MISSISSIPPI DIVISION OF MEDICAID
UNIVERSAL PREFERRED DRUG LIST
(For All Medicaid, MSCAN and CHIP Beneficiaries)

EFFECTIVE 10/01/2022
Version 2022.2
Updated:10-30-2022

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
ACNE AGENTS			
	ANTI-INFECTIVE		**Maximum Age Limit** • **21 years** – all agents except isotretinoins
	clindamycin gel (generic Cleocin-T) clindamycin lotion clindamycin solution	ACZONE (dapsone) 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) dapsone ERY (erythromycin) ERYGEL (erythromycin) erythromycin gel, swabs, solution EVOCLIN (clindamycin) KLARON (sulfacetamide) sulfacetamide WINLEVI(clascoterone)	
	RETINOIDS		
	RETIN-A (tretinoin) tretinoin cream	adapalene AKLIEF (trifarotene) ALTRENO (tretinoin) ARAZLO (tazarotene) ATRALIN (tretinoin) AVITA (tretinoin) DIFFERIN (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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		FABIOR (tazarotene) PLIXDA (adapalene) RETIN-A MICRO (tretinoin) tazarotene TAZORAC (tazarotene) tretinoin gel tretinoin micro TWYNEO (tretinoin/benzoyl peroxide)	
	COMBINATION DRUGS/OTHERS		
	adapalene/benzoyl peroxide (generic EPIDUO) benzoyl peroxide/clindamycin (generic DUAC) sodium sulfacetamide/sulfur foam/gel/suspension SSS 10/5 Cream (sodium sulfacetamide/sulfur)	ACANYA (benzoyl peroxide/clindamycin) adapalene/benzoyl peroxide (generic EPIDUO FORTE) 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)	

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		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)		
	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		
	ACCUTANE (istotretinoin) 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)		

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ALZHEIMER'S AGENTS DUR +			
	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) EXELON Patches (rivastigmine) EXELON Solution (rivastigmine) RAZADYNE (galantamine) RAZADYNE ER (galantamine)	**All Agents** • Documented diagnosis for both preferred and non-preferred **Non-Preferred Criteria** • 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)	**Namzaric** • Documented diagnosis **AND** • 30 days of concurrent therapy with donepezil + memantine in the past 6 months
ANALGESICS, OPIOID- SHORT ACTING DUR +			
	acetaminophen/codeine benzhydrocodone/APAP codeine dihydrocodeine/APAP/caffeine ENDOCET (oxycodone/APAP)	ABSTRAL (fentanyl) ACTIQ (fentanyl) APADAZ (benzhydrocodone/APAP) butalbital/APAP/caffeine/codeine butalbital/ASA/caffeine/codeine	**MS DOM Opioid Initiative** • Short-Acting Opioids • Long-Acting Opioids • Morphine Equivalent Daily Dose

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	hydrocodone/APAP hydromorphone morphine oxycodone capsules oxycodone liquid oxycodone tablets oxycodone/APAP oxycodone/aspirin oxycodone/ibuprofen pentazocine/APAP tramadol tramadol/APAP	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) 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)	• Concomitant use of Opioids and Benzodiazepines Criteria details found here **Minimum Age Limit** • **18 years** – tramadol and codeine products **Quantity Limit** Applicable quantity limit in 31 rolling days • **62 tablets** – bultalbital/codeine combinations, codeine, dihydrocodeine combinations, fentanyl, hydromorphone, levorphanol, meperidine, morphine, oxycodone, oxycodone/ibuprofen, oxymorphone, pentazocine, tapentadol, tramadol • **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 • **280 mL CUMULATIVE** – Qdolo

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		PRIMLEV (oxycodone/APAP) PROLATE (oxycodone/APAP) QDOLO (tramadol) REPREXAINE (hydrocodone/ibuprofen) ROXICET (oxycodone/acetaminophen) ROXICODONE (oxycodone) ROXYBOND (oxycodone) SEGLENTIS (tramadol/celecoxib) SUBSYS (fentanyl) SYNALGOS-DC (dihydrocodeine/ aspirin/caffeine) TYLENOL W/CODEINE (APAP/codeine) TYLOX (oxycodone/APAP) ULTRACET (tramadol/APAP) ULTRAM (tramadol) VICODIN (hydrocodone/APAP) VICOPROFEN (hydrocodone/ibuprofen) XODOL (hydrocodone/acetaminophen) ZAMICET (hydrocodone/APAP) ZOLVIT (hydrocodone/APAP) ZYDONE (hydrocodone/acetaminophen)	
ANALGESICS, OPIOID - LONG ACTING DUR +			
	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)	**MS DOM Opioid Initiative** • Short-Acting Opioids • Long-Acting Opioids • Morphine Equivalent Daily Dose • Concomitant use of Opioids and Benzodiazepines Criteria details found here **Minimum Age Limit**

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		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 ULTRAM ER (tramadol) XARTEMIS XR (oxycodone/APAP) XTAMPZA (oxycodone myristate) ZOHYDRO ER (hydrocodone bitartrate)	• **18 years** – Butrans, Xartemis XR, Zohydro ER, tramadol products **Quantity Limit** Applicable quantity limit per rolling days • **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, oxycodone ER, Oxycontin, Xtampza ER, Zohydro ER • **10 patches/31 days** – Duragesic • **4 patches/31 days** – Butrans • **40 tablets/10 days** – Xartemis XR **Non-Preferred Criteria** • 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 1.5% solution	capsaicin diclofenac epolamine patch DUR +	**Non-Preferred Criteria**

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	VOLTAREN Gel (diclofenac sodium) DUR +	diclofenan sodium 3% gel FLECTOR Patch (diclofenac epolamine) DUR + FROTEK (ketoprofen) LICART (diclofenac epolamine) LIDAMANTLE HC (lidocaine/hydrocortisone) LIDO TRANS PAK (lidocaine) lidocaine lidocaine 5% patch lidocaine/prilocaine LIDODERM (lidocaine) DUR + LIDTOPIC MAX (lidocaine) PENNSAID 2% Solution (diclofenac sodium) DUR + SYNERA (lidocaine/tetracaine) TRANZAREL (lidocaine) VENNGEL ONE 1% kit (diclofenac sodium) XRYLIDERM (lidocaine) xylocaine ZOSTRIX (capsaicin) ZTlido (lidocaine)	• Have tried 1 preferred agent in the past 6 months **Lidoderm** • Documented diagnosis of Herpetic Neuralgia **OR** • Documented diagnosis of Diabetic Neuropathy **ZTlido** • Documented diagnosis of Herpetic Neuralgia
ANDROGENIC AGENTS DUR +			
	ANDRODERM (testosterone patch) testosterone gel packet	ANDROGEL (testosterone gel) ANDROXY (fluoxymesterone) AXIRON (testosterone gel) FORTESTSA (testosterone gel) JATENZO (testosterone undecanoate) NATESTO (testosterone) STRIANT (testosterone) TESTIM (testosterone gel)	**All Agents** • Limited to male gender **Non-Preferred Criteria** • Have tried 2 different preferred agents in the past 6 months

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		testosterone pump TLANDO (testosterone) VOGELXO (testosterone) XYOSTED (testosterone enanthate)	
ANGIOTENSIN MODULATORS DUR +			
	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)	**Minimum Age Limit** • **≤ 6 years** – Epaned DUR + *will automatically be issued for this age* **Non-Preferred Criteria** • Have tried 2 different preferred *single entity* agents in the past 6 months **OR** • 90 consecutive days on the requested agent in the past 105 days
	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)	**Non-Preferred Criteria** **ACE Inhibitor/CCB** • Have tried 2 different preferred *ACEI/CCB* agents in the past 6 months **OR** • 90 consecutive days on the requested agent in the past 105 days

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		UNIRETIC (moexipril/HCTZ) VASERETIC (enalapril/HCTZ) ZESTORETIC (lisinopril/HCTZ)	**ACE Inhibitor/Diuretic** • Have tried 2 different preferred *ACEI/Diuretic* 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** • Have tried 2 different preferred *single entity* agents in the past 6 months **OR** • 90 consecutive days on the requested agent in the past 105 days
	ARB COMBINATIONS		
	ENTRESTO (valsartan/sacubitril) DUR + irbesartan/HCTZ losartan/HCTZ olmesartan/amlodipine olmesartan/HCTZ telmisartan/HCTZ valsartan/amlodipine valsartan/amlodipine/HCTZ	ATACAND-HCT (candesartan/HCTZ) AVALIDE (irbesartan/HCTZ) AZOR (olmesartan/amlodipine) BENICAR-HCT (olmesartan/HCTZ) BYVALSON (nebivolol/valsartan) candesartan/HCTZ DIOVAN-HCT (valsartan/HCTZ) EDARBYCLOR (azilsartan/chlorthalidone)	**Entresto** • Age ≥ 18 years **AND** • Documented diagnosis of heart failure **OR** • Age ≥ 1 year **AND** • Documented diagnosis of heart failure with systemic ventricular systolic dysfunction

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	valsartan/HCTZ	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)	**Non-Preferred Criteria ARB/Beta Blocker, ARB/CCB or ARB/CCB/Diuretic** • Have tried 1 preferred *ARB/CCB* agent in the past 6 months **OR** • 90 consecutive days on the requested agent in the past 105 days **ARB/Diuretic** • Have tried 2 different preferred *ARB/Diuretic* products in the past 6 months **OR** • 90 consecutive days on the requested agent in the past 105 days
DIRECT RENIN INHIBITORS			
		TEKTURNA (aliskiren)	**Non-Preferred Criteria** • Documented diagnosis of hypertension **AND** • Have tried 2 different preferred *ACEI or ARB single-entity* 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)	**Non-Preferred Criteria**

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		TEKTURNA-HCT (aliskiren/hctz) VALTURNA (aliskiren/valsartan)	• Documented diagnosis of hypertension **AND** • Have tried 2 different preferred *ACEI or ARB diuretic agents* 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	AEMCOLO (rifaximin) DIFICID (fidaxomicin) FLAGYL (metronidazole) FLAGYL ER (metronidazole) paromomycin TINDAMAX (tinidazole) VANCOCIN (vancomycin) vancomycin XIFAXAN (rifaximin)	
ANTIBIOTICS (MISCELLANEOUS)			
	KETOLIDES		
		KETEK (telithromycin)	
	LINCOSAMIDE ANTIBIOTICS		
	clindamycin capsules clindamycin solution	CLEOCIN (clindamycin) CLEOCIN SOLUTION (clindamycin)	
	MACROLIDES		

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	azithromycin clarithromycin ER clarithromycin IR clarithromycin suspension ERY-TAB (erythromycin) erythromycin erythromycin ethylsuccinate	BIAXIN (clarithromycin) BIAXIN SUSPENSION (clarithromycin) BIAXIN XL (clarithromycin) E.E.S. FILM TAB (erythromycin ethylsuccinate) E.E.S. Suspension (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 macrocyrstals	FURADANTIN (nitrofurantoin) MACROBID (nitrofurantoin monohydrate macrocyrstals) MACRODANTIN (nitrofurantoin)	
OXAZOLIDINONES			
		SIVEXTRO (tedizolid) ZYVOX (linezolid)	**Sivextro – MANUAL PA** **Zyvox - MANUAL PA** **Quantity Limit** • **6 tablets/month** – Sivextro
PLEUROMUTLINS			
		XENLETA (lefamulin	

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
ANTIBIOTICS (Topical)			
	bacitracin[OTC] bacitracin/polymixin[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 DUR +			
	ORAL		
	COUMADIN (warfarin) ELIQUIS (apixaban) PRADAXA (dabigatran) warfarin XARELTO (rivaroxaban)	BEVYXXA (betrixaban) SAVAYSA (edoxaban tosylate)	**DVT Prophylaxis - following hip replacement** XARELTO 10MG, ELIQUIS, PRADAXA 110MG • 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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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			DVT Prophylaxis - following knee replacement XARELTO 10MG & ELIQUIS • 70 total days of therapy per calendar year • Documented diagnosis of knee replacement **AND** • Duration of therapy limited to 12 days **Eliquis 5mg Starter Pack** - ONLY approved for treatment of DVT/PE **XARELTO 2.5MG** • 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 **Non-Preferred Criteria** • Have tried 2 different preferred agents in the past 6 months **OR** • 1 claim with the requested agent in the past 90 days

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	LOW MOLECULAR WEIGHT HEPARIN (LMWH)		
	enoxaparin	ARIXTRA (fondaparinux) fondaparinux FRAGMIN (dalteparin) LOVENOX (enoxaparin) Prefilled Syringe	**LMWH – All Agents** • LMWH therapy in the past 3 months **AND** ○ Documented diagnosis of cancer **OR** ○ Female and age 8 to 51 years **OR** • NO LMWH therapy in the past 3 months **AND** ○ 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 **LMWH Non-Preferred Criteria** • Have tried 1 different preferred agent in the past 6 months **OR** • 90 consecutive days on the requested agent in the past 105 days
ANTICONVULSANTS DUR +			

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MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

(For All Medicaid, MSCAN and CHIP Beneficiaries)

EFFECTIVE 10/01/2022
Version 2022.2
Updated:10-30-2022

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	ADJUVANTS		
	carbamazepine carbamazepine suspension carbamazepine ER DEPAKOTE ER (divalproex) DEPAKOTE SPRINKLE (divalproex) divalproex divalproex ER divalproex sprinkle EPIDIOLEX (cannabidiol) EPITOL (carbamazepine) gabapentin GABITRIL (tiagabine) lacosamide lamotrigine levetiracetam levetiracetam ER oxcarbazepine oxcarbazepine suspension topiramate tablet topiramate sprinkle capsule valproic acid zonisamide	APTIOM (eslicarbazepine) BANZEL (rufinamide) BRIVIACT (brivaracetam) carbamazepine XR CARBATROL (carbamazepine) DEPAKENE (valproic acid) DEPAKOTE (divalproex) DIACOMIT (stiripentol) ELEPSIA XR (levetiracetam) EPRONTIA (topiramate solution) 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) ROWEEPRA (levetiracetam) SABRIL (vigabatrin)	**Minimum Age Limit** • 1 year – Banzel, Epidiolex • 2 years – Diacomit, Onfi, Sympazan **Non-Preferred Criteria** • 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 **Banzel, Onfi, Sympazan** • 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 **Diacomit** • Documented diagnosis of Dravet syndrome **AND** • Active claim for clobazam **Epidiolex**

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		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) TROKENDI XR (topiramate) vigabatrin VIMPAT (lacosamide) XCOPRI (cenobamate)	• Documented diagnosis of Dravet syndrome or seizures associated with tuberous sclerosis complex **OR** • Documented diagnosis of Lennox-Gastaut **OR** • 1 claim for the requested agent in the past 30 days **Fintepla** • Requires clinical review **Sabril Powder for Oral Solution** • 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 days **AND** • Documented diagnosis of seizure **Topiramate ER – Step Edit** • 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		

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	clobazam diazepam rectal gel NAYZILAM (midazolam) VALTOCO (diazepam)	DIASTAT (diazepam rectal) DIASTAT ACCUDIAL (diazepam rectal) ONFI (clobazam) ONFI SUSPENSION (clobazam) SYMPAZAN (clobazam)	**Minimum Age Limit** • **12 years** – Nayzilam • **6 years** – Valtoco **Quantity Limit** • **2 Twin Packs/31 days** – Diastat • **2 Packages /31 days** – Nayzilam **2 Cartons/31 days** - Valtoco
	HYDANTOINS		
	DILANTIN (phenytoin) PHENYTEK (phenytoin) phenytoin	PEGANONE (ethotoin)	
	SUCCINIMIDES		
	ethosuximide	CELONTIN (methsuximide) ZARONTIN (ethosuximide)	
ANTIDEPRESSANTS, OTHER DUR +			
	bupropion bupropion SR bupropion XL TRINTELLIX (vortioxetine) mirtazapine trazodone venlafaxine venlafaxine ER capsules	APLENZIN (bupropion HBr) desvenlafaxine ER desvenlafaxine fumarate ER DESYREL (trazodone) DRIZALMA SPRINKLE (duloxetine DR) EFFEXOR (venlafaxine) EFFEXOR XR (venlafaxine) EMSAM (selegiline transdermal)	**Minimum Age Limit** • **18 years** - all drugs • 7-17 years – duloxetine (except Drizalma Sprinkle) *DUR + will automatically be issued for this age range with a diagnosis of GAD (generalized anxiety disorder)* • **7-11 years** – Drizalma Sprinkle

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	VIIBRYD (vilazodone)	FETZIMA ER (levomilnacipran) FORFIVO XL (bupropion) KHEDEZLA ER (desvenlafaxine) MARPLAN (isocarboxazid) NARDIL (phenelzine) nefazodone OLEPTRO ER (trazodone) PARNATE (tranylcypromine) phenelzine PRISTIQ (desvenlafaxine) REMERON (mirtazapine) tranylcypromine venlafaxine XR venlafaxine ER tablets WELLBUTRIN (bupropion) WELLBUTRIN SR (bupropion) WELLBUTRIN XL (bupropion HCl)	*DUR + 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 'Antidepressants, Other'* in the past 6 months **OR** • 90 consecutive days on the requested agent in the past 105 days **Cymbalta and Irenka (see Fibromyalgia Agents)**
ANTIDEPRESSANTS, SSRIs DUR +			
	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 SUPENSION (paroxetine) PAXIL Tablets (paroxetine)	**Minimum Age Limit** • **6 years** - Zoloft • **7 years** – Prozac • **8 years** - Luvox • **12 years** - Lexapro • **18 years** – Celexa, Luvox CR, Paxil, Pexeva, Prozac 90 mg **Citalopram Criteria**

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		PEXEVA (paroxetine) PROZAC (fluoxetine) SARAFEM (fluoxetine) ZOLOFT (sertraline)	• <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** • Have tried 2 different preferred agents in the past 6 months **OR** • 90 consecutive days on the requested agent in the past 105 days
ANTIEMETICS DUR +			
	5HT3 RECEPTOR BLOCKERS		
	ondansetron ondansetron ODT ondansetron solution	ANZEMET (dolasetron) granisetron SANCUSO (granisetron) ZOFRAN (ondansetron) ZOFRAN ODT (ondansetron) ZUPLENZ (ondansetron)	**Quantity Limit** • **6 tablets/31 days** – Akynzeo • **30 tablets/31 days** – Zofran tablets/ODT • **100 ml/31 days** – Zofran solution **Non-Preferred Agents** • Have tried 1 preferred agent in the past 6 months Injectables in this class closed to point of sale. PA required if not administered in clinic/hospital
	ANTIEMETIC COMBINATIONS		

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		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	
ANTIFUNGALS (Oral) DUR +			
	clotrimazole fluconazole griseofulvin microsize suspension nystatin terbinafine	ANCOBON (flucytosine) ^ BREXAFEMME (ibrexafungerp) 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) ^	**Minimum Age Limit** • **4-12 years** – Lamisil Granules *DUR + will automatically be issued for this age range* • **12-17 years** – griseofulvin tablets *DUR + will automatically be issued for this age range* **Non-Preferred Criteria** • Have tried 2 different preferred agents in the past 6 months **HIV opportunistic infection** • Non-Preferred agent indicated for treatment (^) **AND** • Documented diagnosis of HIV

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		posaconazole^ SPORANOX (itraconazole) ^ TERBINEX Kit (terbinafine/ciclopirox) TOLSURA (itraconazole) VFEND (voriconazole) ^ voriconazole ^	**Cresemba - MANUAL PA** • Minimum age limit > 18 years **AND** • Documented diagnosis of invasive aspergillosis **OR** invasive mucormycosis **AND** • Prescriber is an oncologist/hematologist or infectious disease specialist **Sporanox** • HIV opportunistic infection criteria **OR** • Documented diagnosis of a transplant **OR** • History of an immunosuppressant in the past 6 months **OR** • Have tried 2 different preferred agents in the past 6 months
ANTIFUNGALS (Topical) DUR +			
	ANTIFUNGALS		
	ciclopirox cream/gel/solution/suspension clotrimazole cream/solution Rx & OTC ketoconazole shampoo LUZU (luliconazole) 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)	**Non-Preferred Criteria** • Have tried 2 different preferred agents in the past 6 months

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		EXTINA (ketoconazole) JUBLIA (efinaconazole) KERYDIN (tavaborole) ketoconazole cream ketoconazole foam LAMISIL (terbinafine) solution LOPROX (ciclopirox) luliconazole MENTAX (butenafine) naftifine NAFTIN (naftifine) NIZORAL (ketoconazole) oxiconazole OXISTAT (oxiconazole) PEDIADERM AF (nystatin) PENLAC (ciclopirox) VUSION (miconazole/petrolatum/zinc oxide)	
	ANTIFUNGAL/STEROID COMBINATIONS		
	clotrimazole/betamethasone cream nystatin/triamcinolone	clotrimazole/betamethasone lotion LOTRISONE (clotrimazole/betamethasone)	
ANTIFUNGALS (VAGINAL)			
	clotrimazole vaginal cream^{OTC} miconazole 1, 7cream^{OTC} miconazole 3 vaginal cream, suppository^{OTC} TERAZOL 3 Cream (terconazole) – currently unavailable from manufacturer	GYNAZOLE 1 (butoconazole) TERAZOL 3 Suppository (terconazole) TERAZOL 7 (terconazole) terconazole suppository	

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	terconazole cream tioconazole		
ANTIHISTAMINES, MINIMALLY SEDATING AND COMBINATIONS DUR +			
	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 syrup fexofenadine table levocetirizine syrup levocetirizine tablet XYZAL Solution (levocetirizine) XYZAL Tablets (levocetirizine)	**Non-Preferred Criteria** • 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)	
ANTIMIGRAINE AGENTS, ACUTE TREATMENT			
	CGRP ORAL		

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	NURTEC ODT (rimegepant)	UBRELVY (ubrogepant)	**Minimum Age Limit** • **18 years** – Nurtec ODT, Ubrelvy **Quantity Limit** • **8 tablets/31 day –** Nurtec ODT • **16 tablets/31 day –** Ubrelvy **Nurtec ODT** • Documented diagnosis of migraine **AND** • Have tried 2 different triptans in the past 6 months **AND** • No concurrent therapy with another CGRP agent **Ubrelvy** • 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
TRIPTANS & RELATED AGENTS ORAL DUR +			
	naratriptan rizatriptan rizatriptan ODT	almotriptan AMERGE (naratriptan) AXERT (almotriptan)	**Minimum Age Limit – ALL FORMULATIONS** • **6 years –** Maxalt

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	sumatriptan tablets zolmitriptan zolmitriptan ODT	eletriptan FROVA (frovatriptan) frovatriptan IMITREX (sumatriptan) MAXALT (rizatriptan) MAXALT MLT (rizatriptan) RELPAX (eletriptan) REYVOW (lasmiditan) TREXIMET (sumatriptan/naproxen) ZOMIG (zolmitriptan)	• **12-17 years** – Axert, Treximet, Zomig nasal spray *DUR + will automatically be issued for this age range* • **18 years** – Amerge, Frova, Imitrex, Onzetra Xsail, Relpax, Reyvow, Tosymra, Zembrace Symtouch, Zomig tablets **Quantity Limit - ORAL** • **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 **Non-Preferred Criteria - ORAL** • Have tried 2 preferred oral agents in the past 90 days **Reyvow** • 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
	NASAL		

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	sumatriptan zolmitriptan	IMITREX (sumatriptan) ONZETRA Xsail (sumatriptan) TOSYMRA (sumatriptan) ZOMIG (zolmitriptan)	**Quantity Limit - NASAL** • **1 box/31 days** **Non-Preferred Criteria - NASAL** • 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)	**CUMULATIVE Quantity Limit - INJECTION** **4 injections/31 days**
ANTIMIGRAINE AGENTS, PROPHYLAXIS			
	INJECTIBLES		
	AIMOVIG AUTOINJECTOR (erenumab-aooe) AJOVY AUTOINJECTOR (fremanezumab-vfrm) AJOVY SYRINGE (fremanezumab-vfrm)	EMGALITY PEN (galcanezumab-gnlm) EMGALITY SYRINGE (galcanezumab-gnlm) VYEPTI (eptinezumab-jjmr)	**Aimovig** - MANUAL PA **Ajovy** - MANUAL PA **Emgality** - MANUAL PA **Vyepti** - MANUAL PA
	ORAL		
		NURTEC ODT (rimegepant) QULIPTA (atogepant)	• See Antimigraine Agents, Acute
***ANTINEOPLASTICS – SELECTED SYSTEMIC ENZYME INHIBITORS**			
	AFINITOR (everolimus) BOSULIF (bosutinib) CAPRELSA (vandetanib) COMETRIQ (cabozantinib) COTELLIC (cobimetinib) GILOTRIF (afatanib)	ALECENSA (alectinib) ALUNBRIG (brigatnib) AYVAKIT (avapritinib) BALVERSA (erdafitinib) BRAFTOVI (encorafenib) BRUKINSA (zanubrutinib)	**Farydak** - MANUAL PA • Documented diagnosis of multiple myeloma **AND**

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	ICLUSIG (ponatinib) imatinib mesylate IMBRUVICA (ibrutnib) INLYTA (axitinib) IRESSA (gefitinib) 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 (ceritnib)	CABOMETYX (cabozantinib s-malate) CALQUENCE (acalabrutinib) COPIKTRA (duvelisib) DAURISMO (glasdegib) ERIVEDGE (vismodegib) ERLEADA (apalutamide) erlotinib everolimus EXKIVITY (mobocertinib) FARYDAK (panobinostat) FOTIVDA (tivozanib) GAVRETO (pralsetinib) GLEEVEC (imatinib mesylate) GLEOSTINE (lomustine) IBRANCE (palbociclib) DUR + IDHIFA (enasidenib) INQOVI (cedazuridine/decitabine) INREBIC (fedratinib) KISQALI (ribociclib) KOSELUGO (selumetinib) lapatinib ditosylate LENVIMA (lenvatinib) DUR + LORBRENA (lorlatinib) LUMAKRAS (sotorasib) LYNPARZA (olaparib) DUR + MEKTOVI (binimetnib) NERLYNX (neratinib maleate) NUBEQA (darolutamide) ODOMZO (sonidegib) ONUREG (azacitidine) ORGOVYX (relugolix) PEMAZYRE (pemigatinib)	• Used in combination with bortezomib and dexamethasone per PI **AND** • History of 2 prior regimens including bortezomib and an immunomodulatory agent **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 **OR** • All other indications evaluated through clinical review **Lynparza Capsules - MANUAL PA** **Lynparza Tablets**

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		PIQRAY (alpelisib) QINLOCK (ripretinib) RETEVMO (selpercatinib) RUBRACA (rucaparib) RYDAPT (midostaurin) SCEMBLIX (asciminib) TABRECTA (capmatinib) TAGRISSO (osimertinib) TALZENNA (talazoparib) TAZVERIK (tazemetostat) TEPMETKO (tepotinib) TIBSOVO (ivosidenib) TRUSELTIQ (infigratinib) TUKYSA (tucatinib) UKONIQ (umbralisib) VERZENIO (abemaciclib) VITRAKVI (larotrectinib) VIZIMPRO (dacomitinib) WELIREG (belzutifan) XATMEP (methotrexate) XOSPATA (gilteritinib) XPOVIO (selinexor) ZEJULA (niraparib)	• 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
ANTIPARASITICS (Topical) DUR +			
	PEDICULICIDES		
	permethrin 1%OTC NATROBA (spinosad)	lindane malathion OVIDE (malathion) SKLICE (ivermectin) spinosad	**Minimum Age/Weight Limit for Pediculicides** • **50 kg -** lindane shampoo • **2 months –** permethrin 1%(OTC) • **6 months** – Natroba, Sklice

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		VANALICE (piperonyl butoxide/pyrethrins)	• **2 years –** piperonyl/pyrethrins (OTC) • **6 years –** Ovide **Non-Preferred Criteria** • Have tried 2 preferred topical lice agents in the past 90 days
	SCABICIDES		
	permethrin 5% ivermectin	ELIMITE (permethrin) EURAX CREAM (crotamiton) EURAX LOTION (crotamiton) STROMECTOL Tablet (ivermectin)	**Minimum Age/Weight Limit for Topical Scabicides** • **50 kg -** lindane lotion • **2 months –** permethrin 5% • **4 years -** Natroba • **18 years** – Eurax **Non-Preferred Criteria** • History of permethrin 5% in the past 90 days
ANTIPARKINSON'S AGENTS (Oral) DUR +			
	ANTICHOLINERGICS		
	benztropine trihexyphenidyl	COGENTIN (benztropine)	**Non-Preferred Criteria** • 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		

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	entacapone	COMTAN (entacapone) ONGENTYS (opicapone) 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)	**Xadago** • 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
	OTHERS		
	amantadine bromocriptine carbidopa levodopa/carbidopa	DUOPA (levodopa/carbidopa) GOCOVRI (amantadine) INBRIJA (levodopa) levodopa/carbidopa ODT levodopa/carbidopa/entacapone	**Lodosyn and Inbrija** • Documented diagnosis of Parkinson's disease **AND**

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		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)	• History of a carbidopa/levodopa combination product in the past 45 days **Nourianz** • 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 DUR +			
	ORAL		
	amitriptyline/perphenazine aripiprazole clozapine fluphenazine haloperidol olanzapine olanzapine ODT perphenazine quetiapine quetiapine XR risperidone risperidone ODT SAPHRIS (asenapine) thioridazine	ABILIFY (aripiprazole) ABILIFY MYCITE (aripiprazole) ADASUVE (loxapine) aripiprazole solution aripiprazole ODT asenapine CAPLYTA (lumateperone) chlorpromazine clozapine ODT CLOZARIL (clozapine) FANAPT (iloperidone) FAZACLO (clozapine) GEODON (ziprasidone) HALDOL (haloperidol)	**Minimum Age Limit** • **2 years –** Droperidol • **3 years –** Haldol • **5 years –** Risperdal, thioridazine • **6 years –** Abilify, trifluoperazine • **10 years –** Latuda, Saphris, Seroquel, Symbyax • **12 years –** Invega, Molidone, perphenazine, pimozole, thiothixene • **13 years –** Zyprexa • **18 years –** Abilify Mycite, Amitriptyline/perphenazine, Caplyta, Clozaril, Fanapt,

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	thiothixene trifluoperazine ziprasidone	INVEGA ER (paliperidone) LATUDA (lurasidone) LYBALVI (olanzapine/samidorphan) NUPLAZID (pimavanserin) olanzapine/fluoxetine paliperidone ER REXULTI (brexpiprazole) RISPERDAL (risperidone) SEROQUEL (quetiapine) SEROQUEL XR (quetiapine) SYMBYAX (olanzapine/fluoxetine) VERSACLOZ (clnazpine) VRAYLAR (cariprazine) ZYPREXA (olanzapine)	fluphenazine, Geodon, 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 DUR +		
	ABILIFY MAINTENA (aripirazole) ARISTADA ER (aripiprazole lauroxil) ARISTADA INITIO (aripiprazole lauroxil) INVEGA HAFYERA (paliperidone) INVEGA SUSTENNA (paliperidone palmitate) INVEGA TRINZA (paliperidone) PERSERIS (risperidone) RISPERDAL CONSTA (risperidone)	ABILIFY (aripiprazole) GEODON (ziprasidone) olanzapine ZYPREXA (olanzapine) ZYPREXA RELPREVV (olanzapine)	**Minimum Age Limit** • **18 years –** all injectable agents **Quantity Limit** • **3 syringes/year –** Aristada Initio **Long-Acting Injectable Agents All Agents**

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			• Documented diagnosis of schizophrenia or schizoaffective disorder **Abilify Maintena or Risperdal Consta** • Documented diagnosis of schizophrenia or schizoaffective disorder **OR** • Documented diagnosis of bipolar disorder
	TRANSDERMAL, ATYPICALS		
		SECUADO (asenapine)	
ANTIRETROVIRALS DUR +			
	SINGLE PRODUCT REGIMENS		
	BIKTARVY (bictegravir/emtricitabine/tenofovir) CABENUVA (cabotegravir/rilpivirine) DELSTRIGO (doravirine/lamivudine/tenofovir) DOVATO (dolutegravir/lamivudine) efavirenz/emtricitabine/tenofovir labeler GENVOYA (elvitegravir/cobicistat/emtricitabine/tenofovir) JULUCA (dolutegravir/rilpivirine) ODEFSEY (emtricitabine/rilpivirine/tenofovir AF) SYMFI (efavirenz/lamivudine/tenofovir) SYMFI-LO (efavirenz/lamivudine/tenofovir) TRIUMEQ (abacavir/lamivudine/ dolutegravir)	ATRIPLA (efavirenz/emtricitabine/tenofovir) COMPLERA (emtricitabine/rilpivirine/tenofovir) efavirenz/lamivudine/tenofovir efavirenz/lamivudine/tenofovir lo STRIBILD (elvitegravir/cobicistat/emtricitabine/tenofovir) SYMTUZA (darunavir/cobicistat/ emtricitabine/tenofovir)	**Stribild – MANUAL PA** • 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** • CrCl > 70mL/min to initiate therapy **OR** CrCl >50mL/min to continue therapy

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	INTEGRASE STRAND TRANSFER INHIBITORS		
	APRETUDE ER (cabotegravir) ISENTRESS (raltegravir potassium) TIVICAY (dolutegravir sodium) TIVICAY PD (dolutegravir sodium)	ISENTRESS HD (raltegravir potassium) VITEKTA (elvitegravir)	**Non-Preferred Criteria** • 1 claim with the requested agent in the past 105 days
	NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS (NRTI)		
	abacavir sulfate EMTRIVA (emtricitabine) EMTRIVA SOLUTION (emtricitabine) lamivudine tenofovir disoproxil fumarate ZIAGEN Solution (abacavir sulfate) zidovudine	didanosine DR capsule emtricitabine EPIVIR (lamivudine) RETROVIR (zidovudine) stavudine VIDEX EC (didanosine) VIDEX SOLUTION (didanosine) VIREAD (tenofovir disoproxil fumarate) ZIAGEN Tablet (abacavir sulfate)	
	NON-NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITOR (NNRTI)		
	EDURANT (rilpivirine) efavirenz	INTELENCE (etravirine) nevirapine nevirapine ER PIFELTRO (doravirine) RESCRIPTOR (delavirdine mesylate) SUSTIVA (efavirenz) VIRAMUNE (nevirapine) VIRAMUNE ER (nevirapine)	
	PHARMACOENHANCER – 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 CABENUVA (cabotegravir/rilpivirine) DOVATO (dolutegravir/lamivudine) JULUCA (dolutegravir/rilpivirine) lamivudine/zidovudine	abacavir/lamivudine/zidovudine COMBIVIR (lamivudine/zidovudine) EPZICOM (abacavir/lamivudine) TRIZIVIR (abacavir/lamivudine/zidovudine)	

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	COMBINATION PRODUCTS – NUCLEOSIDE & NUCLEOTIDE ANALOG RTIs		
	DESCOVY (emtricitabine/tenofovir alafenam) emtricitabine/tenofovir	TRUVADA (emtricitabine/tenofovir)	
	COMBINATION PRODUCTS – NUCLEOSIDE & NUCLEOTIDE ANALOGS & NON-NUCLEOSIDE RTIs		
	CIMDUO (lamivudine/tenofovir) DELSTRIGO (doravirine/lamivudine/tenofovir) efavirenz/emtricitabine/tenofovir ODEFSEY (emtricitabine/rilpivirine/tenofovir AF)	ATRIPLA (efavirenz/emtricitabine/tenofovir) COMPLERA (emtricitabine/rilpivirine/tenofovir) TEMIXYS (lamivudine/tenofovir)	
	COMBINATION PRODUCTS – PROTEASE INHIBITORS		
	KALETRA (lopinavir/ritonavir)	lopinavir/ritonavi	
	CD4 DIRECTED ATTACHMENT INHIBITOR		
		RUKOBIA (fostemsavir tromethamine ER)	
	CD4 DIRECTED HIV-1 INHIBITOR		
		TROGARZO (ibalizumab)	
ANTIVIRALS (Oral)			
	ANTI-CYTOMEGALOVIRUS AGENTS		
	valganciclovir tablets	LIVTENCITY (maribavir) PREVYMIS (letermovir) VALCYTE (valganciclovir) valganciclovir solution	**valganciclovir solution –** automatic approval for age <12 years **Prevymis**

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			Prevention (prophylaxis) of cytomegalovirus (CMV) infection and disease • ≥ 18 years **AND** • 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)			

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	ZOVIRAX Cream (acyclovir)	acyclovir cream, ointment DENAVIR (penciclovir) XERESE (acyclovir/hydrocortisone) ZOVIRAX Ointment (acyclovir)	
AROMATASE INHIBITORS			
	anastrozole exemestane letrozole	ARIMIDEX (anastrozole) AROMASIN (exemestane) FEMARA (letrozole)	
ATOPIC DERMATITIS DUR +			
	ADBRY (tralokinumab) DUPIXENT (dupilumab) ELIDEL (pimecrolimus) PROTOPIC (tacrolimus) tacrolimus	CIBINQO (abrocitinib) EUCRISA (crisaborole) OPZELURA (ruxolitinib) pimecrolimus	**Minimum Age Limit** • **2 years –** Elidel, Protopic 0.03% • **6 years –** Protopic 0.1% **Adbry- MANUAL PA** **Eucrisa** • 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**

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			• MANUAL PA **Dupixent** Evaluated through Manual PA according to diagnosis **Asthma – MANUAL PA** **Atopic Dermatitis – MANUAL PA** **Eosinophilic Esophagitis-- MANUAL PA** **Nasal Polyposis – MANUAL PA** **Prurigo Nodularis MANUAL PA**
BETA BLOCKERS, ANTIANGINALS & SINUS NODE AGENTS DUR+			
	acebutolol atenolol bisoprolol metoprolol metoprolol ER nadolol nebivolol Step Edit pindolol propranolol propranolol ER sotalol	BETAPACE (sotalol) betaxolol BYSTOLIC (nebivolol) 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)	**Nebivolol** • 90 consecutive days on the requested agent in the past 105 days **OR** • Have tried 1 preferred agent in the past 6 months **Non-Preferred Criteria** • 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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	BETA- AND ALPHA-BLOCKERS		
	carvedilol labetalol	carvedilol CR COREG (carvedilol) COREG CR (carvedilol) TRANDATE (labetalol)	**Coreg CR** • 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)	
	ANTIANGINALS		
		RANEXA (ranolazine) ranolazine	**Ranexa** • Documented diagnosis of angina **AND** • 1 claim for a calcium channel blocker, beta-blocker, nitrate, or combination agent in the past 30 days **OR**

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			• 90 consecutive days on the requested agent in the past 105 days
	SINUS NODE AGENTS		
		CORLANOR (ivabradine)	**Corlanor - MANUAL PA**
BILE SALTS			
	ursodiol	ACTIGALL (ursodiol) BYLVAY (odevixibat) CHENODAL (chenodiol) CHOLBAM (cholic acid) LIVMARLI (maralixibat) OCALIVA (obeticholic acid) URSO (ursodiol) URSO FORTE (ursodiol)	
BLADDER RELAXANT PREPARATIONS DUR+			
	oxybutynin ER oxybutinin IR solifenacin	darifenacin DETROL (tolterodine) DETROL LA (tolterodine) DITROPAN XL (oxybutynin) GELNIQUE (oxybutynin) GEMTESA (vibegron) MYRBETRIQ ER (mirabegron) MYRBETRIQ granules (mirabegron) OXYTROL (oxybutynin) tolterodine tolterodine ER	**Non-Preferred Criteria** • Have tried 2 different preferred agents in the past 6 months

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		TOVIAZ (fesoterodine fumarate) trospium trospium ER VESICARE (solifenacin) VESICARE LS Suspension (solifenacin)	
BONE RESORPTION SUPPRESSION AND RELATED AGENTS DUR+			
	BISPHOSPHONATES		**Non-Preferred Criteria** • Documented diagnosis for osteoporosis or osteopenia **AND** • Have tried 2 different preferred agents in the past 6 months
	alendronate ibandronate risedronate	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	
	OTHERS		
		calcitonin salmon EVENITY (romosozumab-aqqg) EVISTA (raloxifene) FORTEO (teriparatide) MIACALCIN (calcitonin) PROLIA (denosumab) raloxifene TYMLOS (abaloparatide) XGEVA (denosumab)	

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MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

(For All Medicaid, MSCAN and CHIP Beneficiaries)

EFFECTIVE 10/01/2022
Version 2022.2
Updated:10-30-2022

Gainwell Technologies' DUR+ process 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.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
BPH AGENTS DUR+			
	ALPHA BLOCKERS		**Female** • Cardura, Flomax, Proscar, terazosin, or Uroxatral **AND** • Documented diagnosis based on a State accepted diagnosis **Non-Preferred Criteria - MALE** • Have tried 2 different preferred agents in the past 6 months **OR** • 90 consecutive days on the requested agent in the past 105 days
	alfuzosin doxazosin tamsulosin terazosin	CARDURA (doxazosin) CARDURA XL (doxazosin) dutasteride/tamsulosin FLOMAX (tamsulosin) HYTRIN (terazosin) JALYN (dutasteride/tamsulosin) RAPAFLO (silodosin) silodosin UROXATRAL (alfuzosin)	
	5-ALPHA-REDUCTASE (5AR) INHIBITORS		
	finasteride	AVODART (dutasteride) dutasteride PROSCAR (finasteride)	
	PDE5 INHIBITORS		
		CIALIS (tadalafil)	
BRONCHODILATORS & COPD AGENTS			
	ANTICHOLINERGICS & COPD AGENTS		**Minimum Age Limit** **6 years –** Spiriva Respimat **Spiriva Respimat** • Automatic approval for ≥ 6 years with a diagnosis of asthma
	ATROVENT HFA (ipratropium) INCRUSE ELLIPTA (umeclidinium) ipratropium SPIRIVA HANDIHALER (tiotropium)	DALIRESP (roflumilast) LONHALA MAGNAIR (glycopyrrolate) SEEBRI (glycopyrrolate) SPIRIVA RESPIMAT (tiotropium) DUR + TUDORZA PRESSAIR (aclidinium)	

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		YUPELRI (revefenacin)	
	ANTICHOLINERGIC-BETA AGONIST COMBINATIONS		
	albuterol/ipratropium ANORO ELLIPTA (umeclidinium/vilanterol) COMBIVENT RESPIMAT (albuterol/ipratropium) DUR + STIOLTO RESPIMAT (tiotropium/olodaterol)	BEVESPI (glycopyrrolate/formoterol) DUAKLIR PRESSAIR (aclidinium/formoterol)	
	ANTICHOLINERGIC-BETA AGONIST-GLUCOCORTICOIDS COMBINATIONS		
		BREZTRI AEROSPHERE (budesonide/glycopyrrolate/formoterol) TRELEGY ELLIPTA (fluticasone furoate/ umeclidinium/vilanterol)	
BRONCHODILATORS, BETA AGONIST			
	INHALERS, SHORT-ACTING		
	VENTOLIN HFA (albuterol)	albuterol HFA levalbuterol HFA PROAIR DIGIHALER (albuterol) PROAIR RESPICLICK (albuterol) PROVENTIL HFA (albuterol) XOPENEX HFA (levalbuterol) DUR +	**Minimum Age Limit** • **4 years -** Xopenex HFA **Xopenex HFA** • 1 claim for a preferred albuterol inhaler in the past 30 days **ProAir Digihaler** • Requires clinical review
	INHALERS, LONG ACTING DUR +		
	SEREVENT (salmeterol) STRIVERDI RESPIMAT (olodaterol)	ARCAPTA (indacaterol)	**Minimum Age Limit** • **4 years –** Serevent

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			• **18 years** – Arcapta, Striverdi Respimat **Arcapta & Striverdi Respimat** • 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 DUR +		
	albuterol	arformoterol BROVANA (arformoterol) formoterol levalbuterol metaproterenol PERFOROMIST (formoterol) XOPENEX (levalbuterol)	**Minimum Age Limit** • **6 years –** Xopenex • **18 years –** Brovana, Perforomist **Non-Preferred Criteria** • 1 claim for a different preferred agent in the past 6 months **OR** • 3 claims with the requested agent in the past 105 days **Xopenex** • 1 claim for a preferred albuterol in the past 30 days
	ORAL		
	albuterol ER albuterol IR	VOSPIRE ER (albuterol)	

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	metaproterenol terbutaline		
CALCIUM CHANNEL BLOCKERS DUR +			
	SHORT-ACTING		
	diltiazem nicardipine nifedipine verapamil	CALAN (verapamil) CARDIZEM (diltiazem) isradipine nimodipine NYMALIZE SOLUTION (nimodipine) PROCARDIA (nifedipine)	**Quantity Limit - nimodipine** • **252 tablets/ 21 days** • **2520 mL/21 days** **Non-Preferred Criteria** • Have tried 2 different preferred *Short Acting* CCB agents in the past 6 months **OR** • 90 consecutive days on the requested agent in the past 105 days **nimodipine** • 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	ADALAT CC (nifedipine) CALAN SR (verapamil) CARDENE SR (nicardipine) CARDIZEM CD (diltiazem) CARDIZEM LA (diltiazem)	**Non-Preferred Criteria** • Have tried 2 different preferred *Long Acting* CCB agents in the past 6 months **OR**

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	nifedipine ER verapamil ER	DILACOR XR (diltiazem) 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)	• 90 consecutive days on the requested agent in the past 105 days
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		

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	amoxicillin/clavulanate amoxicillin/clavulanate XR	AUGMENTIN 125 and 250 Suspension (amoxicillin/clavulanate) AUGMENTIN (amoxicillin/clavulanate) Tablets AUGMENTIN XR (amoxicillin/clavulanate) MOXATAG (amoxicillin)	
	CEPHALOSPORINS – First Generation DUR +		**Non-Preferred Criteria – all generations** • Have tried 2 different preferred agents in the past 6 months **Maximum Age Limit** • **18 years –** cefdinir suspension
	cefadroxil cephalexin capsules cephalexin suspensio	cephalexin tablets DAXBIA (cephalexin) KEFLEX (cephalexin)	
	CEPHALOSPORINS – Second Generation DUR +		
	cefaclor capsules cefprozil cefuroxime tablets	cefaclor ER cefaclor suspension cefuroxime suspension CEFTIN (cefuroxime)	
	CEPHALOSPORINS – Third Generation DUR +		
	cefdinir suspension cefdinir capsules cefpodoxime	CEDAX (ceftibuten) cefditoren ceftibuten SPECTRACEF (cefditoren) SUPRAX (cefixime)	
COLONY STIMULATING FACTORS			
	NEUPOGEN Syringe (filgrastim) NEUPOGEN Vial (filgrastim) ZIEXTENZO (pegfilgrastim-bmez)	FULPHILA (pegfilgrastim) GRANIX (tbo-filgrastim) LEUKINE (sargramostim) NEULASTA (pegfilgrastim)	

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		NIVESTYM (filgrastim-aafi) NYVEPRIA (pegfilgrastim-apgf) RELEUKO (filgrastim) UDENYCA (pegfilgrastim-cbqv) ZARXIO (filgrastim)	
CYSTIC FIBROSIS AGENTS DUR +			
	tobramycin (generic TOBI)	BETHKIS (tobramycin) BRONCHITOL (mannitol) CAYSTON (aztreonam) colistmethate COLY-MYCIN M (colistimethate sodium) KALYDECO (ivacaftor) KITABIS (tobramycin) ORKAMBI (lumacaftor/ivacaftor) PULMOZYME (dornase alfa) SYMDEKO (tezacaftor/ivacaftor) TOBI (tobramycin) TOBI PODHALER (tobramycin) tobramycin (generic Bethkis) tobramycin (generic Kitabis) 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, Trikafta • **7 years –** Cayston • **12 years –** Orkambi 200/125mg tablet • **18 years -** Bronchitol **Maximum Age Limit** • **5 years –** Kalydeco and Orkambi Granules **All Agents** • Documented diagnosis Cystic Fibrosis **Colistimethate**

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			• Documented diagnosis of Cystic Fibrosis **OR** • Requires clinical review **Kalydeco – MANUAL PA** **Orkambi – MANUAL PA** **Symdeko – MANUAL PA** **Trikafta – MANUAL PA** **TOBI Podhaler** • Requires clinical review
CYTOKINE & CAM ANTAGONISTS[DUR +]			
	ACTEMRA SYRINGE (tocilizumab) ACTEMRA VIAL(tocilizumab) AVSOLA (infliximab) ENBREL (etanercept) HUMIRA (adalimumab) KINERET (anakinra) methotrexate ORENCIA CLICKJET(abatacept) ORENCIA VIAL(abatacept) OTEZLA (apremilast) SIMPONI (golimumab) TALTZ (ixekizumab) XELJANZ IR (tofacitinib)	ACTEMRA ACTPEN (tocilizumab) ARCALYST (rilonacept) CIMZIA (certolizumab) COSENTYX (secukinumab ENTYVIO (vedolizumab) ILARIS (canakinumab) ILUMYA (tildrakizumab) INFLECTRA (infliximab) KEVZARA (sarilumab) OLUMIANT (baricitinib) ORENCIA SYRINGE (abatacept) OTREXUP (methotrexate) RASUVO (methotrexate) REMICADE (infliximab) RENFLEXIS (infliximab-abda) RHEUMATREX (methotrexate) RINVOQ (upadacitinib)	**All preferred agents are subject to approved age and documented diagnosis for appropriate indication.** **Cosentyx** • Age ≥ 6 years **AND** • Documented diagnosis of plaque psoriasis **AND** • Have tried 90 days therapy with both Enbrel and Taltz **OR** • Age ≥ 18 years **AND** • Documented diagnosis of ankylosing spondylitis, plaque psoriasis, or psoriatic arthritis **AND** • Have tried 90 days therapy with both Humira and Taltz **OR**

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		RINVOQ ER (upadacitinib) SILIQ (brodalumab) SKYRIZI (risankizumab) STELARA (ustekinumab) TREMFYA (guselkumab) TREXALL (methotrexate) XELJANZ Oral Solution (tofacitinib) XELJANZ XR (tofacitinib)	• All other indications evaluated through clinical review **All other Non-Preferred Agents** • Require clinical review **IV Administered Agents** • Require clinical review
ERYTHROPOIESIS STIMULATING PROTEINS DUR +			
	EPOGEN (rHuEPO) MIRCERA (methoxy polyethylene glycol-epoetin-beta) RETACRIT (rHuEPO)	ARANESP (darbepoetin) PROCRIT (rHuEPO)	**Mircera** • Documented diagnosis chronic renal failure in the past 2 years **Non-Preferred Criteria** • Documented diagnosis of cancer or chronic renal failure **OR** Antineoplastic therapy in the past 6 months **AND** • Trial of a preferred Retacrit or Epogen in the past 6 months **OR** • 1 claim for the requested agent in the past 105 days
FACTOR DEFICIENCY PRODUCTS			
	FACTOR VIII		
	ADVATE AFSTYLA ALPHANATE	ADYNOVATE ELOCTATE ESPEROCT	

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	FEIBA NF HEMOFIL M HUMATE-P KOATE KOGENATE FS KOVALTRY NOVOEIGHT NUWIQ RECOMBINATE WILATE XYNTHA XYNTHA SOLOFUSE	HEXILATE FS JIVI KCENTRA OBIZUR VONVENDI	
	FACTOR IX		
	ALPHANINE SD ALPROLIX BENEFIX IDELVION IXINITY MONONINE PROFILNINE RIXUBIS	REBINYN	
	OTHER FACTOR PRODUCTS		
	COAGADEX FIBRYGA HEMLIBRA SmartPA RIASTAP	CORIFACT NOVOSEVEN RT SEVENFACT TRETTEN	**Hemlibra** • 1 claim with the requested agent in the past 105 days • **MANUAL PA** – new patients
FIBROMYALGIA/NEUROPATHIC PAIN AGENTS			

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	duloxetine gabapentin pregabalin SAVELLA (milnacipran)	CYMBALTA (duloxetine) DUR + DRIZALMA SPRINKLES (duloxetine DR) duloxetine DR GRALISE (gabapentin) HORIZANT (gabapentin) IRENKA (duloxetine) DUR + LYRICA (pregabalin) LYRICA CR (pregabalin) NEURONTIN (gabapentin) pregabalin ER	**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) DUR +			
	ciprofloxacin tablets levofloxacin tablets	AVELOX (moxifloxacin) BAXDELA (delafloxacin) CIPRO (ciprofloxacin) CIPRO SUSPENSION (ciprofloxacin) CIPRO XR (ciprofloxacin) ciprofloxacin ER ciprofloxacin suspension FACTIVE (gemifloxacin) LEVAQUIN (levofloxacin) levofloxacin solution moxifloxacin NOROXIN (norfloxacin) ofloxacin	**Non-Preferred Criteria** • 1 claim for a preferred agent in past 30 days **Cipro Suspension for age < 12 years** • 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 ○ Penicillin, 2nd or 3rd generation cephalosporin, or macrolide

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			Levaquin solution for age < 12 years • Anthrax infection or exposure **OR** • 7 days of therapy with a preferred agent from 2 of the classes below in the past 3 months ○ Penicillin, 2nd or 3rd generation cephalosporin, or macrolide **AND** • Cipro suspension in the past 3 months
GAUCHER'S DISEASE			
	ELELYSO (taliglucerase alfa) ZAVESCA (miglustat)	CERDELGA (eliglustat) CEREZYME (imiglucerase) miglustat VPRIV (velaglucerase alfa)	
GENITAL WARTS & ACTINIC KERATOSIS AGENTS			
	CONDYLOX (podofilox) Age Edit imiquimod Age Edit podofilox Age Edit	ALDARA (imiquimod) Age Edit CARAC (fluorouracil) diclofenac 3% gel 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	**Minimum Age Limit** • **12 years –** Aldara, Zyclara • **18 years –** Condylox, Picato, Veregen

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Gainwell Technologies' DUR+ process 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.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
GLUCOCORTICOIDS (Inhaled) DUR +			
	GLUCOCORTICOIDS		
	ASMANEX TWISTHALER (mometasone) budesonide 0.25mg and 0.5mg FLOVENT DISKUS (fluticasone) FLOVENT HFA (fluticasone) PULMICORT FLEXHALER (budesonide) QVAR REDIHALER (beclomethasone diproprionate)	ALVESCO (ciclesonide) ARMONAIR Digihaler (fluticasone) ARNUITY ELLIPTA (fluticasone) ASMANEX HFA (mometasone) budesonide 1mg PULMICORT (budesonide) Respules	**Non-Preferred Criteria** • 90 consecutive days on the requested agent in the past 105 days **OR** • Have tried 1 preferred agent in the past 6 months **ArmonAir Digihaler** • Requires clinical review *NOTE:* Institutional sized products are Non-Preferred
	GLUCOCORTICOID/BRONCHODILATOR COMBINATIONS		
	ADVAIR DISKUS (fluticasone/salmeterol) ADVAIR HFA (fluticasone/salmeterol) DULERA (mometasone/formoterol) fluticasone/salmeterol (generic AIRDUO) SYMBICORT (budesonide/formoterol)	AIRDUO Digihaler (fluticasone/salmeterol) AIRDUO Respiclick (fluticasone/salmeterol) BREO ELLIPTA (fluticasone/vilanterol) budesonide/formoterol fluticasone/salmeterol (generic ADVAIR) WIXELA INHUB (fluticasone/salmeterol)	**Non-Preferred Criteria** • 90 consecutive days on the requested agent in the past 105 days **OR** • Have tried 2 different preferred agents in the past 6 months **AirDuo Digihaler** • Requires clinical review
GI ULCER THERAPIES			
	H2 RECEPTOR ANTAGONISTS		
	cimetidine solution famotidine solution	AXID (nizatidine) cimetidine tablets	

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	famotidine tablets nizatidine solution	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	**Prilosec suspension** • Automatic approval for 0 - 2 years
	OTHER		
	misoprostol sucralfate suspension sucralfate tablet	CARAFATE SUSPENSION (sucralfate) CARAFATE TABLET (sucralfate) CYTOTEC (misoprostol) DARTISLA ODT (glycopyrrolate)	
GROWTH HORMONE DUR +			
	NORDITROPIN (somatropin) NUTROPIN AQ (somatropin)	GENOTROPIN (somatropin) HUMATROPE (somatropin) OMNITROPE (somatropin)	**All Agents for Age ≥ 18 years** • Documented diagnosis of craniopharyngioma, panhypopituitarism, Prader-Willi

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		SAIZEN (somatropin) SEROSTIM (somatropin) SKYTROFA (lonapegsomatropin) VOXZOGO (vosoritide) ZOMACTON (somatropin) ZORBTIVE (somatropin)	Syndrome, Turner Syndrome or an approvable adult diagnosis **OR** • Documented procedure of cranial irradiation **All Agents for Age < 18 years** • Documented diagnosis of idiopathic short stature **AND** • Documented approvable pediatric diagnosis **OR** • Documented approvable pediatric diagnosis **Non-Preferred Criteria** • 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)	**Quantity Limit** • 1 treatment course/year
HEPATITIS B TREATMENTS			
	entecavir EPIVIR HBV SOLUTION (lamivudine) lamivudine HBV	adefovir dipivoxil BARACLUDE (entecavir) EPIVIR HBV TABLET (lamivudine)	

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	tenofovir disoproxil fumarate	HEPSERA (adefovir dipivoxil) TYZEKA (telbivudine) VEMLIDY (tenofovir alafenamide fumarate) VIREAD (tenofovir disoproxil fumarate)	
HEPATITIS C TREATMENTS			
	MAVYRET (glecaprevir/pibrentasvir) ∞ MAVYRET PELLETS (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: Epclusa, Harvoni, Mavyret 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)	

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		icatibant KALBITOR VIAL (ecallantide) ORLADEYO (berotralstat hydrochloride) RUCONEST VIAL (C1 esterase inhibitor, recombinant) TAKHZYRO (lanadelumab-flyo)	
HYPERURICEMIA & GOUT DUR +			
	allopurinol colchicine tablet probenecid probenecid/colchicine	colchicine capsule 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 glucagen vial glucagon labeler 00002 ZEGALOGUE (dasiglucagon) Step Edit	glucagon kit (labelers 63323, 00548) GVOKE (glucagon)	**Minimum Age Limit** • **2 years –** Gvoke • **4 years –** Baqsimi • **6 years –** Zegalogue **Quantity Limit** • **2 packs/31 days –** Baqsimi • **2 syringes/31 days –** Gvoke, Zegalogue • **2 kits/31 days –** Glucagon **Non-Preferred Criteria**

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			• Have tried 2 preferred branded glucagon in the past 30 days **Baqsimi** • Have tried 1 different preferred glucagon in the past 365 days **OR** • 1 claim with Baqsimi in the past 365 days **Zegalogue** • Have tried 1 different preferred glucagon in the past 365 days **OR** • 1 claim with Zegalogue in the past 30 days
HYPOGLYCEMICS, BIGUANIDES DUR +			
	metformin HCL tablet metformin HCL ER 24HR tablet (generic GlucophageXR)	FORTAMET ER GLUCOPHAGE (metformin) GLUCOPHAGE XR (metformin ER) GLUMETZA (metformin ER) metformin 24HR (generic Fortamet) metformin 24HR (generic Glumetza) RIOMET SOLUTION* (metformin)	• Clinical review required for 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-durg combination agents count as 3 classes **Riomet Solution**

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			• 90 consecutive days on the requested agent in the past 105 days
HYPOGLYCEMICS, DPP4s and COMBINATON DUR +			
	JANUMET (sitagliptin/metformin) JANUMET XR (sitagliptin/metformin) JANUVIA (sitagliptin) JENTADUETO (linagliptin/metformin) TRADJENTA (linagliptin)	alogliptin alogliptin/metformin alogliptin/pioglitazone JENTADUETO XR (linagliptin/metformin) KAZANO (alogliptin/metformin) KOMBIGLYZE XR (saxagliptin/metformin)* NESINA (alogliptin) ONGLYZA (saxagliptin) * OSENI (alogliptin/pioglitazone)	• Clinical review required with concomitant use of GLP-1 products 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-durg combination agents count as 3 classes **Kombiglyze XR and Onglyza** • 90 consecutive days on the requested agent in the past 105 days
HYPOGLYCEMICS, INCRETIN MIMETICS/ENHANCERS DUR +			
	BYETTA (exenatide) VICTOZA (liraglutide)	ADLYXIN (lixisenatide) BYDUREON (exenatide) BYDUREON BCISE (exenatide) MOUNJARO (tirzepatide)NR OZEMPIC (semaglutide) RYBELSUS (semaglutide) SOLIQUA (insulin glargine/lixisenatide)	• 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 ○ Concurrent therapy with the incoming claim is defined as 20

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		SYMLIN (pramlintide) TRULICITY (dulaglutide) XULTOPHY (insulin degludec/ liraglutide)	or more days' supply of the drug in the past 30 days ○ 2-drug combination agents count as 2 classes and 3-durg combination agents count as 3 classes **Symlin is excluded from all criteria**
HYPOGLYCEMICS, INSULINS AND RELATED AGENTS DUR +			
	HUMULIN N, R, 70/30 VIAL OTC (insulin) HUMULIN R U500 KWIKPEN HUMULIN R U500 VIAL (insulin) HUMALOG MIX 50/50 VIAL HUMALOG MIX 75/25 VIAL insulin aspart insulin aspart flexpen insulin aspart mix insulin aspart mix flexpen Insulin lispro insulin lispro jr kwikpen insulin lispro kwikpen LANTUS SOLOSTAR & VIAL (insulin glargine) LEVEMIR FLEXPEN & VIAL (insulin detemir)	AFREZZA (insulin) ADMELOG (insulin lispro) APIDRA (insulin glulisine) APIDRA SOLOSTAR (insulin glulisine) BASAGLAR (insulin glargine) FIASP (insulin aspart) HUMALOG JR (insulin lispro) 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 insulin glargine LYUMJEV KWIKPEN (insulin lispro) LYUMJEV VIAL (insulin lispro) NOVOLIN N, R, 70/30 FLEXPEN (insulin) OTC NOVOLIN N, R, 70/30 VIAL (insulin) OTC	Insulin pen formulations are not covered for Long Term Care (LTC) beneficiaries. **Non-Preferred Criteria** • Documented diagnosis of Diabetes Mellitus **AND** • Have tried 1 preferred product in the past 6 months **OR** • 1 claim with the requested agent in the past 105 days

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		NOVOLOG FLEXPEN & VIAL (insulin aspart) NOVOLOG MIX FLEXPEN & VIAL (insulin aspart/ aspart protamine) SEMGLEE (insulin glargine) TRESIBA (insulin degludec) TOUJEO (insulin glargine) TOUJEO MAX (insulin glargine)	
HYPOGLYCEMICS, MEGLITINIDES DUR +			
	nateglinide repaglinide	PRANDIMET (repaglinide/metformin) PRANDIN (repaglinide) repaglinide/metformin STARLIX (nateglinide)	• Clinical review required for 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-durg combination agents count as 3 classes
HYPOGLYCEMICS, SODIUM GLUCOSE COTRANSPORTER-2 INHIBITORS DUR +			
	HYPOGLYCEMICS, SODIUM GLUCOSE COTRANSPORTER-2 INHIBITORS		
	FARXIGA (dapagliflozin) INVOKANA (canagliflozin) JARDIANCE (empagliflozin)	STEGLATRO (ertugliflozin)	• Clinical review required for 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

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			○ 2-drug combination agents count as 2 classes and 3-durg combination agents count as 3 classes
	HYPOGLYCEMICS, SODIUM GLUCOSE COTRANSPORTER-2 INHIBITOR COMBINATIONS		
	INVOKAMET (canaglifozin/metformin) SYNJARDY (empagliflozin/metformin)	GLYXAMBI (empagliflozin/linagliptin) INVOKAMET XR (canaglifozin/metformin) QTERN (dapaglifozin/saxagliptin) SEGLUROMET (ertugliflozin/metformin) STEGLUJAN (ertugliflozin/sitagliptin) SYNJARDY XR (empagliflozin/metformin) TRIJARDY XR (empagliflozin/linagliptin/metformin) XIGDUO XR (dapaglifozin/metformin)	
HYPOGLYCEMICS, TZDS			
	THIAZOLIDINEDIONES		
	pioglitazone	ACTOS (pioglitazone) AVANDIA (rosiglitazone)	• Clinical review required for 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-durg combination agents count as 3 classes
	TZD COMBINATIONS		

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	pioglitazone/metformin	ACTOPLUS MET (pioglitazone/metformin) ACTOPLUSMET XR (pioglitazone/metformin) AVANDAMET (rosiglitazone/metformin) AVANDARYL (rosiglitazone/glipizide) DUETACT (pioglitazone/glimepiride) pioglitazone/glimepiride	
IDIOPATHIC PULMONARY FIBROSIS DUR +			
	OFEV (nintedanib)	ESBRIET (pirfenidone) pirfenidone	**All Agents** • Documented diagnosis Idiopathic Pulmonary Fibrosis
IMMUNOSUPPRESSIVE (ORAL) DUR +			
	AZASAN (azathioprine) azathioprine CELLCEPT (mycophenolate) cyclosporine cyclosporine modified GENGRAF (cyclosporine) IMURAN (azathioprine) mycophenolic acid mycophenolate mofetil NEORAL (cyclosporine) RAPAMUNE (sirolimus) SANDIMMUNE (cyclosporine) sirolimus tacrolimus ZORTRESS (everolimus)	ASTAGRAF XL (tacrolimus) ENVARSUS XR (tacrolimus) HECORIA (tacrolimus) MYFORTIC (mycophenolic acid) PROGRAF (tacrolimus) REZUROCK (belumosudil)	**Minimum Age Limit** • **13 years -** Rapamune • **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**

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			• 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
IMMUNE GLOBULINS			
	BIVIGAM CARIMUNE NF FLEBOGAMMA DIF GAMASTAN SD GAMMAGARD GAMMAGARD SD GAMMAKED GAMUNEX-C HIZENTRA HYQVIA	ASCENIV CABLIVI CUTAQUIG CUVITRU GAMMAPLEX OCTAGAM	

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	PANZYGA PRIVIGEN XEMBIFY		
IMMUNOLOGIC THERAPIES FOR ASTHMA			
	DUPIXENT (dupilumab)*	FASENRA PEN AUTOINJECTOR (benralizumab) * NUCALA AUTOINJECTOR (mepolizumab)* NUCALA SYRINGE (mepolizumab)* TEZSPIRE (tezepelumab) XOLAIR SYRINGE (omalizumab)	**Minimum Age Limit** **12 years –** Fasenra pen, Nucala autoinjector, Nucala syringe **Nonpreferred Criteria** • Documented diagnosis of severe persistent asthma **AND** • 90 days therapy with an ICS/LABA combination product in the past 120 days **OR** • 90 days therapy with both an ICS and a LABA or a leukotriene modifier in the past 120 days **AND** • 2 claims for at least 3 days each with an oral corticosteroid in the past 365 days **AND** • 1 claim with an ICS/LABA combination product in the past 30 days **OR** • 1 claim with both an ICS and a LABA or a leukotriene modifier in the past 30 days **AND** • No concurrent therapy with a different asthma immunologic therapy

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			Dupixent – MANUAL PA
INTRANASAL RHINITIS AGENTS			
	ANTICHOLINERGICS		
	ipratropium	ATROVENT (ipratropium)	
	ANTIHISTAMINES		
	azelastine	ASTEPRO (azelastine) olopatadine PATANASE (olopatadine)	
	ANTIHISTAMINE/CORTICOSTEROID COMBINATION DUR +		
		DYMISTA (azelastine/fluticasone) TICALAST (azelastine/fluticasone)	
	CORTICOSTEROIDS DUR +		
	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			

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	deferasirox all strengths (all labelers except those listed as non-preferred) FERRIPROX (deferiprone)	deferasirox (labeler 00093, 16714, 45963, 62332) EXJADE (deferasirox) JADENU (deferasirox) JADENU SPRINKLES (deferasirox)	**Jadenu – MANUAL PA**
IRRITABLE BOWEL SYNDROME/SHORT BOWEL SYNDROME AGENTS/SELECTED GI AGENTS DUR +			
	IRRITABLE BOWEL SYNDROME CONSTIPATION		
	AMITIZA (lubiprostone) LINZESS 145mcg, 290mcg (linaclotide) MOVANTIK (naloxegol)	IBSRELA (tenapanor) LINZESS 72mcg (linaclotide) linaclotide lubiprostone MOTEGRITY (prucalopride) RELISTOR (methylnaltrexone) SYMPROIC (naldemedine) TRULANCE (plecanatide) ZELNORM (tegaserod)	**Minimum Age Limit All Subclasses** • **18 years –** *except Bentyl, Gattex, Levsin* **Gender Limit** • **Female –** Amitiza 8mcg **Chronic Idiopathic Constipation (CIC)** AMITIZA 24MCG, LINZESS 72MCG, LINZESS 145 MCG, MOTEGRITY, TRULANCE **All CIC Agents** • Documented diagnosis of CIC in the past year **AND** • No history of GI or bowel obstruction **Non-Preferred CIC Agents** • Above CIC criteria **AND** • 30 days of therapy with 2 preferred agents in the past 6 months **OR**

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			• 1 claim with the requested agent in the past 105 days **Irritable Bowel Syndrome – Constipation Dominant (IBS-C)** AMITIZA 8MCG, LINZESS 290 MCG, TRULANCE **All IBS-C Agents** • Documented diagnosis of IBS-C in the past year **AND** • No history of GI or bowel obstruction **Non-Preferred IBS-C Agents** • Above IBS-C 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 **Opioid Induced Constipation (OIC)** AMITIZA 24MCG, MOVANTIK, RELISTOR, SYMPROIC **All OIC Agents** • 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**

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			• Documented diagnosis of chronic pain in the past year **Non- Preferred OIC Agents** • 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 **Relistor Injection** • 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		
	dicyclomine hyoscyamine	alosetron BENTYL (dicyclomine) LEVSIN (hyoscyamine) LEVSIN-SL (hyoscyamine) LOTRONEX (alosetron) VIBERZI (eluxadoline)*	**Viberzi** • 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 **Lotronex** • 1 claim for the requested agent in the past 105 days **OR**

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			• **MANUAL PA** - All new patients require manual review **Xifaxan - (see Antibiotics, GI)**
	SHORT BOWEL SYNDROME AND SELECTED GI AGENTS		
		FULYZAQ (crofelemer) GATTEX (teduglutide) MYTESI (crofelemer) NUTRESTORE POWDER PACK (glutamine) XERMELO (telotristat ethyl) ZORBTIVE (somatropin)	**Carcinoid Syndrome Agent** XERMELO • Documented diagnosis of carcinoid syndrome in the past year **AND** • 1 claim for a somatostatin analog in the past 30 days **HIV/AIDS Non-infectious Diarrhea** FULYZAQ, MYTESI • Documented diagnosis of HIV/AIDS in the past year **AND** • Documented diagnosis of non-infectious diarrhea in the past year **AND** • 1 claim for an antiretroviral in the past 30 days **Short Bowel Syndrome (SBS)** GATTEX, NUTRESTORE, ZORBTIVE **Gattex or Zorbtive** • 1 claim for the requested agent in the past 105 days **OR**

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			• All new patients require clinical review **Nutrestore** • Requires clinical review
LEUKOTRIENE MODIFIERS DUR +			
	montelukast granules montelukast tablets zafirlukast	ACCOLATE (zafirlukast) SINGULAIR Tablets (montelukast) SINGULAR GRANULES (montelukast granules) zileuton ZYFLO CR (zileuton)	**Minimum Age Limit** • **12 years –** Zyflo & Zyflo CR **Non-Preferred Criteria** • Have tried 2 different preferred agents in the past 6 months
LIPOTROPICS, OTHER (NON-STATINS) DUR +			
	ACL INHIBITORS AND COMBINATIONS		
		NEXLETOL (bempedoic acid) NEXLIZET (bempedoic acid/ezetimibe)	**Nexletol and Nexlizet** • Requires clinical review
	ANGIOPOIETIN LIKE 3 INHIBITORS		
		EVKEEZA (evinacumab-dgnb)	
	BILE ACID SEQUESTRANTS		
	cholestyramine colestipol	colesevelam COLESTID (colestipol) QUESTRAN (cholestyramine) WELCHOL (colesevelam)	**All Agents, All Sub-Classes both Preferred (exception is Zetia) and Non-Preferred**

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			• 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 ○ 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 **Non-Preferred Criteria** • 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)	**Non-Preferred Criteria** • Have tried 2 different preferred Non-statin Lipotropic agents in the past 6 months
	CHOLESTEROL ABSORPTION INHIBITORS		

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	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
	PCSK-9 INHIBITOR		

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	PRALUENT (alirocumab) REPATHA (evolocumab)	LEQVIO (inclisiran)	**Praluent - MANUAL PA** **Repatha - MANUAL PA**
LIPOTROPICS, STATINS DUR +			
	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** • 12 months of therapy with simvastatin 80mg **AND** • NO myopathy contraindication **Non-Preferred Criteria** • 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** • 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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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	EPINEPHRINE		
	epinephrine autoinject pens (labeler 49502) SYMJEPI (epinephrine)	ADRENACLICK (epinephrine) AUVI-Q (epinephrine) EPINEPHRINE SNAP EMS KIT (epinephrine) EPIPEN (epinephrine) EPIPEN JR (epinephrine)	**Quantity Limit** • **2 kits/31 days**
	MISCELLANEOUS		
	alprazolam CARBAGLU (carglumic acid) hydroxyzine hcl syrup hydroxyzine hcl tablets hydroxyzine pamoate MAKENA (hydroxyprogesterone caproate) megestrol suspension 625mg/5mL REVLIMID (lenalidomide)	alprazolam ER CAMZYOS (mavacamten)^{NR} carglumic acid EVRYSDI (risdiplam) hydroxyprogesterone caproate KORLYM (mifepristone) lenalidomide MEGACE ES (megestrol) VERQUVO (vericiguat) VISTARIL (hydroxyzine pamoate)	**Alprazolam ER CUMULATIVE quantity limit** • **31 tablets/31 days** **Evrysdi** - **MANUAL PA**
	ALLERGEN EXTRACT IMMUNOTHERAPY		
		GRASTEK ORALAIR PALFORZIA RAGWITEK	
	SUBLINGUAL NITROGLYCERIN		
	nitroglycerin lingual 12gm nitroglycerin sublingual NITROLINGUAL PUMPSPRAY (nitroglycerin) 12gm NITROSTAT SUBLINGUAL (nitroglycerin)	nitroglycerin lingual 4.9gm NITROLINGUAL (nitroglycerin) 4.9gm NITROMIST (nitroglycerin)	

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MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

(For All Medicaid, MSCAN and CHIP Beneficiaries)

EFFECTIVE 10/01/2022
Version 2022.2
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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
MOVEMENT DISORDER AGENTS DUR +			
	AUSTEDO (deutetrabenazine) INGREZZA (valbenazine) tetrabenazine (all labelers except those listed as non-preferred)	tetrabenazine (labeler 47335, 51224, 60505, 68180, 686820 XENAZINE (tetrabenazine)	**Austedo** • Documented diagnosis of Huntington's chorea **OR** • Documented diagnosis of tardive dyskinesia **AND** • 90 days therapy with Austedo in the past 105 days **OR** • **MANUAL PA** **Ingrezza** • Documented diagnosis of tardive dyskinesia **AND** • 90 days therapy with Ingrezza in the past 105 days **OR** • **MANUAL PA**
MULTIPLE SCLEROSIS AGENTS DUR +			
	AUBAGIO (teriflunomide) AVONEX (interferon beta-1a) AVONEX PEN (interferon beta-1a) BETASERON (interferon beta-1b) COPAXONE 20mg (glatiramer) dalfampridine dimethyl fumarate GILENYA (fingolimod) REBIF (interferon beta-1a) REBIF REBIDOSE (interferon beta-1a)	AMPYRA (dalfampridine) BAFIERTAM (monomethyl fumarate) COPAXONE 40mg (glatiramer) EXTAVIA (interferon beta-1b) glatiramer GLATOPA (glatiramer) KESIMPTA (ofatumumab) MAVENCLAD (cladribine) MAYZENT (siponimod) OCREVUS (ocrelizumab) PLEGRIDY (interferon beta-1a)	**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, Ponvory and Zeposia** • Requires clinical review

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		PONVORY (ponesimod) TECFIDERA (dimethyl fumarate) VUMERITY (diroximel fumarate) ZEPOSIA (ozanimod)	**Mavenclad – MANUAL PA** **Mayzent – MANUAL PA** **Ocrevus – MANUAL PA**
MUSCULAR DYSTROPHY AGENTS			
		AMONDYS 45 (casimersen) EMFLAZA (deflazacort) EXONDYS 51 (eteplirsen) VILTEPSO (viltolarsen) VYONDYS 53 (golodirsen)	**Emflaza – MANUAL PA** **Exondys – MANUAL PA** **Viltepso –MANUAL PA** **Vyondys – MANUAL PA**
NSAIDS DUR +			
	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	ADVIL (ibuprofen) ANAPROX (naproxen) CAMBIA (diclofenac potassium) CATAFLAM (diclofenac) DAYPRO (oxaprozin) diclofenac potassium etodolac cap etodolac tab SR FELDENE (piroxicam) FENORTHO (fenoprofen) fenoprofen INDOCIN capsules, suspension & suppositories (indomethacin) indomethacin cap ER ketoprofen ER	**Non-Preferred Criteria** • Have tried 2 different preferred non-selective or NSAID/GI protectant combination agents in the past 6 months

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	sulindac	LOFENA(diclofenac potassium) meclofenamate mefenamic acid NALFON (fenoprofen) NAPRELAN (naproxen) NAPROSYN (naproxen) naproxen 275mg and 550mg NUPRIN (ibuprofen) 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)	**Non-Preferred Criteria** • 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 ELYXYB (celecoxib) MOBIC (meloxicam)	**Non-Preferred Criteria – COX II** • Documented diagnosis of Osteoarthritis, Rheumatoid Arthritis,

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		NULOX (meloxicam) QMIIZ ODT (meloxicam) VIVLODEX (meloxicam)	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, 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)	

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		OCUFLOX (ofloxacin) POLYTRIM (polymyxin/trimethoprim) sulfacetamide TOBREX drops (tobramycin) TOBREX ointment (tobramycin) VIGAMOX (moxifloxacin) ZYMAR (gatifloxacin) ZYMAXID (gatifloxacin)	
	ANTIBIOTIC STEROID COMBINATIONS		
	BLEPHAMIDE (sulfacetamide/prednisolone) drops, oint neomycin/bacitracin/polymyxin/hc ointment neomycin/polymyxin/dexamethasone PRED-G (gentamicin/prednisolone) drops, oint sulfacetamide/prednisolone TOBRADEX SUSPENSION/OINTMENT (tobramycin/dexamethasone) ZYLET (loteprednol/tobramycin)	gatifloxacin/prednisolone MAXITROL (neomycin/polymyxin/dexamethasone) neomycin/polymyxin/gramicidin neomycin/polymyxin/hydrocortisone TOBRADEX ST SUSPENSION (tobramycin/dexamethasone) tobramycin/dexamethasone	
OPHTHALMIC ANTI-INFLAMMATORIES DUR +			
	dexamethasone diclofenac difluprednate FLAREX (fluorometholone) fluorometholone flurbiprofen FML FORTE (fluorometholone) FML SOP (fluorometholone) ketorolac	ACULAR (ketorolac) ACULAR LS (ketorolac) ACUVAIL (ketorolac) BROMDAY (bromfenac) bromfenac BROMSITE (bromfenac) DUREZOL (difluprednate) FML (fluorometholone) ILEVRO (nepafenac)	**Non-Preferred Criteria** • Have tried 2 different preferred agents in the past 6 months

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	MAXIDEX (dexamethasone) prednisolone acetate prednisolone NA phosphate PRED MILD (prednisolone) VEXOL (rimexolone)	INVELTYS (loteprednol etabonate) LOTEMAX (loteprednol) LOTEMAX SM (loteprednol) loteprednol etabonate OCUFEN (flurbiprofen) OMNIPRED (prednisolone) NEVANAC (nepafenac) PRED FORTE (prednisolone) PROLENSA (bromfenac) VOLTAREN (diclofenac)	
OPHTHALMICS FOR ALLERGIC CONJUNCTIVITIS DUR +			
	ALREX (loteprednol) azelastine cromolyn olopatadine 0.1% olopatadine 0.2%	ALOCRIL (nedocromil) ALOMIDE (lodoxamide) BEPREVE (bepotastine) epinastine LASTACAFT (alcaftadine) PATADAY (olopatadine) PATANOL (olopatadine) PAZEO (olopatadine) ZERVIATE (cetirizine)	**Non-Preferred Criteria** • Have tried 2 different preferred agents in the past 6 months
OPHTHALMIC, DRY EYE AGENTS			
	RESTASIS droperette (cyclosporine)	CEQUA (cyclosporine 0.09%) EYSUVIS (loteprednol etabonate) RESTASIS Multidose (cyclosporine) TYRVAYA (varaenicline) Nasal XIIDRA (lifitegrast)DUR +	**Minimum Age Limit** • **16 years –** Restasis • **17 years –** Xiidra • **18 years –** Cequa **Quantity Limit**

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			• **5.5 mL/31 days** – Restasis Multidose • **60 units/31 days –** Cequa, Restasis droperette, Xiidra **Non-Preferred Criteria** • History of 4 claims for Restasis in the past 6 months
OPHTHALMIC, GLAUCOMA AGENTS DUR +			
	BETA BLOCKERS		**Non-Preferred Criteria** • Have tried 2 different preferred agents in the past 6 months **OR** • 90 consecutive days on the requested agent in the past 105 days
	BETIMOL (timolol) carteolol ISTALOL (timolol) levobunolol metipranolol timolol drops 0.25%, 0.5%	BETAGAN (levobunolol) betaxolol BETOPTIC S (betaxolol) OPTIPRANOLOL (metipranolol) timolol gel timolol daily drop 0.5% (generic Istalol) TIMOPTIC (timolol) TIMOPTIC XE (timolol)	
	CARBONIC ANHYDRASE INHIBITORS		
	dorzolamide	AZOPT (brinzolamide) TRUSOPT (dorzolamide)	
	COMBINATION AGENTS		
	COMBIGAN (brimonidine/timolol) dorzolamide/timolol SIMBRINZA (brinzolamide/brimonidine)	COSOPT (dorzolamide/timolol) COSOPT PF (dorzolamide/timolol)	
	PARASYMPATHOMIMETICS		

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	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 (latananoprostene bunod) ZIOPTAN (tafluprost)	
	RHO KINASE INHIBITORS/COMBINATIONS		
	RHOPRESSA (netarsudil) ROCKLATAN (netarsudil/latanoprost)		
	SYMPATHOMIMETICS		
	ALPHAGAN P 0.1% (brimonidine) ALPHAGAN P 0.15% (brimonidine) brimonidine 0.2%	brimonidine 0.15% dipivefrin PROPINE (dipivefrin)	
OPIATE DEPENDENCE TREATMENTS			
	DEPENDENCE		
	buprenorphine/naloxone tablets naltrexone tablets SUBOXONE FILM (buprenorphine/naloxone)DUR +	buprenorphine tablets BUNAVAIL (buprenorphine/naloxone) buprenorphine/naloxone films LUCEMYRA (lofexidine) PROBUPHINE (buprenorphine)	**Buprenorphine/Naloxone and buprenorphine** **Non-Preferred Criteria**

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		SUBLOCADE (buprenorphine) VIVITROL (naltrexone) ZUBSOLV (buprenorphine/naloxone)	• Bunavail is preferred over Zubsolv and other generic forms of buprenorphine/naloxone **Bunavail** *NOTE: Bunavail is not indicated for induction therapy* • 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 **Probuphine – MANUAL PA** **Sublocade – MANUAL PA** **Vivitrol - MANUAL PA**
	TREATMENT		
	naloxone injection NARCAN NASAL SPRAY (naloxone) KLOXXADO (naloxone)	EVZIO (naloxone) ZIMHI (naloxone)	
OTIC ANTIBIOTICS			
	CIPRODEX (ciprofloxacin/dexamethasone) CIPRO HC (ciprofloxacin/hydrocortisone) Age Edit CORTISPORIN-TC (colistin/neomycin/ hydrocortisone) neomycin/polymyxin/hydrocortisone ofloxacin	ciprofloxacin ciprofloxacin/dexamethasone ciprofloxacin/fluocinolone DERMOTIC (fluocinolone) FLAC OIL DROP (fluocinolone oil) hydrocortisone/acetic acid drop fluocinolone oil	**Maximum Age Limit** • **9 years -** Cipro HC

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		OTIPRIO (ciprofloxacin) OTOVEL (ciprofloxacin/fluocinolone)	
PANCREATIC ENZYMES DUR +			
	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			
	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 oxyhydronxide)	
PLATELET AGGREGATION INHIBITORS DUR +			

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	BRILINTA (ticagrelor) cilostazol clopidogrel dipyridamole dipyridamole/aspirin pentoxifylline prasugrel	DURLAZA ER (aspirin) EFFIENT (prasugrel) omeprazole/asprin PERSANTINE (dipyridamole) PLAVIX (clopidogrel) PLETAL (cilostazol) ticlopidine YOSPRALA (aspirin/omeprazole) ZONTIVITY (vorapaxar)	**Zontivity – MANUAL PA** **Non-Preferred Criteria** • 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			
	NPLATE (romiplostim) PROMACTA (eltrombopag olamine)	DOPTELET (avatrombopag maleate) MULPLETA (lusutrombopag) PROMACTA powder pack (eltrombopag olamine) TAVALISSE (fostamatinib disodium)	
PRENATAL VITAMINS			
	COMPLETE NATAL DHA COMPLETENATE CHEW Tablet M-NATAL PLUS Tablet NESTABS DHA COMBO PKG PNV 29-1 Tablet PNV 95/Fe/FA Tablet (labeler 00536) PNV 137/Fe/FA Tablet (labeler 009040 PNV-DHA Softgel Capsule PRENATAL VITAMIN PLUS LOW IRON Tablet PREPLUS Ca/Fe27/FA 1 Tablet PRETAB Tablet SE-NATAL19 CHEW Tablet SE-NATAL19 Tablet THRIVITE RX Tablet	Products not listed are assumed to be Non-Preferred.	

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	TRINATAL Rx 1 Tablet VIRT-NATE DHA Softgel Capsule VP-PNV-DHA Softgel Capsule WESTAB PLUS Tablet		
PSEUDOBULBAR AFFECT AGENTS			
		NUEDEXTA (dextromethorphan/quinidine)	**Non-Preferred Criteria** • 90 consecutive days on the requested agent in the past 105 days **OR** • Documented diagnosis of Pseudobulbar Affect
PULMONARY ANTIHYPERTENSIVES DUR +			
	ENDOTHELIN RECEPTOR ANTAGONIST		
	ambrisentan (all labelers except those listed as non-preferred) bosentan tablets	ambrisentan (labeler 42794, 47335, 498840) LETAIRIS (ambrisentan)* OPSUMIT (macitentan) TRACLEER (bosentan)	**All PAH Agents** • Documented diagnosis of pulmonary hypertension **Non-Preferred Criteria** • 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		
	sildenafil (generic Revatio) tablet tadalafil	ADCIRCA (tadalafil) REVATIO (sildenafil) tablet REVATIO (sildenafil) suspension sildenafil (generic Revatio) suspension	**Non-Preferred Criteria** • Have tried 1 preferred PAH agent in the past 6 months **OR**

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			• 90 consecutive days on the requested agent in the past 105 days **Revatio suspension** • < 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 **Revatio tablets** • **< 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

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	PROSTACYCLINS		
		ORENITRAM ER (treprostinil) TYVASO (treprostinil) VENTAVIS (iloprost)	**Non-Preferred Criteria** • 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		
		UPTRAVI (selexipag)	**Non-Preferred Criteria** • 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		
		ADEMPAS (riociguat)	**Adempas** • 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			
	metronidazole (cream, gel, lotion)	AVAR (sulfacetamide sodium/sulfur) FINACEA (azelaic acid) METROCREAM (metronidazole cream) METROGEL (metronidazole gel) METROLOTION (metronidazole lotion)	Topical Sulfonamides used for Rosacea will require a manual PA for ≥21 years. Other labeled indications are limited to <21 years.

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		MIRVASO (brimonidine) NORITATE (metronidazole) OVACE (sulfacetamide sodium) RHOFADE (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 SmartPA		
	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** • Concomitant use of Opioids and Benzodiazepines Criteria details found here **Quantity Limit – CUMULATIVE** Quantity limit per rolling days for all strengths. *DUR +will allow an early refill override for one dose or therapy change per year.*

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			• **31 units/31 days -** all strengths **Triazolam – CUMULATIVE** Quantity limit per rolling days for all strengths • **10 units/31 days** • **60 units/365 days**
	OTHERS DUR +		
	zaleplon zolpidem	AMBIEN (zolpidem) AMBIEN CR (zolpidem) BELSOMRA (sovorexant) doxepin EDLUAR (zolpidem) eszopiclone HETLIOZ (tasimelteon) INTERMEZZO (zolpidem) LUNESTA (eszopiclone) ramelteon ROZEREM (ramelteon) QUVIVIQ (daridorexant) SILENOR (doxepin) SONATA (zaleplon) zolpidem ER zolpidem SL ZOLPIMIST (zolpidem)	**Quantity Limit – CUMULATIVE** Quantity limit per rolling days for all strengths. *DUR +will allow an early refill override for one dose or therapy change per year.* • **31 units/31 days** • **1 canister/31 days** – Zolpimist & male • **1 canister/62 days –** Zolpimist & female • **1 bottle/31 days (48 ml or 158 ml) –** Hetlioz liquid **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 capsules**

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			• Documented diagnosis of circadian rhythm sleep disorder **AND** • Documented diagnosis indicating total blindness of the patient **OR** • Documented diagnosis of Magenis-Smith syndrome **Hetlioz liquid** • Documented diagnosis of Smith-Magenis syndrome **AND** • 3 - 15 years of age
SELECT CONTRACEPTIVE PRODUCTS			
	INJECTABLE CONTRACEPTIVES		
	medroxyprogesterone acetate IM	DEPO-PROVERA IM (medroxyprogesterone acetate) DEPO-SUBQ PROVERA 104 (medroxyprogesterone acetate)	**Non-Preferred Criteria** • 1 claim with the requested agent in the past 105 days
	INTRAVAGINAL CONTRACEPTIVES		
	ANNOVERA (segesterone/ethinyl estradiol) etonogestrel/ethinyl estradiol NUVARING (etonogestrel/ethinyl estradiol)	PHEXXI (lactic acid, citric acid, potassium bitartrate)	
	ORAL CONTRACEPTIVES SmartPA		
	ALL CONTRACEPTIVES ARE PREFERRED EXCEPT FOR THOSE SPECIFICALLY INDICATED AS NON-PREFERRED	AMETHIA (levonorgestrel/ethinyl estradiol) AMETHYST (levonorgestrel/ethinyl estradiol) BALCOLTRA (levonorgestrel/ethinyl estradiol/iron) BEYAZ (ethinyl estradiol / drospirenone/levomefolate)	

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		CAMRESE (levonorgestrel/ethinyl estradiol) CAMRESE LO (levonorgestrel/ethinyl estradiol) GENERESS FE (norethindrone/ethinyl estradiol/fe) GIANVI (ethinyl estradiol/drospirenone) JOLESSA (levonorgestrel/ethinyl estradiol) levonorgestrel/ethinyl estradiol LO LOESTRIN FE (norethindrone/ethinyl estradiol) LOESTRIN (norethindrone acetate/ethinyl estradiol) LOESTRIN FE (norethindrone/ethinyl estradiol/iron) MINASTRIN 24 FE (norethindrone/ethinyl estradiol/iron) NATAZIA (estradiol valerate/dienogest) NEXTSTELLIS (drospirenone/estetrol) OCELLA (ethinyl estradiol/drospirenone) SAFYRAL (ethinyl estradiol/ drospirenone/levomefolate) SIMPESSE (levonorgestrel/ethinyl estradiol) TAYTULLA (norethindrone/ethinyl estradiol/iron) TYDEMY (ethinyl estradiol/drospirenone/ levomefolate calcium) YASMIN (ethinyl estradiol/drospirenone) YAZ (ethinyl estradiol/drospirenone)	
	TRANSDERMAL CONTRACEPTIVES		

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	XULANE (norelgestromin and ethinyl estradiol)	ZAFEMY (norelgestromin and ethinyl estradiol) TWIRLA (levonorgestrel and ethinyl estradiol)	
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 DUR +			
	baclofen chlorzoxazone cyclobenzaprine 5mg, 10mg methocarbamol tizanidine tablets	AMRIX (cyclobenzaprine ER) carisoprodol carisoprodol compound cyclobenzaprine 7.5mg, 15mg cyclobenzaprine ER DANTRIUM (dantrolene) dantrolene FLEQSUVY (baclofen) FEXMID (cyclobenzaprine) FLEXERIL (cyclobenzaprine) LORZONE (chlorzoxazone) metaxalone NORGESIC FORTE (orphenedrine) orphenadrine orphenadrine compound orphenadrine ER PARAFON FORTE DSC (chlorzoxazone) ROBAXIN (methocarbamol) SKELAXIN (metaxalone)	**Non-Preferred Agents** • Documented diagnosis for an approvable indication **AND** • Have tried 2 different preferred agents in the past 6 months **Carisoprodol** • 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** ○ **18 tablets** - to allow tapering off ○ **84 tablets/6 months** **Carisoprodol with codeine**

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		SOMA (carisoprodol) tizanidine capsules ZANAFLEX (tizanidine)	• 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) varenicline	ZYBAN (bupropion)	**Minimum Age Limit - Chantix** • **18 years** **Quantity Limit** • **336 tablets/year –** Chantix 0.5mg, 1mg tablets and continuing pack • **2 treatment courses/year** – Chantix Starter Pack
STEROIDS (Topical) DUR +			
	LOW POTENCY		
	CAPEX (fluocinolone) desonide hydrocortisone cr, oint, soln.	alclometasone DERMA-SMOOTHE-FS (fluocinolone) DESONATE (desonide) DESOWEN (desonide) fluocinolone oil	**Non-Preferred Criteria** • Have tried 2 different preferred low potency agents in the past 6 months

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		hydrocortisone lotion PEDIACARE HC (hydrocortisone) PEDIADERM (hydrocortisone) VERDESO (desonide)	
	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** • 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. fluocinolone triamcinolone	amcinonide oint betameth diprop/prop gly cr, lot, oint betamethasone dipropionate oint. BETA-VAL (betamethasone valerate) desoximetasone diflorasone DIPROLENE AF (betamethasone diprop/prop gly) ELOCON (mometasone) fluocinonide HALOG (halcinonide) KENALOG (triamcinolone)	**Non-Preferred Criteria** • Have tried 2 different preferred high potency agents in the past 6 months

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		PEDIADERM TA (triamcinolone) SERNIVO (betamethasone dipropionate) TOPICORT (desoximetasone) TRIANEX (triamcinolone) VANOS (fluocinonide)	
	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 IMPEKLO (clobetasol) LEXETTE (halobetasol propionate) OLUX (clobetasol) OLUX-E (clobetasol) TEMOVATE Cream (clobetasol propionate) TEMOVATE Ointment (clobetasol propionate) TOVET Foam (clobetasol) ULTRAVATE Lotion (halobetasol)	**Non-Preferred Criteria** • Have tried 2 different preferred very high potency agents in the past 6 months
STIMULANTS AND RELATED AGENTS DUR +			
	SHORT-ACTING		
	amphetamine salt combination dexmethylphenidate IR dextroamphetamine IR	ADDERALL (amphetamine salt combination) amphetamine sulfate (generic EVEKO) DESOXYN (methamphetamine) dextroamphetamine solution	**Minimum Age Limit** • **3 years -** Adderall, Evekeo, Procentra, Zenzedi

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	methylphenidate IR methylphenidate solution PROCENTRA (dextroamphetamine)	EVEKEO (amphetamine) EVEKEO ODT (amphetamine) FOCALIN (dexmethylphenidate) methamphetamine METHYLIN solution (methylphenidate) methylphenidate chewable RITALIN (methylphenidate) ZENZEDI (dextroamphetamine)	• **6 years –** Desoxyn, Evekeo ODT, Focalin, Methylin **Maximum Age Limit** • **18 years –** Evekeo ODT **Quantity Limit** Applicable quantity limit per rolling days • **62 tablets/31 days –** Adderall, Desoxyn, Evekeo, Focalin, Methylin, Zenzedi • **310 mL/31 days –** Methylin solution, Procentra **Documented diagnosis of ADHD –** ALL Short Acting AGENTS **Non-Preferred Criteria ADD/ADHD** • Documented diagnosis of ADD/ADHD **AND** • Have tried 2 different preferred Short Acting agents in the past 6 months **OR** • 1 claim for a 30-day supply with the requested agent in the past 105 days **Documented diagnosis of narcolepsy –** ADDERALL, EVEKEO,

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			METHYLIN, PROCENTRA, RITALIN, ZENZEDI
	LONG-ACTING		
	amphetamine salt combination ER dexmethylphenidate ER dextroamphetamine ER DYANAVEL XR Suspension (amphetamine) methylphenidate CD (generic Metadate CD) methylphenidate ER (generic Concerta) methylphenidate ER Tabs (generic Ritalin SR) methylphenidate ER/LA Caps (generic Ritalin LA) QUILLICHEW (methylphenidate) QUILLIVANT XR (methylphenidate)	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) AZSTARYS (serdexmethylphen/dexmethylphen) CONCERTA (methylphenidate) COTEMPLA XR-ODT (methylphenidate) DAYTRANA (methylphenidate) DEXEDRINE (dextroamphetamine) DYANAVEL XR Tablet (amphetamine) FOCALIN XR (dexmethylphenidate) JORNAY PM (methylphenidate) methylphenidate ER caps (generic Aptensio XR) methylphenidate ER (generic Relexxi) MYDAYIS (amphetamine salt combination) RELEXXI (methylphenidate) RITALIN LA (methylphenidate) RITALIN SR (methylphenidate) VYVANSE (lisdexamfetamine)* VYVANSE CHEWABLE (lisdexamfetamine)*	**Minimum Age Limit** • **6 years –** Adderall XR, Adhansia XR, Adzenys ER Suspension, Adzenys XR ODT, Aptensio XR, Azstarys, Concerta, Cotempla XR ODT, Daytrana, Dexedrine, Dyanavel 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 **Maximum Age Limit** • **18 years –** Cotempla XR ODT, Daytrana **Quantity Limit** **Applicable quantity limit per rolling days** • **31 tablets/31 days –** Adderall XR, Adhansia XR, Adzenys XR ODT, Aptensio XR, Azstarys, Concerta 18, 27, & 54 mg, Cotempla XR-ODT 8.6 mg, Daytrana, Dexedrine Spansule, Focalin XR, Jornay PM,

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			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 –** Dyanavel XR • **372 mL/31 days –** Quillivant XR **Documented diagnosis of ADHD –** ALL Long-Acting AGENTS **Non-Preferred Criteria ADD/ADHD** • 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
	NARCOLEPSY		
	armodafinil modafinil SUNOSI (solriamfetol)	NUVIGIL (armodafinil) PROVIGIL (modafinil) WAKIX (pitolisant) XYREM (sodium oxybate)	**Documented diagnosis of narcolepsy –** ADDERALL XR, APTENSIO XR, CONCERTA ER, DEXEDRINE, METADATE CD, METHYLIN ER, MYDAYIS, NUVIGIL,

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		XYWAV (calcium, magnesium, potassium and sodium oxybates)	PROVIGIL, QUILLICHEW, QUILLIVANT XR, RITALIN LA, SUNOSI **Non-Preferred Criteria narcolepsy** • 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 **Nuvigil** • Documented diagnosis of narcolepsy, obstructive sleep apnea, shift work sleep disorder or bipolar depression **Provigil** • Documented diagnosis of narcolepsy, obstructive sleep apnea, shift work sleep disorder, depression, sleep deprivation or Steinert Myotonic Dystrophy Syndrome

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			Sunosi • Documented diagnosis of narcolepsy or obstructive sleep apnea **AND** • 30 days of therapy with preferred modafinil or armodafinil in the past 6 months **Wakix** • Documented diagnosis of narcolepsy with or 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 **Xyrem and Xywav** • Requires clinical review
	NON-STIMULANTS		
	atomoxetine clonidine ER guanfacine ER Step Edit	INTUNIV (guanfacine ER) QELBREE (viloxazine) STRATTERA (atomoxetine)	**Minimum Age Limit** **6 years –** Intuniv, Kapvay, Qelbree, Strattera **18 years –** Wakix **Maximum Age Limit** • **18 years –** Intuniv, Kapvay, Qelbree

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			• **21 years –** diagnosis of ADD/ADHD is required for Strattera **Quantity Limit** Applicable quantity limit per rolling days • **31 tablets/31 days –** Intuniv, Qelbree 100 mg, Strattera • **62 tablets/31days –** Qelbree 150 mg and 200 mg, Wakix • **124 tablets/31 days – Kapvay** **Intuniv** • 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 **Kapvay** • Documented diagnosis of 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 **Qelbree**

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			• Documented diagnosis of ADD or ADHD **AND** • 1 claim for a 30-day supply with atomoxetine in the past 105 days
TETRACYCLINES DUR +			
	doxycycline hyclate caps/tabs doxycycline monohydrate caps (50mg & 100mg) minocycline caps IR tetracycline	ACTICLATE (doxycyline) ADOXA (doxycycline monohydrate) demeclocycline doxycycline hyclate (generic Doryx) doxycycline monohydrate caps (75mg & 150mg) 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)	**Non-Preferred Agents** • Have tried 2 different preferred agents in the past 6 months **Demeclocycline** • Documented diagnosis of Diabetes Insipidus or SIADH will allow automatic approval
ULCERATIVE COLITIS and CROHN'S AGENTS DUR +**See Cytokine & CAM Antagonists Class for additional agents**			
	ORAL		

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.

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	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) PENTASA 250mg (mesalamine) PENTASA 500mg (mesalamine) UCERIS (budesonide)	**Non-Preferred Criteria** • Documented diagnosis for Ulcerative Colitis **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 **Ortikos ER** • Requires clinical review
	RECTAL		
	mesalamine suppository	CANASA (mesalamine) ROWASA (mesalamine) SF-ROWASA (mesalamine) UCERIS Foam (budesonide)	

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.

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