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OGIVRI (trastuzumab-dkst) 1350/20.000278 *PA applies to new starts only*	**Covered indications:** All FDA-approved indications not otherwise excluded from Part D. **Exclusions:** None **Approvals:** 12 months.
ONTRUZANT (trastuzumab-dttb) 1350/20.000278 *PA applies to new starts only*	**Covered indications:** All FDA-approved indications not otherwise excluded from Part D. **Exclusions:** None **Approvals:** 12 months.
ONUREG (azacitidine) 1350/20.000278 *PA applies to new starts only*	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals:** 12 months.
OPSUMIT (macitentan) 1350/20.000278 *PA applies to new starts only*	**Covered indications:** All FDA-approved indications not otherwise excluded from Part D. **Exclusions:** None **Approvals:** 12 months.
ORGOVYX (relugolix) 1350/20.000278 *PA applies to new starts only*	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals:** 12 months.
ORKAMBI (lumacaftor/ivacaftor) 1350/20.000278	**Covered indications:** All FDA-approved indications not otherwise excluded from Part D. **Exclusions:** None **Approvals:** 12 months.
OXERVATE (cenegermin) 1350/20.000369	**Covered indications:** Neurotrophic Keratitis **Age Restrictions:** Ages 2 and older **Prescriber Restrictions:** Ophthalmologist **Approvals:** 8 weeks.
PEGASYS (peginterferon alfa 2a) 1350/20.000278	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals:** 12 months.
PEMAZYRE (pemigatinib) 1350/20.000278 *PA applies to new starts only*	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals:** 12 months.
PHENYLBUTYRATE 1350/20.000278	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals:** 12 months.

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PHESGO (hyaluronidase-zzxf, pertuzumab, trastuzumab) 1350/20.000278 *PA applies to new starts only*	**Covered indications:** All FDA-approved indications not otherwise excluded from Part D. **Exclusions:** None **Approvals:** 12 months.
PIQRAY (alpelisib) 1350/20.000278 *PA applies to new starts only*	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals:** 12 months.
POMALYST (pomalidomide) 1350/20.000278 *PA applies to new starts only*	**Covered Indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions**: None **Approvals**: 12 months.
PRALUENT (alirocumab) 1350/20.000326	**Covered indications:** All FDA-approved indications not otherwise excluded from Part D. **Exclusions:** None. **Approvals:** 12 months.
PROLIA (denosumab) 1350/20.000235	**Covered indications:** All FDA-approved indications not otherwise excluded from Part D. **Criteria:** For osteoporosis treatment, patients must be at high risk for osteoporotic fracture defined as a previous history of osteoporosis related fracture or a T score of less than or equal to 2.5 or a T-score between -1 and -2.5 with a 10 year hip fracture probability greater than 3% or 10-year major osteoporosis-related fracture probability greater than 20% based on FRAX score and must show failure of six months or more of therapy with a bisphosphonate defined as an osteoporotic fracture while on therapy or a significant reduction in BMD while on therapy, or the patient has a contraindication to bisphosphonates. Contraindications to bisphosphonates include renal insufficiency with a eGFR or estimated creatinine clearance of less than 35 ml per minute or a contraindication to oral bisphosphonate because of an inablility to remain upright for the required 30 to 60 minutes following an oral dose, or esophageal abnormalities that delay esophageal emptying, Barrett's esophagus, or espohageal ulceration. For use to increase bone mass in women at high risk for fracture who are receiving adjuvant aromatase inhibitor therapy for breast cancer, must demonstrate having a baseline BMD T score of -1 to -2.5 at the lumbar spine, total hip, or femoral neck. For use to increase bone mass in men at high risk for fracture who are receiving androgen deprivation therapy for nonmetastatic prostate cancer, must demonstrate having a BMD T score at the lumbar spine, total hip, or femoral neck between -1 and -4 or having a history of an osteoporotic fracture. Must be 18 years or older. Should be administered by a healthcare professional. Dosing is a subcutaneous injections of 60 mg every 6 months. **Age Restrictions:** Approved for those 18 years of age or older. **Exclusions:** None. **Approvals:** 12 months.

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PROMACTA (eltrombopag olamine) 1350/20.000278	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None. **Approvals:** 12 months.
PULMONARY ARTERIAL HYPERTENSION 1350/20.000123 • *sildenafil tabs, suspension* *PA applies to new starts only*	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Prescriber Restrictions:** Cardiologist or pulmonologist **Exclusions:** Concurrent use with a nitrate or nitrous oxide donor, or concur rent use of PDE inhibitor with a soluble guanylate cyclase stimulator. **Approvals:** 12 months.
QINLOCK (ripretinib) 1350/20.000278 *PA applies to new starts only*	**Covered indications**: All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals**: 12 months.
Quinine sulfate 1350/20.000278	**Covered indications**: All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals**: 12 months.
REMICADE (infliximab) 1350/20.000278	**Covered indications**: All FDA-approved indications not otherwise excluded from Part D. **Exclusions:** None **Approvals**: 12 months.
RENFLEXIS (infliximab-ABDA) 1350/20.000278	**Covered indications**: All FDA-approved indications not otherwise excluded from Part D. **Exclusions:** None **Approvals**: 12 months.
REPATHA (evolocumab) 1350/20.000340	**Covered indications**: All FDA-approved indications not otherwise excluded from Part D. **Exclusions:** None. **Approvals**: 12 months.

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RETACRIT (epoetin alfa-EPBX) **1350/20.000365**	**Covered Indications:** For patients with CKD and NOT on dialysis, consider initiating EPO treatment only when the Hgb level is less than 10g/dl and the following considerations apply: If the Hgb level exceeds 10g/dl, reduce or interrupt the dose of EPO. For patients with CKD and on dialysis initiate the treatment of EPO when the Hgb level is less than 10g/dl. If the Hgb level approaches or exceeds 11 g/dl, reduce or interrupt the dose of EPO. For patients on cancer chemotherapy initiate EPO only if the Hgb is less than 10g/dl and if there is a minimum of 2 additional months of planned chemotherapy. If there is no response as measured by Hgb levels or if RBC transfusions are still required after 8 weeks of therapy and following the completion of chemotherapy, EPO should be discontinued. For HIV patients treated with zidovudine, withhold EPO if Hgb levels exceed 12 g/dl. For patients undergoing elective surgery, Hgb should be greater than 10 but less than 13 g/dl. **Exclusions:** All indications: excluded if patient has uncontrolled hypertension. In patients with cancer receiving hormonal agents, biologic products, or radiotherapy unless also receiving concomitant myelosuppressive chemotherapy. In patients with cancer receiving myelosuppressive chemotherapy when the anticipated outcome is cure. In patients with cancer receiving myelosuppressive chemotherapy in whom the anemia can be managed by transfusion. In patients scheduled for surgery who are willing to donate autologus blood. In patients undergoing cardiac or vascular surgery. As a substitute for RBC transfusions in patients who require immediate correction of anemia. **Approvals:** Initial therapy and/or dose changes- 12 weeks. Stable on therapy, CRF- 24 weeks. Anemia of cancer- 12 weeks.
RETEVMO (selpercatinib) **1350/20.000278** *PA applies to new starts only*	**Covered indications**: All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals**: 12 months.
REVLIMID (lenalidomide) **1350/20.000278** *PA applies to new starts only*	**Covered Indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals:** 12 months.
REZUROCK (belumosudil) **1350/20.000278** *PA applies to new starts only*	**Covered Indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals:** 12 months.
RIABNI (rituximab-arrx) **1350/20.000278** *PA applies to new starts only*	**Covered Indications:** All FDA-approved indications not otherwise excluded from Part D. **Exclusions:** None **Approvals:** 12 months.

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RINVOQ (upadacitinib) 1350/20.000278	**Covered Indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals:** 12 months.
RITUXAN (rituximab) 1350/20.000278 *PA applies to new starts only*	**Covered indications:** All FDA-approved indications not otherwise excluded from Part D **Exclusions:** None **Approvals:** 12 months.
RITUXAN HYCELA (rituximab/ hyaluronidase) 1350/20.000278 *PA applies to new starts only*	**Covered indications:** All FDA-approved indications not otherwise excluded from Part D **Exclusions:** None **Approvals:** 12 months.
ROZLYTREK (entrectinib) 1350/20.000278 *PA applies to new starts only*	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals:** 12 months.
RUBRACA (rucaparib) tablets 1350/20.000278 *PA applies to new starts only*	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals:** 12 months.
RUXIENCE (rituximab-pvvr) injection 1350/20.000278 *PA applies to new starts only*	**Covered indications:** All FDA-approved indications not otherwise excluded from Part D. **Exclusions:** None **Approvals:** 12 months.
RYDAPT (midostaurin) capsules 1350/20.000278 *PA applies to new starts only*	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals:** 12 months.
SAJAZIR (icatibant) 1350/20.000278	**Covered indications**: All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals**: 12 months.

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SIGNIFOR (pasireotide) 1350/20.000278	**Covered indications**: All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals**: 12 months.
SIRTURO (bedaquiline) 1350/20.000278	**Covered indications**: All FDA-approved indications not otherwise excluded from Part D. **Exclusions:** None **Approvals**: 12 months.
SKYRIZI (risankizumab rzaa) 1350/20.000278	**Covered indications**: All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals**: 12 months.
SPRYCEL (dasatinib) 1350/20.000184 *PA applies to new starts only*	**Covered indications**: All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Age Restrictions:** Approved for those 18 years of age or older for Ph+CML-CP, PH+ ALL resistant or intolerant to prior therapy, chronic, accelerated or myeloid or lymphoid blast phase PH+CML with resistance or intolerance to prior therapy including imatinib, Approved for those 1 year of age or older in pediatric patients with Ph+ CML in chronic phase and for pediatric patients with newly diagnosed Ph+ ALL in combination with chemotherapy **Approvals**: 12 months.
STEP THERAPY POLICY 1350/20.000268	The step therapy program includes the following criteria: The drugs subject to step therapy and the prerequisite therapy necessary for coverage of these drugs will be determined by the CDPHP pharmacy and therapeutics committee. If it is medically necessary for an enrollee to use a step therapy drug as initial therapy without trying the prerequisite therapy, the prescribing practitioner can request coverage for this drug using the standard medical exception process. The list of drugs that require step therapy is available online at www.cdphp.com under the Rx Corner section of the Provider tab or through the pharmacy department at CDPHP.

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STELARA (ustekinumab) **1350/20.000366**	**Covered indications**: All Medically-Accepted Indications (FDA approved and compendia-supported). **Criteria**: For moderate to severe plaque psoriasis (new starts only) at least 5% of body surface area (BSA) is affected OR crucial body areas (feet, hands, face, neck, groin, intertriginous areas) are affected at the time of diagnosis, AND the patient had an inadequate response, intolerance, or contraindication to at least two of the following: Enbrel, Humira or Skyrizi. For active psoriatic arthritis (PsA) (new starts only) the patient had an inadequate response, intolerance, or contraindication to at least two of the following: Enbrel, Humira, Xeljanz/Xeljanz XR. For moderately to severely active Crohn's disease (new starts only) patient had an inadequate response, intolerance, or contraindication to Humira. For ulcerative colitis (new starts only) patient had an inadequate response, intolerance or contraindication to Humira AND Xeljanz/Xeljanz XR. **Age Restrictions**: Plaque Psoriasis—6 years of age and older. Psoriatic Arthritis or Crohn's—18 years of age and older. **Prescriber Restrictions**: Gastroenterologist, Rheumatologist or Dermatologist. **Approvals**: 12 months.
STIVARGA (regorafenib) **1350/20.000278** *PA applies to new starts only*	**Covered indications**: All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions**: None **Approvals**: 12 months.
SUTENT (sunitinib malate) **1350/20.000278** *PA applies to new starts only*	**Covered indications**: All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions**: None **Approvals**: 12 months.
SYMDEKO (tezacaftor-ivacaftor) **1350/20.000278**	**Covered indications**: All FDA-approved indications not otherwise excluded from Part D. **Exclusions:** None **Approvals**: 12 months.
SYMPAZAN (clobazam) **1350/20.000278** *PA applies to new starts only*	**Covered indications**: All FDA-approved indications not otherwise excluded from Part D. **Exclusions:** None **Approvals**: 12 months.
SYNRIBO (omacetaxine) **1350/20.000278** *PA applies to new starts only*	**Covered indications**: All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals**: 12 months.

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TABRECTA (capmatinib) 1350/20.000278 *PA applies to new starts only*	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals:** 12 months.
TAFINLAR (dabrafenib) 1350/20.000278 *PA applies to new starts only*	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals:** 12 months.
TAGRISSO (osimertinib) 1350/20.000278 *PA applies to new starts only*	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals:** 12 months.
TALTZ (ixekizumab) 1350/20.000374	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). For moderate to severe plaque psoriasis at least 5% of body surface area (BSA) is affected OR crucial body areas (feet, hands, face, neck, groin, intertriginous areas) are affected at the time of diagnosis, AND the patient had an inadequate response, intolerance, or contra-indication to one of the following: Enbrel, Humira or Skyrizi. For active psoriatic arthritis (PsA) the patient had an inadequate response, intolerance, or contraindication to one of the following: Enbrel, Humira , Xeljanz/Xeljanz XR. For ankylosing spondylitis the patient had an inadequate response, intolerance, or contraindication to one of the following: Enbrel or Humira. Active non-radiographic axial spondyloarthritis (nr-axSpA) is covered with no prior treatment required. **Prescriber Restrictions:** Rheumatologist, Dermatologist **Exclusions:** None **Approvals:** 12 months.
TALZENNA (talazoparib) 1350/20.000278 *PA applies to new starts only*	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals:** 12 months.
TASIGNA (nilotinib) 1350/20.000181 *PA applies to new starts only*	**Covered Indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Age Restrictions:** Newly diagnosed Ph+CML in CP: Approved for adults and pediatric patients greater or equal to 1 year of age. Accelerated Phase (AP) Ph+CML resistant/intolerant: Approved for those 18 years of age or older. Ph+CML-CP resistant/intolerant to prior TKI therapy: Approved for adults and pediatric patients greater or equal to 1 year of age. **Approvals:** 12 months.

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TAZVERIK (tazemetustat) 1350/20.000278 *PA applies to new starts only*	**Covered Indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals:** 12 months.
TECENTRIQ (atezolizumab) 1350/20.000278 *PA applies to new starts only*	**Covered indications:** All FDA-approved indications not otherwise excluded from Part D **Exclusions:** None **Approvals:** 12 months.
TEPMETKO (tepotinib) 1350/20.000278 *PA applies to new starts only*	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals:** 12 months.
TETRABENAZINE 1350/20.000278	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals:** 12 months.
THALOMID (thalidomide) 1350/20.000278 *PA applies to new starts only*	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals:** 12 months.
TIBSOVO (ivosidenib) 1350/20.000278 *PA applies to new starts only*	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals:** 12 months.
TRAZIMERA (trastuzumab-qyyp) 1350/20.000278 *PA applies to new starts only*	**Covered indications:** All FDA-approved indications not otherwise excluded from Part D **Exclusions:** None **Approvals:** 12 months.
TRIKAFTA (elexacaftor/tezacaftor/ ivacaftor) 1350/20.000278	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals:** 12 months.
TRUSELTIQ (infigratinib) 1350/20.000278 *PA applies to new starts only*	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals:** 12 months.

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TRUXIMA (rituximab-abbs) 1350/20.000278 *PA applies to new starts only*	**Covered indications:** All FDA-approved indications not otherwise excluded from Part D **Exclusions:** None **Approvals:** 12 months.
TUKYSA (tucatinib) 1350/20.000278 *PA applies to new starts only*	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals:** 12 months.
TURALIO (pexidartinib) 1350/20.000278 *PA applies to new starts only*	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals:** 12 months.
TYKERB (lapatinib) 1350/20.000278 *PA applies to new starts only*	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals:** 12 months.
TYSABRI (natalizumab) 1350/20.000278 *PA applies to new starts only*	**Covered indications:** All FDA-approved indications not otherwise excluded from Part D **Exclusions:** None **Approvals:** 12 months.
UBRELVY (ubrogepant) 1350/20.000346	**Covered indications:** All FDA-approved indications not otherwise excluded from Part D **Criteria:** The requested drug will be covered when the following criteria are met: 1) The requested drug is being prescribed for the acute treatment of migraine in an adult patient AND the patient has a history of 2 to 8 migraines per month with moderate to severe headache pain in the previous 3 months AND the patient has had failure with at least two different formulary triptan agents at maximally indicated dose unless contraindicated. **Exclusions:** None **Prescriber Restrictions:** None **Approvals:** Initial approval 3 months, continuation 12 months.
UKONIQ (umbralisib) 1350/20.000278 *PA applies to new starts only*	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals:** 12 months.
VALCHLOR (mechlorethamine) 1350/20.000278 *PA applies to new starts only*	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals:** 12 months.

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VELCADE (bortezomib) 1350/20.000278 *PA applies to new starts only*	**Covered indications:** All FDA-approved indications not otherwise excluded from Part D **Exclusions:** None **Approvals:** 12 months.
VELTASSA (patiromer sorbitex) 1350/20.000392	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Required Medical Info:** Patient must have tried and failed Lokelma **Exclusions:** None **Approvals:** 12 months.
VENCLEXTA (venetoclax) 1350/20.000278 *PA applies to new starts only*	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals:** 12 months.
VENTAVIS (iloprost) 1350/20.000278 *PA applies to new starts only*	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals:** 12 months.
VERZENIO (abemaciclib) 1350/20.000278 *PA applies to new starts only*	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals:** 12 months.
vigabatrin 1350/20.000278 *PA applies to new starts only*	**Covered indications:** All FDA-approved indications not otherwise excluded from Part D **Exclusions:** None **Approvals:** 12 months.
VITRAKVI (larotrectinib) 1350/20.000278 *PA applies to new starts only*	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals:** 12 months.
VIZIMPRO (dacomitinib) 1350/20.000278 *PA applies to new starts only*	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals:** 12 months.

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VOSEVI (sofosbuvir/velpatasvir/ voxilaprevir) 1350/20.000315	**Covered indications:** All FDA-approved indications not otherwise excluded from Part D. **Prescriber Restrictions:** Gastroenterologist, Hepatologist, HIV or infectious disease specialist **Exclusions:** None **Approvals:** Approval duration will be applied consistent with AASLD/IDSA guidance. **Other Criteria:** Omeprazole 20mg can be administered with Vosevi. Use with other proton-pump inhibitors has not been studied.
VOTRIENT (pazopanib) 1350/20.000278 *PA applies to new starts only*	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals:** 12 months.
Welireg (belzutifan) 1350/20.000278 *PA applies to new starts only*	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals:** 12 months.
XALKORI (crizotinib) 1350/20.000278 *PA applies to new starts only*	**Covered indications**: All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions**: None **Approvals:** 12 months.
XELJANZ (tofacitinib) 1350/20.000278	**Covered indications**: All FDA-approved indications not otherwise excluded from Part D. **Exclusions**: None **Approvals:** 12 months.
XGEVA (denosumab) 1350/20.000278	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals:** 12 months.

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XOLAIR (omalizumab) 1350/20.000125	**Covered Indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Criteria:** Asthma: Documented evidence of reversible airway disease, IgE level greater or equal to 30 and less than or equal to 700 IU/ ml for ages greater than or equal to 12 years old, for patients 6 to 12 years old IgE level greater or equal to 30 and less than or equal to 1300 IU/ ml evidence of specific allergic sensitivity by a positive skin or blood test for specific IgE. Chronic idiopathic urticaria-CIU-documented evidence of daily or almost daily wheals and itching for at least 6 weeks with no obvious cause. Asthma: Inadequately controlled on medium-dose inhaled corticosteroid in combination with a long acting inhaled beta agonist (LABA) or leukotriene receptor agonist, theophylline or Zileuton unless intolerant or contraindicated. CIU-must have documented trial and failure or inadequate control for at least 3 months of therapy of H1 with or without H2 antihistamines unless intolerant or contraindicated. Dose is administered once every 28 days. Asthma and CIU- Patient must be instructed regarding the signs and symptoms of anaphylaxis. If the medication is being obtained at a retail pharmacy it may be covered under Part D if the following conditions are satisfied: A physician is administering the medication and he/she agree to accept brown bagging of the medication and understands that the member will obtain the medication from a pharmacy and have it in their possession until it is delivered to the physician office or clinic for administration (ie pharmacy ships drug to member). If the medication is shipped from the specialty pharmacy directly to the office/clinic it will be covered as a Part B benefit. **Exclusions:** None. **Age Restrictions:** Asthma: Approved for those 6 years of age or older. CIU: Approved for those 12 years of age or older. **Approvals:** 12 months.
XOSPATA (gilteritinib) 1350/20.000278 *PA applies to new starts only*	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions**: None **Approvals**: 12 months.
XPOVIO (selinexor) 1350/20.000278 *PA applies to new starts only*	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions**: None **Approvals**: 12 months.
XTANDI (enzalutamide) 1350/20.000278 *PA applies to new starts only*	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals:** 12 months.

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XYREM (sodium oxybate) 1350/20.000278	**Covered indications:** All FDA-approved indications not otherwise excluded from Part D **Exclusions:** None **Approvals:** 12 months.
ZEJULA (niraparib) 1350/20.000278 *PA applies to new starts only*	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals:** 12 months.
ZELBORAF (vemurafenib) 1350/20.000278 *PA applies to new starts only*	**Covered indications**: All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions**: None **Approvals**: 12 months.
ZIRABEV (bevacizumab-bvzr) injection 1350/20.000278 *PA applies to new starts only*	**Covered indications**: All FDA-approved indications not otherwise excluded from Part D **Exclusions**: None **Approvals**: 12 months.
ZOLINZA (vorinostat) 1350/20.000278 *PA applies to new starts only*	**Covered indications**: All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions**: None **Approvals**: 12 months.
ZYDELIG (idelalsib) 1350/20.000278 *PA applies to new starts only*	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals:** 12 months.
ZYKADIA (ceritinib) capsules/tabs 1350/20.000278 *PA applies to new starts only*	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals:** 12 months.
ZYPREXA RELPREVV (olanzapine) 1350/20.000278 *PA applies to new starts only*	**Covered indications:** All FDA-approved indications not otherwise excluded from Part D **Exclusions:** None **Approvals:** 12 months.