



MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

EFFECTIVE 2/1/2024

Version 2024

Updated:1/31/2024

(For All Medicaid, MSCAN and CHIP Beneficiaries)

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
ACNE AGENTS			
ANTI-INFECTIVE			
	clindamycin gel (generic Cleocin-T) clindamycin lotion clindamycin solution	ACZONE (dapson) 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)	Maximum Age Limit <ul style="list-style-type: none"> • 21 years – all agents except isotretinoin
RETINOIDS			
	RETIN-A (tretinoin) tretinoin cream	adapalene AKLIEF (trifarotene) ALTRENO (tretinoin) ARAZLO (tazarotene) ATRALIN (tretinoin) AVITA (tretinoin) DIFFERIN (adapalene)	

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		FABIOR (tazarotene) PLIXDA (adapalene) RETIN-A MICRO (tretinoin) tazarotene TAZORAC (tazarotene) tretinoin gel tretinoin micro	
	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) CABTREO (clindamycin phosphate/adapalene/ benzoyl peroxide) ^{NR} 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)	

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		SE BPO (benzoyl peroxide) sodium sulfacetamide/sulfur cleanser/cream/lotion/pads sodium sulfacetamide/sulfur/meratan SSS 10/5 Foam (sodium sulfacetamide/sulfur) sulfacetamide sodium/sulfur/urea VELTIN (clindamycin/tretinoin) ZENCIA WASH (sulfacetamide sodium/sulfur) ZIANA (clindamycin/tretinoin)	
KERATOLYTICS (BENZOYL PEROXIDES)			
	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			
	ACUTANE (isotretinoin) AMNESTEEM (isotretinoin) CLARAVIS (isotretinoin) isotretinoin MYORISAN (isotretinoin) ZENATANE (isotretinoin)	ABSORICA (isotretinoin) ABSORICA LD (isotretinoin)	Available for all ages
ALPHA-1 PROTEINASE INHIBITORS			
	ARALAST (alpha-1 proteinase inhibitor) GLASSIA (alpha-1 proteinase inhibitor) PROLASTIN C (alpha-1 proteinase inhibitor)		

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	ZEMAIRA (alpha-1 proteinase inhibitor)		
ALZHEIMER'S AGENTS <small>DUR+</small>			
	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)	<p>All Agents</p> <ul style="list-style-type: none"> • Documented diagnosis for both preferred and non-preferred <p>Non-Preferred Criteria</p> <ul style="list-style-type: none"> • Have tried 2 different preferred agents in the past 6 months
	NMDA RECEPTOR ANTAGONIST		
	memantine	NAMENDA TABS (memantine) NAMENDA SOLUTION (memantine) NAMENDA XR (memantine) memantine XR	
	COMBINATION AGENTS		
		NAMZARIC (memantine/donepezil)	<p>Namzaric</p> <ul style="list-style-type: none"> • Documented diagnosis AND • 30 days of concurrent therapy with donepezil + memantine in the past 6 months
ANALGESICS, OPIOID- SHORT ACTING <small>DUR+</small>			
	acetaminophen/codeine benzhydrocodone/APAP codeine	ABSTRAL (fentanyl) ACTIQ (fentanyl) APADAZ (benzhydrocodone/APAP)	<p>MS DOM Opioid Initiative</p> <ul style="list-style-type: none"> • Short-Acting Opioids • Long-Acting Opioids

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	dihydrocodeine/APAP/caffeine 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/APAP/caffeine/codeine butalbital/ASA/caffeine/codeine butorphanol tartrate (nasal) DEMEROL (meperidine) DILAUDID (hydromorphone) DVORAH (dihydrocodeine/ APAP/caffeine) fentanyl FENTORA (fentanyl) FIORICET W/ CODEINE (butalbital/APAP/caffeine/codeine) FIORINAL W/ CODEINE (butalbital/ASA/caffeine/codeine) 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	<ul style="list-style-type: none"> • Morphine Equivalent Daily Dose • Concomitant use of Opioids and Benzodiazepines <p>Criteria details found here</p> <p>Minimum Age Limit</p> <ul style="list-style-type: none"> • 18 years – tramadol and codeine products <p>Quantity Limit</p> <p>Applicable <u>quantity limit</u> in 31 rolling days</p> <ul style="list-style-type: none"> • 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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		PERCOCET (oxycodone/APAP) PERCODAN (oxycodone/ASA) PRIMLEV (oxycodone/APAP) PROLATE (oxycodone/APAP) QDOLO (tramadol) REPRESAINE (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)	MS DOM Opioid Initiative <ul style="list-style-type: none"> • Short-Acting Opioids • Long-Acting Opioids • Morphine Equivalent Daily Dose • Concomitant use of Opioids and Benzodiazepines

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		EXALGO (hydromorphone) hydromorphone ER HYSINGLA ER (hydrocodone) KADIAN (morphine) methadone 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) XTAMPZA (oxycodone myristate)	<p>Criteria details found here</p> <p>Minimum Age Limit</p> <ul style="list-style-type: none"> • 18 years – Butrans, tramadol products <p>Quantity Limit</p> <p>Applicable <u>quantity limit</u> per rolling days</p> <ul style="list-style-type: none"> • 31 tablets/31 days - Conzip ER, Exalgo ER, Hysingla ER, Ryzolt, Ultram ER • 62 tablets/31 days – Arymo ER, Belbuca, Kadian, methadone, morphine ER, Nucynta ER, Opana ER, oxycodone ER, Oxycontin, Xtampza ER • 10 patches/31 days – Duragesic • 4 patches/31 days – Butrans <p>Non-Preferred Criteria</p> <ul style="list-style-type: none"> • Have tried 2 different preferred agents in the past 6 months OR • Documented diagnosis of cancer OR Antineoplastic therapy AND • 90 consecutive days on the requested agent in the past 105 days

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Therapeutic Drug Class	Preferred Agents	Non-Preferred Agents	PA Criteria
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+} diclofenac 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) ZTIido (lidocaine)	<p>Quantity Limit</p> <ul style="list-style-type: none"> 1 bottle/31 days – Diclofenac 2% solution pump 1 bottle/31 days – Diclofenac 1.5% solution <p>Non-Preferred Criteria</p> <ul style="list-style-type: none"> Have tried 1 preferred agent in the past 6 months <p>Lidocaine 5% Patch</p> <ul style="list-style-type: none"> Documented diagnosis of Herpetic Neuralgia OR Documented diagnosis of Diabetic Neuropathy <p>ZTIido</p> <ul style="list-style-type: none"> 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)	<p>All Agents</p> <ul style="list-style-type: none"> Limited to male gender <p>Non-Preferred Criteria</p> <ul style="list-style-type: none"> Have tried 2 different preferred agents in the past 6 months

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		STRIANT (testosterone) TESTIM (testosterone gel) testosterone pump TLANDO (testosterone) VOGELXO (testosterone) XYOSTED (testosterone enanthate)	Tlando <ul style="list-style-type: none"> 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 <ul style="list-style-type: none"> ≤ 6 years – Epaned DUR + <i>will automatically be issued for this age</i> Non-Preferred Criteria <ul style="list-style-type: none"> Have tried 2 different preferred <i>single entity</i> agents in the past 6 months OR 90 consecutive days on the requested agent in the past 105 days
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 <ul style="list-style-type: none"> Have tried 2 different preferred <i>ACEI/CCB</i> 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)	<ul style="list-style-type: none"> 90 consecutive days on the requested agent in the past 105 days <p>ACE Inhibitor/Diuretic</p> <ul style="list-style-type: none"> Have tried 2 different preferred <u>ACEI/Diuretic</u> agents in the past 6 months OR 90 consecutive days on the requested agent in the past 105 days
ANGIOTENSIN II RECEPTOR BLOCKERS (ARBs)			
	irbesartan losartan olmesartan telmisartan valsartan	ATACAND (candesartan) AVAPRO (irbesartan) BENICAR (olmesartan) candesartan COZAAR (losartan) DIOVAN (valsartan) EDARBI (azilsartan) eprosartan MICARDIS (telmisartan) TEVETEN (eprosartan)	<p>Non-Preferred Criteria</p> <ul style="list-style-type: none"> Have tried 2 different preferred <u>single entity</u> agents in the past 6 months OR 90 consecutive days on the requested agent in the past 105 days
ARB COMBINATIONS			
	ENTRESTO (valsartan/sacubitril) ^{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	<p>Entresto</p> <ul style="list-style-type: none"> 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)	<ul style="list-style-type: none"> Documented diagnosis of heart failure with systemic ventricular systolic dysfunction <p>Non-Preferred Criteria ARB/Beta Blocker, ARB/CCB or ARB/CCB/Diuretic</p> <ul style="list-style-type: none"> Have tried 1 preferred <u>ARB/CCB</u> agent in the past 6 months OR 90 consecutive days on the requested agent in the past 105 days <p>ARB/Diuretic</p> <ul style="list-style-type: none"> Have tried 2 different preferred <u>ARB/Diuretic</u> products in the past 6 months OR 90 consecutive days on the requested agent in the past 105 days
DIRECT RENIN INHIBITORS			
		TEKTURNA (aliskiren) aliskiren	<p>Non-Preferred Criteria</p> <ul style="list-style-type: none"> Documented diagnosis of hypertension AND Have tried 2 different preferred <u>ACEI or ARB single-entity</u> products in the past 6 months OR

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DIRECT RENIN INHIBITOR COMBINATIONS			<ul style="list-style-type: none"> 90 consecutive days on the requested agent in the past 105 days <p>Non-Preferred Criteria</p> <ul style="list-style-type: none"> Documented diagnosis of hypertension AND Have tried 2 different preferred <u>ACEI or ARB diuretic agents</u> in the past 6 months OR 90 consecutive days on the requested agent in the past 105 days
		AMTURNIDE (aliskiren/amlodipine/hctz) TEKAMLO (aliskiren/amlodipine) TEKTRUNA-HCT (aliskiren/hctz) VALTURNA (aliskiren/valsartan)	
ANTIBIOTICS (GI) & RELATED AGENTS			
	FIRVANQ (vancomycin) metronidazole neomycin tinidazole	AEMCOLO (rifaximin) DIFICID (fidaxomicin) FLAGYL (metronidazole) FLAGYL ER (metronidazole) LIKMEZ (metronidazole) ^{NR} paromomycin REBYOTA (fecal microbiota) TINDAMAX (tinidazole) VANCOCIN (vancomycin) vancomycin VOWST (fecal microbiota) XIFAXAN (rifaximin)	
ANTIBIOTICS (MISCELLANEOUS)			
	KETOLIDES		

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		KETEK (telithromycin)	
	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 macrocrystals	FURADANTIN (nitrofurantoin) MACROBID (nitrofurantoin monohydrate macrocrystals) MACRODANTIN (nitrofurantoin)	
	OXAZOLIDINONES		
		SIVEXTRO (tedizolid)	Sivextro – MANUAL PA Zyvox - MANUAL PA

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		ZYVOX (linezolid)	Quantity Limit <ul style="list-style-type: none"> • 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			

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	COUMADIN (warfarin) ELIQUIS (apixaban) PRADAXA (dabigatran) warfarin XARELTO (rivaroxaban)	BEVYXXA (betrixaban) PRADAXA PELLETS (dabigatran) SAVAYSA (edoxaban tosylate)	Non-Preferred Criteria <ul style="list-style-type: none"> Have tried 2 different preferred agents in the past 6 months OR 1 claim with the requested agent in the past 90 days
LOW MOLECULAR WEIGHT HEPARIN (LMWH)			
	enoxaparin	ARIXTRA (fondaparinux) fondaparinux FRAGMIN (dalteparin) LOVENOX (enoxaparin) Prefilled Syringe	LMWH Non-Preferred Criteria <ul style="list-style-type: none"> Have tried 1 different preferred agent in the past 6 months OR 90 consecutive days on the requested agent in the past 105 days
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	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)	Minimum Age Limit <ul style="list-style-type: none"> 6 months-- Diacomit 1 year – Banzel, Epidiolex 2 years –Onfi, Sympazan Epidiolex <ul style="list-style-type: none"> Documented diagnosis of Dravet syndrome. Lennox Gastaut syndrome or seizures associated with tuberous sclerosis complex OR <ul style="list-style-type: none"> 1 claim for the requested agent in the past 30 days

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	levetiracetam levetiracetam ER oxcarbazepine oxcarbazepine suspension tiagabine topiramate tablet topiramate sprinkle capsule valproic acid zonisamide	FINTEPLA (fenfluramine) FYCOMPA (perampanel) GABITRIL (tiagabine) KEPPRA (levetiracetam) KEPPRA XR (levetiracetam) LAMICTAL (lamotrigine) LAMICTAL CHEWABLE (lamotrigine) LAMICTAL ODT (lamotrigine) LAMICTAL XR (lamotrigine) lamotrigine ER/XR lamotrigine ODT MOTPOLY XR (lacosamide) ^{NR} NEURONTIN (gabapentin) OXTELLAR XR (oxcarbazepine) QUDEXY XR (topiramate) ROWEEPRA (levetiracetam) rufinamide 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)	<p style="color: red;">Non-Preferred Criteria</p> <ul style="list-style-type: none"> Have tried 2 different preferred agents in the past 6 months OR 90 consecutive days on the requested agent in the past 105 days AND Documented diagnosis of seizure <p style="color: red;">Banzel, Onfi, Sympazan</p> <ul style="list-style-type: none"> Documented diagnosis of Lennox-Gastaut AND Have tried 1 different preferred agent for Lennox-Gastaut in the past 6 months OR 90 consecutive days on the requested agent in the past 105 days AND Documented diagnosis of seizure <p style="color: red;">Diacomit</p> <ul style="list-style-type: none"> Documented diagnosis of Dravet syndrome AND Active claim for clobazam <p style="color: red;">Fintepla</p> <ul style="list-style-type: none"> Requires clinical review <p style="color: red;">Sabril Powder for Oral Solution</p> <ul style="list-style-type: none"> Documented diagnosis of infantile spasms OR

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		vigabatrin VIMPAT (lacosamide) XCOPRI (cenobamate) ZONISADE (zonisamide suspension) ZTALMY (ganaxolone)	<ul style="list-style-type: none"> • Have tried 2 different preferred agents in the past 6 months OR • 90 consecutive days on the requested agent in the past 105 days AND • Documented diagnosis of seizure <p>Topiramate ER – Step Edit</p> <ul style="list-style-type: none"> • 90 consecutive days on the requested agent in the past 105 days AND • Documented diagnosis of seizure OR • 30-day trial with topiramate IR in the past 6 months <p>Minimum Age Limit</p> <ul style="list-style-type: none"> • 12 years – Nayzilam • 6 years – Valtoco <p>Quantity Limit</p> <ul style="list-style-type: none"> • 2 Twin Packs/31 days – Diastat • 2 Packages /31 days – Nayzilam • 2 Cartons/31 days - Valtoco
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			

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geodon	ethosuximide	CELONTIN (methsuximide) ZARONTIN (ethosuximide)	
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	<p style="color: red;">Minimum Age Limit</p> <ul style="list-style-type: none"> 7-11 years – Drizalma Sprinkle <i>DUR + will automatically be issued for this age range with a diagnosis of generalized anxiety disorder</i> 7-17 years – duloxetine <i>DUR + will automatically be issued for this age range with a diagnosis of generalized anxiety disorder</i> 18 years – all other Antidepressants <p style="color: red;">Non-Preferred Criteria</p> <ul style="list-style-type: none"> Have tried 2 different preferred <u>'Antidepressants, Other' Class</u> in the past 6 months OR Have tried BOTH a preferred <u>'Antidepressant, SSRI' and 'Antidepressants, Other'</u> in the past 6 months OR 90 consecutive days on the requested agent in the past 105 days <p style="color: red;">Auvelity</p> <ul style="list-style-type: none"> Requires clinical review

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		WELLBUTRIN (bupropion) WELLBUTRIN SR (bupropion) WELLBUTRIN XL (bupropion HCl) ZURZUVAE (zuranolone) ^{NR}	Cymbalta and Irenka (see Fibromyalgia Agents)
ANTIDEPRESSANTS, SSRIs ^{DUR+}			
	citalopram escitalopram fluoxetine capsules	CELEXA (citalopram) fluoxetine DR fluvoxamine ER	Minimum Age Limit <ul style="list-style-type: none"> • 6 years – Zoloft • 7 years – Lexapro, Prozac

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	fluvoxamine paroxetine CR paroxetine IR sertraline	LEXAPRO (escitalopram) LUVOX (fluvoxamine) LUVOX CR (fluvoxamine) paroxetine suspension PAXIL CR (paroxetine) PAXIL SUSPENSION (paroxetine) PAXIL Tablets (paroxetine) PEXEVA (paroxetine) PROZAC (fluoxetine) SARAFEM (fluoxetine) ZOLOFT (sertraline)	<ul style="list-style-type: none"> 8 years – Luvox 18 years – Celexa, Luvox CR, Paxil, Pexeva, Prozac 90 mg <p>Maximum Age Limit</p> <ul style="list-style-type: none"> 60 years – Celexa <p>Non-Preferred Criteria</p> <ul style="list-style-type: none"> Have tried 2 different preferred agents in the past 6 months OR 90 consecutive days on the requested agent in the past 105 days
ANTIEMETICS ^{DUR+}			
5HT3 RECEPTOR BLOCKERS			
	ondansetron ondansetron ODT ondansetron solution	ANZEMET (dolasetron) granisetron SANCUSO (granisetron) ZOFRAN (ondansetron) ZOFRAN ODT (ondansetron) ZUPLLENZ (ondansetron)	<p>Quantity Limit</p> <ul style="list-style-type: none"> 6 tablets/31 days – Akynzeo 30 tablets/31 days – Zofran tablets/ODT 100 ml/31 days – Zofran solution <p>Non-Preferred Agents</p> <ul style="list-style-type: none"> Have tried 1 preferred agent in the past 6 months <p>Injectables in this class closed to point of sale. PA required if not administered in clinic/hospital</p>
ANTIEMETIC COMBINATIONS			

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		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 LAMISIL (terbinafine) NOXAFIL (posaconazole) ^ ONMEL (itraconazole) ^	<p>Minimum Age Limit</p> <ul style="list-style-type: none"> • 12-17 years – griseofulvin tablets <i><u>Dur + will automatically be issued for this age range</u></i> <p>Non-Preferred Criteria</p> <ul style="list-style-type: none"> • Have tried 2 different preferred agents in the past 6 months <p>HIV opportunistic infection</p> <ul style="list-style-type: none"> • Non-Preferred agent indicated for treatment (^) AND • Documented diagnosis of HIV <p>Cresemba - MANUAL PA</p> <ul style="list-style-type: none"> • Minimum age limit > 18 years AND

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MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

(For All Medicaid, MSCAN and CHIP Beneficiaries)

EFFECTIVE 2/1/2024
Version 2024
Updated:1/31/2024

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		posaconazole [^] SPORANOX (itraconazole) [^] TERBINEX Kit (terbinafine/ciclopirox) TOLSURA (itraconazole) VFEND (voriconazole) [^] VIVJOA (oteseconazole) voriconazole [^]	<ul style="list-style-type: none"> • Documented diagnosis of invasive aspergillosis OR invasive mucormycosis AND • Prescriber is an oncologist/hematologist or infectious disease specialist <p style="color: red;">Sporanox</p> <ul style="list-style-type: none"> • HIV opportunistic infection criteria OR • Documented diagnosis of a transplant OR • History of an immunosuppressant in the past 6 months OR • Have tried 2 different preferred agents in the past 6 months
ANTIFUNGALS (Topical) ^{DUR+}			
	ANTIFUNGALS		
	ciclopirox cream/gel/solution/suspension clotrimazole cream/solution ^{Rx & OTC} ketoconazole shampoo LUZU (luliconazole) miconazole cream/powder ^{OTC} nystatin terbinafine cream/spray ^{OTC} tolnaftate cream/powder/spray ^{OTC}	BENSAL HP (benzoic acid/salicylic acid) butenafine CICLODAN KIT (ciclopirox kit) ciclopirox kit/shampoo CNL 8 (ciclopirox) econazole ERTACZO (sertaconazole) EXELDERM (sulconazole) EXTINA (ketoconazole) JUBLIA (efinaconazole) KERYDIN (tavaborole)	<p style="color: red;">Non-Preferred Criteria</p> <ul style="list-style-type: none"> • Have tried 2 different preferred agents in the past 6 months

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

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ANTIHISTAMINES, MINIMALLY SEDATING AND COMBINATIONS ^{DUR+}			
MINIMALLY SEDATING ANTIHISTAMINES			
	cetirizine tablets ^{OTC} cetirizine syrup ^{Rx & OTC} loratadine odt ^{OTC} loratadine syrup ^{OTC} loratadine tablet ^{OTC}	cetirizine chewable ^{OTC} CLARINEX (desloratadine) desloratadine ODT desloratadine tablet fexofenadine syrup fexofenadine table levocetirizine syrup levocetirizine tablet XYZAL Solution (levocetirizine) XYZAL Tablets (levocetirizine)	<p style="color: red;">Non-Preferred Criteria</p> <ul style="list-style-type: none"> • Documented diagnosis of allergy or urticaria AND • Have tried 2 different preferred agents in the past 12 months
MINIMALLY SEDATING ANTIHISTAMINE/DECONGESTANT COMBINATIONS			
	cetirizine/pseudoephedrine loratadine/pseudoephedrine	ALLEGRA-D (fexofenadine/ pseudoephedrine) CLARITIN-D (loratadine/pseudoephedrine) CLARINEX-D (desloratadine/ pseudoephedrine) fexofenadine/pseudoephedrine ZYRTEC-D (cetirizine/pseudoephedrine)	
ANTIMIGRAINE AGENTS, ACUTE TREATMENT			
CGRP ORAL AND NASAL			
	NURTEC ODT (rimegepant)	UBRELVY (ubrogepant) ZAVZPRET (zavegepant)	<p style="color: red;">Minimum Age Limit</p> <ul style="list-style-type: none"> • 18 years – Nurtec ODT, Ubrelyv

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			<p>Quantity Limit</p> <ul style="list-style-type: none"> • 8 tablets/31 day – Nurtec ODT • 16 tablets/31 day – Ubrelvy <p>Nurtec ODT</p> <ul style="list-style-type: none"> • Documented diagnosis of migraine AND • Have tried 2 different triptans in the past 6 months AND • No concurrent therapy with another CGRP agent <p>Ubrelvy</p> <ul style="list-style-type: none"> • Documented diagnosis of migraine AND • Have tried 2 different triptans in the past 6 months AND • Have tried preferred Nurtec ODT in the past 6 months AND • No concurrent therapy with another CGRP agent AND • No concurrent therapy with a strong CYP3A4 inhibitor
TRIPTANS & RELATED AGENTS ORAL ^{DUR+}			
	naratriptan rizatriptan rizatriptan ODT sumatriptan tablets zolmitriptan zolmitriptan ODT	almotriptan AMERGE (naratriptan) AXERT (almotriptan) eletriptan FROVA (frovatriptan) frovatriptan	<p>Minimum Age Limit – ALL FORMULATIONS</p> <ul style="list-style-type: none"> • 6 years – Maxalt • 12-17 years – Axert, Treximet, Zomig nasal spray <u>Dur + will</u>

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		IMITREX (sumatriptan) MAXALT (rizatriptan) MAXALT MLT (rizatriptan) RELPAX (eletriptan) REYVOW (lasmiditan) TREXIMET (sumatriptan/naproxen) ZOMIG (zolmitriptan)	<p><i>automatically be issued for this age range</i></p> <ul style="list-style-type: none"> • 18 years – Amerge, Frova, Imitrex, Onzetra Xsail, Relpax, Reyvow, Tosymra, Zembrace Symtouch, Zomig tablets <p>Quantity Limit - ORAL</p> <ul style="list-style-type: none"> • 4 tablets/31 days – Reyvow 50 mg • 6 tablets/31 days - Axert, Relpax Zomig • 8 tablets/31 days – Reyvow 100 mg • 9 tablets/31 days - Amerge, Frova, Imitrex, Treximet • 12 tablets/31 days – Maxalt <p>Non-Preferred Criteria - ORAL</p> <ul style="list-style-type: none"> • Have tried 2 preferred oral agents in the past 90 days <p>Reyvow</p> <ul style="list-style-type: none"> • Documented diagnosis of migraine AND • Have tried 2 different triptans in the past 90 days AND • Have tried preferred Nurtec ODT in the past 90 days <p>Quantity Limit - NASAL</p> <ul style="list-style-type: none"> • 1 box/31 days
	NASAL		
	sumatriptan	IMITREX (sumatriptan)	

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Therapeutic Drug Class	Preferred Agents	Non-Preferred Agents	PA Criteria
		ONZETRA Xsail (sumatriptan) TOSYMRA (sumatriptan) zolmitriptan ZOMIG (zolmitriptan)	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 120mg/mL (galcanezumab-gnlm) EMGALITY SYRINGE 120mg/mL (galcanezumab-gnlm)	EMGALITY SYRINGE 100mg/mL (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 (afatinib)	AFINITOR (everolimus) AKEEGA (niraparib / abiraterone) ALECENSA (alectinib) ALUNBRIG (brigatinib) AUGTYRO (reprotrectinib) ^{NR}	Farydak - MANUAL PA • Documented diagnosis of multiple myeloma AND

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	everolimus ICLUSIG (ponatinib) imatinib mesylate IMBRUVICA (ibrutinib) INLYTA (axitinib) IRESSA (gefitinib) JAKAFI (ruxolitinib) MEKINIST (trametinib dimethyl sulfoxide) NEXAVAR (sorafenib) ROZLYTREK (entrectinib) ROZLYTREK (entrectinib) Pellet Pack ^{NR} SPRYCEL (dasatinib) STIVARGA (regorafenib) SUTENT (sunitinib) TAFINLAR (dabrafenib) TARCEVA (erlotinib) TASIGNA (nilotinib) TURALIO (pexidartinib) TYKERB (lapatinib ditosylate) vandetanib VOTRIENT (pazopanib) XALKORI (crizotinib) XALKORI (crizotinib) Oral Pellets ^{NR} XTANDI (enzalutamide) ZELBORAF (vemurafenib) ZYDELIG (idelalisib) ZYKADIA (ceritinib)	AYWAKIT (avapritinib) BALVERSA (erdafitinib) BRAFTOVI (encorafenib) BRUKINSA (zanubrutinib) CABOMETYX (cabozantinib s-malate) CALQUENCE (acalabrutinib) COPIKTRA (duvelisib) DAURISMO (glasdegib) ERIVEDGE (vismodegib) ERLEADA (apalutamide) erlotinib EXKIVITY (mobocertinib) FARYDAK (panobinostat) FOTIVDA (tivozanib) FRUZAQLA (fruquintinib) ^{NR} GAVRETO (pralsetinib) gefitinib GLEEVEC (imatinib mesylate) GLEOSTINE (lomustine) IBRANCE (palbociclib) ^{DUR+} IDHIFA (enasidenib) INQOVI (cedazuridine/decitabine) INREBIC (fedratinib) IWILFIN (eflornithine) ^{NR} JAYPIRCA (pirtobrutinib) KRAZATI (adagrasib) KISQALI (ribociclib) KOSELUGO (selumetinib) lapatinib ditosylate LENVIMA (lenvatinib) ^{DUR+} LORBRENA (lorlatinib) LUMAKRAS (sotorasib)	<ul style="list-style-type: none"> Used in combination with bortezomib and dexamethasone per PI AND History of 2 prior regimens including bortezomib and an immunomodulatory agent <p>Ibrance</p> <ul style="list-style-type: none"> Documented diagnosis of WD-DDLS for retroperitoneal sarcoma OR All other indications evaluated through clinical review <p>Lenvima</p> <ul style="list-style-type: none"> 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 <p>Lynparza Tablets</p>

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		LYNPARZA (olaparib) ^{DUR+} LYTGOBI (futibatinib) MEKTOVI (binimetnib) NERLYNX (neratinib maleate) NUBEQA (darolutamide) ODOMZO (sonidegib) OGSIVEO (nirogacestat) ^{NR} OJJAARA (mometotinib) ^{NR} ONUREG (azacitidine) ORGOVYX (relugolix) pazopanib ^{NR} 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) TRUQAP (capiwasertib) ^{NR} TUKYSA (tucatinib) UKONIQ (umbralisib) VANFLYTA (quizartinib) VERZENIO (abemaciclib) VITRAKVI (larotrectinib)	<ul style="list-style-type: none"> • Documented diagnosis of ovarian cancer, fallopian tube or peritoneal cancer AND • History of platinum-based chemotherapy in the past 2 years OR • All other indications evaluated through clinical review

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		VIZIMPRO (dacomitinib) VONJO (pacritinib) WELIREG (belzutifan) XATMEP (methotrexate) XOSPATA (gilteritinib) XPOVIO (selinexor) ZEJULA (niraparib)	
ANTIOBESITY SELECT AGENTS			
	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)	<p>Minimum Age/Weight Limit for Pediculicides</p> <ul style="list-style-type: none"> • 50 kg – lindane shampoo • 2 months – permethrin 1%(OTC) • 6 months – Natroba, Sklice • 2 years – piperonyl/pyrethrins (OTC) • 6 years – Ovide <p>Non-Preferred Criteria</p> <ul style="list-style-type: none"> • Have tried 2 preferred topical lice agents in the past 90 days
SCABICIDES			
	permethrin 5% ivermectin	ELIMITE (permethrin) EURAX CREAM (crotamiton)	<p>Minimum Age/Weight Limit for Topical Scabicides</p> <ul style="list-style-type: none"> • 50 kg – lindane lotion

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		EURAX LOTION (crotamiton) STROMEKTOL Tablet (ivermectin)	<ul style="list-style-type: none"> • 2 months – permethrin 5% • 4 years – Natroba • 18 years – Eurax <p>Non-Preferred Criteria</p> <ul style="list-style-type: none"> • History of permethrin 5% in the past 90 days
ANTIPARKINSON'S AGENTS (Oral) ^{DUR+}			
	ANTICHOLINERGICS		<p>Non-Preferred Criteria</p> <ul style="list-style-type: none"> • Documented diagnosis of Parkinson's disease AND • Have tried 2 different preferred agents in the past 6 months OR • 90 consecutive days on the requested agent in the past 105 days
	benztropine trihexyphenidyl	COGENTIN (benztropine)	
	COMT INHIBITORS		
	entacapone	COMTAN (entacapone) ONGENTYS (opicapone) TASMAR (tolcapone) tolcapone	
	DOPAMINE AGONISTS		
	ropinirole	KYNMOBI FILM (apomorphine) MIRAPEX (pramipexole)	

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		MIRAPEX ER (pramipexole) NEUPRO (rotigotine) pramipexole pramipexole ER REQUIP (ropinirole) REQUIP XL (ropinirole) ropinirole ER	
MAO-B INHIBITORS			
	selegiline	AZILECT (rasagiline) ELDEPRYL (selegiline) rasagiline XADAGO (safinamide) ZELAPAR (selegiline)	Xadago <ul style="list-style-type: none"> • Documented diagnosis of Parkinson's disease AND • History of a preferred carbidopa/levodopa combination product in the past 30 days AND • History of selegiline product in the past 45 days
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)	Lodosyn and Inbrija <ul style="list-style-type: none"> • Documented diagnosis of Parkinson's disease AND • History of a carbidopa/levodopa combination product in the past 45 days Nourianz <ul style="list-style-type: none"> • Documented diagnosis of Parkinson's Disease AND • History of a preferred carbidopa/levodopa combination product in the past 30 days AND

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		STALEVO (levodopa/carbidopa/entacapone)	<ul style="list-style-type: none"> History of 30 days therapy with a preferred adjunctive therapy in the past 45 days
ANTIPSYCHOTICS DUR+			
ORAL			
	amitriptyline/perphenazine aripiprazole asenapine clozapine fluphenazine haloperidol olanzapine olanzapine ODT perphenazine quetiapine quetiapine XR risperidone risperidone ODT thioridazine thiothixene trifluoperazine VRAYLAR (cariprazine) ziprasidone	ABILIFY (aripiprazole) ABILIFY MYCITE (aripiprazole) ADASUVE (loxapine) 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)	<p>Minimum Age Limit</p> <ul style="list-style-type: none"> 3 years – Haldol 5 years – Risperdal, thioridazine 6 years – Abilify, trifluoperazine 10 years – Latuda, Saphris, Seroquel, Symbyax 12 years – Invega, molindone, perphenazine, pimozone, thiothixene 13 years – Rexulti, Zyprexa 18 years – Abilify Mycrite, Amitriptyline/perphenazine, Caplyta, Clozaril, Fanapt, fluphenazine, Geodon, loxapine, Lybalvi, Nuplazid, Secuado, Vraylar <p>Concurrent Therapy Limit – Ages 0-17 years</p> <ul style="list-style-type: none"> 90 days with 2 or more antipsychotics in the last 120 days will require a Manual PA <p>Vraylar</p> <ul style="list-style-type: none"> Documented diagnosis of schizophrenia or schizoaffective disorder OR

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		SEROQUEL (quetiapine) SEROQUEL XR (quetiapine) SYMBYAX (olanzapine/fluoxetine) VERSACLOZ (clnazpine) ZYPREXA (olanzapine)	<ul style="list-style-type: none"> • Documented diagnosis of bipolar disorder OR • Documented diagnosis of major depressive disorder AND • 30 days of therapy with an antidepressant in the past 45 days OR • 1 claim for a 90-day supply of an antidepressant in the past 105 days <p>Non-Preferred Criteria- Atypical Agents</p> <ul style="list-style-type: none"> • 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 <p>Nuplazid</p> <ul style="list-style-type: none"> • Documented diagnosis of Parkinson's disease
INJECTABLE, ATYPICALS DUR+			
	ABILIFY ASIMTUFII (aripiprazole) ABILIFY MAINTENA (aripiprazole) ARISTADA ER (aripiprazole lauroxil) ARISTADA INITIO (aripiprazole lauroxil) INVEGA HAFYERA (paliperidone) INVEGA SUSTENNA (paliperidone palmitate)	ABILIFY (aripiprazole) GEODON (ziprasidone) olanzapine ZYPREXA (olanzapine) ZYPREXA RELPREVV (olanzapine) risperidone ^{NR}	<p>Minimum Age Limit</p> <ul style="list-style-type: none"> • 18 years – all injectable agents <p>Quantity Limit</p> <ul style="list-style-type: none"> • 3 syringes/year – Aristada Initio <p>Long-Acting Injectable Agents</p>

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	INVEGA TRINZA (paliperidone) PERSERIS (risperidone) RISPERDAL CONSTA (risperidone) UZEDY (risperidone)	RYKINDO (risperidone) ^{NR}	<p>All Agents</p> <ul style="list-style-type: none"> • Documented diagnosis of schizophrenia or schizoaffective disorder <p>Abilify Maintena, Risperdal Consta and Rykindo ER</p> <ul style="list-style-type: none"> • Documented diagnosis of schizophrenia or schizoaffective disorder OR • Documented diagnosis of bipolar disorder <p>Invega Hafyera</p> <ul style="list-style-type: none"> • Documented diagnosis of schizophrenia or schizoaffective disorder AND • 4 claims for Invega Sustenna in the past year OR • 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)	ATRIPLA (efavirenz/emtricitabine/tenofovir)	Stribild – MANUAL PA

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	CABENUVA (cabotegravir/rilpivirine) DELSTRIGO (doravirine/lamivudine/tenofovir) DOVATO (dolutegravir/lamivudine) efavirenz/emtricitabine/tenofovir labeler GENVOYA (elvitegravir/cobicistat/emtricitabine/tenofovir) ODEFSEY (emtricitabine/rilpivirine/tenofovir AF) SYMFI (efavirenz/lamivudine/tenofovir) SYMFI-LO (efavirenz/lamivudine/tenofovir) TRIUMEQ (abacavir/lamivudine/ dolutegravir)	COMPLERA (emtricitabine/rilpivirine/tenofovir) efavirenz/lamivudine/tenofovir efavirenz/lamivudine/tenofovir lo JULUCA (dolutegravir/rilpivirine) STRIBILD (elvitegravir/cobicistat/emtricitabine/tenofovir) SYMTUZA (darunavir/cobicistat/ emtricitabine/tenofovir)	<ul style="list-style-type: none"> Genotype testing supporting resistance to other regimens OR Intolerance or contraindication to preferred combination of drugs AND Medical reasoning beyond convenience or enhanced compliance over preferred agents AND 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)	<p>Non-Preferred Criteria</p> <ul style="list-style-type: none"> 1 claim with the requested agent in the past 105 days
NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS (NRTI)			
	abacavir sulfate EMTRIVA (emtricitabine) 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)			

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	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) 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)	

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Therapeutic Drug Class	Preferred Agents	Non-Preferred Agents	PA Criteria
ENTRY INHIBITORS – FUSION INHIBITORS			
		FUZEON (enfuvirtide)	
COMBINATION PRODUCTS - NRTIs			
	abacavir/lamivudine CABENUVA (cabotegravir/rilpivirine) DOVATO (dolutegravir/lamivudine) lamivudine/zidovudine	abacavir/lamivudine/zidovudine COMBIVIR (lamivudine/zidovudine) EPZICOM (abacavir/lamivudine) JULUCA (dolutegravir/rilpivirine) TRIZIVIR (abacavir/lamivudine/zidovudine)	
COMBINATION PRODUCTS – NUCLEOSIDE & NUCLEOTIDE ANALOG RTIs			
	DESCOVY (emtricitabine/tenofovir alafenam) emtricitabine/tenofovir	TRUVADA (emtricitabine/tenofovir)	
COMBINATION PRODUCTS – NUCLEOSIDE & NUCLEOTIDE ANALOGS & NON-NUCLEOSIDE RTIs			
	DELSTRIGO (doravirine/lamivudine/tenofovir) efavirenz/emtricitabine/tenofovir ODEFSEY (emtricitabine/rilpivirine/tenofovir AF)	ATRIPLA (efavirenz/emtricitabine/tenofovir) CIMDUO (lamivudine/tenofovir) COMPLERA (emtricitabine/rilpivirine/tenofovir) TEMIXYS (lamivudine/tenofovir)	
COMBINATION PRODUCTS – PROTEASE INHIBITORS			
	lopinavir/ritonavir	KALETRA (lopinavir/ritonavir)	

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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		<p>valganciclovir solution – automatic approval for age <12 years</p> <p>Prevymis Prevention (prophylaxis) of cytomegalovirus (CMV) infection and disease</p> <ul style="list-style-type: none"> • ≥ 18 years 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
	valganciclovir tablets	LIVTENCITY (maribavir) PREVYMIS (letermovir) VALCYTE (valganciclovir) valganciclovir solution	

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ANTI-HERPETIC AGENTS			
	acyclovir valacyclovir	famciclovir FAMVIR (famciclovir) SITAVIG (acyclovir) VALTREX (valacyclovir) ZOVIRAX (acyclovir)	
ANTI-INFLUENZA AGENTS			
	oseltamivir	FLUMADINE (rimantadine) RAPIVAB (peramivir) RELENZA (zanamivir) rimantadine TAMIFLU (oseltamivir) XOFLUZA (baloxavir marboxil)	
ANTIVIRALS (Topical)			
	ZOVIRAX Cream (acyclovir)	acyclovir cream, ointment DENAVIR (penciclovir) XERESE (acyclovir/hydrocortisone) ZOVIRAX Ointment (acyclovir)	
AROMATASE INHIBITORS			
	anastrozole exemestane letrozole	ARIMIDEX (anastrozole) AROMASIN (exemestane) FEMARA (letrozole)	

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ATOPIC DERMATITIS <small>DUR+</small>			
	ADBRY (tralokinumab) DUPIXENT (dupilumab) ELIDEL (pimecrolimus) PROTOPIC (tacrolimus) tacrolimus	CIBINQO (abrocitinib) EUCRISA (crisaborole) OPZELURA (ruxolitinib) pimecrolimus	<p>Minimum Age Limit</p> <ul style="list-style-type: none"> • 2 years – Elidel, Protopic 0.03% • 16 years – Protopic 0.1% <p>Cibinqo and Opzelura</p> <ul style="list-style-type: none"> • Requires clinical review <p>Adbry- MANUAL PA</p> <p>Eucrisa</p> <ul style="list-style-type: none"> • History of 28 days of therapy with a calcineurin inhibitor AND • History of 28 days of therapy with a topical steroid in the past year OR • MANUAL PA <p>Dupixent</p> <p>Evaluated through Manual PA according to diagnosis</p> <p>Asthma – MANUAL PA</p> <p>Atopic Dermatitis – MANUAL PA</p> <p>Eosinophilic Esophagitis--MANUAL PA</p> <p>PA</p> <p>Nasal Polyposis – MANUAL PA</p>

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			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 <ul style="list-style-type: none"> • Have tried 2 different preferred agents in the past 6 months OR • 90 consecutive days on the requested agent in the past 105 days
BETA- AND ALPHA-BLOCKERS			
	carvedilol labetalol	carvedilol CR COREG (carvedilol) COREG CR (carvedilol)	Coreg CR <ul style="list-style-type: none"> • Documented diagnosis for hypertension AND

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		TRANDATE (labetalol)	<ul style="list-style-type: none"> • 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	<p>Ranexa</p> <ul style="list-style-type: none"> • Documented diagnosis of angina AND • 1 claim for a calcium channel blocker, beta-blocker, nitrate, or combination agent in the past 30 days OR • 90 consecutive days on the requested agent in the past 105 days
SINUS NODE AGENTS			
		CORLANOR (ivabradine)	Corlanor - MANUAL PA

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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 oxybutin 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) trospium trospium ER VESICARE (solifenacin) VESICARE LS Suspension (solifenacin)	Non-Preferred Criteria • Have tried 2 different preferred agents in the past 6 months
BONE RESORPTION SUPPRESSION AND RELATED AGENTS ^{DUR+}			
BISPHOSPHONATES			

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	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	<p style="color: red;">Non-Preferred Criteria</p> <ul style="list-style-type: none"> • Documented diagnosis for osteoporosis or osteopenia AND • Have tried 2 different preferred agents in the past 6 months
OTHERS			
		calcitonin salmon EVENTY (romosozumab-aqqg) EVISTA (raloxifene) FORTEO (teriparatide) MIACALCIN (calcitonin) PROLIA (denosumab) raloxifene TYMLOS (abaloparatide) XGEVA (denosumab)	
BPH AGENTS <small>DUR+</small>			
		ALPHA BLOCKERS	
	alfuzosin doxazosin tamsulosin terazosin	CARDURA (doxazosin) CARDURA XL (doxazosin) dutasteride/tamsulosin FLOMAX (tamsulosin) HYTRIN (terazosin)	<p style="color: red;">Female</p> <ul style="list-style-type: none"> • Cardura, Flomax, Proscar, terazosin, or Uroxatral AND • Documented diagnosis based on a State accepted diagnosis

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		JALYN (dutasteride/tamsulosin) RAPAFLO (silodosin) silodosin UROXATRAL (alfuzosin)	<p>Non-Preferred Criteria - MALE</p> <ul style="list-style-type: none"> • Have tried 2 different preferred agents in the past 6 months OR • 90 consecutive days on the requested agent in the past 105 days
	5-ALPHA-REDUCTASE (5AR) INHIBITORS		
	finasteride	AVODART (dutasteride) dutasteride ENTADFI (finasteride/tadalafil) PROSCAR (finasteride)	
	PDE5 INHIBITORS		
		CIALIS (tadalafil)	
BRONCHODILATORS & COPD AGENTS			
	ANTICHOLINERGICS & COPD AGENTS		<p>Minimum Age Limit 6 years – Spiriva Respimat</p> <p>Spiriva Respimat</p> <ul style="list-style-type: none"> • Automatic approval for ≥ 6 years with a diagnosis of asthma
	ATROVENT HFA (ipratropium) INCRUSE ELLIPTA (umeclidinium) ipratropium SPIRIVA HANDIHALER (tiotropium)	DALIRESP (roflumilast) LONHALA MAGNAIR (glycopyrrolate) roflumilast SEEBRI (glycopyrrolate) SPIRIVA RESPIMAT (tiotropium) ^{DUR+} TUDORZA PRESSAIR (aclidinium) YUPELRI (revefenacin)	
	ANTICHOLINERGIC-BETA AGONIST COMBINATIONS		
	albuterol/ipratropium ANORO ELLIPTA (umeclidinium/vilanterol)	BEVESPI (glycopyrrolate/formoterol) DUAKLIR PRESSAIR (aclidinium/formoterol)	

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	COMBIVENT RESPIMAT (albuterol/ipratropium) ^{DUR+} STIOLTO RESPIMAT (tiotropium/olodaterol)		
ANTICHOLINERGIC-BETA AGONIST-GLUCOCORTICOID COMBINATIONS			
		BREZTRI AEROSPHERE (budesonide/glycopyrrolate/formoterol) TRELEGY ELLIPTA (fluticasone furoate/ umeclidinium/vilanterol)	
BRONCHODILATORS, BETA AGONIST			
INHALERS, SHORT-ACTING			
	albuterol HFA PROVENTIL HFA (albuterol) VENTOLIN HFA (albuterol)	levalbuterol HFA PROAIR DIGIHALER (albuterol) PROAIR RESPICLICK (albuterol) XOPENEX HFA (levalbuterol) ^{DUR+}	<p>Minimum Age Limit</p> <ul style="list-style-type: none"> • 4 years - Xopenex HFA <p>Xopenex HFA</p> <ul style="list-style-type: none"> • 1 claim for a preferred albuterol inhaler in the past 30 days <p>ProAir Digihaler</p> <ul style="list-style-type: none"> • Requires clinical review
INHALERS, LONG ACTING^{DUR+}			
	SEREVENT (salmeterol) STRIVERDI RESPIMAT (olodaterol)		<p>Minimum Age Limit</p> <ul style="list-style-type: none"> • 4 years – Serevent • 18 years -Striverdi Respimat

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INHALATION SOLUTION ^{DUR+}				
	albuterol	arformoterol BROVANA (arformoterol) formoterol levalbuterol metaproterenol PERFOROMIST (formoterol) XOPENEX (levalbuterol)	<p>Minimum Age Limit</p> <ul style="list-style-type: none"> • 6 years – Xopenex • 18 years – Brovana, Perforomist <p>Non-Preferred Criteria</p> <ul style="list-style-type: none"> • 1 claim for a different preferred agent in the past 6 months OR • 3 claims with the requested agent in the past 105 days <p>Xopenex</p> <ul style="list-style-type: none"> • 1 claim for a preferred albuterol in the past 30 days 	
ORAL				
	albuterol ER albuterol IR metaproterenol terbutaline	VOSPIRE ER (albuterol)		
CALCIUM CHANNEL BLOCKERS ^{DUR+}				
SHORT-ACTING				

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

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		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 AUGMENTIN XR (amoxicillin/clavulanate) MOXATAG (amoxicillin)	

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CEPHALOSPORINS – First Generation ^{DUR+}			<p style="color: red;">Non-Preferred Criteria – all generations</p> <ul style="list-style-type: none"> • 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+}			<p style="color: red;">Maximum Age Limit</p> <ul style="list-style-type: none"> • 18 years – cefdinir suspension
	cefdinir suspension cefdinir capsules cefpodoxime	CEDAX (ceftibuten) cefditoren ceftibuten SPECTRACEF (cefditoren) SUPRAX (cefixime)	
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) ROLVEDON (eflapegrastim) UDENYCA (pegfilgrastim-cbqv) ZARXIO (filgrastim)	

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		ZIEXTENZO (pegfilgrastim-bmez)	
CYSTIC FIBROSIS AGENTS ^{DUR+}			
	tobramycin (generic TOBI)	BETHKIS (tobramycin) BRONCHITOL (mannitol) CAYSTON (aztreonam) colistimethate 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)	<p>Minimum Age Limit</p> <ul style="list-style-type: none"> • 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 <p>Maximum Age Limit</p> <ul style="list-style-type: none"> • 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 <p>All Agents</p> <ul style="list-style-type: none"> • Documented diagnosis Cystic Fibrosis <p>Colistimethate</p>

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			<ul style="list-style-type: none"> • Documented diagnosis of Cystic Fibrosis OR • Requires clinical review <p>Kalydeco – MANUAL PA Orkambi – MANUAL PA Symdeko – MANUAL PA Trikafta – MANUAL PA</p> <p>TOBI Podhaler</p> <ul style="list-style-type: none"> • 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)	ABRILADA (adalimumab-afzb) ^{NR} ACTEMRA ACTPEN (tocilizumab) AMJEVITA (adalimumab) ARCALYST (rilonacept) BIMZELX (bimekizumab-bkzx) ^{NR} CIMZIA (certolizumab) COSENTYX (secukinumab) COSENTYX VIAL (secukinumab) ^{NR} CYLTEZO (adalimumab-adbm) ENTYVIO (vedolizumab) ENTYVIO SQ (vedolizumab) ^{NR} HADLIMA (adalimumab) HULIO (adalimumab) HYRIMOZ (adalimumab) IDACIO (adalimumab) ILARIS (canakinumab) ILUMYA (tildrakizumab)	<p>All preferred agents are subject to approved age and documented diagnosis for appropriate indication.</p> <p>All Non-Preferred Agents</p> <ul style="list-style-type: none"> • Require clinical review <p>IV Administered Agents</p> <ul style="list-style-type: none"> • Require clinical review

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		INFLECTRA (infliximab) JYLAMVO (methotrexate) ^{NR} KEVZARA (sarilumab) LITFULO (ritlecitinib) OLUMIANT (baricitinib) OMVOH (mirikizumab-mrkz) ^{NR} ORENCIA SYRINGE (abatacept) OTREXUP (methotrexate) RASUVO (methotrexate) REMICADE (infliximab) 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) YUSIMRY (adalimumab)	
ERYTHROPOIESIS STIMULATING PROTEINS ^{DUR+}			

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	EPOGEN (rHuEPO) MIRCERA (methoxy polyethylene glycol-epoetin-beta) RETACRIT (rHuEPO)	ARANESP (darbepoetin) PROCRIPT (rHuEPO) JESDUVROQ (daprodustat) ^{NR}	<p>Mircera</p> <ul style="list-style-type: none"> Documented diagnosis chronic renal failure in the past 2 years <p>Non-Preferred Criteria</p> <ul style="list-style-type: none"> 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 <p>Jesduvroq</p> <ul style="list-style-type: none"> Requires clinical review
FACTOR DEFICIENCY PRODUCTS			
	FACTOR VIII		
	ADVATE AFSTYLA ALPHANATE FEIBA NF HEMOFIL M HUMATE-P KOATE KOGENATE FS KOVALTRY NOVOEIGHT	ADYNOVATE ALTUVIIIIO ELOCTATE ESPEROCT HEXILATE FS JIVI KCENTRA OBIZUR VONVENDI	

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	NUWIQ RECOMBINATE WILATE XYNTHA XYNTHA SOLOFUSE		
FACTOR IX			
	ALPHANINE SD ALPROLIX BENEFIX IDELVION IXINITY MONONINE PROFILNINE RIXUBIS	REBINYN	
OTHER FACTOR PRODUCTS			
	COAGADEX FIBRYGA HEMLIBRA ^{DUR+} RIASTAP	CORIFACT NOVOSEVEN RT SEVENFACT TRETEN	Hemlibra <ul style="list-style-type: none"> 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)	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

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		LYRICA CR (pregabalin) NEURONTIN (gabapentin) pregabalin ER	
FLUOROQUINOLONES ^{DUR+}			
	ciprofloxacin tablets levofloxacin tablets	AVELOX (moxifloxacin) BAXDELA (delafloxacin) CIPRO (ciprofloxacin) CIPRO SUSPENSION (ciprofloxacin) CIPRO XR (ciprofloxacin) ciprofloxacin ER ciprofloxacin suspension FACTIVE (gemifloxacin) LEVAQUIN (levofloxacin) levofloxacin solution moxifloxacin NOROXIN (norfloxacin) ofloxacin	<p style="color: red;">Non-Preferred Criteria</p> <ul style="list-style-type: none"> • 1 claim for a preferred agent in past 30 days <p style="color: red;">Cipro Suspension for age < 12 years</p> <ul style="list-style-type: none"> • Anthrax infection or exposure OR • Cystic Fibrosis OR • Pneumonic plague OR tularemia AND history of doxycycline in the past 3 months OR • 7 days of therapy with a preferred agent from 2 of the classes below in the past 3 months <ul style="list-style-type: none"> ○ Penicillin, 2nd or 3rd generation cephalosporin, or macrolide <p style="color: red;">Levaquin solution for age < 12 years</p> <ul style="list-style-type: none"> • Anthrax infection or exposure OR • 7 days of therapy with a preferred agent from 2 of the classes below in the past 3 months <ul style="list-style-type: none"> ○ Penicillin, 2nd or 3rd generation cephalosporin, or macrolide <p style="color: red;">AND</p>

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			<ul style="list-style-type: none"> • Cipro suspension in the past 3 months
GAUCHER'S DISEASE			
	ELELYSO (taliglucerase alfa) ZAVESCA (miglustat)	CERDELGA (eliglustat) CEREZYME (imiglucerase) miglustat VPRIV (velaglucerase alfa)	
GENITAL WARTS & ACTINIC KERATOSIS AGENTS			
	CONDYLOX (podofilox) ^{Age Edit} imiquimod ^{Age Edit} podofilox ^{Age Edit}	ALDARA (imiquimod) ^{Age Edit} CARAC (fluorouracil) diclofenac 3% gel EFUDEX (fluorouracil) fluorouracil 0.5% cream fluorouracil 5% cream PICATO (ingenol) ^{Age Edit} SOLARAZE (diclofenac) TOLAK (fluorouracil) VEREGEN (sinecatechins) ^{Age Edit} ZYCLARA (imiquimod) ^{Age Edit}	<p style="color: red;">Minimum Age Limit</p> <ul style="list-style-type: none"> • 12 years – Aldara, Zyclara • 18 years – Condylox, Picato, Veregen
GLUCOCORTICOIDS (Inhaled)^{DUR+}			
	GLUCOCORTICOIDS		
	ASMANEX TWISTHALER (mometasone) budesonide 0.25mg and 0.5mg PULMICORT FLEXHALER (budesonide) QVAR REDIHALER (beclomethasone dipropionate)	ALVESCO (ciclesonide) ARMONAIR Digihaler (fluticasone) ARNUITY ELLIPTA (fluticasone) ASMANEX HFA (mometasone) budesonide 1mg	<p style="color: red;">Minimum Age Limit</p> <ul style="list-style-type: none"> • 1 year – Pulmicort respules • 4 years – Asmanex Twisthaler, fluticasone Diskus, fluticasone HFA, Qvar Redihaler • 5 years – Arnuity Ellipta

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		fluticasone diskus fluticasone HFA PULMICORT (budesonide) Respules	<ul style="list-style-type: none"> 6 years – Pulmicort Flexhaler 12 years – Alvesco, ArmonAir, Asmanex HFA <p>Fluticasone HFA (generic Flovent HFA)</p> <ul style="list-style-type: none"> Automatic approval for ages 4-5 years with a diagnosis of asthma OR Have tried 2 preferred agents in the past 6 months OR <ul style="list-style-type: none"> 90 consecutive days on the requested agent in the past 105 days <i>Note: Age waiver prior authorization submission will be required for Fluticasone HFA for children less than 4 years of age</i> <p>Non-Preferred Criteria</p> <ul style="list-style-type: none"> Have tried 2 preferred single entity agents in the past 6 months OR 90 consecutive days on the requested agent in the past 105 days <p>ArmonAir Digihaler</p> <ul style="list-style-type: none"> Requires clinical review <p><u>NOTE:</u> Institutional sized products are Non-Preferred</p>

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GLUCOCORTICOID/BRONCHODILATOR COMBINATIONS			
	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) AIRSUPRA (budesonide/albuterol) ^{NR}	<p>Minimum Age Limit</p> <ul style="list-style-type: none"> • 4 years – Advair Diskus, Wixela Inhub • 5 years – Breo Ellipta 50-25mcg • 6 years – Symbicort • 12 years – Advair HFA, AirDuo Digihaler, AirDuo Respiclick, Breo Ellipta 100-25mcg • 18 years – Airsupra, Breo Ellipta 200-25mcg <p>Quantity Limit</p> <ul style="list-style-type: none"> • 2 inhalers/31 days – Airsupra <p>Non-Preferred Criteria</p> <ul style="list-style-type: none"> • Have tried 2 preferred combination agents in the past 6 months OR • 90 consecutive days on the requested agent in the past 105 days <p>AirDuo Digihaler and Airsupra</p> <ul style="list-style-type: none"> • Requires clinical review
GI ULCER THERAPIES			
H2 RECEPTOR ANTAGONISTS			
	cimetidine solution famotidine solution famotidine tablets	AXID (nizatidine) cimetidine tablets nizatidine tablets	

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	nizatidine solution	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 KONVOME P 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			
	misoprostol sucralfate suspension sucralfate tablet	CARAFATE SUSPENSION (sucralfate) CARAFATE TABLET (sucralfate) CYTOTE C (misoprostol) DARTISLA ODT (glycopyrrolate) VOQUEZNA (vonoprazan) ^{NR}	
GROWTH HORMONE DUR+			
	GENOTROPIN (somatropin)	HUMATROPE (somatropin)	All Agents for Age ≥ 18 years

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	NORDITROPIN (somatropin) NUTROPIN AQ (somatropin)	NGENLA (somatrogon-ghla) OMNITROPE (somatropin) SAIZEN (somatropin) SEROSTIM (somatropin) SKYTROFA (lonapegsomatropin) SOGROYA (somapacitan) VOXZOGO (vosoritide) ZOMACTON (somatropin) ZORBTIVE (somatropin)	<ul style="list-style-type: none"> Documented diagnosis of craniopharyngioma, panhypopituitarism, Prader-Willi Syndrome, Turner Syndrome or an approvable adult diagnosis OR Documented procedure of cranial irradiation <p>All Agents for Age < 18 years</p> <ul style="list-style-type: none"> Documented diagnosis of idiopathic short stature AND Documented approvable pediatric diagnosis OR Documented approvable pediatric diagnosis <p>Minimum Age Limit</p> <ul style="list-style-type: none"> 3 years – Ngenia <p>Maximum Age Limit</p> <ul style="list-style-type: none"> 18 years - Ngenia <p>Non-Preferred Criteria</p> <ul style="list-style-type: none"> Have tried 1 preferred agent in the past 6 months OR 84 consecutive days on the requested agent in the past 105 days

H. PYLORI COMBINATION TREATMENTS

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	PYLERA (bismuth subcitrate potassium, metronidazole, tetracycline)	bismuth subcitrate potassium, metronidazole, tetracycline lansoprazole, amoxicillin, clarithromycin OMECLAMOX (omeprazole, clarithromycin, amoxicillin) PREVPAC (lansoprazole, amoxicillin, clarithromycin) TALICIA (omeprazole, amoxicillin, rifabutin) VOQUEZNA DUAL PAK (vonoprazan, amoxicillin) ^{NR} VOQUEZNA TRIPLE PAK (vonoprazan, amoxicillin, clarithromycin) ^{NR}	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) PEG-INTRON (peginterferon alfa-2b)	COPEGUS (ribavirin) EPCLUSA (sofosbuvir/velpatasvir) ∞ HARVONI (ledipasvir/sofosbuvir) ∞ ledipasvir/sofosbuvir∞	∞ Epclusa, Harvoni, Mavyret, Sovaldi, Vosevi, Zepatier • Require clinical review

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	ribavirin tablets sofosbuvir/velpatasvir [∞]	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) [∞]	<u>Note:</u> Epclusa, Harvoni, Mavyret and Sovaldi have FDA pediatric indications <u>MANUAL PA</u>
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 probenecid/colchicine	colchicine capsule COLCRYS (colchicine) febuxostat GLOPERBA (colchicine)	Non-Preferred Criteria • Have tried 2 different preferred agents in the past 6 months

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		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)	<p>Minimum Age Limit</p> <ul style="list-style-type: none"> • 2 years – Gvoke • 4 years – Baqsimi • 6 years – Zegalogue <p>Quantity Limit</p> <ul style="list-style-type: none"> • 2 packs/31 days – Baqsimi • 2 syringes/31 days – Gvoke, Zegalogue • 2 kits/31 days – Glucagon <p>Gvoke</p> <ul style="list-style-type: none"> • 1 claim with Baqsimi or Zegalogue in the past 30 days <p>Non-Preferred Glucagons</p> <ul style="list-style-type: none"> • Have tried 1 different preferred glucagon in the past 30 days

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Updated:1/31/2024

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
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) ZITUVIO (sitagliptin) ^{NR}	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)	Minimum Age Limit • 10 years – Bydureon Bcise, Trulicity, Victoza • 18 years – Byetta, Mounjaro, Ozempic, Rybelsus

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		OZEMPIC (semaglutide) RYBELSUS (semaglutide) SOLIQUA (insulin glargine/lixisenatide) SYMLIN (pramlintide) XULTOPHY (insulin degludec/ liraglutide)	<p>Preferred Criteria</p> <ul style="list-style-type: none"> • Documented diagnosis for Type 2 Diabetes OR • Have history of 84 days of therapy with the requested agent in the past 105 days <p>Non-Preferred Criteria</p> <ul style="list-style-type: none"> • 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 <p>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.</p>

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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)	Insulin pen formulations are not covered for Long Term Care (LTC) beneficiaries. Non-Preferred Criteria <ul style="list-style-type: none"> • Documented diagnosis of Diabetes Mellitus AND • Have tried 1 preferred product in the past 6 months OR • 1 claim with the requested agent in the past 105 days Quantity Limit <ul style="list-style-type: none"> • Insulin Quantity Limits found here

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Therapeutic Drug Class	Preferred Agents	Non-Preferred Agents	PA Criteria
		REZVOGLAR (insulin glargine) 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)	INPEFA (sotagliflozin) STEGLATRO (ertugliflozin)	
HYPOGLYCEMICS, SODIUM GLUCOSE COTRANSPORTER-2 INHIBITOR COMBINATIONS			
	INVOKAMET (canagliflozin/metformin) SYNJARDY (empagliflozin/metformin)	GLYXAMBI (empagliflozin/linagliptin) INVOKAMET XR (canagliflozin/metformin) QTERN (dapagliflozin/saxagliptin) SEGLUROMET (ertugliflozin/metformin) STEGLUJAN (ertugliflozin/sitagliptin) SYNJARDY XR (empagliflozin/metformin) TRIJARDY XR (empagliflozin/linagliptin/metformin) XIGDUO XR (dapagliflozin/metformin)	
HYPOGLYCEMICS, TZDS			
THIAZOLIDINEDIONES			

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	pioglitazone	ACTOS (pioglitazone) 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)	ASTAGRAF XL (tacrolimus) ENVARUSUS 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

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	SANDIMMUNE (cyclosporine) sirolimus tacrolimus		<ul style="list-style-type: none"> • Documented diagnosis of kidney transplant, RA, or a State accepted diagnosis <p>Gengraf, Neoral, Sandimmune</p> <ul style="list-style-type: none"> • 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 <p>Myfortic</p> <ul style="list-style-type: none"> • Documented diagnosis of kidney transplant or psoriasis <p>Rapamune</p> <ul style="list-style-type: none"> • Documented diagnosis of kidney transplant <p>Zortress</p> <ul style="list-style-type: none"> • Documented diagnosis of kidney transplant or liver transplant
IMMUNE GLOBULINS			
	BIVIGAM CARIMUNE NF FLEBOGAMMA DIF GAMASTAN SD GAMMAGARD	ASCENIV CABLIVI CUTAQUIG CUVITRU GAMMAKED	

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	GAMMAGARD SD GAMUNEX-C HIZENTRA HYQVIA PANZYGA PRIVIGEN XEMBIFY	GAMMAPLEX OCTAGAM	
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)	
ANTIHIISTAMINES			
	azelastine	ASTEPRO (azelastine) olopatadine PATANASE (olopatadine)	
ANTIHIISTAMINE/CORTICOSTEROID COMBINATION ^{DUR+}			
		azelastine/fluticasone DYMISTA (azelastine/fluticasone) RYALTRIS (olopatadine/mometasone) TICALAST (azelastine/fluticasone)	
CORTICOSTEROIDS ^{DUR+}			

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	fluticasone ^{Rx Only}	BECONASE AQ (beclomethasone) budesonide flunisolide mometasone NASONEX (mometasone) OMNARIS (ciclesonide) QNASL (beclomethasone) TICANASE KIT (flonase kit) triamcinolone VERAMYST (fluticasone) XHANCE (fluticasone) ZETONNA (ciclesonide)	Non-Preferred Criteria <ul style="list-style-type: none"> • Documented diagnosis for allergic rhinitis AND • 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)	IBSRELA (tenapanor) LINZESS 72mcg (linaclotide) linaclotide lubiprostone MOTEGRITY (prucalopride) MOVANTIK (naloxegol) RELISTOR (methylnaltrexone) SYMPROIC (naldemedine) TRULANCE (plecanatide)	Minimum Age Limit <ul style="list-style-type: none"> • 1 year – Gattex • 6 years – Linzess 72mcg • 18 years – Amitiza, Ibsrela, Linzess 145mcg & 290mcg, Motegrity, Movantik, Mytesi, Relistor, Symproic, Trulance, Viberzi, Xermelo

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		ZELNORM (tegaserod)	<p>Gender Limit</p> <ul style="list-style-type: none"> • Female – Amitiza 8mcg <p>Chronic Idiopathic Constipation (CIC) AMITIZA 24MCG, LINZESS 72MCG, LINZESS 145 MCG, MOTEGRITY, TRULANCE</p> <p>All CIC Agents</p> <ul style="list-style-type: none"> • Documented diagnosis of CIC in the past year AND • No history of GI or bowel obstruction <p>Non-Preferred CIC Agents</p> <ul style="list-style-type: none"> • Age 18 years AND • Documented diagnosis of CIC AND • No history of GI or bowel obstruction AND • 30 days of therapy with 2 preferred agents in the past 6 months OR • 1 claim with the requested agent in the past 105 days <p>Linzess 72 mcg</p> <ul style="list-style-type: none"> • Age 6-17 years AND

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			<ul style="list-style-type: none"> Documented diagnosis of CIC or pediatric functional constipation in the past year AND No history of GI or bowel obstruction <p><u>Irritable Bowel Syndrome – Constipation Dominant (IBS-C)</u> AMITIZA 8MCG, IBSRELA, LINZESS 290 MCG, TRULANCE</p> <p>All IBS-C Agents</p> <ul style="list-style-type: none"> Documented diagnosis of IBS-C in the past year AND No history of GI or bowel obstruction <p>Non-Preferred IBS-C Agents</p> <ul style="list-style-type: none"> Above IBS-C criteria AND 30 days of therapy with 2 preferred agents in the past 6 months OR 1 claim with the requested agent in the past 105 days <p><u>Opioid Induced Constipation (OIC)</u> AMITIZA 24MCG, MOVANTIK, RELISTOR, SYMPROIC</p> <p>All OIC Agents</p> <ul style="list-style-type: none"> Documented diagnosis of OIC in the past year AND

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			<ul style="list-style-type: none"> • 1 claim for an opioid in the past 30 days AND • No history of GI or bowel obstruction AND • Documented diagnosis of chronic pain in the past year <p>Non- Preferred OIC Agents</p> <ul style="list-style-type: none"> • Above OIC criteria AND • 30 days of therapy with 2 preferred agents in the past 6 months OR • 1 claim with the requested agent in the past 105 days <p>Relistor Injection</p> <ul style="list-style-type: none"> • Above OIC criteria AND • Documented diagnosis of active cancer in the past year AND • Documented diagnosis of palliative care in the past 6 months
IRRITABLE BOWEL SYNDROME DIARRHEA			
	dicyclomine hyoscyamine	alosetron BENTYL (dicyclomine) LEVSIN (hyoscyamine) LEVSIN-SL (hyoscyamine) LOTRONEX (alosetron) VIBERZI (eluxadoline)*	<p>Viberzi</p> <ul style="list-style-type: none"> • Documented diagnosis of Irritable Bowel Syndrome – Diarrhea Dominant (IBS-D) in the past year AND • 30 days of therapy with 2 preferred agents in the past 6 months OR • 1 claim with the requested agent in the past 105 days

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(For All Medicaid, MSCAN and CHIP Beneficiaries)

EFFECTIVE 2/1/2024
Version 2024
Updated:1/31/2024

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			<p>Lotronex</p> <ul style="list-style-type: none"> • 1 claim for the requested agent in the past 105 days OR • MANUAL PA - All new patients require manual review <p>Xifaxan - (see Antibiotics, GI)</p>
SHORT BOWEL SYNDROME AND SELECTED GI AGENTS			
		<p>GATTEX (teduglutide) MYTESI (crofelemer) NUTRESTORE POWDER PACK (glutamine) XERMELO (telotristat ethyl) ZORBTIVE (somatropin)</p>	<p>Carcinoid Syndrome Agent XERMELO</p> <ul style="list-style-type: none"> • Documented diagnosis of carcinoid syndrome in the past year AND • 1 claim for a somatostatin analog in the past 30 days <p>HIV/AIDS Non-infectious Diarrhea MYTESI</p> <ul style="list-style-type: none"> • Documented diagnosis of HIV/AIDS in the past year AND • Documented diagnosis of non-infectious diarrhea in the past year AND • 1 claim for an antiretroviral in the past 30 days <p>Short Bowel Syndrome (SBS) GATTEX, NUTRESTORE, ZORBTIVE</p>

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			<p>Gattex or Zorbtive</p> <ul style="list-style-type: none"> • 1 claim for the requested agent in the past 105 days OR • All new patients require clinical review <p>Nutrestore</p> <ul style="list-style-type: none"> • Requires clinical review
LEUKOTRIENE MODIFIERS ^{DUR+}			
	montelukast granules montelukast tablets zafirlukast	ACCOLATE (zafirlukast) SINGULAIR Tablets (montelukast) SINGULAR GRANULES (montelukast granules) zileuton ZYFLO CR (zileuton)	<p>Minimum Age Limit</p> <ul style="list-style-type: none"> • 12 years – Zyflo & Zyflo CR <p>Non-Preferred Criteria</p> <ul style="list-style-type: none"> • Have tried 2 different preferred agents in the past 6 months
LIPOTROPICS, OTHER (NON-STATINS)			
ACL INHIBITORS AND COMBINATIONS			
		NEXLETOL (bempedoic acid) NEXLIZET (bempedoic acid/ezetimibe)	<p>Nexletol and Nexlizet</p> <ul style="list-style-type: none"> • Requires clinical review
ANGIOPOIETIN LIKE 3 INHIBITORS			
		EVKEEZA (evinacumab-dgnb)	<p>Non-Preferred Criteria</p> <p>Have tried 2 different preferred Non-statin Lipotropic agents in the past 6 months</p>
BILE ACID SEQUESTRANTS			

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	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) TRILIPIX (fenofibric acid)	Fibric Acid Derivative Non-Preferred Criteria <ul style="list-style-type: none"> Have tried 2 different fibric acid derivatives in the past 6 months
MTP INHIBITOR			
		JUXTAPID (lomitapide)	Juxtapid – MANUAL PA
APOLIPOPROTEIN B-100 SYNTHESIS INHIBITOR			

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		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 <small>DUR+</small>			
	STATINS		
	atorvastatin lovastatin pravastatin rosuvastatin simvastatin	ALTOPREV (lovastatin) ATORVALIQ SUSPENSION (atorvastatin) CRESTOR (rosuvastatin) EZALLOR SPRINKLE (rosuvastatin) FLOLIPID (simvastatin) fluvastatin ER fluvastatin LESCOL (fluvastatin) LESCOL XL (fluvastatin) LIPITOR (atorvastatin) LIVALO (pitavastatin) MEVACOR (lovastatin)	Minimum Age Limit • 10 years – Atorvaliq suspension 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 Simvastatin 80mg

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		pitavastatin ^{NR} PRAVACHOL (pravastatin) ZOCOR (simvastatin) ZYPITAMAG (pitavastatin)	<ul style="list-style-type: none"> Daily doses of 80mg and greater require clinical review
STATIN COMBINATIONS			
	ezetimibe/simvastatin SIMCOR (simvastatin/niacin)	ADVICOR (lovastatin/niacin) atorvastatin/amlodipine CADUET (atorvastatin/amlodipine) LIPTRUZET (atorvastatin/ezetimibe) VYTORIN (simvastatin/ezetimibe)	<p style="color: red;">Non-Preferred Criteria</p> <ul style="list-style-type: none"> Have tried 2 different preferred statin or statin combination agents in the past 6 months OR 90 consecutive days on the requested agent in the past 105 days
MISCELLANEOUS BRAND/GENERIC			
EPINEPHRINE			
	epinephrine autoinject pens (labeler 49502) SYMJEPI (epinephrine)	ADRENACLICK (epinephrine) AUVI-Q (epinephrine) EPINEPHRINE SNAP EMS KIT (epinephrine) EPIPEN (epinephrine) EPIPEN JR (epinephrine)	<p style="color: red;">Quantity Limit</p> <ul style="list-style-type: none"> 2 kits/31 days
MISCELLANEOUS			
	alprazolam carglumic acid hydroxyzine hcl syrup hydroxyzine hcl tablets hydroxyzine pamoate megestrol suspension 625mg/5mL REVLIMID (lenalidomide)	alprazolam ER CAMZYOS (mavacamten) CARBAGLU (carglumic acid) EVRYSDI (risdiplam) INPEFA (sotagliflozin) ^{NR} KORLYM (mifepristone) lenalidomide MEGACE ES (megestrol)	<p style="color: red;">Alprazolam ER CUMULATIVE quantity limit</p> <ul style="list-style-type: none"> 31 tablets/31 days <p style="color: red;">EvrySDI - MANUAL PA</p>

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		VERQUVO (vericiguat) VISTARIL (hydroxyzine pamoate)	
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)	<p style="color: red;">Austedo and Austedo XR</p> <ul style="list-style-type: none"> 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 <p style="color: red;">Ingrezza</p> <ul style="list-style-type: none"> Documented diagnosis of Huntington's chorea OR Documented diagnosis of tardive dyskinesia AND

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			<ul style="list-style-type: none"> • 90 days therapy with Ingrezza in the past 105 days OR • MANUAL PA
MULTIPLE SCLEROSIS AGENTS <small>DUR+</small>			
	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)	<p>All Agents</p> <ul style="list-style-type: none"> • Documented diagnosis of multiple sclerosis <p>Non-Preferred Criteria</p> <ul style="list-style-type: none"> • Have tried 2 different preferred agents in the past 6 months OR • 3 claims with the requested agent in the last 105 days <p>Kesimpta, Ponvory, Tascenso ODT, and Zeposia</p> <ul style="list-style-type: none"> • Requires clinical review <p>Mavenclad – MANUAL PA</p> <p>Mayzent – MANUAL PA</p> <p>Ocrevus – MANUAL PA</p>
MUSCULAR DYSTROPHY AGENTS			
	EMFLAZA (deflazacort)	AMONDYS 45 (casimersen) ELEVIDYS (delandistrogene moxeparvovec-rokl) ^{NR}	<p>Emflaza – Clinical Review</p> <p>Exondys – MANUAL PA</p> <p>Viltepsa – MANUAL PA</p>

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		EXONDYS 51 (etelplisen) VILTEPSO (viltolarsen) VYONDYS 53 (golodirsen)	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 NALFON (fenoprofen) NAPRELAN (naproxen) NAPROSYN (naproxen) naproxen 275mg and 550mg NUPRIN (ibuprofen) oxaprozin	<p>Non-Preferred Criteria</p> <ul style="list-style-type: none"> • Have tried 2 different preferred non-selective or NSAID/GI protectant combination agents in the past 6 months <p>Quantity Limit</p> <ul style="list-style-type: none"> • 20 tablets/31 days – ketorolac tablets

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		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 <ul style="list-style-type: none"> • Have tried 2 different preferred non-selective or NSAID/GI protectant combination agents in the past 6 months
		COX II SELECTIVE	
	meloxicam	CELEBREX (celecoxib) celecoxib ELYXYB (celecoxib) MOBIC (meloxicam) NULOX (meloxicam) QMIIZ ODT (meloxicam) VIVLODEX (meloxicam)	Non-Preferred Criteria – COX II <ul style="list-style-type: none"> • Documented diagnosis of Osteoarthritis, Rheumatoid Arthritis, Familial Adenomatous Polyposis, or Ankylosing Spondylitis AND • 90 consecutive days on the requested agent in the past 105 days OR • Have tried 1 preferred COX-II Selective and 1 preferred Non-Selective Agent OR • Have tried 1 preferred COX-II Selective agent and a documented diagnosis of GI Bleed, GERD, PUD,

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			GI Perforation, or Coagulation Disorder 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) NEOSPORIN (bacitracin/neomycin/gramicidin) (oxy-tcn/polymyx sul) OCUFLOX (ofloxacin) POLYTRIM (polymyxin/trimethoprim) sulfacetamide TOBEX drops (tobramycin) TOBEX ointment (tobramycin) VIGAMOX (moxifloxacin)	

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		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 flurbiprofen FML FORTE (fluorometholone) FML SOP (fluorometholone) ketorolac MAXIDEX (dexamethasone) prednisolone acetate prednisolone NA phosphate	ACULAR (ketorolac) ACULAR LS (ketorolac) ACUVAIL (ketorolac) BROMDAY (bromfenac) bromfenac BROMSITE (bromfenac) DUREZOL (difluprednate) FML (fluorometholone) ILEVRO (nepafenac) INVELTYS (loteprednol etabonate) LOTEMAX (loteprednol) LOTEMAX SM (loteprednol)	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
	PRED MILD (prednisolone) VEXOL (rimexolone)	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}	ALOCRI (nedocromil) ALOMIDE (Iodoxamide) BEPREVE (bepotastine) epinastine LASTACAFT (alcaftadine) PATADAY (olopatadine) PATANOL (olopatadine) PAZEO (olopatadine) VERKAZIA (cyclosporine) ZERVIA (cetirizine)	Non-Preferred Criteria <ul style="list-style-type: none"> • Have tried 2 different preferred agents in the past 6 months Verkazia <ul style="list-style-type: none"> • Requires clinical review
OPHTHALMIC, DRY EYE AGENTS			
	RESTASIS droperette (cyclosporine)	CEQUA (cyclosporine 0.09%) EYSUVIS (loteprednol etabonate) MIEBO (perfluorohexyloctane) RESTASIS Multidose (cyclosporine) TYRVAYA (varaenicine) Nasal VEYVE (cyclosporine ophthalmic solution) ^{NR} XIIDRA (lifitegrast) ^{Dur +}	Minimum Age Limit <ul style="list-style-type: none"> • 16 years – Restasis • 17 years – Xiidra • 18 years – Cequa, Miebo, Vevye Quantity Limit <ul style="list-style-type: none"> • 2 ml/31 days – Vevye • 3 ml/31 days – Miebo

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			<ul style="list-style-type: none"> • 5.5 mL/31 days – Restasis Multidose • 60 units/31 days – Cequa, Restasis droperette, Xiidra <p>Eysuvis, Miebo and Tyrvaya</p> <ul style="list-style-type: none"> • Requires clinical review <p>Non-Preferred Criteria</p> <ul style="list-style-type: none"> • History of 4 claims for Restasis in the past 6 months
OPHTHALMIC, GLAUCOMA AGENTS <small>DUR+</small>			
	BETA BLOCKERS		
	BETIMOL (timolol) carteolol ISTALOL (timolol) levobunolol metipranolol timolol drops 0.25%, 0.5%	BETAGAN (levobunolol) betaxolol BETOPTIC S (betaxolol) OPTIPRANOLOL (metipranolol) timolol gel timolol daily drop 0.5% (generic Istalol) TIMOPTIC (timolol) TIMOPTIC XE (timolol)	<p>Non-Preferred Criteria</p> <ul style="list-style-type: none"> • Have tried 2 different preferred agents in the past 6 months OR • 90 consecutive days on the requested agent in the past 105 days <p>Minimum Age Limit</p> <ul style="list-style-type: none"> • 18 years - lyuzeh
	CARBONIC ANHYDRASE INHIBITORS		

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	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 IYUZEH (latanoprost) LUMIGAN (bimatoprost) TRAVATAN Z (travoprost) travoprost VYZULTA (latanoprostene bunod) XALATAN (latanoprost) XELPROS (latanoprost) ZIOPTAN (tafluprost)	
RHO KINASE INHIBITORS/COMBINATIONS			
	RHOPRESSA (netarsudil) ROCKLATAN (netarsudil/latanoprost)		
SYMPATHOMIMETICS			

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	ALPHAGAN P 0.1% (brimonidine) ALPHAGAN P 0.15% (brimonidine) brimonidine 0.2%	brimonidine 0.15% brimonidine 0.1% dipivefrin PROPINE (dipivefrin)	
OPIATE DEPENDENCE TREATMENTS			
DEPENDENCE			
	buprenorphine/naloxone tablets naltrexone tablets SUBOXONE FILM(buprenorphine/naloxone) ^{DUR+}	BRIXADI (buprenorphine) 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) ZIMHI (naloxone)	EVZIO (naloxone) KLOXXADO (naloxone) OPVEE (nalmefene)	
OTIC ANTIBIOTICS			
	CIPRODEX (ciprofloxacin/dexamethasone) CIPRO HC (ciprofloxacin/hydrocortisone) ^{Age Edit} CORTISPORIN-TC (colistin/neomycin/hydrocortisone) neomycin/polymyxin/hydrocortisone ofloxacin	ciprofloxacin ciprofloxacin/dexamethasone ciprofloxacin/fluocinolone DERMOTIC (fluocinolone) FLAC OIL DROP (fluocinolone oil) hydrocortisone/acetic acid drop fluocinolone oil	Maximum Age Limit • 9 years - Cipro HC

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		OTIPRIO (ciprofloxacin) OTOVEL (ciprofloxacin/fluocinolone)	
PANCREATIC ENZYMES ^{DUR+}			
	CREON (pancreatin) ZENPEP (pancrelipase)	PANCREAZE (pancrelipase) PERTZYE (pancrelipase) VIOKACE (pancrelipase)	Non-Preferred Criteria • Have tried 2 different preferred agents in the past 6 months
PARATHYROID AGENTS			
	calcitriol ergocalciferol paricalcitol ROCALTROL (calcitriol) ZEMPLAR (paricalcitol)	cinacalcet doxercalciferol DRISDOL (ergocalciferol) HECTOROL (doxercalciferol) NATPARA (parathyroid hormone) RAYALDEE (calcifediol) SENSIPAR (cinacalcet)	
PHOSPHATE BINDERS			
	calcium acetate ELIPHOS (calcium acetate) PHOSLYRA (calcium acetate) sevelamer carbonate tablets	AURYXIA (ferric citrate) FOSRENOL (lanthanum) lanthanum PHOSLO (calcium acetate) RENAGEL (sevelamer HCl) RENVELA (sevelamer carbonate) sevelamer carbonate powder packets sevelamer HCl VELPHORO (sucroferric oxyhydroxide) XPHOZAH (tenapanor) ^{NR}	

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PLATELET AGGREGATION INHIBITORS ^{DUR+}			
	BRILINTA (ticagrelor) cilostazol clopidogrel dipyridamole dipyridamole/aspirin pentoxifylline prasugrel	DURLAZA ER (aspirin) EFFIENT (prasugrel) omeprazole/aspirin PERSANTINE (dipyridamole) PLAVIX (clopidogrel) PLETAL (cilostazol) ticlopidine YOSPRA LA (aspirin/omeprazole) ZONTIVITY (vorapaxar)	Zontivity – <u>MANUAL PA</u> 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)	
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)	Products not listed are assumed to be Non-Preferred.	

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	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		
PSEUDOBULBAR AFFECT AGENTS^{DUR+}			
		NUEDEXTA (dextromethorphan/quinidine)	Non-Preferred Criteria <ul style="list-style-type: none"> • 90 consecutive days on the requested agent in the past 105 days OR • Documented diagnosis of Pseudobulbar Affect
PULMONARY ANTIHYPERTENSIVES^{DUR+}			
ENDOTHELIN RECEPTOR ANTAGONIST			
	ambrisentan (all labelers except those listed as non-preferred) bosentan tablets	ambrisentan (labeler 42794, 47335, 498840) LETAIRIS (ambrisentan)* OPSUMIT (macitentan) TRACLEER (bosentan)	All PAH Agents <ul style="list-style-type: none"> • Documented diagnosis of pulmonary hypertension Non-Preferred Criteria <ul style="list-style-type: none"> • Have tried 1 preferred PAH agent in the past 6 months OR

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

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			<ul style="list-style-type: none"> • 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 <ul style="list-style-type: none"> • Have tried 1 preferred PAH agent in the past 6 months OR • 90 consecutive days on the requested agent in the past 105 days
SELECTIVE PROSTACYCLIN RECEPTOR AGONISTS			
		UPTRAVI (selexipag)	Non-Preferred Criteria <ul style="list-style-type: none"> • Have tried 1 preferred PAH agent in the past 6 months OR • 90 consecutive days on the requested agent in the past 105 days
SOLUBLE GUANYLATE CYCLASE STIMULATORS			
		ADEMPAS (riociguat)	Adempas <ul style="list-style-type: none"> • 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

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			<ul style="list-style-type: none"> • 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) SUMADAN (sodium sulfacetamide/sulfur wash) SUMAXIN (sodium sulfacetamide/sulfur pads) SUMAXIN TS (sodium sulfacetamide/sulfur suspension) ZILXI AEROSOL (minocycline)	Topical Sulfonamides used for Rosacea will require a manual PA for ≥ 21 years. Other labeled indications are limited to < 21 years.
SEDATIVE HYPNOTICS			

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BENZODIAZEPINES ^{DUR+}			
	estazolam flurazepam temazepam (15mg and 30mg)	DALMANE (flurazepam) DORAL (quazepam) HALCION (triazolam) quazepam RESTORIL (temazepam) temazepam (7.5mg and 22.5mg) triazolam	<p>Single source benzodiazepines and barbiturates are NOT covered – NO PA's will be issued for these drugs.</p> <p>MS DOM Opioid Initiative</p> <ul style="list-style-type: none"> Concomitant use of Opioids and Benzodiazepines <p>Criteria details found here</p> <p>Quantity Limit – CUMULATIVE Quantity limit per rolling days for all strengths. <i>DUR+ will allow an early refill override for one dose or therapy change per year.</i></p> <ul style="list-style-type: none"> 31 units/31 days - all strengths <p>Triazolam – CUMULATIVE Quantity limit per rolling days for all strengths</p> <ul style="list-style-type: none"> 10 units/31 days 60 units/365 days
OTHERS ^{DUR+}			
	zaleplon zolpidem	AMBIEN (zolpidem) AMBIEN CR (zolpidem) BELSOMRA (sovorexant) DAYVIGO (lemborexant) doxepin 3mg, 6mg	<p>Maximum Age Limit</p> <ul style="list-style-type: none"> 64 years – zolpidem 7.5 mg, zolpidem 10 mg, zolpidem 12.5 mg <p>Quantity Limit – CUMULATIVE</p>

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MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

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		EDLUAR (zolpidem) eszopiclone HETLIOZ (tasimelteon) INTERMEZZO (zolpidem) LUNESTA (eszopiclone) ramelteon ROZEREM (ramelteon) QUVIVIQ (daridorexant) SILENOR (doxepin) SONATA (zaleplon) zolpidem ER zolpidem SL ZOLPIMIST (zolpidem)	<p>Quantity limit per rolling days for all strengths. <i>DUR+ will allow an early refill override for one dose or therapy change per year.</i></p> <ul style="list-style-type: none"> • 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 <p>Gender and Dose Limit for zolpidem</p> <ul style="list-style-type: none"> • Female – Ambien 5mg, Ambien CR 6.25mg, Intermezzo 1.75 mg • Male – all zolpidem strengths <p>Non-Preferred Criteria</p> <ul style="list-style-type: none"> • Have tried 2 different preferred agents in the past 6 months <p>Hetlioz capsules</p> <ul style="list-style-type: none"> • Documented diagnosis of circadian rhythm sleep disorder AND • Documented diagnosis indicating total blindness of the patient OR • Documented diagnosis of Magenis-Smith syndrome <p>Hetlioz liquid</p>

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			<ul style="list-style-type: none"> • 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)	<p style="color: red;">Non-Preferred Criteria</p> <ul style="list-style-type: none"> • 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) 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		

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		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) SIMPESS (levonorgestrel/ethinyl estradiol) TAYTULLA (norethindrone/ethinyl estradiol/iron) TYDEMY (ethinyl estradiol/drospirenone/levomefolate calcium) YASMIN (ethinyl estradiol/drospirenone) YAZ (ethinyl estradiol/drospirenone)	
	TRANSDERMAL CONTRACEPTIVES		
	XULANE (norelgestromin and ethinyl estradiol)	ZAFEMY (norelgestromin and ethinyl estradiol) TWIRLA (levonorgestrel and ethinyl estradiol) norelgestromin and ethinyl estradiol ^{NR}	
SICKLE CELL AGENTS			
	DROXIA (hydroxyurea) hydroxyurea	ADAKVEO (crizanlizumab) ENDARI (glutamine) HYDREA (hydroxyurea)	Endari – MANUAL PA Oxbryta – MANUAL PA

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		OXBRYTA (voxelotor) SIKLOS (hydroxyurea)	
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 (orphenadrine) orphenadrine orphenadrine compound orphenadrine ER PARAFON FORTE DSC (chlorzoxazone) ROBAXIN (methocarbamol) SKELAXIN (metaxalone) SOMA (carisoprodol) tizanidine capsules ZANAFLEX (tizanidine)	<p>Non-Preferred Agents</p> <ul style="list-style-type: none"> Documented diagnosis for an approvable indication AND Have tried 2 different preferred agents in the past 6 months <p>Baclofen granules, solution, and suspension</p> <ul style="list-style-type: none"> Requires clinical review <p>Carisoprodol</p> <ul style="list-style-type: none"> Documented diagnosis of acute musculoskeletal condition AND NO history with meprobamate in the past 90 days AND 1 claim for cyclobenzaprine in the past 21 days OR a documented intolerance to cyclobenzaprine AND Quantity Limit <ul style="list-style-type: none"> 18 tablets - to allow tapering off 84 tablets/6 months <p>Carisoprodol with codeine</p> <ul style="list-style-type: none"> Requires clinical review
SMOKING DETERRENT			

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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)	<p style="color: red;">Minimum Age Limit - Chantix</p> <ul style="list-style-type: none"> • 18 years <p style="color: red;">Quantity Limit</p> <ul style="list-style-type: none"> • 336 tablets/year – Chantix 0.5mg, 1mg tablets and continuing pack • 2 treatment courses/year – Chantix Starter Pack
STEROIDS (Topical) ^{DUR+}			
LOW POTENCY			
	CAPEX (fluocinolone) desonide hydrocortisone cr, oint, soln.	alclometasone DERMA-SMOOTH-FS (fluocinolone) DESONATE (desonide) DESOWEN (desonide) fluocinolone oil hydrocortisone lotion PEDIACARE HC (hydrocortisone) PEDIADERM (hydrocortisone) VERDESO (desonide)	<p style="color: red;">Non-Preferred Criteria</p> <ul style="list-style-type: none"> • Have tried 2 different preferred low potency agents in the past 6 months

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Therapeutic Drug Class	Preferred Agents	Non-Preferred Agents	PA Criteria
	MEDIUM POTENCY		
	fluocinolone hydrocortisone mometasone cr, oint. prednicarbate cr PANDEL (hydrocortisone probutate)	betamethasone valerate foam CLODERM (clocortolone) CUTIVATE (fluticasone) DERMATOP (prednicarbate) ELOCON (mometasone) fluticasone LUXIQ (betamethasone) mometasone solution MOMEXIN (mometasone) prednicarbate oint SYNALAR (fluocinolone)	Non-Preferred Criteria <ul style="list-style-type: none"> Have tried 2 different preferred medium potency agents in the past 6 months
	HIGH POTENCY		
	amcinonide cr, lot betamethasone dipropionate cr, gel, lotion betamethasone valerate cr, lotion, oint. fluocinolone triamcinolone	amcinonide oint betameth diprop/prop gly cr, lot, oint betamethasone dipropionate oint. BETA-VAL (betamethasone valerate) desoximetasone diflorasone DIPROLENE AF (betamethasone diprop/prop gly) ELOCON (mometasone) fluocinonide HALOG (halcinonide) KENALOG (triamcinolone) PEDIADERM TA (triamcinolone) SERNIVO (betamethasone dipropionate) TOPICORT (desoximetasone)	Non-Preferred Criteria <ul style="list-style-type: none"> Have tried 2 different preferred high potency agents in the past 6 months

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		TRIANEX (triamcinolone) VANOS (fluocinonide)	
VERY HIGH POTENCY			
	clobetasol lotion clobetasol shampoo, spray clobetasol propionate cream clobetasol propionate ointment halobetasol cream halobetasol ointment	BRYHALI (halobetasol) clobetasol emollient clobetasol propionate foam, ge CLOBEX (clobetasol) DIPROLENE (betamethasone diprop/prop gly) DUOBRII LOTION (halobetasol prop/tazarotene) halobetasol foam IMPEKLO (clobetasol) LEXETTE (halobetasol propionate) OLUX (clobetasol) OLUX-E (clobetasol) TEMOVATE Cream (clobetasol propionate) TEMOVATE Ointment (clobetasol propionate) TOVET Foam (clobetasol) ULTRAVATE Lotion (halobetasol)	Non-Preferred Criteria <ul style="list-style-type: none"> • Have tried 2 different preferred very high potency agents in the past 6 months
STIMULANTS AND RELATED AGENTS ^{DUR+}			
SHORT-ACTING			
	amphetamine salt combination dexamethylphenidate IR dextroamphetamine IR methylphenidate IR methylphenidate solution PROCENTRA (dextroamphetamine)	ADDERALL (amphetamine salt combination) amphetamine sulfate (generic EVEKO) DESOXYN (methamphetamine) dextroamphetamine/amphetamine ER ^{NR} dextroamphetamine solution EVEKEO (amphetamine) EVEKEO ODT (amphetamine)	Minimum Age Limit <ul style="list-style-type: none"> • 3 years - Adderall, Evekeo, Procentra, Zenzedi • 6 years – Desoxyn, Evekeo ODT, Focalin, Methylin Maximum Age Limit

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		FOCALIN (dexmethylphenidate) methamphetamine METHYLIN solution (methylphenidate) methylphenidate chewable RITALIN (methylphenidate) ZENZEDI (dextroamphetamine)	<ul style="list-style-type: none"> • 18 years – Evekeo ODT <p>Quantity Limit Applicable quantity limit per rolling days</p> <ul style="list-style-type: none"> • 62 tablets/31 days – Adderall, Desoxyn, Evekeo, Focalin, Methylin, Zenedi • 310 mL/31 days – Methylin solution, Procentra <p>Documented diagnosis of ADHD ALL Short Acting Agents</p> <p>Non-Preferred Criteria ADD/ADHD</p> <ul style="list-style-type: none"> • Documented diagnosis of ADD/ADHD AND • Have tried 2 different preferred Short Acting agents in the past 6 months OR • 1 claim for a 30-day supply with the requested agent in the past 105 days <p>Documented diagnosis of narcolepsy – ADDERALL, EVEKEO, METHYLIN, PROCENTRA, RITALIN, ZENZEDI</p>

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	<p style="text-align: center;">LONG-ACTING</p> <p>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)</p>	<p>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) RITALIN LA (methylphenidate) RITALIN SR (methylphenidate) VYVANSE (lisdexamfetamine)* VYVANSE CHEWABLE (lisdexamfetamine)* XELSTRYM patch (dextroamphetamine)</p>	<p>Minimum Age Limit</p> <ul style="list-style-type: none"> • 6 years – Adderall XR, Adhansia XR, Adzenys ER Suspension, Adzenys XR ODT, Aptensio XR, Azstarys, Concerta, Cotempla XR ODT, Daytrana, Dexedrine, Dyanavel XR Focalin XR, Jornay PM, Metadate, CD, methylphenidate ER 72mg, Quillichew, Quillivant XR, Relexxi, Ritalin LA, Vyvanse, Xelstrym • 13 years – Mydayis • 16 years – Provigil • 18 years – Nuvigil, Sunosi <p>Maximum Age Limit</p> <ul style="list-style-type: none"> • 18 years – Cotempla XR ODT, Daytrana <p>Vyvanse</p> <ul style="list-style-type: none"> • Documented diagnosis of binge eating disorder OR • Documented diagnosis of ADD/ADHD <p>Quantity Limit</p> <p>Applicable quantity limit per rolling days</p> <ul style="list-style-type: none"> • 31 tablets/31 days – Adderall XR, Adhansia XR, Adzenys XR ODT,

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			<p>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</p> <ul style="list-style-type: none"> • 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 <p>Documented diagnosis of ADHD ALL Long-Acting Agents</p> <p>Non-Preferred Criteria ADD/ADHD</p> <ul style="list-style-type: none"> • Documented diagnosis of ADD/ADHD AND • Have tried 2 different preferred Long-Acting agents in the past 6 months OR • 1 claim for a 30-day supply with the requested agent in the past 105 days

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	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)	<p>Documented diagnosis of narcolepsy – ADDERALL XR, APTENSIO XR, CONCERTA ER, DEXEDRINE, METADATE CD, METHYLIN ER, MYDAYIS, NUVIGIL, PROVIGIL, QUILLICHEW, QUILLIVANT XR, RITALIN LA, SUNOSI</p> <p>Non-Preferred Criteria narcolepsy</p> <ul style="list-style-type: none"> • Documented diagnosis of narcolepsy AND • 30 days of therapy with preferred modafinil or armodafinil in the past 6 months AND • 1 different preferred Long-Acting agent indicated for narcolepsy in the past 6 months OR • 1 claim for a 30-day supply with the requested agent in the past 105 days <p>Nuvigil</p> <ul style="list-style-type: none"> • Documented diagnosis of narcolepsy, obstructive sleep apnea, shift work sleep disorder or bipolar depression <p>Provigil</p>

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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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To search the PDL, press CTRL + F



MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

(For All Medicaid, MSCAN and CHIP Beneficiaries)

EFFECTIVE 2/1/2024
Version 2024
Updated:1/31/2024

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			<ul style="list-style-type: none"> • Documented diagnosis of narcolepsy, obstructive sleep apnea, shift work sleep disorder, depression, sleep deprivation or Steinert Myotonic Dystrophy Syndrome <p>Sunosi</p> <ul style="list-style-type: none"> • Documented diagnosis of narcolepsy or obstructive sleep apnea AND • 30 days of therapy with preferred modafinil or armodafinil in the past 6 months <p>Wakix</p> <ul style="list-style-type: none"> • Documented diagnosis of narcolepsy with or without cataplexy AND • 30 days of therapy with preferred modafinil or armodafinil in the past 6 months OR • Documented diagnosis of narcolepsy without cataplexy or substance abuse disorder <p>Xyrem and Xywav</p> <ul style="list-style-type: none"> • Requires clinical review
NON-STIMULANTS			

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	atomoxetine clonidine ER guanfacine ER	INTUNIV (guanfacine ER) QELBREE (viloxazine) STRATTERA (atomoxetine)	<p>Minimum Age Limit 6 years – Intuniv, Clonidine ER, Qelbree, Strattera 18 years – Wakix</p> <p>Maximum Age Limit</p> <ul style="list-style-type: none"> • 18 years – Intuniv, Clonidine ER, Qelbree • 21 years – diagnosis of ADD/ADHD is required for Strattera <p>Quantity Limit Applicable quantity limit per rolling days</p> <ul style="list-style-type: none"> • 31 tablets/31 days – Intuniv, Qelbree 100 mg, Strattera • 62 tablets/31 days – Qelbree 150 mg and 200 mg, Wakix • 124 tablets/31 days – Clonidine ER <p>Intuniv Documented diagnosis of ADD or ADHD</p> <p>Clonidine ER</p> <ul style="list-style-type: none"> • Documented diagnosis of ADD or ADHD <p>Qelbree</p> <ul style="list-style-type: none"> • Documented diagnosis of ADD or ADHD AND

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			<ul style="list-style-type: none"> 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 (doxycycline) 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) OKEBO (doxycycline) ORACEA (doxycycline) SEYSARA (sarecycline) SOLODYN (minocycline) TARGADOX (doxycycline) VIBRAMYCIN cap/susp/syrup XIMINO (minocycline)	<p>Non-Preferred Agents</p> <ul style="list-style-type: none"> Have tried 2 different preferred agents in the past 6 months <p>Demeclocycline</p> <ul style="list-style-type: none"> Documented diagnosis of SIADH will allow automatic approval
ULCERATIVE COLITIS and CROHN'S AGENTS ^{DUR+} *See Cytokine & CAM Antagonists Class for additional agents			

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	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) VELSIPITY (etrasimod) ^{NR}	<p>Non-Preferred Criteria</p> <ul style="list-style-type: none"> • 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 <p>Ortikos ER</p> <ul style="list-style-type: none"> • Requires clinical review <p>Velsipity</p> <ul style="list-style-type: none"> • Requires clinical review
	RECTAL		
	mesalamine suppository	budesonide foam CANASA (mesalamine) ROWASA (mesalamine) SF-ROWASA (mesalamine) UCERIS Foam (budesonide)	

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