2022 Formulary
List of Covered Drugs

PLEASE READ: THIS DOCUMENT CONTAINS INFORMATION ABOUT THE DRUGS WE COVER IN THIS PLAN

This formulary was updated on 11/30/2022. For more recent information or other questions, please contact Troy Medicare Member Service at 1-888-494-TROY (8769) (TTY users should call 711), five days a week from April 1 to September 30 or seven days a week from October 1 to March 31 from 8:00 AM to 8:00 PM EST or visit troymedicare.com.
Note to existing members: This formulary has changed since last year. Please review this document to make sure that it still contains the drugs you take. When this drug list (formulary) refers to “we,” “us”, or “our,” it means Troy Health, Inc. When it refers to “plan” or “our plan,” it means Troy Medicare. This document includes a list of the drugs (formulary) for our plan which is current as of December 2022. For an updated formulary, please contact us. Our contact information, along with the date we last updated the formulary, appears on the front and back cover pages. You must generally use network pharmacies to use your prescription drug benefit. Benefits, formulary, pharmacy network, and/or copayments/coinsurance may change on January 1, 2023, and from time to time during the year.

What is the Troy Medicare Formulary?
A formulary is a list of covered drugs selected by Troy Medicare in consultation with a team of health care providers, which represents the prescription therapies believed to be a necessary part of a quality treatment program. Troy Medicare will generally cover the drugs listed in our formulary as long as the drug is medically necessary, the prescription is filled at Troy Medicare network pharmacy, and other plan rules are followed. For more information on how to fill your prescriptions, please review your Evidence of Coverage.

Can the Formulary (Drug List) change?
Most changes in drug coverage happen on January 1, but we may add or remove drugs on the Drug List during the year, move them to different cost-sharing tiers, or add new restrictions. We must follow the Medicare rules in making these changes.

Changes that can affect you this year: In the below cases, you will be affected by coverage changes during the year:

- **New generic drugs.** We may immediately remove a brand-name drug on our Drug List if we are replacing it with a new generic drug that will appear on the same or lower cost-sharing tier and with the same or fewer restrictions. Also, when adding the new generic drug, we may decide to keep the brand-name drug on our Drug List, but immediately move it to a different cost-sharing tier or add new restrictions. If you are currently taking that brand-name drug, we may not tell you in advance before we make that change, but we will later provide you with information about the specific change(s) we have made.
  - If we make such a change, you or your prescriber can ask us to make an exception and continue to cover the brand-name drug for you. The notice we provide you will also include information on how to request an exception, and you can find information in the section below titled “How do I request an exception to the Troy Medicare Formulary?”

- **Drugs removed from the market.** If the Food and Drug Administration deems a drug on our formulary to be unsafe or the drug's manufacturer removes the drug from the market, we will immediately remove the drug from our formulary and provide notice to members who take the drug.
● **Other changes.** We may make other changes that affect members currently taking a drug. For instance, we may add a generic drug that is not new to the market to replace a brand-name drug currently on the formulary or add new restrictions to the brand-name drug or move it to a different cost-sharing tier or both. Or we may make changes based on new clinical guidelines. If we remove drugs from our formulary, add prior authorization, quantity limits and/or step therapy restrictions on a drug, or move a drug to a higher cost-sharing tier, we must notify affected members of the change at least 30 days before the change becomes effective, or at the time the member requests a refill of the drug, at which time the member will receive a 30-day supply of the drug.
  o If we make these other changes, you or your prescriber can ask us to make an exception and continue to cover the brand-name drug for you. The notice we provide you will also include information on how to request an exception, and you can also find information in the section below entitled “**How do I request an exception to the Troy Medicare Formulary?**”

**Changes that will not affect you if you are currently taking the drug.** Generally, if you are taking a drug on our 2022 formulary that was covered at the beginning of the year, we will not discontinue or reduce coverage of the drug during the 2022 coverage year except as described above. This means these drugs will remain available at the same cost-sharing and with no new restrictions for those members taking them for the remainder of the coverage year. You will not get direct notice this year about changes that do not affect you. However, on January 1 of the next year, such changes would affect you, and it is important to check the Drug List for the new benefit year for any changes to drugs.

The enclosed formulary is current as of December 2022. To get updated information about the drugs covered by Troy Medicare, please contact us. Our contact information appears on the front and back cover pages. We will update the printed formularies each month and they will be available at [troymedicare.com/prescription-drugs](http://troymedicare.com/prescription-drugs).

**How do I use the Formulary?**

There are two ways to find your drug within the formulary:

**Medical Condition**

The formulary begins on Page 10. The drugs in this formulary are grouped into categories depending on the type of medical conditions that they are used to treat. For example, drugs used to treat a heart condition are listed under the category, “Cardiovascular Agents - Treatment Of Conditions Affecting The Heart And Blood Vessels”. If you know what your drug is used for, look for the category name in the list that begins on Page 10. Then look under the category name for your drug.
Alphabetical Listing
If you are not sure what category to look under, you should look for your drug in the Index that begins on Page 127. The Index provides an alphabetical list of all of the drugs included in this document. Both brand-name drugs and generic drugs are listed in the Index. Look in the Index and find your drug. Next to your drug, you will see the page number where you can find coverage information. Turn to the page listed in the Index and find the name of your drug in the first column of the list.

What are generic drugs?
Troy Medicare covers both brand-name drugs and generic drugs. A generic drug is approved by the FDA as having the same active ingredient as the brand-name drug. Generally, generic drugs cost less than brand-name drugs.

Are there any restrictions on my coverage?
Some covered drugs may have additional requirements or limits on coverage. These requirements and limits may include:

- **Prior Authorization (PA):** Troy Medicare requires you or your physician to get prior authorization for certain drugs. This means that you will need to get approval from Troy Medicare before you fill your prescriptions. If you do not get approval, Troy Medicare may not cover the drug.

- **Quantity Limits (QL):** For certain drugs, Troy Medicare limits the amount of the drug that the plan will cover. For example, Troy Medicare provides up to twelve (12) capsules per prescription for *gabapentin oral capsule 300 mg* per day. This may be in addition to a standard one-month or three-month supply.

- **Step Therapy (ST):** In some cases, Troy Medicare requires you to first try certain drugs to treat your medical condition before we will cover another drug for that condition. For example, if Drug A and Drug B both treat your medical condition, Troy Medicare may not cover Drug B unless you try Drug A first. If Drug A does not work for you, Troy Medicare will then cover Drug B.

You can find out if your drug has any additional requirements or limits by looking in the formulary that begins on Page 10. You can also get more information about the restrictions applied to specific covered drugs by visiting our website. We have posted online documents that explain our prior authorization and step therapy restrictions. You may also ask us to send you a copy. Our contact information, along with the date we last updated the formulary, appears on the front and back cover pages.

You can ask Troy Medicare to make an exception to these restrictions or limits or for a list of other, similar drugs that may treat your health condition. See the section, **How do I request an exception to the Troy Medicare Formulary?** on Page 5 for information about how to request an exception.
What if my drug is not on the Formulary?
If your drug is not included in this formulary (list of covered drugs), you should first contact Member Services and ask if your drug is covered. For more information, please contact us. Our contact information, along with the date we last updated the formulary, appears on the front and back cover pages.

If you learn that Troy Medicare does not cover your drug, you have two options:

- You can ask Member Services for a list of similar drugs that are covered by Troy Medicare. When you receive the list, show it to your doctor and ask him or her to prescribe a similar drug that is covered by Troy Medicare.
- You can ask Troy Medicare to make an exception and cover your drug. See below for information about how to request an exception.

How do I request an exception to the Troy Medicare Formulary?
You can ask Troy Medicare to make an exception to our coverage rules. There are several types of exceptions that you can ask us to make.

- You can ask us to cover a drug even if it is not on our formulary. If approved, this drug will be covered at a pre-determined cost-sharing level, and you would not be able to ask us to provide the drug at a lower cost-sharing level.
- You can ask us to cover a formulary drug at a lower cost-sharing level. If approved, this would lower the amount you must pay for your drug.
- You can ask us to waive coverage restrictions or limits on your drug. For example, for certain drugs, Troy Medicare limits the amount of the drug that we will cover. If your drug has a quantity limit, you can ask us to waive the limit and cover a greater amount.

Generally, Troy Medicare will only approve your request for an exception if the alternative drugs included on the plan’s formulary, the lower cost-sharing drug, or additional utilization restrictions would not be as effective in treating your condition and/or would cause you to have adverse medical effects.

You should contact us to ask us for an initial coverage decision for a formulary, tier, or utilization restriction exception. When you request a formulary, tier, or utilization restriction exception, you should submit a statement from your prescriber or physician supporting your request. Generally, we must make our decision within 72 hours of receiving your prescriber’s supporting statement. You can request an expedited (fast) exception if you or your health care provider believe that your health could be seriously harmed by waiting up to 72 hours for a decision. If your request to expedite is granted, we must give you a decision no later than 24 hours after we get a supporting statement from your doctor or other prescriber.
What do I do before I can talk to my doctor about changing my drugs or requesting an exception?

As a new or continuing member in our plan, you may be taking drugs that are not on our formulary. Or you may be taking a drug that is on our formulary but your ability to get it is limited. For example, you may need a prior authorization from us before you can fill your prescription. You should talk to your doctor to decide if you should switch to an appropriate drug that we cover or request a formulary exception so that we will cover the drug you take. While you talk to your doctor to determine the right course of action for you, we may cover your drug in certain cases during the first 90 days you are a member of our plan.

For each of your drugs that is not on our formulary or if your ability to get your drugs is limited, we will cover a temporary 30-day supply. If your prescription is written for fewer days, we will allow refills to provide up to a maximum 30-day supply of medication. After your first 30-day supply, we will not pay for these drugs, even if you have been a member of the plan less than 90 days.

If you are a resident of a long-term care facility and you need a drug that is not on our formulary or if your ability to get your drugs is limited, but you are past the first 90 days of membership in our plan, we will cover a 31-day emergency supply of that drug while you pursue a formulary exception.

Throughout the plan year, your treatment setting (the place where you receive and take your medicine) may change. These changes include members who:

- Enter long-term care facilities from hospitals.
- Are discharged from a hospital to a home.
- End their skilled nursing facility Medicare Part A stay (where payments include all pharmacy charges) and who need to revert to their Part D plan formulary.
- End an LTC facility stay and return to the community.

For these changes in treatment settings, Troy Medicare will cover up to a one-time 30-day transition supply per drug. If a member has more than one change in level of care in a month, the pharmacy must call our plan to request an extension of the transition policy. During the time when you are getting a temporary supply of a drug, you should talk with your provider to decide what to do when your temporary supply runs out. You can either switch to a different drug covered by the plan or ask the plan to make an exception for you and cover your current drug. You can find more information about our prescription drug transition process by visiting our website.
For More Information
For more detailed information about your Troy Medicare prescription drug coverage, please review your Evidence of Coverage and other plan materials.

If you have questions about Troy Medicare, please contact us. Our contact information, along with the date we last updated the formulary, appears on the front and back cover pages.

If you have general questions about Medicare prescription drug coverage, please call Medicare at 1-800-MEDICARE (1-800-633-4227) 24 hours a day / 7 days a week. TTY users should call 1-877-486-2048, or visit medicare.gov.
The formulary below provides coverage information about the drugs covered by Troy Medicare. If you have trouble finding your drug in the list, turn to the Index that begins on Page 127.

The first column of the chart lists the drug. Brand-name drugs are capitalized (e.g., TRESIBA FLEXTOUCH SUBCUTANEOUS SOLUTION PEN-INJECTOR 300 UNIT/ML) and generic drugs are listed in lower-case italics (e.g., insulin glargine-yfgn subcutaneous solution pen-injector 100 unit/ml).

The information in the Requirements/Limits tells you if Troy Medicare has special requirements for coverage of your drug.

- **Prior Authorization (PA):** Troy Medicare requires you or your physician to get prior authorization for certain drugs. This means that you will need to get approval from Troy Medicare before you fill your prescriptions. If you do not get approval, Troy Medicare may not cover the drug.

- **Quantity Limits (QL):** For certain drugs, Troy Medicare limits the amount of the drug that the plan will cover. For example, Troy Medicare provides 360 per prescription for gabapentin oral capsule 300 mg. This may be in addition to a standard one-month or three-month supply.

- **Step Therapy (ST):** In some cases, Troy Medicare requires you to first try certain drugs to treat your medical condition before we will cover another drug for that condition. For example, if Drug A and Drug B both treat your medical condition, Troy Medicare may not cover Drug B unless you try Drug A first. If Drug A does not work for you, Troy Medicare will then cover Drug B.

- **Medicare Part B or Part D (B/D):** Depending on how this drug is used, it may be covered by either Medicare Part B (doctor and outpatient health care) or Medicare Part D (prescription drugs). Your doctor may need to provide the plan with more information about how this drug will be used to make sure it is correctly covered by Troy Medicare.

- **Morphine Milligram Equivalent (MME):** Additional quantity limits may apply across all drugs in the opioid class used for the treatment of pain. This additional limit is called a cumulative morphine milligram equivalent (MME) and is designed to monitor safe dosing levels of opioids for individuals who may be taking more than 1 opioid drug for pain management. If your prescriber prescribes more than this amount or thinks the limit is not right for your situation, you or your prescriber can ask the plan to cover the additional quantity.
Prescription drugs are grouped into one of six tiers.

Troy Medicare covers both brand-name drugs and generic drugs. Generally, generic drugs cost less than brand-name drugs.

- **Tier 1:** Generic or brand-name drugs that are available at the lowest cost share for the plan.
- **Tier 2:** Generic or brand-name drugs that the plan offers at a higher cost to you than Tier 1 drugs.
- **Tier 3:** Brand-name drugs that the plan offers at a lower cost to you than Tier 4 drugs.
- **Tier 4:** Generic or brand-name drugs that the plan offers at a higher cost to you than Tier 3 drugs.
- **Tier 5:** Specialty drugs.
- **Tier 6:** Vaccines.

How much will I pay for covered drugs?

Troy Medicare pays part of the costs for your covered drugs and you pay part of the costs, too. The amount you pay depends on:

- The tier that your drug is on.
- Whether or not you fill your prescription at a network pharmacy.
- Your current drug payment stage - please read your Evidence of Coverage for more information.

Additional Coverage for Tier 1 Drugs in the Coverage Gap

Troy Medicare provides additional coverage for all Tier 1 drugs in the Coverage Gap phase of the Part D benefit. These Tier 1 drugs are indicated in the formulary with an asterisk (*).

Part D Senior Savings Model

Troy Medicare is a voluntary participant in the CY 2022 Part D Senior Savings Model, which is designed to provide Medicare beneficiaries with options for Part D plans that offer insulin at an affordable and predictable cost. This means that Troy Medicare is offering beneficiaries broad access to multiple types of insulin, marketed by Model-participating pharmaceutical manufacturers, at a maximum copay of $35 each for a month’s supply in the Deductible, Initial Coverage, and Coverage Gap phases of the Part D benefit. These insulin drugs are indicated in the formulary with the following:

- **Select Insulin Drugs (SI):** This represents a formulary insulin included in the Part D Senior Savings model. This insulin medication is available to you at a copay of $25 or less for a retail 30-day supply. You will continue to pay a copay of $25 or less for a retail 30-day supply of this select insulin medication, even during the Coverage Gap phase.

If you qualified for Extra Help with your drug costs, your costs may be different from those described above. Please refer to your Evidence of Coverage or call Member Services to find out what your costs are.
<table>
<thead>
<tr>
<th>Name of Drug</th>
<th>Drug Tier</th>
<th>Requirements/Limits</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Analgesics - Treatment Of Pain</strong></td>
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<td><strong>Analgesics</strong></td>
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<td>ASCOMP-CODEINE ORAL CAPSULE 50-325-40-30 MG</td>
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<td>PA; MME</td>
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<td>BAC ORAL TABLET 50-325-40 MG</td>
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<td>PA</td>
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<td>PA; MME</td>
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<td>MME</td>
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<td>nalbuphine hcl injection solution 10 mg/ml</td>
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<td>MME</td>
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<td><strong>Nonsteroidal Anti-Inflammatory Drugs</strong></td>
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<td>celecoxib oral capsule 100 mg, 200 mg, 400 mg, 50 mg</td>
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<td>Name of Drug</td>
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<td>ec-naproxen oral tablet delayed release 375 mg, 500 mg</td>
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<td>ketorolac tromethamine oral tablet 10 mg</td>
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<td>meclofenamate sodium oral capsule 100 mg, 50 mg</td>
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<td>meloxicam oral tablet 15 mg, 7.5 mg*</td>
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<td>naproxen sodium oral tablet 275 mg, 550 mg</td>
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<td>piroxicam oral capsule 10 mg, 20 mg</td>
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<td>sulindac oral tablet 150 mg, 200 mg</td>
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<td><strong>Opioid Analgesics, Long-Acting</strong></td>
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<tr>
<td>buprenorphine transdermal patch weekly 10 mcg/hr, 15 mcg/hr, 20 mcg/hr, 5 mcg/hr, 7.5 mcg/hr</td>
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<td>Name of Drug</td>
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<td>fentanyl transdermal patch 72 hour 100 mcg/hr, 12 mcg/hr, 25 mcg/hr,</td>
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<td>MME; QL (10 EA per 30 days)</td>
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<td>37.5 mcg/hr, 50 mcg/hr, 62.5 mcg/hr, 75 mcg/hr</td>
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<td>methadone hcl oral solution 10 mg/5ml</td>
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<td>MME; QL (1200 ML per 30 days)</td>
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<td>morphine sulfate er oral tablet extended release 100 mg, 15 mg, 200 mg,</td>
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<td>XTAMPZA ER ORAL CAPSULE ER 12 HOUR ABUSE-DETERRENT 13.5 MG, 18 MG, 27 MG,</td>
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<td>36 MG, 9 MG</td>
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**Opioid Analgesics, Short-Acting**

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<tr>
<th>Name of Drug</th>
<th>Drug Tier</th>
<th>Requirements/Limits</th>
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<tr>
<td>acetaminophen-codeine #2 oral tablet 300-15 mg</td>
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<tr>
<td>acetaminophen-codeine #3 oral tablet 300-30 mg</td>
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</tr>
<tr>
<td>acetaminophen-codeine #4 oral tablet 300-60 mg</td>
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<td>MME</td>
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<td>acetaminophen-codeine oral solution 120-12 mg/5ml</td>
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<td>acetaminophen-codeine oral tablet 300-15 mg, 300-30 mg, 300-60 mg</td>
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<td>butalbital-acetaminophen oral tablet 50-325 mg</td>
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<td>PA</td>
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<td>butorphanol tartrate nasal solution 10 mg/ml</td>
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<td>MME; QL (5 ML per 30 days)</td>
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<tr>
<td>Name of Drug</td>
<td>Drug Tier</td>
<td>Requirements/Limits</td>
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<tr>
<td>--------------------------------------------------</td>
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<td>fentanyl citrate buccal lozenge on a handle 1200 mcg, 1600 mcg, 400 mcg, 600 mcg, 800 mcg</td>
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<td>PA; MME; QL (120 EA per 30 days)</td>
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<td>fentanyl citrate buccal lozenge on a handle 200 mcg</td>
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<td>PA; MME; QL (120 EA per 30 days)</td>
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<td>MME</td>
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<tr>
<td>hydrocodone-ibuprofen oral tablet 10-200 mg, 5-200 mg, 7.5-200 mg</td>
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<td>MME</td>
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<tr>
<td>hydromorphone hcl oral tablet 2 mg, 4 mg, 8 mg</td>
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<td>MME; QL (120 EA per 30 days)</td>
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<tr>
<td>hydromorphone hcl pf injection solution 1 mg/ml, 10 mg/ml, 4 mg/ml, 50 mg/5ml, 500 mg/50ml</td>
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<tr>
<td>meperidine hcl oral solution 50 mg/5ml</td>
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<td>PA; MME; QL (900 ML per 30 days)</td>
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<tr>
<td>meperidine hcl oral tablet 50 mg</td>
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<td>PA; MME; QL (180 EA per 30 days)</td>
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<tr>
<td>morphine sulfate (concentrate) oral solution 100 mg/5ml, 20 mg/ml</td>
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<td>MME; QL (180 ML per 30 days)</td>
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<tr>
<td>morphine sulfate oral tablet 15 mg, 30 mg</td>
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<tr>
<td>oxycodone hcl oral solution 5 mg/5ml</td>
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<td>MME; QL (5400 ML per 30 days)</td>
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<td>oxycodone hcl oral tablet 10 mg, 15 mg, 20 mg, 30 mg, 5 mg</td>
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<tr>
<td>oxycodone-acetaminophen oral tablet 10-325 mg, 2.5-325 mg, 5-325 mg, 7.5-325 mg</td>
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<td>pentazocine-naloxone hcl oral tablet 50-0.5 mg</td>
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<td>tramadol hcl oral tablet 100 mg</td>
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<td>tramadol hcl oral tablet 50 mg</td>
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<td>tramadol-acetaminophen oral tablet 37.5-325 mg</td>
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<td><strong>Anesthetics - Local Treatment Of Pain</strong></td>
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<td><strong>Local Anesthetics</strong></td>
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<td>lidocaine external ointment 5 %</td>
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<td>lidocaine external patch 5 %</td>
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<td>lidocaine hcl external solution 4 %</td>
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<tr>
<td>lidocaine hcl mouth/throat solution 4 %</td>
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<td>lidocaine hcl urethral/mucosal external gel 2 %</td>
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<td>lidocaine hcl urethral/mucosal external prefilled syringe 2 %</td>
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<tr>
<td>lidocaine viscous hcl mouth/throat solution 2 %</td>
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<tr>
<td>lidocaine-prilocaine external cream 2.5-2.5 %</td>
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<tr>
<td>premium lidocaine external ointment 5 %</td>
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<tr>
<td>ZTLIDO EXTERNAL PATCH 1.8 %</td>
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<td><strong>Anti-Addiction/ Substance Abuse Treatment Agents - Treatment Of Substance Abuse Disorders</strong></td>
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<tr>
<td><strong>Alcohol Deterrents/Anti-Craving</strong></td>
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<td>acamprosate calcium oral tablet delayed release 333 mg</td>
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<tr>
<td>disulfiram oral tablet 250 mg, 500 mg</td>
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<tr>
<td><strong>Opioid Dependence</strong></td>
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<td>buprenorphine hcl sublingual tablet sublingual 2 mg, 8 mg</td>
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<td>buprenorphine hcl-naloxone hcl sublingual film 12-3 mg, 2-0.5 mg, 4-1 mg, 8-2 mg</td>
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<td>buprenorphine hcl-naloxone hcl sublingual tablet sublingual 2-0.5 mg, 8-2 mg</td>
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<td>naltrexone hcl oral tablet 50 mg*</td>
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<td><strong>Opioid Reversal Agents</strong></td>
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<td>naloxone hcl injection solution 0.4 mg/ml*</td>
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<td>Name of Drug</td>
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<td>Requirements/Limits</td>
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<tr>
<td>naloxone hcl injection solution cartridge 0.4 mg/ml*</td>
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<td>naloxone hcl injection solution prefilled syringe 2 mg/2ml*</td>
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<td>naloxone hcl nasal liquid 4 mg/0.1ml*</td>
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<td><strong>Smoking Cessation Agents</strong></td>
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<td>bupropion hcl er (smoking det) oral tablet extended release 12 hour 150 mg*</td>
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<td>NICOTROL INHALATION INHALER 10 MG</td>
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<td>NICOTROL NS NASAL SOLUTION 10 MG/ML</td>
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<td>varenicline tartrate oral tablet 0.5 mg, 1mg</td>
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<td>QL (56 EA per 28 days)</td>
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<td>varenicline tartrate oral tablet therapy pack 0.5 mg x 11 &amp; 1 mg x 42</td>
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<td>QL (56 EA per 28 days)</td>
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<td><strong>Antibacterials - Treatment Of Bacterial Infections</strong></td>
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<td><strong>Aminoglycosides</strong></td>
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<td>amikacin sulfate injection solution 500 mg/2ml</td>
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<td>gentamicin in saline intravenous solution 0.8-0.9 mg/ml-%, 1-0.9 mg/ml-%, 1.2-0.9 mg/ml-%, 1.6-0.9 mg/ml-%</td>
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<td>gentamicin sulfate external cream 0.1 %*</td>
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<td>gentamicin sulfate external ointment 0.1 %*</td>
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<td>gentamicin sulfate injection solution 40 mg/ml</td>
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<td>paromomycin sulfate oral capsule 250 mg</td>
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<td>streptomycin sulfate intramuscular solution reconstituted 1 gm</td>
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<td>tobramycin sulfate injection solution 1.2 gm/30ml, 10 mg/ml, 2 gm/50ml, 80 mg/2ml</td>
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<td>tobramycin sulfate injection solution reconstituted 1.2 gm</td>
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<td>Name of Drug</td>
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<td><strong>Antibacterials, Other</strong></td>
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<td>aztreonam injection solution reconstituted 1 gm, 2 gm</td>
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<td>clindamycin hcl oral capsule 150 mg, 300 mg*</td>
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<td>clindamycin hcl oral capsule 75 mg</td>
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<td>clindamycin palmitate hcl oral solution reconstituted 75 mg/5ml</td>
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<td>clindamycin phosphate external swab 1 %</td>
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<td>clindamycin phosphate in d5w intravenous solution 300 mg/50ml, 600 mg/50ml, 900 mg/50ml</td>
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<td>clindamycin phosphate in nacl intravenous solution 300-0.9 mg/50ml-%, 600-0.9 mg/50ml-%, 900-0.9 mg/50ml-%</td>
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<td>clindamycin phosphate injection solution 300 mg/2ml, 600 mg/4ml, 900 mg/6ml</td>
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<td>clindamycin phosphate vaginal cream 2 %</td>
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<td>colistimethate sodium (cb) injection solution reconstituted 150 mg</td>
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<td>daptomycin intravenous solution reconstituted 350 mg</td>
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<td>daptomycin intravenous solution reconstituted 500 mg</td>
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<td>linezolid in sodium chloride intravenous solution 600-0.9 mg/300ml-%</td>
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<td>linezolid intravenous solution 600 mg/300ml</td>
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<td>linezolid oral tablet 600 mg</td>
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<td>methenamine hippurate oral tablet 1 gm</td>
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<td>metronidazole external cream 0.75 %</td>
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<td>Name of Drug</td>
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<td>Requirements/Limits</td>
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<td>metronidazole external gel 0.75 %, 1 %</td>
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<td>metronidazole external lotion 0.75 %</td>
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<td>metronidazole oral capsule 375 mg</td>
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<td>metronidazole oral tablet 250 mg, 500 mg*</td>
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<td>metronidazole vaginal gel 0.75 %</td>
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<td>nitrofurantoin macrystal oral capsule 100 mg, 25 mg, 50 mg</td>
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<td>nitrofurantoin monohyd macro oral capsule 100 mg</td>
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<td>tinidazole oral tablet 250 mg, 500 mg</td>
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<td>trimethoprim oral tablet 100 mg*</td>
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<td>vancomycin hcl intravenous solution reconstituted 1 gm, 10 gm, 100 gm, 1000 mg, 5 gm, 500 mg, 750 mg</td>
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<td>vancomycin hcl oral capsule 125 mg, 250 mg</td>
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<tr>
<td><strong>Beta-Lactam, Cephalosporins</strong></td>
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<tr>
<td>cefaclor er oral tablet extended release 12 hour 500 mg</td>
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<td>cefaclor oral capsule 250 mg, 500 mg</td>
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<td>cefadroxil oral capsule 500 mg*</td>
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<td>cefadroxil oral suspension reconstituted 250 mg/5ml, 500 mg/5ml</td>
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<td>cefadroxil oral tablet 1 gm</td>
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<td>cefazolin sodium injection solution reconstituted 1 gm, 2 gm, 500 mg</td>
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<td>cefazolin sodium intravenous solution reconstituted 1 gm</td>
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<td>cefazolin sodium-dextrose intravenous solution 1-4 gm/50ml-%</td>
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<td>cefazolin sodium-dextrose intravenous solution reconstituted 1-4 gm-%(50ml)</td>
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<td>cefdinir oral capsule 300 mg*</td>
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<td>cefdinir oral suspension reconstituted 125 mg/5ml, 250 mg/5ml</td>
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<td>cefepime hcl injection solution reconstituted 1 gm, 2 gm</td>
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<td>cefepime hcl intravenous solution 1 gm/50ml, 2 gm/100ml</td>
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<td>cefepime hcl intravenous solution reconstituted 2 gm</td>
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<td>cefepime-dextrose intravenous solution reconstituted 1-5 gm-%(50ml), 2-5 gm-%(50ml)</td>
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<td>cefixime oral capsule 400 mg</td>
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<td>cefotaxime sodium injection solution reconstituted 1 gm</td>
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<td>cefoxitin sodium injection solution reconstituted 10 gm</td>
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<td>cefoxitin sodium intravenous solution reconstituted 1 gm, 10 gm, 2 gm</td>
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<td>cefoxitin sodium-dextrose intravenous solution reconstituted 1-4 gm-%(50ml), 2-2.2 gm-%(50ml)</td>
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<td>cefpodoxime proxetil oral suspension reconstituted 100 mg/5ml, 50 mg/5ml</td>
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<td>cefpodoxime proxetil oral tablet 100 mg, 200 mg</td>
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<td>cefprozil oral suspension reconstituted 125 mg/5ml, 250 mg/5ml</td>
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<td>cefprozil oral tablet 250 mg, 500 mg</td>
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<td>ceftazidime and dextrose intravenous solution reconstituted 1-5 gm-%(50ml), 2-5 gm-%(50ml)</td>
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<td>ceftazidime injection solution reconstituted 1 gm, 2 gm, 6 gm</td>
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<td>ceftazidime intravenous solution reconstituted 2 gm</td>
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<td>ceftriaxone sodium in dextrose intravenous solution 20 mg/ml, 40 mg/ml</td>
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<td>Name of Drug</td>
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<tr>
<td>ceftriaxone sodium injection solution reconstituted 1 gm, 100 gm, 2 gm, 250 mg, 500 mg</td>
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<tr>
<td>ceftriaxone sodium intravenous solution reconstituted 1 gm, 10 gm, 2 gm</td>
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<td>ceftriaxone sodium-dextrose intravenous solution reconstituted 1-3.74 gm-% (50ml), 2-2.22 gm-% (50ml)</td>
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<td>cefuroxime axetil oral tablet 250 mg, 500 mg</td>
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<td>cefuroxime sodium injection solution reconstituted 750 mg</td>
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<td>cefuroxime sodium intravenous solution reconstituted 1.5 gm</td>
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<td>cephalexin oral capsule 250 mg, 500 mg*</td>
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<td>cephalexin oral suspension reconstituted 125 mg/5ml, 250 mg/5ml*</td>
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<td>cephalexin oral tablet 250 mg, 500 mg</td>
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<td>TAZICEF INJECTION SOLUTION RECONSTITUTED 1 GM, 2 GM, 6 GM</td>
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<td>TAZICEF INTRAVENOUS SOLUTION RECONSTITUTED 1 GM, 2 GM, 6 GM</td>
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<td>TEFLARO INTRAVENOUS SOLUTION RECONSTITUTED 400 MG, 600 MG</td>
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**Beta-Lactam, Penicillins**

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<thead>
<tr>
<th>Name of Drug</th>
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<th>Requirements/Limits</th>
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<tbody>
<tr>
<td>amoxicillin oral capsule 250 mg, 500 mg*</td>
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<td>amoxicillin oral suspension reconstituted 125 mg/5ml, 200 mg/5ml, 250 mg/5ml, 400 mg/5ml*</td>
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<td>amoxicillin oral tablet 500 mg, 875 mg*</td>
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<td>amoxicillin oral tablet chewable 125 mg, 250 mg*</td>
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<td>amoxicillin-pot clavulanate er oral tablet extended release 12 hour 1000-62.5 mg</td>
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<td>Name of Drug</td>
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<td>Requirements/Limits</td>
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<td>amoxicillin-pot clavulanate oral suspension reconstituted 200-28.5 mg/5ml, 250-62.5 mg/5ml, 400-57 mg/5ml, 600-42.9 mg/5ml</td>
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<tr>
<td>amoxicillin-pot clavulanate oral tablet chewable 200-28.5 mg, 400-57 mg</td>
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<td>amoxicillin sodium intravenous solution reconstituted 1 gm, 10 gm</td>
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<td>amoxicillin-sulbactam sodium injection solution reconstituted 1.5 (1-0.5) gm, 3 (2-1) gm</td>
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<td>BICILLIN L-A INTRAMUSCULAR SUSPENSION 2400000 UNIT/4ML</td>
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<tr>
<td>BICILLIN L-A INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 1200000 UNIT/2ML, 600000 UNIT/ML</td>
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<tr>
<td>dicloxacillin sodium oral capsule 250 mg, 500 mg</td>
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</tr>
<tr>
<td>nafcillin sodium in dextrose intravenous solution 1 gm/50ml</td>
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</tr>
<tr>
<td>nafcillin sodium in dextrose intravenous solution 2 gm/100ml</td>
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</tr>
<tr>
<td>nafcillin sodium injection solution reconstituted 1 gm</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>nafcillin sodium injection solution reconstituted 2 gm</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>nafcillin sodium intravenous solution reconstituted 1 gm</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>nafcillin sodium intravenous solution reconstituted 2 gm</td>
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<td></td>
</tr>
<tr>
<td>penicillin g procaine intramuscular suspension 600000 unit/ml</td>
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<tr>
<td>Name of Drug</td>
<td>Drug Tier</td>
<td>Requirements/Limits</td>
</tr>
<tr>
<td>---------------------------------------------------------------------------------------------------</td>
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<tr>
<td>penicillin g sodium injection solution reconstituted 5000000 unit</td>
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<tr>
<td>penicillin v potassium oral solution reconstituted 125 mg/5ml, 250 mg/5ml</td>
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<tr>
<td>penicillin v potassium oral tablet 250 mg, 500 mg*</td>
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<tr>
<td>piperacillin sod-tazobactam so intravenous solution reconstituted 13.5 (12-1.5) gm, 2.25 (2-0.25) gm, 3-0.375 gm, 3.375 (3-0.375) gm, 4-0.5 gm, 4.5 (4-0.5) gm, 40.5 (36-4.5) gm</td>
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<tr>
<td><strong>Carbapenems</strong></td>
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<tr>
<td>ertapenem sodium injection solution reconstituted 1 gm</td>
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<tr>
<td>imipenem-cilastatin intravenous solution reconstituted 250 mg, 500 mg</td>
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<tr>
<td>meropenem intravenous solution reconstituted 1 gm, 500 mg</td>
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<tr>
<td>meropenem-sodium chloride intravenous solution reconstituted 1 gm/50ml, 500 mg/50ml</td>
<td>2</td>
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<tr>
<td><strong>Macrolides</strong></td>
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<tr>
<td>azithromycin intravenous solution reconstituted 500 mg</td>
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<tr>
<td>azithromycin oral packet 1 gm</td>
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<tr>
<td>azithromycin oral suspension reconstituted 100 mg/5ml, 200 mg/5ml</td>
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<tr>
<td>azithromycin oral tablet 250 mg, 250 mg (6 pack), 500 mg, 500 mg (3 pack), 600 mg*</td>
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<tr>
<td>clarithromycin er oral tablet extended release 24 hour 500 mg</td>
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<tr>
<td>clarithromycin oral suspension reconstituted 125 mg/5ml, 250 mg/5ml</td>
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<tr>
<td>clarithromycin oral tablet 250 mg, 500 mg</td>
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<tr>
<td>DIFICID ORAL SUSPENSION RECONSTITUTED 40 MG/ML</td>
<td>5</td>
<td>PA</td>
</tr>
<tr>
<td>DIFICID ORAL TABLET 200 MG</td>
<td>5</td>
<td>PA</td>
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<tr>
<td>Name of Drug</td>
<td>Drug Tier</td>
<td>Requirements/Limits</td>
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<td>e.e.s. 400 oral tablet 400 mg</td>
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<td>ERYTHROCIN LACTOBIONATE INTRAVENOUS SOLUTION RECONSTITUTED 500 MG</td>
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<tr>
<td>ERYTHROCIN STEARATE ORAL TABLET 250 MG</td>
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<tr>
<td>erythromycin base oral tablet 250 mg, 500 mg</td>
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<tr>
<td>erythromycin ethylsuccinate oral suspension reconstituted 200 mg/5ml</td>
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<td>erythromycin ethylsuccinate oral tablet 400 mg</td>
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<td><strong>Quinolones</strong></td>
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<td>ciprofloxacin hcl ophthalmic solution 0.3 %</td>
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<td>ciprofloxacin hcl oral tablet 100 mg</td>
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<tr>
<td>ciprofloxacin hcl oral tablet 250 mg, 500 mg, 750 mg*</td>
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<tr>
<td>ciprofloxacin in d5w intravenous solution 200 mg/100ml</td>
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<tr>
<td>levofloxacin in d5w intravenous solution 500 mg/100ml, 750 mg/150ml</td>
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<tr>
<td>levofloxacin intravenous solution 25 mg/ml</td>
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<tr>
<td>levofloxacin oral solution 25 mg/ml</td>
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<tr>
<td>levofloxacin oral tablet 250 mg, 500 mg, 750 mg*</td>
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<td>moxifloxacin hcl in nacl intravenous solution 400 mg/250ml</td>
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<td>moxifloxacin hcl intravenous solution 400 mg/250ml</td>
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<tr>
<td>moxifloxacin hcl oral tablet 400 mg</td>
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<tr>
<td>ofloxacin oral tablet 300 mg, 400 mg</td>
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<tr>
<td><strong>Sulfonamides</strong></td>
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<tr>
<td>sulfacetamide sodium (acne) external lotion 10 %</td>
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<td>sulfadiazine oral tablet 500 mg</td>
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<tr>
<td>Name of Drug</td>
<td>Drug Tier</td>
<td>Requirements/Limits</td>
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<tr>
<td>------------------------------------------------------------------------------</td>
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<tr>
<td>sulfamethoxazole-trimethoprim oral suspension 200-40 mg/5ml</td>
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<td>sulfamethoxazole-trimethoprim oral tablet 400-80 mg, 800-160 mg*</td>
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<td><strong>Tetracyclines</strong></td>
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<tr>
<td>DOXY 100 INTRAVENOUS SOLUTION RECONSTITUTED 100 MG</td>
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<td>doxycycline hyclate intravenous solution reconstituted 100 mg</td>
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<tr>
<td>doxycycline hyclate oral capsule 100 mg, 50 mg</td>
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<td>doxycycline hyclate oral tablet 100 mg, 20 mg</td>
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<tr>
<td>doxycycline monohydrate oral capsule 100 mg, 50 mg*</td>
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<tr>
<td>doxycycline monohydrate oral tablet 100 mg, 150 mg, 50 mg, 75 mg</td>
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<tr>
<td>minocycline hcl oral capsule 100 mg, 50 mg, 75 mg*</td>
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<tr>
<td>minocycline hcl oral tablet 100 mg, 50 mg, 75 mg</td>
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<tr>
<td>tetracycline hcl oral capsule 250 mg, 500 mg</td>
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<tr>
<td><strong>Anticonvulsants - Treatment Of Seizures</strong></td>
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<tr>
<td><strong>Anticonvulsants, Other</strong></td>
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<tr>
<td>BRIVIACT ORAL SOLUTION 10 MG/ML</td>
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<tr>
<td>BRIVIACT ORAL TABLET 10 MG, 100 MG, 25 MG, 50 MG, 75 MG</td>
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<tr>
<td>DIACOMIT ORAL CAPSULE 250 MG, 500 MG</td>
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<td>PA</td>
</tr>
<tr>
<td>DIACOMIT ORAL PACKET 250 MG, 500 MG</td>
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<td>PA</td>
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<tr>
<td>divalproex sodium er oral tablet extended release 24 hour 250 mg, 500 mg</td>
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<td>divalproex sodium oral capsule delayed release sprinkle 125 mg</td>
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<tr>
<td>divalproex sodium oral tablet delayed release 125 mg, 250 mg, 500 mg</td>
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</tr>
<tr>
<td>Name of Drug</td>
<td>Drug Tier</td>
<td>Requirements/Limits</td>
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<td>--------------------------------------------------</td>
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<tr>
<td>EPIDIOLEX ORAL SOLUTION 100 MG/ML</td>
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<td>PA</td>
</tr>
<tr>
<td>eprontia oral solution 25 mg/ml</td>
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<td>PA</td>
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<tr>
<td>felbamate oral suspension 600 mg/5ml</td>
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<td>felbamate oral tablet 400 mg, 600 mg</td>
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<tr>
<td>FINTEPLA ORAL SOLUTION 2.2 MG/ML</td>
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<td>PA</td>
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<tr>
<td>FYCOMPA ORAL SUSPENSION 0.5 MG/ML</td>
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<td>FYCOMPA ORAL TABLET 10 MG, 12 MG, 4 MG, 6 MG, 8 MG</td>
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<td>QL (30 EA per 30 days)</td>
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<tr>
<td>FYCOMPA ORAL TABLET 2 MG</td>
<td>4</td>
<td>QL (30 EA per 30 days)</td>
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<tr>
<td>lamotrigine er oral tablet extended release 24 hour 100 mg, 200 mg, 25 mg, 250 mg, 300 mg, 50 mg</td>
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<tr>
<td>lamotrigine oral tablet 25 mg*</td>
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</tr>
<tr>
<td>lamotrigine oral tablet chewable 25 mg, 5 mg</td>
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<tr>
<td>levetiracetam er oral tablet extended release 24 hour 500 mg, 750 mg</td>
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</tr>
<tr>
<td>levetiracetam oral solution 100 mg/ml*</td>
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<td></td>
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<tr>
<td>levetiracetam oral tablet 1000 mg, 250 mg, 500 mg, 750 mg*</td>
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<tr>
<td>PEGANONE ORAL TABLET 250 MG</td>
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<tr>
<td>ROWEEPRA ORAL TABLET 500 MG*</td>
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<tr>
<td>SPRITAM ORAL TABLET DISINTEGRATING SOLUBLE 1000 MG, 250 MG, 500 MG</td>
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<td>ST; QL (60 EA per 30 days)</td>
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<tr>
<td>SPRITAM ORAL TABLET DISINTEGRATING SOLUBLE 750 MG</td>
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<td>ST; QL (120 EA per 30 days)</td>
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<tr>
<td>topiramate oral capsule sprinkle 15 mg, 25 mg</td>
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<tr>
<td>topiramate oral tablet 100 mg, 200 mg, 25 mg, 50 mg*</td>
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<td></td>
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<tr>
<td>valproic acid oral capsule 250 mg</td>
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</tr>
<tr>
<td>valproic acid oral solution 250 mg/5ml</td>
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<tr>
<td>XCOPRI (250 MG DAILY DOSE) ORAL TABLET THERAPY PACK 100 &amp; 150 MG, 50 &amp; 200 MG</td>
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<td>ST</td>
</tr>
<tr>
<td>Name of Drug</td>
<td>Drug Tier</td>
<td>Requirements/Limits</td>
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<tr>
<td>----------------------------------------------------------------------------</td>
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<tr>
<td>XCOPRI (350 MG DAILY DOSE) ORAL TABLET THERAPY PACK 150 &amp; 200 MG</td>
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<td>ST</td>
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<tr>
<td>XCOPRI ORAL TABLET 100 MG, 150 MG, 200 MG, 50 MG</td>
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<td>ST</td>
</tr>
<tr>
<td>XCOPRI ORAL TABLET THERAPY PACK 14 X 12.5 MG &amp; 14 X 25 MG</td>
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<tr>
<td>XCOPRI ORAL TABLET THERAPY PACK 14 X 150 MG &amp; 14 X 200 MG, 14 X 50 MG &amp; 14 X 100 MG</td>
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<td>ST</td>
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<tr>
<td>Calcium Channel Modifying Agents</td>
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<tr>
<td>CELONTIN ORAL CAPSULE 300 MG</td>
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<tr>
<td>ethosuximide oral capsule 250 mg</td>
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</tr>
<tr>
<td>ethosuximide oral solution 250 mg/5ml</td>
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<tr>
<td>pregabalin oral capsule 100 mg, 150 mg, 200 mg, 25 mg, 50 mg, 75 mg*</td>
<td>1</td>
<td>QL (90 EA per 30 days)</td>
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<tr>
<td>pregabalin oral capsule 225 mg, 300 mg*</td>
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<td>QL (60 EA per 30 days)</td>
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<tr>
<td>pregabalin oral solution 20 mg/ml*</td>
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<td>QL (900 ML per 30 days)</td>
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<tr>
<td>Gamma-Aminobutyric Acid (GABA) Augmenting Agents</td>
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<tr>
<td>clobazam oral suspension 2.5 mg/ml</td>
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<td>PA; QL (480 ML per 30 days)</td>
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<tr>
<td>clobazam oral tablet 10 mg, 20 mg</td>
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<td>PA; QL (60 EA per 30 days)</td>
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<tr>
<td>DIASTAT ACUDIAL RECTAL GEL 10 MG, 20 MG</td>
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<tr>
<td>DIASTAT PEDIATRIC RECTAL GEL 2.5 MG</td>
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<tr>
<td>diazepam rectal gel 10 mg, 2.5 mg, 20 mg</td>
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<tr>
<td>gabapentin oral capsule 100 mg, 400 mg</td>
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<td>QL (270 EA per 30 days)</td>
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<tr>
<td>gabapentin oral capsule 300 mg</td>
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<td>QL (360 EA per 30 days)</td>
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<tr>
<td>gabapentin oral solution 250 mg/5ml, 300 mg/6ml</td>
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<td>QL (2160 ML per 30 days)</td>
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<tr>
<td>gabapentin oral tablet 600 mg</td>
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<td>QL (180 EA per 30 days)</td>
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<tr>
<td>gabapentin oral tablet 800 mg</td>
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<td>QL (120 EA per 30 days)</td>
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<tr>
<td>NAYZILAM NASAL SOLUTION 5 MG/0.1ML</td>
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<td>PA</td>
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<tr>
<td>phenobarbital oral elixir 20 mg/5ml</td>
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<td>PA</td>
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<tr>
<td>Name of Drug</td>
<td>Drug Tier</td>
<td>Requirements/Limits</td>
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<td>phenobarbital oral tablet 100 mg, 15 mg, 16.2 mg, 30 mg, 32.4 mg, 60 mg, 64.8 mg, 97.2 mg</td>
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<td>PA</td>
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<td>primidone oral tablet 250 mg, 50 mg</td>
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<tr>
<td>SYMPAZAN ORAL FILM 10 MG, 20 MG</td>
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<td>PA; QL (60 EA per 30 days)</td>
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<tr>
<td>SYMPAZAN ORAL FILM 5 MG</td>
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<td>PA; QL (60 EA per 30 days)</td>
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<tr>
<td>tiagabine hcl oral tablet 12 mg, 16 mg, 2 mg, 4 mg</td>
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<td>VALTOCO 10 MG DOSE NASAL LIQUID 10 MG/0.1ML</td>
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<td>PA</td>
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<tr>
<td>VALTOCO 15 MG DOSE NASAL LIQUID THERAPY PACK 7.5 MG/0.1ML</td>
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<tr>
<td>VALTOCO 20 MG DOSE NASAL LIQUID THERAPY PACK 10 MG/0.1ML</td>
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<td>PA</td>
</tr>
<tr>
<td>VALTOCO 5 MG DOSE NASAL LIQUID 5 MG/0.1ML</td>
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<td>PA</td>
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<tr>
<td>vigabatrin oral packet 500 mg</td>
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<td>PA; QL (180 EA per 30 days)</td>
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<tr>
<td>vigabatrin oral tablet 500 mg</td>
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<td>PA; QL (180 EA per 30 days)</td>
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<tr>
<td>ZTALMY ORAL SUSPENSION 50 MG/ML</td>
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<td>PA</td>
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<td><strong>Sodium Channel Agents</strong></td>
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<tr>
<td>APTIOM ORAL TABLET 200 MG, 400 MG</td>
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<td>ST; QL (30 EA per 30 days)</td>
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<tr>
<td>APTIOM ORAL TABLET 600 MG, 800 MG</td>
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<td>ST; QL (60 EA per 30 days)</td>
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<tr>
<td>carbamazepine er oral tablet extended release 12 hour 100 mg, 200 mg, 400 mg</td>
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<tr>
<td>carbamazepine oral suspension 100 mg/5ml</td>
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<tr>
<td>carbamazepine oral tablet 200 mg*</td>
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<tr>
<td>carbamazepine oral tablet chewable 100 mg</td>
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<tr>
<td>DILANTIN ORAL CAPSULE 100 MG, 30 MG</td>
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<tr>
<td>EPITOL ORAL TABLET 200 MG*</td>
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<td>lacosamide oral solution 10 mg/ml</td>
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<td>QL (1200 ML per 30 days)</td>
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<td>lacosamide oral tablet 100 mg, 150 mg, 200 mg, 50 mg</td>
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<td>QL (60 EA per 30 days)</td>
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<tr>
<td>oxcarbazepine oral suspension 300 mg/5ml</td>
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<tr>
<td>Name of Drug</td>
<td>Drug Tier</td>
<td>Requirements/Limits</td>
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<tr>
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<td>oxcarbazepine oral tablet 150 mg, 300 mg, 600 mg*</td>
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<td>PHENYTOIN INFATABS ORAL TABLET CHEWABLE 50 MG</td>
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<tr>
<td>phenytoin oral suspension 100 mg/4ml, 125 mg/5ml</td>
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<tr>
<td>phenytoin oral tablet chewable 50 mg</td>
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<tr>
<td>phenytoin sodium extended oral capsule 100 mg, 200 mg, 300 mg</td>
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<tr>
<td>rufinamide oral suspension 40 mg/ml</td>
<td>5</td>
<td>PA; QL (2400 ML per 30 days)</td>
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<td>rufinamide oral tablet 200 mg</td>
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<td>PA; QL (240 EA per 30 days)</td>
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<tr>
<td>rufinamide oral tablet 400 mg</td>
<td>5</td>
<td>PA; QL (240 EA per 30 days)</td>
</tr>
<tr>
<td>zonisamide oral capsule 100 mg, 25 mg, 50 mg</td>
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### Antidementia Agents - Management Of Dementia

#### Antidementia Agents, Other

<table>
<thead>
<tr>
<th>Name of Drug</th>
<th>Drug Tier</th>
<th>Requirements/Limits</th>
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<tbody>
<tr>
<td>donepezil hcl oral tablet 10 mg, 5 mg*</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>donepezil hcl oral tablet dispersible 10 mg, 5 mg*</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>ergoloid mesylates oral tablet 1 mg</td>
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<td>PA</td>
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#### Cholinesterase Inhibitors

<table>
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<tbody>
<tr>
<td>donepezil hcl oral tablet 23 mg</td>
<td>2</td>
<td></td>
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<tr>
<td>galantamine hydrobromide er oral capsule extended release 24 hour 16 mg, 24 mg, 8 mg*</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>galantamine hydrobromide oral tablet 12 mg, 4 mg, 8 mg*</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>rivastigmine tartrate oral capsule 1.5 mg, 3 mg, 4.5 mg, 6 mg*</td>
<td>1</td>
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</tr>
<tr>
<td>rivastigmine transdermal patch 24 hour 13.3 mg/24hr, 4.6 mg/24hr, 9.5 mg/24hr</td>
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<td>ST</td>
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#### N-Methyl-D-Aspartate (NMDA) Receptor Antagonist

<table>
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<tr>
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<tbody>
<tr>
<td>memantine hcl er oral capsule extended release 24 hour 14 mg, 21 mg, 28 mg, 7 mg</td>
<td>2</td>
<td>QL (30 EA per 30 days)</td>
</tr>
<tr>
<td>Name of Drug</td>
<td>Drug Tier</td>
<td>Requirements/Limits</td>
</tr>
<tr>
<td>-----------------------------------------------------------------------------</td>
<td>-----------</td>
<td>---------------------</td>
</tr>
<tr>
<td>memantine hcl oral tablet 10 mg, 28 x 5 mg &amp; 21 x 10 mg, 5 mg*</td>
<td>1</td>
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**Antidepressants - Treatment Of Depression**

**Antidepressants, Other**

<table>
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<tr>
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<th>Requirements/Limits</th>
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<tbody>
<tr>
<td>bupropion hcl er (sr) oral tablet extended release 12 hour 100 mg, 150 mg, 200 mg*</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>bupropion hcl er (xl) oral tablet extended release 24 hour 150 mg, 300 mg, 450 mg*</td>
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<tr>
<td>bupropion hcl oral tablet 100 mg, 75 mg*</td>
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<td></td>
</tr>
<tr>
<td>mirtazapine oral tablet 15 mg, 30 mg, 45 mg*</td>
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<tr>
<td>mirtazapine oral tablet 7.5 mg</td>
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<tr>
<td>mirtazapine oral tablet dispersible 15 mg, 30 mg, 45 mg</td>
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<td></td>
</tr>
<tr>
<td>perphenazine-amitriptyline oral tablet 2-10 mg, 2-25 mg, 4-10 mg, 4-25 mg, 4-50 mg</td>
<td>2, PA</td>
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**Monoamine Oxidase Inhibitors**

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<tr>
<td>EMSAM TRANSDERMAL PATCH 24 HOUR 12 MG/24HR, 6 MG/24HR, 9 MG/24HR</td>
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<tr>
<td>MARPLAN ORAL TABLET 10 MG</td>
<td>4</td>
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<tr>
<td>phenelzine sulfate oral tablet 15 mg</td>
<td>2</td>
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<tr>
<td>tranylcypromine sulfate oral tablet 10 mg</td>
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**SSRIs/SNRIs (Selective Serotonin Reuptake Inhibitors/Serotonin And Norepinephrine Reuptake Inhibitors)**

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<th>Name of Drug</th>
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<tr>
<td>citalopram hydrobromide oral solution 10 mg/5ml</td>
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<td></td>
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<tr>
<td>citalopram hydrobromide oral tablet 10 mg, 20 mg, 40 mg*</td>
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<td></td>
</tr>
<tr>
<td>desvenlafaxine succinate er oral tablet extended release 24 hour 100 mg, 25 mg, 50 mg</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Name of Drug</td>
<td>Drug Tier</td>
<td>Requirements/Limits</td>
</tr>
<tr>
<td>-----------------------------------------------------------------------------</td>
<td>-----------</td>
<td>---------------------</td>
</tr>
<tr>
<td>DRIZALMA SPRINKLE ORAL CAPSULE DELAYED RELEASE SPRINKLE 20 MG, 30 MG, 40 MG, 60 MG</td>
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<td>ST</td>
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<tr>
<td>escitalopram oxalate oral solution 5 mg/5ml</td>
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<tr>
<td>escitalopram oxalate oral tablet 10 mg, 20 mg, 5 mg*</td>
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<td></td>
</tr>
<tr>
<td>FETZIMA ORAL CAPSULE EXTENDED RELEASE 24 HOUR 120 MG, 20 MG, 40 MG, 80 MG</td>
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<tr>
<td>FETZIMA TITRATION ORAL CAPSULE ER 24 HOUR THERAPY PACK 20 &amp; 40 MG</td>
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<td>ST</td>
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<tr>
<td>fluoxetine hcl oral capsule 10 mg, 20 mg, 40 mg*</td>
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<tr>
<td>fluoxetine hcl oral capsule delayed release 90 mg</td>
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<tr>
<td>fluoxetine hcl oral solution 20 mg/5ml*</td>
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<tr>
<td>fluoxetine hcl oral tablet 10 mg, 20 mg</td>
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</tr>
<tr>
<td>fluvoxamine maleate oral tablet 100 mg, 25 mg, 50 mg</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>nefazodone hcl oral tablet 100 mg, 150 mg, 200 mg, 250 mg, 50 mg</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>paroxetine hcl er oral tablet extended release 24 hour 12.5 mg, 25 mg, 37.5 mg</td>
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<tr>
<td>paroxetine hcl oral suspension 10 mg/5ml</td>
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<tr>
<td>paroxetine hcl oral tablet 10 mg, 20 mg, 30 mg, 40 mg*</td>
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<tr>
<td>sertraline hcl oral concentrate 20 mg/ml</td>
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<td>sertraline hcl oral tablet 100 mg, 25 mg, 50 mg*</td>
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<td>trazodone hcl oral tablet 100 mg, 150 mg, 50 mg*</td>
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<tr>
<td>trazodone hcl oral tablet 300 mg</td>
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<tr>
<td>TRINTELLIX ORAL TABLET 10 MG, 20 MG, 5 MG</td>
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<td></td>
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<tr>
<td>venlafaxine hcl er oral capsule extended release 24 hour 150 mg, 37.5 mg, 75 mg</td>
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</tr>
<tr>
<td>Name of Drug</td>
<td>Drug Tier</td>
<td>Requirements/Limits</td>
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<tr>
<td>----------------------------------------------------------------------------</td>
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<td>venlafaxine hcl er oral tablet extended release 24 hour 150 mg, 225 mg, 37.5 mg, 75 mg</td>
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<td>venlafaxine hcl oral tablet 100 mg, 25 mg, 37.5 mg, 50 mg, 75 mg</td>
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<tr>
<td>VIIBRYD STARTER PACK ORAL KIT 10 &amp; 20 MG</td>
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<tr>
<td>vilazodone hcl oral tablet 10 mg, 20 mg, 40 mg</td>
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<td><strong>Tricyclics</strong></td>
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<td>amitriptyline hcl oral tablet 10 mg, 100 mg, 150 mg, 25 mg, 50 mg, 75 mg</td>
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<td>PA</td>
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<td>amoxapine oral tablet 100 mg, 150 mg, 25 mg, 50 mg</td>
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<td>clomipramine hcl oral capsule 25 mg, 50 mg, 75 mg</td>
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<td>PA</td>
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<td>desipramine hcl oral tablet 10 mg, 100 mg, 150 mg, 25 mg, 50 mg, 75 mg</td>
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<td></td>
</tr>
<tr>
<td>doxepin hcl oral capsule 10 mg, 100 mg, 150 mg, 25 mg, 50 mg, 75 mg</td>
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<td>PA</td>
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<td>doxepin hcl oral concentrate 10 mg/ml</td>
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<td>PA</td>
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<td>imipramine hcl oral tablet 10 mg, 25 mg, 50 mg</td>
<td>2</td>
<td>PA</td>
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<tr>
<td>imipramine pamoate oral capsule 100 mg, 125 mg, 150 mg, 75 mg</td>
<td>2</td>
<td>PA</td>
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<tr>
<td>nortriptyline hcl oral capsule 10 mg, 25 mg, 50 mg, 75 mg*</td>
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<tr>
<td>nortriptyline hcl oral solution 10 mg/5ml</td>
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<td>protriptyline hcl oral tablet 10 mg, 5 mg</td>
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<td>PA</td>
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<td>trimipramine maleate oral capsule 100 mg, 25 mg, 50 mg</td>
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<tr>
<td><strong>Antiemetics - Treatment Of Vomiting Or Nausea</strong></td>
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<tr>
<td><strong>Antiemetics, Other</strong></td>
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<tr>
<td>chlorpromazine hcl oral concentrate 100 mg/ml, 30 mg/ml</td>
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<td>chlorpromazine hcl oral tablet 10 mg, 100 mg, 200 mg, 25 mg, 50 mg</td>
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<td>meclizine hcl oral tablet 12.5 mg, 25 mg</td>
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</tr>
<tr>
<td>Name of Drug</td>
<td>Drug Tier</td>
<td>Requirements/Limits</td>
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<tr>
<td>-----------------------------------------------------------------------------</td>
<td>-----------</td>
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<td>metoclopramide hcl oral solution 10 mg/10ml, 5 mg/5ml</td>
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<td>metoclopramide hcl oral tablet 10 mg, 5 mg*</td>
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<td>perphenazine oral tablet 16 mg, 2 mg, 4 mg, 8 mg</td>
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</tr>
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<td>prochlorperazine maleate oral tablet 10 mg, 5 mg*</td>
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<td>prochlorperazine rectal suppository 25 mg</td>
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<td>promethazine hcl oral tablet 12.5 mg, 25 mg, 50 mg</td>
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<td>PA</td>
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<tr>
<td>promethazine hcl rectal suppository 12.5 mg, 25 mg</td>
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<td>PA</td>
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<td>PROMETHEGAN RECTAL SUPPOSITORY 50 MG</td>
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<td>scopolamine transdermal patch 72 hour 1 mg/3days</td>
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<td>trimethobenzamide hcl oral capsule 300 mg</td>
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<td><strong>Emetogenic Therapy Adjuncts</strong></td>
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<tr>
<td>aprepitant oral 80 &amp; 125 mg</td>
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<td>aprepitant oral capsule 125 mg, 40 mg, 80 &amp; 125 mg, 80 mg</td>
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<td>B/D</td>
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<td>dronabinol oral capsule 10 mg, 2.5 mg, 5 mg</td>
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<td>EMEND ORAL SUSPENSION RECONSTITUTED 125 MG/5ML</td>
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<td>granisetron hcl oral tablet 1 mg</td>
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<td>B/D</td>
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<td>ondansetron hcl oral solution 4 mg/5ml</td>
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<td>B/D</td>
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<tr>
<td>ondansetron hcl oral tablet 4 mg, 8 mg*</td>
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<td>B/D</td>
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<td>ondansetron oral tablet dispersible 4 mg, 8 mg</td>
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<td>B/D</td>
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<td>SYNDROS ORAL SOLUTION 5 MG/ML</td>
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<tr>
<td><strong>Antifungals - Treatment Of Fungal Or Yeast Infections</strong></td>
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<td><strong>Antifungals</strong></td>
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<td>B/D</td>
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<td>amphotericin b intravenous solution reconstituted 50 mg</td>
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<tr>
<td>amphotericin b liposome intravenous suspension reconstituted 50 mg</td>
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<td>caspofungin acetate intravenous solution reconstituted 70 mg</td>
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<td>ciclopirox olamine external cream 0.77 %</td>
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<tr>
<td>ciclopirox olamine external suspension 0.77 %</td>
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<tr>
<td>clotrimazole anti-fungal external cream 1 %</td>
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</tr>
<tr>
<td>clotrimazole external cream 1 %</td>
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<td>clotrimazole external solution 1 %</td>
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<td>clotrimazole mouth/throat troche 10 mg</td>
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<td>econazole nitrate external cream 1 %</td>
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<td>fluconazole in sodium chloride intravenous solution 200-0.9 mg/100ml-%, 400-0.9 mg/200ml-%</td>
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<td>fluconazole oral suspension reconstituted 10 mg/ml, 40 mg/ml</td>
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<td>fluconazole oral tablet 100 mg, 150 mg, 200 mg, 50 mg</td>
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<td>flucytosine oral capsule 250 mg, 500 mg</td>
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<td>griseofulvin microsize oral suspension 125 mg/5ml</td>
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<td>itraconazole oral capsule 100 mg</td>
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<td>itraconazole oral solution 10 mg/ml</td>
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<tr>
<td>Name of Drug</td>
<td>Drug Tier</td>
<td>Requirements/Limits</td>
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<tr>
<td>ketoconazole external cream 2 %</td>
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<td>ketoconazole external shampoo 2 %*</td>
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<td>ketoconazole oral tablet 200 mg</td>
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<tr>
<td>MENTAX EXTERNAL CREAM 1 %</td>
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<tr>
<td>micafungin sodium intravenous solution reconstituted 100 mg, 50 mg</td>
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<tr>
<td>NOXAFIL ORAL SUSPENSION 40 MG/ML</td>
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<tr>
<td>NYAMYC EXTERNAL POWDER 100000 UNIT/GM</td>
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<td>nystatin external cream 100000 unit/gm*</td>
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<tr>
<td>nystatin external ointment 100000 unit/gm*</td>
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<tr>
<td>nystatin external powder 100000 unit/gm*</td>
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</tr>
<tr>
<td>nystatin mouth/throat suspension 100000 unit/ml</td>
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<tr>
<td>nystatin oral tablet 500000 unit</td>
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<tr>
<td>NYSTOP EXTERNAL POWDER 100000 UNIT/GM</td>
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<td>posaconazole oral tablet delayed release 100 mg</td>
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<tr>
<td>terbinafine hcl oral tablet 250 mg*</td>
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<tr>
<td>terconazole vaginal cream 0.4 %, 0.8 %</td>
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<td>terconazole vaginal suppository 80 mg</td>
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<tr>
<td>voriconazole intravenous solution reconstituted 200 mg</td>
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<td>PA</td>
</tr>
<tr>
<td>voriconazole oral suspension reconstituted 40 mg/ml</td>
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<tr>
<td>voriconazole oral tablet 200 mg, 50 mg</td>
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### Antigout Agents - Treatment Or Prevention Of Gouty Arthritis

#### Antigout Agents

<table>
<thead>
<tr>
<th>Name of Drug</th>
<th>Drug Tier</th>
<th>Requirements/Limits</th>
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</thead>
<tbody>
<tr>
<td>allopurinol oral tablet 100 mg, 300 mg*</td>
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</tr>
<tr>
<td>colchicine oral capsule 0.6 mg</td>
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</tr>
<tr>
<td>colchicine oral tablet 0.6 mg</td>
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<td></td>
</tr>
<tr>
<td>Name of Drug</td>
<td>Drug Tier</td>
<td>Requirements/Limits</td>
</tr>
<tr>
<td>-------------------------------------------------</td>
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<tr>
<td>colchicine-probenecid oral tablet 0.5-500 mg</td>
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<tr>
<td>febuxostat oral tablet 40 mg, 80 mg</td>
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</tr>
<tr>
<td>probenecid oral tablet 500 mg</td>
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**Antimigraine Agents - Treatment Of Migraine Headaches**

**Antimigraine Agents**

<table>
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<tr>
<th>Name of Drug</th>
<th>Drug Tier</th>
<th>Requirements/Limits</th>
</tr>
</thead>
<tbody>
<tr>
<td>NURTEC ORAL TABLET DISPERSIBLE 75 MG</td>
<td>3</td>
<td>PA; QL (15 EA per 30 days)</td>
</tr>
<tr>
<td>UBRELVY ORAL TABLET 100 MG, 50 MG</td>
<td>3</td>
<td>PA; QL (16 EA per 30 days)</td>
</tr>
</tbody>
</table>

**Ergot Alkaloids**

<table>
<thead>
<tr>
<th>Name of Drug</th>
<th>Drug Tier</th>
<th>Requirements/Limits</th>
</tr>
</thead>
<tbody>
<tr>
<td>dihydroergotamine mesylate nasal solution 4 mg/ml</td>
<td>5</td>
<td>QL (8 ML per 30 days)</td>
</tr>
<tr>
<td>ergotamine-caffeine oral tablet 1-100 mg</td>
<td>2</td>
<td></td>
</tr>
</tbody>
</table>

**Prophylactic**

<table>
<thead>
<tr>
<th>Name of Drug</th>
<th>Drug Tier</th>
<th>Requirements/Limits</th>
</tr>
</thead>
<tbody>
<tr>
<td>AIMOVIG SUBCUTANEOUS SOLUTION AUTO-INJECTOR 140 MG/ML, 70 MG/ML</td>
<td>3</td>
<td>PA</td>
</tr>
<tr>
<td>EMGALITY (300 MG DOSE) SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML</td>
<td>3</td>
<td>PA</td>
</tr>
<tr>
<td>EMGALITY SUBCUTANEOUS SOLUTION AUTO-INJECTOR 120 MG/ML</td>
<td>3</td>
<td>PA</td>
</tr>
<tr>
<td>EMGALITY SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 120 MG/ML</td>
<td>3</td>
<td>PA</td>
</tr>
</tbody>
</table>

**Serotonin (5-HT) Receptor Agonist**

<table>
<thead>
<tr>
<th>Name of Drug</th>
<th>Drug Tier</th>
<th>Requirements/Limits</th>
</tr>
</thead>
<tbody>
<tr>
<td>rizatriptan benzoate oral tablet 10 mg, 5 mg</td>
<td>2</td>
<td>QL (12 EA per 30 days)</td>
</tr>
<tr>
<td>rizatriptan benzoate oral tablet dispersible 10 mg, 5 mg</td>
<td>2</td>
<td>QL (12 EA per 30 days)</td>
</tr>
<tr>
<td>sumatriptan nasal solution 20 mg/act, 5 mg/act</td>
<td>2</td>
<td>QL (12 EA per 30 days)</td>
</tr>
<tr>
<td>sumatriptan succinate oral tablet 100 mg, 25 mg, 50 mg</td>
<td>2</td>
<td>QL (9 EA per 30 days)</td>
</tr>
<tr>
<td>sumatriptan succinate refill subcutaneous solution cartridge 4 mg/0.5ml, 6 mg/0.5ml</td>
<td>2</td>
<td>QL (4 ML per 30 days)</td>
</tr>
<tr>
<td>Name of Drug</td>
<td>Drug Tier</td>
<td>Requirements/Limits</td>
</tr>
<tr>
<td>----------------------------------------------------------</td>
<td>-----------</td>
<td>------------------------------</td>
</tr>
<tr>
<td>sumatriptan succinate subcutaneous solution 6 mg/0.5ml</td>
<td>2</td>
<td>QL (4 ML per 30 days)</td>
</tr>
<tr>
<td>sumatriptan succinate subcutaneous solution auto-injector 4 mg/0.5ml, 6 mg/0.5ml</td>
<td>2</td>
<td>QL (4 ML per 30 days)</td>
</tr>
</tbody>
</table>

### Antimyasthenic Agents - Treatment Of Myasthenia

#### Parasympathomimetics

<table>
<thead>
<tr>
<th>Name of Drug</th>
<th>Drug Tier</th>
<th>Requirements/Limits</th>
</tr>
</thead>
<tbody>
<tr>
<td>pyridostigmine bromide er oral tablet extended release 180 mg</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>pyridostigmine bromide oral tablet 60 mg*</td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>

### Antimycobacterials - Treatment For Infections By Tuberculosis-Type Organisms

#### Antimycobacterials, Other

<table>
<thead>
<tr>
<th>Name of Drug</th>
<th>Drug Tier</th>
<th>Requirements/Limits</th>
</tr>
</thead>
<tbody>
<tr>
<td>dapsone oral tablet 100 mg, 25 mg</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>PRIFTIN ORAL TABLET 150 MG</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>rifabutin oral capsule 150 mg</td>
<td>4</td>
<td></td>
</tr>
</tbody>
</table>

#### Antituberculars

<table>
<thead>
<tr>
<th>Name of Drug</th>
<th>Drug Tier</th>
<th>Requirements/Limits</th>
</tr>
</thead>
<tbody>
<tr>
<td>ethambutol hcl oral tablet 100 mg, 400 mg</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>isoniazid oral tablet 100 mg, 300 mg*</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>PASER ORAL PACKET 4 GM</td>
<td>4</td>
<td>PA</td>
</tr>
<tr>
<td>pretomanid oral tablet 200 mg</td>
<td>4</td>
<td>PA</td>
</tr>
<tr>
<td>pyrazinamide oral tablet 500 mg</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>rifampin intravenous solution reconstituted 600 mg</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>rifampin oral capsule 150 mg, 300 mg</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>SIRTURO ORAL TABLET 100 MG, 20 MG</td>
<td>5</td>
<td>PA</td>
</tr>
<tr>
<td>TRECATOR ORAL TABLET 250 MG</td>
<td>4</td>
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</table>

### Antineoplastics - Treatment Of Cancer

#### Alkylating Agents

<table>
<thead>
<tr>
<th>Name of Drug</th>
<th>Drug Tier</th>
<th>Requirements/Limits</th>
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<tbody>
<tr>
<td>cyclophosphamide oral capsule 25 mg, 50 mg</td>
<td>2</td>
<td>B/D</td>
</tr>
<tr>
<td>cyclophosphamide oral tablet 25 mg, 50 mg</td>
<td>2</td>
<td>B/D</td>
</tr>
<tr>
<td>LEUKERAN ORAL TABLET 2 MG</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>Name of Drug</td>
<td>Drug Tier</td>
<td>Requirements/Limits</td>
</tr>
<tr>
<td>--------------------------------------</td>
<td>-----------</td>
<td>--------------------</td>
</tr>
<tr>
<td>MATULANE ORAL CAPSULE 50 MG</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>VALCHLOR EXTERNAL GEL 0.016 %</td>
<td>5</td>
<td>PA</td>
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</table>

**Antiandrogens**

<table>
<thead>
<tr>
<th>Drug</th>
<th>Tier</th>
<th>Requirements/Limits</th>
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</thead>
<tbody>
<tr>
<td>abiraterone acetate oral tablet 250 mg</td>
<td>2</td>
<td>PA</td>
</tr>
<tr>
<td>abiraterone acetate oral tablet 500 mg</td>
<td>5</td>
<td>PA</td>
</tr>
<tr>
<td>bicalutamide oral tablet 50 mg*</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>ERLEADA ORAL TABLET 60 MG</td>
<td>5</td>
<td>PA</td>
</tr>
<tr>
<td>flutamide oral capsule 125 mg</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>nilutamide oral tablet 150 mg</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>NUBEQA ORAL TABLET 300 MG</td>
<td>5</td>
<td>PA</td>
</tr>
<tr>
<td>toremifene citrate oral tablet 60 mg</td>
<td>5</td>
<td>PA</td>
</tr>
<tr>
<td>XTANDI ORAL CAPSULE 40 MG</td>
<td>5</td>
<td>PA</td>
</tr>
<tr>
<td>XTANDI ORAL TABLET 40 MG, 80 MG</td>
<td>5</td>
<td>PA</td>
</tr>
<tr>
<td>YONSA ORAL TABLET 125 MG</td>
<td>5</td>
<td>PA</td>
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**Antiangiogenic Agents**

<table>
<thead>
<tr>
<th>Drug</th>
<th>Tier</th>
<th>Requirements/Limits</th>
</tr>
</thead>
<tbody>
<tr>
<td>lenalidomide oral capsule 10 mg, 15 mg, 2.5 mg, 20 mg, 25 mg, 5 mg</td>
<td>5</td>
<td>PA</td>
</tr>
<tr>
<td>POMALYST ORAL CAPSULE 1 MG, 2 MG, 3 MG, 4 MG</td>
<td>5</td>
<td>PA</td>
</tr>
<tr>
<td>REVLMID ORAL CAPSULE 10 MG, 15 MG, 2.5 mg, 20 mg, 25 mg, 5 MG</td>
<td>5</td>
<td>PA</td>
</tr>
<tr>
<td>THALOMID ORAL CAPSULE 100 MG, 150 MG, 200 MG, 50 MG</td>
<td>5</td>
<td>PA</td>
</tr>
</tbody>
</table>

**Antiestrogens/Modifiers**

<table>
<thead>
<tr>
<th>Drug</th>
<th>Tier</th>
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</thead>
<tbody>
<tr>
<td>EMCYT ORAL CAPSULE 140 MG</td>
<td>5</td>
</tr>
<tr>
<td>SOLTAMOX ORAL SOLUTION 10 MG/5ML</td>
<td>5</td>
</tr>
<tr>
<td>tamoxifen citrate oral tablet 10 mg, 20 mg*</td>
<td>1</td>
</tr>
</tbody>
</table>

**Antimetabolites**

<table>
<thead>
<tr>
<th>Drug</th>
<th>Tier</th>
<th>Requirements/Limits</th>
</tr>
</thead>
<tbody>
<tr>
<td>DROXIA ORAL CAPSULE 200 MG, 300 MG, 400 MG</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>hydroxyurea oral capsule 500 mg</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>INQOVI ORAL TABLET 35-100 MG</td>
<td>5</td>
<td>PA</td>
</tr>
<tr>
<td>ONUREG ORAL TABLET 200 MG, 300 MG</td>
<td>5</td>
<td>PA</td>
</tr>
<tr>
<td>Name of Drug</td>
<td>Drug Tier</td>
<td>Requirements/Limits</td>
</tr>
<tr>
<td>----------------------------------------------------------------------------</td>
<td>-----------</td>
<td>--------------------</td>
</tr>
<tr>
<td>PURIXAN ORAL SUSPENSION 2000 MG/100ML</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>TABLOID ORAL TABLET 40 MG</td>
<td>4</td>
<td>PA</td>
</tr>
<tr>
<td><strong>Antineoplastics, Other</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>besremi subcutaneous solution prefilled syringe 500 mcg/ml</td>
<td>5</td>
<td>PA</td>
</tr>
<tr>
<td>GAVRETO ORAL CAPSULE 100 MG</td>
<td>5</td>
<td>PA</td>
</tr>
<tr>
<td>IDHIFA ORAL TABLET 100 MG, 50 MG</td>
<td>5</td>
<td>PA</td>
</tr>
<tr>
<td>KISQALI FEMARA (400 MG DOSE) ORAL TABLET THERAPY PACK 200 &amp; 2.5 MG</td>
<td>5</td>
<td>PA</td>
</tr>
<tr>
<td>KISQALI FEMARA (600 MG DOSE) ORAL TABLET THERAPY PACK 200 &amp; 2.5 MG</td>
<td>5</td>
<td>PA</td>
</tr>
<tr>
<td>KISQALI FEMARA(200 MG DOSE) ORAL TABLET THERAPY PACK 200 &amp; 2.5 MG</td>
<td>5</td>
<td>PA</td>
</tr>
<tr>
<td>LONSURF ORAL TABLET 15-6.14 MG, 20-8.19 MG</td>
<td>5</td>
<td>PA</td>
</tr>
<tr>
<td>LUMAKRAS ORAL TABLET 120 MG</td>
<td>5</td>
<td>PA</td>
</tr>
<tr>
<td>LYNPARZA ORAL TABLET 100 MG, 150 MG</td>
<td>5</td>
<td>PA</td>
</tr>
<tr>
<td>LYSODREN ORAL TABLET 500 MG</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>NINLARO ORAL CAPSULE 2.3 MG, 3 MG, 4 MG</td>
<td>5</td>
<td>PA</td>
</tr>
<tr>
<td>ORGOVYX ORAL TABLET 120 MG</td>
<td>5</td>
<td>PA</td>
</tr>
<tr>
<td>RETEVMO ORAL CAPSULE 40 MG, 80 MG</td>
<td>5</td>
<td>PA</td>
</tr>
<tr>
<td>RYLAZE INTRAMUSCULAR SOLUTION 10 MG/0.5ML</td>
<td>5</td>
<td>PA</td>
</tr>
<tr>
<td>SYNRIBO SUBCUTANEOUS SOLUTION RECONSTITUTED 3.5 MG</td>
<td>5</td>
<td>PA</td>
</tr>
<tr>
<td>TICE BCG INTRAVESICAL SUSPENSION RECONSTITUTED 50 MG</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>TUKYSA ORAL TABLET 150 MG, 50 MG</td>
<td>5</td>
<td>PA</td>
</tr>
<tr>
<td>welireg oral tablet 40 mg</td>
<td>5</td>
<td>PA</td>
</tr>
<tr>
<td>XPOVIO (100 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 20 MG, 50 MG</td>
<td>5</td>
<td>PA</td>
</tr>
<tr>
<td>XPOVIO (40 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 20 MG, 40 MG</td>
<td>5</td>
<td>PA</td>
</tr>
<tr>
<td>Name of Drug</td>
<td>Drug Tier</td>
<td>Requirements/Limits</td>
</tr>
<tr>
<td>--------------------------------------------------</td>
<td>-----------</td>
<td>--------------------</td>
</tr>
<tr>
<td>XPOVIO (40 MG TWICE WEEKLY) ORAL TABLET THERAPY PACK 20 MG, 40 MG</td>
<td>5</td>
<td>PA</td>
</tr>
<tr>
<td>XPOVIO (60 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 20 MG, 60 MG</td>
<td>5</td>
<td>PA</td>
</tr>
<tr>
<td>XPOVIO (60 MG TWICE WEEKLY) ORAL TABLET THERAPY PACK 20 MG</td>
<td>5</td>
<td>PA</td>
</tr>
<tr>
<td>XPOVIO (80 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 20 MG, 40 MG</td>
<td>5</td>
<td>PA</td>
</tr>
<tr>
<td>XPOVIO (80 MG TWICE WEEKLY) ORAL TABLET THERAPY PACK 20 MG</td>
<td>5</td>
<td>PA</td>
</tr>
<tr>
<td>ZOLINZA ORAL CAPSULE 100 MG</td>
<td>5</td>
<td>PA</td>
</tr>
</tbody>
</table>

**Aromatase Inhibitors, 3rd Generation**

<table>
<thead>
<tr>
<th>Name of Drug</th>
<th>Drug Tier</th>
<th>Requirements/Limits</th>
</tr>
</thead>
<tbody>
<tr>
<td>anastrozole oral tablet 1 mg*</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>exemestane oral tablet 25 mg</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>letrozole oral tablet 2.5 mg*</td>
<td>1</td>
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</tr>
</tbody>
</table>

**Enzyme Inhibitors**

<table>
<thead>
<tr>
<th>Name of Drug</th>
<th>Drug Tier</th>
<th>Requirements/Limits</th>
</tr>
</thead>
<tbody>
<tr>
<td>IBRANCE ORAL TABLET 100 MG, 125 MG, 75 MG</td>
<td>5</td>
<td>PA</td>
</tr>
<tr>
<td>TIBSOVO ORAL TABLET 250 MG</td>
<td>5</td>
<td>PA</td>
</tr>
</tbody>
</table>

**Molecular Target Inhibitors**

<table>
<thead>
<tr>
<th>Name of Drug</th>
<th>Drug Tier</th>
<th>Requirements/Limits</th>
</tr>
</thead>
<tbody>
<tr>
<td>ALECENSA ORAL CAPSULE 150 MG</td>
<td>5</td>
<td>PA</td>
</tr>
<tr>
<td>ALUNBRIG ORAL TABLET 180 MG, 30 MG, 90 MG</td>
<td>5</td>
<td>PA</td>
</tr>
<tr>
<td>ALUNBRIG ORAL TABLET THERAPY PACK 90 &amp; 180 MG</td>
<td>5</td>
<td>PA</td>
</tr>
<tr>
<td>AYVAKIT ORAL TABLET 100 MG, 200 MG, 25 MG, 300 MG, 50 MG</td>
<td>5</td>
<td>PA</td>
</tr>
<tr>
<td>BALVERSA ORAL TABLET 3 MG, 4 MG, 5 MG</td>
<td>5</td>
<td>PA</td>
</tr>
<tr>
<td>BOSULIF ORAL TABLET 100 MG, 400 MG, 500 MG</td>
<td>5</td>
<td>PA</td>
</tr>
<tr>
<td>BRAFTOVI ORAL CAPSULE 75 MG</td>
<td>5</td>
<td>PA</td>
</tr>
<tr>
<td>BRUKINSA ORAL CAPSULE 80 MG</td>
<td>5</td>
<td>PA</td>
</tr>
<tr>
<td>CABOMETYX ORAL TABLET 20 MG, 40 MG, 60 MG</td>
<td>5</td>
<td>PA</td>
</tr>
<tr>
<td>CALQUENCE ORAL CAPSULE 100 MG</td>
<td>5</td>
<td>PA</td>
</tr>
<tr>
<td>calquence oral tablet 100 mg</td>
<td>5</td>
<td>PA</td>
</tr>
<tr>
<td>Name of Drug</td>
<td>Drug Tier</td>
<td>Requirements/Limits</td>
</tr>
<tr>
<td>-----------------------------------------------------------</td>
<td>-----------</td>
<td>---------------------</td>
</tr>
<tr>
<td>CAPRELSA ORAL TABLET 100 MG, 300 MG</td>
<td>5</td>
<td>PA</td>
</tr>
<tr>
<td>COMETRIQ (100 MG DAILY DOSE) ORAL KIT 80 &amp; 20 MG</td>
<td>5</td>
<td>PA</td>
</tr>
<tr>
<td>COMETRIQ (140 MG DAILY DOSE) ORAL KIT 3 X 20 MG &amp; 80 MG</td>
<td>5</td>
<td>PA</td>
</tr>
<tr>
<td>COMETRIQ (60 MG DAILY DOSE) ORAL KIT 20 MG</td>
<td>5</td>
<td>PA</td>
</tr>
<tr>
<td>copiktra oral capsule 15 mg, 25 mg</td>
<td>5</td>
<td>PA</td>
</tr>
<tr>
<td>COTELLIC ORAL TABLET 20 MG</td>
<td>5</td>
<td>PA</td>
</tr>
<tr>
<td>DAURISMO ORAL TABLET 100 MG, 25 MG</td>
<td>5</td>
<td>PA</td>
</tr>
<tr>
<td>ERIVEDGE ORAL CAPSULE 150 MG</td>
<td>5</td>
<td>PA</td>
</tr>
<tr>
<td>erlotinib hcl oral tablet 100 mg, 150 mg, 25 mg</td>
<td>5</td>
<td>PA</td>
</tr>
<tr>
<td>everolimus oral tablet 10 mg, 2.5 mg, 5 mg, 7.5 mg</td>
<td>5</td>
<td>PA</td>
</tr>
<tr>
<td>everolimus oral tablet soluble 3 mg, 5 mg</td>
<td>5</td>
<td>PA</td>
</tr>
<tr>
<td>exkivity oral capsule 40 mg</td>
<td>5</td>
<td>PA</td>
</tr>
<tr>
<td>FOTIVDA ORAL CAPSULE 0.89 MG, 1.34 MG</td>
<td>5</td>
<td>PA</td>
</tr>
<tr>
<td>GILOTRIF ORAL TABLET 20 MG, 30 MG, 40 MG</td>
<td>5</td>
<td>PA</td>
</tr>
<tr>
<td>IBRANCE ORAL CAPSULE 100 MG, 125 MG, 75 MG</td>
<td>5</td>
<td>PA</td>
</tr>
<tr>
<td>ICLUSIG ORAL TABLET 10 MG, 15 MG, 30 MG, 45 MG</td>
<td>5</td>
<td>PA</td>
</tr>
<tr>
<td>imatinib mesylate oral tablet 100 mg, 400 mg</td>
<td>2</td>
<td>PA</td>
</tr>
<tr>
<td>IMBRUVICA ORAL CAPSULE 140 MG, 70 MG</td>
<td>5</td>
<td>PA</td>
</tr>
<tr>
<td>imbruvica oral suspension 70 mg/ml</td>
<td>5</td>
<td>PA</td>
</tr>
<tr>
<td>IMBRUVICA ORAL TABLET 140 MG, 280 MG, 420 MG, 560 MG</td>
<td>5</td>
<td>PA</td>
</tr>
<tr>
<td>INLYTA ORAL TABLET 1 MG, 5 MG</td>
<td>5</td>
<td>PA</td>
</tr>
<tr>
<td>INREBIC ORAL CAPSULE 100 MG</td>
<td>5</td>
<td>PA</td>
</tr>
<tr>
<td>IRESSA ORAL TABLET 250 MG</td>
<td>5</td>
<td>PA</td>
</tr>
<tr>
<td>Name of Drug</td>
<td>Drug Tier</td>
<td>Requirements/Limits</td>
</tr>
<tr>
<td>--------------------------------------------------</td>
<td>-----------</td>
<td>---------------------</td>
</tr>
<tr>
<td>JAKAFI ORAL TABLET 10 MG, 15 MG, 20 MG, 25 MG, 5 MG</td>
<td>5</td>
<td>PA</td>
</tr>
<tr>
<td>KISQALI (200 MG DOSE) ORAL TABLET THERAPY PACK 200 MG</td>
<td>5</td>
<td>PA</td>
</tr>
<tr>
<td>KISQALI (400 MG DOSE) ORAL TABLET THERAPY PACK 200 MG</td>
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<td>KISQALI (600 MG DOSE) ORAL TABLET THERAPY PACK 200 MG</td>
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<tr>
<td>KOSELUGO ORAL CAPSULE 10 MG, 25 MG</td>
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<tr>
<td>lapatinib ditosylate oral tablet 250 mg</td>
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<tr>
<td>LENVIMA (10 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 10 MG</td>
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<td>LENVIMA (12 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 3 X 4 MG</td>
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<tr>
<td>LENVIMA (14 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 10 &amp; 4 MG</td>
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<tr>
<td>LENVIMA (18 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 10 MG &amp; 2 X 4 MG</td>
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<td>LENVIMA (20 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 2 X 10 MG</td>
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<tr>
<td>LENVIMA (24 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 2 X 10 MG &amp; 4 MG</td>
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<td>LENVIMA (4 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 4 MG</td>
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<td>LENVIMA (8 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 2 X 4 MG</td>
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<tr>
<td>LORBRENA ORAL TABLET 100 MG, 25 MG</td>
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<td>PA</td>
</tr>
<tr>
<td>MEKINIST ORAL TABLET 0.5 MG, 2 MG</td>
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<td>PA</td>
</tr>
<tr>
<td>MEKTOVI ORAL TABLET 15 MG</td>
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<td>PA</td>
</tr>
<tr>
<td>NERLYNX ORAL TABLET 40 MG</td>
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<tr>
<td>ODOMZO ORAL CAPSULE 200 MG</td>
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<td>PA</td>
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<tr>
<td>PEMAZYRE ORAL TABLET 13.5 MG, 4.5 MG, 9 MG</td>
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<td>PA</td>
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<tr>
<td>PIQRAY (200 MG DAILY DOSE) ORAL TABLET THERAPY PACK 200 MG</td>
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<td>Name of Drug</td>
<td>Drug Tier</td>
<td>Requirements/Limits</td>
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<td>PIQRAY (250 MG DAILY DOSE) ORAL TABLET THERAPY PACK 200 &amp; 50 MG</td>
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<td>PIQRAY (300 MG DAILY DOSE) ORAL TABLET THERAPY PACK 2 X 150 MG</td>
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<td>QINLOCK ORAL TABLET 50 MG</td>
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<tr>
<td>ROZLYTREK ORAL CAPSULE 100 MG, 200 MG</td>
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<td>PA</td>
</tr>
<tr>
<td>RUBRACA ORAL TABLET 200 MG, 250 MG, 300 MG</td>
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<td>PA</td>
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<tr>
<td>RYDAPT ORAL CAPSULE 25 MG</td>
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<td>PA</td>
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<tr>
<td>scemblix oral tablet 20 mg, 40 mg</td>
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<td>PA</td>
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<tr>
<td>sorafenib tosylate oral tablet 200 mg</td>
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<td>PA</td>
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<td>SPRYCEL ORAL TABLET 100 MG, 140 MG, 20 MG, 50 MG, 70 MG, 80 MG</td>
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<td>STIVARGA ORAL TABLET 40 MG</td>
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</tr>
<tr>
<td>sunitinib malate oral capsule 12.5 mg, 25 mg, 37.5 mg, 50 mg</td>
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<td>TABRECTA ORAL TABLET 150 MG, 200 MG</td>
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<tr>
<td>TAFINLAR ORAL CAPSULE 50 MG, 75 MG</td>
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<td>TAGRISSO ORAL TABLET 40 MG, 80 MG</td>
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<td>TALZENNA ORAL CAPSULE 0.25 MG, 1 MG</td>
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<td>talzenna oral capsule 0.5 mg, 0.75 mg</td>
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<tr>
<td>TASIGNA ORAL CAPSULE 150 MG, 200 MG, 50 MG</td>
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<td>TAZVERIK ORAL TABLET 200 MG</td>
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<tr>
<td>TEPMETKO ORAL TABLET 225 MG</td>
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<td>truseltiq (100mg daily dose) oral capsule therapy pack 100 mg</td>
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<tr>
<td>truseltiq (125mg daily dose) oral capsule therapy pack 100 &amp; 25 mg</td>
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<tr>
<td>truseltiq (50mg daily dose) oral capsule therapy pack 25 mg</td>
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<tr>
<td>truseltiq (75mg daily dose) oral capsule therapy pack 25 mg</td>
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<tr>
<td>TURALIO ORAL CAPSULE 200 MG</td>
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<tr>
<td>Name of Drug</td>
<td>Drug Tier</td>
<td>Requirements/Limits</td>
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<tr>
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<tr>
<td>VENCLEXTA ORAL TABLET 10 MG</td>
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<tr>
<td>VENCLEXTA ORAL TABLET 100 MG, 50 MG</td>
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<tr>
<td>VENCLEXTA STARTING PACK ORAL TABLET THERAPY PACK 10 &amp; 50 &amp; 100 MG</td>
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<tr>
<td>VERZENIO ORAL TABLET 100 MG, 150 MG, 200 MG, 50 MG</td>
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<tr>
<td>VIJOICE ORAL TABLET THERAPY PACK 125 MG, 200 &amp; 50 MG, 50 MG</td>
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<td>VITRAKVI ORAL CAPSULE 100 MG, 25 MG</td>
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<td>VITRAKVI ORAL SOLUTION 20 MG/ML</td>
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<td>VIZIMPRO ORAL TABLET 15 MG, 30 MG, 45 MG</td>
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<tr>
<td>vonjo oral capsule 100 mg</td>
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<tr>
<td>VOTRIENT ORAL TABLET 200 MG</td>
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<tr>
<td>XALKORI ORAL CAPSULE 200 MG, 250 MG</td>
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<td>PA</td>
</tr>
<tr>
<td>XOSPATA ORAL TABLET 40 MG</td>
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<tr>
<td>ZEJULA ORAL CAPSULE 100 MG</td>
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<tr>
<td>ZELBORAF ORAL TABLET 240 MG</td>
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<tr>
<td>ZYDELIG ORAL TABLET 100 MG, 150 MG</td>
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<tr>
<td>ZYKADIA ORAL TABLET 150 MG</td>
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<td>Retinoids</td>
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<td>bexarotene external gel 1%</td>
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<td>bexarotene oral capsule 75 mg</td>
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<td>panretin external gel 0.1%</td>
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<td>tretinoin oral capsule 10 mg</td>
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<td>Treatment Adjuncts</td>
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<td>leucovorin calcium oral tablet 10 mg, 15 mg, 25 mg, 5 mg</td>
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<td>MESNEX ORAL TABLET 400 MG</td>
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<tr>
<td>Antiparasitics - Treatment Of Infections From Parasites</td>
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<td>Anthelmintics</td>
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<tr>
<td>albendazole oral tablet 200 mg</td>
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<tr>
<td>ivermectin oral tablet 3 mg*</td>
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<tr>
<td>Name of Drug</td>
<td>Drug Tier</td>
<td>Requirements/Limits</td>
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<td>praziquantel oral tablet 600 mg</td>
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<td><strong>Antiprotozoals</strong></td>
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<td>atovaquone oral suspension 750 mg/5ml</td>
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<td>atovaquone-proguanil hcl oral tablet 250-100 mg, 62.5-25 mg</td>
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<td>benznidazole oral tablet 100 mg 12.5 mg</td>
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<tr>
<td>chloroquine phosphate oral tablet 250 mg, 500 mg</td>
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<td>COARTEM ORAL TABLET 20-120 MG</td>
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<td>hydroxychloroquine sulfate oral tablet 100 mg, 200 mg, 300 mg, 400 mg*</td>
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<tr>
<td>LAMPIT ORAL TABLET 120 MG, 30 MG</td>
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<tr>
<td>mefloquine hcl oral tablet 250 mg</td>
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<td>nitazoxanide oral tablet 500 mg</td>
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<td>pentamidine isethionate inhalation solution reconstituted 300 mg</td>
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<td>B/D</td>
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<td>pentamidine isethionate injection solution reconstituted 300 mg</td>
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<td>PA</td>
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<tr>
<td>primaquine phosphate oral tablet 26.3 (15 base) mg</td>
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<tr>
<td>pyrimethamine oral tablet 25 mg</td>
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<td>QL (90 EA per 30 days)</td>
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<tr>
<td>quinine sulfate oral capsule 324 mg</td>
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<td><strong>Antiparkinson Agents - Treatment Of Parkinson's Disease</strong></td>
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<td><strong>Anticholinergics</strong></td>
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<tr>
<td>benztropine mesylate oral tablet 0.5 mg, 1 mg, 2 mg*</td>
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<tr>
<td>trihexyphenidyl hcl oral solution 0.4 mg/ml</td>
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<td>PA</td>
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<td>trihexyphenidyl hcl oral tablet 2 mg, 5 mg*</td>
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<td><strong>Antiparkinson Agents, Other</strong></td>
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<tr>
<td>amantadine hcl oral capsule 100 mg*</td>
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<tr>
<td>amantadine hcl oral solution 50 mg/5ml*</td>
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</tr>
<tr>
<td>amantadine hcl oral syrup 50 mg/5ml*</td>
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<tr>
<td>Name of Drug</td>
<td>Drug Tier</td>
<td>Requirements/Limits</td>
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<tr>
<td>amantadine hcl oral tablet 100 mg*</td>
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<tr>
<td>carbidopa-levodopa-entacapone oral tablet 12.5-50-200 mg, 18.75-75-200 mg, 25-100-200 mg, 31.25-125-200 mg, 37.5-150-200 mg, 50-200-200 mg</td>
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<td>entacapone oral tablet 200 mg</td>
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<tr>
<td>ONGENTYS ORAL CAPSULE 25 MG, 50 MG</td>
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**Dopamine Agonists**

<table>
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<tr>
<td>apomorphine hcl subcutaneous solution cartridge 30 mg/3ml</td>
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<tr>
<td>bromocriptine mesylate oral capsule 5 mg</td>
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<tr>
<td>bromocriptine mesylate oral tablet 2.5 mg</td>
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<tr>
<td>GOCOVRI ORAL CAPSULE EXTENDED RELEASE 24 HOUR 137 MG, 68.5 MG</td>
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<tr>
<td>KYNMOBI SUBLINGUAL FILM 10 MG, 15 MG, 20 MG, 25 MG, 30 MG</td>
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<td>PA</td>
</tr>
<tr>
<td>NEUPRO TRANSDERMAL PATCH 24 HOUR 1 MG/24HR, 2 MG/24HR, 3 MG/24HR, 4 MG/24HR, 6 MG/24HR, 8 MG/24HR</td>
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<td>pramipexole dihydrochloride er oral tablet extended release 24 hour 0.375 mg, 0.75 mg, 1.5 mg, 2.25 mg, 3 mg, 3.75 mg, 4.5 mg</td>
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<td>pramipexole dihydrochloride oral tablet 0.125 mg, 0.25 mg, 0.5 mg, 0.75 mg, 1 mg, 1.5 mg*</td>
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<td>ropinirole hcl er oral tablet extended release 24 hour 12 mg, 2 mg, 4 mg, 6 mg, 8 mg</td>
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<tr>
<td>ropinirole hcl oral tablet 0.25 mg, 0.5 mg, 1 mg, 2 mg, 3 mg, 4 mg, 5 mg*</td>
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**Dopamine Precursors And/Or L-Amino Acid Decarboxylase Inhibitors**

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<tr>
<th>Name of Drug</th>
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<th>Requirements/Limits</th>
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<tbody>
<tr>
<td>carbidopa oral tablet 25 mg</td>
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<tr>
<td>carbidopa-levodopa er oral tablet extended release 25-100 mg, 50-200 mg*</td>
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<tr>
<td>Name of Drug</td>
<td>Drug Tier</td>
<td>Requirements/Limits</td>
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<tr>
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<td><strong>carbidopa-levodopa oral tablet</strong> 10-100 mg, 25-100 mg, 25-250 mg*</td>
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<tr>
<td><strong>carbidopa-levodopa oral tablet dispersible</strong> 10-100 mg, 25-100 mg, 25-250 mg*</td>
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<td><strong>Monoamine Oxidase B (MAO-B) Inhibitors</strong></td>
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<tr>
<td>rasagiline mesylate oral tablet 0.5 mg, 1 mg</td>
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<tr>
<td>selegiline hcl oral capsule 5 mg</td>
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<tr>
<td>selegiline hcl oral tablet 5 mg</td>
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<td><strong>Antipsychotics - Treatment Of Behavioral And Emotional Disorders</strong></td>
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<td><strong>1st Generation/Typical</strong></td>
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<td>fluphenazine decanoate injection solution 25 mg/ml</td>
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<td>fluphenazine hcl injection solution 2.5 mg/ml</td>
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<td>fluphenazine hcl oral concentrate 5 mg/ml</td>
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<td>fluphenazine hcl oral elixir 2.5 mg/5ml</td>
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<td>fluphenazine hcl oral tablet 1 mg, 10 mg, 2.5 mg, 5 mg</td>
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<tr>
<td>haloperidol decanoate intramuscular solution 100 mg/ml, 100 mg/ml 1 ml, 50 mg/ml, 50 mg/ml(1ml)</td>
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<td>haloperidol lactate injection solution 5 mg/ml</td>
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<td>haloperidol lactate oral concentrate 2 mg/ml*</td>
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<td>haloperidol oral tablet 0.5 mg, 1 mg, 10 mg, 2 mg, 20 mg, 5 mg*</td>
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<td>loxapine succinate oral capsule 10 mg, 25 mg, 5 mg, 50 mg</td>
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<td>molindone hcl oral tablet 10 mg, 25 mg</td>
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<td>molindone hcl oral tablet 5 mg</td>
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<td>pimozide oral tablet 1 mg, 2 mg</td>
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<tr>
<td>thioridazine hcl oral tablet 10 mg, 100 mg, 25 mg, 50 mg</td>
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</tr>
<tr>
<td>Name of Drug</td>
<td>Drug Tier</td>
<td>Requirements/Limits</td>
</tr>
<tr>
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<td>thiothixene oral capsule 1 mg, 10 mg, 2 mg, 5 mg</td>
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<td>trifluoperazine hcl oral tablet 1 mg, 10 mg, 2 mg, 5 mg</td>
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<td><strong>2nd Generation/Atypical</strong></td>
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<tr>
<td>ABILIFY MAINTENA INTRAMUSCULAR PREFILLED SYRINGE 300 MG, 400 MG</td>
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<td>PA; QL (1 EA per 28 days)</td>
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<tr>
<td>ABILIFY MAINTENA INTRAMUSCULAR SUSPENSION RECONSTITUTED ER 300 MG, 400 MG</td>
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<td>PA; QL (1 EA per 28 days)</td>
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<tr>
<td>aripiprazole oral solution 1 mg/ml</td>
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<td>QL (900 ML per 30 days)</td>
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<td>aripiprazole oral tablet 10 mg, 15 mg, 2 mg, 20 mg, 30 mg, 5 mg</td>
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<td>QL (30 EA per 30 days)</td>
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<tr>
<td>aripiprazole oral tablet dispersible 10 mg, 15 mg</td>
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<td>QL (60 EA per 30 days)</td>
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<td>ARISTADA INITIO INTRAMUSCULAR PREFILLED SYRINGE 675 MG/2.4ML</td>
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<tr>
<td>ARISTADA INTRAMUSCULAR PREFILLED SYRINGE 1064 MG/3.9ML</td>
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<td>PA; QL (3.9 ML per 56 days)</td>
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<tr>
<td>ARISTADA INTRAMUSCULAR PREFILLED SYRINGE 441 MG/1.6ML</td>
<td>5</td>
<td>PA; QL (1.6 ML per 28 days)</td>
</tr>
<tr>
<td>ARISTADA INTRAMUSCULAR PREFILLED SYRINGE 662 MG/2.4ML</td>
<td>5</td>
<td>PA; QL (2.4 ML per 28 days)</td>
</tr>
<tr>
<td>ARISTADA INTRAMUSCULAR PREFILLED SYRINGE 882 MG/3.2ML</td>
<td>5</td>
<td>PA; QL (3.2 ML per 28 days)</td>
</tr>
<tr>
<td>asenapine maleate sublingual tablet sublingual 10 mg, 2.5 mg, 5 mg</td>
<td>2</td>
<td>QL (60 EA per 30 days)</td>
</tr>
<tr>
<td>caplyta oral capsule 10.5 mg, 21 mg</td>
<td>5</td>
<td>PA</td>
</tr>
<tr>
<td>CAPLYTA ORAL CAPSULE 42 MG</td>
<td>5</td>
<td>PA</td>
</tr>
<tr>
<td>FANAPT ORAL TABLET 1 MG, 10 MG, 12 MG, 2 MG, 4 MG, 6 MG, 8 MG</td>
<td>4</td>
<td>PA; QL (60 EA per 30 days)</td>
</tr>
<tr>
<td>FANAPT TITRATION PACK ORAL TABLET 1 &amp; 2 &amp; 4 &amp; 6 MG</td>
<td>4</td>
<td>PA</td>
</tr>
<tr>
<td>INVEGA SUSTENNA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 117 MG/0.75ML</td>
<td>5</td>
<td>QL (0.75 ML per 28 days)</td>
</tr>
<tr>
<td>INVEGA SUSTENNA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 156 MG/ML</td>
<td>5</td>
<td>QL (1 ML per 28 days)</td>
</tr>
<tr>
<td>Name of Drug</td>
<td>Drug Tier</td>
<td>Requirements/Limits</td>
</tr>
<tr>
<td>--------------------------------------------------</td>
<td>-----------</td>
<td>------------------------------</td>
</tr>
<tr>
<td>INVEGA SUSTENNA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 234 MG/1.5ML</td>
<td>5</td>
<td>QL (1.5 ML per 28 days)</td>
</tr>
<tr>
<td>INVEGA SUSTENNA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 39 MG/0.25ML</td>
<td>3</td>
<td>QL (0.25 ML per 28 days)</td>
</tr>
<tr>
<td>INVEGA SUSTENNA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 78 MG/0.5ML</td>
<td>5</td>
<td>QL (0.5 ML per 28 days)</td>
</tr>
<tr>
<td>INVEGA TRINZA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 273 MG/0.88ML</td>
<td>5</td>
<td>PA; QL (0.875 ML per 84 days)</td>
</tr>
<tr>
<td>INVEGA TRINZA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 410 MG/1.32ML</td>
<td>5</td>
<td>PA; QL (1.315 ML per 84 days)</td>
</tr>
<tr>
<td>INVEGA TRINZA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 546 MG/1.75ML</td>
<td>5</td>
<td>PA; QL (1.75 ML per 84 days)</td>
</tr>
<tr>
<td>INVEGA TRINZA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 819 MG/2.63ML</td>
<td>5</td>
<td>PA; QL (2.625 ML per 84 days)</td>
</tr>
<tr>
<td>LATUDA ORAL TABLET 120 MG, 20 MG, 40 MG, 60 MG</td>
<td>4</td>
<td>QL (30 EA per 30 days)</td>
</tr>
<tr>
<td>LATUDA ORAL TABLET 80 MG</td>
<td>4</td>
<td>QL (60 EA per 30 days)</td>
</tr>
<tr>
<td>lybalvi oral tablet 10-10 mg, 15-10 mg, 20-10 mg, 5-10 mg</td>
<td>5</td>
<td>PA</td>
</tr>
<tr>
<td>NUPLAZID ORAL CAPSULE 34 MG</td>
<td>5</td>
<td>PA; QL (30 EA per 30 days)</td>
</tr>
<tr>
<td>NUPLAZID ORAL TABLET 10 MG</td>
<td>5</td>
<td>PA; QL (30 EA per 30 days)</td>
</tr>
<tr>
<td>olanzapine intramuscular solution reconstituted 10 mg</td>
<td>4</td>
<td>QL (90 EA per 30 days)</td>
</tr>
<tr>
<td>olanzapine oral tablet 10 mg, 15 mg, 2.5 mg, 20 mg, 5 mg, 7.5 mg*</td>
<td>1</td>
<td>QL (30 EA per 30 days)</td>
</tr>
<tr>
<td>olanzapine oral tablet dispersible 10 mg, 15 mg, 20 mg, 5 mg</td>
<td>2</td>
<td>QL (30 EA per 30 days)</td>
</tr>
<tr>
<td>paliperidone er oral tablet extended release 24 hour 1.5 mg, 3 mg, 9 mg</td>
<td>2</td>
<td>PA; QL (30 EA per 30 days)</td>
</tr>
<tr>
<td>paliperidone er oral tablet extended release 24 hour 6 mg</td>
<td>2</td>
<td>PA; QL (60 EA per 30 days)</td>
</tr>
<tr>
<td>PERSERIS SUBCUTANEOUS PREFILLED SYRINGE 120 MG, 90 MG</td>
<td>5</td>
<td>PA; QL (1 EA per 28 days)</td>
</tr>
<tr>
<td>Name of Drug</td>
<td>Drug Tier</td>
<td>Requirements/Limits</td>
</tr>
<tr>
<td>--------------------------------------------------</td>
<td>-----------</td>
<td>------------------------------</td>
</tr>
<tr>
<td>quetiapine fumarate er oral tablet extended release 24 hour 150 mg, 200 mg</td>
<td>2</td>
<td>QL (30 EA per 30 days)</td>
</tr>
<tr>
<td>quetiapine fumarate er oral tablet extended release 24 hour 300 mg, 400 mg, 50 mg</td>
<td>2</td>
<td>QL (60 EA per 30 days)</td>
</tr>
<tr>
<td>quetiapine fumarate oral tablet 100 mg, 150 mg, 200 mg, 300 mg, 400 mg*</td>
<td>1</td>
<td>QL (60 EA per 30 days)</td>
</tr>
<tr>
<td>quetiapine fumarate oral tablet 25 mg, 50 mg*</td>
<td>1</td>
<td>QL (90 EA per 30 days)</td>
</tr>
<tr>
<td>REXULTI ORAL TABLET 0.25 MG, 0.5 MG, 1 MG, 2 MG, 3 MG, 4 MG</td>
<td>5</td>
<td>PA; QL (30 EA per 30 days)</td>
</tr>
<tr>
<td>RISPERDAL CONSTA INTRAMUSCULAR SUSPENSION RECONSTITUTED ER 12.5 MG</td>
<td>3</td>
<td>QL (2 EA per 28 days)</td>
</tr>
<tr>
<td>RISPERDAL CONSTA INTRAMUSCULAR SUSPENSION RECONSTITUTED ER 25 MG, 37.5 MG, 50 MG</td>
<td>5</td>
<td>QL (2 EA per 28 days)</td>
</tr>
<tr>
<td>risperidone oral solution 1 mg/ml</td>
<td>2</td>
<td>QL (480 ML per 30 days)</td>
</tr>
<tr>
<td>risperidone oral tablet 0.25 mg, 0.5 mg, 1 mg, 2 mg, 3 mg*</td>
<td>1</td>
<td>QL (60 EA per 30 days)</td>
</tr>
<tr>
<td>risperidone oral tablet 4 mg*</td>
<td>1</td>
<td>QL (120 EA per 30 days)</td>
</tr>
<tr>
<td>risperidone oral tablet dispersible 0.25 mg, 0.5 mg, 1 mg, 2 mg, 3 mg</td>
<td>2</td>
<td>QL (60 EA per 30 days)</td>
</tr>
<tr>
<td>risperidone oral tablet dispersible 4 mg</td>
<td>2</td>
<td>QL (120 EA per 30 days)</td>
</tr>
<tr>
<td>SECUADO TRANSDERMAL PATCH 24 HOUR 3.8 MG/24HR, 5.7 MG/24HR, 7.6 MG/24HR</td>
<td>5</td>
<td>PA; QL (30 EA per 30 days)</td>
</tr>
<tr>
<td>VRAYLAR ORAL CAPSULE 1.5 MG, 3 MG, 4.5 MG, 6 MG</td>
<td>5</td>
<td>PA; QL (30 EA per 30 days)</td>
</tr>
<tr>
<td>VRAYLAR ORAL CAPSULE THERAPY PACK 1.5 &amp; 3 MG</td>
<td>4</td>
<td>PA; QL (14 EA per 365 days)</td>
</tr>
<tr>
<td>ziprasidone hcl oral capsule 20 mg, 40 mg, 60 mg, 80 mg</td>
<td>2</td>
<td>QL (60 EA per 30 days)</td>
</tr>
<tr>
<td>ziprasidone mesylate intramuscular solution reconstituted 20 mg</td>
<td>2</td>
<td>QL (6 EA per 3 days)</td>
</tr>
<tr>
<td>ZYPREXA RELPREVV INTRAMUSCULAR SUSPENSION RECONSTITUTED 210 MG, 300 MG</td>
<td>5</td>
<td>PA; QL (2 EA per 28 days)</td>
</tr>
<tr>
<td>Name of Drug</td>
<td>Drug Tier</td>
<td>Requirements/Limits</td>
</tr>
<tr>
<td>----------------------------------------------------------------------------</td>
<td>-----------</td>
<td>--------------------------</td>
</tr>
<tr>
<td>ZYPREXA RELPREVV INTRAMUSCULAR SUSPENSION RECONSTITUTED 405 MG</td>
<td>5</td>
<td>PA; QL (1 EA per 28 days)</td>
</tr>
</tbody>
</table>

**Treatment-Resistant**

<table>
<thead>
<tr>
<th>Name of Drug</th>
<th>Drug Tier</th>
<th>Requirements/Limits</th>
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</thead>
<tbody>
<tr>
<td>clozapine oral tablet 100 mg</td>
<td>2</td>
<td>QL (270 EA per 30 days)</td>
</tr>
<tr>
<td>clozapine oral tablet 200 mg</td>
<td>2</td>
<td>QL (120 EA per 30 days)</td>
</tr>
<tr>
<td>clozapine oral tablet 25 mg, 50 mg</td>
<td>2</td>
<td>QL (90 EA per 30 days)</td>
</tr>
<tr>
<td>clozapine oral tablet dispersible 100 mg</td>
<td>2</td>
<td>QL (270 EA per 30 days)</td>
</tr>
<tr>
<td>clozapine oral tablet dispersible 12.5 mg, 25 mg</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>clozapine oral tablet dispersible 150 mg</td>
<td>2</td>
<td>QL (180 EA per 30 days)</td>
</tr>
<tr>
<td>clozapine oral tablet dispersible 200 mg</td>
<td>2</td>
<td>QL (120 EA per 30 days)</td>
</tr>
<tr>
<td>VERSACLOZ ORAL SUSPENSION 50 MG/ML</td>
<td>4</td>
<td>QL (540 ML per 30 days)</td>
</tr>
</tbody>
</table>

**Antispasticity Agents - Treatment Of Muscle Spasms**

**Antispasticity Agents**

<table>
<thead>
<tr>
<th>Name of Drug</th>
<th>Drug Tier</th>
<th>Requirements/Limit</th>
</tr>
</thead>
<tbody>
<tr>
<td>baclofen oral tablet 10 mg, 20 mg, 5 mg*</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>dantrolene sodium oral capsule 100 mg, 25 mg, 50 mg</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>tizanidine hcl oral tablet 2 mg, 4 mg*</td>
<td>1</td>
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</tr>
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</table>

**Antivirals - Treatment Of Infections By Viruses**

**Anti-Cytomegalovirus (CMV) Agents**

<table>
<thead>
<tr>
<th>Name of Drug</th>
<th>Drug Tier</th>
<th>Requirements/Limit</th>
</tr>
</thead>
<tbody>
<tr>
<td>PREVYMIS ORAL TABLET 240 MG, 480 MG</td>
<td>5</td>
<td>PA</td>
</tr>
<tr>
<td>valganciclovir hcl oral solution reconstituted 50 mg/ml</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>valganciclovir hcl oral tablet 450 mg</td>
<td>2</td>
<td></td>
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</tbody>
</table>

**Anti-Hepatitis B (HBV) Agents**

<table>
<thead>
<tr>
<th>Name of Drug</th>
<th>Drug Tier</th>
<th>Requirements/Limit</th>
</tr>
</thead>
<tbody>
<tr>
<td>adefovir dipivoxil oral tablet 10 mg</td>
<td>4</td>
<td>PA</td>
</tr>
<tr>
<td>BARACLE ORAL SOLUTION 0.05 MG/ML</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>entecavir oral tablet 0.5 mg, 1 mg</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>EPIVIR HBV ORAL SOLUTION 5 MG/ML</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>lamivudine oral solution 10 mg/ml</td>
<td>2</td>
<td>QL (30 EA per 30 days)</td>
</tr>
<tr>
<td>lamivudine oral tablet 100 mg, 300 mg</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Name of Drug</td>
<td>Drug Tier</td>
<td>Requirements/Limits</td>
</tr>
<tr>
<td>-------------------------------------------------------</td>
<td>-----------</td>
<td>--------------------------------------</td>
</tr>
<tr>
<td>lamivudine oral tablet 150 mg</td>
<td>2</td>
<td>QL (60 EA per 30 days)</td>
</tr>
<tr>
<td>tenofovir disoproxil fumarate oral tablet 300 mg</td>
<td>2</td>
<td>QL (30 EA per 30 days)</td>
</tr>
<tr>
<td>VEMILDY ORAL TABLET 25 MG</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>VIREAD ORAL POWDER 40 MG/GM</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>VIREAD ORAL TABLET 150 MG, 200 MG, 250 MG</td>
<td>5</td>
<td>QL (30 EA per 30 days)</td>
</tr>
<tr>
<td><strong>Anti-Hepatitis C (HCV) Agents</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>mavyret oral packet 50-20 mg</td>
<td>5</td>
<td>PA</td>
</tr>
<tr>
<td>MAVRET ORAL TABLET 100-40 MG</td>
<td>5</td>
<td>PA</td>
</tr>
<tr>
<td>ribavirin oral capsule 200 mg</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>ribavirin oral tablet 200 mg</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>sofosbuvir-velpatasvir oral tablet 400-100 mg</td>
<td>5</td>
<td>PA</td>
</tr>
<tr>
<td>VOSEVI ORAL TABLET 400-100-100 MG</td>
<td>5</td>
<td>PA</td>
</tr>
<tr>
<td><strong>Antiherpetic Agents</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>acyclovir oral capsule 200 mg*</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>acyclovir oral suspension 200 mg/5ml*</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>acyclovir oral tablet 400 mg, 800 mg*</td>
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</tr>
<tr>
<td>acyclovir sodium intravenous solution 50 mg/ml</td>
<td>2</td>
<td>B/D</td>
</tr>
<tr>
<td>famciclovir oral tablet 125 mg, 250 mg, 500 mg</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>trifluridine ophthalmic solution 1 %</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>valacyclovir hcl oral tablet 1 gm, 500 mg</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td><strong>Anti-HIV Agents, Integrase Inhibitors (INSTI)</strong></td>
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<tr>
<td>biktarvy oral tablet 30-120-15 mg</td>
<td>5</td>
<td>QL (30 EA per 30 days)</td>
</tr>
<tr>
<td>BIKTARVY ORAL TABLET 50-200-25 MG</td>
<td>5</td>
<td>QL (30 EA per 30 days)</td>
</tr>
<tr>
<td>DOVATO ORAL TABLET 50-300 MG</td>
<td>5</td>
<td>QL (30 EA per 30 days)</td>
</tr>
<tr>
<td>GENVOYA ORAL TABLET 150-150-200-10 MG</td>
<td>5</td>
<td>QL (30 EA per 30 days)</td>
</tr>
<tr>
<td>ISENTRESS HD ORAL TABLET 600 MG</td>
<td>5</td>
<td>QL (60 EA per 30 days)</td>
</tr>
<tr>
<td>ISENTRESS ORAL PACKET 100 MG</td>
<td>4</td>
<td>QL (60 EA per 30 days)</td>
</tr>
<tr>
<td>ISENTRESS ORAL TABLET 400 MG</td>
<td>5</td>
<td>QL (60 EA per 30 days)</td>
</tr>
<tr>
<td>Name of Drug</td>
<td>Drug Tier</td>
<td>Requirements/Limits</td>
</tr>
<tr>
<td>--------------------------------------------------</td>
<td>-----------</td>
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</tr>
<tr>
<td>ISENTRESS ORAL TABLET CHEWABLE 100 MG, 25 MG</td>
<td>4</td>
<td>QL (180 EA per 30 days)</td>
</tr>
<tr>
<td>STRIBILD ORAL TABLET 150-150-200-300 MG</td>
<td>5</td>
<td>QL (30 EA per 30 days)</td>
</tr>
<tr>
<td>SYMTUZA ORAL TABLET 800-150-200-10 MG</td>
<td>5</td>
<td>QL (30 EA per 30 days)</td>
</tr>
<tr>
<td>TIVICAY ORAL TABLET 10 MG</td>
<td>4</td>
<td>QL (120 EA per 30 days)</td>
</tr>
<tr>
<td>TIVICAY ORAL TABLET 25 MG</td>
<td>5</td>
<td>QL (30 EA per 30 days)</td>
</tr>
<tr>
<td>TIVICAY ORAL TABLET 50 MG</td>
<td>5</td>
<td>QL (60 EA per 30 days)</td>
</tr>
<tr>
<td>TIVICAY PD ORAL TABLET SOLUBLE 5 MG</td>
<td>4</td>
<td>QL (180 EA per 30 days)</td>
</tr>
<tr>
<td>Vocabria oral tablet 30 mg</td>
<td>4</td>
<td>QL (30 EA per 30 days)</td>
</tr>
</tbody>
</table>

**Anti-HIV Agents, Non-Nucleoside Reverse Transcriptase Inhibitors (NNRTI)**

<table>
<thead>
<tr>
<th>Name of Drug</th>
<th>Drug Tier</th>
<th>Requirements/Limits</th>
</tr>
</thead>
<tbody>
<tr>
<td>COMPLERA ORAL TABLET 200-25-300 MG</td>
<td>5</td>
<td>QL (30 EA per 30 days)</td>
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<tr>
<td>EDURANT ORAL TABLET 25 MG</td>
<td>5</td>
<td>QL (60 EA per 30 days)</td>
</tr>
<tr>
<td>Efavirenz oral capsule 200 mg</td>
<td>2</td>
<td>QL (120 EA per 30 days)</td>
</tr>
<tr>
<td>Efavirenz oral capsule 50 mg</td>
<td>2</td>
<td>QL (180 EA per 30 days)</td>
</tr>
<tr>
<td>Efavirenz oral tablet 600 mg</td>
<td>2</td>
<td>QL (30 EA per 30 days)</td>
</tr>
<tr>
<td>Etravirine oral tablet 100 mg</td>
<td>2</td>
<td>QL (120 EA per 30 days)</td>
</tr>
<tr>
<td>Etravirine oral tablet 200 mg</td>
<td>5</td>
<td>QL (60 EA per 30 days)</td>
</tr>
<tr>
<td>INTELENCE ORAL TABLET 25 MG</td>
<td>4</td>
<td>QL (120 EA per 30 days)</td>
</tr>
<tr>
<td>Nevirapine er oral tablet extended release 24 hour 100 mg</td>
<td>2</td>
<td>QL (120 EA per 30 days)</td>
</tr>
<tr>
<td>Nevirapine er oral tablet extended release 24 hour 400 mg</td>
<td>2</td>
<td>QL (30 EA per 30 days)</td>
</tr>
<tr>
<td>Nevirapine oral suspension 50 mg/5ml</td>
<td>2</td>
<td>QL (60 EA per 30 days)</td>
</tr>
<tr>
<td>Nevirapine oral tablet 200 mg</td>
<td>1</td>
<td>QL (60 EA per 30 days)</td>
</tr>
<tr>
<td>PIFELTRO ORAL TABLET 100 MG</td>
<td>5</td>
<td>QL (30 EA per 30 days)</td>
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</tbody>
</table>

**Anti-HIV Agents, Nucleoside And Nucleotide Reverse Transcriptase Inhibitors (NRTI)**

<table>
<thead>
<tr>
<th>Name of Drug</th>
<th>Drug Tier</th>
<th>Requirements/Limits</th>
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<tbody>
<tr>
<td>Abacavir sulfate oral solution 20 mg/ml</td>
<td>2</td>
<td>QL (60 EA per 30 days)</td>
</tr>
<tr>
<td>Abacavir sulfate oral tablet 300 mg</td>
<td>2</td>
<td>QL (60 EA per 30 days)</td>
</tr>
<tr>
<td>Abacavir sulfate-lamivudine oral tablet 600-300 mg</td>
<td>2</td>
<td>QL (30 EA per 30 days)</td>
</tr>
<tr>
<td>Name of Drug</td>
<td>Drug Tier</td>
<td>Requirements/Limits</td>
</tr>
<tr>
<td>--------------------------------------------------</td>
<td>-----------</td>
<td>----------------------------------</td>
</tr>
<tr>
<td>abacavir-lamivudine-zidovudine oral tablet 300-150-300 mg</td>
<td>5</td>
<td>QL (60 EA per 30 days)</td>
</tr>
<tr>
<td>CIMDUO ORAL TABLET 300-300 MG</td>
<td>5</td>
<td>QL (30 EA per 30 days)</td>
</tr>
<tr>
<td>DELSTRIGO ORAL TABLET 100-300-300 MG</td>
<td>5</td>
<td>QL (30 EA per 30 days)</td>
</tr>
<tr>
<td>DESCOVY ORAL TABLET 120-15 MG, 200-25 MG</td>
<td>5</td>
<td>QL (30 EA per 30 days)</td>
</tr>
<tr>
<td>efavirenz-emtricitab-tenofo oral tablet 600-200-300 mg</td>
<td>5</td>
<td>QL (30 EA per 30 days)</td>
</tr>
<tr>
<td>efavirenz-lamivudine-tenofovir oral tablet 400-300-300 mg, 600-300-300 mg</td>
<td>5</td>
<td>QL (30 EA per 30 days)</td>
</tr>
<tr>
<td>emtricitabine oral capsule 200 mg</td>
<td>2</td>
<td>QL (30 EA per 30 days)</td>
</tr>
<tr>
<td>emtricitabine-tenofovir oral tablet 100-150 mg, 133-200 mg, 167-250 mg, 200-300 mg*</td>
<td>1</td>
<td>QL (30 EA per 30 days)</td>
</tr>
<tr>
<td>EMTRIVA ORAL SOLUTION 10 MG/ML</td>
<td>4</td>
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</tr>
<tr>
<td>JULUCA ORAL TABLET 50-25 MG</td>
<td>5</td>
<td>QL (30 EA per 30 days)</td>
</tr>
<tr>
<td>lamivudine-zidovudine oral tablet 150-300 mg</td>
<td>2</td>
<td>QL (60 EA per 30 days)</td>
</tr>
<tr>
<td>ODEFSEY ORAL TABLET 200-25-25 MG</td>
<td>5</td>
<td>QL (30 EA per 30 days)</td>
</tr>
<tr>
<td>stavudine oral capsule 15 mg, 20 mg</td>
<td>2</td>
<td>QL (120 EA per 30 days)</td>
</tr>
<tr>
<td>stavudine oral capsule 30 mg, 40 mg</td>
<td>2</td>
<td>QL (60 EA per 30 days)</td>
</tr>
<tr>
<td>TEMIXYS ORAL TABLET 300-300 MG</td>
<td>5</td>
<td>QL (30 EA per 30 days)</td>
</tr>
<tr>
<td>TRIZIVIR ORAL TABLET 300-150-300 MG</td>
<td>5</td>
<td>QL (60 EA per 30 days)</td>
</tr>
<tr>
<td>zidovudine oral capsule 100 mg</td>
<td>2</td>
<td>QL (180 EA per 30 days)</td>
</tr>
<tr>
<td>zidovudine oral syrup 50 mg/5ml</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>zidovudine oral tablet 300 mg</td>
<td>2</td>
<td>QL (60 EA per 30 days)</td>
</tr>
<tr>
<td>Anti-HIV Agents, Other</td>
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<td></td>
</tr>
<tr>
<td>FUZEON SUBCUTANEOUS SOLUTION RECONSTITUTED 90 MG</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>maraviroc oral tablet 150 mg</td>
<td>5</td>
<td>QL (60 EA per 30 days)</td>
</tr>
<tr>
<td>maraviroc oral tablet 300 mg</td>
<td>5</td>
<td>QL (120 EA per 30 days)</td>
</tr>
<tr>
<td>RUKOBIA ORAL TABLET EXTENDED RELEASE 12 HOUR 600 MG</td>
<td>5</td>
<td>QL (60 EA per 30 days)</td>
</tr>
<tr>
<td>SELZENTRY ORAL SOLUTION 20 MG/ML</td>
<td>4</td>
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</tr>
<tr>
<td>SELZENTRY ORAL TABLET 25 MG</td>
<td>3</td>
<td>QL (120 EA per 30 days)</td>
</tr>
<tr>
<td>Name of Drug</td>
<td>Drug Tier</td>
<td>Requirements/Limits</td>
</tr>
<tr>
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<tr>
<td>SELZENTRY ORAL TABLET 75 MG</td>
<td>4</td>
<td>QL (60 EA per 30 days)</td>
</tr>
<tr>
<td>TRIUMEQ ORAL TABLET 600-50-300 MG</td>
<td>5</td>
<td>QL (30 EA per 30 days)</td>
</tr>
<tr>
<td>triumeq pd oral tablet soluble 60-5-30 mg</td>
<td>5</td>
<td>QL (180 EA per 30 days)</td>
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<tr>
<td>TYBOST ORAL TABLET 150 MG</td>
<td>3</td>
<td>QL (30 EA per 30 days)</td>
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<tr>
<td>Anti-HIV Agents, Protease Inhibitors (PI)</td>
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<tr>
<td>APTIVUS ORAL CAPSULE 250 MG</td>
<td>5</td>
<td>QL (120 EA per 30 days)</td>
</tr>
<tr>
<td>APTIVUS ORAL SOLUTION 100 MG/ML</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>atazanavir sulfate oral capsule 150 mg, 300 mg</td>
<td>2</td>
<td>QL (30 EA per 30 days)</td>
</tr>
<tr>
<td>atazanavir sulfate oral capsule 200 mg</td>
<td>2</td>
<td>QL (60 EA per 30 days)</td>
</tr>
<tr>
<td>CRIXIVAN ORAL CAPSULE 200 MG</td>
<td>4</td>
<td>QL (360 EA per 30 days)</td>
</tr>
<tr>
<td>CRIXIVAN ORAL CAPSULE 400 MG</td>
<td>4</td>
<td>QL (180 EA per 30 days)</td>
</tr>
<tr>
<td>EVOTAZ ORAL TABLET 300-150 MG</td>
<td>5</td>
<td>QL (30 EA per 30 days)</td>
</tr>
<tr>
<td>fosamprenavir calcium oral tablet 700 mg</td>
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<td>QL (120 EA per 30 days)</td>
</tr>
<tr>
<td>INVIRASE ORAL TABLET 500 MG</td>
<td>5</td>
<td>QL (120 EA per 30 days)</td>
</tr>
<tr>
<td>LEXIVA ORAL SUSPENSION 50 MG/ML</td>
<td>4</td>
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</tr>
<tr>
<td>lopinavir-ritonavir oral solution 400-100 mg/5ml</td>
<td>2</td>
<td>QL (390 ML per 30 days)</td>
</tr>
<tr>
<td>lopinavir-ritonavir oral tablet 100-25 mg</td>
<td>2</td>
<td>QL (300 EA per 30 days)</td>
</tr>
<tr>
<td>lopinavir-ritonavir oral tablet 200-50 mg</td>
<td>5</td>
<td>QL (120 EA per 30 days)</td>
</tr>
<tr>
<td>NORVIR ORAL PACKET 100 MG</td>
<td>4</td>
<td>QL (360 EA per 30 days)</td>
</tr>
<tr>
<td>NORVIR ORAL SOLUTION 80 MG/ML</td>
<td>4</td>
<td>QL (450 ML per 30 days)</td>
</tr>
<tr>
<td>PREZCOBIX ORAL TABLET 800-150 MG</td>
<td>5</td>
<td>QL (30 EA per 30 days)</td>
</tr>
<tr>
<td>PREZISTA ORAL SUSPENSION 100 MG/ML</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>PREZISTA ORAL TABLET 150 MG</td>
<td>5</td>
<td>QL (180 EA per 30 days)</td>
</tr>
<tr>
<td>PREZISTA ORAL TABLET 600 MG</td>
<td>5</td>
<td>QL (60 EA per 30 days)</td>
</tr>
<tr>
<td>PREZISTA ORAL TABLET 75 MG</td>
<td>4</td>
<td>QL (300 EA per 30 days)</td>
</tr>
<tr>
<td>PREZISTA ORAL TABLET 800 MG</td>
<td>5</td>
<td>QL (30 EA per 30 days)</td>
</tr>
<tr>
<td>REYATAZ ORAL PACKET 50 MG</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>ritonavir oral tablet 100 mg</td>
<td>2</td>
<td>QL (360 EA per 30 days)</td>
</tr>
<tr>
<td>VIRACEPT ORAL TABLET 250 MG</td>
<td>5</td>
<td>QL (300 EA per 30 days)</td>
</tr>
<tr>
<td>Name of Drug</td>
<td>Drug Tier</td>
<td>Requirements/Limits</td>
</tr>
<tr>
<td>--------------------------------------------------</td>
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<td>------------------------------</td>
</tr>
<tr>
<td>VIRACEPT ORAL TABLET 625 MG</td>
<td>5</td>
<td>QL (120 EA per 30 days)</td>
</tr>
<tr>
<td><strong>Anti-Influenza Agents</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>oseltamivir phosphate oral capsule 30 mg</td>
<td>2</td>
<td>QL (84 EA per 180 days)</td>
</tr>
<tr>
<td>oseltamivir phosphate oral capsule 45 mg, 75 mg</td>
<td>2</td>
<td>QL (42 EA per 180 days)</td>
</tr>
<tr>
<td>oseltamivir phosphate oral suspension reconstituted 6 mg/ml</td>
<td>2</td>
<td>QL (540 ML per 180 days)</td>
</tr>
<tr>
<td>RELENZA DISKHALER INHALATION AEROSOL POWDER BREATH ACTIVATED 5 MG/ACT, 5 MG/BLISTER</td>
<td>4</td>
<td>QL (60 EA per 180 days)</td>
</tr>
<tr>
<td>rimantadine hcl oral tablet 100 mg</td>
<td>2</td>
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</tr>
<tr>
<td><strong>Antivirals</strong></td>
<td></td>
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</tr>
<tr>
<td>LAGEVRIO ORAL CAPSULE 200 MG</td>
<td>3</td>
<td>QL (40 EA per 5 days)</td>
</tr>
<tr>
<td>PAXLOVID (150/100) ORAL TABLET THERAPY PACK 10 X 150 MG &amp; 10 X 100MG</td>
<td>3</td>
<td>QL (20 EA per 5 days)</td>
</tr>
<tr>
<td>PAXLOVID (300/100) ORAL TABLET THERAPY PACK 20 X 150 MG &amp; 10 X 100MG</td>
<td>3</td>
<td>QL (30 EA per 5 days)</td>
</tr>
<tr>
<td><strong>Anxiolytics - Treatment Of Anxiety Or Nervousness</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Anxiolytics, Other</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>buspirone hcl oral tablet 10 mg, 15 mg, 5 mg*</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>buspirone hcl oral tablet 30 mg, 7.5 mg</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>hydroxyzine pamoate oral capsule 100 mg, 25 mg, 50 mg</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td><strong>Benzodiazepines</strong></td>
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<td></td>
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<tr>
<td>ALPRAZOLAM INTENSOL ORAL CONCENTRATE 1 MG/ML</td>
<td>2</td>
<td>QL (300 ML per 30 days)</td>
</tr>
<tr>
<td>alprazolam oral tablet 0.25 mg, 0.5 mg, 1 mg</td>
<td>2</td>
<td>QL (120 EA per 30 days)</td>
</tr>
<tr>
<td>alprazolam oral tablet 2 mg</td>
<td>2</td>
<td>QL (150 EA per 30 days)</td>
</tr>
<tr>
<td>clonazepam oral tablet 0.5 mg, 1 mg</td>
<td>2</td>
<td>QL (90 EA per 30 days)</td>
</tr>
<tr>
<td>clonazepam oral tablet 2 mg</td>
<td>2</td>
<td>QL (300 EA per 30 days)</td>
</tr>
<tr>
<td>clonazepam oral tablet dispersible 0.125 mg, 0.25 mg, 0.5 mg, 1 mg</td>
<td>2</td>
<td>QL (90 EA per 30 days)</td>
</tr>
<tr>
<td>Name of Drug</td>
<td>Drug Tier</td>
<td>Requirements/Limits</td>
</tr>
<tr>
<td>--------------------------------------------------</td>
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<td>----------------------------------</td>
</tr>
<tr>
<td>clonazepam oral tablet dispersible 2 mg</td>
<td>2</td>
<td>QL (300 EA per 30 days)</td>
</tr>
<tr>
<td>clorazepate dipotassium oral tablet 15 mg</td>
<td>2</td>
<td>QL (180 EA per 30 days)</td>
</tr>
<tr>
<td>clorazepate dipotassium oral tablet 3.75 mg, 7.5 mg</td>
<td>2</td>
<td>QL (90 EA per 30 days)</td>
</tr>
<tr>
<td>DIAZEPAM INTENSOL ORAL CONCENTRATE 5 MG/ML</td>
<td>2</td>
<td>QL (240 ML per 30 days)</td>
</tr>
<tr>
<td>diazepam oral concentrate 5 mg/ml</td>
<td>2</td>
<td>QL (240 ML per 30 days)</td>
</tr>
<tr>
<td>diazepam oral solution 5 mg/5ml</td>
<td>2</td>
<td>QL (1200 ML per 30 days)</td>
</tr>
<tr>
<td>diazepam oral tablet 10 mg, 2 mg, 5 mg</td>
<td>2</td>
<td>QL (120 EA per 30 days)</td>
</tr>
<tr>
<td>LORAZEPAM INTENSOL ORAL CONCENTRATE 2 MG/ML</td>
<td>2</td>
<td>QL (150 ML per 30 days)</td>
</tr>
<tr>
<td>lorazepam oral concentrate 2 mg/ml</td>
<td>2</td>
<td>QL (150 ML per 30 days)</td>
</tr>
<tr>
<td>lorazepam oral tablet 0.5 mg, 1 mg</td>
<td>2</td>
<td>QL (90 EA per 30 days)</td>
</tr>
<tr>
<td>lorazepam oral tablet 2 mg</td>
<td>2</td>
<td>QL (150 EA per 30 days)</td>
</tr>
<tr>
<td><strong>Bipolar Agents - Treatment For Bipolar Illnesses</strong></td>
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<tr>
<td><strong>Mood Stabilizers</strong></td>
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<td></td>
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<tr>
<td>carbamazepine er oral capsule extended release 12 hour 100 mg, 200 mg, 300 mg</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>EQUETRO ORAL CAPSULE EXTENDED RELEASE 12 HOUR 100 MG, 200 MG, 300 MG</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>lamotrigine oral tablet 100 mg, 150 mg, 200 mg*</td>
<td>1</td>
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</tr>
<tr>
<td>lamotrigine starter kit-blue oral kit 35 x 25 mg</td>
<td>2</td>
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</tr>
<tr>
<td>lamotrigine starter kit-green oral kit 84 x 25 mg &amp; 14x100 mg</td>
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<td></td>
</tr>
<tr>
<td>lamotrigine starter kit-orange oral kit 42 x 25 mg &amp; 7 x 100 mg</td>
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<td></td>
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<tr>
<td>lithium carbonate er oral tablet extended release 300 mg, 450 mg</td>
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<tr>
<td>lithium carbonate oral capsule 150 mg, 300 mg, 600 mg</td>
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</tr>
<tr>
<td>lithium carbonate oral tablet 300 mg</td>
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<tr>
<td>Name of Drug</td>
<td>Drug Tier</td>
<td>Requirements/Limits</td>
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<tr>
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<tr>
<td>Blood Glucose Regulators - Control Of Diabetes</td>
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<tr>
<td>Antidiabetic Agents</td>
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<tr>
<td>acarbose oral tablet 100 mg, 25 mg, 50 mg</td>
<td>2</td>
<td>QL (90 EA per 30 days)</td>
</tr>
<tr>
<td>glimepiride oral tablet 1 mg*</td>
<td>1</td>
<td>QL (240 EA per 30 days)</td>
</tr>
<tr>
<td>glimepiride oral tablet 2 mg*</td>
<td>1</td>
<td>QL (120 EA per 30 days)</td>
</tr>
<tr>
<td>glimepiride oral tablet 4 mg*</td>
<td>1</td>
<td>QL (60 EA per 30 days)</td>
</tr>
<tr>
<td>glipizide er oral tablet extended release 24 hour 10 mg*</td>
<td>1</td>
<td>QL (60 EA per 30 days)</td>
</tr>
<tr>
<td>glipizide er oral tablet extended release 24 hour 2.5 mg*</td>
<td>1</td>
<td>QL (240 EA per 30 days)</td>
</tr>
<tr>
<td>glipizide er oral tablet extended release 24 hour 5 mg*</td>
<td>1</td>
<td>QL (120 EA per 30 days)</td>
</tr>
<tr>
<td>glipizide oral tablet 10 mg*</td>
<td>1</td>
<td>QL (120 EA per 30 days)</td>
</tr>
<tr>
<td>glipizide oral tablet 5 mg*</td>
<td>1</td>
<td>QL (240 EA per 30 days)</td>
</tr>
<tr>
<td>glipizide xl oral tablet extended release 24 hour 10 mg*</td>
<td>1</td>
<td>QL (60 EA per 30 days)</td>
</tr>
<tr>
<td>glipizide xl oral tablet extended release 24 hour 2.5 mg*</td>
<td>1</td>
<td>QL (240 EA per 30 days)</td>
</tr>
<tr>
<td>glipizide xl oral tablet extended release 24 hour 5 mg*</td>
<td>1</td>
<td>QL (120 EA per 30 days)</td>
</tr>
<tr>
<td>glipizide-metformin hcl oral tablet 2.5-250 mg*</td>
<td>1</td>
<td>QL (240 EA per 30 days)</td>
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<tr>
<td>glipizide-metformin hcl oral tablet 2.5-500 mg, 5-500 mg*</td>
<td>1</td>
<td>QL (120 EA per 30 days)</td>
</tr>
<tr>
<td>glyburide micronized oral tablet 1.5 mg, 3 mg*</td>
<td>1</td>
<td>PA; QL (90 EA per 30 days)</td>
</tr>
<tr>
<td>glyburide micronized oral tablet 6 mg*</td>
<td>1</td>
<td>PA; QL (60 EA per 30 days)</td>
</tr>
<tr>
<td>glyburide oral tablet 1.25 mg, 2.5 mg*</td>
<td>1</td>
<td>PA; QL (60 EA per 30 days)</td>
</tr>
<tr>
<td>glyburide oral tablet 5 mg*</td>
<td>1</td>
<td>PA; QL (120 EA per 30 days)</td>
</tr>
<tr>
<td>glyburide-metformin oral tablet 1.25-250 mg</td>
<td>2</td>
<td>PA; QL (240 EA per 30 days)</td>
</tr>
<tr>
<td>glyburide-metformin oral tablet 2.5-500 mg, 5-500 mg</td>
<td>2</td>
<td>PA; QL (120 EA per 30 days)</td>
</tr>
<tr>
<td>GLYXAMBI ORAL TABLET 10-5 MG, 25-5 MG</td>
<td>3</td>
<td>QL (30 EA per 30 days)</td>
</tr>
<tr>
<td>Name of Drug</td>
<td>Drug Tier</td>
<td>Requirements/Limits</td>
</tr>
<tr>
<td>-------------------------------------------------------</td>
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<td>---------------------------</td>
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<tr>
<td>INVOKAMET ORAL TABLET 150-1000 MG, 150-500 MG, 50-1000 MG</td>
<td>3</td>
<td>QL (60 EA per 30 days)</td>
</tr>
<tr>
<td>INVOKAMET ORAL TABLET 50-500 MG</td>
<td>3</td>
<td>QL (120 EA per 30 days)</td>
</tr>
<tr>
<td>INVOKAMET XR ORAL TABLET EXTENDED RELEASE 24 HOUR 150-1000 MG, 150-500 MG, 50-1000 MG, 50-500 MG</td>
<td>3</td>
<td>QL (60 EA per 30 days)</td>
</tr>
<tr>
<td>INVOKANA ORAL TABLET 100 MG, 300 MG</td>
<td>3</td>
<td>QL (30 EA per 30 days)</td>
</tr>
<tr>
<td>JANUMET ORAL TABLET 50-1000 MG, 50-500 MG</td>
<td>3</td>
<td>QL (60 EA per 30 days)</td>
</tr>
<tr>
<td>JANUMET XR ORAL TABLET EXTENDED RELEASE 24 HOUR 100-1000 MG</td>
<td>3</td>
<td>QL (30 EA per 30 days)</td>
</tr>
<tr>
<td>JANUMET XR ORAL TABLET EXTENDED RELEASE 24 HOUR 50-1000 MG, 50-500 MG</td>
<td>3</td>
<td>QL (60 EA per 30 days)</td>
</tr>
<tr>
<td>JANUVIA ORAL TABLET 100 MG, 25 MG, 50 MG</td>
<td>3</td>
<td>QL (30 EA per 30 days)</td>
</tr>
<tr>
<td>JARDIANCE ORAL TABLET 10 MG, 25 MG</td>
<td>3</td>
<td>QL (30 EA per 30 days)</td>
</tr>
<tr>
<td>JENTADUETO ORAL TABLET 2.5-1000 MG, 2.5-500 MG, 2.5-850 MG</td>
<td>3</td>
<td>QL (60 EA per 30 days)</td>
</tr>
<tr>
<td>JENTADUETO XR ORAL TABLET EXTENDED RELEASE 24 HOUR 2.5-1000 MG</td>
<td>3</td>
<td>QL (60 EA per 30 days)</td>
</tr>
<tr>
<td>JENTADUETO XR ORAL TABLET EXTENDED RELEASE 24 HOUR 5-1000 MG</td>
<td>3</td>
<td>QL (30 EA per 30 days)</td>
</tr>
<tr>
<td>metformin hcl er oral tablet extended release 24 hour 500 mg*</td>
<td>1</td>
<td>QL (120 EA per 30 days)</td>
</tr>
<tr>
<td>metformin hcl er oral tablet extended release 24 hour 750 mg*</td>
<td>1</td>
<td>QL (60 EA per 30 days)</td>
</tr>
<tr>
<td>metformin hcl oral tablet 1000 mg*</td>
<td>1</td>
<td>QL (75 EA per 30 days)</td>
</tr>
<tr>
<td>metformin hcl oral tablet 500 mg*</td>
<td>1</td>
<td>QL (150 EA per 30 days)</td>
</tr>
<tr>
<td>metformin hcl oral tablet 850 mg*</td>
<td>1</td>
<td>QL (90 EA per 30 days)</td>
</tr>
<tr>
<td>nateglinide oral tablet 120 mg, 60 mg</td>
<td>2</td>
<td>QL (90 EA per 30 days)</td>
</tr>
<tr>
<td>OZEMPIC (0.25 OR 0.5 MG/DOSE) SUBCUTANEOUS SOLUTION PEN-INJECTOR 2 MG/1.5ML</td>
<td>3</td>
<td>QL (3 ML per 28 days)</td>
</tr>
<tr>
<td>Name of Drug</td>
<td>Drug Tier</td>
<td>Requirements/Limits</td>
</tr>
<tr>
<td>--------------------------------------------------</td>
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<td>--------------------------</td>
</tr>
<tr>
<td>OZEMPIC (1 MG/DOSE) SUBCUTANEOUS SOLUTION PEN-INJECTOR 2 MG/1.5ML, 4 MG/3ML</td>
<td>3</td>
<td>QL (3 ML per 28 days)</td>
</tr>
<tr>
<td>OZEMPIC (2 MG/DOSE) SUBCUTANEOUS SOLUTION PEN-INJECTOR 8 MG/3ML</td>
<td>3</td>
<td>QL (3 ML per 28 days)</td>
</tr>
<tr>
<td>pioglitazone hcl oral tablet 15 mg, 30 mg, 45 mg</td>
<td>2</td>
<td>QL (30 EA per 30 days)</td>
</tr>
<tr>
<td>pioglitazone hcl-metformin hcl oral tablet 15-500 mg, 15-850 mg</td>
<td>2</td>
<td>QL (90 EA per 30 days)</td>
</tr>
<tr>
<td>repaglinide oral tablet 0.5 mg, 1 mg, 2 mg</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>RYBELSUS ORAL TABLET 14 MG, 3 MG, 7 MG</td>
<td>3</td>
<td>QL (30 EA per 30 days)</td>
</tr>
<tr>
<td>SYMLINPEN 120 SUBCUTANEOUS SOLUTION PEN-INJECTOR 2700 MCG/2.7ML</td>
<td>5</td>
<td>PA</td>
</tr>
<tr>
<td>SYMLINPEN 60 SUBCUTANEOUS SOLUTION PEN-INJECTOR 1500 MCG/1.5ML</td>
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<td>PA</td>
</tr>
<tr>
<td>SYNJARDY ORAL TABLET 12.5-1000 MG, 12.5-500 MG, 5-1000 MG, 5-500 MG</td>
<td>3</td>
<td>QL (60 EA per 30 days)</td>
</tr>
<tr>
<td>SYNJARDY XR ORAL TABLET EXTENDED RELEASE 24 HOUR 10-1000 MG, 12.5-1000 MG, 5-1000 MG</td>
<td>3</td>
<td>QL (60 EA per 30 days)</td>
</tr>
<tr>
<td>SYNJARDY XR ORAL TABLET EXTENDED RELEASE 24 HOUR 25-1000 MG</td>
<td>3</td>
<td>QL (30 EA per 30 days)</td>
</tr>
<tr>
<td>TRADJENTA ORAL TABLET 5 MG</td>
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<td>QL (30 EA per 30 days)</td>
</tr>
<tr>
<td>TRULICITY SUBCUTANEOUS SOLUTION PEN-INJECTOR 0.75 MG/0.5ML, 1.5 MG/0.5ML, 3 MG/0.5ML, 4.5 MG/0.5ML</td>
<td>3</td>
<td>QL (2 ML per 28 days)</td>
</tr>
<tr>
<td>VICTOZA SUBCUTANEOUS SOLUTION PEN-INJECTOR 18 MG/3ML</td>
<td>3</td>
<td>QL (9 ML per 30 days)</td>
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</tbody>
</table>

**Glycemic Agents**

<table>
<thead>
<tr>
<th>Name of Drug</th>
<th>Drug Tier</th>
<th>Requirements/Limits</th>
</tr>
</thead>
<tbody>
<tr>
<td>BAQSIMI ONE PACK NASAL POWDER 3 MG/DOSE</td>
<td>3</td>
<td>QL (4 EA per 30 days)</td>
</tr>
<tr>
<td>BAQSIMI TWO PACK NASAL POWDER 3 MG/DOSE</td>
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<td>QL (4 EA per 30 days)</td>
</tr>
<tr>
<td>diazoxide oral suspension 50 mg/ml</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Name of Drug</td>
<td>Drug Tier</td>
<td>Requirements/Limits</td>
</tr>
<tr>
<td>--------------------------------------------------</td>
<td>-----------</td>
<td>-----------------------------</td>
</tr>
<tr>
<td>GLUCAGEN DIAGNOSTIC INJECTION SOLUTION RECONSTITUTED 1 MG</td>
<td>3</td>
<td>QL (4 EA per 30 days)</td>
</tr>
<tr>
<td>GLUCAGEN HYPOKIT INJECTION SOLUTION RECONSTITUTED 1 MG</td>
<td>3</td>
<td>QL (4 EA per 30 days)</td>
</tr>
<tr>
<td>glucagon emergency injection kit 1 mg</td>
<td>3</td>
<td>QL (4 EA per 30 days)</td>
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<tr>
<td>glucagon emergency injection solution reconstituted 1 mg/ml</td>
<td>3</td>
<td>QL (4 EA per 30 days)</td>
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<tr>
<td>glucagon hcl (diagnostic) injection solution reconstituted 1 mg</td>
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<td>QL (4 EA per 30 days)</td>
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<tr>
<td>KORLYM ORAL TABLET 300 MG</td>
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**Insulins**

<table>
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<th>Name of Drug</th>
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<tbody>
<tr>
<td>BASAGLAR KWIKPEN SUBCUTANEOUS SOLUTION PEN-JECTOR 100 UNIT/ML</td>
<td>2</td>
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</tr>
<tr>
<td>GAUZE EXTERNAL*</td>
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</tr>
<tr>
<td>gauze pad 2&quot;x2&quot;*</td>
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<tr>
<td>GAUZE PAD 2&quot;X2&quot;*</td>
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</tr>
<tr>
<td>HUMALOG INJECTION SOLUTION 100 UNIT/ML</td>
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<td>SI</td>
</tr>
<tr>
<td>HUMALOG JUNIOR KWIKPEN SUBCUTANEOUS SOLUTION PEN-JECTOR 100 UNIT/ML</td>
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<td>SI</td>
</tr>
<tr>
<td>HUMALOG KWIKPEN SUBCUTANEOUS SOLUTION PEN-JECTOR 100 UNIT/ML, 200 UNIT/ML</td>
<td>3</td>
<td>SI</td>
</tr>
<tr>
<td>HUMALOG MIX 50/50 KWIKPEN SUBCUTANEOUS SUSPENSION PEN-JECTOR (50-50) 100 UNIT/ML</td>
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<td>SI</td>
</tr>
<tr>
<td>HUMALOG MIX 50/50 SUBCUTANEOUS SUSPENSION (50-50) 100 UNIT/ML</td>
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<tr>
<td>HUMALOG MIX 75/25 KWIKPEN SUBCUTANEOUS SUSPENSION PEN-JECTOR (75-25) 100 UNIT/ML</td>
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<td>HUMALOG MIX 75/25 SUBCUTANEOUS SUSPENSION (75-25) 100 UNIT/ML</td>
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<td>SI</td>
</tr>
<tr>
<td>HUMALOG SUBCUTANEOUS SOLUTION CARTRIDGE 100 UNIT/ML</td>
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<tr>
<td>HUMULIN 70/30 KWIKPEN SUBCUTANEOUS SUSPENSION PEN-JECTOR (70-30) 100 UNIT/ML</td>
<td>3</td>
<td>SI</td>
</tr>
<tr>
<td>Name of Drug</td>
<td>Drug Tier</td>
<td>Requirements/Limits</td>
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<tr>
<td>HUMULIN 70/30 SUBCUTANEOUS SUSPENSION (70-30) 100 UNIT/ML</td>
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<td>HUMULIN N KWIKPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR 100 UNIT/ML</td>
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<tr>
<td>HUMULIN N SUBCUTANEOUS SUSPENSION 100 UNIT/ML</td>
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<td>SI</td>
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<tr>
<td>HUMULIN R INJECTION SOLUTION 100 UNIT/ML</td>
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<tr>
<td>HUMULIN R U-500 (CONCENTRATED) SUBCUTANEOUS SOLUTION 500 UNIT/ML</td>
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<tr>
<td>HUMULIN R U-500 KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 500 UNIT/ML</td>
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<tr>
<td>insulin asp prot &amp; asp flexpen subcutaneous suspension pen-injector (70-30) 100 unit/ml*</td>
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<tr>
<td>insulin aspart flexpen subcutaneous solution pen-injector 100 unit/ml*</td>
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</tr>
<tr>
<td>insulin aspart injection solution 100 unit/ml*</td>
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</tr>
<tr>
<td>insulin aspart penfill subcutaneous solution cartridge 100 unit/ml*</td>
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<tr>
<td>insulin aspart prot &amp; aspart subcutaneous suspension (70-30) 100 unit/ml*</td>
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<tr>
<td>insulin degludec flextouch subcutaneous solution pen-injector 100 unit/ml, 200 unit/ml*</td>
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<tr>
<td>insulin degludec subcutaneous solution 100 unit/ml*</td>
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<td>insulin glargine-yfgn subcutaneous solution 100 unit/ml*</td>
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<td>insulin glargine-yfgn subcutaneous solution pen-injector 100 unit/ml*</td>
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<tr>
<td>insulin lispro (1 unit dial) subcutaneous solution pen-injector 100 unit/ml*</td>
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<td>SI</td>
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<tr>
<td>insulin lispro injection solution 100 unit/ml*</td>
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<tr>
<td>Name of Drug</td>
<td>Drug Tier</td>
<td>Requirements/Limits</td>
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<tr>
<td>----------------------------------------------------------------------------</td>
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<tr>
<td>insulin lispro junior kwikpen subcutaneous solution pen-injector 100 unit/ml*</td>
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<td>SI</td>
</tr>
<tr>
<td>insulin lispro prot &amp; lispro subcutaneous suspension pen-injector (75-25) 100 unit/ml*</td>
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<td>SI</td>
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<tr>
<td>INSULIN SYRINGE 27G X 1/2&quot; 1 ML, 27G X 5/8&quot; 1 ML, 28G X 1/2&quot; 0.5 ML, 28G X 1/2&quot; 1 ML, 29G 0.3 ML, 29G X 1/2&quot; 0.3 ML, 29G X 1/2&quot; 0.5 ML, 29G X 1/2&quot; 1 ML, 30G X 5/16&quot; 0.3 ML, 30G X 5/16&quot; 0.5 ML, 30G X 5/16&quot; 1 ML, 31G X 15/64&quot; 0.3 ML, 31G X 15/64&quot; 0.5 ML, 31G X 6MM 0.5 ML, U-100 1 ML*</td>
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<tr>
<td>insulin syringe 28g x 1/2&quot; 0.5 ml*</td>
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<td>SI</td>
</tr>
<tr>
<td>LANTUS SOLOSTAR SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML</td>
<td>3</td>
<td>SI</td>
</tr>
<tr>
<td>LANTUS SUBCUTANEOUS SOLUTION 100 UNIT/ML</td>
<td>3</td>
<td>SI</td>
</tr>
<tr>
<td>LEVEMIR FLEXTOUCH SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML</td>
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<td>SI</td>
</tr>
<tr>
<td>LEVEMIR SUBCUTANEOUS SOLUTION 100 UNIT/ML</td>
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<td>SI</td>
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<tr>
<td>NOVOLIN 70/30 FLEXPEN RELION SUBCUTANEOUS SUSPENSION PEN-INJECTOR (70-30) 100 UNIT/ML</td>
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<td>SI</td>
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<tr>
<td>NOVOLIN 70/30 FLEXPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR (70-30) 100 UNIT/ML</td>
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<td>SI</td>
</tr>
<tr>
<td>NOVOLIN 70/30 SUBCUTANEOUS SUSPENSION (70-30) 100 UNIT/ML</td>
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<td>SI</td>
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<tr>
<td>NOVOLIN N FLEXPEN RELION SUBCUTANEOUS SUSPENSION PEN-INJECTOR 100 UNIT/ML</td>
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<td>SI</td>
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<td>NOVOLIN N FLEXPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR 100 UNIT/ML</td>
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<td>SI</td>
</tr>
<tr>
<td>NOVOLIN N SUBCUTANEOUS SUSPENSION 100 UNIT/ML</td>
<td>3</td>
<td>SI</td>
</tr>
<tr>
<td>NOVOLIN R FLEXPEN INJECTION SOLUTION PEN-INJECTOR 100 UNIT/ML</td>
<td>3</td>
<td>SI</td>
</tr>
<tr>
<td>Name of Drug</td>
<td>Drug Tier</td>
<td>Requirements/Limits</td>
</tr>
<tr>
<td>-----------------------------------------------------------------------------</td>
<td>-----------</td>
<td>---------------------------</td>
</tr>
<tr>
<td>NOVOLIN R FLEXPEN RELION INJECTION SOLUTION PEN-Injector 100 UNIT/ML</td>
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</tr>
<tr>
<td>NOVOLIN R INJECTION SOLUTION 100 UNIT/ML</td>
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<td>SI</td>
</tr>
<tr>
<td>NOVOLOG 70/30 FLEXPEN RELION SUBCUTANEOUS SUSPENSION PEN-Injector (70-30) 100 UNIT/ML</td>
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</tr>
<tr>
<td>NOVOLOG FLEXPEN RELION SUBCUTANEOUS SOLUTION PEN-Injector 100 UNIT/ML</td>
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<tr>
<td>NOVOLOG FLEXPEN SUBCUTANEOUS SOLUTION PEN-Injector 100 UNIT/ML</td>
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<td>SI</td>
</tr>
<tr>
<td>NOVOLOG INJECTION SOLUTION 100 UNIT/ML</td>
<td>3</td>
<td>SI</td>
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<tr>
<td>NOVOLOG MIX 70/30 FLEXPEN SUBCUTANEOUS SUSPENSION PEN-Injector (70-30) 100 UNIT/ML</td>
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<td>SI</td>
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<td>NOVOLOG MIX 70/30 RELION SUBCUTANEOUS SUSPENSION (70-30) 100 UNIT/ML</td>
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<td>NOVOLOG MIX 70/30 SUBCUTANEOUS SUSPENSION (70-30) 100 UNIT/ML</td>
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<td>SI</td>
</tr>
<tr>
<td>NOVOLOG PENFILL SUBCUTANEOUS SOLUTION CARTRIDGE 100 UNIT/ML</td>
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<td>SI</td>
</tr>
<tr>
<td>NOVOLOG RELION INJECTION SOLUTION 100 UNIT/ML</td>
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</tr>
<tr>
<td>PEN NEEDLES 29G X 12MM, 30G X 8 MM, 31G X 5 MM, 31G X 6 MM, 31G X 8 MM, 32G X 4 MM, 32G X 6 MM*</td>
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<tr>
<td>pen needles 30g x 5 mm, 30g x 8 mm, 31g x 6 mm, 31g x 8 mm, 32g x 4 mm, 32g x 5 mm*</td>
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<tr>
<td>SOLIQUA SUBCUTANEOUS SOLUTION PEN-Injector 100-33 UNT-MCG/ML</td>
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<td>SI; QL (30 ML per 30 days)</td>
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<tr>
<td>TOUJEOL MAX SOLOSTAR SUBCUTANEOUS SOLUTION PEN-Injector 300 UNIT/ML</td>
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<td>SI</td>
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<td>TOUJEOL SOLOSTAR SUBCUTANEOUS SOLUTION PEN-Injector 300 UNIT/ML</td>
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<tr>
<td>Name of Drug</td>
<td>Drug Tier</td>
<td>Requirements/Limits</td>
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<tr>
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<td>-----------</td>
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</tr>
<tr>
<td>TRESIBA FLEXTOUCH SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML, 200 UNIT/ML</td>
<td>3</td>
<td>SI</td>
</tr>
<tr>
<td>TRESIBA SUBCUTANEOUS SOLUTION 100 UNIT/ML</td>
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<td>SI</td>
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</tbody>
</table>

**Blood Products And Modifiers - Prevention Of Clotting And Increasing Blood Cell Production**

**Anticoagulants**

<table>
<thead>
<tr>
<th>Name of Drug</th>
<th>Drug Tier</th>
<th>Requirements/Limits</th>
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</thead>
<tbody>
<tr>
<td>ELIQUIS DVT/PE STARTER PACK ORAL TABLET THERAPY PACK 5 MG</td>
<td>3</td>
<td>QL (74 EA per 30 days)</td>
</tr>
<tr>
<td>ELIQUIS ORAL TABLET 2.5 MG</td>
<td>3</td>
<td>QL (60 EA per 30 days)</td>
</tr>
<tr>
<td>ELIQUIS ORAL TABLET 5 MG</td>
<td>3</td>
<td>QL (120 EA per 30 days)</td>
</tr>
<tr>
<td>enoxaparin sodium injection solution 300 mg/3ml</td>
<td>2</td>
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<tr>
<td>enoxaparin sodium injection solution prefilled syringe 100 mg/ml, 120 mg/0.8ml, 150 mg/ml, 30 mg/0.3ml, 40 mg/0.4ml, 60 mg/0.6ml, 80 mg/0.8ml</td>
<td>2</td>
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</tr>
<tr>
<td>fondaparinux sodium subcutaneous solution 10 mg/0.8ml, 5 mg/0.4ml, 7.5 mg/0.6ml</td>
<td>5</td>
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</tr>
<tr>
<td>fondaparinux sodium subcutaneous solution 2.5 mg/0.5ml</td>
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</tr>
<tr>
<td>FRAGMIN SUBCUTANEOUS SOLUTION 95000 UNIT/3.8ML</td>
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<tr>
<td>FRAGMIN SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 10000 UNIT/ML, 12500 UNIT/0.5ML, 15000 UNIT/0.6ML, 18000 UNIT/0.72ML, 7500 UNIT/0.3ML</td>
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<tr>
<td>FRAGMIN SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 2500 UNIT/0.2ML, 5000 UNIT/0.2ML</td>
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<td>heparin sodium (porcine) injection solution 1000 unit/ml, 10000 unit/ml, 5000 unit/ml</td>
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<tr>
<td>JANTOVEN ORAL TABLET 1 MG, 10 MG, 2 MG, 2.5 MG, 3 MG, 4 MG, 5 MG, 6 MG, 7.5 MG*</td>
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<tr>
<td>Name of Drug</td>
<td>Drug Tier</td>
<td>Requirements/Limits</td>
</tr>
<tr>
<td>----------------------------------------------------------------------------</td>
<td>-----------</td>
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<tr>
<td>warfarin sodium oral tablet 1 mg, 10 mg, 2 mg, 2.5 mg, 3 mg, 4 mg, 5 mg, 6 mg, 7.5 mg*</td>
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<tr>
<td>XARELTO ORAL TABLET 10 MG, 20 MG</td>
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<td>QL (30 EA per 30 days)</td>
</tr>
<tr>
<td>XARELTO ORAL TABLET 15 MG</td>
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<tr>
<td>XARELTO ORAL TABLET 2.5 MG</td>
<td>3</td>
<td>QL (120 EA per 30 days)</td>
</tr>
<tr>
<td>XARELTO STARTER PACK ORAL TABLET THERAPY PACK 15 &amp; 20 MG</td>
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<td>QL (51 EA per 30 days)</td>
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</table>

**Blood Products And Modifiers, Other**

<table>
<thead>
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<th>Requirements/Limits</th>
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<tbody>
<tr>
<td>anagrelide hcl oral capsule 0.5 mg, 1 mg</td>
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</tr>
<tr>
<td>ARANESP (ALBUMIN FREE) INJECTION SOLUTION 100 MCG/ML, 200 MCG/ML, 60 MCG/ML</td>
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</tr>
<tr>
<td>ARANESP (ALBUMIN FREE) INJECTION SOLUTION 25 MCG/ML, 40 MCG/ML</td>
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<td>PA</td>
</tr>
<tr>
<td>ARANESP (ALBUMIN FREE) INJECTION SOLUTION PREFILLED SYRINGE 10 MCG/0.4ML, 25 MCG/0.42ML, 40 MCG/0.4ML</td>
<td>4</td>
<td>PA</td>
</tr>
<tr>
<td>ARANESP (ALBUMIN FREE) INJECTION SOLUTION PREFILLED SYRINGE 100 MCG/0.5ML, 150 MCG/0.3ML, 200 MCG/0.4ML, 300 MCG/0.6ML, 500 MCG/ML, 60 MCG/0.3ML</td>
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<td>PA</td>
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<tr>
<td>EMPAVELI SUBCUTANEOUS SOLUTION 1080 MG/20ML</td>
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<td>PA</td>
</tr>
<tr>
<td>EPOGEN INJECTION SOLUTION 10000 UNIT/ML, 2000 UNIT/ML, 3000 UNIT/ML, 4000 UNIT/ML</td>
<td>4</td>
<td>PA</td>
</tr>
<tr>
<td>EPOGEN INJECTION SOLUTION 20000 UNIT/ML</td>
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</tr>
<tr>
<td>FULPHILA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 6 MG/0.6ML</td>
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<td>PA</td>
</tr>
<tr>
<td>GRANIX SUBCUTANEOUS SOLUTION 300 MCG/ML, 480 MCG/1.6ML</td>
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<td>PA</td>
</tr>
<tr>
<td>GRANIX SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 300 MCG/0.5ML, 480 MCG/0.8ML</td>
<td>5</td>
<td>PA</td>
</tr>
<tr>
<td>Name of Drug</td>
<td>Drug Tier</td>
<td>Requirements/Limits</td>
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<tr>
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<tr>
<td>LEUKINE INJECTION SOLUTION RECONSTITUTED 250 MCG</td>
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<tr>
<td>NEULASTA ONPRO SUBCUTANEOUS PREFILLED SYRINGE KIT 6 MG/0.6ML</td>
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<td>PA</td>
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<td>NEULASTA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 6 MG/0.6ML</td>
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<td>PA</td>
</tr>
<tr>
<td>NEUPOGEN INJECTION SOLUTION 300 MCG/ML, 480 MCG/1.6ML</td>
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<td>PA</td>
</tr>
<tr>
<td>NEUPOGEN INJECTION SOLUTION PREFILLED SYRINGE 300 MCG/0.5ML, 480 MCG/0.8ML</td>
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<td>PA</td>
</tr>
<tr>
<td>NIVESTYM INJECTION SOLUTION PREFILLED SYRINGE 300 MCG/0.5ML, 480 MCG/0.8ML</td>
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<td>PA</td>
</tr>
<tr>
<td>NYVEPIRA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 6 MG/0.6ML</td>
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<td>OXBRYTA ORAL TABLET 500 MG</td>
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<td>OXBRYTA ORAL TABLET SOLUBLE 300 MG</td>
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<td>PROCRIT INJECTION SOLUTION 10000 UNIT/ML, 20000 UNIT/ML, 40000 UNIT/ML</td>
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<td>PROMACTA ORAL PACKET 12.5 MG, 25 MG</td>
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<td>PROMACTA ORAL TABLET 12.5 MG, 25 MG, 50 MG, 75 MG</td>
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<td>PYRUKYND TAPER PACK ORAL TABLET THERAPY PACK 5 MG, 7 X 20 MG &amp; 7 X 5 MG, 7 X 50 MG &amp; 7 X 20 MG</td>
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<td>UDENYCA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 6 MG/0.6ML</td>
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<td>ZARXIO INJECTION SOLUTION PREFILLED SYRINGE 300 MCG/0.5ML, 480 MCG/0.8ML</td>
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<td>ZIEXTENZO SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 6 MG/0.6ML</td>
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<td><strong>Hemostasis Agents</strong></td>
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<td>BRILINTA ORAL TABLET 60 MG, 90 MG</td>
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<td>cilostazol oral tablet 100 mg, 50 mg*</td>
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<td>dipyridamole oral tablet 25 mg, 50 mg, 75 mg</td>
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<td>DOPETELET ORAL TABLET 20 MG, 20 MG (10 PACK), 20 MG(15 PACK)</td>
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<td>prasugrel hcl oral tablet 10 mg, 5 mg</td>
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<td><strong>Cardiovascular Agents - Treatment Of Conditions Affecting The Heart And Blood Vessels</strong></td>
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<td><strong>Alpha-Adrenergic Agonists</strong></td>
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<td>clonidine hcl oral tablet 0.1 mg, 0.2 mg, 0.3 mg*</td>
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<td>midodrine hcl oral tablet 10 mg, 2.5 mg, 5 mg</td>
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<td><strong>Alpha-Adrenergic Blocking Agents</strong></td>
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<td>valsartan oral tablet 160 mg, 320 mg, 40 mg, 80 mg*</td>
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<td>Name of Drug</td>
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<td><strong>Antiarrhythmics</strong></td>
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<td>quinidine sulfate oral tablet 200 mg, 300 mg</td>
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<td>SORINE ORAL TABLET 120 MG, 160 MG, 240 MG, 80 MG</td>
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<td><strong>Beta-Adrenergic Blocking Agents</strong></td>
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<td>bisoprolol fumarate oral tablet 10 mg, 5 mg*</td>
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<td>Name of Drug</td>
<td>Drug Tier</td>
<td>Requirements/Limits</td>
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<td>timolol maleate oral tablet 10 mg, 20 mg, 5 mg</td>
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**Calcium Channel Blocking Agents, Dihydropyridines**

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<tr>
<th>Name of Drug</th>
<th>Drug Tier</th>
<th>Requirements/Limits</th>
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<td>amlodipine besylate oral tablet 10 mg, 2.5 mg, 5 mg*</td>
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<td>nimodipine oral capsule 30 mg</td>
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<td><strong>Calcium Channel Blocking Agents, Nondihydropyridines</strong></td>
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<td><strong>Cardiovascular Agents, Other</strong></td>
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<td>DIGITEK ORAL TABLET 250 MCG*</td>
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<td>NEXLETOL ORAL TABLET 180 MG</td>
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<td>NEXLIZET ORAL TABLET 180-10 MG</td>
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<td>ORLADEYO ORAL CAPSULE 110 MG, 150 MG</td>
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<td>spironolactone-hctz oral tablet 25-25 mg</td>
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<td>TEKTURNA HCT ORAL TABLET 150-12.5 MG, 150-25 MG, 300-12.5 MG, 300-25 MG</td>
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<td><strong>Diuretics, Loop</strong></td>
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<td>hydrochlorothiazide oral tablet 12.5 mg, 50 mg *</td>
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<td>indapamid oral tablet 1.25 mg, 2.5 mg *</td>
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<td>colestervelam hcl oral tablet 625 mg</td>
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<td>colestipol hcl oral granules 5 gm</td>
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<tr>
<td>colestipol hcl oral packet 5 gm</td>
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<tr>
<td>colestipol hcl oral tablet 1 gm</td>
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<td>ezetimibe oral tablet 10 mg*</td>
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<td>icosapent ethyl oral capsule 0.5 gm, 1 gm</td>
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<tr>
<td>niacin er (antihyperlipidemic) oral tablet extended release 1000 mg, 500 mg, 750 mg</td>
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<td>omega-3-acid ethyl esters oral capsule 1 gm</td>
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<td>PRALUENT SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML, 75 MG/ML</td>
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<td>PREVALITE ORAL PACKET 4 GM</td>
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<td>PREVALITE ORAL POWDER 4 GM/DOSE</td>
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<td>Drug Tier</td>
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<tr>
<td>REPATHA PUSHTRONEX SYSTEM SUBCUTANEOUS SOLUTION CARTRIDGE 420 MG/3.5ML</td>
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<td>REPATHA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 140 MG/ML</td>
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<tr>
<td>REPATHA SURECLICK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 140 MG/ML</td>
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<tr>
<td>VASCEPA ORAL CAPSULE 0.5 GM</td>
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**Vasodilators, Direct-Acting Arterial**

- **hydralazine hcl oral tablet 10 mg, 100 mg, 25 mg, 50 mg**  2
- **isosorb dinitrate-hydralazine oral tablet 20-37.5 mg**  2
- **minoxidil oral tablet 10 mg, 2.5 mg**  2

**Vasodilators, Direct-Acting Arterial/Venous**

- **isosorbide dinitrate oral tablet 10 mg, 20 mg, 30 mg, 5 mg**  1
- **isosorbide mononitrate er oral tablet extended release 24 hour 120 mg, 30 mg, 60 mg**  1
- **isosorbide mononitrate oral tablet 10 mg, 20 mg**  1
- **NITRO-BID TRANSDERMAL OINTMENT 2 %**  4
- **NITRO-DUR TRANSDERMAL PATCH 24 HOUR 0.3 MG/HR, 0.8 MG/HR**  4
- **nitroglycerin sublingual tablet sublingual 0.3 mg, 0.4 mg, 0.6 mg**  2
- **nitroglycerin transdermal patch 24 hour 0.1 mg/hr, 0.2 mg/hr, 0.4 mg/hr, 0.6 mg/hr**  2
- **nitroglycerin translingual solution 0.4 mg/spray**  2
- **RECTIV RECTAL OINTMENT 0.4 %**  4
<table>
<thead>
<tr>
<th>Name of Drug</th>
<th>Drug Tier</th>
<th>Requirements/Limits</th>
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<tbody>
<tr>
<td><strong>Central Nervous System Agents - Treatment Of Disorders Of The Brain And Spinal Column</strong></td>
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<tr>
<td><strong>Attention Deficit Hyperactivity Disorder Agents, Amphetamines</strong></td>
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<tr>
<td>amphetamine-dextroamphetamine oral capsule extended release 24 hour 10 mg, 15 mg, 20 mg, 25 mg, 30 mg, 5 mg</td>
<td>2</td>
<td>QL (30 EA per 30 days)</td>
</tr>
<tr>
<td>amphetamine-dextroamphetamine oral tablet 10 mg, 20 mg, 30 mg, 5 mg, 7.5 mg</td>
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<td>QL (60 EA per 30 days)</td>
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<tr>
<td>amphetamine-dextroamphetamine oral tablet 12.5 mg</td>
<td>2</td>
<td>QL (120 EA per 30 days)</td>
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<tr>
<td>amphetamine-dextroamphetamine oral tablet 15 mg</td>
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<tr>
<td>dextroamphetamine sulfate er oral capsule extended release 24 hour 10 mg</td>
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<td>QL (150 EA per 30 days)</td>
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<tr>
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<td>QL (120 EA per 30 days)</td>
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<tr>
<td>dextroamphetamine sulfate er oral capsule extended release 24 hour 5 mg</td>
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<td>QL (90 EA per 30 days)</td>
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<tr>
<td>dextroamphetamine sulfate oral tablet 10 mg, 5 mg</td>
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<td>QL (180 EA per 30 days)</td>
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<tr>
<td><strong>Attention Deficit Hyperactivity Disorder Agents, Non-Amphetamines</strong></td>
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<td>atomoxetine hcl oral capsule 10 mg, 100 mg, 18 mg, 25 mg, 40 mg, 60 mg, 80 mg</td>
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<td>clonidine hcl er oral tablet extended release 12 hour 0.1 mg</td>
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<td>dextemethylphenidate hcl er oral capsule extended release 24 hour 10 mg, 15 mg, 20 mg, 25 mg, 30 mg, 35 mg, 40 mg, 5 mg</td>
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<tr>
<td>dextemethylphenidate hcl oral tablet 10 mg*</td>
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<tr>
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<td>guanfacine hcl er oral tablet extended release 24 hour 1 mg, 2 mg, 3 mg, 4 mg*</td>
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<td>Name of Drug</td>
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<td>Requirements/Limits</td>
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<tr>
<td>methylphenidate hcl er (cd) oral capsule extended release 10 mg, 20 mg, 30 mg, 40 mg, 50 mg, 60 mg</td>
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<td>methylphenidate hcl er (osm) oral tablet extended release 27 mg</td>
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<td>methylphenidate hcl er oral tablet extended release 24 hour 18 mg</td>
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<td><strong>Central Nervous System, Other</strong></td>
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<td>dimethyl fumarate starter pack oral 120 &amp; 240 mg</td>
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<td>Name of Drug</td>
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<td>MAYZENT STARTER PACK ORAL TABLET THERAPY PACK 12 X 0.25 MG</td>
<td>5</td>
<td>PA</td>
</tr>
<tr>
<td>PONVORY ORAL TABLET 20 MG</td>
<td>5</td>
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</tr>
<tr>
<td>PONVORY STARTER PACK ORAL TABLET THERAPY PACK 2-3-4-5-6-7-8-9 &amp; 10 MG</td>
<td>5</td>
<td>PA</td>
</tr>
<tr>
<td>REBIF REBIDOSE SUBCUTANEOUS SOLUTION AUTO-INJECTOR 22 MCG/0.5ML, 44 MCG/0.5ML</td>
<td>5</td>
<td>PA</td>
</tr>
<tr>
<td>REBIF REBIDOSE TITRATION PACK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 6X8.8 &amp; 6X22 MCG</td>
<td>5</td>
<td>PA</td>
</tr>
<tr>
<td>REBIF SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 22 MCG/0.5ML, 44 MCG/0.5ML</td>
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<td>PA</td>
</tr>
<tr>
<td>REBIF TITRATION PACK SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 6X8.8 &amp; 6X22 MCG</td>
<td>5</td>
<td>PA</td>
</tr>
<tr>
<td>ZEPOSIA 7-DAY STARTER PACK ORAL CAPSULE THERAPY PACK 4 X 0.23MG &amp; 3 X 0.46MG</td>
<td>5</td>
<td>PA</td>
</tr>
<tr>
<td>ZEPOSIA ORAL CAPSULE 0.92 MG</td>
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<td>PA</td>
</tr>
<tr>
<td>ZEPOSIA STARTER KIT ORAL CAPSULE THERAPY PACK 0.23MG &amp; 0.46MG &amp; 0.92MG</td>
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<td>PA</td>
</tr>
</tbody>
</table>

**Dental And Oral Agents - Treatment Of Mouth And Gum Disorders**
<table>
<thead>
<tr>
<th>Name of Drug</th>
<th>Drug Tier</th>
<th>Requirements/Limits</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Dental And Oral Agents</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>cevimeline hcl oral capsule 30 mg</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>chlorhexidine gluconate mouth/throat solution 0.12 %*</td>
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</tr>
<tr>
<td>PERIOGARD MOUTH/THROAT SOLUTION 0.12 %*</td>
<td>1</td>
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</tr>
<tr>
<td>pilocarpine hcl oral tablet 5 mg, 7.5 mg</td>
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</tr>
<tr>
<td>triamcinolone acetonide mouth/throat paste 0.1 %</td>
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</tr>
<tr>
<td><strong>Dermatological Agents - Treatment Of Skin Conditions</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Acne And Rosacea Agents</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>acitretin oral capsule 10 mg, 17.5 mg, 25 mg</td>
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<td>PA</td>
</tr>
<tr>
<td>adapalene external gel 0.1 %</td>
<td>2</td>
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</tr>
<tr>
<td>adapalene-benzoil peroxide external gel 0.1-2.5 %</td>
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</tr>
<tr>
<td>AMNESTEEM ORAL CAPSULE 10 MG, 20 MG, 40 MG</td>
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<td></td>
</tr>
<tr>
<td>benzoyl peroxide-erythromycin external gel 5-3 %</td>
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<td></td>
</tr>
<tr>
<td>CLARAVIS ORAL CAPSULE 10 MG, 20 MG, 30 MG, 40 MG</td>
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<td></td>
</tr>
<tr>
<td>clindamycin phos-benzoil perox external gel 1-5 %, 1.2-2.5 %, 1.2-5 %</td>
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<tr>
<td>isotretinoin oral capsule 10 mg, 20 mg, 30 mg, 40 mg</td>
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<td></td>
</tr>
<tr>
<td>MYORISAN ORAL CAPSULE 10 MG, 20 MG, 30 MG, 40 MG</td>
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<td></td>
</tr>
<tr>
<td>tazarotene external cream 0.1 %</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>tazarotene external gel 0.05 %, 0.1 %</td>
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</tr>
<tr>
<td>TAZORAC EXTERNAL CREAM 0.05 %</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>tretinoin (emollient) external cream 0.05 %</td>
<td>2</td>
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</tr>
<tr>
<td>tretinoin external cream 0.025 %, 0.05 %, 0.1 %</td>
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<td></td>
</tr>
<tr>
<td>tretinoin external gel 0.01 %, 0.025 %</td>
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</tr>
<tr>
<td>ZENATANE ORAL CAPSULE 10 MG, 20 MG, 30 MG, 40 MG</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Name of Drug</td>
<td>Drug Tier</td>
<td>Requirements/Limits</td>
</tr>
<tr>
<td>--------------</td>
<td>-----------</td>
<td>--------------------</td>
</tr>
<tr>
<td><strong>Dermatitis And Pruritus Agents</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>alclometasone dipropionate external cream 0.05 %</td>
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<td></td>
</tr>
<tr>
<td>alclometasone dipropionate external ointment 0.05 %</td>
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<td></td>
</tr>
<tr>
<td>ammonium lactate external cream 12 %</td>
<td>2</td>
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</tr>
<tr>
<td>ammonium lactate external lotion 12 %</td>
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</tr>
<tr>
<td>betamethasone dipropionate aug external gel 0.05 %</td>
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<td></td>
</tr>
<tr>
<td>betamethasone dipropionate aug external lotion 0.05 %</td>
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<td></td>
</tr>
<tr>
<td>betamethasone dipropionate aug external ointment 0.05 %</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>betamethasone dipropionate external cream 0.05 %</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>betamethasone dipropionate external lotion 0.05 %</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>betamethasone valerate external cream 0.1 %</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>betamethasone valerate external lotion 0.1 %</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>betamethasone valerate external ointment 0.1 %</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>clobetasol prop emollient base external cream 0.05 %</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>clobetasol propionate e external cream 0.05 %</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>clobetasol propionate external cream 0.05 %</td>
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<td></td>
</tr>
<tr>
<td>clobetasol propionate external gel 0.05 %</td>
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<tr>
<td>clobetasol propionate external ointment 0.05 %</td>
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<td></td>
</tr>
<tr>
<td>clobetasol propionate external solution 0.05 %</td>
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</tr>
<tr>
<td>desonide external cream 0.05 %</td>
<td>2</td>
<td></td>
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<tr>
<td>desonide external lotion 0.05 %</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>desonide external ointment 0.05 %</td>
<td>2</td>
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</tr>
<tr>
<td>Name of Drug</td>
<td>Drug Tier</td>
<td>Requirements/Limits</td>
</tr>
<tr>
<td>------------------------------------------------</td>
<td>-----------</td>
<td>---------------------------</td>
</tr>
<tr>
<td>desoximetasone external cream 0.05 %, 0.25 %</td>
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</tr>
<tr>
<td>desoximetasone external gel 0.05 %</td>
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</tr>
<tr>
<td>desoximetasone external ointment 0.05 %, 0.25 %</td>
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<tr>
<td>doxepin hcl external cream 5 %</td>
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<td>PA; QL (45 GM per 30 days)</td>
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<tr>
<td>DUPIXENT SUBCUTANEOUS SOLUTION PEN-JECTOR 200 MG/1.14ML, 300 MG/2ML</td>
<td>5</td>
<td>PA</td>
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<tr>
<td>dupixent subcutaneous solution prefilled syringe 100 mg/0.67ml</td>
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<tr>
<td>DUPIXENT SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 200 MG/1.14ML, 300 MG/2ML</td>
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<td>PA</td>
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<tr>
<td>EUCRISA EXTERNAL OINTMENT 2 %</td>
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<td>PA</td>
</tr>
<tr>
<td>fluocinolone acetonide external cream 0.01 %, 0.025 %</td>
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</tr>
<tr>
<td>fluocinolone acetonide external ointment 0.025 %</td>
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</tr>
<tr>
<td>fluocinolone acetonide external solution 0.01 %</td>
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<td></td>
</tr>
<tr>
<td>fluocinonide emulsified base external cream 0.05 %</td>
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<td></td>
</tr>
<tr>
<td>fluocinonide external cream 0.05 %</td>
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<td></td>
</tr>
<tr>
<td>fluocinonide external gel 0.05 %</td>
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<td></td>
</tr>
<tr>
<td>fluocinonide external ointment 0.05 %</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>fluocinonide external solution 0.05 %</td>
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<td></td>
</tr>
<tr>
<td>fluticasone propionate external cream 0.05 %</td>
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</tr>
<tr>
<td>fluticasone propionate external lotion 0.05 %</td>
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</tr>
<tr>
<td>fluticasone propionate external ointment 0.005 %</td>
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<td></td>
</tr>
<tr>
<td>halobetasol propionate external cream 0.05 %</td>
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<tr>
<td>halobetasol propionate external ointment 0.05 %</td>
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<tr>
<td>hydrocortisone (perianal) external cream 1 %, 2.5 %*</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Name of Drug</td>
<td>Drug Tier</td>
<td>Requirements/Limits</td>
</tr>
<tr>
<td>--------------------------------------------------</td>
<td>-----------</td>
<td>---------------------</td>
</tr>
<tr>
<td>hydrocortisone butyr lipo base external cream 0.1 %</td>
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<tr>
<td>hydrocortisone butyrate external cream 0.1 %</td>
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<td>hydrocortisone butyrate external ointment 0.1 %</td>
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<tr>
<td>hydrocortisone butyrate external solution 0.1 %</td>
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<tr>
<td>hydrocortisone external cream 1 %, 2.5 %*</td>
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<tr>
<td>hydrocortisone external lotion 2.5 %*</td>
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<tr>
<td>hydrocortisone external ointment 1 %, 2.5 %*</td>
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<tr>
<td>hydrocortisone valerate external cream 0.2 %</td>
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<tr>
<td>hydrocortisone valerate external ointment 0.2 %</td>
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<tr>
<td>mometasone furoate external cream 0.1 %</td>
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<tr>
<td>mometasone furoate external ointment 0.1 %</td>
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<tr>
<td>mometasone furoate external solution 0.1 %</td>
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<td></td>
</tr>
<tr>
<td>pimecrolimus external cream 1 %</td>
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<td>ST</td>
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<tr>
<td>prednicarbate external ointment 0.1 %</td>
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<tr>
<td>PROCTO-MED HC EXTERNAL CREAM 2.5 %*</td>
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</tr>
<tr>
<td>PROCTO-PAK EXTERNAL CREAM 1 %*</td>
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</tr>
<tr>
<td>PROCTOSOL HC EXTERNAL CREAM 2.5 %</td>
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</tr>
<tr>
<td>PROCTOZONE-HC EXTERNAL CREAM 2.5 %*</td>
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<tr>
<td>selenium sulfide external lotion 2.5 %</td>
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<tr>
<td>tacrolimus external ointment 0.03 %, 0.1 %</td>
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<td>triamcinolone acetonide external cream 0.025 %, 0.1 %</td>
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<tr>
<td>triamcinolone acetonide external lotion 0.025 %, 0.1 %</td>
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</tr>
<tr>
<td>Name of Drug</td>
<td>Drug Tier</td>
<td>Requirements/Limits</td>
</tr>
<tr>
<td>------------------------------------------------------------------------------</td>
<td>-----------</td>
<td>---------------------</td>
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<tr>
<td>triamcinolone acetonide external ointment 0.025 %, 0.05 %, 0.1 %, 0.5 %</td>
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<tr>
<td>triamcinolone in absorbse external ointment 0.05 %</td>
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<tr>
<td><strong>Dermatological Agents, Other</strong></td>
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<tr>
<td>ALCOHOL PAD*</td>
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<tr>
<td>alcohol pad 70 %*</td>
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<tr>
<td>alcohol prep pads pad 70 %*</td>
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<tr>
<td>alcohol sheet 70 %*</td>
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<td>calcipotriene external cream 0.005 %</td>
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<td>calcipotriene external ointment 0.005 %</td>
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<tr>
<td>calcipotriene external solution 0.005 %</td>
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<td>calcitriol external ointment 3 mcg/gm</td>
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<tr>
<td>clotrimazole-betamethasone external cream 1-0.05 %</td>
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<td>clotrimazole-betamethasone external lotion 1-0.05 %</td>
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<tr>
<td>fluorouracil external cream 0.5 %</td>
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<tr>
<td>fluorouracil external cream 5 %</td>
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<tr>
<td>fluorouracil external solution 2 %, 5 %</td>
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<tr>
<td>imiquimod external cream 5 %</td>
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<tr>
<td>methoxsalen rapid oral capsule 10 mg</td>
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<tr>
<td>nystatin-triamcinolone external cream 100000-0.1 unit/gm-%</td>
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<tr>
<td>nystatin-triamcinolone external ointment 100000-0.1 unit/gm%</td>
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<tr>
<td>OTEZLA ORAL TABLET 30 MG</td>
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<td>PA</td>
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<tr>
<td>podofilox external solution 0.5 %</td>
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</tr>
<tr>
<td>REGRANEX EXTERNAL GEL 0.01 %</td>
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<td>PA; QL (15 GM per 30 days)</td>
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<tr>
<td>SANTYL EXTERNAL OINTMENT 250 UNIT/GM</td>
<td>3</td>
<td>QL (90 GM per 30 days)</td>
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<tr>
<td>silver sulfadiazine external cream 1 %</td>
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<tr>
<td>SSD EXTERNAL CREAM 1%</td>
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<tr>
<td><strong>Pediculicides/Scabicides</strong></td>
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<tr>
<td>lindane external shampoo 1 %</td>
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</tr>
<tr>
<td>malathion external lotion 0.5 %</td>
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</tr>
<tr>
<td>Name of Drug</td>
<td>Drug Tier</td>
<td>Requirements/Limits</td>
</tr>
<tr>
<td>--------------------------------------------------</td>
<td>-----------</td>
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</tr>
<tr>
<td>permethrin external cream 5 %</td>
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<tr>
<td><strong>Topical Anti-Infectives</strong></td>
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<tr>
<td>acyclovir external cream 5 %</td>
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</tr>
<tr>
<td>acyclovir external ointment 5 %</td>
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</tr>
<tr>
<td>ciclopirox external solution 8 %</td>
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<tr>
<td>ciclopirox treatment external kit 8 %</td>
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<tr>
<td>acyclovir external ointment 5 %</td>
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<tr>
<td>acyclovir external cream 5 %</td>
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<tr>
<td>acyclovir external ointment 5 %</td>
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<td></td>
</tr>
<tr>
<td>ciclopirox external solution 8 %</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>ciclopirox treatment external kit 8 %</td>
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<td></td>
</tr>
<tr>
<td>clindamycin phosphate external gel 1%</td>
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</tr>
<tr>
<td>clindamycin phosphate external lotion 1%</td>
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<td></td>
</tr>
<tr>
<td>clindamycin phosphate external solution 1%</td>
<td>2</td>
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</tr>
<tr>
<td>DENAVIR EXTERNAL CREAM 1%</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>ery external pad 2 %</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>erythromycin external gel 2 %</td>
<td>2</td>
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</tr>
<tr>
<td>erythromycin external solution 2 %</td>
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</tr>
<tr>
<td>mupirocin external ointment 2 %</td>
<td>2</td>
<td>QL (88 GM per 30 days)</td>
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<tr>
<td><strong>Electrolytes/Minerals/ Metals/ Vitamins</strong></td>
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<td></td>
</tr>
<tr>
<td><strong>Electrolyte/ Mineral Replacement</strong></td>
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<tr>
<td>carglumic acid oral tablet soluble 200 mg</td>
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<td>PA</td>
</tr>
<tr>
<td>ISOLYTE-S INTRAVENOUS SOLUTION</td>
<td>4</td>
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<tr>
<td>ISOLYTE-S PH 7.4 INTRAVENOUS SOLUTION</td>
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<tr>
<td>kcl in dextrose-nacl intravenous solution 20-5-0.45 meq/l-%-%</td>
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</tr>
<tr>
<td>magnesium sulfate injection solution 50 %, 50 % (10ml syringe)</td>
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<tr>
<td>potassium chloride crys er oral tablet extended release 10 meq, 20 meq</td>
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<tr>
<td>potassium chloride er oral capsule extended release 10 meq, 8 meq</td>
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</tr>
<tr>
<td>potassium chloride er oral tablet extended release 10 meq, 20 meq, 8 meq</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Name of Drug</td>
<td>Drug Tier</td>
<td>Requirements/Limits</td>
</tr>
<tr>
<td>------------------------------------------------------------------------------</td>
<td>-----------</td>
<td>--------------------</td>
</tr>
<tr>
<td>potassium chloride intravenous solution 2 meq/ml, 2 meq/ml (20 ml), 40 meq/100ml</td>
<td>2</td>
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<tr>
<td>potassium chloride oral solution 10 %, 20 meq/15ml (10%), 40 meq/15ml (20%)</td>
<td>2</td>
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</tr>
<tr>
<td>potassium citrate er oral tablet extended release 10 meq (1080 mg), 15 meq (1620 mg), 5 meq (540 mg)</td>
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<tr>
<td>sodium chloride (pf) injection solution 0.9 %</td>
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</tr>
<tr>
<td>sodium chloride injection solution 0.9 %</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>sodium chloride intravenous solution 0.45 %, 0.9 %, 3 %</td>
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</tr>
<tr>
<td>sodium chloride irrigation solution 0.9 %</td>
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<td></td>
</tr>
<tr>
<td>sodium fluoride oral tablet 2.2 (1 f) mg</td>
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</tr>
<tr>
<td><strong>Electrolyte/Mineral/Metal Modifiers</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>deferasirox granules oral packet 180 mg, 360 mg, 90 mg</td>
<td>5</td>
<td>PA</td>
</tr>
<tr>
<td>deferasirox oral packet 180 mg, 360 mg, 90 mg</td>
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<td>PA</td>
</tr>
<tr>
<td>deferasirox oral tablet 180 mg, 360 mg</td>
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<td>PA</td>
</tr>
<tr>
<td>deferasirox oral tablet 90 mg</td>
<td>2</td>
<td>PA</td>
</tr>
<tr>
<td>deferasirox oral tablet soluble 125 mg</td>
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<td>PA</td>
</tr>
<tr>
<td>deferasirox oral tablet soluble 250 mg, 500 mg</td>
<td>5</td>
<td>PA</td>
</tr>
<tr>
<td>deferiprone oral tablet 1000 mg, 500 mg</td>
<td>5</td>
<td>PA</td>
</tr>
<tr>
<td>JYNARQUE ORAL TABLET 15 MG, 30 MG</td>
<td>5</td>
<td>PA</td>
</tr>
<tr>
<td>JYNARQUE ORAL TABLET THERAPY PACK 15 MG, 30 &amp; 15 MG, 45 &amp; 15 MG, 60 &amp; 30 MG, 90 &amp; 30 MG</td>
<td>5</td>
<td>PA</td>
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<tr>
<td>penicillamine oral tablet 250 mg</td>
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<td>PA</td>
</tr>
<tr>
<td>tolvaptan oral tablet 15 mg, 30 mg</td>
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<td>PA</td>
</tr>
<tr>
<td>trientine hcl oral capsule 250 mg</td>
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<td>PA</td>
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<tr>
<td><strong>Electrolytes/Minerals/Metals/Vitamins</strong></td>
<td></td>
<td></td>
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<tr>
<td>AMINOSYN II INTRAVENOUS SOLUTION 15 %</td>
<td>4</td>
<td>B/D</td>
</tr>
<tr>
<td>Name of Drug</td>
<td>Drug Tier</td>
<td>Requirements/Limits</td>
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<tr>
<td>--------------</td>
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</tr>
<tr>
<td>AMINOSYN-PF 7% INTRAVENOUS SOLUTION 7%</td>
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<td>B/D</td>
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<tr>
<td>AMINOSYN-PF INTRAVENOUS SOLUTION 7%</td>
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<td>B/D</td>
</tr>
<tr>
<td>CLINIMIX/DEXTROSE (4.25/10) INTRAVENOUS SOLUTION 4.25 %</td>
<td>4</td>
<td>B/D</td>
</tr>
<tr>
<td>CLINISOL SF INTRAVENOUS SOLUTION 15 %</td>
<td>4</td>
<td>B/D</td>
</tr>
<tr>
<td>dextrose intravenous solution 10 %, 5 %</td>
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</tr>
<tr>
<td>dextrose-nacl intravenous solution 10-0.2 %, 10-0.45 %, 2.5-0.45 %, 5-0.2 %, 5-0.225 %, 5-0.33 %, 5-0.45 %, 5-0.9 %</td>
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<tr>
<td>dextrose-sodium chloride intravenous solution 2.5-0.45 %, 5-0.45 %, 5-0.9 %</td>
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<tr>
<td>INTRALIPID INTRAVENOUS EMULSION 20 %, 30 %</td>
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<td>B/D</td>
</tr>
<tr>
<td>ISOLYTE-P IN D5W INTRAVENOUS SOLUTION</td>
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<tr>
<td>levocarnitine oral solution 1 gm/10ml</td>
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<td>levocarnitine oral tablet 330 mg</td>
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</tr>
<tr>
<td>levocarnitine sf oral solution 1 gm/10ml</td>
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<tr>
<td>NUTRILIPID INTRAVENOUS EMULSION 20 %</td>
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**Phosphate Binders**

<table>
<thead>
<tr>
<th>Name of Drug</th>
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<th>Requirements/Limits</th>
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<tbody>
<tr>
<td>calcium acetate (phos binder) oral capsule 667 mg</td>
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</tr>
<tr>
<td>FOSRENOL ORAL PACKET 1000 MG, 750 MG</td>
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<tr>
<td>lanthanum carbonate oral tablet chewable 1000 mg, 500 mg, 750 mg</td>
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<tr>
<td>sevelamer carbonate oral packet 0.8 gm, 2.4 gm</td>
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</tr>
<tr>
<td>sevelamer carbonate oral tablet 800 mg</td>
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**Potassium Binders**

<table>
<thead>
<tr>
<th>Name of Drug</th>
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<th>Requirements/Limits</th>
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<tbody>
<tr>
<td>sodium polystyrene sulfonate oral powder</td>
<td>2</td>
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<tr>
<td>SPS ORAL SUSPENSION 15 GM/60ML</td>
<td>2</td>
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</tr>
<tr>
<td>Name of Drug</td>
<td>Drug Tier</td>
<td>Requirements/Limits</td>
</tr>
<tr>
<td>--------------------------------------------------</td>
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<td>--------------------</td>
</tr>
<tr>
<td><strong>Vitamins</strong></td>
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<tr>
<td>KLOR-CON 10 ORAL TABLET EXTENDED RELEASE 10 MEQ</td>
<td>2</td>
<td></td>
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<tr>
<td>KLOR-CON M10 ORAL TABLET EXTENDED RELEASE 10 MEQ</td>
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<td></td>
</tr>
<tr>
<td>KLOR-CON M15 ORAL TABLET EXTENDED RELEASE 15 MEQ</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>KLOR-CON M20 ORAL TABLET EXTENDED RELEASE 20 MEQ</td>
<td>2</td>
<td></td>
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<tr>
<td>KLOR-CON ORAL TABLET EXTENDED RELEASE 8 MEQ</td>
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<tr>
<td>m-natal plus oral tablet 27-1 mg</td>
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</tr>
<tr>
<td>pnv tabs 29-1 oral tablet 29-1 mg</td>
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</tr>
<tr>
<td>potassium chloride crys er oral tablet extended release 15 meq</td>
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</tr>
<tr>
<td>prenatal oral tablet 27-0.8 mg, 27-1 mg</td>
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<td></td>
</tr>
<tr>
<td>prenatal plus iron oral tablet 29-1 mg</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>prenatal vitamin plus low iron oral tablet 27-1 mg</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>preplus oral tablet 27-1 mg</td>
<td>2</td>
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</tr>
<tr>
<td>pretab oral tablet 29-1 mg</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>thrivite rx oral tablet 29-1 mg</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>trinatal rx 1 oral tablet 60-1 mg</td>
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<tr>
<td><strong>Gastrointestinal Agents - Treatment Of Stomach And Intestinal Conditions</strong></td>
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<tr>
<td><strong>Anti-Constipation Agents</strong></td>
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</tr>
<tr>
<td>constulose oral solution 10 gm/15ml</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>enulose oral solution 10 gm/15ml</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>GAVILYTE-C ORAL SOLUTION RECONSTITUTED 240 GM</td>
<td>2</td>
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</tr>
<tr>
<td>GAVILYTE-G ORAL SOLUTION RECONSTITUTED 236 GM</td>
<td>2</td>
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<tr>
<td>GAVILYTE-N WITH FLAVOR PACK ORAL SOLUTION RECONSTITUTED 420 GM</td>
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</tr>
<tr>
<td>generlac oral solution 10 gm/15ml</td>
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<td></td>
</tr>
<tr>
<td>lactulose encephalopathy oral solution 10 gm/15ml</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Name of Drug</td>
<td>Drug Tier</td>
<td>Requirements/Limits</td>
</tr>
<tr>
<td>--------------------------------------------------</td>
<td>-----------</td>
<td>-----------------------------</td>
</tr>
<tr>
<td>lactulose oral solution 10 gm/15ml, 20 gm/30ml</td>
<td>2</td>
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</tr>
<tr>
<td>LINZESS ORAL CAPSULE 145 MCG, 290 MCG, 72 MCG</td>
<td>3</td>
<td>QL (30 EA per 30 days)</td>
</tr>
<tr>
<td>lubiprostone oral capsule 24 mcg, 8 mcg</td>
<td>2</td>
<td>QL (60 EA per 30 days)</td>
</tr>
<tr>
<td>peg 3350-kcl-na bicarb-nacl oral solution reconstituted 420 gm</td>
<td>2</td>
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</tr>
<tr>
<td>peg-3350/electrolytes oral solution reconstituted 236 gm</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>RELISTOR ORAL TABLET 150 MG</td>
<td>5</td>
<td>PA</td>
</tr>
<tr>
<td>RELISTOR SUBCUTANEOUS SOLUTION 12 MG/0.6ML, 12 MG/0.6ML (0.6ML SYRINGE), 8 MG/0.4ML</td>
<td>5</td>
<td>PA</td>
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</table>

**Anti-Diarrheal Agents**

<table>
<thead>
<tr>
<th>Name of Drug</th>
<th>Drug Tier</th>
<th>Requirements/Limits</th>
</tr>
</thead>
<tbody>
<tr>
<td>alosetron hcl oral tablet 0.5 mg</td>
<td>2</td>
<td>QL (60 EA per 30 days)</td>
</tr>
<tr>
<td>alosetron hcl oral tablet 1 mg</td>
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<td>QL (60 EA per 30 days)</td>
</tr>
<tr>
<td>diphenoxylate-atropine oral liquid 2.5-0.025 mg/5ml</td>
<td>2</td>
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</tr>
<tr>
<td>diphenoxylate-atropine oral tablet 2.5-0.025 mg</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>loperamide hcl oral capsule 2 mg</td>
<td>2</td>
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</tr>
<tr>
<td>XERMELO ORAL TABLET 250 MG</td>
<td>5</td>
<td>PA</td>
</tr>
<tr>
<td>XIFAXAN ORAL TABLET 200 MG</td>
<td>4</td>
<td>PA</td>
</tr>
<tr>
<td>XIFAXAN ORAL TABLET 550 MG</td>
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<td>PA</td>
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**Antispasmodics, Gastrointestinal**

<table>
<thead>
<tr>
<th>Name of Drug</th>
<th>Drug Tier</th>
<th>Requirements/Limits</th>
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<tbody>
<tr>
<td>dicyclomine hcl oral capsule 10 mg*</td>
<td>1</td>
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</tr>
<tr>
<td>dicyclomine hcl oral solution 10 mg/5ml</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>dicyclomine hcl oral tablet 20 mg*</td>
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</tr>
<tr>
<td>glycopyrrolate oral solution 1 mg/5ml</td>
<td>2</td>
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</tr>
<tr>
<td>glycopyrrolate oral tablet 1 mg, 2 mg</td>
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**Gastrointestinal Agents, Other**

<table>
<thead>
<tr>
<th>Name of Drug</th>
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<tbody>
<tr>
<td>GATTEX SUBCUTANEOUS KIT 5 MG</td>
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<td>PA</td>
</tr>
<tr>
<td>LIVMARLI ORAL SOLUTION 9.5 MG/ML</td>
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<td>PA</td>
</tr>
<tr>
<td>OCALIVA ORAL TABLET 10 MG, 5 MG</td>
<td>5</td>
<td>PA</td>
</tr>
<tr>
<td>ursodiol oral capsule 300 mg</td>
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</tr>
<tr>
<td>ursodiol oral tablet 250 mg, 500 mg</td>
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<td></td>
</tr>
<tr>
<td>Name of Drug</td>
<td>Drug Tier</td>
<td>Requirements/Limits</td>
</tr>
<tr>
<td>--------------------------------------------------</td>
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<td>--------------------</td>
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<tr>
<td><strong>Histamine-2 (H2) Receptor Antagonists</strong></td>
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<tr>
<td>cimetidine hcl oral solution 300 mg/5ml, 400 mg/6.67ml</td>
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<tr>
<td>cimetidine oral tablet 200 mg, 300 mg, 400 mg, 800 mg</td>
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</tr>
<tr>
<td>famotidine oral tablet 20 mg, 40 mg*</td>
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<tr>
<td><strong>Protectants</strong></td>
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<tr>
<td>misoprostol oral tablet 100 mcg, 200 mcg</td>
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<tr>
<td>sucralfate oral tablet 1 gm</td>
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<tr>
<td><strong>Proton Pump Inhibitors</strong></td>
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<tr>
<td>DEXILANT ORAL CAPSULE DELAYED RELEASE 30 MG, 60 MG</td>
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<tr>
<td>dxmlansoprazole oral capsule delayed release 30 mg, 60 mg</td>
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<tr>
<td>esomeprazole magnesium oral capsule delayed release 20 mg, 40 mg</td>
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<tr>
<td>lansoprazole oral capsule delayed release 15 mg, 30 mg*</td>
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<tr>
<td>omeprazole oral capsule delayed release 10 mg, 20 mg, 40 mg*</td>
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<td></td>
</tr>
<tr>
<td>pantoprazole sodium oral tablet delayed release 20 mg, 40 mg*</td>
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<td><strong>Genetic Or Enzyme Or Protein Disorder: Replacement, Modifiers, Treatment - Products That Replace, Modify, Or Treat Genetic Or Enzyme Disorders</strong></td>
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<tr>
<td><strong>Genetic Or Enzyme Or Protein Disorder: Replacement, Modifiers, Treatment</strong></td>
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<tr>
<td>ARALAST NP INTRAVENOUS SOLUTION RECONSTITUTED 1000 MG, 500 MG</td>
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<td>PA</td>
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<tr>
<td>betaine oral powder</td>
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<tr>
<td>CERDELGA ORAL CAPSULE 84 MG</td>
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<td>PA</td>
</tr>
<tr>
<td>CHOLBAM ORAL CAPSULE 250 MG, 50 MG</td>
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<td>PA</td>
</tr>
<tr>
<td>Name of Drug</td>
<td>Drug Tier</td>
<td>Requirements/Limits</td>
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<tr>
<td>----------------------------------------------------------------------------</td>
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<tr>
<td>CREON ORAL CAPSULE DELAYED RELEASE PARTICLES 12000-38000 UNIT, 24000-76000 UNIT, 3000-9500 UNIT, 36000-114000 UNIT, 6000-19000 UNIT</td>
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<tr>
<td>CYSTAGON ORAL CAPSULE 150 MG, 50 MG</td>
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<td>PA</td>
</tr>
<tr>
<td>ENDARI ORAL PACKET 5 GM</td>
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<td>PA</td>
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<tr>
<td>GALAFOLD ORAL CAPSULE 123 MG</td>
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<tr>
<td>GLASSIA INTRAVENOUS SOLUTION 1000 MG/50ML</td>
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<tr>
<td>KEVEYIS ORAL TABLET 50 MG</td>
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<td>PA</td>
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<tr>
<td>miglustat oral capsule 100 mg</td>
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<td>PA</td>
</tr>
<tr>
<td>nitisinone oral capsule 10 mg, 2 mg, 5 mg</td>
<td>5</td>
<td>PA</td>
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<tr>
<td>NITYR ORAL TABLET 10 MG, 2 MG, 5 MG</td>
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<td>PA</td>
</tr>
<tr>
<td>ORFADIN ORAL CAPSULE 20 MG</td>
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</tr>
<tr>
<td>ORFADIN ORAL SUSPENSION 4 MG/ML</td>
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</tr>
<tr>
<td>PLENAMINE INTRAVENOUS SOLUTION 15 %</td>
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<tr>
<td>PROLASTIN-C INTRAVENOUS SOLUTION 1000 MG/20ML</td>
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<td>PA</td>
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<td>PROLASTIN-C INTRAVENOUS SOLUTION RECONSTITUTED 1000 MG</td>
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<td>PA</td>
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<tr>
<td>RAVICTI ORAL LIQUID 1.1 GM/ML</td>
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<td>PA</td>
</tr>
<tr>
<td>sapropterin dihydrochloride oral packet 100 mg, 500 mg</td>
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<tr>
<td>sapropterin dihydrochloride oral tablet 100 mg</td>
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</tr>
<tr>
<td>sodium phenylbutyrate oral powder 3 gm/tsp</td>
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<tr>
<td>sodium phenylbutyrate oral tablet 500 mg</td>
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<tr>
<td>SUCRAID ORAL SOLUTION 8500 UNIT/ML</td>
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<tr>
<td>XURIDEN ORAL PACKET 2 GM</td>
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<td>PA</td>
</tr>
<tr>
<td>ZEMAIRA INTRAVENOUS SOLUTION RECONSTITUTED 1000 MG</td>
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<td>PA</td>
</tr>
<tr>
<td>Name of Drug</td>
<td>Drug Tier</td>
<td>Requirements/Limits</td>
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<tr>
<td>ZENPEP ORAL CAPSULE DELAYED RELEASE PARTICLES</td>
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<tr>
<td>10000-32000 UNIT, 15000-47000 UNIT,</td>
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<tr>
<td>20000-63000 UNIT, 25000-79000 UNIT,</td>
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</tr>
<tr>
<td>3000-10000 UNIT, 40000-126000 UNIT,</td>
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<tr>
<td>5000-24000 UNIT</td>
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</table>

Genitourinary Agents - Treatment Of Urinary Tract And Prostate Conditions

Antispasmodics, Urinary

darifenacin hydrobromide er oral tablet extended release 24 hour 15 mg, 7.5 mg | 2 | ST |
| fesoterodine fumarate er oral tablet extended release 24 hour 4 mg, 8 mg | 2 | ST |
| flavoxate hcl oral tablet 100 mg                                    | 2 |     |
| myrbetriq oral suspension reconstituted er 8 mg/ml                  | 3 | QL (300 ML per 30 days) |
| MYRBETRIQ ORAL TABLET EXTENDED RELEASE 24 HOUR 25 MG, 50 MG          | 3 | QL (30 EA per 30 days) |
| oxybutynin chloride er oral tablet extended release 24 hour 10 mg, 15 mg, 5 mg* | 1 | |
| oxybutynin chloride oral syrup 5 mg/5ml*                           | 1 |     |
| oxybutynin chloride oral tablet 5 mg*                              | 1 |     |
| solifenacin succinate oral tablet 10 mg, 5 mg                       | 2 |     |
| tolterodine tartrate er oral capsule extended release 24 hour 2 mg, 4 mg | 2 | ST |
| tolterodine tartrate oral tablet 1 mg, 2 mg                         | 2 |     |
| trospium chloride er oral capsule extended release 24 hour 60 mg    | 2 | ST |
| trospium chloride oral tablet 20 mg                                 | 2 |     |

Benign Prostatic Hypertrophy Agents

alfuzosin hcl er oral tablet extended release 24 hour 10 mg* | 1 |     |
| dutasteride oral capsule 0.5 mg                                  | 2 |     |
| finasteride oral tablet 5 mg*                                   | 1 |     |
| tamsulosin hcl oral capsule 0.4 mg                              | 2 |     |
### Genitourinary Agents, Other

<table>
<thead>
<tr>
<th>Name of Drug</th>
<th>Drug Tier</th>
<th>Requirements/Limits</th>
</tr>
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<tbody>
<tr>
<td>bethanechol chloride oral tablet 10 mg, 25 mg, 5 mg, 50 mg</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>ELMIRON ORAL CAPSULE 100 MG</td>
<td>4</td>
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<tr>
<td>THIOLA EC ORAL TABLET DELAYED RELEASE 100 MG, 300 MG</td>
<td>5</td>
<td>PA</td>
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<tr>
<td>tiopronin oral tablet 100 mg</td>
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<td>PA</td>
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### Hormonal Agents, Stimulant/Replacement/Modifying (Adrenal) - Treatment Of Conditions Requiring Steroids

#### Hormonal Agents, Stimulant/Replacement/Modifying (Adrenal)

<table>
<thead>
<tr>
<th>Name of Drug</th>
<th>Drug Tier</th>
<th>Requirements/Limits</th>
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<tbody>
<tr>
<td>ACTHAR INJECTION GEL 80 UNIT/ML</td>
<td>5</td>
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<tr>
<td>betamethasone dipropionate aug external cream 0.05 %</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>betamethasone dipropionate external ointment 0.05 %</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>cortisone acetate oral tablet 25 mg</td>
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</tr>
<tr>
<td>CORTROPHIN INJECTION GEL 80 UNIT/ML</td>
<td>5</td>
<td>PA</td>
</tr>
<tr>
<td>fludrocortisone acetate oral tablet 0.1 mg</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>hydrocortisone oral tablet 10 mg, 20 mg, 5 mg</td>
<td>2</td>
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</tr>
<tr>
<td>PREDNISONE INTENSOL ORAL CONCENTRATE 5 MG/ML</td>
<td>2</td>
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### Hormonal Agents, Stimulant/Replacement/Modifying (Pituitary) - Treatment Of Pituitary Gland Conditions

#### Hormonal Agents, Stimulant/Replacement/Modifying (Pituitary)

<table>
<thead>
<tr>
<th>Name of Drug</th>
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<th>Requirements/Limits</th>
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<tbody>
<tr>
<td>desmopressin ace spray refrig nasal solution 0.01 %</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>desmopressin acetate oral tablet 0.1 mg, 0.2 mg</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>desmopressin acetate spray nasal solution 0.01 %</td>
<td>2</td>
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</tr>
<tr>
<td>EGRIFTA SV SUBCUTANEOUS SOLUTION RECONSTITUTED 2 MG</td>
<td>5</td>
<td>PA</td>
</tr>
<tr>
<td>GENOTROPIN MINIQUICK SUBCUTANEOUS PREFILLED SYRINGE 0.2 MG</td>
<td>4</td>
<td>PA</td>
</tr>
<tr>
<td>Name of Drug</td>
<td>Drug Tier</td>
<td>Requirements/Limits</td>
</tr>
<tr>
<td>----------------------------------------------------------------------------</td>
<td>-----------</td>
<td>---------------------</td>
</tr>
<tr>
<td>GENOTROPIN MINIQUICK SUBCUTANEOUS PREFILLED SYRINGE 0.4 MG, 0.6 MG, 0.8 MG, 1 MG, 1.2 MG, 1.4 MG, 1.6 MG, 1.8 MG, 2 MG</td>
<td>5</td>
<td>PA</td>
</tr>
<tr>
<td>GENOTROPIN SUBCUTANEOUS CARTRIDGE 12 MG, 5 MG</td>
<td>5</td>
<td>PA</td>
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<tr>
<td>HUMATROPE INJECTION CARTRIDGE 12 MG, 24 MG, 6 MG</td>
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<td>PA</td>
</tr>
<tr>
<td>INCRELEX SUBCUTANEOUS SOLUTION 40 MG/4ML</td>
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<tr>
<td>NORDITROPIN FLEXPRO SUBCUTANEOUS SOLUTION PEN-INJECTOR 10 MG/1.5ML, 15 MG/1.5ML, 30 MG/3ML, 5 MG/1.5ML</td>
<td>5</td>
<td>PA</td>
</tr>
<tr>
<td>NUTROPIN AQ NUSPIN 10 SUBCUTANEOUS SOLUTION PEN-INJECTOR 10 MG/2ML</td>
<td>5</td>
<td>PA</td>
</tr>
<tr>
<td>NUTROPIN AQ NUSPIN 20 SUBCUTANEOUS SOLUTION PEN-INJECTOR 20 MG/2ML</td>
<td>5</td>
<td>PA</td>
</tr>
<tr>
<td>NUTROPIN AQ NUSPIN 5 SUBCUTANEOUS SOLUTION PEN-INJECTOR 5 MG/2ML</td>
<td>5</td>
<td>PA</td>
</tr>
<tr>
<td>OMNITROPE SUBCUTANEOUS SOLUTION CARTRIDGE 10 MG/1.5ML, 5 MG/1.5ML</td>
<td>5</td>
<td>PA</td>
</tr>
<tr>
<td>OMNITROPE SUBCUTANEOUS SOLUTION RECONSTITUTED 5.8 MG</td>
<td>5</td>
<td>PA</td>
</tr>
<tr>
<td>ORILISSA ORAL TABLET 150 MG, 200 MG</td>
<td>5</td>
<td>PA</td>
</tr>
<tr>
<td>SEROSTIM SUBCUTANEOUS SOLUTION RECONSTITUTED 4 MG, 5 MG, 6 MG</td>
<td>5</td>
<td>PA</td>
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<tr>
<td>SKYTROFA SUBCUTANEOUS CARTRIDGE 11 MG, 13.3 MG, 3 MG, 3.6 MG, 4.3 MG, 5.2 MG, 6.3 MG, 7.6 MG, 9.1 MG</td>
<td>5</td>
<td>PA</td>
</tr>
</tbody>
</table>

**Hormonal Agents, Stimulant/Replacement/Modifying (Sex Hormones/Modifiers) - For The Replacement Or Modification Of Sex Hormones**

**Anabolic Steroids**

<table>
<thead>
<tr>
<th>Name of Drug</th>
<th>Drug Tier</th>
<th>Requirements/Limits</th>
</tr>
</thead>
<tbody>
<tr>
<td>oxandrolone oral tablet 10 mg, 2.5 mg</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Name of Drug</td>
<td>Drug Tier</td>
<td>Requirements/Limits</td>
</tr>
<tr>
<td>--------------</td>
<td>-----------</td>
<td>-------------------</td>
</tr>
<tr>
<td><strong>Androgens</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>danazol oral capsule 100 mg, 200 mg, 50 mg</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>methyltestosterone oral capsule 10 mg</td>
<td>5</td>
<td>PA</td>
</tr>
<tr>
<td>testosterone cypionate injection solution 200 mg/ml</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>testosterone cypionate intramuscular solution 100 mg/ml, 200 mg/ml, 200 mg/ml (1 ml)</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>testosterone enanthate intramuscular solution 200 mg/ml</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>testosterone transdermal gel 12.5 mg/act (1%), 20.25 mg/1.25gm (1.62%), 25 mg/2.5gm (1%), 40.5 mg/2.5gm (1.62%), 50 mg/5gm (1%)</td>
<td>2</td>
<td>PA</td>
</tr>
<tr>
<td>testosterone transdermal solution 30 mg/act</td>
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<tr>
<td><strong>Estrogens</strong></td>
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</tr>
<tr>
<td>estradiol oral tablet 0.5 mg, 1 mg, 2 mg*</td>
<td>1</td>
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<tr>
<td>estradiol transdermal patch twice weekly 0.025 mg/24hr, 0.0375 mg/24hr, 0.05 mg/24hr, 0.075 mg/24hr, 0.1 mg/24hr</td>
<td>2</td>
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<tr>
<td>estradiol transdermal patch weekly 0.025 mg/24hr, 0.0375 mg/24hr, 0.05 mg/24hr, 0.06 mg/24hr, 0.075 mg/24hr, 0.1 mg/24hr</td>
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<tr>
<td>estradiol vaginal cream 0.1 mg/gm</td>
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<tr>
<td>estradiol vaginal tablet 10 mcg</td>
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<tr>
<td>estradiol valerate intramuscular oil 20 mg/ml, 40 mg/ml</td>
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<tr>
<td>LYLLANA TRANSDERMAL PATCH TWICE WEEKLY 0.025 MG/24HR, 0.0375 MG/24HR, 0.05 MG/24HR, 0.075 MG/24HR, 0.1 MG/24HR</td>
<td>2</td>
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<tr>
<td>MENEST ORAL TABLET 0.3 MG, 0.625 MG, 1.25 MG</td>
<td>4</td>
<td>PA</td>
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<tr>
<td>MYFEMBREE ORAL TABLET 40-1-0.5 MG</td>
<td>5</td>
<td>PA</td>
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<tr>
<td>PREMARIN ORAL TABLET 0.3 MG, 0.45 MG, 0.625 MG, 0.9 MG, 1.25 MG</td>
<td>3</td>
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<tr>
<td>Name of Drug</td>
<td>Drug Tier</td>
<td>Requirements/Limits</td>
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<tr>
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<tr>
<td>PREMARIN VAGINAL CREAM 0.625 MG/GM</td>
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<tr>
<td>YUVAFEM VAGINAL TABLET 10 MCG</td>
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**Hormonal Agents, Stimulant/Replacement/Modifying (Sex Hormones/Modifiers)**

<table>
<thead>
<tr>
<th>Name of Drug</th>
<th>Drug Tier</th>
<th>Requirements/Limits</th>
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<tbody>
<tr>
<td>AFIRMELLE ORAL TABLET 0.1-20 MG-MCG</td>
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<tr>
<td>ALTAVERA ORAL TABLET 0.15-30 MG-MCG</td>
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<tr>
<td>alyacen 1/35 oral tablet 1-35 mg-mcg</td>
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<tr>
<td>alyacen 7/7/7 oral tablet 0.5/0.75/1-35 mg-mcg</td>
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<tr>
<td>AMABELZ ORAL TABLET 0.5-0.1 MG, 1-0.5 MG</td>
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<tr>
<td>APRI ORAL TABLET 0.15-30 MG-MCG</td>
<td>2</td>
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<tr>
<td>ARANELLE ORAL TABLET 0.5/1/0.5-35 MG-MCG</td>
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<tr>
<td>AUBRA EQ ORAL TABLET 0.1-20 MG-MCG</td>
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<tr>
<td>AUBRA ORAL TABLET 0.1-20 MG-MCG</td>
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<tr>
<td>AUROVELA 1.5/30 ORAL TABLET 1.5-30 MG-MCG</td>
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<td>AUROVELA FE 1.5/30 ORAL TABLET 1.5-30 MG-MCG</td>
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<td>AUROVELA FE 1/20 ORAL TABLET 1-20 MG-MCG</td>
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<tr>
<td>AVIANE ORAL TABLET 0.1-20 MG-MCG</td>
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<tr>
<td>AYUNA ORAL TABLET 0.15-30 MG-MCG</td>
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<tr>
<td>BALZIVA ORAL TABLET 0.4-35 MG-MCG</td>
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<td>BLISOVI FE 1.5/30 ORAL TABLET 1.5-30 MG-MCG</td>
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<td>BLISOVI FE 1/20 ORAL TABLET 1-20 MG-MCG</td>
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<tr>
<td>briellyn oral tablet 0.4-35 mg-mcg</td>
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<td>CHATEAL EQ ORAL TABLET 0.15-30 MG-MCG</td>
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<td>CHATEAL ORAL TABLET 0.15-30 MG-MCG</td>
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<tr>
<td>Name of Drug</td>
<td>Drug Tier</td>
<td>Requirements/Limits</td>
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<tr>
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<td>----------------------------------------------------------</td>
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<tr>
<td>COMBIPATCH TRANSDERMAL PATCH TWICE WEEKLY 0.05-0.14 MG/DAY, 0.05-0.25 MG/DAY</td>
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<tr>
<td>CRYSELLE-28 ORAL TABLET 0.3-30 MG-MCG</td>
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<tr>
<td>CYCLAFEM 1/35 ORAL TABLET 1-35 MG-MCG</td>
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<tr>
<td>CYCLAFEM 7/7/7 ORAL TABLET 0.5/0.75/1-35 MG-MCG</td>
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<td>CYRED EQ ORAL TABLET 0.15-30 MG-MCG</td>
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<td>CYRED ORAL TABLET 0.15-30 MG-MCG</td>
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<td>DELYLA ORAL TABLET 0.1-20 MG-MCG</td>
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<tr>
<td>desogestrel-ethinyl estradiol oral tablet 0.15-0.02/0.01 mg (2/5), 0.15-30 mg-mcg</td>
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<tr>
<td>drospirenone-ethinyl estradiol oral tablet 3-0.02 mg, 3-0.03 mg</td>
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<tr>
<td>ELURYNG VAGINAL RING 0.12-0.015 MG/24HR</td>
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<tr>
<td>EMOQUETTE ORAL TABLET 0.15-30 MG-MCG</td>
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<tr>
<td>ENPRESSE-28 ORAL TABLET 50-30/75-40/125-30 MCG</td>
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<tr>
<td>ENSKYCE ORAL TABLET 0.15-30 MG-MCG</td>
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<tr>
<td>ESTARYLLA ORAL TABLET 0.25-35 MG-MCG</td>
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<tr>
<td>estradiol-norethindrone acet oral tablet 0.5-0.1 mg, 1-0.5 mg</td>
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<tr>
<td>ethynodiol diac-eth estradiol oral tablet 1-35 mg-mcg, 1-50 mg-mcg</td>
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<tr>
<td>etonogestrel-ethinyl estradiol vaginal ring 0.12-0.015 mg/24hr</td>
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<tr>
<td>FALMINA ORAL TABLET 0.1-20 MG-MCG</td>
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<tr>
<td>FEMYNOR ORAL TABLET 0.25-35 MG-MCG</td>
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<tr>
<td>FYAVOLV ORAL TABLET 0.5-2.5 MG-MCG, 1-5 MG-MCG</td>
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<tr>
<td>Name of Drug</td>
<td>Drug Tier</td>
<td>Requirements/Limits</td>
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<tr>
<td>HAILEY 1.5/30 ORAL TABLET 1.5-30 MG-MCG</td>
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<td>HAILEY 24 FE ORAL TABLET 1-20 MG-MCG(24)</td>
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<td>HAILEY FE 1.5/30 ORAL TABLET 1.5-30 MG-MCG</td>
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<td>HAILEY FE 1/20 ORAL TABLET 1-20 MG-MCG</td>
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<td>INCASSIA ORAL TABLET 0.35 MG</td>
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<td>INTROVALE ORAL TABLET 0.15-0.03 MG</td>
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<tr>
<td>ISIBLOOM ORAL TABLET 0.15-30 MG-MCG</td>
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<td>JINTELI ORAL TABLET 1-5 MG-MCG</td>
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<td>JULEBER ORAL TABLET 0.15-30 MG-MCG</td>
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<td>JUNEL 1.5/30 ORAL TABLET 1.5-30 MG-MCG</td>
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<td>JUNEL FE 1/20 ORAL TABLET 1-20 MG-MCG</td>
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<tr>
<td>KALLIGA ORAL TABLET 0.15-30 MG-MCG</td>
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<tr>
<td>KARIVA ORAL TABLET 0.15-0.02/0.01 MG (21/5)</td>
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<tr>
<td>KELNOR 1/35 ORAL TABLET 1-35 MG-MCG</td>
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<td>KELNOR 1/50 ORAL TABLET 1-50 MG-MCG</td>
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<tr>
<td>KUREVELO ORAL TABLET 0.15-30 MG-MCG</td>
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<td>LARIN 1.5/30 ORAL TABLET .5-30 MG-MCG</td>
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<td>LARIN 1/20 ORAL TABLET 1-20 MG-MCG</td>
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<td>LARIN FE 1.5/30 ORAL TABLET 1.5-30 MG-MCG</td>
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<td>LARIN FE 1/20 ORAL TABLET 1-20 MG-MCG</td>
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</tr>
<tr>
<td>LARISSIA ORAL TABLET 0.1-20 MG-MCG</td>
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</tr>
<tr>
<td>Name of Drug</td>
<td>Drug Tier</td>
<td>Requirements/Limits</td>
</tr>
<tr>
<td>------------------------------------------</td>
<td>-----------</td>
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</tr>
<tr>
<td>LEENA ORAL TABLET 0.5/0.5-35 MG-MCG</td>
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</tr>
<tr>
<td>LESSINA ORAL TABLET 0.1-20 MG-MCG</td>
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</tr>
<tr>
<td>LEVONEST ORAL TABLET 50-30/75-40/125-30 MCG</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>levonorgest-eth estrad 91-day oral tablet 0.1-0.02 &amp; 0.01 mg, 0.15-0.03 &amp; 0.01 mg, 0.15-0.03 mg</td>
<td>2</td>
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<tr>
<td>levonorgestrel-ethinyl estrad oral tablet 0.1-20 mg-mcg, 0.15-30 mg-mcg</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>levonorg-eth estrad triphasic oral tablet 50-30/75-40/125-30 mcg</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>LEVORA 0.15/30 (28) ORAL TABLET 0.15-30 MG-MCG</td>
<td>2</td>
<td></td>
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<tr>
<td>LILLOW ORAL TABLET 0.15-30 MG-MCG</td>
<td>2</td>
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<tr>
<td>LOESTRIN 1.5/30 (21) ORAL TABLET 1.5-30 MG-MCG</td>
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<tr>
<td>LOPREEZA ORAL TABLET 1-0.5 MG</td>
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<tr>
<td>LOW-OGESTREL ORAL TABLET 0.3-30 MG-MCG</td>
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<tr>
<td>LUTERA ORAL TABLET 0.1-20 MG-MCG</td>
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<tr>
<td>marlissa oral tablet 0.15-30 mg-mcg</td>
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<tr>
<td>MICROGESTIN 1.5/30 ORAL TABLET 1.5-30 MG-MCG</td>
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<td>MICROGESTIN 1/20 ORAL TABLET 1-20 MG-MCG</td>
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<td>MICROGESTIN 24 FE ORAL TABLET 1-20 MG-MCG</td>
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<td>MICROGESTIN FE 1.5/30 ORAL TABLET 1.5-30 MG-MCG</td>
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<td>MICROGESTIN FE 1/20 ORAL TABLET 1-20 MG-MCG</td>
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<tr>
<td>MILI ORAL TABLET 0.25-35 MG-MCG</td>
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<tr>
<td>MIMVEY ORAL TABLET 1-0.5 MG</td>
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<tr>
<td>NECON 0.5/35 (28) ORAL TABLET 0.5-35 MG-MCG</td>
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</tr>
<tr>
<td>norethin ace-eth estrad-fe oral tablet 1-20 mg-mcg, 1.5-30 mg-mcg</td>
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</tr>
<tr>
<td>Name of Drug</td>
<td>Drug Tier</td>
<td>Requirements/Limits</td>
</tr>
<tr>
<td>--------------</td>
<td>-----------</td>
<td>--------------------</td>
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<tr>
<td>norethindrone acet-ethinyl est oral tablet 1-20 mg-mcg, 1.5-30 mg-mcg</td>
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<tr>
<td>norethindrone-eth estradiol oral tablet 0.5-2.5 mg-mcg</td>
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<tr>
<td>norgestimate-eth estradiol oral tablet 0.25-35 mg-mcg</td>
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<tr>
<td>norgestim-eth estradiol triphasic oral tablet 0.18/0.215/0.25 mg-35 mcg</td>
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<tr>
<td>NORTREL 0.5/35 (28) ORAL TABLET 0.5-35 MG-MCG</td>
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<tr>
<td>NORTREL 1/35 (21) ORAL TABLET 1-35 MG-MCG</td>
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<tr>
<td>NORTREL 1/35 (28) ORAL TABLET 1-35 MG-MCG</td>
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<tr>
<td>NORTREL 7/7/7 ORAL TABLET 0.5/0.75/1-35 MG-MCG</td>
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<tr>
<td>NYLIA 1/35 ORAL TABLET 1-35 MG-MCG</td>
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</tr>
<tr>
<td>NYLIA 7/7/7 ORAL TABLET 0.5/0.75/1-35 MG-MCG</td>
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</tr>
<tr>
<td>OCELLA ORAL TABLET 3-0.03 MG</td>
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<tr>
<td>ORSYTHIA ORAL TABLET 0.1-20 MG-MCG</td>
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<tr>
<td>PIMTREA ORAL TABLET 0.15-0.02/0.01 MG (21/5)</td>
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<tr>
<td>PIRMELLA 1/35 ORAL TABLET 1-35 MG-MCG</td>
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<tr>
<td>PORTIA-28 ORAL TABLET 0.15-30 MG-MCG</td>
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<tr>
<td>PREMPHASE ORAL TABLET 0.625-5 MG</td>
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<tr>
<td>PREMPRO ORAL TABLET 0.3-1.5 MG, 0.45-1.5 MG, 0.625-2.5 MG, 0.625-5 MG</td>
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<td>RECLIPSEN ORAL TABLET 0.15-30 MG-MCG</td>
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<tr>
<td>SETLAKIN ORAL TABLET 0.15-0.03 MG</td>
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<tr>
<td>SHAROBEL ORAL TABLET 0.35 MG</td>
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<td>SIMLIYA ORAL TABLET 0.15-0.02/0.01 MG (21/5)</td>
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<tr>
<td>SPRINTEC 28 ORAL TABLET 0.25-35 MG-MCG</td>
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<td>Name of Drug</td>
<td>Drug Tier</td>
<td>Requirements/Limits</td>
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<td>SRONYX ORAL TABLET 0.1-20 MG-MCG</td>
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<td>TARINA FE 1/20 EQ ORAL TABLET 1-20 MG-MCG</td>
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<tr>
<td>TARINA FE 1/20 ORAL TABLET 1-20 MG-MCG</td>
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<tr>
<td>TRI FEMYNOR ORAL TABLET 0.18/0.215/0.25 MG-35 MCG</td>
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<tr>
<td>TRI-ESTARYLLA ORAL TABLET 0.18/0.215/0.25 MG-35 MCG</td>
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<tr>
<td>TRI-LEGEST FE ORAL TABLET 1-20/1-30/1-35 MG-MCG</td>
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<tr>
<td>TRI-MILI ORAL TABLET 0.18/0.215/0.25 MG-35 MCG</td>
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<tr>
<td>TRI-SPRINTEC ORAL TABLET 0.18/0.215/0.25 MG-35 MCG</td>
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<tr>
<td>TRIVORA (28) ORAL TABLET 50-30/75-40/ 125-30 MG</td>
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<tr>
<td>TRI-VYLIBRA ORAL TABLET 0.18/0.215/0.25 MG-35 MCG</td>
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<tr>
<td>VELIVET ORAL TABLET 0.1/0.125/0.15 -0.025 MG</td>
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<tr>
<td>VIENVA ORAL TABLET 0.1-20 MG-MCG</td>
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<tr>
<td>VOLNEA ORAL TABLET 0.15-0.02/0.01 MG (21/5)</td>
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<tr>
<td>VYFEMLA ORAL TABLET 0.4-35 MG-MCG</td>
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<tr>
<td>VYLIBRA ORAL TABLET 0.25-35 MG-MCG</td>
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<tr>
<td>XULANE TRANSDERMAL PATCH WEEKLY 150-35 MCG/24HR</td>
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<tr>
<td>ZAFEMY TRANSDERMAL PATCH WEEKLY 150-35 MCG/24HR</td>
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<tr>
<td>ZOVIA 1/35 (28) ORAL TABLET 1-35 MG-MCG</td>
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<tr>
<td>ZOVIA 1/35E (28) ORAL TABLET 1-35 MG-MCG</td>
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<tr>
<td><strong>Progestins</strong></td>
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<tr>
<td>CAMILA ORAL TABLET 0.35 MG</td>
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<td></td>
</tr>
<tr>
<td>DEBLITANE ORAL TABLET 0.35 MG</td>
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<tr>
<td>Name of Drug</td>
<td>Drug Tier</td>
<td>Requirements/Limits</td>
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<tr>
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<tr>
<td>DEPO-SUBQ PROVERA 104 SUBCUTANEOUS SUSPENSION PREFILLED SYRINGE 104 MG/0.65ML</td>
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<tr>
<td>ERRIN ORAL TABLET 0.35 MG</td>
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<tr>
<td>LYZA ORAL TABLET 0.35 MG</td>
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<tr>
<td>medroxyprogesterone acetate intramuscular suspension 150 mg/ml</td>
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<tr>
<td>medroxyprogesterone acetate intramuscular suspension prefilled syringe 150 mg/ml</td>
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<tr>
<td>medroxyprogesterone acetate oral tablet 10 mg, 2.5 mg, 5 mg*</td>
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<tr>
<td>megestrol acetate oral suspension 40 mg/ml, 400 mg/10ml, 625 mg/5ml, 800 mg/20ml</td>
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<td>PA</td>
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<tr>
<td>megestrol acetate oral tablet 20 mg, 40 mg</td>
<td>2</td>
<td>PA</td>
</tr>
<tr>
<td>NORA-BE ORAL TABLET 0.35 MG</td>
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<tr>
<td>norethindrone acetate oral tablet 5 mg</td>
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</tr>
<tr>
<td>norethindrone oral tablet 0.35 mg</td>
<td>2</td>
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<tr>
<td>NORLYDA ORAL TABLET 0.35 MG</td>
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<tr>
<td>NORLYROC ORAL TABLET 0.35 MG</td>
<td>2</td>
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<tr>
<td>progesterone oral capsule 100 mg, 200 mg</td>
<td>2</td>
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</tr>
<tr>
<td>TULANA ORAL TABLET 0.35 MG</td>
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</table>

**Selective Estrogen Receptor Modifying Agents**

| DUAVEE ORAL TABLET 0.45-20 MG                                              | 3         |                     |
| raloxifene hcl oral tablet 60 mg                                           | 2         |                     |

**Hormonal Agents, Stimulant/Replacement/Modifying (Thyroid) - Treatment Of Thyroid Conditions**

<p>| LEVO-T ORAL TABLET 100 MCG, 112 MCG, 125 MCG, 137 MCG, 150 MCG, 175 MCG, 200 MCG, 25 MCG, 300 MCG, 50 MCG, 75 MCG, 88 MCG | 4         |                     |</p>
<table>
<thead>
<tr>
<th>Name of Drug</th>
<th>Drug Tier</th>
<th>Requirements/Limits</th>
</tr>
</thead>
<tbody>
<tr>
<td>levothyroxine sodium oral tablet 100 mcg, 112 mcg, 125 mcg, 137 mcg, 150 mcg, 175 mcg, 200 mcg, 25 mcg, 300 mcg, 50 mcg, 75 mcg, 88 mcg*</td>
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<tr>
<td>LEVOXYL ORAL TABLET 100 MCG, 112 MCG, 125 MCG, 137 MCG, 150 MCG, 175 MCG, 200 MCG, 25 MCG, 50 MCG, 75 MCG, 88 MCG</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>liothyronine sodium oral tablet 25 mcg, 5 mcg, 50 mcg</td>
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<td></td>
</tr>
<tr>
<td>SYNTHROID ORAL TABLET 100 MCG, 112 MCG, 125 MCG, 137 MCG, 150 MCG, 175 MCG, 200 MCG, 25 MCG, 300 MCG, 50 MCG, 75 MCG, 88 MCG</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>UNITHROID ORAL TABLET 100 MCG, 112 MCG, 125 MCG, 137 MCG, 150 MCG, 175 MCG, 200 MCG, 25 MCG, 300 MCG, 50 MCG, 75 MCG, 88 MCG</td>
<td>4</td>
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</table>

**Hormonal Agents, Suppressant (Pituitary) - Treatment Of Or Modification Of Pituitary Hormone Secretion**

<table>
<thead>
<tr>
<th>Hormonal Agents, Suppressant (Pituitary)</th>
<th>Drug Tier</th>
<th>Requirements/Limits</th>
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<tbody>
<tr>
<td>cabergoline oral tablet 0.5 mg</td>
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<tr>
<td>CAMCEVI SUBCUTANEOUS PREFILLED SYRINGE 42 MG</td>
<td>4</td>
<td>PA</td>
</tr>
<tr>
<td>ELIGARD SUBCUTANEOUS KIT 22.5 MG, 30 MG, 45 MG, 7.5 MG</td>
<td>4</td>
<td>PA</td>
</tr>
<tr>
<td>FIRMAGON (240 MG DOSE) SUBCUTANEOUS SOLUTION RECONSTITUTED 120 MG/VIAL</td>
<td>5</td>
<td>PA</td>
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<tr>
<td>FIRMAGON SUBCUTANEOUS SOLUTION RECONSTITUTED 80 MG</td>
<td>4</td>
<td>PA</td>
</tr>
<tr>
<td>lanreotide acetate subcutaneous solution 120 mg/0.5ml</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>leuprolide acetate injection kit 1 mg/0.2ml</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>LUPRON DEPOT (1-MONTH) INTRAMUSCULAR KIT 3.75 MG, 7.5 MG</td>
<td>5</td>
<td>PA</td>
</tr>
<tr>
<td>LUPRON DEPOT (3-MONTH) INTRAMUSCULAR KIT 11.25 MG, 22.5 MG</td>
<td>5</td>
<td>PA</td>
</tr>
<tr>
<td>Name of Drug</td>
<td>Drug Tier</td>
<td>Requirements/Limits</td>
</tr>
<tr>
<td>-------------------------------------------------------</td>
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<tr>
<td>LUPRON DEPOT (4-MONTH) INTRAMUSCULAR KIT 30 MG</td>
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<td>PA</td>
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<tr>
<td>LUPRON DEPOT (6-MONTH) INTRAMUSCULAR KIT 45 MG</td>
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<tr>
<td>LUPRON DEPOT-PED (1-MONTH) INTRAMUSCULAR KIT 7.5 MG</td>
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<td>PA</td>
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<tr>
<td>LUPRON DEPOT-PED (3-MONTH) INTRAMUSCULAR KIT 11.25 MG (PED)</td>
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<td>PA</td>
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<tr>
<td>octreotide acetate injection solution 100 mcg/ml, 200 mcg/ml, 50 mcg/ml</td>
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<tr>
<td>octreotide acetate injection solution 1000 mcg/ml, 500 mcg/ml</td>
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</tr>
<tr>
<td>octreotide acetate subcutaneous solution prefilled syringe 100 mcg/ml, 50 mcg/ml</td>
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<tr>
<td>octreotide acetate subcutaneous solution prefilled syringe 500 mcg/ml</td>
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<tr>
<td>RECORLEV ORAL TABLET 150 MG</td>
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<td>PA</td>
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<tr>
<td>SIGNIFOR SUBCUTANEOUS SOLUTION 0.3 MG/ML, 0.6 MG/ML, 0.9 MG/ML</td>
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<td>PA</td>
</tr>
<tr>
<td>SOMATULINE DEPOT SUBCUTANEOUS SOLUTION 120 MG/0.5ML, 60 MG/0.2ML, 90 MG/0.3ML</td>
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<tr>
<td>SOMAVERT SUBCUTANEOUS SOLUTION RECONSTITUTED 10 MG, 15 MG, 20 MG, 25 MG, 30 MG</td>
<td>5</td>
<td>PA</td>
</tr>
<tr>
<td>SYNAREL NASAL SOLUTION 2 MG/ML</td>
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<td>PA</td>
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<tr>
<td>TARPEYO ORAL CAPSULE DELAYED RELEASE 4 MG</td>
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<td>PA</td>
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<tr>
<td>TRELSTAR MIXJECT INTRAMUSCULAR SUSPENSION RECONSTITUTED 11.25 MG, 22.5 MG</td>
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<td>PA</td>
</tr>
<tr>
<td>TRELSTAR MIXJECT INTRAMUSCULAR SUSPENSION RECONSTITUTED 3.75 MG</td>
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</table>

**Hormonal Agents, Suppressant (Thyroid) - Treatment For Overactive Thyroid**

**Antithyroid Agents**

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<thead>
<tr>
<th>Name of Drug</th>
<th>Drug Tier</th>
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<tbody>
<tr>
<td>methimazole oral tablet 10 mg, 5 mg*</td>
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</tr>
<tr>
<td>propylthiouracil oral tablet 50 mg</td>
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<tr>
<td>Name of Drug</td>
<td>Drug Tier</td>
</tr>
<tr>
<td>----------------------------------------------------------------------------</td>
<td>-----------</td>
</tr>
<tr>
<td><strong>Immunological Agents - Medications That Alter The Immune System Including Vaccinations</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Angioedema Agents</strong></td>
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</tr>
<tr>
<td>CINRYZE INTRAVENOUS SOLUTION RECONSTITUTED 500 UNIT</td>
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</tr>
<tr>
<td>HAEGARDA SUBCUTANEOUS SOLUTION RECONSTITUTED 2000 UNIT, 3000 UNIT</td>
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</tr>
<tr>
<td>icatibant acetate subcutaneous solution 30 mg/3ml</td>
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<tr>
<td><strong>Immunoglobulins</strong></td>
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<tr>
<td>FLEBOGAMMA DIF INTRAVENOUS SOLUTION 5 GM/50ML</td>
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</tr>
<tr>
<td>GAMMAGARD INJECTION SOLUTION 1 GM/10ML, 10 GM/100ML, 2.5 GM/25ML, 20 GM/200ML, 30 GM/300ML, 5 GM/50ML</td>
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<tr>
<td>GAMMAGARD S/D LESS IGA INTRAVENOUS SOLUTION RECONSTITUTED 10 GM, 5 GM</td>
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<tr>
<td>GAMMAKED INJECTION SOLUTION 1 GM/10ML</td>
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</tr>
<tr>
<td>GAMMAPLEX INTRAVENOUS SOLUTION 10 GM/100ML, 10 GM/200ML, 20 GM/200ML, 5 GM/50ML</td>
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<tr>
<td>GAMUNEX-C INJECTION SOLUTION 1 GM/10ML</td>
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</tr>
<tr>
<td>PRIVIGEN INTRAVENOUS SOLUTION 10 GM/100ML, 20 GM/200ML, 40 GM/400ML, 5 GM/50ML</td>
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<tr>
<td><strong>Immunological Agents, Other</strong></td>
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<tr>
<td>ARCALYST SUBCUTANEOUS SOLUTION RECONSTITUTED 220 MG</td>
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<tr>
<td>CIBINQO ORAL TABLET 100 MG, 200 MG, 50 MG</td>
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<tr>
<td>COSENTYX (300 MG DOSE) SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML</td>
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<tr>
<td>Name of Drug</td>
<td>Drug Tier</td>
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<tr>
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</tr>
<tr>
<td>COSENTYX SENSOREADY (300 MG) SUBCUTANEOUS SOLUTION AUTO-JECTOR 150 MG/ML</td>
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<tr>
<td>COSENTYX SENSOREADY PEN SUBCUTANEOUS SOLUTION AUTO-JECTOR 150 MG/ML</td>
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<tr>
<td>COSENTYX SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML</td>
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<td>cosentyx subcutaneous solution prefilled syringe 75 mg/0.5ml</td>
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<tr>
<td>ILARIS SUBCUTANEOUS SOLUTION 150 MG/ML</td>
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<tr>
<td>ILUMYA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML</td>
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<tr>
<td>leflunomide oral tablet 10 mg, 20 mg</td>
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<td>OLMIANT ORAL TABLET 1 MG, 2 MG, 4 MG</td>
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</tr>
<tr>
<td>ORENCIA CLICKJECT SUBCUTANEOUS SOLUTION AUTO-JECTOR 125 MG/ML</td>
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<tr>
<td>ORENCIA INTRAVENOUS SOLUTION RECONSTITUTED 250 MG</td>
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</tr>
<tr>
<td>ORENCIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 125 MG/ML, 50 MG/0.4ML, 87.5 MG/0.7ML</td>
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<tr>
<td>RINVOQ ORAL TABLET EXTENDED RELEASE 24 HOUR 15 MG, 30 MG</td>
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<tr>
<td>rinvoq oral tablet extended release 24 hour 45 mg</td>
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<td>SILIQ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 210 MG/1.5ML</td>
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<td>SKYRIZI (150 MG DOSE) SUBCUTANEOUS PREFILLED SYRINGE KIT 75 MG/0.83ML</td>
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<td>SKYRIZI PEN SUBCUTANEOUS SOLUTION AUTO-JECTOR 150 MG/ML</td>
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<td>skyrizi subcutaneous solution cartridge 360 mg/2.4ml</td>
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<td>XELJANZ ORAL TABLET 10 MG, 5 MG</td>
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<tr>
<td>XELJANZ XR ORAL TABLET EXTENDED RELEASE 24 HOUR 11 MG</td>
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<tr>
<td>XOLAIR SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML, 75 MG/0.5ML</td>
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<tr>
<td>XOLAIR SUBCUTANEOUS SOLUTION RECONSTITUTED 150 MG</td>
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**Immunostimulants**

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<tr>
<th>Name of Drug</th>
<th>Drug Tier</th>
<th>Requirements/Limits</th>
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<tr>
<td>ACTIMMUNE SUBCUTANEOUS SOLUTION 20000000 UNIT/0.5ML</td>
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<tr>
<td>INTRON A INJECTION SOLUTION 10000000 UNIT/ML, 6000000 UNIT/ML</td>
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<tr>
<td>INTRON A INJECTION SOLUTION RECONSTITUTED 10000000 UNIT, 18000000 UNIT, 50000000 UNIT</td>
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<tr>
<td>PEGASYS SUBCUTANEOUS SOLUTION 180 MCG/ML</td>
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<td>pegasys subcutaneous solution prefilled syringe 180 mcg/0.5ml</td>
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<td>Name of Drug</td>
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<td><strong>Immunosuppressants</strong></td>
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<td>ACTEMRA ACTPEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 162 MG/0.9ML</td>
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<td>ACTEMRA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 162 MG/0.9ML</td>
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<tr>
<td>ASTAGRAF XL ORAL CAPSULE EXTENDED RELEASE 24 HOUR 0.5 MG, 1 MG</td>
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<td>ASTAGRAF XL ORAL CAPSULE EXTENDED RELEASE 24 HOUR 5 MG</td>
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<td>azathioprine oral tablet 50 mg</td>
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<td>BENLYSTA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 200 MG/ML</td>
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<td>BENLYSTA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 200 MG/ML</td>
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<td>CIMZIA PREFILLED SUBCUTANEOUS PREFILLED SYRINGE KIT 2 X 200 MG/ML</td>
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<td>CIMZIA STARTER KIT SUBCUTANEOUS PREFILLED SYRINGE KIT 6 X 200 MG/ML</td>
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<td>CIMZIA SUBCUTANEOUS KIT 2 X 200 MG</td>
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<td>cyclosporine modified oral capsule 100 mg, 25 mg, 50 mg</td>
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<td>cyclosporine modified oral solution 100 mg/ml</td>
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<td>ENBREL MINI SUBCUTANEOUS SOLUTION CARTRIDGE 50 MG/ML</td>
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<td>ENBREL SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 25 MG/0.5ML, 50 MG/ML</td>
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<td>Name of Drug</td>
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<td>ENVARSUS XR ORAL TABLET EXTENDED RELEASE 24 HOUR 4 MG</td>
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<td>everolimus oral tablet 0.25 mg</td>
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<td>everolimus oral tablet 0.5 mg, 0.75 mg, 1 mg</td>
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<tr>
<td>HUMIRA PEDIATRIC CROHNS START SUBCUTANEOUS PREFILLED SYRINGE KIT 80 MG/0.8ML, 80 MG/0.8ML &amp; 40MG/0.4ML</td>
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<tr>
<td>HUMIRA PEN SUBCUTANEOUS PEN-INJECTOR KIT 40 MG/0.4ML, 40 MG/0.8ML, 80 MG/0.8ML</td>
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<tr>
<td>HUMIRA PEN-CD/UC/HS STARTER SUBCUTANEOUS PEN-INJECTOR KIT 40 MG/0.8ML, 80 MG/0.8ML</td>
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<td>HUMIRA PEN-PEDIATRIC UC START SUBCUTANEOUS PEN-INJECTOR KIT 80 MG/0.8ML</td>
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<td>HUMIRA PEN-PS/UV/ADOL HS START SUBCUTANEOUS PEN-INJECTOR KIT 40 MG/0.8ML</td>
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<tr>
<td>HUMIRA PEN-PSOR/UVEIT STARTER SUBCUTANEOUS PEN-INJECTOR KIT 80 MG/0.8ML &amp; 40MG/0.4ML</td>
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<td>HUMIRA SUBCUTANEOUS PREFILLED SYRINGE KIT 10 MG/0.1ML, 20 MG/0.2ML, 40 MG/0.4ML, 40 MG/0.8ML</td>
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<td>KEVZARA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/1.14ML, 200 MG/1.14ML</td>
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<td>Name of Drug</td>
<td>Drug Tier</td>
<td>Requirements/Limits</td>
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<td>LUPKYNIS ORAL CAPSULE 7.9 MG</td>
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<td>mercaptopurine oral tablet 50 mg</td>
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<td>methotrexate (anti-rheumatic) oral tablet 2.5 mg*</td>
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<td>methotrexate oral tablet 2.5 mg*</td>
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<td>mycophenolate mofetil oral tablet 500 mg</td>
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<td>mycophenolate sodium oral tablet delayed release 180 mg, 360 mg</td>
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<td>OTEZLA ORAL TABLET THERAPY PACK 10 &amp; 20 &amp; 30 MG</td>
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<td>PROGRAF ORAL PACKET 1 MG</td>
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<td>REZUROCK ORAL TABLET 200 MG</td>
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<td>SANDIMMUNE ORAL SOLUTION 100 MG/ML</td>
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<td>sirolimus oral solution 1 mg/ml</td>
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<td>sirolimus oral tablet 0.5 mg, 1 mg, 2 mg</td>
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<td>XATMEP ORAL SOLUTION 2.5 MG/ML</td>
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<td>XELJANZ XR ORAL TABLET EXTENDED RELEASE 24 HOUR 22 MG</td>
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<td><strong>Vaccines</strong></td>
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<td>ADACEL INTRAMUSCULAR SUSPENSION 5-2-15.5 (PREFILLED SYRINGE), 5-2-15.5 LF-MCG/0.5</td>
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<td>bcg vaccine injection solution reconstituted 50 mg</td>
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<td>diphtheria-tetanus toxoids dt intramuscular suspension 25-5 lfu/0.5ml</td>
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<td>prehevbrio intramuscular suspension 10 mcg/ml</td>
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<td>RABAVERT INTRAMUSCULAR SUSPENSION RECONSTITUTED</td>
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<td>RECOMBIVAX HB INJECTION SUSPENSION 10 MCG/ML, 10 MCG/ML (IML SYRINGE), 40 MCG/ML, 5 MCG/0.5ML</td>
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<td>ROTATEQ ORAL SOLUTION</td>
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<td>SHINGRIX INTRAMUSCULAR SUSPENSION RECONSTITUTED 50 MCG/0.5ML</td>
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<td>TDVAX INTRAMUSCULAR SUSPENSION 2-2 LF/0.5ML</td>
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<td>TENIVAC INTRAMUSCULAR INJECTABLE 5-2 LFU</td>
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<td>tetanus-diphtheria toxoids td intramuscular suspension 2-2 lf/0.5ml</td>
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<td>TICOVAC INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 2.4 MCG/0.5ML</td>
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<td>TRUMENBA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE</td>
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<td>TWINRIX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 720-20 ELU-MCG/ML</td>
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<td>TYPHIM VI INTRAMUSCULAR SOLUTION 25 MCG/0.5ML</td>
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<td>TYPHIM VI INTRAMUSCULAR SOLUTION 25 MCG/0.5ML</td>
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<tr>
<td>VAQTA INTRAMUSCULAR SUSPENSION 25 UNIT/0.5ML, 25 UNIT/0.5ML 0.5 ML, 50 UNIT/ML, 50 UNIT/ML 1 ML</td>
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</tr>
<tr>
<td>VARIVAX SUBCUTANEOUS INJECTABLE 1350 PFU/0.5ML</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Name of Drug</td>
<td>Drug Tier</td>
<td>Requirements/Limits</td>
</tr>
<tr>
<td>------------------------------------------------------------------------------</td>
<td>-----------</td>
<td>---------------------</td>
</tr>
<tr>
<td>VARIZIG INTRAMUSCULAR SOLUTION 125 UNIT/1.2ML</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>VAXCHORA ORAL SUSPENSION RECONSTITUTED</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>VAXELIS INTRAMUSCULAR SUSPENSION</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>VAXELIS INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>YF-VAX SUBCUTANEOUS INJECTABLE</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>ZOSTAVAX SUBCUTANEOUS SUSPENSION RECONSTITUTED 19400 UNT/0.65ML</td>
<td>3</td>
<td>QL (1 EA per 999 days)</td>
</tr>
</tbody>
</table>

**Inflammatory Bowel Disease Agents - Treatment Of Ulcerative Colitis Or Crohn’s Disease**

### Aminosalicylates

<table>
<thead>
<tr>
<th></th>
<th>Drug Tier</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>balsalazide disodium oral capsule 750 mg</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>DIPENTUM ORAL CAPSULE 250 MG</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>mesalamine oral capsule delayed release 400 mg</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>mesalamine oral tablet delayed release 1.2 gm</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>mesalamine rectal enema 4 gm</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>mesalamine rectal suppository 1000 mg</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>mesalamine-cleanser rectal kit 4 gm</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>sulfasalazine oral tablet 500 mg</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>sulfasalazine oral tablet delayed release 500 mg</td>
<td>2</td>
<td></td>
</tr>
</tbody>
</table>

### Glucocorticoids

<table>
<thead>
<tr>
<th></th>
<th>Drug Tier</th>
<th>Requirements/Limits</th>
</tr>
</thead>
<tbody>
<tr>
<td>budesonide er oral tablet extended release 24 hour 9 mg</td>
<td>5</td>
<td>PA</td>
</tr>
<tr>
<td>budesonide oral capsule delayed release particles 3 mg</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>DEXAMETHASONE INTENSOL ORAL CONCENTRATE 1 MG/ML</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>dexamethasone oral elixir 0.5 mg/5ml</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Name of Drug</td>
<td>Drug Tier</td>
<td>Requirements/Limits</td>
</tr>
<tr>
<td>--------------------------------------------------</td>
<td>-----------</td>
<td>-------------------</td>
</tr>
<tr>
<td>dexamethasone oral solution 0.5 mg/5ml</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>dexamethasone oral tablet 0.5 mg, 0.75 mg, 1 mg, 1.5 mg, 2 mg, 4 mg, 6 mg*</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>dexamethasone sodium phosphate injection solution 120 mg/30ml, 20 mg/5ml, 4 mg/ml</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>hydrocortisone rectal enema 100 mg/60ml</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>methylprednisolone acetate injection suspension 40 mg/ml, 80 mg/ml</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>methylprednisolone oral tablet 16 mg, 32 mg, 4 mg, 8 mg</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>methylprednisolone oral tablet therapy pack 4 mg</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>prednisolone oral solution 15 mg/5ml</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>prednisolone oral syrup 15 mg/5ml</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>prednisolone sodium phosphate oral solution 15 mg/5ml, 25 mg/5ml, 6.7 (5 base) mg/5ml</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>prednisone oral solution 5 mg/5ml</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>prednisone oral tablet 1 mg, 10 mg, 2.5 mg, 20 mg, 5 mg, 50 mg*</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>prednisone oral tablet therapy pack 10 mg (21), 10 mg (48), 5 mg (21), 5 mg (48)</td>
<td>2</td>
<td></td>
</tr>
</tbody>
</table>

**Metabolic Bone Disease Agents - Treatment Of Bone Diseases Including Osteoporosis**

<table>
<thead>
<tr>
<th>Metabolic Bone Disease Agents</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>alendronate sodium oral tablet 10 mg, 35 mg, 5 mg, 70 mg*</td>
<td>1</td>
</tr>
<tr>
<td>calcitonin (salmon) nasal solution 200 unit/act</td>
<td>2</td>
</tr>
<tr>
<td>calcitriol oral capsule 0.25 mcg, 0.5 mcg</td>
<td>2</td>
</tr>
<tr>
<td>calcitriol oral solution 1 mcg/ml</td>
<td>2</td>
</tr>
<tr>
<td>cinacalcet hcl oral tablet 30 mg, 60 mg</td>
<td>2</td>
</tr>
<tr>
<td>cinacalcet hcl oral tablet 90 mg</td>
<td>2</td>
</tr>
<tr>
<td>Name of Drug</td>
<td>Drug Tier</td>
</tr>
<tr>
<td>----------------------------------------------------------------------------</td>
<td>-----------</td>
</tr>
<tr>
<td>doxercalciferol oral capsule 0.5 mcg, 1 mcg, 2.5 mcg</td>
<td>2</td>
</tr>
<tr>
<td>ibandronate sodium oral tablet 150 mg*</td>
<td>1</td>
</tr>
<tr>
<td>NATPARA SUBCUTANEOUS CARTRIDGE 100 MCG, 25 MCG, 50 MCG, 75 MCG</td>
<td>5</td>
</tr>
<tr>
<td>paricalcitol oral capsule 1 mcg, 2 mcg, 4 mcg</td>
<td>2</td>
</tr>
<tr>
<td>PROLIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 60 MG/ML</td>
<td>4</td>
</tr>
<tr>
<td>risedronate sodium oral tablet 150 mg, 35 mg, 35 mg (12 pack), 35 mg (4 pack), 5 mg</td>
<td>2</td>
</tr>
<tr>
<td>risedronate sodium oral tablet 30 mg</td>
<td>4</td>
</tr>
<tr>
<td>teriparatide (recombinant) subcutaneous solution pen-injector 620 mcg/2.48ml</td>
<td>5</td>
</tr>
<tr>
<td>TYMLOS SUBCUTANEOUS SOLUTION PEN-INJECTOR 3120 MCG/1.56ML</td>
<td>5</td>
</tr>
<tr>
<td>XGEVA SUBCUTANEOUS SOLUTION 120 MG/1.7ML</td>
<td>5</td>
</tr>
</tbody>
</table>

**Ophthalmic Agents - Treatment Of Eye Conditions**

**Ophthalmic Agents, Other**

<table>
<thead>
<tr>
<th>Name of Drug</th>
<th>Drug Tier</th>
<th>Requirements/Limits</th>
</tr>
</thead>
<tbody>
<tr>
<td>atropine sulfate ophthalmic solution 1 %</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>cyclosporine ophthalmic emulsion 0.05 %</td>
<td>2</td>
<td>QL (60 EA per 30 days)</td>
</tr>
<tr>
<td>CYSTARAN OPHTHALMIC SOLUTION 0.44 %</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>dorzolamide hcl-timolol mal ophthalmic solution 22.3-6.8 mg/ml</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>neomycin-polymyxin-dexameth ophthalmic ointment 3.5-10000-0.1*</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>neomycin-polymyxin-dexameth ophthalmic suspension 0.1 %, 3.5-10000-0.1*</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>neomycin-polymyxin-gramicidin ophthalmic solution 1.75-10000-.025</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Name of Drug</td>
<td>Drug Tier</td>
<td>Requirements/Limits</td>
</tr>
<tr>
<td>------------------------------------------------------------------------------</td>
<td>-----------</td>
<td>--------------------</td>
</tr>
<tr>
<td>OXERVATE OPHTHALMIC SOLUTION 0.002 %</td>
<td>5</td>
<td>PA</td>
</tr>
<tr>
<td>polymyxin b-trimethoprim ophthalmic solution 10000-0.1 unit/ml-%*</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>proparacaine hcl ophthalmic solution 0.5 %</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>RESTASIS MULTIDOSE OPHTHALMIC EMULSION 0.05 %</td>
<td>3</td>
<td>QL (11 ML per 30 days)</td>
</tr>
<tr>
<td>sulfacetamide-prednisolone ophthalmic solution 10-0.23 %</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>tobramycin-dexamethasone ophthalmic suspension 0.3-0.1 %</td>
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<td></td>
</tr>
<tr>
<td><strong>Ophthalmic Anti-Allergy Agents</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>azelastine hcl ophthalmic solution 0.05 %*</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>cromolyn sodium ophthalmic solution 4 %*</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>epinastine hcl ophthalmic solution 0.05 %</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>olopatadine hcl ophthalmic solution 0.1 %</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td><strong>Ophthalmic Anti-Infectives</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ak-poly-bac ophthalmic ointment 500-10000 unit/gm*</td>
<td>1</td>
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</tr>
<tr>
<td>bacitracin ophthalmic ointment 500 unit/gm</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>bacitracin-polymyxin b ophthalmic ointment 500-10000 unit/gm*</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>erythromycin ophthalmic ointment 5 mg/gm*</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>GENTAK OPHTHALMIC OINTMENT 0.3 %*</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>gentamicin sulfate ophthalmic solution 0.3 %*</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>NATACYN OPHTHALMIC SUSPENSION 5 %</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>ofloxacin ophthalmic solution 0.3 %</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>sulfacetamide sodium ophthalmic ointment 10 %</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Name of Drug</td>
<td>Drug Tier</td>
<td>Requirements/Limits</td>
</tr>
<tr>
<td>--------------------------------------------------</td>
<td>-----------</td>
<td>--------------------</td>
</tr>
<tr>
<td>sulfacetamide sodium ophthalmic solution 10 %</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>tobramycin ophthalmic solution 0.3 %*</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td><strong>Ophthalmic Anti-Inflammatories</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>dexamethasone sodium phosphate ophthalmic solution 0.1 %</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>diclofenac sodium ophthalmic solution 0.1 %</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>difluprednate ophthalmic emulsion 0.05 %</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>fluorometholone ophthalmic suspension 0.1 %</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>flurbiprofen sodium ophthalmic solution 0.03 %</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>ketorolac tromethamine ophthalmic solution 0.4 %, 0.5 %</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>prednisolone acetate ophthalmic suspension 1 %</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>prednisolone sodium phosphate ophthalmic solution 1 %</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td><strong>Ophthalmic Beta-Adrenergic Blocking Agents</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>carteolol hcl ophthalmic solution 1 %</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>levobunolol hcl ophthalmic solution 0.5 %*</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>timolol maleate ophthalmic solution 0.25 %, 0.5 %*</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td><strong>Ophthalmic Intraocular Pressure Lowering Agents, Other</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>acetazolamide er oral capsule extended release 12 hour 500 mg</td>
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<td></td>
</tr>
<tr>
<td>ALPHAGAN P OPTHALMIC SOLUTION 0.1 %</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>brimonidine tartrate ophthalmic solution 0.2 %*</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>brimonidine tartrate-timolol ophthalmic solution 0.2-0.5 %</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>brinzolamide ophthalmic suspension 1 %</td>
<td>2</td>
<td>ST</td>
</tr>
<tr>
<td>COMBIGAN OPTHALMIC SOLUTION 0.2-0.5 %</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Name of Drug</td>
<td>Drug Tier</td>
<td>Requirements/Limits</td>
</tr>
<tr>
<td>--------------------------------------------------</td>
<td>-----------</td>
<td>--------------------</td>
</tr>
<tr>
<td>dorzolamide hcl ophthalmic solution 2 %</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>methazolamide oral tablet 25 mg, 50 mg</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>pilocarpine hcl ophthalmic solution 1 %, 2 %, 4 %</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>SIMBRINZA OPHTHALMIC SUSPENSION 1-0.2 %</td>
<td>3</td>
<td></td>
</tr>
</tbody>
</table>

**Ophthalmic Prostaglandin And Prostamide Analogs**

<table>
<thead>
<tr>
<th>Name of Drug</th>
<th>Drug Tier</th>
<th>Requirements/Limits</th>
</tr>
</thead>
<tbody>
<tr>
<td>bimatoprost ophthalmic solution 0.03 %*</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>latanoprost ophthalmic solution 0.005 %*</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>LUMIGAN OPHTHALMIC SOLUTION 0.01 %*</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>RHOPRESSA OPHTHALMIC SOLUTION 0.02 %</td>
<td>3</td>
<td>ST</td>
</tr>
<tr>
<td>travoprost (bak free) ophthalmic solution 0.004 %*</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>ZIOPTAN OPHTHALMIC SOLUTION 0.0015 %</td>
<td>3</td>
<td></td>
</tr>
</tbody>
</table>

**Otic Agents - Treatment Of Ear Conditions**

**Otic Agents**

<table>
<thead>
<tr>
<th>Name of Drug</th>
<th>Drug Tier</th>
<th>Requirements/Limits</th>
</tr>
</thead>
<tbody>
<tr>
<td>acetic acid otic solution 2 %</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>hydrocortisone-acetic acid otic solution 1-2 %</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>neomycin-polymyxin-hc otic solution 1 %, 3.5-10000-1</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>neomycin-polymyxin-hc otic suspension 3.5-10000-1</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>ofloxacin otic solution 0.3 %</td>
<td>2</td>
<td></td>
</tr>
</tbody>
</table>

**Respiratory Tract/ Pulmonary Agents - Treatment Of Breathing Conditions**

**Antihistamines**

<table>
<thead>
<tr>
<th>Name of Drug</th>
<th>Drug Tier</th>
<th>Requirements/Limits</th>
</tr>
</thead>
<tbody>
<tr>
<td>azelastine hcl nasal solution 0.1 %, 137 mcg/spray*</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>azelastine hcl nasal solution 0.15 %</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Name of Drug</td>
<td>Drug Tier</td>
<td>Requirements/Limits</td>
</tr>
<tr>
<td>--------------------------------------------------</td>
<td>-----------</td>
<td>--------------------</td>
</tr>
<tr>
<td>cetirizine hcl allergy child oral solution 5 mg/5ml*</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>cetirizine hcl oral solution 1 mg/ml, 5 mg/5ml*</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>clemastine fumarate oral tablet 2.68 mg</td>
<td>2</td>
<td>PA</td>
</tr>
<tr>
<td>cyproheptadine hcl oral syrup 2 mg/5ml</td>
<td>2</td>
<td>PA</td>
</tr>
<tr>
<td>cyproheptadine hcl oral tablet 4 mg</td>
<td>2</td>
<td>PA</td>
</tr>
<tr>
<td>hydroxyzine hcl oral syrup 10 mg/5ml</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>hydroxyzine hcl oral tablet 10 mg, 25 mg, 50 mg*</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>levocetirizine dihydrochloride oral solution 2.5 mg/5ml</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>levocetirizine dihydrochloride oral tablet 5 mg*</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>promethazine hcl oral solution 6.25 mg/5ml</td>
<td>2</td>
<td>PA</td>
</tr>
<tr>
<td>promethazine hcl oral syrup 6.25 mg/5ml</td>
<td>2</td>
<td>PA</td>
</tr>
</tbody>
</table>

### Anti-Inflammatories, Inhaled Corticosteroids

<table>
<thead>
<tr>
<th>Name of Drug</th>
<th>Drug Tier</th>
<th>Requirements/Limits</th>
</tr>
</thead>
<tbody>
<tr>
<td>ARNUITY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100 MCG/ACT, 200 MCG/ACT, 50 MCG/ACT</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>budesonide inhalation suspension 0.25 mg/2ml, 0.5 mg/2ml, 1 mg/2ml</td>
<td>2</td>
<td>B/D</td>
</tr>
<tr>
<td>FLOVENT DISKUS INHALATION AEROSOL POWDER BREATH ACTIVATED 100 MCG/ACT, 100 MCG/BLIST</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>flovent diskus inhalation aerosol powder breath activated 250 mcg/act, 50 mcg/act</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>FLOVENT HFA INHALATION AEROSOL 110 MCG/ACT, 220 MCG/ACT, 44 MCG/ACT</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>flunisolide nasal solution 25 mcg/act (0.025%)</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Name of Drug</td>
<td>Drug Tier</td>
<td>Requirements/Limits</td>
</tr>
<tr>
<td>----------------------------------------------------------------------------</td>
<td>-----------</td>
<td>---------------------</td>
</tr>
<tr>
<td>fluticasone propionate hfa inhalation aerosol 110 mcg/act, 220 mcg/act, 44 mcg/act</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>fluticasone propionate nasal suspension 50 mcg/act*</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>mometasone furoate nasal suspension 50 mcg/act</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>QVAR REDIHALER INHALATION AEROSOL BREATH ACTIVATED 40 MCG/ACT, 80 MCG/ACT</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td><strong>Antileukotrienes</strong></td>
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<td>montelukast sodium oral packet 4 mg</td>
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<td>montelukast sodium oral tablet 10 mg*</td>
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<tr>
<td>montelukast sodium oral tablet chewable 4 mg, 5 mg*</td>
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<tr>
<td>zafirlukast oral tablet 10 mg, 20 mg</td>
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<td><strong>Bronchodilators, Anticholinergic</strong></td>
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<tr>
<td>ATROVENT HFA INHALATION AEROSOL SOLUTION 17 MCG/ACT</td>
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<tr>
<td>incruse ellipta inhalation aerosol powder breath activated 62.5 mcg/act</td>
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<tr>
<td>ipratropium bromide inhalation solution 0.02 %</td>
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<td>ipratropium bromide nasal solution 0.03 %, 0.06 %</td>
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<td>SPIRIVA HANDIHALER INHALATION CAPSULE 18 MCG</td>
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<td>SPIRIVA RESPIMAT INHALATION AEROSOL SOLUTION 1.25 MCG/ACT, 2.5 MCG/ACT</td>
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<tr>
<td>albuterol sulfate hfa inhalation aerosol solution 108 (90 base) mcg/act, 108 (90 base) mcg/act (nda020503), 108 (90 base) mcg/act (nda020983)*</td>
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<td>albuterol sulfate inhalation nebulization solution (2.5 mg/3ml) 0.083%, (5 mg/ml) 0.5%, 0.63 mg/3ml, 1.25 mg/3ml, 2.5 mg/0.5ml*</td>
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<td>albuterol sulfate oral syrup 2 mg/5ml*</td>
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<td>breo ellipta inhalation aerosol powder breath activated 100-25 mcg/act, 200-25 mcg/act</td>
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<td>epinephrine injection solution 0.3 mg/0.3ml</td>
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<td>VENTOLIN HFA INHALATION AEROSOL SOLUTION 108 (90 BASE) MCG/ACT</td>
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**Cystic Fibrosis Agents**

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<td>KALYDECO ORAL TABLET 150 MG</td>
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<td>ORKAMBI ORAL PACKET 100-125 MG, 150-188 MG, 75-94 MG</td>
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<td>pulmozyme inhalation solution 2.5 mg/2.5ml</td>
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<td>TRIKAFTA ORAL TABLET THERAPY PACK 100-50-75 &amp; 150 MG, 50-25-37.5 &amp; 75 MG</td>
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<td>cromolyn sodium oral concentrate 100 mg/5ml</td>
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<td>theophylline er oral tablet extended release 12 hour 300 mg, 450 mg</td>
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<td>theophylline er oral tablet extended release 24 hour 400 mg, 600 mg</td>
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<td>theophylline oral solution 80 mg/15ml</td>
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<td>ADEMPAS ORAL TABLET 0.5 MG, 1 MG, 1.5 MG, 2 MG, 2.5 MG</td>
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<td>ambrisentan oral tablet 10 mg, 5 mg</td>
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<td>bosentan oral tablet 125 mg, 62.5 mg</td>
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<td>sildenafil citrate oral tablet 20 mg</td>
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<td>tadalafil (pah) oral tablet 20 mg</td>
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<td>tyvaso dpi maintenance kit inhalation powder 112 x 32mcg &amp; 112 x 48mcg, 16 mcg, 32 mcg, 48 mcg, 64 mcg</td>
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<td>tyvaso dpi titration kit inhalation powder 112 x 16mcg &amp; 84 x 32mcg, 16 &amp; 32 &amp; 48 mcg</td>
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<tr>
<td>Name of Drug</td>
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<td>UPTRAVI ORAL TABLET 1000 MCG, 1200 MCG, 1400 MCG, 1600 MCG, 200 MCG, 400 MCG, 600 MCG, 800 MCG</td>
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<td>UPTRAVI ORAL TABLET THERAPY PACK 200 &amp; 800 MCG</td>
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<td>VENTAVIS INHALATION SOLUTION 10 MCG/ML, 20 MCG/ML</td>
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<td>ESBRIET ORAL CAPSULE 267 MG</td>
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<td>ESBRIET ORAL TABLET 267 MG, 801 MG</td>
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<td>OFEV ORAL CAPSULE 100 MG, 150 MG</td>
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<td>pirfenidone oral tablet 267 mg, 534 mg, 801 mg</td>
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<td><strong>Respiratory Tract Agents, Other</strong></td>
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<td>acetylcysteine inhalation solution 10 %, 20 %</td>
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<td>ADVAIR HFA INHALATION AEROSOL 115-21 MCG/ACT, 230-21 MCG/ACT, 45-21 MCG/ACT</td>
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<td>anoro ellipta inhalation aerosol powder breath activated 62.5-25 mcg/act</td>
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<td>BEVESPI AEROSPHERE INHALATION AEROSOL 9-4.8 MCG/ACT</td>
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<td>BREZTRI AEROSPHERE INHALATION AEROSOL 160-9-4.8 MCG/ACT</td>
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<td>budesonide-formoterol fumarate inhalation aerosol 160-4.5 mcg/act, 80-4.5 mcg/act</td>
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<td>fluticasone-salmeterol inhalation aerosol powder breath activated 100-50 mcg/act, 250-50 mcg/act, 500-50 mcg/act*</td>
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<td>STIOLTO RESPIMAT INHALATION AEROSOL SOLUTION 2.5-2.5 MCG/ACT</td>
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<td>TRELEGY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100-62.5-25 MCG/ACT, 200-62.5-25 MCG/ACT</td>
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<tr>
<td>Name of Drug</td>
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<td>WIXELA INHUB INHALATION AEROSOL POWDER BREATH ACTIVATED 100-50 MCG/A CT, 250-50 MCG/A CT, 500-50 MCG/A CT</td>
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<td>FASENRA PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 30 MG/ML</td>
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<td>FASENRA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 30 MG/ML</td>
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<td>ipratropium-albuterol inhalation solution 0.5-2.5 (3) mg/3ml</td>
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<td>NUCALA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 100 MG/ML</td>
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<td>NUCALA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML</td>
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<td>NUCALA SUBCUTANEOUS SOLUTION RECONSTITUTED 100 MG</td>
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<td>promethazine vc oral syrup 6.25-5 mg/5ml</td>
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<td>promethazine-phenylephrine oral syrup 6.25-5 mg/5ml</td>
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<td><strong>Skeletal Muscle Relaxants - Treatment Of Muscle Tightness</strong></td>
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<td>carisoprodol oral tablet 250 mg, 350 mg</td>
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<td>chlorzoxazone oral tablet 500 mg</td>
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<td>methocarbamol oral tablet 500 mg, 750 mg*</td>
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<td>orphenadrine citrate er oral tablet extended release 12 hour 100 mg</td>
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<td><strong>Sleep Promoting Agents</strong></td>
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<td>modafinil oral tablet 100 mg, 200 mg</td>
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<tbody>
<tr>
<td>Exclusion Criteria</td>
<td>N/A</td>
</tr>
<tr>
<td>Required Medical Information</td>
<td>For prophylaxis of skin cancer in patients with previously treated skin cancers who have undergone an organ transplantation the request will be approved. For psoriasis: the patient has documented adequate trials and/or has another documented medical reason for not using at least 2 of the treatment options listed: topical steroids, Tazorac (tazarotene), methotrexate, and cyclosporine.</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td>N/A</td>
</tr>
<tr>
<td>Prescriber Restrictions</td>
<td>Prescriber must be a dermatologist or an oncologist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Request will be authorized until the end of the contract year.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td>N/A</td>
</tr>
<tr>
<td>Indications</td>
<td>All Medically-accepted Indications.</td>
</tr>
<tr>
<td>Off-Label Uses</td>
<td>N/A</td>
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</tbody>
</table>
# ACTEMRA

## Products Affected
- ACTEMRA ACTPEN
- ACTEMRA SUBCUTANEOUS

<table>
<thead>
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<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
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<tbody>
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<tr>
<td>Required Medical Information</td>
<td>N/A</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td>N/A</td>
</tr>
<tr>
<td>Prescriber Restrictions</td>
<td>Specialist for submitted diagnosis.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Request will be authorized until the end of the contract year.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td>For RA: Either 1) Trial of, medical reason for not using, or contraindication to 1 of the following: Enbrel or Humira or 2) If utilized within the past 120 days, approve for continuation of therapy. For pJIA: Either 1) Trial of, medical reason for not using, or contraindication to 1 of the following: Enbrel or Humira or 2) If utilized within the past 120 days, approve for continuation of therapy. For sJIA: approve. For sJIA, Giant Cell Arteritis and Systemic Sclerosis-Associated Interstitial Lung Disease: Approve</td>
</tr>
<tr>
<td>Indications</td>
<td>All Medically-accepted Indications.</td>
</tr>
<tr>
<td>Off-Label Uses</td>
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## ACTIMMUNE

### Products Affected
- ACTIMMUNE

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<tr>
<td>Age Restrictions</td>
<td>N/A</td>
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<tr>
<td>Prescriber Restrictions</td>
<td>N/A</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Request will be authorized until the end of the contract year.</td>
</tr>
<tr>
<td>Other Criteria</td>
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<tr>
<td>Indications</td>
<td>All Medically-accepted Indications.</td>
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<tr>
<td>Off-Label Uses</td>
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ADEFOVIR

Products Affected
• adefovir dipivoxil

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<td>Required Medical Information</td>
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<td>Age Restrictions</td>
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<tr>
<td>Prescriber Restrictions</td>
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</tr>
<tr>
<td>Coverage Duration</td>
<td>Request will be authorized until the end of the contract year.</td>
</tr>
<tr>
<td>Other Criteria</td>
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<tr>
<td>Indications</td>
<td>All Medically-accepted Indications.</td>
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<tr>
<td>Off-Label Uses</td>
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## ADEMPAS

### Products Affected
- ADEMPAS

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<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Exclusion Criteria</strong></td>
<td>Concomitant use with PDE inhibitor or nitrate therapy</td>
</tr>
<tr>
<td><strong>Required Medical Information</strong></td>
<td>Documentation of pulmonary arterial hypertension (PAH) WHO Group I and IV classification and PAH Functional Class. Reviewer will verify available patient claim history to confirm patient is not using PDE inhibitors or nitrates.</td>
</tr>
<tr>
<td><strong>Age Restrictions</strong></td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Prescriber Restrictions</strong></td>
<td>Prescriber must be a pulmonologist or cardiologist.</td>
</tr>
<tr>
<td><strong>Coverage Duration</strong></td>
<td>Request will be authorized until the end of the contract year.</td>
</tr>
<tr>
<td><strong>Other Criteria</strong></td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Indications</strong></td>
<td>All Medically-accepted Indications.</td>
</tr>
<tr>
<td><strong>Off-Label Uses</strong></td>
<td>N/A</td>
</tr>
</tbody>
</table>
## ALPHA-1 PROTEINASE INHIBITORS

### Products Affected
- ARALAST NP INTRAVENOUS SOLUTION RECONSTITUTED 1000 MG, 500 MG
- GLASSIA
- PROLASTIN-C
- ZEMAIRA

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
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</thead>
<tbody>
<tr>
<td>Exclusion Criteria</td>
<td>N/A</td>
</tr>
<tr>
<td>Required Medical Information</td>
<td>1) Documentation of hereditary alpha1-antitrypsin deficiency as evident by pretreatment serum AAT levels below 11 micrometer/L and progressive FEVI or FVC decline demonstrating symptomatic lung disease. AND 2) If the medication request is for an Alpha1-Proteinase Inhibitor (human) product other than Prolastin, the patient has a documented medical reason (such as trial, intolerance or contraindication) for not using Prolastin to treat their medical condition.</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td>N/A</td>
</tr>
<tr>
<td>Prescriber Restrictions</td>
<td>Prescriber must be a pulmonologist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Request will be authorized until the end of the contract year.</td>
</tr>
<tr>
<td>Other Criteria</td>
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<td>Indications</td>
<td>All Medically-accepted Indications.</td>
</tr>
<tr>
<td>Off-Label Uses</td>
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</table>
# AMBRISSENTAN

## Products Affected
- *ambrisentan*

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<tbody>
<tr>
<td>Exclusion Criteria</td>
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</tr>
<tr>
<td>Required Medical Information</td>
<td>Documentation of pulmonary arterial hypertension (PAH) WHO Group I classification and PAH Functional Class.</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td>N/A</td>
</tr>
<tr>
<td>Prescriber Restrictions</td>
<td>Prescriber must be a pulmonologist or cardiologist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Request will be authorized until the end of the contract year.</td>
</tr>
<tr>
<td>Other Criteria</td>
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<tr>
<td>Indications</td>
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</tr>
<tr>
<td>Off-Label Uses</td>
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</table>
## APOKYN

### Products Affected
- apomorphine hcl subcutaneous

<table>
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<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
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</thead>
<tbody>
<tr>
<td><strong>Exclusion Criteria</strong></td>
<td>Concomitant use with serotonin 5-HT3 receptor antagonists.</td>
</tr>
<tr>
<td><strong>Required Medical Information</strong></td>
<td>Reviewer will verify available patient claim history to confirm patient is not using 5-HT3 receptor antagonists. If diagnosis is Parkinsons, the patient must have a documented trial of, contraindication to, or medical reason for not using two formulary alternatives such as entacapone, tolcapone, rasagiline, selegiline, carbidopa/levodopa, bromocriptine, pramipexole or ropinirole.</td>
</tr>
<tr>
<td><strong>Age Restrictions</strong></td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Prescriber Restrictions</strong></td>
<td>Prescribed by or in consultation with a neurologist.</td>
</tr>
<tr>
<td><strong>Coverage Duration</strong></td>
<td>Request will be authorized until the end of the contract year.</td>
</tr>
<tr>
<td><strong>Other Criteria</strong></td>
<td>N/A</td>
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<tr>
<td><strong>Indications</strong></td>
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</tr>
<tr>
<td><strong>Off-Label Uses</strong></td>
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## ARCALYST

### Products Affected
- ARCALYST

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<td>Required Medical Information</td>
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<tr>
<td>Age Restrictions</td>
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<tr>
<td>Prescriber Restrictions</td>
<td>N/A</td>
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<tr>
<td>Coverage Duration</td>
<td>Request will be authorized until the end of the contract year.</td>
</tr>
<tr>
<td>Other Criteria</td>
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<tr>
<td>Indications</td>
<td>All Medically-accepted Indications.</td>
</tr>
<tr>
<td>Off-Label Uses</td>
<td>N/A</td>
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</table>
ARIPIPRAZOLE LONG ACTING

Products Affected

- ABILIFY MAINTENA INTRAMUSCULAR PREFILLED SYRINGE
- ABILIFY MAINTENA INTRAMUSCULAR SUSPENSION RECONSTITUTED ER
- ARISTADA INITIO
- ARISTADA INTRAMUSCULAR PREFILLED SYRINGE 1064 MG/3.9ML, 441 MG/1.6ML, 662 MG/2.4ML, 882 MG/3.2ML

<table>
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<th>Criteria Details</th>
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<tbody>
<tr>
<td>Exclusion Criteria</td>
<td>N/A</td>
</tr>
<tr>
<td>Required Medical Information</td>
<td>The member has a documented history of receiving oral aripiprazole without any clinically significant side effects. Additionally, the member has a documented trial and failure or medical reason (e.g. intolerance, hypersensitivity or contraindication) for not utilizing one of these therapies to manage their medical condition: Invega Sustenna, Invega Trinza or Risperdal Consta.</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td>N/A</td>
</tr>
<tr>
<td>Prescriber Restrictions</td>
<td>N/A</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Request will be authorized until the end of the contract year.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td>N/A</td>
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<tr>
<td>Indications</td>
<td>All Medically-accepted Indications.</td>
</tr>
<tr>
<td>Off-Label Uses</td>
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</table>
### BANZEL

#### Products Affected
- rufinamide oral suspension
- rufinamide oral tablet

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<th>Criteria Details</th>
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</thead>
<tbody>
<tr>
<td>Exclusion Criteria</td>
<td>History of familial Short QT syndrome</td>
</tr>
<tr>
<td>Required Medical Information</td>
<td>N/A</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td>N/A</td>
</tr>
<tr>
<td>Prescriber Restrictions</td>
<td>Prescriber must be a neurologist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Request will be authorized until the end of the contract year.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td>Trial of, contraindication to, or medical reason for not using one formulary alternative generic anticonvulsant for appropriate indications.</td>
</tr>
<tr>
<td>Indications</td>
<td>All Medically-accepted Indications.</td>
</tr>
<tr>
<td>Off-Label Uses</td>
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BENLYSTA

Products Affected
- BENLYSTA SUBCUTANEOUS

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<th>PA Criteria</th>
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<tbody>
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<tr>
<td>Required Medical Information</td>
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</tr>
<tr>
<td>Age Restrictions</td>
<td>N/A</td>
</tr>
<tr>
<td>Prescriber Restrictions</td>
<td>Prescriber must be a rheumatologist, nephrologist, or specialist in the treatment of autoimmune disorders.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>New starts: 6 months. Cont of therapy or reauthorization: until end of contract year.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td>For new starts for systemic lupus erythematosus (SLE): trial of two of the following glucocorticoids, azathioprine, methotrexate, mycophenolate, or hydroxychloroquine, chloroquine, and cyclophosphamide. For continuation of therapy or reauthorization for SLE: documentation of clinical response to therapy (i.e. fewer flares that required steroid treatment, lower average daily oral prednisone dose, improved daily function either as measured through a validated functional scale or through improved daily performance documented at clinic visits, etc. For new starts for lupus nephritis (LN): concurrent use of or medical reason for not using background immunosuppressive therapy regimen. For continuation of therapy or reauthorization for LN: Documentation of improvement in renal function (i.e. reduction in UPCR).</td>
</tr>
<tr>
<td>Indications</td>
<td>All Medically-accepted Indications.</td>
</tr>
<tr>
<td>Off-Label Uses</td>
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# BENZNIDAZOLE

**Products Affected**
- *benznidazole*

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<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exclusion Criteria</td>
<td>Patients who have used disulfiram within two weeks of initiation of benznidazole</td>
</tr>
<tr>
<td>Required Medical Information</td>
<td>Patient has not used disulfiram within two weeks prior to benznidazole initiation per claims history for existing members or attestation from provider for members new to the health plan.</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td>N/A</td>
</tr>
<tr>
<td>Prescriber Restrictions</td>
<td>Documentation of a consultation with an infectious disease specialist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Request will be authorized for 80 days.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td>N/A</td>
</tr>
<tr>
<td>Indications</td>
<td>All Medically-accepted Indications.</td>
</tr>
<tr>
<td>Off-Label Uses</td>
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</table>
### BESREMI

**Products Affected**
- *besremi*

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<tbody>
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</tr>
<tr>
<td>Age Restrictions</td>
<td>N/A</td>
</tr>
<tr>
<td>Prescriber Restrictions</td>
<td>Prescriber must be a hematologist, oncologist, or specialist for submitted diagnosis.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>The request will be authorized until the end of the contract year.</td>
</tr>
<tr>
<td>Other Criteria</td>
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<td>Indications</td>
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<td>Off-Label Uses</td>
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**BOSENTAN**

**Products Affected**
- *bosentan*

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<th>Criteria Details</th>
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<tbody>
<tr>
<td>Exclusion Criteria</td>
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<tr>
<td>Required Medical Information</td>
<td>Documentation of pulmonary arterial hypertension (PAH) WHO Group I classification and PAH Functional Class.</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td>N/A</td>
</tr>
<tr>
<td>Prescriber Restrictions</td>
<td>Prescriber must be a pulmonologist or cardiologist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Request will be authorized until the end of the contract year.</td>
</tr>
<tr>
<td>Other Criteria</td>
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<td>Indications</td>
<td>All Medically-accepted Indications.</td>
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<tr>
<td>Off-Label Uses</td>
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</table>
BUDESONIDE ER 9 MG

Products Affected
- budesonide er oral tablet extended release 24 hour

<table>
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<th>Criteria Details</th>
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<tbody>
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<tr>
<td>Prescriber Restrictions</td>
<td>N/A</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Request will be authorized for 8 weeks.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td>Patient must have a documented trial of, contraindication to, or medical reason for not using sulfasalazine, balsalazide, or an oral mesalamine product.</td>
</tr>
<tr>
<td>Indications</td>
<td>All Medically-accepted Indications.</td>
</tr>
<tr>
<td>Off-Label Uses</td>
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</table>
# C1 ESTERASE INHIBITOR

**Products Affected**
- CINRYZE
- HAEGARDA

<table>
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<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
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<tr>
<td>Exclusion Criteria</td>
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<tr>
<td>Required Medical Information</td>
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</tr>
<tr>
<td>Age Restrictions</td>
<td>N/A</td>
</tr>
<tr>
<td>Prescriber Restrictions</td>
<td>Prescriber must be an allergist, immunologist, rheumatologist, or hematologist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Request will be authorized until the end of the contract year.</td>
</tr>
<tr>
<td>Other Criteria</td>
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<td>Indications</td>
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<td>Off-Label Uses</td>
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## CAMZYOS

### Products Affected
- CAMZYOS

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<td>Required Medical Information</td>
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</tr>
<tr>
<td>Age Restrictions</td>
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</tr>
<tr>
<td>Prescriber Restrictions</td>
<td>Prescribed by or in consultation with a cardiologist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>New starts will be authorized for 6 months. Cont of therapy or reauth until end of contract year.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td>For all new starts, ALL of the following must be provided: 1) Diagnosis of symptomatic New York Heart Association (NYHA) class II or III obstructive hypertrophic cardiomyopathy (oHCM) AND 2) Patient has a left ventricular ejection fraction (LVEF) greater than or equal to 55% AND 3) Assessment of Valsalva left ventricular outflow tract (LVOT) gradient AND 4) Trial of, medical reason for not using or contraindication to BOTH of the following: Beta blockers (i.e. metoprolol, propranolol, atenolol) AND Non-dihydropyridine calcium channel blockers (i.e. verapamil, diltiazem) AND 5) Prescriber attests that patient is not using moderate to strong CYP2C19 or CYP3A4 inhibitors or inducers. For continuation of therapy or reauthorization, all of the following must be provided: 1) Documentation of clinical benefit as evidenced by an improvement from baseline in oHCM symptoms (i.e., improvement in fatigue, chest pain, shortness of breath, LVOT, peak oxygen consumption, etc.) OR improvement or no worsening of NYHA functional class AND 2) Member must also have a left</td>
</tr>
<tr>
<td>PA Criteria</td>
<td>Criteria Details</td>
</tr>
<tr>
<td>------------------</td>
<td>----------------------------------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td>ventricular ejection fraction (LVEF) greater than or equal to 50%.</td>
</tr>
<tr>
<td>Indications</td>
<td>All Medically-accepted Indications.</td>
</tr>
<tr>
<td>Off-Label Uses</td>
<td>N/A</td>
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</table>
**CARBAGLU**

**Products Affected**
- carglumic acid oral tablet soluble

<table>
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<th>Criteria Details</th>
</tr>
</thead>
<tbody>
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<tr>
<td>Required Medical Information</td>
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<tr>
<td>Age Restrictions</td>
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<tr>
<td>Prescriber Restrictions</td>
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<tr>
<td>Coverage Duration</td>
<td>Request will be authorized until the end of the contract year.</td>
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<tr>
<td>Other Criteria</td>
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<tr>
<td>Indications</td>
<td>All Medically-accepted Indications.</td>
</tr>
<tr>
<td>Off-Label Uses</td>
<td>N/A</td>
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</table>
# CASPOFUNGIN

**Products Affected**
- caspofungin acetate

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
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</thead>
<tbody>
<tr>
<td>Exclusion Criteria</td>
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<tr>
<td>Required Medical Information</td>
<td>N/A</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td>N/A</td>
</tr>
<tr>
<td>Prescriber Restrictions</td>
<td>Documentation of a consultation with an infectious disease specialist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Request will be authorized until the end of the contract year.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td>N/A</td>
</tr>
<tr>
<td>Indications</td>
<td>All Medically-accepted Indications.</td>
</tr>
<tr>
<td>Off-Label Uses</td>
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</table>
# CERDELGA

## Products Affected
- CERDELGA

<table>
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<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
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</thead>
<tbody>
<tr>
<td>Exclusion Criteria</td>
<td>Patients with undetermined CYP2D6 metabolizer status.</td>
</tr>
<tr>
<td>Required Medical Information</td>
<td>Patient's CYP2D6 metabolizer status, as determined by an FDA approved test.</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td>N/A</td>
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<tr>
<td>Prescriber Restrictions</td>
<td>N/A</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Request will be authorized until the end of the contract year.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td>For reauthorization, documentation has been provided that patient has obtained clinical benefit from medication (e.g. increased platelet count, improvement in anemia, PFTs, improvement in radiographic scans, improved quality of life).</td>
</tr>
<tr>
<td>Indications</td>
<td>All Medically-accepted Indications.</td>
</tr>
<tr>
<td>Off-Label Uses</td>
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## CGRP ANTAGONISTS

### Products Affected
- AIMOVIG
- EMGALITY
- EMGALITY (300 MG DOSE)

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<th>Criteria Details</th>
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<td>Age Restrictions</td>
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<tr>
<td>Prescriber Restrictions</td>
<td>Prescribed by or in consultation with a neurologist, headache specialist, or pain specialist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>New starts will be authorized for 6 months. Cont of therapy or reauth until end of contract year.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td>New starts for migraine prophylaxis: 1) at least 4 migraine days per month or one or more severe migraines lasting for greater than 12 hours despite use of abortive therapy (e.g. triptans or NSAIDs) and 2) trial of, contraindication to, or medical reason for not using at least two of the following agents: a beta adrenergic blocker, an anti-epileptic agent, a tricyclic antidepressant, or a serotonin-norepinephrine reuptake inhibitor. For continuation of therapy or reauthorization for migraine prophylaxis (after 6 month start): reduction of at least 1 headache day per month from baseline. New starts on Emgality for episodic cluster headache: trial of, contraindication to, or medical reason for not using verapamil for at least 4 weeks at minimum effective doses. For continuation of therapy or reauthorization for Emgality for episodic cluster headache: reduction in the frequency of headaches (clinical benefit).</td>
</tr>
<tr>
<td>Indications</td>
<td>All Medically-accepted Indications.</td>
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<td>PA Criteria</td>
<td>Criteria Details</td>
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### CHOLBAM

**Products Affected**
- CHOLBAM

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<tr>
<td>Age Restrictions</td>
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</tr>
<tr>
<td>Prescriber Restrictions</td>
<td>Prescriber must be a hepatologist or gastroenterologist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Request will be authorized until the end of the contract year.</td>
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<tr>
<td>Other Criteria</td>
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<tr>
<td>Indications</td>
<td>All Medically-accepted Indications.</td>
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<tr>
<td>Off-Label Uses</td>
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### CIBINQO

**Products Affected**
- CIBINQO

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<td>Age Restrictions</td>
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<tr>
<td>Prescriber Restrictions</td>
<td>Specialist for submitted diagnosis.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Request will be authorized until the end of the contract year.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td>For atopic dermatitis: trial of, contraindication to, or medical reason for not using Rinvoq.</td>
</tr>
<tr>
<td>Indications</td>
<td>All Medically-accepted Indications.</td>
</tr>
<tr>
<td>Off-Label Uses</td>
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</table>
# CIMZIA

## Products Affected
- CIMZIA PREFILLED SUBCUTANEOUS PREFILLED SYRINGE KIT
- CIMZIA STARTER KIT SUBCUTANEOUS PREFILLED SYRINGE KIT
- CIMZIA SUBCUTANEOUS KIT 2 X 200 MG

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<td>Age Restrictions</td>
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<tr>
<td>Prescriber Restrictions</td>
<td>Specialist for submitted diagnosis.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Request will be authorized until the end of the contract year.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td>For RA: Either 1) Trial of, medical reason for not using, or contraindication to 1 of the following: Enbrel or Humira or 2) If utilized within the past 120 days, approve for continuation of therapy. For PsA: Either 1) Trial of, medical reason for not using, or contraindication to 2 of the following therapies: Cosentyx, Tremfya, Xeljanz, Rinoq, Enbrel, or Humira, or 2) If utilized within the past 120 days, approve for continuation of therapy. For psoriasis: Either 1) Trial of, medical reason for not using, or contraindication to 2 of the following therapies: Cosentyx, Skyrizi, Tremfya, Enbrel, or Humira, or 2) If utilized within the past 120 days, approve for continuation of therapy. For ankylosing spondylitis: Either 1) Trial of, medical reason for not using, or contraindication to 2 of the following therapies: Cosentyx, Enbrel, or Humira, or 2) If utilized within the past 120 days, approve for continuation of therapy. For</td>
</tr>
<tr>
<td>PA Criteria</td>
<td>Criteria Details</td>
</tr>
<tr>
<td>-------------</td>
<td>-----------------</td>
</tr>
<tr>
<td></td>
<td>non-radiographic axial spondyloarthritis: approve. For Crohns Disease: Either 1) Trial of, medical reason for not using, or contraindication to Humira or Skyrizi, or 2) If utilized within the past 120 days, approve for continuation of therapy.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Indications</th>
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<tbody>
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<td>Off-Label Uses</td>
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## CLOBAZAM

### Products Affected
- clobazam oral suspension
- clobazam oral tablet
- SYMPAZAN

<table>
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<th>Criteria Details</th>
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<td>Age Restrictions</td>
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<tr>
<td>Prescriber Restrictions</td>
<td>Prescriber must be a neurologist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Request will be authorized until the end of the contract year.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td>Trial of, contraindication to, or medical reason for not using one formulary alternative generic anticonvulsant for appropriate indications.</td>
</tr>
<tr>
<td>Indications</td>
<td>All Medically-accepted Indications.</td>
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<tr>
<td>Off-Label Uses</td>
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### CORLANOR

#### Products Affected
- CORLANOR

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exclusion Criteria</td>
<td>Blood pressure less than 90/50 mmHg</td>
</tr>
<tr>
<td>Required Medical Information</td>
<td>New starts for chronic heart failure must have all of the following: 1) LVEF of 35% or less 2) Sinus rhythm and have resting heart rate greater than or equal to 70 bpm 3) Blood pressure greater than or equal to 90/50 mmHg, and 4) Trial of, contraindication to, or medical reason for not receiving a beta blocker.</td>
</tr>
<tr>
<td>Age Restrictions</td>
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</tr>
<tr>
<td>Prescriber Restrictions</td>
<td>Prescriber must be a cardiologist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Request will be authorized until the end of the contract year.</td>
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<tr>
<td>Other Criteria</td>
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<td>Indications</td>
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</tr>
<tr>
<td>Off-Label Uses</td>
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# CORTROPHIN

## Products Affected
- CORTROPHIN

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<tbody>
<tr>
<td>Exclusion Criteria</td>
<td>N/A</td>
</tr>
<tr>
<td>Required Medical Information</td>
<td>New starts for MS exacerbation, rheumatic disorders, collagen diseases, dermatologic diseases, serum sickness, edematous state (e.g. nephrotic syndrome without uremia), and respiratory diseases: trial of, contraindication to, or medical reason for not using oral corticosteroids. New starts for ophthalmic disease: trial of, contraindication to, or medical reason for not using oral or ophthalmic corticosteroids. Continuation of therapy or reauthorization for MS exacerbation: documentation of symptom improvement and current use of a multiple sclerosis disease modifying agent for maintenance therapy. Continuation of therapy or reauthorization for all other conditions: documented evidence of response to treatment and symptom improvement.</td>
</tr>
<tr>
<td>Age Restrictions</td>
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</tr>
<tr>
<td>Prescriber Restrictions</td>
<td>Specialist for submitted diagnosis.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>MS exacerbation: 1 month. Other conditions: new start for 3 months and reauth end of contract year.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td>N/A</td>
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<tr>
<td>Indications</td>
<td>All Medically-accepted Indications.</td>
</tr>
<tr>
<td>Off-Label Uses</td>
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</table>
## COSENTYX

### Products Affected
- COSENTYX (300 MG DOSE)
- COSENTYX SENSOREADY (300 MG)
- COSENTYX SENSOREADY PEN
- COSENTYX SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML
- cosentyx subcutaneous solution prefilled syringe 75 mg/0.5ml

<table>
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<th>Criteria Details</th>
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<td>Exclusion Criteria</td>
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<td>Required Medical Information</td>
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<tr>
<td>Age Restrictions</td>
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<tr>
<td>Prescriber Restrictions</td>
<td>Specialist for submitted diagnosis.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Request will be authorized until the end of the contract year.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td>For PsA or psoriasis: approve. For ankylosing spondylitis: Trial of, medical reason for not using, or contraindication to naproxen. For nonradiographic axial spondyloarthritis: approve. For enthesitis-related arthritis: approve.</td>
</tr>
<tr>
<td>Indications</td>
<td>All Medically-accepted Indications.</td>
</tr>
<tr>
<td>Off-Label Uses</td>
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**CYSTAGON**

**Products Affected**
- CYSTAGON

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<td>Required Medical Information</td>
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<tr>
<td>Age Restrictions</td>
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<tr>
<td>Prescriber Restrictions</td>
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<tr>
<td>Coverage Duration</td>
<td>Request will be authorized until the end of the contract year.</td>
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<tr>
<td>Other Criteria</td>
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<td>Indications</td>
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</tr>
<tr>
<td>Off-Label Uses</td>
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# DALFAMPRIDINE ER

## Products Affected
- dalfampridine er

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<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Exclusion Criteria</strong></td>
<td>History of seizure or moderate/severe renal impairment (CrCl 50 mL/min or less).</td>
</tr>
<tr>
<td><strong>Required Medical Information</strong></td>
<td>For new starts: 1) Attestation that creatinine clearance (CrCl) greater than 50 mL/min was confirmed prior to initiation of therapy, AND 2) Documentation has been provided that member is ambulatory (able to walk at least 25 feet) and has a documented walking impairment, AND 3) For appropriate indications, member is currently being treated with a disease modifying agent (e.g. immunomodulator, interferon, etc.) or has a medical reason why member is unable to use a disease modifying agent for their condition. For continuation of therapy or re-authorization requests: 1) Member must experience improvement in walking from baseline due to use of dalfampridine ER.</td>
</tr>
<tr>
<td><strong>Age Restrictions</strong></td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Prescriber Restrictions</strong></td>
<td>Prescriber must be a neurologist.</td>
</tr>
<tr>
<td><strong>Coverage Duration</strong></td>
<td>Request will be authorized until the end of the contract year.</td>
</tr>
<tr>
<td><strong>Other Criteria</strong></td>
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<tr>
<td><strong>Indications</strong></td>
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</tr>
<tr>
<td><strong>Off-Label Uses</strong></td>
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</table>
# DEFERASIROX

**Products Affected**
- deferasirox
- deferasirox granules

<table>
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<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exclusion Criteria</td>
<td>Patients with GFR less than 40 mL/min/1.73 m(2) or patients with platelet counts less than 50,000/mm3.</td>
</tr>
<tr>
<td>Required Medical Information</td>
<td>For all indications: platelet count greater than 50,000/mm3 (within 30 days) and GFR greater than 40 mL/min/1.73 m(2). For chronic iron overload due to transfusions: serum ferritin concentration greater than 1000 mcg/L (lab result with 30 days). For chronic iron overload in non-transfusion-dependent thalassemia syndromes: serum ferritin concentration greater than 300 mcg/L (lab result with 30 days).</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td>N/A</td>
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<tr>
<td>Prescriber Restrictions</td>
<td>N/A</td>
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<tr>
<td>Coverage Duration</td>
<td>Request will be authorized until the end of the contract year.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td>For deferasirox granules oral packets or deferasirox oral soluble tablets, trial of, contradiction to, or medical reason for not using deferasirox tablets.</td>
</tr>
<tr>
<td>Indications</td>
<td>All Medically-accepted Indications.</td>
</tr>
<tr>
<td>Off-Label Uses</td>
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### DEPEN

**Products Affected**  
- *penicillamine oral tablet*

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<th>Criteria Details</th>
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<td>Age Restrictions</td>
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<tr>
<td>Prescriber Restrictions</td>
<td>Specialist for submitted diagnosis.</td>
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<tr>
<td>Coverage Duration</td>
<td>Request will be authorized until the end of the contract year.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td>For RA: Trial of, medical reason for not using, or contraindication to 1 of the following: Enbrel or Humira. For other indications, approve.</td>
</tr>
<tr>
<td>Indications</td>
<td>All Medically-accepted Indications.</td>
</tr>
<tr>
<td>Off-Label Uses</td>
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## DIACOMIT

### Products Affected
- DIACOMIT

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<tbody>
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</tr>
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<td>Age Restrictions</td>
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</tr>
<tr>
<td>Prescriber Restrictions</td>
<td>Prescriber must be a neurologist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Request will be authorized until the end of the contract year.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td>Trial of, contraindication to, or medical reason for not using one formulary generic anticonvulsant for appropriate indications.</td>
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<tr>
<td>Indications</td>
<td>All Medically-accepted Indications.</td>
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<td>Off-Label Uses</td>
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# DIFICID

## Products Affected
- DIFICID

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<tr>
<td>Prescriber Restrictions</td>
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<tr>
<td>Coverage Duration</td>
<td>Request will be authorized for 10 days.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td>Documentation of prior use, or a medical reason for being unable to use oral vancomycin for current infection.</td>
</tr>
<tr>
<td>Indications</td>
<td>All Medically-accepted Indications.</td>
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<td>Off-Label Uses</td>
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## DOPELET

### Products Affected
- DOPELET

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<tr>
<td>Required Medical Information</td>
<td>For new starts for chronic liver disease and chronic immune thrombocytopenia (chronic ITP): documented baseline platelet count of less than 50,000/mcL.</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td>N/A</td>
</tr>
<tr>
<td>Prescriber Restrictions</td>
<td>Prescribed by or in consultation with hematologist, hepatologist or surgeon.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>For thrombocytopenia with CLD getting procedure: 5 days. For chronic ITP: remainder of contract year</td>
</tr>
<tr>
<td>Other Criteria</td>
<td>N/A</td>
</tr>
<tr>
<td>Indications</td>
<td>All Medically-accepted Indications.</td>
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<td>Off-Label Uses</td>
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## DOXEPIN CREAM

### Products Affected
- doxepin hcl external

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<tbody>
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<tr>
<td>Required Medical Information</td>
<td>Documentation of trial of, contraindication to, or medical reason for not using a topical corticosteroid.</td>
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<tr>
<td>Age Restrictions</td>
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<tr>
<td>Prescriber Restrictions</td>
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<tr>
<td>Coverage Duration</td>
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<td>Other Criteria</td>
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<td>Indications</td>
<td>All Medically-accepted Indications.</td>
</tr>
<tr>
<td>Off-Label Uses</td>
<td>N/A</td>
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</tbody>
</table>
# DUPIXENT

## Products Affected
- DUPIXENT SUBCUTANEOUS SOLUTION PEN-INJECTOR
- *dupixent subcutaneous solution* prefilled syringe 100 mg/0.67ml
- DUPIXENT SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 200 MG/1.14ML, 300 MG/2ML

<table>
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<td>Required Medical Information</td>
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</tr>
<tr>
<td>Age Restrictions</td>
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<tr>
<td>Prescriber Restrictions</td>
<td>Specialist for submitted diagnosis.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>New starts will be approved for 6 months. Cont of therapy or reauth until end of contract year.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td>New starts for atopic dermatitis: trial of, contraindication to, or medical reason for not using: 1) topical tacrolimus or pimecrolimus and 2) Eucrisa. New starts for asthma with eosinophilic phenotype: 1) blood eosinophil count greater than or equal to 150 cells per microliter, and 2) symptoms persist with at least 1 exacerbation in the last 12 months requiring additional treatment (e.g. oral systemic steroids) while on a high dose inhaled corticosteroid with a long-acting B2 agonist. New starts for oral corticosteroid asthma: symptoms persist with at least 1 exacerbation in the last 12 months requiring additional treatment, (e.g. oral systemic steroids) while on a high dose inhaled corticosteroid with a long-acting B2 agonist. New starts for chronic rhinosinusitis with nasal polyps: trial of, contraindication to, or medical reason for not using nasal corticosteroids. New starts for eosinophilic esophagitis: approve. Continuation of therapy</td>
</tr>
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<tr>
<td>-------------</td>
<td>-----------------</td>
</tr>
<tr>
<td></td>
<td>or reauthorization for all indications: clinical benefit from use of the drug.</td>
</tr>
<tr>
<td>Indications</td>
<td>All Medically-accepted Indications.</td>
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<td>Off-Label Uses</td>
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## EGRIFTA

### Products Affected
- **EGRIFTA SV**

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<tr>
<td>Required Medical Information</td>
<td>Documentation of active antiretroviral therapy for at least 8 weeks.</td>
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<td>Prescriber Restrictions</td>
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<tr>
<td>Coverage Duration</td>
<td>Request will be authorized until the end of the contract year.</td>
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<td>Other Criteria</td>
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<td>Indications</td>
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**EMPAVELI**

**Products Affected**
- EMPAVELI

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<td>Age Restrictions</td>
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<td>Prescriber Restrictions</td>
<td>Prescriber must be a hematologist, nephrologist, oncologist, or other appropriate specialist.</td>
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<tr>
<td>Coverage Duration</td>
<td>New starts: 3 months. Cont. of therapy or reauthorization: until end of contract year.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td>For new starts, all of the following must be provided: 1) Documentation of vaccination against meningococcal disease or a documented medical reason why the patient cannot receive vaccination or vaccination needs to be delayed, 2) Documentation that antimicrobial prophylaxis with oral antibiotics (such as penicillin, macrolides, ciprofloxacin, etc.) for two weeks has been provided if the meningococcal vaccine is administered less than 2 weeks before starting therapy or a documented medical reason why the patient cannot receive oral antibiotic prophylaxis, 3) Documentation of diagnosis by high sensitivity flow cytometry, AND 4) Documentation of Hemoglobin (Hgb) less than 10.5 g/dL. For continuation of therapy or reauthorization, documentation of clinical response to therapy (e.g., increased Hgb, reduced need for blood transfusions, improvement in quality of life scores).</td>
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<td>Indications</td>
<td>All Medically-accepted Indications.</td>
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ENBREL

Products Affected
- ENBREL MINI
- ENBREL SUBCUTANEOUS SOLUTION 25 MG/0.5ML
- ENBREL SUBCUTANEOUS SOLUTION PREFILLED SYRINGE
- ENBREL SUBCUTANEOUS SOLUTION RECONSTITUTED
- ENBREL SURECLICK SUBCUTANEOUS SOLUTION AUTO-INJECTOR

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<td>Age Restrictions</td>
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<tr>
<td>Prescriber Restrictions</td>
<td>Specialist for submitted diagnosis.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Request will be authorized until the end of the contract year.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td>For RA: Trial of, medical reason for not using, or contraindication to 1 disease modifying antirheumatic drug (DMARD) (methotrexate, leflunomide, or sulfasalazine). For pJIA: Trial of, medical reason for not using, or contraindication to 1 of the following DMARDs: methotrexate or leflunomide. For PsA or psoriasis: approve. For ankylosing spondylitis: Trial of, medical reason for not using, or contraindication to naproxen.</td>
</tr>
<tr>
<td>Indications</td>
<td>All Medically-accepted Indications.</td>
</tr>
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<td>Off-Label Uses</td>
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ENDARI

Products Affected
- ENDARI

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<tr>
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<tr>
<td>Required Medical Information</td>
<td>Documentation that two or more painful sickle cell crises have occurred in the past 12 months. Trial of, contraindication to, or medical reason for not using hydroxyurea for at least three months.</td>
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## EPIDIOLEX

### Products Affected
- EPIDIOLEX

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<td>Prescriber Restrictions</td>
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<td>Coverage Duration</td>
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</tr>
<tr>
<td>Other Criteria</td>
<td>Trial of, contraindication to, or medical reason for not using one formulary generic anticonvulsant for appropriate indications.</td>
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<td>Indications</td>
<td>All Medically-accepted Indications.</td>
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# EPRONTIA

## Products Affected
- eprontia

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<tr>
<td>Prescriber Restrictions</td>
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<td>Coverage Duration</td>
<td>The request will be authorized until the end of the contract year.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td>Documented trial of, contraindication to, or medical reason for not using topiramate.</td>
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<tr>
<td>Indications</td>
<td>All Medically-accepted Indications.</td>
</tr>
<tr>
<td>Off-Label Uses</td>
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</table>
# ERYTHROPOETIN STIMULATING AGENTS

## Products Affected
- ARANESP (ALBUMIN FREE) INJECTION SOLUTION 100 MCG/ML, 200 MCG/ML, 25 MCG/ML, 40 MCG/ML, 60 MCG/ML
- ARANESP (ALBUMIN FREE) INJECTION SOLUTION PREFILLED SYRINGE
- EPOGEN INJECTION SOLUTION 10000 UNIT/ML, 2000 UNIT/ML, 20000 UNIT/ML, 3000 UNIT/ML, 4000 UNIT/ML
- PROCRIT
- RETACRIT INJECTION SOLUTION 10000 UNIT/ML, 10000 UNIT/ML(1ML), 2000 UNIT/ML, 20000 UNIT/ML, 3000 UNIT/ML, 4000 UNIT/ML, 40000 UNIT/ML

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<td>Exclusion Criteria</td>
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<tr>
<td>Required Medical Information</td>
<td>For new starts for all indications: Hgb less than 10 g/dL or within compendia range for treatment of the requested medical condition. If the request for Epogen, Procrit, or Aranesp, trial of, contraindication to, or medical reason for not using Retacrit for appropriate indications. For continuation of therapy or re-authorization: Hgb must not exceed 10 g/dL (anemia related to cancer), 11 g/dL (anemia of CKD), 12 g/dL (zidovudine-related anemia in members with HIV and ribavirin-induced anemia), 13 g/dL (elective, noncardiac, nonvascular surgery needing red blood cell allogeneic transfusion reduction).</td>
</tr>
<tr>
<td>Age Restrictions</td>
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<tr>
<td>Prescriber Restrictions</td>
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<td>Coverage Duration</td>
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<tr>
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# ESBRIET

## Products Affected
- ESBRIET
- pirfenidone

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<th>Criteria Details</th>
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<tbody>
<tr>
<td>Exclusion Criteria</td>
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</tr>
<tr>
<td>Required Medical Information</td>
<td>For diagnosis of idiopathic pulmonary fibrosis: documentation of confirmation of diagnosis on high resolution CT scan or through lung biopsy.</td>
</tr>
<tr>
<td>Age Restrictions</td>
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<tr>
<td>Prescriber Restrictions</td>
<td>Prescriber must be a pulmonologist or lung transplant specialist.</td>
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<tr>
<td>Coverage Duration</td>
<td>Request will be authorized until the end of the contract year.</td>
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<tr>
<td>Other Criteria</td>
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<td>Indications</td>
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<td>Off-Label Uses</td>
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## EUCRISA

**Products Affected**
- EUCRISA

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<td>Age Restrictions</td>
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<tr>
<td>Prescriber Restrictions</td>
<td>Prescriber must be a dermatologist, immunologist or an allergist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Request will be authorized until the end of the contract year.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td>Trial of, contraindication to, or medical reason for not using topical tacrolimus or pimecrolimus.</td>
</tr>
<tr>
<td>Indications</td>
<td>All Medically-accepted Indications.</td>
</tr>
<tr>
<td>Off-Label Uses</td>
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</table>
## EVRYSDI

### Products Affected
- EVRYSDI

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<td><strong>Age Restrictions</strong></td>
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<td><strong>Prescriber Restrictions</strong></td>
<td>Prescriber must be a neurologist.</td>
</tr>
<tr>
<td><strong>Coverage Duration</strong></td>
<td>New starts will be authorized for 6 months. Cont of therapy or reauth until end of contract year.</td>
</tr>
<tr>
<td><strong>Other Criteria</strong></td>
<td>For new starts, all of the following must be included: 1) Documentation of genetic testing confirming diagnosis AND 2) Documentation of baseline motor function or motor milestone achievement [e.g. CHOP Infant Test of Neuromuscular Disorders (CHOP-INTEND) or Hammersmith Infant Neurological Examination (HINE) for Type 1 or Hammersmith Functional Motor Scale Expanded Scores (HFMSE) for Type II and Type III, or 6 minute walk test in subjects able to walk]. For continuation of therapy or reauthorization, documentation of clinical response has been submitted (e.g. improvement in motor function/motor milestone achievement scores using CHOP-INTEND or HFMSE, 6 minute walk test or HINE improvement in more categories of motor milestones than worsening, patient remains permanent ventilation free if no prior ventilator support).</td>
</tr>
</tbody>
</table>

### Indications
- All Medically-accepted Indications.
<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
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<tbody>
<tr>
<td>Off-Label Uses</td>
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# FASENRA

## Products Affected
- FASENRA
- FASENRA PEN

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<td>Age Restrictions</td>
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<tr>
<td>Prescriber Restrictions</td>
<td>Specialist for submitted diagnosis.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>New starts will be approved for 6 months. Cont of therapy or reauth until end of contract year.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td>New starts for severe asthma with an eosinophilic phenotype: 1) blood eosinophil count greater than or equal to 150 cells per microliter within 6 weeks or 300 cells per microliter within 12 months, AND 2) symptoms persist with at least 1 exacerbation in the last 12 months requiring additional treatment (e.g. oral systemic steroids) while on a high dose inhaled corticosteroid with a long-acting B2 agonist. Continuation of therapy or re-authorization for severe asthma with an eosinophilic phenotype: clinical benefit from use of the drug.</td>
</tr>
<tr>
<td>Indications</td>
<td>All Medically-accepted Indications.</td>
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<tr>
<td>Off-Label Uses</td>
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FENTANYL CITRATE TRANSMUCOSAL PRODUCTS

Products Affected
- fentanyl citrate buccal lozenge on a handle

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<th>Criteria Details</th>
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<tr>
<td>Required Medical Information</td>
<td>Documentation must be provided for the all of the following: 1) fentanyl citrate oral transmucosal is being prescribed to treat cancer-related breakthrough pain AND 2) Patient has been taking opioids at a dose equal to 60 MME per day for at least one week.</td>
</tr>
<tr>
<td>Age Restrictions</td>
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<tr>
<td>Prescriber Restrictions</td>
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<td>Other Criteria</td>
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<td>All Medically-accepted Indications.</td>
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<tr>
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# FERRIPROX

## Products Affected
- deferiprone

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<td><strong>Coverage Duration</strong></td>
<td>Request will be authorized until the end of the contract year.</td>
</tr>
<tr>
<td><strong>Other Criteria</strong></td>
<td>For new starts: 1) serum ferritin level above 1,000 mcg/L and absolute neutrophil count (ANC) greater than 1.5x10^9/L within 30 days of request, and 2) Trial of, contraindication to, or medical reason for not using deferasirox tablets. For continuation of therapy or reauthorization, decrease in serum ferritin from baseline.</td>
</tr>
<tr>
<td><strong>Indications</strong></td>
<td>All Medically-accepted Indications.</td>
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<td><strong>Off-Label Uses</strong></td>
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## FINTEPLA

### Products Affected
- FINTEPLA

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<tr>
<td>Prescriber Restrictions</td>
<td>Prescriber must be a neurologist.</td>
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<tr>
<td>Coverage Duration</td>
<td>Request will be authorized until the end of the contract year.</td>
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<tr>
<td>Other Criteria</td>
<td>Trial of, contraindication to, or medical reason for not using one formulary generic anticonvulsant for appropriate indications.</td>
</tr>
<tr>
<td>Indications</td>
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**FIRDAPSE**

**Products Affected**
- FIRDAPSE

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<th>Criteria Details</th>
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<td><strong>Prescriber Restrictions</strong></td>
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## GALAFOLD

### Products Affected
- GALAFOLD

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# GATTEX

## Products Affected
- GATTEX

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<tr>
<td><strong>Age Restrictions</strong></td>
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<tr>
<td><strong>Prescriber Restrictions</strong></td>
<td>Provider is a gastroenterologist.</td>
</tr>
<tr>
<td><strong>Coverage Duration</strong></td>
<td>Request will be authorized until the end of the contract year.</td>
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<td><strong>Other Criteria</strong></td>
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<td><strong>Indications</strong></td>
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<tr>
<td><strong>Off-Label Uses</strong></td>
<td>N/A</td>
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</tbody>
</table>
GNRH AGONISTS

Products Affected
- CAMCEVI
- ELIGARD
- FIRMAGON (240 MG DOSE)
- FIRMAGON SUBCUTANEOUS SOLUTION RECONSTITUTED 80 MG
- LUPRON DEPOT (1-MONTH)
- LUPRON DEPOT (3-MONTH)
- LUPRON DEPOT (4-MONTH)
- LUPRON DEPOT (6-MONTH)
- LUPRON DEPOT-PED (1-MONTH) INTRAMUSCULAR KIT 7.5 MG
- LUPRON DEPOT-PED (3-MONTH) INTRAMUSCULAR KIT 11.25 MG (PED)
- TRELSTAR MIXJECT

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<td>Required Medical Information</td>
<td>If the medication request is for the treatment of prostate cancer and if the request is for any other GnRH agonist other than Eligard, the patient must have a documented trial of, contraindication to, or medical reason for not using Eligard to treat their prostate cancer.</td>
</tr>
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<td>Prescriber Restrictions</td>
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<td>Coverage Duration</td>
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## GOCOVRI

### Products Affected
- GOCOVRI

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<tr>
<td>Required Medical Information</td>
<td>New starts: trial of, contraindication to, or medical reason for not using generic amantadine. Continuation of therapy or reauthorization: Member demonstrates clinical benefit (i.e. improvement in levodopa-induced dyskinesia or decreased off episodes).</td>
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<tr>
<td>Age Restrictions</td>
<td>N/A</td>
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<tr>
<td>Prescriber Restrictions</td>
<td>Prescribed by or in consultation with a neurologist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>New starts will be authorized for 3 months. Cont of therapy or reauth until end of contract year.</td>
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<td>Off-Label Uses</td>
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GROWTH HORMONES

Products Affected
- GENOTROPIN MINIQUICK SUBCUTANEOUS PREFILLED SYRINGE
- GENOTROPIN SUBCUTANEOUS CARTRIDGE
- HUMATROPE INJECTION CARTRIDGE
- NORDITROPIN FLEXPRO SUBCUTANEOUS SOLUTION PEN-INJECTOR
- NUTROPIN AQ NUSPIN 10 SUBCUTANEOUS SOLUTION PEN-INJECTOR
- NUTROPIN AQ NUSPIN 20 SUBCUTANEOUS SOLUTION PEN-INJECTOR
- NUTROPIN AQ NUSPIN 5 SUBCUTANEOUS SOLUTION PEN-INJECTOR
- OMNITROPE SUBCUTANEOUS SOLUTION CARTRIDGE
- OMNITROPE SUBCUTANEOUS SOLUTION RECONSTITUTED
- SKYTROFA

PA Criteria | Criteria Details
--- | ---
Exclusion Criteria | N/A

Required Medical Information
For new starts for growth hormone deficiency: 1) If the request is not for Genotropin, trial of, contraindication to, or medical reason for not using Genotropin, 2) documentation showing bone age testing, height, weight, and Growth Hormone Stimulation Test results OR Insulin Growth Factor 1 level. For continuation of therapy or reauthorization for growth hormone deficiency: documentation (medical records) showing positive response to treatment. For requests for all other medically accepted indications other than growth hormone deficiency, the request will be approved for products other than Skytrofa.

Age Restrictions | N/A

Prescriber Restrictions | Prescriber must be an endocrinologist or nephrologist.

Coverage Duration | New starts will be authorized for 6 months. Cont of therapy or reauth until end of contract year.
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# H. P. ACTHAR

## Products Affected
- ACTHAR

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<tr>
<td>Required Medical Information</td>
<td>New starts for MS exacerbation, rheumatic disorders, collagen diseases, dermatologic diseases, serum sickness, edematous state (e.g. nephrotic syndrome without uremia), and respiratory diseases: trial of, contraindication to, or medical reason for not using oral corticosteroids. New starts for ophthalmic disease: trial of, contraindication to, or medical reason for not using oral or ophthalmic corticosteroids. Continuation of therapy or reauthorization for MS exacerbation: documentation of symptom improvement and current use of a multiple sclerosis disease modifying agent for maintenance therapy. Continuation of therapy or reauthorization for all other conditions: documented evidence of response to treatment and symptom improvement.</td>
</tr>
<tr>
<td>Age Restrictions</td>
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<tr>
<td>Prescriber Restrictions</td>
<td>Specialist for submitted diagnosis.</td>
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<tr>
<td>Coverage Duration</td>
<td>MS exacerbation: 1 month. Other conditions: new start for 3 months and reauth end of contract year.</td>
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<td>Other Criteria</td>
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<td>Indications</td>
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<td>Off-Label Uses</td>
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# HETLIOZ

## Products Affected
- HETLIOZ
- HETLIOZ LQ

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<td>Indications</td>
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<tr>
<td>Off-Label Uses</td>
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</table>
HIGH RISK MEDICATION

Products Affected
- Clemastine fumarate oral tablet 2.68 mg
- Cyproheptadine hcl oral
- Dipyridamole oral
- Disopyramide phosphate oral
- Ergoloid mesylates oral
- Glyburide micronized oral tablet 1.5 mg, 3 mg, 6 mg
- Glyburide oral tablet 1.25 mg, 2.5 mg, 5 mg
- Glyburide-metformin oral tablet 1.25-250 mg, 2.5-500 mg
- Glyburide-metformin oral tablet 5-500 mg
- Guanfacine hcl er
- Guanfacine hcl oral
- Indomethacin er
- Indomethacin oral capsule 25 mg, 50 mg
- Ketorolac tromethamine oral
- Megestrol acetate oral suspension
- Meperidine hcl oral solution
- Meperidine hcl oral tablet 50 mg
- Nifedipine oral
- Norpace CR
- Pentazocine-naloxone hcl
- Promethazine hcl oral
- Promethazine hcl rectal suppository 12.5 mg, 25 mg
- Promethazine vc
- Promethazine-phenylephrine
- Promethegan rectal suppository 50 mg
- Trihexyphenidyl hcl

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<td>For patients 65 years old and older the prescriber has documented: 1) the benefits of treatment with the drug outweigh the potential risks identified for people 65 years old and older, and 2) the risks and side effects have been discussed and will be monitored.</td>
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<td>Age Restrictions</td>
<td>Prior authorization only applies to members 65 years old or older.</td>
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<td>Coverage Duration</td>
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<td>All Medically-accepted Indications.</td>
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<tr>
<td>Off-Label Uses</td>
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# HIGH RISK MEDICATION - PROTECTED CLASS DRUGS

## Products Affected
- amitriptyline hcl oral
- amoxapine
- clomipramine hcl oral
- doxepin hcl oral capsule
- doxepin hcl oral concentrate
- imipramine hcl oral
- imipramine pamoate
- megestrol acetate oral tablet
- MENEST ORAL TABLET 0.3 MG, 0.625 MG, 1.25 MG
- perphenazine-amitriptyline
- phenobarbital oral elixir
- phenobarbital oral tablet
- protriptyline hcl
- trimipramine maleate oral

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<td>Coverage Duration</td>
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<td>Indications</td>
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<tr>
<td>Off-Label Uses</td>
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## HIGH RISK MEDICATION, BUTALBITAL

### Products Affected
- ASCOMP-CODEINE
- BAC
- butalbital-acetaminophen oral tablet 50-325 mg
- butalbital-apap-caff-cod oral capsule 50-325-40-30 mg
- butalbital-apap-caffeine oral capsule 50-325-40 mg
- butalbital-apap-caffeine oral tablet 50-325-40 mg
- butalbital-asa-caff-codeine
- butalbital-asa-caffeine
- butalbital-aspirin-caffeine oral capsule

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<tr>
<td>Off-Label Uses</td>
<td>N/A</td>
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</table>
# HIGH RISK MEDICATION, DIGOXIN

## Products Affected
- DIGITEK ORAL TABLET 250 MCG
- digoxin oral solution
- digoxin oral tablet 250 mcg

## PA Criteria

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<td><strong>Required Medical Information</strong></td>
<td>For patients 65 years old and older the prescriber has documented: 1) the benefits of treatment with the drug outweigh the potential risks identified for people 65 years old and older, 2) the risks and side effects have been discussed and will be monitored, and 3) trial of or medical reason for not using digoxin doses up to 0.125 mg per day.</td>
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<td><strong>Prescriber Restrictions</strong></td>
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<td><strong>Indications</strong></td>
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<tr>
<td><strong>Off-Label Uses</strong></td>
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</tbody>
</table>
# HIGH RISK MEDICATION, SHORT TERM
## MUSCLE RELAXANT

### Products Affected
- carisoprodol oral
- chlorzoxazone oral tablet 500 mg
- metaxalone oral tablet 800 mg
- methocarbamol oral tablet 500 mg, 750 mg
- orphenadrine citrate er

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<td>For patients 65 years old and older the prescriber has documented: 1) the benefits of treatment with the drug outweigh the potential risks identified for people 65 years old and older, and 2) the risks and side effects have been discussed and will be monitored.</td>
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<td>Age Restrictions</td>
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<td>Prescriber Restrictions</td>
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<td>Coverage Duration</td>
<td>New starts will be authorized for 30 days. Continuation of therapy or reauth will be for 90 days.</td>
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<tr>
<td>Off-Label Uses</td>
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</tbody>
</table>
# HIGH RISK MEDICATION, SLEEP AGENTS

## Products Affected
- eszopiclone
- temazepam
- zaleplon
- zolpidem tartrate er
- zolpidem tartrate oral tablet 10 mg

## PA Criteria | Criteria Details
---|---
Exclusion Criteria | N/A

### Required Medical Information
For patients 65 years old and older the prescriber has documented: 1) the benefits of treatment with the drug outweigh the potential risks identified for people 65 years old and older, and 2) the risks and side effects have been discussed and will be monitored. For zolpidem immediate release 10mg and zolpidem ER: trial of or medical reason for not using zolpidem immediate release 5mg.

### Age Restrictions
Prior authorization only applies to members 65 years old or older.

### Prescriber Restrictions
N/A

### Coverage Duration
Request will be authorized until the end of the contract year.

### Other Criteria
N/A

### Indications
All Medically-accepted Indications.

### Off-Label Uses
N/A
HUMIRA

Products Affected

• HUMIRA PEDIATRIC CROHNS START SUBCUTANEOUS PREFILLED SYRINGE KIT 80 MG/0.8ML, 80 MG/0.8ML & 40MG/0.4ML
• HUMIRA PEN SUBCUTANEOUS PEN-INJECTOR KIT
• HUMIRA PEN-CD/UC/HS STARTER
• HUMIRA PEN-PEDIATRIC UC START
• HUMIRA PEN-PS/UV/ADOL HS START SUBCUTANEOUS PEN-INJECTOR KIT 40 MG/0.8ML
• HUMIRA PEN-PSOR/UVEIT STARTER
• HUMIRA SUBCUTANEOUS PREFILLED SYRINGE KIT 10 MG/0.1ML, 20 MG/0.2ML, 40 MG/0.4ML, 40 MG/0.8ML

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<td>Prescriber Restrictions</td>
<td>Specialist for submitted diagnosis.</td>
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<tr>
<td>Coverage Duration</td>
<td>Request will be authorized until the end of the contract year.</td>
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<tr>
<td>Other Criteria</td>
<td>For RA: Trial of, medical reason for not using, or contraindication to 1 disease modifying antirheumatic drug (DMARD) (methotrexate, leflunomide, or sulfasalazine). For pJIA: Trial of, medical reason for not using, or contraindication to 1 of the following DMARDs: methotrexate or leflunomide. For ankylosing spondylitis: Trial of, medical reason for not using, or contraindication to naproxen. For Crohns Disease: Trial of, medical reason for not using, or contraindication to 1 of the following: mercaptopurine, azathioprine, or corticosteroid (e.g., prednisone, methylprednisolone). For UC: Trial of, medical reason for not using, or contraindication to 1 of the following: mercaptopurine, azathioprine, or corticosteroid (e.g., prednisone, methylprednisolone).</td>
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<td>reason for not using, or contraindication to 1 of the following conventional therapies: mercaptopurine, an aminosalicylate (i.e. mesalamine, sulfasalazine, azathioprine), or a corticosteroid (i.e. prednisone, methylprednisolone). For PsA, psoriasis, Hidradenitis Suppurativa, or Uveitis: approve.</td>
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<tr>
<td>Indications</td>
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<td>Off-Label Uses</td>
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**ICATIBANT**

**Products Affected**
- *icatibant acetate*

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<td>Age Restrictions</td>
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<td>Prescriber Restrictions</td>
<td>Prescriber must be an immunologist, allergist, rheumatologist, or hematologist.</td>
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<td>Coverage Duration</td>
<td>Request will be authorized until the end of the contract year.</td>
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<td>Indications</td>
<td>All Medically-accepted Indications.</td>
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<tr>
<td>Off-Label Uses</td>
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# ILARIS

## Products Affected
- ILARIS SUBCUTANEOUS SOLUTION

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<td>Required Medical Information</td>
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<td>Age Restrictions</td>
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<td>Prescriber Restrictions</td>
<td>Specialist for submitted diagnosis.</td>
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<tr>
<td>Coverage Duration</td>
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<td>Other Criteria</td>
<td>For sJIA: approve.</td>
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<td>Indications</td>
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# ILUMYA

## Products Affected
- ILUMYA

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<td>Prescriber Restrictions</td>
<td>Specialist for submitted diagnosis.</td>
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<tr>
<td>Coverage Duration</td>
<td>Request will be authorized until the end of the contract year.</td>
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<tr>
<td>Other Criteria</td>
<td>For psoriasis: Either 1) Trial of, medical reason for not using, or contraindication to 2 of the following therapies: Cosentyx, Skyrizi, Tremfya, Enbrel, or Humira, or 2) If utilized within the past 120 days, approve for continuation of therapy.</td>
</tr>
<tr>
<td>Indications</td>
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<tr>
<td>Off-Label Uses</td>
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## INCRELEX

### Products Affected
- INCRELEX

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<td>Required Medical Information</td>
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</tr>
<tr>
<td>Age Restrictions</td>
<td>N/A</td>
</tr>
<tr>
<td>Prescriber Restrictions</td>
<td>Prescribed by or in consultation with a pediatric endocrinologist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Request will be authorized until the end of the contract year.</td>
</tr>
<tr>
<td>Other Criteria</td>
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</tr>
<tr>
<td>Indications</td>
<td>All Medically-accepted Indications.</td>
</tr>
<tr>
<td>Off-Label Uses</td>
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# INTRON-A

## Products Affected
- INTRON A

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<td>Off-Label Uses</td>
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</tbody>
</table>
### INVEGA TRINZA

#### Products Affected
- INVEGA TRINZA Intramuscular Suspension Prefilled Syringe 273 MG/0.88ML, 410 MG/1.32ML, 546 MG/1.75ML, 819 MG/2.63ML

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<tr>
<td>Exclusion Criteria</td>
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<tr>
<td>Required Medical Information</td>
<td>Documented treatment with Invega Sustenna for at least 4 months.</td>
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<td>Prescriber Restrictions</td>
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<td>Coverage Duration</td>
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<td>Other Criteria</td>
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## KALYDECO

### Products Affected
- KALYDECO

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<tbody>
<tr>
<td><strong>Exclusion Criteria</strong></td>
<td>Combination use with Orkambi, Symdeko, or Trikafta.</td>
</tr>
<tr>
<td><strong>Required Medical Information</strong></td>
<td>Documentation of CFTR gene that is responsive to ivacaftor treatment.</td>
</tr>
<tr>
<td><strong>Age Restrictions</strong></td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Prescriber Restrictions</strong></td>
<td>Prescriber must be a pulmonologist or an expert in the treatment of cystic fibrosis.</td>
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<tr>
<td><strong>Coverage Duration</strong></td>
<td>Request will be authorized until the end of the contract year.</td>
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## KEVEYIS

### Products Affected
- KEVEYIS

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</tr>
<tr>
<td>Required Medical Information</td>
<td>New starts: trial of, contraindication to, or medical reason for not using acetazolamide. Continuation of therapy or reauthorization: documentation of clinical improvement with therapy.</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td>N/A</td>
</tr>
<tr>
<td>Prescriber Restrictions</td>
<td>Prescribed by or in consultation with a geneticist, neurologist, or endocrinologist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>New starts will be authorized for 2 months. Cont of therapy or reauth until end of contract year.</td>
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<td>Other Criteria</td>
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# KEVZARA

## Products Affected
- KEVZARA

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<td>Age Restrictions</td>
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<tr>
<td>Prescriber Restrictions</td>
<td>Specialist for submitted diagnosis.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Request will be authorized until the end of the contract year.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td>For RA: Either 1) Trial of, medical reason for not using, or contraindication to 1 of the following: Enbrel or Humira or 2) If utilized within the past 120 days, approve for continuation of therapy.</td>
</tr>
<tr>
<td>Indications</td>
<td>All Medically-accepted Indications.</td>
</tr>
<tr>
<td>Off-Label Uses</td>
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### KINERET

#### Products Affected
- KINERET SUBCUTANEOUS SOLUTION PREFILLED SYRINGE

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<td>Age Restrictions</td>
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<tr>
<td>Prescriber Restrictions</td>
<td>Specialist for submitted diagnosis.</td>
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<tr>
<td>Coverage Duration</td>
<td>Request will be authorized until the end of the contract year.</td>
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<tr>
<td>Other Criteria</td>
<td>For RA: Either 1) Trial of, medical reason for not using, or contraindication to 1 of the following: Enbrel or Humira or 2) If utilized within the past 120 days, approve for continuation of therapy.</td>
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<tr>
<td>Indications</td>
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KORLYM

Products Affected
- KORLYM

<table>
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<th>PA Criteria</th>
<th>Criteria Details</th>
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<tbody>
<tr>
<td>Exclusion Criteria</td>
<td>For all members patient must not be currently on simvastatin, lovastatin, cyclosporine, dihydroergotamine, ergotamine, fentanyl, pimozide, quinidine, sirolimus, and tacrolimus.</td>
</tr>
<tr>
<td>Required Medical Information</td>
<td>Reviewer will verify available claim history to confirm member is not taking simvastatin, lovastatin, cyclosporine, dihydroergotamine, ergotamine, fentanyl, pimozide, quinidine, sirolimus or tacrolimus concurrently with Korlym.</td>
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<tr>
<td>Age Restrictions</td>
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<td>Prescriber Restrictions</td>
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<td>Coverage Duration</td>
<td>Request will be authorized until the end of the contract year.</td>
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<td>Other Criteria</td>
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<td>Indications</td>
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<td>Off-Label Uses</td>
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# KYNMOBI

## Products Affected
- KYNMOBI

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
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</thead>
<tbody>
<tr>
<td>Exclusion Criteria</td>
<td>Kymnobi (apomorphine hydrochloride) is contraindicated in concomitant use with serotonin 5-HT3 receptor antagonists.</td>
</tr>
<tr>
<td>Required Medical Information</td>
<td>Reviewer will verify available patient claim history to confirm patient is not using 5-HT3 receptor antagonists. For Parkinsons: trial of, contraindication to, or medical reason for not using two formulary alternatives such as entacapone, tolcapone, rasagiline, selegiline, carbidopa/levodopa, bromocriptine, pramipexole or ropinirole.</td>
</tr>
<tr>
<td>Age Restrictions</td>
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<tr>
<td>Prescriber Restrictions</td>
<td>Prescribed by or in consultation with a neurologist.</td>
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<td>Coverage Duration</td>
<td>Request will be authorized until the end of the contract year.</td>
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<td>Other Criteria</td>
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<td>Indications</td>
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## LAMPIT

### Products Affected
- LAMPIT

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</tr>
<tr>
<td>Age Restrictions</td>
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</tr>
<tr>
<td>Prescriber Restrictions</td>
<td>Documentation of a consultation with an infectious disease specialist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Request will be authorized for 90 days.</td>
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<td>Other Criteria</td>
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<td>Indications</td>
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<tr>
<td>Off-Label Uses</td>
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# LIVMARLI

**Products Affected**
- LIVMARLI

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</tr>
<tr>
<td>Age Restrictions</td>
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<tr>
<td>Prescriber Restrictions</td>
<td>Prescribed by or in consultation with a gastroenterologist or hepatologist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>New starts will be authorized for 6 months. Cont of therapy or reauth until end of contract year.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td>For new starts: 1) Trial of, contraindication to, or medical reason for not using both of the following: cholestyramine AND rifampin. 2) Prescriber attests that the member has cholestasis 3) Baseline serum bile acid level is provided. 4) Documentation of patients weight. For continuation of therapy or reauthorization: 1) Documentation submitted indicating the member has had all of the following: an improvement in pruritis (e.g. improved observed scratching, decreased sleep disturbances/nighttime awakenings due to scratching, etc.) AND reduction in serum bile acid level from baseline. 2) Prescriber attests that patient has had no evidence of hepatic decompensation (e.g. variceal hemorrhage, ascites, hepatic encephalopathy, portal hypertension, etc.). 3) Documentation of patients weight.</td>
</tr>
<tr>
<td>Indications</td>
<td>All Medically-accepted Indications.</td>
</tr>
<tr>
<td>Off-Label Uses</td>
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# LUCEMYRA

**Products Affected**
- LUCEMYRA

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<tr>
<td>Required Medical Information</td>
<td>For initial therapy, patient must have documented trial of, contraindication to, or medical reason for not using clonidine. Reauthorization criteria: chart notes that show positive response to prior treatment.</td>
</tr>
<tr>
<td>Age Restrictions</td>
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<tr>
<td>Prescriber Restrictions</td>
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<tr>
<td>Coverage Duration</td>
<td>Request will be authorized for 14 days.</td>
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<td>Indications</td>
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<tr>
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## LUPKYNIS

### Products Affected
- LUPKYNIS

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<tr>
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<th>Criteria Details</th>
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<tr>
<td><strong>Exclusion Criteria</strong></td>
<td>Concurrent use with cyclophosphamide.</td>
</tr>
<tr>
<td><strong>Required Medical Information</strong></td>
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</tr>
<tr>
<td><strong>Age Restrictions</strong></td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Prescriber Restrictions</strong></td>
<td>Prescriber must be rheumatologist, nephrologist, or other specialist in the treatment of autoimmune disorders.</td>
</tr>
<tr>
<td><strong>Coverage Duration</strong></td>
<td>New starts: 6 months. Cont. of therapy or reauthorization: until end of contract year.</td>
</tr>
<tr>
<td><strong>Other Criteria</strong></td>
<td>For new starts: 1) Documentation of urine protein/creatinine ratio (UPCR), 2) Documentation that the member has a baseline eGFR greater than 45 mL/min/1.73m2 or that benefit outweighs risk of using this medication at current eGFR, and 3) Concurrent use of or medical reason for not using background immunosuppressive therapy regimen. For continuation of therapy or reauthorization: Documentation of improvement in renal function (i.e. reduction in UPCR or no confirmed decrease from baseline eGFR greater than or equal to 20%).</td>
</tr>
<tr>
<td><strong>Indications</strong></td>
<td>All Medically-accepted Indications.</td>
</tr>
<tr>
<td><strong>Off-Label Uses</strong></td>
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</table>
**LYBALVI**

**Products Affected**
- lybalvi

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<th>Criteria Details</th>
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</thead>
<tbody>
<tr>
<td>Exclusion Criteria</td>
<td>Concomitant use with opioids.</td>
</tr>
<tr>
<td>Required Medical Information</td>
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</tr>
<tr>
<td>Age Restrictions</td>
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<tr>
<td>Prescriber Restrictions</td>
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</tr>
<tr>
<td>Coverage Duration</td>
<td>Request will be authorized until the end of the contract year.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td>1) Attestation from the provider that the member has had an opioid-free period of a minimum of 7 days after last use of shorting-acting opioids and 14 days from last use of long-acting opioids before initiating Lybalvi, AND 2) Documented trial of, contraindication to, or medical reason for not using at least two generic antipsychotics, one of which must be generic olanzapine.</td>
</tr>
</tbody>
</table>

**Indications**
- All Medically-accepted Indications.

**Off-Label Uses**
- N/A
# MAVYRET

## Products Affected
- mavyret oral packet
- MAVYRET ORAL TABLET

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
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<tbody>
<tr>
<td>Exclusion Criteria</td>
<td>N/A</td>
</tr>
<tr>
<td>Required Medical Information</td>
<td>Labs within 3 months of request: liver function tests, detectable HCV RNA viral load. In addition, documentation of genotype, treatment history, and if cirrhotic, documentation of compensated or decompensated cirrhosis. Prescriber attests to completing HBV screening and agrees to monitor for HBV reactivation if patient has a history of HBV infection.</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td>N/A</td>
</tr>
<tr>
<td>Prescriber Restrictions</td>
<td>Prescriber must be a hepatologist, gastroenterologist, infectious disease specialist, or transplant specialist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Request will be authorized for 8-16 weeks as per AASLD-IDSA guidance.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td>N/A</td>
</tr>
<tr>
<td>Indications</td>
<td>All Medically-accepted Indications.</td>
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<tr>
<td>Off-Label Uses</td>
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METHOXSALEN

Products Affected
- methoxsalen rapid

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<thead>
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<td>Prescriber Restrictions</td>
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<tr>
<td>Off-Label Uses</td>
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# METHYLTESTOSTERONE

## Products Affected
- methyltestosterone oral

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<td>Age Restrictions</td>
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<tr>
<td>Prescriber Restrictions</td>
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<tr>
<td>Coverage Duration</td>
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<td>Off-Label Uses</td>
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# METYROSINE

## Products Affected
- metyrosine

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<tbody>
<tr>
<td>Exclusion Criteria</td>
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</tr>
<tr>
<td>Required Medical Information</td>
<td>Documentation of one of the following: 1) Concurrent use of alpha adrenergic blockers, 2) Medical reason for being unable to use an alpha adrenergic blocker, OR 3) Patient is not a candidate for surgical resection and requires long term treatment with metyrosine.</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td>N/A</td>
</tr>
<tr>
<td>Prescriber Restrictions</td>
<td>N/A</td>
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<tr>
<td>Coverage Duration</td>
<td>Request will be authorized until the end of the contract year.</td>
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<tr>
<td>Other Criteria</td>
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<td>Indications</td>
<td>All Medically-accepted Indications.</td>
</tr>
<tr>
<td>Off-Label Uses</td>
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## MIGLUSTAT

### Products Affected
- *miglustat*

<table>
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<th>PA Criteria</th>
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</thead>
<tbody>
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<td>Exclusion Criteria</td>
<td>N/A</td>
</tr>
<tr>
<td>Required Medical Information</td>
<td>For new starts, documentation of diagnosis for mild to moderate type 1 Gaucher disease. For continuation of therapy or reauthorization: documentation of clinical benefit from use of the drug (i.e. increased platelet count, improvement in anemia, PFT's, improvement in radiographic scans, improved quality of life).</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td>N/A</td>
</tr>
<tr>
<td>Prescriber Restrictions</td>
<td>Prescribed by or in consultation with a specialist in treatment of Gaucher's disease.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Request will be authorized for 6 months.</td>
</tr>
<tr>
<td>Other Criteria</td>
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</tr>
<tr>
<td>Indications</td>
<td>All Medically-accepted Indications.</td>
</tr>
<tr>
<td>Off-Label Uses</td>
<td>N/A</td>
</tr>
</tbody>
</table>
# MULTIPLE SCLEROSIS AGENTS

## Products Affected
- AUBAGIO
- BAFIERTAM
- BETASERON SUBCUTANEOUS KIT
- dimethyl fumarate oral
- dimethyl fumarate starter pack
- EXTAVIA SUBCUTANEOUS KIT
- GILENYA ORAL CAPSULE 0.5 MG
- glatiramer acetate
- GLATOPA
- KESIMPTA
- MAYZENT ORAL TABLET 0.25 MG, 2 MG
- mayzent oral tablet 1 mg
- mayzent starter pack oral tablet therapy pack 0.25 mg
- MAYZENT STARTER PACK ORAL TABLET THERAPY PACK 12 X 0.25 MG
- PONVORY
- PONVORY STARTER PACK
- REBIF REBIDOSE SUBCUTANEOUS SOLUTION AUTO-INJECTOR
- REBIF REBIDOSE TITRATION PACK SUBCUTANEOUS SOLUTION AUTO-INJECTOR
- REBIF SUBCUTANEOUS SOLUTION PREFILLED SYRINGE
- REBIF TITRATION PACK SUBCUTANEOUS SOLUTION PREFILLED SYRINGE
- ZEPOSIA
- ZEPOSIA 7-DAY STARTER PACK
- ZEPOSIA STARTER KIT

<table>
<thead>
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<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exclusion Criteria</td>
<td>N/A</td>
</tr>
<tr>
<td>Required Medical Information</td>
<td>If the medication request is for glatiramer, Glatopa, or dimethyl fumarate, the request will be approved. If the request is not for glatiramer, Glatopa, or dimethyl fumarate for multiple sclerosis, the member must have a documented trial of, contraindication to or a medical reason for not using both dimethyl fumarate AND glatiramer or Glatopa. If the request is for Zeposia for ulcerative colitis: Either 1) Trial of, medical reason for not using, or contraindication Humira or 2) If utilized within the past 120 days, approve for continuation of therapy.</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td>N/A</td>
</tr>
<tr>
<td>Prescriber Restrictions</td>
<td>Specialist for submitted diagnosis.</td>
</tr>
<tr>
<td>PA Criteria</td>
<td>Criteria Details</td>
</tr>
<tr>
<td>------------------</td>
<td>-------------------------------------------------------</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Request will be authorized until the end of the contract year.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td>N/A</td>
</tr>
<tr>
<td>Indications</td>
<td>All Medically-accepted Indications.</td>
</tr>
<tr>
<td>Off-Label Uses</td>
<td>N/A</td>
</tr>
</tbody>
</table>
# MYFEMBREE

## Products Affected
- MYFEMBREE

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exclusion Criteria</td>
<td>Patient has history of osteoporosis or hepatic impairment.</td>
</tr>
<tr>
<td>Required Medical Information</td>
<td>N/A</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td>N/A</td>
</tr>
<tr>
<td>Prescriber Restrictions</td>
<td>Prescriber must be an obstetrician-gynecologist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>New starts: 6 months. Cont. of therapy or reauthorization: until end of contract year.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td>For new starts: Trial of, contraindication to, or medical reason for not using an estrogen-progestin contraceptive therapy. For new starts if one of the following drugs has been tried previously, a trial of estrogen-progestin contraceptive therapy is not required: gonadotropin-releasing hormone (GnRH) agonists or tranexamic acid. For continuation of therapy or reauthorization both of the following are required: 1) Treatment does not exceed the eligible maximum lifetime treatment duration of 2 years, and 2) Documentation has been provided that the member has obtained clinical benefit from medication (e.g. reduced menstrual bleeding from baseline).</td>
</tr>
</tbody>
</table>

## Indications
- All Medically-accepted Indications.

## Off-Label Uses
- N/A
## NASAL ANTISEIZURE AGENTS

### Products Affected
- NAYZILAM
- VALTOCO 10 MG DOSE
- VALTOCO 15 MG DOSE
- VALTOCO 20 MG DOSE
- VALTOCO 5 MG DOSE

<table>
<thead>
<tr>
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<th>Criteria Details</th>
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</thead>
<tbody>
<tr>
<td>Exclusion Criteria</td>
<td>N/A</td>
</tr>
<tr>
<td>Required Medical Information</td>
<td>Provider attests that diazepam rectal gel cannot be used.</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td>N/A</td>
</tr>
<tr>
<td>Prescriber Restrictions</td>
<td>N/A</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Request will be authorized until the end of the contract year.</td>
</tr>
<tr>
<td>Other Criteria</td>
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</tr>
<tr>
<td>Indications</td>
<td>All Medically-accepted Indications.</td>
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<tr>
<td>Off-Label Uses</td>
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# NATPARA

## Products Affected
- NATPARA

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</thead>
<tbody>
<tr>
<td>Exclusion Criteria</td>
<td>N/A</td>
</tr>
<tr>
<td>Required Medical Information</td>
<td>Documentation of serum calcium greater than 7.5 mg/dL and vitamin D level (within 30 days of request).</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td>N/A</td>
</tr>
<tr>
<td>Prescriber Restrictions</td>
<td>Provider is an endocrinologist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Request will be authorized until the end of the contract year.</td>
</tr>
<tr>
<td>Other Criteria</td>
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</tr>
<tr>
<td>Indications</td>
<td>All Medically-accepted Indications.</td>
</tr>
<tr>
<td>Off-Label Uses</td>
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### NEXLETOL

**Products Affected**
- NEXLETOL

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<tbody>
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</tr>
<tr>
<td>Required Medical Information</td>
<td>N/A</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td>N/A</td>
</tr>
<tr>
<td>Prescriber Restrictions</td>
<td>Prescriber must be a cardiologist, endocrinologist, or a specialist in treatment of lipid disorders.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>New starts will be authorized for 4 months. Cont of therapy or reauth until end of contract year.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td>For new starts ALL of the following must be provided: 1) Documentation of baseline low density lipoprotein cholesterol (LDL-C) 2) Member has tried and failed a high-intensity statin (i.e. atorvastatin 40-80 mg, rosuvastatin 20-40 mg) at maximum tolerated dose for 3 months via claim history or chart notes OR documentation has been provided that the member is not able to tolerate a statin 3) Member has tried and failed ezetimibe at a maximum tolerated dose or documentation has been provided that the patient is not able to tolerate ezetimibe AND 4) Member will continue on maximum tolerated statin dose and ezetimibe dose while receiving Nexletol or documentation has been provided that the member is not able to tolerate a statin and/or ezetimibe. In addition to the initial criteria above if the new start is for the diagnosis of hyperlipidemia and atherosclerotic cardiovascular disease (ASCVD), the following are required: 1) Documentation of history of least one of the following: myocardial infarction or acute coronary syndrome, stroke or transient ischemic attack, coronary artery disease with</td>
</tr>
<tr>
<td>PA Criteria</td>
<td>Criteria Details</td>
</tr>
<tr>
<td>-------------</td>
<td>-----------------</td>
</tr>
<tr>
<td></td>
<td>stable angina, coronary or other arterial revascularization, peripheral vascular disease, or aortic aneurysm AND 2) Member must have a fasting LDL-C greater than or equal to 70 mg/dL. For continuation of therapy or reauthorization requests for all indications: 1) Documentation provided that the member has obtained clinical benefit from medication (e.g. LDL-C lowering from baseline) AND 2) Member will continue on maximum tolerated statin and ezetimibe dose while receiving Nexletol or documentation has been provided that the member is not able to tolerate a statin and/or ezetimibe.</td>
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</table>

<table>
<thead>
<tr>
<th>Indications</th>
<th>All Medically-accepted Indications.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Off-Label Uses</td>
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NEXLIZET

Products Affected
- NEXLIZET

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<tr>
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</tr>
<tr>
<td>Required Medical Information</td>
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</tr>
<tr>
<td>Age Restrictions</td>
<td>N/A</td>
</tr>
<tr>
<td>Prescriber Restrictions</td>
<td>Prescriber must be a cardiologist, endocrinologist, or a specialist in treatment of lipid disorders.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>New starts will be authorized for 4 months. Cont of therapy or reauth until end of contract year.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td>For new starts ALL of the following must be provided: 1) Documentation of baseline low density lipoprotein cholesterol (LDL-C), 2) Member has tried and failed a high-intensity statin (i.e. atorvastatin 40-80 mg, rosuvastatin 20-40 mg) at maximum tolerated dose for 3 months via claim history or chart notes OR documentation has been provided that the member is not able to tolerate a statin, AND 3) Member will continue on maximum tolerated statin dose while receiving Nexlizet or documentation has been provided that the member is not able to tolerate a statin. In addition to the initial criteria above if the new start is for the diagnosis of hyperlipidemia and atherosclerotic cardiovascular disease (ASCVD), the following are required: 1) Documentation of history of least one of the following: myocardial infarction or acute coronary syndrome, stroke or transient ischemic attack, coronary artery disease with stable angina, coronary or other arterial revascularization, peripheral vascular disease, or aortic aneurysm, AND 2) Member must have a fasting LDL-C greater than or equal to</td>
</tr>
<tr>
<td>PA Criteria</td>
<td>Criteria Details</td>
</tr>
<tr>
<td>-------------</td>
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</tr>
<tr>
<td></td>
<td>70 mg/dL. For continuation of therapy or reauthorization requests for all indications: 1) Documentation provided that the member has obtained clinical benefit from medication (e.g. LDL-C lowering from baseline), AND 2) Member will continue on maximum tolerated statin while receiving Nexlizet or documentation has been provided that the member is not able to tolerate a statin.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Indications</th>
<th>All Medically-accepted Indications.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Off-Label Uses</td>
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</table>
## NITISINONE

### Products Affected
- nitisinone
- ORFADIN ORAL SUSPENSION
- ORFADIN ORAL CAPSULE 20 MG

<table>
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<tr>
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<th>Criteria Details</th>
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<tr>
<td>Required Medical Information</td>
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</tr>
<tr>
<td>Age Restrictions</td>
<td>N/A</td>
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<tr>
<td>Prescriber Restrictions</td>
<td>Prescriber must be a geneticist, metabolic specialist, hepatologist, or liver transplant specialist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Request will be authorized until the end of the contract year.</td>
</tr>
<tr>
<td>Other Criteria</td>
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<td>Indications</td>
<td>All Medically-accepted Indications.</td>
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<tr>
<td>Off-Label Uses</td>
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# NITYR

## Products Affected
- NITYR

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<tbody>
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<tr>
<td>Required Medical Information</td>
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<tr>
<td>Age Restrictions</td>
<td>N/A</td>
</tr>
<tr>
<td>Prescriber Restrictions</td>
<td>Prescriber must be a geneticist, metabolic specialist, hepatologist, or liver transplant specialist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Request will be authorized until the end of the contract year.</td>
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<tr>
<td>Other Criteria</td>
<td>N/A</td>
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<tr>
<td>Indications</td>
<td>All Medically-accepted Indications.</td>
</tr>
<tr>
<td>Off-Label Uses</td>
<td>N/A</td>
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</table>
NON-AMPHETAMINE CENTRAL NERVOUS SYSTEM AGENTS

Products Affected
- armodafinil
- modafinil

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exclusion Criteria</td>
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<tr>
<td>Required Medical Information</td>
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</tr>
<tr>
<td>Age Restrictions</td>
<td>N/A</td>
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<tr>
<td>Prescriber Restrictions</td>
<td>N/A</td>
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<tr>
<td>Coverage Duration</td>
<td>Request will be authorized until the end of the contract year.</td>
</tr>
<tr>
<td>Other Criteria</td>
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<tr>
<td>Indications</td>
<td>All Medically-accepted Indications.</td>
</tr>
<tr>
<td>Off-Label Uses</td>
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</table>
NOXAFIL

Products Affected
- NOXAFIL ORAL SUSPENSION
- posaconazole

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exclusion Criteria</td>
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</tr>
<tr>
<td>Required Medical Information</td>
<td>N/A</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td>N/A</td>
</tr>
<tr>
<td>Prescriber Restrictions</td>
<td>Documentation of a consultation with an infectious disease specialist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>28 days for oropharyngeal candidiasis, end of contract year for other indications</td>
</tr>
<tr>
<td>Other Criteria</td>
<td>For treatment of oropharyngeal candidiasis: trial of, contraindication to, or medical reason for not using fluconazole or itraconazole. For prophylaxis of invasive aspergillus infections due to being severely immunocompromised: trial of, contraindication to, or medical reason for not using voriconazole.</td>
</tr>
<tr>
<td>Indications</td>
<td>All Medically-accepted Indications.</td>
</tr>
<tr>
<td>Off-Label Uses</td>
<td>N/A</td>
</tr>
</tbody>
</table>
**NUCALA**

### Products Affected
- NUCALA SUBCUTANEOUS SOLUTION AUTO-INJECTOR
- NUCALA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML
- Nucala subcutaneous solution prefilled syringe 40 mg/0.4ml
- NUCALA SUBCUTANEOUS SOLUTION RECONSTITUTED

<table>
<thead>
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<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exclusion Criteria</td>
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<tr>
<td>Required Medical Information</td>
<td>N/A</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td>N/A</td>
</tr>
<tr>
<td>Prescriber Restrictions</td>
<td>Specialist for submitted diagnosis.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>New starts will be approved for 6 months. Cont of therapy or reauth until end of contract year.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td>New starts for severe asthma: 1) blood eosinophil count greater than or equal to 150 cells per microliter within 6 weeks or 300 cells per microliter within 12 months, AND 2) symptoms with equal to or greater than 1 exacerbations in the previous 12 months requiring additional medical treatment, (e.g. oral systemic steroids) while on a high-dose inhaled corticosteroid with a long-acting B2 agonist. New starts for eosinophilic granulomatosis with polyangiitis (EGPA): trial of, contraindication to, or medical reason for not using one of the following medications: cyclophosphamide or methotrexate. New starts for hypereosinophilic syndrome without an identifiable non-hematologic secondary cause: 1) 2 or more flares within the past 12 months AND 2) trial of, contraindication to, or medical reason for not using oral corticosteroids. New starts for chronic rhinosinusitis with nasal polyps: trial of, contraindication to, or medical reason...</td>
</tr>
<tr>
<td>PA Criteria</td>
<td>Criteria Details</td>
</tr>
<tr>
<td>--------------</td>
<td>----------------------------------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td>for not using nasal corticosteroids. Continuation of therapy or re-authorization for all indications: clinical benefit from use of the drug.</td>
</tr>
<tr>
<td>Indications</td>
<td>All Medically-accepted Indications.</td>
</tr>
<tr>
<td>Off-Label Uses</td>
<td>N/A</td>
</tr>
</tbody>
</table>
## NUEDEXTA

### Products Affected
- NUEDEXTA

| PA Criteria          | Criteria Details                                                                                                                                 |
|----------------------|-------------------------------------------------------------------------------------------------------------------------------------------------
| **Exclusion Criteria** | Complete atrioventricular (AV) block without implanted pacemaker, or at high risk of complete AV block. History of heart failure. Concomitant use with MAOIs or use of MAOIs within 14 days. Concomitant use with drugs containing quinidine, quinine, or mefloquine. History of quinine-, mefloquine-, dextromethorphan/quinidine-, or quinidine-induced thrombocytopenia, hepatitis, bone marrow depression, or lupus-like syndrome. Non-Part D indications. |
| **Required Medical Information** | Confirmation diagnosis is for Part D indication. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Request will be authorized until the end of the contract year. |
| **Other Criteria** | N/A |
| **Indications** | All Medically-accepted Indications. |
| **Off-Label Uses** | N/A |
**NUPLAZID**

**Products Affected**
- NUPLAZID ORAL CAPSULE
- NUPLAZID ORAL TABLET 10 MG

<table>
<thead>
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<th>Criteria Details</th>
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</thead>
<tbody>
<tr>
<td>Exclusion Criteria</td>
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</tr>
<tr>
<td>Required Medical Information</td>
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<tr>
<td>Age Restrictions</td>
<td>N/A</td>
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<tr>
<td>Prescriber Restrictions</td>
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</tr>
<tr>
<td>Coverage Duration</td>
<td>Request will be authorized until the end of the contract year.</td>
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<tr>
<td>Other Criteria</td>
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<td>Indications</td>
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</tr>
<tr>
<td>Off-Label Uses</td>
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</table>
# NURTEC

## Products Affected
- NURTEC

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</thead>
<tbody>
<tr>
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<tr>
<td>Required Medical Information</td>
<td>N/A</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td>N/A</td>
</tr>
<tr>
<td>Prescriber Restrictions</td>
<td>Prescribed by or in consultation with a neurologist, headache specialist or pain specialist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>New starts will be approved for 6 months. Cont of therapy or reauth until end of contract year.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td>For new starts for acute treatment of migraines: trial of, contraindication to, or medical reason for not using 2 triptans. For new starts for prevention of episodic migraine: trial of, contraindication to, or medical reason for not using Emgality or Aimovig. For continuation of therapy or reauthorization requests: documentation of improvement in pain and symptom(s) (e.g., photophobia, nausea, phonophobia).</td>
</tr>
<tr>
<td>Indications</td>
<td>All Medically-accepted Indications.</td>
</tr>
<tr>
<td>Off-Label Uses</td>
<td>N/A</td>
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## OCALIVA

### Products Affected
- OCALIVA

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Exclusion Criteria</strong></td>
<td>Members with complete biliary obstruction.</td>
</tr>
<tr>
<td><strong>Required Medical Information</strong></td>
<td>For new starts: 1) Attestation that the member has failed at least a 12 month trial of ursodiol, or has a medical reason (e.g. intolerance, hypersensitivity) for being unable to tolerate ursodiol AND 2) lab results for baseline ALT/AST, alkaline phosphatase (ALP), and bilirubin within 90 days of request. For continuation of therapy or reauthorization: Documentation that the member has responded to Ocaliva (e.g. improved biochemical markers (e.g., ALP, bilirubin, GGT, AST, ALT levels)).</td>
</tr>
<tr>
<td><strong>Age Restrictions</strong></td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Prescriber Restrictions</strong></td>
<td>Prescriber must be a gastroenterologist, hepatologist, or transplant specialist.</td>
</tr>
<tr>
<td><strong>Coverage Duration</strong></td>
<td>New starts will be authorized for 4 months. Cont of therapy or reauth until end of contract year.</td>
</tr>
<tr>
<td><strong>Other Criteria</strong></td>
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</tr>
<tr>
<td><strong>Indications</strong></td>
<td>All Medically-accepted Indications.</td>
</tr>
<tr>
<td><strong>Off-Label Uses</strong></td>
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</tr>
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</table>
# OFEV

## Products Affected
- OFEV

<table>
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<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Exclusion Criteria</strong></td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Required Medical Information</strong></td>
<td>For a diagnosis of idiopathic pulmonary fibrosis: 1) Documentation of disease as demonstrated on a high resolution CT scan or through lung biopsy and 2) Documented trial of, contraindication to, or medical reason for not using Esbriet. For a diagnosis of systemic sclerosis-associated interstitial lung disease (SSc-ILD): documented trial of, contraindication to, or medical reason for not using mycophenolate mofetil or cyclophosphamide. For a diagnosis of chronic fibrosing interstitial lung diseases (ILDs) with a progressive phenotype: documentation is provided confirming diagnosis.</td>
</tr>
<tr>
<td><strong>Age Restrictions</strong></td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Prescriber Restrictions</strong></td>
<td>Prescriber must be a pulmonologist or lung transplant specialist.</td>
</tr>
<tr>
<td><strong>Coverage Duration</strong></td>
<td>Request will be authorized until the end of the contract year.</td>
</tr>
<tr>
<td><strong>Other Criteria</strong></td>
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</tr>
<tr>
<td><strong>Indications</strong></td>
<td>All Medically-accepted Indications.</td>
</tr>
<tr>
<td><strong>Off-Label Uses</strong></td>
<td>N/A</td>
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</table>
## OLUMIANT

### Products Affected
- OLUMIANT

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
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<tr>
<td>Required Medical Information</td>
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<tr>
<td>Age Restrictions</td>
<td>N/A</td>
</tr>
<tr>
<td>Prescriber Restrictions</td>
<td>Specialist for submitted diagnosis.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Request will be authorized until the end of the contract year.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td>For RA: Either 1) Trial of, medical reason for not using, or contraindication to 2 of the following: Enbrel, Humira, Rinoq, or Xeljanz, or 2) If utilized within the past 120 days, approve for continuation of therapy. For alopecia areata: approve.</td>
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<tr>
<td>Indications</td>
<td>All Medically-accepted Indications.</td>
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<tr>
<td>Off-Label Uses</td>
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### ORAL ANTINEOPLASTIC AGENTS

#### Products Affected

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<thead>
<tr>
<th>Products Affected</th>
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<tbody>
<tr>
<td>abiraterone acetate</td>
<td>IRESSA</td>
</tr>
<tr>
<td>ALECENSA</td>
<td>JAKAFI</td>
</tr>
<tr>
<td>ALUNBRIG</td>
<td>KISQALI (200 MG DOSE)</td>
</tr>
<tr>
<td>AYVAKIT</td>
<td>KISQALI (400 MG DOSE)</td>
</tr>
<tr>
<td>BALVERSA</td>
<td>KISQALI (600 MG DOSE)</td>
</tr>
<tr>
<td>BOSULIF</td>
<td>KISQALI FEMARA (400 MG DOSE)</td>
</tr>
<tr>
<td>BRAFTOVI ORAL CAPSULE 75 MG</td>
<td>KISQALI FEMARA (600 MG DOSE)</td>
</tr>
<tr>
<td>BRUKINSA</td>
<td>KISQALI FEMARA(200 MG DOSE)</td>
</tr>
<tr>
<td>CABOMETYX</td>
<td>KOSELUGO</td>
</tr>
<tr>
<td>CALQUENCE ORAL CAPSULE</td>
<td>lapatinib ditosylate</td>
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<tr>
<td>calquence oral tablet</td>
<td>lenalidomide</td>
</tr>
<tr>
<td>CAPRELSA</td>
<td>LENVIMA (10 MG DAILY DOSE)</td>
</tr>
<tr>
<td>COMETRIQ (100 MG DAILY DOSE) ORAL KIT 80 &amp; 20 MG</td>
<td>LENVIMA (12 MG DAILY DOSE)</td>
</tr>
<tr>
<td>COMETRIQ (140 MG DAILY DOSE) ORAL KIT 3 X 20 MG &amp; 80 MG</td>
<td>LENVIMA (14 MG DAILY DOSE)</td>
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<td>COMETRIQ (60 MG DAILY DOSE)</td>
<td>LENVIMA (18 MG DAILY DOSE)</td>
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<td>copiktra</td>
<td>LENVIMA (20 MG DAILY DOSE)</td>
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<tr>
<td>COTELLIC</td>
<td>LENVIMA (24 MG DAILY DOSE)</td>
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<tr>
<td>DAURISMO</td>
<td>LENVIMA (4 MG DAILY DOSE)</td>
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<tr>
<td>ERIVEDGE</td>
<td>LENVIMA (8 MG DAILY DOSE)</td>
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<tr>
<td>ERLLEADA</td>
<td>LONSURF</td>
</tr>
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<td>erlotinib hcl</td>
<td>LORBRENA</td>
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<tr>
<td>everolimus oral tablet 10 mg, 2.5 mg, 5 mg, 7.5 mg</td>
<td>LUMAKRAS</td>
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<tr>
<td>everolimus oral tablet soluble</td>
<td>LYNPARZA ORAL TABLET</td>
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<td>exkivity</td>
<td>MEKINIST</td>
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<td>FOTIVDA</td>
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<td>GAVRETO</td>
<td>NERLYNX</td>
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<td>GILOTIRIF</td>
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<td>IBRANCE</td>
<td>NUBEQA</td>
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<td>ICLUSIG</td>
<td>ONUREG</td>
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<td>IDHIFA</td>
<td>ORGOVYX</td>
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<td>imatinib mesylate</td>
<td>PEMAZYRE</td>
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<td>IMBRUVICA ORAL CAPSULE</td>
<td>PIQRAY (200 MG DAILY DOSE)</td>
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<tr>
<td>imbruvica oral suspension</td>
<td>PIQRAY (250 MG DAILY DOSE)</td>
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<td>IMBRUVICA ORAL TABLET</td>
<td>PIQRAY (300 MG DAILY DOSE)</td>
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<td>INLYTA</td>
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<td>INQOVI</td>
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</table>
- REVLIMID
- ROZLYTREK
- RUBRACA
- RYDAPT
- scemblinx
- sorafenib tosylate
- SPRYCEL
- STIVARGA
- sunitinib malate
- TABLOID
- TABRECTA
- TAFINLAR
- TAGRISSO
- TALZENNA ORAL CAPSULE 0.25 MG, 1 MG
- talzenna oral capsule 0.5 mg, 0.75 mg
- TASIGNA
- TAZVERIK
- TEPMETKO
- THALOMID
- TIBSOVO
- toremifene citrate
- truseltiq (100mg daily dose)
- truseltiq (125mg daily dose)
- truseltiq (50mg daily dose)
- truseltiq (75mg daily dose)
- TUKYSA
- TURALIO
- VENCLEXTA
- VENCLEXTA STARTING PACK
- VERZENIO
- VITRAKVI
- VIZIMPRO
- vonjo
- VOTRIENT
- welireg
- XALKORI
- XOSPATA
- XPOVIO (100 MG ONCE WEEKLY)
- XPOVIO (40 MG ONCE WEEKLY)
- XPOVIO (40 MG TWICE WEEKLY)
- XPOVIO (60 MG ONCE WEEKLY)
- XPOVIO (60 MG TWICE WEEKLY)
- XPOVIO (80 MG TWICE WEEKLY)
- XTANDI
- YONSA
- ZEJULA
- ZELBORAF
- ZOLINZA
- ZYDELIG
- ZYKADIA ORAL TABLET

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<tr>
<td>Age Restrictions</td>
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<td>Prescriber Restrictions</td>
<td>Prescriber must be an oncologist or specialist for submitted diagnosis.</td>
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<td>Coverage Duration</td>
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<td>PA Criteria</td>
<td>Criteria Details</td>
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<tr>
<td>----------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Other Criteria</td>
<td>For new starts of Jakafi and Imbruvica for treatment of graft-versus-host disease (GVHD): documented trial of, contraindication to, or medical reason for not using a systemic corticosteroid. For continuation of therapy of Jakafi and Imbruvica for treatment of Graft-Versus-Host Disease (GVHD): documentation of clinical benefit from use of the drug (i.e. symptom improvement, reduction in corticosteroid dose). For Jakafi and Imbruvica for all other indications, approve.</td>
</tr>
<tr>
<td>Indications</td>
<td>All Medically-accepted Indications.</td>
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<tr>
<td>Off-Label Uses</td>
<td>N/A</td>
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## ORAL ANTIPSYCHOTICS

### Products Affected
- caplyta oral capsule 10.5 mg, 21 mg
- CAPLYTA ORAL CAPSULE 42 MG
- FANAPT
- FANAPT TITRATION PACK
- VRAYLAR ORAL CAPSULE
- VRAYLAR ORAL CAPSULE THERAPY PACK

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<tr>
<td>Required Medical</td>
<td>For schizophrenia and manic or mixed episodes associated with bipolar I disorder: trial of, contraindication to, or medical reason for not using one formulary generic antipsychotic. For major depressive disorder associated with bipolar I or II disorder: trial of, contraindication to, or medical reason for not using two formulary generic antipsychotics.</td>
</tr>
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<td>Medical Information</td>
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<td>Prescriber Restrictions</td>
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<td>Indications</td>
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<td>Off-Label Uses</td>
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ORENCIA

**Products Affected**
- ORENCIA CLICKJECT
- ORENCIA INTRAVENOUS
- ORENCIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE

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<td>Age Restrictions</td>
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<td>Prescriber Restrictions</td>
<td>Specialist for submitted diagnosis.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Request will be authorized until the end of the contract year.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td>For RA: Either 1) Trial of, medical reason for not using, or contraindication to 1 of the following: Enbrel or Humira or 2) If utilized within the past 120 days, approve for continuation of therapy. For pJIA: Either 1) Trial of, medical reason for not using, or contraindication to 1 of the following: Enbrel or Humira or 2) If utilized within the past 120 days, approve for continuation of therapy. For PsA: Either 1) Trial of, medical reason for not using, or contraindication to 2 of the following therapies: Cosentyx, Tremfya, Xeljanz, Rinvoq, Enbrel, or Humira, or 2) If utilized within the past 120 days, approve for continuation of therapy. For acute graft versus host disease: attestation member is taking in combination with a calcineurin inhibitor and methotrexate.</td>
</tr>
<tr>
<td>Indications</td>
<td>All Medically-accepted Indications.</td>
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<tr>
<td>Off-Label Uses</td>
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# ORILISSA

## Products Affected
- ORILISSA

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<th>Criteria Details</th>
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<tbody>
<tr>
<td><strong>Exclusion Criteria</strong></td>
<td>Patient has osteoporosis or severe hepatic impairment.</td>
</tr>
<tr>
<td><strong>Required Medical Information</strong></td>
<td>Trial of, contraindication to, or medical reason for not using the following concurrently for endometriosis: analgesic pain reliever (e.g. NSAIDs, COX-2 inhibitors) AND either combined estrogen-progestin oral contraceptive, progestin (e.g. medroxyprogesterone acetate, norethindrone), gonadotropin-releasing hormone (GnRH) agonists (e.g. Lupron Depot), OR danazol. For reauthorization, continued benefit with use of the drug.</td>
</tr>
<tr>
<td>Age Restrictions</td>
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<tr>
<td>Prescriber Restrictions</td>
<td>Prescriber must be an OB/GYN.</td>
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<tr>
<td>Coverage Duration</td>
<td>Request will be authorized until the end of the contract year.</td>
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<tr>
<td>Other Criteria</td>
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<td>Indications</td>
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<tr>
<td>Off-Label Uses</td>
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ORKAMBI

**Products Affected**
- ORKAMBI

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<th>Criteria Details</th>
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</thead>
<tbody>
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<td><strong>Exclusion Criteria</strong></td>
<td>Combination use with Kalydeco, Symdeko, or Trikafta.</td>
</tr>
<tr>
<td><strong>Required Medical Information</strong></td>
<td>Documentation of CFTR gene that is responsive to lumacaftor-ivacaftor treatment.</td>
</tr>
<tr>
<td><strong>Age Restrictions</strong></td>
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</tr>
<tr>
<td><strong>Prescriber Restrictions</strong></td>
<td>Prescriber must be a pulmonologist or an expert in the treatment of cystic fibrosis.</td>
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<tr>
<td><strong>Coverage Duration</strong></td>
<td>Request will be authorized until the end of the contract year.</td>
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<td><strong>Other Criteria</strong></td>
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<tr>
<td><strong>Indications</strong></td>
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<tr>
<td><strong>Off-Label Uses</strong></td>
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### ORLADEYO

#### Products Affected
- ORLADEYO

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<tr>
<td>Age Restrictions</td>
<td>N/A</td>
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<tr>
<td>Prescriber Restrictions</td>
<td>Prescriber must be an allergist, immunologist, rheumatologist or hematologist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Request will be authorized until the end of the contract year.</td>
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<td>Other Criteria</td>
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<td>Indications</td>
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<td>Off-Label Uses</td>
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## Products Affected
- OTEZLA

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<tr>
<td>Prescriber Restrictions</td>
<td>Specialist for submitted diagnosis.</td>
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<tr>
<td>Coverage Duration</td>
<td>Request will be authorized until the end of the contract year.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td>For PsA: Either 1) Trial of, medical reason for not using, or contraindication to 2 of the following therapies: Cosentyx, Tremfya, Xeljanz, Rinvoq, Enbrel, or Humira, or 2) If utilized within the past 120 days, approve for continuation of therapy. For moderate to severe psoriasis: Either 1) Trial of, medical reason for not using, or contraindication to 2 of the following therapies: Cosentyx, Skyrizi, Tremfya, Enbrel, or Humira, or 2) If utilized within the past 120 days, approve for continuation of therapy. For Behcet's Syndrome or mild psoriasis: Approve.</td>
</tr>
<tr>
<td>Indications</td>
<td>All Medically-accepted Indications.</td>
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<tr>
<td>Off-Label Uses</td>
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## OXBRYTA

### Products Affected
- **OXBRYTA**

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<td>Prescriber Restrictions</td>
<td>Prescriber must be a hematologist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>New starts will be authorized for 6 months. Cont of therapy or reauth until end of contract year.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td>New starts: Baseline labs have been submitted for the following: Hemoglobin (Hb), Indirect bilirubin, Reticulocytes. Documentation was provided that the member has had 1 or more pain crises in the last 12 months. Member has a baseline Hb level less than 10.5 g/dL. Documentation was provided that the member has been taking hydroxyurea at the maximum tolerated dose (or a medical reason was provided why the patient is unable to use hydroxyurea). For Oxbryta soluble tablets, medical reason for not using Oxbryta tablets. Continuation of therapy or reauthorization: Documentation submitted indicates clinical benefit at 6 months from initiation, and continued clinical benefit at subsequent 12-month intervals defined as the following: Documentation of one of the following: Hb increase from baseline (at 6 months from initiation) or maintenance of such Hb increase (at 12-month intervals thereafter) Or documentation of reduced number of vaso-occlusive/pain crises since Oxbryta was started Or documentation of one of</td>
</tr>
<tr>
<td>PA Criteria</td>
<td>Criteria Details</td>
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<tr>
<td>-------------</td>
<td>-----------------</td>
</tr>
<tr>
<td></td>
<td>the following: Decrease in indirect bilirubin from baseline Or decrease in percentage of reticulocytes from baseline.</td>
</tr>
<tr>
<td>Indications</td>
<td>All Medically-accepted Indications.</td>
</tr>
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<td>Off-Label Uses</td>
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## OXERVATE

### Products Affected
- OXERVATE

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<tr>
<td>Off-Label Uses</td>
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# OXYCODONE ER

## Products Affected
- oxycodone hcl er oral tablet er 12 hour abuse-deterrent

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<tr>
<td><strong>Prescriber Restrictions</strong></td>
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<tr>
<td><strong>Coverage Duration</strong></td>
<td>Request will be authorized until the end of the contract year.</td>
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<tr>
<td><strong>Other Criteria</strong></td>
<td>Members being treated for active cancer diagnoses, sickle cell diagnoses, those in hospice care, or receiving palliative care will be excluded from the concurrent benzodiazepine and muscle relaxant therapy requirement. For new starts, ALL of the following are required: (1) Member has documented history of receiving an immediate-release opioid, (2) Member has a documented trial of or intolerance to long-acting morphine sulfate, (3) If member is on concurrent benzodiazepines and/or muscle relaxant therapy, the prescriber attests that concurrent therapy is medically necessary, (4) Member is not being treated for substance abuse with buprenorphine-containing products. For continuing therapy, ALL of the following are required: (1) Member's pain has been assessed within the last 6 months, (2) Member has demonstrated clinical improvement in pain and function on current medication regimen, (3) If member is on concurrent benzodiazepines and/or muscle relaxant therapy, the prescriber attests that concurrent therapy is</td>
</tr>
<tr>
<td>PA Criteria</td>
<td>Criteria Details</td>
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<tr>
<td>-------------</td>
<td>------------------</td>
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<tr>
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<td>medically necessary, (4) Member is not being treated for substance abuse with buprenorphine-containing products.</td>
</tr>
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<td>Indications</td>
<td>All Medically-accepted Indications.</td>
</tr>
<tr>
<td>Off-Label Uses</td>
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## PALIPERIDONE

### Products Affected
- paliperidone er oral tablet
  extended release 24 hour 1.5 mg, 3 mg, 6 mg, 9 mg

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<th>Criteria Details</th>
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<td>Prescriber Restrictions</td>
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<td>Coverage Duration</td>
<td>Request will be authorized until the end of the contract year.</td>
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<td>For schizophrenia: trial of, contraindication to, or medical reason for not using an alternative generic formulary second generation atypical antipsychotic.</td>
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<td>Indications</td>
<td>All Medically-accepted Indications.</td>
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<tr>
<td>Off-Label Uses</td>
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</table>
# PCSK9 INHIBITORS

## Products Affected
- PRALUENT SUBCUTANEOUS SOLUTION AUTO-INJECTOR
- REPATHA
- REPATHA PUSHTRONEX SYSTEM
- REPATHA SURECLICK

<table>
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<td>Age Restrictions</td>
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<td>Prescriber Restrictions</td>
<td>Prescriber must be a cardiologist, endocrinologist, or a specialist in treatment of lipid disorders.</td>
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<td>Coverage Duration</td>
<td>New starts will be authorized for 4 months. Cont of therapy or reauth until end of contract year.</td>
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<tr>
<td>Other Criteria</td>
<td>For ALL diagnoses (including primary hyperlipidemia) for new starts: 1) documentation (copy of dated lab results required) of two fasting lipid panel reports within the past 12 months with abnormal LDL cholesterol results (above 70mg/dL) after treatment for a minimum of 3 months with two high potency statins (atorvastatin and rosuvastatin) or a medical reason (contraindication or intolerance) has been provided as to why the patient is unable to use these therapies, and 2) If patient experiences statin intolerance, trial of statin re-challenge with maximally tolerated dose of statins with continued abnormal LDL cholesterol results (above 70mg/dL) or with documented return of side effects. For familial hypercholesterolemia (FH), TWO of the following: 1) genetic testing (copy of dated lab results required) confirming FH diagnosis, 2) clinical manifestations of FH such as xanthomas or inflamed tendons, 3) a clinical diagnosis of FH using the Dutch Lipid Clinic Diagnostic criteria (total score greater than 8 points), OR Simon-</td>
</tr>
<tr>
<td>PA Criteria</td>
<td>Criteria Details</td>
</tr>
<tr>
<td>-------------</td>
<td>-----------------</td>
</tr>
<tr>
<td></td>
<td>Broome Diagnostic criteria (total cholesterol greater than 290 mg/dL or LDL-C greater than 190 mg/dL, plus tendon xanthoma in patient, first-degree parent, sibling or child) or second-degree relative (grandparent, uncle or aunt). For ASCVD, additional documentation has been provided that includes history of acute coronary syndromes, history of MI, stable or unstable angina, coronary or other arterial revascularization, stroke, TIA, or peripheral arterial disease presumed to be of atherosclerotic origin. For ALL diagnoses for continuation of therapy or reauthorization: repeat LDL cholesterol lab (copy of dated lab result required) showing improvement in LDL from new start.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Indications</th>
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</tr>
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<tbody>
<tr>
<td>Off-Label Uses</td>
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### PEGINTERFERON

**Products Affected**
- **PEGASYS SUBCUTANEOUS SOLUTION 180 MCG/ML**
- *pegasys subcutaneous solution prefilled syringe*

<table>
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<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
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<tbody>
<tr>
<td>Exclusion Criteria</td>
<td>N/A</td>
</tr>
<tr>
<td>Required Medical Information</td>
<td>For Hepatitis C: 1) Labs within 3 months of request: liver function tests and detectable HCV RNA viral load. 2) Documentation of genotype, treatment history, and if cirrhotic, documentation of compensated or decompensated cirrhosis. For Hepatitis B: 1) Labs within 3 months of request: ALT/AST, and 2) HBeAg status.</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td>N/A</td>
</tr>
<tr>
<td>Prescriber Restrictions</td>
<td>Prescriber must be a gastroenterologist, hepatologist, infectious disease doctor or transplant specialist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Request will be authorized for 24 to 48 weeks as defined by compendia.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td>N/A</td>
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<td>Indications</td>
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<tr>
<td>Off-Label Uses</td>
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# PENTAMIDINE SOLUTION FOR INJECTION

## Products Affected
- *pentamidine isethionate injection*

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<tbody>
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<td>Age Restrictions</td>
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<tr>
<td>Prescriber Restrictions</td>
<td>N/A</td>
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<tr>
<td>Coverage Duration</td>
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<td>Other Criteria</td>
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<td>Indications</td>
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<tr>
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## PERSERIS

### Products Affected

- PERSERIS

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<tbody>
<tr>
<td>Exclusion Criteria</td>
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</tr>
<tr>
<td>Required Medical Information</td>
<td>The member has a documented history of receiving oral risperidone without any clinically significant side effects. Additionally, the member has a documented trial and failure or medical reason (e.g. intolerance, hypersensitivity or contraindication) for not utilizing these therapies to manage their medical condition: Invega Sustenna, Invega Trinza or Risperdal Consta.</td>
</tr>
<tr>
<td>Age Restrictions</td>
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<tr>
<td>Prescriber Restrictions</td>
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<tr>
<td>Coverage Duration</td>
<td>Request will be authorized until the end of the contract year.</td>
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<tr>
<td>Off-Label Uses</td>
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# PHENOXYBENZAMINE

## Products Affected
- *phenoxybenzamine hcl oral*

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<tr>
<td>Required Medical Information</td>
<td>Trial of, contraindication to, or medical reason for not using doxazosin.</td>
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<td>Age Restrictions</td>
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<td>Prescriber Restrictions</td>
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<td>Coverage Duration</td>
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## PRETOMANID

### Products Affected
- pretomanid

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<tbody>
<tr>
<td>Exclusion Criteria</td>
<td>MDR-TB that is not treatment-intolerant or nonresponsive to standard therapy</td>
</tr>
<tr>
<td>Required Medical Information</td>
<td>Documentation of use in combination with bedaquiline and linezolid. Laboratory confirmed pulmonary MDR-TB resistant to isoniazid and rifampin</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td>N/A</td>
</tr>
<tr>
<td>Prescriber Restrictions</td>
<td>Documentation of a consultation with an infectious disease specialist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Request will be authorized for 26 weeks.</td>
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<td>Other Criteria</td>
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<td>Indications</td>
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<td>Off-Label Uses</td>
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# PREVYMIS

## Products Affected
- PREVYMIS ORAL

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</tr>
<tr>
<td>Age Restrictions</td>
<td>N/A</td>
</tr>
<tr>
<td>Prescriber Restrictions</td>
<td>Prescriber must be a hematologist, oncologist, infectious disease, or transplant specialist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Request will be authorized for 6 months.</td>
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<td>Other Criteria</td>
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<td>Indications</td>
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<td>Off-Label Uses</td>
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**PROLIA**

**Products Affected**
- PROLIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE

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<tr>
<td>Required Medical Information</td>
<td>For a diagnosis of osteoporosis: Documentation showing patient falls into one of the following categories: Postmenopausal woman or a male patient who has a bone mineral density (BMD) value consistent with osteoporosis (i.e., T-scores equal to or less than -2.5) or who has had an osteoporotic fracture. Postmenopausal woman or man with a T-score between -1 and -2.5 at the femoral neck or spine and a 10 year hip fracture probability greater than 3% or a 10 year major osteoporosis-related fracture probability greater than 20% based on the US-adapted WHO absolute fracture risk model.</td>
</tr>
<tr>
<td>Age Restrictions</td>
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</tr>
<tr>
<td>Prescriber Restrictions</td>
<td>N/A</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Request will be authorized until the end of the contract year.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td>The following criteria is also applicable: trial of, contraindication to, or medical reason for not using an oral bisphosphonate.</td>
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<tr>
<td>Indications</td>
<td>All Medically-accepted Indications.</td>
</tr>
<tr>
<td>Off-Label Uses</td>
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# PROMACTA

## Products Affected
- PROMACTA ORAL PACKET
- PROMACTA ORAL TABLET

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<tr>
<td>Age Restrictions</td>
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<tr>
<td>Prescriber Restrictions</td>
<td>Specialist for submitted diagnosis.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Request will be authorized until the end of the contract year.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td>For chronic immune (idiopathic) thrombocytopenia (ITP): 1) Documented baseline platelet count less than 30,000 cells/microL AND 2) Trial of, medical reason for not using, or contraindication to glucocorticosteroids. For severe aplastic anemia: 1) Prescribed with at least one formulary immunosuppressive agent OR trial of, contraindication to, or medical reason for not using one, AND 2) Documentation of baseline platelet count less than 20,000 cells/microL OR platelet count less than 30,000 cells/microL with bleeding OR reticulocyte count less than 20,000 cells/microL OR absolute neutrophil count less than 500 cells/microL. For thrombocytopenia in patients with Hepatitis C infection: documented baseline platelet count less than 50,000 cells/microL.</td>
</tr>
<tr>
<td>Indications</td>
<td>All Medically-accepted Indications.</td>
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<tr>
<td>Off-Label Uses</td>
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## PYRUKYND

### Products Affected
- PYRUKYND
- PYRUKYND TAPER PACK

<table>
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<tbody>
<tr>
<td>Exclusion Criteria</td>
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</tr>
<tr>
<td>Required Medical Information</td>
<td>For new starts: 1) documentation of diagnosis and 2) baseline hemoglobin level. For continuation of therapy or reauthorization: documentation of clinical improvement (e.g. reduction in number of blood transfusions, or increase or stabilization in hemoglobin level). If the criteria are not met, may authorize up to 14 days of a Pyrukynd Taper Pack to allow for tapering.</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td>N/A</td>
</tr>
<tr>
<td>Prescriber Restrictions</td>
<td>Prescribed by or in consultation with a hematologist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>New starts: 6 mo. Cont of therapy or reauth: end of contract yr. Denial: 14 days for dose tapering.</td>
</tr>
<tr>
<td>Other Criteria</td>
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<tr>
<td>Indications</td>
<td>All Medically-accepted Indications.</td>
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<tr>
<td>Off-Label Uses</td>
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**RADICAVA**

**Products Affected**
- RADICAVA ORS
- RADICAVA ORS STARTER KIT

<table>
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</tr>
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<td>Age Restrictions</td>
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<tr>
<td>Prescriber Restrictions</td>
<td>Prescriber must be a neurologist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>New starts: 6 months. Cont. of therapy or reauthorization: until end of contract year.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td>For new starts: 1) documentation of ALS functional rating scale (ALSFRS-R) score and 2) documentation that the member has been on riluzole, is beginning therapy as an adjunct to treatment with Radicava, or provider has provided a medical reason why patient is unable to use riluzole. For continuation of therapy or reauthorization: documentation from provider of clinical stabilization in symptoms (e.g. stabilization of ALS functional rating scale (ALSFRS-R) score).</td>
</tr>
<tr>
<td>Indications</td>
<td>All Medically-accepted Indications.</td>
</tr>
<tr>
<td>Off-Label Uses</td>
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</table>
# RAVICTI

## Products Affected
- RAVICTI

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<td>Required Medical Information</td>
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</tr>
<tr>
<td>Age Restrictions</td>
<td>N/A</td>
</tr>
<tr>
<td>Prescriber Restrictions</td>
<td>Provider is a geneticist, metabolic specialist, gastroenterologist, hepatologist, or liver transplant specialist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Request will be authorized until the end of the contract year.</td>
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<td>Other Criteria</td>
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<td>Indications</td>
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### RECORLEV

#### Products Affected
- RECORLEV

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<td>Prescriber Restrictions</td>
<td>Specialist for submitted diagnosis.</td>
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<tr>
<td>Coverage Duration</td>
<td>Request will be authorized until the end of the contract year.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td>Trial of, contraindication to, or medical reason for not using ketoconazole tablets.</td>
</tr>
<tr>
<td>Indications</td>
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</tr>
<tr>
<td>Off-Label Uses</td>
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### REGRANEX

#### Products Affected
- REGRANEX

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<td>Prescriber Restrictions</td>
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<td>Coverage Duration</td>
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## RELISTOR

### Products Affected
- RELISTOR ORAL
- RELISTOR SUBCUTANEOUS SOLUTION

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<tr>
<td>Coverage Duration</td>
<td>Request will be authorized until the end of the contract year.</td>
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<tr>
<td>Other Criteria</td>
<td>For appropriate indications, patient must have documented trial of or medical reason for not using the following: 1) lubiprostone, AND 2) lactulose. Additionally, for constipation caused by opioids that are used for chronic, non-cancer pain, patient must have a medical reason for not being able to use oral Relistor in order to receive Relistor injection.</td>
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<tr>
<td>Indications</td>
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# REXULTI

## Products Affected
- **REXULTI**

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</tr>
<tr>
<td>Required Medical Information</td>
<td>For schizophrenia: trial of, contraindication to, or medical reason for not using one formulary generic antipsychotic. For major depressive disorder: trial of, contraindication to, or medical reason for not using to two formulary generic antidepressants.</td>
</tr>
<tr>
<td>Age Restrictions</td>
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<tr>
<td>Prescriber Restrictions</td>
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<td>Coverage Duration</td>
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**REZUROCK**

**Products Affected**
- REZUROCK

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<tr>
<td>Age Restrictions</td>
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<tr>
<td>Prescriber Restrictions</td>
<td>Prescriber must be a hematologist, oncologist, or transplant specialist</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>New starts: 3 months. Cont. of therapy or reauthorization: until end of contract year.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td>For new starts: documented trial of, contraindication to, or medical reason for not using at least two lines of systemic immunosuppressive therapy (e.g. corticosteroids, tacrolimus, mycophenolate mofetil, Imbruvica, or Jakafi), one of which must be a systemic corticosteroid. For continuation of therapy or re-authorization: documentation of clinical benefit from use of the drug (i.e. symptom improvement, reduction in corticosteroid dose).</td>
</tr>
<tr>
<td>Indications</td>
<td>All Medically-accepted Indications.</td>
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<tr>
<td>Off-Label Uses</td>
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**RINVOQ**

**Products Affected**
- RINVOQ ORAL TABLET EXTENDED RELEASE 24 HOUR 15 MG, 30 MG
- *rinvoq oral tablet extended release 24 hour 45 mg*

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<td>Age Restrictions</td>
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<tr>
<td>Prescriber Restrictions</td>
<td>Specialist for submitted diagnosis.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Request will be authorized until the end of the contract year.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td>For RA: Trial of, medical reason for not using, or contraindication to 1 disease modifying antirheumatic drug (DMARD) (methotrexate, leflunomide, or sulfasalazin) and 1 tumor necrosis factor (TNF) blocker (Enbrel or Humira). For PsA: Trial of, medical reason for not using, or contraindication to 1 TNF blocker (Enbrel or Humira). For atopic dermatitis: trial of, contraindication to, or medical reason for not using: 1) topical tacrolimus or pimecrolimus and 2) Eucrisa. For UC: Trial of, medical reason for not using, or contraindication to 1 of the following conventional therapies: mercaptopurine, an aminosalicylate (i.e. mesalamine, sulfasalazine, azathioprine), or a corticosteroid (i.e. prednisone, methylprednisolone) and Humira. For ankylosing spondylitis: Trial of, medical reason for not using, or contraindication to naproxen and 1 TNF blocker (Enbrel or Humira).</td>
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<tr>
<td>Indications</td>
<td>All Medically-accepted Indications.</td>
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### RYLAZE

**Products Affected**
- RYLAZE

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<tr>
<td>Required Medical Information</td>
<td>N/A</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td>N/A</td>
</tr>
<tr>
<td>Prescriber Restrictions</td>
<td>Prescriber must be an oncologist, hematologist, or specialist for submitted diagnosis.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Request will be authorized until the end of the contract year.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td>N/A</td>
</tr>
<tr>
<td>Indications</td>
<td>All Medically-accepted Indications.</td>
</tr>
<tr>
<td>Off-Label Uses</td>
<td>N/A</td>
</tr>
</tbody>
</table>
**SAPROPTERIN**

**Products Affected**
- sapropterin dihydrochloride oral packet
- sapropterin dihydrochloride oral tablet

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exclusion Criteria</td>
<td>N/A</td>
</tr>
<tr>
<td>Required Medical Information</td>
<td>For new starts: documentation of elevated baseline phenylalanine levels. Continuation of therapy or reauthorization: prescriber attests the member has improvement in phenylalanine levels from baseline.</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td>N/A</td>
</tr>
<tr>
<td>Prescriber Restrictions</td>
<td>N/A</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>New starts will be authorized for 3 months. Cont of therapy or reauth until end of contract year.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td>N/A</td>
</tr>
<tr>
<td>Indications</td>
<td>All Medically-accepted Indications.</td>
</tr>
<tr>
<td>Off-Label Uses</td>
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</table>
## SECUADO

### Products Affected
- SECUADO

<table>
<thead>
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<th>PA Criteria</th>
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</thead>
<tbody>
<tr>
<td>Exclusion Criteria</td>
<td>N/A</td>
</tr>
<tr>
<td>Required Medical Information</td>
<td>Trial of, contraindication to, or medical reason for not using to one formulary generic antipsychotics.</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td>N/A</td>
</tr>
<tr>
<td>Prescriber Restrictions</td>
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</tr>
<tr>
<td>Coverage Duration</td>
<td>Request will be authorized until the end of the contract year.</td>
</tr>
<tr>
<td>Other Criteria</td>
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<tr>
<td>Indications</td>
<td>All Medically-accepted Indications.</td>
</tr>
<tr>
<td>Off-Label Uses</td>
<td>N/A</td>
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</table>
## SEROSTIM

### Products Affected
- SEROSTIM SUBCUTANEOUS SOLUTION RECONSTITUTED 4 MG, 5 MG, 6 MG

<table>
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<th>Criteria Details</th>
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<td>Exclusion Criteria</td>
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<tr>
<td>Required Medical Information</td>
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</tr>
<tr>
<td>Age Restrictions</td>
<td>N/A</td>
</tr>
<tr>
<td>Prescriber Restrictions</td>
<td>Prescriber must be a HIV specialist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Request will be authorized for 12 weeks.</td>
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<tr>
<td>Other Criteria</td>
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<tr>
<td>Indications</td>
<td>All Medically-accepted Indications.</td>
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<tr>
<td>Off-Label Uses</td>
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SIGNIFOR

Products Affected
- SIGNIFOR

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<tr>
<td>Required Medical Information</td>
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</tr>
<tr>
<td>Age Restrictions</td>
<td>N/A</td>
</tr>
<tr>
<td>Prescriber Restrictions</td>
<td>Prescribed by or in consultation with an endocrinologist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Request will be authorized until the end of the contract year.</td>
</tr>
<tr>
<td>Other Criteria</td>
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<td>Indications</td>
<td>All Medically-accepted Indications.</td>
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<td>Off-Label Uses</td>
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**SILDENAFIL ORAL**

<table>
<thead>
<tr>
<th>Products Affected</th>
</tr>
</thead>
<tbody>
<tr>
<td>• sildenafil citrate oral suspension reconstituted</td>
</tr>
<tr>
<td>• sildenafil citrate oral tablet 20 mg</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exclusion Criteria</td>
<td>Documentation of concurrent nitrate or Adempas use.</td>
</tr>
<tr>
<td>Required Medical Information</td>
<td>Documentation of pulmonary arterial hypertension (PAH) WHO Group I and PAH Functional Class. Reviewer will verify available patient claim history to confirm patient is not using nitrates or Adempas.</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td>N/A</td>
</tr>
<tr>
<td>Prescriber Restrictions</td>
<td>Prescriber must be a pulmonologist or cardiologist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Request will be authorized until the end of the contract year.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td>For sildenafil suspension: Documentation of trial of, contraindication to, or medical reason for not using sildenafil tablet.</td>
</tr>
<tr>
<td>Indications</td>
<td>All Medically-accepted Indications.</td>
</tr>
<tr>
<td>Off-Label Uses</td>
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## SILIQ

### Products Affected
- SILIQ

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<tbody>
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<td>Required Medical Information</td>
<td>N/A</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td>N/A</td>
</tr>
<tr>
<td>Prescriber Restrictions</td>
<td>Specialist for submitted diagnosis.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Request will be authorized until the end of the contract year.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td>For psoriasis: Either 1) Trial of, medical reason for not using, or contraindication to 2 of the following therapies: Cosentyx, Skyrizi, Tremfya, Enbrel, or Humira, or 2) If utilized within the past 120 days, approve for continuation of therapy.</td>
</tr>
<tr>
<td>Indications</td>
<td>All Medically-accepted Indications.</td>
</tr>
<tr>
<td>Off-Label Uses</td>
<td>N/A</td>
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</table>
**SIMPONI**

### Products Affected
- SIMPONI SUBCUTANEOUS SOLUTION AUTO-INJECTOR
- SIMPONI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE

<table>
<thead>
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<th>PA Criteria</th>
<th>Criteria Details</th>
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<tbody>
<tr>
<td>Exclusion Criteria</td>
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<tr>
<td>Required Medical Information</td>
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</tr>
<tr>
<td>Age Restrictions</td>
<td>N/A</td>
</tr>
<tr>
<td>Prescriber Restrictions</td>
<td>Specialist for submitted diagnosis.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Request will be authorized until the end of the contract year.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td>For RA: Either 1) Trial of, medical reason for not using, or contraindication to 1 of the following: Enbrel or Humira or 2) If utilized within the past 120 days, approve for continuation of therapy. For PsA: Either 1) Trial of, medical reason for not using, or contraindication to 2 of the following therapies: Cosentyx, Tremfya, Xeljanz, Rinvoq, Enbrel, or Humira, or 2) If utilized within the past 120 days, approve for continuation of therapy. For ankylosing spondylitis: Either 1) Trial of, medical reason for not using, or contraindication to 2 of the following therapies: Cosentyx, Enbrel, or Humira, or 2) If utilized within the past 120 days, approve for continuation of therapy. For UC: Either 1) Trial of, medical reason for not using, or contraindication to Humira or 2) If utilized within the past 120 days, approve for continuation of therapy.</td>
</tr>
<tr>
<td>Indications</td>
<td>All Medically-accepted Indications.</td>
</tr>
<tr>
<td>Off-Label Uses</td>
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## SIRTURO

### Products Affected
- SIRTURO

<table>
<thead>
<tr>
<th>PA Criteria</th>
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<tbody>
<tr>
<td>Exclusion Criteria</td>
<td>N/A</td>
</tr>
<tr>
<td>Required Medical Information</td>
<td>Documentation of prior trial of or medical reason for not using first-line TB regimen containing isoniazid and rifampin. Documentation (consistent with pharmacy claims data, OR for new members to the health plan consistent with medical chart history) that the member is currently taking 3 additional antimycobacterial drugs in combination to treat MDR-TB.</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td>N/A</td>
</tr>
<tr>
<td>Prescriber Restrictions</td>
<td>Prescribed by or in consultation with an infectious disease specialist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Request will be authorized for 24 weeks.</td>
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<tr>
<td>Other Criteria</td>
<td>N/A</td>
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<tr>
<td>Indications</td>
<td>All Medically-accepted Indications.</td>
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<tr>
<td>Off-Label Uses</td>
<td>N/A</td>
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</table>
## SKYRIZI

### Products Affected
- SKYRIZI (150 MG DOSE)
- SKYRIZI PEN
- skyrizi subcutaneous solution cartridge
- SKYRIZI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE

<table>
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<th>PA Criteria</th>
<th>Criteria Details</th>
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<td>Exclusion Criteria</td>
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<tr>
<td>Required Medical Information</td>
<td>N/A</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td>N/A</td>
</tr>
<tr>
<td>Prescriber Restrictions</td>
<td>Specialist for submitted diagnosis.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Request will be authorized until the end of the contract year.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td>For psoriasis: approve. For PsA: approve. For Crohns Disease: Trial of, medical reason for not using, or contraindication to 1 of the following: mercaptopurine, azathioprine, or corticosteroid (e.g., prednisone, methylprednisolone).</td>
</tr>
<tr>
<td>Indications</td>
<td>All Medically-accepted Indications.</td>
</tr>
<tr>
<td>Off-Label Uses</td>
<td>N/A</td>
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</tbody>
</table>
# SODIUM PHENYL BUTYRATE

## Products Affected
- sodium phenylbutyrate oral powder 3 gm/tsp
- sodium phenylbutyrate oral tablet

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exclusion Criteria</td>
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</tr>
<tr>
<td>Required Medical Information</td>
<td>N/A</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td>N/A</td>
</tr>
<tr>
<td>Prescriber Restrictions</td>
<td>N/A</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Request will be authorized until the end of the contract year.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td>N/A</td>
</tr>
<tr>
<td>Indications</td>
<td>All Medically-accepted Indications.</td>
</tr>
<tr>
<td>Off-Label Uses</td>
<td>N/A</td>
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</tbody>
</table>
# SOFOSBUVIR/VELPATASVIR

## Products Affected
- sofosbuvir-velpatasvir

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exclusion Criteria</td>
<td>N/A</td>
</tr>
<tr>
<td>Required Medical Information</td>
<td>Labs within 3 months of request: liver function tests and detectable HCV RNA viral load. In addition, documentation of genotype, treatment history, and if cirrhotic, documentation of compensated or decompensated cirrhosis. Prescriber attests to completing HBV screening and agrees to monitor for HBV reactivation if patient has a history of HBV infection.</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td>N/A</td>
</tr>
<tr>
<td>Prescriber Restrictions</td>
<td>Prescriber must be a hepatologist, gastroenterologist, infectious disease specialist, or transplant specialist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Request will be authorized for 12-24 weeks based on AASLD-IDSA guidelines</td>
</tr>
<tr>
<td>Other Criteria</td>
<td>N/A</td>
</tr>
<tr>
<td>Indications</td>
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</tr>
<tr>
<td>Off-Label Uses</td>
<td>N/A</td>
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</table>
# SOMAVERT

## Products Affected
- SOMAVERT

<table>
<thead>
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<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
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</tr>
<tr>
<td>Required Medical Information</td>
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</tr>
<tr>
<td>Age Restrictions</td>
<td>N/A</td>
</tr>
<tr>
<td>Prescriber Restrictions</td>
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</tr>
<tr>
<td>Coverage Duration</td>
<td>Request will be authorized until the end of the contract year.</td>
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<td>Other Criteria</td>
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<td>Indications</td>
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</tr>
<tr>
<td>Off-Label Uses</td>
<td>N/A</td>
</tr>
</tbody>
</table>
# STELARA

## Products Affected
- STELARA SUBCUTANEOUS SOLUTION 45 MG/0.5ML
- STELARA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
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<td>Exclusion Criteria</td>
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<tr>
<td>Required Medical Information</td>
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</tr>
<tr>
<td>Age Restrictions</td>
<td>N/A</td>
</tr>
<tr>
<td>Prescriber Restrictions</td>
<td>Specialist for submitted diagnosis.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Request will be authorized until the end of the contract year.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td>For PsA: Either 1) Trial of, medical reason for not using, or contraindication (e.g., safety concerns, not indicated for patients age) to 2 of the following therapies: Cosentyx, Tremfya, Xeljanz, Rinvoq, Enbrel, or Humira, or 2) If utilized within the past 120 days, approve for continuation of therapy. For psoriasis: Either 1) Trial of, medical reason for not using, or contraindication (e.g., safety concerns, not indicated for patients age) to 2 of the following therapies: Cosentyx, Skyrizi, Tremfya, Enbrel, or Humira, or 2) If utilized within the past 120 days, approve for continuation of therapy. For Crohns Disease: Either 1) Trial of, medical reason for not using, or contraindication (e.g., safety concerns, not indicated for patients age) to Humira or Skyrizi, or 2) If utilized within the past 120 days, approve for continuation of therapy. For UC: Either 1) Trial of, medical reason for not using, or contraindication (e.g., safety concerns, not indicated for patients age) to Humira or 2) If utilized within the past 120 days, approve for continuation of therapy.</td>
</tr>
<tr>
<td>PA Criteria</td>
<td>Criteria Details</td>
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<tr>
<td>Indications</td>
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</tr>
<tr>
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**SUCRAID**

**Products Affected**
- SUCRAID

<table>
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</thead>
<tbody>
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<tr>
<td>Required Medical Information</td>
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<td>Age Restrictions</td>
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<tr>
<td>Prescriber Restrictions</td>
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<tr>
<td>Coverage Duration</td>
<td>Request will be authorized until the end of the contract year.</td>
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<tr>
<td>Other Criteria</td>
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<tr>
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<tr>
<td>Off-Label Uses</td>
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### SYMDEKO

**Products Affected**
- SYMDEKO

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Exclusion Criteria</strong></td>
<td>Combination use with Kalydeco, Orkambi, or Trikafta.</td>
</tr>
<tr>
<td><strong>Required Medical Information</strong></td>
<td>Documentation of CFTR gene that is responsive to tezacaftor-ivacaftor treatment.</td>
</tr>
<tr>
<td><strong>Age Restrictions</strong></td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Prescriber Restrictions</strong></td>
<td>Prescriber must be a pulmonologist or an expert in the treatment of cystic fibrosis.</td>
</tr>
<tr>
<td><strong>Coverage Duration</strong></td>
<td>Request will be authorized until the end of the contract year.</td>
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<tr>
<td><strong>Other Criteria</strong></td>
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<tr>
<td><strong>Indications</strong></td>
<td>All Medically-accepted Indications.</td>
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<tr>
<td><strong>Off-Label Uses</strong></td>
<td>N/A</td>
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</table>
**SYMLIN**

**Products Affected**
- SYMLINPEN 120 SUBCUTANEOUS SOLUTION PEN-INJECTOR
- SYMLINPEN 60 SUBCUTANEOUS SOLUTION PEN-INJECTOR

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exclusion Criteria</td>
<td>Patient has confirmed gastroparesis.</td>
</tr>
<tr>
<td>Required Medical Information</td>
<td>For new starts: HbA1C values within 90 days of request is greater than or equal to 7% despite receiving insulin therapy.</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td>N/A</td>
</tr>
<tr>
<td>Prescriber Restrictions</td>
<td>N/A</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Request will be authorized until the end of the contract year.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td>Trial of, contraindication to, or medical reason for not using two alternative formulary anti-diabetic agents.</td>
</tr>
<tr>
<td>Indications</td>
<td>All Medically-accepted Indications.</td>
</tr>
<tr>
<td>Off-Label Uses</td>
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</table>
## SYNAREL

### Products Affected
- SYNAREL

<table>
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<th>Criteria Details</th>
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<tr>
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<td>Age Restrictions</td>
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<tr>
<td>Prescriber Restrictions</td>
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<tr>
<td>Coverage Duration</td>
<td>Request will be authorized until the end of the contract year.</td>
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<td>Other Criteria</td>
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<td>Indications</td>
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<tr>
<td>Off-Label Uses</td>
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### SYNDROS

#### Products Affected
- SYNDROS

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<tr>
<td>Age Restrictions</td>
<td>N/A</td>
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<tr>
<td>Prescriber Restrictions</td>
<td>N/A</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Request will be authorized until the end of the contract year.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td>Trial of, contraindication to, or medical reason for not being able to use dronabinol capsules.</td>
</tr>
<tr>
<td>Indications</td>
<td>All Medically-accepted Indications.</td>
</tr>
<tr>
<td>Off-Label Uses</td>
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### SYNRIBO

**Products Affected**  
- SYNRIBO

<table>
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<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exclusion Criteria</td>
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<tr>
<td>Required Medical Information</td>
<td>N/A</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td>N/A</td>
</tr>
<tr>
<td>Prescriber Restrictions</td>
<td>Prescriber must be an oncologist or a hematologist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Request will be authorized until the end of the contract year.</td>
</tr>
<tr>
<td>Other Criteria</td>
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</tr>
<tr>
<td>Indications</td>
<td>All Medically-accepted Indications.</td>
</tr>
<tr>
<td>Off-Label Uses</td>
<td>N/A</td>
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</table>
# TADALAFIL

## Products Affected
- **tadalafil (pah)**

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Exclusion Criteria</strong></td>
<td>Documentation of concurrent nitrate or Adempas use.</td>
</tr>
<tr>
<td><strong>Required Medical Information</strong></td>
<td>Documentation of pulmonary arterial hypertension (PAH) WHO Group I and PAH Functional Class. Reviewer will verify available patient claim history to confirm patient is not using nitrates or Adempas.</td>
</tr>
<tr>
<td><strong>Age Restrictions</strong></td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Prescriber Restrictions</strong></td>
<td>Prescriber must be a pulmonologist or cardiologist.</td>
</tr>
<tr>
<td><strong>Coverage Duration</strong></td>
<td>Request will be authorized until the end of the contract year.</td>
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<tr>
<td><strong>Other Criteria</strong></td>
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<td><strong>Indications</strong></td>
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</tr>
<tr>
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### TALTZ

#### Products Affected
- TALTZ

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<tbody>
<tr>
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<td>Age Restrictions</td>
<td>N/A</td>
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<tr>
<td>Prescriber Restrictions</td>
<td>Specialist for submitted diagnosis.</td>
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<tr>
<td>Coverage Duration</td>
<td>Request will be authorized until the end of the contract year.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td>For PsA: Either 1) Trial of, medical reason for not using, or contraindication (e.g., safety concerns, not indicated for patient's age) to 2 of the following therapies: Cosentyx, Tremfya, Xeljanz, Rinvoq, Enbrel, or Humira, or 2) If utilized within the past 120 days, approve for continuation of therapy. For psoriasis: Either 1) Trial of, medical reason for not using, or contraindication (e.g., safety concerns, not indicated for patient's age) to 2 of the following therapies: Cosentyx, Skyrizi, Tremfya, Enbrel, or Humira, or 2) If utilized within the past 120 days, approve for continuation of therapy. For ankylosing spondylitis: Either 1) Trial of, medical reason for not using, or contraindication (e.g., safety concerns, not indicated for patient's age) to 2 of the following therapies: Cosentyx, Enbrel, or Humira, or 2) If utilized within the past 120 days, approve for continuation of therapy. For non-radiographic axial spondyloarthritis: Either 1) Trial of, medical reason for not using, or contraindication (e.g., safety concerns, not indicated for patient's age) to</td>
</tr>
<tr>
<td>PA Criteria</td>
<td>Criteria Details</td>
</tr>
<tr>
<td>-------------</td>
<td>-----------------</td>
</tr>
<tr>
<td></td>
<td>Cosentyx, or 2) If utilized within the past 120 days, approve for continuation of therapy.</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Indications</th>
<th>All Medically-accepted Indications.</th>
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<tr>
<th>Off-Label Uses</th>
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**TARYPEYO**

**Products Affected**
- TARPEYO

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</tr>
</thead>
<tbody>
<tr>
<td>Exclusion Criteria</td>
<td>N/A</td>
</tr>
<tr>
<td>Required Medical Information</td>
<td>For new starts: attestation that member has 1) Diagnosis of primary immunoglobulin A nephropathy (IgAN) and 2) at risk of rapid disease progression. Member has an estimated glomerular filtration rate (eGFR) greater than or equal to 35 mL/min/1.73 m$^2$ and proteinuria (defined as either greater than or equal to 1 g/day or urine protein/creatinine ratio [UPCR] greater than or equal to 1.5 g/g). For continuation of therapy: documentation that member has been on Tarpeyo for less than 9 months. For reauthorizations: Requests will not be allowed as the safety and efficacy of subsequent courses of Tarpeyo have not been established.</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td>N/A</td>
</tr>
<tr>
<td>Prescriber Restrictions</td>
<td>Prescribed by or in consultation with a nephrologist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Request will be authorized for 9 months.</td>
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<td>Other Criteria</td>
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<tr>
<td>Indications</td>
<td>All Medically-accepted Indications.</td>
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## TAVNEOS

### Products Affected
- TAVNEOS

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<th>Criteria Details</th>
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<tr>
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<tr>
<td>Age Restrictions</td>
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</tr>
<tr>
<td>Prescriber Restrictions</td>
<td>Prescribed by or in consultation with a rheumatologist or hematologist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>New starts will be authorized for 6 months. Cont of therapy or reauth until end of contract year.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td>For new starts: 1) Prescriber attests that Tavneos will be prescribed in combination with corticosteroids AND cyclophosphamide unless there is documented trial of, contraindication to, or medical reason for not using these therapies. 2) Documentation of baseline Birmingham Vasculitis Activity Score (BVAS) score 3) Prescriber attestation that the patient will have liver function tests before treatment (ALT, AST, alkaline phosphate, and total bilirubin) and every 4 weeks after start of therapy for the first 6 months of treatment 4) Prescriber attestation that the patient has been screened for and does not have active hepatitis B virus (HBV) infection at baseline. For continuation of therapy or reauthorization: 1) Documentation of remission (BVAS score of 0) OR improvement in BVAS score 2) Prescriber attestation that patient has no abnormality in liver function tests (abnormality: ALT or AST greater than 3 times the upper limit of normal and bilirubin greater than 2 times the upper</td>
</tr>
<tr>
<td>PA Criteria</td>
<td>Criteria Details</td>
</tr>
<tr>
<td>-------------</td>
<td>-----------------</td>
</tr>
<tr>
<td></td>
<td>limit of normal) 3) Prescriber attestation that patient has no active HBV infection.</td>
</tr>
<tr>
<td>Indications</td>
<td>All Medically-accepted Indications.</td>
</tr>
<tr>
<td>Off-Label Uses</td>
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### TEFLARO

#### Products Affected
- TEFLARO

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<tr>
<td>Age Restrictions</td>
<td>N/A</td>
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<tr>
<td>Prescriber Restrictions</td>
<td>Documentation of a consultation with an infectious disease specialist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Request will be authorized for 14 days.</td>
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<td>Other Criteria</td>
<td>N/A</td>
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<tr>
<td>Indications</td>
<td>All Medically-accepted Indications.</td>
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<tr>
<td>Off-Label Uses</td>
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## TERIPARATIDE

### Products Affected
- teriparatide (recombinant)

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<tbody>
<tr>
<td><strong>Exclusion Criteria</strong></td>
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</tr>
<tr>
<td><strong>Required Medical Information</strong></td>
<td>Documentation showing patient falls into one of the following categories: Postmenopausal woman who has a bone mineral density (BMD) value consistent with osteoporosis (i.e., T-scores equal to or less than -2.5) or postmenopausal woman who has had an osteoporotic fracture. Postmenopausal woman who has T-scores from -1.5 to -2.5 and at least one of the following risk factors for fracture: thinness [low body mass index (less than 21 kg/m2)], history of fragility fracture since menopause, or history of hip fracture in a parent. Male greater than or equal to 65 years of age with T-score of -2.5 or less. Male less than 65 years of age with T-score of -2.5 or less and 2 or more risk factors for fractures or previous osteoporotic fracture.</td>
</tr>
<tr>
<td><strong>Age Restrictions</strong></td>
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<tr>
<td><strong>Prescriber Restrictions</strong></td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Coverage Duration</strong></td>
<td>Request will be authorized until the end of the contract year.</td>
</tr>
<tr>
<td><strong>Other Criteria</strong></td>
<td>In addition, the following criteria is also applicable: 1) Trial of, medical reason for not using, or contraindication to an oral bisphosphonate and Prolia and 2) therapy does not exceed the therapy maximum of 2 years.</td>
</tr>
<tr>
<td><strong>Indications</strong></td>
<td>All Medically-accepted Indications.</td>
</tr>
<tr>
<td><strong>Off-Label Uses</strong></td>
<td>N/A</td>
</tr>
</tbody>
</table>
# THIOLA

## Products Affected
- THIOLA EC
- tiopronin oral

<table>
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<tr>
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<tbody>
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<tr>
<td>Age Restrictions</td>
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<td>Prescriber Restrictions</td>
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<tr>
<td>Coverage Duration</td>
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<tr>
<td>Other Criteria</td>
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<tr>
<td>Indications</td>
<td>All Medically-accepted Indications.</td>
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<tr>
<td>Off-Label Uses</td>
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### TOLVAPTAN

#### Products Affected
- JYNARQUE
- tolvaptan

<table>
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<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Exclusion Criteria</strong></td>
<td>Concomitant use with strong CYP3A4 inhibitors (i.e. clarithromycin, ketoconazole, itraconazole, ritonavir, lopinavir-ritonavir, indinavir-ritonavir, indinavir, nelfinavir, saquinavir, nefazodone, conivaptan, and telithromycin).</td>
</tr>
<tr>
<td><strong>Required Medical Information</strong></td>
<td>Reviewer will verify available patient claim history to confirm patient is not using a strong CYP3A4 inhibitor (i.e. clarithromycin, ketoconazole, itraconazole, ritonavir, lopinavir-ritonavir, indinavir-ritonavir, indinavir, nelfinavir, saquinavir, nefazodone, conivaptan, and telithromycin).</td>
</tr>
<tr>
<td><strong>Age Restrictions</strong></td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Prescriber Restrictions</strong></td>
<td>Prescribed by or in consultation with a cardiologist, endocrinologist, hepatologist, or nephrologist.</td>
</tr>
<tr>
<td><strong>Coverage Duration</strong></td>
<td>Request will be authorized until the end of the contract year.</td>
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<td><strong>Other Criteria</strong></td>
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<td><strong>Indications</strong></td>
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</tr>
<tr>
<td><strong>Off-Label Uses</strong></td>
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</tbody>
</table>
# TOPICAL ANTINEOPLASTIC RETINOIDs

**Products Affected**
- bexarotene external
- panretin

<table>
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<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
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<td>Exclusion Criteria</td>
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<td>Required Medical Information</td>
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<td>Age Restrictions</td>
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<tr>
<td>Prescriber Restrictions</td>
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<td>Coverage Duration</td>
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<tr>
<td>Indications</td>
<td>All Medically-accepted Indications.</td>
</tr>
<tr>
<td>Off-Label Uses</td>
<td>N/A</td>
</tr>
</tbody>
</table>
# TOPICAL TESTOSTERONE

## Products Affected
- testosterone transdermal gel 12.5 mg/act (1%), 20.25 mg/1.25gm (1.62%), 25 mg/2.5gm (1%), 40.5 mg/2.5gm (1.62%), 50 mg/5gm (1%)
- testosterone transdermal solution

<table>
<thead>
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<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exclusion Criteria</td>
<td>N/A</td>
</tr>
<tr>
<td>Required Medical Information</td>
<td>Patient initiating topical testosterone therapy for hypogonadism must have both of the following characteristics of hypogonadism: 1) symptoms associated with hypogonadism (e.g. unexplained mild anemia, low libido, decreased energy, etc.) 2) Two instances of low serum total or free testosterone, as defined by the reference range by the lab. For all patients, provider attests that PSA levels, hemoglobin, hematocrit and testosterone levels will be monitored periodically throughout the treatment as indicated in compendia.</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td>N/A</td>
</tr>
<tr>
<td>Prescriber Restrictions</td>
<td>N/A</td>
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<tr>
<td>Coverage Duration</td>
<td>Request will be authorized until the end of the contract year.</td>
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<tr>
<td>Other Criteria</td>
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<td>Indications</td>
<td>All Medically-accepted Indications.</td>
</tr>
<tr>
<td>Off-Label Uses</td>
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</tr>
</tbody>
</table>
# Transdermal Lidocaine

## Products Affected
- Lidocaine external patch 5%
- ZTLIDO

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<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
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<td>Exclusion Criteria</td>
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<td>Required Medical Information</td>
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<td>Age Restrictions</td>
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<td>Prescriber Restrictions</td>
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<td>Coverage Duration</td>
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<td>Other Criteria</td>
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<tr>
<td>Indications</td>
<td>All medically-accepted indications.</td>
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<tr>
<td>Off-Label Uses</td>
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# TREMFYA

## Products Affected
- TREMFYA

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<td>Required Medical Information</td>
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<tr>
<td>Age Restrictions</td>
<td>N/A</td>
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<tr>
<td>Prescriber Restrictions</td>
<td>Specialist for submitted diagnosis.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Request will be authorized until the end of the contract year.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td>For PsA or psoriasis: approve.</td>
</tr>
<tr>
<td>Indications</td>
<td>All Medically-accepted Indications.</td>
</tr>
<tr>
<td>Off-Label Uses</td>
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</table>
**TRIENTINE**

**Products Affected**
- trientine hcl

<table>
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<th>Criteria Details</th>
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<tbody>
<tr>
<td>Exclusion Criteria</td>
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<tr>
<td>Required Medical Information</td>
<td>Trial of, contraindication to, or medical reason for not using penicillamine.</td>
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<tr>
<td>Age Restrictions</td>
<td>N/A</td>
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<tr>
<td>Prescriber Restrictions</td>
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<td>Coverage Duration</td>
<td>Request will be authorized until the end of the contract year.</td>
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**TRIKAFTA**

**Products Affected**
- TRIKAFTA

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<thead>
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<th>PA Criteria</th>
<th>Criteria Details</th>
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<tbody>
<tr>
<td>Exclusion Criteria</td>
<td>Combination use with Kalydeco, Orkambi, or Symdeko.</td>
</tr>
<tr>
<td>Required Medical Information</td>
<td>Documentation of CFTR gene that is responsive to elexacaftor-tezacaftor-ivacaftor treatment.</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td>N/A</td>
</tr>
<tr>
<td>Prescriber Restrictions</td>
<td>Prescriber must be a pulmonologist or an expert in the treatment of cystic fibrosis.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Request will be authorized until the end of the contract year.</td>
</tr>
<tr>
<td>Other Criteria</td>
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<td>Indications</td>
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<td>Off-Label Uses</td>
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## TYMLOS

### Products Affected
- TYMLOS

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<th>PA Criteria</th>
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<td>Exclusion Criteria</td>
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<tr>
<td>Required Medical Information</td>
<td>Documentation showing patient falls into one of the following categories: Postmenopausal woman who has a bone mineral density (BMD) value consistent with osteoporosis (i.e., T-scores equal to or less than -2.5) or postmenopausal woman who has had an osteoporotic fracture. Postmenopausal woman who has T-scores from -1.5 to -2.5 and at least one of the following risk factors for fracture: thinness [low body mass index (less than 21 kg/m2)], history of fragility fracture since menopause, or history of hip fracture in a parent.</td>
</tr>
<tr>
<td>Age Restrictions</td>
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</tr>
<tr>
<td>Prescriber Restrictions</td>
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</tr>
<tr>
<td>Coverage Duration</td>
<td>Request will be authorized until the end of the contract year.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td>The following criteria is also applicable: 1) trial of, contraindication to, or medical reason for not using an oral bisphosphonate and Prolia, and 2) therapy does not exceed 2 years.</td>
</tr>
<tr>
<td>Indications</td>
<td>All Medically-accepted Indications.</td>
</tr>
<tr>
<td>Off-Label Uses</td>
<td>N/A</td>
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</table>
TYVASO

Products Affected
- tyvaso dpi maintenance kit
- tyvaso dpi titration kit

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</tr>
<tr>
<td>Age Restrictions</td>
<td>N/A</td>
</tr>
<tr>
<td>Prescriber Restrictions</td>
<td>Prescriber must be a pulmonologist or cardiologist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Request will be authorized until the end of the contract year.</td>
</tr>
<tr>
<td>Indications</td>
<td>All Medically-accepted Indications.</td>
</tr>
<tr>
<td>Off-Label Uses</td>
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# UBRELVY

## Products Affected
- UBRELVY

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<tbody>
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<tr>
<td>Required Medical Information</td>
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</tr>
<tr>
<td>Age Restrictions</td>
<td>N/A</td>
</tr>
<tr>
<td>Prescriber Restrictions</td>
<td>Prescribed by or in consultation with a neurologist, headache specialist or pain specialist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>New starts will be approved for 6 months. Cont of therapy or reauth until end of contract year.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td>For new starts: trial of, contraindication to, or medical reason for not using 2 triptans. For continuation of therapy or reauthorization requests: documentation of improvement in pain and symptom(s) (e.g., photophobia, nausea, phonophobia).</td>
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<tr>
<td>Indications</td>
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<td>Off-Label Uses</td>
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## UPTRAVI

### Products Affected
- **UPTRAVI ORAL**

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<td><strong>Exclusion Criteria</strong></td>
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<tr>
<td><strong>Required Medical Information</strong></td>
<td>Documentation of pulmonary arterial hypertension (PAH) WHO Group I and PAH Functional Class. Trial of, contraindication to, or medical reason for not using a formulary phosphodiesterase inhibitor in combination with a formulary endothelin receptor antagonist.</td>
</tr>
<tr>
<td><strong>Age Restrictions</strong></td>
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<tr>
<td><strong>Prescriber Restrictions</strong></td>
<td>Prescriber must be a pulmonologist or cardiologist.</td>
</tr>
<tr>
<td><strong>Coverage Duration</strong></td>
<td>Request will be authorized until the end of the contract year.</td>
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<tr>
<td><strong>Other Criteria</strong></td>
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<td><strong>Indications</strong></td>
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## VALCHLOR

### Products Affected
- VALCHLOR

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<td>Age Restrictions</td>
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<td>Prescriber Restrictions</td>
<td>Prescribed by or in consultation with an oncologist or dermatologist.</td>
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<td>Coverage Duration</td>
<td>Request will be authorized until the end of the contract year.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td>Trial of, contraindication to, or medical reason for not being able to use one of the following: a topical corticosteroids or a topical retinoids.</td>
</tr>
<tr>
<td>Indications</td>
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<td>Off-Label Uses</td>
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## VASCEPA

### Products Affected
- icosapent ethyl
- VASCEPA ORAL CAPSULE 0.5 GM

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<td>Prescriber Restrictions</td>
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<td>Coverage Duration</td>
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</tr>
<tr>
<td>Other Criteria</td>
<td>For a diagnosis of hypertriglyceridemia: Documented trial of, contraindication to, or medical reason for not using statins at maximum tolerated dose OR documented statin intolerance AND omega-3-acid ethyl esters capsule. For a diagnosis of cardiovascular risk reduction, ALL the following are required: 1) Documentation of hypertriglyceridemia greater than or equal to 150 mg/dL: 2) Documented trial of, contraindication to, or medical reason for not using statins at maximum tolerated dose for 3 months OR documented statin intolerance AND 3) Documentation of one of the following: Established atherosclerotic cardiovascular disease (e.g., coronary artery disease, cerebrovascular accident, carotid disease, peripheral artery disease) OR age greater than or equal to 50 years old with established diabetes and at least one additional risk factor for cardiovascular disease (e.g., hypertension, renal dysfunction, retinopathy, albuminuria, males age greater than or equal to 55 years old or females age greater than or equal to 65 years old).</td>
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<td>Indications</td>
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**VENTAVIS**

**Products Affected**
- VENTAVIS

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<td>Required Medical Information</td>
<td>Documentation of pulmonary arterial hypertension (PAH) WHO Group I classification and PAH Functional Class.</td>
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<td>Age Restrictions</td>
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<tr>
<td>Prescriber Restrictions</td>
<td>Prescriber must be a pulmonologist or cardiologist.</td>
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<td>Coverage Duration</td>
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# VIGABATRIN

## Products Affected
- vigabatrin

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<tr>
<td>Required Medical Information</td>
<td>For infantile spasms or West syndrome, the request will be approved. Patient must have a diagnosis of refractory complex partial seizures who is currently receiving another antiepileptic drug and the patient has experienced treatment failure from two generic alternative formulary antiepileptic agents.</td>
</tr>
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<td>Age Restrictions</td>
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<td>Prescriber Restrictions</td>
<td>Prescriber must be a neurologist.</td>
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<tr>
<td>Coverage Duration</td>
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### VIJOICE

**Products Affected**
- VIJOICE

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</tr>
<tr>
<td>Required Medical Information</td>
<td>For new starts, all of the following must be included: 1) Documentation of genetic testing confirming diagnosis AND 2) Member has at least one target lesion identified on imaging AND 3) Prescriber attests the patient's condition is severe or life-threatening and necessitates systemic treatment. For continuation of therapy or reauthorization, attestation of a positive clinical response (i.e. reduction in the sum of measurable target lesion volume, absence of progression of non-target lesions, absence of any new lesions, etc.).</td>
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<tr>
<td>Age Restrictions</td>
<td>N/A</td>
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<tr>
<td>Prescriber Restrictions</td>
<td>Prescribed by or in consultation with a geneticist, dermatologist, vascular surgeon, hematologist/oncologist, or other specialist in the treatment of PIK3CA-Related Overgrowth Spectrum (PROS).</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>New starts will be authorized for 6 months. Cont of therapy or reauth until end of contract year.</td>
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<td>Other Criteria</td>
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<td>Indications</td>
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<tr>
<td>Off-Label Uses</td>
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## VMAT-2 INHIBITORS

### Products Affected
- AUSTEDO
- INGREZZA ORAL CAPSULE 40 MG, 80 MG
- ingrezza oral capsule 60 mg
- INGREZZA ORAL CAPSULE THERAPY PACK
- tetrabenazine

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<td>Exclusion Criteria</td>
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<tr>
<td>Required Medical Information</td>
<td>If the request is for tetrabenazine, request will be approved. For Ingrezza, trial of or medical reason for not using the tetrabenazine for tardive dyskinesia. For Austedo, trial of or medical reason for not using the following if applicable for submitted diagnosis 1) Chorea associated with Huntington disease- trial of tetrabenazine. 2) Tardive dyskinesia -trial of tetrabenazine and Ingrezza. Reauthorization: Confirmation of improvement in tardive dyskinesia symptoms or chorea associated with Huntington disease symptoms.</td>
</tr>
<tr>
<td>Age Restrictions</td>
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<tr>
<td>Prescriber Restrictions</td>
<td>Prescriber must be a neurologist, clinical geneticist, or psychiatrist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Request will be authorized until the end of the contract year.</td>
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<tr>
<td>Other Criteria</td>
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## VORICONAZOLE

### Products Affected
- voriconazole intravenous

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<td>Coverage Duration</td>
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**VOSEVI**

### Products Affected
- VOSEVI

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<tbody>
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</tr>
<tr>
<td>Required Medical Information</td>
<td>Labs within 3 months of request: liver function tests and detectable HCV RNA viral load. In addition, documentation of genotype, treatment history, and if cirrhotic, documentation of compensated or decompensated cirrhosis. Prescriber attests to completing HBV screening and agrees to monitor for HBV reactivation if patient has a history of HBV infection.</td>
</tr>
<tr>
<td>Age Restrictions</td>
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</tr>
<tr>
<td>Prescriber Restrictions</td>
<td>Prescriber must be a hepatologist, gastroenterologist, infectious disease specialist, or transplant specialist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Request will be authorized for 12 weeks as per AASLD-IDSA guidance.</td>
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<td>Other Criteria</td>
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<td>Indications</td>
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<tr>
<td>Off-Label Uses</td>
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</tbody>
</table>
# WHITE BLOOD CELL STIMULATORS

## Products Affected
- FULPHILA
- GRANIX
- LEUKINE INJECTION SOLUTION RECONSTITUTED
- NEULASTA ONPRO
- NEULASTA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE
- NEUPOGEN INJECTION SOLUTION 300 MCG/ML, 480 MCG/1.6ML
- NEUPOGEN INJECTION SOLUTION PREFILLED SYRINGE
- NIVESTYM INJECTION SOLUTION PREFILLED SYRINGE
- NYVEPRIA
- UDENYCA
- ZARXIO
- ZIEXTENZO

## PA Criteria

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<tbody>
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<td>Exclusion Criteria</td>
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</tr>
<tr>
<td>Required Medical Information</td>
<td>For new starts for Neupogen and Granix: documentation of trial of, contraindication to, or medical reason for not using Zarfio and Nivestym. For new starts for Neulasta, Fulphila, and Nyvepria: documentation of trial of, contraindication to, or medical reason for not using Udenyca and Ziextenzo. Continuation of therapy or re-authorization criteria: diagnosis of chronic neutropenia or a medical reason for continued need for GCSF.</td>
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<tr>
<td>Age Restrictions</td>
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<tr>
<td>Prescriber Restrictions</td>
<td>Specialist for submitted diagnosis.</td>
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<tr>
<td>Coverage Duration</td>
<td>For new starts: 4 months. Cont of therapy or reauth until end of contract year.</td>
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<td>Indications</td>
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# XATMEP

## Products Affected
- XATMEP

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<tr>
<td>Prescriber Restrictions</td>
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<tr>
<td>Coverage Duration</td>
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**XELJANZ**

**Products Affected**
- XELJANZ
- XELJANZ XR

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<td>Prescriber Restrictions</td>
<td>Specialist for submitted diagnosis.</td>
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<tr>
<td>Coverage Duration</td>
<td>Request will be authorized until the end of the contract year.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td>For RA: Trial of, medical reason for not using, or contraindication to 1 disease modifying antirheumatic drug (DMARD) (methotrexate, leflunomide, or sulfasalazine) and 1 tumor necrosis factor (TNF) blocker (Enbrel or Humira). For pJIA: Trial of, medical reason for not using, or contraindication to 1 of the following DMARDs: methotrexate or leflunomide and 1 TNF blocker (Enbrel or Humira). For PsA: Trial of, medical reason for not using, or contraindication to 1 TNF blocker (Enbrel or Humira). For UC: Trial of, medical reason for not using, or contraindication to 1 of the following conventional therapies: mercaptopurine, an aminosalicylate (i.e. mesalamine, sulfasalazine, azathioprine), or a corticosteroid (i.e. prednisone, methylprednisolone) and 1 TNF blocker (Enbrel or Humira). For ankylosing spondylitis: Trial of, medical reason for not using, or contraindication to naproxen and 1 TNF blocker (Enbrel or Humira).</td>
</tr>
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<td>Indications</td>
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# XERMELO

## Products Affected
- XERMELO

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## XGEVA

### Products Affected
- XGEVA

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<tr>
<td>Other Criteria</td>
<td>New starts: Serum calcium levels. Reauthorization criteria for malignant hypercalcemia: albumin-adjusted serum calcium level below 12.5mg/dl within 30 days of request.</td>
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<td>Indications</td>
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## XIFAXAN

### Products Affected
- XIFAXAN

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<tr>
<td>Required Medical Information</td>
<td>For diagnosis of hepatic encephalopathy (HE): trial of, contraindication to, or medical reason for not using lactulose. For diagnosis of irritable bowel syndrome with diarrhea (IBSD): 1) trial of, contraindication to, or medical reason for not using loperamide and dicyclomine AND 2) no more than 3 courses of 14 days each. For travelers diarrhea (TD) caused by noninvasive strains of E. Coli (with no bloody stools or fever): patient must be intolerant to or must have had a trial of at least 3 days of one of the following agents: ciprofloxacin, ofloxacin, levofloxacin or azithromycin.</td>
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<tr>
<td>Age Restrictions</td>
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<tr>
<td>Prescriber Restrictions</td>
<td>For HE: gastroenterologist or hepatologist. For IBS-D: gastroenterologist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>For HE: contract year. For IBSD: 14 days (cannot exceed 3 courses of 14 days each). For TD: 3 days.</td>
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<td>Other Criteria</td>
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**XOLAIR**

**Products Affected**
- XOLAIR

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<td>Age Restrictions</td>
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<tr>
<td>Prescriber Restrictions</td>
<td>Prescriber must be a pulmonologist, allergist, immunologist, dermatologist, or otolaryngologist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>New Starts: 6 months. Cont of therapy or reauth until end of contract year.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td>New starts for moderate to severe persistent allergic asthma: 1) Evidence of specific allergic sensitivity confirmed by positive skin test (i.e. prick/puncture test) or blood test (i.e. radioallergosorbent test) for a specific IgE or in vitro reactivity to a perennial aeroallergen, AND 2) Pretreatment serum IgE levels greater than 30 IU/mL, AND 3) Symptoms are not adequately controlled with high-dose inhaled corticosteroid (ICS) plus long-acting beta2-agonist (LABA) for at least 3 months, or there is a medical reason for not using these drugs. Continuation of therapy or reauthorization criteria for moderate to severe persistent allergic asthma: 1) Reduction in asthma exacerbation resulting in systemic steroid use and/or hospitalization, OR 2) Reduction of rescue inhaler use, OR 3) Documentation of improvement in pulmonary function tests since baseline (prior to initiation of Xolair). New starts for chronic idiopathic urticaria: 1) inadequate symptomatic relief despite trial of two weeks of two different oral antihistamine therapies (unless contraindicated), AND 2) disease must be severe</td>
</tr>
<tr>
<td>PA Criteria</td>
<td>Criteria Details</td>
</tr>
<tr>
<td>-------------</td>
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</tr>
<tr>
<td></td>
<td>enough to warrant short term systemic corticosteroid therapy for management of urticaria. Continuation of therapy or reauthorization criteria for chronic idiopathic urticaria: 1) improvement from baseline of symptoms associated with urticaria within 6 months of Xolair use. New starts for c: 1) currently using an intranasal corticosteroid, will be prescribed an intranasal corticosteroid with request, or has a medical reason for not using an intranasal corticosteroid. Continuation of therapy or reauthorization criteria for nasal polyps: 1) Documentation has been provided that demonstrates a clinical benefit (e.g. improvements in symptom severity, nasal polyp score [NPS], sino-nasal outcome test-22 [SNOT-22], nasal congestion score [NCS]) AND 2) continued use of intranasal corticosteroid, or has a medical reason for not using one.</td>
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<table>
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<tr>
<th>Indications</th>
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<tbody>
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## XTAMPZA ER

### Products Affected
- XTAMPZA ER

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## XURIDEN

### Products Affected
- XURIDEN

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<td>Prescriber must be an endocrinologist, metabolic specialist, clinical geneticist or hematologist.</td>
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# XYREM

## Products Affected
- XYREM

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<td>For somnolence associated with narcolepsy: trial of, contraindication to, or medical reason for not using an approved formulary CNS stimulant (e.g. methylphenidate, modafinil, armodafinil, etc.). For cataplexy associated with narcolepsy, approve.</td>
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### Indications
All Medically-accepted Indications.

### Off-Label Uses
N/A
## Products Affected

- XYWAV

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<td>For treatment of somnolence associated with narcolepsy, patient must have documentation of either trial of or a medical reason for being unable to use an approved formulary CNS stimulant (e.g. methylphenidate, modafinil, armodafinil, etc.). For the treatment of cataplexy associated with narcolepsy or idiopathic hypersomnia, approve.</td>
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- ZTALMY

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# ZYPREXA RELPREVV

## Products Affected
- **ZYPREXA RELPREVV RECONSTITUTED 210 MG, 300 MG, 405 MG**

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<td>The member has taken oral olanzapine without significant side effects. Trial of, contraindication to, or medical reason for not using Invega Sustenna, Invega Trinza or Risperdal Consta.</td>
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PART B VERSUS PART D

Products Affected

- ABELCET INTRAVENOUS SUSPENSION 5 MG/ML
- acetylcysteine inhalation solution 10 %, 20 %
- acyclovir sodium intravenous solution 50 mg/ml
- albuterol sulfate inhalation nebulization solution (2.5 mg/3ml) 0.083%, (5 mg/ml) 0.5%, 0.63 mg/3ml, 1.25 mg/3ml, 2.5 mg/0.5ml
- AMBISOME INTRAVENOUS SUSPENSION RECONSTITUTED 50 MG
- AMINOSYN II INTRAVENOUS SOLUTION 15 %
- AMINOSYN-PF 7% INTRAVENOUS SOLUTION 7 %
- AMINOSYN-PF INTRAVENOUS SOLUTION 7 %
- amphotericin b intravenous solution reconstituted 50 mg
- amphotericin b liposome intravenous suspension reconstituted 50 mg
- aprepitant oral 80 & 125 mg
- aprepitant oral capsule 125 mg, 40 mg, 80 & 125 mg, 80 mg
- ASTAGRAF XL ORAL CAPSULE EXTENDED RELEASE 24 HOUR 0.5 MG, 1 MG, 5 MG
- azathioprine oral tablet 50 mg
- budesonide inhalation suspension 0.25 mg/2ml, 0.5 mg/2ml, 1 mg/2ml
- CLINIMIX/DEXTROSE (4.25/10) INTRAVENOUS SOLUTION 4.25 %
- CLINISOL SF INTRAVENOUS SOLUTION 15 %
- cromolyn sodium inhalation nebulization solution 20 mg/2ml
- cyclophosphamide oral capsule 25 mg, 50 mg
- cyclophosphamide oral tablet 25 mg, 50 mg
- cyclosporine modified oral capsule 100 mg, 25 mg, 50 mg
- cyclosporine modified oral solution 100 mg/ml
- cyclosporine oral capsule 100 mg, 25 mg
- diphtheria-tetanus toxoids dt intramuscular suspension 25-5 lfu/0.5ml
- dronabinol oral capsule 10 mg, 2.5 mg, 5 mg
- EMEND ORAL SUSPENSION RECONSTITUTED 125 MG/5ML
- ENGERIX-B INJECTION SUSPENSION 10 MCG/0.5ML, 20 MCG/ML
- ENGERIX-B INJECTION SUSPENSION PREFILLED SYRINGE 10 MCG/0.5ML, 20 MCG/ML
- ENVARSUS XR ORAL TABLET EXTENDED RELEASE 24 HOUR 0.75 MG, 1 MG, 4 MG
- everolimus oral tablet 0.25 mg, 0.5 mg, 0.75 mg, 1 mg
- FLEBOGAMMA DIF INTRAVENOUS SOLUTION 5 GM/50ML
- GAMMAGARD INJECTION SOLUTION 1 GM/10ML, 10 GM/100ML, 2.5 GM/25ML, 20 GM/200ML, 30 GM/300ML, 5 GM/50ML
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<td>GAMMAKED INJECTION</td>
<td>SOLUTION 1 GM/10ML</td>
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<tr>
<td>GAMMAPLEX INTRAVENOUS SOLUTION</td>
<td>10 GM/100ML, 10 GM/200ML, 20 GM/200ML, 5 GM/50ML</td>
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<td>GAMMUNEX-C INJECTION</td>
<td>SOLUTION 1 GM/10ML</td>
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<tr>
<td>GENGRAF ORAL CAPSULE</td>
<td>100 MG, 25 MG</td>
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<td>GENGRAF ORAL SOLUTION</td>
<td>100 MG/ML</td>
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<td>granisetron hcl oral tablet</td>
<td>1 mg</td>
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<td>HEPLISAV-B INTRAMUSCULAR SOLUTION</td>
<td>PREFILLED SYRINGE 20 MCG/0.5ML</td>
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<td>IMOVAX RABIES INTRAMUSCULAR INJECTABLE</td>
<td>2.5 UNIT/ML</td>
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<td>ipratropium-albuterol inhalation</td>
<td>solution 0.5-2.5 (3) mg/3ml</td>
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<td>levalbuterol hcl inhalation</td>
<td>nebulization solution 0.31 mg/3ml, 0.63 mg/3ml, 1.25 mg/3ml</td>
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<td>mycophenolate mofetil oral capsule</td>
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<td>NUTRILIPID INTRAVENOUS EMULSION</td>
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- sirolimus oral tablet 0.5 mg, 1 mg, 2 mg
- tacrolimus oral capsule 0.5 mg, 1 mg, 5 mg
- TDVAX INTRAMUSCULAR SUSPENSION 2-2 LF/0.5ML
- tetanus-diphtheria toxoids td intramuscular suspension 2-2 Lf/0.5ml
- tobramycin inhalation nebulization solution 300 mg/5ml

**Details**

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

### Products Affected

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- APTIOM TABLET 400 MG ORAL
- APTIOM TABLET 600 MG ORAL
- APTIOM TABLET 800 MG ORAL
- SPRITAM TABLET DISINTEGRATING SOLUBLE 1000 MG ORAL
- SPRITAM TABLET DISINTEGRATING SOLUBLE 250 MG ORAL
- SPRITAM TABLET DISINTEGRATING SOLUBLE 500 MG ORAL
- SPRITAM TABLET DISINTEGRATING SOLUBLE 750 MG ORAL
- XCOPRI (250 MG DAILY DOSE) TABLET THERAPY PACK 100 & 150 MG ORAL
- XCOPRI (250 MG DAILY DOSE) TABLET THERAPY PACK 50 & 200 MG ORAL
- XCOPRI (350 MG DAILY DOSE) TABLET THERAPY PACK 150 & 200 MG ORAL
- XCOPRI TABLET 100 MG ORAL
- XCOPRI TABLET 150 MG ORAL
- XCOPRI TABLET 200 MG ORAL
- XCOPRI TABLET 50 MG ORAL
- XCOPRI TABLET THERAPY PACK 14 X 12.5 MG & 14 X 25 MG ORAL
- XCOPRI TABLET THERAPY PACK 14 X 150 MG & 14 X 200 MG ORAL
- XCOPRI TABLET THERAPY PACK 14 X 50 MG & 14 X 100 MG ORAL

### Details

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## antidepressant step therapy

### Products Affected

- FETZIMA CAPSULE EXTENDED RELEASE 24 HOUR 120 MG ORAL
- FETZIMA CAPSULE EXTENDED RELEASE 24 HOUR 20 MG ORAL
- FETZIMA CAPSULE EXTENDED RELEASE 24 HOUR 40 MG ORAL

- FETZIMA CAPSULE EXTENDED RELEASE 24 HOUR 80 MG ORAL
- FETZIMA TITRATION CAPSULE ER 24 HOUR THERAPY PACK 20 & 40 MG ORAL

### Details

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brinzolamide step therapy

Products Affected
- brinzolamide suspension 1% ophthalmic

Details

| Criteria | Step 1: First line therapy should be a documented trial of formulary dorzolamide or dorzolamide/timolol. Step 2: Once dorzolamide or dorzolamide/timolol has been tried, the patient can receive therapy with brinzolamide. |
# combivent step therapy

## Products Affected

- COMBIVENT RESPIMAT AEROSOL SOLUTION 20-100 MCG/ACT INHALATION

## Details

| Criteria | Step 1: First line therapy should be a documented trial of Anoro Ellipta, Bevespi Aerosphere, or Stiolto Respimat. Step 2: Once Anoro Ellipta, Bevespi Aerosphere, or Stiolto Respimat has been tried, patients can receive therapy with Combivent Respimat. |
drizalma step therapy

Products Affected
- DRIZALMA SPRINKLE CAPSULE DELAYED RELEASE SPRINKLE 20 MG ORAL
- DRIZALMA SPRINKLE CAPSULE DELAYED RELEASE SPRINKLE 30 MG ORAL
- DRIZALMA SPRINKLE CAPSULE DELAYED RELEASE SPRINKLE 40 MG ORAL
- DRIZALMA SPRINKLE CAPSULE DELAYED RELEASE SPRINKLE 60 MG ORAL

Details

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# ongentys step therapy

## Products Affected
- ONGENTYS CAPSULE 25 MG ORAL
- ONGENTYS CAPSULE 50 MG ORAL

## Details

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**rhopressa step therapy**

**Products Affected**
- RHOPRESSA SOLUTION 0.02 % OPHTHALMIC

**Details**

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rivastigmine patch step therapy

**Products Affected**
- rivastigmine patch 24 hour 13.3 mg/24hr transdermal
- rivastigmine patch 24 hour 4.6 mg/24hr transdermal
- rivastigmine patch 24 hour 9.5 mg/24hr transdermal

**Details**

| Criteria | Step 1: First line therapy should be a documented trial of rivastigmine capsule. Step 2: Once rivastigmine capsule has been tried, patients can receive therapy with rivastigmine patches. |
## topical immunomodulators step therapy

### Products Affected
- pimecrolimus cream 1% external
- tacrolimus ointment 0.03% external
- tacrolimus ointment 0.1% external

### Details

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urinary incontinence agents step therapy

**Products Affected**
- darifenacin hydrobromide er tablet extended release 24 hour 15 mg oral
- darifenacin hydrobromide er tablet extended release 24 hour 7.5 mg oral
- fesoterodine fumarate er tablet extended release 24 hour 4 mg oral
- fesoterodine fumarate er tablet extended release 24 hour 8 mg oral
- tolterodine tartrate er capsule extended release 24 hour 2 mg oral
- tolterodine tartrate er capsule extended release 24 hour 4 mg oral
- trospium chloride er capsule extended release 24 hour 60 mg oral

**Details**

| Criteria | Step 1: First line therapy should be a documented trial of oxybutynin, oxybutynin ER, trospium, tolterodine, or solifenacin. Step 2: Second line therapy should be tolterodine ER, trospium ER, darifenacin ER, or fesoterodine ER. |
zafirlukast step therapy

Products Affected
- zafirlukast tablet 10 mg oral
- zafirlukast tablet 20 mg oral

Details

| Criteria | Step 1: First line therapy should be a documented trial of montelukast. Step 2: Once montelukast has been tried, patients may receive therapy with zafirlukast. |
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This formulary was updated on 11/30/2022. For more recent information or other questions, please contact Troy Medicare Member Service at 1-888-494-TROY (8769) (TTY users should call 711), five days a week from April 1 to September 30 or seven days a week from October 1 to March 31 from 8:00 AM to 8:00 PM EST or visit troymedicare.com.