

Prior Authorization Drug List

Drug Class	Drugs Requiring Prior Authorization	
5-ALPHA-REDUCTASE INHIBITORS	ENTADFI	
5-HT3 RECEPTOR ANTAGONISTS	SANCUSO	
ADAMANTANES (CNS)	GOCOVRI	OSMOLEX ER
ADRENALS	ALKINDI SPRINKLE	<i>budesonide</i>
	EMFLAZA	ORTIKOS
	TARPEYO	UCERIS
ADRENOCORTICAL INSUFFICIENCY	ACTHAR	CORTROPHIN
ALLERGENIC EXTRACTS (THERAPEUTIC)	GRASTEK	ODACTRA
	ORALAIR	PALFORZIA
	RAGWITEK	
ALPHA- AND BETA-ADRENERGIC AGONISTS	AUVI-Q	<i>droxidopa</i>
	EPIPEN	EPIPEN 2-PAK
	EPIPEN JR	EPIPEN JR 2-PAK

CAPITAL LETTERS = BRAND MEDICATIONS
lower case = generic medications

This list is subject to change and does not define coverage.
Only your plan can determine coverage of your benefit.

Drug Class	Drugs Requiring Prior Authorization	
ALPHA-ADRENERGIC AGONISTS		
AMINOGLYCOSIDE ANTIBIOTICS		
ARIKAYCE	BETHKIS	
KITABIS PAK	TOBI	
TOBI PODHALER	<i>tobramycin</i>	
<i>tobramycin in 0.225 % sodium chloride</i>	<i>tobramycin/nebulizer</i>	
AMINOMETHYLCYCLINES		
NUZYRA	SEYSARA	
AMMONIA DETOXICANTS		
RAVICTI	RELYVRIO	
AMPHETAMINE DERIVATIVES		
ADIPEX-P	<i>diethylpropion hcl</i>	
LOMAIRA	<i>phendimetrazine tartrate</i>	
<i>phentermine hcl</i>		
AMPHETAMINES		
<i>benzphetamine hcl</i>		
AMYLINOMIMETICS		
SYMLINPEN 120	SYMLINPEN 60	
ANALGESICS AND ANTIPYRETICS, MISC.		
LYRICA CR	<i>pregabalin</i>	
ANDROGENS		
ANDRODERM	ANDROGEL	
FORTESTA	JATENZO	
KYZATREX	METHITEST	
NATESTO	OXANDRIN	
<i>oxandrolone</i>	TESTIM	
<i>testosterone</i>	TLANDO	
VOGELXO	XYOSTED	

CAPITAL LETTERS = BRAND MEDICATIONS
lower case = generic medications

This list is subject to change and does not define coverage.
Only your plan can determine coverage of your benefit.

Drug Class	Drugs Requiring Prior Authorization
------------	-------------------------------------

ANOREXIGENIC AGENTS, MISCELLANEOUS

QSYMIA

ANTHELMINTICS

albendazole

ALBENZA

BILTRICIDE

EMVERM

ivermectin

praziquantel

STROMEKTOL

ANTI-INFLAMMATORY AGENTS (GI DRUGS)

ASACOL HD

DELZICOL

DIPENTUM

LIALDA

LOTRONEX

mesalamine

ANTIBACTERIALS (SKIN, MUCOUS MEMBRANE)

ACANYA

ALTABAX

BENZACLIN

BENZAMYCIN

CENTANY

CLINDAGEL

clindamycin phosphate

EVOCLIN

METROGEL

NORITATE

VELTIN

XEPI

ZIANA

ZILXI

ANTICONVULSANTS, MISCELLANEOUS

BANZEL

BRIVIACT

DIACOMIT

EPIDIOLEX

EPRONTIA

FELBATOL

FINTEPLA

HORIZANT

rufinamide

SABRIL

vigabatrin

VIGADRONE

XCOPRI

ZONISADE

CAPITAL LETTERS = BRAND MEDICATIONS

lower case = generic medications

This list is subject to change and does not define coverage.
Only your plan can determine coverage of your benefit.

ANTIDEPRESSANTS, MISCELLANEOUS**Drug Class****Drugs Requiring Prior Authorization**

ANTIDEPRESSANTS, MISCELLANEOUS -- Continued

AUVELITY

SPRAVATO

ANTIDIABETIC AGENTS, MISCELLANEOUS

KORLYM

ANTIDIARRHEA AGENTS

XERMELO

ANTIEMETICS, MISCELLANEOUS

MARINOL

SYNDROS

ANTIFIBROTIC AGENTS

ESBRIET

OFEV

pirfenidone

ANTIFUNGALS, MISCELLANEOUS

BREXAFEMME

ANTIGONADTROPINS

CETROTIDE

FYREMADEL

ganirelix acetate

MYFEMBREE

ORGOVYX

ORIAHNN

ORLISSA

ANTIGOUT AGENTS

GLOPERBA

ANTIHISTAMINES (GI DRUGS)

BONJESTA

DICLEGIS

*doxylamine succinate/pyridoxine hcl
(vitamin b6)*

ANTILIPEMIC AGENTS, MISCELLANEOUS*icosapent ethyl*

JUXTAPID

LOVAZA

NEXLETOL

NEXLIZET

VASCEPA

CAPITAL LETTERS = BRAND MEDICATIONS
lower case = generic medications

This list is subject to change and does not define coverage.
Only your plan can determine coverage of your benefit.

Drug Class

Drugs Requiring Prior Authorization

ANTILIPEMIC AGENTS, MISCELLANEOUS -- Continued

ANTIMALARIALS

ARAKODA	<i>atovaquone/proguanil hcl</i>
MALARONE	QUALAQUIN
<i>quinine sulfate</i>	

ANTIMUSCARINICS/ANTISPASMODICS

BEVESPI AEROSPHERE	DUAKLIR PRESSAIR
INCRUSE ELLIPTA	LONHALA MAGNAIR REFILL
LONHALA MAGNAIR STARTER	QBREXZA
TUDORZA PRESSAIR	YUPELRI

ANTINEOPLASTIC AGENTS

<i>abiraterone acetate</i>	AFINITOR
AFINITOR DISPERZ	AKEEGA
ALECENSA	ALUNBRIG
AVASTIN	AYVAKIT
BALVERSA	BESREMI
<i>bexarotene</i>	BOSULIF
BRAFTOVI	BRUKINSA
CABOMETYX	CALQUENCE
<i>capecitabine</i>	CAPRELSA
CARAC	COMETRIQ
COPIKTRA	COTELLIC
<i>cyclophosphamide</i>	DAURISMO
<i>diclofenac sodium</i>	ERIVEDGE
ERLEADA	<i>erlotinib hcl</i>
<i>everolimus</i>	EXKIVITY
FARYDAK	FEMARA
FOTIVDA	GAVRETO
<i>gefitinib</i>	GILOTRIF
GLEEVEC	HERCEPTIN

CAPITAL LETTERS = BRAND MEDICATIONS
 lower case = generic medications

This list is subject to change and does not define coverage.
 Only your plan can determine coverage of your benefit.

Drug Class

Drugs Requiring Prior Authorization

ANTINEOPLASTIC AGENTS -- Continued

HYCAMTIN	IBRANCE
ICLUSIG	IDHIFA
<i>imatinib mesylate</i>	IMBRUVICA
INLYTA	INQOVI
INREBIC	IRESSA
JAKAFI	JAYPIRCA
KANJINTI	KISQALI
KISQALI FEMARA CO-PACK	KOSELUGO
KRAZATI	<i>lapatinib ditosylate</i>
<i>lenalidomide</i>	LENVIMA
LONSURF	LORBRENA
LUMAKRAS	LYNPARZA
LYTGOBI	MEKINIST
MEKTOVI	MVASI
NERLYNX	NEXAVAR
NINLARO	NUBEQA
ODOMZO	OGIVRI
ONUREG	ORSERDU
OTREXUP	PEMAZYRE
PIQRAY	POMALYST
PURIXAN	QINLOCK
RASUVO	RETEVMO
REVLIMID	REZLIDHIA
RITUXAN	RITUXAN HYCELA
ROZLYTREK	RUBRACA
RUXIENCE	RYDAPT
SCEMBLIX	<i>sorafenib tosylate</i>
SPRYCEL	STIVARGA
<i>sunitinib malate</i>	SUTENT
SYNRIBO	TABRECTA

CAPITAL LETTERS = BRAND MEDICATIONS
 lower case = generic medications

This list is subject to change and does not define coverage.
 Only your plan can determine coverage of your benefit.

Drug Class**Drugs Requiring Prior Authorization****ANTINEOPLASTIC AGENTS -- Continued**

TAFINLAR	TAGRISSO
TALZENNA	TARCEVA
TARGRETIN	TASIGNA
TAZVERIK	TEMODAR
<i>temozolomide</i>	TEPMETKO
TIBSOVO	TRAZIMERA
TRUSELTIQ	TUKYSA
TURALIO	TYKERB
UKONIQ	VALCHLOR
VANFLYTA	VENCLEXTA
VENCLEXTA STARTING PACK	VERZENIO
VITRAKVI	VIZIMPRO
VONJO	VOTRIENT
WELIREG	XALKORI
XATMEP	XELODA
XOSPATA	XPOVIO
XTANDI	YONSA
ZEJULA	ZELBORAF
ZIRABEV	ZOLINZA
ZTALMY	ZYDELIG
ZYKADIA	ZYTIGA

ANTIPARATHYROID AGENTS

<i>cinacalcet hcl</i>	SENSIPAR
-----------------------	----------

ANTIPROTOZOALS, MISCELLANEOUS

ALINIA	<i>atovaquone</i>
IMPAVIDO	LAMPIT
MEPRON	<i>nitazoxanide</i>

CAPITAL LETTERS = BRAND MEDICATIONS
lower case = generic medications

This list is subject to change and does not define coverage.
Only your plan can determine coverage of your benefit.

Drug Class	Drugs Requiring Prior Authorization
------------	-------------------------------------

ANTIPRURITICS AND LOCAL ANESTHETICS

PRUDOXIN

ZONALON

ANTIRETROVIRALS

SUNLENCA

ANTISENSE OLIGONUCLEOTIDES

TEGSEDI

ANTITOXINS AND IMMUNE GLOBULINS

ASCENIV

BIVIGAM

CUTAQUIG

CUVITRU

FLEBOGAMMA DIF

GAMMAGARD LIQUID

GAMMAGARD S-D

GAMMAKED

GAMMAPLEX

GAMUNEX-C

HIZENTRA

HYQVIA

HYQVIA IG COMPONENT

OCTAGAM

PANZYGA

PRIVIGEN

XEMBIFY

ANTITUBERCULOSIS AGENTS

pretomanid

SIRTURO

ANTIVIRALS (SKIN AND MUCOUS MEMBRANE)

acyclovir

DENAVIR

penciclovir

XERESE

ZOVIRAX

ANTIVIRALS, MISCELLANEOUS

LIVTENCITY

PREVYMIS

ANXIOLYTICS, SEDATIVES, AND HYPNOTICS, MISC

HETLIOZ

HETLIOZ LQ

tasimelteon

ATYPICAL ANTIPSYCHOTICS

ABILIFY ASIMTUFI

ABILIFY MAINTENA

CAPITAL LETTERS = BRAND MEDICATIONS
 lower case = generic medications

This list is subject to change and does not define coverage.
 Only your plan can determine coverage of your benefit.

Drug Class	Drugs Requiring Prior Authorization	
------------	-------------------------------------	--

ATYPICAL ANTIPSYCHOTICS -- Continued

ABILIFY MYCITE	ARISTADA
ARISTADA INITIO	CAPLYTA
INVEGA HAFYERA	INVEGA SUSTENNA
INVEGA TRINZA	LYBALVI
NUPLAZID	PERSERIS
RISPERDAL CONSTA	UZEDY
ZYPREXA RELPREVV	

AUTONOMIC DRUGS, MISCELLANEOUS

TYRVAYA

AZOLE ANTIFUNGALS

CRESEMBA	SPORANOX
TOLSURA	VIVJOA

AZOLES (SKIN AND MUCOUS MEMBRANE)

JUBLIA	<i>luliconazole</i>
LUZU	

BENZODIAZEPINES (ANTICONVULSANTS)

<i>clobazam</i>	ONFI
SYMPAZAN	

BIGUANIDES

RIOMET	RIOMET ER
--------	-----------

BLOOD DERIVATIVES

RYPLAZIM

BLOOD FORM., COAG, THROMBOSIS AGENTS MISC.

OXBRYTA	PYRUKYND
TAVALISSE	

BONE RESORPTION INHIBITORS

PROLIA	XGEVA
--------	-------

CAPITAL LETTERS = BRAND MEDICATIONS
lower case = generic medications

This list is subject to change and does not define coverage.
Only your plan can determine coverage of your benefit.

Drug Class	Drugs Requiring Prior Authorization
------------	-------------------------------------

BRADYKININ RECEPTOR ANTAGONISTS

<i>icatibant acetate</i>	SAJAZIR
--------------------------	---------

CALCITONIN GENE-RELATED PEPTIDE ANTAG.

AIMOVIG AUTOINJECTOR	AJOVY AUTOINJECTOR
AJOVY SYRINGE	EMGALITY PEN
EMGALITY SYRINGE	NURTEC ODT
QULIPTA	UBRELVY
ZAVZPRET	

CALORIC AGENTS

DOJOLVI

CARBONIC ANHYDRASE INHIBITORS (MISC.)

<i>dichlorphenamide</i>	KEVEYIS
-------------------------	---------

CARDIAC DRUGS, MISCELLANEOUS

CAMZYOS	CORLANOR
---------	----------

CATHARTICS AND LAXATIVES

AMITIZA	<i>lubiprostone</i>
---------	---------------------

CELL STIMULANTS AND PROLIFERANTS

ALTRENO	ATRALIN
RETIN-A	RETIN-A MICRO
RETIN-A MICRO PUMP	<i>tretinoin microspheres</i>

CENTRAL NERVOUS SYSTEM AGENTS, MISC.

ADDYI	DAYBUE
EXSERVAN	LUMRYZ
NOURIANZ	NUEDEXTA
RADICAVA ORS	<i>sodium oxybate</i>
TIGLUTIK	VEOZAH
VYLEESI	XYREM

CAPITAL LETTERS = BRAND MEDICATIONS
lower case = generic medications

This list is subject to change and does not define coverage.
Only your plan can determine coverage of your benefit.

Drug Class	Drugs Requiring Prior Authorization	
CLASS III ANTIARRHYTHMICS		
COMPLEMENT INHIBITORS		
	BERINERT	CINRYZE
	HAEGARDA	RUCONEST
	SOLIRIS	
CORTICOSTEROIDS (EENT)		
	EYSUVIS	XHANCE
CORTICOSTEROIDS (SKIN, MUCOUS MEMBRANE)		
	BRYHALI	<i>halcinonide</i>
	<i>halobetasol propionate</i>	HALOG
	LEXETTE	TOPICORT
CYCLOOXYGENASE-2 (COX-2) INHIBITORS		
	ELYXYB	
CYSTIC FIBROSIS (CFTR) CORRECTORS		
	SYMDEKO	TRIKAFTA
CYSTIC FIBROSIS (CFTR) POTENTIATORS		
	KALYDECO	ORKAMBI
DEVICES		
	DUROLANE	EUFLEXXA
	<i>flash glucose sensor/blood glucose test strips/pen needles</i>	GEL-ONE
	GENVISC 850	HYALGAN
	HYMOVIS	MONOVISC
	ORTHOVISC	SUPARTZ FX
	SYNOJOYNT	SYNVISC
	SYNVISC-ONE	TRIVISC

CAPITAL LETTERS = BRAND MEDICATIONS
lower case = generic medications

This list is subject to change and does not define coverage.
Only your plan can determine coverage of your benefit.

DIGESTANTS

Drug Class	Drugs Requiring Prior Authorization
------------	-------------------------------------

DIGESTANTS -- Continued

PANCREAZE
VIOKACE

PERTZYE

DIHYDROPYRIDINES

CONSENSI

DIPEPTIDYL PEPTIDASE-4(DPP-4) INHIBITORS

alogliptin benzoate

alogliptin benzoate/metformin hcl

alogliptin benzoate/pioglitazone hcl

KAZANO

KOMBIGLYZE XR

NESINA

ONGLYZA

OSENI

saxagliptin hcl

saxagliptin hcl/metformin hcl

DIRECT FACTOR XA INHIBITORS

SAVAYSA

DISEASE-MODIFYING ANTIRHEUMATIC AGENTS

ACTEMRA

ACTEMRA ACTPEN

adalimumab-adaz

adalimumab-fkjp

AMJEVITA(CF)

AMJEVITA(CF) 40MG/0.8ML AUTOIN
(NDC starts with 72511)

AMJEVITA(CF) AUTOINJECTOR

AVSOLA

CIBINQO

CIMZIA

COSENTYX (2 SYRINGES)

COSENTYX SENSOREADY (2 PENS)

COSENTYX SENSOREADY PEN

COSENTYX SYRINGE

COSENTYX UNOREADY PEN

CYLTEZO(CF)

CYLTEZO(CF) PEN

CYLTEZO(CF) PEN CROHN'S-UC-HS

CYLTEZO(CF) PEN PSORIASIS-UV

ENBREL

ENBREL MINI

ENBREL SURECLICK

HADLIMA

HADLIMA PUSHTOUCH

HADLIMA(CF)

HADLIMA(CF) PUSHTOUCH

HULIO(CF)

HULIO(CF) PEN

CAPITAL LETTERS = BRAND MEDICATIONS
lower case = generic medications

This list is subject to change and does not define coverage.
Only your plan can determine coverage of your benefit.

Drug Class

Drugs Requiring Prior Authorization

DISEASE-MODIFYING ANTIRHEUMATIC AGENTS -- Continued

HUMIRA	HUMIRA PEN
HUMIRA PEN CROHN'S-UC-HS	HUMIRA PEN PSOR-UVEITS-ADOL HS
HUMIRA(CF)	HUMIRA(CF) PEDIATRIC CROHN'S
HUMIRA(CF) PEN	HUMIRA(CF) PEN CROHN'S-UC-HS
HUMIRA(CF) PEN PEDIATRIC UC	HUMIRA(CF) PEN PSOR-UV-ADOL HS
HYRIMOZ(CF)	HYRIMOZ(CF) PEDIATRIC CROHN'S
HYRIMOZ(CF) PEN	HYRIMOZ(CF) PEN CROHN-UC START
HYRIMOZ(CF) PEN PSORIASIS	IDACIO(CF)
IDACIO(CF) PEN	IDACIO(CF) PEN CROHN'S-UC
IDACIO(CF) PEN PSORIASIS	INFLECTRA
<i>infliximab</i>	KEVZARA
KINERET	OLUMIANT
ORENCIA	ORENCIA CLICKJECT
OTEZLA	RINVOQ
SIMPONI	SIMPONI ARIA
XELJANZ	XELJANZ XR
YUFLYMA(CF)	YUFLYMA(CF) AUTOINJECTOR
YUSIMRY(CF) PEN	

DOPAMINE PRECURSORS

DUOPA	INBRIJA
-------	---------

EENT ANTI-INFECTIVES, MISCELLANEOUS

XDEMVY

EENT ANTI-INFLAMMATORY AGENTS, MISC.

CEQUA	RESTASIS
RESTASIS MULTIDOSE	VERKAZIA
XIIDRA	

EENT DRUGS, MISCELLANEOUS

CYSTADROPS	CYSTARAN
MIEBO	OXERVATE

CAPITAL LETTERS = BRAND MEDICATIONS
lower case = generic medications

This list is subject to change and does not define coverage.
Only your plan can determine coverage of your benefit.

Drug Class	Drugs Requiring Prior Authorization	
------------	-------------------------------------	--

EENT NONSTEROIDAL ANTI-INFLAM. AGENTS

ILEVRO	NEVANAC
--------	---------

ENZYMES

CEREZYME	ELELYSO
HYQVIA HY COMPONENT	PALYNZIQ
STRENSIQ	SUCRAID
VPRIV	XIAFLEX

ERGOT-DERIV. DOPAMINE RECEPTOR AGONISTS

CYCLOSET	
----------	--

FIBRIC ACID DERIVATIVES

ANTARA	LIPOFEN
--------	---------

GABA-DERIVATIVE SKELETAL MUSCLE RELAXANT

<i>baclofen</i>	FLEOSUVY
LYVISPAH	OZOBAX

GI DRUGS, MISCELLANEOUS

BYLVAY	CHOLBAM
ENDARI	ENTYVIO
GATTEX	HUMIRA(CF) PEDIATRIC CROHN'S
IBSRELA	LIVMARLI
MOVANTIK	OALIVA
RELISTOR	SYMPROIC
TRULANCE	VIBERZI

GONADOTROPINS

ELIGARD	FOLLISTIM AQ
GONAL-F	GONAL-F RFF
GONAL-F RFF REDI-JECT	<i>leuprolide acetate</i>
LUPRON DEPOT	LUPRON DEPOT (LUPANETA)
LUPRON DEPOT-PED	MENOPUR
NOVAREL	OVIDREL
PREGNYL	SYNAREL

CAPITAL LETTERS = BRAND MEDICATIONS
lower case = generic medications

This list is subject to change and does not define coverage.
Only your plan can determine coverage of your benefit.

Drug Class	Drugs Requiring Prior Authorization
------------	-------------------------------------

GONADOTROPINS -- Continued

HCV POLYMERASE INHIBITOR ANTIVIRALS

EPCLUSA	HARVONI
<i>ledipasvir/sofosbuvir</i>	<i>sofosbuvir/velpatasvir</i>
SOVALDI	VOSEVI

HCV PROTEASE INHIBITOR ANTIVIRALS

MAVYRET

HCV REPLICATION COMPLEX INHIBITORS

VIEKIRA PAK	ZEPATIER
-------------	----------

HEAVY METAL ANTAGONISTS

CUPRIMINE	CUVRIOR
D-PENAMINE	<i>deferasirox</i>
<i>deferiprone</i>	DEPEN
EXJADE	FERRIPROX
FERRIPROX (2 TIMES A DAY)	FERRIPROX (3 TIMES A DAY)
JADENU	JADENU SPRINKLE
<i>penicillamine</i>	<i>trientine hcl</i>

HEMATOPOIETIC AGENTS

ARANESP	DOPTELET
EPOGEN	FULPHILA
FYLNETRA	GRANIX
LEUKINE	MIRCERA
MOZOBIL	MULPLETA
NEULASTA	NEULASTA ONPRO
NEUPOGEN	NIVESTYM
NYVEPRIA	<i>plerixafor</i>
PROCRIT	PROMACTA
RELEUKO	RETACRIT
ROLVEDON	STIMUFEND
UDENYCA	UDENYCA AUTOINJECTOR

CAPITAL LETTERS = BRAND MEDICATIONS
lower case = generic medications

This list is subject to change and does not define coverage.
Only your plan can determine coverage of your benefit.

Drug Class**Drugs Requiring Prior Authorization****HEMATOPOIETIC AGENTS -- Continued**

ZIENTENZO

HEMOSTATICS

ADVATE	ADYNOVATE
AFSTYLA	ALPHANATE
ALPROLIX	ALTUVIIIIO
BENEFIX	COAGADEX
ELOCTATE	ESPEROCT
FEIBA NF	HEMLIBRA
HEMOFIL M	HUMATE-P
IDELVION	IXINITY
JIVI	KOATE
KOGENATE FS	KOVALTRY
MONONINE	NOVOEIGHT
NOVOSEVEN RT	NUWIQ
OBIZUR	PROFILNINE
REBINYN	RECOMBINATE
RIXUBIS	SEVENFACT
TRETTEN	VONVENDI
WILATE	XYNTHA
XYNTHA SOLOFUSE	

HIV INTEGRASE INHIBITOR ANTIRETROVIRALS

VOCABRIA

HYPOTENSIVE AGENTS, MISCELLANEOUS

VECAMYL

IMMUNOMODULATORY AGENTS

ACTIMMUNE	AUBAGIO
AVONEX	AVONEX PEN
BAFIERTAM	BETASERON
COPAXONE	<i>dimethyl fumarate</i>

CAPITAL LETTERS = BRAND MEDICATIONS
lower case = generic medications

This list is subject to change and does not define coverage.
Only your plan can determine coverage of your benefit.

Drug Class**Drugs Requiring Prior Authorization****IMMUNOMODULATORY AGENTS -- Continued**

EXTAVIA	<i>fingolimod hcl</i>
GILENYA	<i>glatiramer acetate</i>
GLATOPA	JOENJA
KESIMPTA PEN	MAYZENT
PLEGRIDY	PLEGRIDY PEN
PONVORY	REBIF
REBIF REBIDOSE	REDITREX
TASCENSO ODT	<i>teriflunomide</i>
THALOMID	TYSABRI
VUMERITY	ZEPOSIA

IMMUNOSUPPRESSIVE AGENTS

ASTAGRAF XL	BENLYSTA
ENVARUSUS XR	<i>everolimus</i>
LUPKYNIS	MAVENCLAD
ZORTRESS	

INCRETIN MIMETICS

ADLYXIN	BYDUREON BCISE
BYETTA	MOUNJARO
OZEMPIC	RYBELSUS
SAXENDA	TRULICITY
VICTOZA 2-PAK	VICTOZA 3-PAK
WEGOVY	

INTERFERON ANTIVIRALS

INTRON A	PEGASYS
----------	---------

INTERLEUKIN ANTAGONISTS

DUPIXENT SYRINGE	FASENRA
FASENRA PEN	NUCALA
SKYRIZI	SKYRIZI ON-BODY

CAPITAL LETTERS = BRAND MEDICATIONS
lower case = generic medications

This list is subject to change and does not define coverage.
Only your plan can determine coverage of your benefit.

Drug Class	Drugs Requiring Prior Authorization
------------	-------------------------------------

IRON PREPARATIONS

KALLIKREIN INHIBITORS

KALBITOR	ORLADEYO
TAKHZYRO	

KALLIKREIN-KININ SYSTEM INHIBITORS

EMPAVELI	TAVNEOS
----------	---------

LEPTINS

MYALEPT

LONG-ACTING INSULINS

BASAGLAR KWIKPEN U-100	BASAGLAR TEMPO PEN U-100
<i>insulin degludec</i>	<i>insulin glargine, human recombinant analog</i>
<i>insulin glargine-yfgn</i>	REZVOGLAR KWIKPEN
SEMGLEE	SEMGLEE (YFGN)
SEMGLEE (YFGN) PEN	SEMGLEE PEN
XULTOPHY 100-3.6	

LOOP DIURETICS

FUROSCIX

MELANOCORTIN RECEPTOR ANTAGONISTS

IMCIVREE

MINERALOCORTICOID (ALDOSTERONE) ANTAGNTS

CAROSPIR	KERENDIA
----------	----------

MIOTICS

VUITY

MONOAMINE OXIDASE B INHIBITORS

XADAGO

MONOBACTAM ANTIBIOTICS

CAPITAL LETTERS = BRAND MEDICATIONS
lower case = generic medications

This list is subject to change and does not define coverage.
Only your plan can determine coverage of your benefit.

CAYSTON

Drug Class	Drugs Requiring Prior Authorization
------------	-------------------------------------

MONOCLONAL ANTIBODY ANTIVIRALS

MUCOLYTIC AGENTS

PULMOZYME

NEUROKININ-1 RECEPTOR ANTAGONISTS

AKYNZEO

VARUBI

NITRATES AND NITRITES

GONITRO

NON-SEL.ALPHA-ADRENERGIC BLOCKING AGENTS

dihydroergotamine mesylate

MIGRANAL

TRUDHESA NASAL SPRAY (NDC:
77530072501)

TRUDHESA NASAL SPRAY (NDC:
77530072504)

NONERGOT-DERIV.DOPAMINE RECEPTOR AGONIST

APOKYN

apomorphine hcl

KYNMOBI

NEUPRO

NUCLEOSIDE AND NUCLEOTIDE ANTIVIRALS

BARACLUE

HEPSERA

ribavirin

SITAVIG

VEMLIDY

OPIATE AGONISTS

ACTIQ

CONZIP

fentanyl

fentanyl citrate

FENTORA

hydrocodone bitartrate

hydromorphone hcl

HYSINGLA ER

LAZANDA

methadone hcl

METHADONE INTENSOL

METHADOSE

morphine sulfate

MS CONTIN

NUCYNTA ER

oxymorphone hcl

SEGLENTIS

SUBSYS

tramadol hcl

XTAMPZA ER

CAPITAL LETTERS = BRAND MEDICATIONS
lower case = generic medications

This list is subject to change and does not define coverage.
Only your plan can determine coverage of your benefit.

Drug Class	Drugs Requiring Prior Authorization
------------	-------------------------------------

OPIATE AGONISTS -- Continued

OPIATE ANTAGONISTS

VIVITROL

OPIATE PARTIAL AGONISTS

BELBUCA

buprenorphine

buprenorphine hcl/naloxone hcl

SUBOXONE

BUNAVAIL

buprenorphine hcl

BUTRANS

ZUBSOLV

ORALLY INHALED PREPARATIONS (STEROIDS)

AIRDUO DIGIHALER

ALVESCO

ASMANEX

budesonide/formoterol fumarate

fluticasone furoate/vilanterol trifenate

fluticasone propionate/salmeterol xinafoate

AIRDUO RESPICLICK

ARMONAIR DIGIHALER

ASMANEX HFA

DULERA

fluticasone propionate

OREXIN RECEPTOR ANTAGONISTS

QUVIVIQ

OTHER MACROLIDE ANTIBIOTICS

DIFICID

OTHER MISCELLANEOUS THERAPEUTIC AGENTS

AMPYRA

BOTOX

CERDELGA

dalfampridine

DYSPORT

FILSPARI

GALAFOLD

JAVYGTOR

KUVAN

ARCALYST

BOTOX COSMETIC

CYSTAGON

DAXXIFY

EVRYSDI

FIRDAPSE

ISTURISA

JEUVEAU

LITFULO

CAPITAL LETTERS = BRAND MEDICATIONS
lower case = generic medications

This list is subject to change and does not define coverage.
Only your plan can determine coverage of your benefit.

Drug Class	Drugs Requiring Prior Authorization
------------	-------------------------------------

OTHER MISCELLANEOUS THERAPEUTIC AGENTS -- Continued

<i>nitisinone</i>	NITYR
ORFADIN	PROCYSBI
RECORLEV	REZUROCK
RUZURGI	<i>sapropterin dihydrochloride</i>
SKYCLARYS	THIOLA
THIOLA EC	<i>tiopronin</i>
VIJOICE	VOWST
VOXZOGO	VYNDAMAX
VYNDAQEL	YARGESA
ZAVESCA	ZOKINVY

OTHER NONSTEROIDAL ANTI-INFLAM. AGENTS

CAMBIA	<i>diclofenac potassium</i>
INDOCIN	<i>indomethacin</i>
<i>ketorolac tromethamine</i>	NALFON
SPRIX	VIVLODEX
ZIPSOR	ZORVOLEX

OXABOROLES

KERYDIN	<i>tavorole</i>
---------	-----------------

OXAZOLIDINONE ANTIBIOTICS

SIVEXTRO	ZYVOX
----------	-------

PARATHYROID AGENTS

FORTEO	NATPARA
<i>teriparatide</i>	TYMLOS

PCSK9 INHIBITORS

PRALUENT PEN	REPATHA PUSHTRONEX
REPATHA SURECLICK	REPATHA SYRINGE

CAPITAL LETTERS = BRAND MEDICATIONS
lower case = generic medications

This list is subject to change and does not define coverage.
Only your plan can determine coverage of your benefit.

PHOSPHATE-REMOVING AGENTS**Drug Class****Drugs Requiring Prior Authorization**

PHOSPHATE-REMOVING AGENTS -- ContinuedAURYXIA

PHOSPHODIESTERASE TYPE 4 INHIBITORS

DALIRESP

roflumilast

PHOSPHODIESTERASE TYPE 5 INHIBITORS

ADCIRCA

ALYQ

LIQREV

REVATIO

*sildenafil 20 mg tablet (pah)**sildenafil citrate**tadalafil 20 mg tablet (pah)*TADLIQ

PITUITARY

NOCDURNA

NOCTIVA

NORDITROPIN FLEXPRO

SEROSTIM

PITUITARY FUNCTIONMACRILEN

PLATELET-AGGREGATION INHIBITORSZONTIVITY

PLEUROMUTILINSXENLETA

POTASSIUM-COMPETITIVE ACID BLOCKERS

VOQUEZNA DUAL PAK

VOQUEZNA TRIPLE PAK

POTASSIUM-SPARING DIURETICS

DYRENIUM

triamterene

PROGESTINSDEPO-SUBQ PROVERA 104

PROKINETIC AGENTS

GIMOTI

MOTTEGRITY

CAPITAL LETTERS = BRAND MEDICATIONS
lower case = generic medications

This list is subject to change and does not define coverage.
Only your plan can determine coverage of your benefit.

Drug Class	Drugs Requiring Prior Authorization
------------	-------------------------------------

PROTECTIVE AGENTS

QUINOLONE ANTIBIOTICS

BAXDELA

FACTIVE

RAPID-ACTING INSULINS

ADMELOG

ADMELOG SOLOSTAR

AFREZZA

APIDRA

APIDRA SOLOSTAR

FIASP

FIASP FLEXTOUCH

FIASP PENFILL

HUMALOG TEMPO PEN U-100

*insulin aspart**insulin aspart protamine human/insulin aspart**insulin lispro**insulin lispro protamine and insulin lispro*

LYUMJEV TEMPO PEN U-100

NOVOLOG

NOVOLOG FLEXPEN

NOVOLOG MIX 70-30

NOVOLOG MIX 70-30 FLEXPEN

RELION NOVOLOG U-100 FLEXPEN
(NDC:00169210125)

RESPIRATORY TRACT AGENTS, MISCELLANEOUS

ARALAST NP

BRONCHITOL

GLASSIA

PROLASTIN C

TEZSPIRE

XOLAIR

ZEMAIRA

RIFAMYCIN ANTIBIOTICS

XIFAXAN

SALICYLATES

DURLAZA

SELECTIVE BETA-2-ADRENERGIC AGONISTS
*albuterol hfa 90 mcg inhaler (prasco)**levalbuterol tartrate*

PROAIR DIGIHALER

PROAIR HFA

PROAIR RESPICLICK

PROVENTIL HFA

CAPITAL LETTERS = BRAND MEDICATIONS
lower case = generic medications

This list is subject to change and does not define coverage.
Only your plan can determine coverage of your benefit.

Drug Class

Drugs Requiring Prior Authorization

SELECTIVE BETA-2-ADRENERGIC AGONISTS -- Continued

XOPENEX HFA

SELECTIVE SEROTONIN AGONISTS

REYVOW

sumatriptan succinate/naproxen sodium

TREXIMET

SELECTIVE-SEROTONIN REUPTAKE INHIBITORS

paroxetine hcl

PAXIL

PEXEVA

SKIN AND MUCOUS MEMBRANE AGENTS, MISC.

ABSORICA

ABSORICA LD

ACUTANE

ACZONE

adapalene

ADBRY

AKLIEF

AMNESTEEM

ARAZLO

azelaic acid

calcipotriene/betamethasone dipropionate

CLARAVIS

DIFFERIN

DOVONEX

DUOBRII

DUPIXENT PEN

DUPIXENT SYRINGE

ENSTILAR

EPSOLAY

FABIOR

FINACEA

HYFTOR

isotretinoin

KLISYRI

MYORISAN

OPZELURA

SANTYL

SILIQ

SKYRIZI

SKYRIZI (2 SYRINGES) KIT

SKYRIZI PEN

SORILUX

SOTYKTU

STELARA

TACLONEX

TALTZ AUTOINJECTOR

TALTZ AUTOINJECTOR (2 PACK)

TALTZ AUTOINJECTOR (3 PACK)

TALTZ SYRINGE

tazarotene

CAPITAL LETTERS = BRAND MEDICATIONS
lower case = generic medications

This list is subject to change and does not define coverage.
Only your plan can determine coverage of your benefit.

Drug Class	Drugs Requiring Prior Authorization	
------------	-------------------------------------	--

SKIN AND MUCOUS MEMBRANE AGENTS, MISC. -- Continued

TAZORAC	TREMFYA
VTAMA	WINLEVI
ZENATANE	ZORYVE

SODIUM-GLUC COTRANSPORT 2 (SGLT2) INHIB

BRENZAVVY	INPEFA
INVOKAMET	INVOKAMET XR
INVOKANA	QTERN
SEGLUROMET	STEGLATRO
STEGLUJAN	

SOMATOSTATIN AGONISTS

<i>lanreotide acetate</i>	MYCAPSSA
<i>octreotide acetate</i>	SANDOSTATIN
SANDOSTATIN LAR DEPOT	SIGNIFOR
SIGNIFOR LAR	SOMATULINE DEPOT

SOMATOTROPIN AGONISTS

EGRIFTA SV	INCRELEX
------------	----------

TETRACYCLINE ANTIBIOTICS

<i>minocycline hcl</i>	MINOLIRA ER
ORACEA	XIMINO

THYROID FUNCTION

THYROGEN

VASOCONSTRICTORS

ADRENALIN CHLORIDE	UPNEEQ
--------------------	--------

VASODILATING AGENTS (RESPIRATORY TRACT)

ADEMPAS	<i>ambisentan</i>
<i>bosentan</i>	<i>epoprostenol sodium</i>
<i>epoprostenol sodium (glycine)</i>	FLOLAN
LETAIRIS	OPSUMIT
ORENITRAM ER	ORENITRAM MONTH 1 TITRATION KT

CAPITAL LETTERS = BRAND MEDICATIONS
lower case = generic medications

This list is subject to change and does not define coverage.
Only your plan can determine coverage of your benefit.

Drug Class	Drugs Requiring Prior Authorization	
------------	-------------------------------------	--

VASODILATING AGENTS (RESPIRATORY TRACT) -- Continued

ORENITRAM MONTH 3 TITRATION KT	REMODULIN
TRACLEER	<i>treprostinil sodium</i>
TYVASO	TYVASO DPI
TYVASO INSTITUTIONAL START KIT	TYVASO REFILL KIT
TYVASO STARTER KIT	UPTRAVI
VELETRI	VENTAVIS

VASODILATING AGENTS, MISCELLANEOUS

VERQUVO

VASOPRESSIN ANTAGONISTS

JYNARQUE	SAMSCA
<i>tolvaptan</i>	

VESICULAR MONOAMINE TRANSPORT2 INHIBITOR

AUSTEDO	AUSTEDO XR
AUSTEDO XR TITRATION KT(WK1-4)	INGREZZA
INGREZZA INITIATION PACK	<i>tetrabenazine</i>
XENAZINE	

VITAMIN D

ZEMPLAR

WAKEFULNESS-PROMOTING AGENTS

<i>armodafinil</i>	<i>modafinil</i>
NUVIGIL	PROVIGIL
SUNOSI	WAKIX

CAPITAL LETTERS = BRAND MEDICATIONS
lower case = generic medications

This list is subject to change and does not define coverage.
Only your plan can determine coverage of your benefit.