

## **ABALOPARATIDE (TYMLOS)**

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### **MEDICATION(S)**

TYMLOS

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PRESCRIBER RESTRICTION**

N/A

### **COVERAGE DURATION**

2 years

### **OTHER CRITERIA**

N/A

## **APREMILAST**

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### **MEDICATION(S)**

OTEZLA, OTEZLA/OTEZLA XR INITIATION PK, OTEZLA XR

### **PA INDICATION INDICATOR**

3 - All Medically-Accepted Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PRESCRIBER RESTRICTION**

N/A

### **COVERAGE DURATION**

1 year

### **OTHER CRITERIA**

N/A

## **BELIMUMAB**

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### **MEDICATION(S)**

BENLYSTA 200 MG/ML SOLN A-INJ, BENLYSTA 200 MG/ML SOLN PRSYR

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PRESCRIBER RESTRICTION**

N/A

### **COVERAGE DURATION**

1 year

### **OTHER CRITERIA**

N/A

## **BEMPEDOIC ACID**

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### **MEDICATION(S)**

NEXLETOL

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PRESCRIBER RESTRICTION**

N/A

### **COVERAGE DURATION**

1 year

### **OTHER CRITERIA**

N/A

## **BEXAROTENE (TARGRETIN)**

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### **MEDICATION(S)**

BEXAROTENE 1 % GEL

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PRESCRIBER RESTRICTION**

N/A

### **COVERAGE DURATION**

12 months

### **OTHER CRITERIA**

N/A

## **C1 ESTERASE INHIBITOR**

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### **MEDICATION(S)**

CINRYZE

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PRESCRIBER RESTRICTION**

N/A

### **COVERAGE DURATION**

12 months

### **OTHER CRITERIA**

N/A

## **CANNABIDIOL (EPIDIOLEX)**

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### **MEDICATION(S)**

EPIDIOLEX

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PRESCRIBER RESTRICTION**

N/A

### **COVERAGE DURATION**

12 months

### **OTHER CRITERIA**

N/A

## **DALFAMPRIDINE (AMPYRA)**

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### **MEDICATION(S)**

DALFAMPRIDINE ER

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PRESCRIBER RESTRICTION**

N/A

### **COVERAGE DURATION**

12 months

### **OTHER CRITERIA**

N/A

## **DARBEPOETIN (ARANESP)**

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### **MEDICATION(S)**

ARANESP (ALBUMIN FREE)

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PRESCRIBER RESTRICTION**

N/A

### **COVERAGE DURATION**

6 months

### **OTHER CRITERIA**

N/A

## **DENOSUMAB (XGEVA)**

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### **MEDICATION(S)**

BILPREVDA, WYOST

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PRESCRIBER RESTRICTION**

N/A

### **COVERAGE DURATION**

12 months

### **OTHER CRITERIA**

N/A

## **DEXTROMETHORPHAN/QUINIDINE (NUEDEXTA)**

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### **MEDICATION(S)**

NUEDEXTA

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PRESCRIBER RESTRICTION**

N/A

### **COVERAGE DURATION**

12 months

### **OTHER CRITERIA**

N/A

## **DICLOFENAC EPOLAMINE**

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### **MEDICATION(S)**

DICLOFENAC EPOLAMINE

### **PA INDICATION INDICATOR**

3 - All Medically-Accepted Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PRESCRIBER RESTRICTION**

N/A

### **COVERAGE DURATION**

1 year

### **OTHER CRITERIA**

N/A

## **DICLOFENAC (SOLARAZE)**

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### **MEDICATION(S)**

DICLOFENAC SODIUM 3 % GEL

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PRESCRIBER RESTRICTION**

N/A

### **COVERAGE DURATION**

12 months

### **OTHER CRITERIA**

N/A

## **DRONABINOL**

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### **MEDICATION(S)**

DRONABINOL 10 MG CAP, DRONABINOL 2.5 MG CAP, DRONABINOL 5 MG CAP

### **PA INDICATION INDICATOR**

3 - All Medically-Accepted Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PRESCRIBER RESTRICTION**

N/A

### **COVERAGE DURATION**

1 year

### **OTHER CRITERIA**

N/A

## **DULAGLUTIDE**

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### **MEDICATION(S)**

TRULICITY

### **PA INDICATION INDICATOR**

3 - All Medically-Accepted Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PRESCRIBER RESTRICTION**

N/A

### **COVERAGE DURATION**

1 year

### **OTHER CRITERIA**

N/A

## **DULOXETINE (DRIZALMA SPRINKLE)**

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### **MEDICATION(S)**

DRIZALMA SPRINKLE

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PRESCRIBER RESTRICTION**

N/A

### **COVERAGE DURATION**

12 months

### **OTHER CRITERIA**

N/A

## **DUPIBUMAB**

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### **MEDICATION(S)**

DUPIXENT 200 MG/1.14ML SOLN A-INJ, DUPIXENT 200 MG/1.14ML SOLN PRSYR, DUPIXENT 300 MG/2ML SOLN A-INJ, DUPIXENT 300 MG/2ML SOLN PRSYR

### **PA INDICATION INDICATOR**

3 - All Medically-Accepted Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PRESCRIBER RESTRICTION**

N/A

### **COVERAGE DURATION**

1 year

### **OTHER CRITERIA**

N/A

## **EPOETIN (EPOGEN)**

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### **MEDICATION(S)**

RETACRIT

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PRESCRIBER RESTRICTION**

N/A

### **COVERAGE DURATION**

6 months

### **OTHER CRITERIA**

N/A

## **FILGRASTIM (NEUPOGEN)**

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### **MEDICATION(S)**

NIVESTYM

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

not for afebrile neutropenia

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PRESCRIBER RESTRICTION**

N/A

### **COVERAGE DURATION**

6 months

### **OTHER CRITERIA**

N/A

## **FREMANEZUMAB (AJOVY)**

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### **MEDICATION(S)**

AJOVY

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PRESCRIBER RESTRICTION**

N/A

### **COVERAGE DURATION**

12 months

### **OTHER CRITERIA**

N/A

## **GLECAPREVIR/PIBRENTASVIR (MAVYRET)**

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### **MEDICATION(S)**

MAVYRET 100-40 MG TAB

**PENDING CMS APPROVAL**

## **ISAVUCONAZONIUM SULFATE**

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### **MEDICATION(S)**

CRESEMBA 186 MG CAP, CRESEMBA 74.5 MG CAP

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PRESCRIBER RESTRICTION**

N/A

### **COVERAGE DURATION**

1 year

### **OTHER CRITERIA**

N/A

## **LEDIPASVIR/SOFOSBUVIR (HARVONI)**

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### **MEDICATION(S)**

LEDIPASVIR-SOFOSBUVIR

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PRESCRIBER RESTRICTION**

N/A

### **COVERAGE DURATION**

12 weeks in patients without cirrhosis, 24 weeks in patients with cirrhosis

### **OTHER CRITERIA**

Documentation of medical necessity and inability to use BOTH of the following preferred agents:  
sofosbuvir-velpatasvir or glecaprevir-pibrentasvir

## **LIDOCAINE**

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### **MEDICATION(S)**

LIDOCAINE 5 % PATCH

### **PA INDICATION INDICATOR**

3 - All Medically-Accepted Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PRESCRIBER RESTRICTION**

N/A

### **COVERAGE DURATION**

12 months

### **OTHER CRITERIA**

N/A

## **LOMITAPIDE**

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### **MEDICATION(S)**

JUXTAPID 10 MG CAP, JUXTAPID 20 MG CAP, JUXTAPID 30 MG CAP, JUXTAPID 5 MG CAP

### **PA INDICATION INDICATOR**

3 - All Medically-Accepted Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PRESCRIBER RESTRICTION**

N/A

### **COVERAGE DURATION**

1 year

### **OTHER CRITERIA**

N/A

## **MACITENTAN**

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### **MEDICATION(S)**

OPSUMIT

### **PA INDICATION INDICATOR**

3 - All Medically-Accepted Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PRESCRIBER RESTRICTION**

N/A

### **COVERAGE DURATION**

1 year

### **OTHER CRITERIA**

N/A

## **MEPOLIZUMAB (NUCALA)**

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### **MEDICATION(S)**

NUCALA

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PRESCRIBER RESTRICTION**

N/A

### **COVERAGE DURATION**

12 months

### **OTHER CRITERIA**

N/A

## **METHYLNALTREXONE (RELISTOR)**

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### **MEDICATION(S)**

RELISTOR

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PRESCRIBER RESTRICTION**

N/A

### **COVERAGE DURATION**

12 months

### **OTHER CRITERIA**

N/A

## **MIFEPRISTONE**

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### **MEDICATION(S)**

MIFEPRISTONE 300 MG TAB

### **PA INDICATION INDICATOR**

3 - All Medically-Accepted Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PRESCRIBER RESTRICTION**

N/A

### **COVERAGE DURATION**

1 year

### **OTHER CRITERIA**

N/A

## **MODAFINIL**

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### **MEDICATION(S)**

MODAFINIL 100 MG TAB, MODAFINIL 200 MG TAB

### **PA INDICATION INDICATOR**

3 - All Medically-Accepted Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PRESCRIBER RESTRICTION**

N/A

### **COVERAGE DURATION**

1 year

### **OTHER CRITERIA**

N/A

## OMALIZUMAB

---

### MEDICATION(S)

XOLAIR

### PA INDICATION INDICATOR

3 - All Medically-Accepted Indications

### OFF LABEL USES

N/A

### EXCLUSION CRITERIA

N/A

### REQUIRED MEDICAL INFORMATION

N/A

### AGE RESTRICTION

N/A

### PRESCRIBER RESTRICTION

N/A

### COVERAGE DURATION

1 year

### OTHER CRITERIA

N/A

## PART D VS PART B

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### MEDICATION(S)

ACETYLCYSTEINE 10 % SOLUTION, ACETYLCYSTEINE 20 % SOLUTION, ACYCLOVIR SODIUM, ALBUTEROL SULFATE 0.63 MG/3ML NEBU SOLN, ALBUTEROL SULFATE 1.25 MG/3ML NEBU SOLN, ALBUTEROL SULFATE 2.5 MG/0.5ML NEBU SOLN, ALBUTEROL SULFATE (2.5 MG/3ML) 0.083% NEBU SOLN, ALBUTEROL SULFATE (5 MG/ML) 0.5% NEBU SOLN, AMPHOTERICIN B 50 MG RECON SOLN, AMPHOTERICIN B LIPOSOME, APREPITANT, ARALAST NP, AZATHIOPRINE 100 MG TAB, AZATHIOPRINE 50 MG TAB, AZATHIOPRINE 75 MG TAB, BUDESONIDE 0.25 MG/2ML SUSPENSION, BUDESONIDE 0.5 MG/2ML SUSPENSION, BUDESONIDE 1 MG/2ML SUSPENSION, CINACALCET HCL, CLINIMIX/DEXTROSE (4.25/10), CLINIMIX/DEXTROSE (4.25/5), CLINIMIX/DEXTROSE (5/15), CLINIMIX/DEXTROSE (5/20), CLINIMIX E/DEXTROSE (2.75/5), CLINIMIX E/DEXTROSE (4.25/10), CLINIMIX E/DEXTROSE (4.25/5), CLINIMIX E/DEXTROSE (5/15), CLINIMIX E/DEXTROSE (5/20), CLINISOL SF, CROMOLYN SODIUM 20 MG/2ML NEBU SOLN, CYCLOPHOSPHAMIDE 25 MG CAP, CYCLOPHOSPHAMIDE 50 MG CAP, CYCLOPHOSPHAMIDE 50 MG TAB, CYCLOSPORINE 100 MG CAP, CYCLOSPORINE 25 MG CAP, CYCLOSPORINE MODIFIED, ELIGARD, ENGERIX-B, ENVARISUS XR, EVEROLIMUS 0.25 MG TAB, EVEROLIMUS 0.5 MG TAB, EVEROLIMUS 0.75 MG TAB, EVEROLIMUS 1 MG TAB, GAMMAGARD 2.5 GM/25ML SOLUTION, GAMMAGARD S/D LESS IGA, GAMMAPLEX 10 GM/100ML SOLUTION, GAMMAPLEX 10 GM/200ML SOLUTION, GAMMAPLEX 20 GM/200ML SOLUTION, GAMMAPLEX 5 GM/50ML SOLUTION, GAMUNEX-C 1 GM/10ML SOLUTION, GLASSIA, HEPARIN SODIUM (PORCINE) 10000 UNIT/ML SOLUTION, HEPARIN SODIUM (PORCINE) 1000 UNIT/ML SOLUTION, HEPARIN SODIUM (PORCINE) PF 1000 UNIT/ML SOLUTION, HEPLISAV-B, INTRALIPID, IPRATROPIUM-ALBUTEROL, IPRATROPIUM BROMIDE 0.02 % SOLUTION, LEVALBUTEROL HCL 0.31 MG/3ML NEBU SOLN, LEVALBUTEROL HCL 0.63 MG/3ML NEBU SOLN, LEVALBUTEROL HCL 1.25 MG/0.5ML NEBU SOLN, LEVALBUTEROL HCL 1.25 MG/3ML NEBU SOLN, LUPRON DEPOT, MYCOPHENOLATE MOFETIL 200 MG/ML RECON SUSP, MYCOPHENOLATE MOFETIL 250 MG CAP, MYCOPHENOLATE MOFETIL 500 MG TAB, MYCOPHENOLATE SODIUM, MYCOPHENOLIC ACID, NUTRILIPID, ONDANSETRON 4 MG TAB DISP, ONDANSETRON 8 MG TAB DISP, ONDANSETRON HCL 2 MG/2.5ML SOLUTION, ONDANSETRON HCL 4 MG/5ML SOLUTION, ONDANSETRON HCL 4 MG TAB, ONDANSETRON HCL 8 MG TAB, PENTAMIDINE ISETHIONATE, PREMASOL, PRIVIGEN 20 GM/200ML SOLUTION, PROGRAF 0.2 MG PACKET, PROGRAF 1 MG PACKET, PROLASTIN-C, PROSOL, PULMOZYME, RECOMBIVAX HB, SIROLIMUS 0.5 MG TAB, SIROLIMUS 1 MG/ML SOLUTION, SIROLIMUS 1 MG TAB, SIROLIMUS 2 MG TAB, TACROLIMUS 0.5 MG CAP, TACROLIMUS 1 MG CAP, TACROLIMUS 5 MG CAP, TACROLIMUS ER, TOBRAMYCIN 300 MG/4ML NEBU SOLN, TOBRAMYCIN 300 MG/5ML NEBU SOLN, TRAVASOL, TROPHAMINE, VORICONAZOLE 200 MG RECON SOLN, ZEMAIRA

**DETAILS**

This drug may be covered under Medicare Part B or D depending on the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

## **PIMAVANSERIN TARTRATE (NUPLAZID)**

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### **MEDICATION(S)**

NUPLAZID

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PRESCRIBER RESTRICTION**

N/A

### **COVERAGE DURATION**

12 months

### **OTHER CRITERIA**

N/A

## **RIOCIGUAT**

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### **MEDICATION(S)**

ADEMPAS

### **PA INDICATION INDICATOR**

3 - All Medically-Accepted Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PRESCRIBER RESTRICTION**

N/A

### **COVERAGE DURATION**

1 year

### **OTHER CRITERIA**

N/A

## **SARGRAMOSTIM (LEUKINE)**

---

### **MEDICATION(S)**

LEUKINE

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PRESCRIBER RESTRICTION**

N/A

### **COVERAGE DURATION**

2 months

### **OTHER CRITERIA**

N/A

## **SEMAGLUTIDE (OZEMPIC)**

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### **MEDICATION(S)**

OZEMPIC (0.25 OR 0.5 MG/DOSE) 2 MG/3ML SOLN PEN, OZEMPIC (1 MG/DOSE), OZEMPIC (2 MG/DOSE)

### **PA INDICATION INDICATOR**

3 - All Medically-Accepted Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PRESCRIBER RESTRICTION**

N/A

### **COVERAGE DURATION**

1 year

### **OTHER CRITERIA**

N/A

## **SILDENAFIL CITRATE (REVATIO)**

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### **MEDICATION(S)**

SILDENAFIL CITRATE 20 MG TAB

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PRESCRIBER RESTRICTION**

N/A

### **COVERAGE DURATION**

12 months

### **OTHER CRITERIA**

N/A

## **SODIUM OXYBATE**

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### **MEDICATION(S)**

SODIUM OXYBATE

### **PA INDICATION INDICATOR**

3 - All Medically-Accepted Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PRESCRIBER RESTRICTION**

N/A

### **COVERAGE DURATION**

1 year

### **OTHER CRITERIA**

N/A

## **SOFOSBUVIR AND VELPATASVIR (EPCLUSA)**

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### **MEDICATION(S)**

SOFOSBUVIR-VELPATASVIR

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PRESCRIBER RESTRICTION**

N/A

### **COVERAGE DURATION**

12 weeks

### **OTHER CRITERIA**

Criteria will be applied consistent with current AASLD/IDSA guidance

## **SOFOSBUVIR (SOLVALDI)**

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### **MEDICATION(S)**

SOVALDI 400 MG TAB

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PRESCRIBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Criteria will be applied consistent with current AASLD-IDSA guidance

### **OTHER CRITERIA**

Criteria will be applied consistent with current AASLD-IDSA guidance

## **SOFOSBUVIR/VELPATASVIR/VOXILAPREVIR (VOSEVI)**

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### **MEDICATION(S)**

VOSEVI

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PRESCRIBER RESTRICTION**

N/A

### **COVERAGE DURATION**

12 weeks

### **OTHER CRITERIA**

Criteria will be applied consistent with current AASLD/IDSA guidance

## **SOMATROPIN**

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### **MEDICATION(S)**

GENOTROPIN, GENOTROPIN MINIQUICK, HUMATROPE, NORDITROPIN FLEXPRO 10 MG/1.5ML SOLN PEN, NORDITROPIN FLEXPRO 15 MG/1.5ML SOLN PEN, NORDITROPIN FLEXPRO 5 MG/1.5ML SOLN PEN, OMNITROPE, SEROSTIM

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PRESCRIBER RESTRICTION**

N/A

### **COVERAGE DURATION**

12 months

### **OTHER CRITERIA**

N/A

## **SOTATERCEPT-CSRK**

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### **MEDICATION(S)**

WINREVAIR

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PRESCRIBER RESTRICTION**

N/A

### **COVERAGE DURATION**

1 year

### **OTHER CRITERIA**

N/A

## **TADALAFIL 5MG**

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### **MEDICATION(S)**

TADALAFIL 5 MG TAB

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PRESCRIBER RESTRICTION**

N/A

### **COVERAGE DURATION**

1 year

### **OTHER CRITERIA**

N/A

## **TADALAFIL (ADCIRCA)**

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### **MEDICATION(S)**

TADALAFIL (PAH)

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PRESCRIBER RESTRICTION**

N/A

### **COVERAGE DURATION**

12 months

### **OTHER CRITERIA**

N/A

## **TASIMELTEON**

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### **MEDICATION(S)**

HETLIOZ LQ, TASIMELTEON

### **PA INDICATION INDICATOR**

3 - All Medically-Accepted Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PRESCRIBER RESTRICTION**

N/A

### **COVERAGE DURATION**

1 year

### **OTHER CRITERIA**

N/A

## **TEDUGLUTIDE (GATTEX)**

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### **MEDICATION(S)**

GATTEX

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PRESCRIBER RESTRICTION**

N/A

### **COVERAGE DURATION**

12 months

### **OTHER CRITERIA**

N/A

## **TERIPARATIDE (FORTEO)**

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### **MEDICATION(S)**

TERIPARATIDE

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PRESCRIBER RESTRICTION**

N/A

### **COVERAGE DURATION**

2 years

### **OTHER CRITERIA**

N/A

## **TIRZEPATIDE (MOUNJARO)**

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### **MEDICATION(S)**

MOUNJARO

### **PA INDICATION INDICATOR**

3 - All Medically-Accepted Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PRESCRIBER RESTRICTION**

N/A

### **COVERAGE DURATION**

1 year

### **OTHER CRITERIA**

N/A

## **TOFACITINIB**

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### **MEDICATION(S)**

XELJANZ, XELJANZ XR

### **PA INDICATION INDICATOR**

3 - All Medically-Accepted Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PRESCRIBER RESTRICTION**

N/A

### **COVERAGE DURATION**

1 year

### **OTHER CRITERIA**

N/A