MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

(For All Medicaid, MSCAN and CHIP Beneficiaries)

EFFECTIVE 7/1/2024
Version 2024_9
Updated: 5/31/2024

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
ACNE AGENTS			
	ANTI-INFECTIVE		**Maximum Age Limit** • **21 years** – all agents except isotretinoins
	clindamycin gel (generic Cleocin-T) clindamycin lotion clindamycin solution	ACZONE (dapsone) AKNE-MYCIN (erythromycin) azelaic acid AMZEEQ FOAM (minocycline) AZELEX (azelaic acid) CLEOCIN-T (clindamycin) CLINDAMYCIN PAC (clindamycin) CLINDAGEL (clindamycin) clindamycin foam clindamycin gel daily (generic Clindagel) dapsone ERY (erythromycin) ERYGEL (erythromycin) erythromycin gel, swabs, solution EVOCLIN (clindamycin) KLARON (sulfacetamide) sulfacetamide WINLEVI(clascoterone)	
	RETINOIDS		
	RETIN-A (tretinoin) tretinoin cream	adapalene AKLIEF (trifarotene) ALTRENO (tretinoin) ARAZLO (tazarotene) ATRALIN (tretinoin) AVITA (tretinoin) DIFFERIN (adapalene)	

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

Drugs highlighted in yellow denote a change in PDL status.

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

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

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	ZEMAIRA (alpha-1 proteinase inhibitor)		
ALZHEIMER'S AGENTS DUR+			
	CHOLINESTERASE INHIBITORS		**All Agents** • Documented diagnosis for both preferred and non-preferred **Non-Preferred Criteria** • Have tried 2 different preferred agents in the past 6 months
	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)	
	NMDA RECEPTOR ANTAGONIST		
	memantine	NAMENDA TABS (memantine) NAMENDA SOLUTION (memantine) NAMENDA XR (memantine) memantine XR	
	COMBINATION AGENTS		
		NAMZARIC (memantine/donepezil)	**Namzaric** • Documented diagnosis **AND** • 30 days of concurrent therapy with donepezil + memantine in the past 6 months
ANALGESICS, OPIOID- SHORT ACTING DUR+			
	acetaminophen/codeine benzhydrocodone/APAP codeine	ABSTRAL (fentanyl) ACTIQ (fentanyl) APADAZ (benzhydrocodone/APAP)	**MS DOM Opioid Initiative** • Short-Acting Opioids • Long-Acting Opioids

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	dihydrocodeine/APAP/caffeine ENDOCET (oxycodone/APAP) hydrocodone/APAP hydromorphone morphine oxycodone capsules oxycodone liquid oxycodone tablets oxycodone/APAP oxycodone/aspirin oxycodone/ibuprofen pentazocine/APAP tramadol tramadol/APAP	butalbital/APAP/caffeine/codeine butalbital/ASA/caffeine/codeine butorphanol tartrate (nasal) DEMEROL (meperidine) DILAUDID (hydromorphone) DVORAH (dihydrocodeine/ APAP/caffeine) fentanyl FENTORA (fentanyl) FIORICET W/ CODEINE (butalbital/APAP/caffeine/codeine) FIORINAL W/ CODEINE (butalbital/ASA/caffeine/codeine) hydrocodone/ibuprofen IBUDONE (hydrocodone/ibuprofen) LAZANDA NASAL SPRAY (fentanyl) levorphanol LORCET (hydrocodone/APAP) LORTAB (hydrocodone/APAP) MAGNACET (oxycodone/APAP) meperidine solution meperidine tablet NALOCET (oxycodone/APAP) NORCO (hydrocodone/APAP) NUCYNTA (tapentadol) ONSOLIS (fentanyl) OPANA (oxymorphone) OXAYDO (oxycodone) oxymorphone pentazocine/naloxone	• Morphine Equivalent Daily Dose • Concomitant use of Opioids and Benzodiazepines Criteria details found here **Minimum Age Limit** • **18 years** – tramadol and codeine products **Quantity Limit** Applicable quantity limit in 31 rolling days • **62 tablets** – butalbital/codeine combinations, codeine, dihydrocodeine combinations, fentanyl, hydrocodone, hydromorphone, levorphanol, meperidine, morphine, oxycodone, oxymorphone, pentazocine, tapentadol, tramadol • **186 tablets** –butalbital/APAP,, butalbital/ASA • **5 ml** – butorphanol nasal • **180 ml CUMULATIVE** – oxycodone liquids • **280 ml CUMULATIVE** – Qdolo

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		PERCOCET (oxycodone/APAP) PERCODAN (oxycodone/ASA) PRIMLEV (oxycodone/APAP) PROLATE (oxycodone/APAP) QDOLO (tramadol) REPREXAINE (hydrocodone/ibuprofen) ROXICET (oxycodone/acetaminophen) ROXICODONE (oxycodone) ROXYBOND (oxycodone) SEGLENTIS (tramadol/celecoxib) SUBSYS (fentanyl) SYNALGOS-DC (dihydrocodeine/ aspirin/caffeine) TYLENOL W/CODEINE (APAP/codeine) TYLOX (oxycodone/APAP) ULTRACET (tramadol/APAP) ULTRAM (tramadol) VICODIN (hydrocodone/APAP) VICOPROFEN (hydrocodone/ibuprofen) XODOL (hydrocodone/acetaminophen) ZAMICET (hydrocodone/APAP) ZOLVIT (hydrocodone/APAP) ZYDONE (hydrocodone/acetaminophen)	
ANALGESICS, OPIOID - LONG ACTING DUR+			
	BUTRANS (buprenorphine) fentanyl patches morphine ER tablets	ARYMO ER (morphine) BELBUCA (buprenorphine) buprenorphine patch CONZIP ER (tramadol) DOLOPHINE (methadone) DURAGESIC (fentanyl)	**MS DOM Opioid Initiative** • Short-Acting Opioids • Long-Acting Opioids • Morphine Equivalent Daily Dose • Concomitant use of Opioids and Benzodiazepines

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		EXALGO (hydromorphone) hydromorphone ER HYSINGLA ER (hydrocodone) KADIAN (morphine) methadone morphine ER capsules MS CONTIN (morphine) NUCYNTA ER (tapentadol) OPANA ER (oxymorphone) oxycodone ER OXYCONTIN (oxycodone) oxymorphone ER RYZOLT (tramadol) tramadol ER ULTRAM ER (tramadol) XTAMPZA (oxycodone myristate)	Criteria details found here **Minimum Age Limit** • **18 years** – Butrans, tramadol products **Quantity Limit** Applicable quantity limit per rolling days • **31 tablets/31 days** – Avinza, Exalgo ER, Hysingla ER, tramadol ER • **62 tablets/31 days** – methadone, morphine ER, MS Contin, Nucynta ER, Oxycontin, oxymorphone ER, Xtampza ER, Zohydro ER • **62 films/31 days** – Belbuca • **10 patches/31 days** – Fentanyl patch • **4 patches/31 days** – Butrans **Non-Preferred Criteria** • Have tried 2 different preferred agents in the past 6 months **OR** • Documented diagnosis of cancer **OR** Antineoplastic therapy **AND** • 90 consecutive days on the requested agent in the past 105 days

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ANALGESICS/ANESTHETICS (Topical)			
	diclofenac sodium 1% gel diclofenac sodium 1.5% solution lidocaine 4% cream OTC lidocaine 5% ointment lidocaine 5% patch	capsaicin diclofenac epolamine patch DUR+ diclofenan sodium 3% gel FLECTOR Patch (diclofenac epolamine) DUR+ FROTEK (ketoprofen) LICART (diclofenac epolamine) LIDAMANTLE HC (lidocaine/hydrocortisone) LIDO TRANS PAK (lidocaine) lidocaine/prilocaine LIDODERM (lidocaine) DUR+ LIDTOPIC MAX (lidocaine) PENNSAID 2% Solution (diclofenac sodium) DUR+ SYNERA (lidocaine/tetracaine) TRANZAREL (lidocaine) VENNGEL ONE 1% kit (diclofenac sodium) VOLTAREN Gel (diclofenac sodium) DUR+ XRYLIDERM (lidocaine) xylocaine ZOSTRIX (capsaicin) ZTlido (lidocaine)	**Quantity Limit** • 1 bottle/31 days – Diclofenac 2% solution pump • 1 bottle/31 days – Diclofenac 1.5% solution **Non-Preferred Criteria** • Have tried 1 preferred agent in the past 6 months **Lidocaine 5% Patch** • Documented diagnosis of Herpetic Neuralgia **OR** • Documented diagnosis of Diabetic Neuropathy **ZTlido** • Documented diagnosis of Herpetic Neuralgia
ANDROGENIC AGENTS DUR+			
	ANDRODERM (testosterone patch) testosterone gel packet	ANDROGEL (testosterone gel) ANDROXY (fluoxymesterone) AXIRON (testosterone gel)	**All Agents** • Limited to male gender **Non-Preferred Criteria**

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		FORTESTSA (testosterone gel) JATENZO (testosterone undecanoate) NATESTO (testosterone) STRIANT (testosterone) TESTIM (testosterone gel) testosterone pump TLANDO (testosterone) VOGELXO (testosterone) XYOSTED (testosterone enanthate)	• Have tried 2 different preferred agents in the past 6 months **Tlando** • Requires clinical review
ANGIOTENSIN MODULATORS DUR+			
	ACE INHIBITORS		
	benazepril captopril enalapril fosinopril lisinopril quinapril ramipril trandolapril	ACCUPRIL (quinapril) ACEON (perindopril) ALTACE (ramipril) EPANED (enalapril) LOTENSIN (benazepril) MAVIK (trandolapril) moexipril perindopril PRINIVIL (lisinopril) QBRELIS (lisinopril) UNIVASC (moexipril) VASOTEC (enalapril) ZESTRIL (lisinopril)	**Minimum Age Limit** • **≤ 6 years** – Epaned DUR + *will automatically be issued for this age* **Non-Preferred Criteria** • Have tried 2 different preferred single entity agents in the past 6 months **OR** • 90 consecutive days on the requested agent in the past 105 days
	ACE INHIBITOR COMBINATIONS		
	benazepril/amlodipine benazepril/HCTZ captopril/HCTZ	ACCURETIC (quinapril/HCTZ) CAPOZIDE (captopril/HCTZ) LOTENSIN HCT (benazepril/HCTZ)	**Non-Preferred Criteria** **ACE Inhibitor/CCB**

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	enalapril/HCTZ fosinopril/HCTZ lisinopril/HCTZ quinapril/HCTZ trandolapril/verapamil	LOTREL (benazepril/amlodipine) moexipril/HCTZ PRESTALIA (perindopril/amlodipine) PRINZIDE (lisinopril/HCTZ) TARKA (trandolapril/verapamil) UNIRETIC (moexipril/HCTZ) VASERETIC (enalapril/HCTZ) ZESTORETIC (lisinopril/HCTZ)	• Have tried 2 different preferred ACEI/CCB agents in the past 6 months **OR** • 90 consecutive days on the requested agent in the past 105 days **ACE Inhibitor/Diuretic** • Have tried 2 different preferred ACEI/Diuretic agents in the past 6 months **OR** • 90 consecutive days on the requested agent in the past 105 days
	ANGIOTENSIN II RECEPTOR BLOCKERS (ARBs)		
	irbesartan losartan olmesartan telmisartan valsartan	ATACAND (candesartan) AVAPRO (irbesartan) BENICAR (olmesartan) candesartan COZAAR (losartan) DIOVAN (valsartan) EDARBI (azilsartan) eprosartan MICARDIS (telmisartan) TEVETEN (eprosartan)	**Non-Preferred Criteria** • Have tried 2 different preferred single entity agents in the past 6 months **OR** • 90 consecutive days on the requested agent in the past 105 days
	ARB COMBINATIONS		
	ENTRESTO (valsartan/sacubitril) DUR + irbesartan/HCTZ losartan/HCTZ	ATACAND-HCT (candesartan/HCTZ) AVALIDE (irbesartan/HCTZ) AZOR (olmesartan/amlodipine)	**Entresto** • Age ≥ 18 years **AND**

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	olmesartan/amlodipine olmesartan/HCTZ telmisartan/HCTZ valsartan/amlodipine valsartan/amlodipine/HCTZ valsartan/HCTZ	BENICAR-HCT (olmesartan/HCTZ) BYVALSON (nebivolol/valsartan) candesartan/HCTZ DIOVAN-HCT (valsartan/HCTZ) EDARBYCLOR (azilsartan/chlorthalidone) EXFORGE (valsartan/amlodipine) EXFORGE HCT (valsartan/amlodipine/HCTZ) HYZAAR (losartan/HCTZ) MICARDIS-HCT (telmisartan/HCTZ) olmesartan/amlodipine/HCTZ telmisartan/amlodipine TEVETEN-HCT (eprosartan/HCTZ) TRIBENZOR (olmesartan/amlodipine/HCTZ) TWYNSTA (telmisartan/amlodipine)	• Documented diagnosis of heart failure **OR** • Age ≥ 1 year **AND** • Documented diagnosis of heart failure with systemic ventricular systolic dysfunction **Non-Preferred Criteria ARB/Beta Blocker, ARB/CCB or ARB/CCB/Diuretic** • Have tried 1 preferred ARB/CCB agent in the past 6 months **OR** • 90 consecutive days on the requested agent in the past 105 days **ARB/Diuretic** • Have tried 2 different preferred ARB/Diuretic products in the past 6 months **OR** • 90 consecutive days on the requested agent in the past 105 days
DIRECT RENIN INHIBITORS			
		TEKTURNA (aliskiren) aliskiren	**Non-Preferred Criteria** • Documented diagnosis of hypertension **AND**

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			• Have tried 2 different preferred ACEI or ARB single-entity products in the past 6 months **OR** • 90 consecutive days on the requested agent in the past 105 days
	DIRECT RENIN INHIBITOR COMBINATIONS		
		AMTURNIDE (aliskiren/amlodipine/hctz) TEKAMLO (aliskiren/amlodipine) TEKTURNA-HCT (aliskiren/hctz) VALTURNA (aliskiren/valsartan)	**Non-Preferred Criteria** • Documented diagnosis of hypertension **AND** • Have tried 2 different preferred ACEI or ARB diuretic agents in the past 6 months **OR** • 90 consecutive days on the requested agent in the past 105 days
ANTIBIOTICS (GI) & RELATED AGENTS			
	FIRVANQ (vancomycin) metronidazole tablets neomycin tinidazole	AEMCOLO (rifaximin) DIFICID (fidaxomicin) FLAGYL (metronidazole) FLAGYL ER (metronidazole) LIKMEZ (metronidazole) metronidazole capsules paromomycin REBYOTA (fecal microbiota) TINDAMAX (tinidazole) VANCOCIN (vancomycin) vancomycin VOWST (fecal microbiota)	

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		XIFAXAN (rifaximin)	
ANTIBIOTICS (MISCELLANEOUS)			
	KETOLIDES		
		KETEK (telithromycin)	
	LINCOSAMIDE ANTIBIOTICS		
	clindamycin capsules clindamycin solution	CLEOCIN (clindamycin) CLEOCIN SOLUTION (clindamycin)	
	MACROLIDES		
	azithromycin clarithromycin ER clarithromycin IR clarithromycin suspension ERY-TAB (erythromycin) erythromycin erythromycin ethylsuccinate	BIAXIN (clarithromycin) BIAXIN SUSPENSION (clarithromycin) BIAXIN XL (clarithromycin) E.E.S. FILM TAB (erythromycin ethylsuccinate) E.E.S. Suspension (erythromycin ethylsuccinate) E-MYCIN (erythromycin) ERYC (erythromycin) ERYPED Suspension (erythromycin ethylsuccinate) ERYTHROCIN (erythromycin stearate) erythromycin estolate PCE (erythromycin) ZITHROMAX (azithromycin) ZMAX (azithromycin)	
	NITROFURAN DERIVATIVES		
	nitrofurantoin nitrofurantoin monohydrate macrocyrstals	FURADANTIN (nitrofurantoin)	

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		MACROBID (nitrofurantoin monohydrate macrocyrstals) MACRODANTIN (nitrofurantoin)	
	OXAZOLIDINONES		
		SIVEXTRO (tedizolid) ZYVOX (linezolid)	**Sivextro – MANUAL PA** **Zyvox - MANUAL PA** **Quantity Limit** • **6 tablets/month** – Sivextro
	PLEUROMUTLINS		
		XENLETA (lefamulin	
ANTIBIOTICS (Topical)			
	bacitracin OTC bacitracin/polymixin OTC gentamicin sulfate mupirocin ointment neomycin/bacitracin/polymyxin OTC	ALTABAX (retapamulin) CORTISPORIN (bacitracin/neomycin/ polymyxin/HC) mupirocin cream NEOSPORIN (neomycin/bacitracin/polymyxin) OTC XEPI (ozenoxacin)	
ANTIBIOTICS (VAGINAL)			
	CLEOCIN OVULES (clindamycin) CLINDESSE (clindamycin) metronidazole vaginal	AVC (sulfanilamide) CLEOCIN CREAM (clindamycin) clindamycin cream METROGEL (metronidazole) NUVESSA (metronidazole)	

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		SOLOSEC (secnidazole) VANDAZOLE (metronidazole) XACIATO GEL (clindamycin)	
ANTICOAGULANTS			
	ORAL		**Non-Preferred Criteria** • Have tried 2 different preferred agents in the past 6 months **OR** • 1 claim with the requested agent in the past 90 days
	COUMADIN (warfarin) ELIQUIS (apixaban) PRADAXA (dabigatran) warfarin XARELTO (rivaroxaban)	BEVYXXA (betrixaban) PRADAXA PELLETS (dabigatran) SAVAYSA (edoxaban tosylate)	
	LOW MOLECULAR WEIGHT HEPARIN (LMWH)		**LMWH Non-Preferred Criteria** • Have tried 1 different preferred agent in the past 6 months **OR** • 90 consecutive days on the requested agent in the past 105 days
	enoxaparin	ARIXTRA (fondaparinux) fondaparinux FRAGMIN (dalteparin) LOVENOX (enoxaparin) Prefilled Syringe	
ANTICONVULSANTS DUR+			
	ADJUVANTS		**Minimum Age Limit** • 6 months-- Diacomit • 1 year – Banzel, Epidiolex • 2 years –Onfi, Sympazan **Epidiolex** • Documented diagnosis of Dravet syndrome. Lennox Gastaut
	carbamazepine carbamazepine suspension carbamazepine ER (generic Carbatrol) DEPAKOTE ER (divalproex) DEPAKOTE SPRINKLE (divalproex) divalproex divalproex ER divalproex sprinkle	APTIOM (eslicarbazepine) BANZEL (rufinamide) BRIVIACT (brivaracetam) carbamazepine XR CARBATROL (carbamazepine) DEPAKENE (valproic acid) DEPAKOTE (divalproex) DIACOMIT (stiripentol)	

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	EPIDIOLEX (cannabidiol) EPITOL (carbamazepine) gabapentin lacosamide lamotrigine levetiracetam levetiracetam ER oxcarbazepine oxcarbazepine suspension tiagabine topiramate tablet topiramate sprinkle capsule valproic acid zonisamide	ELEPSIA XR (levetiracetam) EPRONTIA (topiramate solution) EQUETRO (carbamazepine) felbamate FELBATOL (felbamate) FINTEPLA (fenfluramine) FYCOMPA (perampanel) GABITRIL (tiagabine) KEPPRA (levetiracetam) KEPPRA XR (levetiracetam) LAMICTAL (lamotrigine) LAMICTAL CHEWABLE (lamotrigine) LAMICTAL ODT (lamotrigine) LAMICTAL XR (lamotrigine) lamotrigine ER/XR lamotrigine ODT MOTPOLY XR (lacosamide) NEURONTIN (gabapentin) OXTELLAR XR (oxcarbazepine) QUDEXY XR (topiramate) ROWEEPRA (levetiracetam) rufinamide SABRIL (vigabatrin) SPRITAM (levetiracetam) STAVZOR (valproic acid) TEGRETOL (carbamazepine) TEGRETOL SUSPENSION (carbamazepine) TEGRETOL XR (carbamazepine) TOPAMAX TABLET (topiramate)	syndrome or seizures associated with tuberous sclerosis complex **OR** • 1 claim for the requested agent in the past 30 days **Non-Preferred Criteria** • Have tried 2 different preferred agents in the past 6 months **OR** • 90 consecutive days on the requested agent in the past 105 days **AND** • Documented diagnosis of seizure **Banzel, Onfi, Sympazan** • Documented diagnosis of Lennox-Gastaut **AND** • Have tried 1 different preferred agent for Lennox-Gastaut in the past 6 months **OR** • 90 consecutive days on the requested agent in the past 105 days **AND** • Documented diagnosis of seizure **Diacomit** • Documented diagnosis of Dravet syndrome **AND** • Active claim for clobazam **Fintepla**

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		TOPAMAX Sprinkle (topiramate) topiramate ER (generic Qudexy XR) Step Edit TRILEPTAL Tablets (oxcarbazepine) TRILEPTAL Suspension (oxcarbazepine) TROKENDI XR (topiramate) vigabatrin VIGPODER ORAL SOLUTION (vigabatrin) VIMPAT (lacosamide) XCOPRI (cenobamate) ZONISADE (zonisamide supsension) ZTALMY (ganaxolone)	• Requires clinical review **Sabril Powder for Oral Solution** • Documented diagnosis of infantile spasms **OR** • Have tried 2 different preferred agents in the past 6 months **OR** • 90 consecutive days on the requested agent in the past 105 days **AND** • Documented diagnosis of seizure **Topiramate ER – Step Edit** • 90 consecutive days on the requested agent in the past 105 days **AND** • Documented diagnosis of seizure **OR** • 30-day trial with topiramate IR in the past 6 months **Minimum Age Limit** • **12 years** – Nayzilam • **6 years** – Valtoco **Quantity Limit** • **2 Twin Packs/31 days** – Diastat • **2 Packages /31 days** – Nayzilam • **2 Cartons /31 days** – Valtoco
	SELECTED BENZODIAZEPINES		
	clobazam diazepam rectal gel NAYZILAM (midazolam) VALTOCO (diazepam)	DIASTAT (diazepam rectal) DIASTAT ACCUDIAL (diazepam rectal) LIBERVANT (diazepam)NR ONFI (clobazam) ONFI SUSPENSION (clobazam) SYMPAZAN (clobazam)	

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	HYDANTOINS		
	DILANTIN (phenytoin) PHENYTEK (phenytoin) phenytoin	PEGANONE (ethotoin)	
	SUCCINIMIDES		
	ethosuximide	CELONTIN (methsuximide) ZARONTIN (ethosuximide)	

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MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

(For All Medicaid, MSCAN and CHIP Beneficiaries)

EFFECTIVE 7/1/2024
Version 2024_9
Updated: 5/31/2024

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
ANTIDEPRESSANTS, OTHER DUR+			

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(For All Medicaid, MSCAN and CHIP Beneficiaries)

EFFECTIVE 7/1/2024
Version 2024_9
Updated: 5/31/2024

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	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 ZURZUVAE (zuranolone)	**Minimum Age Limit** • **7-11 years** – Drizalma Sprinkle *DUR + PA automatically issued for this age range with a diagnosis of generalized anxiety disorder* • **7-17 years** – duloxetine *DUR + PA automatically issued for this age range with a diagnosis of generalized anxiety disorder* • **18 years –** all other Antidepressants **Non-Preferred Criteria** • Have tried 2 different preferred Antidepressants in the past 6 months **OR** • Have tried BOTH a preferred Antidepressant and a SSRI in the past 6 months **OR** • 90 consecutive days on the requested agent in the past 105 days **Auvelity** • Requires clinical review **Zurzuvae – MANUAL PA** Cymbalta and Irenka (see Fibromyalgia Agents)
ANTIDEPRESSANTS, SSRIs DUR+			

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	citalopram escitalopram fluoxetine capsules fluvoxamine paroxetine CR paroxetine IR sertraline	CELEXA (citalopram) fluoxetine DR fluvoxamine ER LEXAPRO (escitalopram) LUVOX (fluvoxamine) LUVOX CR (fluvoxamine) paroxetine suspension PAXIL CR (paroxetine) PAXIL SUPENSION (paroxetine) PAXIL Tablets (paroxetine) PEXEVA (paroxetine) PROZAC (fluoxetine) SARAFEM (fluoxetine) ZOLOFT (sertraline)	**Minimum Age Limit** • **6 years –** Zoloft • **7 years** – Lexapro, Prozac • **8 years –** Luvox • **18 years** – Celexa, Luvox CR, Paxil, Pexeva, Prozac 90 mg **Maximum Age Limit** • **60 years** – Celexa **Non-Preferred Criteria** • Have tried 2 different preferred agents in the past 6 months **OR** • 90 consecutive days on the requested agent in the past 105 days
ANTIEMETICS DUR+			
	5HT3 RECEPTOR BLOCKERS		
	ondansetron ondansetron ODT ondansetron solution	ANZEMET (dolasetron) granisetron SANCUSO (granisetron) ZOFRAN (ondansetron) ZOFRAN ODT (ondansetron) ZUPLENZ (ondansetron)	**Quantity Limit** • **6 tablets/31 days** – Akynzeo • **30 tablets/31 days** – Zofran tablets/ODT • **100 ml/31 days** – Zofran solution **Non-Preferred Agents** • Have tried 1 preferred agent in the past 6 months

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			Injectables in this class closed to point of sale. PA required if not administered in clinic/hospital **Akynzeo - MANUAL PA**
	ANTIEMETIC COMBINATIONS		
		AKYNZEO (netupitant/palonosetron) BONJESTA (doxylamine/pyridoxine) DICLEGIS (doxylamine/pyridoxine) doxylamine/pyridoxine	
	CANNABINOIDS		
		CESAMET (nabilone) MARINOL (dronabinol) dronabinol SYNDROS (dronabinol)	
	NMDA RECEPTOR ANTAGONIST		
	aprepitant	EMEND (aprepitant)	
ANTIFUNGALS (Oral) DUR+			
	clotrimazole fluconazole griseofulvin microsize suspension nystatin terbinafine	ANCOBON (flucytosine) BREXAFEMME (ibrexafungerp) CRESEMBA (isavuconazonium) DIFLUCAN (fluconazole) flucytosine GRIFULVIN V (griseofulvin, microsize) griseofulvin microsize tablets griseofulvin ultramicrosize tablet GRIS-PEG (griseofulvin) itraconazole ^ ketoconazole	**Minimum Age Limit** • **12-17 years** – griseofulvin tablets *DUR + PA will automatically be issued for this age range* **Non-Preferred Criteria** • Have tried 2 different preferred agents in the past 6 months **HIV opportunistic infection** • Non-Preferred agent indicated for treatment (^) **AND**

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		LAMISIL (terbinafine) NOXAFIL (posaconazole) ^ ONMEL (itraconazole) ^ posaconazole^ SPORANOX (itraconazole) ^ TERBINEX Kit (terbinafine/ciclopirox) TOLSURA (itraconazole) VFEND (voriconazole) ^ VIVJOA (oteseconazole) voriconazole ^	• Documented diagnosis of HIV **Ancobon** • Requires clinical review **Vivjoa** • Requires clinical review **Cresemba - MANUAL PA** • Minimum age limit > 18 years **AND** • Documented diagnosis of invasive aspergillosis **OR** invasive mucormycosis **AND** • Prescriber is an oncologist/hematologist or infectious disease specialist **Sporanox** • HIV opportunistic infection criteria **OR** • Documented diagnosis of a transplant **OR** • History of an immunosuppressant in the past 6 months **OR** • Have tried 2 different preferred agents in the past 6 months
ANTIFUNGALS (Topical) DUR+			
ANTIFUNGALS			

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	ciclopirox cream/gel/solution/suspension clotrimazole cream/solution[Rx & OTC] ketoconazole shampoo LUZU (luliconazole) miconazole cream/powder[OTC] nystatin terbinafine cream/spray[OTC] tolnaftate cream/powder/spray[OTC]	BENSAL HP (benzoic acid/salicylic acid) butenafine CICLODAN KIT (ciclopirox kit) ciclopirox kit/shampoo CNL 8 (ciclopirox) econazole ERTACZO (sertaconazole) EXELDERM (sulconazole) EXTINA (ketoconazole) JUBLIA (efinaconazole) KERYDIN (tavaborole) 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)	**Non-Preferred Criteria** • Have tried 2 different preferred agents in the past 6 months
	ANTIFUNGAL/STEROID COMBINATIONS		

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	clotrimazole/betamethasone cream nystatin/triamcinolone	clotrimazole/betamethasone lotion LOTRISONE (clotrimazole/betamethasone)	
ANTIFUNGALS (VAGINAL)			
	clotrimazole vaginal cream OTC miconazole 1, 7cream OTC miconazole 3 vaginal cream, suppository OTC TERAZOL 3 Cream (terconazole) – currently unavailable from manufacturer terconazole cream tioconazole	GYNAZOLE 1 (butoconazole) TERAZOL 3 Suppository (terconazole) TERAZOL 7 (terconazole) terconazole suppository	
ANTIHISTAMINES, MINIMALLY SEDATING AND COMBINATIONS DUR+			
MINIMALLY SEDATING ANTIHISTAMINES			**Non-Preferred Criteria** • Documented diagnosis of allergy or urticaria **AND** • Have tried 2 different preferred agents in the past 12 months
	cetirizine tablets OTC cetirizine syrup Rx & OTC loratadine odt OTC loratadine syrup OTC loratadine tablet OTC	cetirizine chewable OTC CLARINEX (desloratadine) desloratadine ODT desloratadine tablet fexofenadine syrup fexofenadine table levocetirizine syrup levocetirizine tablet XYZAL Solution (levocetirizine) XYZAL Tablets (levocetirizine)	
MINIMALLY SEDATING ANTIHISTAMINE/DECONGESTANT COMBINATIONS			

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	cetirizine/pseudoephedrine loratadine/pseudoephedrine	ALLEGRA-D (fexofenadine/ pseudoephedrine) CLARITIN-D (loratadine/pseudoephedrine) CLARINEX-D (desloratadine/ pseudoephedrine) fexofenadine/pseudoephedrine ZYRTEC-D (cetirizine/pseudoephedrine)	
ANTIMIGRAINE AGENTS, ACUTE TREATMENT			
	CGRP ORAL AND NASAL		
	NURTEC ODT (rimegepant)	UBRELVY (ubrogepant) ZAVZPRET (zavegepant)	**Minimum Age Limit** • **18 years** – Nurtec ODT, Ubrelvy **Quantity Limit** • **8 tablets/31 day –** Nurtec ODT • **16 tablets/31 day –** Ubrelvy **Nurtec ODT** • Documented diagnosis of migraine **AND** • Have tried 2 different triptans in the past 6 months **AND** • No concurrent therapy with another CGRP agent **Ubrelvy** • Documented diagnosis of migraine **AND** • Have tried 2 different triptans in the past 6 months **AND**

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			• Have tried preferred Nurtec ODT in the past 6 months **AND** • No concurrent therapy with another CGRP agent **AND** • No concurrent therapy with a strong CYP3A4 inhibitor **Minimum Age Limit** • **6 years –** Maxalt • **12-17 years** – Axert, Treximet, Zomig nasal spray • *DUR + PA will automatically be issued for this age range* • **18 years** – Amerge, Frova, Imitrex, Onzetra Xsail, Relpax, Reyvow, Tosymra, Zembrace, Zomig tablets **Quantity Limit - ORAL** • **4 tablets/31 days –** Reyvow 50 mg • **6 tablets/31 days** - Axert, Relpax Zomig • **8 tablets/31 days** – Reyvow 100 mg • **9 tablets/31 days** - Amerge, Frova, Imitrex, Treximet • **12 tablets/31 days –** Maxalt **Non-Preferred Criteria - ORAL** • Have tried 2 preferred oral agents in the past 90 days
	TRIPTANS & RELATED AGENTS ORAL DUR+		
	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)	

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			Reyvow • Documented diagnosis of migraine **AND** • Have tried 2 different triptans in the past 90 days **AND** • Have tried preferred Nurtec ODT in the past 90 days **Quantity Limit - NASAL** • **1 box/31 days** **Non-Preferred Criteria - NASAL** • Have tried 2 preferred oral agents in the past 90 days **AND** • Have tried a preferred nasal agent in the past 90 days **CUMULATIVE Quantity Limit - INJECTION** **4 injections/31 days**
	NASAL		
	sumatriptan	IMITREX (sumatriptan) ONZETRA Xsail (sumatriptan) TOSYMRA (sumatriptan) zolmitriptan ZOMIG (zolmitriptan)	
	INJECTABLES		
	sumatriptan	IMITREX (sumatriptan) ZEMBRACE (sumatriptan)	
ANTIMIGRAINE AGENTS, PROPHYLAXIS			
	INJECTIBLES		**Aimovig - MANUAL PA** **Ajovy - MANUAL PA** **Emgality - MANUAL PA** **Vyepti - MANUAL PA**
	AIMOVIG AUTOINJECTOR (erenumab-aooe) AJOVY AUTOINJECTOR (fremanezumab-vfrm) AJOVY SYRINGE (fremanezumab-vfrm) EMGALITY PEN 120mg/mL(galcanezumab-gnlm) EMGALITY SYRINGE 120mg/mL (galcanezumab-gnlm)	EMGALITY SYRINGE 100mg/mL (galcanezumab-gnlm) VYEPTI (eptinezumab-jjmr)	

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	ORAL		
		NURTEC ODT (rimegepant) QULIPTA (atogepant)	• See Antimigraine Agents, Acute
***ANTINEOPLASTICS – SELECTED SYSTEMIC ENZYME INHIBITORS**			
	BOSULIF (bosutinib) CAPRELSA (vandetanib) COMETRIQ (cabozantinib) COTELLIC (cobimetinib) GILOTRIF (afatanib) everolimus ICLUSIG (ponatinib) imatinib mesylate IMBRUVICA (ibrutnib) INLYTA (axitinib) IRESSA (gefitinib) JAKAFI (ruxolitinib) MEKINIST (trametinib dimethyl sulfoxide) NEXAVAR (sorafenib) ROZLYTREK (entrectinib) ROZLYTREK (entrectinib) Pellet Pack SPRYCEL (dasatinib) STIVARGA (regorafenib) SUTENT (sunitinib) TAFINLAR (dabrafenib) TARCEVA (erlotinib) TASIGNA (nilotinib) TURALIO (pexidartinib) TYKERB (lapatinib ditosylate)	AFINITOR (everolimus) AKEEGA (niraparib / abiraterone) ALECENSA (alectinib) ALUNBRIG (brigatnib) AUGTYRO (repotrectinib) AYVAKIT (avapritinib) BALVERSA (erdafitinib) BOSULIF CAPSULES (bosutinib) BRAFTOVI (encorafenib) BRUKINSA (zanubrutinib) CABOMETYX (cabozantinib s-malate) CALQUENCE (acalabrutinib) COPIKTRA (duvelisib) DAURISMO (glasdegib) ERIVEDGE (vismodegib) ERLEADA (apalutamide) erlotinib EXKIVITY (mobocertinib) FARYDAK (panobinostat) FOTIVDA (tivozanib) FRUZAQLA (fruquintinib) GAVRETO (pralsetinib) gefitinib GLEEVEC (imatinib mesylate)	**Farydak - MANUAL PA** • Documented diagnosis of multiple myeloma **AND** • Used in combination with bortezomib and dexamethasone per PI **AND** • History of 2 prior regimens including bortezomib and an immunomodulatory agent **Ibrance** • Documented diagnosis of WD-DDLS for retroperitoneal sarcoma **OR** • All other indications evaluated through clinical review **Lenvima** • Documented diagnosis of thyroid cancer **OR** • Documented diagnosis of hepatocellular carcinoma **OR**

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	vandetanib VOTRIENT (pazopanib) XALKORI (crizotinib) XALKORI (crizotinib) Oral Pellets XTANDI (enzalutamide) ZELBORAF (vemurafenib) ZYDELIG (idelalisib) ZYKADIA (ceritnib)	GLEOSTINE (lomustine) IBRANCE (palbociclib) DUR+ IDHIFA (enasidenib) INQOVI (cedazuridine/decitabine) INREBIC (fedratinib) IWILFIN (eflornithine) JAYPIRCA (pirtobrutinib) KRAZATI (adagrasib) KISQALI (ribociclib) KOSELUGO (selumetinib) lapatinib ditosylate LENVIMA (lenvatinib)DUR+ LORBRENA (lorlatinib) LUMAKRAS (sotorasib) LYNPARZA (olaparib) DUR+ LYTGOBI (futibatinib) MEKTOVI (binimetnib) NERLYNX (neratinib maleate) NUBEQA (darolutamide) ODOMZO (sonidegib) OGSIVEO (nirogacestat) OJEMDA (tovorafenib)NR OJJAARA (momelotinib) ONUREG (azacitidine) ORGOVYX (relugolix) pazopanibNR PEMAZYRE (pemigatinib) PIQRAY (alpelisib) QINLOCK (ripretinib) REZLIDHIA (lutasidenib) RETEVMO (selpercatinib) RUBRACA (rucaparib)	• Documented diagnosis of renal cell carcinoma **AND** • History of 1 claim for everolimus in the past 30 days **AND** • History of 1 anti-angiogenic agent in the past 2 years **OR** • All other indications evaluated through clinical review **Lynparza Tablets** • Documented diagnosis of ovarian cancer, fallopian tube or peritoneal cancer **AND** • History of platinum-based chemotherapy in the past 2 years **OR** • All other indications evaluated through clinical review

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		RYDAPT (midostaurin) SCEMBLIX (asciminib) TABRECTA (capmatinib) TAGRISSO (osimertinib) TALZENNA (talazoparib) TAZVERIK (tazemetostat) TEPMETKO (tepotinib) TIBSOVO (ivosidenib) TRUSELTIQ (infigratinib) TRUQAP (capivasertib) TUKYSA (tucatinib) UKONIQ (umbralisib) VANFLYTA (quizartinib VERZENIO (abemaciclib) VITRAKVI (larotrectinib) VIZIMPRO (dacomitinib) VONJO (pacritinib) WELIREG (belzutifan) XATMEP (methotrexate) XOSPATA (gilteritinib) XPOVIO (selinexor) ZEJULA (niraparib)	
ANTIOBESITY SELECT AGENTS			
	SAXENDA (liraglutide) WEGOVY (semaglutide)	orlistat XENICAL (orlistat)	All agents require MANUAL PA
ANTIPARASITICS (Topical) DUR+			
	PEDICULICIDES		

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	permethrin 1%[OTC] NATROBA (spinosad)	lindane malathion OVIDE (malathion) SKLICE (ivermectin) spinosad VANALICE (piperonyl butoxide/pyrethrins)	**Minimum Age/Weight Limit for Pediculicides** • **50 kg –** lindane shampoo • **2 months –** permethrin 1%(OTC) • **6 months** – Natroba, Sklice • **2 years –** piperonyl/pyrethrins (OTC) • **6 years –** Ovide **Non-Preferred Criteria** • Have tried 2 preferred topical lice agents in the past 90 days
	SCABICIDES		
	permethrin 5% ivermectin	ELIMITE (permethrin) EURAX CREAM (crotamiton) EURAX LOTION (crotamiton) STROMECTOL Tablet (ivermectin)	**Minimum Age/Weight Limit for Topical Scabicides** • **50 kg –** lindane lotion • **2 months –** permethrin 5% • **4 years –** Natroba • **18 years** – Eurax **Non-Preferred Criteria** • History of permethrin 5% in the past 90 days
ANTIPARKINSON'S AGENTS (Oral) [DUR+]			
	ANTICHOLINERGICS		

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	benztropine trihexyphenidyl	COGENTIN (benztropine)	**Non-Preferred Criteria** • Documented diagnosis of Parkinson's disease **AND** • Have tried 2 different preferred agents in the past 6 months **OR** • 90 consecutive days on the requested agent in the past 105 days
	COMT INHIBITORS		
	entacapone	COMTAN (entacapone) ONGENTYS (opicapone) TASMAR (tolcapone) tolcapone	
	DOPAMINE AGONISTS		
	ropinirole	KYNMOBI FILM (apomorphine) MIRAPEX (pramipexole) MIRAPEX ER (pramipexole) NEUPRO (rotigotine) pramipexole pramipexole ER REQUIP (ropinirole) REQUIP XL (ropinirole) ropinirole ER	
	MAO-B INHIBITORS		
	selegiline	AZILECT (rasagiline) ELDEPRYL (selegiline) rasagiline XADAGO (safinamide) ZELAPAR (selegiline)	**Xadago** • Documented diagnosis of Parkinson's disease **AND**

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			• History of a preferred carbidopa/levodopa combination product in the past 30 days **AND** • History of selegiline product in the past 45 days
	OTHERS		
	amantadine bromocriptine carbidopa levodopa/carbidopa	DUOPA (levodopa/carbidopa) GOCOVRI (amantadine) INBRIJA (levodopa) levodopa/carbidopa ODT levodopa/carbidopa/entacapone LODOSYN (carbidopa) NOURIANZ (istradefylline) OSMOLEX ER (amantadine) PARCOPA (levodopa/carbidopa) PARLODEL (bromocriptine) RYTARY ER (levodopa/carbidopa) SINEMET (levodopa/carbidopa) SINEMET CR (levodopa/carbidopa) STALEVO (levodopa/carbidopa/entacapone)	**Lodosyn and Inbrija** • Documented diagnosis of Parkinson's disease **AND** • History of a carbidopa/levodopa combination product in the past 45 days **Nourianz** • Documented diagnosis of Parkinson's Disease **AND** • History of a preferred carbidopa/levodopa combination product in the past 30 days **AND** • History of 30 days therapy with a preferred adjunctive therapy in the past 45 days
ANTIPSYCHOTICS DUR+			
	ORAL		
	amitriptyline/perphenazine aripiprazole asenapine clozapine fluphenazine	ABILIFY (aripiprazole) ABILIFY MYCITE (aripiprazole) ADASUVE (loxapine) aripiprazole solution aripiprazole ODT	**Minimum Age Limit** • **3 years –** Haldol • **5 years –** Risperdal, thioridazine • **6 years –** Abilify, trifluoperazine • **10 years –** Latuda, Saphris, Seroquel, Symbyax

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	haloperidol olanzapine olanzapine ODT perphenazine quetiapine quetiapine XR risperidone risperidone ODT thioridazine thiothixene trifluoperazine VRAYLAR (cariprazine) ziprasidone	CAPLYTA (lumateperone) chlorpromazine clozapine ODT CLOZARIL (clozapine) FANAPT (iloperidone) FAZACLO (clozapine) GEODON (ziprasidone) HALDOL (haloperidol) INVEGA ER (paliperidone) LATUDA (lurasidone) lurasidone LYBALVI (olanzapine/samidorphan) NUPLAZID (pimavanserin) olanzapine/fluoxetine paliperidone ER REXULTI (brexpiprazole) RISPERDAL (risperidone) SAPHRIS (asenapine) SEROQUEL (quetiapine) SEROQUEL XR (quetiapine) SYMBYAX (olanzapine/fluoxetine) VERSACLOZ (clnazpine) ZYPREXA (olanzapine)	• **12 years –** Invega, molindone, perphenazine, pimozide, thiothixene • **13 years –** Rexulti, Zyprexa • **18 years –** Abilify Mycite, Amitriptyline/perphenazine, Caplyta, Clozaril, Fanapt, fluphenazine, Geodon, loxapine, Lybalvi, Nuplazid, Secuado, Vraylar **Concurrent Therapy Limit – Ages 0-17 years** • 90 days with 2 or more antipsychotics in the last 120 days will require a Manual PA **Vraylar** • Documented diagnosis of schizophrenia or schizoaffective disorder **OR** • Documented diagnosis of bipolar disorder **OR** • Documented diagnosis of major depressive disorder **AND** • 30 days of therapy with an antidepressant in the past 45 days **OR** • 1 claim for a 90-day supply of an antidepressant in the past 105 days

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			Non-Preferred Criteria- Atypical Agents • Have tried 2 preferred atypical antipsychotic agents in the past 12 months **OR** • 30 consecutive days on the requested atypical agent in the past 180 days **Nuplazid** • Documented diagnosis of Parkinson's disease
	INJECTABLE, ATYPICALS DUR+		
	ABILIFY ASIMTUFII (aripiprazole) ABILIFY MAINTENA (aripirazole) ARISTADA ER (aripiprazole lauroxil) ARISTADA INITIO (aripiprazole lauroxil) INVEGA HAFYERA (paliperidone) INVEGA SUSTENNA (paliperidone palmitate) INVEGA TRINZA (paliperidone) PERSERIS (risperidone) RISPERDAL CONSTA (risperidone) UZEDY (risperidone)	ABILIFY (aripiprazole) GEODON (ziprasidone) olanzapine ZYPREXA (olanzapine) ZYPREXA RELPREVV (olanzapine) risperidone microspheres RYKINDO (risperidone)	**Minimum Age Limit** • **18 years –** all injectable agents **Quantity Limit** • **3 syringes/year –** Aristada Initio **Long-Acting Injectable Agents All Agents** • Documented diagnosis of schizophrenia or schizoaffective disorder **Abilify Maintena, Risperdal Consta and Rykindo ER** • Documented diagnosis of schizophrenia or schizoaffective disorder **OR**

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			• Documented diagnosis of bipolar disorder **Invega Hafyera** • Documented diagnosis of schizophrenia or schizoaffective disorder **AND** • 4 claims for Invega Sustenna in the past year **OR** • 1 claim for Invega Trinza in the past year **OR** • 1 claim for Invega Hafyera in the past year
	TRANSDERMAL, ATYPICALS		
		SECUADO (asenapine)	
ANTIRETROVIRALS DUR+			
	SINGLE PRODUCT REGIMENS		
	BIKTARVY (bictegravir/emtricitabine/tenofovir) CABENUVA (cabotegravir/rilpivirine) DELSTRIGO (doravirine/lamivudine/tenofovir) DOVATO (dolutegravir/lamivudine) efavirenz/emtricitabine/tenofovir labeler GENVOYA (elvitegravir/cobicistat/emtricitabine/tenofovir) 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 JULUCA (dolutegravir/rilpivirine) STRIBILD (elvitegravir/cobicistat/emtricitabine/tenofovir) SYMTUZA (darunavir/cobicistat/ emtricitabine/tenofovir)	**Stribild – MANUAL PA** • Genotype testing supporting resistance to other regimens **OR** • Intolerance or contraindication to preferred combination of drugs **AND** • Medical reasoning beyond convenience or enhanced compliance over preferred agents **AND**

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			• CrCl > 70mL/min to initiate therapy **OR** CrCl >50mL/min to continue therapy **Non-Preferred Criteria** • 1 claim with the requested agent in the past 105 days
	INTEGRASE STRAND TRANSFER INHIBITORS		
	APRETUDE ER (cabotegravir) ISENTRESS (raltegravir potassium) TIVICAY (dolutegravir sodium) TIVICAY PD (dolutegravir sodium)	ISENTRESS HD (raltegravir potassium) VITEKTA (elvitegravir)	
	NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS (NRTI)		
	abacavir sulfate EMTRIVA (emtricitabine) EMTRIVA SOLUTION (emtricitabine) lamivudine tenofovir disoproxil fumarate ZIAGEN Solution (abacavir sulfate) zidovudine	didanosine DR capsule emtricitabine EPIVIR (lamivudine) RETROVIR (zidovudine) stavudine VIDEX EC (didanosine) VIDEX SOLUTION (didanosine) VIREAD (tenofovir disoproxil fumarate) ZIAGEN Tablet (abacavir sulfate)	
	NON-NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITOR (NNRTI)		
	EDURANT (rilpivirine) efavirenz	INTELENCE (etravirine) nevirapine nevirapine ER PIFELTRO (doravirine) RESCRIPTOR (delavirdine mesylate) SUSTIVA (efavirenz) VIRAMUNE (nevirapine) VIRAMUNE ER (nevirapine)	

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			Tybost - MANUAL PA
	PHARMACOENHANCER – CYTOCHROME P450 INHIBITOR		
		TYBOST (cobicistat)	
	PROTEASE INHIBITORS (PEPTIDIC)		
	atazanavir EVOTAZ (atazanavir/cobicistat) NORVIR SOLUTION (ritonavir) ritonavir	CRIXIVAN (indinavir) fosamprenavir INVIRASE (saquinavir mesylate) LEXIVA (fosamprenavir) NORVIR POWDER (ritonavir) NORVIR TABLET (ritonavir) REYATAZ (atazanavir) VIRACEPT (nelfinavir mesylate)	
	PROTEASE INHIBITORS (NON-PEPTIDIC)		
	PREZISTA (darunavir ethanolate)	APTIVUS (tipranavir) darunavir ethanolate PREZCOBIX (darunavir/cobicistat)	
	ENTRY INHIBITORS – CCR5 CO-RECEPTOR ANTAGONISTS		
		SELZENTRY (maraviroc)	
	ENTRY INHIBITORS – FUSION INHIBITORS		
		FUZEON (enfuvirtide)	

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	COMBINATION PRODUCTS - NRTIs		
	abacavir/lamivudine CABENUVA (cabotegravir/rilpivirine) DOVATO (dolutegravir/lamivudine) lamivudine/zidovudine	abacavir/lamivudine/zidovudine COMBIVIR (lamivudine/zidovudine) EPZICOM (abacavir/lamivudine) JULUCA (dolutegravir/rilpivirine) TRIZIVIR (abacavir/lamivudine/zidovudine)	
	COMBINATION PRODUCTS – NUCLEOSIDE & NUCLEOTIDE ANALOG RTIs		
	DESCOVY (emtricitabine/tenofovir alafenam) emtricitabine/tenofovir	TRUVADA (emtricitabine/tenofovir)	
	COMBINATION PRODUCTS – NUCLEOSIDE & NUCLEOTIDE ANALOGS & NON-NUCLEOSIDE RTIs		
	DELSTRIGO (doravirine/lamivudine/tenofovir) efavirenz/emtricitabine/tenofovir ODEFSEY (emtricitabine/rilpivirine/tenofovir AF)	ATRIPLA (efavirenz/emtricitabine/tenofovir) CIMDUO (lamivudine/tenofovir) COMPLERA (emtricitabine/rilpivirine/tenofovir) TEMIXYS (lamivudine/tenofovir)	
	COMBINATION PRODUCTS – PROTEASE INHIBITORS		
	lopinavir/ritonavir	KALETRA (lopinavir/ritonavir)	
	CAPSID INHIBITORS		**All agents require clinical review.**
		SUNLENCA (lenacapavir)	

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	CD4 DIRECTED ATTACHMENT INHIBITOR		
		RUKOBIA (fostemsavir tromethamine ER)	
	CD4 DIRECTED HIV-1 INHIBITOR		
		TROGARZO (ibalizumab)	
ANTIVIRALS (Oral)			
	ANTI-CYTOMEGALOVIRUS AGENTS		
	valganciclovir tablets	LIVTENCITY (maribavir) PREVYMIS (letermovir) VALCYTE (valganciclovir) valganciclovir solution	**valganciclovir solution –** automatic approval for age <12 years **Prevymis** Prevention (prophylaxis) of cytomegalovirus (CMV) infection and disease • ≥ 18 years **AND** • Post hematopoietic stem cell transplant (HSCT) within the past 28 days **AND** • CMV sero-positive recipient [R+] **AND** • NO severe (Child-Pugh Class C) hepatic impairment
	ANTI-HERPETIC AGENTS		
	acyclovir valacyclovir	famciclovir FAMVIR (famciclovir) SITAVIG (acyclovir) VALTREX (valacyclovir)	

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		ZOVIRAX (acyclovir)	
	ANTI-INFLUENZA AGENTS		
	oseltamivir	FLUMADINE (rimantadine) RAPIVAB (peramivir) RELENZA (zanamivir) rimantadine TAMIFLU (oseltamivir) XOFLUZA (baloxavir marboxil)	
ANTIVIRALS (Topical)			
	ZOVIRAX Cream (acyclovir)	acyclovir cream, ointment DENAVIR (penciclovir) XERESE (acyclovir/hydrocortisone) ZOVIRAX Ointment (acyclovir)	
AROMATASE INHIBITORS			
	anastrozole exemestane letrozole	ARIMIDEX (anastrozole) AROMASIN (exemestane) FEMARA (letrozole)	

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
ATOPIC DERMATITIS DUR+			
	ADBRY (tralokinumab) DUPIXENT (dupilumab) ELIDEL (pimecrolimus) PROTOPIC (tacrolimus) tacrolimus	CIBINQO (abrocitinib) EUCRISA (crisaborole) OPZELURA (ruxolitinib) pimecrolimus	**Minimum Age Limit** • **2 years –** Elidel, Protopic 0.03% • **16 years –** Protopic 0.1% **Cibinqo and Opzelura** • Require clinical review **Adbry- MANUAL PA** **Eucrisa** • History of 28 days of therapy with a calcineurin inhibitor **AND** • History of 28 days of therapy with a topical steroid in the past year **OR** • **MANUAL PA** **Dupixent** Evaluated through Manual PA according to diagnosis **Asthma – MANUAL PA** **Atopic Dermatitis – MANUAL PA** **Eosinophilic Esophagitis--MANUAL PA** **Nasal Polyposis – MANUAL PA** **Prurigo Nodularis MANUAL PA**
BETA BLOCKERS, ANTIANGINALS & SINUS NODE AGENTS DUR+			
	acebutolol atenolol bisoprolol	AZSRUZYO SPRINKLES (ranolazine) BETAPACE (sotalol) betaxolol	**Non-Preferred Criteria** • Have tried 2 different preferred agents in the past 6 months **OR**

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	metoprolol metoprolol ER nadolol nebivolol pindolol propranolol propranolol ER sotalol	BYSTOLIC (nebivolol) CORGARD (nadolol) HEMANGEOL (propranolol) INDERAL LA (propranolol) INDERAL XL (propranolol) INNOPRAN XL (propranolol) KAPSPARGO SPRINKLES (metoprolol) KERLONE (bextaxolol) LEVATOL (penbutolol) LOPRESSOR (metoprolol) SECTRAL (acebutolol) SOTYLIZE (sotalol) TENORMIN (atenolol) TOPROL XL (metoprolol) ZEBETA (bisoprolol)	• 90 consecutive days on the requested agent in the past 105 days
BETA- AND ALPHA-BLOCKERS			
	carvedilol labetalol	carvedilol CR COREG (carvedilol) COREG CR (carvedilol) TRANDATE (labetalol)	**Coreg CR** • Documented diagnosis for hypertension **AND** • Have tried generic carvedilol **AND** 1 preferred agent in the past 6 months **OR** • 90 consecutive days on the requested agent in the past 105 days
BETA BLOCKER/DIURETIC COMBINATIONS			

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	atenolol/chlorthalidone bisoprolol/HCTZ metoprolol/HCTZ nadolol/bendroflumethiazide propranolol/HCTZ timolol/HCTZ	CORZIDE (nadolol/bendroflumethiazide) DUTOPROL (metoprolol/HCTZ) LOPRESSOR HCT (metoprolol/HCTZ) TENORETIC (atenolol/chlorthalidone) ZIAC (bisoprolol/HCTZ)	
ANTIANGINALS			
		RANEXA (ranolazine) ranolazine	**Ranexa** • Documented diagnosis of angina **AND** • 1 claim for a calcium channel blocker, beta-blocker, nitrate, or combination agent in the past 30 days **OR** • 90 consecutive days on the requested agent in the past 105 days
SINUS NODE AGENTS			
		CORLANOR (ivabradine)	**Corlanor - MANUAL PA**
BILE SALTS			
	ursodiol	ACTIGALL (ursodiol) BYLVAY (odevixibat) CHENODAL (chenodiol) CHOLBAM (cholic acid) LIVMARLI (maralixibat) OCALIVA (obeticholic acid)	

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		URSO (ursodiol) URSO FORTE (ursodiol)	
BLADDER RELAXANT PREPARATIONS DUR+			
	MYRBETRIQ ER (mirabegron) oxybutynin ER oxybutinin IR solifenacin	darifenacin DETROL (tolterodine) DETROL LA (tolterodine) DITROPAN XL (oxybutynin) GELNIQUE (oxybutynin) GEMTESA (vibegron) mirabegron ER[NR] MYRBETRIQ granules (mirabegron) OXYTROL (oxybutynin) tolterodine tolterodine ER TOVIAZ (fesoterodine fumarate) trospium trospium ER VESICARE (solifenacin) VESICARE LS Suspension (solifenacin)	**Non-Preferred Criteria** • Have tried 2 different preferred agents in the past 6 months
BONE RESORPTION SUPPRESSION AND RELATED AGENTS DUR+			
	BISPHOSPHONATES		
	alendronate ibandronate risedronate	ACTONEL (risedronate) ACTONEL WITH CALCIUM (risedronate/calcium) alendronate solution ATELVIA (risedronate) BINOSTO (alendronate) BONIVA (ibandronate)	**Non-Preferred Criteria** • Documented diagnosis for osteoporosis or osteopenia **AND** • Have tried 2 different preferred agents in the past 6 months

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		DIDRONEL (etidronate) FOSAMAX (alendronate) FOSAMAX PLUS D (alendronate/vitamin D) risedronate DR Tablet	
	OTHERS		
		calcitonin salmon EVENITY (romosozumab-aqqg) EVISTA (raloxifene) FORTEO (teriparatide) MIACALCIN (calcitonin) PROLIA (denosumab) raloxifene TYMLOS (abaloparatide) XGEVA (denosumab)	
BPH AGENTS DUR+			
	ALPHA BLOCKERS		
	alfuzosin doxazosin tamsulosin terazosin	CARDURA (doxazosin) CARDURA XL (doxazosin) dutasteride/tamsulosin FLOMAX (tamsulosin) HYTRIN (terazosin) JALYN (dutasteride/tamsulosin) RAPAFLO (silodosin) silodosin UROXATRAL (alfuzosin)	**Female** • Cardura, Flomax, Proscar, terazosin, or Uroxatral **AND** • Documented diagnosis based on a State accepted diagnosis **Non-Preferred Criteria - MALE** • Have tried 2 different preferred agents in the past 6 months **OR** • 90 consecutive days on the requested agent in the past 105 days

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	5-ALPHA-REDUCTASE (5AR) INHIBITORS		**Entadfi** • Requires clinical review
	finasteride	AVODART (dutasteride) dutasteride ENTADFI (finasteride/tadalafil) PROSCAR (finasteride)	
	PDE5 INHIBITORS		
		CIALIS (tadalafil)	
BRONCHODILATORS & COPD AGENTS			
	ANTICHOLINERGICS & COPD AGENTS		**Minimum Age Limit** **6 years –** Spiriva Respimat **Spiriva Respimat** • Automatic approval for ≥ 6 years with a diagnosis of asthma
	ATROVENT HFA (ipratropium) INCRUSE ELLIPTA (umeclidinium) ipratropium SPIRIVA HANDIHALER (tiotropium)	DALIRESP (roflumilast) LONHALA MAGNAIR (glycopyrrolate) roflumilast SEEBRI (glycopyrrolate) SPIRIVA RESPIMAT (tiotropium) DUR+ TUDORZA PRESSAIR (aclidinium) YUPELRI (revefenacin)	
	ANTICHOLINERGIC-BETA AGONIST COMBINATIONS		
	albuterol/ipratropium ANORO ELLIPTA (umeclidinium/vilanterol) COMBIVENT RESPIMAT (albuterol/ipratropium) STIOLTO RESPIMAT (tiotropium/olodaterol)	BEVESPI (glycopyrrolate/formoterol) DUAKLIR PRESSAIR (aclidinium/formoterol)	

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	ANTICHOLINERGIC-BETA AGONIST-GLUCOCORTICOIDS COMBINATIONS		
		BREZTRI AEROSPHERE (budesonide/glycopyrrolate/formoterol) TRELEGY ELLIPTA (fluticasone furoate/ umeclidinium/vilanterol)	
BRONCHODILATORS, BETA AGONIST			
	INHALERS, SHORT-ACTING		
	albuterol HFA PROVENTIL HFA (albuterol) VENTOLIN HFA (albuterol)	AIRSUPRA (budesonide/albuterol) levalbuterol HFA PROAIR DIGIHALER (albuterol) PROAIR RESPICLICK (albuterol) XOPENEX HFA (levalbuterol)DUR+	**Minimum Age Limit** • **4 years –** Xopenex HFA • **18 years -** Airsupra **Quantity Limit** • **2 inhalers/31 days** – Airsupra **Xopenex HFA** • 1 claim for a preferred albuterol inhaler in the past 30 days **Airsupra and ProAir Digihaler** • Requires clinical review
	INHALERS, LONG ACTING DUR+		

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	SEREVENT (salmeterol) STRIVERDI RESPIMAT (olodaterol)		**Minimum Age Limit** • **4 years –** Serevent • **18 years –** Striverdi Respimat
	INHALATION SOLUTION DUR+		
	albuterol	arformoterol BROVANA (arformoterol) formoterol levalbuterol metaproterenol PERFOROMIST (formoterol) XOPENEX (levalbuterol)	**Minimum Age Limit** • **6 years –** Xopenex • **18 years –** Brovana, Perforomist **Non-Preferred Criteria** • 1 claim for a different preferred agent in the past 6 months **OR** • 3 claims with the requested agent in the past 105 days **Xopenex** • 1 claim for a preferred albuterol in the past 30 days
	ORAL		
	albuterol ER albuterol IR metaproterenol terbutaline	VOSPIRE ER (albuterol)	
CALCIUM CHANNEL BLOCKERS DUR+			
	SHORT-ACTING		

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	diltiazem nicardipine nifedipine verapamil	CALAN (verapamil) CARDIZEM (diltiazem) isradipine nimodipine NORLIQVA (amlodipine) NYMALIZE SOLUTION (nimodipine) PROCARDIA (nifedipine)	**Quantity Limit - nimodipine** • **252 tablets/ 21 days** • **2520 mL/21 days** **Non-Preferred Criteria** • Have tried 2 different preferred Short Acting CCB agents in the past 6 months **OR** • 90 consecutive days on the requested agent in the past 105 days **nimodipine** • Documented diagnosis of subarachnoid hemorrhage in the past 45 days **AND** • Duration of therapy limited to 21 days
	LONG-ACTING		
	amlodipine DILT XR 24 HR Caps (diltiazem) diltiazem ER Cap 24 HR (generic Cardizem CD) diltiazem ER Cap 24 HR felodipine ER nifedipine ER verapamil ER	ADALAT CC (nifedipine) CALAN SR (verapamil) CARDENE SR (nicardipine) CARDIZEM CD (diltiazem) CARDIZEM LA (diltiazem) DILACOR XR (diltiazem) diltiazem ER Cap 12 HR diltiazem ER Tab 24 HR KATERZIA (amlodipine) nisoldipine NORVASC (amlodipine)	**Non-Preferred Criteria** • Have tried 2 different preferred Long Acting CCB agents in the past 6 months **OR** • 90 consecutive days on the requested agent in the past 105 days

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

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	CEPHALOSPORINS – First Generation DUR+		**Non-Preferred Criteria – all generations** • Have tried 2 different preferred agents in the past 6 months
	cefadroxil cephalexin capsules cephalexin suspensio	cephalexin tablets DAXBIA (cephalexin) KEFLEX (cephalexin)	
	CEPHALOSPORINS – Second Generation DUR+		
	cefaclor capsules cefprozil cefuroxime tablets	cefaclor ER cefaclor suspension cefuroxime suspension CEFTIN (cefuroxime)	
	CEPHALOSPORINS – Third Generation DUR+		
	cefdinir suspension cefdinir capsules cefpodoxime	CEDAX (ceftibuten) cefditoren ceftibuten SPECTRACEF (cefditoren) SUPRAX (cefixime)	**Maximum Age Limit** • **18 years –** cefdinir suspension
COLONY STIMULATING FACTORS			
	FYLNETRA (pegfilgrastim) STIMUFEND (pegfilgrastim-fpgk) NEUPOGEN Syringe (filgrastim) NEUPOGEN Vial (filgrastim)	FULPHILA (pegfilgrastim) GRANIX (tbo-filgrastim) LEUKINE (sargramostim) NEULASTA (pegfilgrastim) NIVESTYM (filgrastim-aafi) NYVEPRIA (pegfilgrastim-apgf) RELEUKO (filgrastim) ROLVEDON (eflapegrastim) UDENYCA (pegfilgrastim-cbqv) UDENYCA ONBODY (pegfilgrastim-cbqv)	

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		ZARXIO (filgrastim) ZIEXTENZO (pegfilgrastim-bmez)	
CYSTIC FIBROSIS AGENTS DUR+			
	tobramycin (generic TOBI)	BETHKIS (tobramycin) BRONCHITOL (mannitol) CAYSTON (aztreonam) colistmethate COLY-MYCIN M (colistimethate sodium) KALYDECO (ivacaftor) KITABIS (tobramycin) ORKAMBI (lumacaftor/ivacaftor) PULMOZYME (dornase alfa) SYMDEKO (tezacaftor/ivacaftor) TOBI (tobramycin) TOBI PODHALER (tobramycin) tobramycin (generic Bethkis) tobramycin (generic Kitabis) TRIKAFTA (elexacaftor/ tezacaftor/ivacaftor)	**Minimum Age Limit** • **1 month –** Kalydeco Granules • **3 months –** Pulmozyme • **1 year –** Orkambi • **2 years –** Coly-Mycin M, Trikafta Granules • **6 years –** Bethkis, Kalydeco tablet, Kitabis, Symdeko, TOBI, TOBI Podhaler, Trikafta tablet • **7 years –** Cayston • **18 years –** Bronchitol **Maximum Age Limit** • **2 years** – Orkambi 75-94 mg Granules • **5 years** – Kalydeco, Orkambi 100-125 mg Granules, Orkambi 200-125 mg Granules, Trikafta Granules • **11 years –** Trikafta tablets **All Agents** • Documented diagnosis Cystic Fibrosis **Colistimethate**

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			• Documented diagnosis of Cystic Fibrosis **OR** • Requires clinical review **Kalydeco – MANUAL PA** **Orkambi – MANUAL PA** **Symdeko – MANUAL PA** **Trikafta – MANUAL PA** **TOBI Podhaler** • Requires clinical review
CYTOKINE & CAM ANTAGONISTS DUR+			
	ACTEMRA SYRINGE (tocilizumab) ACTEMRA VIAL(tocilizumab) AVSOLA (infliximab) ENBREL (etanercept) HUMIRA (adalimumab) KINERET (anakinra) methotrexate ORENCIA CLICKJET(abatacept) ORENCIA VIAL(abatacept) OTEZLA (apremilast) SIMPONI (golimumab) TALTZ (ixekizumab) XELJANZ IR (tofacitinib)	ABRILADA (adalimumab-afzb) ACTEMRA ACTPEN (tocilizumab) AMJEVITA (adalimumab) ARCALYST (rilonacept) BIMZELX (bimekizumab-bkzx) CIMZIA (certolizumab) COSENTYX (secukinumab) COSENTYX VIAL (secukinumab) CYLTEZO (adalimumab-adbm) ENTYVIO (vedolizumab) ENTYVIO SQ (vedolizumab) HADLIMA (adalimumab) HULIO (adalimumab) HYRIMOZ (adalimumab) IDACIO (adalimumab) ILARIS (canakinumab) ILUMYA (tildrakizumab)	**All preferred agents are subject to approved age and documented diagnosis for appropriate indication.** **All Non-Preferred Agents** • Require clinical review **IV Administered Agents** • Require clinical review

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		INFLECTRA (infliximab) JYLAMVO (methotrexate) KEVZARA (sarilumab) LITFULO (ritlecitinib) OLUMIANT (baricitinib) OMVOH (mirikizumab-mrkz) ORENCIA SYRINGE (abatacept) OTREXUP (methotrexate) RASUVO (methotrexate) REMICADE (infliximab) RENFLEXIS (infliximab-abda) RHEUMATREX (methotrexate) RINVOQ (upadacitinib) RINVOQ ER (upadacitinib) SILIQ (brodalumab) SIMLANDI (adalimumab-ryvk) SKYRIZI (risankizumab) SOTYKTU (deucravacitinib) SPEVIGO (spesolimab) STELARA (ustekinumab) TOFIDENCE (tocilizumab-bavi) TREMFYA (guselkumab) TREXALL (methotrexate) TYENNE (tocilizumab-aazg) XELJANZ Oral Solution (tofacitinib) XELJANZ XR (tofacitinib) YUSIMRY (adalimumab) ZYMFENTRA (infliximab-dyyb)	

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
ERYTHROPOIESIS STIMULATING PROTEINS DUR+			
	EPOGEN (rHuEPO) MIRCERA (methoxy polyethylene glycol-epoetin-beta) RETACRIT (rHuEPO)	ARANESP (darbepoetin) PROCRIT (rHuEPO) JESDUVROQ (daprodustat)	**Mircera** • Documented diagnosis chronic renal failure in the past 2 years **Non-Preferred Criteria** • Documented diagnosis of cancer or chronic renal failure **OR** Antineoplastic therapy in the past 6 months **AND** • Trial of a preferred Retacrit or Epogen in the past 6 months **OR** • 1 claim for the requested agent in the past 105 days **Jesduvroq** • Requires clinical review
FACTOR DEFICIENCY PRODUCTS			
	FACTOR VIII		
	ADVATE AFSTYLA ALPHANATE FEIBA NF HEMOFIL M HUMATE-P	ADYNOVATE ALTUVIIIO BEQVEZ[NR] ELOCTATE ESPEROCT HEXILATE FS	

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	KOATE KOGENATE FS KOVALTRY NOVOEIGHT NUWIQ RECOMBINATE WILATE XYNTHA XYNTHA SOLOFUSE	JIVI KCENTRA OBIZUR VONVENDI	
	FACTOR IX		
	ALPHANINE SD ALPROLIX BENEFIX IDELVION IXINITY MONONINE PROFILNINE RIXUBIS	REBINYN	
	OTHER FACTOR PRODUCTS		
	COAGADEX FIBRYGA HEMLIBRA DUR+ RIASTAP	CORIFACT NOVOSEVEN RT SEVENFACT TRETTEN	**Hemlibra** • 3 claims with Hemlibra in the past 105 days **OR** • New starts require **MANUAL PA**
FIBROMYALGIA/NEUROPATHIC PAIN AGENTS			
	duloxetine gabapentin pregabalin	(duloxetine) DUR+ DRIZALMA SPRINKLES (duloxetine DR) duloxetine DR	**Cymbalta and Irenka (see Antidepressant, Other)**

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	SAVELLA (milnacipran)	gabapentin ER GRALISE (gabapentin) HORIZANT (gabapentin) IRENKA (duloxetine) DUR+ LYRICA (pregabalin) LYRICA CR (pregabalin) NEURONTIN (gabapentin) pregabalin ER	**Minimum Age Limit –** automatic approval for ages 7-17 with a diagnosis of GAD (Generalized Anxiety Disorder) for preferred duloxetine
FLUOROQUINOLONES DUR+			
	ciprofloxacin tablets levofloxacin tablets	AVELOX (moxifloxacin) BAXDELA (delaflozacin) CIPRO (ciprofloxacin) CIPRO SUSPENSION (ciprofloxacin) CIPRO XR (ciprofloxacin) ciprofloxacin ER ciprofloxacin suspension FACTIVE (gemifloxacin) LEVAQUIN (levofloxacin) levofloxacin solution moxifloxacin NOROXIN (norfloxacin) ofloxacin	**Non-Preferred Criteria** • 1 claim for a preferred agent in past 30 days **Cipro Suspension for age < 12 years** • Anthrax infection or exposure **OR** • Cystic Fibrosis **OR** • Pneumonic plague **OR** tularemia AND history of doxycycline in the past 3 months **OR** • 7 days of therapy with a preferred agent from 2 of the classes below in the past 3 months ○ Penicillin, 2nd or 3rd generation cephalosporin, or macrolide **Levaquin solution for age < 12 years** • Anthrax infection or exposure **OR**

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			• 7 days of therapy with a preferred agent from 2 of the classes below in the past 3 months ○ Penicillin, 2nd or 3rd generation cephalosporin, or macrolide **AND** • Cipro suspension in the past 3 months
GAUCHER'S DISEASE			
	ELELYSO (taliglucerase alfa) ZAVESCA (miglustat)	CERDELGA (eliglustat) CEREZYME (imiglucerase) miglustat VPRIV (velaglucerase alfa)	
GENITAL WARTS & ACTINIC KERATOSIS AGENTS			
	CONDYLOX (podofilox) Age Edit imiquimod Age Edit podofilox Age Edit	ALDARA (imiquimod) Age Edit CARAC (fluorouracil) diclofenac 3% gel EFUDEX (fluorouracil) fluorouracil 0.5% cream fluorouracil 5% cream PICATO (ingenol) Age Edit SOLARAZE (diclofenac) TOLAK (fluorouracil) VEREGEN (sinecatechins) Age Edit ZYCLARA (imiquimod) Age Edit	**Minimum Age Limit** • **12 years –** Aldara, Zyclara • **18 years –** Condylox, Picato, Veregen
GLUCOCORTICOIDS (Inhaled) DUR+			
	GLUCOCORTICOIDS		

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

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MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

(For All Medicaid, MSCAN and CHIP Beneficiaries)

EFFECTIVE 7/1/2024
Version 2024_9
Updated: 5/31/2024

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	PROTON PUMP INHIBITORS		**Prilosec suspension** • Automatic approval for 0 - 2 years
	esomeprazole magnesium DR Capsule NEXIUM PACKET (esomeprazole) omeprazole Rx pantoprazole	ACIPHEX Tablet (rabeprazole) DEXILANT (dexlansoprazole) esomeprazole strontium DR Capsule KONVOMEP SUSPENSION (omeprazole/sodium bicarbonate) lansoprazole Rx NEXIUM Rx DR Capsule (esomeprazole) omeprazole sod. bicarb. PREVACID Rx (lansoprazole) PREVACID SOLU-TAB (lansoprazole) PRILOSEC RX (omeprazole) PRILOSEC SUSPENSION (omeprazole) PROTONIX DR (pantoprazole) PROTONIX PACKET (pantoprazole) rabeprazole	
	OTHER		
	misoprostol sucralfate suspension sucralfate tablet	CARAFATE SUSPENSION (sucralfate) CARAFATE TABLET (sucralfate) CYTOTEC (misoprostol) DARTISLA ODT (glycopyrrolate) VOQUEZNA (vonoprazan)	
GROWTH HORMONE DUR+			
	GENOTROPIN (somatropin) NORDITROPIN (somatropin) NUTROPIN AQ (somatropin)	HUMATROPE (somatropin) NGENLA (somatrogon-ghla) OMNITROPE (somatropin) SAIZEN (somatropin) SEROSTIM (somatropin)	**Minimum Age Limit** • 3 years – Ngenia **Maximum Age Limit** • 18 years - Ngenia

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		SKYTROFA (lonapegsomatropin) SOGROYA (somapacitan) VOXZOGO (vosoritide) ZOMACTON (somatropin) ZORBTIVE (somatropin)	**All Agents for Age ≥ 18 years** • Documented diagnosis of craniopharyngioma, panhypopituitarism, Prader-Willi Syndrome, Turner Syndrome or an approvable adult diagnosis **OR** • Documented procedure of cranial irradiation **All Agents for Age < 18 years** • Documented diagnosis of idiopathic short stature **AND** • Documented approvable pediatric diagnosis **OR** • Documented approvable pediatric diagnosis **Non-Preferred Criteria** • Documented approvable diagnosis for age **AND** • Have tried 1 preferred agent in the past 6 months **OR** • 84 consecutive days on the requested agent in the past 105 days
***H. PYLORI* COMBINATION TREATMENTS**			
	PYLERA (bismuth subcitrate potassium, metronidazole, tetracycline)	bismuth subcitrate potassium, metronidazole, tetracycline lansoprazole, amoxicillin, clarithromycin	**Quantity Limit** • 1 treatment course/year

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		OMECLAMOX (omeprazole, clarithromycin, amoxicillin) PREVPAC (lansoprazole, amoxicillin, clarithromycin) TALICIA (omeprazole, amoxicillin, rifabutin) VOQUEZNA DUAL PAK (vonoprazan, amoxicillin) VOQUEZNA TRIPLE PAK (vonoprazan, amoxicillin, clarithromycin)	
HEPATITIS B TREATMENTS			
	entecavir EPIVIR HBV SOLUTION (lamivudine) lamivudine HBV tenofovir disoproxil fumarate	adefovir dipivoxil BARACLUDE (entecavir) EPIVIR HBV TABLET (lamivudine) HEPSERA (adefovir dipivoxil) TYZEKA (telbivudine) VEMLIDY (tenofovir alafenamide fumarate) VIREAD (tenofovir disoproxil fumarate)	
HEPATITIS C TREATMENTS			
	MAVYRET (glecaprevir/pibrentasvir) ∞ MAVYRET PELLETS (glecaprevir/pibrentasvir)∞ PEGASYS (peginterferon alfa-2a) PEG-INTRON (peginterferon alfa-2b) ribavirin tablets sofosbuvir/velpatasvir∞	COPEGUS (ribavirin) EPCLUSA (sofosbuvir/velpatasvir) ∞ HARVONI (ledipasvir/sofosbuvir) ∞ ledipasvir/sofosbuvir∞ MODERIBA (ribavirin) OLYSIO (simeprevir) REBETOL (ribavirin)	∞ **Epclusa, Harvoni, Mavyret, Sovaldi, Vosevi, Zepatier** • Require clinical review Note: Epclusa, Harvoni, Mavyret and Sovaldi have FDA pediatric indications

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		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) ∞	MANUAL PA
HEREDITARY ANGIOEDEMA			
		BERINERT (C1 esterase inhibitor) CINRYZE VIAL (C1 esterase inhibitor) FIRAZYR SYRINGE (icatibant acetate) HAEGARDA (C1 esterase inhibitor) icatibant KALBITOR VIAL (ecallantide) ORLADEYO (berotralstat hydrochloride) RUCONEST VIAL (C1 esterase inhibitor, recombinant) TAKHZYRO (lanadelumab-flyo)	
HYPERURICEMIA & GOUT DUR+			
	allopurinol colchicine tablet probenecid probenecid/colchicine	colchicine capsule COLCRYS (colchicine) febuxostat GLOPERBA (colchicine) MITIGARE (colchicine) ULORIC (febuxostat) ZYLOPRIM (allopurinol)	Non-Preferred Criteria • Have tried 2 different preferred agents in the past 6 months

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
HYPOGLYCEMIA TREATMENT, GLUCAGON			
	BAQSIMI (glucagon) Step Edit glucagen vial glucagon labeler 00002 ZEGALOGUE (dasiglucagon) Step Edit	glucagon kit (labelers 63323, 00548) GVOKE (glucagon)	**Minimum Age Limit** • **2 years** – Gvoke • **4 years** – Baqsimi • **6 years** – Zegalogue **Quantity Limit** • **2 packs/31 days** – Baqsimi • **2 kits/31 days** – Glucagon • **0.2 ml/31 days** – Gvoke 0.1 syringe • **0.4 ml/31 days** – Gvoke 0.2 syringe • **1.2 ml/31 days** - Zegalogue **Gvoke** • Have 1 claim with Baqsimi or Zegalogue in the past 30 days **Non-Preferred Glucagon** • Have tried 1 different preferred glucagon in the past 30 days
HYPOGLYCEMICS, BIGUANIDES			
	metformin HCL tablet metformin HCL ER 24HR tablet (generic Glucophage XR)	FORTAMET ER GLUCOPHAGE (metformin) GLUCOPHAGE XR (metformin ER) GLUMETZA (metformin ER) metformin 24HR (generic Fortamet) metformin 24HR (generic Glumetza) RIOMET SOLUTION* (metformin)	

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
HYPOGLYCEMICS, DPP4s and COMBINATON DUR+			
	JANUMET (sitagliptin/metformin) JANUMET XR (sitagliptin/metformin) JANUVIA (sitagliptin) JENTADUETO (linagliptin/metformin) TRADJENTA (linagliptin)	alogliptin alogliptin/metformin alogliptin/pioglitazone JENTADUETO XR (linagliptin/metformin) KAZANO (alogliptin/metformin) KOMBIGLYZE XR (saxagliptin/metformin)* NESINA (alogliptin) ONGLYZA (saxagliptin) * OSENI (alogliptin/pioglitazone) sitagliptin NR ZITUVIO (sitagliptin)	Concomitant use of a GLP-1 product and a DPP-4 product requires clinical review
HYPOGLYCEMICS, INCRETIN MIMETICS/ENHANCERS DUR+			
	BYETTA (exenatide) TRULICITY (dulaglutide) VICTOZA (liraglutide)	ADLYXIN (lixisenatide) BYDUREON (exenatide) BYDUREON BCISE (exenatide) MOUNJARO (tirzepatide) OZEMPIC (semaglutide) RYBELSUS (semaglutide) SOLIQUA (insulin glargine/lixisenatide) SYMLIN (pramlintide) XULTOPHY (insulin degludec/ liraglutide)	**Minimum Age Limit** • **10 years** – Bydureon Bcise, Trulicity, Victoza • **18 years** – Byetta, Mounjaro, Ozempic, Rybelsus **Preferred Criteria** • Documented diagnosis for Type 2 Diabetes **OR** • Have history of 84 days of therapy with the requested agent in the past 105 days **Non-Preferred Criteria**

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			• Documented diagnosis for Type 2 Diabetes **AND** • Have a history of 84 days of therapy with Trulicity in the past 6 months **AND** • Have a history of 84 days of therapy with 1 of the following preferred single ingredient GLP-1 Agonists in the past 6 months: Byetta or Victoza **OR** • Documented diagnosis for Type 2 Diabetes **AND** • Have a history of 84 days of therapy with the requested agent in the past 105 days 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. Concomitant use of a GLP-1 product and a DPP-4 product requires clinical review
HYPOGLYCEMICS, INSULINS AND RELATED AGENTS DUR+			

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	HUMULIN N, R, 70/30 VIAL OTC (insulin) HUMULIN R U500 KWIKPEN HUMULIN R U500 VIAL (insulin) HUMALOG MIX 50/50 VIAL HUMALOG MIX 75/25 VIAL insulin aspart insulin aspart flexpen insulin aspart mix insulin aspart mix flexpen Insulin lispro insulin lispro jr kwikpen insulin lispro kwikpen LANTUS SOLOSTAR & VIAL (insulin glargine) LEVEMIR FLEXPEN & VIAL (insulin detemir) TOUJEO (insulin glargine) TOUJEO MAX (insulin glargine)	AFREZZA (insulin) ADMELOG (insulin lispro) APIDRA (insulin glulisine) APIDRA SOLOSTAR (insulin glulisine) BASAGLAR (insulin glargine) FIASP (insulin aspart) HUMALOG JR (insulin lispro) HUMALOG KWIKPEN U100 (insulin lispro) HUMALOG KWIKPEN U200 (insulin lispro) HUMALOG MIX KWIKPEN (insulin lispro/ lispro protamine) HUMALOG VIAL (insulin lispro) HUMULIN N, 70/30 KWIKPEN (insulin) OTC insulin glargine LYUMJEV KWIKPEN (insulin lispro) LYUMJEV VIAL (insulin lispro) NOVOLIN N, R, 70/30 FLEXPEN (insulin) OTC NOVOLIN N, R, 70/30 VIAL (insulin) OTC NOVOLOG FLEXPEN & VIAL (insulin aspart) NOVOLOG MIX FLEXPEN & VIAL (insulin aspart/ aspart protamine) REZVOGLAR (insulin glargine) SEMGLEE (insulin glargine) TRESIBA (insulin degludec)	Insulin pen formulations are not covered for Long Term Care (LTC) beneficiaries. **Non-Preferred Criteria** • Documented diagnosis of Diabetes Mellitus **AND** • Have tried 1 preferred product in the past 6 months **OR** • 1 claim with the requested agent in the past 105 days **Quantity Limit** • Insulin Quantity Limits found here
HYPOGLYCEMICS, MEGLITINIDES DUR+			
	nateglinide repaglinide	PRANDIMET (repaglinide/metformin) PRANDIN (repaglinide)	

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		repaglinide/metformin STARLIX (nateglinide)	
HYPOGLYCEMICS, SODIUM GLUCOSE COTRANSPORTER-2 INHIBITORS			DUR+
	HYPOGLYCEMICS, SODIUM GLUCOSE COTRANSPORTER-2 INHIBITORS		
	FARXIGA (dapagliflozin) INVOKANA (canagliflozin) JARDIANCE (empagliflozin)	dapagliflozin INPEFA (sotagliflozin) STEGLATRO (ertugliflozin)	
	HYPOGLYCEMICS, SODIUM GLUCOSE COTRANSPORTER-2 INHIBITOR COMBINATIONS		
	INVOKAMET (canaglifozin/metformin) SYNJARDY (empagliflozin/metformin)	dapaglifozin/metformin GLYXAMBI (empagliflozin/linagliptin) INVOKAMET XR (canaglifozin/metformin) QTERN (dapaglifozin/saxagliptin) SEGLUROMET (ertugliflozin/metformin) STEGLUJAN (ertugliflozin/sitagliptin) SYNJARDY XR (empagliflozin/metformin) TRIJARDY XR (empagliflozin/linagliptin/metformin) XIGDUO XR (dapaglifozin/metformin)	
HYPOGLYCEMICS, TZDS			
	THIAZOLIDINEDIONES		
	pioglitazone	ACTOS (pioglitazone) AVANDIA (rosiglitazone)	
	TZD COMBINATIONS		
	pioglitazone/metformin	ACTOPLUS MET (pioglitazone/metformin) ACTOPLUSMET XR (pioglitazone/metformin)	

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

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			• Clinical review required for a diagnosis of Kimura's disease or multifocal motor neuropathy **Myfortic** • Documented diagnosis of kidney transplant or psoriasis **Rapamune** • Documented diagnosis of kidney transplant **Zortress** • Documented diagnosis of kidney transplant or liver transplant
IMMUNE GLOBULINS			
	BIVIGAM CARIMUNE NF FLEBOGAMMA DIF GAMASTAN SD GAMMAGARD GAMMAGARD SD GAMUNEX-C HIZENTRA HYQVIA PANZYGA PRIVIGEN XEMBIFY	ASCENIV CABLIVI CUTAQUIG CUVITRU GAMMAKED GAMMAPLEX OCTAGAM	

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
IMMUNOLOGIC THERAPIES FOR ASTHMA			
	DUPIXENT (dupilumab)* FASENRA PEN AUTOINJECTOR (benralizumab) FASENRA SYRINGE (benralizumab) XOLAIR AUTOINJECTOR (omalizumab) XOLAIR SYRINGE (omalizumab) XOLAIR VIAL (omalizumab)	CINQAIR (reslizumab) NUCALA AUTOINJECTOR (mepolizumab)* NUCALA SYRINGE (mepolizumab)* TEZSPIRE (tezepelumab)	**All require a clinical review** **Dupixent – MANUAL PA** **Fasenra – MANUAL PA** **Xolair – MANUAL PA**
INTRANASAL RHINITIS AGENTS			
	ANTICHOLINERGICS		
	ipratropium	ATROVENT (ipratropium)	
	ANTIHISTAMINES		
	azelastine	ASTEPRO (azelastine) olopatadine PATANASE (olopatadine)	
	ANTIHISTAMINE/CORTICOSTEROID COMBINATION DUR+		
		azelastine/fluticasone DYMISTA (azelastine/fluticasone) RYALTRIS (olopatadine/mometasone) TICALAST (azelastine/fluticasone)	
	CORTICOSTEROIDS DUR+		
	fluticasone Rx Only	BECONASE AQ (beclomethasone) budesonide flunisolide mometasone NASONEX (mometasone) OMNARIS (ciclesonide) QNASL (beclomethasone)	**Non-Preferred Criteria** • Documented diagnosis for allergic rhinitis **AND** • Have tried 1 different preferred agent in the past 6 months

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		TICANASE KIT (flonase kit) triamcinolone VERAMYST (fluticasone) XHANCE (fluticasone) ZETONNA (ciclesonide)	
IRON CHELATING AGENTS			
	deferasirox all strengths (all labelers except those listed as non-preferred) FERRIPROX (deferiprone)	deferasirox (labeler 00093, 16714, 45963, 62332) EXJADE (deferasirox) JADENU (deferasirox) JADENU SPRINKLES (deferasirox)	**Jadenu – MANUAL PA**
IRRITABLE BOWEL SYNDROME/SHORT BOWEL SYNDROME AGENTS/SELECTED GI AGENTS DUR+			
	IRRITABLE BOWEL SYNDROME CONSTIPATION		
	AMITIZA (lubiprostone) LINZESS 145mcg, 290mcg (linaclotide)	IBSRELA (tenapanor) LINZESS 72mcg (linaclotide) linaclotide lubiprostone MOTEGRITY (prucalopride) MOVANTIK (naloxegol) RELISTOR (methylnaltrexone) SYMPROIC (naldemedine) TRULANCE (plecanatide) ZELNORM (tegaserod)	**Minimum Age Limit** • **1 year –** Gattex • **6 years –** Linzess 72 mcg • **18 years –** Amitiza, Ibsrela, Linzess 145 mcg & 290 mcg, Motegrity, Movantik, Mytesi, Relistor, Symproic, Trulance, Viberzi, Xermelo **Gender Limit** • **Female –** Amitiza 8 mcg **Chronic Idiopathic Constipation (CIC)**

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			AMITIZA 24 MCG, LINZESS 72 MCG, LINZESS 145 MCG, MOTEGRITY, TRULANCE **All CIC Agents** • Documented diagnosis of CIC in the past year **AND** • No history of GI or bowel obstruction **Non-Preferred CIC Agents** • Age 18 years **AND** • Documented diagnosis of CIC **AND** • No history of GI or bowel obstruction **AND** • 30 days of therapy with 2 preferred agents in the past 6 months **OR** • 1 claim with the requested agent in the past 105 days **Linzess 72 mcg** • Age 6-17 years **AND** • Documented diagnosis of CIC or pediatric functional constipation in the past year **AND** • No history of GI or bowel obstruction

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			Irritable Bowel Syndrome – Constipation Dominant (IBS-C) AMITIZA 8 MCG, IBSRELA, LINZESS 290 MCG, TRULANCE **All IBS-C Agents** • Documented diagnosis of IBS-C in the past year **AND** • No history of GI or bowel obstruction **Non-Preferred IBS-C Agents** • Above IBS-C criteria **AND** • 30 days of therapy with 2 preferred agents in the past 6 months **OR** • 1 claim with the requested agent in the past 105 days **Opioid Induced Constipation (OIC)** AMITIZA 24 MCG, MOVANTIK, RELISTOR, SYMPROIC **All OIC Agents** • Documented diagnosis of OIC in the past year **AND** • 1 claim for an opioid in the past 30 days **AND** • No history of GI or bowel obstruction **AND** • Documented diagnosis of chronic pain in the past year

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			Non- Preferred OIC Agents • Above OIC criteria **AND** • 30 days of therapy with 2 preferred agents in the past 6 months **OR** • 1 claim with the requested agent in the past 105 days **Relistor Injection** • Above OIC criteria **AND** • Documented diagnosis of active cancer in the past year **AND** • Documented diagnosis of palliative care in the past 6 months
IRRITABLE BOWEL SYNDROME DIARRHEA			
	dicyclomine hyoscyamine	alosetron BENTYL (dicyclomine) LEVSIN (hyoscyamine) LEVSIN-SL (hyoscyamine) LOTRONEX (alosetron) VIBERZI (eluxadoline)*	**Viberzi** • Documented diagnosis of Irritable Bowel Syndrome – Diarrhea Dominant (IBS-D) in the past year **AND** • 1 claim for Viberzi in the past 105 days **OR** • New starts require clinical review **Lotronex** • 1 claim for Lotronex in the past 105 days **OR** • **MANUAL PA** - All new patients require manual review

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

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
LEUKOTRIENE MODIFIERS DUR+			
	montelukast granules montelukast tablets zafirlukast	ACCOLATE (zafirlukast) SINGULAIR Tablets (montelukast) SINGULAR GRANULES (montelukast granules) zileuton ZYFLO CR (zileuton)	**Minimum Age Limit** • **12 years –** Zyflo & Zyflo CR **Non-Preferred Criteria** • Have tried 2 different preferred agents in the past 6 months
LIPOTROPICS, OTHER (NON-STATINS)			
ACL INHIBITORS AND COMBINATIONS			
		NEXLETOL (bempedoic acid) NEXLIZET (bempedoic acid/ezetimibe)	**Nexletol and Nexlizet** • Require clinical review
ANGIOPOIETIN LIKE 3 INHIBITORS			
		EVKEEZA (evinacumab-dgnb)	**Non-Preferred Criteria** Have tried 2 different preferred Non-statin Lipotropic agents in the past 6 months
BILE ACID SEQUESTRANTS			
	cholestyramine colestipol	colesevelam COLESTID (colestipol) QUESTRAN (cholestyramine) WELCHOL (colesevelam)	
OMEGA-3 FATTY ACIDS			
	omega 3 acid ethyl esters	icosapent LOVAZA (omega-3-acid ethyl esters) VASCEPA (icosapent ethyl)	

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	CHOLESTEROL ABSORPTION INHIBITORS		
	ezetimibe	ZETIA (ezetimibe)	
	FIBRIC ACID DERIVATIVES		
	fenofibrate nanocrystallized gemfibrozil	ANTARA (fenofibrate, micronized) fenofibrate 40mg tablet fenofibrate, micronized fenofibric acid FENOGLIDE (fenofibrate) FIBRICOR (fenofibric acid) LIPOFEN (fenofibrate) LOFIBRA (fenofibrate) LOPID (gemfibrozil) TRICOR (fenofibrate nanocrystallized) TRIGLIDE (fenofibrate) TRILIPIX (fenofibric acid)	**Fibric Acid Derivative Non-Preferred Criteria** • Have tried 2 different fibric acid derivatives in the past 6 months
	MTP INHIBITOR		
		JUXTAPID (lomitapide)	**Juxtapid – MANUAL PA**
	APOLIPOPROTEIN B-100 SYNTHESIS INHIBITOR		
		KYNAMRO (mipomersen)	**Kynamro – MANUAL PA**
	NIACIN		
	niacin ER NIACOR (niacin)	NIASPAN (niacin)	
	PCSK-9 INHIBITOR		

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	PRALUENT (alirocumab) REPATHA (evolocumab)	LEQVIO (inclisiran)	**Leqvio** • Requires clinical review **Praluent - MANUAL PA** **Repatha - MANUAL PA**
LIPOTROPICS, STATINS DUR+			
	STATINS		
	atorvastatin lovastatin pravastatin rosuvastatin simvastatin	ALTOPREV (lovastatin) ATORVALIQ SUSPENSION (atorvastatin) CRESTOR (rosuvastatin) EZALLOR SPRINKLE (rosuvastatin) FLOLIPID (simvastatin) fluvastatin ER fluvastatin LESCOL (fluvastatin) LESCOL XL (fluvastatin) LIPITOR (atorvastatin) LIVALO (pitavastatin) MEVACOR (lovastatin) pitavastatin NR PRAVACHOL (pravastatin) ZOCOR (simvastatin) ZYPITAMAG (pitavastatin)	**Minimum Age Limit** • **10 years –** Atorvaliq suspension **Non-Preferred Criteria** • Have tried 2 different preferred statin or statin combination agents in the past 6 months **OR** • 90 consecutive days on the requested agent in the past 105 days **Simvastatin 80mg** • Daily doses of 80mg and greater require clinical review
	STATIN COMBINATIONS		
	ezetimibe/simvastatin SIMCOR (simvastatin/niacin)	ADVICOR (lovastatin/niacin) atorvastatin/amlodipine CADUET (atorvastatin/amlodipine)	**Non-Preferred Criteria** • Have tried 2 different preferred statin or statin combination agents in the past 6 months **OR**

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		LIPTRUZET (atorvastatin/ezetimibe) VYTORIN (simvastatin/ezetimibe)	• 90 consecutive days on the requested agent in the past 105 days
MISCELLANEOUS BRAND/GENERIC			
	EPINEPHRINE		
	epinephrine autoinject pens (labeler 49502) SYMJEPI (epinephrine)	ADRENACLICK (epinephrine) AUVI-Q (epinephrine) EPINEPHRINE SNAP EMS KIT (epinephrine) EPIPEN (epinephrine) EPIPEN JR (epinephrine)	**Quantity Limit** • **2 kits/31 days**
	MISCELLANEOUS		
	alprazolam carglumic acid hydroxyzine hcl syrup hydroxyzine hcl tablets hydroxyzine pamoate megestrol suspension 625mg/5mL REVLIMID (lenalidomide)	alprazolam ER CAMZYOS (mavacamten) CARBAGLU (carglumic acid) EVRYSDI (risdiplam) INPEFA (sotagliflozin)^{NR} KORLYM (mifepristone) lenalidomide MEGACE ES (megestrol) VERQUVO (vericiguat) VISTARIL (hydroxyzine pamoate)	**Alprazolam ER CUMULATIVE quantity limit** • **31 tablets/31 days** **Evrysdi** – **MANUAL PA**
	ALLERGEN EXTRACT IMMUNOTHERAPY		
		GRASTEK ORALAIR PALFORZIA RAGWITEK	
	SUBLINGUAL NITROGLYCERIN		

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	nitroglycerin lingual 12gm nitroglycerin sublingual NITROLINGUAL PUMPSPRAY (nitroglycerin) 12gm NITROSTAT SUBLINGUAL (nitroglycerin)	nitroglycerin lingual 4.9gm NITROLINGUAL (nitroglycerin) 4.9gm NITROMIST (nitroglycerin)	
MOVEMENT DISORDER AGENTS DUR+			
	AUSTEDO (deutetrabenazine) AUSTEDO XR (deutetrabenazine) INGREZZA (valbenazine) tetrabenazine (all labelers except those listed as non-preferred)	INGREZZA SPRINKLE (valbenazine)NR tetrabenazine (labeler 47335, 51224, 60505, 68180, 686820 XENAZINE (tetrabenazine)	**Austedo and Austedo XR** • Documented diagnosis of Huntington's chorea **OR** • Documented diagnosis of tardive dyskinesia **AND** • 90 days therapy with Austedo or Austedo XR in the past 105 days **OR** • MANUAL PA **Ingrezza capsules** • Documented diagnosis of Huntington's chorea **OR** • Documented diagnosis of tardive dyskinesia **AND** • 90 days therapy with Ingrezza in the past 105 days **OR** • MANUAL PA **Ingrezza Sprinkle capsules** • Require clinical review
MULTIPLE SCLEROSIS AGENTS DUR+			

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	AVONEX (interferon beta-1a) AVONEX PEN (interferon beta-1a) BETASERON (interferon beta-1b) COPAXONE 20mg (glatiramer) dalfampridine dimethyl fumarate fingolimod GILENYA (fingolimod) REBIF (interferon beta-1a) REBIF REBIDOSE (interferon beta-1a) teriflunomide TYSABRI (natalizumab)	AMPYRA (dalfampridine) AUBAGIO (teriflunomide) BAFIERTAM (monomethyl fumarate) BRIUMVI (ublituximab) COPAXONE 40mg (glatiramer) EXTAVIA (interferon beta-1b) glatiramer GLATOPA (glatiramer) KESIMPTA (ofatumumab) MAVENCLAD (cladribine) MAYZENT (siponimod) OCREVUS (ocrelizumab) PLEGRIDY (interferon beta-1a) PONVORY (ponesimod) TASCENSO ODT (fingolimod) TECFIDERA (dimethyl fumarate) VUMERITY (diroximel fumarate) ZEPOSIA (ozanimod)	**All Agents** • Documented diagnosis of multiple sclerosis **Non-Preferred Criteria** • Have tried 2 different preferred agents in the past 6 months **OR** • 3 claims with the requested agent in the last 105 days **Kesimpta, Ponvory, Tascenso ODT, and Zeposia** • Require clinical review **Mavenclad – MANUAL PA** **Mayzent – MANUAL PA** **Ocrevus – MANUAL PA**
MUSCULAR DYSTROPHY AGENTS			
	EMFLAZA (deflazacort)	AGAMREE (vamorolone) AMONDYS 45 (casimersen) deflazacort ELEVIDYS (delandistrogene moxeparvovec-rokl) EXONDYS 51 (eteplirsen) VILTEPSO (viltolarsen) VYONDYS 53 (golodirsen)	**Emflaza – Clinical Review** **Exondys – MANUAL PA** **Viltepso – MANUAL PA** **Vyondys – MANUAL PA**
NSAIDS DUR+			

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	NON-SELECTIVE		
	diclofenac EC diclofenac IR diclofenac SR etodolac IR tab flurbiprofen ibuprofen ibuprofen suspension[OTC] indomethacin ketoprofen ketorolac nabumetone naproxen 250mg and 500mg naproxen suspension piroxicam sulindac	ADVIL (ibuprofen) ANAPROX (naproxen) CAMBIA (diclofenac potassium) CATAFLAM (diclofenac) DAYPRO (oxaprozin) diclofenac potassium etodolac cap etodolac tab SR FELDENE (piroxicam) FENORTHO (fenoprofen) fenoprofen INDOCIN capsules, suspension & suppositories (indomethacin) indomethacin cap ER indomethacin suspension ketoprofen ER KIPROFEN (ketoprofen) LOFENA(diclofenac potassium) meclofenamate mefenamic acid NALFON (fenoprofen) NAPRELAN (naproxen) NAPROSYN (naproxen) naproxen 275mg and 550mg NUPRIN (ibuprofen) oxaprozin PONSTEL (mefenamic acid) PROFENO (fenoprofen)	**Quantity Limit** • 20 tablets/31 days – ketorolac tablets **Non-Preferred Criteria** • Have tried 2 different preferred non-selective or NSAID/GI protectant combination agents in the past 6 months

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		RELAFEN DS (nabumetone) SPRIX NASAL SPRAY (ketorolac) TIVORBEX (indomethacin) tolmetin VOLTAREN XR (diclofenac) ZIPSOR (diclofenac) ZORVOLEX (diclofenac)	
NSAID/GI PROTECTANT COMBINATIONS			
		ARTHROTEC (diclofenac/misoprostol) diclofenac/misoprostol DUEXIS (ibuprofen/famotidine) VIMOVO (naproxen/esomeprazole)	**Non-Preferred Criteria** • Have tried 2 different preferred non-selective or NSAID/GI protectant combination agents in the past 6 months
COX II SELECTIVE			
	meloxicam	CELEBREX (celecoxib) celecoxib ELYXYB (celecoxib) MOBIC (meloxicam) NULOX (meloxicam) QMIIZ ODT (meloxicam) VIVLODEX (meloxicam)	**Non-Preferred Criteria – COX II** • Documented diagnosis of Osteoarthritis, Rheumatoid Arthritis, Familial Adenomatous Polyposis, or Ankylosing Spondylitis **AND** • 90 consecutive days on the requested agent in the past 105 days **OR** • Have tried 1 preferred COX-II Selective and 1 preferred Non-Selective Agent **OR** • Have tried 1 preferred COX-II Selective agent and a documented diagnosis of GI Bleed, GERD, PUD,

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			GI Perforation, or Coagulation Disorder **Elyxyb** • Requires clinical review
OPHTHALMIC ANTIBIOTICS			
	bacitracin/neomycin/gramicidin bacitracin/polymyxin ciprofloxacin erythromycin GENTAK Ointment (gentamicin) gentamicin ILOTYCIN (erythromycin) moxifloxacin ofloxacin polymyxin/trimethoprim tobramycin	AZASITE (azithromycin) bacitracin BESIVANCE (besifloxacin) BLEPH-10 (sulfacetamide) CILOXAN Ointment (ciprofloxacin) CILOXAN Solution (ciprofloxacin) GARAMYCIN (gentamicin) gatifloxacin levofloxacin MOXEZA (moxifloxacin) NATACYN (natamycin) neomycin/bacitracin/polymyxin b NEO-POLYCIN (neomy/baci/polymyxin b) NEOSPORIN (bacitracin/neomycin/gramicidin) (oxy-tcn/polymyx sul) OCUFLOX (ofloxacin) POLYTRIM (polymyxin/trimethoprim) sulfacetamide TOBREX drops (tobramycin) TOBREX ointment (tobramycin) VIGAMOX (moxifloxacin)	

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		ZYMAR (gatifloxacin) ZYMAXID (gatifloxacin)	
	ANTIBIOTIC STEROID COMBINATIONS		
	BLEPHAMIDE (sulfacetamide/prednisolone) drops, oint neomycin/bacitracin/polymyxin/hc ointment neomycin/polymyxin/dexamethasone PRED-G (gentamicin/prednisolone) drops, oint sulfacetamide/prednisolone tobramycin/dexamethasone suspension TOBRADEX OINTMENT (tobramycin/dexamethasone) ZYLET (loteprednol/tobramycin)	gatifloxacin/prednisolone MAXITROL (neomycin/polymyxin/dexamethasone) neomycin/polymyxin/gramicidin neomycin/polymyxin/hydrocortisone TOBRADEX ST SUSPENSION (tobramycin/dexamethasone) TOBRADEX SUSPENSION (tobramycin/dexamethasone)	
OPHTHALMIC ANTI-INFLAMMATORIES DUR+			
	dexamethasone diclofenac difluprednate FLAREX (fluorometholone) fluorometholone flurbiprofen FML FORTE (fluorometholone) FML SOP (fluorometholone) ketorolac MAXIDEX (dexamethasone) prednisolone acetate prednisolone NA phosphate	ACULAR (ketorolac) ACULAR LS (ketorolac) ACUVAIL (ketorolac) BROMDAY (bromfenac) bromfenac BROMSITE (bromfenac) DUREZOL (difluprednate) FML (fluorometholone) ILEVRO (nepafenac) INVELTYS (loteprednol etabonate) LOTEMAX (loteprednol) LOTEMAX SM (loteprednol)	**Non-Preferred Criteria** • Have tried 2 different preferred agents in the past 6 months

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	PRED MILD (prednisolone) VEXOL (rimexolone)	loteprednol etabonate OCUFEN (flurbiprofen) OMNIPRED (prednisolone) NEVANAC (nepafenac) PRED FORTE (prednisolone) PROLENSA (bromfenac) VOLTAREN (diclofenac)	
OPHTHALMICS FOR ALLERGIC CONJUNCTIVITIS DUR+			
	ALREX (loteprednol) azelastine cromolyn ketotifen OTC olopatadine 0.1% olopatadine 0.2% ZADITOR (ketotifen) OTC	ALOCRIL (nedocromil) ALOMIDE (lodoxamide) BEPREVE (bepotastine) epinastine LASTACAFT (alcaftadine) PATADAY (olopatadine) PATANOL (olopatadine) PAZEO (olopatadine) VERKAZIA (cyclosporine) ZERVIATE (cetirizine)	**Non-Preferred Criteria** • Have tried 2 different preferred agents in the past 6 months **Verkazia** • Requires clinical review
OPHTHALMIC, DRY EYE AGENTS			
	RESTASIS droperette (cyclosporine)	CEQUA (cyclosporine 0.09%) EYSUVIS (loteprednol etabonate) MIEBO (perfluorohexyloctane) RESTASIS Multidose (cyclosporine) TYRVAYA (varaenicline) Nasal VEYVE (cyclosporine ophthalmic solution) XIIDRA (lifitegrast) Dur +	**Minimum Age Limit** • **16 years –** Restasis • **17 years –** Xiidra • **18 years –** Cequa, Miebo, Vevye **Quantity Limit** • **2 ml/31 days** – Vevye • **3 ml/31 days** – Miebo

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			• **5.5 mL/31 days** – Restasis Multidose • **60 units/31 days** – Cequa, Restasis droperette, Xiidra **Eysuvis, Miebo, Tyrvaya and Vevye** • Require clinical review **Non-Preferred Criteria** • History of 4 claims for Restasis in the past 6 months
OPHTHALMIC, GLAUCOMA AGENTS DUR+			
	BETA BLOCKERS		
	BETIMOL (timolol) carteolol ISTALOL (timolol) levobunolol metipranolol 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)	**Minimum Age Limit** • **18 years –** Iyuzeh **Non-Preferred Criteria** • Have tried 2 different preferred agents in the past 6 months **OR** • 90 consecutive days on the requested agent in the past 105 days

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	CARBONIC ANHYDRASE INHIBITORS		
	dorzolamide	AZOPT (brinzolamide) TRUSOPT (dorzolamide)	
	COMBINATION AGENTS		
	COMBIGAN (brimonidine/timolol) dorzolamide/timolol SIMBRINZA (brinzolamide/brimonidine)	COSOPT (dorzolamide/timolol) COSOPT PF (dorzolamide/timolol)	
	PARASYMPATHOMIMETICS		
	pilocarpine	CARBOPTIC (carbachol) ISOPTO CARBACHOL (carbachol) ISOPTO CARPINE (pilocarpine) PHOSPHOLINE IODIDE (echothiophate iodide) PILOPINE HS (pilocarpine)	
	PROSTAGLANDIN ANALOGS		
	latanoprost	bimatoprost IYUZEH (latanoprost) LUMIGAN (bimatoprost) TRAVATAN Z (travoprost) travoprost VYZULTA (latananoprostene bunod) XALATAN (latanoprost) XELPROS (lantanoprost) ZIOPTAN (tafluprost)	
	RHO KINASE INHIBITORS/COMBINATIONS		
	RHOPRESSA (netarsudil) ROCKLATAN (netarsudil/latanoprost)		

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	SYMPATHOMIMETICS		
	ALPHAGAN P 0.1% (brimonidine) ALPHAGAN P 0.15% (brimonidine) brimonidine 0.2%	brimonidine 0.15% brimonidine 0.1% dipivefrin PROPINE (dipivefrin)	
OPIATE DEPENDENCE TREATMENTS			
	DEPENDENCE		
	buprenorphine/naloxone tablets naltrexone tablets SUBOXONE FILM(buprenorphine/naloxone) DUR+	BRIXADI (buprenorphine) buprenorphine tablets buprenorphine/naloxone films LUCEMYRA (lofexidine) PROBUPHINE (buprenorphine) SUBLOCADE (buprenorphine) VIVITROL (naltrexone) ZUBSOLV (buprenorphine/naloxone)	Buprenorphine/naloxone provider summary found here **Probuphine – MANUAL PA** **Sublocade – MANUAL PA** **Vivitrol – MANUAL PA**
	TREATMENT		
	KLOXXADO (naloxone) naloxone injection NARCAN NASAL SPRAY (naloxone) OPVEE (nalmefene) ZIMHI (naloxone)	EVZIO (naloxone) REXTOVY NASAL SPRAY (naloxone) NR	
OTIC ANTIBIOTICS			
	CIPRODEX (ciprofloxacin/dexamethasone) CIPRO HC (ciprofloxacin/hydrocortisone) Age Edit CORTISPORIN-TC (colistin/neomycin/hydrocortisone) neomycin/polymyxin/hydrocortisone	ciprofloxacin ciprofloxacin/dexamethasone ciprofloxacin/fluocinolone DERMOTIC (fluocinolone) FLAC OIL DROP (fluocinolone oil)	**Maximum Age Limit** • **9 years –** Cipro HC **Ciprofloxacin/Dexamethasone Suspension Criteria:**

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	ofloxacin	hydrocortisone/acetic acid drop fluocinolone oil OTIPRIO (ciprofloxacin) OTOVEL (ciprofloxacin/fluocinolone)	• Age 6 months or older **AND** • Experiencing otorrhea secondary to recent post tympanostomy tube placement **AND** • Have tried 10 day otic treatment with ofloxacin or ciprofloxacin ophthalmic solution with continued otorrhea.
PANCREATIC ENZYMES DUR+			
	CREON (pancreatin) ZENPEP (pancrelipase)	PANCREAZE (pancrelipase) PERTZYE (pancrelipase) VIOKACE (pancrelipase)	**Non-Preferred Criteria** • Have tried 2 different preferred agents in the past 6 months
PARATHYROID AGENTS			
	calcitriol ergocalciferol paricalcitol ROCALTROL (calcitriol) ZEMPLAR (paricalcitol)	cinacalcet doxercalciferol DRISDOL (ergocalciferol) HECTOROL (doxercalciferol) NATPARA (parathyroid hormone) RAYALDEE (calcifediol) SENSIPAR (cinacalcet)	
PHOSPHATE BINDERS			
	calcium acetate ELIPHOS (calcium acetate) PHOSLYRA (calcium acetate)	AURYXIA (ferric citrate) FOSRENOL (lanthanum) lanthanum	

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	sevelamer carbonate tablets	PHOSLO (calcium acetate) RENAGEL (sevelamer HCl) RENVELA (sevelamer carbonate) sevelamer carbonate powder packets sevelamer HCl VELPHORO (sucroferric oxyhydronxide) XPHOZAH (tenapanor)	
PLATELET AGGREGATION INHIBITORS DUR+			
	BRILINTA (ticagrelor) cilostazol clopidogrel dipyridamole dipyridamole/aspirin pentoxifylline prasugrel	DURLAZA ER (aspirin) EFFIENT (prasugrel) omeprazole/asprin PERSANTINE (dipyridamole) PLAVIX (clopidogrel) PLETAL (cilostazol) ticlopidine YOSPRALA (aspirin/omeprazole) ZONTIVITY (vorapaxar)	**Zontivity – MANUAL PA** **Non-Preferred Criteria** • Documented diagnosis **AND** • Have tried 2 different preferred agents in the past 6 months **OR** • 90 consecutive days on the requested agent in the past 105 days
PLATELET STIMULATING AGENTS			
	NPLATE (romiplostim) PROMACTA (eltrombopag olamine)	ALVAIZ (eltrombopag) DOPTELET (avatrombopag maleate) MULPLETA (lusutrombopag) PROMACTA powder pack (eltrombopag olamine) TAVALISSE (fostamatinib disodium)	
POTASSIUM REMOVING AGENTS			
	LOKELMA (sodium zirconium cyclosilicate)	sodium polystyrene sulfonate SPS ENEMA (sodium polystyrene sulfonate) SPS SUSPENSION (sodium polystyrene sulfonate)	**Lokelma** • Requires clinical review

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		VELTASSA (patiromer calcium sorbitex)	
PRENATAL VITAMINS			
	COMPLETE NATAL DHA COMPLETENATE CHEW Tablet M-NATAL PLUS Tablet NESTABS DHA COMBO PKG NIVA PLUS Tablet PNV 29-1 Tablet PNV 95/Fe/FA Tablet (labeler 00536) PNV 137/Fe/FA Tablet (labeler 009040) PNV-DHA Softgel Capsule PRENATAL VITAMIN PLUS LOW IRON Tablet PRENATAL PLUS IRON/FA PREPLUS Ca/Fe27/FA 1 Tablet PRETAB Tablet SE-NATAL19 CHEW Tablet SE-NATAL19 Tablet THRIVITE RX Tablet TRINATAL Rx 1 Tablet VIRT C DHA Capsule VIRT-NATE DHA Softgel Capsule VP-PNV-DHA Softgel Capsule WESTAB PLUS Tablet	Products not listed are assumed to be Non-Preferred.	
PSEUDOBULBAR AFFECT AGENTS DUR+			
		NUEDEXTA (dextromethorphan/quinidine)	**Non-Preferred Criteria** • 90 consecutive days on the requested agent in the past 105 days **OR** • Documented diagnosis of Pseudobulbar Affect

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PULMONARY ANTIHYPERTENSIVES DUR+			
	ENDOTHELIN RECEPTOR ANTAGONIST		
	ambrisentan (all labelers except those listed as non-preferred) bosentan tablets	ambrisentan (labeler 42794, 47335, 498840) LETAIRIS (ambrisentan)* OPSUMIT (macitentan) OPSYNVI (macitentan/tadalafil) NR TRACLEER (bosentan) TRYVIO (aprocitentan) NR WINREVAIR (sotatercept-csrk) NR	**Minimum Age Limit** • **18 years –** Opsynvi **All PAH Agents** • Documented diagnosis of pulmonary hypertension **Non-Preferred Criteria** • Have tried 1 preferred PAH agent in the past 6 months **OR** • 90 consecutive days on the requested agent in the past 105 days **Opsynvi** • Requires clinical review
	PDE5's		
	sildenafil (generic Revatio) tablet tadalafil	ADCIRCA (tadalafil) LIQREV (sildenafil) suspension REVATIO (sildenafil) tablet REVATIO (sildenafil) suspension sildenafil (generic Revatio) suspension TADLIQ (tadalafil) suspension	**Non-Preferred Criteria** • Have tried 1 preferred PAH agent in the past 6 months **OR** • 90 consecutive days on the requested agent in the past 105 days **Revatio suspension** • < 12 years of age **AND**

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			• Documented diagnosis of Pulmonary Hypertension, Patent Ductus Arteriosus, or Persistent Fetal Circulation or history of heart transplant **OR** • 90 consecutive days on the requested agent in the past 105 days **Revatio tablets** • **< 1 year** of age **AND** • Documented diagnosis of Pulmonary Hypertension, Patent Ductus Arteriosus, or Persistent Fetal Circulation **OR** • 90 consecutive days on the requested agent in the past 105 days **OR** • **> 1 years** of age **AND** • Documented diagnosis of Pulmonary Hypertension **Liqrev and Tadliq** • Require clinical review
	PROSTACYCLINS		
		ORENITRAM ER (treprostinil) TYVASO (treprostinil) VENTAVIS (iloprost)	**Non-Preferred Criteria** • Have tried 1 preferred PAH agent in the past 6 months **OR**

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			• 90 consecutive days on the requested agent in the past 105 days
	SELECTIVE PROSTACYCLIN RECEPTOR AGONISTS		
		UPTRAVI (selexipag)	**Non-Preferred Criteria** • Have tried 1 preferred PAH agent in the past 6 months **OR** 90 consecutive days on the requested agent in the past 105 days
	SOLUABLE GUANYLATE CYCLASE STIMULATORS		
		ADEMPAS (riociguat)	**Adempas** • Documented WHO Group 1 diagnosis of secondary pulmonary arterial hypertension **OR** • Documented WHO Group 4 diagnosis of pulmonary hypertension due to chronic thrombotic embolic disease **OR** • Documented diagnosis of pulmonary hypertension **AND** • Have tried 1 preferred PAH agent in the past 6 months **OR** • 90 consecutive days on the requested agent in the past 105 days
ROSACEA TREATMENTS			
	metronidazole (cream, gel, lotion)	AVAR (sulfacetamide sodium/sulfur) FINACEA (azelaic acid) FINACEA FOAM (azelaic acid)	Topical Sulfonamides used for Rosacea will require a manual PA for

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		METROCREAM (metronidazole cream) METROGEL (metronidazole gel) METROLOTION (metronidazole lotion) MIRVASO (brimonidine) NORITATE (metronidazole) OVACE (sulfacetamide sodium) RHOFADE (oxymetazoline HCl) ROSULA (sodium sulfacetamide/sulfur) sodium sulfacetamide/sulfur (cleanser, pads, suspension) SOOLANTRA (ivermectin) SUMADAN (sodium sulfacetamide/sulfur wash) SUMAXIN (sodium sulfacetamide/sulfur pads) SUMAXIN TS (sodium sulfacetamide/sulfur suspension) ZILXI AEROSOL (minocycline)	≥21 years. Other labeled indications are limited to <21 years.
SEDATIVE HYPNOTICS			
BENZODIAZEPINES DUR+			
	estazolam flurazepam temazepam (15mg and 30mg)	DALMANE (flurazepam) DORAL (quazepam) HALCION (triazolam) quazepam RESTORIL (temazepam) temazepam (7.5mg and 22.5mg) triazolam	Single source benzodiazepines and barbiturates are NOT covered – NO PA's will be issued for these drugs. **MS DOM Opioid Initiative** • Concomitant use of Opioids and Benzodiazepines Criteria details found here **Quantity Limit – CUMULATIVE**

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			Quantity limit per rolling days for all strengths. *DUR+ will allow an early refill override for one dose or therapy change per year.* • **31 units/31 days -** all strengths **Triazolam – CUMULATIVE** Quantity limit per rolling days for all strengths • **10 units/31 days** • **60 units/365 days**
	OTHERS	**DUR+**	
	zaleplon zolpidem	AMBIEN (zolpidem) AMBIEN CR (zolpidem) BELSOMRA (sovorexant) DAYVIGO (lemborexant) doxepin 3mg, 6mg EDLUAR (zolpidem) eszopiclone HETLIOZ (tasimelteon) INTERMEZZO (zolpidem) LUNESTA (eszopiclone) ramelteon ROZEREM (ramelteon) QUVIVIQ (daridorexant) SILENOR (doxepin) SONATA (zaleplon)	**Maximum Age Limit** • **64 years** – zolpidem 7.5 mg, zolpidem 10 mg, zolpidem 12.5 mg **Quantity Limit – CUMULATIVE** Quantity limit per rolling days for all strengths. • **31 units/31 days** *DUR+ will allow an early refill override for one dose or therapy change per year.* • **1 canister/31 days (male)** – Zolpimist • **1 canister/62 days (female)** – Zolpimist • **1 bottle/31 days (48 ml or 158 ml)** – Hetlioz liquid

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		zolpidem ER zolpidem SL ZOLPIMIST (zolpidem)	**Gender and Dose Limit for zolpidem** • **Female** – Ambien 5 mg, Ambien CR 6.25 mg, Intermezzo 1.75 mg • **Male** – all zolpidem strengths **Non-Preferred Criteria** • Have tried 2 different preferred agents in the past 6 months **Hetlioz capsules** • Documented diagnosis of circadian rhythm sleep disorder **AND** • Documented diagnosis indicating total blindness of the patient **OR** • Documented diagnosis of Magenis-Smith syndrome **Hetlioz liquid** • 3 – 15 years of age **AND** • Documented diagnosis of Smith-Magenis
SELECT CONTRACEPTIVE PRODUCTS			
	INJECTABLE CONTRACEPTIVES		
	medroxyprogesterone acetate IM	DEPO-PROVERA IM (medroxyprogesterone acetate) DEPO-SUBQ PROVERA 104 (medroxyprogesterone acetate)	**Non-Preferred Criteria** • 1 claim with the requested agent in the past 105 days

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	INTRAVAGINAL CONTRACEPTIVES		
	ANNOVERA (segesterone/ethinyl estradiol) etonogestrel/ethinyl estradiol NUVARING (etonogestrel/ethinyl estradiol)	PHEXXI (lactic acid, citric acid, potassium bitartrate)	
	ORAL CONTRACEPTIVES DUR+		
	ALL CONTRACEPTIVES ARE PREFERRED EXCEPT FOR THOSE SPECIFICALLY INDICATED AS NON-PREFERRED	AMETHIA (levonorgestrel/ethinyl estradiol) AMETHYST (levonorgestrel/ethinyl estradiol) BALCOLTRA (levonorgestrel/ethinyl estradiol/iron) BEYAZ (ethinyl estradiol / drospirenone/levomefolate) CAMRESE (levonorgestrel/ethinyl estradiol) CAMRESE LO (levonorgestrel/ethinyl estradiol) GENERESS FE (norethindrone/ethinyl estradiol/fe) GIANVI (ethinyl estradiol/drospirenone) JOLESSA (levonorgestrel/ethinyl estradiol) levonorgestrel/ethinyl estradiol 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)	

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		NEXTSTELLIS (drospirenone/estetrol) OCELLA (ethinyl estradiol/drospirenone) SAFYRAL (ethinyl estradiol/ drospirenone/levomefolate) SIMPESSE (levonorgestrel/ethinyl estradiol) TAYTULLA (norethindrone/ethinyl estradiol/iron) TYDEMY (ethinyl estradiol/drospirenone/ levomefolate calcium) YASMIN (ethinyl estradiol/drospirenone) YAZ (ethinyl estradiol/drospirenone)	
	TRANSDERMAL CONTRACEPTIVES		
	XULANE (norelgestromin and ethinyl estradiol)	ZAFEMY (norelgestromin and ethinyl estradiol) TWIRLA (levonorgestrel and ethinyl estradiol) norelgestromin and ethinyl estradiol	
SICKLE CELL AGENTS			
	DROXIA (hydroxyurea) hydroxyurea	ADAKVEO (crizanlizumab) ENDARI (glutamine) HYDREA (hydroxyurea) OXBRYTA (voxelotor) SIKLOS (hydroxyurea	**Endari – MANUAL PA** **Oxbryta – MANUAL PA**
SKELETAL MUSCLE RELAXANTS DUR+			
	baclofen chlorzoxazone cyclobenzaprine 5mg, 10mg methocarbamol tizanidine tablets	AMRIX (cyclobenzaprine ER) baclofen suspension (generic FLEQSUVY) baclofen 15mg carisoprodol carisoprodol compound	**Non-Preferred Agents** • Documented diagnosis for an approvable indication **AND** • Have tried 2 different preferred agents in the past 6 months

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		cyclobenzaprine 7.5mg, 15mg cyclobenzaprine ER DANTRIUM (dantrolene) dantrolene FLEQSUVY (baclofen) FEXMID (cyclobenzaprine) FLEXERIL (cyclobenzaprine) LORZONE (chlorzoxazone) LYVISPAH (baclofen granules) metaxalone NORGESIC FORTE (orphenedrine) orphenadrine orphenadrine compound orphenadrine ER PARAFON FORTE DSC (chlorzoxazone) ROBAXIN (methocarbamol) SKELAXIN (metaxalone) SOMA (carisoprodol) tizanidine capsules ZANAFLEX (tizanidine)	**Baclofen granules, solution, and suspension** • Require clinical review **Carisoprodol** • Documented diagnosis of acute musculoskeletal condition **AND** • NO history with meprobamate in the past 90 days **AND** • 1 claim for cyclobenzaprine in the past 21 days **OR** a documented intolerance to cyclobenzaprine **AND** • **Quantity Limit** ○ **18 tablets** - to allow tapering off ○ **84 tablets/6 months** **Carisoprodol with codeine** • Requires clinical review
SMOKING DETERRENT			
	NICOTINE TYPE		
	nicotine gum[OTC] nicotine lozenge[OTC] nicotine mini lozenge[OTC] nicotine patch[OTC]	NICODERM CQ PATCH[OTC] NICORETTE GUM[OTC] NICORETTE LOZENGE [OTC] NICORETTE MINI LOZENGE[OTC] NICOTROL INHALER CARTRIDGE NICOTROL NASAL SPRAY	

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	NON-NICOTINE TYPE		
	bupropion ER CHANTIX (varenicline) varenicline	ZYBAN (bupropion)	**Minimum Age Limit - Chantix** • **18 years** **Quantity Limit** • **336 tablets/year –** Chantix 0.5mg, 1mg tablets and continuing pack • **2 treatment courses/year** – Chantix Starter Pack
STEROIDS (Topical) DUR+			
	LOW POTENCY		
	CAPEX (fluocinolone) desonide hydrocortisone cr, oint, soln.	alclometasone DERMA-SMOOTHE-FS (fluocinolone) DESONATE (desonide) DESOWEN (desonide) fluocinolone oil hydrocortisone lotion PEDIACARE HC (hydrocortisone) PEDIADERM (hydrocortisone) VERDESO (desonide)	**Non-Preferred Criteria** • Have tried 2 different preferred low potency agents in the past 6 months
	MEDIUM POTENCY		
	fluocinolone hydrocortisone mometasone cr, oint. prednicarbate cr PANDEL (hydrocortisone probutate)	betamethasone valerate foam CLODERM (clocortolone) CUTIVATE (fluticasone) DERMATOP (prednicarbate) ELOCON (mometasone) fluticasone LUXIQ (betamethasone)	**Non-Preferred Criteria** • Have tried 2 different preferred medium potency agents in the past 6 months

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		mometasone solution MOMEXIN (mometasone) prednicarbate oint SYNALAR (fluocinolone)	
	HIGH POTENCY		**Non-Preferred Criteria** • Have tried 2 different preferred high potency agents in the past 6 months
	amcinonide cr, lot betamethasone dipropionate cr, gel, lotion betamethasone valerate cr, lotion, oint. fluocinolone triamcinolone	amcinonide oint betameth diprop/prop gly cr, lot, oint betamethasone dipropionate oint. BETA-VAL (betamethasone valerate) desoximetasone diflorasone DIPROLENE AF (betamethasone diprop/prop gly) ELOCON (mometasone) fluocinonide HALOG (halcinonide) KENALOG (triamcinolone) PEDIADERM TA (triamcinolone) SERNIVO (betamethasone dipropionate) TOPICORT (desoximetasone) TRIANEX (triamcinolone) VANOS (fluocinonide)	
	VERY HIGH POTENCY		**Non-Preferred Criteria** • Have tried 2 different preferred very high potency agents in the past 6 months
	clobetasol lotion clobetasol shampoo, spray clobetasol propionate cream clobetasol propionate ointment	BRYHALI (halobetasol) clobetasol emollient clobetasol propionate foam, ge CLOBEX (clobetasol)	

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	halobetasol cream halobetasol ointment	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)	
STIMULANTS AND RELATED AGENTS DUR+			
	SHORT-ACTING		
	amphetamine salt combination dexmethylphenidate IR dextroamphetamine IR methylphenidate IR methylphenidate solution PROCENTRA (dextroamphetamine)	ADDERALL (amphetamine salt combination) amphetamine sulfate (generic EVEKO) DESOXYN (methamphetamine) dextroamphetamine/amphetamine ER^{NR} dextroamphetamine solution EVEKEO (amphetamine) EVEKEO ODT (amphetamine) FOCALIN (dexmethylphenidate) methamphetamine METHYLIN solution (methylphenidate) methylphenidate chewable RITALIN (methylphenidate) ZENZEDI (dextroamphetamine)	**Minimum Age Limit** • **3 years –** Adderall, Evekeo, Procentra, Zenzedi • **6 years –** Desoxyn, Evekeo ODT, Focalin, Methylin **Maximum Age Limit** • **18 years –** Evekeo ODT **Quantity Limit** Applicable quantity limit per rolling days • **62 tablets/31 days –** Adderall, Desoxyn, Evekeo, Focalin, Methylin, Zenzedi

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			• **310 mL/31 days –** Methylin solution, Procentra **Documented diagnosis of ADHD** ALL Short Acting Agents **Non-Preferred Criteria ADD/ADHD** • Documented diagnosis of ADD/ADHD **AND** • Have tried 2 different preferred Short Acting agents in the past 6 months **OR** • 1 claim for a 30-day supply with the requested agent in the past 105 days **Documented diagnosis of narcolepsy –** ADDERALL, EVEKEO, METHYLIN, PROCENTRA, RITALIN, ZENZEDI
	LONG-ACTING		
	ADDERALL XR (amphetamine salt combination) amphetamine salt combination ER CONCERTA (methylphenidate) dexmethylphenidate ER dextroamphetamine ER DYANAVEL XR SUSPENSION(amphetamine)	ADHANSIA XR (methylphenidate) ADZENYS XR ODT (amphetamine) ADZENYS ER SUSPENSION (amphetamine) amphetamine susp 24 hr (generic ADZENYS ER) APTENSIO XR (methylphenidate) AZSTARYS (serdexmethylphen/dexmethylphen)	**Minimum Age Limit** • **6 years –** Adderall XR, Adhansia XR, Adzenys ER Suspension, Adzenys XR ODT, Aptensio XR, Azstarys, Concerta ER, Cotempla XR ODT, Daytrana, Dexedrine, Dyanavel XR, Focalin XR, Jornay

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	lisdexamfetamine (generic Vyvanse) lisdexamfetamine (generic Vyvanse Chewable) methylphenidate CD (generic Metadate CD) methylphenidate ER (generic Concerta) methylphenidate ER Tabs (generic Ritalin SR) methylphenidate ER/LA Caps (generic Ritalin LA) QUILLICHEW (methylphenidate) QUILLIVANT XR (methylphenidate)	COTEMPLA XR-ODT (methylphenidate) DAYTRANA (methylphenidate) DEXEDRINE (dextroamphetamine) DYANAVEL XR tablet(amphetamine) FOCALIN XR (dexmethylphenidate) JORNAY PM (methylphenidate) methylphenidate ER caps (generic Aptensio XR) methylphenidate ER (generic Relexxi) methylphenidate patch (generic Daytrana) MYDAYIS (amphetamine salt combination) RELEXXI (methylphenidate) RITALIN LA (methylphenidate) RITALIN SR (methylphenidate) VYVANSE (lisdexamfetamine)* VYVANSE CHEWABLE (lisdexamfetamine)* XELSTRYM patch (dextroamphetamine)	PM, Metadate CD, Quillichew, Quillivant XR, Relexxii ER, Ritalin LA, Vyvanse, Xelstrym • **13 years –** Mydayis • **16 years –** Provigil • **18 years –** Nuvigil, Sunosi **Maximum Age Limit** • **18 years –** Cotempla XR ODT, Daytrana **Vyvanse** • Documented diagnosis of binge eating disorder **OR** • Documented diagnosis of ADD/ADHD **Quantity Limit** **Applicable quantity limit per rolling days** • **31 tablets/31 days –** Adderall XR, Adhansia XR, Adzenys XR ODT, Aptensio XR, Azstarys, Concerta ER 18, 27, & 54 mg, Cotempla XR-ODT 8.6 mg, Daytrana, Dexedrine Spansule, Dyanavel XR Tablet, Focalin XR, Jornay PM, Metadate CD, Methylin ER, Mydayis 37.5mg & 50 mg, Nuvigil 150, 200 & 250 mg, Provigil 200 mg, Quillichew,

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			Relexxii ER, Ritalin LA & SR, Vyvanse, Sunosi, Xelstrym • **46.5 tablets/31 days** – Provigil 100 mg • **62 tablets/31 days –** Concerta ER 36 mg, Cotempla XR-ODT 17.3 & 25.9 mg, Nuvigil 50mg • **248 mL/31 days –** Dyanavel XR Suspension • **372 mL/31 days –** Quillivant XR **Documented diagnosis of ADHD** ALL Long-Acting Agents **Non-Preferred Criteria ADD/ADHD** • Documented diagnosis of ADD/ADHD **AND** • Have tried 2 different preferred Long-Acting agents in the past 6 months **OR** • 1 claim for a 30-day supply with the requested agent in the past 105 days
NARCOLEPSY			
	armodafinil modafinil SUNOSI (solriamfetol)	LUMRYZ (sodium oxybate)[NR] NUVIGIL (armodafinil) PROVIGIL (modafinil) sodium oxybate WAKIX (pitolisant) XYREM (sodium oxybate)	**Documented diagnosis of narcolepsy –** ADDERALL XR, APTENSIO XR, CONCERTA ER, DEXEDRINE, METADATE CD, METHYLIN ER, MYDAYIS, NUVIGIL, PROVIGIL, QUILLICHEW,

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		XYWAV (calcium, magnesium, potassium and sodium oxybates)	QUILLIVANT XR, RITALIN LA, SUNOSI **Non-Preferred Criteria narcolepsy** • Documented diagnosis of narcolepsy **AND** • 30 days of therapy with preferred modafinil or armodafinil in the past 6 months **AND** • 1 different preferred agent indicated for narcolepsy in the past 6 months **OR** • 1 claim for a 30-day supply with the requested agent in the past 105 days **Nuvigil** • Documented diagnosis of narcolepsy, obstructive sleep apnea, shift work sleep disorder or bipolar depression **Provigil** • Documented diagnosis of narcolepsy, obstructive sleep apnea, shift work sleep disorder, depression, sleep deprivation or Steinert Myotonic Dystrophy Syndrome **Sunosi**

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			• Documented diagnosis of narcolepsy or obstructive sleep apnea **AND** • 30 days of therapy with preferred modafinil or armodafinil in the past 6 months **Wakix** • Documented diagnosis of narcolepsy with or without cataplexy **AND** • 30 days of therapy with preferred modafinil or armodafinil in the past 6 months **OR** • Documented diagnosis of narcolepsy without or without cataplexy **AND** • Documented diagnosis of substance abuse disorder **Xyrem and Xywav** • Require clinical review
	NON-STIMULANTS		
	atomoxetine clonidine ER guanfacine ER	INTUNIV (guanfacine ER) QELBREE (viloxazine) STRATTERA (atomoxetine)	**Minimum Age Limit** **6 years –** Intuniv, Clonidine ER, Qelbree, Strattera **18 years –** Wakix **Maximum Age Limit**

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			• **18 years –** Intuniv, Clonidine ER, Qelbree • **21 years –** diagnosis of ADD/ADHD is required for Strattera **Quantity Limit** Applicable quantity limit per rolling days • **31 tablets/31 days –** Intuniv, Qelbree 100 mg, Strattera • **62 tablets/31days –** Qelbree 150 mg and 200 mg, Wakix • **124 tablets/31 days** – Clonidine ER **Intuniv** Documented diagnosis of ADD or ADHD **Clonidine ER** • Documented diagnosis of ADD or ADHD **Qelbree** • Documented diagnosis of ADD or ADHD **AND** • 1 claim for a 30-day supply with atomoxetine in the past 105 days
TETRACYCLINES DUR+			
	doxycycline hyclate caps/tabs doxycycline monohydrate caps (50mg & 100mg)	ACTICLATE (doxycyline) ADOXA (doxycycline monohydrate)	**Non-Preferred Agents**

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	minocycline caps IR tetracycline	demeclocycline doxycycline hyclate (generic Doryx) doxycycline hyclate (generic Periostat) doxycycline monohydrate caps (75mg & 150mg) doxycycline monohydrate tabs DORYX (doxycycline hyclate) DYNACIN (minocycline) MINOCIN (minocycline) MINOLIRA (minocycline) minocycline ER minocycline tabs MONODOX (doxycycline monohydrate) NUZYRA (omadacycline tosylate) OKEBO (doxycycline) ORACEA (doxycycline) SEYSARA (sarecycline) SOLODYN (minocycline) TARGADOX (doxycycline) VIBRAMYCIN cap/susp/syrup XIMINO (minocycline)	• Have tried 2 different preferred agents in the past 6 months **Demeclocycline** • Documented diagnosis of SIADH will allow automatic approval
ULCERATIVE COLITIS and CROHN'S AGENTS DUR+ ***See Cytokine & CAM Antagonists Class for additional agents**			
	ORAL		
	APRISO (mesalamine) balsalazide budesonide EC LIALDA (mesalamine) mesalamine tablet (generic Apriso)	AZULFIDINE (sulfasalazine) AZULFIDINE ER (sulfasalazine) budesonide ER tablets COLAZAL (balsalazide) DELZICOL (mesalamine)	**Non-Preferred Criteria** • Documented diagnosis for Ulcerative Colitis **AND** • Have tried 2 different preferred agents in the past 6 months **OR**

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	PENTASA 250mg (mesalamine) PENTASA 500mg (mesalamine) sulfasalazine UCERIS (budesonide)	DIPENTUM (olsalazine) ENTOCORT EC (budesonide) mesalamine tablet (generic Asacol HD) mesalamine capsules (generic Delzicol) ORTIKOS (budesonide) VELSIPITY (etrasimod)	• 90 consecutive days on the requested agent in the past 105 days **Velsipity** • Requires clinical review
RECTAL			
	mesalamine suppository	budesonide foam CANASA (mesalamine) ROWASA (mesalamine) SF-ROWASA (mesalamine) UCERIS Foam (budesonide)	

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