

MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

EFFECTIVE 7/01/2025
VERSION 2025_9
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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	PA CRITERIA
ANTI-INFECTIVES			Maximum Age Limit • 21 years: all acne agents except isotretinoin products Topical Clindamycin 1% lotion • 21 years and older AND • Documented diagnosis of hidradenitis suppurativa Note: Isotretinoin products available for all ages Clindamycin 1% lotion only available for ages 21 years and older with approvable diagnosis Preferred clindamycin 1% lotion for ages < 21 years does not require PA
clindamycin gel (generic CLEOCIN-T)	azelaic acid		
clindamycin lotion, medicated swab, solution	CLEOCIN T (clindamycin)		
	CLINDACIN (clindamycin)		
	CLINDAGEL (clindamycin)		
	clindamycin foam		
	clindamycin gel (generic CLINDAGEL)		
	dapsone		
	ERY (erythromycin)		
	ERYGEL (erythromycin)		
	erythromycin		
	EVOCLIN (clindamycin)		
	KLARON (sulfacetamide)		
	MORGIDOX (doxycycline)		
	sulfacetamide sodium suspension		
	WINLEVI (clascoterone) cream		
ISOTRETINOIN PRODUCTS			
AMNESTEEM (isotretinoin)	ABSORBICA (isotretinoin)		
CLARAVIS (isotretinoin)	isotretinoin		
ZENATANE (isotretinoin)			
KERATOLYTICS (BENZOYL PEROXIDES)			

ACNE MEDICATION (benzoyl peroxide)	BPO towelette (benzoyl peroxide)
benzoyl peroxide	
LINTERA (benzoyl peroxide)	
RETINOIDS	
adapalene gel, gel with pump	adapalene cream
RETIN-A (tretinoin)	AKLIEF (trifarotene)
tretinoin cream	ALTRENO (tretinoin)
	ARAZLO (tazarotene)
	ATRALIN (tretinoin)
	DIFFERIN (adapalene)
	FABIOR (tazarotene)
	RETIN-A MICRO (tretinoin)
	RETIN-A MICRO PUMP (tretinoin)
	tretinoin gel
	tretinoin microsphere
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
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 (butorbital/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

- Minimum Age Limit**
- **18 years:** codeine-containing products and tramadol-containing products
- Quantity Limit** (per 31 rolling days)
- **62 tablets:** butalbital/codeine combinations, codeine combinations, dihydrocodeine combinations, fentanyl, hydrocodone, hydromorphone, levorphanol, meperidine, morphine, oxycodone, oxymorphone, pentazocine, tapentadol, tramadol
 - **186 tablets:** butalbital/acetaminophen, butalbital/aspirin
 - **5 mL:** butorphanol nasal
 - **180 mL:** oxycodone liquid
 - **280 mL:** QDOLO

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

MS DOM Opioid Initiative [Criteria details found here](#)

- Morphine Equivalent Daily Dose
- Concomitant use of Opioids and Benzodiazepines

- Minimum Age Limit**
- **18 years:** BUTRANS and tramadol-containing products

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 posttherpetic 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
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ANGIOTENSIN CONVERTING ENZYME (ACE) INHIBITORS	
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)

- 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

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)	
	XIFAXAN (rifaximin)	

ANTIBIOTICS (MISCELLANEOUS)		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
LINCOSAMIDE ANTIBIOTICS		Quantity Limit 6 tablets/month: SIVEXTRO
clindamycin	CLEOCIN (clindamycin)	

		CELOCIN PEDIATRIC (clindamycin)	SIVEXTRO MANUAL PA ZYVOX MANUAL PA
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 • 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
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)
	VIGODER (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)

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	PA CRITERIA
bupropion	APLENZIN (bupropion)	Minimum Age Limit • 18 years: all agents Non-Preferred Criteria • Have tried 2 different preferred agents in the past 6 months OR • Have tried 1 preferred agent and 1 SSRI in the past 6 months OR • 90 days of therapy with the requested agent in the past 105 days AUVELITY and RALDESY • Requires clinical review DRIZALMA Sprinkles • Automatic approval issued with a diagnosis of Generalized Anxiety Disorder for 7-11 years of age DULOXETINE • Automatic approval issued with a diagnosis of Generalized Anxiety Disorder for 7-17 years of age ZURZUVAE MANUAL PA • 90 days of therapy with the requested agent in the past 105 days
bupropion SR	AUVELITY (bupropion/dextromethorphan)	
bupropion XL	desvenlafaxine ER	
mirtazapine	DESYREL (trazodone)	
trazodone	DRIZALMA SPRINKLE (duloxetine DR)	
TRINTELLIX (vortioxetine)	EFFEXOR XR (venlafaxine)	
venlafaxine	EMSAM (selegiline)	
venlafaxine ER capsule	FETZIMA (levomilnacipran)	
vilazodone	FORFIVO XL (bupropion)	
	MARPLAN (isocarboxazid)	
	NARDIL (phenelzine)	
	nefazodone	
	phenelzine	
	PRISTIQ (desvenlafaxine)	
	REMERON (mirtazapine)	
	tranylcypromine	
	Trazodone solution ^{NR}	
	venlafaxine ER tablet	
	VIIBRYD (vilazodone)	
	WELLBUTRIN SR (bupropion)	
	WELLBUTRIN XL (bupropion)	
	ZURZUVAE (zuranolone)	
ANTIDEPRESSANTS, SSRIs ^{DUR+}		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
citalopram solution, tablet	CELEXA (citalopram)	Minimum Age Limit

escitalopram	citalopram capsule
fluoxetine capsule	fluoxetine solution, tablet
fluvoxamine	fluoxetine DR capsule
paroxetine tablet	fluvoxamine ER capsule
paroxetine CR	LEXAPRO (escitalopram)
paroxetine ER	paroxetine suspension, capsule
sertraline tablet, solution	PAXIL (paroxetine)
	PAXIL CR (paroxetine)
	PROZAC (fluoxetine)
	sertraline capsule
	ZOLOFT (sertraline)

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

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
fluconazole	BREXAFEMME (ibrexafungerp)	
nystatin	CRESEMBA (isavuconazonium sulfate)	
terbinafine	DIFLUCAN (fluconazole)	
	flucytosine	
	griseofulvin	Griseofulvin tablets • Automatic approval issued for 12-17 years of age
	griseofulvin ultramicrosize	
	itraconazole	
	ketoconazole	
	NOXAFIL (posaconazole)	
	ORAVIG (miconazole)	Minimum Age Limit • 18 years: CRESEMBA
	Posaconazole	
	SPORANOX (itraconazole)	
	TOLSURA (itraconazole)	
	VFEND (voriconazole)	
	VIVJOA (oteseconazole)	Non-Preferred Criteria • Have tried 2 different preferred agents in the past 6 months
	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
ciclopirox cream, gel, solution, suspension	BENSAL HP (salicylic acid)	
clotrimazole cream, solution ^{Rx & OTC}	CILODAN (ciclopirox)	
econazole	ciclopirox shampoo	
ketoconazole cream, shampoo	clotrimazole solution (NDC 50228-0502-61)	
LUZU (luliconazole)	ERTACZO (sertaconazole)	MICOTRIN AC, MYCOZYL, and clotrimazole 30 mL solution • Require clinical review
miconazole cream, powder, solution ^{OTC}	EXTINA (ketoconazole)	
miconazole/zinc oxide/petrolatum ointment	JUBLIA (efinaconazole)	
nystatin cream, ointment, powder	ketoconazole foam	
terbinafine ^{OTC}	KETODAN (ketoconazole)	
tolnaftate cream, solution ^{OTC}	LOPROX (ciclopirox)	
	luliconazole	
	MICOTRIN AC (clotrimazole)	
	MYCOZYL AC (clotrimazole)	
	MYCOZYL AP (miconazole)	
	naftifine	
	NAFTIN (naftifine)	
	oxiconazole	
	OXISTAT (oxiconazole)	
	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	fevoxenadine/pseudoephedrine	
ANTIMIGRAINE AGENTS, ACUTE TREATMENT		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
CGRP ORAL AND NASAL		Minimum Age Limit 6 years: MAXALT 12 years: almotriptan, sumatriptan/naproxen, ZOMIG nasal spray 18 years: FROVA, IMITREX, naratriptan, 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
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)	

PREFERRED AGENTS		NON-PREFERRED AGENTS	PA CRITERIA
INJECTABLES			Preferred Injectables - History of 3 claims with the requested agent in the past 105 days OR - New starts require clinical review Non-preferred Injectables - Require clinical review AIMOVIG, AJOVY, and EMGALITY MANUAL PA VYEPTI MANUAL PA
AIMOVIG Autoinjector (erenumab-aooe) DUR+	EMGALITY Syringe (galcanezumab-gnlm) 300 mg/mL		
AJOVY Autoinjector (fremanezumab-vfrm) DUR+	VYEPTI (eptinezumab-jjmr)		
AJOVY Syringe (fremanezumab-vfrm) DUR+			
EMGALITY Pen (galcanezumab-gnlm) DUR+			
EMGALITY Syringe (galcanezumab-gnlm) 120 mg/mL DUR+			
ORAL			
	QULIPTA (atogepant)		
	NURTEC ODT (rimegepant)		
*ANTINEOPLASTICS SELECTED SYSTEMIC ENZYME INHIBITORS			
PREFERRED AGENTS		NON-PREFERRED AGENTS	PA CRITERIA
BOSULIF (bosutinib) tablet	AFINITOR (everolimus)	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	
CAPRESLA (vandetanib)	AFINITOR DISPERZ (everolimus)		
COMETRIQ (cabozantinib)	AKEEGA (niraparib/abiraterone)		
COTELLIC (cobimetinib)	ALECENSA (alectinib)		
everolimus	ALUNBRIG (brigatinib)		
GILOTTRIF (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 deruxtecandlnk) ^{NR}		
SUTENT (sunitinib)	DAURISMO (glasdegib)		
TAFINLAR (dabrafenib)	ERIVEDGE (vismodegib)		
TARCEVA (erlotinib)	ERLEADA (apalutamide)		
TASIGNA (nilotinib)	erlotinib		
TURALIO (pexidartinib)	FOTIVDA (tivozanib)		
TYKERB (lapatinib)	FRUZAQIA (fruquintinib)		
VOTRIENT (pazopanib)	GAVRETO (pralsetinib)		
XALKORI (crizotinib)	gefitinib		
XTANDI (enzalutamide)	GLEEVEC (imatinib)		
ZELBORAF (vemurafenib)	IBRANCE (palbociclib)		
ZYDELIG (idelalisib)	IDHIFA (enasidenib)		
ZYKADIA (ceritinib)	IMKELDI (imatinib)		
	INQOVI (decitabine/cedazuridine)		
	INREBIC (fedratinib)		
	ITOVEBI (inavolisib)		
	IWILFIN (eflornithine)		
	JAYPIRCA (pirtobrutinib)		
	KISQALI (ribociclib)		
	KISQALI-FEMARA CO-PACK (ribociclib/letrozole)		
	KOSELUGO (selumetinib/vitamin E)		
	KRAZATI (adagrasib)		
	lapatinib		
	LAZCLUZE (lazertinib)		
	LENVIMA (lenvatinib)		
	LOBRENA (lorlatinib)		
	LUMAKRAS (sotorasib)		
	LYNPARZA (olaparib)		
	LYTGObI (futibatinib)		
	MEKTOVI (binimetinib)		
	NERLYNX (neratinib)		
	NUBEQA (darolutamide)		
	nilotinib		
	ODOMZO (sonidegib)		
	OGSIVEO (nirogacestat)		
	OJEMDA (tovorafenib)		
	OJJAARA (mometotinib)		
	ONUREG (azacitidine)		
	ORGOVYX (relugolix)		
	pazopanib		
	PEMAZYRE (pemigatinib)		

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)

XADAGO

- 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
	DUOBRII (halobetasol/tazarotene)
	SORILUX (calcipotriene)
	tazarotene
	VECTICAL (calcitriol)
	VTAMA (tapinarof)
	ZORYVE (roflumilast)

ANTIPSYCHOTICS ^{DUR+}

PREFERRED AGENTS	NON-PREFERRED AGENTS
INJECTABLE, ATYPICALS ^{DUR+}	
ABILIFY ASIMTUFIL (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)
	olanzapine/fluoxetine
	OPIZA (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)

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/lamivudine/tenofovir)	ATRIPLA (efavirenz/emtricitabine/tenofovir)
efavirenz/emtricitabine/tenofovir	CIMDUO (lamivudine/tenofovir)
ODEFSEY (emtricitabine/rilpivirine/tenofovir)	COMPLERA (emtricitabine/rilpivirine/tenofovir)
COMBINATION PRODUCTS PROTEASE INHIBITORS	
lopinavir/ritonavir	KALETRA (lopinavir/ritonavir)
ENTRY INHIBITORS CCR5 CO-RECEPTOR ANTAGONISTS	
	maraviroc
	SELZENTRY (maraviroc)
ENTRY INHIBITORS FUSION INHIBITORS	
	FUZEON (enfuvirtide)
INTEGRASE STRAND TRANSFER INHIBITORS	
APRETUDE (cabotegravir)	cabotegravir ER
ISENTRESS (raltegravir)	ISENTRESS HD (raltegravir)
TIVICAY, TIVICAY PD (dolutegravir)	VOCABRIA (cabotegravir)
NON-NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS (NNRTI)	
EDURANT (rilpivirine)	etravirine
efavirenz	INTELENCE (etravirine)
	nevirapine, nevirapine ER
	PIFELTRO (doravirine)
NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS (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)

PA CRITERIA

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](#)

TRIUMEQ (abacavir/dolutegravir/lamivudine)	SYMTUZA (darunavir/cobicistat/emtricitabine/tenofovir alafenamide)	
TRIUMEQ PD (abacavir/dolutegravir/lamivudine)		
ANTIVIRALS, ORAL		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
ANTI-CYTOMEGALOVIRUS AGENTS		PREVYMIS - Requires clinical review Valganciclovir solution - Automatic approval issued for 0-12 years of age
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)	
ANTIVIRALS, TOPICAL		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
ZOVIRAX (acyclovir) cream	acyclovir	
	DENAVIR (penciclovir)	
	penciclovir	
	XERESE (acyclovir/hydrocortisone)	
	ZOVIRAX (acyclovir) ointment	
AROMATASE INHIBITORS		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
anastrozole	ARIMIDEX (anastrozole)	
exemestane	AROMASIN (exemestane)	
letrozole	FEMARA (letrozole)	
ATOPIC DERMATITIS		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
ADBRY (tralokinumab-ldrm)	CIBINQO (abrocitinib)	Minimum Age Limit 3 months: EUCRISA 2 years: ELIDEL, tacrolimus 0.03% 12 years: OPZELURA 16 years: tacrolimus 0.1%
ADBRY Autoinjector (tralokinumab-ldrm)	EBGLYSS Pen (lebrikizumab-lbkz)	
DUPIXENT (dupilumab) DUR+	NEMLUVIO (nemolizumab-ilto)	
ELIDEL (pimecrolimus)	OPZELURA (ruxolitinib)	
EUCRISA (crisaborole) DUR+	ZORYVE (roflumilast) 0.15% cream	
pimecrolimus		
tacrolimus		
ADBRY MANUAL PA		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
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 - Eosinophilic Esophagitis MANUAL PA - Nasal Polyposis MANUAL PA - Prurigo Nodularis MANUAL PA		
BETA BLOCKERS, ANTIANGINALS & SINUS NODE AGENTS DUR+		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
ANTIANGINALS		ASPRUZYO SPRINKLE Requires clinical review
	ASPRUZYO SPRINKLE (ranolazine)	
	ranolazine ER	
BETA- AND ALPHA-BLOCKERS		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
carvedilol	carvedilol ER	
labetalol	COREG (carvedilol)	
	COREG CR (carvedilol)	

BETA-BLOCKER/DIURETIC COMBINATIONS	
atenolol/chlorthalidone	TENORETIC (atenolol/chlorthalidone)
bisoprolol/hydrochlorothiazide	ZIAC (bisoprolol/hydrochlorothiazide)
metoprolol/hydrochlorothiazide	
propranolol/hydrochlorothiazide	
BETA-BLOCKERS	
acebutolol	BETAPACE (sotalol)
atenolol	BETAPACE AF (sotalol)
bisoprolol	betaxolol
HEMANGEOL (propranolol)	BYSTOLIC (nebivolol)
metoprolol succinate	INDERAL LA (propranolol)
metoprolol tartrate	INDERAL XL (propranolol)
nadolol	INNOPRAN XL (propranolol)
nebivolol	KAPSPARGO SPRINKLE (metoprolol succinate)
pindolol	LOPRESSOR (metoprolol tartrate)
propranolol	SOTYLIZE (sotalol)
propranolol ER	TENORMIN (atenolol)
SORINE (sotalol)	TOPROL XL (metoprolol succinate)
sotalol	
sotalol AF	
timolol	
SINUS NODE AGENTS	
	CORLANOR (ivabradine)
	ivabradine

- 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

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)	BONSITY (teriparatide)	
raloxifene	calcitonin salmon	
	EVENITY (romosozumab-aqgg)	
	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	

PREFERRED AGENTS		NON-PREFERRED AGENTS	PA CRITERIA
ANTICHOLINERGIC-BETA AGONIST COMBINATIONS			Minimum Age Limit • 6 years: SPIRIVA RESPIMAT SPIRIVA RESPIMAT • Automatic approval issued for diagnosis of asthma for ≥ 6 years of age BREZTRI AEROSPHERE • 3 claims with BREZTRI AEROSPHERE in the past 105 days OR • New starts require clinical review Non-Preferred Criteria • 1 claim for a preferred agent in the past 6 months OR • 3 claims with the requested agent in the past 105 days
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			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
	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)	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	
ipratropium	roflumilast		
SPIRIVA HANDIHALER (tiotropium)	SPIRIVA RESPIMAT (tiotropium) ^{DUR+}		
	tiotropium		
	TUDORZA PRESSAIR (aclidinium)		
	YUPERI (revafenacin)		
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			

CALCIUM CHANNEL BLOCKERS ^{DUR+}		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
LONG-ACTING		Quantity Limit (per 21 days) 252 capsules: nimodipine 2520 mL: nimodipine Non-Preferred Criteria Long Acting - Have tried 2 different preferred Long Acting CCB agents in the past 6 months OR 90 days of therapy with the requested agent in the past 105 days Non-Preferred Criteria Short Acting - Have tried 2 different preferred Short Acting CCB agents in the past 6 months OR 90 days of therapy with the requested agent in the past 105 days
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)	Nimodipine - Documented diagnosis of subarachnoid hemorrhage in the past 45 days AND - Duration of therapy limited to 21 days
	TIAZAC (diltiazem)	
	verapamil PM	
	VERELAN PM (verapamil)	
SHORT-ACTING		
diltiazem	CARDIZEM (diltiazem)	
nicardipine	isradipine	
nifedipine	nimodipine capsule and solution	
verapamil	NORLIQVA (amlodipine)	
	NYMALIZE (nimodipine)	

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

CEPHALOSPORINS AND RELATED ANTIBIOTICS (ORAL)		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
BETA LACTAM/BETA-LACTAMASE INHIBITOR COMBINATIONS		Non-Preferred Criteria All Cephalosporin Generations Have tried 2 different preferred agents in the past 6 months
amoxicillin/clavulanate	amoxicillin/clavulanate ER	
	AUGMENTIN (amoxicillin/clavulanate)	
CEPHALOSPORINS FIRST GENERATION		Maximum Age Limit 18 years: cefdinir suspension
cefadroxil	cephalexin tablet	
cephalexin capsule, suspension		
CEPHALOSPORINS SECOND GENERATION		
cefaclor capsule	cefaclor ER	
cefprozil	cefaclor suspension	
cefuroxime		
CEPHALOSPORINS THIRD GENERATION		
cefdinir	cefixime suspension	
cefixime capsule	SUPRAX (cefixime)	
cefpodoxime		

COLONY STIMULATING FACTORS		
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 (vanzacافتor/tezacافتor/deutivacافتor)	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
tobramycin (generic TOBI)	BETHKIS (tobramycin)	
	BRONCHITOL (mannitol)	
	CAYSTON (aztreonam)	
	colistimethate	
	COLY-MYCIN M (colistin)	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
	KALYDECO (ivacaftor)	
		Preferred Agents

	KITABIS (tobramycin)	- Documented diagnosis of Cystic Fibrosis OR - Require clinical review
	ORKAMBI (lumacaftor/ivacaftor)	ALYFTREK MANUAL PA
	SYMDEKO (tezacaftor/ivacaftor)	KALYDECO MANUAL PA
	TOBI (tobramycin)	ORKAMBI MANUAL PA
	TOBI PODHALER (tobramycin)	SYMDEKO MANUAL PA
	tobramycin (generic BETHKIS & KITABIS)	TOBI PODHALER Require clinical review
	TRIKAFTA (elexacaftor/tezacaftor/ivacaftor)	TRIKAFTA MANUAL PA
CYTOKINE & CAM ANTAGONISTS ^{DUR+}		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
ACTEMRA (tocilizumab) syringe, vial	ABRILADA (adalimumab-afzb)	Non-Preferred Agents Require clinical review
AVSOLA (infliximab-axxq)	ACTEMRA ACTPEN (tocilizumab)	
ENBREL (etanercept)	adalimumab-aaty	IV Administered Agents Require clinical review
HUMIRA (adalimumab)	adalimumab-adaz	
KINERET (anakinra)	adalimumab-adbm	ACTEMRA (tocilizumab) – Age specific indications: - Age 2 years and older AND - Diagnosis of juvenile arthritis (JIA)
methotrexate	adalimumab-fkjp	
OLUMIANT (baricitinib)	adalimumab-ryvk	- 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
ORENCIA CLICKJECT (abatacept)	AMJEVITA (adalimumab-atto)	
ORENCIA VIAL (abatacept)	ARCALYST (rilonacept)	AYSOLA (infliximab-axxq) – Age specific indications: - Age 6 years and older AND - Diagnosis of Crohn's disease OR - Diagnosis of ulcerative colitis
OTEZLA (apremilast)	BIMZELX (bimekizumab-bkzx)	
RINVOQ (upadacitinib)	CIMZIA (certolizumab)	- 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)
RINVOQ LQ (upadacitinib)	COSENTYX (secukinumab)	
SIMPONI (golimumab)	CYLTEZO (adalimumab-adbm)	ENBREL (etanercept) – Age specific indications: - Age 2 years and older AND - Diagnosis of juvenile arthritis (JIA) OR - Diagnosis of juvenile psoriatic arthritis (PsA)
TALTZ (ixekizumab)	ENTYVIO (vedolizumab)	
TYENNE Syringe, Vial (tocilizumab-aazg)	HADLIMA (adalimumab-bwwd)	- Age 4 years and older AND - Diagnosis of plaque psoriasis (PsO)
XELJANZ (tofacitinib) tablet	HULIO (adalimumab-fkjp)	
	HYRIMOZ (adalimumab-adaz)	- Age 18 years and older AND - Diagnosis of rheumatoid arthritis (RA) OR - Diagnosis of psoriatic arthritis (PsA) OR - Diagnosis of ankylosing spondylitis (AS)
	IDACIO (adalimumab-aacf)	
	ILARIS (canakinumab)	HUMIRA (adalimumab) – Age specific indications: - Age 2 years and older AND - Diagnosis of juvenile idiopathic arthritis (JIA) OR - Diagnosis of uveitis (UV)
	ILUMYA (tildrakizumab-asmn)	
		- 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)

	IMULDOSA (usteinumab-srlf)	KINERET (anakinra) – Age specific indications: • Age 18 years and older AND • Diagnosis of rheumatoid arthritis (RA) • Other indications require clinical review
	INFLECTRA (infliximab-dyyb)	
	infliximab	OLUMIANT (baricitinib) – Age specific indications: • Age 18 years and older AND • Diagnosis of alopecia areata (AA) • Other indications require clinical review
	JYLAMVO (methotrexate)	
	KEVZARA (sarilumab)	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
	LEQSELVI (deuruxolitinib)	
	LITFULO (ritlectinib)	• Age 18 years and older AND • Diagnosis of rheumatoid arthritis (RA) • Non-preferred Orenzia syringe requires clinical review
	OMVOH (mirikizumab-mrkz)	OTEZLA (apremilast) – Age specific indications: • Age 6 years and older AND • Diagnosis of plaque psoriasis (PsO) OR • Diagnosis of psoriatic arthritis (PsA)
	ORENCIA SYRINGE (abatacept)	• Age 18 years and older AND • Diagnosis of Bechet's disease
	OTREXUP (methotrexate)	RINVOQ (upadacitinib): • Age 2 years and older AND • Diagnosis of juvenile idiopathic arthritis (JIA)
	OTULFI (ustekinumab-aaaz)	AND • History of 3 claims with preferred TNF Inhibitor Avsola, Enbrel, Humira or Simponi
	PYZCHIVA (ustekinumab-ttwe)	OR • History of 1 claim with Rinvoq in the past
	RASUVO (methotrexate)	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
	REMICADE (infliximab)	
	RENFLEXIS (infliximab-abda)	• 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
	SILIQ (brodalumab)	AND • History of 3 claims with preferred TNF Inhibitor Avsola, Enbrel, Humira or Simponi
	SIMLANDI (adalimumab-ryvk)	OR • History of 1 claim with Rinvoq in the past
	SIMPONI ARIA (golimumab)	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
	SKYRIZI (risankizumab-rzaa)	
	SOTYKTU (deucravacitinib)	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
	SPEVIGO (spesolimab-sbzo)	
	STELARA (ustekinumab)	
	TOFIDENCE (tocilizumab-bavi)	TALTZ (izekizumab) – Age specific indications: Taltz 20 mg, 40 mg and 80 mg • Age 6 AND • Diagnosis of plaque psoriasis (PsO)
	TREMFYA (guselkumab)	
	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
	XATMEP (methotrexate)	

		• Diagnosis of juvenile arthritis (JIA)
	XELJANZ (tofacitinib) solution	• Age 18 years and older AND • Diagnosis of rheumatoid arthritis (RA) OR • Diagnosis of giant cell arteritis • Non-preferred Tyenne autoinjector requires clinical review
	XELJANZ XR (tofacitinib)	
	YESINTEK (ustekinumab-kfce)	XELJANZ IR (tofacitinib) – Any of the following: • Age 2 year and older AND • Diagnosis of juvenile arthritis (JIA)
	YUFLYMA (adalimumab-aaty)	• 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
	YUSIMRY (adalimumab-aqvh)	
	ZYMFENTRA (infliximab-dyyb)	Preferred methotrexate does not require prior authorization

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)	PROCRT (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	
ALTUVIIIQ	JIVI	
FEIBA	KCENTRA	
HEMOFIL M	OBIZUR	
HUMATE-P	VONVENDI	
KOATE		
KOGENATE FS		
KOVALTRY		
NOVOEIGHT		
NUWIQ		
RECOMBINATE		
WILATE		
XYNTHA, XYNTHA SOLOFUSE		
FACTOR IX		
ALPHANINE SD	BEQVEZ	
ALPROLIX	REBINYN	
BENEFIX		
IDELVION		
IXINITY		
PROFILNINE		
RIXUBIS		
OTHER HEMOPHILIA PRODUCTS		
COAGADEX (factor X)	ALHEMO (concizumab-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 CIPRO Suspension for Age < 12 Years - Documented diagnosis of Cystic Fibrosis or Anthrax infection or exposure OR - 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 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
levofloxacin tablet	CIPRO (ciprofloxacin)	
	ciprofloxacin suspension	
	levofloxacin solution	
	moxifloxacin	
	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 (podoofilox)	CARAC (fluorouracil)	Minimum Age Limit 12 years: ALDARA, ZYCLARA 18 years: CONDYLOX, PICATO, VEREGEN
fluorouracil	EFUDEX (fluorouracil)	
imiquimod	VEREGEN (sinecatechins)	
podoofilox	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 PRILOSEC 10 mg suspension - Requires clinical review
famotidine	cimetidine	
	nizatidine	
	PEPCID (famotidine)	
OTHERS		
CARAFATE (sucralfate) suspension	CARAFATE (sucralfate) tablet	
misoprostol	CYTOTEC (misoprostol)	
sucralfate	DARTISLA (glycopyrrolate)	
	VOQUEZNA (vonoprazan)	
PROTON PUMP INHIBITORS		
esomeprazole capsule	DEXILANT (dexlansoprazole)	
NEXIUM (esomeprazole) packet	dexlansoprazole	
omeprazole	esomeprazole packet	
pantoprazole	KONVOMEF (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
ASMANEX (mometasone)	ALVESCO (ciclesonide)	
budesonide 0.25 mg and 0.5 mg	ARMONAIR DIGIHALER (fluticasone)	
fluticasone diskus	ARNUITY ELLIPTA (fluticasone)	
fluticasone HFA	ASMANEX HFA (mometasone)	

PULMICORT FLEXHALER (budesonide)	budesonide 1 mg	Note: - Institutional-sized products are non-preferred
QVAR REDIHALER (beclomethasone)	FLOVENT HFA (fluticasone)	
	FLOVENT DISKUS (fluticasone)	
	PULMICORT (budesonide) nebulizer solution	
GLUCOCORTICOID/BRONCHODILATOR COMBINATIONS		AIRDUO DIGIHALER Requires clinical review
ADVAIR DISKUS (fluticasone/salmeterol)	AIRDUO DIGIHALER (fluticasone/salmeterol)	ARMONAIR DIGIHALER Requires clinical review
ADVAIR HFA (fluticasone/salmeterol)	AIRSUPRA (albuterol/budesonide)	
DULERA (mometasone/formoterol)	BREO ELLIPTA (fluticasone/vilanterol)	
fluticasone/salmeterol diskus	BREYNA (budesonide/formoterol)	
fluticasone/salmeterol HFA	budesonide/formoterol	Minimum Age Limit 18 years: AIRSUPRA Quantity Limit (per 31 days) 2 inhalers: AIRSUPRA -- MANUAL PA
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, panhypopituitarism, Prader-Willi 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 hypopituitarism, Noonan 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, mosaicism 45, Prader-Willi 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, Noonan Syndrome, 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)	
	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	BRYNOVIN solution (sitagliptin)	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
metformin ER (generic GLUCOPHAGE XR)	GLUMETZA (metformin)	
JANUMET (sitagliptin/metformin)	metformin ER (generic FORTAMET)	
JANUMET XR (sitagliptin/metformin)	metformin ER (generic GLUMETZA)	
JANUVIA (sitagliptin)	metformin solution	
JENTADUETO (linagliptin/metformin)	RIOMET (metformin)	
TRADJENTA (linagliptin)	alogliptin	
	alogliptin/metformin	
	JENTADUETO XR (linagliptin/metformin)	
	KAZANO (alogliptin/metformin)	
	KOMBIGLYZE XR (saxagliptin/metformin)	
	NESINA (alogliptin)	
	ONGLYZA (saxagliptin)	
	QSENI (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,		
insulin aspart protamine mix 70/30 vial	TEMPO PEN (insulin lispro)		
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		
	LEVEMIR (insulin detemir)		
	LYUMJEV (insulin lispro-aabc)		
	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
FASENRA (benralizumab)	NUCALA (mepolizumab)	
XOLAIR (omalizumab)	TEZSPIRE (tezepelumab-ekko)	

DUPIXENT 1 claim with DUPIXENT in the past 60 days OR - New starts require clinical review (see manual PA links below) Asthma MANUAL PA Atopic Dermatitis MANUAL PA COPD MANUAL PA Eosinophilic Esophagitis MANUAL PA Nasal Polyposis MANUAL PA Prurigo Nodularis MANUAL PA	FASENRA - Requires clinical review MANUAL PA NUCALA - Requires clinical review TEZSPIRE - Requires clinical review XOLAIR 1 claim with XOLAIR in the past 45 days OR - New starts require clinical review MANUAL PA	See below for additional PA Criteria/DUR+ Rules
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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	ENVARBUS 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
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- **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 ENVARBUS 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		
ANTI HISTAMINE/CORTICOSTEROID COMBINATIONS		
	azelastine/fluticasone	
	DYMISTA (azelastine/fluticasone)	
	RYALTRIS (olopatadine/mometasone)	
ANTI HISTAMINES		
azelastine	olopatadine	
	PATANASE (olopatadine)	
CORTICOSTEROIDS		
fluticasone	BECONASE AQ (beclomethasone)	
	flunisolide	
	mometasone	
	NASONEX (mometasone)	
	OMNARIS (ciclesonide)	
	QNASL (beclomethasone)	
	XHANCE (fluticasone)	
	ZETONNA (ciclesonide)	

IRON CHELATING AGENTS		
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 1,000 mg tablet	
deferiprone 500 mg tablet	EXJADE (deferasirox)	
FERRIPROX (deferiprone)	JADENU, JADENU SPRINKLE (deferasirox)	

IRRITABLE BOWEL SYNDROME/SHORT BOWEL SYNDROME AGENTS/SELECTED AGENTS ^{DUR+}		
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, MOTTEGRITY, MOVANTIK, MYTESI, RELISTOR, SYMPROIC, TRULANCE, VIBERZI Gender Limit • Female AMITIZA 8 mcg
LINZESS (linaclotide)	AMITIZA (lubiprostone)	
lubiprostone	IBSRELA (tenapanor)	
TRULANCE (plecanatide)	MOTTEGRITY (prucalopride)	
	MOVANTIK (naloxegol)	
	prucalopride	
	RELISTOR (methylnaltrexone)	
	SYMPROIC (naldemedine)	
IRRITABLE BOWEL SYNDROME DIARRHEA		
dicyclomine	alosetron	
ED-SPAZ (hyoscyamine)	LOTRONEX (alosetron) ^{DUR+}	
hyoscyamine, hyoscyamine ER	VIBERZI (eluxadoline) ^{DUR+}	
HYOSYNE (hyoscyamine)		
LEVSIN, LEVSIN-SL (hyoscyamine)		
NULEV (hyoscyamine)		
OSCIMIN, OSCIMIN SL (hyoscyamine)		

SHORT BOWEL SYNDROME AND SELECTED GI AGENTS ^{DUR+}		
	GATTEX (teduglutide)	
	MYTESI (crofelemer)	
IRRITABLE BOWEL SYNDROME CONSTIPATION ^{DUR+}		
Chronic Idiopathic Constipation (CIC): Amitiza 24 mcg, LINZESS 72 mcg, LINZESS 145 mcg, MOTEGRITY, TRULANCE • Preferred CIC Agents ○ Documented diagnosis of CIC in the past year AND ○ No history of GI or bowel obstruction • LINZESS 72 mcg ○ Age 6-17 years AND ○ Documented diagnosis of CIC or pediatric functional constipation in the past year AND ○ No history of GI or bowel obstruction • Non-Preferred CIC Agents ○ Documented diagnosis of CIC AND ○ No history of GI or bowel obstruction AND ○ Have tried 2 preferred CIC agents in the past 6 months OR ○ 1 claim with the requested agent in the past 105 days	Irritable Bowel Syndrome Constipation Dominant (IBS-C): AMITIZA 8 mcg, IBSRELA, LINZESS 290 mcg, TRULANCE • Preferred IBS-C Agents ○ Documented diagnosis of IBS-C in the past year AND ○ No history of GI or bowel obstruction • Non-Preferred IBS-C Agents ○ Documented diagnosis of IBS-C in the past year AND ○ No history of GI or bowel obstruction AND ○ Have tried 2 preferred IBS-C agents in the past 6 months OR ○ 1 claim with the requested agent in the past 105 days	Opioid Induced Constipation (OIC): AMITIZA 24 mcg, MOVANTIK, RELISTOR, SYMPROIC • Preferred OIC Agents ○ Documented diagnosis of OIC and chronic pain in the past year AND ○ No history of GI or bowel obstruction AND ○ 1 claim for an opioid in the past 30 days • Non-Preferred OIC Agents ○ All preferred criteria met AND ○ Have tried 1 preferred OIC agents in the past 6 months OR ○ 1 claim with the requested agent in the past 105 days • Relistor Injection ○ Above OIC criteria OR ○ Documented diagnosis of OIC and active cancer in the past year AND ○ No history of GI or bowel obstruction AND ○ 1 claim for an opioid in the past 30 days
IRRITABLE BOWEL SYNDROME DIARRHEA		
• VIBERZI [New starts require clinical review] Documented diagnosis of IBS D in the past year and 1 claim for Viberzi in the past 105 days ○ • LOTRONEX ○ 1 claim for LOTRONEX in the past 105 days OR ○ New starts require clinical review MANUAL PA • XIFAXAN (see Antibiotics, GI)		
SHORT BOWEL SYNDROME AND SELECTED GI AGENTS ^{DUR+}		
HIV/AIDS Non-infectious Diarrhea • MYTESI ○ Documented diagnosis of HIV/AIDS and non-infectious diarrhea in the past year AND ○ 1 claim for an antiretroviral in the past 30 days	Short Bowel Syndrome (SBS) • GATTEX ○ 1 claim for GATTEX in the past 105 days OR ○ New starts require clinical review	
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
	NEXLETOL (bempedoic acid)	
	NEXLIZET (bempedoic acid/ezetimibe)	JUXTAPID MANUAL PA
ANGIOPOIETIN-LIKE 3 INHIBITORS		
	EVKEEZA (evinacumab-dgnb)	
BILE ACID SEQUESTRANTS		
cholestyramine	colesevelam	KYNAMRO • Requires clinical review
cholestyramine light	COLESTID (colestipol)	
colestipol tablet	colestipol packet	LEQVIO • Requires clinical review
	PREVALITE (cholestyramine)	
	QUESTRAN (cholestyramine)	NEXLETOL and NEXLIZET • Require clinical review
	QUESTRAN LIGHT (cholestyramine)	
	WELCHOL (colesevelam)	PRALUENT MANUAL PA
CHOLESTEROL ABSORPTION INHIBITORS		
ezetimibe	ZETIA (ezetimibe)	REPATHA MANUAL PA
FIBRIC ACID DERIVATIVES		
fenofibrate	fenofibric acid	WELCHOL • Documented diagnosis of Type 2 Diabetes AND • 30 days of therapy with an antidiabetic agent in the past 6 months OR 90 days of therapy with WELCHOL in the past 105 days
gemfibrozil	FENOGLIDE (fenofibrate)	
	FIBRICOR (fenofibric acid)	
	LIPOFEN (fenofibrate)	
	LOPID (gemfibrozil)	

	TRICOR (fenofibrate)
	TRILIPIX (fenofibric acid)
MTP INHIBITOR	
	JUXTAPID (lomitapide)
NIACIN	
niacin ER	
OMEGA-3 FATTY ACIDS	
omega-3 acid ethyl esters	icosapent 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	
hydroxyzine HCL	CAMZYOS (mavacamten)	
hydroxyzine pamoate	CRENESSITY (crinecerfont)	
megestrol	EVRYSDI (risdiplam)	
REVLIMID (lenalidomide)	KORLYM (mifepristone)	
	lenalidomide	
	TRYNGOLZA (olezarsen)	
	VERQUVO (vericiguat)	
	VISTARIL (hydroxyzine pamoate)	
	XANAX, XANAX XR (alprazolam)	
SUBLINGUAL NITROGLYCERIN		
nitroglycerin		
NITROLINGUAL (nitroglycerin)		
NITROSTAT (nitroglycerin)		

MOVEMENT DISORDER AGENTS ^{DUR+}		
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
AUSTEDO XR (deutetrabenazine)	XENAZINE (tetrabenazine)	
INGREZZA (valbenazine)		
INGREZZA SPRINKLE (valbenazine)		
tetrabenazine		
		INGREZZA • Documented diagnosis of Huntington's chorea OR • Documented diagnosis of tardive dyskinesia AND • 90 days of therapy with this agent in the past 105 days OR

MULTIPLE SCLEROSIS AGENTS		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
BETASERON (interferon beta-1b)	AMPYRA (dalfampridine)	Preferred Agents - Documented diagnosis of multiple sclerosis Non-Preferred Criteria - Documented diagnosis of multiple sclerosis AND - Have tried 2 different preferred agents in the past 6 months OR 3 claims with the requested agent in the last 105 days KESIMPTA, PONVORY, TASCENSO ODT, and ZEPOSIA - Require clinical review MAVENCLAD MANUAL PA MAYZENT MANUAL PA OCREVUS and OCREVUS ZUNOVO MANUAL PA
COPAXONE (glatiramer) 20 mg	AUBAGIO (teriflunomide)	
dalfampridine ER	AVONEX (interferon beta-1a)	
dimethyl fumarate	BAFIERTAM (monomethyl fumarate)	
fingolimod	BRIUMVI (ublituximab-xiiy)	
REBIF (interferon beta-1b)	COPAXONE (glatiramer) 40 mg	
REBIF REBIDOSE (interferon beta-1b)	GILENYA (fingolimod)	
teriflunomide	glatiramer	
TYSABRI (natalizumab)	GLATOPA (glatiramer)	
	KESIMPTA PEN (ofatumumab)	
	MAVENCLAD (cladribine)	
	MAYZENT (siponimod)	
	OCREVUS (ocrelizumab)	
	OCREVUS ZUNOVO (ocrelizumab/hyaluronidase-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)	
	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
meloxicam	CELEBREX (celecoxib)	
	celecoxib	ELYXYB Requires clinical review
	ELYXYB (celecoxib)	
NON-SELECTIVE		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
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	
bacitracin/polymyxin	AZASITE (azithromycin)
ciprofloxacin	bacitracin
erythromycin	BESIVANCE (besifloxacin)
gentamicin	CILOXAN (ciprofloxacin)
moxifloxacin	gatifloxacin
ofloxacin	NATACYN (natamycin0
polymyxin B/trimethoprim	neomycin/bacitracin/polymyxin
tobramycin	OCUFLOX (ofloxacin)
	sulfacetamide
	TOBREX (tobramycin)
	VIGAMOX (moxifloxacin)
ANTIBIOTIC-STEROID COMBINATIONS	
BLEPHAMIDE S.O.P. (sulfacetamide/prednisolone)	MAXITROL (neomycin/polymyxin/dexamethasone)
neomycin/bacitracin/polymyxin/hydrocortisone	neomycin/polymyxin/gramicidin
neomycin/polymyxin/dexamethasone	TOBRADEX ST (tobramycin/dexamethasone)
PRED-G (gentamicin/prednisolone)	
sulfacetamide/prednisolone	
TOBRADEX (tobramycin/dexamethasone)	
tobramycin/dexamethasone	
ZYLET (tobramycin/loteprednol)	
ANTI-INFLAMMATORY AGENTS ^{DUR+}	
dexamethasone	ACULAR, ACULAR LS (ketorolac)
diclofenac sodium	ACUVAIL (ketorolac)
difluprednate	bromfenac
FLAREX (fluorometholone)	BROMSITE (bromfenac)
fluorometholone	DUREZOL (difluprednate)
flurbiprofen	FML (fluorometholone)
FML FORTE (fluorometholone)	ILEVRO (nepafenac)
ketorolac	INVELTYS (loteprednol)
MAXIDEX (dexamethasone)	LOTEMAX, LOTEMAX SM (loteprednol)
PRED MILD (prednisolone)	loteprednol
prednisolone acetate	NEVANAC (nepafenac)
prednisolone sodium phosphate	PRED FORTE (prednisolone)
	PROLENSA (bromfenac)
DRY EYE AGENTS	
RESTASIS Droperette (cyclosporine)	CEQUA (cyclosporine)
XIIDRA (lifitegrast)	cyclosporine
	EYSUVIS (loteprednol)
	MIEBO (perfluorohexyloactane)
	RESTASIS Multidose (cyclosporine)
	TYRVAYA (varenicline)
	VEVYE (cyclosporine)

- 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**
- Require clinical review

- MIEBO**
- Requires clinical review

- RESTASIS Multidose**
- Require clinical review

- TRYPTYR**
- Requires clinical review

- TYRVAYA**
- Requires clinical review

- VEVYE**
- Requires clinical review

OPHTHALMIC, GLAUCOMA AGENTS		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
BETA BLOCKERS		Minimum Age Limit • 18 years: IYUZEH Non-Preferred Criteria • Have tried 2 different preferred agents in the past 6 months OR • 90 days of therapy with the requested agent in the past 105 days
BETIMOL (timolol)	betaxolol	
carteolol	BETOPTIC S (betaxolol)	
ISTALOL (timolol)	timolol droperette, daily drop, gel	
levobunolol	TIMOPTIC; TIMOPTIC OCUDOSE, XE (timolol)	
timolol drops 0.25%, 0.5%		
CARBONIC ANHYDRASE INHIBITORS		
dorzolamide	AZOPT (brinzolamide)	
	brinzolamide	
COMBINATION AGENTS		
COMBIGAN (brimonidine/timolol)	brimonidine/timolol	
dorzolamide/timolol	COSOPT (dorzolamide/timolol)	
SIMBRINZA (brinzolamide/brimonidine)	dorzolamide/timolol PF	
PARASYMPATHOMIMETICS		
pilocarpine	PHOSPHOLINE IODIDE (echothiophate iodide)	
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 - Have tried 2 different preferred agents in the past 6 months VERKAZIA - Requires clinical review
azelastine	ALOMIDE (lodoxamide)	
cromolyn	bepotastine	
ketotifen OTC	BEPREVE (bepotastine)	
olopatadine	epinastine	
ZADITOR (ketotifen)	LASTACRAFT (alcaftadine)	
	VERKAZIA (cyclosporine)	
	ZERViate (cetirizine)	

OPIATE DEPENDENCE TREATMENTS

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

BRILINTA (ticagrelor)	PLAVIX (clopidogrel)	• 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
cilostazol	ticagrelor	
clopidogrel		
dipyridamole		
pentoxifylline		
prasugrel		
ZONTIVITY MANUAL PA		
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		Maximum Age Limit • 12 years: REVATIO suspension
	OPSYNVI (macitentan/tadalafil)	
ENDOTHELIN RECEPTOR ANTAGONISTS		Preferred Criteria • PAH Agents ○ Documented diagnosis of pulmonary hypertension
ambrisentan	OPSUMIT (macitentan)	
bosentan	TRACLEER (bosentan)	
LETAIRIS (ambrisentan)	TRYVIO (aprocitentan)	
PDE5 INHIBITORS		• Sildenafil tablets ○ ≤ 1 year of age and documented diagnosis of pulmonary hypertension, patent ductus arteriosus, or persistent fetal circulation OR ○ ≥ 1 year of age and documented diagnosis of pulmonary hypertension OR ○ 90 days of therapy with the requested agent in the past 105 days
sildenafil (generic REVATIO) tablet, suspension	ADCIRCA (tadalafil)	
tadalafil	ALYQ (tadalafil)	
	REVATIO (sildenafil)	
	TADLIQ (tadalafil)	
PROSTACYCLINS		• 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
	ORENITRAM ER (treprostinil)	
	ORENITRAM TITRATION PAK (treprostinil)	
	TYVASO (treprostinil)	
	VENTAVIS (iloprost)	
	YUTREPIA (treprostinil)	
SELECTIVE PROSTACYCLINE RECEPTOR AGONISTS		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
	UPTRAVI (selexipag)	
SOLUABLE GUANYLATE CYCLASE STIMULATORS		
	ADEMPAS (riociguat)	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	PA CRITERIA	
metronidazole	AVAR (sulfacetamide sodium/sulfur)	Note: - Topical Sulfonamides used for Rosacea will require a manual PA for age > 21 years. - Other labeled indications are limited to < 21 years.	
	AVAR LS (sulfacetamide sodium/sulfur)		
	AVAR-E (sulfacetamide sodium/sulfur)		
	BP 10-1 (sulfacetamide sodium/sulfur)		
	brimonidine		
	EPSOLAY (benzoyl peroxide)		
	FINACEA (azelaic acid)		
	METROCREAM (metronidazole)		
	METROGEL (metronidazole)		
	MIRVASO (brimonidine)		
	NORITATE (metronidazole)		
	OVACE (sulfacetamide sodium)		
	OVACE PLUS (sulfacetamide sodium)		
	RHOFADE (oxymetazoline)		
	ROSADAN (metronidazole)		
	ROSULA (sulfacetamide sodium/sulfur)		
	sodium sulfacetamide		
	sodium sulfacetamide/sulfur		
	SOOLANTRA (ivermectin)		
	SUMADAN (sulfacetamide sodium/sulfur)		
	SUMADAN XLT (sulfacetamide sodium/sulfur/avob)		
	SUMAXIN (sulfacetamide sodium/sulfur)		
	SUMAXIN CP (sulfacetamide sodium/sulfur)		
	SUMAXIN TS (sulfacetamide sodium/sulfur)		
SEDATIVE HYPNOTIC AGENTS			
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA	
BENZODIAZEPINES DUR+		MS DOM Opioid Initiative Criteria details found here - Concomitant use of Opioids and Benzodiazepines Maximum Age Limit 64 years: zolpidem 7.5 mg, 10 mg, and 12.5 mg Gender and Dose Limit Female: AMBIEN 5 mg, AMBIEN CR 6.25 mg, INTERMEZZO 1.75 mg Male: all strengths of zolpidem Non-Preferred Criteria - Have tried 2 different preferred agents in the past 6 months HETLIOZ capsules - Age 18 years or older AND - Documented diagnosis of circadian rhythm sleep disorder - OR - Age 16 years and older AND - Documented diagnosis of Smith-Magenis syndrome HETLIOZ liquid - Age 3-15 years AND - Documented diagnosis of Smith-Magenis syndrome Note: - Single-source benzodiazepines and barbiturates are NOT covered. - PA s will NOT be issued for these drugs. See below for additional PA Criteria/DUR+ Rules	
estazolam	flurazepam		
temazepam 15 mg, 30 mg capsule	HALCION (triazolam)		
	quazepam		
	RESTORIL (temazepam)		
	temazepam 7.5 mg, 22.5 mg capsule		
	triazolam		
OTHERS DUR+			
eszopiclone	AMBIEN (zolpidem)		
ramelteon	AMBIEN CR (zolpidem)		
zaleplon	BELSOMRA (suvorexant)		
zolpidem tablet	DAYVIGO (lemborexant)		
	doxepin		
	EDULAR (zolpidem)		
	HETLIOZ LQ (tasimelteon)		
	LUNESTA (eszopiclone)		
	QUVIVIQ (daridorexant)		
	ROZEREM (ramelteon)		
	tasimelteon		
	zolpidem capsule		
	zolpidem sublingual tablet		
	zolpidem ER		

- CUMULATIVE Quantity Limit Benzodiazepines**
- 31 units/31 days:** Quantity limit per rolling days for all strengths. DUR+ will allow an early refill override for one dose or therapy change per year.

- CUMULATIVE Quantity Limit Triazolam**
- 10 units/31 days:** Quantity limit per rolling days for all strengths.
 - 60 units/365 days:** Quantity limit per rolling days for all strengths.

- CUMULATIVE Quantity Limit Non-Benzodiazepines**
- **31 units/31 days:** Quantity limit per rolling days for all strengths. DUR+ will allow an early refill override for one dose or therapy change per year.
- CUMULATIVE Quantity Limit HETLIOZ LQ**
- **1 bottle (48 mL or 158 mL):** Quantity limit per rolling days for all strengths. DUR+ will allow an early refill override for one dose or therapy change per year.
- CUMULATIVE Quantity Limit ZOLPIMIST**
- **1 canister/31 days:** male; Quantity limit per rolling days for all strengths. DUR+ will allow an early refill override for one dose or therapy change per year.
 - **1 canister/62 days:** female; Quantity limit per rolling days for all strengths. DUR+ will allow an early refill override for one dose or therapy change per year.

PREFERRED AGENTS		NON-PREFERRED AGENTS	SELECT CONTRACEPTIVE PRODUCTS	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)			

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

SKELETAL MUSCLE RELAXANTS DUR+		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
baclofen 5 mg, 10 mg, 20 mg tablet	AMRIX (cyclobenzaprine)	Quantity Limit • 84 tablets/180 days: carisoprodol
chlorzoxazone	baclofen 15 mg tablet	
cyclobenzaprine 5 mg, 10 mg tablet	baclofen suspension	Non-Preferred Criteria • Documented diagnosis of an approvable indication AND • Have tried 2 different preferred agents in the past 6 months
methocarbamol	carisoprodol	
tizanidine tablet	carisoprodol/aspirin	Baclofen granules, solution, and suspension • Require clinical review.
	cyclobenzaprine 7.5 mg tablet	
	cyclobenzaprine ER	
	DANTRIUM (dantrolene)	
	dantrolene	

	FEXMID (cyclobenzaprine)	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 - Requires clinical review. Metaxalone 640 mg and TANLOR - Requires clinical review
	FLEQSUVY (baclofen)	
	LORZONE (chlorzoxazone)	
	LYVISPAH (baclofen)	
	metaxalone	
	NORGESIC (orphenadrine/aspirin/cafeine)	
	NORGESIC FORTE (orphenadrine/aspirin/cafeine)	
	orphenadrine	
	orphenadrine/aspirin/cafeine	
	ORPHENGESIC FORTE (orphenadrine/aspirin/cafeine)	
	SOMA (carisoprodol)	
	TANLOR (methocarbamol)	
	tizanidine capsule	
	ZANAFLEX (tizanidine)	
SMOKING DETERRENTS		
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-SMOOTHIE-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	BRYHALI (halobetasol)	
halobetasol	clobetasol emulsion	
	clobetasol 0.025% cream	
	CLOBEX (clobetasol)	
	CLODAN (clobetasol)	
	DIPROLENE (betamethasone)	
	halobetasol	
	IMPEKLO (clobetasol)	
	IMPOYZ (clobetasol) 0.025% cream	
	LEXETTE (halobetasol)	
	OLUX (clobetasol)	
	TEMOVATE (clobetasol)	
	TOVET (clobetasol)	
	ULTRAVATE (halobetasol)	
STIMULANTS AND RELATED AGENTS DUR+		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA

SHORT-ACTING	
dexmethylphenidate	ADDERALL (dextroamphetamine/amphetamine)
dextroamphetamine	amphetamine
dextroamphetamine/amphetamine	EVEKEO (amphetamine)
Methylphenidate tablet	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)	

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, METHYLN, 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, METHYLN 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
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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	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
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Minimum Age Limit

- **3 years:** ADDERALL, EVEKEO, PROCENTRA, ZENZEDI
- **6 years:** ADDERALL XR, ADHANSIA XR, ADZENYS ER SUSPENSION, ADZENYS XR ODT, APTENSIO XR, atomoxetine, AZSTARYS, clonidine ER, CONCERTA ER, COTEMPLA XR ODT, DAYTRANA, DESOXYN, DEXEDRINE, DYANAVEL XR, EVEKEO ODT, FOCALIN, FOCALIN XR, JORNAY PM, METADATE CD, METHYLN, ONYDA XR, QELBREE, QUILLICHEW, QUILLIVANT XR, RELEXXII ER, RITALIN LA, VYVANSE, XELSTRYM
- **7 years:** XYREM
- **13 years:** MYDAYIS
- **16 years:** modafinil
- **18 years:** armodafinil, SUNOSI, WAKIX

Maximum Age Limit

- **18 years:** clonidine ER, COTEMPLA XR ODT, DAYTRANA, EVEKEO ODT, guanfacine ER

Quantity Limit Stimulants (per 31 days)

- **31 tablets:** ADDERALL XR, ADHANSIA XR, ADZENYS XR ODT, APTENSIO XR, AZSTARYS, CONCERTA ER 18, 27, & 54 mg, COTEMPLA XR-ODT 8.6 mg, DAYTRANA, DEXEDRINE Spansule, DYANAVEL XR Tablet, FOCALIN XR, JORNAY PM, METADATE CD, METHYLN 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, METHYLN, RITALIN, ZENZEDI
- **248 mL:** DYANAVEL XR Suspension
- **310 mL:** METHYLN, PROCENTRA
- **372 mL:** QUILLIVANT XR

Quantity Limit Narcolepsy (per 31 days)

- **31 tablets:** armodafinil 150, 200 & 250 mg, modafinil 200 mg, SUNOSI
- **46.5 tablets:** modafinil 100 mg
- **62 tablets:** armodafinil 50 mg, WAKIX

Quantity Limit Non-Stimulants (per 31 days)

- **31 tablets:** atomoxetine, guanfacine ER, QELBREE 100 mg
- **62 tablets:** QELBREE 150 mg and 200 mg
- **124 tablets:** clonidine ER
- **1 bottle (30 mL or 60 mL):** ONYDA XR Suspension

Clonidine ER Documented diagnosis of ADD/ADHD	30 days of therapy with preferred modafinil or armodafinil in the past 6 months
Guanfacine ER Documented diagnosis of ADD/ADHD	VYVANSE - Documented diagnosis of binge eating disorder or ADD/ADHD 90 days of therapy with Vyvanse in the past 90 days
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	VYVANSE chewable Requires clinical review
Modafinil Documented diagnosis of narcolepsy, obstructive sleep apnea, shift work sleep disorder, depression, sleep deprivation or Steinert Myotonic Dystrophy Syndrome	WAKIX Requires clinical review
ONYDA XR 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	PA CRITERIA	
doxycycline hyclate	demeclocycline	Non-Preferred Agents - Have tried 2 different preferred agents in the past 6 months Demeclocycline - Documented diagnosis of Syndrome of Inappropriate Antidiuretic Hormone Secretion (SIADH) will allow for automatic approval ORACEA - Requires clinical review	
doxycycline monohydrate capsule	DORYX (doxycycline hyclate)		
minocycline capsule	DORYX MPC (doxycycline hyclate)		
tetracycline capsule	doxycycline hyclate DR		
	doxycycline IR/DR		
	doxycycline monohydrate suspension, tablet		
	LYMEPAK (doxycycline hyclate)		
	MINOCIN (minocycline)		
	minocycline tablet		
	minocycline ER		
	MINOLIRA ER (minocycline)		
	MORGIDOX (doxycycline hyclate)		
	NUZYRA (omadacycline)		
	ORACEA (doxycycline monohydrate)		
	SOLODYN (minocycline)		
	tetracycline tablet		
ULCERATIVE COLITIS & CROHN'S AGENTS ^{DUR+} *See Cytokine & CAM Antagonists Class for Additional Agents*			
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
APRISO (mesalamine)	AZULFIDINE (sulfasalazine)		
balsalazide	COLAZAL (balsalazide)		
budesonide	DELZICOL (mesalamine)		
PENTASA (mesalamine)	DIPENTUM (olsalazine)		
sulfasalazine	LIALDA (mesalamine)		
sulfasalazine DR	mesalamine		
UCERIS (budesonide)	mesalamine DR, mesalamine ER		
	VELSIPITY (etrasimod)		
RECTAL			
mesalamine suppository	budesonide		
	CANASA (mesalamine)		
	mesalamine enema		
	ROWASA (mesalamine)		
	SFROWASA (mesalamine)		
	UCERIS (budesonide)		
UREA CYCLE DISORDER AGENTS			
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA	
CARBAGLU (carglumic acid)	BUPHENYL (sodium phenylbutyrate)		
	carglumic acid		
	OLPRUVA (sodium phenylbutyrate)		
	PHEBURANE (sodium phenylbutyrate)		
	RAVICTI (glycerol phenylbutyrate)		