

MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

EFFECTIVE 12/1/2025
VERSION 2025_13
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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)	
	clindamycin foam	
	clindamycin gel (generic CLINDAGEL)	
	dapsone	
	ERY (erythromycin)	
	ERYGEL (erythromycin)	
	erythromycin	
	EVOCLIN (clindamycin)	
	MORGIDOX (doxycycline)	
	sulfacetamide sodium suspension	
	WINLEVI (clascoterone) cream	
ISOTRETINOIN PRODUCTS		
AMNESTEEM (isotretinoin)	ABSORBICA (isotretinoin)	
CLARAVIS (isotretinoin)	isotretinoin	
ZENATANE (isotretinoin)		
KERATOLYTICS (BENZOYL PEROXIDES)		
ACNE MEDICATION (benzoyl peroxide)	BPO towelette (benzoyl peroxide)	
benzoyl peroxide		
LINTERA (benzoyl peroxide)		
RETINOIDS		
adapalene gel, gel with pump	adapalene cream	
tretinoin cream	AKLIEF (trifarotene)	
	ATRALIN (tretinoin)	
	DIFFERIN (adapalene)	
	FABIOR (tazarotene)	
	tretinoin gel	
	tretinoin microsphere	
OTHERS/COMBINATION PRODUCTS		
adapalene/benzoyl peroxide gel	CLEANSING WASH (sulfacetamide sodium/sulfur/urea) cleanser	
clindamycin/benzoyl peroxide 1%-5% gel w/pump	clindamycin phosphate/benzoyl peroxide 1.2%-2.5% gel	
sodium sulfacetamide w/sulfur 8%-4%, 9%-4.25%, 10-5% suspension	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	
	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	
	ZMA CLEAR (sodium sulfacetamide/sulfur) suspension	
ALPHA-1 PROTEINASE INHIBITORS		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
ARALAST NP		
GLASSIA		
PROLASTIN C		
ZEMAIRA		
ALZHEIMER’S AGENTS ^{DUR+}		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
CHOLINESTERASE INHIBITORS		Preferred Criteria - Documented approvable diagnosis Non-Preferred Criteria - Documented approvable diagnosis AND - Have tried 2 different preferred agents in the past 6 months NAMZARIC - Requires clinical review ZUNVEYL - Requires clinical review
donepezil 5 mg, 10 mg ODT, tablets	ADLARITY (donepezil)	
galantamine	ARICEPT (donepezil)	
galantamine ER	donepezil 23 mg tablet	
rivastigmine	EXELON (rivastigmine)	
	ZUNVEYL (benzgalantamine gluconate)	
NMDA RECEPTOR ANTAGONISTS		
memantine	memantine ER	
	NAMENDA (memantine)	
	NAMENDA XR (memantine ER)	
COMBINATION AGENTS		

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

	methadone intensol	Have tried 2 preferred agents in the past 6 months
	METHADOSE (methadone)	
	morphine sulfate ER capsule	
	MS CONTIN (morphine)	
	oxycodone ER	
	OXYCONTIN (oxycodone)	
	oxymorphone ER	
	tramadol ER	

ANALGESICS/ANESTHETICS (TOPICAL)

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
diclofenac 1%, 3% gel	DERMACINRX LIDOCAN (lidocaine)	Quantity Limit (per 31 days) 1 bottle (112 mL): diclofenac 2% solution pump 1 bottle (150 mL): diclofenac 1.5% solution Non-Preferred Criteria - Have tried 2 preferred agents in the past 6 months Lidocaine 5% Patch - Documented diagnosis of Herpetic Neuralgia OR - Documented diagnosis of Diabetic Neuropathy ZTLIDO - Documented diagnosis of postherpetic neuralgia OR - History of 3 claims with preferred lidocaine 5% patch in the past 6 months
lidocaine 4% cream, patch, solution	DERMACINRX LIDOGEL (lidocaine)	
lidocaine 5% cream, ointment, patch	DERMACINRX LIDOREX (lidocaine)	
lidocaine 40 mg/mL solution	diclofenac epolamine	
lidocaine/prilocaine cream	diclofenac sodium 2% solution pump	
TRIDACAINE (lidocaine) patch	DICLOGEN (diclofenac/menthol/camphor) kit	
TRIDACAINE XL (lidocaine) patch	DOLOGESIC PAIN RELIEF (lidocaine)	
ULTRA LIDO (lidocaine) cream, gel	LIDAFLEX (lidocaine)	
	lidocaine 3% cream	
	lidocaine 4% kit, liquid	
	lidocaine/hydrocortisone	
	lidocaine/prilocaine kit	
	LIDOCAN II, III, IV, V (lidocaine)	
	LIDOCORT (lidocaine/hydrocortisone)	
	LIDODERM (lidocaine)	
	LIDOTRAL (lidocaine)	
	LIXOFEN (diclofenac)	
	PENNSAID (diclofenac)	
	PLIAGLIS (lidocaine/tetracaine)	
	TRIDACAINE II, III (lidocaine) patch	
	ZTLIDO (lidocaine)	

ANDROGENIC AGENTS ^{DUR+}

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
testosterone	ANDROGEL (testosterone)	All Agents Limited to male gender Non-Preferred Criteria
	JATENZO (testosterone undecanoate)	
	NATESTO (testosterone)	

	TESTIM (testosterone)	- Have tried 2 different preferred agents in the past 6 months TLANDO - Requires clinical review
	TLANDO (testosterone undecanoate)	
	VOGELXO (testosterone)	
	UNDECATREX (testosterone undecanoate)	
ANGIOTENSIN MODULATORS DUR+		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
ANGIOTENSIN CONVERTING ENZYME (ACE) INHIBITORS		EPANED - Automatic approval issued for 0-6 years of age ENTRESTO - Age ≥1 year and documented diagnosis of Heart Failure with Systemic Ventricular Systolic Dysfunction OR - Age ≥ 18 years and documented diagnosis of Heart Failure Non-Preferred Criteria ACEIs: - Have tried 2 different preferred single entity agents in the past 6 months OR 90 days of therapy with the requested agent in the past 105 days ACEI/CCB Combinations: - Have tried 2 different preferred ACEI/CCB agents in the past 6 months OR 90 days of therapy with the requested agent in the past 105 days ACEI/Diuretic Combinations: - Have tried 2 different preferred ACEI/Diuretic agents in the past 6 months OR 90 days of therapy with the requested agent in the past 105 days ARBs: - Have tried 2 different preferred single entity agents in the past 6 months OR 90 days of therapy with the requested agent in the past 105 days ARB/CCB and ARB/CCB/Diuretic Combinations: - Have tried 1 preferred ARB/CCB agent in the past 6 months OR 90 days of therapy with the requested agent in the past 105 days ARB/Diuretic Combinations: - Have tried 2 different preferred ARB/Diuretic agents in the past 6 months OR 90 days of therapy with the requested agent in the past 105 days Direct Renin Inhibitors: - Documented diagnosis of Hypertension AND - Have tried 2 different preferred ACEI or ARB single-entity agents in the past 6 months OR 90 days of therapy with the requested agent in the past 105 days Direct Renin Inhibitor Combinations: - Documented diagnosis of Hypertension AND - Have tried 2 different preferred ACEI or ARB diuretic agents in the past 6 months OR 90 days of therapy with the requested agent in the past 105 days - Have tried 2 different preferred ACEI/Diuretic agents in the past 6 months OR 90 days of therapy with the requested agent in the past 105 days
benazepril	ACCUPRIL (quinapril)	
captopril	ALTACE (ramipril)	
enalapril	EPANED (enalapril)	
fosinopril	LOTENSIN (benazepril)	
lisinopril	moexipril	
quinapril	perindopril	
ramipril	QBRELIS (lisinopril)	
trandolapril	ZESTRIL (lisinopril)	
ACE INHIBITOR (ACEI) COMBINATIONS		
benazepril/amlodipine	ACCURETIC (quinapril/hydrochlorothiazide)	
benazepril/hydrochlorothiazide	LOTENSIN HCT (benazepril/hydrochlorothiazide)	
captopril/hydrochlorothiazide	LOTREL (benazepril/amlodipine)	
enalapril/hydrochlorothiazide	ZESTORETIC (lisinopril/hydrochlorothiazide)	
fosinopril/hydrochlorothiazide		
lisinopril/hydrochlorothiazide		
quinapril/hydrochlorothiazide		
trandolapril/verapamil ER		
ANGIOTENSIN II RECEPTOR BLOCKERS (ARBs)		
irbesartan	ATACAND (candesartan)	
losartan	AVAPRO (irbesartan)	
olmesartan	BENICAR (olmesartan)	
telmisartan	candesartan	
valsartan tablet	COZAAR (losartan)	
	EDARBI (azilsartan)	
	eprosartan	
	MICARDIS (telmisartan)	
	valsartan solution	
ARB COMBINATIONS		
ENTRESTO (valsartan/sacubitril) tablet DUR+	ATACAND HCT (candesartan/hydrochlorothiazide)	

irbesartan/hydrochlorothiazide	AVALIDE (irbesartan/hydrochlorothiazide)	
losartan/hydrochlorothiazide	AZOR (olmesartan/hydrochlorothiazide)	
olmesartan/amlodipine	BENICAR HCT (olmesartan/hydrochlorothiazide)	
olmesartan/hydrochlorothiazide	candesartan/hydrochlorothiazide	
telmisartan/hydrochlorothiazide	DIOVAN-HCT (valsartan/hydrochlorothiazide)	
valsartan/amlodipine	EDARBYCLOR (azilsartan/chlorthalidone)	
valsartan/amlodipine/hydrochlorothiazide	ENTRESTO (valsartan/sacubitril) sprinkle capsule	
valsartan/hydrochlorothiazide	EXFORGE (valsartan/amlodipine)	
	EXFORGE HCT (valsartan/amlodipine/hydrochlorothiazide)	
	olmesartan/amlodipine/hydrochlorothiazide	
	telmisartan/amlodipine	
	TRIBENZOR (olmesartan/amlodipine/hydrochlorothiazide)	
	valsartan/sacubitril	
DIRECT RENIN INHIBITORS		
	aliskiren	
	TEKTURNA (aliskiren)	
DIRECT RENIN INHIBITOR COMBINATIONS		
	TEKTURNA HCT (aliskiren/hydrochlorothiazide)	
ANTIBIOTICS (GI) & RELATED AGENTS		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
metronidazole tablet	AEMCOLO (rifamycin)	
neomycin	DIFICID (fidaxomicin)	
tinidazole	FIRVANQ (vancomycin)	
vancomycin oral solution	FLAGYL (metronidazole)	
	LIKMEZ (metronidazole)	
	metronidazole 125 mg tablet, 375 mg capsule	
	nitazoxanide	
	paromomycin	
	REBYOTA (fecal microbiota, live- <i>jslm</i>)	
	VANCOCIN (vancomycin)	
	vancomycin capsule	

	VOWST (fecal microbiota spore, live-brpk)	
ANTIBIOTICS (MISCELLANEOUS)		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
LINCOSAMIDE ANTIBIOTICS		Quantity Limit • 6 tablets/month: SIVEXTRO SIVEXTRO MANUAL PA ZYVOX MANUAL PA
clindamycin	CLEOCIN (clindamycin)	
	CELOCIN PEDIATRIC (clindamycin)	
MACROLIDES		
azithromycin	ERYPED (erythromycin ethylsuccinate) suspension	
clarithromycin	ERYTHROCIN (erythromycin stearate)	
clarithromycin ER	ZITHROMAX (azithromycin)	
E.E.S. (erythromycin ethylsuccinate) suspension		
ERY-TAB (erythromycin)		
erythromycin		
erythromycin ethylsuccinate		
NITROFURANTOIN DERIVATIVES		
nitrofurantoin capsule	FURADANTIN (nitrofurantoin) suspension	
nitrofurantoin monohydrate macrocrystals	MACROBID (nitrofurantoin monohydrate macrocrystals)	
	nitrofurantoin suspension	
OXAZOLIDINONES		
	linezolid	
	SIVEXTRO (tedizolid)	
	ZYVOX (linezolid)	
ANTIBIOTICS (TOPICAL)		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
bacitracin ^{OTC}	CENTANY (mupirocin)	
bacitracin/polymyxin ^{OTC}	CENTANY AT (mupirocin)	
gentamicin sulfate	mupirocin cream	
mupirocin ointment	XEPI (ozenoxacin)	
neomycin/bacitracin/polymyxin ^{OTC}		
ANTIBIOTICS (VAGINAL)		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
CLEOCIN (clindamycin)	clindamycin phosphate	
NUVESSA (metronidazole)	CLINDESSE (clindamycin)	
	SOLOSEC (secnidazole)	
	XACIATO (clindamycin)	
ANTICOAGULANTS		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA

LOW MOLECULAR WEIGHT HEPARIN (LMWH)		Non-Preferred Criteria • LMWH: ○ Have tried 1 preferred agent in the past 6 months OR ○ 90 days of therapy with the requested agent in the past 105 days • Oral: ○ Have tried 2 different preferred oral agents in the past 6 months OR ○ 90 days of therapy with the requested agent in the past 105 days
enoxaparin	ARIXTRA (fondaparinux)	
	fondaparinux	
	FRAGMIN (dalteparin)	
	LOVENOX (enoxaparin)	
ORAL		
ELIQUIS (apixaban)	dabigatran	
JANTOVEN (warfarin)	PRADAXA (dabigatran) pellet pack	
PRADAXA (dabigatran) capsule	rivaroxaban	
warfarin	SAVAYSA (edoxaban)	
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 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
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)	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
	QUDEXY XR (topiramate)	
	ROWEEPRA (levetiracetam)	
	rufinamide	
	SABRIL (vigabatrin)	
	SPRITAM (levetiracetam)	
	SUBVENITE (lamotrigine)	
	SUBVENITE (lamotrigine) blue, green, orange dose pack	
	TEGRETOL (carbamazepine)	
	TEGRETOL XR (carbamazepine)	
	TOPAMAX TABLET (topiramate)	
	TOPAMAX SPRINKLE (topiramate)	
	topiramate ER capsule (generic Trokendi XR)	
	topiramate ER sprinkle capsule (generic Qudexy XR)	
	topiramate sprinkle 50 mg	
	TRILEPTAL (oxcarbazepine) tablet	
	TROKENDI XR (topiramate)	
	vigabatrin	
	VIGADRONE (vigabatrin)	
	VIGAFYDE (vigabatrin)	
	VIGPODER (vigabatrin)	
	VIMPAT (lacosamide)	
	XCOPRI (cenobamate)	
	ZONISADE (zonisamide) suspension	
	ZTALMY (ganaxolone)	
HYDANTOINS		
	DILANTIN (phenytoin)	
	DILANTIN-125 (phenytoin)	
	PHENYTEK (phenytoin)	
	phenytoin	
	phenytoin ER	
SELECTED BENZODIAZEPINES		
	clobazam	
	DIASTAT (diazepam) rectal gel	
	diazepam rectal gel	
	LIBERVANT (diazepam)	
	NAYZILAM (midazolam)	
	ONFI (clobazam)	
	VALTOCO (diazepam)	
	SYMPAZAN (clobazam)	
SUCCINIMIDES		
	ethosuximide	
	CELONTIN (methsuximide)	
	methsuximide	
	ZARONTIN (ethosuximide)	
ANTIDEPRESSANTS, OTHER ^{DUR+}		

PREFERRED AGENTS		NON-PREFERRED AGENTS	PA CRITERIA
bupropion	AUVELITY (bupropion/dextromethorpha n)	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 EXXUA • Documented diagnosis of unipolar major depressive disorder AND • Met the Non-Preferred Criteria ZURZUVAE MANUAL PA	
bupropion SR	desvenlafaxine ER		
bupropion XL	DESYREL (trazodone)		
mirtazapine	DRIZALMA SPRINKLE (duloxetine DR)		
trazodone	EFFEXOR XR (venlafaxine)		
TRINTELLIX (vortioxetine)	EMSAM (selegiline)		
venlafaxine	EXXUA (gepirone hcl) ^{NR}		
venlafaxine ER capsule	FETZIMA (levomilnacipran)		
vilazodone	FORFIVO XL (bupropion)		
	MARPLAN (isocarboxazid)		
	NARDIL (phenelzine)		
	nefazodone		
	phenelzine		
	PRISTIQ (desvenlafaxine)		
	REMERON (mirtazapine)		
	tranylcypromine		
	Trazodone solution		
	venlafaxine ER tablet		
	VIIBRYD (vilazodone)		
	WELLBUTRIN SR (bupropion)		
	ZURZUVAE (zuranolone)		
ANTIDEPRESSANTS, SSRIs ^{DUR+}			
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA	
citalopram solution, tablet	CELEXA (citalopram)	Minimum Age Limit • 6 years: ZOLOFT • 7 years: LEXAPRO, PROZAC • 8 years: fluvoxamine • 18 years: CELEXA, LUVOX CR, PAXIL, PROZAC 90 mg Maximum Age Limit • 60 years CELEXA Non-Preferred Criteria • Have tried 2 different preferred agents in the past 6 months OR • 90 days of therapy with the requested agent in the past 105 days	
escitalopram solution, tablet	citalopram capsule		
fluoxetine capsule	escitalopram capsule		
fluvoxamine	fluoxetine solution, tablet		
paroxetine tablet	fluoxetine DR capsule		
paroxetine CR	fluvoxamine ER capsule		
paroxetine ER	LEXAPRO (escitalopram)		
sertraline tablet, solution	paroxetine suspension, capsule		
	PAXIL (paroxetine)		
	PAXIL CR (paroxetine)		
	PROZAC (fluoxetine)		
	sertraline capsule		
	ZOLOFT (sertraline)		
ANTIEMETICS ^{DUR+}			
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA	
5HT3 RECEPTOR BLOCKERS		Quantity Limit (per 31 days) • 6 tablets: AKYNZEO • 100 mL: ZOFRAN solution	
ondansetron solution, tablet	ANZIMET (dolasetron)		
ondansetron ODT 4 mg, 8 mg	granisetron		

	ondansetron ODT 16 mg tablet	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.
	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	BREXAFEMME (ibrexafungerp)	Griseofulvin suspension - Automatic approval issued for 0-11 years of age Griseofulvin tablets - Automatic approval issued for 12-17 years of age Minimum Age Limit 18 years: CRESEMBA Non-Preferred Criteria - Have tried 2 different preferred agents in the past 6 months HIV Opportunistic Infection - Non-Preferred agent indicated for treatment (^) AND - Documented diagnosis of HIV CRESEMBA MANUAL PA SPORANOX - Requires clinical review
fluconazole	CRESEMBA (isavuconazonium sulfate)	
nystatin	DIFLUCAN (fluconazole)	
terbinafine	flucytosine^	
	griseofulvin	
	griseofulvin ultramicrosize	
	itraconazole^	
	ketoconazole	
	NOXAFIL (posaconazole)	
	ORAVIG (miconazole)	
	posaconazole^	
	SPORANOX (itraconazole)	
	TOLSURA (itraconazole)	
	VFEND (voriconazole)	
	VIVJOA (oteseconazole)	
	voriconazole^	
ANTIFUNGALS (TOPICAL) ^{DUR+}		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
ANTIFUNGALS		Non-Preferred Criteria - Have tried 2 different preferred agents in the past 6 months MICOTRIN AC, MYCOZYL, and clotrimazole 30 mL solution - Require clinical review
ciclopirox cream, gel, solution, suspension	BENSAL HP (salicylic acid)	
clotrimazole cream, solution ^{Rx & OTC}	CILODAN (ciclopirox)	
econazole	ciclopirox shampoo	
ketoconazole cream, shampoo	clotrimazole solution (NDC 50228-0502-61)	
miconazole cream, powder, solution ^{OTC}	EXTINA (ketoconazole)	
miconazole/zinc oxide/petrolatum ointment	ketoconazole foam	

nystatin cream, ointment, powder	KETODAN (ketoconazole)		
terbinafine ^{OTC}	LOPROX (ciclopirox)		
tolnaftate cream, solution ^{OTC}	luliconazole		
	MICOTRIN AC (clotrimazole)		
	MYCOZYL AC (clotrimazole)		
	MYCOZYL AP (miconazole)		
	naftifine		
	NAFTIN (naftifine)		
	oxiconazole		
	OXISTAT (oxiconazole)		
	tavaborole		
	VOTRIZA-AL (clotrimazole)		
	VUSION (miconazole/zinc oxide/petrolatum)		
ANTIFUNGAL/STEROID COMBINATIONS			
clotrimazole/betamethasone cream	clotrimazole/betamethasone lotion		
nystatin/triamcinolone			
ANTIFUNGALS (VAGINAL)			
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA	
clotrimazole cream ^{OTC}	3-DAY VAGINAL CREAM (clotrimazole)		
clotrimazole-3 cream	GYNAZOLE 1 (butoconazole)		
miconazole kit ^{OTC}	terconazole suppository		
terconazole cream			
ANTIHISTAMINES, MINIMALLY SEDATING AND COMBINATIONS ^{DUR+}			
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA	
MINIMALLY SEDATING ANTIHISTAMINES		Non-Preferred Criteria • Documented diagnosis of Allergy or Urticaria AND • Have tried 2 different preferred agents in the past 12 months	
cetirizine capsule, solution, tablet ^{OTC}	cetirizine chewable tablet ^{OTC}		
loratadine chewable tablet, ODT, solution, tablet ^{OTC}	CLARINEX (desloratadine)		
	desloratadine		
	levocetirizine		
MINIMALLY SEDATING ANTIHISTAMINE/DECONGESTANT COMBINATIONS			
cetirizine/pseudoephedrine	CLARINEX-D 12 HOUR (desloratadine/pseudoephedrine)		
loratadine/pseudoephedrine	fexofenadine/pseudoephedrine		
ANTIMIGRAINE AGENTS, ACUTE TREATMENT			

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
CGRP ORAL AND NASAL		Minimum Age Limit • 6 years: MAXALT • 12 years: almotriptan, sumatriptan/naproxen, ZOMIG nasal spray • 18 years: FROVA, IMITREX, naratriptin, 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 ○ Requires clinical review • INJECTABLES ○ Requires clinical review 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	
	SYMBRAVO (rizatriptan benzoate/meloxicam) ^{NR}	
	ZOMIG (zolmitriptan)	

ANTIMIGRAINE AGENTS, PROPHYLAXIS	
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ANTIMIGRAINE AGENTS, PROPHYLAXIS

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)	
GILOTRIF (afatinib)	AUGTYRO (repotrectinib)	
ICLUSIG (ponatinib)	AYVAKIT (avapritinib)	
imatinib	BALVERSA (erdafitinib)	
IMBRUVICA (ibrutinib)	BOSULIF (bosutinib) capsule	
INLYTA (axitinib)	BRAFTOVI (encorafenib)	
IRESSA (gefitinib)	BRUKINSA (zanubrutinib)	
JAKAFI (ruxolitinib)	CABOMETYX (cabozantinib)	
MEKINIST (trametinib)	CALQUENCE (acalabrutinib)	
NEXAVAR (sorafenib)	COPIKTRA (duvelisib)	
ROZLYTREK (entrectinib)	DANZITEN (nilotinib)	
SPRYCEL (dasatinib)	dasatinib	
STIVARGA (regorafenib)	DAURISMO (glasdegib)	
SUTENT (sunitinib)	ERIVEDGE (vismodegib)	
TAFINLAR (dabrafenib)	ERLEADA (apalutamide)	
TARCEVA (erlotinib)	erlotinib	
TASIGNA (nilotinib)	FOTIVDA (tivozanib)	
TURALIO (pexidartinib)	FRUZAQIA (fruquintinib)	
TYKERB (lapatinib)	GAVRETO (pralsetinib)	
VOTRIENT (pazopanib)	gefitinib	
XALKORI (crizotinib)	GLEEVEC (imatinib)	

XTANDI (enzalutamide)	HERNEXEOS (zongertinib) ^{NR}
ZELBORAF (vemurafenib)	IBRANCE (palbociclib)
ZYDELIG (idelalisib)	IBTROZI (taletrectinib) ^{NR}
ZYKADIA (ceritinib)	IDHIFA (enasidenib)
	IMKELDI (imatinib)
	INLURIYO (imlunestrant tosylate) ^{NR}
	INQOVI (decitabine/cedazuridine)
	INREBIC (fedratinib)
	ITOVEBI (inavolisib)
	IWILFIN (effornithine)
	JAYPIRCA (pirtobrutinib)
	KISQALI (ribociclib)
	KISQALI-FEMARA CO- PACK (ribociclib/letrozole)
	KOSELUGO (selumetinib sulfate)
	KRAZATI (adagrasib)
	lapatinib
	LAZCLUZE (lazertinib)
	LENVIMA (lenvatinib)
	LOBRENA (lorlatinib)
	LUMAKRAS (sotorasib)
	LYNPARZA (olaparib)
	LYTGOBI (futibatinib)
	MEKTOVI (binimetinib)
	MODEYSO (dordaviprone) ^{NR}
	NERLYNX (neratinib)
	nilotinib
	NUBEQA (darolutamide)
	ODOMZO (sonidegib)
	OGSIVEO (nirogacestat)
	OJEMDA (tovorafenib)
	OJJAARA (mometotinib)
	ONUREG (azacitidine)
	ORGOVYX (relugolix)
	pazopanib
	PEMAZYRE (pemigatinib)
	PIQRAY (alpelisib)
	QINLOCK (ripretinib)
	RETEVMO (selpercatinib)
	REVUFORJ (revumenib)
	REZLIDHIA (olutasidenib)
	RUBRACA (rucaparib)
	RYDAPT (midostaurin)
	SCEMBLIX (asciminib)
	sorafenib
	sunitinib
	TABRECTA (capmatinib)
	TAGRISSO (osimertinib)
	TALZENNA (talazoparib)
	TAZVERIK (tazemetostat)

	TECENTRIQ HYBREZA (atezolizumab/hyaluronidase -tqjs)	
	TEPMETKO (tepotinib)	
	TIBSOVO (ivosidenib)	
	TORPENZ (everolimus)	
	TRUQAP (capiwasertib)	
	TUKYSA (tucatinib)	
	VANFLYTA (quizartinib)	
	VERZENIO (abemaciclib)	
	VITRAKVI (larotrectinib)	
	VIZIMPRO (dacomitinib)	
	VONJO (pacritinib)	
	VORANIGO (vorasidenib)	
	WELIREG (belzutifan)	
	XOSPATA (gilteritinib)	
	XPOVIO (selinexor)	
	ZEJULA (niraparib)	
ANTIOBESITY SELECT AGENTS		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
SAXENDA (liraglutide)	liraglutide	All agents MANUAL PA required
WEGOVY (semaglutide)	orlistat	
	XENICAL (orlistat)	
ANTIPARASITICS (TOPICAL) DUR+		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
PEDICULICIDES		Minimum Age Limit • 2 months: permethrin 1% (OTC), permethrin 5% • 6 months: NATROBA, SKLICE • 2 years: piperonyl/pyrethrins (OTC) • 4 years: NATROBA • 6 years: OVIDE • 18 years: EURAX Non-Preferred Criteria • Pediculicides ○ Have tried 2 preferred topical lice agents in the past 90 days • Scabicides • Have tried permethrin 5% in the past 90 days
NATROBA (spinosad)	lindane	
permethrin 1% cream OTC	malathion	
VANALICE (piperonyl butoxide/pyrethrins)	OVIDE (malathion)	
	SKLICE (ivermectin)	
	spinosad	
SCABICIDES		
ivermectin	CROTAN (crotamiton)	
permethrin 5% cream	ELIMITE (permethrin)	
	EURAX (crotamiton)	
	STROMEKTOL (ivermectin)	
ANTIPARKINSON’S AGENTS (INJECTABLE)		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	VYALEV (foscarbidopa/foslevodopa)	VYALEV • Requires clinical review
ANTIPARKINSON’S AGENTS (ORAL) DUR+		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
ANTICHOLINERGICS		Non-Preferred Criteria • Documented diagnosis of Parkinson's disease AND
benztropine		

trihexyphenidyl		• Have tried 2 different preferred agents in the past 6 months OR • 90 days of therapy with a selegiline agent in the past 105 days GOCOVRI • Documented diagnosis of Parkinson's disease AND • 30 days of therapy with amantadine IR in the past 105 days AND • 30 days of therapy with a carbidopa/levodopa combination agent in the past 45 days INBRIJA • Documented diagnosis of Parkinson's disease AND • 30 days of therapy with a carbidopa/levodopa combination agent in the past 45 days NOURIANZ • Documented diagnosis of Parkinson's Disease AND • Have tried 1 preferred carbidopa/levodopa combination agent in the past 30 days AND • 30 days of therapy with a preferred adjunctive therapy in the past 45 days XADAGO • Documented diagnosis of Parkinson's Disease AND • History of 30 days of therapy with a carbidopa/levodopa combination agent in the past 45 days AND • History of 30 days of therapy with a selegiline agent in the past 45 days
COMT INHIBITORS		
entacapone	OGENITYS (opicapone)	
	tolcapone	
DOPAMINE AGONISTS		
pramipexole	NEUPRO (rotigotine)	
ropinirole	pramipexole ER	
	ropinirole ER	
MAO-B INHIBITORS		
selegiline	AZILECT (rasagiline)	
	rasagiline	
	XADAGO (safinamide)	
OTHERS		
amantadine	carbidopa/levodopa ER capsule	
bromocriptine	carbidopa/levodopa ODT	
carbidopa	carbidopa/levodopa/entacapone	
carbidopa/levodopa tablet	CREXONT (carbidopa/levodopa)	
carbidopa/levodopa ER tablet	DHIVY (carbidopa/levodopa)	
	DUOPA (carbidopa/levodopa)	
	GOCOVRI (amantadine)	
	INBRIJA (levodopa)	
	NOURIANZ (istradefylline)	
	OSMOLEX ER (amantadine)	
	RYTARY (carbidopa/levodopa)	
	SINEMET (carbidopa/levodopa)	
	STALEVO (carbidopa/levodopa/entacapone)	

ANTIPSORIATICS (TOPICAL)

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

ANTIPSYCHOTICS ^{DUR+}

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
INJECTABLE, ATYPICALS^{DUR+}		Concurrent Therapy Limit for Age < 18 years 90 days with ≥ 2 agents in the last 120 days will require a MANUAL PA Minimum Age Limit 3 years: HALDOL 5 years: RISPERDAL, thioridazine 6 years: ABILIFY, trifluoperazine 10 years: LATUDA, SAPHRIS, SEROQUEL, SYMBYAX 12 years: INVEGA, molindone, perphenazine, pimozide, thiothixene 13 years: REXULTI, ZYPREXA 18 years: ABILIFY MYCITE, CAPLYTA, CLOZARIL, COBENFY, FANAPT, fluphenazine, GEODON, loxapine, LYBALVI, NUPLAZID, perphenazine/amitriptyline, SECUADO, VRAYLAR, and all injectable agents Quantity Limit 3 syringes/year: ARISTADA INITIO Non-Preferred Criteria Oral Atypical Agents - Have tried 2 preferred agents in the past 12 months OR 30 days of therapy with the requested agent in the past 180 days ARISTADO INTIO, ARISTADO ER, INVEGA SUSTENNA, INVEGA TRINZA and PERSERIS - Documented diagnosis of schizophrenia or schizoaffective disorder ABILIFY MAINTENA, ABILIFY ASIMTUFII, RISPERDAL CONSTA, or UZEDY - Documented diagnosis of schizophrenia, schizoaffective disorder or bipolar disorder INVEGA HAFYERA - Documented diagnosis of schizophrenia or schizoaffective disorder AND 4 claims for INVEGA SUSTENNA in the past year OR 1 claim for INVEGA TRINZA in the past year OR 1 claim for INVEGA HAFYERA in the past year ERZOFRI, generic risperidone ER, RYKINDO ER, and ZYPREXA RELPREVV - Require clinical review NUPLAZID - Documented diagnosis of Parkinson s Disease VRAYLAR - Documented diagnosis of schizophrenia, schizoaffective disorder, bipolar disorder OR - Documented diagnosis major depressive disorder AND 30 days of therapy with an antidepressant in the past 45 days OR 1 claim for a 90-day supply of an antidepressant in the past 105 days ARIPIRAZOLE ODT, CLOZAPINE ODT and OPIPZA - Require clinical review
ABILIFY ASIMTUFII (aripiprazole)	ERZOFRI (paliperidone palmitate)	
ABILIFY MAINTENA (aripiprazole)	GEODON (ziprasidone)	
ARISTADA, ARISTADA INITIO (aripiprazole lauroxil)	olanzapine	
INVEGA HAFYERA (paliperidone)	risperidone ER	
INVEGA SUSTENNA (paliperidone palmitate)	RYKINDO (risperidone)	
INVEGA TRINZA (paliperidone)	ziprasidone	
PERSERIS (risperidone)	ZYPREXA (olanzapine)	
RISPERDAL 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	
	OPIPZA (aripiprazole)	
	paliperidone ER	
	REXULTI (brexpiprazole)	
	RISPERDAL (risperidone)	
	SAPHRIS (asenapine)	
	SEROQUEL (quetiapine)	
	SEROQUEL XR (quetiapine ER)	
	SYMBYAX (olanzapine/fluoxetine)	
	VERSACLOZ (clozapine)	

	ZYPREXA, ZYPREXA ZYDIS (olanzapine)	
TRANSDERMAL, ATYPICALS		
	SECUADO (asenapine)	
ANTIRETROVIRALS ^{DUR+}		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
CAPSID INHIBITORS		Non-Preferred Criteria • 1 claim with the requested agent in the past 105 days
	SUNLENCA (lenacapavir)	
	YEZTUGO (lenacapavir)	STRIBILD MANUAL PA
CD4 DIRECTED ATTACHMENT INHIBITORS		
	RUKOBIA (fostemsavir)	SUNLENCA • Requires clinical review
CD4 DIRECTED HIV-1 INHIBITORS		
	TROGARZO (ibalizumab- uiyk)	TROGARZO • Requires clinical review
COMBINATION PRODUCTS NRTIs		
abacavir/lamivudine	COMBIVIR (lamivudine/zidovudine)	TYBOST MANUAL PA
CABENUVA (cabotegravir/rilpivirine)	EPZICOM (abacavir/lamivudine)	
DOVATO (dolutegravir/lamivudine)		
lamivudine/zidovudine		
COMBINATION PRODUCTS NUCLEOSIDE AND NUCLEOTIDE ANALOG RTIs		
DESCOVY (emtricitabine/tenofovir alafenamide)	TRUVADA (emtricitabine/tenofovir)	
emtricitabine/tenofovir		
COMBINATION PRODUCTS NUCLEOSIDE AND NUCLEOTIDE ANALOG AND NON-NUCLEOSIDE RTIs		
DELSTRIGO (doravirine/lamiviudine/teno fovir)	ATRIPLA (efavirenz/emtricitabine/teno fovir)	
efavirenz/emtricitabine/teno fovir	CIMDUO (lamivudine/tenofovir)	
ODEFSEY (emtricitabine/rilpivirine/ten ofovir)	COMPLERA (emtricitabine/rilpivirine/tenof ovir)	
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)

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
	acyclovir	
	DENAVIR (penciclovir)	
	penciclovir	
	ZELSUVMI (berdazimer) ^{NR}	
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: OPZELURA, pimecrolimus, tacrolimus 0.03% 16 years: tacrolimus 0.1% ADBRY MANUAL PA CIBINQO
ADBRY Autoinjector (tralokinumab-ldrm)	EBGLYSS Pen (lebrikizumab-lbkz)	
DUPIXENT (dupilumab) ^{DUR+}	NEMLUVIO (nemolizumab-ilto)	
EUCRISA (crisaborole) ^{DUR+}	OPZELURA (ruxolitinib)	
pimecrolimus	ZORYVE (roflumilast) 0.15% cream	

tacrolimus		- Requires clinical review DUPIXENT 1 claim with DUPIXENT in the past 60 days OR - New starts require clinical review (see manual PA links below) Asthma MANUAL PA Atopic Dermatitis MANUAL PA Bullous Pemphigoid MANUAL PA COPD MANUAL PA Chronic Spontaneous Urticaria MANUAL PA Eosinophilic Esophagitis MANUAL PA Nasal Polyposis MANUAL PA Prurigo Nodularis MANUAL PA EUCRISA 30 days of therapy with a calcineurin inhibitor or topical steroid in the past 6 months OPZELURA 30 days of therapy with pimecrolimus, EUCRISA or tacrolimus in the past 6 months
BETA BLOCKERS, ANTIANGINALS & SINUS NODE AGENTS ^{DUR+}		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
ANTIANGINALS		ASPRUZYO SPRINKLE - Requires clinical review Ranolazine ER - Documented diagnosis of angina AND 1 claim for a calcium channel blocker, beta-blocker, nitrate, or combination agent in the past 30 days OR 90 days of therapy with the requested agent in the past 105 days Non-Preferred Criteria - Have tried 2 different preferred agents in the past 6 months OR 90 days of therapy with the requested agent in the past 105 days COREG CR - Documented diagnosis of hypertension AND - Have tried generic carvedilol AND 1 preferred agent in the past 6 months OR 90 days of therapy with the requested agent in the past 105 days CORLANOR MANUAL PA HEMANGEOL - Documented diagnosis of infantile hemangioma Lopressor solution - Requires clinical review
	ASPRUZYO SPRINKLE (ranolazine)	
	ranolazine ER	
BETA- AND ALPHA-BLOCKERS		
carvedilol	carvedilol ER	
labetalol	COREG (carvedilol)	
	COREG CR (carvedilol)	
BETA-BLOCKER/DIURETIC COMBINATIONS		
atenolol/chlorthalidone	TENORETIC (atenolol/chlorthalidone)	
bisoprolol/hydrochlorothiazide	ZIAC (bisoprolol/hydrochlorothiazide)	
metoprolol/hydrochlorothiazide		
propranolol/hydrochlorothiazide		
BETA-BLOCKERS		
acebutolol	BETAPACE (sotalol)	
atenolol	BETAPACE AF (sotalol)	
bisoprolol	betaxolol	
HEMANGEOL (propranolol)	BYSTOLIC (nebivolol)	
metoprolol succinate	INDERAL LA (propranolol)	
metoprolol tartrate	INDERAL XL (propranolol)	
nadolol	INNOPRAN XL (propranolol)	
nebivolol	KAPSPARGO SPRINKLE (metoprolol succinate)	

pindolol	LOPRESSOR (metoprolol tartrate)		
propranolol	SOTYLIZE (sotalol)		
propranolol ER	TENORMIN (atenolol)		
SORINE (sotalol)	TOPROL XL (metoprolol succinate)		
sotalol			
sotalol AF			
timolol			
SINUS NODE AGENTS			
	CORLANOR (ivabradine)		
	ivabradine		
BILE SALTS			
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)	BILDYOS (denosumab-nxxp)	
raloxifene	BILPREVDA (denosumab-nxxp)	
	BOMYNTRA (denosumab-bnht) ^{NR}	
	BONSITY (teriparatide)	
	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	
BRONCHODILATORS & COPD AGENTS		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
ANTICHOLINERGIC-BETA AGONIST COMBINATIONS		Minimum Age Limit 4 years: SEREVENT, XOPENEX HFA 6 years: SPIRIVA RESPIMAT, XOPENEX Solution 18 years: BROVANA, PERFOROMIST, STRIVERDI RESPIMAT
ANORO ELLIPTA (umeclidinium/vilanterol)	BEVESPI AEROSPHERE (olvcopvyrolate/formoterol)	

COMBIVENT RESPIMAT (ipratropium/albuterol)	DUAKLIR PRESSAIR (aclidinium/formoterol)	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 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/albuterol		
STIOLTO RESPIMAT (tiotropium/olodaterol)		
ANTICHOLINERGIC-BETA AGONIST- GLUCOCORTICOID COMBINATIONS		
	BREZTRI AEROSPHERE (budesonide/glycopyrrolate/f ormoterol) ^{DUR+}	
	TRELEGY ELLIPTA (fluticasone/umeclidinium/vil anterol)	
ANTICHOLINERGICS AND COPD AGENTS		
ATROVENT HFA (ipratropium)	DALIRESP (roflumilast)	
INCRUSE ELLIPTA (umeclidinium)	OHTUVAYRE (ensifentrine)	
ipratropium	roflumilast	
SPIRIVA HANDIHALER (tiotropium)	SPIRIVA RESPIMAT (tiotropium) ^{DUR+}	
	tiotropium	
	TUDORZA PRESSAIR (aclidinium)	
	YUPELRI (revefenacin)	
INHALATION SOLUTION ^{DUR+}		
albuterol	arformoterol	
	BROVANA (arformoterol)	
	formoterol, formoterol fumarate	
	levalbuterol	
	PERFOROMIST (formoterol)	
INHALERS, LONG ACTING ^{DUR+}		
SEREVENT DISKUS (salmeterol)		
STRIVERDI RESPIMAT (olodaterol)		
INHALERS, SHORT ACTING		
albuterol HFA	levalbuterol HFA	
VENTOLIN HFA (albuterol)	PROAIR DIGIHALER (albuterol)	
	XOPENEX HFA (levalbuterol)	
ORAL		
albuterol IR	albuterol ER	
terbutaline		
CALCIUM CHANNEL BLOCKERS ^{DUR+}		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
LONG-ACTING		Quantity Limit (per 21 days) • 252 capsules: nimodipine
amlodipine	diltiazem ER 12 HR	

CARTIA XT (diltiazem)	diltiazem LA 24 HR	• 2520 mL: nimodipine Non-Preferred Criteria Long Acting • Have tried 2 different preferred Long Acting CCB agents in the past 6 months OR • 90 days of therapy with the requested agent in the past 105 days Non-Preferred Criteria Short Acting • Have tried 2 different preferred Short Acting CCB agents in the past 6 months OR • 90 days of therapy with the requested agent in the past 105 days Nimodipine • Documented diagnosis of subarachnoid hemorrhage in the past 45 days AND • Duration of therapy limited to 21 days
diltiazem ER 24 HR	KATERZIA (amlodipine)	
diltiazem CD 24 HR	levamlodipine	
diltiazem XR 24 HR	MATZIM LA (diltiazem)	
DILT-XR 24 HR (diltiazem)	nisoldipine	
felodipine	NORVASC (amlodipine)	
nifedipine ER	PROCARDIA XL (nifedipine)	
TAZTIA XT (diltiazem)	SULAR (nisoldipine)	
verapamil ER	TIADYLT ER (diltiazem)	
verapamil SR	TIAZAC (diltiazem)	
	verapamil PM	
	VERELAN PM (verapamil)	
SHORT-ACTING		
diltiazem	isradipine	
nicardipine	nimodipine capsule and solution	
nifedipine	NORLIQVA (amlodipine)	
verapamil	NYMALIZE (nimodipine)	
CALORIC AGENTS		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
BOOST	All non-preferred caloric/nutritional agents (which are all other products except those specifically listed as preferred) require a manual prior authorization.	Non-Preferred Agents MANUAL PA
BREAKFAST ESSENTIALS		
BRIGHT BEGINNINGS		
DUOCAL		
ENSURE		
NUTREN		
OSMOLITE		
PEDIASURE		
PROMOD		
RESOURCE		
TWOCAL HN		
CEPHALOSPORINS AND RELATED ANTIBIOTICS (ORAL)		
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 Maximum Age Limit • 18 years: cefdinir suspension
amoxicillin/clavulanate	amoxicillin/clavulanate ER	
	AUGMENTIN (amoxicillin/clavulanate)	
CEPHALOSPORINS FIRST GENERATION		
cefadroxil	cephalexin tablet	
cephalexin capsule, suspension		
CEPHALOSPORINS SECOND GENERATION		
cefaclor capsule	cefaclor ER	
cefprozil	cefaclor suspension	
cefuroxime		
CEPHALOSPORINS THIRD GENERATION		
cefdinir	cefixime suspension	

cefixime capsule	SUPRAX (cefixime)	
cefpodoxime		
COLONY STIMULATING FACTORS		
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)	
	NYPOZI (filgrastim-txid) ^{NR}	
	NYVEPRIA (pegfilgrastim-apgf)	
	RELEUKO (filgrastim-ayow)	
	RYZNEUTA (efbemalenograstim alfa-vuxw)	
	ROLVEDON (eflapegrastim-xnst)	
	STIMUFEND (pegfilgrastim-fpgk)	
	UDENYCA, UDENYCA ONBODY (pegfilgrastim-cbqv)	
	ZARXIO (filgrastim-sndz)	
	ZIEXTENZO (pegfilgrastim-bmez)	
CYSTIC FIBROSIS AGENTS ^{DUR+}		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
PULMOZYME (dornase alfa)	ALYFTREK (vanzacaftor/tezacaftor/deuti vacaftor)	Minimum Age Limit • 1 month: KALYDECO granules • 3 months: PULMOZYME • 1 year: ORKAMBI • 2 years: COLY-MYCIN M, TRIKAFTA granules • 6 years: ALYFTREK, BETHKIS, KALYDECO tablet, KITABIS, SYMDEKO, TOBI, TOBI PODHALER, TRIKAFTA tablet • 7 years: CAYSTON • 18 years: BRONCHITOL Maximum Age Limit • 2 years: ORKAMBI 75-94 mg granules • 5 years: KALYDECO, ORKAMBI 100-125 mg granules, ORKAMBI 200-125 mg granules, TRIKAFTA granules • 11 years: TRIKAFTA 50-25-37.5 mg tablets Preferred Agents • Documented diagnosis of Cystic Fibrosis OR • Require clinical review ALYFTREK MANUAL PA KALYDECO MANUAL PA
tobramycin (generic TOBI)	BETHKIS (tobramycin)	
	BRONCHITOL (mannitol)	
	CAYSTON (aztreonam)	
	colistimethate	
	COLY-MYCIN M (colistin)	
	KALYDECO (ivacaftor)	
	KITABIS (tobramycin)	
	ORKAMBI (lumacaftor/ivacaftor)	
	SYMDEKO (tezacaftor/ivacaftor)	
	TOBI (tobramycin)	
	TOBI PODHALER (tobramycin)	
	tobramycin (generic BETHKIS & KITABIS)	
	TRIKAFTA (elexacaftor/tezacaftor/ivacaftor)	

		ORKAMBI MANUAL PA SYMDEKO MANUAL PA TOBI PODHALER Require clinical review 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)	ANZUPGO (delgocitinib) ^{NR}	AVSOLA (infliximab-axxq) – Age specific indications: - Age 6 years and older AND - Diagnosis of Crohn's disease OR - Diagnosis of ulcerative colitis
OTEZLA (apremilast)	ARCALYST (rilonacept)	
RINVOQ (upadacitinib)	BIMZELX (bimekizumab-bkzx)	- 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)	CIMZIA (certolizumab)	
SIMPONI (golimumab)	COSENTYX (secukinumab)	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)	CYLTEZO (adalimumab-adbm)	
TYENNE Syringe, Vial (tocilizumab-aazg)	ENTYVIO (vedolizumab)	- Age 4 years and older AND - Diagnosis of plaque psoriasis (PsO)
XELJANZ (tofacitinib) tablet	HADLIMA (adalimumab-bwwd)	
	HULIO (adalimumab-fkjp)	- Age 18 years and older AND - Diagnosis of rheumatoid arthritis (RA) OR - Diagnosis of psoriatic arthritis (PsA) OR - Diagnosis of ankylosing spondylitis (AS)
	HYRIMOZ (adalimumab-adaz)	
	IDACIO (adalimumab-aacf)	- Age 18 years and older AND - Diagnosis of rheumatoid arthritis (RA) OR - Diagnosis of psoriatic arthritis (PsA) OR - Diagnosis of ankylosing spondylitis (AS)
	ILARIS (canakinumab)	
	ILUMYA (tildrakizumab-asmn)	- Age 18 years and older AND - Diagnosis of rheumatoid arthritis (RA) OR - Diagnosis of psoriatic arthritis (PsA) OR - Diagnosis of ankylosing spondylitis (AS)
	IMULDOSA (ustekinumab-srlf)	
	INFLECTRA (infliximab-dyyb)	- Age 18 years and older AND - Diagnosis of rheumatoid arthritis (RA) OR - Diagnosis of psoriatic arthritis (PsA) OR - Diagnosis of ankylosing spondylitis (AS)
	infliximab	
	JYLAMVO (methotrexate)	- Age 18 years and older AND - Diagnosis of rheumatoid arthritis (RA) OR - Diagnosis of psoriatic arthritis (PsA) OR - Diagnosis of ankylosing spondylitis (AS)
	KEVZARA (sarilumab)	
	LEQSELVI (deuruxolitinib)	- Age 18 years and older AND - Diagnosis of rheumatoid arthritis (RA) OR - Diagnosis of psoriatic arthritis (PsA) OR - Diagnosis of ankylosing spondylitis (AS)
	LITFULO (ritlecitinib)	
	OMVOH (mirikizumab-mrkz)	

	ORENCIA SYRINGE (abatacept)	HUMIRA (adalimumab) – Age specific indications:
	OTEZLA XR (apremilast) ^{NR}	• Age 2 years and older AND • Diagnosis of juvenile idiopathic arthritis (JIA) OR • Diagnosis of uveitis (UV)
	OTREXUP (methotrexate)	
	OTULFI (ustekinumab-aauz)	
	PYZCHIVA (ustekinumab-ttwe)	• Age 5 years and older AND • Diagnosis of ulcerative colitis (UC) • Age 6 years and older AND • Diagnosis of Crohn's disease (CD)
	RASUVO (methotrexate)	
	REMICADE (infliximab)	
	RENFLEXIS (infliximab-abda)	
	SELARSDI (ustekinumab-aekn)	• Age 12 years and older AND • Diagnosis of hidradenitis suppurativa (HS)
	SIMLANDI (adalimumab-ryvk)	
	SIMPONI ARIA (golimumab)	• 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)
	SKYRIZI (risankizumab-rzaa)	
	SOTYKTU (deucravacitinib)	
	SPEVIGO (spesolimab-sbzo)	KINERET (anakinra) – Age specific indications:
	STARJEMZA (ustekinumab-hmny)	• Age 18 years and older AND • Diagnosis of rheumatoid arthritis (RA) • Other indications require clinical review
	STELARA (ustekinumab)	
	TOFIDENCE (tocilizumab-bavi)	OLUMIANT (baricitinib) – Age specific indications:
	TREMFYA (guselkumab)	• Age 18 years and older AND • Diagnosis of alopecia areata (AA) • Other indications require clinical review
	TREXALL (methotrexate)	
	TYENNE Autoinjector (tocilizumab-aazg)	
	ustekinumab-aauz	ORENCIA (abatacept) – Age specific indications:
	XATMEP (methotrexate)	• Age 2 years and older AND • Diagnosis of juvenile arthritis (JIA) OR • Diagnosis of psoriatic arthritis (PsA) • Other indication requires clinical review
	XELJANZ (tofacitinib) solution	
	XELJANZ XR (tofacitinib)	
	YESINTEK (ustekinumab-kfce)	• Age 18 years and older AND • Diagnosis of rheumatoid arthritis (RA) • Non-preferred Orencia syringe requires clinical review
	YUFLYMA (adalimumab-aaty)	
	YUSIMRY (adalimumab-aqvh)	
	ZYMFENTRA (infliximab-dyyb)	OTEZLA (apremilast) – Age specific indications: • Age 6 years and older AND • Diagnosis of plaque psoriasis (PsO) OR • Diagnosis of psoriatic arthritis (PsA) • Age 18 years and older AND • Diagnosis of Bechet's disease • Non-preferred Otezla XR requires clinical review RINVOQ (upadacitinib): • Age 2 years and older AND • Diagnosis of juvenile idiopathic arthritis (JIA) OR • Diagnosis of psoriatic arthritis AND • History of 3 claims with preferred TNF Inhibitor Avsola, Enbrel, Humira or Simponi

OR

- History of 1 claim with Rinvoq in the past

AND

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

- Age 18 years and older **AND**

- Diagnosis of ankylosing spondylitis **OR**

- Diagnosis of Crohn's disease **OR**

- Diagnosis of giant cell arteritis **OR**

- Diagnosis of active non-radiographic axial spondyloarthritis (nr-axSpA) **OR**

- Diagnosis of rheumatoid arthritis (RA) **OR**

- Diagnosis of ulcerative colitis

AND

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

OR

- History of 1 claim with Rinvoq in the past

AND

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

SIMPONI (golimumab) – Age specific indications:

- Age 18 years and older **AND**

- Diagnosis of rheumatoid arthritis (RA) **OR**

- Diagnosis of psoriatic arthritis (PsA) **OR**

- Diagnosis of ankylosing spondylitis (AS) **OR**

- Diagnosis of ulcerative colitis

- Ages less than 18 years require clinical review

- Non-preferred Simponi Aria requires clinical review

TALTZ (izekizumab) – Age specific indications:

Taltz 20 mg, 40 mg and 80 mg

- Age 6 **AND**

- Diagnosis of plaque psoriasis (PsO)

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 (tocilizumab-aazg) – Age specific indications:

- Age 2 years and older **AND**

- Diagnosis of juvenile arthritis (JIA)

- Age 18 years and older **AND**

- Diagnosis of rheumatoid arthritis (RA) **OR**

- Diagnosis of giant cell arteritis

- Non-preferred Tyenne autoinjector requires clinical review

XELJANZ IR (tofacitinib) – Any of the following:

		• Age 2 year and older AND • Diagnosis of juvenile arthritis (JIA) OR • Diagnosis of psoriatic arthritis (PsA) • Age 18 years and older AND • Diagnosis of rheumatoid arthritis (RA) OR • Diagnosis of ulcerative colitis (UC) OR • Diagnosis of ankylosing spondylitis (AS) • Non-preferred Xeljanz oral solution and Xeljanz XR require clinical review Preferred methotrexate does not require prior authorization
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ERYTHROPOIESIS STIMULATING PROTEINS ^{DUR+}

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
EPOGEN (epoetin alfa)	ARANESP (darbepoetin alfa)	Non-Preferred Criteria • Documented diagnosis of cancer or chronic renal failure OR • Antineoplastic therapy in the past 6 months AND • Have tried a preferred RETACRIT or EPOGEN in the past 6 months OR • 1 claim for the requested agent in the past 105 days JESDUVROQ • Requires clinical review MIRCERA • Documented diagnosis of chronic renal failure in the past 2 years
MIRCERA (methoxy polyethylene glycol-epoetin-beta)	JESDUVROQ (daprodustat)	
RETACRIT (epoetin alfa-epbx)	PROCRIT (epoetin alfa)	
	VAFSEO (vadadustat)	

FACTOR DEFICIENCY PRODUCTS ^{DUR+}

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
FACTOR VIII		HEMLIBRA • 3 claims with HEMLIBRA in the past 105 days OR • New starts require clinical review MANUAL PA
ADVATE	ADYNOVATE	
AFSTYLA	ELOCTATE	
ALPHANATE	ESPEROCT	
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-hncg)	
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	
	TONMYA (cyclobenzaprine) ^{NR}	
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 (podofilox)		VEREGEN (sinecatechins)		Minimum Age Limit • 12 years: ALDARA • 18 years: CONDYLOX, PICATO, VEREGEN	
fluorouracil					
imiquimod					
podofilox					
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			
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 • Note: ○ Institutional-sized products are non-preferred AIRDUO DIGIHALER • Requires clinical review ARMONAIR DIGIHALER • Requires clinical review PROAIR DIGIHALER Require clinical review Minimum Age Limit • 18 years: AIRSUPRA Quantity Limit (per 31 days) • 2 inhalers: AIRSUPRA -- MANUAL PA
ASMANEX (mometasone)	ALVESCO (ciclesonide)		
budesonide 0.25 mg and 0.5 mg	ARMONAIR DIGIHALER (fluticasone)		
fluticasone	ARNUITY ELLIPTA (fluticasone)		
fluticasone diskus	ASMANEX HFA (mometasone)		
fluticasone HFA	budesonide 1 mg		
PULMICORT FLEXHALER (budesonide)	FLOVENT HFA (fluticasone)		
QVAR REDIHALER (beclomethasone)	FLOVENT DISKUS (fluticasone)		
	PULMICORT (budesonide) nebulizer solution		
GLUCOCORTICOID/BRONCHODILATOR COMBINATIONS			
ADVAIR DISKUS (fluticasone/salmeterol)	AIRDUO DIGIHALER (fluticasone/salmeterol)		
ADVAIR HFA (fluticasone/salmeterol)	AIRSUPRA (albuterol/budesonide)		
DULERA (mometasone/formoterol)	BREO ELLIPTA (fluticasone/vilanterol)		
fluticasone/salmeterol diskus	BREYNA (budesonide/formoterol)		
fluticasone/salmeterol HFA	budesonide/formoterol		
SYMBICORT (budesonide/formoterol)	fluticasone/vilanterol		
	WIXELA INHUB (fluticasone/salmeterol)		
GROWTH HORMONES ^{DUR+}			
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	
NORDITROPIN FLEXPRO (somatropin)	NGENLA (somatrogon-ghla)		
SKYTROFA (lonapegsomatropin-tcgd)	OMNITROPE (somatropin)		
	SEROSTIM (somatropin)		
	SOGROYA (somapacitan-beco)		
	VOXZOGO (vosoritide)		
	ZOMACTON (somatropin)		

		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
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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/riton avir)	
	VOSEVI (sofosbuvir/velpatasvir/voxil aprevir) [∞]	
	ZEPATIER (elbasvir/grazoprevir) [∞]	
HEREDITARY ANGIOEDEMA TREATMENTS		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
PROPHYLAXIS		Non-Preferred Criteria • Requires clinical review
HAEGARDA (C1 esterase inhibitor)	ANDEMBRY (garadacimab-gxii)	
	CINRYZE (C1 esterase inhibitor)	
	DAWNZERA (donidalorsen) ^{NR}	
	ORLADEYO (berotralstat)	
	TAKHZYRO (lanadelumab-flyo)	
ACUTE TREATMENT		
BERINERT (C1 esterase inhibitor)	EKTERLY (sebetralstat) ^{NR}	
icatibant	FIRAZYR (icatibant)	
	KALBITOR (ecallantide)	
	RUCONEST (C1 esterase inhibitor)	
	SAJAZIR (icatibant)	
HYPERURICEMIA & GOUT ^{DUR+}		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
allopurinol	ALOPRIM (allopurinol)	Non-Preferred Criteria • Have tried 2 different preferred agents in the past 6 months
colchicine tablet	colchicine capsule	
probenecid	COLCRYS (colchicine)	
probenecid/colchicine	febuxostat	
	GLOPERBA (colchicine)	
	MITIGARE (colchicine)	

	ULORIC (febuxostat)	
	ZYLOPRIM (allopurinol)	
HYPOGLYCEMIA TREATMENT		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
BAQSIMI (glucagon)	GVOKE (glucagon) ^{Step Edit}	Minimum Age Limit • 1 year: BAQSIMI • 2 years: GVOKE • 6 years: ZEGALOGUE Quantity Limit (per 31 days) • 2 packs (or kits): BAQSIMI, glucagon, GVOKE, ZEGALOGUE Non-Preferred Criteria GVOKE • 1 claim with preferred BAQSIMI or ZEGALOGUE in the past 30 days
GLUCAGEN (glucagon)		
glucagon emergency kit		
glucagon vial		
ZEGALOGUE (dasiglucagon)		
HYPOGLYCEMICS, BIGUANIDES		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
metformin	GLUMETZA (metformin)	
metformin ER (generic GLUCOPHAGE XR)	metformin ER (generic FORTAMET)	
	metformin ER (generic GLUMETZA)	
	metformin solution	
	RIOMET (metformin)	
HYPOGLYCEMICS, DPP4s AND COMBINATIONS ^{DUR+}		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
JANUMET (sitagliptin/metformin)	alogliptin	Non-Preferred Criteria • Have tried 2 different preferred DPP4 agents in the past 6 months OR • 90 days of therapy with the requested agent in the past 105 days Note: Concomitant use of a GLP-1 agent and a DPP-4 agent requires clinical review
JANUMET XR (sitagliptin/metformin)	alogliptin/metformin	
JANUVIA (sitagliptin)	BRYNOVIN solution (sitagliptin)	
JENTADUETO (linagliptin/metformin)	JENTADUETO XR (linagliptin/metformin)	Minimum Age Limit • 18 years: BRYNOVIN solution
TRADJENTA (linagliptin)	KAZANO (alogliptin/metformin)	
	KOMBIGLYZE XR (saxagliptin/metformin)	
	linagliptin/metformin ^{NR}	
	NESINA (alogliptin)	
	ONGLYZA (saxagliptin)	
	OSENI (alogliptin/pioglitazone)	
	saxagliptin	
	saxagliptin/metformin ER	
	sitagliptin	
	sitagliptin/metformin	
	ZITUVIMET (sitagliptin/metformin)	

	ZITUVIMET XR (sitagliptin/metformin)	
	ZITUVIO (sitagliptin)	
HYPOGLYCEMICS, INCRETIN MIMETICS/ENHANCERS ^{DUR+}		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
BYETTA (exenatide)	BYDUREON (exenatide)	Minimum Age Limit • 10 years: BYDUREON BCISE, TRULICITY, VICTOZA • 18 years: BYETTA, MOUNJARO, OZEMPIC, RYBELSUS Preferred Criteria • Documented diagnosis of Type 2 Diabetes AND • No history of SAXENDA or WEGOVY in the past 30 days OR • No documented diagnosis for Type 2 Diabetes AND • 84 days of therapy with the requested agent in the past 105 days Non-Preferred Criteria • Documented diagnosis of Type 2 Diabetes AND • No history of SAXENDA or WEGOVY in the past 30 days AND • 84 days of therapy with TRULICITY in the past 6 months AND • 84 days of therapy with either preferred BYETTA or VICTOZA in the past 6 months OR • Documented diagnosis of Type 2 Diabetes AND • 84 days of therapy with the request agent in the past 105 days Note: • Concomitant use of a GLP-1 agonist and a DPP-4 agent requires clinical review. • Please see the PDL category Anti-obesity Select Agents for a list of covered agents. RYBELSUS 1.5 mg and 3 mg • Requires clinical review
TRULICITY (dulaglutide)	exenatide	
VICTOZA (liraglutide)	liraglutide	
	MOUNJARO (tirzepatide)	
	OZEMPIC (semaglutide)	
	RYBELSUS (semaglutide)	
	SOLIQUA (insulin glargine/lixisenatide)	
	SYMLINPEN (pramlintide)	
	XULTOPHY (insulin degludec/liraglutide)	
HYPOGLYCEMICS, INSULINS & RELATED AGENTS ^{DUR+}		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
HUMALOG MIX 75/25 vial (insulin lispro/lispro protamine)	ADMELOG (insulin lispro)	Non-Preferred Criteria • Documented diagnosis of Diabetes Mellitus AND • Have tried 1 preferred agent in the past 6 months OR • 1 claim with the requested agent in the past 105 days Quantity Limit • Insulin quantity limits can be found here Note: • Insulin pen formulations are not covered for Long Term Care (LTC) beneficiaries. BASAGLAR • Requires clinical review
HUMULIN 70/30 vial (insulin NPH/regular)	AFREZZA (insulin regular)	
HUMULIN N (insulin NPH)	APIDRA (insulin glulisine)	
HUMULIN R (insulin regular)	BASAGLAR (insulin glargine)	
HUMULIN R U-500 (insulin regular)	FIASP (insulin aspart/niacinamide)	
insulin aspart	HUMALOG; HUMALOG JUNIOR, KWIKPEN, TEMPO PEN (insulin lispro)	
insulin aspart protamine mix 70/30 vial		
insulin lispro	HUMALOG MIX KWIKPEN 50/50, 75/25 (insulin lispro/lispro protamine)	
insulin lispro protamine mix 75/25 vial	HUMULIN 70/30 KWIKPEN (insulin N/regular)	

LANTUS (insulin glargine)	HUMULIN N KWIKPEN (insulin N)	
TOUJEO (insulin glargine)	insulin degludec	
TOUJEO MAX (insulin glargine)	insulin glargine	
	insulin glargine-yfgn	
	KIRSTY (insulin aspart-xjhz) ^{NR}	
	LEVEMIR (insulin detemir)	
	LYUMJEV (insulin lispro-aabc)	
	MERIOLOG (insulin aspart-szjj) ^{NR}	
	NOVOLIN 70/30 (insulin NPH/regular)	
	NOVOLIN N (insulin NPH)	
	NOVOLIN R (insulin regular)	
	NOVOLOG (insulin aspart)	
	NOVOLOG MIX 70/30 (insulin aspart protamine/aspart)	
	REZVOGLAR (insulin glargine-aglr)	
	SEMGLEE (insulin glargine-yfgn)	
	TRESIBA (insulin degludec)	
HYPOGLYCEMICS, MEGLITINIDES ^{DUR+}		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
nateglinide		
repaglinide		
HYPOGLYCEMICS, SODIUM GLUCOSE COTRANSPORTER-2 (SGLT-2) INHIBITORS ^{DUR+}		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
SGLT-2 INHIBITORS		Non-Preferred Criteria • Have tried 2 different preferred SGLT-2 inhibitors in the past 6 months OR • 90 days of therapy with the requested agent in the past 105 days
FARXIGA (dapagliflozin)	dapagliflozin	
JARDIANCE (empagliflozin)	INPEFA (sotagliflozin)	
	INVOKANA (canagliflozin)	
	STEGLATRO (ertugliflozin)	
SGLT-2 INHIBITOR COMBINATIONS		
GLYXAMBI (empagliflozin/linagliptin)	dapagliflozin/metformin ER	
SYNJARDY (empagliflozin/metformin)	INVOKAMET (canagliflozin/metformin)	
SYNJARDY XR (empagliflozin/metformin)	INVOKAMET XR (canagliflozin/metformin)	
TRIJARDY XR (empagliflozin/linagliptin/metformin)	QTERN (dapagliflozin/saxagliptin)	
	SEGLUROMET (ertugliflozin/metformin)	

	STEGLUJAN (ertugliflozin/sitagliptin)		
	XIGDUO XR (dapagliflozin/metformin)		
HYPOGLYCEMICS, THIAZOLIDINEDIONES (TZDs) and TZD Combinations			
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA	
pioglitazone	ACTOPLUS MET (pioglitazone/metformin)		
pioglitazone/metformin	ACTOS (pioglitazone)		
pioglitazone/glimepiride	DUETACT (pioglitazone/glimepiride)		
IDIOPATHIC PULMONARY FIBROSIS ^{DUR+}			
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA	
OFEV (nintedanib)	ESBRIET (pirfenidone)	All Agents - Documented diagnosis of Idiopathic Pulmonary Fibrosis OFEV - Documented diagnosis of Idiopathic Pulmonary Fibrosis OR 90 days of therapy with Ofev in the past 105 days ESBRIET, JASCAYD, or pirfenidone - Requires clinical review	
	JASCAYD (nerandomilast) ^{NR}		
	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 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	
FASENRA (benralizumab)	NUCALA (mepolizumab)		
XOLAIR (omalizumab)	TEZSPIRE (tezepelumab-ekko)		

		○ COPD MANUAL PA ○ Chronic Spontaneous Urticaria 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 ○ Asthma MANUAL PA ○ Chronic Spontaneous Urticaria MANUAL PA ○ Nasal Polyposis MANUAL PA
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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 Preferred Criteria • AZASAN ○ Documented diagnosis of kidney transplant, RA, or a State-accepted diagnosis • CELLCEPT ○ Documented diagnosis of heart, kidney, or liver transplant or a State-accepted diagnosis • GENGRAF, NEORAL, SANDIMMUNE ○ Documented diagnosis of heart transplant, kidney transplant, liver transplant, psoriasis, RA, or a State-accepted diagnosis • Everolimus ○ Documented diagnosis of kidney or liver transplant • RAPAMUNE ○ Documented diagnosis of kidney transplant • Tacrolimus ○ Documented diagnosis of heart, kidney, liver, or lung transplant or a State-accepted diagnosis Non-Preferred Criteria • MYHIBBIN Suspension ○ Documented diagnosis of heart, kidney, or liver transplant or a State-accepted diagnosis AND ○ 30 days of therapy with mycophenolate suspension in the past 105 days OR ○ 90 days of therapy with MYHIBBIN Suspension in the past 105 days • ASTAGRAF XR or ENVARUS XR ○ Documented diagnosis of heart, kidney, liver, or lung transplant or a State-accepted diagnosis AND
azathioprine	ENVARUS 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		

		○ 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
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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 500 mg tablet	deferiprone 1,000 mg tablet	
FERRIPROX (deferiprone)	EXJADE (deferasirox)	
	JADENU, JADENU SPRINKLE (deferasirox)	

IRRITABLE BOWEL SYNDROME/SHORT BOWEL SYNDROME AGENTS/SELECTED AGENTS ^{DUR+}

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
IRRITABLE BOWEL SYNDROME CONSTIPATION ^{DUR+}		Minimum Age Limit • 1 year: GATTEX • 6 years: LINZESS 72 mcg
LINZESS (linaclotide)	AMITIZA (lubiprostone)	

lubiprostone	IBSRELA (tenapanor)	• 18 years: AMITIZA, IBSRELA, LINZESS 145 mcg & 290 mcg, MOTEGRITY, MOVANTIK, MYTESI, SYMPROIC, VIBERZI Gender Limit • Female AMITIZA 8 mcg
	MOTEGRITY (prucalopride)	
	MOVANTIK (naloxegol)	
	prucalopride	
	SYMPROIC (naldemedine)	
IRRITABLE BOWEL SYNDROME DIARRHEA		
dicyclomine	alosetron	
ED-SPAZ (hyoscyamine)	LOTRONEX (alosetron) ^{DUR+}	
hyoscyamine, hyoscyamine ER	VIBERZI (eluxadoline) ^{DUR+}	
HYOSYNE (hyoscyamine)		
LEVSIN, LEVSIN-SL (hyoscyamine)		
NULEV (hyoscyamine)		
OSCIMIN, OSCIMIN SL (hyoscyamine)		
SHORT BOWEL SYNDROME AND SELECTED GI AGENTS ^{DUR+}		
	GATTEX (teduglutide)	
	MYTESI (crofelemer)	
IRRITABLE BOWEL SYNDROME CONSTIPATION ^{DUR+}		
Chronic Idiopathic Constipation (CIC): Amitiza 24 mcg, LINZESS 72 mcg, LINZESS 145 mcg, MOTEGRITY • Preferred CIC Agents ○ Documented diagnosis of CIC in the past year AND ○ No history of GI or bowel obstruction • LINZESS 72 mcg ○ Age 6-17 years AND ○ Documented diagnosis of CIC or pediatric functional constipation in the past year AND ○ No history of GI or bowel obstruction • Non-Preferred CIC Agents ○ Documented diagnosis of CIC AND ○ No history of GI or bowel obstruction AND ○ Have tried 2 preferred CIC agents in the past 6 months OR ○ 1 claim with the requested agent in the past 105 days	Irritable Bowel Syndrome Constipation Dominant (IBS-C): AMITIZA 8 mcg, IBSRELA, LINZESS 290 mcg • Preferred IBS-C Agents ○ Documented diagnosis of IBS-C in the past year AND ○ No history of GI or bowel obstruction • Non-Preferred IBS-C Agents ○ Documented diagnosis of IBS-C in the past year AND ○ No history of GI or bowel obstruction AND ○ Have tried 2 preferred IBS-C agents in the past 6 months OR ○ 1 claim with the requested agent in the past 105 days	Opioid Induced Constipation (OIC): AMITIZA 24 mcg, MOVANTIK, SYMPROIC • Preferred OIC Agents ○ Documented diagnosis of OIC and chronic pain in the past year AND ○ No history of GI or bowel obstruction AND ○ 1 claim for an opioid in the past 30 days • Non-Preferred OIC Agents ○ All preferred criteria met AND ○ Have tried 1 preferred OIC agents in the past 6 months OR ○ 1 claim with the requested agent in the past 105 days

IRRITABLE BOWEL SYNDROME DIARRHEA

- **VIBERZI** [New starts require clinical review]
Documented diagnosis of IBS D in the past year **and** 1 claim for Viberzi in the past 105 days

- **LOTRONEX**
 - 1 claim for LOTRONEX in the past 105 days **OR**
 - New starts require clinical review **MANUAL PA**

SHORT BOWEL SYNDROME AND SELECTED GI AGENTS ^{DUR+}

HIV/AIDS Non-infectious Diarrhea

- **MYTESI**
 - Documented diagnosis of HIV/AIDS **and** non-infectious diarrhea in the past year **AND**
 - 1 claim for an antiretroviral in the past 30 days

Short Bowel Syndrome (SBS)

- **GATTEX**
 - 1 claim for GATTEX in the past 105 days **OR**
 - New starts require clinical review

LEUKOTRIENE MODIFIERS ^{DUR+}

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
montelukast	ACCOLATE (zafirlukast)	Minimum Age Limit • 12 years: ZYFLO & ZYFLO CR Non-Preferred Criteria • Have tried 2 different preferred agents in the past 6 months
zafirlukast	SINGULAIR (montelukast)	
	zileuton	
	ZYFLO (zileuton)	

LIPOTROPICS, OTHER (NON-STATINS)

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
ACL INHIBITORS AND COMBINATIONS		Non-Preferred Criteria Fibric Acid Derivatives ○ Have tried 2 different preferred Fibric Acid Derivative agents in the past 6 months JUXTAPID MANUAL PA KYNAMRO • Requires clinical review LEQVIO • Requires clinical review NEXLETOL and NEXLIZET • Require clinical review PRALUENT MANUAL PA REPATHA MANUAL PA WELCHOL • Documented diagnosis of Type 2 Diabetes AND • 30 days of therapy with an antidiabetic agent in the past 6 months OR 90 days of therapy with WELCHOL in the past 105 days
	NEXLETOL (bempedoic acid)	
	NEXLIZET (bempedoic acid/ezetimibe)	
ANGIOPOIETIN-LIKE 3 INHIBITORS		
	EVKEEZA (evinacumab-dgnb)	
BILE ACID SEQUESTRANTS		
cholestyramine	colesevelam	
cholestyramine light	COLESTID (colestipol)	
colestipol tablet	colestipol packet	
	PREVALITE (cholestyramine)	
	QUESTRAN (cholestyramine)	
	QUESTRAN LIGHT (cholestyramine)	
	WELCHOL (colesevelam)	
CHOLESTEROL ABSORPTION INHIBITORS		
ezetimibe	ZETIA (ezetimibe)	
FIBRIC ACID DERIVATIVES		
fenofibrate	fenofibric acid	
gemfibrozil	FENOGLIDE (fenofibrate)	
	FIBRICOR (fenofibric acid)	

	LIPOFEN (fenofibrate)	
	LOPID (gemfibrozil)	
	TRICOR (fenofibrate)	
	TRILIPIX (fenofibric acid)	
MTP INHIBITOR		
	JUXTAPID (lomitapide)	
NIACIN		
niacin ER		
OMEGA-3 FATTY ACIDS		
omega-3 acid ethyl esters	icosapent 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
	GRASTEK	
	ORALAIR	
	RAGWITEK	
ANXIOLYTICS		Quantity Limit (per 31 days) • 2 kits: epinephrine EVRYSDI MANUAL PA
alprazolam	alprazolam ER	
hydroxyzine HCL	VISTARIL (hydroxyzine pamoate)	

hydroxyzine pamoate	XANAX, XANAX XR (alprazolam)	RHAPSIDO MANUAL PA *The Miscellaneous subclass contains drugs that do not belong to any PDL drug classes. A non-preferred drug in this subclass may not require a documented history of preferred agents within the Miscellaneous subclass except for a brand name product with a generic equivalent.
EPINEPHRINE		
epinephrine (Mylan)	AUVI-Q (epinephrine)	
	epinephrine (all other manufacturers)	
	EPIPEN (epinephrine)	
	EPIPEN JR (epinephrine)	
	NEFFY (epinephrine)	
MISCELLANEOUS*		
megestrol	BRINSUPRI (brensocatib) ^{NR}	
REVLIMID (lenalidomide)	CAMZYOS (mavacamten)	
	CRENESSITY (crinecerfont)	
	EVRYSDI (risdiplam)	
	HARLIKU (nitisinone) ^{NR}	
	KORLYM (mifepristone)	
	lenalidomide	
	PALSONIFY (paltusotine) ^{NR}	
	RHAPSIDO (remibrutinib) ^{NR}	
	TRYNGOLZA (olezarsen)	
	VERQUVO (vericiguat)	
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 - New starts require clinical review MANUAL PA

MULTIPLE SCLEROSIS AGENTS ^{DUR+}

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
HIGHLY ACTIVE		Preferred Agents Documented diagnosis of multiple sclerosis
fingolimod	BRIUMVI (ublituximab-xiiv)	
TYSABRI (natalizumab)	GILENYA (fingolimod)	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 PEN (ofatumumab)	
	MAVENCLAD (cladribine)	
	MAYZENT (siponimod)	
	OCREVUS (ocrelizumab)	

	OCREVUS ZUNOVO (ocrelizumab/hyaluronidase-ocsq)	KESIMPTA, PONVORY, TASCENSO ODT, and ZEPOSIA Require clinical review MAVENCLAD MANUAL PA MAYZENT MANUAL PA OCREVUS and OCREVUS ZUNOVO MANUAL PA
	PONVORY (ponesimod)	
	TASCENSO ODT (fingolimod)	
	TYRUKO (natalizumab-sztn) ^{NR}	
	ZEPOSIA (ozanimod)	
MILD OR MODERATE ACTIVE		
BETASERON (interferon beta-1b)	AMPYRA (dalfampridine)	
COPAXONE (glatiramer) 20 mg	AUBAGIO (teriflunomide)	
dalfampridine ER	AVONEX (interferon beta-1a)	
dimethyl fumarate	BAFIERTAM (monomethyl fumarate)	
REBIF (interferon beta-1b)	COPAXONE (glatiramer) 40 mg	
REBIF REBIDOSE (interferon beta-1b)	glatiramer	
teriflunomide	GLATOPA (glatiramer)	
	PLEGRIDY (peginterferon beta-1a)	
	TECFIDERA (dimethyl fumarate)	
	VUMERITY (diroximel fumarate)	
MUSCULAR DYSTROPHY AGENTS		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
EMFLAZA (deflazacort)	AGAMREE (vamorolone)	AGAMREE MANUAL PA ELEVIDYS MANUAL PA EMFLAZA MANUAL PA EXONDYS MANUAL PA VILTEPSO MANUAL PA VYONDYS MANUAL PA
	AMONDYS-45 (casimersen)	
	deflazacort	
	DUVYZAT (givinostat)	
	ELEVIDYS (delandistrogene moxeparvovec-rokl)	
	EXONDYS-51 (eteplirsen)	
	JAYTHARI (deflazacort) ^{NR}	
	KYMBEE (deflazacort) ^{NR}	
	VILTEPSO (viltolarsen)	
	VYONDYS-53 (golodirsen)	
NSAIDS		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
COX II SELECTIVE		Quantity Limit (per 31 days) 20 tablets: ketorolac tablets ELYXYB - Requires clinical review
meloxicam	CELEBREX (celecoxib)	
	celecoxib	
	ELYXYB (celecoxib)	
	VYSCOXIA (celecoxib) ^{NR}	
NON-SELECTIVE		

ANTIBIOTIC-STEROID COMBINATIONS		- 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
BLEPHAMIDE S.O.P. (sulfacetamide/prednisolon e)	MAXITROL (neomycin/polymyxin/dexam ethasone)	
neomycin/bacitracin/polymy xin/hydrocortisone	neomycin/polymyxin/gramici din	
neomycin/polymyxin/dexam ethasone	TOBRADEX ST (tobramycin/dexamethasone)	
PRED-G (gentamicin/prednisolone)		
sulfacetamide/prednisolone		
TOBRADEX (tobramycin/dexamethason e)		
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)	
OPHTHALMIC, GLAUCOMA AGENTS		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
BETA BLOCKERS		Minimum Age Limit 18 years: IYUZEH
BETIMOL (timolol)	betaxolol	
carteolol	BETOPTIC S (betaxolol)	

ISTALOL (timolol)	timolol droperette, daily drop, gel	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
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)	LASTACAFIT (alcaftadine)	
	VERKAZIA (cyclosporine)	
	ZERVIAE (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)	
	REVELA (sevelamer)	
	sevelamer carbonate packet, sevelamer HCl	
	VELPHORO (sucroferric oxyhydroxide)	
	XPHOZAH (tenapanor)	
PLATELET AGGREGATION INHIBITORS		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
aspirin/dipyridamole	EFFIENT (prasugrel)	Non-Preferred Criteria - Documented diagnosis AND - Have tried 2 different preferred agents in the past 6 months OR 90 days of therapy with the requested agent in the past 105 days
BRILINTA (ticagrelor)	PLAVIX (clopidogrel)	
cilostazol	ticagrelor ^{NR}	
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)	
	DOPTELET SPRINKLE (avatrombopag maleate) ^{NR}	
	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 (patiomer 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 Maximum Age Limit 12 years: REVATIO suspension Preferred Criteria PAH Agents - Documented diagnosis of pulmonary hypertension Sildenafil tablets ≤ 1 year of age and documented diagnosis of pulmonary hypertension, patent ductus arteriosus, or persistent fetal circulation OR ≥ 1 year of age and documented diagnosis of pulmonary hypertension OR 90 days of therapy with the requested agent in the past 105 days Sildenafil suspension < 12 years of age AND - Documented diagnosis of pulmonary hypertension, patent ductus arteriosus, or persistent fetal circulation, or a history of a heart transplant OR
	WINREVAIR (sotatercept-csrk)	
COMBINATION AGENTS		
	OPSYNVI (macitentan/tadalafil)	
ENDOTHELIN RECEPTOR ANTAGONISTS		
ambrisentan	OPSUMIT (macitentan)	
bosentan	TRACLEER (bosentan)	
LETAIRIS (ambrisentan)	TRYVIO (aprocitentan)	
PDE5 INHIBITORS		
sildenafil (generic REVATIO) tablet, suspension	ADCIRCA (tadalafil)	
tadalafil	ALYQ (tadalafil)	
	REVATIO (sildenafil)	
	TADLIQ (tadalafil)	
PROSTACYCLINS		

	ORENITRAM ER (treprostinil)	• 90 days stable therapy with sildenafil suspension in the past 105 days Non-Preferred Criteria • Documented diagnosis of pulmonary hypertension AND • Have tried 1 preferred PAH agent in the past 6 months OR • 90 days of therapy with the requested agent in the past 105 days OPSUMIT, OPSYNVI, ORENITRAM ER, TYVASO, and VENTAVIS • Require clinical review
	ORENITRAM TITRATION PAK (treprostinil)	
	TYVASO (treprostinil)	
	VENTAVIS (iloprost)	
	YUTREPIA (treprostinil)	
SELECTIVE PROSTACYCLINE RECEPTOR AGONISTS		
	UPTRAVI (selexipag)	
SOLUABLE GUANYLATE CYCLASE STIMULATORS		
	ADEMPAS (riociguat)	

ADEMPAS

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

TADLIQ

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

UPTRAVI

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

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)	
	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.

SELECT CONTRACEPTIVE PRODUCTS

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
INJECTABLE CONTRACEPTIVES		Non-Preferred Criteria 1 claim with the requested agent in the past 105 days
medroxyprogesterone	DEPO-PROVERA (medroxyprogesterone)	
INTRAVAGINAL CONTRACEPTIVES		
ANNOVERA (segesterone/ethinyl estradiol)	PHEXXI (lactic acid/citric acid/potassium bitartrate)	
ENILLORING (etonogestrel/ethinyl estradiol)		
NUVARING (etonogestrel/ethinyl estradiol)		
ORAL CONTRACEPTIVES ^{DUR+}		
All oral contraceptives are preferred except for those specifically indicated as non-preferred.	AMETHIA (levonorgestrel/ethinyl estradiol)	
	AMETHYST (levonorgestrel/ethinyl estradiol)	
	BALCOLTRA (levonorgestrel/ethinyl estradiol)	
	BEYAZ (drospirenone/ethinyl estradiol/levomefolate)	
	CAMRESE (levonorgestrel/ethinyl estradiol)	
	CAMRESE LO (levonorgestrel/ethinyl estradiol)	
	JOLESSA (levonorgestrel/ethinyl estradiol)	
	LO LOESTRIN FE (norethindrone/ethinyl estradiol/iron)	

	LOESTRIN (norethindrone/ethinyl estradiol)	
	LOESTRIN FE (norethindrone/ethinyl estradiol/iron)	
	MINZOYA (levonorgestrel/ethinyl estradiol/iron)	
	NATAZIA (estradiol valerate/dienogest)	
	NEXTSTELLIS (drospirenone/estetrol)	
	OCELLA (ethinyl estradiol/drospirenone)	
	SAFYRAL (drospirenone/ethinyl estradiol/levomefolate)	
	SIMPESSE (levonorgestrel/ethinyl estradiol)	
	TAYTULLA (norethindrone/ethinyl estradiol/iron)	
	TYDEMY (drospirenone/ethinyl estradiol/levomefolate)	
	YASMIN (ethinyl estradiol/drospirenone)	
	YAZ (ethinyl estradiol/drospirenone)	
TRANSDERMAL CONTRACEPTIVES		
XULANE (norelgestromin/ethinyl estradiol)	norelgestromin/ethinyl estradiol	
	TWIRLA (levonorgestrel/ethinyl estradiol)	
	ZAFEMY (norelgestromin/ethinyl estradiol)	
SICKLE CELL AGENTS		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
DROXIA (hydroxyurea)	ADAKVEO (crizanlizumab- tmca)	ENDARI MANUAL PA
hydroxyurea	CASGEVY (exagamglogene autotemcel) ^{NR}	CASGEVY MANUAL PA
	ENDARI (glutamine)	LYFGENIA MANUAL PA
	HYDREA (hydroxyurea)	
	l-glutamine	
	LYFGENIA (lovotibeglogene autotemcel) ^{NR}	
	SIKLOS (hydroxyurea)	

SKELETAL MUSCLE RELAXANTS ^{DUR+}		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
baclofen 5 mg, 10 mg, 20 mg tablet	AMRIX (cyclobenzaprine)	Quantity Limit • 84 tablets/180 days: carisoprodol Non-Preferred Criteria • Documented diagnosis of an approvable indication AND • Have tried 2 different preferred agents in the past 6 months Baclofen granules, solution, and suspension • Require clinical review. Carisoprodol • Documented diagnosis of acute musculoskeletal condition AND • No history with meprobamate in the past 105 days AND • History of 1 claim for cyclobenzaprine in the past 21 days Carisoprodol with codeine • Requires clinical review. Metaxalone 640 mg and TANLOR • Requires clinical review Tizanidine capsule • Requires clinical review
chlorzoxazone	baclofen 15 mg tablet	
cyclobenzaprine 5 mg, 10 mg tablet	baclofen suspension	
methocarbamol	carisoprodol	
tizanidine tablet	carisoprodol/aspirin	
	cyclobenzaprine 7.5 mg tablet	
	cyclobenzaprine ER	
	DANTRIUM (dantrolene)	
	dantrolene	
	FEXMID (cyclobenzaprine)	
	FLEQSUVY (baclofen)	
	LORZONE (chlorzoxazone)	
	LYVISPAH (baclofen)	
	metaxalone	
	NORGESIC (orphenadrine/aspirin/caffeine)	
	NORGESIC FORTE (orphenadrine/aspirin/caffeine)	
	orphenadrine	
	orphenadrine/aspirin/caffeine	
	ORPHENGESIC FORTE (orphenadrine/aspirin/caffeine)	
	SOMA (carisoprodol)	
	TANLOR (methocarbamol)	
	tizanidine capsule	
	ZANAFLEX (tizanidine)	
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

alclometasone	fluocinolone
DERMA-SMOOTH-FS (fluocinolone)	hydrocortisone lotion
desonide	HYDROXYM (hydrocortisone)
hydrocortisone cream, ointment, solution	PROCTOCORT (hydrocortisone)
MEDIUM POTENCY	
fluticasone	BESER (fluticasone)
mometasone	CAPEX (fluocinolone)
PANDEL (hydrocortisone probutate)	clocortolone
prednicarbate cream	CLODERM (clocortolone)
	flurandrenolide
	fluticasone lotion
	LOCOID (hydrocortisone butyrate)
	prednicarbate ointment
	SYNALAR (fluocinolone)
HIGH POTENCY	
betamethasone dipropionate cream, lotion	amcinonide
betamethasone dipropionate augmented	betamethasone dipropionate ointment
betamethasone valerate	desoximetasone
fluocinolone	diflorasone
fluocinonide	Halcinonide
fluocinonide-E	HALOG (halcinonide)
triamcinolone cream, ointment, lotion	KENALOG (triamcinolone)
	TOPICORT (desoximetasone)
	triamcinolone spray
VERY HIGH POTENCY	
clobetasol cream, foam, gel, ointment, shampoo, solution	APEXICON E (diflorasone)
clobetasol-E	clobetasol emulsion
halobetasol	clobetasol 0.025% cream
	CLOBEX (clobetasol)
	CLODAN (clobetasol)
	DIPROLENE (betamethasone)
	halobetasol
	IMPEKLO (clobetasol)
	IMPOYZ (clobetasol) 0.025% cream
	LEXETTE (halobetasol)
	OLUX (clobetasol)
	TEMOVATE (clobetasol)
	TOVET (clobetasol)
	ULTRAVATE (halobetasol)

- **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.

STIMULANTS AND RELATED AGENTS ^{DUR+}

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
SHORT-ACTING		Minimum Age Limit • 3 years: ADDERALL, EVEKEO, PROCENTRA, ZENZEDI • 6 years: ADDERALL XR, ADHANSIA XR, ADZENYS ER SUSPENSION, ADZENYS XR ODT, APTENSIO XR, atomoxetine, AZSTARYS, clonidine ER, CONCERTA ER, COTEMPLA XR ODT, DAYTRANA, DESOXYN, DEXEDRINE, DYANAVEL XR, EVEKEO ODT, FOCALIN, FOCALIN XR, JORNAY PM, METADATE CD, METHYLIN, ONYDA XR, QELBREE, QUILLICHEW, QUILLIVANT XR, RELEXXII ER, RITALIN LA, VYVANSE, XELSTRYM • 7 years: XYREM • 13 years: MYDAYIS • 16 years: modafinil • 18 years: armodafinil, SUNOSI, WAKIX Maximum Age Limit • 18 years: clonidine ER, COTEMPLA XR ODT, DAYTRANA, EVEKEO ODT, guanfacine ER Quantity Limit Stimulants (per 31 days) • 31 tablets: ADDERALL XR, ADHANSIA XR, ADZENYS XR ODT, APTENSIO XR, AZSTARYS, CONCERTA ER 18, 27, & 54 mg, COTEMPLA XR-ODT 8.6 mg, DAYTRANA, DEXEDRINE Spansule, DYANAVEL XR Tablet, FOCALIN XR, JORNAY PM, METADATE CD, METHYLIN ER, MYDAYIS 37.5 mg & 50 mg, QUILLICHEW, RELEXXII ER, RITALIN LA & SR, VYVANSE, XELSTRYM • 62 tablets: ADDERALL, CONCERTA ER 36 mg, COTEMPLA XR-ODT 17.3 & 25.9 mg, DESOXYN, EVEKEO, FOCALIN, METHYLIN, RITALIN, ZENZEDI • 248 mL: DYANAVEL XR Suspension • 310 mL: METHYLIN, PROCENTRA • 372 mL: QUILLIVANT XR Quantity Limit Narcolepsy (per 31 days) • 31 tablets: armodafinil 150, 200 & 250 mg, modafinil 200 mg, SUNOSI • 46.5 tablets: modafinil 100 mg • 62 tablets: armodafinil 50 mg, WAKIX Quantity Limit Non-Stimulants (per 31 days) • 31 tablets: atomoxetine, guanfacine ER, QELBREE 100 mg • 62 tablets: QELBREE 150 mg and 200 mg • 124 tablets: clonidine ER • 1 bottle (30 mL or 60 mL): ONYDA XR Suspension
dexmethylphenidate	ADDERALL (dextroamphetamine/amphe tamine)	
dextroamphetamine	amphetamine	
dextroamphetamine/amphe tamine	EVEKEO (amphetamine)	
methylphenidate tablet, solution	dextroamphetamine solution	
PROCENTRA (dextroamphetamine)	EVEKEO ODT (amphetamine)	
	FOCALIN (dexmethylphenidate)	
	methamphetamine	
	METHYLN (methylphenidate)	
	methylphenidate chewable tablet	
	RITALIN (methylphenidate)	
	ZENZEDI (dextroamphetamine)	
LONG-ACTING		
ADDERALL XR (dextroamphetamine/amphe tamine)	ADZENYS XR ODT (amphetamine)	
CONCERTA (methylphenidate)	APTENSIO XR (methylphenidate)	
dexmethylphenidate ER	AZSTARYS (serdexmethylphenidate/dex methylphenidate)	
dextroamphetamine ER	COTEMPLA XR ODT (methylphenidate)	
dextroamphetamine/amphe tamine ER (generic ADDERALL XR)	DAYTRANA (methylphenidate)	
DYANAVEL XR (amphetamine) suspension	DEXEDRINE (dextroamphetamine)	
lisdexamfetamine	dextroamphetamine/amphet amine 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/amphe tamine)	

	RELEXII (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, METHYLIN, PROCENTRA, RITALIN, ZENZEDI - Documented diagnosis of narcolepsy AND 30 days of therapy with preferred modafinil or armodafinil in the past 6 months AND 1 preferred agent indicated for narcolepsy in the past 6 months OR - Have tried 1 claim for a 30-day supply with the requested agent in the past 105 days Non-Preferred Long Acting Criteria ADD/ADHD - Documented diagnosis of ADD/ADHD AND - Have tried 2 different preferred Long-Acting agents in the past 6 months OR 1 claim for a 30-day supply with the requested agent in the past 105 days Narcolepsy: ADDERALL XR, APTENSIO XR, CONCERTA ER, DEXEDRINE, METADATE CD, METHYLIN ER, MYDAYIS, NUVIGIL, PROVIGIL, QUILLICHEW, QUILLIVANT XR, RITALIN LA - Documented diagnosis of narcolepsy AND 30 days of therapy with preferred modafinil or armodafinil in the past 6 months AND 1 different preferred agent indicated for narcolepsy in the past 6 months OR 1 claim for a 30-day supply with the requested agent in the past 105 days		
Armodafinil - Documented diagnosis of narcolepsy, obstructive sleep apnea, shift work sleep disorder, or bipolar depression Atomoxetine - Age ≥ 21 years AND - Documented diagnosis of ADD/ADHD QELBREE - Documented diagnosis of ADD/ADHD AND 30 days of therapy with a preferred ADHD agent in the past 105 days OR 30 days of therapy with QELBREE in the past 105 days SUNOSI - Documented diagnosis of narcolepsy or obstructive sleep apnea AND 30 days of therapy with preferred modafinil or armodafinil in the past 6 months		

Clonidine ER

- Documented diagnosis of ADD/ADHD

Guanfacine ER

- Documented diagnosis of ADD/ADHD

JORNAY PM

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

Modafinil

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

VYVANSE

- Documented diagnosis of binge eating disorder or ADD/ADHD
- 90 days of therapy with Vyvanse in the past 90 days

WAKIX

- Requires clinical review

XYREM

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

XYWAV

- Requires clinical review

TETRACYCLINES ^{DUR+}

PREFERRED AGENTS	NON-PREFERRED AGENTS	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*

PA CRITERIA		PREFERRED AGENTS	NON-PREFERRED AGENTS
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		ORAL	
		balsalazide	AZULFIDINE (sulfasalazine)
		budesonide	DELZICOL (mesalamine)
		PENTASA (mesalamine)	DIPENTUM (olsalazine)
		sulfasalazine	LIALDA (mesalamine)
		sulfasalazine DR	mesalamine
			mesalamine DR, mesalamine ER
			VELSIPITY (etrasimod)
		RECTAL	
		mesalamine suppository	budesonide
			CANASA (mesalamine)
			mesalamine enema
			ROWASA (mesalamine)
			SFROWASA (mesalamine)
UREA CYCLE DISORDER AGENTS			
PA CRITERIA		PREFERRED AGENTS	NON-PREFERRED AGENTS
		CARBAGLU (carglumic acid)	BUPHENYL (sodium phenylbutyrate)
			carglumic acid
			glycerol phenylbutyrate ^{NR}
			OLPRUVA (sodium phenylbutyrate)
			PHEBURANE (sodium phenylbutyrate)
			RAVICTI (glycerol phenylbutyrate)