MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

(For All Medicaid, MSCAN and CHIP Beneficiaries)

EFFECTIVE 7/1/2024
Version 2024_9
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Gainwell Technologies' DUR+ process is a proprietary electronic prior authorization system used for Medicaid fee for service claims. MSCAN plans may/may not -have electronic PA functionality. However, they must adhere to Medicaid's PA criteria.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
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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		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)	

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		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		**Preferred Criteria** • Documented approvable diagnosis **Non-Preferred Criteria** • Documented approvable diagnosis **AND** • 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 both donepezil and 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

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	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** – oxycodone liquids • **280 ml** – Qdolo

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		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, hydromorphone ER, Hysingla ER, tramadol ER • **62 tablets/31 days** – methadone, morphine ER, 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 days of therapy with the requested agent in the past 105 days

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
ANALGESICS/ANESTHETICS (Topical)			
	diclofenac sodium 1% gel diclofenac sodium 1.5% solution lidocaine 4% cream [OTC] lidocaine 5% ointment lidocaine 5% patch	capsaicin diclofenac epolamine patch [DUR+] 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

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		FORTESTSA (testosterone gel) JATENZO (testosterone undecanoate) NATESTO (testosterone) STRIANT (testosterone) TESTIM (testosterone gel) testosterone pump TLANDO (testosterone) VOGELXO (testosterone) XYOSTED (testosterone enanthate)	**Non-Preferred Criteria** • 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 Automatic approval issued for this age **Non-Preferred Criteria** • Have tried 2 different preferred single entity agents in the past 6 months **OR** • 90 days of therapy with 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**

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	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 days of therapy with 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 days of therapy with 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 days of therapy with 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 days of therapy with 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 days of therapy with the requested agent in the past 105 days
xifa	**DIRECT RENIN INHIBITORS**		
		TEKTURNA (aliskiren) aliskiren	**Non-Preferred Criteria** • Documented diagnosis of hypertension **AND**

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			• Have tried 2 different preferred ACEI or ARB single-entity products in the past 6 months **OR** • 90 days of therapy with 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 days of therapy with 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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		MACROBID (nitrofurantoin monohydrate macrocyrstals) MACRODANTIN (nitrofurantoin)	
OXAZOLIDINONES			Sivextro – MANUAL PA Zyvox - MANUAL PA **Quantity Limit** • **6 tablets/month** – Sivextro
		SIVEXTRO (tedizolid) ZYVOX (linezolid)	
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)	

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

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	divalproex sprinkle EPIDIOLEX (cannabidiol) EPITOL (carbamazepine) gabapentin lacosamide lamotrigine levetiracetam levetiracetam ER oxcarbazepine oxcarbazepine suspension tiagabine topiramate tablet topiramate sprinkle capsule valproic acid zonisamide	DIACOMIT (stiripentol) 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)	**Epidiolex** • Documented diagnosis of Dravet syndrome. Lennox Gastaut syndrome or seizures associated with tuberous sclerosis complex **OR** • 1 claim for the requested agent in the past 30 days **Non-Preferred Criteria** • Have tried 2 different preferred agents in the past 6 months **OR** • 90 days of therapy with 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 days of therapy with the requested agent in the past 105 days **AND** • Documented diagnosis of seizure **Diacomit** • Documented diagnosis of Dravet syndrome **AND**

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

Drugs highlighted in yellow denote a change in PDL status.

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

A # denotes existing users will NOT be grandfathered.

To search the PDL, press CTRL + F

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		TOPAMAX TABLET (topiramate) 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)	• 1 claim for clobazam in the past 30 days **Fintepla** • Requires clinical review **Sabril Powder for Oral Solution** • Documented diagnosis of infantile spasms **OR** • Have tried 2 different preferred agents in the past 6 months **OR** • 90 days of therapy with the requested agent in the past 105 days **AND** • Documented diagnosis of seizure **Topiramate ER – Step Edit** • 90 days of therapy with the requested agent in the past 105 days **AND** • Documented diagnosis of seizure **OR** • 30-day trial with topiramate IR in the past 6 months
	SELECTED BENZODIAZEPINES		
	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)	**Minimum Age Limit** • **12 years** – Nayzilam • **6 years** – Valtoco **Quantity Limit** • **2 Twin Packs/31 days** – Diastat

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			• **2 Packages /31 days** – Nayzilam **2 Cartons/31 day** – Valtoco
	HYDANTOINS		
	DILANTIN (phenytoin) PHENYTEK (phenytoin) phenytoin	PEGANONE (ethotoin)	
	SUCCINIMIDES		
	ethosuximide	CELONTIN (methsuximide) ZARONTIN (ethosuximide)	

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
ANTIDEPRESSANTS, OTHER DUR+			
	bupropion bupropion SR bupropion XL TRINTELLIX (vortioxetine) mirtazapine trazodone venlafaxine venlafaxine ER capsules VIIBRYD (vilazodone)	APLENZIN (bupropion HBr) AUVELITY (dextromethorphan/bupropion) desvenlafaxine ER desvenlafaxine fumarate ER DESYREL (trazodone) DRIZALMA SPRINKLE (duloxetine DR) EFFEXOR (venlafaxine) EFFEXOR XR (venlafaxine) EMSAM (selegiline transdermal) FETZIMA ER (levomilnacipran) FORFIVO XL (bupropion) KHEDEZLA ER (desvenlafaxine) MARPLAN (isocarboxazid) NARDIL (phenelzine) nefazodone OLEPTRO ER (trazodone) PARNATE (tranylcypromine) phenelzine PRISTIQ (desvenlafaxine) REMERON (mirtazapine) tranylcypromine venlafaxine XR venlafaxine ER tablets vilazodone	**Minimum Age Limit** • **7-11 years** – Drizalma Sprinkle Automatic approval issued with a diagnosis of generalized anxiety disorder for this age range • **7-17 years** – duloxetine Automatic approval issued with a diagnosis of generalized anxiety disorder for this age range • **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 days of therapy with the requested agent in the past 105 days **Auvelity** • Requires clinical review

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		ZURZUVAE (zuranolone)	**Zurzuvae – MANUAL PA** Cymbalta and Irenka (see Fibromyalgia Agents)
ANTIDEPRESSANTS, SSRIs DUR+			
	citalopram escitalopram fluoxetine capsules	CELEXA (citalopram) fluoxetine DR fluvoxamine ER	**Minimum Age Limit** • **6 years** – Zoloft • **7 years** – Lexapro, Prozac

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

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
		AKYNZEO (netupitant/palonosetron) BONJESTA (doxylamine/pyridoxine) DICLEGIS (doxylamine/pyridoxine) doxylamine/pyridoxine	**Akynzeo – MANUAL PA**
CANNABINOIDS			
		CESAMET (nabilone) MARINOL (dronabinol) dronabinol SYNDROS (dronabinol)	
NMDA RECEPTOR ANTAGONIST			
	aprepitant	EMEND (aprepitant)	
ANTIFUNGALS (Oral) DUR+			
	clotrimazole fluconazole griseofulvin microsize suspension nystatin terbinafine	ANCOBON (flucytosine) ^ BREXAFEMME (ibrexafungerp) CRESEMBA (isavuconazonium) DIFLUCAN (fluconazole) flucytosine GRIFULVIN V (griseofulvin, microsize) griseofulvin microsize tablets griseofulvin ultramicrosize tablet GRIS-PEG (griseofulvin) itraconazole ^ ketoconazole LAMISIL (terbinafine) NOXAFIL (posaconazole) ^ ONMEL (itraconazole) ^	**Minimum Age Limit** • **12-17 years** – griseofulvin tablets Automatic approval issued for this age range **Non-Preferred Criteria** • Have tried 2 different preferred agents in the past 6 months **HIV opportunistic infection** • Non-Preferred agent indicated for treatment (^) **AND** • Documented diagnosis of HIV **Cresemba - MANUAL PA** • Minimum age limit > 18 years **AND**

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		posaconazole^ SPORANOX (itraconazole) ^ TERBINEX Kit (terbinafine/ciclopirox) TOLSURA (itraconazole) VFEND (voriconazole) ^ VIVJOA (oteseconazole) voriconazole ^	• Documented diagnosis of invasive aspergillosis **OR** invasive mucormycosis **AND** • Prescriber is an oncologist/hematologist or infectious disease specialist **Sporanox** • HIV opportunistic infection criteria **OR** • Documented diagnosis of a transplant **OR** • History of an immunosuppressant in the past 6 months **OR** • Have tried 2 different preferred agents in the past 6 months
ANTIFUNGALS (Topical) DUR+			
	ANTIFUNGALS		
	ciclopirox cream/gel/solution/suspension clotrimazole cream/solution[Rx & OTC] ketoconazole shampoo LUZU (luliconazole) miconazole cream/powder[OTC] nystatin terbinafine cream/spray[OTC] tolnaftate cream/powder/spray[OTC]	BENSAL HP (benzoic acid/salicylic acid) butenafine CICLODAN KIT (ciclopirox kit) ciclopirox kit/shampoo CNL 8 (ciclopirox) econazole ERTACZO (sertaconazole) EXELDERM (sulconazole) EXTINA (ketoconazole) JUBLIA (efinaconazole) KERYDIN (tavaborole)	**Non-Preferred Criteria** • Have tried 2 different preferred agents in the past 6 months

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

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
ANTIHISTAMINES, MINIMALLY SEDATING AND COMBINATIONS DUR+			
	MINIMALLY SEDATING ANTIHISTAMINES		**Non-Preferred Criteria** • Documented diagnosis of allergy or urticaria **AND** • Have tried 2 different preferred agents in the past 12 months
	cetirizine tablets[OTC] cetirizine syrup[Rx & OTC] loratadine odt [OTC] loratadine syrup[OTC] loratadine tablet[OTC]	cetirizine chewable[OTC] CLARINEX (desloratadine) desloratadine ODT desloratadine tablet fexofenadine syrup fexofenadine table levocetirizine syrup levocetirizine tablet XYZAL Solution (levocetirizine) XYZAL Tablets (levocetirizine)	
	MINIMALLY SEDATING ANTIHISTAMINE/DECONGESTANT COMBINATIONS		
	cetirizine/pseudoephedrine loratadine/pseudoephedrine	ALLEGRA-D (fexofenadine/ pseudoephedrine) CLARITIN-D (loratadine/pseudoephedrine) CLARINEX-D (desloratadine/ pseudoephedrine) fexofenadine/pseudoephedrine ZYRTEC-D (cetirizine/pseudoephedrine)	
ANTIMIGRAINE AGENTS, ACUTE TREATMENT			
	CGRP ORAL AND NASAL		
	NURTEC ODT (rimegepant)	UBRELVY (ubrogepant) ZAVZPRET (zavegepant)	**Minimum Age Limit** • **18 years** – Nurtec ODT, Ubrelvy

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			Quantity Limit • **8 tablets/31 day –** Nurtec ODT • **16 tablets/31 day –** Ubrelvy **Nurtec ODT** • Documented diagnosis of migraine **AND** • Have tried 2 different triptans in the past 6 months **AND** • No concurrent therapy with another CGRP agent **Ubrelvy** • Documented diagnosis of migraine **AND** • Have tried 2 different triptans in the past 6 months **AND** • Have tried preferred Nurtec ODT in the past 6 months **AND** • No concurrent therapy with another CGRP agent **AND** • No concurrent therapy with a strong CYP3A4 inhibitor
TRIPTANS & RELATED AGENTS ORAL[DUR+]			
	naratriptan rizatriptan rizatriptan ODT sumatriptan tablets zolmitriptan zolmitriptan ODT	almotriptan AMERGE (naratriptan) AXERT (almotriptan) eletriptan FROVA (frovatriptan) frovatriptan	**Minimum Age Limit** • **6 years –** Maxalt • **12-17 years** – Axert, Treximet, Zomig nasal spray Automatic approval issued for this age range

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		IMITREX (sumatriptan) MAXALT (rizatriptan) MAXALT MLT (rizatriptan) RELPAX (eletriptan) REYVOW (lasmiditan) TREXIMET (sumatriptan/naproxen) ZOMIG (zolmitriptan)	• **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 **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**
	NASAL		
	sumatriptan	IMITREX (sumatriptan) ONZETRA Xsail (sumatriptan) TOSYMRA (sumatriptan) zolmitriptan	

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		ZOMIG (zolmitriptan)	• Have tried 2 preferred oral agents in the past 90 days **AND** • Have tried a preferred nasal agent in the past 90 days
	INJECTABLES		
	sumatriptan	IMITREX (sumatriptan) ZEMBRACE (sumatriptan)	**CUMULATIVE Quantity Limit - Injectables** **4 injections/31 days**
ANTIMIGRAINE AGENTS, PROPHYLAXIS			
	INJECTIBLES		
	AIMOVIG AUTOINJECTOR (erenumab-aooe) AJOVY AUTOINJECTOR (fremanezumab-vfrm) AJOVY SYRINGE (fremanezumab-vfrm) EMGALITY PEN 120mg/mL(galcanezumab-gnlm) EMGALITY SYRINGE 120mg/mL (galcanezumab-gnlm)	EMGALITY SYRINGE 100mg/mL (galcanezumab-gnlm) VYEPTI (eptinezumab-jjmr)	**Aimovig - MANUAL PA** **Ajovy - MANUAL PA** **Emgality -MANUAL PA** **Vyepti - MANUAL PA**
	ORAL		
		NURTEC ODT (rimegepant) QULIPTA (atogepant)	• See Antimigraine Agents, Acute
***ANTINEOPLASTICS – SELECTED SYSTEMIC ENZYME INHIBITORS**			
	BOSULIF (bosutinib) CAPRELSA (vandetanib) COMETRIQ (cabozantinib) COTELLIC (cobimetinib) GILOTRIF (afatanib) everolimus ICLUSIG (ponatinib)	AFINITOR (everolimus) AKEEGA (niraparib / abiraterone) ALECENSA (alectinib) ALUNBRIG (brigatnib) AUGTYRO (repotrectinib) AYVAKIT (avapritinib) BALVERSA (erdafitinib)	**Farydak - MANUAL PA** • Documented diagnosis of multiple myeloma **AND** • Used in combination with bortezomib and dexamethasone per PI **AND**

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	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) vandetanib VOTRIENT (pazopanib) XALKORI (crizotinib) XALKORI (crizotinib) Oral Pellets XTANDI (enzalutamide) ZELBORAF (vemurafenib) ZYDELIG (idelalisib) ZYKADIA (ceritnib)	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) 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+	• History of 2 prior regimens including bortezomib and an immunomodulatory agent **Ibrance** • Documented diagnosis of WD-DDLS for retroperitoneal sarcoma **OR** • All other indications evaluated through clinical review **Lenvima** • Documented diagnosis of thyroid cancer **OR** • Documented diagnosis of hepatocellular carcinoma **OR** • Documented diagnosis of renal cell carcinoma **AND** • History of 1 claim for everolimus in the past 30 days **AND** • History of 1 anti-angiogenic agent in the past 2 years **OR** • All other indications evaluated through clinical review **Lynparza Tablets** • Documented diagnosis of ovarian cancer, fallopian tube or peritoneal cancer **AND**

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		LYTGOBI (futibatinib) MEKTOVI (binimetnib) NERLYNX (neratinib maleate) NUBEQA (darolutamide) ODOMZO (sonidegib) OGSIVEO (nirogacestat) OJEMDA (tovorafenib)[NR] OJJAARA (momelotinib) ONUREG (azacitidine) ORGOVYX (relugolix) pazopanib PEMAZYRE (pemigatinib) PIQRAY (alpelisib) QINLOCK (ripretinib) REZLIDHIA (lutasidenib) RETEVMO (selpercatinib) RUBRACA (rucaparib) RYDAPT (midostaurin) SCEMBLIX (asciminib) TABRECTA (capmatinib) TAGRISSO (osimertinib) TALZENNA (talazoparib) TAZVERIK (tazemetostat) TEPMETKO (tepotinib) TIBSOVO (ivosidenib) TORPENZ (everolimus)[NR] TRUSELTIQ (infigratinib) TRUQAP (capivasertib) TUKYSA (tucatinib) UKONIQ (umbralisib) VANFLYTA (quizartinib VERZENIO (abemaciclib)	• History of platinum-based chemotherapy in the past 2 years **OR** • All other indications evaluated through clinical review

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		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		**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 **Minimum Age/Weight Limit for Topical Scabicides**
	permethrin 1%[OTC] NATROBA (spinosad)	lindane malathion OVIDE (malathion) SKLICE (ivermectin) spinosad VANALICE (piperonyl butoxide/pyrethrins)	
	SCABICIDES		
	permethrin 5%	ELIMITE (permethrin)	

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	ivermectin	EURAX CREAM (crotamiton) EURAX LOTION (crotamiton) STROMECTOL Tablet (ivermectin)	• **50 kg –** lindane lotion • **2 months –** permethrin 5% • **4 years –** Natroba • **18 years** – Eurax **Non-Preferred Criteria** • Have tried permethrin 5% in the past 90 days
ANTIPARKINSON'S AGENTS (Oral) DUR+			
	ANTICHOLINERGICS		**Non-Preferred Criteria** • Documented diagnosis of Parkinson's disease **AND** • Have tried 2 different preferred agents in the past 6 months **OR** • 90 days of therapy with the requested agent in the past 105 days
	benztropine trihexyphenidyl	COGENTIN (benztropine)	
	COMT INHIBITORS		
	entacapone	COMTAN (entacapone) ONGENTYS (opicapone) TASMAR (tolcapone) tolcapone	
	DOPAMINE AGONISTS		

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	ropinirole	KYNMOBI FILM (apomorphine) MIRAPEX (pramipexole) MIRAPEX ER (pramipexole) NEUPRO (rotigotine) pramipexole pramipexole ER REQUIP (ropinirole) REQUIP XL (ropinirole) ropinirole ER	
	MAO-B INHIBITORS		
	selegiline	AZILECT (rasagiline) ELDEPRYL (selegiline) rasagiline XADAGO (safinamide) ZELAPAR (selegiline)	**Xadago** • Documented diagnosis of Parkinson's disease **AND** • History of a preferred carbidopa/levodopa combination product in the past 30 days **AND** • History of a 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)	**Lodosyn and Inbrija** • Documented diagnosis of Parkinson's disease **AND** • History of a carbidopa/levodopa combination product in the past 45 days **Nourianz**

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		SINEMET (levodopa/carbidopa) SINEMET CR (levodopa/carbidopa) STALEVO (levodopa/carbidopa/entacapone)	• 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 haloperidol olanzapine olanzapine ODT perphenazine quetiapine quetiapine XR risperidone risperidone ODT thioridazine thiothixene trifluoperazine VRAYLAR (cariprazine) ziprasidone	ABILIFY (aripiprazole) ABILIFY MYCITE (aripiprazole) ADASUVE (loxapine) aripiprazole solution aripiprazole ODT CAPLYTA (lumateperone) chlorpromazine clozapine ODT CLOZARIL (clozapine) FANAPT (iloperidone) FAZACLO (clozapine) GEODON (ziprasidone) HALDOL (haloperidol) INVEGA ER (paliperidone) LATUDA (lurasidone) lurasidone LYBALVI (olanzapine/samidorphan) NUPLAZID (pimavanserin)	**Minimum Age Limit** • **3 years –** Haldol • **5 years –** Risperdal, thioridazine • **6 years –** Abilify, trifluoperazine • **10 years –** Latuda, Saphris, Seroquel, Symbyax • **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

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		olanzapine/fluoxetine paliperidone ER REXULTI (brexpiprazole) RISPERDAL (risperidone) SAPHRIS (asenapine) SEROQUEL (quetiapine) SEROQUEL XR (quetiapine) SYMBYAX (olanzapine/fluoxetine) VERSACLOZ (clnazpine) ZYPREXA (olanzapine)	**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 **Non-Preferred Criteria- Atypical Agents** • Have tried 2 preferred atypical antipsychotic agents in the past 12 months **OR** • 30 days of therapy with the requested atypical agent in the past 180 days **Nuplazid** • Documented diagnosis of Parkinson's disease
	INJECTABLE, ATYPICALS DUR+		

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

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

Drugs highlighted in yellow denote a change in PDL status.

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

A # denotes existing users will NOT be grandfathered.

To search the PDL, press CTRL + F

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

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	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** • 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	didanosine DR capsule emtricitabine EPIVIR (lamivudine) RETROVIR (zidovudine) stavudine	

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	ZIAGEN Solution (abacavir sulfate) zidovudine	VIDEX EC (didanosine) VIDEX SOLUTION (didanosine) VIREAD (tenofovir disoproxil fumarate) ZIAGEN Tablet (abacavir sulfate)	
	NON-NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITOR (NNRTI)		
	EDURANT (rilpivirine) efavirenz	INTELENCE (etravirine) nevirapine nevirapine ER PIFELTRO (doravirine) RESCRIPTOR (delavirdine mesylate) SUSTIVA (efavirenz) VIRAMUNE (nevirapine) VIRAMUNE ER (nevirapine)	
	PHARMACOENHANCER – CYTOCHROME P450 INHIBITOR		
		TYBOST (cobicistat)	Tybost - MANUAL PA
	PROTEASE INHIBITORS (PEPTIDIC)		
	atazanavir EVOTAZ (atazanavir/cobicistat) NORVIR SOLUTION (ritonavir) ritonavir	CRIXIVAN (indinavir) fosamprenavir INVIRASE (saquinavir mesylate) LEXIVA (fosamprenavir) NORVIR POWDER (ritonavir) NORVIR TABLET (ritonavir) REYATAZ (atazanavir) VIRACEPT (nelfinavir mesylate)	
	PROTEASE INHIBITORS (NON-PEPTIDIC)		

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	PREZISTA (darunavir ethanolate)	APTIVUS (tipranavir) darunavir ethanolate PREZCOBIX (darunavir/cobicistat)	
	ENTRY INHIBITORS – CCR5 CO-RECEPTOR ANTAGONISTS		
		SELZENTRY (maraviroc)	
	ENTRY INHIBITORS – FUSION INHIBITORS		
		FUZEON (enfuvirtide)	
	COMBINATION PRODUCTS - NRTIs		
	abacavir/lamivudine CABENUVA (cabotegravir/rilpivirine) DOVATO (dolutegravir/lamivudine) 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)	

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	COMBINATION PRODUCTS – PROTEASE INHIBITORS		
	lopinavir/ritonavir	KALETRA (lopinavir/ritonavir)	
CAPSID INHIBITORS			**All agents require clinical review**
		SUNLENCA (lenacapavir)	
	CD4 DIRECTED ATTACHMENT INHIBITOR		
		RUKOBIA (fostemsavir tromethamine ER)	
	CD4 DIRECTED HIV-1 INHIBITOR		
		TROGARZO (ibalizumab)	
ANTIVIRALS (Oral)			
	ANTI-CYTOMEGALOVIRUS AGENTS		
	valganciclovir tablets	LIVTENCITY (maribavir) PREVYMIS (letermovir) VALCYTE (valganciclovir) valganciclovir solution	**valganciclovir solution** – automatic approval issued for age <12 years **Prevymis** Prevention (prophylaxis) of cytomegalovirus (CMV) infection and disease • ≥ 18 years **AND**

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			• Post hematopoietic stem cell transplant (HSCT) within the past 28 days **AND** • CMV sero-positive recipient [R+] **AND** • NO severe (Child-Pugh Class C) hepatic impairment
	ANTI-HERPETIC AGENTS		
	acyclovir valacyclovir	famciclovir FAMVIR (famciclovir) SITAVIG (acyclovir) VALTREX (valacyclovir) ZOVIRAX (acyclovir)	
	ANTI-INFLUENZA AGENTS		
	oseltamivir	FLUMADINE (rimantadine) RAPIVAB (peramivir) RELENZA (zanamivir) rimantadine TAMIFLU (oseltamivir) XOFLUZA (baloxavir marboxil)	
ANTIVIRALS (Topical)			
	ZOVIRAX Cream (acyclovir)	acyclovir cream, ointment DENAVIR (penciclovir) XERESE (acyclovir/hydrocortisone) ZOVIRAX Ointment (acyclovir)	

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
AROMATASE INHIBITORS			
	anastrozole exemestane letrozole	ARIMIDEX (anastrozole) AROMASIN (exemestane) FEMARA (letrozole)	
ATOPIC DERMATITIS DUR+			
	ADBRY (tralokinumab) DUPIXENT (dupilumab) ELIDEL (pimecrolimus) PROTOPIC (tacrolimus) tacrolimus	CIBINQO (abrocitinib) EUCRISA (crisaborole) OPZELURA (ruxolitinib) pimecrolimus	**Minimum Age Limit** • **2 years** – Elidel, Protopic 0.03% • **16 years** – Protopic 0.1% **Adbry, Cibinqo, and Opzelura** • Require clinical review **Eucrisa** • 28 days of therapy with a calcineurin inhibitor in the past year **AND** • 28 days of therapy with a topical steroid in the past year **OR** • MANUAL PA **Dupixent**

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			Evaluated through Manual PA according to diagnosis **Asthma – MANUAL PA** **Atopic Dermatitis – MANUAL PA** **Eosinophilic Esophagitis -- MANUAL PA** **Nasal Polyposis – MANUAL PA** **Prurigo Nodularis MANUAL PA**
BETA BLOCKERS, ANTIANGINALS & SINUS NODE AGENTS[DUR+]			
	acebutolol atenolol bisoprolol metoprolol metoprolol ER nadolol nebivolol pindolol propranolol propranolol ER sotalol	AZSRUZYO SPRINKLES (ranolazine) BETAPACE (sotalol) betaxolol BYSTOLIC (nebivolol) CORGARD (nadolol) HEMANGEOL (propranolol) INDERAL LA (propranolol) INDERAL XL (propranolol) INNOPRAN XL (propranolol) KAPSPARGO SPRINKLES (metoprolol) KERLONE (bextaxolol) LEVATOL (penbutolol) LOPRESSOR (metoprolol) SECTRAL (acebutolol) SOTYLIZE (sotalol) TENORMIN (atenolol) TOPROL XL (metoprolol) ZEBETA (bisoprolol)	**Non-Preferred Criteria** • Have tried 2 different preferred agents in the past 6 months **OR** • 90 days of therapy with the requested agent in the past 105 days
	BETA- AND ALPHA-BLOCKERS		

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	carvedilol labetalol	carvedilol CR COREG (carvedilol) COREG CR (carvedilol) TRANDATE (labetalol)	**Coreg CR** • Documented diagnosis of hypertension **AND** • Have tried generic carvedilol **AND** 1 preferred agent in the past 6 months **OR** • 90 days of therapy with the requested agent in the past 105 days
	BETA BLOCKER/DIURETIC COMBINATIONS		
	atenolol/chlorthalidone bisoprolol/HCTZ metoprolol/HCTZ nadolol/bendroflumethiazide propranolol/HCTZ timolol/HCTZ	CORZIDE (nadolol/bendroflumethiazide) DUTOPROL (metoprolol/HCTZ) LOPRESSOR HCT (metoprolol/HCTZ) TENORETIC (atenolol/chlorthalidone) ZIAC (bisoprolol/HCTZ)	
	ANTIANGINALS		
		RANEXA (ranolazine) ranolazine	**Ranexa** • Documented diagnosis of angina **AND** • 1 claim for a calcium channel blocker, beta-blocker, nitrate, or combination agent in the past 30 days **OR** • 90 days of therapy with the requested agent in the past 105 days

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

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		trospium ER VESICARE (solifenacin) VESICARE LS Suspension (solifenacin)	
BONE RESORPTION SUPPRESSION AND RELATED AGENTS DUR+			
BISPHOSPHONATES			**Non-Preferred Criteria** • Documented diagnosis of osteoporosis or osteopenia **AND** • Have tried 2 different preferred agents in the past 6 months
	alendronate ibandronate risedronate	ACTONEL (risedronate) ACTONEL WITH CALCIUM (risedronate/calcium) alendronate solution ATELVIA (risedronate) BINOSTO (alendronate) BONIVA (ibandronate) DIDRONEL (etidronate) FOSAMAX (alendronate) FOSAMAX PLUS D (alendronate/vitamin D) risedronate DR Tablet	
OTHERS			
		calcitonin salmon EVENITY (romosozumab-aqqg) EVISTA (raloxifene) FORTEO (teriparatide) MIACALCIN (calcitonin) PROLIA (denosumab) raloxifene TYMLOS (abaloparatide) XGEVA (denosumab)	
BPH AGENTS DUR+			

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

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		SPIRIVA RESPIMAT (tiotropium) DUR+ TUDORZA PRESSAIR (aclidinium) YUPELRI (revefenacin)	• Automatic approval issued for > 6 years with a diagnosis of asthma
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)	
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**

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
			• 1 claim for a preferred albuterol inhaler in the past 30 days **Airsupra and ProAir Digihaler** • Require clinical review
	INHALERS, LONG ACTING DUR+		
	SEREVENT (salmeterol) STRIVERDI RESPIMAT (olodaterol)		**Minimum Age Limit** • **4 years** – Serevent • **18 years** – Striverdi Respimat
	INHALATION SOLUTION DUR+		
	albuterol	arformoterol BROVANA (arformoterol) formoterol levalbuterol metaproterenol PERFOROMIST (formoterol) XOPENEX (levalbuterol)	**Minimum Age Limit** • **6 years** – Xopenex • **18 years** – Brovana, Perforomist **Non-Preferred Criteria** • 1 claim for a different preferred agent in the past 6 months **OR** • 3 claims with the requested agent in the past 105 days **Xopenex** • 1 claim for a preferred albuterol in the past 30 days
	ORAL		

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	albuterol ER albuterol IR metaproterenol terbutaline	VOSPIRE ER (albuterol)	
CALCIUM CHANNEL BLOCKERS DUR+			
	SHORT-ACTING		
	diltiazem nicardipine nifedipine verapamil	CALAN (verapamil) CARDIZEM (diltiazem) isradipine nimodipine NORLIQVA (amlodipine) NYMALIZE SOLUTION (nimodipine) PROCARDIA (nifedipine)	**Quantity Limit - nimodipine** • **252 tablets/ 21 days** • **2520 mL/21 days** **Non-Preferred Criteria** • Have tried 2 different preferred Short Acting CCB agents in the past 6 months **OR** • 90 days of therapy with 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		

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	amlodipine DILT XR 24 HR Caps (diltiazem) diltiazem ER Cap 24 HR (generic Cardizem CD) diltiazem ER Cap 24 HR felodipine ER nifedipine ER verapamil ER	ADALAT CC (nifedipine) CALAN SR (verapamil) CARDENE SR (nicardipine) CARDIZEM CD (diltiazem) CARDIZEM LA (diltiazem) DILACOR XR (diltiazem) diltiazem ER Cap 12 HR diltiazem ER Tab 24 HR KATERZIA (amlodipine) nisoldipine NORVASC (amlodipine) PROCARDIA XL (nifedipine) SULAR (nisoldipine) TIAZAC (diltiazem) verapamil ER PM VERELAN/VERELAN PM (verapamil)	**Non-Preferred Criteria** • Have tried 2 different preferred Long Acting CCB agents in the past 6 months **OR** • 90 days of therapy with the requested agent in the past 105 days
CALORIC AGENTS			
	BOOST (includes all Boost) BREAKFAST ESSENTIALS BRIGHT BEGINNINGS DUOCAL ENSURE GLUCERNA NUTREN (includes all Nutren) OSMOLITE PEDIASURE PROMOD RESOURCE	All other products (caloric /nutritional agents) not listed as preferred will require a manual prior authorization.	**Non-Preferred Agents – MANUAL PA**

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	SCANDISHAKE TWOCAL HN		
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)	
	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

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

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		tobramycin (generic Kitabis) TRIKAFTA (elexacaftor/ tezacaftor/ivacaftor)	• **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 of Cystic Fibrosis **Colistimethate** • Documented diagnosis of Cystic Fibrosis **OR** • Requires clinical review **Kalydeco – MANUAL PA** **Orkambi – MANUAL PA** **Symdeko – MANUAL PA** **Trikafta – MANUAL PA** **TOBI Podhaler** • Requires clinical review
CYTOKINE & CAM ANTAGONISTS[DUR+]			
	ACTEMRA SYRINGE (tocilizumab) ACTEMRA VIAL(tocilizumab) AVSOLA (infliximab) ENBREL (etanercept) HUMIRA (adalimumab)	ABRILADA (adalimumab-afzb) ACTEMRA ACTPEN (tocilizumab) AMJEVITA (adalimumab) ARCALYST (rilonacept) BIMZELX (bimekizumab-bkzx)	**Preferred Agents** • Age criteria for indication • Documented diagnosis for indication **Non-Preferred Agents**

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	KINERET (anakinra) methotrexate ORENCIA CLICKJET(abatacept) ORENCIA VIAL(abatacept) OTEZLA (apremilast) SIMPONI (golimumab) TALTZ (ixekizumab) XELJANZ IR (tofacitinib)	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) 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 LQ (upadacitinib)[NR] RINVOQ ER (upadacitinib) SILIQ (brodalumab)	• Require clinical review **IV Administered Agents** • Require clinical review

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		SIMLANDI (adalimumab-ryvk) SKYRIZI (risankizumab) SOTYKTU (deucravacitinib) SPEVIGO (spesolimab) STELARA (ustekinumab) TOFIDENCE (tocilizumab-bavi)[NR] TREMFYA (guselkumab) TREXALL (methotrexate) TYENEE (tocilizumab-aazg) XELJANZ Oral Solution (tofacitinib) XELJANZ XR (tofacitinib) YUSIMRY (adalimumab) ZYMFENTRA (infliximab-dyyb)	
ERYTHROPOIESIS STIMULATING PROTEINS [DUR+]			
	EPOGEN (rHuEPO) MIRCERA (methoxy polyethylene glycol-epoetin-beta) RETACRIT (rHuEPO)	ARANESP (darbepoetin) PROCRIT (rHuEPO) JESDUVROQ (daprodustat)	**Mircera** • Documented diagnosis of 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** • Have tried a preferred Retacrit or Epogen in the past 6 months **OR** • 1 claim for the requested agent in the past 105 days

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			Jesduvroq • Requires clinical review
FACTOR DEFICIENCY PRODUCTS			
	FACTOR VIII		
	ADVATE AFSTYLA ALPHANATE FEIBA NF HEMOFIL M HUMATE-P KOATE KOGENATE FS KOVALTRY NOVOEIGHT NUWIQ RECOMBINATE WILATE XYNTHA XYNTHA SOLOFUSE	ADYNOVATE ALTUVIIIO ELOCTATE ESPEROCT HEXILATE FS JIVI KCENTRA OBIZUR VONVENDI	
	FACTOR IX		
	ALPHANINE SD ALPROLIX BENEFIX IDELVION IXINITY MONONINE PROFILNINE	BEQVEZ[NR] REBINYN	

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	RIXUBIS		
	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 SAVELLA (milnacipran)	(duloxetine) DUR+ DRIZALMA SPRINKLES (duloxetine DR) duloxetine DR gabapentin ER GRALISE (gabapentin) HORIZANT (gabapentin) IRENKA (duloxetine) DUR+ LYRICA (pregabalin) LYRICA CR (pregabalin) NEURONTIN (gabapentin) pregabalin ER	Cymbalta, Drizalma sprinkles, and Irenka (see Antidepressants, Other)
FLUOROQUINOLONES DUR+			
	ciprofloxacin tablets levofloxacin tablets	AVELOX (moxifloxacin) BAXDELA (delaflozacin) CIPRO (ciprofloxacin) CIPRO SUSPENSION (ciprofloxacin) CIPRO XR (ciprofloxacin)	**Non-Preferred Criteria** • 1 claim for a preferred agent in the past 30 days

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		ciprofloxacin ER ciprofloxacin suspension FACTIVE (gemifloxacin) LEVAQUIN (levofloxacin) levofloxacin solution moxifloxacin NOROXIN (norfloxacin) ofloxacin	**Cipro Suspension for ages < 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 ages < 12 years** • Anthrax infection or exposure **OR** • 7 days of therapy with a preferred agent from 2 of the classes below in the past 3 months ○ Penicillin, 2nd or 3rd generation cephalosporin, or macrolide **AND** • Cipro suspension in the past 3 months
GAUCHER'S DISEASE			
	ELELYSO (taliglucerase alfa) ZAVESCA (miglustat)	CERDELGA (eliglustat) CEREZYME (imiglucerase) miglustat VPRIV (velaglucerase alfa)	

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
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			
	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 days of therapy with the requested agent in the past 105 days **ArmonAir Digihaler** • Requires clinical review Institutional sized products are Non-Preferred
GLUCOCORTICOID/BRONCHODILATOR COMBINATIONS			

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	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 days of therapy with 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)	
PROTON PUMP INHIBITORS			
	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** • Automatic approval issued for 0 - 2 years

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		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) SKYTROFA (lonapegsomatropin) SOGROYA (somapacitan) VOXZOGO (vosoritide) ZOMACTON (somatropin) ZORBTIVE (somatropin)	**Minimum Age Limit** • **3 years** – Ngenla **Maximum Age Limit** • **18 years** - Ngenla **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**

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			• Documented approvable pediatric diagnosis **OR** • Documented approvable pediatric diagnosis **Non-Preferred Criteria** • Documented approvable diagnosis for age as above **AND** • Have tried 1 preferred agent in the past 6 months **OR** • 84 days of therapy with 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 OMECLAMOX (omeprazole, clarithromycin, amoxicillin) PREVPAC (lansoprazole, amoxicillin, clarithromycin) TALICIA (omeprazole, amoxicillin, rifabutin) VOQUEZNA DUAL PAK (vonoprazan, amoxicillin) VOQUEZNA TRIPLE PAK (vonoprazan, amoxicillin, clarithromycin)	**Quantity Limit** • 1 treatment course/year
HEPATITIS B TREATMENTS			
	entecavir	adefovir dipivoxil	

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	EPIVIR HBV SOLUTION (lamivudine) lamivudine HBV tenofovir disoproxil fumarate	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) 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) ∞	**∞ Epclusa, Harvoni, Mavyret, Sovaldi, Vosevi, Zepatier** • Require MANUAL PA Epclusa, Harvoni, Mavyret and Sovaldi have FDA pediatric indications
HEREDITARY ANGIOEDEMA			

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		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
HYPOGLYCEMIA TREATMENT, GLUCAGON			
	BAQSIMI (glucagon) glucagen vial glucagon labeler 00002 ZEGALOGUE (dasiglucagon)	glucagon kit (labelers 63323, 00548) GVOKE (glucagon) Step Edit	**Minimum Age Limit** • **2 years** – Gvoke • **4 years** – Baqsimi • **6 years** – Zegalogue **Quantity Limit** • **2 packs/31 days –** Baqsimi

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			• **2 packs/31 days** – Gvoke, Zegalogue • **2 kits/31 days** – Glucagon **Gvoke** • 1 claim with preferred 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)	
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)	**Non-Preferred Criteria** • Have tried 2 different preferred DPP4 agents in the past 6 months **OR** • 90 days of therapy with the requested agent in the past 105 days

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		ONGLYZA (saxagliptin) * OSENI (alogliptin/pioglitazone) sitagliptin[NR] sitagliptin/metformin 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 of Type 2 Diabetes **OR** • 84 days of therapy with the requested agent in the past 105 days **Non-Preferred Criteria** • Documented diagnosis of Type 2 Diabetes **AND** • 84 days of therapy with Trulicity in the past 6 months **AND** • 84 days of therapy with either preferred Byetta or Victoza in the past 6 months **OR**

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			• Documented diagnosis of Type 2 Diabetes **AND** • 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+			
	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	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)	Insulin pen formulations are not covered for Long Term Care (LTC) beneficiaries. **Non-Preferred Criteria** • Documented diagnosis of Diabetes Mellitus **AND** • Have tried 1 preferred product in the past 6 months **OR** • 1 claim with the requested agent in the past 105 days

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	insulin lispro jr kwikpen insulin lispro kwikpen LANTUS SOLOSTAR & VIAL (insulin glargine) LEVEMIR FLEXPEN & VIAL (insulin detemir) TOUJEO (insulin glargine) TOUJEO MAX (insulin glargine)	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)	**Quantity Limit** • Insulin Quantity Limits found here
HYPOGLYCEMICS, MEGLITINIDES DUR+			
	nateglinide repaglinide	PRANDIMET (repaglinide/metformin) PRANDIN (repaglinide) repaglinide/metformin STARLIX (nateglinide)	
HYPOGLYCEMICS, SODIUM GLUCOSE COTRANSPORTER-2 INHIBITORS DUR+			
	HYPOGLYCEMICS, SODIUM GLUCOSE COTRANSPORTER-2 INHIBITORS		
	FARXIGA (dapagliflozin) INVOKANA (canagliflozin) JARDIANCE (empagliflozin)	dapagliflozin INPEFA (sotagliflozin) STEGLATRO (ertugliflozin)	**Non-Preferred Criteria** • Have tried 2 different preferred SGLT-2 inhibitors in the past 6 months **OR**

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			• 90 days of therapy with the requested agent in the past 105 days
	HYPOGLYCEMICS, SODIUM GLUCOSE COTRANSPORTER-2 INHIBITOR COMBINATIONS		
	INVOKAMET (canaglifozin/metformin) SYNJARDY (empagliflozin/metformin)	dapaglifozin/metformin GLYXAMBI (empagliflozin/linagliptin) INVOKAMET XR (canaglifozin/metformin) QTERN (dapagliflozin/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) AVANDAMET (rosiglitazone/metformin) AVANDARYL (rosiglitazone/glipizide) DUETACT (pioglitazone/glimepiride) pioglitazone/glimepiride	

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
IDIOPATHIC PULMONARY FIBROSIS DUR+			
	OFEV (nintedanib)	ESBRIET (pirfenidone) pirfenidone	**All Agents** • Documented diagnosis of 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) MYHIBBIN (mycophenolate mofetil oral suspension)NR PROGRAF (tacrolimus) REZUROCK (belumosudil) ZORTRESS (everolimus)	**Minimum Age Limit** • **13 years** – Rapamune • **18 years** – Zortress **Astagraf, Cellcept, Envarsus XR, Hecoria, Prograf** • Documented diagnosis of 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** • Clinical review required for a diagnosis of Kimura's disease or multifocal motor neuropathy

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			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	
IMMUNOLOGIC THERAPIES FOR ASTHMA			

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	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 agents require 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) TICANASE KIT (flonase kit) triamcinolone	**Non-Preferred Criteria** • Documented diagnosis of allergic rhinitis **AND** • Have tried 1 different preferred agent in the past 6 months

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		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)** AMITIZA 24 MCG, LINZESS 72 MCG, LINZESS 145 MCG, MOTEGRITY, TRULANCE

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			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** • Have tried 2 preferred CIC 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 **Irritable Bowel Syndrome – Constipation Dominant (IBS-C)** AMITIZA 8 MCG, IBSRELA, LINZESS 290 MCG, TRULANCE

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			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** • Documented diagnosis of IBS-C in the past year **AND** • No history of GI or bowel obstruction **AND** • Have tried 2 preferred IBS-C 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

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			Non- Preferred 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 **AND** • Have tried 1 preferred OIC agents in the past 6 months **OR** • 1 claim with the requested agent in the past 105 days **Relistor Injection** • Above OIC criteria **OR** • 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 active cancer in the past year
IRRITABLE BOWEL SYNDROME DIARRHEA			
	dicyclomine hyoscyamine	alosetron BENTYL (dicyclomine) LEVSIN (hyoscyamine) LEVSIN-SL (hyoscyamine) LOTRONEX (alosetron)	**Viberzi** • Documented diagnosis of Irritable Bowel Syndrome – Diarrhea

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		VIBERZI (eluxadoline)*	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 **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**

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			• 1 claim for an antiretroviral in the past 30 days **Short Bowel Syndrome (SBS) Gattex or Zorbtive** • 1 claim for the requested agent in the past 105 days **OR** • All new patients require clinical review
LEUKOTRIENE MODIFIERS DUR+			
	montelukast granules montelukast tablets zafirlukast	ACCOLATE (zafirlukast) SINGULAIR Tablets (montelukast) SINGULAR GRANULES (montelukast granules) zileuton ZYFLO CR (zileuton)	**Minimum Age Limit** • **12 years** – Zyflo & Zyflo CR **Non-Preferred Criteria** • Have tried 2 different preferred agents in the past 6 months
LIPOTROPICS, OTHER (NON-STATINS)			
ACL INHIBITORS AND COMBINATIONS			
		NEXLETOL (bempedoic acid) NEXLIZET (bempedoic acid/ezetimibe)	**Nexletol and Nexlizet** • Require clinical review
ANGIOPOIETIN LIKE 3 INHIBITORS			
		EVKEEZA (evinacumab-dgnb)	

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
			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)	**Welchol** • Documented diagnosis of Type 2 Diabetes **AND** • 30 days of therapy with an antidiabetic agent in the past 6 months **OR** • 90 days of therapy with Welchol in the past 105 days
	OMEGA-3 FATTY ACIDS		
	omega 3 acid ethyl esters	icosapent LOVAZA (omega-3-acid ethyl esters) VASCEPA (icosapent ethyl)	
	CHOLESTEROL ABSORPTION INHIBITORS		
	ezetimibe	ZETIA (ezetimibe)	
	FIBRIC ACID DERIVATIVES		
	fenofibrate nanocrystallized gemfibrozil	ANTARA (fenofibrate, micronized) fenofibrate 40mg tablet fenofibrate, micronized fenofibric acid FENOGLIDE (fenofibrate) FIBRICOR (fenofibric acid)	**Fibric Acid Derivative Non-Preferred Criteria** • Have tried 2 different fibric acid derivatives in the past 6 months

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		LIPOFEN (fenofibrate) LOFIBRA (fenofibrate) LOPID (gemfibrozil) TRICOR (fenofibrate nanocrystallized) TRIGLIDE (fenofibrate) TRILIPIX (fenofibric acid)	
MTP INHIBITOR			
		JUXTAPID (lomitapide)	Juxtapid – MANUAL PA
APOLIPOPROTEIN B-100 SYNTHESIS INHIBITOR			
		KYNAMRO (mipomersen)	**Kynamro** • Requires clinical review
NIACIN			
	niacin ER NIACOR (niacin)	NIASPAN (niacin)	
PCSK-9 INHIBITOR			
	PRALUENT (alirocumab) REPATHA (evolocumab)	LEQVIO (inclisiran)	**Leqvio** • Requires clinical review Praluent - MANUAL PA Repatha - MANUAL PA
LIPOTROPICS, STATINS DUR+			
STATINS			

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

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

Drugs highlighted in yellow denote a change in PDL status.

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

A # denotes existing users will NOT be grandfathered.

To search the PDL, press CTRL + F

MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

(For All Medicaid, MSCAN and CHIP Beneficiaries)

EFFECTIVE 7/1/2024
Version 2024_9
Updated: 7/02/2024

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	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 days of therapy with 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) LIPTRUZET (atorvastatin/ezetimibe) VYTORIN (simvastatin/ezetimibe)	**Non-Preferred Criteria** • Have tried 2 different preferred statin or statin combination agents in the past 6 months **OR** • 90 days of therapy with 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)	**Quantity Limit** • **2 kits/31 days** – epinephrine

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		EPIPEN (epinephrine) EPIPEN JR (epinephrine)	
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			
	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 SPRINKLE CAP (valbenazine)[NR]	**Austedo and Austedo XR**

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	INGREZZA (valbenazine) tetrabenazine (all labelers except those listed as non-preferred)	tetrabenazine (labeler 47335, 51224, 60505, 68180, 686820 XENAZINE (tetrabenazine)	• Documented diagnosis of Huntington's chorea **OR** • Documented diagnosis of tardive dyskinesia **AND** • 90 days of therapy with Austedo or Austedo XR in the past 105 days **OR** • **MANUAL PA** **Ingrezza** • Documented diagnosis of Huntington's chorea **OR** • Documented diagnosis of tardive dyskinesia **AND** • 90 days of therapy with Ingrezza in the past 105 days **OR** • **MANUAL PA**
MULTIPLE SCLEROSIS AGENTS DUR+			
	AVONEX (interferon beta-1a) AVONEX PEN (interferon beta-1a) BETASERON (interferon beta-1b) COPAXONE 20mg (glatiramer) dalfampridine dimethyl fumarate fingolimod GILENYA (fingolimod) REBIF (interferon beta-1a) REBIF REBIDOSE (interferon beta-1a)	AMPYRA (dalfampridine) AUBAGIO (teriflunomide) BAFIERTAM (monomethyl fumarate) BRIUMVI (ublituximab) COPAXONE 40mg (glatiramer) EXTAVIA (interferon beta-1b) glatiramer GLATOPA (glatiramer) KESIMPTA (ofatumumab) MAVENCLAD (cladribine)	**All Agents** • Documented diagnosis of multiple sclerosis **Non-Preferred Criteria** • Documented diagnosis of multiple sclerosis **AND** • Have tried 2 different preferred agents in the past 6 months **OR** • 3 claims with the requested agent in the last 105 days

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	teriflunomide TYSABRI (natalizumab)	MAYZENT (siponimod) OCREVUS (ocrelizumab) PLEGRIDY (interferon beta-1a) PONVORY (ponesimod) TASCENSO ODT (fingolimod) TECFIDERA (dimethyl fumarate) VUMERITY (diroximel fumarate) ZEPOSIA (ozanimod)	**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 – Manual PA** **Exondys – MANUAL PA** **Viltepso –MANUAL PA** **Vyondys – MANUAL PA**
NSAIDS DUR+			
	NON-SELECTIVE		
	diclofenac EC diclofenac IR diclofenac SR etodolac IR tab flurbiprofen ibuprofen ibuprofen suspension[OTC] indomethacin ketoprofen	ADVIL (ibuprofen) ANAPROX (naproxen) CAMBIA (diclofenac potassium) CATAFLAM (diclofenac) DAYPRO (oxaprozin) diclofenac potassium etodolac cap etodolac tab SR FELDENE (piroxicam)	**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

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	ketorolac nabumetone naproxen 250mg and 500mg naproxen suspension piroxicam sulindac	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) RELAFEN DS (nabumetone) SPRIX NASAL SPRAY (ketorolac) TIVORBEX (indomethacin) tolmetin VOLTAREN XR (diclofenac) ZIPSOR (diclofenac) ZORVOLEX (diclofenac)	
	NSAID/GI PROTECTANT COMBINATIONS		

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		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 **Non-Preferred Criteria – COX II** • Documented diagnosis of Osteoarthritis, Rheumatoid Arthritis, Familial Adenomatous Polyposis, or Ankylosing Spondylitis **AND** • 90 days of therapy with the requested agent in the past 105 days **OR** • Have tried 1 preferred COX-II Selective AND 1 preferred Non-Selective Agent **OR** • Documented diagnosis of GI Bleed, GERD, PUD, GI Perforation, or Coagulation Disorder **AND** • Have tried 1 preferred COX-II Selective agent **Elyxyb** • Requires clinical review
COX II SELECTIVE			
	meloxicam	CELEBREX (celecoxib) celecoxib ELYXYB (celecoxib) MOBIC (meloxicam) NULOX (meloxicam) QMIIZ ODT (meloxicam) VIVLODEX (meloxicam)	
OPHTHALMIC ANTIBIOTICS			
	bacitracin/neomycin/gramicidin bacitracin/polymyxin	AZASITE (azithromycin) bacitracin	

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	ciprofloxacin erythromycin GENTAK Ointment (gentamicin) gentamicin ILOTYCIN (erythromycin) moxifloxacin ofloxacin polymyxin/trimethoprim tobramycin	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) 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	gatifloxacin/prednisolone MAXITROL (neomycin/polymyxin/dexamethasone) neomycin/polymyxin/gramicidin neomycin/polymyxin/hydrocortisone	

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	tobramycin/dexamethasone suspension TOBRADEX OINTMENT (tobramycin/dexamethasone) ZYLET (loteprednol/tobramycin)	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 PRED MILD (prednisolone) VEXOL (rimexolone)	ACULAR (ketorolac) ACULAR LS (ketorolac) ACUVAIL (ketorolac) BROMDAY (bromfenac) bromfenac BROMSITE (bromfenac) DUREZOL (difluprednate) FML (fluorometholone) ILEVRO (nepafenac) INVELTYS (loteprednol etabonate) LOTEMAX (loteprednol) LOTEMAX SM (loteprednol) loteprednol etabonate OCUFEN (flurbiprofen) OMNIPRED (prednisolone) NEVANAC (nepafenac) PRED FORTE (prednisolone) PROLENSA (bromfenac) VOLTAREN (diclofenac)	**Non-Preferred Criteria** • Have tried 2 different preferred agents in the past 6 months
OPHTHALMICS FOR ALLERGIC CONJUNCTIVITIS DUR+			

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

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			• History of 4 claims for Restasis in the past 6 months
OPHTHALMIC, GLAUCOMA AGENTS DUR+			
	BETA BLOCKERS		**Minimum Age Limit** • **18 years** – Iyuzeh **Non-Preferred Criteria** • Have tried 2 different preferred agents in the past 6 months **OR** • 90 days of therapy with the requested agent in the past 105 days
	BETIMOL (timolol) carteolol ISTALOL (timolol) levobunolol metipranolol timolol drops 0.25%, 0.5%	BETAGAN (levobunolol) betaxolol BETOPTIC S (betaxolol) OPTIPRANOLOL (metipranolol) timolol gel timolol daily drop 0.5% (generic Istalol) TIMOPTIC (timolol) TIMOPTIC XE (timolol)	
	CARBONIC ANHYDRASE INHIBITORS		
	dorzolamide	AZOPT (brinzolamide) TRUSOPT (dorzolamide)	
	COMBINATION AGENTS		
	COMBIGAN (brimonidine/timolol) dorzolamide/timolol SIMBRINZA (brinzolamide/brimonidine)	COSOPT (dorzolamide/timolol) COSOPT PF (dorzolamide/timolol)	
	PARASYMPATHOMIMETICS		

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	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)		
	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		

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	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 ofloxacin	ciprofloxacin ciprofloxacin/dexamethasone ciprofloxacin/fluocinolone DERMOTIC (fluocinolone) FLAC OIL DROP (fluocinolone oil) hydrocortisone/acetic acid drop fluocinolone oil OTIPRIO (ciprofloxacin) OTOVEL (ciprofloxacin/fluocinolone)	**Maximum Age Limit** • **9 years** – Cipro HC **Ciprofloxacin/Dexamethasone Suspension Criteria** • Age 6 months or older **AND** • Experiencing otorrhea secondary to recent post tympanostomy tube placement **AND** • Have tried 10 days otic treatment with ofloxacin or ciprofloxacin ophthalmic solution with continued otorrhea

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
PANCREATIC ENZYMES DUR+			
	CREON (pancreatin) ZENPEP (pancrelipase)	PANCREAZE (pancrelipase) PERTZYE (pancrelipase) VIOKACE (pancrelipase)	**Non-Preferred Criteria** • Have tried 2 different preferred agents in the past 6 months
PARATHYROID AGENTS			
	calcitriol ergocalciferol paricalcitol ROCALTROL (calcitriol) ZEMPLAR (paricalcitol)	cinacalcet doxercalciferol DRISDOL (ergocalciferol) HECTOROL (doxercalciferol) NATPARA (parathyroid hormone) RAYALDEE (calcifediol) SENSIPAR (cinacalcet)	
PHOSPHATE BINDERS			
	calcium acetate ELIPHOS (calcium acetate) PHOSLYRA (calcium acetate) sevelamer carbonate tablets	AURYXIA (ferric citrate) FOSRENOL (lanthanum) lanthanum PHOSLO (calcium acetate) RENAGEL (sevelamer HCl) RENVELA (sevelamer carbonate) sevelamer carbonate powder packets sevelamer HCl VELPHORO (sucroferric oxyhydronxide) XPHOZAH (tenapanor)	

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
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)	**Non-Preferred Criteria** • Documented diagnosis **AND** • Have tried 2 different preferred agents in the past 6 months **OR** • 90 days of therapy with the requested agent in the past 105 days **Zontivity – MANUAL PA**
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) VELTASSA (patiromer calcium sorbitex)	**Lokelma** • Requires clinical review
PRENATAL VITAMINS			
	CLASSIC PRENATAL COMPLETE NATAL DHA COMPLETENATE CHEW M-NATAL PLUS NIVA PLUS PNV, Ca 72/Fe/FA	Products not listed are assumed to be Non-Preferred.	

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	PNV 95/Fe/FA PNV 103/Fe/FA PNV 124/Fe/FA PNV 137/Fe/FA (labeler 00904) PRENATAL PLUS VITAMIN-MINERAL PRENATAL SE-NATAL 19 CHEW SE-NATAL 19 STUART ONE TENDRA-OB THRIVITE RX TRINATAL RX 1 WESNATAL DHA COMPLETE WESTAB PLUS		
PSEUDOBULBAR AFFECT AGENTS DUR+			
		NUEDEXTA (dextromethorphan/quinidine)	**Non-Preferred Criteria** • 90 days of therapy with the requested agent in the past 105 days **OR** • Documented diagnosis of Pseudobulbar Affect
PULMONARY ANTIHYPERTENSIVES DUR+			
ENDOTHELIN RECEPTOR ANTAGONIST			
	ambrisentan (all labelers except those listed as non-preferred) bosentan tablets	ambrisentan (labeler 42794, 47335, 498840) LETAIRIS (ambrisentan)* OPSUMIT (macitentan) OPSYNVI (macitentan/tadalafil)NR TRACLEER (bosentan)	**All PAH Agents** • Documented diagnosis of pulmonary hypertension

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		TRYVIO (aprocitentan)[NR] WINREVAIR (sotatercept-csrk)[NR]	**Non-Preferred Criteria** • Documented diagnosis of pulmonary hypertension **AND** • Have tried 1 preferred PAH agent in the past 6 months **OR** • 90 days of therapy with the requested agent in the past 105 days
	PDE5's		
	sildenafil (generic Revatio) tablet tadalafil	ADCIRCA (tadalafil) LIQREV (sildenafil) suspension REVATIO (sildenafil) tablet REVATIO (sildenafil) suspension sildenafil (generic Revatio) suspension TADLIQ (tadalafil) suspension	**Non-Preferred Criteria** • Documented diagnosis of pulmonary hypertension **AND** • Have tried 1 preferred PAH agent in the past 6 months **OR** • 90 days of therapy with the requested agent in the past 105 days **Revatio suspension** • < 12 years of age **AND** • Documented diagnosis of Pulmonary Hypertension, Patent Ductus Arteriosus, or Persistent Fetal Circulation or history of heart transplant **OR** • 90 days of therapy with the requested agent in the past 105 days

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			Revatio tablets • < 1 year of age **AND** • Documented diagnosis of Pulmonary Hypertension, Patent Ductus Arteriosus, or Persistent Fetal Circulation **OR** • 90 days of therapy with the requested agent in the past 105 days **OR** • > 1 years of age **AND** • Documented diagnosis of Pulmonary Hypertension
	PROSTACYCLINS		
		ORENITRAM ER (treprostinil) TYVASO (treprostinil) VENTAVIS (iloprost)	**Non-Preferred Criteria** • Documented diagnosis of pulmonary hypertension **AND** • Have tried 1 preferred PAH agent in the past 6 months **OR** • 90 days of therapy with the requested agent in the past 105 days
	SELECTIVE PROSTACYCLIN RECEPTOR AGONISTS		
		UPTRAVI (selexipag)	**Non-Preferred Criteria** • Documented diagnosis of pulmonary hypertension **AND** • Have tried 1 preferred PAH agent in the past 6 months **OR** 90 days of therapy with the requested agent in the past 105 days

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	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 days of therapy with the requested agent in the past 105 days
ROSACEA TREATMENTS			
	metronidazole (cream, gel, lotion)	AVAR (sulfacetamide sodium/sulfur) FINACEA (azelaic acid) FINACEA FOAM (azelaic acid) METROCREAM (metronidazole cream) METROGEL (metronidazole gel) METROLOTION (metronidazole lotion) MIRVASO (brimonidine) NORITATE (metronidazole) OVACE (sulfacetamide sodium) RHOFADE (oxymetazoline HCl) ROSULA (sodium sulfacetamide/sulfur)	Topical Sulfonamides used for Rosacea will require a manual PA for ≥21 years. Other labeled indications are limited to <21 years.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		sodium sulfacetamide/sulfur (cleanser, pads, suspension) SOOLANTRA (ivermectin) SUMADAN (sodium sulfacetamide/sulfur wash) SUMAXIN (sodium sulfacetamide/sulfur pads) SUMAXIN TS (sodium sulfacetamide/sulfur suspension) ZILXI AEROSOL (minocycline)	
SEDATIVE HYPNOTICS			
BENZODIAZEPINES DUR+			
	estazolam flurazepam temazepam (15mg and 30mg)	DALMANE (flurazepam) DORAL (quazepam) HALCION (triazolam) quazepam RESTORIL (temazepam) temazepam (7.5mg and 22.5mg) triazolam	Single source benzodiazepines and barbiturates are NOT covered – NO PA's will be issued for these drugs. **MS DOM Opioid Initiative** • Concomitant use of Opioids and Benzodiazepines Criteria details found here **Quantity Limit – CUMULATIVE** Quantity limit per rolling days for all strengths. DUR+ will allow an early refill override for one dose or therapy change per year. • **31 units/31 days** **Triazolam – CUMULATIVE** Quantity limit per rolling days for all strengths • **10 units/31 days**

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			• **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) zolpidem ER zolpidem SL ZOLPIMIST (zolpidem)	**Maximum Age Limit** • **64 years** – zolpidem 7.5 mg, zolpidem 10 mg, zolpidem 12.5 mg **Quantity Limit – CUMULATIVE** Quantity limit per rolling days for all strengths. DUR+ will allow an early refill override for one dose or therapy change per year. • **31 units/31 days** • **1 canister/31 days** – Zolpimist & male • **1 canister/62 days** – Zolpimist & female • **1 bottle/31 days** (48 ml or 158 ml) – Hetlioz liquid **Gender and Dose Limit for zolpidem** • **Female** – Ambien 5 mg, Ambien CR 6.25 mg, Intermezzo 1.75 mg • **Male** – Zolpidem all strengths **Non-Preferred Criteria** • Have tried 2 different preferred agents in the past 6 months

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			Hetlioz capsules • Documented diagnosis of circadian rhythm sleep disorder **AND** • Documented diagnosis indicating total blindness **OR** • Documented diagnosis of Magenis-Smith syndrome **Hetlioz liquid** • Documented diagnosis of Smith-Magenis syndrome **AND** • 3 - 15 years of age
SELECT CONTRACEPTIVE PRODUCTS			
INJECTABLE CONTRACEPTIVES			
	medroxyprogesterone acetate IM	DEPO-PROVERA IM (medroxyprogesterone acetate) DEPO-SUBQ PROVERA 104 (medroxyprogesterone acetate)	
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)	**Non-Preferred Criteria** • 1 claim with the requested agent in the past 105 days

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		BEYAZ (ethinyl estradiol / drospirenone/levomefolate) CAMRESE (levonorgestrel/ethinyl estradiol) CAMRESE LO (levonorgestrel/ethinyl estradiol) GENERESS FE (norethindrone/ethinyl estradiol/fe) GIANVI (ethinyl estradiol/drospirenone) JOLESSA (levonorgestrel/ethinyl estradiol) levonorgestrel/ethinyl estradiol LO LOESTRIN FE (norethindrone/ethinyl estradiol) LOESTRIN (norethindrone acetate/ethinyl estradiol) LOESTRIN FE (norethindrone/ethinyl estradiol/iron) MINASTRIN 24 FE (norethindrone/ethinyl estradiol/iron) NATAZIA (estradiol valerate/dienogest) NEXTSTELLIS (drospirenone/estetrol) OCELLA (ethinyl estradiol/drospirenone) SAFYRAL (ethinyl estradiol/ drospirenone/levomefolate) SIMPESSE (levonorgestrel/ethinyl estradiol) TAYTULLA (norethindrone/ethinyl estradiol/iron) TYDEMY (ethinyl estradiol/drospirenone/ levomefolate calcium) YASMIN (ethinyl estradiol/drospirenone) YAZ (ethinyl estradiol/drospirenone)	

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	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 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	**Quantity Limit** **84 tablets/180 days** – carisoprodol **Non-Preferred Agents** • Documented diagnosis of an approvable indication **AND** • Have tried 2 different preferred agents in the past 6 months **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**

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		orphenadrine compound orphenadrine ER PARAFON FORTE DSC (chlorzoxazone) ROBAXIN (methocarbamol) SKELAXIN (metaxalone) SOMA (carisoprodol) tizanidine capsules ZANAFLEX (tizanidine)	• 1 claim for cyclobenzaprine in the past 21 **Carisoprodol with codeine** • Requires clinical review
SMOKING DETERRENT			
	NICOTINE TYPE		
	nicotine gum[OTC] nicotine lozenge[OTC] nicotine mini lozenge[OTC] nicotine patch[OTC]	NICODERM CQ PATCH[OTC] NICORETTE GUM[OTC] NICORETTE LOZENGE [OTC] NICORETTE MINI LOZENGE[OTC] NICOTROL INHALER CARTRIDGE NICOTROL NASAL SPRAY	
	NON-NICOTINE TYPE		
	bupropion ER CHANTIX (varenicline) varenicline	ZYBAN (bupropion)	**Minimum Age Limit** • **18 years** – **Chantix** **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		

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

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		DIPROLENE AF (betamethasone diprop/prop gly) ELOCON (mometasone) fluocinonide HALOG (halcinonide) KENALOG (triamcinolone) PEDIADERM TA (triamcinolone) SERNIVO (betamethasone dipropionate) TOPICORT (desoximetasone) TRIANEX (triamcinolone) VANOS (fluocinonide)	
VERY HIGH POTENCY			
	clobetasol lotion clobetasol shampoo, spray clobetasol propionate cream clobetasol propionate ointment halobetasol cream halobetasol ointment	BRYHALI (halobetasol) clobetasol emollient clobetasol propionate foam, ge CLOBEX (clobetasol) DIPROLENE (betamethasone diprop/prop gly) DUOBRII LOTION (halobetasol prop/tazarotene) halobetasol foam IMPEKLO (clobetasol) LEXETTE (halobetasol propionate) OLUX (clobetasol) OLUX-E (clobetasol) TEMOVATE Cream (clobetasol propionate) TEMOVATE Ointment (clobetasol propionate) TOVET Foam (clobetasol) ULTRAVATE Lotion (halobetasol)	**Non-Preferred Criteria** • Have tried 2 different preferred very high potency agents in the past 6 months

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
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 • **310 ml/31 days** – Methylin solution, Procentra **Non-Preferred Criteria Short Acting 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

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			Non-Preferred Criteria Short Acting Narcolepsy ADDERALL, EVEKEO, METHYLIN, PROCENTRA, RITALIN, ZENZEDI • 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
	LONG-ACTING		
	ADDERALL XR (amphetamine salt combination) amphetamine salt combination ER CONCERTA (methylphenidate) dexmethylphenidate ER dextroamphetamine ER DYANAVEL XR SUSPENSION(amphetamine) lisdexamfetamine (generic Vyvanse) lisdexamfetamine (generic Vyvanse Chewable) methylphenidate CD (generic Metadate CD)	ADHANSIA XR (methylphenidate) ADZENYS XR ODT (amphetamine) ADZENYS ER SUSPENSION (amphetamine) amphetamine susp 24 hr (generic ADZENYS ER) APTENSIO XR (methylphenidate) AZSTARYS (serdexmethylphen/dexmethylphen) COTEMPLA XR-ODT (methylphenidate) DAYTRANA (methylphenidate) DEXEDRINE (dextroamphetamine)	**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 PM, Metadate CD, Quillichew, Quillivant XR, Relexxii ER, Ritalin LA, Vyvanse, Xelstrym

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	methylphenidate ER (generic Concerta) methylphenidate ER Tabs (generic Ritalin SR) methylphenidate ER/LA Caps (generic Ritalin LA) QUILLICHEW (methylphenidate) QUILLIVANT XR (methylphenidate)	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)	• **13 years** – Mydayis • **16 years** – Provigil • **18 years** – Nuvigil, Sunosi **Maximum Age Limit** • **18 years** – Cotempla XR ODT, Daytrana **Quantity Limit** **Applicable quantity limit per rolling days** • **31 tablets/31 days** – Adderall XR, Adhansia XR, Adzenys XR ODT, Aptensio XR, Azstarys, Concerta 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, 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

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			Non-Preferred Criteria Long Acting 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 **Vyvanse** • Documented diagnosis of binge eating disorder **OR** • Documented diagnosis of ADD/ADHD
	NARCOLEPSY		
	armodafinil modafinil SUNOSI (solriamfetol)	LUMRYZ (sodium oxybate)NR NUVIGIL (armodafinil) PROVIGIL (modafinil) sodium oxybate WAKIX (pitolisant) XYREM (sodium oxybate) XYWAV (calcium, magnesium, potassium and sodium oxybates)	**Non-Preferred Criteria Long Acting Narcolepsy** ADDERALL XR, APTENSIO XR, CONCERTA ER, DEXEDRINE, METADATE CD, METHYLIN ER, MYDAYIS, NUVIGIL, PROVIGIL, QUILLICHEW, QUILLIVANT XR, RITALIN LA, SUNOSI • Documented diagnosis of narcolepsy **AND**

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			• 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** • Documented diagnosis of narcolepsy or obstructive sleep apnea **AND** • 30 days of therapy with preferred modafinil or armodafinil in the past 6 months

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			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** • **18 years** – Intuniv, Clonidine ER, Qelbree • **21 years** – Strattera will approve with a diagnosis of ADD/ADHD

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			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) minocycline caps IR tetracycline	ACTICLATE (doxycyline) ADOXA (doxycycline monohydrate) demeclocycline doxycycline hyclate (generic Doryx) doxycycline hyclate (generic Periostat) doxycycline monohydrate caps (75mg & 150mg) doxycycline monohydrate tabs	**Non-Preferred Agents** • Have tried 2 different preferred agents in the past 6 months **Demeclocycline** • Documented diagnosis of SIADH will allow automatic approval

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		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)	
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) PENTASA 250mg (mesalamine) PENTASA 500mg (mesalamine) sulfasalazine UCERIS (budesonide)	AZULFIDINE (sulfasalazine) AZULFIDINE ER (sulfasalazine) budesonide ER tablets COLAZAL (balsalazide) DELZICOL (mesalamine) DIPENTUM (olsalazine) ENTOCORT EC (budesonide) mesalamine tablet (generic Asacol HD) mesalamine capsules (generic Delzicol) ORTIKOS (budesonide)	**Non-Preferred Criteria** • Documented diagnosis of Ulcerative Colitis **AND** • Have tried 2 different preferred agents in the past 6 months **OR** • 90 days of therapy with the requested agent in the past 105 days **Velsipity** • Requires clinical review

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