Medication	FDA Indications **Note:** Although every effort is made to keep this FDA indication list up to date, please consult the web link in the far right column for the most accurate information.	MFC Specifications	Manufacturer's Prescribing Info (Hold CTRL and click on link to open)
Aimovig (erenumab-aooe)	Indicated for the preventive treatment of migraine in adults.	1. Rx by Neurologist 2. Member must have tried and failed at least 2 previous migraine prophylaxis medications. Examples of migraine prophylaxis medications include, but are not limited to, divalproex, metoprolol, propranolol, timolol, topiramate, amitriptyline, venlafaxine, atenolol.	AIMBOVIG PI
Albenza (albendazole)	Indicated for: 1. parenchymal neurocysticercosis due to active lesions caused by larval forms of the pork tapeworm, Taenia solium. 2. cystic hydatid disease of the liver, lung, and peritoneum, caused by the larval form of the dog tapeworm, Echinococcus granulosus.		ALBENZA PI
Alecensa (alectinib)	Indicated for the treatment of patients with anaplastic lymphoma kinase (ALK)-positive, metastatic non-small cell lung cancer (NSCLC) who have progressed on or are intolerant to crizotinib.	Rx by Oncologist	ALECENSA PI
Alunbrig (brigatinib)	Indicated for the treatment of patients with anaplastic lymphoma kinase (ALK)-positive metastatic non-small cell lung cancer (NSCLC) who have progressed on or are intolerant to crizotinib.	Rx by Oncologist	ALUNBRIG PI
Amitiza (lubiprostone)	Indicated for: 1. treatment of chronic idiopathic constipation in adults. 2. treatment of opioid-induced constipation in adults with chronic, non-cancer pain. 3. treatment of irritable bowel syndrome in women ≥ 18 years old	Failure of at least 2 of the following: docusate, sennosides, polyethylene glycol 3350, lactulose, methylcellulose	AMITIZA PI

Ampyra (dalfampridine)	Indicated to help improve walking in adults with MS.	1. Rx by Neurologist. 2. Documentation of MS with ambulatory dysfunction, but must be able to walk 25 feet within 8-45 seconds at baseline. 3. Members must have a baseline gait assessment by PT within 90 days of beginning Ampyra. 4. Members must have a repeat evaluation after 3 months on Ampyra. Improvement in walking speed must be documented in order to obtain further refills. 5. Members must not have a history of seizure disorder or renal impairment.	AMPYRA PI
Bethkis (tobramycin inh sol)	Indicated for management of cystic fibrosis patients with *Pseudomonas aeruginosa*. **** Safety and efficacy have not been demonstrated in patients under the age of six years, patients with a forced expiratory volume in one second (FEV1) less than 40% or greater than 80% predicted, or patients colonized with Burkholderia cepacia.*	Rx by Pulmonologist	BETHKIS PI
Bosulif (bosutinib)	Indicated for the treatment of adult patients with chronic, accelerated, or blast phase Ph+ chronic myelogenous leukemia (CML) with resistance or intolerance to prior therapy.	Rx by Oncologist	BOSULIF PI

Botox (onabotulinumtoxin A)	Indicated for: 1. treatment of overactive bladder (OAB) with symptoms of urge urinary incontinence, urgency, and frequency, in adults who have an inadequate response to or are intolerant of an anticholinergic medication. 2. treatment of urinary incontinence due to detrusor overactivity associated with a neurologic condition [e.g., spinal cord injury (SCI), multiple sclerosis (MS)] in adults who have an inadequate response to or are intolerant of an anticholinergic medication. 3. prophylaxis of headaches in adult patients with chronic migraine (≥15 days per month with headache lasting 4 hours a day or longer). 4. treatment of spasticity in adult patients. 5. treatment of cervical dystonia in adult patients, to reduce the severity of abnormal head position and neck pain. 6. treatment of severe axillary hyperhidrosis that is inadequately managed by topical agents in adult patients. 7. treatment of blepharospasm associated with dystonia in patients ≥12 years of age. 8. treatment of strabismus in patients ≥12 years of age.	1. Rx by Neurologist, Urologist, Ophthalmologist 2. Botox will **NOT** be approved for cosmetic purposes.	BOTOX PI
Braftovi (encorafenib)	Indicated, in combination with binimetinib, for the treatment of patients with unresectable or metastatic melanoma with a BRAF V600E or V600K mutation, as detected by an FDA-approved test.	Rx by Oncologist	BRAFTOVI PI
Cabometyx (cabozantinib)	Indicated for the treatment of patients with advanced renal cell carcinoma who have received prior anti-angiogenic therapy.	Rx by Oncologist	CABOMETYX PI
Cometriq (cabozantinib)	Indicated for treatment of progressive, metastatic medullary thyroid cancer.	Rx by Oncologist	COMETRIQ PI
Cotellic (cobimetinib)	Indicated for the treatment of patients with unresectable or metastatic melanoma with a BRAF V600E or V600K mutation, in combination with vemurafenib.	Rx by Oncologist	COTELLIC PI
DDAVP (desmopressin)	See **Desmopressin Nasal Spray Products**		

DESMOPRESSIN NASAL SPRAY PRODUCTS: **DDAVP spray**- 0.01% **Stimate spray**- 1.5 mg/mL	**DDAVP** is indicated for: 1. treatment of central Diabetes Insipidus. 2. treatment of transient polyuria and polydipsia post head trauma or neuro-surgery. **Stimate** is indicated for: 1. hemophilia A with Factor VIII coagulant activity levels greater than 5% - will stop bleeding in patients with hemophilia A with episodes of spontaneous or trauma-induced injuries such as hemarthroses, intramuscular hematomas or mucosal bleeding. 2. mild to moderate classic von Willebrand's disease (Type I) with Factor VIII levels greater than 5% - will stop bleeding in patients with episodes of spontaneous or trauma-induced injuries such as hemarthroses, intramuscular hematomas, mucosal bleeding or menorrhagia.	1. **STIMATE**: Hemophilia A with factor VIII coagulant activity greater than 5%: ➢ *peri-operatively to prevent bleeding ➢ to treat spontaneous or trauma induced bleeding ***Note- Patients with factor VIII levels equal to or less than 5% or patients who have factor VIII antibodies are not candidates for the drug. It is contraindicated in patients under 3 months old. It is NOT indicated for Hemophilia B. 2. **STIMATE**: Patients with von Willebrand's Disease (type I) with factor VIII coagulant activity greater than 5%: ➢ used peri-operatively to prevent bleeding. ➢ to treat spontaneous or trauma induced bleeding. ***Note- The drug is NOT indicated for treatment of severe classic von Willebrand's Disease (type I) or when there is evidence of an abnormal molecular form of Factor VIII antigen	DDAVP FDA PI STIMATE PI
Dificid (fidaxomicin)	Indicated for the treatment of *Clostridium difficile*-associated diarrhea in adults (≥18 years of age).	Pt must have documented failures with both metronidazole and vancomycin, or contraindication(s) to the use of these agents.	DIFICID PI
Doptelet (avatrombopag)	Indicated for the treatment of thrombocytopenia in adult patients with chronic liver disease who are scheduled to undergo a procedure.	1. Rx by Hematologist 2. A recent (less than 1 month old) platelet count must be supplied with the clinical request, as well as information regarding the planned procedure.	DOPTELET PI

Dupixent (dupilumab)	Indicated for the treatment of adult patients with moderate-to-severe atopic dermatitis whose disease is not adequately controlled with topical prescription therapies or when those therapies are not advisable. DUPIXENT can be used with or without topical corticosteroids.	Rx by Allergist or Dermatologist	DUPIXENT PI
Eligard (leuprolide SQ)	see **Leuprolide**		
Endari (L-glutamine)	Indicated to reduce the acute complications of sickle cell disease in adult and pediatric patients 5 years of age and older.	Rx by Hematologist	ENDARI PI
Erwinaze (asparaginase *Erwinia chrysanthemi*)	Indicated as a component of a multi-agent chemotherapeutic regimen for the treatment of patients with ALL who have developed hypersensitivity to *E. coli*-derived asparaginase.	Rx by Oncologist	ERWINAZE PI
Esbriet (pirfenidone)	Indicated for the treatment of idiopathic pulmonary fibrosis.	Rx by Pulmonologist or Cardiologist	ESBRIET PI
Fasenra (benralizumab)	Indicated for the add-on maintenance treatment of patients with severe asthma aged 12 years and older, and with an eosinophilic phenotype.	Rx by Pulmonologist or Allergist	FASENRA PI
fentanyl	Indicated for the management of pain in opioid-tolerant patients, severe enough to require daily, around-the-clock, long-term opioid treatment and for which alternative treatment options are inadequate. Patients considered opioid-tolerant are those taking, for one week or longer, at least 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. **Limitations of use:** Because of the risks of addiction, abuse, and misuse with opioids, even at recommended doses, and because of the greater risks of overdose and death with extended-release opioid formulations, reserve DURAGESIC [fentanyl] for use in patients for whom alternative treatment options (e.g., nonopioid analgesics or immediate-release opioids) are ineffective, not tolerated, or would be otherwise inadequate to provide sufficient management of pain. DURAGESIC [fentanyl] is not indicated as an as-needed (prn) analgesic	The Department of Health and Mental Hygiene has mandated that all long-acting opioids require Prior Authorization (PA) as of July 1, 2017. The PA form can be accessed using the following link: OPIOID PRIOR AUTHORIZATION FORM	fentanyl PI
Firazyr (icatibant)	Indicated for the treatment of acute attacks of hereditary angioedema in adults ≥18 years of age (self-administered by the patient).	Rx by Allergist or ENT	FIRAZYR PI
Gralise (gabapentin)	Indicated for the management of Postherpetic Neuralgia (PHN).		GRALISE PI
Growth Hormone	See **Norditropin**; See **Serostim**		

Haegarda (C1 Esterase Inhibitor SubQ (Human))	Indicated for routine prophylaxis to prevent Hereditary Angioedema (HAE) attacks in adolescent and adult patients.	Rx by Allergist/Immunologist	HAEGARDA PI
Hycamtin caps (topotecan)	Indicated for treatment of patients with relapsed small cell lung cancer.	Rx by Oncologist	HYCAMTIN PI
Ibrance (palbociclib)	Indicated for the treatment of hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative advanced or metastatic breast cancer in combination with: 1. an aromatase inhibitor as initial endocrine based therapy in postmenopausal women; or 2. fulvestrant in women with disease progression following endocrine therapy.	Rx by Oncologist	IBRANCE PI
Iclusig (ponatinib)	Indicated for: 1. treatment of adult patients with T315I-positive chronic myeloid leukemia (chronic phase, accelerated phase, or blast phase) or T315I positive Philadelphia chromosome positive acute lymphoblastic leukemia (Ph+ ALL). 2. treatment of adult patients with chronic phase, accelerated phase, or blast phase chronic myeloid leukemia or Ph+ ALL for whom no other tyrosine kinase inhibitor (TKI) therapy is indicated.	Rx by Oncologist	ICLUSIG PI
Imbruvica (ibrutinib)	Indicated for: 1. Mantle cell lymphoma (MCL) who have received at least one prior therapy. Accelerated approval was granted for this indication based on overall response rate. Continued approval for this indication may be contingent upon verification of clinical benefit in confirmatory trials. 2. Chronic lymphocytic leukemia/small lymphocytic lymphoma. 3. Chronic lymphocytic leukemia/small lymphocytic lymphoma with 17p deletion . 4. Waldenström's macroglobulinemia (WM) . 5. Marginal zone lymphoma (MZL) who require systemic therapy and have received at least one prior anti-CD20-based therapy. Accelerated approval was granted for this indication based on overall response rate. Continued approval for this indication may be contingent upon verification and description of clinical benefit in a confirmatory trial. 6. Chronic graft versus host disease after failure of one or more lines of systemic therapy.	Rx by Oncologist	IMBRUVICA PI

Insulin Pens	Age 0-18: Insulin pens will be provided for members ages 0-18 years of age. Age 19 and older: **Basaglar** and **Tresiba** pens do NOT require prior authorization and are available to all members. **All other insulin pens require prior authorization.** The MFC Insulin Pen Policy (Policy 211) states that insulin pens will be approved for members who cannot properly use and draw up insulin from vials into syringes or whose caregiver(s) cannot properly use and draw up insulin from vials into syringes including members with: 1) Poor visual acuity, 2) Poor manual dexterity, or 3) Limited ability to learn proper technique due to educational challenges Medical records may be required to support the PA request.		
Jakafi (ruxolitinib)	Indicated for: 1. treatment of patients with intermediate or high-risk myelofibrosis, including primary myelofibrosis, post-polycythemia vera myelofibrosis, and post-essential thrombocythemia myelofibrosis. 2. treatment of patients with polycythemia vera who have had an inadequate response to or are intolerant of hydroxyurea.	Rx by Hematologist/Oncologist	JAKAFI PI
Jardiance (empagliflozin)	Indicated: 1. as an adjunct to diet and exercise to improve glycemic control in adults with type 2 diabetes mellitus. 2. to reduce the risk of cardiovascular death in adult patients with type 2 diabetes mellitus and established cardiovascular disease.	1. Rx by Cardiology or Endocrinologist 2. Patients must have known cardiovascular disease to qualify for Jardiance.	JARDIANCE PI
Jivi (empagliflozin)	Recombinant DNA-derived, Factor VIII concentrate indicated for use in previously treated adults and adolescents (12 years of age and older) with hemophilia A (congenital Factor VIII deficiency) for: 1. On-demand treatment and control of bleeding episodes. 2. Perioperative management of bleeding. 3. Routine prophylaxis to reduce the frequency of bleeding episodes.	Rx by Hematologist	JIVI PI

Juxtapid (lomitapide)	Indicated as an adjunct to a low-fat diet and other lipid-lowering treatments, including LDL apheresis where available, to reduce low-density lipoprotein cholesterol (LDL-C), total cholesterol (TC), apolipoprotein B (apo B), and non-high-density lipoprotein cholesterol (non-HDL-C) in patients with homozygous familial hypercholesterolemia. ******ONLY available through certified pharmacies and only doctors enrolled and certified in manufacturer's program may prescribe this medication***	Rx by Cardiology or Endocrinologist	JUXTAPID PI
Kalydeco (ivacaftor)	Indicated for the treatment of cystic fibrosis (CF) in patients age 2 years and older who have one mutation in the CFTR gene that is responsive to ivacaftor based on clinical and/or in vitro assay data. If the patient's genotype is unknown, an FDA-cleared CF mutation test should be used to detect the presence of a CFTR mutation followed by verification with bi-directional sequencing when recommended by the mutation test instructions for use.	Rx by Pulmonologist	KALYDECO PI
Kisqali (ribociclib)	Indicated in combination with an aromatase inhibitor as initial endocrine-based therapy for the treatment of postmenopausal women with hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative advanced or metastatic breast cancer.	Rx by Oncologist	KISQALI PI

Kymriah (tisagenlecluecel)	Indicated for the treatment of patients up to 25 years of age with B-cell precursor acute lymphoblastic leukemia (ALL) that is refractory or in second or later relapse. In accordance with criteria developed by the Maryland Medicaid Program, MedStar Family Choice considers Kymriah medically necessary when all of the following conditions are met: 1. Recipient has relapsed or refractory B-cell ALL, defined as a. Second or greater bone marrow relapse; OR b. Any bone marrow relapse after allogeneic stem cell transplantation; OR c. Primary refractory as defined by not achieving a complete remission after 2 cycles of a standard chemotherapy regimen or chemorefractory as defined by not achieving a complete remission after 1 cycle of standard chemotherapy for relapsed leukemia; OR d. Patients with Philadelphia chromosome positive (Ph+) ALL are eligible if they are intolerant to or have failed 2 lines of tyrosine kinase inhibitor therapy (TKI), or if TKI therapy is contraindicated; AND 2. Recipient is 25 years of age or younger; AND 3. Documentation of CD19 tumor expression; AND 4. Performance score on Karnofsky or Lansky Scale is greater than or equal to 50%; AND 5. Life expectancy > 12 weeks; AND 6. Adequate cardiac, pulmonary, and other organ function (as determined by protocol from treatment facility); AND 7. The treatment facility that dispenses and administers Kymriah is enrolled and complies with the Risk Evaluation and Mitigation Strategy; AND 8. One-time, single administration with dosing in accordance with the FDA label. Kymriah is considered investigational and not medically necessary when the above medically necessary criteria are not met, and for all other indications, including but not limited to: 1. Isolated extra-medullary disease relapse; or 2. Patients with Burkitt's lymphoma/leukemia (i.e. patients with mature B-cell ALL, leukemia with B-cell [sIg positive and kappa or lambda restricted positivity] ALL, with FAB L3 morphology and /or a MYC translocation); or 3. Prior malignancy, except carcinoma in situ of the skin or cervix treated with curative intent and with no evidence of active disease; or 4. Treatment with any other chimeric antigen receptor therapy or genetically modified T cell therapy; or 5. Any active uncontrolled infection; or 6. Hepatitis B or C (if viral load is detectable); or 7. Human Immunodeficiency Virus (HIV); or 8. Presence of grade 2 to 4 acute or extensive chronic graft-versus-host disease (GVHD); or 9. Active CNS involvement by malignancy, defined by CNS-3 per NCCN guidelines.	Rx by Oncologist	KYMRIAH PI

LEUPROLIDE PRODUCTS: **Eligard** (leuprolide SQ) **Lupron** (leuprolide acetate) **Lupron Depot** (leuprolide acetate for depot suspension) **Lupron Depot-PED** **(**leuprolide acetate for depot suspension)	Indicated for: 1. palliative treatment for advanced prostate cancer (**Eligard**). 2. treatment of pediatric patients with central precocious puberty (**Lupron Depot- PED**). 3. treatment of endometriosis (**Lupron and Lupron Depot**). 4. uterine leiomyomata (fibroids) along with concurrent iron therapy in preparation for surgery [duration of treatment should be for 6 months or less (**Lupron and Lupron Depot**)].		ELIGARD PI LUPRON 3.75 mg PI LUPRON DEPOT 11.25 MG PI LUPRON DEPOT-PED PI
Libtayo (cemiplimab-rwlc)	Indicated for the treatment of patients with metastatic cutaneous squamous cell carcinoma (CSCC) or locally advanced CSCC who are not candidates for curative surgery or curative radiation.		LIBTAYO PI
Linzess (linaclotide)	Indicated for: 1. irritable bowel syndrome with constipation. 2. chronic idiopathic constipation.	Failure of at least 2 of the following: docusate, sennosides, polyethylene glycol 3350, lactulose, methylcellulose	LINZESS PI
LO Loestrin Fe (norethindrone, ethinyl estradiol and ferrous fumarate)	See **Oral Contraceptive**		LO LOESTRIN PI
Lovaza (omega-3-acid ethyl esters) (historical Omacor)	Indicated as an adjunct to diet to reduce triglyceride (TG) levels in adult patients with severe (≥500 mg/dL) hypertriglyceridemia.		LOVAZA PI
Lumoxiti (moxetumomab pasudotox-tdfk)	Indicated for the treatment of adult patients with relapsed or refractory hairy cell leukemia (HCL) who received at least 2 prior systemic therapies, including treatment with a purine nucleoside analog.		LUMOXITI PI

Lorbrena (lorlatinib)	Indicated for the treatment of patients with anaplastic lymphoma kinase (ALK)-positive metastatic non-small cell lung cancer (NSCLC) whose disease has progressed on: • crizotinib and at least one other ALK inhibitor for metastatic disease; or • alectinib as the first ALK inhibitor therapy for metastatic disease; or • ceritinib as the first ALK inhibitor therapy for metastatic disease	Rx by Oncologist	LORBRENA PI
Lupron and Lupron Depot	See **Leuprolide**		
Lynparza (olaparib)	Indicated for: 1. maintenance treatment of adult patients with recurrent epithelial ovarian, fallopian tube or primary peritoneal cancer, who are in a complete or partial response to platinum-based chemotherapy. 2. treatment of adult patients with deleterious or suspected deleterious germline BRCA-mutated advanced ovarian cancer who have been treated with three or more prior lines of chemotherapy. 3. Treatment of patients with deleterious or suspected deleterious gBRCAm, human epidermal growth factor receptor 2 (HER2)-negative metastatic breast cancer who have been treated with chemotherapy in the neoadjuvant, adjuvant or metastatic setting. Patients with hormone receptor (HR)-positive breast cancer should ha ve been treated with a prior endocrine therapy or be considered inappropriate for endocrine therapy.	Rx by Oncologist	LYNPARZA PI
Macrilen (macimorelin)	Indicated for the diagnosis of adult growth hormone deficiency.	Rx by Endocrinologist	MACRILEN PI

Mavyret (glecaprevir and pibrentasvir) **SEE SPECIAL NOTE REGARDING WEEK 4 VIRAL LOAD TESTING** **********→	MAVYRET is a fixed-dose combination of glecaprevir, a hepatitis C virus (HCV) NS3/4A protease inhibitor, and pibrentasvir, an HCV NS5A inhibitor, and is indicated for the treatment of patients with chronic HCV genotype (GT) 1, 2, 3, 4, 5 or 6 infection without cirrhosis and with compensated cirrhosis (Child-Pugh A). MAVYRET is also indicated for the treatment of adult patients with HCV genotype 1 infection, who previously have been treated with a regimen containing an HCV NS5A inhibitor or an NS3/4A protease inhibitor, but not both. **Please note:** **The Maryland Department of Health (MDH) has *MANDATED* a test of viral load after 2-4 weeks on treatment. If this check is not completed, medication refills will NOT be authorized after week 8 of treatment. This is a MDH requirement and as such, MFC does not have the ability to waive this testing under any circumstances. Viral load testing is also mandatory at 12 weeks and 24 weeks (for extended regimens). Lastly, viral load testing MUST be completed 12 weeks after therapy has ended (to assess SVR).**	**Please submit:** A COMPLETED PRIOR AUTHORIZATION FORM (see link below) via FAX to 410-933-2205 PRIOR AUTHORIZATION AND PRESCRIPTION FORM To view the most up to date DHMH treatment criteria, follow the link below: MDH TREATMENT CRITERIA	MAVYRET PI
Mekinist (trametinib)	Indicated: 1. as a single agent for the treatment of patients with unresectable or metastatic melanoma with BRAF V600E or V600K mutations as detected by an FDA-approved test. 2. in combination with dabrafenib, for the treatment of patients with: • unresectable or metastatic melanoma with BRAF V600E or V600K mutations as detected by an FDA-approved test. • metastatic non-small cell lung cancer (NSCLC) with BRAF V600E mutation as detected by an FDA-approved test.		MEKINIST PI
Mektovi (binimetinib)	Indicated, in combination with encorafenib, for the treatment of patients with unresectable or metastatic melanoma with a BRAF V600E or V600K mutation, as detected by an FDA-approved test.	Rx by Oncologist	MEKTOVI PI

methadone (for pain)	Indicated for management of pain severe enough to require daily, around-the-clock, long-term opioid treatment and for which alternative treatment options are inadequate. **Limitations of Use** Because of the risks of addiction, abuse, and misuse with opioids, even at recommended doses, and because of the greater risks of overdose and death with long-acting opioids, reserve methadone hydrochloride tablets for use in patients for whom alternative treatment options (e.g., non-opioid analgesics or immediate-release opioids) are ineffective, not tolerated, or would be otherwise inadequate to provide sufficient management of pain. Methadone hydrochloride tablets are not indicated as an as needed (prn) analgesic.	The Department of Health and Mental Hygiene has mandated that all long-acting opioids require Prior Authorization (PA) as of July 1, 2017. The PA form can be accessed using the following link: OPIOID PRIOR AUTHORIZATION FORM	METHADONE PI
Minastrin 24 Fe (norethindrone, ethinyl estradiol and ferrous fumarate)	See **Oral Contraceptive** ***CHEWABLE		MINASTRIN 24 Fe PI
Movantik (naloxegol)	Indicated for the treatment of opioid-induced constipation in adults with chronic non-cancer pain, including patients with chronic pain related to prior cancer or its treatment who do not require frequent (e.g., weekly) opioid dosage escalation.	Failure of at least 2 of the following: docusate, sennosides, polyethylene glycol 3350, lactulose, methylcellulose	MOVANTIK PI
MS Contin (morphine sulfate controlled release)	Indicated for the management of moderate to severe pain when a continuous, around-the-clock opioid analgesic is needed for an extended period of time. **Limitations of Use** Because of the risks of addiction, abuse, and misuse with opioids, even at recommended doses, and because of the greater risks of overdose and death with extended-release opioid formulations, reserve MS CONTIN for use in patients for whom alternative treatment options (e.g., non-opioid analgesics or immediate-release opioids) are ineffective, not tolerated, or would be otherwise inadequate to provide sufficient management of pain. MS CONTIN is not indicated as an as-needed (prn) analgesic.	The Department of Health and Mental Hygiene has mandated that all long-acting opioids require Prior Authorization (PA) as of July 1, 2017. The PA form can be accessed using the following link: OPIOID PRIOR AUTHORIZATION FORM	MS CONTIN PI

Natazia (estradiol valerate and estradiol valerate/dienogest)	Indicated for: 1. use by women to prevent pregnancy. 2. treatment of heavy menstrual bleeding in women without organic pathology who choose to use an oral contraceptive as their method of contraception.	ANY OCP on prior authorization requires documentation demonstrating a compelling reason why formulary OCPs cannot be used [ex: intolerance, prior side effects, failures, etc. documented after a 3 month trial of formulary OCP(s)]	NATAZIA PI
Norditropin (somatropin (fDNA origin) injection	Indicated for: 1. treatment of children with growth failure due to growth hormone deficiency (GHD), short stature associated with Noonan syndrome, short stature associated with Turner syndrome and short stature born SGA with no catch-up growth by age 2 to 4 years. 2. treatment of adults with either adult onset or childhood onset GHD.	Rx by Endocrinologist	NORDITROPIN PI
Noxafil (posaconazole)	Indicated for: 1. prophylaxis of invasive *Aspergillus* and *Candida*, ≥13 years of age, who are at high risk of developing these infections due to being severely immunocompromised (such as from: stem cell transplant with GVHD or prolonged neutropenia from chemotherapy).. 2. oropharyngeal candidiasis (OPC), including infections refractory to itraconazole and/or fluconazole.	Rx by ID	NOXAFIL PI
Nucala (mepolizumab)	Indicated for add-on maintenance treatment of patients with severe asthma aged 12 years and older, and with an eosinophilic phenotype.	Rx by Allergist or Pulmonologist	NUCALA PI
Ofev (nintedanib)	Indicated for the treatment of idiopathic pulmonary fibrosis.	Rx by Pulmonologist	OFEV PI
Onpattro (patisiran)	Indicated for the treatment of the polyneuropathy of hereditary transthyretin-mediated amyloidosis in adults.	Rx by Rheumatology or Neurology	ONPATTRO PI

OPIOIDS PRIOR AUTHORIZATION TERMS	The Maryland Department of Health (MDH) and the eight Medicaid Managed Care Organizations (MCOs) in Maryland's HealthChoice Program implemented opiate prescribing policies for all Medicaid Patients, including those served by a MCO or Medicaid Fee-For-Service. These policy changes are being made in light of the increasing volume of opioid-related deaths occurring in Maryland and amongst Maryland Medicaid beneficiaries. **Prior Authorization (Effective July 1, 2017)** **Prior authorization will be required for:** • Long-acting opioids • Fentanyl products • Methadone for pain • Any opioid prescription (or combination of opioid prescriptions) that results in a patient exceeding 90 morphine milliequivalents (MME) per day. Instructions on calculating MME are available at the CDC website. For the sake of illustration of what constitutes 90 MME, the following is a list of daily doses of commonly prescribed opioids that **equal 90 MME/day**: Fentanyl 112.5 mcg/day Hydrocodone 90 mg/day Hydromorphone 22.5 mg/day Morphine 90 mg/day Oxycodone 60 mg/day Oxymorphone 30 mg/day The following are examples of common prescriptions that **equal 90 MME/day**: oxycodone 20 mg tid OxyContin 30 mg bid Methadone 20 mg qd Hydrocodone 10/325, 3 tabs tid **Additionally, some immediate release medications will require prior authorization at less than 90 MME. These medications are as follows:**	OPIOID PRIOR AUTHORIZATION FORM	

Medication	Max per 30 days	Unit	
Codeine compounds	1,000	mL	
	180	tablet/capsule	
Hydrocodeine compounds	2,750	mL	
	180	tablet/capsule	
Hydromorphone	675	mL	
	180	tablet/suppository	
Meperidine	2,700	mL	
	180	tablet	
Morphine	1,350	mL	
	180	suppository	
Oxycodone compounds	1,800	mL	
	180	tablet/capsule	

	Tramadol	180	tablet/capsule		
	In order to receive opioid prior authorization, prescribers **must** attest to the following: • Prescriber has reviewed controlled substance prescriptions in a Prescription Drug Monitoring Program (ex: CRISP- Chesapeake Regional Information System for our Patients). For more information about the PDMP, visit the MDH web site. If you are not already a registered CRISP user you can register for **free** here. • Prescriber will utilize random Urine Drug Screens. • Prescriber has provided or offered a prescription for naloxone to the patient or patient's household if the patient has: ○ a history of substance use disorder ○ requires more than 50 MME (for example, more than Fentanyl 62.5 mcg/72 hours, hydrocodone 50 mg/day, hydromorphone 12.5 mg/day, morphine 50 mg/day, oxycodone 33 mg/ day, and oxymorphone 16 mg/day) ○ is prescribed both opioids and benzodiazepines ○ is prescribed other sedative hypnotics ○ or for any other reason deemed clinically appropriate • Prescriber and patient have signed a Pain Management/Opioid Treatment Agreement/Contract and it is stored in the patient's medical record				
Oral Contraceptives	While some oral contraceptives have additional indications (ex: Beyaz for acne, PMDD, folate replacement; Estrostep Fe for acne; Safyral for folate replacement; Natazia for heavy periods), most are simply indicated for the prevention of pregnancy.			ANY OCP on prior authorization requires documentation demonstrating a compelling reason why formulary OCPs cannot be used [ex: intolerance, prior side effects, failures, etc. documented after a 3 month trial of formulary OCPs]	
Orkambi (lumacaftor/ivacaftor)	Indicated for the treatment of cystic fibrosis in patients age 12 years and older who are homozygous for the *F508del* mutation in the *CFTR* gene. *(If the patient's genotype is unknown, an FDA-cleared CF mutation test should be used to detect the presence of the F508del mutation on both alleles of the CFTR gene.)*			Rx by Pulmonologist	ORKAMBI PI

Otezla (apremilast)	Indicated for: 1. treatment of adult patients with active psoriatic arthritis. 2. treatment of patients with moderate to severe plaque psoriasis who are candidates for phototherapy or systemic therapy.	1. Rx by Dermatologist or Rheumatologist 2. Failure of at least 1 of the following: methotrexate, plaquenil, Arava, Humira, Embrel	OTEZLA PI
oxymorphone ER	Indicated for the relief of moderate to severe pain in patients requiring continuous around-the-clock opioid treatment for an extended period of time.	The Department of Health and Mental Hygiene has mandated that all long-acting opioids require Prior Authorization (PA) as of July 1, 2017. The PA form can be accessed using the following link: OPIOID PRIOR AUTHORIZATION FORM	OPANA ER PI
Prolia (denosumab)	Indicated for: 1. treatment of postmenopausal women with osteoporosis at high risk for fracture. 2. treatment to increase bone mass in men with osteoporosis at high risk for fracture. 3. treatment to increase bone mass in men at high risk for fracture receiving androgen deprivation therapy for nonmetastatic prostate cancer. 4. treatment to increase bone mass in women at high risk for fracture receiving adjuvant aromatase inhibitor therapy for breast cancer.		PROLIA PI
Pulmozyme (dornase alfa) Inhalation solution	Indicated in conjunction with standard therapies for the management of cystic fibrosis (CF) patients to improve pulmonary function.	Rx by Pulmonologist	PULMOZYME PI
Rasuvo (methotrexate inj)	Indicated for: 1. Management of patients with severe, active rheumatoid arthritis (RA) and polyarticular juvenile idiopathic arthritis (pJIA), who are intolerant of or had an inadequate response to first-line therapy. 2. Symptomatic control of severe, recalcitrant, disabling psoriasis in adults who are not adequately responsive to other forms of therapy.	Rx by Rheumatology or Dermatology	RASUVO PI

Repatha (evolocumab)	1. Indicated as an adjunct to diet and maximally tolerated statin therapy for treatment of adults with heterozygous familial hypercholesterolemia (HeFH) or clinical atherosclerotic cardiovascular disease (CVD), who require additional lowering of low density lipoprotein cholesterol (LDL-C). 2. Indicated as an adjunct to diet and other LDL-lowering therapies (e.g., statins, ezetimibe, LDL apheresis) in patients with homozygous familial hypercholesterolemia (HoFH) who require additional lowering of LDL-C. ***The effect of REPATHA on cardiovascular morbidity and mortality has not been determined.***	See Prior Authorization protocol on MFC website by clicking link below: PRIOR AUTHORIZATION FORM To view the most up to date MFC treatment criteria, follow the link below: MFC REPATHA PA CRITERIA After an initial authorization period of 3 months, an updated lipid panel will be required prior to refill authorization.	REPATHA PI
Rituxan Hycela (rituximab and hyaluronidase human)	Indicated for: 1. Follicular Lymphoma (FL) • Relapsed or refractory, follicular lymphoma as a single agent. • Previously untreated follicular lymphoma in combination with first line chemotherapy and, in patients achieving a complete or partial response to rituximab in combination with chemotherapy, as single agent maintenance therapy. • Non-progressing (including stable disease), follicular lymphoma as a single agent after first-line cyclophosphamide, vincristine, and prednisone (CVP) chemotherapy. 2. Diffuse Large B-cell Lymphoma (DLBCL) previously untreated diffuse large B-cell lymphoma in combination with cyclophosphamide, doxorubicin, vincristine, prednisone (CHOP) or other anthracycline-based chemotherapy regimens. 3. Chronic Lymphocytic Leukemia (CLL) previously untreated and previously treated CLL in combination with fludarabine and cyclophosphamide (FC).	Rx by Oncologist	RITUXAN HYCELA PI
Rubraca (rucaparib)	Indicated as monotherapy for the treatment of patients with deleterious BRCA mutation (germline and/or somatic) associated advanced ovarian cancer who have been treated with two or more chemotherapies. Select patients for therapy based on an FDA-approved companion diagnostic for RUBRACA.	Rx by Oncologist	RUBRACA PI
Santyl Ointment Collagenase	Indicated for debriding chronic dermal ulcers and severely burned areas.	Rx by Dermatologist or Wound Care Specialist	SANTYL PI
Serostim (somatropin (rDNA origin)	Indicated for the treatment of HIV patients with wasting or cachexia to increase lean body mass and body weight, and improve physical endurance.	Rx by ID or HIV Specialist	SEROSTIM PI

Seysera (seracycline)	Indicated for the treatment of inflammatory lesions of non-nodular moderate to severe acne vulgaris in patients 9 years of age and older.	1. Rx by Dermatologist. 2. Failure of at least one other oral tetracycline antibiotic.	SEYSERA PI
Sirturo (bedaquiline)	Indicated as part of combination therapy in adults with pulmonary multi-drug resistant TB. [Reserved for use when an effective treatment regimen cannot otherwise be provided; not indicated for the treatment of latent, extra pulmonary or drug-sensitive tuberculosis; should be administered by directly observed therapy].	Rx by ID	SITURO PI
Stimate nasal spray (desmopressin)	See **Desmopressin Products**		
Stivarga (regorafenib)	Indicated for: 1. treatment of metastatic colorectal cancer, previously treated with ALL the following therapies: a. fluoropyrimidine-based chemotherapy b. oxaliplatin-based chemotherapy c. irinotecan-based chemotherapy d. an anti-vascular endothelial growth factor (VEGF) therapy e. if Kirsten RNA Associated Rat Sarcoma 2 Virus Gene (KRAS) wild type, an anti-epidermal growth factor receptor (EGFR) therapy 2. treatment of locally advanced, unresectable or metastatic gastrointestinal stromal tumor (GIST), previously treated with imatinib mesylate and sunitinib malate. 3. hepatocellular carcinoma (HCC) who have been previously treated with sorafenib.	Rx by Oncologist	STIVARGA PI
Synagis (palivizumab)	Indicated for prevention of serious lower respiratory tract disease caused by RSV in children at high risk of RSV disease. MedStar Family Choice uses the newest recommendations of the American Academy of Pediatrics (AAP). Recommendations were last updated in the journal Pediatrics (7/28/2014 issue): **Updated Guidance for Palivizumab Prophylaxis Among Infants and Young Children at Increased Risk of Hospitalization for Respiratory Syncytial Virus Infection**	**Please submit:** A COMPLETED PRIOR AUTHORIZATION FORM (see link below) via FAX to 410-933-2205 PRIOR AUTHORIZATION AND PRESCRIPTION FORM To view the most up to date AAP Synagis Guidelines, follow the link below: AAP SYNAGIS GUIDELINES	SYNAGIS PI

Synjardy & Synjardy XR (empagliflozin/ metformin)	Indicated as an adjunct to diet and exercise to improve glycemic control in adults with type 2 diabetes mellitus when treatment with both empagliflozin and metformin hydrochloride is appropriate. Empagliflozin is indicated to reduce the risk of cardiovascular death in adults with type 2 diabetes mellitus and established cardiovascular disease.	1. Rx by Cardiology or Endocrinologist 2. Patients must have known cardiovascular disease to qualify for Synjardy.	SYNJARDY PI
Synribo (omacetaxine)	Indicated to treat adults with chronic phase (CP) or accelerated phase (AP) CML with resistance and/or intolerance to two or more TKIs.	Rx by Oncologist	SYNRIBO PI
Tafinlar (dabrafenib)	Indicated for the treatment of patients with unresectable or metastatic melanoma with BRAF V600E mutation as detected by an FDA-approved test.	Rx by Oncologist	TAFINLAR PI
Tagrisso (osimertinib)	Indicated for the treatment of patients with metastatic epidermal growth factor receptor (EGFR) T790M mutation-positive non-small cell lung cancer (NSCLC), as detected an FDA-approved test, who have progressed on or after EGFR TKI therapy.	Rx by Oncologist	TAGRISSO PI
Talzenna (talazoparib)	Indicated for the treatment of adult patients with deleterious or suspected deleterious germline BRCA-mutated (*gBRCAm*) HER2-negative locally advanced or metastatic breast cancer.	Rx by Oncologist	TALZENNA PI
Tarceva (erlotinib)	Indicated for: 1. treatment of patients with metastatic non-small cell lung cancer (NSCLC) whose tumors have epidermal growth factor receptor (EGFR) exon 19 deletions or exon 21 (L858R) substitution mutations as detected by an FDA-approved test receiving first-line, maintenance, or second or greater line treatment after progression following at least one prior chemotherapy regimen. 2. first-line treatment of patients with locally advanced, unresectable or metastatic pancreatic cancer, in combination with gemcitabine.	Rx by Oncologist	TARCEVA PI
Tasigna (nilotinib)	Indicated for: 1. treatment of newly diagnosed adult patients with Philadelphia chromosome positive chronic myeloid leukemia (Ph+ CML) in chronic phase. 2. treatment of Philadelphia chromosome-positive CML in adult patients in chronic phase (CML-CP) or accelerated phase (CML-AP) in patients resistant or intolerant to prior therapy, including Gleevec (imatinib).	Rx by Oncologist	TASIGNA PI
Tavalisse (fostamatinib disodium hexahydrate)	Indicated for the treatment of thrombocytopenia in adult patients with chronic immune thrombocytopenia (ITP) who have had an insufficient response to a previous treatment.	Rx by Hematologist	TAVALISSE PI

Taytulla (norethindrone/ ethinyl estradiol capsules and ferrous fumarate)	See **Oral Contraceptive**		TAYTULLA PI
Tibsovo (ivosidenib)	Indicated for the treatment of adult patients with relapsed or refractory acute myeloid leukemia (AML) with a susceptible IDH1 mutation as detected by an FDA-approved test.	Rx by Oncologist	TIBSOVO PI
Tykerb (lapatinib)	Indicated for: 1. the treatment of advanced or metastatic breast cancer, in combination with Xeloda (capecitabine), for patients whose tumors overexpress HER2 and who have received prior therapy including an anthracycline, a taxane, and Herceptin (trastuzumab). 2. the treatment of postmenopausal women, in combination with letrozole, for hormone receptor positive metastatic breast cancer that overexpresses the HER2 receptor when hormonal therapy is indicated.	Rx by Oncologist	TYKERB PI
Venclexta (venetoclax)	Indicated for the treatment of patients with chronic lymphocytic leukemia (CLL) with 17p deletion, as detected by an FDA approved test, who have received at least one prior therapy.	Rx by Oncologist	VENCLEXTA PI
Vitrakvi (larotrectinib)	Indicated for the treatment of adult and pediatric patients with solid tumors that: • have a neurotrophic receptor tyrosine kinase (NTRK) gene fusion without a known acquired resistance mutation, • are metastatic or where surgical resection is likely to result in severe morbidity, and • have no satisfactory alternative treatments or that have progressed following treatment.	Rx by Oncologist	VITRAKVI PI
Vizimpro (dacomitinib)	Indicated for the first-line treatment of patients with metastatic non-small cell lung cancer (NSCLC) with epidermal growth factor receptor (EGFR) exon 19 deletion or exon 21 L858R substitution mutations as detected by an FDA-approved test.	Rx by Oncologist	VIZIMPRO PI
Xadago (safinamide)	Indicated as adjunctive treatment to levodopa/carbidopa in patients with Parkinson's disease (PD) experiencing "off" episodes.	Rx by Neurologist	XADAGO PI
Xalkori (crizotinib)	Indicated for: 1. metastatic non-small cell lung cancer (NSCLC) whose tumors are anaplastic lymphoma kinase (ALK)-positive as detected by an FDA-approved test. 2. metastatic NSCLC whose tumors are ROS1-positive.	Rx by Oncologist	XALKORI PI

Xgeva (denosumab)	Indicated for: 1. prevention of skeletal-related events in patients with bone metastases from solid tumors. (does not include multiple myeloma). 2. treatment of adults and skeletally mature adolescents with giant cell tumor of the bone that is unresectable or where surgical resection is like to result in severe morbidity. 3. treatment of hypercalcemia of malignancy refractory to bisphosphonate therapy.	Rx by Oncologist	XGEVA PI
Xiidra **(lifitegrast ophthal)**	Indicated for the treatment of the signs and symptoms of dry eye disease.		XIIDRA PI
Xolair (omalizumab)	Indicated for: 1. adults and adolescents (≥12 years of age) with moderate to severe persistent asthma who have a positive skin test or *in vitro* reactivity to a perennial aeroallergen and whose symptoms are inadequately controlled with inhaled corticosteroids. 2. Chronic idiopathic urticaria in adults and adolescents (12 years of age and above) who remain symptomatic despite H1 antihistamine treatment	Rx by Allergist or Pulmonologist Regarding **ASTHMA** indication only: 1. moderate to severe persistent ALLERGIC asthma (confirmed by a positive skin test or RAST for ≥ 1 perennial aeroallergen) 2. IgE level obtained prior to initiation of therapy 3. currently using an inhaled corticosteroid at maximum dose; compliance must be confirmed in the patient's Caremark profile 4. currently using a long-acting inhaled $beta_2$-agonist **OR** a leukotriene modifier; compliance must be confirmed in the patient's Caremark profile 5. NOT approved for monotherapy	XOLAIR PI
Xospata (gilteritinib)	Indicated for the treatment of adult patients who have relapsed or refractory acute myeloid leukemia (AML) with a FLT3 mutation as detected by an FDA-approved test. (	Rx by Oncologist	XOSPATA PI

Xyrem (sodium oxybate)	Indicated for: 1. treatment of cataplexy in narcolepsy. 2. treatment of excessive daytime sleepiness (EDS) in narcolepsy. ****Xyrem may only be dispensed to patients enrolled in the Xyrem Success Program*	1. patient > 16 years old 2. alternative diagnoses must have been excluded 3. for cataplexy, must have failed tricyclic or SSRIs 4. for excessive daytime sleepiness, must have failed at least one formulary stimulant treatment (ex: methylphenidate or dextroamphetamine) 5. initial approval for maximum of 1-month supply with subsequent renewals for maximum approval period of 3 months at a time (Patients are to be re-evaluated by physician no less frequently than every 3 months) 6. Rx by Neurologist	XYREM PI

Yescarta (axicabtagene ciloleucel)	Indicated for the treatment of adult patients with relapsed or refractory large B-cell lymphoma after two or more lines of systemic therapy, including diffuse large B-cell lymphoma (DLBCL) not otherwise specified, primary mediastinal large B-cell lymphoma, high grade B-cell lymphoma, and DLBCL arising from follicular lymphoma. In accordance with criteria developed by the Maryland Medicaid Program, MedStar Family Choice considers Yescarta (Axicabtagene Ciloleucel) medically necessary when ALL of the following criteria are met: 1. Recipient is 18 years of age or older; AND 2. Histologically confirmed diagnosis of one of the following types of aggressive non-Hodgkin's lymphoma a. Diffuse large B-cell lymphoma (DLBCL), not otherwise specified; or b. High-grade B-cell lymphoma; or c. Primary mediastinal large B-cell lymphoma; or d. Transformed follicular lymphoma; AND 3. Relapsed or refractory disease, when a. Recipient has previously received two or more lines of systemic therapy; and b. Disease is refractory to the most recent therapy or relapsed within 1 year after autologous hematopoietic stem cell transplantation (HSCT); AND 4. Must have received adequate prior therapy including, at a minimum, all of the following: a. An anthracycline-containing chemotherapy regimen; and b. For CD20+ disease, anti-CD20 monoclonal antibody; and c. For subjects with transformed follicular lymphoma, prior chemotherapy for follicular lymphoma with chemotherapy refractory disease after transformation to DLBCL; AND 5. Documentation of all of the following clinical findings: a. Eastern Cooperative Oncology Group (ECOG) performance status of 0-1; and b. Adequate cardiac, pulmonary, and other organ function (as determined by protocol from treatment facility); AND 6. The treatment facility that dispenses and administers Yescarta is enrolled and complies with the Risk Evaluation and Mitigation Strategy; AND 7. One-time, single administration with dosing in accordance with the FDA label Yescarta (Axicabtagene ciloleucel) is considered investigational and not medically necessary when the above medically necessary criteria are not met, and for all other indications, including but not limited to: 1. History of malignancy other than nonmelanoma skin cancer or carcinoma in situ (e.g. cervix, bladder, breast) or follicular lymphoma unless disease free for at least 3 years; or 2. Any central nervous system (CNS) disease, for example, detectable CSF malignant cells, brain metastases, CNS lymphoma, or a history or presence of CNS disorders such as seizure disorder, cerebrovascular ischemia/hemorrhage, dementia, cerebellar disease, or autoimmune disease with CNS involvement ; or 3. History of allogeneic stem cell transplant, chimeric antigen receptor therapy or other genetically modified T-cell therapy; or 4. Active, uncontrolled infection; or 5. Human immunodeficiency virus (HIV); or 6. Hepatitis B or C (if viral load is detectable).	Rx by Oncologist	YESCARTA PI

Zejula (niraparib)	Indicated for the maintenance treatment of adult patients with recurrent epithelial ovarian, fallopian tube, or primary peritoneal cancer who are in a complete or partial response to platinum-based chemotherapy.	Rx by Oncologist	ZEJULA PI
Zelboraf (vemurafenib)	Indicated for: 1. the treatment of patients with unresectable or metastatic melanoma with BRAF V600E mutation as detected by an FDA-approved test. 2. the treatment of patients with ErdheimChester Disease with BRAF V600 mutation.	Rx by Oncologist or Dermatologist	ZELBORAF PI
Zoladex (goserelin)	Indicated for: 1. palliative treatment of advanced carcinoma of the prostate. 2. use in combination with flutamide for the management of locally confined stage T2b-T4 (Stage B2-C) carcinoma of the prostate. 3. management of endometriosis including pain relief and reduction of endometriotic lesions for the duration of therapy [women ≥18 years of age for 6 months of treatment]. 4. palliative treatment of advanced breast cancer in pre- and peri-menopausal women. 5. use as an agent to cause endometrial thinning agent prior to endometrial ablation for dysfunctional uterine bleeding.	Rx by Oncologist	ZOLADEX 3.6 mg PI ZOLADEX 10.8 mg PI
Zontivity (vorapaxar)	Indicated for the reduction of thrombotic cardiovascular events in patients with a history of myocardial infarction (MI) or with peripheral arterial disease (PAD). **** For use with aspirin and/or clopidogrel according to their indications or standard of care. There is limited clinical experience with other antiplatelet drugs or with ZONTIVITY as the only antiplatelet agent.	Rx by Cardiology, Neurology or Vascular Surgery	ZONTIVITY PI
Zurampic (lesinurad)	Indicated in combination with a xanthine oxidase inhibitor for the treatment of hyperuricemia associated with gout in patients who have not achieved target serum uric acid levels with a xanthine oxidase inhibitor alone.		ZURAMPIC PI
Zydelig (idelalisib)	Indicated for: 1. treatment of patients with relapsed chronic lymphocytic leukemia (CLL), in combination with rituximab, in patients for whom rituximab alone would be considered appropriate therapy due to other co-morbidities. 2. treatment of patients with relapsed follicular B-cell non-Hodgkin lymphoma (FL) in patients who have received at least two prior systemic therapies. 3. treatment of patients with relapsed small lymphocytic lymphoma (SLL) in patients who have received at least two prior systemic therapies.	Rx by Oncologist	ZYDELIG PI