MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

(For All Medicaid, MSCAN and CHIP Beneficiaries)

EFFECTIVE 10/01/2023
Version 2023
Updated:09/29/2023

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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) EPSOLAY (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	ADLARITY (donepezil) 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	ABSTRAL (fentanyl) ACTIQ (fentanyl) APADAZ (benzhydrocodone/APAP) butalbital/APAP/caffeine/codeine	**MS DOM Opioid Initiative** • Short-Acting Opioids • Long-Acting Opioids • Morphine Equivalent Daily Dose

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	ENDOCET (oxycodone/APAP) hydrocodone/APAP hydromorphone morphine oxycodone capsules oxycodone liquid oxycodone tablets oxycodone/APAP oxycodone/aspirin oxycodone/ibuprofen pentazocine/APAP tramadol tramadol/APAP	butalbital/ASA/caffeine/codeine butorphanol tartrate (nasal) DEMEROL (meperidine) DILAUDID (hydromorphone) DVORAH (dihydrocodeine/ APAP/caffeine) fentanyl FENTORA (fentanyl) FIORICET W/ CODEINE (butalbital/APAP/caffeine/codeine) FIORINAL W/ CODEINE (butalbital/ASA/caffeine/codeine) 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)	• 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** – butalbital/codeine combinations, codeine, dihydrocodeine combinations, fentanyl, hydromorphone, levorphanol, meperidine, morphine, oxycodone, oxycodone/ibuprofen, oxymorphone, pentazocine, tapentadol, tramadol • **62 tablets CUMULATIVE** – hydrocodone combinations, oxycodone combinations • **186 tablets** –butalbital/APAP 300, 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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		PERCODAN (oxycodone/ASA) 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)	**MS DOM Opioid Initiative** • Short-Acting Opioids • Long-Acting Opioids • Morphine Equivalent Daily Dose • Concomitant use of Opioids and Benzodiazepines Criteria details found here

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		EXALGO (hydromorphone) hydromorphone ER HYSINGLA ER (hydrocodone) KADIAN (morphine) methadone MORPHABOND (morphine) morphine ER capsules MS CONTIN (morphine) NUCYNTA ER (tapentadol) OPANA ER (oxymorphone) oxycodone ER OXYCONTIN (oxycodone) oxymorphone ER RYZOLT (tramadol) tramadol ER ULTRAM ER (tramadol) XARTEMIS XR (oxycodone/APAP) XTAMPZA (oxycodone myristate) ZOHYDRO ER (hydrocodone bitartrate)	**Minimum Age Limit** • **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

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ANALGESICS/ANESTHETICS (Topical)			
	diclofenac sodium 1% gel diclofenac sodium 1.5% solution lidocaine 4% cream OTC lidocaine 5% ointment lidocaine 5% patch	capsaicin diclofenac epolamine patch DUR+ diclofenan sodium 3% gel FLECTOR Patch (diclofenac epolamine) DUR+ FROTEK (ketoprofen) LICART (diclofenac epolamine) LIDAMANTLE HC (lidocaine/hydrocortisone) LIDO TRANS PAK (lidocaine) 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) VOLTAREN Gel (diclofenac sodium) DUR+ XRYLIDERM (lidocaine) xylocaine ZOSTRIX (capsaicin) ZTlido (lidocaine)	**Non-Preferred Criteria** • Have tried 1 preferred agent in the past 6 months **Lidocaine 5% Patch** • 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)	**All Agents** • Limited to male gender **Non-Preferred Criteria** • Have tried 2 different preferred agents in the past 6 months

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		STRIANT (testosterone) TESTIM (testosterone gel) testosterone pump TLANDO (testosterone) VOGELXO (testosterone) XYOSTED (testosterone enanthate)	**Tlando** • Requires clinical review
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	ACCURETIC (quinapril/HCTZ) CAPOZIDE (captopril/HCTZ) LOTENSIN HCT (benazepril/HCTZ) LOTREL (benazepril/amlodipine) moexipril/HCTZ PRESTALIA (perindopril/amlodipine)	**Non-Preferred Criteria** **ACE Inhibitor/CCB** • Have tried 2 different preferred *ACEI/CCB* agents in the past 6 months **OR**

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	quinapril/HCTZ trandolapril/verapamil	PRINZIDE (lisinopril/HCTZ) TARKA (trandolapril/verapamil) UNIRETIC (moexipril/HCTZ) VASERETIC (enalapril/HCTZ) ZESTORETIC (lisinopril/HCTZ)	• 90 consecutive days on the requested agent in the past 105 days **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	ATACAND-HCT (candesartan/HCTZ) AVALIDE (irbesartan/HCTZ) AZOR (olmesartan/amlodipine) BENICAR-HCT (olmesartan/HCTZ) BYVALSON (nebivolol/valsartan) candesartan/HCTZ	**Entresto** • Age ≥ 18 years **AND** • Documented diagnosis of heart failure **OR** • Age ≥ 1 year **AND**

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	valsartan/amlodipine valsartan/amlodipine/HCTZ valsartan/HCTZ	DIOVAN-HCT (valsartan/HCTZ) EDARBYCLOR (azilsartan/chlorthalidone) EXFORGE (valsartan/amlodipine) EXFORGE HCT (valsartan/amlodipine/HCTZ) HYZAAR (losartan/HCTZ) MICARDIS-HCT (telmisartan/HCTZ) olmesartan/amlodipine/HCTZ telmisartan/amlodipine TEVETEN-HCT (eprosartan/HCTZ) TRIBENZOR (olmesartan/amlodipine/HCTZ) TWYNSTA (telmisartan/amlodipine)	• Documented diagnosis of heart failure with systemic ventricular systolic dysfunction **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**

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			• 90 consecutive days on the requested agent in the past 105 days
	DIRECT RENIN INHIBITOR COMBINATIONS		
		AMTURNIDE (aliskiren/amlodipine/hctz) TEKAMLO (aliskiren/amlodipine) TEKTURNA-HCT (aliskiren/hctz) VALTURNA (aliskiren/valsartan)	**Non-Preferred Criteria** • 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) & RELATED AGENTS			
	FIRVANQ (vancomycin) metronidazole neomycin tinidazole	AEMCOLO (rifaximin) DIFICID (fidaxomicin) FLAGYL (metronidazole) FLAGYL ER (metronidazole) paromomycin REBYOTA (fecal microbiota) TINDAMAX (tinidazole) VANCOCIN (vancomycin) vancomycin VOWST (fecal microbiota) XIFAXAN (rifaximin)	
ANTIBIOTICS (MISCELLANEOUS)			
	KETOLIDES		
		KETEK (telithromycin)	

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	LINCOSAMIDE ANTIBIOTICS		
	clindamycin capsules clindamycin solution	CLEOCIN (clindamycin) CLEOCIN SOLUTION (clindamycin)	
	MACROLIDES		
	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**

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			Quantity Limit • **6 tablets/month** – Sivextro
	PLEUROMUTLINS		
		XENLETA (lefamulin	
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) XACIATO GEL (clindamycin)	
ANTICOAGULANTS			
	ORAL		
	COUMADIN (warfarin) ELIQUIS (apixaban)	BEVYXXA (betrixaban) PRADAXA PELLETS (dabigatran)	**Non-Preferred Criteria** • Have tried 2 different preferred agents in the past 6 months **OR**

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	PRADAXA (dabigatran) warfarin XARELTO (rivaroxaban)	SAVAYSA (edoxaban tosylate)	• 1 claim with the requested agent in the past 90 days
	LOW MOLECULAR WEIGHT HEPARIN (LMWH)		
	enoxaparin	ARIXTRA (fondaparinux) fondaparinux FRAGMIN (dalteparin) LOVENOX (enoxaparin) Prefilled Syringe	**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+			
	ADJUVANTS		
	carbamazepine carbamazepine suspension carbamazepine ER (generic Carbatrol) DEPAKOTE ER (divalproex) DEPAKOTE SPRINKLE (divalproex) divalproex divalproex ER divalproex sprinkle EPIDIOLEX (cannabidiol) EPITOL (carbamazepine) gabapentin lacosamide lamotrigine levetiracetam levetiracetam ER oxcarbazepine	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) GABITRIL (tiagabine)	**Minimum Age Limit** • 6 months-- Diacomit • 1 year – Banzel, Epidiolex • 2 years –Onfi, Sympazan **Epidiolex** • Documented diagnosis of Dravet syndrome. Lennox Gastaut syndrome or seizures associated with tuberous sclerosis complex **OR** • 1 claim for the requested agent in the past 30 days **Non-Preferred Criteria** • Have tried 2 different preferred agents in the past 6 months **OR**

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	oxcarbazepine suspension tiagabine topiramate tablet topiramate sprinkle capsule valproic acid zonisamide	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) SPRITAM (levetiracetam) STAVZOR (valproic acid) TEGRETOL (carbamazepine) TEGRETOL SUSPENSION (carbamazepine) TEGRETOL XR (carbamazepine) 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) ZONISADE (zonisamide supsension) ZTALMY (ganaxolone)	• 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 **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**

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			• 90 consecutive days on the requested agent in the past 105 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 **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
	SELECTED BENZODIAZEPINES		
	clobazam diazepam rectal gel NAYZILAM (midazolam) VALTOCO (diazepam)	DIASTAT (diazepam rectal) DIASTAT ACCUDIAL (diazepam rectal) ONFI (clobazam) ONFI SUSPENSION (clobazam) SYMPAZAN (clobazam)	
	HYDANTOINS		
	DILANTIN (phenytoin) PHENYTEK (phenytoin) phenytoin	PEGANONE (ethotoin)	
	SUCCINIMIDES		
	ethosuximide	CELONTIN (methsuximide) ZARONTIN (ethosuximide)	

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ANTIDEPRESSANTS, OTHER DUR+			
	bupropion bupropion SR bupropion XL TRINTELLIX (vortioxetine) mirtazapine trazodone venlafaxine venlafaxine ER capsules VIIBRYD (vilazodone)	APLENZIN (bupropion HBr) AUVELITY (dextromethorphan/bupropion) desvenlafaxine ER desvenlafaxine fumarate ER DESYREL (trazodone) DRIZALMA SPRINKLE (duloxetine DR) EFFEXOR (venlafaxine) EFFEXOR XR (venlafaxine) EMSAM (selegiline transdermal) FETZIMA ER (levomilnacipran) FORFIVO XL (bupropion) KHEDEZLA ER (desvenlafaxine) MARPLAN (isocarboxazid) NARDIL (phenelzine) nefazodone OLEPTRO ER (trazodone) PARNATE (tranylcypromine) phenelzine PRISTIQ (desvenlafaxine) REMERON (mirtazapine) tranylcypromine venlafaxine XR venlafaxine ER tablets vilazodone WELLBUTRIN (bupropion) WELLBUTRIN SR (bupropion) WELLBUTRIN XL (bupropion HCl)	**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 *Dur + will automatically be issued for this age range with a diagnosis of 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 **Auvelity** • Requires clinical review **Cymbalta and Irenka (see Fibromyalgia Agents)**

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MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

(For All Medicaid, MSCAN and CHIP Beneficiaries)

EFFECTIVE 10/01/2023
Version 2023
Updated:09/29/2023

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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) PEXEVA (paroxetine) PROZAC (fluoxetine) SARAFEM (fluoxetine) ZOLOFT (sertraline)	**Minimum Age Limit** • **6 years** - Zoloft • **7 years** – Lexapro, Prozac • **8 years** - Luvox • **18 years** – Celexa, Luvox CR, Paxil, Pexeva, Prozac 90 mg **Maximum Age Limit** • **60 years** – Celexa **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

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			Injectables in this class closed to point of sale. PA required if not administered in clinic/hospital
	ANTIEMETIC COMBINATIONS		
		AKYNZEO (netupitant/palonosetron) BONJESTA (doxylamine/pyridoxine) DICLEGIS (doxylamine/pyridoxine) doxylamine/pyridoxine	**Akynzeo -** MANUAL PA
	CANNABINOIDS		
		CESAMET (nabilone) MARINOL (dronabinol) dronabinol SYNDROS (dronabinol)	
	NMDA RECEPTOR ANTAGONIST		
	aprepitant	EMEND (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	**Minimum Age Limit** • **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**

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		LAMISIL (terbinafine) NOXAFIL (posaconazole) ^ ONMEL (itraconazole) ^ posaconazole^ SPORANOX (itraconazole) ^ TERBINEX Kit (terbinafine/ciclopirox) TOLSURA (itraconazole) VFEND (voriconazole) ^ VIVJOA (oteseconazole) voriconazole ^	• Documented diagnosis of HIV **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	BENSAL HP (benzoic acid/salicylic acid) butenafine CICLODAN KIT (ciclopirox kit) ciclopirox kit/shampoo CNL 8 (ciclopirox) econazole ERTACZO (sertaconazole)	**Non-Preferred Criteria** • Have tried 2 different preferred agents in the past 6 months

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	tolnaftate cream/powder/spray[OTC]	EXELDERM (sulconazole) 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]	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
	TERAZOL 3 Cream (terconazole) – currently unavailable from manufacturer terconazole cream tioconazole		
ANTIHISTAMINES, MINIMALLY SEDATING AND COMBINATIONS DUR+			
	MINIMALLY SEDATING ANTIHISTAMINES		**Non-Preferred Criteria** • Documented diagnosis of allergy or urticaria **AND** • Have tried 2 different preferred agents in the past 12 months
	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)	
	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			

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	CGRP ORAL AND NASAL		
	NURTEC ODT (rimegepant)	UBRELVY (ubrogepant) ZAVZPRET (zavegepant)	**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	almotriptan AMERGE (naratriptan)	**Minimum Age Limit – ALL FORMULATIONS**

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	rizatriptan ODT sumatriptan tablets zolmitriptan zolmitriptan ODT	AXERT (almotriptan) eletriptan FROVA (frovatriptan) frovatriptan IMITREX (sumatriptan) MAXALT (rizatriptan) MAXALT MLT (rizatriptan) RELPAX (eletriptan) REYVOW (lasmiditan) TREXIMET (sumatriptan/naproxen) ZOMIG (zolmitriptan)	• **6 years –** Maxalt • **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

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MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

(For All Medicaid, MSCAN and CHIP Beneficiaries)

EFFECTIVE 10/01/2023
Version 2023
Updated:09/29/2023

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	NASAL		
	sumatriptan	IMITREX (sumatriptan) ONZETRA Xsail (sumatriptan) TOSYMRA (sumatriptan) zolmitriptan 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 a preferred nasal agent 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**			
	BOSULIF (bosutinib) CAPRELSA (vandetanib) COMETRIQ (cabozantinib) COTELLIC (cobimetinib) GILOTRIF (afatanib) everolimus	AFINITOR (everolimus) ALECENSA (alectinib) ALUNBRIG (brigatnib) AYVAKIT (avapritinib) BALVERSA (erdafitinib) BRAFTOVI (encorafenib)	**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)	BRUKINSA (zanubrutinib) CABOMETYX (cabozantinib s-malate) CALQUENCE (acalabrutinib) COPIKTRA (duvelisib) DAURISMO (glasdegib) ERIVEDGE (vismodegib) ERLEADA (apalutamide) erlotinib EXKIVITY (mobocertinib) FARYDAK (panobinostat) FOTIVDA (tivozanib) GAVRETO (pralsetinib) gefitinib GLEEVEC (imatinib mesylate) GLEOSTINE (lomustine) IBRANCE (palbociclib) DUR+ IDHIFA (enasidenib) INQOVI (cedazuridine/decitabine) INREBIC (fedratinib) JAYPIRCA (pirtobrutinib) KRAZATI (adagrasib) KISQALI (ribociclib) KOSELUGO (selumetinib) lapatinib ditosylate LENVIMA (lenvatinib)DUR+ LORBRENA (lorlatinib) LUMAKRAS (sotorasib) LYNPARZA (olaparib) DUR+ LYTGOBI (futibatinib) MEKTOVI (binimetnib) NERLYNX (neratinib maleate) NUBEQA (darolutamide)	• 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 Tablets**

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		ODOMZO (sonidegib) ONUREG (azacitidine) ORGOVYX (relugolix) PEMAZYRE (pemigatinib) PIQRAY (alpelisib) QINLOCK (ripretinib) REZLIDHIA (lutasidenib) 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) VONJO (pacritinib) 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
ANTIOBESITY SELECT AGENTS			

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	CONTRAVE (naltrexone/bupropion) SAXENDA (liraglutide) WEGOVY (semaglutide)	orlistat XENICAL (orlistat)	All agents require MANUAL PA
ANTIPARASITICS (Topical) DUR+			
	PEDICULICIDES		
	permethrin 1%OTC NATROBA (spinosad)	lindane malathion OVIDE (malathion) SKLICE (ivermectin) spinosad VANALICE (piperonyl butoxide/pyrethrins)	**Minimum Age/Weight Limit for Pediculicides** • **50 kg -** lindane shampoo • **2 months –** permethrin 1%(OTC) • **6 months** – Natroba, Sklice • **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

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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		
	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		

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	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 (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)	**Lodosyn and Inbrija** • Documented diagnosis of Parkinson's disease **AND** • 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 asenapine	ABILIFY (aripiprazole) ABILIFY MYCITE (aripiprazole) ADASUVE (loxapine)	**Minimum Age Limit** • **2 years –** Droperidol • **3 years –** Haldol

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	clozapine fluphenazine haloperidol olanzapine olanzapine ODT perphenazine quetiapine quetiapine XR risperidone risperidone ODT thioridazine thiothixene trifluoperazine ziprasidone	aripiprazole solution aripiprazole ODT CAPLYTA (lumateperone) chlorpromazine clozapine ODT CLOZARIL (clozapine) FANAPT (iloperidone) FAZACLO (clozapine) GEODON (ziprasidone) HALDOL (haloperidol) INVEGA ER (paliperidone) LATUDA (lurasidone) lurasidone LYBALVI (olanzapine/samidorphan) NUPLAZID (pimavanserin) olanzapine/fluoxetine paliperidone ER REXULTI (brexpiprazole) RISPERDAL (risperidone) SAPHRIS (asenapine) SEROQUEL (quetiapine) SEROQUEL XR (quetiapine) SYMBYAX (olanzapine/fluoxetine) VERSACLOZ (clnazpine) VRAYLAR (cariprazine) ZYPREXA (olanzapine)	• **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, fluphenazine, Geodon, loxapine, Lybalvi,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**

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			• 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) ABILIFY ASIMTUFII (aripiprazole) GEODON (ziprasidone) olanzapine UZEDY (risperidone) 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** • 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 **Invega Hafyera** • Documented diagnosis of schizophrenia or schizoaffective disorder **AND** • 4 claims for Invega Sustenna in the past year **OR**

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			• 1 claim for Invega Trinza in the past year **OR** • 1 claim for Invega Hafyera in the past year
	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
	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

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	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**
	PROTEASE INHIBITORS (PEPTIDIC)		
	atazanavir EVOTAZ (atazanavir/cobicistat) NORVIR SOLUTION (ritonavir) ritonavir	CRIXIVAN (indinavir) fosamprenavir INVIRASE (saquinavir mesylate) LEXIVA (fosamprenavir)	

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		NORVIR POWDER (ritonavir) NORVIR TABLET (ritonavir) REYATAZ (atazanavir) VIRACEPT (nelfinavir mesylate)	
	PROTEASE INHIBITORS (NON-PEPTIDIC)		
	PREZISTA (darunavir ethanolate)	APTIVUS (tipranavir) darunavir ethanolate 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)	
	COMBINATION PRODUCTS – NUCLEOSIDE & NUCLEOTIDE ANALOG RTIs		
	DESCOVY (emtricitabine/tenofovir alafenam) emtricitabine/tenofovir	TRUVADA (emtricitabine/tenofovir)	

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	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		
	lopinavir/ritonavir	KALETRA (lopinavir/ritonavir)	
	CAPSID INHIBITORS		**All agents require clinical review.**
		SUNLENCA (lenacapavir)	
	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% • **16 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 pindolol propranolol propranolol ER sotalol	AZSRUZYO SPRINKLES (ranolazine) 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)	**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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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	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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			• 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+			
	MYRBETRIQ ER (mirabegron) oxybutynin ER oxybutinin IR solifenacin	darifenacin DETROL (tolterodine) DETROL LA (tolterodine) DITROPAN XL (oxybutynin) GELNIQUE (oxybutynin) GEMTESA (vibegron) MYRBETRIQ granules (mirabegron) OXYTROL (oxybutynin) tolterodine tolterodine ER TOVIAZ (fesoterodine fumarate)	**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
		trospium trospium ER VESICARE (solifenacin) VESICARE LS Suspension (solifenacin)	
BONE RESORPTION SUPPRESSION AND RELATED AGENTS DUR+			
	BISPHOSPHONATES		
	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	**Non-Preferred Criteria** • Documented diagnosis for osteoporosis or osteopenia **AND** • Have tried 2 different preferred agents in the past 6 months
	OTHERS		
		calcitonin salmon EVENITY (romosozumab-aqqg) EVISTA (raloxifene) FORTEO (teriparatide) MIACALCIN (calcitonin) PROLIA (denosumab) raloxifene TYMLOS (abaloparatide) XGEVA (denosumab)	

MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

(For All Medicaid, MSCAN and CHIP Beneficiaries)

EFFECTIVE 10/01/2023
Version 2023
Updated:09/29/2023

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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 ENTADFI (finasteride/tadalafil) PROSCAR (finasteride)	
	PDE5 INHIBITORS		
		CIALIS (tadalafil)	
BRONCHODILATORS & COPD AGENTS			
	ANTICHOLINERGICS & COPD AGENTS		**Minimum Age Limit** **6 years –** Spiriva Respimat **Spiriva Respimat**
	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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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		YUPELRI (revefenacin)	• Automatic approval for ≥ 6 years with a diagnosis of asthma
	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		
	albuterol HFA PROVENTIL HFA (albuterol) VENTOLIN HFA (albuterol)	levalbuterol HFA PROAIR DIGIHALER (albuterol) PROAIR RESPICLICK (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**

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			• Requires clinical review
	INHALERS, LONG ACTING DUR+		
	SEREVENT (salmeterol) STRIVERDI RESPIMAT (olodaterol)		**Minimum Age Limit** • **4 years –** Serevent • **18 years** -Striverdi Respimat
	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 metaproterenol terbutaline	VOSPIRE ER (albuterol)	

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
CALCIUM CHANNEL BLOCKERS DUR+			
	SHORT-ACTING		
	diltiazem nicardipine nifedipine verapamil	CALAN (verapamil) CARDIZEM (diltiazem) isradipine nimodipine NORLIQVA (amlodipine) 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 nifedipine ER verapamil ER	ADALAT CC (nifedipine) CALAN SR (verapamil) CARDENE SR (nicardipine) CARDIZEM CD (diltiazem) CARDIZEM LA (diltiazem) DILACOR XR (diltiazem) diltiazem ER Cap 12 HR diltiazem ER Tab 24 HR	**Non-Preferred Criteria** • Have tried 2 different preferred *Long Acting* CCB agents in the past 6 months **OR** • 90 consecutive days on the requested agent in the past 105 days

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

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		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
	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)	**Maximum Age Limit** • **18 years –** cefdinir suspension
COLONY STIMULATING FACTORS			
	FYLNETRA (pegfilgrastim) STIMUFEND (pegfilgrastim-fpgk) NEUPOGEN Syringe (filgrastim) NEUPOGEN Vial (filgrastim)	FULPHILA (pegfilgrastim) GRANIX (tbo-filgrastim) LEUKINE (sargramostim) NEULASTA (pegfilgrastim) NIVESTYM (filgrastim-aafi) NYVEPRIA (pegfilgrastim-apgf) RELEUKO (filgrastim)	

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		ROLVEDON (eflapegrastim) UDENYCA (pegfilgrastim-cbqv) ZARXIO (filgrastim) ZIEXTENZO (pegfilgrastim-bmez)	
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** • **1 month –** Kalydeco Granules • **3 months –** Pulmozyme • **1 year-** Orkambi • **2 years –** Coly-Mycin M, Trikafta Granules • **6 years –** Bethkis, Kalydeco tablet, Kitabis, Symdeko, TOBI, TOBI Podhaler, Trikafta tablet • **7 years –** Cayston • **18 years -** Bronchitol **Maximum Age Limit** • **2 years** – Orkambi 75-94 mg Granules • **5 years** – Kalydeco, Orkambi 100-125 mg Granules, Orkambi 200-125 mg Granules, Trikafta Granules • **11 years –** Trikafta tablets **All Agents** • Documented diagnosis Cystic Fibrosis

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			Colistimethate • 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) AMJEVITA (adalimumab) 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)	**All preferred agents are subject to approved age and documented diagnosis for appropriate indication.** **All Non-Preferred Agents** • Require clinical review **IV Administered Agents** • Require clinical review

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		RENFLEXIS (infliximab-abda) RHEUMATREX (methotrexate) RINVOQ (upadacitinib) RINVOQ ER (upadacitinib) SILIQ (brodalumab) SKYRIZI (risankizumab) SOTYKTU (deucravacitinib) SPEVIGO (spesolimab) STELARA (ustekinumab) TREMFYA (guselkumab) TREXALL (methotrexate) XELJANZ Oral Solution (tofacitinib) XELJANZ XR (tofacitinib)	
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			

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	FACTOR VIII		
	ADVATE AFSTYLA ALPHANATE FEIBA NF HEMOFIL M HUMATE-P KOATE KOGENATE FS KOVALTRY NOVOEIGHT NUWIQ RECOMBINATE WILATE XYNTHA XYNTHA SOLOFUSE	ADYNOVATE ALTUVIIIO ELOCTATE ESPEROCT HEXILATE FS JIVI KCENTRA OBIZUR VONVENDI	
	FACTOR IX		
	ALPHANINE SD ALPROLIX BENEFIX IDELVION IXINITY MONONINE PROFILNINE RIXUBIS	REBINYN	
	OTHER FACTOR PRODUCTS		
	COAGADEX FIBRYGA	CORIFACT NOVOSEVEN RT	**Hemlibra**

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	HEMLIBRA DUR+ RIASTAP	SEVENFACT TRETTEN	• 1 claim with the requested agent in the past 105 days • MANUAL PA – new patients
FIBROMYALGIA/NEUROPATHIC PAIN AGENTS			
	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 DUR+			
	ciprofloxacin tablets levofloxacin tablets	AVELOX (moxifloxacin) BAXDELA (delaflozacin) CIPRO (ciprofloxacin) CIPRO SUSPENSION (ciprofloxacin) CIPRO XR (ciprofloxacin) ciprofloxacin ER ciprofloxacin suspension FACTIVE (gemifloxacin) LEVAQUIN (levofloxacin) levofloxacin solution moxifloxacin NOROXIN (norfloxacin)	**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**

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		ofloxacin	• 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 **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	**Minimum Age Limit** • **12 years –** Aldara, Zyclara • **18 years –** Condylox, Picato, Veregen

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		PICATO (ingenol) Age Edit SOLARAZE (diclofenac) TOLAK (fluorouracil) VEREGEN (sinecatechins) Age Edit ZYCLARA (imiquimod) Age Edit	
GLUCOCORTICOIDS (Inhaled) DUR+			
	GLUCOCORTICOIDS		**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
	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	
	GLUCOCORTICOID/BRONCHODILATOR COMBINATIONS		**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
	ADVAIR DISKUS (fluticasone/salmeterol) ADVAIR HFA (fluticasone/salmeterol) DULERA (mometasone/formoterol) fluticasone/salmeterol (generic ADVAIR) fluticasone/salmeterol (generic AIRDUO) SYMBICORT (budesonide/formoterol)	AIRDUO Digihaler (fluticasone/salmeterol) AIRDUO Respiclick (fluticasone/salmeterol) BREO ELLIPTA (fluticasone/vilanterol) budesonide/formoterol WIXELA INHUB (fluticasone/salmeterol)	

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
GI ULCER THERAPIES			
	H2 RECEPTOR ANTAGONISTS		
	cimetidine solution famotidine solution famotidine tablets nizatidine solution	AXID (nizatidine) cimetidine tablets nizatidine tablets PEPCID (famotidine)	
	PROTON PUMP INHIBITORS		
	esomeprazole magnesium DR Capsule NEXIUM PACKET (esomeprazole) omeprazole Rx pantoprazole	ACIPHEX SPRINKLE (rabeprazole) ACIPHEX Tablet (rabeprazole) DEXILANT (dexlansoprazole) esomeprazole strontium DR Capsule KONVOMEP SUSPENSION (omeprazole/sodium bicarbonate) 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		

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	misoprostol sucralfate suspension sucralfate tablet	CARAFATE SUSPENSION (sucralfate) CARAFATE TABLET (sucralfate) CYTOTEC (misoprostol) DARTISLA ODT (glycopyrrolate)	
GROWTH HORMONE DUR+			
	GENOTROPIN (somatropin) NORDITROPIN (somatropin) NUTROPIN AQ (somatropin)	HUMATROPE (somatropin) OMNITROPE (somatropin) SAIZEN (somatropin) SEROSTIM (somatropin) SKYTROFA (lonapegsomatropin) SOGROYA (somapacitan) VOXZOGO (vosoritide) ZOMACTON (somatropin) ZORBTIVE (somatropin) NGENLA (somatrogon-ghla)NR	**All Agents for Age ≥ 18 years** • Documented diagnosis of craniopharyngioma, panhypopituitarism, Prader-Willi 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 **Minimum Age Limit** • 3 years – Ngenia **Maximum Age Limit** • 18 years - Ngenia

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			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 tenofovir disoproxil fumarate	adefovir dipivoxil BARACLUDE (entecavir) EPIVIR HBV TABLET (lamivudine) 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)	COPEGUS (ribavirin) EPCLUSA (sofosbuvir/velpatasvir) ∞ HARVONI (ledipasvir/sofosbuvir) ∞	**∞ Epclusa, Harvoni, Mavyret, Sovaldi, Vosevi, Zepatier** • Require clinical review

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	PEG-INTRON (peginterferon alfa-2b) ribavirin tablets sofosbuvir/velpatasvir∞	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) ∞	Note: Epclusa, Harvoni, Mavyret and Sovaldi have FDA pediatric indications **MANUAL PA**
HEREDITARY ANGIOEDEMA			
		BERINERT (C1 esterase inhibitor) CINRYZE VIAL (C1 esterase inhibitor) FIRAZYR SYRINGE (icatibant acetate) HAEGARDA (C1 esterase inhibitor) icatibant KALBITOR VIAL (ecallantide) ORLADEYO (berotralstat hydrochloride) RUCONEST VIAL (C1 esterase inhibitor, recombinant) TAKHZYRO (lanadelumab-flyo)	
HYPERURICEMIA & GOUT DUR+			
	allopurinol colchicine tablet probenecid	colchicine capsule COLCRYS (colchicine) febuxostat	**Non-Preferred Criteria** • Have tried 2 different preferred agents in the past 6 months

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	probenecid/colchicine	GLOPERBA (colchicine) MITIGARE (colchicine) ULORIC (febuxostat) ZYLOPRIM (allopurinol)	
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 **Gvoke** • 1 claim with Baqsimi or Zegalogue in the past 30 days **Non-Preferred Glucagons** • Have tried 1 different preferred glucagon in the past 30 days

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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)	
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)	Concomitant use of a GLP-1 product and a DPP-4 product requires clinical review
HYPOGLYCEMICS, INCRETIN MIMETICS/ENHANCERS DUR+			
	BYETTA (exenatide) TRULICITY (dulaglutide) VICTOZA (liraglutide)	ADLYXIN (lixisenatide) BYDUREON (exenatide) BYDUREON BCISE (exenatide) MOUNJARO (tirzepatide) OZEMPIC (semaglutide)	**Preferred Criteria** • Documented diagnosis for Type 2 Diabetes **OR**

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		RYBELSUS (semaglutide) SOLIQUA (insulin glargine/lixisenatide) SYMLIN (pramlintide) XULTOPHY (insulin degludec/ liraglutide)	• Have history of 84 days of therapy with the requested agent in the past 105 days **Non-Preferred Criteria** • Documented diagnosis for Type 2 Diabetes **AND** • Have a history of 84 days of therapy with Trulicity in the past 6 months **AND** • Have a history of 84 days of therapy with 1 of the following preferred single ingredient GLP-1 Agonists in the past 6 months: Byetta or Victoza **OR** • Documented diagnosis for Type 2 Diabetes **AND** • Have a history of 84 days of therapy with the requested agent in the past 105 Note: Single ingredient GLP-1 agonists are not indicated for treatment of obesity. Please refer to the PDL for a list of select anti-obesity agents.

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			Concomitant use of a GLP-1 product and a DPP-4 product requires clinical review
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) TOUJEO (insulin glargine) TOUJEO MAX (insulin glargine)	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 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 NOVOLOG FLEXPEN & VIAL (insulin aspart) NOVOLOG MIX FLEXPEN & VIAL (insulin aspart/ aspart protamine) REZVOGLAR (insulin glargine)	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 **Quantity Limit** • Insulin Quantity Limits found here

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		SEMGLEE (insulin glargine) TRESIBA (insulin degludec)	
HYPOGLYCEMICS, MEGLITINIDES DUR+			
	nateglinide repaglinide	PRANDIMET (repaglinide/metformin) PRANDIN (repaglinide) repaglinide/metformin STARLIX (nateglinide)	
HYPOGLYCEMICS, SODIUM GLUCOSE COTRANSPORTER-2 INHIBITORS DUR+			
	HYPOGLYCEMICS, SODIUM GLUCOSE COTRANSPORTER-2 INHIBITORS		
	FARXIGA (dapagliflozin) INVOKANA (canagliflozin) JARDIANCE (empagliflozin)	STEGLATRO (ertugliflozin)	
	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)	

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		AVANDIA (rosiglitazone)	
	TZD COMBINATIONS		
	pioglitazone/metformin	ACTOPLUS MET (pioglitazone/metformin) ACTOPLUSMET XR (pioglitazone/metformin) AVANDAMET (rosiglitazone/metformin) AVANDARYL (rosiglitazone/glipizide) DUETACT (pioglitazone/glimepiride) pioglitazone/glimepiride	
IDIOPATHIC PULMONARY FIBROSIS DUR+			
	OFEV (nintedanib)	ESBRIET (pirfenidone) pirfenidone	**All Agents** • Documented diagnosis Idiopathic Pulmonary Fibrosis
IMMUNOSUPPRESSIVE (ORAL) DUR+			
	AZASAN (azathioprine) azathioprine CELLCEPT (mycophenolate) cyclosporine cyclosporine modified everolimus GENGRAF (cyclosporine) IMURAN (azathioprine) mycophenolic acid mycophenolate mofetil NEORAL (cyclosporine) RAPAMUNE (sirolimus) SANDIMMUNE (cyclosporine)	ASTAGRAF XL (tacrolimus) ENVARSUS XR (tacrolimus) HECORIA (tacrolimus) MYFORTIC (mycophenolic acid) PROGRAF (tacrolimus) REZUROCK (belumosudil) ZORTRESS (everolimus)	**Minimum Age Limit** • **13 years -** Rapamune • **18 years -** Zortress **Astagraf, Cellcept, Envarsus XR, Hecoria, Prograf** • Documented diagnosis for heart transplant, kidney transplant, liver transplant, lung transplant or a State accepted diagnosis **Azasan** • Documented diagnosis of kidney transplant, RA, or a State accepted diagnosis

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	sirolimus tacrolimus		**Gengraf, Neoral, Sandimmune** • Documented diagnosis of heart transplant, kidney transplant, liver transplant, psoriasis, RA, or a State accepted diagnosis **OR** • Clinical review required for a diagnosis of Kimura's disease or multifocal motor neuropathy **Myfortic** • Documented diagnosis of kidney transplant or psoriasis **Rapamune** • Documented diagnosis of kidney transplant **Zortress** • Documented diagnosis of kidney transplant or liver transplant
IMMUNE GLOBULINS			
	BIVIGAM CARIMUNE NF FLEBOGAMMA DIF GAMASTAN SD GAMMAGARD GAMMAGARD SD GAMUNEX-C HIZENTRA	ASCENIV CABLIVI CUTAQUIG CUVITRU GAMMAKED GAMMAPLEX OCTAGAM	

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	HYQVIA PANZYGA PRIVIGEN XEMBIFY		
IMMUNOLOGIC THERAPIES FOR ASTHMA			
	DUPIXENT (dupilumab)* FASENRA PEN AUTOINJECTOR (benralizumab) FASENRA SYRINGE (benralizumab) XOLAIR SYRINGE (omalizumab) XOLAIR VIAL (omalizumab)	CINQAIR (reslizumab) NUCALA AUTOINJECTOR (mepolizumab)* NUCALA SYRINGE (mepolizumab)* TEZSPIRE (tezepelumab)	**All require a clinical review** **Dupixent – MANUAL PA** **Fasenra- MANUAL PA** **Xolair- MANUAL PA**
INTRANASAL RHINITIS AGENTS			
	ANTICHOLINERGICS		
	ipratropium	ATROVENT (ipratropium)	
	ANTIHISTAMINES		
	azelastine	ASTEPRO (azelastine) olopatadine PATANASE (olopatadine)	
	ANTIHISTAMINE/CORTICOSTEROID COMBINATION DUR+		
		DYMISTA (azelastine/fluticasone) RYALTRIS (olopatadine/mometasone) TICALAST (azelastine/fluticasone)	
	CORTICOSTEROIDS DUR+		
	fluticasone Rx Only	BECONASE AQ (beclomethasone) budesonide flunisolide mometasone	**Non-Preferred Criteria** • Documented diagnosis for allergic rhinitis **AND**

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		NASONEX (mometasone) OMNARIS (ciclesonide) QNASL (beclomethasone) TICANASE KIT (flonase kit) triamcinolone VERAMYST (fluticasone) XHANCE (fluticasone) ZETONNA (ciclesonide)	• Have tried 1 different preferred agent in the past 6 months
IRON CHELATING AGENTS			
	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

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			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** • 1 claim with the requested agent in the past 105 days **Irritable Bowel Syndrome – Constipation Dominant (IBS-C)** AMITIZA 8MCG, IBSRELA, 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

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			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** • 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)	**Viberzi** • Documented diagnosis of Irritable Bowel Syndrome – Diarrhea

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		LEVSIN-SL (hyoscyamine) LOTRONEX (alosetron) VIBERZI (eluxadoline)*	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** • **MANUAL PA** - All new patients require manual review **Xifaxan - (see Antibiotics, GI)**
	SHORT BOWEL SYNDROME AND SELECTED GI AGENTS		
		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** MYTESI • Documented diagnosis of HIV/AIDS in the past year **AND** • Documented diagnosis of non-infectious diarrhea in the past year **AND**

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			• 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** • 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)			
	ACL INHIBITORS AND COMBINATIONS		
		NEXLETOL (bempedoic acid) NEXLIZET (bempedoic acid/ezetimibe)	**Nexletol and Nexlizet** • Requires clinical review
	ANGIOPOIETIN LIKE 3 INHIBITORS		

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		EVKEEZA (evinacumab-dgnb)	**Non-Preferred Criteria** Have tried 2 different preferred Non-statin Lipotropic agents in the past 6 months
BILE ACID SEQUESTRANTS			
	cholestyramine colestipol	colesevelam COLESTID (colestipol) QUESTRAN (cholestyramine) WELCHOL (colesevelam)	
OMEGA-3 FATTY ACIDS			
	omega 3 acid ethyl esters	icosapent LOVAZA (omega-3-acid ethyl esters) VASCEPA (icosapent ethyl)	
CHOLESTEROL ABSORPTION INHIBITORS			
	ezetimibe	ZETIA (ezetimibe)	
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)	**Fibric Acid Derivative Non-Preferred Criteria** • Have tried 2 different fibric acid derivatives in the past 6 months

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		TRILIPIX (fenofibric acid)	
	MTP INHIBITOR		
		JUXTAPID (lomitapide)	**Juxtapid – MANUAL PA**
	APOLIPOPROTEIN B-100 SYNTHESIS INHIBITOR		
		KYNAMRO (mipomersen)	**Kynamro – MANUAL PA**
	NIACIN		
	niacin ER NIACOR (niacin)	NIASPAN (niacin)	
	PCSK-9 INHIBITOR		
	PRALUENT (alirocumab) REPATHA (evolocumab)	LEQVIO (inclisiran)	**Leqvio** • Requires clinical review **Praluent - MANUAL PA** **Repatha - MANUAL PA**
LIPOTROPICS, STATINS DUR+			
	STATINS		
	atorvastatin lovastatin pravastatin rosuvastatin simvastatin	ALTOPREV (lovastatin) ATORVALIQ SUSPENSION (atorvastatin) CRESTOR (rosuvastatin) EZALLOR SPRINKLE (rosuvastatin) FLOLIPID (simvastatin) fluvastatin ER	**Simvastatin 80mg** • 12 months of therapy with simvastatin 80mg **AND** • NO myopathy contraindication **Non-Preferred Criteria**

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		fluvastatin LESCOL (fluvastatin) LESCOL XL (fluvastatin) LIPITOR (atorvastatin) LIVALO (pitavastatin) MEVACOR (lovastatin) PRAVACHOL (pravastatin) ZOCOR (simvastatin) ZYPITAMAG (pitavastatin)	• 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			
	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 carglumic acid hydroxyzine hcl syrup	alprazolam ER CAMZYOS (mavacamten) CARBAGLU (carglumic acid)	**Alprazolam ER CUMULATIVE quantity limit** • **31 tablets/31 days**

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	hydroxyzine hcl tablets hydroxyzine pamoate megestrol suspension 625mg/5mL REVLIMID (lenalidomide)	EVRYSDI (risdiplam) INPEFA (sotagliflozin)NR KORLYM (mifepristone) lenalidomide MEGACE ES (megestrol) VERQUVO (vericiguat) VISTARIL (hydroxyzine pamoate)	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)	
MOVEMENT DISORDER AGENTS DUR+			
	AUSTEDO (deutetrabenazine) AUSTEDO XR (deutetrabenazine) INGREZZA (valbenazine) tetrabenazine (all labelers except those listed as non-preferred)	tetrabenazine (labeler 47335, 51224, 60505, 68180, 686820 XENAZINE (tetrabenazine)	**Austedo and Austedo XR** • Documented diagnosis of Huntington's chorea **OR** • Documented diagnosis of tardive dyskinesia **AND** • 90 days therapy with Austedo or Austedo XR in the past 105 days **OR** • MANUAL PA

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			Ingrezza • Documented diagnosis of Huntington's chorea **OR** • Documented diagnosis of tardive dyskinesia **AND** • 90 days therapy with Ingrezza in the past 105 days **OR** • **MANUAL PA**
MULTIPLE SCLEROSIS AGENTS DUR+			
	AVONEX (interferon beta-1a) AVONEX PEN (interferon beta-1a) BETASERON (interferon beta-1b) COPAXONE 20mg (glatiramer) dalfampridine dimethyl fumarate fingolimod GILENYA (fingolimod) REBIF (interferon beta-1a) REBIF REBIDOSE (interferon beta-1a) teriflunomide TYSABRI (natalizumab)	AMPYRA (dalfampridine) AUBAGIO (teriflunomide) BAFIERTAM (monomethyl fumarate) BRIUMVI (ublituximab) COPAXONE 40mg (glatiramer) EXTAVIA (interferon beta-1b) glatiramer GLATOPA (glatiramer) KESIMPTA (ofatumumab) MAVENCLAD (cladribine) MAYZENT (siponimod) OCREVUS (ocrelizumab) PLEGRIDY (interferon beta-1a) PONVORY (ponesimod) TASCENSO ODT (fingolimod) TECFIDERA (dimethyl fumarate) VUMERITY (diroximel fumarate) ZEPOSIA (ozanimod)	**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, Tascenso ODT, and Zeposia** • Requires clinical review **Mavenclad – MANUAL PA** **Mayzent – MANUAL PA** **Ocrevus – MANUAL PA**

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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 sulindac	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 LOFENA(diclofenac potassium) meclofenamate mefenamic acid	**Non-Preferred Criteria** • Have tried 2 different preferred non-selective or NSAID/GI protectant combination agents in the past 6 months **Quantity Limit** • 20 tablets/31 days – ketorolac tablets

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		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) NULOX (meloxicam) QMIIZ ODT (meloxicam) VIVLODEX (meloxicam)	**Non-Preferred Criteria – COX II** • Documented diagnosis of Osteoarthritis, Rheumatoid Arthritis, Familial Adenomatous Polyposis, or Ankylosing Spondylitis **AND**

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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 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 **Elyxyb** • Requires clinical review
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)	

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		NEOSPORIN (bacitracin/neomycin/gramicidin) (oxy-tcn/polymyx sul) 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 tobramycin/dexamethasone suspension TOBRADEX OINTMENT (tobramycin/dexamethasone) ZYLET (loteprednol/tobramycin)	gatifloxacin/prednisolone MAXITROL (neomycin/polymyxin/dexamethasone) neomycin/polymyxin/gramicidin neomycin/polymyxin/hydrocortisone TOBRADEX ST SUSPENSION (tobramycin/dexamethasone) TOBRADEX SUSPENSION (tobramycin/dexamethasone)	
OPHTHALMIC ANTI-INFLAMMATORIES DUR+			
	dexamethasone diclofenac difluprednate FLAREX (fluorometholone) fluorometholone	ACULAR (ketorolac) ACULAR LS (ketorolac) ACUVAIL (ketorolac) BROMDAY (bromfenac) bromfenac	**Non-Preferred Criteria** • Have tried 2 different preferred agents in the past 6 months

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	flurbiprofen FML FORTE (fluorometholone) FML SOP (fluorometholone) ketorolac MAXIDEX (dexamethasone) prednisolone acetate prednisolone NA phosphate PRED MILD (prednisolone) VEXOL (rimexolone)	BROMSITE (bromfenac) DUREZOL (difluprednate) FML (fluorometholone) ILEVRO (nepafenac) 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 ketotifen[OTC] olopatadine 0.1% olopatadine 0.2% ZADITOR (ketotifen)[OTC]	ALOCRIL (nedocromil) ALOMIDE (lodoxamide) BEPREVE (bepotastine) epinastine LASTACAFT (alcaftadine) PATADAY (olopatadine) PATANOL (olopatadine) PAZEO (olopatadine) VERKAZIA (cyclosporine) ZERVIATE (cetirizine)	**Non-Preferred Criteria** • Have tried 2 different preferred agents in the past 6 months **Verkazia** • Requires clinical review
OPHTHALMIC, DRY EYE AGENTS			
	RESTASIS droperette (cyclosporine)	CEQUA (cyclosporine 0.09%)	

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		EYSUVIS (loteprednol etabonate) MIEBO (perfluorohexyloctane)[NR] RESTASIS Multidose (cyclosporine) TYRVAYA (varaenicline) Nasal XIIDRA (lifitegrast)[Dur +]	**Minimum Age Limit** • **16 years –** Restasis • **17 years –** Xiidra • **18 years –** Cequa, Miebo **Quantity Limit** • **5.5 mL/31 days** – Restasis Multidose • **60 units/31 days** – Cequa, Restasis droperette, Xiidra • **3 ml/31 days** – Miebo **Miebo** • Requires clinical review **Non-Preferred Criteria** • History of 4 claims for Restasis in the past 6 months
OPHTHALMIC, GLAUCOMA AGENTS DUR+			
	BETA BLOCKERS		
	BETIMOL (timolol) carteolol ISTALOL (timolol) levobunolol metipranolol	BETAGAN (levobunolol) betaxolol BETOPTIC S (betaxolol) OPTIPRANOLOL (metipranolol) timolol gel	**Non-Preferred Criteria** • Have tried 2 different preferred agents in the past 6 months **OR**

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	timolol drops 0.25%, 0.5%	timolol daily drop 0.5% (generic Istalol) TIMOPTIC (timolol) TIMOPTIC XE (timolol)	• 90 consecutive days on the requested agent in the past 105 days **Minimum Age Limit** • **18 years -** Iyuzeh
	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		
	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)	

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		VYZULTA (latananoprostene bunod) ZIOPTAN (tafluprost) IYUZEH (latanoprost)[NR]	
	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 FIL(buprenorphine/naloxone)[DUR+]	BRIXADI (buprenorphine)[NR] buprenorphine tablets buprenorphine/naloxone films LUCEMYRA (lofexidine) PROBUPHINE (buprenorphine) SUBLOCADE (buprenorphine) VIVITROL (naltrexone) ZUBSOLV (buprenorphine/naloxone)	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			

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	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 OTIPRIO (ciprofloxacin) OTOVEL (ciprofloxacin/fluocinolone)	**Maximum Age Limit** • **9 years -** Cipro HC
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)	AURYXIA (ferric citrate) FOSRENOL (lanthanum) lanthanum	

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	sevelamer carbonate tablets	PHOSLO (calcium acetate) RENAGEL (sevelamer HCl) RENVELA (sevelamer carbonate) sevelamer carbonate powder packets sevelamer HCl VELPHORO (sucroferric oxyhydronxide)	
PLATELET AGGREGATION INHIBITORS DUR+			
	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)	
POTASSIUM REMOVING AGENTS			
	LOKELMA (sodium zirconium cyclosilicate)	sodium polystyrene sulfonate SPS ENEMA (sodium polystyrene sulfonate) SPS SUSPENSION (sodium polystyrene sulfonate) VELTASSA (patiromer calcium sorbitex)	

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PRENATAL VITAMINS			
	COMPLETE NATAL DHA COMPLETENATE CHEW Tablet M-NATAL PLUS Tablet NESTABS DHA COMBO PKG NIVA PLUS Tablet 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 PRENATAL PLUS IRON/FA PREPLUS Ca/Fe27/FA 1 Tablet PRETAB Tablet SE-NATAL19 CHEW Tablet SE-NATAL19 Tablet THRIVITE RX Tablet TRINATAL Rx 1 Tablet VIRT C DHA Capsule VIRT-NATE DHA Softgel Capsule VP-PNV-DHA Softgel Capsule WESTAB PLUS Tablet	Products not listed are assumed to be Non-Preferred.	
PSEUDOBULBAR AFFECT AGENTS DUR+			
		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+			

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	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) LIQREV (sildenafil) suspension REVATIO (sildenafil) tablet REVATIO (sildenafil) suspension sildenafil (generic Revatio) suspension TADLIQ (tadalafil) suspension	**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 **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

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			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** • Documented diagnosis of Pulmonary Hypertension
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**

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			• Documented WHO Group 1 diagnosis of secondary pulmonary arterial hypertension **OR** • Documented WHO Group 4 diagnosis of pulmonary hypertension due to chronic thrombotic embolic disease **OR** • Documented diagnosis of pulmonary hypertension **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
ROSACEA TREATMENTS			
	metronidazole (cream, gel, lotion)	AVAR (sulfacetamide sodium/sulfur) FINACEA (azelaic acid) FINACEA FOAM (azelaic acid) METROCREAM (metronidazole cream) METROGEL (metronidazole gel) METROLOTION (metronidazole lotion) MIRVASO (brimonidine) NORITATE (metronidazole) OVACE (sulfacetamide sodium) RHOFADE (oxymetazoline HCl) ROSULA (sodium sulfacetamide/sulfur) sodium sulfacetamide/sulfur (cleanser, pads, suspension) SOOLANTRA (ivermectin)	Topical Sulfonamides used for Rosacea will require a manual PA for ≥21 years. Other labeled indications are limited to <21 years.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		SUMADAN (sodium sulfacetamide/sulfur wash) SUMAXIN (sodium sulfacetamide/sulfur pads) SUMAXIN TS (sodium sulfacetamide/sulfur suspension) ZILXI AEROSOL (minocycline)	
SEDATIVE HYPNOTICS			
	BENZODIAZEPINES DUR+		
	estazolam flurazepam temazepam (15mg and 30mg)	DALMANE (flurazepam) 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.* • **31 units/31 days -** all strengths **Triazolam – CUMULATIVE** Quantity limit per rolling days for all strengths • **10 units/31 days** • **60 units/365 days**

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	OTHERS	**DUR+**	
	zaleplon zolpidem	AMBIEN (zolpidem) AMBIEN CR (zolpidem) BELSOMRA (sovorexant) DAYVIGO (lemborexant) doxepin 3mg, 6mg EDLUAR (zolpidem) eszopiclone HETLIOZ (tasimelteon) INTERMEZZO (zolpidem) LUNESTA (eszopiclone) ramelteon ROZEREM (ramelteon) QUVIVIQ (daridorexant) SILENOR (doxepin) SONATA (zaleplon) zolpidem ER zolpidem SL ZOLPIMIST (zolpidem)	**Maximum Age Limit** • 64 years – zolpidem 7.5 mg, zolpidem 10 mg, zolpidem 12.5 mg **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 DUR+		
	ALL CONTRACEPTIVES ARE PREFERRED EXCEPT FOR THOSE SPECIFICALLY INDICATED AS NON-PREFERRED	AMETHIA (levonorgestrel/ethinyl estradiol) AMETHYST (levonorgestrel/ethinyl estradiol)	

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		BALCOLTRA (levonorgestrel/ethinyl estradiol/iron) BEYAZ (ethinyl estradiol / drospirenone/levomefolate) 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)	

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		YAZ (ethinyl estradiol/drospirenone)	
	TRANSDERMAL CONTRACEPTIVES		
	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) baclofen suspension (generic FLEQSUVY) carisoprodol carisoprodol compound cyclobenzaprine 7.5mg, 15mg cyclobenzaprine ER DANTRIUM (dantrolene) dantrolene FLEQSUVY (baclofen) FEXMID (cyclobenzaprine) FLEXERIL (cyclobenzaprine) LORZONE (chlorzoxazone) LYVISPAH (baclofen granules) metaxalone NORGESIC FORTE (orphenedrine)	**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

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		orphenadrine orphenadrine compound orphenadrine ER PARAFON FORTE DSC (chlorzoxazone) ROBAXIN (methocarbamol) SKELAXIN (metaxalone) SOMA (carisoprodol) tizanidine capsules ZANAFLEX (tizanidine)	○ **84 tablets/6 months** **Carisoprodol with codeine** • 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+			

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MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

(For All Medicaid, MSCAN and CHIP Beneficiaries)

EFFECTIVE 10/01/2023
Version 2023
Updated:09/29/2023

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	LOW POTENCY		
	CAPEX (fluocinolone) desonide hydrocortisone cr, oint, soln.	alclometasone DERMA-SMOOTHE-FS (fluocinolone) DESONATE (desonide) DESOWEN (desonide) fluocinolone oil hydrocortisone lotion PEDIACARE HC (hydrocortisone) PEDIADERM (hydrocortisone) VERDESO (desonide)	**Non-Preferred Criteria** • Have tried 2 different preferred low potency agents in the past 6 months
	MEDIUM POTENCY		
	fluocinolone hydrocortisone mometasone cr, oint. prednicarbate cr PANDEL (hydrocortisone probutate)	betamethasone valerate foam CLODERM (clocortolone) CUTIVATE (fluticasone) DERMATOP (prednicarbate) ELOCON (mometasone) fluticasone LUXIQ (betamethasone) mometasone solution MOMEXIN (mometasone) prednicarbate oint SYNALAR (fluocinolone)	**Non-Preferred Criteria** • 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	**Non-Preferred Criteria** • Have tried 2 different preferred high potency agents in the past 6 months

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		diflorasone DIPROLENE AF (betamethasone diprop/prop gly) ELOCON (mometasone) fluocinonide HALOG (halcinonide) KENALOG (triamcinolone) PEDIADERM TA (triamcinolone) SERNIVO (betamethasone dipropionate) TOPICORT (desoximetasone) TRIANEX (triamcinolone) VANOS (fluocinonide)	
	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)	**Non-Preferred Criteria** • Have tried 2 different preferred very high potency agents in the past 6 months

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		ULTRAVATE Lotion (halobetasol)	
STIMULANTS AND RELATED AGENTS DUR+			
	SHORT-ACTING		
	amphetamine salt combination dexmethylphenidate IR dextroamphetamine IR methylphenidate IR methylphenidate solution PROCENTRA (dextroamphetamine)	ADDERALL (amphetamine salt combination) amphetamine sulfate (generic EVEKO) DESOXYN (methamphetamine) dextroamphetamine solution EVEKEO (amphetamine) EVEKEO ODT (amphetamine) FOCALIN (dexmethylphenidate) methamphetamine METHYLIN solution (methylphenidate) methylphenidate chewable RITALIN (methylphenidate) ZENZEDI (dextroamphetamine)	**Minimum Age Limit** • **3 years -** Adderall, Evekeo, Procentra, Zenzedi • **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**

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			• 1 claim for a 30-day supply with the requested agent in the past 105 days **Documented diagnosis of narcolepsy –** ADDERALL, EVEKEO, METHYLIN, PROCENTRA, RITALIN, ZENZEDI
	LONG-ACTING		
	ADDERALL XR (amphetamine salt combination) amphetamine salt combination ER CONCERTA (methylphenidate) dexmethylphenidate ER dextroamphetamine ER DYANAVEL XR SUSPENSION(amphetamine) lisdexamfetamine (generic Vyvanse) lisdexamfetamine (generic Vyvanse Chewable) 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)	ADHANSIA XR (methylphenidate) ADZENYS XR ODT (amphetamine) ADZENYS ER SUSPENSION (amphetamine) amphetamine susp 24 hr (generic ADZENYS ER) APTENSIO XR (methylphenidate) AZSTARYS (serdexmethylphen/dexmethylphen) 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) methylphenidate patch (generic Daytrana) MYDAYIS (amphetamine salt combination) RELEXXI (methylphenidate)	**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, Relexxii, Ritalin LA, Vyvanse, Xelstrym • **13 years –** Mydayis • **16 years –** Provigil • **18 years –** Nuvigil, Sunosi **Maximum Age Limit** • **18 years –** Cotempla XR ODT, Daytrana

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		RITALIN LA (methylphenidate) RITALIN SR (methylphenidate) VYVANSE (lisdexamfetamine)* VYVANSE CHEWABLE (lisdexamfetamine)* XELSTRYM patch (dextroamphetamine)	**Vyvanse** • Documented diagnosis of binge eating disorder **OR** • Documented diagnosis of ADD/ADHD **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,Dyanavel XR Tablet, Focalin XR, Jornay PM, Metadate CD, Methylin ER, Mydayis 37.5mg & 50mg, Nuvigil 150, 200 & 250 mg, Provigil 200mg, Quillichew, Relexxii, Ritalin LA & SR, Vyvanse, Sunosi, Xelstrym • **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 Suspension • **372 mL/31 days –** Quillivant XR

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			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)	LUMRYZ (sodium oxybate)[NR] NUVIGIL (armodafinil) PROVIGIL (modafinil) sodium oxybate WAKIX (pitolisant) XYREM (sodium oxybate) XYWAV (calcium, magnesium, potassium and sodium oxybates)	**Documented diagnosis of narcolepsy –** ADDERALL XR, APTENSIO XR, CONCERTA ER, DEXEDRINE, METADATE CD, METHYLIN ER, MYDAYIS, NUVIGIL, 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**

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			• 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 **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**

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			• 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	INTUNIV (guanfacine ER) QELBREE (viloxazine) STRATTERA (atomoxetine)	**Minimum Age Limit** **6 years –** Intuniv, Clonidine ER, Qelbree, Strattera **18 years –** Wakix **Maximum Age Limit** • **18 years –** Intuniv, Clonidine ER, Qelbree • **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 – Clonidine ER**

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			Intuniv Documented diagnosis of ADD or ADHD **Clonidine ER** • Documented diagnosis of ADD or ADHD **Qelbree** • 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 hyclate (generic Periostat) 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)	**Non-Preferred Agents** • Have tried 2 different preferred agents in the past 6 months **Demeclocycline** • Documented diagnosis of SIADH will allow automatic approval

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		OKEBO (doxycycline) ORACEA (doxycycline) SEYSARA (sarecycline) SOLODYN (minocycline) TARGADOX (doxycycline) VIBRAMYCIN cap/susp/syrup XIMINO (minocycline)	
ULCERATIVE COLITIS and CROHN'S AGENTS DUR+ ***See Cytokine & CAM Antagonists Class for additional agents**			
	ORAL		
	balsalazide budesonide EC mesalamine tablet (generic Apriso) sulfasalazine	APRISO (mesalamine) ASACOL HD (mesalamine) AZULFIDINE (sulfasalazine) AZULFIDINE ER (sulfasalazine) COLAZAL (balsalazide) DELZICOL (mesalamine) DIPENTUM (olsalazine) ENTOCORT EC (budesonide) GIAZO (balsalazide) LIALDA (mesalamine) mesalamine tablet (generic Asacol HD) mesalamine tablet (generic Delzicol) ORTIKOS (budesonide) 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		

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	mesalamine suppository	budesonide foam CANASA (mesalamine) ROWASA (mesalamine) SF-ROWASA (mesalamine) UCERIS Foam (budesonide)	

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