Medical Benefit Drug List - January 2025

No prior authorization required for: Emergency Room, Skilled Nursing facility or Inpatient.
*** All medications billed with miscellaneous codes will be reviewed; Explanatory notes must accompany claim. Override unlisted service ID with the one listed.**
Base (TPCT) service ID + place of service 11 (Office) = 13OA, 13OE, 13ON, 13OM, 13OL, 13OB, 13OP, 13OK, 13OX For commercial and Medicare products
"C" codes are used for OP facility claims only
'S' Codes cannot be used for Medicare billing
All services billed by providers designated as Home Infusion providers (HINF) require PA NPS= Non-Preferred specialty 'non-specialty'= not considered specialty under medical benefit

General Prior Authorization forms are now located on the second tab

Drug	Code	Generic	Category	Billing Unit	How Supplied	Line of Business	Coverage Level	Site Of Service	Comment
Abecma (Idecabtagene Vicleucel)	Q2055	idecabtagene vicleucel	Gene/Cellular Therapy	per dose	SD infusion bag	Commercial	Gene Therapy	YES	PA Required – see medical oncology prior authorization form for criteria. Coverage of Abecma is dependent on member's eligibility and benefit plan documents. Priority Health may request documentation, not more frequently than biannually, of follow-up patient assessment(s). Abecma will not be authorized for use in patients that have received a previous treatment course of Abecma or another anti-BCMA02 chimeric antigen-directed receptor (CAR) T-cell therapy. The safety and effectiveness of repeat administration have not been evaluated (one treatment per lifetime)
Abecma (Idecabtagene Vicleucel)	Q2055	idecabtagene vicleucel	Gene/Cellular Therapy	per dose	SD infusion bag	Medicaid	Carve Out	No	Contact Fee for Service Medicaid for coverage
Abecma (Idecabtagene Vicleucel)	Q2055	idecabtagene vicleucel	Gene/Cellular Therapy	per dose	SD infusion bag	Medicare	Medicare Chemo	No	PA Required - click here for criteria. Link for the Prior Authorization form is on the 'General Prior Auth Forms' tab.
Abelcet (amphotericin B) Injection	J0285	Amphotericin B	Antimicrobial	50 mg	100 mg/20 mL SDV	Medicare	Non-specialty	No	Part B vs Part D – See Approved Drug List for covered formulations under Part D - see the Part B vs Part D coverage determination form for criteria
Abilify Asimtufii (aripiprazole)	J0402	aripiprazole	Central Nervous System (CNS) agent	1 mg	720MG/2.4ML Prefilled Syringe 960MG/3.2ML Prefilled Syringe	Commercial	Pref. Specialty	No	No PA required
Abilify Asimtufii (aripiprazole)	J0402	aripiprazole	Central Nervous System (CNS) agent	1 mg	720MG/2.4ML Prefilled Syringe 960MG/3.2ML Prefilled Syringe	Medicaid	Carve Out	No	Contact Fee for Service Medicaid for coverage
Abilify Asimtufii (aripiprazole)	J0402	aripiprazole	Central Nervous System (CNS) agent	1 mg	720MG/2.4ML Prefilled Syringe 960MG/3.2ML Prefilled Syringe	Medicare	Pref. Specialty	No	No PA required
Abilify Maintena (aripiprazole)	J0401	aripiprazole	Central Nervous System (CNS) agent	1 mg	300 mg, 400 mg SD vial/syringe	Commercial	NPS	No	No PA required
Abilify Maintena (aripiprazole)	J0401	aripiprazole	Central Nervous System (CNS) agent	1 mg	300 mg, 400 mg SD vial/syringe	Medicaid	Carve Out	No	Contact Fee for Service Medicaid for coverage
Abilify Maintena (aripiprazole)	J0401	aripiprazole	Central Nervous System (CNS) agent	1 mg	300 mg, 400 mg SD vial/syringe	Medicare	NPS	No	No PA required
Abraxane (paclitaxel-protien bound)	J9264	paclitaxel-protien bound	Oncology	1 mg	100 mg SDV	Commercial	Pref. Specialty	No	No PA required
Abraxane (paclitaxel-protien bound)	J9264	paclitaxel-protien bound	Oncology	1 mg	100 mg SDV	Medicaid	Covered	No	No PA required
Abraxane (paclitaxel-protien bound)	J9264	paclitaxel-protien bound	Oncology	1 mg	100 mg SDV	Medicare	Medicare Chemo	No	No PA required
Abrilada (adalimumab-afzb)	Q5145	adalimumab	Inflammatory Conditions	1 mg	various	Commercial	Refer to ADL	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Abrilada (adalimumab-afzb)	Q5145	adalimumab	Inflammatory Conditions	1 mg	various	Medicaid	Not Covered	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Abrilada (adalimumab-afzb)	Q5145	adalimumab	Inflammatory Conditions	1 mg	various	Medicare	Refer to ADL	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Accuneb (albuterol) Nebulizer Solution ONLY	J7611-2.5mg/0.5 ml J7613-all others	albuterol	Inhalation	1 mg	0.5% (2.5 mg/0.5 mL, 20 mL) MD bottle, SD pouches; 0.021% (0.63 mg/3 mL) SD pouches; 0.042% (1.25 mg/3 mL) SD pouches; 0.083% (2.5 mg/3 mL) SD ampule	Medicare	Non-specialty	No	Part B vs Part D – See Approved Drug List for covered formulations under Part D - see the Part B vs Part D coverage determination form for criteria
Acetaminophen - B Braun Brand ONLY	J0136	acetaminophen	Analgesic	10 mg	500 mg/50 mL, 1000 mg/100 mL SDV	Commercial	Non-specialty	No	No PA required
Acetaminophen - B Braun Brand ONLY	J0136	acetaminophen	Analgesic	10 mg	500 mg/50 mL, 1000 mg/100 mL SDV	Medicaid	Covered	No	No PA required
Acetaminophen - B Braun Brand ONLY	J0136	acetaminophen	Analgesic	10 mg	500 mg/50 mL, 1000 mg/100 mL SDV	Medicare	Non-specialty	No	No PA required
Acetaminophen - Fresenius Kabi Brand ONLY	J0134	acetaminophen	Analgesic	10 mg	500 mg/50 mL, 1000 mg/100 mL SDV	Commercial	Non-specialty	No	No PA required
Acetaminophen - Fresenius Kabi Brand ONLY	J0134	acetaminophen	Analgesic	10 mg	500 mg/50 mL, 1000 mg/100 mL SDV	Medicaid	Covered	No	No PA required
Acetaminophen - Fresenius Kabi Brand ONLY	J0134	acetaminophen	Analgesic	10 mg	500 mg/50 mL, 1000 mg/100 mL SDV	Medicare	Non-specialty	No	No PA required
Acetaminophen - Hikma Brand ONLY	J0137	acetaminophen	Analgesic	10 mg	500 mg/50 mL, 1000 mg/100 mL SDV	Commercial	Non-specialty	No	No PA required
Acetaminophen - Hikma Brand ONLY	J0137	acetaminophen	Analgesic	10 mg	500 mg/50 mL, 1000 mg/100 mL SDV	Medicaid	Covered	No	No PA required
Acetaminophen - Hikma Brand ONLY	J0137	acetaminophen	Analgesic	10 mg	500 mg/50 mL, 1000 mg/100 mL SDV	Medicare	Non-specialty	No	No PA required
Actemra IV (tocilizumab) ***solution vial***	J3262	tocilizumab	Inflammatory Conditions	1 mg	80 mg/4 mL, 200 mg/10 mL, 400 mg/20 mL SDV	Commercial	Not Covered	No	**Not covered - Covered biosimilar: Tyenne**
Actemra IV (tocilizumab) ***solution vial***	J3262	tocilizumab	Inflammatory Conditions	1 mg	80 mg/4 mL, 200 mg/10 mL, 400 mg/20 mL SDV	Medicaid	Covered	YES	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth Forms tab.
Actemra IV (tocilizumab) ***solution vial***	J3262	tocilizumab	Inflammatory Conditions	1 mg	80 mg/4 mL, 200 mg/10 mL, 400 mg/20 mL SDV	Medicare	Pref. Specialty	No	PA Required - click here for criteria. Link for the Prior Authorization form is on the 'General Prior Auth Forms' tab.
Actemra SC (tocilizumab) ***Autoinjector (ACTPen) or Prefilled syringe***	J3262	tocilizumab	Inflammatory Conditions	1 mg	162 mg/0.9 mL syringe/ACTPen	Commercial	Refer to ADL	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Actemra SC (tocilizumab) ***Autoinjector (ACTPen) or Prefilled syringe***	J3262	tocilizumab	Inflammatory Conditions	1 mg	162 mg/0.9 mL syringe/ACTPen	Medicaid	Not Covered	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Actemra SC (tocilizumab) ***Autoinjector (ACTPen) or Prefilled syringe***	J3262	tocilizumab	Inflammatory Conditions	1 mg	162 mg/0.9 mL syringe/ACTPen	Medicare	Refer to ADL	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Acthar (corticotropin)	J0801	corticotropin	Inflammatory Conditions	40 units	80 unit/mL, 5 mL MDV	Commercial	Refer to ADL	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Acthar (corticotropin)	J0801	corticotropin	Inflammatory Conditions	40 units	80 unit/mL, 5 mL MDV	Medicaid	Not Covered	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Acthar (corticotropin)	J0801	corticotropin	Inflammatory Conditions	40 units	80 unit/mL, 5 mL MDV	Medicare	Refer to ADL	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Adakveo (crizanlizumab)	J0791	crizanlizumab	Miscellaneous	5 mg	100 mg/10 mL SDV	Commercial	NPS	YES	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth Forms tab.
Adakveo (crizanlizumab)	J0791	crizanlizumab	Miscellaneous	5 mg	100 mg/10 mL SDV	Medicaid	Covered	YES	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth Forms tab.
Adakveo (crizanlizumab)	J0791	crizanlizumab	Miscellaneous	5 mg	100 mg/10 mL SDV	Medicare	Covered	No	PA Required - click here for criteria. Link for the Prior Authorization form is on the 'General Prior Auth Forms' tab.
Adasuve (loxapine inhalation powder)	J2062	loxapine	inhalation	1 mg	10 mg SD pouch	Commercial	Not Covered for outpatient	No	No PA required-inpatient use only
Adasuve (loxapine inhalation powder)	J2062	loxapine	inhalation	1 mg	10 mg SD pouch	Medicaid	Carve Out	No	Contact Fee for Service Medicaid for coverage
Adasuve (loxapine inhalation powder)	J2062	loxapine	inhalation	1 mg	10 mg SD pouch	Medicare	Not Covered for outpatient	No	No PA required-inpatient use only
Adcetris (brentuximab vedotin)	J9042	brentuximab vedotin	Oncology	1 mg	50 mg SDV	Commercial	Pref. Specialty	No	PA required - see medical oncology prior authorization form for criteria
Adcetris (brentuximab vedotin)	J9042	brentuximab vedotin	Oncology	1 mg	50 mg SDV	Medicaid	Covered	No	No PA Required
Adcetris (brentuximab vedotin)	J9042	brentuximab vedotin	Oncology	1 mg	50 mg SDV	Medicare	Medicare Chemo	No	PA Required (Cancer Therapy) – See Medicare Part B Oncology Prior Authorization form
Adrenalin (epinephrine) in NaCl	J3490	epinephrine in NaCl	Miscellaneous	Additional information required: National Drug Code (NDC), Strength, Dosage administered, Route of administration.	2 mg/250 mL, 4 mg/250 mL, 5 mg/250 mL, 8 mg/250 mL, 10 mg/250 mL 0.9% NaCl solution single dose infusion bag	Commercial	Non-specialty	No	No PA required
Adrenalin (epinephrine) in NaCl	J3490	epinephrine in NaCl	Miscellaneous	Additional information required: National Drug Code (NDC), Strength, Dosage administered, Route of administration.	2 mg/250 mL, 4 mg/250 mL, 5 mg/250 mL, 8 mg/250 mL, 10 mg/250 mL 0.9% NaCl solution single dose infusion bag	Medicaid	Carve Out	No	Contact Fee for Service Medicaid for coverage
Adrenalin (epinephrine) in NaCl	J3490	epinephrine in NaCl	Miscellaneous	Additional information required: National Drug Code (NDC), Strength, Dosage administered, Route of administration.	2 mg/250 mL, 4 mg/250 mL, 5 mg/250 mL, 8 mg/250 mL, 10 mg/250 mL 0.9% NaCl solution single dose infusion bag	Medicare	Non-specialty	No	No PA required
Adrenalin, Epinephrine	J0171 - not for Belcher brand - see J0173	epinephrine	Miscellaneous	0.1 mg	various	Commercial	Non-specialty	No	No PA required
Adrenalin, Epinephrine	J0171 - not for Belcher brand - see J0173	epinephrine	Miscellaneous	0.1 mg	various	Medicaid	Carve Out	No	Contact Fee for Service Medicaid for coverage

Drug	Code	Generic	Category	Billing Unit	How Supplied	Line of Business	Coverage Level	Site Of Service	Comment
Adrenalin, Epinephrine	J0171 - not for Belcher brand - see J0173	epinephrine	Miscellaneous	0.1 mg	various	Medicare	Non-specialty	No	No PA required
Adriamycin (doxorubicin HCl)	J9000	doxorubicin	Oncology	10 mg	10 mg, 50 mg, 150 mg, 200 mg SDV	Commercial	Non-specialty	No	No PA required
Adriamycin (doxorubicin HCl)	J9000	doxorubicin	Oncology	10 mg	10 mg, 20 mg, 50 mg, 150 mg, 200 mg SDV	Medicaid	Covered	No	No PA required
Adriamycin (doxorubicin HCl)	J9000	doxorubicin	Oncology	10 mg	10 mg, 20 mg, 50 mg, 150 mg, 200 mg SDV	Medicare	Non-specialty	No	No PA required
Adrucil (fluorouracil)	J9190	5-fluorouracil	Oncology	500 mg	50 mg, 500 mg, 1 gm, 2.5 gm, 5 gm SDV & MDV (bulk for MDV)	Commercial	Non-specialty	No	No PA required
Adrucil (fluorouracil)	J9190	5-fluorouracil	Oncology	500 mg	50 mg, 500 mg, 1 gm, 2.5 gm, 5 gm SDV & MDV (bulk for MDV)	Medicaid	Covered	No	No PA required
Adrucil (fluorouracil)	J9190	5-fluorouracil	Oncology	500 mg	50 mg, 500 mg, 1 gm, 2.5 gm, 5 gm SDV & MDV (bulk for MDV)	Medicare	Medicare Chemo	No	No PA required
Adstiladrin (nadofaragene firadenovec-vncg)	J9029	nadofaragene firadenovec	Gene/Cellular Therapy	Per dose		Commercial	Gene Therapy	YES	PA Required – see medical oncology prior authorization form for criteria. Coverage of Adstiladrin is dependent on member's eligibility and benefit plan documents. Priority Health may request documentation, not more frequently than biannually, of follow-up patient assessment(s). Duration of approval is limited to 6 months. Continuation of coverage will be based on disease response defined as stabilization or decrease in size of tumor or tumor spread.
Adstiladrin (nadofaragene firadenovec-vncg)	J9029	nadofaragene firadenovec	Gene/Cellular Therapy	Per dose		Medicaid	Covered	No	No PA Required
Adstiladrin (nadofaragene firadenovec-vncg)	J9029	nadofaragene firadenovec	Gene/Cellular Therapy	Per dose		Medicare	Medicare Chemo	No	PA Required (Cancer Therapy) – See Medicare Part B Oncology Prior Authorization form
Aduhelm (aducanumab-avwa)	J0172	aducanumab	Alzheimer's disease	2mg	170 mg/1.7 mL (100 mg/mL), 300 mg/3 mL (100 mg/mL) SDV	Commercial	Not covered	No	**Not covered – See Pharmacy Policy EXPERIMENTAL/INVESTIGATIONAL/UNPROVEN CARE/ BENEFIT EXCEPTIONS for more information**
Aduhelm (aducanumab-avwa)	J0172	aducanumab	Alzheimer's disease	2mg	171 mg/1.7 mL (100 mg/mL), 300 mg/3 mL (100 mg/mL) SDV	Medicaid	Not Covered	No	**Not covered – See Pharmacy Policy EXPERIMENTAL/INVESTIGATIONAL/UNPROVEN CARE/ BENEFIT EXCEPTIONS for more information**
Aduhelm (aducanumab-avwa)	J0172	aducanumab	Alzheimer's disease	2mg	172 mg/1.7 mL (100 mg/mL), 300 mg/3 mL (100 mg/mL) SDV	Medicare	NPS	No	PA Required - click here for criteria. Link for the Prior Authorization form is on the 'General Prior Auth Forms' tab.
Advate (Antihemophilic Factor VIII)	J7192	Antihemophilic Factor VIII	Hemophilia			Commercial	Refer to ADL	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Advate (Antihemophilic Factor VIII)	J7192	Antihemophilic Factor VIII	Hemophilia			Medicaid	Not Covered	No	Refer to the Medicaid Approved Drug List (ADL) for pharmacy benefit coverage. For one-time doses required for planned outpatient procedures (professional/facility claims), authorizations will be reviewed for medical necessity according to the Hemophilia Management Medical Policy 91569
Advate (Antihemophilic Factor VIII)	J7192	Antihemophilic Factor VIII	Hemophilia			Medicare	Pref. Specialty	No	No PA required
Adynovate (Antihemophilic Factor VIII)	J7207	Antihemophilic Factor VIII	Hemophilia			Commercial	Refer to ADL	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Adynovate (Antihemophilic Factor VIII)	J7207	Antihemophilic Factor VIII	Hemophilia			Medicaid	Not Covered	No	Refer to the Medicaid Approved Drug List (ADL) for pharmacy benefit coverage. For one-time doses required for planned outpatient procedures (professional/facility claims), authorizations will be reviewed for medical necessity according to the Hemophilia Management Medical Policy 91569
Adynovate (Antihemophilic Factor VIII)	J7207	Antihemophilic Factor VIII	Hemophilia			Medicare	Pref. Specialty	No	No PA required
Adzynma (ADAMTS13, recombinant-krhn)	J7171	ADAMTS13, recombinant-krhn	Enzyme deficiency	10 IU	500 IU SDV, 1500 IU SDV	Commercial	Pref. Specialty	YES	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth Forms tab.
Adzynma (ADAMTS13, recombinant-krhn)	J7171	ADAMTS13, recombinant-krhn	Enzyme deficiency	10 IU	500 IU SDV, 1500 IU SDV	Medicaid	Covered	YES	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth Forms tab.
Adzynma (ADAMTS13, recombinant-krhn)	J7171	ADAMTS13, recombinant-krhn	Enzyme deficiency	10 IU	500 IU SDV, 1500 IU SDV	Medicare	Pref. Specialty	No	PA Required - click here for criteria. Link for the Prior Authorization form is on the 'General Prior Auth Forms' tab.
AFSTYLA (Antihemophilic Factor VIII)	J7210	Antihemophilic Factor VIII	Hemophilia			Commercial	Refer to ADL	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
AFSTYLA (Antihemophilic Factor VIII)	J7210	Antihemophilic Factor VIII	Hemophilia			Medicaid	Not Covered	No	Refer to the Medicaid Approved Drug List (ADL) for pharmacy benefit coverage. For one-time doses required for planned outpatient procedures (professional/facility claims), authorizations will be reviewed for medical necessity according to the Hemophilia Management Medical Policy 91569
AFSTYLA (Antihemophilic Factor VIII)	J7210	Antihemophilic Factor VIII	Hemophilia			Medicare	Pref. Specialty	No	No PA required
Ajovy (fremanezumab-vfrm)	J3031	fremanezumab	CGRP inhibitor	1 mg	225 mg/1.5 mL prefilled autoinjector	Commercial	Refer to ADL	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Ajovy (fremanezumab-vfrm)	J3031	fremanezumab	CGRP inhibitor	1 mg	225 mg/1.5 mL prefilled autoinjector	Medicaid	Not Covered	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Ajovy (fremanezumab-vfrm)	J3031	fremanezumab	CGRP inhibitor	1 mg	225 mg/1.5 mL prefilled autoinjector	Medicare	Refer to ADL	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Akynzeo IV (fosnetupitant and palonosetron)	J1454	fosnetupitant and palonosetron	Antiemetic	235 mg-0.25 mg	235 mg-0.25 mg SDV	Commercial	Non-specialty	No	No PA required
Akynzeo IV (fosnetupitant and palonosetron)	J1454	fosnetupitant and palonosetron	Antiemetic	235 mg-0.25 mg	235 mg-0.25 mg SDV	Medicaid	Covered	No	No PA required
Akynzeo IV (fosnetupitant and palonosetron)	J1454	fosnetupitant and palonosetron	Antiemetic	235 mg-0.25 mg	235 mg-0.25 mg SDV	Medicare	Non-specialty	No	No PA required
Aldurazyme (laronidase)	J1931	laronidase	Enzyme deficiency	0.1 mg	2.9 mg/5 mL SDV	Commercial	Pref. Specialty	YES	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth Forms tab.
Aldurazyme (laronidase)	J1931	laronidase	Enzyme deficiency	0.1 mg	2.9 mg/5 mL SDV	Medicaid	Covered	YES	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth Forms tab.
Aldurazyme (laronidase)	J1931	laronidase	Enzyme deficiency	0.1 mg	2.9 mg/5 mL SDV	Medicare	Pref. Specialty	No	No PA required
Alfenta (alfentanil)	J0216	alfentanil	Analgesic	500 mcg		Commercial	Non-specialty	No	No PA required
Alfenta (alfentanil)	J0216	alfentanil	Analgesic	500 mcg		Medicaid	Covered	No	No PA required
Alfenta (alfentanil)	J0216	alfentanil	Analgesic	500 mcg		Medicare	Non-specialty	No	No PA required
Alferon N (interferon alfa-n3)	J9215	interferon alfa-n3	interferon	250,000 units	5,000,000 units/mL SDV	Commercial	Non-specialty	No	No PA required
Alferon N (interferon alfa-n3)	J9215	interferon alfa-n3	interferon	250,000 units	5,000,000 units/mL SDV	Medicaid	Covered	No	No PA required
Alferon N (interferon alfa-n3)	J9215	interferon alfa-n3	interferon	250,000 units	5,000,000 units/mL SDV	Medicare	Medicare Chemo	No	No PA required
Alimta (pemetrexed)	J9305	pemetrexed	Oncology	10 mg	100 mg, 500 mg SDV	Commercial	Pref. Specialty	No	No PA required
Alimta (pemetrexed)	J9305	pemetrexed	Oncology	10 mg	100 mg, 500 mg SDV	Medicaid	Covered	No	No PA required
Alimta (pemetrexed)	J9305	pemetrexed	Oncology	10 mg	100 mg, 500 mg SDV	Medicare	Medicare Chemo	No	No PA required
Aliqopa (copanlisib)	J9057	copanlisib	Oncology	1 mg	60 mg SDV	Commercial	Pref. Specialty	No	PA required - see medical oncology prior authorization form for criteria.
Aliqopa (copanlisib)	J9057	copanlisib	Oncology	1 mg	60 mg SDV	Medicaid	Covered	No	No PA Required
Aliqopa (copanlisib)	J9057	copanlisib	Oncology	1 mg	60 mg SDV	Medicare	Medicare Chemo	No	PA Required (Cancer Therapy) – See Medicare Part B Oncology Prior Authorization form
Alkeran (melphalan)	J9245 J8600 is oral tablet	melphalan	Oncology	50 mg	50 mg SDV	Commercial	Non-specialty	No	No PA required
Alkeran (melphalan)	J9245 J8600 is oral tablet	melphalan	Oncology	50 mg	50 mg SDV	Medicaid	Covered	No	No PA required
Alkeran (melphalan)	J9245 J8600 is oral tablet	melphalan	Oncology	50 mg	50 mg SDV	Medicare	Non-specialty	No	No PA required
Aloprim (allopurinol)	J0206	allopurinol		1 mg		Commercial	Non-specialty	No	No PA required
Aloprim (allopurinol)	J0206	allopurinol		1 mg		Medicaid	Covered	No	No PA required
Aloprim (allopurinol)	J0206	allopurinol		1 mg		Medicare	Non-specialty	No	No PA required
Aloxi (palonosetron)	J2469	palonosetron	Antiemetic	25 mcg	0.25 mg/5 mL SD vial/syringe	Commercial	Pref. Specialty	No	No PA required
Aloxi (palonosetron)	J2469	palonosetron	Antiemetic	25 mcg	0.25 mg/5 mL SD vial/syringe	Medicaid	Covered	No	No PA required
Aloxi (palonosetron)	J2469	palonosetron	Antiemetic	25 mcg	0.25 mg/5 mL SD vial/syringe	Medicare	Pref. Specialty	No	No PA required
Alphanate (Antihemophilic Factor VIII/Von Willebrand Factor)	J7186	Antihemophilic Factor VIII/Von Willebrand Factor	Hemophilia			Commercial	Refer to ADL	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Alphanate (Antihemophilic Factor VIII/Von Willebrand Factor)	J7186	Antihemophilic Factor VIII/Von Willebrand Factor	Hemophilia			Medicaid	Not Covered	No	Refer to the Medicaid Approved Drug List (ADL) for pharmacy benefit coverage. For one-time doses required for planned outpatient procedures (professional/facility claims), authorizations will be reviewed for medical necessity according to the Hemophilia Management Medical Policy 91569
Alphanate (Antihemophilic Factor VIII/Von Willebrand Factor)	J7186	Antihemophilic Factor VIII/Von Willebrand Factor	Hemophilia			Medicare	Pref. Specialty	No	No PA required
AlphaNine (Antihemophilic Factor IX)	J7193	Antihemophilic Factor IX	Hemophilia			Commercial	Refer to ADL	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
AlphaNine (Antihemophilic Factor IX)	J7193	Antihemophilic Factor IX	Hemophilia			Medicaid	Not Covered	No	Refer to the Medicaid Approved Drug List (ADL) for pharmacy benefit coverage. For one-time doses required for planned outpatient procedures (professional/facility claims), authorizations will be reviewed for medical necessity according to the Hemophilia Management Medical Policy 91569
AlphaNine (Antihemophilic Factor IX)	J7193	Antihemophilic Factor IX	Hemophilia			Medicare	Pref. Specialty	No	No PA required
Alprolix (Antihemophilic Factor IX Fc Fusion Protein)	J7201	Antihemophilic Factor IX Fc Fusion Protein	Hemophilia			Commercial	Refer to ADL	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Alprolix (Antihemophilic Factor IX Fc Fusion Protein)	J7201	Antihemophilic Factor IX Fc Fusion Protein	Hemophilia			Medicaid	Not Covered	No	Refer to the Medicaid Approved Drug List (ADL) for pharmacy benefit coverage. For one-time doses required for planned outpatient procedures (professional/facility claims), authorizations will be reviewed for medical necessity according to the Hemophilia Management Medical Policy 91569
Alprolix (Antihemophilic Factor IX Fc Fusion Protein)	J7201	Antihemophilic Factor IX Fc Fusion Protein	Hemophilia			Medicare	Pref. Specialty	No	No PA required
Altuviiio (Fc-VWF-XTEN fusion protein ehtl)	J7214	Fc-VWF-XTEN fusion protein ehtl	Hemophilia	1 IU		Commercial	Refer to ADL	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Altuviiio (Fc-VWF-XTEN fusion protein ehtl)	J7214	Fc-VWF-XTEN fusion protein ehtl	Hemophilia	1 IU		Medicaid	Not Covered	No	Refer to the Medicaid Approved Drug List (ADL) for pharmacy benefit coverage. For one-time doses required for planned outpatient procedures (professional/facility claims), authorizations will be reviewed for medical necessity according to the Hemophilia Management Medical Policy 91569

Drug	Code	Generic	Category	Billing Unit	How Supplied	Line of Business	Coverage Level	Site Of Service	Comment
Altuviiio (Fc-VWF-XTEN fusion protein ehtl)	J7214	Fc-VWF-XTEN fusion protein ehtl	Hemophilia	1IU		Medicare	Pref. Specialty	No	No PA required
Alyglo (immune globulin intravenous, human-stwk)	J1552	IVIG	Immune Globulin	Additional information required: National Drug Code (NDC), Strength, Dosage administered, Route of administration.	5 g/50 mL, 10g/ 100 mL, 20 g/200 mL SDV	Commercial	Not Covered	No	**Not Covered**
Alyglo (immune globulin intravenous, human-stwk)	J1552	IVIG	Immune Globulin	Additional information required: National Drug Code (NDC), Strength, Dosage administered, Route of administration.	5 g/50 mL, 10g/ 100 mL, 20 g/200 mL SDV	Medicaid	Not Covered	No	**Not Covered**
Alyglo (immune globulin intravenous, human-stwk)	J1552	IVIG	Immune Globulin	Additional information required: National Drug Code (NDC), Strength, Dosage administered, Route of administration.	5 g/50 mL, 10g/ 100 mL, 20 g/200 mL SDV	Medicare	NPS	No	Part B vs Part D – PA Required – click here for criteria. See Approved Drug List for covered formulations under Part D
Alymsys (bevacizumab-maly)	Q5126	bevacizumab	Oncology	10 mg	100 mg/4 mL, 400 mg/16 mL SDV	Commercial	Not Covered	No	**Not Covered**
Alymsys (bevacizumab-maly)	Q5126	bevacizumab	Oncology	10 mg	100 mg/4 mL, 400 mg/16 mL SDV	Medicaid	Covered	No	No PA required
Alymsys (bevacizumab-maly)	Q5126	bevacizumab	Oncology	10 mg	100 mg/4 mL, 400 mg/16 mL SDV	Medicare	Medicare Chemo	No	PA Required - click here for criteria. Link for the Prior Authorization form is on the 'General Prior Auth. Forms' tab.
Aminosyn (amino acids) Injection		amino acids	TPN			Medicare		No	Part B vs Part D – PA Required – click here for criteria. See Approved Drug List for covered formulations under Part D
Amondys 45 (casimersen)	J1426	casimersen	Muscular Dystrophy	10 mg	100 mg/2 mL SDV	Commercial	Not covered	No	**Not covered – See Pharmacy Policy EXPERIMENTAL/INVESTIGATIONAL/UNPROVEN CARE/ BENEFIT EXCEPTIONS for more information**
Amondys 45 (casimersen)	J1426	casimersen	Muscular Dystrophy	10 mg	100 mg/2 mL SDV	Medicaid	Carve Out	No	Contact Fee for Service Medicaid for coverage
Amondys 45 (casimersen)	J1426	casimersen	Muscular Dystrophy	10 mg	100 mg/2 mL SDV	Medicare	Not Covered	No	**Not covered – See Pharmacy Policy Utilization Management for Part B Drugs in Medicare Advantage**
Amtagvi (lifileucel)	J9999 C9399	lifileucel	Gene/Cellular Therapy	Additional information required: National Drug Code (NDC), Strength, Dosage administered, Route of administration.	≤ 7.5 x 10^9 to 72 x 10^9 viable cells suspended in 1 to 4 patient-specific infusion bag(s)	Commercial	Gene Therapy	YES	PA Required – see medical oncology prior authorization form for criteria. Coverage of Amtagvi is dependent on member's eligibility and benefit plan documents. Priority Health may request documentation, not more frequently than biannually, of follow-up patient assessment(s). Amtagvi will not be authorized for use in patients that have received a previous treatment course of Amtagvi or another T-cell therapy. The safety and effectiveness of repeat administration have not been evaluated. (one treatment per lifetime)0
Amtagvi (lifileucel)	J9999 C9399	lifileucel	Gene/Cellular Therapy	Additional information required: National Drug Code (NDC), Strength, Dosage administered, Route of administration.	≤ 7.5 x 10^9 to 72 x 10^9 viable cells suspended in 1 to 4 patient-specific infusion bag(s)	Medicaid	Covered	No	No PA Required
Amtagvi (lifileucel)	J9999 C9399	lifileucel	Gene/Cellular Therapy	Additional information required: National Drug Code (NDC), Strength, Dosage administered, Route of administration.	≤ 7.5 x 10^9 to 72 x 10^9 viable cells suspended in 1 to 4 patient-specific infusion bag(s)	Medicare	Medicare Chemo	No	PA Required - click here for criteria. Link for the Prior Authorization form is on the 'General Prior Auth. Forms' tab.
Amvuttra (vutrisiran)	J0225	vutrisiran	Miscellaneous	1mg.	25mg/0.5ml SD syringe	Commercial	Pref. Specialty	YES	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth. Forms tab.
Amvuttra (vutrisiran)	J0225	vutrisiran	Miscellaneous	1mg.	25mg/0.5ml SD syringe	Medicaid	Covered	YES	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth. Forms tab.
Amvuttra (vutrisiran)	J0225	vutrisiran	Miscellaneous	1mg.	25mg/0.5ml SD syringe	Medicare	Pref. Specialty	No	PA Required - click here for criteria. Link for the Prior Authorization form is on the 'General Prior Auth. Forms' tab.
Anascorp (Scorpion [Centruroides] Immune F(AB)2)	J0716	Scorpion [Centruroides] Immune FAB2	Antivenom	up to 120 mg	19 mg SDV	Commercial	Pref. Specialty	No	No PA required
Anascorp (Scorpion [Centruroides] Immune F(AB)2)	J0716	Scorpion [Centruroides] Immune FAB2	Antivenom	up to 120 mg	19 mg SDV	Medicaid	Covered	No	No PA required
Anascorp (Scorpion [Centruroides] Immune F(AB)2)	J0716	Scorpion [Centruroides] Immune FAB2	Antivenom	up to 120 mg	19 mg SDV	Medicare	Pref. Specialty	No	No PA required
Anavip (crotaline antivenin)	J0841	crotaline antivenin	Antivenom	120 mg	120 mg SDV	Commercial	Non-specialty	No	No PA required - rattlesnake antivenom
Anavip (crotaline antivenin)	J0841	crotaline antivenin	Antivenom	120 mg	120 mg SDV	Medicaid	Covered	No	No PA required - rattlesnake antivenom
Anavip (crotaline antivenin)	J0841	crotaline antivenin	Antivenom	120 mg	120 mg SDV	Medicare	Non-specialty	No	No PA required - rattlesnake antivenom
Anktiva (ogapendekin alfa inbakicept)	J9028	ogapendekin alfa inbakicept	Oncology	Additional information required: National Drug Code (NDC), Strength, Dosage administered, Route of administration.	400 mcg/0.4 mL, SDV	Commercial	Pref. Specialty	YES	PA required - see medical oncology prior authorization form for criteria.
Anktiva (ogapendekin alfa inbakicept)	J9028	ogapendekin alfa inbakicept	Oncology	Additional information required: National Drug Code (NDC), Strength, Dosage administered, Route of administration.	400 mcg/0.4 mL, SDV	Medicaid	Covered	No	No PA Required
Anktiva (ogapendekin alfa inbakicept)	J9028	ogapendekin alfa inbakicept	Oncology	Additional information required: National Drug Code (NDC), Strength, Dosage administered, Route of administration.	400 mcg/0.4 mL, SDV	Medicare	Medicare Chemo	No	PA Required (Cancer Therapy) – See Medicare Part B Oncology Prior Authorization form
Annovera (segesterone acetate and ethinyl estradiol)	J7295	segesterone acetate and ethinyl estradiol	Contraceptive	1	various	Commercial	Refer to ADL	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Annovera (segesterone acetate and ethinyl estradiol)	J7295	segesterone acetate and ethinyl estradiol	Contraceptive	1	various	Medicaid	Not Covered	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Annovera (segesterone acetate and ethinyl estradiol)	J7295	segesterone acetate and ethinyl estradiol	Contraceptive	1	various	Medicare	Refer to ADL	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Aphexda (motixafortide)	J2277	motixafortide	Hematopoietic agent	0.25 mg	62 mg SDV	Commercial	NPS	No	No PA required
Aphexda (motixafortide)	J2277	motixafortide	Hematopoietic agent	0.25 mg	62 mg SDV	Medicaid	Covered	YES	No PA required when administered in a hospital outpatient infusion center
Aphexda (motixafortide)	J2277	motixafortide	Hematopoietic agent	0.25 mg	62 mg SDV	Medicare	NPS	No	No PA required
Apokyn (apomorphine)	J0364	apomorphine	Parkinson agent	1 mg	30 mg/3 mL cartridge	Commercial	Refer to ADL	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Apokyn (apomorphine)	J0364	apomorphine	Parkinson agent	1 mg	30 mg/3 mL cartridge	Medicaid	Not Covered	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Apokyn (apomorphine)	J0364	apomorphine	Parkinson agent	1 mg	30 mg/3 mL cartridge	Medicare	Refer to ADL	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Aponvie (aprepitant)	J3490, C9145	aprepitant	Antiemetic	1 mg	32mg/4.4ml SDV	Commercial	Pref. Specialty	No	No PA required
Aponvie (aprepitant)	J3490, C9145	aprepitant	Antiemetic	1 mg	32mg/4.4ml SDV	Medicaid	Covered	No	No PA required
Aponvie (aprepitant)	J3490, C9145	aprepitant	Antiemetic	1 mg	32mg/4.4ml SDV	Medicare	Pref. Specialty	No	No PA required
Apretude (cabotegravir)	J0739	cabotegravir	HIV preventative	1 mg	600mg/3ml kit	Commercial	Pref. Specialty	No	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth. Forms tab.
Apretude (cabotegravir)	J0739	cabotegravir	HIV preventative	1 mg	600mg/3ml kit	Medicaid	Carve Out	No	Contact Fee for Service Medicaid for coverage
Apretude (cabotegravir)	J0739	cabotegravir	HIV preventative	1 mg	600mg/3ml kit	Medicare	NPS	No	PA required - See Medicare Medical Part B prior authorization form
Aralast NP (alpha1 proteinase inhibitor-human)	J0256	alpha1 proteinase inhibitor	Enzyme deficiency	10 mg	0.5 gm, 1 gm SDV	Commercial	Pref. Specialty	YES	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth. Forms tab.

Drug	Code	Generic	Category	Billing Unit	How Supplied	Line of Business	Coverage Level	Site Of Service	Comment
Aralast NP (alpha1 proteinase inhibitor-human)	J0256	alpha1 proteinase inhibitor	Enzyme deficiency	10 mg	0.5 gm, 1 gm SDV	Medicaid	Covered	YES	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth Forms tab.
Aralast NP (alpha1 proteinase inhibitor-human)	J0256	alpha1 proteinase inhibitor	Enzyme deficiency	10 mg	0.5 gm, 1 gm SDV	Medicare	Pref. Specialty	No	PA required - See Medicare Medical Part B prior authorization form
Aranesp (darbepoetin alfa)	J0882 (ESRD) J0881 (Non-ESRD)	darbepoetin alfa	Hematopoietic agent	1 mcg	various	Medicare	Pref. Specialty	No	Part B vs Part D – See Approved Drug List for covered formulations under Part D - see the Part B vs Part D coverage determination form for criteria
Aredia (pamidronate disodium)	J2430	pamidronate disodium	Bone modifying agent	30 mg	30 mg, 90 mg SDV	Commercial	Non-specialty	No	No PA required
Aredia (pamidronate disodium)	J2430	pamidronate disodium	Bone modifying agent	30 mg	30 mg, 90 mg SDV	Medicaid	Covered	No	No PA required
Aredia (pamidronate disodium)	J2430	pamidronate disodium	Bone modifying agent	30 mg	30 mg, 90 mg SDV	Medicare	Non-specialty	No	No PA required
Aristada (aripiprazole lauroxil)	J1944	aripiprazole	Central Nervous System (CNS) agent	1 mg	441 mg/1.6 mL, 675 mg/2.4 mL, 882 mg/3.2 mL, 1064 mg/3.9 mL SD syringe	Commercial	NPS	No	No PA required
Aristada (aripiprazole lauroxil)	J1944	aripiprazole	Central Nervous System (CNS) agent	1 mg	441 mg/1.6 mL, 675 mg/2.4 mL, 882 mg/3.2 mL, 1064 mg/3.9 mL SD syringe	Medicaid	Carve Out	No	Contact Fee for Service Medicaid for coverage
Aristada (aripiprazole lauroxil)	J1944	aripiprazole	Central Nervous System (CNS) agent	1 mg	441 mg/1.6 mL, 675 mg/2.4 mL, 882 mg/3.2 mL, 1064 mg/3.9 mL SD syringe	Medicare	NPS	No	No PA required
Aristada Initio (aripiprazole lauroxil)	J1943	aripiprazole	Central Nervous System (CNS) agent	1 mg	675 mg/2.4 mL SD syringe	Commercial	NPS	No	No PA required
Aristada Initio (aripiprazole lauroxil)	J1943	aripiprazole	Central Nervous System (CNS) agent	1 mg	675 mg/2.4 mL SD syringe	Medicaid	Carve Out	No	Contact Fee for Service Medicaid for coverage
Aristada Initio (aripiprazole lauroxil)	J1943	aripiprazole	Central Nervous System (CNS) agent	1 mg	675 mg/2.4 mL SD syringe	Medicare	NPS	No	No PA required
Arzerra (ofatumumab)	J9302	ofatumumab	Oncology	10 mg	100 mg/5 mL, 1000mg/50 mL SDV	Commercial	NPS	No	PA required - see medical oncology prior authorization form for criteria
Arzerra (ofatumumab)	J9302	ofatumumab	Oncology	10 mg	100 mg/5 mL, 1000mg/50 mL SDV	Medicaid	Covered	No	No PA Required
Arzerra (ofatumumab)	J9302	ofatumumab	Oncology	10 mg	100 mg/5 mL, 1000mg/50 mL SDV	Medicare	Medicare Chemo	No	PA Required (Cancer Therapy) – See Medicare Part B Oncology Prior Authorization form
Asceniv (immune globulin) intravenous	J1554	IVIG	Immune Globulin	500 mg	5 gm SDV	Commercial	Not Covered	No	**Not Covered**
Asceniv (immune globulin) intravenous	J1554	IVIG	Immune Globulin	500 mg	5 gm SDV	Medicaid	Not Covered	No	**Not Covered**
Asceniv (immune globulin) intravenous	J1554	IVIG	Immune Globulin	500 mg	5 gm SDV	Medicare	NPS	No	Part B vs Part D – PA Required – click here for criteria. See Approved Drug List for covered formulations under Part D
Asparlas (calaspargase pegol-mknl)	J9118	calaspargase pegol-mknl	Oncology	10 units	3750 units/5 mL SDV	Commercial	NPS	No	No PA required when billed for the following ICD-10 codes: C91.00 – C91.02 , C83.50 – C83.59. For other diagnoses - see medical oncology prior authorization form for criteria
Asparlas (calaspargase pegol-mknl)	J9118	calaspargase pegol-mknl	Oncology	10 units	3750 units/5 mL SDV	Medicaid	Covered	No	No PA Required
Asparlas (calaspargase pegol-mknl)	J9118	calaspargase pegol-mknl	Oncology	10 units	3750 units/5 mL SDV	Medicare	Medicare Chemo	No	No PA required when billed for the following ICD-10 codes: C91.00 – C91.02, C83.50 – C83.59. For other diagnoses - see Medicare Part B oncology prior authorization form for criteria
Astagraf (tacrolimus capsule, extended release)	J7508	tacrolimus	Immunosuppressive agent	0.1 mg	0.5 mg, 1 mg, 5 mg tablet	Medicare	Non-specialty	No	Part B vs Part D – See Approved Drug List for covered formulations under Part D - see the Part B vs Part D coverage determination form for criteria
Atgam (lymphocyte immune globulin-equine)	J7504	Anti-thymocyte IG	Immune Globulin	250 mg	250 mg/5 mL SD ampule	Commercial	Non-specialty	No	No PA required
Atgam (lymphocyte immune globulin-equine)	J7504	Anti-thymocyte IG	Immune Globulin	250 mg	250 mg/5 mL SD ampule	Medicaid	Covered	No	No PA required
Atgam (lymphocyte immune globulin-equine)	J7504	Anti-thymocyte IG	Immune Globulin	250 mg	250 mg/5 mL SD ampule	Medicare	Non-specialty	No	No PA required
Ativan (lorazepam)	J2060	lorazepam	Central Nervous System (CNS) agent	2 mg	2 mg/mL, 20 mg/10 mL, 4 mg/mL, 40 mg/10 mL SD vial/syringe & MDV	Commercial	Non-specialty	No	No PA required
Ativan (lorazepam)	J2060	lorazepam	Central Nervous System (CNS) agent	2 mg	2 mg/mL, 20 mg/10 mL, 4 mg/mL, 40 mg/10 mL SD vial/syringe & MDV	Medicaid	Carve Out	No	Contact Fee for Service Medicaid for coverage
Ativan (lorazepam)	J2060	lorazepam	Central Nervous System (CNS) agent	2 mg	2 mg/mL, 20 mg/10 mL, 4 mg/mL, 40 mg/10 mL SD vial/syringe & MDV	Medicare	Non-specialty	No	No PA required
Auryxia (Ferric citrate)	J0609 (For ESRD on dialysis)	Ferric citrate	phospate binder	3 mg ferric iron	1 GM ferric citrate/tablet (equivalent to 210 MG ferric iron)	Commercial	Refer to ADL	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Auryxia (Ferric citrate)	J0609 (For ESRD on dialysis)	Ferric citrate	phospate binder	3 mg ferric iron	1 GM ferric citrate/tablet (equivalent to 210 MG ferric iron)	Medicaid	Not separately payable	No	Not separately payable
Auryxia (Ferric citrate)	J0609 (For ESRD on dialysis)	Ferric citrate	phospate binder	3 mg ferric iron	1 GM ferric citrate/tablet (equivalent to 210 MG ferric iron)	Medicare	Not separately payable	No	Included in ESRD PPS and not separately payable under Part B
Avastin (bevacizumab) *Avastin also comes in a formulation used to treat cancer as a chemotherapeutic agent (J9035). Ophthalmic indications should not be billed using code J9035	J3590, J7999, C9257	bevacizumab	Ophthalmic	Additional information required: National Drug Code (NDC), Strength, Dosage administered, Route of administration.	Compounded from 100 mg/4 mL SDV (usual 2.5 mg/0.1 mL)	Commercial	Pref. Specialty	No	No PA required when billed for the following ICD-10 codes: B39.4, B39.5, B39.9, E08.311, E08.3211 – E08.3213, E08.3311 – E08.3313, E08.3411 – E08.3413, E08.3511 – E08.3513, E08.3591 – E08.3593, E09.311, E09.3211 – E09.3213, E09.3311 – E09.3313, E09.3411 – E09.3413, E09.3511 – E09.3513, E09.3591 – E09.3593, E10.311, E10.3211 – E10.3213, E10.3311 – E10.3313, E10.3411 – E10.3413, E10.3511-E10.3513, E10.3591-E10.3593, E11.3100-E11.3199, E11.3211-E11.3213, E11.3311-E11.3313, E11.3411-E11.3413, E11.3511-E11.3513, E11.3591-E11.3593, E13.311, E13.3211- E13.3213, E13.3311 – E13.3313, E13.3411-E13.3413, E13.3511, E13.3513, E13.3591-E13.3593, H21.1x1-H21.1x3, H32, H34.8110-H34.8132, H34.8310-H34.8332, H35.051-H35.059, H35.3210 – H35.3233, H35.351 –H35.353, H35.81, H40.89, H44.2a1-H44.2E3
Avastin (bevacizumab) *Avastin also comes in a formulation used to treat cancer as a chemotherapeutic agent (J9035). Ophthalmic indications should not be billed using code J9035	J3590, J7999, C9257	bevacizumab	Ophthalmic	Additional information required: National Drug Code (NDC), Strength, Dosage administered, Route of administration.	Compounded from 100 mg/4 mL SDV (usual 2.5 mg/0.1 mL)	Medicaid	Covered	No	No PA required when billed for the following ICD-10 codes: B39.4, B39.5, B39.9, E08.311, E08.321 – E08.3213, E08.331 – E08.3313, E08.3411 – E08.3413, E08.3511 – E08.3513, E08.3591 – E08.3593, E09.311, E09.3211 – E09.3213, E09.3311 – E09.3313, E09.3411 – E09.3413, E09.3511 – E09.3513, E09.3591 – E09.3593, E10.311, E10.3211 – E10.3213, E10.3311 – E10.3313, E10.3411 – E10.3413, E10.3511-E10.3513, E10.3591-E10.3593, E11.311, E11.3211-E11.3213, E11.3311-E11.3313, E11.3411-E11.3413, E11.3511-E11.3513, E11.3591-E11.3593, E13.311, E13.3211- E13.3213, E13.3311 – E13.3313, E13.3411-E13.3413, E13.3511, E13.3513, E13.3591-E13.3593, H21.1x1-H21.1x3, H32, H34.8110-H34.8132, H34.8310-H34.8332, H35.051-H35.059, H35.3210 – H35.3233, H35.351 –H35.353, H35.81, H40.89, H44.2a1-H44.2E3
Avastin (bevacizumab) *Avastin also comes in a formulation used to treat cancer as a chemotherapeutic agent (J9035). Ophthalmic indications should not be billed using code J9035	J3590, J7999, C9257	bevacizumab	Ophthalmic	Additional information required: National Drug Code (NDC), Strength, Dosage administered, Route of administration.	Compounded from 100 mg/4 mL SDV (usual 2.5 mg/0.1 mL)	Medicare	Pref. Specialty	No	No PA Required when billed with the following ICD-10 codes: B39.4, B39.5, B39.9, E08.311, E08.3211 – E08.3213, E08.3311 – E08.3313, E08.3411 – E08.3413, E08.3511 – E08.3513, E08.3591 – E08.3593, E09.311, E09.3211 – E09.3213, E09.3311 – E09.3313, E09.3411 – E09.3413, E09.3511 – E09.3513, E09.3591 – E09.3593, E10.311, E10.3211 – E10.3213, E10.3311 – E10.3313, E10.3411 – E10.3413, E10.3511-E10.3513, E10.3591-E10.3593, E11.311, E11.3211-E11.3213, E11.3311-E11.3313, E11.3411-E11.3413, E11.3511-E11.3513, E11.3591-E11.3593, E13.311, E13.3211- E13.3213, E13.3311 – E13.3313, E13.3411-E13.3413, E13.3511, E13.3513, E13.3591-E13.3593, H21.1x1-H21.1x3, H32, H34.8110-H34.8132, H34.8310-H34.8332, H35.051-H35.059, H35.3210 – H35.3233, H35.351 –H35.353, H35.81, H40.89, H44.2a1-H44.2E3 ,For all other ICD-10 codes - PA Required - click here for criteria. Link for the Prior Authorization form is on the 'General Prior Auth Forms' tab.
Avastin (bevacizumab) *See ophthalmic category for intra-ocular coverage	J9035	bevacizumab	Oncology	10 mg	100mg/4 mL, 400 mg/16 mL SDV	Commercial	Not covered	No	**Not Covered: See biosimilars Mvasi or Zirabev for non-ophthalmic coverage**
Avastin (bevacizumab) *See ophthalmic category for intra-ocular coverage	J9035	bevacizumab	Oncology	10 mg	100mg/4 mL, 400 mg/16 mL SDV	Medicaid	Covered	No	No PA Required
Avastin (bevacizumab) *See ophthalmic category for intra-ocular coverage	J9035	bevacizumab	Oncology	10 mg	100mg/4 mL, 400 mg/16 mL SDV	Medicare	Medicare Chemo	No	PA Required - click here for criteria. Link for the Prior Authorization form is on the 'General Prior Auth Forms' tab.
Aveed (testosterone undecanoate)	J3145	testosterone	hormone replacement	1 mg	750 mg/3 mL SDV	Commercial	Non-specialty	No	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth Forms tab.
Aveed (testosterone undecanoate)	J3145	testosterone	hormone replacement	1 mg	750 mg/3 mL SDV	Medicaid	Not Covered	No	**Not covered**
Aveed (testosterone undecanoate)	J3145	testosterone	hormone replacement	1 mg	750 mg/3 mL SDV	Medicare	Non-specialty	No	PA Required - click here for criteria. Link for the Prior Authorization form is on the 'General Prior Auth Forms' tab.
Avelox (moxifloxacin)	J2280 - Not for Fresenius Kabi brand - see J2281	moxifloxacin	Antimicrobial	100 mg	400mg/250 mL SD infusion bag	Commercial	Non-specialty	No	No PA required
Avelox (moxifloxacin)	J2280 - Not for Fresenius Kabi brand - see J2281	moxifloxacin	Antimicrobial	100 mg	400mg/250 mL SD infusion bag	Medicaid	Covered	No	No PA required
Avelox (moxifloxacin)	J2280 - Not for Fresenius Kabi brand - see J2281	moxifloxacin	Antimicrobial	100 mg	400mg/250 mL SD infusion bag	Medicare	Non-specialty	No	No PA required
Avsola (infliximab-axxq)	Q5121	infliximab	Inflammatory Conditions	10 mg	100 mg SDV	Commercial	Not covered	No	**Not covered**
Avsola (infliximab-axxq)	Q5121	infliximab	Inflammatory Conditions	10 mg	100 mg SDV	Medicaid	Not Covered	YES	**Not covered**
Avsola (infliximab-axxq)	Q5121	infliximab	Inflammatory Conditions	10 mg	100 mg SDV	Medicare	NPS	No	PA Required - click here for criteria. Link for the Prior Authorization form is on the 'General Prior Auth Forms' tab.
Avycaz (ceftazidime and avibactam)	J0714	ceftazidime and avibactam	Antimicrobial	0.5 gm-0.125 gm	2 gm-0.5 gm SDV	Commercial	NPS	No	No PA required
Avycaz (ceftazidime and avibactam)	J0714	ceftazidime and avibactam	Antimicrobial	0.5 gm-0.125 gm	2 gm-0.5 gm SDV	Medicaid	Covered	No	No PA required
Avycaz (ceftazidime and avibactam)	J0714	ceftazidime and avibactam	Antimicrobial	0.5 gm-0.125 gm	2 gm-0.5 gm SDV	Medicare	NPS	No	No PA required
Axtle (pemetrexed dipotassium)	J9292	pemetrexed	Oncology	10 mg	100 mg & 500mg SDV	Commercial	Not Covered	No	**Not Covered**
Axtle (pemetrexed dipotassium)	J9292	pemetrexed	Oncology	10 mg	100 mg & 500mg SDV	Medicaid	Covered	No	No PA required
Axtle (pemetrexed dipotassium)	J9292	pemetrexed	Oncology	10 mg	100 mg & 500mg SDV	Medicare	Medicare Chemo	No	No PA required
Azactam (aztreonam)	J0457	aztreonam	Antimicrobial	100 mg		Commercial	Non-specialty	No	No PA required
Azactam (aztreonam)	J0457	aztreonam	Antimicrobial	100 mg		Medicaid	Covered	No	No PA required

Drug	Code	Generic	Category	Billing Unit	How Supplied	Line of Business	Coverage Level	Site Of Service	Comment
Azactam (aztreonam)	J0457	aztreonam	Antimicrobial	100 mg		Medicare	Non-specialty	No	No PA required
azathioprine (generic for **Azasan, Imuran**) ORAL ONLY	J7500	azathioprine	Immunosuppressive agent	50 mg	50 mg, 75 mg, 100 mg tablet	Medicare	Non-specialty	No	Part B vs Part D – See Approved Drug List for covered formulations under Part D - see the Part B vs Part D coverage determination form for criteria
Azedra (iobenguane I-131)	A9699, A9590, C9407, C9408	iobenguane I-131	Radio-pharmaceuticals	A9590: 1 millicurie (mCi)	Dosimetric: 30 mCi/2 mL SDV Therapeutic: 337 mCi/22.5 mL SDV	Commercial	NPS	No	PA required - see medical oncology prior authorization form for criteria
Azedra (iobenguane I-131)	A9699, A9590, C9407, C9408	iobenguane I-131	Radio-pharmaceuticals	A9590: 1 millicurie (mCi)	Dosimetric: 30 mCi/2 mL SDV Therapeutic: 337 mCi/22.5 mL SDV	Medicaid	Covered	No	No PA Required
Azedra (iobenguane I-131)	A9699, A9590, C9407, C9408	iobenguane I-131	Radio-pharmaceuticals	A9590: 1 millicurie (mCi)	Dosimetric: 30 mCi/2 mL SDV Therapeutic: 337 mCi/22.5 mL SDV	Medicare	Medicare Chemo	No	PA Required (Cancer Therapy) – See Medicare Part B Oncology Prior Authorization form
Balfaxar (prothrombin complex concentrate (human))	J7165	prothrombin complex concentrate (human)	Miscellaneous	Per I.U.	500 Unit, 1000 Unit Kit	Commercial	non-specialty	No	No PA Required
Balfaxar (prothrombin complex concentrate (human))	J7165	prothrombin complex concentrate (human)	Miscellaneous	Per I.U.	500 Unit, 1000 Unit Kit	Medicaid	Covered	No	No PA Required
Balfaxar (prothrombin complex concentrate (human))	J7165	prothrombin complex concentrate (human)	Miscellaneous	Per I.U.	500 Unit, 1000 Unit Kit	Medicare	non-specialty	No	No PA Required
Barhemsys (amisulpride)	J0184	amisulpride	Miscellaneous	1 mg	5 mg/ 2 mL SDV 10 mg/ 4mL MDV	Commercial	Not covered	No	**Not covered**
Barhemsys (amisulpride)	J0184	amisulpride	Miscellaneous	1 mg	5 mg/ 2 mL SDV 10 mg/ 4mL MDV	Medicaid	Covered	No	No PA Required
Barhemsys (amisulpride)	J0184	amisulpride	Miscellaneous	1 mg	5 mg/ 2 mL SDV 10 mg/ 4mL MDV	Medicare	NPS	No	PA required - See Medicare Medical Part B prior authorization form
Bavencio (avelumab)	J9023	avelumab	Oncology	10 mg	200 mg/10 mL SDV	Commercial	Pref. Specialty	YES	PA required - see medical oncology prior authorization form for criteria
Bavencio (avelumab)	J9023	avelumab	Oncology	10 mg	200 mg/10 mL SDV	Medicaid	Covered	No	No PA Required
Bavencio (avelumab)	J9023	avelumab	Oncology	10 mg	200 mg/10 mL SDV	Medicare	Medicare Chemo	No	PA Required (Cancer Therapy) – See Medicare Part B Oncology Prior Authorization form
Baxdela (delafloxacin)	C9462	delafloxacin	Antimicrobial	1 mg	300 mg SDV	Commercial	Not covered	No	**Not covered**
Baxdela (delafloxacin)	C9462	delafloxacin	Antimicrobial	1 mg	300 mg SDV	Medicaid	Not Covered	No	**Not covered**
Baxdela (delafloxacin)	C9462	delafloxacin	Antimicrobial	1 mg	300 mg SDV	Medicare	NPS	No	PA required - See Medicare Medical Part B prior authorization form
Bebtelovimab	Q0222	Bebtelovimab	COVID 19	175 mg	175 mg/2 mL SDV	Commercial	Not Covered	No	Not Covered for commercially available products after 11-30-2022 (EUA Revoked)
Bebtelovimab	Q0222	Bebtelovimab	COVID 19	175 mg	175 mg/2 mL SDV	Medicaid	Not Covered	No	Not Covered for commercially available products after 11-30-2022 (EUA Revoked)
Bebtelovimab	Q0222	Bebtelovimab	COVID 19	175 mg	175 mg/2 mL SDV	Medicare	Not Covered	No	Not Covered for commercially available products after 11-30-2022 (EUA Revoked)
Beleodaq (belinostat)	J9032	belinostat	Oncology	10 mg	500 mg SDV	Commercial	Pref. Specialty	No	PA required - see medical oncology prior authorization form for criteria
Beleodaq (belinostat)	J9032	belinostat	Oncology	10 mg	500 mg SDV	Medicaid	Covered	No	No PA Required
Beleodaq (belinostat)	J9032	belinostat	Oncology	10 mg	500 mg SDV	Medicare	Medicare Chemo	No	No PA required
Belrapzo (bendamustine HCl)	J9036	bendamustine	Oncology	1 mg	100 mg/4 mL SDV	Commercial	Non-specialty	No	No PA required
Belrapzo (bendamustine HCl)	J9036	bendamustine	Oncology	1 mg	100 mg/4 mL SDV	Medicaid	Covered	No	No PA required
Belrapzo (bendamustine HCl)	J9036	bendamustine	Oncology	1 mg	100 mg/4 mL SDV	Medicare	Medicare Chemo	No	No PA required
Bendeka (bendamustine HCl)	J9034	bendamustine	Oncology	1 mg	100 mg/4 mL SDV	Commercial	Non-specialty	No	No PA required
Bendeka (bendamustine HCl)	J9034	bendamustine	Oncology	1 mg	100 mg/4 mL SDV	Medicaid	Covered	No	No PA required
Bendeka (bendamustine HCl)	J9034	bendamustine	Oncology	1 mg	100 mg/4 mL SDV	Medicare	Medicare Chemo	No	No PA required
BeneFIX (Antihemophilic Factor IX)	J7195	Antihemophilic Factor IX	Hemophilia			Commercial	Refer to ADL	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
BeneFIX (Antihemophilic Factor IX)	J7195	Antihemophilic Factor IX	Hemophilia			Medicaid	Not Covered	No	Refer to the Medicaid Approved Drug List (ADL) for pharmacy benefit coverage. For one-time doses required for planned outpatient procedures (professional/facility claims), authorizations will be reviewed for medical necessity according to the Hemophilia Management Medical Policy 91569
BeneFIX (Antihemophilic Factor IX)	J7195	Antihemophilic Factor IX	Hemophilia			Medicare	Pref. Specialty	No	No PA required
Benlysta IV (belimumab) ***vial***	J0490	belimumab	Lupus	10 mg	120 mg, 400 mg SDV	Commercial	Pref. Specialty	YES	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth Forms tab.
Benlysta IV (belimumab) ***vial***	J0490	belimumab	Lupus	10 mg	120 mg, 400 mg SDV	Medicaid	Covered	YES	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth Forms tab.
Benlysta IV (belimumab) ***vial***	J0490	belimumab	Lupus	10 mg	120 mg, 400 mg SDV	Medicare	Pref. Specialty	No	PA Required - click here for criteria. Link for the Prior Authorization form is on the 'General Prior Auth Forms' tab.
Benlysta SC (belimumab) ***Autoinjector and prefilled syringe***	J0490	belimumab	Lupus	10 mg	200 mg/mL syringe/autoinjector	Commercial	Refer to ADL	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Benlysta SC (belimumab) ***Autoinjector and prefilled syringe***	J0490	belimumab	Lupus	10 mg	200 mg/mL syringe/autoinjector	Medicaid	Not Covered	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Benlysta SC (belimumab) ***Autoinjector and prefilled syringe***	J0490	belimumab	Lupus	10 mg	200 mg/mL syringe/autoinjector	Medicare	Refer to ADL	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Beovu (brolucizumab-dbll)	J0179	brolucizumab	Ophthalmic	1 mg	6 mg/0.05 mL SDV	Commercial	NPS	No	No PA required when billed for the following ICD-10 code: H35.3210-H35.3213, H35.3220-H32.3223, H35.3230-H35.3233, H35.3290-H35.3293
Beovu (brolucizumab-dbll)	J0179	brolucizumab	Ophthalmic	1 mg	6 mg/0.05 mL SDV	Medicaid	Covered	No	No PA required when billed for the following ICD-10 code: H35.3210-H35.3213, H35.3220-H32.3223, H35.3230-H35.3233, H35.3290-H35.3293
Beovu (brolucizumab-dbll)	J0179	brolucizumab	Ophthalmic	1 mg	6 mg/0.05 mL SDV	Medicare	NPS	No	No PA required when billed for the following ICD-10 code: H35.3210-H35.3213, H35.3220-H32.3223, H35.3230-H35.3233, H35.3290-H35.3293 All other ICD-10 diagnoses: PA required - See Medicare Medical Part B prior authorization form
Beqvez (fidanacogene elaparvovec-dzkt)	J1414	fidanacogene elaparvovec-dzkt	Gene/Cellular Therapy	Per treatment	1 × 10^13 vg/mL	Commercial	Gene Therapy	YES	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth Forms tab.
Beqvez (fidanacogene elaparvovec-dzkt)	J1414	fidanacogene elaparvovec-dzkt	Gene/Cellular Therapy	Per treatment	1 × 10^13 vg/mL	Medicaid	Not Covered	No	Not Covered (Pending MDHHS review for Carve-Out consideration)
Beqvez (fidanacogene elaparvovec-dzkt)	J1414	fidanacogene elaparvovec-dzkt	Gene/Cellular Therapy	Per treatment	1 × 10^13 vg/mL	Medicare	Gene Therapy	No	PA Required - click here for criteria. Link for the Prior Authorization form is on the 'General Prior Auth Forms' tab.
Berinert (C-1 esterase inhibitor [human])	J0597	C-1 esterase inhibitor	Hereditary Angioedema agent	10 units	500 unit SDV	Commercial	Refer to ADL	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Berinert (C-1 esterase inhibitor [human])	J0597	C-1 esterase inhibitor	Hereditary Angioedema agent	10 units	500 unit SDV	Medicaid	Not Covered	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Berinert (C-1 esterase inhibitor [human])	J0597	C-1 esterase inhibitor	Hereditary Angioedema agent	10 units	500 unit SDV	Medicare	Refer to ADL	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Besponsa (inotuzumab ozogamicin)	J9229	inotuzumab ozogamicin	Oncology	0.1 mg	0.9 mg SDV	Commercial	Pref. Specialty	No	PA required - see medical oncology prior authorization form for criteria
Besponsa (inotuzumab ozogamicin)	J9229	inotuzumab ozogamicin	Oncology	0.1 mg	0.9 mg SDV	Medicaid	Covered	No	No PA Required
Besponsa (inotuzumab ozogamicin)	J9229	inotuzumab ozogamicin	Oncology	0.1 mg	0.9 mg SDV	Medicare	Medicare Chemo	No	PA Required (Cancer Therapy) – See Medicare Part B Oncology Prior Authorization form
Bethkis (tobramycin) INHALATION	J7682	tobramycin	inhalation	300 mg	300 mg/4 mL SD ampule	Medicare	NPS	No	Part B vs Part D – See Approved Drug List for covered formulations under Part D - see the Part B vs Part D coverage determination form for criteria
Beyfortus (nirsevimab)	90380 - 0.5ml 90381 - 1 ml	nirsevimab	RSV Monoclonal Antibody	1 dose	50 mg/0.5 mL, 100 mg/1 mL SDV	Commercial	Preventative	No	No PA Required for infants up to 8 months. All others - PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth Forms tab.
Beyfortus (nirsevimab)	90380 - 0.5ml 90381 - 1 ml	nirsevimab	RSV Monoclonal Antibody	1 dose	50 mg/0.5 mL, 100 mg/1 mL SDV	Medicaid	Not Covered	No	**Not Covered (Covered through Vaccine for Children)**
Beyfortus (nirsevimab)	90380 - 0.5ml 90381 - 1 ml	nirsevimab	RSV Monoclonal Antibody	1 dose	50 mg/0.5 mL, 100 mg/1 mL SDV	Medicare	Covered	No	PA required - See Medicare Medical Part B prior authorization form
BiCNU (carmustine)	J9050	carmustine	Oncology	100 mg	100 mg SDV	Commercial	Non-specialty	No	No PA required
BiCNU (carmustine)	J9050	carmustine	Oncology	100 mg	100 mg SDV	Medicaid	Covered	No	No PA required
BiCNU (carmustine)	J9050	carmustine	Oncology	100 mg	100 mg SDV	Medicare	Non-specialty	No	No PA required
Bivigam (immune globulin) intravenous	J1556	IVIG	Immune Globulin	500 mg	5 gm SDV	Commercial	Not Covered	No	**Not Covered**
Bivigam (immune globulin) intravenous	J1556	IVIG	Immune Globulin	500 mg	5 gm SDV	Medicaid	Not Covered	No	**Not Covered**
Bivigam (immune globulin) intravenous	J1556	IVIG	Immune Globulin	500 mg	5 gm SDV	Medicare	NPS	No	Part B vs Part D – PA Required – click here for criteria. See Approved Drug List for covered formulations under Part D
Blenrep (belantamab mafodotin-blmf)	J9037	belantamab mafodotin-blmf	Oncology	0.5 mg	100 mg SDV	Commercial	NPS	No	PA Required - GSK initiated Market Withdrawal on 11-22-2022
Blenrep (belantamab mafodotin-blmf)	J9037	belantamab mafodotin-blmf	Oncology	0.5 mg	100 mg SDV	Medicaid	Not Covered	No	Not Covered as of GSK initiated Market Withdrawal on 11-22-2022
Blenrep (belantamab mafodotin-blmf)	J9037	belantamab mafodotin-blmf	Oncology	0.5 mg	100 mg SDV	Medicare	Medicare Chemo	No	PA Required - GSK initiated Market Withdrawal on 11-22-2022
Bleomycin	J9040	bleomycin sulfate	Oncology	15 units	15 unit, 30 unit SDV	Commercial	Non-specialty	No	No PA required
Bleomycin	J9040	bleomycin sulfate	Oncology	15 units	15 unit, 30 unit SDV	Medicaid	Covered	No	No PA required
Bleomycin	J9040	bleomycin sulfate	Oncology	15 units	15 unit, 30 unit SDV	Medicare	Non-specialty	No	No PA required
Blincyto (blinatumomab)	J9039	blinatumomab	Oncology	1 mcg	35 mcg SDV	Commercial	Pref. Specialty	No	PA required - see medical oncology prior authorization form for criteria
Blincyto (blinatumomab)	J9039	blinatumomab	Oncology	1 mcg	35 mcg SDV	Medicaid	Covered	No	No PA Required
Blincyto (blinatumomab)	J9039	blinatumomab	Oncology	1 mcg	35 mcg SDV	Medicare	Medicare Chemo	No	PA Required (Cancer Therapy) – See Medicare Part B Oncology Prior Authorization form
Boniva IV (ibandronate sodium)	J1740	ibandronate		1 mg	3 mg/3 mL SD syringe	Commercial	Not covered	No	**Brand not covered, use generic**
Boniva IV (ibandronate sodium)	J1740	ibandronate	Bone modifying agent	1 mg	3 mg/3 mL SD syringe	Medicaid	Not Covered	No	**Brand not covered, use generic**
Boniva IV (ibandronate sodium)	J1740	ibandronate	Bone modifying agent	1 mg	3 mg/3 mL SD syringe	Medicare	Pref. Specialty	No	PA Required - click here for criteria. Link for the Prior Authorization form is on the 'General Prior Auth Forms' tab.
bortezomib - Hospira Brand ONLY	J9049	bortezomib	Oncology	0.1 mg	3.5 mg SDV	Medicaid	Covered	No	No PA Required
bortezomib - Hospira Brand ONLY	J9049	bortezomib	Oncology	0.1 mg	3.5 mg SDV	Medicare	Medicare Chemo	No	No PA Required
bortezomib - Hospira Brand ONLY	J9049	bortezomib	Oncology	0.1 mg	3.5 mg SDV	Commercial	Pref. Specialty	No	No PA required for ICD-10 codes C90.00-C90.32, C83.10-C83.19 and E85.81 - for all other diagnoses, see medical oncology prior authorization form for criteria.

Drug	Code	Generic	Category	Billing Unit	How Supplied	Line of Business	Coverage Level	Site Of Service	Comment
bortezomib - Dr. Reddy's Brand ONLY	J9046	bortezomib	Oncology	0.1 mg	3.5 mg SDV	Commercial	Pref. Specialty	No	No PA required for ICD-10 codes C90.00-C90.32, C83.10-C83.19 and E85.81 - for all other diagnoses, see medical oncology prior authorization form for criteria.
bortezomib - Dr. Reddy's Brand ONLY	J9046	bortezomib	Oncology	0.1 mg	3.5 mg SDV	Medicaid	Covered	No	No PA Required
bortezomib - Dr. Reddy's Brand ONLY	J9046	bortezomib	Oncology	0.1 mg	3.5 mg SDV	Medicare	Medicare Chemo	No	No PA required

Drug	Code	Generic	Category	Billing Unit	How Supplied	Line of Business	Coverage Level	Site Of Service	Comment
bortezomib - Fresenius Kabi Brand ONLY NDC 63323-0721-10	J9048	bortezomib	Oncology	0.1 mg	3.5 mg SDV	Commercial	Pref. Specialty	No	No PA required for ICD-10 codes C90.00-C90.32, C83.10-C83.19 and E85.81 - for all other diagnoses, see medical oncology prior authorization form for criteria.
bortezomib - Fresenius Kabi Brand ONLY NDC 63323-0721-10	J9048	bortezomib	Oncology	0.1 mg	3.5 mg SDV	Medicaid	Covered	No	No PA Required
bortezomib - Fresenius Kabi Brand ONLY NDC 63323-0721-10	J9048	bortezomib	Oncology	0.1 mg	3.5 mg SDV	Medicare	Medicare Chemo	No	No PA Required
Botox (onabotulinumtoxinA)	J0585	botulinum toxin A	botulinum toxin	1 unit	100 unit, 200 unit SDV	Commercial	Pref. Specialty	No	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth. Forms tab. No auth required when billed by: Neurologist (NEUR), Rehab Medicine (PMR) or Physical Med & Rehab (PT)
Botox (onabotulinumtoxinA)	J0585	botulinum toxin A	botulinum toxin	1 unit	100 unit, 200 unit SDV	Medicaid	Covered	No	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth. Forms tab. No auth required when billed by: Neurologist (NEUR), Rehab Medicine (PMR) or Physical Med & Rehab (PT)
Botox (onabotulinumtoxinA)	J0585	botulinum toxin A	botulinum toxin	1 unit	100 unit, 200 unit SDV	Medicare	Pref. Specialty	No	PA Required - click here for criteria. Link for the Prior Authorization form is on the 'General Prior Auth. Forms' tab. No auth required when billed by: Neurologist (NEUR), Rehab Medicine (PMR) or Physical Med & Rehab (PT)
Brevibloc (esmolol)	J1805	esmolol	Miscellaneous	10 mg		Commercial	Non-specialty	No	No PA required
Brevibloc (esmolol)	J1805	esmolol	Miscellaneous	10 mg		Medicaid	Covered	No	No PA required
Brevibloc (esmolol)	J1805	esmolol	Miscellaneous	10 mg		Medicare	Non-specialty	No	No PA required
Breyanzi (lisocabtagene maraleucel)	Q2054	lisocabtagene maraleucel	Gene/Cellular Therapy	per dose	SD infusion bag	Commercial	Gene Therapy	YES	PA Required – see medical oncology prior authorization form for criteria. Coverage of Breyanzi is dependent on member's eligibility and benefit plan documents. Priority Health may request documentation, not more frequently than biannually, of follow-up patient assessment(s). Breyanzi will not be authorized for use in patients with primary central nervous system lymphoma; OR that have received a previous treatment course of Breyanzi or another CD19-directed chimeric antigen receptor (CAR) T-cell therapy. The safety and effectiveness of repeat administration have not been evaluated (one treatment per lifetime)
Breyanzi (lisocabtagene maraleucel)	Q2054	lisocabtagene maraleucel	Gene/Cellular Therapy	per dose	SD infusion bag	Medicaid	Carve Out	No	Contact Fee for Service Medicaid for coverage
Breyanzi (lisocabtagene maraleucel)	Q2054	lisocabtagene maraleucel	Gene/Cellular Therapy	per dose	SD infusion bag	Medicare	Medicare Chemo	No	PA Required - click here for criteria. Link for the Prior Authorization form is on the 'General Prior Auth. Forms' tab.
Brineura (cerliponase alfa)	J0567	celiponase alfa	Enzyme deficiency	1 mg	150 mg/5 mL SDV	Commercial	Pref. Specialty	No	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth. Forms tab.
Brineura (cerliponase alfa)	J0567	celiponase alfa	Enzyme deficiency	1 mg	150 mg/5 mL SDV	Medicaid	Covered	No	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth. Forms tab.
Brineura (cerliponase alfa)	J0567	celiponase alfa	Enzyme deficiency	1 mg	150 mg/5 mL SDV	Medicare	Pref. Specialty	No	PA required - See Medicare Medical Part B prior authorization form
Briumvi (ublituximab-xiiy)	J2329	ublituximab	Multiple Sclerosis (MS) agent	1 mg	150mg/6ml SDV	Commercial	Pref. Specialty	YES	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth. Forms tab.
Briumvi (ublituximab-xiiy)	J2329	ublituximab	Multiple Sclerosis (MS) agent	1 mg	150mg/6ml SDV	Medicaid	Covered	YES	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth. Forms tab.
Briumvi (ublituximab-xiiy)	J2329	ublituximab	Multiple Sclerosis (MS) agent	1 mg	150mg/6ml SDV	Medicare	Pref. Specialty	No	No PA required
Brixadi (buprenorphine) ***(monthly)***	J0578	buprenorphine	Opioid use disorder	1 mg	Monthly - 64mg/0.18ml, 96mg/0.27ml, 128mg/0.36ml	Commercial	Pref. Specialty	No	No PA Required
Brixadi (buprenorphine) ***(monthly)***	J0578	buprenorphine	Opioid use disorder	1 mg	Monthly - 64mg/0.18ml, 96mg/0.27ml, 128mg/0.36ml	Medicaid	Carve Out	No	Contact Fee for Service Medicaid for coverage
Brixadi (buprenorphine) ***(monthly)***	J0578	buprenorphine	Opioid use disorder	1 mg	Monthly - 64mg/0.18ml, 96mg/0.27ml, 128mg/0.36ml	Medicare	Pref. Specialty	No	No PA Required
Brixadi (buprenorphine) ***(weekly)***	J0577	buprenorphine	Opioid use disorder	1 mg	Weekly - 8mg/0.16ml, 16mg/0.32ml, 24mg/0.48ml, 32mg/0.64ml	Commercial	Pref. Specialty	No	No PA Required
Brixadi (buprenorphine) ***(weekly)***	J0577	buprenorphine	Opioid use disorder	1 mg	Weekly - 8mg/0.16ml, 16mg/0.32ml, 24mg/0.48ml, 32mg/0.64ml	Medicaid	Carve Out	No	Contact Fee for Service Medicaid for coverage
Brixadi (buprenorphine) ***(weekly)***	J0577	buprenorphine	Opioid use disorder	1 mg	Weekly - 8mg/0.16ml, 16mg/0.32ml, 24mg/0.48ml, 32mg/0.64ml	Medicare	Pref. Specialty	No	No PA Required
Brovana (arformoterol)	J7605	arformoterol	inhalation	15 mcg	15 mcg/2 mL SDV	Medicare	Non-specialty	No	Part B vs Part D – See Approved Drug List for covered formulations under Part D - see the Part B vs Part D coverage determination form for criteria
bupivacaine - not otherwise specified	J0665	bupivacaine	miscellaneous	0.5 mg		Commercial	non-specialty	No	No PA Required
bupivacaine - not otherwise specified	J0665	bupivacaine	miscellaneous	0.5 mg		Medicaid	non-specialty	No	No PA Required
bupivacaine - not otherwise specified	J0665	bupivacaine	miscellaneous	0.5 mg		Medicare	non-specialty	No	Only covered for medically accepted indications
Buprenex (buprenorphine)	J0592	buprenorphine	Analgesic	0.1 mg	0.3 mg/mL SD cartidge	Commercial	Non-specialty	No	No PA required
Buprenex (buprenorphine)	J0592	buprenorphine	Analgesic	0.1 mg	0.3 mg/mL SD cartidge	Medicaid	Covered	No	No PA required
Buprenex (buprenorphine)	J0592	buprenorphine	Analgesic	0.1 mg	0.3 mg/mL SD cartidge	Medicare	Non-specialty	No	No PA required
Byooviz (ranibizumab-nuna)	Q5124	ranibizumab-nuna	Ophthalmic	0.1 mg		Commercial	Pref. Specialty	No	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth. Forms tab.
Byooviz (ranibizumab-nuna)	Q5124	ranibizumab-nuna	Ophthalmic	0.1 mg		Medicaid	Covered	No	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth. Forms tab.
Byooviz (ranibizumab-nuna)	Q5124	ranibizumab	Ophthalmic	0.1 mg		Medicare	Pref. Specialty	No	No PA required when billed for the following ICD-10 codes: E08.311, E08.319, E08.3211–E08.3213, E08.3291 – E08.3293, E08.3311–E08.3313, E08.3391 – E08.3393, E08.3411– E08.3413, E08.3491 – E08.3493, E08.3511- E08.3513, E08.3521 – E08.3523, E08.3531 – E08.3533, E08.3541 – E08.3543, E08.3551 – E08.3553, E08.3591 – E08.3593, E09.311, E09.319, E09.3211-E09.3213, E09.3291 – E09.3291, E09.3311-E09.3313, E09.3391 – E09.3393, E09.3411-E09.3413, E09.3491 – E09.3493, E09.3511- E09.3513, E09.3521 – E09.3523, E09.3531 – E09.3533, E09.3541 – E09.3543, E09.3551 – E09.3553, E09.3591 – E09.3593, E10.311, E10.319, E10.3211- E10.3213, E10.3291 - E10.3293, E10.3311- E10.3313, E10.3391 - E10.3393, E10.3411- E10.3413, E10.3491 - E10.3493, E10.3511-E10.3513, E10.3591-E10.3599, E11.3211-E11.3219, E11.3291-E11.3299, E11.3311- E11.3313, E11.3391 - E11.3393, E11.3411- E11.3413, E11.3491 - E11.3493, E11.3511 - E11.3513, E11.3521 – E11.3523, E11.3531 – E11.3533, E11.3541 – E11.3543, E11.3551 – E11.3553, E11.3591 – E11.3593, E13.311, E13.319, E13.3211- E13.3213, E13.3291 - E13.3293, E13.3311- E13.3313, E13.3391 - E13.3393, E13.3411- E13.3413, E13.3491 - E13.3493, E13.3511- E13.3513, E13.3521 – E13.3523, E13.3531 – E13.3533, E13.3541 – E13.3543, E13.3551 – E13.3553, E13.3591 – E13.3593, H34.8110, H34.8120, H34.8130, H34.8310, H34.8320, H34.8330, H34.8390, H35.051 - H35.053, H35.3210 - H35.3233, H35.351 – H35.353, H44.21 – H44.2E9
Cabenuva (cabotegravir and rilpivirine)	J0741	cabotegravir and rilpivirine	HIV agent	2mg/3mg	400 mg-600 mg/2 mL SDV, 600 mg-900mg/3 mL SDV	Commercial	Pref. Specialty	No	No PA required
Cabenuva (cabotegravir and rilpivirine)	J0741	cabotegravir and rilpivirine	HIV agent	2mg/3mg	400 mg-600 mg/2 mL SDV, 600 mg-900mg/3 mL SDV	Medicaid	Carve Out	No	Contact Fee for Service Medicaid for coverage
Cabenuva (cabotegravir and rilpivirine)	J0741	cabotegravir and rilpivirine	HIV agent	2mg/3mg	400 mg-600 mg/2 mL SDV, 600 mg-900mg/3 mL SDV	Medicare	Pref. Specialty	No	PA required - See Medicare Medical Part B prior authorization form
Cablivi (caplacizumab-yhdp)	J3590*, C9047	caplacizumab-yhdp	Miscellaneous	C9047: 1 mg	11 mg SDV	Commercial	Pref. Specialty	No	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth. Forms tab.
Cablivi (caplacizumab-yhdp)	J3590*, C9047	caplacizumab-yhdp	Miscellaneous	C9047: 1 mg	11 mg SDV	Medicaid	Not Covered	No	**Not covered**
Cablivi (caplacizumab-yhdp)	C9047	caplacizumab-yhdp	Miscellaneous	C9047: 1 mg	11 mg SDV	Medicare	Pref. Specialty	No	PA required - See Medicare Medical Part B prior authorization form
Calcijex (calcitriol)	J0636	calcitriol		0.1 mcg	1 mcg/mL ampule	Commercial	Non-specialty	No	No PA required
Calcijex (calcitriol)	J0636	calcitriol		0.1 mcg	1 mcg/mL ampule	Medicaid	Covered	No	No PA required
Calcijex (calcitriol)	J0636	calcitriol		0.1 mcg	1 mcg/mL ampule	Medicare	Non-specialty	No	No PA required
Calcium Acetate (*phosphate binder*)	J0615 (For ESRD on dialysis)	calcium acetate	phospate binder	23 mg	667 mg capsules/tablets	Commercial	Refer to ADL	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Calcium Acetate (*phosphate binder*)	J0615 (For ESRD on dialysis)	calcium acetate	phospate binder	23 mg	667 mg capsules/tablets	Medicaid	Not separately payable	No	Not separately payable
Calcium Acetate (*phosphate binder*)	J0615 (For ESRD on dialysis)	calcium acetate	phospate binder	23 mg	667 mg capsules/tablets	Medicare	Not separately payable	No	Included in ESRD PPS and not separately payable under Part B
Camcevi (leuprolide)	J1952	leuprolide	Oncology	1 mg	42mg SD syringe	Commercial	Pref. Specialty	YES	No PA required
Camcevi (leuprolide)	J1952	leuprolide	Oncology	1 mg	42mg SD syringe	Medicaid	Covered	No	No PA required
Camcevi (leuprolide)	J1952	leuprolide	Oncology	1 mg	42mg SD syringe	Medicare	Medicare Chemo	No	No PA required
Camptosar (irinotecan)	J9206	irinotecan	Oncology	20 mg	40 mg/2 mL, 100 mg/5 mL, 300 mg/15 mL, 500 mg/25 mL SDV	Commercial	Pref. Specialty	No	No PA required
Camptosar (irinotecan)	J9206	irinotecan	Oncology	20 mg	40 mg/2 mL, 100 mg/5 mL, 300 mg/15 mL, 500 mg/25 mL SDV	Medicaid	Covered	No	No PA required
Camptosar (irinotecan)	J9206	irinotecan	Oncology	20 mg	40 mg/2 mL, 100 mg/5 mL, 300 mg/15 mL, 500 mg/25 mL SDV	Medicare	Pref. Specialty	No	No PA required
Cancidas (caspofungin)	J0637	caspofungin	Antimicrobial	5 mg	50 mg, 70 mg SDV	Commercial	Non-specialty	No	No PA required
Cancidas (caspofungin)	J0637	caspofungin	Antimicrobial	5 mg	50 mg, 70 mg SDV	Medicaid	Covered	No	No PA required
Cancidas (caspofungin)	J0637	caspofungin	Antimicrobial	5 mg	50 mg, 70 mg SDV	Medicare	Non-specialty	No	No PA required

Drug	Code	Generic	Category	Billing Unit	How Supplied	Line of Business	Coverage Level	Site Of Service	Comment
Carimune (immune globulin) intravenous	J1566	IVIG	Immune Globulin	500 mg	6 gm, 12 gm SDV	Commercial	Not Covered	No	**Not Covered**
Carimune (immune globulin) intravenous	J1566	IVIG	Immune Globulin	500 mg	6 gm, 12 gm SDV	Medicaid	Not Covered	No	**Not Covered**
Carimune (immune globulin) intravenous	J1566	IVIG	Immune Globulin	500 mg	6 gm, 12 gm SDV	Medicare	Pref. Specialty	No	Part B vs Part D – See Approved Drug List for covered formulations under Part D - see the Part B vs Part D coverage determination form for criteria
Carmustine - Accord	J9052	carmustine	Oncology	100 mg	100 mg SDV	Commercial	Non-specialty	No	No PA required
Carmustine - Accord	J9052	carmustine	Oncology	100 mg	100 mg SDV	Medicaid	Covered	No	No PA required
Carmustine - Accord	J9052	carmustine	Oncology	100 mg	100 mg SDV	Medicare	Non-specialty	No	No PA required
Carnitor (levocarnitine)	J1955	levocarnitine	Miscellaneous	1 gm	1 gm/5 mL SDV	Commercial	Non-specialty	No	No PA required
Carnitor (levocarnitine)	J1955	levocarnitine	Miscellaneous	1 gm	1 gm/5 mL SDV	Medicaid	Covered	No	No PA required
Carnitor (levocarnitine)	J1955	levocarnitine	Miscellaneous	1 gm	1 gm/5 mL SDV	Medicare	Non-specialty	No	No PA required
Carvykti (ciltacabtagene autoleucel)	Q2056	ciltacabtagene autoleucel	Gene/Cellular Therapy	per dose	SD infusion bag	Commercial	Gene Therapy	YES	PA Required – see medical oncology prior authorization form for criteria. Coverage of Carvykti is dependent on member's eligibility and benefit plan documents. Priority Health may request documentation, not more frequently than biannually, of follow-up patient assessment(s). Carvykti will not be authorized for use in patients that have received a previous treatment course of Carvykti or another anti-BCMA02 chimeric antigen-directed receptor (CAR) T-cell therapy. The safety and effectiveness of repeat administration have not been evaluated (one treatment per lifetime).
Carvykti (ciltacabtagene autoleucel)	Q2056	ciltacabtagene autoleucel	Gene/Cellular Therapy	per dose	SD infusion bag	Medicaid	Carve Out	No	Contact Fee for Service Medicaid for coverage
Carvykti (ciltacabtagene autoleucel)	Q2056	ciltacabtagene autoleucel	Gene/Cellular Therapy	per dose	SD infusion bag	Medicare	Medicare Chemo	No	PA Required - click here for criteria. Link for the Prior Authorization form is on the 'General Prior Auth Forms' tab.
Casgevy (exagamglogene autotemcel)	J3392	exagamglogene autotemcel	Gene/Cellular Therapy	per treatment	3 × 10^6 CD34+ cells per kg of body weight, which may be composed of multiple vials.	Commercial	Gene Therapy	YES	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth Forms tab.
Casgevy (exagamglogene autotemcel)	J3392	exagamglogene autotemcel	Gene/Cellular Therapy	per treatment	3 × 10^6 CD34+ cells per kg of body weight, which may be composed of multiple vials.	Medicaid	Carve Out	No	Contact Fee for Service Medicaid for coverage
Casgevy (exagamglogene autotemcel)	J3392	exagamglogene autotemcel	Gene/Cellular Therapy	per treatment	3 × 10^6 CD34+ cells per kg of body weight, which may be composed of multiple vials.	Medicare	Gene Therapy	No	PA Required - click here for criteria. Link for the Prior Authorization form is on the 'General Prior Auth Forms' tab.
Cefazolin sodium - Baxter	J0689	cefazolin	Antimicrobial	500 mg	various	Commercial	Non-specialty	No	No PA required
Cefazolin sodium - Baxter	J0689	cefazolin	Antimicrobial	500 mg	various	Medicaid	Non-specialty	No	No PA required
Cefazolin sodium - Baxter	J0689	cefazolin	Antimicrobial	500 mg	various	Medicare	Non-specialty	No	No PA required
Cefazolin sodium - Hikma	J0688	cefazolin	Antimicrobial	500 mg	various	Commercial	Non-specialty	No	No PA required
Cefazolin sodium - Hikma	J0688	cefazolin	Antimicrobial	500 mg	various	Medicaid	Non-specialty	No	No PA required
Cefazolin sodium - Hikma	J0688	cefazolin	Antimicrobial	500 mg	various	Medicare	Non-specialty	No	No PA required
Cefazolin sodium - WG Critical Care	J0687	cefazolin	Antimicrobial	500 mg	various	Commercial	Non-specialty	No	No PA required
Cefazolin sodium - WG Critical Care	J0687	cefazolin	Antimicrobial	500 mg	various	Medicaid	Non-specialty	No	No PA required
Cefazolin sodium - WG Critical Care	J0687	cefazolin	Antimicrobial	500 mg	various	Medicare	Non-specialty	No	No PA required
Cellcept (Mycophenolate mofetil) ORAL ONLY	J7517	mycophenolate	Immunosuppressive agent	250 mg	250 mg capsule, 500 mg tablet	Medicare	Non-specialty	No	Part B vs Part D – See Approved Drug List for covered formulations under Part D - see the Part B vs Part D coverage determination form for criteria
Cerezyme (imiglucerase)	J1786	imiglucerase	Enzyme deficiency	10 units	400 unit SDV	Commercial	Pref. Specialty	YES	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth Forms tab.
Cerezyme (imiglucerase)	J1786	imiglucerase	Enzyme deficiency	10 units	400 unit SDV	Medicaid	Covered	YES	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth Forms tab.
Cerezyme (imiglucerase)	J1786	imiglucerase	Enzyme deficiency	10 units	400 unit SDV	Medicare	Pref. Specialty	No	No PA required
Cimerli (ranibizumab-eqrn)	Q5128	ranibizumab	Ophthalmic	Additional information required: National Drug Code (NDC), Strength, Dosage administered, Route of administration.		Commercial	Pref. Specialty	No	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth Forms tab.
Cimerli (ranibizumab-eqrn)	Q5128	ranibizumab	Ophthalmic	Additional information required: National Drug Code (NDC), Strength, Dosage administered, Route of administration.		Medicaid	Covered	No	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth Forms tab.
Cimerli (ranibizumab-eqrn)	Q5128	ranibizumab	Ophthalmic	Additional information required: National Drug Code (NDC), Strength, Dosage administered, Route of administration.		Medicare	Pref. Specialty	No	No PA required when billed for the following ICD-10 codes: E08.311, E08.319, E08.3211-E08.3213, E08.3291 – E08.3293, E08.3311-E08.3313, E08.3391 – E08.3393, E08.3411- E08.3413, E08.3491 – E08.3493, E08.3511- E08.3513, E08.3521 – E08.3523, E08.3531 – E08.3533, E08.3541 – E08.3543, E08.3551 – E08.3553, E08.3591 – E08.3593, E09.311, E09.319, E09.3211-E09.3213, E09.3291 – E09.3293, E09.3311-E09.3313, E09.3391 – E09.3393, E09.3411- E09.3413, E09.3491 – E09.3493, E09.3511- E09.3513, E09.3521 – E09.3523, E09.3531 – E09.3533, E09.3541 – E09.3543, E09.3551 – E09.3553, E09.3591 – E09.3593, E10.311, E10.319, E10.3211- E10.3213, E10.3291 - E10.3293, E10.3311 - E10.3313, E10.3391 - E10.3393, E10.3411- E10.3413, E10.3491 - E10.3493, E10.3511-E10.3513, E10.3591-E10.3599, E11.3211-E11.3219, E11.3291-E11.3299, E11.3311- E11.3313, E11.3391 - E11.3393, E11.3411- E11.3413, E11.3491 - E11.3493, E11.3511 - E11.3513, E11.3521 – E11.3523, E11.3531 – E11.3533, E11.3541 – E11.3543, E11.3551 – E11.3553, E11.3591 – E11.3593, E13.311, E13.319, E13.3211- E13.3213, E13.3291 - E13.3293, E13.3311- E13.3313, E13.3391 - E13.3393, E13.3411- E13.3413, E13.3491 - E13.3493, E13.3511- E13.3513, E13.3521 – E13.3523, E13.3531 – E13.3533, E13.3541 – E13.3543, E13.3551 – E13.3553, E13.3591 – E13.3593, H34.8110, H34.8120, H34.8130, H34.8310, H34.8320, H34.8330, H34.8390, H35.051 - H35.053, H35.3210 - H35.3233, H35.351 – H35.353, H44.21 – H44.2E9
Cimzia (certolizumab pegol) ***lyophilized powder kit***	J0717	certolizumab pegol	Inflammatory Conditions	1 mg	200 mg SDV	Commercial	NPS	YES	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth Forms tab.
Cimzia (certolizumab pegol) ***lyophilized powder kit***	J0717	certolizumab pegol	Inflammatory Conditions	1 mg	200 mg SDV	Medicaid	Covered	YES	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth Forms tab.
Cimzia (certolizumab pegol) ***lyophilized powder kit***	J0717	certolizumab pegol	Inflammatory Conditions	1 mg	200 mg SDV	Medicare	NPS	No	PA Required - click here for criteria. Link for the Prior Authorization form is on the 'General Prior Auth Forms' tab.
Cimzia (certolizumab pegol) ***prefilled syringe***	J0717	certolizumab pegol	Inflammatory Conditions	1 mg	200 mg/mL SD sryinge	Commercial	Refer to ADL	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Cimzia (certolizumab pegol) ***prefilled syringe***	J0717	certolizumab pegol	Inflammatory Conditions	1 mg	200 mg/mL SD sryinge	Medicaid	Not Covered	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Cimzia (certolizumab pegol) ***prefilled syringe***	J0717	certolizumab pegol	Inflammatory Conditions	1 mg	200 mg/mL SD sryinge	Medicare	NPS	No	PA Required - click here for criteria. Link for the Prior Authorization form is on the 'General Prior Auth Forms' tab.
Cinqair (reslizumab)	J2786	reslizumab	Respiratory Biologic	1 mg	100 mg/10 mL SDV	Commercial	NPS	YES	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth Forms tab.
Cinqair (reslizumab)	J2786	reslizumab	Respiratory Biologic	1 mg	100 mg/10 mL SDV	Medicaid	Covered	YES	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth Forms tab.
Cinqair (reslizumab)	J2786	reslizumab	Respiratory Biologic	1 mg	100 mg/10 mL SDV	Medicare	NPS	No	PA Required - click here for criteria. Link for the Prior Authorization form is on the 'General Prior Auth Forms' tab.
Cinryze (C-1 esterase inhibitor [human])	J0598	C-1 esterase inhibitor	Hereditary Angioedema agent	10 units	500 unit SDV	Commercial	Not covered	No	**Not covered**
Cinryze (C-1 esterase inhibitor [human])	J0598	C-1 esterase inhibitor	Hereditary Angioedema agent	10 units	500 unit SDV	Medicaid	Not Covered	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Cinryze (C-1 esterase inhibitor [human])	J0598	C-1 esterase inhibitor	Hereditary Angioedema agent	10 units	500 unit SDV	Medicare	Pref. Specialty	No	PA Required - click here for criteria. Link for the Prior Authorization form is on the 'General Prior Auth Forms' tab.
Cinvanti (aprepitant emulsion)	J0185	aprepitant	Antiemetic	1 mg	130 mg/18 mL SDV	Commercial	Non-specialty	No	No PA required
Cinvanti (aprepitant emulsion)	J0185	aprepitant	Antiemetic	1 mg	130 mg/18 mL SDV	Medicaid	Covered	No	No PA required
Cinvanti (aprepitant emulsion)	J0185	aprepitant	Antiemetic	1 mg	130 mg/18 mL SDV	Medicare	Non-specialty	No	No PA required
Cleocin (clindamycin)	J0736	clindamycin	Antimicrobial	300 mg		Commercial	Non-specialty	No	No PA required
Cleocin (clindamycin)	J0736	clindamycin	Antimicrobial	300 mg		Medicaid	Covered	No	No PA required
Cleocin (clindamycin)	J0736	clindamycin	Antimicrobial	300 mg		Medicare	Non-specialty	No	No PA required
clindamycin - Baxter brand only	J0737	clindamycin	Antimicrobial	300 mg		Commercial	Not Covered	No	Not Covered until ASP established
clindamycin - Baxter brand only	J0737	clindamycin	Antimicrobial	300 mg		Medicaid	Not Covered	No	Not Covered until ASP established
clindamycin - Baxter brand only	J0737	clindamycin	Antimicrobial	300 mg		Medicare	Non-specialty	No	No PA required
Clinimix (amino acids) Injection		amino acids	TPN			Medicare		No	Part B vs Part D – See Approved Drug List for covered formulations under Part D - see the Part B vs Part D coverage determination form for criteria
Coagadex (Antihemophilic Factor X)	J7175	Antihemophilic Factor X	Hemophilia			Commercial	Refer to ADL	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Coagadex (Antihemophilic Factor X)	J7175	Antihemophilic Factor X	Hemophilia			Medicaid	Not Covered	No	Refer to the Medicaid Approved Drug List (ADL) for pharmacy benefit coverage. For one-time doses required for planned outpatient procedures (professional/facility claims), authorizations will be reviewed for medical necessity according to the Hemophilia Management Medical Policy 91569
Coagadex (Antihemophilic Factor X)	J7175	Antihemophilic Factor X	Hemophilia			Medicare	Pref. Specialty	No	No PA required
Cogentin (benztropine)	J0515	benztropine mesylate	Central Nervous System (CNS) agent	1 mg	2 mg/2 mL SDV	Commercial	Non-specialty	No	No PA required
Cogentin (benztropine)	J0515	benztropine mesylate	Central Nervous System (CNS) agent	1 mg	2 mg/2 mL SDV	Medicaid	Carve Out	No	Contact Fee for Service Medicaid for coverage
Cogentin (benztropine)	J0515	benztropine mesylate	Central Nervous System (CNS) agent	1 mg	2 mg/2 mL SDV	Medicare	Non-specialty	No	No PA required
Columvi (glofitamab-gxmb)	J9286	glofitamab	Oncology	2.5 mg		Commercial	Pref. Specialty	YES	PA required - see medical oncology prior authorization form for criteria
Columvi (glofitamab-gxmb)	J9286	glofitamab	Oncology	2.5 mg		Medicaid	Covered	No	No PA Required
Columvi (glofitamab-gxmb)	J9286	glofitamab	Oncology	2.5 mg		Medicare	Medicare Chemo	No	PA Required (Cancer Therapy) – See Medicare Part B Oncology Prior Authorization form.
Combogesic (acetaminophen/ibuprofen)	J0138	acetaminophen/ ibuprofen	analgesic	1.0 mg/3mg	1,000 mg/100 mL acetaminophen and 300 mg/100 mL ibuprofen SDV	Commercial	Not covered	No	**Not covered**
Combogesic (acetaminophen/ibuprofen)	J0138	acetaminophen/ ibuprofen	analgesic	1.0 mg/3mg	1,000 mg/100 mL acetaminophen and 300 mg/100 mL ibuprofen SDV	Medicaid	Not Covered	No	**Not covered**

Drug	Code	Generic	Category	Billing Unit	How Supplied	Line of Business	Coverage Level	Site Of Service	Comment
Combogesic (acetaminophen/ibuprofen)	J0138	acetaminophen/ ibuprofen	analgesic	1 0 mg/3mg	1,000 mg/100 mL acetaminophen and 300 mg/100 mL ibuprofen SDV	Medicare	Non-specialty	No	No PA required
Corifact (Factor XIII Concentrate (Human))	J7180	Factor XIII Concentrate (Human)	Hemophilia	1 unit	1000-1600 unit SDV	Commercial	Refer to ADL	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Corifact (Factor XIII Concentrate (Human))	J7180	Factor XIII Concentrate (Human)	Hemophilia	1 unit	1000-1600 unit SDV	Medicaid	Not Covered	No	Refer to the Medicaid Approved Drug List (ADL) for pharmacy benefit coverage. For one-time doses required for planned outpatient procedures (professional/facility claims), authorizations will be reviewed for medical necessity according to the Hemophilia Management Medical Policy 91569
Corifact (Factor XIII Concentrate (Human))	J7180	Factor XIII Concentrate (Human)	Hemophilia	1 unit	1000-1600 unit SDV	Medicare	Pref. Specialty	No	No PA required
Cortrophin (corticotropin)	J0802	corticotropin	Inflammatory Conditions		80 unit/mL, 5 mL MDV	Commercial	Refer to ADL	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Cortrophin (corticotropin)	J0802	corticotropin	Inflammatory Conditions		80 unit/mL, 5 mL MDV	Medicaid	Not Covered	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Cortrophin (corticotropin)	J0802	corticotropin	Inflammatory Conditions		80 unit/mL, 5 mL MDV	Medicare	Refer to ADL	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Cosela (trilaciclib)	J1448	trilaciclib	Miscellaneous	1 mg	300 mg SDV	Commercial	Pref. Specialty	No	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth. Forms tab.
Cosela (trilaciclib)	J1448	trilaciclib	Miscellaneous	1 mg	300 mg SDV	Medicaid	Covered	No	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth. Forms tab.
Cosela (trilaciclib)	J1448	trilaciclib	Miscellaneous	1 mg	300 mg SDV	Medicare	Pref. Specialty	No	PA required - See Medicare Medical Part B prior authorization form
Cosentyx IV (secukinumab) ***125mg/5 mL vial***	J3247	secukinumab	Inflammatory Conditions	1 mg	125mg/ 5mL SDV	Commercial	Not Covered	No	**Not Covered**
Cosentyx IV (secukinumab) ***125mg/5 mL vial***	J3247	secukinumab	Inflammatory Conditions	1 mg	125mg/ 5mL SDV	Medicaid	NPS	YES	No PA required when administered in a hospital outpatient infusion center
Cosentyx IV (secukinumab) ***125mg/5 mL vial***	J3247	secukinumab	Inflammatory Conditions	1 mg	125mg/ 5mL SDV	Medicare	NPS	No	PA Required - click here for criteria. Link for the Prior Authorization form is on the 'General Prior Auth. Forms' tab.
Cosentyx SC (secukinumab) ***Prefilled syringe & Senoready/UnoReady Pen***	J3590, C9399*	secukinumab	Inflammatory Conditions		75 mg/mL, 150 mg/mL, 300 mg/2 mL PFS 150 mg/mL Sensoready Pen 300 mg/2 mL UnoReady Pen	Commercial	Refer to ADL	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Cosentyx SC (secukinumab) ***Prefilled syringe & Senoready/UnoReady Pen***	J3590, C9399*	secukinumab	Inflammatory Conditions		75 mg/mL, 150 mg/mL, 300 mg/2 mL PFS 150 mg/mL Sensoready Pen 300 mg/2 mL UnoReady Pen	Medicaid	Not Covered	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Cosentyx SC (secukinumab) ***Prefilled syringe & Senoready/UnoReady Pen***	J3590, C9399*	secukinumab	Inflammatory Conditions		75 mg/mL, 150 mg/mL, 300 mg/2 mL PFS 150 mg/mL Sensoready Pen 300 mg/2 mL UnoReady Pen	Medicare	Refer to ADL	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Cosmegen (dactinomycin)	J9120	dactinomycin	Oncology	0.5 mg	500 mcg (0.5 mg) SDV	Commercial	Non-specialty	No	No PA required
Cosmegen (dactinomycin)	J9120	dactinomycin	Oncology	0.5 mg	500 mcg (0.5 mg) SDV	Medicaid	Covered	No	No PA required
Cosmegen (dactinomycin)	J9120	dactinomycin	Oncology	0.5 mg	500 mcg (0.5 mg) SDV	Medicare	Non-specialty	No	No PA required
Cresemba (isavuconazonium)	J1833	isavuconazonium	Antimicrobial	1 mg	372 mg SDV	Commercial	Pref. Specialty	No	No PA required
Cresemba (isavuconazonium)	J1833	isavuconazonium	Antimicrobial	1 mg	372 mg SDV	Medicaid	Covered	No	No PA required
Cresemba (isavuconazonium)	J1833	isavuconazonium	Antimicrobial	1 mg	372 mg SDV	Medicare	Pref. Specialty	No	No PA required
cromolyn sodium (cromolyn) INHALATION ONLY	J7631	cromolyn	inhalation	10 mg	20 mg/2 mL SDV	Medicare		No	Part B vs Part D – See Approved Drug List for covered formulations under Part D - see the Part B vs Part D coverage determination form for criteria
Crysvita (burosumab-twza)	J0584	burosumab	Miscellaneous	1 mg	10 mg/mL, 20 mg/mL, 30 mg/mL SDV	Commercial	Pref. Specialty	YES	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth. Forms tab.
Crysvita (burosumab-twza)	J0584	burosumab	Miscellaneous	1 mg	10 mg/mL, 20 mg/mL, 30 mg/mL SDV	Medicaid	Covered	YES	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth. Forms tab.
Crysvita (burosumab-twza)	J0584	burosumab	Miscellaneous	1 mg	10 mg/mL, 20 mg/mL, 30 mg/mL SDV	Medicare	Pref. Specialty	No	PA required - See Medicare Medical Part B prior authorization form
Cubicin (daptomycin lyophilisate)	J0878 - Not for Hospira brand - See J0877	daptomycin	Antimicrobial	1 mg	350 mg, 500 mg SDV	Commercial	Non-specialty	No	No PA required
Cubicin (daptomycin lyophilisate)	J0878 - Not for Hospira brand - See J0877	daptomycin	Antimicrobial	1 mg	350 mg, 500 mg SDV	Medicaid	Covered	No	No PA required
Cubicin (daptomycin lyophilisate)	J0878 - Not for Hospira brand - See J0877	daptomycin	Antimicrobial	1 mg	350 mg, 500 mg SDV	Medicare	Non-specialty	No	No PA required
cutaquig (immune globulin) subcutaneous	J1551, 90284	SCIG	Immune Globulin	100 mg	1 gm, 2 gm, 4 gm, 8 gm SDV	Commercial	Pref. Specialty	YES	PA required - see IVIG/SCIG prior authorization form for criteria
cutaquig (immune globulin) subcutaneous	J1551, 90284	SCIG	Immune Globulin	100 mg	1 gm, 2 gm, 4 gm, 8 gm SDV	Medicaid	Covered	No	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth. Forms tab.
cutaquig (immune globulin) subcutaneous	J1551, 90284	SCIG	Immune Globulin	100 mg	1 gm, 2 gm, 4 gm, 8 gm SDV	Medicare	Pref. Specialty	No	Part B vs Part D – See Approved Drug List for covered formulations under Part D - see the Part B vs Part D coverage determination form for criteria
Cuvitru (immune globulin) subcutaneous	J1555	SCIG	Immune Globulin	100 mg	1 gm, 2 gm, 4 gm, 8 gm, 10 gm SDV	Commercial	Pref. Specialty	YES	PA required - see IVIG/SCIG prior authorization form for criteria
Cuvitru (immune globulin) subcutaneous	J1555	SCIG	Immune Globulin	100 mg	1 gm, 2 gm, 4 gm, 8 gm, 10 gm SDV	Medicaid	Covered	No	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth. Forms tab.
Cuvitru (immune globulin) subcutaneous	J1555	SCIG	Immune Globulin	100 mg	1 gm, 2 gm, 4 gm, 8 gm, 10 gm SDV	Medicare	Pref. Specialty	No	Part B vs Part D – See Approved Drug List for covered formulations under Part D - see the Part B vs Part D coverage determination form for criteria
Cyclophosphamide - Auromedics brand only	J9071	cyclophosphamide	Oncology	5mg	500 mg, 1 gm SDV	Commercial	Non-specialty	No	No PA required
Cyclophosphamide - Auromedics brand only	J9071	cyclophosphamide	Oncology	5mg	500 mg, 1 gm SDV	Medicaid	Covered	No	No PA required - Reference CHAMPS to ensure this drug & NDC is covered for your provider type on the date of Service
Cyclophosphamide - Auromedics brand only	J9071	cyclophosphamide	Oncology	5mg	500 mg, 1 gm SDV	Medicare	Medicare Chemo	No	No PA required
Cyclophosphamide - Avyxa brand only	J9072	cyclophosphamide	Oncology	5mg	500 mg, 1 gm, 2 gm SDV	Commercial	Non-specialty	No	No PA required
Cyclophosphamide - Avyxa brand only	J9072	cyclophosphamide	Oncology	5mg	500 mg, 1 gm, 2 gm SDV	Medicaid	Covered	No	No PA required - Reference CHAMPS to ensure this drug & NDC is covered for your provider type on the date of Service
Cyclophosphamide - Avyxa brand only	J9072	cyclophosphamide	Oncology	5mg	500 mg, 1 gm, 2 gm SDV	Medicare	Medicare Chemo	No	No PA required
Cyclophosphamide - Baxter brand only	J9076	cyclophosphamide	Oncology	5mg	500 mg, 1 gm SDV	Commercial	Non-specialty	No	No PA required
Cyclophosphamide - Baxter brand only	J9076	cyclophosphamide	Oncology	5mg	500 mg, 1 gm SDV	Medicaid	Covered	No	No PA required
Cyclophosphamide - Baxter brand only	J9076	cyclophosphamide	Oncology	5mg	500 mg, 1 gm SDV	Medicare	Medicare Chemo	No	No PA required
Cyclophosphamide - Ingenus brand only	J9073	cyclophosphamide	Oncology	5mg	500 mg, 1 gm SDV	Commercial	Non-specialty	No	No PA required
Cyclophosphamide - Ingenus brand only	J9073	cyclophosphamide	Oncology	5mg	500 mg, 1 gm SDV	Medicaid	Covered	No	No PA required - Reference CHAMPS to ensure this drug & NDC is covered for your provider type on the date of Service
Cyclophosphamide - Ingenus brand only	J9073	cyclophosphamide	Oncology	5mg	500 mg, 1 gm SDV	Medicare	Medicare Chemo	No	No PA required
Cyclophosphamide - Sandoz brand only	J9074	cyclophosphamide	Oncology	5mg	500 mg, 1 gm SDV	Commercial	Non-specialty	No	No PA required
Cyclophosphamide - Sandoz brand only	J9074	cyclophosphamide	Oncology	5mg	500 mg, 1 gm SDV	Medicaid	Covered	No	No PA required - Reference CHAMPS to ensure this drug & NDC is covered for your provider type on the date of Service
Cyclophosphamide - Sandoz brand only	J9074	cyclophosphamide	Oncology	5mg	500 mg, 1 gm SDV	Medicare	Medicare Chemo	No	No PA required
Cyltezo (adalimumab-adbm)	Q5143	adalimumab	Inflammatory Conditions	1 mg	various	Commercial	Refer to ADL	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Cyltezo (adalimumab-adbm)	Q5143	adalimumab	Inflammatory Conditions	1 mg	various	Medicaid	Not Covered	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Cyltezo (adalimumab-adbm)	Q5143	adalimumab	Inflammatory Conditions	1 mg	various	Medicare	Refer to ADL	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit

Drug	Code	Generic	Category	Billing Unit	How Supplied	Line of Business	Coverage Level	Site Of Service	Comment
Cyramza (ramucirumab)	J9308	ramucirumab	Oncology	5 mg	100 mg/10 mL, 500 mg/50 mL SDV	Commercial	Pref. Specialty	No	PA required - see medical oncology prior authorization form for criteria
Cyramza (ramucirumab)	J9308	ramucirumab	Oncology	5 mg	100 mg/10 mL, 500 mg/50 mL SDV	Medicaid	Covered	No	No PA Required
Cyramza (ramucirumab)	J9308	ramucirumab	Oncology	5 mg	100 mg/10 mL, 500 mg/50 mL SDV	Medicare	Medicare Chemo	No	PA Required (Cancer Therapy) – See Medicare Part B Oncology Prior Authorization form
Cytovene (ganciclovir sodium)	J1570 - Not for Exela Pharma brand - See J1574	ganciclovir	Antimicrobial	500 mg	500 mg SDV	Commercial	Non-specialty	No	No PA required
Cytovene (ganciclovir sodium)	J1570 - Not for Exela Pharma brand - See J1574	ganciclovir	Antimicrobial	500 mg	500 mg SDV	Medicaid	Covered	No	No PA required
Cytovene (ganciclovir sodium)	J1570 - Not for Exela Pharma brand - See J1574	ganciclovir	Antimicrobial	500 mg	500 mg SDV	Medicare	Non-specialty	No	No PA required
Cytoxan (cyclophosphamide)	J9075 J8530 is oral tablet	cyclophosphamide	Oncology	5 mg	500 mg, 1 gm, 2 gm SDV	Commercial	Non-specialty	No	No PA required
Cytoxan (cyclophosphamide)	J9075 J8530 is oral tablet	cyclophosphamide	Oncology	5 mg	500 mg, 1 gm, 2 gm SDV	Medicaid	Covered	No	No PA required - Reference CHAMPS to ensure this drug & NDC is covered for your provider type on the date of Service
Cytoxan (cyclophosphamide)	J9075 J8530 is oral tablet	cyclophosphamide	Oncology	5 mg	500 mg, 1 gm, 2 gm SDV	Medicare	Medicare Chemo	No	No PA required
Cytoxan (cyclophosphamide) ORAL ONLY	J8530	cyclophosphamide	Oncology	25 mg	25 mg, 50 mg capsule/tablet	Medicare	Non-specialty	No	Part B vs Part D – See Approved Drug List for covered formulations under Part D - see the Part B vs Part D coverage determination form for criteria
dacarbazine lyophilisate	J9130	dacarbazine	Oncology	100 mg	100 mg, 200 mg SDV	Commercial	Non-specialty	No	No PA required
dacarbazine lyophilisate	J9130	dacarbazine	Oncology	100 mg	100 mg, 200 mg SDV	Medicaid	Covered	No	No PA required
dacarbazine lyophilisate	J9130	dacarbazine	Oncology	100 mg	100 mg, 200 mg SDV	Medicare	Non-specialty	No	No PA required
Dacogen (decitabine)	J0894 - Not for Sun Pharma brand	decitabine	Oncology	1 mg	50 mg SDV	Commercial	Pref. Specialty	No	No PA required
Dacogen (decitabine)	J0894 - Not for Sun Pharma brand	decitabine	Oncology	1 mg	50 mg SDV	Medicaid	Covered	No	No PA required
Dacogen (decitabine)	J0894 - Not for Sun Pharma brand	decitabine	Oncology	1 mg	50 mg SDV	Medicare	Pref. Specialty	No	No PA required
Dalvance (dalbavancin)	J0875	dalbavancin	Antimicrobial	5 mg	500 mg SDV	Commercial	NPS	YES	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth. Forms tab.
Dalvance (dalbavancin)	J0875	dalbavancin	Antimicrobial	5 mg	500 mg SDV	Medicaid	Covered	No	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth. Forms tab.
Dalvance (dalbavancin)	J0875	dalbavancin	Antimicrobial	5 mg	500 mg SDV	Medicare	NPS	No	No PA required
Danyelza (naxitamab-gqgk)	J9348	naxitamab	Oncology	1 mg	40 mg/10 mL SDV	Commercial	Pref. Specialty	No	PA required - see medical oncology prior authorization form for criteria
Danyelza (naxitamab-gqgk)	J9348	naxitamab	Oncology	1 mg	40 mg/10 mL SDV	Medicaid	Covered	No	No PA Required
Danyelza (naxitamab-gqgk)	J9348	naxitamab	Oncology	1 mg	40 mg/10 mL SDV	Medicare	Medicare Chemo	No	PA Required (Cancer Therapy) – See Medicare Part B Oncology Prior Authorization form
Daptomycin - Baxter Brand ONLY	J0874	daptomycin	Antimicrobial	1 mg	350 mg, 500 mg SDV	Commercial	Non-specialty	No	No PA required
Daptomycin - Baxter Brand ONLY	J0874	daptomycin	Antimicrobial	1 mg	350 mg, 500 mg SDV	Medicaid	Covered	No	No PA required
Daptomycin - Baxter Brand ONLY	J0874	daptomycin	Antimicrobial	1 mg	350 mg, 500 mg SDV	Medicare	Non-specialty	No	No PA required
Daptomycin - Hospira Brand ONLY	J0877	daptomycin	Antimicrobial	1 mg	350 mg, 500 mg SDV	Commercial	Non-specialty	No	No PA required
Daptomycin - Hospira Brand ONLY	J0877	daptomycin	Antimicrobial	1 mg	350 mg, 500 mg SDV	Medicaid	Covered	No	No PA required
Daptomycin - Hospira Brand ONLY	J0877	daptomycin	Antimicrobial	1 mg	350 mg, 500 mg SDV	Medicare	Non-specialty	No	No PA required
Daptomycin - Xellia Brand refrigerated ONLY	J0873	daptomycin	Antimicrobial	1 mg	350 mg, 500 mg SDV	Commercial	Non-specialty	No	No PA required
Daptomycin - Xellia Brand refrigerated ONLY	J0873	daptomycin	Antimicrobial	1 mg	350 mg, 500 mg SDV	Medicaid	Covered	No	No PA required
Daptomycin - Xellia Brand refrigerated ONLY	J0873	daptomycin	Antimicrobial	1 mg	350 mg, 500 mg SDV	Medicare	Non-specialty	No	No PA required
Daptomycin - Xellia Brand unrefrigerated ONLY	J0872	daptomycin	Antimicrobial	1 mg	350 mg, 500 mg SDV	Commercial	Non-specialty	No	No PA required
Daptomycin - Xellia Brand unrefrigerated ONLY	J0872	daptomycin	Antimicrobial	1 mg	350 mg, 500 mg SDV	Medicaid	Covered	No	No PA required
Daptomycin - Xellia Brand unrefrigerated ONLY	J0872	daptomycin	Antimicrobial	1 mg	350 mg, 500 mg SDV	Medicare	Non-specialty	No	No PA required
Darzalex (daratumumab)	J9145	daratumumab	Oncology	10 mg	100 mg/5 mL, 400 mg/20 mL SDV	Commercial	Pref. Specialty	No	No PA required when billed with the following ICD-10 codes: C90.00-C90.32 (multiple myeloma) or E85.81 - for other ICD 10 codes, see medical oncology prior authorization form for criteria
Darzalex (daratumumab)	J9145	daratumumab	Oncology	10 mg	100 mg/5 mL, 400 mg/20 mL SDV	Medicaid	Covered	No	No PA Required
Darzalex (daratumumab)	J9145	daratumumab	Oncology	10 mg	100 mg/5 mL, 400 mg/20 mL SDV	Medicare	Medicare Chemo	No	No PA required when billed with the following ICD-10 codes:C90.00-C90.32 (multiple myeloma) or E85.81 - For other diagnoses, see Medicare Part B Oncology Prior Authorization form
Darzalex Faspro (daratumumab and hyaluronidase-fihj)	J9144	daratumumab and hyaluronidase	Oncology	10 mg	1,800 mg-30,000 units/15 mL SDV	Commercial	Pref. Specialty	No	No PA required when billed with the following ICD-10 codes:C90.00-C90.32 (multiple myeloma) or E85.81 - For other diagnoses - see medical oncology prior authorization form for criteria
Darzalex Faspro (daratumumab and hyaluronidase-fihj)	J9144	daratumumab and hyaluronidase	Oncology	10 mg	1,800 mg-30,000 units/15 mL SDV	Medicaid	Covered	No	No PA Required
Darzalex Faspro (daratumumab and hyaluronidase-fihj)	J9144	daratumumab and hyaluronidase	Oncology	10 mg	1,800 mg-30,000 units/15 mL SDV	Medicare	Medicare Chemo	No	No PA required when billed with the following ICD-10 codes:C90.00-C90.32 (multiple myeloma) or E85.81 - For other diagnoses, see Medicare Part B Oncology Prior Authorization form
Daxxify (daxibotulinumtoxinA)	J0589	daxibotulinumtoxinA	botulinum toxin	1 Unit	50 unit and 100 unit SDV	Commercial	Pref. Specialty	No	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth. Forms tab. No auth required when billed by: Neurologist (NEUR), Rehab Medicine (PMR) or Physical Med & Rehab (PT)
Daxxify (daxibotulinumtoxinA)	J0589	daxibotulinumtoxinA	botulinum toxin	1 Unit	50 unit and 100 unit SDV	Medicaid	Covered	No	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth. Forms tab. No auth required when billed by: Neurologist (NEUR), Rehab Medicine (PMR) or Physical Med & Rehab (PT)
Daxxify (daxibotulinumtoxinA)	J0589	daxibotulinumtoxinA	botulinum toxin	1 Unit	50 unit and 100 unit SDV	Medicare	Pref. Specialty	No	PA Required - click here for criteria. Link for the Prior Authorization form is on the 'General Prior Auth. Forms' tab. No auth required when billed by: Neurologist (NEUR), Rehab Medicine (PMR) or Physical Med & Rehab (PT)
DDAVP (desmopressin acetate)	J2597	desmopressin	Miscellaneous	1 mcg	4 mcg/mL SDV, 40 mcg/10 mL MDV	Commercial	Non-specialty	No	No PA required
DDAVP (desmopressin acetate)	J2597	desmopressin	Miscellaneous	1 mcg	4 mcg/mL SDV, 40 mcg/10 mL MDV	Medicaid	Covered	No	No PA required
DDAVP (desmopressin acetate)	J2597	desmopressin	Miscellaneous	1 mcg	4 mcg/mL SDV, 40 mcg/10 mL MDV	Medicare	Non-specialty	No	No PA required
Decitabine - Sun Pharma Brand ONLY	J0893	decitabine	Oncology	1 mg	50 mg SDV	Commercial	Pref. Specialty	No	No PA required
Decitabine - Sun Pharma Brand ONLY	J0893	decitabine	Oncology	1 mg	50 mg SDV	Medicaid	Covered	No	No PA required
Decitabine - Sun Pharma Brand ONLY	J0893	decitabine	Oncology	1 mg	50 mg SDV	Medicare	Pref. Specialty	No	No PA required
Defencath (taurolidine/heparin)	J0911	taurolidine/heparin	Miscellaneous	1.35mg/100 units	1000-13.5 Unit-mg/mL 3 mL SDV	Commercial	Not Separately Payable	No	Not Separately Payable - Not Reviewed by Pharmacy
Defencath (taurolidine/heparin)	J0911	taurolidine/heparin	Miscellaneous	1.35mg/100 units	1000-13.5 Unit-mg/mL 3 mL SDV	Medicaid	Not Covered	No	**Not Covered**
Defencath (taurolidine/heparin)	J0911	taurolidine/heparin	Miscellaneous	1.35mg/100 units	1000-13.5 Unit-mg/mL 3 mL SDV	Medicare	Not Separately Payable	No	Not Separately Payable - Not Reviewed by Pharmacy
Demerol (meperidine hcl)	J2175	meperidine	Analgesic	100 mg	25 mg/mL, 50 mg/mL, 75 mg/mL, 100 mg/mL SD syringe; 300 mg/30 mL MDV	Commercial	Non-specialty	No	No PA required
Demerol (meperidine hcl)	J2175	meperidine	Analgesic	100 mg	25 mg/mL, 50 mg/mL, 75 mg/mL, 100 mg/mL SD syringe; 300 mg/30 mL MDV	Medicaid	Covered	No	No PA required
Demerol (meperidine hcl)	J2175	meperidine	Analgesic	100 mg	25 mg/mL, 50 mg/mL, 75 mg/mL, 100 mg/mL SD syringe; 300 mg/30 mL MDV	Medicare	Non-specialty	No	No PA required
Depacon (valproate sodium)	J3490*	valproate	Antiepileptic agent	Additional information required: National Drug Code (NDC), Strength, Dosage administered, Route of administration.	500 mg/5 mL SDV	Commercial	Non-specialty	No	No PA required
Depacon (valproate sodium)	J3490*	valproate	Antiepileptic agent	Additional information required: National Drug Code (NDC), Strength, Dosage administered, Route of administration.	500 mg/5 mL SDV	Medicaid	Covered	No	No PA required
Depacon (valproate sodium)	J3490*	valproate	Antiepileptic agent	Additional information required: National Drug Code (NDC), Strength, Dosage administered, Route of administration.	500 mg/5 mL SDV	Medicare	Non-specialty	No	No PA required
Depo-Estradiol IM oil (estradiol cypionate)	J1000	estradiol	hormone replacement	5 mg	5 mg/mL SDV	Commercial	Non-specialty	No	No PA required

Drug	Code	Generic	Category	Billing Unit	How Supplied	Line of Business	Coverage Level	Site Of Service	Comment
Depo-Estradiol IM oil (estradiol cypionate)	J1000	estradiol	hormone replacement	5 mg	5 mg/mL SDV	Medicaid	Covered	No	No PA required
Depo-Estradiol IM oil (estradiol cypionate)	J1000	estradiol	hormone replacement	5 mg	5 mg/mL SDV	Medicare	Non-specialty	No	No PA required
Depo-Medrol (methylprednisolone acetate)	J1010	methylprednisolone	Steroid	1 mg	20 mg/mL, 40 mg/mL, 80 mg/mL SDV	Commercial	Non-specialty	No	No PA required
Depo-Medrol (methylprednisolone acetate)	J1010	methylprednisolone	Steroid	1 mg	20 mg/mL, 40 mg/mL, 80 mg/mL SDV	Medicaid	Covered	No	No PA required
Depo-Medrol (methylprednisolone acetate)	J1010	methylprednisolone	Steroid	1 mg	20 mg/mL, 40 mg/mL, 80 mg/mL SDV	Medicare	Non-specialty	No	No PA required
Descovy (Emtricitabine and tenofovir alafenamide - PrEP ONLY)	J0751	Emtricitabine and tenofovir alafenamide	HIV preventative	Per dose	Emtricitabine 200mg and tenofovir alafenamide 25mg	Commercial	Refer to ADL	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Descovy (Emtricitabine and tenofovir alafenamide - PrEP ONLY)	J0751	Emtricitabine and tenofovir alafenamide	HIV preventative	Per dose	Emtricitabine 200mg and tenofovir alafenamide 25mg	Medicaid	Not Covered	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Descovy (Emtricitabine and tenofovir alafenamide - PrEP ONLY)	J0751	Emtricitabine and tenofovir alafenamide	HIV agent	Per dose	Emtricitabine 200mg and tenofovir alafenamide 25mg	Medicare	Refer to ADL	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit.
Desferal (deferoxamine mesylate)	J0895	deferoxamine	Chelating agent	500 mg	500 mg, 2000 mg SDV	Commercial	NPS	No	Only covered when billed with following ICD-10 codes: D56.0-D56.9, D57.00-D57.819, E72.00 – E72.09, E83.00 – E83.09, E83.10 – E83.19, E83.52, K74.3, K74.4, K74.5, T56.0x1A - T56.0x4S, T56.1x1A - T56.1x4S, T56.3x1A - T56.3x4S, T56.4x1A - T56.4x4S, T56.5x1A - T56.5x4S, T56.811A - T56.814S, T56.891A - T56.894S, T56.91xA - T56.94xS, T57.0x1A - T57.0X4S, T80.92xA - T80.92xS
Desferal (deferoxamine mesylate)	J0895	deferoxamine	Chelating agent	500 mg	500 mg, 2000 mg SDV	Medicaid	Covered	No	Only covered when billed with following ICD-10 codes: D56.0-D56.9, D57.00-D57.819, E72.00 – E72.09, E83.00 – E83.09, E83.10 – E83.19, E83.52, K74.3, K74.4, K74.5, T56.0x1A - T56.0x4S, T56.1x1A - T56.1x4S, T56.3x1A - T56.3x4S, T56.4x1A - T56.4x4S, T56.5x1A - T56.5x4S, T56.811A - T56.814S, T56.891A - T56.894S, T56.91xA - T56.94xS, T57.0x1A - T57.0X4S, T80.92xA - T80.92xS
Desferal (deferoxamine mesylate)	J0895	deferoxamine	Chelating agent	500 mg	500 mg, 2000 mg SDV	Medicare	NPS	No	No PA required when billed with the following ICD-10 diagnoses: D56.0-D56.9, D57.00-D57.819, E72.00-E72.09, E83.00-E83.09, E83.10-E83.19, E83.52, K74.3, K74.4, K74.5, T56.0X1A-T56.0X4S, T56.1X1A-T56.1X4S, T56.3X1A-T56.3X4S, T56.4X1A-T56.4X4S, T56.5X1A-T56.0X4S, T56.811A-T56.814S, T56.891A-T56.894S, T56.91A-T56.94X2, T57.01A-T57.0X4S, T80.92XA-T80.92XS All other ICD-10 diagnoses: PA required - See Medicare Medical Part B prior authorization form
Dexrazoxane HCl (**Zinecard, Totect**)	J1190	Dexrazoxane	Oncology	250 mg	250 mg, 500 mg SDV	Commercial	Non-specialty	No	No PA required
Dexrazoxane HCl (**Zinecard, Totect**)	J1190	Dexrazoxane	Oncology	250 mg	250 mg, 500 mg SDV	Medicaid	Covered	No	No PA required
Dexrazoxane HCl (**Zinecard, Totect**)	J1190	Dexrazoxane	Oncology	250 mg	250 mg, 500 mg SDV	Medicare	Non-specialty	No	No PA required
Dexycu (dexamethasone 9% intraocular)	J1095	dexamethasone	Ophthalmic	1 mcg	9% (103.4 mg/mL) 0.5 mL SDV kit	Commercial	Not covered	No	**Not covered**
Dexycu (dexamethasone 9% intraocular)	J1095	dexamethasone	Ophthalmic	1 mcg	9% (103.4 mg/mL) 0.5 mL SDV kit	Medicaid	Not Covered	No	**Not covered**
Dexycu (dexamethasone 9% intraocular)	J1095	dexamethasone	Ophthalmic	1 mcg	9% (103.4 mg/mL) 0.5 mL SDV kit	Medicare	Non-specialty	No	No PA required
diazepam	J3360	diazepam	Central Nervous System (CNS) agent	5 mg	10 mg/2 mL SD syringe, 50 mg/10 mL MDV	Commercial	Non-specialty	No	No PA required
diazepam	J3360	diazepam	Central Nervous System (CNS) agent	5 mg	10 mg/2 mL SD syringe, 50 mg/10 mL MDV	Medicaid	Carve Out	No	Contact Fee for Service Medicaid for coverage
diazepam	J3360	diazepam	Central Nervous System (CNS) agent	5 mg	10 mg/2 mL SD syringe, 50 mg/10 mL MDV	Medicare	Non-specialty	No	No PA required
Dilaudid (hydromorphone)	J1171	hydromorphone	Analgesic	0.1 mg	various	Commercial	Non-specialty	No	No PA required
Dilaudid (hydromorphone)	J1171	hydromorphone	Analgesic	0.1 mg	various	Medicaid	Covered	No	No PA required
Dilaudid (hydromorphone)	J1171	hydromorphone	Analgesic	0.1 mg	various	Medicare	Non-specialty	No	No PA required
diphenydramine HCL	J1200	diphenydramine	miscellaneous	50 mg	50 mg/mL SD syringe/vial, 500 mg/10 mL MDV	Commercial	Non-specialty	No	No PA required
diphenydramine HCL	J1200	diphenydramine	miscellaneous	50 mg	50 mg/mL SD syringe/vial, 500 mg/10 mL MDV	Medicaid	Carve Out	No	Contact Fee for Service Medicaid for coverage
diphenydramine HCL	J1200	diphenydramine	miscellaneous	50 mg	50 mg/mL SD syringe/vial, 500 mg/10 mL MDV	Medicare	Non-specialty	No	No PA required
Docivyx (docetaxel)	J9172	docetaxel	Oncology	1 mg	20 mg/2 mL, 80 mg/8 mL and 160 mg/16 mL SDV	Commercial	Not Covered	No	**Not Covered**
Docivyx (docetaxel)	J9172	docetaxel	Oncology	1 mg	20 mg/2 mL, 80 mg/8 mL and 160 mg/16 mL SDV	Medicaid	Covered	No	No PA Required
Docivyx (docetaxel)	J9172	docetaxel	Oncology	1 mg	20 mg/2 mL, 80 mg/8 mL and 160 mg/16 mL SDV	Medicare	Pref. Specialty	No	PA Required - click here for criteria. Link for the Prior Authorization form is on the 'General Prior Auth Forms' tab.
doxercalciferol (doxercalciferol)	J8499	doxercalciferol	Miscellaneous	Additional information required: National Drug Code (NDC), Strength, Dosage administered, Route of administration.	0.5 mcg, 1 mcg, 2.5 mcg capsule	Medicare		No	Part B vs Part D – See Approved Drug List for covered formulations under Part D - see the Part B vs Part D coverage determination form for criteria
DOXY 100 (Doxycycline Hyclate) INJECTION ONLY	J3490	doxycycline	Antimicrobial	Additional information required: National Drug Code (NDC), Strength, Dosage administered, Route of administration.	100 mg SDV	Medicare		No	Part B vs Part D – See Approved Drug List for covered formulations under Part D - see the Part B vs Part D coverage determination form for criteria
Duoneb (ipratropium and albuterol) NEBULIZER SOLUTION ONLY	J7620	ipratropium and albuterol	inhalation	0.5 mg-2.5 mg	0.5 mg-3 mg/3 mL SD ampule	Medicare	Non-specialty	No	Part B vs Part D – See Approved Drug List for covered formulations under Part D - see the Part B vs Part D coverage determination form for criteria
Duopa (carbidopa and levodopa)	J7340	carbidopa and levodopa	Parkinson agent	5 mg-20 mg	463 mg-2,000 mg/100 mL cartridge	Commercial	NPS	No	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth Forms tab.
Duopa (carbidopa and levodopa)	J7340	carbidopa and levodopa	Parkinson agent	5 mg-20 mg	463 mg-2,000 mg/100 mL cartridge	Medicaid	Covered	No	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth Forms tab.
Duopa (carbidopa and levodopa)	J7340	carbidopa and levodopa	Parkinson agent	5 mg-20 mg	463 mg-2,000 mg/100 mL cartridge	Medicare	NPS	No	No PA required
Durolane (hyaluronate sodium/ hyaluronic acid) for intra-articular injection	J7318	hyaluronate sodium/ hyaluronic acid	Hyaluronic acid derivatives	1 mg	60 mg/3 mL SD syringe	Commercial	Not covered	No	**Not covered – See Pharmacy Policy EXPERIMENTAL/INVESTIGATIONAL/UNPROVEN CARE/ BENEFIT EXCEPTIONS for more information**
Durolane (hyaluronate sodium/ hyaluronic acid) for intra-articular injection	J7318	hyaluronate sodium/ hyaluronic acid	Hyaluronic acid derivatives	1 mg	60 mg/3 mL SD syringe	Medicaid	Not Covered	No	**Not covered**
Durolane (hyaluronate sodium/ hyaluronic acid) for intra-articular injection	J7318	hyaluronate sodium/ hyaluronic acid	Hyaluronic acid derivatives	1 mg	60 mg/3 mL SD syringe	Medicare	Pref. Specialty	No	No PA required
Durysta (bimatoprost implant)	J7351	bimatoprost	Ophthalmic	1 mcg	10 mcg implant	Commercial	Not covered	No	**Not covered**
Durysta (bimatoprost implant)	J7351	bimatoprost	Ophthalmic	1 mcg	10 mcg implant	Medicaid	Not Covered	No	**Not covered**
Durysta (bimatoprost implant)	J7351	bimatoprost	Ophthalmic	1 mcg	10 mcg implant	Medicare	NPS	No	PA Required - click here for criteria. Link for the Prior Authorization form is on the 'General Prior Auth Forms' tab.
Dysport (abobotulinumtoxin A)	J0586	botulinum toxin A	botulinum toxin	5 units	300 unit, 500 unit SDV	Commercial	Pref. Specialty	No	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth Forms tab. No auth required when billed by: Neurologist (NEUR), Rehab Medicine (PMR) or Physical Med & Rehab (PT)
Dysport (abobotulinumtoxin A)	J0586	botulinum toxin A	botulinum toxin	5 units	300 unit, 500 unit SDV	Medicaid	Covered	No	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth Forms tab. No auth required when billed by: Neurologist (NEUR), Rehab Medicine (PMR) or Physical Med & Rehab (PT)
Dysport (abobotulinumtoxin A)	J0586	botulinum toxin A	botulinum toxin	5 units	300 unit, 500 unit SDV	Medicare	Pref. Specialty	No	PA Required - click here for criteria. Link for the Prior Authorization form is on the 'General Prior Auth Forms' tab. No auth required when billed by: Neurologist (NEUR), Rehab Medicine (PMR) or Physical Med & Rehab (PT)
Elahere (mirvetuximab soravtansine)	J9063	mirvetuximab soravtansine	Oncology	1mg	100mg/20mL SDV	Commercial	Pref. Specialty	YES	PA required - see medical oncology prior authorization form for criteria
Elahere (mirvetuximab soravtansine)	J9063	mirvetuximab soravtansine	Oncology	1mg	100mg/20mL SDV	Medicaid	Covered	No	No PA Required
Elahere (mirvetuximab soravtansine)	J9063	mirvetuximab soravtansine	Oncology	1mg	100mg/20mL SDV	Medicare	Medicare Chemo	No	PA Required (Cancer Therapy) – See Medicare Part B Oncology Prior Authorization form
Elaprase (idursulfase)	J1743	idursulfase	Enzyme deficiency	1 mg	6 mg/3 mL SDV	Commercial	Pref. Specialty	YES	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth Forms tab.
Elaprase (idursulfase)	J1743	idursulfase	Enzyme deficiency	1 mg	6 mg/3 mL SDV	Medicaid	Covered	YES	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth Forms tab.
Elaprase (idursulfase)	J1743	idursulfase	Enzyme deficiency	1 mg	6 mg/3 mL SDV	Medicare	Medicare Chemo	No	No PA required
Elelyso (taglucerase alfa)	J3060	taglucerase	Miscellaneous	10 units	200 unit SDV	Commercial	Pref. Specialty	YES	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth Forms tab.
Elelyso (taglucerase alfa)	J3060	taglucerase	Miscellaneous	10 units	200 unit SDV	Medicaid	Covered	YES	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth Forms tab.
Elelyso (taglucerase alfa)	J3060	taglucerase	Miscellaneous	10 units	200 unit SDV	Medicare	Medicare Chemo	No	No PA required
Elevidys (delandistrogene moxeparvovec-rokl)	J1413	delandistrogene moxeparvovec	Gene/Cellular Therapy	Per dose	1.33 x 1014 vector genomes per kilogram (vg/kg) of body weight as a single dose	Commercial	Not Covered	No	**Not covered – See Pharmacy Policy EXPERIMENTAL/INVESTIGATIONAL/UNPROVEN CARE/ BENEFIT EXCEPTIONS for more information**
Elevidys (delandistrogene moxeparvovec-rokl)	J1413	delandistrogene moxeparvovec	Gene/Cellular Therapy	Per dose	1.33 x 1014 vector genomes per kilogram (vg/kg) of body weight as a single dose	Medicaid	Carve Out	No	Contact Fee for Service Medicaid for coverage
Elevidys (delandistrogene moxeparvovec-rokl)	J1413	delandistrogene moxeparvovec	Gene/Cellular Therapy	Per dose	1.33 x 1014 vector genomes per kilogram (vg/kg) of body weight as a single dose	Medicare	Gene Therapy	No	PA Required - click here for criteria. Link for the Prior Authorization form is on the 'General Prior Auth Forms' tab.
Elfabrio (Pegunigalsidase Alfa-iwxj)	J2508	Pegunigalsidase Alfa	Enzyme deficiency	1 mg	20 mg/10 mL (2 mg/mL) solution SDV	Commercial	Pref. Specialty	YES	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth Forms tab.
Elfabrio (Pegunigalsidase Alfa-iwxj)	J2508	Pegunigalsidase Alfa	Enzyme deficiency	1 mg	20 mg/10 mL (2 mg/mL) solution SDV	Medicaid	Covered	YES	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth Forms tab.
Elfabrio (Pegunigalsidase Alfa-iwxj)	J2508	Pegunigalsidase Alfa	Enzyme deficiency	1 mg	20 mg/10 mL (2 mg/mL) solution SDV	Medicare	Pref. Specialty	No	PA required - See Medicare Medical Part B prior authorization form
Eligard (leuprolide acetate)	J9217	leuprolide	Oncology	7.5 mg	7.5 mg, 22.5 mg, 30 mg, 45 mg SD syringe	Commercial	Pref. Specialty	YES	No PA required
Eligard (leuprolide acetate)	J9217	leuprolide	Oncology	7.5 mg	7.5 mg, 22.5 mg, 30 mg, 45 mg SD syringe	Medicaid	Covered	No	No PA required
Eligard (leuprolide acetate)	J9217	leuprolide	Oncology	7.5 mg	7.5 mg, 22.5 mg, 30 mg, 45 mg SD syringe	Medicare	Medicare Chemo	No	No PA required
Elitek (rasburicase)	J2783	rasburicase	Oncology	0.5 mg	1.5 mg, 7.5 mg SDV	Commercial	Non-specialty	No	No PA required
Elitek (rasburicase)	J2783	rasburicase	Oncology	0.5 mg	1.5 mg, 7.5 mg SDV	Medicaid	Covered	No	No PA required
Elitek (rasburicase)	J2783	rasburicase	Oncology	0.5 mg	1.5 mg, 7.5 mg SDV	Medicare	Non-specialty	No	No PA required

Drug	Code	Generic	Category	Billing Unit	How Supplied	Line of Business	Coverage Level	Site Of Service	Comment
Ellence (epirubicin hydrochloride)	J9178	epirubicin	Oncology	2 mg	50 mg/25 mL, 200 mg/100 mL SDV	Commercial	Pref. Specialty	No	No PA required
Ellence (epirubicin hydrochloride)	J9178	epirubicin	Oncology	2 mg	50 mg/25 mL, 200 mg/100 mL SDV	Medicaid	Covered	No	No PA required
Ellence (epirubicin hydrochloride)	J9178	epirubicin	Oncology	2 mg	50 mg/25 mL, 200 mg/100 mL SDV	Medicare	Pref. Specialty	No	No PA required
Eloctate (Antihemophilic Factor VIII Fc Fusion Protein)	J7205	Antihemophilic Factor VIII Fc Fusion Protein	Hemophilia			Commercial	Refer to ADL	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Eloctate (Antihemophilic Factor VIII Fc Fusion Protein)	J7205	Antihemophilic Factor VIII Fc Fusion Protein	Hemophilia			Medicaid	Not Covered	No	Refer to the Medicaid Approved Drug List (ADL) for pharmacy benefit coverage. For one-time doses required for planned outpatient procedures (professional/facility claims), authorizations will be reviewed for medical necessity according to the Hemophilia Management Medical Policy 91569
Eloctate (Antihemophilic Factor VIII Fc Fusion Protein)	J7205	Antihemophilic Factor VIII Fc Fusion Protein	Hemophilia			Medicare	Pref. Specialty	No	No PA required
Elrexfio (elranatamab-bcmm)	J1323	elranatamab	Oncology	1 mg	76mg/1.9mL SDV 44mg/1.1mL SDV	Commercial	Not covered	No	**Not covered**
Elrexfio (elranatamab-bcmm)	J1323	elranatamab	Oncology	1 mg	76mg/1.9mL SDV 44mg/1.1mL SDV	Medicaid	Covered	No	Reference CHAMPS to ensure this drug & NDC is covered for your provider type on the date of service
Elrexfio (elranatamab-bcmm)	J1323	elranatamab	Oncology	1 mg	76mg/1.9mL SDV 44mg/1.1mL SDV	Medicare	Medicare Chemo	No	PA Required (Cancer Therapy) – See Medicare Part B Oncology Prior Authorization form

Drug	Code	Generic	Category	Billing Unit	How Supplied	Line of Business	Coverage Level	Site Of Service	Comment
Elzonris (tagraxofusperzs)	J9269	tagraxofusp-erzs	Oncology	10 mcg	1000 mcg/mL SDV	Commercial	Pref. Specialty	No	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth. Forms tab.
Elzonris (tagraxofusperzs)	J9269	tagraxofusp-erzs	Oncology	10 mcg	1000 mcg/mL SDV	Medicaid	Covered	No	No PA Required
Elzonris (tagraxofusperzs)	J9269	tagraxofusp-erzs	Oncology	10 mcg	1000 mcg/mL SDV	Medicare	Medicare Chemo	No	PA Required (Cancer Therapy) - See Medicare Part B Oncology Prior Authorization form
Emend (aprepitant) ORAL ONLY	J8501	aprepitant	Antiemetic	5 mg	40 mg, 80 mg, 125 mg capsule	Medicare	Non-specialty	No	Part B vs Part D – See Approved Drug List for covered formulations under Part D - see the Part B vs Part D coverage determination form for criteria
Emend IV (fosaprepitant dimeglumine)	J1453 - Not for Teva brand	fosaprepitant	Antiemetic	1 mg	150 mg SDV	Commercial	Non-specialty	No	No PA required
Emend IV (fosaprepitant dimeglumine)	J1453 - Not for Teva brand	fosaprepitant	Antiemetic	1 mg	150 mg SDV	Medicaid	Covered	No	No PA required
Emend IV (fosaprepitant dimeglumine)	J1453 - Not for Teva brand	fosaprepitant	Antiemetic	1 mg	150 mg SDV	Medicare	Non-specialty	No	No PA required
Empaveli (pegcetacoplan)	J3490, J3590* C9399	pegcetacoplan	Miscellaneous		1,080 mg/20 mL (54 mg/mL) SDV	Commercial	Pref. Specialty	YES	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth. Forms tab.
Empaveli (pegcetacoplan)	J3490, J3590* C9399	pegcetacoplan	Miscellaneous		1,080 mg/20 mL (54 mg/mL) SDV	Medicaid	Covered	YES	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth. Forms tab.
Empaveli (pegcetacoplan)	J3490* C9399	pegcetacoplan	Miscellaneous		1,080 mg/20 mL (54 mg/mL) SDV	Medicare	Pref. Specialty	No	Part B vs Part D – See Approved Drug List for covered formulations under Part D - see the Part B vs Part D coverage determination form for criteria
Empliciti (elotuzumab)	J9176	elotuzumab	Oncology	1 mg	300 mg, 400 mg SDV	Commercial	Pref. Specialty	No	No PA required
Empliciti (elotuzumab)	J9176	elotuzumab	Oncology	1 mg	300 mg, 400 mg SDV	Medicaid	Covered	No	No PA required
Empliciti (elotuzumab)	J9176	elotuzumab	Oncology	1 mg	300 mg, 400 mg SDV	Medicare	Pref. Specialty	No	No PA required
Enbrel (etanercept)	J1438	etanercept	Inflammatory Conditions	25 mg	50 mg/0.5 mL SD syringe, 25 mg SDV	Commercial	Refer to ADL	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Enbrel (etanercept)	J1438	etanercept	Inflammatory Conditions	25 mg	50 mg/0.5 mL SD syringe, 25 mg SDV	Medicaid	Not Covered	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Enbrel (etanercept)	J1438	etanercept	Inflammatory Conditions	25 mg	50 mg/0.5 mL SD syringe, 25 mg SDV	Medicare	Refer to ADL	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Energix-B [Hepatitis B Vaccine (Recombinant)]		Hepatitis B Vaccine (Recombinant)	vaccine			Medicare		No	Part B vs Part D – See Approved Drug List for covered formulations under Part D - see the Part B vs Part D coverage determination form for criteria
Enhertu (fam-trastuzumab deruxtecan)	J9358	fam-trastuzumab deruxtecan	Oncology	1 mg	100 mg SDV	Commercial	Pref. Specialty	No	PA required - see medical oncology prior authorization form for criteria
Enhertu (fam-trastuzumab deruxtecan)	J9358	fam-trastuzumab deruxtecan	Oncology	1 mg	100 mg SDV	Medicaid	Covered	No	No PA Required
Enhertu (fam-trastuzumab deruxtecan)	J9358	fam-trastuzumab deruxtecan	Oncology	1 mg	100 mg SDV	Medicare	Medicare Chemo	No	PA Required (Cancer Therapy) – See Medicare Part B Oncology Prior Authorization form
Enjaymo (sutimlimab-jome)	J1302	sutimlimab	Miscellaneous	10 mg	1,100 mg/22ml (50mg/ml) SDV	Commercial	NPS	YES	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth. Forms tab.
Enjaymo (sutimlimab-jome)	J1302	sutimlimab	Miscellaneous	10 mg	1,100 mg/22ml (50mg/ml) SDV	Medicaid	Covered	YES	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth. Forms tab.
Enjaymo (sutimlimab-jome)	J1302	sutimlimab	Miscellaneous	10 mg	1,100 mg/22ml (50mg/ml) SDV	Medicare	NPS	No	PA Required - click here for criteria. Link for the Prior Authorization form is on the 'General Prior Auth. Forms' tab.
Entyvio IV (vedolizumab) ***300mg vial***	J3380	vedolizumab	Inflammatory Conditions	1 mg	300 mg SDV	Commercial	NPS	YES	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth. Forms tab.
Entyvio IV (vedolizumab) ***300mg vial***	J3380	vedolizumab	Inflammatory Conditions	1 mg	300 mg SDV	Medicaid	Covered	YES	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth. Forms tab.
Entyvio IV (vedolizumab) ***300mg vial***	J3380	vedolizumab	Inflammatory Conditions	1 mg	300 mg SDV	Medicare	NPS	No	PA Required - click here for criteria. Link for the Prior Authorization form is on the 'General Prior Auth. Forms' tab.
Entyvio SC (vedolizumab) ***108mg/0.68 mL Prefilled syringe and Pen***	J3380 Starting 4-1-2024 J3590, C9399	vedolizumab	Inflammatory Conditions		108 mg/0.68 mL PFS and Pen	Commercial	Refer to ADL	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Entyvio SC (vedolizumab) ***108mg/0.68 mL Prefilled syringe and Pen***	J3380 Starting 4-1-2024 J3590, C9399	vedolizumab	Inflammatory Conditions		108 mg/0.68 mL PFS and Pen	Medicaid	Not Covered	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Entyvio SC (vedolizumab) ***108mg/0.68 mL Prefilled syringe and Pen***	J3380 Starting 4-1-2024 J3590, C9399	vedolizumab	Inflammatory Conditions		108 mg/0.68 mL PFS and Pen	Medicare	Refer to ADL	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Envarsus (tacrolimus tablet, extended release)	J7503	tacrolimus	Immunosuppressive agent	0.25 mg	0.75 mg, 1 mg, 4 mg tablet	Medicare	Non-specialty	No	Part B vs Part D – See Approved Drug List for covered formulations under Part D - see the Part B vs Part D coverage determination form for criteria
Epinephrine - Belcher Brand ONLY	J0173	epinephrine	Miscellaneous	0.1 mg		Commercial	Non-specialty	No	No PA required
Epinephrine - Belcher Brand ONLY	J0173	epinephrine	Miscellaneous	0.1 mg		Medicaid	Carve Out	No	Contact Fee for Service Medicaid for coverage
Epinephrine - Belcher Brand ONLY	J0173	epinephrine	Miscellaneous	0.1 mg		Medicare	Non-specialty	No	No PA required
Epkinly (epcoritamab-bysp)	J9321	epcoritamab	Oncology	0.16 mg	4mg/0.8mL SDV 48mg/0.8mL SDV	Commercial	Pref. Specialty	No	PA required - see medical oncology prior authorization form for criteria
Epkinly (epcoritamab-bysp)	J9321	epcoritamab	Oncology	0.16 mg	4mg/0.8mL SDV 48mg/0.8mL SDV	Medicaid	Covered	No	No PA Required
Epkinly (epcoritamab-bysp)	J9321	epcoritamab	Oncology	0.16 mg	4mg/0.8mL SDV 48mg/0.8mL SDV	Medicare	Medicare Chemo	No	PA Required (Cancer Therapy) – See Medicare Part B Oncology Prior Authorization form
Epogen (epoetin alpha)	J0885-Non ESRD Q4081-ESRD	epoetin alpha	Hematopoietic agent	1000 units (J0885) 100 units (Q4081)	2000 unit, 3000 unit, 4000 unit, 10000 unit, 20000 unit SDV	Medicare	NPS	No	Part B vs Part D – PA Required – click here for criteria. See Approved Drug List for covered formulations under Part D
Erbitux (cetuximab)	J9055	cetuximab	Oncology	10 mg	100 mg/50 mL, 200 mg/100 mL SDV	Commercial	Pref. Specialty	No	PA required - see medical oncology prior authorization form for criteria
Erbitux (cetuximab)	J9055	cetuximab	Oncology	10 mg	100 mg/50 mL, 200 mg/100 mL SDV	Medicaid	Covered	No	No PA Required
Erbitux (cetuximab)	J9055	cetuximab	Oncology	10 mg	100 mg/50 mL, 200 mg/100 mL SDV	Medicare	Medicare Chemo	No	PA Required (Cancer Therapy) – See Medicare Part B Oncology Prior Authorization form
Erwinase (asparaginase erwinia chrysanthemi)	J9019	asparaginase erwinia chrysanthemi	Oncology	1,000 IU	10,000 unit SDV	Commercial	NPS	No	PA required - see medical oncology prior authorization form for criteria
Erwinase (asparaginase erwinia chrysanthemi)	J9019	asparaginase erwinia chrysanthemi	Oncology	1,000 IU	10,000 unit SDV	Medicaid	Covered	No	No PA Required
Erwinase (asparaginase erwinia chrysanthemi)	J9019	asparaginase erwinia chrysanthemi	Oncology	1,000 IU	10,000 unit SDV	Medicare	Medicare Chemo	No	PA Required (Cancer Therapy) – See Medicare Part B Oncology Prior Authorization form
esmolol - WG Critical Care brand ONLY	J1806	esmolol	Miscellaneous	10 mg		Commercial	Non-specialty	No	No PA required
esmolol - WG Critical Care brand ONLY	J1806	esmolol	Miscellaneous	10 mg		Medicaid	Covered	No	No PA required
esmolol - WG Critical Care brand ONLY	J1806	esmolol	Miscellaneous	10 mg		Medicare	Non-specialty	No	No PA required
Esperoct (Antihemophilic Factor VIII)	J7204	Antihemophilic Factor VIII	Hemophilia			Commercial	Refer to ADL	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Esperoct (Antihemophilic Factor VIII)	J7204	Antihemophilic Factor VIII	Hemophilia			Medicaid	Not Covered	No	Refer to the Medicaid Approved Drug List (ADL) for pharmacy benefit coverage. For one-time doses required for planned outpatient procedures (professional/facility claims), authorizations will be reviewed for medical necessity according to the Hemophilia Management Medical Policy 91569
Esperoct (Antihemophilic Factor VIII)	J7204	Antihemophilic Factor VIII	Hemophilia			Medicare	Pref. Specialty	No	No PA required
Ethyol (amifostine)	J0207	amifostine	Oncology	500 mg	500 mg SDV	Commercial	Pref. Specialty	No	No PA required
Ethyol (amifostine)	J0207	amifostine	Oncology	500 mg	500 mg SDV	Medicaid	Covered	No	No PA required
Ethyol (amifostine)	J0207	amifostine	Oncology	500 mg	500 mg SDV	Medicare	Pref. Specialty	No	No PA required
Euflexxa (hyaluronan/ hyaluronic acid) for intra-articular injection	J7323	hyaluronate sodium/ hyaluronic acid	Hyaluronic acid derivatives	Per dose	20 mg/2 mL SD syringe	Commercial	Not covered	No	**Not covered – See Pharmacy Policy EXPERIMENTAL/INVESTIGATIONAL/UNPROVEN CARE/ BENEFIT EXCEPTIONS for more information**
Euflexxa (hyaluronan/ hyaluronic acid) for intra-articular injection	J7323	hyaluronate sodium/ hyaluronic acid	Hyaluronic acid derivatives	Per dose	20 mg/2 mL SD syringe	Medicaid	Not Covered	No	**Not covered**
Euflexxa (hyaluronan/ hyaluronic acid) for intra-articular injection	J7323	hyaluronate sodium/ hyaluronic acid	Hyaluronic acid derivatives	Per dose	20 mg/2 mL SD syringe	Medicare	Pref. Specialty	No	No PA required
Evenity (romosozumab-aqqg)	J3111	romosozumab-aqqg	Bone modifying agent	1 mg	105 mg/1.17 mL, 210 mg/2.34 mL SD syringe	Commercial	Pref. Specialty	YES	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth. Forms tab.
Evenity (romosozumab-aqqg)	J3111	romosozumab-aqqg	Bone modifying agent	1 mg	105 mg/1.17 mL, 210 mg/2.34 mL SD syringe	Medicaid	Covered	YES	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth. Forms tab.
Evenity (romosozumab-aqqg)	J3111	romosozumab-aqqg	Bone modifying agent	1 mg	105 mg/1.17 mL, 210 mg/2.34 mL SD syringe	Medicare	Pref. Specialty	No	PA Required - click here for criteria. Link for the Prior Authorization form is on the 'General Prior Auth. Forms' tab.
Evkeeza (evinacumab-dgnb)	J1305	evinacumab	Miscellaneous	5 mg	345 mg/2.3 mL, 1200 mg/8 mL SDV	Commercial	Pref. Specialty	No	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth. Forms tab.
Evkeeza (evinacumab-dgnb)	J1305	evinacumab	Miscellaneous	5 mg	345 mg/2.3 mL, 1200 mg/8 mL SDV	Medicaid	Covered	YES	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth. Forms tab.
Evkeeza (evinacumab-dgnb)	J1305	evinacumab	Miscellaneous	5 mg	345 mg/2.3 mL, 1200 mg/8 mL SDV	Medicare	Pref. Specialty	No	PA Required - click here for criteria. Link for the Prior Authorization form is on the 'General Prior Auth. Forms' tab.
Evomela (melphalan)	J9246	melphalan	Oncology	1 mg	50 mg SDV	Commercial	Pref. Specialty	No	PA required - see medical oncology prior authorization form for criteria
Evomela (melphalan)	J9246	melphalan	Oncology	1 mg	50 mg SDV	Medicaid	Covered	No	No PA Required
Evomela (melphalan)	J9246	melphalan	Oncology	1 mg	50 mg SDV	Medicare	Medicare Chemo	No	PA Required (Cancer Therapy) – See Medicare Part B Oncology Prior Authorization form
Exondys 51 (eteplirsen)	J1428	eteplirsen	Muscular Dystrophy	10 mg	100 mg/2 mL, 500 mg/10 mL SDV	Commercial	Not covered	No	**Not covered – See Pharmacy Policy EXPERIMENTAL/INVESTIGATIONAL/UNPROVEN CARE/ BENEFIT EXCEPTIONS for more information**
Exondys 51 (eteplirsen)	J1428	eteplirsen	Muscular Dystrophy	10 mg	100 mg/2 mL, 500 mg/10 mL SDV	Medicaid	Carve Out	No	Contact Fee for Service Medicaid for coverage
Exondys 51 (eteplirsen)	J1428	eteplirsen	Muscular Dystrophy	10 mg	100 mg/2 mL, 500 mg/10 mL SDV	Medicare	Not Covered	No	**Not covered – See Pharmacy Policy Utilization Management for Part B Drugs in Medicare Advantage**
Exparel (bupivacaine liposome)	J0666	bupivacaine liposome	miscellaneous	1 mg		Commercial	non-specialty	No	No PA Required
Exparel (bupivacaine liposome)	J0666	bupivacaine liposome	miscellaneous	1 mg		Medicaid	non-specialty	No	No PA Required
Exparel (bupivacaine liposome)	J0666	bupivacaine liposome	miscellaneous	1 mg		Medicare	non-specialty	No	Only covered for medically accepted indications

Drug	Code	Generic	Category	Billing Unit	How Supplied	Line of Business	Coverage Level	Site Of Service	Comment
Extavia (interferon beta-1b)	J1830	interferon beta-1b	Multiple Sclerosis (MS) agent	0.25 mg	0.3 mg SDV	Commercial	Refer to ADL	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Extavia (interferon beta-1b)	J1830	interferon beta-1b	interferon	0.25 mg	0.3 mg SDV	Medicaid	Not Covered	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Extavia (interferon beta-1b)	J1830	interferon beta-1b	interferon	0.25 mg	0.3 mg SDV	Medicare	Refer to ADL	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Eylea (aflibercept)	J0178	aflibercept	Ophthalmic	1 mg	2 mg/0.05 mL SDV	Commercial	Pref Specialty	No	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth Forms tab.
Eylea (aflibercept)	J0178	aflibercept	Ophthalmic	1 mg	2 mg/0.05 mL SDV	Medicaid	Covered	No	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth Forms tab.
Eylea (aflibercept)	J0178	aflibercept	Ophthalmic	1 mg	2 mg/0.05 mL SDV	Medicare	Pref Specialty	No	No PA required when billed with the following ICD-10 diagnoses: A18.53, E08.311, E08.319, E08.3211 – E08.3213, E08.3291 - E08.3293, E08.3311 - E08.3313, E08.3391 - E08.3393, E08.3411 - E08.3413, E08.3491 - E08.3493, E08.3511 - E08.3513, E08.3521 - E08.3523, E08.3531 - E08.3533, E08.3541 - E08.3543, E08.3551 - E08.3553, E08.3591 - E08.3593, E09.311, E09.319, E09.3211 - E09.3213, E09.3291 - E09.3293, E09.3311 - E09.3313, E09.3391 - E09.3393, E09.3411 - E09.3413, E09.3491 - E09.3493, E09.3511 - E09.3513, E09.3521 - E09.3523, E09.3531 - E09.3533, E09.3541 - E09.3543, E09.3551 - E09.3553, E09.3591 - E09.3593, E10.311, E10.319, E10.3211 - E10.3213, E10.3291 - E10.3293, E10.3311 - E10.3313, E10.3391 - E10.3393, E10.3411 - E10.3413, E10.3491 - E10.3493, E10.3511 – E10.3513, E10.3591 – E10.3599, E11.3211-E11.3219, E11.3291-E11.3299, E11.3311- E11.3313, E11.3391 - E11.3393, E11.3411- E11.3413, E11.3491 - E11.3493, E11.3511 – E11.3513, E11.3521 – E11.3523, E11.3531 – E11.3533, E11.3541 – E11.3543, E11.3551 – E11.3553, E11.3591 – E11.3593, E13.311, E13.319, E13.3211- E13.3213, E13.3291 - E13.3293, E13.3311- E13.3313, E13.3391 - E13.3393, E13.3411-E13.3413, E13.3491 - E13.3493, E13.3511- E13.3513, E13.3521 – E13.3523, E13.3531 – E13.3533, E13.3541 – E13.3543, E13.3551 – E13.3553, E13.3591 – E13.3593, H34.8110, H34.8120, H34.8130, H34.8190, H34.8310, H34.8320, H34.8330, H34.8390, H35.051 - H35.053, H35.101 – H35.169, H35.3210 - H35.3233, H35.351 – H35.353. All other ICD-10 diagnoses: PA required - See Medicare Medical Part B prior authorization form.
Eylea HD (aflibercept)	J0177	aflibercept	Ophthalmic	1 mg	8 mg/0.07 mL SDV	Commercial	Pref Specialty	No	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth Forms tab.
Eylea HD (aflibercept)	J0177	aflibercept	Ophthalmic	1 mg	8 mg/0.07 mL SDV	Medicaid	Covered	No	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth Forms tab.
Eylea HD (aflibercept)	J0177	aflibercept	Ophthalmic	1 mg	8 mg/0.07 mL SDV	Medicare	Pref Specialty	No	No PA required when billed with the following ICD-10 diagnoses: A18.53, E08.311, E08.319, E08.3211 – E08.3213, E08.3291 - E08.3293, E08.3311 - E08.3313, E08.3391 - E08.3393, E08.3411 - E08.3413, E08.3491 - E08.3493, E08.3511 - E08.3513, E08.3521 - E08.3523, E08.3531 - E08.3533, E08.3541 - E08.3543, E08.3551 - E08.3553, E08.3591 - E08.3593, E09.311, E09.319, E09.3211 - E09.3213, E09.3291 - E09.3293, E09.3311 - E09.3313, E09.3391 - E09.3393, E09.3411 - E09.3413, E09.3491 - E09.3493, E09.3511 - E09.3513, E09.3521 - E09.3523, E09.3531 - E09.3533, E09.3541 - E09.3543, E09.3551 - E09.3553, E09.3591 - E09.3593, E10.311, E10.319, E10.3211 - E10.3213, E10.3291 - E10.3293, E10.3311 - E10.3313, E10.3391 - E10.3393, E10.3411 - E10.3413, E10.3491 - E10.3493, E10.3511 – E10.3513, E10.3591 – E10.3599, E11.3211-E11.3219, E11.3291-E11.3299, E11.3311- E11.3313, E11.3391 - E11.3393, E11.3411- E11.3413, E11.3491 - E11.3493, E11.3511 – E11.3513, E11.3521 – E11.3523, E11.3531 – E11.3533, E11.3541 – E11.3543, E11.3551 – E11.3553, E11.3591 – E11.3593, E13.311, E13.319, E13.3211- E13.3213, E13.3291 - E13.3293, E13.3311- E13.3313, E13.3391 - E13.3393, E13.3411-E13.3413, E13.3491 - E13.3493, E13.3511- E13.3513, E13.3521 – E13.3523, E13.3531 – E13.3533, E13.3541 – E13.3543, E13.3551 – E13.3553, E13.3591 – E13.3593, H34.8110, H34.8120, H34.8130, H34.8190, H34.8310, H34.8320, H34.8330, H34.8390, H35.051 - H35.053, H35.101 – H35.169, H35.3210 - H35.3233, H35.351 – H35.353. All other ICD-10 diagnoses: PA required - See Medicare Medical Part B prior authorization form.
Fabrazyme (agalsidase beta)	J0180	agalsidase beta	Enzyme deficiency	1 mg	5 mg, 35 mg SDV	Commercial	Pref. Specialty	YES	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth Forms tab.
Fabrazyme (agalsidase beta)	J0180	agalsidase beta	Enzyme deficiency	1 mg	5 mg, 35 mg SDV	Medicaid	Covered	YES	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth Forms tab.
Fabrazyme (agalsidase beta)	J0180	agalsidase beta	Enzyme deficiency	1 mg	5 mg, 35 mg SDV	Medicare	Pref. Specialty	No	PA required - See Medicare Medical Part B prior authorization form
Fasenra (benralizumab) ***auto-injector pen***	J0517	benralizumab	Respiratory Biologic	1 mg	30 mg/mL SD syringe	Commercial	Refer to ADL	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Fasenra (benralizumab) ***auto-injector pen***	J0517	benralizumab	Respiratory Biologic	1 mg	30 mg/mL SD syringe	Medicaid	Not Covered	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Fasenra (benralizumab) ***auto-injector pen***	J0517	benralizumab	Respiratory Biologic	1 mg	30 mg/mL Autoinjector	Medicare	Refer to ADL	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Fasenra (benralizumab) ***prefilled syringe***	J0517	benralizumab	Respiratory Biologic	1 mg	30 mg/mL SD syringe	Commercial	Pref. Specialty	YES	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth Forms tab.
Fasenra (benralizumab) ***prefilled syringe***	J0517	benralizumab	Respiratory Biologic	1 mg	30 mg/mL SD syringe	Medicaid	Covered	YES	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth Forms tab.
Fasenra (benralizumab) ***prefilled syringe***	J0517	benralizumab	Respiratory Biologic	1 mg	30 mg/mL SD syringe	Medicare	Pref. Specialty	No	PA Required - click here for criteria. Link for the Prior Authorization form is on the 'General Prior Auth Forms' tab.
Faslodex (fulvestrant)	J9395 - Not for Teva or Fresenius Kabi brands	fluvestrant	Oncology	25 mg	250 mg/5 mL SD syringe	Commercial	Pref. Specialty	No	No PA required
Faslodex (fulvestrant)	J9395 - Not for Teva or Fresenius Kabi brands	fluvestrant	Oncology	25 mg	250 mg/5 mL SD syringe	Medicaid	Covered	No	No PA required
Faslodex (fulvestrant)	J9395 - Not for Teva or Fresenius Kabi brands	fluvestrant	Oncology	25 mg	250 mg/5 mL SD syringe	Medicare	Medicare Chemo	No	No PA required
Feiba (Anti-Inhibitor Coagulant Complex)	J7198	Anti-Inhibitor Coagulant Complex	Hemophilia			Commercial	Refer to ADL	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Feiba (Anti-Inhibitor Coagulant Complex)	J7198	Anti-Inhibitor Coagulant Complex	Hemophilia			Medicaid	Not Covered	No	Refer to the Medicaid Approved Drug List (ADL) for pharmacy benefit coverage. For one-time doses required for planned outpatient procedures (professional/facility claims), authorizations will be reviewed for medical necessity according to the Hemophilia Management Medical Policy 91569
Feiba (Anti-Inhibitor Coagulant Complex)	J7198	Anti-Inhibitor Coagulant Complex	Hemophilia			Medicare	Pref. Specialty	No	No PA required
Fensolvi (leuprolide acetate)	J1951	leuprolide	Endocrine	0.25 mg	45 mg SD syringe	Commercial	Pref. Specialty	YES	No PA required
Fensolvi (leuprolide acetate)	J1951	leuprolide	Endocrine	0.25 mg	45 mg SD syringe	Medicaid	Covered	No	No PA required
Fensolvi (leuprolide acetate)	J1951	leuprolide	Endocrine	0.25 mg	45 mg SD syringe	Medicare	Pref. Specialty	No	PA required - See Medicare Medical Part B prior authorization form
Feraheme (ferumoxytol)	Q0138-Non-ERSD Q0139 - ESRD	ferumoxytol	Iron replacement	1 mg	510 mg/17 mL SDV	Commercial	Non-specialty	No	No PA required
Feraheme (ferumoxytol)	Q0138-Non-ERSD Q0139 - ESRD	ferumoxytol	Iron replacement	1 mg	510 mg/17 mL SDV	Medicaid	Covered	No	No PA required
Feraheme (ferumoxytol)	Q0138-Non-ERSD Q0139 - ESRD	ferumoxytol	Iron replacement	1 mg	510 mg/17 mL SDV	Medicare	Non-specialty	No	No PA required
Ferrlecit (sodium ferric gluconate)	J2916	sodium ferric gluconate	Iron replacement	12.5 mg	62.5 mg/5 mL SDV	Commercial	Non-specialty	No	No PA required
Ferrlecit (sodium ferric gluconate)	J2916	sodium ferric gluconate	Iron replacement	12.5 mg	62.5 mg/5 mL SDV	Medicaid	Covered	No	No PA required
Ferrlecit (sodium ferric gluconate)	J2916	sodium ferric gluconate	Iron replacement	12.5 mg	62.5 mg/5 mL SDV	Medicare	Non-specialty	No	No PA required
Fetroja (cefiderocol)	J0699	cefiderocol	Antimicrobial	10 mg	1000 mg SDV	Commercial	Not Covered	No	**Not Covered**
Fetroja (cefiderocol)	J0699	cefiderocol	Antimicrobial	10 mg	1000 mg SDV	Medicaid	Not Covered	No	**Not Covered**
Fetroja (cefiderocol)	J0699	cefiderocol	Antimicrobial	10 mg	1000 mg SDV	Medicare	Non-specialty	No	No PA required
Fibryga (human fibrinogen concentrate)	J7177	human fibrinogen concentrate	Hemophilia	1 mg	1000 mg SDV	Commercial	Not Separately Payable	No	Not Separately Payable - Not Reviewed by Pharmacy
Fibryga (human fibrinogen concentrate)	J7177	human fibrinogen concentrate	Hemophilia	1 mg	1000 mg SDV	Medicaid	Covered	No	No PA required
Fibryga (human fibrinogen concentrate)	J7177	human fibrinogen concentrate	Hemophilia	1 mg	1000 mg SDV	Medicare	Not Separately Payable	No	Not Separately Payable - Not Reviewed by Pharmacy
Firazyr (icatibant)	J1744	icatibant	Hereditary Angioedema agent	1 mg	30 mg/3 mL SD syringe	Commercial	Refer to ADL	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Firazyr (icatibant)	J1744	icatibant	Hereditary Angioedema agent	1 mg	30 mg/3 mL SD syringe	Medicaid	Not Covered	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Firazyr (icatibant)	J1744	icatibant	Hereditary Angioedema agent	1 mg	30 mg/3 mL SD syringe	Medicare	Refer to ADL	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Firmagon (degrelix)	J9155	degrelix	Oncology	1 mg	80 mg, 240 mg SDV	Commercial	Non-specialty	No	No PA required when billed for ICD-10 diagnoses: C61, C79.82 and D07.5 All other ICD-10 diagnoses: PA required - see medical oncology prior authorization form for criteria
Firmagon (degrelix)	J9155	degrelix	Oncology	1 mg	80 mg, 240 mg SDV	Medicaid	Covered	No	No PA Required
Firmagon (degrelix)	J9155	degrelix	Oncology	1 mg	80 mg, 240 mg SDV	Medicare	Non-specialty	No	No PA required when billed for ICD-10 diagnoses: C61, C79.82 and D07.5 All other ICD-10 diagnoses:PA Required (Cancer Therapy) – See Medicare Part B Oncology Prior Authorization form
Flagyl (metronidazole)	J1836	metronidazole	Antimicrobial	10 mg		Commercial	Non-specialty	No	No PA required
Flagyl (metronidazole)	J1836	metronidazole	Antimicrobial	10 mg		Medicaid	Covered	No	No PA required
Flagyl (metronidazole)	J1836	metronidazole	Antimicrobial	10 mg		Medicare	Non-specialty	No	No PA required
Flebogamma (immune globulin) intravenous	J1572	IVIG	Immune Globulin	500 mg	0.5 gm, 2.5 gm, 5 gm, 10 gm, 20 gm SDV	Commercial	Pref. Specialty	YES	PA required - see IVIG/SCIG prior authorization form for criteria
Flebogamma (immune globulin) intravenous	J1572	IVIG	Immune Globulin	500 mg	0.5 gm, 2.5 gm, 5 gm, 10 gm, 20 gm SDV	Medicaid	Covered	YES	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth Forms tab.
Flebogamma (immune globulin) intravenous	J1572	IVIG	Immune Globulin	500 mg	0.5 gm, 2.5 gm, 5 gm, 10 gm, 20 gm SDV	Medicare	Pref. Specialty	No	Part B vs Part D – See Approved Drug List for covered formulations under Part D - see the Part B vs Part D coverage determination form for criteria
Flolan (epoprostenol sodium)	J1325	epoprostenol	pulmonary arterial hypertension (PAH) agent	0.5 mg	0.5 mg, 1.5 mg SDV	Commercial	NPS	YES	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth Forms tab.

Drug	Code	Generic	Category	Billing Unit	How Supplied	Line of Business	Coverage Level	Site Of Service	Comment
Flolan (epoprostenol sodium)	J1325	epoprostenol	pulmonary arterial hypertension (PAH) agent	0.5 mg	0.5 mg, 1.5 mg SDV	Medicaid	Covered	No	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth Forms tab.
Flolan (epoprostenol sodium)	J1325	epoprostenol	pulmonary arterial hypertension (PAH) agent	0.5 mg	0.5 mg, 1.5 mg SDV	Medicare	NPS	No	No PA required
floxuridine (**FUDR**)	J9200	floxuridine	Oncology	500 mg	500 mg SDV	Commercial	Non-specialty	No	No PA required
floxuridine (**FUDR**)	J9200	floxuridine	Oncology	500 mg	500 mg SDV	Medicaid	Covered	No	No PA required
floxuridine (**FUDR**)	J9200	floxuridine	Oncology	500 mg	500 mg SDV	Medicare	Non-specialty	No	No PA required
fluphenazine decanoate (**Prolixin Decanoate**)	J2680	fluphenazine	Central Nervous System (CNS) agent	25 mg	125 mg/5 mL MDV	Commercial	Non-specialty	No	No PA required
fluphenazine decanoate (**Prolixin Decanoate**)	J2680	fluphenazine	Central Nervous System (CNS) agent	25 mg	125 mg/5 mL MDV	Medicaid	Carve Out	No	Contact Fee for Service Medicaid for coverage
fluphenazine decanoate (**Prolixin Decanoate**)	J2680	fluphenazine	Central Nervous System (CNS) agent	25 mg	125 mg/5 mL MDV	Medicare	Non-specialty	No	No PA required
fluphenazine HCl (**Prolixin**)	J2679	fluphenazine	Central Nervous System (CNS) agent	1.25 mg	125 mg/5 mL MDV	Commercial	Non-specialty	No	No PA required
fluphenazine HCl (**Prolixin**)	J2679	fluphenazine	Central Nervous System (CNS) agent	1.25 mg	125 mg/5 mL MDV	Medicaid	Carve Out	No	Contact Fee for Service Medicaid for coverage
fluphenazine HCl (**Prolixin**)	J2679	fluphenazine	Central Nervous System (CNS) agent	1.25 mg	125 mg/5 mL MDV	Medicare	Not Covered	No	No PA required
Focinvez (fosaprepitant dimeglumine)	J1434	Fosaprepitant	antiemetic	1 mg	150 mg/50mL SDV	Commercial	Not covered	No	**Not covered**
Focinvez (fosaprepitant dimeglumine)	J1434	Fosaprepitant	antiemetic	1 mg	150 mg/50mL SDV	Medicaid	Covered	No	No PA required
Focinvez (fosaprepitant dimeglumine)	J1434	Fosaprepitant	antiemetic	1 mg	150 mg/50mL SDV	Medicare	NPS	No	No PA required

Drug	Code	Generic	Category	Billing Unit	How Supplied	Line of Business	Coverage Level	Site Of Service	Comment
Folotyn (pralatrexate)	J9307	pralatrexate	Oncology	1 mg	20 mg/mL, 40 mg/2 mL SDV	Commercial	Pref. Specialty	No	PA required - see medical oncology prior authorization form for criteria
Folotyn (pralatrexate)	J9307	pralatrexate	Oncology	1 mg	20 mg/mL, 40 mg/2 mL SDV	Medicaid	Covered	No	No PA Required
Folotyn (pralatrexate)	J9307	pralatrexate	Oncology	1 mg	20 mg/mL, 40 mg/2 mL SDV	Medicare	Medicare Chemo	No	No PA required
Forteo (teriparatide)	J3110	teriparatide	Bone modifying agent	10 mcg	20 mcg SD syringe	Commercial	Refer to ADL	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Forteo (teriparatide)	J3110	teriparatide	Bone modifying agent	10 mcg	20 mcg SD syringe	Medicaid	Not Covered	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Forteo (teriparatide)	J3110	teriparatide	Bone modifying agent	10 mcg	20 mcg SD syringe	Medicare	Refer to ADL	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
fosaprepitant - Teva Brand ONLY	J1456	fosaprepitant	Antiemetic	1 mg	150 mg SDV	Commercial	Non-specialty	No	No PA required
fosaprepitant - Teva Brand ONLY	J1456	fosaprepitant	Antiemetic	1 mg	150 mg SDV	Medicaid	Covered	No	No PA required
fosaprepitant - Teva Brand ONLY	J1456	fosaprepitant	Antiemetic	1 mg	150 mg SDV	Medicare	Non-specialty	No	No PA required
Fosrenol (lanthanum carbonate) *chewable tablet*	J0607 (For ESRD on dialysis)	Lanthanum carbonate	phospate binder	5 mg	500 mg, 750 mg, 1000mg chewable tablets	Commercial	Refer to ADL	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Fosrenol (lanthanum carbonate) *chewable tablet*	J0607 (For ESRD on dialysis)	Lanthanum carbonate	phospate binder	5 mg	500 mg, 750 mg, 1000mg chewable tablets	Medicaid	Not separately payable	No	Not separately payable
Fosrenol (lanthanum carbonate) *chewable tablet*	J0607 (For ESRD on dialysis)	Lanthanum carbonate	phospate binder	5 mg	500 mg, 750 mg, 1000mg chewable tablets	Medicare	Not separately payable	No	Included in ESRD PPS and not separately payable under Part B
Fosrenol (lanthanum carbonate) *powder packet*	J0608 (For ESRD on dialysis)	Lanthanum carbonate	phospate binder	5 mg	750 mg, 1000 mg powder packet	Commercial	Refer to ADL	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Fosrenol (lanthanum carbonate) *powder packet*	J0608 (For ESRD on dialysis)	Lanthanum carbonate	phospate binder	5 mg	750 mg, 1000 mg powder packet	Medicaid	Not separately payable	No	Not separately payable
Fosrenol (lanthanum carbonate) *powder packet*	J0608 (For ESRD on dialysis)	Lanthanum carbonate	phospate binder	5 mg	750 mg, 1000 mg powder packet	Medicare	Not separately payable	No	Included in ESRD PPS and not separately payable under Part B
Fulphila (pegfilgrastim-jmdb)	Q5108	pegfilgrastim	Hematopoietic agent	0.5mg	6 mg/0.6 mL SD syringe	Commercial	Pref. Specialty	No	No PA required
Fulphila (pegfilgrastim-jmdb)	Q5108	pegfilgrastim	Hematopoietic agent	0.5 mg	6 mg/0.6 mL SD syringe	Medicaid	Covered	No	No PA required
Fulphila (pegfilgrastim-jmdb)	Q5108	pegfilgrastim	Hematopoietic agent	0.5 mg	6 mg/0.6 mL SD syringe	Medicare	Pref. Specialty	No	No PA required
fulvestrant - FRESENIUS KABI Brand ONLY	J9394	fluvestrant	Oncology	25 mg	250 mg/5 mL SD syringe	Commercial	Pref. Specialty	No	No PA required
fulvestrant - FRESENIUS KABI Brand ONLY	J9394	fluvestrant	Oncology	25 mg	250 mg/5 mL SD syringe	Medicaid	Covered	No	No PA required
fulvestrant - FRESENIUS KABI Brand ONLY	J9394	fluvestrant	Oncology	25 mg	250 mg/5 mL SD syringe	Medicare	Medicare Chemo	No	No PA required
fulvestrant - TEVA Brand ONLY	J9393	fluvestrant	Oncology	25 mg	250 mg/5 mL SD syringe	Commercial	Pref. Specialty	No	No PA required
fulvestrant - TEVA Brand ONLY	J9393	fluvestrant	Oncology	25 mg	250 mg/5 mL SD syringe	Medicaid	Covered	No	No PA required
fulvestrant - TEVA Brand ONLY	J9393	fluvestrant	Oncology	25 mg	250 mg/5 mL SD syringe	Medicare	Medicare Chemo	No	No PA required
Furoscix (furosemide)	J1941	furosemide	Miscellaneous			Commercial	Not Covered	No	**Not Covered**
Furoscix (furosemide)	J1941	furosemide	Miscellaneous			Medicaid	Not Covered	No	**Not Covered**
Furoscix (furosemide)	J1941	furosemide	Miscellaneous			Medicare	Refer to ADL	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Fusilev (levoleucovorin)	J0641	levoleucovorin	Oncology	0.5 mg	50 mg SDV	Commercial	Pref. Specialty	No	No PA required
Fusilev (levoleucovorin)	J0641	levoleucovorin	Oncology	0.5 mg	50 mg SDV	Medicaid	Covered	No	No PA required
Fusilev (levoleucovorin)	J0641	levoleucovorin	Oncology	0.5 mg	50 mg SDV	Medicare	Pref. Specialty	No	No PA required
Fyarro (sirolimus protein-bound particles)	J9331	sirolimus protein-bound particles	Oncology	1 mg	100 mg SDV	Commercial	Pref. Specialty	No	PA required - see medical oncology prior authorization form for criteria
Fyarro (sirolimus protein-bound particles)	J9331	sirolimus protein-bound particles	Oncology	1 mg	100 mg SDV	Medicaid	Covered	No	No PA Required
Fyarro (sirolimus protein-bound particles)	J9331	sirolimus protein-bound particles	Oncology	1 mg	100 mg SDV	Medicare	Medicare Chemo	No	PA Required (Cancer Therapy) – See Medicare Part B Oncology Prior Authorization form
Fylnetra (pegfilgrastim-pbbk)	Q5130	pegfilgrastim	Hematopoietic agent	0.5 mg	6 mg/0.6 mL prefilled syringe	Commercial	Not Covered	No	**Not covered**
Fylnetra (pegfilgrastim-pbbk)	Q5130	pegfilgrastim	Hematopoietic agent	0.5 mg	7 mg/0.6 mL prefilled syringe	Medicaid	Not Covered	No	**Not Covered**
Fylnetra (pegfilgrastim-pbbk)	Q5130	pegfilgrastim	Hematopoietic agent	0.5 mg	8 mg/0.6 mL prefilled syringe	Medicare	NPS	No	PA Required - click here for criteria. Link for the Prior Authorization form is on the 'General Prior Auth Forms' tab.
Gamifant (emapalumab-lzsg)	J9210	emapalumab-lzsg	Miscellaneous	1 mg	10 mg/2 mL, 50 mg/10 mL, 100 mg/20 mL SDV	Commercial	Pref. Specialty	No	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth. Forms tab.
Gamifant (emapalumab-lzsg)	J9210	emapalumab-lzsg	Miscellaneous	1 mg	10 mg/2 mL, 50 mg/10 mL, 100 mg/20 mL SDV	Medicaid	Covered	YES	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth. Forms tab.
Gamifant (emapalumab-lzsg)	J9210	emapalumab-lzsg	Miscellaneous	1 mg	10 mg/2 mL, 50 mg/10 mL, 100 mg/20 mL SDV	Medicare	Pref. Specialty	No	PA required - See Medicare Medical Part B prior authorization form
Gammagard S/D (immune globulin) intravenous	J1566	IVIG	Immune Globulin	500 mg	5 gm, 10 gm SDV	Commercial	Not Covered	No	**Not Covered**
Gammagard S/D (immune globulin) intravenous	J1566	IVIG	Immune Globulin	500 mg	5 gm, 10 gm SDV	Medicaid	Not Covered	No	**Not Covered**
Gammagard S/D (immune globulin) intravenous	J1566	IVIG	Immune Globulin	500 mg	5 gm, 10 gm SDV	Medicare	Pref. Specialty	No	Part B vs Part D – See Approved Drug List for covered formulations under Part D - see the Part B vs Part D coverage determination form for criteria
Gammagard Liquid (immune globulin) intravenous	J1569	IVIG	Immune Globulin	500 mg	1 gm, 2.5 gm, 5 gm, 10 gm, 20 gm, 30 gm SDV	Commercial	Pref. Specialty	YES	PA required - see IVIG/SCIG prior authorization form for criteria
Gammagard Liquid (immune globulin) intravenous	J1569	IVIG	Immune Globulin	500 mg	1 gm, 2.5 gm, 5 gm, 10 gm, 20 gm, 30 gm SDV	Medicaid	Covered	YES	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth. Forms tab.
Gammagard Liquid (immune globulin) intravenous	J1569	IVIG	Immune Globulin	500 mg	1 gm, 2.5 gm, 5 gm, 10 gm, 20 gm, 30 gm SDV	Medicare	Pref. Specialty	No	Part B vs Part D – See Approved Drug List for covered formulations under Part D - see the Part B vs Part D coverage determination form for criteria
Gammaplex (immune globulin) intravenous	J1557	IVIG	Immune Globulin	500 mg	5 gm, 10 gm, 20 gm SDV	Commercial	Pref. Specialty	YES	PA required - see IVIG/SCIG prior authorization form for criteria
Gammaplex (immune globulin) intravenous	J1557	IVIG	Immune Globulin	500 mg	5 gm, 10 gm, 20 gm SDV	Medicaid	Covered	YES	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth. Forms tab.
Gammaplex (immune globulin) intravenous	J1557	IVIG	Immune Globulin	500 mg	5 gm, 10 gm, 20 gm SDV	Medicare	Pref. Specialty	No	Part B vs Part D – See Approved Drug List for covered formulations under Part D - see the Part B vs Part D coverage determination form for criteria
Gamunex-C/Gammaked (immune globulin) intravenous	J1561	IVIG	Immune Globulin	500 mg	1 gm, 2.5 gm, 5 gm, 10 gm, 20 gm, 40 gm SDV	Commercial	Pref. Specialty	YES	PA required - see IVIG/SCIG prior authorization form for criteria
Gamunex-C/Gammaked (immune globulin) intravenous	J1561	IVIG	Immune Globulin	500 mg	1 gm, 2.5 gm, 5 gm, 10 gm, 20 gm, 40 gm SDV	Medicaid	Covered	YES	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth. Forms tab.
Gamunex-C/Gammaked (immune globulin) intravenous	J1561	IVIG	Immune Globulin	500 mg	1 gm, 2.5 gm, 5 gm, 10 gm, 20 gm, 40 gm SDV	Medicare	Pref. Specialty	No	Part B vs Part D – See Approved Drug List for covered formulations under Part D - see the Part B vs Part D coverage determination form for criteria
Ganciclovir - Exela Pharma Brand ONLY	J1574	ganciclovir	Antimicrobial	500 mg	500 mg SDV	Commercial	Non-specialty	No	No PA required
Ganciclovir - Exela Pharma Brand ONLY	J1574	ganciclovir	Antimicrobial	500 mg	500 mg SDV	Medicaid	Covered	No	No PA required
Ganciclovir - Exela Pharma Brand ONLY	J1574	ganciclovir	Antimicrobial	500 mg	500 mg SDV	Medicare	Non-specialty	No	No PA required
Gattex (teduglutide)	J3490*, C9399*	teduglutide	Miscellaneous		5 mg SDV	Commercial	Refer to ADL	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Gattex (teduglutide)	J3490*, C9399*	teduglutide	Miscellaneous		5 mg SDV	Medicaid	Not Covered	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Gattex (teduglutide)	J3490*, C9399*	teduglutide	Miscellaneous		5 mg SDV	Medicare	Refer to ADL	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Gazyva (obinutuzumab)	J9301	obinutuzumab	Oncology	10 mg	1000 mg/40 mL SDV	Commercial	Pref. Specialty	No	PA required - see medical oncology prior authorization form for criteria
Gazyva (obinutuzumab)	J9301	obinutuzumab	Oncology	10 mg	1000 mg/40 mL SDV	Medicaid	Covered	No	No PA Required
Gazyva (obinutuzumab)	J9301	obinutuzumab	Oncology	10 mg	1000 mg/40 mL SDV	Medicare	Medicare Chemo	No	No PA required
Gel-One (hyaluronan/ hyaluronic acid) for intra-articular injection	J7326	hyaluronate sodium/ hyaluronic acid	Hyaluronic acid derivatives	Per dose	30 mg/3 mL SD syringe	Commercial	Not covered	No	**Not covered – See Pharmacy Policy EXPERIMENTAL/INVESTIGATIONAL/UNPROVEN CARE/ BENEFIT EXCEPTIONS for more information**
Gel-One (hyaluronan/ hyaluronic acid) for intra-articular injection	J7326	hyaluronate sodium/ hyaluronic acid	Hyaluronic acid derivatives	Per dose	30 mg/3 mL SD syringe	Medicaid	Not Covered	No	**Not covered**
Gel-One (hyaluronan/ hyaluronic acid) for intra-articular injection	J7326	hyaluronate sodium/ hyaluronic acid	Hyaluronic acid derivatives	Per dose	30 mg/3 mL SD syringe	Medicare	NPS	No	PA Required - click here for criteria. Link for the Prior Authorization form is on the 'General Prior Auth. Forms' tab.
Gelsyn-3 (hyaluronan/ hyaluronic acid) for intra-articular injection	J7328	hyaluronate sodium/ hyaluronic acid	Hyaluronic acid derivatives	0.1 mg	16.8 mg/2 mL SD syringe	Commercial	Not covered	No	**Not covered – See Pharmacy Policy EXPERIMENTAL/INVESTIGATIONAL/UNPROVEN CARE/ BENEFIT EXCEPTIONS for more information**
Gelsyn-3 (hyaluronan/ hyaluronic acid) for intra-articular injection	J7328	hyaluronate sodium/ hyaluronic acid	Hyaluronic acid derivatives	0.1 mg	16.8 mg/2 mL SD syringe	Medicaid	Not Covered	No	**Not covered**
Gelsyn-3 (hyaluronan/ hyaluronic acid) for intra-articular injection	J7328	hyaluronate sodium/ hyaluronic acid	Hyaluronic acid derivatives	0.1 mg	16.8 mg/2 mL SD syringe	Medicare	PS	No	No PA required

Drug	Code	Generic	Category	Billing Unit	How Supplied	Line of Business	Coverage Level	Site Of Service	Comment
gemcitabine HCl - (accord brand only)	J9196	gemcitabine	Oncology	200 mg		Commercial	Pref Specialty	No	No PA Required
gemcitabine HCl - (accord brand only)	J9196	gemcitabine	Oncology	200 mg		Medicaid	Covered	No	No PA Required
gemcitabine HCl - (accord brand only)	J9196	gemcitabine	Oncology	200 mg		Medicare	Medicare Chemo	No	No PA Required
Gemzar (gemcitabine HCl)	J9201	gemcitabine	Oncology	200 mg		Commercial	Pref Specialty	No	No PA Required
Gemzar (gemcitabine HCl)	J9201	gemcitabine	Oncology	200 mg		Medicaid	Covered	No	No PA Required
Gemzar (gemcitabine HCl)	J9201	gemcitabine	Oncology	200 mg		Medicare	Medicare Chemo	No	No PA Required
Gengraf (cyclosporin, modified) ORAL ONLY	J7515-25mg J7502-100mg	cyclosporin	Immunosuppressive agent	25 mg (J7515) 100 mg (J7502)	25 mg, 50 mg, 100 mg capsule	Medicare	Non-specialty	No	Part B vs Part D – See Approved Drug List for covered formulations under Part D - see the Part B vs Part D coverage determination form for criteria
GenVisc 850 (hyaluronan/ hyaluronic acid) for intra-articular injection	J7320	hyaluronate sodium/ hyaluronic acid	Hyaluronic acid derivatives	1 mg	25 mg/2.5 mL SD syringe	Commercial	Not covered	No	**Not covered – See Pharmacy Policy EXPERIMENTAL/INVESTIGATIONAL/UNPROVEN CARE/ BENEFIT EXCEPTIONS for more information**
GenVisc 850 (hyaluronan/ hyaluronic acid) for intra-articular injection	J7320	hyaluronate sodium/ hyaluronic acid	Hyaluronic acid derivatives	1 mg	25 mg/2.5 mL SD syringe	Medicaid	Not Covered	No	**Not covered**
GenVisc 850 (hyaluronan/ hyaluronic acid) for intra-articular injection	J7320	hyaluronate sodium/ hyaluronic acid	Hyaluronic acid derivatives	1 mg	25 mg/2.5 mL SD syringe	Medicare	NPS	No	PA Required - click here for criteria. Link for the Prior Authorization form is on the 'General Prior Auth. Forms' tab.
Geodon (ziprasidone mesylate)	J3486	ziprasidone	Central Nervous System (CNS) agent	10 mg	20 mg SDV	Commercial	Non-specialty	No	No PA required
Geodon (ziprasidone mesylate)	J3486	ziprasidone	Central Nervous System (CNS) agent	10 mg	20 mg SDV	Medicaid	Carve Out	No	Contact Fee for Service Medicaid for coverage
Geodon (ziprasidone mesylate)	J3486	ziprasidone	Central Nervous System (CNS) agent	10 mg	20 mg SDV	Medicare	Non-specialty	No	No PA required
Givlaari (givosiran)	J0223	givosiran	Miscellaneous	0.5 mg	189 mg/mL SDV	Commercial	Pref. Specialty	YES	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth. Forms tab.
Givlaari (givosiran)	J0223	givosiran	Miscellaneous	0.5 mg	189 mg/mL SDV	Medicaid	Covered	YES	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth. Forms tab.
Givlaari (givosiran)	J0223	givosiran	Miscellaneous	0.5 mg	189 mg/mL SDV	Medicare	Pref. Specialty	No	PA required - See Medicare Medical Part B prior authorization form
Glassia (alpha1 proteinase inhibitor)	J0257	alpha1 proteinase inhibitor	Enzyme deficiency	10 mg	1000 mg/50 mL SDV	Commercial	Pref. Specialty	YES	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth. Forms tab.
Glassia (alpha1 proteinase inhibitor)	J0257	alpha1 proteinase inhibitor	Enzyme deficiency	10 mg	1000 mg/50 mL SDV	Medicaid	Covered	YES	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth. Forms tab.
Glassia (alpha1 proteinase inhibitor)	J0257	alpha1 proteinase inhibitor	Enzyme deficiency	10 mg	1000 mg/50 mL SDV	Medicare	Pref. Specialty	No	PA required - See Medicare Medical Part B prior authorization form
GlucaGen (Glucagon)	J1610 - Not for Fresenius Kabi brand - See J1611	glucagon	Miscellaneous	1 mg	1 mg SDV	Commercial	Non-specialty	No	No PA required
GlucaGen (Glucagon)	J1610 - Not for Fresenius Kabi brand - See J1611	glucagon	Miscellaneous	1 mg	1 mg SDV	Medicaid	Covered	No	No PA required
GlucaGen (Glucagon)	J1610 - Not for Fresenius Kabi brand - See J1611	glucagon	Miscellaneous	1 mg	1 mg SDV	Medicare	Non-specialty	No	No PA required
Glucagon - Fresenius Kabi Brand ONLY	J1611	glucagon	Miscellaneous	1 mg	1 mg SDV	Commercial	Non-specialty	No	No PA required
Glucagon - Fresenius Kabi Brand ONLY	J1611	glucagon	Miscellaneous	1 mg	1 mg SDV	Medicaid	Covered	No	No PA required
Glucagon - Fresenius Kabi Brand ONLY	J1611	glucagon	Miscellaneous	1 mg	1 mg SDV	Medicare	Non-specialty	No	No PA required
Granix (tbo-filgrastim)	J1447	filgrastim	Hematopoietic agent	1 mcg	300 mcg/0.5 mL, 480 mcg/0.8 mL SD syringe, 300 mcg/mL, 480 mcg/1.6 mL SDV	Commercial	NPS	No	No PA required
Granix (tbo-filgrastim)	J1447	filgrastim	Hematopoietic agent	1 mcg	300 mcg/0.5 mL, 480 mcg/0.8 mL SD syringe, 300 mcg/mL, 480 mcg/1.6 mL SDV	Medicaid	Covered	No	No PA required
Granix (tbo-filgrastim)	J1447	filgrastim	Hematopoietic agent	1 mcg	300 mcg/0.5 mL, 480 mcg/0.8 mL SD syringe, 300 mcg/mL, 480 mcg/1.6 mL SDV	Medicare	NPS	No	PA Required - click here for criteria. Link for the Prior Authorization form is on the 'General Prior Auth. Forms' tab.
Haegarda (C1 esterase inhibitor [human])	J0599	C-1 esterase inhibitor	Hereditary Angioedema agent	10 units	2000 unit, 3000 unit SDV	Commercial	Refer to ADL	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Haegarda (C1 esterase inhibitor [human])	J0599	C-1 esterase inhibitor	Hereditary Angioedema agent	10 units	2000 unit, 3000 unit SDV	Medicaid	Not Covered	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Haegarda (C1 esterase inhibitor [human])	J0599	C-1 esterase inhibitor	Hereditary Angioedema agent	10 units	2000 unit, 3000 unit SDV	Medicare	Refer to ADL	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Halaven (eribulin mesylate)	J9179	eribulin	Oncology	0.1 mg	1 mg/2 mL SDV	Commercial	NPS	No	No PA required
Halaven (eribulin mesylate)	J9179	eribulin	Oncology	0.1 mg	1 mg/2 mL SDV	Medicaid	Covered	No	No PA required
Halaven (eribulin mesylate)	J9179	eribulin	Oncology	0.1 mg	1 mg/2 mL SDV	Medicare	NPS	No	No PA required
Haldol (haloperidol decanoate)	J1631	haloperidol	Central Nervous System (CNS) agent	50 mg	50 mg/mL, 100 mg/mL SDV, 250 mg/5 mL, 500 mg/5 mL MDV	Commercial	Non-specialty	No	No PA required
Haldol (haloperidol decanoate)	J1631	haloperidol	Central Nervous System (CNS) agent	50 mg	50 mg/mL, 100 mg/mL SDV, 250 mg/5 mL, 500 mg/5 mL MDV	Medicaid	Carve Out	No	Contact Fee for Service Medicaid for coverage
Haldol (haloperidol decanoate)	J1631	haloperidol	Central Nervous System (CNS) agent	50 mg	50 mg/mL, 100 mg/mL SDV, 250 mg/5 mL, 500 mg/5 mL MDV	Medicare	Non-specialty	No	No PA required
Haldol (haloperidol lactate)	J1630	haloperidol	Central Nervous System (CNS) agent	5 mg	5 mg/mL SD syringe, 50 mg/10 mL MDV	Commercial	Non-specialty	No	No PA required
Haldol (haloperidol lactate)	J1630	haloperidol	Central Nervous System (CNS) agent	5 mg	5 mg/mL SD syringe, 50 mg/10 mL MDV	Medicaid	Carve Out	No	Contact Fee for Service Medicaid for coverage
Haldol (haloperidol lactate)	J1630	haloperidol	Central Nervous System (CNS) agent	5 mg	5 mg/mL SD syringe, 50 mg/10 mL MDV	Medicare	Non-specialty	No	No PA required
Helixate FS (Antihemophilic Factor VIII)	J7192	Antihemophilic Factor VIII	Hemophilia			Commercial	Refer to ADL	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Helixate FS (Antihemophilic Factor VIII)	J7192	Antihemophilic Factor VIII	Hemophilia			Medicaid	Not Covered	No	Refer to the Medicaid Approved Drug List (ADL) for pharmacy benefit coverage. For one-time doses required for planned outpatient procedures (professional/facility claims), authorizations will be reviewed for medical necessity according to the Hemophilia Management Medical Policy 91569
Helixate FS (Antihemophilic Factor VIII)	J7192	Antihemophilic Factor VIII	Hemophilia			Medicare	Pref. Specialty	No	No PA required
Hemgenix (etranacogene dezaparvovec-drlb)	J1411	etranacogene dezaparvovec-drlb	Gene/Cellular Therapy	per dose	SD infusion bag	Commercial	Gene Therapy	YES	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth. Forms tab.
Hemgenix (etranacogene dezaparvovec-drlb)	J1411	etranacogene dezaparvovec-drlb	Gene/Cellular Therapy	per dose	SD infusion bag	Medicaid	Carve Out	No	Contact Fee for Service Medicaid for coverage
Hemgenix (etranacogene dezaparvovec-drlb)	J1411	etranacogene dezaparvovec-drlb	Gene/Cellular Therapy	per dose	SD infusion bag	Medicare	Gene Therapy	No	PA Required - click here for criteria. Link for the Prior Authorization form is on the 'General Prior Auth. Forms' tab.
Hemlibra (Emicizumab)	J7170	Emicizumab	Hemophilia			Commercial	Refer to ADL	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Hemlibra (Emicizumab)	J7170	Emicizumab	Hemophilia			Medicaid	Not Covered	No	Refer to the Medicaid Approved Drug List (ADL) for pharmacy benefit coverage. For one-time doses required for planned outpatient procedures (professional/facility claims), authorizations will be reviewed for medical necessity according to the Hemophilia Management Medical Policy 91569
Hemlibra (Emicizumab)	J7170	Emicizumab	Hemophilia			Medicare	Pref. Specialty	No	No PA required
Hemofil M (Antihemophilic Factor VIII)	J7190	Antihemophilic Factor VIII	Hemophilia			Commercial	Refer to ADL	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Hemofil M (Antihemophilic Factor VIII)	J7190	Antihemophilic Factor VIII	Hemophilia			Medicaid	Not Covered	No	Refer to the Medicaid Approved Drug List (ADL) for pharmacy benefit coverage. For one-time doses required for planned outpatient procedures (professional/facility claims), authorizations will be reviewed for medical necessity according to the Hemophilia Management Medical Policy 91569
Hemofil M (Antihemophilic Factor VIII)	J7190	Antihemophilic Factor VIII	Hemophilia			Medicare	Pref. Specialty	No	No PA required
Hepagam (hepatitis B immune globulin)	J1573	Hepatitis B IG	Immune Globulin	0.5 mL	At least 312 units/mL (1 mL and 5 mL SDV)--actual potency varies by lot	Commercial	Non-Specialty	No	No PA required
Hepagam (hepatitis B immune globulin)	J1573	Hepatitis B IG	Immune Globulin	0.5 mL	At least 312 units/mL (1 mL and 5 mL SDV)--actual potency varies by lot	Medicaid	Covered	No	No PA required
Hepagam (hepatitis B immune globulin)	J1573	Hepatitis B IG	Immune Globulin	0.5 mL	At least 312 units/mL (1 mL and 5 mL SDV)--actual potency varies by lot	Medicare	Non-Specialty	No	No PA required
Hepzato Kit (melphalan)	J9248	melphalan	Oncology	1 mg	5 x 50 mg SDV Kit	Commercial	Pref. Specialty	No	PA required - see medical oncology prior authorization form for criteria
Hepzato Kit (melphalan)	J9248	melphalan	Oncology	1 mg	5 x 50 mg SDV Kit	Medicaid	Covered	No	No PA Required
Hepzato Kit (melphalan)	J9248	melphalan	Oncology	1 mg	5 x 50 mg SDV Kit	Medicare	Medicare Chemo	No	PA Required (Cancer Therapy) – See Medicare Part B Oncology Prior Authorization form

Drug	Code	Generic	Category	Billing Unit	How Supplied	Line of Business	Coverage Level	Site Of Service	Comment
Herceptin (trastuzumab)	J9355	trastuzumab	Oncology	10 mg	150 mg SDV	Commercial	Not covered	No	**Not covered**
Herceptin (trastuzumab)	J9355	trastuzumab	Oncology	10 mg	150 mg SDV	Medicaid	Covered	No	No PA Required
Herceptin (trastuzumab)	J9355	trastuzumab	Oncology	10 mg	150 mg SDV	Medicare	Medicare Chemo	No	PA Required - click here for criteria. Link for the Prior Authorization form is on the 'General Prior Auth Forms' tab.
Herceptin Hylecta (trastuzumab and hyaluronidase)	J9356	trastuzumab and hyaluronidase	Oncology	10 mg	600 mg-10000 unit/5 mL SDV	Commercial	Not covered	No	**Not covered. Use biosimilars Trazimera or Kanjinti**
Herceptin Hylecta (trastuzumab and hyaluronidase)	J9356	trastuzumab and hyaluronidase	Oncology	10 mg	600 mg-10000 unit/5 mL SDV	Medicaid	Covered	No	No PA Required
Herceptin Hylecta (trastuzumab and hyaluronidase)	J9356	trastuzumab and hyaluronidase	Oncology	10 mg	600 mg-10000 unit/5 mL SDV	Medicare	Medicare Chemo	No	PA Required - click here for criteria. Link for the Prior Authorization form is on the 'General Prior Auth Forms' tab.
Hercessi (trastuzumab-strf)	Q5146	trastuzumab	Oncology	10 mg	150 mg, 420 mg SDV	Commercial	Not Covered	No	**Not Covered until evaluated at P & T**
Hercessi (trastuzumab-strf)	Q5146	trastuzumab	Oncology	10 mg	150 mg, 420 mg SDV	Medicaid	Covered	No	No PA required
Hercessi (trastuzumab-strf)	Q5146	trastuzumab	Oncology	10 mg	150 mg, 420 mg SDV	Medicare	Medicare Chemo	No	PA Required (Cancer Therapy) – See Medicare Part B Oncology Prior Authorization form
Herzuma (trastuzumab-pkrb)	Q5113	trastuzumab	Oncology	10 mg	150 mg, 420 mg SDV	Commercial	Not covered	No	**Not covered**
Herzuma (trastuzumab-pkrb)	Q5113	trastuzumab	Oncology	10 mg	150 mg, 420 mg SDV	Medicaid	Covered	No	No PA Required
Herzuma (trastuzumab-pkrb)	Q5113	trastuzumab	Oncology	10 mg	150 mg, 420 mg SDV	Medicare	Medicare Chemo	No	PA Required - click here for criteria. Link for the Prior Authorization form is on the 'General Prior Auth Forms' tab.
Hizentra (immune globulin) subcutaneous	J1559	SCIG	Immune Globulin	100 mg	1 gm, 2 gm, 4 gm, 10 gm SDV, 1 gm, 2 gm, 4 gm SD syringe	Commercial	Pref. Specialty	YES	PA required - see IVIG/SCIG prior authorization form for criteria
Hizentra (immune globulin) subcutaneous	J1559	SCIG	Immune Globulin	100 mg	1 gm, 2 gm, 4 gm, 10 gm SDV, 1 gm, 2 gm, 4 gm SD syringe	Medicaid	Covered	No	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth Forms tab.
Hizentra (immune globulin) subcutaneous	J1559	SCIG	Immune Globulin	100 mg	1 gm, 2 gm, 4 gm, 10 gm SDV, 1 gm, 2 gm, 4 gm SD syringe	Medicare	Pref. Specialty	No	Part B vs Part D – See Approved Drug List for covered formulations under Part D - see the Part B vs Part D coverage determination form for criteria
Hulio (adalimumab-fkjp)	Q5140	adalimumab	Inflammatory Conditions	1 mg	various	Commercial	Refer to ADL	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Hulio (adalimumab-fkjp)	Q5140	adalimumab	Inflammatory Conditions	1 mg	various	Medicaid	Not Covered	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Hulio (adalimumab-fkjp)	Q5140	adalimumab	Inflammatory Conditions	1 mg	various	Medicare	Refer to ADL	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Humate-P (Von Willebrand Factor)	J7187	Von Willebrand Factor	Hemophilia			Commercial	Refer to ADL	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Humate-P (Von Willebrand Factor)	J7187	Von Willebrand Factor	Hemophilia			Medicaid	Not Covered	No	Refer to the Medicaid Approved Drug List (ADL) for pharmacy benefit coverage. For one-time doses required for planned outpatient procedures (professional/facility claims), authorizations will be reviewed for medical necessity according to the Hemophilia Management Medical Policy 91569
Humate-P (Von Willebrand Factor)	J7187	Von Willebrand Factor	Hemophilia			Medicare	Pref. Specialty	No	No PA required
Humatrope, Saizen, Genotropin, Norditropin Omnitrope, Nutropin, Serostim, Tev-Tropin (somatropin)	J2941	Somatropin	Human Growth Hormone			Commercial	Refer to ADL	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Humatrope, Saizen, Genotropin, Norditropin Omnitrope, Nutropin, Serostim, Tev-Tropin (somatropin)	J2941	Somatropin	Human Growth Hormone			Medicaid	Not Covered	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Humatrope, Saizen, Genotropin, Norditropin Omnitrope, Nutropin, Serostim, Tev-Tropin (somatropin)	J2941	Somatropin	Human Growth Hormone			Medicare	Refer to ADL	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit

Drug	Code	Generic	Category	Billing Unit	How Supplied	Line of Business	Coverage Level	Site Of Service	Comment
Humira (adalimumab)	J0139	adalimumab	Inflammatory Conditions	1 mg	various	Commercial	Refer to ADL	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Humira (adalimumab)	J0139	adalimumab	Inflammatory Conditions	1 mg	various	Medicaid	Not Covered	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Humira (adalimumab)	J0139	adalimumab	Inflammatory Conditions	1 mg	various	Medicare	Refer to ADL	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Hyalgan (hyaluronan/ hyaluronic acid) for intra-articular injection	J7321	hyaluronate sodium/ hyaluronic acid	Hyaluronic acid derivatives	per dose	20mg/2 ml SD syringe 20mg/2 ml SDV	Commercial	Not covered	No	**Not covered – See Pharmacy Policy EXPERIMENTAL/INVESTIGATIONAL/UNPROVEN CARE/ BENEFIT EXCEPTIONS for more information**
Hyalgan (hyaluronan/ hyaluronic acid) for intra-articular injection	J7321	hyaluronate sodium/ hyaluronic acid	Hyaluronic acid derivatives	per dose	20mg/2 ml SD syringe 20mg/2 ml SDV	Medicaid	Not Covered	No	**Not covered**
Hyalgan (hyaluronan/ hyaluronic acid) for intra-articular injection	J7321	hyaluronate sodium/ hyaluronic acid	Hyaluronic acid derivatives	per dose	20mg/2 ml SD syringe 20mg/2 ml SDV	Medicare	NPS	No	PA Required - click here for criteria. Link for the Prior Authorization form is on the 'General Prior Auth Forms' tab.
Hycamtin (topotecan)	J9351	topotecan	Oncology	0.1 mg	4 mg SDV	Commercial	Pref. Specialty	No	No PA required
Hycamtin (topotecan)	J9351	topotecan	Oncology	0.1 mg	4 mg SDV	Medicaid	Covered	No	No PA required
Hycamtin (topotecan)	J9351	topotecan	Oncology	0.1 mg	4 mg SDV	Medicare	Pref. Specialty	No	No PA required
hydroxyprogesterone caproate (generic)	J1729	hydroxyprogesterone	Miscellaneous	10 mg	1.25g/5 mL MDV	Commercial	Pref. Specialty	No	No PA required when billed with the following ICD-10 codes: C54-C54.9, C55, E23.0, E28.31-E28.319, E28.39, E28.9, N91-N91.5, N92.1, N92.5, N92.6, N93.8, N93.9, N95.1, N97.0, and Z85.42. For all other diagnoses - Use general Medical Drug Request form here
hydroxyprogesterone caproate (generic)	J1729	hydroxyprogesterone	Miscellaneous	10 mg	1.25g/5 mL MDV	Medicaid	Covered	No	J1729 = Delalutin. No prior authorization required. Only covered when used for FDA approved indications.
hydroxyprogesterone caproate (generic)	J1729	hydroxyprogesterone	Miscellaneous	10 mg	1.25g/5 mL MDV	Medicare	Pref. Specialty	No	No PA Required when billed with the following ICD-10 Codes: C54-C54.9, C55, E23.0, E28.31-E28.319, E28.39, E28.9, N91-N91.5, N92.1, N92.5, N92.6, N93.8, N93.9, N95.1, N97.0, and Z85.42. All other diagnoses. Prior Authorization required. Use general Medicare Part B form for request.
Hymovis (hyaluronan/ hyaluronic acid) for intra-articular injection	J7322	hyaluronate sodium/ hyaluronic acid	Hyaluronic acid derivatives	1 mg	24 mg/3 mL SD syringe	Commercial	Not covered	No	**Not covered – See Pharmacy Policy EXPERIMENTAL/INVESTIGATIONAL/UNPROVEN CARE/ BENEFIT EXCEPTIONS for more information**
Hymovis (hyaluronan/ hyaluronic acid) for intra-articular injection	J7322	hyaluronate sodium/ hyaluronic acid	Hyaluronic acid derivatives	1 mg	24 mg/3 mL SD syringe	Medicaid	Not Covered	No	**Not covered**
Hymovis (hyaluronan/ hyaluronic acid) for intra-articular injection	J7322	hyaluronate sodium/ hyaluronic acid	Hyaluronic acid derivatives	1 mg	24 mg/3 mL SD syringe	Medicare	NPS	No	PA Required - click here for criteria. Link for the Prior Authorization form is on the 'General Prior Auth Forms' tab.
HyQvia (immune globulin and hyaluronidase) subcutaneous	J1575	SCIG	Immune Globulin	100 mg	2.5 gm, 5 gm, 10 gm, 20 gm, 30 gm SDV	Commercial	Pref. Specialty	YES	PA required - see IVIG/SCIG prior authorization form for criteria
HyQvia (immune globulin and hyaluronidase) subcutaneous	J1575	SCIG	Immune Globulin	100 mg	2.5 gm, 5 gm, 10 gm, 20 gm, 30 gm SDV	Medicaid	Covered	No	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth Forms tab.
HyQvia (immune globulin and hyaluronidase) subcutaneous	J1575	SCIG	Immune Globulin	100 mg	2.5 gm, 5 gm, 10 gm, 20 gm, 30 gm SDV	Medicare	Pref. Specialty	No	Part B vs Part D – See Approved Drug List for covered formulations under Part D - see the Part B vs Part D coverage determination form for criteria
Ibandronate (generic **Boniva**)	J1740	Ibandronate	Bone modifying agent	1 mg	3 mg/3 mL SDV	Commercial	Pref. Specialty	No	No PA required
Ibandronate (generic **Boniva**)	J1740	Ibandronate	Bone modifying agent	1 mg	3 mg/3 mL SDV	Medicaid	Covered	No	No PA required
Ibandronate (generic **Boniva**)	J1740	Ibandronate	Bone modifying agent	1 mg	3 mg/3 mL SDV	Medicare	Pref. Specialty	No	PA required - See Medicare Medical Part B prior authorization form
Idacio (adalimumab-aacf)	Q5144	adalimumab	Inflammatory Conditions	1 mg	various	Commercial	Refer to ADL	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Idacio (adalimumab-aacf)	Q5144	adalimumab	Inflammatory Conditions	1 mg	various	Medicaid	Not Covered	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Idacio (adalimumab-aacf)	Q5144	adalimumab	Inflammatory Conditions	1 mg	various	Medicare	Refer to ADL	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Idamycin (idarubicin)	J9211	idarubicin	Oncology	5 mg	5 mg/5 mL, 10 mg/10 mL, 20 mg/20 mL SDV	Commercial	Non-specialty	No	No PA required
Idamycin (idarubicin)	J9211	idarubicin	Oncology	5 mg	5 mg/5 mL, 10 mg/10 mL, 20 mg/20 mL SDV	Medicaid	Covered	No	No PA required
Idamycin (idarubicin)	J9211	idarubicin	Oncology	5 mg	5 mg/5 mL, 10 mg/10 mL, 20 mg/20 mL SDV	Medicare	Non-specialty	No	No PA required
Idelvion (Antihemophilic Factor IX Albumin Fusion Protein)	J7202	Antihemophilic Factor IX Albumin Fusion Protein	Hemophilia			Commercial	Refer to ADL	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Idelvion (Antihemophilic Factor IX Albumin Fusion Protein)	J7202	Antihemophilic Factor IX Albumin Fusion Protein	Hemophilia			Medicaid	Not Covered	No	Refer to the Medicaid Approved Drug List (ADL) for pharmacy benefit coverage. For one-time doses required for planned outpatient procedures (professional/facility claims), authorizations will be reviewed for medical necessity according to the Hemophilia Management Medical Policy 91569
Idelvion (Antihemophilic Factor IX Albumin Fusion Protein)	J7202	Antihemophilic Factor IX Albumin Fusion Protein	Hemophilia			Medicare	Pref. Specialty	No	No PA required
iDose TR (travoprost intracameral implant)	J7355	travoprost	Ophthalmic	1 mcg	75 mcg per each	Commercial	Not Covered	No	Not Covered
iDose TR (travoprost intracameral implant)	J7355	travoprost	Ophthalmic	1 mcg	75 mcg per each	Medicaid	Not Covered	No	Not Covered
iDose TR (travoprost intracameral implant)	J7355	travoprost	Ophthalmic	1 mcg	75 mcg per each	Medicare	NPS	No	PA Required - click here for criteria. Link for the Prior Authorization form is on the 'General Prior Auth Forms' tab.
Ifex (ifosfamide)	J9208	ifosfamide	Oncology	1 gm	1 gm, 3 gm SDV	Commercial	Non-specialty	No	No PA required
Ifex (ifosfamide)	J9208	ifosfamide	Oncology	1 gm	1 gm, 3 gm SDV	Medicaid	Covered	No	No PA required
Ifex (ifosfamide)	J9208	ifosfamide	Oncology	1 gm	1 gm, 3 gm SDV	Medicare	Non-specialty	No	No PA required
Iheezo (chloroprocaine)	J2403	chloroprocaine HCl	Ophthalmic	1 mg		Commercial	Not Covered	No	Not Covered
Iheezo (chloroprocaine)	J2403	chloroprocaine HCl	Ophthalmic	1 mg		Medicaid	Not Covered	No	Not Covered
Iheezo (chloroprocaine)	J2403	chloroprocaine HCl	Ophthalmic	1 mg		Medicare	NPS	No	PA required - See Medicare Medical Part B prior authorization form
Ilaris (canakinumab)	J0638	canakinumab	Inflammatory Conditions	1 mg	150 mg SDV	Commercial	NPS	YES	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth Forms tab.
Ilaris (canakinumab)	J0638	canakinumab	Inflammatory Conditions	1 mg	150 mg SDV	Medicaid	Covered	YES	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth Forms tab.
Ilaris (canakinumab)	J0638	canakinumab	Inflammatory Conditions	1 mg	150 mg SDV	Medicare	NPS	No	No PA required - Starting 1-1-2025, PA Required for new starts
Illuccix (Gallium 68)	A9596	Gallium 68	Radio-pharmaceuticals	1 millicurie (mCi)	1 kit containing 3 vials	Commercial	Non-Specialty	No	No PA Required
Illuccix (Gallium 68)	A9596	Gallium 68	Radio-pharmaceuticals	1 millicurie (mCi)	1 kit containing 3 vials	Medicaid	Non-Specialty	No	No PA Required
Illuccix (Gallium 68)	A9596	Gallium 68	Radio-pharmaceuticals	1 millicurie (mCi)	1 kit containing 3 vials	Medicare	Non-Specialty	No	No PA Required
Ilumya (tildrakizumab)	J3245	tildrakizumab	Inflammatory Conditions	1 mg	100 mg SD syringe	Commercial	NPS	No	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth Forms tab.
Ilumya (tildrakizumab)	J3245	tildrakizumab	Inflammatory Conditions	1 mg	100 mg SD syringe	Medicaid	Covered	YES	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth Forms tab.
Ilumya (tildrakizumab)	J3245	tildrakizumab	Inflammatory Conditions	1 mg	100 mg SD syringe	Medicare	NPS	No	PA Required - click here for criteria. Link for the Prior Authorization form is on the 'General Prior Auth Forms' tab.
Iluvien (fluocinolone acetonide, intravitreal implant)	J7313	fluocinolone	Ophthalmic	0.01 mg	0.19 mg implant	Commercial	Pref. Specialty	No	No PA required when billed for the following ICD-10 codes: E08.311, E08.3211-E08.3213, E08.3311-E08.3313, E08.3411-E08.3413, E08.3511-E08.3513, E09.311, E09.3211- E09.3213, E09.3311-E09.3313, E09.3411-E09.3413, E09.3511-E09.3513, E10.311, E10.321 –E10.3213, E10.3311-E10.3313, E10.3411-E10.3413, E10.3511-E10.3513, E10.3511-E10.3513, E11.311, E11.3211-E11.3213, E11.3311- E11.3313, E11.3411-E11.3413, E11.3511-E11.353, E13.3111-E13.3113, E13.3211-E13.3213, E13.3311-E13.3313, E13.3411-E13.3413, E13.3511-E13.353
Iluvien (fluocinolone acetonide, intravitreal implant)	J7313	fluocinolone	Ophthalmic	0.01 mg	0.19 mg implant	Medicaid	Covered	No	No PA required when billed for the following ICD-10 codes: E08.311, E08.3211-E08.3213, E08.3311-E08.3313, E08.3411-E08.3413, E08.3511-E08.3513, E09.311, E09.3211- E09.3213, E09.3311-E09.3313, E09.3411-E09.3413, E09.3511-E09.3513, E10.311, E10.321 –E10.3213, E10.3311-E10.3313, E10.3411-E10.3413, E10.3511-E10.3513, E10.3511-E10.3513, E11.311, E11.3211-E11.3213, E11.3311- E11.3313, E11.3411-E11.3413, E11.3511-E11.353, E13.3111-E13.3113, E13.3211-E13.3213, E13.3311-E13.3313, E13.3411-E13.3413, E13.3511-E13.353
Iluvien (fluocinolone acetonide, intravitreal implant)	J7313	fluocinolone	Ophthalmic	0.01 mg	0.19 mg implant	Medicare	Pref. Specialty	No	PA Required - click here for criteria. Link for the Prior Authorization form is on the 'General Prior Auth Forms' tab.
Imdeltra (tarlatamab-dlle)	J9026	tarlatamab	Oncology	1 mg	1 mg, 10 mg SDV	Commercial	Pref. Specialty	YES	PA required - see medical oncology prior authorization form for criteria
Imdeltra (tarlatamab-dlle)	J9026	tarlatamab	Oncology	1 mg	1 mg, 10 mg SDV	Medicaid	Covered	No	No PA Required
Imdeltra (tarlatamab-dlle)	J9026	tarlatamab	Oncology	1 mg	1 mg, 10 mg SDV	Medicare	Medicare Chemo	No	PA Required (Cancer Therapy) – See Medicare Part B Oncology Prior Authorization form
Imfinzi (durvalumab)	J9173	durvalumab	Oncology	10 mg	120 mg/2.4 mL, 500 mg/10 mL SDV	Commercial	Pref. Specialty	YES	PA required - see medical oncology prior authorization form for criteria
Imfinzi (durvalumab)	J9173	durvalumab	Oncology	10 mg	120 mg/2.4 mL, 500 mg/10 mL SDV	Medicaid	Covered	No	No PA Required
Imfinzi (durvalumab)	J9173	durvalumab	Oncology	10 mg	120 mg/2.4 mL, 500 mg/10 mL SDV	Medicare	Medicare Chemo	No	PA Required (Cancer Therapy) – See Medicare Part B Oncology Prior Authorization form
Imjudo (tremelimumab-actl)	J9347	tremelimumab	Oncology	1mg	25mg/1.25mL SDV 300mg/15mL SDV	Commercial	Pref. Specialty	YES	PA required - see medical oncology prior authorization form for criteria
Imjudo (tremelimumab-actl)	J9347	tremelimumab	Oncology	1mg	25mg/1.25mL SDV 300mg/15mL SDV	Medicaid	Covered	No	No PA Required
Imjudo (tremelimumab-actl)	J9347	tremelimumab	Oncology	1mg	25mg/1.25mL SDV 300mg/15mL SDV	Medicare	Medicare Chemo	No	PA Required (Cancer Therapy) – See Medicare Part B Oncology Prior Authorization form
Imlygic (talimogene laherparepvec)	J9325	talimogene laherparepvec	Gene/Cellular Therapy	1 million PFU	1 million, 100 million PFU SDV	Commercial	NPS	No	PA required - see medical oncology prior authorization form for criteria
Imlygic (talimogene laherparepvec)	J9325	talimogene laherparepvec	Gene/Cellular Therapy	1 million PFU	1 million, 100 million PFU SDV	Medicaid	Covered	No	No PA Required
Imlygic (talimogene laherparepvec)	J9325	talimogene laherparepvec	Gene/Cellular Therapy	1 million PFU	1 million, 100 million PFU SDV	Medicare	Medicare Chemo	No	PA Required (Cancer Therapy) – See Medicare Part B Oncology Prior Authorization form
Immphentiv (phenylephrine)	J2373	phenylephrine	Miscellaneous	20 mcg	0.5 mg/5 mL, 1 mg/10 mL SDV	Commercial	Non-specialty	No	No PA required
Immphentiv (phenylephrine)	J2373	phenylephrine	Miscellaneous	20 mcg	0.5 mg/5 mL, 1 mg/10 mL SDV	Medicaid	Covered	No	No PA required
Immphentiv (phenylephrine)	J2373	phenylephrine	Miscellaneous	20 mcg	0.5 mg/5 mL, 1 mg/10 mL SDV	Medicare	Non-specialty	No	No PA required

Drug	Code	Generic	Category	Billing Unit	How Supplied	Line of Business	Coverage Level	Site Of Service	Comment
Increlex (mecasermin)	J2170	mecasermin	Miscellaneous	1 mg	40 mg/4 mL SDV	Commercial	Refer to ADL	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Increlex (mecasermin)	J2170	mecasermin	Miscellaneous	1 mg	40 mg/4 mL SDV	Medicaid	Not Covered	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Increlex (mecasermin)	J2170	mecasermin	Miscellaneous	1 mg	40 mg/4 mL SDV	Medicare	Refer to ADL	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Infed (iron dextran)	J1750	iron dextran	Iron replacement	50 mg	100 mg/2 mL SDV	Commercial	Non-specialty	No	No PA required
Infed (iron dextran)	J1750	iron dextran	Iron replacement	50 mg	100 mg/2 mL SDV	Medicaid	Covered	No	No PA required
Infed (iron dextran)	J1750	iron dextran	Iron replacement	50 mg	100 mg/2 mL SDV	Medicare	Non-specialty	No	No PA required
Inflectra (infliximab-dyyb)	Q5103	infliximab	Inflammatory Conditions	10 mg	100 mg SDV	Commercial	Pref. Specialty	YES	No PA required
Inflectra (infliximab-dyyb)	Q5103	infliximab	Inflammatory Conditions	10 mg	100 mg SDV	Medicaid	Covered	YES	No PA required when administered in a hospital outpatient infusion center
Inflectra (infliximab-dyyb)	Q5103	infliximab	Inflammatory Conditions	10 mg	100 mg SDV	Medicare	Pref. Specialty	No	No PA required
Infliximab - Janssen brand ONLY)	J1745	infliximab	Inflammatory Conditions	10 mg	100 mg SDV	Commercial	Not covered	YES	**Not covered - Covered biosimilars: Inflectra & Renflexis**
Infliximab - Janssen brand ONLY)	J1745	infliximab	Inflammatory Conditions	10 mg	100 mg SDV	Medicaid	Not Covered	YES	**Not covered - Covered biosimilars: Inflectra & Renflexis**
Infliximab - Janssen brand ONLY)	J1745	infliximab	Inflammatory Conditions	10 mg	100 mg SDV	Medicare	NPS	No	PA Required - click here for criteria. Link for the Prior Authorization form is on the 'General Prior Auth Forms' tab.
Infugem (gemcitabine HCl)	J9198	gemcitabine	Oncology	100 mg	1200 mg/120 mL, 1300 mg/130 mL, 1400 mg/140 mL, 1500 mg/150 mL, 1600 mg/160 mL, 1700 mg/170 mL, 1800 mg/180 mL, 1900 mg/190 mL, 2000 mg/200 mL, 2200 mg/220 mL single dose infusion bag	Commercial	Not covered	No	**Not covered**
Infugem (gemcitabine HCl)	J9198	gemcitabine	Oncology	100 mg	1200 mg/120 mL, 1300 mg/130 mL, 1400 mg/140 mL, 1500 mg/150 mL, 1600 mg/160 mL, 1700 mg/170 mL, 1800 mg/180 mL, 1900 mg/190 mL, 2000 mg/200 mL, 2200 mg/220 mL single dose infusion bag	Medicaid	Covered	No	No PA Required
Infugem (gemcitabine HCl)	J9198	gemcitabine	Oncology	100 mg	1200 mg/120 mL, 1300 mg/130 mL, 1400 mg/140 mL, 1500 mg/150 mL, 1600 mg/160 mL, 1700 mg/170 mL, 1800 mg/180 mL, 1900 mg/190 mL, 2000 mg/200 mL, 2200 mg/220 mL single dose infusion bag	Medicare	Medicare Chemo	No	PA Required - click here for criteria. Link for the Prior Authorization form is on the 'General Prior Auth Forms' tab.
Injectafer (ferric carboxymaltose)	J1439	ferric carboxymaltose	Iron replacement	1 mg	750 mg/15 mL SDV	Commercial	NPS	No	No PA required
Injectafer (ferric carboxymaltose)	J1439	ferric carboxymaltose	Iron replacement	1 mg	750 mg/15 mL SDV	Medicaid	Covered	No	No PA required
Injectafer (ferric carboxymaltose)	J1439	ferric carboxymaltose	Iron replacement	1 mg	750 mg/15 mL SDV	Medicare	NPS	No	No PA required
Intralipid (lipid emulsion) Injection		Lipid emulsion	TPN			Medicare		No	Part B vs Part D – See Approved Drug List for covered formulations under Part D - see the Part B vs Part D coverage determination form for criteria
Intron A (interferon alpha-2b)	J9214	interferon alpha-2b	interferon	1,000,000 units	10 million unit, 18 million unit, 50 million unit SDV; 18 million unit, 25 million unit MDV	Medicare	Pref. Specialty	No	Part B vs Part D – See Approved Drug List for covered formulations under Part D - see the Part B vs Part D coverage determination form for criteria
Invanz (ertapenem)	J1335	ertapenem	Antimicrobial	500 mg	1 gm SDV	Commercial	Non-specialty	No	No PA required
Invanz (ertapenem)	J1335	ertapenem	Antimicrobial	500 mg	1 gm SDV	Medicaid	Covered	No	No PA required
Invanz (ertapenem)	J1335	ertapenem	Antimicrobial	500 mg	1 gm SDV	Medicare	Non-specialty	No	No PA required
Invega Hafyera (paliperidone palmitate ER 6 month depot)	J2427	paliperidone	Central Nervous System (CNS) agent	1 mg		Commercial	Pref. Specialty	No	No PA required
Invega Hafyera (paliperidone palmitate ER 6 month depot)	J2427	paliperidone	Central Nervous System (CNS) agent	1 mg		Medicaid	Carve Out	No	Contact Fee for Service Medicaid for coverage
Invega Hafyera (paliperidone palmitate ER 6 month depot)	J2427	paliperidone	Central Nervous System (CNS) agent	1 mg		Medicare	Pref. Specialty	No	No PA required
Invega Sustenna (paliperidone palmitate ER montly)	J2426	paliperidone	Central Nervous System (CNS) agent	1 mg	39 mg/0.25 mL, 78 mg/0.5 mL, 117 mg/0.75 mL, 156 mg/1 mL, 234 mg/1.5 mL SD syringe	Commercial	Pref. Specialty	No	No PA required
Invega Sustenna (paliperidone palmitate ER montly)	J2426	paliperidone	Central Nervous System (CNS) agent	1 mg	39 mg/0.25 mL, 78 mg/0.5 mL, 117 mg/0.75 mL, 156 mg/1 mL, 234 mg/1.5 mL SD syringe	Medicaid	Carve Out	No	Contact Fee for Service Medicaid for coverage
Invega Sustenna (paliperidone palmitate ER montly)	J2426	paliperidone	Central Nervous System (CNS) agent	1 mg	39 mg/0.25 mL, 78 mg/0.5 mL, 117 mg/0.75 mL, 156 mg/1 mL, 234 mg/1.5 mL SD syringe	Medicare	Pref. Specialty	No	No PA required
Invega Trinza (paliperidone palmitate ER 3 month depot)	J2427	paliperidone	Central Nervous System (CNS) agent	1 mg	273 mg, 410 mg, 546 mg, 819 mg SD syringe	Commercial	Pref. Specialty	No	No PA required
Invega Trinza (paliperidone palmitate ER 3 month depot)	J2427	paliperidone	Central Nervous System (CNS) agent	1 mg	273 mg, 410 mg, 546 mg, 819 mg SD syringe	Medicaid	Carve Out	No	Contact Fee for Service Medicaid for coverage
Invega Trinza (paliperidone palmitate ER 3 month depot)	J2427	paliperidone	Central Nervous System (CNS) agent	1 mg	273 mg, 410 mg, 546 mg, 819 mg SD syringe	Medicare	Pref. Specialty	No	No PA required
ipratropium (Ipratropium) NEBULIZER SOLUTION ONLY	J7644	Ipratropium	inhalation	1 mg	0.02% (0.5 mg/2.5 mL) SDV	Medicare	Non-specialty	No	Part B vs Part D – See Approved Drug List for covered formulations under Part D - see the Part B vs Part D coverage determination form for criteria
Istodax (romidepsin, lyophilized)	J9319	romidepsin	Oncology	0.1 mg	10 mg SDV	Commercial	Pref. Specialty	No	PA required - see medical oncology prior authorization form for criteria
Istodax (romidepsin, lyophilized)	J9319	romidepsin	Oncology	0.1 mg	10 mg SDV	Medicaid	Covered	No	No PA Required
Istodax (romidepsin, lyophilized)	J9319	romidepsin	Oncology	0.1 mg	10 mg SDV	Medicare	Medicare Chemo	No	PA Required (Cancer Therapy) – See Medicare Part B Oncology Prior Authorization form
Ixempra (ixabepilone)	J9207	ixabepilone	Oncology	1 mg	15 mg, 45 mg SDV	Commercial	Non-specialty	No	No PA required
Ixempra (ixabepilone)	J9207	ixabepilone	Oncology	1 mg	15 mg, 45 mg SDV	Medicaid	Covered	No	No PA required
Ixempra (ixabepilone)	J9207	ixabepilone	Oncology	1 mg	15 mg, 45 mg SDV	Medicare	Non-specialty	No	No PA required
Ixinity (Antihemophilic Factor IX)	J7213	Antihemophilic Factor IX	Hemophilia			Commercial	Refer to ADL	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Ixinity (Antihemophilic Factor IX)	J7213	Antihemophilic Factor IX	Hemophilia			Medicaid	Not Covered	No	Refer to the Medicaid Approved Drug List (ADL) for pharmacy benefit coverage. For one-time doses required for planned outpatient procedures (professional/facility claims), authorizations will be reviewed for medical necessity according to the Hemophilia Management Medical Policy 91569
Ixinity (Antihemophilic Factor IX)	J7213	Antihemophilic Factor IX	Hemophilia			Medicare	Pref. Specialty	No	No PA required
Izervay (avacincaptad pegol)	J2782	avacincaptad pegol	Ophthalmic	0.1 mg	20 mg/mL SDV	Commercial	Not Covered	No	Not Covered
Izervay (avacincaptad pegol)	J2782	avacincaptad pegol	Ophthalmic	0.1 mg	20 mg/mL SDV	Medicaid	Not Covered	No	Not Covered
Izervay (avacincaptad pegol)	J2782	avacincaptad pegol	Ophthalmic	0.1 mg	20 mg/mL SDV	Medicare	Pref Specialty	No	PA Required - click here for criteria. Link for the Prior Authorization form is on the 'General Prior Auth Forms' tab.
Jelmyto (mitomycin)	J9281	mitomycin	Oncology	1 mg	1 kit = two 40 mg SDV = 80mg	Commercial	NPS	No	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth Forms tab.
Jelmyto (mitomycin)	J9281	mitomycin	Oncology	1 mg	1 kit = two 40 mg SDV = 80mg	Medicaid	Covered	No	No PA Required
Jelmyto (mitomycin)	J9281	mitomycin	Oncology	1 mg	1 kit = two 40 mg SDV = 80mg	Medicare	Medicare Chemo	No	PA Required (Cancer Therapy) – See Medicare Part B Oncology Prior Authorization form
Jemperli (dostarlimab-gxly)	J9272	dostarlimab	Oncology	10 mg	500 mg/10 mL (50 mg/mL) SDV	Commercial	Pref. Specialty	YES Starting 7-1-2024	PA required - see medical oncology prior authorization form for criteria. Starting 7-1-2024, Site of Service will apply.
Jemperli (dostarlimab-gxly)	J9272	dostarlimab	Oncology	10 mg	500 mg/10 mL (50 mg/mL) SDV	Medicaid	Covered	No	No PA Required
Jemperli (dostarlimab-gxly)	J9272	dostarlimab	Oncology	10 mg	500 mg/10 mL (50 mg/mL) SDV	Medicare	Medicare Chemo	No	PA Required (Cancer Therapy) – See Medicare Part B Oncology Prior Authorization form
Jetrea (ocriplasmin)	J7316	ocriplasmin	Ophthalmic	0.125 mg	1.25 mg/mL, 2.5 mg/mL	Commercial	Pref. Specialty	No	No PA required when billed with the following ICD10 codes: H43.821 – H43.829 Vitreomacular adhesion
Jetrea (ocriplasmin)	J7316	ocriplasmin	Ophthalmic	0.125 mg	1.25 mg/mL, 2.5 mg/mL	Medicaid	Covered	No	No PA required when billed with the following ICD10 codes: H43.821 – H43.829 Vitreomacular adhesion
Jetrea (ocriplasmin)	J7316	ocriplasmin	Ophthalmic	0.125 mg	1.25 mg/mL, 2.5 mg/mL	Medicare	Pref. Specialty	No	No PA required when billed with the following ICD10 codes: H43.821 – H43.829 All other ICD-10 diagnoses: PA required - See Medicare Medical Part B prior authorization form
Jevtana (cabazitaxel)	J9043	cabazitaxel	Oncology	1 mg	60 mg/1.5 mL SDV	Commercial	NPS	No	PA required - see medical oncology prior authorization form for criteria
Jevtana (cabazitaxel)	J9043	cabazitaxel	Oncology	1 mg	60 mg/1.5 mL SDV	Medicaid	Covered	No	No PA Required
Jevtana (cabazitaxel)	J9043	cabazitaxel	Oncology	1 mg	60 mg/1.5 mL SDV	Medicare	Medicare Chemo	No	PA Required (Cancer Therapy) – See Medicare Part B Oncology Prior Authorization form
Jivi (Antihemophilic Factor VIII)	J7208	Antihemophilic Factor VIII	Hemophilia			Commercial	Refer to ADL	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Jivi (Antihemophilic Factor VIII)	J7208	Antihemophilic Factor VIII	Hemophilia			Medicaid	Not Covered	No	Refer to the Medicaid Approved Drug List (ADL) for pharmacy benefit coverage. For one-time doses required for planned outpatient procedures (professional/facility claims), authorizations will be reviewed for medical necessity according to the Hemophilia Management Medical Policy 91569
Jivi (Antihemophilic Factor VIII)	J7208	Antihemophilic Factor VIII	Hemophilia			Medicare	Pref. Specialty	No	No PA required
Jylamvo (methotrexate) ORAL ONLY	J8611	methotrexate	Oncology	2.5 mg	2.5 mg/mL oral solution (60 mL)	Medicare	Non-specialty	No	Part B vs Part D – See Approved Drug List for covered formulations under Part D - see the Part B vs Part D coverage determination form for criteria
Kadcyla (ado-trastuzumab emtansine)	J9354	ado-trastuzumab emtansine	Oncology	1 mg	100 mg, 160 mg SDV	Commercial	Pref. Specialty	No	PA required - see medical oncology prior authorization form for criteria
Kadcyla (ado-trastuzumab emtansine)	J9354	ado-trastuzumab emtansine	Oncology	1 mg	100 mg, 160 mg SDV	Medicaid	Covered	No	No PA Required
Kadcyla (ado-trastuzumab emtansine)	J9354	ado-trastuzumab emtansine	Oncology	1 mg	100 mg, 160 mg SDV	Medicare	Medicare Chemo	No	No PA required
Kalbitor (ecallantide)	J1290	ecallantide	Hereditary Angioedema agent	1 mg		Commercial	Refer to ADL	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Kalbitor (ecallantide)	J1290	ecallantide	Hereditary Angioedema agent	1 mg		Medicaid	Not Covered	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Kalbitor (ecallantide)	J1290	ecallantide	Hereditary Angioedema agent	1 mg		Medicare	Refer to ADL	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit

Drug	Code	Generic	Category	Billing Unit	How Supplied	Line of Business	Coverage Level	Site Of Service	Comment
Kanjinti (trastuzumab-anns)	Q5117	trastuzumab	Oncology	10 mg	150 mg, 420 mg SDV	Commercial	Not Covered	No	**Not Covered**
Kanjinti (trastuzumab-anns)	Q5117	trastuzumab	Oncology	10 mg	150 mg, 420 mg SDV	Medicaid	Covered	No	No PA required
Kanjinti (trastuzumab-anns)	Q5117	trastuzumab	Oncology	10 mg	150 mg, 420 mg SDV	Medicare	Medicare Chemo	No	PA Required - click here for criteria. Link for the Prior Authorization form is on the 'General Prior Auth Forms' tab.
Kanuma (sebelipase alfa)	J2840	sebelipase	Enzyme deficiency	1 mg	20 mg/10 mL SDV	Commercial	Pref. Specialty	YES	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth Forms tab.
Kanuma (sebelipase alfa)	J2840	sebelipase	Enzyme deficiency	1 mg	20 mg/10 mL SDV	Medicaid	Covered	YES	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth Forms tab.
Kanuma (sebelipase alfa)	J2840	sebelipase	Enzyme deficiency	1 mg	20 mg/10 mL SDV	Medicare	Pref. Specialty	No	PA required - See Medicare Medical Part B prior authorization form
Kefzol (cefazolin sodium)	J0690	cefazolin	Antimicrobial	500 mg	various	Commercial	Non-specialty	No	No PA required
Kefzol (cefazolin sodium)	J0690	cefazolin	Antimicrobial	500 mg	various	Medicaid	Non-specialty	No	No PA required
Kefzol (cefazolin sodium)	J0690	cefazolin	Antimicrobial	500 mg	various	Medicare	Non-specialty	No	No PA required
Kepivance (palifermin)	J2425	palifermin	Oncology	50 mcg	6.25 mg SDV	Commercial	Non-specialty	No	No PA required
Kepivance (palifermin)	J2425	palifermin	Oncology	50 mcg	6.25 mg SDV	Medicaid	Covered	No	No PA required
Kepivance (palifermin)	J2425	palifermin	Oncology	50 mcg	6.25 mg SDV	Medicare	Non-specialty	No	No PA required
Kesimpta (ofatumumab)	J9302	ofatumumab	Multiple Sclerosis (MS) agent	10 mg	20 mg/0.4 mL SD syringe	Commercial	Refer to ADL	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Kesimpta (ofatumumab)	J9302	ofatumumab	Multiple Sclerosis (MS) agent	10 mg	20 mg/0.4 mL SD syringe	Medicaid	Not Covered	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Kesimpta (ofatumumab)	J9302	ofatumumab	Multiple Sclerosis (MS) agent	10 mg	20 mg/0.4 mL SD syringe	Medicare	Refer to ADL	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Ketalar (ketamine hydrochloride)	J3490*	ketamine	Miscellaneous	Additional information required: National Drug Code (NDC), Strength, Dosage administered, Route of administration.	200 mg/10 mL, 500 mg/5 mL, 500 mg/10 mL MDV	Commercial	Not Covered when billed separately	No	anesthetic agent – covered only when billed in conjunction with an anesthesia service for a covered procedure. Ketamine is **not** covered as a stand-alone injection for ANY reason for ANY plan.
Ketalar (ketamine hydrochloride)	J3490*	ketamine	Miscellaneous	Additional information required: National Drug Code (NDC), Strength, Dosage administered, Route of administration.	200 mg/10 mL, 500 mg/5 mL, 500 mg/10 mL MDV	Medicaid	Not Covered when billed separately	No	anesthetic agent – covered only when billed in conjunction with an anesthesia service for a covered procedure. Ketamine is **not** covered as a stand-alone injection for ANY reason for ANY plan.
Ketalar (ketamine hydrochloride)	J3490*	ketamine	Miscellaneous	Additional information required: National Drug Code (NDC), Strength, Dosage administered, Route of administration.	200 mg/10 mL, 500 mg/5 mL, 500 mg/10 mL MDV	Medicare	Not Covered when billed separately	No	anesthetic agent – covered when billed in conjunction with an anesthesia service for a covered procedure. Requests for ketamine as a stand-alone injection must be reviewed for a medically-accepted indication and are not covered when the use is considered experimental or investigational.
ketamine hydrochloride	J3490*	ketamine	Miscellaneous	Additional information required: National Drug Code (NDC), Strength, Dosage administered, Route of administration.	200 mg/10 mL, 500 mg/5 mL, 500 mg/10 mL MDV	Commercial	Not Covered when billed separately	No	anesthetic agent – covered only when billed in conjunction with an anesthesia service for a covered procedure. Ketamine is **not** covered as a stand-alone injection for ANY reason for ANY plan.
ketamine hydrochloride	J3490*	ketamine	Miscellaneous	Additional information required: National Drug Code (NDC), Strength, Dosage administered, Route of administration.	200 mg/10 mL, 500 mg/5 mL, 500 mg/10 mL MDV	Medicaid	Not Covered when billed separately	No	anesthetic agent – covered only when billed in conjunction with an anesthesia service for a covered procedure. Ketamine is **not** covered as a stand-alone injection for ANY reason for ANY plan.
ketamine hydrochloride	J3490*	ketamine	Miscellaneous	Additional information required: National Drug Code (NDC), Strength, Dosage administered, Route of administration.	200 mg/10 mL, 500 mg/5 mL, 500 mg/10 mL MDV	Medicare	Not Covered when billed separately	No	anesthetic agent – covered when billed in conjunction with an anesthesia service for a covered procedure. Requests for ketamine as a stand-alone injection must be reviewed for a medically-accepted indication and are not covered when the use is considered experimental or investigational.
Kevzara (sarilumab)	J3590*, C9399*	sarilumab	Inflammatory Conditions		150 mg/1.14 mL, 200 mg/1.14 mL SD syringe	Commercial	Refer to ADL	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Kevzara (sarilumab)	J3590*, C9399*	sarilumab	Inflammatory Conditions		150 mg/1.14 mL, 200 mg/1.14 mL SD syringe	Medicaid	Not Covered	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Kevzara (sarilumab)	J3590*, C9399*	sarilumab	Inflammatory Conditions		150 mg/1.14 mL, 200 mg/1.14 mL SD syringe	Medicare	Refer to ADL	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Keytruda (pembrolizumab)	J9271	pembrolizumab	Oncology	1 mg	50 mg, 100 mg SDV	Commercial	Pref. Specialty	YES	PA required - see medical oncology prior authorization form for criteria
Keytruda (pembrolizumab)	J9271	pembrolizumab	Oncology	1 mg	50 mg, 100 mg SDV	Medicaid	Covered	No	No PA Required
Keytruda (pembrolizumab)	J9271	pembrolizumab	Oncology	1 mg	50 mg, 100 mg SDV	Medicare	Medicare Chemo	No	PA Required (Cancer Therapy) – See Medicare Part B Oncology Prior Authorization form
Khapzory (levoleucovorin)	J0642	levoleucovorin	Oncology	0.5 mg	175 mg, 300 mg SDV	Commercial	Pref. Specialty	No	No PA required
Khapzory (levoleucovorin)	J0642	levoleucovorin	Oncology	0.5 mg	175 mg, 300 mg SDV	Medicaid	Covered	No	No PA required
Khapzory (levoleucovorin)	J0642	levoleucovorin	Oncology	0.5 mg	175 mg, 300 mg SDV	Medicare	Pref. Specialty	No	No PA required
Kimmtrak (tebentafusp-tebn)	J9274	sirolimus protein-bound particles	Oncology	1mcg	100 mcg /0.5ml SDV	Commercial	Pref. Specialty	No	PA required - see medical oncology prior authorization form for criteria
Kimmtrak (tebentafusp-tebn)	J9274	sirolimus protein-bound particles	Oncology	1mcg	100 mcg /0.5ml SDV	Medicaid	Covered	No	No PA Required
Kimmtrak (tebentafusp-tebn)	J9274	sirolimus protein-bound particles	Oncology	1mcg	100 mcg /0.5ml SDV	Medicare	Medicare Chemo	No	PA Required (Cancer Therapy) – See Medicare Part B Oncology Prior Authorization form
Kimyrsa (oritavancin)	J2406	oritavancin	Antimicrobial	1200mg	1200mg SDV	Commercial	NPS	No	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth Forms tab.
Kimyrsa (oritavancin)	J2406	oritavancin	Antimicrobial	1200mg	1200mg SDV	Medicaid	Covered	No	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth Forms tab.
Kimyrsa (oritavancin)	J2406	oritavancin	Antimicrobial	1200mg	1200mg SDV	Medicare	NPS	No	PA Required - click here for criteria. Link for the Prior Authorization form is on the 'General Prior Auth Forms' tab.
Kineret (anakinra)	J3590*, J9999*	anakinra	Inflammatory Conditions		100 mg/0.67 mL SD syringe	Commercial	Refer to ADL	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Kineret (anakinra)	J3590*, J9999*	anakinra	Inflammatory Conditions		100 mg/0.67 mL SD syringe	Medicaid	Not Covered	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Kineret (anakinra)	J3590*, J9999*	anakinra	Inflammatory Conditions		100 mg/0.67 mL SD syringe	Medicare	Refer to ADL	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Kinevac (sincalide)	J2805	sincalide	Miscellaneous	5 mcg		Commercial	Non-specialty	No	No PA required
Kinevac (sincalide)	J2805	sincalide	Miscellaneous	5 mcg		Medicaid	Covered	No	No PA required
Kinevac (sincalide)	J2805	sincalide	Miscellaneous	5 mcg		Medicare	Non-specialty	No	No PA required
Kisunla (donanemab-azbt)	J0175	donanemab	Alzheimer's disease	2mg	350 mg/20 mL SDV	Commercial	Not Covered	No	**Not covered**
Kisunla (donanemab-azbt)	J0175	donanemab	Alzheimer's disease	2mg	350 mg/20 mL SDV	Medicaid	Not Covered	No	**Not covered**
Kisunla (donanemab-azbt)	J0175	donanemab	Alzheimer's disease	2mg	350 mg/20 mL SDV	Medicare	NPS	No	PA Required - click here for criteria. Link for the Prior Authorization form is on the 'General Prior Auth Forms' tab.
Koate (Antihemophilic Factor VIII)	J7190	Antihemophilic Factor VIII	Hemophilia			Commercial	Refer to ADL	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Koate (Antihemophilic Factor VIII)	J7190	Antihemophilic Factor VIII	Hemophilia			Medicaid	Not Covered	No	Refer to the Medicaid Approved Drug List (ADL) for pharmacy benefit coverage. For one-time doses required for planned outpatient procedures (professional/facility claims), authorizations will be reviewed for medical necessity according to the Hemophilia Management Medical Policy 91569
Koate (Antihemophilic Factor VIII)	J7190	Antihemophilic Factor VIII	Hemophilia			Medicare	Pref. Specialty	No	No PA required
Kogenate FS (Antihemophilic Factor VIII)	J7192	Antihemophilic Factor VIII	Hemophilia			Commercial	Refer to ADL	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Kogenate FS (Antihemophilic Factor VIII)	J7192	Antihemophilic Factor VIII	Hemophilia			Medicaid	Not Covered	No	Refer to the Medicaid Approved Drug List (ADL) for pharmacy benefit coverage. For one-time doses required for planned outpatient procedures (professional/facility claims), authorizations will be reviewed for medical necessity according to the Hemophilia Management Medical Policy 91569
Kogenate FS (Antihemophilic Factor VIII)	J7192	Antihemophilic Factor VIII	Hemophilia			Medicare	Pref. Specialty	No	No PA required
Korsuva (difelikefalin acetate)	J0879	difelikefalin	Miscellaneous	0.1 mcg	65 mcg/1.3 mL (50 mcg/mL) SDV	Commercial	Pref. Specialty	No	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth Forms tab.
Korsuva (difelikefalin acetate)	J0879	difelikefalin	Miscellaneous	0.1 mcg	65 mcg/1.3 mL (50 mcg/mL) SDV	Medicaid	Not Covered	No	Not separately payable as of 1/1/2024
Korsuva (difelikefalin acetate)	J0879	difelikefalin	Miscellaneous	0.1 mcg	65 mcg/1.3 mL (50 mcg/mL) SDV	Medicare	Not Separately payable	No	Included in ESRD PPS and not separately payable under Part B
Kovaltry (Antihemophilic Factor VIII)	J7211	Antihemophilic Factor VIII	Hemophilia			Commercial	Refer to ADL	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Kovaltry (Antihemophilic Factor VIII)	J7211	Antihemophilic Factor VIII	Hemophilia			Medicaid	Not Covered	No	Refer to the Medicaid Approved Drug List (ADL) for pharmacy benefit coverage. For one-time doses required for planned outpatient procedures (professional/facility claims), authorizations will be reviewed for medical necessity according to the Hemophilia Management Medical Policy 91569
Kovaltry (Antihemophilic Factor VIII)	J7211	Antihemophilic Factor VIII	Hemophilia			Medicare	Pref. Specialty	No	No PA required
Krystexxa (pegloticase)	J2507	pegloticase	Gout agent	1 mg	8 mg SDV	Commercial	Pref. Specialty	YES	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth Forms tab.
Krystexxa (pegloticase)	J2507	pegloticase	Gout agent	1 mg	8 mg SDV	Medicaid	Covered	YES	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth Forms tab.
Krystexxa (pegloticase)	J2507	pegloticase	Gout agent	1 mg	8 mg SDV	Medicare	Pref. Specialty	No	PA Required - click here for criteria. Link for the Prior Authorization form is on the 'General Prior Auth Forms' tab.
Kybella (deoxycholic acid)	J0591	deoxycholic acid	Cosmetic	1 mg	20 mg SDV	Commercial	Not covered	No	**Not covered**
Kybella (deoxycholic acid)	J0591	deoxycholic acid	Cosmetic	1 mg	20 mg SDV	Medicaid	Not Covered	No	**Not covered**
Kybella (deoxycholic acid)	J0591	deoxycholic acid	Cosmetic	1 mg	20 mg SDV	Medicare	Not covered	No	**Not covered**
Kyleena (levonorgestrel-releasing IUD)	J7296	levonorgestrel	Contraceptive	19.5 mg	19.5 mg device	Commercial	Refer to Contraceptive Coverage	No	Refer to contraceptive coverage
Kyleena (levonorgestrel-releasing IUD)	J7296	levonorgestrel	Contraceptive	19.5 mg	19.5 mg device	Medicaid	Refer to Contraceptive Coverage	No	Refer to contraceptive coverage
Kyleena (levonorgestrel-releasing IUD)	J7296	levonorgestrel	Contraceptive	19.5 mg	19.5 mg device	Medicare	Refer to Contraceptive Coverage	No	Refer to contraceptive coverage
Kymriah (tisagenlecleucel)	Q2042	tisagenlecleucel	Gene/Cellular Therapy	per dose	SD infusion bag	Commercial	Gene Therapy	YES	PA Required – see medical oncology prior authorization form for criteria. Coverage of Kymriah is dependent on member's eligibility and benefit plan documents. Priority Health may request documentation, not more frequently than biannually, of follow-up patient assessment(s). Kymriah will not be authorized for use in patients with primary central nervous system lymphoma; OR that have received a previous treatment course of Kymriah or another CD19-directed chimeric antigen receptor (CAR) T-cell therapy. The safety and effectiveness of repeat administration have not been evaluated (one treatment per lifetime)
Kymriah (tisagenlecleucel)	Q2042	tisagenlecleucel	Gene/Cellular Therapy	per dose	SD infusion bag	Medicaid	Carve Out	No	Contact Fee for Service Medicaid for coverage
Kymriah (tisagenlecleucel)	Q2042	tisagenlecleucel	Gene/Cellular Therapy	per dose	SD infusion bag	Medicare	Medicare Chemo	No	PA Required - click here for criteria. Link for the Prior Authorization form is on the 'General Prior Auth Forms' tab.

Drug	Code	Generic	Category	Billing Unit	How Supplied	Line of Business	Coverage Level	Site Of Service	Comment
Kyprolis (carfilzomib)	J9047	carfilzomib	Oncology	1 mg	10 mg, 30 mg, 60 mg SDV	Commercial	Pref. Specialty	No	No PA required when billed with the following ICD-10 codes:C90.00-C90.32 (multiple myeloma) - for other ICD 10 codes, see medical oncology prior authorization form for criteria
Kyprolis (carfilzomib)	J9047	carfilzomib	Oncology	1 mg	10 mg, 30 mg, 60 mg SDV	Medicaid	Covered	No	No PA Required
Kyprolis (carfilzomib)	J9047	carfilzomib	Oncology	1 mg	10 mg, 30 mg, 60 mg SDV	Medicare	Medicare Chemo	No	No PA required
Kytril (granisetron)	J1626	granisetron	Antiemetic	100 mcg	0.1 mg, 1 mg SD vial/ampule; 4 mg MDV	Commercial	Non-specialty	No	No PA required
Kytril (granisetron)	J1626	granisetron	Antiemetic	100 mcg	0.1 mg, 1 mg SD vial/ampule; 4 mg MDV	Medicaid	Covered	No	No PA required
Kytril (granisetron)	J1626	granisetron	Antiemetic	100 mcg	0.1 mg, 1 mg SD vial/ampule; 4 mg MDV	Medicare	Non-specialty	No	No PA required
Kytril (granisetron) ORAL ONLY	Q0166	granisetron	Antiemetic	1 mg	1 mg tablet	Medicare	Non-specialty	No	Part B vs Part D – See Approved Drug List for covered formulations under Part D - see the Part B vs Part D coverage determination form for criteria
labetalol - Hikma brand ONLY	J1921	labetalol	Miscellaneous			Commercial	Non-specialty	No	No PA required
labetalol - Hikma brand ONLY	J1921	labetalol	Miscellaneous			Medicaid	Covered	No	No PA required
labetalol - Hikma brand ONLY	J1921	labetalol	Miscellaneous			Medicare	Non-specialty	No	No PA required
Lamzede (velmanase alfa)	J0217	velmanase alfa	Enzyme deficiency	1 mg	10 mg SD Kit	Commercial	Pref. Specialty	YES	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth Forms tab.
Lamzede (velmanase alfa)	J0217	velmanase alfa	Enzyme deficiency	1 mg	10 mg SD Kit	Medicaid	Carve Out	No	Contact Fee for Service Medicaid for coverage
Lamzede (velmanase alfa)	J0217	velmanase alfa	Enzyme deficiency	1 mg	10 mg SD Kit	Medicare	Pref. Specialty	No	PA Required - click here for criteria. Link for the Prior Authorization form is on the 'General Prior Auth Forms' tab.
Lanoxin (digoxin)	J1160	digoxin	Miscellaneous	0.5 mg	0.1 mg SDV; 0.25 mg SD syringe/ampule; 0.5 mg SD ampule	Commercial	Non-specialty	No	No PA required
Lanoxin (digoxin)	J1160	digoxin	Miscellaneous	0.5 mg	0.1 mg SDV; 0.25 mg SD syringe/ampule; 0.5 mg SD ampule	Medicaid	Covered	No	No PA required
Lanoxin (digoxin)	J1160	digoxin	Miscellaneous	0.5 mg	0.1 mg SDV; 0.25 mg SD syringe/ampule; 0.5 mg SD ampule	Medicare	Non-specialty	No	No PA required
lanreotide (Non-**Somatuline**) - Cipla brand only	J1932	lanreotide	Miscellaneous	1 mg	60mg/0.2ml, 90mg/0.3ml, 120mg/0.5ml SD syringe	Commercial	Non-specialty	No	No PA required
lanreotide (Non-**Somatuline**) - Cipla brand only	J1932	lanreotide	Miscellaneous	1 mg	60mg/0.2ml, 90mg/0.3ml, 120mg/0.5ml SD syringe	Medicaid	Covered	No	No PA required
lanreotide (Non-**Somatuline**) - Cipla brand only	J1932	lanreotide	Miscellaneous	1 mg	60mg/0.2ml, 90mg/0.3ml, 120mg/0.5ml SD syringe	Medicare	Non-specialty	No	No PA required
Lantidra (donislecel-jujn)	J3590 C9399	donislecel-jujn	Gene/Cellular Therapy	Additional information required: National Drug Code (NDC), Strength, Dosage administered, Route of administration.	400 mL infusion bag containing not more than 10 cc of estimated packed islet tissue and not more than 1 x 106 EIN	Commercial	Pref. Specialty	No	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth Forms tab.
Lantidra (donislecel-jujn)	J3590 C9399	donislecel-jujn	Gene/Cellular Therapy	Additional information required: National Drug Code (NDC), Strength, Dosage administered, Route of administration.	400 mL infusion bag containing not more than 10 cc of estimated packed islet tissue and not more than 1 x 106 EIN	Medicaid	Not Covered	No	**Not covered until added to both the MDHHS fee schedule AND the MDHHS NDC/HCPCS crosswalk**
Lantidra (donislecel-jujn)	J3590 C9399	donislecel-jujn	Gene/Cellular Therapy	Additional information required: National Drug Code (NDC), Strength, Dosage administered, Route of administration.	400 mL infusion bag containing not more than 10 cc of estimated packed islet tissue and not more than 1 x 106 EIN	Medicare	NPS	No	PA Required - click here for criteria. Link for the Prior Authorization form is on the 'General Prior Auth Forms' tab.
Lasix (furosemide)	J1940	furosemide	Miscellaneous			Commercial	Non-specialty	No	No PA required
Lasix (furosemide)	J1940	furosemide	Miscellaneous			Medicaid	Covered	No	No PA required
Lasix (furosemide)	J1940	furosemide	Miscellaneous			Medicare	Non-specialty	No	No PA required
Lemtrada (alemtuzumab)	J0202	alemtuzumab	Multiple Sclerosis (MS) agent	1 mg	12 mg/1.2 mL SDV	Commercial	Not covered	No	**Not covered**
Lemtrada (alemtuzumab)	J0202	alemtuzumab	Multiple Sclerosis (MS) agent	1 mg	12 mg/1.2 mL SDV	Medicaid	Not Covered	No	**Not covered**
Lemtrada (alemtuzumab)	J0202	alemtuzumab	Multiple Sclerosis (MS) agent	1 mg	12 mg/1.2 mL SDV	Medicare	NPS	No	PA required - See Medicare Medical Part B prior authorization form
Lenmeldy (atidarsagene autotemcel)	J3590* C9399*	atidarsagene autotemcel	Gene/Cellular Therapy	Additional information required: National Drug Code (NDC), Strength, Dosage administered, Route of administration.	2 to11.8 × 10^6 cells/mL (1.8 to 11.8 x 10^6 CD34+ cells/ml) per infusion bag	Commercial	Gene Therapy	YES	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth Forms tab.
Lenmeldy (atidarsagene autotemcel)	J3590* C9399*	atidarsagene autotemcel	Gene/Cellular Therapy	Additional information required: National Drug Code (NDC), Strength, Dosage administered, Route of administration.	2 to11.8 × 10^6 cells/mL (1.8 to 11.8 x 10^6 CD34+ cells/ml) per infusion bag	Medicaid	Not Covered	No	**Not covered**
Lenmeldy (atidarsagene autotemcel)	J3590* C9399*	atidarsagene autotemcel	Gene/Cellular Therapy	Additional information required: National Drug Code (NDC), Strength, Dosage administered, Route of administration.	2 to11.8 × 10^6 cells/mL (1.8 to 11.8 x 10^6 CD34+ cells/ml) per infusion bag	Medicare	Gene Therapy	No	PA Required - click here for criteria. Link for the Prior Authorization form is on the 'General Prior Auth Forms' tab.
Leqembi (lecanemab-irmb)	J0174	lecanemab	Alzheimer's disease	1mg	200 mg/2 ml SDV 500 mg/5 ml SDV	Commercial	Not covered	No	**Not covered**
Leqembi (lecanemab-irmb)	J0174	lecanemab	Alzheimer's disease	1mg	200 mg/2 ml SDV 500 mg/5 ml SDV	Medicaid	Not Covered	No	**Not covered**
Leqembi (lecanemab-irmb)	J0174	lecanemab	Alzheimer's disease	1mg	200 mg/2 ml SDV 500 mg/5 ml SDV	Medicare	NPS	No	PA Required - click here for criteria. Link for the Prior Authorization form is on the 'General Prior Auth Forms' tab.
Leqvio (inclisiran)	J1306	inclisiran	Hyper-cholesterolemia	1 mg	284 mg/1.5 mL prefilled syringe	Commercial	NPS	YES	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth Forms tab.
Leqvio (inclisiran)	J1306	inclisiran	Hyper-cholesterolemia	1 mg	284 mg/1.5 mL prefilled syringe	Medicaid	Covered	YES	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth Forms tab.
Leqvio (inclisiran)	J1306	inclisiran	Hyper-cholesterolemia	1 mg	284 mg/1.5 mL prefilled syringe	Medicare	NPS	No	PA Required - click here for criteria. Link for the Prior Authorization form is on the 'General Prior Auth Forms' tab.
Leukine (sargramostim)	J2820	sargramostim	Hematopoietic agent	50 mcg	250 mcg, 500 mcg SDV	Commercial	Pref. Specialty	No	No PA required
Leukine (sargramostim)	J2820	sargramostim	Hematopoietic agent	50 mcg	250 mcg, 500 mcg SDV	Medicaid	Covered	No	No PA required
Leukine (sargramostim)	J2820	sargramostim	Hematopoietic agent	50 mcg	250 mcg, 500 mcg SDV	Medicare	Pref. Specialty	No	No PA required
Leuprolide acetate - Cipla Brand ONLY (Lutrate)	J1954	leuprolide	Endocrine	7.5 mg	22.5 mg SD vial	Commercial	Not Covered	No	**Not Covered**
Leuprolide acetate - Cipla Brand ONLY (Lutrate)	J1954	leuprolide	Endocrine	7.5 mg	22.5 mg SD vial	Medicaid	Covered	No	No PA required
Leuprolide acetate - Cipla Brand ONLY (Lutrate)	J1954	leuprolide	Endocrine	7.5 mg	22.5 mg SD vial	Medicare	Medicare Chemo	No	No PA required
Leustatin (cladribine)	J9065	cladribine	Oncology	1 mg	10 mg SDV	Commercial	Non-specialty	No	No PA required
Leustatin (cladribine)	J9065	cladribine	Oncology	1 mg	10 mg SDV	Medicaid	Covered	No	No PA required
Leustatin (cladribine)	J9065	cladribine	Oncology	1 mg	10 mg SDV	Medicare	Non-specialty	No	No PA required
levothyroxine, Fresenius Kabi Brand ONLY	J0651	desmopressin	Miscellaneous	1.0 mcg		Commercial	Non-specialty	No	No PA required
levothyroxine, Fresenius Kabi Brand ONLY	J0651	desmopressin	Miscellaneous	1.0 mcg		Medicaid	Covered	No	Reference CHAMPS to ensure this drug & NDC is covered for your provider type on the date of service
levothyroxine, Fresenius Kabi Brand ONLY	J0651	desmopressin	Miscellaneous	1.0 mcg		Medicare	Non-specialty	No	No PA required
levothyroxine, Hikma Brand ONLY	J0652	desmopressin	Miscellaneous	1.0 mcg		Commercial	Non-specialty	No	No PA required
levothyroxine, Hikma Brand ONLY	J0652	desmopressin	Miscellaneous	1.0 mcg		Medicaid	Covered	No	Reference CHAMPS to ensure this drug & NDC is covered for your provider type on the date of service
levothyroxine, Hikma Brand ONLY	J0652	desmopressin	Miscellaneous	1.0 mcg		Medicare	Non-specialty	No	No PA required
levothyroxine, not otherwise specified	J0650	desmopressin	Miscellaneous	1.0 mcg		Commercial	Non-specialty	No	No PA required
levothyroxine, not otherwise specified	J0650	desmopressin	Miscellaneous	1.0 mcg		Medicaid	Covered	No	Reference CHAMPS to ensure this drug & NDC is covered for your provider type on the date of service
levothyroxine, not otherwise specified	J0650	desmopressin	Miscellaneous	1.0 mcg		Medicare	Non-specialty	No	No PA required
Levulan Kerastick (topical aminolevulinic acid)	J7308	aminolevulinic acid	Topical	20% single unit dosage form	20% applicator kit	Commercial	Non-specialty	No	No PA required
Levulan Kerastick (topical aminolevulinic acid)	J7308	aminolevulinic acid	Topical	20% single unit dosage form	20% applicator kit	Medicaid	Covered	No	No PA required
Levulan Kerastick (topical aminolevulinic acid)	J7308	aminolevulinic acid	Topical	20% single unit dosage form	20% applicator kit	Medicare	Non-specialty	No	No PA required
Libtayo (cemiplimab)	J9119	cemiplimab	Oncology	1 mg	350 mg/7 mL SDV	Commercial	Pref. Specialty	YES	PA required - see medical oncology prior authorization form for criteria
Libtayo (cemiplimab)	J9119	cemiplimab	Oncology	1 mg	350 mg/7 mL SDV	Medicaid	Covered	No	No PA Required
Libtayo (cemiplimab)	J9119	cemiplimab	Oncology	1 mg	350 mg/7 mL SDV	Medicare	Medicare Chemo	No	PA Required (Cancer Therapy) – See Medicare Part B Oncology Prior Authorization form
linezolid - Hospira Brand ONLY	J2020	linezolid	Antimicrobial	200 mg	200 mg/100 mL, 600 mg/300 mL SD bag	Commercial	Pref. Specialty	No	No PA required
linezolid - Hospira Brand ONLY	J2020	linezolid	Antimicrobial	200 mg	200 mg/100 mL, 600 mg/300 mL SD bag	Medicaid	Covered	No	No PA required
linezolid - Hospira Brand ONLY	J2020	linezolid	Antimicrobial	200 mg	200 mg/100 mL, 600 mg/300 mL SD bag	Medicare	Pref. Specialty	No	No PA required
linezolid (generic **Zyvox**)	J2020 - Not for Hospira brand - See J2021	linezolid	Antimicrobial	200 mg	200 mg/100 mL, 600 mg/300 mL SD bag	Commercial	Pref. Specialty	No	No PA required

Drug	Code	Generic	Category	Billing Unit	How Supplied	Line of Business	Coverage Level	Site Of Service	Comment
linezolid (generic **Zyvox**)	J2020 - Not for Hospira brand - See J2021	linezolid	Antimicrobial	200 mg	200 mg/100 mL, 600 mg/300 mL SD bag	Medicaid	Covered	No	No PA required
linezolid (generic **Zyvox**)	J2020 - Not for Hospira brand - See J2021	linezolid	Antimicrobial	200 mg	200 mg/100 mL, 600 mg/300 mL SD bag	Medicare	Pref. Specialty	No	No PA required
Lioresal Intrathecal (baclofen)	J0475, J0476	baclofen	Muscle relaxant	50 mcg for IT trial (J0476) 10 mg (J0475)	50 mcg/mL SD ampule; 10 mg/5 mL, 10 mg/20 mL, 40 mg/20 mL SD ampules	Commercial	Non-specialty	No	No PA required
Lioresal Intrathecal (baclofen)	J0475, J0476	baclofen	Muscle relaxant	50 mcg for IT trial (J0476) 10 mg (J0475)	50 mcg/mL SD ampule; 10 mg/5 mL, 10 mg/20 mL, 40 mg/20 mL SD ampules	Medicaid	Covered	No	No PA required
Lioresal Intrathecal (baclofen)	J0475, J0476	baclofen	Muscle relaxant	50 mcg for IT trial (J0476) 10 mg (J0475)	50 mcg/mL SD ampule; 10 mg/5 mL, 10 mg/20 mL, 40 mg/20 mL SD ampules	Medicare	Non-specialty	No	No PA required
Loqtorzi (toripalimab-tpzi)	J3263	toripalimab	Oncology	1 mg	240 mg/6 mL SDV	Commercial	Pref. Specialty	No	PA required - see medical oncology prior authorization form for criteria
Loqtorzi (toripalimab-tpzi)	J3263	toripalimab	Oncology	1 mg	240 mg/6 mL SDV	Medicaid	Covered	No	No PA Required - Reference CHAMPS to ensure this drug & NDC is covered for your provider type on the date of service
Loqtorzi (toripalimab-tpzi)	J3263	toripalimab	Oncology	1 mg	240 mg/6 mL SDV	Medicare	Medicare Chemo	No	PA Required (Cancer Therapy) – See Medicare Part B Oncology Prior Authorization form
Lucentis (ranibizumab)	J2778	ranibizumab	Ophthalmic	0.1 mg	0.3 mg, 0.5 mg SD syringe/vial	Commercial	NPS	No	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth Forms tab.
Lucentis (ranibizumab)	J2778	ranibizumab	Ophthalmic	0.1 mg	0.3 mg, 0.5 mg SD syringe/vial	Medicaid	Covered	No	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth Forms tab.
Lucentis (ranibizumab)	J2778	ranibizumab	Ophthalmic	0.1 mg	0.3 mg, 0.5 mg SD syringe/vial	Medicare	Pref. Specialty	No	No PA required when billed for the following ICD-10 codes: E08.311, E08.319, E08.3211–E08.3213, E08.3291 – E08.3293, E08.3311–E08.3313, E08.3391 – E08.3393, E08.3411– E08.3413, E08.3491 – E08.3493, E08.3511- E08.3513, E08.3521 – E08.3523, E08.3531 – E08.3533, E08.354 – E08.3543, E08.3551 – E08.3553, E08.3591 – E08.3593, E09.311, E09.319, E09.3211-E09.3213, E09.3291 – E09.3293, E09.3311-E09.3313, E09.3391 – E09.3393, E09.3411-E09.3413, E09.3491 – E09.3493, E09.3511- E09.3513, E09.3521 – E09.3523, E09.3531 – E09.3533, E09.354 – E09.3543, E09.3551 – E09.3553, E09.3591 – E09.3593, E10.311, E10.319, E10.3211- E10.3213, E10.3291 - E10.3293, E10.3311- E10.3313, E10.3391 - E10.3393, E10.3411- E10.3413, E10.3491 - E10.3493, E10.3511-E10.3513, E10.3591-E10.3599, E11.3211-E11.3219, E11.3291-E11.3299, E11.3311- E11.3313, E11.3391 - E11.3393, E11.3411- E11.3413, E11.3491 - E11.3493, E11.3511 - E11.3513, E11.3521 – E11.3523, E11.3531 – E11.3533, E11.3541 – E11.3543, E11.3551 – E11.3553, E11.3591 – E11.3593, E13.311, E13.319, E13.3211- E13.3213, E13.3291 - E13.3293, E13.3311- E13.3313, E13.3391 - E13.3393, E13.3411- E13.3413, E13.3491 - E13.3493, E13.3511- E13.3513, E13.3521 – E13.3523, E13.3531 – E13.3533, E13.3541 – E13.3543, E13.3551 – E13.3553, E13.3591 – E13.3593, H34.8110, H34.8120, H34.8130, H34.8310, H34.8320, H34.8330, H34.8390, H35.051 - H35.053, H35.3210 - H35.3233, H35.351 – H35.353, H44.21 – H44.2E9 All other ICD-10 diagnoses: PA required - See Medicare Medical Part B prior authorization form
Lumizyme (alglucosidase alfa)	J0221	alglucosidase alfa	Enzyme deficiency	10 mg	50 mg SDV	Commercial	Pref. Specialty	YES	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth Forms tab.
Lumizyme (alglucosidase alfa)	J0221	alglucosidase alfa	Enzyme deficiency	10 mg	50 mg SDV	Medicaid	Covered	YES	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth Forms tab.
Lumizyme (alglucosidase alfa)	J0221	alglucosidase alfa	Enzyme deficiency	10 mg	50 mg SDV	Medicare	Pref. Specialty	No	PA Required - click here for criteria. Link for the Prior Authorization form is on the 'General Prior Auth Forms' tab.
Lumoxiti (moxetumomab pasudotox)	J9313	moxetumomab pasudotox	Oncology	0.01 mg	1 mg SDV	Commercial	Pref. Specialty	No	PA required - see medical oncology prior authorization form for criteria
Lumoxiti (moxetumomab pasudotox)	J9313	moxetumomab pasudotox	Oncology	0.01 mg	1 mg SDV	Medicaid	Covered	No	No PA Required
Lumoxiti (moxetumomab pasudotox)	J9313	moxetumomab pasudotox	Oncology	0.01 mg	1 mg SDV	Medicare	Medicare Chemo	No	PA Required (Cancer Therapy) – See Medicare Part B Oncology Prior Authorization form
Lunsumio (mosunetuzumab-axgb)	J9350	mosunetuzumab	Oncology	1 mg	1 mg/ml SDV 30mg/30 ml SDV	Commercial	Pref. Specialty	No	PA required - see medical oncology prior authorization form for criteria
Lunsumio (mosunetuzumab-axgb)	J9350	mosunetuzumab	Oncology	1 mg	1 mg/ml SDV 30mg/30 ml SDV	Medicaid	Covered	No	No PA Required
Lunsumio (mosunetuzumab-axgb)	J9350	mosunetuzumab	Oncology	1 mg	1 mg/ml SDV 30mg/30 ml SDV	Medicare	Medicare Chemo	No	PA Required (Cancer Therapy) – See Medicare Part B Oncology Prior Authorization form
Lupaneta (leuprolide acetate and norethindrone kit)	J3490	leuprolide acetate and norethindrone	Miscellaneous	3.75 mg (leuprolide)	3.75 mg, 11.25 mg kit	Commercial	Pref. Specialty	No	No PA required
Lupaneta (leuprolide acetate and norethindrone kit)	J3490	leuprolide acetate and norethindrone	Miscellaneous	3.75 mg (leuprolide)	3.75 mg, 11.25 mg kit	Medicaid	Covered	No	No PA required
Lupaneta (leuprolide acetate and norethindrone kit)	J3490	leuprolide acetate and norethindrone	Miscellaneous	3.75 mg (leuprolide)	3.75 mg, 11.25 mg kit	Medicare	Pref. Specialty	No	No PA required
Lupron (leuprolide acetate)--non depot formulation	J9218	leuprolide	Oncology	1 mg	14 mg/2.8 mL MDV kit	Commercial	Non-specialty	YES	No PA required
Lupron (leuprolide acetate)--non depot formulation	J9218	leuprolide	Oncology	1 mg	14 mg/2.8 mL MDV kit	Medicaid	Covered	No	No PA required
Lupron (leuprolide acetate)--non depot formulation	J9218	leuprolide	Oncology	1 mg	14 mg/2.8 mL MDV kit	Medicare	Refer to ADL	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Lupron Depot (leuprolide acetate)	J1950, J9217	leuprolide	Miscellaneous	3.75 mg, 7.5 mg	various	Commercial	Pref. Specialty	YES	No PA required
Lupron Depot (leuprolide acetate)	J1950, J9217	leuprolide	Miscellaneous	3.75 mg, 7.5 mg	various	Medicaid	Covered	No	No PA required
Lupron Depot (leuprolide acetate)	J1950, J9217	leuprolide	Miscellaneous	3.75 mg, 7.5 mg	various	Medicare	Pref. Specialty	No	No PA required
Lupron Depot-PED (leuprolide acetate)	J1950	leuprolide	Endocrine	0.25 mg	3.5mg, 7.5mg, 11.25mg, 15mg, 30mg, 45 mg SD syringe	Commercial	Pref. Specialty	No	No PA required
Lupron Depot-PED (leuprolide acetate)	J1950	leuprolide	Endocrine	0.25 mg	3.5mg, 7.5mg, 11.25mg, 15mg, 30mg, 45 mg SD syringe	Medicaid	Covered	No	No PA required
Lupron Depot-PED (leuprolide acetate)	J1950	leuprolide	Endocrine	0.25 mg	3.5mg, 7.5mg, 11.25mg, 15mg, 30mg, 45 mg SD syringe	Medicare	Pref. Specialty	No	No PA required
Lutathera (lutetium LU 177 dotatate)	A9513, J9999*	lutetium LU 177 dotatate	Radio-pharmaceuticals	1 millicurie (mCi)	10 millicurie/mL SDV (each vial will have between 20.5 mL to 25 mL to provide 200 mCi of radioactivity)	Commercial	Pref. Specialty	No	PA required - see medical oncology prior authorization form for criteria
Lutathera (lutetium LU 177 dotatate)	A9513, J9999*	lutetium LU 177 dotatate	Radio-pharmaceuticals	1 millicurie (mCi)	10 millicurie/mL SDV (each vial will have between 20.5 mL to 25 mL to provide 200 mCi of radioactivity)	Medicaid	Covered	No	No PA Required
Lutathera (lutetium LU 177 dotatate)	A9513, J9999*	lutetium LU 177 dotatate	Radio-pharmaceuticals	1 millicurie (mCi)	10 millicurie/mL SDV (each vial will have between 20.5 mL to 25 mL to provide 200 mCi of radioactivity)	Medicare	Pref. Specialty	No	PA Required (Cancer Therapy) – See Medicare Part B Oncology Prior Authorization form
Luxturna (voretigene neparvovec)	J3398	voretigene neparvovec	Gene/Cellular Therapy	1 billion vector genomes	150 billiable units per eye	Commercial	Gene Therapy	YES	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth Forms tab.
Luxturna (voretigene neparvovec)	J3398	voretigene neparvovec	Gene/Cellular Therapy	1 billion vector genomes	150 billiable units per eye	Medicaid	Carve Out	No	Contact Fee for Service Medicaid for coverage
Luxturna (voretigene neparvovec)	J3398	voretigene neparvovec	Gene/Cellular Therapy	1 billion vector genomes	150 billiable units per eye	Medicare	Gene Therapy	No	PA required - See Medicare Medical Part B prior authorization form
Lyfgenia (lovotibeglogene autotemcel)	J3394	lovotibeglogene autotemcel	Gene/Cellular Therapy	Per therapeutic dose	f.3 × 10^6 CD34+ cells/kg of body weight, in one to four infusion bags	Commercial	Not Covered	No	**Not covered**
Lyfgenia (lovotibeglogene autotemcel)	J3394	lovotibeglogene autotemcel	Gene/Cellular Therapy	Per therapeutic dose	f.3 × 10^6 CD34+ cells/kg of body weight, in one to four infusion bags	Medicaid	Carve Out	No	Contact Fee for Service Medicaid for coverage
Lyfgenia (lovotibeglogene autotemcel)	J3394	lovotibeglogene autotemcel	Gene/Cellular Therapy	Per therapeutic dose	f.3 × 10^6 CD34+ cells/kg of body weight, in one to four infusion bags	Medicare	Gene Therapy	No	PA Required - click here for criteria. Link for the Prior Authorization form is on the 'General Prior Auth Forms' tab.
Makena (brand only--hydroxyprogesterone caproate)	J1726	hydroxyprogesterone	Preterm Labor preventative	10 mg	1,250 mg/5 mL SDV, 275mg/1.1ml Autoinjector	Commercial	Not covered	No	**Not covered- FDA Approval withdrawn 4-6-2023**

Drug	Code	Generic	Category	Billing Unit	How Supplied	Line of Business	Coverage Level	Site Of Service	Comment
Makena (brand only--hydroxyprogesterone caproate)	J1726	hydroxyprogesterone	Preterm Labor preventative	10 mg	1,250 mg/5 mL SDV, 275mg/1.1ml Autoinjector	Medicaid	Not Covered	No	**Not covered- FDA Approval withdrawn 4-6-2023**
Makena (brand only--hydroxyprogesterone caproate)	J1726	hydroxyprogesterone	Preterm Labor preventative	10 mg	1,250 mg/5 mL SDV, 275mg/1.1ml Autoinjector	Medicare	Not covered	No	**Not covered- FDA Approval withdrawn 4-6-2023**
Margenza (margetuximab-cmkb)	J9333	margetuximab	Oncology	5 mg	250 mg/10 mL SDV	Commercial	Pref. Specialty	No	PA required - see medical oncology prior authorization form for criteria
Margenza (margetuximab-cmkb)	J9333	margetuximab	Oncology	5 mg	250 mg/10 mL SDV	Medicaid	Covered	No	No PA Required
Margenza (margetuximab-cmkb)	J9333	margetuximab	Oncology	5 mg	250 mg/10 mL SDV	Medicare	Pref. Specialty	No	PA Required - click here for criteria. Link for the Prior Authorization form is on the 'General Prior Auth Forms' tab.
Marinol (dronabinol)	Q0167	Dronabinol	Antiemetic	2.5 mg	2.5 mg, 5 mg, 10 mg capsule	Medicare	Non-specialty	No	Part B vs Part D – See Approved Drug List for covered formulations under Part D - see the Part B vs Part D coverage determination form for criteria
Marqibo (vincristine liposome)	J9371	vincristine	Oncology	1 mg	5 mg/31 mL SD kit	Commercial	NPS	No	PA required - see medical oncology prior authorization form for criteria
Marqibo (vincristine liposome)	J9371	vincristine	Oncology	1 mg	5 mg/31 mL SD kit	Medicaid	Covered	No	No PA Required
Marqibo (vincristine liposome)	J9371	vincristine	Oncology	1 mg	5 mg/31 mL SD kit	Medicare	Medicare Chemo	No	No PA required
meperidine	J2175	meperidine	Analgesic	100 mg	various	Commercial	Non-specialty	No	No PA required
meperidine	J2175	meperidine	Analgesic	100 mg	various	Medicaid	Covered	No	No PA required
meperidine	J2175	meperidine	Analgesic	100 mg	various	Medicare	Non-specialty	No	No PA required
Mepsevii (vestronidase alfa-vjbk)	J3397	vetronidase alfa	Enzyme deficiency	1 mg	10 mg/5 mL SDV	Commercial	Not covered	No	**Not covered**
Mepsevii (vestronidase alfa-vjbk)	J3397	vetronidase alfa	Enzyme deficiency	1 mg	10 mg/5 mL SDV	Medicaid	Not Covered	No	**Not covered**
Mepsevii (vestronidase alfa-vjbk)	J3397	vetronidase alfa	Enzyme deficiency	1 mg	10 mg/5 mL SDV	Medicare	NPS	No	PA required - See Medicare Medical Part B prior authorization form
meropenem - B Braun Brand ONLY	J2184	meropenem	Antimicrobial	100 mg	500 mg, 1000 mg SDV	Commercial	Pref. Specialty	No	No PA required
meropenem - B Braun Brand ONLY	J2184	meropenem	Antimicrobial	100 mg	500 mg, 1000 mg SDV	Medicaid	Covered	No	No PA required
meropenem - B Braun Brand ONLY	J2184	meropenem	Antimicrobial	100 mg	500 mg, 1000 mg SDV	Medicare	Pref. Specialty	No	No PA required
meropenem - WG Critical Care ONLY	J2183	meropenem	Antimicrobial	100 mg	2000 mg SDV	Commercial	Pref. Specialty	No	No PA required
meropenem - WG Critical Care ONLY	J2183	meropenem	Antimicrobial	100 mg	2000 mg SDV	Medicaid	Covered	No	No PA required
meropenem - WG Critical Care ONLY	J2183	meropenem	Antimicrobial	100 mg	2000 mg SDV	Medicare	Pref. Specialty	No	No PA required
Merrem (meropenem)	J2185	meropenem	Antimicrobial	100 mg	500 mg, 1000 mg SDV	Commercial	Pref. Specialty	No	No PA required
Merrem (meropenem)	J2185	meropenem	Antimicrobial	100 mg	500 mg, 1000 mg SDV	Medicaid	Covered	No	No PA required
Merrem (meropenem)	J2185	meropenem	Antimicrobial	100 mg	500 mg, 1000 mg SDV	Medicare	Pref. Specialty	No	No PA required
Mesnex (mesna)	J9209	mesna	Oncology	200 mg	1000 mg/10 mL MDV	Commercial	Non-specialty	No	No PA required
Mesnex (mesna)	J9209	mesna	Oncology	200 mg	1000 mg/10 mL MDV	Medicaid	Covered	No	No PA required
Mesnex (mesna)	J9209	mesna	Oncology	200 mg	1000 mg/10 mL MDV	Medicare	Non-specialty	No	No PA required
Methergine (methylergonovine maleate)	J2210	methylergonovine	Miscellaneous	0.2 mg	0.2 mg/mL SDV	Commercial	Non-specialty	No	No PA required
Methergine (methylergonovine maleate)	J2210	methylergonovine	Miscellaneous	0.2 mg	0.2 mg/mL SDV	Medicaid	Covered	No	No PA required
Methergine (methylergonovine maleate)	J2210	methylergonovine	Miscellaneous	0.2 mg	0.2 mg/mL SDV	Medicare	Non-specialty	No	No PA required
Micafungin - Baxter ONLY	J2246	micafungin	Antimicrobial	1 mg	50 mg, 100 mg SDV	Commercial	Pref. Specialty	No	No PA required
Micafungin - Baxter ONLY	J2246	micafungin	Antimicrobial	1 mg	50 mg, 100 mg SDV	Medicaid	Covered	No	No PA required
Micafungin - Baxter ONLY	J2246	micafungin	Antimicrobial	1 mg	50 mg, 100 mg SDV	Medicare	Non-specialty	No	No PA required
Micafungin - Par Pharm Brand ONLY	J2247	micafungin	Antimicrobial	1 mg	50 mg, 100 mg SDV	Commercial	Pref. Specialty	No	No PA required
Micafungin - Par Pharm Brand ONLY	J2247	micafungin	Antimicrobial	1 mg	50 mg, 100 mg SDV	Medicaid	Covered	No	No PA required
Micafungin - Par Pharm Brand ONLY	J2247	micafungin	Antimicrobial	1 mg	50 mg, 100 mg SDV	Medicare	Pref. Specialty	No	No PA required
Mircera (Methoxy polyethylene glycol-epoetin beta)	J0887 (ESRD) J0888 (Non-ESRD)	Methoxy polyethylene glycol-epoetin beta	Hematopoietic agent	1 mcg	50 mcg/0.3 mL, 75 mcg/0.3 mL, 100 mcg/0.3 mL, 150 mcg/0.3 mL, 200 mcg/0.3 mL, 250 mcg/0.3 mL SD syringe	Commercial	Pref. Specialty	No	No PA required
Mircera (Methoxy polyethylene glycol-epoetin beta)	J0887 (ESRD) J0888 (Non-ESRD)	Methoxy polyethylene glycol-epoetin beta	Hematopoietic agent	1 mcg	50 mcg/0.3 mL, 75 mcg/0.3 mL, 100 mcg/0.3 mL, 150 mcg/0.3 mL, 200 mcg/0.3 mL, 250 mcg/0.3 mL SD syringe	Medicaid	Covered	No	No PA required
Mircera (Methoxy polyethylene glycol-epoetin beta)	J0887 (ESRD) J0888 (Non-ESRD)	Methoxy polyethylene glycol-epoetin beta	Hematopoietic agent	1 mcg	50 mcg/0.3 mL, 75 mcg/0.3 mL, 100 mcg/0.3 mL, 150 mcg/0.3 mL, 200 mcg/0.3 mL, 250 mcg/0.3 mL SD syringe	Medicare	Pref. Specialty	No	Part B vs Part D – See Approved Drug List for covered formulations under Part D - see the Part B vs Part D coverage determination form for criteria
mitomycin	J9280	mitomycin	Oncology	5 mg	5 mg, 20 mg, 40 mg SDV	Commercial	Non-specialty	No	No PA required
mitomycin	J9280	mitomycin	Oncology	5 mg	5 mg, 20 mg, 40 mg SDV	Medicaid	Covered	No	No PA required
mitomycin	J9280	mitomycin	Oncology	5 mg	5 mg, 20 mg, 40 mg SDV	Medicare	Non-specialty	No	No PA required
Mitosol (mitomycin) ophthalmic	J7315	mitomycin	Ophthalmic	0.2 mg	0.2 mg SD kit	Commercial	Non-specialty	No	No PA required
Mitosol (mitomycin) ophthalmic	J7315	mitomycin	Ophthalmic	0.2 mg	0.2 mg SD kit	Medicaid	Covered	No	No PA required
Mitosol (mitomycin) ophthalmic	J7315	mitomycin	Ophthalmic	0.2 mg	0.2 mg SD kit	Medicare	Non-specialty	No	No PA required
Monjuvi (tafasitamab-cxix)	J9349	tafasitamab	Oncology	2 mg	200 mg SDV	Commercial	Pref. Specialty	No	PA required - see medical oncology prior authorization form for criteria
Monjuvi (tafasitamab-cxix)	J9349	tafasitamab	Oncology	2 mg	200 mg SDV	Medicaid	Covered	No	No PA Required
Monjuvi (tafasitamab-cxix)	J9349	tafasitamab	Oncology	2 mg	200 mg SDV	Medicare	Medicare Chemo	No	PA Required (Cancer Therapy) – See Medicare Part B Oncology Prior Authorization form
Monoferric (ferric derisomaltose)	J1437	ferric derisomaltose	Iron replacement	10 mg	1000 mg/10 mL SDV	Commercial	NPS	No	No PA required
Monoferric (ferric derisomaltose)	J1437	ferric derisomaltose	Iron replacement	10 mg	1000 mg/10 mL SDV	Medicaid	Covered	No	No PA required
Monoferric (ferric derisomaltose)	J1437	ferric derisomaltose	Iron replacement	10 mg	1000 mg/10 mL SDV	Medicare	NPS	No	No PA required
Mononine (Antihemophilic Factor IX)	J7193	Antihemophilic Factor IX	Hemophilia			Commercial	Refer to ADL	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Mononine (Antihemophilic Factor IX)	J7193	Antihemophilic Factor IX	Hemophilia			Medicaid	Not Covered	No	Refer to the Medicaid Approved Drug List (ADL) for pharmacy benefit coverage. For one-time doses required for planned outpatient procedures (professional/facility claims), authorizations will be reviewed for medical necessity according to the Hemophilia Management Medical Policy 91569
Mononine (Antihemophilic Factor IX)	J7193	Antihemophilic Factor IX	Hemophilia			Medicare	Pref. Specialty	No	No PA required
Monovisc (hyaluronan/ hyaluronic acid) for intra-articular injection	J7327	hyaluronate sodium/ hyaluronic acid	Hyaluronic acid derivatives	per dose	88 mg/4 mL SD syringe	Commercial	Not covered	No	**Not covered – See Pharmacy Policy EXPERIMENTAL/INVESTIGATIONAL/UNPROVEN CARE/ BENEFIT EXCEPTIONS for more information**
Monovisc (hyaluronan/ hyaluronic acid) for intra-articular injection	J7327	hyaluronate sodium/ hyaluronic acid	Hyaluronic acid derivatives	per dose	88 mg/4 mL SD syringe	Medicaid	Not Covered	No	**Not covered**
Monovisc (hyaluronan/ hyaluronic acid) for intra-articular injection	J7327	hyaluronate sodium/ hyaluronic acid	Hyaluronic acid derivatives	per dose	88 mg/4 mL SD syringe	Medicare	NPS	No	PA Required - click here for criteria. Link for the Prior Authorization form is on the 'General Prior Auth Forms' tab.
Moxifloxacin - Fresenius Kabi Brand ONLY	J2281	moxifloxacin	Antimicrobial	100 mg	400mg/250 mL SD infusion bag	Commercial	Non-specialty	No	No PA required
Moxifloxacin - Fresenius Kabi Brand ONLY	J2281	moxifloxacin	Antimicrobial	100 mg	400mg/250 mL SD infusion bag	Medicaid	Covered	No	No PA required
Moxifloxacin - Fresenius Kabi Brand ONLY	J2281	moxifloxacin	Antimicrobial	100 mg	400mg/250 mL SD infusion bag	Medicare	Non-specialty	No	No PA required
Mozobil (plerixafor)	J2562	plerixafor	Oncology	1 mg	24 mg/1.2 mL SDV	Commercial	NPS	No	No PA required
Mozobil (plerixafor)	J2562	plerixafor	Oncology	1 mg	24 mg/1.2 mL SDV	Medicaid	Covered	No	No PA required
Mozobil (plerixafor)	J2562	plerixafor	Oncology	1 mg	24 mg/1.2 mL SDV	Medicare	NPS	No	No PA required
Mucomyst (acetylcysteine) INHALATION ONLY	J7608	acetylcysteine	inhalation	1 gram	10%, 20% 3ml, 4ml, 10 mL and 30 mL SDV	Medicare	Non-specialty	No	Part B vs Part D – See Approved Drug List for covered formulations under Part D - see the Part B vs Part D coverage determination form for criteria
Mvasi (bevacizumab-awwb)	Q5107	bevacizumab	Oncology	10 mg	100 mg/4 mL, 400 mg/16 mL SDV	Commercial	Pref. Specialty	No	No PA required
Mvasi (bevacizumab-awwb)	Q5107	bevacizumab	Oncology	10 mg	100 mg/4 mL, 400 mg/16 mL SDV	Medicaid	Covered	No	No PA required
Mvasi (bevacizumab-awwb)	Q5107	bevacizumab	Oncology	10 mg	100 mg/4 mL, 400 mg/16 mL SDV	Medicare	Medicare Chemo	No	No PA required
Mycamine (micafungin)	J2248 - Not for Par Pharm brand - See J2247	micafungin	Antimicrobial	1 mg	50 mg, 100 mg SDV	Commercial	Pref. Specialty	No	No PA required
Mycamine (micafungin)	J2248 - Not for Par Pharm brand - See J2247	micafungin	Antimicrobial	1 mg	50 mg, 100 mg SDV	Medicaid	Covered	No	No PA required
Mycamine (micafungin)	J2248 - Not for Par Pharm brand - See J2247	micafungin	Antimicrobial	1 mg	50 mg, 100 mg SDV	Medicare	Pref. Specialty	No	No PA required
Myfortic (Mycophenolate sodium or Mycophenolic acid) ORAL ONLY	J7518	mycophenolate	Immunosuppressive agent	180 mg	180 mg, 360 mg tablet	Medicare	Non-specialty	No	Part B vs Part D – See Approved Drug List for covered formulations under Part D - see the Part B vs Part D coverage determination form for criteria
Myhibbin (Mycophenolate mofetil) ORAL ONLY	J7514	mycophenolate	Immunosuppressive agent	100mg	200 mg/mL oral suspension (175ml bottle)	Medicare	Non-specialty	No	Part B vs Part D – See Approved Drug List for covered formulations under Part D - see the Part B vs Part D coverage determination form for criteria
Mylotarg (gemtuzumab ozogamicin)	J9203	gemtuzumab	Oncology	0.1 mg	4.5 mg SDV	Commercial	NPS	No	PA required - see medical oncology prior authorization form for criteria
Mylotarg (gemtuzumab ozogamicin)	J9203	gemtuzumab	Oncology	0.1 mg	4.5 mg SDV	Medicaid	Covered	No	No PA Required
Mylotarg (gemtuzumab ozogamicin)	J9203	gemtuzumab	Oncology	0.1 mg	4.5 mg SDV	Medicare	Medicare Chemo	No	PA Required (Cancer Therapy) – See Medicare Part B Oncology Prior Authorization form

Drug	Code	Generic	Category	Billing Unit	How Supplied	Line of Business	Coverage Level	Site Of Service	Comment
Myobloc (rimabotulinumtoxinB)	J0587	botulinum toxin B	botulinum toxin	100 units	2500 unit/0.5 mL, 5000 unit/mL, 10,000 unit/2 mL SDV	Commercial	Pref. Specialty	No	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth. Forms tab. No auth required when billed by: Neurologist (NEUR), Rehab Medicine (PMR) or Physical Med & Rehab (PT)
Myobloc (rimabotulinumtoxinB)	J0587	botulinum toxin B	botulinum toxin	100 units	2500 unit/0.5 mL, 5000 unit/mL, 10,000 unit/2 mL SDV	Medicaid	Covered	No	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth. Forms tab. No auth required when billed by: Neurologist (NEUR), Rehab Medicine (PMR) or Physical Med & Rehab (PT)
Myobloc (rimabotulinumtoxinB)	J0587	botulinum toxin B	botulinum toxin	100 units	2500 unit/0.5 mL, 5000 unit/mL, 10,000 unit/2 mL SDV	Medicare	Pref. Specialty	No	PA Required - click here for criteria. Link for the Prior Authorization form is on the 'General Prior Auth. Forms' tab. No auth required when billed by: Neurologist (NEUR), Rehab Medicine (PMR) or Physical Med & Rehab (PT)
Naglazyme (galsulfase)	J1458	galsulfase	Enzyme deficiency	1 mg	5 mg/5 mL SDV	Commercial	Pref. Specialty	YES	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth. Forms tab.
Naglazyme (galsulfase)	J1458	galsulfase	Enzyme deficiency	1 mg	5 mg/5 mL SDV	Medicaid	Covered	YES	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth. Forms tab.
Naglazyme (galsulfase)	J1458	galsulfase	Enzyme deficiency	1 mg	5 mg/5 mL SDV	Medicare	Pref. Specialty	No	No PA required
Navelbine (vinorelbine)	J9390	vinorelbine	Oncology	10 mg	10 mg/mL, 50 mg/5 mL SDV	Commercial	Non-specialty	No	No PA required
Navelbine (vinorelbine)	J9390	vinorelbine	Oncology	10 mg	10 mg/mL, 50 mg/5 mL SDV	Medicaid	Covered	No	No PA required
Navelbine (vinorelbine)	J9390	vinorelbine	Oncology	10 mg	10 mg/mL, 50 mg/5 mL SDV	Medicare	Non-specialty	No	No PA required
Nebupent (pentamidine isethionate) inhalation	J2545	pentamidine	inhalation	300 mg	300 mg SDV	Commercial	Non-specialty	No	No PA required
Nebupent (pentamidine isethionate) inhalation	J2545	pentamidine	inhalation	300 mg	300 mg SDV	Medicaid	Covered	No	No PA required
Nebupent (pentamidine isethionate) inhalation	J2545	pentamidine	inhalation	300 mg	300 mg SDV	Medicare	Non-specialty	No	No PA required
Neoral (cyclosporin, modified) ORAL ONLY	J7515-25mg J7502-100mg	cyclosporin	Immunosuppressive agent	25 mg (J7515) 100 mg (J7502)	25 mg, 50 mg, 100 mg capsule	Medicare	Non-specialty	No	Part B vs Part D – See Approved Drug List for covered formulations under Part D - see the Part B vs Part D coverage determination form for criteria.
Nephramine (amino acids) Injection		amino acids	TPN			Medicare		No	Part B vs Part D – See Approved Drug List for covered formulations under Part D - see the Part B vs Part D coverage determination form for criteria.
Neulasta (pegfilgrastim)	J2506	pegfilgrastim	Hematopoietic agent	0.5 mg	6 mg/0.6 mL SD syringe and Onpro kit	Commercial	Pref. Specialty	No	No PA required
Neulasta (pegfilgrastim)	J2506	pegfilgrastim	Hematopoietic agent	0.5 mg	6 mg/0.6 mL SD syringe and Onpro kit	Medicaid	Covered	No	No PA required
Neulasta (pegfilgrastim)	J2506	pegfilgrastim	Hematopoietic agent	0.5 mg	6 mg/0.6 mL SD syringe and Onpro kit	Medicare	Pref. Specialty	No	No PA required
Neupogen (filgrastim)	J1442	filgrastim	Hematopoietic agent	1 mcg	300 mcg/0.5 mL, 300 mcg/1 mL, 480 mcg/0.8 mL, 480 mcg/1.6 mL SD vial/syringe	Commercial	NPS	No	No PA required
Neupogen (filgrastim)	J1442	filgrastim	Hematopoietic agent	1 mcg	300 mcg/0.5 mL, 300 mcg/1 mL, 480 mcg/0.8 mL, 480 mcg/1.6 mL SD vial/syringe	Medicaid	Covered	No	No PA required
Neupogen (filgrastim)	J1442	filgrastim	Hematopoietic agent	1 mcg	300 mcg/0.5 mL, 300 mcg/1 mL, 480 mcg/0.8 mL, 480 mcg/1.6 mL SD vial/syringe	Medicare	NPS	No	PA Required - click here for criteria. Link for the Prior Authorization form is on the 'General Prior Auth. Forms' tab.
Nexplanon (etonogestrel implant)	J7307	etonogestrel	Contraceptive	per each	68 mg implant	Commercial	Refer to Contraceptive Coverage	No	Refer to contraceptive coverage
Nexplanon (etonogestrel implant)	J7307	etonogestrel	Contraceptive	per each	68 mg implant	Medicaid	Refer to Contraceptive Coverage	No	Refer to contraceptive coverage
Nexplanon (etonogestrel implant)	J7307	etonogestrel	Contraceptive	per each	68 mg implant	Medicare	Refer to Contraceptive Coverage	No	Refer to contraceptive coverage
Nexviazyme (avalglucosidase alfa-ngpt)	J0219	avalglucosidase alfa	Enzyme deficiency	4mg	100mg SDV	Commercial	NPS	YES	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth. Forms tab.
Nexviazyme (avalglucosidase alfa-ngpt)	J0219	avalglucosidase alfa	Enzyme deficiency	4mg	100mg SDV	Medicaid	Covered	YES	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth. Forms tab.
Nexviazyme (avalglucosidase alfa-ngpt)	J0219	avalglucosidase alfa	Enzyme deficiency	4mg	100mg SDV	Medicare	NPS	No	PA Required - click here for criteria. Link for the Prior Authorization form is on the 'General Prior Auth. Forms' tab.
Ngenia (somatrogon-ghla)	J3590 C9399	somatrogon	Human Growth Hormone			Commercial	Refer to ADL	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Ngenia (somatrogon-ghla)	J3590 C9399	somatrogon	Human Growth Hormone			Medicaid	Not Covered	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Ngenia (somatrogon-ghla)	J3590 C9399	somatrogon	Human Growth Hormone			Medicare	Refer to ADL	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Nipent (pentostatin)	J9268	pentostatin	Oncology	10 mg	10 mg SDV	Commercial	Pref. Specialty	No	No PA required
Nipent (pentostatin)	J9268	pentostatin	Oncology	10 mg	10 mg SDV	Medicaid	Covered	No	No PA required
Nipent (pentostatin)	J9268	pentostatin	Oncology	10 mg	10 mg SDV	Medicare	Pref. Specialty	No	No PA required
Nivestym (filgrastim-aafi)	Q5110	filgrastim	Hematopoietic agent	1 mcg	300 mcg/0.5 mL, 300 mcg/1 mL, 480 mcg/0.8 mL, 480 mcg/1.6 mL SD vial/syringe	Commercial	Pref. Specialty	No	No PA required
Nivestym (filgrastim-aafi)	Q5110	filgrastim	Hematopoietic agent	1 mcg	300 mcg/0.5 mL, 300 mcg/1 mL, 480 mcg/0.8 mL, 480 mcg/1.6 mL SD vial/syringe	Medicaid	Covered	No	No PA required
Nivestym (filgrastim-aafi)	Q5110	filgrastim	Hematopoietic agent	1 mcg	300 mcg/0.5 mL, 300 mcg/1 mL, 480 mcg/0.8 mL, 480 mcg/1.6 mL SD vial/syringe	Medicare	Pref. Specialty	No	No PA required
Novantrone (mitoxantrone)	J9293	mitoxantrone	Oncology	5 mg	20 mg/10 mL, 25 mg/12.5 mL, 30 mg/15 mL SDV	Commercial	Non-specialty	No	No PA required
Novantrone (mitoxantrone)	J9293	mitoxantrone	Oncology	5 mg	20 mg/10 mL, 25 mg/12.5 mL, 30 mg/15 mL SDV	Medicaid	Covered	No	No PA required
Novantrone (mitoxantrone)	J9293	mitoxantrone	Oncology	5 mg	20 mg/10 mL, 25 mg/12.5 mL, 30 mg/15 mL SDV	Medicare	Non-specialty	No	No PA required
Novoeight (Antihemophilic Factor VIII)	J7182	Antihemophilic Factor VIII	Hemophilia			Commercial	Refer to ADL	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Novoeight (Antihemophilic Factor VIII)	J7182	Antihemophilic Factor VIII	Hemophilia			Medicaid	Not Covered	No	Refer to the Medicaid Approved Drug List (ADL) for pharmacy benefit coverage. For one-time doses required for planned outpatient procedures (professional/facility claims), authorizations will be reviewed for medical necessity according to the Hemophilia Management Medical Policy 91569
Novoeight (Antihemophilic Factor VIII)	J7182	Antihemophilic Factor VIII	Hemophilia			Medicare	Pref. Specialty	No	No PA required
NovoSeven (Antihemophilic Factor VIIa)	J7189	Antihemophilic Factor VIIa	Hemophilia			Commercial	Refer to ADL	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
NovoSeven (Antihemophilic Factor VIIa)	J7189	Antihemophilic Factor VIIa	Hemophilia			Medicaid	Not Covered	No	Refer to the Medicaid Approved Drug List (ADL) for pharmacy benefit coverage. For one-time doses required for planned outpatient procedures (professional/facility claims), authorizations will be reviewed for medical necessity according to the Hemophilia Management Medical Policy 91569
NovoSeven (Antihemophilic Factor VIIa)	J7189	Antihemophilic Factor VIIa	Hemophilia			Medicare	Pref. Specialty	No	No PA required
Nplate (romiplostim)	J2802	romiplostim	Hematopoietic agent	1 mcg	125 mcg, 250 mcg, 500 mcg SDV	Commercial	Pref. Specialty	No	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth. Forms tab.
Nplate (romiplostim)	J2802	romiplostim	Hematopoietic agent	1 mcg	125 mcg, 250 mcg, 500 mcg SDV	Medicaid	Covered	No	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth. Forms tab.
Nplate (romiplostim)	J2802	romiplostim	Hematopoietic agent	1 mcg	125 mcg, 250 mcg, 500 mcg SDV	Medicare	Pref. Specialty	No	PA required - See Medicare Medical Part B prior authorization form
Nucala (mepolizumab) ***Prefilled Syringe & Auto Injector***	J2182	mepolizumab	Respiratory Biologic			Commercial	Refer to ADL	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Nucala (mepolizumab) ***Prefilled Syringe & Auto Injector***	J2182	mepolizumab	Respiratory Biologic			Medicaid	Not Covered	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Nucala (mepolizumab) ***Prefilled Syringe & Auto Injector***	J2182	mepolizumab	Respiratory Biologic			Medicare	Refer to ADL	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Nucala (mepolizumab) ***Vial***	J2182	mepolizumab	Respiratory Biologic	1 mg	100 mg SDV	Commercial	NPS	YES	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth. Forms tab.
Nucala (mepolizumab) ***Vial***	J2182	mepolizumab	Respiratory Biologic	1 mg	100 mg SDV	Medicaid	Not Covered	No	**Not covered**
Nucala (mepolizumab) ***Vial***	J2182	mepolizumab	Respiratory Biologic	1 mg	100 mg SDV	Medicare	Pref Specialty	No	PA Required - click here for criteria. Link for the Prior Authorization form is on the 'General Prior Auth. Forms' tab.
Nulibry (fosdenopterin)	J3490	fosdenopterin	Miscellaneous	Additional information required: National Drug Code (NDC), Strength, Dosage administered, Route of administration.	9.5 mg SDV	Commercial	Pref. Specialty	No	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth. Forms tab.
Nulibry (fosdenopterin)	J3490	fosdenopterin	Miscellaneous	Additional information required: National Drug Code (NDC), Strength, Dosage administered, Route of administration.	9.5 mg SDV	Medicaid	Not Covered	No	**Not Covered**
Nulibry (fosdenopterin)	J3490	fosdenopterin	Miscellaneous	Additional information required: National Drug Code (NDC), Strength, Dosage administered, Route of administration.	9.5 mg SDV	Medicare	Pref. Specialty	No	PA required - See Medicare Medical Part B prior authorization form
Nulojix (belatacept)	J0485	belatacept	Immunosuppressive agent	1 mg	250 mg SDV	Commercial	NPS	YES	No PA Required
Nulojix (belatacept)	J0485	belatacept	Immunosuppressive agent	1 mg	250 mg SDV	Medicaid	Covered	No	No PA Required
Nulojix (belatacept)	J0485	belatacept	Immunosuppressive agent	1 mg	250 mg SDV	Medicare	NPS	No	PA Required - click here for criteria. Link for the Prior Authorization form is on the 'General Prior Auth. Forms' tab.
Nuvaring (ethinyl estradiol and etonogestrel)	J7295	ethinyl estradiol and etonogestrel	Contraceptive	1	various	Commercial	Refer to ADL	No	
Nuvaring (ethinyl estradiol and etonogestrel)	J7295	ethinyl estradiol and etonogestrel	Contraceptive	1	various	Medicaid	Not Covered	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Nuvaring (ethinyl estradiol and etonogestrel)	J7295	ethinyl estradiol and etonogestrel	Contraceptive	1	various	Medicare	Refer to ADL	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Nuwiq (Antihemophilic Factor VIII)	J7209	Antihemophilic Factor VIII	Hemophilia			Commercial	Refer to ADL	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Nuwiq (Antihemophilic Factor VIII)	J7209	Antihemophilic Factor VIII	Hemophilia			Medicaid	Not Covered	No	Refer to the Medicaid Approved Drug List (ADL) for pharmacy benefit coverage. For one-time doses required for planned outpatient procedures (professional/facility claims), authorizations will be reviewed for medical necessity according to the Hemophilia Management Medical Policy 91569
Nuwiq (Antihemophilic Factor VIII)	J7209	Antihemophilic Factor VIII	Hemophilia			Medicare	Pref. Specialty	No	No PA required

Drug	Code	Generic	Category	Billing Unit	How Supplied	Line of Business	Coverage Level	Site Of Service	Comment
Nuzyra (omadacycline)	J0121	omadacycline	Antimicrobial	1 mg	100 mg SDV	Commercial	Not covered	No	**Not covered**

Drug	Code	Generic	Category	Billing Unit	How Supplied	Line of Business	Coverage Level	Site Of Service	Comment
Nuzyra (omadacycline)	J0121	omadacycline	Antimicrobial	1 mg	100 mg SDV	Medicaid	Not Covered	No	**Not covered**
Nuzyra (omadacycline)	J0121	omadacycline	Antimicrobial	1 mg	100 mg SDV	Medicare	NPS	No	PA required - See Medicare Medical Part B prior authorization form
Nypozi (filgrastim-txid)	J3590*, C9173	filgrastim	Hematopoietic agent	1 mcg	300 mcg/0.5mL, 480 mcg/0.8 mL prefilled syringe	Commercial	Not Covered	No	**Not Covered**
Nypozi (filgrastim-txid)	J3590*, C9173	filgrastim	Hematopoietic agent	1 mcg	300 mcg/0.5mL, 480 mcg/0.8 mL prefilled syringe	Medicaid	Covered	No	No PA required
Nypozi (filgrastim-txid)	J3590*, C9173	filgrastim	Hematopoietic agent	1 mcg	300 mcg/0.5mL, 480 mcg/0.8 mL prefilled syringe	Medicare	NPS	No	PA Required - click here for criteria. Link for the Prior Authorization form is on the 'General Prior Auth Forms' tab.
Nyvepria (pegfilgrastim-apgf)	Q5122	pegfilgrastim	Hematopoietic agent	0.5 mg	6 mg/0.6 mL SD syringe	Commercial	Pref. Specialty	No	No PA required
Nyvepria (pegfilgrastim-apgf)	Q5122	pegfilgrastim	Hematopoietic agent	0.5 mg	6 mg/0.6 mL SD syringe	Medicaid	Covered	No	No PA required
Nyvepria (pegfilgrastim-apgf)	Q5122	pegfilgrastim	Hematopoietic agent	0.5 mg	6 mg/0.6 mL SD syringe	Medicare	Pref. Specialty	No	No PA required
Obizur (Antihemophilic Factor VIII)	J7188	Antihemophilic Factor VIII	Hemophilia			Commercial	Refer to ADL	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Obizur (Antihemophilic Factor VIII)	J7188	Antihemophilic Factor VIII	Hemophilia			Medicaid	Not Covered	No	Refer to the Medicaid Approved Drug List (ADL) for pharmacy benefit coverage. For one-time doses required for planned outpatient procedures (professional/facility claims), authorizations will be reviewed for medical necessity according to the Hemophilia Management Medical Policy 91569
Obizur (Antihemophilic Factor VIII)	J7188	Antihemophilic Factor VIII	Hemophilia			Medicare	Pref. Specialty	No	No PA required
Ocrevus (ocrelizumab) *(IV infusion)*	J2350	ocrelizumab	Multiple Sclerosis (MS) agent	1 mg	300 mg/10 mL SDV	Commercial	Pref. Specialty	YES	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth Forms tab.
Ocrevus (ocrelizumab) *(IV infusion)*	J2350	ocrelizumab	Multiple Sclerosis (MS) agent	1 mg	300 mg/10 mL SDV	Medicaid	Covered	YES	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth Forms tab.
Ocrevus (ocrelizumab) *(IV infusion)*	J2350	ocrelizumab	Multiple Sclerosis (MS) agent	1 mg	300 mg/10 mL SDV	Medicare	Pref. Specialty	No	No PA required
Ocrevus Zunovo (ocrelizumab & hyaluronidase-ocsq) *(Subcutaneous injection)*	J3590*, C9399*	ocrelizumab & hyaluronidase	Multiple Sclerosis (MS) agent	Additional information required: National Drug Code (NDC), Strength, Dosage administered, Route of administration.	920 mg and 23,000 units/23 mL SDV	Commercial	Pref. Specialty	YES	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth Forms tab.
Ocrevus Zunovo (ocrelizumab & hyaluronidase-ocsq) *(Subcutaneous injection)*	J3590*, C9399*	ocrelizumab & hyaluronidase	Multiple Sclerosis (MS) agent	Additional information required: National Drug Code (NDC), Strength, Dosage administered, Route of administration.	920 mg and 23,000 units/23 mL SDV	Medicaid	Covered	YES	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth Forms tab.
Ocrevus Zunovo (ocrelizumab & hyaluronidase-ocsq) *(Subcutaneous injection)*	J3590*, C9399*	ocrelizumab & hyaluronidase	Multiple Sclerosis (MS) agent	Additional information required: National Drug Code (NDC), Strength, Dosage administered, Route of administration.	920 mg and 23,000 units/23 mL SDV	Medicare	Pref. Specialty	No	No PA required
Octagam (immune globulin) intravenous	J1568	IVIG	Immune Globulin	500 mg	1 gm, 2.5 gm, 5 gm, 10 gm, 25 gm, 30 gm SDV	Commercial	Pref. Specialty	YES	PA required - see IVIG/SCIG prior authorization form for criteria
Octagam (immune globulin) intravenous	J1568	IVIG	Immune Globulin	500 mg	1 gm, 2.5 gm, 5 gm, 10 gm, 25 gm, 30 gm SDV	Medicaid	Covered	YES	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth Forms tab.
Octagam (immune globulin) intravenous	J1568	IVIG	Immune Globulin	500 mg	1 gm, 2.5 gm, 5 gm, 10 gm, 25 gm, 30 gm SDV	Medicare	Pref. Specialty	No	Part B vs Part D – See Approved Drug List for covered formulations under Part D - see the Part B vs Part D coverage determination form for criteria
Ofirmev (acetaminophen)	J0131 - verify manufacturer - some have their own specific HCPCS code	acetaminophen	Analgesic	10 mg	500 mg/50 mL, 1000 mg/100 mL SDV	Commercial	Non-specialty	No	No PA required
Ofirmev (acetaminophen)	J0131 - verify manufacturer - some have their own specific HCPCS code	acetaminophen	Analgesic	10 mg	500 mg/50 mL, 1000 mg/100 mL SDV	Medicaid	Covered	No	No PA required
Ofirmev (acetaminophen)	J0131 - verify manufacturer - some have their own specific HCPCS code	acetaminophen	Analgesic	10 mg	500 mg/50 mL, 1000 mg/100 mL SDV	Medicare	Non-specialty	No	No PA required
Ogivri (trastuzumab-dkst)	Q5114	trastuzumab	Oncology	10 mg	150 mg, 420 mg SDV	Commercial	Pref Specialty	No	No PA required
Ogivri (trastuzumab-dkst)	Q5114	trastuzumab	Oncology	10 mg	150 mg, 420 mg SDV	Medicaid	Covered	No	No PA required
Ogivri (trastuzumab-dkst)	Q5114	trastuzumab	Oncology	10 mg	150 mg, 420 mg SDV	Medicare	Medicare Chemo	No	No PA required
Ohtuvayre (ensifentrine)	J7601	ensifentrine	COPD	3 mg	3 mg/2.5mL ampule	Commercial	Refer to ADL	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Ohtuvayre (ensifentrine)	J7601	ensifentrine	COPD	3 mg	3 mg/2.5mL ampule	Medicaid	Not Covered	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Ohtuvayre (ensifentrine)	J7601	ensifentrine	COPD	3 mg	3 mg/2.5mL ampule	Medicare	NPS	No	PA Required - click here for criteria. Link for the Prior Authorization form is on the 'General Prior Auth Forms' tab.
Omidria (Phenylephrine/ketorolac)	J1097	Phenylephrine/ ketorolac	Ophthalmic	1ml	4ml SDV	Commercial	non-specialty	No	No PA Required
Omidria (Phenylephrine/ketorolac)	J1097	Phenylephrine/ ketorolac	Ophthalmic	1ml	4ml SDV	Medicaid	non-specialty	No	No PA Required
Omidria (Phenylephrine/ketorolac)	J1097	Phenylephrine/ ketorolac	Ophthalmic	1ml	4ml SDV	Medicare	non-specialty	No	Only covered for medically accepted indications
Omisirge (omidubicel)	J3590 C9399	omidubicel	Gene/Cellular Therapy	Additional information required: National Drug Code (NDC), Strength, Dosage administered, Route of administration.	Kit	Commercial	Pref. Specialty	No	PA required - see medical oncology prior authorization form for criteria
Omisirge (omidubicel)	J3590 C9399	omidubicel	Gene/Cellular Therapy	Additional information required: National Drug Code (NDC), Strength, Dosage administered, Route of administration.	Kit	Medicaid	Covered	No	No PA Required
Omisirge (omidubicel)	J3590 C9399	omidubicel	Gene/Cellular Therapy	Additional information required: National Drug Code (NDC), Strength, Dosage administered, Route of administration.	Kit	Medicare	Medicare Chemo	No	PA Required (Cancer Therapy) – See Medicare Part B Oncology Prior Authorization form
Omvoh (mirikizumab-mrkz) ***300 mg/15 mL vial***	J2267	mirikizumab	Inflammatory Conditions	1 mg	300 mg/15 mL SDV	Commercial	NPS	No	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth Forms tab.
Omvoh (mirikizumab-mrkz) ***300 mg/15 mL vial***	J2267	mirikizumab	Inflammatory Conditions	1 mg	300 mg/15 mL SDV	Medicaid	Covered	YES	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth Forms tab.
Omvoh (mirikizumab-mrkz) ***300 mg/15 mL vial***	J2267	mirikizumab	Inflammatory Conditions	1 mg	300 mg/15 mL SDV	Medicare	NPS	No	PA Required - click here for criteria. Link for the Prior Authorization form is on the 'General Prior Auth Forms' tab.
Omvoh SC (mirikizumab-mrkz) ***prefilled pen***	J2267	mirikizumab	Inflammatory Conditions		100 mg/mL Prefilled Pen	Commercial	Refer to ADL	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Omvoh SC (mirikizumab-mrkz) ***prefilled pen***	J2267	mirikizumab	Inflammatory Conditions		101 mg/mL Prefilled Pen	Medicaid	Not Covered	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Omvoh SC (mirikizumab-mrkz) ***prefilled pen***	J2267	mirikizumab	Inflammatory Conditions		102 mg/mL Prefilled Pen	Medicare	Refer to ADL	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Oncaspar (pegaspargase)	J9266	pegaspargase	Oncology	per SDV	3750 unit/5 mL SDV	Commercial	Pref. Specialty	No	No PA required when billed for the following ICD-10 codes: C91.00 – C91.02 , C83.50 – C83.59. For other diagnoses - see medical oncology prior authorization form for criteria
Oncaspar (pegaspargase)	J9266	pegaspargase	Oncology	per SDV	3750 unit/5 mL SDV	Medicaid	Covered	No	No PA Required
Oncaspar (pegaspargase)	J9266	pegaspargase	Oncology	per SDV	3750 unit/5 mL SDV	Medicare	Medicare Chemo	No	No PA required when billed for the following ICD-10 codes: C91.00 – C91.02, C83.50 – C83.59. For other diagnoses - see Medicare Part B oncology prior authorization form for criteria
Onivyde (irinotecan liposome)	J9205	irinotecan	Oncology	1 mg	4.3 mg/10 mL SDV	Commercial	Pref. Specialty	No	PA required - see medical oncology prior authorization form for criteria
Onivyde (irinotecan liposome)	J9205	irinotecan	Oncology	1 mg	4.3 mg/10 mL SDV	Medicaid	Covered	No	No PA Required
Onivyde (irinotecan liposome)	J9205	irinotecan	Oncology	1 mg	4.3 mg/10 mL SDV	Medicare	Medicare Chemo	No	PA Required (Cancer Therapy) – See Medicare Part B Oncology Prior Authorization form
Onpattro (patisiran)	J0222	patisiran	Miscellaneous	0.1 mg	10 mg/5 mL SDV	Commercial	Pref. Specialty	YES	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth Forms tab.
Onpattro (patisiran)	J0222	patisiran	Miscellaneous	0.1 mg	10 mg/5 mL SDV	Medicaid	Covered	YES	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth Forms tab.
Onpattro (patisiran)	J0222	patisiran	Miscellaneous	0.1 mg	10 mg/5 mL SDV	Medicare	Pref. Specialty	No	PA Required - click here for criteria. Link for the Prior Authorization form is on the 'General Prior Auth Forms' tab.
Ontruzant (trastuzumab-dttb)	Q5112	trastuzumab	Oncology	10 mg	150 mg, 420 mg SDV	Commercial	Not covered	No	**Not covered**
Ontruzant (trastuzumab-dttb)	Q5112	trastuzumab	Oncology	10 mg	150 mg, 420 mg SDV	Medicaid	Covered	No	No PA Required
Ontruzant (trastuzumab-dttb)	Q5112	trastuzumab	Oncology	10 mg	150 mg, 420 mg SDV	Medicare	Medicare Chemo	No	PA Required - click here for criteria. Link for the Prior Authorization form is on the 'General Prior Auth Forms' tab.
Opdivo (nivolumab)	J9299	nivolumab	Oncology	1 mg	40 mg/4 mL, 100 mg/10 mL, 120 mg/12 mL, 240 mg/24 mL SDV	Commercial	Pref. Specialty	YES	PA required - see medical oncology prior authorization form for criteria
Opdivo (nivolumab)	J9299	nivolumab	Oncology	1 mg	40 mg/4 mL, 100 mg/10 mL, 120 mg/12 mL, 240 mg/24 mL SDV	Medicaid	Covered	No	No PA Required
Opdivo (nivolumab)	J9299	nivolumab	Oncology	1 mg	40 mg/4 mL, 100 mg/10 mL, 120 mg/12 mL, 240 mg/24 mL SDV	Medicare	Medicare Chemo	No	PA Required (Cancer Therapy) – See Medicare Part B Oncology Prior Authorization form
Opdualag (Nivolumab and Relatlimab-rmbw)	J9298	Nivolumab and Relatlimab	Oncology	3mg/1mg	Nivolumab 240mg/Relatlimab-rmbw 80mg - 20mL SDV	Commercial	Pref. Specialty	YES	PA Required - see medical oncology prior authorization form for criteria
Opdualag (Nivolumab and Relatlimab-rmbw)	J9298	Nivolumab and Relatlimab	Oncology	3mg/1mg	Nivolumab 240mg/Relatlimab-rmbw 80mg - 20mL SDV	Medicaid	Covered	No	No PA Required
Opdualag (Nivolumab and Relatlimab-rmbw)	J9298	Nivolumab and Relatlimab	Oncology	3mg/1mg	Nivolumab 240mg/Relatlimab-rmbw 80mg - 20mL SDV	Medicare	Medicare Chemo	No	PA Required (Cancer Therapy) – See Medicare Part B Oncology Prior Authorization form
Opfolda (miglustat)	J1202	miglustat	Enzyme deficiency	65 mg	65 mg capsule	Commercial	Pref. Specialty	YES	PA required - SEE ALSO POMBILITI. Click here for criteria. Link for the Prior Authorization form is on the General Prior Auth Forms tab.

Drug	Code	Generic	Category	Billing Unit	How Supplied	Line of Business	Coverage Level	Site Of Service	Comment
Opfolda (miglustat)	J1202	miglustat	Enzyme deficiency	65 mg	65 mg capsule	Medicaid	Covered	YES	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth. Forms tab.
Opfolda (miglustat)	J1203	miglustat	Enzyme deficiency	65 mg	65 mg capsule	Medicare	Refer to ADL	No	SEE ALSO POMBILITI. This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Orbactiv (oritavancin)	J2407	oritavancin	Antimicrobial	10 mg	400 mg SDV	Commercial	NPS	No	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth. Forms tab.
Orbactiv (oritavancin)	J2407	oritavancin	Antimicrobial	10 mg	400 mg SDV	Medicaid	Covered	No	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth. Forms tab.
Orbactiv (oritavancin)	J2407	oritavancin	Antimicrobial	10 mg	400 mg SDV	Medicare	NPS	No	PA Required - click here for criteria. Link for the Prior Authorization form is on the 'General Prior Auth. Forms' tab.
Orencia IV (abatacept) ***Vial***	J0129	abatacept	Inflammatory Conditions	10 mg	250 mg SDV	Commercial	NPS	YES	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth. Forms tab.
Orencia IV (abatacept) ***Vial***	J0129	abatacept	Inflammatory Conditions	10 mg	250 mg SDV	Medicaid	Covered	YES	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth. Forms tab.
Orencia IV (abatacept) ***Vial***	J0129	abatacept	Inflammatory Conditions	10 mg	250 mg SDV	Medicare	NPS	No	PA Required - click here for criteria. Link for the Prior Authorization form is on the 'General Prior Auth. Forms' tab.
Orencia SC (abatacept) ***Clickjet (autoinjector) and prefilled syringe***	J0129	abatacept	Inflammatory Conditions			Commercial	Refer to ADL	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Orencia SC (abatacept) ***Clickjet (autoinjector) and prefilled syringe***	J0129	abatacept	Inflammatory Conditions			Medicaid	Not Covered	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Orencia SC (abatacept) ***Clickjet (autoinjector) and prefilled syringe***	J0129	abatacept	Inflammatory Conditions			Medicare	Refer to ADL	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Orthovisc (hyaluronan/ hyaluronic acid) for intra-articular injection	J7324	hyaluronate sodium/ hyaluronic acid	Hyaluronic acid derivatives	per dose	30 mg/2 mL SD syringe	Commercial	Not covered	No	**Not covered – See Pharmacy Policy EXPERIMENTAL/INVESTIGATIONAL/UNPROVEN CARE/ BENEFIT EXCEPTIONS for more information**
Orthovisc (hyaluronan/ hyaluronic acid) for intra-articular injection	J7324	hyaluronate sodium/ hyaluronic acid	Hyaluronic acid derivatives	per dose	30 mg/2 mL SD syringe	Medicaid	Not Covered	No	**Not covered**
Orthovisc (hyaluronan/ hyaluronic acid) for intra-articular injection	J7324	hyaluronate sodium/ hyaluronic acid	Hyaluronic acid derivatives	per dose	30 mg/2 mL SD syringe	Medicare	NPS	No	PA Required - click here for criteria. Link for the Prior Authorization form is on the 'General Prior Auth. Forms' tab.
Oxlumo (lumasiran)	J0224	lumasiran	Miscellaneous	0.5 mg	94.5 mg/0.5 mL SDV	Commercial	Pref. Specialty	YES	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth. Forms tab.
Oxlumo (lumasiran)	J0224	lumasiran	Miscellaneous	0.5 mg	94.5 mg/0.5 mL SDV	Medicaid	Covered	YES	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth. Forms tab.
Oxlumo (lumasiran)	J0224	lumasiran	Miscellaneous	0.5 mg	94.5 mg/0.5 mL SDV	Medicare	Pref. Specialty	No	PA required - See Medicare Medical Part B prior authorization form
Ozurdex (dexamethasone, intravitreal implant)	J7312	dexamethasone	Ophthalmic	0.1 mg	0.7 mg implant	Commercial	Pref. Specialty	No	No PA required when billed with the following ICD-10 diagnoses: E08.311, E08.3211-E08.3213, E08.3311-E08.3313, E08.3411-E08.3413, E08.3511-E08.3513, E09.311, E09.3211- E09.3213, E09.3311-E09.3313, E09.3411-E09.3413, E09.3511-E09.3513, E10.311E10.321 –E10.3213, E10.3311-E10.3313, E10.3411-E10.3413, E10.3511-E10.3513, E10.3511-E10.3513, E11.311, E11.3211-E11.3213, E11.3311- E11.3313, E11.3411-E11.3413, E11.3511-E11.353, E13.3111-E13.3113, E13.3211-E13.3213, E13.3311-E13.3313, E13.3411-E13.3413, E13.3511-E13.353, H30.001-H30.93, H34.8110, H34.8120, H34.8130, H34.8310, H34.8320, H34.8330, H34.8390
Ozurdex (dexamethasone, intravitreal implant)	J7312	dexamethasone	Ophthalmic	0.1 mg	0.7 mg implant	Medicaid	Covered	No	No PA required when billed with the following ICD-10 diagnoses: E08.311, E08.3211-E08.3213, E08.3311-E08.3313, E08.3411-E08.3413, E08.3511-E08.3513, E09.311, E09.3211- E09.3213, E09.3311-E09.3313, E09.3411-E09.3413, E09.3511-E09.3513, E10.311E10.321 –E10.3213, E10.3311-E10.3313, E10.3411-E10.3413, E10.3511-E10.3513, E10.3511-E10.3513, E11.311, E11.3211-E11.3213, E11.3311- E11.3313, E11.3411-E11.3413, E11.3511-E11.353, E13.3111-E13.3113, E13.3211-E13.3213, E13.3311-E13.3313, E13.3411-E13.3413, E13.3511-E13.353, H30.001-H30.93, H34.8110, H34.8120, H34.8130, H34.8310, H34.8320, H34.8330, H34.8390
Ozurdex (dexamethasone, intravitreal implant)	J7312	dexamethasone	Ophthalmic	0.1 mg	0.7 mg implant	Medicare	Pref Specialty	No	PA Required - click here for criteria. Link for the Prior Authorization form is on the 'General Prior Auth. Forms' tab.
Padcev (enfortumab vedotin-ejfv)	J9177	enfortumab vedotin	Oncology	0.25 mg	20 mg, 30 mg SDV	Commercial	Pref. Specialty	No	PA required - see medical oncology prior authorization form for criteria
Padcev (enfortumab vedotin-ejfv)	J9177	enfortumab vedotin	Oncology	0.25 mg	20 mg, 30 mg SDV	Medicaid	Covered	No	No PA Required
Padcev (enfortumab vedotin-ejfv)	J9177	enfortumab vedotin	Oncology	0.25 mg	20 mg, 30 mg SDV	Medicare	Medicare Chemo	No	PA Required (Cancer Therapy) – See Medicare Part B Oncology Prior Authorization form
Palforzia (Arachis hypogaea)	J3590*	Arachis hypogaea	Miscellaneous	N/A	0.5 mg, 1 mg, 10 mg, 20 mg and 100 mg capsules or 300 mg sachets (powder for oral administration)	Commercial	Pref. Specialty	No	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth. Forms tab.
Palforzia (Arachis hypogaea)	J3590*	Arachis hypogaea	Miscellaneous			Medicaid	Not Covered	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Palforzia (Arachis hypogaea)	J3590*	Arachis hypogaea	Miscellaneous	N/A	0.5 mg, 1 mg, 10 mg, 20 mg and 100 mg capsules or 300 mg sachets (powder for oral administration)	Medicare	Pref. Specialty	No	PA required - See Medicare Medical Part B prior authorization form
palonosetron - Avyxa brand ONLY	J2468	palonosetron	Antiemetic	25 mcg		Commercial	Pref. Specialty	No	No PA required
palonosetron - Avyxa brand ONLY	J2468	palonosetron	Antiemetic	25 mcg		Medicaid	Covered	No	No PA required
palonosetron - Avyxa brand ONLY	J2468	palonosetron	Antiemetic	25 mcg		Medicare	Pref. Specialty	No	No PA required
Panzyga (immune globulin) intravenous	J1576	IVIG	Immune Globulin	500 mg	1 gm, 2.5 gm, 5 gm, 10 gm, 20 gm, 30 gm SDV	Commercial	Not Covered	No	**Not Covered**
Panzyga (immune globulin) intravenous	J1576	IVIG	Immune Globulin	500 mg	1 gm, 2.5 gm, 5 gm, 10 gm, 20 gm, 30 gm SDV	Medicaid	Not Covered	No	**Not Covered**
Panzyga (immune globulin) intravenous	J1576	IVIG	Immune Globulin	500 mg	1 gm, 2.5 gm, 5 gm, 10 gm, 20 gm, 30 gm SDV	Medicare	NPS	No	Part B vs Part D – PA Required – click here for criteria. See Approved Drug List for covered formulations under Part D
Paraplatin (carboplatin)	J9045	carboplatin	Oncology	50 mg	various	Commercial	Non-specialty	No	No PA required
Paraplatin (carboplatin)	J9045	carboplatin	Oncology	50 mg	various	Medicaid	Covered	No	No PA required
Paraplatin (carboplatin)	J9045	carboplatin	Oncology	50 mg	various	Medicare	Non-specialty	No	No PA required
Parsabiv (etelcalcetide)	J0606	etelcalcetide	Miscellaneous	0.1 mg	2.5 mg/0.5 mL, 5 mg/mL, 10 mg/2 mL SDV	Commercial	NPS	No	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth. Forms tab.
Parsabiv (etelcalcetide)	J0606	etelcalcetide	Miscellaneous	0.1 mg	2.5 mg/0.5 mL, 5 mg/mL, 10 mg/2 mL SDV	Medicaid	Not Covered	No	**Not covered**
Parsabiv (etelcalcetide)	J0606	etelcalcetide	Miscellaneous	0.1 mg	2.5 mg/0.5 mL, 5 mg/mL, 10 mg/2 mL SDV	Medicare	NPS	No	PA required – When used for the provision of renal dialysis services in a patient with end-stage renal disease (ESRD), it is included in the Medicare Part B bundled payment made to the ESRD dialysis facility and is not separately covered under the member's Medicare Part B benefit. - See Medicare Part B vs Part D prior authorization form
Pemetrexed - Accord Brand ONLY	J9296	pemetrexed	Oncology	10 mg	100 mg, 500 mg SDV	Commercial	Pref. Specialty	No	No PA required
Pemetrexed - Accord Brand ONLY	J9296	pemetrexed	Oncology	10 mg	100 mg, 500 mg SDV	Medicaid	Covered	No	No PA required
Pemetrexed - Accord Brand ONLY	J9296	pemetrexed	Oncology	10 mg	100 mg, 500 mg SDV	Medicare	Medicare Chemo	No	No PA required
Pemetrexed - Bluepoint Brand ONLY	J9322	pemetrexed	Oncology	10 mg	100 mg, 500 mg SDV	Commercial	Not Covered	No	Not Covered until ASP established
Pemetrexed - Bluepoint Brand ONLY	J9322	pemetrexed	Oncology	10 mg	100 mg, 500 mg SDV	Medicaid	Covered	No	No PA Required
Pemetrexed - Bluepoint Brand ONLY	J9322	pemetrexed	Oncology	10 mg	100 mg, 500 mg SDV	Medicare	Medicare Chemo	No	No PA Required
Pemetrexed ditromethamine	J9323	pemetrexed	Oncology	10 mg	100 mg, 500 mg SDV	Commercial	Not Covered	No	Not Covered until ASP established
Pemetrexed ditromethamine	J9323	pemetrexed	Oncology	10 mg	100 mg, 500 mg SDV	Medicaid	Covered	No	No PA Required
Pemetrexed ditromethamine	J9323	pemetrexed	Oncology	10 mg	100 mg, 500 mg SDV	Medicare	Medicare Chemo	No	No PA Required
Pemetrexed - Hospira Brand ONLY	J9294	pemetrexed	Oncology	10 mg	100 mg, 500 mg SDV	Commercial	Pref. Specialty	No	No PA required
Pemetrexed - Hospira Brand ONLY	J9294	pemetrexed	Oncology	10 mg	100 mg, 500 mg SDV	Medicaid	Covered	No	No PA required
Pemetrexed - Hospira Brand ONLY	J9294	pemetrexed	Oncology	10 mg	100 mg, 500 mg SDV	Medicare	Medicare Chemo	No	No PA required
Pemetrexed - Sandoz Brand ONLY	J9297	pemetrexed	Oncology	10 mg	100 mg, 500 mg SDV	Commercial	Pref. Specialty	No	No PA required
Pemetrexed - Sandoz Brand ONLY	J9297	pemetrexed	Oncology	10 mg	100 mg, 500 mg SDV	Medicaid	Covered	No	No PA required
Pemetrexed - Sandoz Brand ONLY	J9297	pemetrexed	Oncology	10 mg	100 mg, 500 mg SDV	Medicare	Medicare Chemo	No	No PA required
Pemetrexed - Teva Brand ONLY	J9314	pemetrexed	Oncology	10 mg	100 mg, 500 mg SDV	Commercial	Pref. Specialty	No	No PA required
Pemetrexed - Teva Brand ONLY	J9314	pemetrexed	Oncology	10 mg	100 mg, 500 mg SDV	Medicaid	Covered	No	No PA required
Pemetrexed - Teva Brand ONLY	J9314	pemetrexed	Oncology	10 mg	100 mg, 500 mg SDV	Medicare	Medicare Chemo	No	No PA required
Pemfexy (pemetrexed)	J9304	pemetrexed	Oncology	10 mg	500 mg/20ml MDV	Commercial	Not Covered	No	**Not Covered**

Drug	Code	Generic	Category	Billing Unit	How Supplied	Line of Business	Coverage Level	Site Of Service	Comment
Pemfexy (pemetrexed)	J9304	pemetrexed	Oncology	10 mg	500 mg/20ml MDV	Medicaid	Covered	No	No PA required
Pemfexy (pemetrexed)	J9304	pemetrexed	Oncology	10 mg	500 mg/20ml MDV	Medicare	Medicare Chemo	No	PA Required - click here for criteria. Link for the Prior Authorization form is on the 'General Prior Auth Forms' tab.
Pemgarda (pemivibart)	Q0224	pemivibart	COVID 19	4,500 mg	500mg/4mL SDV	Commercial	Not Covered	No	**Not Covered**
Pemgarda (pemivibart)	Q0224	pemivibart	COVID 19	4,500 mg	500mg/4mL SDV	Medicaid	Covered	No	No PA required
Pemgarda (pemivibart)	Q0224	pemivibart	COVID 19	4,500 mg	500mg/4mL SDV	Medicare	Covered	No	No PA required
Pemrydi RTU (pemetrexed disodium)	J9324	pemetrexed	Oncology	10 mg	100 mg/10 mL, 500 mg/50 mL, 1,000 mg/100 mL SDV	Commercial	Not Covered	No	**Not Covered**
Pemrydi RTU (pemetrexed disodium)	J9324	pemetrexed	Oncology	10 mg	100 mg/10 mL, 500 mg/50 mL, 1,000 mg/100 mL SDV	Medicaid	Covered	No	No PA required
Pemrydi RTU (pemetrexed disodium)	J9324	pemetrexed	Oncology	10 mg	100 mg/10 mL, 500 mg/50 mL, 1,000 mg/100 mL SDV	Medicare	Medicare Chemo	No	PA Required - click here for criteria. Link for the Prior Authorization form is on the 'General Prior Auth Forms' tab.
Pentam (pentamidine isethionate lyophilisate) injection	J7676	pentamidine	Antimicrobial	300 mg	300 mg SDV	Commercial	Non-specialty	No	No PA required
Pentam (pentamidine isethionate lyophilisate) injection	J7676	pentamidine	Antimicrobial	300 mg	300 mg SDV	Medicaid	Covered	No	No PA required
Pentam (pentamidine isethionate lyophilisate) injection	J7676	pentamidine	Antimicrobial	300 mg	300 mg SDV	Medicare	Non-specialty	No	No PA required
Pepaxto (melphalan flufenamide)	J9247	melphalan	Oncology	1 mg	20 mg SDV	Commercial	Not Covered	No	Not Covered. Drug withdrawn from market 10-25-2021
Pepaxto (melphalan flufenamide)	J9247	melphalan	Oncology	1 mg	20 mg SDV	Medicaid	Not Covered	No	Not Covered. Drug withdrawn from market 10-25-2021
Pepaxto (melphalan flufenamide)	J9247	melphalan	Oncology	1 mg	20 mg SDV	Medicare	Not Covered	No	Not Covered. Drug withdrawn from market 10-25-2021
Pepcid (famotidine)	S0028	famotidine	Antacid	20 mg	20 mg/2 mL SDV, 40 mg/4 mL SDV, 200 mg/20 mL MDV	Commercial	Non-specialty	No	No PA required
Pepcid (famotidine)	S0028	famotidine	Antacid	20 mg	20 mg/2 mL SDV, 40 mg/4 mL SDV, 200 mg/20 mL MDV	Medicaid	Covered	No	No PA required
Pepcid (famotidine)	S0028	famotidine	Antacid	20 mg	20 mg/2 mL SDV, 40 mg/4 mL SDV, 200 mg/20 mL MDV	Medicare	Non-specialty	No	No PA required
Perforomist (formoterol)	J7606	formoterol	inhalation	20 mcg	20 mcg/2 mL SDV	Medicare	Non-specialty	No	Part B vs Part D - See Approved Drug List for covered formulations under Part D - see the Part B vs Part D coverage determination form for criteria
Perjeta (pertuzumab)	J9306	pertuzumab	Oncology	1 mg	420 mg/14 mL SDV	Commercial	Pref. Specialty	No	No PA required when billed with ICD-10 code C50. All other diagnoses, - see medical oncology prior authorization form for criteria
Perjeta (pertuzumab)	J9306	pertuzumab	Oncology	1 mg	420 mg/14 mL SDV	Medicaid	Covered	No	No PA Required
Perjeta (pertuzumab)	J9306	pertuzumab	Oncology	1 mg	420 mg/14 mL SDV	Medicare	Medicare Chemo	No	No PA required
Perseris (risperidone)	J2798	risperidone	Central Nervous System (CNS) agent	0.5 mg	90 mg, 120 mg SD kit	Commercial	NPS	No	No PA required
Perseris (risperidone)	J2798	risperidone	Central Nervous System (CNS) agent	0.5 mg	90 mg, 120 mg SD kit	Medicaid	Carve Out	No	Contact Fee for Service Medicaid for coverage
Perseris (risperidone)	J2798	risperidone	Central Nervous System (CNS) agent	0.5 mg	90 mg, 120 mg SD kit	Medicare	NPS	No	No PA required
Phenergan (promethazine)	J2550	promethazine	Antiemetic	50 mg	25 mg/mL, 50 mg/mL SDV	Commercial	Non-specialty	No	No PA required
Phenergan (promethazine)	J2550	promethazine	Antiemetic	50 mg	25 mg/mL, 50 mg/mL SDV	Medicaid	Covered	No	No PA required
Phenergan (promethazine)	J2550	promethazine	Antiemetic	50 mg	25 mg/mL, 50 mg/mL SDV	Medicare	Non-specialty	No	No PA required
phenobarbital sodium	J2560	phenobarbital	Antiepileptic agent	120 mg	65 mg/mL, 130 mg/mL SDV	Commercial	Non-specialty	No	No PA required
phenobarbital sodium	J2560	phenobarbital	Antiepileptic agent	120 mg	65 mg/mL, 130 mg/mL SDV	Medicaid	Carve Out	No	Contact Fee for Service Medicaid for coverage
phenobarbital sodium	J2560	phenobarbital	Antiepileptic agent	120 mg	65 mg/mL, 130 mg/mL SDV	Medicare	Non-specialty	No	No PA required
phenylephrine - Biorphen Brand ONLY	J2372	phenylephrine	Miscellaneous	20 mcg	0.5 mg/5 mL SDV	Commercial	Non-specialty	No	No PA required
phenylephrine - Biorphen Brand ONLY	J2372	phenylephrine	Miscellaneous	20 mcg	0.5 mg/5 mL SDV	Medicaid	Covered	No	No PA required
phenylephrine - Biorphen Brand ONLY	J2372	phenylephrine	Miscellaneous	20 mcg	0.5 mg/5 mL SDV	Medicare	Non-specialty	No	No PA required
Phesgo (pertuzumab, trastuzumab, and hyaluronidase-zzxf)	J9316	pertuzumab, trastuzumab, and hyaluronidase	Oncology	10 mg	600 mg-600 mg-20,000 unit/10 mL, 1200 mg-600 mg-30,000 unit/15 mL SDV	Commercial	Not covered	No	**Not covered**

Drug	Code	Generic	Category	Billing Unit	How Supplied	Line of Business	Coverage Level	Site Of Service	Comment
Phesgo (pertuzumab, trastuzumab, and hyaluronidase-zzxf)	J9316	pertuzumab, trastuzumab, and hyaluronidase	Oncology	10 mg	600 mg-600 mg-20,000 unit/10 mL, 1200 mg-600 mg-30,000 unit/15 mL SDV	Medicaid	Covered	No	No PA Required
Phesgo (pertuzumab, trastuzumab, and hyaluronidase-zzxf)	J9316	pertuzumab, trastuzumab, and hyaluronidase	Oncology	10 mg	600 mg-600 mg-20,000 unit/10 mL, 1200 mg-600 mg-30,000 unit/15 mL SDV	Medicare	Medicare Chemo	No	PA Required - click here for criteria. Link for the Prior Authorization form is on the 'General Prior Auth Forms' tab.
Photofrin (porfimer)	J9600	porfimer	Oncology	75 mg	75 mg SDV	Commercial	Pref. Specialty	No	No PA required
Photofrin (porfimer)	J9600	porfimer	Oncology	75 mg	75 mg SDV	Medicaid	Covered	No	No PA required
Photofrin (porfimer)	J9600	porfimer	Oncology	75 mg	75 mg SDV	Medicare	Pref. Specialty	No	No PA required
Photrexa (riboflavin 5-phosphate)	J2787	riboflavin	Miscellaneous	3 mL	3 mL SD syringe	Commercial	Pref. Specialty	No	No PA required
Photrexa (riboflavin 5-phosphate)	J2787	riboflavin	Miscellaneous	3 mL	3 mL SD syringe	Medicaid	Covered	No	No PA required
Photrexa (riboflavin 5-phosphate)	J2787	riboflavin	Miscellaneous	3 mL	3 mL SD syringe	Medicare	Pref. Specialty	No	No PA required
PiaSky (crovalimab-akkz)	J1307	crovalimab-akkz	Miscellaneous	10 mg	340mg/2mL SDV	Commercial	Preferred Specialty	YES	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth Forms tab.
PiaSky (crovalimab-akkz)	J1307	crovalimab-akkz	Miscellaneous	10 mg	340mg/2mL SDV	Medicaid	Not Covered	YES	**Not covered until added to both the MDHHS fee schedule AND the MDHHS NDC/HCPCS crosswalk**
PiaSky (crovalimab-akkz)	J1307	crovalimab-akkz	Miscellaneous	10 mg	340mg/2mL SDV	Medicare	Preferred Specialty	No	PA Required - click here for criteria. Link for the Prior Authorization form is on the 'General Prior Auth Forms' tab.
Platinol (cisplatin)	J9060	cisplatin	Oncology	10 mg	50 mg/50 mL, 100 mg/100 mL, 200 mg/200 mL SDV 50 mg/50 mL MDV	Commercial	Non-specialty	No	No PA required
Platinol (cisplatin)	J9060	cisplatin	Oncology	10 mg	50 mg/50 mL, 100 mg/100 mL, 200 mg/200 mL SDV 50 mg/50 mL MDV	Medicaid	Covered	No	No PA required
Platinol (cisplatin)	J9060	cisplatin	Oncology	10 mg	50 mg/50 mL, 100 mg/100 mL, 200 mg/200 mL SDV 50 mg/50 mL MDV	Medicare	Non-specialty	No	No PA required
Pluvicto (Lutetium Lu 177 Vipivotide Tetraxetan)	A9607	Lutetium Lu 177 Vipivotide Tetraxetan	Radio-pharmaceuticals	1 millicurie (mCi)	27 millicurie/mL SDV (each vial will have between 7.5 mL to 12.5 mL to provide 200 mCi of radioactivity)	Commercial	Pref. Specialty	No	PA required - see medical oncology prior authorization form for criteria
Pluvicto (Lutetium Lu 177 Vipivotide Tetraxetan)	A9607	Lutetium Lu 177 Vipivotide Tetraxetan	Radio-pharmaceuticals	1 millicurie (mCi)	27 millicurie/mL SDV (each vial will have between 7.5 mL to 12.5 mL to provide 200 mCi of radioactivity)	Medicaid	Covered	No	No PA Required
Pluvicto (Lutetium Lu 177 Vipivotide Tetraxetan)	A9607	Lutetium Lu 177 Vipivotide Tetraxetan	Radio-pharmaceuticals	1 millicurie (mCi)	27 millicurie/mL SDV (each vial will have between 7.5 mL to 12.5 mL to provide 200 mCi of radioactivity)	Medicare	Medicare Chemo	No	PA Required (Cancer Therapy) – See Medicare Part B Oncology Prior Authorization form
Polivy (polatuzumab vedotin-piiq)	J9309	polatuzumab vedotin	Oncology	1 mg	30 mg, 140 mg SDV	Commercial	NPS	No	PA required - see medical oncology prior authorization form for criteria
Polivy (polatuzumab vedotin-piiq)	J9309	polatuzumab vedotin	Oncology	1 mg	30 mg, 140 mg SDV	Medicaid	Covered	No	No PA Required
Polivy (polatuzumab vedotin-piiq)	J9309	polatuzumab vedotin	Oncology	1 mg	30 mg, 140 mg SDV	Medicare	Medicare Chemo	No	PA Required (Cancer Therapy) – See Medicare Part B Oncology Prior Authorization form
Pombiliti (cipaglucosidase-alfa)	J1203	cipaglucosidase-alfa	Enzyme deficiency	5 mg	105 mg SDV	Commercial	Pref. Specialty	No	PA required - SEE OPFOLDA LISTING - Click here for criteria. Link for the Prior Authorization form is on the General Prior Auth Forms tab.
Pombiliti (cipaglucosidase-alfa)	J1203	cipaglucosidase-alfa	Enzyme deficiency	5 mg	105 mg SDV	Medicaid	Covered	YES	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth Forms tab.
Pombiliti (cipaglucosidase-alfa)	J1203	cipaglucosidase-alfa	Enzyme deficiency	5 mg	105 mg SDV	Medicare	Pref. Specialty	No	PA Required - SEE OPFOLDA listing. Click here for criteria. Link for the Prior Authorization form is on the 'General Prior Auth Forms' tab.
Portrazza (necitumumab)	J9295	necitumumab	Oncology	1 mg	800 mg/50 mL SDV	Commercial	Not covered	No	**Not covered**
Portrazza (necitumumab)	J9295	necitumumab	Oncology	1 mg	800 mg/50 mL SDV	Medicaid	Covered	No	No PA Required
Portrazza (necitumumab)	J9295	necitumumab	Oncology	1 mg	800 mg/50 mL SDV	Medicare	Medicare Chemo	No	PA Required (Cancer Therapy) – See Medicare Part B Oncology Prior Authorization form
Posimir (bupivacaine solution)	J3490, C9144	bupivacaine	miscellaneous	1mg		Commercial	non-specialty	No	No PA Required
Posimir (bupivacaine solution)	J3490, C9144	bupivacaine	miscellaneous	1mg		Medicaid	non-specialty	No	No PA Required
Posimir (bupivacaine solution)	J3490, C9144	bupivacaine	miscellaneous	1mg		Medicare	non-specialty	No	Only covered for medically accepted indications
Potelligeo (mogamulizumab-kpkc)	J9204	mogamulizumab	Oncology	1 mg	20 mg/5 mL SDV	Commercial	NPS	No	PA required - see medical oncology prior authorization form for criteria
Potelligeo (mogamulizumab-kpkc)	J9204	mogamulizumab	Oncology	1 mg	20 mg/5 mL SDV	Medicaid	Covered	No	No PA Required
Potelligeo (mogamulizumab-kpkc)	J9204	mogamulizumab	Oncology	1 mg	20 mg/5 mL SDV	Medicare	Medicare Chemo	No	No PA required
Premasol (amino acids) Injection		amino acids	TPN			Medicare		No	Part B vs Part D – See Approved Drug List for covered formulations under Part D - see the Part B vs Part D coverage determination form for criteria
Prevymis (letermovir) IV	J3490*, C9399*	letermovir	Antimicrobial	Additional information required: National Drug Code (NDC), Strength, Dosage administered, Route of administration.	240 mg/12 mL, 480 mg/24 mL SDV	Commercial	Pref. Specialty	No	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth Forms tab.
Prevymis (letermovir) IV	J3490*, C9399*	letermovir	Antimicrobial	Additional information required: National Drug Code (NDC), Strength, Dosage administered, Route of administration.	240 mg/12 mL, 480 mg/24 mL SDV	Medicaid	Covered	No	Np PA Required
Prevymis (letermovir) IV	J3490*, C9399*	letermovir	Antimicrobial	Additional information required: National Drug Code (NDC), Strength, Dosage administered, Route of administration.	240 mg/12 mL, 480 mg/24 mL SDV	Medicare	Pref. Specialty	No	PA required - See Medicare Medical Part B prior authorization form
Prialt (ziconotide)	J2278	ziconotide	Analgesic	1 mcg	100 mcg/mL, 500 mcg/5 mL, 500 mcg/20 mL SDV	Commercial	Pref. Specialty	No	No PA required
Prialt (ziconotide)	J2278	ziconotide	Analgesic	1 mcg	100 mcg/mL, 500 mcg/5 mL, 500 mcg/20 mL SDV	Medicaid	Covered	No	No PA required
Prialt (ziconotide)	J2278	ziconotide	Analgesic	1 mcg	100 mcg/mL, 500 mcg/5 mL, 500 mcg/20 mL SDV	Medicare	Pref. Specialty	No	No PA required
Privigen (immune globulin) intravenous	J1459	IVIG	Immune Globulin	500 mg	5 gm, 10 gm, 20 gm, 40 gm SDV	Commercial	Pref. Specialty	YES	PA required - see IVIG/SCIG prior authorization form for criteria
Privigen (immune globulin) intravenous	J1459	IVIG	Immune Globulin	500 mg	5 gm, 10 gm, 20 gm, 40 gm SDV	Medicaid	Covered	YES	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth Forms tab.
Privigen (immune globulin) intravenous	J1459	IVIG	Immune Globulin	500 mg	5 gm, 10 gm, 20 gm, 40 gm SDV	Medicare	Pref. Specialty	No	Part B vs Part D – See Approved Drug List for covered formulations under Part D - see the Part B vs Part D coverage determination form for criteria
Procalamine (amino acids) Injection		amino acids	TPN			Medicare		No	Part B vs Part D – See Approved Drug List for covered formulations under Part D - see the Part B vs Part D coverage determination form for criteria
Procrit (epoetin alpha)	J0885-Non ESRD Q4081-ESRD	epoetin alpha	Hematopoietic agent	1000 units (J0885) 100 units (Q4081)	2000 unit, 3000 unit, 4000 unit, 10000 unit, 20000 unit, 40000 unit SDV	Medicare	NPS	No	Part B vs Part D – See Approved Drug List for covered formulations under Part D - see the Part B vs Part D coverage determination form for criteria
Profilnine (Antihemophilic Factor IX)	J7194	Antihemophilic Factor IX	Hemophilia			Commercial	Refer to ADL	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Profilnine (Antihemophilic Factor IX)	J7194	Antihemophilic Factor IX	Hemophilia			Medicaid	Not Covered	No	Refer to the Medicaid Approved Drug List (ADL) for pharmacy benefit coverage. For one-time doses required for planned outpatient procedures (professional/facility claims), authorizations will be reviewed for medical necessity according to the Hemophilia Management Medical Policy 91569
Profilnine (Antihemophilic Factor IX)	J7194	Antihemophilic Factor IX	Hemophilia			Medicare	Pref. Specialty	No	No PA required
Prograf (tacrolimus)	J7525	tacrolimus	Immunosuppressive agent	5 mg	5 mg/1 mL SD ampule	Commercial	Non-specialty	No	No PA required
Prograf (tacrolimus)	J7525	tacrolimus	Immunosuppressive agent	5 mg	5 mg/1 mL SD ampule	Medicaid	Covered	No	No PA required
Prograf (tacrolimus)	J7525	tacrolimus	Immunosuppressive agent	5 mg	5 mg/1 mL SD ampule	Medicare	Non-specialty	No	No PA required
Prograf (tacrolimus, immediate release) ORAL ONLY	J7507	tacrolimus	Immunosuppressive agent	1 mg	0.5 mg, 1 mg, 5 mg capsule	Medicare	Non-specialty	No	Part B vs Part D – See Approved Drug List for covered formulations under Part D - see the Part B vs Part D coverage determination form for criteria
Prolastin-C (alpha1 proteinase inhibitor-human)	J0256	alpha1 proteinase inhibitor	Enzyme deficiency	10 mg	1000 mg/20 mL SDV	Commercial	Pref. Specialty	YES	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth Forms tab.
Prolastin-C (alpha1 proteinase inhibitor-human)	J0256	alpha1 proteinase inhibitor	Enzyme deficiency	10 mg	1000 mg/20 mL SDV	Medicaid	Covered	YES	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth Forms tab.
Prolastin-C (alpha1 proteinase inhibitor-human)	J0256	alpha1 proteinase inhibitor	Enzyme deficiency	10 mg	1000 mg/20 mL SDV	Medicare	Pref. Specialty	No	PA required - See Medicare Medical Part B prior authorization form
Proleukin (aldesleukin)	J9015	aldesleukin	Oncology	per vial	22,000,000 unit SDV	Commercial	Non-specialty	No	No PA required
Proleukin (aldesleukin)	J9015	aldesleukin	Oncology	per vial	22,000,000 unit SDV	Medicaid	Covered	No	No PA required
Proleukin (aldesleukin)	J9015	aldesleukin	Oncology	per vial	22,000,000 unit SDV	Medicare	Non-specialty	No	No PA required
Prolia (denosumab)	J0897	denosumab	Bone modifying agent	1 mg	60 mg/mL SD syringe	Commercial	Pref. Specialty	YES	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth Forms tab.
Prolia (denosumab)	J0897	denosumab	Bone modifying agent	1 mg	60 mg/mL SD syringe	Medicaid	Covered	YES	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth Forms tab.
Prolia (denosumab)	J0897	denosumab	Bone modifying agent	1 mg	60 mg/mL SD syringe	Medicare	Pref. Specialty	No	PA Required - click here for criteria. Link for the Prior Authorization form is on the 'General Prior Auth Forms' tab.
Provenge (sipuleucel-T)	Q2043	sipuleucel-T	Gene/Cellular Therapy	per infusion	minimum of 50 million activated, autologous CD54+ cells per 250 mL infusion	Commercial	NPS	No	PA required - see medical oncology prior authorization form for criteria
Provenge (sipuleucel-T)	Q2043	sipuleucel-T	Gene/Cellular Therapy	per infusion	minimum of 50 million activated, autologous CD54+ cells per 250 mL infusion	Medicaid	Covered	No	No PA Required
Provenge (sipuleucel-T)	Q2043	sipuleucel-T	Gene/Cellular Therapy	per infusion	minimum of 50 million activated, autologous CD54+ cells per 250 mL infusion	Medicare	Medicare Chemo	No	PA Required (Cancer Therapy) – See Medicare Part B Oncology Prior Authorization form
Pulmicort (budesonide) NEBULIZER ONLY	J7626	budesonide	inhalation	0.5 mg	0.25 mg/2 mL, 0.5 mg/2 mL, 1 mg/2 mL SD ampule	Medicare	Non-specialty	No	Part B vs Part D – See Approved Drug List for covered formulations under Part D - see the Part B vs Part D coverage determination form for criteria
Pulmozyme (Dornase alfa, inhalation solution)	J7639	Dornase alfa	inhalation	1 mg	2.5 mg/2.5 mL SD ampule	Commercial	Refer to ADL	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Pulmozyme (Dornase alfa, inhalation solution)	J7639	Dornase alfa	inhalation	1 mg	2.5 mg/2.5 mL SD ampule	Medicaid	Not Covered	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Pulmozyme (Dornase alfa, inhalation solution)	J7639	Dornase alfa	inhalation	1 mg	2.5 mg/2.5 mL SD ampule	Medicare		No	Part B vs Part D – See Approved Drug List for covered formulations under Part D - see the Part B vs Part D coverage determination form for criteria
Qalsody (tofersen)	J1304	tofersen	miscellaneous	1 mg	100 mg/15 mL (6.7 mg/mL) solution SDV	Commercial	Not covered	No	**Not covered – See Pharmacy Policy EXPERIMENTAL/INVESTIGATIONAL/UNPROVEN CARE/ BENEFIT EXCEPTIONS for more information**
Qalsody (tofersen)	J1304	tofersen	miscellaneous	1 mg	100 mg/15 mL (6.7 mg/mL) solution SDV	Medicaid	Not Covered	No	**Not covered – See Pharmacy Policy EXPERIMENTAL/INVESTIGATIONAL/UNPROVEN CARE/ BENEFIT EXCEPTIONS for more information**
Qalsody (tofersen)	J1304	tofersen	miscellaneous	1 mg	100 mg/15 mL (6.7 mg/mL) solution SDV	Medicare	NPS	No	PA Required - click here for criteria. Link for the Prior Authorization form is on the 'General Prior Auth Forms' tab.

Drug	Code	Generic	Category	Billing Unit	How Supplied	Line of Business	Coverage Level	Site Of Service	Comment
Qutenza (capsaicin 8% patch)	J7336	Capsaicin	topical	square centimeter	1 patch is equal to 280 cm^2 billing units	Commercial	NPS	No	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth. Forms tab.
Qutenza (capsaicin 8% patch)	J7336	Capsaicin	topical	square centimeter	1 patch is equal to 280 cm^2 billing units	Medicaid	Covered	No	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth. Forms tab.
Qutenza (capsaicin 8% patch)	J7336	Capsaicin	topical	square centimeter	1 patch is equal to 280 cm^2 billing units	Medicare	NPS	No	PA Required - click here for criteria. Link for the Prior Authorization form is on the 'General Prior Auth. Forms' tab.
Quzyttir (IV cetirizine)	J1201	cetirizine	antihistamine	0.5 mg	10 mg/1 mL SDV	Commercial	Not covered	No	**Not covered**
Quzyttir (IV cetirizine)	J1201	cetirizine	antihistamine	0.5 mg	10 mg/1 mL SDV	Medicaid	Not Covered	No	**Not covered**
Quzyttir (IV cetirizine)	J1201	cetirizine	antihistamine	0.5 mg	10 mg/1 mL SDV	Medicare	NPS	No	PA Required - click here for criteria. Link for the Prior Authorization form is on the 'General Prior Auth. Forms' tab.
Radicava (edaravone)	J1301	edaravone	Miscellaneous	1 mg	30 mg/100 mL SD bag	Commercial	NPS	YES	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth. Forms tab.
Radicava (edaravone)	J1301	edaravone	Miscellaneous	1 mg	30 mg/100 mL SD bag	Medicaid	Covered	No	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth. Forms tab.
Radicava (edaravone)	J1301	edaravone	Miscellaneous	1 mg	30 mg/100 mL SD bag	Medicare	NPS	No	PA required - See Medicare Medical Part B prior authorization form
Rapamune (sirolimus)	J7520	sirolimus	Immunosuppressive agent	1 mg	0.5 mg, 1 mg, 2 mg tablet; 1 mg/mL oral solution	Medicare	Non-specialty	No	Part B vs Part D – See Approved Drug List for covered formulations under Part D - see the Part B vs Part D coverage determination form for criteria.
Rebinyn (Antihemophilic Factor IX)	J7203	Antihemophilic Factor IX	Hemophilia			Commercial	Refer to ADL	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Rebinyn (Antihemophilic Factor IX)	J7203	Antihemophilic Factor IX	Hemophilia			Medicaid	Not Covered	No	Refer to the Medicaid Approved Drug List (ADL) for pharmacy benefit coverage. For one-time doses required for planned outpatient procedures (professional/facility claims), authorizations will be reviewed for medical necessity according to the Hemophilia Management Medical Policy 91569
Rebinyn (Antihemophilic Factor IX)	J7203	Antihemophilic Factor IX	Hemophilia			Medicare	Pref. Specialty	No	No PA required
Reblozyl (luspatercept)	J0896	luspatercept	Hematopoietic agent	0.25 mg	25 mg, 75 mg SDV	Commercial	Pref. Specialty	No	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth. Forms tab.
Reblozyl (luspatercept)	J0896	luspatercept	Hematopoietic agent	0.25 mg	25 mg, 75 mg SDV	Medicaid	Covered	YES	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth. Forms tab.
Reblozyl (luspatercept)	J0896	luspatercept	Hematopoietic agent	0.25 mg	25 mg, 75 mg SDV	Medicare	Pref. Specialty	No	PA required - See Medicare Medical Part B prior authorization form
Rebyota (fecal microbiota live-jslm)	J1440	fecal microbiota	Miscellaneous	1 ml	150ml Rectal Suspension	Commercial	Not covered	No	**Not covered**
Rebyota (fecal microbiota live-jslm)	J1440	fecal microbiota	Miscellaneous	1 ml	150ml Rectal Suspension	Medicaid	Not Covered	No	**Not covered**
Rebyota (fecal microbiota live-jslm)	J1440	fecal microbiota	Miscellaneous	1 ml	150ml Rectal Suspension	Medicare	NPS	No	PA Required - click here for criteria. Link for the Prior Authorization form is on the 'General Prior Auth. Forms' tab.
Recarbrio (imipenem-cilastatin-relebactam)	J0742		Antimicrobial	4 mg-4 mg-2 mg	500 mg-500 mg-250 mg SDV	Commercial	Not covered	No	**Not covered, inpatient only drug**
Recarbrio (imipenem-cilastatin-relebactam)	J0742		Antimicrobial	4 mg-4 mg-2 mg	500 mg-500 mg-250 mg SDV	Medicaid	Not Covered	No	**Not covered, inpatient only drug**
Recarbrio (imipenem-cilastatin-relebactam)	J0742		Antimicrobial	4 mg-4 mg-2 mg	500 mg-500 mg-250 mg SDV	Medicare	NPS	No	PA required - See Medicare Medical Part B prior authorization form
Recombinate (Antihemophilic Factor VIII)	J7192	Antihemophilic Factor VIII	Hemophilia			Commercial	Refer to ADL	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Recombinate (Antihemophilic Factor VIII)	J7192	Antihemophilic Factor VIII	Hemophilia			Medicaid	Not Covered	No	Refer to the Medicaid Approved Drug List (ADL) for pharmacy benefit coverage. For one-time doses required for planned outpatient procedures (professional/facility claims), authorizations will be reviewed for medical necessity according to the Hemophilia Management Medical Policy 91569
Recombinate (Antihemophilic Factor VIII)	J7192	Antihemophilic Factor VIII	Hemophilia			Medicare	Pref. Specialty	No	No PA required
Recombivax [Hepatitis B Vaccine (Recombinant)]		Hepatitis B Vaccine (Recombinant)	vaccine			Medicare		No	Part B vs Part D – See Approved Drug List for covered formulations under Part D - see the Part B vs Part D coverage determination form for criteria.
Releuko (filgrastim-ayow)	Q5125	filgrastim	Hematopoietic agent	0.1mg	300 mcg/mL SDV, 480 mcg/1.6 mL SDV, 300 mcg/0.5 mL PFS, and 480 mcg/0.8 mL PFS	Commercial	Pref. Specialty	No	No PA required
Releuko (filgrastim-ayow)	Q5125	filgrastim	Hematopoietic agent	0.1mg	300 mcg/mL SDV, 480 mcg/1.6 mL SDV, 300 mcg/0.5 mL PFS, and 480 mcg/0.8 mL PFS	Medicaid	Covered	No	No PA required
Releuko (filgrastim-ayow)	Q5125	filgrastim	Hematopoietic agent	0.1mg	300 mcg/mL SDV, 480 mcg/1.6 mL SDV, 300 mcg/0.5 mL PFS, and 480 mcg/0.8 mL PFS	Medicare	NPS	No	PA Required - click here for criteria. Link for the Prior Authorization form is on the 'General Prior Auth. Forms' tab.
Relistor (methylnaltrexone bromide)	J2212	methylnaltrexone	Opioid induced constipation	0.1 mg	8 mg/0.4 mL, 12 mg/0.6 mL SD syringe	Commercial	NPS	No	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth. Forms tab.
Relistor (methylnaltrexone bromide)	J2212	methylnaltrexone	Opioid induced constipation	0.1 mg	8 mg/0.4 mL, 12 mg/0.6 mL SD syringe	Medicaid	Not Covered	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Relistor (methylnaltrexone bromide)	J2212	methylnaltrexone	Opioid induced constipation	0.1 mg	8 mg/0.4 mL, 12 mg/0.6 mL SD syringe	Medicare	NPS	No	No PA required
Remicade (infliximab)	J1745	infliximab	Inflammatory Conditions	10 mg	100 mg SDV	Commercial	Not covered	YES	**Not covered - Covered biosimilars: Inflectra & Renflexis**
Remicade (infliximab)	J1745	infliximab	Inflammatory Conditions	10 mg	100 mg SDV	Medicaid	Not Covered	YES	**Not covered - Covered biosimilars: Inflectra & Renflexis**
Remicade (infliximab)	J1745	infliximab	Inflammatory Conditions	10 mg	100 mg SDV	Medicare	NPS	No	PA Required - click here for criteria. Link for the Prior Authorization form is on the 'General Prior Auth. Forms' tab.
Remodulin (treprostinil sodium)	J3285	treprostinil	pulmonary arterial hypertension (PAH) agent	1 mg	20 mg/20mL, 50 mg/20 mL, 100 mg/20 mL, 200 mg/20 mL SDV	Commercial	Pref. Specialty	YES	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth. Forms tab.
Remodulin (treprostinil sodium)	J3285	treprostinil	pulmonary arterial hypertension (PAH) agent	1 mg	20 mg/20mL, 50 mg/20 mL, 100 mg/20 mL, 200 mg/20 mL SDV	Medicaid	Covered	No	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth. Forms tab.
Remodulin (treprostinil sodium)	J3285	treprostinil	pulmonary arterial hypertension (PAH) agent	1 mg	20 mg/20mL, 50 mg/20 mL, 100 mg/20 mL, 200 mg/20 mL SDV	Medicare	Pref. Specialty	No	PA required - See Medicare Medical Part B prior authorization form
Renflexis (infliximab-abda)	Q5104	infliximab	Inflammatory Conditions	10 mg	100 mg SDV	Commercial	Pref. Specialty	YES	No PA required
Renflexis (infliximab-abda)	Q5104	infliximab	Inflammatory Conditions	10 mg	100 mg SDV	Medicaid	Covered	YES	No PA required when administered in a hospital outpatient infusion center
Renflexis (infliximab-abda)	Q5104	infliximab	Inflammatory Conditions	10 mg	100 mg SDV	Medicare	Pref. Specialty	No	No PA required
Retacrit (epoetin Alfa, biosimilar)	Q5105 (ESRD) Q5106 (Non-ESRD)	epoetin	Hematopoietic agent	100 units (Q5105), 1000 units (Q5106)	2000 unit/mL, 3000 unit/mL, 4000 unit/mL, 10000 unit/mL, 40000 unit/mL SDV	Commercial	NPS	No	No PA required
Retacrit (epoetin Alfa, biosimilar)	Q5105 (ESRD) Q5106 (Non-ESRD)	epoetin	Hematopoietic agent	100 units (Q5105), 1000 units (Q5106)	2000 unit/mL, 3000 unit/mL, 4000 unit/mL, 10000 unit/mL, 40000 unit/mL SDV	Medicaid	Covered	No	No PA required
Retacrit (epoetin Alfa, biosimilar)	Q5105 (ESRD) Q5106 (Non-ESRD)	epoetin	Hematopoietic agent	100 units (Q5105), 1000 units (Q5106)	2000 unit/mL, 3000 unit/mL, 4000 unit/mL, 10000 unit/mL, 40000 unit/mL SDV	Medicare	NPS	No	Part B vs Part D – See Approved Drug List for covered formulations under Part D - see the Part B vs Part D coverage determination form for criteria.
Rethymic (allogeneic processed thymus tissue-agdc)	J3590*, C9399*	allogeneic processed thymus tissue-agdc	Gene/Cellular Therapy	Additional information required: National Drug Code (NDC), Strength, Dosage administered, Route of administration.	sliced processed thymus tissue	Commercial	Gene/Cellular Therapy	YES	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth. Forms tab.
Rethymic (allogeneic processed thymus tissue-agdc)	J3590*, C9399*	allogeneic processed thymus tissue-agdc	Gene/Cellular Therapy	Additional information required: National Drug Code (NDC), Strength, Dosage administered, Route of administration.	sliced processed thymus tissue	Medicaid	Gene/Cellular Therapy	No	**Not covered until added to both the MDHHS fee schedule AND the MDHHS NDC/HCPCS crosswalk**
Rethymic (allogeneic processed thymus tissue-agdc)	J3590*, C9399*	allogeneic processed thymus tissue-agdc	Gene/Cellular Therapy	Additional information required: National Drug Code (NDC), Strength, Dosage administered, Route of administration.	sliced processed thymus tissue	Medicare	Gene/Cellular Therapy	No	PA Required - click here for criteria. Link for the Prior Authorization form is on the 'General Prior Auth. Forms' tab.
Retisert (fluocinolone acetonide, intravitreal implant)	J7311	fluocinolone	Ophthalmic	0.01 mg	0.59 mg implant	Commercial	Not Covered	No	**Not Covered**
Retisert (fluocinolone acetonide, intravitreal implant)	J7311	fluocinolone	Ophthalmic	0.01 mg	0.59 mg implant	Medicaid	Not Covered	No	**Not Covered**
Retisert (fluocinolone acetonide, intravitreal implant)	J7311	fluocinolone	Ophthalmic	0.01 mg	0.59 mg implant	Medicare	NPS	No	PA Required - click here for criteria. Link for the Prior Authorization form is on the 'General Prior Auth. Forms' tab.
Revcovi (elapegademase-lvlr)	J3590*	elapegademase	Enzyme deficiency	Additional information required: National Drug Code (NDC), Strength, Dosage administered, Route of administration.	2.4 mg/1.5 mL SDV	Commercial	Pref. Specialty	No	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth. Forms tab.
Revcovi (elapegademase-lvlr)	J3590*	elapegademase	Enzyme deficiency		2.4 mg/1.5 mL SDV	Medicaid	Not Covered	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Revcovi (elapegademase-lvlr)	J3590*	elapegademase	Enzyme deficiency	Additional information required: National Drug Code (NDC), Strength, Dosage administered, Route of administration.	2.4 mg/1.5 mL SDV	Medicare	Pref. Specialty	No	PA required - See Medicare Medical Part B prior authorization form
Rezipres (Ephedrine HCl)	J3490*	ephedrine	Miscellaneous	Additional information required: National Drug Code (NDC), Strength, Dosage administered, Route of administration.	23.5mg/5mL , 47/5mL, 47/mL SD ampule	Commercial	non-specialty	No	No PA Required
Rezipres (Ephedrine HCl)	J3490*	ephedrine	Miscellaneous	Additional information required: National Drug Code (NDC), Strength, Dosage administered, Route of administration.	23.5mg/5mL , 47/5mL, 47/mL SD ampule	Medicaid	Covered	No	No PA Required

Drug	Code	Generic	Category	Billing Unit	How Supplied	Line of Business	Coverage Level	Site Of Service	Comment
Rezipres (Ephedrine HCl)	J3490*	ephedrine	Miscellaneous	Additional information required: National Drug Code (NDC), Strength, Dosage administered, Route of administration.	23.5mg/5mL , 47/5mL, 47/mL SD ampule	Medicare	non-specialty	No	No PA Required
Rezzayo (rezafungin)	J0349	rezafungin	Antimicrobial	1 mg	200mg Powder for Solution Infusion	Commercial	Not Covered	No	**Not Covered**
Rezzayo (rezafungin)	J0349	rezafungin	Antimicrobial	1 mg	200mg Powder for Solution Infusion	Medicaid	Covered	YES	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth. Forms tab.
Rezzayo (rezafungin)	J0349	rezafungin	Antimicrobial	1 mg	200mg Powder for Solution Infusion	Medicare	NPS	No	PA Required - click here for criteria. Link for the Prior Authorization form is on the 'General Prior Auth. Forms' tab.
Rhogam (Rho (D) immune globulin)	J2790	Rho (D) IG	Immune Globulin	1500 units (300 mcg)	1500 unit SD syringe	Commercial	Non-specialty	No	No PA required
Rhogam (Rho (D) immune globulin)	J2790	Rho (D) IG	Immune Globulin	1500 units (300 mcg)	1500 unit SD syringe	Medicaid	Covered	No	No PA required
Rhogam (Rho (D) immune globulin)	J2790	Rho (D) IG	Immune Globulin	1500 units (300 mcg)	1500 unit SD syringe	Medicare	Non-specialty	No	No PA required
Rhophylac (Rho (D) immune globulin)	J2791	Rho (D) IG	Immune Globulin	100 units	1500 unit SD syringe	Commercial	Non-Specialty	No	No PA required
Rhophylac (Rho (D) immune globulin)	J2791	Rho (D) IG	Immune Globulin	100 units	1500 unit SD syringe	Medicaid	Covered	No	No PA required
Rhophylac (Rho (D) immune globulin)	J2791	Rho (D) IG	Immune Globulin	100 units	1500 unit SD syringe	Medicare	Non-Specialty	No	No PA required
Riabni (rituximab-arrx)	Q5123	rituximab	Oncology	10 mg	100 mg/10 mL, 500 mg/50 mL SDV	Commercial	Not covered	No	**Not covered - Use biosimilars Ruxience or Truxima**
Riabni (rituximab-arrx)	Q5123	rituximab	Oncology	10 mg	100 mg/10 mL, 500 mg/50 mL SDV	Medicaid	Covered	No	No PA Required

Drug	Code	Generic	Category	Billing Unit	How Supplied	Line of Business	Coverage Level	Site Of Service	Comment
Riabni (rituximab-arrx)	Q5123	rituximab	Oncology	10 mg	100 mg/10 mL, 500 mg/50 mL SDV	Medicare	Medicare Chemo	No	PA Required - click here for criteria. Link for the Prior Authorization form is on the 'General Prior Auth Forms' tab.
Riabni (rituximab-arrx)	Q5123	rituximab	Oncology	10 mg	100 mg/10 mL, 500 mg/50 mL SDV	Medicare	NPS	No	PA Required - click here for criteria. Link for the Prior Authorization form is on the 'General Prior Auth Forms' tab.
RisperDAL Consta (risperidone)	J2794	risperidone	Central Nervous System (CNS) agent	0.5 mg	12.5 mg, 25 mg, 37.5 mg, 50 mg SDV	Commercial	Pref. Specialty	No	No PA required
RisperDAL Consta (risperidone)	J2794	risperidone	Central Nervous System (CNS) agent	0.5 mg	12.5 mg, 25 mg, 37.5 mg, 50 mg SDV	Medicaid	Carve Out	No	Contact Fee for Service Medicaid for coverage
RisperDAL Consta (risperidone)	J2794	risperidone	Central Nervous System (CNS) agent	0.5 mg	12.5 mg, 25 mg, 37.5 mg, 50 mg SDV	Medicare	Pref. Specialty	No	No PA required
Rituxan (rituximab)	J9312	rituximab	Oncology	10 mg	100 mg/10 mL, 500 mg/50 mL SDV	Commercial	Not covered	No	**Not covered. Use biosimilars Truxima or Ruxience**
Rituxan (rituximab)	J9312	rituximab	Oncology	10 mg	100 mg/10 mL, 500 mg/50 mL SDV	Medicaid	Covered	No	No PA Required
Rituxan (rituximab)	J9312	rituximab	Oncology	10 mg	100 mg/10 mL, 500 mg/50 mL SDV	Medicare	Medicare Chemo	No	PA Required - click here for criteria. Link for the Prior Authorization form is on the 'General Prior Auth Forms' tab.
Rituxan Hycela (rituximab/ hyaluronidase)	J9311	rituximab	Oncology	10 mg	1400 mg-23400 units/11.7 mL, 1600 mg-26800 units/13.4 mL SDV	Commercial	Not covered	No	**Not covered. Use biosimilars Truxima or Ruxience**
Rituxan Hycela (rituximab/ hyaluronidase)	J9311	rituximab	Oncology	10 mg	1400 mg-23400 units/11.7 mL, 1600 mg-26800 units/13.4 mL SDV	Medicaid	Covered	No	No PA Required
Rituxan Hycela (rituximab/ hyaluronidase)	J9311	rituximab	Oncology	10 mg	1400 mg-23400 units/11.7 mL, 1600 mg-26800 units/13.4 mL SDV	Medicare	Medicare Chemo	No	PA Required - click here for criteria. Link for the Prior Authorization form is on the 'General Prior Auth Forms' tab.
Rivfloza (nedosiran)	J3490* C9399*	nedosiran	Miscellaneous	Additional information required: National Drug Code (NDC), Strength, Dosage administered, Route of administration.	128 mg/ 0.8 mL and 160 mg/mL prefilled syringe and 80 mg/0.5 mL SDV	Commercial	Not Covered	No	**Not Covered**
Rivfloza (nedosiran)	J3490* C9399*	nedosiran	Miscellaneous	Additional information required: National Drug Code (NDC), Strength, Dosage administered, Route of administration.	128 mg/ 0.8 mL and 160 mg/mL prefilled syringe and 80 mg/0.5 mL SDV	Medicaid	Not Covered	No	**Not Covered**
Rivfloza (nedosiran)	J3490* C9399*	nedosiran	Miscellaneous	Additional information required: National Drug Code (NDC), Strength, Dosage administered, Route of administration.	128 mg/ 0.8 mL and 160 mg/mL prefilled syringe and 80 mg/0.5 mL SDV	Medicare	Pref Specialty	No	PA Required - click here for criteria. Link for the Prior Authorization form is on the 'General Prior Auth Forms' tab.
Rixubis (Antihemophilic Factor IX)	J7200	Antihemophilic Factor IX	Hemophilia			Commercial	Refer to ADL	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Rixubis (Antihemophilic Factor IX)	J7200	Antihemophilic Factor IX	Hemophilia			Medicaid	Not Covered	No	Refer to the Medicaid Approved Drug List (ADL) for pharmacy benefit coverage. For one-time doses required for planned outpatient procedures (professional/facility claims), authorizations will be reviewed for medical necessity according to the Hemophilia Management Medical Policy 91569
Rixubis (Antihemophilic Factor IX)	J7200	Antihemophilic Factor IX	Hemophilia			Medicare	Pref. Specialty	No	No PA required
Rocaltrol (calcitriol) ORAL ONLY	J8499	calcitriol	Miscellaneous	Additional information required: National Drug Code (NDC), Strength, Dosage administered, Route of administration.	0.25 mcg, 0.5 mcg capsule; 1 mcg/mL oral solution	Medicare		No	Part B vs Part D – See Approved Drug List for covered formulations under Part D - see the Part B vs Part D coverage determination form for criteria
Roctavian (valoctocogene roxaparvovec-rvox)	J1412	valoctocogene roxaparvovec	Gene/Cellular Therapy	1 ml	SD infusion bag	Commercial	Gene Therapy	YES	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth Forms tab.
Roctavian (valoctocogene roxaparvovec-rvox)	J1412	valoctocogene roxaparvovec	Gene/Cellular Therapy	1 ml	SD infusion bag	Medicaid	Not Covered	No	**Not covered**
Roctavian (valoctocogene roxaparvovec-rvox)	J1412	valoctocogene roxaparvovec	Gene/Cellular Therapy	1 ml	SD infusion bag	Medicare	Gene Therapy	No	PA Required - click here for criteria. Link for the Prior Authorization form is on the 'General Prior Auth Forms' tab.
Rolvedon (eflapegrastim-xnst)	J1449	eflapegrastim	Hematopoietic agent	0.1mg	13.2 mg/0.6 mL prefilled syringe	Commercial	Not Covered	No	**Not covered**
Rolvedon (eflapegrastim-xnst)	J1449	eflapegrastim	Hematopoietic agent	0.1mg	13.2 mg/0.6 mL prefilled syringe	Medicaid	Not Covered	No	**Not Covered**
Rolvedon (eflapegrastim-xnst)	J1449	eflapegrastim	Hematopoietic agent	0.1mg	13.2 mg/0.6 mL prefilled syringe	Medicare	NPS	No	PA Required - click here for criteria. Link for the Prior Authorization form is on the 'General Prior Auth Forms' tab.
romidepsin, non-lyophilized (non-**Istodax**)	J9318	romidepsin	Oncology	0.1 mg	27.5 mg/5.5 mL SDV	Commercial	Pref. Specialty	No	PA required - see medical oncology prior authorization form for criteria
romidepsin, non-lyophilized (non-**Istodax**)	J9318	romidepsin	Oncology	0.1 mg	27.5 mg/5.5 mL SDV	Medicaid	Covered	No	No PA Required
romidepsin, non-lyophilized (non-**Istodax**)	J9318	romidepsin	Oncology	0.1 mg	27.5 mg/5.5 mL SDV	Medicare	Medicare Chemo	No	PA Required (Cancer Therapy) – See Medicare Part B Oncology Prior Authorization form
Ruconest (C1 esterase inhibitor)	J0596	C-1 esterase inhibitor	Hereditary Angioedema agent	10 units	2100 unit SDV	Commercial	Refer to ADL	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Ruconest (C1 esterase inhibitor)	J0596	C-1 esterase inhibitor	Hereditary Angioedema agent	10 units	2100 unit SDV	Medicaid	Not Covered	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Ruconest (C1 esterase inhibitor)	J0596	C-1 esterase inhibitor	Hereditary Angioedema agent	10 units	2100 unit SDV	Medicare	Refer to ADL	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Ruxience (rituximab-pvvr)	Q5119	rituximab	Oncology	10 mg	100 mg/10 mL, 500 mg/50 mL SDV	Commercial	Pref. Specialty	YES	No PA required
Ruxience (rituximab-pvvr)	Q5119	rituximab	Oncology	10 mg	100 mg/10 mL, 500 mg/50 mL SDV	Medicaid	Covered	No	No PA required
Ruxience (rituximab-pvvr)	Q5119	rituximab	Oncology	10 mg	100 mg/10 mL, 500 mg/50 mL SDV	Medicare	Medicare Chemo	No	No PA required
Rybrevant (amivantamab-vmjw)	J9061	amivantamab	Oncology	2 mg	350 mg/7 mL (50 mg/mL) SDV	Commercial	Pref. Specialty	No	PA required - see medical oncology prior authorization form for criteria
Rybrevant (amivantamab-vmjw)	J9061	amivantamab	Oncology	2 mg	350 mg/7 mL (50 mg/mL) SDV	Medicaid	Covered	No	No PA Required
Rybrevant (amivantamab-vmjw)	J9061	amivantamab	Oncology	2 mg	350 mg/7 mL (50 mg/mL) SDV	Medicare	Medicare Chemo	No	PA Required (Cancer Therapy) – See Medicare Part B Oncology Prior Authorization form
Rylaze (asparaginase erwinia chrysanthemi (recombinant)-rywn)	J9021	asparaginase erwinia chrysanthemi	Oncology	0.1 mg	10 mg/0.5 mL SDV	Commercial	Pref. Specialty	No	PA required - see medical oncology prior authorization form for criteria
Rylaze (asparaginase erwinia chrysanthemi (recombinant)-rywn)	J9021	asparaginase erwinia chrysanthemi	Oncology	0.1 mg	10 mg/0.5 mL SDV	Medicaid	Covered	No	No PA Required
Rylaze (asparaginase erwinia chrysanthemi (recombinant)-rywn)	J9021	asparaginase erwinia chrysanthemi	Oncology	0.1 mg	10 mg/0.5 mL SDV	Medicare	Medicare Chemo	No	PA Required (Cancer Therapy) – See Medicare Part B Oncology Prior Authorization form
Ryplazim (plasminogen, human-tvmh)	J2998	plasminogen, human-tvmh	Miscellaneous	1 mg	68.8 mg/12.5 mL SDV	Commercial	Pref. Specialty	YES	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth Forms tab.
Ryplazim (plasminogen, human-tvmh)	J2998	plasminogen, human-tvmh	Miscellaneous	1 mg	68.8 mg/12.5 mL SDV	Medicaid	Covered	YES	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth Forms tab.
Ryplazim (plasminogen, human-tvmh)	J2998	plasminogen, human-tvmh	Miscellaneous	1 mg	68.8 mg/12.5 mL SDV	Medicare	Pref. Specialty	No	PA Required - click here for criteria. Link for the Prior Authorization form is on the 'General Prior Auth Forms' tab.
Rystiggo (rozanolixizumab-noli)	J9333	rozanolixizumab	Myasthenia Gravis	1 mg	280mg/2ml (140mg/ml) Single Dose Vial	Commercial	Pref. Specialty	YES	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth Forms tab.
Rystiggo (rozanolixizumab-noli)	J9333	rozanolixizumab	Myasthenia Gravis	1 mg	280mg/2ml (140mg/ml) Single Dose Vial	Medicaid	Covered	YES	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth Forms tab.
Rystiggo (rozanolixizumab-noli)	J9333	rozanolixizumab	Myasthenia Gravis	1 mg	280mg/2ml (140mg/ml) Single Dose Vial	Medicare	Pref Specialty	No	PA Required - click here for criteria. Link for the Prior Authorization form is on the 'General Prior Auth Forms' tab.
Rytelo (imetelstat)	J0870	imetelstat	Oncology	1 mg	47 mg and 188 mg lyophilized powder SDV	Commercial	Pref Specialty	YES	PA required - see medical oncology prior authorization form for criteria
Rytelo (imetelstat)	J0870	imetelstat	Oncology	1 mg	47 mg and 188 mg lyophilized powder SDV	Medicaid	Covered	No	No PA required
Rytelo (imetelstat)	J0870	imetelstat	Oncology	1 mg	47 mg and 188 mg lyophilized powder SDV	Medicare	Medicare Chemo	No	PA Required (Cancer Therapy) – See Medicare Part B Oncology Prior Authorization form
Sandimmune (cyclosporin)	J7516	cyclosporin	Immunosuppressive agent	250 mg	30mg/5mL SDV 153mg/1.7mL SDV	Commercial	Non-specialty	No	No PA required
Sandimmune (cyclosporin)	J7516	cyclosporin	Immunosuppressive agent	250 mg	250 mg/5 mL SD ampule	Medicaid	Covered	No	No PA required
Sandimmune (cyclosporin)	J7516	cyclosporin	Immunosuppressive agent	250 mg	250 mg/5 mL SD ampule	Medicare	Non-specialty	No	No PA required
Sandimmune (cyclosporin) ORAL ONLY	J7515, J7502	cyclosporin	Immunosuppressive agent	25 mg (J7515) 100 mg (J7502)	25 mg, 50 mg, 100 mg capsule; 100 mg/mL oral solution	Medicare	Non-specialty	No	Part B vs Part D – See Approved Drug List for covered formulations under Part D - see the Part B vs Part D coverage determination form for criteria
Sandostatin LAR (octreotide depot)	J2353	octreotide	Endocrine	1 mg	10 mg, 20 mg, 30 mg SDV	Commercial	Pref. Specialty	No	No PA required
Sandostatin LAR (octreotide depot)	J2353	octreotide	Endocrine	1 mg	10 mg, 20 mg, 30 mg SDV	Medicaid	Covered	No	No PA required
Sandostatin LAR (octreotide depot)	J2353	octreotide	Endocrine	1 mg	10 mg, 20 mg, 30 mg SDV	Medicare	Pref. Specialty	No	No PA required
Saphnelo (anifrolumab-fnia)	J0491	anifrolumab	Lupus	1mg	300mg/2ml	Commercial	Not covered	No	**Not covered**
Saphnelo (anifrolumab-fnia)	J0491	anifrolumab	Lupus	1mg	300mg/2ml	Medicaid	Not Covered	No	**Not covered**
Saphnelo (anifrolumab-fnia)	J0491	anifrolumab	Lupus	1mg	300mg/2ml	Medicare	NPS	No	PA Required - click here for criteria. Link for the Prior Authorization form is on the 'General Prior Auth Forms' tab.
Sarclisa (isatuximab-irfc)	J9227	isatuximab	Oncology	10 mg	100 mg/5 mL, 500 mg/25 mL SDV	Commercial	Pref. Specialty	No	PA required - see medical oncology prior authorization form for criteria
Sarclisa (isatuximab-irfc)	J9227	isatuximab	Oncology	10 mg	100 mg/5 mL, 500 mg/25 mL SDV	Medicaid	Covered	No	No PA Required
Sarclisa (isatuximab-irfc)	J9227	isatuximab	Oncology	10 mg	100 mg/5 mL, 500 mg/25 mL SDV	Medicare	Medicare Chemo	No	PA Required (Cancer Therapy) – See Medicare Part B Oncology Prior Authorization form
Scenesse (afamelanotide implant)	J7352	afamelanotide	Miscellaneous	1 mg	16 mg implant	Commercial	Pref. Specialty	No	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth Forms tab.
Scenesse (afamelanotide implant)	J7352	afamelanotide	Miscellaneous	1 mg	16 mg implant	Medicaid	Covered	YES	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth Forms tab.
Scenesse (afamelanotide implant)	J7352	afamelanotide	Miscellaneous	1 mg	16 mg implant	Medicare	Pref. Specialty	No	
Sensipar (cinacalcet) ORAL ONLY	J0604 - ESRD on Dialysis ONLY	cinacalcet	Miscellaneous	1 mg	30 mg, 60 mg, 90 mg tablet	Medicare		No	Part B vs Part D – See Approved Drug List for covered formulations under Part D - see the Part B vs Part D coverage determination form for criteria
Sevenfact (Antihemophilic Factor VIIa)	J7212	Antihemophilic Factor VIIa	Hemophilia			Commercial	Refer to ADL	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Sevenfact (Antihemophilic Factor VIIa)	J7212	Antihemophilic Factor VIIa	Hemophilia			Medicaid	Not Covered	No	Refer to the Medicaid Approved Drug List (ADL) for pharmacy benefit coverage. For one-time doses required for planned outpatient procedures (professional/facility claims), authorizations will be reviewed for medical necessity according to the Hemophilia Management Medical Policy 91569

Drug	Code	Generic	Category	Billing Unit	How Supplied	Line of Business	Coverage Level	Site Of Service	Comment
Sevenfact (Antihemophilic Factor VIIa)	J7212	Antihemophilic Factor VIIa	Hemophilia			Medicare	Pref. Specialty	No	No PA required
Sezaby (phenobarbital)	J2561	phenobarbital	Antiepileptic agent	1 mg		Commercial	Not Covered	No	Not Covered until ASP established
Sezaby (phenobarbital)	J2561	phenobarbital	Antiepileptic agent	1 mg		Medicaid	Carve Out	No	Contact Fee for Service Medicaid for coverage
Sezaby (phenobarbital)	J2561	phenobarbital	Antiepileptic agent	1 mg		Medicare	Non-specialty	No	No PA required
Signifor LAR (pasireotide)	J2502	pasireotide	Endocrine	1 mg	10 mg, 20 mg, 30 mg, 40 mg, 60 mg SDV	Commercial	NPS	No	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth. Forms tab.
Signifor LAR (pasireotide)	J2502	pasireotide	Endocrine	1 mg	10 mg, 20 mg, 30 mg, 40 mg, 60 mg SDV	Medicaid	Covered	YES	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth. Forms tab.
Signifor LAR (pasireotide)	J2502	pasireotide	Endocrine	1 mg	10 mg, 20 mg, 30 mg, 40 mg, 60 mg SDV	Medicare	NPS	No	PA Required - click here for criteria. Link for the Prior Authorization form is on the 'General Prior Auth. Forms' tab.
Siliq (brodalumab)	J3590*	brodalumab	Inflammatory Conditions			Commercial	Refer to ADL	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Siliq (brodalumab)	J3590*	brodalumab	Inflammatory Conditions			Medicaid	Not Covered	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Siliq (brodalumab)	J3590*	brodalumab	Inflammatory Conditions			Medicare	Refer to ADL	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Simlandi (adalimumab-ryvk)	Q5142	adalimumab	Inflammatory Conditions	1 mg	various	Commercial	Refer to ADL	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Simlandi (adalimumab-ryvk)	Q5142	adalimumab	Inflammatory Conditions	1 mg	various	Medicaid	Not Covered	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Simlandi (adalimumab-ryvk)	Q5142	adalimumab	Inflammatory Conditions	1 mg	various	Medicare	Refer to ADL	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Simponi (golimumab) SC	J3590*, C9399*	golimumab	Inflammatory Conditions			Commercial	Refer to ADL	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Simponi (golimumab) SC	J3590*, C9399*	golimumab	Inflammatory Conditions			Medicaid	Not Covered	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Simponi (golimumab) SC	J3590*, C9399*	golimumab	Inflammatory Conditions			Medicare	Refer to ADL	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Simponi Aria (golimumab) IV	J1602	golimumab	Inflammatory Conditions	1 mg	50 mg/4 mL SDV	Commercial	NPS	YES	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth. Forms tab.
Simponi Aria (golimumab) IV	J1602	golimumab	Inflammatory Conditions	1 mg	50 mg/4 mL SDV	Medicaid	Covered	YES	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth. Forms tab.
Simponi Aria (golimumab) IV	J1602	golimumab	Inflammatory Conditions	1 mg	50 mg/4 mL SDV	Medicare	NPS	No	PA Required - click here for criteria. Link for the Prior Authorization form is on the 'General Prior Auth. Forms' tab.
Simulect (basiliximab)	J0480	basiliximab	immunosuppressive agent	20 mg	10 mg, 20 mg SDV	Commercial	Pref. Specialty	No	No PA required
Simulect (basiliximab)	J0480	basiliximab	immunosuppressive agent	20 mg	10 mg, 20 mg SDV	Medicaid	Covered	No	No PA required
Simulect (basiliximab)	J0480	basiliximab	immunosuppressive agent	20 mg	10 mg, 20 mg SDV	Medicare	Pref. Specialty	No	No PA required
Sinuva, Propel (mometasone furoate)	J7402, S1091	mometasone	Steroid (nasal)	10 mcg	1350 mcg implant	Commercial	Not covered	No	**Not covered**
Sinuva, Propel (mometasone furoate)	J7402, S1091	mometasone	Steroid (nasal)	10 mcg	1350 mcg implant	Medicaid	Not Covered	No	**Not covered**
Sinuva, Propel (mometasone furoate)	J7402, S1091	mometasone	Steroid (nasal)	10 mcg	1350 mcg implant	Medicare	NPS	No	PA required - See Medicare Medical Part B prior authorization form
Sivextro (tedizolid)	J3090	tedizolid	Antimicrobial	1 mg	200 mg SDV	Commercial	Pref. Specialty	No	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth. Forms tab.
Sivextro (tedizolid)	J3090	tedizolid	Antimicrobial	1 mg	200 mg SDV	Medicaid	Covered	No	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth. Forms tab.
Sivextro (tedizolid)	J3090	tedizolid	Antimicrobial	1 mg	200 mg SDV	Medicare	Pref. Specialty	No	PA Required - click here for criteria. Link for the Prior Authorization form is on the 'General Prior Auth. Forms' tab.
Skyla (levonorgestrel-releasing IUD)	J7301	levonorgestrel	Contraceptive	13.5 mg	13.5 mg insert	Commercial	Refer to Contraceptive Coverage	No	Refer to contraceptive coverage
Skyla (levonorgestrel-releasing IUD)	J7301	levonorgestrel	Contraceptive	13.5 mg	13.5 mg insert	Medicaid	Refer to Contraceptive Coverage	No	Refer to contraceptive coverage
Skyla (levonorgestrel-releasing IUD)	J7301	levonorgestrel	Contraceptive	13.5 mg	13.5 mg insert	Medicare	Refer to Contraceptive Coverage	No	Refer to contraceptive coverage
Skyrizi IV (risankizumab-rzaa) ***600mg/10ml vial***	J2327	risankizumab	Inflammatory Conditions	1 mg	600mg/10 mL SDV	Commercial	Pref. Specialty	YES	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth. Forms tab.
Skyrizi IV (risankizumab-rzaa) ***600mg/10ml vial***	J2327	risankizumab	Inflammatory Conditions	1 mg	600mg/10 mL SDV	Medicaid	Covered	YES	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth. Forms tab.
Skyrizi IV (risankizumab-rzaa) ***600mg/10ml vial***	J2327	risankizumab	Inflammatory Conditions	1 mg	600mg/10 mL SDV	Medicare	Pref. Specialty	No	PA Required - click here for criteria. Link for the Prior Authorization form is on the 'General Prior Auth. Forms' tab.
Skyrizi SC (risankizumab-rzaa) ***prefilled syringe/pen and 360mg/2.4ml on-body kit***		risankizumab	Inflammatory Conditions			Commercial	Refer to ADL	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Skyrizi SC (risankizumab-rzaa) ***prefilled syringe/pen and 360mg/2.4ml on-body kit***		risankizumab	Inflammatory Conditions			Medicaid	Refer to ADL	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Skyrizi SC (risankizumab-rzaa) ***prefilled syringe/pen and 360mg/2.4ml on-body kit***		risankizumab	Inflammatory Conditions			Medicare	Refer to ADL	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Skysona (elivaldogene autotemcel)	J3590*, C9399*	elivaldogene autotemcel	Gene/Cellular Therapy	Additional information required: National Drug Code (NDC), Strength, Dosage administered, Route of administration.	20mL infusion bag	Commercial	Gene Therapy	YES	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth. Forms tab.
Skysona (elivaldogene autotemcel)	J3590*, C9399*	elivaldogene autotemcel	Gene/Cellular Therapy	Additional information required: National Drug Code (NDC), Strength, Dosage administered, Route of administration.	20mL infusion bag	Medicaid	Not Covered	No	**Not Covered**
Skysona (elivaldogene autotemcel)	J3590*, C9399*	elivaldogene autotemcel	Gene/Cellular Therapy	Additional information required: National Drug Code (NDC), Strength, Dosage administered, Route of administration.	20mL infusion bag	Medicare	Gene Therapy	No	PA Required - click here for criteria. Link for the Prior Authorization form is on the 'General Prior Auth. Forms' tab.
Soliris (eculizumab)	J1300	eculizumab	Miscellaneous	10 mg	300 mg/30 mL SDV	Commercial	Pref. Specialty	YES	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth. Forms tab.
Soliris (eculizumab)	J1300	eculizumab	Miscellaneous	10 mg	300 mg/30 mL SDV	Medicaid	Covered	YES	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth. Forms tab.
Soliris (eculizumab)	J1300	eculizumab	Miscellaneous	10 mg	300 mg/30 mL SDV	Medicare	Pref. Specialty	No	PA Required - click here for criteria. Link for the Prior Authorization form is on the 'General Prior Auth. Forms' tab.
Solu-Medrol (methylprednisolone)	J2919	methylprednisolone	Steroid	5 mg	various	Commercial	Non-specialty	No	No PA required
Solu-Medrol (methylprednisolone)	J2919	methylprednisolone	Steroid	5 mg	various	Medicaid	Covered	No	No PA required
Solu-Medrol (methylprednisolone)	J2919	methylprednisolone	Steroid	5 mg	various	Medicare	Non-specialty	No	No PA required
Somatuline Depot (lanreotide)	J1930	lanreotide	Miscellaneous	1 mg	60mg/0.2ml, 90mg/0.3ml, 120mg/0.5ml SD syringe	Commercial	Non-specialty	No	No PA required
Somatuline Depot (lanreotide)	J1930	lanreotide	Miscellaneous	1 mg	60mg/0.2ml, 90mg/0.3ml, 120mg/0.5ml SD syringe	Medicaid	Covered	No	No PA required
Somatuline Depot (lanreotide)	J1930	lanreotide	Miscellaneous	1 mg	60mg/0.2ml, 90mg/0.3ml, 120mg/0.5ml SD syringe	Medicare	Non-specialty	No	No PA required
Spevigo (spesolimab-sbzo)	J1747	spesolimab	Inflammatory Conditions	1mg	450 mg/7.5 ml SDV	Commercial	Not Covered	No	**Not Covered**
Spevigo (spesolimab-sbzo)	J1747	spesolimab	Inflammatory Conditions	1mg	450 mg/7.5 ml SDV	Medicaid	Not Covered	No	**Not Covered**
Spevigo (spesolimab-sbzo)	J1747	spesolimab	Inflammatory Conditions	1mg	450 mg/7.5 ml SDV	Medicare	NPS	No	PA Required - click here for criteria. Link for the Prior Authorization form is on the 'General Prior Auth. Forms' tab.
Spinraza (nusinersen sodium)	J2326	nusinersen	Miscellaneous	0.1 mg	12 mg/5 mL SDV	Commercial	Pref. Specialty	No	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth. Forms tab.
Spinraza (nusinersen sodium)	J2326	nusinersen	Miscellaneous	0.1 mg	12 mg/5 mL SDV	Medicaid	Carve Out	No	Contact Fee for Service Medicaid for coverage
Spinraza (nusinersen sodium)	J2326	nusinersen	Miscellaneous	0.1 mg	12 mg/5 mL SDV	Medicare	Pref. Specialty	No	PA Required - click here for criteria. Link for the Prior Authorization form is on the 'General Prior Auth. Forms' tab.
Spravato (esketamine)	S0013	esketamine	Central Nervous System (CNS) agent	1 mg	56 mg, 84 mg nasal spray kit (each kit contains 28 mg unit dose)	Commercial	NPS	No	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth. Forms tab.
Spravato (esketamine)	S0013	esketamine	Central Nervous System (CNS) agent	1 mg	56 mg, 84 mg nasal spray kit (each kit contains 28 mg unit dose)	Medicaid	Covered	No	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth. Forms tab.
Spravato (esketamine)	G2082 - up to 56mg G2083 - greater than 56mg	esketamine	Central Nervous System (CNS) agent	1 mg	56 mg, 84 mg nasal spray kit (each kit contains 28 mg unit dose)	Medicare	NPS	No	PA Required - click here for criteria. Link for the Prior Authorization form is on the 'General Prior Auth. Forms' tab.
Stelara IV (ustekinumab) ***130mg/26ml vial***	J3358	ustekinumab	Inflammatory Conditions	1 mg	130 mg/26 mL SDV	Commercial	Pref. Specialty	YES	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth. Forms tab.
Stelara IV (ustekinumab) ***130mg/26ml vial***	J3358	ustekinumab	Inflammatory Conditions	1 mg	130 mg/26 mL SDV	Medicaid	Covered	YES	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth. Forms tab.
Stelara IV (ustekinumab) ***130mg/26ml vial***	J3358	ustekinumab	Inflammatory Conditions	1 mg	130 mg/26 mL SDV	Medicare	Pref. Specialty	No	PA Required - click here for criteria. Link for the Prior Authorization form is on the 'General Prior Auth. Forms' tab.
Stelara SC (ustekinumab) ***prefilled syringe & 45mg/0.5ml vial***	J3357	ustekinumab	Inflammatory Conditions			Commercial	Refer to ADL	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Stelara SC (ustekinumab) ***prefilled syringe & 45mg/0.5ml vial***	J3357	ustekinumab	Inflammatory Conditions			Medicaid	Not Covered	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Stelara SC (ustekinumab) ***prefilled syringe & 45mg/0.5ml vial***	J3357	ustekinumab	Inflammatory Conditions			Medicare	Refer to ADL	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit

Drug	Code	Generic	Category	Billing Unit	How Supplied	Line of Business	Coverage Level	Site Of Service	Comment
Stimufend (pegfilgrastim-fpgk)	Q5127	pegfilgrastim	Hematopoietic agent	0.5 mg	6 mg/0.6 mL prefilled syringe	Commercial	Not Covered	No	**Not Covered**
Stimufend (pegfilgrastim-fpgk)	Q5127	pegfilgrastim	Hematopoietic agent	0.5 mg	7 mg/0.6 mL prefilled syringe	Medicaid	Not Covered	No	**Not Covered**
Stimufend (pegfilgrastim-fpgk)	Q5127	pegfilgrastim	Hematopoietic agent	0.5 mg	8 mg/0.6 mL prefilled syringe	Medicare	NPS	No	PA Required - click here for criteria. Link for the Prior Authorization form is on the 'General Prior Auth. Forms' tab.
Sublocade (buprenorphine)	Q9991, Q9992	buprenorphine	Opioid use disorder	<=100mg (Q9991) >100mg (Q9992)	100 mg/0.5 mL, 300 mg/1.5 mL SD syringe	Commercial	Pref. Specialty	No	No PA Required
Sublocade (buprenorphine)	Q9991, Q9992	buprenorphine	Opioid use disorder	<=100mg (Q9991) >100mg (Q9992)	100 mg/0.5 mL, 300 mg/1.5 mL SD syringe	Medicaid	Carve Out	No	Contact Fee for Service Medicaid for coverage
Sublocade (buprenorphine)	Q9991, Q9992	buprenorphine	Opioid use disorder	<=100mg (Q9991) >100mg (Q9992)	100 mg/0.5 mL, 300 mg/1.5 mL SD syringe	Medicare	Pref. Specialty	No	No PA required
Sunlenca (lenacapavir) ***Subcutaneous Injection***	J1961	lenacapavir	HIV agent	1 mg	463.5 mg/1.5 ml SDV	Commercial	Pref. Specialty	No	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth. Forms tab.
Sunlenca (lenacapavir) ***Subcutaneous Injection***	J1961	lenacapavir	HIV agent	1 mg	463.5 mg/1.5 ml SDV	Medicaid	Carve Out	No	Contact Fee for Service Medicaid for coverage
Sunlenca (lenacapavir) ***Subcutaneous Injection***	J1961	lenacapavir	HIV agent	1 mg	463.5 mg/1.5 ml SDV	Medicare	Pref. Specialty	No	PA required - See Medicare Medical Part B prior authorization form
Sunlenca (lenacapavir) ***TABLETS***		lenacapavir	HIV agent			Commercial	Refer to ADL	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Sunlenca (lenacapavir) ***TABLETS***		lenacapavir	HIV agent			Medicaid	Refer to ADL	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Sunlenca (lenacapavir) ***TABLETS***		lenacapavir	HIV agent			Medicare	Refer to ADL	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Supartz FX (hyaluronan/ hyaluronic acid) for intra-articular injection	J7321	hyaluronate sodium/ hyaluronic acid	Hyaluronic acid derivatives	per dose	2.5 mL SD syringe	Commercial	Not covered	No	**Not covered – See Pharmacy Policy EXPERIMENTAL/INVESTIGATIONAL/UNPROVEN CARE/ BENEFIT EXCEPTIONS for more information**
Supartz FX (hyaluronan/ hyaluronic acid) for intra-articular injection	J7321	hyaluronate sodium/ hyaluronic acid	Hyaluronic acid derivatives	per dose	2.5 mL SD syringe	Medicaid	Not Covered	No	**Not covered**
Supartz FX (hyaluronan/ hyaluronic acid) for intra-articular injection	J7321	hyaluronate sodium/ hyaluronic acid	Hyaluronic acid derivatives	per dose	2.5 mL SD syringe	Medicare	Pref. Specialty	No	No PA required
Supprelin LA (histrelin acetate implant)	J9226	histrelin	Endocrine	50 mg	50 mg implant	Commercial	NPS	No	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth. Forms tab.
Supprelin LA (histrelin acetate implant)	J9226	histrelin	Endocrine	50 mg	50 mg implant	Medicaid	Covered	YES	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth. Forms tab.
Supprelin LA (histrelin acetate implant)	J9226	histrelin	Endocrine	50 mg	50 mg implant	Medicare	NPS	No	PA Required - click here for criteria. Link for the Prior Authorization form is on the 'General Prior Auth. Forms' tab.
Sustol (granisetron extended release)	J1627	granisetron	Antiemetic	0.1 mg	10 mg/0.4 mL SD syringe	Commercial	Not covered	No	**Not covered**
Sustol (granisetron extended release)	J1627	granisetron	Antiemetic	0.1 mg	10 mg/0.4 mL SD syringe	Medicaid	Not Covered	No	**Not covered**
Sustol (granisetron extended release)	J1627	granisetron	Antiemetic	0.1 mg	10 mg/0.4 mL SD syringe	Medicare	Pref. Specialty	No	PA required - See Medicare Medical Part B prior authorization form
Susvimo (ranibizumab)	J2779	ranibizumab	Ophthalmic	0.1 mg	100 mg/mL SDV	Commercial	Not Covered	No	**Not Covered**
Susvimo (ranibizumab)	J2779	ranibizumab	Ophthalmic	0.1 mg	100 mg/mL SDV	Medicaid	Not Covered	No	**Not Covered**
Susvimo (ranibizumab)	J2779	ranibizumab	Ophthalmic	0.1 mg	100 mg/mL SDV	Medicare	NPS	No	PA Required - click here for criteria. Link for the Prior Authorization form is on the 'General Prior Auth. Forms' tab.
Syfovre (pegcetacoplan)	J2781	pegcetacoplan	Ophthalmic	1 mg	15mg/0.1mL SDV	Commercial	Pref. Specialty	No	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth. Forms tab.
Syfovre (pegcetacoplan)	J2781	pegcetacoplan	Ophthalmic	1 mg	15mg/0.1mL SDV	Medicaid	Covered	No	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth. Forms tab.
Syfovre (pegcetacoplan)	J2781	pegcetacoplan	Ophthalmic	1 mg	15mg/0.1mL SDV	Medicare	Pref Specialty	No	PA Required - click here for criteria. Link for the Prior Authorization form is on the 'General Prior Auth. Forms' tab.
Sylvant (siltuximab)	J2860	siltuximab	Oncology	10 mg	100 mg, 400 mg SDV	Commercial	Pref. Specialty	No	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth. Forms tab.
Sylvant (siltuximab)	J2860	siltuximab	Oncology	10 mg	100 mg, 400 mg SDV	Medicaid	Covered	YES	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth. Forms tab.
Sylvant (siltuximab)	J2860	siltuximab	Oncology	10 mg	100 mg, 400 mg SDV	Medicare	Pref. Specialty	No	No PA required
Synagis (palivizumab)	90378 (IM)	palivizumab	RSV Monoclonal Antibody	50 mg	50 mg/0.5 mL, 100 mg/1 mL SDV	Commercial	Pref. Specialty	No	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth. Forms tab.

Drug	Code	Generic	Category	Billing Unit	How Supplied	Line of Business	Coverage Level	Site Of Service	Comment
Synagis (palivizumab)	90378 (IM)	palivizumab	RSV Monoclonal Antibody	50 mg	50 mg/0.5 mL, 100 mg/1 mL SDV	Medicaid	Covered	No	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth. Forms tab.
Synagis (palivizumab)	90378 (IM)	palivizumab	RSV Monoclonal Antibody	50 mg	50 mg/0.5 mL, 100 mg/1 mL SDV	Medicare	Pref. Specialty	No	PA required - See Medicare Medical Part B prior authorization form
Syndros (dronabinol)	Q0155	Dronabinol	Antiemetic	0.1 mg	5mg/mL (30 mL MDV)	Medicare	Non-specialty	No	Part B vs Part D – See Approved Drug List for covered formulations under Part D - see the Part B vs Part D coverage determination form for criteria
Synojoynt (hyaluronan or derivative for intra-articular injection	J7331	hyaluronate sodium/ hyaluronic acid	Hyaluronic acid derivatives	1 mg	16 mg/2 mL SD syringe (Synvisc); 48 mg/6 mL SD syringe (Synvisc-One)	Commercial	Not covered	No	**Not covered – See Pharmacy Policy EXPERIMENTAL/INVESTIGATIONAL/UNPROVEN CARE/ BENEFIT EXCEPTIONS for more information**
Synojoynt (hyaluronan or derivative for intra-articular injection)	J7331	hyaluronate sodium/ hyaluronic acid	Hyaluronic acid derivatives	1 mg	16 mg/2 mL SD syringe (Synvisc); 48 mg/6 mL SD syringe (Synvisc-One)	Medicaid	Not Covered	No	**Not covered**
Synojoynt (hyaluronan or derivative for intra-articular injection)	J7331	hyaluronate sodium/ hyaluronic acid	Hyaluronic acid derivatives	1 mg	16 mg/2 mL SD syringe (Synvisc); 48 mg/6 mL SD syringe (Synvisc-One)	Medicare	NPS	No	PA Required - click here for criteria. Link for the Prior Authorization form is on the 'General Prior Auth. Forms' tab.
Synribo (omacetaxine mepesuccinate)	J9262	omacetaxine	Oncology	0.01 mg	3.5 mg SDV	Commercial	NPS	No	PA required - see medical oncology prior authorization form for criteria
Synribo (omacetaxine mepesuccinate)	J9262	omacetaxine	Oncology	0.01 mg	3.5 mg SDV	Medicaid	Covered	No	No PA Required
Synribo (omacetaxine mepesuccinate)	J9262	omacetaxine	Oncology	0.01 mg	3.5 mg SDV	Medicare	Medicare Chemo	No	No PA required
Synvisc/Synvisc One (hyaluronan/ hyaluronic acid) for intra-articular injection	J7325	hyaluronate sodium/ hyaluronic acid	Hyaluronic acid derivatives	1 mg	16 mg/2 mL SD syringe (Synvisc); 48 mg/6 mL SD syringe (Synvisc-One)	Commercial	Not covered	No	**Not covered – See Pharmacy Policy EXPERIMENTAL/INVESTIGATIONAL/UNPROVEN CARE/ BENEFIT EXCEPTIONS for more information**
Synvisc/Synvisc One (hyaluronan/ hyaluronic acid) for intra-articular injection	J7325	hyaluronate sodium/ hyaluronic acid	Hyaluronic acid derivatives	1 mg	16 mg/2 mL SD syringe (Synvisc); 48 mg/6 mL SD syringe (Synvisc-One)	Medicaid	Not Covered	No	**Not covered**
Synvisc/Synvisc One (hyaluronan/ hyaluronic acid) for intra-articular injection	J7325	hyaluronate sodium/ hyaluronic acid	Hyaluronic acid derivatives	1 mg	16 mg/2 mL SD syringe (Synvisc); 48 mg/6 mL SD syringe (Synvisc-One)	Medicare	NPS	No	PA Required - click here for criteria. Link for the Prior Authorization form is on the 'General Prior Auth. Forms' tab.
Takhyzro (lanadelumab-flyo)	J0593	lanadelumab	Hereditary Angioedema agent	1 mg	300 mg/2 mL SDV	Commercial	Refer to ADL	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Takhyzro (lanadelumab-flyo)	J0593	lanadelumab	Hereditary Angioedema agent	1 mg	300 mg/2 mL SDV	Medicaid	Not Covered	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Takhyzro (lanadelumab-flyo)	J0593	lanadelumab	Hereditary Angioedema agent	1 mg	300 mg/2 mL SDV	Medicare	NPS	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Talvey (talquetamab-tgvs)	J3055	talquetamab	Oncology	0.25 mg	3 mg/1.5 mL SDV 40 mg/mL SDV	Commercial	NPS	No	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth. Forms tab.
Talvey (talquetamab-tgvs)	J3055	talquetamab	Oncology	0.25 mg	3 mg/1.5 mL SDV 40 mg/mL SDV	Medicaid	Covered	No	Reference CHAMPS to ensure this drug & NDC is covered for your provider type on the date of service
Talvey (talquetamab-tgvs)	J3055	talquetamab	Oncology	0.25 mg	3 mg/1.5 mL SDV 40 mg/mL SDV	Medicare	Medicare Chemo	No	PA Required (Cancer Therapy) – See Medicare Part B Oncology Prior Authorization form
Tauvid (Flortaucipir F18)	A9601	Flortaucipir F18	Radio-pharmaceuticals	1 millicurie (mCi)	50 mL or 100 mL multi-dose vials (8.1 mCi/mL to 100 mCi/mL)	Commercial	non-specialty	No	No PA Required
Tauvid (Flortaucipir F18)	A9601	Flortaucipir F18	Radio-pharmaceuticals	1 millicurie (mCi)	50 mL or 100 mL multi-dose vials (8.1 mCi/mL to 100 mCi/mL)	Medicaid	Covered	No	No PA Required
Tauvid (Flortaucipir F18)	A9601	Flortaucipir F18	Radio-pharmaceuticals	1 millicurie (mCi)	50 mL or 100 mL multi-dose vials (8.1 mCi/mL to 100 mCi/mL)	Medicare	non-specialty	No	No PA Required
Taxotere (docetaxel)	J9171	docetaxel	Oncology	1 mg	Regular: 20 mg/2 mL, 80 mg/8 mL, 160 mg/16 mL, 200 mg/20 mL SDV Concentrate: 20 mg/mL, 80 mg/4 mL, 160 mg/8 mL SDV	Commercial	Pref. Specialty	No	No PA required
Taxotere (docetaxel)	J9171	docetaxel	Oncology	1 mg	Regular: 20 mg/2 mL, 80 mg/8 mL, 160 mg/16 mL, 200 mg/20 mL SDV Concentrate: 20 mg/mL, 80 mg/4 mL, 160 mg/8 mL SDV	Medicaid	Covered	No	No PA required
Taxotere (docetaxel)	J9171	docetaxel	Oncology	1 mg	Regular: 20 mg/2 mL, 80 mg/8 mL, 160 mg/16 mL, 200 mg/20 mL SDV Concentrate: 20 mg/mL, 80 mg/4 mL, 160 mg/8 mL SDV	Medicare	Pref. Specialty	No	No PA required
Tecartus (brexucabtagene autoleucel)	Q2053	brexucabtagene autoleucel	Gene/Cellular Therapy	per dose	SD infusion bag	Commercial	Gene Therapy	YES	PA Required – see medical oncology prior authorization form for criteria. Coverage of Tecartus is dependent on member's eligibility and benefit plan documents. Priority Health may request documentation, not more frequently than biannually, of follow-up patient assessment(s). Tecartus will not be authorized for use in patients: with primary central nervous system lymphoma; OR that have received a previous treatment course of Tecartus or another CD19-directed chimeric antigen receptor (CAR) T-cell therapy. The safety and effectiveness of repeat administration have not been evaluated (one treatment per lifetime)
Tecartus (brexucabtagene autoleucel)	Q2053	brexucabtagene autoleucel	Gene/Cellular Therapy	per dose	SD infusion bag	Medicaid	Carve Out	No	Contact Fee for Service Medicaid for coverage
Tecartus (brexucabtagene autoleucel)	Q2053	brexucabtagene autoleucel	Gene/Cellular Therapy	per dose	SD infusion bag	Medicare	Medicare Chemo	No	PA Required - click here for criteria. Link for the Prior Authorization form is on the 'General Prior Auth. Forms' tab.
Tecelra (afamitresgene autoleuce)	J9999* C9399*	afamitresgene autoleuce	Gene/Cellular Therapy	per dose	SD infusion bag	Commercial	Gene Therapy	YES	PA Required – see medical oncology prior authorization form for criteria. Coverage of Tecelra is dependent on member's eligibility and benefit plan documents. Priority Health may request documentation, not more frequently than biannually, of follow-up patient assessment(s). Tecelra will not be authorized for use in patients that have received a previous treatment course of Tecelra or another genetically modified autologous T-cell immunotherapy. The safety and effectiveness of repeat administration have not been evaluated (one treatment per lifetime).
Tecelra (afamitresgene autoleuce)	J9999* C9399*	afamitresgene autoleuce	Gene/Cellular Therapy	per dose	SD infusion bag	Medicaid	Covered	No	No PA Required
Tecelra (afamitresgene autoleuce)	J9999* C9399*	afamitresgene autoleuce	Gene/Cellular Therapy	per dose	SD infusion bag	Medicare	Medicare Chemo	No	PA required (Cancer Therapy) – See Medicare Part B Oncology Prior Authorization form
Tecentriq (atezolizumab) *(IV infusion)*	J9022	atezolizumab	Oncology	10 mg	840 mg/14 mL, 1200 mg/20 mL SDV	Commercial	Pref. Specialty	YES	PA required - see medical oncology prior authorization form for criteria
Tecentriq (atezolizumab) *(IV infusion)*	J9022	atezolizumab	Oncology	10 mg	840 mg/14 mL, 1200 mg/20 mL SDV	Medicaid	Covered	No	No PA Required
Tecentriq (atezolizumab) *(IV infusion)*	J9022	atezolizumab	Oncology	10 mg	840 mg/14 mL, 1200 mg/20 mL SDV	Medicare	Medicare Chemo	No	PA required (Cancer Therapy) – See Medicare Part B Oncology Prior Authorization form
Tecentriq Hybreza (atezolizumab & hyaluronidase-tqjs) *(Subcutaneous injection)*	J9999*, C9399*	atezolizumab & hyaluronidase	Oncology	Additional information required: National Drug Code (NDC), Strength, Dosage administered, Route of administration.	1,875 mg and 30,000 units/15 mL SDV	Commercial	Pref. Specialty	YES	PA required - see medical oncology prior authorization form for criteria
Tecentriq Hybreza (atezolizumab & hyaluronidase-tqjs) *(Subcutaneous injection)*	J9999*, C9399*	atezolizumab & hyaluronidase	Oncology	Additional information required: National Drug Code (NDC), Strength, Dosage administered, Route of administration.	1,875 mg and 30,000 units/15 mL SDV	Medicaid	Covered	No	No PA Required
Tecentriq Hybreza (atezolizumab & hyaluronidase-tqjs) *(Subcutaneous injection)*	J9999*, C9399*	atezolizumab & hyaluronidase	Oncology	Additional information required: National Drug Code (NDC), Strength, Dosage administered, Route of administration.	1,875 mg and 30,000 units/15 mL SDV	Medicare	Medicare Chemo	No	PA required (Cancer Therapy) – See Medicare Part B Oncology Prior Authorization form
Tecvayli (teclistamab-cqyv)	J9380	polatuzumab vedotin	Oncology	0.5mg	30mg/3mL SDV (Step-Up Dosing) 153mg/1.7mL SDV (Maintenance)	Commercial	NPS	No	PA required - see medical oncology prior authorization form for criteria
Tecvayli (teclistamab-cqyv)	J9380	polatuzumab vedotin	Oncology	0.5mg	30mg/3mL SDV 153mg/1.7mL SDV	Medicaid	Covered	No	No PA Required
Tecvayli (teclistamab-cqyv)	J9380	polatuzumab vedotin	Oncology	0.5mg	30mg/3mL SDV 153mg/1.7mL SDV	Medicare	Medicare Chemo	No	PA Required (Cancer Therapy) – See Medicare Part B Oncology Prior Authorization form
Teflaro (ceftaroline fosamil)	J0712	ceftaroline	Antimicrobial	10 mg	400 mg, 600 mg SDV	Commercial	NPS	No	No PA required
Teflaro (ceftaroline fosamil)	J0712	ceftaroline	Antimicrobial	10 mg	400 mg, 600 mg SDV	Medicaid	Covered	No	No PA required
Teflaro (ceftaroline fosamil)	J0712	ceftaroline	Antimicrobial	10 mg	400 mg, 600 mg SDV	Medicare	NPS	No	No PA required
Tepezza (teprotumumab-trbw)	J3241	teprotumumab	Miscellaneous	10 mg	500 mg SDV	Commercial	Pref. Specialty	YES	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth. Forms tab.
Tepezza (teprotumumab-trbw)	J3241	teprotumumab	Miscellaneous	10 mg	500 mg SDV	Medicaid	Covered	YES	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth. Forms tab.
Tepezza (teprotumumab-trbw)	J3241	teprotumumab	Miscellaneous	10 mg	500 mg SDV	Medicare	Pref. Specialty	No	PA Required - click here for criteria. Link for the Prior Authorization form is on the 'General Prior Auth. Forms' tab.
Terbutaline	J3105, J7680, J7681	terbutaline		1 mg	1 mg/mL SDV	Commercial	Non-specialty	No	No PA required
Terbutaline	J3105, J7680, J7681	terbutaline		1 mg	1 mg/mL SDV	Medicaid	Covered	No	No PA required
Terbutaline	J3105, J7680, J7681	terbutaline		1 mg	1 mg/mL SDV	Medicare	Non-specialty	No	No PA required
Testopel (testosterone implant)	J3490*, S0189	testosterone	hormone replacement	75 mg	75 mg pellet	Commercial	Non-specialty	No	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth. Forms tab.
Testopel (testosterone implant)	J3490*, S0189	testosterone	hormone replacement	75 mg	75 mg pellet	Medicaid	Covered	No	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth. Forms tab.
Testopel (testosterone implant)	J3490*, S0189	testosterone	hormone replacement	75 mg	75 mg pellet	Medicare	Non-specialty	No	PA Required - click here for criteria. Link for the Prior Authorization form is on the 'General Prior Auth. Forms' tab.
Tevimbra (tislelizumab)	J9329	tislelizumab	Oncology	1mg	100 mg/10 mL SDV	Commercial	Pref Specialty	YES	PA required - see medical oncology prior authorization form for criteria
Tevimbra (tislelizumab)	J9329	tislelizumab	Oncology	1mg	100 mg/10 mL SDV	Medicaid	Covered	No	No PA Required
Tevimbra (tislelizumab)	J9329	tislelizumab	Oncology	1mg	100 mg/10 mL SDV	Medicare	Medicare Chemo	No	PA Required (Cancer Therapy) – See Medicare Part B Oncology Prior Authorization form
Tezspire (tezepelumab-ekko) ***Pre-filled Autoinjector Pen***	J2356	tezepelumab-ekko	Respiratory Biologic	1 mg	210 mg/1.91 mL (110 mg/mL) Pen-injector	Commercial	Refer to ADL	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Tezspire (tezepelumab-ekko) ***Pre-filled Autoinjector Pen***	J2356	tezepelumab-ekko	Respiratory Biologic	1 mg	210 mg/1.91 mL (110 mg/mL) Pen-injector	Medicaid	Refer to ADL	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit

Drug	Code	Generic	Category	Billing Unit	How Supplied	Line of Business	Coverage Level	Site Of Service	Comment
Tezspire (tezepelumab-ekko) ***Pre-filled Autoinjector Pen***	J2356	tezepelumab-ekko	Respiratory Biologic	1 mg	210 mg/1.91 mL (110 mg/mL) Pen-injector	Medicare	Pref Specialty	No	PA Required - click here for criteria. Link for the Prior Authorization form is on the 'General Prior Auth Forms' tab.
Tezspire (tezepelumab-ekko) ***Prefilled Syringe***	J2356	tezepelumab-ekko	Respiratory Biologic	1 mg	210 mg/1.91 mL (110 mg/mL) prefilled syringe	Commercial	Not Covered	No	**Not covered**
Tezspire (tezepelumab-ekko) ***Prefilled Syringe***	J2356	tezepelumab-ekko	Respiratory Biologic	1 mg	210 mg/1.91 mL (110 mg/mL) prefilled syringe	Medicaid	Covered	No	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth Forms tab.
Tezspire (tezepelumab-ekko) ***Prefilled Syringe***	J2356	tezepelumab-ekko	Respiratory Biologic	1 mg	210 mg/1.91 mL (110 mg/mL) prefilled syringe	Medicare	Pref Specialty	No	PA Required - click here for criteria. Link for the Prior Authorization form is on the 'General Prior Auth Forms' tab.
Thiotepa	J9340	thiotepa	Oncology	15 mg	15 mg, 100 mg SDV	Commercial	Non-specialty	No	No PA required
Thiotepa	J9340	thiotepa	Oncology	15 mg	15 mg, 100 mg SDV	Medicaid	Covered	No	No PA required
Thiotepa	J9340	thiotepa	Oncology	15 mg	15 mg, 100 mg SDV	Medicare	Non-specialty	No	No PA required
Thorazine (chlorpromazine HCl)	J3230	chlorpromazine	Central Nervous System (CNS) agent	50 mg	25 mg/mL, 50 mg/2 mL ampule	Commercial	Non-specialty	No	No PA required
Thorazine (chlorpromazine HCl)	J3230	chlorpromazine	Central Nervous System (CNS) agent	50 mg	25 mg/mL, 50 mg/2 mL ampule	Medicaid	Carve Out	No	Contact Fee for Service Medicaid for coverage
Thorazine (chlorpromazine HCl)	J3230	chlorpromazine	Central Nervous System (CNS) agent	50 mg	25 mg/mL, 50 mg/2 mL ampule	Medicare	Non-specialty	No	No PA required
Thyrogen (thyrotropin alpha)	J3240	thyrotropin		0.9 mg (provided in 1.1 mg vial)	1.1 mg SDV	Commercial	Pref. Specialty	No	No PA required
Thyrogen (thyrotropin alpha)	J3240	thyrotropin		0.9 mg (provided in 1.1 mg vial)	1.1 mg SDV	Medicaid	Covered	No	No PA required
Thyrogen (thyrotropin alpha)	J3240	thyrotropin		0.9 mg (provided in 1.1 mg vial)	1.1 mg SDV	Medicare	Pref. Specialty	No	No PA required
Tice BCG (BCG live)	J9030	BCG live	Oncology	1 mg	50 mg SDV	Commercial	Non-specialty	No	No PA required
Tice BCG (BCG live)	J9030	BCG live	Oncology	1 mg	50 mg SDV	Medicaid	Covered	No	No PA required
Tice BCG (BCG live)	J9030	BCG live	Oncology	1 mg	50 mg SDV	Medicare	Non-specialty	No	No PA required
Tivdak (tisotumab vedotin-tftv)	J9273	pembrolizumab	Oncology	1mg	40mg SDV	Commercial	Pref. Specialty	No	PA required - see medical oncology prior authorization form for criteria.
Tivdak (tisotumab vedotin-tftv)	J9273	pembrolizumab	Oncology	1mg	40mg SDV	Medicaid	Covered	No	No PA Required
Tivdak (tisotumab vedotin-tftv)	J9273	pembrolizumab	Oncology	1mg	40mg SDV	Medicare	Medicare Chemo	No	PA Required (Cancer Therapy) - See Medicare Part B Oncology Prior Authorization form
TOBI (tobramycin) - INHALATION	J7682	tobramycin	inhalation	300 mg	300 mg/5 mL SD ampule	Medicare	NPS	No	Part B vs Part D – See Approved Drug List for covered formulations under Part D - see the Part B vs Part D coverage determination form for criteria
TOBI Podhaler(tobramycin) - INHALATION	N/A	tobramycin	inhalation			Medicare	Refer to ADL	No	this drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Tocilizumab for COVID-19	Q0249	Tocilizumab	COVID 19			Commercial	Not Covered for outpatient	No	No PA required-inpatient use only
Tocilizumab for COVID-19	Q0249	Tocilizumab	COVID 19			Medicaid	Not Covered for outpatient	No	No PA required-inpatient use only
Tocilizumab for COVID-19	Q0249	Tocilizumab	COVID 19			Medicare	Not Covered for outpatient	No	No PA required-inpatient use only
Tofidence (tocilizumab-bavi)	Q5133	tocilizumab	Inflammatory Conditions	1 mg	80 mg/4 mL, 200 mg/10 mL, 400 mg/20 mL SDV	Commercial	Not Covered	No	**Not Covered**
Tofidence (tocilizumab-bavi)	Q5133	tocilizumab	Inflammatory Conditions	1 mg	80 mg/4 mL, 200 mg/10 mL, 400 mg/20 mL SDV	Medicaid	Not Covered	No	**Not Covered until added to both the MDHHS fee schedule AND the MDHHS NDC/HCPCS crosswalk**
Tofidence (tocilizumab-bavi)	Q5133	tocilizumab	Inflammatory Conditions	1 mg	80 mg/4 mL, 200 mg/10 mL, 400 mg/20 mL SDV	Medicare	NPS	No	PA Required - click here for criteria. Link for the Prior Authorization form is on the 'General Prior Auth Forms' tab.
Toposar (etoposide)	J9181	etoposide	Oncology	10 mg	100 mg/5 mL, 500 mg/25 mL, 1000 mg/50 mL MDV	Commercial	Non-specialty	No	No PA required
Toposar (etoposide)	J9181	etoposide	Oncology	10 mg	100 mg/5 mL, 500 mg/25 mL, 1000 mg/50 mL MDV	Medicaid	Covered	No	No PA required
Toposar (etoposide)	J9181	etoposide	Oncology	10 mg	100 mg/5 mL, 500 mg/25 mL, 1000 mg/50 mL MDV	Medicare	Non-specialty	No	No PA required
Trandate (labetalol)	J1920	labetalol	Miscellaneous			Commercial	Non-specialty	No	No PA required
Trandate (labetalol)	J1920	labetalol	Miscellaneous			Medicaid	Covered	No	No PA required
Trandate (labetalol)	J1920	labetalol	Miscellaneous			Medicare	Non-specialty	No	No PA required
Tranexamic Acid in NaCL	J3490*	Tranexamic Acid	Miscellaneous	Additional information required: National Drug Code (NDC), Strength, Dosage administered, Route of administration.	1,000 mg/100 mL 0.7% NaCL solution single dose bag	Commercial	non-specialty	No	No PA Required
Tranexamic Acid in NaCL	J3490*	Tranexamic Acid	Miscellaneous	Additional information required: National Drug Code (NDC), Strength, Dosage administered, Route of administration.	1,000 mg/100 mL 0.7% NaCL solution single dose bag	Medicaid	Covered	No	No PA Required
Tranexamic Acid in NaCL	J3490*	Tranexamic Acid	Miscellaneous	Additional information required: National Drug Code (NDC), Strength, Dosage administered, Route of administration.	1,000 mg/100 mL 0.7% NaCL solution single dose bag	Medicare	non-specialty	No	No PA Required
Trazimera (trastuzumab-qyyp, biosimilar)	Q5116	trastuzumab	Oncology	10 mg	150 mg, 420 mg SDV	Commercial	Pref. Specialty	No	No PA required
Trazimera (trastuzumab-qyyp, biosimilar)	Q5116	trastuzumab	Oncology	10 mg	150 mg, 420 mg SDV	Medicaid	Covered	No	No PA required
Trazimera (trastuzumab-qyyp, biosimilar)	Q5116	trastuzumab	Oncology	10 mg	150 mg, 420 mg SDV	Medicare	Medicare Chemo	No	No PA required
Treanda (bendamustine HCl)	J9033	bendamustine	Oncology	1 mg	25 mg, 100 mg SDV	Commercial	Non-specialty	No	No PA required
Treanda (bendamustine HCl)	J9033	bendamustine	Oncology	1 mg	25 mg, 100 mg SDV	Medicaid	Covered	No	No PA required
Treanda (bendamustine HCl)	J9033	bendamustine	Oncology	1 mg	25 mg, 100 mg SDV	Medicare	Medicare Chemo	No	No PA required
Trelstar (triptorelin pamoate)	J3315	triptorelin	Oncology	3.75 mg	3.75 mg, 11.25 mg, 22.5 mg SDV	Commercial	Non-specialty	No	No PA required
Trelstar (triptorelin pamoate)	J3315	triptorelin	Oncology	3.75 mg	3.75 mg, 11.25 mg, 22.5 mg SDV	Medicaid	Covered	No	No PA required
Trelstar (triptorelin pamoate)	J3315	triptorelin	Oncology	3.75 mg	3.75 mg, 11.25 mg, 22.5 mg SDV	Medicare	Non-specialty	No	Part B vs Part D – See Approved Drug List for covered formulations under Part D - see the Part B vs Part D coverage determination form for criteria
Tremfya (guselkumab) ***200mg/20ml vial*** *(IV infusion)*	J1628	guselkumab	Inflammatory Conditions	1 mg	200mg20 mL SDV	Commercial	Pref. Specialty	YES	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth Forms tab.
Tremfya (guselkumab) ***200mg/20ml vial*** *(IV infusion)*	J1628	guselkumab	Inflammatory Conditions	1 mg	200mg20 mL SDV	Medicaid	Covered	YES	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth Forms tab.
Tremfya (guselkumab) ***200mg/20ml vial*** *(IV infusion)*	J1628	guselkumab	Inflammatory Conditions	1 mg	200mg20 mL SDV	Medicare	NPS	No	PA Required - click here for criteria. Link for the Prior Authorization form is on the 'General Prior Auth Forms' tab.
Tremfya (guselkumab) ***prefilled syringe & auto-injector*** *(subcutaneous injection)*	J1628	guselkumab	Inflammatory Conditions			Commercial	Refer to ADL	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Tremfya (guselkumab) ***prefilled syringe & auto-injector*** *(subcutaneous injection)*	J1628	guselkumab	Inflammatory Conditions			Medicaid	Not Covered	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Tremfya (guselkumab) ***prefilled syringe & auto-injector*** *(subcutaneous injection)*	J1628	guselkumab	Inflammatory Conditions			Medicare	Refer to ADL	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Tretten (Coagulation Factor XIII A)	J7181	Coagulation Factor XIII A	Hemophilia			Commercial	Refer to ADL	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Tretten (Coagulation Factor XIII A)	J7181	Coagulation Factor XIII A	Hemophilia			Medicaid	Not Covered	No	Refer to the Medicaid Approved Drug List (ADL) for pharmacy benefit coverage. For one-time doses required for planned outpatient procedures (professional/facility claims), authorizations will be reviewed for medical necessity according to the Hemophilia Management Medical Policy 91569
Tretten (Coagulation Factor XIII A)	J7181	Coagulation Factor XIII A	Hemophilia			Medicare	Pref. Specialty	No	No PA required
Trexall (methotrexate) ORAL ONLY	J8610	methotrexate	Oncology	2.5 mg	2.5 mg, 5 mg, 7.5 mg, 10 mg, 15 mg tablet, 2.5 mg/mL oral solution	Medicare	Non-specialty	No	Part B vs Part D – See Approved Drug List for covered formulations under Part D - see the Part B vs Part D coverage determination form for criteria
Tridil (nitroglycerin)	J2305	nitroglycerin	Miscellaneous			Commercial	Non-specialty	No	No PA required
Tridil (nitroglycerin)	J2305	nitroglycerin	Miscellaneous			Medicaid	Covered	No	No PA required
Tridil (nitroglycerin)	J2305	nitroglycerin	Miscellaneous			Medicare	Non-specialty	No	No PA required
Triluron (hyaluronan/ hyaluronic acid) for intra-articular injection	J7332	hyaluronate sodium/ hyaluronic acid	Hyaluronic acid derivatives	1 mg	20 mg/2 mL SD syringe	Commercial	Not covered	No	**Not covered – See Pharmacy Policy EXPERIMENTAL/INVESTIGATIONAL/UNPROVEN CARE/ BENEFIT EXCEPTIONS for more information**
Triluron (hyaluronan/ hyaluronic acid) for intra-articular injection	J7332	hyaluronate sodium/ hyaluronic acid	Hyaluronic acid derivatives	1 mg	20 mg/2 mL SD syringe	Medicaid	Not Covered	No	**Not covered**
Triluron (hyaluronan/ hyaluronic acid) for intra-articular injection	J7332	hyaluronate sodium/ hyaluronic acid	Hyaluronic acid derivatives	1 mg	20 mg/2 mL SD syringe	Medicare	NPS	No	PA Required - click here for criteria. Link for the Prior Authorization form is on the 'General Prior Auth Forms' tab.
Triptodur (triptorelin pamoate, extended release)	J3316	triptorelin	Endocrine	3.75 mg	22.5 mg SD kit	Commercial	NPS	No	No PA required
Triptodur (triptorelin pamoate, extended release)	J3316	triptorelin	Endocrine	3.75 mg	22.5 mg SD kit	Medicaid	Not Covered	No	**Not covered**
Triptodur (triptorelin pamoate, extended release)	J3316	triptorelin	Endocrine	3.75 mg	22.5 mg SD kit	Medicare	NPS	No	No PA required
Trivisc (hyaluronan/ hyaluronic acid) for intra-articular injection	J7329	hyaluronate sodium/ hyaluronic acid	Hyaluronic acid derivatives	1 mg	25 mg/2.5 mL SD syringe	Commercial	Not covered	No	**Not covered – See Pharmacy Policy EXPERIMENTAL/INVESTIGATIONAL/UNPROVEN CARE/ BENEFIT EXCEPTIONS for more information**
Trivisc (hyaluronan/ hyaluronic acid) for intra-articular injection	J7329	hyaluronate sodium/ hyaluronic acid	Hyaluronic acid derivatives	1 mg	25 mg/2.5 mL SD syringe	Medicaid	Not Covered	No	**Not covered**
Trivisc (hyaluronan/ hyaluronic acid) for intra-articular injection	J7329	hyaluronate sodium/ hyaluronic acid	Hyaluronic acid derivatives	1 mg	25 mg/2.5 mL SD syringe	Medicare	NPS	No	PA Required - click here for criteria. Link for the Prior Authorization form is on the 'General Prior Auth Forms' tab.
Trodelvy (sacituzumab govitecan)	J9317	sacituzumab	Oncology	2.5 mg	180 mg SDV	Commercial	Pref. Specialty	No	PA required - see medical oncology prior authorization form for criteria.

Drug	Code	Generic	Category	Billing Unit	How Supplied	Line of Business	Coverage Level	Site Of Service	Comment
Trodelvy (sacituzumab govitecan)	J9317	sacituzumab	Oncology	2.5 mg	180 mg SDV	Medicaid	Covered	No	No PA Required
Trodelvy (sacituzumab govitecan)	J9317	sacituzumab	Oncology	2.5 mg	180 mg SDV	Medicare	Medicare Chemo	No	PA Required (Cancer Therapy) - See Medicare Part B Oncology Prior Authorization form
Trogarzo (ibalizumab-uiyk)	J1746	ibalizumab	HIV agent	10 mg	200 mg/1.33 mL SDV	Commercial	Pref. Specialty	No	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth. Forms tab.
Trogarzo (ibalizumab-uiyk)	J1746	ibalizumab	HIV agent	10 mg	200 mg/1.33 mL SDV	Medicaid	Carve Out	No	Contact Fee for Service Medicaid for coverage
Trogarzo (ibalizumab-uiyk)	J1746	ibalizumab	HIV agent	10 mg	200 mg/1.33 mL SDV	Medicare	Pref. Specialty	No	PA required - See Medicare Medical Part B prior authorization form
Trophamine (amino acids) Injection		amino acids	TPN			Medicare		No	Part B vs Part D – See Approved Drug List for covered formulations under Part D - see the Part B vs Part D coverage determination form for criteria
Truvada (Emtricitabine and tenofovir disoproxil fumarate - PrEP ONLY)	J0750	Emtricitabine and tenofovir disoproxil fumarate	HIV preventative	Per dose	Emtricitabine 200mg and tenofovir disoproxil fumarate 300mg	Commercial	Refer to ADL	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Truvada (Emtricitabine and tenofovir disoproxil fumarate - PrEP ONLY)	J0750	Emtricitabine and tenofovir disoproxil fumarate	HIV preventative	Per dose	Emtricitabine 200mg and tenofovir disoproxil fumarate 300mg	Medicaid	Not Covered	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Truvada (Emtricitabine and tenofovir disoproxil fumarate - PrEP ONLY)	J0750	Emtricitabine and tenofovir disoproxil fumarate	HIV agent	Per dose	Emtricitabine 200mg and tenofovir disoproxil fumarate 300mg	Medicare	Refer to ADL	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Truxima (rituximab-abbs)	Q5115	rituximab	Oncology	10 mg	100 mg/10 mL, 500 mg/50 mL SDV	Commercial	Pref. Specialty	YES	No PA required
Truxima (rituximab-abbs)	Q5115	rituximab	Oncology	10 mg	100 mg/10 mL, 500 mg/50 mL SDV	Medicaid	Covered	No	No PA required
Truxima (rituximab-abbs)	Q5115	rituximab	Oncology	10 mg	100 mg/10 mL, 500 mg/50 mL SDV	Medicare	Medicare Chemo	No	No PA required
Tyenne IV (tocilizumab-aazg)	Q5135	tocilizumab	Inflammatory Conditions	Additional information required: National Drug Code (NDC), Strength, Dosage administered, Route of administration.	80 mg/4 mL, 200 mg/10 mL, 400 mg/20 mL SDV	Commercial	Not Covered	YES	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth. Forms tab.
Tyenne IV (tocilizumab-aazg)	Q5135	tocilizumab	Inflammatory Conditions	Additional information required: National Drug Code (NDC), Strength, Dosage administered, Route of administration.	80 mg/4 mL, 200 mg/10 mL, 400 mg/20 mL SDV	Medicaid	Covered	YES	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth. Forms tab.
Tyenne IV (tocilizumab-aazg)	Q5135	tocilizumab	Inflammatory Conditions	Additional information required: National Drug Code (NDC), Strength, Dosage administered, Route of administration.	80 mg/4 mL, 200 mg/10 mL, 400 mg/20 mL SDV	Medicare	NPS	No	PA Required - click here for criteria. Link for the Prior Authorization form is on the 'General Prior Auth. Forms' tab.
Tyenne SC (tocilizumab-aazg)	J3590* C9399*	tocilizumab	Inflammatory Conditions		162 mg/0.9 mL autoinjector/ prefilled syringe	Commercial	Refer to ADL	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Tyenne SC (tocilizumab-aazg)	J3590* C9399*	tocilizumab	Inflammatory Conditions		162 mg/0.9 mL autoinjector/ prefilled syringe	Medicaid	Not Covered	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Tyenne SC (tocilizumab-aazg)	J3590* C9399*	tocilizumab	Inflammatory Conditions		162 mg/0.9 mL autoinjector/ prefilled syringe	Medicare	Refer to ADL	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Tysabri (natalizumab)	J2323	natalizumab	Multiple Sclerosis (MS) agent	1 mg	300 mg/15 mL SDV	Commercial	NPS	YES	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth. Forms tab.
Tysabri (natalizumab)	J2323	natalizumab	Multiple Sclerosis (MS) agent	1 mg	300 mg/15 mL SDV	Medicaid	Covered	YES	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth. Forms tab.
Tysabri (natalizumab)	J2323	natalizumab	Multiple Sclerosis (MS) agent	1 mg	300 mg/15 mL SDV	Medicare	NPS	No	PA required - See Medicare Medical Part B prior authorization form
Tyvaso (treprostinil) inhalation	J7686	treprostinil	pulmonary arterial hypertension (PAH) agent	1.74 mg	1.74 mg/2.9 mL SD ampule	Commercial	Pref. Specialty	YES	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth. Forms tab.
Tyvaso (treprostinil) inhalation	J7686	treprostinil	pulmonary arterial hypertension (PAH) agent			Medicaid	Not Covered	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Tyvaso (treprostinil) inhalation	J7686	treprostinil	pulmonary arterial hypertension (PAH) agent	1.74 mg	1.74 mg/2.9 mL SD ampule	Medicare	Pref. Specialty	No	Part B vs Part D – PA Required – click here for criteria. See Approved Drug List for covered formulations under Part D
Tzield (teplizumab-mzwv)	J9381	teplizumab	Miscellaneous	5mcg	2mg/2mL SDV	Commercial	NPS	No	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth. Forms tab.
Tzield (teplizumab-mzwv)	J9381	teplizumab	Miscellaneous	5mcg	2mg/2mL SDV	Medicaid	Covered	YES	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth. Forms tab.

Drug	Code	Generic	Category	Billing Unit	How Supplied	Line of Business	Coverage Level	Site Of Service	Comment
Tzield (teplizumab-mzwv)	J9381	teplizumab	Miscellaneous	5mcg	2mg/2mL SDV	Medicare	NPS	No	PA Required - click here for criteria. Link for the Prior Authorization form is on the 'General Prior Auth Forms' tab.
Udenyca (pegfilgrastim-cbqv)	Q5111	pegfilgrastim	Hematopoietic agent	0.5 mg	6 mg/0.6 mL SD syringe	Commercial	Not Covered	No	**Not covered**
Udenyca (pegfilgrastim-cbqv)	Q5111	pegfilgrastim	Hematopoietic agent	0.5 mg	6 mg/0.6 mL SD syringe	Medicaid	Not Covered	No	**Not Covered**
Udenyca (pegfilgrastim-cbqv)	Q5111	pegfilgrastim	Hematopoietic agent	0.5 mg	6 mg/0.6 mL SD syringe	Medicare	NPS	No	PA Required - click here for criteria. Link for the Prior Authorization form is on the 'General Prior Auth Forms' tab.
Ultomiris (ravulizumab-cwvz)	J1303	ravulizumab	Miscellaneous	10 mg	300 mg/3 mL, 300 mg/30 mL, 1100 mg/11 mL SDV	Commercial	Pref. Specialty	YES	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth Forms tab.
Ultomiris (ravulizumab-cwvz)	J1303	ravulizumab	Miscellaneous	10 mg	300 mg/3 mL, 300 mg/30 mL, 1100 mg/11 mL SDV	Medicaid	Covered	YES	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth Forms tab.
Ultomiris (ravulizumab-cwvz)	J1303	ravulizumab	Miscellaneous	10 mg	300 mg/3 mL, 300 mg/30 mL, 1100 mg/11 mL SDV	Medicare	Pref. Specialty	No	PA Required - click here for criteria. Link for the Prior Authorization form is on the 'General Prior Auth Forms' tab.
Unituxin (dinutuximab)	J9999*, C9399*	dinutuximab	Oncology	Additional information required: National Drug Code (NDC), Strength, Dosage administered, Route of administration.	17.5 mg/5 mL SDV	Commercial	Pref. Specialty	No	PA required - see medical oncology prior authorization form for criteria
Unituxin (dinutuximab)	J9999*, C9399*	dinutuximab	Oncology	Additional information required: National Drug Code (NDC), Strength, Dosage administered, Route of administration.	17.5 mg/5 mL SDV	Medicaid	Covered	No	No PA Required
Unituxin (dinutuximab)	J9999*, C9399*	dinutuximab	Oncology	Additional information required: National Drug Code (NDC), Strength, Dosage administered, Route of administration.	17.5 mg/5 mL SDV	Medicare	Medicare Chemo	No	PA Required (Cancer Therapy) – See Medicare Part B Oncology Prior Authorization form
Uplizna (inebilizumab-cdon)	J1823	inebilizumab	Miscellaneous	1 mg	100 mg/10 mL SDV	Commercial	Pref. Specialty	YES	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth Forms tab.
Uplizna (inebilizumab-cdon)	J1823	inebilizumab	Miscellaneous	1 mg	100 mg/10 mL SDV	Medicaid	Covered	YES	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth Forms tab.
Uplizna (inebilizumab-cdon)	J1823	inebilizumab	Miscellaneous	1 mg	100 mg/10 mL SDV	Medicare	Pref. Specialty	No	PA Required - click here for criteria. Link for the Prior Authorization form is on the 'General Prior Auth Forms' tab.
Uzedy (risperidone)	J2799	risperidone	Central Nervous System (CNS) agent	1 mg	50 mg/0.14 mL, 75 mg/0.21 mL, 100 mg/0.28 mL, 125 mg/0.35 mL, 150 mg/0.42 mL, 200 mg/0.56 mL, 250 mg/0.7 mL Prefilled syringe	Commercial	Pref. Specialty	No	No PA required
Uzedy (risperidone)	J2799	risperidone	Central Nervous System (CNS) agent	1 mg	50 mg/0.14 mL, 75 mg/0.21 mL, 100 mg/0.28 mL, 125 mg/0.35 mL, 150 mg/0.42 mL, 200 mg/0.56 mL, 250 mg/0.7 mL Prefilled syringe	Medicaid	Carve Out	No	Contact Fee for Service Medicaid for coverage
Uzedy (risperidone)	J2799	risperidone	Central Nervous System (CNS) agent	1 mg	50 mg/0.14 mL, 75 mg/0.21 mL, 100 mg/0.28 mL, 125 mg/0.35 mL, 150 mg/0.42 mL, 200 mg/0.56 mL, 250 mg/0.7 mL Prefilled syringe	Medicare	NPS	No	No PA required
Vabomere (meropenem and vaborbactam)	J2186	meropenem and vaborbactam	Antimicrobial	10 mg-10 mg (20 mg)	1000 mg-1000 mg SDV	Commercial	Pref. Specialty	No	No PA required
Vabomere (meropenem and vaborbactam)	J2186	meropenem and vaborbactam	Antimicrobial	10 mg-10 mg (20 mg)	1000 mg-1000 mg SDV	Medicaid	Covered	No	No PA required
Vabomere (meropenem and vaborbactam)	J2186	meropenem and vaborbactam	Antimicrobial	10 mg-10 mg (20 mg)	1000 mg-1000 mg SDV	Medicare	Pref. Specialty	No	No PA required
Vabysmo (faricimab-svoa)	J2777	faricimab	Ophthalmic	0.1 mg	6 mg/0.05 mL SDV and prefilled syringe	Commercial	Pref. Specialty	No	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth Forms tab.
Vabysmo (faricimab-svoa)	J2777	faricimab	Ophthalmic	0.1 mg	6 mg/0.05 mL SDV and prefilled syringe	Medicaid	Covered	No	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth Forms tab.
Vabysmo (faricimab-svoa)	J2777	faricimab	Ophthalmic	0.1 mg	6 mg/0.05 mL SDV and prefilled syringe	Medicare	Pref Specialty	No	No PA required when billed with the following ICD-10 diagnoses: A18.53, E08.311, E08.319, E08.3211 – E08.3213, E08.3291 - E08.3293, E08.3311 - E08.3313, E08.3391 - E08.3393, E08.3411 - E08.3413, E08.3491 - E08.3493, E08.3511 - E08.3513, E08.3521 - E08.3523, E08.3531 - E08.3533, E08.3541 - E08.3543, E08.3551 - E08.3553, E08.3591 - E08.3593, E09.311, E09.319, E09.3211 - E09.3213, E09.3291 - E09.3293, E09.3311 - E09.3313, E09.3391 - E09.3393, E09.3411 - E09.3413, E09.3491 - E09.3493, E09.3511 - E09.3513, E09.3521 - E09.3523, E09.3531 - E09.3533, E09.3541 - E09.3543, E09.3551 - E09.3553, E09.3591 - E09.3593, E10.311, E10.319, E10.3211 - E10.3213, E10.3291 - E10.3293, E10.3311 - E10.3313, E10.3391 - E10.3393, E10.3411 - E10.3413, E10.3491 - E10.3493, E10.3511 - E10.3513, E10.3591 - E10.3599, E11.3211-E11.3219, E11.3291-E11.3299, E11.3311- E11.3313, E11.3391 - E11.3393, E11.3411- E11.3413, E11.3491 - E11.3493, E11.3511 - E11.3513, E11.3521 – E11.3523, E11.3531 – E11.3533, E11.3541 – E11.3543, E11.3551 – E11.3553, E11.3591 – E11.3593, E13.311, E13.319, E13.3211- E13.3213, E13.3291 - E13.3293, E13.3311- E13.3313, E13.3391 - E13.3393, E13.3411-E13.3413, E13.3491 - E13.3493, E13.3511- E13.3513, E13.3521 – E13.3523, E13.3531 – E13.3533, E13.3541 – E13.3543, E13.3551 – E13.3553, E13.3591 – E13.3593, H34.8110, H34.8120, H34.8130, H34.8190, H34.8310, H34.8320, H34.8330, H34.8390, H35.051 - H35.053, H35.101 – H35.169, H35.3210 - H35.3233, H35.351 – H35.353. All other ICD-10 diagnoses: PA required - See Medicare Medical Part B prior authorization form
Vafseo (vadadustat)	J0901	vadadustat	Miscellaneous	1 mg	150 mg, 300 mg, 450 mg tablet	Commercial	Not Covered	No	**Not Covered**
Vafseo (vadadustat)	J0901	vadadustat	Miscellaneous	1 mg	150 mg, 300 mg, 450 mg tablet	Medicaid	Not Covered	No	**Not Covered**
Vafseo (vadadustat)	J0901	vadadustat	Miscellaneous	1 mg	150 mg, 300 mg, 450 mg tablet	Medicare	Not separately payable	No	Not separately payable
Vantas (histrelin implant)	J9225	histrelin	Oncology	50 mg	50 mg implant	Commercial	Pref. Specialty	No	No PA required
Vantas (histrelin implant)	J9225	histrelin	Oncology	50 mg	50 mg implant	Medicaid	Covered	No	No PA required
Vantas (histrelin implant)	J9225	histrelin	Oncology	50 mg	50 mg implant	Medicare	Pref. Specialty	No	No PA required
Varubi (rolapitant)	J2797	rolapitant	Antiemetic	0.5 mg	166.5 mg/92.5 mL SDV	Commercial	Non-specialty	No	No PA required
Varubi (rolapitant)	J2797	rolapitant	Antiemetic	0.5 mg	166.5 mg/92.5 mL SDV	Medicaid	Covered	No	No PA required
Varubi (rolapitant)	J2797	rolapitant	Antiemetic	0.5 mg	166.5 mg/92.5 mL SDV	Medicare	Non-specialty	No	No PA required
vasopressin - American Regent Brand ONLY	J2599	vasopressin	Miscellaneous	1 unit		Commercial	Non-specialty	No	No PA required
vasopressin - American Regent Brand ONLY	J2599	vasopressin	Miscellaneous	1 unit		Medicaid	Covered	No	No PA required
vasopressin - American Regent Brand ONLY	J2599	vasopressin	Miscellaneous	1 unit		Medicare	Non-specialty	No	No PA required
vasopressin - Baxter Brand ONLY	J2601	vasopressin	Miscellaneous	1 unit		Commercial	Non-specialty	No	No PA required
vasopressin - Baxter Brand ONLY	J2601	vasopressin	Miscellaneous	1 unit		Medicaid	Covered	No	No PA required
vasopressin - Baxter Brand ONLY	J2601	vasopressin	Miscellaneous	1 unit		Medicare	Non-specialty	No	No PA required
vasopressin in NS	J3490*, C9399*	vasopressin in NaCl	Miscellaneous	Additional information required: National Drug Code (NDC), Strength, Dosage administered, Route of administration.	100 mL at 20 units/100 mL 100 mL at 40 units/100 mL 50 mL at 50 units/50 mL	Commercial	Non-specialty	No	No PA required
vasopressin in NS	J3490*, C9399*	vasopressin in NaCl	Miscellaneous	Additional information required: National Drug Code (NDC), Strength, Dosage administered, Route of administration.	100 mL at 20 units/100 mL 100 mL at 40 units/100 mL 50 mL at 50 units/50 mL	Medicaid	Covered	No	No PA required
vasopressin in NS	J3490*, C9399*	vasopressin in NaCl	Miscellaneous	Additional information required: National Drug Code (NDC), Strength, Dosage administered, Route of administration.	100 mL at 20 units/100 mL 100 mL at 40 units/100 mL 50 mL at 50 units/50 mL	Medicare	Non-specialty	No	No PA required
Vasostrict - (vasopressin)	J2598	vasopressin	Miscellaneous	1 unit		Commercial	Non-specialty	No	No PA required
Vasostrict - (vasopressin)	J2598	vasopressin	Miscellaneous	1 unit		Medicaid	Covered	No	No PA required
Vasostrict - (vasopressin)	J2598	vasopressin	Miscellaneous	1 unit		Medicare	Non-specialty	No	No PA required
Vazculep (phenylephrine)	J2371	phenylephrine	Miscellaneous	20 mg		Commercial	Non-specialty	No	No PA required
Vazculep (phenylephrine)	J2371	phenylephrine	Miscellaneous	20 mg		Medicaid	Covered	No	No PA required
Vazculep (phenylephrine)	J2371	phenylephrine	Miscellaneous	20 mg		Medicare	Non-specialty	No	No PA required
Vectibix (panitumumab)	J9303	panitumumab	Oncology	10 mg	100 mg/5 mL, 400 mg/20 mL SDV	Commercial	Pref. Specialty	No	PA required - see medical oncology prior authorization form for criteria
Vectibix (panitumumab)	J9303	panitumumab	Oncology	10 mg	100 mg/5 mL, 400 mg/20 mL SDV	Medicaid	Covered	No	No PA Required
Vectibix (panitumumab)	J9303	panitumumab	Oncology	10 mg	100 mg/5 mL, 400 mg/20 mL SDV	Medicare	Medicare Chemo	No	No PA required when billed for the following ICD 10 codes: C18.0 – C21.8, C17.0 – C17.8 , C78.01 – C78.02, C78.6 – C78.7. For all other diagnoses - see Medicare Part B oncology prior authorization form for criteria
Vegzelma (bevacizumab-adcd)	Q5129	bevacizumab	Oncology	10 mg	100 mg/4 mL SDV 400 mg/16 mL SDV	Commercial	Not Covered	No	**Not Covered**
Vegzelma (bevacizumab-adcd)	Q5129	bevacizumab	Oncology	10 mg	101 mg/4 mL SDV 400 mg/16 mL SDV	Medicaid	Covered	No	No PA Required
Vegzelma (bevacizumab-adcd)	Q5129	bevacizumab	Oncology	10 mg	102 mg/4 mL SDV 400 mg/16 mL SDV	Medicare	Medicare Chemo	No	PA Required - click here for criteria. Link for the Prior Authorization form is on the 'General Prior Auth Forms' tab.
Veklury (remdesivir)	J0248	remdesivir	COVID 19	1 mg	100mg SDV	Commercial	NPS	No	No PA required
Veklury (remdesivir)	J0248	remdesivir	COVID 19	1 mg	100mg SDV	Medicaid	Covered	No	No PA required
Veklury (remdesivir)	J0248	remdesivir	COVID 19	1 mg	100mg SDV	Medicare	NPS	No	No PA required

Drug	Code	Generic	Category	Billing Unit	How Supplied	Line of Business	Coverage Level	Site Of Service	Comment
Velcade (bortezomib)	J9041	bortezomib	Oncology	0.1 mg	3.5 mg SDV	Commercial	Pref. Specialty	No	No PA required for ICD-10 codes C90.00-C90.32, C83.10-C83.19 and E85.81 - for all other diagnoses, see medical oncology prior authorization form for criteria.
Velcade (bortezomib)	J9041	bortezomib	Oncology	0.1 mg	3.5 mg SDV	Medicaid	Covered	No	No PA Required
Velcade (bortezomib)	J9041	bortezomib	Oncology	0.1 mg	3.5 mg SDV	Medicare	Medicare Chemo	No	No PA required
Veletri (epoprostenol sodium)	J1325	epoprostenol	pulmonary arterial hypertension (PAH) agent	0.5 mg	0.5 mg, 1.5 mg SDV	Commercial	NPS	YES	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth Forms tab.
Veletri (epoprostenol sodium)	J1325	epoprostenol	pulmonary arterial hypertension (PAH) agent	0.5 mg	0.5 mg, 1.5 mg SDV	Medicaid	Covered	No	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth Forms tab.
Veletri (epoprostenol sodium)	J1325	epoprostenol	pulmonary arterial hypertension (PAH) agent	0.5 mg	0.5 mg, 1.5 mg SDV	Medicare	NPS	No	No PA required
Venofer (iron sucrose)	J1756	iron	iron replacement	1 mg	50 mg/2.5 mL, 100 mg/5 mL, 200 mg/10 mL SDV	Commercial	Non-specialty	No	No PA required
Venofer (iron sucrose)	J1756	iron	iron replacement	1 mg	50 mg/2.5 mL, 100 mg/5 mL, 200 mg/10 mL SDV	Medicaid	Covered	No	No PA required
Venofer (iron sucrose)	J1756	iron	iron replacement	1 mg	50 mg/2.5 mL, 100 mg/5 mL, 200 mg/10 mL SDV	Medicare	Non-specialty	No	No PA required
Ventavis (iloprost)	Q4074	iloprost	pulmonary arterial hypertension (PAH) agent	20 mcg	10 mcg/mL, 20 mcg/2 mL SD ampules	Commercial	NPS	YES	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth Forms tab.
Ventavis (iloprost)	Q4074	iloprost	pulmonary arterial hypertension (PAH) agent			Medicaid	Not Covered	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Ventavis (iloprost)	Q4074		pulmonary arterial hypertension (PAH) agent	20 mcg	10 mcg/mL, 20 mcg/2 mL SD ampules	Medicare	NPS	No	Part B vs Part D – PA Required – click here for criteria. See Approved Drug List for covered formulations under Part D
Veopoz (pozelimab-bbfg)	J9376	pozelimab	Miscellaneous	1 mg	400 mg/2 mL SDV	Commercial	Pref. Specialty	YES	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth Forms tab.
Veopoz (pozelimab-bbfg)	J9376	pozelimab	Miscellaneous	1 mg	400 mg/2 mL SDV	Medicaid	Not Covered	YES	**Not covered until added to both the MDHHS fee schedule AND the MDHHS NDC/HCPCS crosswalk**
Veopoz (pozelimab-bbfg)	J9376	pozelimab	Miscellaneous	1 mg	400 mg/2 mL SDV	Medicare	Pref. Specialty	No	PA Required - click here for criteria. Link for the Prior Authorization form is on the 'General Prior Auth Forms' tab.
Vfend (voriconazole)	J3465	voriconazole	Antimicrobial	10 mg	200 mg SDV	Commercial	Pref. Specialty	No	No PA required
Vfend (voriconazole)	J3465	voriconazole	Antimicrobial	10 mg	200 mg SDV	Medicaid	Covered	No	No PA required
Vfend (voriconazole)	J3465	voriconazole	Antimicrobial	10 mg	200 mg SDV	Medicare	Pref. Specialty	No	No PA required
Vibativ (telavancin)	J3095	telavancin	Antimicrobial	10 mg	750 mg SDV	Commercial	NPS	No	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth Forms tab.
Vibativ (telavancin)	J3095	telavancin	Antimicrobial	10 mg	750 mg SDV	Medicaid	Covered	No	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth Forms tab.
Vibativ (telavancin)	J3095	telavancin	Antimicrobial	10 mg	750 mg SDV	Medicare	NPS	No	PA Required - click here for criteria. Link for the Prior Authorization form is on the 'General Prior Auth Forms' tab.
Viltepso (viltolarsen)	J1427	viltolarsen	Muscular Dystrophy	10 mg	250 mg/5 mL SDV	Commercial	Not covered	No	**Not covered – See Pharmacy Policy EXPERIMENTAL/INVESTIGATIONAL/UNPROVEN CARE/ BENEFIT EXCEPTIONS for more information**
Viltepso (viltolarsen)	J1427	viltolarsen	Muscular Dystrophy	10 mg	250 mg/5 mL SDV	Medicaid	Carve Out	No	Contact Fee for Service Medicaid for coverage
Viltepso (viltolarsen)	J1427	viltolarsen	Muscular Dystrophy	10 mg	250 mg/5 mL SDV	Medicare	NPS	No	PA required - See Medicare Medical Part B prior authorization form
Vimizim (elosulfase alfa)	J1322	elosulfase alfa	Enzyme deficiency	1 mg	1 mg/mL SDV	Commercial	Pref. Specialty	YES	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth Forms tab.
Vimizim (elosulfase alfa)	J1322	elosulfase alfa	Enzyme deficiency	1 mg	1 mg/mL SDV	Medicaid	Carve Out	No	Contact Fee for Service Medicaid for coverage
Vimizim (elosulfase alfa)	J1322	elosulfase alfa	Enzyme deficiency	1 mg	1 mg/mL SDV	Medicare	Pref. Specialty	No	No PA required when billed for the following ICD-10 codes: E76.210 For all other diagnoses, see Medicare Part B prior authorization form
vinblastine	J9360	vinblastine	Oncology	1 mg	1 mg/mL SDV	Commercial	Non-specialty	No	No PA required
vinblastine	J9360	vinblastine	Oncology	1 mg	1 mg/mL SDV	Medicaid	Covered	No	No PA required
vinblastine	J9360	vinblastine	Oncology	1 mg	1 mg/mL SDV	Medicare	Non-specialty	No	No PA required
Vincasar (vincristine)	J9370	vincristine	Oncology	1 mg	1 mg/mL, 2 mg/2 mL SDV	Commercial	Non-specialty	No	No PA required
Vincasar (vincristine)	J9370	vincristine	Oncology	1 mg	1 mg/mL, 2 mg/2 mL SDV	Medicaid	Covered	No	No PA required
Vincasar (vincristine)	J9370	vincristine	Oncology	1 mg	1 mg/mL, 2 mg/2 mL SDV	Medicare	Non-specialty	No	No PA required
Visco-3 (hyaluronan/ hyaluronic acid) for intra-articular injection	J7321	hyaluronate sodium/ hyaluronic acid	Hyaluronic acid derivatives	per dose	25 mg/2.5 mL SD syringe	Commercial	Not covered	No	**Not covered – See Pharmacy Policy EXPERIMENTAL/INVESTIGATIONAL/UNPROVEN CARE/ BENEFIT EXCEPTIONS for more information**
Visco-3 (hyaluronan/ hyaluronic acid) for intra-articular injection	J7321	hyaluronate sodium/ hyaluronic acid	Hyaluronic acid derivatives	per dose	25 mg/2.5 mL SD syringe	Medicaid	Not Covered	No	**Not covered**
Visco-3 (hyaluronan/ hyaluronic acid) for intra-articular injection	J7321	hyaluronate sodium/ hyaluronic acid	Hyaluronic acid derivatives	per dose	25 mg/2.5 mL SD syringe	Medicare	NPS	No	PA Required - click here for criteria. Link for the Prior Authorization form is on the 'General Prior Auth Forms' tab.
Visudyne (verteporfin)	J3396	verteporfin	Ophthalmic	0.1 mg	15 mg SDV	Commercial	Pref. Specialty	No	No PA required when billed for the following ICD-10 codes: B39.4,B39.5, H32,H35.3210-H35.3233, H35.711 – H35.713, H44.20-H44.2E9
Visudyne (verteporfin)	J3396	verteporfin	Ophthalmic	0.1 mg	15 mg SDV	Medicaid	Covered	No	No PA required when billed for the following ICD-10 codes: B39.4,B39.5, H32,H35.3210-H35.3233, H35.711 – H35.713, H44.20-H44.2E9
Visudyne (verteporfin)	J3396	verteporfin	Ophthalmic	0.1 mg	15 mg SDV	Medicare	Pref. Specialty	No	No PA required when billed for the following ICD-10 codes: B39.4,B39.5, H32,H35.3210-H35.3233, H35.711 – H35.713, H44.20-H44.2E9
Vivimusta (bendamustine HCl)	J9056	bendamustine	Oncology	Additional information required: National Drug Code (NDC), Strength, Dosage administered, Route of administration.	100mg/ 4 ml MDV	Commercial	Not Covered	No	**Not Covered**
Vivimusta (bendamustine HCl)	J9056	bendamustine	Oncology	Additional information required: National Drug Code (NDC), Strength, Dosage administered, Route of administration.	100mg/ 4 ml MDV	Medicaid	Covered	No	No PA required
Vivimusta (bendamustine HCl)	J9056	bendamustine	Oncology	Additional information required: National Drug Code (NDC), Strength, Dosage administered, Route of administration.	100mg/ 4 ml MDV	Medicare	Medicare Chemo	No	PA Required - click here for criteria. Link for the Prior Authorization form is on the 'General Prior Auth Forms' tab.
Vivitrol (naltrexone, depot form)	J2315	naltrexone	Opioid use disorder	1 mg	380 mg kit	Commercial	Pref. Specialty	No	No PA required
Vivitrol (naltrexone, depot form)	J2315	naltrexone	Opioid use disorder	1 mg	380 mg kit	Medicaid	Carve Out	No	Contact Fee for Service Medicaid for coverage
Vivitrol (naltrexone, depot form)	J2315	naltrexone	Opioid use disorder	1 mg	380 mg kit	Medicare	Pref. Specialty	No	No PA required
Vonvendi (Von Willebrand Factor)	J7179	Von Willebrand Factor	Hemophilia			Commercial	Refer to ADL	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Vonvendi (Von Willebrand Factor)	J7179	Von Willebrand Factor	Hemophilia			Medicaid	Not Covered	No	Refer to the Medicaid Approved Drug List (ADL) for pharmacy benefit coverage. For one-time doses required for planned outpatient procedures (professional/facility claims), authorizations will be reviewed for medical necessity according to the Hemophilia Management Medical Policy 91569
Vonvendi (Von Willebrand Factor)	J7179	Von Willebrand Factor	Hemophilia			Medicare	Pref. Specialty	No	No PA required
Vpriv (velaglucerase alfa)	J3385	velaglucerase	Enzyme deficiency	100 units	400 unit SDV	Commercial	Pref. Specialty	YES	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth Forms tab.
Vpriv (velaglucerase alfa)	J3385	velaglucerase	Enzyme deficiency	100 units	400 unit SDV	Medicaid	Covered	YES	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth Forms tab.
Vpriv (velaglucerase alfa)	J3385	velaglucerase	Enzyme deficiency	100 units	400 unit SDV	Medicare	Pref. Specialty	No	No PA required
Vumon (teniposide)	Q2017	teniposide	Oncology	50 mg	50 mg/5 mL SDV	Commercial	Non-specialty	No	No PA required
Vumon (teniposide)	Q2017	teniposide	Oncology	50 mg	50 mg/5 mL SDV	Medicaid	Covered	No	No PA required
Vumon (teniposide)	Q2017	teniposide	Oncology	50 mg	50 mg/5 mL SDV	Medicare	Non-specialty	No	No PA required
Vyepti (eptinezumab-jjmr)	J3032	eptinezumab	CGRP inhibitor	1 mg	100 mg/mL SDV	Commercial	NPS	No	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth Forms tab.
Vyepti (eptinezumab-jjmr)	J3032	eptinezumab	CGRP inhibitor	1 mg	100 mg/mL SDV	Medicaid	Covered	YES	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth Forms tab.
Vyepti (eptinezumab-jjmr)	J3032	eptinezumab	CGRP inhibitor	1 mg	100 mg/mL SDV	Medicare	NPS	No	PA Required - click here for criteria. Link for the Prior Authorization form is on the 'General Prior Auth Forms' tab.
Vyjuvek beremagene geperpavec	J3401	beremagene geperpavec	Gene/Cellular Therapy	0.1 ml	5 x 109 pfu/1ml Topical Gel	Commercial	Gene Therapy	YES	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth Forms tab.
Vyjuvek beremagene geperpavec	J3401	beremagene geperpavec	Gene/Cellular Therapy	0.1 ml	5 x 109 pfu/1ml Topical Gel	Medicaid	Not Covered	No	**Not covered**
Vyjuvek beremagene geperpavec	J3401	beremagene geperpavec	Gene/Cellular Therapy	0.1 ml	5 x 109 pfu/1ml Topical Gel	Medicare	Gene Therapy	No	PA Required - click here for criteria. Link for the Prior Authorization form is on the 'General Prior Auth Forms' tab.
Vyondys 53 (golodirsen)	J1429	golodirsen	Muscular Dystrophy	10 mg	100 mg/2 mL SDV	Commercial	Not covered	No	**Not covered – See Pharmacy Policy EXPERIMENTAL/INVESTIGATIONAL/UNPROVEN CARE/ BENEFIT EXCEPTIONS for more information**
Vyondys 53 (golodirsen)	J1429	golodirsen	Muscular Dystrophy	10 mg	100 mg/2 mL SDV	Medicaid	Carve Out	No	Contact Fee for Service Medicaid for coverage
Vyondys 53 (golodirsen)	J1429	golodirsen	Muscular Dystrophy	10 mg	100 mg/2 mL SDV	Medicare	Not Covered	No	**Not covered – See Pharmacy Policy Utilization Management for Part B Drugs in Medicare Advantage**
Vyvgart (efgartigimod alfa-fcab)	J9332	efgartigimod alfa-fcab	Myasthenia Gravis	2 mg	400mg/20ml SDV	Commercial	Pref. Specialty	YES	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth Forms tab.
Vyvgart (efgartigimod alfa-fcab)	J9332	efgartigimod alfa-fcab	Myasthenia Gravis	2 mg	400mg/20ml SDV	Medicaid	Covered	YES	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth Forms tab.
Vyvgart (efgartigimod alfa-fcab)	J9332	efgartigimod alfa-fcab	Myasthenia Gravis	2 mg	400mg/20ml SDV	Medicare	Pref. Specialty	No	PA Required - click here for criteria. Link for the Prior Authorization form is on the 'General Prior Auth Forms' tab.
Vyvgart Hytrulo (efgartigimod alfa-fcab and hyaluronidase-qvfc)	J9334	efgartigimod alfa/hyaluronidase	Myasthenia Gravis	2 mg (efgartigimod)	1,008 mg efgartigimod alfa and 11,200 units hyaluronidase in a 5.6 mL (180 mg/2,000 units per mL) single-dose vial	Commercial	Pref. Specialty	YES	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth Forms tab.
Vyvgart Hytrulo (efgartigimod alfa-fcab and hyaluronidase-qvfc)	J9334	efgartigimod alfa/hyaluronidase	Myasthenia Gravis	2 mg (efgartigimod)	1,008 mg efgartigimod alfa and 11,200 units hyaluronidase in a 5.6 mL (180 mg/2,000 units per mL) single-dose vial	Medicaid	Covered	YES	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth Forms tab.
Vyvgart Hytrulo (efgartigimod alfa-fcab and hyaluronidase-qvfc)	J9334	efgartigimod alfa/hyaluronidase	Myasthenia Gravis	2 mg (efgartigimod)	1,008 mg efgartigimod alfa and 11,200 units hyaluronidase in a 5.6 mL (180 mg/2,000 units per mL) single-dose vial	Medicare	Pref. Specialty	No	PA Required - click here for criteria. Link for the Prior Authorization form is on the 'General Prior Auth Forms' tab.

Drug	Code	Generic	Category	Billing Unit	How Supplied	Line of Business	Coverage Level	Site Of Service	Comment
Vyxeos (daunorubicin liposomal/cytarabine liposomal)	J9153	daunorubicin and cytarabine	Oncology	1 mg-2.27 mg	44 mg-100mg SDV kit	Commercial	Pref. Specialty	No	PA required - see medical oncology prior authorization form for criteria
Vyxeos (daunorubicin liposomal/cytarabine liposomal)	J9153	daunorubicin and cytarabine	Oncology	1 mg-2.27 mg	44 mg-100mg SDV kit	Medicaid	Covered	No	No PA Required
Vyxeos (daunorubicin liposomal/cytarabine liposomal)	J9153	daunorubicin and cytarabine	Oncology	1 mg-2.27 mg	44 mg-100mg SDV kit	Medicare	Medicare Chemo	No	PA Required (Cancer Therapy) – See Medicare Part B Oncology Prior Authorization form
Wilate (Von Willebrand Factor)	J7183	Von Willebrand Factor	Hemophilia			Commercial	Refer to ADL	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Wilate (Von Willebrand Factor)	J7183	Von Willebrand Factor	Hemophilia			Medicaid	Not Covered	No	Refer to the Medicaid Approved Drug List (ADL) for pharmacy benefit coverage. For one-time doses required for planned outpatient procedures (professional/facility claims), authorizations will be reviewed for medical necessity according to the Hemophilia Management Medical Policy 91569
Wilate (Von Willebrand Factor)	J7183	Von Willebrand Factor	Hemophilia			Medicare	Pref. Specialty	No	No PA required
Winrevair (sotatercept-csrk)	J3950* C9399*	sotatercept	pulmonary arterial hypertension (PAH) agent	Additional information required: National Drug Code (NDC), Strength, Dosage administered, Route of administration.	45mg, 60mg SDV	Commercial	Pref. Specialty	No	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth Forms tab.
Winrevair (sotatercept-csrk)	J3950* C9399*	sotatercept	pulmonary arterial hypertension (PAH) agent	Additional information required: National Drug Code (NDC), Strength, Dosage administered, Route of administration.	45mg, 60mg SDV	Medicaid	Not Covered	No	**Not covered until added to both the MDHHS fee schedule AND the MDHHS NDC/HCPCS crosswalk**
Winrevair (sotatercept-csrk)	J3950* C9399*	sotatercept	pulmonary arterial hypertension (PAH) agent	Additional information required: National Drug Code (NDC), Strength, Dosage administered, Route of administration.	45mg, 60mg SDV	Medicare	NPS	No	PA Required - click here for criteria. Link for the Prior Authorization form is on the 'General Prior Auth Forms' tab.
Xaracoll (bupivacaine collagen-matrix)	J3490, C9089	bupivacaine	miscellaneous	Additional information required: National Drug Code (NDC), Strength, Dosage administered, Route of administration.		Commercial	Not Covered	No	**Not Covered**
Xaracoll (bupivacaine collagen-matrix)	J3490, C9089	bupivacaine	miscellaneous	Additional information required: National Drug Code (NDC), Strength, Dosage administered, Route of administration.		Medicaid	Covered	No	No PA required
Xaracoll (bupivacaine collagen-matrix)	J3490, C9089	bupivacaine	miscellaneous	Additional information required: National Drug Code (NDC), Strength, Dosage administered, Route of administration.		Medicare	non-specialty	No	Only covered for medically accepted indications
Xatmep (methotrexate) ORAL ONLY	J8612	methotrexate	Oncology	2.5 mg	2.5 mg/mL oral solution (60 mL & 120 mL)	Medicare	Non-specialty	No	Part B vs Part D – See Approved Drug List for covered formulations under Part D - see the Part B vs Part D coverage determination form for criteria
Xeloda (capecitabine)	J8522	Capecitabine	Oncology	50mg	150 mg, 500 mg tablet	Medicare	Non-specialty	No	Part B vs Part D – See Approved Drug List for covered formulations under Part D - see the Part B vs Part D coverage determination form for criteria
Xembify (immune globulin) subcutaneous	J1558	SCIG	Immune Globulin	100 mg	1 gm, 2 gm, 4 gm, 10 gm SDV	Commercial	Pref. Specialty	YES	PA required - see IVIG/SCIG prior authorization form for criteria
Xembify (immune globulin) subcutaneous	J1558	SCIG	Immune Globulin	100 mg	1 gm, 2 gm, 4 gm, 10 gm SDV	Medicaid	Covered	No	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth Forms tab.
Xembify (immune globulin) subcutaneous	J1558	SCIG	Immune Globulin	100 mg	1 gm, 2 gm, 4 gm, 10 gm SDV	Medicare	Pref. Specialty	No	Part B vs Part D – See Approved Drug List for covered formulations under Part D - see the Part B vs Part D coverage determination form for criteria
Xenleta (lefamulin)	J0691	lefamulin	Antimicrobial	1 mg	150 mg/15 mL SDV	Commercial	Not covered	No	**Not covered**

Drug	Code	Generic	Category	Billing Unit	How Supplied	Line of Business	Coverage Level	Site Of Service	Comment
Xenleta (lefamulin)	J0691	lefamulin	Antimicrobial	1 mg	150 mg/15 mL SDV	Medicaid	Not Covered	No	**Not covered**
Xenleta (lefamulin)	J0691	lefamulin	Antimicrobial	1 mg	150 mg/15 mL SDV	Medicare	Pref. Specialty	No	PA Required - click here for criteria. Link for the Prior Authorization form is on the 'General Prior Auth Forms' tab.
Xenpozyme (olipudase alfa-rpcp)	J0218	Hydrolytic lysosomal sphingomyelin-specific enzyme	Enzyme deficiency	1mg	20mg SDV	Commercial	Pref. Specialty	YES	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth Forms tab.
Xenpozyme (olipudase alfa-rpcp)	J0218	Hydrolytic lysosomal sphingomyelin-specific enzyme	Enzyme deficiency	1mg	20mg SDV	Medicaid	Covered	YES	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth Forms tab.
Xenpozyme (olipudase alfa-rpcp)	J0218	Hydrolytic lysosomal sphingomyelin-specific enzyme	Enzyme deficiency	1mg	20mg SDV	Medicare	Pref. Specialty	No	PA required - See Medicare Medical Part B prior authorization form
Xeomin (incobotulinumtoxin A)	J0588	incobotulinumtoxin A	botulinum toxin	1 unit	50 unit, 100 unit, 200 unit SDV	Commercial	Pref. Specialty	No	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth Forms tab. No auth required when billed by: Neurologist (NEUR), Rehab Medicine (PMR) or Physical Med & Rehab (PT)
Xeomin (incobotulinumtoxin A)	J0588	incobotulinumtoxin A	botulinum toxin	1 unit	50 unit, 100 unit, 200 unit SDV	Medicaid	Covered	No	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth Forms tab. No auth required when billed by: Neurologist (NEUR), Rehab Medicine (PMR) or Physical Med & Rehab (PT)
Xeomin (incobotulinumtoxin A)	J0588	botulinum toxin A	botulinum toxin	1 unit	50 unit, 100 unit, 200 unit SDV	Medicare	Pref. Specialty	No	PA Required - click here for criteria. Link for the Prior Authorization form is on the 'General Prior Auth Forms' tab. No auth required when billed by: Neurologist (NEUR), Rehab Medicine (PMR) or Physical Med & Rehab (PT)
Xerava (eravacycline)	J0122	eravacycline	Antimicrobial	1 mg	50 mg, 100 mg SDV	Commercial	Not covered	No	**Not covered**
Xerava (eravacycline)	J0122	eravacycline	Antimicrobial	1 mg	50 mg, 100 mg SDV	Medicaid	Not Covered	No	**Not covered**
Xerava (eravacycline)	J0122	eravacycline	Antimicrobial	1 mg	50 mg, 100 mg SDV	Medicare	Non-specialty	No	No PA required
Xgeva (denosumab)	J0897	denosumab	Bone modifying agent	1 mg	120 mg/1.7 mL SDV	Commercial	Pref. Specialty	YES	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth Forms tab.
Xgeva (denosumab)	J0897	denosumab	Bone modifying agent	1 mg	120 mg/1.7 mL SDV	Medicaid	Covered	No	No PA required
Xgeva (denosumab)	J0897	denosumab	Bone modifying agent	1 mg	120 mg/1.7 mL SDV	Medicare	Pref. Specialty	No	PA Required - click here for criteria. Link for the Prior Authorization form is on the 'General Prior Auth Forms' tab.
Xiaflex (collagenase clostridium histolyticum)	J0775	collagenase clostridium histolyticum	Miscellaneous	0.01 mg	0.9 mg SDV	Commercial	Pref. Specialty	No	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth Forms tab.
Xiaflex (collagenase clostridium histolyticum)	J0775	collagenase clostridium histolyticum	Miscellaneous	0.01 mg	0.9 mg SDV	Medicaid	Covered	No	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth Forms tab.
Xiaflex (collagenase clostridium histolyticum)	J0775	collagenase clostridium histolyticum	Miscellaneous	0.01 mg	0.9 mg SDV	Medicare	Pref. Specialty	No	No PA required for Medicare ICD-10 diagnoses: M72.0 or N48.6 For all other diagnoses - See Medicare Medical Part B prior authorization form
Xipere (triamcinolone)	J3299	triamcinolone	Ophthalmic	1 mg	40 mg/mL SDV	Commercial	Not Covered	No	**Not Covered**
Xipere (triamcinolone)	J3299	triamcinolone	Ophthalmic	1 mg	40 mg/mL SDV	Medicaid	Not Covered	No	**Not Covered**
Xipere (triamcinolone)	J3299	triamcinolone	Ophthalmic	1 mg	40 mg/mL SDV	Medicare	NPS	No	PA Required - click here for criteria. Link for the Prior Authorization form is on the 'General Prior Auth Forms' tab.
Xofigo (radium ra-223 dichloride)	A9606	radium ra-223	Radio-pharmaceuticals	per **micro**curie (kBq)	30 **micro**curie/mL, 6 mL SDV (each vial will provide 178 mCi of radioactivity)	Commercial	NPS	No	PA required - see medical oncology prior authorization form for criteria
Xofigo (radium ra-223 dichloride)	A9606	radium ra-223	Radio-pharmaceuticals	per **micro**curie (kBq)	30 **micro**curie/mL, 6 mL SDV (each vial will provide 178 mCi of radioactivity)	Medicaid	Covered	No	No PA Required
Xofigo (radium ra-223 dichloride)	A9606	radium ra-223	Radio-pharmaceuticals	per **micro**curie (kBq)	30 **micro**curie/mL, 6 mL SDV (each vial will provide 178 mCi of radioactivity)	Medicare	Medicare Chemo	No	No PA required
Xolair (omalizumab) **Vial/Prefilled syringe**	J2357	omalizumab	Respiratory Biologic	5 mg	150 mg SDV,; 75 mg, 150 mg SD syringe	Commercial	Pref. Specialty	YES	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth Forms tab.
Xolair (omalizumab) **Vial/Prefilled syringe**	J2357	omalizumab	Respiratory Biologic	5 mg	150 mg SDV,; 75 mg, 150 mg SD syringe	Medicaid	Covered	YES	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth Forms tab.
Xolair (omalizumab) **Vial/Prefilled syringe**	J2357	omalizumab	Respiratory Biologic	5 mg	150 mg SDV,; 75 mg, 150 mg SD syringe	Medicare	Pref. Specialty	No	PA Required - click here for criteria. Link for the Prior Authorization form is on the 'General Prior Auth Forms' tab.
Xolair (omalizumab) ***Autoinjector***	J2357	omalizumab	Respiratory Biologic	5 mg	75mg/0.5 mL, 150mg/mL, 300mg/mL	Commercial	Refer to ADL	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Xolair (omalizumab) ***Autoinjector***	J2357	omalizumab	Respiratory Biologic	5 mg	150 mg SDV,; 75 mg, 150 mg SD syringe	Medicaid	Covered	YES	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth Forms tab.
Xolair (omalizumab) ***Autoinjector***	J2357	omalizumab	Respiratory Biologic	5 mg	75mg/0.5 mL, 150mg/mL, 300mg/mL	Medicare	Pref. Specialty	No	PA Required - click here for criteria. Link for the Prior Authorization form is on the 'General Prior Auth Forms' tab.
Xopenex (levalbuterol) NEBULIZER SOLUTION ONLY	J7612-1.25mg/0.5ml concentrated J7614-all others unit dose	levalbuterol	Inhalation	0.5 mg (J7612) 0.5 mg (J7614)	1.25 mg/0.5 mL SDV; 0.31 mg/3 mL, 0.63 mg/3 mL, 1.25 mg/3 mL SD ampules	Medicare	Non-specialty	No	Part B vs Part D – See Approved Drug List for covered formulations under Part D - see the Part B vs Part D coverage determination form for criteria
Xyntha (Antihemophilic Factor VIII)	J7185	Antihemophilic Factor VIII	Hemophilia			Commercial	Refer to ADL	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Xyntha (Antihemophilic Factor VIII)	J7185	Antihemophilic Factor VIII	Hemophilia			Medicaid	Not Covered	No	Refer to the Medicaid Approved Drug List (ADL) for pharmacy benefit coverage. For one-time doses required for planned outpatient procedures (professional/facility claims), authorizations will be reviewed for medical necessity according to the Hemophilia Management Medical Policy 91569
Xyntha (Antihemophilic Factor VIII)	J7185	Antihemophilic Factor VIII	Hemophilia			Medicare	Pref. Specialty	No	No PA required
Ycanth (cantharidin)	J7354	cantharidin	Miscellaneous	3.2 mg	0.7% topical solution	Commercial	Non-specialty	No	No PA required
Ycanth (cantharidin)	J7354	cantharidin	Miscellaneous	3.2 mg	0.7% topical solution	Medicaid	Covered	No	No PA Required
Ycanth (cantharidin)	J7354	cantharidin	Miscellaneous	3.2 mg	0.7% topical solution	Medicare	Non-specialty	No	No PA required
Yervoy (ipilimumab)	J9228	ipilimumab	Oncology	1 mg	50 mg/10 mL, 200 mg/40 mL SDV	Commercial	Pref. Specialty	YES	PA required - see medical oncology prior authorization form for criteria
Yervoy (ipilimumab)	J9228	ipilimumab	Oncology	1 mg	50 mg/10 mL, 200 mg/40 mL SDV	Medicaid	Covered	No	No PA Required
Yervoy (ipilimumab)	J9228	ipilimumab	Oncology	1 mg	50 mg/10 mL, 200 mg/40 mL SDV	Medicare	Medicare Chemo	No	PA Required (Cancer Therapy) – See Medicare Part B Oncology Prior Authorization form
Yescarta (axicabtagene ciloleucel)	Q2041	axicabtagene ciloleucel	Gene/Cellular Therapy	per dose	SD infusion bag	Commercial	Gene Therapy	YES	PA Required – see medical oncology prior authorization form for criteria. Coverage of Yescarta is dependent on member's eligibility and benefit plan documents. Priority Health may request documentation, not more frequently than biannually, of follow-up patient assessment(s). Yescarta will not be authorized for use in patients with primary central nervous system lymphoma; OR that have received a previous treatment course of Yescarta or another CD19-directed chimeric antigen receptor (CAR) T-cell therapy. The safety and effectiveness of repeat administration have not been evaluated (one treatment per lifetime)
Yescarta (axicabtagene ciloleucel)	Q2041	axicabtagene ciloleucel	Gene/Cellular Therapy	per dose	SD infusion bag	Medicaid	Carve Out	No	Contact Fee for Service Medicaid for coverage
Yescarta (axicabtagene ciloleucel)	Q2041	axicabtagene ciloleucel	Gene/Cellular Therapy	per dose	SD infusion bag	Medicare	Medicare Chemo	No	PA Required - click here for criteria. Link for the Prior Authorization form is on the 'General Prior Auth Forms' tab.
Yondelis (trabectedin)	J9352	trabectedin	Oncology	0.1 mg	1 mg SDV	Commercial	Pref. Specialty	No	PA required - see medical oncology prior authorization form for criteria
Yondelis (trabectedin)	J9352	trabectedin	Oncology	0.1 mg	1 mg SDV	Medicaid	Covered	No	No PA Required
Yondelis (trabectedin)	J9352	trabectedin	Oncology	0.1 mg	1 mg SDV	Medicare	Medicare Chemo	No	PA Required (Cancer Therapy) – See Medicare Part B Oncology Prior Authorization form
Yorvipath (palopegteriparatide)	J3490* C9399*	palopegteriparatide	Miscellaneous		168 mcg/0.56 mL pen 294 mcg/0.98 mL pen 420 mcg/1.4 mL pen	Commercial	Refer to ADL	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Yorvipath (palopegteriparatide)	J3490* C9399*	palopegteriparatide	Miscellaneous		168 mcg/0.56 mL pen 294 mcg/0.98 mL pen 420 mcg/1.4 mL pen	Medicaid	Not Covered	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Yorvipath (palopegteriparatide)	J3490* C9399*	palopegteriparatide	Miscellaneous		168 mcg/0.56 mL pen 294 mcg/0.98 mL pen 420 mcg/1.4 mL pen	Medicare	Refer to ADL	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Yuflyma (adalimumab-aaty)	Q5141	adalimumab	Inflammatory Conditions	1 mg	various	Commercial	Refer to ADL	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Yuflyma (adalimumab-aaty)	Q5141	adalimumab	Inflammatory Conditions	1 mg	various	Medicaid	Not Covered	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Yuflyma (adalimumab-aaty)	Q5141	adalimumab	Inflammatory Conditions	1 mg	various	Medicare	Refer to ADL	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Yupelri (revefenacin)	J7677	revefenacin	inhalation	1 mcg	175 mcg/3 mL SDV	Commercial	Not Covered	No	**Not Covered**
Yupelri (revefenacin)	J7677	revefenacin	inhalation	1 mcg	175 mcg/3 mL SDV	Medicaid	Not Covered	No	**Not Covered**
Yupelri (revefenacin)	J7677	revefenacin	inhalation	1 mcg	175 mcg/3 mL SDV	Medicare	NPS	No	PA Required - click here for criteria. Link for the Prior Authorization form is on the 'General Prior Auth Forms' tab.
Yutiq (fluocinolone implant)	J7314	fluocinolone	Ophthalmic	0.01 mg	0.18 mg implant	Commercial	Pref. Specialty	No	No PA required when billed with the following ICD-10 codes: H30.001-H30.039, H30.20-H30.23,H35.021-H35.029, H35.061-H35.069, H44.111-H44.119
Yutiq (fluocinolone implant)	J7314	fluocinolone	Ophthalmic	0.01 mg	0.18 mg implant	Medicaid	Covered	No	No PA required when billed with the following ICD-10 codes: H30.001-H30.039, H30.20-H30.23,H35.021-H35.029, H35.061-H35.069, H44.111-H44.119
Yutiq (fluocinolone implant)	J7314	fluocinolone	Ophthalmic	0.01 mg	0.18 mg implant	Medicare	Pref. Specialty	No	PA Required - click here for criteria. Link for the Prior Authorization form is on the 'General Prior Auth Forms' tab.
Zaltrap (ziv-aflibercept)	J9400	aflibercept	Oncology	1 mg	100 mg/4 mL, 200 mg/8 mL SDV	Commercial	NPS	No	No PA required
Zaltrap (ziv-aflibercept)	J9400	aflibercept	Oncology	1 mg	100 mg/4 mL, 200 mg/8 mL SDV	Medicaid	Covered	No	No PA required
Zaltrap (ziv-aflibercept)	J9400	aflibercept	Oncology	1 mg	100 mg/4 mL, 200 mg/8 mL SDV	Medicare	NPS	No	No PA required
Zanosar (streptozocin)	J9320	streptozocin	Oncology	1 gm	1 gm SDV	Commercial	Non-specialty	No	No PA required
Zanosar (streptozocin)	J9320	streptozocin	Oncology	1 gm	1 gm SDV	Medicaid	Covered	No	No PA required
Zanosar (streptozocin)	J9320	streptozocin	Oncology	1 gm	1 gm SDV	Medicare	Non-specialty	No	No PA required
Zarxio (filgrastim-sndz)	Q5101	filgrastim	Hematopoietic agent	1 mcg	300 mcg/0.5 mL, 480 mcg/0.8 mL SD syringe	Commercial	Pref. Specialty	No	No PA required
Zarxio (filgrastim-sndz)	Q5101	filgrastim	Hematopoietic agent	1 mcg	300 mcg/0.5 mL, 480 mcg/0.8 mL SD syringe	Medicaid	Covered	No	No PA required
Zarxio (filgrastim-sndz)	Q5101	filgrastim	Hematopoietic agent	1 mcg	300 mcg/0.5 mL, 480 mcg/0.8 mL SD syringe	Medicare	Pref. Specialty	No	No PA required
Zemaira (alpha1 proteinase inhibitor–human)	J0256	alpha1 proteinase inhibitor	Enzyme deficiency	10 mg	1000 mg, 4000 mg, 5000 mg SDV	Commercial	Pref. Specialty	YES	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth Forms tab.

Drug	Code	Generic	Category	Billing Unit	How Supplied	Line of Business	Coverage Level	Site Of Service	Comment
Zemaira (alpha1 proteinase inhibitor–human)	J0256	alpha1 proteinase inhibitor	Enzyme deficiency	10 mg	1000 mg, 4000 mg, 5000 mg SDV	Medicaid	Covered	YES	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth. Forms tab.
Zemaira (alpha1 proteinase inhibitor–human)	J0256	alpha1 proteinase inhibitor	Enzyme deficiency	10 mg	1000 mg, 4000 mg, 5000 mg SDV	Medicare	Pref. Specialty	No	PA required - See Medicare Medical Part B prior authorization form
Zemdri IV (plazomicin)	J0291	plazomicin	Antimicrobial	5 mg	500 mg/10 mL SDV	Commercial	Not covered	No	**Not covered**
Zemdri IV (plazomicin)	J0291	plazomicin	Antimicrobial	5 mg	500 mg/10 mL SDV	Medicaid	Not Covered	No	**Not covered**
Zemdri IV (plazomicin)	J0291	plazomicin	Antimicrobial	5 mg	500 mg/10 mL SDV	Medicare	NPS	No	No PA required
Zepzelca (lurbinectedin)	J9223	lurbinectedin	Oncology	0.1 mg	4 mg SDV	Commercial	Non-specialty	No	PA required - see medical oncology prior authorization form for criteria
Zepzelca (lurbinectedin)	J9223	lurbinectedin	Oncology	0.1 mg	4 mg SDV	Medicaid	Covered	No	No PA Required
Zepzelca (lurbinectedin)	J9223	lurbinectedin	Oncology	0.1 mg	4 mg SDV	Medicare	Medicare Chemo	No	PA Required (Cancer Therapy) – See Medicare Part B Oncology Prior Authorization form
Zerbaxa (ceftolozane/tazobactam)	J0695	ceftolozane and tazobactam	Antimicrobial	50 mg-25 mg	1000 mg-500 mg SDV	Commercial	Pref. Specialty	No	No PA required
Zerbaxa (ceftolozane/tazobactam)	J0695	ceftolozane and tazobactam	Antimicrobial	50 mg-25 mg	1000 mg-500 mg SDV	Medicaid	Covered	No	No PA required
Zerbaxa (ceftolozane/tazobactam)	J0695	ceftolozane and tazobactam	Antimicrobial	50 mg-25 mg	1000 mg-500 mg SDV	Medicare	Pref. Specialty	No	No PA required
Zevalin (ibritumomab tiuxetan for Yttrium-90)	A9543	ibritumomab tiuxetan	Radio-pharmaceuticals	40 millicuries (mCi)	3.2 mg/2 mL kit (radiolabeled with 40 mCi of Y-90)	Commercial	Pref. Specialty	No	PA required - see medical oncology prior authorization form for criteria
Zevalin (ibritumomab tiuxetan for Yttrium-90)	A9543	ibritumomab tiuxetan	Radio-pharmaceuticals	40 millicuries (mCi)	3.2 mg/2 mL kit (radiolabeled with 40 mCi of Y-90)	Medicaid	Covered	No	No PA Required
Zevalin (ibritumomab tiuxetan for Yttrium-90)	A9543	ibritumomab tiuxetan	Radio-pharmaceuticals	40 millicuries (mCi)	3.2 mg/2 mL kit (radiolabeled with 40 mCi of Y-90)	Medicare	Pref. Specialty	No	PA Required (Cancer Therapy) – See Medicare Part B Oncology Prior Authorization form
Ziextenzo (pegfilgrastim-bmez)	Q5120	pegfilgrastim	Hematopoietic agent	0.5 mg	6 mg/0.6 mL SD syringe	Commercial	Not Covered	No	**Not covered**
Ziextenzo (pegfilgrastim-bmez)	Q5120	pegfilgrastim	Hematopoietic agent	0.5 mg	6 mg/0.6 mL SD syringe	Medicaid	Not Covered	No	**Not covered**
Ziextenzo (pegfilgrastim-bmez)	Q5120	pegfilgrastim	Hematopoietic agent	0.5 mg	6 mg/0.6 mL SD syringe	Medicare	NPS	No	PA Required - click here for criteria. Link for the Prior Authorization form is on the 'General Prior Auth. Forms' tab.
Zilbrysq (zilucoplan)	J3490* C9399*	zilucoplan	Myasthenia Gravis	Additional information required: National Drug Code (NDC), Strength, Dosage administered, Route of administration.	16.6 mg/0.416 mL, 23 mg/0.574 mL, and 32.4 mg/0.81 mL prefilled syringes	Commercial	Refer to ADL	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Zilbrysq (zilucoplan)	J3490* C9399*	zilucoplan	Myasthenia Gravis	Additional information required: National Drug Code (NDC), Strength, Dosage administered, Route of administration.	16.6 mg/0.416 mL, 23 mg/0.574 mL, and 32.4 mg/0.81 mL prefilled syringes	Medicaid	Refer to ADL	No	This drug is not covered under the medical benefit. Refer to the Approved Drug List (ADL) for coverage under the pharmacy benefit
Zilbrysq (zilucoplan)	J3490* C9399*	zilucoplan	Myasthenia Gravis	Additional information required: National Drug Code (NDC), Strength, Dosage administered, Route of administration.	16.6 mg/0.416 mL, 23 mg/0.574 mL, and 32.4 mg/0.81 mL prefilled syringes	Medicare	NPS	No	PA Required - click here for criteria. Link for the Prior Authorization form is on the 'General Prior Auth. Forms' tab.
Zilretta (triamcinolone)	J3304	triamcinolone	Steroid	1 mg	32 mg SDV	Commercial	Not covered	No	**Not covered**
Zilretta (triamcinolone)	J3304	triamcinolone	Steroid	1 mg	32 mg SDV	Medicaid	Not Covered	No	**Not covered**
Zilretta (triamcinolone)	J3304	triamcinolone	Steroid	1 mg	32 mg SDV	Medicare	Non-specialty	No	No PA required
Zimhi (naltrexone hydrochloride) Brand ONLY	J2311	naltrexone	Opioid Overdose	1 mg	5mg/0.5ml syringe	Commercial	Non-specialty	No	No PA required
Zimhi (naltrexone hydrochloride) Brand ONLY	J2311	naltrexone	Opioid Overdose	1 mg	5mg/0.5ml syringe	Medicaid	Carve Out	No	Contact Fee for Service Medicaid for coverage
Zimhi (naltrexone hydrochloride) Brand ONLY	J2311	naltrexone	Opioid Overdose	1 mg	5mg/0.5ml syringe	Medicare	Non-specialty	No	No PA required
Zinecard (dexrazoxane)	J1190	dexrazoxane	Oncology	250 mg	250 mg, 500 mg SDV	Commercial	Non-specialty	No	No PA required
Zinecard (dexrazoxane)	J1190	dexrazoxane	Oncology	250 mg	250 mg, 500 mg SDV	Medicaid	Covered	No	No PA required
Zinecard (dexrazoxane)	J1190	dexrazoxane	Oncology	250 mg	250 mg, 500 mg SDV	Medicare	Non-specialty	No	No PA required
Zinplava (bezlotoxumab)	J0565	bezlotoxumab	Miscellaneous	10 mg	1000 mg/40 mL SDV	Commercial	Not covered	No	**Not covered**
Zinplava (bezlotoxumab)	J0565	bezlotoxumab	Miscellaneous	10 mg	1000 mg/40 mL SDV	Medicaid	Not Covered	No	**Not covered**
Zinplava (bezlotoxumab)	J0565	bezlotoxumab	Miscellaneous	10 mg	1000 mg/40 mL SDV	Medicare	Pref. Specialty	No	PA required - See Medicare Medical Part B prior authorization form
ziprasidone	J3486	ziprasidone	Central Nervous System (CNS) agent	10 mg	20 mg SDV	Commercial	Non-specialty	No	No PA required
ziprasidone	J3486	ziprasidone	Central Nervous System (CNS) agent	10 mg	20 mg SDV	Medicaid	Carve Out	No	Contact Fee for Service Medicaid for coverage
ziprasidone	J3486	ziprasidone	Central Nervous System (CNS) agent	10 mg	20 mg SDV	Medicare	Non-specialty	No	No PA required
Zirabev (bevacizumab-bvzr, biosimilar)	Q5118	bevacizumab	Oncology	10 mg	100 mg/4 mL, 400 mg/16 mL SDV	Commercial	Pref. Specialty	No	No PA required
Zirabev (bevacizumab-bvzr, biosimilar)	Q5118	bevacizumab	Oncology	10 mg	100 mg/4 mL, 400 mg/16 mL SDV	Medicaid	Covered	No	No PA required
Zirabev (bevacizumab-bvzr, biosimilar)	Q5118	bevacizumab	Oncology	10 mg	100 mg/4 mL, 400 mg/16 mL SDV	Medicare	Medicare Chemo	No	No PA required
Zofran (ondansetron) IV	J2405	ondansetron	Antiemetic	1 mg	4 mg/2 mL SD vial/syringe; 40 mg/20 mL MDV	Commercial	Non-specialty	No	No PA required
Zofran (ondansetron) IV	J2405	ondansetron	Antiemetic	1 mg	4 mg/2 mL SD vial/syringe; 40 mg/20 mL MDV	Medicaid	Covered	No	No PA required
Zofran (ondansetron) IV	J2405	ondansetron	Antiemetic	1 mg	4 mg/2 mL SD vial/syringe; 40 mg/20 mL MDV	Medicare	Non-specialty	No	No PA required
Zofran (ondansetron) ORAL ONLY	Q0162	ondansetron	Antiemetic	1 mg	4 mg, 8 mg, 24 mg tablet; 4mg, 8mg, 16 mg ODT, 4 mg/5 mL oral solution	Medicare	Non-specialty	No	Part B vs Part D – See Approved Drug List for covered formulations under Part D - see the Part B vs Part D coverage determination form for criteria
Zoladex (goserlin acetate implant)	J9202	goserlin	Oncology	3.6 mg	3.6 mg, 10.8 mg implant	Commercial	Pref. Specialty	No	No PA required
Zoladex (goserlin acetate implant)	J9202	goserlin	Oncology	3.6 mg	3.6 mg, 10.8 mg implant	Medicaid	Covered	No	No PA required
Zoladex (goserlin acetate implant)	J9202	goserlin	Oncology	3.6 mg	3.6 mg, 10.8 mg implant	Medicare	Pref. Specialty	No	No PA required
Zoledronic acid (generic for **Reclast** & **Zometa**)	J3489	zoledronic acid	Bone modifying agent	1 mg	Reclast generic: 5 mg/100 mL SD bag Zometa generic: 4 mg/5 mL SDV, 4 mg/100 mL SD bag	Commercial	Non-specialty	No	No PA required

Drug	Code	Generic	Category	Billing Unit	How Supplied	Line of Business	Coverage Level	Site Of Service	Comment
Zoledronic acid (generic for **Reclast** & **Zometa**)	J3489	zoledronic acid	Bone modifying agent	1 mg	Reclast generic: 5 mg/100 mL SD bag Zometa generic: 4 mg/5 mL SDV, 4 mg/100 mL SD bag	Medicaid	Covered	No	No PA required
Zoledronic acid (generic for **Reclast** & **Zometa**)	J3489	zoledronic acid	Bone modifying agent	1 mg	Reclast generic: 5 mg/100 mL SD bag Zometa generic: 4 mg/5 mL SDV, 4 mg/100 mL SD bag	Medicare	Non-specialty	No	No PA required
Zolgensma (onasemnogene abeparvovec)	J3399	onasemnogene abeparvovec	Gene/Cellular Therapy	5 x 10^15 vector genomes	5.5 mL or 8.3 mL SDV (each kit will provide sufficient number of vials based on patient weight)	Commercial	Gene Therapy	YES	PA required - click here for criteria. Link for the Prior Authorization form is on the General Prior Auth Forms tab.
Zolgensma (onasemnogene abeparvovec)	J3399	onasemnogene abeparvovec	Gene/Cellular Therapy	5 x 10^15 vector genomes	5.5 mL or 8.3 mL SDV (each kit will provide sufficient number of vials based on patient weight)	Medicaid	Carve Out	No	Contact Fee for Service Medicaid for coverage
Zolgensma (onasemnogene abeparvovec)	J3399	onasemnogene abeparvovec	Gene/Cellular Therapy	5 x 10^15 vector genomes	5.5 mL or 8.3 mL SDV (each kit will provide sufficient number of vials based on patient weight)	Medicare	Gene Therapy	No	PA Required - click here for criteria. Link for the Prior Authorization form is on the 'General Prior Auth Forms' tab.
Zortress (everolimus)	J7527	everolimus	Immunosuppressive agent	0.25 mg	0.25 mg, 0.5 mg, 0.75 mg, 1 mg tablet	Medicare	Non-specialty	No	Part B vs Part D – See Approved Drug List for covered formulations under Part D - see the Part B vs Part D coverage determination form for criteria.
Zosyn (piperacillin/ tazobactam)	J2543	piperacillin and tazobactam	Antimicrobial	1 gm-0.125 gm (1.125 gm)	2.25 gm, 3.375 gm, 4.5 gm SDV	Commercial	Non-specialty	No	No PA required
Zosyn (piperacillin/ tazobactam)	J2543	piperacillin and tazobactam	Antimicrobial	1 gm-0.125 gm (1.125 gm)	2.25 gm, 3.375 gm, 4.5 gm SDV	Medicaid	Covered	No	No PA required
Zosyn (piperacillin/ tazobactam)	J2543	piperacillin and tazobactam	Antimicrobial	1 gm-0.125 gm (1.125 gm)	2.25 gm, 3.375 gm, 4.5 gm SDV	Medicare	Non-specialty	No	No PA required
Zovirax (acyclovir) INJECTION ONLY	J0133	acyclovir	Antimicrobial	5 mg	500 mg, 1000 mg SDV	Medicare		No	Part B vs Part D – See Approved Drug List for covered formulations under Part D - see the Part B vs Part D coverage determination form for criteria.
Zulresso (brexanolone)	J1632	brexanolone	Central Nervous System (CNS) agent	1 mg	100 mg/20 mL SDV	Commercial	NPS	No	No PA required when billed for the following ICD-10 Code: F53.0. For all other diagnoses, complete the General Medical PA form.
Zulresso (brexanolone)	J1632	brexanolone	Central Nervous System (CNS) agent	1 mg	100 mg/20 mL SDV	Medicaid	Carve Out	No	Contact Fee for Service Medicaid for coverage
Zulresso (brexanolone)	J1632	brexanolone	Central Nervous System (CNS) agent	1 mg		Medicare	NPS	No	No PA required
Zymfentra (infliximab-dyyb)	J1748	infliximab	Inflammatory Conditions	10 mg	120 mg/mL prefilled syringe and prefilled pen	Commercial	Not Covered	No	**Not Covered**
Zymfentra (infliximab-dyyb)	J1748	infliximab	Inflammatory Conditions	10 mg	120 mg/mL prefilled syringe and prefilled pen	Medicaid	Not Covered	No	**Not Covered**
Zymfentra (infliximab-dyyb)	J1748	infliximab	Inflammatory Conditions	10 mg	120 mg/mL prefilled syringe and prefilled pen	Medicare	NPS	No	PA Required - click here for criteria. Link for the Prior Authorization form is on the 'General Prior Auth Forms' tab.
Zynlonta (loncastuximab teririne-lpyl)	J9359	loncastuximab	Oncology	0.075mg	10mg SDV	Commercial	Pref. Specialty	No	PA required - see medical oncology prior authorization form for criteria.
Zynlonta (loncastuximab teririne-lpyl)	J9359	loncastuximab	Oncology	0.075mg	10mg SDV	Medicaid	Covered	No	No PA Required
Zynlonta (loncastuximab teririne-lpyl)	J9359	loncastuximab	Oncology	0.075mg	10mg SDV	Medicare	Medicare Chemo	No	PA Required (Cancer Therapy) – See Medicare Part B Oncology Prior Authorization form.
Zynrelef (bupivacaine/meloxicam)	J3490, C9088	bupivacaine/ meloxicam	miscellaneous	Additional information required: National Drug Code (NDC), Strength, Dosage administered, Route of administration.	400 mg/12 mg 14 ml SDV, 300 mg/9 mg 10.5 ml SDV, 200 mg/6 mg 7 ml SDV, 60 mg/1.8 mg 2.3 ml SDV	Commercial	Not Covered	No	**Not Covered**
Zynrelef (bupivacaine/meloxicam)	J3490, C9088	bupivacaine/ meloxicam	miscellaneous	Additional information required: National Drug Code (NDC), Strength, Dosage administered, Route of administration.	401 mg/12 mg 14 ml SDV, 300 mg/9 mg 10.5 ml SDV, 200 mg/6 mg 7 ml SDV, 60 mg/1.8 mg 2.3 ml SDV	Medicaid	Not Covered	No	**Not Covered**
Zynrelef (bupivacaine/meloxicam)	J3490, C9088	bupivacaine/ meloxicam	miscellaneous	Additional information required: National Drug Code (NDC), Strength, Dosage administered, Route of administration.	402 mg/12 mg 14 ml SDV, 300 mg/9 mg 10.5 ml SDV, 200 mg/6 mg 7 ml SDV, 60 mg/1.8 mg 2.3 ml SDV	Medicare	non-specialty	No	Only covered for medically accepted indications
Zynteglo (betibeglogene autotemcel)	J3393	elivaldogene autotemcel	Gene/Cellular Therapy	Per treatment	20mL infusion bag	Commercial	Not Covered	No	**Not Covered**
Zynteglo (betibeglogene autotemcel)	J3393	elivaldogene autotemcel	Gene/Cellular Therapy	Per treatment	20mL infusion bag	Medicaid	Carve Out	No	Contact Fee for Service Medicaid for coverage
Zynteglo (betibeglogene autotemcel)	J3393	elivaldogene autotemcel	Gene/Cellular Therapy	Per treatment	20mL infusion bag	Medicare	Gene Therapy	No	PA Required - click here for criteria. Link for the Prior Authorization form is on the 'General Prior Auth Forms' tab.
Zynyz (retifanlimab-dlwr)	J9345	retifanlimab	Oncology	1 mg		Commercial	Pref. Specialty	YES	PA required - see medical oncology prior authorization form for criteria.
Zynyz (retifanlimab-dlwr)	J9345	retifanlimab	Oncology	1 mg		Medicaid	Covered	No	No PA Required
Zynyz (retifanlimab-dlwr)	J9345	retifanlimab	Oncology	1 mg		Medicare	Medicare Chemo	No	PA Required (Cancer Therapy) – See Medicare Part B Oncology Prior Authorization form.
Zyprexa (olanzapine)	J2359	olanzapine	Central Nervous System (CNS) agent	0.5 mg	20 mg SDV	Commercial	Pref. Specialty	No	No PA required
Zyprexa (olanzapine)	J2359	olanzapine	Central Nervous System (CNS) agent	0.5 mg	20 mg SDV	Medicaid	Carve Out	No	Contact Fee for Service Medicaid for coverage
Zyprexa (olanzapine)	J2359	olanzapine	Central Nervous System (CNS) agent	0.5 mg	20 mg SDV	Medicare	Pref. Specialty	No	No PA required
Zyprexa Relprevv (olanzapine, long-acting)	J2358	olanzapine	Central Nervous System (CNS) agent	1 mg	210 mg, 300 mg, 405 mg SDV	Commercial	Pref. Specialty	No	No PA required
Zyprexa Relprevv (olanzapine, long-acting)	J2358	olanzapine	Central Nervous System (CNS) agent	1 mg	210 mg, 300 mg, 405 mg SDV	Medicaid	Carve Out	No	Contact Fee for Service Medicaid for coverage
Zyprexa Relprevv (olanzapine, long-acting)	J2358	olanzapine	Central Nervous System (CNS) agent	1 mg	210 mg, 300 mg, 405 mg SDV	Medicare	Pref. Specialty	No	No PA required
Zyvox IV (linezolid)	J2020	linezolid	Antimicrobial	200 mg	200 mg/100 mL, 600 mg/300 mL SD bag	Commercial	Not Covered	No	**Brand not covered, use generic**
Zyvox IV (linezolid)	J2020	linezolid	Antimicrobial	200 mg	200 mg/100 mL, 600 mg/300 mL SD bag	Medicaid	Not Covered	No	**Brand not covered, use generic**
Zyvox IV (linezolid)	J2020	linezolid	Antimicrobial	200 mg	200 mg/100 mL, 600 mg/300 mL SD bag	Medicare	Pref. Specialty	No	PA required - See Medicare Medical Part B prior authorization form