



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

ABALOPARATIDE

Products Affected

- TYMLOS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	24 MONTHS
Other Criteria	OSTEOPOROSIS: HAS NOT RECEIVED A TOTAL OF 24 MONTHS CUMULATIVE TREATMENT WITH ANY PARATHYROID HORMONE THERAPY.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

ABATACEPT IV

Products Affected

- ORENCIA (WITH MALTOSE)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	INITIAL: RHEUMATOID ARTHRITIS (RA), POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS (PJIA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST. PSORIATIC ARTHRITIS (PSA): PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST OR RHEUMATOLOGIST.
Coverage Duration	RA, PJIA, PSA: INITIAL: 6 MOS, RENEWAL: 12 MOS. ACUTE GRAFT VERSUS HOST DISEASE (AGVHD): 1 MO.
Other Criteria	INITIAL: RA: TRIAL OF OR CONTRAINDICATION TO 3 MONTHS OF TREATMENT WITH ONE DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG) - IF PATIENT TRIED METHOTREXATE, THEN TRIAL AT A DOSE GREATER THAN OR EQUAL TO 20 MG PER WEEK OR MAXIMALLY TOLERATED DOSE IS REQUIRED. PJIA: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR PJIA. PSA: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR PSA. RENEWAL: RA: CONTINUES TO BENEFIT FROM THE MEDICATION. PJIA: 1) CONTINUES TO BENEFIT FROM THE MEDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR PJIA. PSA: 1) CONTINUES TO BENEFIT FROM THE MEDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR PSA.
Indications	All FDA-approved Indications.

Updated: 11.01.2025

Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

PA Criteria	Criteria Details
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

ABATACEPT SQ

Products Affected

- ORENCIA
- ORENCIA CLICKJECT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	INITIAL: RHEUMATOID ARTHRITIS (RA), POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS (PJIA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST. PSORIATIC ARTHRITIS (PSA): PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST OR RHEUMATOLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	INITIAL: RA: TRIAL OF OR CONTRAINDICATION TO 3 MONTHS OF TREATMENT WITH ONE DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG) - IF PATIENT TRIED METHOTREXATE, THEN TRIAL AT A DOSE GREATER THAN OR EQUAL TO 20 MG PER WEEK OR MAXIMALLY TOLERATED DOSE IS REQUIRED. PJIA: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR PJIA. PSA: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR PSA. RENEWAL: RA: CONTINUES TO BENEFIT FROM THE MEDICATION. PJIA: 1) CONTINUES TO BENEFIT FROM THE MEDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR PJIA. PSA: 1) CONTINUES TO BENEFIT FROM THE MEDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR PSA.
Indications	All FDA-approved Indications.

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

PA Criteria	Criteria Details
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

ABEMACICLIB

Products Affected

- VERZENIO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

ABIRATERONE

Products Affected

- *abiraterone*
- *abirtega*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	METASTATIC HIGH-RISK CASTRATION-SENSITIVE PROSTATE CANCER (MCSPC), METASTATIC CASTRATION-RESISTANT PROSTATE CANCER (MCRPC): 1) RECEIVED A BILATERAL ORCHIECTOMY, 2) CASTRATE LEVEL OF TESTOSTERONE (I.E., LESS THAN 50 NG/DL), OR 3) CONCURRENT USE WITH A GONADOTROPIN RELEASING HORMONE (GNRH) ANALOG
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

ABIRATERONE SUBMICRONIZED

Products Affected

- YONSA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	METASTATIC CASTRATION-RESISTANT PROSTATE CANCER (MCRPC): 1) RECEIVED A BILATERAL ORCHIECTOMY, 2) CASTRATE LEVEL OF TESTOSTERONE (I.E., LESS THAN 50 NG/DL), OR 3) CONCURRENT USE WITH A GONADOTROPIN RELEASING HORMONE (GNRH) ANALOG.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

ACALABRUTINIB

Products Affected

- CALQUENCE
- CALQUENCE (ACALABRUTINIB MAL)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

ADAGRASIB

Products Affected

- KRAZATI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

ADALIMUMAB

Products Affected

- HUMIRA PEN
- HUMIRA PEN CROHNS-UC-HS START
- HUMIRA PEN PSOR-UVEITS-ADOL HS
- HUMIRA SUBCUTANEOUS SYRINGE KIT 40 MG/0.8 ML
- HUMIRA(CF)
- HUMIRA(CF) PEDI CROHNS STARTER
- HUMIRA(CF) PEN
- HUMIRA(CF) PEN CROHNS-UC-HS
- HUMIRA(CF) PEN PEDIATRIC UC
- HUMIRA(CF) PEN PSOR-UV-ADOL HS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: PLAQUE PSORIASIS (PSO): PSORIASIS COVERING 3 PERCENT OR MORE OF BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, FACE, SCALP, OR GENITAL AREA.
Age Restrictions	
Prescriber Restrictions	INITIAL: RA, PJIA, ANKYLOSING SPONDYLITIS (AS): PRESCRIBED BY OR IN CONSULTATION WITH RHEUMATOLOGIST. PSORIATIC ARTHRITIS (PSA): PRESCRIBED BY OR IN CONSULTATION WITH DERMATOLOGIST OR RHEUMATOLOGIST. PSO, HIDRADENITIS SUPPURATIVA (HS): PRESCRIBED BY OR IN CONSULTATION WITH DERMATOLOGIST. CROHNS DISEASE (CD), ULCERATIVE COLITIS (UC): PRESCRIBED BY OR IN CONSULTATION WITH GASTROENTEROLOGIST. UVEITIS: PRESCRIBED BY OR IN CONSULTATION WITH OPHTHALMOLOGIST
Coverage Duration	INITIAL: RA, PSO, PJIA, AS, PSA, CD, UC, UVEITIS: 6 MONTHS, HS: 12 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	INITIAL: RHEUMATOID ARTHRITIS (RA): TRIAL OF OR CONTRAINDICATION TO 3 MONTHS OF TREATMENT WITH ONE DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG) - IF PATIENT TRIED METHOTREXATE, THEN TRIAL AT A DOSE GREATER THAN OR EQUAL TO 20 MG PER WEEK OR MAXIMALLY TOLERATED DOSE IS REQUIRED.

Updated: 11.01.2025
Y0150_PBM200_C (v2)

PA Criteria	Criteria Details
	POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS (PJIA): NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR PJIA. PSA: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR PSA. AS: 1) TRIAL OF OR CONTRAINDICATION TO AN NSAID AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR AS. PSO: 1) ONE OF THE FOLLOWING: (A) AT LEAST A 3 MONTH TRIAL OF ONE ORAL IMMUNOSUPPRESSANT (CYCLOSPORINE, METHOTREXATE, TACROLIMUS) OR PUVA (PHOTOTHERAPY) FOR THE TREATMENT OF PSO, (B) CONTRAINDICATION OR INTOLERANCE TO BOTH IMMUNOSUPPRESSANT AND PUVA FOR THE TREATMENT OF PSO, OR (C) PATIENT IS SWITCHING FROM A DIFFERENT BIOLOGIC, PDE-4 INHIBITOR, OR JAK INHIBITOR FOR THE SAME INDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR PSO. CD: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR CD. UC: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR UC. HS: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR HS. UVEITIS: NO ISOLATED ANTERIOR UVEITIS. RENEWAL: RA, HS, UVEITIS: CONTINUES TO BENEFIT FROM THE MEDICATION. PJIA: 1) CONTINUES TO BENEFIT FROM MEDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR PJIA. PSA: 1) CONTINUES TO BENEFIT FROM MEDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR PSA. AS: 1) CONTINUES TO BENEFIT FROM MEDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR AS. PSO: 1) CONTINUES TO BENEFIT FROM THE MEDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR PSO. CD: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR CD. UC: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR UC.



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

ADALIMUMAB-AATY

Products Affected

- YUFLYMA(CF)
- YUFLYMA(CF) AI CROHN'S-UC-HS
- YUFLYMA(CF) AUTOINJECTOR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: PLAQUE PSORIASIS (PSO): PSORIASIS COVERING 3 PERCENT OR MORE OF BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, FACE, SCALP, OR GENITAL AREA.
Age Restrictions	
Prescriber Restrictions	INITIAL: RA, PJIA, ANKYLOSING SPONDYLITIS (AS): PRESCRIBED BY OR IN CONSULTATION WITH RHEUMATOLOGIST. PSORIATIC ARTHRITIS (PSA): PRESCRIBED BY OR IN CONSULTATION WITH DERMATOLOGIST OR RHEUMATOLOGIST. PSO, HIDRADENITIS SUPPURATIVA (HS): PRESCRIBED BY OR IN CONSULTATION WITH DERMATOLOGIST. CROHNS DISEASE (CD), ULCERATIVE COLITIS (UC): PRESCRIBED BY OR IN CONSULTATION WITH GASTROENTEROLOGIST. UVEITIS: PRESCRIBED BY OR IN CONSULTATION WITH OPHTHALMOLOGIST
Coverage Duration	INITIAL: RA, PSO, PJIA, AS, PSA, CD, UC, UVEITIS: 6 MONTHS, HS: 12 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	INITIAL: RHEUMATOID ARTHRITIS (RA): TRIAL OF OR CONTRAINDICATION TO 3 MONTHS OF TREATMENT WITH ONE DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG) - IF PATIENT TRIED METHOTREXATE, THEN TRIAL AT A DOSE GREATER THAN OR EQUAL TO 20 MG PER WEEK OR MAXIMALLY TOLERATED DOSE IS REQUIRED. POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS (PJIA): NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR PJIA. PSA: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR PSA. AS: 1) TRIAL OF OR CONTRAINDICATION TO AN NSAID AND 2) NO CONCURRENT

Updated: 11.01.2025

Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

PA Criteria	Criteria Details
	USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR AS. PSO: 1) ONE OF THE FOLLOWING: (A) AT LEAST A 3 MONTH TRIAL OF ONE ORAL IMMUNOSUPPRESSANT (CYCLOSPORINE, METHOTREXATE, TACROLIMUS) OR PUVA (PHOTOTHERAPY) FOR THE TREATMENT OF PSO, (B) CONTRAINDICATION OR INTOLERANCE TO BOTH IMMUNOSUPPRESSANT AND PUVA FOR THE TREATMENT OF PSO, OR (C) PATIENT IS SWITCHING FROM A DIFFERENT BIOLOGIC, PDE-4 INHIBITOR, OR JAK INHIBITOR FOR THE SAME INDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR PSO. CD: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR CD. UC: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR UC. HS: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR HS. UVEITIS: NO ISOLATED ANTERIOR UVEITIS. RENEWAL: RA, HS, UVEITIS: CONTINUES TO BENEFIT FROM MEDICATION. PJIA: 1) CONTINUES TO BENEFIT FROM MEDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR PJIA. PSA: 1) CONTINUES TO BENEFIT FROM MEDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR PSA. AS: 1) CONTINUES TO BENEFIT FROM MEDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR AS. PSO: 1) CONTINUES TO BENEFIT FROM MEDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR PSO. CD: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR CD. UC: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR UC.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

ADALIMUMAB-ADBIM

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: PLAQUE PSORIASIS (PSO): PSORIASIS COVERING 3 PERCENT OR MORE OF BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, FACE, SCALP, OR GENITAL AREA.
Age Restrictions	
Prescriber Restrictions	INITIAL: RA, PJIA, ANKYLOSING SPONDYLITIS (AS): PRESCRIBED BY OR IN CONSULTATION WITH RHEUMATOLOGIST. PSORIATIC ARTHRITIS (PSA): PRESCRIBED BY OR IN CONSULTATION WITH DERMATOLOGIST OR RHEUMATOLOGIST. PSO, HIDRADENITIS SUPPURATIVA (HS): PRESCRIBED BY OR IN CONSULTATION WITH DERMATOLOGIST. CROHN'S DISEASE (CD), ULCERATIVE COLITIS (UC): PRESCRIBED BY OR IN CONSULTATION WITH GASTROENTEROLOGIST. UVEITIS: PRESCRIBED BY OR IN CONSULTATION WITH OPHTHALMOLOGIST
Coverage Duration	INITIAL: RA, PSO, PJIA, AS, PSA, CD, UC, UVEITIS: 6 MONTHS, HS: 12 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	INITIAL: RHEUMATOID ARTHRITIS (RA): TRIAL OF OR CONTRAINDICATION TO 3 MONTHS OF TREATMENT WITH ONE DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG) - IF PATIENT TRIED METHOTREXATE, THEN TRIAL AT A DOSE GREATER THAN OR EQUAL TO 20 MG PER WEEK OR MAXIMALLY TOLERATED DOSE IS REQUIRED. POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS (PJIA): NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR PJIA. PSA: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR PSA. AS: 1) TRIAL OF OR

Updated: 11.01.2025

Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

PA Criteria	Criteria Details
	CONTRAINDICATION TO AN NSAID AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR AS. PSO: 1) ONE OF THE FOLLOWING: (A) AT LEAST A 3 MONTH TRIAL OF ONE ORAL IMMUNOSUPPRESSANT (CYCLOSPORINE, METHOTREXATE, TACROLIMUS) OR PUVA (PHOTOTHERAPY) FOR THE TREATMENT OF PSO, (B) CONTRAINDICATION OR INTOLERANCE TO BOTH IMMUNOSUPPRESSANT AND PUVA FOR THE TREATMENT OF PSO, OR (C) PATIENT IS SWITCHING FROM A DIFFERENT BIOLOGIC, PDE-4 INHIBITOR, OR JAK INHIBITOR FOR THE SAME INDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR PSO. CD: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR CD. UC: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR UC. HS: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR HS. UVEITIS: NO ISOLATED ANTERIOR UVEITIS. RENEWAL: RA, HS, UVEITIS: CONTINUES TO BENEFIT FROM MEDICATION. PJIA: 1) CONTINUES TO BENEFIT FROM MEDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR PJIA. PSA: 1) CONTINUES TO BENEFIT FROM MEDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR PSA. AS: 1) CONTINUES TO BENEFIT FROM MEDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR AS. PSO: 1) CONTINUES TO BENEFIT FROM MEDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR PSO. CD: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR CD. UC: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR UC.
Indications	All FDA-approved Indications.
Off Label Uses	

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

PA Criteria	Criteria Details
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

AFATINIB

Products Affected

- GILOTRIF

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	METASTATIC NON-SMALL CELL LUNG CANCER (NSCLC) WITH EGFR MUTATION: NOT ON CONCURRENT THERAPY WITH AN EGFR TYROSINE KINASE INHIBITOR.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

ALECTINIB

Products Affected

- ALECENSA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

ALPELISIB-PIQRAY

Products Affected

- PIQRAY ORAL TABLET 200 MG/DAY (200 MG X 1), 250 MG/DAY (200 MG X 1-50 MG X1), 300 MG/DAY (150 MG X 2)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

AMIKACIN LIPOSOMAL INH

Products Affected

- ARIKAYCE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	MYCOBACTERIUM AVIUM COMPLEX (MAC) LUNG DISEASE: RENEWAL: 1) NO POSITIVE MAC SPUTUM CULTURE AFTER CONSECUTIVE NEGATIVE CULTURES, AND 2) IMPROVEMENT IN SYMPTOMS. ADDITIONALLY, FOR FIRST RENEWAL, APPROVAL REQUIRES AT LEAST ONE NEGATIVE SPUTUM CULTURE FOR MAC BY SIX MONTHS OF ARIKAYCE TREATMENT. FOR SECOND AND SUBSEQUENT RENEWALS, APPROVAL REQUIRES AT LEAST THREE NEGATIVE SPUTUM CULTURES FOR MAC BY 12 MONTHS OF ARIKAYCE TREATMENT.
Age Restrictions	
Prescriber Restrictions	MAC LUNG DISEASE: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A PULMONOLOGIST OR INFECTIOUS DISEASE SPECIALIST.
Coverage Duration	INITIAL/RENEWAL: 6 MONTHS.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

AMIVANTAMAB-VMJW

Products Affected

- RYBREVANT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

ANAKINRA

Products Affected

- KINERET

PA Criteria	Criteria Details
Exclusion Criteria	CORONAVIRUS DISEASE 2019 (COVID-19) IN HOSPITALIZED ADULTS.
Required Medical Information	INITIAL: CRYOPYRIN-ASSOCIATED PERIODIC SYNDROMES (CAPS): 1) ONE OF THE FOLLOWING: (A) GENETIC TEST FOR GAIN-OF-FUNCTION MUTATIONS IN THE NLRP3 GENE, OR (B) HAS INFLAMMATORY MARKERS (I.E., ELEVATED CRP, ESR, SERUM AMYLOID A PROTEIN (SAA) OR S100 PROTEINS), AND 2) TWO OF THE FOLLOWING: URTICARIAL-LIKE RASH (NEUTROPHILIC DERMATITIS), COLD-TRIGGERED EPISODES, SENSORINEURAL HEARING LOSS, MUSCULOSKELETAL SYMPTOMS, CHRONIC ASEPTIC MENINGITIS, SKELETAL ABNORMALITIES. DEFICIENCY OF INTERLEUKIN-1 RECEPTOR ANTAGONIST (DIRA): 1) ONE OF THE FOLLOWING: (A) GENETIC TEST FOR GAIN-OF-FUNCTION MUTATIONS IN THE IL1RN GENE, OR (B) HAS INFLAMMATORY MARKERS (I.E., ELEVATED CRP, ESR), AND 2) ONE OF THE FOLLOWING: PUSTULAR PSORIASIS-LIKE RASHES, OSTEOMYELITIS, ABSENCE OF BACTERIAL OSTEOMYELITIS, ONYCHOMADESIS.
Age Restrictions	
Prescriber Restrictions	INITIAL: RHEUMATOID ARTHRITIS (RA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST.
Coverage Duration	RA: INITIAL: 6 MONTHS, RENEWAL: 12 MONTHS. CAPS, DIRA: LIFETIME.
Other Criteria	INITIAL: RA: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: ENBREL, HUMIRA/CYLTEZO/YUFLYMA, XELJANZ, RINVOQ, ORENCIA. CAPS, DIRA: NO CONCURRENT USE WITH OTHER IL-1 INHIBITORS. RENEWAL: RA: CONTINUES TO BENEFIT FROM THE MEDICATION.
Indications	All FDA-approved Indications.



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

PA Criteria	Criteria Details
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

APALUTAMIDE

Products Affected

- ERLEADA ORAL TABLET 240 MG, 60 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL/RENEWAL: 12 MONTHS.
Other Criteria	INITIAL: NON-METASTATIC CASTRATION-RESISTANT PROSTATE CANCER (NMCRPC): HIGH RISK PROSTATE CANCER (I.E., RAPIDLY INCREASING PROSTATE SPECIFIC ANTIGEN [PSA] LEVELS). NMCRPC, METASTATIC CASTRATION-SENSITIVE PROSTATE CANCER (MCSPC): 1) RECEIVED A BILATERAL ORCHIECTOMY, 2) CASTRATE LEVEL OF TESTOSTERONE (I.E., LESS THAN 50 NG/DL), OR 3) CONCURRENT USE WITH A GONADOTROPIN RELEASING HORMONE (GNRH) ANALOG. RENEWAL: NMCRPC, MCSPC: 1) RECEIVED A BILATERAL ORCHIECTOMY, 2) CASTRATE LEVEL OF TESTOSTERONE (I.E., LESS THAN 50 NG/DL), OR 3) CONCURRENT USE WITH A GNRH ANALOG.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

APOMORPHINE - ONAPGO

Products Affected

- ONAPGO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	PARKINSONS DISEASE (PD): INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST.
Coverage Duration	INITIAL/RENEWAL: 12 MONTHS.
Other Criteria	PD: RENEWAL: IMPROVEMENT IN MOTOR SYMPTOMS WHILE ON THERAPY.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

APOMORPHINE - SL

Products Affected

- KYNMOBI SUBLINGUAL FILM 10 MG, 10-15-20-25-30 MG, 15 MG, 20 MG, 25 MG, 30 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	PARKINSONS DISEASE (PD): INITIAL: 18 YEARS OF AGE OR OLDER.
Prescriber Restrictions	PD: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS
Other Criteria	PD: RENEWAL: IMPROVEMENT WITH MOTOR FLUCTUATIONS DURING OFF EPISODES WITH THE USE OF THERAPY.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

APREMILAST

Products Affected

- OTEZLA
- OTEZLA STARTER

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: MILD PLAQUE PSORIASIS (PSO): 1) PSORIASIS COVERING 2 PERCENT OF BODY SURFACE AREA (BSA), 2) STATIC PHYSICIAN GLOBAL ASSESSMENT (SPGA) SCORE OF 2, OR 3) PSORIASIS AREA AND SEVERITY INDEX (PASI) SCORE OF 2 TO 9. MODERATE TO SEVERE PSO: PSORIASIS COVERING 3 PERCENT OR MORE OF BSA, OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, FACE, SCALP, OR GENITAL AREA.
Age Restrictions	
Prescriber Restrictions	INITIAL: PSORIATIC ARTHRITIS (PSA): PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST OR RHEUMATOLOGIST. PSO: PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST. BEHCETS DISEASE: PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	INITIAL: PSA: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR PSA. MILD PSO: TRIAL OF OR CONTRAINDICATION TO ONE CONVENTIONAL SYSTEMIC THERAPY (E.G., METHOTREXATE, ACITRETIN, CYCLOSPORINE) OR ONE CONVENTIONAL TOPICAL THERAPY (E.G., PUVA [PHOTOTHERAPY], UVB [ULTRAVIOLET LIGHT B], TOPICAL CORTICOSTEROIDS). MODERATE TO SEVERE PSO: 1) ONE OF THE FOLLOWING: (A) AT LEAST A 3 MONTH TRIAL OF ONE ORAL IMMUNOSUPPRESSANT (CYCLOSPORINE, METHOTREXATE, TACROLIMUS) OR PUVA (PHOTOTHERAPY) FOR THE TREATMENT OF PSO, (B) CONTRAINDICATION OR

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

PA Criteria	Criteria Details
	INTOLERANCE TO BOTH IMMUNOSUPPRESSANT AND PUVA FOR THE TREATMENT OF PSO, OR (C) PATIENT IS SWITCHING FROM A DIFFERENT BIOLOGIC, PDE-4 INHIBITOR, OR JAK INHIBITOR FOR THE SAME INDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR MODERATE TO SEVERE PSO. BEHCETS DISEASE: 1) HAS ORAL ULCERS OR A HISTORY OF RECURRENT ORAL ULCERS BASED ON CLINICAL SYMPTOMS, AND 2) TRIAL OF OR CONTRAINDICATION TO ONE OR MORE CONSERVATIVE TREATMENTS (E.G., COLCHICINE, TOPICAL CORTICOSTEROID, ORAL CORTICOSTEROID). RENEWAL: MILD PSO, BEHCETS DISEASE: CONTINUES TO BENEFIT FROM THE MEDICATION. PSA: 1) CONTINUES TO BENEFIT FROM THE MEDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR PSA. MODERATE TO SEVERE PSO: 1) CONTINUES TO BENEFIT FROM THE MEDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR MODERATE TO SEVERE PSO.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

ARIMOCLOMOL

Products Affected

- MIPLYFFA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	NIEMANN-PICK DISEASE TYPE C (NPC): INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH NEUROLOGIST OR GENETICIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	NPC: RENEWAL: IMPROVEMENT OR SLOWING OF DISEASE PROGRESSION.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

ASCIMINIB

Products Affected

- SCEMBLIX ORAL TABLET 100 MG, 20 MG, 40 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	PREVIOUSLY TREATED OR T315I MUTATION PHILADELPHIA CHROMOSOME-POSITIVE CHRONIC MYELOID LEUKEMIA (Ph+ CML); MUTATIONAL ANALYSIS PRIOR TO INITIATION AND SCEMBLIX IS APPROPRIATE PER NCCN GUIDELINE TABLE FOR TREATMENT RECOMMENDATIONS BASED ON BCR-ABL1 MUTATION PROFILE.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

ASFOTASE ALFA

Products Affected

- STRENSIQ

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	HYPOPHOSPHATASIA (HPP): INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH AN ENDOCRINOLOGIST, GENETICIST, OR METABOLIC SPECIALIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	INITIAL: PERINATAL/INFANTILE-ONSET HPP: 1) 6 MONTHS OF AGE OR YOUNGER AT ONSET OF HPP, AND 2) POSITIVE FOR A TISSUE NON-SPECIFIC ALKALINE PHOSPHATASE (TNSALP) (ALPL) GENE MUTATION AS CONFIRMED BY GENETIC TESTING OR TWO OF THE FOLLOWING: (A) SERUM ALKALINE PHOSPHATASE (ALP) LEVEL BELOW THAT OF NORMAL RANGE FOR PATIENT AGE, (B) ELEVATED SERUM PYRIDOXAL-5'-PHOSPHATE (PLP) LEVELS AND NO VITAMIN B6 SUPPLEMENTATION IN THE PREVIOUS WEEK, (C) URINE PHOSPHOETHANOLAMINE (PEA) LEVEL ABOVE THAT OF NORMAL RANGE FOR PATIENT AGE, (D) RADIOGRAPHIC EVIDENCE OF HPP, (E) AT LEAST TWO OF THE FOLLOWING: (I) RACHITIC CHEST DEFORMITY, (II) CRANIOSYNOSTOSIS, (III) DELAY IN SKELETAL GROWTH RESULTING IN DELAY OF MOTOR DEVELOPMENT, (IV) HISTORY OF VITAMIN B6 DEPENDENT SEIZURES, (V) NEPHROCALCINOSIS OR HISTORY OF ELEVATED SERUM CALCIUM, (VI) HISTORY OR PRESENCE OF NON-TRAUMATIC POSTNATAL FRACTURE AND DELAYED FRACTURE HEALING. JUVENILE-ONSET HPP: 1) 18 YEARS OF AGE OR YOUNGER AT ONSET OF HPP, AND 2) POSITIVE FOR A

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

PA Criteria	Criteria Details
	TNSALP ALPL GENE MUTATION AS CONFIRMED BY GENETIC TESTING OR TWO OF THE FOLLOWING: (A) SERUM ALP LEVEL BELOW THAT OF NORMAL RANGE FOR PATIENT AGE, (B) ELEVATED SERUM PLP LEVELS AND NO VITAMIN B6 SUPPLEMENTATION IN THE PREVIOUS WEEK, (C) URINE PEA LEVEL ABOVE THAT OF NORMAL RANGE FOR PATIENT AGE, (D) RADIOGRAPHIC EVIDENCE OF HPP, (E) AT LEAST TWO OF THE FOLLOWING: (I) RACHITIC DEFORMITIES, (II) PREMATURE LOSS OF PRIMARY TEETH PRIOR TO 5 YEARS OF AGE, (III) DELAY IN SKELETAL GROWTH RESULTING IN DELAY OF MOTOR DEVELOPMENT, (IV) HISTORY OR PRESENCE OF NON-TRAUMATIC FRACTURES OR DELAYED FRACTURE HEALING. ALL INDICATIONS: 1) NOT CURRENTLY RECEIVING TREATMENT WITH A BISPHOSPHONATE, 2) CALCIUM OR PHOSPHATE LEVELS ARE NOT BELOW THE NORMAL RANGE, 3) NOT HAVE A TREATABLE FORM OF RICKETS. RENEWAL: ALL INDICATIONS: 1) IMPROVEMENT IN THE SKELETAL CHARACTERISTICS OF HPP, AND 2) NOT CURRENTLY RECEIVING TREATMENT WITH A BISPHOSPHONATE.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

ATOGEPANT

Products Affected

- QULIPTA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	MIGRAINE PREVENTION: INITIAL/RENEWAL: NO CONCURRENT USE WITH OTHER CGRP INHIBITORS FOR MIGRAINE PREVENTION. RENEWAL: REDUCTION IN MIGRAINE OR HEADACHE FREQUENCY, MIGRAINE SEVERITY, OR MIGRAINE DURATION WITH THERAPY.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

AVACOPAN

Products Affected

- TAVNEOS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	ANTI-NEUTROPHIL CYTOPLASMIC AUTOANTIBODY (ANCA)-ASSOCIATED VASCULITIS: INITIAL: ANCA SEROPOSITIVE (ANTI-PR3 OR ANTI-MPO).
Age Restrictions	
Prescriber Restrictions	ANCA-ASSOCIATED VASCULITIS: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST OR NEPHROLOGIST.
Coverage Duration	INITIAL/RENEWAL: 6 MONTHS.
Other Criteria	ANCA-ASSOCIATED VASCULITIS: RENEWAL: CONTINUES TO BENEFIT FROM THERAPY.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

AVAPRITINIB

Products Affected

- AYVAKIT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

AVUTOMETINIB-DEFACTINIB

Products Affected

- AVMAPKI
- AVMAPKI-FAKZYNJA
- FAKZYNJA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

AXATILIMAB-CSFR

Products Affected

- NIKTIMVO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

AXITINIB

Products Affected

- INLYTA ORAL TABLET 1 MG, 5 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

AZACITIDINE

Products Affected

- ONUREG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

AZTREONAM INHALED

Products Affected

- CAYSTON

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	7 YEARS OF AGE OR OLDER
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

BEDAQUILINE

Products Affected

- SIRTURO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	24 WEEKS
Other Criteria	PULMONARY TUBERCULOSIS (TB): USE IN COMBINATION WITH 3 OTHER ANTIBIOTICS
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

BELIMUMAB

Products Affected

- BENLYSTA SUBCUTANEOUS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	INITIAL: SYSTEMIC LUPUS ERYTHEMATOSUS (SLE): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST. LUPUS NEPHRITIS (LN): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST OR NEPHROLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS
Other Criteria	INITIAL: SLE: CURRENTLY TAKING CORTICOSTEROIDS, ANTIMALARIALS, NSAIDS, OR IMMUNOSUPPRESSIVE AGENTS. RENEWAL: SLE: PATIENT HAD CLINICAL IMPROVEMENT. LN: IMPROVEMENT IN RENAL RESPONSE FROM BASELINE LABORATORY VALUES (I.E., EGFR OR PROTEINURIA) AND/OR CLINICAL PARAMETERS.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

BELUMOSUDIL

Products Affected

- REZUROCK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

BELZUTIFAN

Products Affected

- WELIREG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

BENDAMUSTINE

Products Affected

- *bendamustine intravenous recon soln*
- BENDAMUSTINE INTRAVENOUS SOLUTION
- BENDEKA
- VIVIMUSTA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

BENRALIZUMAB

Products Affected

- FASENRA
- FASENRA PEN

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	ASTHMA: INITIAL: BLOOD EOSINOPHIL LEVEL OF AT LEAST 150 CELLS/MCL WITHIN THE PAST 12 MONTHS.
Age Restrictions	
Prescriber Restrictions	ASTHMA: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A PHYSICIAN SPECIALIZING IN ALLERGY OR PULMONARY MEDICINE.
Coverage Duration	INITIAL/RENEWAL: 12 MONTHS.
Other Criteria	INITIAL: ASTHMA: 1) CONCURRENT THERAPY WITH A MEDIUM, HIGH-DOSE, OR MAXIMALLY TOLERATED DOSE OF AN INHALED CORTICOSTEROID (ICS) AND ONE OTHER MAINTENANCE MEDICATION, 2) ONE ASTHMA EXACERBATION REQUIRING SYSTEMIC CORTICOSTEROID BURST LASTING 3 OR MORE DAYS WITHIN THE PAST 12 MONTHS, OR AT LEAST ONE SERIOUS EXACERBATION REQUIRING HOSPITALIZATION OR ER VISIT WITHIN THE PAST 12 MONTHS, OR POOR SYMPTOM CONTROL DESPITE CURRENT THERAPY AS EVIDENCED BY AT LEAST THREE OF THE FOLLOWING WITHIN THE PAST 4 WEEKS: (A) DAYTIME ASTHMA SYMPTOMS MORE THAN TWICE/WEEK, (B) ANY NIGHT WAKING DUE TO ASTHMA, (C) SABA RELIEVER FOR SYMPTOMS MORE THAN TWICE/WEEK, (D) ANY ACTIVITY LIMITATION DUE TO ASTHMA, AND 3) NO CONCURRENT USE WITH XOLAIR, DUPIXENT, TEZSPIRE, OR OTHER ANTI-IL5 BIOLOGICS WHEN USED FOR ASTHMA. EOSINOPHILIC GRANULOMATOSIS WITH POLYANGIITIS (EGPA): NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-2 INHIBITOR) FOR EGPA. RENEWAL: ASTHMA: 1) NO

Updated: 11.01.2025

Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

PA Criteria	Criteria Details
	CONCURRENT USE WITH XOLAIR, DUPIXENT, TEZSPIRE, OR OTHER ANTI-IL5 BIOLOGICS WHEN USED FOR ASTHMA, 2) CONTINUED USE OF ICS AND ONE OTHER MAINTENANCE MEDICATION, AND 3) CLINICAL RESPONSE AS EVIDENCED BY: (A) REDUCTION IN ASTHMA EXACERBATIONS FROM BASELINE, (B) DECREASED UTILIZATION OF RESCUE MEDICATIONS, (C) INCREASE IN PERCENT PREDICTED FEV1 FROM PRETREATMENT BASELINE, OR (D) REDUCTION IN SEVERITY OR FREQUENCY OF ASTHMA-RELATED SYMPTOMS. EGPA: 1) REDUCTION IN EGPA SYMPTOMS COMPARED TO BASELINE OR ABILITY TO REDUCE/ELIMINATE CORTICOSTEROID USE, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR EGPA.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

BETAINE

Products Affected

- *betaine*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

BEVACIZUMAB-ADCD

Products Affected

- VEGZELMA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

BEVACIZUMAB-AWWB

Products Affected

- MVASI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

BEVACIZUMAB-BVZR

Products Affected

- ZIRABEV

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

BEXAROTENE

Products Affected

- *bexarotene*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

BINIMETINIB

Products Affected

- MEKTOVI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

BORTEZOMIB

Products Affected

- *bortezomib injection*
- BORUZU

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

BOSENTAN

Products Affected

- *bosentan oral tablet*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	PULMONARY ARTERIAL HYPERTENSION (PAH): INITIAL: DIAGNOSIS CONFIRMED BY RIGHT HEART CATHETERIZATION WITH THE FOLLOWING PARAMETERS: 1) MEAN PULMONARY ARTERY PRESSURE (PAP) GREATER THAN 20 MMHG, 2) PULMONARY CAPILLARY WEDGE PRESSURE (PCWP) OF 15 MMHG OR LESS, AND 3) PULMONARY VASCULAR RESISTANCE (PVR) GREATER THAN 2 WOOD UNITS.
Age Restrictions	
Prescriber Restrictions	PAH: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A CARDIOLOGIST OR PULMONOLOGIST.
Coverage Duration	INITIAL/RENEWAL: 12 MONTHS.
Other Criteria	PAH: INITIAL: 1) DOES NOT HAVE ELEVATED LIVER ENZYMES (ALT, AST) MORE THAN 3 TIMES UPPER LIMIT OF NORMAL (ULN) OR INCREASE IN BILIRUBIN BY 2 OR MORE TIMES ULN, AND 2) NO CONCURRENT USE WITH CYCLOSPORINE A OR GLYBURIDE. RENEWAL: NO CONCURRENT USE WITH CYCLOSPORINE A OR GLYBURIDE.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

BOSUTINIB

Products Affected

- BOSULIF ORAL CAPSULE 100 MG, 50 MG
- BOSULIF ORAL TABLET 100 MG, 400 MG, 500 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	PREVIOUSLY TREATED PHILADELPHIA CHROMOSOME-POSITIVE CHRONIC MYELOID LEUKEMIA (Ph+ CML): MUTATIONAL ANALYSIS PRIOR TO INITIATION AND BOSULIF IS APPROPRIATE PER NCCN GUIDELINE TABLE FOR TREATMENT RECOMMENDATIONS BASED ON BCR-ABL1 MUTATION PROFILE.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

BRIGATINIB

Products Affected

- ALUNBRIG ORAL TABLET 180 MG, 30 MG, 90 MG
- ALUNBRIG ORAL TABLETS,DOSE PACK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

C1 ESTERASE INHIBITOR-HAEGARDA

Products Affected

- HAEGARDA SUBCUTANEOUS
RECON SOLN 2,000 UNIT, 3,000 UNIT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	HEREDITARY ANGIOEDEMA (HAE): INITIAL: DIAGNOSIS CONFIRMED BY ONE OF THE FOLLOWING COMPLEMENT TESTING: C1INH PROTEIN LEVELS, C4 PROTEIN LEVELS, C1-INH FUNCTIONAL LEVELS, C1Q.
Age Restrictions	
Prescriber Restrictions	HAE: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A HEMATOLOGIST, IMMUNOLOGIST, ALLERGIST OR PULMONOLOGIST.
Coverage Duration	INITIAL/RENEWAL: 12 MONTHS.
Other Criteria	HAE: INITIAL: NOT ON CONCURRENT TREATMENT WITH ALTERNATIVE PROPHYLACTIC AGENT FOR HAE ATTACKS. RENEWAL: 1) IMPROVEMENT COMPARED TO BASELINE IN HAE ATTACKS (I.E., REDUCTIONS IN ATTACK FREQUENCY OR ATTACK SEVERITY), AND 2) NOT ON CONCURRENT TREATMENT WITH ALTERNATIVE PROPHYLACTIC AGENT FOR HAE ATTACKS.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

CABOZANTINIB CAPSULE

Products Affected

- COMETRIQ ORAL CAPSULE 100 MG/DAY(80 MG X1-20 MG X1), 140 MG/DAY(80 MG X1-20 MG X3), 60 MG/DAY (20 MG X 3/DAY)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

CABOZANTINIB TABLET

Products Affected

- CABOMETYX ORAL TABLET 20 MG, 40 MG, 60 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

CANNABIDIOL

Products Affected

- EPIDIOLEX

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	DRAVET SYNDROME (DS), LENNOX-GASTAUT SYNDROME (LGS), TUBEROUS SCLEROSIS COMPLEX (TSC): PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST.
Coverage Duration	INITIAL/RENEWAL: 12 MONTHS.
Other Criteria	INITIAL: LENNOX-GASTAUT SYNDROME (LGS): TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING ANTIEPILEPTIC MEDICATIONS: RUFINAMIDE, FELBAMATE, CLOBAZAM, TOPIRAMATE, LAMOTRIGINE, CLONAZEPAM.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

CAPIVASERTIB

Products Affected

- TRUQAP

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

CAPMATINIB

Products Affected

- TABRECTA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

CARGLUMIC ACID

Products Affected

- *carglumic acid*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: ACUTE OR CHRONIC HYPERAMMONEMIA (HA) DUE TO N ACETYLGLUTAMATE SYNTHASE (NAGS) DEFICIENCY: NAGS GENE MUTATION IS CONFIRMED BY BIOCHEMICAL OR GENETIC TESTING. ACUTE HA DUE TO PROPIONIC ACIDEMIA (PA): 1) CONFIRMED BY ELEVATED METHYLCITRIC ACID AND NORMAL METHYLMALONIC ACID, OR 2) GENETIC TESTING CONFIRMS MUTATION IN THE PCCA OR PCCB GENE. ACUTE HA DUE TO METHYLMALONIC ACIDEMIA (MMA): 1) CONFIRMED BY ELEVATED METHYLMALONIC ACID, METHYLCITRIC ACID, OR 2) GENETIC TESTING CONFIRMS MUTATION IN THE MMUT, MMA, MMAB OR MMADHC GENES.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	ACUTE HA DUE TO NAGS/PA/MMA: 7 DAYS. CHRONIC HA DUE TO NAGS: INITIAL: 6 MOS, RENEWAL: 12 MOS.
Other Criteria	RENEWAL: CHRONIC HA DUE TO NAGS: PATIENT HAS SHOWN CLINICAL IMPROVEMENT.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

CERITINIB

Products Affected

- ZYKADIA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

CERTOLIZUMAB PEGOL

Products Affected

- CIMZIA POWDER FOR RECONST
- CIMZIA SUBCUTANEOUS SYRINGE KIT 400 MG/2 ML (200 MG/ML X 2)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: PLAQUE PSORIASIS (PSO): PSORIASIS COVERING 3 PERCENT OR MORE OF BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, FACE, SCALP, OR GENITAL AREA. NON-RADIOGRAPHIC AXIAL SPONDYLOARTHRITIS (NR-AXSPA): 1) C-REACTIVE PROTEIN (CRP) LEVELS ABOVE THE UPPER LIMIT OF NORMAL, OR 2) SACROILIITIS ON MAGNETIC RESONANCE IMAGING (MRI).
Age Restrictions	
Prescriber Restrictions	INITIAL: RHEUMATOID ARTHRITIS (RA), ANKYLOSING SPONDYLITIS (AS), NR-AXSPA, POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS (PJIA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST. PSORIATIC ARTHRITIS (PSA): PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST OR RHEUMATOLOGIST. CROHNS DISEASE (CD): PRESCRIBED BY OR IN CONSULTATION WITH A GASTROENTEROLOGIST. PSO: PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	INITIAL: RA: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: ENBREL, HUMIRA/CYLTEZO/YUFLYMA, XELJANZ, RINVOQ, ORENCIA. PSA: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: COSENTYX, ENBREL, HUMIRA/CYLTEZO/YUFLYMA, STELARA/SELARSDI/YESINTEK, XELJANZ, RINVOQ, SKYRIZI, TREMFYA, ORENCIA, OTEZLA. PSO: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: COSENTYX, ENBREL, HUMIRA/CYLTEZO/YUFLYMA, STELARA/SELARSDI/YESINTEK,

Updated: 11.01.2025

Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

PA Criteria	Criteria Details
	SKYRIZI, TREMFYA, OTEZLA. AS: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: COSENTYX, ENBREL, HUMIRA/CYLTEZO/YUFLYMA, XELJANZ, RINVOQ. CD: TRIAL OF OR CONTRAINDICATION TO ONE OF THE FOLLOWING PREFERRED AGENTS: STELARA/SELARSDI/YESINTEK, HUMIRA/CYLTEZO/YUFLYMA, RINVOQ, SKYRIZI, TREMFYA. NR-AXSPA: TRIAL OF OR CONTRAINDICATION TO AN NSAID. PJIA: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: ENBREL, HUMIRA/CYLTEZO/YUFLYMA, XELJANZ IR, ORENCIA, RINVOQ. INITIAL FOR RA, PSA, PSO, AS, CD, PJIA: TRIAL OF OR CONTRAINDICATION TO THE STEP AGENTS IS NOT REQUIRED IF THE PATIENT IS PREGNANT, BREASTFEEDING, OR TRYING TO BECOME PREGNANT. INITIAL/RENEWAL FOR PSA, PSO, AS, CD, NR-AXSPA, PJIA: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR SAME INDICATION. RENEWAL FOR RA, PSA, AS, PSO, NR-AXSPA, PJIA: CONTINUES TO BENEFIT FROM MEDICATION.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

CETUXIMAB

Products Affected

- ERBITUX

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

CLADRIBINE

Products Affected

- MAVENCLAD (10 TABLET PACK)
- MAVENCLAD (4 TABLET PACK)
- MAVENCLAD (5 TABLET PACK)
- MAVENCLAD (6 TABLET PACK)
- MAVENCLAD (7 TABLET PACK)
- MAVENCLAD (8 TABLET PACK)
- MAVENCLAD (9 TABLET PACK)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	48 WEEKS.
Other Criteria	RELAPSING FORM OF MULTIPLE SCLEROSIS (MS): HAS NOT RECEIVED A TOTAL OF TWO YEARS OF MAVENCLAD TREATMENT (I.E., TWO YEARLY TREATMENT COURSES OF TWO CYCLES IN EACH).
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

CLOBAZAM-SYMPAZAN

Products Affected

- SYMPAZAN

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	INITIAL: LENNOX-GASTAUT SYNDROME (LGS): THERAPY IS PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST.
Coverage Duration	INITIAL/RENEWAL: 12 MONTHS
Other Criteria	LGS: INITIAL: CONTRAINDICATION TO OR UNABLE TO SWALLOW CLOBAZAM TABLETS OR SUSPENSION.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

COBIMETINIB

Products Affected

- COTELLIC

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

CORTICOTROPIN

Products Affected

- ACTHAR
- ACTHAR SELFJECT
- SUBCUTANEOUS PEN INJECTOR 40 UNIT/0.5 ML, 80 UNIT/ML
- CORTROPHIN GEL INJECTION

PA Criteria	Criteria Details
Exclusion Criteria	INITIAL: NOT APPROVED FOR DIAGNOSTIC PURPOSES.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	INITIAL: ALL FDA APPROVED INDICATIONS EXCEPT INFANTILE SPASMS AND MULTIPLE SCLEROSIS (MS): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST, DERMATOLOGIST, ALLERGIST/IMMUNOLOGIST, OPHTHALMOLOGIST, PULMONOLOGIST OR NEPHROLOGIST.
Coverage Duration	INFANTILE SPASMS AND MS: 28 DAYS. ALL OTHER FDA APPROVED INDICATIONS: INITIAL/RENEWAL: 12 MONTHS.
Other Criteria	INITIAL: ALL FDA APPROVED INDICATIONS EXCEPT INFANTILE SPASMS: TRIAL OF OR CONTRAINDICATION TO INTRAVENOUS (IV) CORTICOSTEROIDS. RENEWAL: ALL FDA APPROVED INDICATIONS EXCEPT INFANTILE SPASMS AND MS: DEMONSTRATED CLINICAL BENEFIT WHILE ON THERAPY AS INDICATED BY SYMPTOM RESOLUTION AND/OR NORMALIZATION OF LABORATORY TESTS. PART B BEFORE PART D STEP THERAPY, APPLIES ONLY TO BENEFICIARIES IN AN MA-PD PLAN.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	Yes

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

CRIZOTINIB CAPSULE

Products Affected

- XALKORI ORAL CAPSULE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

CRIZOTINIB PELLETS

Products Affected

- XALKORI ORAL PELLET 150 MG, 20 MG, 50 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	NON-SMALL CELL LUNG CANCER (NSCLC), ANAPLASTIC LARGE CELL LYMPHOMA (ALCL), INFLAMMATORY MYOFIBROBLASTIC TUMOR (IMT): UNABLE TO SWALLOW CAPSULES.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

DABRAFENIB CAPSULES

Products Affected

- TAFINLAR ORAL CAPSULE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

DABRAFENIB SUSPENSION

Products Affected

- TAFINLAR ORAL TABLET FOR SUSPENSION

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	UNABLE TO SWALLOW TAFINLAR CAPSULES.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

DACOMITINIB

Products Affected

- VIZIMPRO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	METASTATIC NON-SMALL CELL LUNG CANCER (NSCLC): NOT ON CONCURRENT THERAPY WITH AN EGFR TYROSINE KINASE-INHIBITOR.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

DALFAMPRIDINE

Products Affected

- *dalfampridine*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	MULTIPLE SCLEROSIS (MS): INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST.
Coverage Duration	INITIAL: 3 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	MS: INITIAL: HAS SYMPTOMS OF A WALKING DISABILITY SUCH AS MILD TO MODERATE BILATERAL LOWER EXTREMITY WEAKNESS OR UNILATERAL WEAKNESS PLUS LOWER EXTREMITY OR TRUNCAL ATAXIA. RENEWAL: IMPROVEMENT IN WALKING ABILITY.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

DAROLUTAMIDE

Products Affected

- NUBEQA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL/RENEWAL: 12 MONTHS
Other Criteria	INITIAL: NON-METASTATIC CASTRATION-RESISTANT PROSTATE CANCER (NMCRPC): HIGH RISK PROSTATE CANCER (I.E., RAPIDLY INCREASING PROSTATE SPECIFIC ANTIGEN [PSA] LEVELS). NMCRPC, METASTATIC CASTRATION-SENSITIVE PROSTATE CANCER (MCSPC): 1) RECEIVED A BILATERAL ORCHIECTOMY, 2) CASTRATE LEVEL OF TESTOSTERONE (I.E., LESS THAN 50 NG/DL), OR 3) CONCURRENT USE WITH A GONADOTROPIN RELEASING HORMONE (GNRH) ANALOG. RENEWAL: NMCRPC, MCSPC: 1) RECEIVED A BILATERAL ORCHIECTOMY, 2) CASTRATE LEVEL OF TESTOSTERONE (I.E., LESS THAN 50 NG/DL), OR 3) CONCURRENT USE WITH A GNRH ANALOG.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

DASATINIB

Products Affected

- dasatinib oral tablet 100 mg, 140 mg, 20 mg, 50 mg, 70 mg, 80 mg

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	PREVIOUSLY TREATED PHILADELPHIA CHROMOSOME-POSITIVE CHRONIC MYELOID LEUKEMIA (Ph+ CML): MUTATIONAL ANALYSIS PRIOR TO INITIATION AND DASATINIB IS APPROPRIATE PER NCCN GUIDELINE TABLE FOR TREATMENT RECOMMENDATIONS BASED ON BCR-ABL1 MUTATION PROFILE.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

DATOPOTAMAB DERUXTECAN-DLNK

Products Affected

- DATROWAY

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

DECITABINE/CEDAZURIDINE

Products Affected

- INQOVI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

DEFERASIROX

Products Affected

- *deferasirox oral granules in packet*
- *deferasirox oral tablet*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: CHRONIC IRON OVERLOAD DUE TO BLOOD TRANSFUSIONS: SERUM FERRITIN LEVEL CONSISTENTLY ABOVE 1000 MCG/L (AT LEAST TWO LAB VALUES IN THE PREVIOUS THREE MONTHS). CHRONIC IRON OVERLOAD IN NON-TRANSFUSION DEPENDENT THALASSEMIA (NTDT): 1) SERUM FERRITIN LEVEL CONSISTENTLY ABOVE 300 MCG/L (AT LEAST TWO LAB VALUES IN THE PREVIOUS THREE MONTHS), AND 2) LIVER IRON CONCENTRATION (LIC) OF 5 MG FE/G OF DRY LIVER WEIGHT OR GREATER. RENEWAL: CHRONIC IRON OVERLOAD DUE TO BLOOD TRANSFUSIONS: SERUM FERRITIN LEVEL CONSISTENTLY ABOVE 500 MCG/L (AT LEAST TWO LAB VALUES IN THE PREVIOUS THREE MONTHS). NTDT: 1) SERUM FERRITIN LEVEL CONSISTENTLY ABOVE 300 MCG/L (AT LEAST TWO LAB VALUES IN THE PREVIOUS THREE MONTHS) OR 2) LIC OF 3 MG FE/G OF DRY LIVER WEIGHT OR GREATER.
Age Restrictions	
Prescriber Restrictions	INITIAL (CHRONIC IRON OVERLOAD): PRESCRIBED BY OR IN CONSULTATION WITH A HEMATOLOGIST OR HEMATOLOGIST/ONCOLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	INITIAL (CHRONIC IRON OVERLOAD): DEFERASIROX SPRINKLE PACKETS: TRIAL OF OR CONTRAINDICATION TO GENERIC DEFERASIROX ORAL TABLET OR TABLET FOR ORAL SUSPENSION.
Indications	All FDA-approved Indications.

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

PA Criteria	Criteria Details
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

DENOSUMAB-BMWO - OSENVELT

Products Affected

- OSENVELT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

DENOSUMAB-XGEVA

Products Affected

- XGEVA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

DEUTETRABENAZINE

Products Affected

- AUSTEDO ORAL TABLET 12 MG, 6 MG, 9 MG
- AUSTEDO XR ORAL TABLET EXTENDED RELEASE 24 HR 12 MG,
- 18 MG, 24 MG, 30 MG, 36 MG, 42 MG, 48 MG, 6 MG
- AUSTEDO XR TITRATION KT(WK1-4)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	HUNTINGTON DISEASE: PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST OR MOVEMENT DISORDER SPECIALIST. TARDIVE DYSKINESIA: PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST, PSYCHIATRIST, OR MOVEMENT DISORDER SPECIALIST.
Coverage Duration	12 MONTHS
Other Criteria	TARDIVE DYSKINESIA: HISTORY OF USING AGENTS THAT CAUSE TARDIVE DYSKINESIA.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

DICLOFENAC TOPICAL SOLUTION

Products Affected

- *diclofenac sodium topical solution in metered-dose pump*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 MONTHS
Other Criteria	OSTEOARTHRITIS OF THE KNEE: TRIAL OF OR CONTRAINDICATION TO A FORMULARY VERSION OF DICLOFENAC SODIUM 1% TOPICAL GEL AND A FORMULARY VERSION OF DICLOFENAC SODIUM 1.5% TOPICAL DROPS.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

DICLOFENAC-FLECTOR

Products Affected

- *diclofenac epolamine*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

DIMETHYL FUMARATE

Products Affected

- *dimethyl fumarate oral capsule, delayed release(dr/ec) 120 mg, 120 mg (14)- 240 mg (46), 240 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

DIROXIMEL FUMARATE

Products Affected

- VUMERITY

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

DORDAVIPRONE

Products Affected

- MODEYSO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

DOSTARLIMAB-GXLY

Products Affected

- JEMPERLI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

DRONABINOL CAPSULE

Products Affected

- *dronabinol*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 MONTHS
Other Criteria	NAUSEA AND VOMITING ASSOCIATED WITH CANCER CHEMOTHERAPY: TRIAL OF OR CONTRAINDICATION TO ONE ANTIEMETIC THERAPY. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D FOR THE INDICATION OF NAUSEA AND VOMITING ASSOCIATED WITH CANCER CHEMOTHERAPY.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

DROXIDOPA

Products Affected

- *droxidopa*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	NEUROGENIC ORTHOSTATIC HYPOTENSION (NOH): INITIAL: 1) BASELINE BLOOD PRESSURE READINGS WHILE THE PATIENT IS SITTING AND ALSO WITHIN 3 MINUTES OF STANDING FROM A SUPINE POSITION. 2) A DECREASE OF AT LEAST 20 MMHG IN SYSTOLIC BLOOD PRESSURE OR 10 MMHG DIASTOLIC BLOOD PRESSURE WITHIN THREE MINUTES AFTER STANDING FROM A SITTING POSITION.
Age Restrictions	
Prescriber Restrictions	NOH: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST OR CARDIOLOGIST.
Coverage Duration	INITIAL: 3 MONTHS RENEWAL: 12 MONTHS
Other Criteria	NOH: RENEWAL: CONTINUES TO BENEFIT FROM THE MEDICATION.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

DUPILUMAB

Products Affected

- DUPIXENT PEN
- DUPIXENT SYRINGE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: EOSINOPHILIC ASTHMA: BLOOD EOSINOPHIL LEVEL OF 150 TO 1500 CELLS/MCL WITHIN THE PAST 12 MONTHS. EOSINOPHILIC ESOPHAGITIS (EOE): DIAGNOSIS CONFIRMED BY ESOPHAGOGASTRODUODENOSCOPY (EGD) WITH BIOPSY. ATOPIC DERMATITIS (AD): AD COVERING AT LEAST 10 PERCENT OF BODY SURFACE AREA OR AD AFFECTING THE FACE, HEAD, NECK, HANDS, FEET, GROIN, OR INTERTRIGINOUS AREAS.
Age Restrictions	
Prescriber Restrictions	INITIAL: AD, PRURIGO NODULARIS (PN): PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST, ALLERGIST OR IMMUNOLOGIST. ASTHMA: PRESCRIBED BY OR IN CONSULTATION WITH A PHYSICIAN SPECIALIZING IN ALLERGY OR PULMONARY MEDICINE. CRSWNP: PRESCRIBED BY OR IN CONSULTATION WITH AN OTOLARYNGOLOGIST, ALLERGIST OR IMMUNOLOGIST. EOE: PRESCRIBED BY OR IN CONSULTATION WITH A GASTROENTEROLOGIST, ALLERGIST, OR IMMUNOLOGIST. EOSINOPHILIC COPD: PRESCRIBED BY OR IN CONSULTATION WITH A PULMONOLOGIST.
Coverage Duration	BP: 12 MO. AD/CRSWNP/EOE/PN/CSU: INITIAL/RENEWAL: 6 MO/12 MO. ASTHMA/COPD: INITIAL/RENEWAL: 12 MO.
Other Criteria	INITIAL/RENEWAL: AD: NO CONCURRENT USE WITH OTHER SYSTEMIC BIOLOGICS OR JAK INHIBITORS FOR AD. ASTHMA: NO CONCURRENT USE WITH XOLAIR, TEZSPIRE, OR OTHER ANTI-IL5 BIOLOGICS WHEN USED FOR ASTHMA. CRSWNP: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR AN AUTOIMMUNE INDICATION. EOSINOPHILIC COPD: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR

Updated: 11.01.2025

Y0150_PBM200_C (v2)

PA Criteria	Criteria Details
	THE SAME INDICATION. INITIAL: AD: 1) INTRACTABLE PRURITUS OR CRACKING/OOZING/BLEEDING OF AFFECTED SKIN, AND 2) TRIAL OF OR CONTRAINDICATION TO ONE TOPICAL (CORTICOSTEROID, CALCINEURIN INHIBITOR, PDE4 INHIBITOR, OR JAK INHIBITOR). ASTHMA: 1) CONCURRENT THERAPY WITH A MEDIUM, HIGH-DOSE OR MAXIMALLY-TOLERATED DOSE OF AN INHALED CORTICOSTEROID (ICS) AND ONE OTHER MAINTENANCE MEDICATION, AND 2) ONE ASTHMA EXACERBATION REQUIRING SYSTEMIC CORTICOSTEROID BURST LASTING 3 OR MORE DAYS WITHIN THE PAST 12 MONTHS, OR ONE SERIOUS EXACERBATION REQUIRING HOSPITALIZATION OR ER VISIT WITHIN THE PAST 12 MONTHS, OR POOR SYMPTOM CONTROL DESPITE CURRENT THERAPY AS EVIDENCED BY AT LEAST THREE OF THE FOLLOWING WITHIN THE PAST 4 WEEKS: (A) DAYTIME ASTHMA SYMPTOMS MORE THAN TWICE/WEEK, (B) ANY NIGHT WAKING DUE TO ASTHMA, (C) SABA RELIEVER FOR SYMPTOMS MORE THAN TWICE/WEEK, (D) ANY ACTIVITY LIMITATION DUE TO ASTHMA. CHRONIC RHINOSINUSITIS WITH NASAL POLYPS (CRSWNP): A 56 DAY TRIAL OF ONE TOPICAL NASAL CORTICOSTEROID. PRURIGO NODULARIS (PN): CHRONIC PRURITUS (ITCH MORE THAN 6 WEEKS), MULTIPLE PRURIGINOUS LESIONS, AND HISTORY OR SIGN OF A PROLONGED SCRATCHING BEHAVIOR. EOSINOPHILIC COPD: USED IN COMBINATION WITH A LAMA/LABA/ICS. CHRONIC SPONTANEOUS URTICARIA (CSU): 1) TRIAL OF AND MAINTAINED ON, OR CONTRAINDICATION TO A SECOND GENERATION H1 ANTI-HISTAMINE AND 2) STILL EXPERIENCES HIVES OR ANGIOEDEMA MOST DAYS OF THE WEEK FOR AT LEAST 6 WEEKS. RENEWAL: AD, CRSWNP, EOE: IMPROVEMENT WHILE ON THERAPY. ASTHMA: 1) CONTINUED USE OF ICS AND ONE OTHER MAINTENANCE MEDICATION, AND 2) CLINICAL RESPONSE AS EVIDENCED BY: (A) REDUCTION IN ASTHMA EXACERBATIONS FROM BASELINE, (B) DECREASED UTILIZATION OF RESCUE MEDICATIONS, (C) INCREASE IN PERCENT PREDICTED FEV1 FROM PRETREATMENT BASELINE, OR (D) REDUCTION IN SEVERITY OR FREQUENCY OF ASTHMA-RELATED SYMPTOMS. PN: IMPROVEMENT OR REDUCTION OF PRURITUS OR PRURIGINOUS LESIONS. EOSINOPHILIC COPD: 1) USED IN COMBINATION WITH A LAMA/LABA/ICS, AND 2) CLINICAL RESPONSE AS EVIDENCED BY (A) REDUCTION IN

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

PA Criteria	Criteria Details
	COPD EXACERBATIONS FROM BASELINE, (B) REDUCTION IN SEVERITY OR FREQUENCY OF COPD-RELATED SYMPTOMS, OR (C) INCREASE IN FEV1 OF AT LEAST 5 PERCENT FROM PRETREATMENT BASELINE. CSU: MAINTAINED ON OR CONTRAINDICATION TO A SECOND GENERATION H1 ANTI-HISTAMINE.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

DUVELISIB

Products Affected

- COPIKTRA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

EFLORNITHINE

Products Affected

- IWILFIN

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	24 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

ELACESTRANT

Products Affected

- ORSERDU ORAL TABLET 345 MG, 86 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

ELAGOLIX

Products Affected

- ORILISSA ORAL TABLET 150 MG, 200 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	MODERATE TO SEVERE PAIN ASSOCIATED WITH ENDOMETRIOSIS: INITIAL: DIAGNOSIS IS CONFIRMED VIA SURGICAL OR DIRECT VISUALIZATION (E.G., PELVIC ULTRASOUND) OR HISTOPATHOLOGICAL CONFIRMATION (E.G., LAPAROSCOPY OR LAPAROTOMY) IN THE LAST 10 YEARS.
Age Restrictions	MODERATE TO SEVERE PAIN ASSOCIATED WITH ENDOMETRIOSIS: INITIAL: 18 YEARS OF AGE OR OLDER.
Prescriber Restrictions	MODERATE TO SEVERE PAIN ASSOCIATED WITH ENDOMETRIOSIS: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH AN OBSTETRICIAN/GYNECOLOGIST.
Coverage Duration	INITIAL: 6 MONTHS, RENEWAL: 12 MONTHS
Other Criteria	MODERATE TO SEVERE PAIN ASSOCIATED WITH ENDOMETRIOSIS: INITIAL: 1) NO CONCURRENT USE WITH ANOTHER GNRH-MODULATING AGENT, AND 2) TRIAL OF OR CONTRAINDICATION TO AN NSAID AND A PROGESTIN-CONTAINING PREPARATION. RENEWAL: 1) IMPROVEMENT IN PAIN ASSOCIATED WITH ENDOMETRIOSIS WHILE ON THERAPY, AND 2) NO CONCURRENT USE WITH ANOTHER GNRH-MODULATING AGENT
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

ELRANATAMAB-BCMM

Products Affected

- ELREXFIO 44 MG/1.1 ML VIAL INNER, SUV, P/F
- ELREXFIO SUBCUTANEOUS SOLUTION 40 MG/ML

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	RELAPSED OR REFRACTORY MULTIPLE MYELOMA: RENEWAL: 1) HAS RECEIVED AT LEAST 24 WEEKS OF TREATMENT WITH ELREXFIO, AND 2) HAS RESPONDED TO TREATMENT (PARTIAL RESPONSE OR BETTER), AND HAS MAINTAINED THIS RESPONSE FOR AT LEAST 2 MONTHS. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

ELTROMBOPAG - ALVAIZ

Products Affected

- ALVAIZ

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	PERSISTENT OR CHRONIC IMMUNE THROMBOCYTOPENIA (ITP): INITIAL: 1) PLATELET COUNT IS LESS THAN $30 \times 10^9/L$, OR 2) PLATELET COUNT IS LESS THAN $50 \times 10^9/L$ AND HAD A PRIOR BLEEDING EVENT.
Age Restrictions	
Prescriber Restrictions	INITIAL: ITP: PRESCRIBED BY OR IN CONSULTATION WITH A HEMATOLOGIST OR IMMUNOLOGIST.
Coverage Duration	ITP: INITIAL: 6 MO, RENEWAL: 12 MO. HEPATITIS C, SEVERE APLASTIC ANEMIA: 12 MO.
Other Criteria	INITIAL: ITP: 1) TRIAL OF OR CONTRAINDICATION TO ONE CORTICOSTEROID OR IMMUNOGLOBULIN, OR AN INSUFFICIENT RESPONSE TO SPLENECTOMY, AND 2) NO CONCURRENT USE WITH OTHER THROMBOPOIETIN RECEPTOR AGONISTS (TPO-RAS). RENEWAL: ITP: 1) IMPROVEMENT IN PLATELET COUNT FROM BASELINE OR REDUCTION IN BLEEDING EVENTS, AND 2) NO CONCURRENT USE WITH OTHER TPO-RAS.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

ELTROMBOPAG - PROMACTA

Products Affected

- *eltrombopag olamine oral powder in packet 12.5 mg, 25 mg*
- *eltrombopag olamine oral tablet 12.5 mg, 25 mg, 50 mg, 75 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	PERSISTENT OR CHRONIC IMMUNE THROMBOCYTOPENIA (ITP): INITIAL: 1) PLATELET COUNT OF LESS THAN $30 \times 10^9/L$, OR 2) PLATELET COUNT OF LESS THAN $50 \times 10^9/L$ AND A PRIOR BLEEDING EVENT.
Age Restrictions	
Prescriber Restrictions	INITIAL: ITP: PRESCRIBED BY OR IN CONSULTATION WITH A HEMATOLOGIST OR IMMUNOLOGIST.
Coverage Duration	ITP: INITIAL: 6 MO, RENEWAL: 12 MO. HEPATITIS C, SEVERE APLASTIC ANEMIA: 12 MO.
Other Criteria	INITIAL: ITP: 1) TRIAL OF OR CONTRAINDICATION TO ONE CORTICOSTEROID OR IMMUNOGLOBULIN, OR HAD AN INSUFFICIENT RESPONSE TO SPLENECTOMY, AND 2) NO CONCURRENT USE WITH OTHER THROMBOPOIETIN RECEPTOR AGONISTS (TPO-RAS). ALL INDICATIONS: APPROVAL FOR ELTROMBOPAG ORAL SUSPENSION PACKETS REQUIRES A TRIAL OF A FORMULARY VERSION OF ELTROMBOPAG TABLET OR PATIENT IS UNABLE TOLERATE TABLET FORMULATION. RENEWAL: ITP: 1) IMPROVEMENT IN PLATELET COUNTS FROM BASELINE OR REDUCTION IN BLEEDING EVENTS, AND 2) NO CONCURRENT USE WITH OTHER TPO-RAS.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

ENASIDENIB

Products Affected

- IDHIFA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

ENCORAFENIB

Products Affected

- BRAFTOVI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

ENTRECTINIB CAPSULES

Products Affected

- ROZLYTREK ORAL CAPSULE 100 MG, 200 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

ENTRECTINIB PELLETS

Products Affected

- ROZLYTREK ORAL PELLETS IN PACKET

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	METASTATIC NON-SMALL CELL LUNG CANCER (NSCLC), SOLID TUMORS: 1) TRIAL OF OR CONTRAINDICATION TO ROZLYTREK CAPSULES MADE INTO AN ORAL SUSPENSION, AND 2) DIFFICULTY OR UNABLE TO SWALLOW CAPSULES.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

ENZALUTAMIDE

Products Affected

- XTANDI ORAL CAPSULE
- XTANDI ORAL TABLET 40 MG, 80 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL: ALL INDICATIONS: 12 MONTHS. RENEWAL: MCRPC, NMCRPC, MCSPC: 12 MONTHS.
Other Criteria	INITIAL: NON-METASTATIC CASTRATION-RESISTANT PROSTATE CANCER (NMCRPC): HIGH RISK PROSTATE CANCER (I.E. RAPIDLY INCREASING PROSTATE SPECIFIC ANTIGEN [PSA] LEVELS). NON-METASTATIC CASTRATION-SENSITIVE PROSTATE CANCER (NMCSPC): HIGH RISK FOR METASTASIS (I.E. PSA DOUBLING TIME OF 9 MONTHS OR LESS). METASTATIC CRPC (MCRPC), NMCRPC, METASTATIC CSPC (MCSPC), NMCSPC : 1) RECEIVED A BILATERAL ORCHIECTOMY, 2) CASTRATE LEVEL OF TESTOSTERONE (I.E., LESS THAN 50 NG/DL), OR 3) CONCURRENT USE WITH A GONADOTROPIN RELEASING HORMONE (GNRH) ANALOG. RENEWAL: MCRPC, NMCRPC, MCSPC: 1) RECEIVED A BILATERAL ORCHIECTOMY, 2) CASTRATE LEVEL OF TESTOSTERONE (I.E., LESS THAN 50 NG/DL), OR 3) CONCURRENT USE WITH A GNRH ANALOG.
Indications	All FDA-approved Indications.
Off Label Uses	



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

PA Criteria	Criteria Details
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

EPCORITAMAB-BYSP

Products Affected

- EPKINLY

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

EPOETIN ALFA-EPBX

Products Affected

- RETACRIT INJECTION SOLUTION 3,000 UNIT/ML, 4,000 UNIT/ML, 40,000 UNIT/ML, 10,000 UNIT/ML, 2,000 UNIT/ML, 20,000 UNIT/2 ML, 20,000 UNIT/ML,

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: CHRONIC KIDNEY DISEASE (CKD), ANEMIA RELATED TO ZIDOVUDINE, OR CANCER CHEMOTHERAPY: HEMOGLOBIN LEVEL IS LESS THAN 10G/DL. ELECTIVE, NON-CARDIAC, NON-VASCULAR SURGERY: HEMOGLOBIN LEVEL IS LESS THAN 13G/DL. RENEWAL: 1) CKD IN ADULTS NOT ON DIALYSIS: (A) HEMOGLOBIN LEVEL IS LESS THAN 10G/DL, OR (B) HEMOGLOBIN LEVEL HAS REACHED 10G/DL AND THE DOSE IS BEING OR HAS BEEN REDUCED/INTERRUPTED TO DECREASE THE NEED FOR BLOOD TRANSFUSIONS. 2) CKD IN PEDIATRIC PATIENTS: (A) HEMOGLOBIN LEVEL IS LESS THAN 10G/DL, OR (B) HEMOGLOBIN LEVEL HAS APPROACHED OR EXCEEDS 12G/DL AND THE DOSE IS BEING OR HAS BEEN REDUCED/INTERRUPTED TO DECREASE THE NEED FOR BLOOD TRANSFUSIONS. 3) ANEMIA RELATED TO ZIDOVUDINE: HEMOGLOBIN LEVEL BETWEEN 10G/DL AND 12G/DL. 4) CANCER CHEMOTHERAPY: (A) HEMOGLOBIN LEVEL IS LESS THAN 10 G/DL, OR (B) HEMOGLOBIN LEVEL DOES NOT EXCEED A LEVEL NEEDED TO AVOID RBC TRANSFUSION.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	ANEMIA FROM CHEMO/CKD WITHOUT DIALYSIS/ZIDOVUDINE: INITIAL/RENEWAL: 12 MONTHS. SURGERY: 1 MONTH.
Other Criteria	RENEWAL: CKD: NOT RECEIVING DIALYSIS TREATMENT. THIS DRUG MAY BE EITHER BUNDLED WITH AND COVERED UNDER END STAGE RENAL DISEASE DIALYSIS RELATED SERVICES OR COVERED UNDER MEDICARE D DEPENDING UPON THE CIRCUMSTANCES.

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

ERDAFITINIB

Products Affected

- BALVERSA ORAL TABLET 3 MG, 4 MG, 5 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

ERENUMAB-AOOE

Products Affected

- AIMOVIG AUTOINJECTOR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	MIGRAINE PREVENTION: INITIAL/RENEWAL: NO CONCURRENT USE WITH OTHER CGRP INHIBITORS FOR MIGRAINE PREVENTION. RENEWAL: REDUCTION IN MIGRAINE OR HEADACHE FREQUENCY, MIGRAINE SEVERITY, OR MIGRAINE DURATION WITH THERAPY.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

ERLOTINIB

Products Affected

- *erlotinib oral tablet 100 mg, 150 mg, 25 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	METASTATIC NON-SMALL CELL LUNG CANCER (NSCLC) WITH EGFR MUTATION: NOT ON CONCURRENT THERAPY WITH AN EGFR TYROSINE KINASE INHIBITOR.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

ESKETAMINE

Products Affected

- SPRAVATO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	INITIAL: TREATMENT-RESISTANT DEPRESSION (TRD), MAJOR DEPRESSIVE DISORDER (MDD); PRESCRIBED BY OR IN CONSULTATION WITH A PSYCHIATRIST.
Coverage Duration	INITIAL: TRD: 3 MONTHS. MDD: 4 WEEKS. RENEWAL: TRD, MDD: 12 MONTHS.
Other Criteria	INITIAL: TRD, MDD: 1) NON-PSYCHOTIC, UNIPOLAR DEPRESSION, AND 2) NO ACTIVE SUBSTANCE ABUSE. RENEWAL: TRD, MDD: DEMONSTRATED CLINICAL BENEFIT (IMPROVEMENT IN DEPRESSION) COMPARED TO BASELINE.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

ETANERCEPT

Products Affected

- ENBREL
- ENBREL SURECLICK
- ENBREL MINI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: PLAQUE PSORIASIS (PSO): PSORIASIS COVERING 3 PERCENT OR MORE OF BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, FACE, SCALP, OR GENITAL AREA.
Age Restrictions	
Prescriber Restrictions	INITIAL: RHEUMATOID ARTHRITIS (RA), POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS (PJIA), ANKYLOSING SPONDYLITIS (AS): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST. PSORIATIC ARTHRITIS (PSA): PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST OR RHEUMATOLOGIST. PSO: PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST.
Coverage Duration	INITIAL: 6 MONTHS, RENEWAL: 12 MONTHS.
Other Criteria	INITIAL: RA: TRIAL OF OR CONTRAINDICATION TO 3 MONTHS OF TREATMENT WITH ONE DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG) - IF PATIENT TRIED METHOTREXATE, THEN TRIAL AT A DOSE GREATER THAN OR EQUAL TO 20 MG PER WEEK OR MAXIMALLY TOLERATED DOSE IS REQUIRED. PJIA: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR PJIA. PSA: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR PSA. AS: 1) TRIAL OF OR CONTRAINDICATION TO AN NSAID, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR AS. PSO: 1) ONE OF THE FOLLOWING: (A) AT LEAST A 3 MONTH TRIAL OF ONE ORAL IMMUNOSUPPRESSANT (CYCLOSPORINE, METHOTREXATE,

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

PA Criteria	Criteria Details
	TACROLIMUS) OR PUVA (PHOTOTHERAPY) FOR THE TREATMENT OF PSO, (B) CONTRAINDICATION OR INTOLERANCE TO BOTH IMMUNOSUPPRESSANT AND PUVA FOR THE TREATMENT OF PSO, OR (C) PATIENT IS SWITCHING FROM A DIFFERENT BIOLOGIC, PDE-4 INHIBITOR, OR JAK INHIBITOR FOR THE SAME INDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR PSO. RENEWAL: RA: CONTINUES TO BENEFIT FROM THE MEDICATION. PJIA: 1) CONTINUES TO BENEFIT FROM THE MEDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR PJIA. PSA: 1) CONTINUES TO BENEFIT FROM THE MEDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR PSA. AS: 1) CONTINUES TO BENEFIT FROM THE MEDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR AS. PSO: 1) CONTINUES TO BENEFIT FROM THE MEDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR PSO.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

EVEROLIMUS-AFINITOR

Products Affected

- *everolimus (antineoplastic) oral tablet 10 mg, 2.5 mg, 5 mg, 7.5 mg*
- *torpenz oral tablet 10 mg, 2.5 mg, 5 mg, 7.5 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

EVEROLIMUS-AFINITOR DISPERZ

Products Affected

- *everolimus (antineoplastic) oral tablet for suspension*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

FECAL MICROBIOTA CAPSULE

Products Affected

- VOWST

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	30 DAYS
Other Criteria	CLOSTRIDIoidES DIFFICILE INFECTION (CDI): 1) HAS NOT PREVIOUSLY RECEIVED VOWST: COMPLETION OF ANTIBIOTIC TREATMENT FOR RECURRENT CDI (AT LEAST 3 CDI EPISODES), OR 2) PREVIOUSLY RECEIVED VOWST: (A) TREATMENT FAILURE (DEFINED AS THE PRESENCE OF CDI DIARRHEA WITHIN 8 WEEKS OF FIRST DOSE OF VOWST AND A POSITIVE STOOL TEST FOR C. DIFFICILE), AND (B) HAS NOT RECEIVED MORE THAN ONE TREATMENT COURSE OF VOWST WHICH WAS AT LEAST 12 DAYS AND NOT MORE THAN 8 WEEKS PRIOR.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

FEDRATINIB

Products Affected

- INREBIC

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS
Other Criteria	MYELOFIBROSIS: INITIAL: TRIAL OF OR CONTRAINDICATION TO JAKAFI (RUXOLITINIB). RENEWAL: CONTINUES TO BENEFIT FROM THE MEDICATION.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

FENFLURAMINE

Products Affected

- FINTEPLA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	INITIAL: DRAVET SYNDROME, LENNOX-GASTAUT SYNDROME (LGS); PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST.
Coverage Duration	INITIAL/RENEWAL: 12 MONTHS.
Other Criteria	INITIAL: LGS: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING ANTIEPILEPTIC MEDICATIONS: RUFINAMIDE, FELBAMATE, CLOBAZAM, TOPIRAMATE, LAMOTRIGINE, CLONAZEPAM.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

FENTANYL CITRATE

Products Affected

- *fentanyl citrate buccal lozenge on a handle*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	CANCER RELATED PAIN: 1) CURRENTLY ON A MAINTENANCE DOSE OF CONTROLLED-RELEASE OPIOID PAIN MEDICATION, AND 2) TRIAL OF OR CONTRAINDICATION TO AT LEAST ONE IMMEDIATE-RELEASE ORAL OPIOID PAIN AGENT OR PATIENT HAS DIFFICULTY SWALLOWING TABLETS/CAPSULES.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

FEZOLINETANT

Products Affected

- VEOZAH

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	MENOPAUSAL VASOMOTOR SYMPTOMS (VMS): INITIAL: 1) EXPERIENCES 7 OR MORE HOT FLASHES PER DAY, AND 2) TRIAL OF OR CONTRAINDICATION TO HORMONAL THERAPY (E.G., ESTRADIOL TRANSDERMAL PATCH, ORAL CONJUGATED ESTROGENS). RENEWAL: 1) CONTINUED NEED FOR VMS TREATMENT (I.E., PERSISTENT HOT FLASHES), AND 2) REDUCTION IN VMS FREQUENCY OR SEVERITY DUE TO VEOZAH TREATMENT.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

FILGRASTIM-AAFI

Products Affected

- NIVESTYM

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR IN CONSULTATION WITH A HEMATOLOGIST OR ONCOLOGIST.
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

FINERENONE

Products Affected

- KERENDIA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: HEART FAILURE (HF): 1) NEW YORK HEART ASSOCIATION (NYHA) CLASS II-IV, AND 2) LEFT VENTRICULAR EJECTION FRACTION OF AT LEAST 40 PERCENT NOT DUE TO AN UNDERLYING CAUSE (E.G., INFILTRATIVE CARDIOMYOPATHY, HYPERTROPHIC CARDIOMYOPATHY, VALVULAR DISEASE, PERICARDIAL DISEASE, HIGH-OUTPUT HEART FAILURE).
Age Restrictions	
Prescriber Restrictions	INITIAL: HF: PRESCRIBED BY OR IN CONSULTATION WITH A CARDIOLOGIST.
Coverage Duration	CHRONIC KIDNEY DISEASE ASSOCIATED WITH TYPE 2 DIABETES: 12 MOS. INITIAL/RENEWAL: HF: 12 MOS.
Other Criteria	INITIAL/RENEWAL: HF: NO CONCURRENT USE WITH ANOTHER MINERALOCORTICOID (ALDOSTERONE) RECEPTOR ANTAGONIST.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

FINGOLIMOD

Products Affected

- *fingolimod*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

FOSCARBIDOPA-FOSLEVODOPA

Products Affected

- VYALEV

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	PARKINSONS DISEASE (PD): INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST.
Coverage Duration	INITIAL: 3 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	PD: INITIAL: 1) RESPONSIVE TO LEVODOPA, 2) CURRENT REGIMEN INCLUDES AT LEAST 400 MG/DAY OF LEVODOPA, AND 3) MOTOR SYMPTOMS ARE CURRENTLY UNCONTROLLED (DEFINED AS AN AVERAGE OFF TIME OF AT LEAST 2.5 HOURS/DAY OVER 3 CONSECUTIVE DAYS WITH A MINIMUM OF 2 HOURS EACH DAY). RENEWAL: IMPROVEMENT IN MOTOR SYMPTOMS WHILE ON THERAPY.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

FREMANEZUMAB-VFRM

Products Affected

- AJOVY AUTOINJECTOR
- AJOVY SYRINGE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL: 6 MONTHS, RENEWAL: 12 MONTHS.
Other Criteria	MIGRAINE PREVENTION: INITIAL/RENEWAL: NO CONCURRENT USE WITH OTHER CGRP INHIBITORS FOR MIGRAINE PREVENTION. RENEWAL: REDUCTION IN MIGRAINE OR HEADACHE FREQUENCY, MIGRAINE SEVERITY, OR MIGRAINE DURATION WITH THERAPY.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

FRUQUINTINIB

Products Affected

- FRUZAQLA ORAL CAPSULE 1 MG, 5 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

FUTIBATINIB

Products Affected

- LYTGOBI ORAL TABLET 12 MG/DAY (4 MG X 3), 16 MG/DAY (4 MG X 4), 20 MG/DAY (4 MG X 5)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INTRAHEPATIC CHOLANGIOCARCINOMA (ICCA): COMPLETE A COMPREHENSIVE OPHTHALMOLOGICAL EXAMINATION, INCLUDING OPTICAL COHERENCE TOMOGRAPHY (OCT), PRIOR TO THE INITIATION OF THERAPY AND AT THE RECOMMENDED SCHEDULED INTERVALS.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

GALCANEZUMAB-GNLM

Products Affected

- EMGALITY PEN MG/ML, 300 MG/3 ML (100 MG/ML X 3)
- EMGALITY SYRINGE
- SUBCUTANEOUS SYRINGE 120

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL: MIGRAINE PREVENTION: 6 MOS. EPISODIC CLUSTER HEADACHE: 3 MOS. RENEWAL (ALL): 12 MOS.
Other Criteria	MIGRAINE PREVENTION: INITIAL/RENEWAL: NO CONCURRENT USE WITH OTHER CGRP INHIBITORS FOR MIGRAINE PREVENTION. RENEWAL: REDUCTION IN MIGRAINE OR HEADACHE FREQUENCY, MIGRAINE SEVERITY, OR MIGRAINE DURATION WITH THERAPY. EPISODIC CLUSTER HEADACHE: RENEWAL: IMPROVEMENT IN EPISODIC CLUSTER HEADACHE FREQUENCY AS COMPARED TO BASELINE.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

GANAXOLONE

Products Affected

- ZTALMY

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

GEFITINIB

Products Affected

- *gefitinib*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	METASTATIC NON-SMALL CELL LUNG CANCER (NSCLC) WITH EGFR MUTATION: NOT ON CONCURRENT THERAPY WITH AN EGFR TYROSINE KINASE INHIBITOR.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

GILTERITINIB

Products Affected

- XOSPATA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

GLASDEGIB

Products Affected

- DAURISMO ORAL TABLET 100 MG,
25 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

GLATIRAMER

Products Affected

- *glatiramer subcutaneous syringe 20 mg/ml, 40 mg/ml*
- *glatopa subcutaneous syringe 20 mg/ml, 40 mg/ml*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

GLP1-DULAGLUTIDE

Products Affected

- TRULICITY

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

GLP1-SEMAGLUTIDE

Products Affected

- OZEMPIC
- RYBELSUS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

GLP1-TIRZEPATIDE

Products Affected

- MOUNJARO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

GOSERELIN

Products Affected

- ZOLADEX

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	ENDOMETRIOSIS: DIAGNOSIS IS CONFIRMED VIA SURGICAL OR DIRECT VISUALIZATION (E.G., PELVIC ULTRASOUND) OR HISTOPATHOLOGICAL CONFIRMATION (E.G., LAPAROSCOPY OR LAPAROTOMY) IN THE LAST 10 YEARS.
Age Restrictions	
Prescriber Restrictions	ENDOMETRIOSIS: PRESCRIBED BY OR IN CONSULTATION WITH AN OBSTETRICIAN/GYNECOLOGIST.
Coverage Duration	STAGE B2-C PROSTATIC CARCINOMA: 4 MOS. ENDOMETRIOSIS: 6 MOS PER LIFETIME. ALL OTHERS: 12 MONTHS.
Other Criteria	ENDOMETRIOSIS: 1) NO CONCURRENT USE WITH ANOTHER GNRH-MODULATING AGENT, 2) TRIAL OF OR CONTRAINDICATION TO NSAID AND PROGESTIN-CONTAINING PREPARATION, AND 3) HAS NOT RECEIVED A TOTAL OF 6 MONTHS OF TREATMENT PER LIFETIME. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

GUSELKUMAB

Products Affected

- TREMFYA INTRAVENOUS
- TREMFYA ONE-PRESS
- TREMFYA PEN INDUCTION PK-CROHN
- TREMFYA PEN SUBCUTANEOUS PEN INJECTOR 200 MG/2 ML
- TREMFYA SUBCUTANEOUS SYRINGE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: PLAQUE PSORIASIS (PSO): PSORIASIS COVERING 3 PERCENT OR MORE OF BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, FACE, SCALP, OR GENITAL AREA.
Age Restrictions	
Prescriber Restrictions	INITIAL: PSO: PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST. PSORIATIC ARTHRITIS (PSA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST OR DERMATOLOGIST. ULCERATIVE COLITIS (UC), CROHNS DISEASE (CD): PRESCRIBED BY OR IN CONSULTATION WITH A GASTROENTEROLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS
Other Criteria	INITIAL: PSA: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR PSA. PSO: 1) ONE OF THE FOLLOWING: (A) AT LEAST A 3 MONTH TRIAL OF ONE ORAL IMMUNOSUPPRESSANT (CYCLOSPORINE, METHOTREXATE, TACROLIMUS) OR PUVA (PHOTOTHERAPY) FOR THE TREATMENT OF PSO, (B) CONTRAINDICATION OR INTOLERANCE TO BOTH IMMUNOSUPPRESSANT AND PUVA FOR THE TREATMENT OF PSO, OR (C) PATIENT IS SWITCHING FROM A DIFFERENT BIOLOGIC, PDE-4 INHIBITOR, OR JAK INHIBITOR FOR THE SAME INDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR PSO. UC: NO

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

PA Criteria	Criteria Details
	CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR UC. CD: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR CD. RENEWAL: PSA: 1) CONTINUES TO BENEFIT FROM THE MEDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR PSA. PSO: 1) CONTINUES TO BENEFIT FROM THE MEDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR PSO. UC: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR UC. CD: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR CD.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

HIGH CONCENTRATION ORAL OPIOID SOLUTIONS

Products Affected

- morphine concentrate oral solution*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	OPIOID TOLERANT: 12 MONTHS. HOSPICE, PALLIATIVE CARE OR END OF LIFE CARE: LIFETIME.
Other Criteria	1) OPIOID TOLERANT (I.E. PREVIOUS USE OF 60 MG ORAL MORPHINE PER DAY, 25 MCG TRANSDERMAL FENTANYL PER HOUR, 30 MG ORAL OXYCODONE PER DAY, 8 MG ORAL HYDROMORPHONE PER DAY, 25 MG ORAL OXYMORPHONE PER DAY, 60 MG ORAL HYDROCODONE PER DAY, OR AN EQUIANALGESIC DOSE OF ANOTHER OPIOID) AND HAS TROUBLE SWALLOWING OPIOID TABLETS, CAPSULES, OR LARGE VOLUMES OF LIQUID, OR 2) ENROLLED IN HOSPICE OR PALLIATIVE CARE OR END OF LIFE CARE.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

HIGH RISK DRUGS IN THE ELDERLY - BUTALBITAL-CONTAINING AGENTS

Products Affected

- *butalbital-acetaminop-caff-cod oral capsule 50-325-40-30 mg*
- *butalbital-acetaminophen-caff oral capsule*
- *butalbital-acetaminophen-caff oral tablet*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	PRESCRIBER ACKNOWLEDGEMENT/AWARENESS DRUG IS CONSIDERED HIGH RISK FOR PATIENTS 65 YEARS AND OLDER. HOSPICE PATIENTS ARE APPROVED WITHOUT REQUIRING ADDITIONAL CRITERIA.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

HIGH RISK DRUGS IN THE ELDERLY - CONJUGATED ESTROGEN

Products Affected

- PREMARIN ORAL

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	VULVAR/VAGINAL ATROPHY, OSTEOPOROSIS AND VASOMOTOR SYMPTOMS OF MENOPAUSE: PRESCRIBER ACKNOWLEDGEMENT/AWARENESS THAT THE DRUG IS CONSIDERED HIGH RISK FOR PATIENTS 65 YEARS AND OLDER. HYPOESTROGENISM TREATMENT, PALLIATIVE TREATMENT, AND HOSPICE PATIENTS WILL BE APPROVED WITHOUT REQUIRING ADDITIONAL CRITERIA.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

HIGH RISK DRUGS IN THE ELDERLY - DIPYRIDAMOLE

Products Affected

- *dipyridamole oral tablet 50 mg, 75 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	PRESCRIBER ACKNOWLEDGEMENT/AWARENESS THAT THE DRUG IS CONSIDERED HIGH RISK FOR PATIENTS 65 YEARS AND OLDER. HOSPICE PATIENTS WILL BE APPROVED WITHOUT REQUIRING ADDITIONAL CRITERIA.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

HIGH RISK DRUGS IN THE ELDERLY - ESTRADIOL

Products Affected

- *estradiol oral*
- *estradiol transdermal patch weekly*
- *estradiol transdermal patch semiweekly*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	VULVAR/VAGINAL ATROPHY, OSTEOPOROSIS AND VASOMOTOR SYMPTOMS OF MENOPAUSE: PRESCRIBER ACKNOWLEDGEMENT/AWARENESS THAT THE DRUG IS CONSIDERED HIGH RISK FOR PATIENTS 65 YEARS AND OLDER. HYPOESTROGENISM TREATMENT, PALLIATIVE TREATMENT, AND HOSPICE PATIENTS WILL BE APPROVED WITHOUT REQUIRING ADDITIONAL CRITERIA.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

HIGH RISK DRUGS IN THE ELDERLY - ESTRADIOL-NORETHINDRONE

Products Affected

- *abigale*
- *estradiol-norethindrone acet*
- *mimvey*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	VULVAR/VAGINAL ATROPHY, OSTEOPOROSIS, AND VASOMOTOR SYMPTOMS OF MENOPAUSE: PRESCRIBER ACKNOWLEDGEMENT/AWARENESS THAT THE DRUG IS CONSIDERED HIGH RISK FOR PATIENTS 65 YEARS AND OLDER. HYPOESTROGENISM TREATMENT AND HOSPICE PATIENTS WILL BE APPROVED WITHOUT REQUIRING ADDITIONAL CRITERIA.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

HIGH RISK DRUGS IN THE ELDERLY - ESTROGEN-BAZEDOXIFENE

Products Affected

- DUAVEE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	PRESCRIBER ACKNOWLEDGEMENT/AWARENESS THAT THE DRUG IS CONSIDERED HIGH RISK FOR PATIENTS 65 YEARS AND OLDER. HOSPICE PATIENTS WILL BE APPROVED WITHOUT REQUIRING ADDITIONAL CRITERIA.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

HIGH RISK DRUGS IN THE ELDERLY - ESTROGEN-MEDROXYPROGESTERONE

Products Affected

- PREMPHASE
- PREMPRO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	PRESCRIBER ACKNOWLEDGEMENT/AWARENESS THAT THE DRUG IS CONSIDERED HIGH RISK FOR PATIENTS 65 YEARS AND OLDER. HOSPICE PATIENTS WILL BE APPROVED WITHOUT REQUIRING ADDITIONAL CRITERIA.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

HIGH RISK DRUGS IN THE ELDERLY - GLYBURIDE FORMULATIONS

Products Affected

- *glyburide*
- *glyburide-metformin*
- *glyburide micronized*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	TYPE 2 DIABETES MELLITUS (DM): 1) TRIAL OF OR CONTRAINDICATION TO GLIMEPIRIDE OR GLIPIZIDE, OR 2) PRESCRIBER ACKNOWLEDGEMENT/AWARENESS THAT THE DRUG IS CONSIDERED HIGH RISK FOR PATIENTS 65 YEARS AND OLDER. HOSPICE PATIENTS ARE APPROVED WITHOUT REQUIRING ADDITIONAL CRITERIA.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

HIGH RISK DRUGS IN THE ELDERLY - KETOROLAC

Products Affected

- *ketorolac oral*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.
Prescriber Restrictions	
Coverage Duration	30 DAYS
Other Criteria	PREScriBER ACKNOWLEDGEMENT/AWARENESS THAT THE DRUG IS CONSIDERED HIGH RISK FOR PATIENTS 65 YEARS AND OLDER. HOSPICE PATIENTS WILL BE APPROVED WITHOUT REQUIRING ADDITIONAL CRITERIA.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

HIGH RISK DRUGS IN THE ELDERLY - PHENOBARBITAL

Products Affected

- *phenobarbital*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	EPILEPSY/SEIZURES: PATIENTS WHO ARE NEWLY PRESCRIBED PHENOBARBITAL: 1) HAS NOT RESPONDED TO AT LEAST ONE ANTICONVULSANT, OR 2) PRESCRIBER ACKNOWLEDGEMENT/AWARENESS THAT THE DRUG IS CONSIDERED HIGH RISK FOR PATIENTS 65 YEARS AND OLDER. HOSPICE PATIENTS WILL BE APPROVED WITHOUT REQUIRING ADDITIONAL CRITERIA.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

HIGH RISK DRUGS IN THE ELDERLY - PROMETHAZINE

Products Affected

- *promethazine injection solution 25 mg/ml*
- *promethazine oral tablet*
- *promethazine rectal suppository 25 mg*
- *promethegan rectal suppository 12.5 mg, 25 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	PRURITUS/URTICARIA/SEASONAL/PERENNIAL ALLERGY: 1) TRIAL OF OR CONTRAINDICATION TO A NON-SEDATING ANTIHISTAMINE SUCH AS LEVOCETIRIZINE, OR 2) PRESCRIBER ACKNOWLEDGEMENT/AWARENESS THAT THE DRUG IS CONSIDERED HIGH RISK FOR PATIENTS 65 YEARS AND OLDER. NAUSEA AND VOMITING: PRESCRIBER ACKNOWLEDGEMENT/AWARENESS THAT THE DRUG IS CONSIDERED HIGH-RISK FOR PATIENTS 65 YEARS AND OLDER. HOSPICE PATIENTS REQUIRE PHYSICIAN ATTESTATION THAT REQUESTED MEDICATION IS USED TO TREAT A DIAGNOSIS UNRELATED TO THE TERMINAL ILLNESS OR RELATED CONDITION, AND ARE APPROVED WITHOUT TRIAL OF FORMULARY ALTERNATIVES NOR REQUIRING PRESCRIBER ACKNOWLEDGEMENT.
Indications	All FDA-approved Indications.
Off Label Uses	

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

PA Criteria	Criteria Details
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

HIGH RISK DRUGS IN THE ELDERLY - SCOPOLAMINE

Products Affected

- *scopolamine base*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	PREScriBER ACKNOWLEDGEMENT/AWARENESS THAT THE DRUG IS CONSIDERED HIGH RISK FOR PATIENTS 65 YEARS AND OLDER. HOSPICE PATIENTS REQUIRE PHYSICIAN ATTESTATION THAT REQUESTED MEDICATION IS USED TO TREAT A DIAGNOSIS UNRELATED TO THE TERMINAL ILLNESS OR RELATED CONDITION, AND ARE APPROVED WITHOUT REQUIRING PREScriBER ACKNOWLEDGEMENT.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

HIGH RISK DRUGS IN THE ELDERLY - SKELETAL MUSCLE RELAXANTS

Products Affected

- *cyclobenzaprine oral tablet 10 mg, 5 mg*
- *methocarbamol oral tablet 500 mg, 750 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	PRESCRIBER ACKNOWLEDGEMENT/AWARENESS THAT THE DRUG IS CONSIDERED A HIGH RISK MEDICATION FOR PATIENTS 65 YEARS AND OLDER. HOSPICE PATIENTS WILL BE APPROVED WITHOUT REQUIRING ADDITIONAL CRITERIA.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

HIGH RISK DRUGS IN THE ELDERLY- DIPHENOXYLATE-ATROPINE

Products Affected

- *diphenoxylate-atropine oral tablet*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	PRESCRIBER ACKNOWLEDGEMENT/AWARENESS THAT THE DRUG IS CONSIDERED HIGH RISK FOR PATIENTS 65 YEARS AND OLDER. HOSPICE PATIENTS WILL BE APPROVED WITHOUT REQUIRING ADDITIONAL CRITERIA.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

HIGH RISK DRUGS IN THE ELDERLY- INDOMETHACIN

Products Affected

- *indomethacin oral capsule*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	PRESCRIBER ACKNOWLEDGEMENT/AWARENESS DRUG IS CONSIDERED HIGH RISK FOR PATIENTS 65 YEARS AND OLDER. HOSPICE PATIENTS WILL BE APPROVED WITHOUT REQUIRING ADDITIONAL CRITERIA.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

HIGH RISK DRUGS IN THE ELDERLY- MEGESTROL

Products Affected

- *megestrol oral suspension 400 mg/10 ml (40 mg/ml), 625 mg/5 ml (125 mg/ml)*
- *megestrol oral tablet*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	PREScriBER ACKNOWLEDGEMENT/AWARENESS THAT THE DRUG IS CONSIDERED HIGH RISK FOR PATIENTS 65 YEARS AND OLDER. HOSPICE PATIENTS WILL BE APPROVED WITHOUT REQUIRING ADDITIONAL CRITERIA.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

HIGH RISK DRUGS IN THE ELDERLY- PAROXETINE

Products Affected

- *paroxetine hcl oral suspension*
- *paroxetine hcl oral tablet*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	PRESCRIBER ACKNOWLEDGEMENT/AWARENESS THAT THE DRUG IS CONSIDERED HIGH RISK FOR PATIENTS 65 YEARS AND OLDER. HOSPICE PATIENTS WILL BE APPROVED WITHOUT REQUIRING ADDITIONAL CRITERIA.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

IBRUTINIB

Products Affected

- IMBRUVICA ORAL CAPSULE 140 MG, 70 MG
- IMBRUVICA ORAL SUSPENSION
- IMBRUVICA ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

ICATIBANT

Products Affected

- *icatibant*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	HEREDITARY ANGIOEDEMA (HAE): DIAGNOSIS CONFIRMED BY COMPLEMENT TESTING.
Age Restrictions	
Prescriber Restrictions	HAE: PRESCRIBED BY OR IN CONSULTATION WITH AN ALLERGIST, IMMUNOLOGIST, OR HEMATOLOGIST.
Coverage Duration	12 MONTHS
Other Criteria	HAE: NO CONCURRENT USE WITH OTHER MEDICATIONS FOR TREATMENT OF ACUTE HAE ATTACKS.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

IDEALALISIB

Products Affected

- ZYDELIG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

IMATINIB

Products Affected

- *imatinib oral tablet 100 mg, 400 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	ADJUVANT GASTROINTESTINAL STROMAL TUMOR TREATMENT: 36 MONTHS. ALL OTHER DIAGNOSES: 12 MONTHS.
Other Criteria	PHILADELPHIA CHROMOSOME POSITIVE CHRONIC MYELOID LEUKEMIA: PATIENT HAS NOT RECEIVED A PREVIOUS TREATMENT WITH ANOTHER TYROSINE KINASE INHIBITOR.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

IMATINIB SOLUTION

Products Affected

- IMKELDI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	ADJUVANT GASTROINTESTINAL STROMAL TUMOR TREATMENT: 36 MONTHS. ALL OTHER DIAGNOSES: 12 MONTHS.
Other Criteria	PHILADELPHIA CHROMOSOME POSITIVE CHRONIC MYELOID LEUKEMIA: PATIENT HAS NOT RECEIVED A PREVIOUS TREATMENT WITH ANOTHER TYROSINE KINASE INHIBITOR. ALL INDICATIONS: UNABLE TO SWALLOW GENERIC IMATINIB TABLETS.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

IMETELSTAT

Products Affected

- RYTELO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

INAVOLISIB

Products Affected

- ITOVEBI ORAL TABLET 3 MG, 9 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

INFLIXIMAB

Products Affected

- infliximab*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: PLAQUE PSORIASIS (PSO): PSORIASIS COVERING 3 PERCENT OR MORE OF BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, GENITAL AREA, SCALP, OR FACE.
Age Restrictions	
Prescriber Restrictions	INITIAL: RHEUMATOID ARTHRITIS (RA), ANKYLOSING SPONDYLITIS (AS): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST. PSORIATIC ARTHRITIS (PSA): PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST OR RHEUMATOLOGIST. PSO: PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST. CROHNS DISEASE (CD), ULCERATIVE COLITIS (UC): PRESCRIBED BY OR IN CONSULTATION WITH A GASTROENTEROLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	INITIAL: RA: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: ENBREL, HUMIRA/CYLTEZO/YUFLYMA, XELJANZ, RINVOQ, ORENCIA. PSA: 1) TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: COSENTYX, ENBREL, HUMIRA/CYLTEZO/YUFLYMA, STELARA/SELARSDI/YESINTEK, XELJANZ, RINVOQ, SKYRIZI, TREMFYA, ORENCIA, OTEZLA, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR PSA. PSO: 1) TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: COSENTYX, ENBREL, HUMIRA/CYLTEZO/YUFLYMA, STELARA/SELARSDI/YESINTEK, SKYRIZI, TREMFYA, OTEZLA, AND 2) NO CONCURRENT USE

Updated: 11.01.2025
Y0150_PBM200_C (v2)

PA Criteria	Criteria Details
	WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR PSO. AS: 1) TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: COSENTYX, ENBREL, HUMIRA/CYLTEZO/YUFLYMA, XELJANZ, RINVOQ, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR AS. MODERATE TO SEVERE CD: 1) TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS, WHERE AGES ALIGN: STELARA/SELARSDI/YESINTEK, HUMIRA/CYLTEZO/YUFLYMA, RINVOQ, SKYRIZI, TREMFYA, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR CD. UC: 1) TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS, WHERE AGES ALIGN: STELARA/SELARSDI/YESINTEK, XELJANZ, HUMIRA/CYLTEZO/YUFLYMA, RINVOQ, SKYRIZI, TREMFYA, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR UC. RENEWAL: RA: CONTINUES TO BENEFIT FROM THE MEDICATION. PSA: 1) CONTINUES TO BENEFIT FROM THE MEDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR PSA. PSO: 1) CONTINUES TO BENEFIT FROM THE MEDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR PSO. AS: 1) CONTINUES TO BENEFIT FROM THE MEDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR AS. MODERATE TO SEVERE CD: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR CD. UC: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR UC. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

INSULIN SUPPLIES PAYMENT DETERMINATION

Products Affected

- 1ST TIER UNIFINE PENTP 5MM 31G
- 1ST TIER UNIFINE PNTIP 4MM 32G
- 1ST TIER UNIFINE PNTIP 6MM 31G
- 1ST TIER UNIFINE PNTIP 8MM 31G STRL,SINGLE-USE,SHRT
- 1ST TIER UNIFINE PNTIP 29GX1/2"
- 1ST TIER UNIFINE PNTIP 31GX3/16
- 1ST TIER UNIFINE PNTIP 32GX5/32
- ABOUTTIME PEN NEEDLE
- ADVOCATE INS 0.3 ML 30GX5/16"
- ADVOCATE INS 0.3 ML 31GX5/16"
- ADVOCATE INS 0.5 ML 30GX5/16"
- ADVOCATE INS 0.5 ML 31GX5/16"
- ADVOCATE INS 1 ML 31GX5/16"
- ADVOCATE INS SYR 0.3 ML 29GX1/2
- ADVOCATE INS SYR 0.5 ML 29GX1/2
- ADVOCATE INS SYR 1 ML 29GX1/2"
- ADVOCATE INS SYR 1 ML 30GX5/16
- ADVOCATE PEN NDL 12.7MM 29G
- ADVOCATE PEN NEEDLE 32G 4MM
- ADVOCATE PEN NEEDLE 4MM 33G
- ADVOCATE PEN NEEDLES 5MM 31G
- ADVOCATE PEN NEEDLES 8MM 31G
- ALCOHOL 70% SWABS
- ALCOHOL PADS
- ALCOHOL PREP SWABS
- ALCOHOL WIPES
- AQINJECT PEN NEEDLE 31G 5MM
- AQINJECT PEN NEEDLE 32G 4MM
- ASSURE ID DUO PRO NDL 31G 5MM
- ASSURE ID DUO-SHIELD 30GX3/16"
- ASSURE ID DUO-SHIELD 30GX5/16"
- ASSURE ID INSULIN SAFETY SYRINGE 1 ML 29 GAUGE X 1/2"
- ASSURE ID PEN NEEDLE 30GX3/16"
- ASSURE ID PEN NEEDLE 30GX5/16"
- ASSURE ID PEN NEEDLE 31GX3/16"
- ASSURE ID PRO PEN NDL 30G 5MM
- ASSURE ID SYR 0.5 ML 31GX15/64"
- ASSURE ID SYR 1 ML 31GX15/64"
- AUTOSHIELD DUO PEN NDL 30G 5MM
- BD AUTOSHIELD DUO NDL 5MMX30G
- BD ECLIPSE 30GX1/2" SYRINGE
- BD ECLIPSE NEEDLE 30GX1/2" (OTC)
- BD INS SYR 0.3 ML 8MMX31G(1/2)
- BD INS SYR UF 0.3 ML 12.7MMX30G
- BD INS SYR UF 0.5 ML 12.7MMX30G NOT FOR RETAIL SALE
- BD INSULIN SYR 1 ML 25GX1"
- BD INSULIN SYR 1 ML 25GX5/8"
- BD INSULIN SYR 1 ML 26GX1/2"
- BD INSULIN SYR 1 ML 27GX12.7MM
- BD INSULIN SYR 1 ML 27GX5/8" MICRO-FINE
- BD INSULIN SYRINGE SLIP TIP
- BD LO-DOSE ULTRA-FINE
- BD NANO 2 GEN PEN NDL 32G 4MM
- BD SAFETGLD INS 0.3 ML 29G 13MM
- BD SAFETGLD INS 0.5 ML 13MMX29G
- BD SAFETYGLD INS 0.3 ML 31G 8MM
- BD SAFETYGLD INS 0.5 ML 30G 8MM
- BD SAFETYGLD INS 1 ML 29G 13MM
- BD SAFETYGLID INS 1 ML 6MMX31G
- BD SAFETYGLIDE SYRINGE 27GX5/8
- BD SAFTYGLD INS 0.3 ML 6MMX31G
- BD SAFTYGLD INS 0.5 ML 29G 13MM
- BD SAFTYGLD INS 0.5 ML 6MMX31G
- BD SINGLE USE SWAB
- BD UF MICRO PEN NEEDLE 6MMX32G
- BD UF MINI PEN NEEDLE 5MMX31G

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

- BD UF NANO PEN NEEDLE 4MMX32G
- BD UF ORIG PEN NDL 12.7MMX29G
- BD UF SHORT PEN NEEDLE 8MMX31G
- BD VEO INS 0.3 ML 6MMX31G (1/2)
- BD VEO INS SYRING 1 ML 6MMX31G
- BD VEO INS SYRN 0.3 ML 6MMX31G
- BD VEO INS SYRN 0.5 ML 6MMX31G
- BORDERED GAUZE 2"X2"
- CAREFINE PEN NEEDLE 12.7MM 29G
- CAREFINE PEN NEEDLE 4MM 32G
- CAREFINE PEN NEEDLE 5MM 32G
- CAREFINE PEN NEEDLE 6MM 31G
- CAREFINE PEN NEEDLE 8MM 30G
- CAREFINE PEN NEEDLES 6MM 32G
- CAREFINE PEN NEEDLES 8MM 31G
- CARETOUCH ALCOHOL 70% PREP PAD
- CARETOUCH PEN NEEDLE 29G 12MM
- CARETOUCH PEN NEEDLE 31GX1/4"
- CARETOUCH PEN NEEDLE 31GX3/16"
- CARETOUCH PEN NEEDLE 31GX5/16"
- CARETOUCH PEN NEEDLE 32GX3/16"
- CARETOUCH PEN NEEDLE 32GX5/32"
- CARETOUCH SYR 0.3 ML 31GX5/16"
- CARETOUCH SYR 0.5 ML 30GX5/16"
- CARETOUCH SYR 0.5 ML 31GX5/16"
- CARETOUCH SYR 1 ML 28GX5/16"
- CARETOUCH SYR 1 ML 29GX5/16"
- CARETOUCH SYR 1 ML 30GX5/16"
- CARETOUCH SYR 1 ML 31GX5/16"
- CLICKFINE PEN NEEDLE 32GX5/32" 32GX4MM, STERILE
- COMFORT EZ 0.3 ML 31G 15/64"
- COMFORT EZ 0.5 ML 31G 15/64"
- COMFORT EZ INS 0.3 ML 30GX1/2"
- COMFORT EZ INS 0.3 ML 30GX5/16"
- COMFORT EZ INS 1 ML 31G 15/64"
- COMFORT EZ INS 1 ML 31GX5/16"
- COMFORT EZ INSULIN SYR 0.3 ML
- COMFORT EZ INSULIN SYR 0.5 ML
- COMFORT EZ PEN NEEDLE 12MM 29G
- COMFORT EZ PEN NEEDLES 4MM 32G SINGLE USE, MICRO
- COMFORT EZ PEN NEEDLES 4MM 33G
- COMFORT EZ PEN NEEDLES 5MM 31G MINI
- COMFORT EZ PEN NEEDLES 5MM 32G SINGLE USE, MINI, HRI
- COMFORT EZ PEN NEEDLES 5MM 33G
- COMFORT EZ PEN NEEDLES 6MM 31G
- COMFORT EZ PEN NEEDLES 6MM 32G
- COMFORT EZ PEN NEEDLES 6MM 33G
- COMFORT EZ PEN NEEDLES 8MM 31G SHORT
- COMFORT EZ PEN NEEDLES 8MM 32G
- COMFORT EZ PEN NEEDLES 8MM 33G
- COMFORT EZ PRO PEN NDL 30G 8MM
- COMFORT EZ PRO PEN NDL 31G 4MM
- COMFORT EZ PRO PEN NDL 31G 5MM
- COMFORT EZ SYR 0.3 ML 29GX1/2"
- COMFORT EZ SYR 0.5 ML 28GX1/2"
- COMFORT EZ SYR 0.5 ML 29GX1/2"
- COMFORT EZ SYR 0.5 ML 30GX1/2"
- COMFORT EZ SYR 1 ML 28GX1/2"
- COMFORT EZ SYR 1 ML 29GX1/2"
- COMFORT EZ SYR 1 ML 30GX1/2"
- COMFORT EZ SYR 1 ML 30GX5/16"
- COMFORT POINT PEN NDL 31GX1/3"
- COMFORT POINT PEN NDL 31GX1/6"

Updated: 11.01.2025

Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

- COMFORT TOUCH PEN NDL 31G 4MM
- COMFORT TOUCH PEN NDL 31G 5MM
- COMFORT TOUCH PEN NDL 31G 6MM
- COMFORT TOUCH PEN NDL 31G 8MM
- COMFORT TOUCH PEN NDL 32G 4MM
- COMFORT TOUCH PEN NDL 32G 5MM
- COMFORT TOUCH PEN NDL 32G 6MM
- COMFORT TOUCH PEN NDL 32G 8MM
- COMFORT TOUCH PEN NDL 33G 4MM
- COMFORT TOUCH PEN NDL 33G 6MM
- COMFORT TOUCH PEN NDL 33GX5MM
- CURAD GAUZE PADS 2" X 2"
- CURITY ALCOHOL PREPS 2 PLY,MEDIUM
- CURITY GAUZE PADS
- CURITY GAUZE SPONGES (12 PLY)-200/BAG
- DERMACEA 2"X2" GAUZE 12 PLY, USP TYPE VII
- DERMACEA GAUZE 2"X2" SPONGE 8 PLY
- DERMACEA NON-WOVEN 2"X2" SPNGE
- DROPLET 0.3 ML 29G 12.7MM(1/2)
- DROPLET 0.3 ML 30G 12.7MM(1/2)
- DROPLET 0.5 ML 29GX12.5MM(1/2)
- DROPLET 0.5 ML 30GX12.5MM(1/2)
- DROPLET INS 0.3 ML 29GX12.5MM
- DROPLET INS 0.3 ML 30G 8MM(1/2)
- DROPLET INS 0.3 ML 30GX12.5MM
- DROPLET INS 0.3 ML 31G 6MM(1/2)
- DROPLET INS 0.3 ML 31G 8MM(1/2)
- DROPLET INS 0.5 ML 29G 12.7MM
- DROPLET INS 0.5 ML 30G 12.7MM
- DROPLET INS 0.5 ML 30GX6MM(1/2)
- DROPLET INS 0.5 ML 30GX8MM(1/2)
- DROPLET INS 0.5 ML 31GX6MM(1/2)
- DROPLET INS 0.5 ML 31GX8MM(1/2)
- DROPLET INS SYR 0.3 ML 30GX6MM
- DROPLET INS SYR 0.3 ML 30GX8MM
- DROPLET INS SYR 0.3 ML 31GX6MM
- DROPLET INS SYR 0.3 ML 31GX8MM
- DROPLET INS SYR 0.5 ML 30G 8MM
- DROPLET INS SYR 0.5 ML 31G 6MM
- DROPLET INS SYR 0.5 ML 31G 8MM
- DROPLET INS SYR 1 ML 29G 12.7MM
- DROPLET INS SYR 1 ML 30G 8MM
- DROPLET INS SYR 1 ML 30GX12.5MM
- DROPLET INS SYR 1 ML 30GX6MM
- DROPLET INS SYR 1 ML 31G 6MM
- DROPLET INS SYR 1 ML 31GX6MM
- DROPLET INS SYR 1 ML 31GX8MM
- DROPLET MICRON 34G X 9/64"
- DROPLET PEN NEEDLE 29G 10MM
- DROPLET PEN NEEDLE 29G 12MM
- DROPLET PEN NEEDLE 30G 8MM
- DROPLET PEN NEEDLE 31G 5MM
- DROPLET PEN NEEDLE 31G 6MM
- DROPLET PEN NEEDLE 31G 8MM
- DROPLET PEN NEEDLE 32G 4MM
- DROPLET PEN NEEDLE 32G 5MM
- DROPLET PEN NEEDLE 32G 6MM
- DROPLET PEN NEEDLE 32G 8MM
- DROPSAFE ALCOHOL 70% PREP PADS
- DROPSAFE INS SYR 0.3 ML 31G 6MM
- DROPSAFE INS SYR 0.3 ML 31G 8MM
- DROPSAFE INS SYR 0.5 ML 31G 6MM
- DROPSAFE INS SYR 0.5 ML 31G 8MM
- DROPSAFE INSUL SYR 1 ML 31G 6MM
- DROPSAFE INSUL SYR 1 ML 31G 8MM

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

- DROPSAFE INSULN 1 ML 29G 12.5MM
- DROPSAFE PEN NEEDLE 31GX1/4"
- DROPSAFE PEN NEEDLE 31GX3/16"
- DROPSAFE PEN NEEDLE 31GX5/16"
- DRUG MART ULTRA COMFORT SYR
- EASY CMFT SFTY PEN NDL 31G 5MM
- EASY CMFT SFTY PEN NDL 31G 6MM
- EASY CMFT SFTY PEN NDL 32G 4MM
- EASY COMFORT 0.3 ML 31G 1/2"
- EASY COMFORT 0.3 ML 31G 5/16"
- EASY COMFORT 0.3 ML SYRINGE
- EASY COMFORT 0.5 ML 30GX1/2"
- EASY COMFORT 0.5 ML 31GX5/16"
- EASY COMFORT 0.5 ML 32GX5/16"
- EASY COMFORT 0.5 ML SYRINGE
- EASY COMFORT 1 ML 31GX5/16"
- EASY COMFORT 1 ML 32GX5/16"
- EASY COMFORT ALCOHOL 70% PAD
- EASY COMFORT INSULIN 1 ML SYR
- EASY COMFORT PEN NDL 29G 4MM
- EASY COMFORT PEN NDL 29G 5MM
- EASY COMFORT PEN NDL 31GX1/4"
- EASY COMFORT PEN NDL 31GX3/16"
- EASY COMFORT PEN NDL 31GX5/16"
- EASY COMFORT PEN NDL 32GX5/32"
- EASY COMFORT PEN NDL 33G 4MM
- EASY COMFORT PEN NDL 33G 5MM
- EASY COMFORT PEN NDL 33G 6MM
- EASY COMFORT SYR 0.5 ML 29G 8MM
- EASY COMFORT SYR 1 ML 29G 8MM
- EASY COMFORT SYR 1 ML 30GX1/2"
- EASY GLIDE INS 0.3 ML 31GX6MM
- EASY GLIDE INS 0.5 ML 31GX6MM
- EASY GLIDE INS 1 ML 31GX6MM
- EASY GLIDE PEN NEEDLE 4MM 33G
- EASY TOUCH 0.3 ML SYR 30GX1/2"
- EASY TOUCH 0.5 ML SYR 27GX1/2"
- EASY TOUCH 0.5 ML SYR 29GX1/2"
- EASY TOUCH 0.5 ML SYR 30GX1/2"
- EASY TOUCH 0.5 ML SYR 30GX5/16
- EASY TOUCH 1 ML SYR 27GX1/2"
- EASY TOUCH 1 ML SYR 29GX1/2"
- EASY TOUCH 1 ML SYR 30GX1/2"
- EASY TOUCH ALCOHOL 70% PADS GAMMA-STERILIZED
- EASY TOUCH FLIPLOK 1 ML 27GX0.5
- EASY TOUCH INSULIN 1 ML 29GX1/2
- EASY TOUCH INSULIN 1 ML 30GX1/2
- EASY TOUCH INSULIN SYR 0.3 ML
- EASY TOUCH INSULIN SYR 0.5 ML
- EASY TOUCH INSULIN SYR 1 ML
- EASY TOUCH INSULIN SYR 1 ML RETRACTABLE
- EASY TOUCH INSULN 1 ML 29GX1/2"
- EASY TOUCH INSULN 1 ML 30GX1/2"
- EASY TOUCH INSULN 1 ML 30GX5/16
- EASY TOUCH INSULN 1 ML 31GX5/16
- EASY TOUCH LUER LOK INSUL 1 ML
- EASY TOUCH PEN NEEDLE 29GX1/2"
- EASY TOUCH PEN NEEDLE 30GX5/16
- EASY TOUCH PEN NEEDLE 31GX1/4"
- EASY TOUCH PEN NEEDLE 31GX3/16
- EASY TOUCH PEN NEEDLE 31GX5/16
- EASY TOUCH PEN NEEDLE 32GX1/4"
- EASY TOUCH PEN NEEDLE 32GX3/16
- EASY TOUCH PEN NEEDLE 32GX5/32
- EASY TOUCH SAF PEN NDL 29G 5MM
- EASY TOUCH SAF PEN NDL 29G 8MM
- EASY TOUCH SAF PEN NDL 30G 5MM
- EASY TOUCH SAF PEN NDL 30G 8MM
- EASY TOUCH SYR 0.5 ML 28G 12.7MM
- EASY TOUCH SYR 0.5 ML 29G 12.7MM
- EASY TOUCH SYR 1 ML 27G 16MM
- EASY TOUCH SYR 1 ML 28G 12.7MM
- EASY TOUCH SYR 1 ML 29G 12.7MM
- EASY TOUCH UNI-SLIP SYR 1 ML
- EASYTOUCH SAF PEN NDL 30G 6MM

Updated: 11.01.2025

Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

- EMBRACE PEN NEEDLE 29G 12MM
- EMBRACE PEN NEEDLE 30G 5MM
- EMBRACE PEN NEEDLE 30G 8MM
- EMBRACE PEN NEEDLE 31G 5MM
- EMBRACE PEN NEEDLE 31G 6MM
- EMBRACE PEN NEEDLE 31G 8MM
- EMBRACE PEN NEEDLE 32G 4MM
- EQL INSULIN 0.5 ML SYRINGE
- EQL INSULIN 0.5 ML SYRINGE SHORT NEEDLE
- FP INSULIN 1 ML SYRINGE
- FREESTYLE PREC 0.5 ML 30GX5/16
- FREESTYLE PREC 0.5 ML 31GX5/16
- FREESTYLE PREC 1 ML 30GX5/16"
- FREESTYLE PREC 1 ML 31GX5/16"
- GAUZE PAD TOPICAL BANDAGE 2 X 2 "
- GNP CLICKFINE 31G X 1/4" NDL 6MM, UNIVERSAL
- GNP CLICKFINE 31G X 5/16" NDL 8MM, UNIVERSAL
- GNP SIMPLI PEN NEEDLE 32G 4MM
- GNP ULT C 0.3 ML 29GX1/2" (1/2) 1/2 UNIT
- GNP ULT CMFRT 0.5 ML 29GX1/2"
- GNP ULTRA COMFORT 0.5 ML SYR
- GNP ULTRA COMFORT 1 ML SYRINGE
- GNP ULTRA COMFORT 3/10 ML SYR
- GS PEN NEEDLE 31G X 5MM
- GS PEN NEEDLE 31G X 8MM
- HEALTHWISE INS 0.3 ML 30GX5/16"
- HEALTHWISE INS 0.3 ML 31GX5/16"
- HEALTHWISE INS 0.5 ML 30GX5/16"
- HEALTHWISE INS 0.5 ML 31GX5/16"
- HEALTHWISE INS 1 ML 30GX5/16"
- HEALTHWISE INS 1 ML 31GX5/16"
- HEALTHWISE PEN NEEDLE 31G 5MM
- HEALTHWISE PEN NEEDLE 31G 8MM
- HEALTHWISE PEN NEEDLE 32G 4MM
- HEALTHY ACCENTS PENTIP 4MM 32G
- HEALTHY ACCENTS PENTIP 5MM 31G
- HEALTHY ACCENTS PENTIP 6MM 31G
- HEALTHY ACCENTS PENTIP 8MM 31G
- HEALTHY ACCENTS PENTIP 12MM 29G
- HEB INCONTROL ALCOHOL 70% PADS
- INCONTROL PEN NEEDLE 12MM 29G
- INCONTROL PEN NEEDLE 4MM 32G
- INCONTROL PEN NEEDLE 5MM 31G
- INCONTROL PEN NEEDLE 6MM 31G
- INCONTROL PEN NEEDLE 8MM 31G
- INSULIN 1 ML SYRINGE
- INSULIN SYR 0.3 ML 31GX1/4(1/2)
- INSULIN SYR 0.5 ML 28G 12.7MM (OTC)
- INSULIN SYRIN 0.5 ML 30GX1/2" (RX)
- INSULIN SYRING 0.5 ML 27G 1/2" INNER
- INSULIN SYRINGE 0.3 ML
- INSULIN SYRINGE 0.3 ML 31GX1/4
- INSULIN SYRINGE 0.5 ML
- INSULIN SYRINGE 0.5 ML 31GX1/4
- INSULIN SYRINGE 1 ML
- INSULIN SYRINGE 1 ML 27G 1/2" INNER
- INSULIN SYRINGE 1 ML 27G 16MM
- INSULIN SYRINGE 1 ML 28G 12.7MM (OTC)
- INSULIN SYRINGE 1 ML 30GX1/2" SHORT NEEDLE (OTC)
- INSULIN SYRINGE 1 ML 31GX1/4"
- INSULIN SYRINGE NEEDLELESS
- INSULIN SYRINGE-NEEDLE U-100 SYRINGE 0.3 ML 29 GAUGE, 1 ML 29 GAUGE X 1/2", 1/2 ML 28 GAUGE
- INSULIN U-500 SYRINGE-NEEDLE
- INSUPEN 30G ULTRAFIN NEEDLE

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

- INSUPEN 31G ULTRAFIN NEEDLE
- INSUPEN 32G 8MM PEN NEEDLE
- INSUPEN PEN NEEDLE 29GX12MM
- INSUPEN PEN NEEDLE 31G 8MM
- INSUPEN PEN NEEDLE 31GX3/16"
- INSUPEN PEN NEEDLE 32G 6MM (RX)
- INSUPEN PEN NEEDLE 32GX4MM
- INSUPEN PEN NEEDLE 33GX4MM
- IV ANTISEPTIC WIPES
- KENDALL ALCOHOL 70% PREP PAD
- LISCO SPONGES 100/BAG
- LITE TOUCH 31GX1/4" PEN NEEDLE
- LITE TOUCH INSULIN 0.5 ML SYR
- LITE TOUCH INSULIN 1 ML SYR
- LITE TOUCH INSULIN SYR 1 ML
- LITE TOUCH PEN NEEDLE 29G
- LITE TOUCH PEN NEEDLE 31G
- LITETOUCH INS 0.3 ML 29GX1/2"
- LITETOUCH INS 0.3 ML 30GX5/16"
- LITETOUCH INS 0.3 ML 31GX5/16"
- LITETOUCH INS 0.5 ML 31GX5/16"
- LITETOUCH SYR 0.5 ML 28GX1/2"
- LITETOUCH SYR 0.5 ML 29GX1/2"
- LITETOUCH SYR 0.5 ML 30GX5/16"
- LITETOUCH SYRIN 1 ML 28GX1/2"
- LITETOUCH SYRIN 1 ML 29GX1/2"
- LITETOUCH SYRIN 1 ML 30GX5/16"
- MAGELLAN INSUL SYRINGE 0.3 ML
- MAGELLAN INSUL SYRINGE 0.5 ML
- MAGELLAN INSULIN SYR 0.3 ML
- MAGELLAN INSULIN SYR 0.5 ML
- MAGELLAN INSULIN SYRINGE 1 ML
- MAXI-COMFORT INS 0.5 ML 28G
- MAXI-COMFORT INS 1 ML 28GX1/2"
- MAXICOMFORT II PEN NDL 31GX6MM
- MAXICOMFORT INS 0.5 ML 27GX1/2"
- MAXICOMFORT INS 1 ML 27GX1/2"
- MAXICOMFORT PEN NDL 29G X 5MM
- MAXICOMFORT PEN NDL 29G X 8MM
- MICRODOT PEN NEEDLE 31GX6MM
- MICRODOT PEN NEEDLE 32GX4MM
- MICRODOT PEN NEEDLE 33GX4MM
- MICRODOT READYGARD NDL 31G 5MM OUTER
- MINI PEN NEEDLE 32G 4MM
- MINI PEN NEEDLE 32G 5MM
- MINI PEN NEEDLE 32G 6MM
- MINI PEN NEEDLE 32G 8MM
- MINI PEN NEEDLE 33G 4MM
- MINI PEN NEEDLE 33G 5MM
- MINI PEN NEEDLE 33G 6MM
- MINI ULTRA-THIN II PEN NDL 31G STERILE
- MONOJECT 0.5 ML SYRN 28GX1/2"
- MONOJECT 1 ML SYRN 27X1/2"
- MONOJECT 1 ML SYRN 28GX1/2" (OTC)
- MONOJECT INSUL SYR U100 (OTC)
- MONOJECT INSUL SYR U100 .5ML,29GX1/2" (OTC)
- MONOJECT INSUL SYR U100 0.5 ML CONVERTS TO 29G (OTC)
- MONOJECT INSUL SYR U100 1 ML
- MONOJECT INSUL SYR U100 1 ML 3'S, 29GX1/2" (OTC)
- MONOJECT INSUL SYR U100 1 ML W/O NEEDLE (OTC)
- MONOJECT INSULIN SYR 0.3 ML
- MONOJECT INSULIN SYR 0.3 ML (OTC)
- MONOJECT INSULIN SYR 0.5 ML
- MONOJECT INSULIN SYR 0.5 ML (OTC)
- MONOJECT INSULIN SYR 1 ML 3'S (OTC)
- MONOJECT INSULIN SYR U-100
- MONOJECT SYRINGE 0.3 ML
- MONOJECT SYRINGE 0.5 ML
- MONOJECT SYRINGE 1 ML
- MS INSULIN SYR 1 ML 31GX5/16" (OTC)
- MS INSULIN SYRINGE 0.3 ML
- NANO 2 GEN PEN NEEDLE 32G 4MM
- NANO PEN NEEDLE 32G 4MM

Updated: 11.01.2025

Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

- NOVOFINE 30
- NOVOFINE 32G NEEDLES
- NOVOFINE PLUS PEN NDL 32GX1/6"
- NOVOTWIST
- PC UNIFINE PENTIPS 8MM NEEDLE SHORT
- PEN NEEDLE 30G 5MM OUTER
- PEN NEEDLE 30G 8MM INNER
- PEN NEEDLE 30G X 5/16"
- PEN NEEDLE 31G X 1/4" HRI
- PEN NEEDLE 6MM 31G 6MM
- PEN NEEDLE, DIABETIC NEEDLE 29 GAUGE X 1/2"
- PEN NEEDLES 12MM 29G 29GX12MM,STRL
- PEN NEEDLES 4MM 32G
- PEN NEEDLES 5MM 31G 31GX5MM,STRL,MINI (OTC)
- PEN NEEDLES 8MM 31G 31GX8MM,STRL,SHORT (OTC)
- PENTIPS PEN NEEDLE 29G 1/2"
- PENTIPS PEN NEEDLE 31G 1/4"
- PENTIPS PEN NEEDLE 31GX3/16" MINI, 5MM
- PENTIPS PEN NEEDLE 31GX5/16" SHORT, 8MM
- PENTIPS PEN NEEDLE 32G 1/4"
- PENTIPS PEN NEEDLE 32GX5/32" 4MM
- PIP PEN NEEDLE 31G X 5MM
- PIP PEN NEEDLE 32G X 4MM
- PREFPLS INS SYR 1 ML 30GX5/16" (OTC)
- PREVENT PEN NEEDLE 31GX1/4"
- PREVENT PEN NEEDLE 31GX5/16"
- PRO COMFORT 0.5 ML 30GX1/2"
- PRO COMFORT 0.5 ML 30GX5/16"
- PRO COMFORT 0.5 ML 31GX5/16"
- PRO COMFORT 1 ML 30GX1/2"
- PRO COMFORT 1 ML 30GX5/16"
- PRO COMFORT 1 ML 31GX5/16"
- PRO COMFORT ALCOHOL 70% PADS
- PRO COMFORT PEN NDL 32G 8MM
- PRO COMFORT PEN NDL 32G X 1/4"
- PRO COMFORT PEN NDL 4MM 32G
- PRO COMFORT PEN NDL 5MM 32G
- PRODIGY INS SYR 1 ML 28GX1/2"
- PRODIGY SYRNG 0.5 ML 31GX5/16"
- PRODIGY SYRNGE 0.3 ML 31GX5/16"
- PURE CMFT SFTY PEN NDL 31G 5MM
- PURE CMFT SFTY PEN NDL 31G 6MM
- PURE CMFT SFTY PEN NDL 32G 4MM
- PURE COMFORT ALCOHOL 70% PADS
- PURE COMFORT PEN NDL 32G 4MM
- PURE COMFORT PEN NDL 32G 5MM
- PURE COMFORT PEN NDL 32G 6MM
- PURE COMFORT PEN NDL 32G 8MM
- RAYA SURE PEN NEEDLE 29G 12MM
- RAYA SURE PEN NEEDLE 31G 4MM
- RAYA SURE PEN NEEDLE 31G 5MM
- RAYA SURE PEN NEEDLE 31G 6MM
- RELI-ON INSULIN 1 ML SYR
- RELION INS SYR 0.3 ML 31GX6MM
- RELION INS SYR 0.5 ML 31GX6MM
- RELION INS SYR 1 ML 31GX15/64"
- SAFESNAP INS SYR UNITS-100 0.3 ML 30GX5/16",10X10
- SAFESNAP INS SYR UNITS-100 0.5 ML 29GX1/2",10X10
- SAFESNAP INS SYR UNITS-100 0.5 ML 30GX5/16",10X10
- SAFESNAP INS SYR UNITS-100 1 ML 28GX1/2",10X10
- SAFESNAP INS SYR UNITS-100 1 ML 29GX1/2",10X10
- SAFETY PEN NEEDLE 31G 4MM
- SAFETY PEN NEEDLE 5MM X 31G
- SAFETY SYRINGE 0.5 ML 30G 1/2"
- SECURESAFE PEN NDL 30GX5/16" OUTER
- SECURESAFE SYR 0.5 ML 29G 1/2" OUTER
- SECURESAFE SYRNG 1 ML 29G 1/2" OUTER
- SKY SAFETY PEN NEEDLE 30G 5MM

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

- SKY SAFETY PEN NEEDLE 30G 8MM
- SM ULT CFT 0.3 ML 31GX5/16(1/2)
- STERILE PADS 2" X 2"
- SURE CMFT SFTY PEN NDL 31G 6MM
- SURE CMFT SFTY PEN NDL 32G 4MM
- SURE COMFORT 0.5 ML SYRINGE
- SURE COMFORT 1 ML SYRINGE
- SURE COMFORT 3/10 ML SYRINGE
- SURE COMFORT 3/10 ML SYRINGE INSULIN SYRINGE
- SURE COMFORT 30G PEN NEEDLE
- SURE COMFORT ALCOHOL PREP PADS
- SURE COMFORT INS 0.3 ML 31GX1/4
- SURE COMFORT INS 0.5 ML 31GX1/4
- SURE COMFORT INS 1 ML 31GX1/4"
- SURE COMFORT PEN NDL 29GX1/2" 12.7MM
- SURE COMFORT PEN NDL 31G 5MM
- SURE COMFORT PEN NDL 31G 8MM
- SURE COMFORT PEN NDL 32G 4MM
- SURE COMFORT PEN NDL 32G 6MM
- SURE-FINE PEN NEEDLES 12.7MM
- SURE-FINE PEN NEEDLES 5MM
- SURE-FINE PEN NEEDLES 8MM
- SURE-JECT INSU SYR U100 0.3 ML
- SURE-JECT INSU SYR U100 0.5 ML
- SURE-JECT INSU SYR U100 1 ML
- SURE-JECT INSUL SYR U100 1 ML
- SURE-JECT INSULIN SYRINGE 1 ML
- SURE-PREP ALCOHOL PREP PADS
- TECHLITE 0.3 ML 29GX12MM (1/2)
- TECHLITE 0.3 ML 30GX8MM (1/2)
- TECHLITE 0.3 ML 31GX6MM (1/2)
- TECHLITE 0.3 ML 31GX8MM (1/2)
- TECHLITE 0.5 ML 30GX12MM (1/2)
- TECHLITE 0.5 ML 30GX8MM (1/2)
- TECHLITE 0.5 ML 31GX6MM (1/2)
- TECHLITE 0.5 ML 31GX8MM (1/2)
- TECHLITE INS SYR 1 ML 29GX12MM
- TECHLITE INS SYR 1 ML 30GX12MM
- TECHLITE INS SYR 1 ML 31GX6MM
- TECHLITE INS SYR 1 ML 31GX8MM
- TECHLITE PEN NEEDLE 29GX1/2"
- TECHLITE PEN NEEDLE 29GX3/8"
- TECHLITE PEN NEEDLE 31GX1/4"
- TECHLITE PEN NEEDLE 31GX3/16"
- TECHLITE PEN NEEDLE 31GX5/16"
- TECHLITE PEN NEEDLE 32GX1/4"
- TECHLITE PEN NEEDLE 32GX5/16"
- TECHLITE PEN NEEDLE 32GX5/32"
- TECHLITE PLUS PEN NDL 32G 4MM
- TERUMO INS SYRINGE U100-1 ML
- TERUMO INS SYRINGE U100-1/2 ML
- TERUMO INS SYRINGE U100-1/3 ML
- TERUMO INS SYRNG U100-1/2 ML
- THINPRO INS SYRIN U100-0.3 ML
- THINPRO INS SYRIN U100-0.5 ML
- THINPRO INS SYRIN U100-1 ML
- TOPCARE CLICKFINE 31G X 1/4"
- TOPCARE CLICKFINE 31G X 5/16"
- TOPCARE ULTRA COMFORT SYRINGE
- TRUE CMFRT PRO 0.5 ML 30G 5/16"
- TRUE CMFRT PRO 0.5 ML 31G 5/16"
- TRUE CMFRT PRO 0.5 ML 32G 5/16"
- TRUE CMFT SFTY PEN NDL 31G 5MM
- TRUE CMFT SFTY PEN NDL 31G 6MM
- TRUE CMFT SFTY PEN NDL 32G 4MM
- TRUE COMFORT 0.5 ML 30G 1/2"
- TRUE COMFORT 0.5 ML 30G 5/16"
- TRUE COMFORT 0.5 ML 31G 5/16"
- TRUE COMFORT 0.5 ML 31GX5/16"
- TRUE COMFORT 1 ML 31GX5/16"
- TRUE COMFORT ALCOHOL 70% PADS
- TRUE COMFORT PEN NDL 31G 8MM
- TRUE COMFORT PEN NDL 31GX5MM
- TRUE COMFORT PEN NDL 31GX6MM
- TRUE COMFORT PEN NDL 32G 5MM
- TRUE COMFORT PEN NDL 32G 6MM
- TRUE COMFORT PEN NDL 32GX4MM
- TRUE COMFORT PEN NDL 33G 4MM
- TRUE COMFORT PEN NDL 33G 5MM
- TRUE COMFORT PEN NDL 33G 6MM

Updated: 11.01.2025

Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

- TRUE COMFORT PRO 1 ML 30G 1/2"
- TRUE COMFORT PRO 1 ML 30G 5/16"
- TRUE COMFORT PRO 1 ML 31G 5/16"
- TRUE COMFORT PRO 1 ML 32G 5/16"
- TRUE COMFORT PRO ALCOHOL PADS
- TRUE COMFORT SFTY 1 ML 30G 1/2"
- TRUE COMFORT PRO 0.5 ML 30G 1/2"
- TRUE COMFORT SFTY 1 ML 30G 5/16"
- TRUE COMFORT SFTY 1 ML 31G 5/16"
- TRUE COMFORT SFTY 1 ML 32G 5/16"
- TRUEPLUS PEN NEEDLE 29GX1/2"
- TRUEPLUS PEN NEEDLE 31G X 1/4"
- TRUEPLUS PEN NEEDLE 31GX3/16"
- TRUEPLUS PEN NEEDLE 31GX5/16"
- TRUEPLUS PEN NEEDLE 32GX5/32"
- TRUEPLUS SYR 0.3 ML 29GX1/2"
- TRUEPLUS SYR 0.3 ML 30GX5/16"
- TRUEPLUS SYR 0.3 ML 31GX5/16"
- TRUEPLUS SYR 0.5 ML 28GX1/2"
- TRUEPLUS SYR 0.5 ML 29GX1/2"
- TRUEPLUS SYR 0.5 ML 30GX5/16"
- TRUEPLUS SYR 0.5 ML 31GX5/16"
- TRUEPLUS SYR 1 ML 28GX1/2"
- TRUEPLUS SYR 1 ML 29GX1/2"
- TRUEPLUS SYR 1 ML 30GX5/16"
- TRUEPLUS SYR 1 ML 31GX5/16"
- ULTICARE INS 0.3 ML 31GX1/4(1/2)
- ULTICARE INS 1 ML 31GX1/4"
- ULTICARE INS SYR 0.3 ML 30G 8MM
- ULTICARE INS SYR 0.3 ML 31G 6MM
- ULTICARE INS SYR 0.3 ML 31G 8MM
- ULTICARE INS SYR 0.5 ML 30G 8MM (OTC)
- ULTICARE INS SYR 0.5 ML 31G 6MM
- ULTICARE INS SYR 0.5 ML 31G 8MM (OTC)
- ULTICARE INS SYR 1 ML 30GX1/2"
- ULTICARE PEN NEEDLE 31GX3/16"
- ULTICARE PEN NEEDLE 6MM 31G
- ULTICARE PEN NEEDLE 8MM 31G
- ULTICARE PEN NEEDLES 12MM 29G
- ULTICARE PEN NEEDLES 4MM 32G MICRO, 32GX4MM
- ULTICARE PEN NEEDLES 6MM 32G
- ULTICARE SAFE PEN NDL 30G 8MM
- ULTICARE SAFE PEN NDL 5MM 30G
- ULTICARE SAFETY 0.5 ML 29GX1/2 (RX)
- ULTICARE SYR 0.3 ML 29G 12.7MM
- ULTICARE SYR 0.3 ML 30GX1/2"
- ULTICARE SYR 0.3 ML 31GX5/16" SHORT NDL
- ULTICARE SYR 0.5 ML 30GX1/2"
- ULTICARE SYR 0.5 ML 31GX5/16" SHORT NDL
- ULTICARE SYR 1 ML 31GX5/16"
- ULTIGUARD SAFE 1 ML 30G 12.7MM
- ULTIGUARD SAFE 0.3 ML 30G 12.7MM
- ULTIGUARD SAFE 0.5 ML 30G 12.7MM
- ULTIGUARD SAFE PACK 1 ML 31G 8MM
- ULTIGUARD SAFE PACK 29G 12.7MM
- ULTIGUARD SAFE PACK 31G 5MM
- ULTIGUARD SAFE PACK 31G 6MM
- ULTIGUARD SAFE PACK 31G 8MM
- ULTIGUARD SAFE PACK 32G 4MM
- ULTIGUARD SAFE PACK 32G 6MM
- ULTIGUARD SAFE PK 0.3 ML 31G 8MM
- ULTIGUARD SAFE PK 0.5 ML 31G 8MM
- ULTILET ALCOHOL STERIL SWAB
- ULTILET INSULIN SYRINGE 0.3 ML
- ULTILET INSULIN SYRINGE 0.5 ML
- ULTILET INSULIN SYRINGE 1 ML
- ULTILET PEN NEEDLE
- ULTILET PEN NEEDLE 4MM 32G
- ULTRA COMFORT 0.3 ML SYRINGE
- ULTRA COMFORT 0.5 ML 28GX1/2" CONVERTS TO 29G
- ULTRA COMFORT 0.5 ML 29GX1/2"
- ULTRA COMFORT 0.5 ML SYRINGE

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

- ULTRA COMFORT 1 ML 31GX5/16"
- ULTRA COMFORT 1 ML SYRINGE
- ULTRA FLO 0.3 ML 30G 1/2" (1/2)
- ULTRA FLO 0.3 ML 30G 5/16"(1/2)
- ULTRA FLO 0.3 ML 31G 5/16"(1/2)
- ULTRA FLO PEN NEEDLE 31G 5MM
- ULTRA FLO PEN NEEDLE 31G 8MM
- ULTRA FLO PEN NEEDLE 32G 4MM
- ULTRA FLO PEN NEEDLE 33G 4MM
- ULTRA FLO PEN NEEDLES 12MM 29G
- ULTRA FLO SYR 0.3 ML 29GX1/2"
- ULTRA FLO SYR 0.3 ML 30G 5/16"
- ULTRA FLO SYR 0.3 ML 31G 5/16"
- ULTRA FLO SYR 0.5 ML 29G 1/2"
- ULTRA THIN PEN NDL 32G X 4MM
- ULTRA-FINE 0.3 ML 30G 12.7MM
- ULTRA-FINE 0.3 ML 31G 6MM (1/2)
- ULTRA-FINE 0.3 ML 31G 8MM (1/2)
- ULTRA-FINE 0.5 ML 30G 12.7MM
- ULTRA-FINE INS SYR 1 ML 31G 6MM
- ULTRA-FINE INS SYR 1 ML 31G 8MM
- ULTRA-FINE PEN NDL 29G 12.7MM
- ULTRA-FINE PEN NEEDLE 31G 5MM
- ULTRA-FINE PEN NEEDLE 31G 8MM
- ULTRA-FINE PEN NEEDLE 32G 6MM
- ULTRA-FINE SYR 0.3 ML 31G 8MM
- ULTRA-FINE SYR 0.5 ML 31G 6MM
- ULTRA-FINE SYR 0.5 ML 31G 8MM
- ULTRA-FINE SYR 1 ML 30G 12.7MM
- ULTRA-THIN II 1 ML 31GX5/16"
- ULTRA-THIN II INS 0.3 ML 30G
- ULTRA-THIN II INS 0.3 ML 31G
- ULTRA-THIN II INS 0.5 ML 29G
- ULTRA-THIN II INS 0.5 ML 30G
- ULTRA-THIN II INS 0.5 ML 31G
- ULTRA-THIN II INS SYR 1 ML 29G
- ULTRA-THIN II INS SYR 1 ML 30G
- ULTRA-THIN II PEN NDL 29GX1/2"
- ULTRA-THIN II PEN NDL 31GX5/16
- ULTRACARE INS 0.3 ML 30GX5/16"
- ULTRACARE INS 0.3 ML 31GX5/16"
- ULTRACARE INS 0.5 ML 30GX1/2"
- ULTRACARE INS 0.5 ML 30GX5/16"
- ULTRACARE INS 0.5 ML 31GX5/16"
- ULTRACARE INS 1 ML 30G X 5/16"
- ULTRACARE INS 1 ML 30GX1/2"
- ULTRACARE INS 1 ML 31G X 5/16"
- ULTRACARE PEN NEEDLE 31GX1/4"
- ULTRACARE PEN NEEDLE 31GX3/16"
- ULTRACARE PEN NEEDLE 31GX5/16"
- ULTRACARE PEN NEEDLE 32GX1/4"
- ULTRACARE PEN NEEDLE 32GX3/16"
- ULTRACARE PEN NEEDLE 32GX5/32"
- ULTRACARE PEN NEEDLE 33GX5/32"
- UNIFINE OTC PEN NEEDLE 31G 5MM
- UNIFINE OTC PEN NEEDLE 32G 4MM
- UNIFINE PEN NEEDLE 32G 4MM
- UNIFINE PENTIPS 12MM 29G 29GX12MM, STRL
- UNIFINE PENTIPS 31GX3/16" 31GX5MM,STRL,MINI
- UNIFINE PENTIPS 32G 4MM
- UNIFINE PENTIPS 32GX1/4"
- UNIFINE PENTIPS 33GX5/32"
- UNIFINE PENTIPS 6MM 31G
- UNIFINE PENTIPS MAX 30GX3/16"
- UNIFINE PENTIPS NEEDLES 29G
- UNIFINE PENTIPS PLUS 29GX1/2" 12MM
- UNIFINE PENTIPS PLUS 30GX3/16"
- UNIFINE PENTIPS PLUS 31GX1/4" ULTRA SHORT, 6MM
- UNIFINE PENTIPS PLUS 31GX3/16" MINI
- UNIFINE PENTIPS PLUS 31GX5/16" SHORT
- UNIFINE PENTIPS PLUS 32GX5/32"
- UNIFINE PENTIPS PLUS 33GX5/32"
- UNIFINE PROTECT 30G 5MM
- UNIFINE PROTECT 30G 8MM
- UNIFINE PROTECT 32G 4MM
- UNIFINE SAFECONTROL 30G 5MM
- UNIFINE SAFECONTROL 30G 8MM
- UNIFINE SAFECONTROL 31G 5MM
- UNIFINE SAFECONTROL 31G 6MM
- UNIFINE SAFECONTROL 31G 8MM
- UNIFINE SAFECONTROL 32G 4MM

Updated: 11.01.2025

Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

- UNIFINE ULTRA PEN NDL 31G 5MM
- UNIFINE ULTRA PEN NDL 31G 6MM
- UNIFINE ULTRA PEN NDL 31G 8MM
- UNIFINE ULTRA PEN NDL 32G 4MM
- VANISHPOINT 0.5 ML 30GX1/2" SY OUTER
- VANISHPOINT INS 1 ML 30GX3/16"
- VANISHPOINT U-100 29X1/2 SYR
- VERIFINE INS SYR 1 ML 29G 1/2"
- VERIFINE PEN NEEDLE 29G 12MM
- VERIFINE PEN NEEDLE 31G 5MM
- VERIFINE PEN NEEDLE 31G X 6MM
- VERIFINE PEN NEEDLE 31G X 8MM
- VERIFINE PEN NEEDLE 32G 6MM
- VERIFINE PEN NEEDLE 32G X 4MM
- VERIFINE PEN NEEDLE 32G X 5MM
- VERIFINE PLUS PEN NDL 31G 5MM
- VERIFINE PLUS PEN NDL 31G 8MM
- VERIFINE PLUS PEN NDL 32G 4MM
- VERIFINE PLUS PEN NDL 32G 4MM-SHARPS CONTAINER
- VERIFINE SYRING 0.5 ML 29G 1/2"
- VERIFINE SYRING 1 ML 31G 5/16"
- VERIFINE SYRNG 0.3 ML 31G 5/16"
- VERIFINE SYRNG 0.5 ML 31G 5/16"
- VERSALON ALL PURPOSE SPONGE 25'S,N-STERILE,3PLY
- WEBCOL ALCOHOL PREPS 20'S,LARGE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	LIFETIME
Other Criteria	ONLY COVERED UNDER PART D WHEN USED CONCURRENTLY WITH INSULIN.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

INTERFERON FOR MS-AVONEX

Products Affected

- AVONEX INTRAMUSCULAR PEN INJECTOR KIT
- AVONEX INTRAMUSCULAR SYRINGE KIT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

INTERFERON FOR MS-BETASERON

Products Affected

- BETASERON SUBCUTANEOUS KIT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

INTERFERON FOR MS-PLEGRIDY

Products Affected

- PLEGRIDY SUBCUTANEOUS PEN INJECTOR 125 MCG/0.5 ML, 63 MCG/0.5 ML- 94 MCG/0.5 ML
- PLEGRIDY SUBCUTANEOUS SYRINGE 125 MCG/0.5 ML, 63 MCG/0.5 ML- 94 MCG/0.5 ML

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

INTERFERON GAMMA-1B

Products Affected

- ACTIMMUNE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	INITIAL: CHRONIC GRANULOMATOUS DISEASE (CGD): PRESCRIBED BY OR IN CONSULTATION WITH A HEMATOLOGIST, INFECTIOUS DISEASE SPECIALIST, OR IMMUNOLOGIST. SEVERE MALIGNANT OSTEOPETROSIS (SMO): PRESCRIBED BY OR IN CONSULTATION WITH AN ENDOCRINOLOGIST OR HEMATOLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS
Other Criteria	RENEWAL: CGD, SMO: 1) DEMONSTRATED CLINICAL BENEFIT COMPARED TO BASELINE, AND 2) HAS NOT RECEIVED HEMATOPOIETIC CELL TRANSPLANTATION.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

IPILIMUMAB

Products Affected

- YERVOY

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL: UNRESECT/MET MEL: 4MO, RCC/CRC/HCC: 3MO, ALL OTHERS: 12MO. INITIAL/RENEWAL: CUTAN MEL: 6MO
Other Criteria	RENEWAL: ADJUVANT CUTANEOUS MELANOMA: NO EVIDENCE OF DISEASE RECURRENCE (DEFINED AS THE APPEARANCE OF ONE OR MORE NEW MELANOMA LESIONS: LOCAL, REGIONAL OR DISTANT METASTASIS). THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

ISAVUCONAZONIUM

Products Affected

- CRESEMBA ORAL

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	INVASIVE ASPERGILLOSIS, INVASIVE MUCORMYCOSIS: PRESCRIBED BY OR IN CONSULTATION WITH AN INFECTIOUS DISEASE SPECIALIST.
Coverage Duration	6 MONTHS
Other Criteria	INVASIVE ASPERGILLOSIS: TRIAL OF OR CONTRAINDICATION TO VORICONAZOLE. CONTINUATION OF THERAPY AFTER HOSPITAL DISCHARGE REQUIRES NO EXTRA CRITERIA.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

IVACAFTOR

Products Affected

- KALYDECO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	CYSTIC FIBROSIS (CF): INITIAL: CONFIRMED MUTATION IN CFTR GENE ACCEPTABLE FOR THE TREATMENT OF CYSTIC FIBROSIS
Age Restrictions	
Prescriber Restrictions	CF: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A PULMONOLOGIST OR CYSTIC FIBROSIS EXPERT
Coverage Duration	INITIAL: 12 MONTHS. RENEWAL: LIFETIME
Other Criteria	CF: INITIAL: NOT HOMOZYGOUS FOR F508DEL MUTATION IN CFTR GENE. RENEWAL: IMPROVEMENT IN CLINICAL STATUS.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

IVOSIDENIB

Products Affected

- TIBSOVO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

IXAZOMIB

Products Affected

- NINLARO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

LANREOTIDE

Products Affected

- lanreotide subcutaneous syringe 120 mg/0.5 ml
- SOMATULINE DEPOT SUBCUTANEOUS SYRINGE 60 MG/0.2 ML, 90 MG/0.3 ML

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	ACROMEGALY: INITIAL: THERAPY IS PRESCRIBED BY OR IN CONSULTATION WITH AN ENDOCRINOLOGIST.
Coverage Duration	ACROMEGALY: INITIAL: 3 MOS, RENEWAL: 12 MOS.GEP-NETS, CARCINOID SYNDROME: 12 MOS.
Other Criteria	ACROMEGALY: INITIAL: TRIAL OF OR CONTRAINDICATION TO ONE GENERIC OCTREOTIDE INJECTION. RENEWAL: 1) REDUCTION, NORMALIZATION, OR MAINTENANCE OF IGF-1 LEVELS BASED ON AGE AND GENDER, AND 2) IMPROVEMENT OR SUSTAINED REMISSION OF CLINICAL SYMPTOMS.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

LAPATINIB

Products Affected

- *lapatinib*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

LAROTRECTINIB

Products Affected

- VITRAKVI ORAL CAPSULE 100 MG, 25 MG
- VITRAKVI ORAL SOLUTION

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	VITRAKVI ORAL SOLUTION: 1) TRIAL OF VITRAKVI CAPSULES, OR 2) UNABLE TO TAKE CAPSULE FORMULATION.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

LAZERTINIB

Products Affected

- LAZCLUZE ORAL TABLET 240 MG,
80 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

LEDIPASVIR-SOFOSBUVIR

Products Affected

- HARVONI ORAL PELLETS IN PACKET 33.75-150 MG, 45-200 MG
- HARVONI ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	HCV RNA LEVEL WITHIN PAST 6 MONTHS.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE.
Other Criteria	1) CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE, AND 2) NOT CONCURRENTLY TAKING ANY OF THE FOLLOWING: CARBAMAZEPINE, PHENYTOIN, PHENOBARBITAL, OXCARBAZEPINE, RIFAMPIN, RIFABUTIN, RIFAPENTINE, ROSUVASTATIN, TIPRANA VIR/RITONAVIR, SOFOSBUVIR (AS A SINGLE AGENT), EPCLUSA, ZEPATIER, MAVYRET, OR VOSEVI.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

LENALIDOMIDE

Products Affected

- *lenalidomide*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

LENVATINIB

Products Affected

- LENVIMA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

LETERMOVIR

Products Affected

- PREVYMIS ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	HSCT: NOT AT RISK FOR LATE CMV: 4 MOS, AT RISK FOR LATE CMV: 7 MOS. KIDNEY TRANSPLANT: 7 MOS.
Other Criteria	HEMATOPOIETIC STEM CELL TRANSPLANT (HSCT): 1) THERAPY WILL BE INITIATED BETWEEN DAY 0 AND DAY 28 POST TRANSPLANT, AND 2) WILL NOT RECEIVE THE MEDICATION BEYOND 100 DAYS POST TRANSPLANT IF NOT AT RISK FOR LATE CYTOMEGALOVIRUS (CMV) INFECTION AND DISEASE, OR BEYOND 200 DAYS POST TRANSPLANT IF AT RISK FOR LATE CMV INFECTION AND DISEASE. KIDNEY TRANSPLANT: 1) THERAPY WILL BE INITIATED BETWEEN DAY 0 AND DAY 7 POST TRANSPLANT, AND 2) WILL NOT RECEIVE THE MEDICATION BEYOND 200 DAYS POST TRANSPLANT.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

LEUPROLIDE

Products Affected

- *leuprolide subcutaneous kit*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PROSTATE CANCER: 12 MONTHS.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

LEUPROLIDE DEPOT

Products Affected

- *leuprolide acetate (3 month)*
- LUTRATE DEPOT (3 MONTH)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

LEUPROLIDE-ELIGARD

Products Affected

- ELIGARD
- ELIGARD (3 MONTH)
- ELIGARD (4 MONTH)
- ELIGARD (6 MONTH)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

LEUPROLIDE-LUPRON DEPOT

Products Affected

- LUPRON DEPOT
- LUPRON DEPOT (3 MONTH)
- LUPRON DEPOT (4 MONTH)
- LUPRON DEPOT (6 MONTH)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: ENDOMETRIOSIS: DIAGNOSIS IS CONFIRMED VIA SURGICAL OR DIRECT VISUALIZATION (E.G., PELVIC ULTRASOUND) OR HISTOPATHOLOGICAL CONFIRMATION (E.G., LAPAROSCOPY OR LAPAROTOMY) IN THE LAST 10 YEARS.
Age Restrictions	
Prescriber Restrictions	INITIAL: ENDOMETRIOSIS: PRESCRIBED BY OR IN CONSULTATION WITH AN OBSTETRICIAN/GYNECOLOGIST.
Coverage Duration	PROSTATE CA: 12 MOS. UTERINE FIBROIDS: 3 MOS. ENDOMETRIOSIS: INITIAL/RENEWAL: 6 MOS.
Other Criteria	INITIAL: ENDOMETRIOSIS: 1) NO CONCURRENT USE WITH ANOTHER GNRH-MODULATING AGENT, 2) TRIAL OF OR CONTRAINDICATION TO NSAID AND PROGESTIN-CONTAINING PREPARATION, AND 3) HAS NOT RECEIVED A TOTAL OF 12 MONTHS OF TREATMENT PER LIFETIME. RENEWAL: ENDOMETRIOSIS: 1) IMPROVEMENT OF PAIN RELATED TO ENDOMETRIOSIS WHILE ON THERAPY, 2) RECEIVING CONCOMITANT ADD-BACK THERAPY (I.E., COMBINATION ESTROGEN-PROGESTIN OR PROGESTIN-ONLY CONTRACEPTIVE PREPARATION), 3) NO CONCURRENT USE WITH ANOTHER GNRH-MODULATING AGENT, AND 4) HAS NOT RECEIVED A TOTAL OF 12 MONTHS OF TREATMENT PER LIFETIME. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

PA Criteria	Criteria Details
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

LEUPROLIDE-LUPRON DEPOT-PED

Products Affected

- LUPRON DEPOT-PED (3 MONTH)
- LUPRON DEPOT-PED INTRAMUSCULAR SYRINGE KIT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	CENTRAL PRECOCIOUS PUBERTY (CPP): INITIAL: FEMALES: ELEVATED LEVELS OF FOLLICLE-STIMULATING HORMONE (FSH) GREATER THAN 4.0 MIU/ML AND LUTEINIZING HORMONE (LH) LEVEL GREATER THAN 0.2 TO 0.3 MIU/ML AT DIAGNOSIS. MALES: ELEVATED LEVELS OF FSH GREATER THAN 5.0 MIU/ML AND LH LEVEL GREATER THAN 0.2 TO 0.3 MIU/ML AT DIAGNOSIS.
Age Restrictions	
Prescriber Restrictions	CPP: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH AN ENDOCRINOLOGIST.
Coverage Duration	INITIAL/RENEWAL: 12 MONTHS.
Other Criteria	CPP: INITIAL: FEMALES: 1) YOUNGER THAN 8 YEARS OF AGE AT ONSET OF CPP, AND 2) AT TANNER STAGE 2 OR ABOVE FOR BREAST DEVELOPMENT AND PUBIC HAIR GROWTH. MALES: 1) YOUNGER THAN 9 YEARS OF AGE AT ONSET OF CPP, AND 2) AT TANNER STAGE 2 OR ABOVE FOR GENITAL DEVELOPMENT AND PUBIC HAIR GROWTH. RENEWAL: 1) TANNER STAGING AT INITIAL DIAGNOSIS HAS STABILIZED OR REGRESSED DURING THREE SEPARATE MEDICAL VISITS IN THE PREVIOUS YEAR, AND 2) HAS NOT REACHED ACTUAL AGE WHICH CORRESPONDS TO CURRENT PUBERTAL AGE. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

PA Criteria	Criteria Details
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

L-GLUTAMINE

Products Affected

- *glutamine (sickle cell)*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	SICKLE CELL DISEASE(SCD): INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A HEMATOLOGIST
Coverage Duration	INITIAL: 12 MONTHS. RENEWAL: LIFETIME.
Other Criteria	SCD: INITIAL: AGES 18 YEARS OR OLDER: 1) AT LEAST 2 SICKLE CELL CRISES IN THE PAST YEAR, 2) SICKLE-CELL ASSOCIATED SYMPTOMS WHICH ARE INTERFERING WITH ACTIVITIES OF DAILY LIVING, OR 3) HISTORY OF OR HAS RECURRENT ACUTE CHEST SYNDROME. AGES 5 TO 17 YEARS: APPROVED WITHOUT ADDITIONAL CRITERIA. RENEWAL: MAINTAINED OR EXPERIENCED A REDUCTION IN ACUTE COMPLICATIONS OF SCD.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

LIDOCAINE OINTMENT

Products Affected

- *lidocaine topical ointment*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	THIS DRUG MAY BE EITHER BUNDLED WITH AND COVERED UNDER END STAGE RENAL DISEASE DIALYSIS RELATED SERVICES OR COVERED UNDER MEDICARE D DEPENDING UPON THE CIRCUMSTANCES.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

LIDOCAINE PATCH

Products Affected

- *dermacinrx lidocan 5% patch outer*
- *lidocaine topical adhesive patch,medicated 5 %*
- *lidocan iii*
- *ZTLIDO*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	1) PAIN ASSOCIATED WITH POST-HERPETIC NEURALGIA, 2) NEUROPATHY DUE TO DIABETES MELLITUS, 3) CHRONIC BACK PAIN, OR 4) OSTEOARTHRITIS OF THE KNEE OR HIP.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

LIDOCAINE PRILOCAINE

Products Affected

- *lidocaine-prilocaine topical cream*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	THIS DRUG MAY BE EITHER BUNDLED WITH AND COVERED UNDER END STAGE RENAL DISEASE DIALYSIS RELATED SERVICES OR COVERED UNDER MEDICARE D DEPENDING UPON THE CIRCUMSTANCES. INFORMATION MAY NEED TO BE SUBMITTED DESCRIBING THE USE AND SETTING OF THE DRUG TO MAKE THE DETERMINATION.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

LINVOSELTAMAB-GCPT

Products Affected

- LYNOZYFIC INTRAVENOUS SOLUTION 2 MG/ML, 20 MG/ML

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

LONCASTUXIMAB TESIRINE-LPYL

Products Affected

- ZYNLONTA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

LORLATINIB

Products Affected

- LORBRENA ORAL TABLET 100 MG, 25 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

LOTILANER

Products Affected

- XDEMVY

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	DEMODEX BLEPHARITIS: 18 YEARS OF AGE OR OLDER
Prescriber Restrictions	
Coverage Duration	6 WEEKS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

LUMACAFITOR-IVACAFITOR

Products Affected

- ORKAMBI ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: CYSTIC FIBROSIS (CF); CONFIRMED MUTATION IN CFTR GENE ACCEPTABLE FOR THE TREATMENT OF CF.
Age Restrictions	
Prescriber Restrictions	CF: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A PULMONOLOGIST OR CF EXPERT.
Coverage Duration	INITIAL: 6 MONTHS, RENEWAL: LIFETIME.
Other Criteria	CF: RENEWAL: IMPROVEMENT IN CLINICAL STATUS.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

MACITENTAN

Products Affected

- OPSUMIT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	PULMONARY ARTERIAL HYPERTENSION (PAH): INITIAL: DIAGNOSIS CONFIRMED BY RIGHT HEART CATHETERIZATION WITH THE FOLLOWING PARAMETERS: 1) MEAN PULMONARY ARTERY PRESSURE (PAP) GREATER THAN 20 MMHG, 2) PULMONARY CAPILLARY WEDGE PRESSURE (PCWP) OF 15 MMHG OR LESS, AND 3) PULMONARY VASCULAR RESISTANCE (PVR) GREATER THAN 2 WOOD UNITS.
Age Restrictions	
Prescriber Restrictions	PAH: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A CARDIOLOGIST OR PULMONOLOGIST.
Coverage Duration	INITIAL/RENEWAL: 12 MONTHS.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

MARGETUXIMAB-CMKB

Products Affected

- MARGENZA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

MARIBAVIR

Products Affected

- LIVTENCITY

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

MAVACAMTEN

Products Affected

- CAMZYOS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	OBSTRUCTIVE HYPERTROPHIC CARDIOMYOPATHY(HCM): INITIAL: LEFT VENTRICULAR OUTFLOW TRACK (LVOT) GRADIENT OF 50 MMHG OR HIGHER
Age Restrictions	
Prescriber Restrictions	OBSTRUCTIVE HCM: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A CARDIOLOGIST
Coverage Duration	INITIAL: 4 MONTHS, RENEWAL: 12 MONTHS.
Other Criteria	OBSTRUCTIVE HCM: INITIAL: TRIAL OF OR CONTRAINDICATION TO A BETA-BLOCKER OR A NON-DIHYDROPYRIDINE CALCIUM CHANNEL BLOCKER. RENEWAL: CONTINUED CLINICAL BENEFIT (E.G., REDUCTION OF SYMPTOMS, NYHA CLASSIFICATION IMPROVEMENT)
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

MECASERMIN

Products Affected

- INCRELEX

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH AN ENDOCRINOLOGIST OR NEPHROLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	INITIAL: OPEN EPIPHYSES AS CONFIRMED BY RADIOGRAPH OF WRIST AND HAND. RENEWAL: IMPROVEMENT WHILE ON THERAPY (I.E., INCREASE IN HEIGHT OR INCREASE IN HEIGHT VELOCITY).
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

MECHLORETHAMINE

Products Affected

- VALCHLOR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

MEPOLIZUMAB

Products Affected

- NUCALA SUBCUTANEOUS AUTO-INJECTOR
- NUCALA SUBCUTANEOUS RECON SOLN
- NUCALA SUBCUTANEOUS SYRINGE 100 MG/ML, 40 MG/0.4 ML

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: ASTHMA: BLOOD EOSINOPHIL LEVEL OF AT LEAST 150 CELLS/MCL WITHIN THE PAST 12 MONTHS.
Age Restrictions	
Prescriber Restrictions	INITIAL: ASTHMA: PRESCRIBED BY OR IN CONSULTATION WITH A PHYSICIAN SPECIALIZING IN PULMONARY OR ALLERGY MEDICINE. CRSWNP: PRESCRIBED BY OR IN CONSULTATION WITH AN OTOLARYNGOLOGIST, ALLERGIST OR IMMUNOLOGIST. EOSINOPHILIC COPD: PRESCRIBED BY OR IN CONSULTATION WITH A PULMONOLOGIST.
Coverage Duration	INITIAL: ASTHMA, COPD: 12 MO. CRSWNP: 6 MO. OTHERS: 12 MO. RENEWAL: CRSWNP, ASTHMA, COPD: 12 MO.
Other Criteria	INITIAL: ASTHMA: 1) CONCURRENT THERAPY WITH A MEDIUM, HIGH-DOSE OR MAXIMALLY TOLERATED DOSE OF AN INHALED CORTICOSTEROID (ICS) AND AT LEAST ONE OTHER MAINTENANCE MEDICATION, 2) ONE OF THE FOLLOWING: (A) AT LEAST ONE ASTHMA EXACERBATION REQUIRING SYSTEMIC CORTICOSTEROID BURST LASTING 3 OR MORE DAYS WITHIN THE PAST 12 MONTHS OR AT LEAST ONE SERIOUS EXACERBATION REQUIRING HOSPITALIZATION OR ER VISIT WITHIN THE PAST 12 MONTHS, OR (B) POOR SYMPTOM CONTROL DESPITE CURRENT THERAPY AS EVIDENCED BY AT LEAST THREE OF THE FOLLOWING WITHIN THE PAST 4 WEEKS: DAYTIME ASTHMA SYMPTOMS MORE THAN TWICE/WEEK, ANY NIGHT WAKING DUE TO ASTHMA, SABA RELIEVER FOR SYMPTOMS MORE THAN TWICE/WEEK, ANY ACTIVITY LIMITATION DUE TO ASTHMA, AND 3) NO

Updated: 11.01.2025
Y0150_PBM200_C (v2)

PA Criteria	Criteria Details
	CONCURRENT USE WITH XOLAIR, DUPIXENT, TEZSPIRE, OR OTHER ANTI-IL5 BIOLOGICS WHEN USED FOR ASTHMA. CRSWNP: 1) A 56 DAY TRIAL OF ONE TOPICAL NASAL CORTICOSTEROID, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR AN AUTOIMMUNE INDICATION. EOSINOPHILIC COPD: 1) USED IN COMBINATION WITH A LAMA/LABA/ICS, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR THE SAME INDICATION. RENEWAL: ASTHMA: 1) NO CONCURRENT USE WITH XOLAIR, DUPIXENT, TEZSPIRE, OR OTHER ANTI-IL5 BIOLOGICS WHEN USED FOR ASTHMA, 2) CONTINUED USE OF ICS AND AT LEAST ONE OTHER MAINTENANCE MEDICATION, AND 3) CLINICAL RESPONSE AS EVIDENCED BY: (A) REDUCTION IN ASTHMA EXACERBATIONS FROM BASELINE, (B) DECREASED UTILIZATION OF RESCUE MEDICATIONS, (C) REDUCTION IN SEVERITY OR FREQUENCY OF ASTHMA-RELATED SYMPTOMS, OR (D) INCREASE IN PERCENT PREDICTED FEV1 FROM PRETREATMENT BASELINE. CRSWNP: 1) CLINICAL BENEFIT COMPARED TO BASELINE, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR AN AUTOIMMUNE INDICATION. EOSINOPHILIC COPD: 1) USED IN COMBINATION WITH A LAMA/LABA/ICS, 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR THE SAME INDICATION, AND 3) CLINICAL RESPONSE AS EVIDENCED BY (A) REDUCTION IN COPD EXACERBATIONS FROM BASELINE, (B) REDUCTION IN SEVERITY OR FREQUENCY OF COPD-RELATED SYMPTOMS, OR (C) INCREASE IN FEV1 OF AT LEAST 5 PERCENT FROM PRETREATMENT BASELINE.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

MIDOSTAURIN

Products Affected

- RYDAPT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	ACUTE MYELOID LEUKEMIA: 6 MONTHS. ADVANCED SYSTEMIC MASTOCYTOSIS: 12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

MIFEPRISTONE

Products Affected

- *mifepristone oral tablet 300 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	CUSHINGS SYNDROME (CS): INITIAL: DIAGNOSIS CONFIRMED BY: 1) 24-HR URINE FREE CORTISOL (2 OR MORE TESTS TO CONFIRM), 2) OVERNIGHT 1MG DEXAMETHASONE TEST, OR 3) LATE NIGHT SALIVARY CORTISOL (2 OR MORE TESTS TO CONFIRM).
Age Restrictions	
Prescriber Restrictions	CS: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH AN ENDOCRINOLOGIST.
Coverage Duration	INITIAL/RENEWAL: 12 MONTHS
Other Criteria	CS: INITIAL: HYPERCORTISOLISM IS NOT A RESULT OF CHRONIC GLUCOCORTICOID. RENEWAL: 1) CONTINUES TO HAVE IMPROVEMENT OF GLUCOSE TOLERANCE OR STABLE GLUCOSE TOLERANCE (E.G., REDUCED A1C, IMPROVED FASTING GLUCOSE, ETC.), 2) CONTINUES TO HAVE TOLERABILITY TO THERAPY, AND 3) CONTINUES TO NOT BE A CANDIDATE FOR SURGICAL TREATMENT OR HAS FAILED SURGERY.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

MILTEFOSINE

Products Affected

- IMPAVIDO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

MIRDAMETINIB

Products Affected

- GOMEKLI ORAL CAPSULE 1 MG, 2 MG
- GOMEKLI ORAL TABLET FOR SUSPENSION

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

MIRVETUXIMAB SORAVTANSINE-GYNX

Products Affected

- ELAHERE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	EPITHELIAL OVARIAN, FALLOPIAN TUBE, OR PRIMARY PERITONEAL CANCER: AN OPHTHALMIC EXAM, INCLUDING VISUAL ACUITY AND SLIT LAMP EXAM, WILL BE COMPLETED PRIOR TO THE INITIATION OF THERAPY AND AT THE RECOMMENDED SCHEDULED INTERVALS.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

MOMELOTINIB

Products Affected

- OJJAARA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

MOSUNETUZUMAB-AXGB

Products Affected

- LUNSUMIO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	RELAPSED OR REFRACTORY FOLLICULAR LYMPHOMA: INITIAL: 6 MONTHS. RENEWAL: 7 MONTHS.
Other Criteria	RELAPSED OR REFRACTORY FOLLICULAR LYMPHOMA: RENEWAL: 1) HAS ACHIEVED A PARTIAL RESPONSE TO TREATMENT, AND 2) HAS NOT PREVIOUSLY RECEIVED MORE THAN 17 CYCLES OF TREATMENT. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

NARCOLEPSY AGENTS

Products Affected

- *armodafinil*
- *modafinil oral tablet 100 mg, 200 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

NAXITAMAB-GQGK

Products Affected

- DANYELZA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

NERATINIB

Products Affected

- NERLYNX

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	EARLY-STAGE (STAGE I-III) BREAST CANCER: MEDICATION IS BEING REQUESTED WITHIN 2 YEARS OF COMPLETING THE LAST TRASTUZUMAB DOSE. ALL OTHER FDA APPROVED INDICATIONS ARE COVERED WITHOUT ADDITIONAL CRITERIA, EXCEPT THOSE CRITERIA IN THE FDA APPROVED LABEL.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

NILOTINIB

Products Affected

- TASIGNA ORAL CAPSULE 150 MG, 200 MG, 50 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	PREVIOUSLY TREATED PHILADELPHIA CHROMOSOME-POSITIVE CHRONIC MYELOID LEUKEMIA (Ph+ CML): MUTATIONAL ANALYSIS PRIOR TO INITIATION AND REQUESTED MEDICATION IS APPROPRIATE PER NCCN GUIDELINE TABLE FOR TREATMENT RECOMMENDATIONS BASED ON BCR-ABL1 MUTATION PROFILE.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

NILOTINIB-DANZITEN

Products Affected

- DANZITEN

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	PREVIOUSLY TREATED PHILADELPHIA CHROMOSOME-POSITIVE CHRONIC MYELOID LEUKEMIA (Ph+ CML): 1) PERFORMED MUTATIONAL ANALYSIS PRIOR TO INITIATION OF THERAPY, AND 2) THERAPY IS APPROPRIATE PER NCCN GUIDELINE TABLE FOR TREATMENT RECOMMENDATIONS BASED ON BCR-ABL1 MUTATION PROFILE.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

NINTEDANIB

Products Affected

- OFEV

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: IDIOPATHIC PULMONARY FIBROSIS (IPF): 1) A USUAL INTERSTITIAL PNEUMONIA (UIP) PATTERN AS EVIDENCED BY HIGH-RESOLUTION COMPUTED TOMOGRAPHY (HRCT) ALONE OR VIA A COMBINATION OF SURGICAL LUNG BIOPSY AND HRCT, AND 2) BASELINE FORCED VITAL CAPACITY (FVC) AT LEAST 50% OF PREDICTED VALUE. SYSTEMIC SCLEROSIS-ASSOCIATED INTERSTITIAL LUNG DISEASE (SSC-ILD): 1) AT LEAST 10% FIBROSIS ON A CHEST HRCT, AND 2) BASELINE FVC AT LEAST 40% OF PREDICTED VALUE. CHRONIC FIBROSING INTERSTITIAL LUNG DISEASE WITH A PROGRESSIVE PHENOTYPE (PF-ILD): 1) AT LEAST 10% FIBROSIS ON A CHEST HRCT, AND 2) BASELINE FVC AT LEAST 45% OF PREDICTED VALUE.
Age Restrictions	
Prescriber Restrictions	INITIAL: IPF: PRESCRIBED BY OR IN CONSULTATION WITH A PULMONOLOGIST. SSC-ILD, PF-ILD: PRESCRIBED BY OR IN CONSULTATION WITH A PULMONOLOGIST OR RHEUMATOLOGIST.
Coverage Duration	INITIAL: SSC-ILD: 6 MOS. IPF, PF-ILD: 12 MOS. RENEWAL (ALL INDICATIONS): 12 MOS.
Other Criteria	INITIAL: IPF: 1) DOES NOT HAVE OTHER KNOWN CAUSES OF INTERSTITIAL LUNG DISEASE (E.G., CONNECTIVE TISSUE DISEASE, DRUG TOXICITY, ASBESTOS OR BERYLLIUM EXPOSURE, HYPERSENSITIVITY PNEUMONITIS), AND 2) TRIAL OF OR CONTRAINDICATION TO THE PREFERRED AGENT: ESBRIET (PIRFENIDONE). SSC-ILD: 1) DOES NOT HAVE OTHER KNOWN CAUSES OF INTERSTITIAL LUNG DISEASE (E.G., HEART FAILURE/FLUID OVERLOAD, DRUG-INDUCED LUNG TOXICITY, RECURRENT ASPIRATION), AND 2) TRIAL OF OR

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

PA Criteria	Criteria Details
	CONTRAINDICATION TO THE PREFERRED AGENT: ACTEMRA SUBQ. PF-ILD: LUNG FUNCTION AND RESPIRATORY SYMPTOMS OR CHEST IMAGING HAVE WORSENERD/PROGRESSED DESPITE TREATMENT WITH MEDICATIONS USED IN CLINICAL PRACTICE FOR ILD (NOT ATTRIBUTABLE TO COMORBIDITIES SUCH AS INFECTION, HEART FAILURE). RENEWAL: IPF, SSC-ILD, PF-ILD: CLINICAL MEANINGFUL IMPROVEMENT OR MAINTENANCE IN ANNUAL RATE OF DECLINE.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

NIRAPARIB

Products Affected

- ZEJULA ORAL CAPSULE
- ZEJULA ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	RECURRENT EPITHELIAL OVARIAN, FALLOPIAN TUBE, OR PRIMARY PERITONEAL CANCER: 1) ZEJULA WILL BE USED AS MONOTHERAPY, AND 2) ZEJULA IS STARTED NO LATER THAN 8 WEEKS AFTER THE MOST RECENT PLATINUM-CONTAINING REGIMEN.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

NIRAPARIB-ABIRATERONE

Products Affected

- AKEEGA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	METASTATIC CASTRATION-RESISTANT PROSTATE CANCER (MCRPC): 1) RECEIVED A BILATERAL ORCHIECTOMY, 2) CASTRATE LEVEL OF TESTOSTERONE (I.E., LESS THAN 50 NG/DL), OR 3) CONCURRENT USE WITH A GONADOTROPIN RELEASING HORMONE (GNRH) ANALOG.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

NIROGACESTAT

Products Affected

- OGSIVEO ORAL TABLET 100 MG, 150 MG, 50 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

NITISINONE

Products Affected

- nitisinone*
- ORFADIN ORAL SUSPENSION

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	HEREDITARY TYROSINEMIA TYPE 1 (HT-1): INITIAL: DIAGNOSIS CONFIRMED BY ELEVATED URINARY OR PLASMA SUCCINYLACETONE LEVELS OR A MUTATION IN THE FUMARYLACETOACETATE HYDROLASE GENE. RENEWAL: URINARY OR PLASMA SUCCINYLACETONE LEVELS HAVE DECREASED FROM BASELINE WHILE ON TREATMENT WITH NITISINONE.
Age Restrictions	
Prescriber Restrictions	HT-1: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A PRESCRIBER SPECIALIZING IN INHERITED METABOLIC DISEASES.
Coverage Duration	INITIAL: 6 MONTHS, RENEWAL: 12 MONTHS.
Other Criteria	HT-1: INITIAL: ORFADIN SUSPENSION: TRIAL OF OR CONTRAINDICATION TO PREFERRED NITISINONE TABLETS OR CAPSULES.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

NIVOLUMAB

Products Affected

- OPDIVO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	UNRESECTABLE OR METASTATIC MELANOMA: NO CONCURRENT USE WITH TARGETED THERAPY (I.E., BRAF INHIBITORS, MEK INHIBITORS, AND NTRK INHIBITORS).
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

NIVOLUMAB-HYALURONIDASE-NVHY

Products Affected

- OPDIVO QVANTIG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

NIVOLUMAB-RELATLIMAB-RMBW

Products Affected

- OPDUALAG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

NOGAPENDEKIN ALFA

Products Affected

- ANKTIVA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	40 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

OCRELIZUMAB

Products Affected

- OCREVUS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	RELAPSING FORM OF MULTIPLE SCLEROSIS (MS): TRIAL OF TWO AGENTS INDICATED FOR THE TREATMENT OF RELAPSING FORMS OF MS. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

OCRELIZUMAB-HYALURONIDASE-OCSQ

Products Affected

- OCREVUS ZUNOVO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	RELAPSING FORM OF MULTIPLE SCLEROSIS (MS): TRIAL OF TWO AGENTS INDICATED FOR THE TREATMENT OF RELAPSING FORMS OF MS. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

OFATUMUMAB-SQ

Products Affected

- KESIMPTA PEN

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

OLANZAPINE/SAMIDORPHAN

Products Affected

- LYBALVI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	SCHIZOPHRENIA, BIPOLAR I: PRESCRIBED BY OR IN CONSULTATION WITH A PSYCHIATRIST
Coverage Duration	12 MONTHS
Other Criteria	SCHIZOPHRENIA: 1) AT HIGH RISK FOR WEIGHT GAIN, AND 2) TRIAL OF OR CONTRAINDICATION TO A FORMULARY VERSION OF LURASIDONE OR ONE OF THE FOLLOWING ORAL ANTIPSYCHOTICS: RISPERIDONE, CLOZAPINE TABLET, OLANZAPINE, IMMEDIATE RELEASE QUETIAPINE FUMARATE, ZIPRASIDONE, ARIPIPRAZOLE. BIPOLAR I: 1) AT HIGH RISK FOR WEIGHT GAIN, AND 2) TRIAL OF OR CONTRAINDICATION TO ONE OF THE FOLLOWING ORAL ANTIPSYCHOTICS: RISPERIDONE, OLANZAPINE, IMMEDIATE RELEASE QUETIAPINE FUMARATE, ZIPRASIDONE, ARIPIPRAZOLE.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

OLAPARIB

Products Affected

- LYNPARZA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	RECURRENT EPITHELIAL OVARIAN, FALLOPIAN TUBE OR PRIMARY PERITONEAL CANCER: MEDICATION WILL BE USED AS MONOTHERAPY. METASTATIC CASTRATION-RESISTANT PROSTATE CANCER: 1) RECEIVED A BILATERAL ORCHIECTOMY, 2) CASTRATE LEVEL OF TESTOSTERONE (I.E., LESS THAN 50 NG/DL), OR 3) CONCURRENT USE WITH A GONADOTROPIN RELEASING HORMONE (GNRH) ANALOG. ALL OTHER FDA APPROVED INDICATIONS ARE COVERED WITHOUT ADDITIONAL CRITERIA, EXCEPT THOSE CRITERIA IN THE FDA APPROVED LABEL.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

OLUTASIDENIB

Products Affected

- REZLIDHIA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

OMACETAXINE

Products Affected

- SYNRIBO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

OMALIZUMAB

Products Affected

- XOLAIR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: ASTHMA: POSITIVE SKIN PRICK OR BLOOD TEST (E.G., ELISA, FEIA) TO A PERENNIAL AEROALLERGEN AND A BASELINE IGE SERUM LEVEL OF AT LEAST 30 IU/ML. FOOD ALLERGY: 1) IGE SERUM LEVEL OF AT LEAST 30 IU/ML, AND 2) ALLERGEN SPECIFIC IGE SERUM LEVEL OF AT LEAST 6 KUA/L TO AT LEAST ONE FOOD, OR POSITIVE SKIN PRICK TEST TO AT LEAST ONE FOOD, OR POSITIVE MEDICALLY MONITORED FOOD CHALLENGE TO AT LEAST ONE FOOD.
Age Restrictions	
Prescriber Restrictions	INITIAL/RENEWAL: CHRONIC SPONTANEOUS URTICARIA (CSU): PRESCRIBED BY OR IN CONSULTATION WITH AN ALLERGIST, DERMATOLOGIST, OR IMMUNOLOGIST. INITIAL: CHRONIC RHINOSINUSITIS WITH NASAL POLYPS (CRSWNP): PRESCRIBED BY OR IN CONSULTATION WITH AN OTOLARYNGOLOGIST, ALLERGIST OR IMMUNOLOGIST. ASTHMA: PRESCRIBED BY OR IN CONSULTATION WITH A PHYSICIAN SPECIALIZING IN ALLERGY OR PULMONARY MEDICINE. FOOD ALLERGY: PRESCRIBED BY OR IN CONSULTATION WITH ALLERGIST OR IMMUNOLOGIST.
Coverage Duration	INITIAL/RENEWAL: ASTHMA 12 MO/12 MO, CSU 6 MO/12 MO, CRSWNP 6 MO/12 MO, FOOD ALLERGY 12 MO/24 MO
Other Criteria	INITIAL: CSU: 1) TRIAL OF AND MAINTAINED ON, OR CONTRAINDICATION TO A SECOND GENERATION H1 ANTI-HISTAMINE AND 2) STILL EXPERIENCES HIVES OR ANGIOEDEMA ON MOST DAYS OF THE WEEK FOR AT LEAST 6 WEEKS. CRSWNP: 1) A 56 DAY TRIAL OF ONE TOPICAL NASAL CORTICOSTEROID, 2) TRIAL OF OR CONTRAINDICATION TO ONE PREFERRED AGENT: NUCALA, DUPIXENT, AND 3) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4

Updated: 11.01.2025

Y0150_PBM200_C (v2)

PA Criteria	Criteria Details
	INHIBITOR) FOR AN AUTOIMMUNE INDICATION. ASTHMA: 1) CONCURRENT THERAPY WITH A MEDIUM, HIGH-DOSE OR MAXIMALLY TOLERATED DOSE OF AN INHALED CORTICOSTEROID (ICS) AND AT LEAST ONE OTHER MAINTENANCE MEDICATION, 2) ONE OF THE FOLLOWING: (A) AT LEAST ONE ASTHMA EXACERBATION REQUIRING SYSTEMIC CORTICOSTEROID BURST LASTING 3 OR MORE DAYS WITHIN THE PAST 12 MONTHS OR AT LEAST ONE SERIOUS EXACERBATION REQUIRING HOSPITALIZATION OR ER VISIT WITHIN THE PAST 12 MONTHS, OR (B) POOR SYMPTOM CONTROL DESPITE CURRENT THERAPY AS EVIDENCED BY AT LEAST THREE OF THE FOLLOWING WITHIN THE PAST 4 WEEKS: DAYTIME ASTHMA SYMPTOMS MORE THAN TWICE/WEEK, ANY NIGHT WAKING DUE TO ASTHMA, SABA RELIEVER FOR SYMPTOMS MORE THAN TWICE/WEEK, ANY ACTIVITY LIMITATION DUE TO ASTHMA, AND 3) NO CONCURRENT USE WITH DUPIXENT, TEZSPIRE, OR ANTI-IL5 BIOLOGICS WHEN USED FOR ASTHMA. FOOD ALLERGY: 1) CONCURRENT USE WITH AN ACTIVE PRESCRIPTION FOR EPINEPHRINE AUTO-INJECTOR/INJECTION, AND 2) NO CONCURRENT USE WITH PEANUT-SPECIFIC IMMUNOTHERAPY. RENEWAL: CSU: MAINTAINED ON OR CONTRAINDICATION TO A SECOND GENERATION H1 ANTI-HISTAMINE. CRSWNP: 1) CLINICAL BENEFIT COMPARED TO BASELINE, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR AN AUTOIMMUNE INDICATION. ASTHMA: 1) NO CONCURRENT USE WITH DUPIXENT, TEZSPIRE, OR ANTI-IL5 BIOLOGICS WHEN USED FOR ASTHMA, 2) CONTINUED USE OF ICS AND AT LEAST ONE OTHER MAINTENANCE MEDICATION, AND 3) CLINICAL RESPONSE AS EVIDENCED BY ONE OF THE FOLLOWING: (A) REDUCTION IN ASTHMA EXACERBATIONS FROM BASELINE, (B) DECREASED UTILIZATION OF RESCUE MEDICATIONS, (C) REDUCTION IN SEVERITY OR FREQUENCY OF ASTHMA-RELATED SYMPTOMS, OR (D) INCREASE IN PERCENT PREDICTED FEV1 FROM PRETREATMENT BASELINE. FOOD ALLERGY: 1) PERSISTENT IGE-MEDIATED FOOD ALLERGY, 2) CONCURRENT USE WITH AN ACTIVE PRESCRIPTION FOR EPINEPHRINE AUTO-INJECTOR/INJECTION, AND 3) NO



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

PA Criteria	Criteria Details
	CONCURRENT USE WITH PEANUT-SPECIFIC IMMUNOTHERAPY.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

OSIMERTINIB

Products Affected

- TAGRISSO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

OXANDROLONE

Products Affected

- *oxandrolone*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 MONTHS
Other Criteria	PROTEIN CATABOLISM, BONE PAIN: 1) MONITORED FOR PELIOSIS HEPATIS, LIVER CELL TUMORS, AND BLOOD LIPID CHANGES, 2) DOES NOT HAVE KNOWN OR SUSPECTED: CARCINOMA OF THE PROSTATE OR BREAST IN MALE PATIENTS, CARCINOMA OF THE BREAST IN FEMALES WITH HYPERCALCEMIA, NEPHROSIS (THE NEPHROTIC PHASE OF NEPHRITIS), OR HYPERCALCEMIA, AND 3) DOES NOT HAVE SEVERE HEPATIC DYSFUNCTION.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

PACRITINIB

Products Affected

- VONJO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS
Other Criteria	MYELOFIBROSIS; RENEWAL: CONTINUES TO BENEFIT FROM THE MEDICATION
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

PALBOCICLIB

Products Affected

- IBRANCE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

PARATHYROID HORMONE

Products Affected

- NATPARA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	HYPOCALCEMIA SECONDARY TO HYPOPARATHYROIDISM: PRESCRIBED BY OR IN CONSULTATION WITH AN ENDOCRINOLOGIST.
Coverage Duration	12 MONTHS
Other Criteria	HYPOCALCEMIA SECONDARY TO HYPOPARATHYROIDISM: 1) TRIAL OF OR CONTRAINDICATION TO CALCITRIOL, 2) HYPOPARATHYROIDISM IS NOT DUE TO A CALCIUM SENSING RECEPTOR (CSR) MUTATION, AND 3) HYPOPARATHYROIDISM IS NOT CONSIDERED ACUTE POST-SURGICAL HYPOPARATHYROIDISM.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

PASIREOTIDE DIASPARTATE

Products Affected

- SIGNIFOR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	CUSHINGS DISEASE (CD): INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH AN ENDOCRINOLOGIST.
Coverage Duration	INITIAL: 6 MONTHS, RENEWAL: 12 MONTHS.
Other Criteria	CD: RENEWAL: 1) CONTINUED IMPROVEMENT OF CUSHINGS DISEASE, AND 2) MAINTAINED TOLERABILITY TO SIGNIFOR.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

PAZOPANIB

Products Affected

- *pazopanib*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	ADVANCED SOFT TISSUE SARCOMA (STS): NOT USED FOR ADIPOCYTIC STS OR GASTROINTESTINAL STROMAL TUMORS (GIST)
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

PEGFILGRASTIM - APGF

Products Affected

- NYVEPRIA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR IN CONSULTATION WITH A HEMATOLOGIST OR ONCOLOGIST.
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

PEGFILGRASTIM-NEULASTA ONPRO

Products Affected

- NEULASTA ONPRO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR IN CONSULTATION WITH A HEMATOLOGIST OR ONCOLOGIST.
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

PEGINTERFERON ALFA-2A

Products Affected

- PEGASYS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	HEPATITIS B: PRESCRIBED BY OR IN CONSULTATION WITH A GASTROENTEROLOGIST, INFECTIOUS DISEASE SPECIALIST, OR PHYSICIAN SPECIALIZING IN THE TREATMENT OF HEPATITIS (E.G., HEPATOLOGIST).
Coverage Duration	HEP B/HEP C: 48 WEEKS.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

PEGVISOMANT

Products Affected

- SOMAVERT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

PEMBROLIZUMAB

Products Affected

- KEYTRUDA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	UNRESECTABLE OR METASTATIC MELANOMA: NO CONCURRENT USE WITH TARGETED THERAPY (I.E., BRAF INHIBITORS, MEK INHIBITORS, AND NTRK INHIBITORS).
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

PEMIGATINIB

Products Affected

- PEMAZYRE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	CHOLANGIOCARCINOMA, MYELOID/LYMPHOID NEOPLASMS: COMPREHENSIVE OPHTHALMOLOGICAL EXAMINATION, INCLUDING OPTICAL COHERENCE TOMOGRAPHY (OCT), WILL BE COMPLETED PRIOR TO INITIATION OF THERAPY AND AT THE RECOMMENDED SCHEDULED INTERVALS.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

PENICILLAMINE TABLET

Products Affected

- *penicillamine oral tablet*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: CYSTINURIA: HAS NEPHROLITHIASIS AND ONE OF THE FOLLOWING: 1) STONE ANALYSIS SHOWING PRESENCE OF CYSTINE, 2) PRESENCE OF PATHOGNOMONIC HEXAGONAL CYSTINE CRYSTALS ON URINALYSIS, OR 3) FAMILY HISTORY OF CYSTINURIA AND POSITIVE CYANIDE-NITROPRUSSIDE SCREENING.
Age Restrictions	
Prescriber Restrictions	INITIAL: WILSONS DISEASE: PRESCRIBED BY OR IN CONSULTATION WITH A HEPATOLOGIST OR GASTROENTEROLOGIST. CYSTINURIA: PRESCRIBED BY OR IN CONSULTATION WITH A NEPHROLOGIST. RHEUMATOID ARTHRITIS (RA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST.
Coverage Duration	INITIAL: 12 MONTHS, RENEWAL: LIFETIME.
Other Criteria	INITIAL: WILSONS DISEASE: 1) LEIPZIG SCORE OF 4 OR GREATER. RA: 1) NO HISTORY OR OTHER EVIDENCE OF RENAL INSUFFICIENCY, AND 2) TRIAL OF OR CONTRAINDICATION TO 3 MONTHS OF TREATMENT WITH ONE DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG) - IF PATIENT TRIED METHOTREXATE, THEN TRIAL AT A DOSE GREATER THAN OR EQUAL TO 20 MG PER WEEK OR MAXIMALLY TOLERATED DOSE IS REQUIRED. RENEWAL: RA: 1) NO HISTORY OR OTHER EVIDENCE OF RENAL INSUFFICIENCY, AND 2) EXPERIENCED OR MAINTAINED IMPROVEMENT IN TENDER JOINT COUNT OR SWOLLEN JOINT COUNT COMPARED TO BASELINE. WILSONS DISEASE, CYSTINURIA: CONTINUES TO BENEFIT FROM THE MEDICATION.
Indications	All FDA-approved Indications.

Updated: 11.01.2025

Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

PA Criteria	Criteria Details
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

PEXIDARTINIB

Products Affected

- TURALIO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

PIMAVANSERIN

Products Affected

- NUPLAZID

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	PSYCHOSIS IN PARKINSONS DISEASE (PD): INITIAL: 18 YEARS OR OLDER
Prescriber Restrictions	PSYCHOSIS IN PD: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST, GERIATRICIAN, OR A BEHAVIORAL HEALTH SPECIALIST (E.G., PSYCHIATRIST).
Coverage Duration	INITIAL/RENEWAL: 12 MONTHS.
Other Criteria	PSYCHOSIS IN PD: RENEWAL: IMPROVEMENT IN PSYCHOSIS SYMPTOMS FROM BASELINE AND DEMONSTRATES A CONTINUED NEED FOR TREATMENT.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

PIRFENIDONE

Products Affected

- *pirfenidone oral capsule*
- *pirfenidone oral tablet 267 mg, 534 mg, 801 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	IDIOPATHIC PULMONARY FIBROSIS (IPF): INITIAL: 1) A USUAL INTERSTITIAL PNEUMONIA (UIP) PATTERN AS EVIDENCED BY HIGH-RESOLUTION COMPUTED TOMOGRAPHY (HRCT) ALONE OR VIA A COMBINATION OF SURGICAL LUNG BIOPSY AND HRCT, AND 2) PREDICTED FORCED VITAL CAPACITY (FVC) OF AT LEAST 50% AT BASELINE.
Age Restrictions	IPF: INITIAL: 18 YEARS OR OLDER.
Prescriber Restrictions	IPF: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A PULMONOLOGIST.
Coverage Duration	INITIAL/RENEWAL: 12 MONTHS.
Other Criteria	IPF: INITIAL: 1) DOES NOT HAVE OTHER KNOWN CAUSES OF INTERSTITIAL LUNG DISEASE (E.G., CONNECTIVE TISSUE DISEASE, DRUG TOXICITY, ASBESTOS OR BERYLLIUM EXPOSURE, HYPERSENSITIVITY PNEUMONITIS, SYSTEMIC SCLEROSIS, RHEUMATOID ARTHRITIS, RADIATION, SARCOIDOSIS, BRONCHIOLITIS OBLITERANS ORGANIZING PNEUMONIA, HUMAN IMMUNODEFICIENCY VIRUS (HIV) INFECTION, VIRAL HEPATITIS, OR CANCER). RENEWAL: CLINICAL MEANINGFUL IMPROVEMENT OR MAINTENANCE IN ANNUAL RATE OF DECLINE.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

PIRTOBRUTINIB

Products Affected

- JAYPIRCA ORAL TABLET 100 MG, 50 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

POMALIDOMIDE

Products Affected

- POMALYST

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

PONATINIB

Products Affected

- ICLUSIG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	CHRONIC MYELOID LEUKEMIA (CML): MUTATIONAL ANALYSIS PRIOR TO INITIATION AND ICLUSIG IS APPROPRIATE PER NCCN GUIDELINE TABLE FOR TREATMENT RECOMMENDATIONS BASED ON BCR-ABL1 MUTATION PROFILE.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

POSACONAZOLE TABLET

Products Affected

- *posaconazole oral tablet, delayed release (dr/ec)*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	CONTINUATION OF THERAPY AFTER HOSPITAL DISCHARGE, PROPHYLAXIS: 6 MONTHS. TREATMENT: 12 WEEKS.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

PRALSETINIB

Products Affected

- GAVRETO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

PYRIMETHAMINE

Products Affected

- *pyrimethamine*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	TOXOPLASMOSIS: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH AN INFECTIOUS DISEASE SPECIALIST.
Coverage Duration	TOXOPLASMOSIS: INITIAL: 8 WEEKS, RENEWAL: 6 MOS.
Other Criteria	TOXOPLASMOSIS: RENEWAL: ONE OF THE FOLLOWING: (1) PERSISTENT CLINICAL DISEASE (HEADACHE, NEUROLOGICAL SYMPTOMS, OR FEVER) AND PERSISTENT RADIOGRAPHIC DISEASE (ONE OR MORE MASS LESIONS ON BRAIN IMAGING), OR (2) CD4 COUNT LESS THAN 200 CELLS/MM3 AND CURRENTLY TAKING AN ANTI-RETROVIRAL THERAPY IF HIV POSITIVE.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

QUININE

Products Affected

- *quinine sulfate*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

QUIZARTINIB

Products Affected

- VANFLYTA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

REGORAFENIB

Products Affected

- STIVARGA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

RELUGOLIX

Products Affected

- ORGOVYX

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

REPOTRECTINIB

Products Affected

- AUGTYRO ORAL CAPSULE 160 MG, 40 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

RESLIZUMAB

Products Affected

- CINQAIR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	ASTHMA: INITIAL: BLOOD EOSINOPHIL LEVEL OF AT LEAST 150 CELLS/MCL WITHIN THE PAST 12 MONTHS.
Age Restrictions	
Prescriber Restrictions	ASTHMA: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A PHYSICIAN SPECIALIZING IN ALLERGY OR PULMONARY MEDICINE.
Coverage Duration	INITIAL/RENEWAL: 12 MONTHS.
Other Criteria	ASTHMA: INITIAL: 1) CONCURRENT THERAPY WITH A MEDIUM, HIGH-DOSE OR MAXIMALLY TOLERATED DOSE OF AN INHALED CORTICOSTEROID (ICS) AND ONE OTHER MAINTENANCE MEDICATION, 2) ONE ASTHMA EXACERBATION REQUIRING SYSTEMIC CORTICOSTEROID BURST LASTING 3 OR MORE DAYS WITHIN THE PAST 12 MONTHS, OR AT LEAST ONE SERIOUS EXACERBATION REQUIRING HOSPITALIZATION OR ER VISIT WITHIN THE PAST 12 MONTHS, OR POOR SYMPTOM CONTROL DESPITE CURRENT THERAPY AS EVIDENCED BY AT LEAST THREE OF THE FOLLOWING WITHIN THE PAST 4 WEEKS: (A) DAYTIME ASTHMA SYMPTOMS MORE THAN TWICE/WEEK, (B) ANY NIGHT WAKING DUE TO ASTHMA, (C) SABA RELIEVER FOR SYMPTOMS MORE THAN TWICE/WEEK, (D) ANY ACTIVITY LIMITATION DUE TO ASTHMA, 3) TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: FASENRA, NUCALA, DUPIXENT, AND 4) NO CONCURRENT USE WITH XOLAIR, DUPIXENT, TEZSPIRE, OR OTHER ANTI-IL5 BIOLOGICS WHEN USED FOR ASTHMA. RENEWAL: 1) NO CONCURRENT USE WITH XOLAIR, DUPIXENT, TEZSPIRE, OR OTHER ANTI-IL5 BIOLOGICS WHEN USED FOR

Updated: 11.01.2025

Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

PA Criteria	Criteria Details
	ASTHMA, 2) CONTINUED USE OF ICS AND ONE OTHER MAINTENANCE MEDICATION, AND 3) CLINICAL RESPONSE AS EVIDENCED BY: (A) REDUCTION IN ASTHMA EXACERBATIONS FROM BASELINE, (B) DECREASED UTILIZATION OF RESCUE MEDICATIONS, (C) REDUCTION IN SEVERITY OR FREQUENCY OF ASTHMA-RELATED SYMPTOMS, OR (D) INCREASE IN PERCENT PREDICTED FEV1 FROM PRETREATMENT BASELINE. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

RETIFANLIMAB-DLWR

Products Affected

- ZYNYZ

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

REVUMENIB

Products Affected

- REVUFORJ ORAL TABLET 110 MG, 160 MG, 25 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

RIBOCICLIB

Products Affected

- KISQALI ORAL TABLET 200 MG/DAY (200 MG X 1), 400 MG/DAY (200 MG X 2), 600 MG/DAY (200 MG X 3)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

RIBOCICLIB-LETROZOLE

Products Affected

- KISQALI FEMARA CO-PACK ORAL MG, 400 MG/DAY(200 MG X 2)-2.5
TABLET 200 MG/DAY(200 MG X 1)-2.5 MG, 600 MG/DAY(200 MG X 3)-2.5 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

RIFAXIMIN

Products Affected

- XIFAXAN ORAL TABLET 200 MG, 550 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	TRAVELERS DIARRHEA, HEPATIC ENCEPHALOPATHY (HE): 12 MOS. IBS-D: 8 WKS.
Other Criteria	HE: TRIAL OF OR CONTRAINDICATION TO LACTULOSE OR CONCURRENT LACTULOSE THERAPY.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

RILONACEPT

Products Affected

- ARCALYST

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	CRYOPYRIN-ASSOCIATED PERIODIC SYNDROMES (CAPS): 1) ONE OF THE FOLLOWING: (A) GENETIC TEST FOR GAIN-OF-FUNCTION MUTATIONS IN THE NLRP3 GENE, OR (B) HAS INFLAMMATORY MARKERS (I.E., ELEVATED CRP, ESR, SERUM AMYLOID A PROTEIN (SAA) OR S100 PROTEINS), AND 2) TWO OF THE FOLLOWING: URTICARIAL-LIKE RASH (NEUTROPHILIC DERMATITIS), COLD-TRIGGERED EPISODES, SENSORINEURAL HEARING LOSS, MUSCULOSKELETAL SYMPTOMS, CHRONIC ASEPTIC MENINGITIS, SKELETAL ABNORMALITIES. DEFICIENCY OF INTERLEUKIN-1 RECEPTOR ANTAGONIST (DIRA): 1) ONE OF THE FOLLOWING: (A) GENETIC TEST FOR GAIN-OF-FUNCTION MUTATIONS IN THE IL1RN GENE, OR (B) HAS INFLAMMATORY MARKERS (I.E., ELEVATED CRP, ESR), AND 2) ONE OF THE FOLLOWING: PUSTULAR PSORIASIS-LIKE RASHES, OSTEOMYELITIS, ABSENCE OF BACTERIAL OSTEOMYELITIS, ONYCHOMADESIS. RECURRENT PERICARDITIS (RP): TWO OF THE FOLLOWING: CHEST PAIN CONSISTENT WITH PERICARDITIS, PERICARDIAL FRICTION RUB, ECG SHOWING DIFFUSE ST-SEGMENT ELEVATION OR PR-SEGMENT DEPRESSION, NEW OR WORSENING PERICARDIAL EFFUSION.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	CAPS, DIRA: LIFETIME. RP: 12 MONTHS.
Other Criteria	CAPS: NO CONCURRENT USE WITH OTHER IL-1 INHIBITORS. DIRA: 1) NO CONCURRENT USE WITH OTHER IL-1 INHIBITORS, AND 2) TRIAL OF THE PREFERRED AGENT: KINERET. RP: 1)

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

PA Criteria	Criteria Details
	HAD AN EPISODE OF ACUTE PERICARDITIS, 2) SYMPTOM-FREE FOR 4 TO 6 WEEKS, AND 3) NO CONCURRENT USE WITH OTHER IL-1 INHIBITORS.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

RIMEGEPANT

Products Affected

- NURTEC ODT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	ACUTE MIGRAINE TREATMENT: INITIAL: TRIAL OF OR CONTRAINDICATION TO ONE TRIPTAN (E.G., SUMATRIPTAN, RIZATRIPTAN). INITIAL/RENEWAL: NO CONCURRENT USE WITH OTHER CGRP INHIBITORS FOR ACUTE MIGRAINE TREATMENT. RENEWAL: 1) IMPROVEMENT FROM BASELINE IN A VALIDATED ACUTE TREATMENT PATIENT-REPORTED OUTCOME QUESTIONNAIRE, OR 2) THERAPY WORKS CONSISTENTLY IN MAJORITY OF MIGRAINE ATTACKS. EPISODIC MIGRAINE PREVENTION: INITIAL/RENEWAL: NO CONCURRENT USE WITH OTHER CGRP INHIBITORS FOR MIGRAINE PREVENTION. RENEWAL: REDUCTION IN MIGRAINE OR HEADACHE FREQUENCY, MIGRAINE SEVERITY, OR MIGRAINE DURATION WITH THERAPY.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

RIOCIQUAT

Products Affected

- ADEMPAS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: PULMONARY ARTERIAL HYPERTENSION (PAH): DIAGNOSIS CONFIRMED BY RIGHT HEART CATHETERIZATION WITH THE FOLLOWING PARAMETERS: 1) MEAN PULMONARY ARTERY PRESSURE (PAP) GREATER THAN 20 MMHG, 2) PULMONARY CAPILLARY WEDGE PRESSURE (PCWP) OF 15 MMHG OR LESS, AND 3) PULMONARY VASCULAR RESISTANCE (PVR) GREATER THAN 2 WOOD UNITS. PERSISTENT/RECURRENT CHRONIC THROMBOEMBOLIC PULMONARY HYPERTENSION (CTEPH) (WHO GROUP 4): WHO FUNCTIONAL CLASS II-IV SYMPTOMS.
Age Restrictions	
Prescriber Restrictions	INITIAL: PAH, CTEPH: PRESCRIBED BY OR IN CONSULTATION WITH A CARDIOLOGIST OR PULMONOLOGIST.
Coverage Duration	INITIAL/RENEWAL: 12 MONTHS.
Other Criteria	INITIAL: PAH: NO CONCURRENT USE WITH NITRATES, NITRIC OXIDE DONORS, PHOSPHODIESTERASE (PDE) INHIBITORS, OR NON-SPECIFIC PDE INHIBITORS. CTEPH: 1) NO CONCURRENT USE WITH NITRATES, NITRIC OXIDE DONORS, PDE INHIBITORS, OR NON-SPECIFIC PDE INHIBITORS, AND 2) NOT A CANDIDATE FOR SURGERY OR HAS INOPERABLE CTEPH OR HAS PERSISTENT OR RECURRENT DISEASE AFTER SURGICAL TREATMENT. RENEWAL: PAH, CTEPH: NO CONCURRENT USE WITH NITRATES, NITRIC OXIDE DONORS, PDE INHIBITORS, OR NON-SPECIFIC PDE INHIBITORS.
Indications	All FDA-approved Indications.
Off Label Uses	



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

PA Criteria	Criteria Details
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

RIPRETINIB

Products Affected

- QINLOCK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

RISANKIZUMAB-RZAA

Products Affected

- SKYRIZI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: PLAQUE PSORIASIS (PSO): PLAQUE PSORIASIS COVERING 3 PERCENT OR MORE OF BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, FACE, SCALP, OR GENITAL AREA.
Age Restrictions	
Prescriber Restrictions	INITIAL: PSO: PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST. PSORIATIC ARTHRITIS (PSA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST OR DERMATOLOGIST. CROHNS DISEASE (CD), ULCERATIVE COLITIS (UC): PRESCRIBED BY OR IN CONSULTATION WITH A GASTROENTEROLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS
Other Criteria	INITIAL: PSO: 1) ONE OF THE FOLLOWING: (A) AT LEAST A 3 MONTH TRIAL OF ONE ORAL IMMUNOSUPPRESSANT (CYCLOSPORINE, METHOTREXATE, TACROLIMUS) OR PUVA (PHOTOTHERAPY) FOR THE TREATMENT OF PSO, (B) CONTRAINDICATION OR INTOLERANCE TO BOTH IMMUNOSUPPRESSANT AND PUVA FOR THE TREATMENT OF PSO, OR (C) PATIENT IS SWITCHING FROM A DIFFERENT BIOLOGIC, PDE-4 INHIBITOR, OR JAK INHIBITOR FOR THE SAME INDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR PSO. PSA: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR PSA. CD: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR CD. UC: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

PA Criteria	Criteria Details
	TARGETED SMALL MOLECULES FOR UC. RENEWAL: PSO: 1) CONTINUES TO BENEFIT FROM THE MEDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR PSO. PSA: 1) CONTINUES TO BENEFIT FROM THE MEDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR PSA. CD: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR CD. UC: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR UC.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

RITUXIMAB AND HYALURONIDASE HUMAN-SQ

Products Affected

- RITUXAN HYCELA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	FOLLICULAR LYMPHOMA (FL), DIFFUSE LARGE B-CELL LYMPHOMA (DLBCL), CHRONIC LYMPHOCYTIC LEUKEMIA (CLL); HAS RECEIVED OR WILL RECEIVE AT LEAST ONE FULL DOSE OF A RITUXIMAB PRODUCT BY INTRAVENOUS INFUSION PRIOR TO INITIATION OF RITUXIMAB AND HYALURONIDASE. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

RITUXIMAB-ABBS

Products Affected

- TRUXIMA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	INITIAL: RHEUMATOID ARTHRITIS (RA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST. NON-HODGKINS LYMPHOMA (NHL), CHRONIC LYMPHOCYTIC LEUKEMIA (CLL): PRESCRIBED BY OR IN CONSULTATION WITH AN ONCOLOGIST.
Coverage Duration	RA: INITIAL: 6 MO, RENEWAL: 12 MO. NHL, GPA, MPA, PV: 12 MO. CLL: 6 MO.
Other Criteria	RA: INITIAL: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: ENBREL, HUMIRA/CYLTEZO/YUFLYMA, XELJANZ, RINVOQ, ORENCIA. RENEWAL: CONTINUES TO BENEFIT FROM THE MEDICATION. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

RITUXIMAB-ARRX

Products Affected

- RIABNI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	RHEUMATOID ARTHRITIS (RA): INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST. NON-HODGKINS LYMPHOMA (NHL), CHRONIC LYMPHOCYTIC LEUKEMIA (CLL): PRESCRIBED BY OR IN CONSULTATION WITH AN ONCOLOGIST.
Coverage Duration	RA: INITIAL: 6 MO, RENEWAL: 12 MO. NHL, GPA, MPA, PV: 12 MO. CLL: 6 MO.
Other Criteria	RA: INITIAL: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: ENBREL, HUMIRA/CYLTEZO/YUFLYMA, XELJANZ, RINVOQ, ORENCIA. RENEWAL: CONTINUES TO BENEFIT FROM THE MEDICATION. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

RITUXIMAB-PVVR

Products Affected

- RUXIENCE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	RA: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST. NON-HODGKINS LYMPHOMA (NHL), CHRONIC LYMPHOCYTIC LEUKEMIA (CLL): PRESCRIBED BY OR IN CONSULTATION WITH AN ONCOLOGIST.
Coverage Duration	RA: INITIAL: 6 MO, RENEWAL: 12 MO. NHL, GPA, MPA, PV: 12 MO. CLL: 6 MO.
Other Criteria	RA: INITIAL: TRIAL OF OR CONTRAINDICATION TO TWO PREFERRED AGENTS: ENBREL, HUMIRA/CYLTEZO/YUFLYMA, XELJANZ, RINVOQ, ORENCIA. RENEWAL: CONTINUES TO BENEFIT FROM THE MEDICATION. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

ROPEGINTERFERON ALFA-2B-NJFT

Products Affected

- BESREMI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

RUCAPARIB

Products Affected

- RUBRACA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	METASTATIC CASTRATION-RESISTANT PROSTATE CANCER: ONE OF THE FOLLOWING: 1) RECEIVED A BILATERAL ORCHIECTOMY, 2) CASTRATE LEVEL OF TESTOSTERONE (I.E., LESS THAN 50 NG/DL), OR 3) CONCURRENT USE WITH A GONADOTROPIN RELEASING HORMONE (GNRH) ANALOG.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

RUXOLITINIB

Products Affected

- JAKAFI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	MYELOFIBROSIS: INITIAL: 6 MONTHS, RENEWAL: 12 MONTHS. POLYCYTHEMIA VERA, GVHD: 12 MONTHS
Other Criteria	MYELOFIBROSIS: RENEWAL: CONTINUES TO BENEFIT FROM THE MEDICATION.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

SAPROPTERIN

Products Affected

- *javygtor oral tablet,soluble*
- *sapropterin oral tablet,soluble*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL: 2 MONTHS, RENEWAL 12 MONTHS.
Other Criteria	HYPERPHENYLALANINEMIA (HPA): INITIAL: NO CONCURRENT USE WITH PALYNZIQ. RENEWAL: 1) CONTINUES TO BENEFIT FROM TREATMENT, AND 2) NO CONCURRENT USE WITH PALYNZIQ.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

SECUKINUMAB IV

Products Affected

- COSENTYX INTRAVENOUS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: NON-RADIOGRAPHIC AXIAL SPONDYLOARTHRITIS (NR-AXSPA): 1) C-REACTIVE PROTEIN (CRP) LEVELS ABOVE THE UPPER LIMIT OF NORMAL, OR 2) SACROILIITIS ON MAGNETIC RESONANCE IMAGING (MRI).
Age Restrictions	
Prescriber Restrictions	INITIAL: PSORIATIC ARTHRITIS (PSA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST OR A DERMATOLOGIST. ANKYLOSING SPONDYLITIS (AS), NR-AXSPA: PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS
Other Criteria	INITIAL: PSA: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR PSA. AS: 1) TRIAL OF OR CONTRAINDICATION TO AN NSAID, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR AS. NR-AXSPA: 1) TRIAL OF OR CONTRAINDICATION TO AN NSAID, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR NR-AXSPA. RENEWAL: PSA: 1) CONTINUES TO BENEFIT FROM THE MEDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR PSA. AS: 1) CONTINUES TO BENEFIT FROM THE MEDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR AS. NR-AXSPA: 1) CONTINUES TO BENEFIT FROM THE MEDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

PA Criteria	Criteria Details
	TARGETED SMALL MOLECULES FOR NR-AXSPA. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

SECUKINUMAB SQ

Products Affected

- COSENTYX (2 SYRINGES)
- COSENTYX PEN (2 PENS)
- COSENTYX SUBCUTANEOUS SYRINGE 75 MG/0.5 ML
- COSENTYX UNOREADY PEN

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: PLAQUE PSORIASIS (PSO): PSORIASIS COVERING 3 PERCENT OR MORE OF BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, GENITAL AREA, SCALP, OR FACE. NON-RADIOGRAPHIC AXIAL SPONDYLOARTHRITIS (NR-AXSPA): 1) C-REACTIVE PROTEIN (CRP) LEVELS ABOVE THE UPPER LIMIT OF NORMAL, OR 2) SACROILIITIS ON MAGNETIC RESONANCE IMAGING (MRI).
Age Restrictions	
Prescriber Restrictions	INITIAL: PSO, HIDRADENITIS SUPPURATIVA (HS): PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST. PSORIATIC ARTHRITIS (PSA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST OR A DERMATOLOGIST. ANKYLOSING SPONDYLITIS (AS), NR-AXSPA, ENTHESITIS-RELATED ARTHRITIS (ERA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST.
Coverage Duration	INITIAL: HS: 12 MONTHS, ALL OTHER INDICATIONS: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	INITIAL: PSO: 1) ONE OF THE FOLLOWING: (A) AT LEAST A 3 MONTH TRIAL OF ONE ORAL IMMUNOSUPPRESSANT (CYCLOSPORINE, METHOTREXATE, TACROLIMUS) OR PUVA (PHOTOTHERAPY) FOR THE TREATMENT OF PSO, (B) CONTRAINDICATION OR INTOLERANCE TO BOTH IMMUNOSUPPRESSANT AND PUVA FOR THE TREATMENT OF PSO, OR (C) PATIENT IS SWITCHING FROM A DIFFERENT BIOLOGIC, PDE-4 INHIBITOR, OR JAK INHIBITOR FOR THE SAME INDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

PA Criteria	Criteria Details
	MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR PSO. PSA: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR PSA. AS: 1) TRIAL OF OR CONTRAINDICATION TO AN NSAID, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR AS. NR-AXSPA: 1) TRIAL OF OR CONTRAINDICATION TO AN NSAID, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR NR-AXSPA. ERA: TRIAL OF OR CONTRAINDICATION TO ONE NSAID, SULFASALAZINE, OR METHOTREXATE. HS: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR HS. RENEWAL: PSO: 1) CONTINUES TO BENEFIT FROM THE MEDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR PSO. PSA: 1) CONTINUES TO BENEFIT FROM THE MEDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR PSA. AS: 1) CONTINUES TO BENEFIT FROM THE MEDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR AS. NR-AXSPA: 1) CONTINUES TO BENEFIT FROM THE MEDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR NR-AXSPA. ERA, HS: CONTINUES TO BENEFIT FROM THE MEDICATION.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

SELEXIPAG

Products Affected

- UPTRAVI INTRAVENOUS 200 MCG, 400 MCG, 600 MCG, 800 MCG
- UPTRAVI ORAL TABLET 1,000 MCG, 1,200 MCG, 1,400 MCG, 1,600 MCG, • UPTRAVI ORAL TABLETS, DOSE PACK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	PULMONARY ARTERIAL HYPERTENSION (PAH): INITIAL: DIAGNOSIS CONFIRMED BY RIGHT HEART CATHETERIZATION WITH THE FOLLOWING PARAMETERS: 1) MEAN PULMONARY ARTERY PRESSURE (PAP) GREATER THAN 20 MMHG, 2) PULMONARY CAPILLARY WEDGE PRESSURE (PCWP) OF 15 MMHG OR LESS, AND 3) PULMONARY VASCULAR RESISTANCE (PVR) GREATER THAN 2 WOOD UNITS.
Age Restrictions	
Prescriber Restrictions	PAH: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A CARDIOLOGIST OR PULMONOLOGIST.
Coverage Duration	INITIAL/RENEWAL: 12 MONTHS
Other Criteria	PAH: INITIAL: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING AGENTS FROM DIFFERENT DRUG CLASSES: 1) FORMULARY VERSION OF AN ORAL ENDOTHELIN RECEPTOR ANTAGONIST, 2) FORMULARY VERSION OF AN ORAL PHOSPHODIESTERASE TYPE-5 INHIBITOR FOR PAH, 3) FORMULARY VERSION OF AN ORAL CGMP STIMULATOR.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

SELINEXOR

Products Affected

- XPOVIO ORAL TABLET 100 MG/WEEK (50 MG X 2), 40 MG/WEEK (10 MG X 4), 40 MG/WEEK (40 MG X 1), 40MG TWICE WEEK (40 MG X 2), 60 MG/WEEK (60 MG X 1), 60MG TWICE WEEK (120 MG/WEEK), 80 MG/WEEK (40 MG X 2), 80MG TWICE WEEK (160 MG/WEEK)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

SELPERCATINIB

Products Affected

- RETEVMO ORAL CAPSULE 40 MG, 80 MG
- RETEVMO ORAL TABLET 120 MG, 160 MG, 40 MG, 80 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

SELUMETINIB

Products Affected

- KOSELUGO ORAL CAPSULE 10 MG, 25 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

SILDENAFIL TABLET

Products Affected

- *sildenafil (pulm.hypertension) oral tablet*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	PULMONARY ARTERIAL HYPERTENSION (PAH): INITIAL: AGES 18 YEARS OR OLDER: DIAGNOSIS CONFIRMED BY RIGHT HEART CATHETERIZATION WITH THE FOLLOWING PARAMETERS: 1) MEAN PULMONARY ARTERY PRESSURE (PAP) GREATER THAN 20 MMHG, 2) PULMONARY CAPILLARY WEDGE PRESSURE (PCWP) OF 15 MMHG OR LESS, AND 3) PULMONARY VASCULAR RESISTANCE (PVR) GREATER THAN 2 WOOD UNITS. AGES 1 TO 17 YEARS: DIAGNOSIS CONFIRMED BY RIGHT HEART CATHETERIZATION WITH THE FOLLOWING PARAMETERS: 1) MEAN PAP GREATER THAN 20 MMHG, 2) PCWP OF 15 MMHG OR LESS, AND 3) PVR OF 3 WOOD UNITS OR GREATER.
Age Restrictions	
Prescriber Restrictions	PAH: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A CARDIOLOGIST OR PULMONOLOGIST.
Coverage Duration	INITIAL/RENEWAL: 12 MONTHS.
Other Criteria	PAH: INITIAL/RENEWAL: 1) NOT CONCURRENTLY OR INTERMITTENTLY TAKING ORAL ERECTILE DYSFUNCTION AGENTS (E.G. CIALIS, VIAGRA) OR ANY ORGANIC NITRATES IN ANY FORM AND 2) NO CONCURRENT USE WITH GUANYLATE CYCLASE STIMULATORS.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

SIPONIMOD

Products Affected

- MAYZENT ORAL TABLET 0.25 MG, 1 MG, 2 MG
- MAYZENT STARTER(FOR 1MG MAINT)
- MAYZENT STARTER(FOR 2MG MAINT)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

SIROLIMUS PROTEIN-BOUND

Products Affected

- FYARRO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

SODIUM OXYBATE-XYREM

Products Affected

- *sodium oxybate*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	INITIAL: CATAPLEXY IN NARCOLEPSY, EXCESSIVE DAYTIME SLEEPINESS (EDS) IN NARCOLEPSY: PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST, PSYCHIATRIST, OR SPECIALIST IN SLEEP MEDICINE
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS
Other Criteria	INITIAL: EDS IN NARCOLEPSY: 1) NO CONCURRENT USE WITH A SEDATIVE HYPNOTIC AGENT, 2) AGES 18 YEARS OR OLDER: TRIAL, FAILURE OF, OR CONTRAINDICATION TO A FORMULARY VERSION OF MODAFINIL, ARMODAFINIL, OR SUNOSI AND ONE GENERIC STIMULANT INDICATED FOR EDS IN NARCOLEPSY, AND 3) AGES 7 TO 17 YEARS: TRIAL, FAILURE OF, OR CONTRAINDICATION TO ONE GENERIC STIMULANT INDICATED FOR EDS IN NARCOLEPSY. CATAPLEXY IN NARCOLEPSY: NO CONCURRENT USE WITH A SEDATIVE HYPNOTIC AGENT. RENEWAL: CATAPLEXY IN NARCOLEPSY, EDS IN NARCOLEPSY: 1) SUSTAINED IMPROVEMENT OF SYMPTOMS COMPARED TO BASELINE, AND 2) NO CONCURRENT USE WITH A SEDATIVE HYPNOTIC AGENT.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

SOFOSBUVIR/VELPATASVIR

Products Affected

- EPCLUSA ORAL PELLETS IN PACKET 150-37.5 MG, 200-50 MG
- EPCLUSA ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	HCV RNA LEVEL WITHIN PAST 6 MONTHS.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE.
Other Criteria	1) CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE, 2) NOT CONCURRENTLY TAKING ANY OF THE FOLLOWING MEDICATIONS: AMIODARONE, CARBAMAZEPINE, PHENYTOIN, PHENOBARBITAL, OXCARBAZEPINE, RIFAMPIN, RIFABUTIN, RIFAPENTINE, HIV REGIMEN THAT CONTAINS EFAVIRENZ, ROSUVASTATIN AT DOSES ABOVE 10MG, TIPRANA VIR/RITONAVIR, TOPOTECAN, SOVALDI (AS A SINGLE AGENT), HARVONI, ZEPATIER, MAVYRET, OR VOSEVI, AND 3) PATIENTS WITH DECOMPENSATED CIRRHOSIS REQUIRE CONCURRENT RIBAVIRIN UNLESS RIBAVIRIN INELIGIBLE.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

SOFOSBUVIR/VELPATASVIR/VOXILAPREVIR

Products Affected

- VOSEVI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	HCV RNA LEVEL WITHIN PAST 6 MONTHS
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE.
Other Criteria	1) CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE, 2) NOT CONCURRENTLY TAKING ANY OF THE FOLLOWING MEDICATIONS: AMIODARONE, CARBAMAZEPINE, PHENYTOIN, PHENOBARBITAL, OXCARBAZEPINE, RIFAMPIN, RIFABUTIN, RIFAPENTINE, CYCLOSPORINE, PITAVASTATIN, PRAVASTATIN (DOSES ABOVE 40MG), ROSUVASTATIN, METHOTREXATE, MITOXANTRONE, IMATINIB, IRINOTECAN, LAPATINIB, SULFASALAZINE, TOPOTECAN, OR HIV REGIMEN THAT CONTAINS EFAVIRENZ, ATAZANAVIR, LOPINAVIR, TIPRANAVIR/RITONAVIR, SOVALDI (AS A SINGLE AGENT), EPCLUSA, HARVONI, ZEPATIER, OR MAVYRET, AND 3) DOES NOT HAVE MODERATE OR SEVERE HEPATIC IMPAIRMENT (CHILD-PUGH B OR C).
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

SOMATROPIN - NORDITROPIN

Products Affected

- NORDITROPIN FLEXPRO

PA Criteria	Criteria Details
Exclusion Criteria	INITIAL/RENEWAL: ATHLETIC ENHANCEMENT, ANTI-AGING PURPOSES.
Required Medical Information	INITIAL: PEDIATRIC GROWTH HORMONE DEFICIENCY (GHD), IDIOPATHIC SHORT STATURE (ISS), SMALL FOR GESTATIONAL AGE (SGA), TURNER SYNDROME (TS), NOONAN SYNDROME: HEIGHT AT LEAST 2 STANDARD DEVIATIONS BELOW THE MEAN HEIGHT FOR CHILDREN OF THE SAME AGE AND GENDER. PRADER WILLI SYNDROME (PWS): CONFIRMED GENETIC DIAGNOSIS.
Age Restrictions	
Prescriber Restrictions	INITIAL/RENEWAL: ALL INDICATIONS: PRESCRIBED BY OR IN CONSULTATION WITH AN ENDOCRINOLOGIST.
Coverage Duration	INITIAL/RENEWAL: 12 MONTHS.
Other Criteria	INITIAL: ADULT GHD: GHD ALONE OR ASSOCIATED WITH MULTIPLE HORMONE DEFICIENCIES (HYPOPHYSECTOMY), AS A RESULT OF PITUITARY DISEASE, HYPOTHALAMIC DISEASE, SURGERY, RADIATION THERAPY, OR TRAUMA, OR FOR CONTINUATION OF THERAPY FROM CHILDHOOD ONSET GHD. PEDIATRIC GHD, ISS, SGA, TS, NOONAN SYNDROME: OPEN EPIPHYSES AS CONFIRMED BY RADIOGRAPH OF THE WRIST AND HAND. RENEWAL: PEDIATRIC GHD: 1) IMPROVEMENT WHILE ON THERAPY (I.E., INCREASED HEIGHT OR INCREASED GROWTH VELOCITY), AND 2) OPEN EPIPHYSES AS CONFIRMED BY RADIOGRAPH OF THE WRIST AND HAND OR HAS NOT COMPLETED PREPUBERTAL GROWTH. ISS, SGA, TS, NOONAN SYNDROME: 1) IMPROVEMENT WHILE ON THERAPY (I.E., INCREASED HEIGHT OR INCREASED GROWTH VELOCITY), AND 2) OPEN EPIPHYSES AS CONFIRMED BY RADIOGRAPH OF THE WRIST AND HAND. PWS: IMPROVEMENT IN BODY COMPOSITION.

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

SOMATROPIN - SEROSTIM

Products Affected

- SEROSTIM SUBCUTANEOUS RECON
SOLN 4 MG, 5 MG, 6 MG

PA Criteria	Criteria Details
Exclusion Criteria	INITIAL/RENEWAL: ATHLETIC ENHANCEMENT, ANTI-AGING PURPOSES
Required Medical Information	INITIAL: HIV/WASTING: ONE OF THE FOLLOWING FOR WEIGHT LOSS: 1) 10% UNINTENTIONAL WEIGHT LOSS OVER 12 MONTHS, 2) 7.5% UNINTENTIONAL WEIGHT LOSS OVER 6 MONTHS, 3) 5% BODY CELL MASS (BCM) LOSS WITHIN 6 MONTHS, 4) BCM LESS THAN 35% (MEN) OF TOTAL BODY WEIGHT AND BODY MASS INDEX (BMI) LESS THAN 27 KG PER METER SQUARED, 5) BCM LESS THAN 23% (WOMEN) OF TOTAL BODY WEIGHT AND BMI LESS THAN 27 KG PER METER SQUARED, OR 6) BMI LESS THAN 18.5 KG PER METER SQUARED.
Age Restrictions	
Prescriber Restrictions	HIV/WASTING: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A GASTROENTEROLOGIST, NUTRITIONAL SUPPORT SPECIALIST, OR INFECTIOUS DISEASE SPECIALIST.
Coverage Duration	INITIAL/RENEWAL: 3 MONTHS.
Other Criteria	HIV/WASTING: INITIAL: 1) INADEQUATE RESPONSE TO ONE PREVIOUS THERAPY (E.G., MEGACE, APPETITE STIMULANTS, ANABOLIC STEROIDS). RENEWAL: 1) CLINICAL BENEFIT IN MUSCLE MASS AND WEIGHT.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

SONIDEGIB

Products Affected

- ODOMZO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	LOCALLY ADVANCED BASAL CELL CARCINOMA (BCC): BASELINE SERUM CREATINE KINASE (CK) AND SERUM CREATININE LEVELS
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

SORAFENIB

Products Affected

- *sorafenib*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

SOTATERCEPT-CSRK

Products Affected

- WINREVAIR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	PULMONARY ARTERIAL HYPERTENSION (PAH): INITIAL: DIAGNOSIS CONFIRMED BY RIGHT HEART CATHETERIZATION WITH THE FOLLOWING PARAMETERS: 1) MEAN PULMONARY ARTERY PRESSURE (PAP) GREATER THAN 20 MMHG, 2) PULMONARY CAPILLARY WEDGE PRESSURE (PCWP) OF 15 MMHG OR LESS, AND 3) PULMONARY VASCULAR RESISTANCE (PVR) GREATER THAN 2 WOOD UNITS.
Age Restrictions	
Prescriber Restrictions	PAH: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A CARDIOLOGIST OR PULMONOLOGIST.
Coverage Duration	INITIAL/RENEWAL: 12 MONTHS.
Other Criteria	PAH: INITIAL: 1) ON BACKGROUND PAH THERAPY (FOR AT LEAST 3 MONTHS) WITH AT LEAST TWO OF THE FOLLOWING AGENTS FROM DIFFERENT DRUG CLASSES: A) ORAL ENDOTHELIN RECEPTOR ANTAGONIST, B) ORAL PHOSPHODIESTERASE TYPE-5 INHIBITOR FOR PAH, C) ORAL CGMP STIMULATOR, D) IV/SQ PROSTACYCLIN, OR 2) ON ONE AGENT FROM ONE OF THE ABOVE DRUG CLASSES, AND HAS A CONTRAINDICATION OR INTOLERANCE TO ALL OF THE OTHER DRUG CLASSES.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

SOTORASIB

Products Affected

- LUMAKRAS ORAL TABLET 120 MG, 240 MG, 320 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

STIRIPENTOL

Products Affected

- DIACOMIT ORAL CAPSULE 250 MG, 500 MG
- DIACOMIT ORAL POWDER IN PACKET 250 MG, 500 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	DRAVET SYNDROME: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST.
Coverage Duration	INITIAL/RENEWAL: 12 MONTHS.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

SUNITINIB

Products Affected

- *sunitinib malate*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	GASTROINTESTINAL STROMAL TUMORS (GIST): TRIAL OF OR CONTRAINDICATION TO IMATINIB (GLEEVEC).
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

TADALAFIL - ADCIRCA, ALYQ

Products Affected

- *alyq*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	PULMONARY ARTERIAL HYPERTENSION (PAH): INITIAL: DIAGNOSIS CONFIRMED BY RIGHT HEART CATHETERIZATION WITH THE FOLLOWING PARAMETERS: 1) MEAN PULMONARY ARTERY PRESSURE (PAP) GREATER THAN 20 MMHG, 2) PULMONARY CAPILLARY WEDGE PRESSURE (PCWP) OF 15 MMHG OR LESS, AND 3) PULMONARY VASCULAR RESISTANCE (PVR) GREATER THAN 2 WOOD UNITS.
Age Restrictions	
Prescriber Restrictions	PAH: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A CARDIOLOGIST OR PULMONOLOGIST.
Coverage Duration	INITIAL/RENEWAL: 12 MONTHS.
Other Criteria	PAH: INITIAL/RENEWAL: 1) NOT CONCURRENTLY OR INTERMITTENTLY TAKING ORAL ERECTILE DYSFUNCTION AGENTS (E.G. CIALIS, VIAGRA) OR ANY ORGANIC NITRATES IN ANY FORM, AND 2) NO CONCURRENT USE WITH GUANYLATE CYCLASE STIMULATORS.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

TADALAFIL-CIALIS

Products Affected

- *tadalafil oral tablet 2.5 mg, 5 mg*

PA Criteria	Criteria Details
Exclusion Criteria	ERECTILE DYSFUNCTION WITHOUT DIAGNOSIS OF BENIGN PROSTATIC HYPERPLASIA (BPH).
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	BPH: 1) TRIAL OF ONE ALPHA BLOCKER (E.G., DOXAZOSIN, TERAZOSIN, TAMSULOSIN, ALFUZOSIN), AND 2) TRIAL OF ONE 5-ALPHA-REDUCTASE INHIBITOR (E.G., FINASTERIDE, DUTASTERIDE). APPLIES TO 2.5MG AND 5MG STRENGTHS ONLY
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

TALAZOPARIB

Products Affected

- TALZENNA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	ADVANCED OR METASTATIC BREAST CANCER: 1) HAS BEEN TREATED WITH CHEMOTHERAPY IN THE NEOADJUVANT, ADJUVANT, OR METASTATIC SETTING, AND 2) IF HORMONE RECEPTOR (HR)-POSITIVE BREAST CANCER, RECEIVED PRIOR TREATMENT WITH ENDOCRINE THERAPY OR IS CONSIDERED INAPPROPRIATE FOR ENDOCRINE THERAPY. METASTATIC CASTRATION-RESISTANT PROSTATE CANCER: 1) RECEIVED A BILATERAL ORCHIECTOMY, 2) CASTRATE LEVEL OF TESTOSTERONE (I.E., LESS THAN 50 NG/DL), OR 3) CONCURRENT USE WITH A GONADOTROPIN RELEASING HORMONE (GNRH) ANALOG.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

TALETRECTINIB

Products Affected

- IBTROZI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

TALQUETAMAB-TGVS

Products Affected

- TALVEY

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

TARLATAMAB-DLLE

Products Affected

- IMDELLTRA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

TAZEMETOSTAT

Products Affected

- TAZVERIK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

TEBENTAFUSP-TEBN

Products Affected

- KIMMTRAK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

TECLISTAMAB-CQYV

Products Affected

- TECVAYLI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

TELISOTUZUMAB VEDOTIN-TLLV

Products Affected

- EMRELIS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

TELOTRISTAT

Products Affected

- XERMELO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	CARCINOID SYNDROME DIARRHEA: PRESCRIBED BY OR IN CONSULTATION WITH AN ONCOLOGIST OR GASTROENTEROLOGIST
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

TEPOTINIB

Products Affected

- TEPMETKO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

TERIPARATIDE

Products Affected

- *teriparatide subcutaneous pen injector 20 mcg/dose (560mcg/2.24ml)*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	24 MONTHS
Other Criteria	OSTEOPOROSIS: HAS NOT RECEIVED A TOTAL OF 24 MONTHS CUMULATIVE TREATMENT WITH ANY PARATHYROID HORMONE THERAPY, UNLESS REMAINS AT OR HAS RETURNED TO HAVING A HIGH RISK FOR FRACTURE.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

TESTOSTERONE

Products Affected

- testosterone transdermal gel in metered-dose pump 12.5 mg/ 1.25 gram (1 %), 20.25 mg/1.25 gram (1.62 %)
- testosterone transdermal gel in packet 1 % (25 mg/2.5gram), 1 % (50 mg/5 gram)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	MALE HYPOGONADISM: INITIAL: CONFIRMED BY: 1) AT LEAST TWO TOTAL SERUM TESTOSTERONE LEVELS OF LESS THAN 300 NG/DL TAKEN ON SEPARATE OCCASIONS, OR 2) FREE SERUM TESTOSTERONE LEVEL OF LESS THAN 5 NG/DL.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL/RENEWAL: 12 MONTHS
Other Criteria	MALE HYPOGONADISM: INITIAL: 1) 40 YEARS OR OLDER: PROSTATE SPECIFIC ANTIGEN (PSA) HAS BEEN EVALUATED FOR PROSTATE CANCER SCREENING. RENEWAL: 1) 40 YEARS OR OLDER: PSA HAS BEEN EVALUATED FOR PROSTATE CANCER SCREENING, AND 2) IMPROVED SYMPTOMS COMPARED TO BASELINE AND TOLERANCE TO TREATMENT.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

TESTOSTERONE CYPIONATE

Products Affected

- *testosterone cypionate*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	MALE HYPOGONADISM: INITIAL: CONFIRMED BY: 1) AT LEAST TWO TOTAL SERUM TESTOSTERONE LEVELS OF LESS THAN 300 NG/DL TAKEN ON SEPARATE OCCASIONS, OR 2) FREE SERUM TESTOSTERONE LEVEL OF LESS THAN 5 NG/DL.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL/RENEWAL: 12 MONTHS
Other Criteria	MALE HYPOGONADISM: INITIAL: 1) 40 YEARS OR OLDER: PROSTATE SPECIFIC ANTIGEN (PSA) HAS BEEN EVALUATED FOR PROSTATE CANCER SCREENING. RENEWAL: 1) 40 YEARS OR OLDER: PSA HAS BEEN EVALUATED FOR PROSTATE CANCER SCREENING, AND 2) IMPROVED SYMPTOMS COMPARED TO BASELINE AND TOLERANCE TO TREATMENT.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

TESTOSTERONE ENANTHATE

Products Affected

- *testosterone enanthate*
- XYOSTED

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	MALE HYPOGONADISM: INITIAL: CONFIRMED BY: 1) AT LEAST TWO TOTAL SERUM TESTOSTERONE LEVELS OF LESS THAN 300 NG/DL TAKEN ON SEPARATE OCCASIONS, OR 2) FREE SERUM TESTOSTERONE LEVEL OF LESS THAN 5 NG/DL.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL/RENEWAL: MALE DELAYED PUBERTY: 6MO, MALE HYPOGONADISM: 12 MO. OTHER INDICATIONS: 12 MO.
Other Criteria	INITIAL: MALE HYPOGONADISM: 1) 40 YEARS OR OLDER: PROSTATE SPECIFIC ANTIGEN (PSA) HAS BEEN EVALUATED FOR PROSTATE CANCER SCREENING. RENEWAL: MALE HYPOGONADISM: 1) 40 YEARS OR OLDER: PSA HAS BEEN EVALUATED FOR PROSTATE CANCER SCREENING, AND 2) IMPROVED SYMPTOMS COMPARED TO BASELINE AND TOLERANCE TO TREATMENT. MALE DELAYED PUBERTY: HAS NOT RECEIVED MORE THAN TWO 6-MONTH COURSES OF TESTOSTERONE REPLACEMENT THERAPY
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

TETRABENAZINE

Products Affected

- *tetrabenazine*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	HUNTINGTONS DISEASE: PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST OR MOVEMENT DISORDER SPECIALIST
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

THALIDOMIDE

Products Affected

- THALOMID

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

TISLELIZUMAB-JSGR

Products Affected

- TEVIMBRA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

TISOTUMAB VEDOTIN-TFTV

Products Affected

- TIVDAK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

TIVOZANIB

Products Affected

- FOTIVDA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

TOCILIZUMAB IV

Products Affected

- ACTEMRA

PA Criteria	Criteria Details
Exclusion Criteria	CORONAVIRUS DISEASE 2019 (COVID-19) IN HOSPITALIZED ADULTS
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	INITIAL: RHEUMATOID ARTHRITIS (RA), POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS (PJIA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST. SYSTEMIC JUVENILE IDIOPATHIC ARTHRITIS (SJIA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST, DERMATOLOGIST, OR IMMUNOLOGIST.
Coverage Duration	INITIAL: RA, PJIA, SJIA, GCA: 6 MONTHS. CRS: 1 MONTH. RENEWAL: RA, PJIA, SJIA, GCA: 12 MONTHS.
Other Criteria	INITIAL: RA: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: ENBREL, HUMIRA/CYLTEZO/YUFLYMA, XELJANZ, RINVOQ, ORENCIA. PJIA: 1) TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: ENBREL, HUMIRA/CYLTEZO/YUFLYMA, XELJANZ IR, RINVOQ, ORENCIA, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR PJIA. SJIA: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR SJIA. RENEWAL: RA: CONTINUES TO BENEFIT FROM THE MEDICATION. PJIA: 1) CONTINUES TO BENEFIT FROM THE MEDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR PJIA. SJIA: 1) CONTINUES TO BENEFIT FROM THE MEDICATION, AND 2) NO

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

PA Criteria	Criteria Details
	CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR SJIA.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

TOCILIZUMAB SQ

Products Affected

- ACTEMRA
- ACTEMRA ACTPEN

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	INITIAL: RHEUMATOID ARTHRITIS (RA), POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS (PJIA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST. SYSTEMIC JUVENILE IDIOPATHIC ARTHRITIS (SJIA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST, DERMATOLOGIST, OR IMMUNOLOGIST. SYSTEMIC SCLEROSIS-ASSOCIATED INTERSTITIAL LUNG DISEASE (SSC-ILD): PRESCRIBED BY OR IN CONSULTATION WITH A PULMONOLOGIST OR RHEUMATOLOGIST.
Coverage Duration	INITIAL: 6 MONTHS, RENEWAL: 12 MONTHS.
Other Criteria	INITIAL: RA: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: ENBREL, HUMIRA/CYLTEZO/YUFLYMA, XELJANZ, RINVOQ, ORENCIA. PJIA: 1) TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: ENBREL, HUMIRA/CYLTEZO/YUFLYMA, XELJANZ IR, RINVOQ, ORENCIA, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR PJIA. SJIA: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR SJIA. SSC-ILD: DOES NOT HAVE OTHER KNOWN CAUSES OF INTERSTITIAL LUNG DISEASE (E.G., CONNECTIVE TISSUE DISEASE, DRUG TOXICITY, ASBESTOS OR BERYLLIUM EXPOSURE,

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

PA Criteria	Criteria Details
	HYPERSENSITIVITY PNEUMONITIS). RENEWAL: RA: CONTINUES TO BENEFIT FROM THE MEDICATION. PJIA: 1) CONTINUES TO BENEFIT FROM THE MEDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR PJIA. SJIA: 1) CONTINUES TO BENEFIT FROM THE MEDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR SJIA. SSC-ILD: CLINICAL MEANINGFUL IMPROVEMENT OR MAINTENANCE IN ANNUAL RATE OF DECLINE.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

TOCILIZUMAB-AAZG

Products Affected

- TYENNE
- TYENNE AUTOINJECTOR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	INITIAL: RHEUMATOID ARTHRITIS (RA), POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS (PJIA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST. SYSTEMIC JUVENILE IDIOPATHIC ARTHRITIS (SJIA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST, DERMATOLOGIST, OR IMMUNOLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	INITIAL: RA: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: ENBREL, HUMIRA/CYLTEZO/YUFLYMA, XELJANZ, RINVOQ, ORENCIA. PJIA: 1) TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: ENBREL, HUMIRA/CYLTEZO/YUFLYMA, XELJANZ IR, ORENCIA, RINVOQ, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR PJIA. SJIA: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR SJIA. RENEWAL: RA: CONTINUES TO BENEFIT FROM THE MEDICATION. PJIA: 1) CONTINUES TO BENEFIT FROM THE MEDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR PJIA. SJIA: 1) CONTINUES TO BENEFIT FROM THE MEDICATION, AND 2) NO

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

PA Criteria	Criteria Details
	CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR SJIA.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

TOCILIZUMAB-AAZG IV

Products Affected

- TYENNE

PA Criteria	Criteria Details
Exclusion Criteria	CORONAVIRUS DISEASE 2019 (COVID-19) IN HOSPITALIZED ADULTS
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	INITIAL: RHEUMATOID ARTHRITIS (RA), POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS (PJIA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST. SYSTEMIC JUVENILE IDIOPATHIC ARTHRITIS (SJIA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST, DERMATOLOGIST, OR IMMUNOLOGIST.
Coverage Duration	INITIAL: RA, PJIA, SJIA, GCA: 6 MOS. CRS: 1 MO. RENEWAL: RA, PJIA, SJIA, GCA: 12 MOS.
Other Criteria	INITIAL: RA: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: ENBREL, HUMIRA/CYLTEZO/YUFLYMA, XELJANZ, RINVOQ, ORENCIA. PJIA: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: ENBREL, HUMIRA/CYLTEZO/YUFLYMA, XELJANZ IR, ORENCIA, RINVOQ. CYTOKINE RELEASE SYNDROME (CRS): NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR CRS. INITIAL/RENEWAL FOR PJIA, SJIA: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR SAME INDICATION. RENEWAL FOR RA, PJIA, SJIA: CONTINUES TO BENEFIT FROM MEDICATION.
Indications	All FDA-approved Indications.
Off Label Uses	

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

PA Criteria	Criteria Details
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

TOFACITINIB

Products Affected

- XELJANZ
- XELJANZ XR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	INITIAL: RHEUMATOID ARTHRITIS (RA), ANKYLOSING SPONDYLITIS (AS), POLYARTICULAR COURSE JUVENILE IDIOPATHIC ARTHRITIS (PCJIA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST. PSORIATIC ARTHRITIS (PSA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST OR DERMATOLOGIST. ULCERATIVE COLITIS (UC): PRESCRIBED BY OR IN CONSULTATION WITH A GASTROENTEROLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	INITIAL: RA: TRIAL OF OR CONTRAINDICATION TO 3 MONTHS OF TREATMENT WITH ONE DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG) - IF A PATIENT TRIED METHOTREXATE, THEN TRIAL AT A DOSE GREATER THAN OR EQUAL TO 20 MG PER WEEK OR MAXIMALLY TOLERATED DOSE IS REQUIRED. PSA: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR PSA. PCJIA: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR PCJIA. AS: 1) TRIAL OF OR CONTRAINDICATION TO AN NSAID, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR AS. UC: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR UC. RENEWAL: RA: CONTINUES TO

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

PA Criteria	Criteria Details
	BENEFIT FROM THE MEDICATION. PSA: 1) CONTINUES TO BENEFIT FROM THE MEDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR PSA. AS: 1) CONTINUES TO BENEFIT FROM THE MEDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR AS. PCJIA: 1) CONTINUES TO BENEFIT FROM THE MEDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR PCJIA. UC: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR UC.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

TOLVAPTAN

Products Affected

- *tolvaptan (polycys kidney dis) oral tablet*
- *tolvaptan (polycys kidney dis) oral tablets, sequential*

PA Criteria	Criteria Details
Exclusion Criteria	PA Criteria: Pending CMS Approval
Required Medical Information	PA Criteria: Pending CMS Approval
Age Restrictions	PA Criteria: Pending CMS Approval
Prescriber Restrictions	PA Criteria: Pending CMS Approval
Coverage Duration	PA Criteria: Pending CMS Approval
Other Criteria	PA Criteria: Pending CMS Approval
Indications	PA Criteria: Pending CMS Approval
Off Label Uses	PA Criteria: Pending CMS Approval
Part B Prerequisite	No

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

TOPICAL TRETINOIN

Products Affected

- ALTRENO
- *tretinoin topical cream*

PA Criteria	Criteria Details
Exclusion Criteria	COSMETIC INDICATIONS SUCH AS WRINKLES, PHOTOAGING, MELASMA.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	ACNE VULGARIS: BRAND TOPICAL TRETINOIN REQUIRES TRIAL OF OR CONTRAINDICATION TO A GENERIC TOPICAL TRETINOIN PRODUCT.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

TORIPALIMAB-TPZI

Products Affected

- LOQTORZI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	NASOPHARYNGEAL CARCINOMA (NPC): FIRST LINE TREATMENT: 24 MOS, PREVIOUSLY TREATED: LIFETIME.
Other Criteria	THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

TOVORAFENIB

Products Affected

- OJEMDA ORAL SUSPENSION FOR RECONSTITUTION
- OJEMDA ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

TRAMETINIB SOLUTION

Products Affected

- MEKINIST ORAL RECON SOLN

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	UNRESECTABLE OR METASTATIC MELANOMA, MELANOMA, METASTATIC NON-SMALL CELL LUNG CANCER (NSCLC), LOCALLY ADVANCED OR METASTATIC ANAPLASTIC THYROID CANCER (ATC), UNRESECTABLE OR METASTATIC SOLID TUMOR, LOW-GRADE GLIOMA (LGG): UNABLE TO SWALLOW MEKINIST TABLETS.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

TRAMETINIB TABLET

Products Affected

- MEKINIST ORAL TABLET 0.5 MG, 2 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

TRASTUZUMAB-DKST

Products Affected

- OGIVRI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

TRASTUZUMAB-DTTB

Products Affected

- ONTRUZANT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

TRASTUZUMAB-HYALURONIDASE-OYSK

Products Affected

- HERCEPTIN HYLECTA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	ADJUVANT BREAST CANCER, METASTATIC BREAST CANCER: TRIAL OF OR CONTRAINDICATION TO ONE OF THE FOLLOWING PREFERRED AGENTS: HERZUMA, OGIVRI, ONTRUZANT, TRAZIMERA.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

TRASTUZUMAB-PKRB

Products Affected

- HERZUMA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

TRASTUZUMAB-QYYP

Products Affected

- TRAZIMERA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

TRAZODONE

Products Affected

- RALDESY

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	MAJOR DEPRESSIVE DISORDER (MDD): CONTRAINDICATION TO OR UNABLE TO SWALLOW TRAZODONE TABLETS.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

TREMELIMUMAB-ACTL

Products Affected

- IMJUDO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	UHCC: 30 DAYS. METASTATIC NON-SMALL CELL LUNG CANCER (NSCLC): 5 MONTHS.
Other Criteria	UNRESECTABLE HEPATOCELLULAR CARCINOMA (UHCC): HAS NOT RECEIVED PRIOR TREATMENT WITH IMJUDO. NSCLC: HAS NOT RECEIVED A TOTAL OF 5 DOSES OF IMJUDO.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

TRIENTINE CAPSULE

Products Affected

- *trientine oral capsule 250 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	WILSONS DISEASE: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A HEPATOLOGIST OR GASTROENTEROLOGIST.
Coverage Duration	INITIAL: 12 MONTHS, RENEWAL: LIFETIME.
Other Criteria	WILSONS DISEASE: INITIAL: 1) LEIPZIG SCORE OF 4 OR GREATER, AND 2) TRIAL OF OR CONTRAINDICATION TO FORMULARY VERSION OF PENICILLAMINE TABLET. RENEWAL: CONTINUES TO BENEFIT FROM THE MEDICATION.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

TRIFLURIDINE/TIPIRACIL

Products Affected

- LONSURF ORAL TABLET 15-6.14 MG,
20-8.19 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

TRIPTORELIN-TRELSTAR

Products Affected

- TRELSTAR INTRAMUSCULAR
SUSPENSION FOR RECONSTITUTION

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS.
Other Criteria	THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

TUCATINIB

Products Affected

- TUKYSA ORAL TABLET 150 MG, 50 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

UBROGEPANT

Products Affected

- UBRELVY

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	ACUTE MIGRAINE TREATMENT: INITIAL: 1) TRIAL OF OR CONTRAINDICATION TO ONE TRIPTAN (E.G., SUMATRIPTAN, RIZATRIPTAN), AND 2) NO CONCURRENT USE WITH OTHER CGRP INHIBITORS FOR ACUTE MIGRAINE TREATMENT. RENEWAL: 1) NO CONCURRENT USE WITH OTHER CGRP INHIBITORS FOR ACUTE MIGRAINE TREATMENT, AND 2) ONE OF THE FOLLOWING: (A) IMPROVEMENT FROM BASELINE IN A VALIDATED ACUTE TREATMENT PATIENT-REPORTED OUTCOME QUESTIONNAIRE, OR (B) THERAPY WORKS CONSISTENTLY IN MAJORITY OF MIGRAINE ATTACKS.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

UPADACITINIB

Products Affected

- RINVOQ
- RINVOQ LQ

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: NON-RADIOGRAPHIC AXIAL SPONDYLOARTHRITIS (NR-AXSPA): 1) C-REACTIVE PROTEIN LEVELS ABOVE THE UPPER LIMIT OF NORMAL, OR 2) SACROILIITIS ON MAGNETIC RESONANCE IMAGING (MRI). ATOPIC DERMATITIS (AD): ATOPIC DERMATITIS COVERING AT LEAST 10 PERCENT OF BODY SURFACE AREA OR ATOPIC DERMATITIS AFFECTING THE FACE, HEAD, NECK, HANDS, FEET, GROIN, OR INTERTRIGINOUS AREAS
Age Restrictions	
Prescriber Restrictions	INITIAL: RHEUMATOID ARTHRITIS (RA), ANKYLOSING SPONDYLITIS (AS), NR-AXSPA, POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS (PJIA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST. PSORIATIC ARTHRITIS: PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST OR DERMATOLOGIST. AD: PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST, ALLERGIST, OR IMMUNOLOGIST. ULCERATIVE COLITIS (UC), CROHNS DISEASE (CD): PRESCRIBED BY OR IN CONSULTATION WITH A GASTROENTEROLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	INITIAL: RA: TRIAL OF OR CONTRAINDICATION TO 3 MONTHS OF TREATMENT WITH ONE DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG) - IF A PATIENT TRIED METHOTREXATE, THEN TRIAL AT A DOSE GREATER THAN OR EQUAL TO 20 MG PER WEEK OR MAXIMALLY TOLERATED DOSE IS REQUIRED. PSA: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR PSA.

Updated: 11.01.2025
Y0150_PBM200_C (v2)

PA Criteria	Criteria Details
	PJIA: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR PJIA. AD: 1) INTRACTABLE PRURITUS OR CRACKING/OOZING/BLEEDING OF AFFECTED SKIN, 2) TRIAL OF OR CONTRAINDICATION TO A TOPICAL CORTICOSTEROID, TOPICAL CALCINEURIN INHIBITOR, TOPICAL PDE4 INHIBITOR, OR TOPICAL JAK INHIBITOR, AND 3) NO CONCURRENT USE WITH OTHER SYSTEMIC BIOLOGICS FOR ATOPIC DERMATITIS OR OTHER JAK INHIBITORS FOR ANY INDICATION. UC: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR UC. CD: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR CD. AS: 1) TRIAL OF OR CONTRAINDICATION TO AN NSAID (NON-STEROIDAL ANTI-INFLAMMATORY DRUG), AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR AS. NR-AXSPA: 1) TRIAL OF OR CONTRAINDICATION TO AN NSAID, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR NR-AXSPA. GIANT CELL ARTERITIS (GCA): HAS COMPLETED, STARTED, OR WILL SOON START A TAPERING COURSE OF GLUCOCORTICOID. RENEWAL: RA: CONTINUES TO BENEFIT FROM THE MEDICATION. AD: 1) IMPROVEMENT WHILE ON THERAPY, AND 2) NO CONCURRENT USE WITH OTHER SYSTEMIC BIOLOGICS FOR ATOPIC DERMATITIS OR OTHER JAK INHIBITOR FOR ANY INDICATION. PSA: 1) CONTINUES TO BENEFIT FROM MEDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR PSA. AS: 1) CONTINUES TO BENEFIT MEDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR AS. NR-AXSPA: 1) CONTINUES TO BENEFIT FROM MEDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR NR-AXSPA. PJIA: 1) CONTINUES TO BENEFIT FROM MEDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR PJIA. UC: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR UC. CD: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR CD.



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

USTEKINUMAB

Products Affected

- STELARA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: PLAQUE PSORIASIS (PSO): PSORIASIS COVERING 3 PERCENT OR MORE OF BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, GENITAL AREA, SCALP OR FACE.
Age Restrictions	
Prescriber Restrictions	INITIAL: PSORIATIC ARTHRITIS (PSA): PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST OR RHEUMATOLOGIST. PSO: PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST. CROHNS DISEASE (CD), ULCERATIVE COLITIS (UC): PRESCRIBED BY OR IN CONSULTATION WITH A GASTROENTEROLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	INITIAL: PSA: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR PSA. PSO: 1) ONE OF THE FOLLOWING: (A) AT LEAST A 3 MONTH TRIAL OF ONE ORAL IMMUNOSUPPRESSANT (CYCLOSPORINE, METHOTREXATE, TACROLIMUS) OR PUVA (PHOTOTHERAPY) FOR THE TREATMENT OF PSO, (B) CONTRAINDICATION OR INTOLERANCE TO BOTH IMMUNOSUPPRESSANT AND PUVA FOR THE TREATMENT OF PSO, OR (C) PATIENT IS SWITCHING FROM A DIFFERENT BIOLOGIC, PDE-4 INHIBITOR, OR JAK INHIBITOR FOR THE SAME INDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR PSO. CD: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR CD. UC: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR UC. RENEWAL: PSA: 1) CONTINUES

Updated: 11.01.2025

Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

PA Criteria	Criteria Details
	TO BENEFIT FROM THE MEDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR PSA. PSO: 1) CONTINUES TO BENEFIT FROM THE MEDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR PSO. CD: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR CD. UC: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR UC.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

USTEKINUMAB IV

Products Affected

- STELARA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	CROHNS DISEASE (CD), ULCERATIVE COLITIS (UC): PRESCRIBED BY OR IN CONSULTATION WITH A GASTROENTEROLOGIST.
Coverage Duration	2 MONTHS
Other Criteria	CD: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR CD. UC: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR UC. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

USTEKINUMAB-AEKN IV

Products Affected

- SELARSDI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: PLAQUE PSORIASIS (PSO): PSORIASIS COVERING 3 PERCENT OR MORE OF BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, GENITAL AREA, SCALP OR FACE.
Age Restrictions	
Prescriber Restrictions	INITIAL: PSORIATIC ARTHRITIS (PSA): PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST OR RHEUMATOLOGIST. PSO: PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST. CROHNS DISEASE (CD), ULCERATIVE COLITIS (UC): PRESCRIBED BY OR IN CONSULTATION WITH A GASTROENTEROLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	INITIAL: PSA: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR PSA. PSO: 1) ONE OF THE FOLLOWING: (A) AT LEAST A 3 MONTH TRIAL OF ONE ORAL IMMUNOSUPPRESSANT (CYCLOSPORINE, METHOTREXATE, TACROLIMUS) OR PUVA (PHOTOTHERAPY) FOR THE TREATMENT OF PSO, (B) CONTRAINDICATION OR INTOLERANCE TO BOTH IMMUNOSUPPRESSANT AND PUVA FOR THE TREATMENT OF PSO, OR (C) PATIENT IS SWITCHING FROM A DIFFERENT BIOLOGIC, PDE-4 INHIBITOR, OR JAK INHIBITOR FOR THE SAME INDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR PSO. CD: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR CD. UC: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

PA Criteria	Criteria Details
	SMALL MOLECULES FOR UC. RENEWAL: PSA: 1) CONTINUES TO BENEFIT FROM THE MEDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR PSA. PSO: 1) CONTINUES TO BENEFIT FROM THE MEDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR PSO. CD: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR CD. UC: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR UC.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

USTEKINUMAB-AEKN SQ

Products Affected

- SELARSDI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: PLAQUE PSORIASIS (PSO): PSORIASIS COVERING 3 PERCENT OR MORE OF BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, GENITAL AREA, SCALP OR FACE.
Age Restrictions	
Prescriber Restrictions	INITIAL: PSORIATIC ARTHRITIS (PSA): PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST OR RHEUMATOLOGIST. PSO: PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST. CROHNS DISEASE (CD), ULCERATIVE COLITIS (UC): PRESCRIBED BY OR IN CONSULTATION WITH A GASTROENTEROLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	INITIAL: PSA: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR PSA. PSO: 1) ONE OF THE FOLLOWING: (A) AT LEAST A 3 MONTH TRIAL OF ONE ORAL IMMUNOSUPPRESSANT (CYCLOSPORINE, METHOTREXATE, TACROLIMUS) OR PUVA (PHOTOTHERAPY) FOR THE TREATMENT OF PSO, (B) CONTRAINDICATION OR INTOLERANCE TO BOTH IMMUNOSUPPRESSANT AND PUVA FOR THE TREATMENT OF PSO, OR (C) PATIENT IS SWITCHING FROM A DIFFERENT BIOLOGIC, PDE-4 INHIBITOR, OR JAK INHIBITOR FOR THE SAME INDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR PSO. CD: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR CD. UC: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

PA Criteria	Criteria Details
	SMALL MOLECULES FOR UC. RENEWAL: PSA: 1) CONTINUES TO BENEFIT FROM THE MEDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR PSA. PSO: 1) CONTINUES TO BENEFIT FROM THE MEDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR PSO. CD: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR CD. UC: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR UC.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

USTEKINUMAB-KFCE IV

Products Affected

- YESINTEK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: PLAQUE PSORIASIS (PSO): PSORIASIS COVERING 3 PERCENT OR MORE OF BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, GENITAL AREA, SCALP OR FACE.
Age Restrictions	
Prescriber Restrictions	INITIAL: PSORIATIC ARTHRITIS (PSA): PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST OR RHEUMATOLOGIST. PSO: PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST. CROHNS DISEASE (CD), ULCERATIVE COLITIS (UC): PRESCRIBED BY OR IN CONSULTATION WITH A GASTROENTEROLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	INITIAL: PSA: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR PSA. PSO: 1) ONE OF THE FOLLOWING: (A) AT LEAST A 3 MONTH TRIAL OF ONE ORAL IMMUNOSUPPRESSANT (CYCLOSPORINE, METHOTREXATE, TACROLIMUS) OR PUVA (PHOTOTHERAPY) FOR THE TREATMENT OF PSO, (B) CONTRAINDICATION OR INTOLERANCE TO BOTH IMMUNOSUPPRESSANT AND PUVA FOR THE TREATMENT OF PSO, OR (C) PATIENT IS SWITCHING FROM A DIFFERENT BIOLOGIC, PDE-4 INHIBITOR, OR JAK INHIBITOR FOR THE SAME INDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR PSO. CD: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR CD. UC: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

PA Criteria	Criteria Details
	SMALL MOLECULES FOR UC. RENEWAL: PSA: 1) CONTINUES TO BENEFIT FROM THE MEDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR PSA. PSO: 1) CONTINUES TO BENEFIT FROM THE MEDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR PSO. CD: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR CD. UC: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR UC.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

USTEKINUMAB-KFCE SQ

Products Affected

- YESINTEK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: PLAQUE PSORIASIS (PSO): PSORIASIS COVERING 3 PERCENT OR MORE OF BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, GENITAL AREA, SCALP OR FACE.
Age Restrictions	
Prescriber Restrictions	INITIAL: PSORIATIC ARTHRITIS (PSA): PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST OR RHEUMATOLOGIST. PSO: PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST. CROHNS DISEASE (CD), ULCERATIVE COLITIS (UC): PRESCRIBED BY OR IN CONSULTATION WITH A GASTROENTEROLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	INITIAL: PSA: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES (E.G., JAK INHIBITOR, PDE-4 INHIBITOR) FOR PSA. PSO: 1) ONE OF THE FOLLOWING: (A) AT LEAST A 3 MONTH TRIAL OF ONE ORAL IMMUNOSUPPRESSANT (CYCLOSPORINE, METHOTREXATE, TACROLIMUS) OR PUVA (PHOTOTHERAPY) FOR THE TREATMENT OF PSO, (B) CONTRAINDICATION OR INTOLERANCE TO BOTH IMMUNOSUPPRESSANT AND PUVA FOR THE TREATMENT OF PSO, OR (C) PATIENT IS SWITCHING FROM A DIFFERENT BIOLOGIC, PDE-4 INHIBITOR, OR JAK INHIBITOR FOR THE SAME INDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR PSO. CD: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR CD. UC: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

PA Criteria	Criteria Details
	SMALL MOLECULES FOR UC. RENEWAL: PSA: 1) CONTINUES TO BENEFIT FROM THE MEDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR PSA. PSO: 1) CONTINUES TO BENEFIT FROM THE MEDICATION, AND 2) NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR PSO. CD: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR CD. UC: NO CONCURRENT USE WITH ANOTHER SYSTEMIC BIOLOGIC OR TARGETED SMALL MOLECULES FOR UC.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

VALBENAZINE

Products Affected

- INGREZZA
- INGREZZA INITIATION PK(TARDIV)
- INGREZZA SPRINKLE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	TARDIVE DYSKINESIA (TD): PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST, PSYCHIATRIST, OR MOVEMENT DISORDER SPECIALIST. CHOREA ASSOCIATED WITH HUNTINGTONS DISEASE: PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST OR MOVEMENT DISORDER SPECIALIST.
Coverage Duration	12 MONTHS
Other Criteria	TD: HISTORY OF USING AGENTS THAT CAUSE TARDIVE DYSKINESIA.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

VANDETANIB

Products Affected

- CAPRELSA ORAL TABLET 100 MG, 300 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	CURRENTLY STABLE ON CAPRELSA REQUIRES NO EXTRA CRITERIA.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

VANZACAFTOR-TEZACAFTOR-DEUTIVACAFTOR

Products Affected

- ALYFTREK ORAL TABLET 10-50-125 MG, 4-20-50 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	CF: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A PULMONOLOGIST OR CYSTIC FIBROSIS EXPERT.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: LIFETIME.
Other Criteria	CF: INITIAL: NO CONCURRENT USE WITH ANOTHER CFTR MODULATOR. RENEWAL: 1) IMPROVEMENT IN CLINICAL STATUS, AND 2) NO CONCURRENT USE WITH ANOTHER CFTR MODULATOR.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

VEMURAFENIB

Products Affected

- ZELBORAF

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	MELANOMA: ZELBORAF WILL BE USED ALONE OR IN COMBINATION WITH COTELLIC
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

VENETOCLAX

Products Affected

- VENCLEXTA ORAL TABLET 10 MG, 100 MG, 50 MG
- VENCLEXTA STARTING PACK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

VERICIGUAT

Products Affected

- VERQUVO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL/RENEWAL:12 MONTHS.
Other Criteria	HEART FAILURE (HF): INITIAL: 1) TRIAL OF OR CONTRAINDICATION TO ONE PREFERRED SGLT-2 INHIBITOR, AND 2) TRIAL OF OR CONTRAINDICATION TO ONE AGENT FROM ANY OF THE FOLLOWING STANDARD OF CARE CLASSES: (A) ACE INHIBITOR, ARB, OR ARNI, (B) BETA BLOCKER (BISOPROLOL, CARVEDILOL, METOPROLOL SUCCINATE), OR (C) ALDOSTERONE ANTAGONIST (SPIRONOLACTONE, EPLERENONE). INITIAL/RENEWAL: NO CONCURRENT USE WITH RIOCIGUAT OR PDE-5 INHIBITORS.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

VIGABATRIN

Products Affected

- *vigabatrin*
- *vigadrone*
- *vigpoder*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	REFRACTORY COMPLEX PARTIAL SEIZURES (CPS), INFANTILE SPASMS: PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST.
Coverage Duration	12 MONTHS
Other Criteria	CPS: TRIAL OF OR CONTRAINDICATION TO TWO ANTIEPILEPTIC AGENTS.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

VIMSELTINIB

Products Affected

- ROMVIMZA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

VISMODEGIB

Products Affected

- ERIVEDGE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

VORASIDENIB

Products Affected

- VORANIGO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

VORICONAZOLE SUSPENSION

Products Affected

- *voriconazole oral suspension for reconstitution*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	CANDIDA INFECTIONS: 3 MOS. CONTINUATION OF THERAPY, ALL OTHER INDICATIONS: 6 MOS.
Other Criteria	CANDIDA INFECTIONS: 1) TRIAL OF OR CONTRAINDICATION TO FLUCONAZOLE, AND 2) UNABLE TO SWALLOW TABLETS. ALL INDICATIONS EXCEPT ESOPHAGEAL CANDIDIASIS: UNABLE TO SWALLOW TABLETS. CONTINUATION OF THERAPY AFTER HOSPITAL DISCHARGE REQUIRES NO EXTRA CRITERIA.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

ZANIDATAMAB-HRII

Products Affected

- ZIIHERA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

ZANUBRUTINIB

Products Affected

- BRUKINSA ORAL CAPSULE
- BRUKINSA ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

ZENOCUTUZUMAB-ZBCO

Products Affected

- BIZENGRI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

ZOLBETUXIMAB-CLZB

Products Affected

- VYLOY

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Updated: 11.01.2025
Y0150_PBM200_C (v2)



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

ZONGERTINIB

Products Affected

- HERNEXEOS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

ZURANOLONE

Products Affected

- ZURZUVAE ORAL CAPSULE 20 MG, 25 MG, 30 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	14 DAYS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Updated: 11.01.2025
Y0150_PBM200_C (v2)

INDEX

1

1ST TIER UNIFINE PENTP 5MM 31G174,
183, 184
1ST TIER UNIFINE PNTIP 4MM 32G 174,
183, 184
1ST TIER UNIFINE PNTIP 6MM 31G 174,
183, 184
1ST TIER UNIFINE PNTIP 8MM 31G
STRL,SINGLE-USE,SHRT 174, 183, 184
1ST TIER UNIFINE PNTIP 29GX1/2.... 174,
183, 184
1ST TIER UNIFINE PNTIP 31GX3/16.. 174,
183, 184
1ST TIER UNIFINE PNTIP 32GX5/32.. 174,
183, 184

A

abigale 152
abiraterone..... 7
abirtega..... 7
ABOUTTIME PEN NEEDLE 174, 183, 184
ACTEMRA.....352, 353, 354, 355
ACTEMRA ACTPEN 354, 355
ACTHAR 73
ACTHAR SELFJECT SUBCUTANEOUS
PEN INJECTOR 40 UNIT/0.5 ML, 80
UNIT/ML..... 73
ACTIMMUNE..... 188
ADEMPAS..... 296
ADVOCATE INS 0.3 ML 30GX5/16 ... 174,
183, 184
ADVOCATE INS 0.3 ML 31GX5/16 ... 174,
183, 184
ADVOCATE INS 0.5 ML 30GX5/16 ... 174,
183, 184
ADVOCATE INS 0.5 ML 31GX5/16 ... 174,
183, 184
ADVOCATE INS 1 ML 31GX5/16..... 174,
183, 184
ADVOCATE INS SYR 0.3 ML 29GX1/2
..... 174, 183, 184
ADVOCATE INS SYR 0.5 ML 29GX1/2
..... 174, 183, 184

ADVOCATE INS SYR 1 ML 29GX1/2 174,
183, 184
ADVOCATE INS SYR 1 ML 30GX5/16
.....174, 183, 184
ADVOCATE PEN NDL 12.7MM 29G .174,
183, 184
ADVOCATE PEN NEEDLE 32G 4MM
.....174, 183, 184
ADVOCATE PEN NEEDLE 4MM 33G
.....174, 183, 184
ADVOCATE PEN NEEDLES 5MM 31G
.....174, 183, 184
ADVOCATE PEN NEEDLES 8MM 31G
.....174, 183, 184
AIMOVIG AUTOINJECTOR..... 116
AJOVY AUTOINJECTOR 132
AJOVY SYRINGE 132
AKEEGA..... 240
ALCOHOL 70% SWABS174, 183, 184
ALCOHOL PADS174, 183, 184
ALCOHOL PREP SWABS....174, 183, 184
ALCOHOL WIPES.....174, 183, 184
ALECENSA..... 19
ALTRENO 362
ALUNBRIG ORAL TABLET 180 MG, 30
MG, 90 MG 58
ALUNBRIG ORAL TABLETS,DOSE
PACK 58
ALVAIZ..... 105
ALYFTREK ORAL TABLET 10-50-125
MG, 4-20-50 MG 394
alyq 331
ANKTIVA..... 246
AQINJECT PEN NEEDLE 31G 5MM.. 174,
183, 184
AQINJECT PEN NEEDLE 32G 4MM.. 174,
183, 184
ARCALYST..... 293, 294
ARIKAYCE..... 21
armodafinil 232
ASSURE ID DUO PRO NDL 31G 5MM
.....174, 183, 184



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

ASSURE ID DUO-SHIELD 30GX3/16 174, 183, 184	BD ECLIPSE NEEDLE 30GX1/2 .174, 183, 184
ASSURE ID DUO-SHIELD 30GX5/16 174, 183, 184	BD INS SYR 0.3 ML 8MMX31G(1/2)..174, 183, 184
ASSURE ID INSULIN SAFETY SYRINGE 1 ML 29 GAUGE X 1/2 ..174, 183, 184	BD INS SYR UF 0.3 ML 12.7MMX30G174, 183, 184
ASSURE ID PEN NEEDLE 30GX3/16 174, 183, 184	BD INS SYR UF 0.5 ML 12.7MMX30G NOT FOR RETAIL SALE..174, 183, 184
ASSURE ID PEN NEEDLE 30GX5/16 174, 183, 184	BD INSULIN SYR 1 ML 25GX1 ..174, 183, 184
ASSURE ID PEN NEEDLE 31GX3/16 174, 183, 184	BD INSULIN SYR 1 ML 25GX5/8.....174, 183, 184
ASSURE ID PRO PEN NDL 30G 5MM174, 183, 184	BD INSULIN SYR 1 ML 26GX1/2.....174, 183, 184
ASSURE ID SYR 0.5 ML 31GX15/64..174, 183, 184	BD INSULIN SYR 1 ML 27GX12.7MM174, 183, 184
ASSURE ID SYR 1 ML 31GX15/64.....174, 183, 184	BD INSULIN SYR 1 ML 27GX5/8.....174, 183, 184
AUGTYRO ORAL CAPSULE 160 MG, 40 MG285	BD INSULIN SYRINGE SLIP TIP.....174, 183, 184
AUSTEDO ORAL TABLET 12 MG, 6 MG, 9 MG88	BD LO-DOSE ULTRA-FINE.174, 183, 184
AUSTEDO XR ORAL TABLET EXTENDED RELEASE 24 HR 12 MG, 18 MG, 24 MG, 30 MG, 36 MG, 42 MG, 48 MG, 6 MG.....88	BD NANO 2 GEN PEN NDL 32G 4MM174, 183, 184
AUSTEDO XR TITRATION KT(WK1-4)88	BD SAFETGLD INS 0.3 ML 29G 13MM174, 183, 184
AUTOSHIELD DUO PEN NDL 30G 5MM174, 183, 184	BD SAFETGLD INS 0.5 ML 13MMX29G174, 183, 184
AVMAPKI.....37	BD SAFETYGLD INS 0.3 ML 31G 8MM174, 183, 184
AVMAPKI-FAKZYNJA.....37	BD SAFETYGLD INS 0.5 ML 30G 8MM174, 183, 184
AVONEX INTRAMUSCULAR PEN INJECTOR KIT.....185	BD SAFETYGLD INS 1 ML 29G 13MM174, 183, 184
AVONEX INTRAMUSCULAR SYRINGE KIT185	BD SAFETYGLID INS 1 ML 6MMX31G174, 183, 184
AYVAKIT36	BD SAFETYGLIDE SYRINGE 27GX5/8174, 183, 184
B	BD SAFTYGLD INS 0.3 ML 6MMX31G174, 183, 184
BALVERSA ORAL TABLET 3 MG, 4 MG, 5 MG.....115	BD SAFTYGLD INS 0.5 ML 29G 13MM174, 183, 184
BD AUTOSHIELD DUO NDL 5MMX30G174, 183, 184	BD SAFTYGLD INS 0.5 ML 6MMX31G174, 183, 184
BD ECLIPSE 30GX1/2174, 183, 184	BD SINGLE USE SWAB.....174, 183, 184

BD UF MICRO PEN NEEDLE 6MMX32G
 174, 183, 184
 BD UF MINI PEN NEEDLE 5MMX31G
 174, 183, 184
 BD UF NANO PEN NEEDLE 4MMX32G
 174, 183, 184
 BD UF ORIG PEN NDL 12.7MMX29G
 174, 183, 184
 BD UF SHORT PEN NEEDLE 8MMX31G
 174, 183, 184
 BD VEO INS 0.3 ML 6MMX31G (1/2) 174,
 183, 184
 BD VEO INS SYRING 1 ML 6MMX31G
 175, 183, 184
 BD VEO INS SYRN 0.3 ML 6MMX31G
 175, 183, 184
 BD VEO INS SYRN 0.5 ML 6MMX31G
 175, 183, 184
 bendamustine intravenous recon soln 46
 BENDAMUSTINE INTRAVENOUS
 SOLUTION..... 46
 BENDEKA..... 46
 BENLYSTA SUBCUTANEOUS 43
 BESREMI 304
 betaine 49
 BETASERON SUBCUTANEOUS KIT 186
 bexarotene 53
 BIZENGRI..... 405
 BORDERED GAUZE 2 175, 183, 184
 bortezomib injection 55
 BORUZU 55
 bosentan oral tablet 56
 BOSULIF ORAL CAPSULE 100 MG, 50
 MG 57
 BOSULIF ORAL TABLET 100 MG, 400
 MG, 500 MG..... 57
 BRAFTOVI..... 108
 BRUKINSA ORAL CAPSULE..... 404
 BRUKINSA ORAL TABLET 404
 butalbital-acetaminop-caf-cod oral capsule
 50-325-40-30 mg 148
 butalbital-acetaminophen-caff oral capsule
 148
 butalbital-acetaminophen-caff oral tablet 148

C

CABOMETYX ORAL TABLET 20 MG, 40
 MG, 60 MG 61
 CALQUENCE..... 9
 CALQUENCE (ACALABRUTINIB MAL)
 9
 CAMZYOS 220
 CAPRELSA ORAL TABLET 100 MG, 300
 MG..... 393
 CAREFINE PEN NEEDLE 12.7MM 29G
 175, 183, 184
 CAREFINE PEN NEEDLE 4MM 32G . 175,
 183, 184
 CAREFINE PEN NEEDLE 5MM 32G . 175,
 183, 184
 CAREFINE PEN NEEDLE 6MM 31G . 175,
 183, 184
 CAREFINE PEN NEEDLE 8MM 30G . 175,
 183, 184
 CAREFINE PEN NEEDLES 6MM 32G 175,
 183, 184
 CAREFINE PEN NEEDLES 8MM 31G 175,
 183, 184
 CARETOUCH ALCOHOL 70% PREP
 PAD 175, 183, 184
 CARETOUCH PEN NEEDLE 29G 12MM
 175, 183, 184
 CARETOUCH PEN NEEDLE 31GX1/4
 175, 183, 184
 CARETOUCH PEN NEEDLE 31GX3/16
 175, 183, 184
 CARETOUCH PEN NEEDLE 31GX5/16
 175, 183, 184
 CARETOUCH PEN NEEDLE 32GX3/16
 175, 183, 184
 CARETOUCH PEN NEEDLE 32GX5/32
 175, 183, 184
 CARETOUCH SYR 0.3 ML 31GX5/16 175,
 183, 184
 CARETOUCH SYR 0.5 ML 30GX5/16 175,
 183, 184
 CARETOUCH SYR 0.5 ML 31GX5/16 175,
 183, 184
 CARETOUCH SYR 1 ML 28GX5/16... 175,
 183, 184



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

CARETOUCH SYR 1 ML 29GX5/16...	175, 183, 184	COMFORT EZ PEN NEEDLES 5MM 33G	175, 183, 184
CARETOUCH SYR 1 ML 30GX5/16...	175, 183, 184	COMFORT EZ PEN NEEDLES 6MM 31G	175, 183, 184
CARETOUCH SYR 1 ML 31GX5/16...	175, 183, 184	COMFORT EZ PEN NEEDLES 6MM 32G	175, 183, 184
carglumic acid.....	65	COMFORT EZ PEN NEEDLES 6MM 33G	175, 183, 184
CAYSTON.....	41	COMFORT EZ PEN NEEDLES 8MM 31G	175, 183, 184
CIMZIA POWDER FOR RECONST.	67, 68	SHORT.....	175, 183, 184
CIMZIA SUBCUTANEOUS SYRINGE		COMFORT EZ PEN NEEDLES 8MM 32G	175, 183, 184
KIT 400 MG/2 ML (200 MG/ML X 2)	67, 68	COMFORT EZ PEN NEEDLES 8MM 33G	175, 183, 184
CINQAIR.....	286, 287	COMFORT EZ PRO PEN NDL 30G 8MM	175, 183, 184
CLICKFINE PEN NEEDLE 32GX5/32	175, 183, 184	COMFORT EZ PRO PEN NDL 31G 4MM	175, 183, 184
COMETRIQ ORAL CAPSULE 100		COMFORT EZ PRO PEN NDL 31G 5MM	175, 183, 184
MG/DAY(80 MG X1-20 MG X1),	140	COMFORT EZ SYR 0.3 ML 29GX1/2.	175, 183, 184
MG/DAY(80 MG X1-20 MG X3),	60	COMFORT EZ SYR 0.5 ML 28GX1/2.	175, 183, 184
MG/DAY (20 MG X 3/DAY).....	60	COMFORT EZ SYR 0.5 ML 29GX1/2.	175, 183, 184
COMFORT EZ 0.3 ML 31G 15/64	175, 183, 184	COMFORT EZ SYR 0.5 ML 30GX1/2.	175, 183, 184
COMFORT EZ 0.5 ML 31G 15/64	175, 183, 184	COMFORT EZ SYR 1 ML 28GX1/2	175, 183, 184
COMFORT EZ INS 0.3 ML 30GX1/2 ..	175, 183, 184	COMFORT EZ SYR 1 ML 29GX1/2	175, 183, 184
COMFORT EZ INS 0.3 ML 30GX5/16	175, 183, 184	COMFORT EZ SYR 1 ML 30GX1/2	175, 183, 184
COMFORT EZ INS 1 ML 31G 15/64...	175, 183, 184	COMFORT EZ SYR 1 ML 30GX5/16 ..	175, 183, 184
COMFORT EZ INS 1 ML 31GX5/16 ...	175, 183, 184	COMFORT POINT PEN NDL 31GX1/3	175, 183, 184
COMFORT EZ INSULIN SYR 0.3 ML	175, 183, 184	COMFORT POINT PEN NDL 31GX1/6	175, 183, 184
COMFORT EZ INSULIN SYR 0.5 ML	175, 183, 184	COMFORT TOUCH PEN NDL 31G 4MM	175, 183, 184
COMFORT EZ PEN NEEDLE 12MM 29G		COMFORT TOUCH PEN NDL 31G 5MM	175, 183, 184
.....	175, 183, 184		
COMFORT EZ PEN NEEDLES 4MM 32G			
SINGLE USE, MICRO	175, 183, 184		
COMFORT EZ PEN NEEDLES 4MM 33G			
.....	175, 183, 184		
COMFORT EZ PEN NEEDLES 5MM 31G			
MINI.....	175, 183, 184		
COMFORT EZ PEN NEEDLES 5MM 32G			
SINGLE USE,MINI,HRI	175, 183, 184		



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

COMFORT TOUCH PEN NDL 31G 6MM	175, 183, 184
COMFORT TOUCH PEN NDL 31G 8MM	175, 183, 184
COMFORT TOUCH PEN NDL 32G 4MM	175, 183, 184
COMFORT TOUCH PEN NDL 32G 5MM	176, 183, 184
COMFORT TOUCH PEN NDL 32G 6MM	176, 183, 184
COMFORT TOUCH PEN NDL 32G 8MM	176, 183, 184
COMFORT TOUCH PEN NDL 33G 4MM	176, 183, 184
COMFORT TOUCH PEN NDL 33G 6MM	176, 183, 184
COMFORT TOUCH PEN NDL 33GX5MM	176, 183, 184
COPIKTRA.....	100
CORTROPHIN GEL INJECTION	73
COSENTYX (2 SYRINGES).....	310, 311
COSENTYX INTRAVENOUS	308, 309
COSENTYX PEN (2 PENS).....	310, 311
COSENTYX SUBCUTANEOUS SYRINGE 75 MG/0.5 ML	310, 311
COSENTYX UNOREADY PEN....	310, 311
COTELLIC	72
CRESEMBA ORAL.....	190
CURAD GAUZE PADS 2	176, 183, 184
CURITY ALCOHOL PREPS 2 PLY,MEDIUM	176, 183, 184
CURITY GAUZE PADS.....	176, 183, 184
CURITY GAUZE SPONGES (12 PLY)-200/BAG	176, 183, 184
cyclobenzaprine oral tablet 10 mg, 5 mg	160
CYLTEZO(CF).....	16, 17
CYLTEZO(CF) PEN	16, 17
CYLTEZO(CF) PEN CROHN'S-UC-HS	16, 17
CYLTEZO(CF) PEN PSORIASIS-UV ...	16, 17
D	
dalfampridine	79
DANYELZA.....	233
DANZITEN	236
dasatinib oral tablet 100 mg, 140 mg, 20 mg, 50 mg, 70 mg, 80 mg	81
DATROWAY	82
DAURISMO ORAL TABLET 100 MG, 25 MG.....	139
deferasirox oral granules in packet.....	84, 85
deferasirox oral tablet	84, 85
DERMACEA 2	176, 183, 184
DERMACEA GAUZE 2	176, 183, 184
DERMACEA NON-WOVEN 2	176, 183, 184
dermacinrx lidocan 5% patch outer	210
DIACOMIT ORAL CAPSULE 250 MG, 500 MG	329
DIACOMIT ORAL POWDER IN PACKET 250 MG, 500 MG.....	329
diclofenac epolamine	90
diclofenac sodium topical solution in metered-dose pump	89
dimethyl fumarate oral capsule,delayed release(dr/ec) 120 mg, 120 mg (14)- 240 mg (46), 240 mg.....	91
diphenoxylate-atropine oral tablet.....	161
dipyridamole oral tablet 50 mg, 75 mg ...	150
dronabinol.....	95
DROPLET 0.3 ML 29G 12.7MM(1/2) ..	176, 183, 184
DROPLET 0.3 ML 30G 12.7MM(1/2) ..	176, 183, 184
DROPLET 0.5 ML 29GX12.5MM(1/2)	176, 183, 184
DROPLET 0.5 ML 30GX12.5MM(1/2)	176, 183, 184
DROPLET INS 0.3 ML 29GX12.5MM.	176, 183, 184
DROPLET INS 0.3 ML 30G 8MM(1/2)	176, 183, 184
DROPLET INS 0.3 ML 30GX12.5MM.	176, 183, 184
DROPLET INS 0.3 ML 31G 6MM(1/2)	176, 183, 184
DROPLET INS 0.3 ML 31G 8MM(1/2)	176, 183, 184
DROPLET INS 0.5 ML 29G 12.7MM...	176, 183, 184



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

DROPLET INS 0.5 ML 30G 12.7MM.. 176, 183, 184	DROPLET PEN NEEDLE 30G 8MM... 176, 183, 184
DROPLET INS 0.5 ML 30GX6MM(1/2) 176, 183, 184	DROPLET PEN NEEDLE 31G 5MM... 176, 183, 184
DROPLET INS 0.5 ML 30GX8MM(1/2) 176, 183, 184	DROPLET PEN NEEDLE 31G 6MM... 176, 183, 184
DROPLET INS 0.5 ML 31GX6MM(1/2) 176, 183, 184	DROPLET PEN NEEDLE 31G 8MM... 176, 183, 184
DROPLET INS 0.5 ML 31GX8MM(1/2) 176, 183, 184	DROPLET PEN NEEDLE 32G 4MM... 176, 183, 184
DROPLET INS SYR 0.3 ML 30GX6MM 176, 183, 184	DROPLET PEN NEEDLE 32G 5MM... 176, 183, 184
DROPLET INS SYR 0.3 ML 30GX8MM 176, 183, 184	DROPLET PEN NEEDLE 32G 6MM... 176, 183, 184
DROPLET INS SYR 0.3 ML 31GX6MM 176, 183, 184	DROPLET PEN NEEDLE 32G 8MM... 176, 183, 184
DROPLET INS SYR 0.3 ML 31GX8MM 176, 183, 184	DROPSAFE ALCOHOL 70% PREP PADS 176, 183, 184
DROPLET INS SYR 0.5 ML 30G 8MM 176, 183, 184	DROPSAFE INS SYR 0.3 ML 31G 6MM 176, 183, 184
DROPLET INS SYR 0.5 ML 31G 6MM 176, 183, 184	DROPSAFE INS SYR 0.3 ML 31G 8MM 176, 183, 184
DROPLET INS SYR 0.5 ML 31G 8MM 176, 183, 184	DROPSAFE INS SYR 0.5 ML 31G 6MM 176, 183, 184
DROPLET INS SYR 1 ML 29G 12.7MM 176, 183, 184	DROPSAFE INS SYR 0.5 ML 31G 8MM 176, 183, 184
DROPLET INS SYR 1 ML 30G 8MM.. 176, 183, 184	DROPSAFE INSUL SYR 1 ML 31G 6MM 176, 183, 184
DROPLET INS SYR 1 ML 30GX12.5MM 176, 183, 184	DROPSAFE INSUL SYR 1 ML 31G 8MM 176, 183, 184
DROPLET INS SYR 1 ML 30GX6MM 176, 183, 184	DROPSAFE INSULN 1 ML 29G 12.5MM 176, 183, 184
DROPLET INS SYR 1 ML 31G 6MM.. 176, 183, 184	DROPSAFE PEN NEEDLE 31GX1/4... 176, 183, 184
DROPLET INS SYR 1 ML 31GX6MM 176, 183, 184	DROPSAFE PEN NEEDLE 31GX3/16. 176, 183, 184
DROPLET INS SYR 1 ML 31GX8MM 176, 183, 184	DROPSAFE PEN NEEDLE 31GX5/16. 176, 183, 184
DROPLET MICRON 34G X 9/64. 176, 183, 184	droxidopa..... 96
DROPLET PEN NEEDLE 29G 10MM. 176, 183, 184	DRUG MART ULTRA COMFORT SYR 176, 183, 184
DROPLET PEN NEEDLE 29G 12MM. 176, 183, 184	DUAVEE..... 153
	DUPIXENT PEN 97, 99
	DUPIXENT SYRINGE 97, 99



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

E

EASY CMFT SFTY PEN NDL 31G 5MM
..... 176, 183, 184
EASY CMFT SFTY PEN NDL 31G 6MM
..... 176, 183, 184
EASY CMFT SFTY PEN NDL 32G 4MM
..... 176, 183, 184
EASY COMFORT 0.3 ML 31G 1/2 176,
183, 184
EASY COMFORT 0.3 ML 31G 5/16 176,
183, 184
EASY COMFORT 0.3 ML SYRINGE.. 176,
183, 184
EASY COMFORT 0.5 ML 30GX1/2 176,
183, 184
EASY COMFORT 0.5 ML 31GX5/16.. 176,
183, 184
EASY COMFORT 0.5 ML 32GX5/16.. 177,
183, 184
EASY COMFORT 0.5 ML SYRINGE.. 177,
183, 184
EASY COMFORT 1 ML 31GX5/16 177,
183, 184
EASY COMFORT 1 ML 32GX5/16 177,
183, 184
EASY COMFORT ALCOHOL 70% PAD
..... 177, 183, 184
EASY COMFORT INSULIN 1 ML SYR
..... 177, 183, 184
EASY COMFORT PEN NDL 29G 4MM
..... 177, 183, 184
EASY COMFORT PEN NDL 29G 5MM
..... 177, 183, 184
EASY COMFORT PEN NDL 31GX1/4 177,
183, 184
EASY COMFORT PEN NDL 31GX3/16
..... 177, 183, 184
EASY COMFORT PEN NDL 31GX5/16
..... 177, 183, 184
EASY COMFORT PEN NDL 32GX5/32
..... 177, 183, 184
EASY COMFORT PEN NDL 33G 4MM
..... 177, 183, 184
EASY COMFORT PEN NDL 33G 5MM
..... 177, 183, 184

EASY COMFORT PEN NDL 33G 6MM
..... 177, 183, 184
EASY COMFORT SYR 0.5 ML 29G 8MM
..... 177, 183, 184
EASY COMFORT SYR 1 ML 29G 8MM
..... 177, 183, 184
EASY COMFORT SYR 1 ML 30GX1/2
..... 177, 183, 184
EASY GLIDE INS 0.3 ML 31GX6MM 177,
183, 184
EASY GLIDE INS 0.5 ML 31GX6MM 177,
183, 184
EASY GLIDE INS 1 ML 31GX6MM ... 177,
183, 184
EASY GLIDE PEN NEEDLE 4MM 33G
..... 177, 183, 184
EASY TOUCH 0.3 ML SYR 30GX1/2 . 177,
183, 184
EASY TOUCH 0.5 ML SYR 27GX1/2 . 177,
183, 184
EASY TOUCH 0.5 ML SYR 29GX1/2 . 177,
183, 184
EASY TOUCH 0.5 ML SYR 30GX1/2 . 177,
183, 184
EASY TOUCH 0.5 ML SYR 30GX5/16 177,
183, 184
EASY TOUCH 1 ML SYR 27GX1/2 177,
183, 184
EASY TOUCH 1 ML SYR 29GX1/2 177,
183, 184
EASY TOUCH 1 ML SYR 30GX1/2 177,
183, 184
EASY TOUCH ALCOHOL 70% PADS
GAMMA-STERILIZED..... 177, 183, 184
EASY TOUCH FLIPLOK 1 ML 27GX0.5
..... 177, 183, 184
EASY TOUCH INSULIN 1 ML 29GX1/2
..... 177, 183, 184
EASY TOUCH INSULIN 1 ML 30GX1/2
..... 177, 183, 184
EASY TOUCH INSULIN SYR 0.3 ML 177,
183, 184
EASY TOUCH INSULIN SYR 0.5 ML 177,
183, 184



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

EASY TOUCH INSULIN SYR 1 ML... 177, 183, 184	EASY TOUCH SYR 1 ML 28G 12.7MM177, 183, 184
EASY TOUCH INSULIN SYR 1 ML RETRACTABLE..... 177, 183, 184	EASY TOUCH SYR 1 ML 29G 12.7MM177, 183, 184
EASY TOUCH INSULN 1 ML 29GX1/2 177, 183, 184	EASY TOUCH UNI-SLIP SYR 1 ML ..177, 183, 184
EASY TOUCH INSULN 1 ML 30GX1/2 177, 183, 184	EASYTOUCH SAF PEN NDL 30G 6MM177, 183, 184
EASY TOUCH INSULN 1 ML 30GX5/16 177, 183, 184	ELAHERE..... 229
EASY TOUCH INSULN 1 ML 31GX5/16 177, 183, 184	ELIGARD 204
EASY TOUCH LUER LOK INSUL 1 ML 177, 183, 184	ELIGARD (3 MONTH)..... 204
EASY TOUCH PEN NEEDLE 29GX1/2 177, 183, 184	ELIGARD (4 MONTH)..... 204
EASY TOUCH PEN NEEDLE 30GX5/16 177, 183, 184	ELIGARD (6 MONTH)..... 204
EASY TOUCH PEN NEEDLE 31GX1/4 177, 183, 184	ELREXFIO 44 MG/1.1 ML VIAL INNER, SUV, P/F 104
EASY TOUCH PEN NEEDLE 31GX3/16 177, 183, 184	ELREXFIO SUBCUTANEOUS SOLUTION 40 MG/ML..... 104
EASY TOUCH PEN NEEDLE 31GX5/16 177, 183, 184	eltrombopag olamine oral powder in packet 12.5 mg, 25 mg 106
EASY TOUCH PEN NEEDLE 32GX1/4 177, 183, 184	eltrombopag olamine oral tablet 12.5 mg, 25 mg, 50 mg, 75 mg 106
EASY TOUCH PEN NEEDLE 32GX3/16 177, 183, 184	EMBRACE PEN NEEDLE 29G 12MM177, 183, 184
EASY TOUCH PEN NEEDLE 32GX5/32 177, 183, 184	EMBRACE PEN NEEDLE 30G 5MM.. 177, 183, 184
EASY TOUCH SAF PEN NDL 29G 5MM 177, 183, 184	EMBRACE PEN NEEDLE 30G 8MM.. 177, 183, 184
EASY TOUCH SAF PEN NDL 29G 8MM 177, 183, 184	EMBRACE PEN NEEDLE 31G 5MM.. 177, 183, 184
EASY TOUCH SAF PEN NDL 30G 5MM 177, 183, 184	EMBRACE PEN NEEDLE 31G 6MM.. 177, 183, 184
EASY TOUCH SAF PEN NDL 30G 8MM 177, 183, 184	EMBRACE PEN NEEDLE 31G 8MM.. 177, 183, 184
EASY TOUCH SYR 0.5 ML 28G 12.7MM 177, 183, 184	EMBRACE PEN NEEDLE 32G 4MM.. 177, 183, 184
EASY TOUCH SYR 0.5 ML 29G 12.7MM 177, 183, 184	EMGALITY PEN 135
EASY TOUCH SYR 1 ML 27G 16MM 177, 183, 184	EMGALITY SYRINGE SUBCUTANEOUS SYRINGE 120 MG/ML, 300 MG/3 ML (100 MG/ML X 3)..... 135
	EMRELIS..... 340
	ENBREL 119, 120
	ENBREL MINI..... 119, 120
	ENBREL SURECLICK..... 119, 120

EPCLUSA ORAL PELLETS IN PACKET	
150-37.5 MG, 200-50 MG	320
EPCLUSA ORAL TABLET	
	320
EPIDIOLEX.....	
	62
EPKINLY.....	
	112
EQL INSULIN 0.5 ML SYRINGE 177, 183,	
184	
EQL INSULIN 0.5 ML SYRINGE SHORT	
NEEDLE	177, 183, 184
ERBITUX	
	69
ERIVEDGE.....	
	400
ERLEADA ORAL TABLET 240 MG, 60	
MG	25
erlotinib oral tablet 100 mg, 150 mg, 25 mg	
.....	117
estradiol oral.....	
	151
estradiol transdermal patch semiweekly .	
	151
estradiol transdermal patch weekly	
	151
estradiol-norethindrone acet	
	152
everolimus (antineoplastic) oral tablet 10	
mg, 2.5 mg, 5 mg, 7.5 mg.....	121
everolimus (antineoplastic) oral tablet for	
suspension	122
F	
FAKZYNJA.....	
	37
FASENRA	
	47, 48
FASENRA PEN.....	
	47, 48
fentanyl citrate buccal lozenge on a handle	
.....	126
fingolimod.....	
	130
FINTEPLA.....	
	125
FOTIVDA	
	351
FP INSULIN 1 ML SYRINGE177, 183, 184	
FREESTYLE PREC 0.5 ML 30GX5/16 177,	
183, 184	
FREESTYLE PREC 0.5 ML 31GX5/16 177,	
183, 184	
FREESTYLE PREC 1 ML 30GX5/16... 177,	
183, 184	
FREESTYLE PREC 1 ML 31GX5/16... 177,	
183, 184	
FRUZAQLA ORAL CAPSULE 1 MG, 5	
MG	133
FYARRO	
	318

G	
GAUZE PAD TOPICAL BANDAGE 2 X 2	
.....	177, 183, 184
GAVRETO.....	
	279
gefitinib	
	137
GILOTRIF.....	
	18
glatiramer subcutaneous syringe 20 mg/ml,	
40 mg/ml	140
glatopa subcutaneous syringe 20 mg/ml, 40	
mg/ml.....	140
glutamine (sickle cell).....	
	208
glyburide.....	
	155
glyburide micronized	
	155
glyburide-metformin	
	155
GNP CLICKFINE 31G X 1/4..177, 183, 184	
GNP CLICKFINE 31G X 5/16177, 183, 184	
GNP SIMPLI PEN NEEDLE 32G 4MM	
.....	178, 183, 184
GNP ULT C 0.3 ML 29GX1/2 178, 183, 184	
GNP ULT CMFRT 0.5 ML 29GX1/2.... 178,	
183, 184	
GNP ULTRA COMFORT 0.5 ML SYR178,	
183, 184	
GNP ULTRA COMFORT 1 ML SYRINGE	
.....	178, 183, 184
GNP ULTRA COMFORT 3/10 ML SYR	
.....	178, 183, 184
GOMEKLI ORAL CAPSULE 1 MG, 2 MG	
.....	228
GOMEKLI ORAL TABLET FOR	
SUSPENSION	228
GS PEN NEEDLE 31G X 5MM....178, 183,	
184	
GS PEN NEEDLE 31G X 8MM....178, 183,	
184	
H	
HAEGARDA SUBCUTANEOUS RECON	
SOLN 2,000 UNIT, 3,000 UNIT.....	59
HARVONI ORAL PELLETS IN PACKET	
33.75-150 MG, 45-200 MG.....	198
HARVONI ORAL TABLET.....	
	198
HEALTHWISE INS 0.3 ML 30GX5/16 178,	
183, 184	
HEALTHWISE INS 0.3 ML 31GX5/16 178,	
183, 184	



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

HEALTHWISE INS 0.5 ML 30GX5/16 178, 183, 184	HUMIRA(CF) PEN PSOR-UV-ADOL HS 11, 12, 13
HEALTHWISE INS 0.5 ML 31GX5/16 178, 183, 184	I
HEALTHWISE INS 1 ML 30GX5/16... 178, 183, 184	IBRANCE 260
HEALTHWISE INS 1 ML 31GX5/16... 178, 183, 184	IBTROZI 334
HEALTHWISE PEN NEEDLE 31G 5MM 178, 183, 184	icatibant 166
HEALTHWISE PEN NEEDLE 31G 8MM 178, 183, 184	ICLUSIG 277
HEALTHWISE PEN NEEDLE 32G 4MM 178, 183, 184	IDHIFA 107
HEALTHY ACCENTS PENTIP 4MM 32G 178, 183, 184	imatinib oral tablet 100 mg, 400 mg 168
HEALTHY ACCENTS PENTIP 5MM 31G 178, 183, 184	IMBRUVICA ORAL CAPSULE 140 MG, 70 MG..... 165
HEALTHY ACCENTS PENTIP 6MM 31G 178, 183, 184	IMBRUVICA ORAL SUSPENSION 165
HEALTHY ACCENTS PENTIP 8MM 31G 178, 183, 184	IMBRUVICA ORAL TABLET 165
HEALTHY ACCENTS PENTP 12MM 29G 178, 183, 184	IMDELLTRA..... 336
HEB INCONTROL ALCOHOL 70% PADS 178, 183, 184	IMJUDO..... 373
HERCEPTIN HYLECTA..... 369	IMKELDI..... 169
HERNEXEOS..... 407	IMPAVIDO 227
HERZUMA..... 370	INCONTROL PEN NEEDLE 12MM 29G 178, 183, 184
HUMIRA PEN..... 11, 12, 13	INCONTROL PEN NEEDLE 4MM 32G 178, 183, 184
HUMIRA PEN CROHNS-UC-HS START 11, 12, 13	INCONTROL PEN NEEDLE 5MM 31G 178, 183, 184
HUMIRA PEN PSOR-UEITS-ADOL HS 11, 12, 13	INCONTROL PEN NEEDLE 6MM 31G 178, 183, 184
HUMIRA SUBCUTANEOUS SYRINGE KIT 40 MG/0.8 ML 11, 12, 13	INCONTROL PEN NEEDLE 8MM 31G 178, 183, 184
HUMIRA(CF)..... 11, 12, 13	INCRELEX..... 221
HUMIRA(CF) PEDI CROHNS STARTER 11, 12, 13	indomethacin oral capsule 162
HUMIRA(CF) PEN 11, 12, 13	infliximab 172, 173
HUMIRA(CF) PEN CROHNS-UC-HS... 11, 12, 13	INGREZZA..... 392
HUMIRA(CF) PEN PEDIATRIC UC11, 12, 13	INGREZZA INITIATION PK(TARDIV) 392
	INGREZZA SPRINKLE 392
	INLYTA ORAL TABLET 1 MG, 5 MG.. 39
	INQOVI..... 83
	INREBIC..... 124
	INSULIN 1 ML SYRINGE 178, 183, 184
	INSULIN SYR 0.3 ML 31GX1/4(1/2)... 178, 183, 184
	INSULIN SYR 0.5 ML 28G 12.7MM (OTC) 178, 183, 184
	INSULIN SYRIN 0.5 ML 30GX1/2 178, 183, 184



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

INSULIN SYRINGE 0.5 ML 27G 1/2.....	178, 183, 184
INSULIN SYRINGE 0.3 ML..	178, 183, 184
INSULIN SYRINGE 0.3 ML 31GX1/4.	178, 183, 184
INSULIN SYRINGE 0.5 ML..	178, 183, 184
INSULIN SYRINGE 0.5 ML 31GX1/4.	178, 183, 184
INSULIN SYRINGE 1 ML.....	178, 183, 184
INSULIN SYRINGE 1 ML 27G 1/2.....	178, 183, 184
INSULIN SYRINGE 1 ML 27G 16MM	178, 183, 184
INSULIN SYRINGE 1 ML 28G 12.7MM (OTC).....	178, 183, 184
INSULIN SYRINGE 1 ML 30GX1/2....	178, 183, 184
INSULIN SYRINGE 1 ML 31GX1/4....	178, 183, 184
INSULIN SYRINGE NEEDLELESS....	178, 183, 184
INSULIN SYRINGE-NEEDLE U-100 SYRINGE 0.3 ML 29 GAUGE, 1 ML 29 GAUGE X 1/2	178, 183, 184
INSULIN U-500 SYRINGE-NEEDLE .	178, 183, 184
INSUPEN 30G ULTRAFIN NEEDLE..	178, 183, 184
INSUPEN 31G ULTRAFIN NEEDLE..	178, 183, 184
INSUPEN 32G 8MM PEN NEEDLE....	178, 183, 184
INSUPEN PEN NEEDLE 29GX12MM	178, 183, 184
INSUPEN PEN NEEDLE 31G 8MM....	178, 183, 184
INSUPEN PEN NEEDLE 31GX3/16....	178, 183, 184
INSUPEN PEN NEEDLE 32G 6MM (RX)	178, 183, 184
INSUPEN PEN NEEDLE 32GX4MM..	178, 183, 184
INSUPEN PEN NEEDLE 33GX4MM..	178, 183, 184
ITOVEBI ORAL TABLET 3 MG, 9 MG	171
IV ANTISEPTIC WIPES	178, 183, 184
IWILFIN.....	101
J	
JAKAFI	306
javygtor oral tablet,soluble	307
JAYPIRCA ORAL TABLET 100 MG, 50 MG.....	275
JEMPERLI	94
K	
KALYDECO.....	191
KENDALL ALCOHOL 70% PREP PAD	178, 183, 184
KERENDIA	129
KESIMPTA PEN	249
ketorolac oral.....	156
KEYTRUDA.....	268
KIMMTRAK.....	338
KINERET.....	23, 24
KISQALI FEMARA CO-PACK ORAL TABLET 200 MG/DAY(200 MG X 1)-2.5 MG, 400 MG/DAY(200 MG X 2)-2.5 MG, 600 MG/DAY(200 MG X 3)-2.5 MG.....	291
KISQALI ORAL TABLET 200 MG/DAY (200 MG X 1), 400 MG/DAY (200 MG X 2), 600 MG/DAY (200 MG X 3).....	290
KOSELUGO ORAL CAPSULE 10 MG, 25 MG.....	315
KRAZATI	10
KYNMOBI SUBLINGUAL FILM 10 MG, 10-15-20-25-30 MG, 15 MG, 20 MG, 25 MG, 30 MG	27
L	
lanreotide subcutaneous syringe 120 mg/0.5 ml.....	194
lapatinib	195
LAZCLUZE ORAL TABLET 240 MG, 80 MG.....	197
lenalidomide.....	199
LENVIMA	200
leuprolide acetate (3 month)	203
leuprolide subcutaneous kit	202



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

lidocaine topical adhesive patch,medicated 5 %.....	210	LUNSUMIO.....	231
lidocaine topical ointment	209	LUPRON DEPOT.....	205, 206
lidocaine-prilocaine topical cream	211	LUPRON DEPOT (3 MONTH).....	205, 206
lidocan iii.....	210	LUPRON DEPOT (4 MONTH).....	205, 206
LISCO SPONGES 100/BAG ..	178, 183, 184	LUPRON DEPOT (6 MONTH).....	205, 206
LITE TOUCH 31GX1/4.....	178, 183, 184	LUPRON DEPOT-PED (3 MONTH).....	207
LITE TOUCH INSULIN 0.5 ML SYR..	178, 183, 184	LUPRON DEPOT-PED	
LITE TOUCH INSULIN 1 ML SYR.....	178, 183, 184	INTRAMUSCULAR SYRINGE KIT	207
LITE TOUCH INSULIN SYR 1 ML.....	178, 183, 184	LUTRATE DEPOT (3 MONTH).....	203
LITE TOUCH PEN NEEDLE 29G	178, 183, 184	LYBALVI	250
LITE TOUCH PEN NEEDLE 31G	178, 183, 184	LYNOZYFIC INTRAVENOUS	
LITETOUCH INS 0.3 ML 29GX1/2	178, 183, 184	SOLUTION 2 MG/ML, 20 MG/ML...	212
LITETOUCH INS 0.3 ML 30GX5/16 ...	178, 183, 184	LYNPARZA.....	251
LITETOUCH INS 0.3 ML 31GX5/16 ...	178, 183, 184	LYTGOBI ORAL TABLET 12 MG/DAY	
LITETOUCH INS 0.5 ML 31GX5/16 ...	178, 183, 184	(4 MG X 3), 16 MG/DAY (4 MG X 4),	
LITETOUCH SYR 0.5 ML 28GX1/2.....	178, 183, 184	20 MG/DAY (4 MG X 5).....	134
LITETOUCH SYR 0.5 ML 29GX1/2.....	178, 183, 184	M	
LITETOUCH SYR 0.5 ML 30GX5/16..	178, 183, 184	MAGELLAN INSUL SYRINGE 0.3 ML	
LITETOUCH SYRIN 1 ML 28GX1/2 ..	178, 183, 184		179, 183, 184
LITETOUCH SYRIN 1 ML 29GX1/2 ..	178, 183, 184	MAGELLAN INSUL SYRINGE 0.5 ML	
LITETOUCH SYRIN 1 ML 30GX5/16	179, 183, 184		179, 183, 184
LIVTENCITY.....	219	MAGELLAN INSULIN SYR 0.3 ML...	179, 183, 184
LONSURF ORAL TABLET 15-6.14 MG,			179, 183, 184
20-8.19 MG.....	375	MAGELLAN INSULIN SYR 0.5 ML...	179, 183, 184
LOQTORZI.....	363	MAGELLAN INSULIN SYRINGE 1 ML	
LORBRENA ORAL TABLET 100 MG, 25			179, 183, 184
MG	214	MARGENZA	218
LUMAKRAS ORAL TABLET 120 MG,		MAVENCLAD (10 TABLET PACK).....	70
240 MG, 320 MG	328	MAVENCLAD (4 TABLET PACK).....	70
		MAVENCLAD (5 TABLET PACK).....	70
		MAVENCLAD (6 TABLET PACK).....	70
		MAVENCLAD (7 TABLET PACK).....	70
		MAVENCLAD (8 TABLET PACK).....	70
		MAVENCLAD (9 TABLET PACK).....	70
		MAXICOMFORT II PEN NDL 31GX6MM	
			179, 183, 184
		MAXICOMFORT INS 0.5 ML 27GX1/2	
			179, 183, 184
		MAXI-COMFORT INS 0.5 ML 28G	179, 183, 184
		MAXICOMFORT INS 1 ML 27GX1/2.	179, 183, 184
		MAXI-COMFORT INS 1 ML 28GX1/2	179, 183, 184



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

MAXICOMFORT PEN NDL 29G X 5MM 179, 183, 184	MIPLYFFA 30
MAXICOMFORT PEN NDL 29G X 8MM 179, 183, 184	modafinil oral tablet 100 mg, 200 mg 232
MAYZENT ORAL TABLET 0.25 MG, 1 MG, 2 MG..... 317	MODEYSO 93
MAYZENT STARTER(FOR 1MG MAINT)..... 317	MONOJECT 0.5 ML SYRN 28GX1/2 .. 179, 183, 184
MAYZENT STARTER(FOR 2MG MAINT)..... 317	MONOJECT 1 ML SYRN 27X1/2 179, 183, 184
megestrol oral suspension 400 mg/10 ml (40 mg/ml), 625 mg/5 ml (125 mg/ml) 163	MONOJECT 1 ML SYRN 28GX1/2 179, 183, 184
megestrol oral tablet 163	MONOJECT INSUL SYR U100 (OTC) 179, 183, 184
MEKINIST ORAL RECON SOLN..... 365	MONOJECT INSUL SYR U100 .5ML,29GX1/2..... 179, 183, 184
MEKINIST ORAL TABLET 0.5 MG, 2 MG 366	MONOJECT INSUL SYR U100 0.5 ML CONVERTS TO 29G (OTC) 179, 183, 184
MEKTOVI 54	MONOJECT INSUL SYR U100 1 ML . 179, 183, 184
methocarbamol oral tablet 500 mg, 750 mg 160	MONOJECT INSUL SYR U100 1 ML 3'S, 29GX1/2..... 179, 183, 184
MICRODOT PEN NEEDLE 31GX6MM 179, 183, 184	MONOJECT INSUL SYR U100 1 ML W/O NEEDLE (OTC) 179, 183, 184
MICRODOT PEN NEEDLE 32GX4MM 179, 183, 184	MONOJECT INSULIN SYR 0.3 ML 179, 183, 184
MICRODOT PEN NEEDLE 33GX4MM 179, 183, 184	MONOJECT INSULIN SYR 0.3 ML (OTC) 179, 183, 184
MICRODOT READYGARD NDL 31G 5MM OUTER..... 179, 183, 184	MONOJECT INSULIN SYR 0.5 ML 179, 183, 184
mifepristone oral tablet 300 mg..... 226	MONOJECT INSULIN SYR 0.5 ML (OTC) 179, 183, 184
mimvey..... 152	MONOJECT INSULIN SYR 1 ML 3'S (OTC)..... 179, 183, 184
MINI PEN NEEDLE 32G 4MM.... 179, 183, 184	MONOJECT INSULIN SYR U-100..... 179, 183, 184
MINI PEN NEEDLE 32G 5MM.... 179, 183, 184	MONOJECT SYRINGE 0.3 ML.... 179, 183, 184
MINI PEN NEEDLE 32G 6MM.... 179, 183, 184	MONOJECT SYRINGE 0.5 ML.... 179, 183, 184
MINI PEN NEEDLE 32G 8MM.... 179, 183, 184	MONOJECT SYRINGE 1 ML 179, 183, 184
MINI PEN NEEDLE 33G 4MM.... 179, 183, 184	morphine concentrate oral solution 147
MINI PEN NEEDLE 33G 5MM.... 179, 183, 184	MOUNJARO..... 143
MINI PEN NEEDLE 33G 6MM.... 179, 183, 184	MS INSULIN SYR 1 ML 31GX5/16..... 179, 183, 184
MINI ULTRA-THIN II PEN NDL 31G STERILE..... 179, 183, 184	MS INSULIN SYRINGE 0.3 ML .. 179, 183, 184



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

MVASI.....	51	OPDIVO QVANTIG	244
N		OPDUALAG.....	245
NANO 2 GEN PEN NEEDLE 32G 4MM		OPSUMIT	217
.....	179, 183, 184	ORENCIA	4, 5
NANO PEN NEEDLE 32G 4MM .	179, 183, 184	ORENCIA (WITH MALTOSE)	2, 3
		ORENCIA CLICKJECT.....	4, 5
NATPARA.....	261	ORFADIN ORAL SUSPENSION	242
NERLYNX.....	234	ORGOVYX.....	284
NEULASTA ONPRO.....	265	ORLISSA ORAL TABLET 150 MG, 200	
NIKTIMVO	38	MG.....	103
NINLARO.....	193	ORKAMBI ORAL TABLET	216
nitisinone	242	ORSERDU ORAL TABLET 345 MG, 86	
NIVESTYM.....	128	MG.....	102
NORDITROPIN FLEXPPO	322, 323	OSENVELT	86
NOVOFINE 30	179, 183, 184	OTEZLA	28, 29
NOVOFINE 32G NEEDLES..	179, 183, 184	OTEZLA STARTER	28, 29
NOVOFINE PLUS PEN NDL 32GX1/6179,		oxandrolone	258
183, 184		OZEMPIC	142
NOVOTWIST.....	179, 183, 184	P	
NUBEQA	80	paroxetine hcl oral suspension.....	164
NUCALA SUBCUTANEOUS AUTO-		paroxetine hcl oral tablet.....	164
INJECTOR.....	223, 224	pazopanib.....	263
NUCALA SUBCUTANEOUS RECON		PC UNIFINE PENTIPS 8MM NEEDLE	
SOLN	223, 224	SHORT.....	179, 183, 184
NUCALA SUBCUTANEOUS SYRINGE		PEGASYS	266
100 MG/ML, 40 MG/0.4 ML.....	223, 224	PEMAZYRE	269
NUPLAZID.....	273	PEN NEEDLE 30G 5MM OUTER	179, 183,
NURTEC ODT	295	184	
NYVEPRIA	264	PEN NEEDLE 30G 8MM INNER.	179, 183,
O		184	
OCREVUS.....	247	PEN NEEDLE 30G X 5/16	179, 183, 184
OCREVUS ZUNOVO.....	248	PEN NEEDLE 31G X 1/4	179, 183, 184
ODOMZO	325	PEN NEEDLE 6MM 31G 6MM....	179, 183,
OFEV	237, 238	184	
OGIVRI.....	367	PEN NEEDLE, DIABETIC NEEDLE 29	
OGSIVEO ORAL TABLET 100 MG, 150		GAUGE X 1/2.....	179, 183, 184
MG, 50 MG.....	241	PEN NEEDLES 12MM 29G	
OJEMDA ORAL SUSPENSION FOR		29GX12MM,STRL.....	179, 183, 184
RECONSTITUTION.....	364	PEN NEEDLES 4MM 32G	179, 183, 184
OJEMDA ORAL TABLET.....	364	PEN NEEDLES 5MM 31G	
OJJAARA	230	31GX5MM,STRL,MINI (OTC).179, 183,	
ONAPGO.....	26	184	
ONTRUZANT	368	PEN NEEDLES 8MM 31G	
ONUREG.....	40	31GX8MM,STRL,SHORT (OTC).....	179,
OPDIVO.....	243	183, 184	



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

penicillamine oral tablet	270, 271	PRO COMFORT 0.5 ML 30GX1/2	180, 183, 184
PENTIPS PEN NEEDLE 29G 1/2.	179, 183, 184	PRO COMFORT 0.5 ML 30GX5/16	180, 183, 184
PENTIPS PEN NEEDLE 31G 1/4.	179, 183, 184	PRO COMFORT 0.5 ML 31GX5/16	180, 183, 184
PENTIPS PEN NEEDLE 31GX3/16	179, 183, 184	PRO COMFORT 1 ML 30GX1/2 ..	180, 183, 184
PENTIPS PEN NEEDLE 31GX5/16	179, 183, 184	PRO COMFORT 1 ML 30GX5/16	180, 183, 184
PENTIPS PEN NEEDLE 32G 1/4.	179, 183, 184	PRO COMFORT 1 ML 31GX5/16	180, 183, 184
PENTIPS PEN NEEDLE 32GX5/32	179, 183, 184	PRO COMFORT ALCOHOL 70% PADS	180, 183, 184
phenobarbital.....	157	PRO COMFORT PEN NDL 32G 8MM	180, 183, 184
PIP PEN NEEDLE 31G X 5MM...	179, 183, 184	PRO COMFORT PEN NDL 32G X 1/4	180, 183, 184
PIP PEN NEEDLE 32G X 4MM...	180, 183, 184	PRO COMFORT PEN NDL 4MM 32G	180, 183, 184
PIQRAY ORAL TABLET 200 MG/DAY (200 MG X 1), 250 MG/DAY (200 MG X1-50 MG X1), 300 MG/DAY (150 MG X 2).....	20	PRO COMFORT PEN NDL 5MM 32G	180, 183, 184
pirfenidone oral capsule.....	274	PRODIGY INS SYR 1 ML 28GX1/2	180, 183, 184
pirfenidone oral tablet 267 mg, 534 mg, 801 mg.....	274	PRODIGY SYRNG 0.5 ML 31GX5/16.	180, 183, 184
PLEGRIDY SUBCUTANEOUS PEN INJECTOR 125 MCG/0.5 ML, 63 MCG/0.5 ML- 94 MCG/0.5 ML	187	PRODIGY SYRNGE 0.3 ML 31GX5/16	180, 183, 184
PLEGRIDY SUBCUTANEOUS SYRINGE 125 MCG/0.5 ML, 63 MCG/0.5 ML- 94 MCG/0.5 ML	187	promethazine injection solution 25 mg/ml	158
POMALYST	276	promethazine oral tablet.....	158
posaconazole oral tablet,delayed release (dr/ec).....	278	promethazine rectal suppository 25 mg...	158
PREFPLS INS SYR 1 ML 30GX5/16 ...	180, 183, 184	promethagan rectal suppository 12.5 mg, 25 mg	158
PREMARIN ORAL.....	149	PURE CMFT SFTY PEN NDL 31G 5MM	180, 183, 184
PREMPHASE.....	154	PURE CMFT SFTY PEN NDL 31G 6MM	180, 183, 184
PREMPRO	154	PURE CMFT SFTY PEN NDL 32G 4MM	180, 183, 184
PREVENT PEN NEEDLE 31GX1/4.....	180, 183, 184	PURE COMFORT ALCOHOL 70% PADS	180, 183, 184
PREVENT PEN NEEDLE 31GX5/16...	180, 183, 184	PURE COMFORT PEN NDL 32G 4MM	180, 183, 184
PREVYMIS ORAL TABLET.....	201		



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

PURE COMFORT PEN NDL 32G 5MM	180, 183, 184
PURE COMFORT PEN NDL 32G 6MM	180, 183, 184
PURE COMFORT PEN NDL 32G 8MM	180, 183, 184
pyrimethamine	280
Q	
QINLOCK.....	297
quinine sulfate	281
QULIPTA.....	34
R	
RALDESY	372
RAYA SURE PEN NEEDLE 29G 12MM	180, 183, 184
RAYA SURE PEN NEEDLE 31G 4MM	180, 183, 184
RAYA SURE PEN NEEDLE 31G 5MM	180, 183, 184
RAYA SURE PEN NEEDLE 31G 6MM	180, 183, 184
RELION INS SYR 0.3 ML 31GX6MM	180, 183, 184
RELION INS SYR 0.5 ML 31GX6MM	180, 183, 184
RELION INS SYR 1 ML 31GX15/64 ...	180, 183, 184
RELI-ON INSULIN 1 ML SYR	180, 183, 184
RETACRIT INJECTION SOLUTION	
10,000 UNIT/ML, 2,000 UNIT/ML,	
20,000 UNIT/2 ML, 20,000 UNIT/ML,	
3,000 UNIT/ML, 4,000 UNIT/ML,	
40,000 UNIT/ML.....	113, 114
RETEVMO ORAL CAPSULE 40 MG, 80	
MG	314
RETEVMO ORAL TABLET 120 MG, 160	
MG, 40 MG, 80 MG	314
REVUFORJ ORAL TABLET 110 MG, 160	
MG, 25 MG.....	289
REZLIDHIA	252
REZUROCK	44
RIABNI.....	302
RINVOQ	379, 380
RINVOQ LQ.....	379, 380
RITUXAN HYCELA	300
ROMVIMZA.....	399
ROZLYTREK ORAL CAPSULE 100 MG,	
200 MG	109
ROZLYTREK ORAL PELLETS IN	
PACKET	110
RUBRACA.....	305
RUXIENCE.....	303
RYBELSUS	142
RYBREVANT	22
RYDAPT	225
RYTELO	170
S	
SAFESNAP INS SYR UNITS-100 0.3 ML	
30GX5/16.....	180, 183, 184
SAFESNAP INS SYR UNITS-100 0.5 ML	
29GX1/2.....	180, 183, 184
SAFESNAP INS SYR UNITS-100 0.5 ML	
30GX5/16.....	180, 183, 184
SAFESNAP INS SYR UNITS-100 1 ML	
28GX1/2.....	180, 183, 184
SAFESNAP INS SYR UNITS-100 1 ML	
29GX1/2.....	180, 183, 184
SAFETY PEN NEEDLE 31G 4MM.....	180, 183, 184
SAFETY PEN NEEDLE 5MM X 31G ..	180, 183, 184
SAFETY SYRINGE 0.5 ML 30G 1/2....	180, 183, 184
sapropterin oral tablet,soluble.....	307
SCEMBLIX ORAL TABLET 100 MG, 20	
MG, 40 MG	31
scopolamine base	159
SECURESAFE PEN NDL 30GX5/16 ...	180, 183, 184
SECURESAFE SYR 0.5 ML 29G 1/2 ...	180, 183, 184
SECURESAFE SYRNG 1 ML 29G 1/2	180, 183, 184
SELARSDI.....	384, 385, 386, 387
SEROSTIM SUBCUTANEOUS RECON	
SOLN 4 MG, 5 MG, 6 MG	324
SIGNIFOR	262
sildenafil (pulm.hypertension) oral tablet	316
SIRTURO.....	42



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

SKY SAFETY PEN NEEDLE 30G 5MM
..... 180, 183, 184
SKY SAFETY PEN NEEDLE 30G 8MM
..... 180, 183, 184
SKYRIZI..... 298, 299
SM ULT CFT 0.3 ML 31GX5/16(1/2) .. 180,
183, 184
sodium oxybate..... 319
SOMATULINE DEPOT
SUBCUTANEOUS SYRINGE 60
MG/0.2 ML, 90 MG/0.3 ML..... 194
SOMAVERT..... 267
sorafenib..... 326
SPRAVATO..... 118
STELARA..... 381, 382, 383
STERILE PADS 2 180, 183, 184
STIVARGA 283
STRENSIQ..... 32, 33
sunitinib malate..... 330
SURE CMFT SFTY PEN NDL 31G 6MM
..... 180, 183, 184
SURE CMFT SFTY PEN NDL 32G 4MM
..... 180, 183, 184
SURE COMFORT 0.5 ML SYRINGE.. 180,
183, 184
SURE COMFORT 1 ML SYRINGE..... 180,
183, 184
SURE COMFORT 3/10 ML SYRINGE 180,
183, 184
SURE COMFORT 3/10 ML SYRINGE
INSULIN SYRINGE..... 180, 183, 184
SURE COMFORT 30G PEN NEEDLE 180,
183, 184
SURE COMFORT ALCOHOL PREP
PADS 180, 183, 184
SURE COMFORT INS 0.3 ML 31GX1/4
..... 180, 183, 184
SURE COMFORT INS 0.5 ML 31GX1/4
..... 180, 183, 184
SURE COMFORT INS 1 ML 31GX1/4 180,
183, 184
SURE COMFORT PEN NDL 29GX1/2 180,
183, 184
SURE COMFORT PEN NDL 31G 5MM
..... 180, 183, 184

SURE COMFORT PEN NDL 31G 8MM
..... 180, 183, 184
SURE COMFORT PEN NDL 32G 4MM
..... 180, 183, 184
SURE COMFORT PEN NDL 32G 6MM
..... 180, 183, 184
SURE-FINE PEN NEEDLES 12.7MM. 180,
183, 184
SURE-FINE PEN NEEDLES 5MM 180,
183, 184
SURE-FINE PEN NEEDLES 8MM 180,
183, 184
SURE-JECT INSU SYR U100 0.3 ML . 180,
183, 184
SURE-JECT INSU SYR U100 0.5 ML . 180,
183, 184
SURE-JECT INSU SYR U100 1 ML 180,
183, 184
SURE-JECT INSUL SYR U100 1 ML .. 180,
183, 184
SURE-JECT INSULIN SYRINGE 1 ML
..... 180, 183, 184
SURE-PREP ALCOHOL PREP PADS. 180,
183, 184
SYMPAZAN..... 71
SYNRIBO 253
T
TABRECTA..... 64
tadalafil oral tablet 2.5 mg, 5 mg..... 332
TAFINLAR ORAL CAPSULE..... 76
TAFINLAR ORAL TABLET FOR
SUSPENSION 77
TAGRISSO 257
TALVEY 335
TALZENNA..... 333
TASIGNA ORAL CAPSULE 150 MG, 200
MG, 50 MG..... 235
TAVNEOS 35
TAZVERIK..... 337
TECHLITE 0.3 ML 29GX12MM (1/2) . 180,
183, 184
TECHLITE 0.3 ML 30GX8MM (1/2) ... 180,
183, 184
TECHLITE 0.3 ML 31GX6MM (1/2) ... 180,
183, 184



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

TECHLITE 0.3 ML 31GX8MM (1/2)... 180, 183, 184	TERUMO INS SYRINGE U100-1/3 ML181, 183, 184
TECHLITE 0.5 ML 30GX12MM (1/2). 180, 183, 184	TERUMO INS SYRNG U100-1/2 ML.. 181, 183, 184
TECHLITE 0.5 ML 30GX8MM (1/2)... 181, 183, 184	testosterone cypionate 345
TECHLITE 0.5 ML 31GX6MM (1/2)... 181, 183, 184	testosterone enanthate 346
TECHLITE 0.5 ML 31GX8MM (1/2)... 181, 183, 184	testosterone transdermal gel in metered-dose pump 12.5 mg/ 1.25 gram (1 %), 20.25 mg/1.25 gram (1.62 %)... 344
TECHLITE INS SYR 1 ML 29GX12MM 181, 183, 184	testosterone transdermal gel in packet 1 % (25 mg/2.5gram), 1 % (50 mg/5 gram) 344
TECHLITE INS SYR 1 ML 30GX12MM 181, 183, 184	tetrabenazine..... 347
TECHLITE INS SYR 1 ML 31GX6MM 181, 183, 184	TEVIMBRA..... 349
TECHLITE INS SYR 1 ML 31GX8MM 181, 183, 184	THALOMID..... 348
TECHLITE PEN NEEDLE 29GX1/2.... 181, 183, 184	THINPRO INS SYRIN U100-0.3 ML... 181, 183, 184
TECHLITE PEN NEEDLE 29GX3/8.... 181, 183, 184	THINPRO INS SYRIN U100-0.5 ML... 181, 183, 184
TECHLITE PEN NEEDLE 31GX1/4.... 181, 183, 184	THINPRO INS SYRIN U100-1 ML 181, 183, 184
TECHLITE PEN NEEDLE 31GX3/16.. 181, 183, 184	TIBSOVO..... 192
TECHLITE PEN NEEDLE 31GX5/16.. 181, 183, 184	TIVDAK..... 350
TECHLITE PEN NEEDLE 32GX1/4.... 181, 183, 184	tolvaptan (polycys kidney dis) oral tablet 361
TECHLITE PEN NEEDLE 32GX5/16.. 181, 183, 184	tolvaptan (polycys kidney dis) oral tablets, sequential..... 361
TECHLITE PEN NEEDLE 32GX5/32.. 181, 183, 184	TOPCARE CLICKFINE 31G X 1/4 181, 183, 184
TECHLITE PLUS PEN NDL 32G 4MM 181, 183, 184	TOPCARE CLICKFINE 31G X 5/16 181, 183, 184
TECVAYLI..... 339	TOPCARE ULTRA COMFORT SYRINGE 181, 183, 184
TEPMETKO 342	torpenz oral tablet 10 mg, 2.5 mg, 5 mg, 7.5 mg..... 121
teriparatide subcutaneous pen injector 20 mcg/dose (560mcg/2.24ml)..... 343	TRAZIMERA 371
TERUMO INS SYRINGE U100-1 ML. 181, 183, 184	TRELSTAR INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION 376
TERUMO INS SYRINGE U100-1/2 ML 181, 183, 184	TREMFYA INTRAVENOUS..... 145, 146
	TREMFYA ONE-PRESS 145, 146
	TREMFYA PEN INDUCTION PK- CROHN..... 145, 146
	TREMFYA PEN SUBCUTANEOUS PEN INJECTOR 200 MG/2 ML..... 145, 146
	TREMFYA SUBCUTANEOUS SYRINGE 145, 146



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

tretinoin topical cream	362	TRUE COMFORT PRO 1 ML 30G 1/2	181, 183, 184
trientine oral capsule 250 mg	374	TRUE COMFORT PRO 1 ML 30G 5/16	181, 183, 184
TRUE CMFRT PRO 0.5 ML 30G 5/16.	181, 183, 184	TRUE COMFORT PRO 1 ML 31G 5/16	181, 183, 184
TRUE CMFRT PRO 0.5 ML 31G 5/16.	181, 183, 184	TRUE COMFORT PRO 1 ML 32G 5/16	181, 183, 184
TRUE CMFRT PRO 0.5 ML 32G 5/16.	181, 183, 184	TRUE COMFORT PRO ALCOHOL PADS	181, 183, 184
TRUE CMFT SFTY PEN NDL 31G 5MM	181, 183, 184	TRUE COMFORT SFTY 1 ML 30G 1/2	181, 183, 184
TRUE CMFT SFTY PEN NDL 31G 6MM	181, 183, 184	TRUE COMFRT PRO 0.5 ML 30G 1/2	181, 183, 184
TRUE CMFT SFTY PEN NDL 32G 4MM	181, 183, 184	TRUE COMFRT SFTY 1 ML 30G 5/16	181, 183, 184
TRUE COMFORT 0.5 ML 30G 1/2	181, 183, 184	TRUE COMFRT SFTY 1 ML 31G 5/16	181, 183, 184
TRUE COMFORT 0.5 ML 30G 5/16	181, 183, 184	TRUE COMFRT SFTY 1 ML 32G 5/16	181, 183, 184
TRUE COMFORT 0.5 ML 31G 5/16	181, 183, 184	TRUEPLUS PEN NEEDLE 29GX1/2...	181, 183, 184
TRUE COMFORT 0.5 ML 31GX5/16..	181, 183, 184	TRUEPLUS PEN NEEDLE 31G X 1/4.	181, 183, 184
TRUE COMFORT 1 ML 31GX5/16	181, 183, 184	TRUEPLUS PEN NEEDLE 31GX3/16.	181, 183, 184
TRUE COMFORT ALCOHOL 70% PADS	181, 183, 184	TRUEPLUS PEN NEEDLE 31GX5/16.	181, 183, 184
TRUE COMFORT PEN NDL 31G 8MM	181, 183, 184	TRUEPLUS PEN NEEDLE 32GX5/32.	181, 183, 184
TRUE COMFORT PEN NDL 31GX5MM	181, 183, 184	TRUEPLUS SYR 0.3 ML 29GX1/2	181, 183, 184
TRUE COMFORT PEN NDL 31GX6MM	181, 183, 184	TRUEPLUS SYR 0.3 ML 30GX5/16	181, 183, 184
TRUE COMFORT PEN NDL 32G 5MM	181, 183, 184	TRUEPLUS SYR 0.3 ML 31GX5/16	181, 183, 184
TRUE COMFORT PEN NDL 32G 6MM	181, 183, 184	TRUEPLUS SYR 0.5 ML 28GX1/2	181, 183, 184
TRUE COMFORT PEN NDL 32GX4MM	181, 183, 184	TRUEPLUS SYR 0.5 ML 29GX1/2	181, 183, 184
TRUE COMFORT PEN NDL 33G 4MM	181, 183, 184	TRUEPLUS SYR 0.5 ML 30GX5/16	181, 183, 184
TRUE COMFORT PEN NDL 33G 5MM	181, 183, 184	TRUEPLUS SYR 0.5 ML 31GX5/16	181, 183, 184
TRUE COMFORT PEN NDL 33G 6MM	181, 183, 184		



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

TRUEPLUS SYR 1 ML 28GX1/2. 181, 183, 184	ULTICARE PEN NEEDLES 4MM 32G MICRO, 32GX4MM182, 183, 184
TRUEPLUS SYR 1 ML 29GX1/2. 181, 183, 184	ULTICARE PEN NEEDLES 6MM 32G182, 183, 184
TRUEPLUS SYR 1 ML 30GX5/16181, 183, 184	ULTICARE SAFE PEN NDL 30G 8MM182, 183, 184
TRUEPLUS SYR 1 ML 31GX5/16181, 183, 184	ULTICARE SAFE PEN NDL 5MM 30G182, 183, 184
TRULICITY..... 141	ULTICARE SAFETY 0.5 ML 29GX1/2 (RX).....182, 183, 184
TRUQAP..... 63	ULTICARE SYR 0.3 ML 29G 12.7MM182, 183, 184
TRUXIMA 301	ULTICARE SYR 0.3 ML 30GX1/2..... 182, 183, 184
TUKYSA ORAL TABLET 150 MG, 50 MG 377	ULTICARE SYR 0.3 ML 31GX5/16..... 182, 183, 184
TURALIO 272	ULTICARE SYR 0.5 ML 30GX1/2..... 182, 183, 184
TYENNE..... 356, 357, 358	ULTICARE SYR 0.5 ML 31GX5/16..... 182, 183, 184
TYENNE AUTOINJECTOR 356, 357	ULTIGUARD SAFE 1 ML 30G 12.7MM182, 183, 184
TYMLOS 1	ULTIGUARD SAFE0.3 ML 30G 12.7MM182, 183, 184
U	ULTIGUARD SAFE0.5 ML 30G 12.7MM182, 183, 184
UBRELVY 378	ULTIGUARD SAFEPACK 1 ML 31G 8MM.....182, 183, 184
ULTICAR INS 0.3 ML 31GX1/4(1/2) .. 181, 183, 184	ULTIGUARD SAFEPACK 29G 12.7MM182, 183, 184
ULTICARE INS 1 ML 31GX1/4... 181, 183, 184	ULTIGUARD SAFEPACK 31G 5MM. 182, 183, 184
ULTICARE INS SYR 0.3 ML 30G 8MM 181, 183, 184	ULTIGUARD SAFEPACK 31G 6MM. 182, 183, 184
ULTICARE INS SYR 0.3 ML 31G 6MM 181, 183, 184	ULTIGUARD SAFEPACK 31G 8MM. 182, 183, 184
ULTICARE INS SYR 0.3 ML 31G 8MM 181, 183, 184	ULTIGUARD SAFEPACK 32G 4MM. 182, 183, 184
ULTICARE INS SYR 0.5 ML 30G 8MM (OTC)..... 181, 183, 184	ULTIGUARD SAFEPACK 32G 6MM. 182, 183, 184
ULTICARE INS SYR 0.5 ML 31G 6MM 181, 183, 184	ULTIGUARD SAFEPAK 0.3 ML 31G 8MM182, 183, 184
ULTICARE INS SYR 0.5 ML 31G 8MM (OTC)..... 181, 183, 184	
ULTICARE INS SYR 1 ML 30GX1/2.. 181, 183, 184	
ULTICARE PEN NEEDLE 31GX3/16. 181, 183, 184	
ULTICARE PEN NEEDLE 6MM 31G. 181, 183, 184	
ULTICARE PEN NEEDLE 8MM 31G. 182, 183, 184	
ULTICARE PEN NEEDLES 12MM 29G 182, 183, 184	



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

ULTIGUARD SAFE PK 0.5 ML 31G 8MM 182, 183, 184	ULTRA FLO SYR 0.3 ML 31G 5/16 182, 183, 184
ULTILET ALCOHOL STERL SWAB . 182, 183, 184	ULTRA FLO SYR 0.5 ML 29G 1/2 182, 183, 184
ULTILET INSULIN SYRINGE 0.3 ML 182, 183, 184	ULTRA THIN PEN NDL 32G X 4MM 182, 183, 184
ULTILET INSULIN SYRINGE 0.5 ML 182, 183, 184	ULTRACARE INS 0.3 ML 30GX5/16.. 182, 183, 184
ULTILET INSULIN SYRINGE 1 ML .. 182, 183, 184	ULTRACARE INS 0.3 ML 31GX5/16.. 182, 183, 184
ULTILET PEN NEEDLE..... 182, 183, 184	ULTRACARE INS 0.5 ML 30GX1/2.... 182, 183, 184
ULTILET PEN NEEDLE 4MM 32G 182, 183, 184	ULTRACARE INS 0.5 ML 30GX5/16.. 182, 183, 184
ULTRA COMFORT 0.3 ML SYRINGE 182, 183, 184	ULTRACARE INS 0.5 ML 31GX5/16.. 182, 183, 184
ULTRA COMFORT 0.5 ML 28GX1/2 . 182, 183, 184	ULTRACARE INS 1 ML 30G X 5/16... 182, 183, 184
ULTRA COMFORT 0.5 ML 29GX1/2 . 182, 183, 184	ULTRACARE INS 1 ML 30GX1/2..... 182, 183, 184
ULTRA COMFORT 0.5 ML SYRINGE 182, 183, 184	ULTRACARE INS 1 ML 31G X 5/16... 183, 184
ULTRA COMFORT 1 ML 31GX5/16 .. 182, 183, 184	ULTRACARE PEN NEEDLE 31GX1/4 183, 184
ULTRA COMFORT 1 ML SYRINGE.. 182, 183, 184	ULTRACARE PEN NEEDLE 31GX3/16 183, 184
ULTRA FLO 0.3 ML 30G 1/2 182, 183, 184	ULTRACARE PEN NEEDLE 31GX5/16 183, 184
ULTRA FLO 0.3 ML 30G 5/16 182, 183, 184	ULTRACARE PEN NEEDLE 32GX1/4 183, 184
ULTRA FLO 0.3 ML 31G 5/16 182, 183, 184	ULTRACARE PEN NEEDLE 32GX3/16 183, 184
ULTRA FLO PEN NEEDLE 31G 5MM 182, 183, 184	ULTRACARE PEN NEEDLE 32GX5/32 183, 184
ULTRA FLO PEN NEEDLE 31G 8MM 182, 183, 184	ULTRACARE PEN NEEDLE 33GX5/32 183, 184
ULTRA FLO PEN NEEDLE 32G 4MM 182, 183, 184	ULTRA-FINE 0.3 ML 30G 12.7MM..... 182, 183, 184
ULTRA FLO PEN NEEDLE 33G 4MM 182, 183, 184	ULTRA-FINE 0.3 ML 31G 6MM (1/2). 182, 183, 184
ULTRA FLO PEN NEEDLES 12MM 29G 182, 183, 184	ULTRA-FINE 0.3 ML 31G 8MM (1/2). 182, 183, 184
ULTRA FLO SYR 0.3 ML 29GX1/2 182, 183, 184	ULTRA-FINE 0.5 ML 30G 12.7MM..... 182, 183, 184
ULTRA FLO SYR 0.3 ML 30G 5/16 182, 183, 184	



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

ULTRA-FINE INS SYR 1 ML 31G 6MM 182, 183, 184	UNIFINE PEN NEEDLE 32G 4MM..... 183, 184
ULTRA-FINE INS SYR 1 ML 31G 8MM 182, 183, 184	UNIFINE PENTIPS 12MM 29G 29GX12MM, STRL..... 183, 184
ULTRA-FINE PEN NDL 29G 12.7MM 182, 183, 184	UNIFINE PENTIPS 31GX3/16..... 183, 184
ULTRA-FINE PEN NEEDLE 31G 5MM 182, 183, 184	UNIFINE PENTIPS 32G 4MM 183, 184
ULTRA-FINE PEN NEEDLE 31G 8MM 182, 183, 184	UNIFINE PENTIPS 32GX1/4..... 183, 184
ULTRA-FINE PEN NEEDLE 32G 6MM 182, 183, 184	UNIFINE PENTIPS 33GX5/32..... 183, 184
ULTRA-FINE SYR 0.3 ML 31G 8MM 182, 183, 184	UNIFINE PENTIPS 6MM 31G 183, 184
ULTRA-FINE SYR 0.5 ML 31G 6MM 182, 183, 184	UNIFINE PENTIPS MAX 30GX3/16... 183, 184
ULTRA-FINE SYR 0.5 ML 31G 8MM 182, 183, 184	UNIFINE PENTIPS NEEDLES 29G..... 183, 184
ULTRA-FINE SYR 1 ML 30G 12.7MM 182, 183, 184	UNIFINE PENTIPS PLUS 29GX1/2..... 183, 184
ULTRA-THIN II 1 ML 31GX5/16 182, 183, 184	UNIFINE PENTIPS PLUS 30GX3/16... 183, 184
ULTRA-THIN II INS 0.3 ML 30G 182, 183, 184	UNIFINE PENTIPS PLUS 31GX1/4..... 183, 184
ULTRA-THIN II INS 0.3 ML 31G 182, 183, 184	UNIFINE PENTIPS PLUS 31GX3/16... 183, 184
ULTRA-THIN II INS 0.5 ML 29G 182, 183, 184	UNIFINE PENTIPS PLUS 31GX5/16... 183, 184
ULTRA-THIN II INS 0.5 ML 30G 182, 183, 184	UNIFINE PENTIPS PLUS 32GX5/32... 183, 184
ULTRA-THIN II INS 0.5 ML 31G 182, 183, 184	UNIFINE PENTIPS PLUS 33GX5/32... 183, 184
ULTRA-THIN II INS SYR 1 ML 29G.. 182, 183, 184	UNIFINE PROTECT 30G 5MM 183, 184
ULTRA-THIN II INS SYR 1 ML 30G.. 182, 183, 184	UNIFINE PROTECT 30G 8MM 183, 184
ULTRA-THIN II PEN NDL 29GX1/2 .. 182, 183, 184	UNIFINE PROTECT 32G 4MM 183, 184
ULTRA-THIN II PEN NDL 31GX5/16 182, 183, 184	UNIFINE SAFECONTROL 30G 5MM 183, 184
UNIFINE OTC PEN NEEDLE 31G 5MM 183, 184	UNIFINE SAFECONTROL 30G 8MM 183, 184
UNIFINE OTC PEN NEEDLE 32G 4MM 183, 184	UNIFINE SAFECONTROL 31G 5MM 183, 184
	UNIFINE SAFECONTROL 31G 6MM 183, 184
	UNIFINE SAFECONTROL 31G 8MM 183, 184
	UNIFINE SAFECONTROL 32G 4MM 183, 184
	UNIFINE ULTRA PEN NDL 31G 5MM 183, 184



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

UNIFINE ULTRA PEN NDL 31G 6MM	183, 184
UNIFINE ULTRA PEN NDL 31G 8MM	183, 184
UNIFINE ULTRA PEN NDL 32G 4MM	183, 184
UPTRAVI INTRAVENOUS	312
UPTRAVI ORAL TABLET 1,000 MCG, 1,200 MCG, 1,400 MCG, 1,600 MCG, 200 MCG, 400 MCG, 600 MCG, 800 MCG.....	312
UPTRAVI ORAL TABLETS,DOSE PACK	312
V	
VALCHLOR.....	222
VANFLYTA	282
VANISHPOINT 0.5 ML 30GX1/2. 183, 184	
VANISHPOINT INS 1 ML 30GX3/16.. 183, 184	
VANISHPOINT U-100 29X1/2 SYR.... 183, 184	
VEGZELMA.....	50
VENCLEXTA ORAL TABLET 10 MG, 100 MG, 50 MG	396
VENCLEXTA STARTING PACK	396
VEOZAH	127
VERIFINE INS SYR 1 ML 29G 1/2 183, 184	
VERIFINE PEN NEEDLE 29G 12MM 183, 184	
VERIFINE PEN NEEDLE 31G 5MM .. 183, 184	
VERIFINE PEN NEEDLE 31G X 6MM	183, 184
VERIFINE PEN NEEDLE 31G X 8MM	183, 184
VERIFINE PEN NEEDLE 32G 6MM .. 183, 184	
VERIFINE PEN NEEDLE 32G X 4MM	183, 184
VERIFINE PEN NEEDLE 32G X 5MM	183, 184
VERIFINE PLUS PEN NDL 31G 5MM183, 184	
VERIFINE PLUS PEN NDL 31G 8MM183, 184	
VERIFINE PLUS PEN NDL 32G 4MM183, 184	
VERIFINE PLUS PEN NDL 32G 4MM-SHARPS CONTAINER	183, 184
VERIFINE SYRING 0.5 ML 29G 1/2... 183, 184	
VERIFINE SYRING 1 ML 31G 5/16.... 183, 184	
VERIFINE SYRNG 0.3 ML 31G 5/16 ..183, 184	
VERIFINE SYRNG 0.5 ML 31G 5/16 ..183, 184	
VERQUVO	397
VERSALON ALL PURPOSE SPONGE 25'S,N-STERILE,3PLY.....	183, 184
VERZENIO.....	6
vigabatrin.....	398
vigadrone.....	398
vigpoder.....	398
VITRAKVI ORAL CAPSULE 100 MG, 25 MG.....	196
VITRAKVI ORAL SOLUTION.....	196
VIVIMUSTA	46
VIZIMPRO.....	78
VONJO.....	259
VORANIGO.....	401
voriconazole oral suspension for reconstitution.....	402
VOSEVI	321
VOWST.....	123
VUMERITY.....	92
VYALEV.....	131
VYLOY	406
W	
WEBCOL ALCOHOL PREPS 20'S,LARGE	183, 184
WELIREG	45
WINREVAIR.....	327
X	
XALKORI ORAL CAPSULE.....	74
XALKORI ORAL PELLETT 150 MG, 20 MG, 50 MG.....	75
XDEMVY	215



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

XELJANZ	359, 360
XELJANZ XR	359, 360
XERMELO	341
XGEVA.....	87
XIFAXAN ORAL TABLET 200 MG, 550 MG	292
XOLAIR.....	254, 255, 256
XOSPATA	138
XPOVIO ORAL TABLET 100 MG/WEEK (50 MG X 2), 40 MG/WEEK (10 MG X 4), 40 MG/WEEK (40 MG X 1), 40MG TWICE WEEK (40 MG X 2), 60 MG/WEEK (60 MG X 1), 60MG TWICE WEEK (120 MG/WEEK), 80 MG/WEEK (40 MG X 2), 80MG TWICE WEEK (160 MG/WEEK).....	313
XTANDI ORAL CAPSULE	111
XTANDI ORAL TABLET 40 MG, 80 MG	111
XYOSTED	346
Y	
YERVOY	189

YESINTEK	388, 389, 390, 391
YONSA	8
YUFLYMA(CF)	14, 15
YUFLYMA(CF) AI CROHN'S-UC-HS..	14, 15
YUFLYMA(CF) AUTOINJECTOR...	14, 15
Z	
ZEJULA ORAL CAPSULE	239
ZEJULA ORAL TABLET.....	239
ZELBORAF	395
ZIIHERA.....	403
ZIRABEV.....	52
ZOLADEX	144
ZTALMY	136
ZTLIDO.....	210
ZURZUVAE ORAL CAPSULE 20 MG, 25 MG, 30 MG.....	408
ZYDELIG.....	167
ZYKADIA.....	66
ZYNLONTA	213
ZYNYZ	288