

General Preferred Drug List Information

- Gainwell Technologies' DUR+ process is a proprietary electronic prior authorization system used for Medicaid pharmacy claims. MSCAN plans may/may not have electronic PA functionality. However, they must adhere to Medicaid's PA criteria.
- Drug coverage subject to the rules and regulations set forth in Sec. 1927 of Social Security Act. This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
- **PREFERRED BRANDS** will not count toward the two-brand monthly Rx Limit.
- Drugs highlighted in **yellow** denote change in PDL status.
- An * denotes existing users will be grandfathered; grandfathering is defined as approving a Non-Preferred agent for an existing user; all other changes will not qualify for grandfathering.
- A # denotes existing users will NOT be grandfathered.
- To search the PDL, **press CTRL + F**.



PREFERRED AGENTS		NON-PREFERRED AGENTS		PA CRITERIA	
ACNE AGENTS					
ANTI-INFECTIVES				Maximum Age Limit • 21 years: all acne agents except isotretinoin products Note: • Isotretinoin products available for all ages	
clindamycin gel (generic CLEOCIN-T)		azelaic acid			
clindamycin lotion, medicated swab, solution		CLEOCIN T (clindamycin)			
		CLINDACIN (clindamycin)			
		CLINDAGEL (clindamycin)			
		clindamycin foam			
		clindamycin gel (generic CLINDAGEL)			
		dapsone			
		ERY (erythromycin)			
		ERYGEL (erythromycin)			
		erythromycin			
		EVOCLIN (clindamycin)			
		KLARON (sulfacetamide)			
		MORGIDOX (doxycycline)			
		sulfacetamide sodium suspension			
		WINLEVI (clascoterone) cream			
ISOTRETINOIN PRODUCTS					
AMNESTEEM (isotretinoin)		ABSORBICA (isotretinoin)			
CLARAVIS (isotretinoin)		isotretinoin			
ZENATANE (isotretinoin)					
KERATOLYTICS (BENZOYL PEROXIDES)					
ACNE MEDICATION (benzoyl peroxide)		BPO towelette (benzoyl peroxide)			
benzoyl peroxide					
LINTERA (benzoyl peroxide)					
RETINOIDS					
adapalene gel, gel with pump		adapalene cream			
RETIN-A (tretinoin)		AKLIEF (trifarotene)			
tretinoin cream		ALTRENO (tretinoin)			
		ARAZLO (tazarotene)			
		ATRALIN (tretinoin)			
		DIFFERIN (adapalene)			
		FABIOR (tazarotene)			
		RETIN-A MICRO (tretinoin)			
		RETIN-A MICRO PUMP (tretinoin)			
		tretinoin gel			
		tretinoin microsphere			

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PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
ACNE AGENTS (continued)		
OTHERS/COMBINATION PRODUCTS		Maximum Age Limit 21 years: all acne agents except isotretinoin products
adapalene/benzoyl peroxide gel	ACANYA (benzoyl peroxide/clindamycin) gel	
clindamycin/benzoyl peroxide 1.2(1)%-5% gel	BENZAMYCIN (benzoyl peroxide/erythromycin) gel	
clindamycin/benzoyl peroxide 1%-5% gel w/pump	CABTREO (clindamycin/adapalene/benzoyl peroxide) gel	
sodium sulfacetamide w/sulfur 8%-4%, 9%-4.25%, 10-5% suspension	CLEANSING WASH (sulfacetamide sodium/sulfur/urea) cleanser	
	clindamycin phosphate/benzoyl peroxide 1.2%-2.5% gel	
	clindamycin phosphate/tretinoin 1.2%-0.025% gel	
	clindamycin/benzoyl peroxide 1%-5% gel	
	clindamycin/benzoyl peroxide 1.2%-3.75% gel w/pump (generic ONEXTON)	
	EPIDUO FORTE (adapalene/benzoyl peroxide) gel	
	erythromycin/benzoyl peroxide gel	
	NEUAC (benzoyl peroxide/clindamycin) cream, gel	
	ONEXTON (benzoyl peroxide/clindamycin) gel	
	sodium sulfacetamide w/sulfur 8%-4% cleanser	
	sodium sulfacetamide w/sulfur 10%-2% cream	
	sodium sulfacetamide w/sulfur 10%-5% cream, lotion	
	SSS (sodium sulfacetamide/sulfur)10-5 cream, foam	
	TWYNEO (benzoyl peroxide/tretinoin) cream	
	ZIANA (clindamycin/tretinoin) gel	
	ZMA CLEAR (sodium sulfacetamide/sulfur) suspension	
ALPHA-1 PROTEINASE INHIBITORS		
ARALAST NP		
GLASSIA		
PROLASTIN C		
ZEMAIRA		
ALZHEIMER'S AGENTS ^{DUR+}		
CHOLINESTERASE INHIBITORS		Preferred Criteria - Documented approvable diagnosis Non-Preferred Criteria - Documented approvable diagnosis AND - Have tried 2 different preferred agents in the past 6 months
donepezil 5 mg, 10 mg ODT, tablets	ADLARITY (donepezil)	
galantamine	ARICEPT (donepezil)	
galantamine ER	donepezil 23 mg tablet	
rivastigmine	EXELON (rivastigmine)	
NMDA RECETPOR ANTAGONISTS		NAMZARIC - Documented approvable diagnosis AND 30 days of concurrent therapy with both donepezil and memantine in the past 6 months
memantine	memantine ER	
	NAMENDA (memantine)	
	NAMENDA XR (memantine ER)	
COMBINATION AGENTS		
	NAMZARIC (memantine/donepezil)	
	memantine/donepezil ER ^{NR}	

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ANALGESICS, OPIOID-SHORT ACTING DUR+		
acetaminophen/caffeine/dihydrocodeine	ACTIQ (fentanyl)	MS DOM Opioid Initiative – Criteria details found here • Morphine Equivalent Daily Dose • Concomitant use of Opioids and Benzodiazepines Minimum Age Limit • 18 years: codeine-containing products and tramadol-containing products Quantity Limit (per 31 rolling days) • 62 tablets: butalbital/codeine combinations, codeine, dihydrocodeine combinations; fentanyl, hydrocodone, hydromorphone, levorphanol, meperidine, morphine, oxycodone, oxymorphone, pentazocine, tapentadol, tramadol • 186 tablets: butalbital/acetaminophen, butalbital/aspirin • 5 mL: butorphanol nasal • 180 mL: oxycodone liquid • 280 mL: QDOLO Non-Preferred Criteria • Have tried 2 different preferred agents in the past 6 months
acetaminophen/codeine	aspirin/butalbital/caffeine/codeine	
codeine	butalbital/acetaminophen/caffeine/codeine	
ENDOCET (oxycodone/acetaminophen)	butorphanol	
hydrocodone/acetaminophen	DILAUDID (hydromorphone)	
hydromorphone	DSUVIA (sufentanil)	
morphine sulfate	fentanyl citrate	
oxycodone	FENTORA (fentanyl)	
oxycodone/acetaminophen (325 mg acetaminophen formulations)	FIORICET W/CODEINE (butalbital/acetaminophen/codeine)	
tramadol 50 mg tablet	hydrocodone/ibuprofen	
tramadol/acetaminophen	meperidine	
	NALOCET (oxycodone/acetaminophen)	
	levorphanol	
	oxymorphone	
	pentazocine/naloxone	
	PERCOCET (oxycodone/acetaminophen)	
	PROLATE (oxycodone/acetaminophen)	
	ROXICODONE (oxycodone)	
	ROXYBOND (oxycodone)	
	SEGLENTIS (tramadol/celecoxib)	
	tramadol 25 mg, 75 mg, 100 mg tablet	
	tramadol solution	
ANALGESICS, OPIOID-LONG ACTING DUR+		
BUTRANS (buprenorphine)	BELBUCA (buprenorphine)	MS DOM Opioid Initiative – Criteria details found here • Morphine Equivalent Daily Dose • Concomitant use of Opioids and Benzodiazepines Minimum Age Limit • 18 years: BUTRANS and tramadol-containing products Quantity Limit (per 31 rolling days) • 31 tablets: AVINZA, hydromorphone ER, HYSINGLA ER, tramadol ER • 62 tablets: methadone, morphine ER, OXYCONTIN, oxymorphone ER, ZOHYDRO ER • 62 films: BELBUCA • 10 patches: fentanyl • 4 patches: BUTRANS Non-Preferred Criteria • Have tried 2 different preferred agents in the past 6 months
fentanyl patch	buprenorphine patch	
morphine sulfate ER tablet	CONZIP (tramadol)	
	hydrocodone bitartrate ER	
	hydromorphone ER	
	HYSINGLA ER (hydrocodone)	
	methadone	
	methadone intensol	
	METHADOSE (methadone)	
	morphine sulfate ER capsule	
	MS CONTIN (morphine)	
	oxycodone ER	
	OXYCONTIN (oxycodone)	
	oxymorphone ER	
	tramadol ER	

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PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
ANALGESICS/ANESTHETICS (TOPICAL)		
diclofenac 1%, 3% gel	DERMACINRX LIDOCAN (lidocaine)	Quantity Limit (per 31 days) • 1 bottle (112 mL): diclofenac 2% solution pump • 1 bottle (150 mL): diclofenac 1.5% solution Non-Preferred Criteria • Have tried 2 preferred agents in the past 6 months Lidocaine 5% Patch • Documented diagnosis of Herpetic Neuralgia OR • Documented diagnosis of Diabetic Neuropathy ZTLIDO • Documented diagnosis of Herpetic Neuralgia
lidocaine 4% cream, patch, solution	DERMACINRX LIDOGEL (lidocaine)	
lidocaine 5% cream, ointment, patch	DERMACINRX LIDOREX (lidocaine)	
lidocaine 40 mg/mL solution	diclofenac epolamine	
lidocaine/prilocaine cream	diclofenac sodium 2% solution pump	
TRIDACAINE (lidocaine) patch	DICLOGEN (diclofenac/menthol/camphor) kit	
TRIDACAINE XL (lidocaine) patch	DOLOGESIC PAIN RELIEF (lidocaine)	
ULTRA LIDO (lidocaine) cream, gel	LIDAFLEX (lidocaine)	
	lidocaine 3% cream	
	lidocaine 4% kit, liquid	
	lidocaine/hydrocortisone	
	lidocaine/prilocaine kit	
	LIDOCAN II, III, IV, V (lidocaine)	
	LIDOCORT (lidocaine/hydrocortisone)	
	LIDODERM (lidocaine)	
	LIDOTRAL (lidocaine)	
	LIXOFEN (diclofenac)	
	PENNSAID (diclofenac)	
	PLIAGLIS (lidocaine/tetracaine)	
	TRIDACAINE II, III (lidocaine) patch	
	ZTLIDO (lidocaine)	
ANDROGENIC AGENTS ^{DUR+}		
testosterone	ANDROGEL (testosterone)	All Agents • Limited to male gender Non-Preferred Criteria • Have tried 2 different preferred agents in the past 6 months TLANDO • Requires clinical review
	JATENZO (testosterone undecanoate)	
	NATESTO (testosterone)	
	TESTIM (testosterone)	
	TLANDO (testosterone)	
	VOGELXO (testosterone)	
ANGIOTENSIN MODULATORS ^{DUR+}		
ANGIOTENSIN CONVERTING ENZYME (ACE) INHIBITORS		See next page for PA Criteria/DUR+ Rules
benazepril	ACCUPRIL (quinapril)	
captopril	ALTACE (ramipril)	
enalapril	EPANED (enalapril)	
fosinopril	LOTENSIN (benazepril)	
lisinopril	moexipril	
quinapril	perindopril	
ramipril	QBRELIS (lisinopril)	
trandolapril	VASOTEC (enalapril)	
	ZESTRIL (lisinopril)	

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ANGIOTENSIN MODULATORS ^{DUR+} (continued)		
ACE INHIBITOR (ACEI) COMBINATIONS		EPANED – Automatic approval issued for 0-6 years of age ENTRESTO • Age ≥ 1 year and documented diagnosis of heart failure with systemic ventricular systolic dysfunction OR • Age ≥ 18 years and documented diagnosis of heart failure Non-Preferred Criteria • ACEIs: ○ 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 • ACEI/CCB Combinations: ○ Have tried 2 different preferred ACEI/CCB agents in the past 6 months OR ○ 90 days of therapy with the requested agent in the past 105 days • ACEI/Diuretic Combinations: ○ 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 • ARBs: ○ 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/CCB and ARB/CCB/Diuretic Combinations: ○ Have tried 1 preferred ARB/CCB agent in the past 6 months OR ○ 90 days of therapy with the requested agent in the past 105 days • ARB/Diuretic Combinations: ○ Have tried 2 different preferred ARB/Diuretic agents in the past 6 months OR ○ 90 days of therapy with the requested agent in the past 105 days • Direct Renin Inhibitors: ○ Documented diagnosis of hypertension AND ○ Have tried 2 different preferred ACEI or ARB single-entity agents in the past 6 months OR ○ 90 days of therapy with the requested agent in the past 105 days • Direct Renin Inhibitor Combinations: ○ 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
benazepril/amlodipine	ACCURETIC (quinapril/hydrochlorothiazide)	
benazepril/hydrochlorothiazide	LOTENSIN HCT (benazepril/hydrochlorothiazide)	
captopril/hydrochlorothiazide	LOTREL (benazepril/amlodipine)	
enalapril/hydrochlorothiazide	VASERETIC (enalapril/hydrochlorothiazide)	
fosinopril/hydrochlorothiazide	ZESTORETIC (lisinopril/hydrochlorothiazide)	
lisinopril/hydrochlorothiazide		
quinapril/hydrochlorothiazide		
trandolapril/verapamil ER		
ANGIOTENSIN II RECEPTOR BLOCKERS (ARBs)		
irbesartan	ATACAND (candesartan)	
losartan	AVAPRO (irbesartan)	
olmesartan	BENICAR (olmesartan)	
telmisartan	candesartan	
valsartan tablet	COZAAR (losartan)	
	DIOVAN (valsartan)	
	EDARBI (azilsartan)	
	eprosartan	
	MICARDIS (telmisartan)	
	valsartan solution	
ARB COMBINATIONS		
ENTRESTO (valsartan/sacubitril) tablet ^{DUR+}	ATACAND HCT (candesartan/hydrochlorothiazide)	
irbesartan/hydrochlorothiazide	AVALIDE (irbesartan/hydrochlorothiazide)	
losartan/hydrochlorothiazide	AZOR (olmesartan/hydrochlorothiazide)	
olmesartan/amlodipine	BENICAR HCT (olmesartan/hydrochlorothiazide)	
olmesartan/hydrochlorothiazide	candesartan/hydrochlorothiazide	
telmisartan/hydrochlorothiazide	DIOVAN-HCT (valsartan/hydrochlorothiazide)	
valsartan/amlodipine	EDARBYCLOR (azilsartan/chlorthalidone)	
valsartan/amlodipine/hydrochlorothiazide	ENTRESTO (valsartan/sacubitril) sprinkle capsule	
valsartan/hydrochlorothiazide	EXFORGE (valsartan/amlodipine)	
	EXFORGE HCT (valsartan/amlodipine/hydrochlorothiazide)	
	olmesartan/amlodipine/hydrochlorothiazide	
	telmisartan/amlodipine	
	TRIBENZOR (olmesartan/amlodipine/hydrochlorothiazide)	
	valsartan/sacubitril	
DIRECT RENIN INHIBITORS		
	aliskiren	
	TEKTURNA (aliskiren)	
DIRECT RENIN INHIBITOR COMBINATIONS		
	TEKTURNA HCT (aliskiren/hydrochlorothiazide)	

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ANTIBIOTICS (GI) & RELATED AGENTS		
metronidazole tablet	AEMCOLO (rifamycin)	
neomycin	DIFICID (fidaxomicin)	
tindazole	FIRVANQ (vancomycin)	
vancomycin oral solution	FLAGYL (metronidazole)	
	LIKMEZ (metronidazole)	
	metronidazole capsule	
	nitazoxanide	
	paromomycin	
	REBYOTA (fecal microbiota, live-jslm)	
	VANCOCIN (vancomycin)	
	vancomycin capsule	
	VOWST (fecal microbio spore, live-brpk)	
	XIFAXAN (rifamixin)	
ANTIBIOTICS (MISCELLANEOUS)		
LINCOSAMIDE ANTIBIOTICS		Quantity Limit • 6 tablets/month: SIVEXTRO SIVEXTRO – MANUAL PA ZYVOX – MANUAL PA
clindamycin	CLEOCIN (clindamycin)	
	CELOCIN PEDIATRIC (clindamycin)	
MACROLIDES		
azithromycin	ERYPED (erythromycin ethylsuccinate) suspension	
clarithromycin	erythrocin stearate	
clarithromycin ER	ZITHROMAX (azithromycin)	
E.E.S (erythromycin ethylsuccinate) suspension		
ERY-TAB (erythromycin)		
erythromycin		
erythromycin ethylsuccinate		
NITROFURANTOIN DERIVATIVES		
nitrofurantoin capsule	FURADANTIN (nitrofurantoin) suspension	
nitrofurantoin monohydrate macrocrystals	MACROBID (nitrofurantoin monohydrate macrocrystals)	
	nitrofurantoin suspension	
OXAZOLIDINONES		
	Linezolid	
	SIVEXTRO (tedizolid)	
	ZYVOX (linezolid)	
ANTIBIOTICS (TOPICAL)		
bacitracin ^{OTC}	CENTANY (mupirocin)	
bacitracin/polymyxin ^{OTC}	CENTANY AT (mupirocin)	
gentamicin sulfate	mupirocin cream	
mupirocin ointment	XEPI (ozenoxacin)	
neomycin/bacitracin/polymyxin ^{OTC}		

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ANTIBIOTICS (VAGINAL)					
CLEOCIN (clindamycin)		clindamycin phosphate			
NUVESSA (metronidazole)		CLINDESSE (clindamycin)			
		SOLOSEC (secnidazole)			
		XACIATO (clindamycin)			
ANTICOAGULANTS					
LOW MOLECULAR WEIGHT HEPARIN (LMWH)				Non-Preferred Criteria • LMWH: ○ Have tried 1 preferred agent in the past 6 months OR ○ 90 days of therapy with the requested agent in the past 105 days • Oral: ○ Have tried 2 different preferred oral agents in the past 6 months OR ○ 90 days of therapy with the requested agent in the past 105 days	
enoxaparin		ARIXTRA (fondaparinux)			
		fondaparinux			
		FRAGMIN (dalteparin)			
		LOVENOX (enoxaparin)			
ORAL					
ELIQUIS (apixaban)		dabigatran			
JANTOVEN (warfarin)		PRADAXA (dabigatran) pellet pack			
PRADAXA (dabigatran) capsule		SAVAYSA (edoxaban)			
warfarin					
XARELTO (rivaroxaban)					
ANTICONVULSANTS ^{DUR+}					
ADJUVANTS				Minimum Age Limit • 6 months: DIACOMIT • 1 year: BANZEL, EPIDIOLEX • 2 years: ONFI, SYMPAZAN • 6 years: VALTOCO • 12 years: NAYZILAM Maximum Age Limit • 2 years: VIGAFYDE Quantity Limit (per 31 days) • 2 twin packs: DIASTAT • 2 packages: NAYZILAM • 2 cartons: VALTOCO Non-Preferred Criteria • Have tried 2 different preferred agents in the past 6 months OR • Documented diagnosis of seizure AND • 90 days of therapy with the requested agent in the past 105 days See next page for additional PA Criteria/DUR+ Rules	
carbamazepine		APTIOM (eslicarbazine)			
carbamazepine ER 12-hour capsule		BANZEL (rufinamide)			
DEPAKOTE ER (divalproex)		BRIVIACT (brivaracetam)			
DEPAKOTE SPRINKLE (divalproex)		carbamazepine ER 12-hour tablet			
divalproex		CARBATROL (carbamazepine)			
divalproex ER		DEPAKOTE (divalproex)			
divalproex sprinkle		DIACOMIT (stiripentol)			
EPIDIOLEX (cannabidiol)		ELEPSIA XR (levetiracetam)			
lacosamide		EPRONTIA (topiramate)			
lamotrigine		EQUETRO (carbamazepine)			
lamotrigine blue, green, orange dose pack		felbamate			
levetiracetam		FELBATOL (felbamate)			
levetiracetam ER		FINTEPLA (fenfluramine)			
oxcarbazepine tablet		FYCOMPA (perampanel)			
tiagabine		KEPPRA (levetiracetam)			
topiramate		KEPPRA XR (levetiracetam)			
topiramate sprinkle		LAMICTAL (lamotrigine)			
TRILEPTAL (oxcarbazepine) suspension		LAMICTAL XR (lamotrigine)			
valproic acid		lamotrigine ER			
zonisamide		lamotrigine ODT			
		lamotrigine ODT blue, green, orange dose pack			
		MOTPOLY XR (lacosamide)			

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ANTICONVULSANTS ^{DUR+} (continued)		
ADJUVANTS (continued)		See previous page for additional PA Criteria/DUR+ Rules
	oxcarbazepine suspension	Banzel, Onfi, and Sympazan - Documented diagnosis of Lennox-Gastaut syndrome and have tried 1 preferred agent for Lennox-Gastaut syndrome in the past 6 months OR - Documented diagnosis of seizure and 90 days of therapy with the requested agent in the past 105 days DIACOMIT - Documented diagnosis of Dravet syndrome AND 1 claim for clobazam in the past 30 days EPIDIOLEX - Documented diagnosis of Dravet syndrome, Lennox-Gastaut syndrome, or seizures associated with tuberous sclerosis complex OR 1 claim for EPIDIOLEX in the past 30 days FINTEPLA – Requires clinical review SABRIL Powder for Oral Solution - Documented diagnosis of infantile spasms OR - Have tried 2 different preferred agents in the past 6 months OR - Documented diagnosis of seizure AND 90 days of therapy with the requested agent in the past 105 days Topiramate ER - Documented diagnosis of seizure AND 90 days of therapy with the requested agent in the past 105 days OR 30 days of therapy with topiramate IR in the past 6 months VIGAFYDE - Age 0-2 years AND - Documented diagnosis of infantile spasms
	oxcarbazepine ER	
	OXTELLAR XR (oxcarbazepine)	
	QUDEXY XR (topiramate)	
	ROWEEPRA (levetiracetam)	
	rufinamide	
	SABRIL (vigabatrin)	
	SPRITAM (levetiracetam)	
	SUBVENITE (lamotrigine)	
	SUBVENITE (lamotrigine) blue, green, orange dose pack	
	TEGRETOL (carbamazepine)	
	TEGRETOL XR (carbamazepine)	
	TOPAMAX (topiramate)	
	topiramate ER	
	TRILEPTAL (oxcarbazepine) tablet	
	TROKENDI XR (topiramate)	
	vigabatrin	
	VIGADRONE (vigabatrin)	
	VIGAFYDE (vigabatrin)	
	VIGPODER (vigabatrin)	
	VIMPAT (lacosamide)	
	XCORPI (cenobamate)	
	ZONISADE (zonisamide) suspension	
	ZTALMY (ganaxolone)	
HYDANTOINS		
	DILANTIN (phenytoin)	
	DILANTIN-125 (phenytoin)	
	PHENYTEK (phenytoin)	
	phenytoin	
	phenytoin ER	
SELECTED BENZODIAZEPINES		
	clobazam	DIASTAT (diazepam) rectal gel
	diazepam rectal gel	LIBERVANT (diazepam)
	NAYZILAM (midazolam)	ONFI (clobazam)
	VALTOCO (diazepam)	SYMPAZAN (clobazam)
SUCCINIMIDES		
	ethosuximide	CELONTIN (methsuximide)
		methsuximide
		ZARONTIN (ethosuximide)

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ANTIDEPRESSANTS, OTHER ^{DUR+}		
bupropion	APLENZIN (bupropion)	Minimum Age Limit • 18 years: all agents Non-Preferred Criteria • Have tried 2 different preferred agents in the past 6 months OR • Have tried 1 preferred agent and 1 SSRI in the past 6 months OR • 90 days of therapy with the requested agent in the past 105 days AUVELITY • Requires clinical review DRIZALMA Sprinkles • Automatic approval issued with a diagnosis of generalized anxiety disorder for 7-11 years of age Duloxetine • Automatic approval issued with a diagnosis of generalized anxiety disorder for 7-17 years of age ZURZUVAE – MANUAL PA
bupropion SR	AUVELITY (bupropion/dextromethorphan)	
bupropion XL	desvenlafaxine ER	
mirtazapine	EFFEXOR XR (venlafaxine)	
trazodone	EMSAM (selegiline)	
TRINTELLIX (vortioxetine)	FETZIMA (levomilnacipran)	
venlafaxine	FORFIVO XL (bupropion)	
venlafaxine ER capsule	MARPLAN (isocarboxazid)	
vilazodone	NARDIL (phenelzine)	
	nefazodone	
	phenelzine	
	PRISTIQ (desvenlafaxine)	
	REMERON (mirtazapine)	
	tranylcypromine	
	venlafaxine ER tablet	
	VIIBRYD (vilazodone)	
	WELLBUTRIN SR (bupropion)	
	WELLBUTRIN XL (bupropion)	
	ZURZUVAE (zuranolone)	
ANTIDEPRESSANTS, SSRIs ^{DUR+}		
citalopram solution, tablet	CELEXA (citalopram)	Minimum Age Limit • 6 years: ZOLOFT • 7 years: LEXAPRO, PROZAC • 8 years: LUVOX • 18 years: CELEXA, LUVOX CR, PAXIL, PEXEVA, PROZAC 90 mg Maximum Age Limit • 60 years: CELEXA Non-Preferred Criteria • Have tried 2 different preferred agents in the past 6 months OR • 90 days of therapy with the requested agent in the past 105 days
escitalopram	citalopram capsule	
fluoxetine capsule	fluoxetine solution, tablet	
fluvoxamine	fluoxetine DR capsule	
paroxetine tablet	fluvoxamine ER capsule	
paroxetine CR	LEXAPRO (escitalopram)	
paroxetine ER	paroxetine suspension, capsule	
sertraline tablet, solution	PAXIL (paroxetine)	
	PAXIL CR (paroxetine)	
	PROZAC (fluoxetine)	
	sertraline capsule	
	ZOLOFT (sertraline)	

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ANTIEMETICS ^{DUR+}			
5HT3 RECEPTOR BLOCKERS			Quantity Limit (per 31 days) • 6 tablets: AKYNZEO • 100 mL: ZOFRAN solution Non-Preferred Agents • Have tried 1 preferred agent in the past 6 months AKYNZEO – MANUAL PA Note: Injectables in this class are closed to point of sale. PA required if not administered in clinic/hospital.
ondansetron solution, tablet	ANZIMET (dolasetron)		
ondansetron ODT 4 mg, 8 mg	granisetron		
	ondansetron ODT 16 mg tablet		
	SANCUSO (granisetron)		
ANTIEMETIC COMBINATIONS			
DICLEGIS (doxylamine/pyridoxine)	AKYNZEO (netupitant/palonosetron)		
	BONJESTA (doxylamine/pyridoxine)		
	doxylamine/pyridoxine		
CANNABINOIDS			
	dronabinol		
	MARINOL (dronabinol)		
NMDA RECEPTOR ANTAGONISTS			
aprepitant	EMEND (aprepitant)		
ANTIFUNGALS (ORAL) ^{DUR+}			
clotrimazole	ANCOBON (flucytosine)		Griseofulvin suspension • Automatic approval issued for 0-11 years of age Griseofulvin tablets • Automatic approval issued for 12-17 years of age Minimum Age Limit • 18 years: CRESEMBA Non-Preferred Criteria • Have tried 2 different preferred agents in the past 6 months HIV Opportunistic Infection • Non-Preferred agent indicated for treatment (^) AND • Documented diagnosis of HIV CRESEMBA – MANUAL PA SPORANOX • Requires clinical review
fluconazole	BREXAFEMME (ibrexafungerp)		
nystatin	CRESEMBA (isavuconazoium)		
terbinafine	DIFLUCAN (fluconazole)		
	flucytosine		
	griseofulvin		
	griseofulvin ultramicrosize		
	itraconazole		
	ketoconazole		
	NOXAFIL (posaconazole)		
	ORAVIG (miconazole)		
	posaconazole		
	SPORANOX (itraconazole)		
	TOLSURA (itraconazole)		
	VFEND (voriconazole)		
	VIVJOA (oteseconazole)		
	voriconazole		

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA	
ANTIFUNGALS (TOPICAL) DUR+			
ANTIFUNGALS		Non-Preferred Criteria - Have tried 2 different preferred agents in the past 6 months MICOTRIN AC, MYCOZYL, and clotrimazole 30 mL solution - Require clinical review	
ciclopirox cream, gel, solution, suspension	BENSAL HP (salicylic acid)		
clotrimazole cream, solution Rx & OTC	CILODAN (ciclopirox)		
econazole	ciclopirox shampoo		
ketoconazole cream, shampoo	clotrimazole solution (NDC 50228-0502-61)		
LUZU (luliconazole)	ERTACZO (sertaconazole)		
miconazole cream, powder, solution OTC	EXTINA (ketoconazole)		
miconazole/zinc oxide/petrolatum ointment	JUBLIA (efinaconazole)		
nystatin cream, ointment, powder	ketoconazole foam		
terbinafine OTC	KETODAN (ketoconazole)		
tolnaftate cream, solution OTC	LOPROX (ciclopirox)		
	luliconazole		
	MICOTRIN AC (clotrimazole)		
	MYCOZYL AC (clotrimazole)		
	MYCOZYL AP (miconazole)		
	naftifine		
	NAFTIN (naftifine)		
	oxiconazole		
	OXISTAT (oxiconazole)		
	yavaborole		
	VOTRIZA-AL (clotrimazole)		
	VUSION (miconazole/zinc oxide/petrolatum)		
ANTIFUNGAL/STEROID COMBINATIONS			
clotrimazole/betamethasone cream	clotrimazole/betamethasone lotion		
nystatin/triamcinolone			
ANTIFUNGALS (VAGINAL)			
clotrimazole cream OTC	3-DAY VAGINAL CREAM (clotrimazole)		
clotrimazole-3 cream	GYNAZOLE 1 (butoconazole)		
miconazole kit OTC	terconazole suppository		
terconazole cream			
ANTI-HISTAMINES, MINIMALLY SEDATING AND COMBINATIONS DUR+			
MINIMALLY SEDATING ANTIHISTAMINES		Non-Preferred Criteria - Documented diagnosis of allergy or urticaria AND - Have tried 2 different preferred agents in the past 12 months	
cetirizine capsule, solution, tablet OTC	cetirizine chewable tablet OTC		
loratadine chewable tablet, ODT, solution, tablet OTC	CLARINEX (desloratadine)		
	desloratadine		
	levocetirizine		
MINIMALLY SEDATING ANTIHISTAMINE/DECONGESTANT COMBINATIONS			
cetirizine/pseudoephedrine	CLARINEX-D 12 HOUR (desloratadine/pseudoephedrine)		
loratadine/pseudoephedrine	fexofenadine/pseudoephedrine		

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ANTIMIGRAINE AGENTS, PROPHYLAXIS					
INJECTABLES				Preferred Injectables - History of 3 claims with the requested agent in the past 105 days OR - New starts require clinical review Non-preferred Injectables - Require clinical review AIMOVIG – MANUAL PA EMGALITY – MANUAL PA AJOVY – MANUAL PA VYEPTI – MANUAL PA	
AIMOVIG Autoinjector (erenumab-aooe) ^{DUR+}		EMGALITY Syringe (galcanezumab-gnlm) 300 mg/mL			
AJOVY Autoinjector (fremanezumab-vfrm) ^{DUR+}		VYEPTI (eptinezumab-jjmr)			
AJOVY Syringe (fremanezumab-vfrm) ^{DUR+}					
EMGALITY Pen (galcanezumab-gnlm) ^{DUR+}					
EMGALITY Syringe (galcanezumab-gnlm) 120 mg/mL ^{DUR+}					
ORAL					
		QULIPTA (atogepant)			
*ANTINEOPLASTICS – SELECTED SYSTEMIC ENZYME INHIBITORS					
BOSULIF (bosutinib) tablet		AFINITOR, AFINITOR DISPERZ (everolimus)		FARYDAK – MANUAL PA - Documented diagnosis of multiple myeloma AND - Used in combination with bortezomib and dexamethasone per PI AND - History of 2 prior regimens including bortezomib and an immunomodulatory agent IBRANCE - Documented diagnosis of WD-DDLS for retroperitoneal sarcoma OR - All other indications require clinical review LENVIMA - Documented diagnosis of thyroid cancer OR - Documented diagnosis of hepatocellular carcinoma OR - Documented diagnosis of renal cell carcinoma AND - History of 1 claim for everolimus in the past 30 days AND - History of 1 anti-angiogenic agent in the past 2 years OR - All other indications require clinical review LYNPARZA Tablets – Criteria details found here - Documented diagnosis of ovarian cancer, fallopian tube or peritoneal cancer AND - History of platinum-based chemotherapy in the past 2 years OR - All other indications require clinical review	
CAPRESLA (vandetanib)		AKEEGA (niraparib/abiraterone)			
COMETRIQ (cabozantinib)		ALECENSA (alectinib)			
COTELLIC (cobimetinib)		ALUNBRIG (brigatinib)			
everolimus		AUGTYRO (repotrectinib)			
GILOTRIF (afatinib)		AYVAKIT (avapritinib)			
ICLUSIG (ponatinib)		BALVERSA (erdafitinib)			
imatinib		BOSULIF (bosutinib) capsule			
IMBRUVICA (ibrutinib)		BRAFTOVI (encorafenib)			
INLYTA (axitinib)		BRUKINSA (zanubrutinib)			
IRESSA (gefitinib)		CABOMETYX (cabozantinib)			
JAKAFI (ruxolitinib)		CALQUENCE (acalabrutinib)			
MEKINIST (trametinib)		COPIKTRA (duvelisib)			
NEXAVAR (sorafenib)		DANZITEN (nilotinib)			
ROZLYTREK (entrectinib)		dasatinib			
SPRYCEL (dasatinib)		DATROWAY (datopotamab) ^{NR}			
STIVARGA (regorafenib)		DAURISMO (glasdegib)			
SUTENT (sunitinib)		ERIVEDGE (vismodegib)			
TAFINLAR (dabrafenib)		ERLEADA (apalutamide)			
TARCEVA (erlotinib)		erlotinib			
TASIGNA (nilotinib)		FOTIVDA (tivozanib)			
TURALIO (pexidartinib)		FURZAQLA (fruquintinib)			
TYKERB (lapatinib)		GAVRETO (pralsetinib)			
VOTRIENT (pazopanib)		gefitinib			
XALKORI (crizotinib)		GLEEVEC (imatinib)			
XTANDI (enzalutamide)		IBRANCE (palbociclib)			
ZELBORAF (vemurafenib)		IDHIFA (enasidenib)			
ZYDELIG (idelalisib)		IMKELDI (imatinib)			
ZYKADIA (ceritinib)		INQOVI (decitabine/cedazuridine)			
		INREBIC (fedratinib)			

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*ANTINEOPLASTICS – SELECTED SYSTEMIC ENZYME INHIBITORS <i>(continued)</i>		
	ITOVEBI (inavolisib)	See previous page for PA Criteria/DUR+ Rules
	IWILFIN (eflornithine)	
	JAYPIRCA (pirtobrutinib)	
	KISQALI (ribociclib)	
	KISQALI-FEMARA CO-PACK (ribociclib/letrozole)	
	KOSELUGO (selumetinib/vitamin e)	
	KRAZATI (adagrasib)	
	lapatinib	
	LAZCLUZE (lazertinib)	
	LENVIMA (lenvatinib)	
	LOBRENA (lorlatinib)	
	LUMAKRAS (sotorasib)	
	LYNPARZA (olaparib)	
	LYTGOBI (futibatinib)	
	MEKTOVI (binimetinib)	
	NERLYNX (neratinib)	
	NUBEQA (darolutamide)	
	ODOMZO (sonidegib)	
	OGSIVEO (nirogacestat)	
	OJEMDA (tovorafenib)	
	OJJAARA (mometotinib)	
	ONUREG (azacitidine)	
	ORGOVYX (relugolix)	
	pazopanib	
	PEMAZYRE (pemigatinib)	
	PIQRAY (alpelisib)	
	QINLOCK (ripretinib)	
	RETEVMO (selpercatinib)	
	REVUFORJ (revumenib)	
	REZLIDHIA (olutasidenib)	
	RUBRACA (rucaparib)	
	RYDAPT (midostaurin)	
	SCEMBLIX (asciminib)	
	sorafenib	
	sunitinib	
	TABRECTA (capmatinib)	
	TAGRISSO (Osimertinib)	
	TALZENNA (talazoparib)	
	TAZVERIK (tazemetostat)	
	TECENTRIZ HYBREZA (atezolizumab-hayluranoidase)	
	TEPMETKO (tepotinib)	

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*ANTINEOPLASTICS – SELECTED SYSTEMIC ENZYME INHIBITORS (continued)		
	TIBSOVO (ivosidenib)	See previous page for PA Criteria/DUR+ Rules
	TORPENZ (everolimus)	
	TRUQAP (capiwasertib)	
	TUKYSA (tucatinib)	
	VANFLYTA (quizartinib)	
	VERZENIO (abemaciclib)	
	VITRAKVI (larotrectinib)	
	VIZIMPRO (dacomitinib)	
	VONJO (pacritinib)	
	VORANIGO (vorasidenib)	
	WELIREG (belzutifan)	
	XOSPATA (gilteritinib)	
	XPOVIO (selinexor)	
	ZEJULA (niraparib)	
ANTIOBESITY SELECT AGENTS		
SAXENDA (liraglutide)	orlistat	All agents – <u>MANUAL PA</u> required
WEGOVY (semaglutide)	XENICAL (orlistat)	
ANTIPARASITICS (TOPICAL) DUR+		
PEDICULICIDES		Minimum Age Limit • 2 months: permethrin 1% (OTC), permethrin 5% • 6 months: NATROBA, SKLICE • 2 years: piperonyl/pyrethrins (OTC) • 4 years: NATROBA • 6 years: OVIDE • 18 years: EURAX Non-Preferred Criteria • Pediculicides ○ Have tried 2 preferred topical lice agents in the past 90 days • Scabicides ○ Have tried permethrin 5% in the past 90 days
NATROBA (spinosad)	lindane	
permethrin 1% cream OTC	malathion	
VANALICE (piperonyl butoxide/pyrethrins)	OVIDE (malathion)	
	SKLICE (ivermectin)	
	spinosad	
SCABICIDES		
ivermectin	CROTAN (crotamiton)	
permethrin 5% cream	ELIMITE (permethrin)	
	EURAX (crotamiton)	
	STROMEKTOL (ivermectin)	
ANTIPARKINSON’S AGENTS (INJECTABLE)		
	VYALEV (foscarbidopa/foslevodopa) NR	VYALEV • Requires clinical review

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ANTIPARKINSON'S AGENTS (ORAL)		DUR+
ANTICHOLINERGICS		Non-Preferred Criteria
benztropine		- 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
trihexyphenidyl		
COMT INHIBITORS		XADAGO
entacapone	OAGENTYS (opicapone)	- Documented diagnosis of Parkinson's disease AND 30 days of therapy with a carbidopa/levodopa combination agent in the past 45 days AND 30 days of therapy with a selegiline agent in the past 45 days
	TASMAR (tocapone)	
	tolcapone	
DOPAMINE AGONISTS		GOCOVRI
pramipexole	NEUPRO (rotigotine)	- Documented diagnosis of Parkinson's disease AND 30 days of therapy with amantadine IR in the past 105 days AND 30 days of therapy with a carbidopa/levodopa combination agent in the past 45 days
ropinirole	pramipexole ER	
	ropinirole ER	
MAO-B INHIBITORS		LODOSYN and INBRIJA
selegiline	AZILECT (rasagiline)	- Documented diagnosis of Parkinson's disease AND 30 days of therapy with a carbidopa/levodopa combination agent in the past 45 days
	rasagiline	
	XADAGO (safinamide)	
	ZELAPAR (selegiline)	
OTHERS		NOURIANZ
amantadine	carbidopa/levodopa ODT	- Documented diagnosis of Parkinson's Disease AND - Have tried 1 preferred carbidopa/levodopa combination agent in the past 30 days AND 30 days of therapy with a preferred adjunctive therapy in the past 45 days
bromocriptine	carbidopa/levodopa/entacapone	
carbidopa	CREXONT (carbidopa/levodopa)	
carbidopa/levodopa tablet	DHIVY (carbidopa/levodopa)	
carbidopa/levodopa ER	DUOPA (carbidopa/levodopa)	
	GOCOVRI (amantadine)	
	INBRIJA (levodopa)	
	LODOSYN (carbidopa)	
	NOURIANZ (istradefylline)	
	OSMOLEX ER (amantadine)	
	RYTARY (carbidopa/levodopa)	
	SINEMET (carbidopa/levodopa)	
	STALEVO (carbidopa/levodopa/entacapone)	
ANTIPSORIATICS (TOPICAL)		
calcipotriene cream	calcipotriene foam, ointment, solution	
ENSTILAR (calcipotriene/betamethasone)	calcipotriene/betamethasone	
TACLONEX (calcipotriene/betamethasone)	calcitriol ointment	
	DUOBRII (halobetasol/tazarotene)	
	SORILUX (calcipotriene)	
	tazarotene	
	VECTICAL (calcitriol)	
	VTAMA (tapinarof)	
	ZORYVE (roflumilast)	

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ANTIPSYCHOTICS ^{DUR+}		
INJECTABLE, ATYPICALS ^{DUR+}		Concurrent Therapy Limit for Age < 18 years 90 days with ≥ 2 agents in the last 120 days will require a MANUAL PA Minimum Age Limit 3 years: HALDOL 5 years: RISPERDAL, thioridazine 6 years: ABILIFY, trifluoperazine 10 years: LATUDA, SAPHRIS, SEROQUEL, SYMBYAX 12 years: INVEGA, molindone, perphenazine, pimozide, thiothixene 13 years: REXULTI, ZYPREXA 18 years: ABILIFY MYCITE, CAPLYTA, CLOZARIL, COBENFY, FANAPT, fluphenazine, GEODON, loxapine, LYBALVI, NUPLAZID, perphenazine/amitriptyline, SECUADO, VRAYLAR, and all injectable agents Quantity Limit 3 syringes/year: ARISTADA INITIO Non-Preferred Criteria – Atypical Agents - Have tried 2 preferred agents in the past 12 months OR 30 days of therapy with the requested agent in the past 180 days All Long-Acting Injectable Agents - Documented diagnosis of schizophrenia or schizoaffective disorder ABILIFY MAINTENA, ABILIFY ASIMTUFII, RISPERDAL CONSTA, and RYKINDO ER - Documented diagnosis of schizophrenia, schizoaffective disorder, or bipolar disorder INVEGA HAFYERA - 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 COBENFY and OPIPZA - Require clinical review NUPLAZID - Documented diagnosis of Parkinson's disease VRAYLAR - Documented diagnosis of schizophrenia, schizoaffective disorder, bipolar disorder, or major depressive disorder AND 30 days of therapy with an antidepressant in the past 45 days OR 1 claim for a 90-day supply of an antidepressant in the past 105 days
ABILIFY ASIMTUFII (aripiprazole) ABILIFY MAINTENA (aripiprazole) ARISTADA, ARISTADA INITIO (aripiprazole lauroxil) INVEGA HAFYERA (paliperidone) INVEGA SUSTENNA (paliperidone palmitate) INVEGA TRINZA (paliperidone) PERSERIS (risperidone) RISPERDAL CONSTA (risperidone) UZEDY (risperidone)	ERZOFRI (paliperidone palmitate) ^{NR} GEODON (ziprasidone) olanzapine risperidone ER RYKINDO (risperidone) ziprasidone ZYPREXA (olanzapine) ZYPREXA RELPREVV (olanzapine)	
ORAL		
aripiprazole tablet asenapine clozapine tablet fluphenazine haloperidol haloperidol lactate olanzapine perphenazine perphenazine/amitriptyline quetiapine quetiapine ER risperidone thioridazine trifluoperazine VRAYLAR (cariprazine) ziprasidone	ABILIFY (aripiprazole) ABILIFY MYCITE (aripiprazole) ADASUVE (loxapine) aripiprazole ODT, solution CAPLYTA (lumateperone) chlorpromazine clozapine ODT CLOZARIL (clozapine) COBENFY (xanomeline/trospium) ^{NR} FANAPT (iloperidone) GEODON (ziprasidone) IGALMI (dexmedetomidine) INVEGA (paliperidone) LATUDA (lurasidone) lurasidone LYBALVI (olanzapine/samidorphan) NUPLAZID (pimavanserin) olanzapine/fluoxetine OPIPZA (aripiprazole) paliperidone ER REXULTI (brexpiprazole) RISPERDAL (risperidone) SAPHRIS (asenapine) SEROQUEL (quetiapine) SEROQUEL XR (quetiapine ER) SYMBYAX (olanzapine/fluoxetine) VERSACLOZ (clozapine) ZYPREXA, ZYPREXA ZYDIS (olanzapine)	
TRANSDERMAL, ATYPICALS		
	SECUADO (asenapine)	

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ANTIRETROVIRALS ^{DUR+}		
CAPSID INHIBITORS		Non-Preferred Criteria 1 claim with the requested agent in the past 105 days STRIBILD – MANUAL PA SUNLENCA - Requires clinical review TYBOST – MANUAL PA
	SUNLENCA (lenacapavir)	
CD4 DIRECTED ATTACHMENT INHIBITORS		
	RUKOBIA (fostemsavir)	
CD4 DIRECTED HIV-1 INHIBITORS		
	TROGARZO (ibalizumab-uiyk)	
COMBINATION PRODUCTS – NRTIs		
abacavir/lamivudine	COMBIVIR (lamivudine/zidovudine)	
CABENUVA (cabotegravir/rilpivirine)	EPZICOM (abacavir/lamivudine)	
DOVATO (dolutegravir/lamivudine)		
lamivudine/zidovudine		
COMBINATION PRODUCTS – NUCLEOSIDE AND NUCLEOTIDE ANALOG RTIs		
DESCOVY (emtricitabine/tenofovir alafenamide)	TRUVADA (emtricitabine/tenofovir)	
emtricitabine/tenofovir		
COMBINATION PRODUCTS – NUCLEOSIDE AND NUCLEOTIDE ANALOG AND NON-NUCLEOSIDE RTIs		
DELSTRIGO (doravirine/lamivudine/tenofovir)	ATRIPLA (efavirenz/emtricitabine/tenofovir)	
efavirenz/emtricitabine/tenofovir	CIMDUO (lamivudine/tenofovir)	
ODEFSEY (emtricitabine/rilpivirine/tenofovir)	COMPLERA (emtricitabine/rilpivirine/tenofovir)	
COMBINATION PRODUCTS – PROTEASE INHIBITORS		
lopinavir/ritonavir	KALETRA (lopinavir/ritonavir)	
ENTRY INHIBITORS – CCR5 CO-RECEPTOR ANTAGONISTS		
	maraviroc	
	SELZENTRY (maraviroc)	
ENTRY INHIBITORS – FUSION INHIBITORS		
	FUZEON (enfuvirtide)	
INTEGRASE STRAND TRANSFER INHIBITORS		
APRETUDE (cabotegravir)	cabotegravir ER	
ISENTRESS (raltegravir)	ISENTRESS HD (raltegravir)	
TIVICAY, TIVICAY PD (dolutegravir)	VOCABRIA (cabotegravir)	
NON-NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS (NNRTI)		
EDURANT (rilpivirine)	etravirine	
efavirenz	INTELENCE (etravirine)	
	nevirapine, nevirapine ER	
	PIFELTRO (doravirine)	

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
ANTIRETROVIRALS ^{DUR+} (continued)		
NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS (NRTI)		Non-Preferred Criteria 1 claim with the requested agent in the past 105 days STRIBILD – MANUAL PA SUNLENCA - Requires clinical review TYBOST – MANUAL PA
abacavir	didanosine	
EMTRIVA (emtricitabine)	emtricitabine	
lamivudine	EPIVIR (lamivudine)	
ZIAGEN (abacavir)	RETROVIR (zidovudine)	
zidovudine	stavudine	
	VIREAD (tenofovir disoproxil fumarate)	
PHARMACOENHANCER – CYTOCHROME P450 INHIBITORS		
	TYBOST (cobicistat)	
PROTEASE INHIBITORS (NON-PEPTIDIC)		
PREZISTA (darunavir)	APTIVUS (tipranavir)	
	darunavir	
	PREZCOBIX (darunavir/cobicistat)	
PROTEASE INHIBITORS (PEPTIDIC)		
atazanavir	fosamprenavir	
EVOTAZ (atazanavir/cobicistat)	LEXIVA (fosamprenavir)	
ritonavir	NORIVIR (ritonavir)	
	REYATAZ (atazanavir)	
	VIRACEPT (nelfinavir)	
SINGLE PRODUCT REGIMENS		
BIKTARVY (bictegravir/emtricitabine/tenofovir)	efavirenz/lamivudine/tenofovir	
GENVOYA (elvitegravir/cobicistat/emtricitabine/tenofovir alafenamide)	JULUCA (dolutegravir/rilpivirine)	
SYMFI (efavirenz/lamivudine/tenofovir)	rilpivirine ER	
SYMFI LO (efavirenz/lamivudine/tenofovir)	STRIBILD (elvitegravir/cobicistat/emtricitabine/tenofovir disoproxil fumarate)	
TRIUMEQ (abacavir/dolutegravir/lamivudine)	SYMTUZA (darunavir/cobicistat/emtricitabine/tenofovir alafenamide)	
TRIUMEQ PD (abacavir/dolutegravir/lamivudine)		
ANTIVIRALS, ORAL		
ANTI-CYTOMEGALOVIRUS AGENTS		Valganciclovir solution - Automatic approval issued for 0-12 years of age PREVYMIS - Requires clinical review
valganciclovir tablet	LIVTENCITY (maribavir)	
	PREVYMIS (letermovir)	
	VALCYTE (valganciclovir)	
	valganciclovir solution	
ANTI-HERPETIC AGENTS		
acyclovir	SITAVIG (acyclovir)	
famciclovir	VALTREX (valacyclovir)	
valacyclovir		

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PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
ANTIVIRALS, ORAL (continued)		
ANTI-INFLUENZA AGENTS		
oseltamivir	FLUMADINE (rimantadine)	
	RAPIVAB (peramivir)	
	RELENZA (zanamivir)	
	rimantadine	
	TAMIFLU (oseltamivir)	
	XOFLUZA (baloxavir)	
ANTIVIRALS, TOPICAL		
ZOVIRAX (acyclovir) cream	acyclovir	
	DENAVIR (penciclovir)	
	penciclovir	
	XERESE (acyclovir/hydrocortisone)	
	ZOVIRAX (acyclovir) ointment	
AROMATASE INHIBITORS		
anastrozole	ARIMIDEX (anastrozole)	
exemestane	AROMASIN (exemestane)	
letrozole	FEMARA (letrozole)	
ATOPIC DERMATITIS		
ADBRY (tralokinumab-ldrm)	CIBINQO (abrocitinib)	Minimum Age Limit • 3 months: EUCRISA • 2 years: ELIDEL, PROTOPIC 0.03% • 12 years: OPZELURA • 16 years: PROTOPIC 0.1% ADBRY – MANUAL PA CIBINQO and EBGLYSS – Require clinical review DUPIXENT • 1 claim with DUPIXENT in the past 60 days OR • New starts require clinical review (see manual PA links below) ○ Asthma – MANUAL PA ○ Atopic Dermatitis – MANUAL PA ○ Eosinophilic Esophagitis – MANUAL PA ○ Nasal Polyposis – MANUAL PA ○ Prurigo Nodularis – MANUAL PA EUCRISA • 30 days of therapy with a calcineurin inhibitor or topical steroid in the past 6 months OPZELURA • 30 days of therapy with ELIDEL, EUCRISA or PROTOPIC
ADBRY AUTOINJECTOR (tralokinumab-ldrm)	EBGLYSS PEN (lebrikizumab-lbkz) ^{NR}	
DUPIXENT (dupilumab) ^{DUR+}	OPZELURA (ruxolitinib)	
ELIDEL (pimecrolimus)	ZORYVE (roflumilast) 0.15% cream	
EUCRISA (crisaborole) ^{DUR+}		
pimecrolimus		
tacrolimus		

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BETA BLOCKERS, ANTIANGINALS & SINUS NODE AGENTS ^{DUR+}		
ANTIANGINALS		Non-Preferred Criteria • Have tried 2 different preferred agents in the past 6 months OR • 90 days of therapy with the requested agent in the past 105 days COREG CR • Documented diagnosis of hypertension AND • Have tried generic carvedilol AND 1 preferred agent in the past 6 months OR • 90 days of therapy with the requested agent in the past 105 days CORLANOR – MANUAL PA HEMANGEOL • Documented diagnosis of infantile hemangioma RANEXA • Documented diagnosis of angina AND • 1 claim for a calcium channel blocker, beta-blocker, nitrate, or combination agent in the past 30 days OR • 90 days of therapy with the requested agent in the past 105 days
	ASPRUZYO SPRINKLE (ranolazine)	
	ranolazine ER	
BETA- AND ALPHA-BLOCKERS		
carvedilol	carvedilol ER	
labetalol	COREG (carvedilol)	
	COREG CR (carvedilol)	
BETA-BLOCKER/DIURETIC COMBINATIONS		
atenolol/chlorthalidone	TENORETIC (atenolol/chlorthalidone)	
bisoprolol/hydrochlorothiazide	ZIAC (bisoprolol/hydrochlorothiazide)	
metoprolol/hydrochlorothiazide		
propranolol/hydrochlorothiazide		
BETA-BLOCKERS		
acebutolol	BETAPACE (sotalol)	
atenolol	BETAPACE AF (sotalol)	
bisoprolol	betaxolol	
HEMANGEOL (propranolol)	BYSTOLIC (nebivolol)	
metoprolol succinate	INDERAL LA (propranolol)	
metoprolol tartrate	INDERAL XL (propranolol)	
nadolol	INNOPRAN XL (propranolol)	
nebivolol	KAPSPARGO SPRINKLE (metoprolol succinate)	
pindolol	LOPRESSOR (metoprolol tartrate)	
propranolol	SOTYLIZE (sotalol)	
propranolol ER	TENORMIN (atenolol)	
SORINE (sotalol)	TOPROL XL (metoprolol succinate)	
sotalol		
sotalol AF		
timolol		
SINUS NODE AGENTS		
	CORLANOR (ivabradine)	
	ivabradine	
BILE SALTS		
ursodiol	BYLVAY (odevixibat)	
	CHENODAL (chenodiol)	
	IQIRVO (elafibranor)	
	LIVDELZI (seladelpar)	
	LIVMARLI (maralixibat)	
	OICALIVA (obeticholic acid)	
	RELTONE (ursodiol)	
	URSO FORTE (ursodiol)	

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BLADDER RELAXANT PREPARATIONS ^{DUR+}		
MYRBETRIQ (mirabegron)	darifenacin ER	Non-Preferred Criteria Have tried 2 different preferred agents in the past 6 months
oxybutynin	DETROL (tolterodine)	
oxybutynin ER	DETROL LA (tolterodine)	
solifenacin	fesoterodine	
	GEMTESA (vibegron)	
	mirabegron ER	
	tolterodine	
	tolterodine ER	
	TOVIAZ (fesoterodine)	
	trospium	
	trospium ER	
	VESICARE (solifenacin)	
	VESICARE LS (solifenacin)	
BONE RESORPTION SUPPRESSION AND RELATED AGENTS ^{DUR+}		
BISPHOSPHONATES		Non-Preferred Criteria - Documented diagnosis of osteoporosis or osteopenia AND - Have tried 2 different preferred agents in the past 6 months
alendronate tablet	ACTONEL (risedronate)	
ibandronate tablet	alendronate solution	
risedronate	ATELVIA (risedronate)	
	BINOSTO (alendronate)	
	FOSAMAX (alendronate)	
	FOSAMAX PLUS D (alendronate/vitamin D3)	
	ibandronate syringe/vial	
	risedronate DR	
OTHERS		
FORTEO (teriparatide)	calcitonin salmon	
raloxifene	EVENITY (romosozumab-aqgg)	
	EVISTA (raloxifene)	
	MIACALCIN (calcitonin salmon)	
	PROLIA (denosumab)	
	teriparatide	
	TYMLOS (abaloparatide)	
	XGEVA (denosumab)	

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BPH AGENTS ^{DUR+}			
5-ALPHA-REDUCTASE (5AR) INHIBITORS			CARDURA, FLOMAX, PROSCAR, terazosin, or UROXATRAL – Female - Documented State-accepted diagnosis Non-Preferred Criteria – Male - Have tried 2 different preferred agents in the past 6 months OR 90 days of therapy with the requested agent in the past 105 days ENTADFI - Requires clinical review
dutasteride	AVODART (dutasteride)		
finasteride	ENTADFI (finasteride/tadalafil)		
	PROSCAR (finasteride)		
ALPHA BLOCKERS			
alfuzosin ER	CARDURA (doxazosin)		
doxazosin	CARDURA XL (doxazosin)		
tamsulosin	dutasteride/tamsulosin		
terazosin	FLOMAX (tamsulosin)		
	RAPAFLO (silodosin)		
	silodosin		
PDE5 INHIBITORS			
	CIALIS (tadalafil)		
	tadalafil		
BRONCHODILATORS & COPD AGENTS			
ANTICHOLINERGIC-BETA AGONIST COMBINATIONS			Minimum Age Limit 6 years: SPIRIVA RESPIMAT SPIRIVA RESPIMAT - Automatic approval issued for diagnosis of asthma for ≥ 6 years BREZTRI AEROSPHERE – New starts require clinical review 3 claims with BREZTRI AEROSPHERE in the past 105 days
ANORO ELLIPTA (umeclidinium/vilanterol)	BEVESPI AEROSPHERE (glycopyrrolate/formoterol)		
COMBIVENT RESPIMAT (ipratropium/albuterol)	DUAKLIR PRESSAIR (aclidinium/formoterol)		
ipratropium/albuterol			
STIOLTO RESPIMAT (tiotropium/olodaterol)			
ANTICHOLINERGIC-BATA AGONIST-GLUCOCORTICOID COMBINATIONS			
	BREZTRI AEROSPHERE (budesonide/glycopyrrolate/formoterol) ^{DUR+}		
	TRELEGY ELLIPTA (fluticasone/umeclidinium/vilanterol)		
ANTICHOLINERGICS AND COPD AGENTS			
ATROVENT HFA (ipratropium)	DALIRESP (roflumilast)		
INCRUSE ELLIPTA (umeclidinium)	OHTUVAYRE (ensifentrine)		
ipratropium	roflumilast		
SPIRIVA HANDIHALER (tiotropium)	SPIRIVA RESPIMAT (tiotropium) ^{DUR+}		
	tiotropium		
	TUDORZA PRESSAIR (aclidinium)		
	YUPLERI (revefenacin)		
BRONCHODILATORS, BETA AGONISTS			
INHALATION SOLUTION ^{DUR+}			Non-Preferred Criteria 1 claim for a preferred agent in the past 6 months OR 3 claims with the requested agent in the past 105 days
albuterol	arformoterol		
	BROVANA (arformoterol)		
	formoterol		
	levalbuterol		
	PERFOROMIST (formoterol)		

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BRONCHODILATORS, BETA AGONISTS (continued)					
INHALERS, LONG ACTING ^{DUR+}				Minimum Age Limit • 4 years: SEREVENT, XOPENEX HFA • 6 years: XOPENEX Solution • 18 years: AIRSUPRA, BROVANA, PERFOROMIST, STRIVERDI RESPIMAT Quantity Limit (per 31 days) • 2 inhalers: AIRSUPRA AIRSUPRA and PROAIR DIGIHALER – Require clinical review XOPENEX HFA • 1 claim for a preferred albuterol inhaler in the past 30 days XOPENEX Solution • 1 claim for a preferred albuterol in the past 30 days	
SEREVENT DISKUS (salmeterol)					
STRIVERDI RESPIMAT (olodaterol)					
INHALERS, SHORT ACTING					
albuterol HFA		AIRSUPRA (albuterol/budesonide)			
VENTOLIN HFA (albuterol)		levalbuterol HFA			
		PROAIR DIGIHALER (albuterol)			
		XOPENEX HFA (levalbuterol)			
ORAL					
albuterol IR		albuterol ER			
terbutaline					
CALCIUM CHANNEL BLOCKERS ^{DUR+}					
LONG-ACTING				Quantity Limit (per 21 days) • 252 tablets: nimodipine • 2520 mL: nimodipine Non-Preferred Criteria – Long Acting • 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 Non-Preferred Criteria – Short Acting • Have tried 2 different preferred Short Acting CCB agents in the past 6 months OR • 90 days of therapy with the requested agent in the past 105 days Nimodipine • Documented diagnosis of subarachnoid hemorrhage in the past 45 days AND • Duration of therapy limited to 21 days	
amlodipine		CARDIZEM CD (diltiazem)			
CARTIA XT (diltiazem)		CARDIZEM LA (diltiazem)			
diltiazem ER 24 HR		diltiazem ER 12 HR			
diltiazem CD 24 HR		diltiazem LA 24 HR			
diltiazem XR 24 HR		KATERZIA (amlodipine)			
DILT-XR 24 HR (diltiazem)		levamlodipine			
felodipine		MATZIM LA (diltiazem)			
nifedipine ER		nisoldipine			
TAZTIA XT (diltiazem)		NORVASC			
verapamil ER		PROCARDIA XL			
verapamil SR		SULAR (nisoldipine)			
		TIADYLT ER (diltiazem)			
		TIAZAC (diltiazem)			
		verapamil PM			
		VERELAN PM (verapamil)			
SHORT-ACTING					
diltiazem		CARDIZEM (diltiazem)			
nicardipine		isradipine			
nifedipine		nimodipine			
verapamil		NORLIQVA (amlodipine)			
		NYMALIZE (nimodipine)			

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
CALORIC AGENTS		
BOOST (includes all Boost) BREAKFAST ESSENTIALS BRIGHT BEGINNINGS DUOCAL ENSURE NUTREN (includes all Nutren) OSMOLITE PEDIASURE PROMOD RESOURCE TWOCAL HN	**All other products (caloric/nutritional agents) not listed as preferred will require a manual prior authorization.	Non-Preferred Agents – MANUAL PA
CEPHALOSPORINS AND RELATED ANTIBIOTICS (ORAL)		
BETA LACATAM/BETA-LACTAMASE INHIBITOR COMBINATIONS		Non-Preferred Criteria – All Cephalosporin Generations - Have tried 2 different preferred agents in the past 6 months Maximum Age Limit 18 years: cefdinir suspension
amoxicillin/clavulanate	amoxicillin/clavulanate ER	
	AUGMENTIN (amoxicillin/clavulanate)	
CEPHALOSPORINS – FIRST GENERATION		
cefadroxil	cephalexin tablet	
cephalexin capsule, suspension		
CEPHALOSPORINS – SECOND GENERATION		
cefaclor capsule	cefaclor ER	
cefprozil	cefaclor suspension	
cefuroxime		
CEPHALOSPORINS – THIRD GENERATION		
cefdinir	cefixime suspension	
cefixime capsule	SUPRAX (cefixime)	
cefpodoxime		
COLONY STIMULATING FACTORS		
FULPHILA (pegfilgrastim-jmdb)	FYLNETRA (pegfilgrastim-pbbk)	
NEUPOGEN (filgrastim)	GRANIX (tbo-filgrastim)	
	LEUKINE (sargramostim)	
	NEULASTA, NEULASTA ONPRO (pegfilgrastim)	
	NIVESTYM (filgrastim-aafi)	
	NYVEPRIA (pegfilgrastim-appf)	
	RELEUKO (filgrastim-ayow)	
	ROLVEDON (eflapegrastim-xnst)	
	STIMUFEND (pegfilgrastim-fpgk)	
	UDENYCA, UDENYCA ONBODY (pegfilgrastim-cbqv)	
	ZARXIO (filgrastim-sndz)	
	ZIEXTENZO (pegfilgratim-bmez)	

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CYSTIC FIBROSIS AGENTS ^{DUR+}		
PULMOZYME (dornase alfa)	ALYFTREK (vanzacaftor/tezacaftor/deutivacaftor) ^{NR}	Minimum Age Limit • 1 month: KALYDECO granules • 3 months: PULMOZYME • 1 year: ORKAMBI • 2 years: COLY-MYCIN M, TRIKAFTA granules • 6 years: ALYFTREK, BETHKIS, KALYDECO tablet, KITABIS, SYMDEKO, TOBI, TOBI PODHALER, TRIKAFTA tablet • 7 years: CAYSTON • 18 years: BRONCHITOL Maximum Age Limit • 2 years: ORKAMBI 75-94 mg granules • 5 years: KALYDECO, ORKAMBI 100-125 mg granules, ORKAMBI 200-125 mg granules, TRIKAFTA granules • 11 years: TRIKAFTA tablets Preferred Agents • Documented diagnosis of Cystic Fibrosis OR • Require clinical review ALYFTREK and TOBI PODHALER – Require clinical review KALYDECO – MANUAL PA ORKAMBI – MANUAL PA SYMDEKO – MANUAL PA TRIKAFTA – MANUAL PA
tobramycin (generic TOBI)	BETHKIS (tobramycin)	
	BRONCHITOL (mannitol)	
	CAYSTON (aztreonam)	
	colistimethate	
	COLY-MYCIN M (colistin)	
	KALYDECO (ivacaftor)	
	KITABIS (tobramycin)	
	ORKAMBI (lumacaftor/ivacaftor)	
	SYMDEKO (tezacaftor/ivacaftor)	
	TOBI (tobramycin)	
	TOBI PODHALER (tobramycin)	
	tobramycin (generic BETHKIS & KITABIS)	
	TRIKAFTA (elexacaftor/tezacaftor/ivacaftor)	
CYTOKINE & CAM ANTAGONISTS ^{DUR+}		
ACTEMRA (tocilizumab) syringe, vial	ABRILADA (adalimuab-afzb)	Preferred Agents – Criteria details found here Non-Preferred Agents • Require clinical review IV Administered Agents • Require clinical review
AVSOLA (infliximab-axxq)	ACTEMRA ACTPEN (tocilizumab)	
ENBREL (etanercept)	adalimumab-aacf	
HUMIRA (adalimumab)	adalimumab-aaty	
KINERET (anakinra)	adalimumab-adaz	
methotrexate	adalimumab-adbm	
OLUMIANT (baricitinib)	adalimumab-fkjp	
OTEZLA (apremilast)	adalimumab-ryvk	
RINVOQ (upadacitinib)	AMJEVITA (adalimuab-atto)	
RINVOQ LQ (upadacitinib)	ARCALYST (rilonacept)	
SIMPONI (golimumab)	BIMZELX (bimekizumab-bkzx)	
TALTZ (ixekizumab)	CIMZIA (certolizumab)	
TYENNE (tocilizumab-aazg) syringe, vial	COSENTYX (secukinumab)	
XELJANZ (tofacitinib) tablet	CYLTEZO (adalimuab-adbm)	

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CYTOKINE & CAM ANTAGONISTS ^{DUR+} (continued)		
	ENTYVIO (vedolizumab)	Preferred Agents – Criteria details found here Non-Preferred Agents - Require clinical review IV Administered Agents - Require clinical review
	HADLIMA (adalimumab-bwwd)	
	HULIO (adalimumab-fkjp)	
	HYRIMOZ (adalimumab-adaz)	
	IDACIO (adalimumab-aacf)	
	ILARIS (canakinumab)	
	ILUMYA (tildrakizumab-asmn)	
	INFLECTRA (infliximab-dyyb)	
	infliximab	
	JYLAMVO (methotrexate)	
	KEVZARA (sarilumab)	
	LITFULO (rittlecitinib)	
	NEMLUVIO (nemolizumab) ^{NR}	
	OMVOH (mirikizumab-mrkz)	
	ORENCIA (abatacept)	
	OTREXUP (methotrexate)	
	RASUVO (methotrexate)	
	REMICADE (infliximab)	
	RENFLEXIS (infliximab-abda)	
	SILIQ (brodalumab)	
	SIMLANDI (adalimumab-ryvk)	
	SIMPONI ARIA (golimumab)	
	SKYRIZI (risankizumab-rzaa)	
	SOTYKTU (deucravacitinib)	
	SPEVIGO (spesolimab-sbzo)	
	STELARA (ustekinumab)	
	TOFIDENCE (tocilizumab-bavi)	
	TREMFYA (guselkumab)	
	TREXALL (methotrexate)	
	TYENNE AUTOINJECTOR (tocilizumab-aazg)	
	ustekinumab-kfce ^{NR}	
	XATMEP (methotrexate)	
	XELJANZ (tofacitinib) solution	
	XELJANZ XR (tofacitinib)	
	YUFLYMA (adalimumab-aaty)	
	YUSIMRY (adalimumab-aqvh)	
	ZYMFENTRA (infliximab-dyyb)	

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
ERYTHROPOIESIS STIMULATING PROTEINS ^{DUR+}		
EPOGEN (epoetin alfa)	ARANESP (darbepoetin alfa)	Non-Preferred Criteria • Documented diagnosis of cancer or chronic renal failure OR • Antineoplastic therapy in the past 6 months AND • Have tried a preferred RETACRIT or EPOGEN in the past 6 months OR • 1 claim for the requested agent in the past 105 days JESDUVROQ – Requires clinical review MIRCERA – Documented diagnosis of chronic renal failure in the past 2 years
MIRCERA (methoxy polyethylene glycol-epoetin-beta)	JESDUVROQ (daprodustat)	
RETACRIT (epoetin alfa-epbx)	PROCRIT (epoetin alfa)	
	VAFSEO (vadadustat)	
FACTOR DEFICIENCY PRODUCTS ^{DUR+}		
FACTOR VIII		HEMLIBRA • 3 claims with HEMLIBRA in the past 105 days OR • New starts require clinical review – MANUAL PA
ADVATE	ADYNOVATE	
AFSTYLA	ELOCTATE	
ALPHANATE	ESPEROCT	
ALTUVIIIQ	JIVI	
FEIBA	KCENTRA	
HEMOFIL M	OBIZUR	
HUMATE-P	VONVENDI	
KOATE		
KOGENATE FS		
KOVALTRY		
NOVOEIGHT		
NUWIQ		
RECOMBINATE		
WILATE		
XYNTHA, XYNTHA SOLOFUSE		
FACTOR IX		
ALPHANINE SD	BEQVEZ	
ALPROLIX	REBINYN	
BENEFIX		
IDELVION		
IXINITY		
PROFILNINE		
RIXUBIS		
OTHER HEMOPHILIA PRODUCTS		
COAGADEX (factor X)	ALHEMO (concizumab-mtcj) ^{NR}	
FIBRYGA (fibrinogen)	CORIFACT (factor XIII) ^{NR}	
HEMLIBRA (emicizumab-kxwh) ^{DUR+}	HYMPAVZI (marstacimab-hncq) ^{NR}	
RIASTAP (fibrinogen)	NOVOSEVEN RT (factor VII)	
	SEVENFACT (factor VII)	
	TRETTEN (factor XIII)	

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FIBROMYALGIA/NEUROPATHIC PAIN AGENTS		
duloxetine	CYMBALTA (duloxetine)	
gabapentin	DIRZALMA SPRINKLE (duloxetine)	
pregabalin	gabapentin ER	
SAVELLA (milnacipran)	GABARONE (gabapentin) ^{NR}	
	GRALISE (gabapentin)	
	HORIZANT (gabapentin enacarbil)	
	LYRICA, LYRICA CR (pregabalin)	
	NEURONTIN (gabapentin)	
	pregabalin ER	
FLUOROQUINOLONES ^{DUR+}		
ciprofloxacin tablet	BAXDELA (delafloxacin)	Non-Preferred Criteria • 1 claim for a preferred agent in the past 30 days CIPRO Suspension Criteria for Age < 12 Years • Anthrax infection or exposure, cystic fibrosis, pneumonic plague, or tularemia AND • History of doxycycline in the past 3 months OR • 7 days of therapy with a preferred agent from 2 of the classes below in the past 3 months: ◦ Penicillin ◦ 2nd or 3rd generation cephalosporin ◦ Macrolide LEVAQUIN Solution Criteria for Age < 12 Years • Anthrax infection or exposure AND • CIPRO suspension in the past 3 months OR • 7 days of therapy with a preferred agent from 2 of the classes below in the past 3 months: ◦ Penicillin ◦ 2nd or 3rd generation cephalosporin ◦ Macrolide
levofloxacin tablet	CIPRO (ciprofloxacin)	
	ciprofloxacin suspension	
	levofloxacin solution	
	moxifloxacin	
	ofloxacin	
GAUCHER’S DISEASE		
ELELYSO (taliglucerase alfa)	CERDELGA (eliglustat)	
ZAVESCA (miglustat)	CEREZYME (imiglucerase)	
	miglustat	
	VPRIV (velaglucerase alfa)	
	YARGESA (miglustat)	
GENITAL WARTS & ACTINIC KERATOSIS AGENTS		
CONDYLOX (podofilox)	CARAC (fluorouracil)	Minimum Age Limit • 12 years: ALDARA, ZYCLARA • 18 years: CONDYLOX, PICATO, VEREGEN
fluorouracil	EFUDEX (fluorouracil)	
imiquimod	VEREGEN (sinecatechins)	
podofilox	ZYCLARA (imiquimod)	

PREFERRED AGENTS		NON-PREFERRED AGENTS		PA CRITERIA	
GI ULCER THERAPIES					
H2 RECEPTOR ANTAGONISTS				Prilosec suspension Automatic approval issued for age 0-2 years	
famotidine		cimetidine			
		nizatidine			
		PEPCID (famotidine)			
OTHERS					
CARAFATE (sucralfate) suspension		CARAFATE (sucralfate) tablet			
misoprostol		CYTOTEC (misoprostol)			
sucralfate		DARTISLA (glycopyrrolate)			
		VOQUEZNA (vonoprazan)			
PROTON PUMP INHIBITORS					
esomeprazole capsule		DEXILANT (dexlansoprazole)			
NEXIUM (esomeprazole) packet		dexlansoprazole			
omeprazole		esomeprazole packet			
pantoprazole		KONVOMEK (omeprazole/sodium bicarbonate)			
		lansoprazole Rx			
		NEXIUM (esomeprazole) capsule			
		omeprazole/sodium bicarbonate			
		PREVACID (lansoprazole)			
		PRILOSEC (omeprazole) packet			
		PROTONIX (pantoprazole)			
		rabeprazole			
		ZEGERID (omeprazole/sodium bicarbonate)			
GLUCOCORTICOIDS (INHALED)					
GLUCOCORTICOIDS				Non-Preferred Criteria Glucocorticoids 2 preferred single-entity agents in the past 6 months OR 90 days of therapy with the requested agent in the past 105 days Glucocorticoid/Bronchodilator Combinations 2 preferred combination agents in the past 6 months OR 90 days of therapy with the requested agent in the past 105 days Note: - Institutional-sized products are non-preferred AIRDUO DIGIHALER - Requires clinical review ARMONAIR DIGIHALER - Require clinical review	
ASMANEX (mometasone)		ALVESCO (ciclesonide)			
budesonide 0.25 mg and 0.5 mg		ARMONAIR DIGIHALER (fluticasone)			
FLOVENT DISKUS (fluticasone)		ARNUIITY ELLIPTA (fluticasone)			
PULMICORT FLEXHALER (budesonide)		ASMANEX HFA (mometasone)			
QVAR REDIHALER (beclomethasone)		budesonide 1 mg			
		FLOVENT HFA (fluticasone)			
		fluticasone diskus			
		fluticasone HFA			
		PULMICORT (budesonide) nebulizer solution			
GLUCOCORTICOID/BRONCHODILATOR COMBINATIONS					
ADVAIR DISKUS (fluticasone/salmeterol)		AIRDUO DIGIHALER (fluticasone/salmeterol)			
ADVAIR HFA (fluticasone/salmeterol)		BREO ELLIPTA (fluticasone/vilanterol)			
DULERA (mometasone/formoterol)		BREYNA (budesonide/formoterol)			
fluticasone/salmeterol diskus		budesonide/formoterol			
fluticasone/salmeterol HFA		fluticasone/vilanterol			
SYMBICORT (budesonide/formoterol)		WIXELA INHUB (fluticasone/salmeterol)			

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GROWTH HORMONES ^{DUR+}					
GENOTROPIN (somatropin)		HUMATROPE (somatropin)		All Agents • Age ≥ 18 years ◦ Documented diagnosis of craniopharyngioma, panhypopituitarism, Prader-Willi Syndrome, Turner Syndrome or an approvable adult diagnosis OR ◦ Documented procedure of cranial irradiation • Age < 18 years ◦ Documented diagnosis of idiopathic short stature AND ◦ Documented approvable pediatric diagnosis OR ◦ Documented approvable pediatric diagnosis Minimum Age Limit • 3 years: NGENLA • 18 years: SKYTROFA Maximum Age Limit • 18 years: NGENLA Non-Preferred Criteria • Documented approvable diagnosis for age as above AND • Have tried 1 preferred agent in the past 6 months OR • 84 days of therapy with the requested agent in the past 105 days SKYTROFA • ≥ 18 years AND • No history of diagnosis of Prader-Willi Syndrome AND • 28 days of therapy with a preferred short-acting growth hormone in the past 105 days	
NORDITROPIN FLEXPPO (somatropin)		NGENLA (somatropin-ghla)			
SKYTROFA (lonapegsomatropin-tcgd)		OMNITROPE (somatropin)			
		SEROSTIM (somatropin)			
		SOGROYA (somapacitan-beco)			
		VOXZOGO (vosoritide)			
		ZOMACTON (somatropin)			
H. PYLORI COMBINATION TREATMENTS					
PYLERA (bismuth subcitrate potassium/metronidazole /tetracycline)		bismuth subcitrate potassium/metronidazole/tetracycline		Quantity Limit • 1 treatment course/year: all agents	
		lansoprazole/amoxicillin/clarithromycin			
		OMECLAMOX (omeprazole/clarithromycin/amoxicillin)			
		TALICIA (omeprazole/amoxicillin/rifabutin)			
		VOQUEZNA DUAL PAK (vonoprazan/amoxicillin)			
		VOQUEZNA TRIPLE PAK (vonoprazan/amoxicillin/clarithromycin)			
HEPATITIS B TREATMENTS					
entecavir		adefovir dipivoxil			
lamivudine HBV		BARACLUDE (entecavir)			
tenofovir disoproxil fumarate		VEMLIDY (tenofovir alafenamide)			
		VIREAD (tenofovir disoproxil fumarate)			

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HEPATITIS C TREATMENTS		
MAVYRET (glecaprevir/pibrentasvir) [™]	EPCLUSA (sofosbuvir/velpatasvir) [™]	∞ EPCLUSA, HARVONI, MAVYRET, SOVALDI, VOSEVI, ZEPATIER • Require MANUAL PA Note: • EPCLUSA, HARVONI, MAVYRET and SOVALDI have FDA-approved pediatric indications
PEGASYS (peginterferon alfa-2a)	HARVONI (ledipasvir/sofosbuvir) [™]	
ribavirin tablet	ledipasvir/sofosbuvir [™]	
sofosbuvir/velpatasvir	ribavirin capsule	
	SOVALDI (sofosbuvir) [™]	
	VIEKIRA PAK (ombitasvir/paritaprevir/ritonavir)	
	VOSEVI (sofosbuvir/velpatasvir/voxilaprevir) [™]	
	ZEPATIER (elbasvir/grazoprevir) [™]	
HEREDITARY ANGIOEDEMA		
BERINERT (C1 esterase inhibitor)	CINRYZE (C1 esterase inhibitor)	
icatibant	FIRAZYR (icatibant)	
	KALBITOR (ecallantide)	
	ORLADEYO (berotralstat)	
	RUCONEST (C1 esterase inhibitor)	
	SAJAZIR (icatibant)	
	TAKHZYRO (lanadelumab-flyo)	
HYPERURICEMIA & GOUT ^{DUR+}		
allopurinol	ALOPRIM (allopurinol)	Non-Preferred Criteria • Have tried 2 different preferred agents in the past 6 months
colchicine tablet	colchicine capsule	
probenecid	COLCRYS (colchicine)	
probenecid/colchicine	febuxostat	
	GLOPERBA (colchicine)	
	MITIGARE (colchicine)	
	ULORIC (febuxostat)	
	ZYLOPRIM (allopurinol)	
HYPOGLYCEMIA TREATMENT, GLUCAGON		
BAQSIMI (glucagon)	GVOKE (glucagon) ^{Step Edit}	Minimum Age Limit • 2 years: GVOKE • 4 years: BAQSIMI • 6 years: ZEGALOGUE Quantity Limit (per 31 days) • 2 packs (or kits): BAQSIMI, glucagon, GVOKE, ZEGALOGUE Non-Preferred Criteria – GVOKE • 1 claim with preferred BAQSIMI or ZEGALOGUE in the past 30 days
GLUCAGEN (glucagon)		
glucagon emergency kit		
glucagon vial		
ZEGALOGUE (dasiglucagon)		
HYPOGLYCEMICS, BIGUANIDES		
metformin	GLUMETZA (metformin)	
metformin ER (generic GLUCOPHAGE XR)	metformin ER (generic FORTAMET)	
	metformin ER (generic GLUMETZA)	
	metformin solution	
	RIOMET (metformin)	

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HYPOGLYCEMICS, DPP4s AND COMBINATIONS ^{DUR+}		
JANUMET (sitagliptin/metformin)	alogliptin	Non-Preferred Criteria - Have tried 2 different preferred DPP4 agents in the past 6 months OR 90 days of therapy with the requested agent in the past 105 days Note: - Concomitant use of a GLP-1 agent and a DPP-4 agent requires clinical review.
JANUMET XR (sitagliptin/metformin)	alogliptin/metformin	
JANUVIA (sitagliptin)	JENTADUETO XR (linagliptin/metformin)	
JENTADUETO (linagliptin/metformin)	KAZANO (alogliptin/metformin)	
TRADJENTA (linagliptin)	KOMBIGLYZE XR (saxagliptin/metformin)	
	NESINA (alogliptin)	
	ONGLYZA (saxagliptin)	
	OSENI (alogliptin/pioglitazone)	
	saxagliptin	
	saxagliptin/metformin ER	
	sitagliptin	
	sitagliptin/metformin	
	ZITUVIMET (sitagliptin/metformin)	
	ZITUVIMET XR (sitagliptin/metformin)	
	ZITUVIO (sitagliptin)	
HYPOGLYCEMICS, INCRETIN MIMETICS/ENHANCERS ^{DUR+}		
BYETTA (exenatide)	BYDUREON (exenatide)	Minimum Age Limit 10 years: BYDUREON BCISE, TRULICITY, VICTOZA 18 years: BYETTA, MOUNJARO, OZEMPIC, RYBELSUS Preferred Criteria - Documented diagnosis of Type 2 Diabetes and no history of SAXENDA or WEGOVY in the past 30 days OR - No documented diagnosis for Type 2 Diabetes and 84 days of therapy with the requested agent in the past 105 days Non-Preferred Criteria - Documented diagnosis of Type 2 Diabetes AND - No history of SAXENDA or WEGOVY in the past 30 days AND 84 days of therapy with TRULICITY in the past 6 months AND 84 days of therapy with either BYETTA or VICTOZA in the past 6 months OR 84 days of therapy with the requested agent in the past 105 days Note: - Concomitant use of a GLP-1 agonist and a DPP-4 agent requires clinical review. - Please see the PDL category Anti-obesity Select Agents for a list of covered agents.
TRULICITY (dulaglutide)	exenatide	
VICTOZA (liraglutide)	liraglutide	
	MOUNJARO (tirzepatide)	
	OZEMPIC (semaglutide)	
	RYBELSUS (semaglutide)	
	SOLIQUA (insulin glargine/lixisenatide)	
	SYMLINPEN (pramlintide)	
	XULTOPHY (insulin degludec/liraglutide)	

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HYPOGLYCEMICS, INSULINS & RELATED AGENTS ^{DUR+}					
HUMALOG MIX 75/25 (insulin lispro/lispro protamine)		ADMELOG (insulin lispro)		Non-Preferred Criteria • Documented diagnosis of Diabetes Mellitus AND • Have tried 1 preferred agent in the past 6 months OR • 1 claim with the requested agent in the past 105 days Quantity Limit • Insulin quantity limits can be found here Note: • Insulin pen formulations are not covered for Long Term Care (LTC) beneficiaries.	
HUMULIN 70/30 (insulin NPH/regular)		AFREZZA (insulin regular)			
HUMULIN N (insulin NPH)		APIDRA (insulin glulisine)			
HUMULIN R (insulin regular)		BASAGLAR (insulin glargine)			
HUMULIN R U-500 (insulin regular)		FIASP (insulin aspart/niacinamide)			
insulin aspart		HUMALOG (insulin lispro)			
insulin aspart protamine mix 70/30		HUMALOG JUNIOR, KWIKPEN, TEMPO PEN (insulin lispro)			
insulin lispro		HUMALOG MIX KWIKPEN 50/50, 75/25 (insulin lispro/lispro protamine)			
insulin lispro protamine mix 75/25		HUMULIN 70/30 (insulin NPH/regular)			
LANTUS (insulin glargine)		HUMULIN N KWIKPEN (insulin NPH)			
TOUJEO (insulin glargine)		insulin degludec			
TOUJEO MAX (insulin glargine)		insulin glargine, insulin glargine MAX SOLOSTAR			
		insulin glargine-yfgn			
		LEVEMIR (insulin detemir)			
		LYUMJEV (insulin lispro-aabc)			
		NOVOLIN 70/30 (insulin NPH/regular)			
		NOVOLIN R (insulin regular)			
		NOVOLOG (insulin aspart)			
		NOVOLOG MIX 70/30 (insulin aspart/aspart protamine)			
		REZVOGLAR (insulin glargine-aglr)			
		SEMGLEE (YFGN) (insulin glargine-yfgn)			
		TRESIBA (insulin degludec)			
HYPOGLYCEMICS, MEGLITINIDES ^{DUR+}					
nateglinide					
repaglinide					
HYPOGLYCEMICS, SODIUM GLUCOSE COTRANSPORTER-2 (SGLT-2) INHIBITORS ^{DUR+}					
SGLT-2 INHIBITORS				Non-Preferred Criteria • Have tried 2 different preferred SGLT-2 inhibitors in the past 6 months OR • 90 days of therapy with the requested agent in the past 105 days	
FARXIGA (dapagliflozin)		dapagliflozin			
JARDIANCE (empagliflozin)		INPEFA (sotagliflozin)			
		INVOKANA (canagliflozin)			
		STEGLATRO (ertugliflozin)			
SGLT-2 INHIBITOR COMBINATIONS					
GLYXAMBI (empagliflozin/linagliptin)		dapagliflozin/metformin ER			
SYNJARDY (empagliflozin/metformin)		INVOKAMET (canagliflozin/metformin)			
SYNJARDY XR (empagliflozin/metformin)		INVOKAMET XR (canagliflozin/metformin)			
TRIJARDY XR (empagliflozin/linagliptin/metformin)		QTERN (dapagliflozin/saxagliptin)			
		SEGLUROMET (ertugliflozin/metformin)			
		STEGLUJAN (ertugliflozin/sitagliptin)			
		XIGDUO XR (dapagliflozin/metformin)			

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HYPOGLYCEMICS, SULFONYLUREAS		
glimepiride		
glipizide		
glipizide ER		
glipizide XL		
glyburide		
glyburide micronized		
HYPOGLYCEMICS, THIAZOLIDINEDIONES (TZDs) and TZD Combinations		
pioglitazone	ACTOPLUS MET (pioglitazone/metformin)	
pioglitazone/metformin	ACTOS (pioglitazone)	
	DUETACT (pioglitazone/metformin)	
IDIOPATHIC PULMONARY FIBROSIS ^{DUR+}		
OFEV (nintedanib)	ESBRIET (pirfenidone)	All Agents Documented diagnosis of Idiopathic Pulmonary Fibrosis
	pirfenidone	
IMMUNE GLOBULINS		
BIVIGAM	ALYGLO	
FLEBOGAMMA	ASCENIV	
GAMASTAN	CABLIVI	
GAMMAGARD	CUTAQUIG	
GAMMAGARD S-D	CUVITRU	
GAMUNEX-C	GAMMAKED	
HIZENTRA	GAMMAPLEX	
HYQVIA	OCTAGAM	
PANZYGA		
PRIVIGEN		
XEMBIFY		
IMMUNOLOGIC THERAPIES FOR ASTHMA		
DUPIXENT (dupilumab) ^{DUR+}	CINQAIR (reslizumab)	CINQAIR, FASENRA, NUCALA, and TEZSPIRE - Require clinical review DUPIXENT 1 claim with DUPIXENT in the past 60 days OR - New starts require clinical review (see manual PA links below) Asthma – MANUAL PA Atopic Dermatitis – MANUAL PA Eosinophilic Esophagitis – MANUAL PA Nasal Polyposis – MANUAL PA Prurigo Nodularis – MANUAL PA FASENRA – MANUAL PA XOLAIR 1 claim with XOLAIR in the past 45 days OR - New starts require clinical review – MANUAL PA
FASENRA (benralizumab)	NUCALA (mepolizumab)	
XOLAIR (omalizumab)	TEZSPIRE (tezepelumab-ekko)	

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IMMUNOSUPPRESSIVE AGENTS, ORAL		
AZASAN (azathioprine)	ASTAGRAF XL (tacrolimus)	Minimum Age Limit 13 years: RAPAMUNE 18 years: ZORTRESS Maximum Age Limit 12 years: PROGRAF Granules See below for additional PA Criteria/DUR+ Rules
azathioprine	ENVARSUS XR (tacrolimus)	
CELLCEPT (mycophenolate)	MYFORTIC (mycophenolate)	
cyclosporine	PROGRAF (tacrolimus)	
everolimus	REZUROCK (belumosudil)	
mycophenolate	ZORTRESS (everolimus)	
mycophenolic acid		
NEORAL (cyclosporine)		
RAPAMUNE (sirolimus)		
SANDIMMUNE (cyclosporine)		
sirolimus		
tacrolimus		
Preferred Criteria AZASAN - Documented diagnosis of kidney transplant, RA, or a State-accepted diagnosis CELLCEPT - Documented diagnosis of heart, kidney, or liver transplant or a State-accepted diagnosis GENGRAF, NEORAL, SANDIMMUNE - Documented diagnosis of heart transplant, kidney transplant, liver transplant, psoriasis, RA, or a State-accepted diagnosis Everolimus - Documented diagnosis of kidney or liver transplant RAPAMUNE - Documented diagnosis of kidney transplant Tacrolimus - Documented diagnosis of heart, kidney, liver, or lung transplant or a State-accepted diagnosis Non-Preferred Criteria MYHIBBIN Suspension - Documented diagnosis of heart, kidney, or liver transplant or a State-accepted diagnosis AND 30 days of therapy with mycophenolate suspension in the past 105 days OR 90 days of therapy with this agent in the past 105 days ASTAGRAF XR or ENVARSUS XR - Documented diagnosis of heart, kidney, liver, or lung transplant or a State-accepted diagnosis AND 30 days of therapy with mycophenolate suspension in the past 105 days OR 90 days of therapy with Myhibbin suspension in the past 105 days PROGRAF Granules - Age ≤ 11 years AND - Documented diagnosis of heart, kidney, liver, or lung transplant or a State-accepted diagnosis MYFORTIC - Documented diagnosis of kidney transplant or psoriasis ZORTRESS - Documented diagnosis of kidney or liver transplant		

PREFERRED AGENTS		NON-PREFERRED AGENTS		PA CRITERIA		
INTRANASAL RHINITIS AGENTS						
ANTICHOLINERGICS			Non-Preferred Criteria – Corticosteroids • Documented diagnosis of allergic rhinitis AND • Have tried 1 different preferred agent in the past 6 months			
ipratropium						
ANTI-HISTAMINE/CORTICOSTEROID COMBINATIONS						
	azelastine/fluticasone					
	DYMISTA (azelastine/fluticasone)					
	RYALTRIS (olopatadine/mometasone)					
ANTI-HISTAMINES						
azelastine		olopatadine				
	PATANASE (olopatadine)					
CORTICOSTEROIDS						
fluticasone		BECONASE AQ (beclomethasone)				
	flunisolide					
	mometasone					
	NASONEX (mometasone)					
	OMNARIS (ciclesonide)					
	QNASL (beclomethasone)					
	XHANCE (fluticasone)					
	ZETONNA (ciclesonide)					
IRON CHELATING AGENTS						
deferasirox (all manufacturers except those listed as non-preferred)		deferasirox (manufacturers starting with 45963, 62332)		JADENU – MANUAL PA		
		deferiprone 1,000 mg tablet				
deferiprone 500 mg tablet		EXJADE (deferasirox)				
FERRIPROX (deferiprone)		JADENU, JADENU SPRINKLE (deferasirox)				
IRRITABLE BOWEL SYNDROME/SHORT BOWEL SYNDROME AGENTS/SELECTED AGENTS ^{DUR+}						
IRRITABLE BOWEL SYNDROME CONSTIPATION ^{DUR+}			Minimum Age Limit • 1 year: GATTEX • 6 years: LINZESS 72 mcg • 18 years: AMITIZA, IBSRELA, LINZESS 145 mcg & 290 mcg, MOTTEGRITY, MOVANTIK, MYTESI, RELISTOR, SYMPROIC, TRULANCE, VIBERZI Gender Limit • Female – AMITIZA 8 mcg See next page for additional PA Criteria/DUR+ Rules			
LINZESS (linaclotide)		AMITIZA (lubiprostone)				
lubiprostone		IBSRELA (tenapanor)				
TRULANCE (plecanatide)		MOTTEGRITY (prucalopride)				
	MOVANTIK (naloxegol)					
	prucalopride ^{NR}					
	RELISTOR (methylnaltrexone)					
	SYMPROIC (naldemedine)					
IRRITABLE BOWEL SYNDROME DIARRHEA						
dicyclomine		alosetron				
ED-SPAZ (hyoscyamine)		LOTROXEX (alosetron) ^{DUR+}				
hyoscyamine, hyoscyamine ER		VIBERZI (eluxadoline) ^{DUR+}				
HYOSYNE (hyoscyamine)						
LEVSIN, LEVSIN-SL (hyoscyamine)						
NULEV (hyoscyamine)						
OSCIMIN, OSCIMIN SL (hyoscyamine)						
SHORT BOWEL SYNDROME AND SELECTED GI AGENTS ^{DUR+}						
	GATTEX (teduglutide)					
	MYTESI (crofelemer)					

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IRRITABLE BOWEL SYNDROME/SHORT BOWEL SYNDROME AGENTS/SELECTED AGENTS^{DUR+} (continued)		
See previous page for additional PA Criteria/DUR+ Rules		
IRRITABLE BOWEL SYNDROME – CONSTIPATION^{DUR+}		
Chronic Idiopathic Constipation (CIC): Amitiza 24 mcg, LINZESS 72 mcg, LINZESS 145 mcg, MOTEGRITY, TRULANCE • Preferred CIC Agents - o Documented diagnosis of CIC in the past year AND - o No history of GI or bowel obstruction • LINZESS 72 mcg - o Age 6-17 years AND - o Documented diagnosis of CIC or pediatric functional constipation in the past year AND - o No history of GI or bowel obstruction • Non-Preferred CIC Agents - o Documented diagnosis of CIC AND - o No history of GI or bowel obstruction AND - o Have tried 2 preferred CIC agents in the past 6 months OR - o 1 claim with the requested agent in the past 105 days	Irritable Bowel Syndrome – Constipation Dominant (IBS-C): AMITIZA 8 mcg, IBSRELA, LINZESS 290 mcg, TRULANCE • Preferred IBS-C Agents - o Documented diagnosis of IBS-C in the past year AND - o No history of GI or bowel obstruction • Non-Preferred IBS-C Agents - o Documented diagnosis of IBS-C in the past year AND - o No history of GI or bowel obstruction AND - o Have tried 2 preferred IBS-C agents in the past 6 months OR - o 1 claim with the requested agent in the past 105 days	Opioid Induced Constipation (OIC): AMITIZA 24 mcg, MOVANTIK, RELISTOR, SYMPROIC • Preferred OIC Agents - o Documented diagnosis of OIC and chronic pain in the past year AND - o No history of GI or bowel obstruction AND - o 1 claim for an opioid in the past 30 days • Non-Preferred OIC Agents - o All preferred criteria met AND - o Have tried 1 preferred OIC agents in the past 6 months OR - o 1 claim with the requested agent in the past 105 days • Relistor Injection - o Above OIC criteria OR - o Documented diagnosis of OIC and active cancer in the past year AND - o No history of GI or bowel obstruction AND - o 1 claim for an opioid in the past 30 days
IRRITABLE BOWEL SYNDROME – DIARRHEA		
• VIBERZI [New starts require clinical review] - o Documented diagnosis of IBS – D in the past year and 1 claim for Viberzi in the past 105 days • LOTROXEX - o 1 claim for LOTROXEX in the past 105 days OR - o New starts require clinical review – MANUAL PA • XIFAXAN – (see Antibiotics, GI)		
SHORT BOWEL SYNDROME AND SELECTED GI AGENTS^{DUR+}		
HIV/AIDS Non-infectious Diarrhea • MYTESI - o Documented diagnosis of HIV/AIDS and non-infectious diarrhea in the past year AND - o 1 claim for an antiretroviral in the past 30 days	Short Bowel Syndrome (SBS) • GATTEX - o 1 claim for GATTEX in the past 105 days OR - o New starts require clinical review	

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LEUKOTRIENE MODIFIERS ^{DUR+}		
montelukast	ACCOLATE (zafirlukast)	Minimum Age Limit • 12 years: ZYFLO & ZYFLO CR Non-Preferred Criteria • Have tried 2 different preferred agents in the past 6 months
zafirlukast	SINGULAIR (montelukast)	
	zileuton	
	ZYFLO (zileuton)	
LIPOTROPICS, OTHER (NON-STATINS)		
ACL INHIBITORS AND COMBINATIONS		Non-Preferred Criteria • Fibric Acid Derivatives ◦ Have tried 2 different preferred Fibric Acid Derivative agents in the past 6 months • Angiopietin-Like 3 Inhibitors ◦ Have tried 2 different preferred Non-Statin Lipotropic agents in the past 6 months JUXTAPID – MANUAL PA KYNAMRO • Requires clinical review LEQVIO • Requires clinical review NEXLETOL and NEXLIZET • Require clinical review PRALUENT – MANUAL PA REPATHA – MANUAL PA 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
	NEXLETOL (bempedoic acid)	
	NEXLIZET (bempedoic acid/ezetimibe)	
ANGIOPOIETIN-LIKE 3 INHIBITORS		
	EVKEEZA (evinacumab-dgnb)	
BILE ACID SEQUESTRANTS		
cholestyramine	colesevelam	
cholestyramine light	COLESTID (colestipol)	
colestipol tablet	colestipol packet	
	PREVALITE (cholestyramine)	
	QUESTRAN (cholestyramine)	
	QUESTRAN LIGHT (cholestyramine)	
	WELCHOL (colesevelam)	
CHOLESTEROL ABSORPTION INHIBITORS		
ezetimibe	ZETIA (ezetimibe)	
FIBRIC ACID DERIVATIVES		
fenofibrate	fenofibric acid	
gemfibrozil	FENOGLIDE (fenofibrate)	
	FIBRICOR (fenofibric acid)	
	LIPOFEN (fenofibrate)	
	LOPID (gemfibrozil)	
	TRICOR (fenofibrate)	
	TRILIPIX (fenofibric acid)	
MTP INHIBITOR		
	JUXTAPID (lomitapide)	
NIACIN		
niacin ER		
OMEGA-3 FATTY ACIDS		
omega-3 acid ethyl esters	icosapent	
	LOVAZA (omega-3 acid ethyl esters)	
PCSK-9 INHIBITORS		
REPATHA (evolocumab)	LEQVIO (inclisiran)	
	PRALUENT (alirocumab)	

PREFERRED AGENTS		NON-PREFERRED AGENTS		PA CRITERIA	
LIPOTROPICS, STATINS ^{DUR+}					
STATINS				Minimum Age Limit • 10 years: ATORVALIQ suspension Non-Preferred Criteria • Have tried 2 different preferred statin or statin combination agents in the past 6 months OR • 90 days of therapy with the requested agent in the past 105 days Simvastatin • Daily doses ≥ 80 mg require clinical review	
atorvastatin	ALTOPREV (lovastatin)				
lovastatin	ATORVALIQ (atorvastatin)				
pravastatin	CRESTOR (rosuvastatin)				
rosuvastatin	EZALLOR SPRINKLE (rosuvastatin)				
simvastatin	FLOLIPID (simvastatin)				
	fluvastatin				
	fluvastatin ER				
	LESCOL XL (fluvastatin)				
	LIPITOR (atorvastatin)				
	LIVALO (pitavastatin)				
	pitavastatin				
	ZOCOR (simvastatin)				
	ZYPITAMAG (pitavastatin)				
STATIN COMBINATIONS					
ezetimibe/simvastatin	amlodipine/atorvastatin				
	CADUET (amlodipine/atorvastatin)				
	VYTORIN (ezetimibe/simvastatin)				
MISCELLANEOUS BRAND/GENERIC					
ALLERGEN EXTRACT IMMUNOTHERAPY				CUMULATIVE quantity limit (per 31 days) • 31 tablets: alprazolam ER Quantity Limit (per 31 days) • 2 kits: epinephrine EVRYSDI – MANUAL PA PALFORZIA – MANUAL PA	
	GRASTEK				
	ORALAIR				
	PALFORZIA				
	RAGWITEK				
EPINEPHRINE					
epinephrine (Mylan)	AUVI-Q (epinephrine)				
	epinephrine (all other manufacturers)				
	EPIPEN (epinephrine)				
	EPIPEN JR (epinephrine)				
	NEFFY (epinephrine) ^{NR}				
MISCELLANEOUS					
alprazolam	alprazolam ER				
hydroxyzine HCL	CAMZYOS (mavacamten)				
hydroxyzine pamoate	CRENESSITY (crinecerfont) ^{NR}				
megestrol	EVRYSDI (risdiplam)				
REVLIMID (lenalidomide)	KORLYM (mifepristone)				
	lenalidomide				
	VERQUVO (vericiguat)				
	VISTARIL (hydroxyzine pamoate)				
	XANAX, XANAX XR (alprazolam)				

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MISCELLANEOUS BRAND/GENERIC (continued)		
SUBLINGUAL NITROGLYCERIN		
nitroglycerin		
NITROLINGUAL (nitroglycerin)		
NITROSTAT (nitroglycerin)		
MOVEMENT DISORDER AGENTS ^{DUR+}		
AUSTEDO (deutetrabenazine)	INGREZZA INITIATION PACK (valbenazine)	AUSTEDO and AUSTEDO XR - Documented diagnosis of Huntington's chorea OR - Documented diagnosis of tardive dyskinesia AND 90 days of therapy with either agent in the past 105 days OR - New starts require clinical review – MANUAL PA INGREZZA - Documented diagnosis of Huntington's chorea OR - Documented diagnosis of tardive dyskinesia AND 90 days of therapy with this agent in the past 105 days OR - New starts require clinical review – MANUAL PA
AUSTEOD XR (deutetrabenazine)	XENAZINE (tetrabenazine)	
INGREZZA (valbenazine)		
INGREZZA SPRINKLE (valbenazine)		
tetrabenazine		
MULTIPLE SCLEROSIS AGENTS ^{DUR+}		
BETASERON (interferon beta-1b)	AMPYRA (dalfampridine)	Preferred Agents - Documented diagnosis of multiple sclerosis Non-Preferred Criteria - Documented diagnosis of multiple sclerosis AND - Have tried 2 different preferred agents in the past 6 months OR 3 claims with the requested agent in the last 105 days KESIMPTA, PONVORY, TASCENSO ODT, and ZEPOSIA - Require clinical review MAVENCLAD – MANUAL PA MAYZENT – MANUAL PA OCREVUS and OCREVUS ZUNOVO – MANUAL PA
COPAXONE (glatiramer) 20 mg	AUBAGIO (teriflunomide)	
dalfampridine ER	AVONEX (interferon beta-1a)	
dimethyl fumarate	BAFIERTAM (monomethyl fumarate)	
fingolimod	BRIUMVI (ublituximab-xiiy)	
REBIF (interferon beta-1b)	COPAXONE (glatiramer) 40 mg	
REBIF REBIDOSE (interferon beta-1b)	GILENYA (fingolimod)	
teriflunomide	glatiramer	
TYSABRI (natalizumab)	GLATOPA (glatiramer)	
	KESIMPTA PEN (ofatumumab)	
	MAVENCLAD (cladribine)	
	MAYZENT (siponimod)	
	OCREVUS (ocrelizumab)	
	OCREVUS ZUNOVO (ocrelizumab-hyaluronidase)	
	PLEGRIDY (peginterferon beta-1a)	
	PONVORY (ponesimod)	
	TASCENSO ODT (fingolimod)	
	TECFIDERA (dimethyl fumarate)	
	VUMERITY (diroximel fumarate)	
	ZEPOSIA (ozanimod)	

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MUSCULAR DYSTROPHY AGENTS			
EMFLAZA (deflazacort)	AGAMREE (vamorolone)	ELEVIDYS – MANUAL PA EMFLAZA – MANUAL PA EXONDYS – MANUAL PA VILTEPSO – MANUAL PA VYONDYS – MANUAL PA	
	AMONDYS-45 (casimersen)		
	deflazacort		
	DUVYZAT (givinostat)		
	ELEVIDYS (delandistrogene moxeparvovec-rokl)		
	EXONDYS-51 (eteplirsen)		
	VILTEPSO (viltolarsen)		
	VYONDYS-53 (golodirsen)		
NSAIDS			
COX II SELECTIVE		Quantity Limit (per 31 days) • 20 tablets: ketorolac tablets ELYXYB • Requires clinical review	
meloxicam	CELEBREX (celecoxib)		
	celecoxib		
	ELYXYB (celecoxib)		
NON-SELECTIVE		Non-Preferred Criteria • Non-Selective & Combinations ○ Have tried 2 different preferred non-selective or NSAID/GI protectant combination agents in the past 6 months • COX II Selective ○ 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 Agent 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	
diclofenac sodium	DAYPRO (oxaprozin)		
diclofenac sodium ER	diclofenac potassium		
EC-naproxen DR 500 mg tablet	DOLOBID (diflunisal)		
etodolac tablet	etodolac capsule, etodolac ER		
flurbiprofen	FELDENE (piroxicam)		
ibuprofen	fenoprofen		
indomethacin capsule	indomethacin suppository, indomethacin ER		
ketoprofen	ketoprofen		
ketorolac	kiprofen		
nabumetone	LOFENA (diclofenac potassium)		
naproxen	meclofenamate		
piroxicam	mefenamic acid		
sulindac	NALFON (fenoprofen)		
	NAPRELAN (naproxen)		
	NAPROSYN (naproxen)		
	naproxen, naproxen CR, naproxen ER		
	oxaprozin		
	RELAFEN DS (nabumetone)		
	TOLECTIN 600 (tolmetin)		
	tolmetin		
NSAID/GI PROTECTANT COMBINATIONS			
	ARTHROTEC 50, 75 (diclofenac/misoprostol)		
	diclofenac/misoprostol		
	ibuprofen/famotidine		
	naproxen/esomeprazole		
	VIMOVO (naproxen/esomeprazole)		

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OPHTHALMIC, ANTIBIOTICS		
ANTIBIOTICS		
bacitracin/polymyxin	AZASITE (azithromycin)	
ciprofloxacin	bacitracin	
erythromycin	BESIVANCE (besifloxacin)	
gentamicin	CILOXAN (ciprofloxacin)	
moxifloxacin	gatifloxacin	
ofloxacin	NATACYN (natamycin0	
polymyxin B/trimethoprim	neomycin/bacitracin/polymyxin	
tobramycin	OCUFLOX (ofloxacin)	
	sulfacetamide	
	TOBREX (tobramycin)	
	VIGAMOX (moxifloxacin)	
ANTIBIOTIC STEROID COMBINATIONS		
BLEPHAMIDE S.O.P. (sulfacetamide/prednisolone)	MAXITROL (neomycin/polymyxin/dexamethasone)	
neomycin/bacitracin/polymyxin/hydrocortisone	neomycin/polymyxin/gramicidin	
neomycin/polymyxin/dexamethasone	TOBRADEX ST (tobramycin/dexamethasone)	
PRED-G (gentamicin/prednisolone)		
sulfacetamide/prednisolone		
TOBRADEX (tobramycin/dexamethasone)		
tobramycin/dexamethasone		
ZYLET (tobramycin/loteprednol)		
OPHTHALMIC, ANTI-INFLAMMATORIES		
dexamethasone	ACULAR (ketorolac)	Non-Preferred Criteria Have tried 2 different preferred agents in the past 6 months
diclofenac sodium	ACULAR LS (ketorolac)	
difluprednate	ACUVAIL (ketorolac)	
FLAREX (fluorometholone)	bromfenac	
fluorometholone	bromsite (bromfenac)	
flurbiprofen	DUREZOL (difluprednate)	
FML FORTE (fluorometholone)	FML (fluorometholone)	
ketorolac	ILEVRO (nepafenac)	
MAXIDEX (dexamethasone)	INVELTYS (loteprednol)	
PRED MILD (prednisolone)	LOTEMAX (loteprednol)	
prednisolone acetate	LOTAMAX SM (loteprednol)	
prednisolone sodium phosphate	loteprednol	
	NEVANAC (nepafenac)	
	PRED FORTE (prednisolone)	
	PROLENSA (bromfenac)	

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OPHTHALMIC, DRY EYE AGENTS			
RESTASIS DROPERETTE (cyclosporine)	CEQUA (cyclosporine)	Minimum Age Limit 16 years: RESTASIS 17 years: XIIDRA 18 years: CEQUA, MIEBO, VEVYE Quantity Limit per 31 days) 2 mL: VEVYE 3 mL: MIEBO 5.5 mL: RESTASIS Multidose 60 units: CEQUA, RESTASIS Droperette, XIIDRA EYSUVIS, MIEBO, RESTASIS MULTIDOSE, TYRVAYA, and VEVYE - Require clinical review Non-preferred CEQUA 4 claims for RESTASIS Droperette and XIIDRA in the past 6 months	
XIIDRA (lifitegrast)	cyclosporine		
	EYSUVIS (loteprednol)		
	MIEBO (perfluorohexyloactane)		
	RESTASIS MULTIDOSE (cyclosporine)		
	TYRVAYA (varenicline)		
	VEVYE (cyclosporine)		
OPHTHALMIC, GLAUCOMA AGENTS			
BETA BLOCKERS		Minimum Age Limit 18 years: LYUZEH Non-Preferred Criteria - Have tried 2 different preferred agents in the past 6 months OR 90 days of therapy with the requested agent in the past 105 days	
BETIMOL (timolol)	betaxolol		
carteolol	BETOPTIC S (betaxolol)		
ISTALOL (timolol)	timolol droperette, daily drop, gel		
levobunolol	TIMOPTIC (timolol)		
timolol drops 0.25%, 0.5%	TIMOPTIC OCUDOSE (timolol)		
	TIMOPTIC-XE (timolol)		
CARBONIC ANHYDRASE INHIBITORS			
dorzolamide	AZOPT (brinzolamide)		
	brinzolamide)		
COMBINATION AGENTS			
COMBIGAN (brimonidine/timolol)	brimonidine/timolol		
dorzolamide/timolol	COSOPT (dorzolamide/timolol)		
SIMBRINZA (brinzolamide/brimonidine)	COSOPT (dorzolamide/timolol)		
	dorzolamide/timolol PF		
PARASYMPATHOMIMETICS			
pilocarpine	PHOSPHOLINE IODIDE (echothiophate iodide)		

PREFERRED AGENTS		NON-PREFERRED AGENTS		PA CRITERIA	
OPHTHALMIC, GLAUCOMA AGENTS (continued)					
PROSTAGLANDIN ANALOGS				Minimum Age Limit 18 years: LYUZEH Non-Preferred Criteria - Have tried 2 different preferred agents in the past 6 months OR 90 days of therapy with the requested agent in the past 105 days	
latanoprost		bimatoprost			
		IYUZEH (latanoprost)			
		LUMIGAN (bimatoprost)			
		tafluprost			
		TRAVATAN Z (travoprost)			
		travoprost			
		VYZULTA (latanoprost)			
		XALATAN (latanoprost)			
		XELPROS (latanoprost)			
		ZIOPTAN (tafluprost)			
RHO KINASE INHIBITORS/COMBINATIONS					
RHOPRESSA (netarsudil)					
ROCKLATAN (netarsudil/latanoprost)					
SYMPATHOMIMETICS					
ALPHAGAN P (brimonidine)		brimonidine 0.1%, 0.15%			
brimonidine 0.2%					
OPHTHALMICS FOR ALLERGIC CONJUNCTIVITIS					
ALREX (loteprednol)		ALOCRIL (nedocromil)		Non-Preferred Criteria - Have tried 2 different preferred agents in the past 6 months VERKAZIA - Requires clinical review	
azelastine		ALOMIDE (lodoxamide)			
cromolyn		bepotastine			
ketotifen ^{OTC}		BEPREVE (bepotastine)			
olopatadine		epinastine			
ZADITOR (ketotifen)		LASTACRAFT (alcaftadine)			
		VERKAZIA (cyclosporine)			
		ZERVIAE (cetirizine)			
OPIATE DEPENDENCE TREATMENTS					
DEPENDENCE				Buprenorphine/naloxone provider summary found here	
buprenorphine/naloxone SL tablet		BRIXADI (buprenorphine)		PROBUPHINE – MANUAL PA	
naltrexone		buprenorphine		SUBLOCADE – MANUAL PA	
SUBOXONE (buprenorphine/naloxone)		buprenorphine/naloxone film		VIVITROL – MANUAL PA	
		lofexidine			
		LUCEMYRA (lofexidine)			
		SUBLOCADE (buprenorphine)			
		VIVITROL (naltrexone)			
		ZUBSOLV (buprenorphine/naloxone)			

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OPIATE DEPENDENCE TREATMENTS (continued)					
TREATMENT			Buprenorphine/naloxone provider summary found here		
KLOXXADO (naloxone)		LIFEMS NALOXONE (naloxone)		PROBUPHINE – MANUAL PA SUBLOCADE – MANUAL PA VIVITROL – MANUAL PA	
naloxone					
NARCAN (naloxone)					
OPVEE (nalmefene)					
REXTOVY (naloxone)					
ZIMHI (naloxone)					
OTIC ANTIBIOTICS					
CIPRO HC (ciprofloxacin/hydrocortisone)		ciprofloxacin		Maximum Age Limit 9 years: CIPRO HC Ciprofloxacin/Dexamethasone Suspension Criteria - Age ≥ 6 months AND - Experiencing otorrhea secondary to recent, post-tympanostomy tube placement AND - Continued otorrhea after 10 days of treatment with: EITHER - Ofloxacin or ciprofloxacin ophthalmic solution OR - Ciprofloxacin ophthalmic solution and MAXIDEX (dexamethasone) ophthalmic suspension	
CORTISPORIN-TC (neomycin/colistin/hydrocortisone)		ciprofloxacin/fluocinolone			
fluocinolone		ciprofloxacin/dexamethasone			
neomycin/polymyxin/hydrocortisone		DERMOTIC (fluocinolone)			
		FLAC OTIC OIL (fluocinolone)			
		hydrocortisone/acetic acid			
		OTOVEL (ciprofloxacin/fluocinolone)			
PANCREATIC ENZYMES					
CREON (lipase/protease/amylase)		PERTZYE (lipase/protease/amylase)		Non-Preferred Criteria Have tried 2 different preferred agents in the past 6 months	
ZENPEP (lipase/protease/amylase)		VIOKACE (lipase/protease/amylase)			
PARATHYROID AGENTS					
calcitriol		doxercalciferol			
cinacalcet		RAYALDEE (calcifediol)			
ergocalciferol		ROCALTROL (calcitriol)			
paricalcitol		SENSIPAR (cinacalcet)			
ZEMPLAR (paricalcitol)		YORVIPATH (palopegteriparatide)			
PHOSPHATE BINDERS					
calcium acetate		AURYXIA (ferric citrate)			
CALPHRON (calcium acetate)		FOSRENOL (lanthanum)			
sevelamer carbonate tablet		lanthanum			
		MAGNEBIND (calcium carbonate/magnesium)			
		REVELA (sevelamer)			
		sevelamer carbonate packet			
		sevelamer HCl			
		VELPHORO (sucroferric oxyhydroxide)			
		XPHOZAH (tenapanor)			

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PLATELET AGGREGATION INHIBITORS		
aspirin/dipyridamole	EFFIENT (prasugrel)	Non-Preferred Criteria • Documented diagnosis AND • Have tried 2 different preferred agents in the past 6 months OR • 90 days of therapy with the requested agent in the past 105 days ZONTIVITY – MANUAL PA
BRILINTA (ticagrelor)	PLAVIX (clopidogrel)	
cilostazol		
clopidogrel		
dipyridamole		
pentoxifylline		
prasugrel		
PLATELET STIMULATING AGENTS		
NPLATE (romiplostim)	ALVAIZ (eltrombopag)	
PROMACTA (eltrombopag) tablet	DOPTelet (avatrombopag)	
	MULPLETA (lusutrombopag)	
	PROMACTA (eltrombopag) packet	
	TAVALLISSE (fostamatinib)	
POTASSIUM REMOVING AGENTS		
LOKELMA (sodium zirconium cyclosilicate)	KIONEX (sodium polystyrene sulfonate)	
SPS (sodium polystyrene sulfonate) suspension	sodium polystyrene sulfonate	
	SPS (sodium polystyrene sulfonate) enema	
	VELTASSA (patiomer calcium sorbitex)	
PRENATAL VITAMINS		
CLASSIC PRENATAL	**Products not listed are assumed to be non-preferred**	List of Preferred NDC's for Prenatal Vitamins can be found here
COMPLETE NATAL DHA		
COMPLETENATE		
M-NATAL PLUS		
NIVA-PLUS		
PRENATAL PLUS VITAMIN-MINERAL		
PNV 72, 95, 124, and 137 / IRON / FOLIC ACID		
SE-NATAL-19		
STUART ONE		
THRIVITE RX		
TRICARE		
TRINATAL RX 1		
WESNATAL DHA COMPLETE		
WESTAB PLUS		
PSEUDOBULBAR AFFECT AGENTS		
	NUEDEXTA (dextromethorphan/quinidine)	Non-Preferred Criteria • Documented diagnosis of pseudobulbar affect disorder OR • 90 days of therapy with NUEDEXTA in the past 105 days



PREFERRED AGENTS		NON-PREFERRED AGENTS		PA CRITERIA	
PULMONARY ANTIHYPERTENSIVE AGENTS					
ACTIVIN SIGNALING INHIBITORS				Minimum Age Limit 18 years: ADEMPAS, OPSYNVI, TADLIQ	
	WINREVAIR (sotatercept-csrk)				
COMBINATION AGENTS				Maximum Age Limit 12 years: REVATIO suspension	
	OPSYNVI (macitentan/tadalafil)				
ENDOTHELIN RECEPTOR ANTAGONISTS				Preferred Criteria – PAH Agents Documented diagnosis of pulmonary hypertension	
ambrisentan		OPSUMIT (macitentan)			
bosentan		TRACLEER (bosentan)			
LETAIRIS (ambrisentan)		TRYVIO (aprocitentan)			
PDE5's				Sildenafil tablets < 1 year of age and documented diagnosis of pulmonary hypertension, patent ductus arteriosus, or persistent fetal circulation OR ≥ 1 year of age and documented diagnosis of Pulmonary Hypertension OR 90 days of therapy with the requested agent in the past 105 days	
sildenafil (generic REVATIO) tablet		ADCIRCA (tadalafil)			
tadalafil		ALYQ (tadalafil)			
		LIQREV (sildenafil)			
		REVATIO (sildenafil)			
		sildenafil (generic REVATIO) suspension		Non-Preferred Criteria - Documented diagnosis of pulmonary hypertension AND - Have tried 1 preferred PAH agent in the past 6 months OR 90 days of therapy with the requested agent in the past 105 days	
		TADLIQ (tadalafil)			
PROSTACYCLINS					
		ORENITRAM ER (treprostinil)			
		ORENITRAM TITRATION PAK (treprostinil)			
		TYVASO (treprostinil)		ADEMPAS - Documented diagnosis of persistent/recurrent chronic thromboembolic pulmonary hypertension (WHO Group 4) or pulmonary arterial hypertension (WHO Group 1) OR - Have tried 1 preferred PAH agent in the past 6 months OR 90 days of therapy with ADEMPAS in the past 105 days	
		VENTAVIS (iloprost)			
SELECTIVE PROSTACYCLINE RECEPTOR AGONISTS					
		UPTRAVI (selexipag)			
SOLUABLE GUANYLATE CYCLASE STIMULATORS					
		ADEMPAS (riociguat)		LIQREV, OPSUMIT, OPSYNVI, ORENITRAM ER, TYVASO, and VENTAVIS Require clinical review	
				REVATIO suspension ≤ 12 years of age and documented diagnosis of pulmonary hypertension, patent ductus arteriosus, persistent fetal circulation, or history of a heart transplant OR 90 days stable therapy with this agent in the past 105 days	
				TADLIQ - Documented diagnosis of pulmonary hypertension AND - Have tried preferred generic suspension in the past 6 months OR 90 days of therapy with TADLIQ in the past 105 days	
				UPTRAVI - Documented diagnosis of pulmonary hypertension AND - Have tried 1 preferred endothelin receptor antagonist AND 1 preferred PDE5 inhibitor in the past 6 months OR 90 days of therapy with UPTRAVI in the past 105 days	

[illegible]

PREFERRED AGENTS		NON-PREFERRED AGENTS		PA CRITERIA	
SEDATIVE HYPNOTIC AGENTS					
BENZODIAZEPINES ^{DUR+}			MS DOM Opioid Initiative – Criteria details found here • Concomitant use of Opioids and Benzodiazepines Maximum Age Limit • 64 years: zolpidem 7.5 mg, 10 mg, and 12.5 mg Gender and Dose Limit • Female: AMBIEN 5 mg, AMBIEN CR 6.25 mg, INTERMEZZO 1.75 mg • Male: all strengths of zolpidem Non-Preferred Criteria • Have tried 2 different preferred agents in the past 6 months HETLIOZ capsules • Documented diagnosis of circadian rhythm sleep disorder AND • Documented diagnosis indicating total blindness OR • Documented diagnosis of Smith-Magenis syndrome HETLIOZ liquid • Age 3-15 years AND • Documented diagnosis of Smith-Magenis syndrome Note: • Single-source benzodiazepines and barbiturates are NOT covered. ◦ PA's will NOT be issued for these drugs. See below for additional PA Criteria/DUR+ Rules		
estazolam		flurazepam			
temazepam 15 mg, 30 mg capsule		HALCION (triazolam)			
		quazepam			
		RESTORIL (temazepam)			
		temazepam 7.5 mg, 22.5 mg capsule			
		triazolam			
OTHERS ^{DUR+}					
eszopiclone		AMBIEN (zolpidem)			
ramelteon		AMBIEN CR (zolpidem)			
zaleplon		BELSOMRA (suvorexant)			
zolpidem tablet		DAYVIGO (lemborexant)			
		doxepin			
		EDULAR (zolpidem)			
		HETLIOZ LQ (tasimelteon)			
		LUNESTA (eszopiclone)			
		QUVIVIQ (daridorexant)			
		ROZEREM (ramelteon)			
		tasimelteon			
		zolpidem capsule			
		zolpidem sublingual tablet			
		zolpidem ER			
CUMULATIVE Quantity Limit – Benzodiazepines • 31 units/31 days: Quantity limit per rolling days for all strengths. DUR+ will allow an early refill override for one dose or therapy change per year. CUMULATIVE Quantity Limit – Triazolam • 10 units/31 days: Quantity limit per rolling days for all strengths. • 60 units/365 days: Quantity limit per rolling days for all strengths. CUMULATIVE Quantity Limit – Non-Benzodiazepines • 31 units/31 days: Quantity limit per rolling days for all strengths. DUR+ will allow an early refill override for one dose or therapy change per year. CUMULATIVE Quantity Limit – HETLIOZ LQ • 1 bottle (48 mL or 158 mL): Quantity limit per rolling days for all strengths. DUR+ will allow an early refill override for one dose or therapy change per year. CUMULATIVE Quantity Limit – ZOLPIMIST • 1 canister/31 days: male; Quantity limit per rolling days for all strengths. DUR+ will allow an early refill override for one dose or therapy change per year. • 1 canister/62 days: female; Quantity limit per rolling days for all strengths. DUR+ will allow an early refill override for one dose or therapy change per year.					

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SELECT CONTRACEPTIVE PRODUCTS					
INJECTABLE CONTRACEPTIVES			Non-Preferred Criteria 1 claim with the requested agent in the past 105 days		
medroxyprogesterone		DEPO-PROVERA (medroxyprogesterone)			
INTRAVAGINAL CONTRACEPTIVES					
ENILLORING (etonogestrel/ethinyl estradiol)		PHEXXI (lactic acid/citric acid/potassium bitartrate)			
ORAL ^{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)			
		BEYAZ (drosprienone/ethinyl estradiol/levomefolate)			
		CAMRESE (levonorgestrel/ethinyl estradiol)			
		CAMRESE LO ((levonorgestrel/ethinyl estradiol))			
		JOLESSA ((levonorgestrel/ethinyl estradiol))			
		LO LOESTRIN FE (norethindrone/ethinyl estradiol/iron)			
		LOESTRIN (norethindrone/ethinyl estradiol)			
		LOESTRIN FE (norethindrone/ethinyl estradiol/iron)			
		MINZOYA (levonorgestrel/ethinyl estradiol/iron)			
		NATAZIA (estradiol valerate/dienogest)			
		NEXTSTELLIS (drospirenone/estetrol)			
		OCELLA (ethinyl estradiol/drospirenone)			
		SAFYRAL (drospirenone/ethinyl estradiol/levomefolate)			
		SIMPESSE (levonorgestrel/ethinyl estradiol)			
		TAYTULLA (norethindrone/ethinyl estradiol/iron)			
		TYDEMY (drospirenone/ethinyl estradiol/levomefolate)			
		YASMIN (ethinyl estradiol/drospirenone)			
		YAZ (ethinyl estradiol/drospirenone)			
TRANSDERMAL CONTRACEPTIVES					
XULANE (norelgestromin/ethinyl estradiol)		norelgestromin/ethinyl estradiol			
		TWIRLA (levonorgestrel/ethinyl estradiol)			
		ZAFEMY (norelgestromin/ethinyl estradiol)			
SICKLE CELL AGENTS					
DROXIA (hydroxyurea)		ADAKVEO (crizanlizumab-tmca)		ENDARI – MANUAL PA	
hydroxyurea		CASGEVY (exagamglogene autotemcel)			
		ENDARI (glutamine)			
		HYDREA (hydroxyurea)			
		l-glutamine			
		LYFGENIA (lovotibeglogene autotemcel)			
		SIKLOS (hydroxyurea)			

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SKELETAL MUSCLE RELAXANTS		
DUR+		
baclofen 5 mg, 10 mg, 20 mg tablet	AMRIX (cyclobenzaprine)	Non-Preferred Criteria - Documented diagnosis of an approvable indication AND - Have tried 2 different preferred agents in the past 6 months Baclofen granules, solution, and suspension - Require clinical review Carisoprodol - Documented diagnosis of acute musculoskeletal condition AND - No history with meprobamate in the past 90 days AND 1 claim for cyclobenzaprine in the past 21 Carisoprodol with codeine - Requires clinical review Tanlor - Requires Clinical Review Quantity Limit 84 tablets/180 days: carisoprodol
chlorzoxazone	baclofen 15 mg tablet	
cyclobenzaprine 5 mg, 10 mg tablet	baclofen suspension	
methocarbamol	carisoprodol	
tizanidine tablet	carisoprodol/aspirin	
	cyclobenzaprine 7.5 mg tablet	
	cyclobenzaprine ER	
	DANTRIUM (dantrolene)	
	dantrolene	
	FEXMID (cyclobenzaprine)	
	FLEQSUVY (baclofen)	
	LORZONE (chlorzoxazone)	
	LYVISPAH (baclofen)	
	metaxalone	
	NORGESIC (orphenadrine/aspirin/cafeine)	
	NORGESIC FORTE (orphenadrine/aspirin/cafeine)	
	orphenadrine	
	orphenadrine/aspirin/cafeine	
	ORPHENGESIC FORTE (orphenadrine/aspirin/cafeine)	
	SOMA (carisoprodol)	
	TANLOR (methocarbamol)	
	tizanidine capsule	
	ZANAFLEX (tizanidine)	
SMOKING DETERRENTS		
NICOTINE TYPE		Minimum Age Limit 18 years: CHANTIX Quantity Limit 336 tablets/year: CHANTIX 0.5 mg tabs, 1 mg tabs, and continuing pack 2 treatment courses/year: CHANTIX Starter Pack
nicotine gum ^{OTC}	NICOTROL INHALER CARTRIDGE	
nicotine lozenge ^{OTC}	NICOTROL NASAL SPRAY	
nicotine patch ^{OTC}		
NON-NICOTINE TYPE		
bupropion SR		
CHANTIX (varenicline)		
varenicline		

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
STEROIDS (TOPICAL)		
LOW POTENCY		Non-Preferred Criteria – Low Potency - Have tried 2 different preferred low potency agents in the past 6 months Non-Preferred Criteria – Medium Potency - Have tried 2 different preferred medium potency agents in the past 6 months Non-Preferred Criteria – High Potency - Have tried 2 different preferred high potency agents in the past 6 months Non-Preferred Criteria – Very High Potency - Have tried 2 different preferred very high potency agents in the past 6 months
alclometasone	fluocinolone	
DERMA-SMOOTH-FS (fluocinolone)	hydrocortisone lotion	
desonide	HYDROXYM (hydrocortisone)	
hydrocortisone cream, ointment, solution	PROCTOCORT (hydrocortisone)	
MEDIUM POTENCY		
fluticasone	BESER (fluticasone)	
mometasone	CAPEX (fluocinolone)	
PANDEL (hydrocortisone probutate)	clocortolone	
prednicarbate cream	CLODERM (clocortolone)	
	flurandrenolide	
	fluticasone lotion	
	LOCOID (hydrocortisone butyrate)	
	prednicarbate ointment	
	SYNALAR (fluocinolone)	
HIGH POTENCY		
betamethasone dipropionate cream, lotion	amcinonide	
betamethasone dipropionate augmented	betamethasone dipropionate ointment	
betamethasone valerate	desoximetasone	
fluocinolone	diflorasone	
fluocinonide	halcinonide	
fluocinonide-E	HALOG (halcinonide)	
triamcinolone cream, ointment, lotion	KENALOG (triamcinolone)	
	TOPICORT (desoximetasone)	
	triamcinolone spray	
	VANOS (fluocinonide)	
VERY HIGH POTENCY		
clobetasol cream, foam, gel, ointment, shampoo, solution	APEXICON E (diflorasone)	
	BRYHALI (halobetasol)	
clobetasol-E	clobetasol emulsion	
halobetasol	CLOBEX (clobetasol)	
	CLODAN (clobetasol)	
	DIPROLENE (betamethasone)	
	halobetasol	
	IMPEKLO (clobetasol)	
	LEXETTE (halobetasol)	
	OLUX (clobetasol)	
	TEMOVATE (clobetasol)	
	TOVET (clobetasol)	
	ULTRAVATE (halobetasol)	

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STIMULANTS AND RELATED AGENTS		DUR+	
SHORT-ACTING		Minimum Age Limit • 3 years: ADDERALL, EVEKEO, PROCENTRA, ZENZEDI • 6 years: ADDERALL XR, ADHANSIA XR, ADZENYS ER SUSPENSION, ADZENYS XR ODT, APTENSIO XR, atomoxetine, AZSTARYS, clonidine ER, CONCERTA ER, COTEMPLA XR ODT, DAYTRANA, DESOXYN, DEXEDRINE, DYANAVEL XR, EVEKEO ODT, FOCALIN, FOCALIN XR, JORNAY PM, METADATE CD, METHYLIN, ONYDA XR, QUELBREE, QUILLICHEW, QUILLIVANT XR, RELEXII ER, RITALIN LA, VYVANSE, XELSTRYM • 7 years: XYREM • 13 years: MYDAYIS • 16 years: modafinil • 18 years: armodafinil, SUNOSI, WAKIX	
dexmethylphenidate	ADDERALL (dextroamphetamine/amphetamine)		
dextroamphetamine	amphetamine		
dextroamphetamine/amphetamine	EVEKEO (amphetamine)		
methylphenidate	EVEKEO ODT (amphetamine)		
PROCENTRA (dextroamphetamine)	FOCALIN (dexmethylphenidate)		
	methamphetamine		
	METHYLN (methylphenidate)		
	methylphenidate		
	RITALIN (methylphenidate)		
	ZENZEDI (dextroamphetamine)		
LONG-ACTING		Maximum Age Limit • 18 years: clonidine ER, COTEMPLA XR ODT, DAYTRANA, EVEKEO ODT, guanfacine ER	
ADDERALL XR (dextroamphetamine/amphetamine)	ADZENYS XR ODT (amphetamine)		
CONCERTA (methylphenidate)	APTENSIO XR (methylphenidate)		
dexmethylphenidate ER	AZSTARYS (serdexmethylphenidate/dexmethylphenidate)		
dextroamphetamine ER	COTEMPLA XR ODT (methylphenidate)		
dextroamphetamine/amphetamine ER	DAYTRANA (methylphenidate)		
DYANAVEL XR (amphetamine) suspension	DEXEDRINE (dextroamphetamine)		
lisdexamfetamine	dextroamphetamine/amphetamine ER		
methylphenidate CD	DYANAVEL XR (amphetamine) tablets		
methylphenidate ER tablet	FOCALIN XR (dexmethylphenidate)		
methylphenidate LA	JORNAY PM (methylphenidate)	Quantity Limit – Stimulants (per 31 days) • 31 tablets: ADDERALL XR, ADHANSIA XR, ADZENYS XR ODT, APTENSIO XR, AZSTARYS, CONCERTA ER 18, 27, & 54 mg, COTEMPLA XR-ODT 8.6 mg, DAYTRANA, DEXEDRINE Spansule, DYANAVEL XR Tablet, FOCALIN XR, JORNAY PM, METADATE CD, METHYLIN ER, MYDAYIS 37.5 mg & 50 mg, QUILLICHEW, RELEXII ER, RITALIN LA & SR, VYVANSE, XELSTRYM • 62 tablets: ADDERALL, CONCERTA ER 36 mg, COTEMPLA XR-ODT 17.3 & 25.9 mg, DESOXYN, EVEKEO, FOCALIN, METHYLIN, ZENZEDI • 248 mL: DYANAVEL XR Suspension • 310 mL: METHYLIN, PROCENTRA • 372 mL: QUILLIVANT XR	
QUILLICHEW ER (methylphenidate)	methylphenidate patch		
QUILLIVANT XR (methylphenidate)	methylphenidate ER capsule		
VYVANSE (lisdexamfetamine) capsules	MYDAYIS (dextroamphetamine/amphetamine)		
	RELEXII (methylphenidate)		
	RITALIN LA (methylphenidate)		
	VYVANSE (lisdexamfetamine) chewable tablets		
	XELSTRYM (dextroamphetamine)		
NARCOLEPSY			Quantity Limit – Narcolepsy (per 31 days) • 31 tablets: armodafinil 150, 200 & 250 mg, modafinil 200 mg, SUNOSI • 46.5 tablets: modafinil 100 mg • 62 tablets: armodafinil 50 mg, WAKIX
armodafinil	NUVIGIL (armodafinil)		
modafinil	PROVIGIL (modafinil)		
SUNOSI (solriamfetol)	sodium oxybate		
XYREM (sodium oxybate)	WAKIX (pitolisant)		
	XYWAV (calcium/magnesium/potassium/sodium oxybate)		
NON-STIMULANTS		Quantity Limit – Non-Stimulants (per 31 days) • 31 tablets: atomoxetine, guanfacine ER, QELBREE 100 mg • 62 tablets: QELBREE 150 mg and 200 mg • 124 tablets: clonidine ER • 1 bottle (30 mL or 60 mL): ONYDA XR Suspension	
atomoxetine	INTUNIV (guanfacine)		
clonidine ER	NEXICLON XR (clonidine)		
guanfacine ER	ONYDA XR (clonidine)		
QELBREE (viloxazine)	STRATTERA (atomoxetine)		

See next page for additional PA Criteria/DUR+ Rules

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
STIMULANTS AND RELATED AGENTS^{DUR+} (continued)		
See previous page for additional PA Criteria/DUR+ Rules		
Non-Preferred Short Acting Criteria ADD/ADHD - Documented diagnosis of ADD/ADHD AND - Have tried 2 different preferred Short Acting agents in the past 6 months OR 1 claim for a 30-day supply with the requested agent in the past 105 days Narcolepsy: ADDERALL, EVEKEO, METHYLIN, PROCENTRA, RITALIN, ZENZEDI - Documented diagnosis of narcolepsy AND 30 days of therapy with preferred modafinil or armodafinil in the past 6 months AND 1 preferred agent indicated for narcolepsy in the past 6 months OR - Have tried 1 claim for a 30-day supply with the requested agent in the past 105 days Armodafinil - Documented diagnosis of narcolepsy, obstructive sleep apnea, shift work sleep disorder, or bipolar depression Atomoxetine - Age ≥ 21 years AND - Documented diagnosis of ADD/ADHD Clonidine ER - Documented diagnosis of ADD/ADHD Guanfacine ER - Documented diagnosis of ADD/ADHD JORNAY PM - Documented diagnosis of ADD/ADHD AND 84 days of therapy with 2 different preferred LA methylphenidate agents in the past 12 months AND 84 days of therapy with 1 preferred non-methylphenidate LA stimulant agent in the past 12 months OR - Documented diagnosis of ADD/ADHD AND 84 days of therapy with JORNAY PM in the past 105 days Modafinil - Documented diagnosis of narcolepsy, obstructive sleep apnea, shift work sleep disorder, depression, sleep deprivation or Steinert Myotonic Dystrophy Syndrome	Non-Preferred Long Acting Criteria ADD/ADHD - Documented diagnosis of ADD/ADHD AND - Have tried 2 different preferred Long-Acting agents in the past 6 months OR 1 claim for a 30-day supply with the requested agent in the past 105 days Narcolepsy: ADDERALL XR, APTENSIO XR, CONCERTA ER, DEXEDRINE, METADATE CD, METHYLIN ER, MYDAYIS, NUVIGIL, PROVIGIL, QUILLICHEW, QUILLIVANT XR, RITALIN LA - 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 ONYDA XR - Requires clinical review QELBREE - Documented diagnosis of ADD/ADHD AND 30 days of therapy with a preferred ADHD agent in the past 105 days OR 30 days of therapy with QELBREE in the past 105 days SUNOSI - Documented diagnosis of narcolepsy or obstructive sleep apnea AND 30 days of therapy with preferred modafinil or armodafinil in the past 6 months VYVANSE - Documented diagnosis of binge eating disorder or ADD/ADHD WAKIX - Requires clinical review XYREM Documented diagnosis of narcolepsy or excessive daytime sleepiness OR 30 days of therapy with this agent in the past 105 days XYWAV - Requires clinical review	

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TETRACYCLINES ^{DUR+}			
doxycycline hyclate	demeclocycline	Non-Preferred Agents - Have tried 2 different preferred agents in the past 6 months Demeclocycline - Documented diagnosis of Syndrome of Inappropriate Antidiuretic Hormone Secretion (SIADH) will allow automatic approval ORACEA - Requires clinical review	
doxycycline monohydrate capsule	DORYX (doxycycline hyclate)		
minocycline capsule	DORYX MPC (doxycycline hyclate)		
tetracycline capsule	doxycycline hyclate DR		
	doxycycline IR/DR		
	doxycycline monohydrate suspension, tablet		
	LYMEPAK (doxycycline hyclate)		
	MINOCIN (minocycline)		
	minocycline tablet		
	minocycline ER		
	MINOLIRA ER (minocycline)		
	MORGIDOX (doxycycline hyclate)		
	NUZYRA (omadacycline)		
	ORACEA (doxycycline monohydrate)		
	SOLODYN (minocycline)		
	tetracycline tablet		
ULCERATIVE COLITIS & CROHN'S AGENTS ^{DUR+} *See Cytokine & CAM Antagonists Class for Additional Agents*			
ORAL		Non-Preferred Criteria - Documented diagnosis of Ulcerative Colitis AND - Have tried 2 different preferred agents in the past 6 months OR 90 days of therapy with the requested agent in the past 105 days VELSIPITY - Requires clinical review	
APRISO (mesalamine)	AZULFIDINE (sulfasalazine)		
balsalazide	COLAZAL (balsalazide)		
budesonide	DELZICOL (mesalamine)		
PENTASA (mesalamine)	DIPENTUM (olsalazine)		
sulfasalazine	LIALDA (mesalamine)		
sulfasalazine DR	mesalamine		
UCERIS (budesonide)	mesalamine DR		
	mesalamine ER		
	VELSIPITY (etrasimod)		
RECTAL			
mesalamine suppository	budesonide		
	CANASA (mesalamine)		
	mesalamine enema		
	ROWASA (mesalamine)		
	SFROWASA (mesalamine)		
	UCERIS (budesonide)		
UREA CYCLE DISORDER AGENTS			
CARBAGLU (carglumic acid)	BUPHENYL (sodium phenylbutyrate)		
carglumic acid	OLPRUVA (sodium phenylbutyrate)		
	PHEBURANE (sodium phenylbutyrate)		
	RAVICTI (glycerol phenylbutyrate)		