

ACUTE MIGRAINE AGENTS

MEDICATION(S)

ELYXYB, REYVOW

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

N/A

ALTERNATIVE DOSAGE FORM

MEDICATION(S)

ARBLI, DIGOXIN 0.05 MG/ML SOLUTION, DIURIL, ENALAPRIL 1 MG/ML ORAL SOLN, ENTRESTO SPRINKLE, FAMOTIDINE 40 MG/5 ML SUSP, GLYCOPYRROLATE 1 MG/5 ML SOLN, LINEZOLID 100 MG/5 ML SUSP, MEMANTINE HCL 10 MG/5 ML CUP, MEMANTINE HCL 2 MG/ML SOLUTION, NIMODIPINE 60 MG/20 ML SOLN, NITROFURANTOIN 25 MG/5 ML SUSP, NYMALIZE, PROPRANOLOL 20 MG/5 ML SOLN, PROPRANOLOL 40 MG/5 ML SOLN, QBRELIS, TONMYA

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

N/A

AMIFAMPRIDINE

MEDICATION(S)

FIRDAPSE

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

N/A

ANDROGEN/ANABOLIC STEROIDS

MEDICATION(S)

DANAZOL 100 MG CAPSULE, DANAZOL 200 MG CAPSULE, DANAZOL 50 MG CAPSULE, DEPO-TESTOSTERONE, METHITEST, METHYLTESTOSTERONE 10 MG CAP, TESTOSTERONE 1% (25MG/2.5G) PK, TESTOSTERONE 1% (50 MG/5 G) PK, TESTOSTERONE 1.62% GEL PUMP, TESTOSTERONE 12.5 MG/1.25 GRAM, TESTOSTERONE 30 MG/1.5 ML PUMP, TESTOSTERONE 50 MG/5 GRAM GEL, TESTOSTERONE CYP 1,000 MG/10ML, TESTOSTERONE CYP 2,000 MG/10ML, TESTOSTERONE CYP 200 MG/ML, TESTOSTERON ENAN 1,000 MG/5 ML, TESTOSTERONE ENAN 200 MG/ML, XYOSTED

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

N/A

ANZUPGO

MEDICATION(S)

ANZUPGO

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

N/A

ARIKAYCE

MEDICATION(S)

ARIKAYCE

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

N/A

ATTR AMYLOIDOSIS

MEDICATION(S)

ATTRUBY, TEGSEDI, VYNDAMAX, VYNDAQEL, WAINUA 45 MG/0.8 ML AUTOINJECT

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

N/A

BEMPEDOIC ACID

MEDICATION(S)

NEXLETOL, NEXLIZET

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

N/A

BRENSOCATIB

MEDICATION(S)

BRINSUPRI

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

N/A

CANNABIDIOL

MEDICATION(S)

EPIDIOLEX

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

N/A

CARBAGLU

MEDICATION(S)

CARGLUMIC ACID

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

N/A

CARDIAC MYOSIN INHIBITORS

MEDICATION(S)

CAMZYOS

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

N/A

MEDICATION(S)

ALYFTREK, KALYDECO, ORKAMBI, SYMDEKO, TRIKAFTA

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

N/A

MEDICATION(S)

AIMOVIG AUTOINJECTOR, AJOVY AUTOINJECTOR, AJOVY AUTOINJECTOR (3 PACK), AJOVY SYRINGE, EMGALITY PEN, EMGALITY SYRINGE, NURTEC ODT, QULIPTA, UBRELVY

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

N/A

CHOLESTASIS PRURITUS

MEDICATION(S)

BYLVAY, LIVMARLI

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

N/A

CIBINQO

MEDICATION(S)

CIBINQO

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

N/A

COAGULATION FACTOR VIIA

MEDICATION(S)

NOVOSEVEN RT, SEVENFACT

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

N/A

CORTICOTROPIN

MEDICATION(S)

ACTHAR

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

N/A

CRENESSITY

MEDICATION(S)

CRENESSITY

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

N/A

CTEXLI

MEDICATION(S)

CTEXLI

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

N/A

DAYBUE

MEDICATION(S)

DAYBUE, DAYBUE STIX

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

N/A

DUVYZAT

MEDICATION(S)

DUVYZAT

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

N/A

EFGARTIGIMOD

MEDICATION(S)

VYVGART HYTRULO 1,000MG-10,000

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

N/A

ELAGOLIX/RELUGOLIX

MEDICATION(S)

MYFEMBREE, ORIAHNN, ORLISSA

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

N/A

ELMIRON

MEDICATION(S)

ELMIRON

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

N/A

EMPAVELI

MEDICATION(S)

EMPAVELI

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

N/A

ENDARI

MEDICATION(S)

L-GLUTAMINE 5 GRAM POWDER PKT

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

N/A

ENSPRYNG

MEDICATION(S)

ENSPRYNG

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

N/A

ERYTHROPOIETINS

MEDICATION(S)

ARANESP, EPOGEN, MIRCERA, PROCRIT, RETACRIT

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

N/A

FABHALTA

MEDICATION(S)

FABHALTA

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

N/A

FACTOR VIII AND VON WILLEBRAND FACTOR

MEDICATION(S)

ADVATE, ADYNOVATE, AFSTYLA, ALPHANATE, ALTUVIIIIO, ELOCTATE, ESPEROCT, HEMOFIL M, HUMATE-P, JIVI, KOATE, KOGENATE FS, KOVALTRY, NOVOEIGHT, NUWIQ, RECOMBINATE, VONVENDI, WILATE, XYNTHA, XYNTHA SOLOFUSE

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

N/A

FAMILIAL CHYLOMICRONEMIA SYNDROME

MEDICATION(S)

TRYNGOLZA

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

N/A

FILSPARI

MEDICATION(S)

FILSPARI

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

N/A

FILSUVEZ

MEDICATION(S)

FILSUVEZ

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

N/A

FINTEPLA

MEDICATION(S)

FINTEPLA

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

N/A

GALAFOLD

MEDICATION(S)

GALAFOLD

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

N/A

GATTEX

MEDICATION(S)

GATTEX

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

N/A

GONADOTROPIN HORMONES

MEDICATION(S)

FOLLISTIM AQ, FYREMADEL, GANIRELIX ACETATE, MENOPUR, OVIDREL, PREGNYL

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

N/A

PYRUKYND

MEDICATION(S)

PYRUKYND

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

N/A

MEDICATION(S)

ABIRATERONE ACETATE, ABIRTEGA, AKEEGA, ALECENSA, ALUNBRIG, AUGTYRO, AVMAPKI-FAKZYNJA, AYWAKIT, BALVERSA, BESREMI, BEXAROTENE 75 MG CAPSULE, BOSULIF, BRAFTOVI, BRUKINSA, CABOMETYX, CALQUENCE, CAPECITABINE, CAPRELSA, COMETRIQ, COPIKTRA, COTELLIC, DASATINIB, DAURISMO, ENSACOVE, ERIVEDGE, ERLEADA, ERLOTINIB HCL 100 MG TABLET, ERLOTINIB HCL 150 MG TABLET, ERLOTINIB HCL 25 MG TABLET, EVEROLIMUS 10 MG TABLET, EVEROLIMUS 2 MG TAB FOR SUSP, EVEROLIMUS 2.5 MG TABLET, EVEROLIMUS 3 MG TAB FOR SUSP, EVEROLIMUS 5 MG TAB FOR SUSP, EVEROLIMUS 5 MG TABLET, EVEROLIMUS 7.5 MG TABLET, FOTIVDA, FRUZAQLA, GAVRETO, GEFITINIB, GILOTRIF, GOMEKLI, HERNEXEOS, HYCAMTIN, IBRANCE, IBTROZI, ICLUSIG, IDHIFA, IMATINIB MESYLATE 100 MG TAB, IMATINIB MESYLATE 400 MG TAB, IMBRUVICA, INLURIYO, INLYTA, INQOVI, INREBIC, ITOVEBI, IWILFIN, JAKAFI, JAYPIRCA, KISQALI, KISQALI FEMARA CO-PACK, KOSELUGO, KRAZATI, LAPATINIB, LAZCLUZE, LENALIDOMIDE, LENVIMA, LONSURF, LORBRENA, LUMAKRAS, LYNPARZA, LYSODREN, LYTGOBI, MATULANE, MEKINIST, MEKTOVI, MODEYSO, NERLYNX, NILOTINIB HCL, NINLARO, NUBEQA, ODOMZO, OGSIVEO, OJEMDA, OJJAARA, ONUREG, ORGOVYX, ORSERDU, PAZOPANIB HCL, PEMAZYRE, PIQRAY, POMALIDOMIDE, POMALYST, QINLOCK, RETEVMO, REVUFORJ, REZLIDHIA, ROMVIMZA, ROZLYTREK, RUBRACA, RYDAPT, SCEMBLIX, SORAFENIB, STIVARGA, SUNITINIB MALATE, TABRECTA, TAFINLAR, TAGRISSO, TALZENNA, TAZVERIK, TEMOZOLOMIDE, TEPMETKO, THALOMID, TIBSOVO, TORPENZ, TRETINOIN 10 MG CAPSULE, TRUQAP, TUKYSA, TURALIO, VANFLYTA, VENCLEXTA, VENCLEXTA STARTING PACK, VERZENIO, VITRAKVI, VIZIMPRO, VONJO, VORANIGO, WELIREG, XALKORI, XOSPATA, XPOVIO, XTANDI, YONSA, ZEJULA, ZELBORAF, ZOLINZA, ZYDELIG, ZYKADIA

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

N/A

TRANSMUCOSAL IMMEDIATE RELEASE FENTANYL

MEDICATION(S)

FENTANYL CIT OTFC 1,200 MCG, FENTANYL CIT OTFC 1,600 MCG, FENTANYL CITRATE OTFC 200 MCG, FENTANYL CITRATE OTFC 400 MCG, FENTANYL CITRATE OTFC 600 MCG, FENTANYL CITRATE OTFC 800 MCG

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

N/A