ACCRUFER

MEDICATION(S)
ACCRUFER

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

ACUTE MIGRAINE AGENTS

MEDICATION(S)

BREKIYA, DIHYDROERGOTAMINE 4 MG/ML SPRY, ELYXYB, MIGRANAL, REYVOW, TRUDHESA

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

AFREZZA

MEDICATION(S)
AFREZZA

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

AGAMREE, EMFLAZA

MEDICATION(S)

AGAMREE, DEFLAZACORT, EMFLAZA, JAYTHARI, KYMBEE, PYQUVI

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

ALHEMO

MEDICATION(S)
ALHEMO PEN

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

ALPHA-1 PROTEINASE INHIBITOR

MEDICATION(S)
GLASSIA

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)

ADLARITY, ARBLI, ASPRUZYO SPRINKLE, ATMEKSI, BACLOFEN 10 MG/5 ML SOLUTION, BACLOFEN 25 MG/5 ML SUSPENSION, BACLOFEN 5 MG/5 ML SOLUTION, CAROSPIR, CIMETIDINE 300 MG/5 ML SOLN, CUVPOSA, DARTISLA, DESLORATADINE 0.5 MG/ML SOLN, DESMODA, DIGOXIN 0.05 MG/ML SOLUTION, DIURIL, DRONABINOL 5 MG/ML SOLUTION, ENALAPRIL 1 MG/ML ORAL SOLN, ENBUMYST, ENTRESTO SPRINKLE, EPANED, EXSERVAN, FAMOTIDINE 40 MG/5 ML SUSP, FLEQSUVY, FUROSEMIDE 10 MG/ML SOLUTION, FUROSEMIDE 40 MG/5 ML SOLN, GLYCOPYRROLATE 1 MG/5 ML SOLN, GRANISOL, INDOCIN 50 MG SUPPOSITORY, INDOMETHACIN 50 MG SUPPOSITORY, INZIRQO, JAVADIN, JYLAMVO, KATERZIA, LIKMEZ, LINEZOLID 100 MG/5 ML SUSP, LOPRESSOR 10 MG/ML ORAL SOLN, LYVISPAH, MEMANTINE HCL 10 MG/5 ML CUP, MEMANTINE HCL 2 MG/ML SOLUTION, METFORMIN HCL 500 MG/5 ML SOLN, NIMODIPINE 60 MG/20 ML SOLN, NITROFURANTOIN 25 MG/5 ML SUSP, NITROFURANTOIN 50 MG/5 ML SUSP, NORLIQVA, NYMALIZE, ONTRALFY, OZOBAX, OZOBAX DS, POKONZA 5% (10 MEQ/15 ML) SOLN, PROPRANOLOL 20 MG/5 ML SOLN, PROPRANOLOL 40 MG/5 ML SOLN, QBRELIS, RALDESY, RIOMET, SDAMLO, SOTYLIZE, SPIRONOLACTONE 25 MG/5 ML SUSP, SUCRALFATE 1 GM/10 ML SUSP, SUCRALFATE 1 GM/10 ML SUSP CUP, SYNDROS, TEZRULY, TIGLUTIK, TONMYA, XATMEP, XROMI, ZYVOX 100 MG/5 ML SUSPENSION

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)

ANDROGEL, DANAZOL 100 MG CAPSULE, DANAZOL 200 MG CAPSULE, DANAZOL 50 MG CAPSULE, DEPO-TESTOSTERONE, JATENZO, KYZATREX, METHITEST, METHYLTESTOSTERONE 10 MG CAP, NATESTO, TESTIM, TESTOSTERONE 1% (25MG/2.5G) PK, TESTOSTERONE 1% (50 MG/5 G) PK, TESTOSTERONE 1.62% (2.5 G) PKT, TESTOSTERONE 1.62% GEL PUMP, TESTOSTERONE 1.62%(1.25 G) PKT, TESTOSTERONE 10 MG GEL PUMP, TESTOSTERONE 12.5 MG/1.25 GRAM, TESTOSTERONE 30 MG/1.5 ML PUMP, TESTOSTERONE 50 MG/5 GRAM GEL, TESTOSTERONE 50 MG/5 GRAM PKT, 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, TLANDO, UNDECATREX, VOGELXO, 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

AQVESME

MEDICATION(S)
AQVESME

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, 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

MEDICATION(S)

ABRILADA(CF), ABRILADA(CF) PEN, ABRILADA(CF) PEN (2 PACK), ACTEMRA 162 MG/0.9 ML SYRINGE, ACTEMRA ACTPEN, ADALIMUMAB-AACF(CF) (2 PK), ADALIMUMAB-AACF(CF) PEN (2 PK), ADALIMUMAB-AACF(CF) PEN CROHNS, ADALIMUMAB-AACF(CF) PEN PS-UV, ADALIMUMAB-AATY(CF), ADALIMUMAB-AATY(CF) AI CROHNS, ADALIMUMAB-AATY(CF) AUTOINJECT, ADALIMUMAB-ADAZ(CF), ADALIMUMAB-ADAZ(CF) PEN, ADALIMUMAB-ADBM(CF), ADALIMUMAB-ADBM(CF) PEN, ADALIMUMAB-ADBM(CF) PEN CROHNS, ADALIMUMAB-ADBM(CF) PEN PS-UV, ADALIMUMAB-ADBM(CF)PEN, ADALIMUMAB-BWWD(CF), ADALIMUMAB-BWWD(CF) AUTOINJECT, ADALIMUMAB-FKJP(CF), ADALIMUMAB-FKJP(CF) PEN, ADALIMUMAB-RYVK(CF), ADALIMUMAB-RYVK(CF) AUTOINJECT, AMJEVITA(CF), AMJEVITA(CF) AUTOINJECTOR, AVTOZMA 162 MG/0.9 ML SYRINGE, AVTOZMA AUTOINJECTOR, BIMZELX, BIMZELX AUTOINJECTOR, CIMZIA, CIMZIA 2X200 MG/ML SYRINGE KIT, COSENTYX (2 SYRINGES), COSENTYX SENSOREADY (2 PENS), COSENTYX SENSOREADY PEN, COSENTYX SYRINGE, COSENTYX UNOREADY PEN, CYLTEZO(CF), CYLTEZO(CF) PEN, CYLTEZO(CF) PEN CROHN'S-UC-HS, CYLTEZO(CF) PEN PSORIASIS-UV, ENBREL, ENBREL MINI, ENBREL SURECLICK, ENTYVIO PEN, HADLIMA, HADLIMA PUSHTOUCH, HADLIMA(CF), HADLIMA(CF) PUSHTOUCH, HULIO(CF), HULIO(CF) PEN, HUMIRA, HUMIRA PEN, HUMIRA(CF), HUMIRA(CF) PEN, HUMIRA(CF) PEN CROHN'S-UC-HS, HUMIRA(CF) PEN PSOR-UV-ADOL HS, HYRIMOZ, HYRIMOZ PEN, HYRIMOZ(CF), HYRIMOZ(CF) PEDIATRIC CROHN'S, HYRIMOZ(CF) PEN, HYRIMOZ(CF) PEN CROHN-UC START, HYRIMOZ(CF) PEN PSORIASIS, ICOTYDE, IDACIO(CF) (2 PACK), IDACIO(CF) PEN (2 PACK), IDACIO(CF) PEN CROHN'S-UC(6PK), IDACIO(CF) PEN PSORIASIS (4PK), IMULDOSA 45 MG/0.5 ML SYRINGE, IMULDOSA 90 MG/ML SYRINGE, KEVZARA, KINERET, LEQSELVI, LITFULO, OLUMIANT, OMVOH 100 MG/ML SYRINGE, OMVOH 200 MG DOSE - 2 SYRINGES, OMVOH 200 MG/2 ML SYRINGE, OMVOH 300 MG DOSE - 2 SYRINGES, OMVOH PEN, ORENCIA 125 MG/ML SYRINGE, ORENCIA 50 MG/0.4 ML SYRINGE, ORENCIA 87.5 MG/0.7 ML SYRINGE, ORENCIA CLICKJECT, OTULFI 45 MG/0.5 ML SYRINGE, OTULFI 45 MG/0.5 ML VIAL, OTULFI 90 MG/ML SYRINGE, CDV PYZCHIVA 45 MG/0.5 ML SYR, CDV PYZCHIVA 90 MG/ML SYRINGE, PYZCHIVA 45 MG/0.5 ML SYRINGE, PYZCHIVA 45 MG/0.5 ML VIAL, PYZCHIVA 90 MG/ML SYRINGE, PYZCHIVA AUTOINJECTOR, RINVOQ, RINVOQ LQ, SELARSDI 45 MG/0.5 ML SYRINGE, SELARSDI 45 MG/0.5 ML VIAL, SELARSDI 90 MG/ML SYRINGE, SILIQ, SIMLANDI(CF), SIMLANDI(CF) AUTOINJECTOR, SIMPONI, SKYRIZI 150 MG/ML SYRINGE, SKYRIZI 55 MG/0.37 ML SYRINGE, SKYRIZI ON-BODY, SKYRIZI PEN, SOTYKTU, STARJEMZA 45 MG/0.5 ML SYRINGE, STARJEMZA 45 MG/0.5 ML VIAL, STARJEMZA 90 MG/ML SYRINGE, STELARA 45 MG/0.5 ML SYRINGE, STELARA 45 MG/0.5 ML VIAL, STELARA 90 MG/ML SYRINGE, STEQEYMA 45 MG/0.5 ML SYRINGE, STEQEYMA 45 MG/0.5 ML VIAL, STEQEYMA 90 MG/ML SYRINGE, TALTZ AUTOINJECTOR, TALTZ AUTOINJECTOR (2 PACK), TALTZ AUTOINJECTOR (3 PACK), TALTZ SYRINGE, TOFACITINIB 1 MG/ML SOLUTION, TOFACITINIB 10 MG TABLET, TOFACITINIB 5 MG TABLET, TOFACITINIB CITRATE ER, TREMFYA 100 MG/ML SYRINGE, TREMFYA 200 MG/2 ML SYRINGE, TREMFYA ONE-

PRESS, TREMFYA PEN, TREMFYA PEN INDUCTION (2 PEN), TYENNE 162 MG/0.9 ML SYRINGE, TYENNE AUTOINJECTOR, USTEKINUMAB 45 MG/0.5 ML VIAL, USTEKINUMAB 45MG/0.5ML SYRINGE, USTEKINUMAB 90 MG/ML SYRINGE, USTEKINUMAB-AAUZ, USTEKINUMAB-AEKN, USTEKINUMAB-TTWE 45 MG SYRINGE, USTEKINUMAB-TTWE 45MG/0.5ML VL, USTEKINUMAB-TTWE 90 MG/ML SYR, VELSIPITY, WEZLANA 45 MG/0.5 ML SYRINGE, WEZLANA 45 MG/0.5 ML VIAL, WEZLANA 90 MG/ML SYRINGE, XELJANZ, XELJANZ XR, YESINTEK 45 MG/0.5 ML SYRINGE, YESINTEK 45 MG/0.5 ML VIAL, YESINTEK 90 MG/ML SYRINGE, YUFLYMA(CF), YUFLYMA(CF) AI CROHN'S-UC-HS, YUFLYMA(CF) AUTOINJECTOR, YUSIMRY(CF) PEN, ZYMFENTRA, ZYMFENTRA PEN

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

BONJESTA DICLEGIS

MEDICATION(S)

BONJESTA, DICLEGIS, DOXYLAMINE SUCC-PYRIDOXINE HCL

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

N/A

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)
CARBAGLU, 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

CARDAMYST

MEDICATION(S)
CARDAMYST

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, MYQORZO

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

CFTR

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

CGM

MEDICATION(S)

DEXCOM G6 RECEIVER, DEXCOM G6 SENSOR, DEXCOM G6 TRANSMITTER, DEXCOM G7 15 DAY SENSOR, DEXCOM G7 RECEIVER, DEXCOM G7 SENSOR, FREESTYLE LIBRE 14 DAY READER, FREESTYLE LIBRE 14 DAY SENSOR, FREESTYLE LIBRE 2 PLUS SENSOR, FREESTYLE LIBRE 2 READER, FREESTYLE LIBRE 2 SENSOR, FREESTYLE LIBRE 3 PLUS SENSOR, FREESTYLE LIBRE 3 READER, FREESTYLE LIBRE 3 SENSOR

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

N/A

CGRP

MEDICATION(S)

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

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

COMBINATION NSAID

MEDICATION(S)

ASPIRIN-OMEPRAZOLE, DUEXIS, IBUPROFEN-FAMOTIDINE, NAPROXEN-ESOMEPRAZOLE MAG, VIMOVO, YOSPRALA

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

CONSTIPATION AGENTS

MEDICATION(S)

AMITIZA, IBSRELA, LINZESS, LUBIPROSTONE, MOTEGRITY, MOVANTIK, PRUCALOPRIDE, RELISTOR, SYMPROIC, TRULANCE

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, CORTROPHIN GEL 400 UNIT/5 ML, CORTROPHIN GEL 80 UNIT/ML VIAL

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

N/A

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

DOJOLVI

MEDICATION(S)
DOJOLVI

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

DRY EYE DISEASE

MEDICATION(S)

CEQUA, EYSUVIS, MIEBO, RESTASIS, RESTASIS MULTIDOSE, TRYPTYR, TYRVAYA, VEVYE, XIIDRA

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, ORILISSA

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
N/A

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)

ENDARI, 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

EOHILIA

MEDICATION(S)
EOHILIA

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 10,000 UNIT/ML VIAL, PROCRIT 2,000 UNITS/ML VIAL, PROCRIT 20,000 UNIT/2 ML VIAL, PROCRIT 20,000 UNITS/ML VIAL, PROCRIT 3,000 UNITS/ML VIAL, PROCRIT 40,000 UNITS/ML VIAL, 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, ALTUVIIIO, 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)
REDEMPLO, 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

GLP-1

MEDICATION(S)

BYDUREON BCISE, BYETTA, EXENATIDE, LIRAGLUTIDE 2-PAK 18 MG/3 ML, LIRAGLUTIDE 3-PAK 18 MG/3 ML, MOUNJARO, OZEMPIC, RYBELSUS, TRULICITY, VICTOZA 2-PAK, VICTOZA 3-PAK

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

N/A

GONADOTROPIN HORMONES

MEDICATION(S)

CETRORELIX ACETATE, CETROTIDE, CHORIONIC GONAD 10,000 UNIT VL, FOLLISTIM AQ, FYREMADEL, GANIRELIX ACETATE, GONAL-F, GONAL-F RFF, GONAL-F RFF REDI-JECT, MENOPUR, NOVAREL, 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

GRANULOCYTE COLONY STIMULATING FACTORS

MEDICATION(S)

FULPHILA, FYLNETRA, GRANIX, LEUKINE, NEULASTA, NEULASTA ONPRO, NEUPOGEN, NIVESTYM, NYPOZI, NYVEPRIA, RELEUKO, STIMUFEND, UDENYCA, UDENYCA AUTOINJECTOR, UDENYCA ONBODY, ZARXIO, ZIEXTENZO

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

GROWTH HORMONE

MEDICATION(S)

GENOTROPIN, HUMATROPE, NGENLA, NORDITROPIN FLEXPRO, NUTROPIN AQ NUSPIN, OMNITROPE, SEROSTIM, SKYTROFA, SOGROYA, ZOMACTON

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

HAE

MEDICATION(S)

ANDEMBRY AUTOINJECTOR, BERINERT 500 UNIT KIT, DAWNZERA, EKTERLY, FIRAZYR, HAEGARDA, ICATIBANT, ORLADEYO, RUCONEST, SAJAZIR, TAKHZYRO

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

HARLIKU

MEDICATION(S)
HARLIKU

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

HCN CHANNEL BLOCKER

MEDICATION(S)
CORLANOR, IVABRADINE HCL

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
N/A

HEMLIBRA

MEDICATION(S)
HEMLIBRA

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

HEMOPHILIA IX

MEDICATION(S)

ALPHANINE SD, ALPROLIX, BENEFIX, IDELVION, IXINITY, PROFILNINE, REBINYN, RIXUBIS

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

HEPATITIS C DIRECT ACTING ANTIVIRALS

MEDICATION(S)

EPCLUSA, HARVONI, LEDIPASVIR-SOFOSBUVIR, MAVYRET, SOFOSBUVIR-VELPATASVIR, SOVALDI, VOSEVI, ZEPATIER

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

HETLIOZ

MEDICATION(S)

HETLIOZ, HETLIOZ LQ, TASIMELTEON

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)

ALKINDI SPRINKLE, ALLOPURINOL 200 MG TABLET, ALPHAGAN P 0.15% EYE DROPS, AMLODIPINE-VALSARTAN-HCTZ, ATACAND HCT, AZILSARTAN MEDOXOMIL, AZOPT, BRIMONIDINE TARTRATE 0.15% DRP, BRIMONIDINE TARTRATE-TIMOLOL, BRINZOLAMIDE, BROMFENAC SODIUM 0.09% EYE DRP, BUDESONIDE ER, CANDESARTAN-HYDROCHLOROTHIAZID, CARBINOXAMINE 4 MG/5 ML LIQUID, CARBINOXAMINE MALEATE 6 MG TAB, CARBZAH, CARDIZEM CD 360 MG CAPSULE, CARVEDILOL ER, CLEMASTINE 0.5 MG/5 ML SYRUP, COLCHICINE 0.6 MG CAPSULE, COMBIGAN, CONDYLOX, COREG CR, CROTAN, CUPRIMINE, CUVRIOR, DICHLORPHENAMIDE, DILTIAZEM 12HR ER 120 MG CAP, DILTIAZEM 12HR ER 60 MG CAP, DILTIAZEM 24H ER(CD) 360 MG CP, DUTASTERIDE-TAMSULOSIN, EDARBI, EDARBYCLOR, EXFORGE HCT, FENOFIBRATE 120 MG TABLET, FENOFIBRATE 40 MG TABLET, FENOGLIDE, GOCOVRI, INDERAL XL 80 MG CAPSULE, INNOPRAN XL 80 MG CAPSULE, ISORDIL, ISOSORBIDE DINITRATE 40 MG TAB, JALYN, KEVEYIS, KHINDIVI, METAXALONE 400 MG TABLET, METAXALONE 640 MG TABLET, MICARDIS HCT, MIRAPEX ER, MITIGARE, NORGESIC FORTE, ONGENTYS 50 MG CAPSULE, ORMALVI, ORPHENGESIC FORTE, PENICILLAMINE 250 MG CAPSULE, PODOFILOX 0.5% GEL, PRAMIPEXOLE ER, PRURADIK, RYVENT, TELMISARTAN-HYDROCHLOROTHIAZID, TIMOLOL 0.5% GEL-SOLUTION, TIMOLOL 0.5% GFS GEL-SOLUTION, TIMOLOL MALEATE 0.5% EYE DROP, TIMOPTIC 0.5% OCUDOSE DROP, TIZANIDINE HCL 8 MG CAPSULE, UCERIS 9 MG ER TABLET, ZANAFLEX 8 MG CAPSULE, ZILEUTON ER

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

N/A

MEDICATION(S)
ADDYI, VYLEESI

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

HYFTOR

MEDICATION(S)
HYFTOR

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

HYMPAVZI

MEDICATION(S)
HYMPAVZI PEN

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

HYPERHIDROSIS

MEDICATION(S)
QBREXZA, SOFDRA

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

IL-31 INHIBITOR

MEDICATION(S)
NEMLUVIO

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

IMCIVREE

MEDICATION(S)
IMCIVREE

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

INSULIN PUMPS

MEDICATION(S)

ILET INSULIN PUMP, OMNIPOD 5 (LIBRE 2/3 PLUS), OMNIPOD 5 DEXG7G6 INTRO(GEN 5), OMNIPOD 5 DEXG7G6 PODS (GEN 5), OMNIPOD 5 INTRO (LIBRE2/3PLUS), OMNIPOD DASH INTRO KIT (GEN 4), OMNIPOD DASH PODS (GEN 4), TWIIST REFILL KT(CSST-NDL-SYR), TWIIST RFL(INFUS-CSST-NDL-SYR), TWIIST STARTER KIT

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

INTERLEUKIN (IL)-1 INHIBITOR

MEDICATION(S)
ARCALYST

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

INTERLEUKIN-13 (IL-13) ANTAGONIST

MEDICATION(S)

ADBRY, ADBRY AUTOINJECTOR, EBGLYSS PEN, EBGLYSS SYRINGE

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

N/A

INTERLEUKIN-4 (IL-4) INHIBITORS

MEDICATION(S)

DUPIXENT PEN, DUPIXENT SYRINGE

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

N/A

INTERLEUKIN-5 (IL-5) INHIBITORS

MEDICATION(S)

FASENRA PEN, NUCALA 100 MG/ML AUTO-INJECTOR, NUCALA 100 MG/ML SYRINGE, NUCALA 40 MG/0.4 ML SYRINGE

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

N/A

INTERSTITIAL LUNG DISEASE

MEDICATION(S)

ESBRIET, JASCAYD, NINTEDANIB ESYLATE, OFEV, PIRFENIDONE

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

ISTURISA

MEDICATION(S)
ISTURISA

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
N/A

JOENJA

MEDICATION(S)

JOENJA

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

JYNARQUE

MEDICATION(S)
JYNARQUE

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

KORLYM

MEDICATION(S)

KORLYM, MIFEPRISTONE 300 MG TABLET

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

N/A

LEQEMBI

MEDICATION(S)
LEQEMBI IQLIK

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

LEUCOVORIN

MEDICATION(S)

LEUCOVORIN CALCIUM 10 MG TAB, LEUCOVORIN CALCIUM 15 MG TAB, LEUCOVORIN CALCIUM 25 MG TAB, LEUCOVORIN CALCIUM 5 MG TAB

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

LONG ACTING INSULIN

MEDICATION(S)

INSULIN DEGLUDEC, INSULIN DEGLUDEC PEN (U-100), INSULIN DEGLUDEC PEN (U-200), INSULIN GLARGINE-YFGN U100 PEN, LANTUS, LANTUS SOLOSTAR, REZVOGLAR KWIKPEN

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

LUPUS

MEDICATION(S)

BENLYSTA 200 MG/ML AUTOINJECT, BENLYSTA 200 MG/ML SYRINGE, LUPKYNIS

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

MULTIPLE SCLEROSIS

MEDICATION(S)

AUBAGIO, AVONEX (4 PACK), AVONEX PEN (4 PACK), BAFIERTAM, BETASERON 0.3 MG KIT, CLADRIBINE 10 MG X 1 TB DAY PK, CLADRIBINE 10 MG X 10 TAB PK, CLADRIBINE 10 MG X 2 TB DAY PK, CLADRIBINE 10 MG X 4 TABLET PK, CLADRIBINE 10 MG X 5 TABLET PK, CLADRIBINE 10 MG X 6 TABLET PK, CLADRIBINE 10 MG X 7 TABLET PK, CLADRIBINE 10 MG X 8 TABLET PK, CLADRIBINE 10 MG X 9 TABLET PK, COPAXONE, GILENYA, KESIMPTA PEN, MAVENCLAD, MAYZENT, PLEGRIDY, PLEGRIDY PEN, PONVORY, REBIF, REBIF REBIDOSE, TASCENSO ODT, TECFIDERA, VUMERITY

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

MYALEPT

MEDICATION(S)
MYALEPT

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

NEUROTROPHIC KERATITIS

MEDICATION(S)
OXERVATE

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

NIEMANN-PICK DISEASE TYPE C AGENT

MEDICATION(S)
AQNEURSA, MIPLYFFA

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

OHTUVAYRE

MEDICATION(S)
OHTUVAYRE

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

OPIOIDS ER

MEDICATION(S)

BELBUCA, BUPRENORPHINE, BUTRANS, CONZIP, FENTANYL, HYDROCODONE BITARTRATE ER, HYDROMORPHONE ER, HYSINGLA ER, MORPHINE SULFATE ER, MS CONTIN, NUCYNTA ER, OXYCODONE HCL ER, OXYCONTIN, OXYMORPHONE HCL ER, TAPENTADOL ER, TRAMADOL HCL ER, XTAMPZA ER

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

N/A

OPZELURA

MEDICATION(S)
OPZELURA

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

ORAL TETRACYCLINE DERIVATIVES

MEDICATION(S)

DORYX, DORYX MPC, DOXYCYCLINE 50 MG TABLET, DOXYCYCLINE HYC DR 100 MG TAB, DOXYCYCLINE HYC DR 150 MG TAB, DOXYCYCLINE HYC DR 200 MG TAB, DOXYCYCLINE HYC DR 50 MG TAB, DOXYCYCLINE HYC DR 75 MG TAB, DOXYCYCLINE HYC DR 80 MG TAB, DOXYCYCLINE HYCLATE 150 MG TAB, DOXYCYCLINE HYCLATE 75 MG TAB, DOXYCYCLINE IR-DR, DOXYCYCLINE MONO 150 MG CAP, DOXYCYCLINE MONO 75 MG CAPSULE, EMROSI, MINOCYCLINE ER, MINOCYCLINE HCL 100 MG TABLET, MINOCYCLINE HCL 75 MG TABLET, MINOCYCLINE HCL ER, MONDOXYNE NL 75 MG CAPSULE, ORACEA, SEYSARA, TARGADOX, TETRACYCLINE 250 MG TABLET, TETRACYCLINE 500 MG TABLET, XIMINO

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

OTEZLA

MEDICATION(S)

OTEZLA 10-20 MG STARTER 28 DAY, OTEZLA 10-20-30MG START 28 DAY, OTEZLA 20 MG TABLET, OTEZLA 30 MG TABLET, OTEZLA XR

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

N/A

OXYBATE

MEDICATION(S)

LUMRYZ, LUMRYZ STARTER PACK, SODIUM OXYBATE, XYREM, XYWAV

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

PAH

MEDICATION(S)

ADCIRCA, ADEMPAS, ALYQ, AMBRISENTAN, BOSENTAN, LETAIRIS, LIQREV, MACITENTAN, OPSUMIT, OPSYNVI, ORENITRAM ER, ORENITRAM MONTH 1 TITRATION KT, ORENITRAM MONTH 2 TITRATION KT, ORENITRAM MONTH 3 TITRATION KT, REVATIO 20 MG TABLET, SILDENAFIL 10 MG/ML ORAL SUSP, SILDENAFIL 20 MG TABLET, TADALAFIL 20 MG TABLET, TADLIQ, TRACLEER, TYVASO, TYVASO DPI, TYVASO REFILL KIT, TYVASO STARTER KIT, UPTRAVI 1,000 MCG TABLET, UPTRAVI 1,200 MCG TABLET, UPTRAVI 1,400 MCG TABLET, UPTRAVI 1,600 MCG TABLET, UPTRAVI 100 MCG TABLET, UPTRAVI 150 MCG TABLET, UPTRAVI 200 MCG TABLET, UPTRAVI 200-800 TITRATION PACK, UPTRAVI 400 MCG TABLET, UPTRAVI 600 MCG TABLET, UPTRAVI 800 MCG TABLET, VENTAVIS, WINREVAIR 45 MG ONE-VIAL KIT, WINREVAIR 60 MG ONE-VIAL KIT, WINREVAIR (2 PACK), YUTREPIA

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

PARATHYROID HORMONE ANALOG FOR OSTEOPOROSIS

MEDICATION(S)

BONSITY, FORTEO, TERIPARATIDE, TYMLOS

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

N/A

PCSK-9 INHIBITORS

MEDICATION(S)

PRALUENT PEN, REPATHA PUSHTRONEX, REPATHA SURECLICK, REPATHA SYRINGE

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

N/A

PEGINTERFERON

MEDICATION(S)
PEGASYS

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

PHENYLKETONURIA

MEDICATION(S)

JAVYGTOR, KUVAN, PALYNZIQ, SAPROPTERIN DIHYDROCHLORIDE, SEPHIENCE, ZELVYSIA

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

PRIMARY BILIARY CHOLANGITIS

MEDICATION(S)
IQIRVO, LIVDELZI

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

PROCYSBI

MEDICATION(S)
PROCYSBI

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

PSEUDOBULBAR AFFECT

MEDICATION(S)
DEXTROMETHORPHAN HBR-QUINIDINE, NUEDEXTA

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
N/A

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

QFITLIA

MEDICATION(S)
QFITLIA, QFITLIA PEN

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

RADICAVA

MEDICATION(S)
RADICAVA ORS

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

RAPID TO INTERMEDIATE ACTING INSULIN

MEDICATION(S)

ADMELOG, ADMELOG SOLOSTAR, APIDRA, APIDRA SOLOSTAR, INSULIN ASPART, INSULIN ASPART FLEXPEN, INSULIN ASPART PENFILL, INSULIN ASPART PROT MIX 70-30, INSULIN LISPRO, INSULIN LISPRO JUNIOR KWIKPEN, INSULIN LISPRO KWIKPEN U-100, INSULIN LISPRO PROTAMINE MIX, KIRSTY, KIRSTY PEN, MERILOG, MERILOG SOLOSTAR

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

RAYOS

MEDICATION(S)

PREDNISONE DR 1 MG TABLET, PREDNISONE DR 2 MG TABLET, PREDNISONE DR 5 MG TABLET, RAYOS

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

RECORLEV

MEDICATION(S)
RECORLEV

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

RESISTANT HYPERTENSION AGENTS

MEDICATION(S)
TRYVIO

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

RESMETIROM

MEDICATION(S)
REZDIFFRA

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

REZUROCK

MEDICATION(S)
REZUROCK

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

RHAPSIDO (REMIBRUTINIB)

MEDICATION(S)
RHAPSIDO

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

RISDIPLAM

MEDICATION(S)
EVRYSDI

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
N/A

RIVFLOZA

MEDICATION(S)
RIVFLOZA

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, AFINITOR, AFINITOR DISPERZ, AKEEGA, ALECENSA, ALUNBRIG, AUGTYRO, AVMAPKI-FAKZYNJA, AYVAKIT, BALVERSA, BESREMI, BESREMI PEN, BEXAROTENE, BOSULIF, BOSUTINIB, BRAFTOVI, BRUKINSA, CABOMETYX, CALQUENCE, CAPECITABINE, CAPRELSA, COMETRIQ, COPIKTRA, COTELLIC, DANZITEN, 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, GLEEVEC, GOMEKLI, HERNEXEOS, HYCAMTIN, HYRNUO, IBRANCE, IBTROZI, ICLUSIG, IDHIFA, IMATINIB MESYLATE 100 MG TAB, IMATINIB MESYLATE 400 MG TAB, IMBRUVICA, IMKELDI, INLURIYO, INLYTA, INQOVI, INREBIC, IRESSA, ITOVEBI, IWILFIN, JAKAFI, JAYPIRCA, KISQALI, KOMZIFTI, KOSELUGO, KRAZATI, LAPATINIB, LAZCLUZE, LENALIDOMIDE, LENVIMA, LONSURF, LORBRENA, LUMAKRAS, LYNPARZA, LYSODREN, LYTGOBI, MATULANE, MEKINIST, MEKTOVI, MODEYSO, NERLYNX, NEXAVAR, NILOTINIB D-TARTRATE, NILOTINIB HCL, NINLARO, NUBEQA, ODOMZO, OGSIVEO, OJEMDA, OJJAARA, ONUREG, ORGOVYX, ORSERDU, PAZOPANIB HCL, PEMAZYRE, PHYRAGO, PIQRAY, POMALIDOMIDE, POMALYST, QINLOCK, RETEVMO, REVLIMID, REVUFORJ, REZLIDHIA, ROMVIMZA, ROZLYTREK, RUBRACA, RYDAPT, SCEMBLIX, SORAFENIB, SPRYCEL, STIVARGA, SUNITINIB MALATE, SUTENT, TABRECTA, TAFINLAR, TAGRISSO, TALZENNA, TARCEVA, TARGRETIN, TASIGNA, TAZVERIK, TEMOZOLOMIDE, TEPMETKO, THALOMID, TIBSOVO, TORPENZ, TRETINOIN 10 MG CAPSULE, TRUQAP, TUKYSA, TURALIO, TYKERB, VANFLYTA, VENCLEXTA, VENCLEXTA STARTING PACK, VERZENIO, VITRAKVI, VIZIMPRO, VONJO, VORANIGO, VOTRIENT, WELIREG, XALKORI, XELODA, XOSPATA, XPOVIO, XTANDI, YONSA, YULITHIRA, ZEJULA, ZELBORAF, ZOLINZA, ZYDELIG, ZYKADIA, ZYTIGA

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

SENSIPAR

MEDICATION(S)
CINACALCET HCL, SENSIPAR

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

SKYCLARYS

MEDICATION(S)
SKYCLARYS

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
N/A

SOHONOS

MEDICATION(S)
SOHONOS

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

SOMATOSTATIN ANALOGS

MEDICATION(S)

BYNFEZIA, MYCAPSSA, OCTREOTIDE ACETATE, PALSONIFY, SANDOSTATIN, SOMAVERT

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

N/A

SPEVIGO

MEDICATION(S)

SPEVIGO 150 MG/ML SYRINGE, SPEVIGO 300 MG/2 ML SYRINGE

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

N/A

SSIA

MEDICATION(S)
NUPLAZID

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

STRENSIQ

MEDICATION(S)
STRENSIQ

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

SUBCUTANEOUS FUROSEMIDE

MEDICATION(S)

FUROSCIX, FUROSCIX READYFLOW, LASIX ONYU 80 MG/2.67 ML KIT

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

SUBSTRATE REDUCTION THERAPY

MEDICATION(S)

CERDELGA, MIGLUSTAT, OPFOLDA, YARGESA, ZAVESCA

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

SUCRAID

MEDICATION(S)
SUCRAID

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

SUNOSI

MEDICATION(S)
SUNOSI

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

TARPEYO

MEDICATION(S)
TARPEYO

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

TAVNEOS

MEDICATION(S)
TAVNEOS

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
N/A

TEZSPIRE

MEDICATION(S)
TEZSPIRE 210 MG/1.91 ML PEN

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

TOPICAL ACTINIC KERATOSIS, BCC, GW AGENTS

MEDICATION(S)

CARAC, DICLOFENAC SODIUM 3% GEL, EFUDEX, FLUOROURACIL 0.5% CREAM, FLUOROURACIL 5% CREAM, IMIQUIMOD 3.75% CREAM, IMIQUIMOD 3.75% CREAM PUMP, KLISYRI, TOLAK, ZYCLARA

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

TOPICAL DOXEPIN

MEDICATION(S)

DOXEPIN 5% CREAM, PRUDOXIN, ZONALON

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

TOPICAL LIDOCAINE

MEDICATION(S)

DERMACINRX LIDOCAN, LIDOCAINE 5% OINTMENT, LIDOCAINE 5% PATCH, LIDOCAINE HCL 4% SOLUTION, LIDOCAN III, LIDOCAN IV, LIDOCAN V, LIDODERM, PLIAGLIS, ZTLIDO

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

TOPIRAMATE ER

MEDICATION(S)

QUDEXY XR, TOPIRAMATE ER, TOPIRAMATE ER SPRINKLE, TROKENDI XR

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

N/A

TPO-RA, TAVALISSE AND WAYRILZ

MEDICATION(S)

ALVAIZ, DOPTELET, DOPTELET SPRINKLE, ELTROMBOPAG OLAMINE, MULPLETA, PROMACTA, TAVALISSE, WAYRILZ

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

UREA CYCLE DISORDERS

MEDICATION(S)

BUPHENYL, GLYCEROL PHENYLBUTYRATE, OLPRUVA, PHEBURANE, RAVICTI, SODIUM PHENYLBUTYRATE

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

VANRAFIA

MEDICATION(S)
VANRAFIA

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

VASCEPA

MEDICATION(S)
VASCEPA

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

VASOMOTOR SYMPTOMS

MEDICATION(S)
LYNKUET, VEOZAH

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

VERKAZIA

MEDICATION(S)
VERKAZIA

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

VERQUVO

MEDICATION(S)
VERQUVO

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

VIJOICE

MEDICATION(S)
VIJOICE

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

VMAT2 INHIBITOR

MEDICATION(S)

AUSTEDO, AUSTEDO XR, AUSTEDO XR TITRATION KT(WK1-4), INGREZZA, INGREZZA INITIATION PK(TARDIV), INGREZZA SPRINKLE, TETRABENAZINE, XENAZINE

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

VOWST

MEDICATION(S)
VOWST

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

VOXZOGO

MEDICATION(S)
VOXZOGO

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

VOYDEYA

MEDICATION(S)
VOYDEYA

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

VOYXACT

MEDICATION(S)
VOYXACT

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

VTAMA

MEDICATION(S)
VTAMA

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

VYJUVEK

MEDICATION(S)
VYJUVEK

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

VYKAT XR

MEDICATION(S)
VYKAT XR

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
N/A

WAKIX

MEDICATION(S)
WAKIX

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

WEIGHT LOSS AGENTS

MEDICATION(S)

ADIPEX-P, CONTRAVE, LOMAIRA, ORLISTAT 120 MG CAPSULE, PHENTERMINE 15 MG CAPSULE, PHENTERMINE 30 MG CAPSULE, PHENTERMINE 37.5 MG CAPSULE, PHENTERMINE 37.5 MG TABLET, PHENTERMINE 8 MG TABLET, PHENTERMINE-TOPIRAMATE ER, QSYMIA, XENICAL

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)

FOUNDAYO, LIRAGLUTIDE 18 MG/3 ML PEN, LIRAGLUTIDE 5-PAK 18 MG/3 ML, SAXENDA, WEGOVY, WEGOVY HD, ZEPBOUND 10 MG/0.5 ML PEN, ZEPBOUND 12.5 MG/0.5 ML PEN, ZEPBOUND 15 MG/0.5 ML PEN, ZEPBOUND 2.5 MG/0.5 ML PEN, ZEPBOUND 5 MG/0.5 ML PEN, ZEPBOUND 7.5 MG/0.5 ML PEN

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

XDEMVY

MEDICATION(S)
XDEMVY

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

XHANCE

MEDICATION(S)
XHANCE

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

XOLAIR

MEDICATION(S)

XOLAIR 150 MG/ML AUTOINJECTOR, XOLAIR 150 MG/ML SYRINGE, XOLAIR 300 MG/2 ML AUTOINJECT, XOLAIR 300 MG/2 ML SYRINGE, XOLAIR 75 MG/0.5 ML AUTOINJECT, XOLAIR 75 MG/0.5 ML SYRINGE

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

N/A

XOLREMDI

MEDICATION(S)
XOLREMDI

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

XPHOZAH

MEDICATION(S)
XPHOZAH

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

YORVIPATH

MEDICATION(S)
YORVIPATH

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

ZELSUVMI (BERDAZIMER)

MEDICATION(S)
ZELSUVMI

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

ZEPOSIA

MEDICATION(S)
ZEPOSIA

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

ZILBRYSQ

MEDICATION(S)
ZILBRYSQ

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

ZOKINVY

MEDICATION(S)
ZOKINVY

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

ZORYVE

MEDICATION(S)
ZORYVE

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