



MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

EFFECTIVE 10/01/2024

Version 2024_14

Updated: 12/01/2024

(For All Medicaid, MSCAN and CHIP Beneficiaries)

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

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
ACNE AGENTS			
ANTI-INFECTIVE			
	clindamycin gel (generic Cleocin-T) clindamycin lotion clindamycin solution	ACZONE (dapsons) AKNE-MYCIN (erythromycin) azelaic acid AMZEEQ FOAM (minocycline) AZELEX (azelaic acid) CLEOCIN-T (clindamycin) CLINDAMYCIN PAC (clindamycin) CLINDAGEL (clindamycin) clindamycin foam clindamycin gel daily (generic Clindagel) dapsons ERY (erythromycin) ERYGEL (erythromycin) erythromycin gel, swabs, solution EVOCLIN (clindamycin) KLARON (sulfacetamide) sulfacetamide WINLEVI (clascoterone)	Maximum Age Limit <ul style="list-style-type: none"> • 21 years – all agents except isotretinoin
RETINIDS			
	RETIN-A (tretinoin) tretinoin cream	adapalene AKLIEF (trifarotene) ALTRENO (tretinoin) ARAZLO (tazarotene) ATRALIN (tretinoin) AVITA (tretinoin) DIFFERIN (adapalene)	

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

Drugs highlighted in yellow denote a change in PDL status.

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

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		PRASCION (sulfacetamide sodium/sulfur) ROSANIL (sulfacetamide sodium/sulfur) SE BPO (benzoyl peroxide) sodium sulfacetamide/sulfur cleanser/cream/lotion/pads sodium sulfacetamide/sulfur/meratan SSS 10/5 Foam (sodium sulfacetamide/sulfur) sulfacetamide sodium/sulfur/urea VELTIN (clindamycin/tretinoin) ZENCIA WASH (sulfacetamide sodium/sulfur) ZIANA (clindamycin/tretinoin)	
KERATOLYTICS (BENZOYL PEROXIDES)			
	benzoyl peroxide bar, cleanser, cream, gel, lotion, wash ^{Rx & OTC}	benzoyl peroxide foam ^{Rx & OTC} BP 5.5% (benzoyl peroxide) BPO (benzoyl peroxide) ^{Rx & OTC} INOVA (benzoyl peroxide) LAVOCLEN (benzoyl peroxide) PANOXYL BAR 10% (benzoyl peroxide) ^{OTC} PANOXYL CREAM 3% (benzoyl peroxide) ^{OTC} OC8 GEL (benzoyl peroxide) ^{OTC}	
ISOTRETINOIN			
	ACCUTANE (isotretinoin) AMNESTEEM (isotretinoin) CLARAVIS (isotretinoin) isotretinoin MYORISAN (isotretinoin) ZENATANE (isotretinoin)	ABSORICA (isotretinoin) ABSORICA LD (isotretinoin)	Available for all ages

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Therapeutic Drug Class	Preferred Agents	Non-Preferred Agents	PA Criteria
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)		
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)	<p style="text-align: center;">Preferred Criteria</p> <ul style="list-style-type: none"> • Documented approvable diagnosis <p style="text-align: center;">Non-Preferred Criteria</p> <ul style="list-style-type: none"> • 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)	<p style="text-align: center;">Namzaric</p> <ul style="list-style-type: none"> • Documented diagnosis AND • 30 days of concurrent therapy with both donepezil and memantine in the past 6 months

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ANALGESICS, OPIOID- SHORT ACTING ^{DUR+}			
	acetaminophen/codeine benzhydrocodone/APAP 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	ABSTRAL (fentanyl) ACTIQ (fentanyl) 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)	<p style="color: red;">MS DOM Opioid Initiative</p> <ul style="list-style-type: none"> Morphine Equivalent Daily Dose Concomitant use of Opioids and Benzodiazepines <p style="color: blue;">Criteria details found here</p> <p style="color: red;">Minimum Age Limit</p> <ul style="list-style-type: none"> 18 years – tramadol and codeine products <p style="color: red;">Quantity Limit</p> <p>Applicable quantity limit in 31 rolling days</p> <ul style="list-style-type: none"> 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 <ul style="list-style-type: none"> 5 ml – butorphanol nasal 180 ml – oxycodone liquids <ul style="list-style-type: none"> 280 ml – Qdolo

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		OPANA (oxymorphone) OXAYDO (oxycodone) oxycodone/APAP (oxycodone/APAP 300MG) oxymorphone pentazocine/naloxone PERCOCET (oxycodone/APAP) PERCODAN (oxycodone/ASA) PRIMLEV (oxycodone/APAP) PROLATE (oxycodone/APAP) QDOLO (tramadol) REPREXAIN (hydrocodone/ibuprofen) ROXICET (oxycodone/acetaminophen) ROXICODONE (oxycodone) ROXYBOND (oxycodone) SEGLENTIS (tramadol/celecoxib) SUBSYS (fentanyl) SYNALGOS-DC (dihydrocodeine/ aspirin/caffeine) TYLENOL W/CODEINE (APAP/codeine) TYLOX (oxycodone/APAP) ULTRACET (tramadol/APAP) ULTRAM (tramadol) VICODIN (hydrocodone/APAP) VICOPROFEN (hydrocodone/ibuprofen) XODOL (hydrocodone/acetaminophen) ZAMICET (hydrocodone/APAP) ZOLVIT (hydrocodone/APAP) ZYDONE (hydrocodone/acetaminophen)	

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ANALGESICS, OPIOID - LONG ACTING ^{DUR+}			
	BUTRANS (buprenorphine) fentanyl patches morphine ER tablets	ARYMO ER (morphine) BELBUCA (buprenorphine) buprenorphine patch CONZIP ER (tramadol) DOLOPHINE (methadone) DURAGESIC (fentanyl) EXALGO (hydromorphone) hydromorphone ER HYSINGLA ER (hydrocodone) KADIAN (morphine) methadone morphine ER capsules MS CONTIN (morphine) NUCYNTA ER (tapentadol) OPANA ER (oxymorphone) oxycodone ER OXYCONTIN (oxycodone) oxymorphone ER RYZOLT (tramadol) tramadol ER ULTRAM ER (tramadol) XTAMPZA (oxycodone myristate)	<p style="color: red;">MS DOM Opioid Initiative</p> <ul style="list-style-type: none"> Morphine Equivalent Daily Dose Concomitant use of Opioids and Benzodiazepines Criteria details found here <p style="color: red;">Minimum Age Limit</p> <ul style="list-style-type: none"> 18 years – Butrans, tramadol products <p style="color: red;">Quantity Limit</p> <p>Applicable quantity limit per rolling days</p> <ul style="list-style-type: none"> 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 <p style="color: red;">Non-Preferred Criteria</p> <ul style="list-style-type: none"> Have tried 2 different preferred agents in the past 6 months

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ANALGESICS/ANESTHETICS (Topical)			
	diclofenac sodium 1% gel diclofenac sodium 1.5% solution lidocaine 4% cream ^{OTC} lidocaine 5% ointment lidocaine 5% patch	capsaicin diclofenac epolamine patch ^{DUR+} diclofenac sodium 3% gel FLECTOR Patch (diclofenac epolamine) ^{DUR+} FROTEK (ketoprofen) LICART (diclofenac epolamine) LIDAMANTLE HC (lidocaine/hydrocortisone) LIDO TRANS PAK (lidocaine) lidocaine/prilocaine LIDODERM (lidocaine) ^{DUR+} LIDTOPIC MAX (lidocaine) PENNSAID 2% Solution (diclofenac sodium) ^{DUR+} SYNERA (lidocaine/tetracaine) TRANZAREL (lidocaine) VENNGEL ONE 1% kit (diclofenac sodium) VOLTAREN Gel (diclofenac sodium) ^{DUR+} XRYLIDERM (lidocaine) xylocaine ZOSTRIX (capsaicin) ZTlido (lidocaine)	<p style="color: red;">Quantity Limit</p> <ul style="list-style-type: none"> • 1 bottle/31 days (112 ml)– Diclofenac 2% solution pump • 1 bottle/31 days (150ml) – Diclofenac 1.5% solution <p style="color: red;">Non-Preferred Criteria</p> <ul style="list-style-type: none"> • Have tried 2 preferred agents in the past 6 months <p style="color: red;">Lidocaine 5% Patch</p> <ul style="list-style-type: none"> • Documented diagnosis of Herpetic Neuralgia OR • Documented diagnosis of Diabetic Neuropathy <p style="color: red;">ZTlido</p> <ul style="list-style-type: none"> • Documented diagnosis of Herpetic Neuralgia
ANDROGENIC AGENTS ^{DUR+}			
	ANDRODERM (testosterone patch) testosterone gel packet	ANDROGEL (testosterone gel) ANDROXY (flouxymesterone) AXIRON (testosterone gel) AZMIRO (testosterone cypionate) ^{NR} FORTESTSA (testosterone gel)	<p style="color: red;">All Agents</p> <ul style="list-style-type: none"> • Limited to male gender <p style="color: red;">Non-Preferred Criteria</p>

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		JATENZO (testosterone undecanoate) NATESTO (testosterone) STRIANT (testosterone) TESTIM (testosterone gel) testosterone pump TLANDO (testosterone) UNDECATREX (testosterone undecanoate) ^{NR} VOGELXO (testosterone) XYOSTED (testosterone enanthate)	<ul style="list-style-type: none"> Have tried 2 different preferred agents in the past 6 months <p style="text-align: center;">Tlando</p> <ul style="list-style-type: none"> Requires clinical review
ANGIOTENSIN MODULATORS ^{DUR+}			
ACE INHIBITORS			
	benazepril captopril enalapril fosinopril lisinopril quinapril ramipril trandolapril	ACCUPRIL (quinapril) ACEON (perindopril) ALTACE (ramipril) EPANED (enalapril) LOTENSIN (benazepril) MAVIK (trandolapril) moexipril perindopril PRINIVIL (lisinopril) QBRELIS (lisinopril) UNIVASC (moexipril) VASOTEC (enalapril) ZESTRIL (lisinopril)	<p style="text-align: center;">Minimum Age Limit</p> <ul style="list-style-type: none"> ≤ 6 years – Epaned Automatic approval issued for this age <p style="text-align: center;">Non-Preferred Criteria</p> <ul style="list-style-type: none"> 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	ACCURETIC (quinapril/HCTZ) CAPOZIDE (captopril/HCTZ) LOTENSIN HCT (benazepril/HCTZ) LOTREL (benazepril/amlodipine)	<p style="text-align: center;">Non-Preferred Criteria ACE Inhibitor/CCB</p> <ul style="list-style-type: none"> Have tried 2 different preferred ACEI/CCB agents in the past 6 months OR

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	fosinopril/HCTZ lisinopril/HCTZ quinapril/HCTZ trandolapril/verapamil	moexipril/HCTZ PRESTALIA (perindopril/amlodipine) PRINZIDE (lisinopril/HCTZ) TARKA (trandolapril/verapamil) UNIRETIC (moexipril/HCTZ) VASERETIC (enalapril/HCTZ) ZESTORETIC (lisinopril/HCTZ)	<ul style="list-style-type: none"> 90 days of therapy with the requested agent in the past 105 days <p style="color: red; text-align: center;">ACE Inhibitor/Diuretic</p> <ul style="list-style-type: none"> 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)	<p style="color: red; text-align: center;">Non-Preferred Criteria</p> <ul style="list-style-type: none"> 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	ATACAND-HCT (candesartan/HCTZ) AVALIDE (irbesartan/HCTZ) AZOR (olmesartan/amlodipine) BENICAR-HCT (olmesartan/HCTZ)	<p style="color: red; text-align: center;">Entresto</p> <ul style="list-style-type: none"> Age ≥ 18 years AND Documented diagnosis of heart failure OR Age ≥ 1 year AND

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	olmesartan/HCTZ telmisartan/HCTZ valsartan/amlodipine valsartan/amlodipine/HCTZ valsartan/HCTZ	BYVALSON (nebivolol/valsartan) candesartan/HCTZ DIOVAN-HCT (valsartan/HCTZ) EDARBYCLOR (azilsartan/chlorthalidone) ENTRESTO SPRINKLE (valsartan/sacubitril) ^{NR} EXFORGE (valsartan/amlodipine) EXFORGE HCT (valsartan/amlodipine/HCTZ) HYZAAR (losartan/HCTZ) MICARDIS-HCT (telmisartan/HCTZ) olmesartan/amlodipine/HCTZ telmisartan/amlodipine TEVETEN-HCT (eprosartan/HCTZ) TRIBENZOR (olmesartan/amlodipine/HCTZ) TWYNSTA (telmisartan/amlodipine)	<ul style="list-style-type: none"> Documented diagnosis of heart failure with systemic ventricular systolic dysfunction <p>Non-Preferred Criteria ARB/Beta Blocker, ARB/CCB or ARB/CCB/Diuretic</p> <ul style="list-style-type: none"> Have tried 1 preferred ARB/CCB agent in the past 6 months OR <ul style="list-style-type: none"> 90 days of therapy with the requested agent in the past 105 days <p>ARB/Diuretic</p> <ul style="list-style-type: none"> Have tried 2 different preferred ARB/Diuretic products in the past 6 months OR <ul style="list-style-type: none"> 90 days of therapy with the requested agent in the past 105 days
DIRECT RENIN INHIBITORS			
		TEKTURNA (aliskiren) aliskiren	<p>Non-Preferred Criteria</p> <ul style="list-style-type: none"> Documented diagnosis of hypertension AND Have tried 2 different preferred ACEI or ARB single-entity products in the past 6 months OR <ul style="list-style-type: none"> 90 days of therapy with the requested agent in the past 105 days

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DIRECT RENIN INHIBITOR COMBINATIONS			
		TEKURNA-HCT (aliskiren/hctz)	<p>Non-Preferred Criteria</p> <ul style="list-style-type: none"> • Documented diagnosis of hypertension AND • Have tried 2 different preferred ACEI or ARB diuretic agents in the past 6 months OR • 90 days of therapy with the requested agent in the past 105 days
ANTIBIOTICS (GI) & RELATED AGENTS			
	FIRVANQ (vancomycin) metronidazole tablets neomycin tinidazole	AEMCOLO (rifaximin) DIFICID (fidaxomicin) FLAGYL (metronidazole) FLAGYL ER (metronidazole) LIKMEZ (metronidazole) metronidazole capsules paromomycin REBYOTA (fecal microbiota) TINDAMAX (tinidazole) VANCOCIN (vancomycin) vancomycin VOWST (fecal microbiota) XIFAXAN (rifaximin)	
ANTIBIOTICS (MISCELLANEOUS)			
KETOLIDES			
		KETEK (telithromycin)	

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LINCOSAMIDE ANTIBIOTICS			
	clindamycin capsules clindamycin solution	CLEOCIN (clindamycin) CLEOCIN SOLUTION (clindamycin)	
MACROLIDES			
	azithromycin clarithromycin ER clarithromycin IR clarithromycin suspension ERY-TAB (erythromycin) erythromycin erythromycin ethylsuccinate	BIAXIN (clarithromycin) BIAXIN SUSPENSION (clarithromycin) BIAXIN XL (clarithromycin) E.E.S. FILM TAB (erythromycin ethylsuccinate) E.E.S. Suspension (erythromycin ethylsuccinate) E-MYCIN (erythromycin) ERYC (erythromycin) ERYPED Suspension (erythromycin ethylsuccinate) ERYTHROCIN (erythromycin stearate) erythromycin estolate PCE (erythromycin) ZITHROMAX (azithromycin) ZMAX (azithromycin)	
NITROFURAN DERIVATIVES			
	nitrofurantoin nitrofurantoin monohydrate macrocrystals	FURADANTIN (nitrofurantoin) MACROBID (nitrofurantoin monohydrate macrocrystals) MACRODANTIN (nitrofurantoin)	
OXAZOLIDINONES			
		SIVEXTRO (tedizolid) ZYVOX (linezolid)	Sivextro – MANUAL PA Zyvox - MANUAL PA Quantity Limit • 6 tablets/month – Sivextro

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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 OVULES (clindamycin) CLINDESSE (clindamycin) metronidazole vaginal	AVC (sulfanilamide) CLEOCIN CREAM (clindamycin) clindamycin cream METROGEL (metronidazole) NUVESSA (metronidazole) SOLOSEC (secnidazole) VANDAZOLE (metronidazole) XACIATO GEL (clindamycin)	
ANTICOAGULANTS			
ORAL			
	COUMADIN (warfarin) ELIQUIS (apixaban) PRADAXA (dabigatran) warfarin XARELTO (rivaroxaban)	BEVYXXA (betrixaban) PRADAXA PELLETS (dabigatran) SAVAYSA (odonatan tosylate)	<p style="color: red;">Non-Preferred Criteria</p> <ul style="list-style-type: none"> • Have tried 2 different preferred oral agents in the past 6 months OR <ul style="list-style-type: none"> • 90 days of therapy with the requested agent in the past 105 days

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LOW MOLECULAR WEIGHT HEPARIN (LMWH)			
	enoxaparin	ARIXTRA (fondaparinux) fondaparinux FRAGMIN (dalteparin) LOVENOX (enoxaparin) Prefilled Syringe	LMWH Non-Preferred Criteria <ul style="list-style-type: none"> Have tried 1 different preferred agent in the past 6 months OR <ul style="list-style-type: none"> 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 levetiracetam levetiracetam ER oxcarbazepine oxcarbazepine suspension tiagabine topiramate tablet	APTOM (eslicarbazepine) BANZEL (rufinamide) BRIVIACT (brivaracetam) carbamazepine XR CARBATROL (carbamazepine) DEPAKENE (valproic acid) DEPAKOTE (divalproex) DIACOMIT (stiripentol) ELEPSIA XR (levetiracetam) EPRONTIA (topiramate solution) EQUETRO (carbamazepine) felbamate FELBATOL (felbamate) FINTEPLA (fenfluramine) FYCOMPA (perampanel) GABITRIL (tiagabine) KEPPRA (levetiracetam) KEPPRA XR (levetiracetam) LAMICTAL (lamotrigine)	Minimum Age Limit <ul style="list-style-type: none"> 6 months-- Diacomit 1 year – Banzel, Epidiolex 2 years –Onfi, Sympazan Epidiolex <ul style="list-style-type: none"> Documented diagnosis of Dravet syndrome. Lennox Gastaut syndrome or seizures associated with tuberous sclerosis complex OR 1 claim for the requested agent in the past 30 days Non-Preferred Criteria <ul style="list-style-type: none"> Have tried 2 different preferred agents in the past 6 months OR

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	topiramate sprinkle capsule valproic acid zonisamide	LAMICTAL CHEWABLE (lamotrigine) LAMICTAL ODT (lamotrigine) LAMICTAL XR (lamotrigine) lamotrigine ER/XR lamotrigine ODT MOTPOLY XR (lacosamide) NEURONTIN (gabapentin) OXTELLAR XR (oxcarbazepine) QUDEXY XR (topiramate) ROWEEPRA (levetiracetam) rufinamide SABRIL (vigabatrin) SPRITAM (levetiracetam) STAVZOR (valproic acid) TEGRETOL (carbamazepine) TEGRETOL SUSPENSION (carbamazepine) TEGRETOL XR (carbamazepine) TOPAMAX TABLET (topiramate) TOPAMAX Sprinkle (topiramate) topiramate ER (generic Qudexy XR) ^{Step Edit} TRILEPTAL Tablets (oxcarbazepine) TRILEPTAL Suspension (oxcarbazepine) TROKENDI XR (topiramate) Vigabatrin VIGAFYDE (vigabatrin) ^{NR} VIGPODER ORAL SOLUTION (vigabatrin) VIMPAT (lacosamide) XCOPRI (cenobamate) ZONISADE (zonisamide suspension)	<ul style="list-style-type: none"> • 90 days of therapy with the requested agent in the past 105 days AND • Documented diagnosis of seizure <p style="text-align: center; color: red;">Banzel, Onfi, Sympazan</p> <ul style="list-style-type: none"> • Documented diagnosis of Lennox-Gastaut AND • Have tried 1 different preferred agent for Lennox-Gastaut in the past 6 months OR <ul style="list-style-type: none"> • 90 days of therapy with the requested agent in the past 105 days AND • Documented diagnosis of seizure <p style="text-align: center; color: red;">Diacomit</p> <ul style="list-style-type: none"> • Documented diagnosis of Dravet syndrome AND • 1 claim for clobazam in the past 30 days <p style="text-align: center; color: red;">Fintepla</p> <ul style="list-style-type: none"> • Requires clinical review <p style="text-align: center; color: red;">Vigafyde</p> <ul style="list-style-type: none"> • Documented diagnosis of infantile spasms

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		ZTALMY (ganaxolone)	<p>Sabril Powder for Oral Solution</p> <ul style="list-style-type: none"> • Documented diagnosis of infantile spasms OR • Have tried 2 different preferred agents in the past 6 months OR <ul style="list-style-type: none"> • 90 days of therapy with the requested agent in the past 105 days AND • Documented diagnosis of seizure <p>Topiramate ER – Step Edit</p> <ul style="list-style-type: none"> • 90 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) SYMPAZAN (clobazam)	<p>Minimum Age Limit</p> <ul style="list-style-type: none"> • 12 years – Nayzilam • 6 years – Valtoco <p>Quantity Limit</p> <ul style="list-style-type: none"> • 2 Twin Packs/31 days – Diastat • 2 Packages /31 days – Nayzilam • 2 Cartons/31 day – Valtoco

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

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ANTIDEPRESSANTS, OTHER ^{DUR+}			
	bupropion bupropion SR bupropion XL TRINTELLIX (vortioxetine) mirtazapine trazodone venlafaxine venlafaxine ER capsules VIIBRYD (vilazodone)	APLENZIN (bupropion HBr) AUVELITY (dextromethorphan/bupropion) desvenlafaxine ER desvenlafaxine fumarate ER DESYREL (trazodone) DRIZALMA SPRINKLE (duloxetine DR) EFFEXOR (venlafaxine) EFFEXOR XR (venlafaxine) EMSAM (selegiline transdermal) FETZIMA ER (levomilnacipran) FORFIVO XL (bupropion) KHEDEZLA ER (desvenlafaxine) MARPLAN (isocarboxazid) NARDIL (phenelzine) nefazodone OLEPTRO ER (trazodone) PARNATE (tranylcypromine) phenelzine PRISTIQ (desvenlafaxine) REMERON (mirtazapine) tranylcypromine venlafaxine XR venlafaxine ER tablets vilazodone ZURZUVAE (zuranolone)	<p style="color: red;">Minimum Age Limit</p> <ul style="list-style-type: none"> 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 <p style="color: red;">Non-Preferred Criteria</p> <ul style="list-style-type: none"> 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 <p style="color: red;">Auvelity</p> <ul style="list-style-type: none"> Requires clinical review <p style="color: red;">Zurzuvae – <u>MANUAL PA</u></p> <p>Cymbalta and Irenka (see Fibromyalgia Agents)</p>

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ANTIDEPRESSANTS, SSRIs ^{DUR+}			
	citalopram escitalopram fluoxetine capsules fluvoxamine paroxetine CR paroxetine IR sertraline	CELEXA (citalopram) fluoxetine DR fluvoxamine ER LEXAPRO (escitalopram) LUVOX (fluvoxamine) LUVOX CR (fluvoxamine) paroxetine suspension PAXIL CR (paroxetine) PAXIL SUPENSION (paroxetine) PAXIL Tablets (paroxetine) PEXEVA (paroxetine) PROZAC (fluoxetine) SARAFEM (fluoxetine) ZOLOFT (sertraline)	<p>Minimum Age Limit</p> <ul style="list-style-type: none"> • 6 years – Zoloft • 7 years – Lexapro, Prozac • 8 years – Luvox • 18 years – Celexa, Luvox CR, Paxil, Pexeva, Prozac 90 mg <p>Maximum Age Limit</p> <ul style="list-style-type: none"> • 60 years – Celexa <p>Non-Preferred Criteria</p> <ul style="list-style-type: none"> • Have tried 2 different preferred agents in the past 6 months OR • 90 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) ZUPLLENZ (ondansetron)	<p>Quantity Limit</p> <ul style="list-style-type: none"> • 6 tablets/31 days – Akynzeo • 100 ml/31 days – Zofran solution <p>Non-Preferred Agents</p> <ul style="list-style-type: none"> • Have tried 1 preferred agent in the past 6 months Injectables in this class closed to point of sale. PA required if not administered in clinic/hospital

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ANTIEMETIC COMBINATIONS			
		AKYNZEO (netupitant/palonosetron) BONJESTA (doxylamine/pyridoxine) DICLEGIS (doxylamine/pyridoxine) doxylamine/pyridoxine	Akynzeo – MANUAL PA
CANNABINOIDS			
		CESAMET (nabilone) MARINOL (dronabinol) dronabinol SYNDROS (dronabinol)	
NMDA RECEPTOR ANTAGONIST			
	aprepitant	EMEND (aprepitant)	
ANTIFUNGALS (Oral) ^{DUR+}			
	clotrimazole fluconazole griseofulvin microsize suspension nystatin terbinafine	ANCOBON (flucytosine) ^ BREXAFEMME (ibrexafungerp) CRESEMBA (isavuconazonium) DIFLUCAN (fluconazole) flucytosine GRIFULVIN V (griseofulvin, microsize) griseofulvin microsize tablets griseofulvin ultramicrosize tablet GRIS-PEG (griseofulvin) itraconazole ^ ketoconazole LAMISIL (terbinafine) NOXAFIL (posaconazole) ^ ONMEL (itraconazole) ^	<p>Minimum Age Limit</p> <ul style="list-style-type: none"> • 12-17 years – griseofulvin tablets Automatic approval issued for this age range <p>Non-Preferred Criteria</p> <ul style="list-style-type: none"> • Have tried 2 different preferred agents in the past 6 months <p>HIV opportunistic infection</p> <ul style="list-style-type: none"> • Non-Preferred agent indicated for treatment (^) AND • Documented diagnosis of HIV <p>Cresemba - MANUAL PA</p>

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

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		KERYDIN (tavaborole) ketoconazole cream ketoconazole foam LAMISIL (terbinafine) solution LOPROX (ciclopirox) luliconazole MENTAX (butenafine) naftifine NAFTIN (naftifine) NIZORAL (ketoconazole) oxiconazole OXISTAT (oxiconazole) PEDIADERM AF (nystatin) PENLAC (ciclopirox) VUSION (miconazole/petrolatum/zinc oxide)	
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)	<p style="color: red;">Non-Preferred Criteria</p> <ul style="list-style-type: none"> • Documented diagnosis of allergy or urticaria AND • Have tried 2 different preferred agents in the past 12 months
MINIMALLY SEDATING ANTIHISTAMINE/DECONGESTANT COMBINATIONS			
	cetirizine/pseudoephedrine loratadine/pseudoephedrine	ALLEGRA-D (fexofenadine/ pseudoephedrine) CLARITIN-D (loratadine/pseudoephedrine) CLARINEX-D (desloratadine/ pseudoephedrine) fexofenadine/pseudoephedrine ZYRTEC-D (cetirizine/pseudoephedrine)	

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

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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)	<p style="color: red;">Minimum Age Limit</p> <ul style="list-style-type: none"> • 6 years – Maxalt • 12-17 years – Axert, Treximet, Zomig nasal spray <p>Automatic approval issued for this age range</p> <ul style="list-style-type: none"> • 18 years – Amerge, Frova, Imitrex, Onzetra Xsail, Relpax, Reyvow, Tosymra, Zembrace, Zomig tablets <p style="color: red;">Quantity Limit - ORAL</p> <ul style="list-style-type: none"> • 4 tablets/31 days – Reyvow 50 mg • 6 tablets/31 days - Axert, Relpax Zomig • 8 tablets/31 days – Reyvow 100 mg • 9 tablets/31 days - Amerge, Frova, Imitrex, Treximet • 12 tablets/31 days – Maxalt <p style="color: red;">Non-Preferred Criteria - ORAL</p> <ul style="list-style-type: none"> • Have tried 2 preferred oral agents in the past 90 days <p style="color: red;">Reyvow</p> <ul style="list-style-type: none"> • Documented diagnosis of migraine AND • Have tried 2 different triptans in the past 90 days AND

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NASAL			<ul style="list-style-type: none"> Have tried preferred Nurtec ODT in the past 90 days
	sumatriptan	IMITREX (sumatriptan) ONZETRA Xsail (sumatriptan) TOSYMRA (sumatriptan) zolmitriptan ZOMIG (zolmitriptan)	<p style="color: red;">Quantity Limit - NASAL</p> <ul style="list-style-type: none"> 1 box/31 days <p style="color: red;">Non-Preferred Criteria - NASAL</p> <ul style="list-style-type: none"> 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)	<p style="color: red;">CUMULATIVE Quantity Limit - Injectables</p> <p style="color: red;">4 injections/31 days</p>
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)	<p style="color: red;">Preferred Injectables</p> <ul style="list-style-type: none"> History of 3 claims with the requested agent in the past 105 days New starts require clinical review <p style="color: red;">Non-preferred Injectables</p> <ul style="list-style-type: none"> Requires clinical review

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			<p>Aimovig - MANUAL PA Ajovy - MANUAL PA Emgality - MANUAL PA Vyepti - MANUAL PA</p>
		ORAL	
		NURTEC ODT (rimegepant) QULIPTA (atogepant)	<ul style="list-style-type: none"> • 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 (ibrutinib) 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 (brigatinib) 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)	<p>Farydak - MANUAL PA</p> <ul style="list-style-type: none"> • Documented diagnosis of multiple myeloma AND <ul style="list-style-type: none"> • Used in combination with bortezomib and dexamethasone per PI AND • History of 2 prior regimens including bortezomib and an immunomodulatory agent <p style="text-align: center;">Ibrance</p> <ul style="list-style-type: none"> • Documented diagnosis of WD-DDLS for retroperitoneal sarcoma OR • All other indications evaluated through clinical review <p style="text-align: center;">Lenvima</p> <ul style="list-style-type: none"> • Documented diagnosis of thyroid cancer OR

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	TASIGNA (nilotinib) TURALIO (pexidartinib) TYKERB (lapatinib ditosylate) vandetanib VOTRIENT (pazopanib) XALKORI (crizotinib) XALKORI (crizotinib) Oral Pellets XTANDI (enzalutamide) ZELBORAF (vemurafenib) ZYDELIG (idelalisib) ZYKADIA (ceritinib)	GAVRETO (pralsetinib) gefitinib GLEEVEC (imatinib mesylate) GLEOSTINE (lomustine) IBRANCE (palbociclib) ^{DUR+} IDHIFA (enasidenib) INQOVI (cedazuridine/decitabine) INREBIC (fedratinib) ITOVEBI (inavolisib) 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)	<ul style="list-style-type: none"> 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 <ul style="list-style-type: none"> All other indications evaluated through clinical review <p style="text-align: center;">Lynparza Tablets</p> <ul style="list-style-type: none"> Documented diagnosis of ovarian cancer, fallopian tube or peritoneal cancer AND <ul style="list-style-type: none"> History of platinum-based chemotherapy in the past 2 years OR All other indications evaluated through clinical review

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		QINLOCK (ripretinib) REZLIDHIA (lutasidenib) RETEVMO (selpercatinib) ^{NR} 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) ^{NR} WELIREG (belzutifan) XATMEP (methotrexate) XOSPATA (gilteritinib) XPOVIO (selinexor) ZEJULA (niraparib)	
ANTIOBESITY SELECT AGENTS			
	SAXENDA (liraglutide)	orlistat	All agents require

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	WEGOVY (semaglutide)	XENICAL (orlistat)	MANUAL PA
ANTIPARASITICS (Topical) ^{DUR+} PEDICULICIDES			
	permethrin 1% ^{OTC} NATROBA (spinosad)	lindane malathion OVIDE (malathion) SKLICE (ivermectin) spinosad VANALICE (piperonyl butoxide/pyrethrins)	<p>Minimum Age/Weight Limit for Pediculicides</p> <ul style="list-style-type: none"> • 50 kg – lindane shampoo • 2 months – permethrin 1%(OTC) • 6 months – Natroba, Sklice • 2 years – piperonyl/pyrethrins (OTC) • 6 years – Ovide <p>Non-Preferred Criteria</p> <ul style="list-style-type: none"> • Have tried 2 preferred topical lice agents in the past 90 days
SCABICIDES			
	permethrin 5% ivermectin	ELIMITE (permethrin) EURAX CREAM (crotamiton) EURAX LOTION (crotamiton) STROMEKTOL Tablet (ivermectin)	<p>Minimum Age/Weight Limit for Topical Scabicides</p> <ul style="list-style-type: none"> • 50 kg – lindane lotion • 2 months – permethrin 5% • 4 years – Natroba • 18 years – Eurax <p>Non-Preferred Criteria</p> <ul style="list-style-type: none"> • Have tried permethrin 5% in the past 90 days

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(For All Medicaid, MSCAN and CHIP Beneficiaries)

EFFECTIVE 10/01/2024

Version 2024_14

Updated: 12/01/2024

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
ANTIPARKINSON'S AGENTS (Oral) ^{DUR+}			
ANTICHOLINERGICS			
	benztropine trihexyphenidyl	COGENTIN	<p>Non-Preferred Criteria</p> <ul style="list-style-type: none"> • Documented diagnosis of Parkinson's disease AND • Have tried 2 different preferred agents in the past 6 months OR • 90 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	KYNMOBI FILM (apomorphine) MIRAPEX (pramipexole) MIRAPEX ER (pramipexole) NEUPRO (rotigotine) pramipexole pramipexole ER REQUIP (ropinirole) REQUIP XL (ropinirole) ropinirole ER	
MAO-B INHIBITORS			
	selegiline	AZILECT (rasagiline) ELDEPRYL (selegiline) rasagiline	<p>Xadago</p> <ul style="list-style-type: none"> • Documented diagnosis of Parkinson's disease AND

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		XADAGO (safinamide) ZELAPAR (selegiline)	<ul style="list-style-type: none"> 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)	<p style="text-align: center;">Gocovri</p> <ul style="list-style-type: none"> 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 <p style="text-align: center;">Lodosyn and Inbrija</p> <ul style="list-style-type: none"> 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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			<p style="color: red; margin: 0;">Nourianz</p> <ul style="list-style-type: none"> Documented diagnosis of Parkinson's Disease AND History of a preferred carbidopa/levodopa combination product in the past 30 days AND History of 30 days therapy with a preferred adjunctive therapy in the past 45 days
ANTIPARKINSON'S AGENTS (Injectable)			
		VYALEV (foscarbidopa and foslevodopa) ^{NR}	<ul style="list-style-type: none"> Requires clinical review
ANTIPSYCHOTICS ^{DUR+}			
ORAL			
	amitriptyline/perphenazine aripiprazole asenapine clozapine fluphenazine haloperidol olanzapine olanzapine ODT perphenazine quetiapine quetiapine XR	ABILIFY (aripiprazole) ABILIFY MYCITE (aripiprazole) ADASUVE (loxapine) aripiprazole solution aripiprazole ODT CAPLYTA (lumateperone) chlorpromazine clozapine ODT CLOZARIL (clozapine) COBENFY (xanomeline and trospium chloride) ^{NR} FANAPT (iloperidone)	<p style="color: red; margin: 0;">Minimum Age Limit</p> <ul style="list-style-type: none"> 3 years – Haldol 5 years – Risperdal, thioridazine 6 years – Abilify, trifluoperazine 10 years – Latuda, Saphris, Seroquel, Symbyax 12 years – Invega, molindone, perphenazine, pimozide, thiothixene 13 years – Rexulti, Zyprexa 18 years – Abilify Mycite, Amitriptyline/perphenazine, Caplyta, Clozaril, Cobenfy, Fanapt,

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	risperidone risperidone ODT thioridazine thiothixene trifluoperazine VRAYLAR (cariprazine) ziprasidone	FAZACLO (clozapine) GEODON (ziprasidone) HALDOL (haloperidol) INVEGA ER (paliperidone) LATUDA (lurasidone) lurasidone LYBALVI (olanzapine/samidorphan) NUPLAZID (pimavanserin) olanzapine/fluoxetine OPIPZA (aripiprazole) ^{NR} paliperidone ER REXULTI (brexpiprazole) RISPERDAL (risperidone) SAPHRIS (asenapine) SEROQUEL (quetiapine) SEROQUEL XR (quetiapine) SYMBYAX (olanzapine/fluoxetine) VERSACLOZ (clnazpine) ZYPREXA (olanzapine)	fluphenazine, Geodon, loxapine, Lybalvi, Nuplazid, Secuado, Vraylar Concurrent Therapy Limit – Ages 0-17 years <ul style="list-style-type: none"> 90 days with 2 or more antipsychotics in the last 120 days will require a Manual PA <p style="text-align: center;">Cobenfy</p> <ul style="list-style-type: none"> Requires clinical review <p style="text-align: center;">Vraylar</p> <ul style="list-style-type: none"> Documented diagnosis of schizophrenia or schizoaffective disorder OR Documented diagnosis of bipolar disorder OR Documented diagnosis of major depressive disorder AND <ul style="list-style-type: none"> 30 days of therapy with an antidepressant in the past 45 days <p style="text-align: center;">OR</p> <ul style="list-style-type: none"> 1 claim for a 90-day supply of an antidepressant in the past 105 days <p style="text-align: center;">Non-Preferred Criteria- Atypical Agents</p>

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			<ul style="list-style-type: none"> • 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 <p style="text-align: center;">Nuplazid</p> <ul style="list-style-type: none"> • Documented diagnosis of Parkinson's disease
INJECTABLE, ATYPICALS ^{DUR+}			
	ABILIFY ASIMTUFII (aripiprazole) ABILIFY MAINTENA (aripiprazole) ARISTADA ER (aripiprazole lauroxil) ARISTADA INITIO (aripiprazole lauroxil) INVEGA HAFYERA (paliperidone) INVEGA SUSTENNA (paliperidone palmitate) 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)	<p style="text-align: center;">Minimum Age Limit</p> <ul style="list-style-type: none"> • 18 years – all injectable agents <p style="text-align: center;">Quantity Limit</p> <ul style="list-style-type: none"> • 3 syringes/year – Aristada Initio <p style="text-align: center;">Long-Acting Injectable Agents All Agents</p> <ul style="list-style-type: none"> • Documented diagnosis of schizophrenia or schizoaffective disorder <p style="text-align: center;">Abilify Maintena, Abilify Asimtufii, Risperdal Consta and Rykindo ER</p> <ul style="list-style-type: none"> • Documented diagnosis of schizophrenia or schizoaffective disorder OR • Documented diagnosis of bipolar disorder

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			<p style="text-align: center;">Invega Hafyera</p> <ul style="list-style-type: none"> • Documented diagnosis of schizophrenia or schizoaffective disorder AND • 4 claims for Invega Sustenna or Erzofri 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)	<p style="text-align: center;">Stribild – <u>MANUAL PA</u></p> <ul style="list-style-type: none"> • Genotype testing supporting resistance to other regimens OR • Intolerance or contraindication to preferred combination of drugs AND <ul style="list-style-type: none"> • Medical reasoning beyond convenience or enhanced compliance over preferred agents <p style="text-align: center;">AND</p> <ul style="list-style-type: none"> • CrCl > 70mL/min to initiate therapy OR CrCl >50mL/min to continue therapy
INTEGRASE STRAND TRANSFER INHIBITORS			
	APRETUDE ER (cabotegravir) ISENTRESS (raltegravir potassium)	ISENTRESS HD (raltegravir potassium) VITEKTA (elvitegravir)	

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Therapeutic Drug Class	Preferred Agents	Non-Preferred Agents	PA Criteria
	TIVICAY (dolutegravir sodium) TIVICAY PD (dolutegravir sodium)		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 - <u>MANUAL PA</u>
PROTEASE INHIBITORS (PEPTIDIC)			
	atazanavir EVOTAZ (atazanavir/cobicistat)	CRIXIVAN (indinavir) fosamprenavir	

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	NORVIR SOLUTION (ritonavir) ritonavir	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)	
COMBINATION PRODUCTS – NUCLEOSIDE & NUCLEOTIDE ANALOG RTIs			
	DESCOVY (emtricitabine/tenofovir alafenam) emtricitabine/tenofovir	TRUVADA (emtricitabine/tenofovir)	

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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)	
ANTIVIRALS (Oral)			
ANTI-CYTOMEGALOVIRUS AGENTS			
	valganciclovir tablets	LIVTENCITY (maribavir) PREVYMIS (letermovir)	valganciclovir solution – automatic approval issued for age <12 years

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		VALCYTE (valganciclovir) valganciclovir solution	<p style="color: red;">Prevymis</p> <p>Prevention (prophylaxis) of cytomegalovirus (CMV) infection and disease</p> <ul style="list-style-type: none"> • \geq 18 years AND • Post hematopoietic stem cell transplant (HSCT) within the past 28 days AND • CMV sero-positive recipient [R+] AND • NO severe (Child-Pugh Class C) hepatic impairment
ANTI-HERPETIC AGENTS			
	acyclovir valacyclovir	famciclovir FAMVIR (famciclovir) SITAVIG (acyclovir) VALTREX (valacyclovir) ZOVIRAX (acyclovir)	
ANTI-INFLUENZA AGENTS			
	oseltamivir	FLUMADINE (rimantadine) RAPIVAB (peramivir) RELENZA (zanamivir) rimantadine TAMIFLU (oseltamivir) XOFLUZA (baloxavir marboxil)	

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ANTIVIRALS (Topical)			
	ZOVIRAX Cream (acyclovir)	acyclovir cream, ointment DENA VIR (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) DUPIXENT (dupilumab) ^{DUR+} ELIDEL (pimecrolimus) pimecrolimus PROTOPIC (tacrolimus) tacrolimus	CIBINQO (abrocitinib) EBGLYSS (lebrikizumab-lbkz) ^{NR} EUCRISA (crisaborole) ^{DUR+} OPZELURA (ruxolitinib) ZORYVE (roflumilast) 0.15% cream	<p style="color: red;">Minimum Age Limit</p> <ul style="list-style-type: none"> 2 years – Elidel, Protopic 0.03% 16 years – Protopic 0.1% <p style="color: red;">Adbry, Cibirno, and Opzelura</p> <ul style="list-style-type: none"> Require clinical review <p style="color: red;">Eucrisa</p> <ul style="list-style-type: none"> 28 days of therapy with a calcineurin inhibitor in the past year AND 28 days of therapy with a topical steroid in the past year OR <ul style="list-style-type: none"> MANUAL PA <p style="color: red;">Dupixent</p> <ul style="list-style-type: none"> History of 1 claim with Dupixent in the past 60 days New starts require clinical review <p style="color: red;">Asthma – MANUAL PA Atopic Dermatitis – MANUAL PA Eosinophilic Esophagitis -- MANUAL PA Nasal Polyposis – MANUAL PA Prurigo Nodularis MANUAL PA</p>

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BETA BLOCKERS, ANTIANGINALS & SINUS NODE AGENTS^{DUR+}			
	acebutolol atenolol bisoprolol metoprolol metoprolol ER nadolol nebivolol pindolol propranolol propranolol ER sotalol	AZSRUZYO SPRINKLES (ranolazine) BETAPACE (sotalol) betaxolol BYSTOLIC (nebivolol) CORGARD (nadolol) HEMANGEOL (propranolol) INDERAL LA (propranolol) INDERAL XL (propranolol) INNOPRAN XL (propranolol) KAPSPARGO SPRINKLES (metoprolol) KERLONE (betaxolol) LEVATOL (penbutolol) LOPRESSOR (metoprolol) SECTRAL (acebutolol) SOTYLIZE (sotalol) TENORMIN (atenolol) TOPROL XL (metoprolol) ZEBETA (bisoprolol)	<p style="color: red;">Non-Preferred Criteria</p> <ul style="list-style-type: none"> • Have tried 2 different preferred agents in the past 6 months OR <ul style="list-style-type: none"> • 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)	<p style="color: red;">Coreg CR</p> <ul style="list-style-type: none"> • Documented diagnosis of hypertension AND • Have tried generic carvedilol AND 1 preferred agent in the past 6 months OR <ul style="list-style-type: none"> • 90 days of therapy with the requested agent in the past 105 days

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BETA BLOCKER/DIURETIC COMBINATIONS			
	atenolol/chlorthalidone bisoprolol/HCTZ metoprolol/HCTZ nadolol/bendroflumethiazide propranolol/HCTZ timolol/HCTZ	CORZIDE (nadolol/bendroflumethiazide) DUTOPROL (metoprolol/HCTZ) LOPRESSOR HCT (metoprolol/HCTZ) TENORETIC (atenolol/chlorthalidone) ZIAC (bisoprolol/HCTZ)	
ANTIANGINALS			
		RANEXA (ranolazine) ranolazine	<p style="text-align: center;">Ranexa</p> <ul style="list-style-type: none"> • Documented diagnosis of angina AND • 1 claim for a calcium channel blocker, beta-blocker, nitrate, or combination agent in the past 30 days OR • 90 days of therapy with the requested agent in the past 105 days
SINUS NODE AGENTS			
		CORLANOR (ivabradine) ivabradine	Corlanor - <u>MANUAL PA</u>
BILE SALTS			
	ursodiol	ACTIGALL (ursodiol) BYLVAY (odevixibat) CHENODAL (chenodiol) CHOLBAM (cholic acid) IQIRVO (elafibranor) ^{NR}	

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		LIVDELZI (seladelpar) ^{NR} 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) VESICARE LS Suspension (solifenacin)	<p style="color: red;">Non-Preferred Criteria</p> <ul style="list-style-type: none"> • Have tried 2 different preferred agents in the past 6 months
BONE RESORPTION SUPPRESSION AND RELATED AGENTS ^{DUR+}			
BISPHOSPHONATES			
	alendronate ibandronate risedronate	ACTONEL (risedronate) ACTONEL WITH CALCIUM (risedronate/calcium)	<p style="color: red;">Non-Preferred Criteria</p> <ul style="list-style-type: none"> • Documented diagnosis of osteoporosis or osteopenia AND

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		alendronate solution ATELVIA (risedronate) BINOSTO (alendronate) BONIVA (ibandronate) DIDRONEL (etidronate) FOSAMAX (alendronate) FOSAMAX PLUS D (alendronate/vitamin D) risedronate DR Tablet	<ul style="list-style-type: none"> Have tried 2 different preferred agents in the past 6 months
OTHERS			
		calcitonin salmon EVENITY (romosozumab-aqqg) EVISTA (raloxifene) FORTEO (teriparatide) MIACALCIN (calcitonin) PROLIA (denosumab) raloxifene TYMLOS (abaloparatide) XGEVA (denosumab)	
BPH AGENTS ^{DUR+}			
ALPHA BLOCKERS			
	alfuzosin doxazosin tamsulosin terazosin	CARDURA (doxazosin) CARDURA XL (doxazosin) dutasteride/tamsulosin FLOMAX (tamsulosin) HYTRIN (terazosin) JALYN (dutasteride/tamsulosin) RAPAFLO (silodosin) silodosin	<p style="color: red; text-align: center;">Female</p> <ul style="list-style-type: none"> Cardura, Flomax, Proscar, terazosin, or Uroxatral AND Documented diagnosis based on a State accepted diagnosis <p style="color: red; text-align: center;">Non-Preferred Criteria - MALE</p> <ul style="list-style-type: none"> Have tried 2 different preferred agents in the past 6 months OR

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		UROXATRAL (alfuzosin)	<ul style="list-style-type: none"> 90 days of therapy with the requested agent in the past 105 days
5-ALPHA-REDUCTASE (5AR) INHIBITORS			
	finasteride	dutasteride ENTADFI (finasteride/tadalafil) PROSCAR (finasteride)	<p style="text-align: center; color: red;">Entadfi</p> <ul style="list-style-type: none"> 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) ^{NR} roflumilast SEEBRI (glycopyrrolate) SPIRIVA RESPIMAT (tiotropium) ^{DUR+} TUDORZA PRESSAIR (aclidinium) YUPELRI (revefenacin)	<p style="text-align: center; color: red;">Minimum Age Limit</p> <p style="text-align: center; color: red;">6 years – Spiriva Respimat</p> <p style="text-align: center; color: red;">Spiriva Respimat</p> <ul style="list-style-type: none"> Automatic approval issued for ≥ 6 years with a diagnosis of asthma
ANTICHOLINERGIC-BETA AGONIST COMBINATIONS			
	albuterol/ipratropium ANORO ELLIPTA (umeclidinium/vilanterol) COMBIVENT RESPIMAT (albuterol/ipratropium) STIOLTO RESPIMAT (tiotropium/olodaterol)	BEVESPI (glycopyrrolate/formoterol) DUAKLIR PRESSAIR (aclidinium/formoterol)	

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ANTICHOLINERGIC-BETA AGONIST-GLUCOCORTICOID COMBINATIONS			
		BREZTRI AEROSPHERE ^{DUR+} (budesonide/glycopyrrolate/formoterol) TRELEGY ELLIPTA (fluticasone furoate/ umeclidinium/vilanterol)	Breztri Aerosphere <ul style="list-style-type: none"> 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 <ul style="list-style-type: none"> 4 years – Xopenex HFA 18 years – Airsupra Quantity Limit <ul style="list-style-type: none"> 2 inhalers/31 days – Airsupra Xopenex HFA <ul style="list-style-type: none"> 1 claim for a preferred albuterol inhaler in the past 30 days Airsupra and ProAir Digihaler <ul style="list-style-type: none"> Require clinical review

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INHALERS, LONG ACTING ^{DUR+}			
	SEREVENT (salmeterol) STRIVERDI RESPIMAT (olodaterol)		<p>Minimum Age Limit</p> <ul style="list-style-type: none"> • 4 years – Serevent • 18 years – Striverdi Respimat
INHALATION SOLUTION ^{DUR+}			
	albuterol	arformoterol BROVANA (arformoterol) formoterol levalbuterol metaproterenol PERFOROMIST (formoterol) XOPENEX (levalbuterol)	<p>Minimum Age Limit</p> <ul style="list-style-type: none"> • 6 years – Xopenex • 18 years – Brovana, Perforomist <p>Non-Preferred Criteria</p> <ul style="list-style-type: none"> • 1 claim for a different preferred agent in the past 6 months OR • 3 claims with the requested agent in the past 105 days <p>Xopenex</p> <ul style="list-style-type: none"> • 1 claim for a preferred albuterol in the past 30 days
ORAL			
	albuterol ER albuterol IR metaproterenol terbutaline	VOSPIRE ER (albuterol)	

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CALCIUM CHANNEL BLOCKERS ^{DUR+}			
SHORT-ACTING			
	diltiazem nicardipine nifedipine verapamil	CALAN (verapamil) CARDIZEM (diltiazem) isradipine nimodipine NORLIQVA (amlodipine) NYMALIZE SOLUTION (nimodipine) PROCARDIA (nifedipine)	<p>Quantity Limit - nimodipine</p> <ul style="list-style-type: none"> • 252 tablets/ 21 days • 2520 mL/21 days <p>Non-Preferred Criteria</p> <ul style="list-style-type: none"> • Have tried 2 different preferred Short Acting CCB agents in the past 6 months OR • 90 days of therapy with the requested agent in the past 105 days <p>Nimodipine</p> <ul style="list-style-type: none"> • Documented diagnosis of subarachnoid hemorrhage in the past 45 days AND • Duration of therapy limited to 21 days
LONG-ACTING			
	amlodipine DILT XR 24 HR Caps (diltiazem) diltiazem ER Cap 24 HR (generic Cardizem CD) diltiazem ER Cap 24 HR felodipine ER nifedipine ER verapamil ER	ADALAT CC (nifedipine) CALAN SR (verapamil) CARDENE SR (nicardipine) CARDIZEM CD (diltiazem) CARDIZEM LA (diltiazem) DILACOR XR (diltiazem) diltiazem ER Cap 12 HR diltiazem ER Tab 24 HR	<p>Non-Preferred Criteria</p> <ul style="list-style-type: none"> • Have tried 2 different preferred Long Acting CCB agents in the past 6 months OR • 90 days of therapy with the requested agent in the past 105 days

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		KATERZIA (amlodipine) nisoldipine NORVASC (amlodipine) PROCARDIA XL (nifedipine) SULAR (nisoldipine) TIAZAC (diltiazem) verapamil ER PM VERELAN/VERELAN PM (verapamil)	
CALORIC AGENTS			
	BOOST (includes all Boost) BREAKFAST ESSENTIALS BRIGHT BEGINNINGS DUOCAL ENSURE GLUCERNA NUTREN (includes all Nutren) OSMOLITE PEDIASURE PROMOD RESOURCE SCANDISHAKE TWOCAL HN	All other products (caloric /nutritional agents) not listed as preferred will require a manual prior authorization.	Non-Preferred Agents – MANUAL PA

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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 cefepodoxime	CEDAX (ceftibuten) cefditoren ceftibuten SPECTRACEF (cefditoren) SUPRAX (cefixime)	Maximum Age Limit • 18 years – cefdinir suspension

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COLONY STIMULATING FACTORS			
	FYLNETRA (pegfilgrastim) STIMUFEND (pegfilgrastim-fpgk) NEUPOGEN Syringe (filgrastim) NEUPOGEN Vial (filgrastim)	FULPHILA (pegfilgrastim) GRANIX (tbo-filgrastim) LEUKINE (sargramostim) NEULASTA (pegfilgrastim) NIVESTYM (filgrastim-aafi) NYVEPRIA (pegfilgrastim-apgf) RELEUKO (filgrastim) ROLVEDON (eflapegrastim) UDENYCA (pegfilgrastim-cbqv) UDENYCA ONBODY (pegfilgrastim-cbqv) ZARXIO (filgrastim) ZIENTENZO (pegfilgrastim-bmez)	
CYSTIC FIBROSIS AGENTS ^{DUR+}			
	tobramycin (generic TOBI)	BETHKIS (tobramycin) BRONCHITOL (mannitol) CAYSTON (aztreonam) colistimethate COLY-MYCIN M (colistimethate sodium) KALYDECO (ivacaftor) KITABIS (tobramycin) ORKAMBI (lumacaftor/ivacaftor) PULMOZYME (dornase alfa) SYMDEKO (tezacaftor/ivacaftor) TOBI (tobramycin)	<p style="text-align: center;">Minimum Age Limit</p> <ul style="list-style-type: none"> • 1 month – Kalydeco Granules • 3 months – Pulmozyme <ul style="list-style-type: none"> • 1 year – Orkambi • 2 years – Coly-Mycin M, Trikafta Granules • 6 years – Bethkis, Kalydeco tablet, Kitabis, Symdeko, TOBI, TOBI Podhaler, Trikafta tablet <ul style="list-style-type: none"> • 7 years – Cayston

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MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

(For All Medicaid, MSCAN and CHIP Beneficiaries)

EFFECTIVE 10/01/2024
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		TOBI PODHALER (tobramycin) tobramycin (generic Bethkis) tobramycin (generic Kitabis) TRIKAFTA (elxacaftor/ tezacaftor/ivacaftor)	<ul style="list-style-type: none"> • 18 years – Bronchitol • Maximum Age Limit • 2 years – Orkambi 75-94 mg Granules • 5 years – Kalydeco, Orkambi 100-125 mg Granules, Orkambi 200-125 mg Granules, Trikafta Granules • 11 years – Trikafta tablets • All Agents • Documented diagnosis 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)	ABRILADA (adalimumab-afzb) ACTEMRA ACTPEN (tocilizumab)	<ul style="list-style-type: none"> • Preferred Agents • Age criteria for indication

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	AVSOLA (infliximab) ENBREL (etanercept) HUMIRA (adalimumab) KINERET (anakinra) methotrexate ORENCIA CLICKJET (abatacept) ORENCIA VIAL (abatacept) OTEZLA (apremilast) SIMPONI (golimumab) TALTZ (ixekizumab) TYENNE (tocilizumab-aazg) XELJANZ IR (tofacitinib)	adalimumab-aacf adalimumab-aaty adalimumab-adaz adalimumab-adbm adalimumab-fkjp adalimumab-ryvk AMJEVITA (adalimumab) ARCALYST (riloncept) 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 (ritlectinib) NEMLUVIO (nemolizumab-ilto) ^{NR} OLUMIANT (baricitinib) OMVOH (mirikizumab-mrkz)	<ul style="list-style-type: none"> • Documented diagnosis for indication <p>Non-Preferred Agents</p> <ul style="list-style-type: none"> • Require clinical review <p>IV Administered Agents</p> <ul style="list-style-type: none"> • Require clinical review

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		ORENCIA SYRINGE (abatacept) OTREXUP (methotrexate) RASUVO (methotrexate) REMICADE (infliximab) RENFLEXIS (infliximab-abda) RHEUMATREX (methotrexate) RINVOQ (upadacitinib) RINVOQ LQ (upadacitinib) RINVOQ ER (upadacitinib) 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) PROCRT (rHuEPO) VAFSEO (vadadustat) ^{NR}	<p style="text-align: center;">Mircera</p> <ul style="list-style-type: none"> Documented diagnosis of chronic renal failure in the past 2 years

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			<p style="color: red;">Non-Preferred Criteria</p> <ul style="list-style-type: none"> • Documented diagnosis of cancer or chronic renal failure OR Antineoplastic therapy in the past 6 months AND • Have tried a preferred Retacrit or Epogen in the past 6 months OR • 1 claim for the requested agent in the past 105 days <p style="color: red;">Jesduvroq</p> <ul style="list-style-type: none"> • Requires clinical review
FACTOR DEFICIENCY PRODUCTS			
FACTOR VIII			
	ADVATE AFSTYLA ALPHANATE FEIBA NF HEMOFIL M HUMATE-P KOATE KOGENATE FS KOVALTRY NOVOEIGHT NUWIQ RECOMBINATE WILATE XYNTHA	ADYNOVATE ALTUVIIIIO ELOCTATE ESPEROCT HEXILATE FS JIVI KCENTRA OBIZUR VONVENDI	

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	XYNTHA SOLOFUSE		
FACTOR IX			
	ALPHANINE SD ALPROLIX BENEFIX IDELVION IXINITY MONONINE PROFILNINE RIXUBIS	REBINYN	
OTHER HEMOPHILIA PRODUCTS			
	COAGADEX FIBRYGA HEMLIBRA ^{DUR+} RIASTAP	BEQVEZ CORIFACT HYMPAVZI ^{NR} NOVOSEVEN RT SEVENFACT TRETEN	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)	Cymbalta, Drizalma sprinkles, and Irenka (see Antidepressants, Other)

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

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			<ul style="list-style-type: none"> ○ Penicillin, 2nd or 3rd generation cephalosporin, or macrolide AND ● Cipro suspension in the past 3 months
GAUCHER'S DISEASE			
	ELELYSO (taliglucerase alfa) ZAVESCA (miglustat)	CERDELGA (eliglustat) CEREZYME (imiglucerase) miglustat VPRIV (velaglucerase alfa)	
GENITAL WARTS & ACTINIC KERATOSIS AGENTS			
	CONDYLOX (podofilox) ^{Age Edit} imiquimod ^{Age Edit} podofilox ^{Age Edit}	ALDARA (imiquimod) ^{Age Edit} CARAC (fluorouracil) diclofenac 3% gel EFUDEX (fluorouracil) fluorouracil 0.5% cream fluorouracil 5% cream PICATO (ingenol) ^{Age Edit} SOLARAZE (diclofenac) TOLAK (fluorouracil) VEREGEN (sinecatechins) ^{Age Edit} ZYCLARA (imiquimod) ^{Age Edit}	<p style="color: red; margin: 0;">Minimum Age Limit</p> <ul style="list-style-type: none"> ● 12 years – Aldara, Zyclara ● 18 years – Condylox, Picato, Veregen

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GLUCOCORTICIDS (Inhaled) ^{DUR+}			
GLUCOCORTICIDS			
	ASMANEX TWISTHALER (mometasone) budesonide 0.25mg and 0.5mg fluticasone HFA PULMICORT FLEXHALER (budesonide) QVAR REDHALER (beclomethasone dipropionate)	ALVESCO (ciclesonide) ARMONAIR Digihaler (fluticasone) ARNUITY ELLIPTA (fluticasone) ASMANEX HFA (mometasone) budesonide 1mg fluticasone Diskus PULMICORT (budesonide) Respules	<p>Non-Preferred Criteria</p> <ul style="list-style-type: none"> Have tried 2 preferred single entity agents in the past 6 months OR <ul style="list-style-type: none"> 90 days of therapy with the requested agent in the past 105 days <p>ArmonAir Digihaler</p> <ul style="list-style-type: none"> Requires clinical review <p>Institutional sized products are Non-Preferred</p>
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 Resplick (fluticasone/salmeterol) BREO ELLIPTA (fluticasone/vilanterol) BREYNA (budesonide/formoterol) budesonide/formoterol WIXELA INHUB (fluticasone/salmeterol)	<p>Non-Preferred Criteria</p> <ul style="list-style-type: none"> Have tried 2 preferred combination agents in the past 6 months OR <ul style="list-style-type: none"> 90 days of therapy with the requested agent in the past 105 days <p>AirDuo Digihaler</p> <ul style="list-style-type: none"> Requires clinical review

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GI ULCER THERAPIES			
H2 RECEPTOR ANTAGONISTS			
	cimetidine solution famotidine solution famotidine tablets nizatidine solution	AXID (nizatidine) cimetidine tablets nizatidine tablets PEPCID (famotidine)	
PROTON PUMP INHIBITORS			
	esomeprazole magnesium DR Capsule NEXIUM PACKET (esomeprazole) omeprazole Rx pantoprazole	ACIPHEX Tablet (rabeprazole) DEXILANT (dexlansoprazole) esomeprazole strontium DR Capsule KONVOMEK 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			
	misoprostol sucralfate suspension	CARAFATE SUSPENSION (sucralfate) CARAFATE TABLET (sucralfate) CYTOTEC (misoprostol)	

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	sucralfate tablet	DARTISLA ODT (glycopyrrolate) VOQUEZNA (vonoprazan)	
GROWTH HORMONE ^{DUR+}			
	GENOTROPIN (somatropin) NORDITROPIN (somatropin) NUTROPIN AQ (somatropin)	HUMATROPE (somatropin) NGENLA (somatrogon-ghla) OMNITROPE (somatropin) SAIZEN (somatropin) SEROSTIM (somatropin) SKYTROFA (lonapegsomatropin) SOGROYA (somapacitan) VOXZOGO (vosoritide) ZOMACTON (somatropin) ZORBTIVE (somatropin)	<p>Minimum Age Limit</p> <ul style="list-style-type: none"> • 3 years – Ngenla <p>Maximum Age Limit</p> <ul style="list-style-type: none"> • 18 years - Ngenla <p>All Agents for Age ≥ 18 years</p> <ul style="list-style-type: none"> • Documented diagnosis of craniopharyngioma, panhypopituitarism, Prader-Willi Syndrome, Turner Syndrome or an approvable adult diagnosis OR • Documented procedure of cranial irradiation <p>All Agents for Age < 18 years</p> <ul style="list-style-type: none"> • Documented diagnosis of idiopathic short stature AND • Documented approvable pediatric diagnosis OR • Documented approvable pediatric diagnosis <p>Non-Preferred Criteria</p> <ul style="list-style-type: none"> • Documented approvable diagnosis for age as above AND

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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)	<ul style="list-style-type: none"> • Have tried 1 preferred agent in the past 6 months OR • 84 days of therapy with the requested agent in the past 105 days <p style="text-align: center;">Quantity Limit</p> <ul style="list-style-type: none"> • 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)	

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(For All Medicaid, MSCAN and CHIP Beneficiaries)

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

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		RUCONEST VIAL (C1 esterase inhibitor, recombinant) TAKHZYRO (lanadelumab-flyo)	
HYPERURICEMIA & GOUT ^{DUR+}			
	allopurinol colchicine tablet probenecid probenecid/colchicine	colchicine capsule COLCRYS (colchicine) febuxostat GLOPERBA (colchicine) MITIGARE (colchicine) ULORIC (febuxostat) ZYLOPRIM (allopurinol)	Non-Preferred Criteria • Have tried 2 different preferred agents in the past 6 months
HYPOGLYCEMIA TREATMENT, GLUCAGON			
	BAQSIMI (glucagon) glucagon 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

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			<p style="text-align: center; color: red;">Gvoke</p> <ul style="list-style-type: none"> • 1 claim with preferred Baqsimi or Zegalogue in the past 30 days <p style="text-align: center; color: red;">Non-Preferred Glucagon</p> <ul style="list-style-type: none"> • Have tried 1 different preferred glucagon in the past 30 days
HYPOGLYCEMICS, BIGUANIDES			
	metformin HCL tablet metformin HCL ER 24HR tablet (generic Glucophage XR)	FORTAMET ER GLUCOPHAGE (metformin) GLUCOPHAGE XR (metformin ER) GLUMETZA (metformin ER) metformin 24HR (generic Fortamet) metformin 24HR (generic Glumetza) RIOMET SOLUTION* (metformin)	
HYPOGLYCEMICS, DPP4s and COMBINATON ^{DUR+}			
	JANUMET (sitagliptin/metformin) JANUMET XR (sitagliptin/metformin) JANUVIA (sitagliptin) JENTADUETO (linagliptin/metformin) TRADJENTA (linagliptin)	alogliptin alogliptin/metformin alogliptin/pioglitazone JENTADUETO XR (linagliptin/metformin) KAZANO (alogliptin/metformin) KOMBIGLYZE XR (saxagliptin/metformin)* NESINA (alogliptin) ONGLYZA (saxagliptin) * OSENI (alogliptin/pioglitazone) sitagliptin sitagliptin/metformin ZITUVIO (sitagliptin)	<p style="text-align: center; color: red;">Non-Preferred Criteria</p> <ul style="list-style-type: none"> • 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 <p style="text-align: center;">Concomitant use of a GLP-1 product and a DPP-4 product requires clinical review</p>

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		ZITUVIMET (sitagliptin/metformin) ^{NR} ZITUVIMET XR (sitagliptin/metformin) ^{NR}	
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)	<p style="color: red; margin: 0;">Minimum Age Limit</p> <ul style="list-style-type: none"> 10 years – Bydureon Bcise, Trulicity, Victoza 18 years – Byetta, Mounjaro, Ozempic, Rybelsus <p style="color: red; margin: 0;">Preferred Criteria</p> <ul style="list-style-type: none"> Documented diagnosis of Type 2 Diabetes AND No history of 1 claim with Saxenda or Wegovy in the past 30 days OR No documented diagnosis for Type 2 Diabetes AND Have history of 84 days of therapy with the requested agent in the past 105 days <p style="color: red; margin: 0;">Non-Preferred Criteria</p> <ul style="list-style-type: none"> 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

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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	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)	<ul style="list-style-type: none"> • 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 <p>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</p> <p style="text-align: center;">Insulin pen formulations are not covered for Long Term Care (LTC) beneficiaries.</p> <p style="text-align: center;">Non-Preferred Criteria</p> <ul style="list-style-type: none"> • Documented diagnosis of Diabetes Mellitus AND • Have tried 1 preferred product in the past 6 months OR

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	Insulin lispro insulin lispro jr kwikpen insulin lispro kwikpen LANTUS SOLOSTAR & VIAL (insulin glargine) LEVEMIR (insulin detemir) TOUJEO (insulin glargine) TOUJEO MAX (insulin glargine)	HUMALOG MIX KWIKPEN (insulin lispro/ lispro protamine) HUMALOG VIAL (insulin lispro) HUMULIN N, 70/30 KWIKPEN (insulin) ^{OTC} insulin glargine LYUMJEV KWIKPEN (insulin lispro) LYUMJEV VIAL (insulin lispro) NOVOLIN N, R, 70/30 FLEXPEN (insulin) ^{OTC} NOVOLIN N, R, 70/30 VIAL (insulin) ^{OTC} NOVOLOG FLEXPEN & VIAL (insulin aspart) NOVOLOG MIX FLEXPEN & VIAL (insulin aspart/ aspart protamine) REZVOGLAR (insulin glargine) SEMGLEE (insulin glargine) TRESIBA (insulin degludec)	<ul style="list-style-type: none"> 1 claim with the requested agent in the past 105 days <p style="text-align: center;">Quantity Limit</p> <ul style="list-style-type: none"> Insulin Quantity Limits found here
HYPOGLYCEMICS, MEGLITINIDES ^{DUR+}			
	nateglinide repaglinide	PRANDIMET (repaglinide/metformin) PRANDIN (repaglinide) repaglinide/metformin STARLIX (nateglinide)	
HYPOGLYCEMICS, SODIUM GLUCOSE COTRANSPORTER-2 INHIBITORS ^{DUR+}			
HYPOGLYCEMICS, SODIUM GLUCOSE COTRANSPORTER-2 INHIBITORS			
	FARXIGA (dapagliflozin) INVOKANA (canagliflozin) JARDIANCE (empagliflozin)	dapagliflozin INPEFA (sotagliflozin) STEGLATRO (ertugliflozin)	<p style="text-align: center;">Non-Preferred Criteria</p> <ul style="list-style-type: none"> Have tried 2 different preferred SGLT-2 inhibitors in the past 6 months OR

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			<ul style="list-style-type: none"> 90 days of therapy with the requested agent in the past 105 days
HYPOGLYCEMICS, SODIUM GLUCOSE COTRANSPORTER-2 INHIBITOR COMBINATIONS			
	INVOKAMET (canagliflozin/metformin) SYNJARDY (empagliflozin/metformin)	dapagliflozin/metformin GLYXAMBI (empagliflozin/linagliptin) INVOKAMET XR (canagliflozin/metformin) QTERN (dapagliflozin/saxagliptin) SEGLUROMET (ertugliflozin/metformin) STEGLUJAN (ertugliflozin/sitagliptin) SYNJARDY XR (empagliflozin/metformin) TRIJARDY XR (empagliflozin/linagliptin/metformin) XIGDUO XR (dapagliflozin/metformin)	
HYPOGLYCEMICS, TZDS			
THIAZOLIDINEDIONES			
	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	

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IDIOPATHIC PULMONARY FIBROSIS ^{DUR+}			
	OFEV (nintedanib)	ESBRIET (pirfenidone) pirfenidone	<p>All Agents</p> <ul style="list-style-type: none"> Documented diagnosis of Idiopathic Pulmonary Fibrosis
IMMUNOSUPPRESSIVE (ORAL) ^{DUR+}			
	AZASAN (azathioprine) azathioprine CELLCEPT (mycophenolate) cyclosporine cyclosporine modified everolimus GENGRAF (cyclosporine) IMURAN (azathioprine) mycophenolic acid mycophenolate mofetil NEORAL (cyclosporine) RAPAMUNE (sirolimus) SANDIMMUNE (cyclosporine) sirolimus tacrolimus	ASTAGRAF XL (tacrolimus) ENVARSUS XR (tacrolimus) HECORIA (tacrolimus) MYFORTIC (mycophenolic acid) MYHIBBIN (mycophenolate mofetil oral suspension) PROGRAF (tacrolimus) REZUROCK (belumosudil) ZORTRESS (everolimus)	<p>Minimum Age Limit</p> <ul style="list-style-type: none"> 13 years – Rapamune 18 years – Zortress <p>Astagraf, Cellcept, Envarsus XR, Hecoria, Prograf</p> <ul style="list-style-type: none"> Documented diagnosis of heart transplant, kidney transplant, liver transplant, lung transplant or a State accepted diagnosis <p>Azasan</p> <ul style="list-style-type: none"> Documented diagnosis of kidney transplant, RA, or a State accepted diagnosis <p>Gengraf, Neoral, Sandimmune</p> <ul style="list-style-type: none"> Documented diagnosis of heart transplant, kidney transplant, liver transplant, psoriasis, RA, or a State accepted diagnosis OR Clinical review required for a diagnosis of Kimura's disease or multifocal motor neuropathy

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			<p style="color: red; text-align: center;">Myfortic</p> <ul style="list-style-type: none"> • Documented diagnosis of kidney transplant or psoriasis <p style="color: red; text-align: center;">Rapamune</p> <ul style="list-style-type: none"> • Documented diagnosis of kidney transplant <p style="color: red; text-align: center;">Zortress</p> <ul style="list-style-type: none"> • Documented diagnosis of kidney transplant or liver transplant
IMMUNE GLOBULINS			
	BIVIGAM CARIMUNE NF FLEBOGAMMA DIF GAMASTAN SD GAMMAGARD GAMMAGARD SD GAMUNEX-C HIZENTRA HYQVIA PANZYGA PRIVIGEN XEMBIFY	ALYGLO ^{NR} ASCENIV CABLIVI CUTAQUIG CUVITRU GAMMAKED GAMMAPLEX OCTAGAM	

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IMMUNOLOGIC THERAPIES FOR ASTHMA			
	DUPIXENT (dupilumab) ^{DUR+} FASENRA (benralizumab) XOLAIR (omalizumab) ^{DUR+}	CINQAIR (reslizumab) NUCALA (mepolizumab)* TEZSPIRE (tezepelumab)	<p>All agents require clinical review</p> <p>Dupixent</p> <ul style="list-style-type: none"> History of 1 claim with Dupixent in the past 45 days New starts require clinical review <p>Xolair</p> <ul style="list-style-type: none"> History of 1 claim with Xolair in the past 45 days New starts require clinical review <p>Dupixent – MANUAL PA Fasenra- MANUAL PA Xolair- MANUAL PA</p>
INTRANASAL RHINITIS AGENTS			
ANTICHOLINERGICS			
	ipratropium	ATROVENT (ipratropium)	
ANTI-HISTAMINES			
	azelastine	ASTEPRO (azelastine) olopatadine PATANASE (olopatadine)	
ANTI-HISTAMINE/CORTICOSTEROID COMBINATION ^{DUR+}			
		azelastine/fluticasone DYMISTA (azelastine/fluticasone) RYALTRIS (olopatadine/mometasone) TICALAST (azelastine/fluticasone)	

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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 <ul style="list-style-type: none"> • Documented diagnosis of allergic rhinitis AND • Have tried 1 different preferred agent in the past 6 months
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 – <u>MANUAL PA</u>
IRRITABLE BOWEL SYNDROME/SHORT BOWEL SYNDROME AGENTS/SELECTED GI AGENTS ^{DUR+}			
IRRITABLE BOWEL SYNDROME CONSTIPATION			
	AMITIZA (lubiprostone) LINZESS 145mcg, 290mcg (linaclotide)	IBSRELA (tenapanor) LINZESS 72mcg (linaclotide) linaclotide lubiprostone MOTEGRITY (prucalopride) MOVANTIK (naloxegol) RELISTOR (methylnaltrexone)	Minimum Age Limit <ul style="list-style-type: none"> • 1 year – Gattex • 6 years – Linzess 72 mcg • 18 years – Amitiza, Ibsrela, Linzess 145 mcg & 290 mcg, Motegrity, Movantik, Mytesi, Relistor,

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		SYMPROIC (naldemedine) TRULANCE (plecanatide) ZELNORM (tegaserod)	Symproic, Trulance, Viberzi, Xermelo Gender Limit <ul style="list-style-type: none"> • Female – Amitiza 8 mcg Chronic Idiopathic Constipation (CIC) AMITIZA 24 MCG, LINZESS 72 MCG, LINZESS 145 MCG, MOTEGRITY, TRULANCE All CIC Agents <ul style="list-style-type: none"> • Documented diagnosis of CIC in the past year AND • No history of GI or bowel obstruction Non-Preferred CIC Agents <ul style="list-style-type: none"> • 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 <ul style="list-style-type: none"> • Age 6-17 years AND

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			<ul style="list-style-type: none"> Documented diagnosis of CIC or pediatric functional constipation in the past year AND No history of GI or bowel obstruction <p>Irritable Bowel Syndrome – Constipation Dominant (IBS-C) AMITIZA 8 MCG, IBSRELA, LINZESS 290 MCG, TRULANCE</p> <p>All IBS-C Agents</p> <ul style="list-style-type: none"> Documented diagnosis of IBS-C in the past year AND <ul style="list-style-type: none"> No history of GI or bowel obstruction <p>Non-Preferred IBS-C Agents</p> <ul style="list-style-type: none"> Documented diagnosis of IBS-C in the past year AND No history of GI or bowel obstruction 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 <p>Opioid Induced Constipation (OIC) AMITIZA 24 MCG, MOVANTIK, RELISTOR, SYMPROIC</p>

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			<p>All OIC Agents</p> <ul style="list-style-type: none"> • 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 <p>Non- Preferred OIC Agents</p> <ul style="list-style-type: none"> • Documented diagnosis of OIC in the past year AND • 1 claim for an opioid in the past 30 days AND • No history of GI or bowel obstruction AND • Documented diagnosis of chronic pain in the past year AND • Have tried 1 preferred OIC agents in the past 6 months OR • 1 claim with the requested agent in the past 105 days <p>Relistor Injection</p> <ul style="list-style-type: none"> • Above OIC criteria OR • Documented diagnosis of OIC in the past year AND

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			<ul style="list-style-type: none"> • 1 claim for an opioid in the past 30 days AND • No history of GI or bowel obstruction AND • Documented diagnosis of active cancer in the past year
IRRITABLE BOWEL SYNDROME DIARRHEA			
	dicyclomine hyoscyamine	alosetron BENTYL (dicyclomine) LEVSIN (hyoscyamine) LEVSIN-SL (hyoscyamine) LOTRONEX (alosetron) VIBERZI (eluxadoline)*	<p style="text-align: center;">Viberzi</p> <ul style="list-style-type: none"> • 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 <p style="text-align: center;">Lotronex</p> <ul style="list-style-type: none"> • 1 claim for Lotronex in the past 105 days OR • MANUAL PA - All new patients require manual review <p style="text-align: center;">Xifaxan – (see Antibiotics, GI)</p>
SHORT BOWEL SYNDROME AND SELECTED GI AGENTS			
		GATTEX (teduglutide)	Carcinoid Syndrome Agent

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		MYTESI (crofelemer) NUTRESTORE POWDER PACK (glutamine) XERMELO (telotristat ethyl) ZORBTIVE (somatropin)	XERMELO <ul style="list-style-type: none"> • Documented diagnosis of carcinoid syndrome in the past year AND • 1 claim for a somatostatin analog in the past 30 days HIV/AIDS Non-infectious Diarrhea MYTESI <ul style="list-style-type: none"> • Documented diagnosis of HIV/AIDS in the past year AND <ul style="list-style-type: none"> • 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 <ul style="list-style-type: none"> • 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 <ul style="list-style-type: none"> • 12 years – Zyflo & Zyflo CR Non-Preferred Criteria <ul style="list-style-type: none"> • Have tried 2 different preferred agents in the past 6 months

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LIPOTROPICS, OTHER (NON-STATINS)			
ACL INHIBITORS AND COMBINATIONS			
		NEXLETOL (bempedoic acid) NEXLIZET (bempedoic acid/ezetimibe)	Nexletol and Nexlizet • Require clinical review
ANGIOTENSIN LIKE 3 INHIBITORS			
		EVKEEZA (evinacumab-dgnb)	Non-Preferred Criteria • Have tried 2 different preferred Non-statin Lipotropic agents in the past 6 months
BILE ACID SEQUESTRANTS			
	cholestyramine colestipol	colesevelam COLESTID (colestipol) QUESTRAN (cholestyramine) WELCHOL (colesevelam)	Welchol • Documented diagnosis of Type 2 Diabetes AND • 30 days of therapy with an antidiabetic agent in the past 6 months OR • 90 days of therapy with Welchol in the past 105 days
OMEGA-3 FATTY ACIDS			
	omega 3 acid ethyl esters	icosapent LOVAZA (omega-3-acid ethyl esters) VASCEPA (icosapent ethyl)	
CHOLESTEROL ABSORPTION INHIBITORS			
	ezetimibe	ZETIA (ezetimibe)	

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FIBRIC ACID DERIVATIVES			
	fenofibrate nanocrystallized gemfibrozil	ANTARA (fenofibrate, micronized) fenofibrate 40mg tablet fenofibrate, micronized fenofibric acid FENOGLIDE (fenofibrate) FIBRICOR (fenofibric acid) LIPOFEN (fenofibrate) LOFIBRA (fenofibrate) LOPID (gemfibrozil) TRICOR (fenofibrate nanocrystallized) TRIGLIDE (fenofibrate) TRILIPIX (fenofibric acid)	Fibric Acid Derivative Non-Preferred Criteria • Have tried 2 different fibric acid derivatives in the past 6 months
MTP INHIBITOR			
		JUXTAPID (lomitapide)	Juxtapid – MANUAL PA
APOLIPOPROTEIN B-100 SYNTHESIS INHIBITOR			
		KYNAMRO (mipomersen)	Kynamro • Requires clinical review
NIACIN			
	niacin ER NIACOR (niacin)	NIASPAN (niacin)	
PCSK-9 INHIBITOR			
	PRALUENT (alirocumab) REPATHA (evolocumab)	LEQVIO (inclisiran)	Leqvio • Requires clinical review Praluent - MANUAL PA Repatha - MANUAL PA

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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) ZYPITAMAG (pitavastatin)	<p style="color: red;">Minimum Age Limit</p> <ul style="list-style-type: none"> • 10 years – Atorvaliq suspension <p style="color: red;">Non-Preferred Criteria</p> <ul style="list-style-type: none"> • Have tried 2 different preferred statin or statin combination agents in the past 6 months OR • 90 days of therapy with the requested agent in the past 105 days <p style="color: red;">Simvastatin 80mg</p> <ul style="list-style-type: none"> • Daily doses of 80mg and greater require clinical review
STATIN COMBINATIONS			
	ezetimibe/simvastatin SIMCOR (simvastatin/niacin)	ADVICOR (lovastatin/niacin) atorvastatin/amlodipine CADUET (atorvastatin/amlodipine) LIPTRUZET (atorvastatin/ezetimibe) VYTORIN (simvastatin/ezetimibe)	<p style="color: red;">Non-Preferred Criteria</p> <ul style="list-style-type: none"> • Have tried 2 different preferred statin or statin combination agents in the past 6 months OR • 90 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
MISCELLANEOUS BRAND/GENERIC			
EPINEPHRINE			
	epinephrine autoinject pens	ADRENALICK (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 carglumic acid hydroxyzine hcl syrup hydroxyzine hcl tablets hydroxyzine pamoate megestrol suspension 625mg/5mL REVLIMID (lenalidomide)	alprazolam ER CAMZYOS (mavacamten) CARBAGLU (carglumic acid) EVRYSDI (risdiplam) INPEFA (sotagliflozin) KORLYM (mifepristone) lenalidomide MEGACE ES (megestrol) VERQUVO (vericiguat) VISTARIL (hydroxyzine pamoate)	Alprazolam ER CUMULATIVE quantity limit • 31 tablets/31 days EvrySDI - MANUAL PA
ALLERGEN EXTRACT IMMUNOTHERAPY			
		GRASTEK ORALAIR PALFORZIA RAGWITEK	
SUBLINGUAL NITROGLYCERIN			
	nitroglycerin lingual 12gm nitroglycerin sublingual	nitroglycerin lingual 4.9gm NITROLINGUAL (nitroglycerin) 4.9gm	

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	NITROLINGUAL PUMPSPRAY (nitroglycerin) 12gm NITROSTAT SUBLINGUAL (nitroglycerin)	NITROMIST (nitroglycerin)	
MOVEMENT DISORDER AGENTS ^{DUR+}			
	AUSTEDO (deutetrabenazine) AUSTEDO XR (deutetrabenazine) INGREZZA (valbenazine) INGREZZA SPRINKLE (valbenazine) tetrabenazine	XENAZINE (tetrabenazine)	<p>Austedo and Austedo XR</p> <ul style="list-style-type: none"> • Documented diagnosis of Huntington's chorea OR • Documented diagnosis of tardive dyskinesia AND • 90 days of therapy with Austedo or Austedo XR in the past 105 days OR • MANUAL PA <p>Ingrezza</p> <ul style="list-style-type: none"> • Documented diagnosis of Huntington's chorea OR • Documented diagnosis of tardive dyskinesia AND • 90 days of therapy with Ingrezza in the past 105 days OR • MANUAL PA
MULTIPLE SCLEROSIS AGENTS ^{DUR+}			
	AVONEX (interferon beta-1a) AVONEX PEN (interferon beta-1a) BETASERON (interferon beta-1b) COPAXONE 20mg (glatiramer) dalfampridine	AMPYRA (dalfampridine) AUBAGIO (teriflunomide) BAFIERTAM (monomethyl fumarate) BRIUMVI (ublituximab) COPAXONE 40mg (glatiramer)	<p>All Agents</p> <ul style="list-style-type: none"> • Documented diagnosis of multiple sclerosis <p>Non-Preferred Criteria</p>

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	dimethyl fumarate fingolimod GILENYA (fingolimod) REBIF (interferon beta-1a) REBIF REBIDOSE (interferon beta-1a) teriflunomide TYSABRI (natalizumab)	EXTAVIA (interferon beta-1b) glatiramer GLATOPA (glatiramer) KESIMPTA (ofatumumab) MAVENCLAD (cladribine) MAYZENT (siponimod) OCREVUS (ocrelizumab) PLEGRIDY (interferon beta-1a) PONVORY (ponesimod) TASCENSO ODT (fingolimod) TECFIDERA (dimethyl fumarate) VUMERITY (diroximel fumarate) ZEPOSIA (ozanimod)	<ul style="list-style-type: none"> 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 <p>Kesimpta, Ponvory, Tascenso ODT, and Zeposia</p> <ul style="list-style-type: none"> Require clinical review <p>Mavenclad – MANUAL PA</p> <p>Mayzent – MANUAL PA</p> <p>Ocrevus – MANUAL PA</p>
MUSCULAR DYSTROPHY AGENTS			
	EMFLAZA (deflazacort)	AGAMREE (vamorolone) AMONDYS 45 (casimersen) deflazacort ELEVIDYS (delandistrogene moxeparvovec-rokl) EXONDYS 51 (eteplirsen) VILTEPSO (viltolarsen) VYONDYS 53 (golodirsen)	<p>Emflaza – Manual PA</p> <p>Exondys – MANUAL PA</p> <p>Viltepsa – MANUAL PA</p> <p>Vyondys – MANUAL PA</p>
NSAIDS ^{DUR+}			
NON-SELECTIVE			
	diclofenac EC diclofenac IR diclofenac SR	ADVIL (ibuprofen) ANAPROX (naproxen) CAMBIA (diclofenac potassium) CATAFLAM (diclofenac)	<p>Quantity Limit</p> <ul style="list-style-type: none"> 20 tablets/31 days – ketorolac tablets

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	etodolac IR tab flurbiprofen ibuprofen ibuprofen suspension ^{OTC} indomethacin ketoprofen ketorolac nabumetone naproxen 250mg and 500mg naproxen suspension piroxicam sulindac	DAYPRO (oxaprozin) diclofenac potassium etodolac cap etodolac tab SR FELDENE (piroxicam) FENORTHO (fenoprofen) fenoprofen INDOCIN capsules, suspension & suppositories (indomethacin) indomethacin cap ER indomethacin suspension ketoprofen ER KIPROFEN (ketoprofen) LOFENA(diclofenac potassium) meclofenamate mefenamic acid NALFON (fenoprofen) NAPRELAN (naproxen) NAPROSYN (naproxen) naproxen 275mg and 550mg NUPRIN (ibuprofen) oxaprozin PONSTEL (mefenamic acid) PROFENO (fenoprofen) RELAFEN DS (nabumetone) SPRIX NASAL SPRAY (ketorolac) TIVORBEX (indomethacin) tolmetin VOLTAREN XR (diclofenac)	<p style="text-align: center;">Non-Preferred Criteria</p> <ul style="list-style-type: none"> • Have tried 2 different preferred non-selective or NSAID/GI protectant combination agents in the past 6 months

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		ZIPSOR (diclofenac) ZORVOLEX (diclofenac)	
NSAID/GI PROTECTANT COMBINATIONS			
		ARTHROTEC (diclofenac/misoprostol) diclofenac/misoprostol DUEXIS (ibuprofen/famotidine) VIMOVO (naproxen/esomeprazole)	<p style="color: red; text-align: center;">Non-Preferred Criteria</p> <ul style="list-style-type: none"> Have tried 2 different preferred non-selective or NSAID/GI protectant combination agents in the past 6 months
COX II SELECTIVE			
	meloxicam	CELEBREX (celecoxib) celecoxib ELYXYB (celecoxib) MOBIC (meloxicam) NULOX (meloxicam) QMIIZ ODT (meloxicam) VIVLODEX (meloxicam)	<p style="color: red; text-align: center;">Non-Preferred Criteria – COX II</p> <ul style="list-style-type: none"> Documented diagnosis of Osteoarthritis, Rheumatoid Arthritis, Familial Adenomatous Polyposis, or Ankylosing Spondylitis AND 90 days of therapy with the requested agent in the past 105 days OR Have tried 1 preferred COX-II Selective AND 1 preferred Non-Selective Agent OR Documented diagnosis of GI Bleed, GERD, PUD, GI Perforation, or Coagulation Disorder AND Have tried 1 preferred COX-II Selective agent <p style="color: red; text-align: center;">Elyxyb</p> <ul style="list-style-type: none"> Requires clinical review

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OPHTHALMIC ANTIBIOTICS			
	bacitracin/neomycin/gramicidin bacitracin/polymyxin ciprofloxacin erythromycin GENTAK Ointment (gentamicin) gentamicin ILOTYCIN (erythromycin) moxifloxacin ofloxacin polymyxin/trimethoprim tobramycin	AZASITE (azithromycin) bacitracin BESIVANCE (besifloxacin) BLEPH-10 (sulfacetamide) CILOXAN Ointment (ciprofloxacin) CILOXAN Solution (ciprofloxacin) GARAMYCIN (gentamicin) gatifloxacin levofloxacin MOXEZA (moxifloxacin) NATACYN (natamycin) neomycin/bacitracin/polymyxin b NEO-POLYCIN (neomy/baci/polymyxin b) NEOSPORIN (bacitracin/neomycin/gramicidin) (oxy-tcn/polymyx sul) OCUFLOX (ofloxacin) POLYTRIM (polymyxin/trimethoprim) sulfacetamide TOBEX drops (tobramycin) TOBEX ointment (tobramycin) VIGAMOX (moxifloxacin) ZYMAR (gatifloxacin) ZYMAXID (gatifloxacin)	
ANTIBIOTIC STEROID COMBINATIONS			
	BLEPHAMIDE (sulfacetamide/prednisolone) drops, oint neomycin/bacitracin/polymyxin/hc ointment	gatifloxacin/prednisolone MAXITROL (neomycin/polymyxin/dexamethasone)	

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	neomycin/polymyxin/dexamethasone PRED-G (gentamicin/prednisolone) drops, oint sulfacetamide/prednisolone tobramycin/dexamethasone suspension TOBRADEX OINTMENT (tobramycin/dexamethasone) ZYLET (loteprednol/tobramycin)	neomycin/polymyxin/gramicidin neomycin/polymyxin/hydrocortisone TOBRADEX ST SUSPENSION (tobramycin/dexamethasone) TOBRADEX SUSPENSION (tobramycin/dexamethasone)	
OPHTHALMIC ANTI-INFLAMMATORIES ^{DUR+}			
	dexamethasone diclofenac difluprednate FLAREX (fluorometholone) fluorometholone flurbiprofen FML FORTE (fluorometholone) FML SOP (fluorometholone) ketorolac MAXIDEX (dexamethasone) prednisolone acetate prednisolone NA phosphate PRED MILD (prednisolone) VEXOL (rimexolone)	ACULAR (ketorolac) ACULAR LS (ketorolac) ACUVAIL (ketorolac) BROMDAY (bromfenac) bromfenac BROMSITE (bromfenac) DUREZOL (difluprednate) FML (fluorometholone) ILEVRO (nepafenac) INVELTYS (loteprednol etabonate) LOTEMAX (loteprednol) LOTEMAX SM (loteprednol) loteprednol etabonate OCUFEN (flurbiprofen) OMNIPRED (prednisolone) NEVANAC (nepafenac) PRED FORTE (prednisolone) PROLENSA (bromfenac) VOLTAREN (diclofenac)	<p style="text-align: center;">Non-Preferred Criteria</p> <ul style="list-style-type: none"> • Have tried 2 different preferred agents in the past 6 months

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OPHTHALMICS FOR ALLERGIC CONJUNCTIVITIS ^{DUR+}			
	ALREX (loteprednol) azelastine cromolyn ketotifen ^{OTC} olopatadine 0.1% olopatadine 0.2% ZADITOR (ketotifen) ^{OTC}	ALOCRI (nedocromil) ALOMIDE (lodoxamide) BEPREVE (bepotastine) epinastine LASTACFT (alcaftadine) PATADAY (olopatadine) PATANOL (olopatadine) PAZEO (olopatadine) VERKAZIA (cyclosporine) ZERVIA (cetirizine)	<p style="color: red;">Non-Preferred Criteria</p> <ul style="list-style-type: none"> Have tried 2 different preferred agents in the past 6 months <p style="color: red;">Verkazia</p> <ul style="list-style-type: none"> Requires clinical review
OPHTHALMIC, DRY EYE AGENTS			
	RESTASIS droperette (cyclosporine)	CEQUA (cyclosporine 0.09%) EYSUVIS (loteprednol etabonate) MIEBO (perfluorohexyloctane) RESTASIS Multidose (cyclosporine) TYRVAYA (varaenicline) Nasal VEYVE (cyclosporine ophthalmic solution) XIIDRA (lifitegrast) ^{Dur+}	<p style="color: red;">Minimum Age Limit</p> <ul style="list-style-type: none"> 16 years – Restasis 17 years – Xiidra 18 years – Cequa, Miebo, Vevye <p style="color: red;">Quantity Limit</p> <ul style="list-style-type: none"> 2 ml/31 days – Vevye 3 ml/31 days – Miebo 5.5 mL/31 days – Restasis Multidose 60 units/31 days – Cequa, Restasis droperette, Xiidra <p style="color: red;">Eysuvis, Miebo, Tyrvaya and Vevye</p> <ul style="list-style-type: none"> Require clinical review

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			<p style="color: red;">Non-Preferred Criteria</p> <ul style="list-style-type: none"> 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)	<p style="color: red;">Minimum Age Limit</p> <ul style="list-style-type: none"> 18 years – Iyuzeh <p style="color: red;">Non-Preferred Criteria</p> <ul style="list-style-type: none"> Have tried 2 different preferred agents in the past 6 months OR <ul style="list-style-type: none"> 90 days of therapy with the requested agent in the past 105 days
CARBONIC ANHYDRASE INHIBITORS			
	dorzolamide	AZOPT (brinzolamide) TRUSOPT (dorzolamide)	
COMBINATION AGENTS			
	COMBIGAN (brimonidine/timolol) dorzolamide/timolol SIMBRINZA (brinzolamide/brimonidine)	COSOPT (dorzolamide/timolol) COSOPT PF (dorzolamide/timolol)	

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PARASYMPATHOMIMETICS			
	pilocarpine	CARBOPTIC (carbachol) ISOPTO CARBACHOL (carbachol) ISOPTO CARPINE (pilocarpine) PHOSPHOLINE IODIDE (echothiophate iodide) PILOPINE HS (pilocarpine)	
PROSTAGLANDIN ANALOGS			
	latanoprost	bimatoprost IYUZEH (latanoprost) LUMIGAN (bimatoprost) TRAVATAN Z (travoprost) travoprost VYZULTA (latanoprostene bunod) XALATAN (latanoprost) XELPROS (latanoprost) ZIOPTAN (tafluprost)	
RHO KINASE INHIBITORS/COMBINATIONS			
	RHOPRESSA (netarsudil) ROCKLATAN (netarsudil/latanoprost)		
SYMPATHOMIMETICS			
	ALPHAGAN P 0.1% (brimonidine) ALPHAGAN P 0.15% (brimonidine) brimonidine 0.2%	brimonidine 0.15% brimonidine 0.1% dipivefrin PROPINE (dipivefrin)	

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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 (nalmeferene) REXTOVY (naloxone) ZIMHI (naloxone)	EVZIO (naloxone)	
OTIC ANTIBIOTICS			
	CIPRO HC (ciprofloxacin/hydrocortisone) ^{Age Edit} CORTISPORIN-TC (colistin/neomycin/hydrocortisone)	ciprofloxacin ciprofloxacin/dexamethasone ciprofloxacin/fluocinolone	Maximum Age Limit • 9 years – Cipro HC

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Therapeutic Drug Class	Preferred Agents	Non-Preferred Agents	PA Criteria
	neomycin/polymyxin/hydrocortisone ofloxacin <u>Preferred Ophthalmic Formulations for Otic Use</u> ciprofloxacin ophthalmic dexamethasone ophthalmic MAXIDEX (dexamethasone) ophthalmic	DERMOTIC (fluocinolone) FLAC OIL DROP (fluocinolone oil) hydrocortisone/acetic acid drop fluocinolone oil OTIPRIO (ciprofloxacin) OTOVEL (ciprofloxacin/fluocinolone)	Ciprofloxacin/Dexamethasone Suspension Criteria <ul style="list-style-type: none"> 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 <ul style="list-style-type: none"> Have tried 2 different preferred agents in the past 6 months
PARATHYROID AGENTS			
	calcitriol ergocalciferol paricalcitol ROCALTROL (calcitriol) ZEMPLAR (paricalcitol)	cinacalcet doxercalciferol DRISDOL (ergocalciferol) HECTOROL (doxercalciferol) NATPARA (parathyroid hormone) RAYALDEE (calcifediol) SENSIPAR (cinacalcet)	

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		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 oxyhydroxide) XPHOZAH (tenapanor)	
PLATELET AGGREGATION INHIBITORS ^{DUR+}			
	BRILINTA (ticagrelor) cilostazol clopidogrel dipyridamole dipyridamole/aspirin pentoxifylline prasugrel	DURLAZA ER (aspirin) EFFIENT (prasugrel) omeprazole/aspirin PERSANTINE (dipyridamole) PLAVIX (clopidogrel) PLETAL (cilostazol) ticlopidine YOSPRALA (aspirin/omeprazole) ZONTIVITY (vorapaxar)	<p>Non-Preferred Criteria</p> <ul style="list-style-type: none"> • Documented diagnosis AND • Have tried 2 different preferred agents in the past 6 months OR <ul style="list-style-type: none"> • 90 days of therapy with the requested agent in the past 105 days <p>Zontivity – <u>MANUAL PA</u></p>
PLATELET STIMULATING AGENTS			
	NPLATE (romiplostim) PROMACTA (eltrombopag olamine)	ALVAIZ (eltrombopag) DOPTELET (avatrombopag maleate) MULPLETA (lusutrombopag)	

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		PROMACTA powder pack (eltrombopag olamine) TAVALISSE (fostamatinib disodium)	
POTASSIUM REMOVING AGENTS			
	LOKELMA (sodium zirconium cyclosilicate)	sodium polystyrene sulfonate SPS ENEMA (sodium polystyrene sulfonate) SPS SUSPENSION (sodium polystyrene sulfonate) VELTASSA (patiomer 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
PSEUDOBLBAR AFFECT AGENTS ^{DUR+}			
		NUEDEXTA (dextromethorphan/quinidine)	Non-Preferred Criteria • 90 days of therapy with the requested agent in the past 105 days OR

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MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

(For All Medicaid, MSCAN and CHIP Beneficiaries)

EFFECTIVE 10/01/2024
Version 2024_14
Updated: 12/01/2024

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			<ul style="list-style-type: none"> Documented diagnosis of Pseudobulbar Affect
PULMONARY ANTIHYPERTENSIVES^{DUR+}			
ACTIVIN SIGNALING INHIBITORS			
		WINREVAIR (sotatercept-csrk)	<p style="color: red; text-align: center;">All PAH Agents</p> <ul style="list-style-type: none"> Documented diagnosis of pulmonary hypertension <p style="color: red; text-align: center;">Non-Preferred Criteria</p> <ul style="list-style-type: none"> Documented diagnosis of pulmonary hypertension AND Have tried 1 preferred PAH agent in the past 6 months OR <ul style="list-style-type: none"> 90 days of therapy with the requested agent in the past 105 days
COMBINATION AGENTS			
		OPSYNVI (macitentan/tadalafil)	<p style="color: red; text-align: center;">Non-Preferred Criteria</p> <ul style="list-style-type: none"> Documented diagnosis of pulmonary hypertension AND Have tried 1 preferred PAH agent in the past 6 months OR <ul style="list-style-type: none"> 90 days of therapy with the requested agent in the past 105 days
ENDOTHELIN RECEPTOR ANTAGONIST			

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	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}	<p style="color: red;">Non-Preferred Criteria</p> <ul style="list-style-type: none"> • Documented diagnosis of pulmonary hypertension AND • Have tried 1 preferred PAH agent in the past 6 months OR • 90 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	<p style="color: red;">Sildenafil tablets</p> <p style="text-align: center;">< 1 year of age</p> <ul style="list-style-type: none"> • 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 <p style="text-align: center;">> 1 years of age AND</p> <ul style="list-style-type: none"> • Documented diagnosis of Pulmonary Hypertension <p style="color: red;">Revatio suspension</p> <ul style="list-style-type: none"> • < 12 years of age AND • Documented diagnosis of pulmonary hypertension, patent ductus arteriosus or persistent fetal circulation or history of a heart transplant

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			<p style="text-align: center;">OR</p> <ul style="list-style-type: none"> • 90 days stable therapy with Revatio suspension in the past 105 days <p style="text-align: center;">Non-Preferred Criteria</p> <ul style="list-style-type: none"> • Documented diagnosis of pulmonary hypertension AND • Have tried 1 preferred PAH agent in the past 6 months OR <ul style="list-style-type: none"> • 90 days of therapy with the requested agent in the past 105 days
PROSTACYCLINS			
		ORENITRAM ER (treprostinil) TYVASO (treprostinil) VENTAVIS (iloprost)	<p style="text-align: center;">Non-Preferred Criteria</p> <ul style="list-style-type: none"> • Documented diagnosis of pulmonary hypertension AND • Have tried 1 preferred PAH agent in the past 6 months OR <ul style="list-style-type: none"> • 90 days of therapy with the requested agent in the past 105 days
SELECTIVE PROSTACYCLIN RECEPTOR AGONISTS			
		UPTRAVI (selexipag)	<p style="text-align: center;">Non-Preferred Criteria</p> <ul style="list-style-type: none"> • Documented diagnosis of pulmonary hypertension AND

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			<ul style="list-style-type: none"> • Have tried 1 preferred PAH agent in the past 6 months OR <ul style="list-style-type: none"> • 90 days of therapy with the requested agent in the past 105 days
SOLUBLE GUANYLATE CYCLASE STIMULATORS			
		ADEMPAS (riociguat)	<p style="text-align: center;">Adempas</p> <ul style="list-style-type: none"> • Documented WHO Group 1 diagnosis of secondary pulmonary arterial hypertension OR • Documented WHO Group 4 diagnosis of pulmonary hypertension due to chronic thrombotic embolic disease OR <ul style="list-style-type: none"> • Documented diagnosis of pulmonary hypertension AND • Have tried 1 preferred PAH agent in the past 6 months OR <ul style="list-style-type: none"> • 90 days of therapy with the requested agent in the past 105 days
ROSACEA TREATMENTS			
	metronidazole (cream, gel, lotion)	AVAR (sulfacetamide sodium/sulfur) FINACEA (azelaic acid) FINACEA FOAM (azelaic acid) METROCREAM (metronidazole cream) METROGEL (metronidazole gel) METROLOTION (metronidazole lotion) MIRVASO (brimonidine)	Topical Sulfonamides used for Rosacea will require a manual PA for ≥ 21 years. Other labeled indications are limited to < 21 years.

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		NORITATE (metronidazole) OVACE (sulfacetamide sodium) RHOFADÉ (oxymetazoline HCl) ROSULA (sodium sulfacetamide/sulfur) sodium sulfacetamide/sulfur (cleanser, pads, suspension) SOOLANTRA (ivermectin) SUMADAN (sodium sulfacetamide/sulfur wash) SUMAXIN (sodium sulfacetamide/sulfur pads) SUMAXIN TS (sodium sulfacetamide/sulfur suspension) ZILXI AEROSOL (minocycline)	
SEDATIVE HYPNOTICS			
BENZODIAZEPINES ^{DUR+}			
	estazolam flurazepam temazepam (15mg and 30mg)	DALMANE (flurazepam) DORAL (quazepam) HALCION (triazolam) quazepam RESTORIL (temazepam) temazepam (7.5mg and 22.5mg) triazolam	Single source benzodiazepines and barbiturates are NOT covered – NO PA's will be issued for these drugs. MS DOM Opioid Initiative <ul style="list-style-type: none"> 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

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			refill override for one dose or therapy change per year. <ul style="list-style-type: none"> • 31 units/31 days <p style="text-align: center;">Triazolam – CUMULATIVE</p> Quantity limit per rolling days for all strengths <ul style="list-style-type: none"> • 10 units/31 days • 60 units/365 days
OTHERS ^{DUR+}			
	zaleplon zolpidem	AMBIEN (zolpidem) AMBIEN CR (zolpidem) BELSOMRA (sovorexant) DAYVIGO (lemborexant) doxepin 3mg, 6mg EDLUAR (zolpidem) eszopiclone HETLIOZ (tasimelteon) INTERMEZZO (zolpidem) LUNESTA (eszopiclone) ramelteon ROZEREM (ramelteon) QUVIVIQ (daridorexant) SILENOR (doxepin) SONATA (zaleplon) zolpidem ER zolpidem SL ZOLPIMIST (zolpidem)	<p style="text-align: center;">Maximum Age Limit</p> <ul style="list-style-type: none"> • 64 years – zolpidem 7.5 mg, zolpidem 10 mg, zolpidem 12.5 mg <p style="text-align: center;">Quantity Limit – CUMULATIVE</p> Quantity limit per rolling days for all strengths. DUR+ will allow an early refill override for one dose or therapy change per year. <ul style="list-style-type: none"> • 31 units/31 days • 1 canister/31 days – Zolpimist & male • 1 canister/62 days – Zolpimist & female • 1 bottle/31 days (48 ml or 158 ml) – Hetlioz liquid <p style="text-align: center;">Gender and Dose Limit for zolpidem</p>

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			<ul style="list-style-type: none"> • Female – Ambien 5 mg, Ambien CR 6.25 mg, Intermezzo 1.75 mg • Male – Zolpidem all strengths <p style="text-align: center; color: red;">Non-Preferred Criteria</p> <ul style="list-style-type: none"> • Have tried 2 different preferred agents in the past 6 months <p style="text-align: center; color: red;">Hetlioz capsules</p> <ul style="list-style-type: none"> • Documented diagnosis of circadian rhythm sleep disorder AND • Documented diagnosis indicating total blindness OR • Documented diagnosis of Magenis-Smith syndrome <p style="text-align: center; color: red;">Hetlioz liquid</p> <ul style="list-style-type: none"> • Documented diagnosis of Smith-Magenis syndrome AND <ul style="list-style-type: none"> • 3 - 15 years of age
SELECT CONTRACEPTIVE PRODUCTS			
INJECTABLE CONTRACEPTIVES			
	medroxyprogesterone acetate IM	DEPO-PROVERA IM (medroxyprogesterone acetate) DEPO-SUBQ PROVERA 104 (medroxyprogesterone acetate)	

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INTRAVAGINAL CONTRACEPTIVES			
	ANNOVERA (segesterone/ethinyl estradiol) etonogestrel/ethinyl estradiol NUVARING (etonogestrel/ethinyl estradiol)	PHEXXI (lactic acid, citric acid, potassium bitartrate)	
ORAL CONTRACEPTIVES ^{DUR+}			
	ALL CONTRACEPTIVES ARE PREFERRED EXCEPT FOR THOSE SPECIFICALLY INDICATED AS NON-PREFERRED	AMETHIA (levonorgestrel/ethinyl estradiol) AMETHYST (levonorgestrel/ethinyl estradiol) BALCOLTRA (levonorgestrel/ethinyl estradiol/iron) BEYAZ (ethinyl estradiol / drospirenone/levomefolate) CAMRESE (levonorgestrel/ethinyl estradiol) CAMRESE LO (levonorgestrel/ethinyl estradiol) GENERESS FE (norethindrone/ethinyl estradiol/fe) GIANVI (ethinyl estradiol/drospirenone) JOLESSA (levonorgestrel/ethinyl estradiol) levonorgestrel/ethinyl estradiol LO LOESTRIN FE (norethindrone/ethinyl estradiol) LOESTRIN (norethindrone acetate/ethinyl estradiol) LOESTRIN FE (norethindrone/ethinyl estradiol/iron) MINASTRIN 24 FE (norethindrone/ethinyl estradiol/iron) NATAZIA (estradiol valerate/dienogest)	Non-Preferred Criteria • 1 claim with the requested agent in the past 105 days

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		NEXTSTELLIS (drospirenone/estetrol) OCELLA (ethinyl estradiol/drospirenone) SAFYRAL (ethinyl estradiol/drospirenone/levomefolate) SIMPESS (levonorgestrel/ethinyl estradiol) TAYTULLA (norethindrone/ethinyl estradiol/iron) TYDEMY (ethinyl estradiol/drospirenone/levomefolate calcium) YASMIN (ethinyl estradiol/drospirenone) YAZ (ethinyl estradiol/drospirenone)	
TRANSDERMAL CONTRACEPTIVES			
	XULANE (norelgestromin and ethinyl estradiol)	ZAFEMY (norelgestromin and ethinyl estradiol) TWIRLA (levonorgestrel and ethinyl estradiol norelgestromin and ethinyl estradiol)	
SICKLE CELL AGENTS			
	DROXIA (hydroxyurea) hydroxyurea	ADAKVEO (crizanlizumab) ENDARI (glutamine glutamine) HYDREA (hydroxyurea) SIKLOS (hydroxyurea)	Endari – <u>MANUAL PA</u>
SKELETAL MUSCLE RELAXANTS ^{DUR+}			
	baclofen chlorzoxazone cyclobenzaprine 5mg, 10mg methocarbamol tizanidine tablets	AMRIX (cyclobenzaprine ER) baclofen suspension (generic FLEQSUVY) baclofen 15mg carisoprodol carisoprodol compound	Quantity Limit 84 tablets/180 days – carisoprodol Non-Preferred Agents • Documented diagnosis of an approvable indication AND

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		cyclobenzaprine 7.5mg, 15mg cyclobenzaprine ER DANTRIUM (dantrolene) dantrolene FLEQSUVY (baclofen) FEXMID (cyclobenzaprine) FLEXERIL (cyclobenzaprine) LORZONE (chlorzoxazone) LYVISPAH (baclofen granules) metaxalone NORGESIC FORTE (orphenadrine) orphenadrine orphenadrine compound orphenadrine ER PARAFON FORTE DSC (chlorzoxazone) ROBAXIN (methocarbamol) SKELAXIN (metaxalone) SOMA (carisoprodol) TANLOR (methocarbamol) tizanidine capsules ZANAFLEX (tizanidine)	<ul style="list-style-type: none"> Have tried 2 different preferred agents in the past 6 months <p>Baclofen granules, solution, and suspension</p> <ul style="list-style-type: none"> Require clinical review <p>Carisoprodol</p> <ul style="list-style-type: none"> Documented diagnosis of acute musculoskeletal condition AND No history with meprobamate in the past 90 days AND 1 claim for cyclobenzaprine in the past 21 <p>Carisoprodol with codeine</p> <ul style="list-style-type: none"> Requires clinical review <p>Tanlor</p> <ul style="list-style-type: none"> Requires Clinical Review
SMOKING DETERRENT			
NICOTINE TYPE			
	nicotine gum ^{OTC} nicotine lozenge ^{OTC} nicotine mini lozenge ^{OTC} nicotine patch ^{OTC}	NICODERM CQ PATCH ^{OTC} NICORETTE GUM ^{OTC} NICORETTE LOZENGE ^{OTC} NICORETTE MINI LOZENGE ^{OTC}	

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

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MEDIUM POTENCY			
	fluocinolone hydrocortisone mometasone cream, ointment prednicarbate cream PANDEL (hydrocortisone probutate)	betamethasone valerate foam CLODERM (clocortolone) CUTIVATE (fluticasone) DERMATOP (prednicarbate) ELOCON (mometasone) fluticasone LUXIQ (betamethasone) mometasone solution MOMEXIN (mometasone) prednicarbate oint SYNALAR (fluocinolone)	<p style="color: red;">Non-Preferred Criteria</p> <ul style="list-style-type: none"> • Have tried 2 different preferred medium potency agents in the past 6 months
HIGH POTENCY			
	amcinonide cream, lotion betamethasone dipropionate cream, gel, lotion betamethasone valerate cream, lotion, ointment fluocinolone triamcinolone 0.025% and 0.1% cream, ointment, lotion	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) fluocinonide halcinonide HALOG (halcinonide) KENALOG (triamcinolone) PEDIADERM TA (triamcinolone)	<p style="color: red;">Non-Preferred Criteria</p> <ul style="list-style-type: none"> • Have tried 2 different preferred high potency agents in the past 6 months

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		SERNIVO (betamethasone dipropionate) TOPICORT (desoximetasone) triamcinolone 0.05% ointment TRIANEX (triamcinolone) VANOS (fluocinonide)	
VERY HIGH POTENCY			
	clobetasol lotion clobetasol shampoo, spray clobetasol propionate cream clobetasol propionate ointment halobetasol cream halobetasol ointment	BRYHALI (halobetasol) clobetasol emollient clobetasol propionate foam, gel 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 dextroamphetamine IR methylphenidate IR methylphenidate solution	ADDERALL (amphetamine salt combination) amphetamine sulfate (generic EVEKO) DESOXYN (methamphetamine) dextroamphetamine/amphetamine ER dextroamphetamine solution	Minimum Age Limit • 3 years – Adderall, Evekeo, Procentra, Zenzedi • 6 years – Desoxyn, Evekeo ODT, Focalin, Methylin

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

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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) methylphenidate ER (generic Relexxii)	<p style="text-align: center;">Minimum Age Limit</p> <ul style="list-style-type: none"> • 6 years – Adderall XR, Adhansia XR, Adzenys ER Suspension, Adzenys XR ODT, Aptensio XR, Azstarys, Concerta ER, Cotempla XR ODT, Daytrana, Dexedrine, Dyanavel XR, Focalin XR, Jornay PM, Metadate CD, Quillichew, Quillivant XR, Relexxii ER, Ritalin LA, Vyvanse, Xelstrym • 13 years – Mydayis • 16 years – Provigil • 18 years – Nuvigil, Sunosi <p style="text-align: center;">Maximum Age Limit</p> <ul style="list-style-type: none"> • 18 years – Cotempla XR ODT, Daytrana

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		methylphenidate patch (generic Daytrana) MYDAYIS (amphetamine salt combination) RELEXXI (methylphenidate) RITALIN LA (methylphenidate) RITALIN SR (methylphenidate) VYVANSE (lisdexamfetamine)* VYVANSE CHEWABLE (lisdexamfetamine)* XELSTRYM patch (dextroamphetamine)	<p style="text-align: center;">Quantity Limit</p> <p style="text-align: center;">Applicable quantity limit per rolling days</p> <ul style="list-style-type: none"> • 31 tablets/31 days – Adderall XR, Adhansia XR, Adzenys XR ODT, Aptensio XR, Azstarys, Concerta ER 18, 27, & 54 mg, Cotelpla 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, Cotelpla XR-ODT 17.3 & 25.9 mg, Nuvigil 50mg • 248 mL/31 days – Dyanavel XR Suspension • 372 mL/31 days – Quillivant XR <p style="text-align: center;">Non-Preferred Criteria Long Acting ADD/ADHD</p> <ul style="list-style-type: none"> • Documented diagnosis of ADD/ADHD AND • Have tried 2 different preferred Long-Acting agents in the past 6 months OR

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			<ul style="list-style-type: none"> • 1 claim for a 30-day supply with the requested agent in the past 105 days <li style="padding-left: 20px;">Jornay PM <li style="padding-left: 40px;">• Documented diagnosis of ADD/ADHD AND • 84 days of therapy with 2 different preferred LA methylphenidate agents in the past 12 months AND <ul style="list-style-type: none"> • 84 days of therapy with 1 preferred non-methylphenidate LA stimulant agent in the past 12 months OR <li style="padding-left: 40px;">• Documented diagnosis of ADD/ADHD AND <li style="padding-left: 40px;">• 84 days of therapy with the requested agent in the past 105 days. <li style="padding-left: 20px;">Vyvanse <li style="padding-left: 40px;">• Documented diagnosis of binge eating disorder OR <li style="padding-left: 40px;">• Documented diagnosis of ADD/ADHD

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NARCOLEPSY			
	armodafinil modafinil SUNOSI (solriamfetol)	NUVIGIL (armodafinil) PROVIGIL (modafinil) sodium oxybate WAKIX (pitolisant) XYREM (sodium oxybate) XYWAV (calcium, magnesium, potassium and sodium oxybates)	<p style="color: red;">Non-Preferred Criteria Long Acting Narcolepsy</p> ADDERALL XR, APTENSIO XR, CONCERTA ER, DEXEDRINE, METADATE CD, METHYLIN ER, MYDAYIS, NUVIGIL, PROVIGIL, QUILLICHEW, QUILLIVANT XR, RITALIN LA, SUNOSI <ul style="list-style-type: none"> Documented diagnosis of narcolepsy AND 30 days of therapy with preferred modafinil or armodafinil in the past 6 months AND 1 different preferred agent indicated for narcolepsy in the past 6 months OR 1 claim for a 30-day supply with the requested agent in the past 105 days <p style="color: red;">Nuvigil</p> <ul style="list-style-type: none"> Documented diagnosis of narcolepsy, obstructive sleep apnea, shift work sleep disorder or bipolar depression <p style="color: red;">Provigil</p> <ul style="list-style-type: none"> Documented diagnosis of narcolepsy, obstructive sleep

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			<p>apnea, shift work sleep disorder, depression, sleep deprivation or Steinert Myotonic Dystrophy Syndrome</p> <p style="text-align: center;">Sunosi</p> <ul style="list-style-type: none"> • Documented diagnosis of narcolepsy or obstructive sleep apnea AND • 30 days of therapy with preferred modafinil or armodafinil in the past 6 months <p style="text-align: center;">Wakix</p> <ul style="list-style-type: none"> • Documented diagnosis of narcolepsy with or without cataplexy AND • 30 days of therapy with preferred modafinil or armodafinil in the past 6 months OR • Documented diagnosis of narcolepsy without or without cataplexy AND • Documented diagnosis of substance abuse disorder <p style="text-align: center;">Xyrem and Xywav</p> <ul style="list-style-type: none"> • Require clinical review
NON-STIMULANTS			
	atomoxetine clonidine ER	INTUNIV (guanfacine ER) ONYDA XR (clonidine extended release) ^{NR}	<p style="text-align: center;">Minimum Age Limit</p> <p>6 years – Intuniv, Clonidine ER, Onyda XR, Qelbree, Strattera</p>

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	guanfacine ER	QELBREE (viloxazine) STRATTERA (atomoxetine)	<p>18 years – Wakix</p> <p>Maximum Age Limit</p> <ul style="list-style-type: none"> • 18 years – Intuniv, Clonidine ER, Qelbree • 21 years – Strattera will approve with a diagnosis of ADD/ADHD <p>Quantity Limit</p> <p>Applicable quantity limit per rolling days</p> <ul style="list-style-type: none"> • 31 tablets/31 days – Intuniv, Qelbree 100 mg, Strattera • 62 tablets/31 days – Qelbree 150 mg and 200 mg, Wakix • 124 tablets/31 days – Clonidine ER • 30 ml/31 days (30 ml bottle) – Onyda XR Suspension • 60 ml/31 days (60 ml bottle) – Onyda XR Suspension <p>Intuniv</p> <ul style="list-style-type: none"> • Documented diagnosis of ADD or ADHD <p>Clonidine ER</p> <ul style="list-style-type: none"> • Documented diagnosis of ADD or ADHD <p>Onyda XR</p> <ul style="list-style-type: none"> • Requires Clinical review

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			<p style="color: red; text-align: center;">Qelbree</p> <ul style="list-style-type: none"> • Documented diagnosis of ADD or ADHD AND • 1 claim for a 30-day supply with atomoxetine in the past 105 days
TETRACYCLINES ^{DUR+}			
	doxycycline hyclate caps/tabs doxycycline monohydrate caps (50mg & 100mg) minocycline caps IR tetracycline	ACTICLATE (doxycycline) ADOXA (doxycycline monohydrate) demeclocycline DORYX (doxycycline hyclate) doxycycline (generic Oracea) doxycycline hyclate (generic Doryx) doxycycline hyclate (generic Periostat) doxycycline monohydrate caps (75mg & 150mg) doxycycline monohydrate tabs DYNACIN (minocycline) MINOCIN (minocycline) MINOLIRA (minocycline) minocycline ER minocycline tabs MONODOX (doxycycline monohydrate) NUZYRA (omadacycline tosylate) OKEBO (doxycycline) ORACEA (doxycycline) SEYSARA (sarecycline) SOLODYN (minocycline) TARGADOX (doxycycline)	<p style="color: red; text-align: center;">Non-Preferred Agents</p> <ul style="list-style-type: none"> • Have tried 2 different preferred agents in the past 6 months <p style="color: red; text-align: center;">Demeclocycline</p> <ul style="list-style-type: none"> • Documented diagnosis of SIADH will allow automatic approval

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Therapeutic Drug Class	Preferred Agents	Non-Preferred Agents	PA Criteria
		VIBRAMYCIN cap/susp/syrup XIMINO (minocycline)	
ULCERATIVE COLITIS and CROHN'S AGENTS ^{DUR+} *See Cytokine & CAM Antagonists Class for additional agents			
ORAL			
	APRISO (mesalamine) balsalazide budesonide EC LIALDA (mesalamine) mesalamine tablet (generic Apriso) PENTASA 250mg (mesalamine) PENTASA 500mg (mesalamine) sulfasalazine UCERIS (budesonide)	AZULFIDINE (sulfasalazine) AZULFIDINE ER (sulfasalazine) budesonide ER tablets COLAZAL (balsalazide) DELZICOL (mesalamine) DIPENTUM (olsalazine) ENTOCORT EC (budesonide) mesalamine tablet (generic Asacol HD) mesalamine capsules (generic Delzicol) ORTIKOS (budesonide) VELSIPITY (etrasimod)	<p>Non-Preferred Criteria</p> <ul style="list-style-type: none"> • 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 <p>Velsipity</p> <ul style="list-style-type: none"> • Requires clinical review
RECTAL			
	mesalamine suppository	budesonide foam CANASA (mesalamine) ROWASA (mesalamine) SF-ROWASA (mesalamine) UCERIS Foam (budesonide)	

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