MISSISSIPPI DIVISION OF MEDICAID
UNIVERSAL PREFERRED DRUG LIST

EFFECTIVE 04/01/2025
Version 2025_5
Updated 05/30/2025

General Preferred Drug List Information

- Gainwell Technologies' DUR+ process is a proprietary electronic prior authorization system used for Medicaid pharmacy claims.
- 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.
- To search the PDL, **press CTRL + F**.

Medication Coverage Status Search Tool - **Pharmacy Drug Coverage Inquiry**

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
ACNE AGENTS		
ANTI-INFECTIVES		**Maximum Age Limit** • **21 years**: all acne agents except isotretinoin products **Topical Clindamycin 1% lotion** • **21 years** and older **AND** • Documented diagnosis of hidradenitis suppurativa Note: • Isotretinoin products available for all ages • Clindamycin 1% lotion only available for ages 21 years and older with approvable diagnosis • Preferred clindamycin 1% lotion for ages < 21 years does not require PA **Maximum Age Limit** • **21 years**: all acne agents except isotretinoin products
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	

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
ACNE AGENTS (*continued*)		
OTHERS/COMBINATION PRODUCTS		See previous page for additional PA Criteria/DUR+ Rules
adapalene/benzoyl peroxide gel	ACANYA (benzoyl peroxide/clindamycin) 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** See next page for additional PA Criteria/DUR+ Rules
donepezil 5 mg, 10 mg ODT, tablets	ADLARITY (donepezil)	
galantamine	ARICEPT (donepezil)	
galantamine ER	donepezil 23 mg tablet	
rivastigmine	EXELON (rivastigmine)	

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
ALZHEIMER'S AGENTS DUR+ *(continued)*		
	Zunveyl (benzgalantamine gluconate)NR	See previous page for additional PA Criteria/DUR+ Rules • Have tried 2 different preferred agents in the past 6 months **NAMZARIC** • Requires clinical review **ZUNVEYL** • Requires clinical review
NMDA RECETPOR ANTAGONISTS		
memantine	memantine ER	
	NAMENDA (memantine)	
	NAMENDA XR (memantine ER)	
COMBINATION AGENTS		
	NAMZARIC (memantine/donepezil)	
	memantine/donepezil ER	
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 combinations, 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 **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
acetaminophen/codeine	aspirin/butalbital/caffeine/codeine	
codeine	butalbital/acetaminophen/caffeine/codeine	
ENDOCET (oxycodone/acetaminophen)	butorphanol	
hydrocodone/acetaminophen	DILAUDID (hydromorphone)	
hydromorphone	fentanyl citrate	
morphine sulfate	FENTORA (fentanyl)	
oxycodone	FIORICET W/CODEINE (butalbital/acetaminophen/codeine)	
oxycodone/acetaminophen (325 mg acetaminophen formulations)	hydrocodone/ibuprofen	
tramadol 50 mg tablet	meperidine	
tramadol/acetaminophen	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)	See next page for additional PA Criteria/DUR+ Rules
fentanyl patch	buprenorphine patch	
morphine sulfate ER tablet	CONZIP (tramadol)	
	hydrocodone bitartrate ER	
	hydromorphone ER	

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
ANALGESICS, OPIOID-LONG ACTING DUR+ *(continued)*		
	HYSINGLA ER (hydrocodone)	See previous page for additional PA Criteria/DUR+ Rules **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
	methadone	
	methadone intensol	
	METHADOSE (methadone)	
	morphine sulfate ER capsule	
	MS CONTIN (morphine)	
	oxycodone ER	
	OXYCONTIN (oxycodone)	
	oxymorphone ER	
	tramadol ER	
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 postherpetic neuralgia **OR** • History of 3 claims with preferred lidocaine 5% patch in the past 6 months
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 See next page for additional PA Criteria/DUR+ Rules
	JATENZO (testosterone undecanoate)	
	NATESTO (testosterone)	
	TESTIM (testosterone)	
	TLANDO (testosterone undecanoate)	
	VOGELXO (testosterone)	

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
ANDROGENIC AGENTS DUR+ *(continued)*		
	UNDECATREX (testosterone undecanoate)	See previous page for additional PA Criteria/DUR+ Rules **TLANDO** • Requires clinical review
ANGIOTENSIN MODULATORS DUR+		
ANGIOTENSIN CONVERTING ENZYME (ACE) INHIBITORS		**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	ACCUPRIL (quinapril)	
captopril	ALTACE (ramipril)	
enalapril	EPANED (enalapril)	
ANGIOTENSIN CONVERTING ENZYME (ACE) INHIBITORS		
fosinopril	LOTENSIN (benazepril)	
lisinopril	moexipril	
quinapril	perindopril	
ramipril	QBRELIS (lisinopril)	
trandolapril	VASOTEC (enalapril)	
	ZESTRIL (lisinopril)	
ACE INHIBITOR (ACEI) COMBINATIONS		
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)	
	EDARBI (azilsartan)	
	eprosartan	
	MICARDIS (telmisartan)	
ANGIOTENSIN II RECEPTOR BLOCKERS (ARBs)		
	valsartan solution	

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
ANGIOTENSIN MODULATORS DUR+ *(continued)*		
ARB COMBINATIONS		See previous page for additional PA Criteria/DUR+ Rules
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)	
ANTIBIOTICS (GI) & RELATED AGENTS		
metronidazole tablet	AEMCOLO (rifamycin)	
neomycin	DIFICID (fidaxomicin)	
tinidazole	FIRVANQ (vancomycin)	
vancomycin oral solution	FLAGYL (metronidazole)	
	LIKMEZ (metronidazole)	
	metronidazole 125 mg tablet, 375 mg capsule	
	nitazoxanide	
	paromomycin	
	REBYOTA (fecal microbiota, live-jslm)	
	VANCOCIN (vancomycin)	
	vancomycin capsule	
	VOWST (fecal microbio spore, live-brpk)	
	XIFAXAN (rifaximin)	

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
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 (erythromycin 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		
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** See next page for additional PA Criteria/DUR+ Rules
enoxaparin	ARIXTRA (fondaparinux)	
	fondaparinux	
	FRAGMIN (dalteparin)	

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
ANTICOAGULANTS *(continued)*		
	LOVENOX (enoxaparin)	See previous page for additional PA Criteria/DUR+ Rules
ORAL		
ELIQUIS (apixaban)	dabigatran	○ 90 days of therapy with the requested agent in the past 105 days
JANTOVEN (warfarin)	PRADAXA (dabigatran) pellet pack	
PRADAXA (dabigatran) capsule	SAVAYSA (edoxaban)	• **Oral**:
warfarin	rivaroxaban	○ 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
XARELTO (rivaroxaban)		
ANTICONVULSANTS DUR+		
ADJUVANTS		**Minimum Age Limit** • **6 months**: DIACOMIT • **1 year**: BANZEL, EPIDIOLEX • **2 years**: ONFI, SYMPAZAN • **2 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 **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 See next page for additional PA Criteria/DUR+ Rules
carbamazepine	APTIOM (eslicarbazepine acetate)	
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 15, 25 mg (generic Topamax)	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)	
	oxcarbazepine suspension	
	oxcarbazepine ER	
	OXTELLAR XR (oxcarbazepine)	
	QUDEXY XR (topiramate)	
	ROWEEPRA (levetiracetam)	
	rufinamide	
	SABRIL (vigabatrin)	

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
ANTICONVULSANTS DUR+ *(continued)*		
ADJUVANTS *(continued)*		See previous page for additional PA Criteria/DUR+ Rules
	SPRITAM (levetiracetam)	
	SUBVENITE (lamotrigine)	
	SUBVENITE (lamotrigine) blue, green, orange dose pack	
	TEGRETOL (carbamazepine)	
	TEGRETOL XR (carbamazepine)	
	TOPAMAX TABLET (topiramate)	
	TOPAMAX SPRINKLE (topiramate)	
	topiramate ER capsule (generic Trokendi XR)	
	topiramate ER sprinkle capsule (generic Qudexy XR)	
	topiramate sprinkle 50 mg	
	TRILEPTAL (oxcarbazepine) tablet	
	TROKENDI XR (topiramate)	
	vigabatrin	
	VIGADRONE (vigabatrin)	
	VIGAFYDE (vigabatrin)	
	VIGPODER (vigabatrin)	
	VIMPAT (lacosamide)	
	XCOPRI (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)	

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 ≤ 2 years **AND**
- Documented diagnosis of infantile spasms

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
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 and RALDESY** • 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	DESYREL (trazodone)	
trazodone	DRIZALMA SPRINKLE (duloxetine DR)	
TRINTELLIX (vortioxetine)	EFFEXOR XR (venlafaxine)	
venlafaxine	EMSAM (selegiline)	
venlafaxine ER capsule	FETZIMA (levomilnacipran)	
vilazodone	FORFIVO XL (bupropion)	
	MARPLAN (isocarboxazid)	
	NARDIL (phenelzine)	
	nefazodone	
	phenelzine	
	PRISTIQ (desvenlafaxine)	
	REMERON (mirtazapine)	
	tranylcypromine	
	Trazodone solution[NR]	
	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
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)	
ANTIEMETICS DUR+		
5HT3 RECEPTOR BLOCKERS		**Quantity Limit** (per 31 days) • **6 tablets**: AKYNZEO • **100 mL**: ZOFRAN solution See next page for additional PA Criteria/DUR+ Rules
ondansetron solution, tablet	ANZIMET (dolasetron)	
ondansetron ODT 4 mg, 8 mg	granisetron	
	ondansetron ODT 16 mg tablet	

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
ANTIEMETICS DUR+ *(continued)*		
	SANCUSO (granisetron)	See previous page for additional PA Criteria/DUR+ Rules **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.
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 (isavuconazonium sulfate)	
terbinafine	DIFLUCAN (fluconazole)	
	flucytosine	
	griseofulvin	
	griseofulvin ultramicrosize	
	itraconazole	
	ketoconazole	
	NOXAFIL (posaconazole)	
	ORAVIG (miconazole)	
	Posaconazole	
	SPORANOX (itraconazole)	
	TOLSURA (itraconazole)	
	VFEND (voriconazole)	
	VIVJOA (oteseconazole)	
	voriconazole	
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)	

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
ANTIFUNGALS (TOPICAL) DUR+ *(continued)*		
nystatin cream, ointment, powder	ketoconazole foam	See previous page for additional PA Criteria/DUR+ Rules
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)	
	tavaborole	
	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		
ANTIHISTAMINES, MINIMALLY SEDATING AND COMBINATIONS DUR+		
MINIMALLY SEDATING ANTIHISTAMINES		**Non-Preferred Criteria** • Documented diagnosis of Allergy or Urticaria **AND** • Have tried 2 different preferred agents in the past 12 months
cetirizine 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	
ANTIMIGRAINE AGENTS, ACUTE TREATMENT		
CGRP ORAL AND NASAL		**Minimum Age Limit** See next page for additional PA Criteria/DUR+ Rules
NURTEC ODT (rimegepant)	ZAVZPRET (zavegepant)	
UBRELVY (ubrogepant)		

<table>
<tr><th>PREFERRED AGENTS</th><th>NON-PREFERRED AGENTS</th><th>PA CRITERIA</th></tr>
<tr><th colspan="3">ANTIMIGRAINE AGENTS, ACUTE TREATMENT DUR+ (continued)</th></tr>
<tr><td colspan="2">INJECTABLES</td><td rowspan="2">See previous page for additional PA Criteria/DUR+ Rules
• 6 years: MAXALT
• 12 years: almotriptan, sumatriptan/naproxen, ZOMIG nasal spray
• 18 years: FROVA, IMITREX, naratripin, NURTEC ODT, RELPAX, REYVOW, SYMBRAVO, TOSYMRA, UBRELVY, ZEMBRACE, ZOMIG tablets

Quantity Limit (per 31 days)
• ORAL
○ 4 tablets: REYVOW 50 mg
○ 6 tablets: almotriptan, RELPAX, ZOMIG
○ 8 tablets: NURTEC ODT, REYVOW 100 mg
○ 9 tablets: naratriptan, FROVA, IMITREX, sumatriptan/naproxen, SYMBRAVO
○ 12 tablets: MAXALT
○ 16 tablets: UBRELVY
• NASAL
○ 1 box: all agents

CUMULATIVE Quantity Limit (per 31 days)
• INJECTABLES
○ 4 injections: all agents

Non-Preferred Criteria
• ORAL
○ Have tried 2 preferred oral agents in the past 90 days
• NASAL
○ Have tried 2 preferred oral agents in the past 90 days AND
○ Have tried a preferred nasal agent in the past 90 days

Almotriptan and sumatriptan/naproxen
• Automatic approval for 12-17 years of age

NURTEC ODT and UBRELVY – MANUAL PA
• Documented diagnosis of Migraine AND
• Have tried 2 different triptans in the past 6 months AND
• No concurrent therapy with another CGRP agent or strong CYP3A4 inhibitor

REYVOW
• Documented diagnosis of Migraine AND
• Have tried 2 different triptans in the past 90 days AND
• Have tried preferred NURTEC ODT in the past 90 days

SYMBRAVO
• Requires clinical review

See next page for additional PA Criteria/DUR+ Rules</td></tr>
<tr><td>sumatriptan</td><td>IMITREX (sumatriptan)
ZEMBRACE SYMTOUCH (sumatriptan)</td></tr>
</table>

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
ANTIMIGRAINE AGENTS, ACUTE TREATMENT DUR+ *(continued)*		
NASAL		See previous page for additional PA Criteria/DUR+ Rules **ZAVZPRET – MANUAL PA** • Documented diagnosis of Migraine **AND** • Have tried 2 different triptans in the past 6 months **AND** • Have tried both NURTEC ODT and UBRELVY in the past 6 months **AND** No concurrent therapy with another CGRP AGENT
sumatriptan	IMITREX (sumatriptan)	
	TOSYMRA (sumatriptan)	
	zolmitriptan	
	ZOMIG (zolmitriptan)	
TRIPTANS AND RELATED AGENTS (ORAL) DUR+		
naratriptan	almotriptan	
rizatriptan	eletriptan	
sumatriptan	FROVA (frovatriptan)	
zolmitriptan	frovatriptan	
zolmitriptan ODT	IMITREX (sumatriptan)	
	MAXALT (rizatriptan)	
	MAXALT MLT (rizatriptan)	
	RELPAX (eletriptan)	
	REYVOW (lasmiditan)	
	sumatriptan/naproxen	
	ZOMIG (zolmitriptan)	
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, AJOVY, and EMGALITY – 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)	
	NURTEC ODT (rimegepant)	
***ANTINEOPLASTICS – SELECTED SYSTEMIC ENZYME INHIBITORS**		
BOSULIF (bosutinib) tablet	AFINITOR (everolimus)	**FARYDAK – MANUAL PA** **IBRANCE** • Documented diagnosis of WD-DDLS for retroperitoneal sarcoma **OR** • All other indications require clinical review See next page for additional PA Criteria/DUR+ Rules
CAPRESLA (vandetanib)	AFINITOR DISPERZ (everolimus)	
COMETRIQ (cabozantinib)	AKEEGA (niraparib/abiraterone)	
COTELLIC (cobimetinib)	ALECENSA (alectinib)	
everolimus	ALUNBRIG (brigatinib)	
GILOTRIF (afatinib)	AUGTYRO (repotrectinib)	
ICLUSIG (ponatinib)	AYVAKIT (avapritinib)	
imatinib	BALVERSA (erdafitinib)	

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
***ANTINEOPLASTICS – SELECTED SYSTEMIC ENZYME INHIBITORS** (*continued*)		
IMBRUVICA (ibrutinib)	BOSULIF (bosutinib) capsule	
INLYTA (axitinib)	BRAFTOVI (encorafenib)	
IRESSA (gefitinib)	BRUKINSA (zanubrutinib)	
JAKAFI (ruxolitinib)	CABOMETYX (cabozantinib)	
MEKINIST (trametinib)	CALQUENCE (acalabrutinib)	
NEXAVAR (sorafenib)	COPIKTRA (duvelisib)	
ROZLYTREK (entrectinib)	DANZITEN (nilotinib)	
SPRYCEL (dasatinib)	dasatinib	
STIVARGA (regorafenib)	DATROWAY (datopotomab deruxtecan-dlnk)[NR]	See previous page for additional PA Criteria/DUR+ Rules **LENVIMA** Documented diagnosis of thyroid cancer, hepatocellular carcinoma, or 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** • 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 – **MANUAL PA**
SUTENT (sunitinib)	DAURISMO (glasdegib)	
TAFINLAR (dabrafenib)	ERIVEDGE (vismodegib)	
TARCEVA (erlotinib)	ERLEADA (apalutamide)	
TASIGNA (nilotinib)	erlotinib	
TURALIO (pexidartinib)	FOTIVDA (tivozanib)	
TYKERB (lapatinib)	FRUZAQIA (fruquintinib)	
VOTRIENT (pazopanib)	GAVRETO (pralsetinib)	
XALKORI (crizotinib)	gefitinib	
XTANDI (enzalutamide)	GLEEVEC (imatinib)	
ZELBORAF (vemurafenib)	IBRANCE (palbociclib)	
ZYDELIG (idelalisib)	IDHIFA (enasidenib)	
ZYKADIA (ceritinib)	IMKELDI (imatinib)	
	INQOVI (decitabine/cedazuridine)	
	INREBIC (fedratinib)	
	ITOVEBI (inavolisib)	
	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)	

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
***ANTINEOPLASTICS – SELECTED SYSTEMIC ENZYME INHIBITORS** (*continued*)		
	ODOMZO (sonidegib)	See previous page for additional PA Criteria/DUR+ Rules
	OGSIVEO (nirogacestat)	
	OJEMDA (tovorafenib)	
	OJJAARA (momelotinib)	
	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)	
	TECENTRIQ HYBREZA (atezolizumab/hyaluronidase-tqjs)	
	TEPMETKO (tepotinib)	
	TIBSOVO (ivosidenib)	
	TORPENZ (everolimus)	
	TRUQAP (capivasertib)	
	TUKYSA (tucatinib)	
	VANFLYTA (quizartinib)	
	VERZENIO (abemaciclib)	
	VITRAKVI (larotrectinib)	
	VIZIMPRO (dacomitinib)	
	VONJO (pacritinib)	
	VORANIGO (vorasidenib)	
	WELIREG (belzutifan)	
	XOSPATA (gilteritinib)	
	XPOVIO (selinexor)	
	ZEJULA (niraparib)	

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
ANTIOBESITY SELECT AGENTS		
SAXENDA (liraglutide)	orlistat	**All agents** – MANUAL PA required **Wegovy Initial Authorization** • Age 18 years or older **AND** • Documented diagnosis of Body Mass Index (BMI) >/= 30 **AND** • History of </= 6 claims with Wegovy in the past 9 months **AND** • No history of a claim with Imcivree, Xenical, or any other GLP-1 agonist indicated for treatment of obesity or diabetes in the past 30 days **OR** • **Manual PA required when criteria is not met** • Initial authorization is defined as no more than 6 claims for Wegovy within 9 month period • Reauthorization and maintenance reauthorization require clinical review
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)	
	STROMECTOL (ivermectin)	
ANTIPARKINSON'S AGENTS (INJECTABLE)		
	VYALEV (foscarbidopa/foslevodopa)	**VYALEV** • Requires clinical review
ANTIPARKINSON'S AGENTS (ORAL) DUR+		
ANTICHOLINERGICS		• 30 days of therapy with a selegiline agent in the past 45 days **GOCOVRI** • 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 See next page for additional PA Criteria/DUR+ Rules
benztropine		
trihexyphenidyl		
COMT INHIBITORS		
entacapone	OGENTYS (opicapone)	
	TASMAR (tocapone)	
	tolcapone	
ropinirole	pramipexole ER	
	ropinirole ER	

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
ANTIPARKINSON'S AGENTS (ORAL) DUR+ *(continued)*		
MAO-B INHIBITORS		See previous page for additional PA Criteria/DUR+ Rules **LODOSYN and INBRIJA** • Documented diagnosis of Parkinson's disease **AND** • 30 days of therapy with a carbidopa/levodopa combination agent in the past 45 days **NOURIANZ** • 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
selegiline	AZILECT (rasagiline)	
	rasagiline	
	XADAGO (safinamide)	
	ZELAPAR (selegiline)	
OTHERS		
amantadine	carbidopa/levodopa ODT	
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)	
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
ABILIFY ASIMTUFII (aripiprazole)	ERZOFRI (paliperidone palmitate)	
ABILIFY MAINTENA (aripiprazole)	GEODON (ziprasidone)	
ARISTADA, ARISTADA INITIO (aripiprazole lauroxil)	olanzapine	
INJECTABLE, ATYPICALS DUR+		
INVEGA HAFYERA (paliperidone)	risperidone ER	
INVEGA SUSTENNA (paliperidone palmitate)	RYKINDO (risperidone)	
INVEGA TRINZA (paliperidone)	ziprasidone	

See next page for additional PA Criteria/DUR+ Rules

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
ANTIPSYCHOTICS DUR+ (*continued*)		
PERSERIS (risperidone)	ZYPREXA (olanzapine)	See previous page for additional PA Criteria/DUR+ Rules • **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 **ARISTADO INTIO, ARISTADO ER, INVEGA SUSTENNA, INVEGA TRINZA, PERSERID AND ZYPREXA RELPREEV** • Documented diagnosis of schizophrenia or schizoaffective disorder **ABILIFY MAINTENA, ABILIFY ASIMTUFII, or RISPERDAL CONSTA** • Documented diagnosis of schizophrenia, schizoaffective disorder or bipolar disorder **INVEGA HAFYERA** • Documented diagnosis of schizophrenia or schizoaffective disorder **AND** • 4 claims for INVEGA SUSTENNA in the past year **OR** • 1 claim for INVEGA TRINZA in the past year **OR** • 1 claim for INVEGA HAFYERA in the past year **ERZOFRI and risperidone ER** • Require clinical review **NUPLAZID** • Documented diagnosis of Parkinson's Disease **Quantity Limit** • **3 syringes/year**: ARISTADA INITIO See next page for additional PA Criteria/DUR+ Rules
RISPERIDAL CONSTA (risperidone)	ZYPREXA RELPREVV (olanzapine)	
UZEDY (risperidone)		
ORAL		
aripiprazole tablet	ABILIFY (aripiprazole)	
asenapine	ABILIFY MYCITE (aripiprazole)	
clozapine tablet	ADASUVE (loxapine)	
fluphenazine	aripiprazole ODT, solution	
haloperidol	CAPLYTA (lumateperone)	
haloperidol lactate	chlorpromazine	
olanzapine	clozapine ODT	
perphenazine	CLOZARIL (clozapine)	
perphenazine/amitriptyline	COBENFY (xanomeline/trospium)	
quetiapine	FANAPT (iloperidone)	
quetiapine ER	GEODON (ziprasidone)	
risperidone	IGALMI (dexmedetomidine)	
thioridazine	INVEGA (paliperidone)	
trifluoperazine	LATUDA (lurasidone)	
VRAYLAR (cariprazine)	lurasidone	
ziprasidone	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)	

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		See previous page for additional PA Criteria/DUR+ Rules **VRAYLAR** • Documented diagnosis of schizophrenia, schizoaffective disorder, bipolar disorder **OR** • Documented diagnosis major depressive disorder **AND** o 30 days of therapy with an antidepressant in the past 45 days **OR** o 1 claim for a 90-day supply of an antidepressant in the past 105 days
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		

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
ANTIRETROVIRALS DUR+ (*continued*)		
COMBINATION PRODUCTS – NUCLEOSIDE AND NUCLEOTIDE ANALOG AND NON-NUCLEOSIDE RTIs		See previous page for additional PA Criteria/DUR+ Rules
DELSTRIGO (doravirine/lamiviudine/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 INHIBTORS (NNRTI)		
EDURANT (rilpivirine)	etravirine	
efavirenz	INTELENCE (etravirine)	
	nevirapine, nevirapine ER	
	PIFELTRO (doravirine)	
NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBTORS (NRTI)		
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)	

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
ANTIRETROVIRALS DUR+ (*continued*)		
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		
ANTI-INFLUENZA AGENTS		
oseltamivir	FLUMADINE (rimantadine)	
	RAPIVAB (peramivir)	
	RELENZA (zanamivir)	
	rimantadine	
	TAMIFLU (oseltamivir)	
	XOFLUZA (baloxavir)	

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
ANTIVIRALS, TOPICAL		
ZOVIRAX (acyclovir) cream	acyclovir	
	DENAVIR (penciclovir)	
	penciclovir	
	XERESE (acyclovir/hydrocortisone)	
	ZOVIRAX (acyclovir) ointment	
AROMATASE INHIBITORS		
anastrozole	ARIMIDEX (anastrazole)	
exemestane	AROMASIN (exemestane)	
letrozole	FEMARA (letrozole)	
ATOPIC DERMATITIS		
ADBRY (tralokinumab-ldrm)	CIBINQO (abrocitinib)	**Minimum Age Limit** • **3 months**: EUCRISA • **2 years**: ELIDEL, tacrolimus 0.03% • **12 years**: OPZELURA • **16 years**: tacrolimus 0.1%
ADBRY Autoinjector (tralokinumab-ldrm)	EBGLYSS Pen (lebrikizumab-lbkz)	
DUPIXENT (dupilumab) DUR+	NEMLUVIO (nemolizumab-ilto)	
ELIDEL (pimecrolimus)	OPZELURA (ruxolitinib)	
EUCRISA (crisaborole) DUR+	ZORYVE (roflumilast) 0.15% cream	
pimecrolimus		
tacrolimus		

ADBRY – **MANUAL PA**

CIBINQO
- Requires 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**
  - **COPD** – **MANUAL PA**
  - **Eosinophilic Esophagitis** – **MANUAL PA**
  - **Nasal Polyposis** – **MANUAL PA**
  - **Prurigo Nodularis** – **MANUAL PA**

EBGLYSS
- Requires clinical review

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 tacrolimus in the past 6 months

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
BETA BLOCKERS, ANTIANGINALS & SINUS NODE AGENTS DUR+		
ANTIANGINALS		**ASPRUZYO SPRINKLE** • Requires clinical review **Ranolazine ER** • 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 **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 **HEMANGEOL** • Documented diagnosis of infantile hemangioma **CORLANOR** – **MANUAL PA**
	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)	
	OCALIVA (obeticholic acid)	
	RELTONE (ursodiol)	

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
BILE SALTS *(continued)*		
	URSO FORTE (ursodiol)	
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-aqqg)	
	EVISTA (raloxifene)	
	MIACALCIN (calcitonin salmon)	
	PROLIA (denosumab)	
	teriparatide	
	TYMLOS (abaloparatide)	
	XGEVA (denosumab)	

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
BPH AGENTS DUR+		
5-ALPHA-REDUCTASE 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	
PHOSPHODIESTERASE TYPE 5 (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 of age **BREZTRI AEROSPHERE** • 3 claims with BREZTRI AEROSPHERE in the past 105 days **OR** • New starts require clinical review **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 **Minimum Age Limit** • **4 years**: SEREVENT, XOPENEX HFA • **6 years**: XOPENEX Solution • **18 years**: BROVANA, PERFOROMIST, STRIVERDI RESPIMAT **Quantity Limit** (per 31 days) • **10.7 units –** Breztri Aerosphere **XOPENEX HFA and Solution** • 1 claim for a preferred albuterol (inhaler or vials) in the past 30 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-GLUCOCORTICOIDS 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)	
	YUPERI (revefenacin)	

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
BRONCHODILATORS & COPD AGENTS *(continued)*		
INHALATION SOLUTION DUR+		See previous page for additional PA Criteria/DUR+ Rules
albuterol	arformoterol	
	BROVANA (arformoterol)	
	formoterol, formoterol fumarate	
	levalbuterol	
	PERFOROMIST (formoterol)	
INHALERS, LONG ACTING DUR+		
SEREVENT DISKUS (salmeterol)		
STRIVERDI RESPIMAT (olodaterol)		
INHALERS, SHORT ACTING		
albuterol HFA	levalbuterol HFA	
VENTOLIN HFA (albuterol)	PROAIR DIGIHALER (albuterol)	
	XOPENEX HFA (levalbuterol)	
ORAL		
albuterol IR	albuterol ER	
terbutaline		
CALCIUM CHANNEL BLOCKERS DUR+		
LONG-ACTING		**Quantity Limit** (per 21 days) • **252 capsules**: 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 (amlodipine)	
verapamil ER	PROCARDIA XL (nifedipine)	
LONG-ACTING		
verapamil SR	SULAR (nisoldipine)	
	TIADYLT ER (diltiazem)	
	TIAZAC (diltiazem)	
	verapamil PM	
	VERELAN PM (verapamil)	
SHORT-ACTING		
diltiazem	CARDIZEM (diltiazem)	
nicardipine	isradipine	
nifedipine	nimodipine capsule and solution	
verapamil	NORLIQVA (amlodipine)	

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
CALCIUM CHANNEL BLOCKERS DUR+ *(continued)*		
	NYMALIZE (nimodipine)	
CALORIC AGENTS		
BOOST	All non-preferred caloric/nutritional agents (which are all other products except those specifically listed as preferred) require a manual prior authorization.	**Non-Preferred Agents** – **MANUAL PA**
BREAKFAST ESSENTIALS		
BRIGHT BEGINNINGS		
DUOCAL		
ENSURE		
NUTREN		
OSMOLITE		
PEDIASURE		
PROMOD		
RESOURCE		
TWOCAL HN		
CEPHALOSPORINS AND RELATED ANTIBIOTICS (ORAL)		
BETA LACTAM/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-apgf)	

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
COLONY STIMULATING FACTORS *(continued)*		
	RELEUKO (filgrastim-ayow)	
	ROLVEDON (eflapegrastim-xnst)	
	STIMUFEND (pegfilgrastim-fpgk)	
	UDENYCA, UDENYCA ONBODY (pegfilgrastim-cbqv)	
	ZARXIO (filgrastim-sndz)	
	ZIEXTENZO (pegfilgrastim-bmez)	
CYSTIC FIBROSIS AGENTS DUR+		
PULMOZYME (dornase alfa)	ALYFTREK (vanzacaftor/tezacaftor/deutivacaftor)	**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 50-25-37.5 mg tablets **Preferred Agents** • Documented diagnosis of Cystic Fibrosis **OR** • Require clinical review **ALYFTREK –** MANUAL PA **KALYDECO** – MANUAL PA **ORKAMBI** – MANUAL PA **SYMDEKO** – MANUAL PA **TOBI PODHALER** – Require clinical review **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)	

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
CYTOKINE & CAM ANTAGONISTS DUR+		
ACTEMRA (tocilizumab) syringe, vial	ABRILADA (adalimumab-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)	IDACIO (adalimumab-aacf)	
HUMIRA (adalimumab)	adalimumab-aaty	
KINERET (anakinra)	adalimumab-adaz	
methotrexate	adalimumab-adbm	
OLUMIANT (baricitinib)	adalimumab-fkjp	
OTEZLA (apremilast)	adalimumab-ryvk	
RINVOQ (upadacitinib)	AMJEVITA (adalimumab-atto)	
RINVOQ LQ (upadacitinib)	ARCALYST (rilonacept)	
SIMPONI (golimumab)	BIMZELX (bimekizumab-bkzx)	
TALTZ (ixekizumab)	CIMZIA (certolizumab)	
TYENNE Syringe, Vial (tocilizumab-aazg)	COSENTYX (secukinumab)	
XELJANZ (tofacitinib) tablet	CYLTEZO (adalimumab-adbm)	
	ENTYVIO (vedolizumab)	
	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 (ritlecitinib)	
	OMVOH (mirikizumab-mrkz)	
	ORENCIA (abatacept)	
	OTREXUP (methotrexate)	
	OTULFI (ustekinumab-aauz)	
	PYZCHIVA (ustekinumab-ttwe)	
	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)	

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
CYTOKINE & CAM ANTAGONISTS DUR+ *(continued)*		
	TOFIDENCE (tocilizumab-bavi)	See previous page for additional PA Criteria/DUR+ Rules
	TREMFYA (guselkumab)	
	TREXALL (methotrexate)	
	TYENNE Autoinjector (tocilizumab-aazg)	
	XATMEP (methotrexate)	
	XELJANZ (tofacitinib) solution	
	XELJANZ XR (tofacitinib)	
	YESINTEK (ustekinumab-kfce)	
	YUFLYMA (adalimumab-aaty)	
	YUSIMRY (adalimumab-aqvh)	
	ZYMFENTRA (infliximab-dyyb)	
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	
ALTUVIIIO	JIVI	
FEIBA	KCENTRA	
HEMOFIL M	OBIZUR	
HUMATE-P	VONVENDI	
KOATE		
KOGENATE FS		
FACTOR VIII		
KOVALTRY		
NOVOEIGHT		
NUWIQ		
RECOMBINATE		
WILATE		
XYNTHA, XYNTHA SOLOFUSE		

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
FACTOR DEFICIENCY PRODUCTS DUR+ *(continued)*		
FACTOR IX		
ALPHANINE SD	BEQVEZ	
ALPROLIX	REBINYN	
BENEFIX		
IDELVION		
IXINITY		
PROFILNINE		
RIXUBIS		
OTHER HEMOPHILIA PRODUCTS		
COAGADEX (factor X)	ALHEMO (concizumab-mtci)	
FIBRYGA (fibrinogen)	CORIFACT (factor XIII)	
HEMLIBRA (emicizumab-kxwh) DUR+	HYMPAVZI (marstacimab-hncq)	
RIASTAP (fibrinogen)	NOVOSEVEN RT (factor VII)	
	SEVENFACT (factor VII)	
	TRETTEN (factor XIII)	
FIBROMYALGIA/NEUROPATHIC PAIN AGENTS		
duloxetine (generic CYMBALTA)	CYMBALTA (duloxetine)	
gabapentin	DIRZALMA SPRINKLE (duloxetine)	
pregabalin	duloxetine 40 mg DR capsules (generic IRENKA)	
SAVELLA (milnacipran)	gabapentin ER	
	GABARONE (gabapentin)	
	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**
		
		See next page for additional PA Criteria/DUR+ Rules

levofloxacin tablet	CIPRO (ciprofloxacin)	
	ciprofloxacin suspension	
	levofloxacin solution	
	moxifloxacin	
	ofloxacin	

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
FLUOROQUINOLONES DUR+ *(continued)*		
		See previous page for additional PA Criteria/DUR+ Rules • 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
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)	
GI ULCER THERAPIES		
H2 RECEPTOR ANTAGONISTS		**Prilosec suspension** • Automatic approval issued for 0-2 years of age
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	KONVOMEP (omeprazole/sodium bicarbonate)	
	lansoprazole Rx	
	NEXIUM (esomeprazole) capsule	
	omeprazole/sodium bicarbonate	
	PREVACID (lansoprazole)	
	PRILOSEC (omeprazole) packet	
	PROTONIX (pantoprazole)	
	rabeprazole	
	ZEGERID (omeprazole/sodium bicarbonate)	

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
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** • Requires clinical review **PROAIR DIGIHALER** – Require clinical review **Minimum Age Limit** • **18 years**: AIRSUPRA **Quantity Limit** (per 31 days) • **2 inhalers**: AIRSUPRA -- **MANUAL PA**
ASMANEX (mometasone)	ALVESCO (ciclesonide)	
budesonide 0.25 mg and 0.5 mg	ARMONAIR DIGIHALER (fluticasone)	
fluticasone diskus	ARNUITY ELLIPTA (fluticasone)	
fluticasone HFA	ASMANEX HFA (mometasone)	
PULMICORT FLEXHALER (budesonide)	budesonide 1 mg	
QVAR REDIHALER (beclomethasone)	FLOVENT HFA (fluticasone)	
	FLOVENT DISKUS (fluticasone)	
	PULMICORT (budesonide) nebulizer solution	
GLUCOCORTICOID/BRONCHODILATOR COMBINATIONS		
ADVAIR DISKUS (fluticasone/salmeterol)	AIRDUO DIGIHALER (fluticasone/salmeterol)	
ADVAIR HFA (fluticasone/salmeterol)	AIRSUPRA (albuterol/budesonide)	
DULERA (mometasone/formoterol)	BREO ELLIPTA (fluticasone/vilanterol)	
fluticasone/salmeterol diskus	BREYNA (budesonide/formoterol)	
fluticasone/salmeterol HFA	budesonide/formoterol	
SYMBICORT (budesonide/formoterol)	fluticasone/vilanterol	
	WIXELA INHUB (fluticasone/salmeterol)	
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 **Maximum Age Limit** • **18 years**: NGENLA and SKYTROFA See next page for additional PA Criteria/DUR+ Rules
NORDITROPIN FLEXPRO (somatropin)	NGENLA (somatrogon-ghla)	
SKYTROFA (lonapegsomatropin-tcgd)	OMNITROPE (somatropin)	
	SEROSTIM (somatropin)	
	SOGROYA (somapacitan-beco)	
	VOXZOGO (vosoritide)	
	ZOMACTON (somatropin)	

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		See previous page for additional PA Criteria/DUR+ Rules **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
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)	
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)	

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
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		
BAQSIMI (glucagon)	GVOKE (glucagon) Step Edit	**Minimum Age Limit** • **1 year**: BAQSIMI • **2 years**: GVOKE • **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)	**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
metformin ER (generic GLUCOPHAGE XR)	metformin ER (generic FORTAMET)	
	metformin ER (generic GLUMETZA)	
	metformin solution	
	RIOMET (metformin)	
JANUMET (sitagliptin/metformin)	alogliptin	
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)	

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
HYPOGLYCEMICS, INCRETIN MIMETICS/ENHANCERS DUR+		
BYETTA (exenatide) TRULICITY (dulaglutide) VICTOZA (liraglutide)	BYDUREON (exenatide) exenatide liraglutide MOUNJARO (tirzepatide) OZEMPIC (semaglutide) RYBELSUS (semaglutide) SOLIQUA (insulin glargine/lixisenatide) SYMLINPEN (pramlintide) XULTOPHY (insulin degludec/liraglutide)	**Minimum Age Limit** • **10 years**: BYDUREON BCISE, TRULICITY, VICTOZA • **18 years**: BYETTA, MOUNJARO, OZEMPIC, RYBELSUS **Preferred Criteria** Documented diagnosis of Type 2 Diabetes **and** no history of 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 preferred BYETTA or VICTOZA in the past 6 months • **OR** • Documented diagnosis of Type 2 Diabetes **AND** • 84 days of therapy with the request 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. **RYBELSUS 1.5 mg and 3 mg** Require clinical review
HYPOGLYCEMICS, INSULINS & RELATED AGENTS DUR+		
HUMALOG MIX 75/25 vial (insulin lispro/lispro protamine) HUMULIN 70/30 vial (insulin NPH/regular) HUMULIN N (insulin NPH) HUMULIN R (insulin regular) HUMULIN R U-500 (insulin regular) insulin aspart insulin aspart protamine mix 70/30 vial insulin lispro insulin lispro protamine mix 75/25 vial LANTUS (insulin glargine) TOUJEO (insulin glargine) TOUJEO MAX (insulin glargine)	ADMELOG (insulin lispro) AFREZZA (insulin regular) APIDRA (insulin glulisine) BASAGLAR (insulin glargine) FIASP (insulin aspart/niacinamide) HUMALOG; HUMALOG JUNIOR, KWIKPEN, TEMPO PEN (insulin lispro) HUMALOG MIX KWIKPEN 50/50, 75/25 (insulin lispro/lispro protamine) HUMULIN 70/30 KWIKPEN (insulin N/regular) HUMULIN N KWIKPEN (insulin N) insulin degludec insulin glargine insulin glargine-yfgn LEVEMIR (insulin detemir) LYUMJEV (insulin lispro-aabc) NOVOLIN 70/30 (insulin NPH/regular)	**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.

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
HYPOGLYCEMICS, INSULINS & RELATED AGENTS DUR+ *(continued)*		
	NOVOLIN N (insulin NPH)	See previous page for additional PA Criteria/DUR+ Rules
	NOVOLIN R (insulin regular)	
	NOVOLOG (insulin aspart)	
	NOVOLOG MIX 70/30 (insulin aspart protamine/aspart)	
	REZVOGLAR (insulin glargine-aglr)	
	SEMGLEE (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)	
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 **OFEV** • Documented diagnosis of Idiopathic Pulmonary Fibrosis **OR** • 90 days of therapy with Ofev in the past 105 days **ESBRIET or pirfenidone** • Requires clinical review
	pirfenidone	

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
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** • Requires clinical review See below for additional PA Criteria/DUR+ Rules
FASENRA (benralizumab)	NUCALA (mepolizumab)	
XOLAIR (omalizumab)	TEZSPIRE (tezepelumab-ekko)	
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** ○ **COPD** – **MANUAL PA** ○ **Eosinophilic Esophagitis** – **MANUAL PA** ○ **Nasal Polyposis** – **MANUAL PA** ○ **Prurigo Nodularis** – **MANUAL PA**		**FASENRA** • Requires clinical review – **MANUAL PA** **NUCALA** • Requires clinical review **TEZSPIRE** • Requires clinical review **XOLAIR** • 1 claim with XOLAIR in the past 45 days **OR** • New starts require clinical review – **MANUAL PA**
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 next page 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 AGENTS	NON-PREFERRED AGENTS	PA CRITERIA

See previous page for additional PA Criteria/DUR+ Rules

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 MYHIBBIN Suspension 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 tacrolimus IR in the past 105 days **OR**
  - 90 days of therapy with the requested agent 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		
ANTIHISTAMINE/CORTICOSTEROID COMBINATIONS		
	azelastine/fluticasone	
	DYMISTA (azelastine/fluticasone)	
	RYALTRIS (olopatadine/mometasone)	
ANTIHISTAMINES		
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 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, MOTEGRITY, 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)	MOTEGRITY (prucalopride)	
	MOVANTIK (naloxegol)	
	prucalopride	
	RELISTOR (methylnaltrexone)	
	SYMPROIC (naldemedine)	
IRRITABLE BOWEL SYNDROME DIARRHEA		
dicyclomine	alosetron	
ED-SPAZ (hyoscyamine)	LOTRONEX (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)	

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

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
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 **JUXTAPID** – **MANUAL PA** **KYNAMRO** • Requires clinical review **LEQVIO** • Requires clinical review **NEXLETOL and NEXLIZET** • Require clinical review **PRALUENT** – **MANUAL PA**
	NEXLETOL (bempedoic acid)	
	NEXLIZET (bempedoic acid/ezetimibe)	
ANGIOPOIETIN-LIKE 3 INHIBITORS		
	EVKEEZA (evinacumab-dgnb)	
BILE ACID SEQUESTRANTS		
cholestyramine	colesevelam	
cholestyramine light	COLESTID (colestipol)	
LIPOTROPICS, OTHER (NON-STATINS)		
colestipol tablet	colestipol packet	**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
	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)	

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
LIPOTROPICS, OTHER (NON-STATINS) *(continued)*		
NIACIN		See previous page for additional PA Criteria/DUR+ Rules
niacin ER		
OMEGA-3 FATTY ACIDS		
omega-3 acid ethyl esters	icosapent ethyl	
	LOVAZA (omega-3 acid ethyl esters)	
PCSK-9 INHIBITORS		
REPATHA (evolocumab)	LEQVIO (inclisiran)	
	PRALUENT (alirocumab)	
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**
	GRASTEK	
	ORALAIR	
	RAGWITEK	
EPINEPHRINE		
epinephrine (Mylan)	AUVI-Q (epinephrine)	
	epinephrine (all other manufacturers)	
	EPIPEN (epinephrine)	
	EPIPEN JR (epinephrine)	
	NEFFY (epinephrine)	

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
MISCELLANEOUS BRAND/GENERIC *(continued)*		
MISCELLANEOUS		See previous page for additional PA Criteria/DUR+ Rules
alprazolam	alprazolam ER	
hydroxyzine HCL	CAMZYOS (mavacamten)	
hydroxyzine pamoate	CRENESSITY (crinecerfont)	
megestrol	EVRYSDI (risdiplam)	
REVLIMID (lenalidomide)	KORLYM (mifepristone)	
	lenalidomide	
	TRYNGOLZA (olezarsen)	
	VERQUVO (vericiguat)	
	VISTARIL (hydroxyzine pamoate)	
	XANAX, XANAX XR (alprazolam)	
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**
AUSTEOD XR (deutetrabenazine)	XENAZINE (tetrabenazine)	
INGREZZA (valbenazine)		
INGREZZA SPRINKLE (valbenazine)		
tetrabenazine		
		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** ew starts require clinical review – **MANUAL PA**
MULTIPLE SCLEROSIS AGENTS DUR+		
BETASERON (interferon beta-1b)	AMPYRA (dalfampridine)	**Preferred Agents** • Documented diagnosis of multiple sclerosis
COPAXONE (glatiramer) 20 mg	AUBAGIO (teriflunomide)	
dalfampridine ER	AVONEX (interferon beta-1a)	
dimethyl fumarate	BAFIERTAM (monomethyl fumarate)	**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
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, PONVORY, TASCENSO ODT, and ZEPOSIA** • Require clinical review
	KESIMPTA PEN (ofatumumab)	
	MAVENCLAD (cladribine)	See next page for additional PA Criteria/DUR+ Rules

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
MULTIPLE SCLEROSIS AGENTS DUR+ *(continued)*		
	MAYZENT (siponimod)	See previous page for additional PA Criteria/DUR+ Rules **MAVENCLAD** – **MANUAL PA** **MAYZENT** – **MANUAL PA** **OCREVUS and OCREVUS ZUNOVO** – **MANUAL PA**
	OCREVUS (ocrelizumab)	
	OCREVUS ZUNOVO (ocrelizumab/hyaluronidase-ocsq)	
	PLEGRIDY (peginterferon beta-1a)	
	PONVORY (ponesimod)	
	TASCENSO ODT (fingolimod)	
	TECFIDERA (dimethyl fumarate)	
	VUMERITY (diroximel fumarate)	
	ZEPOSIA (ozanimod)	
MUSCULAR DYSTROPHY AGENTS		
EMFLAZA (deflazacort)	AGAMREE (vamorolone)	**AGAMREE** – **MANUAL PA** **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 **Non-Preferred Criteria – COX II Selective** • No history of a contraindicated GI disorder or coagulation disorder **AND** • Documented diagnosis of Osteoarthritis, Rheumatoid Arthritis, Familial Adenomatous Polyposis, or Ankylosing Spondylitis **AND** • Have tried 1 preferred COX-II selective agent **OR** • 90 days of therapy with the requested agent in the past 105 days See next page for additional PA Criteria/DUR+ Rules
meloxicam	CELEBREX (celecoxib)	
	celecoxib	
	ELYXYB (celecoxib)	
NON-SELECTIVE		
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 ER, indomethacin suppository	
ketoprofen	ketoprofen	

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
NSAIDS *(continued)*		
ketorolac	kiprofen	See previous page for additional PA Criteria/DUR+ Rules
nabumetone	LOFENA (diclofenac potassium)	
naproxen 250 mg, 500 mg	meclofenamate	**Non-Preferred Criteria – Non-Selective & Combinations** • No history of a contraindicated GI disorder or coagulation disorder **AND** • Have tried 2 different preferred non-selective agents in the past 6 months
piroxicam	mefenamic acid	
sulindac	NALFON (fenoprofen)	
	NAPRELAN (naproxen)	
	NAPROSYN 375 mg (naproxen)	
	naproxen 375 mg, naproxen CR 375 mg, naproxen ER 500 mg	
	oxaprozin	
	RELAFEN DS (nabumetone)	
	TOLECTIN 600 mg (tolmetin)	
	tolmetin	
NSAID/GI PROTECTANT COMBINATIONS		
	ARTHROTEC 50 mg, 75 mg (diclofenac/misoprostol)	
	diclofenac/misoprostol	
	ibuprofen/famotidine	
	naproxen/esomeprazole	
	VIMOVO (naproxen/esomeprazole)	
OPHTHALMIC AGENTS		

ANTIBIOTICS		**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
		
		Non-Preferred Criteria
		• **Anti-Inflammatory Agents**
		  ○ Have tried 2 different preferred agents in the past 6 months
		• **Dry Eye Agents / CEQUA**
		  ○ 4 claims for RESTASIS Droperette and XIIDRA in the past 6 months
		EYSUVIS
		Requires clinical review
		
		See next page for additional PA Criteria/DUR+ Rules

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)		

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
OPHTHALMIC AGENTS *(continued)*		
tobramycin/dexamethasone		See previous page for additional PA Criteria/DUR+ Rules
ZYLET (tobramycin/loteprednol)		
ANTI-INFLAMMATORY AGENTS		**MIEBO** • Requires clinical review **RESTASIS Multidose** • Require clinical review **TYRVAYA** • Requires clinical review **VEVYE** Requires clinical review
dexamethasone	ACULAR, ACULAR LS (ketorolac)	
diclofenac sodium	ACUVAIL (ketorolac)	
difluprednate	bromfenac	
FLAREX (fluorometholone)	BROMSITE (bromfenac)	
fluorometholone	DUREZOL (difluprednate)	
flurbiprofen	FML (fluorometholone)	
FML FORTE (fluorometholone)	ILEVRO (nepafenac)	
ketorolac	INVELTYS (loteprednol)	
MAXIDEX (dexamethasone)	LOTEMAX, LOTEMAX SM (loteprednol)	
PRED MILD (prednisolone)	loteprednol	
prednisolone acetate	NEVANAC (nepafenac)	
prednisolone sodium phosphate	PRED FORTE (prednisolone)	
	PROLENSA (bromfenac)	
DRY EYE AGENTS		
RESTASIS Droperette (cyclosporine)	CEQUA (cyclosporine)	
XIIDRA (lifitegrast)	cyclosporine	
	EYSUVIS (loteprednol)	
	MIEBO (perfluorohexyloactane)	
	RESTASIS Multidose (cyclosporine)	
	TYRVAYA (varenicline)	
	VEVYE (cyclosporine)	
OPHTHALMIC, GLAUCOMA AGENTS		
BETA BLOCKERS		**Minimum Age Limit** • **18 years**: IYUZEH **Non-Preferred Criteria** • Have tried 2 different preferred agents in the past 6 months **OR** • 90 days of therapy with the requested agent in the past 105 days
BETIMOL (timolol)	betaxolol	
carteolol	BETOPTIC S (betaxolol)	
ISTALOL (timolol)	timolol droperette, daily drop, gel	
levobunolol	TIMOPTIC; TIMOPTIC OCUDOSE, XE (timolol)	
timolol drops 0.25%, 0.5%		
CARBONIC ANHYDRASE INHIBITORS		
dorzolamide	AZOPT (brinzolamide)	
	brinzolamide	
COMBINATION AGENTS		
COMBIGAN (brimonidine/timolol)	brimonidine/timolol	
dorzolamide/timolol	COSOPT (dorzolamide/timolol)	
SIMBRINZA (brinzolamide/brimonidine)	dorzolamide/timolol PF	
PARASYMPATHOMIMETICS		
pilocarpine	PHOSPHOLINE IODIDE (echothiophate iodide)	

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
OPHTHALMIC, GLAUCOMA AGENTS *(continued)*		
PROSTAGLANDIN ANALOGS		See previous page for additional PA Criteria/DUR+ Rules
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)	LASTACAFT (alcaftadine)	
	VERKAZIA (cyclosporine)	
	ZERVIATE (cetirizine)	
OPIATE DEPENDENCE TREATMENTS		
DEPENDENCE		Buprenorphine/naloxone provider summary found **here** **SUBLOCADE** – **MANUAL PA** **VIVITROL** – **MANUAL PA**
buprenorphine/naloxone SL tablet DUR+	BRIXADI (buprenorphine)	
naltrexone	buprenorphine DUR+	
SUBOXONE (buprenorphine/naloxone) DUR+	buprenorphine/naloxone film DUR+	
	lofexidine	
	LUCEMYRA (lofexidine)	
	SUBLOCADE (buprenorphine)	
	VIVITROL (naltrexone)	
	ZUBSOLV (buprenorphine/naloxone)	
TREATMENT		
KLOXXADO (naloxone)	LIFEMS NALOXONE (naloxone convenience kit)	
naloxone		
NARCAN (naloxone)		

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
OPIATE DEPENDENCE TREATMENTS *(continued)*		
OPVEE (nalmefene)		See previous page for additional PA Criteria/DUR+ Rules
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 otic treatment with ciprofloxacin ophthalmic solution **and** 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)	
	RENVELA (sevelamer)	
	sevelamer carbonate packet, sevelamer HCl	
	VELPHORO (sucroferric oxyhydroxide)	
	XPHOZAH (tenapanor)	
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		

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
PLATELET STIMULATING AGENTS		
NPLATE (romiplostim)	ALVAIZ (eltrombopag)	
PROMACTA (eltrombopag) tablet	DOPTELET (avatrombopag)	
	MULPLETA (lusutrombopag)	
	PROMACTA (eltrombopag) packet	
	TAVALISSE (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 (patiromer calcium sorbitex)	
PRENATAL VITAMINS		
CLASSIC PRENATAL	All prenatal vitamins are non-preferred except for those specifically indicated as 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		
PRENATAL VITAMINS *(continued)*		
PNV 72, 95, 124, and 137 / IRON / FOLIC ACID	All prenatal vitamins are non-preferred except for those specifically indicated as preferred.	List of Preferred NDC's for Prenatal Vitamins can be found **here**
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
PULMONARY ANTIHYPERTENSIVE AGENTS		
ACTIVIN SIGNALING INHIBITORS		**Minimum Age Limit** • **18 years**: ADEMPAS, OPSYNVI, TADLIQ **Maximum Age Limit** • **12 years**: REVATIO suspension **Preferred Criteria** • **PAH Agents** See next page for additional PA Criteria/DUR+ Rules
	WINREVAIR (sotatercept-csrk)	
COMBINATION AGENTS		
	OPSYNVI (macitentan/tadalafil)	
ENDOTHELIN RECEPTOR ANTAGONISTS		
ambrisentan	OPSUMIT (macitentan)	
bosentan	TRACLEER (bosentan)	
LETAIRIS (ambrisentan)	TRYVIO (aprocitentan)	

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
PULMONARY ANTIHYPERTENSIVE AGENTS (*continued*)		
PDE5 INHIBITORS		See previous page for additional PA Criteria/DUR+ Rules
sildenafil (generic REVATIO) tablet, suspension	ADCIRCA (tadalafil)	○ Documented diagnosis of pulmonary hypertension • **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 suspension** • < 12 years of age **AND** • Documented diagnosis of pulmonary hypertension, patent ductus arteriosus, or persistent fetal circulation, or a history of a heart transplant **OR** • 90 days stable therapy with sildenafil suspension in the past 105 days **Non-Preferred Criteria** • Documented diagnosis of pulmonary hypertension **AND** • Have tried 1 preferred PAH agent in the past 6 months **OR** • 90 days of therapy with the requested agent in the past 105 days **LIQREV, OPSUMIT, OPSYNVI, ORENITRAM ER, TYVASO, and VENTAVIS** • Require clinical review
tadalafil	ALYQ (tadalafil)	
	LIQREV (sildenafil)	
	REVATIO (sildenafil)	
	TADLIQ (tadalafil)	
PROSTACYCLINS		
	ORENITRAM ER (treprostinil)	
	ORENITRAM TITRATION PAK (treprostinil)	
	TYVASO (treprostinil)	
	VENTAVIS (iloprost)	
SELECTIVE PROSTACYCLINE RECEPTOR AGONISTS		
	UPTRAVI (selexipag)	
SOLUABLE GUANYLATE CYCLASE STIMULATORS		
	ADEMPAS (riociguat)	

ADEMPAS
- Documented diagnosis of persistent/recurrent chronic thromboembolic pulmonary hypertension (WHO Group 4) or pulmonary arterial hypertension (WHO Group 1) **AND**
- Have tried 1 preferred PAH agent in the past 6 months **OR**
- 90 days of therapy with ADEMPAS in the past 105 days

TADLIQ
- Documented diagnosis of pulmonary hypertension **AND**
- Have tried preferred sildenafil 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 in the past 6 months **AND**
- Have tried 1 preferred PDE5 inhibitor in the past 6 months **OR**
- 90 days of therapy with UPTRAVI in the past 105 days

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
ROSACEA TREATMENTS		
metronidazole	AVAR (sulfacetamide sodium/sulfur)	Note: • Topical Sulfonamides used for Rosacea will require a manual PA for age > 21 years. • Other labeled indications are limited to < 21 years.
	AVAR LS (sulfacetamide sodium/sulfur)	
	AVAR-E (sulfacetamide sodium/sulfur)	
	BP 10-1 (sulfacetamide sodium/sulfur)	
	brimonidine	
	EPSOLAY (benzoyl peroxide)	
	FINACEA (azelaic acid)	
	METROCREAM (metronidazole)	
	METROGEL (metronidazole)	
	MIRVASO (brimonidine)	
	NORITATE (metronidazole)	
	OVACE (sulfacetamide sodium)	
	OVACE PLUS (sulfacetamide sodium)	
	RHOFADE (oxymetazoline)	
	ROSADAN (metronidazole)	
	ROSULA (sulfacetamide sodium/sulfur)	
	sodium sulfacetamide	
	sodium sulfacetamide/sulfur	
	SOOLANTRA (ivermectin)	
	SUMADAN (sulfacetamide sodium/sulfur)	
	SUMADAN XLT (sulfacetamide sodium/sulfur/avob	
	SUMAXIN (sulfacetamide sodium/sulfur)	
	SUMAXIN CP (sulfacetamide sodium/sulfur)	
	SUMAXIN TS (sulfacetamide sodium/sulfur)	
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 See next page 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	

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
SEDATIVE HYPNOTIC AGENTS *(continued)*		
OTHERS DUR+		See previous page for additional PA Criteria/DUR+ Rules
eszopiclone	AMBIEN (zolpidem)	**HETLIOZ capsules** • Age 18 years or older **AND** • Documented diagnosis of circadian rhythm sleep disorder OR • Age 16 years and older **AND** • 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
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.

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
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 CONTRACEPTIVES DUR+		
All oral contraceptives are preferred except for those specifically indicated as non-preferred.	AMETHIA (levonorgestrel/ethinyl estradiol)	
	AMETHYST (levonorgestrel/ethinyl estradiol)	
	BALCOLTRA (levonorgestrel/ethinyl estradiol)	
	BEYAZ (drospirenone/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)	

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
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)	
SKELETAL MUSCLE RELAXANTS DUR+		
baclofen 5 mg, 10 mg, 20 mg tablet	AMRIX (cyclobenzaprine)	**Quantity Limit** • **84 tablets/180 days**: carisoprodol **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 105 days **AND** • History of 1 claim for cyclobenzaprine in the past 21 **Carisoprodol with codeine** • Requires clinical review. **Metaxalone 640 mg and TANLOR** • Requires clinical review
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/caffeine)	
	NORGESIC FORTE (orphenadrine/aspirin/caffeine)	
	orphenadrine	
	orphenadrine/aspirin/caffeine	
	ORPHENGESIC FORTE (orphenadrine/aspirin/caffeine)	
	SOMA (carisoprodol)	
	TANLOR (methocarbamol)	
	tizanidine capsule	
	ZANAFLEX (tizanidine)	

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
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		
STEROIDS (TOPICAL)		

LOW POTENCY		**Non-Preferred Criteria**
		• **Low Potency**
		  ○ Have tried 2 different preferred low potency agents in the past 6 months
		• **Medium Potency**
		  ○ Have tried 2 different preferred medium potency agents in the past 6 months
		• **High Potency**
		  ○ Have tried 2 different preferred high potency agents in the past 6 months
		• **Very High Potency**
		  ○ Have tried 2 different preferred very high potency agents in the past 6 months
		
		Clobetasol 0.025%
		• Requires clinical review

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)	

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
STEROIDS (TOPICAL) *(continued)*		
VERY HIGH POTENCY		See previous page for additional PA Criteria/DUR+ Rules
clobetasol cream, foam, gel, ointment, shampoo, solution	APEXICON E (diflorasone)	
clobetasol-E	BRYHALI (halobetasol)	
halobetasol	clobetasol emulsion	
	clobetasol 0.025% cream	
	CLOBEX (clobetasol)	
	CLODAN (clobetasol)	
	DIPROLENE (betamethasone)	
	halobetasol	
	IMPEKLO (clobetasol)	
	IMPOYZ (clobetasol) 0.025% cream	
	LEXETTE (halobetasol)	
	OLUX (clobetasol)	
	TEMOVATE (clobetasol)	
	TOVET (clobetasol)	
	ULTRAVATE (halobetasol)	
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, QELBREE, QUILLICHEW, QUILLIVANT XR, RELEXXII ER, RITALIN LA, VYVANSE, XELSTRYM • **7 years**: XYREM • **13 years**: MYDAYIS • **16 years**: modafinil • **18 years**: armodafinil, SUNOSI, WAKIX **Maximum Age Limit** • **18 years**: clonidine ER, COTEMPLA XR ODT, DAYTRANA, EVEKEO ODT, guanfacine ER **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 See next page for additional PA Criteria/DUR+ Rules
dexmethylphenidate	ADDERALL (dextroamphetamine/amphetamine)	
dextroamphetamine	amphetamine	
dextroamphetamine/amphetamine	EVEKEO (amphetamine)	
Methylphenidate tablet	EVEKEO ODT (amphetamine)	
PROCENTRA (dextroamphetamine)	FOCALIN (dexmethylphenidate)	
	methamphetamine	
	METHYLN (methylphenidate)	
	Methylphenidate chewable tablet	
	RITALIN (methylphenidate)	
	ZENZEDI (dextroamphetamine)	
LONG-ACTING		
ADDERALL XR (dextroamphetamine/amphetamine)	ADZENYS XR ODT (amphetamine)	
CONCERTA (methylphenidate)	APTENSIO XR (methylphenidate)	

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
STIMULANTS AND RELATED AGENTS DUR+ *(continued)*		
dexmethylphenidate ER	AZSTARYS (serdexmethylphenidate/dexmethylphenidate)	See previous page for additional PA Criteria/DUR+ Rules Spansule, DYANAVEL XR Tablet, FOCALIN XR, JORNAY PM, METADATE CD, METHYLIN ER, MYDAYIS 37.5 mg & 50 mg, QUILLICHEW, RELEXXII 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 **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 **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 **VYVANSE** • Documented diagnosis of binge eating disorder or ADD/ADHD OR • 90 days of therapy with Vyvanse in the past 90 days See next page for additional PA Criteria/DUR+ Rules
dextroamphetamine ER	COTEMPLA XR ODT (methylphenidate)	
dextroamphetamine/amphetamine ER (generic ADDERALL XR)	DAYTRANA (methylphenidate)	
DYANAVEL XR (amphetamine) suspension	DEXEDRINE (dextroamphetamine)	
lisdexamfetamine	dextroamphetamine/amphetamine ER (generic MYDAYIS ER)	
methylphenidate CD	DYANAVEL XR (amphetamine) tablets	
methylphenidate ER tablet	FOCALIN XR (dexmethylphenidate)	
methylphenidate LA	JORNAY PM (methylphenidate)	
QUILLICHEW ER (methylphenidate)	methylphenidate patch	
QUILLIVANT XR (methylphenidate)	methylphenidate ER capsule	
VYVANSE (lisdexamfetamine) capsules	MYDAYIS (dextroamphetamine/amphetamine)	
	RELEXXII (methylphenidate)	
	RITALIN LA (methylphenidate)	
	VYVANSE (lisdexamfetamine) chewable tablets	
	XELSTRYM (dextroamphetamine)	
NARCOLEPSY		
armodafinil	NUVIGIL (armodafinil)	
modafinil	PROVIGIL (modafinil)	
SUNOSI (solriamfetol)	sodium oxybate	
XYREM (sodium oxybate)	WAKIX (pitolisant)	
	XYWAV (calcium/magnesium/potassium/sodium oxybate)	
NON-STIMULANTS		
atomoxetine	INTUNIV (guanfacine)	
clonidine ER	NEXICLON XR (clonidine)	
guanfacine ER	ONYDA XR (clonidine)	
QELBREE (viloxazine)	STRATTERA (atomoxetine)	

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

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

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

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

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		
Modafinil • Documented diagnosis of narcolepsy, obstructive sleep apnea, shift work sleep disorder, depression, sleep deprivation or Steinert Myotonic Dystrophy Syndrome		
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 for 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)	

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
UREA CYCLE DISORDER AGENTS		
CARBAGLU (carglumic acid)	BUPHENYL (sodium phenylbutyrate)	
	carglumic acid	
	OLPRUVA (sodium phenylbutyrate)	
	PHEBURANE (sodium phenylbutyrate)	
	RAVICTI (glycerol phenylbutyrate)	