MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

(For All Medicaid, MSCAN and CHIP Beneficiaries)

EFFECTIVE 01/01/2025
Version 2024_15
Updated: 01/01/2025

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

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

Drugs highlighted in yellow denote a change in PDL status.

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		DIFFERIN (adapalene) 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) SSS 10/5 Cream (sodium sulfacetamide/sulfur)	ACANYA (benzoyl peroxide/clindamycin) adapalene/benzoyl peroxide (generic EPIDUO FORTE) BENZAMYCIN gel (benzoyl peroxide/ erythromycin) BPO towelette CABTREO (clindamycin phosphate/adapalene/ benzoyl peroxide) CLINDACIN ETZ kit/med swab CLINDACIN foam CLINDACIN P med swab clindamycin phosphate-benzoyl peroxide gel 1.2-3.75% (generic ONEXTON) EPIDUO (adapalene/benzoyl peroxide) EPIDUO FORTE (adapalene/benzoyl peroxide) EPSOLAY (benzoyl peroxide) erythromycin/benzoyl peroxide NEUAC (benzoyl peroxide/clindamycin) ONEXTON (benzoyl peroxide/clindamycin)	

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		sodium sulfacetamide/sulfur cleanser/cream/lotion/pads sulfacetamide sodium w/ sulfur suspension 10-5% SSS 10/5 Foam (sodium sulfacetamide/sulfur) sulfacetamide sodium/sulfur/urea VELTIN (clindamycin/tretinoin) 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 (isotretinoin) AMNESTEEM (isotretinoin) CLARAVIS (isotretinoin) MYORISAN (isotretinoin) ZENATANE (isotretinoin)	ABSORICA (isotretinoin) ABSORICA LD (isotretinoin) isotretinoin	Available for all ages
ALPHA-1 PROTEINASE INHIBITORS			
	ARALAST (alpha-1 proteinase inhibitor) GLASSIA (alpha-1 proteinase inhibitor) PROLASTIN C (alpha-1 proteinase inhibitor) ZEMAIRA (alpha-1 proteinase inhibitor)		

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ALZHEIMER'S AGENTS DUR+			
CHOLINESTERASE INHIBITORS			
	donepezil (tablets and ODT) 5mg, 10mg galantamine galantamine ER rivastigmine capsules rivastigmine patches	ADLARITY (donepezil) ARICEPT (donepezil) ARICEPT 23 MG (donepezil) ARICEPT ODT (donepezil) donepezil 23mg EXELON Capsules (rivastigmine) EXELON Patches (rivastigmine) EXELON Solution (rivastigmine) RAZADYNE (galantamine) RAZADYNE ER (galantamine)	**Preferred Criteria** • Documented approvable diagnosis **Non-Preferred Criteria** • Documented approvable diagnosis **AND** • Have tried 2 different preferred agents in the past 6 months
NMDA RECEPTOR ANTAGONIST			
	memantine	NAMENDA TABS (memantine) NAMENDA SOLUTION (memantine) NAMENDA XR (memantine) memantine XR	
COMBINATION AGENTS			
		NAMZARIC (memantine/donepezil)	**Namzaric** • Documented diagnosis **AND** • 30 days of concurrent therapy with both donepezil and memantine in the past 6 months
ANALGESICS, OPIOID- SHORT ACTING DUR+			
	acetaminophen/codeine benzhydrocodone/APAP	ABSTRAL (fentanyl) ACTIQ (fentanyl)	**MS DOM Opioid Initiative** • Morphine Equivalent Daily Dose

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	codeine dihydrocodeine/APAP/caffeine ENDOCET (oxycodone/APAP) hydrocodone/APAP hydromorphone morphine oxycodone capsules oxycodone liquid oxycodone tablets oxycodone/APAP **(oxycodone/APAP 325MG)** oxycodone/aspirin oxycodone/ibuprofen pentazocine/APAP tramadol tramadol/APAP	APADAZ (benzhydrocodone/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) oxycodone/APAP (**oxycodone/APAP 300MG)**	• 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

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		oxymorphone pentazocine/naloxone 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)	

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ANALGESICS, OPIOID - LONG ACTING DUR+			
	BUTRANS (buprenorphine) fentanyl patches morphine ER tablets XTAMPZA (oxycodone myristate)	ARYMO ER (morphine) BELBUCA (buprenorphine) buprenorphine patch CONZIP ER (tramadol) DOLOPHINE (methadone) DURAGESIC (fentanyl) 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)	**MS DOM Opioid Initiative** • Morphine Equivalent Daily Dose • Concomitant use of Opioids and Benzodiazepines 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

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ANALGESICS/ANESTHETICS (Topical)			
	diclofenac sodium 1% gel diclofenac sodium 1.5% solution lidocaine 4% cream OTC lidocaine 5% ointment lidocaine 5% patch lidocaine/prilocaine	capsaicin DERMACINRX LIDOCAN (lidocaine) diclofenac epolamine patch DUR+ diclofenac sodium 3% gel FLECTOR Patch (diclofenac epolamine) DUR+ FROTEK (ketoprofen) LICART (diclofenac epolamine) LIDAMANTLE HC (lidocaine/hydrocortisone) LIDOCAN II, III, IV, V (lidocaine) LIDO TRANS PAK (lidocaine) LIDODERM (lidocaine) DUR+ LIDTOPIC MAX (lidocaine) PENNSAID 2% Solution (diclofenac sodium)DUR+ SYNERA (lidocaine/tetracaine) TRANZAREL (lidocaine) TRIDACAINE II, III (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 (112 ml)–** Diclofenac 2% solution pump • **1 bottle/31 days (150ml)** – Diclofenac 1.5% solution **Non-Preferred Criteria** • Have tried 2 preferred agents 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 testosterone gel pump testosterone pump	ANDROGEL (testosterone gel) ANDROXY (fluoxymesterone) AXIRON (testosterone gel) FORTESTSA (testosterone gel)	**All Agents** • Limited to male gender

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		JATENZO (testosterone undecanoate) NATESTO (testosterone) STRIANT (testosterone) TESTIM (testosterone gel) TLANDO (testosterone) UNDECATREX (testosterone undecanoate)NR 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 enalapril/HCTZ fosinopril/HCTZ	ACCURETIC (quinapril/HCTZ) CAPOZIDE (captopril/HCTZ) LOTENSIN HCT (benazepril/HCTZ) LOTREL (benazepril/amlodipine) moexipril/HCTZ	**Non-Preferred Criteria** **ACE Inhibitor/CCB** • Have tried 2 different preferred ACEI/CCB agents in the past 6 months **OR**

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	lisinopril/HCTZ quinapril/HCTZ trandolapril/verapamil	PRESTALIA (perindopril/amlodipine) PRINZIDE (lisinopril/HCTZ) TARKA (trandolapril/verapamil) UNIRETIC (moexipril/HCTZ) VASERETIC (enalapril/HCTZ) ZESTORETIC (lisinopril/HCTZ)	• 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 olmesartan/amlodipine olmesartan/HCTZ telmisartan/HCTZ	ATACAND-HCT (candesartan/HCTZ) AVALIDE (irbesartan/HCTZ) AZOR (olmesartan/amlodipine) BENICAR-HCT (olmesartan/HCTZ) BYVALSON (nebivolol/valsartan) candesartan/HCTZ	**Entresto** • Age ≥ 18 years **AND** • Documented diagnosis of heart failure **OR** • Age ≥ 1 year **AND**

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

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DIRECT RENIN INHIBITOR COMBINATIONS			
		TEKTURNA-HCT (aliskiren/hctz)	**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			
	metronidazole tablets neomycin tinidazole vancomycin solution (generic FIRVANQ)	AEMCOLO (rifaximin) DIFICID (fidaxomicin) FIRVANQ (vancomycin) FLAGYL (metronidazole) FLAGYL ER (metronidazole) LIKMEZ (metronidazole) metronidazole capsules paromomycin REBYOTA (fecal microbiota) TINDAMAX (tinidazole) VANCOCIN (vancomycin) vancomycin VOWST (fecal microbiota) XIFAXAN (rifaximin)	

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
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 capsule nitrofurantoin monohydrate macrocrystals	FURADANTIN (nitrofurantoin) MACROBID (nitrofurantoin monohydrate macrocrystals) MACRODANTIN (nitrofurantoin) nitrofurantoin suspension	

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MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

(For All Medicaid, MSCAN and CHIP Beneficiaries)

EFFECTIVE 01/01/2025
Version 2024_15
Updated: 01/01/2025

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
OXAZOLIDINONES			
		SIVEXTRO (tedizolid) ZYVOX (linezolid)	**Sivextro – MANUAL PA** **Zyvox - MANUAL PA** **Quantity Limit** • **6 tablets/month** – Sivextro
ANTIBIOTICS (Topical)			
	bacitracin OTC bacitracin/polymyxin 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 CREAM (clindamycin) CLEOCIN OVULES (clindamycin) metronidazole vaginal NUVESSA (metronidazole)	AVC (sulfanilamide) clindamycin cream CLINDESSE (clindamycin) METROGEL (metronidazole) SOLOSEC (secnidazole) VANDAZOLE (metronidazole) XACIATO GEL (clindamycin)	
ANTICOAGULANTS			
ORAL			
	COUMADIN (warfarin) ELIQUIS (apixaban)	BEVYXXA (betrixaban) PRADAXA PELLETS (dabigatran)	**Non-Preferred Criteria**

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	PRADAXA (dabigatran) warfarin XARELTO (rivaroxaban)	SAVAYSA (odonatan tosylate)	• 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 divalproex sprinkle EPIDIOLEX (cannabidiol) EPITOL (carbamazepine) gabapentin lacosamide lamotrigine	APTIOM (eslicarbazepine) BANZEL (rufinamide) BRIVIACT (brivaracetam) carbamazepine XR CARBATROL (carbamazepine) DEPAKENE (valproic acid) DEPAKOTE (divalproex) DIACOMIT (stiripentol) ELEPSIA XR (levetiracetam) EPRONTIA (topiramate solution) EQUETRO (carbamazepine) felbamate FELBATOL (felbamate) FINTEPLA (fenfluramine)	**Minimum Age Limit** • **6 months**-- Diacomit • **1 year** – Banzel, Epidiolex • **2 years** –Onfi, Sympazan **Epidiolex** • Documented diagnosis of Dravet syndrome. Lennox Gastaut syndrome or seizures associated with tuberous sclerosis complex **OR**

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	levetiracetam levetiracetam ER oxcarbazepine tiagabine topiramate tablet topiramate sprinkle capsule TRILEPTAL Suspension (oxcarbazepine) valproic acid zonisamide	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) oxcarbazepine suspension OXTELLAR XR (oxcarbazepine) QUDEXY XR (topiramate) ROWEEPRA (levetiracetam) rufinamide SABRIL (vigabatrin) SPRITAM (levetiracetam) STAVZOR (valproic acid) TEGRETOL (carbamazepine) TEGRETOL SUSPENSION (carbamazepine) TEGRETOL XR (carbamazepine) TOPAMAX TABLET (topiramate) TOPAMAX Sprinkle (topiramate) topiramate ER (generic Qudexy XR) Step Edit TRILEPTAL Tablets (oxcarbazepine) TROKENDI XR (topiramate) Vigabatrin	• 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** • 1 claim for clobazam in the past 30 days

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		VIGAFYDE (vigabatrin) VIGPODER ORAL SOLUTION (vigabatrin) VIMPAT (lacosamide) XCOPRI (cenobamate) ZONISADE (zonisamide suspension) ZTALMY (ganaxolone)	**Fintepla** • Requires clinical review **Vigafyde** • Documented diagnosis of infantile spasms **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) ONFI (clobazam) ONFI SUSPENSION (clobazam)	**Minimum Age Limit** • **12 years** – Nayzilam • **6 years** – Valtoco **Quantity Limit**

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		SYMPAZAN (clobazam)	• **2 Twin Packs/31 days** – Diastat • **2 Packages /31 days** – Nayzilam • **2 Cartons/31 day** – Valtoco
HYDANTOINS			
	DILANTIN (phenytoin) PHENYTEK (phenytoin) phenytoin	PEGANONE (ethotoin)	
SUCCINIMIDES			
	ethosuximide	CELONTIN (methsuximide) ZARONTIN (ethosuximide)	

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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 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 VIIBRYD (vilazodone) ZURZUVAE (zuranolone)	**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 **Zurzuvae – MANUAL PA** Cymbalta and Irenka (see Fibromyalgia Agents)

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ANTIDEPRESSANTS, SSRIs DUR+			
	citalopram tablet escitalopram fluoxetine capsules fluvoxamine paroxetine CR paroxetine IR sertraline tablet	CELEXA (citalopram) citalopram capsule fluoxetine DR fluvoxamine ER LEXAPRO (escitalopram) LUVOX (fluvoxamine) LUVOX CR (fluvoxamine) paroxetine suspension PAXIL CR (paroxetine) PAXIL SUPENSION (paroxetine) PAXIL Tablets (paroxetine) PEXEVA (paroxetine) PROZAC (fluoxetine) SARAFEM (fluoxetine) sertraline capsule ZOLOFT (sertraline)	**Minimum Age Limit** • **6 years** – Zoloft • **7 years** – Lexapro, Prozac • **8 years** – Luvox • **18 years** – Celexa, Luvox CR, Paxil, Pexeva, Prozac 90 mg **Maximum Age Limit** • **60 years** – Celexa **Non-Preferred Criteria** • Have tried 2 different preferred agents in the past 6 months **OR** • 90 days of therapy with the requested agent in the past 105 days
ANTIEMETICS DUR+			
5HT3 RECEPTOR BLOCKERS			
	ondansetron ondansetron ODT 4mg, 8mg ondansetron solution	ANZEMET (dolasetron) granisetron ondansetron ODT 16mg SANCUSO (granisetron) ZOFRAN (ondansetron) ZOFRAN ODT (ondansetron) ZUPLENZ (ondansetron)	**Quantity Limit** • **6 tablets/31 days** – Akynzeo • **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

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ANTIEMETIC COMBINATIONS			
	DICLEGIS (doxylamine/pyridoxine)	AKYNZEO (netupitant/palonosetron) BONJESTA (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 nystatin terbinafine	ANCOBON (flucytosine) ^ BREXAFEMME (ibrexafungerp) CRESEMBA (isavuconazonium) DIFLUCAN (fluconazole) flucytosine GRIFULVIN V (griseofulvin, microsize) griseofulvin microsize suspension 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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		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 econazole ketoconazole cream 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 clotrimazole solution (NDC 50228-0502-61) CNL 8 (ciclopirox) ERTACZO (sertaconazole) EXELDERM (sulconazole) EXTINA (ketoconazole) JUBLIA (efinaconazole) KERYDIN (tavaborole)	**Non-Preferred Criteria** • Have tried 2 different preferred agents in the past 6 months

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

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ANTIHISTAMINES, MINIMALLY SEDATING AND COMBINATIONS DUR+			
MINIMALLY SEDATING ANTIHISTAMINES			
	cetirizine tablet 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)	**Non-Preferred Criteria** • Documented diagnosis of allergy or urticaria **AND** • Have tried 2 different preferred agents in the past 12 months
MINIMALLY SEDATING ANTIHISTAMINE/DECONGESTANT COMBINATIONS			
	cetirizine/pseudoephedrine loratadine/pseudoephedrine	ALLEGRA-D (fexofenadine/ pseudoephedrine) CLARITIN-D (loratadine/pseudoephedrine) CLARINEX-D (desloratadine/ pseudoephedrine) fexofenadine/pseudoephedrine ZYRTEC-D (cetirizine/pseudoephedrine)	

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ANTIMIGRAINE AGENTS, ACUTE TREATMENT			
CGRP ORAL AND NASAL			
	NURTEC ODT (rimegepant) UBRELVY (ubrogepant)	ZAVZPRET (zavegepant)	**Minimum Age Limit** • **18 years** – Nurtec ODT, Ubrelvy **Quantity Limit** • **8 tablets/31 day –** Nurtec ODT • **16 tablets/31 day –** Ubrelvy **Nurtec ODT** • Documented diagnosis of migraine **AND** • Have tried 2 different triptans in the past 6 months **AND** • No concurrent therapy with another CGRP agent **Ubrelvy** • Documented diagnosis of migraine **AND** • Have tried 2 different triptans in the past 6 months **AND** • 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

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
TRIPTANS & RELATED AGENTS ORAL DUR+			
	naratriptan rizatriptan rizatriptan ODT sumatriptan tablets zolmitriptan zolmitriptan ODT	almotriptan AMERGE (naratriptan) AXERT (almotriptan) eletriptan FROVA (frovatriptan) frovatriptan IMITREX (sumatriptan) MAXALT (rizatriptan) MAXALT MLT (rizatriptan) RELPAX (eletriptan) REYVOW (lasmiditan) TREXIMET (sumatriptan/naproxen) ZOMIG (zolmitriptan)	**Minimum Age Limit** • **6 years –** Maxalt • **12-17 years** – Axert, Treximet, Zomig nasal spray Automatic approval issued for this age range • **18 years** – Amerge, Frova, Imitrex, Onzetra Xsail, Relpax, Reyvow, Tosymra, Zembrace, Zomig tablets **Quantity Limit - ORAL** • **4 tablets/31 days –** Reyvow 50 mg • **6 tablets/31 days** - Axert, Relpax Zomig • **8 tablets/31 days** – Reyvow 100 mg • **9 tablets/31 days** - Amerge, Frova, Imitrex, Treximet • **12 tablets/31 days –** Maxalt **Non-Preferred Criteria - ORAL** • Have tried 2 preferred oral agents in the past 90 days **Reyvow** • Documented diagnosis of migraine **AND** • Have tried 2 different triptans in the past 90 days **AND**

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			• Have tried preferred Nurtec ODT in the past 90 days
NASAL			
	sumatriptan	IMITREX (sumatriptan) ONZETRA Xsail (sumatriptan) TOSYMRA (sumatriptan) zolmitriptan ZOMIG (zolmitriptan)	**Quantity Limit - NASAL** • **1 box/31 days** **Non-Preferred Criteria - NASAL** • Have tried 2 preferred oral agents in the past 90 days **AND** • Have tried a preferred nasal agent in the past 90 days
INJECTABLES			
	sumatriptan	IMITREX (sumatriptan) ZEMBRACE (sumatriptan)	**CUMULATIVE Quantity Limit - Injectables** **4 injections/31 days**
ANTIMIGRAINE AGENTS, PROPHYLAXIS			
INJECTABLES			
	AIMOVIG AUTOINJECTOR (erenumab-aooe) DUR+ AJOVY AUTOINJECTOR (fremanezumab-vfrm) DUR+ AJOVY SYRINGE (fremanezumab-vfrm) DUR+ EMGALITY PEN 120mg/mL(galcanezumab-gnlm) DUR+ EMGALITY SYRINGE 120mg/mL (galcanezumab-gnlm) DUR+	EMGALITY SYRINGE 100mg/mL (galcanezumab-gnlm) VYEPTI (eptinezumab-jjmr)	**Preferred Injectables** • History of 3 claims with the requested agent in the past 105 days • New starts require clinical review **Non-preferred Injectables** • Requires clinical review

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			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) 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)	AFINITOR (everolimus) AKEEGA (niraparib / abiraterone) ALECENSA (alectinib) ALUNBRIG (brigatnib) AUGTYRO (repotrectinib) AYVAKIT (avapritinib) BALVERSA (erdafitinib) BOSULIF CAPSULES (bosutinib) BRAFTOVI (encorafenib) BRUKINSA (zanubrutinib) CABOMETYX (cabozantinib s-malate) CALQUENCE (acalabrutinib) COPIKTRA (duvelisib) DAURISMO (glasdegib) ERIVEDGE (vismodegib) ERLEADA (apalutamide) erlotinib EXKIVITY (mobocertinib) FARYDAK (panobinostat) FOTIVDA (tivozanib) FRUZAQLA (fruquintinib)	**Farydak** - MANUAL PA • Documented diagnosis of multiple myeloma **AND** • Used in combination with bortezomib and dexamethasone per PI **AND** • History of 2 prior regimens including bortezomib and an immunomodulatory agent **Ibrance** • Documented diagnosis of WD-DDLS for retroperitoneal sarcoma **OR** • All other indications evaluated through clinical review **Lenvima** • Documented diagnosis of thyroid cancer **OR**

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	TASIGNA (nilotinib) TURALIO (pexidartinib) TYKERB (lapatinib ditosylate) vandetanib VOTRIENT (pazopanib) XALKORI (crizotinib) XALKORI (crizotinib) Oral Pellets XTANDI (enzalutamide) ZELBORAF (vemurafenib) ZYDELIG (idelalisib) ZYKADIA (ceritnib)	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+ LYTGOBI (futibatinib) MEKTOVI (binimetnib) NERLYNX (neratinib maleate) NUBEQA (darolutamide) ODOMZO (sonidegib) OGSIVEO (nirogacestat) OJEMDA (tovorafenib) OJJAARA (momelotinib) ONUREG (azacitidine) ORGOVYX (relugolix) pazopanib PEMAZYRE (pemigatinib) PIQRAY (alpelisib) QINLOCK (ripretinib)	• 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** • History of platinum-based chemotherapy in the past 2 years **OR** • All other indications evaluated through clinical review

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		REZLIDHIA (lutasidenib) RETEVMO (selpercatinib) RUBRACA (rucaparib) RYDAPT (midostaurin) SCEMBLIX (asciminib) TABRECTA (capmatinib) TAGRISSO (osimertinib) TALZENNA (talazoparib) TAZVERIK (tazemetostat) TECENTRIQ (atezolizumab)NR TEPMETKO (tepotinib) TIBSOVO (ivosidenib) TORPENZ (everolimus) TRUSELTIQ (infigratinib) TRUQAP (capivasertib) TUKYSA (tucatinib) UKONIQ (umbralisib) VANFLYTA (quizartinib VERZENIO (abemaciclib) VITRAKVI (larotrectinib) VIZIMPRO (dacomitinib) VONJO (pacritinib) VORANIGO (vorasidenib) 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

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

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
ANTIPARKINSON'S AGENTS (Oral) DUR+			
ANTICHOLINERGICS			
	benztropine trihexyphenidyl	COGENTIN	**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
COMT INHIBITORS			
	entacapone	COMTAN (entacapone) ONGENTYS (opicapone) TASMAR (tolcapone) tolcapone	
DOPAMINE AGONISTS			
	ropinirole pramipexole	KYNMOBI FILM (apomorphine) MIRAPEX (pramipexole) MIRAPEX ER (pramipexole) NEUPRO (rotigotine) pramipexole ER REQUIP (ropinirole) REQUIP XL (ropinirole) ropinirole ER	
MAO-B INHIBITORS			
	selegiline	AZILECT (rasagiline) ELDEPRYL (selegiline) rasagiline XADAGO (safinamide)	**Xadago** • Documented diagnosis of Parkinson's disease **AND**

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		ZELAPAR (selegiline)	• History of 30 days of therapy with a carbidopa/levodopa combination agent in the past 45 days • History of 30 days of therapy with a selegiline agent in the past 45 days
OTHERS			
	amantadine bromocriptine carbidopa levodopa/carbidopa	CREXONT (carbidopa and levodopa)[NR] DUOPA (levodopa/carbidopa) GOCOVRI (amantadine) INBRIJA (levodopa) levodopa/carbidopa ODT levodopa/carbidopa/entacapone LODOSYN (carbidopa) NOURIANZ (istradefylline) OSMOLEX ER (amantadine) PARCOPA (levodopa/carbidopa) PARLODEL (bromocriptine) RYTARY ER (levodopa/carbidopa) SINEMET (levodopa/carbidopa) SINEMET CR (levodopa/carbidopa) STALEVO (levodopa/carbidopa/entacapone)	**Gocovri** • Documented diagnosis of Parkinson's disease **AND** • History of 30 days of therapy with amantadine IR in the past 105 days **AND** • History of 30 days of therapy with a carbidopa/levodopa combination agent in the past 45 days **Lodosyn and Inbrija** • Documented diagnosis of Parkinson's disease **AND** • History of 30 days of therapy with a carbidopa/levodopa combination agent in the past 45 days

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			Nourianz • Documented diagnosis of Parkinson's Disease **AND** • History of a preferred carbidopa/levodopa combination product in the past 30 days **AND** • History of 30 days therapy with a preferred adjunctive therapy in the past 45 days
ANTIPARKINSON'S AGENTS (Injectable)			
		VYALEV (foscarbidopa and foslevodopa)[NR]	
ANTIPSORIATICS (Topical)			
	calcipotriene cream ENSTILAR (calcipotriene/betamethasone) TACLONEX (calcipotriene/betamethasone)	calcipotriene foam/oint/solution calcipotriene/betamethasone oint/suspension calcitriol ointment DUOBRII (halobetasol) SORILUX (calcipotriene) VTAMA (tapinarof)	
ANTIPSYCHOTICS DUR+			
ORAL			
	amitriptyline/perphenazine aripiprazole asenapine clozapine fluphenazine haloperidol	ABILIFY (aripiprazole) ABILIFY MYCITE (aripiprazole) ADASUVE (loxapine) aripiprazole solution aripiprazole ODT CAPLYTA (lumateperone)	**Minimum Age Limit** • **3 years –** Haldol • **5 years –** Risperdal, thioridazine • **6 years –** Abilify, trifluoperazine • **10 years –** Latuda, Saphris, Seroquel, Symbyax

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

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

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			• Documented diagnosis of bipolar disorder **Invega Hafyera** • Documented diagnosis of schizophrenia or schizoaffective disorder **AND** • 4 claims for Invega Sustenna in the past year **OR** • 1 claim for Invega Trinza in the past year **OR** • 1 claim for Invega Hafyera in the past year
TRANSDERMAL, ATYPICALS			
		SECUADO (asenapine)	
ANTIRETROVIRALS DUR+			
SINGLE PRODUCT REGIMENS			
	BIKTARVY (boceprevir/emtricitabine/tenofovir) CABENUVA (cabotegravir/rilpivirine) DELSTRIGO (doravirine/lamivudine/tenofovir) DOVATO (dolutegravir/lamivudine) efavirenz/emtricitabine/tenofovir 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

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
INTEGRASE STRAND TRANSFER INHIBITORS			
	APRETUDE ER (cabotegravir) ISENTRESS (raltegravir potassium) TIVICAY (dolutegravir sodium) TIVICAY PD (dolutegravir sodium)	ISENTRESS HD (raltegravir potassium) VITEKTA (elvitegravir)	**Non-Preferred Criteria** • 1 claim with the requested agent in the past 105 days
NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS (NRTI)			
	abacavir sulfate EMTRIVA (emtricitabine) EMTRIVA SOLUTION (emtricitabine) lamivudine tenofovir disoproxil fumarate ZIAGEN Solution (abacavir sulfate) zidovudine	didanosine DR capsule emtricitabine EPIVIR (lamivudine) RETROVIR (zidovudine) stavudine VIDEX EC (didanosine) VIDEX SOLUTION (didanosine) VIREAD (tenofovir disoproxil fumarate) ZIAGEN Tablet (abacavir sulfate)	
NON-NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITOR (NNRTI)			
	EDURANT (rilpivirine) efavirenz	INTELENCE (etravirine) nevirapine nevirapine ER PIFELTRO (doravirine) RESCRIPTOR (delavirdine mesylate) SUSTIVA (efavirenz) VIRAMUNE (nevirapine) VIRAMUNE ER (nevirapine)	
PHARMACOENHANCER – CYTOCHROME P450 INHIBITOR			
		TYBOST (cobicistat)	**Tybost - MANUAL PA**

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
PROTEASE INHIBITORS (PEPTIDIC)			
	atazanavir EVOTAZ (atazanavir/cobicistat) NORVIR SOLUTION (ritonavir) ritonavir	CRIXIVAN (indinavir) fosamprenavir INVIRASE (saquinavir mesylate) LEXIVA (fosamprenavir) NORVIR POWDER (ritonavir) NORVIR TABLET (ritonavir) REYATAZ (atazanavir) VIRACEPT (nelfinavir mesylate)	
PROTEASE INHIBITORS (NON-PEPTIDIC)			
	PREZISTA (darunavir ethanolate)	APTIVUS (tipranavir) darunavir ethanolate PREZCOBIX (darunavir/cobicistat)	
ENTRY INHIBITORS – CCR5 CO-RECEPTOR ANTAGONISTS			
		SELZENTRY (maraviroc)	
ENTRY INHIBITORS – FUSION INHIBITORS			
		FUZEON (enfuvirtide)	
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)	

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

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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** • 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 famciclovir valacyclovir	FAMVIR (famciclovir) SITAVIG (acyclovir) VALTREX (valacyclovir) ZOVIRAX (acyclovir)	
ANTI-INFLUENZA AGENTS			
	oseltamivir	FLUMADINE (rimantadine) RAPIVAB (peramivir) RELENZA (zanamivir) rimantadine	

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		TAMIFLU (oseltamivir) XOFLUZA (baloxavir marboxil)	
ANTIVIRALS (Topical)			
	ZOVIRAX Cream (acyclovir)	acyclovir cream, ointment DENAVIR (penciclovir) XERESE (acyclovir/hydrocortisone) ZOVIRAX Ointment (acyclovir)	
AROMATASE INHIBITORS			
	anastrozole exemestane letrozole	ARIMIDEX (anastrozole) AROMASIN (exemestane) FEMARA (letrozole)	

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
ATOPIC DERMATITIS			
	ADBRY (tralokinumab) ADBRY autoinjector (tralokinumab) DUPIXENT (dupilumab) DUR+ ELIDEL (pimecrolimus) EUCRISA (crisaborole) DUR+ PROTOPIC (tacrolimus) tacrolimus	CIBINQO (abrocitinib) EBGLYSS (lebrikizumab-lbkz)NR OPZELURA (ruxolitinib) pimecrolimus ZORYVE (roflumilast) 0.15% cream	**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 **OR** • 28 days of therapy with a topical steroid in the past year **Dupixent** •History of 1 claim with Dupixent in the past 45 days •New starts require clinical review **Asthma – MANUAL PA** **Atopic Dermatitis – MANUAL PA** **Eosinophilic Esophagitis -- MANUAL PA** **Nasal Polyposis – MANUAL PA** **Prurigo Nodularis MANUAL PA**

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
BETA BLOCKERS, ANTIANGINALS & SINUS NODE AGENTS DUR+			
	acebutolol atenolol bisoprolol HEMANGEOL (propranolol) metoprolol metoprolol ER nadolol nebivolol pindolol propranolol propranolol ER sotalol	AZSRUZYO SPRINKLES (ranolazine) BETAPACE (sotalol) betaxolol BYSTOLIC (nebivolol) CORGARD (nadolol) INDERAL LA (propranolol) INDERAL XL (propranolol) INNOPRAN XL (propranolol) KAPSPARGO SPRINKLES (metoprolol) KERLONE (betaxolol) 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			
	carvedilol labetalol	carvedilol CR COREG (carvedilol) COREG CR (carvedilol) TRANDATE (labetalol)	**Coreg CR** • Documented diagnosis of hypertension **AND**

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			• 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
SINUS NODE AGENTS			
		CORLANOR (ivabradine) ivabradine	**Corlanor - MANUAL PA**

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BILE SALTS			
	ursodiol	ACTIGALL (ursodiol) BYLVAY (odevixibat) CHENODAL (chenodiol) CHOLBAM (cholic acid) IQIRVO (elafibranor) LIVDELZI (seladelpar) LIVMARLI (maralixibat) OCALIVA (obeticholic acid) URSO (ursodiol) URSO FORTE (ursodiol)	
BLADDER RELAXANT PREPARATIONS DUR+			
	MYRBETRIQ ER (mirabegron) oxybutynin ER oxybutynin IR solifenacin	darifenacin DETROL (tolterodine) DETROL LA (tolterodine) DITROPAN XL (oxybutynin) GELNIQUE (oxybutynin) GEMTESA (vibegron) mirabegron ER MYRBETRIQ granules (mirabegron) OXYTROL (oxybutynin) tolterodine tolterodine ER TOVIAZ (fesoterodine fumarate) trospium trospium ER VESICARE (solifenacin)	**Non-Preferred Criteria** • Have tried 2 different preferred agents in the past 6 months

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

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	terazosin	FLOMAX (tamsulosin) HYTRIN (terazosin) JALYN (dutasteride/tamsulosin) RAPAFLO (silodosin) silodosin UROXATRAL (alfuzosin)	• 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
	5-ALPHA-REDUCTASE (5AR) INHIBITORS		
	dutasteride finasteride	ENTADFI (finasteride/tadalafil) PROSCAR (finasteride)	**Entadfi** • Requires clinical review
	PDE5 INHIBITORS		
		CIALIS (tadalafil)	
BRONCHODILATORS & COPD AGENTS			
	ANTICHOLINERGICS & COPD AGENTS		
	ATROVENT HFA (ipratropium) INCRUSE ELLIPTA (umeclidinium) ipratropium SPIRIVA HANDIHALER (tiotropium)	DALIRESP (roflumilast) LONHALA MAGNAIR (glycopyrrolate) OHTUVAYRE (ensifentrine) roflumilast SEEBRI (glycopyrrolate) SPIRIVA RESPIMAT (tiotropium) DUR+ TUDORZA PRESSAIR (aclidinium) YUPELRI (revefenacin)	**Minimum Age Limit** **6 years** – Spiriva Respimat **Spiriva Respimat** • 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)	BEVESPI (glycopyrrolate/formoterol) DUAKLIR PRESSAIR (aclidinium/formoterol)	

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	STIOLTO RESPIMAT (tiotropium/olodaterol)		
ANTICHOLINERGIC-BETA AGONIST-GLUCOCORTICOIDS COMBINATIONS			
		BREZTRI AEROSPHERE DUR+ (budesonide/glycopyrrolate/formoterol) TRELEGY ELLIPTA (fluticasone furoate/ umeclidinium/vilanterol)	**Breztri Aerosphere** • History of 3 claims with Breztri Aerosphere in the past 105 days • New starts require clinical review
BRONCHODILATORS, BETA AGONIST			
INHALERS, SHORT-ACTING			
	albuterol HFA PROVENTIL HFA (albuterol) VENTOLIN HFA (albuterol)	AIRSUPRA (budesonide/albuterol) levalbuterol HFA PROAIR DIGIHALER (albuterol) PROAIR RESPICLICK (albuterol) XOPENEX HFA (levalbuterol)DUR+	**Minimum Age Limit** • **4 years** – Xopenex HFA • **18 years** – Airsupra **Quantity Limit** • 2 inhalers/31 days – Airsupra **Xopenex HFA** • 1 claim for a preferred albuterol inhaler in the past 30 days **Airsupra and ProAir Digihaler** • Require clinical review

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

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
CALCIUM CHANNEL BLOCKERS DUR+			
SHORT-ACTING			
	diltiazem nicardipine nifedipine verapamil	CALAN (verapamil) CARDIZEM (diltiazem) isradipine nimodipine NORLIQVA (amlodipine) NYMALIZE SOLUTION (nimodipine) PROCARDIA (nifedipine)	**Quantity Limit - nimodipine** • **252 tablets/ 21 days** • **2520 mL/21 days** **Non-Preferred Criteria** • Have tried 2 different preferred Short Acting CCB agents in the past 6 months **OR** • 90 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			
	amlodipine DILT XR 24 HR Caps (diltiazem) diltiazem ER Cap 24 HR (generic Cardizem CD) diltiazem ER Cap 24 HR felodipine ER	ADALAT CC (nifedipine) CALAN SR (verapamil) CARDENE SR (nicardipine) CARDIZEM CD (diltiazem) CARDIZEM LA (diltiazem)	**Non-Preferred Criteria** • Have tried 2 different preferred Long Acting CCB agents in the past 6 months **OR**

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	nifedipine ER verapamil ER	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)	• 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 SCANDISHAKE TWOCAL HN	All other products (caloric /nutritional agents) not listed as preferred will require a manual prior authorization.	**Non-Preferred Agents – MANUAL PA**

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
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+			
	cefadroxil cephalexin capsules cephalexin suspension	cephalexin tablets DAXBIA (cephalexin) KEFLEX (cephalexin)	**Non-Preferred Criteria – all generations** • Have tried 2 different preferred agents in the past 6 months
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 cefixime capsule cefpodoxime	CEDAX (ceftibuten) Cefditoren cefixime suspension ceftibuten SPECTRACEF (cefditoren) SUPRAX (cefixime)	**Maximum Age Limit** • **18 years** – cefdinir suspension

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Drugs highlighted in yellow denote a change in PDL status.

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
COLONY STIMULATING FACTORS			
	FULPHILA (pegfilgrastim) NEUPOGEN Syringe (filgrastim) NEUPOGEN Vial (filgrastim)	FYLNETRA (pegfilgrastim) GRANIX (tbo-filgrastim) LEUKINE (sargramostim) NEULASTA (pegfilgrastim) NIVESTYM (filgrastim-aafi) NYVEPRIA (pegfilgrastim-apgf) RELEUKO (filgrastim) ROLVEDON (eflapegrastim) STIMUFEND (pegfilgrastim-fpgk) UDENYCA (pegfilgrastim-cbqv) UDENYCA ONBODY (pegfilgrastim-cbqv) ZARXIO (filgrastim) ZIEXTENZO (pegfilgrastim-bmez)	
CYSTIC FIBROSIS AGENTS DUR+			
	PULMOZYME (dornase alfa) tobramycin (generic TOBI)	BETHKIS (tobramycin) BRONCHITOL (mannitol) CAYSTON (aztreonam) colistimethate COLY-MYCIN M (colistimethate sodium) KALYDECO (ivacaftor) KITABIS (tobramycin) ORKAMBI (lumacaftor/ivacaftor) SYMDEKO (tezacaftor/ivacaftor) TOBI (tobramycin) TOBI PODHALER (tobramycin)	**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

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		tobramycin (generic Bethkis) tobramycin (generic Kitabis) TRIKAFTA (elexacaftor/ tezacaftor/ivacaftor)	**Maximum Age Limit** • **2 years** – Orkambi 75-94 mg Granules • **5 years** – Kalydeco, Orkambi 100-125 mg Granules, Orkambi 200-125 mg Granules, Trikafta Granules • **11 years** – Trikafta tablets **All Agents** • Documented diagnosis 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)	ABRILADA (adalimumab-afzb) ACTEMRA ACTPEN (tocilizumab) adalimumab-aacf	**Preferred Agents** • Age criteria for indication • Documented diagnosis for indication

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MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

(For All Medicaid, MSCAN and CHIP Beneficiaries)

EFFECTIVE 01/01/2025
Version 2024_15
Updated: 01/01/2025

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	ENBREL (etanercept) HUMIRA (adalimumab) KINERET (anakinra) Methotrexate OLUMIANT (baricitinib) ORENCIA CLICKJET (abatacept) ORENCIA VIAL (abatacept) OTEZLA (apremilast) RINVOQ (upadacitinib) SIMPONI (golimumab) TALTZ (ixekizumab) TYENNE (tocilizumab-aazg) XELJANZ IR (tofacitinib)	adalimumab-aaty adalimumab-adaz adalimumab-adbm adalimumab-fkjp adalimumab-ryvk AMJEVITA (adalimumab) ARCALYST (rilonacept) BIMZELX (bimekizumab-bkzx) CIMZIA (certolizumab) COSENTYX (secukinumab) COSENTYX VIAL (secukinumab) CYLTEZO (adalimumab-adbm) ENTYVIO (vedolizumab) ENTYVIO SQ (vedolizumab) HADLIMA (adalimumab) HULIO (adalimumab) HYRIMOZ (adalimumab) IDACIO (adalimumab) ILARIS (canakinumab) ILUMYA (tildrakizumab) INFLECTRA (infliximab) JYLAMVO (methotrexate) KEVZARA (sarilumab) LITFULO (ritlecitinib) OMVOH (mirikizumab-mrkz) ORENCIA SYRINGE (abatacept) OTREXUP (methotrexate) RASUVO (methotrexate)	**Non-Preferred Agents** • Require clinical review **IV Administered Agents** • Require clinical review

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		REMICADE (infliximab) RENFLEXIS (infliximab-abda) RHEUMATREX (methotrexate) SILIQ (brodalumab) SIMLANDI (adalimumab-ryvk) SKYRIZI (risankizumab) SOTYKTU (deucravacitinib) SPEVIGO (spesolimab) STELARA (ustekinumab) TOFIDENCE (tocilizumab-bavi) TREMFYA (guselkumab) TREXALL (methotrexate) XELJANZ Oral Solution (tofacitinib) XELJANZ XR (tofacitinib) YUFLYMA (adalimumab) YUSIMRY (adalimumab) ZYMFENTRA (infliximab-dyyb)	
ERYTHROPOIESIS STIMULATING PROTEINS DUR+			
	EPOGEN (rHuEPO) MIRCERA (methoxy polyethylene glycol-epoetin-beta) RETACRIT (rHuEPO)	ARANESP (darbepoetin) JESDUVROQ (daprodustat) PROCRIT (rHuEPO) VAFSEO (vadadustat)NR	**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**

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			• 1 claim for the requested agent in the past 105 days **Jesduvroq** • Requires clinical review
FACTOR DEFICIENCY PRODUCTS			
FACTOR VIII			
	ADVATE ALTUVIIIO AFSTYLA ALPHANATE FEIBA NF HEMOFIL M HUMATE-P KOATE KOGENATE FS KOVALTRY NOVOEIGHT NUWIQ RECOMBINATE WILATE XYNTHA XYNTHA SOLOFUSE	ADYNOVATE ELOCTATE ESPEROCT HEXILATE FS JIVI KCENTRA OBIZUR VONVENDI	
FACTOR IX			
	ALPHANINE SD ALPROLIX BENEFIX IDELVION	REBINYN	

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	IXINITY MONONINE PROFILNINE RIXUBIS		
OTHER HEMOPHILIA PRODUCTS			
	COAGADEX FIBRYGA HEMLIBRA DUR+ RIASTAP	BEQVEZ 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)

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
FLUOROQUINOLONES DUR+			
	ciprofloxacin tablets levofloxacin tablets	AVELOX (moxifloxacin) BAXDELA (delaflozacin) CIPRO (ciprofloxacin) CIPRO SUSPENSION (ciprofloxacin) CIPRO XR (ciprofloxacin) ciprofloxacin ER ciprofloxacin suspension FACTIVE (gemifloxacin) LEVAQUIN (levofloxacin) levofloxacin solution moxifloxacin NOROXIN (norfloxacin) ofloxacin	**Non-Preferred Criteria** • 1 claim for a preferred agent in the past 30 days **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

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
GAUCHER'S DISEASE			
	ELELYSO (taliglucerase alfa) ZAVESCA (miglustat)	CERDELGA (eliglustat) CEREZYME (imiglucerase) miglustat VPRIV (velaglucerase alfa)	
GENITAL WARTS & ACTINIC KERATOSIS AGENTS			
	CONDYLOX (podofilox) Age Edit fluorouracil imiquimod Age Edit podofilox Age Edit	ALDARA (imiquimod) Age Edit CARAC (fluorouracil) diclofenac 3% gel EFUDEX (fluorouracil) 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

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			Institutional sized products are Non-Preferred
GLUCOCORTICOID/BRONCHODILATOR COMBINATIONS			
	ADVAIR DISKUS (fluticasone/salmeterol) ADVAIR HFA (fluticasone/salmeterol) DULERA (mometasone/formoterol) fluticasone/salmeterol (generic ADVAIR) fluticasone/salmeterol (generic AIRDUO) SYMBICORT (budesonide/formoterol)	AIRDUO Digihaler (fluticasone/salmeterol) AIRDUO Respiclick (fluticasone/salmeterol) BREO ELLIPTA (fluticasone/vilanterol) BREYNA (budesonide/formoterol) budesonide/formoterol WIXELA INHUB (fluticasone/salmeterol)	**Non-Preferred Criteria** • Have tried 2 preferred combination agents in the past 6 months **OR** • 90 days of therapy with the requested agent in the past 105 days **AirDuo Digihaler** • Requires clinical review
GI ULCER THERAPIES			
H2 RECEPTOR ANTAGONISTS			
	famotidine solution famotidine tablets nizatidine solution	AXID (nizatidine) cimetidine solution cimetidine tablets nizatidine tablets PEPCID (famotidine)	

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MISSISSIPPI DIVISION OF MEDICAID
UNIVERSAL PREFERRED DRUG LIST
(For All Medicaid, MSCAN and CHIP Beneficiaries)

EFFECTIVE 01/01/2025
Version 2024_15
Updated: 01/01/2025

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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 (omeprazole) PROTONIX DR (pantoprazole) PROTONIX PACKET (pantoprazole) rabeprazole	**Prilosec suspension** • Automatic approval issued for 0 - 2 years
OTHER			
	CARAFATE SUSPENSION (sucralfate) misoprostol sucralfate tablet	CARAFATE TABLET (sucralfate) CYTOTEC (misoprostol) DARTISLA ODT (glycopyrrolate) sucralfate suspension VOQUEZNA (vonoprazan)	
GROWTH HORMONE DUR+			
	GENOTROPIN (somatropin) NORDITROPIN (somatropin) NUTROPIN AQ (somatropin) SKYTROFA (lonapegsomatropin)	HUMATROPE (somatropin) NGENLA (somatrogon-ghla) OMNITROPE (somatropin) SAIZEN (somatropin) SEROSTIM (somatropin)	**Minimum Age Limit** • **3 years** – Ngenla **Maximum Age Limit** • **18 years** - Ngenla

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		SOGROYA (somapacitan) VOXZOGO (vosoritide) ZOMACTON (somatropin) ZORBTIVE (somatropin)	**All Agents for Age ≥ 18 years** • Documented diagnosis of craniopharyngioma, panhypopituitarism, Prader-Willi Syndrome, Turner Syndrome or an approvable adult diagnosis **OR** • Documented procedure of cranial irradiation **All Agents for Age < 18 years** • Documented diagnosis of idiopathic short stature **AND** • Documented approvable pediatric diagnosis **OR** • Documented approvable pediatric diagnosis **Non-Preferred Criteria** • Documented approvable diagnosis for age 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

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
***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 EPIVIR HBV SOLUTION (lamivudine) lamivudine HBV tenofovir disoproxil fumarate	adefovir dipivoxil BARACLUDE (entecavir) EPIVIR HBV TABLET (lamivudine) HEPSERA (adefovir dipivoxil) TYZEKA (telbivudine) VEMLIDY (tenofovir alafenamide fumarate) VIREAD (tenofovir disoproxil fumarate)	
HEPATITIS C TREATMENTS			
	MAVYRET (glecaprevir/pibrentasvir) ∞ MAVYRET PELLETS (glecaprevir/pibrentasvir)∞ PEGASYS (peginterferon alfa-2a) PEG-INTRON (peginterferon alfa-2b) ribavirin tablets	COPEGUS (ribavirin) EPCLUSA (sofosbuvir/velpatasvir) ∞ HARVONI (ledipasvir/sofosbuvir) ∞ ledipasvir/sofosbuvir∞ MODERIBA (ribavirin)	**∞ Epclusa, Harvoni, Mavyret, Sovaldi, Vosevi, Zepatier** • Require **MANUAL PA**

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	sofosbuvir/velpatasvir∞	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 and Sovaldi have FDA pediatric indications
HEREDITARY ANGIOEDEMA			
	BERINERT (C1 esterase inhibitor) HAEGARDA (C1 esterase inhibitor) icatibant	CINRYZE VIAL (C1 esterase inhibitor) FIRAZYR SYRINGE (icatibant acetate) 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)	**Non-Preferred Criteria** • Have tried 2 different preferred agents in the past 6 months

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

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		RIOMET SOLUTION* (metformin)	
HYPOGLYCEMICS, DPP4s and COMBINATON DUR+			
	JANUMET (sitagliptin/metformin) JANUMET XR (sitagliptin/metformin) JANUVIA (sitagliptin) JENTADUETO (linagliptin/metformin) TRADJENTA (linagliptin)	alogliptin alogliptin/metformin alogliptin/pioglitazone JENTADUETO XR (linagliptin/metformin) KAZANO (alogliptin/metformin) KOMBIGLYZE XR (saxagliptin/metformin)* NESINA (alogliptin) ONGLYZA (saxagliptin) * OSENI (alogliptin/pioglitazone) sitagliptin sitagliptin/metformin ZITUVIO (sitagliptin) ZITUVIMET (sitagliptin/metformin)NR ZITUVIMET XR (sitagliptin/metformin)NR	**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 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)	BYDUREON (exenatide) BYDUREON BCISE (exenatide) liraglutide 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 **AND** • No history of 1 claim with Saxenda or Wegovy in the past 30 days **OR**

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			• No documented diagnosis for Type 2 Diabetes **AND** • Have history of 84 days of therapy with the requested agent in the past 105 days **Non-Preferred Criteria** • Documented diagnosis for Type 2 Diabetes **AND** • No history of 1 claim with Saxenda or Wegovy in the past 30 days **AND** • Have a history of 84 days of therapy with Trulicity in the past 6 months **AND** • Have a history of 84 days of therapy with 1 of the following preferred single ingredient GLP-1 Agonists in the past 6 months: Byetta or Victoza **OR** • Documented diagnosis for Type 2 Diabetes **AND** • No history of 1 claim with Saxenda or Wegovy in the past 30 days **AND** • Have a history of 84 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
			Note: Please see the PDL category Antiobesity Select Agents for a list of covered agents. Concomitant use of a GLP-1 agonist and a DPP-4 agent requires clinical review
HYPOGLYCEMICS, INSULINS AND RELATED AGENTS DUR+			
	HUMULIN N, R, 70/30 VIAL OTC (insulin) HUMULIN R U500 KWIKPEN HUMULIN R U500 VIAL (insulin) HUMALOG MIX 50/50 VIAL HUMALOG MIX 75/25 VIAL insulin aspart insulin aspart flexpen insulin aspart mix insulin aspart mix flexpen Insulin lispro insulin lispro jr kwikpen insulin lispro kwikpen LANTUS SOLOSTAR & VIAL (insulin glargine) TOUJEO (insulin glargine) TOUJEO MAX (insulin glargine)	AFREZZA (insulin) ADMELOG (insulin lispro) APIDRA (insulin glulisine) APIDRA SOLOSTAR (insulin glulisine) BASAGLAR (insulin glargine) FIASP (insulin aspart) HUMALOG JR (insulin lispro) HUMALOG KWIKPEN U100 (insulin lispro) HUMALOG KWIKPEN U200 (insulin lispro) HUMALOG MIX KWIKPEN (insulin lispro/ lispro protamine) HUMALOG VIAL (insulin lispro) HUMULIN N, 70/30 KWIKPEN (insulin) OTC insulin glargine LEVEMIR (insulin detemir) 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)	Insulin pen formulations are not covered for Long Term Care (LTC) beneficiaries. **Non-Preferred Criteria** • Documented diagnosis of Diabetes Mellitus **AND** • Have tried 1 preferred product in the past 6 months **OR** • 1 claim with the requested agent in the past 105 days **Quantity Limit** • Insulin Quantity Limits found here

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		NOVOLOG MIX FLEXPEN & VIAL (insulin aspart/ aspart protamine) REZVOGLAR (insulin glargine) SEMGLEE (insulin glargine) TRESIBA (insulin degludec)	
HYPOGLYCEMICS, MEGLITINIDES DUR+			
	nateglinide repaglinide	PRANDIMET (repaglinide/metformin) PRANDIN (repaglinide) repaglinide/metformin STARLIX (nateglinide)	
HYPOGLYCEMICS, SODIUM GLUCOSE COTRANSPORTER-2 INHIBITORS DUR+			
HYPOGLYCEMICS, SODIUM GLUCOSE COTRANSPORTER-2 INHIBITORS			
	FARXIGA (dapagliflozin) JARDIANCE (empagliflozin)	dapagliflozin INPEFA (sotagliflozin) INVOKANA (canagliflozin) STEGLATRO (ertugliflozin)	**Non-Preferred Criteria** • Have tried 2 different preferred SGLT-2 inhibitors in the past 6 months **OR** • 90 days of therapy with the requested agent in the past 105 days
HYPOGLYCEMICS, SODIUM GLUCOSE COTRANSPORTER-2 INHIBITOR COMBINATIONS			
	GLYXAMBI (empagliflozin/linagliptin) SYNJARDY (empagliflozin/metformin) SYNJARDY XR (empagliflozin/metformin) TRIJARDY XR (empagliflozin/linagliptin/metformin)	dapaglifozin/metformin INVOKAMET (canaglifozin/metformin) INVOKAMET XR (canaglifozin/metformin) QTERN (dapaglifozin/saxagliptin) SEGLUROMET (ertugliflozin/metformin) STEGLUJAN (ertugliflozin/sitagliptin) XIGDUO XR (dapaglifozin/metformin)	

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
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	
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)	ASTAGRAF XL (tacrolimus) ENVARSUS XR (tacrolimus) HECORIA (tacrolimus) MYFORTIC (mycophenolic acid) MYHIBBIN (mycophenolate mofetil oral suspension) 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

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	RAPAMUNE (sirolimus) SANDIMMUNE (cyclosporine) sirolimus tacrolimus		**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 **Myfortic** • Documented diagnosis of kidney transplant or psoriasis **Rapamune** • Documented diagnosis of kidney transplant **Zortress** • Documented diagnosis of kidney transplant or liver transplant

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MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

(For All Medicaid, MSCAN and CHIP Beneficiaries)

EFFECTIVE 01/01/2025
Version 2024_15
Updated: 01/01/2025

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
IMMUNE GLOBULINS			
	BIVIGAM CARIMUNE NF FLEBOGAMMA DIF GAMASTAN SD GAMMAGARD GAMMAGARD SD GAMUNEX-C HIZENTRA HYQVIA PANZYGA PRIVIGEN XEMBIFY	ALYGLO[NR] ASCENIV CABLIVI CUTAQUIG CUVITRU GAMMAKED GAMMAPLEX OCTAGAM	
IMMUNOLOGIC THERAPIES FOR ASTHMA			
	DUPIXENT (dupilumab)[DUR+] FASENRA (benralizumab) XOLAIR (omalizumab)[DUR+]	CINQAIR (reslizumab) NUCALA (mepolizumab)[*] TEZSPIRE (tezepelumab)	**All agents require clinical review** **Dupixent** • History of 1 claim with Dupixent in the past 45 days • New starts require clinical review **Xolair** • History of 1 claim with Xolair in the past 45 days • New starts require clinical review **Dupixent – MANUAL PA** **Fasenra- MANUAL PA** **Xolair- MANUAL PA**

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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 VERAMYST (fluticasone) XHANCE (fluticasone) ZETONNA (ciclesonide)	**Non-Preferred Criteria** • Documented diagnosis of allergic rhinitis **AND** • Have tried 1 different preferred agent in the past 6 months

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IRON CHELATING AGENTS			
	deferasirox all strengths (all manufacturers except those listed as non-preferred) FERRIPROX (deferiprone)	deferasirox (manufacturers starting with 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			
	LINZESS 72mcg (linaclotide) LINZESS 145mcg, 290mcg (linaclotide) Lubiprostone TRULANCE (plecanatide)	AMITIZA (lubiprostone) IBSRELA (tenapanor) linaclotide MOTEGRITY (prucalopride) MOVANTIK (naloxegol) RELISTOR (methylnaltrexone) SYMPROIC (naldemedine) 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 **All CIC Agents** • Documented diagnosis of CIC in the past year **AND**

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

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			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 **Non- Preferred OIC Agents** • Documented diagnosis of OIC in the past year **AND** • 1 claim for an opioid in the past 30 days **AND**

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			• 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 (eluxadoline)*	**Viberzi** • Documented diagnosis of Irritable Bowel Syndrome – Diarrhea Dominant (IBS-D) in the past year **AND** • 1 claim for Viberzi in the past 105 days **OR** • New starts require clinical review

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			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** • 1 claim for an antiretroviral in the past 30 days **Short Bowel Syndrome (SBS)** **Gattex or Zorbtive**

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			• 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)	**Non-Preferred Criteria** • Have tried 2 different preferred Non-statin Lipotropic agents in the past 6 months
BILE ACID SEQUESTRANTS			
	cholestyramine colestipol tablet colestipol granule, packet	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**

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			• 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, micronized fenofibrate nanocrystallized fenofibric acid gemfibrozil	ANTARA (fenofibrate, micronized) FENOGLIDE (fenofibrate) FIBRICOR (fenofibric acid) LIPOFEN (fenofibrate) LOFIBRA (fenofibrate) LOPID (gemfibrozil) TRICOR (fenofibrate nanocrystallized) TRIGLIDE (fenofibrate) TRILIPIX (fenofibric acid)	**Fibric Acid Derivative Non-Preferred Criteria** • Have tried 2 different fibric acid derivatives in the past 6 months
MTP INHIBITOR			
		JUXTAPID (lomitapide)	**Juxtapid – MANUAL PA**

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MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

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EFFECTIVE 01/01/2025
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Updated: 01/01/2025

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APOLIPOPROTEIN B-100 SYNTHESIS INHIBITOR			
		KYNAMRO (mipomersen)	**Kynamro** • Requires clinical review
NIACIN			
	niacin ER NIACOR (niacin)	NIASPAN (niacin)	
PCSK-9 INHIBITOR			
	REPATHA (evolocumab)	LEQVIO (inclisiran) PRALUENT (alirocumab)	**Leqvio** • Requires clinical review **Praluent - MANUAL PA** **Repatha - MANUAL PA**
LIPOTROPICS, STATINS DUR+			
STATINS			
	atorvastatin lovastatin pravastatin rosuvastatin simvastatin	ALTOPREV (lovastatin) ATORVALIQ SUSPENSION (atorvastatin) CRESTOR (rosuvastatin) EZALLOR SPRINKLE (rosuvastatin) FLOLIPID (simvastatin) fluvastatin ER fluvastatin LESCOL (fluvastatin) LESCOL XL (fluvastatin) LIPITOR (atorvastatin) LIVALO (pitavastatin) MEVACOR (lovastatin) pitavastatin PRAVACHOL (pravastatin) ZOCOR (simvastatin)	**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

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		ZYPITAMAG (pitavastatin)	
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	ADRENACLICK (epinephrine) AUVI-Q (epinephrine) EPINEPHRINE SNAP EMS KIT (epinephrine) EPIPEN (epinephrine) EPIPEN JR (epinephrine) NEFFY (epinephrine)[NR]	**Quantity Limit** • **2 kits/31 days** – epinephrine
MISCELLANEOUS			
	alprazolam hydroxyzine hcl syrup hydroxyzine hcl tablets hydroxyzine pamoate megestrol suspension 625mg/5mL REVLIMID (lenalidomide)	alprazolam ER CAMZYOS (mavacamten) EVRYSDI (risdiplam) INPEFA (sotagliflozin) KORLYM (mifepristone) lenalidomide MEGACE ES (megestrol) VERQUVO (vericiguat) VISTARIL (hydroxyzine pamoate)	**Alprazolam ER CUMULATIVE quantity limit** • **31 tablets/31 days** **Evrysdi** - **MANUAL PA**

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ALLERGEN EXTRACT IMMUNOTHERAPY			
		GRASTEK ORALAIR PALFORZIA RAGWITEK	
SUBLINGUAL NITROGLYCERIN			
	nitroglycerin lingual 12gm nitroglycerin sublingual NITROLINGUAL PUMPSPRAY (nitroglycerin) 12gm NITROSTAT SUBLINGUAL (nitroglycerin)	nitroglycerin lingual 4.9gm NITROLINGUAL (nitroglycerin) 4.9gm NITROMIST (nitroglycerin)	
MOVEMENT DISORDER AGENTS DUR+			
	AUSTEDO (deutetrabenazine) AUSTEDO XR (deutetrabenazine) INGREZZA (valbenazine) tetrabenazine	XENAZINE (tetrabenazine)	**Austedo and Austedo XR** • 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

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MULTIPLE SCLEROSIS AGENTS DUR+			
	BETASERON (interferon beta-1b) COPAXONE 20mg (glatiramer) dalfampridine dimethyl fumarate fingolimod REBIF (interferon beta-1a) teriflunomide TYSABRI (natalizumab)	AMPYRA (dalfampridine) AUBAGIO (teriflunomide) AVONEX (interferon beta-1a) BAFIERTAM (monomethyl fumarate) BRIUMVI (ublituximab) COPAXONE 40mg (glatiramer) EXTAVIA (interferon beta-1b) Glatiramer GILENYA (fingolimod) GLATOPA (glatiramer) KESIMPTA (ofatumumab) MAVENCLAD (cladribine) MAYZENT (siponimod) OCREVUS (ocrelizumab) PLEGRIDY (interferon beta-1a) PONVORY (ponesimod) TASCENSO ODT (fingolimod) TECFIDERA (dimethyl fumarate) VUMERITY (diroximel fumarate) ZEPOSIA (ozanimod)	**All Agents** • Documented diagnosis of multiple sclerosis **Non-Preferred Criteria** • 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 **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)	**Emflaza – Manual PA** **Exondys – MANUAL PA** **Viltepso –MANUAL PA** **Vyondys – MANUAL PA**

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		VYONDYS 53 (golodirsen)	
NSAIDS DUR+			
	NON-SELECTIVE		
	diclofenac EC diclofenac IR diclofenac SR etodolac IR tab flurbiprofen ibuprofen ibuprofen suspension OTC indomethacin ketoprofen ketorolac nabumetone naproxen 250mg and 500mg naproxen suspension piroxicam sulindac	ADVIL (ibuprofen) ANAPROX (naproxen) CAMBIA (diclofenac potassium) CATAFLAM (diclofenac) DAYPRO (oxaprozin) diclofenac potassium etodolac cap etodolac tab SR FELDENE (piroxicam) FENORTHO (fenoprofen) fenoprofen INDOCIN capsules, suspension & suppositories (indomethacin) indomethacin cap ER indomethacin suspension ketoprofen ER KIPROFEN (ketoprofen) LOFENA(diclofenac potassium) meclofenamate mefenamic acid NALFON (fenoprofen) NAPRELAN (naproxen) NAPROSYN (naproxen) naproxen 275mg and 550mg NUPRIN (ibuprofen)	**Quantity Limit** • **20 tablets/31 days** – ketorolac tablets **Non-Preferred Criteria** • Have tried 2 different preferred non-selective or NSAID/GI protectant combination agents in the past 6 months

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		oxaprozin PONSTEL (mefenamic acid) PROFENO (fenoprofen) RELAFEN DS (nabumetone) SPRIX NASAL SPRAY (ketorolac) TIVORBEX (indomethacin) tolmetin VOLTAREN XR (diclofenac) ZIPSOR (diclofenac) ZORVOLEX (diclofenac)	
NSAID/GI PROTECTANT COMBINATIONS			
		ARTHROTEC (diclofenac/misoprostol) diclofenac/misoprostol DUEXIS (ibuprofen/famotidine) VIMOVO (naproxen/esomeprazole)	**Non-Preferred Criteria** • Have tried 2 different preferred non-selective or NSAID/GI protectant combination agents in the past 6 months
COX II SELECTIVE			
	meloxicam	CELEBREX (celecoxib) celecoxib ELYXYB (celecoxib) MOBIC (meloxicam) NULOX (meloxicam) QMIIZ ODT (meloxicam) VIVLODEX (meloxicam)	**Non-Preferred Criteria – COX II** • Documented diagnosis of Osteoarthritis, Rheumatoid Arthritis, Familial Adenomatous Polyposis, or Ankylosing Spondylitis **AND** • 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**

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			• 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
OPHTHALMIC ANTIBIOTICS			
	bacitracin/neomycin/gramicidin bacitracin/polymyxin ciprofloxacin erythromycin GENTAK Ointment (gentamicin) gentamicin ILOTYCIN (erythromycin) moxifloxacin ofloxacin polymyxin/trimethoprim tobramycin	AZASITE (azithromycin) bacitracin BESIVANCE (besifloxacin) BLEPH-10 (sulfacetamide) CILOXAN Ointment (ciprofloxacin) CILOXAN Solution (ciprofloxacin) GARAMYCIN (gentamicin) gatifloxacin levofloxacin MOXEZA (moxifloxacin) NATACYN (natamycin) neomycin/bacitracin/polymyxin b NEO-POLYCIN (neomy/baci/polymyxin b) NEOSPORIN (bacitracin/neomycin/gramicidin) (oxy-tcn/polymyx sul) OCUFLOX (ofloxacin) POLYTRIM (polymyxin/trimethoprim) sulfacetamide TOBREX drops (tobramycin)	

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

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

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			• **5.5 mL/31 days** – Restasis Multidose • **60 units/31 days** – Cequa, Restasis droperette, Xiidra **Eysuvis, Miebo, Tyrvaya and Vevye** • Require clinical review **Non-Preferred Criteria** • History of 4 claims for Restasis in the past 6 months
OPHTHALMIC, GLAUCOMA AGENTS DUR+			
BETA BLOCKERS			
	BETIMOL (timolol) carteolol ISTALOL (timolol) levobunolol metipranolol timolol drops 0.25%, 0.5%	BETAGAN (levobunolol) betaxolol BETOPTIC S (betaxolol) OPTIPRANOLOL (metipranolol) timolol gel timolol daily drop 0.5% (generic Istalol) TIMOPTIC (timolol) TIMOPTIC XE (timolol)	**Minimum Age Limit** • **18 years** – Iyuzeh **Non-Preferred Criteria** • Have tried 2 different preferred agents in the past 6 months **OR** • 90 days of therapy with the requested agent in the past 105 days

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

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SYMPATHOMIMETICS			
	ALPHAGAN P 0.1% (brimonidine) ALPHAGAN P 0.15% (brimonidine) brimonidine 0.2%	brimonidine 0.15% brimonidine 0.1% dipivefrin PROPINE (dipivefrin)	
OPIATE DEPENDENCE TREATMENTS			
DEPENDENCE			
	buprenorphine/naloxone tablets DUR+ naltrexone tablets SUBOXONE FILM(buprenorphine/naloxone) DUR+	BRIXADI (buprenorphine) buprenorphine tablets DUR+ buprenorphine/naloxone films DUR+ lofexidine 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 (naloxone) OPVEE (nalmefene) REXTOVY (naloxone) ZIMHI (naloxone)	EVZIO (naloxone)	

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MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

(For All Medicaid, MSCAN and CHIP Beneficiaries)

EFFECTIVE 01/01/2025
Version 2024_15
Updated: 01/01/2025

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
OTIC ANTIBIOTICS			
	CIPRO HC (ciprofloxacin/hydrocortisone) Age Edit CORTISPORIN-TC (colistin/neomycin/ hydrocortisone) fluocinolone oil neomycin/polymyxin/hydrocortisone ofloxacin **Preferred Ophthalmic Formulations for Otic Use** ciprofloxacin ophthalmic dexamethasone ophthalmic MAXIDEX (dexamethasone) ophthalmic	ciprofloxacin ciprofloxacin/dexamethasone ciprofloxacin/fluocinolone DERMOTIC (fluocinolone) FLAC OIL DROP (fluocinolone oil) hydrocortisone/acetic acid drop 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 • Have tried 10 days otic treatment with ciprofloxacin ophthalmic solution and Maxidex (dexamethasone) ophthalmic suspension with continued otorrhea
PANCREATIC ENZYMES DUR+			
	CREON (pancreatin) ZENPEP (pancrelipase)	PANCREAZE (pancrelipase) PERTZYE (pancrelipase) VIOKACE (pancrelipase)	**Non-Preferred Criteria** • Have tried 2 different preferred agents in the past 6 months

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PARATHYROID AGENTS			
	calcitriol cinacalcet ergocalciferol paricalcitol ZEMPLAR (paricalcitol)	doxercalciferol DRISDOL (ergocalciferol) HECTOROL (doxercalciferol) NATPARA (parathyroid hormone) RAYALDEE (calcifediol) ROCALTROL (calcitriol) SENSIPAR (cinacalcet) YORVIPATH (palopegteriparatide)NR	
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)	
PLATELET AGGREGATION INHIBITORS DUR+			
	BRILINTA (ticagrelor) cilostazol clopidogrel dipyridamole dipyridamole/aspirin pentoxifylline	DURLAZA ER (aspirin) EFFIENT (prasugrel) omeprazole/aspirin PERSANTINE (dipyridamole) PLAVIX (clopidogrel) PLETAL (cilostazol) ticlopidine	**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

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	prasugrel	YOSPRALA (aspirin/omeprazole) ZONTIVITY (vorapaxar)	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) SPS SUSPENSION (sodium polystyrene sulfonate)	sodium polystyrene sulfonate SPS ENEMA (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 PNV 95/Fe/FA PNV 103/Fe/FA PNV 137/Fe/FA SE-NATAL 19 CHEW SE-NATAL 19 THRIVITE RX TRINATAL RX 1 WESNATAL DHA COMPLETE WESTAB PLUS	Products not listed are assumed to be Non-Preferred.	Link to Preferred Prenatal NDC's

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
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+			
ACTIVIN SIGNALING INHIBITORS			
		WINREVAIR (sotatercept-csrk)	**All PAH Agents** • Documented diagnosis of pulmonary hypertension **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
COMBINATION AGENTS			
		OPSYNVI (macitentan/tadalafil)	**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
ENDOTHELIN RECEPTOR ANTAGONIST			
	ambrisentan (all manufacturers except those listed as non-preferred) bosentan tablets	ambrisentan (manufacturers starting with 42794) LETAIRIS (ambrisentan)* OPSUMIT (macitentan) TRACLEER (bosentan) TRYVIO (aprocitentan)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	**Sildenafil tablets** < 1 year of age • 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

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			> 1 years of age **AND** • Documented diagnosis of Pulmonary Hypertension **Revatio suspension** • < 12 years of age **AND** • Documented diagnosis of pulmonary hypertension, patent ductus arteriosus or persistent fetal circulation or history of a heart transplant **OR** • 90 days stable therapy with Revatio suspension in the past 105 days **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
PROSTACYCLINS			
		ORENITRAM ER (treprostinil) TYVASO (treprostinil) VENTAVIS (iloprost)	**Non-Preferred Criteria** • Documented diagnosis of pulmonary hypertension **AND**

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

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
ROSACEA TREATMENTS			
	metronidazole (cream, gel, lotion)	AVAR (sulfacetamide sodium/sulfur) FINACEA (azelaic acid) FINACEA FOAM (azelaic acid) METROCREAM (metronidazole cream) METROGEL (metronidazole gel) METROLOTION (metronidazole lotion) MIRVASO (brimonidine) NORITATE (metronidazole) OVACE (sulfacetamide sodium) RHOFADE (oxymetazoline HCl) ROSULA (sodium sulfacetamide/sulfur) sodium sulfacetamide/sulfur (cleanser, pads, suspension) SOOLANTRA (ivermectin) SUMADAN (sodium sulfacetamide/sulfur wash) SUMAXIN (sodium sulfacetamide/sulfur pads) SUMAXIN TS (sodium sulfacetamide/sulfur suspension) ZILXI AEROSOL (minocycline)	Topical Sulfonamides used for Rosacea will require a manual PA for ≥21 years. Other labeled indications are limited to <21 years.
SEDATIVE HYPNOTICS			
BENZODIAZEPINES DUR+			
	estazolam temazepam (15mg and 30mg)	DALMANE (flurazepam) DORAL (quazepam) flurazepam HALCION (triazolam)	Single source benzodiazepines and barbiturates are NOT covered – NO PA's will be issued for these drugs.

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		quazepam RESTORIL (temazepam) temazepam (7.5mg and 22.5mg) triazolam	**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** • **60 units/365 days**
OTHERS DUR+			
	eszopiclone ramelteon zaleplon zolpidem tablet	AMBIEN (zolpidem) AMBIEN CR (zolpidem) BELSOMRA (suvorexant) DAYVIGO (lemborexant) doxepin 3mg, 6mg EDLUAR (zolpidem) HETLIOZ (tasimelteon) INTERMEZZO (zolpidem) LUNESTA (eszopiclone) ROZEREM (ramelteon) QUVIVIQ (daridorexant)	**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

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		SILENOR (doxepin) SONATA (zaleplon) zolpidem capsule zolpidem ER zolpidem SL ZOLPIMIST (zolpidem)	• **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 **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

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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) 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)	**Non-Preferred Criteria** • 1 claim with the requested agent in the past 105 days

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		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)	
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) glutamine HYDREA (hydroxyurea) SIKLOS (hydroxyurea	Endari – MANUAL PA

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
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 (orphenadrine) orphenadrine orphenadrine compound orphenadrine ER PARAFON FORTE DSC (chlorzoxazone) ROBAXIN (methocarbamol) SKELAXIN (metaxalone) SOMA (carisoprodol) TANLOR (methocarbamol) tizanidine capsules ZANAFLEX (tizanidine)	**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** • 1 claim for cyclobenzaprine in the past 21 **Carisoprodol with codeine** • Requires clinical review **Tanlor** • Requires Clinical Review

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
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			
	alclometasone DERMA-SMOOTHE-FS (fluocinolone) desonide hydrocortisone cream, ointment, solution	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

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
MEDIUM POTENCY			
	fluocinolone fluticasone cream, ointment hydrocortisone mometasone cream, ointment mometasone solution prednicarbate cream PANDEL (hydrocortisone probutate)	betamethasone valerate foam CLODERM (clocortolone) CUTIVATE (fluticasone) DERMATOP (prednicarbate) ELOCON (mometasone) fluticasone lotion LUXIQ (betamethasone) MOMEXIN (mometasone) prednicarbate oint SYNALAR (fluocinolone)	**Non-Preferred Criteria** • Have tried 2 different preferred medium potency agents in the past 6 months
HIGH POTENCY			
	betamethasone dipropionate cream, gel, lotion betamethasone valerate cream, lotion, ointment fluocinolone fluocinonide triamcinolone 0.025% and 0.1% cream, ointment, lotion	amcinonide cream amcinonide ointment betamethasone diprop/prop gly cream, lotion, ointment betamethasone dipropionate ointment BETA-VAL (betamethasone valerate) desoximetasone diflorasone DIPROLENE AF (betamethasone diprop/prop gly) ELOCON (mometasone) halcinonide HALOG (halcinonide) KENALOG (triamcinolone) PEDIADERM TA (triamcinolone)	**Non-Preferred Criteria** • Have tried 2 different preferred high potency agents in the past 6 months

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		SERNIVO (betamethasone dipropionate) TOPICORT (desoximetasone) triamcinolone aerosol triamcinolone 0.05% ointment TRIANEX (triamcinolone) VANOS (fluocinonide)	
VERY HIGH POTENCY			
	clobetasol emollient clobetasol lotion clobetasol shampoo, spray clobetasol propionate cream clobetasol propionate foam, gel clobetasol propionate ointment halobetasol cream halobetasol ointment	BRYHALI (halobetasol) 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
STIMULANTS AND RELATED AGENTS DUR+			
SHORT-ACTING			
	amphetamine salt combination dexmethylphenidate IR	ADDERALL (amphetamine salt combination) amphetamine sulfate (generic EVEKO)	**Minimum Age Limit** • **3 years** – Adderall, Evekeo, Procentra, Zenzedi

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	dextroamphetamine IR methylphenidate IR methylphenidate solution PROCENTRA (dextroamphetamine)	DESOXYN (methamphetamine) dextroamphetamine/amphetamine ER dextroamphetamine solution EVEKEO (amphetamine) EVEKEO ODT (amphetamine) FOCALIN (dexmethylphenidate) methamphetamine METHYLIN solution (methylphenidate) methylphenidate chewable RITALIN (methylphenidate) ZENZEDI (dextroamphetamine)	• **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 **Non-Preferred Criteria Short Acting Narcolepsy** ADDERALL, EVEKEO, METHYLIN, PROCENTRA, RITALIN, ZENZEDI

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			• 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) methylphenidate ER (generic Concerta) methylphenidate ER Tabs (generic Ritalin SR) methylphenidate ER/LA Caps (generic Ritalin LA) QUILLICHEW (methylphenidate) QUILLIVANT XR (methylphenidate)	ADHANSIA XR (methylphenidate) ADZENYS XR ODT (amphetamine) ADZENYS ER SUSPENSION (amphetamine) amphetamine susp 24 hr (generic ADZENYS ER) APTENSIO XR (methylphenidate) AZSTARYS (serdexmethylphenidate/dexmethylphenidate) COTEMPLA XR-ODT (methylphenidate) DAYTRANA (methylphenidate) DEXEDRINE (dextroamphetamine) DYANAVEL XR tablet(amphetamine) FOCALIN XR (dexmethylphenidate) JORNAY PM (methylphenidate) methylphenidate ER caps (generic Aptensio XR)	**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, Onyda XR, Quillichew, Quillivant XR, Relexxii ER, Ritalin LA, Vyvanse, Xelstrym • **13 years** – Mydayis • **16 years** – Provigil • **18 years** – Nuvigil, Sunosi

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	VYVANSE (lisdexamfetamine)	methylphenidate ER (generic Relexxii) methylphenidate patch (generic Daytrana) MYDAYIS (amphetamine salt combination) ONYDA XR (clonidine extended release)NR RELEXXI (methylphenidate) RITALIN LA (methylphenidate) RITALIN SR (methylphenidate) VYVANSE CHEWABLE (lisdexamfetamine)* XELSTRYM patch (dextroamphetamine)	**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 • **30 ml/31 days (30 ml bottle) –** Onyda XR Suspension • **60 ml/31 days (60 ml bottle) –** Onyda 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 **Jornay PM** • Documented diagnosis of ADD/ADHD **AND** • 84 days of therapy with 2 different preferred LA methylphenidate agents in the past 12 months **AND** • 84 days of therapy with 1 preferred non-methylphenidate LA stimulant agent in the past 12 months **OR** • Documented diagnosis of ADD/ADHD **AND** • 84 days of therapy with the requested agent in the past 105 days. **Onyda XR** • Requires Clinical review

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			Vyvanse • Documented diagnosis of binge eating disorder **OR** • Documented diagnosis of ADD/ADHD
NARCOLEPSY			
	armodafinil modafinil SUNOSI (solriamfetol) XYREM (sodium oxybate)	LUMRYZ (sodium oxybate) NUVIGIL (armodafinil) PROVIGIL (modafinil) sodium oxybate WAKIX (pitolisant) 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** • 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

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			apnea, shift work sleep disorder or bipolar depression **Provigil** • Documented diagnosis of narcolepsy, obstructive sleep apnea, shift work sleep disorder, depression, sleep deprivation or Steinert Myotonic Dystrophy Syndrome **Sunosi** • Documented diagnosis of narcolepsy or obstructive sleep apnea **AND** • 30 days of therapy with preferred modafinil or armodafinil in the past 6 months **Wakix** • Documented diagnosis of narcolepsy with or without cataplexy **AND** • 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

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			Xyrem and Xywav • Require clinical review
NON-STIMULANTS			
	atomoxetine clonidine ER guanfacine ER QELBREE (viloxazine)	INTUNIV (guanfacine ER) 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 **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

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			Clonidine ER • Documented diagnosis of ADD or ADHD **Qelbree** • Documented diagnosis of ADD or ADHD **AND** • 1 claim for a 30-day supply with a preferred ADHD product
TETRACYCLINES DUR+			
	doxycycline hyclate caps/tabs doxycycline monohydrate caps (50mg & 100mg) minocycline caps IR tetracycline	ACTICLATE (doxycycline) ADOXA (doxycycline monohydrate) demeclocycline doxycycline hyclate (generic Doryx) doxycycline hyclate (generic Periostat) doxycycline monohydrate caps (75mg & 150mg) doxycycline monohydrate tabs DORYX (doxycycline hyclate) DYNACIN (minocycline) MINOCIN (minocycline) MINOLIRA (minocycline) minocycline ER minocycline tabs MONODOX (doxycycline monohydrate) NUZYRA (omadacycline tosylate) OKEBO (doxycycline) ORACEA (doxycycline)	**Non-Preferred Agents** • Have tried 2 different preferred agents in the past 6 months **Demeclocycline** • Documented diagnosis of SIADH will allow automatic approval

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		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 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) LIALDA (mesalamine) mesalamine tablet (generic Asacol HD) mesalamine tablet (generic Apriso) mesalamine capsules (generic Delzicol) ORTIKOS (budesonide) VELSIPITY (etrasimod)	**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
RECTAL			
	mesalamine suppository	budesonide foam CANASA (mesalamine) ROWASA (mesalamine) SF-ROWASA (mesalamine) UCERIS Foam (budesonide)	

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
UREA CYCLE DISORDERS			
	CARBAGLU (carglumic acid)	buphenyl powder buphenyl tablet carglumic acid OLPRUVA PHEBURANE RAVICTI	

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