

PRIOR AUTHORIZATION CRITERIA

This list is current as of 10/1/2026 and pertains to the following formulary:

2027 Independent Health's Medicare Advantage C-SNP Part D Formulary

Independent Health requires you (or your physician) to get prior authorization for certain drugs. This means that you will need to get approval from us before you fill your prescriptions. If you do not get approval, we may not cover the drug. These drugs are listed with a "PA" in the Requirements/Limits column on the formularies. This document contains the Prior Authorization requirements that are associated with our Medicare Advantage Part D formularies.

If you have any questions, please contact our Medicare Member Services Department at 1-800-665-1502 or, for TTY users 711, October 1st – March 31st: Monday through Sunday from 8 a.m. to 8 p.m., April 1st – September 30th: Monday through Friday from 8 a.m. to 8 p.m.

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

ADAPALENE

Products Affected

- *adapalene external cream*
- *adapalene external gel 0.3 %*

PA Criteria	Criteria Details
Exclusion Criteria	Cosmetic use (e.g., hyperpigmentation, keloids, photoaging, wrinkles)
Required Medical Information	Diagnosis of acne vulgaris.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	For each annual reauthorization, confirmation of a symptomatic or clinical improvement (or maintenance of improvement previously achieved) is required. Adapalene products will not be approved for cosmetic uses as these uses are currently excluded from coverage under Medicare Part D.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

10/1/2026

ALECENSA (alectinib)

Products Affected

- ALECENSA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use, submission of test confirming presence of ALK-positive tumor.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to oncology
Coverage Duration	1 year
Other Criteria	This policy applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

10/1/2026

ALUNBRIG (brigatinib)

Products Affected

- ALUNBRIG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use, submission of test confirming presence of ALK-positive tumor.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to oncology
Coverage Duration	1 year
Other Criteria	This policy applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

10/1/2026

ATTRUBY (acoramidis)

Products Affected

- ATTRUBY

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of transthyretin amyloid cardiomyopathy (ATTRwt or ATTRm) confirmed by one of the following: (1) presence of amyloid deposits on cardiac biopsy, (2) presence of transthyretin precursor protein confirmed on immunohistochemical analysis, (3) technetium 99-labeled nuclear scintigraphy or single-photon emission computer tomography (SPECT), or (4) a TTR genetic mutation plus cardiac involvement defined as thickening of the interseptal ventricular wall.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to cardiology
Coverage Duration	1 year
Other Criteria	This policy applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

10/1/2026

AUSTEDO (deutetrabenazine)

Products Affected

- AUSTEDO ORAL TABLET 12 MG, 6 MG, 9 MG
- AUSTEDO XR ORAL TABLET EXTENDED RELEASE 24 HOUR 12 MG, 18 MG, 24 MG, 30 MG, 36 MG, 42 MG, 48 MG, 6 MG
- AUSTEDO XR PATIENT TITRATION ORAL TABLET EXTENDED RELEASE THERAPY PACK 12 & 18 & 24 & 30 MG

PA Criteria	Criteria Details
Exclusion Criteria	Hepatic impairment (Child-Pugh class A, B, or C)
Required Medical Information	Diagnosis of covered use, submission of liver function testing or Child-Pugh score. For treatment of chorea associated with Huntington's disease, submission of current or previous therapies used to treat the condition (see Other Criteria).
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to neurology and psychiatry
Coverage Duration	1 year
Other Criteria	For initial authorization for treatment of chorea associated with Huntington's disease, the patient must have tried and failed to have an adequate response to or had an intolerance/contraindication to tetrabenazine. For each annual reauthorization for tardive dyskinesia, confirmation of a symptomatic or clinical improvement (or maintenance of an improvement previously achieved) is required.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

10/1/2026

AUVELITY (dextromethorphan/bupropion)

Products Affected

- AUVELITY
- AUVELITY TITRATION PACK

PA Criteria	Criteria Details
Exclusion Criteria	Current or prior diagnosis of bulimia or anorexia nervosa
Required Medical Information	Diagnosis of covered use, attestation patient has been screened for and does not have bipolar disorder or contraindicated eating disorders. For major depressive disorder (MDD), submission of current or previous therapies used to treat the condition (see Other Criteria).
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to neurology and psychiatry
Coverage Duration	1 year
Other Criteria	For initial authorization for MDD, the patient must have tried and failed to have an adequate response to or had an intolerance to two generic on-formulary antidepressants (e.g., bupropion, SSRI, SNRI). This policy applies to new starts only.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

10/1/2026

AVMAPKI/FAKZYNJA (avutometinib/defactinib)

Products Affected

- AVMAPKI FAKZYNJA CO-PACK

PA Criteria	Criteria Details
Exclusion Criteria	Coadministration with warfarin, proton pump inhibitors, or H2 receptor antagonists
Required Medical Information	Diagnosis of covered use, submission of test confirming presence of KRAS mutation, attestation patient has received at least one prior systemic therapy.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to oncology
Coverage Duration	1 year
Other Criteria	This policy applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

10/1/2026

BENLYSTA (belimumab)

Products Affected

- BENLYSTA SUBCUTANEOUS

PA Criteria	Criteria Details
Exclusion Criteria	Severe active central nervous system lupus
Required Medical Information	Diagnosis of covered use, submission of current therapies used to treat the condition (see Other Criteria).
Age Restrictions	
Prescriber Restrictions	Restricted to immunology, nephrology, and rheumatology
Coverage Duration	1 year
Other Criteria	For initial authorization, the patient must be using standard therapy, defined as at least one of the following: systemic corticosteroids (e.g., prednisone), antimalarials (e.g., hydroxychloroquine), or immunosuppressants (e.g., azathioprine, methotrexate, mycophenolate mofetil). For each annual reauthorization, confirmation patient is still using some form of standard therapy (as defined above), unless contraindicated, is required.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

10/1/2026

BEXAROTENE GEL

Products Affected

- *bexarotene external*

PA Criteria	Criteria Details
Exclusion Criteria	Pregnancy
Required Medical Information	Diagnosis of covered use.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to dermatology and oncology
Coverage Duration	1 year
Other Criteria	This policy applies to new starts only.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

10/1/2026

BRAFTOVI (encorafenib)

Products Affected

- BRAFTOVI ORAL CAPSULE 75 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use, submission of test confirming presence of BRAF V600E mutation (or V600K mutation for a melanoma diagnosis). For metastatic melanoma or metastatic non-small cell lung cancer, confirmation that encorafenib and binimetinib will be co-administered. For metastatic colorectal cancer, confirmation that encorafenib and cetuximab will be co-administered.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to oncology
Coverage Duration	1 year
Other Criteria	This policy applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

10/1/2026

BRUKINSA (zanubrutinib)

Products Affected

- BRUKINSA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use. For follicular lymphoma, submission of at least two prior systemic regimens tried and failed and attestation medication will be coadministered with obinutuzumab. For mantle cell lymphoma, submission of prior systemic regimen(s) used. For marginal zone lymphoma, documentation patient has tried and failed at least one anti-CD20-based regimen.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to hematology and oncology
Coverage Duration	1 year
Other Criteria	This policy applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

10/1/2026

BUTALBITAL-ACETAMINOPHEN-CAFFEINE

Products Affected

- *butalbital-apap-caffeine oral capsule*
- *butalbital-apap-caffeine oral tablet 50-325-40 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use, documentation patient has tried and failed a preferred alternative such as ibuprofen or rizatriptan, or has contraindications to all alternatives.
Age Restrictions	PA applies to patients 65 years of age or older. PA does not apply to patients 64 years of age or younger.
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

10/1/2026

BUTALBITAL-ASPIRIN-CAFFEINE

Products Affected

- *butalbital-aspirin-caffeine oral capsule*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use, documentation patient has tried and failed a preferred alternative such as ibuprofen or rizatriptan, or has contraindications to all alternatives.
Age Restrictions	PA applies to patients 65 years of age or older. PA does not apply to patients 64 years of age or younger.
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

10/1/2026

CABOMETYX (cabozantinib)

Products Affected

- CABOMETYX

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use. For hepatocellular carcinoma, confirmation patient was previously treated with sorafenib. For differentiated thyroid cancer, attestation patient is radioactive iodine-refractory or ineligible and submission of previous therapy or therapies tried and failed, which must include a VEGFR-targeted therapy at minimum.
Age Restrictions	12 years of age or older
Prescriber Restrictions	Restricted to oncology
Coverage Duration	1 year
Other Criteria	This policy applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

10/1/2026

CALQUENCE (acalabrutinib)

Products Affected

- CALQUENCE ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use. For previously untreated mantle cell lymphoma, attestation patient is ineligible for autologous hematopoietic stem cell transplantation.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to hematology and oncology
Coverage Duration	1 year
Other Criteria	This policy applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

10/1/2026

CAPRELSA (vandetanib)

Products Affected

- CAPRELSA

PA Criteria	Criteria Details
Exclusion Criteria	History of congenital long QT syndrome
Required Medical Information	Diagnosis of covered use.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to oncology
Coverage Duration	1 year
Other Criteria	This policy applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

10/1/2026

COBENFY (xanomeline/trospium)

Products Affected

- COBENFY
- COBENFY STARTER PACK

PA Criteria	Criteria Details
Exclusion Criteria	Dementia-related psychosis, moderate to severe hepatic impairment (Child-Pugh class B or C)
Required Medical Information	Diagnosis of covered use, submission of liver function testing or Child-Pugh score, submission of current or previous therapies used to treat the condition (see Other Criteria).
Age Restrictions	
Prescriber Restrictions	Restricted to psychiatry
Coverage Duration	1 year
Other Criteria	For initial authorization, the patient must have tried and failed to have an adequate response to or had an intolerance to aripiprazole and at least one other generic second-generation atypical antipsychotic. This policy applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

10/1/2026

COMETRIQ (cabozantinib)

Products Affected

- COMETRIQ (100 MG DAILY DOSE) ORAL KIT 80 & 20 MG
- COMETRIQ (140 MG DAILY DOSE) ORAL KIT 3 X 20 MG & 80 MG
- COMETRIQ (60 MG DAILY DOSE)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to oncology
Coverage Duration	1 year
Other Criteria	This policy applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

10/1/2026

COPIKTRA (duvelisib)

Products Affected

- COPIKTRA ORAL CAPSULE 15 MG, 25 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use, submission of at least two prior systemic therapies tried and failed.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to hematology and oncology
Coverage Duration	1 year
Other Criteria	This policy applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

10/1/2026

COTELLIC (cobimetinib)

Products Affected

- COTELLIC

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use including verification of BRAF V600 mutation as needed for diagnosis.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to oncology
Coverage Duration	1 year
Other Criteria	This policy applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

10/1/2026

CRESEMBA (isavuconazonium)

Products Affected

- CRESEMBA ORAL CAPSULE 186 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use.
Age Restrictions	6 years of age or older
Prescriber Restrictions	Restricted to hematology, infectious diseases, and oncology
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

10/1/2026

CYCLOBENZAPRINE IN OLDER PATIENTS

Products Affected

- *cyclobenzaprine hcl oral tablet 10 mg, 5 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of muscle spasm associated with an acute musculoskeletal condition (defined as short-term pain not lasting longer than a 3-month period), documentation patient has tried and failed a preferred alternative such as baclofen or tizanidine, or has contraindications to all alternatives, attestation prescriber is aware of the risks of long-term anticholinergic medication treatment in older patients.
Age Restrictions	PA applies to patients 65 years of age or older. PA does not apply to patients 64 years of age or younger.
Prescriber Restrictions	
Coverage Duration	Through the end of the plan year (see Other Criteria)
Other Criteria	Cyclobenzaprine is a potent anticholinergic considered high-risk in older patients due to risks of confusion, dry mouth, constipation, and decreased clearance with advanced age. Prior authorization is only required if the total number of days of supply of medication exceeds 30 days per plan year.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

10/1/2026

CYSTEAMINE EYE DROPS

Products Affected

- CYSTADROPS
- CYSTARAN

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use, confirmation of corneal cysteine crystal deposits as seen on slit-lamp examination.
Age Restrictions	
Prescriber Restrictions	Restricted to metabolic diseases specialty, ophthalmology, and optometry
Coverage Duration	1 year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

10/1/2026

DALFAMPRIDINE

Products Affected

- *dalfampridine er*

PA Criteria	Criteria Details
Exclusion Criteria	Moderate or severe renal impairment (CrCl less than or equal to 50 mL/min)
Required Medical Information	Diagnosis of covered use, submission of creatinine clearance (or serum creatinine, actual body weight, and height to calculate estimated creatinine clearance), confirmation that patient is able to walk.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to neurology
Coverage Duration	1 year
Other Criteria	For each annual reauthorization, updated creatinine clearance since the previous authorization and confirmation patient is able to walk is required.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

10/1/2026

DASATINIB

Products Affected

- *dasatinib oral tablet 100 mg, 140 mg, 20 mg, 50 mg, 70 mg, 80 mg*

PA Criteria	Criteria Details
Exclusion Criteria	Coadministration with proton pump inhibitors or H2 receptor antagonists
Required Medical Information	Diagnosis of covered use. For adults with resistance or intolerance to prior therapy, documentation of prior therapy.
Age Restrictions	
Prescriber Restrictions	Restricted to hematology and oncology
Coverage Duration	1 year
Other Criteria	This policy applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

10/1/2026

DAURISMO (glasdegib)

Products Affected

- DAURISMO ORAL TABLET 100 MG, 25 MG

PA Criteria	Criteria Details
Exclusion Criteria	Pregnancy
Required Medical Information	Diagnosis of covered use, confirmation patient will also be receiving cytarabine as part of chemotherapeutic regimen. If patient is under 75 years of age, documentation of comorbidities that preclude use of intensive induction chemotherapy, submission of pregnancy status for female patients of childbearing potential.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to hematology and oncology
Coverage Duration	1 year
Other Criteria	This policy applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

10/1/2026

DIACOMIT (stiripentol)

Products Affected

- DIACOMIT

PA Criteria	Criteria Details
Exclusion Criteria	Requests for monotherapy
Required Medical Information	Diagnosis of covered use, confirmation patient is also receiving clobazam.
Age Restrictions	
Prescriber Restrictions	Restricted to neurology
Coverage Duration	1 year
Other Criteria	This policy applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

10/1/2026

DICHLORPHENAMIDE

Products Affected

- *dichlorphenamide*
- *ormalvi*

PA Criteria	Criteria Details
Exclusion Criteria	Severe pulmonary disease limiting compensation to metabolic acidosis, hepatic insufficiency
Required Medical Information	Diagnosis of covered use.
Age Restrictions	18 years of age or older
Prescriber Restrictions	
Coverage Duration	Initially 2 months, then 1 year
Other Criteria	For each reauthorization, confirmation of a symptomatic or clinical improvement (or maintenance of an improvement previously achieved) is required.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

10/1/2026

DICLOFENAC PATCH

Products Affected

- *diclofenac epolamine external*

PA Criteria	Criteria Details
Exclusion Criteria	Treatment of peri-operative pain in the setting of coronary artery bypass graft (CABG) surgery, use on non-intact or damaged skin resulting from any etiology including exudative dermatitis, eczema, infection lesions, burns, or wounds, pregnancy after 30 weeks gestation
Required Medical Information	Diagnosis of acute pain, defined as short-term pain not lasting longer than a 3-month period.
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

10/1/2026

DIGOXIN IN OLDER PATIENTS

Products Affected

- *digoxin oral tablet 250 mcg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use. Patient must have tried and failed to respond adequately to 0.125 mg of digoxin.
Age Restrictions	PA applies to patients 65 years of age or older. PA does not apply to patients 64 years of age or younger.
Prescriber Restrictions	PA not required for cardiology
Coverage Duration	1 year
Other Criteria	PA not required for doses less than or equal to 0.125 mg per day. For each annual reauthorization, provider must attest patient is undergoing required laboratory testing to monitor kidney function and electrolytes and patient is not experiencing signs or symptoms of digoxin toxicity related to drug administration.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

10/1/2026

DRONABINOL

Products Affected

- *dronabinol oral capsule*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use. If authorization is requested for treatment of nausea and vomiting associated with cancer therapy, submission of current or previous therapies used to treat the condition (see Other Criteria).
Age Restrictions	18 years of age or older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	For initial authorization for treatment of nausea and vomiting associated with cancer therapy, the patient must have tried and failed to have an adequate response to or had an intolerance to at least one 5-HT ₃ receptor antagonist (e.g., granisetron, ondansetron). If the medication is being administered related to cancer treatment and is a full replacement for intravenous administration of antiemetic therapy within 48 hours of cancer treatment, it is covered as a Part B benefit. To be eligible for Part B coverage, the prescribing physician must indicate this on the prescription.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

10/1/2026

ENSACOVE (ensartinib)

Products Affected

- ENSACOVE

PA Criteria	Criteria Details
Exclusion Criteria	Prior ALK-inhibitor use
Required Medical Information	Diagnosis of covered use, submission of test confirming presence of ALK-positive tumor, pregnancy status for female patients of childbearing potential, attestation patient has not previously received an ALK-inhibitor.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to oncology
Coverage Duration	1 year
Other Criteria	This policy applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

10/1/2026

EPIDIOLEX (cannabidiol)

Products Affected

- EPIDIOLEX

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use.
Age Restrictions	
Prescriber Restrictions	Restricted to neurology
Coverage Duration	1 year
Other Criteria	This policy applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

10/1/2026

ERIVEDGE (vismodegib)

Products Affected

- ERIVEDGE

PA Criteria	Criteria Details
Exclusion Criteria	Pregnancy
Required Medical Information	Diagnosis of covered use, submission of pregnancy status for female patients of childbearing potential.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to oncology
Coverage Duration	1 year
Other Criteria	This policy applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

10/1/2026

ESZOPICLONE

Products Affected

- *eszopiclone*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use, documentation at least two of the following medications were tried and deemed ineffective or intolerable: Belsomra, doxepin tablets, ramelteon, and trazodone.
Age Restrictions	PA applies to patients 65 years of age or older. PA does not apply to patients 64 years of age or younger.
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Sedative hypnotic medications are high-risk medications in older patients due to increased risks of cognitive impairment, delirium, unsteady gait, syncope, falls, fractures, and motor vehicle accidents. This policy applies to new starts only.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

10/1/2026

EVEROLIMUS

Products Affected

- *everolimus oral tablet 10 mg, 2.5 mg, 5 mg, 7.5 mg*
- *everolimus oral tablet soluble 2 mg, 3 mg, 5 mg*
- *torpenz oral tablet 10 mg, 2.5 mg, 5 mg, 7.5 mg*
- *yulithira oral tablet 10 mg, 2.5 mg, 5 mg, 7.5 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use. For postmenopausal women with advanced hormone receptor-positive, HER2-negative breast cancer, documentation of treatment failure with letrozole or anastrozole and confirmation drug is being used in combination with exemestane.
Age Restrictions	
Prescriber Restrictions	Restricted to neurology and oncology
Coverage Duration	1 year
Other Criteria	This policy applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

10/1/2026

EXXUA (gepirone)

Products Affected

- EXXUA
- EXXUA TITRATION PACK

PA Criteria	Criteria Details
Exclusion Criteria	QTc interval greater than 450 msec at treatment initiation, severe hepatic impairment (Child-Pugh class C)
Required Medical Information	Diagnosis of covered use, submission of baseline QTc interval, liver function testing or Child-Pugh score, submission of current or previous therapies used to treat the condition (see Other Criteria).
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to psychiatry
Coverage Duration	1 year
Other Criteria	For initial authorization, the patient must have tried and failed to have an adequate response to or had an intolerance to medications with an indication for monotherapy of major depressive disorder from at least 2 of the following classes: (1) tricyclic antidepressants, (2) MAOIs, (3) selective serotonin reuptake inhibitors, (4) serotonin-norepinephrine reuptake inhibitors, or (5) atypical antidepressants (i.e., bupropion, mirtazapine, nefazodone, trazodone, vilazodone, vortioxetine). This policy applies to new starts only.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

10/1/2026

FANAPT (iloperidone)

Products Affected

- FANAPT ORAL TABLET 1 MG, 10 MG, 12 MG, 2 MG, 4 MG, 6 MG, 8 MG
- FANAPT TITRATION PACK A
- FANAPT TITRATION PACK B ORAL TABLET
- FANAPT TITRATION PACK C ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	Dementia-related psychosis
Required Medical Information	Diagnosis of covered use, submission of current or previous therapies used to treat the condition (see Other Criteria).
Age Restrictions	
Prescriber Restrictions	Restricted to psychiatry
Coverage Duration	1 year
Other Criteria	For initial authorization for schizophrenia or acute treatment of manic/mixed episodes of bipolar I disorder, the patient must have tried and failed to have an adequate response to or had an intolerance to aripiprazole and at least one other generic second-generation atypical antipsychotic. This policy applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

10/1/2026

FINTEPLA (fenfluramine)

Products Affected

- FINTEPLA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use.
Age Restrictions	
Prescriber Restrictions	Restricted to neurology
Coverage Duration	1 year
Other Criteria	This policy applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

10/1/2026

FOTIVDA (tivozanib)

Products Affected

- FOTIVDA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use, submission of current or previous therapies used to treat the condition (see Other Criteria).
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to oncology
Coverage Duration	1 year
Other Criteria	For initial authorization, the patient must have tried and failed to have an adequate response to a minimum of two previous systemic therapies, including the failure of at least one prior VEGFR inhibitor. This policy applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

10/1/2026

FRUZAQLA (fruquintinib)

Products Affected

- FRUZAQLA ORAL CAPSULE 1 MG, 5 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use, submission of current or previous therapies used to treat the condition (see Other Criteria).
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to oncology
Coverage Duration	1 year
Other Criteria	For initial authorization, the patient must have documentation of previous treatment with fluoropyrimidine-, oxaliplatin-, and irinotecan-based chemotherapy, an anti-VEGF therapy, and, if RAS wild-type and medically appropriate, an anti-EGFR therapy. This policy applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

10/1/2026

GATTEX (teduglutide)

Products Affected

- GATTEX

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use including confirmation of dependency on parenteral nutrition.
Age Restrictions	
Prescriber Restrictions	Restricted to gastroenterology
Coverage Duration	Initially 6 months, then 1 year
Other Criteria	For the first reauthorization for adults 18 years of age or older, submission of reduction in weekly parenteral nutrition/intravenous support volume from baseline and documentation that a colonoscopy or alternate imaging of the entire colon and upper GI endoscopy with polyp removal and showing no active gastrointestinal malignancy is required. For each annual reauthorization, documented maintenance of a clinical benefit is required.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

10/1/2026

GEFITINIB

Products Affected

- *gefitinib*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use, submission of test confirming presence of EGFR exon 19 deletions or exon 21 (L858R) substitution mutations.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to oncology
Coverage Duration	1 year
Other Criteria	This policy applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

10/1/2026

GILOTRIF (afatinib)

Products Affected

- GILOTRIF

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use. For non-small cell lung cancer, submission of test confirming presence of non-resistant epidermal growth factor receptor mutations. For metastatic squamous non-small cell lung cancer, documentation of progression after platinum-based chemotherapy.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to oncology
Coverage Duration	1 year
Other Criteria	This policy applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

10/1/2026

GOMEKLI (mirdametinib)

Products Affected

- GOMEKLI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use.
Age Restrictions	
Prescriber Restrictions	Restricted to neurology and oncology
Coverage Duration	1 year
Other Criteria	This policy applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

10/1/2026

HAEGARDA (C1 esterase inhibitor)

Products Affected

- HAEGARDA

PA Criteria	Criteria Details
Exclusion Criteria	Requests for acute hereditary angioedema (HAE) therapy (attacks)
Required Medical Information	Diagnosis of covered use, submission of objective or subjective documentation that prophylactic therapy is medically necessary, including, but not limited to activity of disease and disease burden, the frequency of HAE attacks, and quality of life.
Age Restrictions	Age must be consistent with the prescribing information of the drug
Prescriber Restrictions	Restricted to allergy, dermatology, hematology, and immunology
Coverage Duration	1 year
Other Criteria	This policy applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

10/1/2026

HEART FAILURE RISK - CILOSTAZOL

Products Affected

- *cilostazol*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use, attestation prescriber is aware of the medication's risk when used in patients with heart failure and benefit to the patient outweighs the risk of worsening condition.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Members in the chronic condition special needs plan (C-SNP) have a diagnosis of heart failure. The medications covered by this policy have known risks in patients with heart failure and should only be used if the benefits of the medication clearly outweigh the risk to the patient.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

10/1/2026

HEART FAILURE RISK - ITRACONAZOLE

Products Affected

- *itraconazole oral*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use, attestation prescriber is aware of the medication's risk when used in patients with heart failure and benefit to the patient outweighs the risk of worsening condition.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Members in the chronic condition special needs plan (C-SNP) have a diagnosis of heart failure. The medications covered by this policy have known risks in patients with heart failure and should only be used if the benefits of the medication clearly outweigh the risk to the patient.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

10/1/2026

HEART FAILURE RISK - MINOXIDIL

Products Affected

- *minoxidil oral*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use, attestation prescriber is aware of the medication's risk when used in patients with heart failure and benefit to the patient outweighs the risk of worsening condition.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Members in the chronic condition special needs plan (C-SNP) have a diagnosis of heart failure. The medications covered by this policy have known risks in patients with heart failure and should only be used if the benefits of the medication clearly outweigh the risk to the patient.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

10/1/2026

HEART FAILURE RISK - MULTAQ

Products Affected

- MULTAQ

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use, attestation prescriber is aware of the medication's risk when used in patients with heart failure and benefit to the patient outweighs the risk of worsening condition.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Members in the chronic condition special needs plan (C-SNP) have a diagnosis of heart failure. The medications covered by this policy have known risks in patients with heart failure and should only be used if the benefits of the medication clearly outweigh the risk to the patient.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

10/1/2026

HEART FAILURE RISK - PIOGLITAZONE

Products Affected

- *pioglitazone hcl*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use, attestation prescriber is aware of the medication's risk when used in patients with heart failure and benefit to the patient outweighs the risk of worsening condition.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Members in the chronic condition special needs plan (C-SNP) have a diagnosis of heart failure. The medications covered by this policy have known risks in patients with heart failure and should only be used if the benefits of the medication clearly outweigh the risk to the patient.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

10/1/2026

HYDROXYZINE IN OLDER PATIENTS

Products Affected

- *hydroxyzine hcl oral tablet*
- *hydroxyzine pamoate oral capsule 25 mg, 50 mg*

PA Criteria	Criteria Details
Exclusion Criteria	Off-label uses for allergic rhinitis, seasonal allergies, or insomnia
Required Medical Information	Diagnosis of anxiety, atopic dermatitis, chronic urticaria, contact dermatitis, histamine-mediated pruritus, nausea/vomiting, post-operative nausea/vomiting (PONV) or prophylaxis for PONV, attestation prescriber is aware of the risks of long-term anticholinergic medication treatment in older patients.
Age Restrictions	PA applies to patients 65 years of age or older. PA does not apply to patients 64 years of age or younger.
Prescriber Restrictions	
Coverage Duration	Through the end of the plan year (see Other Criteria)
Other Criteria	Hydroxyzine is a potent anticholinergic considered high-risk in older patients due to risks of confusion, dry mouth, constipation, and decreased clearance with advanced age. Prior authorization is only required if the total number of days of supply of medication exceeds 30 days per plan year.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

10/1/2026

HYRNUO (sevabertinib)

Products Affected

- HYRNUO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use including documentation the tumor is nonsquamous, submission of test confirming primary tumor type is HER2-positive, documentation of at least one previous systemic therapy that was tried and failed.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to oncology
Coverage Duration	1 year
Other Criteria	This policy applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

10/1/2026

ICATIBANT

Products Affected

- *icatibant acetate subcutaneous solution prefilled syringe*
- *sajazir subcutaneous solution prefilled syringe*

PA Criteria	Criteria Details
Exclusion Criteria	Requests for prophylactic hereditary angioedema therapy
Required Medical Information	Diagnosis of covered use.
Age Restrictions	Age must be consistent with the prescribing information of the drug
Prescriber Restrictions	Restricted to allergy, dermatology, hematology, and immunology
Coverage Duration	1 year
Other Criteria	This policy applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

10/1/2026

ICLUSIG (ponatinib)

Products Affected

- ICLUSIG

PA Criteria	Criteria Details
Exclusion Criteria	Newly diagnosed chronic phase chronic myeloid leukemia (CP-CML), uncontrolled hypertension
Required Medical Information	Diagnosis of covered use, documentation of T315I mutation status (present or absent), attestation patient does not have uncontrolled hypertension. For newly-diagnosed Ph+ acute lymphoblastic leukemia (ALL), attestation drug will be used with chemotherapy. For CP-CML that is not T315I-positive, documentation of resistance or intolerance to at least two prior kinase inhibitors. For Philadelphia chromosome-positive, T315I-negative ALL (monotherapy requests only), accelerated phase CML, or blast phase CML, attestation no other kinase inhibitors are indicated.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to hematology and oncology
Coverage Duration	1 year
Other Criteria	This policy applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

10/1/2026

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	Diagnosis of covered use. For chronic graft-versus-host disease, documentation of treatment failure with any other systemic immunosuppressive agent.
Age Restrictions	
Prescriber Restrictions	Restricted to hematology, oncology, and transplant specialty
Coverage Duration	1 year
Other Criteria	This policy applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

10/1/2026

IMKELDI (imatinib)

Products Affected

- IMKELDI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use, submission of clinical rationale or documentation detailing why the patient cannot use imatinib oral tablets.
Age Restrictions	
Prescriber Restrictions	Restricted to allergy, dermatology, hematology, and oncology
Coverage Duration	1 year
Other Criteria	This policy applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

10/1/2026

INLYTA (axitinib)

Products Affected

- INLYTA

PA Criteria	Criteria Details
Exclusion Criteria	Uncontrolled hypertension
Required Medical Information	Diagnosis of covered use, attestation patient does not have uncontrolled hypertension and that axitinib will be used with either avelumab or pembrolizumab or, if being used as a single agent, documentation of at least one previous systemic therapy that was tried and failed.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to oncology
Coverage Duration	1 year
Other Criteria	This policy applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

10/1/2026

INQOVI (decitabine/cedazuridine)

Products Affected

- INQOVI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use. For acute myeloid leukemia, confirmation patient will also be receiving venetoclax as part of chemotherapeutic regimen, and, if patient is under 75 years of age, documentation of comorbidities that preclude use of intensive induction chemotherapy.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to hematology and oncology
Coverage Duration	1 year
Other Criteria	This policy applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

10/1/2026

INREBIC (fedratinib)

Products Affected

- INREBIC

PA Criteria	Criteria Details
Exclusion Criteria	Thiamine deficiency
Required Medical Information	Diagnosis of covered use, submission of thiamine level (see Other Criteria), submission of current or previous therapies used to treat the condition (see Other Criteria).
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to hematology and oncology
Coverage Duration	1 year
Other Criteria	For initial authorization, the patient must have tried and failed to have an adequate response to or had an intolerance/contraindication to ruxolitinib. If baseline thiamine level is low, coverage will be delayed until thiamine is repleted. This policy applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

10/1/2026

JAKAFI (ruxolitinib)

Products Affected

- JAKAFI

PA Criteria	Criteria Details
Exclusion Criteria	For myelofibrosis, platelet count less than $50 \times 10^9/L$
Required Medical Information	Diagnosis of covered use. For myelofibrosis, submission of baseline platelet count. For polycythemia vera, documented intolerance or inadequate response to hydroxyurea. For acute graft-versus-host disease, documented inadequate response to systemic corticosteroids. For chronic graft-versus-host-disease, documented failure of at least one previous line of systemic therapy.
Age Restrictions	
Prescriber Restrictions	Restricted to hematology, oncology, and transplant specialty
Coverage Duration	1 year
Other Criteria	This policy applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

10/1/2026

JIDEYTRO (zidesamtinib)

Products Affected

- JIDEYTRO ORAL TABLET 100 MG, 25 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use, submission of test confirming presence of ROS1-positive tumor, submission of current or previous therapies used to treat the condition (see Other Criteria).
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to oncology
Coverage Duration	1 year
Other Criteria	For initial authorization, the patient must have had disease progression while using crizotinib, entrectinib, repotrectinib, or taletrectinib. This policy applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

10/1/2026

KERENDIA (finerenone)

Products Affected

- KERENDIA

PA Criteria	Criteria Details
Exclusion Criteria	Adrenal insufficiency, estimated glomerular filtration rate (eGFR) less than 25 mL/min/1.73 m ² , serum potassium above 5.0 mEq/L at initiation of therapy, severe hepatic impairment (Child-Pugh class C)
Required Medical Information	Diagnosis of covered use, submission of eGFR, liver function testing or Child-Pugh score, serum potassium level from within previous 6 months, and current or previous therapies used to treat the condition (see Other Criteria).
Age Restrictions	18 years of age or older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	For initial authorization, the patient must have tried and failed to have an adequate response to or had an intolerance to dapagliflozin or empagliflozin. For each annual reauthorization, documented maintenance or further improvement of a clinical benefit is required.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

10/1/2026

KISQALI (ribociclib)

Products Affected

- KISQALI (200 MG DOSE)
- KISQALI (400 MG DOSE)
- KISQALI (600 MG DOSE)

PA Criteria	Criteria Details
Exclusion Criteria	QTcF interval greater than or equal to 450 msec at treatment initiation
Required Medical Information	Diagnosis of covered use, submission of genetic tumor testing confirming the primary tumor type is HR-positive, HER2-negative, submission of QTcF interval with the requirement it is less than 450 msec at treatment initiation, attestation that the treatment regimen will include concomitant use of an aromatase inhibitor or fulvestrant.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to oncology
Coverage Duration	1 year
Other Criteria	This policy applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

10/1/2026

KOSELUGO (selumetinib)

Products Affected

- KOSELUGO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use.
Age Restrictions	
Prescriber Restrictions	Restricted to neurology and oncology
Coverage Duration	1 year
Other Criteria	This policy applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

10/1/2026

LAZCLUZE (lazertinib)

Products Affected

- LAZCLUZE ORAL TABLET 240 MG, 80 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use, submission of test confirming epidermal growth factor receptor (EGFR) exon 19 deletions or exon 21 L858R substitution mutations, attestation that the medication will be used in combination with amivantamab and will be given with anticoagulant prophylaxis for the first four months of therapy.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to oncology
Coverage Duration	1 year
Other Criteria	This policy applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

10/1/2026

LEUKINE (sargramostim, GM-CSF)

Products Affected

- LEUKINE INJECTION SOLUTION
RECONSTITUTED

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 months
Other Criteria	A description of how the drug will be used and/or obtained may be required to determine whether it will be covered under Medicare Part B or Part D.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

10/1/2026

L-GLUTAMINE

Products Affected

- *L-glutamine oral packet*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of sickle cell disease, submission of current or previous therapies used to treat the condition (see Other Criteria).
Age Restrictions	
Prescriber Restrictions	Restricted to hematology
Coverage Duration	1 year
Other Criteria	For initial authorization, the patient must be using, tried and failed to have an adequate response to, or had an intolerance/contraindication to hydroxyurea. This policy applies to new starts only.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

10/1/2026

LIDOCAINE TRANSDERMAL PATCHES

Products Affected

- *lidocaine external patch 5 %*
- *lidocan*
- *tridacaine ii*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use.
Age Restrictions	18 years of age or older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

10/1/2026

LIPFENDRA (enlicitide)

Products Affected

- LIPFENDRA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use, submission of current or previous therapies used to treat the condition (see Other Criteria).
Age Restrictions	18 years of age or older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	For initial authorization for reducing major adverse cardiovascular events or heterozygous familial hypercholesterolemia, the patient must (1) have tried and failed to achieve an LDL below 70 mg/dL despite at least 8 weeks of high-intensity statin therapy, or (2) experienced rhabdomyolysis while using a statin, or (3) had a skeletal muscle intolerance to both atorvastatin and rosuvastatin that resolved upon discontinuation. For initial authorization for homozygous familial hypercholesterolemia, the patient must (1) have tried and failed to have an adequate response to achieve an LDL below goal despite at least 8 weeks of high-intensity statin therapy, or (2) experienced rhabdomyolysis while using a statin, or (3) had an skeletal muscle intolerance to both atorvastatin and rosuvastatin that resolved upon discontinuation, or (4) are statin-intolerant for reasons other than (2) or (3). This policy applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	

10/1/2026

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

10/1/2026

LIVTENCITY (maribavir)

Products Affected

- LIVTENCITY

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use including a documented history of hematopoietic stem cell or solid organ transplant, submission of current or previous therapies used to treat the condition (see Other Criteria).
Age Restrictions	12 years of age or older
Prescriber Restrictions	Restricted to hematology, infectious diseases, oncology, and transplant specialty
Coverage Duration	8 weeks
Other Criteria	For authorization, the patient must have tried and failed to have an adequate response to at least one of cidofovir, foscarnet, ganciclovir, or valganciclovir.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

10/1/2026

LONSURF (trifluridine/tipiracil)

Products Affected

- LONSURF

PA Criteria	Criteria Details
Exclusion Criteria	Moderate or severe hepatic impairment (Child-Pugh class B or C)
Required Medical Information	Diagnosis of covered use, submission of liver function testing or Child-Pugh score. For colorectal cancer, documentation of KRAS status and attestation patient was previously treated with fluoropyrimidine-, oxaliplatin-, and irinotecan-based chemotherapy, an anti-VEGF biological therapy, and, depending on KRAS status, an anti-EGFR therapy. For gastric cancer, attestation patient was previously treated with at least two lines of chemotherapy that included a fluoropyrimidine, a platinum, either a taxane or irinotecan, and if appropriate, HER2/neu-targeted therapy.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to oncology
Coverage Duration	1 year
Other Criteria	This policy applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

10/1/2026

LORBRENA (lorlatinib)

Products Affected

- LORBRENA ORAL TABLET 100 MG, 25 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use, submission of test confirming presence of ALK-positive tumor.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to oncology
Coverage Duration	1 year
Other Criteria	This policy applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

10/1/2026

MAVYRET (glecaprevir/pibrentasvir)

Products Affected

- MAVYRET ORAL PACKET
- MAVYRET ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	Moderate or severe hepatic impairment (Child-Pugh class B or C)
Required Medical Information	Diagnosis of covered use, laboratory confirmation of hepatitis C virus (HCV) infection and HCV genotype, submission of liver function testing or Child-Pugh score.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Criteria for coverage duration will be applied consistent with current AASLD-IDSA guidance.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

10/1/2026

MECLIZINE IN OLDER PATIENTS

Products Affected

- *meclizine hcl oral tablet 12.5 mg, 25 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of nausea/vomiting and/or dizziness associated with motion sickness or vertigo, attestation prescriber is aware of the risks of long-term anticholinergic medication treatment in older patients.
Age Restrictions	PA applies to patients 65 years of age or older. PA does not apply to patients 64 years of age or younger.
Prescriber Restrictions	
Coverage Duration	Through the end of the plan year (see Other Criteria)
Other Criteria	Meclizine is a potent anticholinergic considered high-risk in older patients due to risks of confusion, dry mouth, constipation, and decreased clearance with advanced age. Prior authorization is only required if the total number of days of supply of medication exceeds 30 days per plan year.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

10/1/2026

MEGESTROL IN OLDER PATIENTS

Products Affected

- *megestrol acetate oral suspension 40 mg/ml, 625 mg/5ml*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use.
Age Restrictions	PA applies to patients 65 years of age or older. PA does not apply to patients 64 years of age or younger.
Prescriber Restrictions	PA not required for hematology or oncology
Coverage Duration	1 year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

10/1/2026

MEMANTINE/DONEPEZIL

Products Affected

- *memantine hcl-donepezil hcl er oral capsule* RELEASE 24 HOUR 7-10 MG
extended release 24 hour 14-10 mg, 21-10
mg, 28-10 mg
- NAMZARIC ORAL CAPSULE EXTENDED

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use, submission of documentation that the patient has tolerated donepezil 10 mg daily for a minimum of 1 month.
Age Restrictions	18 years of age or older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

10/1/2026

MOUNJARO (tirzepatide)

Products Affected

- MOUNJARO SUBCUTANEOUS SOLUTION
AUTO-INJECTOR 10 MG/0.5ML, 12.5
MG/0.5ML, 15 MG/0.5ML, 2.5 MG/0.5ML, 5
MG/0.5ML, 7.5 MG/0.5ML

PA Criteria	Criteria Details
Exclusion Criteria	Off-label use for weight management
Required Medical Information	Diagnosis of type 2 diabetes confirmed through one of the following: (1) medical record, or (2) ICD-10 on medical claims, or (3) laboratory results (hemoglobin A1c, fasting plasma glucose, 2-hour postprandial blood glucose after an oral glucose tolerance test, or random plasma blood glucose combined with classic signs/symptoms of hyperglycemia or hyperglycemic crisis).
Age Restrictions	Age must be consistent with the prescribing information of the drug and condition being treated
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	This policy applies to new starts only.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

10/1/2026

MYTESI (crofelemer)

Products Affected

- MYTESI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use, attestation infectious causes of diarrhea have been ruled out.
Age Restrictions	18 years of age or older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	For each annual reauthorization, confirmation of a symptomatic or clinical improvement (or maintenance of an improvement previously achieved) is required.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

10/1/2026

NILOTINIB

Products Affected

- *nilotinib hcl*

PA Criteria	Criteria Details
Exclusion Criteria	Uncorrected hypokalemia or hypomagnesemia, long QT syndrome, coadministration with proton pump inhibitors
Required Medical Information	Diagnosis of covered use, confirmation of positive Philadelphia chromosome (Ph) status, serum potassium and magnesium levels from within previous 6 months.
Age Restrictions	
Prescriber Restrictions	Restricted to hematology and oncology
Coverage Duration	1 year
Other Criteria	This policy applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

10/1/2026

NINLARO (ixazomib)

Products Affected

- NINLARO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use, attestation that medication will be administered concomitantly with lenalidomide and dexamethasone, documentation of prior therapy regimen for multiple myeloma.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to hematology and oncology
Coverage Duration	1 year
Other Criteria	This policy applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

10/1/2026

NUEDEXTA (dextromethorphan/quinidine)

Products Affected

- dextromethorphan-quinidine*

PA Criteria	Criteria Details
Exclusion Criteria	Agitation or Alzheimer's disease without pseudobulbar affect, prolonged QT interval, heart failure, uncorrected hypokalemia or hypomagnesemia
Required Medical Information	Diagnosis of covered use, submission of serum potassium and magnesium levels from within previous 6 months. In patients with an increased risk of QT prolongation, including patients taking drugs that prolong the QT interval, taking moderate or strong CYP3A4 inhibitors, with left ventricular hypertrophy, or with left ventricular dysfunction, submission of electrocardiographic (ECG) evaluation of baseline QT interval.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to neurology and psychiatry
Coverage Duration	1 year
Other Criteria	For each annual reauthorization, submission of updated potassium and magnesium levels and confirmation of a symptomatic or clinical improvement (or maintenance of an improvement previously achieved) is required.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

10/1/2026

NUPLAZID (pimavanserin)

Products Affected

- NUPLAZID ORAL CAPSULE
- NUPLAZID ORAL TABLET 10 MG

PA Criteria	Criteria Details
Exclusion Criteria	Psychosis unrelated to Parkinson's disease psychosis, uncorrected hypokalemia or hypomagnesemia
Required Medical Information	Diagnosis of covered use, submission of serum potassium and magnesium levels from within previous 6 months.
Age Restrictions	18 years of age or older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	This policy applies to new starts only.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

10/1/2026

ODOMZO (sonidegib)

Products Affected

- ODOMZO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use, attestation patient is not a candidate for surgery or radiation therapy or carcinoma has recurred following surgery or radiation therapy.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to oncology
Coverage Duration	1 year
Other Criteria	This policy applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

10/1/2026

OGSIVEO (nirogacestat)

Products Affected

- OGSIVEO ORAL TABLET 100 MG, 150 MG

PA Criteria	Criteria Details
Exclusion Criteria	Coadministration with proton pump inhibitors or H2 receptor antagonists
Required Medical Information	Diagnosis of covered use with documentation of tumor progression.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to oncology and sarcoma specialty
Coverage Duration	1 year
Other Criteria	This policy applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

10/1/2026

OJJAARA (mometotinib)

Products Affected

- OJJAARA ORAL TABLET 100 MG, 150 MG, 200 MG

PA Criteria	Criteria Details
Exclusion Criteria	Active infection
Required Medical Information	Diagnosis of covered use.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to hematology and oncology
Coverage Duration	1 year
Other Criteria	This policy applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

10/1/2026

ORGOVYX (relugolix)

Products Affected

- ORGOVYX

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use, submission of current or previous therapies used to treat the condition (see Other Criteria).
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to oncology and urology
Coverage Duration	1 year
Other Criteria	For initial authorization, the patient must have tried and failed to have an adequate response to or had an intolerance to Eligard or Trelstar or have contraindications to both Eligard and Trelstar. This policy applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

10/1/2026

ORIAHNN (elagolix/estradiol/norethindrone)

Products Affected

- ORIAHNN

PA Criteria	Criteria Details
Exclusion Criteria	Pregnancy, women who are at increased risk of, have a history of, or currently have thrombotic or thromboembolic disorders (including women over 35 years of age who smoke and women with uncontrolled hypertension)
Required Medical Information	Diagnosis of covered use, attestation patient is premenopausal and patient does not have uncontrolled hypertension, submission of pregnancy status for female patients of childbearing potential.
Age Restrictions	
Prescriber Restrictions	Restricted to endocrinology and gynecology
Coverage Duration	2 years (see Other Criteria)
Other Criteria	Use of this drug for more than 2 years increases risk of bone loss and requests for therapy for more than 2 years will not be approved.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

10/1/2026

OZEMPIC/RYBELSUS (semaglutide)

Products Affected

- OZEMPIC (0.25 OR 0.5 MG/DOSE) SUBCUTANEOUS SOLUTION PEN-INJECTOR 2 MG/3ML
- OZEMPIC (1 MG/DOSE) SUBCUTANEOUS SOLUTION PEN-INJECTOR 4 MG/3ML
- OZEMPIC (2 MG/DOSE)
- OZEMPIC ORAL TABLET 1.5 MG, 4 MG, 9 MG
- RYBELSUS ORAL TABLET 14 MG, 3 MG, 7 MG

PA Criteria	Criteria Details
Exclusion Criteria	Off-label use for weight management
Required Medical Information	Diagnosis of type 2 diabetes confirmed through one of the following: (1) medical record, or (2) ICD-10 on medical claims, or (3) laboratory results (hemoglobin A1c, fasting plasma glucose, 2-hour postprandial blood glucose after an oral glucose tolerance test, or random plasma blood glucose combined with classic signs/symptoms of hyperglycemia or hyperglycemic crisis).
Age Restrictions	Age must be consistent with the prescribing information of the drug and condition being treated
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	This policy applies to new starts only.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

10/1/2026

PEGFILGRASTIM

Products Affected

- UDENYCA
- UDENYCA ONBODY

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of FDA-approved indication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	A description of how the drug will be used and/or obtained may be required to determine whether it will be covered under Medicare Part B or Part D.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

10/1/2026

PRETOMANID

Products Affected

- *pretomanid*

PA Criteria	Criteria Details
Exclusion Criteria	Inability to use bedaquiline or linezolid, drug-sensitive tuberculosis, coadministration with moderate or strong CYP3A4 inducers
Required Medical Information	Diagnosis of covered use, attestation pretomanid will be used in combination with bedaquiline and linezolid.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to infectious diseases and pulmonology
Coverage Duration	26 weeks
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

10/1/2026

PROMETHAZINE IN OLDER PATIENTS

Products Affected

- *promethazine hcl oral solution 6.25 mg/5ml* • PROMETHEGAN
- *promethazine hcl oral tablet*
- *promethazine hcl rectal suppository 12.5 mg, 25 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use. For allergic conditions, documentation must be submitted showing patient has tried and failed or had an inadequate response to a second-generation antihistamine.
Age Restrictions	PA applies to patients 65 years of age or older. PA does not apply to patients 64 years of age or younger.
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Promethazine is a potent anticholinergic considered high-risk in older patients due to risks of confusion, dry mouth, constipation, and decreased clearance with advanced age.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

10/1/2026

QINLOCK (ripretinib)

Products Affected

- QINLOCK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use, submission of previous kinase inhibitor therapies.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to oncology
Coverage Duration	1 year
Other Criteria	This policy applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

10/1/2026

REVCovi (elapegademase-lvlr)

Products Affected

- REVCovi

PA Criteria	Criteria Details
Exclusion Criteria	Severe thrombocytopenia
Required Medical Information	Diagnosis of covered use confirmed by either biochemical testing showing less than 1% of adenosine deaminase (ADA) catalytic activity in red blood cells or genetic testing showing biallelic ADA pathogenic variants, submission of baseline plasma ADA level (if genetic testing was submitted as confirmation of diagnosis) and platelet count, with the requirement it is at least $50 \times 10^9/L$.
Age Restrictions	
Prescriber Restrictions	Restricted to hematology, immunology, and specialists in genetic diseases
Coverage Duration	1 year
Other Criteria	For each annual reauthorization, submission of updated plasma ADA level demonstrating an improvement from baseline and updated platelet count of at least $50 \times 10^9/L$ is required.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

10/1/2026

REZUROCK (belumosudil)

Products Affected

- REZUROCK

PA Criteria	Criteria Details
Exclusion Criteria	Moderate or severe hepatic impairment (Child-Pugh class B or C) without liver graft-versus-host disease
Required Medical Information	Diagnosis of covered use, submission of at least 2 previous therapies tried and failed for chronic graft-versus-host disease, liver function testing or Child-Pugh score.
Age Restrictions	12 years of age or older
Prescriber Restrictions	Restricted to hematology, oncology, and transplant specialty
Coverage Duration	1 year
Other Criteria	This policy applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

10/1/2026

ROMVIMZA (vimseltinib)

Products Affected

- ROMVIMZA

PA Criteria	Criteria Details
Exclusion Criteria	Active liver or biliary tract disease (including increased ALP), pre-existing increased serum transaminases, total or direct bilirubin greater than the upper limit of normal
Required Medical Information	Diagnosis of covered use (and attestation surgical intervention is not possible or practical), submission of serum transaminases, total and direct bilirubin, and ALP.
Age Restrictions	18 years of age or older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	This policy applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

10/1/2026

SAPROPTERIN

Products Affected

- *javygtor*
- *sapropterin dihydrochloride oral packet*
- *sapropterin dihydrochloride oral tablet*
- *zelvysia*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use, submission of blood phenylalanine concentration with the requirement it exceeds 360 micromol/L.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Initially 6 months, then 1 year
Other Criteria	For the first reauthorization, documentation of reduction in blood phenylalanine concentration from pre-treatment baseline is required. For each annual reauthorization, documented maintenance of a clinical benefit is required.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

10/1/2026

SCEMBLIX (asciminib)

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use. For use in patients with a T315I mutation, documentation patient has first tried and failed or become intolerant to ponatinib.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to hematology and oncology
Coverage Duration	1 year
Other Criteria	This policy applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

10/1/2026

SECUADO (asenapine)

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	Dementia-related psychosis, severe hepatic impairment (Child-Pugh class C)
Required Medical Information	Diagnosis of covered use, submission of liver function testing or Child-Pugh score, submission of current or previous therapies used to treat the condition (see Other Criteria).
Age Restrictions	
Prescriber Restrictions	Restricted to psychiatry
Coverage Duration	1 year
Other Criteria	For initial authorization, the patient must have tried and failed to have an adequate response to or had an intolerance to aripiprazole and at least one other generic second-generation atypical antipsychotic. This policy applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

10/1/2026

SIGNIFOR (pasireotide)

Products Affected

- SIGNIFOR

PA Criteria	Criteria Details
Exclusion Criteria	Severe hepatic impairment (Child-Pugh class C)
Required Medical Information	Diagnosis of covered use, submission of 24-hour urine free cortisol (UFC) level demonstrating a baseline value more than 1.5 times the upper limit of normal (50 micrograms or 145 nmol), attestation pituitary gland surgery is not an option for the patient or has not been curative, submission of liver function testing or Child-Pugh score.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to endocrinology
Coverage Duration	1 year
Other Criteria	For the first reauthorization, documentation of clinically relevant response to therapy including but not limited to reduction of 24-hour UFC level is required. For each annual reauthorization, documented maintenance of a clinical benefit is required.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

10/1/2026

SORAFENIB

Products Affected

- *sorafenib tosylate*

PA Criteria	Criteria Details
Exclusion Criteria	Congenital long QT syndrome, coadministration with strong CYP3A4 inducers
Required Medical Information	Diagnosis of covered use. For differentiated thyroid cancer, attestation patient is radioactive iodine-refractory or ineligible.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to oncology
Coverage Duration	1 year
Other Criteria	This policy applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

10/1/2026

SPECIALTY RESTRICTIONS - DICLOFENAC 3% GEL

Products Affected

- *diclofenac sodium external gel 3 %*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use.
Age Restrictions	
Prescriber Restrictions	PA not required for dermatology or oncology
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

10/1/2026

SPECIALTY RESTRICTIONS - IVABRADINE

Products Affected

- *ivabradine hcl oral tablet 5 mg, 7.5 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use.
Age Restrictions	
Prescriber Restrictions	PA not required for cardiology
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

10/1/2026

SPECIALTY RESTRICTIONS - NAYZILAM

Products Affected

- NAYZILAM

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use.
Age Restrictions	
Prescriber Restrictions	PA not required for neurology
Coverage Duration	1 year
Other Criteria	This policy applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

10/1/2026

SPECIALTY RESTRICTIONS - PEGASYS

Products Affected

- PEGASYS SUBCUTANEOUS SOLUTION 180 MCG/ML
- PEGASYS SUBCUTANEOUS SOLUTION PREFILLED SYRINGE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use.
Age Restrictions	
Prescriber Restrictions	PA not required for gastroenterology, hepatology, or infectious diseases
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

10/1/2026

SPECIALTY RESTRICTIONS - VALTOCO

Products Affected

- VALTOCO 10 MG DOSE THERAPY PACK 2 X 10 MG/0.1ML
- VALTOCO 15 MG DOSE NASAL LIQUID THERAPY PACK 2 X 7.5 MG/0.1ML
- VALTOCO 20 MG DOSE NASAL LIQUID
- VALTOCO 5 MG DOSE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use.
Age Restrictions	
Prescriber Restrictions	PA not required for neurology
Coverage Duration	1 year
Other Criteria	This policy applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

10/1/2026

STIVARGA (regorafenib)

Products Affected

- STIVARGA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use. For metastatic colorectal cancer, documentation of previous treatment with fluoropyrimidine-, oxaliplatin- and irinotecan-based chemotherapy, an anti-VEGF therapy, and, if RAS wild-type, an anti-EGFR therapy. For gastrointestinal stromal tumor, documentation of previous treatment with imatinib and sunitinib. For hepatocellular carcinoma, documentation of previous treatment with sorafenib.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to oncology
Coverage Duration	1 year
Other Criteria	This policy applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

10/1/2026

SUNITINIB

Products Affected

- *sunitinib malate*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use. For gastrointestinal stromal tumor, documentation of prior use of imatinib.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to oncology
Coverage Duration	1 year
Other Criteria	This policy applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

10/1/2026

TADALAFIL FOR BPH

Products Affected

- *tadalafil oral tablet 2.5 mg, 5 mg*

PA Criteria	Criteria Details
Exclusion Criteria	Erectile dysfunction indication (see Other Criteria)
Required Medical Information	Diagnosis of benign prostatic hyperplasia (BPH), submission of current or previous therapies used to treat the condition (see Other Criteria).
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to urology
Coverage Duration	1 year
Other Criteria	For initial authorization, if the patient must have tried and failed to have an adequate response to or had an intolerance to alfuzosin, doxazosin, dutasteride, finasteride, tamsulosin, or terazosin. For each annual reauthorization, confirmation of a symptomatic or clinical improvement (or maintenance of an improvement previously achieved) is required. This product will not be approved for erectile dysfunction as this use is currently excluded from coverage under Medicare Part D.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

10/1/2026

TAFINLAR (dabrafenib)

Products Affected

- TAFINLAR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use, submission of test confirming presence of BRAF V600E or V600K mutation.
Age Restrictions	
Prescriber Restrictions	Restricted to oncology
Coverage Duration	1 year
Other Criteria	This policy applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

10/1/2026

TAKHZYRO (lanadelumab-flyo)

Products Affected

- TAKHZYRO SUBCUTANEOUS SOLUTION
PREFILLED SYRINGE 300 MG/2ML

PA Criteria	Criteria Details
Exclusion Criteria	Requests for acute hereditary angioedema (HAE) therapy (attacks)
Required Medical Information	Diagnosis of covered use, submission of objective or subjective documentation that prophylactic therapy is medically necessary, including, but not limited to activity of disease and disease burden, the frequency of HAE attacks, and quality of life.
Age Restrictions	Age must be consistent with the prescribing information of the drug
Prescriber Restrictions	Restricted to allergy, dermatology, hematology, and immunology
Coverage Duration	1 year
Other Criteria	This policy applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

10/1/2026

TAZAROTENE

Products Affected

- *tazarotene external cream*
- *tazarotene external gel*
- *trilitas*

PA Criteria	Criteria Details
Exclusion Criteria	Cosmetic use (e.g., hyperpigmentation, keloids, photoaging, wrinkles)
Required Medical Information	Diagnosis of acne vulgaris or plaque psoriasis.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	For each annual reauthorization, confirmation of a symptomatic or clinical improvement (or maintenance of improvement previously achieved) is required. Tazarotene products will not be approved for cosmetic uses as these uses are currently excluded from coverage under Medicare Part D.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

10/1/2026

TESTOSTERONE REPLACEMENT PRODUCTS

Products Affected

- *testosterone transdermal gel 12.5 mg/act (1%), 20.25 mg/act (1.62%), 25 mg/2.5gm (1%), 50 mg/5gm (1%)*
- *testosterone transdermal solution*

PA Criteria	Criteria Details
Exclusion Criteria	Breast cancer or known or suspected prostate cancer
Required Medical Information	Diagnosis of covered use, submission of serum testosterone level below the normal range, attestation that patient has been evaluated for the presence of prostate cancer prior to initiation of therapy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	For each annual reauthorization, submission of increased serum testosterone level (or maintenance of a previous increase in serum testosterone level) is required.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

10/1/2026

TRETINOIN TOPICAL

Products Affected

- *tretinoin external cream*
- *tretinoin external gel 0.01 %, 0.025 %*

PA Criteria	Criteria Details
Exclusion Criteria	Cosmetic use (e.g., hyperpigmentation, keloids, photoaging, wrinkles)
Required Medical Information	Diagnosis of covered use.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	For each annual reauthorization, confirmation of a symptomatic or clinical improvement (or maintenance of improvement previously achieved) is required. Tretinoin products will not be approved for cosmetic uses as these uses are currently excluded from coverage under Medicare Part D.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

10/1/2026

TRIKAFTA (elixacaftor/tezacaftor/ivacaftor)

Products Affected

- TRIKAFTA ORAL TABLET THERAPY PACK 100-50-75 & 150 MG, 50-25-37.5 & 75 MG
- TRIKAFTA ORAL THERAPY PACK

PA Criteria	Criteria Details
Exclusion Criteria	Severe hepatic impairment (Child-Pugh class C)
Required Medical Information	Diagnosis of covered use, submission of cystic fibrosis (CF) mutation test confirming presence of CFTR gene mutations as indicated in the prescribing information, liver function testing or Child-Pugh score.
Age Restrictions	Age must be consistent with the prescribing information of the drug
Prescriber Restrictions	Restricted to pulmonology
Coverage Duration	1 year
Other Criteria	This policy applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

10/1/2026

TRULICITY (dulaglutide)

Products Affected

- TRULICITY SUBCUTANEOUS SOLUTION
AUTO-INJECTOR

PA Criteria	Criteria Details
Exclusion Criteria	Off-label use for weight management
Required Medical Information	Diagnosis of type 2 diabetes confirmed through one of the following: (1) medical record, or (2) ICD-10 on medical claims, or (3) laboratory results (hemoglobin A1c, fasting plasma glucose, 2-hour postprandial blood glucose after an oral glucose tolerance test, or random plasma blood glucose combined with classic signs/symptoms of hyperglycemia or hyperglycemic crisis).
Age Restrictions	Age must be consistent with the prescribing information of the drug and condition being treated
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	This policy applies to new starts only.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

10/1/2026

UBRELVY (ubrogepant)

Products Affected

- UBRELVY

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use, submission of current or previous therapies used to treat the condition (see Other Criteria).
Age Restrictions	18 years of age or older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	For initial authorization for acute migraine treatment, the patient must have have tried and failed to have an adequate response to one triptan or have a documented contraindication to triptan use.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

10/1/2026

VALCHLOR (mechlorethamine)

Products Affected

- VALCHLOR

PA Criteria	Criteria Details
Exclusion Criteria	Use as initial therapy
Required Medical Information	Diagnosis of covered use, submission of previous skin-directed therapy.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to dermatology and oncology
Coverage Duration	1 year
Other Criteria	This policy applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

10/1/2026

VELSIPITY (etrasimod)

Products Affected

- VELSIPITY

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use, submission of current or previous therapies used to treat the condition (see Other Criteria).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	For initial authorization, the patient must have tried and failed to have an adequate response to or had an intolerance to at least two preferred agents (an adalimumab biosimilar, Rinvoq, Skyrizi, an ustekinumab biosimilar, and Xeljanz/Xeljanz XR) for the indication submitted, where possible.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

10/1/2026

VENCLEXTA (venetoclax)

Products Affected

- VENCLEXTA ORAL TABLET 10 MG, 100 MG, 50 MG
- VENCLEXTA STARTING PACK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use. For newly-diagnosed acute myeloid leukemia, if patient is under 75 years of age, documentation of comorbidities that preclude use of intensive induction chemotherapy.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to hematology and oncology
Coverage Duration	1 year
Other Criteria	This policy applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

10/1/2026

VEOZAH (fezolinetant)

Products Affected

- VEOZAH

PA Criteria	Criteria Details
Exclusion Criteria	Estimated glomerular filtration rate (eGFR) less than 30 mL/min, known cirrhosis, any aminotransferase or total bilirubin at or above 2 times the upper limit of normal
Required Medical Information	Diagnosis of covered use, submission of eGFR, liver function testing, current or previous therapies used to treat the condition (see Other Criteria).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	For initial authorization, the patient must have tried and failed to have an adequate response to or had an intolerance to at least two prior systemic hormone therapies or FDA-approved or compendia-supported non-hormonal therapies (e.g., SSRI, SNRI, clonidine, gabapentin, etc.) for the treatment of vasomotor symptoms due to menopause. The drugs tried must come from different medication classes. For each annual reauthorization, confirmation of a symptomatic or clinical improvement (or maintenance of an improvement previously achieved) is required.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

10/1/2026

VEPPANU (vepdegestrant)

Products Affected

- VEPPANU

PA Criteria	Criteria Details
Exclusion Criteria	QTc interval greater than 470 msec at treatment initiation
Required Medical Information	Diagnosis of covered use, submission of test confirming the primary tumor type is ER-positive, HER2-negative, and ESR1-mutated, submission of baseline QTc interval with the requirement it is less than or equal to 470 msec at treatment initiation, attestation patient had disease progression after at least one prior endocrine therapy.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to oncology
Coverage Duration	1 year
Other Criteria	This policy applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

10/1/2026

VERZENIO (abemaciclib)

Products Affected

- VERZENIO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use, submission of genetic tumor testing confirming that the primary tumor type is HR-positive, HER2-negative.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to oncology
Coverage Duration	1 year
Other Criteria	This policy applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

10/1/2026

VIVJOA (oteseconazole)

Products Affected

- VIVJOA

PA Criteria	Criteria Details
Exclusion Criteria	Women of reproductive potential
Required Medical Information	Diagnosis of covered use, including attestation patient has had at least three episodes of vulvovaginal candidiasis in the previous 12 months, attestation patient is either (1) postmenopausal, or (2) infertile.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 weeks
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

10/1/2026

VIZIMPRO (dacomitinib)

Products Affected

- VIZIMPRO ORAL TABLET 15 MG, 30 MG, 45 MG

PA Criteria	Criteria Details
Exclusion Criteria	Coadministration with a proton pump inhibitor
Required Medical Information	Diagnosis of covered use, submission of test confirming presence of EGFR exon 19 deletions or exon 21 L858R substitution mutations.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to oncology
Coverage Duration	1 year
Other Criteria	This policy applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

10/1/2026

VOSEVI (sofosbuvir/velpatasvir/voxilaprevir)

Products Affected

- VOSEVI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use, documentation patient has a contraindication to or is otherwise not a candidate for a regimen recommended by the AASLD-IDSA guidance containing Mavyret or sofosbuvir/velpatasvir.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to gastroenterology, hepatology, and infectious diseases
Coverage Duration	Criteria for coverage duration will be applied consistent with current AASLD-IDSA guidance.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

10/1/2026

VTAMA (tapinarof)

Products Affected

- VTAMA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use, submission of current or previous therapies used to treat the condition (see Other Criteria).
Age Restrictions	
Prescriber Restrictions	Restricted to dermatology
Coverage Duration	1 year
Other Criteria	For initial authorization for atopic dermatitis, the patient must have tried and failed to have an adequate response to or had an intolerance to at least (1) a Class/Group 3 high potency or stronger topical corticosteroid for at least 4 weeks, and (2) a topical calcineurin inhibitor (CNI) for at least 4 weeks, unless clinical documentation is submitted as to why a topical corticosteroid and/or topical CNI cannot be used. For initial authorization for plaque psoriasis, the patient must (1) have tried and failed to have an adequate response to or had an intolerance to at least (a) one Class/Group 3 high potency or stronger topical corticosteroid, and (b) one other prescription topical agent indicated for plaque psoriasis (e.g., calcipotriene, calcitriol, tazarotene), or (2) be using a systemic medication (biologic or otherwise) to manage plaque psoriasis. For each annual reauthorization, confirmation of a symptomatic or clinical improvement or maintenance of an improvement previously achieved is required.
Indications	All FDA-approved Indications.
Off Label Uses	

10/1/2026

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

10/1/2026

WELIREG (belzutifan)

Products Affected

- WELIREG

PA Criteria	Criteria Details
Exclusion Criteria	Pregnancy
Required Medical Information	Diagnosis of covered use, submission of pregnancy status for female patients of childbearing potential. For von Hippel-Lindau (VHL) disease, confirmation of a germline VHL alteration and attestation patient does not require immediate surgery. For advanced renal cell carcinoma, confirmation patient was previously treated with a programmed death receptor-1 or programmed death-ligand 1 inhibitor and a vascular endothelial growth factor tyrosine kinase inhibitor.
Age Restrictions	12 years of age or older
Prescriber Restrictions	Restricted to oncology
Coverage Duration	1 year
Other Criteria	This policy applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

10/1/2026

XALKORI (crizotinib)

Products Affected

- XALKORI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use, submission of test confirming presence of ALK or ROS1-positive tumor.
Age Restrictions	For ALK-positive systemic anaplastic large cell lymphoma only, 1 year of age to 21 years of age
Prescriber Restrictions	Restricted to hematology and oncology
Coverage Duration	1 year
Other Criteria	This policy applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

10/1/2026

XERMELO (telotristat)

Products Affected

- XERMELO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use, documentation patient has been on at least 12 weeks of prior somatostatin analog therapy.
Age Restrictions	18 years of age or older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	For each reauthorization, documentation patient remains on somatostatin analog therapy (unless contraindicated) and confirmation that the patient has not experienced episodes of severe constipation is required.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

10/1/2026

XPOVIO (selinexor)

Products Affected

- XPOVIO (100 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 50 MG
- XPOVIO (40 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 10 MG
- XPOVIO (40 MG TWICE WEEKLY) ORAL TABLET THERAPY PACK 40 MG
- XPOVIO (60 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 60 MG
- XPOVIO (60 MG TWICE WEEKLY)
- XPOVIO (80 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 40 MG, 80 MG
- XPOVIO (80 MG TWICE WEEKLY)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use. For multiple myeloma in combination with bortezomib and dexamethasone, documented failure of at least one previous therapy. For relapsed or refractory multiple myeloma, documented failure of at least four previous lines of systemic therapy including at least two proteasome inhibitors, at least two immunomodulatory agents, and an anti-CD38 monoclonal antibody.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to hematology and oncology
Coverage Duration	1 year
Other Criteria	This policy applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

10/1/2026

XTANDI (enzalutamide)

Products Affected

- XTANDI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use. For metastatic castration-resistant prostate cancer (mCRPC) only, submission of current or previous therapies used to treat the condition (see Other Criteria).
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to oncology and urology
Coverage Duration	1 year
Other Criteria	For initial authorization of Xtandi for mCRPC, the patient must have an intolerance or contraindication to abiraterone. This policy applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

10/1/2026

ZALEPLON

Products Affected

- *zaleplon*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use, documentation at least two of the following medications were tried and deemed ineffective or intolerable: Belsomra, doxepin tablets, ramelteon, and trazodone.
Age Restrictions	PA applies to patients 65 years of age or older. PA does not apply to patients 64 years of age or younger.
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Sedative hypnotic medications are high-risk medications in older patients due to increased risks of cognitive impairment, delirium, unsteady gait, syncope, falls, fractures, and motor vehicle accidents. This policy applies to new starts only.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

10/1/2026

ZENBEXUS (iberdomide)

Products Affected

- ZENBEXUS

PA Criteria	Criteria Details
Exclusion Criteria	Pregnancy
Required Medical Information	Diagnosis of covered use, attestation patient was previously treated with at least one prior line of therapy including a proteasome inhibitor and an immunomodulatory agent, attestation patient does not have disease that was refractory to previous receipt of an anti-CD38 monoclonal antibody, attestation patient will be taking iberdomide concurrently with and daratumumab-hyaluronidase and dexamethasone, submission of pregnancy status for female patients of childbearing potential.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to hematology and oncology
Coverage Duration	1 year
Other Criteria	This policy applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

10/1/2026

ZOLPIDEM

Products Affected

- *zolpidem tartrate oral tablet*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use, documentation at least two of the following medications were tried and deemed ineffective or intolerable: Belsomra, doxepin tablets, ramelteon, and trazodone.
Age Restrictions	PA applies to patients 65 years of age or older. PA does not apply to patients 64 years of age or younger.
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Sedative hypnotic medications are high-risk medications in older patients due to increased risks of cognitive impairment, delirium, unsteady gait, syncope, falls, fractures, and motor vehicle accidents. This policy applies to new starts only.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

10/1/2026

ZTALMY (ganaxolone)

Products Affected

- ZTALMY

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use confirmed by genetic testing including either (1) a CDKL5 gene that is pathogenic or likely to be pathogenic, or (2) CDKL5 deficiency.
Age Restrictions	
Prescriber Restrictions	Restricted to neurology
Coverage Duration	1 year
Other Criteria	This policy applies to new starts only.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

10/1/2026

ZYDELIG (idelalisib)

Products Affected

- ZYDELIG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use, attestation therapy will be coadministered with rituximab, documentation of at least one previous line of systemic therapy.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to hematology and oncology
Coverage Duration	1 year
Other Criteria	This policy applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

10/1/2026

ZYKADIA (ceritinib)

Products Affected

- ZYKADIA ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use, submission of test confirming presence of ALK-positive tumor.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to oncology
Coverage Duration	1 year
Other Criteria	This policy applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

10/1/2026

INDEX

ACTIMMUNE	1	CABOMETYX	28
<i>adapalene external cream</i>	2	CALQUENCE ORAL TABLET	29
<i>adapalene external gel 0.3 %</i>	2	CAMZYOS	30
ADEMPAS ORAL TABLET 0.5 MG, 1 MG, 1.5 MG, 2 MG, 2.5 MG	3	CAPLYTA ORAL CAPSULE 10.5 MG, 21 MG, 42 MG	32
AIMOVIG	5	CAPRELSA	34
AKEEGA	6	<i>carglumic acid oral tablet soluble</i>	35
ALECENSA	7	CERDELGA	36
ALUNBRIG	8	<i>cilostazol</i>	86
<i>alyq</i>	246	COBENFY	37
<i>ambrisentan oral tablet 10 mg, 5 mg</i>	9	COBENFY STARTER PACK	37
ARIKAYCE	10	COMETRIQ (100 MG DAILY DOSE) ORAL KIT 80 & 20 MG	38
ATTRUBY	11	COMETRIQ (140 MG DAILY DOSE) ORAL KIT 3 X 20 MG & 80 MG	38
AUGTYRO	12	COMETRIQ (60 MG DAILY DOSE)	38
AUSTEDO ORAL TABLET 12 MG, 6 MG, 9 MG	13	COPIKTRA ORAL CAPSULE 15 MG, 25 MG	39
AUSTEDO XR ORAL TABLET EXTENDED RELEASE 24 HOUR 12 MG, 18 MG, 24 MG, 30 MG, 36 MG, 42 MG, 48 MG, 6 MG	13	CORTROPHIN	40
AUSTEDO XR PATIENT TITRATION ORAL TABLET EXTENDED RELEASE THERAPY PACK 12 & 18 & 24 & 30 MG	13	CORTROPHIN GEL	40
AUVELITY	14	COTELIC	41
AUVELITY TITRATION PACK	14	CRESEMBA ORAL CAPSULE 186 MG	42
AVMAPKI FAKZYNJA CO-PACK	15	<i>cyclobenzaprine hcl oral tablet 10 mg, 5 mg</i>	43
AYVAKIT ORAL TABLET 100 MG, 200 MG, 25 MG, 300 MG, 50 MG	16	CYSTADROPS	44
BALVERSA	17	CYSTARAN	44
BENLYSTA SUBCUTANEOUS	18	<i>dalfampridine er</i>	45
BESREMI	19	<i>dasatinib oral tablet 100 mg, 140 mg, 20 mg, 50 mg, 70 mg, 80 mg</i>	46
BESREMI PEN	19	DAURISMO ORAL TABLET 100 MG, 25 MG ..	47
<i>bexarotene external</i>	20	<i>deferasirox oral tablet soluble</i>	48
<i>bosentan oral tablet 125 mg, 62.5 mg</i>	21	<i>dextromethorphan-quinidine</i>	171
BOSULIF ORAL CAPSULE 100 MG, 50 MG	22	DIACOMIT	49
BOSULIF ORAL TABLET 100 MG, 500 MG	22	<i>dichlorphenamide</i>	50
<i>bosutinib</i>	22	<i>diclofenac epolamine external</i>	51
BRAFTOVI ORAL CAPSULE 75 MG	23	<i>diclofenac sodium external gel 3 %</i>	234
BRUKINSA	24	<i>digoxin oral tablet 250 mcg</i>	52
<i>butalbital-apap-caffeine oral capsule</i>	25	DOPTLET ORAL TABLET 20 MG	53
<i>butalbital-apap-caffeine oral tablet 50-325-40 mg</i>	25	<i>dronabinol oral capsule</i>	55
<i>butalbital-aspirin-caffeine oral capsule</i>	26	DUPIXENT SUBCUTANEOUS SOLUTION AUTO-INJECTOR	56
CABLIVI	27	DUPIXENT SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 200 MG/1.14ML, 300 MG/2ML	56

<i>eltrombopag olamine oral packet</i>	59	IBTROZI.....	95
<i>eltrombopag olamine oral tablet 12.5 mg, 25 mg, 50 mg, 75 mg</i>	59	<i>icatibant acetate subcutaneous solution prefilled syringe</i>	96
EMGALITY.....	61	ICLUSIG.....	97
EMGALITY (300 MG DOSE).....	61	IDHIFA.....	98
ENSACOVE.....	62	IMBRUVICA ORAL CAPSULE.....	99
ENTYVIO PEN.....	63	IMBRUVICA ORAL SUSPENSION.....	99
EOHILIA.....	65	IMBRUVICA ORAL TABLET 140 MG, 280 MG, 420 MG.....	99
EPIDIOLEX.....	66	IMKELDI.....	100
ERIVEDGE.....	67	INBRIJA.....	103
ERLEADA.....	68	INCRELEX.....	149
<i>eszopiclone</i>	69	INLURIYO.....	104
<i>everolimus oral tablet 10 mg, 2.5 mg, 5 mg, 7.5 mg</i>	70	INLYTA.....	105
<i>everolimus oral tablet soluble 2 mg, 3 mg, 5 mg</i>	70	INQOVI.....	106
EVRYSDI.....	71	INREBIC.....	107
EXXUA.....	72	INVEGA HAFYERA.....	108
EXXUA TITRATION PACK.....	72	INVEGA TRINZA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 273 MG/0.88ML, 410 MG/1.32ML, 546 MG/1.75ML, 819 MG/2.63ML.....	108
FANAPT ORAL TABLET 1 MG, 10 MG, 12 MG, 2 MG, 4 MG, 6 MG, 8 MG.....	73	ISTURISA ORAL TABLET 1 MG, 5 MG.....	109
FANAPT TITRATION PACK A.....	73	ITOVEBI ORAL TABLET 3 MG, 9 MG.....	110
FANAPT TITRATION PACK B ORAL TABLET ...	73	<i>itraconazole oral</i>	87
FANAPT TITRATION PACK C ORAL TABLET ...	73	<i>ivabradine hcl oral tablet 5 mg, 7.5 mg</i>	235
FILSPARI.....	74	IWILFIN.....	112
FINTEPLA.....	76	JAKAFI.....	113
FOTIVDA.....	77	<i>javygtor</i>	220
FRUZAQLA ORAL CAPSULE 1 MG, 5 MG.....	78	JAYPIRCA.....	114
GAMMAGARD.....	101	JIDEYTRO ORAL TABLET 100 MG, 25 MG...	115
GAMMAGARD ERC.....	101	JOENJA.....	116
GAMMAGARD S/D LESS IGA.....	101	JUXTAPID ORAL CAPSULE 10 MG, 20 MG, 30 MG, 5 MG.....	117
GATTEX.....	79	KALYDECO.....	119
GAVRETO.....	80	KERENDIA.....	120
<i>gefitinib</i>	81	KINERET SUBCUTANEOUS SOLUTION PREFILLED SYRINGE.....	121
GILOTRIF.....	82	KISQALI (200 MG DOSE).....	123
GOMEKLI.....	83	KISQALI (400 MG DOSE).....	123
HAEGARDA.....	85	KISQALI (600 MG DOSE).....	123
HERNEXEOS.....	91	KOMZIFTI.....	124
<i>hydroxyzine hcl oral tablet</i>	92	KOSELUGO.....	125
<i>hydroxyzine pamoate oral capsule 25 mg, 50 mg</i>	92	KRAZATI.....	126
HYRNUO.....	93	<i>lapatinib ditosylate</i>	127
IBRANCE ORAL CAPSULE 100 MG, 125 MG..	94		
IBRANCE ORAL TABLET.....	94		

LAZCLUZE ORAL TABLET 240 MG, 80 MG...	128	MOUNJARO SUBCUTANEOUS SOLUTION	
<i>lenalidomide</i>	129	AUTO-INJECTOR 10 MG/0.5ML, 12.5	
LENVIMA (10 MG DAILY DOSE).....	131	MG/0.5ML, 15 MG/0.5ML, 2.5 MG/0.5ML,	
LENVIMA (12 MG DAILY DOSE).....	131	5 MG/0.5ML, 7.5 MG/0.5ML.....	158
LENVIMA (14 MG DAILY DOSE).....	131	MULTAQ.....	89
LENVIMA (18 MG DAILY DOSE).....	131	MYTESI.....	159
LENVIMA (20 MG DAILY DOSE).....	131	NAMZARIC ORAL CAPSULE EXTENDED	
LENVIMA (24 MG DAILY DOSE).....	131	RELEASE 24 HOUR 7-10 MG.....	154
LENVIMA (4 MG DAILY DOSE).....	131	NAYZILAM.....	236
LENVIMA (8 MG DAILY DOSE).....	131	NERLYNX.....	160
LEQEMBI IQLIK.....	132	NEXLETOL.....	161
LEQEMBI IQLIK (500 MG DOSE).....	132	NEXLIZET.....	162
LEUKINE INJECTION SOLUTION		<i>nilotinib hcl</i>	163
RECONSTITUTED.....	133	NINLARO.....	164
<i>l-glutamine oral packet</i>	134	<i>nintedanib esylate</i>	165
<i>lidocaine external patch 5 %</i>	135	<i>nitisinone</i>	166
<i>lidocan</i>	135	NORDITROPIN FLEXPOR SUBCUTANEOUS	
LIFYORLI (125 MG DOSE).....	136	SOLUTION PEN-INJECTOR 10 MG/1.5ML,	
LIFYORLI (150 MG DOSE).....	136	15 MG/1.5ML, 5 MG/1.5ML.....	84
LIPFENDRA.....	137	NUBEQA.....	167
LIVTENCITY.....	139	NUCALA SUBCUTANEOUS SOLUTION	
LONSURF.....	140	AUTO-INJECTOR.....	168
LORBRENA ORAL TABLET 100 MG, 25 MG.	141	NUCALA SUBCUTANEOUS SOLUTION	
LUMAKRAS.....	142	PREFILLED SYRINGE 100 MG/ML.....	168
LYBALVI.....	143	NUCALA SUBCUTANEOUS SOLUTION	
LYNPARZA ORAL TABLET.....	144	RECONSTITUTED.....	168
LYTGOBI (12 MG DAILY DOSE).....	146	NUPLAZID ORAL CAPSULE.....	172
LYTGOBI (16 MG DAILY DOSE).....	146	NUPLAZID ORAL TABLET 10 MG.....	172
LYTGOBI (20 MG DAILY DOSE).....	146	NURTEC.....	173
<i>macitentan</i>	147	OCTAGAM INTRAVENOUS SOLUTION 1	
MAVYRET ORAL PACKET.....	148	GM/20ML, 10 GM/100ML, 10 GM/200ML,	
MAVYRET ORAL TABLET.....	148	2 GM/20ML, 2.5 GM/50ML, 20	
<i>meclizine hcl oral tablet 12.5 mg, 25 mg...</i>	150	GM/200ML, 5 GM/100ML, 5 GM/50ML....	101
<i>megestrol acetate oral suspension 40</i>		ODOMZO.....	174
<i>mg/ml, 625 mg/5ml</i>	151	OFEV.....	165
MEKINIST.....	152	OGSIVEO ORAL TABLET 100 MG, 150 MG..	175
MEKTOVI.....	153	OJEMDA.....	176
<i>memantine hcl-donepezil hcl er oral</i>		OJJAARA ORAL TABLET 100 MG, 150 MG,	
<i>capsule extended release 24 hour 14-10</i>		200 MG.....	177
<i>mg, 21-10 mg, 28-10 mg</i>	154	ONUREG.....	180
<i>mifepristone oral tablet 300 mg</i>	155	ORENITRAM.....	181
<i>miglustat</i>	156	ORENITRAM MONTH 1.....	181
<i>minoxidil oral</i>	88	ORENITRAM MONTH 2.....	181
MODEYSO.....	157	ORENITRAM MONTH 3.....	181

ORGOVYX.....	182	REPATHA.....	204
ORIAHNN.....	183	REPATHA SURECLICK.....	204
ORLISSA ORAL TABLET 150 MG, 200 MG..	184	RETACRIT INJECTION SOLUTION 10000	
ORKAMBI ORAL PACKET.....	186	UNIT/ML, 2000 UNIT/ML, 20000 UNIT/ML,	
ORKAMBI ORAL TABLET.....	186	3000 UNIT/ML, 4000 UNIT/ML, 40000	
<i>ormalvi</i>	50	UNIT/ML.....	206
ORSERDU.....	187	RETEVMO ORAL TABLET 120 MG, 160 MG,	
OZEMPIC (0.25 OR 0.5 MG/DOSE)		40 MG, 80 MG.....	207
SUBCUTANEOUS SOLUTION PEN-INJECTOR		REVCOVI.....	208
2 MG/3ML.....	188	REVUFORJ ORAL TABLET 110 MG, 160 MG,	
OZEMPIC (1 MG/DOSE) SUBCUTANEOUS		25 MG.....	209
SOLUTION PEN-INJECTOR 4 MG/3ML.....	188	REXULTI ORAL TABLET 0.25 MG, 0.5 MG, 1	
OZEMPIC (2 MG/DOSE).....	188	MG, 2 MG, 3 MG, 4 MG.....	210
OZEMPIC ORAL TABLET 1.5 MG, 4 MG, 9		REZDIFFRA.....	211
MG.....	188	REZLIDHIA.....	213
PANRETIN.....	189	REZUROCK.....	214
<i>pazopanib hcl oral tablet 200 mg</i>	190	RIVFLOZA.....	215
PEGASYS SUBCUTANEOUS SOLUTION 180		ROMVIMZA.....	216
MCG/ML.....	237	ROZLYTREK.....	217
PEGASYS SUBCUTANEOUS SOLUTION		RUBRACA.....	218
PREFILLED SYRINGE.....	237	RYBELSUS ORAL TABLET 14 MG, 3 MG, 7	
PEMAZYRE ORAL TABLET 13.5 MG, 4.5		MG.....	188
MG, 9 MG.....	192	RYDAPT.....	219
<i>pioglitazone hcl</i>	90	<i>sajazir subcutaneous solution prefilled</i>	
PIQRAY (200 MG DAILY DOSE).....	193	<i>syringe</i>	96
PIQRAY (250 MG DAILY DOSE).....	193	<i>sapropterin dihydrochloride oral packet</i>	220
PIQRAY (300 MG DAILY DOSE).....	193	<i>sapropterin dihydrochloride oral tablet</i>	220
<i>pirfenidone oral tablet 267 mg, 801 mg</i>	194	SCEMBLIX ORAL TABLET 100 MG, 20 MG,	
<i>pomalidomide</i>	195	40 MG.....	221
POMALYST.....	195	SECUADO TRANSDERMAL PATCH 24 HOUR	
<i>pretomanid</i>	196	3.8 MG/24HR, 5.7 MG/24HR, 7.6	
PREVYMIS ORAL TABLET.....	197	MG/24HR.....	222
PROLASTIN-C INTRAVENOUS SOLUTION....	198	SIGNIFOR.....	223
<i>promethazine hcl oral solution 6.25</i>		<i>sildenafil citrate oral suspension</i>	
<i>mg/5ml</i>	199	<i>reconstituted</i>	224
<i>promethazine hcl oral tablet</i>	199	<i>sildenafil citrate oral tablet 20 mg</i>	224
<i>promethazine hcl rectal suppository 12.5</i>		SIRTURO.....	225
<i>mg, 25 mg</i>	199	SKYCLARYS.....	226
PROMETHEGAN.....	199	<i>sodium oxybate</i>	227
QINLOCK.....	200	<i>sofosbuvir-velpatasvir</i>	228
QULIPTA.....	201	SOMAVERT.....	229
RADICAVA ORS.....	202	<i>sorafenib tosylate</i>	231
RADICAVA ORS STARTER KIT.....	202	SOTYKTU.....	232
REDEMPLO.....	203	STIVARGA.....	239

SUCRAID	240	TRUQAP ORAL TABLET THERAPY PACK	264
<i>sunitinib malate</i>	241	TUKYSA ORAL TABLET 150 MG, 50 MG	265
SUNOSI ORAL TABLET 150 MG, 75 MG	242	TURALIO ORAL CAPSULE 125 MG	266
SYMDEKO	243	UBRELVY	267
TABRECTA	244	UDENYCA	191
<i>tadalafil (pah)</i>	246	UDENYCA ONBODY	191
<i>tadalafil oral tablet 2.5 mg, 5 mg</i>	245	<i>ustekinumab subcutaneous</i>	268
TAFINLAR	247	UZEDY	269
TAGRISSO	248	VALCHLOR	270
TAKHZYRO SUBCUTANEOUS SOLUTION		VALTOCO 10 MG DOSE	238
PREFILLED SYRINGE 300 MG/2ML	249	VALTOCO 15 MG DOSE NASAL LIQUID	
TALZENNA ORAL CAPSULE 0.1 MG, 0.25		THERAPY PACK 2 X 7.5 MG/0.1ML	238
MG, 0.35 MG, 0.5 MG, 0.75 MG, 1 MG	250	VALTOCO 20 MG DOSE NASAL LIQUID	
TARPEYO	251	THERAPY PACK 2 X 10 MG/0.1ML	238
<i>tasimelteon</i>	252	VALTOCO 5 MG DOSE	238
<i>tazarotene external cream</i>	253	VANFLYTA	271
<i>tazarotene external gel</i>	253	VANRAFIA	272
TEPMETKO	254	VELSIPITY	273
<i>teriparatide subcutaneous solution pen-</i>		VENCLEXTA ORAL TABLET 10 MG, 100 MG,	
<i>injector 560 mcg/2.24ml</i>	255	50 MG	274
<i>testosterone transdermal gel 12.5 mg/act</i>		VENCLEXTA STARTING PACK	274
<i>(1%), 20.25 mg/act (1.62%), 25 mg/2.5gm</i>		VEOZAH	275
<i>(1%), 50 mg/5gm (1%)</i>	257	VEPPANU	276
<i>testosterone transdermal solution</i>	257	VERQUVO ORAL TABLET 10 MG, 2.5 MG, 5	
TIBSOVO	258	MG	277
<i>tolvaptan (hyponatremia) oral tablet 15</i>		VERZENIO	279
<i>mg, 30 mg</i>	260	VIBERZI	280
<i>tolvaptan oral tablet 15 mg, 30 mg</i>	259	VIJOICE ORAL PACKET	281
<i>tolvaptan oral tablet therapy pack 15 mg,</i>		VIJOICE ORAL TABLET THERAPY PACK 125	
<i>30 & 15 mg, 45 & 15 mg, 60 & 30 mg, 90 &</i>		MG, 200 & 50 MG, 50 MG	281
<i>30 mg</i>	259	VITRAKVI ORAL CAPSULE 100 MG, 25 MG	282
<i>torpenz oral tablet 10 mg, 2.5 mg, 5 mg,</i>		VITRAKVI ORAL SOLUTION	282
<i>7.5 mg</i>	70	VIVJOA	283
<i>tretinoin external cream</i>	261	VIZIMPRO ORAL TABLET 15 MG, 30 MG, 45	
<i>tretinoin external gel 0.01 %, 0.025 %</i>	261	MG	284
<i>tridacaine ii</i>	135	VONJO	285
TRIKAFTA ORAL TABLET THERAPY PACK		VOQUEZNA ORAL TABLET 10 MG, 20 MG	286
100-50-75 & 150 MG, 50-25-37.5 & 75 MG		VORANIGO ORAL TABLET 10 MG, 40 MG	288
.....	262	VOSEVI	289
TRIKAFTA ORAL THERAPY PACK	262	VOWST	290
<i>trilistas</i>	253	VOYXACT	291
TRULICITY SUBCUTANEOUS SOLUTION		VTAMA	292
AUTO-INJECTOR	263	WEGOVY ORAL	294
TRUQAP ORAL TABLET 200 MG	264		

WEGOVY SUBCUTANEOUS SOLUTION	
AUTO-INJECTOR 0.25 MG/0.5ML, 0.5	
MG/0.5ML, 1 MG/0.5ML, 1.7 MG/0.75ML,	
2.4 MG/0.75ML.....	294
WELIREG.....	296
WINREVAIR SUBCUTANEOUS KIT 2 X 45	
MG, 2 X 60 MG, 45 MG, 60 MG.....	297
XALKORI.....	299
XDEMVI.....	300
XERMELO.....	301
XIFAXAN ORAL TABLET 550 MG.....	302
XOLAIR.....	178
XOSPATA.....	304
XPOVIO (100 MG ONCE WEEKLY) ORAL	
TABLET THERAPY PACK 50 MG.....	305
XPOVIO (40 MG ONCE WEEKLY) ORAL	
TABLET THERAPY PACK 10 MG.....	305
XPOVIO (40 MG TWICE WEEKLY) ORAL	
TABLET THERAPY PACK 40 MG.....	305
XPOVIO (60 MG ONCE WEEKLY) ORAL	
TABLET THERAPY PACK 60 MG.....	305
XPOVIO (60 MG TWICE WEEKLY).....	305
XPOVIO (80 MG ONCE WEEKLY) ORAL	
TABLET THERAPY PACK 40 MG, 80 MG.....	305
XPOVIO (80 MG TWICE WEEKLY).....	305
XTANDI.....	306
<i>yargesa</i>	156
<i>yulithira oral tablet 10 mg, 2.5 mg, 5 mg,</i>	
<i>7.5 mg</i>	70
<i>zaleplon</i>	307
ZEJULA ORAL TABLET.....	308
ZELBORAF.....	309
<i>zelvysia</i>	220
ZENBEXUS.....	310
<i>zolpidem tartrate oral tablet</i>	311
ZORYVE EXTERNAL CREAM 0.3 %.....	312
ZTALMY.....	313
ZURZUVAE.....	314
ZYDELIG.....	315
ZYKADIA ORAL TABLET.....	316
ZYMFENTRA (2 PEN).....	317
ZYMFENTRA (2 SYRINGE).....	317