MISSISSIPPI DIVISION OF MEDICAID
UNIVERSAL PREFERRED DRUG LIST

EFFECTIVE 10/1/2025
VERSION 2025_11
Updated 10/1/2025

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

ACNE AGENTS

PREFERRED AGENTS	NON-PREFERRED AGENTS
ANTI-INFECTIVES	
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
tretinoin cream	AKLIEF (trifarotene)
	ALTRENO (tretinoin)
	ATRALIN (tretinoin)
	DIFFERIN (adapalene)
	FABIOR (tazarotene)
	tretinoin gel

PA CRITERIA

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

	tretinoin microsphere
OTHERS/COMBINATION PRODUCTS	
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

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
ARALAST NP		
GLASSIA		
PROLASTIN C		
ZEMAIRA		

ALZHEIMER'S AGENTS DUR+

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
CHOLINESTERASE INHIBITORS		**Preferred Criteria** • Documented approvable diagnosis **Non-Preferred Criteria** • Documented approvable diagnosis **AND** • Have tried 2 different preferred agents in the past 6 months **NAMZARIC** • Requires clinical review **ZUNVEYL** • Requires clinical review
donepezil 5 mg, 10 mg ODT, tablets	ADLARITY (donepezil)	
galantamine	ARICEPT (donepezil)	
galantamine ER	donepezil 23 mg tablet	
rivastigmine	EXELON (rivastigmine)	
	ZUNVEYL (benzgalantamine gluconate)	
NMDA RECEPTOR ANTAGONISTS		
memantine	memantine ER	
	NAMENDA (memantine)	
	NAMENDA XR (memantine ER)	
COMBINATION AGENTS		
	NAMZARIC (memantine/donepezil)	
	memantine/donepezil ER	

ANALGESICS, OPIOID-SHORT ACTING DUR+

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
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, oxy 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+

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
BUTRANS (buprenorphine)	BELBUCA (buprenorphine)	**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 preferred agents in the past 6 months
fentanyl patch	buprenorphine patch	
morphine sulfate ER tablet	CONZIP (tramadol)	
	hydrocodone bitartrate ER	
	hydromorphone ER	
	HYSINGLA ER (hydrocodone)	
	methadone	
	methadone intensol	
	METHADOSE (methadone)	
	morphine sulfate ER capsule	
	MS CONTIN (morphine)	

	oxycodone ER	
	OXYCONTIN (oxycodone)	
	oxymorphone ER	
	tramadol ER	

ANALGESICS/ANESTHETICS (TOPICAL)

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
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+

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
testosterone	ANDROGEL (testosterone)	**All Agents** • Limited to male gender **Non-Preferred Criteria** • Have tried 2 different preferred agents in the past 6 months **TLANDO** • Requires clinical review
	JATENZO (testosterone undecanoate)	
	NATESTO (testosterone)	
	TESTIM (testosterone)	
	TLANDO (testosterone undecanoate)	
	VOGELXO (testosterone)	
	UNDECATREX (testosterone undecanoate)	

ANGIOTENSIN MODULATORS DUR+

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
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 ○ 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
benazepril	ACCUPRIL (quinapril)	
captopril	ALTACE (ramipril)	
enalapril	EPANED (enalapril)	
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)	
	valsartan solution	
ARB COMBINATIONS		
ENTRESTO (valsartan/sacubitril) tablet DUR+	ATACAND HCT (candesartan/hydrochlorothiazide)	
irbesartan/hydrochlorothiazide	AVALIDE (irbesartan/hydrochlorothiazide)	
losartan/hydrochlorothiazide	AZOR (olmesartan/hydrochlorothiazide)	
olmesartan/amlodipine	BENICAR HCT (olmesartan/hydrochlorothiazide)	
olmesartan/hydrochlorothiazide	candesartan/hydrochlorothiazide	
telmisartan/hydrochlorothiazide	DIOVAN-HCT (valsartan/hydrochlorothiazide)	
valsartan/amlodipine	EDARBYCLOR (azilsartan/chlorthalidone)	
valsartan/amlodipine/hydrochlorothiazide	ENTRESTO (valsartan/sacubitril) sprinkle capsule	
valsartan/hydrochlorothiazide	EXFORGE (valsartan/amlodipine)	
	EXFORGE HCT (valsartan/amlodipine/hydrochlorothiazide)	
	olmesartan/amlodipine/hydrochlorothiazide	
	telmisartan/amlodipine	
	TRIBENZOR (olmesartan/amlodipine/hydrochlorothiazide)	
	valsartan/sacubitril	
DIRECT RENIN INHIBITORS		
	aliskiren	

	TEKTURNA (aliskiren)	
DIRECT RENIN INHIBITOR COMBINATIONS		
	TEKTURNA HCT (aliskiren/hydrochlorothiazide)	

ANTIBIOTICS (GI) & RELATED AGENTS

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
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)	

ANTIBIOTICS (MISCELLANEOUS)

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
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)

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
bacitracin OTC	CENTANY (mupirocin)	
bacitracin/polymyxin OTC	CENTANY AT (mupirocin)	
gentamicin sulfate	mupirocin cream	
mupirocin ointment	XEPI (ozenoxacin)	
neomycin/bacitracin/polymyxin OTC		

ANTIBIOTICS (VAGINAL)

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
CLEOCIN (clindamycin)	clindamycin phosphate	
NUVESSA (metronidazole)	CLINDESSE (clindamycin)	
	SOLOSEC (secnidazole)	
	XACIATO (clindamycin)	

ANTICOAGULANTS

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
LOW MOLECULAR WEIGHT HEPARIN (LMWH)		**Non-Preferred Criteria** • **LMWH**: ○ Have tried 1 preferred agent in the past 6 months **OR** ○ 90 days of therapy with the requested agent in the past 105 days • **Oral**: ○ Have tried 2 different preferred oral agents in the past 6 months **OR** ○ 90 days of therapy with the requested agent in the past 105 days
enoxaparin	ARIXTRA (fondaparinux)	
	fondaparinux	
	FRAGMIN (dalteparin)	
	LOVENOX (enoxaparin)	
ORAL		
ELIQUIS (apixaban)	dabigatran	
JANTOVEN (warfarin)	PRADAXA (dabigatran) pellet pack	
PRADAXA (dabigatran) capsule	SAVAYSA (edoxaban)	
warfarin	rivaroxaban	
XARELTO (rivaroxaban)		

ANTICONVULSANTS DUR+

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
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 • **5 blister packs**: VALTOCO **Non-Preferred Criteria**
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	Eslicarbazepine	
levetiracetam	felbamate	
levetiracetam ER	FELBATOL (felbamate)	
oxcarbazepine tablet	FINTEPLA (fenfluramine)	

tiagabine	FYCOMPA (perampanel)
topiramate	KEPPRA (levetiracetam)
topiramate sprinkle 15, 25 mg (generic Topamax)	KEPPRA XR (levetiracetam)
TRILEPTAL (oxcarbazepine) suspension	LAMICTAL (lamotrigine)
valproic acid	LAMICTAL XR (lamotrigine)
zonisamide	lamotrigine ER
	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)
	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)

- 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

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

XCOPRI
- Age ≥ 18 years

ANTIDEPRESSANTS, OTHER DUR+

PREFERRED AGENTS	NON-PREFERRED AGENTS
bupropion	AUVELITY (bupropion/dextromethorphan)
bupropion SR	desvenlafaxine ER
bupropion XL	DESYREL (trazodone)
mirtazapine	DRIZALMA SPRINKLE (duloxetine DR)
trazodone	EFFEXOR XR (venlafaxine)
TRINTELLIX (vortioxetine)	EMSAM (selegiline)
venlafaxine	FETZIMA (levomilnacipran)
venlafaxine ER capsule	FORFIVO XL (bupropion)
vilazodone	MARPLAN (isocarboxazid)
	NARDIL (phenelzine)
	nefazodone
	phenelzine
	PRISTIQ (desvenlafaxine)
	REMERON (mirtazapine)
	tranylcypromine
	Trazodone solution
	venlafaxine ER tablet
	VIIBRYD (vilazodone)
	WELLBUTRIN SR (bupropion)
	ZURZUVAE (zuranolone)

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
- 90 days of therapy with the requested agent in the past 105 days

ANTIDEPRESSANTS, SSRIs DUR+

PREFERRED AGENTS	NON-PREFERRED AGENTS
citalopram solution, tablet	CELEXA (citalopram)
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)

Minimum Age Limit
- **6 years**: ZOLOFT
- **7 years**: LEXAPRO, PROZAC
- **8 years**: fluvoxamine
- **18 years**: CELEXA, LUVOX CR, PAXIL, PROZAC 90 mg

Maximum Age Limit
- 60 years CELEXA

Non-Preferred Criteria
- Have tried 2 different preferred agents in the past 6 months **OR**

	sertraline capsule	• 90 days of therapy with the requested agent in the past 105 days
	ZOLOFT (sertraline)	

ANTIEMETICS DUR+

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
5HT3 RECEPTOR BLOCKERS		**Quantity Limit** (per 31 days) • **6 tablets**: AKYNZEO • **100 mL**: ZOFRAN solution **Non-Preferred Agents** • Have tried 1 preferred agent in the past 6 months **AKYNZEO** MANUAL PA Note: Injectables in this class are closed to point of sale. PA required if not administered in clinic/hospital.
ondansetron solution, tablet	ANZIMET (dolasetron)	
ondansetron ODT 4 mg, 8 mg	granisetron	
	ondansetron ODT 16 mg tablet	
	SANCUSO (granisetron)	
ANTIEMETIC COMBINATIONS		
DICLEGIS (doxylamine/pyridoxine)	AKYNZEO (netupitant/palonosetron)	
	BONJESTA (doxylamine/pyridoxine)	
	doxylamine/pyridoxine	
CANNABINOIDS		
	dronabinol	
	MARINOL (dronabinol)	
NMDA RECEPTOR ANTAGONISTS		
aprepitant	EMEND (aprepitant)	

ANTIFUNGALS (ORAL) DUR+

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
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+

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
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)	
miconazole cream, powder, solution OTC	ERTACZO (sertaconazole)	
miconazole/zinc oxide/petrolatum ointment	EXTINA (ketoconazole)	
nystatin cream, ointment, powder	ketoconazole foam	
terbinafine OTC	KETODAN (ketoconazole)	
tolnaftate cream, solution OTC	LOPROX (ciclopirox)	
	luliconazole	
	MICOTRIN AC (clotrimazole)	
	MYCOZYL AC (clotrimazole)	
	MYCOZYL AP (miconazole)	
	naftifine	
	NAFTIN (naftifine)	
	oxiconazole	
	OXISTAT (oxiconazole)	
	tavaborole	
	VOTRIZA-AL (clotrimazole)	
	VUSION (miconazole/zinc oxide/petrolatum)	
ANTIFUNGAL/STEROID COMBINATIONS		
clotrimazole/betamethasone cream	clotrimazole/betamethasone lotion	
nystatin/triamcinolone		

ANTIFUNGALS (VAGINAL)

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
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+

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
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

PREFERRED AGENTS	NON-PREFERRED AGENTS
CGRP ORAL AND NASAL	
NURTEC ODT (rimegepant)	ZAVZPRET (zavegepant)
UBRELVY (ubrogepant)	
INJECTABLES	
sumatriptan	IMITREX (sumatriptan)
	ZEMBRACE SYMTOUCH (sumatriptan)
NASAL	
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)

PA CRITERIA

Minimum Age Limit
- **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

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

ANTIMIGRAINE AGENTS, PROPHYLAXIS

PREFERRED AGENTS	NON-PREFERRED AGENTS
INJECTABLES	
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)

PA CRITERIA

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

*ANTINEOPLASTICS SELECTED SYSTEMIC ENZYME INHIBITORS

PREFERRED AGENTS	NON-PREFERRED AGENTS
BOSULIF (bosutinib) tablet	AFINITOR (everolimus)
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)
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
SUTENT (sunitinib)	DAURISMO (glasdegib)
TAFINLAR (dabrafenib)	ERIVEDGE (vismodegib)

PA CRITERIA

FARYDAK MANUAL PA

IBRANCE
- Documented diagnosis of WD-DDLS for retroperitoneal sarcoma **OR**
- All other indications require clinical review

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**

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)	HERNEXEOS (zongertinib)[NR]
ZYDELIG (idelalisib)	IBRANCE (palbociclib)
ZYKADIA (ceritinib)	IBTROZI (taletrectinib)[NR]
	IDHIFA (enasidenib)
	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)
	MODEYSO (dordaviprone)[NR]
	NERLYNX (neratinib)
	NUBEQA (darolutamide)
	nilotinib
	ODOMZO (sonidegib)
	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)

ANTIOBESITY SELECT AGENTS

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
SAXENDA (liraglutide)	orlistat	**All agents** MANUAL PA required
WEGOVY (semaglutide)	XENICAL (orlistat)	

ANTIPARASITICS (TOPICAL) DUR+

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
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
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)

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

ANTIPARKINSON'S AGENTS (INJECTABLE)

PREFERRED AGENTS	NON-PREFERRED AGENTS
	VYALEV (foscarbidopa/foslevodopa)

VYALEV
- Requires clinical review

ANTIPARKINSON'S AGENTS (ORAL) DUR+

PREFERRED AGENTS	NON-PREFERRED AGENTS
ANTICHOLINERGICS	
benztropine	
trihexyphenidyl	
COMT INHIBITORS	
entacapone	OGENTYS (opicapone)
	tolcapone
DOPAMINE AGONISTS	
pramipexole	NEUPRO (rotigotine)
ropinirole	pramipexole ER
	ropinirole ER
MAO-B INHIBITORS	
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)

Non-Preferred Criteria
- Documented diagnosis of Parkinson's disease **AND**
- Have tried 2 different preferred agents in the past 6 months **OR**
- 90 days of therapy with a selegiline agent in the past 105 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

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

XADAGO
- Documented diagnosis of Parkinso' s Disease **AND**
- History of 30 days of therapy with a carbidopa/levodopa combination agent in the past 45 days **AND**
- History of 30 days of therapy with a selegiline agent the in past 45 days

ANTIPSORIATICS (TOPICAL)

PREFERRED AGENTS	NON-PREFERRED AGENTS
calcipotriene cream	calcipotriene foam, ointment, solution
ENSTILAR (calcipotriene/betamethasone)	calcipotriene/betamethasone
TACLONEX (calcipotriene/betamethasone)	calcitriol ointment
	SORILUX (calcipotriene)
	tazarotene
	VECTICAL (calcitriol)
	VTAMA (tapinarof)
	ZORYVE (roflumilast)

ANTIPSYCHOTICS DUR+

PREFERRED AGENTS	NON-PREFERRED AGENTS
INJECTABLE, ATYPICALS DUR+	
ABILIFY ASIMTUFII (aripiprazole)	ERZOFRI (paliperidone palmitate)
ABILIFY MAINTENA (aripiprazole)	GEODON (ziprasidone)
ARISTADA, ARISTADA INITIO (aripiprazole lauroxil)	olanzapine
INVEGA HAFYERA (paliperidone)	risperidone ER
INVEGA SUSTENNA (paliperidone palmitate)	RYKINDO (risperidone)
INVEGA TRINZA (paliperidone)	ziprasidone
PERSERIS (risperidone)	ZYPREXA (olanzapine)
RISPERIDAL CONSTA (risperidone)	ZYPREXA RELPREVV (olanzapine)
UZEDY (risperidone)	
ORAL DUR+	
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)

Concurrent Therapy Limit for Age < 18 years
- 90 days with ≥ 2 agents in the last 120 days will require a MANUAL PA

Minimum Age Limit
- **3 years**: HALDOL
- **5 years**: RISPERDAL, thioridazine
- **6 years**: ABILIFY, trifluoperazine
- **10 years**: LATUDA, SAPHRIS, SEROQUEL, SYMBYAX
- **12 years**: INVEGA, molindone, perphenazine, pimozide, thiothixene
- **13 years**: REXULTI, ZYPREXA
- **18 years**: ABILIFY MYCITE, CAPLYTA, CLOZARIL, COBENFY, FANAPT, fluphenazine, GEODON, loxapine, LYBALVI, NUPLAZID, perphenazine/amitriptyline, SECUADO, VRAYLAR, and all

Quantity Limit
- **3 syringes/year**: ARISTADA INITIO

Non-Preferred Criteria Oral 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 and PERSERIS
- 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

	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)	

ERZOFRI, generic risperidone ER, RYKINDO ER, and ZYPREXA RELPREVV
- Require clinical review

NUPLAZID
- Documented diagnosis of Parkinson s Disease

VRAYLAR
- Documented diagnosis of schizophrenia, schizoaffective disorder, bipolar disorder **OR**
- Documented diagnosis major depressive disorder **AND**
  - 30 days of therapy with an antidepressant in the past 45 days **OR**
  - 1 claim for a 90-day supply of an antidepressant in the past 105 days

ARIPIPRAZOLE ODT, CLOZAPINE ODT and OPIPZA
- Require clinical review

ANTIRETROVIRALS DUR+

PREFERRED AGENTS	NON-PREFERRED AGENTS
CAPSID INHIBITORS	
	SUNLENCA (lenacapavir)
	YEZTUGO (lenacapvir)
CD4 DIRECTED ATTACHMENT INHIBITORS	
	RUKOBIA (fostemsavir)
CD4 DIRECTED HIV-1 INHIBITORS	
	TROGARZO (ibalizumab-uiyk)
COMBINATION PRODUCTS NRTIs	
abacavir/lamivudine	COMBIVIR (lamivudine/zidovudine)
CABENUVA (cabotegravir/rilpivirine)	EPZICOM (abacavir/lamivudine)
DOVATO (dolutegravir/lamivudine)	
lamivudine/zidovudine	
COMBINATION PRODUCTS NUCLEOSIDE AND NUCLEOTIDE ANALOG RTIs	
DESCOVY (emtricitabine/tenofovir alafenamide)	TRUVADA (emtricitabine/tenofovir)
emtricitabine/tenofovir	
COMBINATION PRODUCTS NUCLEOSIDE AND NUCLEOTIDE ANALOG AND NON-NUCLEOSIDE RTIs	
DELSTRIGO (doravirine/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)
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)	

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

STRIBILD MANUAL PA

SUNLENCA
- Requires clinical review

TROGARZO
- Requires clinical review

TYBOST MANUAL PA

ANTIVIRALS, ORAL

PREFERRED AGENTS	NON-PREFERRED AGENTS
ANTI-CYTOMEGALOVIRUS AGENTS	
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)

PA CRITERIA

PREVYMIS
- Requires clinical review

Valganciclovir solution
- Automatic approval issued for 0-12 years of age

ANTIVIRALS, TOPICAL

PREFERRED AGENTS	NON-PREFERRED AGENTS
ZOVIRAX (acyclovir) cream	acyclovir
	DENAVIR (penciclovir)
	penciclovir
	XERESE (acyclovir/hydrocortisone)
	ZELSUVMI (berdazimer)[NR]
	ZOVIRAX (acyclovir) ointment

PA CRITERIA

AROMATASE INHIBITORS

PREFERRED AGENTS	NON-PREFERRED AGENTS
anastrozole	ARIMIDEX (anastrazole)
exemestane	AROMASIN (exemestane)
letrozole	FEMARA (letrozole)

PA CRITERIA

ATOPIC DERMATITIS

PREFERRED AGENTS	NON-PREFERRED AGENTS
ADBRY (tralokinumab-ldrm)	CIBINQO (abrocitinib)
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	

PA CRITERIA

Minimum Age Limit
- **3 months**: EUCRISA
- **2 years**: ELIDEL, tacrolimus 0.03%
- **12 years**: OPZELURA
- **16 years**: tacrolimus 0.1%

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
  - **Bullous Pemphigoid** MANUAL PA
  - **COPD** MANUAL PA
  - **Chronic Spontaneous Urticaria** 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

BETA BLOCKERS, ANTIANGINALS & SINUS NODE AGENTS [DUR+]

PREFERRED AGENTS	NON-PREFERRED AGENTS
ANTIANGINALS	
	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)

PA CRITERIA

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

CORLANOR MANUAL PA

HEMANGEOL
- Documented diagnosis of infantile hemangioma

Lopressor solution
- Requires clinical review

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

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
ursodiol	BYLVAY (odevixibat)	
	CHENODAL (chenodiol)	
	IQIRVO (elafibranor)	
	LIVDELZI (seladelpar)	
	LIVMARLI (maralixibat)	
	OCALIVA (obeticholic acid)	
	RELTONE (ursodiol)	
	URSO FORTE (ursodiol)	

BLADDER RELAXANT PREPARATIONS DUR+

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
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+

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
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)	BOMYNTRA (denosumab-bnht)[NR]	
raloxifene	BONSITY (teriparatide)	
	calcitonin salmon	
	EVENITY (romosozumab-aqqg)	
	EVISTA (raloxifene)	
	JUBBONTI (denosumab-bbdz)	
	MIACALCIN (calcitonin salmon)	
	OSENVELT (denosumab-bmwo)	
	PROLIA (denosumab)	
	teriparatide	
	STOBOCLO (denoxumab-bmwo)	
	TYMLOS (abaloparatide)	
	WYOST (denosumab-bbdz)	
	XGEVA (denosumab)	

BPH AGENTS DUR+

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
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

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
ANTICHOLINERGIC-BETA AGONIST COMBINATIONS		**Minimum Age Limit** • **6 years**: SPIRIVA RESPIMAT **SPIRIVA RESPIMAT**
ANORO ELLIPTA (umeclidinium/vilanterol)	BEVESPI AEROSPHERE (glycopyrrolate/formoterol)	
COMBIVENT RESPIMAT (ipratropium/albuterol)	DUAKLIR PRESSAIR (aclidinium/formoterol)	
ipratropium/albuterol		

STIOLTO RESPIMAT (tiotropium/olodaterol)	
ANTICHOLINERGIC-BETA 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)
INHALATION SOLUTION DUR+	
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	

- 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

CALCIUM CHANNEL BLOCKERS DUR+

PREFERRED AGENTS	NON-PREFERRED AGENTS
LONG-ACTING	
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)
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)
	NYMALIZE (nimodipine)

PA CRITERIA

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

CALORIC AGENTS

PREFERRED AGENTS	NON-PREFERRED AGENTS
BOOST	All non-preferred caloric/nutritional agents (which are all other products except those specifically listed as preferred) require a manual prior authorization.
BREAKFAST ESSENTIALS	
BRIGHT BEGINNINGS	
DUOCAL	
ENSURE	
NUTREN	
OSMOLITE	
PEDIASURE	
PROMOD	
RESOURCE	
TWOCAL HN	

PA CRITERIA

Non-Preferred Agents MANUAL PA

CEPHALOSPORINS AND RELATED ANTIBIOTICS (ORAL)

PREFERRED AGENTS	NON-PREFERRED AGENTS
BETA LACTAM/BETA-LACTAMASE INHIBITOR COMBINATIONS	
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	

PA CRITERIA

Non-Preferred Criteria All Cephalosporin Generations
- Have tried 2 different preferred agents in the past 6 months

Maximum Age Limit
- **18 years**: cefdinir suspension

COLONY STIMULATING FACTORS

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
FULPHILA (pegfilgrastim-jmdb)	FYLNETRA (pegfilgrastim-pbbk)	
NEUPOGEN (filgrastim)	GRANIX (tbo-filgrastim)	
	LEUKINE (sargramostim)	
	NEULASTA, NEULASTA ONPRO (pegfilgrastim)	
	NIVESTYM (filgrastim-aafi)	
	NYVEPRIA (pegfilgrastim-apgf)	
	RELEUKO (filgrastim-ayow)	
	RYZNEUTA (efbemalenograstim alfa-vuxw)	
	ROLVEDON (eflapegrastim-xnst)	
	STIMUFEND (pegfilgrastim-fpgk)	
	UDENYCA, UDENYCA ONBODY (pegfilgrastim-cbqv)	
	ZARXIO (filgrastim-sndz)	
	ZIEXTENZO (pegfilgrastim-bmez)	

CYSTIC FIBROSIS AGENTS DUR+

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
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)	

CYTOKINE & CAM ANTAGONISTS DUR+

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
ACTEMRA (tocilizumab) syringe, vial	ABRILADA (adalimumab-afzb)	**Non-Preferred Agents** • Require clinical review **IV Administered Agents** • Require clinical review **ACTEMRA (tocilizumab) – Age specific indications:** • Age 2 years and older **AND** • Diagnosis of juvenile arthritis (JIA) • Age 18 years and older **AND** • Diagnosis of rheumatoid arthritis (RA) **OR** • Diagnosis of lung disease with systemic sclerosis (SSc-ILD) **OR** • Diagnosis of giant cell arteritis • Other indications require clinical review • Non-preferred Actemra Actpen requires clinical review **AYSOLA (infliximab-axxq) – Age specific indications:** • Age 6 years and older **AND** • Diagnosis of Crohn's disease **OR** • Diagnosis of ulcerative colitis • Age 18 years and older **AND** • Diagnosis of rheumatoid arthritis (RA) **OR** • Diagnosis of plaque psoriasis (PsO) **OR** • Diagnosis of psoriatic arthritis (PsA) **OR** • Diagnosis of ankylosing spondylitis (AS) **ENBREL (etanercept) – Age specific indications:** • Age 2 years and older **AND** • Diagnosis of juvenile arthritis (JIA) **OR** • Diagnosis of juvenile psoriatic arthritis (PsA) • Age 4 years and older **AND** • Diagnosis of plaque psoriasis (PsO) • Age 18 years and older **AND**
AVSOLA (infliximab-axxq)	ACTEMRA ACTPEN (tocilizumab)	
ENBREL (etanercept)	adalimumab-aaty	
HUMIRA (adalimumab)	adalimumab-adaz	
KINERET (anakinra)	adalimumab-adbm	
methotrexate	adalimumab-fkjp	
OLUMIANT (baricitinib)	adalimumab-ryvk	
ORENCIA CLICKJECT (abatacept)	AMJEVITA (adalimumab-atto)	
ORENCIA VIAL (abatacept)	ANZUPGO (delgocitinib)[NR]	
OTEZLA (apremilast)	ARCALYST (rilonacept)	
RINVOQ (upadacitinib)	BIMZELX (bimekizumab-bkzx)	
RINVOQ LQ (upadacitinib)	CIMZIA (certolizumab)	
SIMPONI (golimumab)	COSENTYX (secukinumab)	

TALTZ (ixekizumab)	CYLTEZO (adalimumab-adbm)
TYENNE Syringe, Vial (tocilizumab-aazg)	ENTYVIO (vedolizumab)
XELJANZ (tofacitinib) tablet	HADLIMA (adalimumab-bwwd)
	HULIO (adalimumab-fkjp)
	HYRIMOZ (adalimumab-adaz)
	IDACIO (adalimumab-aacf)
	ILARIS (canakinumab)
	ILUMYA (tildrakizumab-asmn)
	IMULDOSA (ustekinumab-srlf)
	INFLECTRA (infliximab-dyyb)
	infliximab
	JYLAMVO (methotrexate)
	KEVZARA (sarilumab)
	LEQSELVI (deuruxolitinib)
	LITFULO (ritlecitinib)
	OMVOH (mirikizumab-mrkz)
	ORENCIA SYRINGE (abatacept)
	OTREXUP (methotrexate)
	OTULFI (ustekinumab-aauz)
	PYZCHIVA (ustekinumab-ttwe)
	RASUVO (methotrexate)
	REMICADE (infliximab)
	RENFLEXIS (infliximab-abda)
	SIMLANDI (adalimumab-ryvk)
	SIMPONI ARIA (golimumab)
	SKYRIZI (risankizumab-rzaa)
	SOTYKTU (deucravacitinib)
	SPEVIGO (spesolimab-sbzo)
	STELARA (ustekinumab)
	TOFIDENCE (tocilizumab-bavi)

- Diagnosis of rheumatoid arthritis (RA) **OR**
- Diagnosis of psoriatic arthritis (PsA) **OR**
- Diagnosis of ankylosing spondylitis (AS)

HUMIRA (adalimumab) – Age specific indications:
- Age 2 years and older **AND**
- Diagnosis of juvenile idiopathic arthritis (JIA) **OR**
- Diagnosis of uveitis (UV)

- Age 5 years and older **AND**
- Diagnosis of ulcerative colitis (UC)
- Age 6 years and older **AND**
- Diagnosis of Crohn's disease (CD)

- Age 12 years and older **AND**
- Diagnosis of hidradenitis suppurativa (HS)

- Age 18 years and older **AND**
- Diagnosis of rheumatoid arthritis (RA) **OR**
- Diagnosis of plaque psoriasis (PsO) **OR**
- Diagnosis of psoriatic arthritis (PsA) **OR**
- Diagnosis of ankylosing spondylitis (AS)

KINERET (anakinra) – Age specific indications:
- Age 18 years and older **AND**
- Diagnosis of rheumatoid arthritis (RA)
- Other indications require clinical review

OLUMIANT (baricitinib) – Age specific indications:
- Age 18 years and older **AND**
- Diagnosis of alopecia areata (AA)
- Other indications require clinical review

ORENCIA (abatacept) – Age specific indications:
- Age 2 years and older **AND**
- Diagnosis of juvenile arthritis (JIA) **OR**
- Diagnosis of psoriatic arthritis (PsA)
- Other indication requires clinical review

- Age 18 years and older **AND**
- Diagnosis of rheumatoid arthritis (RA)
- Non-preferred Orencia syringe requires clinical review

OTEZLA (apremilast) – Age specific indications:
- Age 6 years and older **AND**
- Diagnosis of plaque psoriasis (PsO) **OR**
- Diagnosis of psoriatic arthritis (PsA)

- Age 18 years and older **AND**
- Diagnosis of Bechet's disease

RINVOQ (upadacitinib):
- Age 2 years and older **AND**
- Diagnosis of juvenile idiopathic arthritis (JIA)

AND
- History of 3 claims with preferred TNF Inhibitor Avsola, Enbrel, Humira or Simponi

OR
- History of 1 claim with Rinvoq in the past

AND
- NO history of concomitant therapy in the past 30 days with any of the following:
  - A different JAK Inhibitor
  - A different biologic
  - Immunosuppressant azathioprine or cyclosporine

- Age 18 years and older **AND**
- Diagnosis of ankylosing spondylitis **OR**
- Diagnosis of Crohn's disease **OR**
- Diagnosis of giant cell arteritis **OR**
- Diagnosis of active non-radiographic axial spondyloarthritis (nr-axSpA) **OR**
- Diagnosis of rheumatoid arthritis (RA) **OR**
- Diagnosis of ulcerative colitis

AND
- History of 3 claims with preferred TNF Inhibitor Avsola, Enbrel, Humira or Simponi

OR
- History of 1 claim with Rinvoq in the past

AND
- NO history of concomitant therapy in the past 30 days with any of the following:
  - A different JAK Inhibitor
  - A different biologic
  - Immunosuppressant azathioprine or cyclosporine

SIMPONI (golimumab) – Age specific indications:
- Age 18 years and older **AND**
- Diagnosis of rheumatoid arthritis (RA) **OR**
- Diagnosis of psoriatic arthritis (PsA) **OR**
- Diagnosis of ankylosing spondylitis (AS) **OR**
- Diagnosis of ulcerative colitis
- Non-preferred Simponi Aria requires clinical review

TALTZ (izekizumab) – Age specific indications:
Taltz 20 mg, 40 mg and 80 mg

	TREMFYA (guselkumab)	• Age 6 **AND** • Diagnosis of plaque psoriasis (PsO)
	TREXALL (methotrexate)	**TALTZ 80 mg** • Age 18 years and older **AND** • Diagnosis of psoriatic arthritis (PsA) **OR** • Diagnosis of ankylosing spondylitis (AS) **OR** • Diagnosis of active non-radiographic axial spondyloarthritis (nr-axSpA)
	TYENNE Autoinjector (tocilizumab-aazg)	**TYENNE (tocilizumab-aazg) – Age specific indications:** • Age 2 years and older **AND** • Diagnosis of juvenile arthritis (JIA) • Age 18 years and older **AND** • Diagnosis of rheumatoid arthritis (RA) **OR** • Diagnosis of giant cell arteritis • Non-preferred Tyenne autoinjector requires clinical review
	XATMEP (methotrexate)	**XELJANZ IR (tofacitinib) – Any of the following:** • Age 2 year and older **AND** • Diagnosis of juvenile arthritis (JIA) • Age 18 years and older **AND** • Diagnosis of rheumatoid arthritis (RA) **OR** • Diagnosis of ulcerative colitis (UC) **OR** • Diagnosis of plaque psoriasis (PsO) **OR** • Diagnosis of ankylosing spondylitis (AS) • Non-preferred Xeljanz oral solution and Xeljanz XR require clinical review **Preferred methotrexate does not require prior authorization**
	XELJANZ (tofacitinib) solution	
	XELJANZ XR (tofacitinib)	
	YESINTEK (ustekinumab-kfce)	
	YUFLYMA (adalimumab-aaty)	
	YUSIMRY (adalimumab-aqvh)	
	ZYMFENTRA (infliximab-dyyb)	

ERYTHROPOIESIS STIMULATING PROTEINS DUR+

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
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+

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
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		
KOVALTRY		
NOVOEIGHT		
NUWIQ		
RECOMBINATE		
WILATE		
XYNTHA, XYNTHA SOLOFUSE		
FACTOR IX		
ALPHANINE SD	BEQVEZ	
ALPROLIX	REBINYN	
BENEFIX		
IDELVION		
IXINITY		
PROFILNINE		
RIXUBIS		
OTHER HEMOPHILIA PRODUCTS		
COAGADEX (factor X)	ALHEMO (concizumab-mtci)	
FIBRYGA (fibrinogen)	CORIFACT (factor XIII)	
HEMLIBRA (emicizumab-kxwh) DUR+	HYMPAVZI (marstacimab-hncq)	
RIASTAP (fibrinogen)	NOVOSEVEN RT (factor VII)	
	QFITLIA (fitusiran)	
	SEVENFACT (factor VII)	
	TRETTEN (factor XIII)	

FIBROMYALGIA/NEUROPATHIC PAIN AGENTS

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA

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+

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
ciprofloxacin tablet	BAXDELA (delafloxacin)	**Non-Preferred Criteria** • 1 claim for a preferred agent in the past 30 days
levofloxacin tablet	CIPRO (ciprofloxacin)	**CIPRO Suspension for Age < 12 Years** • Documented diagnosis of Cystic Fibrosis or Anthrax infection or exposure **OR**
	ciprofloxacin suspension	• Documented diagnosis or Pneumonic plague or tularemia **AND** • History of doxycycline in the past 3 months **OR** • 7 days of therapy with a preferred agent from 2 of the classes below in the past 3 months: ○ Penicillin, 2nd or 3rd generation cephalosporin or macrolide
	levofloxacin solution	
	moxifloxacin	**LEVAQUIN Suspension for Age < 12 Years** • Documented diagnosis of Anthrax infection or exposure **OR** • History of 7 days of therapy with a preferred from 2 of the following classes in the past 3 months ○ Penicillin, 2nd or 3rd generation cephalosporins, or macrolide **AND** • History of ciprofloxacin suspension in the past 3 months
	ofloxacin	

GAUCHER'S DISEASE

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
ELELYSO (taliglucerase alfa)	CERDELGA (eliglustat)	
ZAVESCA (miglustat)	CEREZYME (imiglucerase)	
	miglustat	
	VPRIV (velaglucerase alfa)	
	YARGESA (miglustat)	

GENITAL WARTS & ACTINIC KERATOSIS AGENTS

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
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

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
H2 RECEPTOR ANTAGONISTS		**PRILOSEC 2.5 mg suspension** • Automatic approval issued for 0-2 years of age
famotidine	cimetidine	
	nizatidine	**PRILOSEC 10 mg suspension** • Requires clinical review
	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)	

GLUCOCORTICOIDS (INHALED)

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
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
ASMANEX (mometasone)	ALVESCO (ciclesonide)	
budesonide 0.25 mg and 0.5 mg	ARMONAIR DIGIHALER (fluticasone)	
fluticasone	ARNUITY ELLIPTA (fluticasone)	
fluticasone diskus	ASMANEX HFA (mometasone)	
fluticasone HFA	budesonide 1 mg	
PULMICORT FLEXHALER (budesonide)	FLOVENT HFA (fluticasone)	
QVAR REDIHALER (beclomethasone)	FLOVENT DISKUS (fluticasone)	
	PULMICORT (budesonide) nebulizer solution	
GLUCOCORTICOID/BRONCHODILATOR COMBINATIONS		
ADVAIR DISKUS (fluticasone/salmeterol)	AIRDUO DIGIHALER (fluticasone/salmeterol)	**AIRDUO DIGIHALER** • Requires clinical review
		ARMONAIR DIGIHALER • Requires clinical review

ADVAIR HFA (fluticasone/salmeterol)	AIRSUPRA (albuterol/budesonide)	**PROAIR DIGIHALER** Require clinical review **Minimum Age Limit** • **18 years**: AIRSUPRA **Quantity Limit** (per 31 days) • **2 inhalers**: AIRSUPRA -- MANUAL PA
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+

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
GENOTROPIN (somatropin)	HUMATROPE (somatropin)	**Preferred Criteria** • **Age ≥ 18 years** • Documented diagnosis of craniopharyngioma, HIV associated cachexia, iatrogenic growth deficiency due to drug-induced or post-procedural hypopituitarism, Noonan Syndrome, panhypopitu Syndrome, renal function impairment growth disorders, short stature shox deficiency, Turner Syndrome or history of cranial irradiation • **Age < 18 years** • Diagnosis of approvable pediatric diagnosis or history of cranial irradiation **Minimum Age Limit** • **3 years**: NGENLA **Maximum Age Limit** • **18 years**: NGENLA **Non-Preferred Criteria** Age ≥ 18 years • Documented approvable diagnosis for age as above diagnosis of craniopharyngioma, HIV associated cachexia, iatrogenic growth deficiency due to drug-induced or post-procedural hy Syndrome, panhypopituitarism, Prader-Willi Syndrome, renal function impairment growth disorders, short stature shox deficiency, Turner Syndrome or history of cranial irradiation **AND** • History of 28 days of therapy with a preferred Growth Hormone in the past 6 months **OR** • 84 days of therapy with the requested agent in the past 105 days Age < 18 years • Diagnosis of congenital malformation syndrome, HIV associated cachexia, hypopituitarism, iatrogenic growth deficiency due to drug-induced or post-procedural hypopituitarism, mosai Syndrome, renal function impairment growth disorders, short stature due to endocrine disorder, small for gestational age or Turner Syndrome **AND** • History of 28 days of therapy with a preferred Growth Hormone in the past 6 months **OR** • 84 days of therapy with the requested agent in the past 105 days **SKYTROFA** Age ≥ 18 years • Documented diagnosis of craniopharyngioma, HIV associated cachexia, iatrogenic growth deficiency growth deficiency due to drug-induced or post-procedural hypopituitarism, Noona panhypopituitarism, renal function impairment growth disorders, short stature shox deficiency, Turner Syndrome or history of cranial irradiation **AND** • No history of diagnosis of Prader Willi Syndrome **AND** • History of 28 days of therapy with a preferred Short-Acting Growth Hormone in the past 6 months **OR** • 84 days of therapy with Skytrofa in the past 105 days Age < 18 years • No history of diagnosis of Prader Willi Syndrome **AND** • **AND** • History of 28 days of therapy with a preferred Short-Acting Growth Hormone in the past 6 months **OR** • 84 days of therapy with Skytrofa in the past 105 days
NORDITROPIN FLEXPRO (somatropin)	NGENLA (somatrogon-ghla)	
SKYTROFA (lonapegsomatropin-tcgd)	OMNITROPE (somatropin)	
	SEROSTIM (somatropin)	
	SOGROYA (somapacitan-beco)	
	VOXZOGO (vosoritide)	
	ZOMACTON (somatropin)	

H. PYLORI COMBINATION TREATMENTS

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
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

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
entecavir	adefovir dipivoxil	
lamivudine HBV	BARACLUDE (entecavir)	
tenofovir disoproxil fumarate	VEMLIDY (tenofovir alafenamide)	
	VIREAD (tenofovir disoproxil fumarate)	

HEPATITIS C TREATMENTS

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
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 TREATMENTS

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
BERINERT (C1 esterase inhibitor)	ANDEMBRY (garadacimab-gxii)	
icatibant	CINRYZE (C1 esterase inhibitor)	
	DAWNZERA (donidalorsen)NR	
	EKTERLY (sebetralstat)NR	

	FIRAZYR (icatibant)	
	KALBITOR (ecallantide)	
	ORLADEYO (berotralstat)	
	RUCONEST (C1 esterase inhibitor)	
	SAJAZIR (icatibant)	
	TAKHZYRO (lanadelumab-flyo)	

HYPERURICEMIA & GOUT DUR+

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
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

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
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

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
metformin	GLUMETZA (metformin)	
metformin ER (generic GLUCOPHAGE XR)	metformin ER (generic FORTAMET)	
	metformin ER (generic GLUMETZA)	
	metformin solution	
	RIOMET (metformin)	

HYPOGLYCEMICS, DPP4s AND COMBINATIONS DUR+

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
JANUMET (sitagliptin/metformin)	alogliptin	**Non-Preferred Criteria** • Have tried 2 different preferred DPP4 agents in the past 6 months **OR** • 90 days of therapy with the requested agent in the past 105 days Note: Concomitant use of a GLP-1 agent and a DPP-4 agent requires clinical review **Minimum Age Limit** • **18 years**: BRYNOVIN solution
JANUMET XR (sitagliptin/metformin)	alogliptin/metformin	
JANUVIA (sitagliptin)	BRYNOVIN solution (sitagliptin)	
JENTADUETO (linagliptin/metformin)	JENTADUETO XR (linagliptin/metformin)	
TRADJENTA (linagliptin)	KAZANO (alogliptin/metformin)	
	KOMBIGLYZE XR (saxagliptin/metformin)	
	NESINA (alogliptin)	
	ONGLYZA (saxagliptin)	
	OSENI (alogliptin/pioglitazone)	
	saxagliptin	
	saxagliptin/metformin ER	
	sitagliptin	
	sitagliptin/metformin	
	ZITUVIMET (sitagliptin/metformin)	
	ZITUVIMET XR (sitagliptin/metformin)	
	ZITUVIO (sitagliptin)	

HYPOGLYCEMICS, INCRETIN MIMETICS/ENHANCERS DUR+

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
BYETTA (exenatide)	BYDUREON (exenatide)	**Minimum Age Limit** • **10 years**: BYDUREON BCISE, TRULICITY, VICTOZA • **18 years**: BYETTA, MOUNJARO, OZEMPIC, RYBELSUS **Preferred Criteria** • Documented diagnosis of Type 2 Diabetes **AND** • No history of SAXENDA or WEGOVY in the past 30 days **OR** • No documented diagnosis for Type 2 Diabetes **AND** • 84 days of therapy with the requested agent in the past 105 days **Non-Preferred Criteria** • Documented diagnosis of Type 2 Diabetes **AND** • No history of SAXENDA or WEGOVY in the past 30 days **AND** • 84 days of therapy with TRULICITY in the past 6 months **AND** • 84 days of therapy with either 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** • Requires clinical review
TRULICITY (dulaglutide)	exenatide	
VICTOZA (liraglutide)	liraglutide	
	MOUNJARO (tirzepatide)	
	OZEMPIC (semaglutide)	
	RYBELSUS (semaglutide)	
	SOLIQUA (insulin glargine/lixisenatide)	
	SYMLINPEN (pramlintide)	
	XULTOPHY (insulin degludec/liraglutide)	

HYPOGLYCEMICS, INSULINS & RELATED AGENTS DUR+

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA

HUMALOG MIX 75/25 vial (insulin lispro/lispro protamine)	ADMELOG (insulin lispro)	**Non-Preferred Criteria** • Documented diagnosis of Diabetes Mellitus **AND** • Have tried 1 preferred agent in the past 6 months **OR** • 1 claim with the requested agent in the past 105 days **Quantity Limit** • Insulin quantity limits can be found here **Note**: • Insulin pen formulations are not covered for Long Term Care (LTC) beneficiaries. **BASAGLAR** • Requires clinical review
HUMULIN 70/30 vial (insulin NPH/regular)	AFREZZA (insulin regular)	
HUMULIN N (insulin NPH)	APIDRA (insulin glulisine)	
HUMULIN R (insulin regular)	BASAGLAR (insulin glargine)	
HUMULIN R U-500 (insulin regular)	FIASP (insulin aspart/niacinamide)	
insulin aspart	HUMALOG; HUMALOG JUNIOR, KWIKPEN, TEMPO PEN (insulin lispro)	
insulin aspart protamine mix 70/30 vial		
insulin lispro	HUMALOG MIX KWIKPEN 50/50, 75/25 (insulin lispro/lispro protamine)	
insulin lispro protamine mix 75/25 vial	HUMULIN 70/30 KWIKPEN (insulin N/regular)	
LANTUS (insulin glargine)	HUMULIN N KWIKPEN (insulin N)	
TOUJEO (insulin glargine)	insulin degludec	
TOUJEO MAX (insulin glargine)	insulin glargine	
	insulin glargine-yfgn	
	KIRSTY (insulin aspart-xjhz)[NR]	
	LEVEMIR (insulin detemir)	
	LYUMJEV (insulin lispro-aabc)	
	MERILOG (insulin aspart-szjj)[NR]	
	NOVOLIN 70/30 (insulin NPH/regular)	
	NOVOLIN N (insulin NPH)	
	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+

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
nateglinide		
repaglinide		

HYPOGLYCEMICS, SODIUM GLUCOSE COTRANSPORTER-2 (SGLT-2) INHIBITORS DUR+

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
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

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
pioglitazone	ACTOPLUS MET (pioglitazone/metformin)	
pioglitazone/metformin	ACTOS (pioglitazone)	
pioglitazone/glimepiride	DUETACT (pioglitazone/glimepiride)	

IDIOPATHIC PULMONARY FIBROSIS DUR+

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
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	

IMMUNE GLOBULINS

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
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

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
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**

FASENRA
• Requires clinical review MANUAL PA

- New starts require clinical review (see manual PA links below)
  - **Asthma** MANUAL PA
  - **Atopic Dermatitis** MANUAL PA
  - **Bullous Pemphigoid** MANUAL PA
  - **COPD** MANUAL PA
  - **Chronic Spontaneous Urticaria** MANUAL PA
  - **Eosinophilic Esophagitis** MANUAL PA
  - **Nasal Polyposis** MANUAL PA
  - **Prurigo Nodularis** 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

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
AZASAN (azathioprine)	ASTAGRAF XL (tacrolimus)	**Minimum Age Limit** • **13 years**: RAPAMUNE • **18 years**: ZORTRESS **Maximum Age Limit** • **12 years**: PROGRAF Granules
azathioprine	ENVARSUS XR (tacrolimus)	
CELLCEPT (mycophenolate)	MYFORTIC (mycophenolate)	
cyclosporine	PROGRAF (tacrolimus)	
everolimus	REZUROCK (belumosudil)	
mycophenolate	ZORTRESS (everolimus)	
mycophenolic acid		
NEORAL (cyclosporine)		
RAPAMUNE (sirolimus)		
SANDIMMUNE (cyclosporine)		
sirolimus		
tacrolimus		

Preferred Criteria
- **AZASAN**
  - Documented diagnosis of kidney transplant, RA, or a State-accepted diagnosis
- **CELLCEPT**
  - Documented diagnosis of heart, kidney, or liver transplant or a State-accepted diagnosis
- **GENGRAF, NEORAL, SANDIMMUNE**
  - Documented diagnosis of heart transplant, kidney transplant, liver transplant, psoriasis, RA, or a State-accepted diagnosis
- **Everolimus**
  - Documented diagnosis of kidney or liver transplant
- **RAPAMUNE**
  - Documented diagnosis of kidney transplant
- **Tacrolimus**
  - Documented diagnosis of heart, kidney, liver, or lung transplant or a State-accepted diagnosis

Non-Preferred Criteria
- **MYHIBBIN Suspension**
  - Documented diagnosis of heart, kidney, or liver transplant or a State-accepted diagnosis **AND**
  - 30 days of therapy with mycophenolate suspension in the past 105 days **OR**
  - 90 days of therapy with 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

INTRANASAL RHINITIS AGENTS

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
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

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
deferasirox (all manufacturers except those listed as non-preferred)	deferasirox (manufacturers starting with 45963, 62332)	**JADENU** MANUAL PA
deferiprone 500 mg tablet	deferiprone 1,000 mg tablet	
FERRIPROX (deferiprone)	EXJADE (deferasirox)	
	JADENU, JADENU SPRINKLE (deferasirox)	

IRRITABLE BOWEL SYNDROME/SHORT BOWEL SYNDROME AGENTS/SELECTED AGENTS DUR+

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
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, SYMPROIC, VIBERZI **Gender Limit** • **Female** AMITIZA 8 mcg
LINZESS (linaclotide)	AMITIZA (lubiprostone)	
lubiprostone	IBSRELA (tenapanor)	
	MOTEGRITY (prucalopride)	
	MOVANTIK (naloxegol)	
	prucalopride	
	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)	

IRRITABLE BOWEL SYNDROME CONSTIPATION DUR+

Chronic Idiopathic Constipation (CIC): Amitiza 24 mcg, LINZESS 72 mcg, LINZESS 145 mcg, MOTEGRITY

- **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

- **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, 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

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**

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

LEUKOTRIENE MODIFIERS DUR+

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
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)

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
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** **REPATHA MANUAL PA** **WELCHOL** • Documented diagnosis of Type 2 Diabetes **AND**
	NEXLETOL (bempedoic acid)	
	NEXLIZET (bempedoic acid/ezetimibe)	
ANGIOPOIETIN-LIKE 3 INHIBITORS		
	EVKEEZA (evinacumab-dgnb)	
BILE ACID SEQUESTRANTS		
cholestyramine	colesevelam	
cholestyramine light	COLESTID (colestipol)	
colestipol tablet	colestipol packet	
	PREVALITE (cholestyramine)	
	QUESTRAN (cholestyramine)	
	QUESTRAN LIGHT (cholestyramine)	
	WELCHOL (colesevelam)	
CHOLESTEROL ABSORPTION INHIBITORS		
ezetimibe	ZETIA (ezetimibe)	
FIBRIC ACID DERIVATIVES		
fenofibrate	fenofibric acid	
gemfibrozil	FENOGLIDE (fenofibrate)	

	FIBRICOR (fenofibric acid)	• 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
	LIPOFEN (fenofibrate)	
	LOPID (gemfibrozil)	
	TRICOR (fenofibrate)	
	TRILIPIX (fenofibric acid)	
MTP INHIBITOR		
	JUXTAPID (lomitapide)	
NIACIN		
niacin ER		
OMEGA-3 FATTY ACIDS		
omega-3 acid ethyl esters	icosapent ethyl	
	LOVAZA (omega-3 acid ethyl esters)	
PCSK-9 INHIBITORS		
REPATHA (evolocumab)	LEQVIO (inclisiran)	
	PRALUENT (alirocumab)	

LIPOTROPICS, STATINS DUR+

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
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

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
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)	
MISCELLANEOUS		
alprazolam	alprazolam ER	
	BRINSUPRI (brensocatib)NR	
hydroxyzine HCL	CAMZYOS (mavacamten)	
hydroxyzine pamoate	CRENESSITY (crinecerfont)	
megestrol	EVRYSDI (risdiplam)	
REVLIMID (lenalidomide)	HARLIKU (nitisinone)NR	
	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+

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
AUSTEDO (deutetrabenazine)	INGREZZA INITIATION PACK (valbenazine)	**AUSTEDO and AUSTEDO XR** • Documented diagnosis of Huntington's chorea **OR** • Documented diagnosis of tardive dyskinesia **AND** • 90 days of therapy with either agent in the past 105 days **OR** • New starts require clinical review MANUAL PA **INGREZZA** • Documented diagnosis of Huntington's chorea **OR** • Documented diagnosis of tardive dyskinesia **AND** • 90 days of therapy with this agent in the past 105 days **OR** • New starts require clinical review MANUAL PA
AUSTEDO XR (deutetrabenazine)	XENAZINE (tetrabenazine)	
INGREZZA (valbenazine)		
INGREZZA SPRINKLE (valbenazine)		
tetrabenazine		

MULTIPLE SCLEROSIS AGENTS DUR+

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
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)	
fingolimod	BRIUMVI (ublituximab-xiiy)	**Non-Preferred Criteria** • Documented diagnosis of multiple sclerosis **AND** • Have tried 2 different preferred agents in the past 6 months **OR** • 3 claims with the requested agent in the last 105 days **KESIMPTA, PONVORY, TASCENSO ODT, and ZEPOSIA** • Require clinical review **MAVENCLAD MANUAL PA** **MAYZENT MANUAL PA** **OCREVUS and OCREVUS ZUNOVO MANUAL PA**
REBIF (interferon beta-1b)	COPAXONE (glatiramer) 40 mg	
REBIF REBIDOSE (interferon beta-1b)	GILENYA (fingolimod)	
teriflunomide	glatiramer	
TYSABRI (natalizumab)	GLATOPA (glatiramer)	
	KESIMPTA PEN (ofatumumab)	
	MAVENCLAD (cladribine)	
	MAYZENT (siponimod)	
	OCREVUS (ocrelizumab)	
	OCREVUS ZUNOVO (ocrelizumab/hyaluronidase-ocsq)	
	PLEGRIDY (peginterferon beta-1a)	
	PONVORY (ponesimod)	
	TASCENSO ODT (fingolimod)	
	TECFIDERA (dimethyl fumarate)	
	VUMERITY (diroximel fumarate)	
	ZEPOSIA (ozanimod)	

MUSCULAR DYSTROPHY AGENTS

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
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)	
	JAYTHARI (deflazacort)[NR]	
	VILTEPSO (viltolarsen)	
	VYONDYS-53 (golodirsen)	

NSAIDS

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
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 **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
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	
ketorolac	kiprofen	
nabumetone	LOFENA (diclofenac potassium)	
naproxen 250 mg, 500 mg	meclofenamate	
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

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
ANTIBIOTICS		**Minimum Age Limit** • **16 years**: RESTASIS • **17 years**: XIIDRA • **18 years**: CEQUA, MIEBO, TRYPTYR, VEVYE **Quantity Limit** (per 31 days) • **2 mL**: VEVYE • **3 mL**: MIEBO • **5.5 mL**: RESTASIS Multidose • **60 units**: CEQUA, RESTASIS Droperette, TRYPTYR, XIIDRA **Non-Preferred Criteria** • **Anti-Inflammatory Agents** ○ Have tried 2 different preferred agents in the past 6 months • **Dry Eye Agents** ○ History of 1 claim for both RESTASIS Droperette and XIIDRA in the past 6 months **EYSUVIS**
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)		• Require clinical review
tobramycin/dexamethasone		
ZYLET (tobramycin/loteprednol)		**MIEBO**
ANTI-INFLAMMATORY AGENTS DUR+		• Requires clinical review
dexamethasone	ACULAR, ACULAR LS (ketorolac)	
diclofenac sodium	ACUVAIL (ketorolac)	**RESTASIS Multidose**
difluprednate	bromfenac	• Require clinical review
FLAREX (fluorometholone)	BROMSITE (bromfenac)	
fluorometholone	DUREZOL (difluprednate)	**TRYPTYR**
flurbiprofen	FML (fluorometholone)	• Requires clinical review
FML FORTE (fluorometholone)	ILEVRO (nepafenac)	
ketorolac	INVELTYS (loteprednol)	**TYRVAYA**
MAXIDEX (dexamethasone)	LOTEMAX, LOTEMAX SM (loteprednol)	• Requires clinical review
PRED MILD (prednisolone)	loteprednol	
prednisolone acetate	NEVANAC (nepafenac)	**VEVYE**
prednisolone sodium phosphate	PRED FORTE (prednisolone)	• Requires clinical review
	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

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
BETA BLOCKERS		**Minimum Age Limit**
BETIMOL (timolol)	betaxolol	• **18 years**: IYUZEH
carteolol	BETOPTIC S (betaxolol)	
ISTALOL (timolol)	timolol droperette, daily drop, gel	**Non-Preferred Criteria**
levobunolol	TIMOPTIC; TIMOPTIC OCUDOSE, XE (timolol)	• Have tried 2 different preferred agents in the past 6 months **OR**
timolol drops 0.25%, 0.5%		• 90 days of therapy with the requested agent in the past 105 days
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)	
PROSTAGLANDIN ANALOGS		
latanoprost	bimatoprost	
	IYUZEH (latanoprost)	
	LUMIGAN (bimatoprost)	
	tafluprost	
	TRAVATAN Z (travoprost)	
	travoprost	
	VYZULTA (latanoprostene bunod)	
	XALATAN (latanoprost)	
	XELPROS (latanoprost)	
	ZIOPTAN (tafluprost)	
RHO KINASE INHIBITORS/COMBINATIONS		
RHOPRESSA (netarsudil)		
ROCKLATAN (netarsudil/latanoprost)		
SYMPATHOMIMETICS		
ALPHAGAN P (brimonidine)	brimonidine 0.1%, 0.15%	
brimonidine 0.2%		

OPHTHALMICS FOR ALLERGIC CONJUNCTIVITIS

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
ALREX (loteprednol)	ALOCRIL (nedocromil)	**Non-Preferred Criteria**
azelastine	ALOMIDE (lodoxamide)	• Have tried 2 different preferred agents in the past 6 months
cromolyn	bepotastine	
ketotifen OTC	BEPREVE (bepotastine)	**VERKAZIA**
olopatadine	epinastine	• Requires clinical review
ZADITOR (ketotifen)	LASTACAFT (alcaftadine)	
	VERKAZIA (cyclosporine)	
	ZERVIATE (cetirizine)	

OPIATE DEPENDENCE TREATMENTS

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
DEPENDENCE		Buprenorphine/naloxone provider summary found here
buprenorphine/naloxone SL tablet DUR+	BRIXADI (buprenorphine)	
naltrexone	buprenorphine DUR+	
SUBOXONE (buprenorphine/naloxone) DUR+	buprenorphine/naloxone film DUR+	**SUBLOCADE MANUAL PA**
	lofexidine	
	LUCEMYRA (lofexidine)	**VIVITROL MANUAL PA**
	SUBLOCADE (buprenorphine)	
	VIVITROL (naltrexone)	
	ZUBSOLV (buprenorphine/naloxone)	
TREATMENT		
KLOXXADO (naloxone)	LIFEMS NALOXONE (naloxone convenience kit)	
naloxone		

NARCAN (naloxone)		
OPVEE (nalmefene)		
REXTOVY (naloxone)		
ZIMHI (naloxone)		

OTIC ANTIBIOTICS

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
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

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
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

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
calcitriol	doxercalciferol	
cinacalcet	RAYALDEE (calcifediol)	
ergocalciferol	ROCALTROL (calcitriol)	
paricalcitol	SENSIPAR (cinacalcet)	
ZEMPLAR (paricalcitol)	YORVIPATH (palopegteriparatide)	

PHOSPHATE BINDERS

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
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

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
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	ticagrelor	
clopidogrel		
dipyridamole		
pentoxifylline		
prasugrel		

PLATELET STIMULATING AGENTS

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
NPLATE (romiplostim)	ALVAIZ (eltrombopag)	
PROMACTA (eltrombopag) tablet	DOPTELET (avatrombopag)	
	MULPLETA (lusutrombopag)	
	PROMACTA (eltrombopag) packet	
	TAVALISSE (fostamatinib)	

POTASSIUM REMOVING AGENTS

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
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

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
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		
PNV 72, 95, 124, and 137 / IRON / FOLIC ACID		
SE-NATAL-19		
STUART ONE		
THRIVITE RX		
TRICARE		
TRINATAL RX 1		
WESNATAL DHA COMPLETE		
WESTAB PLUS		

PSEUDOBULBAR AFFECT AGENTS

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	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

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
ACTIVIN SIGNALING INHIBITORS		**Minimum Age Limit** • **18 years**: ADEMPAS, OPSYNVI, TADLIQ

	WINREVAIR (sotatercept-csrk)
COMBINATION AGENTS	
	OPSYNVI (macitentan/tadalafil)
ENDOTHELIN RECEPTOR ANTAGONISTS	
ambrisentan	OPSUMIT (macitentan)
bosentan	TRACLEER (bosentan)
LETAIRIS (ambrisentan)	TRYVIO (aprocitentan)
PDE5 INHIBITORS	
sildenafil (generic REVATIO) tablet, suspension	ADCIRCA (tadalafil)
tadalafil	ALYQ (tadalafil)
	REVATIO (sildenafil)
	TADLIQ (tadalafil)
PROSTACYCLINS	
	ORENITRAM ER (treprostinil)
	ORENITRAM TITRATION PAK (treprostinil)
	TYVASO (treprostinil)
	VENTAVIS (iloprost)
	YUTREPIA (treprostinil)
SELECTIVE PROSTACYCLINE RECEPTOR AGONISTS	
	UPTRAVI (selexipag)
SOLUABLE GUANYLATE CYCLASE STIMULATORS	
	ADEMPAS (riociguat)

Maximum Age Limit
- **12 years**: REVATIO suspension

Preferred Criteria
- **PAH Agents**
  - 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

OPSUMIT, OPSYNVI, ORENITRAM ER, TYVASO, and VENTAVIS
- Require clinical review

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

ROSACEA TREATMENTS

PREFERRED AGENTS	NON-PREFERRED AGENTS
metronidazole	AVAR (sulfacetamide sodium/sulfur)
	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)
	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)

PA CRITERIA

Note:
- Topical Sulfonamides used for Rosacea will require a manual PA for age > 21 years.
- Other labeled indications are limited to < 21 years.

SEDATIVE HYPNOTIC AGENTS

PREFERRED AGENTS	NON-PREFERRED AGENTS
BENZODIAZEPINES DUR+	
estazolam	flurazepam
temazepam 15 mg, 30 mg capsule	HALCION (triazolam)
	quazepam
	RESTORIL (temazepam)
	temazepam 7.5 mg, 22.5 mg capsule
	triazolam
OTHERS DUR+	
eszopiclone	AMBIEN (zolpidem)
ramelteon	AMBIEN CR (zolpidem)
zaleplon	BELSOMRA (suvorexant)
zolpidem tablet	DAYVIGO (lemborexant)
	doxepin
	EDULAR (zolpidem)
	HETLIOZ LQ (tasimelteon)
	LUNESTA (eszopiclone)

PA CRITERIA

MS DOM Opioid Initiative Criteria details found here
- Concomitant use of Opioids and Benzodiazepines

Maximum Age Limit
- **64 years**: zolpidem 7.5 mg, 10 mg, and 12.5 mg

Gender and Dose Limit
- **Female**: AMBIEN 5 mg, AMBIEN CR 6.25 mg, INTERMEZZO 1.75 mg
- **Male**: all strengths of zolpidem

Non-Preferred Criteria
- Have tried 2 different preferred agents in the past 6 months

HETLIOZ capsules
- 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

	QUVIVIQ (daridorexant)	• 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
	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.

SELECT CONTRACEPTIVE PRODUCTS

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
INJECTABLE CONTRACEPTIVES		**Non-Preferred Criteria** • 1 claim with the requested agent in the past 105 days
medroxyprogesterone	DEPO-PROVERA (medroxyprogesterone)	
INTRAVAGINAL CONTRACEPTIVES		
ANNOVERA (segesterone/ethinyl estradiol)	PHEXXI (lactic acid/citric acid/potassium bitartrate)	
ENILLORING (etonogestrel/ethinyl estradiol)		
NUVARING (etonogestrel/ethinyl estradiol)		
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)	

SICKLE CELL AGENTS

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
DROXIA (hydroxyurea)	ADAKVEO (crizanlizumab-tmca)	**ENDARI** MANUAL PA
hydroxyurea	CASGEVY (exagamglogene autotemcel)NR	
	ENDARI (glutamine)	
	HYDREA (hydroxyurea)	
	l-glutamine	
	LYFGENIA (lovotibeglogene autotemcel)NR	
	SIKLOS (hydroxyurea)	

SKELETAL MUSCLE RELAXANTS DUR+

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
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 days **Carisoprodol with codeine**
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	• Requires clinical review.
	orphenadrine/aspirin/caffeine	
	ORPHENGESIC FORTE (orphenadrine/aspirin/caffeine)	
	SOMA (carisoprodol)	**Metaxalone 640 mg and TANLOR**
	TANLOR (methocarbamol)	• Requires clinical review
	tizanidine capsule	
	ZANAFLEX (tizanidine)	

SMOKING DETERRENTS

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
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)

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
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-SMOOTHE-FS (fluocinolone)	hydrocortisone lotion	
desonide	HYDROXYM (hydrocortisone)	
hydrocortisone cream, ointment, solution	PROCTOCORT (hydrocortisone)	
MEDIUM POTENCY		
fluticasone	BESER (fluticasone)	
mometasone	CAPEX (fluocinolone)	
PANDEL (hydrocortisone probutate)	clocortolone	
prednicarbate cream	CLODERM (clocortolone)	
	flurandrenolide	
	fluticasone lotion	
	LOCOID (hydrocortisone butyrate)	
	prednicarbate ointment	
	SYNALAR (fluocinolone)	
HIGH POTENCY		
betamethasone dipropionate cream, lotion	amcinonide	
betamethasone dipropionate augmented	betamethasone dipropionate ointment	
betamethasone valerate	desoximetasone	
fluocinolone	diflorasone	
fluocinonide	Halcinonide	
fluocinonide-E	HALOG (halcinonide)	
triamcinolone cream, ointment, lotion	KENALOG (triamcinolone)	
	TOPICORT (desoximetasone)	
	triamcinolone spray	
	VANOS (fluocinonide)	
VERY HIGH POTENCY		
clobetasol cream, foam, gel, ointment, shampoo, solution	APEXICON E (diflorasone)	
clobetasol-E	clobetasol emulsion	
halobetasol	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+

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
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, DESOXYN, DEXEDRINE, DYANAVEL XR, EVEKEO ODT, FOCALIN, FOCALIN XR, JORNAY PM, METADATE CD, METHYLIN, ONYDA XR, QELBREE, QUILLICHEW, QUILLIVANT XR, RE 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 Spa 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, RITALIN, ZENZEDI • **248 mL**: DYANAVEL XR Suspension • **310 mL**: METHYLIN, PROCENTRA • **372 mL**: QUILLIVANT XR **Quantity Limit** **Narcolepsy** (per 31 days)
dexmethylphenidate	ADDERALL (dextroamphetamine/amphetamine)	
dextroamphetamine	amphetamine	
dextroamphetamine/amphetamine	EVEKEO (amphetamine)	
methylphenidate tablet, solution	dextroamphetamine solution	
PROCENTRA (dextroamphetamine)	EVEKEO ODT (amphetamine)	
	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)	
dexmethylphenidate ER	AZSTARYS (serdexmethylphenidate/dexmethylphenidate)	
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 (generic Kapvay only)	ONYDA XR (clonidine)
guanfacine ER	STRATTERA (atomoxetine)
QELBREE (viloxazine)	

- **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

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
- Diagnosis of ADD/ADHD **AND**
  - History of 84 days of therapy (each) with 2 different preferred LA methylphenidate products in the past 12 months **AND**
  - History of 84 days of therapy with 1 preferred non-methylphenidate LA stimulant in the past 12 months **OR**
  - History of 84 days of therapy with JORNAY PM in the past 105 days

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

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
- 90 days of therapy with Vyvanse in the past 90 days

VYVANSE chewable
- Requires clinical review

WAKIX
- Requires clinical review

XYREM
- Diagnosis of narcolepsy or excessive daytime sleepiness **OR**
- 30 days of therapy with this agent in the past 105 days

XYWAV
- Requires clinical review

TETRACYCLINES DUR+

PREFERRED AGENTS	NON-PREFERRED AGENTS
doxycycline hyclate	demeclocycline
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)

PA CRITERIA

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

	tetracycline tablet	

ULCERATIVE COLITIS & CROHN'S AGENTS DUR+ *See Cytokine & CAM Antagonists Class for Additional Agents*

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
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
balsalazide	AZULFIDINE (sulfasalazine)	
budesonide	COLAZAL (balsalazide)	
PENTASA (mesalamine)	DELZICOL (mesalamine)	
sulfasalazine	DIPENTUM (olsalazine)	
sulfasalazine DR	LIALDA (mesalamine)	
	mesalamine	
	mesalamine DR, mesalamine ER	
	VELSIPITY (etrasimod)	
RECTAL		
mesalamine suppository	budesonide	
	CANASA (mesalamine)	
	mesalamine enema	
	ROWASA (mesalamine)	
	SFROWASA (mesalamine)	

UREA CYCLE DISORDER AGENTS

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