



MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

EFFECTIVE 01/01/2021

Version 2020.5b

Updated: 12-10-2020

(For All Medicaid, MSCAN and CHIP Beneficiaries)

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
ACNE AGENTS			
	ANTI-INFECTIVE		Maximum Age Limit <ul style="list-style-type: none"> • 21 years – all agents except isotretinoins
	clindamycin gel (generic Cleocin-T) clindamycin lotion clindamycin solution	ACZONE (dapsons) AKNE-MYCIN (erythromycin) azelaic acid AMZEEQ FOAM (minocycline) AZELEX (azelaic acid) CLEOCIN-T (clindamycin) CLINDAMYCIN PAC (clindamycin) CLINDAGEL (clindamycin) clindamycin foam clindamycin gel daily (generic Clindagel) dapsons ERY (erythromycin) ERYGEL (erythromycin) erythromycin gel, swabs, solution EVOCLIN (clindamycin) KLARON (sulfacetamide) sulfacetamide	
	RETINOIDS		
	RETIN-A (tretinoin) tretinoin cream	adapalene AKLIEF (trifarotene) ALTRENO (tretinoin) ARAZLO (tazarotene) ATRALIN (tretinoin) AVITA (tretinoin) DIFFERIN (adapalene) FABIOR (tazarotene) PLIXDA (adapalene)	

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PREFERRED BRANDS will not count toward the two brand monthly Rx limit.

Drugs highlighted in yellow denote a change in PDL status.

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		RETIN-A MICRO (tretinoin) tazarotene TAZORAC (tazarotene) tretinoin gel tretinoin micro	
	COMBINATION DRUGS/OTHERS		
	adapalene/benzoyl peroxide benzoyl peroxide/clindamycin (generic DUAC) sodium sulfacetamide/sulfur foam/gel/suspension SSS 10/5 Cream (sodium sulfacetamide/sulfur)	ACANYA (benzoyl peroxide/clindamycin) AKTIPAK (erythromycin/benzoyl peroxide) BENZACLIN GEL (benzoyl peroxide/clindamycin) BENZACLIN KIT (benzoyl peroxide/clindamycin) BENZAMYCIN PAK (benzoyl peroxide/erythromycin) DUAC (benzoyl peroxide/clindamycin) EPIDUO (adapalene/benzoyl peroxide) EPIDUO FORTE (adapalene/benzoyl peroxide) erythromycin/benzoyl peroxide INOVA 4/1 (benzoyl peroxide/salicylic acid) INOVA 8/2 (benzoyl peroxide/salicylic acid) NEUAC (benzoyl peroxide/clindamycin) ONEXTON (benzoyl peroxide/clindamycin) PRASCION (sulfacetamide sodium/sulfur) ROSANIL (sulfacetamide sodium/sulfur) SE BPO (benzoyl peroxide) sodium sulfacetamide/sulfur cleanser/cream/lotion/pads sodium sulfacetamide/sulfur/meratan SSS 10/5 Foam (sodium sulfacetamide/sulfur) sulfacetamide sodium/sulfur/urea VELTIN (clindamycin/tretinoin) ZENCIA WASH (sulfacetamide sodium/sulfur) ZIANA (clindamycin/tretinoin)	
	KERATOLYTICS (BENZOYL PEROXIDES)		

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	benzoyl peroxide bar, cleanser, cream, gel, lotion, wash ^{Rx & OTC}	benzoyl peroxide foam ^{Rx & OTC} BP 5.5% (benzoyl peroxide) BPO (benzoyl peroxide) ^{Rx & OTC} INOVA (benzoyl peroxide) LAVOCLEN (benzoyl peroxide) PANOXYL BAR 10% (benzoyl peroxide) ^{OTC} PANOXYL CREAM 3% (benzoyl peroxide) ^{OTC} OC8 GEL (benzoyl peroxide) ^{OTC}	
ISOTRETINOIN			
	AMNESTEEM (isotretinoin) CLARAVIS (isotretinoin) isotretinoin MYORISAN(isotretinoin) ZENATANE (isotretinoin)	ABSORICA (isotretinoin) ABSORICA LD (isotretinoin)	Available for all ages
ALPHA-1 PROTEINASE INHIBITORS			
	ARALAST (alpha-1 proteinase inhibitor) GLASSIA (alpha-1 proteinase inhibitor) PROLASTIN C (alpha-1 proteinase inhibitor) ZEMAIRA (alpha-1 proteinase inhibitor)		
ALZHEIMER'S AGENTS <small>SmartPA</small>			
CHOLINESTERASE INHIBITORS			
	donepezil (tablets and ODT) 5mg, 10mg galantamine galantamine ER rivastigmine capsules rivastigmine patches	ARICEPT (donepezil) ARICEPT 23 MG (donepezil) ARICEPT ODT (donepezil) donepezil 23mg EXELON Capsules (rivastigmine)	All Agents • Documented diagnosis for both preferred and non-preferred Non-Preferred Criteria

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		EXELON Patches (rivastigmine) EXELON Solution (rivastigmine) RAZADYNE (galantamine) RAZADYNE ER (galantamine)	<ul style="list-style-type: none"> Have tried 2 different preferred agents in the past 6 months
NMDA RECEPTOR ANTAGONIST			
	memantine	NAMENDA TABS (memantine) NAMENDA SOLUTION(memantine) NAMENDA XR (memantine) memantine XR	
COMBINATION AGENTS			
		NAMZARIC (memantine/donepezil)	<p>Namzarcic</p> <ul style="list-style-type: none"> Documented diagnosis AND 30 days of concurrent therapy with donepezil + memantine in the past 6 months
ANALGESICS, NARCOTIC - SHORT ACTING			
	acetaminophen/codeine benzhydrocodone/APAP codeine dihydrocodeine/ APAP/caffeine ENDOCET (oxycodone/APAP) hydrocodone/APAP hydromorphone morphine oxycodone capsules oxycodone liquid oxycodone tablets oxycodone/APAP oxycodone/aspirin oxycodone/ibuprofen pentazocine/APAP	ABSTRAL (fentanyl) ACTIQ (fentanyl) APADAZ (benzhydrocodone/APAP) butalbital/APAP/caffeine/codeine butalbital/ASA/caffeine/codeine butorphanol tartrate (nasal) DEMEROL (meperidine) DILAUDID (hydromorphone) DVORAH (dihydrocodeine/ APAP/caffeine) fentanyl FENTORA (fentanyl) FIORICET W/ CODEINE (butalbital/APAP/caffeine/codeine) FIORINAL W/ CODEINE (butalbital/ASA/caffeine/codeine)	<p>MS DOM Opioid Initiative</p> <ul style="list-style-type: none"> Short-Acting Opioids Long-Acting Opioids Morphine Equivalent Daily Dose Concomitant use of Opioids and Benzodiazepines <p>Criteria details found here</p> <p>Minimum Age Limit 18 years – tramadol and codeine products</p> <p>Quantity Limit Applicable <u>quantity limit</u> in 31 rolling days.</p> <ul style="list-style-type: none"> 62 tablets – bultalbital/codeine combinations, codeine,

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<p>tramadol tramadol/APAP</p>	<p>hydrocodone/ibuprofen IBUDONE (hydrocodone/ibuprofen) LAZANDA NASAL SPRAY (fentanyl) levorphanol LORCET (hydrocodone/APAP) LORTAB (hydrocodone/APAP) MAGNACET (oxycodone/APAP) meperidine solution meperidine tablet NALOCET (oxycodone/APAP) NORCO (hydrocodone/APAP) NUCYNTA (tapentadol) ONSOLIS (fentanyl) OPANA (oxymorphone) OXAYDO (oxycodone) oxymorphone pentazocine/naloxone PERCOCET (oxycodone/APAP) PERCODAN (oxycodone/ASA) PRIMLEV (oxycodone/APAP) PROLATE (oxycodone/APAP) REPREXAINE (hydrocodone/ibuprofen) ROXICET (oxycodone/acetaminophen) ROXICODONE (oxycodone) ROXYBOND (oxycodone) RYBIX (tramadol) SUBSYS (fentanyl) SYNALGOS-DC (dihydrocodeine/ aspirin/caffeine) TYLENOL W/CODEINE (APAP/codeine) TYLOX (oxycodone/APAP) ULTRACET (tramadol/APAP) ULTRAM (tramadol) VICODIN (hydrocodone/APAP)</p>	<p>dihydrocodeine combinations, fentanyl, hydromorphone, levorphanol, meperidine, morphine, oxycodone, oxycodone/ibuprofen, oxymorphone, pentazocine, tapentadol, tramadol</p> <ul style="list-style-type: none"> • 62 tablets CUMULATIVE – hydrocodone combinations, oxycodone combinations • 124 tablets – butalbital/APAP 750 • 145 tablets – butalbital/APAP 650 • 186 tablets – butalbital/APAP 325, butalbital/ASA 325 • 5mL (2 x 2.5 bottles) – butorphanol nasal • 180 mL CUMULATIVE – oxycodone liquids
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		VICOPROFEN (hydrocodone/ibuprofen) XODOL (hydrocodone/acetaminophen) ZAMICET (hydrocodone/APAP) ZOLVIT (hydrocodone/APAP) ZYDONE (hydrocodone/acetaminophen)	
ANALGESICS, NARCOTIC - LONG ACTING <small>SmartPA</small>			
	BUTRANS (buprenorphine) fentanyl patches morphine ER tablets	ARYMO ER (morphine) BELBUCA (buprenorphine) buprenorphine patch CONZIP ER (tramadol) DOLOPHINE (methadone) DURAGESIC (fentanyl) EMBEDA (morphine/naltrexone) EXALGO (hydromorphone) hydromorphone ER HYSINGLA ER (hydrocodone) KADIAN (morphine) methadone MORPHABOND (morphine) morphine ER capsules MS CONTIN (morphine) NUCYNTA ER (tapentadol) OPANA ER (oxymorphone) oxycodone ER OXYCONTIN (oxycodone) oxymorphone ER RYZOLT (tramadol) tramadol ER	<p>MS DOM Opioid Initiative</p> <ul style="list-style-type: none"> • Short-Acting Opioids • Long-Acting Opioids • Morphine Equivalent Daily Dose • Concomitant use of Opioids and Benzodiazepines <p>Criteria details found here</p> <p>Minimum Age Limit</p> <ul style="list-style-type: none"> • 18 years – Xartemis XR, Zohydro ER, tramadol products <p>Quantity Limit</p> <p>Applicable <u>quantity limit</u> per rolling days</p> <ul style="list-style-type: none"> • 31 tablets/31 days - Conzip ER, Exalgo ER, Hysingla ER, Ryzolt, Ultram ER • 62 tablets/31 days – Arymo ER, Belbuca, Embeda, Kadian, methadone, Morphabond, morphine ER, Nucynta ER, Opana ER,

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		ULTRAM ER (tramadol) XARTEMIS XR (oxycodone/APAP) XTAMPZA (oxycodone myristate) ZOHYDRO ER (hydrocodone bitartrate)	oxycodone ER, Oxycontin, Xtampza ER, Zohydro ER <ul style="list-style-type: none"> • 10 patches/31 days – Duragesic • 4 patches/31 days – Butrans • 40 tablets/10 days – Xartemis XR <p>Non-Preferred Criteria</p> <ul style="list-style-type: none"> • Have tried 2 different preferred agents in the past 6 months OR • Documented diagnosis of cancer OR Antineoplastic therapy AND • 90 consecutive days on the requested agent in the past 105 days
ANALGESICS/ANESTHETICS (Topical)			
	diclofenac sodium 1% gel diclofenac sodium solution VOLTAREN Gel (diclofenac sodium) SmartPA	capsaicin DICLO GEL KIT(diclofenac sodium) FLECTOR (diclofenac epolamine) SmartPA FROTEK (ketoprofen) LIDAMANTLE HC (lidocaine/hydrocortisone) LIDO TRANS PAK (lidocaine) lidocaine lidocaine 5% patch lidocaine/prilocaine LIDODERM (lidocaine) SmartPA LIDTOPIC MAX (lidocaine) PENNSAID Solution (diclofenac sodium) SmartPA SYNERA (lidocaine/tetracaine) TRANZAREL (lidocaine) XRYLIDERM (lidocaine)	<p>Non-Preferred Criteria</p> <ul style="list-style-type: none"> • Have tried 1 preferred agent in the past 6 months <p>Lidoderm</p> <ul style="list-style-type: none"> • Documented diagnosis of Herpetic Neuralgia OR • Documented diagnosis of Diabetic Neuropathy <p>ZTlido</p> <ul style="list-style-type: none"> • Documented diagnosis of Herpetic Neuralgia

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		xylocaine ZOSTRIX (capsaicin) ZTlido (lidocaine)	
ANDROGENIC AGENTS SmartPA			
	ANDRODERM (testosterone patch) testosterone gel packets	ANDROGEL (testosterone gel) ANDROXY (fluoxymesterone) AXIRON (testosterone gel) FORTESTSA (testosterone gel) JATENZO (testosterone undecanoate) NATESTO (testosterone) STRIANT (testosterone) TESTIM (testosterone gel) testosterone pump VOGELXO (testosterone) XYOSTED (testosterone enanthate)	<p>All Agents</p> <ul style="list-style-type: none"> Limited to male gender <p>Non-Preferred Criteria</p> <ul style="list-style-type: none"> Have tried 2 different preferred agents in the past 6 months
ANGIOTENSIN MODULATORS SmartPA			
ACE INHIBITORS			
	benazepril captopril enalapril fosinopril lisinopril quinapril ramipril trandolapril	ACCUPRIL (quinapril) ACEON (perindopril) ALTACE (ramipril) EPANED (enalapril) LOTENSIN (benazepril) MAVIK (trandolapril) moexipril perindopril PRINIVIL (lisinopril) QBRELIS (lisinopril) UNIVASC (moexipril) VASOTEC (enalapril) ZESTRIL (lisinopril)	<p>Minimum Age Limit</p> <ul style="list-style-type: none"> ≤ 6 years – Epaned <i>Smart PA will automatically be issued for this age</i> <p>Non-Preferred Criteria</p> <ul style="list-style-type: none"> Have tried 2 different preferred <i>single entity</i> agents in the past 6 months OR 90 consecutive days on the requested agent in the past 105 days

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ACE INHIBITOR COMBINATIONS		
benazepril/amlodipine benazepril/HCTZ captopril/HCTZ enalapril/HCTZ fosinopril/HCTZ lisinopril/HCTZ quinapril/HCTZ trandolapril/verapamil	ACCURETIC (quinapril/HCTZ) CAPOZIDE (captopril/HCTZ) LOTENSIN HCT (benazepril/HCTZ) LOTREL (benazepril/amlodipine) moexipril/HCTZ PRESTALIA (perindopril/amlodipine) PRINZIDE (lisinopril/HCTZ) TARKA (trandolapril/verapamil) UNIRETIC (moexipril/HCTZ) VASERETIC (enalapril/HCTZ) ZESTORETIC (lisinopril/HCTZ)	Non-Preferred Criteria ACE Inhibitor/CCB <ul style="list-style-type: none"> • Have tried 2 different preferred <u>ACEI/CCB</u> agents in the past 6 months OR • 90 consecutive days on the requested agent in the past 105 days ACE Inhibitor/Diuretic <ul style="list-style-type: none"> • Have tried 2 different preferred <u>ACEI/Diuretic</u> agents in the past 6 months OR • 90 consecutive days on the requested agent in the past 105 days
ANGIOTENSIN II RECEPTOR BLOCKERS (ARBs)		
irbesartan losartan olmesartan telmisartan valsartan	ATACAND (candesartan) AVAPRO (irbesartan) BENICAR (olmesartan) candesartan COZAAR (losartan) DIOVAN (valsartan) EDARBI (azilsartan) eprosartan MICARDIS (telmisartan) TEVETEN (eprosartan)	Non-Preferred Criteria <ul style="list-style-type: none"> • Have tried 2 different preferred <u>single entity</u> agents in the past 6 months OR • 90 consecutive days on the requested agent in the past 105 days
ARB COMBINATIONS		
ENTRESTO (valsartan/sacubitril) ^{Smart PA} irbesartan/HCTZ	ATACAND-HCT (candesartan/HCTZ) AVALIDE (irbesartan/HCTZ)	Entresto <ul style="list-style-type: none"> • Age ≥ 18 years AND

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losartan/HCTZ olmesartan/amlodipine olmesartan/HCTZ telmisartan/HCTZ valsartan/amlodipine valsartan/amlodipine/HCTZ valsartan/HCTZ	AZOR (olmesartan/amlodipine) BENICAR-HCT (olmesartan/HCTZ) BYVALSON (nebivolol/valsartan) candesartan/HCTZ DIOVAN-HCT (valsartan/HCTZ) EDARBYCLOL (azilsartan/chlorthalidone) EXFORGE (valsartan/amlodipine) EXFORGE HCT (valsartan/amlodipine/HCTZ) HYZAAR (losartan/HCTZ) MICARDIS-HCT (telmisartan/HCTZ) olmesartan/amlodipine/HCTZ telmisartan/amlodipine TEVETEN-HCT (eprosartan/HCTZ) TRIBENZOR (olmesartan/amlodipine/HCTZ) TWYNSTA (telmisartan/amlodipine)	<ul style="list-style-type: none"> • Documented diagnosis of heart failure OR • Age \geq 1 year AND • Documented diagnosis of heart failure with systemic ventricular systolic dysfunction <p>Non-Preferred Criteria ARB/Beta Blocker, ARB/CCB or ARB/CCB/Diuretic</p> <ul style="list-style-type: none"> • Have tried 1 preferred <u>ARB/CCB</u> agent in the past 6 months OR • 90 consecutive days on the requested agent in the past 105 days <p>ARB/Diuretic</p> <ul style="list-style-type: none"> • Have tried 2 different preferred <u>ARB/Diuretic</u> products in the past 6 months OR • 90 consecutive days on the requested agent in the past 105 days
DIRECT RENIN INHIBITORS		
	TEKTURN (aliskiren)	<p>Non-Preferred Criteria</p> <ul style="list-style-type: none"> • Documented diagnosis of hypertension AND

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			<ul style="list-style-type: none"> • Have tried 2 different preferred <u>ACEI or ARB single-entity</u> products in the past 6 months OR • 90 consecutive days on the requested agent in the past 105 days
DIRECT RENIN INHIBITOR COMBINATIONS			
		AMTURNIDE (aliskiren/amlodipine/hctz) TEKAMLO (aliskiren/amlodipine) TEKTURNA-HCT (aliskiren/hctz) VALTURNA (aliskiren/valsartan)	Non-Preferred Criteria <ul style="list-style-type: none"> • Documented diagnosis of hypertension AND • Have tried 2 different preferred <u>ACEI or ARB diuretic agents</u> in the past 6 months OR • 90 consecutive days on the requested agent in the past 105 days
ANTIBIOTICS (GI)			
	FIRVANQ (vancomycin) metronidazole neomycin tinidazole	DIFICID (fidaxomicin) FLAGYL (metronidazole) FLAGYL ER (metronidazole) paromomycin TINDAMAX (tinidazole) VANCOCIN (vancomycin) vancomycin XIFAXAN (rifaximin)	
ANTIBIOTICS (MISCELLANEOUS)			
KETOLIDES			
		KETEK (telithromycin)	

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(For All Medicaid, MSCAN and CHIP Beneficiaries)

EFFECTIVE 01/01/2021
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LINCOSAMIDE ANTIBIOTICS	
clindamycin capsules clindamycin solution	CLEOCIN (clindamycin) CLEOCIN SOLUTION (clindamycin)
MACROLIDES	
azithromycin clarithromycin ER clarithromycin IR clarithromycin suspension E.E.S. Suspension 200 (erythromycin ethylsuccinate) ERY-TAB (erythromycin) erythromycin	BIAXIN (clarithromycin) BIAXIN SUSPENSION (clarithromycin) BIAXIN XL (clarithromycin) E.E.S. (erythromycin ethylsuccinate) E.E.S. Suspension 400 (erythromycin ethylsuccinate) E-MYCIN (erythromycin) ERYC (erythromycin) ERYPED Suspension (erythromycin ethylsuccinate) ERYTHROCIN (erythromycin stearate) erythromycin estolate PCE (erythromycin) ZITHROMAX (azithromycin) ZMAX (azithromycin)
NITROFURAN DERIVATIVES	
nitrofurantoin nitrofurantoin monohydrate macrocrystals	FURADANTIN (nitrofurantoin) MACROBID (nitrofurantoin monohydrate macrocrystals) MACRODANTIN (nitrofurantoin)
OXAZOLIDINONES	
	SIVEXTRO (tedizolid) ZYVOX (linezolid)

Sivextro – [MANUAL PA](#)
Zyvox - [MANUAL PA](#)

Quantity Limit
• 6 tablets/month – Sivextro

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PLEUROMUTLINS	
	XENLETA (lefamulin)
ANTIBIOTICS (Topical)	
bacitracin ^{OTC} bacitracin/polymyxin ^{OTC} gentamicin sulfate mupirocin ointment neomycin/bacitracin/polymyxin ^{OTC}	ALTABAX (retapamulin) CORTISPORIN (bacitracin/neomycin/ polymyxin/Hc) mupirocin cream NEOSPORIN (neomycin/bacitracin/polymyxin) ^{OTC} XEPI (ozenoxacin)
ANTIBIOTICS (VAGINAL)	
CLEOCIN OVULES (clindamycin) CLINDESSE (clindamycin) metronidazole vaginal	AVC (sulfanilamide) CLEOCIN CREAM (clindamycin) clindamycin cream METROGEL (metronidazole) NUVESSA (metronidazole) SOLOSEC (secnidazole) VANDAZOLE (metronidazole)
ANTICOAGULANTS <small>SmartPA</small>	
ORAL	
COUMADIN (warfarin) ELIQUIS (apixaban) PRADAXA (dabigatran) warfarin XARELTO (rivaroxaban)	BEVYXXA (betrixaban) SAVAYSA (edoxaban tosylate)
	<p><u>DVT Prophylaxis - following hip replacement</u> XARELTO 10MG, ELIQUIS, PRADAXA 110MG</p> <ul style="list-style-type: none"> 70 total days of therapy per calendar year Documented diagnosis of hip replacement AND Duration of therapy limited to 35 days

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			<p>DVT Prophylaxis - following knee replacement XARELTO 10MG & ELIQUIS</p> <ul style="list-style-type: none"> • 70 total days of therapy per calendar year • Documented diagnosis of knee replacement AND • Duration of therapy limited to 12 days <p>Eliquis 5mg Starter Pack - ONLY approved for treatment of DVT/PE</p> <p>XARELTO 2.5MG</p> <ul style="list-style-type: none"> • Documented diagnosis of coronary artery disease OR • Documented diagnosis of peripheral artery disease AND • History of therapy with aspirin in the past 30 days AND • History of 90 days therapy with anti-platelet agent in the past year OR • History of 30 days therapy with warfarin in the past year <p>Non-Preferred Criteria</p> <ul style="list-style-type: none"> • Have tried 2 different preferred agents in the past 6 months OR • 1 claim with the requested agent in the past 90 days
LOW MOLECULAR WEIGHT HEPARIN (LMWH)			

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	enoxaparin	ARIXTRA (fondaparinux) fondaparinux FRAGMIN (dalteparin) LOVENOX (enoxaparin) Prefilled Syringe	<p>LMWH – All Agents</p> <ul style="list-style-type: none"> • LMWH therapy in the past 3 months AND <ul style="list-style-type: none"> ○ Documented diagnosis of cancer OR ○ Female and age 8 to 51 years OR • NO LMWH therapy in the past 3 months AND <ul style="list-style-type: none"> ○ Duration of therapy is ≤ 17 days OR ○ Documented diagnosis of cancer OR ○ Female age 8 to 51 years OR ○ Total hip/knee replacement or hip fracture surgery in the past 6 months AND ○ Duration of therapy ≤ 35 days <p>LMWH Non-Preferred Criteria</p> <ul style="list-style-type: none"> • Have tried 1 different preferred agent in the past 6 months OR • 90 consecutive days on the requested agent in the past 105 days
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ANTICONVULSANTS SmartPA

ADJUVANTS		
	carbamazepine carbamazepine suspension carbamazepine ER DEPAKOTE ER (divalproex) DEPAKOTE SPRINKLE (divalproex) divalproex	APTIOM (eslicarbazepine) BANZEL (rufinamide) BRIVIACT (brivaracetam) carbamazepine XR CARBATROL (carbamazepine) DEPAKENE (valproic acid)

Minimum Age Limit

- **1 year** – Banzel, Epidiolex
- **2 years** – Diacomit, Onfi, Sympazan

Non-Preferred Criteria

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<ul style="list-style-type: none"> divalproex ER divalproex sprinkle EPITOL (carbamazepine) gabapentin GABITRIL (tiagabine) lamotrigine levetiracetam levetiracetam ER oxcarbazepine oxcarbazepine suspension topiramate tablet topiramate sprinkle capsule valproic acid VIMPAT (lacosamide) zonisamide 	<ul style="list-style-type: none"> DEPAKOTE (divalproex) DIACOMIT (stiripentol) EPIDIOLEX (cannabidiol) EQUETRO (carbamazepine) felbamate FELBATOL (felbamate) FINTEPLA (fenfluramine) FYCOMPA (perampanel) KEPPRA (levetiracetam) KEPPRA XR (levetiracetam) LAMICTAL (lamotrigine) LAMICTAL CHEWABLE (lamotrigine) LAMICTAL ODT (lamotrigine) LAMICTAL XR (lamotrigine) lamotrigine ER/XR lamotrigine ODT NEURONTIN (gabapentin) OXTELLAR XR (oxcarbazepine) QUDEXY XR (topiramate) ROWEEPR (levetiracetam) SABRIL (vigabatrin) SPRITAM (levetiracetam) STAVZOR (valproic acid) TEGRETOL (carbamazepine) TEGRETOL SUSPENSION (carbamazepine) TEGRETOL XR (carbamazepine) tiagabine TOPAMAX TABLET (topiramate) TOPAMAX Sprinkle (topiramate) topiramate ER (generic Qudexy XR) ^{Step Edit} TRILEPTAL Tablets (oxcarbazepine) TRILEPTAL Suspension (oxcarbazepine) 	<ul style="list-style-type: none"> • Have tried 2 different preferred agents in the past 6 months OR • 90 consecutive days on the requested agent in the past 105 days days AND • Documented diagnosis of seizure <p>Banzel/Onfi/Sympazan</p> <ul style="list-style-type: none"> • Documented diagnosis of Lennox-Gastaut AND • Have tried 1 different preferred agent for Lennox-Gastaut in the past 6 months OR • 90 consecutive days on the requested agent in the past 105 days days AND • Documented diagnosis of seizure <p>Diacomit</p> <ul style="list-style-type: none"> • Documented diagnosis of Dravet syndrome AND • Active claim for clobazam <p>Epidiolex</p> <ul style="list-style-type: none"> • Documented diagnosis of Dravet syndrome or seizures associated with tuberous sclerosis complex OR • Documented diagnosis of Lennox-Gastaut AND • Have tried 1 different preferred agent for Lennox-Gastaut in the past 6 months OR • 1 claim for the requested agent in the past 30 days
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		TROKENDI XR (topiramate) vigabatrin XCOPRI (cenobamate)	<p>Fintepla</p> <ul style="list-style-type: none"> • Requires clinical review <p>Sabril Powder for Oral Solution</p> <ul style="list-style-type: none"> • Documented diagnosis of infantile spasms OR • Have tried 2 different preferred agents in the past 6 months OR • 90 consecutive days on the requested agent in the past 105 days AND • Documented diagnosis of seizure <p>Topiramate ER – Step Edit</p> <ul style="list-style-type: none"> • 90 consecutive days on the requested agent in the past 105 days AND • Documented diagnosis of seizure OR • 30 day trial with topiramate IR in the past 6 months
SELECTED BENZODIAZEPINES			
	clobazam diazepam rectal gel NAYZILAM (midazolam) VALTOCO (diazepam)	DIASTAT (diazepam rectal) DIASTAT ACCUDIAL (diazepam rectal) ONFI (clobazam) ONFI SUSPENSION (clobazam) SYMPAZAN (clobazam)	<p>Minimum Age Limit</p> <ul style="list-style-type: none"> • 12 years – Nayzilam • 6 years – Valtoco <p>Quantity Limit</p> <ul style="list-style-type: none"> • 2 Twin Packs/31 days – Diastat • 2 Packages /31 days – Nayzilam • 2 Cartons/31 days - Valtoco

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HYDANTOINS	
DILANTIN (phenytoin) PHENYTEK (phenytoin) phenytoin	PEGANONE (ethotoin)
SUCCINIMIDES	
ethosuximide	CELONTIN (methsuximide) ZARONTIN (ethosuximide)
ANTIDEPRESSANTS, OTHER <small>SmartPA</small>	
bupropion bupropion SR bupropion XL TRINTELLIX (vortioxetine) mirtazapine trazodone venlafaxine venlafaxine ER capsules VIIBRYD (vilazodone)	APLENZIN (bupropion HBr) desvenlafaxine ER desvenlafaxine fumarate ER DESYREL (trazodone) DRIZALMA SPRINKLE (duloxetine) EFFEXOR (venlafaxine) EFFEXOR XR (venlafaxine) EMSAM (selegiline transdermal) FETZIMA ER (levomilnacipran) FORFIVO XL (bupropion) KHEDEZLA ER (desvenlafaxine) MARPLAN (isocarboxazid) NARDIL (phenelzine) nefazodone OLEPTRO ER (trazodone) PARNATE (tranylcypromine) phenelzine PRISTIQ (desvenlafaxine) REMERON (mirtazapine)

Minimum Age Limit

- **18 years** - all drugs
- **7-17 years** – duloxetine (except Drizalma Sprinkle)
Smart PA will automatically be issued for this age range with a diagnosis of GAD (generalized anxiety disorder)
- **7-11 years** – Drizalma Sprinkle
Smart PA will automatically be issued for this age range with a diagnosis of GAD (generalized anxiety disorder)

Non-Preferred Criteria

- Have tried 2 different preferred '*Antidepressants, Other*' Class in the past 6 months **OR**
- Have tried BOTH a preferred '*Antidepressant, SSRI*' and

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		tranylcypromine venlafaxine XR venlafaxine ER tablets WELLBUTRIN (bupropion) WELLBUTRIN SR (bupropion) WELLBUTRIN XL (bupropion HCl)	<i>'Antidepressants, Other'</i> in the past 6 months OR <ul style="list-style-type: none"> • 90 consecutive days on the requested agent in the past 105 days Cymbalta and Irenka (see Fibromyalgia Agents)
ANTIDEPRESSANTS, SSRIs <small>SmartPA</small>			
	citalopram escitalopram fluoxetine capsules fluvoxamine paroxetine CR paroxetine IR sertraline	CELEXA (citalopram) fluoxetine DR fluvoxamine ER LEXAPRO (escitalopram) LUVOX (fluvoxamine) LUVOX CR (fluvoxamine) paroxetine suspension PAXIL CR (paroxetine) PAXIL SUSPENSION (paroxetine) PAXIL Tablets (paroxetine) PEXEVA (paroxetine) PROZAC (fluoxetine) SARAFEM (fluoxetine) ZOLOFT (sertraline)	Minimum Age Limit <ul style="list-style-type: none"> • 6 years - Zoloft • 7 years – Prozac • 8 years - Luvox • 12 years - Lexapro • 18 years – Celexa, Luvox CR, Paxil, Pexeva, Prozac 90 mg Citalopram Criteria <ul style="list-style-type: none"> • <18 years and 90 consecutive days on citalopram in the past 105 days OR • < 60 years AND max daily dose ≤ 40 mg/day OR • ≥ 60 years AND max daily dose ≤ 20 mg/day Non-Preferred Criteria <ul style="list-style-type: none"> • Have tried 2 different preferred agents in the past 6 months OR • 90 consecutive days on the requested agent in the past 105 days

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ANTIEMETICS <small>SmartPA</small>		
5HT3 RECEPTOR BLOCKERS		
ondansetron ondansetron ODT ondansetron solution	ANZEMET (dolasetron) granisetron SANCUSO (granisetron) ZOFRAN (ondansetron) ZOFRAN ODT (ondansetron) ZUPLENZ (ondansetron)	<p>Quantity Limit</p> <ul style="list-style-type: none"> • 4 tablets/28 days - Varubi • 6 tablets/31 days – Akynzeo • 30 tablets/31 days – Zofran tablets/ODT • 100 ml/31 days – Zofran solution <p>Non-Preferred Agents</p> <ul style="list-style-type: none"> • Have tried 1 preferred agent in the past 6 months <p>Injectables in this class closed to point of sale. PA required if not administered in clinic/hospital</p>
ANTIEMETIC COMBINATIONS		
	AKYNZEO (netupitant/palonosetron) BONJESTA (doxylamine/pyridoxine) DICLEGIS (doxylamine/pyridoxine) doxylamine/pyridoxine	Akynzeo - MANUAL PA
CANNABINOIDS		
	CESAMET (nabilone) MARINOL (dronabinol) dronabinol SYNDROS (dronabinol)	
NMDA RECEPTOR ANTAGONIST		
EMEND (aprepitant)	aprepitant VARUBI (rolapitant)	Varubi - MANUAL PA
ANTIFUNGALS (Oral) <small>SmartPA</small>		

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<p>clotrimazole fluconazole griseofulvin microsize suspension nystatin terbinafine</p>	<p>ANCOBON (flucytosine) ^ CRESEMBA (isavuconazonium) DIFLUCAN (fluconazole) flucytosine GRIFULVIN V (griseofulvin, microsize) griseofulvin microsize tablets griseofulvin ultramicrosize tablet GRIS-PEG (griseofulvin) itraconazole ^ ketoconazole LAMISIL (terbinafine) NOXAFIL (posaconazole) ^ ONMEL (itraconazole) ^ SPORANOX (itraconazole) ^ TERBINEX Kit (terbinafine/ciclopirox) TOLSURA (itraconazole) VFEND (voriconazole) ^ voriconazole ^</p>	<p>Minimum Age Limit</p> <ul style="list-style-type: none"> • 4-12 years – Lamisil Granules <u>Smart PA will automatically be issued for this age range</u> • 12-17 years – griseofulvin tablets <u>Smart PA will automatically be issued for this age range</u> <p>Non-Preferred Criteria</p> <ul style="list-style-type: none"> • Have tried 2 different preferred agents in the past 6 months <p>HIV opportunistic infection</p> <ul style="list-style-type: none"> • Non-Preferred agent indicated for treatment (^) AND • Documented diagnosis of HIV <p>Cresemba - <u>MANUAL PA</u></p> <ul style="list-style-type: none"> • Minimum age limit ≥ 18 years AND • Documented diagnosis of invasive aspergillosis OR invasive mucormycosis AND • Prescriber is an oncologist/hematologist or infectious disease specialist <p>Sporanox</p> <ul style="list-style-type: none"> • HIV opportunistic infection criteria OR • Documented diagnosis of a transplant OR • History of an immunosuppressant in the past 6 months OR
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ANTIFUNGALS (Topical) <small>SmartPA</small>		ANTIFUNGALS	<ul style="list-style-type: none"> • Have tried 2 different preferred agents in the past 6 months
	ciclopirox cream/gel/solution/suspension clotrimazole cream/solution ^{Rx & OTC} ketoconazole shampoo miconazole cream/powder ^{OTC} nystatin terbinafine cream/spray ^{OTC} tolnaftate cream/powder/spray ^{OTC}	BENSAL HP (benzoic acid/salicylic acid) butenafine CICLODAN KIT (ciclopirox kit) ciclopirox kit/shampoo CNL 8 (ciclopirox) econazole ERTACZO (sertaconazole) EXELDERM (sulconazole) EXTINA (ketoconazole) JUBLIA (efinaconazole) KERYDIN (tavaborole) ketoconazole cream ketoconazole foam LAMISIL (terbinafine) solution LOPROX (ciclopirox) LUZU (luliconazole) MENTAX (butenafine) naftifine NAFTIN (naftifine) NIZORAL (ketoconazole) oxiconazole OXISTAT (oxiconazole) PEDIADERM AF (nystatin) PENLAC (ciclopirox) VUSION (miconazole/petrolatum/zinc oxide)	Non-Preferred Criteria <ul style="list-style-type: none"> • Have tried 2 different preferred agents in the past 6 months

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ANTIFUNGAL/STEROID COMBINATIONS		
	clotrimazole/betamethasone cream nystatin/triamcinolone	clotrimazole/betamethasone lotion LOTRISONE (clotrimazole/betamethasone)
ANTIFUNGALS (VAGINAL)		
	clotrimazole vaginal cream ^{OTC} miconazole 1, 7cream ^{OTC} TERAZOL 3 Cream (terconazole) – currently unavailable from manufacturer tioconazole	GYNAZOLE 1 (butoconazole) miconazole 3 vaginal cream, suppository ^{OTC} TERAZOL 3 Suppository (terconazole) TERAZOL 7 (terconazole) terconazole
ANTI-HISTAMINES, MINIMALLY SEDATING AND COMBINATIONS <small>SmartPA</small>		
MINIMALLY SEDATING ANTIHISTAMINES		
	cetirizine tablets ^{OTC} cetirizine syrup ^{Rx & OTC} loratadine odt ^{OTC} loratadine syrup ^{OTC} loratadine tablet ^{OTC}	cetirizine chewable ^{OTC} CLARINEX (desloratadine) desloratadine ODT desloratadine tablet fexofenadine syru fexofenadine table levocetirizine syrup levocetirizine tablet XYZAL Solution (levocetirizine) XYZAL Tablets (levocetirizine)
		Non-Preferred Criteria <ul style="list-style-type: none"> • Documented diagnosis of allergy or urticaria AND • Have tried 2 different preferred agents in the past 12 months
MINIMALLY SEDATING ANTIHISTAMINE/DECONGESTANT COMBINATIONS		
	cetirizine/pseudoephedrine loratadine/pseudoephedrine	ALLEGRA-D (fexofenadine/ pseudoephedrine) CLARITIN-D (loratadine/pseudoephedrine) CLARINEX-D (desloratadine/ pseudoephedrine) fexofenadine/pseudoephedrine ZYRTEC-D (cetirizine/pseudoephedrine)

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ANTIMIGRAINE AGENTS, CALCITONIN GENE RELATED PEPTIDE INHIBITOR		
ORAL		
	NURTEC ODT (rimegepant)**	UBRELVY (ubrogepant)
		<p>Minimum Age Limit</p> <ul style="list-style-type: none"> • 18 years – Nurtec ODT, Ubrelyvy <p>Quantity Limit</p> <ul style="list-style-type: none"> • 8 tablets/31 day – Nurtec ODT • 16 tablets/31 day – Ubrelyvy <p>Nurtec ODT</p> <ul style="list-style-type: none"> • Documented diagnosis of migraine AND • Have tried 2 different triptans in the past 6 months AND • No concurrent therapy with another CGRP agent <p>Ubrelyvy</p> <ul style="list-style-type: none"> • Documented diagnosis of migraine AND • Have tried 2 different triptans in the past 6 months AND • Have tried preferred Nurtec ODT in the past 6 months AND • No concurrent therapy with another CGRP agent AND • No concurrent therapy with a strong CYP3A4 inhibitor

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INJECTIBLES		
AIMOVIG AUTOINJECTOR (erenumab-aooe)	EMGALITY PEN (galcanezumab-gnlm)	
AJOVY AUTOINJECTOR (fremanezumab-vfrm)	EMGALITY SYRINGE (galcanezumab-gnlm)	
AJOVY SYRINGE (fremanezumab-vfrm)	VYEPTI (eptinezumab-jjmr)	
ANTIMIGRAINE AGENTS, TRIPTANS & RELATED AGENTS ^{SmartPA}		
ORAL		
naratriptan rizatriptan rizatriptan ODT sumatriptan tablets zolmitriptan zolmitriptan ODT	almotriptan AMERGE (naratriptan) AXERT (almotriptan) eletriptan FROVA (frovatriptan) frovatriptan IMITREX (sumatriptan) MAXALT (rizatriptan) MAXALT MLT(rizatriptan) RELPAX (eletriptan) REYVOW (lasmiditan) TREXIMET (sumatriptan/naproxen) ZOMIG (zolmitriptan)	<p>Minimum Age Limit – ALL FORMULATIONS</p> <ul style="list-style-type: none"> • 6 years – Maxalt • 12-17 years – Axert, Treximet, Zomig nasal spray <i>Smart PA will automatically be issued for this age range</i> • 18 years – Amerge, Frova, Imitrex, Onzetra Xsail, Relpax, Reyvow, Tosymra, Zembrace Symtouch, Zomig tablets <p>Quantity Limit - ORAL</p> <ul style="list-style-type: none"> • 4 tablets/31 days – Reyvow 50 mg • 6 tablets/31 days - Axert, Relpax Zomig • 8 tablets/31 days – Reyvow 100 mg • 9 tablets/31 days - Amerge, Frova, Imitrex, Treximet • 12 tablets/31 days – Maxalt <p>Non-Preferred Criteria - ORAL</p> <ul style="list-style-type: none"> • Have tried 2 preferred preferred oral agents in the past 90 days

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			<p>Reyvow</p> <ul style="list-style-type: none"> Documented diagnosis of migraine AND Have tried 2 different triptans in the past 90 days AND Have tried preferred Nurtec ODT in the past 90 days AND
NASAL			
	sumatriptan	IMITREX (sumatriptan) ONZETRA Xsail (sumatriptan) TOSYMRA (sumatriptan) ZOMIG (zolmitriptan)	<p>Quantity Limit - NASAL</p> <ul style="list-style-type: none"> 1 box/31 days <p>Non-Preferred Criteria - NASAL</p> <ul style="list-style-type: none"> Have tried 2 preferred oral agents in the past 90 days AND Have tried either a preferred nasal sumatriptan or injectable sumatriptan in the past 90 days
INJECTABLES			
	sumatriptan	IMITREX (sumatriptan) ZEMBRACE (sumatriptan)	<p>CUMULATIVE Quantity Limit - INJECTION</p> <p>4 injections/31 days</p>
* ANTINEOPLASTICS – SELECTED SYSTEMIC ENZYME INHIBITORS			
	AFINITOR (everolimus) BOSULIF (bosutinib) CAPRELSA (vandetanib) COMETRIQ (cabozantinib) COTELLIC (cobimetinib) GILOTRIF (afatinib) ICLUSIG (ponatinib) imatinib mesylate IMBRUVICA (ibrutinib) INLYTA (axitinib) IRESSA (gefitinib)	ALECENSA (alectinib) ALUNBRIG (brigatinib) AYYAKIT (avapritinib) BALVERSA (erdafitinib) BRAFTOVI (encorafenib) BRUKINSA (zanubrutinib) COPIKTRA (duvelisib) CABOMETYX (cabozantinib s-malate) CALQUENCE (acalabrutinib) DAURISMO (glasdegib) ERLEADA (apalutamide)	<p>Farydak - <u>MANUAL PA</u></p> <ul style="list-style-type: none"> Documented diagnosis of multiple myeloma AND Used in combination with bortezomib and dexamethasone per PI AND History of 2 prior regimens including bortezomib and an immunomodulatory agent

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JAKAFI (ruxolitinib)
MEKINIST (trametinib dimethyl sulfoxide)
NEXAVAR (sorafenib)
ROZLYTREK (entrectinib)
SPRYCEL (dasatinib)
STIVARGA (regorafenib)
SUTENT (sunitinib)
TAFINLAR (dabrafenib)
TARCEVA (erlotinib)
TASIGNA (nilotinib)
TURALIO (pexidartinib)
TYKERB (lapatinib ditosylate)
vandetanib
VOTRIENT (pazopanib)
XALKORI (crizotinib)
XTANDI (enzalutamide)
ZELBORAF (vemurafenib)
ZYDELIG (idelalisib)
ZYKADIA (ceritinib)

FARYDAK (panobinostat)
GLEEVEC (imatinib mesylate)
GLEOSTINE (lomustine)
IBRANCE (palbociclib) ^{SmartPA}
IDHIFA (enasidenib)
INREBIC (fedratinib)
KISQALI (ribociclib)
KOSELUGO (selumetinib)
LENVIMA (lenvatinib) ^{SmartPA}
LORBRENA (lorlatinib)
LYNPARZA (olaparib) ^{SmartPA}
MEKTOVI (binimetinib)
NERLYNX (neratinib maleate)
NUBEQA (darolutamide)
PEMAZYRE (pemigatinib)
PIQRAY (alpelisib)
QINLOCK (ripretinib)
RETEVMO (selpercatinib)
RUBRACA (rucaparib)
RYDAPT (midostaurin)
TABRECTA (capmatinib)
TAGRISSO (osimertinib)
TALZENNA (talazoparib)
TAZVERIK (tazemetostat)
TIBSOVO (ivosidenib)
TUKYSA (tucatinib)
VERZENIO (abemaciclib)
VITRAKVI (larotrectinib)
VIZIMPRO (dacomitinib)
XATMEP (methotrexate)
XOSPATA (gilteritinib)
XPOVIO (selinexor)
ZEJULA (niraparib)

Ibrance

- Documented diagnosis of WD-DDLS for retroperitoneal sarcoma **OR**
- All other indications evaluated through clinical review

Lenvima

- Documented diagnosis of thyroid cancer **OR**
- Documented diagnosis of hepatocellular carcinoma **OR**
- Documented diagnosis of renal cell carcinoma **AND**
- History of 1 claim for everolimus in the past 30 days **AND**
- History of 1 anti-angiogenic agent in the past 2 years.

Lynparza Capsules - [MANUAL PA](#)

Lynparza Tablets

- Documented diagnosis of ovarian cancer, fallopian tube or peritoneal cancer **AND**
- History of platinum-based chemotherapy in the past 2 years **OR**
- All other indications evaluated through clinical review

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ANTIPARASITICS (Topical) <small>SmartPA</small>			
PEDICULICIDES			
	permethrin 1% ^{OTC} NATROBA (spinosad)	lindane malathion OVIDE (malathion) SKLICE (ivermectin) spinosad VANALICE (piperonyl butoxide/pyrethrins)	Minimum Age/Weight Limit for Pediculicides <ul style="list-style-type: none"> 50 kg - lindane shampoo 2 months – permethrin 1%(OTC) 6 months – Natroba, Sklice 2 years – piperonyl/pyrethrins (OTC) 6 years – Ovide Non-Preferred Criteria <ul style="list-style-type: none"> History of 2 preferred topical lice agents in the past 90 days
SCABICIDES			
	permethrin 5% STROMECTOL Tablet (ivermectin)	ELIMITE (permethrin) EURAX CREAM (crotamiton) EURAX LOTION (crotamiton)	Minimum Age/Weight Limit for Topical Scabicides <ul style="list-style-type: none"> 50 kg - lindane lotion 2 months – permethrin 5% 18 years – Eurax Non-Preferred Criteria <ul style="list-style-type: none"> History of permethrin 5% in the past 90 days
ANTIPARKINSON'S AGENTS (Oral) <small>SmartPA</small>			
ANTICHOLINERGICS			

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	benztropine trihexyphenidyl	COGENTIN (benztropine)	<p>Non-Preferred Criteria</p> <ul style="list-style-type: none"> • Documented diagnosis of Parkinson's disease AND • Have tried 2 different preferred agents in the past 6 months OR • 90 consecutive days on the requested agent in the past 105 days
COMT INHIBITORS			
	entacapone	COMTAN (entacapone) TASMAR (tolcapone) tolcapone	
DOPAMINE AGONISTS			
	ropinirole	KYNMOBI FILM (apomorphine) MIRAPEX (pramipexole) MIRAPEX ER (pramipexole) NEUPRO (rotigotine) pramipexole pramipexole ER REQUIP (ropinirole) REQUIP XL (ropinirole) ropinirole ER	
MAO-B INHIBITORS			
	selegiline	AZILECT (rasagiline) ELDEPRYL (selegiline) rasagiline XADAGO (safinamide) ZELAPAR (selegiline)	<p>Xadago</p> <ul style="list-style-type: none"> • Documented diagnosis of Parkinson's disease AND • History of a preferred carbidopa/levodopa combination product in the past 30 days AND • History of selegiline product in the past 45 days

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OTHERS			
	amantadine bromocriptine carbidopa levodopa/carbidopa	DUOPA (levodopa/carbidopa) GOCOVRI (amantadine) INBRIJA (levodopa) levodopa/carbidopa ODT levodopa/carbidopa/entacapone LODOSYN (carbidopa) NOURIANZ (istradefylline) OSMOLEX ER (amantadine) PARCOPA (levodopa/carbidopa) PARLODEL (bromocriptine) RYTARY ER (levodopa/carbidopa) SINEMET (levodopa/carbidopa) SINEMET CR (levodopa/carbidopa) STALEVO (levodopa/carbidopa/entacapone)	<p>Lodosyn and Inbrija</p> <ul style="list-style-type: none"> Documented diagnosis of Parkinson's disease AND History of a carbidopa/levodopa combination product in the past 45 days <p>Nouriaz</p> <ul style="list-style-type: none"> Documented diagnosis of Parkinson's Disease AND History of a preferred carbidopa/levodopa combination product in the past 30 days AND History of 30 days therapy with a preferred adjunctive therapy in the past 45 days
ANTIPSYCHOTICS <small>SmartPA</small>			
ORAL			
	amitriptyline/perphenazine aripiprazole clozapine fluphenazine haloperidol olanzapine olanzapine ODT perphenazine quetiapine quetiapine XR risperidone	ABILIFY (aripiprazole) ABILIFY MYCITE (aripiprazole) ADASUVE (loxapine) aripiprazole solution aripiprazole ODT CAPLYTA (lumateperone) chlorpromazine clozapine ODT CLOZARIL (clozapine) FANAPT (iloperidone) FAZACLO (clozapine)	<p>Minimum Age Limit</p> <ul style="list-style-type: none"> 2 years – Droperidol 3 years – Haldol 5 years – Risperdal, thioridazine 6 years – Abilify, trifluoperazine 10 years – Latuda, Saphris, Seroquel, Symbyax 12 years – Molidone, perphenazine, pimozole, thiothixene 13 years – Zyprexa

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<ul style="list-style-type: none"> risperidone ODT SAPHRIS (asenapine) thioridazine thiothixene trifluoperazine ziprasidone 	<ul style="list-style-type: none"> GEODON (ziprasidone) HALDOL (haloperidol) INVEGA ER(paliperidone) LATUDA (lurasidone) NUPLAZID (pimavanserin) olanzapine/fluoxetine paliperidone ER REXULTI (brexpiprazole) RISPERDAL (risperidone) SEROQUEL (quetiapine) SEROQUEL XR (quetiapine) SYMBYAX (olanzapine/fluoxetine) VERSACLOZ (clonazpine) VRAYLAR (cariprazine) ZYPREXA (olanzapine) 	<ul style="list-style-type: none"> • 18 years – Abilify Mycite, Amitriptyline/perphenazine, Caplyta, Clozaril, Fanapt, fluphenazine, Geodon, Invega, loxapine, Nuplazid, Rexulti, Secuado, Vraylar, Concurrent Therapy Limit – Ages 0-17 years • 90 days with >2 antipsychotics in the last 120 days will require a Manual PA Non-Preferred Criteria- Atypical Agents • Have tried 2 preferred atypical antipsychotic agents in the past 12 months OR • 30 consecutive days on the requested atypical agent in the past 180 days Nuplazid • Documented diagnosis of Parkinson's disease
INJECTABLE, ATYPICALS SmartPA		
<ul style="list-style-type: none"> ARISTADA ER (aripiprazole lauroxil) ARISTADA INITIO (aripiprazole lauroxil) ABILIFY MAINTENA (aripiprazole) INVEGA SUSTENNA (paliperidone palmitate) INVEGA TRINZA (paliperidone) PERSERIS (risperidone) 	<ul style="list-style-type: none"> ABILIFY (aripiprazole) GEODON (ziprasidone) olanzapine ZYPREXA (olanzapine) ZYPREXA RELPREVV (olanzapine) 	<ul style="list-style-type: none"> Minimum Age Limit • 18 years – all injectable agents Quantity Limit • 3 syringes/year – Aristada Initio

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	RISPERDAL CONSTA (risperidone)		
			<p>Long Acting Injectable Agents All Agents</p> <ul style="list-style-type: none"> Documented diagnosis of schizophrenia or schizoaffective disorder <p>Abilify Maintena or Risperdal Consta</p> <ul style="list-style-type: none"> Documented diagnosis of schizophrenia or schizoaffective disorder OR Documented diagnosis of bipolar disorder
TRANSDERMAL, ATYPICALS			
		SECUADO (asenapine)	
ANTIRETROVIRALS <small>SmartPA</small>			
SINGLE TABLET REGIMENS			
	ATRIPLA (efavirenz/emtricitabine/tenofovir) BIKTARVY (bictegravir/emtricitabine/tenofovir) DELSTRIGO (doravirine/lamivudine/tenofovir) GENVOYA (elvitegravir/cobicistat/emtricitabine/tenofovir) ODEFSEY (emtricitabine/rilpivirine/tenofovir AF) SYMFI (efavirenz/lamivudine/tenofovir) SYMFI-LO (efavirenz/lamivudine/tenofovir)	COMPLERA (emtricitabine/rilpivirine/tenofovir) DOVATO (dolutegravir/lamivudine) JULUCA (dolutegravir/rilpivirine) STRIBILD (elvitegravir/cobicistat/emtricitabine/tenofovir) SYMTUZA (darunavir/cobicistat/emtricitabine/tenofovir) TRIUMEQ (abacavir/lamivudine/ dolutegravir)	<p>Stribild – <u>MANUAL PA</u></p> <ul style="list-style-type: none"> Genotype testing supporting resistance to other regimens OR Intolerance or contraindication to preferred combination of drugs AND Medical reasoning beyond convenience or enhanced compliance over preferred agents AND

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			<ul style="list-style-type: none"> • CrCl > 70mL/min to initiate therapy OR CrCl >50mL/min to continue therapy
INTEGRASE STRAND TRANSFER INHIBITORS			
	ISENTRESS (raltegravir potassium) TIVICAY (dolutegravir sodium) TIVICAY PD (dolutegravir sodium)	ISENTRESS HD (raltegravir potassium) VITEKTA (elvitegravir)	Non-Preferred Criteria <ul style="list-style-type: none"> • 1 claim with the requested agent in the past 105 days
NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS (NRTI)			
	abacavir sulfate EMTRIVA (emtricitabine) lamivudine tenofovir disoproxil fumarate ZIAGEN Solution (abacavir sulfate) zidovudine	didanosine DR capsule EPIVIR (lamivudine) RETROVIR (zidovudine) stavudine VIDEX EC (didanosine) VIDEX SOLUTION (didanosine) VIREAD (tenofovir disoproxil fumarate) ZERIT (stavudine) ZIAGEN Tablet (abacavir sulfate)	
NON-NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITOR (NNRTI)			
	EDURANT (rilpivirine) SUSTIVA (efavirenz)	efavirenz INTELENCE (etravirine) nevirapine nevirapine ER PIFELTRO (doravirine) RESCRIPTOR (delavirdine mesylate) VIRAMUNE (nevirapine) VIRAMUNE ER (nevirapine)	
PHARMACOEHANCER – CYTOCHROME P450 INHIBITOR			
		TYBOST (cobicistat)	Tybost - MANUAL PA

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PROTEASE INHIBITORS (PEPTIDIC)	
atazanavir EVOTAZ (atazanavir/cobicistat) NORVIR SOLUTION (ritonavir) ritonavir	CRIXIVAN (indinavir) fosamprenavir INVIRASE (saquinavir mesylate) LEXIVA (fosamprenavir) NORVIR POWDER(ritonavir) NORVIR TABLET (ritonavir) REYATAZ (atazanavir) VIRACEPT (nelfinavir mesylate)
PROTEASE INHIBITORS (NON-PEPTIDIC)	
PREZISTA (darunavir ethanolate)	APTIVUS (tipranavir) PREZCOBIX (darunavir/cobicistat)
ENTRY INHIBITORS – CCR5 CO-RECEPTOR ANTAGONISTS	
	SELZENTRY (maraviroc)
ENTRY INHIBITORS – FUSION INHIBITORS	
	FUZEON (enfuvirtide)
COMBINATION PRODUCTS - NRTIs	
abacavir/lamivudine lamivudine/zidovudine	abacavir/lamivudine/zidovudine COMBIVIR (lamivudine/zidovudine) DOVATO (dolutegravir/lamivudine) EPZICOM (abacavir/lamivudine) JULUCA (dolutegravir/rilpivirine) TRIZIVIR (abacavir/lamivudine/zidovudine)
COMBINATION PRODUCTS – NUCLEOSIDE & NUCLEOTIDE ANALOG RTIs	
DESCOVY (emtricitabine/tenofovir alafenam) TRUVADA (emtricitabine/tenofovir)	

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COMBINATION PRODUCTS – NUCLEOSIDE & NUCLEOTIDE ANALOGS & NON-NUCLEOSIDE RTIs		
ATRIPLA (efavirenz/emtricitabine/tenofovir) CIMDUO (lamivudine/tenofovir) DELSTRIGO (doravirine/lamivudine/tenofovir) ODEFSEY (emtricitabine/rilpivirine/tenofovir AF)	COMPLERA (emtricitabine/rilpivirine/tenofovir) TEMIXYS (lamivudine/tenofovir)	
COMBINATION PRODUCTS – PROTEASE INHIBITORS		
KALETRA (lopinavir/ritonavir)	lopinavir/ritonavir	
CD4 DIRECTED ATTACHMENT INHIBITOR		
	RUKOBIA (fostemsavir tromethamine ER)	
CD4 DIRECTED HIV-1 INHIBITOR		
	TROGARZO (ibalizumab)	
ANTIVIRALS (Oral)		
ANTI-CYTOMEGALOVIRUS AGENTS		
valganciclovir tablets	PREVYMIS (letermovir) VALCYTE (valganciclovir) valganciclovir solution	<p>valganciclovir solution – automatic approval for age <12 years</p> <p>Prevymis Prevention (prophylaxis) of cytomegalovirus (CMV) infection and disease</p> <ul style="list-style-type: none"> • 18 years or older AND

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			<ul style="list-style-type: none"> • Post hematopoietic stem cell transplant (HSCT) within the past 28 days AND • CMV sero-positive recipient [R+] AND • NO severe (Child-Pugh Class C) hepatic impairment
ANTI-HERPETIC AGENTS			
	acyclovir valacyclovir	famciclovir FAMVIR (famciclovir) SITAVIG (acyclovir) VALTREX (valacyclovir) ZOVIRAX (acyclovir)	
ANTI-INFLUENZA AGENTS			
	oseltamivir	FLUMADINE (rimantadine) RAPIVAB (peramivir) RELENZA (zanamivir) rimantadine TAMIFLU (oseltamivir) XOFLUZA (baloxavir marboxil)	
ANTIVIRALS (Topical)			
	ZOVIRAX Cream (acyclovir)	acyclovir cream, ointment DENA VIR (penciclovir) XERESE (acyclovir/hydrocortisone) ZOVIRAX Ointment (acyclovir)	
AROMATASE INHIBITORS			

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	anastrozole exemestane letrozole	ARIMIDEX (anastrozole) AROMASIN (exemestane) FEMARA (letrozole)	
ATOPIC DERMATITIS SmartPA			
	pimecrolimus labeler 68682 tacrolimus	DUPIXENT (dupilumab) ELIDEL (pimecrolimus) EUCRISA (crisaborole) pimecrolimus PROTOPIC (tacrolimus)	<p>Minimum Age Limit</p> <ul style="list-style-type: none"> • 2 years – Elidel, Protopic 0.03% • 6 years – Protopic 0.1% <p>Non-Preferred Criteria</p> <ul style="list-style-type: none"> • Have tried 1 preferred agent in the past 6 months <p>Eucrisa</p> <ul style="list-style-type: none"> • History of 28 days of therapy with a calcineurin inhibitor AND • History of 28 days of therapy with a topical steroid in the past year OR • MANUAL PA <p>Dupixent – Evaluated through Manual PA according to diagnosis</p> <p>Asthma – MANUAL PA</p> <p>Atopic Dermatitis – MANUAL PA</p> <p>Nasal Polyposis – MANUAL PA</p>
BETA BLOCKERS, ANTIANGINALS & SINUS NODE AGENTS SmartPA			

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	acebutolol atenolol bisoprolol BYSTOLIC (nebivolol) ^{Step Edit} metoprolol metoprolol ER nadolol pindolol propranolol propranolol ER sotalol	BETAPACE (sotalol) betaxolol CORGARD (nadolol) HEMANGEOL (propranolol) INDERAL LA (propranolol) INDERAL XL (propranolol) INNOPRAN XL (propranolol) KAPSPARGO SPRINKLES (metoprolol) KERLONE (bextaxolol) LEVATOL (penbutolol) LOPRESSOR (metoprolol) SECTRAL (acebutolol) SOTYLIZE (sotalol) TENORMIN (atenolol) TOPROL XL (metoprolol) ZEBETA (bisoprolol)	<p>Bystolic</p> <ul style="list-style-type: none"> • 90 consecutive days on the requested agent in the past 105 days OR • Have tried 1 preferred agent in the past 6 months <p>Non-Preferred Criteria</p> <ul style="list-style-type: none"> • Have tried 2 different preferred agents in the past 6 months OR • 90 consecutive days on the requested agent in the past 105 days
BETA- AND ALPHA-BLOCKERS			
	carvedilol labetalol	carvedilol CR COREG (carvedilol) COREG CR (carvedilol) TRANDATE (labetalol)	<p>Coreg CR</p> <ul style="list-style-type: none"> • Documented diagnosis for hypertension AND • Have tried generic carvedilol AND 1 preferred agent in the past 6 months OR • 90 consecutive days on the requested agent in the past 105 days
BETA BLOCKER/DIURETIC COMBINATIONS			
	atenolol/chlorthalidone bisoprolol/HCTZ metoprolol/HCTZ nadolol/bendroflumethiazide propranolol/HCTZ timolol/HCTZ	CORZIDE (nadolol/bendroflumethiazide) DUTOPROL (metoprolol/HCTZ) LOPRESSOR HCT (metoprolol/HCTZ) TENORETIC (atenolol/chlorthalidone) ZIAC (bisoprolol/HCTZ)	

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ANTIANGINALS			
		RANEXA (ranolazine) ranolazine	Ranexa <ul style="list-style-type: none"> • Documented diagnosis of angina AND • 1 claim for a calcium channel blocker, beta-blocker, nitrate, or combination agent in the past 30 days OR • 90 consecutive days on the requested agent in the past 105 days
SINUS NODE AGENTS			
		CORLANOR (ivabradine)	Corlanor - <u>MANUAL PA</u>
BILE SALTS			
	ursodiol	ACTIGALL (ursodiol) CHENODAL (chenodiol) CHOLBAM (cholic acid) OCALIVA (obeticholic acid) URSO (ursodiol) URSO FORTE (ursodiol)	
BLADDER RELAXANT PREPARATIONS <small>SmartPA</small>			
	oxybutynin ER oxybutynin IR solifenacin	darifenacin DETROL (tolterodine) DETROL LA (tolterodine) DITROPAN XL (oxybutynin) ENABLEX (darifenacin)	Non-Preferred Criteria <ul style="list-style-type: none"> • Have tried 2 different preferred agents in the past 6 months

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		<p>GELNIQUE (oxybutynin) MYRBETRIQ (mirabegron) OXYTROL (oxybutynin) tolterodine tolterodine ER TOVIAZ (fesoterodine fumarate) trospium trospium ER VESICARE (solifenacin)</p>	
BONE RESORPTION SUPPRESSION AND RELATED AGENTS <small>SmartPA</small>			
BISPHOSPHONATES			
	<p>alendronate ibandronate risedronate</p>	<p>ACTONEL (risedronate) ACTONEL WITH CALCIUM (risedronate/calcium) alendronate solution ATELVIA (risedronate) BINOSTO (alendronate) BONIVA (ibandronate) DIDRONEL (etidronate) FOSAMAX (alendronate) FOSAMAX PLUS D (alendronate/vitamin D) risedronate DR Tablet</p>	<p>Non-Preferred Criteria</p> <ul style="list-style-type: none"> • Documented diagnosis for osteoporosis or osteopenia AND • Have tried 2 different preferred agents in the past 6 months
OTHERS			
		<p>calcitonin salmon EVENITY (romosozumab-aqqg) EVISTA (raloxifene) FORTEO (teriparatide) MIACALCIN (calcitonin) PROLIA (denosumab) raloxifene</p>	

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		TYMLOS (abaloparatide) XGEVA (denosumab)	
BPH AGENTS SmartPA			
ALPHA BLOCKERS			
	alfuzosin doxazosin tamsulosin terazosin	CARDURA (doxazosin) CARDURA XL (doxazosin) dutasteride/tamsulosin FLOMAX (tamsulosin) HYTRIN (terazosin) JALYN (dutasteride/tamsulosin) RAPAFLO (silodosin) silodosin UROXATRAL (alfuzosin)	<p>Female</p> <ul style="list-style-type: none"> Cardura, Flomax, Proscar, terazosin, or Uroxatral AND Documented diagnosis based on a State accepted diagnosis <p>Non-Preferred Criteria - MALE</p> <ul style="list-style-type: none"> Have tried 2 different preferred agents in the past 6 months OR 90 consecutive days on the requested agent in the past 105 days
5-ALPHA-REDUCTASE (5AR) INHIBITORS			
	finasteride	AVODART (dutasteride) dutasteride PROSCAR (finasteride)	
PDE5 INHIBITORS			
		CIALIS (tadalafil)	
BRONCHODILATORS & COPD AGENTS			
ANTICHOLINERGICS & COPD AGENTS			
	ATROVENT HFA (ipratropium) ipratropium SPIRIVA HANDIHALER (tiotropium)	DALIRESP (roflumilast) INCRUSE ELLIPTA (umeclidinium) LONHALA MAGNAIR (glycopyrrolate) SEEBRI (glycopyrrolate)	<p>Minimum Age Limit 6 years – Spiriva Respimat</p> <p>Spiriva Respimat</p>

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		SPIRIVA RESPIMAT (tiotropium) ^{SmartPA} TUDORZA PRESSAIR (aclidinium) YUPELRI (revefenacin)	<ul style="list-style-type: none"> Automatic approval for ≥ 6 years with a diagnosis of asthma
ANTICHOLINERGIC-BETA AGONIST COMBINATIONS			
	albuterol/ipratropium ANORO ELLIPTA (umeclidinium/vilanterol) BEVESPI (glycopyrrolate/formoterol) COMBIVENT RESPIMAT (albuterol/ipratropium) ^{SmartPA} UTIBRON (indacaterol/glycopyrrolate)	DUAKLIR PRESSAIR (aclidinium/formoterol) STIOLTO RESPIMAT (tiotropium/olodaterol)	
ANTICHOLINERGIC-BETA AGONIST-GLUCOCORTICOID COMBINATIONS			
		BREZTRI AEROSPHERE (budesonide/glycopyrrolate/formoterol) TRELEGY ELLIPTA (fluticasone furoate/umeclidinium/vilanterol)	
BRONCHODILATORS, BETA AGONIST			
INHALERS, SHORT-ACTING			
	PROAIR HFA (albuterol) PROAIR RESPICLICK (albuterol) VENTOLIN HFA (albuterol)	albuterol HFA levalbuterol HFA PROAIR DIGIHALER (albuterol) PROVENTIL HFA (albuterol) XOPENEX HFA (levalbuterol) ^{SmartPA}	<p>Minimum Age Limit</p> <ul style="list-style-type: none"> 4 years - Xopenex HFA <p>Xopenex HFA</p> <ul style="list-style-type: none"> 1 claim for a preferred albuterol inhaler in the past 30 days <p>ProAir Digihaler</p> <ul style="list-style-type: none"> Requires clinical review
INHALERS, LONG ACTING ^{SmartPA}			
	SEREVENT (salmeterol)	ARCAPTA (indacaterol)	Minimum Age Limit

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		STRIVERDI RESPIMAT (olodaterol)	<ul style="list-style-type: none"> • 4 years – Serevent • 18 years – Arcapta, Striverdi Respimat <p>Arcapta & Striverdi Respimat</p> <ul style="list-style-type: none"> • Documented diagnosis of COPD AND • Have tried 1 preferred agent in the past 6 months OR • 90 consecutive days on the requested agent in the past 105 days
INHALATION SOLUTION SmartPA			
	albuterol	BROVANA (arformoterol) levalbuterol metaproterenol PERFOROMIST (formoterol) XOPENEX (levalbuterol)	<p>Minimum Age Limit</p> <ul style="list-style-type: none"> • 6 years – Xopenex • 18 years – Brovana, Perforomist <p>Non-Preferred Criteria</p> <ul style="list-style-type: none"> • 1 claim for a different preferred agent in the past 6 months OR • 3 claims with the requested agent in the past 105 days <p>Xopenex</p> <ul style="list-style-type: none"> • 1 claim for a preferred albuterol in the past 30 days
ORAL			

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MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

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	albuterol ER albuterol IR metaproterenol terbutaline	VOSPIRE ER (albuterol)	
CALCIUM CHANNEL BLOCKERS <small>SmartPA</small>			
SHORT-ACTING			
	diltiazem nicardipine nifedipine verapamil	CALAN (verapamil) CARDIZEM (diltiazem) isradipine nimodipine NYMALIZE SOLUTION (nimodipine) PROCARDIA (nifedipine)	<p>Quantity Limit - nimodipine</p> <ul style="list-style-type: none"> • 252 tablets/ 21 days • 2520 mL/21 days <p>Non-Preferred Criteria</p> <ul style="list-style-type: none"> • Have tried 2 different preferred <u>Short Acting</u> CCB agents in the past 6 months OR • 90 consecutive days on the requested agent in the past 105 days <p>nimodipine</p> <ul style="list-style-type: none"> • Documented diagnosis of subarachnoid hemorrhage in the past 45 days AND • Duration of therapy limited to 21 days
LONG-ACTING			
	amlodipine DILT XR 24 HR Caps (diltiazem) diltiazem ER Cap 24 HR (generic Cardizem CD) diltiazem ER Cap 24 HR felodipine ER nifedipine ER	ADALAT CC (nifedipine) CALAN SR (verapamil) CARDENE SR (nicardipine) CARDIZEM CD (diltiazem) CARDIZEM LA (diltiazem) DILACOR XR (diltiazem)	<p>Non-Preferred Criteria</p> <ul style="list-style-type: none"> • Have tried 2 different preferred <u>Long Acting</u> CCB agents in the past 6 months OR • 90 consecutive days on the requested agent in the past 105 days

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	verapamil ER	diltiazem ER Cap 12 HR diltiazem ER Tab 24 HR KATERZIA (amlodipine) nisoldipine NORVASC (amlodipine) PROCARDIA XL (nifedipine) SULAR (nisoldipine) TIAZAC (diltiazem) verapamil ER PM VERELAN/VERELAN PM (verapamil)	
CALORIC AGENTS			
	BOOST (includes all Boost) BREAKFAST ESSENTIALS BRIGHT BEGINNINGS DUOCAL ENSURE GLUCERNA NUTREN (includes all Nutren) OSMOLITE PEDIASURE PROMOD RESOURCE SCANDISHAKE TWOCAL HN	All other products (caloric /nutritional agents) not listed as preferred will require a manual prior authorization.	Non-Preferred Agents - MANUAL PA
CEPHALOSPORINS AND RELATED ANTIBIOTICS (Oral)			
BETA LACTAM/BETA-LACTAMASE INHIBITOR COMBINATIONS			
	amoxicillin/clavulanate amoxicillin/clavulanate XR	AUGMENTIN 125 and 250 Suspension (amoxicillin/clavulanate)	

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		AUGMENTIN (amoxicillin/clavulanate) Tablets AUGMENTIN XR (amoxicillin/clavulanate) MOXATAG (amoxicillin)		
CEPHALOSPORINS – First Generation SmartPA				
	cefadroxil cephalexin capsules cephalexin suspension	cephalexin tablets DAXBIA (cephalexin) KEFLEX (cephalexin)	<p>Non-Preferred Criteria – all generations</p> <ul style="list-style-type: none"> • Have tried 2 different preferred agents in the past 6 months 	
CEPHALOSPORINS – Second Generation SmartPA				
	cefaclor capsules cefprozil cefuroxime tablets	cefaclor ER cefaclor suspension cefuroxime suspension CEFTIN (cefuroxime)		
CEPHALOSPORINS – Third Generation SmartPA				
	cefdinir suspension cefdinir capsules cefopodoxime	CEDAX (ceftibuten) cefditoren ceftibuten SPECTRACEF (cefditoren) SUPRAX (cefixime)	<p>Maximum Age Limit</p> <ul style="list-style-type: none"> • 18 years – cefdinir suspension 	
COLONY STIMULATING FACTORS				
	GRANIX (tbo-filgrastim) NEUPOGEN Syringe (filgrastim) NEUPOGEN Vial (filgrastim)	FULPHILA (pegfilgrastim) LEUKINE (sargramostim) NEULASTA (pegfilgrastim) NIVESTYM (filgrastim-aafi) UDENYCA (pegfilgrastim-cbqv) ZARXIO (filgrastim) ZIEXTENZO (pegfilgrastim-bmez)		

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CYSTIC FIBROSIS AGENTS SmartPA

BETHKIS (tobramycin)
KITABIS (tobramycin)
tobramycin(generic TOB I) labeler 00093,00781,
17478, 43598, 65162, 68180

CAYSTON (aztreonam)
COLY-MYCIN M (colistimethate sodium)
KALYDECO (ivacaftor)
ORKAMBI (lumacaftor/ivacaftor)
PULMOZYME (dornase alfa)
SYMDEKO (tezacaftor/ivacaftor)
TOBI (tobramycin)
TOBI PODHALER (tobramycin)
tobramycin (generic Kitabis) labeler 70644
TRIKAFTA (elexacaftor/ tezacaftor/ivacaftor)

Minimum Age Limit

- **3 months** – Pulmozyme
- **4 months** – Kalydeco Granules
- **2 years** – Coly-Mycin M, Orkambi Granules
- **6 years** – Bethkis, Kalydeco Tablet, Kitabis, Orkambi 100/125mg Tablet, Symdeko, TOBI, TOBI Podhaler
- **7 years** – Cayston
- **12 years** – Orkambi 200/125mg Tablet, Trikafta

Maximum Age Limit

- **5 years** – Kalydeco and Orkambi Granules

All Agents

- Documented diagnosis Cystic Fibrosis

Kalydeco – [MANUAL PA](#)

Orkambi – [MANUAL PA](#)

Symdeko – [MANUAL PA](#)

Trikafta – [MANUAL PA](#)

TOBI Podhaler

- Requires clinical review

CYTOKINE & CAM ANTAGONISTS

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	ENBREL (etanercept) HUMIRA (adalimumab) methotrexate TALTZ (ixekizumab) XELJANZ (tofacitinib)	ACTEMRA (tocilizumab) ARCALYST (rilonacept) CIMZIA (certolizumab) COSENTYX (secukinumab) ENTYVIO (vedolizumab) ILARIS (canakinumab) ILUMYA (tildrakizumab) INFLECTRA (infliximab) KEVZARA (sarilumab) KINERET (anakinra) OLUMIANT (baricitinib) ORENCIA (abatacept) OTEZLA (apremilast) OTREXUP (methotrexate) RASUVO (methotrexate) REMICADE (infliximab) RENFLEXIS (infliximab-abda) RHEUMATREX (methotrexate) RINVOQ (upadacitinib) SILIQ (brodalumab) SIMPONI (golimumab) SKYRIZI (risankizumab) STELARA (ustekinumab) TREMFYA (guselkumab) TREXALL (methotrexate) XELJANZ XR (tofacitinib)	<p>Drugs with manufacturer recommendations for first dose delivery to be administered in a clinical setting with lifesaving equipment on hand will not be granted a pharmacy PA until a paid medical claim is verified.</p> <p>Verified clinic administered first doses do not negate the preferred/nonpreferred status.</p> <p>** Non-preferred agents will require a trial and failure of 2 preferred products for approval and will be evaluated through clinical review.</p>
ERYTHROPOIESIS STIMULATING PROTEINS SmartPA			
	EPOGEN (rHuEPO) MIRCERA (methoxy polyethylene glycol-epoetin-beta)	ARANESP (darbepoetin) PROCIT (rHuEPO)	Mircera <ul style="list-style-type: none"> Documented diagnosis chronic renal failure in the past 2 years

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	ALPHANINE SD ALPROLIX BENEFIX IXINITY MONONINE PROFILNINE RIXUBIS	IDELVION REBINYN	Hemlibra <ul style="list-style-type: none"> • 1 claim with the requested agent in the past 105 days • MANUAL PA – new patients
OTHER FACTOR PRODUCTS			
	COAGADEX FIBRYGA RIASTAP	CORIFACT HEMLIBRA <small>SmartPA</small> TRETEN	
FIBROMYALGIA/NEUROPATHIC PAIN AGENTS			
	duloxetine gabapentin pregabalin SAVELLA (milnacipran)	CYMBALTA (duloxetine) <small>SmartPA</small> duloxetine DR GRALISE (gabapentin) HORIZANT (gabapentin) IRENKA (duloxetine) <small>SmartPA</small> LYRICA (pregabalin) LYRICA CR (pregabalin) NEURONTIN (gabapentin)	Cymbalta and Irenka (see Antidepressant, Other) Minimum Age Limit – automatic approval for ages 7-17 with a diagnosis of GAD (Generalized Anxiety Disorder) for preferred duloxetine
FLUOROQUINOLONES (Oral) <small>SmartPA</small>			
	ciprofloxacin tablets levofloxacin tablets	AVELOX (moxifloxacin) BAXDELA (delaflozacin) CIPRO (ciprofloxacin)	Non-Preferred Criteria <ul style="list-style-type: none"> • 1 claim for a preferred agent in past 30 days

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		<p>CIPRO SUSPENSION (ciprofloxacin) CIPRO XR (ciprofloxacin) ciprofloxacin ER ciprofloxacin suspension FACTIVE (gemifloxacin) LEVAQUIN (levofloxacin) levofloxacin solution moxifloxacin NOROXIN (norfloxacin) ofloxacin</p>	<p>Cipro Suspension for age < 12 years</p> <ul style="list-style-type: none"> • Anthrax infection or exposure OR • Cystic Fibrosis OR • Pneumonic plague OR tularemia AND history of doxycycline in the past 3 months OR • 7 days of therapy with a preferred agent from 2 of the classes below in the past 3 months <ul style="list-style-type: none"> ◦ Penicillin, 2nd or 3rd generation cephalosporin, or macrolide <p>Levaquin solution for age < 12 years</p> <ul style="list-style-type: none"> • Anthrax infection or exposure OR • 7 days of therapy with a preferred agent from 2 of the classes below in the past 3 months <ul style="list-style-type: none"> ◦ Penicillin, 2nd or 3rd generation cephalosporin, or macrolide AND • Cipro suspension in the past 3 months
GAUCHER'S DISEASE			
	<p>ELELYSO (taliglucerase alfa) ZAVESCA (miglustat)</p>	<p>CERDELGA (eliglustat) CEREZYME(imiglucerase) miglustat VPRIV (velaglucerase alfa)</p>	
GENITAL WARTS & ACTINIC KERATOSIS AGENTS			

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	ALDARA (imiquimod) ^{Age Edit} CONDYLOX (podofilox) ^{Age Edit} podofilox ^{Age Edit}	CARAC (fluorouracil) diclofenac 3% gel imiquimod ^{Age Edit} EFUDEX (fluorouracil) fluorouracil 0.5% cream fluorouracil 5% cream PICATO (ingenol) ^{Age Edit} SOLARAZE (diclofenac) TOLAK (fluorouracil) VEREGEN (sinecatechins) ^{Age Edit} ZYCLARA (imiquimod) ^{Age Edit}	<p>Minimum Age Limit</p> <ul style="list-style-type: none"> • 12 years – Aldara • 18 years – Condylox, Picato, Veregen
GLUCOCORTICOIDS (Inhaled) ^{SmartPA}			
GLUCOCORTICOIDS			
	ASMANEX TWISTHALER (mometasone) budesonide 0.25mg and 0.5mg FLOVENT DISKUS (fluticasone) FLOVENT HFA (fluticasone) PULMICORT FLEXHALER (budesonide) QVAR REDHALER (beclomethasone dipropionate)	ALVESCO (ciclesonide) ARMONAIR Digihaler (fluticasone) ARNUITY ELLIPTA (fluticasone) ASMANEX HFA (mometasone) budesonide 1mg PULMICORT (budesonide) Respules	<p>Non-Preferred Criteria</p> <ul style="list-style-type: none"> • 90 consecutive days on the requested agent in the past 105 days OR • Have tried 1 preferred agent in the past 6 months <p>ArmonAir Digihaler</p> <ul style="list-style-type: none"> • Requires clinical review <p><u>NOTE:</u> Institutional sized products are Non-Preferred</p>
GLUCOCORTICOID/BRONCHODILATOR COMBINATIONS			
	<p style="background-color: yellow;">ADVAIR DISKUS (fluticasone/salmeterol)</p> ADVAIR HFA (fluticasone/salmeterol)	AIRDUO Digihaler (fluticasone/salmeterol) AIRDUO Respiclick (fluticasone/salmeterol) BREO ELLIPTA (fluticasone/vilanterol)	<p>Non-Preferred Criteria</p>

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	DULERA (mometasone/formoterol) fluticasone/salmeterol (generic AIRDUO) SYMBICORT (budesonide/formoterol)	budesonide/formoterol fluticasone/salmeterol (generic ADVAIR) WIXELA INHUB (fluticasone/salmeterol)	<ul style="list-style-type: none"> • 90 consecutive days on the requested agent in the past 105 days OR • Have tried 2 different preferred agents in the past 6 months <p>AirDuo Digihaler</p> <ul style="list-style-type: none"> • Requires clinical review
GI ULCER THERAPIES			
H2 RECEPTOR ANTAGONISTS			
	cimetidine solution famotidine solution famotidine tablets nizatidine solution	AXID (nizatidine) cimetidine tablets nizatidine tablets PEPCID (famotidine)	
PROTON PUMP INHIBITORS			
	esomeprazole magnesium DR Capsule NEXIUM PACKET (esomeprazole) omeprazole Rx pantoprazole	ACIPHEX SPRINKLE (rabeprazole) ACIPHEX Tablet (rabeprazole) DEXILANT (dexlansoprazole) esomeprazole strontium DR Capsule lansoprazole Rx NEXIUM Rx DR Capsule (esomeprazole) omeprazole sod. bicarb. PREVACID Rx (lansoprazole) PREVACID SOLU-TAB (lansoprazole) PRILOSEC RX (omeprazole) PRILOSEC SUSPENSION (omeprazole) PROTONIX DR (pantoprazole) PROTONIX PACKET (pantoprazole) rabeprazole	<p>Prilosec suspension</p> <ul style="list-style-type: none"> • Automatic approval for 0 - 2 years

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OTHER			
	CARAFATE SUSPENSION (sucralfate) misoprostol sucralfate tablet	CARAFATE TABLET (sucralfate) CYTOTEC (misoprostol) sucralfate suspension	
GROWTH HORMONE <small>SmartPA</small>			
	NORDITROPIN (somatropin) NUTROPIN AQ (somatropin)	GENOTROPIN (somatropin) HUMATROPE (somatropin) OMNITROPE (somatropin) SAIZEN (somatropin) SEROSTIM (somatropin) ZOMACTON (somatropin) ZORBTIVE (somatropin)	<p>All Agents for Age ≥ 18 years</p> <ul style="list-style-type: none"> Documented diagnosis of craniopharyngioma, panhypopituitarism, Prader-Willi Syndrome, Turner Syndrome or an approvable indication OR Documented procedure of cranial irradiation <p>Non-Preferred Criteria</p> <ul style="list-style-type: none"> Have tried 1 preferred agent in the past 6 months OR 84 consecutive days on the requested agent in the past 105 days
H. PYLORI COMBINATION TREATMENTS			
	PYLERA (bismuth subcitrate potassium, metronidazole, tetracycline)	lansoprazole, amoxicillin, clarithromycin OMECLAMOX (omeprazole, clarithromycin, amoxicillin) PREVPAC (lansoprazole, amoxicillin, clarithromycin) TALICIA (omeprazole, amoxicillin, rifabutin)	<p>Quantity Limit</p> <ul style="list-style-type: none"> 1 treatment course/year
HEPATITIS B TREATMENTS			
	entecavir EPIVIR HBV SOLUTION (lamivudine)	adefovir dipivoxil BARACLUDE (entecavir)	

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	lamivudine HBV tenofovir disoproxil fumarate	EPIVIR HBV TABLET (lamivudine) HEPSERA (adefovir dipivoxil) TYZEKA (telbivudine) VEMLIDY (tenofovir alafenamide fumarate) VIREAD (tenofovir disoproxil fumarate)	
HEPATITIS C TREATMENTS			
	MAVYRET (glecaprevir/pibrentasvir)∞ PEGASYS (peginterferon alfa-2a) PEG-INTRON (peginterferon alfa-2b) ribavirin tablets sofosbuvir/velpatasvir∞	COPEGUS (ribavirin) DAKLINZA (daclatasvir) ∞ EPCLUSA (sofosbuvir/velpatasvir) ∞ HARVONI (ledipasvir/sofosbuvir)∞ ledipasvir/sofosbuvir∞ MODERIBA (ribavirin) OLYSIO (simeprevir) REBETOL (ribavirin) RIBASPHERE (ribavirin) RIBASPHERE RIBAPAK DOSEPACK (ribavirin) ribavirin capsules SOVALDI (sofosbuvir)∞ TECHNIVIE (ombitasvir/paritaprevir/ritonavir) VIEKIRA (ombitasvir/paritaprevir/ritonavir) VIEKIRA XR (ombitasvir/paritaprevir/ritonavir) VOSEVI (sofosbuvir/velpatasvir/voxilaprevir)∞ ZEPATIER (elbasvir/grazoprevir)∞	Daklinza, Epclusa, Harvoni, Mavyret, Sovaldi, Vosevi, Zepatier • Require clinical review Note: Harvoni and Sovaldi have FDA pediatric indications
HEREDITARY ANGIOEDEMA			
		BERINERT (C1 esterase inhibitor) CINRYZE VIAL (C1 esterase inhibitor) FIRAZYR SYRINGE (icatibant acetate) HAEGARDA (C1 esterase inhibitor) icatibant KALBITOR VIAL (ecallantide)	

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		RUCONEST VIAL (C1 esterase inhibitor, recombinant) TAKHZYRO (lanadelumab-flyo)	
HYPERURICEMIA & GOUT <small>SmartPA</small>			
	allopurinol colchicine capsule probenecid probenecid/colchicine	colchicine tablet COLCRYS (colchicine) febuxostat LOPERBA (colchicine) MITIGARE (colchicine) ULORIC (febuxostat) ZYLOPRIM (allopurinol)	Non-Preferred Criteria • Have tried 2 different preferred agents in the past 6 months
HYPOGLYCEMIA TREATMENT, GLUCAGON			
	BAQSIMI (glucagon) ^{Step Edit} glucagon vial glucagon kit	GVOKE (glucagon)	Minimum Age Limit • 2 years – Gvoke • 4 years – Baqsimi Quantity Limit • 2 packs/31 days – Baqsimi • 2 syringes/31days – Gvoke Baqsimi Approved after a trial and failure of generic
HYPOGLYCEMICS, BIGUANIDES <small>SmartPA</small>			
	metformin HCL tablet metformin HCL ER 24HR tablet (generic GlucophageXR)	FORTAMET ER GLUCOPHAGE (metformin) GLUCOPHAGE XR (metformin ER)	• Clinical review required for addition of a fourth concurrent

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		<p>GLUMETZA (metformin ER) metformin 24HR (generic Fortamet) metformin 24 HR(generic Glumetza) RIOMET SOLUTION* (metformin)</p>	<p>oral agent in a different drug class</p> <ul style="list-style-type: none"> ○ Concurrent therapy with the incoming claim is defined as 20 or more days' supply of the drug in the past 30 days ○ 2-drug combination agents count as 2 classes and 3-drug combination agents count as 3 classes <p>Riomet Solution</p> <ul style="list-style-type: none"> ● 90 consecutive days on the requested agent in the past 105 days
HYPOGLYCEMICS, DPP4s and COMBINATON <small>SmartPA</small>			
	<p>JANUMET (sitagliptin/metformin) JANUMET XR (sitagliptin/metformin) JANUVIA (sitagliptin) JENTADUETO (linagliptin/metformin) TRADJENTA (linagliptin)</p>	<p>alogliptin alogliptin/metformin alogliptin/pioglitazone JENTADUETO XR (linagliptin/metformin) KAZANO (alogliptin/metformin) KOMBIGLYZE XR (saxagliptin/metformin)* NESINA (alogliptin) ONGLYZA (saxagliptin) * OSENI (alogliptin/pioglitazone)</p>	<ul style="list-style-type: none"> ● Clinical review required with concomitant use of GLP-1 product in the past 30 days OR ● Addition of a fourth concurrent oral agent in a different drug class ○ Concurrent therapy with the incoming claim is defined as 20 or more days' supply of the drug in the past 30 days ○ 2-drug combination agents count as 2 classes and 3-drug combination agents count as 3 classes <p>Kombiglyze XR and Onglyza</p>

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			<ul style="list-style-type: none"> 90 consecutive days on the requested agent in the past 105 days
HYPOGLYCEMICS, INCRETIN MIMETICS/ENHANCERS <small>SmartPA</small>			
	BYETTA (exenatide) VICTOZA (liraglutide)	ADLYXIN (lixisenatide) BYDUREON (exenatide) BYDUREON BCISE (exenatide) OZEMPIC (semaglutide) RYBELSUS (semaglutide) SOLIQUA (insulin glargine/lixisenatide) SYMLIN (pramlintide) TRULICITY (dulaglutide) XULTOPHY (insulin degludec/ liraglutide)	<ul style="list-style-type: none"> Clinical review required with concomitant use of DPP-4 product in the past 30 days OR Addition of a fourth concurrent oral agent in a different drug class <ul style="list-style-type: none"> Concurrent therapy with the incoming claim is defined as 20 or more days' supply of the drug in the past 30 days 2-drug combination agents count as 2 classes and 3-drug combination agents count as 3 classes <p>Symlin is excluded from all criteria</p>
HYPOGLYCEMICS, INSULINS AND RELATED AGENTS <small>SmartPA</small>			
	HUMULIN N, R, 70/30 VIAL ^{OTC} (insulin) HUMULIN R U500 VIAL (insulin) insulin aspart insulin aspart flexpen insulin aspart mix insulin aspart mix flexpen Insulin lispro	AFREZZA (insulin) ADMELOG (insulin lispro) APIDRA (insulin glulisine) APIDRA SOLOSTAR (insulin glulisine) BASAGLAR (insulin glargine) FIASP (insulin aspart) HUMALOG JR (insulin lispro)	Insulin pen formulations are not covered for Long Term Care (LTC) beneficiaries. Non-Preferred Criteria <ul style="list-style-type: none"> Documented diagnosis of Diabetes Mellitus AND

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	<p>insulin lispro kwikpen LANTUS SOLOSTAR & VIAL (insulin glargine) LEVEMIR FLEXPEN & VIAL (insulin detemir)</p>	<p>HUMALOG KWIKPEN U100 (insulin lispro) HUMALOG KWIKPEN U200 (insulin lispro) HUMALOG MIX KWIKPEN (insulin lispro/ lispro protamine) HUMALOG MIX VIAL (insulin lispro/ lispro protamine) HUMALOG VIAL (insulin lispro) HUMULIN N, 70/30 KWIKPEN (insulin) ^{OTC} HUMULIN R U500 KWIKPEN* LYUMJEV KWIKPEN (insulin lispro) LYUMJEV VIAL (insulin lispro) NOVOLIN N, R, 70/30 FLEXPEN (insulin) ^{OTC} NOVOLIN N, R, 70/30 VIAL (insulin) ^{OTC} NOVOLOG FLEXPEN & VIAL (insulin aspart) NOVOLOG MIX FLEXPEN & VIAL (insulin aspart/ aspart protamine) TRESIBA (insulin degludec) TOUJEO (insulin glargine) TOUJEO MAX(insulin glargine)</p>	<ul style="list-style-type: none"> • Have tried 1 preferred product in the past 6 months OR • 1 claim with the requested agent in the past 105 days
HYPOGLYCEMICS, MEGLITINIDES ^{SmartPA}			
	<p>nateglinide repaglinide</p>	<p>PRANDIMET (repaglinide/metformin) PRANDIN (repaglinide) repaglinide/metformin STARLIX (nateglinide)</p>	<ul style="list-style-type: none"> • Clinical review required with addition of a fourth concurrent oral agent in a different drug class <ul style="list-style-type: none"> ○ Concurrent therapy with the incoming claim is defined as 20 or more days' supply of the drug in the past 30 days

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			<ul style="list-style-type: none"> ○ 2-drug combination agents count as 2 classes and 3-drug combination agents count as 3 classes
HYPOGLYCEMICS, SODIUM GLUCOSE COTRANSPORTER-2 INHIBITORS ^{SmartPA}			
HYPOGLYCEMICS, SODIUM GLUCOSE COTRANSPORTER-2 INHIBITORS			
	FARXIGA (dapagliflozin) INVOKANA (canagliflozin) JARDIANCE (empagliflozin)	STEGLATRO (ertugliflozin)	<ul style="list-style-type: none"> • Clinical review required with addition of a fourth concurrent oral agent in a different drug class <ul style="list-style-type: none"> ○ Concurrent therapy with the incoming claim is defined as 20 or more days' supply of the drug in the past 30 days ○ 2-drug combination agents count as 2 classes and 3-drug combination agents count as 3 classes
HYPOGLYCEMICS, SODIUM GLUCOSE COTRANSPORTER-2 INHIBITOR COMBINATIONS			
	INVOKAMET (canagliflozin/metformin) SYNJARDY (empagliflozin/metformin)	GLYXAMBI (empagliflozin/linagliptin) INVOKAMET XR (canagliflozin/metformin) QTERN (dapagliflozin/saxagliptin) SEGLUROMET (ertugliflozin/metformin) STEGLUJAN (ertugliflozin/sitagliptin) SYNJARDY XR (empagliflozin/metformin) TRIJARDYXR (empagliflozin/linagliptin/metformin) XIGDUO XR (dapagliflozin/metformin)	
HYPOGLYCEMICS, TZDS			

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THIAZOLIDINEDIONES		
pioglitazone	ACTOS (pioglitazone) AVANDIA (rosiglitazone)	<ul style="list-style-type: none"> Clinical review required for addition of a fourth concurrent oral agent in a different drug class <ul style="list-style-type: none"> Concurrent therapy with the incoming claim is defined as 20 or more days' supply of the drug in the past 30 days 2-drug combination agents count as 2 classes and 3-drug combination agents count as 3 classes
TZD COMBINATIONS		
pioglitazone/metformin	ACTOPLUS MET (pioglitazone/metformin) ACTOPLUSMET XR (pioglitazone/metformin) AVANDAMET (rosiglitazone/metformin) AVANDARYL (rosiglitazone/glipizide) DUETACT (pioglitazone/glimepiride) pioglitazone/glimepiride	
IDIOPATHIC PULMONARY FIBROSIS <small>SmartPA</small>		
ESBRIET (pirfenidone) OFEV (nintedanib)		<p>All Agents</p> <ul style="list-style-type: none"> Documented diagnosis Idiopathic Pulmonary Fibrosis <p>Esbriet & OFEV</p> <ul style="list-style-type: none"> No concurrent therapy with either agent
IMMUNOSUPPRESSIVE (ORAL) <small>SmartPA</small>		
AZASAN (azathioprine) azathioprine	ASTAGRAF XL (tacrolimus) ENVARUSUS XR (tacrolimus)	<p>Minimum Age Limit</p> <ul style="list-style-type: none"> 13 years - Rapamune

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<p>CELLCEPT (mycophenolate) cyclosporine cyclosporine modified GENGRAF (cyclosporine) IMURAN (azathioprine) mycophenolic acid mycophenolate mofetil NEORAL (cyclosporine) RAPAMUNE (sirolimus) SANDIMMUNE (cyclosporine) sirolimus tacrolimus ZORTRESS (everolimus)</p>	<p>HECORIA (tacrolimus) MYFORTIC (mycophenolic acid) PROGRAF (tacrolimus)</p>	<ul style="list-style-type: none"> • 18 years - Zortress Astagraf, Cellcept, Envarsus XR, Hecoria, Prograf • Documented diagnosis for heart transplant, kidney transplant, liver transplant, or a State accepted diagnosis Azasan • Documented diagnosis of kidney transplant, RA, or a State accepted diagnosis Gengraf, Neoral, Sandimmune • Documented diagnosis of heart transplant, kidney transplant, liver transplant, psoriasis, RA, or a State accepted diagnosis OR • Clinical review required for a diagnosis of Kimura's disease or multifocal motor neuropathy Myfortic • Documented diagnosis of kidney transplant or psoriasis Rapamune • Documented diagnosis of kidney transplant Zortress • Documented diagnosis of kidney transplant or liver transplant
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IMMUNE GLOBULINS			
	CARIMUNE NF FLEBOGAMMA DIF GAMASTAN SD GAMMAGARD GAMMAKED GAMUNEX-C HIZENTRA HYQVIA OCTAGAM PANZYGA XEMBIFY	ASCENIV BIVIGAM CABLIVI CUTAQUIG CUVITRU GAMMAGARD SD GAMMAPLEX PRIVIGEN	
IMMUNOLOGIC THERAPIES FOR ASTHMA			
	FASENRA PEN AUTOINJECTOR (benralizumab) [∞] NUCALA AUTOINJECTOR (mepolizumab) [∞] NUCALA SYRINGE (mepolizumab) [∞]	DUPIXENT (dupilumab)*	∞ once criteria is met
INTRANASAL RHINITIS AGENTS			
	ANTICHOLINERGICS		
	ipratropium	ATROVENT (ipratropium)	
	ANTI-HISTAMINES		
	azelastine	ASTEPRO (azelastine) olopatadine PATANASE (olopatadine)	
	ANTI-HISTAMINE/CORTICOSTEROID COMBINATION ^{SmartPA}		
		DYMISTA (azelastine/fluticasone)	

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		TICALAST (azelastine/fluticasone)	
CORTICOSTEROIDS SmartPA			
	fluticasone Rx Only	BECONASE AQ (beclomethasone) budesonide flunisolide mometasone NASONEX (mometasone) OMNARIS (ciclesonide) QNASL (beclomethasone) TICANASE KIT (flonase kit) triamcinolone VERAMYST (fluticasone) XHANCE (fluticasone) ZETONNA (ciclesonide)	Non-Preferred Criteria • Documented diagnosis for allergic rhinitis AND • Have tried 1 different preferred agent in the past 6 months
IRON CHELATING AGENTS			
	deferasirox all strenghts FERRIPROX (deferiprone)	EXJADE (deferasirox) JADENU (deferasirox) JADENU SPRINKLES (deferasirox)	Jadenu – MANUAL PA
IRRITABLE BOWEL SYNDROME/SHORT BOWEL SYNDROME AGENTS/SELECTED GI AGENTS SmartPA			
IRRITABLE BOWEL SYNDROME CONSTIPATION			
	AMITIZA (lubiprostone) LINZESS 145mcg, 290mcg (linaclotide) MOVANTI (naloxegol)	LINZESS 72mcg (linaclotide) MOTEGRITY (prucalopride) RELISTOR (methylnaltrexone) SYMPROIC (naldemedine) TRULANCE (plecanatide) ZELNORM (tegaserod)	Minimum Age Limit All Subclasses • 18 years – except <i>Bentyl, Gattex, Levsin</i> Gender Limit • Female – Amitiza 8mcg

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			<p><u>Chronic Idiopathic Constipation (CIC)</u> AMITIZA 24MCG, LINZESS 72MCG, LINZESS 145 MCG, MOTTEGRITY, TRULANCE</p> <p>All CIC Agents:</p> <ul style="list-style-type: none"> • Documented diagnosis of CIC in the past year AND • No history of GI or bowel obstruction <p>Non-Preferred CIC Agents</p> <ul style="list-style-type: none"> • Above CIC criteria AND • 30 days of therapy with 2 preferred agents in the past 6 months OR • 1 claim with the requested agent in the past 105 days <p><u>Irritable Bowel Syndrome – Constipation Dominant (IBS-C)</u> AMITIZA 8MCG, LINZESS 290 MCG, TRULANCE</p> <p>All IBS-C Agents:</p> <ul style="list-style-type: none"> • Documented diagnosis of IBS-C in the past year AND • No history of GI or bowel obstruction <p>Non-Preferred IBS-C Agents</p> <ul style="list-style-type: none"> • Above IBS-C criteria AND • 30 days of therapy with 2 preferred agents in the past 6 months OR
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		<ul style="list-style-type: none"> • 1 claim with the requested agent in the past 105 days <p>Opioid Induced Constipation (OIC) AMITIZA 24MCG, MOVANTIK, RELISTOR, SYMPROIC</p> <p>All OIC Agents:</p> <ul style="list-style-type: none"> • Documented diagnosis of OIC in the past year AND • 1 claim for an opioid in the past 30 days AND • No history of GI or bowel obstruction AND • Documented diagnosis of chronic pain in the past year <p>Non- Preferred OIC Agents</p> <ul style="list-style-type: none"> • Above OIC criteria AND • 30 days of therapy with 2 preferred agents in the past 6 months OR • 1 claim with the requested agent in the past 105 days <p>Relistor Injection</p> <ul style="list-style-type: none"> • Above OIC criteria AND • Documented diagnosis of active cancer in the past year AND • Documented diagnosis of palliative care in the past 6 months
IRRITABLE BOWEL SYNDROME DIARRHEA		

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EFFECTIVE 01/01/2021
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	dicyclomine hyoscyamine	alosetron BENTYL (dicyclomine) LEVSIN (hyoscyamine) LEVSIN-SL (hyoscyamine) LOTRONEX (alosetron) VIBERZI (eluxadoline)*	<p>Viberzi</p> <ul style="list-style-type: none"> Documented diagnosis of Irritable Bowel Syndrome – Diarrhea Dominant (IBS-D) in the past year AND 30 days of therapy with 2 preferred agents in the past 6 months OR 1 claim with the requested agent in the past 105 days <p>Lotronex</p> <ul style="list-style-type: none"> 1 claim for the requested agent in the past 105 days OR MANUAL PA - All new patients require manual review. <p>Xifaxan - (see Antibiotics, GI)</p>
SHORT BOWEL SYNDROME AND SELECTED GI AGENTS			
		FULYZAQ (crofelemer) GATTEX (teduglutide) MYTESI (crofelemer) NUTRESTORE POWDER PACK (glutamine) XERMELO (telotristat ethyl) ZORBATIVE (somatropin)	<p>Carcinoid Syndrome Agent XERMELO</p> <ul style="list-style-type: none"> Documented diagnosis of carcinoid syndrome in the past year AND 1 claim for a somatostatin analog in the past 30 days <p>HIV/AIDS Non-infectious Diarrhea FULYZAQ, MYTESI</p> <ul style="list-style-type: none"> Documented diagnosis of HIV/AIDS in the past year AND

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			<ul style="list-style-type: none"> • Documented diagnosis of non-infectious diarrhea in the past year AND • 1 claim for an antiretroviral in the past 30 days <p>Short Bowel Syndrome (SBS) GATTEX, NUTRESTORE, ZORBTIVE</p> <p>Gattex or Zorbtive</p> <ul style="list-style-type: none"> • 1 claim for the requested agent in the past 105 days OR • All new patients require clinical review <p>Nutrestore</p> <ul style="list-style-type: none"> • Requires clinical review
LEUKOTRIENE MODIFIERS SmartPA			
	montelukast granules montelukast tablets zafirlukast	ACCOLATE (zafirlukast) SINGULAIR Tablets (montelukast) SINGULAR GRANULES (montelukast granules) zileuton ZYFLO CR (zileuton)	<p>Minimum Age Limit</p> <ul style="list-style-type: none"> • 12 years – Zyflo & Zyflo CR <p>Non-Preferred Criteria</p> <ul style="list-style-type: none"> • Have tried 2 different preferred agents in the past 6 months
LIPOTROPICS, OTHER (NON-STATINS) SmartPA			
ACL INHIBITORS AND COMBINATIONS			
		NEXLETOL (bempedoic acid) NEXLIZET (bempedoic acid/ezetimibe)	<p>Nexletol and Nexlizet</p> <ul style="list-style-type: none"> • Requires clinical review

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BILE ACID SEQUESTRANTS			
	cholestyramine colestipol	colesevelam COLESTID (colestipol) QUESTRAN (cholestyramine) WELCHOL (colesevelam)	<p>All Agents, All Sub-Classes both Preferred (exception is Zetia) and Non-Preferred</p> <ul style="list-style-type: none"> • 90 consecutive days on the requested agent in the past 105 days OR • Have tried 1 statin or statin combination agent in the past year OR • One of the following exceptions: <ul style="list-style-type: none"> ○ Welchol AND Type 2 diabetes AND 1 preferred oral antidiabetic agent in the past 180 days OR ○ Pregnant female OR ○ Documented diagnosis of liver disease OR ○ Documented diagnosis for hypertriglyceridemia OR ○ Clinical justification a statin or statin combination product cannot be used <p>Non-Preferred Criteria</p> <ul style="list-style-type: none"> • Have tried 2 different preferred Non-statin Lipotropic agents in the past 6 months
OMEGA-3 FATTY ACIDS			
	omega 3 acid ethyl esters	LOVAZA (omega-3-acid ethyl esters) VASCEPA (icosapent ethyl)	<p>Non-Preferred Criteria</p> <ul style="list-style-type: none"> • Have tried 2 different preferred Non-statin Lipotropic agents in the past 6 months

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CHOLESTEROL ABSORPTION INHIBITORS			
	ezetimibe	ZETIA (ezetimibe)	Zetia does not have to meet the trial of 1 statin or statin combination agent in the past year
FIBRIC ACID DERIVATIVES			
	fenofibrate nanocrystallized gemfibrozil	ANTARA (fenofibrate, micronized) fenofibrate 40mg tablet fenofibrate, micronized fenofibric acid FENOGLIDE (fenofibrate) FIBRICOR (fenofibric acid) LIPOFEN (fenofibrate) LOFIBRA (fenofibrate) LOPID (gemfibrozil) TRICOR (fenofibrate nanocrystallized) TRIGLIDE (fenofibrate) TRILIPIX (fenofibric acid)	Fibric Acid Derivative Non-Preferred Criteria • Have tried 2 different fibric acid derivatives in the past 6 months
MTP INHIBITOR			
		JUXTAPID (lomitapide)	Juxtapid – MANUAL PA
APOLIPOPROTEIN B-100 SYNTHESIS INHIBITOR			
		KYNAMRO (mipomersen)	Kynamro – MANUAL PA
NIACIN			
	niacin ER NIACOR (niacin)	NIASPAN (niacin)	Non-Preferred Criteria • Have tried 2 different preferred Non-statin Lipotropic agents in the past 6 months

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PCSK-9 INHIBITOR		
	PRALUENT (alirocumab) REPATHA (evolocumab)	Praluent - MANUAL PA Repatha - MANUAL PA
LIPOTROPICS, STATINS <small>SmartPA</small>		
STATINS		
atorvastatin lovastatin pravastatin rosuvastatin simvastatin	ALTOPREV (lovastatin) CRESTOR (rosuvastatin) EZALLOR SPRINKLE (rosuvastatin) FLOLIPID (simvastatin) fluvastatin ER fluvastatin LESCOL (fluvastatin) LESCOL XL (fluvastatin) LIPITOR (atorvastatin) LIVALO (pitavastatin) MEVACOR (lovastatin) PRAVACHOL (pravastatin) ZOCOR (simvastatin) ZYPITAMAG (pitavastatin)	Simvastatin 80mg <ul style="list-style-type: none"> • 12 months of therapy with simvastatin 80mg AND • NO myopathy contraindication Non-Preferred Criteria <ul style="list-style-type: none"> • Have tried 2 different preferred statin or statin combination agents in the past 6 months OR • 90 consecutive days on the requested agent in the past 105 days
STATIN COMBINATIONS		
ezetimibe/simvastatin SIMCOR (simvastatin/niacin)	ADVICOR (lovastatin/niacin) atorvastatin/amlodipine CADUET (atorvastatin/amlodipine) LIPTRUZET (atorvastatin/ezetimibe) VYTORIN (simvastatin/ezetimibe)	Non-Preferred Criteria <ul style="list-style-type: none"> • Have tried 2 different preferred statin or statin combination agents in the past 6 months OR • 90 consecutive days on the requested agent in the past 105 days
MISCELLANEOUS BRAND/GENERIC		

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CLONIDINE	
clonidine patches clonidine tablets	CATAPRES (clonidine) CATAPRES-TTS (clonidine)
EPINEPHRINE	
epinephrine autoinject pens (labeler 49502) SYMJEPI (epinephrine)	ADRENACLICK (epinephrine) AUVI-Q (epinephrine) EPINEPHRINE SNAP EMS KIT (epinephrine) EPIPEN (epinephrine) EPIPEN JR (epinephrine)
MISCELLANEOUS	
alprazolam hydroxyzine hcl syrup hydroxyzine pamoate MAKENA (hydroxyprogesterone caproate) megestrol suspension 625mg/5mL	alprazolam ER EVRYSDI (risdiplam) hydroxyprogesterone caproate hydroxyzine hcl tablets KORLYM (mifepristone) MEGACE ES (megestrol) VISTARIL (hydroxyzine pamoate)
ALLERGEN EXTRACT IMMUNOTHERAPY	
	GRASTEK ORALAIR PALFORZIA RAGWITEK
SUBLINGUAL NITROGLYCERIN	
nitroglycerin lingual 12gm nitroglycerin sublingual NITROLINGUAL PUMPSPRAY (nitroglycerin) 12gm	nitroglycerin lingual 4.9gm NITROLINGUAL (nitroglycerin) 4.9gm NITROMIST (nitroglycerin)

Quantity Limit
• 2 kits/31 days

Alprazolam ER CUMULATIVE quantity limit
• 31 tablets/31 days

Hydroxyzine HCl 10mg tablets
• 6-12 years - *Smart PA will automatically be issued for this age range*

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	NITROSTAT SUBLINGUAL (nitroglycerin)		
MOVEMENT DISORDER AGENTS <small>SmartPA</small>			
	AUSTEDO (deutetrabenazine) INGREZZA (valbenazine) tetrabenazine	XENAZINE (tetrabenazine)	Ingrezza – <u>MANUAL PA</u> tetrabenazine: • Documented diagnosis of Huntington's Chorea Austedo: • <u>MANUAL PA</u> for diagnosis of tardive dyskinesia OR • Documented diagnosis of Huntington's Chorea
MULTIPLE SCLEROSIS AGENTS <small>SmartPA</small>			
	AUBAGIO (teriflunomide) AVONEX (interferon beta-1a) AVONEX PEN (interferon beta-1a) BETASERON (interferon beta-1b) COPAXONE 20mg (glatiramer) dalfampridine GILENYA (fingolimod) REBIF (interferon beta-1a) REBIF REBIDOSE (interferon beta-1a)	AMPYRA (dalfampridine) BAFIERTAM (monomethyl fumarate) COPAXONE 40mg (glatiramer) dimethyl fumarate EXTAVIA (interferon beta-1b) glatiramer GLATOPA (glatiramer) MAVENCLAD (cladribine) MAYZENT (siponimod) OCREVUS (ocrelizumab) PLEGRIDY (interferon beta-1a) TECFIDERA (dimethyl fumarate) VUMERITY (diroximel fumarate) ZEPOSIA (ozanimod) ZINBRYTA (daclizumab)	All Agents • Documented diagnosis of multiple sclerosis Non-Preferred Criteria • Have tried 2 different preferred agents in the past 6 months OR • 3 claims with the requested agent in the last 105 days Kesimpta • Requires clinical review Mavenclad – <u>MANUAL PA</u> Mayzent – <u>MANUAL PA</u> Ocrevus – <u>MANUAL PA</u>

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MUSCULAR DYSTROPHY AGENTS			
		EMFLAZA (deflazacort) EXONDYS 51 (eteplirsen) VILTEPSO (viltolarsen) VYONDYS 53 (golodirsen)	Emflaza – MANUAL PA Exondys – MANUAL PA Vyondys – MANUAL PA
NSAIDS <small>SmartPA</small>			
	NON-SELECTIVE		
	diclofenac EC diclofenac IR diclofenac SR etodolac IR tab flurbiprofen ibuprofen ibuprofen suspension ^{OTC} indomethacin ketoprofen ketorolac nabumetone naproxen 250mg and 500mg naproxen suspension piroxicam sulindac	ADVIL (ibuprofen) ANAPROX (naproxen) CAMBIA (diclofenac) CATAFLAM (diclofenac) DAYPRO (oxaprozin) etodolac cap etodolac tab SR FELDENE (piroxicam) FENORTHO (fenoprofen) fenoprofen INDOCIN capsules, suspension & suppositories (indomethacin) indomethacin cap ER ketoprofen ER meclofenamate mefenamic acid NALFON (fenoprofen) NAPRELAN (naproxen) NAPROSYN (naproxen) naproxen 275mg and 550mg NUPRIN (ibuprofen)	Non-Preferred Criteria <ul style="list-style-type: none"> Have tried 2 different preferred non-selective or NSAID/GI protectant combination agents in the past 6 months

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		oxaprozin PONSTEL (mefenamic acid) PROFENO (fenoprofen) RELAFEN DS (nabumetone) SPRIX NASAL SPRAY (ketorolac) TIVORBEX (indomethacin) tolmetin VOLTAREN XR (diclofenac) ZIPSOR (diclofenac) ZORVOLEX (diclofenac)	
NSAID/GI PROTECTANT COMBINATIONS			
		ARTHROTEC (diclofenac/misoprostol) diclofenac/misoprostol DUEXIS (ibuprofen/famotidine) VIMOVO (naproxen/esomeprazole)	<p>Non-Preferred Criteria</p> <ul style="list-style-type: none"> • Have tried 2 different preferred non-selective or NSAID/GI protectant combination agents in the past 6 months
COX II SELECTIVE			
	meloxicam	CELEBREX (celecoxib) celecoxib MOBIC (meloxicam) NULOX (meloxicam) QMIIZ ODT (meloxicam) VIVLODEX (meloxicam)	<p>Non-Preferred Criteria – COX II</p> <ul style="list-style-type: none"> • Documented diagnosis of Osteoarthritis, Rheumatoid Arthritis, Familial Adenomatous Polyposis, or Ankylosing Spondylitis AND • 90 consecutive days on the requested agent in the past 105 days OR • Have tried 1 preferred COX-II Selective and 1 preferred Non-Selective Agent OR • Have tried 1 preferred COX-II Selective agent and a documented diagnosis of GI Bleed, GERD, PUD,

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			GI Perforation, or Coagulation Disorder
OPHTHALMIC ANTIBIOTICS			
	bacitracin/neomycin/gramicidin bacitracin/polymyxin ciprofloxacin erythromycin GENTAK Ointment (gentamicin) gentamicin ILOTYCIN (erythromycin) moxifloxacin ofloxacin polymyxin/trimethoprim tobramycin	AZASITE (azithromycin) bacitracin BESIVANCE (besifloxacin) BLEPH-10 (sulfacetamide) CILOXAN Ointment (ciprofloxacin) CILOXAN Solution (ciprofloxacin) GARAMYCIN (gentamicin) gatifloxacin levofloxacin MOXEZA (moxifloxacin) NATACYN (natamycin) neomycin/bacitracin/polymyxin b NEO-POLYCIN (neomy/baci/polymyxin b) NEOSPORIN (bacitracin/neomycin/gramicidin) (oxy-tcn/polymyx sul) OCUFLOX (ofloxacin) POLYTRIM (polymyxin/trimethoprim) sulfacetamide TOBEX drops (tobramycin) TOBEX ointment (tobramycin) VIGAMOX (moxifloxacin) ZYMAR (gatifloxacin) ZYMAXID (gatifloxacin)	
ANTIBIOTIC STEROID COMBINATIONS			
	BLEPHAMIDE (sulfacetamide/prednisolone) drops, oint	gatifloxacin/prednisolone MAXITROL (neomycin/polymyxin/dexamethasone)	

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	neomycin/bacitracin/polymyxin/hc ointment neomycin/polymyxin/dexamethasone PRED-G (gentamicin/prednisolone)drops, oint sulfacetamide/prednisolone TOBRADEX SUSPENSION/OINTMENT (tobramycin/dexamethasone) ZYLET (loteprednol/tobramycin)	neomycin/polymyxin/gramicidin neomycin/polymyxin/hydrocortisone TOBRADEX ST SUSPENSION (tobramycin/dexamethasone) tobramycin/dexamethasone	
OPHTHALMIC ANTI-INFLAMMATORIES SmartPA			
	dexamethasone diclofenac DUREZOL (difluprednate) FLAREX (fluorometholone) fluorometholone flurbiprofen FML FORTE (fluorometholone) FML SOP (fluorometholone) ketorolac loteprednol etabonate MAXIDEX (dexamethasone) prednisolone acetate prednisolone NA phosphate PRED MILD (prednisolone) VEXOL (rimexolone)	ACULAR (ketorolac) ACULAR LS (ketorolac) ACUVAIL (ketorolac) BROMDAY (bromfenac) bromfenac BROMSITE (bromfenac) FML (fluorometholone) ILEVRO (nepafenac) INVELTYS (loteprednol etabonate) LOTEMAX (loteprednol) LOTEMAX SM (loteprednol) OCUFEN (flurbiprofen) OMNIPRED (prednisolone) NEVANAC (nepafenac) PRED FORTE (prednisolone) PROLENSA (bromfenac) VOLTAREN (diclofenac)	Non-Preferred Criteria <ul style="list-style-type: none"> • Have tried 2 different preferred agents in the past 6 months
OPHTHALMICS FOR ALLERGIC CONJUNCTIVITIS SmartPA			
	ALREX (loteprednol) azelastine cromolyn	ALOCRIL (nedocromil) ALOMIDE (lodoxamide) BEPREVE (bepotastine)	Non-Preferred Criteria <ul style="list-style-type: none"> • Have tried 2 different preferred agents in the past 6 months

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	olopatadine 0.1% olopatadine 0.2%	epinastine LASTACAFT (alcaftadine) PATADAY (olopatadine) PATANOL (olopatadine) PAZEO (olopatadine) ZERVIAE (cetirizine)	
OPHTHALMIC, DRY EYE AGENTS			
	RESTASIS droperette (cyclosporine)	CEQUA (cyclosporine 0.09%) RESTASIS Multidose (cyclosporine) XIIDRA (lifitegrast) ^{Smart PA}	<p>Minimum Age Limit</p> <ul style="list-style-type: none"> • 16 years – Restasis • 17 years – Xiidra • 18 years – Cequa <p>Quantity Limit</p> <ul style="list-style-type: none"> • 5.5 mL/31 days – Restasis Multidose • 60 units/31 days – Cequa, Restasis droperette, Xiidra <p>Non-Preferred Criteria:</p> <ul style="list-style-type: none"> • History of 4 claims for Restasis in the past 6 months
OPHTHALMIC, GLAUCOMA AGENTS ^{SmartPA}			
BETA BLOCKERS			
	BETIMOL (timolol) carteolol ISTALOL (timolol) levobunolol	BETAGAN (levobunolol) betaxolol BETOPTIC S (betaxolol) OPTIPRANOLOL (metipranolol) timolol gel	<p>Non-Preferred Criteria</p> <ul style="list-style-type: none"> • Have tried 2 different preferred agents in the past 6 months OR

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metipranolol timolol drops 0.25%, 0.5%	timolol daily drop 0.5% (generic Istalol) TIMOPTIC (timolol) TIMOPTIC XE (timolol)	<ul style="list-style-type: none"> 90 consecutive days on the requested agent in the past 105 days
CARBONIC ANHYDRASE INHIBITORS		
dorzolamide	AZOPT (brinzolamide) TRUSOPT (dorzolamide)	
COMBINATION AGENTS		
COMBIGAN (brimonidine/timolol) dorzolamide/timolol	COSOPT (dorzolamide/timolol) COSOPT PF(dorzolamide/timolol) SIMBRINZA (brinzolamide/brimonidine)	
PARASYMPATHOMIMETICS		
pilocarpine	CARBOPTIC (carbachol) ISOPTO CARBACHOL (carbachol) ISOPTO CARPINE (pilocarpine) PHOSPHOLINE IODIDE (echothiophate iodide) PILOPINE HS (pilocarpine)	
PROSTAGLANDIN ANALOGS		
latanoprost	bimatoprost LUMIGAN (bimatoprost) TRAVATAN Z (travoprost) travoprost XALATAN (latanoprost) XELPROS (lantanoprost) VYZULTA (latanoprostene bunod) ZIOPTAN (tafluprost)	
RHO KINASE INHIBITORS/COMBINATIONS		
RHOPRESSA (netarsudil)		

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	ROCKLATAN (netarsudil/latanoprost)		
SYMPATHOMIMETICS			
	brimonidine 0.2%	ALPHAGAN P 0.1% (brimonidine) ALPHAGAN P 0.15% (brimonidine) brimonidine 0.15% dipivefrin PROPINE (dipivefrin)	
OPIATE DEPENDENCE TREATMENTS			
DEPENDENCE			
	buprenorphine/naloxone film labeler 52427 buprenorphine/naloxone tablets naltrexone tablets SUBOXONE FILM (buprenorphine/naloxone) ^{SmartPA}	buprenorphine tablets BUNAVAIL (buprenorphine/naloxone) buprenorphine/naloxone films all other labelers LUCEMYRA (lofexidine) PROBUPHINE (buprenorphine) SUBLOCADE (buprenorphine) VIVITROL (naltrexone) ZUBSOLV (buprenorphine/naloxone)	<p><u>Buprenorphine/Naloxone and buprenorphine:</u></p> <p>Non-Preferred Criteria:</p> <ul style="list-style-type: none"> Bunavail is preferred over Zubsolv and other generic forms of buprenorphine/naloxone <p>Bunavail <i>NOTE: Bunavail is not indicated for induction therapy</i></p> <ul style="list-style-type: none"> History of Suboxone therapy within the past 6 months OR History of Bunavail therapy within the past 3 months AND All other buprenorphine/naloxone provider summary found here <p>Probuphine – <u>MANUAL PA</u> Sublocade – <u>MANUAL PA</u> Vivitrol - <u>MANUAL PA</u></p>
TREATMENT			

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	naloxone injection NARCAN NASAL SPRAY (naloxone)	EVZIO (naloxone)	
OTIC ANTIBIOTICS			
	CIPRODEX (ciprofloxacin/dexamethasone) CIPRO HC (ciprofloxacin/hydrocortisone) ^{Age Edit} ofloxacin	ciprofloxacin ciprofloxacin/dexamethasone ciprofloxacin/fluocinolone CORTISPORIN-TC (colistin/neomycin/ hydrocortisone) DERMOTIC (fluocinolone) FLAC OIL DROP (fluocinolone oil) hydrocortisone/acetic acid drop fluocinolone oil neomycin/polymyxin/hydrocortisone OTIPRIO (ciprofloxacin) OTOVEL (ciprofloxacin/fluocinolone)	Maximum Age Limit • 9 years - Cipro HC
PANCREATIC ENZYMES ^{SmartPA}			
	CREON (pancreatin) ZENPEP (pancrelipase)	PANCREAZE (pancrelipase) PERTZYE (pancrelipase) VIOKACE (pancrelipase)	Non-Preferred Criteria • Have tried 2 different preferred agents in the past 6 months
PARATHYROID AGENTS			
	calcitriol ergocalciferol paricalcitol ROCALTROL (calcitriol) ZEMPLAR (paricalcitol)	cinacalcet doxercalciferol DRISDOL (ergocalciferol) HECTOROL (doxercalciferol) NATPARA (parathyroid hormone) RAYALDEE (calcifediol) SENSIPAR (cinacalcet)	
PHOSPHATE BINDERS			

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	calcium acetate ELIPHOS (calcium acetate) PHOSLYRA (calcium acetate) sevelamer carbonate tablets	AURYXIA (ferric citrate) FOSRENOL (lanthanum) lanthanum PHOSLO (calcium acetate) RENAGEL (sevelamer HCl) RENVELA (sevelamer carbonate) sevelamer carbonate powder packets sevelamer HCl VELPHORO (sucroferric oxyhydroxide)	
PLATELET AGGREGATION INHIBITORS <small>SmartPA</small>			
	AGGRENOX (dipyridamole/aspirin) BRILINTA (ticagrelor) cilostazol clopidogrel dipyridamole dipyridamole/aspirin labeler 70436 pentoxifylline prasugrel	dipyridamole/aspirin all other labelers DURLAZA ER (aspirin) EFFIENT (prasugrel) omeprazole/aspirin PERSANTINE (dipyridamole) PLAVIX (clopidogrel) PLETAL (cilostazol) ticlopidine YOSPRALA (aspirin/omeprazole) ZONTIVITY (vorapaxar)	Zontivity – MANUAL PA Non-Preferred Criteria <ul style="list-style-type: none"> • Documented diagnosis AND • Have tried 2 different preferred agents in the past 6 months OR • 90 consecutive days on the requested agent in the past 105 days
PLATELET STIMULATING AGENTS			
	PROMACTA (eltrombopag olamine)	DOPTELET (avatrombopag maleate) MULPLETA (lusutrombopag) NPLATE (romiplostim) TAVALISSE (fostamatinib disodium)	
PRENATAL VITAMINS			

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	<p>COMPLETE NATAL DHA CONCEPT DHA Capsule M-NATAL PLUS Tablet PRENATAL VITAMIN PLUS LOW IRON Tablet PREPLUS Ca/Fe27/FA 1 Tablet PRETAB Tablet TRINATAL Rx 1 Tablet TRIVEEN-DUO DHA COMBO PACK VOL-PLUS Tablet</p>	<p>Products not listed here are assumed to be Non-Preferred.</p>	
PSEUDOBULBAR AFFECT AGENTS			
		<p>NUEDEXTA (dextromethorphan/quinidine)</p>	<p>Non-Preferred Criteria</p> <ul style="list-style-type: none"> • 90 consecutive days on the requested agent in the past 105 days OR • Documented diagnosis for Pseudobulbar Affect
PULMONARY ANTIHYPERTENSIVES^{SmartPA}			
ENDOTHELIN RECEPTOR ANTAGONIST			
	<p>ambrisentan TRACLEER (bosentan) Tablets</p>	<p>bosentan LETAIRIS (ambrisentan)* OPSUMIT (macitentan) TRACLEER (bosentan) Suspension</p>	<p>All PAH Agents</p> <ul style="list-style-type: none"> • Documented diagnosis of pulmonary hypertension <p>Non-Preferred Criteria</p> <ul style="list-style-type: none"> • Have tried 1 preferred PAH agent in the past 6 months OR • 90 consecutive days on the requested agent in the past 105 days
PDE5's			
	<p>sildenafil (generic Revatio) tablet tadalafil</p>	<p>ADCIRCA (tadalafil) REVATIO (sildenafil) tablet</p>	<p>Non-Preferred Criteria</p>

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	<p>REVATIO (sildenafil) suspension sildenafil (generic Revatio) suspension</p>	<ul style="list-style-type: none"> • Have tried 1 preferred PAH agent in the past 6 months OR • 90 consecutive days on the requested agent in the past 105 days <p>Revatio suspension</p> <ul style="list-style-type: none"> • < 12 years of age AND • Documented diagnosis of Pulmonary Hypertension, Patent Ductus Arteriosus, or Persistent Fetal Circulation or history of heart transplant OR • 90 consecutive days on the requested agent in the past 105 days <p>Revatio tablets</p> <ul style="list-style-type: none"> • < 1 year of age AND • Documented diagnosis of Pulmonary Hypertension, Patent Ductus Arteriosus, or Persistent Fetal Circulation OR • 90 consecutive days on the requested agent in the past 105 days OR • > 1 years of age AND • Have tried 1 preferred PAH agent in the past 6 months OR • 90 consecutive days on the requested agent in the past 105 days
PROSTACYCLINS		

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		<p>ORENITRAM ER (treprostinil) TYVASO (treprostinil) VENTAVIS (iloprost)</p>	<p>Non-Preferred Criteria</p> <ul style="list-style-type: none"> • Have tried 1 preferred PAH agent in the past 6 months OR • 90 consecutive days on the requested agent in the past 105 days
SELECTIVE PROSTACYCLIN RECEPTOR AGONISTS			
		<p>UPTRAVI (selexipag)</p>	<p>Non-Preferred Criteria</p> <ul style="list-style-type: none"> • Have tried 1 preferred PAH agent in the past 6 months OR • 90 consecutive days on the requested agent in the past 105 days
SOLUABLE GUANYLATE CYCLASE STIMULATORS			
		<p>ADEMPAS (riociguat)</p>	<p>Adempas</p> <ul style="list-style-type: none"> • Have tried 1 preferred PAH agent in the past 6 months OR • 90 consecutive days on the requested agent in the past 105 days OR • Clinical review required for PAH WHO Group 4
ROSACEA TREATMENTS			
	<p>metronidazole (cream, gel, lotion)</p>	<p>AVAR (sulfacetamide sodium/sulfur) FINACEA (azelaic acid) METROCREAM (metronidazole cream) METROGEL (metronidazole gel) METROLOTION (metronidazole lotion)</p>	<p>Topical Sulfonamides used for Rosacea will require a manual PA for ≥ 21 years. Other labeled indications are limited to < 21 years.</p>

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		MIRVASO (brimonidine) NORITATE (metronidazole) OVACE (sulfacetamide sodium) RHOFADÉ (oxymetazoline HCl) ROSULA (sodium sulfacetamide/sulfur) sodium sulfacetamide/sulfur (cleanser, pads, suspension) SOOLANTRA (ivermectin) SUMADAN(sodium sulfacetamide/sulfur wash) SUMAXIN(sodium sulfacetamide/sulfur pads) SUMAXIN TS(sodium sulfacetamide/sulfur suspension) ZILXI AEROSOL (minocycline)	
SEDATIVE HYPNOTICS			
BENZODIAZEPINES <small>SmartPA</small>			
	estazolam flurazepam temazepam (15mg and 30mg)	DALMANE (flurazepam) DAYVIGO (lemborexant) DORAL (quazepam) HALCION (triazolam) quazepam RESTORIL (temazepam) temazepam (7.5mg and 22.5mg) triazolam	Single source benzodiazepines and barbiturates are NOT covered – NO PA's will be issued for these drugs. MS DOM Opioid Initiative <ul style="list-style-type: none"> Concomitant use of Opioids and Benzodiazepines Criteria details found here Quantity Limit – CUMULATIVE Quantity limit per rolling days for all strengths. <i>SmartPA will allow an early refill override for one dose or therapy change per year.</i> <ul style="list-style-type: none"> 31 units/31 days - all strengths Triazolam – CUMULATIVE

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		SmartPA	Quantity limit per rolling days for all strengths • 10 units/31 days • 60 units/365 days
OTHERS			
	zaleplon zolpidem	AMBIEN (zolpidem) AMBIEN CR (zolpidem) BELSOMRA (sovorexant) doxepin EDLUAR (zolpidem) eszopiclone HETLIOZ (tasimelteon) INTERMEZZO (zolpidem) LUNESTA (eszopiclone) ramelteon ROZEREM (ramelteon) SILENOR (doxepin) SONATA (zaleplon) zolpidem ER zolpidem SL ZOLPIMIST (zolpidem)	Quantity Limit – CUMULATIVE Quantity limit per rolling days for all strengths. <i>SmartPA will allow an early refill override for one dose or therapy change per year.</i> • 31 units/31 days • 1 canister/31 days – Zolpimist & male • 1 canister/62 days – Zolpimist & female Gender and Dose Limit for zolpidem • Female – Ambien 5mg, Ambien CR 6.25mg, Intermezzo 1.75 mg • Male – all zolpidem strengths Non-Preferred Criteria • Have tried 2 different preferred agents in the past 6 months Hetlioz • Circadian rhythm sleep disorder AND • Diagnosis indicating total blindness of the patient
SELECT CONTRACEPTIVE PRODUCTS			

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INJECTABLE CONTRACEPTIVES	
medroxyprogesterone acetate IM	DEPO-PROVERA IM (medroxyprogesterone acetate) DEPO-SUBQ PROVERA 104 (medroxyprogesterone acetate)
INTRAVAGINAL CONTRACEPTIVES	
ANNOVERA (segesterone/ethinyl estradiol) etonogestrel/ethinyl estradiol NUVARING (etonogestrel/ethinyl estradiol)	
ORAL CONTRACEPTIVES SmartPA	
ALL CONTRACEPTIVES ARE PREFERRED EXCEPT FOR THOSE SPECIFICALLY INDICATED AS NON-PREFERRED	AMETHIA (levonorgestrel/ethinyl estradiol) AMETHYST (levonorgestrel/ethinyl estradiol) AUROVELA 24FE (norethindrone/ethinyl estradiol/iron) BEYAZ (ethinyl estradiol / drospirenone/levomefolate) BLISOVI 24FE (norethindrone/ethinyl estradiol/iron) BRIELLYN (norethindrone/ethinyl estradiol) CAMRESE (levonorgestrel/ethinyl estradiol) CAMRESE LO (levonorgestrel/ethinyl estradiol ethinyl estradiol/drospirenone) GENERESS FE (norethindrone/ethinyl estradiol/fe) GIANVI (ethinyl estradiol/drospirenone) HAILEY 24 FE (norethindrone/ethinylestradiol/iron) JOLESSA (levonorgestrel/ethinyl estradiol) JUNEL 24 FE (norethindrone/ethinylestradiol/iron) LARIN 24 FE (norethindrone/ethinylestradiol/iron) LAYOLIS FE (norethindrone/ethinylestradiol/iron)

- Non-Preferred Criteria**
- 1 claim with the requested agent in the past 105 days

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		levonorgestrel/ethinyl estradiol LO LOESTRIN FE (norethindrone/ethinyl estradiol) LORYNA (ethinyl estradiol/drospirenone) LO-ZUMANDIMINE (ethinyl estradiol/drospirenone) NATAZIA (estradiol valerate/dienogest) norethindrone/ethinyl estradiol/fe chew tab OCELLA (ethinyl estradiol/drospirenone) PHILITH (norethindrone/ethinyl estradiol) SAFYRAL (ethinyl estradiol/drospirenone/levomefolate) SIMPESE (levonorgestrel/ethinyl estradiol) SYEDA (ethinyl estradiol/drospirenone) TARNIA (norethindrone/ethinyl estradiol/iron) WYMZYA FE (norethindrone/ethinyl estradiol/fe) ZARAH (ethinyl estradiol/drospirenone) ZUMANDIMINE (ethinyl estradiol/drospirenone)	
SICKLE CELL AGENTS			
	DROXIA (hydroxyurea) hydroxyurea	ADAKVEO (crizanlizumab) ENDARI (glutamine) HYDREA (hydroxyurea) OXBRYTA (voxelotor) SIKLOS (hydroxyurea)	Endari – MANUAL PA Oxbryta – MANUAL PA
SKELETAL MUSCLE RELAXANTS <small>SmartPA</small>			
	baclofen chlorzoxazone cyclobenzaprine 5mg, 10mg methocarbamol tizanidine tablets	AMRIX (cyclobenzaprine ER) carisoprodol carisoprodol compound cyclobenzaprine 7.5mg, 15mg cyclobenzaprine ER DANTRIUM (dantrolene)	Non-Preferred Agents <ul style="list-style-type: none"> Documented diagnosis for an approvable indication AND Have tried 2 different preferred agents in the past 6 months

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		dantrolene FEXMID (cyclobenzaprine) FLEXERIL (cyclobenzaprine) LORZONE (chlorzoxazone) metaxalone NORGESIC FORTE (orphenadrine) orphenadrine orphenadrine compound orphenadrine ER PARAFON FORTE DSC (chlorzoxazone) ROBAXIN (methocarbamol) SKELAXIN (metaxalone) SOMA (carisoprodol) tizanidine capsules ZANAFLEX (tizanidine)	Carisoprodol <ul style="list-style-type: none"> Documented diagnosis of acute musculoskeletal condition AND NO history with meprobamate in the past 90 days AND 1 claim for cyclobenzaprine in the past 21 days OR a documented intolerance to cyclobenzaprine AND Quantity Limit <ul style="list-style-type: none"> 18 tablets - to allow tapering off 84 tablets/6 months Carisoprodol with codeine <ul style="list-style-type: none"> Requires clinical review
SMOKING DETERRENT			
	NICOTINE TYPE		
	nicotine gum ^{OTC} nicotine lozenge ^{OTC} nicotine mini lozenge ^{OTC} nicotine patch ^{OTC}	NICODERM CQ PATCH ^{OTC} NICORETTE GUM ^{OTC} NICORETTE LOZENGE ^{OTC} NICORETTE MINI LOZENGE ^{OTC} NICOTROL INHALER CARTRIDGE NICOTROL NASAL SPRAY	
	NON-NICOTINE TYPE		
	bupropion ER CHANTIX (varenicline)	ZYBAN (bupropion)	Minimum Age Limit - Chantix <ul style="list-style-type: none"> 18 years Quantity Limit

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			<ul style="list-style-type: none"> • Chantix 0.5 mg, 1mg tablets and continuing pack – 336 tablets/year • Chantix Starter – 2 treatment courses/year
STEROIDS (Topical) SmartPA			
LOW POTENCY			
	CAPEX (fluocinolone) desonide hydrocortisone cr, oint, soln.	alclometasone DERMA-SMOOTH-FS (fluocinolone) DESONATE (desonide) DESOWEN (desonide) fluocinolone oil hydrocortisone lotion PEDIACARE HC (hydrocortisone) PEDIADERM (hydrocortisone) VERDESO (desonide)	Non-Preferred Criteria <ul style="list-style-type: none"> • Have tried 2 different preferred low potency agents in the past 6 months
MEDIUM POTENCY			
	fluocinolone hydrocortisone mometasone cr, oint. prednicarbate cr PANDEL (hydrocortisone probutate)	betamethasone valerate foam CLODERM (clocortolone) CUTIVATE (fluticasone) DERMATOP (prednicarbate) ELOCON (mometasone) fluticasone LUXIQ (betamethasone) mometasone solution MOMEXIN (mometasone) prednicarbate oint SYNALAR (fluocinolone)	Non-Preferred Criteria <ul style="list-style-type: none"> • Have tried 2 different preferred medium potency agents in the past 6 months
HIGH POTENCY			
	amcinonide cr, lot betamethasone dipropionate cr, gel, lotion betamethasone valerate cr, lotion, oint.	amcinonide oint betameth diprop/prop gly cr, lot, oint betamethasone dipropionate oint.	Non-Preferred Criteria

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	fluocinolone triamcinolone	BETA-VAL (betamethasone valerate) desoximetasone diflorasone DIPROLENE AF (betamethasone diprop/prop gly) ELOCON (mometasone) fluocinonide HALOG (halcinonide) KENALOG (triamcinolone) PEDIADERM TA (triamcinolone) SERNIVO (betamethasone dipropionate) TOPICORT (desoximetasone) TRIANEX (triamcinolone) VANOS (fluocinonide)	<ul style="list-style-type: none"> • Have tried 2 different preferred high potency agents in the past 6 months
VERY HIGH POTENCY			
	clobetasol lotion clobetasol shampoo, spray clobetasol propionate cream clobetasol propionate ointment halobetasol cream halobetasol ointment	BRYHALI (halobetasol) clobetasol emollient clobetasol propionate foam, ge CLOBEX (clobetasol) DIPROLENE (betamethasone diprop/prop gly) DUOBRII LOTION (halobetasol prop/tazarotene) halobetasol foam HALONATE (halobetasol/ammonium lactate) HALAC (halobetasol/ammonium lac) LEXETTE (halobetasol propionate) OLUX (clobetasol) OLUX-E (clobetasol) TEMOVATE Cream (clobetasol propionate) TEMOVATE Ointment (clobetasol propionate) TOVET Foam (clobetasol)	<p>Non-Preferred Criteria</p> <ul style="list-style-type: none"> • Have tried 2 different preferred very high potency agents in the past 6 months

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		ULTRAVATE Cream, Lotion (halobetasol) ULTRAVATE Ointment (halobetasol)	
STIMULANTS AND RELATED AGENTS <small>SmartPA</small>			
SHORT-ACTING			
amphetamine salt combination dexamethylphenidate IR dextroamphetamine IR methylphenidate IR methylphenidate solution PROCENTRA (dextroamphetamine)	ADDERALL (amphetamine salt combination) Amphetamine sulfate (generic EVEKO) DESOXYN (methamphetamine) dextroamphetamine solution EVEKEO (amphetamine) EVEKEO ODT(amphetamine) FOCALIN (dexamethylphenidate) methamphetamine METHYLIN solution (methylphenidate) methylphenidate chewable RITALIN (methylphenidate) ZENZEDI (dextroamphetamine)	<p>Minimum Age Limit</p> <ul style="list-style-type: none"> • 3 years - Adderall, Evekeo, Procentra, Zenzedi • 6 years – Desoxyn, Evekeo ODT, Focalin, Methylin <p>Maximum Age Limit</p> <ul style="list-style-type: none"> • 18 years – Evekeo ODT <p>Quantity Limit</p> <p>Applicable <u>quantity limit</u> per rolling days</p> <ul style="list-style-type: none"> • 62 tablets/31 days – Adderall, Desoxyn, Evekeo, Focalin, Methylin, Zenzedi • 310 mL/31 days – Methylin solution, Procentra <p><u>Documented diagnosis of ADHD – ALL Short Acting AGENTS</u></p> <p>Non-Preferred Criteria ADD/ADHD:</p> <ul style="list-style-type: none"> • Documented diagnosis of ADD/ADHD AND • Have tried 2 different preferred Short Acting agents in the past 6 months OR 	

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		<ul style="list-style-type: none"> 1 claim for a 30 day supply with the requested agent in the past 105 days <p>Documented diagnosis of narcolepsy – ADDERALL, EVEKEO, METHYLIN, PROCENTRA, RITALIN, ZENZEDI</p>
LONG-ACTING		
amphetamine salt combination ER DYNAVEL XR (amphetamine) FOCALIN XR (dexamethylphenidate) methylphenidate CD (generic Metadate CD) methylphenidate ER (generic Concerta) methylphenidate ER Tabs (generic Ritalin SR) methylphenidate LA QUILLICHEW (methylphenidate) VYVANSE (lisdexamfetamine) VYVANSE CHEWABLE (lisdexamfetamine)	ADDERALL XR (amphetamine salt combination) ADHANSIA XR (methylphenidate) ADZENYS XR ODT (amphetamine) ADZENYS ER SUSPENSION (amphetamine) amphetamine susp 24 hr (generic ADZENYS ER) APTENSIO XR (methylphenidate) CONCERTA (methylphenidate) COTEMPLA XR-ODT (methylphenidate) DAYTRANA (methylphenidate) DEXEDRINE (dextroamphetamine) dexmethylphenidate ER dextroamphetamine ER JORNAY PM (methylphenidate) methylphenidate ER caps (generic Aptensio XR) methylphenidate ER caps (generic Ritalin LA) methylphenidate ER (generic Relexxi) MYDAYIS (amphetamine salt combination) QUILLIVANT XR (methylphenidate) RELEXXI (methylphenidate) RITALIN LA (methylphenidate)	<p>Minimum Age Limit</p> <ul style="list-style-type: none"> 6 years – Adderall XR, Adhansia XR, Adzenys ER Suspension, Adzenys XR ODT, Aptensio XR, Concerta, Cotempla XR ODT, Daytrana, Dexedrine, Dynavel XR Focalin XR, Jornay PM, Metadate, CD, methylphenidate ER 72mg, Quillichew, Quillivant XR, Ritalin LA, Vyvanse 13 years – Mydayis 16 years – Provigil 18 years – Nuvigil, Sunosi <p>Maximum Age Limit</p> <ul style="list-style-type: none"> 18 years – Cotempla XR ODT, Daytrana <p>Quantity Limit Applicable <u>quantity limit</u> per rolling days</p>

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	RITALIN SR (methylphenidate)	<ul style="list-style-type: none"> • 31 tablets/31 days – Adderall XR, Adhansia XR, Adzenys XR ODT, Aptensio XR, Concerta 18, 27, & 54 mg, Cotempla XR-ODT 8.6 mg, Daytrana, Dexedrine Spansule, Focalin XR, Jornay PM, Metadate CD, Methylin ER, methylphenidate ER 72mg, Nuvigil 150, 200 & 250 mg, Provigil 200mg, Quillichew, Ritalin LA & SR, Vyvanse, Sunosi • 46.5 tablets/31 days – Provigil 100 mg • 62 tablets/31 days – Concerta 36mg, Cotempla XR-ODT 17.3 & 25.9 mg, Nuvigil 50mg • 248 mL/31 days – Dynavel XR • 372 mL/31 days – Quillivant XR <p><u>Documented diagnosis of ADHD</u> – ALL Long Acting AGENTS</p> <p><u>Documented diagnosis of binge eating disorder</u> – VYVANSE</p> <p>Non-Preferred Criteria ADD/ADHD:</p> <ul style="list-style-type: none"> • Documented diagnosis of ADD/ADHD AND • Have tried 2 different preferred Long Acting agents in the past 6 months OR • 1 claim for a 30 day supply with the requested agent in the past 105 days
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NARCOLEPSY		
armodafinil modafinil	NUVIGIL (armodafinil) PROVIGIL (modafinil) SUNOSI (solriamfetol) WAKIX (pitolisant) XYREM (sodium oxybate) XYWAV (calcium, magnesium, potassium and sodium oxyblates) ^{NR}	<p>Documented diagnosis of narcolepsy – ADDERALL XR, APTENSIO XR, CONCERTA ER, DEXEDRINE, METADATE CD, METHYLIN ER, MYDAYIS, NUVIGIL, PROVIGIL, QUILLICHEW, QUILLIVANT XR, RITALIN LA, SUNOSI</p> <p>Non-Preferred Criteria narcolepsy:</p> <ul style="list-style-type: none"> • Documented diagnosis of narcolepsy AND • 30 days of therapy with preferred modafinil or armodafinil in the past 6 months AND • 1 different preferred Long Acting agent indicated for narcolepsy in the past 6 months OR 1 claim for a 30 day supply with the • requested agent in the past 105 days <p>Nuvigil</p> <ul style="list-style-type: none"> • Documented diagnosis of narcolepsy, obstructive sleep apnea, shift work sleep disorder or bipolar depression <p>Provigil</p> <ul style="list-style-type: none"> • Documented diagnosis of narcolepsy, obstructive sleep apnea, shift work sleep disorder,

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			<p>depression, sleep deprivation or Steinert Myotonic Dystrophy Syndrome</p> <p>Sunosi</p> <ul style="list-style-type: none"> • Documented diagnosis of narcolepsy or obstructive sleep apnea AND • 30 days of therapy with preferred modafinil or armodafinil in the past 6 months <p>Wakix</p> <ul style="list-style-type: none"> • Diagnosis of narcolepsy without cataplexy AND • 30 days of therapy with preferred modafinil or armodafinil in the past 6 months OR • Documented diagnosis of narcolepsy without cataplexy or substance abuse disorder <p>Xyrem and Xywav</p> <ul style="list-style-type: none"> • Requires clinical review
NON-STIMULANTS			
	<p>atomoxetine</p> <p>guanfacine ER <small>Step Edit</small></p>	<p>clonidine ER</p> <p>INTUNIV (guanfacine ER)</p> <p>KAPVAY (clonidine extended-release)</p> <p>STRATTERA (atomoxetine)</p>	<p>Minimum Age Limit</p> <p>6 years – Intuniv, Kapvay, Strattera</p> <p>18 years – Wakix</p> <p>Maximum Age Limit</p> <ul style="list-style-type: none"> • 18 years – Intuniv, Kapvay • 21 years – diagnosis of ADD/ADHD is required for Strattera

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			<p>Quantity Limit Applicable <u>quantity limit</u> per rolling days</p> <ul style="list-style-type: none"> • 31 tablets/31 days – Intuniv, Strattera • 62 tablets/31 days - Wakix • 124 tablets/31 days – Kapvay <p>Intuniv</p> <ul style="list-style-type: none"> • Have tried the short acting guanfacine in the past 6 months OR • 1 claim for a 30 day supply with guanfacine ER in the past 105 days <p>Kapvay</p> <ul style="list-style-type: none"> • Diagnosis for ADD or ADHD AND • Have tried 1 Short or Long Acting stimulant in the past 6 months OR • Have tried 1 preferred Non-Stimulant in the past 6 months OR • Have tried the short acting product in the past 6 months
TETRACYCLINES <small>SmartPA</small>			
	doxycycline hyclate caps/tabs doxycycline monohydrate caps (50mg & 100mg) minocycline caps IR tetracycline	ACTICLATE (doxycycline) ADOXA (doxycycline monohydrate) demeclocycline doxycycline hyclate (generic Doryx) doxycycline monohydrate caps (75mg & 150mg)	<p>Non-Preferred Agents</p> <ul style="list-style-type: none"> • Have tried 2 different preferred agents in the past 6 months <p>Demeclocycline</p>

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		doxycycline monohydrate tabs DORYX (doxycycline hyclate) DYNACIN (minocycline) MINOCIN (minocycline) MINOLIRA (minocycline) minocycline ER minocycline tabs MONODOX (doxycycline monohydrate) NUZYRA (omadacycline tosylate) OKEBO (doxycycline) ORACEA (doxycycline) SEYSARA (sarecycline) SOLODYN (minocycline) TARGADOX (doxycycline) VIBRAMYCIN cap/susp/syrup XIMINO (minocycline)	<ul style="list-style-type: none"> Documented diagnosis of Diabetes Insipidus or SIADH will allow automatic approval.
ULCERATIVE COLITIS and CROHN'S AGENTS <small>SmartPA</small> *See Cytokine & CAM Antagonists Class for additional agents			
ORAL			
	balsalazide budesonide EC mesalamine tablet (generic Apriso) sulfasalazine	APRISO (mesalamine) ASACOL HD (mesalamine) AZULFIDINE (sulfasalazine) AZULFIDINE ER (sulfasalazine) COLAZAL (balsalazide) DELZICOL (mesalamine) DIPENTUM (olsalazine) ENTOCORT EC (budesonide) GIAZO (balsalazide) LIALDA (mesalamine) mesalamine tablet (generic Asacol HD) mesalamine tablet (generic Delzicol) ORTIKOS (budesonide)	<p>Gender Limit</p> <ul style="list-style-type: none"> Male - Giazio <p>Non-Preferred Criteria</p> <ul style="list-style-type: none"> Documented diagnosis for Ulcerative Colitis AND 2 different preferred agents in the past 6 months OR 90 consecutive days on the requested agent in the past 105 days <p>budesonide EC</p>

Drug coverage subject to the rules and regulations set forth in Sec. 1927 of Social Security Act. This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.

PREFERRED BRANDS will not count toward the two brand monthly Rx limit.

Drugs highlighted in yellow denote a change in PDL status.

An * denotes existing users will be grandfathered; grandfathering is defined as approving a Non-Preferred agent for an existing user; all other changes will not qualify for grandfathering.

A # denotes existing users will NOT be grandfathered.

To search the PDL, press CTRL + F



MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

EFFECTIVE 01/01/2021

Version 2020.5b

Updated: 12-10-2020

(For All Medicaid, MSCAN and CHIP Beneficiaries)

Conduent's SmartPA Pharmacy Application (SmartPA) is a proprietary electronic prior authorization system used for Medicaid fee for service claims. MSCAN plans may/may not have electronic PA functionality. However, they must adhere to Medicaid's PA criteria.

		PENTASA 250mg (mesalamine) PENTASA 500mg (mesalamine) UCERIS (budesonide)	<ul style="list-style-type: none"> • Documented diagnosis for Crohn's disease OR • Documented diagnosis for Ulcerative Coliti
RECTAL			
	mesalamine suppository	CANASA (mesalamine) ROWASA (mesalamine) SF-ROWASA (mesalamine) UCERIS Foam (budesonide)	

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