii. carbamazepine, iv. valproic acid, v. Atypical Antipsychotics (e.g., aripiprazole, lurasidone, quetiapine). b. adjunct therapy: will be used with either lithium or valproic acid.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One (1) year
Other Criteria	Continuation criteria: positive clinical response to therapy.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy	Yes

PA Criteria	Criteria Details
Required	

Farydak (panobinostat)

Products Affected

- Farydak

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For Non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium or there must be a Class I or IIa recommendation in the Thomson Micromedex DrugDex compendium.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Fasenra (benralizumab)

Products Affected

- Fasenra
- Fasenra Pen

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	FDA approved for asthma maintenance add-on therapy in severe asthma (eosinophilic phenotype), medical records must document IgE level, AND inadequate control with an inhaled corticosteroid and a long acting beta-2 agonist combination therapy, AND evidence of persistent symptoms requiring frequent rescue therapy, practitioner visits despite inhaled corticosteroids, ER visits OR inadequate control OR intolerance OR contraindication to inhaled corticosteroid and a long acting beta-2 agonist combination. Not to be used as monotherapy or concomitantly with other biologics. Continuation Criteria: Documentation of a reduction in exacerbation frequency and/or severity. For Eosinophilic Granulomatosis with polyangiitis: within the past 2 years, the patient has experienced relapsing disease requiring dose or dose escalation of corticosteroids or immunosuppressant, or hospitalization -OR- with the prior 6 months following induction with standard therapy. Patient is currently on standard therapy (e.g., systemic corticosteroids) with or without immunosuppressive therapy (e.g., cyclophosphamide).
Age Restrictions	
Prescriber Restrictions	Allergist, Pulmonologist, Dermatologist, Rheumatologist, or Immunologist
Coverage Duration	Initial: 9 months Continuation: 12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B	No

PA Criteria	Criteria Details
Prerequisite	
Prerequisite Therapy Required	Yes

Fensolvi (leuprolide)

Products Affected

- Fensolvi
- Fensolvi (6 Month)

PA Criteria	Criteria Details
Exclusion Criteria	Not covered for treatment of prostate cancer
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Ferriprox (deferiprone)

Products Affected

- Deferiprone

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient must have an absolute neutrophil count (ANC) greater than $1.5 \times 10^9/L$ before starting therapy. Patient must have tried and failed or have a contraindication to deferasirox. ANC levels are not required for iron transfusional overload in patients with sickle cell disease or other anemias.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	For renewal, must receive documentation demonstrating clinical efficacy.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Firazyr (icatibant)

Products Affected

- Icatibant Acetate
- Sajazir

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Medical records must document a diagnosis of hereditary angioedema (HAE). The patient must not be concurrently taking an angiotensin converting enzyme (ACE) inhibitor or estrogen replacement therapy and must be experiencing at least one symptom of a moderate or severe attack (ie. swelling of the face, throat, or abdomen).
Age Restrictions	18 years or older
Prescriber Restrictions	Allergist or Immunologist
Coverage Duration	6 months
Other Criteria	Medical records documenting frequency of acute HAE attacks and the patient's response to therapy must be provided. If the patient is experiencing more than one acute HAE attack per month medical records documenting use of a long-term prophylactic therapy (LTP) or the clinical rationale for avoiding LTP must be provided.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Firdapse (amifampridine)

Products Affected

- Firdapse

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Confirmed diagnosis of Lambert-Eaton myasthenic syndrome (LEMS), documentation of baseline confirmatory diagnostic test results including but not limited to: a Repetitive Nerve Stimulation (RNS), a positive anti-P/Q type voltage-gated calcium channel antibody test, a Quantitative Myasthenia Gravis (QMG) score, a triple-timed up-and-go test (3TUG), a Timed 25-foot walk test (T25FW).
Age Restrictions	6 years of age and older
Prescriber Restrictions	Neurologist
Coverage Duration	Initial: 6 months Renewal: 1 year
Other Criteria	Dose does not exceed 80mg per day. Renewal: Documentation of clinical improvement in symptoms
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Forteo (teriparatide)

Products Affected

- Forteo Subcutaneous Solution Pen-Injector
560 MCG/2.24ML, 600 MCG/2.4ML

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	A diagnosis of osteoporosis and a T-score of -2.5 or less at the femoral neck, total hip or lumbar spine by DXA. The patient has failed or is intolerant to at least one other available osteoporosis therapy (oral bisphosphates, IV zoledronic acid).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	Yes
Prerequisite Therapy Required	Yes

Fotivda (Tivozanib)

Products Affected

- Fotivda

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Fruzaqla (fruquintinib)

Products Affected

- Fruzaqla

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Six (6) months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Gamunex-C (human immune globulin)

Products Affected

- Flebogamma DIF
- Gamunex-C

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Gattex (teduglutide)

Products Affected

- Gattex

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documented diagnosis of short-bowel syndrome who require parenteral nutrition.
Age Restrictions	1 year of age and older
Prescriber Restrictions	Gastroenterologist
Coverage Duration	1 year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Gavreto (pralsetinib)

Products Affected

- Gavreto

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Y0055_MPC092560_NSR_C_10022025

Formulary ID 0026395

Version 046

Last Updated: 05/21/2026

Page | 90

Gilotrif (afatinib)

Products Affected

- Gilotrif

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Y0055_MPC092560_NSR_C_10022025

Formulary ID 0026395

Version 046

Last Updated: 05/21/2026

Page | 91

Gleevec (imatinib)

Products Affected

- Imatinib Mesylate Oral

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

GLP-1 Agonists

Products Affected

- Mounjaro
- Trulicity

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of Type 2 Diabetes Mellitus (T2DM).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 Months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Gomekli (mirdametinib)

Products Affected

- Gomekli

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Hadlima (adalimumab-bwwd)

Products Affected

- Hadlima
- Hadlima PushTouch

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	<p>1. Ankylosing Spondylitis (AS): peripheral arthritis must have a trial of sulfasalazine and an NSAID. Patients with axial disease and failure of NSAIDs can be started without a trial of sulfasalazine. 2. Crohn's disease (CD): Documented diagnosis of moderately to severely active CD as evidenced by colonoscopy, CT scan, MRI, or capsule endoscopy. 3. Juvenile Idiopathic Arthritis (JIA): An adequate trial (3 months or more) of one of the following DMARDs: i. Leflunomide ii. Methotrexate iii. Sulfasalazine. 4. Plaque Psoriasis (PsO): a. The patient must have at least 3% of their body surface area (BSA) affected by plaque psoriasis (unless on hands, feet, scalp, face, or genital area). b. The disease is severe as defined by a total Psoriasis Area Severity Index (PASI) of at least 5 or more and/or a Dermatology Life Quality Index (DLQI) of more than 5. c. The patient has failed to adequately respond to, or is intolerant, a 3-month trial of a topical agent (topical corticosteroid, topical calcineurin inhibitor, topical vitamin D analogs, etc.). 5. Psoriatic Arthritis (PsA): Documented diagnosis of psoriatic arthritis. 6. Rheumatoid Arthritis (RA): Moderate to severe RA is defined as: DAS-28 more than 3.2 or CDAI more than 10.1. c. An adequate trial (3 months or more) of one of the following other DMARDs: i. Hydroxychloroquine ii. Leflunomide iii. Methotrexate iv. Sulfasalazine 7. Ulcerative Colitis (UC): Documented diagnosis of moderately to severely active ulcerative colitis. 8. Hidradenitis Suppurativa (HS): Documented diagnosis of Hurley Stage III HS or refractory Hurley Stage II hidradenitis suppurativa.</p>
Age Restrictions	

PA Criteria	Criteria Details
Prescriber Restrictions	1. AS/RA/JIA - prescribed by or in consultation with a rheumatologist. 2. CD/UC- prescribed by or in consultation with a gastroenterologist. 3. PsO/HS - prescribed by or in consultation with a dermatologist. 4. PsA - prescribed by or in consultation with a dermatologist or rheumatologist. 5. UC prescribed by or in consultation with a gastroenterologist. 6. UV prescribed by or in consultation with an ophthalmologist.
Coverage Duration	One (1) year
Other Criteria	Uveitis: a. Documented diagnosis of non-infectious intermediate, posterior and panuveitis in adult patients and meets the following: i. A documented trial and failure, contraindication, or intolerance to at least one conventional therapy such as ophthalmic or systemic corticosteroids AND immunosuppressive drugs (e.g. azathioprine, cyclosporine, methotrexate, or tacrolimus). For all diagnoses: 1. Current PPD (tuberculosis) negative skin test or negative QuantiFERON-TB Gold test before the initiation of therapy, 2. The appropriate Disease Specific Criteria has been met. CONTINUATION CRITERIA: Documentation of positive response with treatment
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Hernexeos (zongertinib)

Products Affected

- Hernexeos

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Hetlioz (tasimelteon)

Products Affected

- Tasimelteon

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Must have a documented diagnosis of (1) Non-24-Hour Sleep-Wake Disorder in adults or (2) Nighttime sleep disturbances in Smith-Magenis Syndrome (SMS) in patients 16 years of age and older.
Age Restrictions	
Prescriber Restrictions	Sleep Specialist or Neurologist
Coverage Duration	Initial: 6 months Renewal: 1 year
Other Criteria	For renewal, chart notes must show clinical response to therapy.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Hexalen (altretamine)

Products Affected

- Hexalen

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For Non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium or there must be a Class I or IIa recommendation in the Thomson Micromedex DrugDex compendium.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

High Risk Medication - Paroxetine

Products Affected

- PARoxetine HCl
- Paxil Oral Suspension

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	You must have taken two (2) of the following drugs: a selective serotonin reuptake inhibitor (SSRI) or a serotonin norepinephrine reuptake inhibitor (SNRI).
Age Restrictions	No Prior Authorization is required if 64 years of age or less.
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

High Risk Medications

Products Affected

- chlordiazePOXIDE HCl
- chlorproMAZINE HCl Oral Tablet
- Scopolamine

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	No Prior Authorization is required if 64 years of age or less.
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

High Risk Medications (estrogen containing products)

Products Affected

- Abigale
- Jinteli
- Abigale Lo
- Lopreeza
- Alora
- Lyllana
- Amabelz
- Menest
- Dotti
- Mimvey
- Estradiol Oral Tablet 2 MG
- Mimvey Lo
- Estradiol-Norethindrone Acet
- Norethindrone-Eth Estradiol
- Estropipate Oral
- Premarin Oral
- Evamist
- Premphase
- Fyavolv
- Prempro
- Jevantique Lo

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	No Prior Authorization is required if 64 years of age or less.
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All FDA-approved Indications.

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

Hydroxyzine HCl and Pamoate

Products Affected

- hydrOXYzine HCl Oral Tablet
- hydrOXYzine Pamoate Oral

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Anxiety: Chart notes documenting at least two medications tried and failed for anxiety (e.g., buspirone, citalopram, fluoxetine, sertraline, duloxetine, venlafaxine). Pruritis: Chart notes documenting at least one medication used for itching (e.g. oral antihistamine, topical steroid).
Age Restrictions	No Prior Authorization is required if 64 years of age or less.
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Hyruno (sevabertinib)

Products Affected

- Hyruno

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Ibrance (palbociclib)

Products Affected

- Ibrance

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Y0055_MPC092560_NSR_C_10022025

Formulary ID 0026395

Version 046

Last Updated: 05/21/2026

Page | 106

Ibtrozi (taletrectinib)

Products Affected

- Ibtrozi

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Iclusig (ponatinib)

Products Affected

- Iclusig

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	18 years or older
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Idhifa (enasidenib)

Products Affected

- IDHIFA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	Documentation of an isocitrate dehydrogenase-2 (IDH2) mutation detected by an FDA-approved test.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Imbruvica (ibrutinib)

Products Affected

- Imbruvica Oral Capsule
- Imbruvica Oral Suspension
- Imbruvica Oral Tablet 140 MG, 280 MG, 420 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Imkeldi (imatinib)

Products Affected

- Imkeldi

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Increlex (mecasermin)

Products Affected

- Increlex

PA Criteria	Criteria Details
Exclusion Criteria	Secondary forms of IGF-1 deficiency.
Required Medical Information	Documentation of all of the following: height standard deviation score less than or equal to negative 3, basal IGF-1 standard deviation score less than or equal to negative 3, normal or elevated GH levels, predicted adult height more than 1.5 standard deviations below the mid-parenteral height, growth rate less than 7 cm/year if less than or equal to 3 years old and less than 5 cm if greater than 3 years old, and open epiphyses on bone radiograph.
Age Restrictions	2 to 18 years of age
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Inlyta (axitinib)

Products Affected

- Inlyta

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Inqovi (cedazuridine/decitabine)

Products Affected

- Inqovi

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Inrebic (fedratinib)

Products Affected

- Inrebic

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Iressa (gefitinib)

Products Affected

- Gefitinib

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Itovebi (inavolisib)

Products Affected

- Itovebi

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Ivermectin (s)

Products Affected

- Ivermectin Oral Tablet 3 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Strongyloidiasis: Diagnosis of intestinal (i.e., nondisseminated) strongyloidiasis due to the nematode parasite Strongyloides stercoralis OR both of the following: member received the drug within the past 120 days and member requires continuation of therapy. Onchocerciasis: Diagnosis of onchocerciasis due to the nematode parasite Onchocerca volvulus OR both of the following: member received the drug within the past 120 days and member requires continuation of therapy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Strongyloidiasis: 3 weeks. Onchocerciasis: 6 months.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Iwilfin (eflornithine)

Products Affected

- Iwilfin

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Y0055_MPC092560_NSR_C_10022025

Formulary ID 0026395

Version 046

Last Updated: 05/21/2026

Page | 119

Jakafi (ruxolitinib)

Products Affected

- Jakafi

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Jaypirca (pirtobrutinib)

Products Affected

- Jaypirca

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium or, one of the following: a Class I, Iia, or Iib recommendation in the Thomsn Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, or an Evidence Level A by Lexi-Drugs.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Six (6) months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Juxtapid (lomitapide)

Products Affected

- Juxtapid Oral Capsule 10 MG, 20 MG, 30 MG, 40 MG, 5 MG, 60 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	A diagnosis of homozygous familial hypercholesterolemia (HoFH) as defined by the presence of at least one of the following clinical criteria: (1) documented functional mutation(s) in both low-density lipoprotein (LDL) receptor alleles or alleles known to affect LDL receptor functionality, or (2) skin fibroblast LDL receptor activity less than 20% normal, or (3) untreated total cholesterol (TC) greater than 500 mg/dL and triglycerides (TG) less than 300 mg/dL and both parents with documented untreated TC greater than 250 mg/dL. Patient must have tried and failed a high intensity statin at maximum tolerated dose OR have a documented intolerance or contraindication to statins. Must be used in combination with other lipid-lowering treatments.
Age Restrictions	18 years or older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy	Yes

PA Criteria	Criteria Details
Required	

Jynarque (tolvaptan)

Products Affected

- Tolvaptan (Hyponatremia) Oral Tablet 30 MG
- Tolvaptan Oral Tablet 30 MG
- Tolvaptan Oral Tablet Therapy Pack

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	a. Must be 18 years of age or older. b. Diagnosis of ADPKD. c. Positive genetic test for ADPKD (mutation in PKD1 or PKD2 gene), OR i. In members aged 18 to less than 40 years with a first degree relative with ADPKD: greater than or equal to 3 cysts (unilateral or bilateral) using any radiologic method. ii. In members aged 40 to less than 60 years with a first degree relative with ADPKD: greater than or equal to 2 cysts per kidney using any radiologic method. iii. In members aged 60 or older with a first degree relative with ADPKD: greater than or equal to 4 cysts per kidney using any radiologic method. d. Must have CKD stage 2 through 4. eGFR is great than or equal to 25 mL/min/1.73 m2.
Age Restrictions	
Prescriber Restrictions	Prescribed by a nephrologist.
Coverage Duration	Initial: 6 months Renewal: 1 year
Other Criteria	Continuation criteria: Positive clinical response to therapy as evidenced by slowed kidney function decline and eGFR remains greater than or equal to 25 mL/min/1.73 m2.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite	No

PA Criteria	Criteria Details
Therapy Required	

Kalydeco (ivacaftor)

Products Affected

- Kalydeco Oral Packet 25 MG, 50 MG, 75 MG
- Kalydeco Oral Tablet

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	1 month old to 5 years of age: Oral granules. 6 years of age or older: Oral tablets.
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Kerendia (finerenone)

Products Affected

- Kerendia Oral Tablet 10 MG, 20 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	1. Member has a documented diagnosis chronic kidney disease (CKD) associated with type 2 diabetes (T2D). 2. Diagnosis is defined by one of the following: a. UACR of 30 to 300 mg/g, minimum eGFR of 25 mL/min/1.73 m ² , and diabetic retinopathy, or, b. UACR of greater than or equal to 300 mg/g and a minimum eGFR 25 ml/min/1.73 m ² . 3. Therapy will not be initiated if serum potassium is greater than 5 mEq/L. 4. Member has been on a maximally tolerated dose of either an angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB), unless otherwise contraindicated or not tolerated, Or, 5. Member has a documented diagnosis of heart failure with an ejection fraction of 40% or greater.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One (1) year
Other Criteria	Continuation criteria: Documentation of positive clinical response to therapy.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy	Yes

Y0055_MPC092560_NSR_C_10022025

Formulary ID 0026395

Version 046

Last Updated: 05/21/2026

Page | 127

PA Criteria	Criteria Details
Required	

Kineret (anakinra)

Products Affected

- Kineret Subcutaneous Solution Prefilled Syringe

PA Criteria	Criteria Details
Exclusion Criteria	Will not be approved for use in combination with TNF antagonists.
Required Medical Information	Rheumatoid Arthritis (RA): Moderate to severe RA is defined as: DAS-28 more than 3.2 or CDAI more than 10.1. An adequate trial (3 months or more) of one of the following other DMARDs: hydroxychloroquine, leflunomide, methotrexate, sulfasalazine. Trial and failure of two of the following, unless contraindicated or not tolerated: Amjevita, Enbrel, Hadlima, Xeljanz.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	Continuation criteria: Documentation of positive clinical response to treatment.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Kisqali (ribociclib)

Products Affected

- Kisqali (200 MG Dose)
- Kisqali (400 MG Dose)
- Kisqali (600 MG Dose)
- Kisqali 200 Dose
- Kisqali 400 Dose
- Kisqali 600 Dose
- Kisqali Femara (200 MG Dose)
- Kisqali Femara (400 MG Dose)
- Kisqali Femara (600 MG Dose)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

Y0055_MPC092560_NSR_C_10022025

Formulary ID 0026395

Version 046

Last Updated: 05/21/2026

Page | 130

PA Criteria	Criteria Details
Prerequisite Therapy Required	No

Korlym (mifepristone)

Products Affected

- miFEPRIStone Oral Tablet 300 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	18 years or older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Koselugo (selumetinib)

Products Affected

- Koselugo

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Krazati (adagrasib)

Products Affected

- Krazati

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Kuvan (sapropterin)

Products Affected

- Sapropterin Dihydrochloride

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Initial Authorizations: Medical records documenting all of the following: the target Phe blood level for the patient and dose does not exceed FDA approved maximum for the diagnosis. Renewal: Recent Phe level is at target range.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Initial authorization: 2 months Renewal: 6 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Lazcluze (lazertinib)

Products Affected

- Lazcluze

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Lenvima (lenvatinib)

Products Affected

- Lenvima (10 MG Daily Dose)
- Lenvima (12 MG Daily Dose)
- Lenvima (14 MG Daily Dose)
- Lenvima (18 MG Daily Dose)
- Lenvima (20 MG Daily Dose)
- Lenvima (24 MG Daily Dose)
- Lenvima (4 MG Daily Dose)
- Lenvima (8 MG Daily Dose)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite	No

PA Criteria	Criteria Details
Therapy Required	

Leukine (sargramostim)

Products Affected

- Leukine Injection Solution Reconstituted
- Leukine Intravenous

PA Criteria	Criteria Details
Exclusion Criteria	Combination use with pegfilgrastim or filgrastim.
Required Medical Information	Medical records documenting neutropenia which is defined as an absolute neutrophil count less than 500/mm ³ .
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Lidoderm (lidocaine topical patch)

Products Affected

- Lidocaine External Patch 5 %

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Livtency (maribavir)

Products Affected

- Livtency

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	1. Patient is 12 years of age or older. 2. History of hematopoietic stem cell transplant or solid organ transplant. 3. Diagnosis of post-transplant CMV infection/disease with CMV DNA of 2730 IU/mL or greater in whole blood or 910 IU/mL or greater in plasma. 4. CMV disease refractory to previous treatment with intravenous ganciclovir, valganciclovir, foscarnet, or cidofovir. 5. Patient should not be on any other CMV antivirals.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Eight (8) Weeks
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Lonsurf (tipiracil/trifluridine)

Products Affected

- Lonsurf

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Lorbrena (lorlatinib)

Products Affected

- Lorbrena

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Y0055_MPC092560_NSR_C_10022025

Formulary ID 0026395

Version 046

Last Updated: 05/21/2026

Page | 143

Lotronex (alosetron)

Products Affected

- Alosetron HCl

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	1. Diagnosis of severe diarrhea-predominant irritable bowel syndrome (IBS) with symptoms persisting for at least six (6) months. 2. Patient was female at birth. 3. Patient has not responded adequately to conventional therapy (i.e., loperamide, antispasmodics).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Initial: 6 months Renewal: 1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Lumakras (sotorasib)

Products Affected

- Lumakras

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Lybalvi

Products Affected

- Lybalvi

PA Criteria	Criteria Details
Exclusion Criteria	Know opioid use disorder or is dependent on opioids for a chronic health condition. Patients undergoing acute opioid withdrawal.
Required Medical Information	1. Schizophrenia: a. Trial and failure of two (2) atypical antipsychotics for a minimum of 4 weeks (non-responders) or 12 weeks (partial responders) - e.g., aripiprazole, lurasidone, olanzapine, quetiapine, risperidone, ziprasidone, first-generation antipsychotics, OR member has a current diagnosis of metabolic syndrome, pre-metabolic syndrome, or diabetes mellitus and has failed aripiprazole AND ziprasidone, unless there is a documented contraindication or intolerance. 2. Bipolar: a. Monotherapy: Trial and failure of two alternatives from the following: i. lamotrigine, ii. lithium, iii. carbamazepine, iv. valproic acid, v. Atypical Antipsychotics (e.g., aripiprazole, lurasidone, quetiapine). b. adjunct therapy: will be used with either lithium or valproic acid.
Age Restrictions	18 years of age or older.
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Patient does not have a known opioid use disorder or is dependent on opioids for a chronic health condition. There should be a 7-day opioid-free interval from the last use of short-acting opioids, and at least a 14-day opioid-free interval from the last use of long-acting opioids to avoid precipitation of opioid withdrawal.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

Y0055_MPC092560_NSR_C_10022025

Formulary ID 0026395

Version 046

Last Updated: 05/21/2026

Page | 146

PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

Lynparza (olaparib)

Products Affected

- Lynparza

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Lytgobi (futibatinib)

Products Affected

- Lytgobi (12 MG Daily Dose)
- Lytgobi (16 MG Daily Dose)
- Lytgobi (20 MG Daily Dose)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium or, one of the following: a Class I, Iia, or Iib recommendation in the Thomsn Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, or an Evidence Level A by Lexi-Drugs.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Six (6) months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Marinol (dronabinol)

Products Affected

- Dronabinol

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	If using for nausea and vomiting associated with cancer chemotherapy, the patient must be receiving cancer chemotherapy and has failed one 5-HT ₃ antagonist and one of the following: corticosteroid, anti-histamine, anti-psychotic, or prokinetic. If using for anorexia associated with weight loss due to HIV/AIDS, the patient must have a trial and failure, contraindication or intolerance to Megace ES (megestrol oral suspension).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Matulane (procarbazine)

Products Affected

- Matulane

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Mavyret (glecaprevir/pibrentasvir)

Products Affected

- Mavyret

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Medical records documenting the diagnosis of acute or chronic Hepatitis C, including laboratory documentation of genotype and subtype, detectable HCV RNA levels at baseline, HIV status and liver transplant status.
Age Restrictions	3 year of age and older.
Prescriber Restrictions	Gastroenterologist or Infectious Disease specialist or Hepatologist
Coverage Duration	Duration as per package insert or Class I or II recommendation by the AASLD/IDSA/IAS-USA guidelines
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Mekinist (trametinib)

Products Affected

- Mekinist

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

MEKTOVI (binimetinib)

Products Affected

- Mektovi

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Y0055_MPC092560_NSR_C_10022025

Formulary ID 0026395

Version 046

Last Updated: 05/21/2026

Page | 154

Modeyso (dordavipron)

Products Affected

- Modeyso

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Movantik (naloxegol)

Products Affected

- Movantik

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Chart notes documenting a trial/failure of lactulose oral or lubiprostone.
Age Restrictions	18 years or older
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Muscle Relaxants

Products Affected

- Cyclobenzaprine HCl Oral
- Orphenadrine Citrate ER

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Prior authorization required for patients 65 years of age and older.
Age Restrictions	Prior authorization required for patients 65 years of age and older.
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Natpara (parathyroid hormone)

Products Affected

- Natpara

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Medical records must document a diagnosis of hypocalcemia due to chronic hypoparathyroidism. The prescriber must provide documentation that the patient must have a normal 25-hydroxyvitamin D level and a serum calcium level above 7.5mg/dL. For renewal the albumin-corrected total serum calcium level between 7.5 mg/dL and 10.6 mg/dL should be achieved with standard of care.
Age Restrictions	
Prescriber Restrictions	Endocrinologist
Coverage Duration	6 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Nerlynx (neratinib)

Products Affected

- Nerlynx

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	Lab values for total bilirubin, AST, ALT, and alkaline phosphate levels prior to starting treatment.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Y0055_MPC092560_NSR_C_10022025

Formulary ID 0026395

Version 046

Last Updated: 05/21/2026

Page | 159

Nexavar (sorafenib)

Products Affected

- SORafenib Tosylate

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Ninlaro (ixazomib)

Products Affected

- Ninlaro

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Y0055_MPC092560_NSR_C_10022025

Formulary ID 0026395

Version 046

Last Updated: 05/21/2026

Page | 161

Northera (droxidopa)

Products Affected

- Droxidopa

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	18 years or older
Prescriber Restrictions	
Coverage Duration	2 weeks
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Noxafil (posaconazole)

Products Affected

- Posaconazole Oral

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	2 years of age and older
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Nubeqa (darolutamide)

Products Affected

- Nubeqa

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Y0055_MPC092560_NSR_C_10022025

Formulary ID 0026395

Version 046

Last Updated: 05/21/2026

Page | 164

Nuplazid (pimavanserin)

Products Affected

- Nuplazid Oral Capsule
- Nuplazid Oral Tablet 10 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	For renewal: Chart notes must document an 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

Nuvigil (armodafinil)

Products Affected

- Armodafinil

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	If using for obstructive sleep apnea (OSA), must provide documentation that the patient has OSA and has been evaluated by a sleep specialist.
Age Restrictions	
Prescriber Restrictions	Neurologist or Sleep Specialist
Coverage Duration	1 year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Ocrevus (ocrelizumab)

Products Affected

- Ocrevus

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Chart notes documenting a diagnosis of Primary Progressive Multiple Sclerosis. Patients with primary progressive multiple sclerosis will not be required to have a trial and failure of other medications. Diagnosis of Relapsing Multiple Sclerosis, chart notes must document a trial/failure of interferon or glatiramer.
Age Restrictions	
Prescriber Restrictions	Neurologist
Coverage Duration	6 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Odomzo (sonidegib)

Products Affected

- Odomzo

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Ofev (nintedanib)

Products Affected

- Ofev

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	1. Idiopathic Pulmonary Fibrosis: a. Diagnosis confirmed by high-resolution computed tomography (HRCT). b. Exclusion of other known causes such as domestic and occupational environmental exposures, connective tissue disease, and drug toxicity. c. Baseline Forced Vital Capacity (FVC) greater than or equal to 50% (pulmonary function tests - PFTs - within the past 60 days). 2. Systemic Sclerosis-associated Interstitial Lung Disease: a. High-resolution computed tomography showing fibrosis affecting greater than or equal to 10%. b. Baseline Forced Vital Capacity (FVC) greater than or equal to 40% (pulmonary function tests - PFTs- within the past 60 days). 3. Chronic Fibrosis Interstitial Lung Disease: a. Progressive phenotype (e.g., hypersensitivity pneumonitis, autoimmune interstitial lung disease, idiopathic nonspecific interstitial pneumonia). b. High-resolution fibrosis affecting greater than or equal to 10% of the lungs. c. Progressive disease has been demonstrated by one of the following within the past 24 months: i. Forced Vital Capacity (FVC) decline greater than or equal to 10% - OR - ii. Two of the following: FVC decline greater than or equal to 5% and less than 10%, worsening respiratory symptoms, increased fibrosis on HRCT.
Age Restrictions	18 years or older
Prescriber Restrictions	Pulmonologist or rheumatologist
Coverage Duration	1 year
Other Criteria	Baseline Liver Function tests
Indications	All FDA-approved Indications.
Off Label Uses	

Y0055_MPC092560_NSR_C_10022025

Formulary ID 0026395

Version 046

Last Updated: 05/21/2026

Page | 169

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

Ogsiveo (nirogacestat)

Products Affected

- Ogsiveo

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Six (6 months)
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Ojemda (tovorafenib)

Products Affected

- Ojemda

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Six (6) months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Ojjaara (momelotinib)

Products Affected

- Ojjaara

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Omnitrope (somatropin)

Products Affected

- Omnitrope

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	<p>Adult onset growth hormone deficiency (GHD) - Multiple hormone deficiencies (hypopituitarism) resulting from pituitary disease, hypothalamic disease, surgery, radiation therapy or trauma. a) Patient has greater than or equal to 2 of the following pituitary hormone deficiencies: thyroid stimulating hormone deficiency, adrenocorticotropin hormone deficiency, gonadotropin deficiency, an arginine vasopressin (AKA vasopressin or antidiuretic hormone (ADH)) deficiency. b) Low serum IGF-I. c) Patient must exhibit clinical features of adult GHD including: increased body fat, decreased muscle mass, poor exercise performance, decreased bone density, and cardiovascular risk factors (high LDL, low HDL). d) Documentation of baseline information (IGF-I levels, lipids, bone density, cardiovascular factors, body composition, exercise capacity) provided with each request. Childhood onset GHD - Adults who were GH deficient as children or adolescents. a) Patient has subnormal response to at least 2 provocative stimulation tests (less than or equal to 5 ng/ml) following a GH washout period of 1-3 months. b) Patient must exhibit clinical features of adult GHD including: increased body fat, decreased muscle mass, poor exercise performance, decreased bone density, and cardiovascular risk factors. c) Documentation of baseline information (IGF-I levels, lipids, bone density, cardiovascular factors, body composition, exercise capacity) provided with each request.</p>
Age Restrictions	
Prescriber Restrictions	Endocrinologist
Coverage Duration	1 year
Other Criteria	

Y0055_MPC092560_NSR_C_10022025

Formulary ID 0026395

Version 046

Last Updated: 05/21/2026

Page | 174

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

Onureg (Azacitidine)

Products Affected

- Onureg

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Opsumit (macitentan)

Products Affected

- Opsumit

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	1. Member has a confirmed diagnosis or primary or secondary pulmonary arterial hypertension (WHO Group 1) by right heart catheterization. 2. Confirmed diagnosis will show the following: mean arterial pressure (mPAP) greater than 20 mmHG at rest, pulmonary capillary wedge pressure (PCWP) less than or equal to 15 mmHG, pulmonary vascular resistance greater than 3 wood units. 3. Member has WHO functional class II-IV symptoms. 4. Inadequate response to bosentan or ambrisentan, unless contraindicated or not tolerated.
Age Restrictions	18 years or older
Prescriber Restrictions	Prescribed by or in consultation with a pulmonologist or cardiologist.
Coverage Duration	Initial: six (6) months. Continuation: one (1) year.
Other Criteria	Chart notes documenting clinically significant improvement or stabilization in clinical signs and symptoms of disease (including but not limited to improvement in walk distance, dyspnea, and/or functional class.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Y0055_MPC092560_NSR_C_10022025

Formulary ID 0026395

Version 046

Last Updated: 05/21/2026

Page | 177

Orencia (abatacept SubQ)

Products Affected

- Orencia ClickJect
- Orencia Subcutaneous Solution Prefilled Syringe

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	1. Rheumatoid Arthritis (RA): Moderate to severe RA is defined as: DAS-28 more than 3.2 or CDAI more than 10.1. Inadequate response, unless contraindicated or not tolerated to two of the following: Amjevita, Enbrel, Hadlima, Xeljanz. 2. Juvenile Idiopathic Arthritis (JIA): Inadequate response to two of the following, unless contraindicated or not tolerated: Amjevita, Enbrel, Hadlima, Xeljanz. 3. Psoriatic Arthritis (PsA): Inadequate response to two of the following (adult patients), unless contraindicated or not tolerated: Amjevita, Enbrel, Hadlima, Xeljanz.
Age Restrictions	
Prescriber Restrictions	1. RA/JIA - Prescribed by or in consultation with a rheumatologist. 2. PsA - prescribed by or in consultation with a dermatologist or rheumatologist.
Coverage Duration	1 year
Other Criteria	CONTINUATION CRITERIA: Documentation of positive clinical response to treatment.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Orfadin (nitisinone)

Products Affected

- Nitisinone

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Orgovyx (Relugolix)

Products Affected

- Orgovyx

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Orkambi (ivacaftor/lumacaftor)

Products Affected

- Orkambi Oral Tablet

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	1 year and older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Orserdu (elacestrant)

Products Affected

- Orserdu

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium or, one of the following: a Class I, Iia, or Iib recommendation in the Thomsn Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, or an Evidence Level A by Lexi-Drugs.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Six (6) months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Otezla (apremilast)

Products Affected

- Otezla
- Otezla XR
- Otezla/Otezla XR Initiation Pk

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Psoriatic Arthritis, active (PsA): The patient has had at least a trial and failure of two of the following: Amjevita, Enbrel, Hadlima, or Xeljanz. Plaque psoriasis (PsO): a. For mild to moderate PsO: patient has had an inadequate response to topical treatment (e.g., corticosteroids, vitamin D analog, calcineurin inhibitor). b. For moderate to severe PsO: The patient must have at least 3% of their body surface area (BSA) affected by plaque psoriasis. i. Moderate to severe disease is defined by a total Psoriasis Area Severity Index (PASI) of at least 5 or more and/or a Dermatology Life Quality Index (DLQI) of more than 5, OR, crucial body areas are affected, such as hands, feet, scalp, face, genital area. ii. The patient has failed to adequately respond to one of the following: Amjevita (adult patients only), Enbrel, Hadlima (adult patients only). Behcet's syndrome: Documented diagnosis of Behcet's syndrome.
Age Restrictions	Approved for patients 6 years of age or older
Prescriber Restrictions	Must be prescribed by or in consultation with a Rheumatologist, Dermatologist or Ophthalmologist
Coverage Duration	Initial: 6 months Reauthorization: 1 year
Other Criteria	Reauthorization: Documentation of positive clinical response to therapy.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Y0055_MPC092560_NSR_C_10022025

Formulary ID 0026395

Version 046

Last Updated: 05/21/2026

Page | 183

PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

Parathyroid Hormone Analogs

Products Affected

- Teriparatide Subcutaneous Solution Pen-Injector 560 MCG/2.24ML, 620 MCG/2.48ML
- Tymlos

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	1. Bone Mineral Density (BMD) T-score -3.5 or less based on BMD measurements from lumbar spine, femoral neck, total hip, and/or one-third radius (wrist) -OR- 2. Bone mineral density (BMD) T-score between -2.5 and -3.5 in the lumbar spine, femoral neck, total hip, and/or one-third radius (wrist) -OR- a. History of one of the following: i. Vertebral compression fracture ii. Fracture of the hip iii. Fracture of the distal radius iv. Fracture of the pelvis v. Fracture of the proximal humerus -OR- 3. BMD T-score between -1.0 and -2.5 and one of the following FRAX 10-year fracture probabilities: i. Major osteoporotic fracture at 20% or more ii. Hip fracture at 3% or more -OR- 4. History of failure, contraindication, or intolerance to an intravenous bisphosphonate AND Prolia.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One (1) year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	Yes
Prerequisite	Yes

PA Criteria	Criteria Details
Therapy Required	

Pemazyre (pemigatinib)

Products Affected

- Pemazyre

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Phyrago (dasatinib)

Products Affected

- Phyrago

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Piqray (alpelisib)

Products Affected

- Piqray (200 MG Daily Dose)
- Piqray (250 MG Daily Dose)
- Piqray (300 MG Daily Dose)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Pomalyst (pomalidomide)

Products Affected

- Pomalidomide

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Prolastin (alpha-1-proteinase inhibitor [human])

Products Affected

- Prolastin-C

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	The member has a diagnosis of congenital alpha1-antitrypsin deficiency with clinically evident emphysema and chronic replacement therapy is needed. The member has an alpha1-antitrypsin phenotype of PiZZ, PiZ(null), or Pi (null, null) or phenotypes associated with serum alpha 1-antitrypsin concentrations of less than 50mg/dL if/when measured by laboratories using nephelometry instead of radial immunodiffusion. Otherwise, a deficiency is shown at 80mg/dL. (These products should not be used in individuals with the PiMZ or PiMS phenotypes of alpha1-antitrypsin deficiency because these individuals appear to be at small risk of developing clinically evident emphysema.)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Initial: 6 months Continuation: 1 year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Promacta (eltrombopag olamine)

Products Affected

- Eltrombopag Olamine

PA Criteria	Criteria Details
Exclusion Criteria	Coverage will not be provided when used in combination with Nplate.
Required Medical Information	If using for idiopathic thrombocytopenia, patient must have a trial and failure or contraindication to at least two of the following treatments: corticosteroids, immunoglobulin, or splenectomy. Dose may not exceed the FDA-approved maximum dose. If using for thrombocytopenia due to chronic hepatitis C, and the patient is currently on antiviral interferon therapy or will be starting interferon therapy, the patient must have a platelet count less than 75,000/microliter. Severe aplastic anemia (initial): Diagnosis of severe aplastic anemia. Patient has a platelet count less than 30,000/microliter. Trial and failure, intolerance, or contraindication to immunosuppressive therapy with antithymocyte globulin and cyclosporine. First-line treatment of severe aplastic anemia in combination with standard immunosuppressive therapy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy	Yes

PA Criteria	Criteria Details
Required	

Pulmonary Arterial Hypertension - ERA

Products Affected

- Ambrisentan
- Bosentan

PA Criteria	Criteria Details
Exclusion Criteria	Pregnancy, Idiopathic Pulmonary Fibrosis
Required Medical Information	1. Member has a confirmed diagnosis of primary or secondary pulmonary arterial hypertension (WHO Group 1) by right heart catheterization. 2. Confirmed diagnosis will show all of the following: a) Mean pulmonary artery pressure (mPAP) greater than 20 mmHG at rest, b) Pulmonary capillary wedge pressure (PCWP) less than or equal to 15 mmHg, c) Pulmonary vascular resistance greater than 3 Wood units. 3. Individual has WHO functional class II-IV symptoms.
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with a pulmonologist or cardiologist.
Coverage Duration	Initial: 6 months Continuation: 1 year
Other Criteria	Continuation criteria: Chart notes documenting clinically significant improvement or stabilization in clinical signs and symptoms of disease (including but not limited to improvement in walk distance, dyspnea, and/or functional class).
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Y0055_MPC092560_NSR_C_10022025

Formulary ID 0026395

Version 046

Last Updated: 05/21/2026

Page | 194

Purixan (mercaptopurine)

Products Affected

- Mercaptopurine Oral Suspension

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Qinlock (ripretinib)

Products Affected

- Qinlock

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Y0055_MPC092560_NSR_C_10022025

Formulary ID 0026395

Version 046

Last Updated: 05/21/2026

Page | 196

Qualaquin (quinine sulfate)

Products Affected

- QuiNINE Sulfate Oral

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 month
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Rebyota (fecal microbiota, live - jslm)

Products Affected

- Rebyota

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For the prevention of the recurrence of Clostridioides Difficile (rCDI) infection in patients who meet all of the criteria: Diagnosis of recurrent Clostridioides Difficile Infection (CDI) as defined by both of the following: Presence of diarrhea defined as a passage of 3 or more loose bowel movements within a 24-hour period for 2 consecutive day, and A positive stool test for Clostridioides difficile toxin, and Patient is 18 years of age or older, and Patient has had one or more recurrence(s) of CDI following an initial episode of CDI, and Both of the following: Patient has completed at least 10 days of one of the following antibiotic therapies for rCDI between 24 to 72 hours prior to initiating Rebyota: Oral vancomycin, or Dificid (fidaxomicin) and Previous episode of CDI is under control [e.g., less than 3 unformed/loose (i.e., Bristol Stool Scale type 6-7) stools/day for 2 consecutive days] and Prescribed by or in consultation with one of the following: Gastroenterologist, Infectious disease specialist. Authorization will be issued for a single dose treatment only.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One (1) month
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B	No

Y0055_MPC092560_NSR_C_10022025

Formulary ID 0026395

Version 046

Last Updated: 05/21/2026

Page | 198

PA Criteria	Criteria Details
Prerequisite	
Prerequisite Therapy Required	Yes

Relistor (methylnaltrexone)

Products Affected

- Relistor

PA Criteria	Criteria Details
Exclusion Criteria	Non-opioid induced constipation. Fecal impaction. Acute diverticular disease. Acute surgical abdomen.
Required Medical Information	Documentation that the patient is on chronic opioid therapy, and documented trial and failure of naloxegol (for approval of oral tablets only). Documented trial and failure of naloxegol not required for injection.
Age Restrictions	18 years or older
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Repatha (evolocumab)

Products Affected

- Repatha
- Repatha SureClick

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Treating provider attests to ONE of the following: a. Patient has been receiving at least 8 consecutive weeks. b. Patient is unable to tolerate* moderate- and high-intensity statins. ii. Patient has been receiving at least 8 consecutive weeks of low-intensity statin therapy and will continue to receive a low-intensity statin at maximally tolerated dose. d. Patient is unable to tolerate* low-, moderate-, and high-intensity statins, , or ii. Has a labeled contraindication to all statins or iii. Has experienced rhabdomyolysis or muscle symptoms with statin treatment with CK elevations greater than 10 times the upper limit of normal (ULN). 2. LDL-C equal to or greater than 70mg/dl (or 55 mg/dl if using for the prevention of major adverse cardiac events or in those at high high risk for major adverse cardiac events), or less than 50% LDL-C reduction from baseline while on maximally tolerated lipid lowering regimen. 3. Medication is used as adjunct to a low-fat diet and exercise.
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with one of the following: cardiologist, endocrinologist, or lipid specialist.
Coverage Duration	1 year
Other Criteria	Trial and failure of the preferred formulary drug (Repatha) is required before consideration of non-formulary drugs in this class. All drugs are subject to formulary quantity limits and approved dosages. *Statin Intolerance for the purpose of this criteria is defined as intolerable and persistent (i.e. more than 2 weeks) symptoms: 1) Myalgia (muscle symptoms without CK elevations), or 2) Myositis (muscle symptoms with CK elevations greater than 10 times upper limit of normal [ULN])Table 1.HIGH-INTENSITY statin atorvastatin 40-80 mg, Crestor (rosuvastatin)

Y0055_MPC092560_NSR_C_10022025

Formulary ID 0026395

Version 046

Last Updated: 05/21/2026

Page | 201

PA Criteria	Criteria Details
	20-40 mg MODERATE-INTENSITY statin atorvastatin 10-20 mg, rosuvastatin 5-10 mg, simvastatin greater than 20 mg, pravastatin more than 40 mg, lovastatin 40 mg, fluvastatin XL 80 mg, fluvastatin 40 mg twice daily, or pitavastatin greater than 2 mg LOW-INTENSITY statin simvastatin 10 mg, pravastatin 10-20 mg, lovastatin 20 mg, fluvastatin 20-40 mg, pitavastatin 1 mg Quantity limit: 120 mg every 2 weeks or 420 mg once monthly.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Retevmo (selpercatinib)

Products Affected

- Retevmo

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Revatio (sildenafil)

Products Affected

- Sildenafil Citrate Oral Tablet 20 MG

PA Criteria	Criteria Details
Exclusion Criteria	Sildenafil is excluded from coverage for the treatment of Erectile Dysfunction.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Revcovi (elapegademase-lvlr)

Products Affected

- Revcovi

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	a. Diagnosis of adenosine deaminase deficiency (ADA) with Severe Combined Immunodeficiency (SCID) phenotype confirmed by one of the following: i. Absent ADA levels in lysed erythrocytes from fresh blood samples or dried blood spots. ii. Marked increase in deoxyadenosine triphosphate (dATP) levels in erythrocyte lysates (with levels that vary by laboratory). iii. Decrease in ATP concentration in red blood cells. iv. Absent or extremely low levels of S-adenosylhomocysteine hydrolase in red blood cells. v. Increase in 2'-deoxyadenosine in urine and plasma, as well as in dried blood spots vi. Genetic testing showing biallelic variants in the ADA1 gene. b. Patient does not have thrombocytopenia.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Revlimid (lenalidomide)

Products Affected

- Lenalidomide

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Revuforj (revumenib)

Products Affected

- Revuforj

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Rexulti (brexpiprazole)

Products Affected

- Rexulti

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	<p>1. Major Depressive Disorder (MDD): Must be used as adjunctive or add on treatment for MDD, not as monotherapy, AND a. The patient must have a documented trial and failure (minimum of 4 weeks) of at least one (1) drug from the following classes: SSRI, SNRI, bupropion, or mirtazapine, AND b. Trial and failure of aripiprazole or quetiapine in combination with an antidepressant for at least four (4) weeks. 2. Schizophrenia: Trial and failure of two (2) atypical antipsychotics for a minimum of four (4) weeks (non-responders) or 12 weeks (partial responders) - e.g., aripiprazole, lurasidone, olanzapine, quetiapine, risperidone, ziprasidone, first-generation antipsychotics, OR member has a current diagnosis of metabolic syndrome, pre-metabolic syndrome, or diabetes mellitus and has failed aripiprazole and ziprasidone, unless there is a documented contraindication or intolerance. 3. Documented diagnosis of agitation associated with dementia due to Alzheimer's disease (AD).</p>
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

Rezdiffra (resmetirom)

Products Affected

- Rezdiffra

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	a. 18 years or older. b. Diagnosis confirmed with F2/F3 fibrosis. c. Prescribed by or in consultation with a hepatologist or gastroenterologist.
Age Restrictions	
Prescriber Restrictions	Hepatologist or gastroenterologist.
Coverage Duration	1 year
Other Criteria	Continuation criteria: positive clinical response to therapy as evidenced by improvement in liver fibrosis and no worsening of steatohepatitis.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Rezlidhia (olutasidenib)

Products Affected

- Rezlidhia

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Six (6) months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Rezurock (belumosudil)

Products Affected

- Rezurock

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	1. Diagnosis of chronic graft-versus-host disease (GVHD). 2. History of failure of at least two prior lines of systemic therapy (e.g., corticosteroids, mycophenolate, tacrolimus, etc.).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One (1) year
Other Criteria	Continuation criteria: positive clinical response to therapy.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Romvimza (vimseltinib)

Products Affected

- Romvimza

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Rozlytrek (entrectinib)

Products Affected

- Rozlytrek

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Rubraca (rucaparib)

Products Affected

- Rubraca

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Rydapt (midostaurin)

Products Affected

- Rydapt

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Scemblix

Products Affected

- Scemblix

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Secuado (asenapine transdermal)

Products Affected

- Secuado

PA Criteria	Criteria Details
Exclusion Criteria	Patients with dementia-related psychosis
Required Medical Information	1. Schizophrenia: a. Trial and failure of two (2) atypical antipsychotics for a minimum of 4 weeks (non-responders) or 12 weeks (partial responders) - e.g., aripiprazole, lurasidone, olanzapine, quetiapine, risperidone, ziprasidone, first-generation antipsychotics, OR member has a current diagnosis of metabolic syndrome, pre-metabolic syndrome, or diabetes mellitus and has failed aripiprazole AND ziprasidone, unless there is a documented contraindication or intolerance.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Signifor (pasireotide)

Products Affected

- Signifor

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient must have a baseline 24-hour urine free cortisol (UFC) greater than 1.5 times the upper limit of normal (ULN).
Age Restrictions	18 years or older
Prescriber Restrictions	Endocrinologist
Coverage Duration	1 year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Siklos (hydroxyurea)

Products Affected

- Siklos

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Sirturo (bedaquiline)

Products Affected

- Sirturo Oral Tablet 100 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documented diagnosis of multi-drug resistant tuberculosis (MDR-TB).
Age Restrictions	2 years of age weighing at least 8 kg.
Prescriber Restrictions	Infectious Disease
Coverage Duration	24 weeks
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Solaraze

Products Affected

- Diclofenac Sodium External Gel 3 %
- Diclofenac Sodium Transdermal Gel 3 %

PA Criteria	Criteria Details
Exclusion Criteria	Treatment of osteoarthritis, pain
Required Medical Information	Documented diagnosis of actinic keratosis.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	90 days
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Somavert (pegvisomant)

Products Affected

- Somavert

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documented diagnosis of acromgaly by 1) serum growth hormone (GH) level greater than 1 ng/mL after a 2 hour oral glucose tolerance test (OGTT) at time of diagnosis, or 2) elevated serum IGF-1 levels (above the age and gender adjusted normal range as provided by the physician) at the time of diagnosis. The member must have also had an inadequate response to surgery, radiotherapy, or a dopamine agonist (e.g., cabergoline, bromocriptine), or is not a candidate for surgery, radiotherapy, or dopamine agonist therapy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Initial: 6 months Continuation: 1 year.
Other Criteria	Continuation criteria: Documentation of positive clinical response to therapy.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Sprycel (dasatinib)

Products Affected

- Dasatinib

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Y0055_MPC092560_NSR_C_10022025

Formulary ID 0026395

Version 046

Last Updated: 05/21/2026

Page | 224

Stelara (ustekinumab)

Products Affected

- Stelara Subcutaneous Solution 45 MG/0.5ML
- Stelara Subcutaneous Solution Prefilled Syringe
- Ustekinumab Subcutaneous

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of moderate to severe Plaque Psoriasis (PsO). The patient must have at least 3% of their body surface area (BSA) affected by plaque psoriasis, or less than 3% if the condition affects a crucial area of the body. The disease is defined by a total Psoriasis Area Severity Index (PASI) of at least 5 or more and/or a Dermatology Life Quality Index (DLQI) of more than 5. The patient has failed to adequately respond to two of the following: Amjevita, Cosentyx, Enbrel, or Hadlima. Diagnosis of active Psoriatic Arthritis (PsA). The patient has failed to adequately respond to two of the following: Amjevita, Cosentyx, Enbrel, Hadlima, or Xeljanz. Crohns Disease CD: Documented diagnosis of moderately to severely active CD as evidenced by colonoscopy, CT scan, MRI, or capsule endoscopy. Inadequate response to Amjevita or Hadlima. Ulcerative Colitis (UC): Documented diagnosis of moderately to severely active UC as evidenced by colonoscopy, CT scan, MRI, or capsule endoscopy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Initial: six (6) months. Renewal: one (1) year.
Other Criteria	Continuation: Documentation of a positive clinical response to therapy.
Indications	All FDA-approved Indications.
Off Label Uses	

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

Stivarga (regorafenib)

Products Affected

- Stivarga

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Strensiq (asfotase alfa)

Products Affected

- Strensiq Subcutaneous Solution 40 MG/ML, 80 MG/0.8ML

PA Criteria	Criteria Details
Exclusion Criteria	Adult-onset hypophosphatasia
Required Medical Information	Documented diagnosis of perinatal/infantile onset or juvenile-onset hypophosphatasia (HPP) confirmed by all of the following: a)Patient is less than or equal to 18 at age of onset of disease, b)Radiographic evidence of HPP, c)Rachitic deformities, d)premature loss of primary teeth prior to age 5, e)Delay in skeletal growth resulting in delay of motor development, f)History or presence of non-traumatic fractures or delayed fracture healing. Molecular genetic testing and results for mutation(s) in the ALPL gene. Baseline serum alkaline phosphatase (ALP), below normal range for patients age. Serum vitamin B-6 levels, elevated and the patient has not received vitamin B6 supplementation in the previous week. Elevated serum or urine Phosphoethanolamine (PEA) level. Baseline ophthalmologic exam and renal ultrasound being monitored for signs and symptoms of ectopic calcifications.
Age Restrictions	
Prescriber Restrictions	Must be prescribed by, or in consultation with, an endocrinologist, geneticist or a metabolic specialist.
Coverage Duration	6 months
Other Criteria	Continuation criteria: Documentation that the patient is tolerating treatment and responding to treatment, as evidenced by improvement in respiratory status, or radiographic findings. Dose is not to exceed FDA label maximum. Strensiq can be injected three times per week or six times per week. Strensiq is only covered as a three times per week injection.
Indications	All FDA-approved Indications.
Off Label Uses	

Y0055_MPC092560_NSR_C_10022025

Formulary ID 0026395

Version 046

Last Updated: 05/21/2026

Page | 228

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

Subvenite

Products Affected

- Subvenite Oral Suspension

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient is unable to swallow tablets or chewable tablets.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One (1) year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Sutent (sunitinib)

Products Affected

- SUNItinib Malate

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Y0055_MPC092560_NSR_C_10022025

Formulary ID 0026395

Version 046

Last Updated: 05/21/2026

Page | 231

Sylatron (peginterferon alfa-2b)

Products Affected

- Sylatron Subcutaneous Kit 200 MCG, 300 MCG, 600 MCG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For Non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium or there must be a Class I or IIa recommendation in the Thomson Micromedex DrugDex compendium.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Symdeko (ivacaftor / tezacaftor)

Products Affected

- Symdeko

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	6 years of age and older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Synarel (nafarelin acetate)

Products Affected

- Synarel

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Endometriosis: Documented contraindication, intolerance, or treatment failure with Lupron Depot (leuprolide).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Tabloid (thioguanine)

Products Affected

- Tabloid

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Tabrecta (capmatinib)

Products Affected

- Tabrecta

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Tadalafil

Products Affected

- Tadalafil Oral Tablet 5 MG

PA Criteria	Criteria Details
Exclusion Criteria	Erectile Dysfunction
Required Medical Information	Diagnosis of benign prostatic hyperplasia.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Tafinlar (dabrafenib)

Products Affected

- Tafinlar

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Tagrisso (osimertinib)

Products Affected

- Tagrisso

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Takhzyro (Ivanadelumab-flyo)

Products Affected

- Takhzyro

PA Criteria	Criteria Details
Exclusion Criteria	Not to be used in combination with other prophylactics (Cinryze or Haegarda)
Required Medical Information	A diagnosis of hereditary angioedema (HAE) has been clinically established by or in consultation with an Allergist or Immunologist.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Initial: 6 months Renewal: 1 year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Talzenna (talazoparib)

Products Affected

- Talzenna

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Tarceva (erlotinib)

Products Affected

- Erlotinib HCl

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	FFor non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Targretin (bexarotene)

Products Affected

- Bexarotene

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Tasigna (nilotinib)

Products Affected

- Nilotinib D-Tartrate
- Nilotinib HCl

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Tavneos (avacopan)

Products Affected

- Tavneos

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of of severe active anti-neutrophil cytoplasmic antibody (ANCA)-associated vasculitis (granulomatosis with polyangiitis [GPA] and microscopic polyangiitis [MPA]. Positive test of either anti-PR3 or anti-MPO. Patient is currently receiving standard therapy with cyclophosphamide or rituximab.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Initial: six (6) months. Renewal: one (1) year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Tazverik (tazemetostat)

Products Affected

- Tazverik

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	must be at least 16 years old
Prescriber Restrictions	
Coverage Duration	Initial: 6 months Renewal: 1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Tepmetko (tepotinib)

Products Affected

- Tepmetko

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Testosterone injection

Products Affected

- Testosterone Cypionate Intramuscular Solution 100 MG/ML, 200 MG/ML, 200 MG/ML (1 ML)
- Testosterone Enanthate Intramuscular Solution

PA Criteria	Criteria Details
Exclusion Criteria	Testosterone replacement will not be covered for the treatment of sexual dysfunction.
Required Medical Information	If using for primary hypogonadism, the patient must have two low total testosterone levels (drawn on separate days) with elevated luteinizing hormone (LH) and follicular stimulating hormone (FSH) levels. If using for hypogonadotropic hypogonadism, the patient must have two low total testosterone levels (drawn on separate days) with low to low-normal LH and FSH levels.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Y0055_MPC092560_NSR_C_10022025

Formulary ID 0026395

Version 046

Last Updated: 05/21/2026

Page | 248

Thalomid (thalidomide)

Products Affected

- Thalomid

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Tibsovo (ivosidenib)

Products Affected

- Tibsovo

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Trikafta (elexacaftor-tezacaftor-ivacaftor)

Products Affected

- Trikafta

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	a.Documented diagnosis of cystic fibrosis.b. Submission of laboratory results documenting that the patient has at least one of the following mutations in the CFTR gene: i. F508del mutation, or ii. A mutation that is responsive based on in vitro data (refer to prescribing information). c. Documentation of all of the following: i. Pretreatment of ppFEV1 within the past 30 days. ii. Member has two negative respiratory cultures in the past 12 months for any of the following: Burkholderia cenocepacia, Burkholderia dolosa, or Mycobacterium abscessus. iii.Baseline ALT, AST, and bilirubin that are less than 3X the upper limit of normal, and are monitored every 3 months during the first year of treatment and annually thereafter. iv. Baseline ophthalmic exam for pediatric patients. d. No dual therapy with another CFTR potentiator is planned.
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with a pulmonologist.
Coverage Duration	Initial: 6 months Renewal: 1 year
Other Criteria	Continuation criteria: patient has responded positively to therapy.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy	No

Y0055_MPC092560_NSR_C_10022025

Formulary ID 0026395

Version 046

Last Updated: 05/21/2026

Page | 251

PA Criteria	Criteria Details
Required	

Truqap (capivasertib)

Products Affected

- Truqap Oral Tablet
- Truqap Oral Tablet Therapy Pack 160 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Six (6) months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Truseltiq (infigratinib)

Products Affected

- Truseltiq (100MG Daily Dose)
- Truseltiq (50MG Daily Dose)
- Truseltiq (125MG Daily Dose)
- Truseltiq (75MG Daily Dose)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For Non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium or, one of the following: a Class I, Iia, or Iib recommendation in the Thomson Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, or an Evidence Level A by Lexi-Drugs.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Tukysa (tucatinib)

Products Affected

- Tukysa

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Turalio (pexidartinib)

Products Affected

- Turalio Oral Capsule 125 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Tyenne (tocilizumab-aazg)

Products Affected

- Tyenne Subcutaneous

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	1. Rheumatoid Arthritis (RA): Moderate to severe RA is defined as: DAS-28 more than 3.2 or CDAI more than 10.1. Inadequate response to two of the following, unless contraindicated or not tolerated: Amjevita, Enbrel, Hadlima, Xeljanz. 2. Juvenile Idiopathic Arthritis (JIA): Documented diagnosis of JIA. 3. Adult patients with Giant Cell Arteritis (GCA): Documented diagnosis of GCA. 4. Systemic Sclerosis-associated Interstitial Lung Disease (SSc-ILD): High resolution computed tomography (HRCT) showing fibrosis affecting greater than or equal to 10%. Baseline FVC greater than or equal to 40% (within the past 60 days).
Age Restrictions	
Prescriber Restrictions	1. RA/JIA/GCA - prescribed by or in consultation with a rheumatologist. 2. SSc-ILD prescribed by or in consultation with a pulmonologist or a rheumatologist.
Coverage Duration	Initial: 6 months Renewal: 1 year
Other Criteria	For all diagnoses: 1. Current PPD (tuberculosis) negative skin test or negative QuantiFERON-TB Gold test before the initiation of therapy. 2. The appropriate Disease Specific Criteria has been met. CONTINUATION CRITERIA: Documentation of positive clinical response to treatment.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Y0055_MPC092560_NSR_C_10022025

Formulary ID 0026395

Version 046

Last Updated: 05/21/2026

Page | 257

PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

Tykerb (lapatinib ditosylate)

Products Affected

- Lapatinib Ditosylate

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Tyvaso (treprostinil)

Products Affected

- Tyvaso DPI Maintenance Kit Inhalation Powder 112 x 32MCG & 112 x64MCG, 112 x 48MCG & 112 x64MCG, 16 MCG, 32 MCG, 48 MCG, 64 MCG, 80 MCG
- Tyvaso DPI Titration Kit Inhalation Powder 16 & 32 & 48 MCG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	a. Pulmonary Arterial Hypertension: i. Diagnosis of pulmonary arterial hypertension confirmed by right heart catheterization (except for interstitial lung disease - interstitial lung disease may be diagnosed by high resolution computed Ct and pulmonary function tests). ii. Currently on an endothelin receptor agonist - ERA (ambrisentan or bosentan) AND sildenafil. iii. Patient will continue current background therapy. b. Pulmonary Hypertension Associated with Interstitial Lung Disease: i. Patient has WHO Group 3 pulmonary hypertension. ii. Right heart catheterization confirming all of the following: 1. Pulmonary vascular resistance (PVR) greater 3 Wood Units (WU), 2. Pulmonary capillary wedge pressure (PCWP) of less than 15 mmHg, 3. Mean pulmonary arterial pressure (mPAP) of greater than or equal 25 mmHg.
Age Restrictions	
Prescriber Restrictions	Cardiologist or Pulmonologist
Coverage Duration	Initial: 6 months Renewal: 1 year
Other Criteria	Continuation criteria: positive clinical response to therapy.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

Uceris (budesonide tablets)

Products Affected

- Budesonide ER Oral Tablet Extended Release 24 Hour

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	1. The member has a diagnosis of active mild to moderate ulcerative colitis, AND 2. The member must have had previous treatment or intolerance to at least two of the following: sulfasalazine, balsalazide, or mesalamine.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	8 weeks
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Ukoniq (umbralisib)

Products Affected

- Ukoniq

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For Non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium or there must be a Class I or IIa recommendation in the Thomson Micromedex DrugDex compendium.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Uloric (febuxostat)

Products Affected

- Febuxostat

PA Criteria	Criteria Details
Exclusion Criteria	Current azathioprine or mercaptopurine use.
Required Medical Information	1. Documented diagnosis of gout. 2. One of the following must be met: a. Documented failure at maximally tolerated dose of allopurinol - a documented failure is considered as non-resolution of tophi or at least 4 gout attacks (joint flares) per year - OR - b. documented intolerance to allopurinol (examples of intolerance include skin reactions or cytopenias).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One (1) year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Ustekinumab

Products Affected

- Imuldosa Subcutaneous
- Steqeyma Subcutaneous Solution Prefilled Syringe
- Yesintek Subcutaneous

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	<p>Diagnosis of moderate to severe Plaque Psoriasis (PsO). The patient must have at least 3% of their body surface area (BSA) affected by plaque psoriasis, or crucial body areas are affected. The disease is defined by a total Psoriasis Area Severity Index (PASI) of at least 5 or more and/or a Dermatology Life Quality Index (DLQI) of more than 5. The patient has failed to adequately respond to two of the following: Amjevita, Cosentyx, Enbrel, or Hadlima. Diagnosis of active Psoriatic Arthritis (PsA). The patient has failed to adequately respond to two of the following: Amjevita, Cosentyx, Enbrel, Hadlima, or Xeljanz. Crohns Disease (CD): Documented diagnosis of moderately to severely active CD as evidenced by colonoscopy, CT scan, MRI, or capsule endoscopy. Ulcerative Colitis (UC): Documented diagnosis of moderately to severely active UC as evidenced by colonoscopy, CT scan, MRI, or capsule endoscopy.</p>
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Initial: six (6) months. Renewal: one (1) year.
Other Criteria	Continuation: Documentation of a positive clinical response to therapy.
Indications	All FDA-approved Indications.
Off Label Uses	

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

Valchlor (mechlorethamine)

Products Affected

- Valchlor

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Vanflyta (quizartinib)

Products Affected

- Vanflyta

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Veltassa (patiromer)

Products Affected

- Veltassa Oral Packet 16.8 GM, 25.2 GM, 8.4 GM

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documents showing the following is required- 1. Baseline potassium 5.1 to less than 6.5mmol/liter at two screenings2 . Medications known to cause hyperkalemia has been discontinued or reduced to the lowest effective dose. Adequate trial of diuretics (loop or thiazides) or there are medical reasons for avoiding them. Adequate trial is defined as at least 4 weeks of a stable doseb.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Six (6) months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Venclexta (venetoclax)

Products Affected

- Venclexta
- Venclexta Starting Pack

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Verquvo (vericiguat)

Products Affected

- Verquvo

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	1. Diagnosis heart failure classified as one of the following: a. New York Heart Association Class II, III, or IV. 2. Ejection fraction is less than 45 percent. 3. One of the following: a. hospitalization for heart failure within the past six months. b. outpatient IV diuretics for heart failure within the past three (3) months. 4. patient is on a stabilized dose and receiving concomitant therapy with a maximally tolerated dose of all of the following: (unless contraindicated or not tolerated): a. beta-blocker (eg., bisoprolol, carvedilol, metoprolol) b. angiotensin converting enzyme (ACE) inhibitor (e.g., captopril, lisinopril), angiotensin II receptor blocker (ARB) (e.g., losartan, valsartan), or angiotensin receptor-neprilysin inhibitor (ARNI) (e.g., Entresto), c. aldosterone antagonist (e.g., spironolactone).
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with a cardiologist.
Coverage Duration	One (1) year
Other Criteria	Continuation criteria: positive clinical response to therapy.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy	Yes

Y0055_MPC092560_NSR_C_10022025

Formulary ID 0026395

Version 046

Last Updated: 05/21/2026

Page | 271

PA Criteria	Criteria Details
Required	

Verzenio (abemaciclib)

Products Affected

- Verzenio

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Vfend (voriconazole)

Products Affected

- Voriconazole Intravenous
- Voriconazole Oral Tablet 200 MG
- Voriconazole Oral Suspension Reconstituted

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documented diagnosis of invasive aspergillosis, candidemia, esophageal candidiasis, a disseminated (widespread) Candida infection in the skin, or a Candida infection in the abdomen, kidney, bladder wall, or wounds and a documented trial/failure of fluconazole. Documented fungal infection caused by Fusariosis or Scedosporium species. Culture and sensitivity report.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Vitrakvi (larotrectinib)

Products Affected

- Vitrakvi

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Vizimpro (dacomitinib)

Products Affected

- Vizimpro

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Vonjos (pacritinib)

Products Affected

- Vonjo

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Voranigo (vorasidenib)

Products Affected

- Voranigo

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Votrient (pazopanib)

Products Affected

- PAZOPanib HCl Oral Tablet 200 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Y0055_MPC092560_NSR_C_10022025

Formulary ID 0026395

Version 046

Last Updated: 05/21/2026

Page | 279

Vowst (fecal microbiota spores, live-bprk)

Products Affected

- Vowst

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For the prevention of the recurrence of Clostridioides Difficile (rCDI) infection in patients who meet all of the criteria: Diagnosis of recurrent Clostridioides Difficile Infection (CDI) as defined by both of the following: Presence of diarrhea defined as a passage of 3 or more loose bowel movements within a 24-hour period for 2 consecutive day, and A positive stool test for Clostridioides difficile toxin, and Patient is 18 years of age or older, and Patient has had one or more recurrence(s) of CDI following an initial episode of CDI, and Both of the following: Patient has completed at least 10 days of one of the following antibiotic therapies for rCDI between 24 to 72 hours prior to initiating Vowst: Oral vancomycin, or Dificid (fidaxomicin) and Previous episode of CDI is under control [e.g., less than 3 unformed/loose (i.e., Bristol Stool Scale type 6-7) stools/day for 2 consecutive days] and Prescribed by or in consultation with one of the following: Gastroenterologist, Infectious disease specialist. Authorization will be issued for a single dose treatment only.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One (1) month
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Y0055_MPC092560_NSR_C_10022025

Formulary ID 0026395

Version 046

Last Updated: 05/21/2026

Page | 280

PA Criteria	Criteria Details
Prerequisite Therapy Required	No

Vraylar (cariprazine)

Products Affected

- Vraylar

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	1. Major Depressive Disorder (MDD): Must be used as adjunctive or add on treatment for Major Depressive Disorder (MDD), not as monotherapy. AND a. The patient must have a documented trial and failure (minimum of 4 weeks) of at least one (1) drug from the following classes: SSRI, SNRI, bupropion, or mirtazapine, AND b. Trial and failure of aripiprazole or quetiapine in combination with an antidepressant for at least four (4) weeks. 2. Schizophrenia: Trial and failure of two (2) atypical antipsychotics for a minimum of four (4) weeks (non-responders) or 12 weeks (partial responders) - e.g., aripiprazole, lurasidone, olanzapine, quetiapine, risperidone, ziprasidone, first-generation antipsychotics, OR member has a current diagnosis of metabolic syndrome, pre-metabolic syndrome, or diabetes mellitus and has failed aripiprazole and ziprasidone, unless there is a documented contraindication or intolerance. 3. Bipolar: Bipolar: a. Trial and failure of two (2) alternatives from the following: i. lamotrigine, ii. lithium, iii. carbamazepine, iv. valproic acid, v. Atypical Antipsychotics (e.g., aripiprazole, lurasidone, quetiapine).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B	No

Y0055_MPC092560_NSR_C_10022025

Formulary ID 0026395

Version 046

Last Updated: 05/21/2026

Page | 282

PA Criteria	Criteria Details
Prerequisite	
Prerequisite Therapy Required	Yes

Vyndamax (tafamidis)

Products Affected

- Vyndamax

PA Criteria	Criteria Details
Exclusion Criteria	Less than 18 years of age, concomitant use with patisiran or inotersen.
Required Medical Information	All of the following must be met: Diagnosis of transthyretin (ATTR)-mediated amyloidosis with cardiomyopathy (ATTR-CM) - AND, one of the following: documentation that the member has a pathogenic TTR mutation (e.g., V30M) - OR, cardiac or non-cardiac tissue biopsy showing histologic confirmation of ATTR amyloid deposits - OR, all of the following: echocardiogram or cardiac magnetic resonance imaging suggestive of amyloidosis - AND, radionuclide imaging (99mTc-DPD, 99mTc-HMDP) showing grade 2 or grade 3 cardiac uptake - AND, absence of light chain amyloidosis - AND, member has New York Heart Association (NYHA) Functional Class I, II, or III heart failure - AND, one of the following: history of heart failure with at least one hospitalization for heart failure - OR, presence of clinical signs and symptoms of heart failure (e.g., shortness of breath, edema).
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with a cardiologist.
Coverage Duration	Initial: 6 months Renewal: 1 year
Other Criteria	Renewal: Patient has experienced a positive clinical response (e.g. cardiac function, serum TTR levels).
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

PA Criteria	Criteria Details
Prerequisite Therapy Required	No

Vyndaqel (tafamidis meglumine)

Products Affected

- Vyndaqel

PA Criteria	Criteria Details
Exclusion Criteria	Less than 18 years of age, concomitant use with patisiran or inotersen.
Required Medical Information	All of the following must be met: Diagnosis of transthyretin (ATTR)-mediated amyloidosis with cardiomyopathy (ATTR-CM) - AND, one of the following: documentation that the member has a pathogenic TTR mutation (e.g., V30M) - OR, cardiac or non-cardiac tissue biopsy showing histologic confirmation of ATTR amyloid deposits - OR, all of the following: echocardiogram or cardiac magnetic resonance imaging suggestive of amyloidosis - AND, radionuclide imaging (99mTc-DPD, 99mTc-HMDP) showing grade 2 or grade 3 cardiac uptake - AND, absence of light chain amyloidosis - AND, member has New York Heart Association (NYHA) Functional Class I, II, or III heart failure - AND, one of the following: history of heart failure with at least one hospitalization for heart failure - OR, presence of clinical signs and symptoms of heart failure (e.g., shortness of breath, edema).
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with a cardiologist.
Coverage Duration	Initial: 6 months Renew: 1 year
Other Criteria	Renew: Patient has experienced a positive clinical response (e.g. cardiac function, serum TTR levels).
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

PA Criteria	Criteria Details
Prerequisite Therapy Required	No

Vyvanse (lisdexamphetamine)

Products Affected

- Lisdexamfetamine Dimesylate Oral
Capsule 10 MG, 20 MG, 30 MG, 40 MG,
50 MG, 60 MG, 70 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	1. Attention Deficit Hyperactivity Disorder (ADHD): a. diagnosis of ADHD. b. Patient has had an inadequate response to at least one-month trial of at least two of the following generic medications: amphetamine, amphetamine/dextroamphetamine, dexamethylphenidate, dextroamphetamine, methylphenidate. 2. Binge Eating Disorder (BED): a. diagnosis of BED. b. Inadequate response to a selective serotonin reuptake inhibitor (SSRI) or topiramate.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One (1) year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Welireg (belzurifan)

Products Affected

- Welireg

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Winrevair (sotatercept-csrk)

Products Affected

- Winrevair

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	a. 18 years of age or older. b. Diagnosis of pulmonary arterial hypertension (WHO Group 1) confirmed by right heart catheterization. c. Currently on an endothelin receptor agonist - ERA (e.g., ambrisentan or bosentan) AND sildenafil. d. Will be used in combination with current background therapies. e. Platelet count is greater than 50.f. Prescribed by or in consultation with a cardiologist or pulmonologist.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Cardiologist or Pulmonologist
Coverage Duration	Initial: 6 months Renewal: 1 year
Other Criteria	Continuation criteria: positive clinical response to therapy.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Xalkori (crizotinib)

Products Affected

- Xalkori

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Xeljanz (tofacitinib)

Products Affected

- Xeljanz
- Xeljanz XR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	<p>1. Rheumatoid Arthritis (RA): Moderate to severe RA is defined as: DAS-28 more than 3.2 or CDAI more than 10.1. An adequate trial (3 months or more) of one of the following other DMARDs: hydroxychloroquine, leflunomide, methotrexate, sulfasalazine. Trial and failure, unless contraindicated or not tolerated, to at least one tumor necrosis factor (TNF) blocker (e.g., Amjevita, Enbrel, Hadlima). 2. Psoriatic Arthritis (PsA): Documented diagnosis of psoriatic arthritis. Trial and failure, unless contraindicated or not tolerated, to at least one tumor necrosis factor (TNF) blocker (e.g., Amjevita, Enbrel, Hadlima). 3. Ulcerative Colitis (UC): Trial and failure of one or more tumor necrosis factor (TNF) blocker. 4. Juvenile Idiopathic Arthritis (JIA): a. An adequate trial (3 months or more) of one of the following DMARDs: leflunomide, methotrexate, sulfasalazine. Trial and failure to at least one tumor necrosis factor (TNF) blocker (e.g., Amjevita, Enbrel, Hadlima). 5. Ankylosing Spondylitis (AS): peripheral arthritis must have a trial of sulfasalazine and an NSAID. Patients with axial disease and failure of NSAIDs can be started without a trial of sulfasalazine. Trial and failure of at least one tumor necrosis factor (TNF) blocker (e.g., Amjevita, Enbrel, Hadlima).</p>
Age Restrictions	
Prescriber Restrictions	<p>1. RA/JIA/AS- prescribed by or in consultation with a rheumatologist. 2. PsA- prescribed by or in consultation with a dermatologist or rheumatologist. 3. UC- prescribed by or in consultation with a gastroenterologist.</p>
Coverage Duration	One (1) year

PA Criteria	Criteria Details
Other Criteria	For all diagnoses: 1. Current PPD (tuberculosis) negative skin test or negative QuantiFERON-TB Gold test before the initiation of therapy. 2. The appropriate Disease Specific Criteria has been met. CONTINUATION CRITERIA: Documentation of positive clinical response to treatment.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Xenazine (tetrabenazine)

Products Affected

- Tetrabenazine

PA Criteria	Criteria Details
Exclusion Criteria	Tetrabenazine is not covered for patients who are actively suicidal, who have untreated or inadequately treated depression, who have impaired hepatic function, or who are currently taking monoamine oxidase inhibitors or reserpine.
Required Medical Information	Treatment of chorea associated with Huntington's disease. Documentation that member is being monitored for depression and suicidal ideation. Renewal: Chart notes documenting that the patient's disease has improved based on prescriber's assessment while on therapy.
Age Restrictions	
Prescriber Restrictions	Neurologist
Coverage Duration	Initial: 6 months Renewal: 1 year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Xermelo (telotristat)

Products Affected

- Xermelo

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Chart notes documenting ALL of the following: 1)A diagnosis of carcinoid syndrome diarrhea, 2)An inadequate treatment response to a somatostatin analog (SSA), at a maximum tolerated dose, after at least 3 months of therapy, 3)A documented trial/failure of adjunct treatment with an anti-diarrheal medication, such as loperamide or ondansetron, 4)Chart notes documenting at least four bowel movements per day, 5)Xermelo will be used by the patient in combination with a SSA.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Oncologist or Gastroenterologist
Coverage Duration	Initial: 12 weeks Renewal: 1 year
Other Criteria	Renewal: Diagnosis of carcinoid syndrome diarrhea, and the patient will continue to use Xermelo with a SSA. Chart notes documenting a decrease in baseline in the amount of daily bowel movements.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Y0055_MPC092560_NSR_C_10022025

Formulary ID 0026395

Version 046

Last Updated: 05/21/2026

Page | 295

Xgeva (denosumab)

Products Affected

- Xgeva

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Xifaxan (rifaximin)

Products Affected

- Xifaxan

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	If using for traveler's diarrhea (TD), trial and failure of an oral antibiotic such as Zithromax (azithromycin), Levaquin (levofloxacin) or Floxin (ofloxacin). If using for hepatic encephalopathy (HE), trial and failure or documented intolerance/contraindication to lactulose oral solution. If using for Irritable Bowel Syndrome, Diarrhea Predominant (IBS-D) documented diagnosis of IBS-D, trial and failure of at least two (2) of the following: anti-diarrheals, antispasmodics, or tricyclic antidepressants.
Age Restrictions	TD: 12 years or older HE: 18 years or older IBS-D: 18 years or older
Prescriber Restrictions	
Coverage Duration	TD: 3 days per request HE: 1 year IBS-D: 14 days per request
Other Criteria	Quantity limits will be diagnosis dependent: TD three times daily, HE twice daily dosing, IBS-D three times daily.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Xiidra (lifitegrast)

Products Affected

- Xiidra

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of dry eye disease and the patient has suppressed tear production due to ocular inflammation as determined by at least one of the following diagnostic tests: Schirmer Tear Test (STT), Corneal Fluorescein Staining (CFS), tear break-up time, tear film osmolarity, ocular surface dye staining.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Initial: 6 months Renewal: 1 year
Other Criteria	Renewal: Documentation of positive clinical response to Xiidra therapy (increased tear production or improvement in dry eye symptoms).
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Xolair (omalizumab)

Products Affected

- Xolair

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	If using for persistent asthma (PA), medical records must document all of the following: IgE level greater than or equal to 30 IU/mL, specific evidence of allergic asthma, supported by clinical and lab findings such as positive skin tests, symptom patterns, etc., inadequate control with an inhaled corticosteroid and a long acting beta-2 agonist combination therapy, and evidence of persistent symptoms requiring frequent rescue therapy, practitioner visits despite inhaled corticosteroids, ER visits OR inadequate control OR intolerance OR contraindication to inhaled corticosteroid and a long acting beta-2 agonist combination. If using for chronic idiopathic urticaria (CIU) (initial request): Documentation of the following: 30-day trial of a second generation non-sedating anti-histamine. CIU (renewal request): Documentation of a reduction in exacerbation frequency and intensity. For nasal polyps, evidence of nasal polyps as as found on examination and a documented inadequate response to nasal corticosteroids.
Age Restrictions	
Prescriber Restrictions	Allergist, Pulmonologist, Dermatologist, Immunologist, or Otolaryngologist.
Coverage Duration	Initial: six (6) months. Renewal: one (1) year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Y0055_MPC092560_NSR_C_10022025

Formulary ID 0026395

Version 046

Last Updated: 05/21/2026

Page | 299

PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

Xospata (gilteritinib)

Products Affected

- Xospata

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Xpovio (selinexor)

Products Affected

- Xpovio (100 MG Once Weekly)
- Xpovio (40 MG Once Weekly)
- Xpovio (40 MG Twice Weekly)
- Xpovio (60 MG Once Weekly)
- Xpovio (60 MG Twice Weekly)
- Xpovio (80 MG Once Weekly)
- Xpovio (80 MG Twice Weekly)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite	No

Y0055_MPC092560_NSR_C_10022025

Formulary ID 0026395

Version 046

Last Updated: 05/21/2026

Page | 302

PA Criteria	Criteria Details
Therapy Required	

Xtandi (enzalutamide)

Products Affected

- Xtandi

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	1. Diagnosis of metastatic, castration-resistant prostate cancer AND history of failure, contraindication, or intolerance to abiraterone (Zytiga), OR diagnosis of metastatic, castration-sensitive prostate cancer AND history of failure, contraindication, or intolerance to abiraterone (Zytiga), OR diagnosis of non-metastatic, castration-resistant prostate cancer AND history of failure, contraindication, or intolerance to Nubeqa. 2. Diagnosis of non-metastatic castration-sensitive prostate cancer with biochemical recurrence at high risk for metastasis.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	For Non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium or, one of the following: a Class I, Iia, or Iib recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, or an Evidence Level A by Lexi-Drugs.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite	No

PA Criteria	Criteria Details
Therapy Required	

Xyrem (sodium oxybate)

Products Affected

- Xyrem

PA Criteria	Criteria Details
Exclusion Criteria	Will not be approved in combination with sedative hypnotics or alcohol, or if patient has a succinic semialdehyde dehydrogenase deficiency.
Required Medical Information	Adults: If using for excessive daytime sleepiness in narcolepsy, trial and failure of, or intolerance to a cerebral stimulant (methylphenidate or dextroamphetamine) and Nuvigil (armodafinil). Pediatric patients will not be required to first try and fail a cerebral stimulant or armodafinil
Age Restrictions	7 years of age or older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Yonsa (abiraterone)

Products Affected

- Yonsa

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Zejula (niraparib)

Products Affected

- Zejula Oral Tablet

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Zelboraf (vemurafenib)

Products Affected

- Zelboraf

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Zolinza (vorinostat)

Products Affected

- Zolinza

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Zydelig (idelalisib)

Products Affected

- Zydelig

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Zykadia (ceritinib)

Products Affected

- Zykadia Oral Tablet

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Zymfentra (infliximab-dyyb)

Products Affected

- Zymfentra (1 Pen)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Crohn's Disease (CD) and Ulcerative Colitis (UC): Documented diagnosis of moderately to severely active CD as evidenced by colonoscopy, CT scan, MRI, or capsule endoscopy.
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with a gastroenterologist.
Coverage Duration	Initial: 6 months Renewal: 1 year
Other Criteria	For all diagnoses: 1. Current PPD (tuberculosis) negative skin test or negative QuantiFERON-TB Gold test before the initiation of therapy, 2. The appropriate Disease Specific Criteria has been met. CONTINUATION CRITERIA: Documentation of positive response to treatment.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Zyvox (linezolid)

Products Affected

- Linezolid Oral

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Medical records documenting all of the following: Prescribed by or in consultation with an infectious disease specialist. Culture and sensitivity report documents that the isolated pathogen is susceptible to linezolid and the patient has failed one formulary antibiotic to which the isolated pathogen is susceptible per the culture and sensitivity report. OR the request is for continuation of therapy that was initiated in an acute care hospital from which the patient was discharged.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Non-VREF: 14 days VREF: 28 days
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Index**A**

Abigale.....	102, 103
Abigale Lo.....	102, 103
Abilify MyCite.....	2
Abilify MyCite Maintenance Kit Oral Tablet Therapy Pack 15 MG, 2 MG, 20 MG, 5 MG	2
Abilify MyCite Starter Kit Oral Tablet Therapy Pack 10 MG.....	2
Adempas.....	5
Aimovig.....	37
Akeega.....	8
Alecensa.....	9
Alora.....	102, 103
Alosetron HCl.....	144
Alunbrig.....	10
Alyq.....	4
Amabelz.....	102, 103
Ambrisentan.....	194
Amjevita Subcutaneous Solution Auto-Injector	11, 12
Amjevita Subcutaneous Solution Prefilled Syringe 40 MG/0.4ML, 40 MG/0.8ML.....	11, 12
Amjevita-Ped 10kg to <15kg.....	11, 12
Amjevita-Ped 15kg to <30kg.....	11, 12
Androderm Transdermal Patch 24 Hour....	13
Apokyn Subcutaneous Solution Cartridge.	15
Apomorphine HCl Subcutaneous.....	15

Aprepitant.....	62
Arcalyst.....	16
Armodafinil.....	166
Augtyro.....	17
Austedo.....	18
Austedo Patient Titration Kit.....	18
Austedo XR.....	18
Austedo XR Patient Titration.....	18
Auvelity.....	19
Avmapki Fakzynja Co-Pack.....	20
Ayvakit.....	21
B	
Balversa.....	22
Benlysta Subcutaneous.....	23
Besremi.....	24
Bexarotene.....	243
Bosentan.....	194
Bosulif.....	25
Braftovi.....	26
Bronchitol.....	27
Brukinsa.....	28
Budesonide ER Oral Tablet Extended Release 24 Hour.....	262
Budesonide Oral.....	68
C	
Cabometyx.....	30
Calquence.....	31

Caplyta.....	32, 33	Daurismo.....	54
Caprelsa.....	34	Deferasirox Oral Tablet.....	55, 56
Carglumic Acid.....	35	Deferasirox Oral Tablet Soluble.....	55, 56
Cayston.....	36	Deferiprone.....	82
chlordiazepoxide HCl.....	101	Diclofenac Sodium External Gel 3 %.....	222
chlorpromazine HCl Oral Tablet.....	101	Diclofenac Sodium Transdermal Gel 3 %.....	222
Cibinqo.....	38	Dotti.....	102, 103
Cinryze.....	39	Drizalma Sprinkle.....	58
Cobenfy.....	41	Dronabinol.....	150
Cobenfy Starter Pack.....	41	Droxidopa.....	162
Cometriq (100 MG Daily Dose).....	44	Dupixent.....	59, 60, 61
Cometriq (140 MG Daily Dose).....	44	E	
Cometriq (60 MG Daily Dose).....	44	Eltrombopag Olamine.....	192, 193
Copiktra.....	45	Emend Oral Suspension Reconstituted.....	62
Corlanor Oral Solution.....	46	Emgality.....	63
Cosentyx (300 MG Dose).....	47, 48	Enbrel Mini.....	64, 65
Cosentyx Sensoready (300 MG).....	47, 48	Enbrel Subcutaneous Solution 25 MG/0.5ML	64, 65
Cosentyx Subcutaneous Solution Prefilled Syringe 75 MG/0.5ML.....	47, 48	Enbrel Subcutaneous Solution Prefilled Syringe	64, 65
Cosentyx UnoReady.....	47, 48	Enbrel Subcutaneous Solution Reconstituted.....	64, 65
Cotellic.....	49	Enbrel SureClick Subcutaneous Solution Auto- Injector.....	64, 65
Cresemba Oral.....	50	Ensacove.....	67
Cyclobenzaprine HCl Oral.....	157	Epidiolex.....	70
Cystaran.....	51	Erivedge.....	71
D		Erleada.....	72
Danziten.....	52		
Dasatinib.....	224		

Erlotinib HCl.....	242	Fyavolv.....	102, 103
Erzofri.....	74	G	
Estradiol Oral Tablet 2 MG.....	102, 103	Gamunex-C.....	88
Estradiol-Norethindrone Acet.....	102, 103	Gattex.....	89
Estropipate Oral.....	102, 103	Gavreto.....	90
Evamist.....	102, 103	Gefitinib.....	116
Everolimus Oral Tablet 10 MG, 2.5 MG, 5 MG, 7.5 MG.....	6	Gilotrif.....	91
Everolimus Oral Tablet Soluble.....	7	Gomekli.....	94
F		H	
Fanapt.....	76, 77	Hadlima.....	95, 96
Fanapt Titration Pack.....	76, 77	Hadlima PushTouch.....	95, 96
Fanapt Titration Pack A.....	76, 77	Hernexeos.....	97
Farydak.....	78	Hexalen.....	99
Fasenra.....	79, 80	hydroOXYzine HCl Oral Tablet.....	104
Fasenra Pen.....	79, 80	hydroOXYzine Pamoate Oral.....	104
Febuxostat.....	264	Hyrnuo.....	105
Fensolvi.....	81	I	
Fensolvi (6 Month).....	81	Ibrance.....	106
fentaNYL Citrate Buccal Lozenge On A Handle 1200 MCG, 1600 MCG, 400 MCG, 600 MCG, 800 MCG.....	3	Ibtrozi.....	107
Firdapse.....	84	Icatibant Acetate.....	83
Flebogamma DIF.....	88	Iclusig.....	108
Forteo Subcutaneous Solution Pen-Injector 560 MCG/2.24ML, 600 MCG/2.4ML.....	85	IDHIFA.....	109
Fotivda.....	86	Imatinib Mesylate Oral.....	92
Fruzaqla.....	87	Imbruvica Oral Capsule.....	110
		Imbruvica Oral Suspension.....	110
		Imbruvica Oral Tablet 140 MG, 280 MG, 420 MG.....	110

Imkeldi.....	111	Kisqali 400 Dose.....	130, 131
Imuldosa Subcutaneous.....	265, 266	Kisqali 600 Dose.....	130, 131
Increlex.....	112	Kisqali Femara (200 MG Dose).....	130, 131
Inlyta.....	113	Kisqali Femara (400 MG Dose).....	130, 131
Inqovi.....	114	Kisqali Femara (600 MG Dose).....	130, 131
Inrebic.....	115	Koselugo.....	133
Itovebi.....	117	Krazati.....	134
Ivabradine HCl.....	46	L	
Ivermectin Oral Tablet 3 MG.....	118	L-Glutamine Oral Packet.....	66
Iwilfin.....	119	Lapatinib Ditosylate.....	259
J		Lazcluze.....	136
Jakafi.....	120	Lenalidomide.....	206
Jaypirca.....	121	Lenvima (10 MG Daily Dose).....	137, 138
Jevantique Lo.....	102, 103	Lenvima (12 MG Daily Dose).....	137, 138
Jinteli.....	102, 103	Lenvima (14 MG Daily Dose).....	137, 138
Juxtapid Oral Capsule 10 MG, 20 MG, 30 MG, 40 MG, 5 MG, 60 MG.....	122, 123	Lenvima (18 MG Daily Dose).....	137, 138
K		Lenvima (20 MG Daily Dose).....	137, 138
Kalydeco Oral Packet 25 MG, 50 MG, 75 MG	126	Lenvima (24 MG Daily Dose).....	137, 138
Kalydeco Oral Tablet.....	126	Lenvima (4 MG Daily Dose).....	137, 138
Kerendia Oral Tablet 10 MG, 20 MG.....	127, 128	Lenvima (8 MG Daily Dose).....	137, 138
Kineret Subcutaneous Solution Prefilled Syringe	129	Leukine Injection Solution Reconstituted.....	139
Kisqali (200 MG Dose).....	130, 131	Leukine Intravenous.....	139
Kisqali (400 MG Dose).....	130, 131	Lidocaine External Patch 5 %.....	140
Kisqali (600 MG Dose).....	130, 131	Linezolid Oral.....	314
Kisqali 200 Dose.....	130, 131	Lisdexamfetamine Dimesylate Oral Capsule 10 MG, 20 MG, 30 MG, 40 MG, 50 MG, 60 MG, 70 MG.....	288
		Livtency.....	141

Lonsurf.....	142	Nilotinib HCl.....	244
Lopreeza.....	102, 103	Ninlaro.....	161
Lorbrena.....	143	Nitisinone.....	179
Lumakras.....	145	Norethindrone-Eth Estradiol.....	102, 103
Lybalvi.....	146, 147	Nubeqa.....	164
Lyllana.....	102, 103	Nuplazid Oral Capsule.....	165
Lynparza.....	148	Nuplazid Oral Tablet 10 MG.....	165
Lytgobi (12 MG Daily Dose).....	149	O	
Lytgobi (16 MG Daily Dose).....	149	Ocrevus.....	167
Lytgobi (20 MG Daily Dose).....	149	Odomzo.....	168
M		Ofev.....	169, 170
Matulane.....	151	Ogsiveo.....	171
Mavyret.....	152	Ojemda.....	172
Mekinist.....	153	Ojjaara.....	173
Mektovi.....	154	Omnitrope.....	174, 175
Menest.....	102, 103	Onureg.....	176
Mercaptopurine Oral Suspension.....	195	Opsumit.....	177
miFEPRISone Oral Tablet 300 MG.....	132	Orencia ClickJect.....	178
Mimvey.....	102, 103	Orencia Subcutaneous Solution Prefilled Syringe.....	178
Mimvey Lo.....	102, 103	Orgovyx.....	180
Modeyso.....	155	Orkambi Oral Tablet.....	181
Mounjaro.....	93	Orphenadrine Citrate ER.....	157
Movantik.....	156	Orserdu.....	182
N		Otezla.....	183, 184
Natpara.....	158	Otezla XR.....	183, 184
Nerlynx.....	159	Otezla/Otezla XR Initiation Pk.....	183, 184
Nilotinib D-Tartrate.....	244		

P	Retacrit Injection Solution 10000 UNIT/ML, 10000 UNIT/ML(1ML), 2000 UNIT/ML, 3000 UNIT/ML, 4000 UNIT/ML, 40000 UNIT/ML.....	73
PARoxetine HCl.....		100
Paxil Oral Suspension.....		100
PAZOPanib HCl Oral Tablet 200 MG....	Retevmo.....	203
Pemazyre.....	Revcovi.....	205
penicillAMINE Oral Tablet.....	Revuforj.....	207
Phyrago.....	Rexulti.....	208, 209
Piqray (200 MG Daily Dose).....	Rezdifra.....	210
Piqray (250 MG Daily Dose).....	Rezlidhia.....	211
Piqray (300 MG Daily Dose).....	Rezurock.....	212
Pirfenidone Oral Capsule.....	Romvimza.....	213
Pirfenidone Oral Tablet 267 MG, 801 MG	Rozlytrek.....	214
75	Rubraca.....	215
Pomalidomide.....	Rydapt.....	216
Posaconazole Oral.....	S	
Premarin Oral.....	Sajazir.....	83
Premphase.....	Sapropterin Dihydrochloride.....	135
Prempro.....	Scemblix.....	217
Prolastin-C.....	Scopolamine.....	101
Pyrimethamine Oral.....	Secuado.....	218
Q	Signifor.....	219
Qinlock.....	Siklos.....	220
QuiNINE Sulfate Oral.....	Sildenafil Citrate Oral Tablet 20 MG.....	204
R	Sirturo Oral Tablet 100 MG.....	221
Rebyota.....	Sodium Phenylbutyrate Oral Powder 3 GM/TSP	29
Relistor.....	Sodium Phenylbutyrate Oral Tablet.....	29
Repatha.....		
Repatha SureClick.....		

Sofosbuvir-Velpatasvir.....	69	Tazverik.....	246
Somavert.....	223	Tepmetko.....	247
SORafenib Tosylate.....	160	Teriparatide Subcutaneous Solution Pen- Injector 560 MCG/2.24ML, 620 MCG/2.48ML.....	185, 186
Stelara Subcutaneous Solution 45 MG/0.5ML	225, 226	Testosterone Cypionate Intramuscular Solution 100 MG/ML, 200 MG/ML, 200 MG/ML (1 ML).....	248
Stelara Subcutaneous Solution Prefilled Syringe	225, 226	Testosterone Enanthate Intramuscular Solution	248
Steqeyma Subcutaneous Solution Prefilled Syringe.....	265, 266	Testosterone Transdermal Gel 1.62 %, 10 MG/ACT (2%), 12.5 MG/ACT (1%), 20.25 MG/1.25GM (1.62%), 20.25 MG/ACT (1.62%), 25 MG/2.5GM (1%), 40.5 MG/2.5GM (1.62%), 50 MG/5GM (1%)14	
Stivarga.....	227	Tetrabenazine.....	294
Strensiq Subcutaneous Solution 40 MG/ML, 80 MG/0.8ML.....	228, 229	Thalomid.....	249
Subvenite Oral Suspension.....	230	Tibsovo.....	250
SUNItinib Malate.....	231	Tolvaptan (Hyponatremia) Oral Tablet 30 MG	124, 125
Sylatron Subcutaneous Kit 200 MCG, 300 MCG, 600 MCG.....	232	Tolvaptan Oral Tablet 30 MG.....	124, 125
Symdeko.....	233	Tolvaptan Oral Tablet Therapy Pack	124, 125
Synarel.....	234	Torpenz.....	6
T		Trientine HCl.....	40
Tabloid.....	235	Trikafta.....	251, 252
Tabrecta.....	236	Trulicity.....	93
Tadalafil (PAH).....	4	Truqap Oral Tablet.....	253
Tadalafil Oral Tablet 5 MG.....	237	Truqap Oral Tablet Therapy Pack 160 MG	253
Tafinlar.....	238	Truseltiq (100MG Daily Dose).....	254
Tagrisso.....	239	Truseltiq (125MG Daily Dose).....	254
Takhzyro.....	240		
Talzenna.....	241		
Tasimelton.....	98		
Tavneos.....	245		

Truseltiq (50MG Daily Dose).....	254	Voranigo.....	278
Truseltiq (75MG Daily Dose).....	254	Voriconazole Intravenous.....	274
Tukysa.....	255	Voriconazole Oral Suspension Reconstituted.....	274
Turalio Oral Capsule 125 MG.....	256	Voriconazole Oral Tablet 200 MG.....	274
Tyenne Subcutaneous.....	257, 258	Vowst.....	280, 281
Tymlos.....	185, 186	Vraylar.....	282, 283
Tyvaso DPI Maintenance Kit Inhalation Powder 112 x 32MCG & 112 x64MCG, 112 x 48MCG & 112 x64MCG, 16 MCG, 32 MCG, 48 MCG, 64 MCG, 80 MCG.....	260, 261	Vyndamax.....	284, 285
		Vyndaqel.....	286, 287
		w	
Tyvaso DPI Titration Kit Inhalation Powder 16 & 32 & 48 MCG.....	260, 261	Welireg.....	289
U		Winrevair.....	290
Udenyca Subcutaneous Solution Prefilled Syringe.....	42, 43	x	
Ukoniq.....	263	Xalkori.....	291
Ustekinumab Subcutaneous.....	225, 226	Xeljanz.....	292, 293
v		Xeljanz XR.....	292, 293
Valchlor.....	267	Xermelo.....	295
Vanflyta.....	268	Xgeva.....	296
Veltassa Oral Packet 16.8 GM, 25.2 GM, 8.4 GM.....	269	Xifaxan.....	297
Venclexta.....	270	Xiidra.....	298
Venclexta Starting Pack.....	270	Xolair.....	299, 300
Verquvo.....	271, 272	Xospata.....	301
Verzenio.....	273	Xpovio (100 MG Once Weekly).....	302, 303
Vitrakvi.....	275	Xpovio (40 MG Once Weekly).....	302, 303
Vizimpro.....	276	Xpovio (40 MG Twice Weekly).....	302, 303
Vonjo.....	277	Xpovio (60 MG Once Weekly).....	302, 303
		Xpovio (60 MG Twice Weekly).....	302, 303
		Xpovio (80 MG Once Weekly).....	302, 303

Xpovio (80 MG Twice Weekly).....	302, 303	Zarxio.....	42, 43
Xtandi.....	304, 305	Zejula Oral Tablet.....	308
Xyrem.....	306	Zelboraf.....	309
Y		Zolinza.....	310
Yesintek Subcutaneous.....	265, 266	Zydelig.....	311
Yonsa.....	307	Zykadia Oral Tablet.....	312
Z		Zymfentra (1 Pen).....	313

Notice of Availability

English	ATTENTION: If you speak English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-855-592-7737 (TTY: 711) or speak to your provider.
Spanish Español	ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 1-855-592-7737 (TTY: 711) o hable con su proveedor.
Navajo Diné	SHOOH: Diné bee yánítí'gogo, saad bee aná'awo' bee áka'anída'awo'ít'áá jiiik'eh ná hóló. Bee ahíł hane'go bee nida'anishí t'áá ákodaat'éhígíí dóó bee áka'anída'wo'í áko bee baa hane'í bee hadadilyaa bich'í' ahoot'í'ígíí éí t'áá jiiik'eh hóló. Kohjí' 1-855-592-7737 (TTY:711) hodíilnih doodago nika'análwo'í bich'í' hanidziih.
Vietnamese Việt	LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 1-855-592-7737 (Người khuyết tật: TTY: 711) hoặc trao đổi với người cung cấp dịch vụ của bạn.
German Deutsch	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistentendienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 1-855-592-7737 (TTY: 711) an oder sprechen Sie mit Ihrem Provider.
Chinese Simplified 简体中文	注意：如果您使用简体中文，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以提供无障碍格式版信息。请拨打 1-855-592-7737 (TTY: 711) 或咨询您的服务提供者。
Chinese Traditional 繁體中文	注意：如果您使用繁體中文，我們將免費為您提供語言協助服務。我們還免費提供適當的輔助工具和服务，以提供無障礙格式版資訊。請致電 1-855-592-7737 (TTY:711) 或諮詢您的服務提供者。
Japanese 日本語	注：日本語を話される場合、無料の言語支援サービスをご利用いただけます。アクセシブル（誰もが利用できるよう配慮された）な形式で情報を提供するための適切な補助支援やサービスも無料でご利用いただけます。1-855-592-7737 (TTY: 711) までお電話ください。または、ご利用の事業者にご相談ください。
Filipino	ATTENTION: Kung marunong kang magsalita ng Filipino, makakagamit ka ng mga libreng serbisyo sa tulong sa wika. Ang mga angkop na karagdagang tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format ay magagamit din nang libre. Tumawag sa 1-855-592-7737 (TTY: 711) o makipag-usap sa iyong provider.
Korean 한국어	주의: 한국어를 사용하는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 접근 가능한 형식으로 정보를 제공하기 위한 적절한 보조 도구 및 서비스도 무료로 제공됩니다. 1-855-592-7737(TTY: 711)로 전화하거나 서비스 제공업체에 문의하세요.

French Français	ATTENTION : Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-855-592-7737 (TTY : 711) ou parlez à votre fournisseur.
Tagalog	PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 1-855-592-7737 (TTY: 711) o makipag-usap sa iyong provider.
Russian РУССКИЙ	ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 1-855-592-7737 (TTY: 711) или обратитесь к своему поставщику услуг.
Urdu اردو	توجہ دیں: اگر آپ اردو بولتے ہیں تو، مفت لسانی اعانت کی خدمات آپ کے لیے دستیاب ہیں۔ مناسب ضمنی امداد اور خدمات بھی قابل رسائی فارمیٹس میں معلومات فراہم کرنے کے لیے بلا معاوضہ دستیاب ہیں۔ 1-855-592-7737 (TTY: 711) پر کال کریں یا اپنے فراہم کنندہ سے بات کریں۔
Nepali नेपाली	ध्यान दिनुहोस्: तपाईं नेपाली बोल्नुहुन्छ भने तपाईंका लागि निःशुल्क भाषा सहायता सेवाहरू उपलब्ध छन्। पहुँचयोग्य ढाँचाहरूमा जानकारी प्रदान गर्न उपयुक्त सहायक सहायताहरू र सेवाहरू पनि निःशुल्क उपलब्ध छन्। 1-855-592-7737 (TTY: 711) मा फोन गर्नुहोस् वा आफ्नो प्रदायकसँग कुरा गर्नुहोस्।
Bengali বাংলা	মনোযোগ দিন: আপনি যদি বাংলায় কথা বলেন, তাহলে বিনামূল্যে ভাষা সহায়তা পরিষেবা আপনার জন্য উপলব্ধ। অ্যাক্সেসযোগ্য ফর্ম্যাটে তথ্য প্রদানের জন্য উপযুক্ত সহায়ক সहाয়তা এবং পরিষেবাগুলিও বিনামূল্যে পাওয়া যায়। 1-855-592-7737 (TTY: 711) নম্বরে কল করুন অথবা আপনার প্রদানকারীর সাথে কথা বলুন।
Hindi हिंदी	ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए निःशुल्क भाषा सहायता सेवाएँ उपलब्ध हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक सहायताएँ और सेवाएँ भी निःशुल्क उपलब्ध हैं। 1-855-592-7737 (TTY: 711) पर कॉल करें या अपने प्रदाता से बात करें।
Arabic اللغة العربية	تنبيه: إذا كنت تتحدث العربية، فمتاح لك خدمات لغوية بالمجان. و متاح بالمجان أيضًا مساعدات وخدمات إضافية مناسبة لتقديم المعلومات بتنسيقات يسهل الحصول عليها. اتصل بالرقم 1-855-592-7737 (TTY: 711) (خدمة الهاتف النصي) أو تحدث إلى مزود الخدمة المعني بك.
Turkish Türkçe	DİKKATİNİZE: Türkçe biliyorsanız, ücretsiz dil destek hizmetlerinden faydalanabilirsiniz. Ayrıca ücretsiz olarak, uygun yardımcı araçlarla ve hizmetlerle erişilebilir formatlarda bilgi de sağlanmaktadır. 1-855-592-7737 (TTY (İşitme ve Konuşma Engelli Destek Hattı): 711) numaralı telefondan bize ulaşabilir veya hizmet sağlayıcınız ile görüşebilirsiniz.