

# MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

EFFECTIVE 4/1/2026  
VERSION 2026\_5  
Updated 3/31/2026

## 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
<b>ANTI-INFECTIVES</b>		<p><b>Maximum Age Limit</b></p> <ul style="list-style-type: none"> <li>• <b>21 years:</b> all acne agents except isotretinoin products</li> </ul> <p><b>Topical Clindamycin 1% lotion</b></p> <ul style="list-style-type: none"> <li>• <b>21 years</b> and older <b>AND</b></li> <li>• Documented diagnosis of hidradenitis suppurativa</li> </ul> <p>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 &lt; 21 years does not require PA</p>
clindamycin gel (generic CLEOCIN-T)	azelaic acid	
clindamycin lotion, medicated swab, solution	CLEOCIN T (clindamycin)	
erythromycin gel, solution	CLINDACIN (clindamycin)	
	clindamycin foam	
	clindamycin gel (generic CLINDAGEL)	
	dapsone	
	ERY (erythromycin)	
	ERYGEL (erythromycin)	
	EVOCLIN (clindamycin)	
	MORGIDOX (doxycycline)	
	sulfacetamide sodium suspension	
	WINLEVI (clascoterone) cream	
<b>ISOTRETINOIN PRODUCTS</b>		
AMNESTEEM (isotretinoin)	ABSORBICA (isotretinoin)	
CLARAVIS (isotretinoin)	isotretinoin	
ZENATANE (isotretinoin)		
<b>KERATOLYTICS (BENZOYL PEROXIDES)</b>		
ACNE MEDICATION (benzoyl peroxide)	BPO towelette (benzoyl peroxide)	
benzoyl peroxide		
LINTERA (benzoyl peroxide)		
<b>RETINOIDS</b>		
adapalene gel, gel with pump	adapalene cream	
tretinoin cream	AKLIEF (trifarotene)	
	ATRALIN (tretinoin)	
	DIFFERIN (adapalene)	
	FABIOR (tazarotene)	
	tretinoin gel	
	tretinoin microsphere	
<b>OTHERS/COMBINATION PRODUCTS</b>		
adapalene/benzoyl peroxide gel	CLEANSING WASH (sulfacetamide sodium/sulfur/urea) cleanser	
clindamycin/benzoyl peroxide 1%-5% gel	clindamycin phosphate/benzoyl peroxide 1.2%-2.5% gel	
clindamycin phosphate/benzoyl peroxide 1.2%-5% gel	clindamycin phosphate/tretinoin 1.2%-0.025% gel	
sodium sulfacetamide w/sulfur 8%-4%, 9%-4.25%, 10-5% suspension	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 <sup>DUR+</sup>

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
<b>CHOLINESTERASE INHIBITORS</b>		<b>Preferred Criteria</b>
donepezil 5 mg, 10 mg ODT, tablets	ADLARITY (donepezil)	<ul style="list-style-type: none"> <li>Documented approvable diagnosis</li> </ul>
galantamine	ARICEPT (donepezil)	<b>Non-Preferred Criteria</b>
galantamine ER	donepezil 23 mg tablet	<ul style="list-style-type: none"> <li>Documented approvable diagnosis <b>AND</b></li> </ul>
rivastigmine	EXELON (rivastigmine)	<ul style="list-style-type: none"> <li>Have tried 2 different preferred agents in the past 6 months</li> </ul>
	ZUNVEYL (benzgalantamine gluconate)	<b>NAMZARIC</b>
		<ul style="list-style-type: none"> <li>Requires clinical review</li> </ul>
<b>NMDA RECEPTOR ANTAGONISTS</b>		<b>ZUNVEYL</b>
memantine	memantine ER	<ul style="list-style-type: none"> <li>Requires clinical review</li> </ul>
	NAMENDA (memantine)	
	NAMENDA XR (memantine ER)	
<b>COMBINATION AGENTS</b>		
	NAMZARIC (memantine/donepezil)	
	memantine/donepezil ER	

### ANALGESICS, OPIOID-SHORT ACTING <sup>DUR+</sup>

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
acetaminophen/caffeine/dihydrocodeine	ACTIQ (fentanyl)	<p><b>MS DOM Opioid Initiative Criteria details found here</b></p> <ul style="list-style-type: none"> <li>• Morphine Equivalent Daily Dose</li> <li>• Concomitant use of Opioids and Benzodiazepines</li> </ul> <p><b>Minimum Age Limit</b></p> <ul style="list-style-type: none"> <li>• <b>18 years:</b> codeine-containing products and tramadol-containing products</li> </ul> <p><b>Quantity Limit</b> (per 31 rolling days)</p> <ul style="list-style-type: none"> <li>• <b>62 tablets:</b> butalbital/codeine combinations, codeine combinations, dihydrocodeine combinations, fentanyl, hydrocodone, hydromorphone, levorphanol, meperidine, morphine, oxycodone, oxymorphone, pentazocine, tapentadol, tramadol</li> <li>• <b>186 tablets:</b> butalbital/acetaminophen, butalbital/aspirin</li> <li>• <b>5 mL:</b> butorphanol nasal</li> <li>• <b>180 mL:</b> oxycodone liquid</li> <li>• <b>280 mL:</b> QDOLO</li> </ul> <p><b>Non-Preferred Criteria</b></p> <ul style="list-style-type: none"> <li>• Have tried 2 different preferred agents in the past 6 months</li> </ul> <p><b>MS DOM Opioid Initiative Criteria details found here</b></p> <ul style="list-style-type: none"> <li>• Morphine Equivalent Daily Dose</li> <li>• Concomitant use of Opioids and Benzodiazepines</li> </ul> <p><b>Minimum Age Limit</b></p> <ul style="list-style-type: none"> <li>• <b>18 years:</b> BUTRANS and tramadol-containing products</li> </ul>
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)	
	tapentadol	
	tramadol 25 mg, 75 mg, 100 mg tablet	
	tramadol solution	
	XYVONA (levorphanol) <sup>NIR</sup>	

### ANALGESICS, OPIOID-LONG ACTING <sup>DUR+</sup>

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
BUTRANS (buprenorphine)	BELBUCA (buprenorphine)	<p><b>Quantity Limit</b> (per 31 rolling days)</p> <ul style="list-style-type: none"> <li>• <b>31 tablets:</b> AVINZA, hydromorphone ER, HYSINGLA ER, tramadol ER</li> <li>• <b>62 tablets:</b> methadone, morphine ER, OXYCONTIN, oxymorphone ER, ZOHYDRO ER</li> <li>• <b>62 films:</b> BELBUCA</li> <li>• <b>10 patches:</b> fentanyl</li> <li>• <b>4 patches:</b> BUTRANS</li> </ul> <p><b>Non-Preferred Criteria</b></p> <ul style="list-style-type: none"> <li>• Have tried 2 preferred agents in the past 6 months</li> </ul>
fentanyl patch	buprenorphine patch	
morphine sulfate ER tablet	CONZIP (tramadol)	
	hydrocodone bitartrate ER	
	hydromorphone ER	
	HYSINGLA ER (hydrocodone)	
	methadone	
	methadone intensol	
	METHADOSE (methadone)	
	morphine sulfate ER capsule	

	MS CONTIN (morphine)
	oxycodone ER
	OXYCONTIN (oxycodone)
	oxymorphone ER
	tapentadol ER
	tramadol ER

### ANALGESICS/ANESTHETICS (TOPICAL)

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
diclofenac 1%, 3% gel	DERMACINRX LIDOCAN (lidocaine)	<p><b>Quantity Limit</b> (per 31 days)</p> <ul style="list-style-type: none"> <li>• <b>1 bottle (112 mL):</b> diclofenac 2% solution pump</li> <li>• <b>1 bottle (150 mL):</b> diclofenac 1.5% solution</li> </ul> <p><b>Non-Preferred Criteria</b></p> <ul style="list-style-type: none"> <li>• Have tried 2 preferred agents in the past 6 months</li> </ul> <p><b>Lidocaine 5% Patch</b></p> <ul style="list-style-type: none"> <li>• Documented diagnosis of Herpetic Neuralgia <b>OR</b></li> <li>• Documented diagnosis of Diabetic Neuropathy</li> </ul> <p><b>ZTLIDO</b></p> <ul style="list-style-type: none"> <li>• Documented diagnosis of postherpetic neuralgia <b>OR</b></li> <li>• History of 3 claims with preferred lidocaine 5% patch in the past 6 months</li> </ul>
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 <sup>DUR+</sup>

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
testosterone	ANDROGEL (testosterone)	<p><b>All Agents</b></p> <ul style="list-style-type: none"> <li>• Limited to male gender</li> </ul> <p><b>Non-Preferred Criteria</b></p> <ul style="list-style-type: none"> <li>• Have tried 2 different preferred agents in the past 6 months</li> </ul> <p><b>TLANDO</b></p> <ul style="list-style-type: none"> <li>• Requires clinical review</li> </ul>
	JATENZO (testosterone undecanoate)	
	NATESTO (testosterone)	
	TESTIM (testosterone)	
	TLANDO (testosterone undecanoate)	
	VOGELXO (testosterone)	

	UNDECATREX (testosterone undecanoate)	
<b>ANGIOTENSIN MODULATORS</b> <sup>DUR+</sup>		
<b>PREFERRED AGENTS</b>	<b>NON-PREFERRED AGENTS</b>	<b>PA CRITERIA</b>
<b>ANGIOTENSIN CONVERTING ENZYME (ACE) INHIBITORS</b>		<p><b>EPANED</b></p> <ul style="list-style-type: none"> <li>• Automatic approval issued for 0-6 years of age</li> </ul> <p><b>valsartan/sacubitril</b></p> <ul style="list-style-type: none"> <li>• Age ≥1 year <b>and</b> documented diagnosis of Heart Failure with Systemic Ventricular Systolic Dysfunction <b>OR</b></li> <li>• Age ≥ 18 years <b>and</b> documented diagnosis of Heart Failure</li> </ul> <p><b>Non-Preferred Criteria</b></p> <ul style="list-style-type: none"> <li>• <b>ACEIs:</b> <ul style="list-style-type: none"> <li>○ Have tried 2 different preferred single entity agents in the past 6 months <b>OR</b></li> <li>○ 90 days of therapy with the requested agent in the past 105 days</li> </ul> </li> <li>• <b>ACEI/CCB Combinations:</b> <ul style="list-style-type: none"> <li>○ Have tried 2 different preferred ACEI/CCB agents in the past 6 months <b>OR</b></li> <li>○ 90 days of therapy with the requested agent in the past 105 days</li> </ul> </li> <li>• <b>ACEI/Diuretic Combinations:</b> <ul style="list-style-type: none"> <li>○ Have tried 2 different preferred ACEI/Diuretic agents in the past 6 months <b>OR</b></li> <li>○ 90 days of therapy with the requested agent in the past 105 days</li> </ul> </li> <li>• <b>ARBs:</b> <ul style="list-style-type: none"> <li>○ Have tried 2 different preferred single entity agents in the past 6 months <b>OR</b></li> <li>○ 90 days of therapy with the requested agent in the past 105 days</li> </ul> </li> <li>• <b>ARB/CCB and ARB/CCB/Diuretic Combinations:</b> <ul style="list-style-type: none"> <li>○ Have tried 1 preferred ARB/CCB agent in the past 6 months <b>OR</b></li> <li>○ 90 days of therapy with the requested agent in the past 105 days</li> </ul> </li> <li>• <b>ARB/Diuretic Combinations:</b> <ul style="list-style-type: none"> <li>○ Have tried 2 different preferred ARB/Diuretic agents in the past 6 months <b>OR</b></li> <li>○ 90 days of therapy with the requested agent in the past 105 days</li> </ul> </li> <li>• <b>Direct Renin Inhibitors:</b> <ul style="list-style-type: none"> <li>○ Documented diagnosis of Hypertension <b>AND</b></li> <li>○ Have tried 2 different preferred ACEI or ARB single-entity agents in the past 6 months <b>OR</b></li> <li>○ 90 days of therapy with the requested agent in the past 105 days</li> </ul> </li> <li>• <b>Direct Renin Inhibitor Combinations:</b> <ul style="list-style-type: none"> <li>○ Documented diagnosis of Hypertension <b>AND</b></li> <li>○ Have tried 2 different preferred ACEI or ARB diuretic agents in the past 6 months <b>OR</b></li> <li>○ 90 days of therapy with the requested agent in the past 105 days</li> <li>○ Have tried 2 different preferred ACEI/Diuretic agents in the past 6 months <b>OR</b></li> <li>○ 90 days of therapy with the requested agent in the past 105 days</li> </ul> </li> </ul>
benazepril	ACCUPRIL (quinapril)	
captopril	ALTACE (ramipril)	
enalapril	EPANED (enalapril)	
fosinopril	LOTENSIN (benazepril)	
lisinopril	moexipril	
quinapril	perindopril	
ramipril	QBRELIS (lisinopril)	
trandolapril	ZESTRIL (lisinopril)	
<b>ACE INHIBITOR (ACEI) COMBINATIONS</b>		
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		
<b>ANGIOTENSIN II RECEPTOR BLOCKERS (ARBs)</b>		
irbesartan	ATACAND (candesartan)	
losartan	AVAPRO (irbesartan)	
olmesartan	BENICAR (olmesartan)	
telmisartan	candesartan	
valsartan tablet	COZAAR (losartan)	
	EDARBI (azilsartan)	
	eprosartan	
	MICARDIS (telmisartan)	
	valsartan solution	
<b>ARB COMBINATIONS</b>		
irbesartan/hydrochlorothiazide	ATACAND HCT (candesartan/hydrochlorothiazide)	
losartan/hydrochlorothiazide	AVALIDE (irbesartan/hydrochlorothiazide)	

olmesartan/amlodipine	AZOR (olmesartan/hydrochlorothiazide)
olmesartan/amlodipine/hydrochlorothiazide	BENICAR HCT (olmesartan/hydrochlorothiazide)
olmesartan/hydrochlorothiazide	candesartan/hydrochlorothiazide
telmisartan/hydrochlorothiazide	DIOVAN-HCT (valsartan/hydrochlorothiazide)
valsartan/amlodipine	EDARBYCLOR (azilsartan/chlorthalidone)
valsartan/hydrochlorothiazide	ENTRESTO (valsartan/sacubitril)
valsartan/sacubitril <sup>DUR+</sup>	EXFORGE (valsartan/amlodipine)
	EXFORGE HCT (valsartan/amlodipine/hydrochlorothiazide)
	telmisartan/amlodipine
	TRIBENZOR (olmesartan/amlodipine/hydrochlorothiazide)
	valsartan/amlodipine/hydrochlorothiazide
<b>DIRECT RENIN INHIBITORS</b>	
	aliskiren
	TEKTURNA (aliskiren)
<b>DIRECT RENIN INHIBITOR COMBINATIONS</b>	
	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 capsule, oral solution	FLAGYL (metronidazole)	
	LIKMEZ (metronidazole)	
	metronidazole 125 mg tablet, 375 mg capsule	
	nitazoxanide	
	paromomycin	
	REBYOTA (fecal microbiota, live-jslm)	
	VANCOCIN (vancomycin)	
	VOWST (fecal microbiota spore, live-brpk)	

### ANTIBIOTICS (MISCELLANEOUS)

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
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LINCOSAMIDE ANTIBIOTICS		<b>Quantity Limit</b> • 6 tablets/month: SIVEXTRO  <b>SIVEXTRO MANUAL PA</b>
clindamycin	CLEOCIN (clindamycin)	
	CELOCIN PEDIATRIC (clindamycin)	
MACROLIDES		
azithromycin	E. E. S. (erythromycin ethylsuccinate) suspension	
clarithromycin	ERYPED (erythromycin ethylsuccinate) suspension	
clarithromycin ER	ERYTHROCIN (erythromycin stearate)	
E. E. S. (erythromycin ethylsuccinate) 400mg tablet	ZITHROMAX (azithromycin)	
ERY-TAB (erythromycin)		
erythromycin		
erythromycin ethylsuccinate		
NITROFURANTOIN DERIVATIVES		
nitrofurantoin capsule	FURADANTIN (nitrofurantoin) suspension	
nitrofurantoin monohydrate macrocrystals	MACROBID (nitrofurantoin monohydrate macrocrystals) nitrofurantoin suspension	
OXAZOLIDINONES		
linezolid tablet	linezolid suspension	
	SIVEXTRO (tedizolid)	
	ZYVOX (linezolid)	

### ANTIBIOTICS (TOPICAL)

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

### 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)		<b>Non-Preferred Criteria</b> • LMWH: ○ Have tried 1 preferred agent in the past 6 months <b>OR</b> ○ 90 days of therapy with the requested agent in the past 105 days
enoxaparin	ARIXTRA (fondaparinux)	
	fondaparinux	
	FRAGMIN (dalteparin)	

	LOVENOX (enoxaparin)	<ul style="list-style-type: none"> <li>• <b>Oral:</b> <ul style="list-style-type: none"> <li>○ Have tried 2 different preferred oral agents in the past 6 months <b>OR</b></li> <li>○ 90 days of therapy with the requested agent in the past 105 days</li> </ul> </li> </ul> <p><b>XARELTO Dose Pack</b></p> <ul style="list-style-type: none"> <li>• Requires clinical review</li> </ul>
<b>ORAL</b>		
dabigatran	PRADAXA (dabigatran)	
ELIQUIS (apixaban)	rivaroxaban	
ELIQUIS SPRINKLE (apixaban)	SAVAYSA (edoxaban)	
JANTOVEN (warfarin)	XARELTO (rivaroxaban) dose pack	
warfarin		
XARELTO (rivaroxaban) tablet, suspension		

## ANTICONVULSANTS <sup>DUR+</sup>

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
<b>ADJUVANTS</b>		
carbamazepine	APTIOM (eslicarbazepine acetate)	<p><b>Minimum Age Limit</b></p> <ul style="list-style-type: none"> <li>• <b>6 months:</b> DIACOMIT</li> <li>• <b>1 year:</b> BANZEL, EPIDIOLEX</li> <li>• <b>2 years:</b> ONFI, SYMPAZAN, SUBVENITE, VALTOCO</li> <li>• <b>12 years:</b> NAYZILAM</li> </ul>
carbamazepine ER 12-hour capsule	BANZEL (rufinamide)	
DEPAKOTE ER (divalproex)	brivaracetam	<p><b>Maximum Age Limit</b></p> <ul style="list-style-type: none"> <li>• <b>2 years:</b> VIGAFYDE</li> </ul>
DEPAKOTE SPRINKLE (divalproex)	BRIVIACT (brivaracetam)	
divalproex	carbamazepine ER 12-hour tablet	<p><b>Quantity Limit</b> (per 31 days)</p> <ul style="list-style-type: none"> <li>• <b>2 twin packs:</b> DIASTAT</li> <li>• <b>2 packages:</b> NAYZILAM</li> <li>• <b>5 blister packs:</b> VALTOCO</li> </ul>
divalproex ER	CARBATROL (carbamazepine)	
divalproex sprinkle	DEPAKOTE (divalproex)	<p><b>Non-Preferred Criteria</b></p> <ul style="list-style-type: none"> <li>• Have tried 2 different preferred agents in the past 6 months <b>OR</b></li> <li>• Documented diagnosis of Seizure <b>AND</b></li> <li>• 90 days of therapy with the requested agent in the past 105 days</li> </ul>
EPIDIOLEX (cannabidiol)	DIACOMIT (stiripentol)	
lacosamide	ELEPSIA XR (levetiracetam)	<p><b>BANZEL, ONFI, and SYMPAZAN</b></p> <ul style="list-style-type: none"> <li>• Documented diagnosis of Lennox-Gastaut Syndrome <b>and</b> have tried 1 preferred agent for Lennox-Gastaut Syndrome in the past 6 months</li> </ul> <p><b>OR</b></p> <ul style="list-style-type: none"> <li>• Documented diagnosis of Seizure <b>and</b> 90 days of therapy with the requested agent in the past 105 days</li> </ul>
lamotrigine	EPRONTIA (topiramate)	
lamotrigine blue, green, orange dose pack	EQUETRO (carbamazepine)	<p><b>DIACOMIT</b></p> <ul style="list-style-type: none"> <li>• Documented diagnosis of Dravet Syndrome <b>AND</b></li> <li>• 1 claim for clobazam in the past 30 days</li> </ul>
levetiracetam	eslicarbazepine	
levetiracetam ER	felbamate	<p><b>EPIDIOLEX</b></p> <ul style="list-style-type: none"> <li>• Documented diagnosis of Dravet Syndrome, Lennox-Gastaut Syndrome, or Seizures associated with Tuberous Sclerosis Complex <b>OR</b></li> <li>• 1 claim for EPIDIOLEX in the past 30 days</li> </ul>
oxcarbazepine tablet	FELBATOL (felbamate)	
tiagabine	FINTEPLA (fenfluramine)	<p><b>FINTEPLA</b></p> <ul style="list-style-type: none"> <li>• Requires clinical review</li> </ul>
topiramate	FYCOMPA (perampanel)	
topiramate sprinkle 15, 25 mg (generic Topamax)	KEPPRA (levetiracetam)	<p><b>SABRIL Powder for Oral Solution</b></p> <ul style="list-style-type: none"> <li>• Documented diagnosis of Infantile Spasms <b>OR</b></li> <li>• Have tried 2 different preferred agents in the past 6 months <b>OR</b></li> <li>• Documented diagnosis of Seizure <b>AND</b></li> <li>• 90 days of therapy with the requested agent in the past 105 days</li> </ul>
TRILEPTAL (oxcarbazepine) suspension	KEPPRA XR (levetiracetam)	
valproic acid	LAMICTAL (lamotrigine)	
zonisamide	LAMICTAL XR (lamotrigine)	
	lamotrigine ER	
	lamotrigine ODT	
	lamotrigine ODT blue, green, orange dose pack	
	MOTPOLY XR (lacosamide)	
	oxcarbazepine suspension	
	oxcarbazepine ER	
	OXTELLAR XR (oxcarbazepine)	
	perampanel <sup>NR</sup>	

	QUDEXY XR (topiramate)	<p><b>TOPIRAMATE ER</b></p> <ul style="list-style-type: none"> <li>• Documented diagnosis of Seizure <b>AND</b></li> <li>• 90 days of therapy with the requested agent in the past 105 days <b>OR</b></li> <li>• 30 days of therapy with topiramate IR in the past 6 months</li> </ul> <p><b>VIGAFYDE</b></p> <ul style="list-style-type: none"> <li>• Age ≤ 2 years <b>AND</b></li> <li>• Documented diagnosis of infantile spasms</li> </ul> <p><b>XCOPRI</b></p> <ul style="list-style-type: none"> <li>• Age ≥ 18 years</li> </ul>
	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)	
<b>HYDANTOINS</b>		
	DILANTIN (phenytoin)	
	DILANTIN-125 (phenytoin)	
	PHENYTEK (phenytoin)	
	phenytoin	
	phenytoin ER	
<b>SELECTED BENZODIAZEPINES</b>		
clobazam	DIASTAT (diazepam) rectal gel	
diazepam rectal gel	LIBERVANT (diazepam)	
NAYZILAM (midazolam)	ONFI (clobazam)	
VALTOCO (diazepam)	SYMPAZAN (clobazam)	
<b>SUCCINIMIDES</b>		
ethosuximide	CELONTIN (methsuximide) methsuximide	
	ZARONTIN (ethosuximide)	
<b>ANTIDEPRESSANTS, OTHER <sup>DUR+</sup></b>		
<b>PREFERRED AGENTS</b>	<b>NON-PREFERRED AGENTS</b>	<b>PA CRITERIA</b>

bupropion	AUVELITY (bupropion/dextromethorphan)	<b>Minimum Age Limit</b> • <b>18 years:</b> all agents
bupropion SR	CYMBALTA (duloxetine)	<b>Non-Preferred Criteria</b> • Have tried 2 different preferred agents in the past 6 months <b>OR</b> • Have tried 1 preferred agent and 1 SSRI in the past 6 months <b>OR</b> • 90 days of therapy with the requested agent in the past 105 days
bupropion XL	desvenlafaxine ER	
duloxetine 20 mg, 30 mg, 60 mg DR capsule	DESYREL (trazodone)	<b>AUVELITY</b> • 90 days of therapy with the requested agent in the past 105 days <b>OR</b> • Have tried preferred bupropion for 60 days in the past 6 months <b>AND</b> • Have tried another preferred agent that is not bupropion for 60 days in the past 6 months
mirtazapine	DRIZALMA SPRINKLE (duloxetine DR)	
trazodone	duloxetine 40 mg DR capsule	<b>DRIZALMA SPRINKLE</b> • Automatic approval issued with a diagnosis of Generalized Anxiety Disorder for 7-11 years of age  <b>duloxetine 20 mg, 30 mg, 60 mg DR capsule</b> • Automatic approval issued with a diagnosis of Generalized Anxiety Disorder for 7-17 years of age <b>OR</b> • 90 days of therapy with the requested agent in the past 105 days
TRINTELLIX (vortioxetine)	EFFEXOR XR (venlafaxine)	
venlafaxine	EMSAM (selegiline)	<b>EXXUA</b> • Documented diagnosis of unipolar major depressive disorder <b>AND</b> • Have tried 2 different preferred agents in the past 6 months <b>OR</b> • Have tried 1 preferred agent and 1 SSRI in the past 6 months <b>OR</b> • 90 days of therapy with the requested agent in the past 105 days
venlafaxine HCl ER	<b>EXXUA (gepirone hcl)</b>	
vilazodone	FETZIMA (levomilnacipran)	<b>RALDESY</b> • Requires clinical review  <b>ZURZUVAE MANUAL PA</b>
	FORFIVO XL (bupropion)	
	MARPLAN (isocarboxazid)	
	NARDIL (phenelzine)	
	nefazodone	
	phenelzine	
	PRISTIQ (desvenlafaxine)	
	REMERON (mirtazapine)	
	tranylcypromine	
	Trazodone solution	
	venlafaxine besylate ER	
	VIIBRYD (vilazodone)	
	WELLBUTRIN SR (bupropion)	
	ZURZUVAE (zuranolone)	

### ANTIDEPRESSANTS, SSRIs <sup>DUR+</sup>

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
citalopram solution, tablet	CELEXA (citalopram)	<b>Minimum Age Limit</b> • <b>6 years:</b> ZOLOFT • <b>7 years:</b> LEXAPRO, PROZAC • <b>8 years:</b> fluvoxamine • <b>18 years:</b> CELEXA, LUVOX CR, PAXIL, PROZAC 90 mg  <b>Maximum Age Limit</b> • 60 years CELEXA  <b>Non-Preferred Criteria</b> • Have tried 2 different preferred agents in the past 6 months <b>OR</b> • 90 days of therapy with the requested agent in the past 105 days
escitalopram solution, tablet	citalopram capsule	
fluoxetine capsule, solution	escitalopram capsule	
fluvoxamine	fluoxetine 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 <sup>DUR+</sup>

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
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<b>5HT3 RECEPTOR BLOCKERS</b>		<b>Quantity Limit</b> (per 31 days) <ul style="list-style-type: none"> <li>• <b>6 tablets:</b> AKYNZEO</li> <li>• <b>100 mL:</b> ZOFRAN solution</li> </ul> <b>Non-Preferred Agents</b> <ul style="list-style-type: none"> <li>• Have tried 1 preferred agent in the past 6 months</li> </ul> <b>AKYNZEO MANUAL PA</b>  Note: Injectables in this class are closed to point of sale. PA required if not administered in clinic/hospital.
ondansetron solution, tablet	ANZIMET (dolasetron)	
ondansetron ODT 4 mg, 8 mg	granisetron	
	ondansetron ODT 16 mg tablet	
	SANCUSO (granisetron)	
<b>ANTIEMETIC COMBINATIONS</b>		
DICLEGIS (doxylamine/pyridoxine)	AKYNZEO (netupitant/palonosetron)	
	BONJESTA (doxylamine/pyridoxine)	
	doxylamine/pyridoxine	
<b>CANNABINOIDS</b>		
	dronabinol	
	MARINOL (dronabinol)	
<b>NMDA RECEPTOR ANTAGONISTS</b>		
aprepitant	EMEND (aprepitant)	

### ANTIFUNGALS (ORAL) <sup>DUR+</sup>

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
clotrimazole	BREXAFEMME (ibrexafungerp)	<b>Minimum Age Limit</b> <ul style="list-style-type: none"> <li>• <b>18 years:</b> CRESEMBA</li> </ul> <b>Non-Preferred Criteria</b> <ul style="list-style-type: none"> <li>• Have tried 2 different preferred agents in the past 6 months</li> </ul> <b>HIV Opportunistic Infection</b> <ul style="list-style-type: none"> <li>• Non-Preferred agent indicated for treatment (^) <b>AND</b></li> <li>• Documented diagnosis of HIV</li> </ul> <b>CRESEMBA MANUAL PA</b>  <b>griseofulvin suspension</b> <ul style="list-style-type: none"> <li>• Automatic approval issued for 0-11 years of age</li> </ul> <b>griseofulvin tablets</b> <ul style="list-style-type: none"> <li>• Automatic approval issued for 12-17 years of age</li> </ul> <b>SPORANOX</b> <ul style="list-style-type: none"> <li>• Requires clinical review</li> </ul>
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) <sup>DUR+</sup>

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
<b>ANTIFUNGALS</b>		<b>Non-Preferred Criteria</b> <ul style="list-style-type: none"> <li>• Have tried 2 different preferred agents in the past 6 months</li> </ul> <b>clotrimazole 30 mL solution</b> <ul style="list-style-type: none"> <li>• Require clinical review</li> </ul>
ciclopirox cream, gel, solution, suspension	BENSAL HP (salicylic acid)	
clotrimazole cream, solution <small>Rx &amp; OTC</small>	CILODAN (ciclopirox)	
econazole	ciclopirox shampoo	
ketoconazole cream, shampoo	clotrimazole solution (NDC 50228-0502-61)	

miconazole cream, powder, solution <sup>OTC</sup>	EXTINA (ketoconazole)
nystatin cream, ointment, powder	ketoconazole foam
terbinafine <sup>OTC</sup>	KETODAN (ketoconazole)
tolnaftate cream, powder <sup>OTC</sup>	LOPROX (ciclopirox)
tavaborole	luliconazole
	miconazole/zinc oxide/petrolatum ointment
	MICOTRIN AC (clotrimazole)
	MICOTRIN AP (miconazole nitrate powder)
	MYCOZYL AC (clotrimazole)
	MYCOZYL AP (miconazole)
	naftifine
	NAFTIN (naftifine)
	oxiconazole
	OXISTAT (oxiconazole)
	VOTRIZA-AL (clotrimazole)
	VUSION (miconazole/zinc oxide/petrolatum)
<b>ANTIFUNGAL/STEROID COMBINATIONS</b>	
clotrimazole/betamethasone cream	clotrimazole/betamethasone lotion
nystatin/triamcinolone	

### ANTIFUNGALS (VAGINAL)

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
3-DAY VAGINAL CREAM (clotrimazole)	GYNAZOLE 1 (butoconazole)	
clotrimazole cream <sup>OTC</sup>	miconazole 3 kit <sup>OTC</sup>	
clotrimazole-3 cream	terconazole suppository	
miconazole 1 <sup>OTC</sup>		
miconazole 3 combo pack <sup>OTC</sup> , cream <sup>OTC</sup> , suppository		
miconazole 7 <sup>OTC</sup>		
terconazole cream		

### ANTIHISTAMINES, MINIMALLY SEDATING AND COMBINATIONS <sup>DUR+</sup>

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
<b>MINIMALLY SEDATING ANTIHISTAMINES</b>		<p><b>Non-Preferred Criteria</b></p> <ul style="list-style-type: none"> <li>Documented diagnosis of Allergy or Urticaria <b>AND</b></li> <li>Have tried 2 different preferred agents in the past 12 months</li> </ul> <p><b>Quantity Limit</b></p> <ul style="list-style-type: none"> <li><b>118 mL:</b> desloratadine solution</li> </ul> <p><b>DES Loratadine Solution</b></p> <ul style="list-style-type: none"> <li>Requires clinical review</li> </ul>
cetirizine capsule, solution, tablet <sup>OTC</sup>	cetirizine chewable tablet <sup>OTC</sup>	
loratadine chewable tablet, ODT, solution, tablet <sup>OTC</sup>	CLARINEX (desloratadine)	
	desloratadine levocetirizine	
<b>MINIMALLY SEDATING ANTIHISTAMINE/DECONGESTANT COMBINATIONS</b>		

cetirizine/pseudoephedrine	CLARINEX-D 12 HOUR (desloratadine/pseudoephedrine)	
loratadine/pseudoephedrine OTC		
<b>ANTIMIGRAINE AGENTS, ACUTE TREATMENT</b>		
<b>PREFERRED AGENTS</b>	<b>NON-PREFERRED AGENTS</b>	<b>PA CRITERIA</b>
<b>CGRP ORAL AND NASAL</b>		<b>Minimum Age Limit</b> <ul style="list-style-type: none"> <li>• <b>6 years:</b> MAXALT</li> <li>• <b>12 years:</b> almotriptan, sumatriptan/naproxen, ZOMIG nasal spray</li> <li>• <b>18 years:</b> FROVA, IMITREX, naratriptan, NURTEC ODT, RELPAX, REYVOW, SYMBRAVO, TOSYMRA, UBRELVY, ZEMBRACE, ZOMIG tablets</li> </ul>
NURTEC ODT (rimegepant)	ZAVZPRET (zavegepant)	
UBRELVY (ubrogepant)		
<b>INJECTABLES</b>		<b>Quantity Limit</b> (per 31 days) <ul style="list-style-type: none"> <li>• <b>ORAL</b> <ul style="list-style-type: none"> <li>○ <b>4 tablets:</b> REYVOW 50 mg</li> <li>○ <b>6 tablets:</b> almotriptan, RELPAX, ZOMIG</li> <li>○ <b>8 tablets:</b> NURTEC ODT, REYVOW 100 mg</li> <li>○ <b>9 tablets:</b> naratriptan, FROVA, IMITREX, sumatriptan/naproxen, SYMBRAVO</li> <li>○ <b>12 tablets:</b> MAXALT</li> <li>○ <b>16 tablets:</b> UBRELVY</li> </ul> </li> <li>• <b>NASAL</b> <ul style="list-style-type: none"> <li>○ <b>1 box:</b> all agents</li> </ul> </li> </ul>
sumatriptan pen injector, vial	IMITREX (sumatriptan)	
	sumatriptan cartridge	
	ZEMBRACE SYMTOUCH (sumatriptan)	
<b>NASAL</b>		<b>CUMULATIVE Quantity Limit</b> (per 31 days) <ul style="list-style-type: none"> <li>• <b>INJECTABLES</b> <ul style="list-style-type: none"> <li>○ <b>4 injections:</b> all agents</li> </ul> </li> </ul>
sumatriptan spray	IMITREX (sumatriptan)	
zolmitriptan spray	TOSYMRA (sumatriptan) ZOMIG (zolmitriptan)	
<b>TRIPTANS AND RELATED AGENTS (ORAL) DUR+</b>		<b>Non-Preferred Criteria</b> <ul style="list-style-type: none"> <li>• <b>ORAL</b> <ul style="list-style-type: none"> <li>○ Have tried 2 preferred oral agents in the past 90 days</li> </ul> </li> <li>• <b>NASAL</b> <ul style="list-style-type: none"> <li>○ Requires clinical review</li> </ul> </li> <li>• <b>INJECTABLES</b> <ul style="list-style-type: none"> <li>○ Requires clinical review</li> </ul> </li> </ul> <b>Almotriptan and sumatriptan/naproxen</b> <ul style="list-style-type: none"> <li>• Automatic approval for 12-17 years of age</li> </ul> <b>NURTEC ODT and UBRELVY MANUAL PA</b> <ul style="list-style-type: none"> <li>• Documented diagnosis of Migraine <b>AND</b></li> <li>• Have tried 2 different triptans in the past 6 months <b>AND</b></li> <li>• No concurrent therapy with another CGRP agent or strong CYP3A4 inhibitor</li> </ul> <b>REYVOW</b> <ul style="list-style-type: none"> <li>• Documented diagnosis of Migraine <b>AND</b></li> <li>• Have tried 2 different triptans in the past 90 days <b>AND</b></li> <li>• Have tried preferred NURTEC ODT in the past 90 days</li> </ul> <b>SYMBRAVO</b> <ul style="list-style-type: none"> <li>• Requires clinical review</li> </ul> <b>ZAVZPRET MANUAL PA</b> <ul style="list-style-type: none"> <li>• Documented diagnosis of Migraine <b>AND</b></li> <li>• Have tried 2 different triptans in the past 6 months <b>AND</b></li> </ul>
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)	
	ZOMIG (zolmitriptan)	

		<ul style="list-style-type: none"> <li>• Have tried both NURTEC ODT and UBRELVY in the past 6 months <b>AND</b></li> <li>• No concurrent therapy with another CGRP AGENT</li> </ul>
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### ANTIMIGRAINE AGENTS, PROPHYLAXIS

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
<b>INJECTABLES</b>		
AIMOVIG Autoinjector (erenumab-aooe) <sup>DUR+</sup>	EMGALITY Syringe (galcanezumab-gnlm) 300 mg/mL	<p><b>Preferred Injectables</b></p> <ul style="list-style-type: none"> <li>• History of 3 claims with the requested agent in the past 105 days <b>OR</b></li> <li>• New starts require manual PA (see criteria below)</li> <li>• AJOVY Autoinjector 3 Pack requires clinical review</li> </ul> <p><b>Non-preferred Injectables</b></p> <ul style="list-style-type: none"> <li>• Requires clinical review</li> </ul> <p><b>Quantity Limit</b></p> <ul style="list-style-type: none"> <li>• <b>4.5 mL (per 90 days):</b> AJOVY Autoinjector 3 Pack</li> </ul> <p><b>AIMOVIG, AJOVY (except Autoinjector 3 Pack), EMGALITY, NURTEC ODT, and QULIPTA MANUAL PA</b></p> <p><b>VYEPTI MANUAL PA</b></p>
AJOVY Autoinjector (fremanezumab-vfrm) <sup>DUR+</sup>	VYEPTI (eptinezumab-jjmr)	
AJOVY Syringe (fremanezumab-vfrm) <sup>DUR+</sup>		
EMGALITY Pen (galcanezumab-gnlm) <sup>DUR+</sup>		
EMGALITY Syringe (galcanezumab-gnlm) 120 mg/mL <sup>DUR+</sup>		
<b>ORAL</b>		
	QULIPTA (atogepant)	
	NURTEC ODT (rimegepant)	

### ANTINEOPLASTICS SELECTED SYSTEMIC ENZYME INHIBITORS

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
BOSULIF (bosutinib) tablet	AFINITOR (everolimus)	<p><b>FARYDAK MANUAL PA</b></p> <p><b>LYNPARZA Tablets MANUAL PA</b></p>
CAPRESLA (vandetanib)	AFINITOR DISPERZ (everolimus)	
COMETRIQ (cabozantinib)	AKEEGA (niraparib/abiraterone)	
COTELLIC (cobimetinib)	ALECENSA (alectinib)	
everolimus	ALUNBRIG (brigatinib)	
GILOTRIF (afatinib)	AUGTYRO (repotrectinib)	
<b>IBTROZI (taletrectinib)</b>	AYVAKIT (avapritinib)	
ICLUSIG (ponatinib)	BALVERSA (erdafitinib)	
imatinib	BOSULIF (bosutinib) capsule	
IMBRUVICA (ibrutinib)	BRAFTOVI (encorafenib)	
INLYTA (axitinib)	BRUKINSA (zanubrutinib)	
IRESSA (gefitinib)	CABOMETYX (cabozantinib)	
JAKAFI (ruxolitinib)	CALQUENCE (acalabrutinib)	
MEKINIST (trametinib)	COPIKTRA (duvelisib)	
NEXAVAR (sorafenib)	DANZITEN (nilotinib)	
ROZLYTREK (entrectinib)	dasatinib	
SPRYCEL (dasatinib)	DAURISMO (glasdegib)	
STIVARGA (regorafenib)	ENSACOVE (ensartinib hydrochloride) <sup>NR</sup>	
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)
ZELBORAF (vemurafenib)	HYRNUO (sevabertinib)
ZYDELIG (idelalisib)	IBRANCE (palbociclib)
ZYKADIA (ceritinib)	IDHIFA (enasidenib)
	IMKELDI (imatinib)
	INLURIYO (imlunestran tosylate)
	INQOVI (decitabine/cedazuridine)
	INREBIC (fedratinib)
	ITOVEBI (inavolisib)
	IWILFIN (eflornithine)
	JAYPIRCA (pirtobrutinib)
	KISQALI (ribociclib)
	KISQALI-FEMARA CO- PACK (ribociclib/letrozole)
	KOMZIFTI (ziftomenib) <sup>NR</sup>
	KOSELUGO (selumetinib sulfate)
	KRAZATI (adagrasib)
	lapatinib
	LAZCLUZE (lazertinib)
	LENVIMA (lenvatinib)
	LOBRENA (lorlatinib)
	LUMAKRAS (sotorasib)
	LYNPARZA (olaparib)
	LYTGOBI (futibatinib)
	MEKTOVI (binimetinib)
	MODEYSO (dordaviprone)
	NERLYNX (neratinib)
	nilotinib
	NUBEQA (darolutamide)
	ODOMZO (sonidegib)
	OGSIVEO (nirogacestat)
	OJEMDA (tovorafenib)
	OJJAARA (momelotinib)
	ONUREG (azacitidine)
	ORGOVYX (relugolix)
	ORSERDU (elacestrant)
	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)	
	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	<b>All agents MANUAL PA</b> required  <b>WEGOYV</b> <ul style="list-style-type: none"> <li>Submission of a manual PA and clinical review may be required when DUR+ electronic PA criteria are not met.</li> <li>Reauthorization after 12 months requires submission of a manual PA to confirm continued appropriateness of therapy.</li> </ul>
WEGOYV (semaglutide) <sup>DUR+</sup>	orlistat	
	XENICAL (orlistat)	

### ANTIPARASITICS (TOPICAL) <sup>DUR+</sup>

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
<b>PEDICULICIDES</b>		<b>Minimum Age Limit</b> <ul style="list-style-type: none"> <li><b>2 months:</b> permethrin 1% (OTC), permethrin 5%</li> <li><b>6 months:</b> NATROBA, SKLICE</li> <li><b>2 years:</b> piperonyl/pyrethrins (OTC)</li> <li><b>4 years:</b> NATROBA</li> <li><b>6 years:</b> OVIDE</li> <li><b>18 years:</b> EURAX</li> </ul> <b>Non-Preferred Criteria</b> <ul style="list-style-type: none"> <li><b>Pediculicides</b> <ul style="list-style-type: none"> <li>Have tried 2 preferred topical lice agents in the past 90 days</li> </ul> </li> <li><b>Scabicides</b> <ul style="list-style-type: none"> <li>Have tried permethrin 5% in the past 90 days</li> </ul> </li> </ul>
permethrin 1% cream <sup>OTC</sup>	lindane	
spinosad	NATROBA (spinosad)	
VANALICE (piperonyl butoxide/pyrethrins)	malathion	
	OVIDE (malathion)	
	SKLICE (ivermectin)	
<b>SCABICIDES</b>		
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)	<b>VYALEV</b> <ul style="list-style-type: none"> <li>Requires clinical review</li> </ul>

### ANTIPARKINSON'S AGENTS (ORAL) <sup>DUR+</sup>

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
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ZORYVE (roflumilast)		<b>ANTIPSYCHOTICS</b> <sup>DUR+</sup>	
<b>PREFERRED AGENTS</b>	<b>NON-PREFERRED AGENTS</b>	<b>PA CRITERIA</b>	
<b>INJECTABLE, ATYPICALS</b> <sup>DUR+</sup>		<p><b>Concurrent Therapy Limit for Age &lt; 18 years</b></p> <ul style="list-style-type: none"> <li>90 days with ≥ 2 agents in the last 120 days will require a <b>MANUAL PA</b></li> </ul> <p><b>Minimum Age Limit</b></p> <ul style="list-style-type: none"> <li><b>3 years:</b> HALDOL</li> <li><b>5 years:</b> RISPERDAL, thioridazine</li> <li><b>6 years:</b> ABILIFY, trifluoperazine</li> <li><b>10 years:</b> LATUDA, SAPHRIS, SEROQUEL, SYMBYAX, VRAYLAR (0.5, 0.75, 1.5, 3, 4.5 mg)</li> <li><b>12 years:</b> INVEGA, molindone, perphenazine, pimozide, thiothixene</li> <li><b>13 years:</b> REXULTI, ZYPREXA</li> <li><b>18 years:</b> ABILIFY MYCITE, CAPLYTA, CLOZARIL, COBENFY, FANAPT, fluphenazine, GEODON, loxapine, LYBALVI, NUPLAZID, perphenazine/amitriptyline, SECUADO, VRAYLAR 6 mg, and all injectable agents</li> </ul> <p><b>Quantity Limit</b></p> <ul style="list-style-type: none"> <li><b>3 syringes/year:</b> ARISTADA INITIO</li> </ul> <p><b>Non-Preferred Criteria Oral Atypical Agents (unless specified below)</b></p> <ul style="list-style-type: none"> <li>Have tried 2 preferred agents in the past 12 months <b>OR</b></li> <li>30 days of therapy with the requested agent in the past 180 days</li> </ul>	
<b>ORAL</b> <sup>DUR+</sup>		<p><b>ARISTADA INTIO, ARISTADA ER, INVEGA SUSTENNA, INVEGA TRINZA and PERSERIS</b></p> <ul style="list-style-type: none"> <li>Documented diagnosis of schizophrenia or schizoaffective disorder</li> </ul> <p><b>ABILIFY MAINTENA, ABILIFY ASIMTUFII, RISPERDAL CONSTA, or UZEDY</b></p> <ul style="list-style-type: none"> <li>Documented diagnosis of schizophrenia, schizoaffective disorder or bipolar disorder</li> </ul> <p><b>CAPLYTA</b></p> <ul style="list-style-type: none"> <li>30 days of therapy with the requested agent in the past 105 days</li> <li><b>OR</b></li> <li>Documented diagnosis of Bipolar II Depression</li> <li><b>OR</b></li> <li>Documented diagnosis of Bipolar I Depression <b>AND</b></li> <li>30 days of therapy with a preferred oral atypical antipsychotic indicated for requested diagnosis in the past 105 days</li> <li><b>OR</b></li> <li>Documented diagnosis of Major Depressive Disorder <b>AND</b></li> <li>120 days of therapy with two antidepressants that are not atypical antipsychotics in the past 180 days <b>AND</b></li> <li>30 days of therapy with a preferred oral atypical antipsychotic indicated for requested diagnosis in the past 105 days</li> <li><b>OR</b></li> <li>Documented diagnosis of schizophrenia <b>AND</b></li> <li>30 days of therapy with a preferred oral atypical antipsychotic indicated for requested diagnosis in the past 105 days</li> </ul> <p><b>INVEGA HAFYERA</b></p> <ul style="list-style-type: none"> <li>Documented diagnosis of schizophrenia or schizoaffective disorder <b>AND</b> <ul style="list-style-type: none"> <li>4 claims for INVEGA SUSTENNA in the past year <b>OR</b></li> <li>1 claim for INVEGA TRINZA in the past year <b>OR</b></li> <li>1 claim for INVEGA HAFYERA in the past year</li> </ul> </li> </ul> <p><b>ERZOFRI, generic risperidone ER, RYKINDO ER, and ZYPREXA RELPREV</b></p> <ul style="list-style-type: none"> <li>Require clinical review</li> </ul> <p><b>NUPLAZID</b></p>	
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 RELPREV (olanzapine)		
UZEDY (risperidone)			
aripiprazole tablet	ABILIFY (aripiprazole)		
asenapine	ABILIFY MYCITE (aripiprazole)		
clozapine tablet	ADASUVE (loxapine)		
fluphenazine	aripiprazole ODT, solution		
haloperidol	CAPLYTA (lumateperone)		
haloperidol lactate	chlorpromazine		
lurasidone	clozapine ODT		
olanzapine	CLOZARIL (clozapine)		
perphenazine	COBENFY (xanomeline/trospium)		
perphenazine/amitriptyline	FANAPT (iloperidone)		
quetiapine	GEODON (ziprasidone)		
quetiapine ER	IGALMI (dexmedetomidine)		
risperidone	INVEGA (paliperidone)		
thioridazine	LATUDA (lurasidone)		
trifluoperazine	LYBALVI (olanzapine/samidorphane)		
ziprasidone	molindone		
	NUPLAZID (pimavanserin)		
	olanzapine/fluoxetine		
	OPIPZA (aripiprazole)		
	paliperidone ER		
	REXULTI (brexipiprazole)		
	RISPERDAL (risperidone)		
	SAPHRIS (asenapine)		
	SEROQUEL (quetiapine)		
	SEROQUEL XR (quetiapine ER)		
	SYMBYAX (olanzapine/fluoxetine)		

	VERSACLOZ (clozapine)	<ul style="list-style-type: none"> <li>• Documented diagnosis of Parkinson's Disease</li> </ul>
	VRAYLAR (cariprazine)	
	ZYPREXA, ZYPREXA	
	ZYDIS (olanzapine)	
<b>TRANSDERMAL, ATYPICALS</b>		
	SECUADO (asenapine)	<p><b>VRAYLAR</b></p> <ul style="list-style-type: none"> <li>• 30 days of therapy with the requested agent in the past 105 days</li> </ul> <p><b>OR</b></p> <ul style="list-style-type: none"> <li>• Age 10-17 years or older <b>AND</b></li> <li>• Documented diagnosis of bipolar 1 disorder <b>AND</b></li> <li>• 30 days of therapy with a preferred oral atypical antipsychotic indicated for requested diagnosis in the past 105 days</li> </ul> <p><b>OR</b></p> <ul style="list-style-type: none"> <li>• Age 13-17 years or older <b>AND</b></li> <li>• Documented diagnosis of schizophrenia or schizoaffective disorder <b>AND</b></li> <li>• 30 days of therapy with a preferred oral atypical antipsychotic indicated for requested diagnosis in the past 105 days</li> </ul> <p><b>OR</b></p> <ul style="list-style-type: none"> <li>• Age 18 years or older <b>AND</b></li> <li>• Documented diagnosis of schizophrenia, schizoaffective disorder, bipolar disorder <b>AND</b></li> <li>• 30 days of therapy with a preferred oral atypical antipsychotic indicated for requested diagnosis in the past 105 days</li> </ul> <p><b>OR</b></p> <ul style="list-style-type: none"> <li>• Age 18 years or older <b>AND</b></li> <li>• Documented diagnosis of major depressive disorder <b>AND</b></li> <li>• 120 days of therapy with two antidepressants that are not atypical antipsychotics in the past 180 days <b>AND</b></li> <li>• 30 days of therapy with a preferred oral atypical antipsychotic indicated for requested diagnosis in the past 105 days</li> </ul> <p><b>ARIPIRAZOLE ODT, CLOZAPINE ODT and OPIZA</b></p> <ul style="list-style-type: none"> <li>• Require clinical review</li> </ul>

### ANTIRETROVIRALS <sup>DUR+</sup>

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
<b>CAPSID INHIBITORS</b>		
YEZTUGO** (lenacapavir) tablet and injection	SUNLENCA (lenacapavir)	<p><b>Minimum Age Limit</b></p> <ul style="list-style-type: none"> <li>• <b>10 years:</b> YEZTUGO</li> </ul>
<b>CD4 DIRECTED ATTACHMENT INHIBITORS</b>		
	RUKOBIA (fostemsavir)	<p><b>Non-Preferred Criteria</b></p> <ul style="list-style-type: none"> <li>• 1 claim with the requested agent in the past 105 days</li> </ul>
<b>CD4 DIRECTED HIV-1 INHIBITORS</b>		
	TROGARZO (ibalizumab-uiyk)	<p><b>STRIBILD MANUAL PA</b></p> <p><b>SUNLENCA</b></p> <ul style="list-style-type: none"> <li>• Requires clinical review</li> </ul> <p><b>TROGARZO</b></p> <ul style="list-style-type: none"> <li>• Requires clinical review</li> </ul> <p><b>TYBOST MANUAL PA</b></p>
<b>COMBINATION PRODUCTS NRTIs</b>		
abacavir/lamivudine	COMBIVIR (lamivudine/zidovudine)	
CABENUVA (cabotegravir/rilpivirine)	EPZICOM (abacavir/lamivudine)	
DOVATO (dolutegravir/lamivudine)		
lamivudine/zidovudine		
<b>COMBINATION PRODUCTS NUCLEOSIDE AND NUCLEOTIDE ANALOG RTIs</b>		
DESCOVY** (emtricitabine/tenofovir alafenamide)	TRUVADA** (emtricitabine/tenofovir)	
emtricitabine/tenofovir**		
<b>COMBINATION PRODUCTS NUCLEOSIDE AND NUCLEOTIDE ANALOG AND NON-NUCLEOSIDE RTIs</b>		

**NOTE: Agents with \*\* are indicated for Pre-Exposure Prophylaxis (PrEP).**

DELSTRIGO (doravirine/lamivudine/tenofovir)	ATRIPLA (efavirenz/emtricitabine/tenofovir)
efavirenz/emtricitabine/tenofovir	CIMDUO (lamivudine/tenofovir)
ODEFSEY (emtricitabine/rilpivirine/tenofovir)	COMPLERA (emtricitabine/rilpivirine/tenofovir)
<b>COMBINATION PRODUCTS PROTEASE INHIBITORS</b>	
lopinavir/ritonavir	KALETRA (lopinavir/ritonavir)
<b>ENTRY INHIBITORS CCR5 CO-RECEPTOR ANTAGONISTS</b>	
	maraviroc
	SELZENTRY (maraviroc)
<b>ENTRY INHIBITORS FUSION INHIBITORS</b>	
	FUZEON (enfuvirtide)
<b>INTEGRASE STRAND TRANSFER INHIBITORS</b>	
APRETUDE** (cabotegravir)	cabotegravir ER
ISENTRESS (raltegravir)	ISENTRESS HD (raltegravir)
TIVICAY, TIVICAY PD (dolutegravir)	VOCABRIA (cabotegravir)
<b>NON-NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS (NNRTI)</b>	
EDURANT (rilpivirine)	etravirine
efavirenz	INTELENCE (etravirine)
	nevirapine, nevirapine ER
	PIFELTRO (doravirine)
	rilpivirine <sup>NR</sup>
<b>NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS (NRTI)</b>	
abacavir	didanosine
EMTRIVA (emtricitabine)	emtricitabine
lamivudine	EPIVIR (lamivudine)
ZIAGEN (abacavir)	RETROVIR (zidovudine)
zidovudine	stavudine
	VIREAD (tenofovir disoproxil fumarate)
<b>PHARMACOENHANCER CYTOCHROME P450 INHIBITORS</b>	
	TYBOST (cobicistat)
<b>PROTEASE INHIBITORS (NON-PEPTIDIC)</b>	
darunavir	APTIVUS (tipranavir)
PREZISTA (darunavir) 75mg tablet, 150mg tablet, 100mg/mL suspension	PREZCOBIX (darunavir/cobicistat)
	PREZISTA (darunavir) 600mg tablet, 800mg tablet
<b>PROTEASE INHIBITORS (PEPTIDIC)</b>	

atazanavir	fosamprenavir	
EVOTAZ (atazanavir/cobicistat)	LEXIVA (fosamprenavir)	
ritonavir	NORIVIR (ritonavir)	
	REYATAZ (atazanavir)	
	VIRACEPT (nelfinavir)	
<b>SINGLE PRODUCT REGIMENS</b>		
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
<b>ANTI-CYTOMEGALOVIRUS AGENTS</b>		
valganciclovir tablet	LIVTENCITY (maribavir)	<b>PREVYMIS</b> <ul style="list-style-type: none"> <li>Requires clinical review</li> </ul>
	PREVYMIS (letermovir)	
	VALCYTE (valganciclovir)	<b>Valganciclovir solution</b> <ul style="list-style-type: none"> <li>Automatic approval issued for 0-12 years of age</li> </ul>
	valganciclovir solution	
<b>ANTI-HERPETIC AGENTS</b>		
acyclovir	SITAVIG (acyclovir)	
famciclovir	VALTREX (valacyclovir)	
valacyclovir		
<b>ANTI-INFLUENZA AGENTS</b>		
oseltamivir	FLUMADINE (rimantadine)	
	RAPIVAB (peramivir)	
	RELENZA (zanamivir)	
	rimantadine	
	TAMIFLU (oseltamivir)	
	XOFLUZA (baloxavir)	
<b>COVID-19</b>		
PAXLOVID (nirmatrelvir/ritonavir)		

### ANTIVIRALS, TOPICAL

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
acyclovir cream, ointment	DENAVIR (penciclovir)	<b>ZELSUVM</b> <a href="#">MANUAL PA</a>

	penciclovir	
	ZELSUVMI (berdazimer)	
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
SYSTEMIC		
ADBRY (tralokinumab-ldrm)	CIBINQO (abrocitinib)	<p><b>Minimum Age Limit</b></p> <ul style="list-style-type: none"> <li>• <b>3 months:</b> EUCRISA</li> <li>• <b>2 years:</b> OPZELURA, pimecrolimus, tacrolimus 0.03%</li> <li>• <b>16 years:</b> tacrolimus 0.1%</li> </ul> <p><b>ADBRY MANUAL PA</b></p> <p><b>ANZUPGO</b></p> <ul style="list-style-type: none"> <li>• Requires clinical review</li> </ul> <p><b>CIBINQO</b></p> <ul style="list-style-type: none"> <li>• Requires clinical review</li> </ul> <p><b>DUPIXENT</b></p> <ul style="list-style-type: none"> <li>• 1 claim with DUPIXENT in the past 60 days <b>OR</b></li> <li>• New starts require clinical review (see manual PA links below) <ul style="list-style-type: none"> <li>○ <b>Asthma MANUAL PA</b></li> <li>○ <b>Atopic Dermatitis MANUAL PA</b></li> <li>○ <b>Bullous Pemphigoid MANUAL PA</b></li> <li>○ <b>COPD MANUAL PA</b></li> <li>○ <b>Chronic Spontaneous Urticaria MANUAL PA</b></li> <li>○ <b>Eosinophilic Esophagitis MANUAL PA</b></li> <li>○ <b>Nasal Polyposis MANUAL PA</b></li> <li>○ <b>Prurigo Nodularis MANUAL PA</b></li> </ul> </li> </ul> <p><b>EBGLYSS MANUAL PA</b></p> <p><b>EUCRISA</b></p> <ul style="list-style-type: none"> <li>• 30 days of therapy with a calcineurin inhibitor or topical steroid in the past 6 months</li> </ul> <p><b>NEMLUVIO</b></p> <ul style="list-style-type: none"> <li>• Atopic Dermatitis <b>MANUAL PA</b></li> <li>• Prurigo Nodularis <b>MANUAL PA</b></li> </ul> <p><b>OPZELURA</b></p> <ul style="list-style-type: none"> <li>• 30 days of therapy with pimecrolimus, EUCRISA or tacrolimus in the past 6 months</li> </ul>
ADBRY Autoinjector (tralokinumab-ldrm)	NEMLUVIO (nemolizumab-ilto)	
DUPIXENT (dupilumab) DUR+		
EBGLYSS pen and syringe (lebrikizumab-lbkz)		
TOPICAL		
EUCRISA (crisaborole) DUR+	ANZUPGO (delgocitinib)	
pimecrolimus	OPZELURA (ruxolitinib)	
tacrolimus	ZORYVE (roflumilast) 0.15% cream	
BETA BLOCKERS, ANTIANGINALS & SINUS NODE AGENTS DUR+		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
ANTIANGINALS		
ranolazine ER	ASPRUZYO SPRINKLE (ranolazine)	<p><b>Non-Preferred Criteria</b></p> <ul style="list-style-type: none"> <li>• Have tried 2 different preferred agents in the past 6 months <b>OR</b></li> <li>• 90 days of therapy with the requested agent in the past 105 days</li> </ul>

	RANEXA (ranolazine ER)
<b>BETA- AND ALPHA-BLOCKERS</b>	
carvedilol	carvedilol ER
labetalol	COREG (carvedilol)
	COREG CR (carvedilol)
<b>BETA-BLOCKER/DIURETIC COMBINATIONS</b>	
atenolol/chlorthalidone	TENORETIC (atenolol/chlorthalidone)
bisoprolol/hydrochlorothiazide	ZIAC (bisoprolol/hydrochlorothiazide)
metoprolol/hydrochlorothiazide	
propranolol/hydrochlorothiazide	
<b>BETA-BLOCKERS</b>	
acebutolol	BETAPACE (sotalol)
atenolol	BETAPACE AF (sotalol)
bisoprolol	betaxolol
HEMANGEOL (propranolol)	BYSTOLIC (nebivolol)
metoprolol succinate	INDERAL LA (propranolol)
metoprolol tartrate (except 12.5 mg tablet)	INDERAL XL (propranolol)
nadolol	INNOPRAN XL (propranolol)
nebivolol	KAPSPARGO SPRINKLE (metoprolol succinate)
pindolol	LOPRESSOR (metoprolol tartrate)
propranolol	metoprolol tartrate 12.5 mg tablet
propranolol ER	SOTYLIZE (sotalol)
SORINE (sotalol)	TENORMIN (atenolol)
sotalol	TOPROL XL (metoprolol succinate)
sotalol AF	
timolol	
<b>SINUS NODE AGENTS</b>	
	CORLANOR (ivabradine)
	ivabradine

**ASPRUZYO SPRINKLE, LOPRESSOR SOLUTION, and metoprolol tartrate 12.5 mg tablet**

- Requires clinical review

**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

**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 <sup>DUR+</sup>**

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
MYRBETRIQ (mirabegron)	darifenacin ER	<b>Non-Preferred Criteria</b> <ul style="list-style-type: none"> <li>Have tried 2 different preferred agents in the past 6 months</li> </ul>
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

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
<b>BISPHOSPHONATES</b> <sup>DUR+</sup>		<b>Non-Preferred Bisphosphonate Criteria</b> <ul style="list-style-type: none"> <li>Documented diagnosis of osteoporosis or osteopenia <b>AND</b></li> <li>Have tried 2 different preferred agents in the past 6 months</li> </ul> <b>Non-Preferred Others</b> <ul style="list-style-type: none"> <li>Requires clinical review</li> </ul>
alendronate tablet	ACTONEL (risedronate)	
ibandronate tablet	alendronate solution	
risedronate	AELVIA (risedronate)	
	BINOSTO (alendronate)	
	FOSAMAX (alendronate)	
	FOSAMAX PLUS D (alendronate/vitamin D3)	
	ibandronate syringe/vial	
	risedronate DR	
<b>OTHERS</b>		
BILDYOS (denosumab-nxxp)	AUKELSO (denosumab-kyqq)	
BILPREVDA (denosumab-nxxp)	BOMYNTRA (denosumab-bnht)	
FORTEO (teriparatide)	BONSITY (teriparatide)	
raloxifene	BOSAYA (denosumab-kyqq)	
	calcitonin salmon	
	CONEXXENCE (denosumab-bnht)	
	ENOBY (denosumab-qbde) <sup>NR</sup>	
	EVENTY (romosozumab-aqqg)	
	EVISTA (raloxifene)	
	JUBBONTI (denosumab-bbdz)	
	MIACALCIN (calcitonin salmon)	
	OSEVELT (denosumab-bmwo)	
	PROLIA (denosumab)	
	STOBOCLO (denosumab-bmwo)	
	teriparatide	
	TYMLOS (abaloparatide)	

	WYOST (denosumab-bbdz)	
	XGEVA (denosumab)	
	XTRENBO (denosumab-qbde) <sup>NR</sup>	
BPH AGENTS <sup>DUR+</sup>		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
5-ALPHA-REDUCTASE INHIBITORS		<p><b>CARDURA, FLOMAX, PROSCAR, terazosin, or UROXATRAL Female</b></p> <ul style="list-style-type: none"> <li>Documented State-accepted diagnosis</li> </ul> <p><b>Non-Preferred Criteria Male</b></p> <ul style="list-style-type: none"> <li>Have tried 2 different preferred agents in the past 6 months <b>OR</b></li> <li>90 days of therapy with the requested agent in the past 105 days</li> </ul> <p><b>ENTADFI</b></p> <ul style="list-style-type: none"> <li>Requires clinical review</li> </ul>
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		<p><b>Minimum Age Limit</b></p> <ul style="list-style-type: none"> <li><b>4 years:</b> SEREVENT, XOPENEX HFA</li> <li><b>6 years:</b> SPIRIVA RESPIMAT, XOPENEX Solution</li> <li><b>18 years:</b> BROVANA, BREZTRI AEROSPHERE, PERFOROMIST, STRIVERDI RESPIMAT, TRELEGY ELLIPTA</li> </ul> <p><b>Non-Preferred Criteria</b></p> <ul style="list-style-type: none"> <li>1 claim for a preferred agent in the past 6 months <b>OR</b></li> <li>3 claims with the requested agent in the past 105 days</li> </ul>
ANORO ELLIPTA (umeclidinium/vilanterol)	BEVESPI AEROSPHERE (glycopyrrolate/formoterol)	
COMBIVENT RESPIMAT (ipratropium/albuterol)	DUAKLIR PRESSAIR (aclidinium/formoterol)	
ipratropium/albuterol		
STIOLTO RESPIMAT (tiotropium/olodaterol)		
ANTICHOLINERGIC-BETA AGONIST-GLUCOCORTICOID COMBINATIONS <sup>DUR+</sup>		<p><b>Quantity Limit</b> (per 31 days)</p> <ul style="list-style-type: none"> <li><b>10.7 units</b> BREZTRI AEROSPHERE</li> </ul> <p><b>BREZTRI AEROSPHERE</b></p> <ul style="list-style-type: none"> <li>Documented diagnosis of COPD <b>AND</b></li> <li>1 claim with the BREZTRI AEROSPHERE or TRELEGY ELLIPTA in the past 105 days</li> </ul> <p><b>OR</b></p> <ul style="list-style-type: none"> <li>Documented diagnosis of COPD <b>AND</b></li> <li>60 days of therapy with a preferred anticholinergic product in the past 90 days <b>AND</b></li> <li>60 days of therapy with a preferred ICS-LABA product in the past 90 days</li> </ul> <p><b>TRELEGY ELLIPTA</b></p> <ul style="list-style-type: none"> <li>Documented diagnosis of asthma or COPD <b>AND</b></li> <li>1 claim with the BREZTRI AEROSPHERE or TRELEGY ELLIPTA in the past 105 days</li> </ul> <p><b>OR</b></p> <ul style="list-style-type: none"> <li>Documented diagnosis of asthma or COPD <b>AND</b></li> <li>60 days of therapy with a preferred anticholinergic product in the past 90 days <b>AND</b></li> </ul>
BREZTRI AEROSPHERE (budesonide/glycopyrrolate/formoterol)		
TRELEGY ELLIPTA (fluticasone/umeclidinium/vilanterol)		
ANTICHOLINERGICS AND COPD AGENTS		
ATROVENT HFA (ipratropium)	DALIRESP (roflumilast)	
ipratropium solution	INCRUSE ELLIPTA (umeclidinium)	
SPIRIVA HANDIHALER (tiotropium)	ipratropium HFA <sup>NR</sup>	
SPIRIVA RESPIMAT (tiotropium)	OHTUVAYRE (ensifentrine)	

	roflumilast	<ul style="list-style-type: none"> <li>• 60 days of therapy with a preferred ICS-LABA product in the past 90 days</li> </ul>
	tiotropium	
	TUDORZA PRESSAIR (aclidinium)	
	YUPELRI (revefenacin)	
<b>INHALATION SOLUTION</b> <sup>DUR+</sup>		
albuterol	arformoterol	
	BROVANA (arformoterol)	
	formoterol, formoterol fumarate	
	levalbuterol	
	PERFOROMIST (formoterol)	
<b>INHALERS, LONG ACTING</b> <sup>DUR+</sup>		
SEREVENT DISKUS (salmeterol)		
STRIVERDI RESPIMAT (olodaterol)		
<b>INHALERS, SHORT ACTING</b>		
albuterol HFA	levalbuterol HFA	
VENTOLIN HFA (albuterol)	PROAIR DIGIHALER (albuterol)	
	XOPENEX HFA (levalbuterol)	
<b>ORAL</b>		
albuterol IR	albuterol ER	
terbutaline		

**XOPENEX HFA and Solution**

- 1 claim for a preferred albuterol (inhaler or vials) in the past 30 days

**CALCIUM CHANNEL BLOCKERS** <sup>DUR+</sup>

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
<b>LONG-ACTING</b>		<p><b>Quantity Limit</b> (per 21 days)</p> <ul style="list-style-type: none"> <li>• <b>252 capsules:</b> nimodipine</li> <li>• <b>2520 mL:</b> nimodipine</li> </ul> <p><b>Non-Preferred Criteria Long Acting</b></p> <ul style="list-style-type: none"> <li>• Have tried 2 different preferred Long Acting CCB agents in the past 6 months <b>OR</b></li> <li>• 90 days of therapy with the requested agent in the past 105 days</li> </ul> <p><b>Non-Preferred Criteria Short Acting</b></p> <ul style="list-style-type: none"> <li>• Have tried 2 different preferred Short Acting CCB agents in the past 6 months <b>OR</b></li> <li>• 90 days of therapy with the requested agent in the past 105 days</li> </ul> <p><b>CARDAMYST, SDAMLO</b></p> <ul style="list-style-type: none"> <li>• Requires clinical review</li> </ul> <p><b>nimodipine</b></p> <ul style="list-style-type: none"> <li>• Documented diagnosis of subarachnoid hemorrhage in the past 45 days <b>AND</b></li> <li>• Duration of therapy limited to 21 days</li> </ul>
amlodipine	diltiazem ER 12 HR	
CARTIA XT (diltiazem)	diltiazem LA 24 HR	
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	NORLIQVA (amlodipine)	
nifedipine ER	NORVASC (amlodipine)	
TAZTIA XT (diltiazem)	PROCARDIA XL (nifedipine)	
TIADYLT ER (diltiazem)	SDAMLO (amlodipine) <sup>NR</sup>	
verapamil ER	SULAR (nisoldipine)	
verapamil SR	TIAZAC (diltiazem)	
	verapamil PM	
	VERELAN PM (verapamil)	
<b>SHORT-ACTING</b>		
diltiazem	CARDAMYST (etripamil) <sup>NR</sup>	
nicardipine	isradipine	
nifedipine	nimodipine	
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.	<b>Non-Preferred Agents MANUAL PA</b>
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
<b>BETA LACTAM/BETA-LACTAMASE INHIBITOR COMBINATIONS</b>		<b>Non-Preferred Criteria All Cephalosporin Generations</b> <ul style="list-style-type: none"> <li>Have tried 2 different preferred agents in the past 6 months</li> </ul> <b>Maximum Age Limit</b> <ul style="list-style-type: none"> <li><b>18 years:</b> cefdinir suspension</li> </ul>
amoxicillin/clavulanate	amoxicillin/clavulanate ER	
	AUGMENTIN (amoxicillin/clavulanate)	
<b>CEPHALOSPORINS FIRST GENERATION</b>		
cefadroxil capsule, suspension	cefadroxil tablet	
cephalexin capsule, suspension	cephalexin tablet	
<b>CEPHALOSPORINS SECOND GENERATION</b>		
cefaclor capsule	cefaclor ER	
cefprozil	cefaclor suspension	
cefuroxime		
<b>CEPHALOSPORINS THIRD GENERATION</b>		
cefdinir	cefixime suspension, tablet <sup>NR</sup>	
cefixime capsule	SUPRAX (cefixime)	
cefpodoxime		

### COLONY STIMULATING FACTORS

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
<b>LONG-ACTING</b>		
FULPHILA (pegfilgrastim-jmdb)	FYLNETRA (pegfilgrastim-pbbk)	
	NEULASTA, NEULASTA ONPRO (pegfilgrastim)	
	NYVEPRIA (pegfilgrastim-apgf)	
	RYZNEUTA (efbemalenograstim alfa-vuxw)	
	ROLVEDON (eflapegrastim-xnst)	

	STIMUFEND (pegfilgrastim-fpgk)
	UDENYCA, UDENYCA ONBODY (pegfilgrastim-cbqv)
	ZIEXTENZO (pegfilgrastim-bmez)
<b>SHORT-ACTING</b>	
NEUPOGEN (filgrastim)	GRANIX (tbo-filgrastim)
RELEUKO (filgrastim-ayow)	LEUKINE (sargramostim)
	NIVESTYM (filgrastim-aafi)
	<b>NYPOZI (filgrastim-txid)</b>
	ZARXIO (filgrastim-sndz)

### CYSTIC FIBROSIS AGENTS <sup>DUR+</sup>

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
PULMOZYME (dornase alfa)	ALYFTREK (vanzacaftor/tezacaftor/deutivacaftor)	<p><b>Minimum Age Limit</b></p> <ul style="list-style-type: none"> <li>• <b>1 month:</b> KALYDECO granules</li> <li>• <b>3 months:</b> PULMOZYME</li> <li>• <b>1 year:</b> ORKAMBI</li> <li>• <b>2 years:</b> COLY-MYCIN M, TRIKAFTA granules</li> <li>• <b>6 years:</b> ALYFTREK, BETHKIS, KALYDECO tablet, KITABIS, SYMDEKO, TOBI, TOBI PODHALER, TRIKAFTA tablet</li> <li>• <b>7 years:</b> CAYSTON</li> <li>• <b>18 years:</b> BRONCHITOL</li> </ul> <p><b>Maximum Age Limit</b></p> <ul style="list-style-type: none"> <li>• <b>2 years:</b> ORKAMBI 75-94 mg granules</li> <li>• <b>5 years:</b> KALYDECO, ORKAMBI 100-125 mg granules, ORKAMBI 200-125 mg granules, TRIKAFTA granules</li> <li>• <b>11 years:</b> TRIKAFTA 50-25-37.5 mg tablets</li> </ul> <p><b>Preferred Agents</b></p> <ul style="list-style-type: none"> <li>• Documented diagnosis of Cystic Fibrosis <b>OR</b></li> <li>• Require clinical review</li> </ul> <p><b>ALYFTREK MANUAL PA</b></p> <p><b>KALYDECO MANUAL PA</b></p> <p><b>ORKAMBI MANUAL PA</b></p> <p><b>SYMDEKO MANUAL PA</b></p> <p><b>TOBI PODHALER</b> Require clinical review</p> <p><b>TRIKAFTA MANUAL PA</b></p>
tobramycin (generic TOBI)	BETHKIS (tobramycin)	
	BRONCHITOL (mannitol)	
	CAYSTON (aztreonam)	
	colistimethate	
	COLY-MYCIN M (colistin)	
	KALYDECO (ivacaftor)	
	KITABIS (tobramycin)	
	ORKAMBI (lumacaftor/ivacaftor)	
	SYMDEKO (tezacaftor/ivacaftor)	
	TOBI (tobramycin)	
	TOBI PODHALER (tobramycin)	
	tobramycin (generic BETHKIS & KITABIS)	
	TRIKAFTA (elexacaftor/tezacaftor/ivacaftor)	

### CYTOKINE & CAM ANTAGONISTS <sup>DUR+</sup>

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
adalimumab-aaty autoinject	ABRILADA (adalimumab-afzb)	<p><b>Non-Preferred Agents</b></p> <ul style="list-style-type: none"> <li>• Require clinical review</li> </ul>
AVSOLA (infliximab-axxq)	ACTEMRA (tocilizumab)	

CYLTEZO (adalimumab-adbm)	adalimumab-aaty syringe	<b>IV Administered Agents</b> • Require clinical review
ENBREL (etanercept)	adalimumab-adaz	
HADLIMA (adalimumab-bwwd)	adalimumab-adbm	<b>adalimumab-aaty autoinject, HADLIMA (adalimumab-bwwd), and YUFLYMA (adalimumab-aaty) – Age specific indications:</b>
HUMIRA (adalimumab)	adalimumab-fkjp	• Age 2 years and older <b>AND</b>
IMULDOSA (ustekinumab-srlf)	adalimumab-ryvk	• Diagnosis of juvenile idiopathic arthritis (JIA)
KINERET (anakinra)	AMJEVITA (adalimumab-atto)	• Age 6 years and older <b>AND</b>
methotrexate	ARCALYST (rilonacept)	• Diagnosis of Crohn's disease (CD)
OLUMIANT (baricitinib)	AVTOZMA (tocilizumab-anoh)	• Age 18 years and older <b>AND</b>
ORENCIA CLICKJECT (abatacept)	AVTOZMA AUTOINJECTOR (tocilizumab-anoh)	• Diagnosis of rheumatoid arthritis (RA) <b>OR</b>
ORENCIA VIAL (abatacept)	BIMZELX (bimekizumab-bkzx)	• Diagnosis of plaque psoriasis (PsO) <b>OR</b>
OTEZLA (apremilast)	CIMZIA (certolizumab)	• Diagnosis of psoriatic arthritis (PsA) <b>OR</b>
PYZCHIVA (ustekinumab-ttwe)	COSENTYX (secukinumab)	• Diagnosis of ulcerative colitis (UC) <b>OR</b>
RINVOQ (upadacitinib)	ENTYVIO (vedolizumab)	• Diagnosis of hidradenitis suppurativa (HS) <b>OR</b>
RINVOQ LQ (upadacitinib)	HULIO (adalimumab-fkjp)	• Diagnosis of ankylosing spondylitis (AS) <b>OR</b>
SELARSDI (ustekinumab-aekn)	HYRIMOZ (adalimumab-adaz)	• Diagnosis of uveitis (UV)
SIMPONI (golimumab)	ICOTYDE (icotrokinra) <sup>NR</sup>	<b>AVSOLA (infliximab-axxq) – Age specific indications:</b>
STARJEMZA (ustekinumab-hmny)	IDACIO (adalimumab-aacf)	• Age 6 years and older <b>AND</b>
TALTZ (ixekizumab)	ILARIS (canakinumab)	• Diagnosis of Crohn's disease <b>OR</b>
TYENNE (tocilizumab-aazg)	ILUMYA (tildrakizumab-asmn)	• Diagnosis of ulcerative colitis
ustekinumab-aauz	INFLECTRA (infliximab-dyyb)	• Age 18 years and older <b>AND</b>
XELJANZ (tofacitinib) tablet	infliximab	• Diagnosis of rheumatoid arthritis (RA) <b>OR</b>
YUFLYMA (adalimumab-aaty)	JYLAMVO (methotrexate)	• Diagnosis of plaque psoriasis (PsO) <b>OR</b>
	KEVZARA (sarilumab)	• Diagnosis of psoriatic arthritis (PsA) <b>OR</b>
	LEQSELVI (deuruxolitinib)	• Diagnosis of ankylosing spondylitis (AS)
	LITFULO (ritlecitinib)	<b>CYLTEZO (adalimumab-adbm) – Age specific indications:</b>
	OMVOH (mirikizumab-mrkz)	• Age 2 years and older <b>AND</b>
	ORENCIA SYRINGE (abatacept)	• Diagnosis of juvenile idiopathic arthritis (JIA) <b>OR</b>
	OTEZLA XR (apremilast)	• Diagnosis of uveitis (UV)
	OTREXUP (methotrexate)	• Age 6 years and older <b>AND</b>
	OTULFI (ustekinumab-aauz)	• Diagnosis of Crohn's disease (CD)
	RASUVO (methotrexate)	• Age 12 years and older <b>AND</b>
	REMICADE (infliximab)	• Diagnosis of hidradenitis suppurativa (HS)
	RENFLEXIS (infliximab-abda)	• Age 18 years and older <b>AND</b>
	SIMLANDI (adalimumab-ryvk)	• Diagnosis of rheumatoid arthritis (RA) <b>OR</b>
	SIMPONI ARIA (golimumab)	• Diagnosis of plaque psoriasis (PsO) <b>OR</b>
	SKYRIZI (risankizumab-rzaa)	• Diagnosis of psoriatic arthritis (PsA) <b>OR</b>
	SOTYKTU (deucravacitinib)	• Diagnosis of ulcerative colitis (UC) <b>OR</b>
		• Diagnosis of ankylosing spondylitis (AS)
		<b>ENBREL (etanercept) – Age specific indications:</b>
		• Age 2 years and older <b>AND</b>
		• Diagnosis of juvenile arthritis (JIA) <b>OR</b>
		• Diagnosis of juvenile psoriatic arthritis (PsA)

	SPEVIGO (spesolimab-sbzo)	<ul style="list-style-type: none"> <li>• Age 4 years and older <b>AND</b></li> <li>• Diagnosis of plaque psoriasis (PsO)</li> </ul>
	STELARA (ustekinumab)	
	TOFIDENCE (tocilizumab-bavi)	<ul style="list-style-type: none"> <li>• Age 18 years and older <b>AND</b></li> <li>• Diagnosis of rheumatoid arthritis (RA) <b>OR</b></li> </ul>
	TREMFYA (guselkumab)	<ul style="list-style-type: none"> <li>• Diagnosis of psoriatic arthritis (PsA) <b>OR</b></li> </ul>
	TREXALL (methotrexate)	<ul style="list-style-type: none"> <li>• Diagnosis of ankylosing spondylitis (AS)</li> </ul>
	XATMEP (methotrexate)	
	XELJANZ (tofacitinib) solution	<p><b>HUMIRA (adalimumab) – Age specific indications:</b></p> <ul style="list-style-type: none"> <li>• Age 2 years and older <b>AND</b></li> <li>• Diagnosis of juvenile idiopathic arthritis (JIA) <b>OR</b></li> <li>• Diagnosis of uveitis (UV)</li> </ul>
	XELJANZ XR (tofacitinib)	
	YESINTEK (ustekinumab-kfce)	
	YUSIMRY (adalimumab-aqvh)	<ul style="list-style-type: none"> <li>• Age 5 years and older <b>AND</b></li> <li>• Diagnosis of ulcerative colitis (UC)</li> <li>• Age 6 years and older <b>AND</b></li> <li>• Diagnosis of Crohn's disease (CD)</li> </ul>
	ZYMFENTRA (infliximab-dyyb)	<ul style="list-style-type: none"> <li>• Age 12 years and older <b>AND</b></li> <li>• Diagnosis of hidradenitis suppurativa (HS)</li> </ul> <p>• Age 18 years and older <b>AND</b></p> <ul style="list-style-type: none"> <li>• Diagnosis of rheumatoid arthritis (RA) <b>OR</b></li> <li>• Diagnosis of plaque psoriasis (PsO) <b>OR</b></li> <li>• Diagnosis of psoriatic arthritis (PsA) <b>OR</b></li> <li>• Diagnosis of ankylosing spondylitis (AS)</li> </ul> <p><b>IMULDOSA (ustekinumab-srlf), PYZCHIVA (ustekinumab-ttwe), SELARSDI (ustekinumab-aekn), STARJEMZA (ustekinumab-hmny), and ustekinumab-aaaz – Age specific indications:</b></p> <ul style="list-style-type: none"> <li>• Age 6 years and older <b>AND</b></li> <li>• Diagnosis of plaque psoriasis (PsO) <b>OR</b></li> <li>• Diagnosis of psoriatic arthritis (PsA)</li> </ul> <p>• Age 18 years and older <b>AND</b></p> <ul style="list-style-type: none"> <li>• Diagnosis of ulcerative colitis (UC) <b>OR</b></li> <li>• Diagnosis of Crohn's disease (CD)</li> </ul> <p><b>KINERET (anakinra) – Age specific indications:</b></p> <ul style="list-style-type: none"> <li>• Age 18 years and older <b>AND</b></li> <li>• Diagnosis of rheumatoid arthritis (RA)</li> <li>• Other indications require clinical review</li> </ul> <p><b>OLUMIANT (baricitinib) – Age specific indications:</b></p> <ul style="list-style-type: none"> <li>• Age 18 years and older <b>AND</b></li> <li>• Diagnosis of alopecia areata (AA)</li> <li>• Other indications require clinical review</li> </ul> <p><b>ORENCIA (abatacept) – Age specific indications:</b></p> <ul style="list-style-type: none"> <li>• Age 2 years and older <b>AND</b></li> <li>• Diagnosis of juvenile arthritis (JIA) <b>OR</b></li> <li>• Diagnosis of psoriatic arthritis (PsA)</li> <li>• Other indication requires clinical review</li> </ul> <p>• Age 18 years and older <b>AND</b></p> <ul style="list-style-type: none"> <li>• Diagnosis of rheumatoid arthritis (RA)</li> <li>• Non-preferred Orenzia syringe requires clinical review</li> </ul>

**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

- Atopic Dermatitis **MANUAL PA**

**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

**STELARA MANUAL PA**

**TALTZ (ixekizumab) – Age specific indications:**

Taltz 20 mg, 40 mg and 80 mg

		<ul style="list-style-type: none"> <li>• Age 6 <b>AND</b></li> <li>• Diagnosis of plaque psoriasis (PsO)</li> </ul> <p>Taltz 80 mg</p> <ul style="list-style-type: none"> <li>• Age 18 years and older <b>AND</b></li> <li>• Diagnosis of psoriatic arthritis (PsA) <b>OR</b></li> <li>• Diagnosis of ankylosing spondylitis (AS) <b>OR</b></li> <li>• Diagnosis of active non-radiographic axial spondyloarthritis (nr-axSpA)</li> </ul> <p><b>TYENNE (tocilizumab-aazg) – Age specific indications:</b></p> <ul style="list-style-type: none"> <li>• Age 2 years and older <b>AND</b></li> <li>• Diagnosis of juvenile arthritis (JIA)</li> </ul> <ul style="list-style-type: none"> <li>• Age 18 years and older <b>AND</b></li> <li>• Diagnosis of rheumatoid arthritis (RA) <b>OR</b></li> <li>• Diagnosis of giant cell arteritis</li> </ul> <p><b>XELJANZ IR (tofacitinib) – Any of the following:</b></p> <ul style="list-style-type: none"> <li>• Age 2 year and older <b>AND</b></li> <li>• Diagnosis of juvenile arthritis (JIA) <b>OR</b></li> <li>• Diagnosis of psoriatic arthritis (PsA)</li> </ul> <ul style="list-style-type: none"> <li>• Age 18 years and older <b>AND</b></li> <li>• Diagnosis of rheumatoid arthritis (RA) <b>OR</b></li> <li>• Diagnosis of ulcerative colitis (UC) <b>OR</b></li> <li>• Diagnosis of ankylosing spondylitis (AS)</li> <li>• Non-preferred Xeljanz oral solution and Xeljanz XR require clinical review</li> </ul> <p><b>Preferred methotrexate does not require prior authorization</b></p>
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**ERYTHROPOIESIS STIMULATING PROTEINS <sup>DUR+</sup>**

<b>PREFERRED AGENTS</b>	<b>NON-PREFERRED AGENTS</b>	<b>PA CRITERIA</b>
EPOGEN (epoetin alfa)	ARANESP (darbepoetin alfa)	<p><b>Non-Preferred Criteria</b></p> <ul style="list-style-type: none"> <li>• Documented diagnosis of cancer or chronic renal failure <b>OR</b></li> <li>• Antineoplastic therapy in the past 6 months <b>AND</b></li> <li>• Have tried a preferred RETACRIT or EPOGEN in the past 6 months <b>OR</b></li> <li>• 1 claim for the requested agent in the past 105 days</li> </ul> <p><b>JESDUVROQ</b></p> <ul style="list-style-type: none"> <li>• Requires clinical review</li> </ul> <p><b>MIRCERA</b></p> <ul style="list-style-type: none"> <li>• Documented diagnosis of chronic renal failure in the past 2 years</li> </ul>
MIRCERA (methoxy polyethylene glycol-epoetin-beta)	JESDUVROQ (daprodustat)	
RETACRIT (epoetin alfa-epbx)	PROCRIT (epoetin alfa)	
	VAFSEO (vadadustat)	

**FACTOR DEFICIENCY PRODUCTS <sup>DUR+</sup>**

<b>PREFERRED AGENTS</b>	<b>NON-PREFERRED AGENTS</b>	<b>PA CRITERIA</b>
<b>FACTOR VIII</b>		<p><b>HEMLIBRA</b></p> <ul style="list-style-type: none"> <li>• 3 claims with HEMLIBRA in the past 105 days <b>OR</b></li> <li>• New starts require clinical review <b>MANUAL PA</b></li> </ul>
ADVATE	ADYNOVATE	
AFSTYLA	ELOCTATE	
ALPHANATE	ESPEROCT	
ALTUVIIIIO	JIVI	
FEIBA	KCENTRA	
HEMOFIL M	OBIZUR	

HUMATE-P	VONVENDI
KOATE	
KOGENATE FS	
KOVALTRY	
NOVOEIGHT	
NUWIQ	
RECOMBINATE	
WILATE	
XYNTHA, XYNTHA SOLOFUSE	
<b>FACTOR IX</b>	
ALPHANINE SD	BEQVEZ
ALPROLIX	
BENEFIX	
IDELVION	
IXINITY	
PROFILNINE	
REBINYN	
RIXUBIS	
<b>OTHER HEMOPHILIA PRODUCTS</b>	
COAGADEX (factor X)	ALHEMO (concizumab-mtci)
FIBRYGA (fibrinogen)	CORIFACT (factor XIII)
HEMLIBRA (emicizumab-kxwh) <sup>DUR+</sup>	HYMPAVZI (marstacimab-hncq)
RIASTAP (fibrinogen)	NOVOSEVEN RT (factor VII)
	QFITLIA (fitusiran)
	SEVENFACT (factor VII)
	TRETTEN (factor XIII)

### FIBROMYALGIA/NEUROPATHIC PAIN AGENTS

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
duloxetine 20 mg, 30 mg, 60 mg DR capsule	CYMBALTA (duloxetine)	<p><b>Minimum Age Limit</b></p> <ul style="list-style-type: none"> <li>• <b>18 years:</b> CYMBALTA, DRIZALMA SPRINKLE, duloxetine DR capsule</li> </ul> <p><b>TONMYA MANUAL PA</b></p>
gabapentin	DRIZALMA SPRINKLE (duloxetine)	
pregabalin	duloxetine 40 mg DR capsule	
SAVELLA (milnacipran)	gabapentin ER	
	GABARONE (gabapentin)	
	GRALISE (gabapentin)	
	HORIZANT (gabapentin enacarbil)	
	LYRICA, LYRICA CR (pregabalin)	
	milnacipran <sup>NR</sup>	
	NEURONTIN (gabapentin)	
	pregabalin ER	
	<b>TONMYA (cyclobenzaprine)</b>	

### FLUOROQUINOLONES <sup>DUR+</sup>

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
ciprofloxacin tablet	BAXDELA (delafloxacin)	<b>Non-Preferred Criteria</b>

levofloxacin tablet	CIPRO (ciprofloxacin)	<ul style="list-style-type: none"> <li>• 1 claim for a preferred agent in the past 30 days</li> </ul> <p><b>CIPRO Suspension for Age &lt; 12 Years</b></p> <ul style="list-style-type: none"> <li>• Documented diagnosis of Cystic Fibrosis or Anthrax infection or exposure <b>OR</b></li> <li>• Documented diagnosis or Pneumonic plague or tularemia <b>AND</b></li> <li>• History of doxycycline in the past 3 months <b>OR</b></li> <li>• 7 days of therapy with a preferred agent from 2 of the classes below in the past 3 months: <ul style="list-style-type: none"> <li>◦ Penicillin, 2nd or 3rd generation cephalosporin or macrolide</li> </ul> </li> </ul> <p><b>LEVAQUIN Suspension for Age &lt; 12 Years</b></p> <ul style="list-style-type: none"> <li>• Documented diagnosis of Anthrax infection or exposure <b>OR</b></li> <li>• History of 7 days of therapy with a preferred from 2 of the following classes in the past 3 months <ul style="list-style-type: none"> <li>◦ Penicillin, 2nd or 3rd generation cephalosporins, or macrolide <b>AND</b></li> </ul> </li> <li>• History of ciprofloxacin suspension in the past 3 months</li> </ul>
	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)	<p><b>Minimum Age Limit</b></p> <ul style="list-style-type: none"> <li>• <b>12 years:</b> ALDARA</li> <li>• <b>18 years:</b> CONDYLOX, PICATO, VEREGEN</li> </ul>
fluorouracil		
imiquimod		
podofilox		

## GI ULCER THERAPIES

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
<b>H2 RECEPTOR ANTAGONISTS</b>		<p><b>PRILOSEC 2.5 mg suspension</b></p> <ul style="list-style-type: none"> <li>• Automatic approval issued for 0-2 years of age</li> </ul> <p><b>PRILOSEC 10 mg suspension</b></p> <ul style="list-style-type: none"> <li>• Requires clinical review</li> </ul>
famotidine	cimetidine	
	nizatidine	
	ranitidine	
<b>OTHERS</b>		
CARAFATE (sucralfate) suspension	CARAFATE (sucralfate) tablet	
misoprostol	CYTOTEC (misoprostol)	
sucralfate	DARTISLA (glycopyrrolate)	
	EOHILIA (budesonide)	
	VOQUEZNA (vonoprazan)	
<b>PROTON PUMP INHIBITORS</b>		
esomeprazole capsule	DEXILANT (dexlansoprazole)	
NEXIUM (esomeprazole) packet	dexlansoprazole	
omeprazole	esomeprazole packet	

pantoprazole	KONVOMEK (omeprazole/sodium bicarbonate)	
	lansoprazole Rx	
	NEXIUM (esomeprazole) capsule	
	omeprazole/sodium bicarbonate	
	PREVACID (lansoprazole)	
	PRILOSEC (omeprazole) packet	
	PROTONIX (pantoprazole)	
	rabeprazole	
	ZEGERID (omeprazole/sodium bicarbonate)	

### GLUCOCORTICOIDS (INHALED)

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
<b>GLUCOCORTICOIDS</b>		<p><b>Non-Preferred Criteria</b></p> <ul style="list-style-type: none"> <li>• <b>Glucocorticoids</b> <ul style="list-style-type: none"> <li>○ 2 preferred single-entity agents in the past 6 months <b>OR</b></li> <li>○ 90 days of therapy with the requested agent in the past 105 days</li> </ul> </li> <li>• <b>Glucocorticoid/Bronchodilator Combinations</b> <ul style="list-style-type: none"> <li>○ 2 preferred combination agents in the past 6 months <b>OR</b></li> <li>○ 90 days of therapy with the requested agent in the past 105 days</li> </ul> </li> <li>• <b>Note:</b> <ul style="list-style-type: none"> <li>○ Institutional-sized products are non-preferred</li> </ul> </li> </ul> <p><b>AIRDUO DIGIHALER</b></p> <ul style="list-style-type: none"> <li>• Requires clinical review</li> </ul> <p><b>ARMONAIR DIGIHALER</b></p> <ul style="list-style-type: none"> <li>• Requires clinical review</li> </ul> <p><b>PROAIR DIGIHALER</b> Require clinical review</p> <p><b>Minimum Age Limit</b></p> <ul style="list-style-type: none"> <li>• <b>18 years:</b> AIRSUPRA</li> </ul> <p><b>Quantity Limit</b> (per 31 days)</p> <ul style="list-style-type: none"> <li>• <b>2 inhalers:</b> AIRSUPRA <b>MANUAL PA</b></li> </ul>
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	beclomethasone <sup>NR</sup>	
QVAR REDIHALER (beclomethasone)	budesonide 1 mg	
	FLOVENT HFA (fluticasone)	
	FLOVENT DISKUS (fluticasone)	
	PULMICORT (budesonide) nebulizer solution	
<b>GLUCOCORTICOID/BRONCHODILATOR COMBINATIONS</b>		
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)	
SYMBICORT (budesonide/formoterol)	budesonide/formoterol	
	fluticasone/salmeterol HFA	
	fluticasone/vilanterol	
	WIXELA INHUB (fluticasone/salmeterol)	

### GROWTH HORMONES <sup>DUR+</sup>

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
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GENOTROPIN (somatropin)	HUMATROPE (somatropin)	<p><b>Preferred Criteria</b></p> <ul style="list-style-type: none"> <li>• <b>Age ≥ 18 years</b></li> <li>• 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</li> <li>• <b>Age &lt; 18 years</b></li> <li>• Diagnosis of approvable pediatric diagnosis or history of cranial irradiation</li> </ul> <p><b>Minimum Age Limit</b></p> <ul style="list-style-type: none"> <li>• <b>3 years:</b> NGENLA</li> </ul> <p><b>Maximum Age Limit</b></p> <ul style="list-style-type: none"> <li>• <b>18 years:</b> NGENLA</li> </ul> <p><b>Non-Preferred Criteria</b></p> <p>Age ≥ 18 years</p> <ul style="list-style-type: none"> <li>• Documented approvable diagnosis for age as above diagnosis of craniopharyngioma, HIV associated cachexia, iatrogenic growth deficiency due to drug-induced or post-procedural hypopituitarism, Noonan Syndrome, panhypopituitarism, Prader-Willi Syndrome, renal function impairment growth disorders, short stature shox deficiency, Turner Syndrome or history of cranial irradiation <b>AND</b></li> <li>• History of 28 days of therapy with a preferred Growth Hormone in the past 6 months <b>OR</b></li> <li>• 84 days of therapy with the requested agent in the past 105 days</li> </ul> <p>Age &lt; 18 years</p> <ul style="list-style-type: none"> <li>• 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 <b>AND</b></li> <li>• History of 28 days of therapy with a preferred Growth Hormone in the past 6 months <b>OR</b></li> <li>• 84 days of therapy with the requested agent in the past 105 days</li> </ul> <p><b>SKYTROFA</b></p> <p>Age ≥ 18 years</p> <ul style="list-style-type: none"> <li>• 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 <b>AND</b></li> <li>• No history of diagnosis of Prader Willi Syndrome <b>AND</b></li> <li>• History of 28 days of therapy with a preferred Short-Acting Growth Hormone in the past 6 months <b>OR</b></li> <li>• 84 days of therapy with Skytrofa in the past 105 days</li> </ul> <p>Age &lt; 18 years</p> <ul style="list-style-type: none"> <li>• No history of diagnosis of Prader Willi Syndrome <b>AND</b></li> <li>• History of 28 days of therapy with a preferred Short-Acting Growth Hormone in the past 6 months <b>OR</b></li> <li>• 84 days of therapy with Skytrofa in the past 105 days</li> </ul>
NORDITROPIN FLEXPRO (somatropin)	NGENLA (somatrogon-ghla)	
SKYTROFA (lonapegsomatropin-tcgd)	OMNITROPE (somatropin)	
	SEROSTIM (somatropin)	
	SOGROYA (somapacitan-beco)	
	ZOMACTON (somatropin)	

## H. PYLORI COMBINATION TREATMENTS

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
PYLERA (bismuth subcitrate potassium/metronidazole/tetracycline)	bismuth subcitrate potassium/metronidazole/tetracycline	<p><b>Quantity Limit</b></p> <ul style="list-style-type: none"> <li>• <b>1 treatment course/year:</b> all agents</li> </ul>
	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) <sup>∞</sup>	EPCLUSA (sofosbuvir/velpatasvir) <sup>∞</sup>	<b>∞ EPCLUSA, HARVONI, MAVYRET, SOVALDI, VOSEVI, ZEPATIER</b>
PEGASYS (peginterferon alfa-2a)	HARVONI (ledipasvir/sofosbuvir) <sup>∞</sup>	• Require <b>MANUAL PA</b>
ribavirin tablet	ledipasvir/sofosbuvir <sup>∞</sup>	Note:
sofosbuvir/velpatasvir	ribavirin capsule	• <b>EPCLUSA, HARVONI, MAVYRET and SOVALDI</b> have FDA-approved pediatric indications
	SOVALDI (sofosbuvir) <sup>∞</sup>	
	VIEKIRA PAK (ombitasvir/paritaprevir/ritonavir)	
	VOSEVI (sofosbuvir/velpatasvir/voxilaprevir) <sup>∞</sup>	
	ZEPATIER (elbasvir/grazoprevir) <sup>∞</sup>	
HEREDITARY ANGIOEDEMA TREATMENTS		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
PROPHYLAXIS		<b>Non-Preferred Criteria</b>
HAEGARDA (C1 esterase inhibitor)	ANDEMBRY (garadacimab-gxii)	• Requires clinical review
	CINRYZE (C1 esterase inhibitor)	
	DAWNZERA (donidalorsen)	
	ORLADEYO (berotralstat)	
	TAKHZYRO (lanadelumab-flyo)	
ACUTE TREATMENT		
BERINERT (C1 esterase inhibitor)	EKTERLY (sebetralstat)	
icatibant	FIRAZYR (icatibant)	

	KALBITOR (ecallantide)	
	RUCONEST (C1 esterase inhibitor)	
	SAJAZIR (icatibant)	
HYPERURICEMIA & GOUT <sup>DUR+</sup>		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
allopurinol	ALOPRIM (allopurinol)	<b>Non-Preferred Criteria</b> <ul style="list-style-type: none"> <li>Have tried 2 different preferred agents in the past 6 months</li> </ul>
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) <sup>Step Edit</sup>	<b>Minimum Age Limit</b> <ul style="list-style-type: none"> <li><b>1 year:</b> BAQSIMI</li> <li><b>2 years:</b> GVOKE</li> <li><b>6 years:</b> ZEGALOGUE</li> </ul> <b>Quantity Limit</b> (per 31 days) <ul style="list-style-type: none"> <li><b>2 packs (or kits):</b> BAQSIMI, glucagon, GVOKE, ZEGALOGUE</li> </ul> <b>Non-Preferred Criteria GVOKE</b> <ul style="list-style-type: none"> <li>1 claim with preferred BAQSIMI or ZEGALOGUE in the past 30 days</li> </ul>
GLUCAGEN (glucagon)		
glucagon emergency kit		
glucagon vial		
ZEGALOGUE (dasiglucagon)		
HYPOGLYCEMICS, BIGUANIDES		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
metformin 500 mg, 850 mg, 1,000 mg tablets	GLUMETZA (metformin)	
metformin ER (generic GLUCOPHAGE XR)	metformin 625 mg, 750 mg tablets	
	metformin ER (generic FORTAMET)	
	metformin ER (generic GLUMETZA)	
	metformin solution	
	RIOMET (metformin)	
HYPOGLYCEMICS, DPP4s AND COMBINATIONS <sup>DUR+</sup>		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
JANUMET (sitagliptin/metformin)	alogliptin	<b>Non-Preferred Criteria</b> <ul style="list-style-type: none"> <li>Have tried 2 different preferred DPP4 agents in the past 6 months <b>OR</b></li> <li>90 days of therapy with the requested agent in the past 105 days</li> </ul> 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)	
		<b>Minimum Age Limit</b>

TRADJENTA (linagliptin)	KAZANO (alogliptin/metformin)	<ul style="list-style-type: none"> <li>• <b>18 years:</b> BRYNOVIN solution</li> </ul>
	KOMBIGLYZE XR (saxagliptin/metformin)	
	linagliptin/metformin	
	NESINA (alogliptin)	
	ONGLYZA (saxagliptin)	
	OSENI (alogliptin/pioglitazone)	
	saxagliptin	
	saxagliptin/metformin ER	
	sitagliptin	
	sitagliptin/metformin	
	ZITUVIMET (sitagliptin/metformin)	
	ZITUVIMET XR (sitagliptin/metformin)	
	ZITUVIO (sitagliptin)	

### HYPOGLYCEMICS, INCRETIN MIMETICS/ENHANCERS <sup>DUR+</sup>

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
BYETTA (exenatide)	BYDUREON (exenatide)	<p><b>Minimum Age Limit</b></p> <ul style="list-style-type: none"> <li>• <b>10 years:</b> BYDUREON BCISE, MOUNJARO, TRULICITY, VICTOZA</li> <li>• <b>18 years:</b> BYETTA, OZEMPIC, RYBELSUS</li> </ul> <p><b>Preferred Criteria</b></p> <ul style="list-style-type: none"> <li>• Documented diagnosis of Type 2 Diabetes <b>AND</b></li> <li>• No history of SAXENDA or WEGOVY in the past 30 days</li> </ul> <p><b>OR</b></p> <ul style="list-style-type: none"> <li>• No documented diagnosis for Type 2 Diabetes <b>AND</b></li> <li>• 84 days of therapy with the requested agent in the past 105 days</li> </ul> <p><b>Non-Preferred Criteria</b></p> <ul style="list-style-type: none"> <li>• Documented diagnosis of Type 2 Diabetes <b>AND</b></li> <li>• No history of SAXENDA or WEGOVY in the past 30 days <b>AND</b></li> <li>• 84 days of therapy with TRULICITY in the past 6 months <b>AND</b></li> <li>• 84 days of therapy with either preferred BYETTA or VICTOZA in the past 6 months</li> </ul> <p><b>OR</b></p> <ul style="list-style-type: none"> <li>• Documented diagnosis of Type 2 Diabetes <b>AND</b></li> <li>• 84 days of therapy with the request agent in the past 105 days</li> </ul> <p>Note:</p> <ul style="list-style-type: none"> <li>• Concomitant use of a GLP-1 agonist and a DPP-4 agent requires clinical review.</li> <li>• Please see the PDL category Anti-obesity Select Agents for a list of covered agents.</li> </ul> <p><b>RYBELSUS 1.5 mg and 3 mg</b></p> <ul style="list-style-type: none"> <li>• Requires clinical review</li> </ul>
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 <sup>DUR+</sup>

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
HUMALOG MIX 75/25 vial (insulin lispro/lispro protamine)	ADMELOG (insulin lispro)	<p><b>Non-Preferred Criteria</b></p> <ul style="list-style-type: none"> <li>• Documented diagnosis of Diabetes Mellitus <b>AND</b></li> </ul>

HUMULIN 70/30 vial (insulin NPH/regular)	AFREZZA (insulin regular)	<ul style="list-style-type: none"> <li>• Have tried 1 preferred agent in the past 6 months <b>OR</b></li> <li>• 1 claim with the requested agent in the past 105 days</li> </ul>
HUMULIN N (insulin NPH)	APIDRA (insulin glulisine)	
HUMULIN R (insulin regular)	BASAGLAR (insulin glargine)	<p><b>Quantity Limit</b></p> <ul style="list-style-type: none"> <li>• <a href="#">Insulin quantity limits can be found here</a></li> </ul> <p><b>Note:</b></p> <ul style="list-style-type: none"> <li>• Insulin pen formulations are not covered for Long Term Care (LTC) beneficiaries.</li> </ul> <p><b>BASAGLAR</b></p> <ul style="list-style-type: none"> <li>• Requires clinical review</li> </ul>
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	HUMALOG MIX KWIKPEN 50/50, 75/25 (insulin lispro/lispro protamine)	
insulin lispro	HUMULIN 70/30 KWIKPEN (insulin N/regular)	
insulin lispro protamine mix 75/25 vial	HUMULIN N KWIKPEN (insulin N)	
LANTUS (insulin glargine)	insulin degludec	
TOUJEO (insulin glargine)	insulin glargine	
TOUJEO MAX (insulin glargine)	insulin glargine-yfgn	
	KIRSTY (insulin aspart-xjhz)	
	LEVEMIR (insulin detemir)	
	LYUMJEV (insulin lispro-aabc)	
	MERIOLOG (insulin aspart-szji)	
	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 <sup>DUR+</sup>

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
nateglinide		
repaglinide		

### HYPOGLYCEMICS, SODIUM GLUCOSE COTRANSPORTER-2 (SGLT-2) INHIBITORS <sup>DUR+</sup>

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
<b>SGLT-2 INHIBITORS</b>		
FARXIGA (dapagliflozin)	dapagliflozin	<p><b>Non-Preferred Criteria</b></p> <ul style="list-style-type: none"> <li>• Have tried 2 different preferred SGLT-2 inhibitors in the past 6 months <b>OR</b></li> <li>• 90 days of therapy with the requested agent in the past 105 days</li> </ul>
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 <sup>DUR+</sup>		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
OFEV (nintedanib)	ESBRIET (pirfenidone)	<p><b>All Agents</b></p> <ul style="list-style-type: none"> <li>Documented diagnosis of Idiopathic Pulmonary Fibrosis</li> </ul> <p><b>OFEV</b></p> <ul style="list-style-type: none"> <li>Documented diagnosis of Idiopathic Pulmonary Fibrosis, Progressive Pulmonary Fibrosis, or Systemic Sclerosis-associated Interstitial Lung Disease <b>OR</b></li> <li>90 days of therapy with Ofev in the past 105 days</li> </ul> <p><b>pirfenidone</b></p> <ul style="list-style-type: none"> <li>Documented diagnosis of Idiopathic Pulmonary Fibrosis <b>OR</b></li> <li>90 days of therapy with pirfenidone or Esbriet in the past 105 days</li> </ul> <p><b>ESBRIET</b></p> <ul style="list-style-type: none"> <li>Requires clinical review</li> </ul> <p><b>JASCAYD MANUAL PA</b></p>
pirfenidone	<b>JASCAYD (nerandomilast)</b>	
IMMUNE GLOBULINS		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
BIVIGAM	ALYGLO	
FLEBOGAMMA	ASCENIV	
GAMASTAN	CABLIVI	
GAMMAGARD	CUTAQUIG	
GAMMAGARD S-D	CUVITRU	
GAMUNEX-C	GAMMAGARD ERC <sup>NR</sup>	
HIZENTRA	GAMMAKED	

HYQVIA	GAMMAPLEX
PANZYGA	OCTAGAM
PRIVIGEN	QIVIGY <sup>NR</sup>
XEMBIFY	

### IMMUNOLOGIC THERAPIES FOR ASTHMA

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
DUPIXENT (dupilumab) DUR+	NUCALA (mepolizumab)	<p><b>DUPIXENT</b></p> <ul style="list-style-type: none"> <li>• 1 claim with DUPIXENT in the past 60 days <b>OR</b></li> <li>• New starts require clinical review (see manual PA links below) <ul style="list-style-type: none"> <li>○ <b>Asthma</b> <a href="#">MANUAL PA</a></li> <li>○ <b>Atopic Dermatitis</b> <a href="#">MANUAL PA</a></li> <li>○ <b>Bullous Pemphigoid</b> <a href="#">MANUAL PA</a></li> <li>○ <b>COPD</b> <a href="#">MANUAL PA</a></li> <li>○ <b>Chronic Spontaneous Urticaria</b> <a href="#">MANUAL PA</a></li> <li>○ <b>Eosinophilic Esophagitis</b> <a href="#">MANUAL PA</a></li> <li>○ <b>Nasal Polyposis</b> <a href="#">MANUAL PA</a></li> <li>○ <b>Prurigo Nodularis</b> <a href="#">MANUAL PA</a></li> </ul> </li> </ul> <p><b>FASENRA</b></p> <ul style="list-style-type: none"> <li>• Requires clinical review <a href="#">MANUAL PA</a></li> </ul> <p><b>NUCALA</b></p> <ul style="list-style-type: none"> <li>• Requires clinical review</li> </ul> <p><b>TEZSPIRE</b></p> <ul style="list-style-type: none"> <li>• Requires clinical review</li> </ul> <p><b>XOLAIR</b></p> <ul style="list-style-type: none"> <li>• 1 claim with XOLAIR in the past 45 days <b>OR</b></li> <li>• New starts require clinical review <ul style="list-style-type: none"> <li>○ <b>Asthma</b> <a href="#">MANUAL PA</a></li> <li>○ <b>Chronic Spontaneous Urticaria</b> <a href="#">MANUAL PA</a></li> <li>○ <b>Nasal Polyposis</b> <a href="#">MANUAL PA</a></li> </ul> </li> </ul>
FASENRA (benralizumab)	TEZSPIRE (tezepelumab-ekko)	
XOLAIR (omalizumab)		

### IMMUNOSUPPRESSIVE AGENTS, ORAL

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
AZASAN (azathioprine)	ASTAGRAF XL (tacrolimus)	<p><b>Minimum Age Limit</b></p> <ul style="list-style-type: none"> <li>• <b>13 years:</b> RAPAMUNE</li> <li>• <b>18 years:</b> ZORTRESS</li> </ul> <p><b>Maximum Age Limit</b></p> <ul style="list-style-type: none"> <li>• <b>12 years:</b> PROGRAF Granules</li> </ul> <p><b>Preferred Criteria</b></p> <ul style="list-style-type: none"> <li>• <b>AZASAN</b> <ul style="list-style-type: none"> <li>○ Documented diagnosis of kidney transplant, RA, or a State-accepted diagnosis</li> </ul> </li> <li>• <b>CELLCEPT</b> <ul style="list-style-type: none"> <li>○ Documented diagnosis of heart, kidney, or liver transplant or a State-accepted diagnosis</li> </ul> </li> <li>• <b>GENGRAF, NEORAL, SANDIMMUNE</b> <ul style="list-style-type: none"> <li>○ Documented diagnosis of heart transplant, kidney transplant, liver transplant, psoriasis, RA, or a State-accepted diagnosis</li> </ul> </li> <li>• <b>everolimus</b></li> </ul>
azathioprine	ENVARUS XR (tacrolimus)	
CELLCEPT (mycophenolate)	LUPKYNIS (voclosporin)	
cyclosporine	MYFORTIC (mycophenolate)	
everolimus	MYHIBBIN (mycophenolate)	
mycophenolate	PROGRAF (tacrolimus)	
mycophenolic acid	REZUROCK (belumosudil)	
NEORAL (cyclosporine)	ZORTRESS (everolimus)	
RAPAMUNE (sirolimus)		
SANDIMMUNE (cyclosporine)		
sirolimus		
tacrolimus		

		<ul style="list-style-type: none"> <li>○ Documented diagnosis of kidney or liver transplant</li> <li>• <b>RAPAMUNE</b> <ul style="list-style-type: none"> <li>○ Documented diagnosis of kidney transplant</li> </ul> </li> <li>• <b>tacrolimus</b> <ul style="list-style-type: none"> <li>○ Documented diagnosis of heart, kidney, liver, or lung transplant or a State-accepted diagnosis</li> </ul> </li> </ul> <p><b>Non-Preferred Criteria</b></p> <ul style="list-style-type: none"> <li>• <b>ASTAGRAF XR or ENVARUS XR</b> <ul style="list-style-type: none"> <li>○ Documented diagnosis of heart, kidney, liver, or lung transplant or a State-accepted diagnosis <b>AND</b></li> <li>○ 30 days of therapy with tacrolimus IR in the past 105 days <b>OR</b></li> <li>○ 90 days of therapy with the requested agent in the past 105 days</li> </ul> </li> <li>• <b>PROGRAF Granules</b> <ul style="list-style-type: none"> <li>○ Age ≤ 11 years <b>AND</b></li> <li>○ Documented diagnosis of heart, kidney, liver, or lung transplant or a State-accepted diagnosis</li> </ul> </li> <li>• <b>MYFORTIC</b> <ul style="list-style-type: none"> <li>○ Documented diagnosis of kidney transplant or psoriasis</li> </ul> </li> <li>• <b>MYHIBBIN</b> <ul style="list-style-type: none"> <li>○ Documented diagnosis of heart, kidney, or liver transplant or a State-accepted diagnosis <b>AND</b></li> <li>○ 30 days of therapy with mycophenolate suspension in the past 105 days <b>OR</b></li> <li>○ 90 days of therapy with MYHIBBIN Suspension in the past 105 days</li> </ul> </li> <li>• <b>ZORTRESS</b> <ul style="list-style-type: none"> <li>○ Documented diagnosis of kidney or liver transplant</li> </ul> </li> </ul> <p><b>LUPKYNIS and REZUROCK</b></p> <ul style="list-style-type: none"> <li>• Requires clinical review</li> </ul>
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### INTRANASAL RHINITIS AGENTS

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
<b>ANTICHOLINERGICS</b>		<p><b>Non-Preferred Criteria Corticosteroids</b></p> <ul style="list-style-type: none"> <li>• Documented diagnosis of allergic rhinitis <b>AND</b></li> <li>• Have tried 1 different preferred agent in the past 6 months</li> </ul>
ipratropium		
<b>ANTIHISTAMINE/CORTICOSTEROID COMBINATIONS</b>		
	azelastine/fluticasone	
	DYMISTA (azelastine/fluticasone)	
	RYALTRIS (olopatadine/mometasone)	
<b>ANTIHISTAMINES</b>		
azelastine	olopatadine	
	PATANASE (olopatadine)	
<b>CORTICOSTEROIDS</b>		
fluticasone	BECONASE AQ (beclomethasone)	
NASONEX 24 HOUR ALLERGY SPRAY <sup>OTC</sup>	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)	<b>JADENU and JADENU SPRINKLE MANUAL PA</b>
deferiprone 500 mg tablet	deferiprone 1,000 mg tablet	
FERRIPROX (deferiprone)	EXJADE (deferasirox)	
	JADENU (deferasirox)	
	JADENU SPRINKLE (deferasirox)	

**IRRITABLE BOWEL SYNDROME/SHORT BOWEL SYNDROME AGENTS/SELECTED AGENTS <sup>DUR+</sup>**

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
<b>IRRITABLE BOWEL SYNDROME CONSTIPATION <sup>DUR+</sup></b>		<p><b>Minimum Age Limit</b></p> <ul style="list-style-type: none"> <li>• <b>1 year:</b> GATTEX</li> <li>• <b>6 years:</b> LINZESS 72 mcg</li> <li>• <b>7 years:</b> LINZESS 145 mcg</li> <li>• <b>18 years:</b> AMITIZA, IBSRELA, LINZESS 290 mcg, MOTTEGRITY, MOVANTIK, MYTESI, SYMPROIC, VIBERZI</li> </ul> <p><b>Gender Limit</b></p> <ul style="list-style-type: none"> <li>• <b>Female</b> AMITIZA 8 mcg</li> </ul>
LINZESS (linaclotide)	AMITIZA (lubiprostone)	
lubiprostone	IBSRELA (tenapanor)	
	MOTTEGRITY (prucalopride)	
	MOVANTIK (naloxegol)	
	prucalopride	
	SYMPROIC (naldemedine)	
<b>IRRITABLE BOWEL SYNDROME DIARRHEA</b>		
dicyclomine	alosetron	
ED-SPAZ (hyoscyamine)	LOTRONEX (alosetron) <sup>DUR+</sup>	
hyoscyamine, hyoscyamine ER	VIBERZI (eluxadoline) <sup>DUR+</sup>	
HYOSYNE (hyoscyamine)		
LEVSIN, LEVSIN-SL (hyoscyamine)		
NULEV (hyoscyamine)		
OSCIMIN, OSCIMIN SL (hyoscyamine)		
<b>SHORT BOWEL SYNDROME AND SELECTED GI AGENTS <sup>DUR+</sup></b>		
	GATTEX (teduglutide)	
	MYTESI (crofelemer)	

**IRRITABLE BOWEL SYNDROME CONSTIPATION <sup>DUR+</sup>**

<p><b>Chronic Idiopathic Constipation (CIC):</b> Amitiza 24 mcg, LINZESS, MOTTEGRITY</p> <ul style="list-style-type: none"> <li>• <b>LINZESS 72 mcg</b> <ul style="list-style-type: none"> <li>○ Age 6-17 years <b>AND</b></li> <li>○ Documented diagnosis pediatric functional constipation in the past year <b>AND</b></li> <li>○ No history of GI or bowel obstruction</li> </ul> </li> </ul> <p><b>OR</b></p>	<p><b>Irritable Bowel Syndrome Constipation Dominant (IBS-C):</b> AMITIZA 8 mcg, IBSRELA, LINZESS 290 mcg</p> <ul style="list-style-type: none"> <li>• <b>Preferred IBS-C Agents</b> <ul style="list-style-type: none"> <li>○ Documented diagnosis of IBS-C in the past year <b>AND</b></li> <li>○ No history of GI or bowel obstruction</li> </ul> </li> <li>• <b>Non-Preferred IBS-C Agents</b> <ul style="list-style-type: none"> <li>○ Documented diagnosis of IBS-C in the past year <b>AND</b></li> </ul> </li> </ul>	<p><b>Opioid Induced Constipation (OIC):</b> AMITIZA 24 mcg, MOVANTIK, SYMPROIC</p> <ul style="list-style-type: none"> <li>• <b>Preferred OIC Agents</b> <ul style="list-style-type: none"> <li>○ Documented diagnosis of OIC <b>and</b> chronic pain in the past year <b>AND</b></li> <li>○ No history of GI or bowel obstruction <b>AND</b></li> <li>○ 1 claim for an opioid in the past 30 days</li> </ul> </li> <li>• <b>Non-Preferred OIC Agents</b> <ul style="list-style-type: none"> <li>○ All preferred criteria met <b>AND</b></li> <li>○ Have tried 1 preferred OIC agents in the past 6 months <b>OR</b></li> <li>○ 1 claim with the requested agent in the past 105 days</li> </ul> </li> </ul>
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<ul style="list-style-type: none"> <li>○ Age 18 years or older <b>AND</b></li> <li>○ Documented diagnosis of CIC in the past year <b>AND</b></li> <li>○ No history of GI or bowel obstruction</li> <li>• <b>LINZESS 145 mcg and lubiprostone 24 mcg</b></li> <li>○ Age 18 years or older <b>AND</b></li> <li>○ Documented diagnosis of CIC in the past year <b>AND</b></li> <li>○ No history of GI or bowel obstruction</li> <li>• <b>LINZESS 290 mcg</b></li> <li>○ Age 18 years or older <b>AND</b></li> <li>○ Documented diagnosis of CIC in the past year <b>AND</b></li> <li>○ No history of GI or bowel obstruction <b>AND</b></li> <li>○ 1 claim with LINZESS 145 mcg in the past 45 days</li> <li>• <b>Non-Preferred CIC Agents</b></li> <li>○ Documented diagnosis of CIC <b>AND</b></li> <li>○ No history of GI or bowel obstruction <b>AND</b></li> <li>○ Have tried 2 preferred CIC agents in the past 6 months <b>OR</b></li> <li>○ 1 claim with the requested agent in the past 105 days</li> </ul>	<ul style="list-style-type: none"> <li>○ No history of GI or bowel obstruction <b>AND</b></li> <li>○ Have tried 2 preferred IBS-C agents in the past 6 months <b>OR</b></li> <li>○ 1 claim with the requested agent in the past 105 days</li> </ul>	
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**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 **MANUAL PA**

**SHORT BOWEL SYNDROME AND SELECTED GI AGENTS <sup>DUR+</sup>**

**HIV/AIDS Non-infectious Diarrhea**

- **MYTESI**
- Documented diagnosis of HIV/AIDS **and** non-infectious diarrhea in the past year **AND**

**Short Bowel Syndrome (SBS)**

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

- o 1 claim for an antiretroviral in the past 30 days

## LEUKOTRIENE MODIFIERS <sup>DUR+</sup>

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
montelukast	ACCOLATE (zafirlukast)	<b>Minimum Age Limit</b> <ul style="list-style-type: none"> <li>• 12 years: ZYFLO &amp; ZYFLO CR</li> </ul> <b>Non-Preferred Criteria</b> <ul style="list-style-type: none"> <li>• Have tried 2 different preferred agents in the past 6 months</li> </ul>
zafirlukast	SINGULAIR (montelukast)	
	zileuton	
	ZYFLO (zileuton)	

## LIPOTROPICS, OTHER (NON-STATINS)

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
<b>ACL INHIBITORS AND COMBINATIONS</b>		<b>JUXTAPID MANUAL PA</b>
	NEXLETOL (bempedoic acid)	<b>KYNAMRO</b> <ul style="list-style-type: none"> <li>• Requires clinical review</li> </ul>
	NEXLIZET (bempedoic acid/ezetimibe)	
<b>ANGIOPOIETIN-LIKE 3 INHIBITORS</b>		<b>LEQVIO</b> <ul style="list-style-type: none"> <li>• Requires clinical review</li> </ul>
	EVKEEZA (evinacumab-dqnb)	<b>NEXLETOL and NEXLIZET</b> <ul style="list-style-type: none"> <li>• Require clinical review</li> </ul>
<b>BILE ACID SEQUESTRANTS</b>		
cholestyramine	colesevelam	<b>PRALUENT MANUAL PA</b>  <b>REPATHA MANUAL PA</b>  <b>WELCHOL</b> <ul style="list-style-type: none"> <li>• Documented diagnosis of Type 2 Diabetes <b>AND</b></li> <li>• 30 days of therapy with an antidiabetic agent in the past 6 months <b>OR</b></li> <li>• 90 days of therapy with WELCHOL in the past 105 days</li> </ul>
cholestyramine light	COLESTID (colestipol)	
colestipol tablet	colestipol packet	
	PREVALITE (cholestyramine)	
	QUESTRAN (cholestyramine)	
	QUESTRAN LIGHT (cholestyramine)	
	WELCHOL (colesevelam)	
<b>CHOLESTEROL ABSORPTION INHIBITORS</b>		
ezetimibe	ZETIA (ezetimibe)	
<b>FIBRIC ACID DERIVATIVES</b>		
fenofibrate	fenofibric acid	
gemfibrozil	FENOGLIDE (fenofibrate)	
	FIBRICOR (fenofibric acid)	
	LIPOFEN (fenofibrate)	
	LOPID (gemfibrozil)	
	TRICOR (fenofibrate)	
	TRILIPIX (fenofibric acid)	
<b>MTP INHIBITOR</b>		
	JUXTAPID (lomitapide)	
<b>NIACIN</b>		
niacin ER	niacin	
<b>OMEGA-3 FATTY ACIDS</b>		
omega-3 acid ethyl esters	icosapent ethyl	
	LOVAZA (omega-3 acid ethyl esters)	
<b>PCSK-9 INHIBITORS</b>		
REPATHA (evolocumab)	LEQVIO (inclisiran)	

	PRALUENT (alirocumab)	
LIPOTROPICS, STATINS		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
<b>STATINS DUR+</b>		<p><b>Minimum Age Limit</b></p> <ul style="list-style-type: none"> <li>• <b>10 years:</b> ATORVALIQ Suspension</li> </ul> <p><b>Non-Preferred Criteria Statins</b></p> <ul style="list-style-type: none"> <li>• Have tried 2 different preferred statin or statin combination agents in the past 6 months <b>OR</b></li> <li>• 90 days of therapy with the requested agent in the past 105 days</li> </ul> <p><b>Simvastatin</b></p> <ul style="list-style-type: none"> <li>• Daily doses ≥ 80 mg require clinical review</li> </ul>
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)	
<b>STATIN COMBINATIONS</b>		
ezetimibe/simvastatin	amlodipine/atorvastatin	
	CADUET (amlodipine/atorvastatin)	
	VYTORIN (ezetimibe/simvastatin)	
MISCELLANEOUS BRAND/GENERIC		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
<b>ALLERGEN EXTRACT IMMUNOTHERAPY</b>		<p><b>CUMULATIVE Quantity Limit</b> (per 31 days)</p> <ul style="list-style-type: none"> <li>• <b>31 tablets:</b> alprazolam ER</li> </ul> <p><b>Quantity Limit</b> (per 31 days)</p> <ul style="list-style-type: none"> <li>• <b>2 kits:</b> epinephrine</li> </ul> <p><b>EVRYSDI MANUAL PA</b></p> <p><b>RHAPSIDO MANUAL PA</b></p> <p><b>*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.</b></p>
	GRASTEK	
	ORALAIR	
	RAGWITEK	
<b>ANXIOLYTICS</b>		
alprazolam	alprazolam ER	
hydroxyzine HCL	VISTARIL (hydroxyzine pamoate)	
hydroxyzine pamoate	XANAX, XANAX XR (alprazolam)	
<b>EPINEPHRINE</b>		
epinephrine (Mylan)	AUVI-Q (epinephrine)	
	epinephrine (all other manufacturers)	
	EPIPEN (epinephrine)	
	EPIPEN JR (epinephrine)	
	NEFFY (epinephrine)	
<b>FAMILIAL CHYLOMICRONEMIA SYNDROME</b>		
	REDEMPLO (plozasiran sodium) <sup>NR</sup>	
	TRYNGOLZA (olezarsen)	
<b>MISCELLANEOUS*</b>		
megestrol	BLUJEPA (gepotidacin)	
REVLIMID (lenalidomide)	BRINSUPRI (brensocaticib)	

	CAMZYOS (mavacamten)
	CRENESSITY (crinecerfont)
	ERGOMAR (ergotamine)
	EVRYSDI (risdiplam)
	HARLIKU (nitisinone)
	KORLYM (mifepristone)
	lenalidomide
	MYQORZO (aficamten) <sup>NR</sup>
	<b>PALSONIFY (paltusotine)</b>
	pomalidomide
	POMALYST (pomalidomide)
	<b>RHAPSIDO (remibrutinib)</b>
	TARPEYO (budesonide)
	VERQUVO (vericiguat)
<b>SUBLINGUAL NITROGLYCERIN</b>	
	nitroglycerin
	NITROLINGUAL (nitroglycerin)
	NITROSTAT (nitroglycerin)

### MOVEMENT DISORDER AGENTS <sup>DUR+</sup>

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
AUSTEDO (deutetrabenazine)	INGREZZA INITIATION PACK (valbenazine)	<p><b>AUSTEDO and AUSTEDO XR</b></p> <ul style="list-style-type: none"> <li>• Documented diagnosis of Huntington's chorea <b>AND</b></li> <li>• 30 days of therapy with tetrabenazine in the past 180 days <b>OR</b></li> <li>• 90 days of therapy with either agent in the past 105 days</li> </ul> <p>• Documented diagnosis of tardive dyskinesia <b>AND</b></p> <ul style="list-style-type: none"> <li>• 90 days of therapy with either agent in the past 105 days <b>OR</b></li> <li>• New starts require clinical review <b>MANUAL PA</b></li> </ul> <p><b>INGREZZA and INGREZZA SPRINKLE</b></p> <ul style="list-style-type: none"> <li>• Documented diagnosis of Huntington's chorea <b>AND</b></li> <li>• 30 days of therapy with tetrabenazine in the past 180 days <b>OR</b></li> <li>• 90 days of therapy with the requested agent in the past 105 days</li> </ul> <p>• Documented diagnosis of tardive dyskinesia <b>AND</b></p> <ul style="list-style-type: none"> <li>• 90 days of therapy with the requested agent in the past 105 days <b>OR</b></li> <li>• New starts require clinical review <b>MANUAL PA</b></li> </ul>
AUSTEDO XR (deutetrabenazine)	XENAZINE (tetrabenazine)	
INGREZZA (valbenazine)		
INGREZZA SPRINKLE (valbenazine)		
tetrabenazine		

### MULTIPLE SCLEROSIS AGENTS <sup>DUR+</sup>

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
<b>HIGHLY ACTIVE</b>		<p><b>Preferred Agents</b></p> <ul style="list-style-type: none"> <li>• Documented diagnosis of multiple sclerosis</li> </ul> <p><b>Preferred Agents</b></p> <ul style="list-style-type: none"> <li>• Documented diagnosis of multiple sclerosis</li> </ul> <p><b>Non-Preferred Criteria (Highly Active)</b></p> <ul style="list-style-type: none"> <li>• Requires clinical review</li> </ul>
TYSABRI (natalizumab)	BRIUMVI (ublituximab-xiyy)	
	<b>cladribine</b>	
	KESIMPTA PEN (ofatumumab)	
	MAVENCLAD (cladribine)	
	OCREVUS (ocrelizumab)	
	OCREVUS ZUNOVO (ocrelizumab/hyaluronidase-ocsq)	
	<b>TYRUKO (natalizumab-sztn)</b>	

MODERATELY ACTIVE		<b>Non-Preferred Criteria (Mildly Active)</b> <ul style="list-style-type: none"> <li>Documented diagnosis of multiple sclerosis <b>AND</b></li> <li>Have tried 2 different preferred agents in the past 6 months <b>OR</b></li> <li>3 claims with the requested agent in the last 105 days</li> </ul> <b>GILENYA, KESIMPTA, PONVORY, TASCENSO ODT, and ZEPOSIA</b> <ul style="list-style-type: none"> <li>Requires clinical review</li> </ul>
fingolimod	GILENYA (fingolimod)	
	MAYZENT (siponimod)	
	PONVORY (ponesimod)	
	TASCENSO ODT (fingolimod)	
	ZEPOSIA (ozanimod)	
MILDLY ACTIVE		<b>cladribine and MAVENCLAD MANUAL PA</b> <b>MAYZENT MANUAL PA</b> <b>OCREVUS and OCREVUS ZUNOVO MANUAL PA</b>
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-1a)	COPAXONE (glatiramer) 40 mg	
REBIF REBIDOSE (interferon beta-1a)	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)	<b>AGAMREE MANUAL PA</b>
	AMONDYS-45 (casimersen)	<b>AMONDYS-45 MANUAL PA</b>
	deflazacort	
	DUVYZAT (givinostat)	<b>DUVYZAT MANUAL PA</b>
	ELEVIDYS (delandistrogene moxeparvovec-rokl)	<b>ELEVIDYS MANUAL PA</b>
	EXONDYS-51 (eteplirsen)	<b>EXONDYS MANUAL PA</b>
	JAYTHARI (deflazacort)	<b>JAYTHARI MANUAL PA</b>
	<b>KYMBEE (deflazacort)</b>	<b>KYMBEE MANUAL PA</b>
	VILTEPSO (viltolarsen)	<b>VILTEPSO MANUAL PA</b>
	VYONDYS-53 (golodirsen)	<b>VYONDYS MANUAL PA</b>

### NSAIDS

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
COX II SELECTIVE		<b>Quantity Limit</b> (per 31 days) <ul style="list-style-type: none"> <li><b>20 tablets:</b> ketorolac tablets</li> </ul> <b>Non-Preferred Criteria COX II Selective</b> <ul style="list-style-type: none"> <li>Requires clinical review</li> </ul>
CELEBREX (celecoxib)	ELYXYB (celecoxib)	
celecoxib	meloxicam capsule	
meloxicam tablet	<b>VYSCOXA (celecoxib)</b>	
	ZYBIC (meloxicam) <sup>NR</sup>	

NON-SELECTIVE DUR+	
diclofenac sodium	COXANTO (oxaprozin)
diclofenac sodium ER	DAYPRO (oxaprozin)
EC-naproxen DR 500 mg tablet	diclofenac potassium
etodolac tablet	DOLOBID (diflunisal)
flurbiprofen	etodolac capsule, etodolac ER
ibuprofen	FELDENE (piroxicam)
indomethacin capsule	fenoprofen
indomethacin ER	indomethacin suppository
ketorolac	ketoprofen
nabumetone	LOFENA (diclofenac potassium)
naproxen 250 mg, 500 mg	meclofenamate
piroxicam	mefenamic acid
sulindac	NALFON (fenoprofen)
	NAPRELAN (naproxen)
	NAPROSYN 375 mg (naproxen)
	naproxen 375 mg, naproxen CR 375 mg, naproxen ER 500 mg
	ORUDIS (ketoprofen) <sup>NR</sup>
	oxaprozin
	RELAFEN DS (nabumetone)
	TOLECTIN 600 mg (tolmetin)
	tolmetin
NSAID/GI PROTECTANT COMBINATIONS DUR+	
	ARTHROTEC 50 mg, 75 mg (diclofenac/misoprostol)
	diclofenac/misoprostol
	ibuprofen/famotidine
	naproxen/esomeprazole
	VIMOVO (naproxen/esomeprazole)

### Non-Preferred Criteria Non-Selective & Combinations

- No history of a contraindicated GI disorder or coagulation disorder **AND**
- Have tried 2 different preferred non-selective agents in the past 6 months

### COXANTO, fenoprofen, ibuprofen 300mg, ORUDIS, oxaprozin 300mg

- Requires clinical review

## OPHTHALMIC AGENTS

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
ANTIBIOTICS		
bacitracin/polymyxin	AZASITE (azithromycin)	<b>Minimum Age Limit</b> <ul style="list-style-type: none"> <li>• <b>16 years:</b> RESTASIS</li> <li>• <b>17 years:</b> XIIDRA</li> <li>• <b>18 years:</b> CEQUA, EYSUVIS, MIEBO, TRYPTYR, VEVEE</li> </ul> <b>Quantity Limit</b> (per 31 days) <ul style="list-style-type: none"> <li>• <b>2 mL:</b> VEVEE</li> <li>• <b>3 mL:</b> MIEBO</li> <li>• <b>5.5 mL:</b> RESTASIS Multidose</li> <li>• <b>8.3 mL:</b> EYSUVIS</li> <li>• <b>60 units:</b> CEQUA, RESTASIS Droperette, TRYPTYR, XIIDRA</li> </ul>
ciprofloxacin	bacitracin	
erythromycin	besifloxacin <sup>NR</sup>	
gentamicin	BESIVANCE (besifloxacin)	
moxifloxacin	CILOXAN (ciprofloxacin)	
ofloxacin	gatifloxacin	
polymyxin B/trimethoprim	NATACYN (natamycin)	
tobramycin	neomycin/bacitracin/polymyxin	
	OCUFLOX (ofloxacin)	
	sulfacetamide	

	TOBEX (tobramycin)	<b>Non-Preferred Criteria</b> <ul style="list-style-type: none"> <li>• <b>Anti-Inflammatory Agents</b> <ul style="list-style-type: none"> <li>○ Have tried 2 different preferred agents in the past 6 months</li> </ul> </li> <li>• <b>Dry Eye Agents</b> <ul style="list-style-type: none"> <li>○ History of 1 claim for both RESTASIS Droperette and XIIDRA in the past 6 months</li> </ul> </li> </ul> <b>MIEBO</b> <ul style="list-style-type: none"> <li>• Requires clinical review</li> </ul> <b>RESTASIS Multidose</b> <ul style="list-style-type: none"> <li>• Require clinical review</li> </ul> <b>TRYPTYR</b> <ul style="list-style-type: none"> <li>• Requires clinical review</li> </ul> <b>TYRVAYA</b> <ul style="list-style-type: none"> <li>• Requires clinical review</li> </ul> <b>VEVYE</b> <ul style="list-style-type: none"> <li>• Requires clinical review</li> </ul>
	VIGAMOX (moxifloxacin)	
<b>ANTIBIOTIC-STEROID COMBINATIONS</b>		
BLEPHAMIDE S.O.P. (sulfacetamide/prednisolone)	MAXITROL (neomycin/polymyxin/dexamethasone)	
neomycin/bacitracin/polymyxin/hydrocortisone	neomycin/polymyxin/gramicidin	
neomycin/polymyxin/dexamethasone	TOBRADEX ST (tobramycin/dexamethasone)	
PRED-G (gentamicin/prednisolone)	tobramycin/loteprednol <sup>NR</sup>	
sulfacetamide/prednisolone		
TOBRADEX (tobramycin/dexamethasone)		
tobramycin/dexamethasone		
ZYLET (tobramycin/loteprednol)		
<b>ANTI-INFLAMMATORY AGENTS<sup>DUR+</sup></b>		
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)	
<b>DRY EYE AGENTS</b>		
EYSUVIS (loteprednol)	CEQUA (cyclosporine)	
RESTASIS Droperette (cyclosporine)	cyclosporine	
XIIDRA (lifitegrast)	MIEBO (perfluorohexyloactane)	
	RESTASIS Multidose (cyclosporine)	
	TYRVAYA (varenicline)	
	VEVYE (cyclosporine)	
<b>OPHTHALMIC, GLAUCOMA AGENTS</b>		
<b>PREFERRED AGENTS</b>	<b>NON-PREFERRED AGENTS</b>	<b>PA CRITERIA</b>
<b>BETA BLOCKERS</b>		<b>Minimum Age Limit</b> <ul style="list-style-type: none"> <li>• <b>18 years:</b> IYUZEH</li> </ul>
BETIMOL (timolol)	betaxolol	
carteolol	BETOPTIC S (betaxolol)	

ISTALOL (timolol)	timolol droperette, daily drop, gel	<b>Non-Preferred Criteria</b> <ul style="list-style-type: none"> <li>• Have tried 2 different preferred agents in the past 6 months <b>OR</b></li> <li>• 90 days of therapy with the requested agent in the past 105 days</li> </ul>
levobunolol	TIMOPTIC; TIMOPTIC OCUDOSE, XE (timolol)	
timolol drops 0.25%, 0.5%		
<b>CARBONIC ANHYDRASE INHIBITORS</b>		
dorzolamide	AZOPT (brinzolamide) brinzolamide	
<b>COMBINATION AGENTS</b>		
COMBIGAN (brimonidine/timolol)	brimonidine/timolol	
dorzolamide/timolol	COSOPT (dorzolamide/timolol)	
SIMBRINZA (brinzolamide/brimonidine)	dorzolamide/timolol PF	
<b>PARASYMPATHOMIMETICS</b>		
pilocarpine	PHOSPHOLINE IODIDE (echothiophate iodide)	
<b>PROSTAGLANDIN ANALOGS</b>		
latanoprost	bimatoprost IYUZEH (latanoprost) LUMIGAN (bimatoprost) tafluprost TRAVATAN Z (travoprost) travoprost VYZULTA (latanoprostene bunod) XALATAN (latanoprost) XELPROS (latanoprost) ZIOPTAN (tafluprost)	
<b>RHO KINASE INHIBITORS/COMBINATIONS</b>		
RHOPRESSA (netarsudil)		
ROCKLATAN (netarsudil/latanoprost)		
<b>SYMPATHOMIMETICS</b>		
ALPHAGAN P (brimonidine)	brimonidine 0.1%, 0.15%	
brimonidine 0.2%		

### OPHTHALMICS FOR ALLERGIC CONJUNCTIVITIS

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
ALREX (loteprednol)	ALOCRI (nedocromil)	<b>Non-Preferred Criteria</b> <ul style="list-style-type: none"> <li>• Have tried 2 different preferred agents in the past 6 months</li> </ul> <b>VERKAZIA</b> <ul style="list-style-type: none"> <li>• Requires clinical review</li> </ul>
azelastine	ALOMIDE (loodoxamide)	
cromolyn	bepotastine	
ketotifen <sup>OTC</sup>	BEPREVE (bepotastine)	
olopatadine	epinastine	
ZADITOR (ketotifen)	LASTACFT (alcaftadine)	
	VERKAZIA (cyclosporine)	
	ZERVIA (cetirizine)	

### OPIATE DEPENDENCE TREATMENTS

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
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DEPENDENCE	
buprenorphine/naloxone SL tablet <sup>DUR+</sup>	BRIXADI (buprenorphine)
naltrexone	buprenorphine <sup>DUR+</sup>
SUBOXONE (buprenorphine/naloxone) <sup>DUR+</sup>	buprenorphine/naloxone film <sup>DUR+</sup>
	lofexidine
	LUCEMYRA (lofexidine)
	SUBLOCADE (buprenorphine)
	VIVITROL (naltrexone) <sup>DUR+</sup>
	ZUBSOLV (buprenorphine/naloxone)
TREATMENT	
KLOXXADO (naloxone)	LIFEMS NALOXONE (naloxone convenience kit)
naloxone	
NARCAN (naloxone)	
OPVEE (nalmefene)	
REXTOVY (naloxone)	
ZIMHI (naloxone)	

Buprenorphine/naloxone provider summary found [here](#)

**Minimum Age Limit**  
• 18 years: VIVITROL

**SUBLOCADE MANUAL PA**

**VIVITROL**  
• Documented diagnosis of opioid related disorder  
• Diagnosis of alcohol dependence requires **MANUAL PA**

### OTIC ANTIBIOTICS

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
CIPRO HC (ciprofloxacin/hydrocortisone)	ciprofloxacin	<b>Maximum Age Limit</b> • 9 years: CIPRO HC and ciprofloxacin/hydrocortisone  <b>Ciprofloxacin/Dexamethasone Suspension Criteria</b> • Age ≥ 6 months <b>AND</b> • Experiencing otorrhea secondary to recent, post-tympanostomy tube placement <b>AND</b> • Continued otorrhea after 10 days of otic treatment with ciprofloxacin ophthalmic solution <b>and</b> dexamethasone ophthalmic suspension
CORTISPORIN-TC (neomycin/colistin/hydrocortisone)	ciprofloxacin/dexamethasone	
fluocinolone	ciprofloxacin/fluocinolone	
neomycin/polymyxin/hydrocortisone	<b>ciprofloxacin/hydrocortisone</b>	
	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)	VIOKACE (lipase/protease/amylase)	<b>Non-Preferred Criteria</b> • Have tried 2 different preferred agents in the past 6 months
PERTZYE (lipase/protease/amylase)		
ZENPEP (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	BRILINTA (ticagrelor)	<b>Non-Preferred Criteria</b> <ul style="list-style-type: none"> <li>• Documented diagnosis <b>AND</b></li> <li>• Have tried 2 different preferred agents in the past 6 months <b>OR</b></li> <li>• 90 days of therapy with the requested agent in the past 105 days</li> </ul> <b>ZONTIVITY MANUAL PA</b>
cilostazol	EFFIENT (prasugrel)	
clopidogrel	PLAVIX (clopidogrel)	
dipyridamole		
pentoxifylline		
prasugrel		
ticagrelor		

### PLATELET STIMULATING AGENTS

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
NPLATE (romiplostim)	ALVAIZ (eltrombopag)	
PROMACTA (eltrombopag) tablet	DOPTELET (avatrombopag)	
	<b>DOPTELET SPRINKLE (avatrombopag maleate)</b>	
	MULPLETA (lusutrombopag)	
	PROMACTA (eltrombopag) packet	
	TAVALISSE (fostamatinib)	

### POTASSIUM REMOVING AGENTS

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
LOKELMA (sodium zirconium cyclosilicate)	KIONEX (sodium polystyrene sulfonate)	
SPS (sodium polystyrene sulfonate) suspension	sodium polystyrene sulfonate	
	SPS (sodium polystyrene sulfonate) enema	

	VELTASSA (patiromer calcium sorbitex)	
PRENATAL VITAMINS		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
CLASSIC PRENATAL COMPLETE NATAL DHA COMPLETENATE CONCEPT DHA CONCEPT OB M-NATAL PLUS PRENATAL PRENATAL PLUS VITAMIN-MINERAL PRENATAL VITAMIN PRENATAL VITAMIN PLUS LOW IRON PRENATAL VITAMINS PROVIDA OB SELECT-OB + DHA SE-NATAL-19 STUART ONE THRIVITE RX TRICARE TRINATAL RX 1 VITAFOL FE PLUS VITAFOL ULTRA VITAFOL-OB VITAFOL-ONE WESNATAL DHA COMPLETE WESTAB PLUS	All prenatal vitamins are non-preferred except for those specifically indicated as preferred.	List of Preferred NDC's for Prenatal Vitamins can be found <a href="#">here</a>
PSEUDOBULBAR AFFECT AGENTS		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	NUEDEXTA (dextromethorphan/quinidine)	<b>Non-Preferred Criteria</b> <ul style="list-style-type: none"> <li>• Documented diagnosis of pseudobulbar affect disorder <b>OR</b></li> <li>• 90 days of therapy with NUEDEXTA in the past 105 days</li> </ul>
PULMONARY ANTIHYPERTENSIVE AGENTS		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
ACTIVIN SIGNALING INHIBITORS		<b>Minimum Age Limit</b> <ul style="list-style-type: none"> <li>• <b>18 years:</b> ADEMPAS, OPSYNVI, TADLIQ</li> </ul>
	WINREVAIR (sotatercept-csrk)	
COMBINATION AGENTS		<b>Maximum Age Limit</b> <ul style="list-style-type: none"> <li>• <b>12 years:</b> REVATIO suspension</li> </ul>
	OPSYNVI (macitentan/tadalafil)	
ENDOTHELIN RECEPTOR ANTAGONISTS		<b>Preferred Criteria</b> <ul style="list-style-type: none"> <li>• <b>PAH Agents</b> <ul style="list-style-type: none"> <li>○ Documented diagnosis of pulmonary hypertension</li> </ul> </li> </ul>
ambrisentan	OPSUMIT (macitentan)	
bosentan	TRACLEER (bosentan)	
LETAIRIS (ambrisentan)	TRYVIO (aprocitentan)	

PDE5 INHIBITORS	
sildenafil (generic REVATIO) tablet, suspension	ADCIRCA (tadalafil)
tadalafil	ALYQ (tadalafil)
	REVATIO (sildenafil)
	TADLIQ (tadalafil)
PROSTACYCLINS	
	ORENITRAM ER (treprostinil)
	ORENITRAM TITRATION PAK (treprostinil)
	TYVASO (treprostinil)
	VENTAVIS (iloprost)
	YUTREPIA (treprostinil)
SELECTIVE PROSTACYCLINE RECEPTOR AGONISTS	
	UPTRAVI (selexipag)
SOLUABLE GUANYLATE CYCLASE STIMULATORS	
	ADEMPAS (riociguat)

- **Sildenafil tablets**
  - ≤ 1 year of age **and** documented diagnosis of pulmonary hypertension, patent ductus arteriosus, or persistent fetal circulation **OR**
  - ≥ 1 year of age **and** documented diagnosis of pulmonary hypertension **OR**
  - 90 days of therapy with the requested agent in the past 105 days

- **Sildenafil suspension**
- < 12 years of age **AND**
- Documented diagnosis of pulmonary hypertension, patent ductus arteriosus, or persistent fetal circulation, or a history of a heart transplant **OR**
- 90 days stable therapy with sildenafil suspension in the past 105 days

**Non-Preferred Criteria**

- Documented diagnosis of pulmonary hypertension **AND**
- Have tried 1 preferred PAH agent in the past 6 months **OR**
- 90 days of therapy with the requested agent in the past 105 days

**OPSUMIT, OPSYNOVI, ORENITRAM ER, TYVASO, and VENTAVIS**

- Require clinical review

**ADEMPAS**

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

**TADLIQ**

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

**UPTRAVI**

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

**ROSACEA TREATMENTS**

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
metronidazole	AVAR (sulfacetamide sodium/sulfur)	Note: • Topical Sulfonamides used for Rosacea will require a manual PA for age > 21 years. • Other labeled indications are limited to < 21 years.
	AVAR LS (sulfacetamide sodium/sulfur)	
	AVAR-E (sulfacetamide sodium/sulfur)	
	BP 10-1 (sulfacetamide sodium/sulfur)	
	brimonidine	
	EPSOLAY (benzoyl peroxide)	
	FINACEA (azelaic acid)	
	METROCREAM (metronidazole)	
	METROGEL (metronidazole)	
	MIRVASO (brimonidine)	
	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
<b>BENZODIAZEPINES</b> <sup>DUR+</sup>		
estazolam	flurazepam	<p><b>MS DOM Opioid Initiative Criteria details found here</b></p> <ul style="list-style-type: none"> <li>Concomitant use of Opioids and Benzodiazepines</li> </ul> <p><b>Maximum Age Limit</b></p> <ul style="list-style-type: none"> <li><b>64 years:</b> zolpidem 7.5 mg, 10 mg, and 12.5 mg</li> </ul> <p><b>Gender and Dose Limit</b></p> <ul style="list-style-type: none"> <li><b>Female:</b> AMBIEN 5 mg, AMBIEN CR 6.25 mg, INTERMEZZO 1.75 mg</li> <li><b>Male:</b> all strengths of zolpidem</li> </ul> <p><b>Non-Preferred Criteria</b></p> <ul style="list-style-type: none"> <li>Have tried 2 different preferred agents in the past 6 months</li> </ul> <p><b>HETLIOZ capsules</b></p> <ul style="list-style-type: none"> <li>Age 18 years or older <b>AND</b></li> <li>Documented diagnosis of circadian rhythm sleep disorder</li> <li>OR</li> <li>Age 16 years and older <b>AND</b></li> <li>Documented diagnosis of Smith-Magenis syndrome</li> </ul> <p><b>HETLIOZ liquid</b></p> <ul style="list-style-type: none"> <li>Age 3-15 years <b>AND</b></li> <li>Documented diagnosis of Smith-Magenis syndrome</li> </ul> <p>Note:</p> <ul style="list-style-type: none"> <li>Single-source benzodiazepines and barbiturates are NOT covered.               <ul style="list-style-type: none"> <li>PA s will NOT be issued for these drugs.</li> </ul> </li> </ul> <p style="background-color: yellow;">See below for additional PA Criteria/DUR+ Rules</p>
temazepam 15 mg, 30 mg capsule	HALCION (triazolam)	
	quazepam	
	RESTORIL (temazepam)	
	temazepam 7.5 mg, 22.5 mg capsule	
	triazolam	
<b>OTHERS</b> <sup>DUR+</sup>		
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
<b>INJECTABLE CONTRACEPTIVES</b>		<p><b>Non-Preferred Criteria</b></p> <ul style="list-style-type: none"> <li>• 1 claim with the requested agent in the past 105 days</li> </ul>
medroxyprogesterone	DEPO-PROVERA (medroxyprogesterone)	
<b>INTRAVAGINAL CONTRACEPTIVES</b>		
ENILLORING (etonogestrel/ethinyl estradiol)	ANNOVERA (segesterone/ethinyl estradiol)	
NUVARING (etonogestrel/ethinyl estradiol)	PHEXXI (lactic acid/citric acid/potassium bitartrate)	
<b>ORAL CONTRACEPTIVES <sup>DUR+</sup></b>		
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)	
<b>TRANSDERMAL CONTRACEPTIVES</b>		
TWIRLA (levonorgestrel/ethinyl estradiol)	norelgestromin/ethinyl estradiol	
XULANE (norelgestromin/ethinyl estradiol)		
ZAFEMY (norelgestromin/ethinyl estradiol)		
<b>SICKLE CELL AGENTS</b>		
<b>PREFERRED AGENTS</b>	<b>NON-PREFERRED AGENTS</b>	<b>PA CRITERIA</b>
CASGEVY (exagamglogene autotemcel)	ADAKVEO (crizanlizumab-tmca)	<b>ENDARI MANUAL PA</b>
DROXIA (hydroxyurea)	ENDARI (glutamine)	<b>CASGEVY MANUAL PA</b>
hydroxyurea	HYDREA (hydroxyurea)	<b>LYFGENIA MANUAL PA</b>
LYFGENIA (lovotibeglogene autotemcel)	l-glutamine	
	SIKLOS (hydroxyurea)	
<b>SKELETAL MUSCLE RELAXANTS <sup>DUR+</sup></b>		

PREFERRED AGENTS		NON-PREFERRED AGENTS	PA CRITERIA
baclofen 5 mg, 10 mg, 20 mg tablet	AMRIX (cyclobenzaprine)		<p><b>Quantity Limit</b></p> <ul style="list-style-type: none"> <li>• <b>84 tablets/180 days:</b> carisoprodol</li> </ul> <p><b>Non-Preferred Criteria</b></p> <ul style="list-style-type: none"> <li>• Documented diagnosis of an approvable indication <b>AND</b></li> <li>• Have tried 2 different preferred agents in the past 6 months</li> </ul> <p><b>Baclofen granules, solution, and suspension</b></p> <ul style="list-style-type: none"> <li>• Require clinical review.</li> </ul> <p><b>Carisoprodol</b></p> <ul style="list-style-type: none"> <li>• Documented diagnosis of acute musculoskeletal condition <b>AND</b></li> <li>• No history with meprobamate in the past 105 days <b>AND</b></li> <li>• History of 1 claim for cyclobenzaprine in the past 21 days</li> </ul> <p><b>AMRIX, cyclobenzaprine ER, metaxalone 640 mg, ONTRALFY, TANLOR, and tizanidine capsules</b></p> <ul style="list-style-type: none"> <li>• Requires clinical review</li> </ul>
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		
	FLEXMID (cyclobenzaprine)		
	FLEQSUVY (baclofen)		
	LORZONE (chlorzoxazone)		
	LYVISPAH (baclofen)		
	metaxalone		
	NORGESIC (orphenadrine/aspirin/caffeine)		
	NORGESIC FORTE (orphenadrine/aspirin/caffeine)		
	ONTRALFY (tizanidine)		
	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
<b>NICOTINE TYPE</b>			<p><b>Minimum Age Limit</b></p> <ul style="list-style-type: none"> <li>• <b>18 years:</b> CHANTIX</li> </ul> <p><b>Quantity Limit</b></p> <ul style="list-style-type: none"> <li>• <b>336 tablets/year:</b> CHANTIX 0.5 mg tabs, 1 mg tabs, and continuing pack</li> <li>• <b>2 treatment courses/year:</b> CHANTIX Starter Pack</li> </ul>
nicotine gum <sup>OTC</sup>	NICOTROL INHALER CARTRIDGE		
nicotine lozenge <sup>OTC</sup>	NICOTROL NASAL SPRAY		
nicotine patch <sup>OTC</sup>			
<b>NON-NICOTINE TYPE</b>			
bupropion SR			
CHANTIX (varenicline)			
varenicline			

### STEROIDS (TOPICAL) <sup>DUR+</sup>

PREFERRED AGENTS		NON-PREFERRED AGENTS	PA CRITERIA
<b>LOW POTENCY</b>			<p><b>Non-Preferred Criteria</b></p> <ul style="list-style-type: none"> <li>• <b>Low Potency</b></li> </ul>
alclometasone	fluocinolone		

DERMA-SMOOTHIE-FS (fluocinolone)	hydrocortisone lotion	<ul style="list-style-type: none"> <li>○ Have tried 2 different preferred low potency agents in the past 6 months</li> <li>● <b>Medium Potency</b> <ul style="list-style-type: none"> <li>○ Have tried 2 different preferred medium potency agents in the past 6 months</li> </ul> </li> <li>● <b>High Potency</b> <ul style="list-style-type: none"> <li>○ Have tried 2 different preferred high potency agents in the past 6 months</li> </ul> </li> <li>● <b>Very High Potency</b> <ul style="list-style-type: none"> <li>○ Have tried 2 different preferred very high potency agents in the past 6 months</li> </ul> </li> </ul>
desonide	HYDROXYM (hydrocortisone)	
hydrocortisone cream, ointment, solution	MICORT-HC (hydrocortisone)	
	PROCTOCORT (hydrocortisone)	
<b>MEDIUM POTENCY</b>		
fluticasone	BESER (fluticasone)	
mometasone	CAPEX (fluocinolone)	
PANDEL (hydrocortisone probutate)	clorcortolone	
prednicarbate cream	CLODERM (clorcortolone)	
	flurandrenolide	
	fluticasone lotion	
	LOCOID (hydrocortisone butyrate)	
	prednicarbate ointment	
	SYNALAR (fluocinolone)	
<b>HIGH POTENCY</b>		
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	
<b>VERY HIGH POTENCY</b>		
clobetasol cream, foam, gel, ointment, shampoo, solution	APEXICON E (diflorasone)	
clobetasol-E	clobetasol emulsion	
halobetasol cream and ointment	clobetasol 0.025% cream	
	CLOBEX (clobetasol)	
	CLODAN (clobetasol)	
	DIPROLENE (betamethasone)	
	halobetasol foam and lotion	
	IMPEKLO (clobetasol)	
	IMPOYZ (clobetasol) 0.025% cream	
	LEXETTE (halobetasol)	
	OLUX (clobetasol)	
	TEMOVATE (clobetasol)	
	TOVET (clobetasol)	
	ULTRAVATE (halobetasol)	
<b>STIMULANTS AND RELATED AGENTS</b> DUR+		

**MICORT-HC**  
 • Requires clinical review.

**Clobetasol 0.025%**  
 • Requires clinical review.

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
<b>SHORT-ACTING</b>		<p><b>Minimum Age Limit</b></p> <ul style="list-style-type: none"> <li>• <b>3 years:</b> ADDERALL, EVEKEO, PROCENTRA, ZENZEDI</li> <li>• <b>6 years:</b> 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, WAKIX, XELSTRYM</li> <li>• <b>7 years:</b> XYREM</li> <li>• <b>13 years:</b> MYDAYIS</li> <li>• <b>16 years:</b> modafinil</li> <li>• <b>18 years:</b> armodafinil, SUNOSI</li> </ul> <p><b>Maximum Age Limit</b></p> <ul style="list-style-type: none"> <li>• <b>18 years:</b> clonidine ER, COTEMPLA XR ODT, DAYTRANA, EVEKEO ODT, guanfacine ER</li> </ul> <p><b>Quantity Limit Stimulants</b> (per 31 days)</p> <ul style="list-style-type: none"> <li>• <b>31 tablets:</b> ADDERALL XR, ADHANSIA XR, ADZENYS XR ODT, APTENSIO XR, AZSTARYS, CONCERTA ER 18, 27, &amp; 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 &amp; 50 mg, QUILLICHEW, RELEXXII ER, RITALIN LA &amp; SR, VYVANSE, XELSTRYM</li> <li>• <b>62 tablets:</b> ADDERALL, CONCERTA ER 36 mg, COTEMPLA XR-ODT 17.3 &amp; 25.9 mg, DESOXYN, EVEKEO, FOCALIN, METHYLIN, RITALIN, ZENZEDI</li> <li>• <b>248 mL:</b> DYANAVEL XR Suspension</li> <li>• <b>310 mL:</b> METHYLIN, PROCENTRA</li> <li>• <b>372 mL:</b> QUILLIVANT XR</li> </ul> <p><b>Quantity Limit Narcolepsy</b> (per 31 days)</p> <ul style="list-style-type: none"> <li>• <b>31 tablets:</b> armodafinil 150, 200 &amp; 250 mg, modafinil 200 mg, SUNOSI</li> <li>• <b>46.5 tablets:</b> modafinil 100 mg</li> <li>• <b>62 tablets:</b> armodafinil 50 mg, WAKIX</li> </ul> <p><b>Quantity Limit Non-Stimulants</b> (per 31 days)</p> <ul style="list-style-type: none"> <li>• <b>31 tablets:</b> atomoxetine, guanfacine ER</li> <li>• <b>93 tablets:</b> QELBREE 200 mg</li> <li>• <b>124 tablets:</b> clonidine ER</li> <li>• <b>1 bottle (30 mL or 60 mL):</b> ONYDA XR Suspension</li> </ul>
dexmethylphenidate	ADDERALL (dextroamphetamine/amphetamine)	
dextroamphetamine	amphetamine	
dextroamphetamine/amphetamine	EVEKEO (amphetamine)	
methylphenidate tablet, solution	dextroamphetamine solution	
PROCENTRA (dextroamphetamine)	EVEKEO ODT (amphetamine)	
	FOCALIN (dexmethylphenidate)	
	methamphetamine	
	METHYLIN (methylphenidate)	
	methylphenidate chewable tablet	
	RITALIN (methylphenidate)	
	ZENZEDI (dextroamphetamine)	
<b>LONG-ACTING</b>		
ADDERALL XR (dextroamphetamine/amphetamine)	ADZENYS XR ODT (amphetamine)	
CONCERTA (methylphenidate)	amphetamine ER ODT (generic ADZENYS XR ODT)	
dexmethylphenidate ER	APTENSIO XR (methylphenidate)	
dextroamphetamine ER	ARYNTA (lisdexamfetamine) solution <sup>NR</sup>	
dextroamphetamine/amphetamine ER (generic ADDERALL XR)	AZSTARYS (serdexmethylphenidate/dexmethylphenidate)	
DYANAVEL XR (amphetamine) suspension	COTEMPLA XR ODT (methylphenidate)	
lisdexamfetamine	DAYTRANA (methylphenidate)	
methylphenidate CD	DEXEDRINE (dextroamphetamine)	
methylphenidate ER tablet	dextroamphetamine/amphetamine ER (generic MYDAYIS ER)	
methylphenidate LA	DYANAVEL XR (amphetamine) tablets	
QUILLICHEW ER (methylphenidate)	FOCALIN XR (dexmethylphenidate)	
QUILLIVANT XR (methylphenidate)	JORNAY PM (methylphenidate)	
VYVANSE (lisdexamfetamine) capsules	methylphenidate patch	

	methylphenidate ER capsule
	MYDAYIS (dextroamphetamine/amphe tamine)
	RELEXII (methylphenidate)
	RITALIN LA (methylphenidate)
	VYVANSE (lisdexamfetamine) chewable tablets
	XELSTRYM (dextroamphetamine)
<b>NARCOLEPSY</b>	
armodafinil	NUVIGIL (armodafinil)
modafinil	PROVIGIL (modafinil)
SUNOSI (solriamfetol)	sodium oxybate
XYREM (sodium oxybate)	WAKIX (pitolisant)
	XYWAV (calcium/magnesium/potassi um/sodium oxybate)
<b>NON-STIMULANTS</b>	
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**

**QELBREE 100 mg**

- Quantity of 1 per day **AND**
- Documented diagnosis of ADD/ADHD **AND**
- No history of a different strength of QELBREE in the past 26 days **AND**
- 30 days of therapy with a preferred ADHD agent in the past 105 days

**OR**

- Age ≥ 21 years **AND**
- Documented diagnosis of ADD/ADHD

**Clonidine ER**

- Documented diagnosis of ADD/ADHD

**Guanfacine ER**

- Documented diagnosis of ADD/ADHD

**JORNAY PM**

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

**Modafinil**

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

**ONYDA XR MANUAL PA**

- 30 days of therapy with QELBREE in the past 105 days

**QELBREE 150 mg**

- Quantity of ≤ 2 per day **AND**
- Documented diagnosis of ADD/ADHD **AND**
- No history of a different strength of QELBREE in the past 26 days **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

**QELBREE 200 mg**

- Age 18 years and older **AND**
- Quantity of ≤ 3 per day **AND**
- Documented diagnosis of ADD/ADHD **AND**
- No history of a different strength of QELBREE in the past 26 days **AND**
- 30 days of therapy with a preferred ADHD agent in the past 105 days **OR**
- Age 6-17 years **AND**
- Quantity of <math>\leq 2</math> tablets per day **AND**
- Documented diagnosis of ADD/ADHD **AND**
- No history of a different strength of Qelbree in the past 26 days **AND**
- 30 days of therapy with a preferred ADHD agent in the past 105 days **OR**
- 30 days of therapy with QELBREE in the past 105 days

**SUNOSI**

- Documented diagnosis of narcolepsy or obstructive sleep apnea **AND**
- 30 days of therapy with preferred modafinil or armodafinil in the past 6 months

**VYVANSE**

- Documented diagnosis of binge eating disorder or ADD/ADHD **OR**
- 90 days of therapy with Vyvanse in the past 105 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	<p><b>Non-Preferred Agents</b></p> <ul style="list-style-type: none"> <li>• Have tried 2 different preferred agents in the past 6 months</li> </ul> <p><b>Demeclocycline</b></p> <ul style="list-style-type: none"> <li>• Documented diagnosis of Syndrome of Inappropriate Antidiuretic Hormone Secretion (SIADH) will allow for automatic approval</li> </ul> <p><b>ORACEA</b></p> <ul style="list-style-type: none"> <li>• Requires clinical review</li> </ul>
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 <sup>DUR+</sup> \*See Cytokine & CAM Antagonists Class for Additional Agents\***

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
<b>ORAL</b>		<p><b>Non-Preferred Criteria</b></p> <ul style="list-style-type: none"> <li>• Documented diagnosis of Ulcerative Colitis <b>AND</b></li> <li>• Have tried 2 different preferred agents in the past 6 months <b>OR</b></li> <li>• 90 days of therapy with the requested agent in the past 105 days</li> </ul> <p><b>VELSIPITY</b></p> <ul style="list-style-type: none"> <li>• Requires clinical review</li> </ul>
balsalazide	AZULFIDINE (sulfasalazine)	
budesonide	DELZICOL (mesalamine)	
PENTASA (mesalamine)	DIPENTUM (olsalazine)	
sulfasalazine	LIALDA (mesalamine)	
sulfasalazine DR	mesalamine	
	mesalamine DR, mesalamine ER	
	VELSIPITY (etrasimod)	
<b>RECTAL</b>		
mesalamine suppository	budesonide	
	CANASA (mesalamine)	
	mesalamine enema	
	ROWASA (mesalamine)	
	SFROWASA (mesalamine)	

**UREA CYCLE DISORDER AGENTS**

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