



# MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

EFFECTIVE 07/01/2023

Version 2023.8

Updated: 09/01/2023

(For All Medicaid, MSCAN and CHIP Beneficiaries)

Gainwell Technologies' DUR+ process is a proprietary electronic prior authorization system used for Medicaid fee for service claims. MSCAN plans may/may not -have electronic PA functionality. However, they must adhere to Medicaid's PA criteria.

Therapeutic Drug Class	Preferred Agents	Non-Preferred Agents	PA Criteria
<b>ACNE AGENTS</b>			
	<b>ANTI-INFECTIVE</b>		
	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) dapson ERY (erythromycin) ERYGEL (erythromycin) erythromycin gel, swabs, solution EVOCLIN (clindamycin) KLARON (sulfacetamide) sulfacetamide WINLEVI (clascoterone)	<b>Maximum Age Limit</b> <ul style="list-style-type: none"> <li>• <b>21 years</b> – all agents except isotretinoins</li> </ul>
	<b>RETINOIDS</b>		
	RETIN-A (tretinoin) tretinoin cream	adapalene AKLIEF (trifarotene) ALTRENO (tretinoin) ARAZLO (tazarotene) ATRALIN (tretinoin) AVITA (tretinoin) DIFFERIN (adapalene)	

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

Drugs highlighted in yellow denote a change in PDL status.

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

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		FABIOR (tazarotene) PLIXDA (adapalene) RETIN-A MICRO (tretinoin) tazarotene TAZORAC (tazarotene) tretinoin gel tretinoin micro TWYNEO (tretinoin/benzoyl peroxide)	
<b>COMBINATION DRUGS/OTHERS</b>			
	adapalene/benzoyl peroxide (generic EPIDUO) benzoyl peroxide/clindamycin (generic DUAC) sodium sulfacetamide/sulfur foam/gel/suspension SSS 10/5 Cream (sodium sulfacetamide/sulfur)	ACANYA (benzoyl peroxide/clindamycin) adapalene/benzoyl peroxide (generic EPIDUO FORTE) AKTIPAK (erythromycin/benzoyl peroxide) BENZACLIN GEL (benzoyl peroxide/clindamycin) BENZACLIN KIT (benzoyl peroxide/ clindamycin) BENZAMYCIN PAK (benzoyl peroxide/ erythromycin) DUAC (benzoyl peroxide/clindamycin) EPIDUO (adapalene/benzoyl peroxide) EPIDUO FORTE (adapalene/benzoyl peroxide) EPSOLAY (benzoyl peroxide) erythromycin/benzoyl peroxide INOVA 4/1 (benzoyl peroxide/salicylic acid) INOVA 8/2 (benzoyl peroxide/salicylic acid) NEUAC (benzoyl peroxide/clindamycin) ONEXTON (benzoyl peroxide/clindamycin) PRASCION (sulfacetamide sodium/sulfur) ROSANIL (sulfacetamide sodium/sulfur) SE BPO (benzoyl peroxide)	

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		sodium sulfacetamide/sulfur cleanser/cream/lotion/pads sodium sulfacetamide/sulfur/meratan SSS 10/5 Foam (sodium sulfacetamide/sulfur) sulfacetamide sodium/sulfur/urea VELTIN (clindamycin/tretinoin) ZENCIA WASH (sulfacetamide sodium/sulfur) ZIANA (clindamycin/tretinoin)	
<b>KERATOLYTICS (BENZOYL PEROXIDES)</b>			
	benzoyl peroxide bar, cleanser, cream, gel, lotion, wash <sup>Rx &amp; OTC</sup>	benzoyl peroxide foam <sup>Rx &amp; OTC</sup> BP 5.5% (benzoyl peroxide) BPO (benzoyl peroxide) <sup>Rx &amp; OTC</sup> INOVA (benzoyl peroxide) LAVOCLEN (benzoyl peroxide) PANOXYL BAR 10% (benzoyl peroxide) <sup>OTC</sup> PANOXYL CREAM 3% (benzoyl peroxide) <sup>OTC</sup> OC8 GEL (benzoyl peroxide) <sup>OTC</sup>	
<b>ISOTRETINOIN</b>			
	ACUTANE (isotretinoin) AMNESTEEM (isotretinoin) CLARAVIS (isotretinoin) isotretinoin MYORISAN (isotretinoin) ZENATANE (isotretinoin)	ABSORICA (isotretinoin) ABSORICA LD (isotretinoin)	Available for all ages
<b>ALPHA-1 PROTEINASE INHIBITORS</b>			
	ARALAST (alpha-1 proteinase inhibitor) GLASSIA (alpha-1 proteinase inhibitor) PROLASTIN C (alpha-1 proteinase inhibitor) ZEMAIRA (alpha-1 proteinase inhibitor)		

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

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	ENDOCET (oxycodone/APAP) hydrocodone/APAP hydromorphone morphine oxycodone capsules oxycodone liquid oxycodone tablets oxycodone/APAP oxycodone/aspirin oxycodone/ibuprofen pentazocine/APAP tramadol tramadol/APAP	butalbital/ASA/caffeine/codeine butorphanol tartrate (nasal) DEMEROL (meperidine) DILAUDID (hydromorphone) DVORAH (dihydrocodeine/ APAP/caffeine) fentanyl FENTORA (fentanyl) FIORICET W/ CODEINE (butalbital/APAP/caffeine/codeine) FIORINAL W/ CODEINE (butalbital/ASA/caffeine/codeine) hydrocodone/ibuprofen IBUDONE (hydrocodone/ibuprofen) LAZANDA NASAL SPRAY (fentanyl) levorphanol LORCET (hydrocodone/APAP) LORTAB (hydrocodone/APAP) MAGNACET (oxycodone/APAP) meperidine solution meperidine tablet NALOCET (oxycodone/APAP) NORCO (hydrocodone/APAP) NUCYNTA (tapentadol) ONSOLIS (fentanyl) OPANA (oxymorphone) OXAYDO (oxycodone) oxymorphone pentazocine/naloxone PERCOCET (oxycodone/APAP)	<ul style="list-style-type: none"> <li>Concomitant use of Opioids and Benzodiazepines <a href="#">Criteria details found here</a></li> <li><b>Minimum Age Limit</b></li> <li><b>18 years</b> – tramadol and codeine products</li> <li><b>Quantity Limit</b> Applicable <u>quantity limit</u> in 31 rolling days</li> <li><b>62 tablets</b> – butalbital/codeine combinations, codeine, dihydrocodeine combinations, fentanyl, hydromorphone, levorphanol, meperidine, morphine, oxycodone, oxycodone/ibuprofen, oxymorphone, pentazocine, tapentadol, tramadol</li> <li><b>62 tablets CUMULATIVE</b> – hydrocodone combinations, oxycodone combinations</li> <li><b>186 tablets</b> –butalbital/APAP 300, butalbital/APAP 325, butalbital/ASA 325</li> <li><b>5mL (2 x 2.5 bottles)</b> – butorphanol nasal</li> <li><b>180 mL CUMULATIVE</b> – oxycodone liquids</li> <li><b>280 mL CUMULATIVE</b> – Qdolo</li> </ul>

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		PERCODAN (oxycodone/ASA) PRIMLEV (oxycodone/APAP) PROLATE (oxycodone/APAP) QDOLO (tramadol) REPREXAIN (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)	
<b>ANALGESICS, OPIOID - LONG ACTING <sup>DUR+</sup></b>			
	BUTRANS (buprenorphine) fentanyl patches morphine ER tablets	ARYMO ER (morphine) BELBUCA (buprenorphine) buprenorphine patch CONZIP ER (tramadol) DOLOPHINE (methadone) DURAGESIC (fentanyl) EMBEDA (morphine/naltrexone)	<b>MS DOM Opioid Initiative</b> <ul style="list-style-type: none"> <li>• Short-Acting Opioids</li> <li>• Long-Acting Opioids</li> <li>• Morphine Equivalent Daily Dose</li> <li>• Concomitant use of Opioids and Benzodiazepines</li> </ul> <a href="#">Criteria details found here</a>

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		EXALGO (hydromorphone) hydromorphone ER HYSINGLA ER (hydrocodone) KADIAN (morphine) methadone MORPHABOND (morphine) morphine ER capsules MS CONTIN (morphine) NUCYNTA ER (tapentadol) OPANA ER (oxymorphone) oxycodone ER OXYCONTIN (oxycodone) oxymorphone ER RYZOLT (tramadol) tramadol ER ULTRAM ER (tramadol) XARTEMIS XR (oxycodone/APAP) XTAMPZA (oxycodone myristate) ZOHYDRO ER (hydrocodone bitartrate)	<p><b>Minimum Age Limit</b></p> <ul style="list-style-type: none"> <li>• <b>18 years</b> – Butrans, Xartemis XR, Zohydro ER, tramadol products</li> </ul> <p><b>Quantity Limit</b></p> <p>Applicable <u>quantity limit</u> per rolling days</p> <ul style="list-style-type: none"> <li>• <b>31 tablets/31 days</b> - Conzip ER, Exalgo ER, Hysingla ER, Ryzolt, Ultram ER</li> <li>• <b>62 tablets/31 days</b> – Arymo ER, Belbuca, Embeda, Kadian, methadone, Morphabond, morphine ER, Nucynta ER, Opana ER, oxycodone ER, Oxycontin, Xtampza ER, Zohydro ER</li> <li>• <b>10 patches/31 days</b> – Duragesic</li> <li>• <b>4 patches/31 days</b> – Butrans</li> <li>• <b>40 tablets/10 days</b> – Xartemis XR</li> </ul> <p><b>Non-Preferred Criteria</b></p> <ul style="list-style-type: none"> <li>• Have tried 2 different preferred agents in the past 6 months <b>OR</b></li> <li>• Documented diagnosis of cancer <b>OR</b> Antineoplastic therapy <b>AND</b></li> <li>• 90 consecutive days on the requested agent in the past 105 days</li> </ul>

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<b>ANALGESICS/ANESTHETICS (Topical)</b>			
	diclofenac sodium 1% gel diclofenac sodium 1.5% solution lidocaine 4% cream <sup>OTC</sup> lidocaine 5% ointment lidocaine 5% patch	capsaicin diclofenac epolamine patch <sup>DUR+</sup> diclofenac sodium 3% gel FLECTOR Patch (diclofenac epolamine) <sup>DUR+</sup> FROTEK (ketoprofen) LICART (diclofenac epolamine) LIDAMANTLE HC (lidocaine/hydrocortisone) LIDO TRANS PAK (lidocaine) lidocaine/prilocaine LIDODERM (lidocaine) <sup>DUR+</sup> LIDTOPIC MAX (lidocaine) PENNSAID 2% Solution (diclofenac sodium) <sup>DUR+</sup> SYNERA (lidocaine/tetracaine) TRANZAREL (lidocaine) VENNGEL ONE 1% kit (diclofenac sodium) <b>VOLTAREN Gel (diclofenac sodium) <sup>DUR+</sup></b> XRYLIDERM (lidocaine) xylocaine ZOSTRIX (capsaicin) ZTlido (lidocaine)	<p><b>Non-Preferred Criteria</b></p> <ul style="list-style-type: none"> <li>Have tried 1 preferred agent in the past 6 months</li> </ul> <p><b>Lidocaine 5% Patch</b></p> <ul style="list-style-type: none"> <li>Documented diagnosis of Herpetic Neuralgia <b>OR</b></li> <li>Documented diagnosis of Diabetic Neuropathy</li> </ul> <p><b>ZTlido</b></p> <ul style="list-style-type: none"> <li>Documented diagnosis of Herpetic Neuralgia</li> </ul>
<b>ANDROGENIC AGENTS <sup>DUR+</sup></b>			
	ANDRODERM (testosterone patch) testosterone gel packet	ANDROGEL (testosterone gel) ANDROXY (fluoxymesterone) AXIRON (testosterone gel) FORTESTSA (testosterone gel) JATENZO (testosterone undecanoate) NATESTO (testosterone)	<p><b>All Agents</b></p> <ul style="list-style-type: none"> <li>Limited to male gender</li> </ul> <p><b>Non-Preferred Criteria</b></p> <ul style="list-style-type: none"> <li>Have tried 2 different preferred agents in the past 6 months</li> </ul>

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		STRIANT (testosterone) TESTIM (testosterone gel) testosterone pump TLANDO (testosterone) VOGELXO (testosterone) XYOSTED (testosterone enanthate)	<b>Tlando</b> <ul style="list-style-type: none"> <li>Requires clinical review</li> </ul>
<b>ANGIOTENSIN MODULATORS</b> <sup>DUR+</sup>			
<b>ACE INHIBITORS</b>			
	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)	<b>Minimum Age Limit</b> <ul style="list-style-type: none"> <li>≤ 6 years – Epaned Dur + <i>will automatically be issued for this age</i></li> </ul> <b>Non-Preferred Criteria</b> <ul style="list-style-type: none"> <li>Have tried 2 different preferred <i>single entity</i> agents in the past 6 months <b>OR</b></li> <li>90 consecutive days on the requested agent in the past 105 days</li> </ul>
<b>ACE INHIBITOR COMBINATIONS</b>			
	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)	<b>Non-Preferred Criteria</b> <b>ACE Inhibitor/CCB</b> <ul style="list-style-type: none"> <li>Have tried 2 different preferred <i>ACE/CCB</i> agents in the past 6 months <b>OR</b></li> </ul>

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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"> <li>90 consecutive days on the requested agent in the past 105 days</li> </ul> <p><b>ACE Inhibitor/Diuretic</b></p> <ul style="list-style-type: none"> <li>Have tried 2 different preferred <u>ACEI/Diuretic</u> agents in the past 6 months <b>OR</b></li> <li>90 consecutive days on the requested agent in the past 105 days</li> </ul>
<b>ANGIOTENSIN II RECEPTOR BLOCKERS (ARBs)</b>			
	irbesartan losartan olmesartan telmisartan valsartan	ATACAND (candesartan) AVAPRO (irbesartan) BENICAR (olmesartan) candesartan COZAAR (losartan) DIOVAN (valsartan) EDARBI (azilsartan) eprosartan MICARDIS (telmisartan) TEVETEN (eprosartan)	<p><b>Non-Preferred Criteria</b></p> <ul style="list-style-type: none"> <li>Have tried 2 different preferred <u>single entity</u> agents in the past 6 months <b>OR</b></li> <li>90 consecutive days on the requested agent in the past 105 days</li> </ul>
<b>ARB COMBINATIONS</b>			
	ENTRESTO (valsartan/sacubitril) <sup>DUR +</sup> 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><b>Entresto</b></p> <ul style="list-style-type: none"> <li>Age ≥ 18 years <b>AND</b></li> <li>Documented diagnosis of heart failure <b>OR</b></li> <li>Age ≥ 1 year <b>AND</b></li> </ul>

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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"> <li>Documented diagnosis of heart failure with systemic ventricular systolic dysfunction</li> </ul> <p><b>Non-Preferred Criteria ARB/Beta Blocker, ARB/CCB or ARB/CCB/Diuretic</b></p> <ul style="list-style-type: none"> <li>Have tried 1 preferred <u>ARB/CCB</u> agent in the past 6 months <b>OR</b></li> <li>90 consecutive days on the requested agent in the past 105 days</li> </ul> <p><b>ARB/Diuretic</b></p> <ul style="list-style-type: none"> <li>Have tried 2 different preferred <u>ARB/Diuretic</u> products in the past 6 months <b>OR</b></li> <li>90 consecutive days on the requested agent in the past 105 days</li> </ul>
<b>DIRECT RENIN INHIBITORS</b>			
		TEKTURNA (aliskiren)	<p><b>Non-Preferred Criteria</b></p> <ul style="list-style-type: none"> <li>Documented diagnosis of hypertension <b>AND</b></li> <li>Have tried 2 different preferred <u>ACEI or ARB single-entity</u> products in the past 6 months <b>OR</b></li> </ul>

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

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<b>LINCOSAMIDE ANTIBIOTICS</b>			
	clindamycin capsules clindamycin solution	CLEOCIN (clindamycin) CLEOCIN SOLUTION (clindamycin)	
<b>MACROLIDES</b>			
	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)	
<b>NITROFURAN DERIVATIVES</b>			
	nitrofurantoin nitrofurantoin monohydrate macrocrystals	FURADANTIN (nitrofurantoin) MACROBID (nitrofurantoin monohydrate macrocrystals) MACRODANTIN (nitrofurantoin)	
<b>OXAZOLIDINONES</b>			
		SIVEXTRO (tedizolid) ZYVOX (linezolid)	<b>Sivextro – <a href="#">MANUAL PA</a></b> <b>Zyvox – <a href="#">MANUAL PA</a></b>

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<b>PLEUROMUTLINS</b>			<b>Quantity Limit</b> <ul style="list-style-type: none"> <li>• 6 tablets/month – Sivextro</li> </ul>
		XENLETA (lefamulin)	
<b>ANTIBIOTICS (Topical)</b>			
	bacitracin <sup>OTC</sup> bacitracin/polymyxin <sup>OTC</sup> gentamicin sulfate mupirocin ointment neomycin/bacitracin/polymyxin <sup>OTC</sup>	ALTABAX (retapamulin) CORTISPORIN (bacitracin/neomycin/polymyxin/HC) mupirocin cream NEOSPORIN (neomycin/bacitracin/polymyxin) <sup>OTC</sup> XEPI (ozenoxacin)	
<b>ANTIBIOTICS (VAGINAL)</b>			
	CLEOCIN OVULES (clindamycin) CLINDESSE (clindamycin) metronidazole vaginal	AVC (sulfanilamide) CLEOCIN CREAM (clindamycin) clindamycin cream METROGEL (metronidazole) NUVESSA (metronidazole) SOLOSEC (secnidazole) VANDAZOLE (metronidazole) <b>XACIATO GEL (clindamycin)</b>	
<b>ANTICOAGULANTS</b>			
<b>ORAL</b>			<b>Non-Preferred Criteria</b> <ul style="list-style-type: none"> <li>• Have tried 2 different preferred agents in the past 6 months <b>OR</b></li> </ul>
	COUMADIN (warfarin) ELIQUIS (apixaban)	BEVYXXA (betrixaban) PRADAXA PELLETS (dabigatran)	

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	PRADAXA (dabigatran) warfarin XARELTO (rivaroxaban)	SAVAYSA (edoxaban tosylate)	<ul style="list-style-type: none"> <li>1 claim with the requested agent in the past 90 days</li> </ul>
<b>LOW MOLECULAR WEIGHT HEPARIN (LMWH)</b>			
	enoxaparin	ARIXTRA (fondaparinux) fondaparinux FRAGMIN (dalteparin) LOVENOX (enoxaparin) Prefilled Syringe	<p style="color: red;"><b>LMWH Non-Preferred Criteria</b></p> <ul style="list-style-type: none"> <li>Have tried 1 different preferred agent in the past 6 months <b>OR</b></li> <li>90 consecutive days on the requested agent in the past 105 days</li> </ul>
<b>ANTICONVULSANTS</b> <sup>DUR+</sup>			
<b>ADJUVANTS</b>			
	carbamazepine carbamazepine suspension carbamazepine ER DEPAKOTE ER (divalproex) DEPAKOTE SPRINKLE (divalproex) divalproex divalproex ER divalproex sprinkle EPIDIOLEX (cannabidiol) EPITOL (carbamazepine) gabapentin lacosamide lamotrigine levetiracetam levetiracetam ER oxcarbazepine	APTIOM (eslicarbazepine) BANZEL (rufinamide) BRIVIACT (brivaracetam) carbamazepine XR CARBATROL (carbamazepine) DEPAKENE (valproic acid) DEPAKOTE (divalproex) DIACOMIT (stiripentol) ELEPSIA XR (levetiracetam) EPRONTIA (topiramate solution) EQUETRO (carbamazepine) felbamate FELBATOL (felbamate) FINTEPLA (fenfluramine) FYCOMPA (perampanel) <b>GABITRIL (tiagabine)</b>	<p style="color: red;"><b>Minimum Age Limit</b></p> <ul style="list-style-type: none"> <li>6 months-- Diacomit</li> <li>1 year – Banzel, Epidiolex</li> <li>2 years –Onfi, Sympazan</li> </ul> <p style="color: red;"><b>Epidiolex</b></p> <ul style="list-style-type: none"> <li>Documented diagnosis of Dravet syndrome. Lennox Gastaut syndrome or seizures associated with tuberous sclerosis complex</li> </ul> <p><b>OR</b></p> <ul style="list-style-type: none"> <li>1 claim for the requested agent in the past 30 days</li> </ul> <p style="color: red;"><b>Non-Preferred Criteria</b></p> <ul style="list-style-type: none"> <li>Have tried 2 different preferred agents in the past 6 months <b>OR</b></li> </ul>

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	oxcarbazepine suspension <b>tiagabine</b> topiramate tablet topiramate sprinkle capsule valproic acid zonisamide	KEPPRA (levetiracetam) KEPPRA XR (levetiracetam) LAMICTAL (lamotrigine) LAMICTAL CHEWABLE (lamotrigine) LAMICTAL ODT (lamotrigine) LAMICTAL XR (lamotrigine) lamotrigine ER/XR lamotrigine ODT NEURONTIN (gabapentin) OXTELLAR XR (oxcarbazepine) QUDEXY XR (topiramate) ROWEEPRA (levetiracetam) SABRIL (vigabatrin) SPRITAM (levetiracetam) STAVZOR (valproic acid) TEGRETOL (carbamazepine) TEGRETOL SUSPENSION (carbamazepine) TEGRETOL XR (carbamazepine) TOPAMAX TABLET (topiramate) TOPAMAX Sprinkle (topiramate) topiramate ER (generic Qudexy XR) <sup>Step Edit</sup> TRILEPTAL Tablets (oxcarbazepine) TRILEPTAL Suspension (oxcarbazepine) TROKENDI XR (topiramate) vigabatrin VIMPAT (lacosamide) XCOPRI (cenobamate) ZONISADE (zonisamide suspension) ZTALMY (ganaxolone)	<ul style="list-style-type: none"> <li>• 90 consecutive days on the requested agent in the past 105 days <b>AND</b></li> <li>• Documented diagnosis of seizure</li> </ul> <p><b>Banzel, Onfi, Sympazan</b></p> <ul style="list-style-type: none"> <li>• Documented diagnosis of Lennox-Gastaut <b>AND</b></li> <li>• Have tried 1 different preferred agent for Lennox-Gastaut in the past 6 months <b>OR</b></li> <li>• 90 consecutive days on the requested agent in the past 105 days <b>AND</b></li> <li>• Documented diagnosis of seizure</li> </ul> <p><b>Diacomit</b></p> <ul style="list-style-type: none"> <li>• Documented diagnosis of Dravet syndrome <b>AND</b></li> <li>• Active claim for clobazam</li> </ul> <p><b>Fintepla</b></p> <ul style="list-style-type: none"> <li>• Requires clinical review</li> </ul> <p><b>Sabril Powder for Oral Solution</b></p> <ul style="list-style-type: none"> <li>• Documented diagnosis of infantile spasms <b>OR</b></li> <li>• Have tried 2 different preferred agents in the past 6 months <b>OR</b></li> </ul>

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			<ul style="list-style-type: none"> <li>90 consecutive days on the requested agent in the past 105 days <b>AND</b></li> <li>Documented diagnosis of seizure</li> </ul> <p><b>Topiramate ER – Step Edit</b></p> <ul style="list-style-type: none"> <li>90 consecutive days on the requested agent in the past 105 days <b>AND</b></li> <li>Documented diagnosis of seizure <b>OR</b></li> <li>30-day trial with topiramate IR in the past 6 months</li> </ul>
<b>SELECTED BENZODIAZEPINES</b>			
	clobazam diazepam rectal gel NAYZILAM (midazolam) VALTOCO (diazepam)	DIASTAT (diazepam rectal) DIASTAT ACCUDIAL (diazepam rectal) ONFI (clobazam) ONFI SUSPENSION (clobazam) SYMPAZAN (clobazam)	<p><b>Minimum Age Limit</b></p> <ul style="list-style-type: none"> <li>12 years – Nayzilam</li> <li>6 years – Valtoco</li> </ul> <p><b>Quantity Limit</b></p> <ul style="list-style-type: none"> <li>2 Twin Packs/31 days – Diastat</li> <li>2 Packages /31 days – Nayzilam</li> <li>2 Cartons/31 days - Valtoco</li> </ul>
<b>HYDANTOINS</b>			
	DILANTIN (phenytoin) PHENYTEK (phenytoin) phenytoin	PEGANONE (ethotoin)	
<b>SUCCINIMIDES</b>			
	ethosuximide	CELONTIN (methsuximide) ZARONTIN (ethosuximide)	

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<b>ANTIDEPRESSANTS, OTHER <sup>DUR+</sup></b>			
	bupropion bupropion SR bupropion XL TRINTELLIX (vortioxetine) mirtazapine trazodone venlafaxine venlafaxine ER capsules VIIBRYD (vilazodone)	APLENZIN (bupropion HBr) AUVELITY (dextromethorphan/bupropion) desvenlafaxine ER desvenlafaxine fumarate ER DESYREL (trazodone) DRIZALMA SPRINKLE (duloxetine DR) EFFEXOR (venlafaxine) EFFEXOR XR (venlafaxine) EMSAM (selegiline transdermal) FETZIMA ER (levomilnacipran) FORFIVO XL (bupropion) KHEDEZLA ER (desvenlafaxine) MARPLAN (isocarboxazid) NARDIL (phenelzine) nefazodone OLEPTRO ER (trazodone) PARNATE (tranylcypromine) phenelzine PRISTIQ (desvenlafaxine) REMERON (mirtazapine) tranylcypromine venlafaxine XR venlafaxine ER tablets vilazodone WELLBUTRIN (bupropion) WELLBUTRIN SR (bupropion) WELLBUTRIN XL (bupropion HCl)	<p><b>Minimum Age Limit</b></p> <ul style="list-style-type: none"> <li>• <b>18 years</b> - all drugs</li> <li>• 7-17 years – duloxetine (except Drizalma Sprinkle) <i>Dur + will automatically be issued for this age range with a diagnosis of GAD (generalized anxiety disorder)</i></li> <li>• <b>7-11 years</b> – Drizalma Sprinkle <i>Dur + will automatically be issued for this age range with a diagnosis of generalized anxiety disorder</i></li> </ul> <p><b>Non-Preferred Criteria</b></p> <ul style="list-style-type: none"> <li>• Have tried 2 different preferred '<u>Antidepressants, Other</u>' Class in the past 6 months <b>OR</b></li> <li>• Have tried BOTH a preferred '<u>Antidepressant, SSRI</u>' and '<u>Antidepressants, Other</u>' in the past 6 months <b>OR</b></li> <li>• 90 consecutive days on the requested agent in the past 105 days</li> </ul> <p><b>Auvelity</b></p> <ul style="list-style-type: none"> <li>• Requires clinical review</li> </ul> <p><b>Cymbalta and Irenka (see Fibromyalgia Agents)</b></p>

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
<b>ANTIDEPRESSANTS, SSRIs</b> <sup>DUR+</sup>			
	citalopram escitalopram fluoxetine capsules fluvoxamine paroxetine CR paroxetine IR sertraline	CELEXA (citalopram) fluoxetine DR fluvoxamine ER LEXAPRO (escitalopram) LUVOX (fluvoxamine) LUVOX CR (fluvoxamine) paroxetine suspension PAXIL CR (paroxetine) PAXIL SUPENSION (paroxetine) PAXIL Tablets (paroxetine) PEXEVA (paroxetine) PROZAC (fluoxetine) SARAFEM (fluoxetine) ZOLOFT (sertraline)	<p><b>Minimum Age Limit</b></p> <ul style="list-style-type: none"> <li>• <b>6 years</b> - Zoloft</li> <li>• <b>7 years</b> – Lexapro, Prozac</li> <li>• <b>8 years</b> - Luvox</li> <li>• <b>18 years</b> – Celexa, Luvox CR, Paxil, Pexeva, Prozac 90 mg</li> </ul> <p><b>Maximum Age Limit</b></p> <ul style="list-style-type: none"> <li>• <b>60 years</b> – Celexa</li> </ul> <p><b>Non-Preferred Criteria</b></p> <ul style="list-style-type: none"> <li>• Have tried 2 different preferred agents in the past 6 months <b>OR</b></li> <li>• 90 consecutive days on the requested agent in the past 105 days</li> </ul>
<b>ANTIEMETICS</b> <sup>DUR+</sup>			
<b>5HT3 RECEPTOR BLOCKERS</b>			
	ondansetron ondansetron ODT ondansetron solution	ANZEMET (dolasetron) granisetron SANCUSO (granisetron) ZOFRAN (ondansetron) ZOFRAN ODT (ondansetron) ZUPLLENZ (ondansetron)	<p><b>Quantity Limit</b></p> <ul style="list-style-type: none"> <li>• <b>6 tablets/31 days</b> – Akynzeo</li> <li>• <b>30 tablets/31 days</b> – Zofran tablets/ODT</li> <li>• <b>100 ml/31 days</b> – Zofran solution</li> </ul> <p><b>Non-Preferred Agents</b></p> <ul style="list-style-type: none"> <li>• Have tried 1 preferred agent in the past 6 months</li> </ul>

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			Injectables in this class closed to point of sale. PA required if not administered in clinic/hospital
	<b>ANTIEMETIC COMBINATIONS</b>		
		AKYNZEO (netupitant/palonosetron) BONJESTA (doxylamine/pyridoxine) DICLEGIS (doxylamine/pyridoxine) doxylamine/pyridoxine	<b>Akynzeo - <a href="#">MANUAL PA</a></b>
	<b>CANNABINOIDS</b>		
		CESAMET (nabilone) MARINOL (dronabinol) dronabinol SYNDROS (dronabinol)	
	<b>NMDA RECEPTOR ANTAGONIST</b>		
	aprepitant	EMEND (aprepitant)	
<b>ANTIFUNGALS (Oral) <sup>DUR+</sup></b>			
	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	<p><b>Minimum Age Limit</b></p> <ul style="list-style-type: none"> <li>• <b>12-17 years</b> – griseofulvin tablets <i><u>Dur + will automatically be issued for this age range</u></i></li> </ul> <p><b>Non-Preferred Criteria</b></p> <ul style="list-style-type: none"> <li>• Have tried 2 different preferred agents in the past 6 months</li> </ul> <p><b>HIV opportunistic infection</b></p> <ul style="list-style-type: none"> <li>• Non-Preferred agent indicated for treatment (^) <b>AND</b></li> </ul>

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		LAMISIL (terbinafine) NOXAFIL (posaconazole) ^ ONMEL (itraconazole) ^ posaconazole^ SPORANOX (itraconazole) ^ TERBINEX Kit (terbinafine/ciclopirox) TOLSURA (itraconazole) VFEND (voriconazole) ^ VIVJOA (oteseconazole) voriconazole ^	<ul style="list-style-type: none"> <li>Documented diagnosis of HIV</li> </ul> <p><b>Cresemba - MANUAL PA</b></p> <ul style="list-style-type: none"> <li>Minimum age limit &gt; 18 years <b>AND</b></li> <li>Documented diagnosis of invasive aspergillosis <b>OR</b> invasive mucormycosis <b>AND</b></li> <li>Prescriber is an oncologist/hematologist or infectious disease specialist</li> </ul> <p><b>Sporanox</b></p> <ul style="list-style-type: none"> <li>HIV opportunistic infection criteria <b>OR</b></li> <li>Documented diagnosis of a transplant <b>OR</b></li> <li>History of an immunosuppressant in the past 6 months <b>OR</b></li> <li>Have tried 2 different preferred agents in the past 6 months</li> </ul>
<b>ANTIFUNGALS (Topical) DUR+</b>			
	<b>ANTIFUNGALS</b>		
	ciclopirox cream/gel/solution/suspension clotrimazole cream/solution <sup>Rx &amp; OTC</sup> ketoconazole shampoo LUZU (luliconazole) miconazole cream/powder <sup>OTC</sup> nystatin terbinafine cream/spray <sup>OTC</sup>	BENSAL HP (benzoic acid/salicylic acid) butenafine CICLODAN KIT (ciclopirox kit) ciclopirox kit/shampoo CNL 8 (ciclopirox) econazole ERTACZO (sertaconazole)	<p><b>Non-Preferred Criteria</b></p> <ul style="list-style-type: none"> <li>Have tried 2 different preferred agents in the past 6 months</li> </ul>

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	tolnaftate cream/powder/spray <sup>OTC</sup>	EXELDERM (sulconazole) EXTINA (ketoconazole) JUBLIA (efinaconazole) KERYDIN (tavaborole) ketoconazole cream ketoconazole foam LAMISIL (terbinafine) solution LOPROX (ciclopirox) luliconazole MENTAX (butenafine) naftifine NAFTIN (naftifine) NIZORAL (ketoconazole) oxiconazole OXISTAT (oxiconazole) PEDIADERM AF (nystatin) PENLAC (ciclopirox) VUSION (miconazole/petrolatum/zinc oxide)	
<b>ANTIFUNGAL/STEROID COMBINATIONS</b>			
	clotrimazole/betamethasone cream nystatin/triamcinolone	clotrimazole/betamethasone lotion LOTRISONE (clotrimazole/betamethasone)	
<b>ANTIFUNGALS (VAGINAL)</b>			
	clotrimazole vaginal cream <sup>OTC</sup> miconazole 1, 7cream <sup>OTC</sup> miconazole 3 vaginal cream, suppository <sup>OTC</sup>	GYNAZOLE 1 (butoconazole) TERAZOL 3 Suppository (terconazole) TERAZOL 7 (terconazole) terconazole suppository	

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	TERAZOL 3 Cream (terconazole) – currently unavailable from manufacturer terconazole cream tioconazole		
<b>ANTIHISTAMINES, MINIMALLY SEDATING AND COMBINATIONS</b> <sup>DUR+</sup>			
<b>MINIMALLY SEDATING ANTIHISTAMINES</b>			
	cetirizine tablets <sup>OTC</sup> cetirizine syrup <sup>Rx &amp; OTC</sup> loratadine odt <sup>OTC</sup> loratadine syrup <sup>OTC</sup> loratadine tablet <sup>OTC</sup>	cetirizine chewable <sup>OTC</sup> CLARINEX (desloratadine) desloratadine ODT desloratadine tablet fexofenadine syrup fexofenadine table levocetirizine syrup levocetirizine tablet XYZAL Solution (levocetirizine) XYZAL Tablets (levocetirizine)	<b>Non-Preferred Criteria</b> <ul style="list-style-type: none"> <li>• Documented diagnosis of allergy or urticaria <b>AND</b></li> <li>• Have tried 2 different preferred agents in the past 12 months</li> </ul>
<b>MINIMALLY SEDATING ANTIHISTAMINE/DECONGESTANT COMBINATIONS</b>			
	cetirizine/pseudoephedrine loratadine/pseudoephedrine	ALLEGRA-D (fexofenadine/ pseudoephedrine) CLARITIN-D (loratadine/pseudoephedrine) CLARINEX-D (desloratadine/ pseudoephedrine) fexofenadine/pseudoephedrine ZYRTEC-D (cetirizine/pseudoephedrine)	
<b>ANTIMIGRAINE AGENTS, ACUTE TREATMENT</b>			

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	<b>CGRP ORAL</b>		
	NURTEC ODT (rimegepant)	UBRELVY (ubrogepant)	<p><b>Minimum Age Limit</b></p> <ul style="list-style-type: none"> <li>• 18 years – Nurtec ODT, Ubrelvy</li> </ul> <p><b>Quantity Limit</b></p> <ul style="list-style-type: none"> <li>• 8 tablets/31 day – Nurtec ODT</li> <li>• 16 tablets/31 day – Ubrelvy</li> </ul> <p><b>Nurtec ODT</b></p> <ul style="list-style-type: none"> <li>• Documented diagnosis of migraine <b>AND</b></li> <li>• Have tried 2 different triptans in the past 6 months <b>AND</b></li> <li>• No concurrent therapy with another CGRP agent</li> </ul> <p><b>Ubrelvy</b></p> <ul style="list-style-type: none"> <li>• Documented diagnosis of migraine <b>AND</b></li> <li>• Have tried 2 different triptans in the past 6 months <b>AND</b></li> <li>• Have tried preferred Nurtec ODT in the past 6 months <b>AND</b></li> <li>• No concurrent therapy with another CGRP agent <b>AND</b></li> <li>• No concurrent therapy with a strong CYP3A4 inhibitor</li> </ul>
	<b>CGRP NASAL</b>		
		ZAVZPRET (zavegepant) <sup>NR</sup>	

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	<b>TRIPTANS &amp; RELATED AGENTS ORAL<sup>DUR+</sup></b>		
	naratriptan rizatriptan rizatriptan ODT sumatriptan tablets zolmitriptan zolmitriptan ODT	almotriptan AMERGE (naratriptan) AXERT (almotriptan) eletriptan FROVA (frovatriptan) frovatriptan IMITREX (sumatriptan) MAXALT (rizatriptan) MAXALT MLT (rizatriptan) RELPAX (eletriptan) REYVOW (lasmiditan) TREXIMET (sumatriptan/naproxen) ZOMIG (zolmitriptan)	<p><b>Minimum Age Limit – ALL FORMULATIONS</b></p> <ul style="list-style-type: none"> <li>• <b>6 years</b> – Maxalt</li> <li>• <b>12-17 years</b> – Axert, Treximet, Zomig nasal spray <u><i>Dur + will automatically be issued for this age range</i></u></li> <li>• <b>18 years</b> – Amerge, Frova, Imitrex, Onzetra Xsail, Relpax, Reyvow, Tosymra, Zembrace Symtouch, Zomig tablets</li> </ul> <p><b>Quantity Limit - ORAL</b></p> <ul style="list-style-type: none"> <li>• <b>4 tablets/31 days</b> – Reyvow 50 mg</li> <li>• <b>6 tablets/31 days</b> - Axert, Relpax Zomig</li> <li>• <b>8 tablets/31 days</b> – Reyvow 100 mg</li> <li>• <b>9 tablets/31 days</b> - Amerge, Frova, Imitrex, Treximet</li> <li>• <b>12 tablets/31 days</b> – Maxalt</li> </ul> <p><b>Non-Preferred Criteria - ORAL</b></p> <ul style="list-style-type: none"> <li>• Have tried 2 preferred oral agents in the past 90 days</li> </ul> <p><b>Reyvow</b></p> <ul style="list-style-type: none"> <li>• Documented diagnosis of migraine <b>AND</b></li> </ul>

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<b>NASAL</b>			<ul style="list-style-type: none"> <li>• Have tried 2 different triptans in the past 90 days <b>AND</b></li> <li>• Have tried preferred Nurtec ODT in the past 90 days</li> </ul> <p><b>Quantity Limit - NASAL</b></p> <ul style="list-style-type: none"> <li>• <b>1 box/31 days</b></li> </ul> <p><b>Non-Preferred Criteria - NASAL</b></p> <ul style="list-style-type: none"> <li>• Have tried 2 preferred oral agents in the past 90 days <b>AND</b></li> <li>• Have tried a preferred nasal agent in the past 90 days</li> </ul> <p><b>CUMULATIVE Quantity Limit - INJECTION</b></p> <p><b>4 injections/31 days</b></p>
	sumatriptan	IMITREX (sumatriptan) ONZETRA Xsail (sumatriptan) TOSYMRA (sumatriptan) zolmitriptan ZOMIG (zolmitriptan)	
<b>INJECTABLES</b>			
	sumatriptan	IMITREX (sumatriptan) ZEMBRACE (sumatriptan)	
<b>ANTIMIGRAINE AGENTS, PROPHYLAXIS</b>			
<b>INJECTIBLES</b>			
	AIMOVIG AUTOINJECTOR (erenumab-aooe) AJOVY AUTOINJECTOR (fremanezumab-vfrm) AJOVY SYRINGE (fremanezumab-vfrm)	EMGALITY PEN (galcanezumab-gnlm) EMGALITY SYRINGE (galcanezumab-gnlm) VYEPTI (eptinezumab-jjmr)	<p><b>Aimovig - <a href="#">MANUAL PA</a></b></p> <p><b>Ajovy - <a href="#">MANUAL PA</a></b></p> <p><b>Emgality - <a href="#">MANUAL PA</a></b></p> <p><b>Vyepti - <a href="#">MANUAL PA</a></b></p>
<b>ORAL</b>			
		NURTEC ODT (rimegepant) QULIPTA (atogepant)	<ul style="list-style-type: none"> <li>• See Antimigraine Agents, Acute</li> </ul>
<b>*ANTINEOPLASTICS – SELECTED SYSTEMIC ENZYME INHIBITORS</b>			
	BOSULIF (bosutinib) CAPRELSA (vandetanib)	<b>AFINITOR (everolimus)</b> ALECENSA (alectinib)	<b>Farydak - <a href="#">MANUAL PA</a></b>

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	COMETRIQ (cabozantinib) COTELLIC (cobimetinib) GILOTRIF (afatinib) <b>everolimus</b> ICLUSIG (ponatinib) imatinib mesylate IMBRUVICA (ibrutinib) INLYTA (axitinib) IRESSA (gefitinib) JAKAFI (ruxolitinib) MEKINIST (trametinib dimethyl sulfoxide) NEXAVAR (sorafenib) ROZLYTREK (entrectinib) SPRYCEL (dasatinib) STIVARGA (regorafenib) SUTENT (sunitinib) TAFINLAR (dabrafenib) TARCEVA (erlotinib) TASIGNA (nilotinib) TURALIO (pexidartinib) TYKERB (lapatinib ditosylate) vandetanib VOTRIENT (pazopanib) XALKORI (crizotinib) XTANDI (enzalutamide) ZELBORAF (vemurafenib) ZYDELIG (idelalisib) ZYKADIA (ceritinib)	ALUNBRIG (brigatinib) 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) GAVRETO (pralsetinib) gefitinib GLEEVEC (imatinib mesylate) GLEOSTINE (lomustine) IBRANCE (palbociclib) <sup>DUR+</sup> IDHIFA (enasidenib) INQOVI (cedazuridine/decitabine) INREBIC (fedratinib) <b>JAYPIRCA (pirtobrutinib)</b> <b>KRAZATI (adagrasib)</b> KISQALI (ribociclib) KOSELUGO (selumetinib) lapatinib ditosylate LENVIMA (lenvatinib) <sup>DUR+</sup> LORBRENA (lorlatinib) LUMAKRAS (sotorasib) LYNPARZA (olaparib) <sup>DUR+</sup>	<ul style="list-style-type: none"> <li>Documented diagnosis of multiple myeloma <b>AND</b></li> <li>Used in combination with bortezomib and dexamethasone per PI <b>AND</b></li> <li>History of 2 prior regimens including bortezomib and an immunomodulatory agent</li> </ul> <p><b>Ibrance</b></p> <ul style="list-style-type: none"> <li>Documented diagnosis of WD-DDLS for retroperitoneal sarcoma <b>OR</b></li> <li>All other indications evaluated through clinical review</li> </ul> <p><b>Lenvima</b></p> <ul style="list-style-type: none"> <li>Documented diagnosis of thyroid cancer <b>OR</b></li> <li>Documented diagnosis of hepatocellular carcinoma <b>OR</b></li> <li>Documented diagnosis of renal cell carcinoma <b>AND</b></li> <li>History of 1 claim for everolimus in the past 30 days <b>AND</b></li> <li>History of 1 anti-angiogenic agent in the past 2 years <b>OR</b></li> <li>All other indications evaluated through clinical review</li> </ul> <p><b>Lynparza Tablets</b></p>

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EFFECTIVE 09/01/2023

Version 2023.8

Updated:09/01/2023

(For All Medicaid, MSCAN and CHIP Beneficiaries)

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		<p><b>LYTGOBI (futibatinib)</b>            MEKTOVI (binimetnib)            NERLYNX (neratinib maleate)            NUBEQA (darolutamide)            ODOMZO (sonidegib)            ONUREG (azacitidine)            ORGOVYX (relugolix)            PEMAZYRE (pemigatinib)            PIQRAY (alpelisib)            QINLOCK (ripretinib)  <b>REZLIDHIA (lutasidenib)</b>            RETEVMO (selpercatinib)            RUBRACA (rucaparib)            RYDAPT (midostaurin)            SCEMBLIX (asciminib)            TABRECTA (capmatinib)            TAGRISSO (osimertinib)            TALZENNA (talazoparib)            TAZVERIK (tazemetostat)            TEPMETKO (tepotinib)            TIBSOVO (ivosidenib)            TRUSELTIQ (infigratinib)            TUKYSA (tucatinib)            UKONIQ (umbralisib)            VERZENIO (abemaciclib)            VITRAKVI (larotrectinib)            VIZIMPRO (dacomitinib)            VONJO (pacritinib)            WELIREG (belzutifan)            XATMEP (methotrexate)            XOSPATA (gilteritinib)            XPOVIO (selinexor)</p>	<ul style="list-style-type: none"> <li>• Documented diagnosis of ovarian cancer, fallopian tube or peritoneal cancer <b>AND</b></li> <li>• History of platinum-based chemotherapy in the past 2 years <b>OR</b></li> <li>• All other indications evaluated through clinical review</li> </ul>

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		ZEJULA (niraparib)	
<b>ANTIOBESITY SELECT AGENTS</b>			
	CONTRAVE (naltrexone/bupropion) SAXENDA (liraglutide) WEGOVY (semaglutide)	orlistat XENICAL (orlistat)	All agents require <a href="#">MANUAL PA</a>
<b>ANTIPARASITICS (Topical) <sup>DUR+</sup></b>			
<b>PEDICULICIDES</b>			
	permethrin 1% <sup>OTC</sup> NATROBA (spinosad)	lindane malathion OVIDE (malathion) SKLICE (ivermectin) spinosad VANALICE (piperonyl butoxide/pyrethrins)	<b>Minimum Age/Weight Limit for Pediculicides</b> <ul style="list-style-type: none"> <li>• <b>50 kg</b> - lindane shampoo</li> <li>• <b>2 months</b> – permethrin 1%(OTC)</li> <li>• <b>6 months</b> – Natroba, Sklice</li> <li>• <b>2 years</b> – piperonyl/pyrethrins (OTC)</li> <li>• <b>6 years</b> – Ovide</li> </ul> <b>Non-Preferred Criteria</b> <ul style="list-style-type: none"> <li>• Have tried 2 preferred topical lice agents in the past 90 days</li> </ul>
<b>SCABICIDES</b>			
	permethrin 5% ivermectin	ELIMITE (permethrin) EURAX CREAM (crotamiton) EURAX LOTION (crotamiton) STROMEKTOL Tablet (ivermectin)	<b>Minimum Age/Weight Limit for Topical Scabicides</b> <ul style="list-style-type: none"> <li>• <b>50 kg</b> - lindane lotion</li> <li>• <b>2 months</b> – permethrin 5%</li> <li>• <b>4 years</b> - Natroba</li> <li>• <b>18 years</b> – Eurax</li> </ul> <b>Non-Preferred Criteria</b>

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			<ul style="list-style-type: none"> <li>History of permethrin 5% in the past 90 days</li> </ul>	
<b>ANTIPARKINSON'S AGENTS (Oral) <sup>DUR+</sup></b>				
<b>ANTICHOLINERGICS</b>				
	benztropine trihexyphenidyl	COGENTIN (benztropine)	<p><b>Non-Preferred Criteria</b></p> <ul style="list-style-type: none"> <li>Documented diagnosis of Parkinson's disease <b>AND</b></li> <li>Have tried 2 different preferred agents in the past 6 months <b>OR</b></li> <li>90 consecutive days on the requested agent in the past 105 days</li> </ul>	
<b>COMT INHIBITORS</b>				
	entacapone	COMTAN (entacapone) ONGENTYS (opicapone) TASMAR (tolcapone) tolcapone		
<b>DOPAMINE AGONISTS</b>				
	ropinirole	KYNMOBI FILM (apomorphine) MIRAPEX (pramipexole) MIRAPEX ER (pramipexole) NEUPRO (rotigotine) pramipexole pramipexole ER REQUIP (ropinirole)		

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		REQUIP XL (ropinirole) ropinirole ER	
	<b>MAO-B INHIBITORS</b>		
	selegiline	AZILECT (rasagiline) ELDEPRYL (selegiline) rasagiline XADAGO (safinamide) ZELAPAR (selegiline)	<b>Xadago</b> <ul style="list-style-type: none"> <li>Documented diagnosis of Parkinson's disease <b>AND</b></li> <li>History of a preferred carbidopa/levodopa combination product in the past 30 days <b>AND</b></li> <li>History of selegiline product in the past 45 days</li> </ul>
	<b>OTHERS</b>		
	amantadine bromocriptine carbidopa levodopa/carbidopa	DUOPA (levodopa/carbidopa) GOCOVRI (amantadine) INBRIJA (levodopa) levodopa/carbidopa ODT levodopa/carbidopa/entacapone LODOSYN (carbidopa) NOURIANZ (istradefylline) OSMOLEX ER (amantadine) PARCOPA (levodopa/carbidopa) PARLODEL (bromocriptine) RYTARY ER (levodopa/carbidopa) SINEMET (levodopa/carbidopa) SINEMET CR (levodopa/carbidopa) STALEVO (levodopa/carbidopa/entacapone)	<b>Lodosyn and Inbrija</b> <ul style="list-style-type: none"> <li>Documented diagnosis of Parkinson's disease <b>AND</b></li> <li>History of a carbidopa/levodopa combination product in the past 45 days</li> </ul> <b>Nourianz</b> <ul style="list-style-type: none"> <li>Documented diagnosis of Parkinson's Disease <b>AND</b></li> <li>History of a preferred carbidopa/levodopa combination product in the past 30 days <b>AND</b></li> <li>History of 30 days therapy with a preferred adjunctive therapy in the past 45 days</li> </ul>
<b>ANTIPSYCHOTICS DUR+</b>			

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	<b>ORAL</b>		
	amitriptyline/perphenazine aripiprazole <b>asenapine</b> clozapine fluphenazine haloperidol olanzapine olanzapine ODT perphenazine quetiapine quetiapine XR risperidone risperidone ODT thioridazine thiothixene trifluoperazine 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 (brexipiprazole) RISPERDAL (risperidone) <b>SAPHRIS (asenapine)</b> SEROQUEL (quetiapine) SEROQUEL XR (quetiapine) SYMBYAX (olanzapine/fluoxetine) VERSACLOZ (clnazpine)	<p><b>Minimum Age Limit</b></p> <ul style="list-style-type: none"> <li>• <b>2 years</b> – Droperidol</li> <li>• <b>3 years</b> – Haldol</li> <li>• <b>5 years</b> – Risperdal, thioridazine</li> <li>• <b>6 years</b> – Abilify, trifluoperazine</li> <li>• <b>10 years</b> – Latuda, Saphris, Seroquel, Symbyax</li> <li>• <b>12 years</b> – Invega, Molidone, perphenazine, pimozone, thiothixene</li> <li>• <b>13 years</b> – Zyprexa</li> <li>• <b>18 years</b> – Abilify Mycite, Amitriptyline/perphenazine, Caplyta, Clozaril, Fanapt, fluphenazine, Geodon, loxapine, Lybalvi, Nuplazid, Rexulti, Secuado, Vraylar</li> </ul> <p><b>Concurrent Therapy Limit – Ages 0-17 years</b></p> <ul style="list-style-type: none"> <li>• 90 days with &gt;2 antipsychotics in the last 120 days will require a Manual PA</li> </ul> <p><b>Non-Preferred Criteria- Atypical Agents</b></p> <ul style="list-style-type: none"> <li>• Have tried 2 preferred atypical antipsychotic agents in the past 12 months <b>OR</b></li> </ul>

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		VRAYLAR (cariprazine) ZYPREXA (olanzapine)	<ul style="list-style-type: none"> <li>• 30 consecutive days on the requested atypical agent in the past 180 days</li> </ul> <p><b>Nuplazid</b></p> <ul style="list-style-type: none"> <li>• Documented diagnosis of Parkinson's disease</li> </ul>
<b>INJECTABLE, ATYPICALS <sup>DUR+</sup></b>			
	ABILIFY MAINTENA (aripiprazole) ARISTADA ER (aripiprazole lauroxil) ARISTADA INITIO (aripiprazole lauroxil) INVEGA HAFYERA (paliperidone) INVEGA SUSTENNA (paliperidone palmitate) INVEGA TRINZA (paliperidone) PERSERIS (risperidone) RISPERDAL CONSTA (risperidone)	ABILIFY (aripiprazole) ABILIFY ASIMTUFII (aripiprazole) <sup>NR</sup> GEODON (ziprasidone) olanzapine UZEDY (risperidone) <sup>NR</sup> ZYPREXA (olanzapine) ZYPREXA RELPREVV (olanzapine)	<p><b>Minimum Age Limit</b></p> <ul style="list-style-type: none"> <li>• <b>18 years</b> – all injectable agents</li> </ul> <p><b>Quantity Limit</b></p> <ul style="list-style-type: none"> <li>• <b>3 syringes/year</b> – Aristada Initio</li> </ul> <p><b>Long-Acting Injectable Agents All Agents</b></p> <ul style="list-style-type: none"> <li>• Documented diagnosis of schizophrenia or schizoaffective disorder</li> </ul> <p><b>Abilify Maintena or Risperdal Consta</b></p> <ul style="list-style-type: none"> <li>• Documented diagnosis of schizophrenia or schizoaffective disorder <b>OR</b></li> <li>• Documented diagnosis of bipolar disorder</li> </ul> <p><b>Invega Hafyera</b></p>

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			<ul style="list-style-type: none"> <li>• Documented diagnosis of schizophrenia or schizoaffective disorder <b>AND</b></li> <li>• 4 claims for Invega Sustenna in the past year <b>OR</b></li> <li>• 1 claim for Invega Trinza in the past year <b>OR</b></li> <li>• 1 claim for Invega Hafyera in the past year</li> </ul>
<b>TRANSDERMAL, ATYPICALS</b>			
		SECUADO (asenapine)	
<b>ANTIRETROVIRALS</b> <sup>DUR+</sup>			
<b>SINGLE PRODUCT REGIMENS</b>			
	BIKTARVY (bictegravir/emtricitabine/tenofovir) CABENUVA (cabotegravir/rilpivirine) DELSTRIGO (doravirine/lamivudine/tenofovir) DOVATO (dolutegravir/lamivudine) efavirenz/emtricitabine/tenofovir labeler GENVOYA (elvitegravir/cobicistat/emtricitabine/tenofovir) JULUCA (dolutegravir/rilpivirine) ODEFSEY (emtricitabine/rilpivirine/tenofovir AF) SYMFI (efavirenz/lamivudine/tenofovir) SYMFI-LO (efavirenz/lamivudine/tenofovir) TRIUMEQ (abacavir/lamivudine/ dolutegravir)	ATRIPLA (efavirenz/emtricitabine/tenofovir) COMPLERA (emtricitabine/rilpivirine/tenofovir) efavirenz/lamivudine/tenofovir efavirenz/lamivudine/tenofovir lo STRIBILD (elvitegravir/cobicistat/emtricitabine/tenofovir) SYMTUZA (darunavir/cobicistat/ emtricitabine/tenofovir)	<b>Stribild – MANUAL PA</b> <ul style="list-style-type: none"> <li>• Genotype testing supporting resistance to other regimens <b>OR</b></li> <li>• Intolerance or contraindication to preferred combination of drugs <b>AND</b></li> <li>• Medical reasoning beyond convenience or enhanced compliance over preferred agents <b>AND</b></li> <li>• CrCl &gt; 70mL/min to initiate therapy <b>OR</b> CrCl &gt;50mL/min to continue therapy</li> </ul>
<b>INTEGRASE STRAND TRANSFER INHIBITORS</b>			

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	APRETUDE ER (cabotegravir) ISENTRESS (raltegravir potassium) TIVICAY (dolutegravir sodium) TIVICAY PD (dolutegravir sodium)	ISENTRESS HD (raltegravir potassium) VITEKTA (elvitegravir)	<p><b>Non-Preferred Criteria</b></p> <ul style="list-style-type: none"> <li>• 1 claim with the requested agent in the past 105 days</li> </ul>
<b>NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS (NRTI)</b>			
	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)	
<b>NON-NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITOR (NNRTI)</b>			
	EDURANT (rilpivirine) efavirenz	INTELENCE (etravirine) nevirapine nevirapine ER PIFELTRO (doravirine) RESCRIPTOR (delavirdine mesylate) SUSTIVA (efavirenz) VIRAMUNE (nevirapine) VIRAMUNE ER (nevirapine)	
<b>PHARMACOENHANCER – CYTOCHROME P450 INHIBITOR</b>			
		TYBOST (cobicistat)	<b>Tybost - <a href="#">MANUAL PA</a></b>

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	<b>PROTEASE INHIBITORS (PEPTIDIC)</b>		
	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)	
	<b>PROTEASE INHIBITORS (NON-PEPTIDIC)</b>		
	PREZISTA (darunavir ethanolate)	APTIVUS (tipranavir) darunavir ethanolate PREZCOBIX (darunavir/cobicistat)	
	<b>ENTRY INHIBITORS – CCR5 CO-RECEPTOR ANTAGONISTS</b>		
		SELZENTRY (maraviroc)	
	<b>ENTRY INHIBITORS – FUSION INHIBITORS</b>		
		FUZEON (enfuvirtide)	
	<b>COMBINATION PRODUCTS - NRTIs</b>		
	abacavir/lamivudine CABENUVA (cabotegravir/rilpivirine) DOVATO (dolutegravir/lamivudine) JULUCA (dolutegravir/rilpivirine) lamivudine/zidovudine	abacavir/lamivudine/zidovudine COMBIVIR (lamivudine/zidovudine) EPZICOM (abacavir/lamivudine) TRIZIVIR (abacavir/lamivudine/zidovudine)	

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	<b>COMBINATION PRODUCTS – NUCLEOSIDE &amp; NUCLEOTIDE ANALOG RTIs</b>		
	DESCOVY (emtricitabine/tenofovir alafenam) emtricitabine/tenofovir	TRUVADA (emtricitabine/tenofovir)	
	<b>COMBINATION PRODUCTS – NUCLEOSIDE &amp; NUCLEOTIDE ANALOGS &amp; NON-NUCLEOSIDE RTIs</b>		
	CIMDUO (lamivudine/tenofovir) DELSTRIGO (doravirine/lamivudine/tenofovir) efavirenz/emtricitabine/tenofovir ODEFSEY (emtricitabine/rilpivirine/tenofovir AF)	ATRIPLA (efavirenz/emtricitabine/tenofovir) COMPLERA (emtricitabine/rilpivirine/tenofovir) TEMIXYS (lamivudine/tenofovir)	
	<b>COMBINATION PRODUCTS – PROTEASE INHIBITORS</b>		
	lopinavir/ritonavir	KALETRA (lopinavir/ritonavir)	
	<b>CAPSID INHIBITORS</b>		<b>All agents require clinical review.</b>
		SUNLENCA (lenacapavir)	
	<b>CD4 DIRECTED ATTACHMENT INHIBITOR</b>		
		RUKOBIA (fostemsavir tromethamine ER)	
	<b>CD4 DIRECTED HIV-1 INHIBITOR</b>		
		TROGARZO (ibalizumab)	
<b>ANTIVIRALS (Oral)</b>			

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(For All Medicaid, MSCAN and CHIP Beneficiaries)

EFFECTIVE 09/01/2023  
Version 2023.8  
Updated:09/01/2023

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
<b>ANTI-CYTOMEGALOVIRUS AGENTS</b>			
	valganciclovir tablets	LIVTENCITY (maribavir) PREVYMIS (letermovir) VALCYTE (valganciclovir) valganciclovir solution	<b>valganciclovir solution</b> – automatic approval for age <12 years  <b>Prevymis</b> Prevention (prophylaxis) of cytomegalovirus (CMV) infection and disease <ul style="list-style-type: none"> <li>• ≥ 18 years <b>AND</b></li> <li>• Post hematopoietic stem cell transplant (HSCT) within the past 28 days <b>AND</b></li> <li>• CMV sero-positive recipient [R+] <b>AND</b></li> <li>• NO severe (Child-Pugh Class C) hepatic impairment</li> </ul>
<b>ANTI-HERPETIC AGENTS</b>			
	acyclovir valacyclovir	famciclovir FAMVIR (famciclovir) SITAVIG (acyclovir) VALTREX (valacyclovir) ZOVIRAX (acyclovir)	
<b>ANTI-INFLUENZA AGENTS</b>			
	oseltamivir	FLUMADINE (rimantadine) RAPIVAB (peramivir) RELENZA (zanamivir)	

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		rimantadine TAMIFLU (oseltamivir) XOFLUZA (baloxavir marboxil)	
<b>ANTIVIRALS (Topical)</b>			
	ZOVIRAX Cream (acyclovir)	acyclovir cream, ointment DENAVIR (penciclovir) XERESE (acyclovir/hydrocortisone) ZOVIRAX Ointment (acyclovir)	
<b>AROMATASE INHIBITORS</b>			
	anastrozole exemestane letrozole	ARIMIDEX (anastrozole) AROMASIN (exemestane) FEMARA (letrozole)	
<b>ATOPIC DERMATITIS <sup>DUR+</sup></b>			

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	ADBRY (tralokinumab) DUPIXENT (dupilumab) ELIDEL (pimecrolimus) PROTOPIC (tacrolimus) tacrolimus	CIBINQO (abrocitinib) EUCRISA (crisaborole) OPZELURA (ruxolitinib) pimecrolimus	<p><b>Minimum Age Limit</b></p> <ul style="list-style-type: none"> <li>• <b>2 years</b> – Elidel, Protopic 0.03%</li> <li>• <b>16 years</b> – Protopic 0.1%</li> </ul> <p><b>Adbry- <a href="#">MANUAL PA</a></b></p> <p><b>Eucrisa</b></p> <ul style="list-style-type: none"> <li>• History of 28 days of therapy with a calcineurin inhibitor <b>AND</b></li> <li>• History of 28 days of therapy with a topical steroid in the past year <b>OR</b></li> <li>• <a href="#">MANUAL PA</a></li> </ul> <p><b>Dupixent</b>            Evaluated through Manual PA according to diagnosis  <b>Asthma – <a href="#">MANUAL PA</a></b>  <b>Atopic Dermatitis – <a href="#">MANUAL PA</a></b>  <b>Eosinophilic Esophagitis--  <a href="#">MANUAL PA</a></b>  <b>Nasal Polyposis – <a href="#">MANUAL PA</a></b>  <b>Prurigo Nodularis <a href="#">MANUAL PA</a></b></p>
<b>BETA BLOCKERS, ANTIANGINALS &amp; SINUS NODE AGENTS</b> <sup>DUR+</sup>			
	acebutolol atenolol bisoprolol metoprolol metoprolol ER nadolol	AZSRUZYO SPRINKLES (ranolazine) BETAPACE (sotalol) betaxolol BYSTOLIC (nebivolol) CORGARD (nadolol) HEMANGEOL (propranolol)	<p><b>Non-Preferred Criteria</b></p> <ul style="list-style-type: none"> <li>• Have tried 2 different preferred agents in the past 6 months <b>OR</b></li> <li>• 90 consecutive days on the requested agent in the past 105 days</li> </ul>

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	nebivolol pindolol propranolol propranolol ER sotalol	INDERAL LA (propranolol) INDERAL XL (propranolol) INNOPRAN XL (propranolol) KAPSPARGO SPRINKLES (metoprolol) KERLONE (bexetaxolol) LEVATOL (penbutolol) LOPRESSOR (metoprolol) SECTRAL (acebutolol) SOTYLIZE (sotalol) TENORMIN (atenolol) TOPROL XL (metoprolol) ZEBETA (bisoprolol)	
<b>BETA- AND ALPHA-BLOCKERS</b>			
	carvedilol labetalol	carvedilol CR COREG (carvedilol) COREG CR (carvedilol) TRANDATE (labetalol)	<b>Coreg CR</b> <ul style="list-style-type: none"> <li>• Documented diagnosis for hypertension <b>AND</b></li> <li>• Have tried generic carvedilol <b>AND</b> 1 preferred agent in the past 6 months <b>OR</b></li> <li>• 90 consecutive days on the requested agent in the past 105 days</li> </ul>
<b>BETA BLOCKER/DIURETIC COMBINATIONS</b>			

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	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)	
<b>ANTIANGINALS</b>			
		RANEXA (ranolazine) ranolazine	<b>Ranexa</b> <ul style="list-style-type: none"> <li>• Documented diagnosis of angina <b>AND</b></li> <li>• 1 claim for a calcium channel blocker, beta-blocker, nitrate, or combination agent in the past 30 days <b>OR</b></li> <li>• 90 consecutive days on the requested agent in the past 105 days</li> </ul>
<b>SINUS NODE AGENTS</b>			
		CORLANOR (ivabradine)	<b>Corlanor - <u>MANUAL PA</u></b>
<b>BILE SALTS</b>			
	ursodiol	ACTIGALL (ursodiol) BYLVAY (odevixibat) CHENODAL (chenodiol) CHOLBAM (cholic acid) LIVMARLI (maralixibat) OCALIVA (obeticholic acid)	

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		URSO (ursodiol) URSO FORTE (ursodiol)	
<b>BLADDER RELAXANT PREPARATIONS</b> <sup>DUR+</sup>			
	MYRBETRIQ ER (mirabegron) oxybutynin ER oxybutynin 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)	<b>Non-Preferred Criteria</b> • Have tried 2 different preferred agents in the past 6 months
<b>BONE RESORPTION SUPPRESSION AND RELATED AGENTS</b> <sup>DUR+</sup>			
	<b>BISPHOSPHONATES</b>		
	alendronate ibandronate risedronate	ACTONEL (risedronate) ACTONEL WITH CALCIUM (risedronate/calcium) alendronate solution ATELVIA (risedronate) BINOSTO (alendronate) BONIVA (ibandronate) DIDRONEL (etidronate)	<b>Non-Preferred Criteria</b> • Documented diagnosis for osteoporosis or osteopenia <b>AND</b> • Have tried 2 different preferred agents in the past 6 months

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		FOSAMAX (alendronate) FOSAMAX PLUS D (alendronate/vitamin D) risedronate DR Tablet	
<b>OTHERS</b>			
		calcitonin salmon EVENTY (romosozumab-aqqg) EVISTA (raloxifene) FORTEO (teriparatide) MIACALCIN (calcitonin) PROLIA (denosumab) raloxifene TYMLOS (abaloparatide) XGEVA (denosumab)	
<b>BPH AGENTS</b> <sup>DUR+</sup>			
<b>ALPHA BLOCKERS</b>			
	alfuzosin doxazosin tamsulosin terazosin	CARDURA (doxazosin) CARDURA XL (doxazosin) dutasteride/tamsulosin FLOMAX (tamsulosin) HYTRIN (terazosin) JALYN (dutasteride/tamsulosin) RAPAFLO (silodosin) silodosin UROXATRAL (alfuzosin)	<p><b>Female</b></p> <ul style="list-style-type: none"> <li>• Cardura, Flomax, Proscar, terazosin, or Uroxatral <b>AND</b></li> <li>• Documented diagnosis based on a State accepted diagnosis</li> </ul> <p><b>Non-Preferred Criteria - MALE</b></p> <ul style="list-style-type: none"> <li>• Have tried 2 different preferred agents in the past 6 months <b>OR</b></li> <li>• 90 consecutive days on the requested agent in the past 105 days</li> </ul>
<b>5-ALPHA-REDUCTASE (5AR) INHIBITORS</b>			

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	finasteride	AVODART (dutasteride) dutasteride ENTADFI (finasteride/tadalafil) PROSCAR (finasteride)	
<b>PDE5 INHIBITORS</b>			
		CIALIS (tadalafil)	
<b>BRONCHODILATORS &amp; COPD AGENTS</b>			
<b>ANTICHOLINERGICS &amp; COPD AGENTS</b>			
	ATROVENT HFA (ipratropium) INCRUSE ELLIPTA (umeclidinium) ipratropium SPIRIVA HANDIHALER (tiotropium)	DALIRESP (roflumilast) LONHALA MAGNAIR (glycopyrrolate) SEEBRI (glycopyrrolate) SPIRIVA RESPIMAT (tiotropium) <sup>DUR-</sup> TUDORZA PRESSAIR (aclidinium) YUPELRI (revefenacin)	<b>Minimum Age Limit</b> <b>6 years</b> – Spiriva Respimat  <b>Spiriva Respimat</b> • Automatic approval for ≥ 6 years with a diagnosis of asthma
<b>ANTICHOLINERGIC-BETA AGONIST COMBINATIONS</b>			
	albuterol/ipratropium ANORO ELLIPTA (umeclidinium/vilanterol) COMBIVENT RESPIMAT (albuterol/ipratropium) <sup>DUR+</sup> STIOLTO RESPIMAT (tiotropium/olodaterol)	BEVESPI (glycopyrrolate/formoterol) DUAKLIR PRESSAIR (aclidinium/formoterol)	
<b>ANTICHOLINERGIC-BETA AGONIST-GLUCOCORTICOID COMBINATIONS</b>			
		BREZTRI AEROSPHERE (budesonide/glycopyrrolate/formoterol) TRELEGY ELLIPTA (fluticasone furoate/umeclidinium/vilanterol)	

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<b>BRONCHODILATORS, BETA AGONIST</b>			
<b>INHALERS, SHORT-ACTING</b>			
	<b>albuterol HFA</b> PROVENTIL HFA (albuterol) VENTOLIN HFA (albuterol)	levalbuterol HFA PROAIR DIGIHALER (albuterol) PROAIR RESPICLICK (albuterol) XOPENEX HFA (levalbuterol) <sup>DUR+</sup>	<b>Minimum Age Limit</b> <ul style="list-style-type: none"> <li>• 4 years - Xopenex HFA</li> </ul> <b>Xopenex HFA</b> <ul style="list-style-type: none"> <li>• 1 claim for a preferred albuterol inhaler in the past 30 days</li> </ul> <b>ProAir Digihaler</b> <ul style="list-style-type: none"> <li>• Requires clinical review</li> </ul>
<b>INHALERS, LONG ACTING<sup>DUR+</sup></b>			
	SEREVENT (salmeterol) STRIVERDI RESPIMAT (olodaterol)		<b>Minimum Age Limit</b> <ul style="list-style-type: none"> <li>• 4 years – Serevent</li> <li>• 18 years -Striverdi Respimat</li> </ul>
<b>INHALATION SOLUTION<sup>DUR+</sup></b>			
	albuterol	arformoterol BROVANA (arformoterol) formoterol levalbuterol metaproterenol PERFOROMIST (formoterol)	<b>Minimum Age Limit</b> <ul style="list-style-type: none"> <li>• 6 years – Xopenex</li> <li>• 18 years – Brovana, Performist</li> </ul> <b>Non-Preferred Criteria</b>

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		XOPENEX (levalbuterol)	<ul style="list-style-type: none"> <li>• 1 claim for a different preferred agent in the past 6 months <b>OR</b></li> <li>• 3 claims with the requested agent in the past 105 days</li> </ul>
<b>ORAL</b>			
	albuterol ER albuterol IR metaproterenol terbutaline	VOSPIRE ER (albuterol)	<p><b>Xopenex</b></p> <ul style="list-style-type: none"> <li>• 1 claim for a preferred albuterol in the past 30 days</li> </ul>
<b>CALCIUM CHANNEL BLOCKERS <sup>DUR+</sup></b>			
<b>SHORT-ACTING</b>			
	diltiazem nicardipine nifedipine verapamil	CALAN (verapamil) CARDIZEM (diltiazem) isradipine nimodipine NORLIQVA (amlodipine) NYMALIZE SOLUTION (nimodipine) PROCARDIA (nifedipine)	<p><b>Quantity Limit - nimodipine</b></p> <ul style="list-style-type: none"> <li>• 252 tablets/ 21 days</li> <li>• 2520 mL/21 days</li> </ul> <p><b>Non-Preferred Criteria</b></p> <ul style="list-style-type: none"> <li>• Have tried 2 different preferred <u>Short Acting</u> CCB agents in the past 6 months <b>OR</b></li> <li>• 90 consecutive days on the requested agent in the past 105 days</li> </ul> <p><b>nimodipine</b></p>

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<b>LONG-ACTING</b>			
	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) PROCARDIA XL (nifedipine) SULAR (nisoldipine) TIAZAC (diltiazem) verapamil ER PM VERELAN/VERELAN PM (verapamil)	<ul style="list-style-type: none"> <li>Documented diagnosis of subarachnoid hemorrhage in the past 45 days <b>AND</b></li> <li>Duration of therapy limited to 21 days</li> </ul> <p><b>Non-Preferred Criteria</b></p> <ul style="list-style-type: none"> <li>Have tried 2 different preferred <u>Long Acting</u> CCB agents in the past 6 months <b>OR</b></li> <li>90 consecutive days on the requested agent in the past 105 days</li> </ul>
<b>CALORIC AGENTS</b>			
	BOOST (includes all Boost) BREAKFAST ESSENTIALS BRIGHT BEGINNINGS DUOCAL ENSURE	All other products (caloric /nutritional agents) not listed as preferred will require a manual prior authorization.	<p><b>Non-Preferred Agents - <u>MANUAL PA</u></b></p>

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	GLUCERNA NUTREN (includes all Nutren) OSMOLITE PEDIASURE PROMOD RESOURCE SCANDISHAKE TWOCAL HN			
<b>CEPHALOSPORINS AND RELATED ANTIBIOTICS (Oral)</b>				
<b>BETA LACTAM/BETA-LACTAMASE INHIBITOR COMBINATIONS</b>				
	amoxicillin/clavulanate amoxicillin/clavulanate XR	AUGMENTIN 125 and 250 Suspension (amoxicillin/clavulanate) AUGMENTIN (amoxicillin/clavulanate) Tablets AUGMENTIN XR (amoxicillin/clavulanate) MOXATAG (amoxicillin)		
<b>CEPHALOSPORINS – First Generation <sup>DUR+</sup></b>				
	cefadroxil cephalixin capsules cephalixin suspensio	cephalixin tablets DAXBIA (cephalexin) KEFLEX (cephalexin)	<b>Non-Preferred Criteria – all generations</b> <ul style="list-style-type: none"> <li>• Have tried 2 different preferred agents in the past 6 months</li> </ul>	
<b>CEPHALOSPORINS – Second Generation <sup>DUR+</sup></b>				
	cefaclor capsules cefprozil cefuroxime tablets	cefaclor ER cefaclor suspension cefuroxime suspension CEFTIN (cefuroxime)		
<b>CEPHALOSPORINS – Third Generation <sup>DUR+</sup></b>				

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	cefdinir suspension cefdinir capsules cefpodoxime	CEDAX (ceftibuten) cefditoren ceftibuten SPECTRACEF (cefditoren) SUPRAX (cefixime)	<b>Maximum Age Limit</b> • <b>18 years</b> – cefdinir suspension
<b>COLONY STIMULATING FACTORS</b>			
	FYLNETRA (pegfilgrastim) <b>STIMUFEND (pegfilgrastim-fpgk)</b> NEUPOGEN Syringe (filgrastim) NEUPOGEN Vial (filgrastim)	FULPHILA (pegfilgrastim) GRANIX (tbo-filgrastim) LEUKINE (sargramostim) NEULASTA (pegfilgrastim) NIVESTYM (filgrastim-aafi) NYVEPRIA (pegfilgrastim-apgf) RELEUKO (filgrastim) <b>ROLVEDON (eflapegrastim)</b> UDENYCA (pegfilgrastim-cbqv) ZARXIO (filgrastim) ZIEXTENZO (pegfilgrastim-bmez)	
<b>CYSTIC FIBROSIS AGENTS <sup>DUR+</sup></b>			
	tobramycin (generic TOBI)	BETHKIS (tobramycin) BRONCHITOL (mannitol) CAYSTON (aztreonam) colistmethate COLY-MYCIN M (colistimethate sodium) KALYDECO (ivacaftor) KITABIS (tobramycin) ORKAMBI (lumacaftor/ivacaftor) PULMOZYME (dornase alfa) SYMDEKO (tezacaftor/ivacaftor)	<b>Minimum Age Limit</b> • <b>1 month</b> – Kalydeco Granules • <b>3 months</b> – Pulmozyme • <b>1 year</b> - Orkambi • <b>2 years</b> – Coly-Mycin M, Trikafta Granules • <b>6 years</b> – Bethkis, Kalydeco tablet, Kitabis, Symdeko, TOBI, TOBI Podhaler, Trikafta tablet

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		TOBI (tobramycin) TOBI PODHALER (tobramycin) tobramycin (generic Bethkis) tobramycin (generic Kitabis) TRIKAFTA (elexacaftor/ tezacaftor/ivacaftor)	<ul style="list-style-type: none"> <li>• <b>7 years</b> – Cayston</li> <li>• <b>18 years</b> - Bronchitol</li> </ul> <p><b>Maximum Age Limit</b></p> <ul style="list-style-type: none"> <li>• <b>2 years</b> – Orkambi 75-94 mg Granules</li> <li>• <b>5 years</b> – Kalydeco, Orkambi 100-125 mg Granules, Orkambi 200-125 mg Granules, Trikafta Granules</li> <li>• <b>11 years</b> – Trikafta tablets</li> </ul> <p><b>All Agents</b></p> <ul style="list-style-type: none"> <li>• Documented diagnosis Cystic Fibrosis</li> </ul> <p><b>Colistimethate</b></p> <ul style="list-style-type: none"> <li>• Documented diagnosis of Cystic Fibrosis <b>OR</b></li> <li>• Requires clinical review</li> </ul> <p><b>Kalydeco</b> – <a href="#">MANUAL PA</a>  <b>Orkambi</b> – <a href="#">MANUAL PA</a>  <b>Symdeko</b> – <a href="#">MANUAL PA</a>  <b>Trikafta</b> – <a href="#">MANUAL PA</a></p> <p><b>TOBI Podhaler</b></p> <ul style="list-style-type: none"> <li>• Requires clinical review</li> </ul>
<b>CYTOKINE &amp; CAM ANTAGONISTS<sup>DUR+</sup></b>			

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	ACTEMRA SYRINGE (tocilizumab) ACTEMRA VIAL(tocilizumab) AVSOLA (infliximab) ENBREL (etanercept) HUMIRA (adalimumab) KINERET (anakinra) methotrexate ORENCIA CLICKJET(abatacept) ORENCIA VIAL(abatacept) OTEZLA (apremilast) SIMPONI (golimumab) TALTZ (ixekizumab) XELJANZ IR (tofacitinib)	ACTEMRA ACTPEN (tocilizumab) <b>AMJEVITA (adalimumab)</b> ARCALYST (rilonacept) CIMZIA (certolizumab) COSENTYX (secukinumab) ENTYVIO (vedolizumab) ILARIS (canakinumab) ILUMYA (tildrakizumab) INFLECTRA (infliximab) KEVZARA (sarilumab) OLUMIANT (baricitinib) ORENCIA SYRINGE (abatacept) OTREXUP (methotrexate) RASUVO (methotrexate) REMICADE (infliximab) RENFLEXIS (infliximab-abda) RHEUMATREX (methotrexate) RINVOQ (upadacitinib) RINVOQ ER (upadacitinib) SILIQ (brodalumab) SKYRIZI (risankizumab) SOTYKTU (deucravacitinib) SPEVIGO (spesolimab) STELARA (ustekinumab) TREMFYA (guselkumab) TREXALL (methotrexate) XELJANZ Oral Solution (tofacitinib) XELJANZ XR (tofacitinib)	<p><b>All preferred agents are subject to approved age and documented diagnosis for appropriate indication.</b></p> <p><b>All Non-Preferred Agents</b></p> <ul style="list-style-type: none"> <li>• Require clinical review</li> </ul> <p><b>IV Administered Agents</b></p> <ul style="list-style-type: none"> <li>• Require clinical review</li> </ul>

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<b>ERYTHROPOIESIS STIMULATING PROTEINS <sup>DUR+</sup></b>			
	EPOGEN (rHuEPO) MIRCERA (methoxy polyethylene glycol-epoetin-beta) RETACRIT (rHuEPO)	ARANESP (darbepoetin) PROCRT (rHuEPO)	<p><b>Mircera</b></p> <ul style="list-style-type: none"> <li>• Documented diagnosis chronic renal failure in the past 2 years</li> </ul> <p><b>Non-Preferred Criteria</b></p> <ul style="list-style-type: none"> <li>• Documented diagnosis of cancer or chronic renal failure <b>OR</b> Antineoplastic therapy in the past 6 months <b>AND</b></li> <li>• Trial of a preferred Retacrit or Epogen in the past 6 months <b>OR</b></li> <li>• 1 claim for the requested agent in the past 105 days</li> </ul>
<b>FACTOR DEFICIENCY PRODUCTS</b>			
<b>FACTOR VIII</b>			
	ADVATE AFSTYLA ALPHANATE FEIBA NF HEMOFIL M HUMATE-P KOATE KOGENATE FS KOVALTRY NOVOEIGHT	ADYNOVATE ELOCTATE ESPEROCT HEXILATE FS JIVI KCENTRA OBIZUR VONVENDI	

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	NUWIQ RECOMBINATE WILATE XYNTHA XYNTHA SOLOFUSE		
<b>FACTOR IX</b>			
	ALPHANINE SD ALPROLIX BENEFIX IDELVION IXINITY MONONINE PROFILNINE RIXUBIS	REBINYN	
<b>OTHER FACTOR PRODUCTS</b>			
	COAGADEX FIBRYGA HEMLIBRA <sup>DUR+</sup> RIASTAP	CORIFACT NOVOSEVEN RT SEVENFACT TRETEN	<b>Hemlibra</b> <ul style="list-style-type: none"> <li>• 1 claim with the requested agent in the past 105 days</li> <li>• <a href="#">MANUAL PA</a> – new patients</li> </ul>
FIBROMYALGIA/NEUROPATHIC PAIN AGENTS			
	duloxetine gabapentin pregabalin SABELLA (milnacipran)	CYMBALTA (duloxetine) <sup>DUR+</sup> DRIZALMA SPRINKLES (duloxetine DR) duloxetine DR GRALISE (gabapentin) HORIZANT (gabapentin) IRENKA (duloxetine) <sup>DUR+</sup> LYRICA (pregabalin)	<b>Cymbalta and Irenka (see Antidepressant, Other)</b>  <b>Minimum Age Limit</b> – 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	
<b>FLUOROQUINOLONES</b> DUR+			
	ciprofloxacin tablets levofloxacin tablets	AVELOX (moxifloxacin) BAXDELA (delaflozacin) CIPRO (ciprofloxacin) CIPRO SUSPENSION (ciprofloxacin) CIPRO XR (ciprofloxacin) ciprofloxacin ER ciprofloxacin suspension FACTIVE (gemifloxacin) LEVAQUIN (levofloxacin) levofloxacin solution moxifloxacin NOROXIN (norfloxacin) ofloxacin	<p><b>Non-Preferred Criteria</b></p> <ul style="list-style-type: none"> <li>• 1 claim for a preferred agent in past 30 days</li> </ul> <p><b>Cipro Suspension for age &lt; 12 years</b></p> <ul style="list-style-type: none"> <li>• Anthrax infection or exposure <b>OR</b></li> <li>• Cystic Fibrosis <b>OR</b></li> <li>• Pneumonic plague <b>OR</b> tularemia <b>AND</b> history of doxycycline in the past 3 months <b>OR</b></li> <li>• 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"> <li>○ Penicillin, 2nd or 3rd generation cephalosporin, or macrolide</li> </ul> </li> </ul> <p><b>Levaquin solution for age &lt; 12 years</b></p> <ul style="list-style-type: none"> <li>• Anthrax infection or exposure <b>OR</b></li> <li>• 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"> <li>○ Penicillin, 2nd or 3rd generation cephalosporin, or macrolide</li> </ul> </li> </ul> <p><b>AND</b></p>

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			<ul style="list-style-type: none"> <li>Cipro suspension in the past 3 months</li> </ul>
<b>GAUCHER'S DISEASE</b>			
	ELELYSO (taliglucerase alfa) ZAVESCA (miglustat)	CERDELGA (eliglustat) CEREZYME (imiglucerase) miglustat VPRIV (velaglucerase alfa)	
<b>GENITAL WARTS &amp; ACTINIC KERATOSIS AGENTS</b>			
	CONDYLOX (podofilox) <sup>Age Edit</sup> imiquimod <sup>Age Edit</sup> podofilox <sup>Age Edit</sup>	ALDARA (imiquimod) <sup>Age Edit</sup> CARAC (fluorouracil) diclofenac 3% gel EFUDEX (fluorouracil) fluorouracil 0.5% cream fluorouracil 5% cream PICATO (ingenol) <sup>Age Edit</sup> SOLARAZE (diclofenac) TOLAK (fluorouracil) VEREGEN (sinecatechins) <sup>Age Edit</sup> ZYCLARA (imiquimod) <sup>Age Edit</sup>	<b>Minimum Age Limit</b> <ul style="list-style-type: none"> <li><b>12 years</b> – Aldara, Zyclara</li> <li><b>18 years</b> – Condylox, Picato, Veregen</li> </ul>
<b>GLUCOCORTICOIDS (Inhaled)<sup>DUR+</sup></b>			
	<b>GLUCOCORTICOIDS</b>		
	ASMANEX TWISTHALER (mometasone) budesonide 0.25mg and 0.5mg FLOVENT DISKUS (fluticasone) FLOVENT HFA (fluticasone) PULMICORT FLEXHALER (budesonide)	ALVESCO (ciclesonide) ARMONAIR Digihaler (fluticasone) ARNUITY ELLIPTA (fluticasone) ASMANEX HFA (mometasone) budesonide 1mg	<b>Non-Preferred Criteria</b> <ul style="list-style-type: none"> <li>90 consecutive days on the requested agent in the past 105 days <b>OR</b></li> <li>Have tried 1 preferred agent in the past 6 months</li> </ul>

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	QVAR REDHALER (beclomethasone dipropionate)	PULMICORT (budesonide) Respules	<p><b>ArmonAir Digihaler</b></p> <ul style="list-style-type: none"> <li>Requires clinical review</li> </ul> <p><i>NOTE:</i> Institutional sized products are Non-Preferred</p>
<b>GLUCOCORTICOID/BRONCHODILATOR COMBINATIONS</b>			
	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 Resplick (fluticasone/salmeterol) BREO ELLIPTA (fluticasone/vilanterol) budesonide/formoterol WIXELA INHUB (fluticasone/salmeterol)	<p><b>Non-Preferred Criteria</b></p> <ul style="list-style-type: none"> <li>90 consecutive days on the requested agent in the past 105 days <b>OR</b></li> <li>Have tried 2 different preferred agents in the past 6 months</li> </ul> <p><b>AirDuo Digihaler</b></p> <ul style="list-style-type: none"> <li>Requires clinical review</li> </ul>
<b>GI ULCER THERAPIES</b>			
<b>H2 RECEPTOR ANTAGONISTS</b>			
	cimetidine solution famotidine solution famotidine tablets nizatidine solution	AXID (nizatidine) cimetidine tablets nizatidine tablets PEPCID (famotidine)	
<b>PROTON PUMP INHIBITORS</b>			
	esomeprazole magnesium DR Capsule NEXIUM PACKET (esomeprazole) omeprazole Rx pantoprazole	ACIPHEX SPRINKLE (rabeprazole) ACIPHEX Tablet (rabeprazole) DEXILANT (dexlansoprazole) esomeprazole strontium DR Capsule	<p><b>Prilosec suspension</b></p> <ul style="list-style-type: none"> <li>Automatic approval for 0 - 2 years</li> </ul>

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# MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

(For All Medicaid, MSCAN and CHIP Beneficiaries)

EFFECTIVE 09/01/2023  
Version 2023.8  
Updated:09/01/2023

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		KONVOMEK SUSPENSION (omeprazole/sodium bicarbonate) <sup>NR</sup> 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	
<b>OTHER</b>			
	misoprostol sucralfate suspension sucralfate tablet	CARAFATE SUSPENSION (sucralfate) CARAFATE TABLET (sucralfate) CYTOTEK (misoprostol) DARTISLA ODT (glycopyrrolate)	
<b>GROWTH HORMONE</b> DUR+			
	GENOTROPIN (somatropin) NORDITROPIN (somatropin) NUTROPIN AQ (somatropin)	HUMATROPE (somatropin) OMNITROPE (somatropin) SAIZEN (somatropin) SEROSTIM (somatropin) SKYTROFA (lonapegsomatropin) SOGROYA (somapacitan) <sup>NR</sup> VOZOGO (vosoritide) ZOMACTON (somatropin) ZORBTIVE (somatropin)	<p style="color: red;"><b>All Agents for Age ≥ 18 years</b></p> <ul style="list-style-type: none"> <li>• Documented diagnosis of craniopharyngioma, panhypopituitarism, Prader-Willi Syndrome, Turner Syndrome or an approvable adult diagnosis <b>OR</b></li> <li>• Documented procedure of cranial irradiation</li> </ul> <p style="color: red;"><b>All Agents for Age &lt; 18 years</b></p>

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			<ul style="list-style-type: none"> <li>Documented diagnosis of idiopathic short stature <b>AND</b></li> <li>Documented approvable pediatric diagnosis <b>OR</b></li> <li>Documented approvable pediatric diagnosis</li> </ul> <p><b>Non-Preferred Criteria</b></p> <ul style="list-style-type: none"> <li>Have tried 1 preferred agent in the past 6 months <b>OR</b></li> <li>84 consecutive days on the requested agent in the past 105 days</li> </ul>
<b>H. PYLORI COMBINATION TREATMENTS</b>			
	PYLERA (bismuth subcitrate potassium, metronidazole, tetracycline)	lansoprazole, amoxicillin, clarithromycin OMECLAMOX (omeprazole, clarithromycin, amoxicillin) PREVPAC (lansoprazole, amoxicillin, clarithromycin) TALICIA (omeprazole, amoxicillin, rifabutin)	<p><b>Quantity Limit</b></p> <ul style="list-style-type: none"> <li>1 treatment course/year</li> </ul>
<b>HEPATITIS B TREATMENTS</b>			
	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)	

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<b>HEPATITIS C TREATMENTS</b>			
	MAVYRET (glecaprevir/pibrentasvir) ∞ MAVYRET PELLETS ( glecaprevir/pibrentasvir)∞ PEGASYS (peginterferon alfa-2a) PEG-INTRON (peginterferon alfa-2b) ribavirin tablets sofosbuvir/velpatasvir∞	COPEGUS (ribavirin) EPCLUSA (sofosbuvir/velpatasvir) ∞ HARVONI (ledipasvir/sofosbuvir) ∞ ledipasvir/sofosbuvir∞ MODERIBA (ribavirin) OLYSIO (simeprevir) REBETOL (ribavirin) RIBASPHERE (ribavirin) RIBASPHERE RIBAPAK DOSEPACK (ribavirin) ribavirin capsules SOVALDI (sofosbuvir)∞ TECHNIVIE (ombitasvir/paritaprevir/ritonavir) VIEKIRA (ombitasvir/paritaprevir/ritonavir) VIEKIRA XR (ombitasvir/paritaprevir/ritonavir) VOSEVI (sofosbuvir/velpatasvir/voxilaprevir) ∞ ZEPATIER (elbasvir/grazoprevir) ∞	∞ <b>Epclusa, Harvoni, Mavyret, Sovaldi, Vosevi, Zepatier</b> • Require clinical review  <u>Note:</u> Epclusa, Harvoni, Mavyret and Sovaldi have FDA pediatric indications  <a href="#">MANUAL PA</a>
<b>HEREDITARY ANGIOEDEMA</b>			
		BERINERT (C1 esterase inhibitor) CINRYZE VIAL (C1 esterase inhibitor) FIRAZYR SYRINGE (icatibant acetate) HAEGARDA (C1 esterase inhibitor) icatibant KALBITOR VIAL (ecallantide) ORLADEYO (berotralstat hydrochloride)	

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		RUCONEST VIAL (C1 esterase inhibitor, recombinant) TAKHZYRO (Ivanomec)	
<b>HYPERURICEMIA &amp; GOUT</b> <small>DUR+</small>			
	allopurinol colchicine tablet probenecid probenecid/colchicine	colchicine capsule COLCRYS (colchicine) febuxostat GLOPERBA (colchicine) MITIGARE (colchicine) ULORIC (febuxostat) ZYLOPRIM (allopurinol)	<b>Non-Preferred Criteria</b> <ul style="list-style-type: none"> <li>• Have tried 2 different preferred agents in the past 6 months</li> </ul>
<b>HYPOGLYCEMIA TREATMENT, GLUCAGON</b>			
	BAQSIMI (glucagon) <small>Step Edit</small> glucagon vial glucagon labeler 00002 ZEGALOGUE (dasiglucagon) <small>Step Edit</small>	glucagon kit (labelers 63323, 00548) GVOKE (glucagon)	<b>Minimum Age Limit</b> <ul style="list-style-type: none"> <li>• 2 years – Gvoke</li> <li>• 4 years – Baqsimi</li> <li>• 6 years – Zegalogue</li> </ul> <b>Quantity Limit</b> <ul style="list-style-type: none"> <li>• 2 packs/31 days – Baqsimi</li> <li>• 2 syringes/31 days – Gvoke, Zegalogue</li> <li>• 2 kits/31 days – Glucagon</li> </ul> <b>Baqsimi</b> <ul style="list-style-type: none"> <li>• Have tried 1 different preferred glucagon in the past 365 days <b>OR</b></li> <li>• 1 claim with Baqsimi in the past 365 days</li> </ul>

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			<p><b>Zegalogue</b></p> <ul style="list-style-type: none"> <li>• Have tried 1 different preferred glucagon in the past 365 days <b>OR</b></li> <li>• 1 claim with Baqsimi in the past 365 days</li> </ul> <p><b>Gvoke</b></p> <ul style="list-style-type: none"> <li>• 1 claim with Baqsimi or Zegalogue in the past 30 days</li> </ul> <p><b>Non-Preferred Glucagons</b></p> <ul style="list-style-type: none"> <li>• Have tried 1 different preferred glucagon in the past 30 days</li> </ul>
<b>HYPOGLYCEMICS, BIGUANIDES</b> <sup>DUR+</sup>			
	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)	
<b>HYPOGLYCEMICS, DPP4s and COMBINATON</b> <sup>DUR+</sup>			
	JANUMET (sitagliptin/metformin) JANUMET XR (sitagliptin/metformin) JANUVIA (sitagliptin) JENTADUETO (linagliptin/metformin)	alogliptin alogliptin/metformin alogliptin/pioglitazone JENTADUETO XR (linagliptin/metformin)	Concomitant use of a GLP-1 product and a DPP-4 product requires clinical review

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	TRADJENTA (linagliptin)	KAZANO (alogliptin/metformin) KOMBIGLYZE XR (saxagliptin/metformin)* NESINA (alogliptin) ONGLYZA (saxagliptin) * OSEN! (alogliptin/pioglitazone)	
<b>HYPOGLYCEMICS, INCRETIN MIMETICS/ENHANCERS</b> <sup>DUR+</sup>			
	BYETTA (exenatide) TRULICITY (dulaglutide) VICTOZA (liraglutide)	ADLYXIN (lixisenatide) BYDUREON (exenatide) BYDUREON BCISE (exenatide) MOUNJARO (tirzepatide) OZEMPIC (semaglutide) RYBELSUS (semaglutide) SOLIQUA (insulin glargine/lixisenatide) SYMLIN (pramlintide) XULTOPHY (insulin degludec/ liraglutide)	<p><b>Preferred Criteria</b></p> <ul style="list-style-type: none"> <li>• Documented diagnosis for Type 2 Diabetes <b>OR</b></li> <li>• Have history of 84 days of therapy with the requested agent in the past 105 days</li> </ul> <p><b>Non-Preferred Criteria</b></p> <ul style="list-style-type: none"> <li>• Documented diagnosis for Type 2 Diabetes <b>AND</b></li> <li>• Have a history of 84 days of therapy with Trulicity in the past 6 months <b>AND</b></li> <li>• 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 <b>OR</b></li> <li>• Documented diagnosis for Type 2 Diabetes <b>AND</b></li> </ul>

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<b>HYPOGLYCEMICS, INSULINS AND RELATED AGENTS <sup>DUR+</sup></b>			
	HUMULIN N, R, 70/30 VIAL <sup>OTC</sup> (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	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)	<ul style="list-style-type: none"> <li>Have a history of 84 days of therapy with the requested agent in the past 105</li> </ul> <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> <p>Concomitant use of a GLP-1 product and a DPP-4 product requires clinical review</p> <p>Insulin pen formulations are not covered for Long Term Care (LTC) beneficiaries.</p> <p><b>Non-Preferred Criteria</b></p> <ul style="list-style-type: none"> <li>Documented diagnosis of Diabetes Mellitus <b>AND</b></li> <li>Have tried 1 preferred product in the past 6 months <b>OR</b></li> <li>1 claim with the requested agent in the past 105 days</li> </ul>

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Therapeutic Drug Class	Preferred Agents	Non-Preferred Agents	PA Criteria
	LANTUS SOLOSTAR & VIAL (insulin glargine) LEVEMIR FLEXPEN & VIAL (insulin detemir) TOUJEO (insulin glargine) TOUJEO MAX (insulin glargine)	HUMULIN N, 70/30 KWIKPEN (insulin) <sup>OTC</sup> insulin glargine LYUMJEV KWIKPEN (insulin lispro) LYUMJEV VIAL (insulin lispro) NOVOLIN N, R, 70/30 FLEXPEN (insulin) <sup>OTC</sup> NOVOLIN N, R, 70/30 VIAL (insulin) <sup>OTC</sup> NOVOLOG FLEXPEN & VIAL (insulin aspart) NOVOLOG MIX FLEXPEN & VIAL (insulin aspart/ aspart protamine) SEMGLEE (insulin glargine) TRESIBA (insulin degludec)	<b>Quantity Limit</b> • <a href="#">Insulin Quantity Limits found here</a>
<b>HYPOGLYCEMICS, MEGLITINIDES</b> <sup>DUR+</sup>			
	nateglinide repaglinide	PRANDIMET (repaglinide/metformin) PRANDIN (repaglinide) repaglinide/metformin STARLIX (nateglinide)	
<b>HYPOGLYCEMICS, SODIUM GLUCOSE COTRANSPORTER-2 INHIBITORS</b> <sup>DUR+</sup>			
<b>HYPOGLYCEMICS, SODIUM GLUCOSE COTRANSPORTER-2 INHIBITORS</b>			
	FARXIGA (dapagliflozin) INVOKANA (canagliflozin) JARDIANCE (empagliflozin)	STEGLATRO (ertugliflozin)	
<b>HYPOGLYCEMICS, SODIUM GLUCOSE COTRANSPORTER-2 INHIBITOR COMBINATIONS</b>			
	INVOKAMET (canagliflozin/metformin) SYNJARDY (empagliflozin/metformin)	GLYXAMBI (empagliflozin/linagliptin) INVOKAMET XR (canagliflozin/metformin) QTERN (dapagliflozin/saxagliptin)	

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		SEGLUROMET (ertugliflozin/metformin) STEGLUJAN (ertugliflozin/sitagliptin) SYNJARDY XR (empagliflozin/metformin) TRIJARDY XR (empagliflozin/linagliptin/metformin) XIGDUO XR (dapagliflozin/metformin)	
<b>HYPOGLYCEMICS, TZDS</b>			
<b>THIAZOLIDINEDIONES</b>			
	pioglitazone	ACTOS (pioglitazone) AVANDIA (rosiglitazone)	
<b>TZD COMBINATIONS</b>			
	pioglitazone/metformin	ACTOPLUS MET (pioglitazone/metformin) ACTOPLUSMET XR (pioglitazone/metformin) AVANDAMET (rosiglitazone/metformin) AVANDARYL (rosiglitazone/glipizide) DUETACT (pioglitazone/glimepiride) pioglitazone/glimepiride	
<b>IDIOPATHIC PULMONARY FIBROSIS <sup>DUR+</sup></b>			
	OFEV (nintedanib)	ESBRIET (pirfenidone) pirfenidone	<b>All Agents</b> • Documented diagnosis Idiopathic Pulmonary Fibrosis
<b>IMMUNOSUPPRESSIVE (ORAL) <sup>DUR+</sup></b>			
	AZASAN (azathioprine) azathioprine CELLCEPT (mycophenolate) cyclosporine cyclosporine modified	ASTAGRAF XL (tacrolimus) ENVARUS XR (tacrolimus) HECORIA (tacrolimus) MYFORTIC (mycophenolic acid) PROGRAF (tacrolimus)	<b>Minimum Age Limit</b> • <b>13 years</b> - Rapamune • <b>18 years</b> - Zortress

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	<p><b>everolimus</b>            GENGRAF (cyclosporine)            IMURAN (azathioprine)            mycophenolic acid            mycophenolate mofetil            NEORAL (cyclosporine)            RAPAMUNE (sirolimus)            SANDIMMUNE (cyclosporine)            sirolimus            tacrolimus</p>	<p>REZUROCK (belumosudil)  <b>ZORTRESS (everolimus)</b></p>	<p><b>Astagraf, Cellcept, Envarsus XR, Hecoria, Prograf</b></p> <ul style="list-style-type: none"> <li>• Documented diagnosis for heart transplant, kidney transplant, liver transplant, lung transplant or a State accepted diagnosis</li> </ul> <p><b>Azasan</b></p> <ul style="list-style-type: none"> <li>• Documented diagnosis of kidney transplant, RA, or a State accepted diagnosis</li> </ul> <p><b>Gengraf, Neoral, Sandimmune</b></p> <ul style="list-style-type: none"> <li>• Documented diagnosis of heart transplant, kidney transplant, liver transplant, psoriasis, RA, or a State accepted diagnosis <b>OR</b></li> <li>• Clinical review required for a diagnosis of Kimura's disease or multifocal motor neuropathy</li> </ul> <p><b>Myfortic</b></p> <ul style="list-style-type: none"> <li>• Documented diagnosis of kidney transplant or psoriasis</li> </ul> <p><b>Rapamune</b></p> <ul style="list-style-type: none"> <li>• Documented diagnosis of kidney transplant</li> </ul>

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Therapeutic Drug Class	Preferred Agents	Non-Preferred Agents	PA Criteria
			<b>Zortress</b> • Documented diagnosis of kidney transplant or liver transplant
<b>IMMUNE GLOBULINS</b>			
	BIVIGAM CARIMUNE NF FLEBOGAMMA DIF GAMASTAN SD GAMMAGARD GAMMAGARD SD GAMUNEX-C HIZENTRA HYQVIA PANZYGA PRIVIGEN XEMBIFY	ASCENIV CABLIVI CUTAQUIG CUVITRU GAMMAKED GAMMAPLEX OCTAGAM	
<b>IMMUNOLOGIC THERAPIES FOR ASTHMA</b>			
	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)	<b>All require a clinical review</b>  <b>Dupixent – <a href="#">MANUAL PA</a></b> <b>Fasenra- <a href="#">MANUAL PA</a></b> <b>Xolair- <a href="#">MANUAL PA</a></b>
<b>INTRANASAL RHINITIS AGENTS</b>			
<b>ANTICHOLINERGICS</b>			
	ipratropium	ATROVENT (ipratropium)	
<b>ANTI-HISTAMINES</b>			

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	azelastine	ASTEPRO (azelastine) olopatadine PATANASE (olopatadine)	
<b>ANTIHISTAMINE/CORTICOSTEROID COMBINATION <sup>DUR+</sup></b>			
		DYMISTA (azelastine/fluticasone) RYALTRIS (olopatadine/mometasone) TICALAST (azelastine/fluticasone)	
<b>CORTICOSTEROIDS <sup>DUR+</sup></b>			
	fluticasone <sup>Rx Only</sup>	BECONASE AQ (beclomethasone) budesonide flunisolide mometasone NASONEX (mometasone) OMNARIS (ciclesonide) QNASL (beclomethasone) TICANASE KIT (flonase kit) triamcinolone VERAMYST (fluticasone) XHANCE (fluticasone) ZETONNA (ciclesonide)	<b>Non-Preferred Criteria</b> <ul style="list-style-type: none"> <li>• Documented diagnosis for allergic rhinitis <b>AND</b></li> <li>• Have tried 1 different preferred agent in the past 6 months</li> </ul>
<b>IRON CHELATING AGENTS</b>			
	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)	<b>Jadenu – <a href="#">MANUAL PA</a></b>
<b>IRRITABLE BOWEL SYNDROME/SHORT BOWEL SYNDROME AGENTS/SELECTED GI AGENTS <sup>DUR+</sup></b>			

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<b>IRRITABLE BOWEL SYNDROME CONSTIPATION</b>			
	AMITIZA (lubiprostone) LINZESS 145mcg, 290mcg (linaclotide) MOVANTIK (naloxegol)	IBSRELA (tenapanor) LINZESS 72mcg (linaclotide) linaclotide lubiprostone MOTEGRITY (prucalopride) RELISTOR (methylnaltrexone) SYMPROIC (naldemedine) TRULANCE (plecanatide) ZELNORM (tegaserod)	<p><b>Minimum Age Limit All Subclasses</b></p> <ul style="list-style-type: none"> <li>• <b>18 years</b> – except <i>Bentyl, Gattex, Levsin</i></li> </ul> <p><b>Gender Limit</b></p> <ul style="list-style-type: none"> <li>• <b>Female</b> – Amitiza 8mcg</li> </ul> <p><b>Chronic Idiopathic Constipation (CIC)</b></p> <p>AMITIZA 24MCG, LINZESS 72MCG, LINZESS 145 MCG, MOTEGRITY, TRULANCE</p> <p><b>All CIC Agents</b></p> <ul style="list-style-type: none"> <li>• Documented diagnosis of CIC in the past year <b>AND</b></li> <li>• No history of GI or bowel obstruction</li> </ul> <p><b>Non-Preferred CIC Agents</b></p> <ul style="list-style-type: none"> <li>• Above CIC criteria <b>AND</b></li> <li>• 30 days of therapy with 2 preferred agents in the past 6 months <b>OR</b></li> <li>• 1 claim with the requested agent in the past 105 days</li> </ul> <p><b>Irritable Bowel Syndrome – Constipation Dominant (IBS-C)</b></p> <p>AMITIZA 8MCG, IBSRELA, LINZESS 290 MCG, TRULANCE</p>

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			<p><b>All IBS-C Agents</b></p> <ul style="list-style-type: none"> <li>• Documented diagnosis of IBS-C in the past year <b>AND</b></li> <li>• No history of GI or bowel obstruction</li> </ul> <p><b>Non-Preferred IBS-C Agents</b></p> <ul style="list-style-type: none"> <li>• Above IBS-C criteria <b>AND</b></li> <li>• 30 days of therapy with 2 preferred agents in the past 6 months <b>OR</b></li> <li>• 1 claim with the requested agent in the past 105 days</li> </ul> <p><b><u>Opioid Induced Constipation (OIC)</u></b> AMITIZA 24MCG, MOVANTIK, RELISTOR, SYMPROIC</p> <p><b>All OIC Agents</b></p> <ul style="list-style-type: none"> <li>• Documented diagnosis of OIC in the past year <b>AND</b></li> <li>• 1 claim for an opioid in the past 30 days <b>AND</b></li> <li>• No history of GI or bowel obstruction <b>AND</b></li> <li>• Documented diagnosis of chronic pain in the past year</li> </ul> <p><b>Non- Preferred OIC Agents</b></p> <ul style="list-style-type: none"> <li>• Above OIC criteria <b>AND</b></li> <li>• 30 days of therapy with 2 preferred agents in the past 6 months <b>OR</b></li> </ul>

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			<ul style="list-style-type: none"> <li>• 1 claim with the requested agent in the past 105 days</li> </ul> <p><b>Relistor Injection</b></p> <ul style="list-style-type: none"> <li>• Above OIC criteria <b>AND</b></li> <li>• Documented diagnosis of active cancer in the past year <b>AND</b></li> <li>• Documented diagnosis of palliative care in the past 6 months</li> </ul>
<b>IRRITABLE BOWEL SYNDROME DIARRHEA</b>			
	dicyclomine hyoscyamine	alosetron BENTYL (dicyclomine) LEVSIN (hyoscyamine) LEVSIN-SL (hyoscyamine) LOTRONEX (alosetron) VIBERZI (eluxadoline)*	<p><b>Viberzi</b></p> <ul style="list-style-type: none"> <li>• Documented diagnosis of Irritable Bowel Syndrome – Diarrhea Dominant (IBS-D) in the past year <b>AND</b></li> <li>• 30 days of therapy with 2 preferred agents in the past 6 months <b>OR</b></li> <li>• 1 claim with the requested agent in the past 105 days</li> </ul> <p><b>Lotronex</b></p> <ul style="list-style-type: none"> <li>• 1 claim for the requested agent in the past 105 days <b>OR</b></li> <li>• <b>MANUAL PA</b> - All new patients require manual review</li> </ul> <p><b>Xifaxan - (see Antibiotics, GI)</b></p>
<b>SHORT BOWEL SYNDROME AND SELECTED GI AGENTS</b>			
		GATTEX (teduglutide)	<b>Carcinoid Syndrome Agent</b>

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		MYTESI (crofelemer) NUTRESTORE POWDER PACK (glutamine) XERMELO (telotristat ethyl) ZORBTIVE (somatropin)	<p><b>XERMELO</b></p> <ul style="list-style-type: none"> <li>Documented diagnosis of carcinoid syndrome in the past year <b>AND</b></li> <li>1 claim for a somatostatin analog in the past 30 days</li> </ul> <p><b>HIV/AIDS Non-infectious Diarrhea</b></p> <p><b>MYTESI</b></p> <ul style="list-style-type: none"> <li>Documented diagnosis of HIV/AIDS in the past year <b>AND</b></li> <li>Documented diagnosis of non-infectious diarrhea in the past year <b>AND</b></li> <li>1 claim for an antiretroviral in the past 30 days</li> </ul> <p><b>Short Bowel Syndrome (SBS)</b></p> <p><b>GATTEX, NUTRESTORE, ZORBTIVE</b></p> <p><b>Gattex or Zorbtive</b></p> <ul style="list-style-type: none"> <li>1 claim for the requested agent in the past 105 days <b>OR</b></li> <li>All new patients require clinical review</li> </ul> <p><b>Nutrestore</b></p> <ul style="list-style-type: none"> <li>Requires clinical review</li> </ul>
<b>LEUKOTRIENE MODIFIERS <sup>DUR+</sup></b>			
	montelukast granules montelukast tablets	ACCOLATE (zafirlukast) SINGULAIR Tablets (montelukast)	<p><b>Minimum Age Limit</b></p> <ul style="list-style-type: none"> <li><b>12 years</b> – Zyflo &amp; Zyflo CR</li> </ul>

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	zafirlukast	SINGULAR GRANULES (montelukast granules) zileuton ZYFLO CR (zileuton)	<b>Non-Preferred Criteria</b> • Have tried 2 different preferred agents in the past 6 months
<b>LIPOTROPICS, OTHER (NON-STATINS)</b>			
<b>ACL INHIBITORS AND COMBINATIONS</b>			
		NEXLETOL (bempedoic acid) NEXLIZET (bempedoic acid/ezetimibe)	<b>Nexletol and Nexlizet</b> • Requires clinical review
<b>ANGIOPHOTIN LIKE 3 INHIBITORS</b>			
		EVKEEZA (evinacumab-dgnb)	<b>Non-Preferred Criteria</b> Have tried 2 different preferred Non-statin Lipotropic agents in the past 6 months
<b>BILE ACID SEQUESTRANTS</b>			
	cholestyramine colestipol	colesevelam COLESTID (colestipol) QUESTRAN (cholestyramine) WELCHOL (colesevelam)	
<b>OMEGA-3 FATTY ACIDS</b>			
	omega 3 acid ethyl esters	icosapent LOVAZA (omega-3-acid ethyl esters) VASCEPA (icosapent ethyl)	
<b>CHOLESTEROL ABSORPTION INHIBITORS</b>			
	ezetimibe	ZETIA (ezetimibe)	

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	<b>FIBRIC ACID DERIVATIVES</b>		
	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)	<b>Fibric Acid Derivative Non-Preferred Criteria</b> • Have tried 2 different fibric acid derivatives in the past 6 months
	<b>MTP INHIBITOR</b>		
		JUXTAPID (lomitapide)	<b>Juxtapid – <a href="#">MANUAL PA</a></b>
	<b>APOLIPOPROTEIN B-100 SYNTHESIS INHIBITOR</b>		
		KYNAMRO (mipomersen)	<b>Kynamro – <a href="#">MANUAL PA</a></b>
	<b>NIACIN</b>		
	niacin ER NIACOR (niacin)	NIASPAN (niacin)	
	<b>PCSK-9 INHIBITOR</b>		
	PRALUENT (alirocumab) REPATHA (evolocumab)	LEQVIO (inclisiran)	<b>Leqvio</b> • Requires clinical review  <b>Praluent - <a href="#">MANUAL PA</a></b>

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			Repatha - <a href="#">MANUAL PA</a>
<b>LIPOTROPICS, STATINS</b> <sup>DUR+</sup>			
	<b>STATINS</b>		
	atorvastatin lovastatin pravastatin rosuvastatin simvastatin	ALTOPREV (lovastatin) ATORVALIQ SUSPENSION (atorvastatin calcium) <sup>NR</sup> CRESTOR (rosuvastatin) EZALLOR SPRINKLE (rosuvastatin) FLOLIPID (simvastatin) fluvastatin ER fluvastatin LESCOL (fluvastatin) LESCOL XL (fluvastatin) LIPITOR (atorvastatin) LIVALO (pitavastatin) MEVACOR (lovastatin) PRAVACHOL (pravastatin) ZOCOR (simvastatin) ZYPITAMAG (pitavastatin)	<b>Simvastatin 80mg</b> <ul style="list-style-type: none"> <li>• 12 months of therapy with simvastatin 80mg <b>AND</b></li> <li>• NO myopathy contraindication</li> </ul> <b>Non-Preferred Criteria</b> <ul style="list-style-type: none"> <li>• Have tried 2 different preferred statin or statin combination agents in the past 6 months <b>OR</b></li> <li>• 90 consecutive days on the requested agent in the past 105 days</li> </ul>
	<b>STATIN COMBINATIONS</b>		
	ezetimibe/simvastatin SIMCOR (simvastatin/niacin)	ADVICOR (lovastatin/niacin) atorvastatin/amlodipine CADUET (atorvastatin/amlodipine) LIPTRUZET (atorvastatin/ezetimibe) VYTORIN (simvastatin/ezetimibe)	<b>Non-Preferred Criteria</b> <ul style="list-style-type: none"> <li>• Have tried 2 different preferred statin or statin combination agents in the past 6 months <b>OR</b></li> <li>• 90 consecutive days on the requested agent in the past 105 days</li> </ul>

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<b>MISCELLANEOUS BRAND/GENERIC</b>			
<b>EPINEPHRINE</b>			
	epinephrine autoinject pens (labeler 49502) SYMJEPI (epinephrine)	ADRENALIN (epinephrine) AUVI-Q (epinephrine) EPINEPHRINE SNAP EMS KIT (epinephrine) EPIPEN (epinephrine) EPIPEN JR (epinephrine)	<b>Quantity Limit</b> • 2 kits/31 days
<b>MISCELLANEOUS</b>			
	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) <sup>NR</sup> KORLYM (mifepristone) lenalidomide MEGACE ES (megestrol) VERQUVO (vericiguat) VISTARIL (hydroxyzine pamoate)	<b>Alprazolam ER CUMULATIVE quantity limit</b> • 31 tablets/31 days  <b>Evrysdi - <a href="#">MANUAL PA</a></b>
<b>ALLERGEN EXTRACT IMMUNOTHERAPY</b>			
		GRASTEK ORALAIR PALFORZIA RAGWITEK	
<b>SUBLINGUAL NITROGLYCERIN</b>			
	nitroglycerin lingual 12gm nitroglycerin sublingual	nitroglycerin lingual 4.9gm NITROLINGUAL (nitroglycerin) 4.9gm NITROMIST (nitroglycerin)	

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(For All Medicaid, MSCAN and CHIP Beneficiaries)

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	NITROLINGUAL PUMPSPRAY (nitroglycerin) 12gm NITROSTAT SUBLINGUAL (nitroglycerin)		
<b>MOVEMENT DISORDER AGENTS</b> DUR+			
	AUSTEDO (deutetrabenazine) AUSTEDO XR (deutetrabenazine) <sup>NR</sup> INGREZZA (valbenazine) tetraabenazine (all labelers except those listed as non-preferred)	tetrabenazine (labeler 47335, 51224, 60505, 68180, 686820) XENAZINE (tetrabenazine)	<p><b>Austedo and Austedo XR</b></p> <ul style="list-style-type: none"> <li>Documented diagnosis of Huntington's chorea <b>OR</b></li> <li>Documented diagnosis of tardive dyskinesia <b>AND</b></li> <li>90 days therapy with Austedo or Austedo XR in the past 105 days <b>OR</b></li> <li><a href="#">MANUAL PA</a></li> </ul> <p><b>Ingrezza</b></p> <ul style="list-style-type: none"> <li>Documented diagnosis of tardive dyskinesia <b>AND</b></li> <li>90 days therapy with Ingrezza in the past 105 days <b>OR</b></li> <li><a href="#">MANUAL PA</a></li> </ul>
<b>MULTIPLE SCLEROSIS AGENTS</b> DUR+			
	AVONEX (interferon beta-1a) AVONEX PEN (interferon beta-1a) BETASERON (interferon beta-1b) COPAXONE 20mg (glatiramer) dalfampridine dimethyl fumarate <b>fingolimod</b>	AMPYRA (dalfampridine) <b>AUBAGIO (teriflunomide)</b> BAFIERTAM (monomethyl fumarate) <b>BRIUMVI (ublituximab)</b> COPAXONE 40mg (glatiramer) EXTAVIA (interferon beta-1b) glatiramer	<p><b>All Agents</b></p> <ul style="list-style-type: none"> <li>Documented diagnosis of multiple sclerosis</li> </ul> <p><b>Non-Preferred Criteria</b></p> <ul style="list-style-type: none"> <li>Have tried 2 different preferred agents in the past 6 months <b>OR</b></li> </ul>

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	GILENYA (fingolimod) REBIF (interferon beta-1a) REBIF REBIDOSE (interferon beta-1a) <b>teriflunomide</b> TYSABRI (natalizumab)	GLATOPA (glatiramer) KESIMPTA (ofatumumab) MAVENCLAD (cladribine) MAYZENT (siponimod) OCREVUS (ocrelizumab) PLEGRIDY (interferon beta-1a) PONVORY (ponesimod) <b>TASCENSO ODT (fingolimod)</b> TECFIDERA (dimethyl fumarate) VUMERITY (diroximel fumarate) ZEPOSIA (ozanimod)	<ul style="list-style-type: none"> <li>3 claims with the requested agent in the last 105 days</li> </ul> <p><b>Kesimpta, Ponvory, Tascenso ODT, and Zeposia</b></p> <ul style="list-style-type: none"> <li>Requires clinical review</li> </ul> <p><b>Mavenclad – <a href="#">MANUAL PA</a></b></p> <p><b>Mayzent – <a href="#">MANUAL PA</a></b></p> <p><b>Ocrevus – <a href="#">MANUAL PA</a></b></p>
<b>MUSCULAR DYSTROPHY AGENTS</b>			
		AMONDYS 45 (casimersen) EMFLAZA (deflazacort) EXONDYS 51 (eteplirsen) VILTEPSO (viltolarsen) VYONDYS 53 (golodirsen)	<p><b>Emflaza – <a href="#">MANUAL PA</a></b></p> <p><b>Exondys – <a href="#">MANUAL PA</a></b></p> <p><b>Viltepsos – <a href="#">MANUAL PA</a></b></p> <p><b>Vyondys – <a href="#">MANUAL PA</a></b></p>
<b>NSAIDS <sup>DUR+</sup></b>			
<b>NON-SELECTIVE</b>			
	diclofenac EC diclofenac IR diclofenac SR etodolac IR tab flurbiprofen ibuprofen ibuprofen suspension <sup>OTC</sup> indomethacin	ADVIL (ibuprofen) ANAPROX (naproxen) CAMBIA (diclofenac potassium) CATAFLAM (diclofenac) DAYPRO (oxaprozin) diclofenac potassium etodolac cap etodolac tab SR	<p><b>Non-Preferred Criteria</b></p> <ul style="list-style-type: none"> <li>Have tried 2 different preferred non-selective or NSAID/GI protectant combination agents in the past 6 months</li> </ul>

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	ketoprofen ketorolac nabumetone naproxen 250mg and 500mg naproxen suspension piroxicam sulindac	FELDENE (piroxicam) FENORTHO (fenoprofen) fenoprofen INDOCIN capsules, suspension & suppositories (indomethacin) indomethacin cap ER ketoprofen ER LOFENA(diclofenac potassium) meclufenamate mefenamic acid NALFON (fenoprofen) NAPRELAN (naproxen) NAPROSYN (naproxen) naproxen 275mg and 550mg NUPRIN (ibuprofen) oxaprozin PONSTEL (mefenamic acid) PROFENO (fenoprofen) RELAFEN DS (nabumetone) SPRIX NASAL SPRAY (ketorolac) TIVORBEX (indomethacin) tolmetin VOLTAREN XR (diclofenac) ZIPSOR (diclofenac) ZORVOLEX (diclofenac)	<p style="color: red;"><b>Quantity Limit</b></p> <ul style="list-style-type: none"> <li>20 tablets/31 days – ketorolac tablets</li> </ul>
<b>NSAID/GI PROTECTANT COMBINATIONS</b>			
		ARTHROTEC (diclofenac/misoprostol) diclofenac/misoprostol	<p style="color: red;"><b>Non-Preferred Criteria</b></p> <ul style="list-style-type: none"> <li>Have tried 2 different preferred non-selective or NSAID/GI protectant</li> </ul>

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		DUEXIS (ibuprofen/famotidine) VIMOVO (naproxen/esomeprazole)	combination agents in the past 6 months
<b>COX II SELECTIVE</b>			
	meloxicam	CELEBREX (celecoxib) celecoxib ELYXYB (celecoxib) MOBIC (meloxicam) NULOX (meloxicam) QMIIZ ODT (meloxicam) VIVLODEX (meloxicam)	<p style="color: red;"><b>Non-Preferred Criteria – COX II</b></p> <ul style="list-style-type: none"> <li>Documented diagnosis of Osteoarthritis, Rheumatoid Arthritis, Familial Adenomatous Polyposis, or Ankylosing Spondylitis <b>AND</b></li> <li>90 consecutive days on the requested agent in the past 105 days <b>OR</b></li> <li>Have tried 1 preferred COX-II Selective and 1 preferred Non-Selective Agent <b>OR</b></li> <li>Have tried 1 preferred COX-II Selective agent and a documented diagnosis of GI Bleed, GERD, PUD, GI Perforation, or Coagulation Disorder</li> </ul> <p style="color: red;"><b>Elyxyb</b></p> <ul style="list-style-type: none"> <li>Requires clinical review</li> </ul>
<b>OPHTHALMIC ANTIBIOTICS</b>			
	bacitracin/neomycin/gramicidin bacitracin/polymyxin ciprofloxacin erythromycin GENTAK Ointment (gentamicin)	AZASITE (azithromycin) bacitracin BESIVANCE (besifloxacin) BLEPH-10 (sulfacetamide) CILOXAN Ointment (ciprofloxacin)	

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	gentamicin ILOTYCIN (erythromycin) moxifloxacin ofloxacin polymyxin/trimethoprim tobramycin	CILOXAN Solution (ciprofloxacin) GARAMYCIN (gentamicin) gatifloxacin levofloxacin MOXEZA (moxifloxacin) NATACYN (natamycin) neomycin/bacitracin/polymyxin b NEO-POLYCIN (neomy/baci/polymyxin b) NEOSPORIN (bacitracin/neomycin/gramicidin) (oxy-tcn/polymyx sul) OCUFLOX (ofloxacin) POLYTRIM (polymyxin/trimethoprim) sulfacetamide TOBEX drops (tobramycin) TOBEX ointment (tobramycin) VIGAMOX (moxifloxacin) ZYMAR (gatifloxacin) ZYMAXID (gatifloxacin)	
<b>ANTIBIOTIC STEROID COMBINATIONS</b>			
	BLEPHAMIDE (sulfacetamide/prednisolone) drops, oint neomycin/bacitracin/polymyxin/hc ointment neomycin/polymyxin/dexamethasone PRED-G (gentamicin/prednisolone) drops, oint sulfacetamide/prednisolone <b>tobramycin/dexamethasone suspension</b> TOBRADEX OINTMENT (tobramycin/dexamethasone)	gatifloxacin/prednisolone MAXITROL (neomycin/polymyxin/dexamethasone) neomycin/polymyxin/gramicidin neomycin/polymyxin/hydrocortisone TOBRADEX ST SUSPENSION (tobramycin/dexamethasone) <b>TOBRADEX SUSPENSION</b> <b>(tobramycin/dexamethasone)</b>	

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	ZYLET (loteprednol/tobramycin)		
<b>OPHTHALMIC ANTI-INFLAMMATORIES</b> <sup>DUR+</sup>			
	dexamethasone diclofenac difluprednate FLAREX (fluorometholone) fluorometholone flurbiprofen FML FORTE (fluorometholone) FML SOP (fluorometholone) ketorolac MAXIDEX (dexamethasone) prednisolone acetate prednisolone NA phosphate PRED MILD (prednisolone) VEXOL (rimexolone)	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) loteprednol etabonate OCUFEN (flurbiprofen) OMNIPRED (prednisolone) NEVANAC (nepafenac) PRED FORTE (prednisolone) PROLENSA (bromfenac) VOLTAREN (diclofenac)	<b>Non-Preferred Criteria</b> <ul style="list-style-type: none"> <li>• Have tried 2 different preferred agents in the past 6 months</li> </ul>
<b>OPHTHALMICS FOR ALLERGIC CONJUNCTIVITIS</b> <sup>DUR+</sup>			
	ALREX (loteprednol) azelastine cromolyn ketotifen <sup>OTC</sup>	ALOCRIL (nedocromil) ALOMIDE (lodoxamide) BEPREVE (bepotastine) epinastine	<b>Non-Preferred Criteria</b> <ul style="list-style-type: none"> <li>• Have tried 2 different preferred agents in the past 6 months</li> </ul>

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	olopatadine 0.1% olopatadine 0.2% ZADITOR (ketotifen) <sup>OTC</sup>	LASTACRAFT (alcaftadine) PATADAY (olopatadine) PATANOL (olopatadine) PAZEO (olopatadine) <b>VERKAZIA (cyclosporine)</b> ZERVIAATE (cetirizine)	<b>Verkazia</b> <ul style="list-style-type: none"> <li>Requires clinical review</li> </ul>
<b>OPHTHALMIC, DRY EYE AGENTS</b>			
	RESTASIS droperette (cyclosporine)	CEQUA (cyclosporine 0.09%) EYSUVIS (loteprednol etabonate) MIEBO (perfluorohexyloctane) <sup>NR</sup> RESTASIS Multidose (cyclosporine) TYRVAYA (varaenicine) Nasal XIIDRA (lifitegrast) <sup>Dur +</sup>	<b>Minimum Age Limit</b> <ul style="list-style-type: none"> <li>16 years – Restasis</li> <li>17 years – Xiidra</li> <li>18 years – Cequa, Miebo</li> </ul> <b>Quantity Limit</b> <ul style="list-style-type: none"> <li>5.5 mL/31 days – Restasis Multidose</li> <li>60 units/31 days – Cequa, Restasis droperette, Xiidra</li> <li>3 ml/31 days – Miebo</li> </ul> <b>Miebo</b> <ul style="list-style-type: none"> <li>Requires clinical review</li> </ul> <b>Non-Preferred Criteria</b> <ul style="list-style-type: none"> <li>History of 4 claims for Restasis in the past 6 months</li> </ul>

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<b>OPHTHALMIC, GLAUCOMA AGENTS</b> <sup>DUR+</sup>				
<b>BETA BLOCKERS</b>				
	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><b>Non-Preferred Criteria</b></p> <ul style="list-style-type: none"> <li>• Have tried 2 different preferred agents in the past 6 months <b>OR</b></li> <li>• 90 consecutive days on the requested agent in the past 105 days</li> </ul>	
<b>CARBONIC ANHYDRASE INHIBITORS</b>				
	dorzolamide	AZOPT (brinzolamide) TRUSOPT (dorzolamide)		
<b>COMBINATION AGENTS</b>				
	COMBIGAN (brimonidine/timolol) dorzolamide/timolol SIMBRINZA (brinzolamide/brimonidine)	COSOPT (dorzolamide/timolol) COSOPT PF (dorzolamide/timolol)		
<b>PARASYMPATHOMIMETICS</b>				
	pilocarpine	CARBOPTIC (carbachol) ISOPTO CARBACHOL (carbachol) ISOPTO CARPINE (pilocarpine) PHOSPHOLINE IODIDE (echothiophate iodide) PILOPINE HS (pilocarpine)		
<b>PROSTAGLANDIN ANALOGS</b>				
	latanoprost	bimatoprost LUMIGAN (bimatoprost) TRAVATAN Z (travoprost)		

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		travoprost XALATAN (latanoprost) XELPROS (latanoprost) VYZULTA (latanoprostene bunod) ZIOPTAN (tafluprost)	
	<b>RHO KINASE INHIBITORS/COMBINATIONS</b>		
	RHOPRESSA (netarsudil) ROCKLATAN (netarsudil/latanoprost)		
	<b>SYMPATHOMIMETICS</b>		
	ALPHAGAN P 0.1% (brimonidine) ALPHAGAN P 0.15% (brimonidine) brimonidine 0.2%	brimonidine 0.15% dipivefrin PROPINE (dipivefrin)	
<b>OPIATE DEPENDENCE TREATMENTS</b>			
	<b>DEPENDENCE</b>		
	buprenorphine/naloxone tablets naltrexone tablets SUBOXONE FIL(buprenorphine/naloxone) <sup>DUR+</sup>	BRIXADI (buprenorphine) <sup>NR</sup> buprenorphine tablets buprenorphine/naloxone films LUCEMYRA (lofexidine) PROBUPHINE (buprenorphine) SUBLOCADE (buprenorphine) VIVITROL (naltrexone) ZUBSOLV (buprenorphine/naloxone)	Buprenorphine/naloxone provider summary found <a href="#">here</a>  <b>Probuphine – <a href="#">MANUAL PA</a></b> <b>Sublocade – <a href="#">MANUAL PA</a></b> <b>Vivitrol - <a href="#">MANUAL PA</a></b>
	<b>TREATMENT</b>		
	naloxone injection NARCAN NASAL SPRAY (naloxone) KLOXXADO (naloxone)	EVZIO (naloxone) ZIMHI (naloxone)	
<b>OTIC ANTIBIOTICS</b>			

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# MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

(For All Medicaid, MSCAN and CHIP Beneficiaries)

EFFECTIVE 09/01/2023

Version 2023.8

Updated:09/01/2023

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Therapeutic Drug Class	Preferred Agents	Non-Preferred Agents	PA Criteria
	CIPRODEX (ciprofloxacin/dexamethasone) CIPRO HC (ciprofloxacin/hydrocortisone) <sup>Age Edit</sup> CORTISPORIN-TC (colistin/neomycin/hydrocortisone) neomycin/polymyxin/hydrocortisone ofloxacin	ciprofloxacin ciprofloxacin/dexamethasone ciprofloxacin/fluocinolone DERMOTIC (fluocinolone) FLAC OIL DROP (fluocinolone oil) hydrocortisone/acetic acid drop fluocinolone oil OTIPRIO (ciprofloxacin) OTOVEL (ciprofloxacin/fluocinolone)	<b>Maximum Age Limit</b> • 9 years - Cipro HC
<b>PANCREATIC ENZYMES</b> <sup>DUR+</sup>			
	CREON (pancreatin) ZENPEP (pancrelipase)	PANCREAZE (pancrelipase) PERTZYE (pancrelipase) VIOKACE (pancrelipase)	<b>Non-Preferred Criteria</b> • Have tried 2 different preferred agents in the past 6 months
<b>PARATHYROID AGENTS</b>			
	calcitriol ergocalciferol paricalcitol ROCALTROL (calcitriol) ZEMPLAR (paricalcitol)	cinacalcet doxercalciferol DRISDOL (ergocalciferol) HECTOROL (doxercalciferol) NATPARA (parathyroid hormone) RAYALDEE (calcifediol) SENSIPAR (cinacalcet)	
<b>PHOSPHATE BINDERS</b>			
	calcium acetate ELIPHOS (calcium acetate) PHOSLYRA (calcium acetate)	AURYXIA (ferric citrate) FOSRENOL (lanthanum) lanthanum	

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	sevelamer carbonate tablets	PHOSLO (calcium acetate) RENAGEL (sevelamer HCl) RENVELA (sevelamer carbonate) sevelamer carbonate powder packets sevelamer HCl VELPHORO (sucroferric oxyhydroxide)	
<b>PLATELET AGGREGATION INHIBITORS</b> <sup>DUR+</sup>			
	BRILINTA (ticagrelor) cilostazol clopidogrel dipyridamole dipyridamole/aspirin pentoxifylline prasugrel	DURLAZA ER (aspirin) EFFIENT (prasugrel) omeprazole/aspirin PERSANTINE (dipyridamole) PLAVIX (clopidogrel) PLETAL (cilostazol) ticlopidine YOSPRALA (aspirin/omeprazole) ZONTIVITY (vorapaxar)	<b>Zontivity – MANUAL PA</b>  <b>Non-Preferred Criteria</b> <ul style="list-style-type: none"> <li>• Documented diagnosis <b>AND</b></li> <li>• Have tried 2 different preferred agents in the past 6 months <b>OR</b></li> <li>• 90 consecutive days on the requested agent in the past 105 days</li> </ul>
<b>PLATELET STIMULATING AGENTS</b>			
	NPLATE (romiplostim) PROMACTA (eltrombopag olamine)	DOPTELET (avatrombopag maleate) MULPLETA (lusutrombopag) PROMACTA powder pack (eltrombopag olamine) TAVALISSE (fostamatinib disodium)	
<b>POTASSIUM REMOVING AGENTS</b>			
	LOKELMA (sodium zirconium cyclosilicate)	sodium polystyrene sulfonate SPS ENEMA (sodium polystyrene sulfonate) SPS SUSPENSION (sodium polystyrene sulfonate) VELTASSA (patiromer calcium sorbitex)	

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<b>PRENATAL VITAMINS</b>			
	COMPLETE NATAL DHA COMPLETENATE CHEW Tablet M-NATAL PLUS Tablet NIVA PLUS Tablet PNV 29-1 Tablet PNV 95/Fe/FA Tablet (labeler 00536) PNV 137/Fe/FA Tablet (labeler 009040) PNV-DHA Softgel Capsule PRENATAL VITAMIN PLUS LOW IRON Tablet PRENATAL PLUS IRON/FA PREPLUS Ca/Fe27/FA 1 Tablet PRETAB Tablet SE-NATAL19 CHEW Tablet SE-NATAL19 Tablet THRIVITE RX Tablet TRINATAL Rx 1 Tablet VIRT C DHA Capsule VIRT-NATE DHA Softgel Capsule VP-PNV-DHA Softgel Capsule WESTAB PLUS Tablet	Products not listed are assumed to be Non-Preferred.	
<b>PSEUDOBLBAR AFFECT AGENTS<sup>DUR+</sup></b>			
		NUDEXTA (dextromethorphan/quinidine)	<b>Non-Preferred Criteria</b> <ul style="list-style-type: none"> <li>• 90 consecutive days on the requested agent in the past 105 days <b>OR</b></li> <li>• Documented diagnosis of Pseudobulbar Affect</li> </ul>
<b>PULMONARY ANTIHYPERTENSIVES<sup>DUR+</sup></b>			
<b>ENDOTHELIN RECEPTOR ANTAGONIST</b>			

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	ambrisentan (all labelers except those listed as non-preferred) bosentan tablets	ambrisentan (labeler 42794, 47335, 498840) LETAIRIS (ambrisentan)* OPSUMIT (macitentan) TRACLEER (bosentan)	<p><b>All PAH Agents</b></p> <ul style="list-style-type: none"> <li>Documented diagnosis of pulmonary hypertension</li> </ul> <p><b>Non-Preferred Criteria</b></p> <ul style="list-style-type: none"> <li>Have tried 1 preferred PAH agent in the past 6 months <b>OR</b></li> <li>90 consecutive days on the requested agent in the past 105 days</li> </ul>
<b>PDE5's</b>			
	sildenafil (generic Revatio) tablet tadalafil	ADCIRCA (tadalafil) LIQREV (sildenafil) suspension <sup>NR</sup> REVATIO (sildenafil) tablet REVATIO (sildenafil) suspension sildenafil (generic Revatio) suspension TADLIQ (tadalafil) suspension	<p><b>Non-Preferred Criteria</b></p> <ul style="list-style-type: none"> <li>Have tried 1 preferred PAH agent in the past 6 months <b>OR</b></li> <li>90 consecutive days on the requested agent in the past 105 days</li> </ul> <p><b>Revatio suspension</b></p> <ul style="list-style-type: none"> <li>&lt; 12 years of age <b>AND</b></li> <li>Documented diagnosis of Pulmonary Hypertension, Patent Ductus Arteriosus, or Persistent Fetal Circulation or history of heart transplant <b>OR</b></li> <li>90 consecutive days on the requested agent in the past 105 days</li> </ul> <p><b>Revatio tablets</b></p>

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			<ul style="list-style-type: none"> <li>• &lt; 1 year of age <b>AND</b></li> <li>• Documented diagnosis of Pulmonary Hypertension, Patent Ductus Arteriosus, or Persistent Fetal Circulation <b>OR</b></li> <li>• 90 consecutive days on the requested agent in the past 105 days <b>OR</b></li> <li>• &gt; 1 years of age <b>AND</b></li> <li>• Documented diagnosis of Pulmonary Hypertension</li> </ul>
<b>PROSTACYCLINS</b>			
		ORENITRAM ER (treprostinil) TYVASO (treprostinil) VENTAVIS (iloprost)	<b>Non-Preferred Criteria</b> <ul style="list-style-type: none"> <li>• Have tried 1 preferred PAH agent in the past 6 months <b>OR</b></li> <li>• 90 consecutive days on the requested agent in the past 105 days</li> </ul>
<b>SELECTIVE PROSTACYCLIN RECEPTOR AGONISTS</b>			
		UPTRAVI (selexipag)	<b>Non-Preferred Criteria</b> <ul style="list-style-type: none"> <li>• Have tried 1 preferred PAH agent in the past 6 months <b>OR</b></li> <li>• 90 consecutive days on the requested agent in the past 105 days</li> </ul>
<b>SOLUBLE GUANYLATE CYCLASE STIMULATORS</b>			
		ADEMPAS (riociguat)	<b>Adempas</b> <ul style="list-style-type: none"> <li>• Documented WHO Group 1 diagnosis of secondary pulmonary arterial hypertension <b>OR</b></li> </ul>

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			<ul style="list-style-type: none"> <li>• Documented WHO Group 4 diagnosis of pulmonary hypertension due to chronic thrombotic embolic disease <b>OR</b></li> <li>• Documented diagnosis of pulmonary hypertension <b>AND</b></li> <li>• Have tried 1 preferred PAH agent in the past 6 months <b>OR</b></li> <li>• 90 consecutive days on the requested agent in the past 105 days</li> </ul>
<b>ROSACEA TREATMENTS</b>			
	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) RHOFADÉ (oxymetazoline HCl) ROSULA (sodium sulfacetamide/sulfur) sodium sulfacetamide/sulfur (cleanser, pads, suspension) SOOLANTRA (ivermectin) SUMADAN (sodium sulfacetamide/sulfur wash) SUMAXIN (sodium sulfacetamide/sulfur pads)	Topical Sulfonamides used for Rosacea will require a manual PA for ≥21 years. Other labeled indications are limited to <21 years.

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		SUMAXIN TS (sodium sulfacetamide/sulfur suspension) ZILXI AEROSOL (minocycline)	
<b>SEDATIVE HYPNOTICS</b>			
<b>BENZODIAZEPINES DUR+</b>			
	estazolam flurazepam temazepam (15mg and 30mg)	DALMANE (flurazepam) DORAL (quazepam) HALCION (triazolam) quazepam RESTORIL (temazepam) temazepam (7.5mg and 22.5mg) triazolam	Single source benzodiazepines and barbiturates are NOT covered – NO PA's will be issued for these drugs.  <b>MS DOM Opioid Initiative</b> <ul style="list-style-type: none"> <li>Concomitant use of Opioids and Benzodiazepines</li> </ul> <a href="#">Criteria details found here</a>  <b>Quantity Limit – CUMULATIVE</b> 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> <ul style="list-style-type: none"> <li><b>31 units/31 days</b> - all strengths</li> </ul> <b>Triazolam – CUMULATIVE</b> Quantity limit per rolling days for all strengths <ul style="list-style-type: none"> <li><b>10 units/31 days</b></li> <li><b>60 units/365 days</b></li> </ul>
<b>OTHERS DUR+</b>			

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	zaleplon zolpidem	AMBIEN (zolpidem) AMBIEN CR (zolpidem) BELSOMRA (sovorexant) DAYVIGO (lemborexant) doxepin 3mg, 6mg EDLUAR (zolpidem) eszopiclone HETLIOZ (tasimelteon) INTERMEZZO (zolpidem) LUNESTA (eszopiclone) ramelteon ROZEREM (ramelteon) QUVIVIQ (daridorexant) SILENOR (doxepin) SONATA (zaleplon) zolpidem ER zolpidem SL ZOLPIMIST (zolpidem)	<p><b>Maximum Age Limit</b></p> <ul style="list-style-type: none"> <li>64 years – zolpidem 7.5 mg, zolpidem 10 mg, zolpidem 12.5 mg</li> </ul> <p><b>Quantity Limit – CUMULATIVE</b> 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"> <li><b>31 units/31 days</b></li> <li><b>1 canister/31 days</b> – Zolpimist &amp; male</li> <li><b>1 canister/62 days</b> – Zolpimist &amp; female</li> <li><b>1 bottle/31 days (48 ml or 158 ml)</b> – Hetlioz liquid</li> </ul> <p><b>Gender and Dose Limit for zolpidem</b></p> <ul style="list-style-type: none"> <li><b>Female</b> – Ambien 5mg, Ambien CR 6.25mg, Intermezzo 1.75 mg</li> <li><b>Male</b> – all zolpidem strengths</li> </ul> <p><b>Non-Preferred Criteria</b></p> <ul style="list-style-type: none"> <li>Have tried 2 different preferred agents in the past 6 months</li> </ul> <p><b>Hetlioz capsules</b></p> <ul style="list-style-type: none"> <li>Documented diagnosis of circadian rhythm sleep disorder <b>AND</b></li> </ul>

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<b>SELECT CONTRACEPTIVE PRODUCTS</b>			
<b>INJECTABLE CONTRACEPTIVES</b>			
	medroxyprogesterone acetate IM	DEPO-PROVERA IM (medroxyprogesterone acetate) DEPO-SUBQ PROVERA 104 (medroxyprogesterone acetate)	<ul style="list-style-type: none"> <li>• Documented diagnosis indicating total blindness of the patient <b>OR</b></li> <li>• Documented diagnosis of Magenis-Smith syndrome</li> </ul> <p><b>Hetlioz liquid</b></p> <ul style="list-style-type: none"> <li>• Documented diagnosis of Smith-Magenis syndrome <b>AND</b></li> <li>• 3 - 15 years of age</li> </ul>
<b>INTRAVAGINAL CONTRACEPTIVES</b>			
	ANNOVERA (segesterone/ethinyl estradiol) etonogestrel/ethinyl estradiol NUVARING (etonogestrel/ethinyl estradiol) PHEXXI (lactic acid, citric acid, potassium bitartrate)		<p><b>Non-Preferred Criteria</b></p> <ul style="list-style-type: none"> <li>• 1 claim with the requested agent in the past 105 days</li> </ul>
<b>ORAL CONTRACEPTIVES <sup>DUR+</sup></b>			
	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)	

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

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<b>TRANSDERMAL CONTRACEPTIVES</b>			
	XULANE (norelgestromin and ethinyl estradiol)	ZAFEMY (norelgestromin and ethinyl estradiol) TWIRLA (levonorgestrel and ethinyl estradiol)	
<b>SICKLE CELL AGENTS</b>			
	DROXIA (hydroxyurea) hydroxyurea	ADAKVEO (crizanlizumab) ENDARI (glutamine) HYDREA (hydroxyurea) OXBRYTA (voxelotor) SIKLOS (hydroxyurea)	Endari – <a href="#">MANUAL PA</a> Oxbryta – <a href="#">MANUAL PA</a>
<b>SKELETAL MUSCLE RELAXANTS <sup>DUR+</sup></b>			
	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	<b>Non-Preferred Agents</b> <ul style="list-style-type: none"> <li>Documented diagnosis for an approvable indication <b>AND</b></li> <li>Have tried 2 different preferred agents in the past 6 months</li> </ul> <b>Carisoprodol</b> <ul style="list-style-type: none"> <li>Documented diagnosis of acute musculoskeletal condition <b>AND</b></li> <li>NO history with meprobamate in the past 90 days <b>AND</b></li> <li>1 claim for cyclobenzaprine in the past 21 days <b>OR</b> a documented intolerance to cyclobenzaprine <b>AND</b></li> </ul> <b>Quantity Limit</b> <ul style="list-style-type: none"> <li>18 tablets - to allow tapering off</li> <li>84 tablets/6 months</li> </ul> <b>Carisoprodol with codeine</b>

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Version 2023.8

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		PARAFON FORTE DSC (chlorzoxazone) ROBAXIN (methocarbamol) SKELAXIN (metaxalone) SOMA (carisoprodol) tizanidine capsules ZANAFLEX (tizanidine)	<ul style="list-style-type: none"> <li>Requires clinical review</li> </ul>
<b>SMOKING DETERRENT</b>			
	<b>NICOTINE TYPE</b>		
	nicotine gum <sup>OTC</sup> nicotine lozenge <sup>OTC</sup> nicotine mini lozenge <sup>OTC</sup> nicotine patch <sup>OTC</sup>	NICODERM CQ PATCH <sup>OTC</sup> NICORETTE GUM <sup>OTC</sup> NICORETTE LOZENGE <sup>OTC</sup> NICORETTE MINI LOZENGE <sup>OTC</sup> NICOTROL INHALER CARTRIDGE NICOTROL NASAL SPRAY	
	<b>NON-NICOTINE TYPE</b>		
	bupropion ER CHANTIX (varenicline) varenicline	ZYBAN (bupropion)	<b>Minimum Age Limit - Chantix</b> <ul style="list-style-type: none"> <li>18 years</li> </ul> <b>Quantity Limit</b> <ul style="list-style-type: none"> <li>336 tablets/year – Chantix 0.5mg, 1mg tablets and continuing pack</li> <li>2 treatment courses/year – Chantix Starter Pack</li> </ul>
<b>STEROIDS (Topical) <sup>DUR+</sup></b>			
	<b>LOW POTENCY</b>		
	CAPEX (fluocinolone) desonide	alclometasone DERMA-SMOOTH-FS (fluocinolone)	<b>Non-Preferred Criteria</b>

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	hydrocortisone cr, oint, soln.	DESONATE (desonide) DESOWEN (desonide) fluocinolone oil hydrocortisone lotion PEDIACARE HC (hydrocortisone) PEDIADERM (hydrocortisone) VERDESO (desonide)	<ul style="list-style-type: none"> <li>Have tried 2 different preferred low potency agents in the past 6 months</li> </ul>
<b>MEDIUM POTENCY</b>			
	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)	<b>Non-Preferred Criteria</b> <ul style="list-style-type: none"> <li>Have tried 2 different preferred medium potency agents in the past 6 months</li> </ul>
<b>HIGH POTENCY</b>			
	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)	<b>Non-Preferred Criteria</b> <ul style="list-style-type: none"> <li>Have tried 2 different preferred high potency agents in the past 6 months</li> </ul>

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		ELOCON (mometasone) fluocinonide HALOG (halcinonide) KENALOG (triamcinolone) PEDIADERM TA (triamcinolone) SERNIVO (betamethasone dipropionate) TOPICORT (desoximetasone) TRIANEX (triamcinolone) VANOS (fluocinonide)	
<b>VERY HIGH POTENCY</b>			
	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)	<b>Non-Preferred Criteria</b> <ul style="list-style-type: none"> <li>• Have tried 2 different preferred very high potency agents in the past 6 months</li> </ul>
<b>STIMULANTS AND RELATED AGENTS <sup>DUR+</sup> SHORT-ACTING</b>			

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	amphetamine salt combination dexamethylphenidate IR dextroamphetamine IR methylphenidate IR methylphenidate solution PROCENTRA (dextroamphetamine)	ADDERALL (amphetamine salt combination) amphetamine sulfate (generic EVEKO) DESOXYN (methamphetamine) dextroamphetamine solution EVEKEO (amphetamine) EVEKEO ODT (amphetamine) FOCALIN (dexamethylphenidate) methamphetamine METHYLIN solution (methylphenidate) methylphenidate chewable RITALIN (methylphenidate) ZENZEDI (dextroamphetamine)	<p><b>Minimum Age Limit</b></p> <ul style="list-style-type: none"> <li>• <b>3 years</b> - Adderall, Evekeo, Procentra, Zenedi</li> <li>• <b>6 years</b> – Desoxyn, Evekeo ODT, Focalin, Methylin</li> </ul> <p><b>Maximum Age Limit</b></p> <ul style="list-style-type: none"> <li>• <b>18 years</b> – Evekeo ODT</li> </ul> <p><b>Quantity Limit</b></p> <p>Applicable quantity limit per rolling days</p> <ul style="list-style-type: none"> <li>• <b>62 tablets/31 days</b> – Adderall, Desoxyn, Evekeo, Focalin, Methylin, Zenedi</li> <li>• <b>310 mL/31 days</b> – Methylin solution, Procentra</li> </ul> <p><b>Documented diagnosis of ADHD – ALL Short Acting AGENTS</b></p> <p><b>Non-Preferred Criteria ADD/ADHD</b></p> <ul style="list-style-type: none"> <li>• Documented diagnosis of ADD/ADHD <b>AND</b></li> <li>• Have tried 2 different preferred Short Acting agents in the past 6 months <b>OR</b></li> <li>• 1 claim for a 30-day supply with the requested agent in the past 105 days</li> </ul>

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			<u>Documented diagnosis of narcolepsy</u> – ADDERALL, EVEKEO, METHYLIN, PROCENTRA, RITALIN, ZENZEDI
	<b>LONG-ACTING</b>		
	ADDERALL XR (amphetamine salt combination) amphetamine salt combination ER CONCERTA (methylphenidate) dexmethylphenidate ER dextroamphetamine ER DYANAVEL XR SUSPENSION(amphetamine) methylphenidate CD (generic Metadate CD) methylphenidate ER (generic Concerta) methylphenidate ER Tabs (generic Ritalin SR) methylphenidate ER/LA Caps (generic Ritalin LA) QUILLICHEW (methylphenidate) QUILLIVANT XR (methylphenidate)	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)*	<div style="color: red;"><b>Minimum Age Limit</b></div> <ul style="list-style-type: none"> <li><b>6 years</b> – 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</li> <li><b>13 years</b> – Mydayis</li> <li><b>16 years</b> – Provigil</li> <li><b>18 years</b> – Nuvigil, Sunosi</li> </ul> <div style="color: red;"><b>Maximum Age Limit</b></div> <ul style="list-style-type: none"> <li><b>18 years</b> – Cotempla XR ODT, Daytrana</li> </ul> <div style="color: red;"><b>Vyvanse</b></div> <ul style="list-style-type: none"> <li>Documented diagnosis of binge eating disorder <b>OR</b></li> </ul>

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		XELSTRYM patch (dextroamphetamine)	<ul style="list-style-type: none"> <li>Documented diagnosis of ADD/ADHD <b>AND</b></li> <li>Have tried 2 different preferred Long-Acting agents in the past 6 months <b>OR</b></li> <li>1 claim for a 30-day supply with the requested agent in the past 105 days</li> </ul> <p><b>Quantity Limit</b> <b>Applicable quantity limit per rolling days</b></p> <ul style="list-style-type: none"> <li><b>31 tablets/31 days</b> – Adderall XR, Adhansia XR, Adzenys XR ODT, Aptensio XR, Azstarys, Concerta 18, 27, &amp; 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 &amp; 50mg, Nuvigil 150, 200 &amp; 250 mg, Provigil 200mg, Quillichew, Relexxii, Ritalin LA &amp; SR, Vyvanse, Sunosi, Xelstrym</li> <li><b>46.5 tablets/31 days</b> – Provigil 100 mg</li> <li><b>62 tablets/31 days</b> – Concerta 36mg, Cotempla XR-ODT 17.3 &amp; 25.9 mg, Nuvigil 50mg</li> <li><b>248 mL/31 days</b> – Dyanavel XR Suspension</li> </ul>

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			<ul style="list-style-type: none"> <li>• <b>372 mL/31 days</b> – Quillivant XR</li> </ul> <p><b>Documented diagnosis of ADHD – ALL Long-Acting AGENTS</b></p> <p><b>Non-Preferred Criteria ADD/ADHD</b></p> <ul style="list-style-type: none"> <li>• Documented diagnosis of ADD/ADHD <b>AND</b></li> <li>• Have tried 2 different preferred Long-Acting agents in the past 6 months <b>OR</b></li> <li>• 1 claim for a 30-day supply with the requested agent in the past 105 days</li> </ul>
<b>NARCOLEPSY</b>			
	armodafinil modafinil SUNOSI (solriamfetol)	LUMRYZ (sodium oxybate) <sup>NR</sup> NUVIGIL (armodafinil) PROVIGIL (modafinil) sodium oxybate WAKIX (pitolisant) XYREM (sodium oxybate) XYWAV (calcium, magnesium, potassium and sodium oxybates)	<p><b>Documented diagnosis of narcolepsy – ADDERALL XR, APTENSIO XR, CONCERTA ER, DEXEDRINE, METADATE CD, METHYLIN ER, MYDAYIS, NUVIGIL, PROVIGIL, QUILLICHEW, QUILLIVANT XR, RITALIN LA, SUNOSI</b></p> <p><b>Non-Preferred Criteria narcolepsy</b></p> <ul style="list-style-type: none"> <li>• Documented diagnosis of narcolepsy <b>AND</b></li> <li>• 30 days of therapy with preferred modafinil or armodafinil in the past 6 months <b>AND</b></li> </ul>

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			<ul style="list-style-type: none"> <li>• 1 different preferred Long-Acting agent indicated for narcolepsy in the past 6 months <b>OR</b></li> <li>• 1 claim for a 30-day supply with the requested agent in the past 105 days</li> </ul> <p><b>Nuvigil</b></p> <ul style="list-style-type: none"> <li>• Documented diagnosis of narcolepsy, obstructive sleep apnea, shift work sleep disorder or bipolar depression</li> </ul> <p><b>Provigil</b></p> <ul style="list-style-type: none"> <li>• Documented diagnosis of narcolepsy, obstructive sleep apnea, shift work sleep disorder, depression, sleep deprivation or Steinert Myotonic Dystrophy Syndrome</li> </ul> <p><b>Sunosi</b></p> <ul style="list-style-type: none"> <li>• Documented diagnosis of narcolepsy or obstructive sleep apnea <b>AND</b></li> <li>• 30 days of therapy with preferred modafinil or armodafinil in the past 6 months</li> </ul> <p><b>Wakix</b></p>

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<b>NON-STIMULANTS</b>			
	atomoxetine clonidine ER guanfacine ER	INTUNIV (guanfacine ER) QELBREE (viloxazine) STRATTERA (atomoxetine)	<ul style="list-style-type: none"> <li>Documented diagnosis of narcolepsy with or without cataplexy <b>AND</b></li> <li>30 days of therapy with preferred modafinil or armodafinil in the past 6 months <b>OR</b></li> <li>Documented diagnosis of narcolepsy without cataplexy or substance abuse disorder</li> </ul> <p><b>Xyrem and Xywav</b></p> <ul style="list-style-type: none"> <li>Requires clinical review</li> </ul> <p><b>Minimum Age Limit</b> <b>6 years</b> – Intuniv, Clonidine ER, Qelbree, Strattera <b>18 years</b> – Wakix</p> <p><b>Maximum Age Limit</b></p> <ul style="list-style-type: none"> <li><b>18 years</b> – Intuniv, Clonidine ER, Qelbree</li> <li><b>21 years</b> – diagnosis of ADD/ADHD is required for Strattera</li> </ul> <p><b>Quantity Limit</b> Applicable quantity limit per rolling days</p> <ul style="list-style-type: none"> <li><b>31 tablets/31 days</b> – Intuniv, Qelbree 100 mg, Strattera</li> <li><b>62 tablets/31 days</b> – Qelbree 150 mg and 200 mg, Wakix</li> </ul>

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			<ul style="list-style-type: none"> <li>• <b>124 tablets/31 days – Clonidine ER</b></li> </ul> <p><b>Intuniv</b> Documented diagnosis of ADD or ADHD</p> <p><b>Clonidine ER</b></p> <ul style="list-style-type: none"> <li>• Documented diagnosis of ADD or ADHD</li> </ul> <p><b>Qelbree</b></p> <ul style="list-style-type: none"> <li>• Documented diagnosis of ADD or ADHD <b>AND</b></li> <li>• 1 claim for a 30-day supply with atomoxetine in the past 105 days</li> </ul>
<b>TETRACYCLINES</b> <sup>DUR+</sup>			
	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	<p><b>Non-Preferred Agents</b></p> <ul style="list-style-type: none"> <li>• Have tried 2 different preferred agents in the past 6 months</li> </ul> <p><b>Demeclocycline</b></p> <ul style="list-style-type: none"> <li>• Documented diagnosis of SIADH will allow automatic approval</li> </ul>

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

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

Drugs highlighted in yellow denote a change in PDL status.

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

A # denotes existing users will NOT be grandfathered.

To search the PDL, press CTRL + F



# MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

EFFECTIVE 09/01/2023

Version 2023.8

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(For All Medicaid, MSCAN and CHIP Beneficiaries)

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		minocycline tabs MONODOX (doxycycline monohydrate) NUZYRA (omadacycline tosylate) OKEBO (doxycycline) ORACEA (doxycycline) SEYSARA (sarecycline) SOLODYN (minocycline) TARGADOX (doxycycline) VIBRAMYCIN cap/susp/syrup XIMINO (minocycline)	
<b>ULCERATIVE COLITIS and CROHN'S AGENTS</b> <sup>DUR+</sup> *See Cytokine & CAM Antagonists Class for additional agents			
<b>ORAL</b>			
	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)	<p><b>Non-Preferred Criteria</b></p> <ul style="list-style-type: none"> <li>• Documented diagnosis for Ulcerative Colitis <b>AND</b></li> <li>• Have tried 2 different preferred agents in the past 6 months <b>OR</b></li> <li>• 90 consecutive days on the requested agent in the past 105 days</li> </ul> <p><b>Ortikos ER</b></p> <ul style="list-style-type: none"> <li>• Requires clinical review</li> </ul>

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

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