MISSISSIPPI DIVISION OF MEDICAID
UNIVERSAL PREFERRED DRUG LIST

EFFECTIVE 7/1/2026
VERSION 2026_8
Updated 5/20/2026

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
ANTI-INFECTIVES	
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)
	MORGIDOX (doxycycline)
	sulfacetamide sodium suspension
	WINLEVI (clascoterone) cream
ISOTRETINOIN PRODUCTS	
AMNESTEEM (isotretinoin)	ABSORBICA (isotretinoin)
CLARAVIS (isotretinoin)	isotretinoin
ZENATANE (isotretinoin)	
KERATOLYTICS (BENZOYL PEROXIDES)	
ACNE MEDICATION (benzoyl peroxide)	BPO towelette (benzoyl peroxide)
benzoyl peroxide	
RETINOIDS	
adapalene gel, gel with pump	adapalene cream
tretinoin cream	AKLIEF (trifarotene)
	ATRALIN (tretinoin)
	DIFFERIN (adapalene)
	FABIOR (tazarotene)
	tretinoin gel
	tretinoin microsphere
OTHERS/COMBINATION PRODUCTS	
adapalene/benzoyl peroxide gel	CLEANSING WASH (sulfacetamide sodium/sulfur/urea) cleanser
clindamycin/benzoyl peroxide 1%-5% gel	clindamycin phosphate/benzoyl peroxide 1.2%-2.5% gel
clindamycin phosphate/benzoyl peroxide 1.2%-5% gel	clindamycin/benzoyl peroxide 1.2%-3.75% gel w/pump (generic ONEXTON)
sodium sulfacetamide w/sulfur 8%-4%, 9%-4.25%, 10-5% suspension	clindamycin phosphate/tretinoin 1.2%-0.025% gel
	EPIDUO FORTE (adapalene/benzoyl peroxide) gel

PA CRITERIA

Maximum Age Limit

- **21 years**: all acne agents except isotretinoin products

Topical Clindamycin 1% lotion

- **21 years** and older **AND**
- Documented diagnosis of hidradenitis suppurativa

Note:
Isotretinoin products available for all ages
Clindamycin 1% lotion only available for ages 21 years and older with approvable diagnosis
Preferred clindamycin 1% lotion for ages < 21 years does not require PA

	erythromycin/benzoyl peroxide gel	
	NEUAC (benzoyl peroxide/clindamycin) cream, gel	
	sodium sulfacetamide w/sulfur 9.8%-4.8%	
	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	

ALPHA-1 PROTEINASE INHIBITORS

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

ALZHEIMER'S AGENTS DUR+

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

ANALGESICS, OPIOID-SHORT ACTING DUR+

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
acetaminophen/caffeine/dihydrocodeine	ASCOMP WITH CODEINE (aspirin/butalbital/caffeine/codeine)	**MS DOM Opioid Initiative Criteria details found here** • Morphine Equivalent Daily Dose • Concomitant use of Opioids and Benzodiazepines
acetaminophen/codeine	aspirin/butalbital/caffeine/codeine	

codeine	butalbital/acetaminophen/caffeine/codeine	**Minimum Age Limit** • **18 years**: codeine-containing products and tramadol-containing products **Quantity Limit** (per 31 rolling days) • **62 tablets**: butalbital/codeine combinations, codeine combinations, dihydrocodeine combinations, fentanyl, hydrocodone, hydromorphone, levorphanol, meperidine, morphine, oxycodone, oxymorphone, pentazocine, tapentadol, tramadol • **186 tablets**: butalbital/acetaminophen, butalbital/aspirin • **5 mL**: butorphanol nasal • **180 mL**: oxycodone liquid • **280 mL**: QDOLO **Non-Preferred Criteria** • Have tried 2 different preferred agents in the past 6 months
ENDOCET (oxycodone/acetaminophen)	butorphanol	
hydrocodone/acetaminophen	carisoprodol/aspirin/codeine	
hydromorphone	DILAUDID (hydromorphone)	
morphine sulfate	FIORICET WITH CODEINE (butalbital/acetaminophen/codeine)	
oxycodone	hydrocodone/ibuprofen	
oxycodone/acetaminophen (325 mg acetaminophen formulations)	levorphanol	
tramadol 50 mg tablet	meperidine	
tramadol/acetaminophen	NALOCET (oxycodone/acetaminophen)	
	oxymorphone	
	pentazocine/naloxone	
	PERCOCET (oxycodone/acetaminophen)	
	PROLATE (oxycodone/acetaminophen)	
	ROXICODONE (oxycodone)	
	ROXYBOND (oxycodone)	
	tapentadol	
	tramadol 25 mg, 75 mg, 100 mg tablet	
	tramadol solution	
	XYVONA (levorphanol)	

ANALGESICS, OPIOID-LONG ACTING DUR+

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
BUTRANS (buprenorphine)	BELBUCA (buprenorphine)	**Quantity Limit** (per 31 rolling days) • **31 tablets**: AVINZA, hydromorphone ER, HYSINGLA ER, tramadol ER • **62 tablets**: methadone, morphine ER, OXYCONTIN, oxymorphone ER, ZOHYDRO ER • **62 films**: BELBUCA • **10 patches**: fentanyl • **4 patches**: BUTRANS **Non-Preferred Criteria** • Have tried 2 preferred agents in the past 6 months **Minimum Age Limit** • **18 years**: BUTRANS
fentanyl patch	buprenorphine patch	
morphine sulfate ER tablet	CONZIP (tramadol)	
	DISKETS (methadone)	
	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 3% gel	DERMACINRX LIDOCAINE (lidocaine)	**Quantity Limit** (per 31 days) • **1 bottle (112 mL)**: diclofenac 2% solution pump **Non-Preferred Criteria** • Have tried 2 preferred agents in the past 6 months **Lidocaine 5% Patch** • Documented diagnosis of Herpetic Neuralgia **OR** • Documented diagnosis of Diabetic Neuropathy **ZTLIDO** • Documented diagnosis of postherpetic neuralgia **OR** • History of 3 claims with preferred lidocaine 5% patch in the past 6 months
lidocaine 2% viscous solution	DERMACINRX LIDOCAN (lidocaine)	
lidocaine 4% cream, solution	DERMACINRX LIDOGEL (lidocaine)	
lidocaine 5% ointment, patch	DERMACINRX LIDOREX (lidocaine)	
lidocaine/prilocaine cream	diclofenac epolamine	
TRIDACAINE (lidocaine) patch	diclofenac sodium 2% solution pump	
TRIDACAINE XL (lidocaine) patch	DICLOGEN (diclofenac/menthol/camphor) kit	
	DOLOGESIC PAIN RELIEF (lidocaine)	
	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)	
	PLIAGLIS (lidocaine/tetracaine)	
	TRIDACAINE II, III (lidocaine) patch	
	ZTLIDO (lidocaine)	

ANDROGENIC AGENTS DUR+

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

ANGIOTENSIN MODULATORS DUR+

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
ANGIOTENSIN CONVERTING ENZYME (ACE) INHIBITORS		**EPANED** • Automatic approval issued for 0-6 years of age
benazepril	ACCUPRIL (quinapril)	

captopril	ALTACE (ramipril)
enalapril	EPANED (enalapril)
fosinopril	LOTENSIN (benazepril)
lisinopril	moexipril
quinapril	perindopril
ramipril	QBRELIS (lisinopril)
trandolapril	ZESTRIL (lisinopril)
ACE INHIBITOR (ACEI) COMBINATIONS	
benazepril/amlodipine	ACCURETIC (quinapril/hydrochlorothiazide)
benazepril/hydrochlorothiazide	LOTENSIN HCT (benazepril/hydrochlorothiazide)
captopril/hydrochlorothiazide	LOTREL (benazepril/amlodipine)
enalapril/hydrochlorothiazide	ZESTORETIC (lisinopril/hydrochlorothiazide)
fosinopril/hydrochlorothiazide	
lisinopril/hydrochlorothiazide	
quinapril/hydrochlorothiazide	
trandolapril/verapamil ER	
ANGIOTENSIN II RECEPTOR BLOCKERS (ARBs)	
irbesartan	ARBLI (losartan)
losartan	ATACAND (candesartan)
olmesartan	AVAPRO (irbesartan)
telmisartan	azilsartan
valsartan tablet	BENICAR (olmesartan)
	candesartan
	COZAAR (losartan)
	DIOVAN (valsartan)
	EDARBI (azilsartan)
	MICARDIS (telmisartan)
	valsartan solution
ARB COMBINATIONS	
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

valsartan/sacubitril

- Age ≥1 year **and** documented diagnosis of Heart Failure with Systemic Ventricular Systolic Dysfunction **OR**
- Age ≥ 18 years **and** documented diagnosis of Heart Failure

Non-Preferred Criteria

- **ACEIs**:
  - Have tried 2 different preferred single entity agents in the past 6 months **OR**
  - 90 days of therapy with the requested agent in the past 105 days
- **ACEI Combinations**:
  - Have tried 2 different preferred ACEI combination agents in the past 6 months **OR**
  - 90 days of therapy with the requested agent in the past 105 days
- **ACEI/Diuretic Combinations**:
  - Have tried 2 different preferred ACEI/Diuretic agents in the past 6 months **OR**
  - 90 days of therapy with the requested agent in the past 105 days
- **ARBs**:
  - Have tried 2 different preferred single entity agents in the past 6 months **OR**
  - 90 days of therapy with the requested agent in the past 105 days
- **ARB Combinations**:
  - Have tried 1 preferred ARB combination agent in the past 6 months **OR**
  - 90 days of therapy with the requested agent in the past 105 days
- **ARB/Diuretic Combinations**:
  - Have tried 2 different preferred ARB/Diuretic agents in the past 6 months **OR**
  - 90 days of therapy with the requested agent in the past 105 days
- **Direct Renin Inhibitors**:
  - Documented diagnosis of Hypertension **AND**
  - Have tried 2 different preferred ACEI or ARB single-entity agents in the past 6 months **OR**
  - 90 days of therapy with the requested agent in the past 105 days
- **Direct Renin Inhibitor Combinations**:
  - Documented diagnosis of Hypertension **AND**
  - Have tried 2 different preferred ACEI or ARB diuretic agents in the past 6 months **OR**
  - 90 days of therapy with the requested agent in the past 105 days
  - Have tried 2 different preferred ACEI/Diuretic agents in the past 6 months **OR**
  - 90 days of therapy with the requested agent in the past 105 days

telmisartan/hydrochlorothiazide	DIOVAN-HCT (valsartan/hydrochlorothiazide)	
valsartan/amlodipine	EDARBYCLOR (azilsartan/chlorthalidone)	
valsartan/hydrochlorothiazide	ENTRESTO (valsartan/sacubitril)	
valsartan/sacubitril[DUR+]	EXFORGE (valsartan/amlodipine)	
	EXFORGE HCT (valsartan/amlodipine/hydrochlorothiazide)	
	HYZAAR (losartan/hydrochlorothiazide)	
	MICARDIS HCT (telmisartan/hydrochlorothiazide)	
	telmisartan/amlodipine	
	TRIBENZOR (olmesartan/amlodipine/hydrochlorothiazide)	
	valsartan/amlodipine/hydrochlorothiazide	
	WIDAPLIK (telmisartan/amlodipine/indapamide)	
DIRECT RENIN INHIBITORS		
	aliskiren	
	TEKTURNA (aliskiren)	

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
LINCOSAMIDE ANTIBIOTICS		**Quantity Limit** • **6 tablets/month**: SIVEXTRO
clindamycin	CLEOCIN (clindamycin)	

	CELOCIN PEDIATRIC (clindamycin)	**SIVEXTRO MANUAL PA**
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 OTC	CENTANY (mupirocin)	
bacitracin/polymyxin OTC	CENTANY AT (mupirocin)	
gentamicin sulfate	mupirocin cream	
mupirocin ointment	XEPI (ozenoxacin)	
neomycin/bacitracin/polymyxin OTC		

ANTIBIOTICS (VAGINAL)

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

ANTICOAGULANTS

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
LOW MOLECULAR WEIGHT HEPARIN (LMWH)		**Non-Preferred Criteria** • **LMWH**: ○ Have tried 1 preferred agent in the past 6 months **OR** ○ 90 days of therapy with the requested agent in the past 105 days • **Oral**:
enoxaparin	ARIXTRA (fondaparinux)	
	fondaparinux	
	FRAGMIN (dalteparin)	
	LOVENOX (enoxaparin)	

ORAL	
dabigatran	PRADAXA (dabigatran)
ELIQUIS (apixaban)	rivaroxaban
ELIQUIS SPRINKLE (apixaban)	SAVAYSA (edoxaban)
JANTOVEN (warfarin)	XARELTO (rivaroxaban) dose pack
warfarin	
XARELTO (rivaroxaban) tablet, suspension	

- Have tried 2 different preferred oral agents in the past 6 months **OR**
- 90 days of therapy with the requested agent in the past 105 days

XARELTO Dose Pack
- Requires clinical review

ANTICONVULSANTS DUR+

PREFERRED AGENTS	NON-PREFERRED AGENTS
ADJUVANTS	
carbamazepine	APTIOM (eslicarbazepine acetate)
carbamazepine ER 12-hour capsule	BANZEL (rufinamide)
DEPAKOTE ER (divalproex)	brivaracetam
DEPAKOTE SPRINKLE (divalproex)	BRIVIACT (brivaracetam)
divalproex	carbamazepine ER 12-hour tablet
divalproex ER	CARBATROL (carbamazepine)
divalproex sprinkle	DEPAKOTE (divalproex)
EPIDIOLEX (cannabidiol)	DIACOMIT (stiripentol)
lacosamide	ELEPSIA XR (levetiracetam)
lamotrigine	EPRONTIA (topiramate)
lamotrigine blue, green, orange dose pack	EQUETRO (carbamazepine)
levetiracetam	eslicarbazepine
levetiracetam ER	felbamate
oxcarbazepine tablet	FELBATOL (felbamate)
tiagabine	FINTEPLA (fenfluramine)
topiramate	FYCOMPA (perampanel)
topiramate sprinkle 15, 25 mg (generic Topamax)	KEPPRA (levetiracetam)
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

Minimum Age Limit
- **6 months**: DIACOMIT
- **1 year**: BANZEL, EPIDIOLEX
- **2 years**: ONFI, SYMPAZAN, SUBVENITE, VALTOCO
- **12 years**: NAYZILAM

Maximum Age Limit
- **2 years**: VIGAFYDE

Quantity Limit (per 31 days)
- **2 twin packs**: DIASTAT
- **2 packages**: NAYZILAM
- **5 blister packs**: VALTOCO

Non-Preferred Criteria
- Have tried 2 different preferred agents in the past 6 months **OR**
- Documented diagnosis of Seizure **AND**
- 90 days of therapy with the requested agent in the past 105 days

BANZEL, ONFI, and SYMPAZAN
- Documented diagnosis of Lennox-Gastaut Syndrome **and** have tried 1 preferred agent for Lennox-Gastaut Syndrome in the past 6 months **OR**
- Documented diagnosis of Seizure **AND** 90 days of therapy with the requested agent in the past 105 days

DIACOMIT
- Documented diagnosis of Dravet Syndrome **AND**
- 1 claim for clobazam in the past 30 days

EPIDIOLEX
- Documented diagnosis of Dravet Syndrome, Lennox-Gastaut Syndrome, or Seizures associated with Tuberous Sclerosis Complex **OR**
- 1 claim for EPIDIOLEX in the past 30 days

FINTEPLA
- Requires clinical review

SABRIL Powder for Oral Solution
- Documented diagnosis of Infantile Spasms **OR**
- Have tried 2 different preferred agents in the past 6 months **OR**
- Documented diagnosis of Seizure **AND**
- 90 days of therapy with the requested agent in the past 105 days

	QUDEXY XR (topiramate)	**TOPIRAMATE ER** • Documented diagnosis of Seizure **AND** • 90 days of therapy with the requested agent in the past 105 days **OR** • 30 days of therapy with topiramate IR in the past 6 months **VIGAFYDE** • Age ≤ 2 years **AND** • Documented diagnosis of infantile spasms **XCOPRI** • Age ≥ 18 years
	ROWEEPRA (levetiracetam)	
	rufinamide	
	SABRIL (vigabatrin)	
	SPRITAM (levetiracetam)	
	SUBVENITE (lamotrigine)	
	SUBVENITE (lamotrigine) blue, green, orange dose pack	
	TEGRETOL (carbamazepine)	
	TEGRETOL XR (carbamazepine)	
	TOPAMAX TABLET (topiramate)	
	TOPAMAX SPRINKLE (topiramate)	
	topiramate ER capsule (generic Trokendi XR)	
	topiramate ER sprinkle capsule (generic Qudexy XR)	
	topiramate sprinkle 50 mg	
	TRILEPTAL (oxcarbazepine) tablet	
	TROKENDI XR (topiramate)	
	vigabatrin	
	VIGADRONE (vigabatrin)	
	VIGAFYDE (vigabatrin)	
	VIGPODER (vigabatrin)	
	VIMPAT (lacosamide)	
	XCOPRI (cenobamate)	
	ZONISADE (zonisamide) suspension	
	ZTALMY (ganaxolone)	
HYDANTOINS		
DILANTIN (phenytoin)		
DILANTIN-125 (phenytoin)		
PHENYTEK (phenytoin)		
phenytoin		
phenytoin ER		
SELECTED BENZODIAZEPINES		
clobazam	DIASTAT (diazepam) rectal gel	
diazepam rectal gel	LIBERVANT (diazepam)	
NAYZILAM (midazolam)	ONFI (clobazam)	
VALTOCO (diazepam)	SYMPAZAN (clobazam)	
SUCCINIMIDES		
ethosuximide	CELONTIN (methsuximide)	
	methsuximide	
	ZARONTIN (ethosuximide)	
ANTIDEPRESSANTS, OTHER DUR+		

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
bupropion	AUVELITY (bupropion/dextromethorphan)	**Minimum Age Limit** • **18 years**: all agents **Non-Preferred Criteria** • Have tried 2 different preferred agents in the past 6 months **OR** • Have tried 1 preferred agent and 1 SSRI in the past 6 months **OR** • 90 days of therapy with the requested agent in the past 105 days **AUVELITY** • Documented diagnosis of major depressive disorder **AND** • 90 days of therapy with the requested agent in the past 105 days **OR** • Have tried preferred bupropion for 60 days in the past 6 months **AND** • Have tried another preferred agent that is not bupropion for 60 days in the past 6 months • Indication of agitation associated with dementia due to Alzheimer's disease requires clinical review **DRIZALMA SPRINKLE** • Automatic approval issued with a diagnosis of Generalized Anxiety Disorder for 7-11 years of age **duloxetine 20 mg, 30 mg, 60 mg DR capsule** • Automatic approval issued with a diagnosis of Generalized Anxiety Disorder for 7-17 years of age **OR** • 90 days of therapy with the requested agent in the past 105 days **EXXUA** • Documented diagnosis of unipolar major depressive disorder **AND** • Have tried 2 different preferred agents in the past 6 months **OR** • Have tried 1 preferred agent and 1 SSRI in the past 6 months **OR** • 90 days of therapy with the requested agent in the past 105 days **RALDESY** • Requires clinical review **ZURZUVAE MANUAL PA**
bupropion SR	CYMBALTA (duloxetine)	
bupropion XL	desvenlafaxine ER	
duloxetine 20 mg, 30 mg, 60 mg DR capsule	DESYREL (trazodone)	
mirtazapine	DRIZALMA SPRINKLE (duloxetine DR)	
trazodone	duloxetine 40 mg DR capsule	
TRINTELLIX (vortioxetine)	EFFEXOR XR (venlafaxine)	
venlafaxine	EMSAM (selegiline)	
venlafaxine HCl ER	EXXUA (gepirone hcl)	
vilazodone	FETZIMA (levomilnacipran)	
	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 DUR+

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

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
5HT3 RECEPTOR BLOCKERS		**Quantity Limit** (per 31 days) • **6 tablets**: AKYNZEO • **100 mL**: ZOFRAN solution **Non-Preferred Agents** • Have tried 1 preferred agent in the past 6 months **AKYNZEO MANUAL PA** **GRANISOL, NEREUS** • Requires clinical review 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	
	GRANISOL (granisetron)	
	ondansetron ODT 16 mg tablet	
	SANCUSO (granisetron)	
ANTIEMETIC COMBINATIONS		
DICLEGIS (doxylamine/pyridoxine)	AKYNZEO (netupitant/palonosetron)	
	BONJESTA (doxylamine/pyridoxine)	
	doxylamine/pyridoxine	
CANNABINOIDS		
	dronabinol	
	MARINOL (dronabinol)	
NMDA RECEPTOR ANTAGONISTS		
aprepitant	EMEND (aprepitant)	
	NEREUS (tradipitant)^{NR}	

ANTIFUNGALS (ORAL) DUR+

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
clotrimazole	BREXAFEMME (ibrexafungerp)	**Minimum Age Limit** • **18 years**: CRESEMBA **Non-Preferred Criteria** • Have tried 2 different preferred agents in the past 6 months **HIV Opportunistic Infection** • Non-Preferred agent indicated for treatment (^) **AND** • Documented diagnosis of HIV **CRESEMBA MANUAL PA** **griseofulvin suspension** • Automatic approval issued for 0-11 years of age **griseofulvin tablets (all except ultramicrodose 165 mg)** • Automatic approval issued for 12-17 years of age **FULVICIN P-G, griseofulvin ultramicrodose 165 mg tablets, SPORANOX** • Requires clinical review
fluconazole	CRESEMBA (isavuconazonium sulfate)	
nystatin	DIFLUCAN (fluconazole)	
terbinafine	flucytosine^	
	FULVICIN P-G (griseofulvin ultramicrosize)	
	griseofulvin	
	griseofulvin ultramicrosize	
	itraconazole^	
	ketoconazole	
	NOXAFIL (posaconazole)	
	ORAVIG (miconazole)	
	posaconazole^	
	SPORANOX (itraconazole)	
	TOLSURA (itraconazole)	
	VFEND (voriconazole)	
	VIVJOA (oteseconazole)	
	voriconazole^	

ANTIFUNGALS (TOPICAL) DUR+

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
ANTIFUNGALS		**Non-Preferred Criteria** • Have tried 2 different preferred agents in the past 6 months **LASOLEX, clotrimazole 30 mL solution** • Require clinical review
ciclopirox cream, gel, solution, suspension	BENSAL HP (salicylic acid)	
clotrimazole cream, solution Rx & OTC	CILODAN (ciclopirox)	
econazole	ciclopirox shampoo	
ketoconazole cream, shampoo	clotrimazole solution (NDCs 50228-0502-61, 82568-0036-06)	
miconazole cream, powder, solution OTC	EXTINA (ketoconazole)	
nystatin cream, ointment, powder	ketoconazole foam	
terbinafine OTC	KETODAN (ketoconazole)	
tolnaftate cream, powder OTC	LASOLEX (clotrimazole) OTC	
tavaborole	LOPROX (ciclopirox)	
	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)	
ANTIFUNGAL/STEROID COMBINATIONS		
clotrimazole/betamethasone cream	clotrimazole/betamethasone lotion	
nystatin/triamcinolone		

ANTIFUNGALS (VAGINAL)

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

ANTIHISTAMINES, MINIMALLY SEDATING AND COMBINATIONS DUR+

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
MINIMALLY SEDATING ANTIHISTAMINES		**Non-Preferred Criteria** • Documented diagnosis of Allergy or Urticaria **AND** • Have tried 2 different preferred agents in the past 12 months **Quantity Limit** • **118 mL**: desloratadine solution **DESLORATADINE SOLUTION** • Requires clinical review
cetirizine capsule, solution, tablet OTC	cetirizine chewable tablet OTC	
loratadine chewable tablet, ODT, solution, tablet OTC	CLARINEX (desloratadine)	
	desloratadine	
	levocetirizine	
MINIMALLY SEDATING ANTIHISTAMINE/DECONGESTANT COMBINATIONS		
cetirizine/pseudoephedrine	CLARINEX-D 12 HOUR (desloratadine/pseudoephedrine)	
loratadine/pseudoephedrine OTC		

ANTIMIGRAINE AGENTS, ACUTE TREATMENT

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA

CGRP ORAL AND NASAL		**Minimum Age Limit**
		• **6 years**: MAXALT
		• **12 years**: almotriptan, sumatriptan/naproxen, ZOMIG nasal spray
		• **18 years**: FROVA, IMITREX, naratriptan, NURTEC ODT, RELPAX, REYVOW, SYMBRAVO, TOSYMRA, UBRELVY, ZEMBRACE, ZOMIG tablets
		
		Quantity Limit (per 31 days)
		• **ORAL**
		  ○ **4 tablets**: REYVOW 50 mg
		  ○ **6 tablets**: almotriptan, RELPAX, ZOMIG
		  ○ **8 tablets**: NURTEC ODT, REYVOW 100 mg
		  ○ **9 tablets**: naratriptan, FROVA, IMITREX, sumatriptan/naproxen, SYMBRAVO
		  ○ **12 tablets**: MAXALT
		  ○ **16 tablets**: UBRELVY
		• **NASAL**
		  ○ **1 box**: all agents
		
		CUMULATIVE Quantity Limit (per 31 days)
		• **INJECTABLES**
		  ○ **4 injections**: all agents
		
		Non-Preferred Criteria
		• **ORAL**
		  ○ Have tried 2 preferred oral agents in the past 90 days
		• **NASAL**
		  ○ Requires clinical review
		• **INJECTABLES**
		  ○ Requires clinical review
		
		Almotriptan and sumatriptan/naproxen
		• Automatic approval for 12-17 years of age
		
		NURTEC ODT and UBRELVY MANUAL PA

NURTEC ODT (rimegepant)	ZAVZPRET (zavegepant)	
UBRELVY (ubrogepant)		
INJECTABLES		
sumatriptan pen injector, vial	IMITREX (sumatriptan)	
	sumatriptan cartridge	
	ZEMBRACE SYMTOUCH (sumatriptan)	
NASAL		
sumatriptan spray	IMITREX (sumatriptan)	
zolmitriptan spray	TOSYMRA (sumatriptan)	
	ZOMIG (zolmitriptan)	
TRIPTANS AND RELATED AGENTS (ORAL) DUR+		
naratriptan	almotriptan	
rizatriptan	eletriptan	
sumatriptan	FROVA (frovatriptan)	
zolmitriptan	frovatriptan	
zolmitriptan ODT	IMITREX (sumatriptan)	
	MAXALT (rizatriptan)	
	MAXALT MLT (rizatriptan)	
	RELPAX (eletriptan)	
	REYVOW (lasmiditan)	
	sumatriptan/naproxen	
	SYMBRAVO (rizatriptan benzoate/meloxicam)	
	ZOMIG (zolmitriptan)	

		• Documented diagnosis of Migraine **AND** • Have tried 2 different triptans in the past 6 months **AND** • No concurrent therapy with another CGRP agent or strong CYP3A4 inhibitor **REYVOW** • Documented diagnosis of Migraine **AND** • Have tried 2 different triptans in the past 90 days **AND** • Have tried preferred NURTEC ODT in the past 90 days **SYMBRAVO** • Requires clinical review **ZAVZPRET MANUAL PA** • Documented diagnosis of Migraine **AND** • Have tried 2 different triptans in the past 6 months **AND** • Have tried both NURTEC ODT and UBRELVY in the past 6 months **AND** • No concurrent therapy with another CGRP AGENT

ANTIMIGRAINE AGENTS, PROPHYLAXIS

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
INJECTABLES		**Preferred Injectables** • History of 3 claims with the requested agent in the past 105 days **OR** • New starts require manual PA (see criteria below) • AJOVY Autoinjector 3 Pack requires clinical review **Non-preferred Injectables** • Requires clinical review **Quantity Limit** • **4.5 mL (per 90 days)**: AJOVY Autoinjector 3 Pack **AIMOVIG, AJOVY (except Autoinjector 3 Pack), EMGALITY, NURTEC ODT, and QULIPTA MANUAL PA** **VYEPTI MANUAL PA**
AIMOVIG Autoinjector (erenumab-aooe) DUR+	EMGALITY Syringe (galcanezumab-gnlm) 300 mg/mL	
AJOVY Autoinjector (fremanezumab-vfrm) DUR+	VYEPTI (eptinezumab-jjmr)	
AJOVY Syringe (fremanezumab-vfrm) DUR+		
EMGALITY Pen (galcanezumab-gnlm) DUR+		
EMGALITY Syringe (galcanezumab-gnlm) 120 mg/mL DUR+		
ORAL		
	QULIPTA (atogepant)	
	NURTEC ODT (rimegepant)	

ANTINEOPLASTICS SELECTED SYSTEMIC ENZYME INHIBITORS

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
BOSULIF (bosutinib) tablet	AFINITOR (everolimus)	**LYNPARZA Tablets MANUAL PA**
CAPRESLA (vandetanib)	AFINITOR DISPERZ (everolimus)	
COMETRIQ (cabozantinib)	AKEEGA (niraparib/abiraterone)	
COTELLIC (cobimetinib)	ALECENSA (alectinib)	
ENSACOVE (ensartinib hydrochloride)	ALUNBRIG (brigatinib)	
everolimus	AUGTYRO (repotrectinib)	
GILOTRIF (afatinib)	AYVAKIT (avapritinib)	
IBTROZI (taletrectinib)	BALVERSA (erdafitinib)	

ICLUSIG (ponatinib)	BOSULIF (bosutinib) capsule
imatinib	BRAFTOVI (encorafenib)
IMBRUVICA (ibrutinib)	BRUKINSA (zanubrutinib)
INLYTA (axitinib)	CABOMETYX (cabozantinib)
IRESSA (gefitinib)	CALQUENCE (acalabrutinib)
JAKAFI (ruxolitinib)	COPIKTRA (duvelisib)
JAKAFI XR (ruxolitinib)	DANZITEN (nilotinib)
MEKINIST (trametinib)	dasatinib
NEXAVAR (sorafenib)	DAURISMO (glasdegib)
ROZLYTREK (entrectinib)	ERIVEDGE (vismodegib)
SPRYCEL (dasatinib)	ERLEADA (apalutamide)
STIVARGA (regorafenib)	erlotinib
SUTENT (sunitinib)	FOTIVDA (tivozanib)
TAFINLAR (dabrafenib)	FRUZAQIA (fruquintinib)
TARCEVA (erlotinib)	GAVRETO (pralsetinib)
TASIGNA (nilotinib)	gefitinib
TURALIO (pexidartinib)	GLEEVEC (imatinib)
TYKERB (lapatinib)	HERNEXEOS (zongertinib)
VOTRIENT (pazopanib)	HYRNUO (sevabertinib)
XALKORI (crizotinib)	IBRANCE (palbociclib)
XTANDI (enzalutamide)	IDHIFA (enasidenib)
ZELBORAF (vemurafenib)	IMKELDI (imatinib)
ZYDELIG (idelalisib)	INLURIYO (imlunestrant tosylate)
ZYKADIA (ceritinib)	INQOVI (decitabine/cedazuridine)
	INREBIC (fedratinib)
	ITOVEBI (inavolisib)
	IWILFIN (eflornithine)
	JAYPIRCA (pirtobrutinib)
	KISQALI (ribociclib)
	KISQALI-FEMARA CO-PACK (ribociclib/letrozole)
	KOMZIFTI (ziftomenib)
	KOSELUGO (selumetinib sulfate)
	KRAZATI (adagrasib)
	lapatinib
	LAZCLUZE (lazertinib)
	LENVIMA (lenvatinib)
	LIFYORLI (relacorilant)[NR]
	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 (capivasertib)	
	TUKYSA (tucatinib)	
	VANFLYTA (quizartinib)	
	VERZENIO (abemaciclib)	
	VITRAKVI (larotrectinib)	
	VIZIMPRO (dacomitinib)	
	VONJO (pacritinib)	
	VORANIGO (vorasidenib)	
	WELIREG (belzutifan)	
	XOSPATA (gilteritinib)	
	XPOVIO (selinexor)	
	ZEJULA (niraparib)	

ANTIOBESITY SELECT AGENTS

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
FOUNDAYO (orforglipron)	liraglutide	**All agents MANUAL PA** required **WEGOVY** • Submission of a manual PA and clinical review may be required when DUR+ electronic PA criteria are not met. • Reauthorization after 12 months requires submission of a manual PA to confirm continued appropriateness of therapy.
SAXENDA (liraglutide)	orlistat	
WEGOVY (semaglutide)[DUR+]	XENICAL (orlistat)	
ZEPBOUND (tirzepatide)		

ANTIPARASITICS (TOPICAL) [DUR+]

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
PEDICULICIDES		**Minimum Age Limit** • **2 months**: permethrin 1% (OTC), permethrin 5% • **6 months**: NATROBA, SKLICE • **2 years**: piperonyl/pyrethrins (OTC) • **4 years**: NATROBA
permethrin 1% cream [OTC]	lindane	
spinosad	NATROBA (spinosad)	
VANALICE (piperonyl butoxide/pyrethrins)	malathion	

	OVIDE (malathion)	• **6 years**: OVIDE
		• **18 years**: EURAX
		
		Non-Preferred Criteria
		• **Pediculicides**
		  ○ Have tried 2 preferred topical lice agents in the past 90 days
		• **Scabicides**
		  ○ Have tried permethrin 5% in the past 90 days

	SKLICE (ivermectin)	
SCABICIDES		
ivermectin	CROTAN (crotamiton)	
permethrin 5% cream	ELIMITE (permethrin)	
	EURAX (crotamiton)	
	STROMECTOL (ivermectin)	
ANTIPARKINSON'S AGENTS (INJECTABLE)		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
	VYALEV (foscarbidopa/foslevodopa)	**VYALEV** • Requires clinical review
ANTIPARKINSON'S AGENTS (ORAL) DUR+		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
ANTICHOLINERGICS		**Non-Preferred Criteria** • Documented diagnosis of Parkinson's disease **AND** • Have tried 2 different preferred agents in the past 6 months **OR** • 90 days of therapy with a selegiline agent in the past 105 days **GOCOVRI** • Documented diagnosis of Parkinson's disease **AND** • 30 days of therapy with amantadine IR in the past 105 days **AND** • 30 days of therapy with a carbidopa/levodopa combination agent in the past 45 days **INBRIJA** • Documented diagnosis of Parkinson's disease **AND** • 30 days of therapy with a carbidopa/levodopa combination agent in the past 45 days **NOURIANZ** • Documented diagnosis of Parkinson's Disease **AND** • Have tried 1 preferred carbidopa/levodopa combination agent in the past 30 days **AND** • 30 days of therapy with a preferred adjunctive therapy in the past 45 days **XADAGO** • Documented diagnosis of Parkinson' s Disease **AND** • History of 30 days of therapy with a carbidopa/levodopa combination agent in the past 45 days **AND** • History of 30 days of therapy with a selegiline agent the in past 45 days
benztropine		
trihexyphenidyl		
COMT INHIBITORS		
entacapone	OGENTYS (opicapone)	
DOPAMINE AGONISTS		
pramipexole	NEUPRO (rotigotine)	
ropinirole	pramipexole ER	
	ropinirole ER	
MAO-B INHIBITORS		
selegiline	AZILECT (rasagiline)	
	rasagiline	
	XADAGO (safinamide)	
OTHERS		
amantadine	bromocriptine capsule	
bromocriptine tablet	carbidopa	
carbidopa/levodopa ER tablet	carbidopa/levodopa ER capsule	
carbidopa/levodopa tablet	carbidopa/levodopa ODT	
	carbidopa/levodopa/entacapone	
	CREXONT (carbidopa/levodopa)	
	DHIVY (carbidopa/levodopa)	
	DUOPA (carbidopa/levodopa)	
	GOCOVRI (amantadine)	
	INBRIJA (levodopa)	
	NOURIANZ (istradefylline)	
	OSMOLEX ER (amantadine)	
	RYTARY (carbidopa/levodopa)	
	SINEMET (carbidopa/levodopa)	

	STALEVO (carbidopa/levodopa/entacapone)	

ANTIPSORIATICS (TOPICAL)

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

ANTIPSYCHOTICS DUR+

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
INJECTABLE, ATYPICALS DUR+		**Concurrent Therapy Limit for Age < 18 years** • 90 days with ≥ 2 agents in the last 120 days will require a **MANUAL PA** **Minimum Age Limit** • **3 years**: HALDOL • **5 years**: RISPERDAL, thioridazine • **6 years**: ABILIFY, trifluoperazine • **10 years**: LATUDA, SAPHRIS, SEROQUEL, SYMBYAX, VRAYLAR (0.5, 0.75, 1.5, 3, 4.5 mg) • **12 years**: INVEGA, molindone, perphenazine, pimozide, thiothixene • **13 years**: REXULTI, ZYPREXA • **18 years**: ABILIFY MYCITE, CAPLYTA, CLOZARIL, COBENFY, FANAPT, fluphenazine, GEODON, loxapine, LYBALVI, NUPLAZID, perphenazine/amitriptyline, SECUADO, VRAYLAR 6 mg, and all injectable agents **Quantity Limit** • **3 syringes/year**: ARISTADA INITIO **Non-Preferred Criteria Oral Atypical Agents (unless specified below)** • Have tried 2 preferred agents in the past 12 months **OR** • 30 days of therapy with the requested agent in the past 180 days **ARISTADA INTIO, ARISTADA ER, INVEGA SUSTENNA, INVEGA TRINZA and PERSERIS** • Documented diagnosis of schizophrenia or schizoaffective disorder **ABILIFY MAINTENA, ABILIFY ASIMTUFII, RISPERDAL CONSTA, or UZEDY** • Documented diagnosis of schizophrenia, schizoaffective disorder or bipolar disorder **CAPLYTA** • 30 days of therapy with the requested agent in the past 105 days **OR** • Documented diagnosis of Bipolar II Depression **OR**
ABILIFY ASIMTUFII (aripiprazole)	ERZOFRI (paliperidone palmitate)	
ABILIFY MAINTENA (aripiprazole)	GEODON (ziprasidone)	
ARISTADA, ARISTADA INITIO (aripiprazole lauroxil)	olanzapine	
INVEGA HAFYERA (paliperidone)	risperidone ER	
INVEGA SUSTENNA (paliperidone palmitate)	RYKINDO (risperidone)	
INVEGA TRINZA (paliperidone)	ziprasidone	
PERSERIS (risperidone)	ZYPREXA (olanzapine)	
RISPERIDAL CONSTA (risperidone)	ZYPREXA RELPREVV (olanzapine)	
UZEDY (risperidone)		
ORAL DUR+		
aripiprazole tablet	ABILIFY (aripiprazole)	
asenapine	ABILIFY MYCITE (aripiprazole)	
clozapine tablet	ADASUVE (loxapine)	
fluphenazine	aripiprazole ODT, solution	
haloperidol	BYSANTI (milsaperidone) NR	
haloperidol lactate	CAPLYTA (lumateperone)	
lurasidone	chlorpromazine	
olanzapine	clozapine ODT	
perphenazine	CLOZARIL (clozapine)	
perphenazine/amitriptyline	COBENFY (xanomeline/trospium)	

quetiapine	FANAPT (iloperidone)	• Documented diagnosis of Bipolar I Depression **AND** • 30 days of therapy with a preferred oral atypical antipsychotic indicated for requested diagnosis in the past 105 days **OR** • Documented diagnosis of Major Depressive Disorder **AND** • 120 days of therapy with two antidepressants that are not atypical antipsychotics in the past 180 days **AND** • 30 days of therapy with a preferred oral atypical antipsychotic indicated for requested diagnosis in the past 105 days **OR** • Documented diagnosis of schizophrenia **AND** • 30 days of therapy with a preferred oral atypical antipsychotic indicated for requested diagnosis in the past 105 days **INVEGA HAFYERA** • Documented diagnosis of schizophrenia or schizoaffective disorder **AND** ○ 4 claims for INVEGA SUSTENNA in the past year **OR** ○ 1 claim for INVEGA TRINZA in the past year **OR** ○ 1 claim for INVEGA HAFYERA in the past year **ERZOFRI, generic risperidone ER, RYKINDO ER, and ZYPREXA RELPREVV** • Require clinical review **NUPLAZID** • Documented diagnosis of Parkinson's Disease **VRAYLAR** • 30 days of therapy with the requested agent in the past 105 days **OR** • Age 10-17 years or older **AND** • Documented diagnosis of bipolar 1 disorder **AND** • 30 days of therapy with a preferred oral atypical antipsychotic indicated for requested diagnosis in the past 105 days **OR** • Age 13-17 years or older **AND** • Documented diagnosis of schizophrenia or schizoaffective disorder **AND** • 30 days of therapy with a preferred oral atypical antipsychotic indicated for requested diagnosis in the past 105 days **OR** • Age 18 years or older **AND** • Documented diagnosis of schizophrenia, schizoaffective disorder, bipolar disorder **AND** • 30 days of therapy with a preferred oral atypical antipsychotic indicated for requested diagnosis in the past 105 days **OR** • Age 18 years or older **AND** • Documented diagnosis of major depressive disorder **AND** • 120 days of therapy with two antidepressants that are not atypical antipsychotics in the past 180 days **AND** • 30 days of therapy with a preferred oral atypical antipsychotic indicated for requested diagnosis in the past 105 days **ARIPIPRAZOLE ODT, CLOZAPINE ODT and OPIPZA** • Require clinical review
quetiapine ER	GEODON (ziprasidone)	
risperidone	IGALMI (dexmedetomidine)	
thioridazine	INVEGA (paliperidone)	
trifluoperazine	LATUDA (lurasidone)	
ziprasidone	LYBALVI (olanzapine/samidorphan)	
	molindone	
	NUPLAZID (pimavanserin)	
	olanzapine/fluoxetine	
	OPIPZA (aripiprazole)	
	paliperidone ER	
	REXULTI (brexpiprazole)	
	RISPERDAL (risperidone)	
	SAPHRIS (asenapine)	
	SEROQUEL (quetiapine)	
	SEROQUEL XR (quetiapine ER)	
	SYMBYAX (olanzapine/fluoxetine)	
	VERSACLOZ (clozapine)	
	VRAYLAR (cariprazine)	
	ZYPREXA, ZYPREXA ZYDIS (olanzapine)	
TRANSDERMAL, ATYPICALS		
	SECUADO (asenapine)	

ANTIRETROVIRALS DUR+

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
CAPSID INHIBITORS		**Minimum Age Limit** • **10 years**: YEZTUGO **Non-Preferred Criteria** • 1 claim with the requested agent in the past 105 days
YEZTUGO** (lenacapavir) tablet and injection	SUNLENCA (lenacapavir)	
CD4 DIRECTED ATTACHMENT INHIBITORS		
	RUKOBIA (fostemsavir)	
CD4 DIRECTED HIV-1 INHIBITORS		

	TROGARZO (ibalizumab-uiyk)	**STRIBILD MANUAL PA** **SUNLENCA** • Requires clinical review **TROGARZO** • Requires clinical review **TYBOST MANUAL PA** **NOTE: Agents with ** are indicated for Pre-Exposure Prophylaxis (PrEP).**
COMBINATION PRODUCTS NRTIs		
abacavir/lamivudine	COMBIVIR (lamivudine/zidovudine)	
CABENUVA (cabotegravir/rilpivirine)	EPZICOM (abacavir/lamivudine)	
DOVATO (dolutegravir/lamivudine)		
lamivudine/zidovudine		
COMBINATION PRODUCTS NUCLEOSIDE AND NUCLEOTIDE ANALOG RTIs		
DESCOVY** (emtricitabine/tenofovir alafenamide)	TRUVADA** (emtricitabine/tenofovir)	
emtricitabine/tenofovir**		
COMBINATION PRODUCTS NUCLEOSIDE AND NUCLEOTIDE ANALOG AND NON-NUCLEOSIDE RTIs		
DELSTRIGO (doravirine/lamivudine/tenofovir)	ATRIPLA (efavirenz/emtricitabine/tenofovir)	
efavirenz/emtricitabine/tenofovir	CIMDUO (lamivudine/tenofovir)	
ODEFSEY (emtricitabine/rilpivirine/tenofovir)	COMPLERA (emtricitabine/rilpivirine/tenofovir)	
	IDVYNSO (doravirine/islatravir)[NR]	
COMBINATION PRODUCTS PROTEASE INHIBITORS		
lopinavir/ritonavir	KALETRA (lopinavir/ritonavir)	
ENTRY INHIBITORS CCR5 CO-RECEPTOR ANTAGONISTS		
	maraviroc	
	SELZENTRY (maraviroc)	
ENTRY INHIBITORS FUSION INHIBITORS		
	FUZEON (enfuvirtide)	
INTEGRASE STRAND TRANSFER INHIBITORS		
APRETUDE** (cabotegravir)	cabotegravir ER	
ISENTRESS (raltegravir)	ISENTRESS HD (raltegravir)	
TIVICAY, TIVICAY PD (dolutegravir)	VOCABRIA (cabotegravir)	
NON-NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBTORS (NNRTI)		
EDURANT (rilpivirine)	etravirine	
efavirenz	INTELENCE (etravirine)	
	nevirapine, nevirapine ER	

	PIFELTRO (doravirine)	
	rilpivirine	
NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBTORS (NRTI)		
abacavir	didanosine	
EMTRIVA (emtricitabine)	emtricitabine	
lamivudine	EPIVIR (lamivudine)	
ZIAGEN (abacavir)	RETROVIR (zidovudine)	
zidovudine	stavudine	
	VIREAD (tenofovir disoproxil fumarate)	
PHARMACOENHANCER CYTOCHROME P450 INHIBITORS		
	TYBOST (cobicistat)	
PROTEASE INHIBITORS (NON-PEPTIDIC)		
darunavir	APTIVUS (tipranavir)	
PREZISTA (darunavir) 75mg tablet, 150mg tablet, 100mg/mL suspension	PREZCOBIX (darunavir/cobicistat)	
	PREZISTA (darunavir) 600mg tablet, 800mg tablet	
PROTEASE INHIBITORS (PEPTIDIC)		
atazanavir	fosamprenavir	
EVOTAZ (atazanavir/cobicistat)	LEXIVA (fosamprenavir)	
ritonavir	NORIVIR (ritonavir)	
	REYATAZ (atazanavir)	
	VIRACEPT (nelfinavir)	
SINGLE PRODUCT REGIMENS		
BIKTARVY (bictegravir/emtricitabine/tenofovir)	efavirenz/lamivudine/tenofovir	
GENVOYA (elvitegravir/cobicistat/emtricitabine/ tenofovir alafenamide)	JULUCA (dolutegravir/rilpivirine)	
SYMFI (efavirenz/lamivudine/tenofovir)	rilpivirine ER	
SYMFI LO (efavirenz/lamivudine/tenofovir)	STRIBILD (elvitegravir/cobicistat/emtricitabine/tenofovir disoproxil fumarate)	
TRIUMEQ (abacavir/dolutegravir/lamivudine)	SYMTUZA (darunavir/cobicistat/emtricitabine/tenofovir alafenamide)	
TRIUMEQ PD (abacavir/dolutegravir/lamivudine)		

ANTIVIRALS, ORAL		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
ANTI-CYTOMEGALOVIRUS AGENTS		**PREVYMIS**

valganciclovir tablet	LIVTENCITY (maribavir)	• Requires clinical review **Valganciclovir solution** • Automatic approval issued for 0-12 years of age
	PREVYMIS (letermovir)	
	VALCYTE (valganciclovir)	
	valganciclovir solution	
ANTI-HERPETIC AGENTS		
acyclovir	SITAVIG (acyclovir)	
famciclovir	VALTREX (valacyclovir)	
valacyclovir		
ANTI-INFLUENZA AGENTS		
oseltamivir	FLUMADINE (rimantadine)	
	RAPIVAB (peramivir)	
	RELENZA (zanamivir)	
	rimantadine	
	TAMIFLU (oseltamivir)	
	XOFLUZA (baloxavir)	
COVID-19		
PAXLOVID (nirmatrelvir/ritonavir)		

ANTIVIRALS, TOPICAL

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
acyclovir cream, ointment	DENAVIR (penciclovir)	**ZELSUVMI MANUAL PA**
	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		**Minimum Age Limit**
		• **3 months**: EUCRISA
		• **2 years**: OPZELURA, pimecrolimus, tacrolimus 0.03%
		• **16 years**: tacrolimus 0.1%
		
		ADBRY MANUAL PA
		
		ANZUPGO
		• Requires clinical review
		
		CIBINQO
		• Requires clinical review
		
		DUPIXENT
		• 1 claim with DUPIXENT in the past 60 days **OR**
		• New starts require clinical review (see manual PA links below)
		  ○ **Allergic Fungal Rhinosinusitis MANUAL PA**
		  ○ **Asthma MANUAL PA**

ADBRY (tralokinumab-ldrm)	CIBINQO (abrocitinib)	
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	

		○ **Atopic Dermatitis MANUAL PA** ○ **Bullous Pemphigoid MANUAL PA** ○ **COPD MANUAL PA** ○ **Chronic Spontaneous Urticaria MANUAL PA** ○ **Eosinophilic Esophagitis MANUAL PA** ○ **Nasal Polyposis MANUAL PA** ○ **Prurigo Nodularis MANUAL PA** **EBGLYSS MANUAL PA** **EUCRISA** • 30 days of therapy with a calcineurin inhibitor or topical steroid in the past 6 months **NEMLUVIO** • Atopic Dermatitis **MANUAL PA** • Prurigo Nodularis **MANUAL PA** **OPZELURA** • 30 days of therapy with pimecrolimus, EUCRISA or tacrolimus in the past 6 months

BETA BLOCKERS, ANTIANGINALS & SINUS NODE AGENTS DUR+

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
ANTIANGINALS		**Non-Preferred Criteria** • Have tried 2 different preferred agents in the past 6 months **OR** • 90 days of therapy with the requested agent in the past 105 days **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
ranolazine ER	ASPRUZYO SPRINKLE (ranolazine)	
	RANEXA (ranolazine ER)	
BETA- AND ALPHA-BLOCKERS		
carvedilol	carvedilol ER	
labetalol	COREG (carvedilol)	
	COREG CR (carvedilol)	
BETA-BLOCKER/DIURETIC COMBINATIONS		
atenolol/chlorthalidone	TENORETIC (atenolol/chlorthalidone)	
bisoprolol/hydrochlorothiazide	ZIAC (bisoprolol/hydrochlorothiazide)	
metoprolol/hydrochlorothiazide		
propranolol/hydrochlorothiazide		
BETA-BLOCKERS		
acebutolol	BETAPACE (sotalol)	
atenolol	BETAPACE AF (sotalol)	
bisoprolol	betaxolol	
HEMANGEOL (propranolol)	BYSTOLIC (nebivolol)	
metoprolol succinate	INDERAL LA (propranolol)	
metoprolol tartrate (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		
SINUS NODE AGENTS		
	CORLANOR (ivabradine)	
	ivabradine	

BILE SALTS

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

BLADDER RELAXANT PREPARATIONS DUR+

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
MYRBETRIQ (mirabegron)	darifenacin ER	**Non-Preferred Criteria** • Have tried 2 different preferred agents in the past 6 months
oxybutynin	DETROL (tolterodine)	
oxybutynin ER	DETROL LA (tolterodine)	
solifenacin	fesoterodine	
	GEMTESA (vibegron)	
	mirabegron ER	
	tolterodine	
	tolterodine ER	
	TOVIAZ (fesoterodine)	
	trospium	
	trospium ER	
	VESICARE (solifenacin)	
	VESICARE LS (solifenacin)	

BONE RESORPTION SUPPRESSION AND RELATED AGENTS

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
BISPHOSPHONATES DUR+		**Non-Preferred Bisphosphonate Criteria** • Documented diagnosis of osteoporosis or osteopenia **AND** • Have tried 2 different preferred agents in the past 6 months **Non-Preferred Others** • Requires clinical review
alendronate tablet	ACTONEL (risedronate)	
ibandronate tablet	alendronate solution	
risedronate	ATELVIA (risedronate)	
	BINOSTO (alendronate)	
	FOSAMAX (alendronate)	
	FOSAMAX PLUS D (alendronate/vitamin D3)	

	ibandronate syringe/vial	
	risedronate DR	
OTHERS		
BILDYOS (denosumab-nxxp)	AUKELSO (denosumab-kyqq)	
BILPREVDA (denosumab-nxxp)	BOMYNTRA (denosumab-bnht)	
ENOBY (denosumab-qbde)	BONSITY (teriparatide)	
FORTEO (teriparatide)	BOSAYA (denosumab-kyqq)	
raloxifene	calcitonin salmon	
XTRENBO (denosumab-qbde)	CONEXXENCE (denosumab-bnht)	
	EVENITY (romosozumab-aqqg)	
	EVISTA (raloxifene)	
	JUBBONTI (denosumab-bbdz)	
	MIACALCIN (calcitonin salmon)	
	OSENVELT (denosumab-bmwo)	
	PROLIA (denosumab)	
	STOBOCLO (denosumab-bmwo)	
	teriparatide	
	TYMLOS (abaloparatide)	
	WYOST (denosumab-bbdz)	
	XGEVA (denosumab)	
BPH AGENTS DUR+		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
5-ALPHA-REDUCTASE INHIBITORS		**CARDURA, FLOMAX, PROSCAR, terazosin, or UROXATRAL Female** • Documented State-accepted diagnosis **Non-Preferred Criteria Male** • Have tried 2 different preferred agents in the past 6 months **OR** • 90 days of therapy with the requested agent in the past 105 days **ENTADFI** • Requires clinical review
dutasteride	AVODART (dutasteride)	
finasteride	ENTADFI (finasteride/tadalafil)	
	PROSCAR (finasteride)	
ALPHA BLOCKERS		
alfuzosin ER	CARDURA (doxazosin)	
doxazosin	CARDURA XL (doxazosin)	
tamsulosin	dutasteride/tamsulosin	
terazosin	FLOMAX (tamsulosin)	
	RAPAFLO (silodosin)	
	silodosin	
PHOSPHODIESTERASE TYPE 5 (PDE5) INHIBITORS		
	CIALIS (tadalafil)	
	tadalafil	
BRONCHODILATORS & COPD AGENTS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**

ANTICHOLINERGIC-BETA AGONIST COMBINATIONS	
ANORO ELLIPTA (umeclidinium/vilanterol)	BEVESPI AEROSPHERE (glycopyrrolate/formoterol)
COMBIVENT RESPIMAT (ipratropium/albuterol)	DUAKLIR PRESSAIR (aclidinium/formoterol)
ipratropium/albuterol	
STIOLTO RESPIMAT (tiotropium/olodaterol)	
ANTICHOLINERGIC-BETA AGONIST-GLUCOCORTICOIDS COMBINATIONS DUR+	
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
SPIRIVA RESPIMAT (tiotropium)	OHTUVAYRE (ensifentrine)
	roflumilast
	tiotropium
	TUDORZA PRESSAIR (aclidinium)
	umeclidinium ellipta
	YUPELRI (revefenacin)
INHALATION SOLUTION DUR+	
albuterol	arformoterol
	BROVANA (arformoterol)
	formoterol, formoterol fumarate
	levalbuterol
	PERFOROMIST (formoterol)
INHALERS, LONG ACTING DUR+	
SEREVENT DISKUS (salmeterol)	
STRIVERDI RESPIMAT (olodaterol)	
INHALERS, SHORT ACTING	
albuterol HFA	levalbuterol HFA
VENTOLIN HFA (albuterol)	PROAIR DIGIHALER (albuterol)
	XOPENEX HFA (levalbuterol)
ORAL	
albuterol IR	albuterol ER

Minimum Age Limit

- **4 years**: SEREVENT, XOPENEX HFA
- **6 years**: SPIRIVA RESPIMAT, XOPENEX Solution
- **18 years**: BROVANA, BREZTRI AEROSPHERE, PERFOROMIST, STRIVERDI RESPIMAT, TRELEGY ELLIPTA

Non-Preferred Criteria

- 1 claim for a preferred agent in the past 6 months **OR**
- 3 claims with the requested agent in the past 105 days

Quantity Limit (per 31 days)

- **10.7 units** BREZTRI AEROSPHERE

BREZTRI AEROSPHERE

- Documented diagnosis of COPD **AND**
- 1 claim with the BREZTRI AEROSPHERE or TRELEGY ELLIPTA in the past 105 days

OR

- Documented diagnosis of COPD **AND**
- 60 days of therapy with a preferred anticholinergic product in the past 90 days **AND**
- 60 days of therapy with a preferred ICS-LABA product in the past 90 days

TRELEGY ELLIPTA

- Documented diagnosis of asthma or COPD **AND**
- 1 claim with the BREZTRI AEROSPHERE or TRELEGY ELLIPTA in the past 105 days

OR

- Documented diagnosis of asthma or COPD **AND**
- 60 days of therapy with a preferred anticholinergic product in the past 90 days **AND**
- 60 days of therapy with a preferred ICS-LABA product in the past 90 days

XOPENEX HFA and Solution

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

terbutaline		

CALCIUM CHANNEL BLOCKERS DUR+

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
LONG-ACTING		**Quantity Limit** (per 21 days) • **252 capsules**: nimodipine • **2520 mL**: nimodipine **Non-Preferred Criteria Long Acting** • Have tried 2 different preferred Long Acting CCB agents in the past 6 months **OR** • 90 days of therapy with the requested agent in the past 105 days **Non-Preferred Criteria Short Acting** • Have tried 2 different preferred Short Acting CCB agents in the past 6 months **OR** • 90 days of therapy with the requested agent in the past 105 days **CARDAMYST, SDAMLO** • Requires clinical review **nimodipine** • Documented diagnosis of subarachnoid hemorrhage in the past 45 days **AND** • Duration of therapy limited to 21 days
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)	
verapamil ER	SULAR (nisoldipine)	
verapamil SR	TIAZAC (diltiazem)	
	verapamil PM	
	VERELAN PM (verapamil)	
SHORT-ACTING		
diltiazem	CARDAMYST (etripamil)	
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.	**Non-Preferred Agents MANUAL PA**
BREAKFAST ESSENTIALS		
BRIGHT BEGINNINGS		
DUOCAL		
ENSURE		
NUTREN		
OSMOLITE		
PEDIASURE		
PROMOD		
RESOURCE		
TWOCAL HN		

CEPHALOSPORINS AND RELATED ANTIBIOTICS (ORAL)

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
BETA LACTAM/BETA-LACTAMASE INHIBITOR COMBINATIONS		**Non-Preferred Criteria All Cephalosporin Generations** • Have tried 2 different preferred agents in the past 6 months **Maximum Age Limit** • **18 years**: cefdinir suspension
amoxicillin/clavulanate	amoxicillin/clavulanate ER	
	AUGMENTIN (amoxicillin/clavulanate)	
CEPHALOSPORINS FIRST GENERATION		
cefadroxil capsule, suspension	cefadroxil tablet	

cephalexin capsule, suspension	cephalexin tablet	
CEPHALOSPORINS SECOND GENERATION		
cefaclor capsule	cefaclor ER	
cefprozil	cefaclor suspension	
cefuroxime		
CEPHALOSPORINS THIRD GENERATION		
cefdinir	cefixime suspension, tablet	
cefixime capsule	SUPRAX (cefixime)	
cefpodoxime		

COLONY STIMULATING FACTORS

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
LONG-ACTING		
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)	
SHORT-ACTING		
NEUPOGEN (filgrastim)	FILKRI (filgrastim-laha)[NR]	
RELEUKO (filgrastim-ayow)	GRANIX (tbo-filgrastim)	
	LEUKINE (sargramostim)	
	NIVESTYM (filgrastim-aafi)	
	NYPOZI (filgrastim-txid)	
	ZARXIO (filgrastim-sndz)	

CYSTIC FIBROSIS AGENTS DUR+

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
PULMOZYME (dornase alfa)	ALYFTREK (vanzacaftor/tezacaftor/deutivacaftor)	**Minimum Age Limit** • **1 month**: KALYDECO granules • **3 months**: PULMOZYME • **1 year**: ORKAMBI • **2 years**: COLY-MYCIN M, TRIKAFTA granules • **6 years**: ALYFTREK, BETHKIS, KALYDECO tablet, KITABIS, SYMDEKO, TOBI, TOBI PODHALER, TRIKAFTA tablet • **7 years**: CAYSTON • **18 years**: BRONCHITOL
tobramycin (generic TOBI)	BETHKIS (tobramycin)	
	BRONCHITOL (mannitol)	
	CAYSTON (aztreonam)	
	colistimethate	
	COLY-MYCIN M (colistin)	
	KALYDECO (ivacaftor)	

	KITABIS (tobramycin)	**Maximum Age Limit** • **2 years**: ORKAMBI 75-94 mg granules • **5 years**: KALYDECO, ORKAMBI 100-125 mg granules, ORKAMBI 200-125 mg granules, TRIKAFTA granules • **11 years**: TRIKAFTA 50-25-37.5 mg tablets **Preferred Agents** • Documented diagnosis of Cystic Fibrosis **OR** • Require clinical review **ALYFTREK MANUAL PA** **KALYDECO MANUAL PA** **ORKAMBI MANUAL PA** **SYMDEKO MANUAL PA** **TOBI PODHALER** Require clinical review **TRIKAFTA MANUAL PA**
	ORKAMBI (lumacaftor/ivacaftor)	
	SYMDEKO (tezacaftor/ivacaftor)	
	TOBI (tobramycin)	
	TOBI PODHALER (tobramycin)	
	tobramycin (generic BETHKIS & KITABIS)	
	TRIKAFTA (elexacaftor/tezacaftor/ivacaftor)	

CYTOKINE & CAM ANTAGONISTS DUR+

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
adalimumab-aaty autoinject	ABRILADA (adalimumab-afzb)	**Non-Preferred Agents** • Require clinical review **IV Administered Agents** • Require clinical review **adalimumab-aaty autoinject, HADLIMA (adalimumab-bwwd), and YUFLYMA (adalimumab-aaty) – Age specific indications:** • Age 2 years and older **AND** • Diagnosis of juvenile idiopathic arthritis (JIA) • Age 6 years and older **AND** • Diagnosis of Crohn's disease (CD) • Age 18 years and older **AND** • Diagnosis of rheumatoid arthritis (RA) **OR** • Diagnosis of plaque psoriasis (PsO) **OR** • Diagnosis of psoriatic arthritis (PsA) **OR** • Diagnosis of ulcerative colitis (UC) **OR** • Diagnosis of hidradenitis suppurativa (HS) **OR** • Diagnosis of ankylosing spondylitis (AS) **OR** • Diagnosis of uveitis (UV) **AVSOLA (infliximab-axxq) – Age specific indications:** • Age 6 years and older **AND** • Diagnosis of Crohn's disease **OR** • Diagnosis of ulcerative colitis • Age 18 years and older **AND**
AVSOLA (infliximab-axxq)	ACTEMRA (tocilizumab)	
CYLTEZO (adalimumab-adbm)	adalimumab-aaty syringe	
ENBREL (etanercept)	adalimumab-adaz	
HADLIMA (adalimumab-bwwd)	adalimumab-adbm	
HUMIRA (adalimumab)	adalimumab-fkjp	
IMULDOSA (ustekinumab-srlf)	adalimumab-ryvk	
KINERET (anakinra)	AMJEVITA (adalimumab-atto)	
methotrexate	ARCALYST (rilonacept)	
OLUMIANT (baricitinib)	AVTOZMA (tocilizumab-anoh)	
ORENCIA CLICKJECT (abatacept)	AVTOZMA AUTOINJECTOR (tocilizumab-anoh)	
ORENCIA VIAL (abatacept)	BIMZELX (bimekizumab-bkzx)	
OTEZLA (apremilast)	CIMZIA (certolizumab)	
PYZCHIVA (ustekinumab-ttwe)	COSENTYX (secukinumab)	
RINVOQ (upadacitinib)	ENTYVIO (vedolizumab)	
RINVOQ LQ (upadacitinib)	HULIO (adalimumab-fkjp)	
SELARSDI (ustekinumab-aekn)	HYRIMOZ (adalimumab-adaz)	
SIMPONI (golimumab)	ICOTYDE (icotrokinra)NR	

STARJEMZA (ustekinumab-hmny)	IDACIO (adalimumab-aacf)	• Diagnosis of rheumatoid arthritis (RA) **OR** • Diagnosis of plaque psoriasis (PsO) **OR** • Diagnosis of psoriatic arthritis (PsA) **OR** • Diagnosis of ankylosing spondylitis (AS) **CYLTEZO (adalimumab-adbm) – Age specific indications:** • Age 2 years and older **AND** • Diagnosis of juvenile idiopathic arthritis (JIA) **OR** • Diagnosis of uveitis (UV) • Age 6 years and older **AND** • Diagnosis of Crohn's disease (CD) • Age 12 years and older **AND** • Diagnosis of hidradenitis suppurativa (HS) • Age 18 years and older **AND** • Diagnosis of rheumatoid arthritis (RA) **OR** • Diagnosis of plaque psoriasis (PsO) **OR** • Diagnosis of psoriatic arthritis (PsA) **OR** • Diagnosis of ulcerative colitis (UC) **OR** • Diagnosis of ankylosing spondylitis (AS) **ENBREL (etanercept) – Age specific indications:** • Age 2 years and older **AND** • Diagnosis of juvenile arthritis (JIA) **OR** • Diagnosis of juvenile psoriatic arthritis (PsA) • Age 4 years and older **AND** • Diagnosis of plaque psoriasis (PsO) • Age 18 years and older **AND** • Diagnosis of rheumatoid arthritis (RA) **OR** • Diagnosis of psoriatic arthritis (PsA) **OR** • Diagnosis of ankylosing spondylitis (AS) **HUMIRA (adalimumab) – Age specific indications:** • Age 2 years and older **AND** • Diagnosis of juvenile idiopathic arthritis (JIA) **OR** • Diagnosis of uveitis (UV) • Age 5 years and older **AND** • Diagnosis of ulcerative colitis (UC) • Age 6 years and older **AND** • Diagnosis of Crohn's disease (CD) • Age 12 years and older **AND** • Diagnosis of hidradenitis suppurativa (HS) • Age 18 years and older **AND** • Diagnosis of rheumatoid arthritis (RA) **OR** • Diagnosis of plaque psoriasis (PsO) **OR** • Diagnosis of psoriatic arthritis (PsA) **OR** • Diagnosis of ankylosing spondylitis (AS)
TALTZ (ixekizumab)	ILARIS (canakinumab)	
TYENNE (tocilizumab-aazg)	ILUMYA (tildrakizumab-asmn)	
ustekinumab-aauz	INFLECTRA (infliximab-dyyb)	
XELJANZ (tofacitinib) tablet	infliximab	
YUFLYMA (adalimumab-aaty)	JYLAMVO (methotrexate)	
	KEVZARA (sarilumab)	
	LEQSELVI (deuruxolitinib)	
	LITFULO (ritlecitinib)	
	OMVOH (mirikizumab-mrkz)	
	ORENCIA SYRINGE (abatacept)	
	OTEZLA XR (apremilast)	
	OTREXUP (methotrexate)	
	OTULFI (ustekinumab-aauz)	
	RASUVO (methotrexate)	
	REMICADE (infliximab)	
	RENFLEXIS (infliximab-abda)	
	SIMLANDI (adalimumab-ryvk)	
	SIMPONI ARIA (golimumab)	
	SKYRIZI (risankizumab-rzaa)	
	SOTYKTU (deucravacitinib)	
	SPEVIGO (spesolimab-sbzo)	
	STELARA (ustekinumab)	
	STEQEYMA (ustekinumab-stba)	
	TOFIDENCE (tocilizumab-bavi)	
	TREMFYA (guselkumab)	
	TREXALL (methotrexate)	
	ustekinumab	
	ustekinumab-aekn	
	ustekinumab-ttwe	
	XATMEP (methotrexate)	
	XELJANZ (tofacitinib) solution	
	XELJANZ XR (tofacitinib)	
	YESINTEK (ustekinumab-kfce)	
	YUSIMRY (adalimumab-aqvh)	
	ZYMFENTRA (infliximab-dyyb)	

		IMULDOSA (ustekinumab-srlf), PYZCHIVA (ustekinumab-ttwe), SELARSDI (ustekinumab-aekn), STARJEMZA (ustekinumab-hmny), and ustekinumab-aauz – 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 ulcerative colitis (UC) **OR** • Diagnosis of Crohn's disease (CD) **KINERET (anakinra) – Age specific indications:** • Age 18 years and older **AND** • Diagnosis of rheumatoid arthritis (RA) • Other indications require clinical review **OLUMIANT (baricitinib) – Age specific indications:** • Age 18 years and older **AND** • Diagnosis of alopecia areata (AA) • Other indications require clinical review **ORENCIA (abatacept) – Age specific indications:** • Age 2 years and older **AND** • Diagnosis of juvenile arthritis (JIA) **OR** • Diagnosis of psoriatic arthritis (PsA) • Other indication requires clinical review • Age 18 years and older **AND** • Diagnosis of rheumatoid arthritis (RA) • Non-preferred Orencia syringe requires clinical review **OTEZLA (apremilast) – Age specific indications:** • Age 6 years and older **AND** • Diagnosis of plaque psoriasis (PsO) **OR** • Diagnosis of psoriatic arthritis (PsA) • Age 18 years and older **AND** • Diagnosis of Bechet's disease • 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: o A different JAK Inhibitor o A different biologic o 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
		• Age 6 **AND**
		• Diagnosis of plaque psoriasis (PsO)
		
		Taltz 80 mg
		• Age 18 years and older **AND**
		• Diagnosis of psoriatic arthritis (PsA) **OR**
		• Diagnosis of ankylosing spondylitis (AS) **OR**
		• Diagnosis of active non-radiographic axial spondyloarthritis (nr-axSpA)
		
		TYENNE (tocilizumab-aazg) – Age specific indications:
		• Age 2 years and older **AND**
		• Diagnosis of juvenile arthritis (JIA)
		
		• Age 18 years and older **AND**
		• Diagnosis of rheumatoid arthritis (RA) **OR**
		• Diagnosis of giant cell arteritis
		
		XELJANZ IR (tofacitinib) – Any of the following:
		• Age 2 year and older **AND**
		• Diagnosis of juvenile arthritis (JIA) **OR**
		• Diagnosis of psoriatic arthritis (PsA)
		
		• Age 18 years and older **AND**
		• Diagnosis of rheumatoid arthritis (RA) **OR**
		• Diagnosis of ulcerative colitis (UC) **OR**

		• Diagnosis of ankylosing spondylitis (AS) • Non-preferred Xeljanz oral solution and Xeljanz XR require clinical review **Preferred methotrexate does not require prior authorization**

ERYTHROPOIESIS STIMULATING PROTEINS DUR+

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

FACTOR DEFICIENCY PRODUCTS DUR+

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
FACTOR VIII		**HEMLIBRA** • 3 claims with HEMLIBRA in the past 105 days **OR** • New starts require clinical review **MANUAL PA**
ADVATE	ADYNOVATE	
AFSTYLA	ELOCTATE	
ALPHANATE	ESPEROCT	
ALTUVIIIO	JIVI	
FEIBA	KCENTRA	
HEMOFIL M	OBIZUR	
HUMATE-P	VONVENDI	
KOATE		
KOGENATE FS		
KOVALTRY		
NOVOEIGHT		
NUWIQ		
RECOMBINATE		
WILATE		
XYNTHA, XYNTHA SOLOFUSE		
FACTOR IX		
ALPHANINE SD	BEQVEZ	
ALPROLIX		
BENEFIX		
IDELVION		
IXINITY		
PROFILNINE		
REBINYN		
RIXUBIS		
OTHER HEMOPHILIA PRODUCTS		
COAGADEX (factor X)	ALHEMO (concizumab-mtci)	
FIBRYGA (fibrinogen)	CORIFACT (factor XIII)	

HEMLIBRA (emicizumab-kxwh) DUR+	FESILTY (fibrinogen)NR	
RIASTAP (fibrinogen)	HYMPAVZI (marstacimab-hncq)	
	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)	**Minimum Age Limit** • **18 years**: CYMBALTA, DRIZALMA SPRINKLE, duloxetine DR capsule **TONMYA MANUAL PA** **RELGAABI** • Requires clinical review
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	
	NEURONTIN (gabapentin)	
	pregabalin ER	
	RELGAABI (gabapentin)	
	TONMYA (cyclobenzaprine)	

FLUOROQUINOLONES DUR+

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA

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

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

GAUCHER'S DISEASE

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA

ELELYSO (taliglucerase alfa)	CERDELGA (eliglustat)	
ZAVESCA (miglustat)	CEREZYME (imiglucerase)	
	miglustat	
	VPRIV (velaglucerase alfa)	
	YARGESA (miglustat)	

GENITAL WARTS & ACTINIC KERATOSIS AGENTS

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
CONDYLOX (podofilox)	VEREGEN (sinecatechins)	**Minimum Age Limit** • **12 years**: ALDARA • **18 years**: CONDYLOX, PICATO, VEREGEN
fluorouracil		
imiquimod		
podofilox		

GI ULCER THERAPIES

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
H2 RECEPTOR ANTAGONISTS		**PRILOSEC 2.5 mg suspension** • Automatic approval issued for 0-2 years of age **PRILOSEC 10 mg suspension** • Requires clinical review
famotidine	cimetidine	
	nizatidine	
	ranitidine	
OTHERS		
CARAFATE (sucralfate) suspension	CARAFATE (sucralfate) tablet	
misoprostol	CYTOTEC (misoprostol)	
sucralfate	DARTISLA (glycopyrrolate)	
	EOHILIA (budesonide)	
	VOQUEZNA (vonoprazan)	
PROTON PUMP INHIBITORS		
esomeprazole capsule	DEXILANT (dexlansoprazole)	
NEXIUM (esomeprazole) packet	dexlansoprazole	
omeprazole	esomeprazole packet	
pantoprazole	KONVOMEP (omeprazole/sodium bicarbonate)	
	lansoprazole Rx	
	NEXIUM (esomeprazole) capsule	
	omeprazole/sodium bicarbonate	
	PREVACID (lansoprazole)	
	PRILOSEC (omeprazole) packet	
	PROTONIX (pantoprazole)	
	rabeprazole	
	ZEGERID (omeprazole/sodium bicarbonate)	

GLUCOCORTICOIDS (INHALED)

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
GLUCOCORTICOIDS		**Non-Preferred Criteria** • **Glucocorticoids** ○ 2 preferred single-entity agents in the past 6 months **OR** ○ 90 days of therapy with the requested agent in the past 105 days • **Glucocorticoid/Bronchodilator Combinations** ○ 2 preferred combination agents in the past 6 months **OR** ○ 90 days of therapy with the requested agent in the past 105 days • **Note**: ○ Institutional-sized products are non-preferred **AIRDUO DIGIHALER** • Requires clinical review **ARMONAIR DIGIHALER** • Requires clinical review **Minimum Age Limit** • **18 years**: AIRSUPRA **Quantity Limit** (per 31 days) • **2 inhalers**: AIRSUPRA **MANUAL PA**
ASMANEX (mometasone)	ALVESCO (ciclesonide)	
budesonide 0.25 mg and 0.5 mg	ARMONAIR DIGIHALER (fluticasone)	
fluticasone	ARNUITY ELLIPTA (fluticasone)	
fluticasone diskus	ASMANEX HFA (mometasone)	
fluticasone HFA	beclomethasone	
QVAR REDIHALER (beclomethasone)	budesonide 1 mg	
	FLOVENT HFA (fluticasone)	
	FLOVENT DISKUS (fluticasone)	
	PULMICORT (budesonide) nebulizer solution	
GLUCOCORTICOID/BRONCHODILATOR COMBINATIONS		
ADVAIR DISKUS (fluticasone/salmeterol)	AIRDUO DIGIHALER (fluticasone/salmeterol)	
ADVAIR HFA (fluticasone/salmeterol)	AIRSUPRA (albuterol/budesonide)	
DULERA (mometasone/formoterol)	BREO ELLIPTA (fluticasone/vilanterol)	
fluticasone/salmeterol diskus	BREYNA (budesonide/formoterol)	
SYMBICORT (budesonide/formoterol)	budesonide/formoterol	
	fluticasone/salmeterol HFA	
	fluticasone/vilanterol	
	WIXELA INHUB (fluticasone/salmeterol)	

GROWTH HORMONES DUR+

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
GENOTROPIN (somatropin)	HUMATROPE (somatropin)	**Preferred Criteria** • **Age ≥ 18 years** • Documented diagnosis of craniopharyngioma, HIV associated cachexia, iatrogenic growth deficiency due to drug-induced or post-procedural hypopituitarism, Noonan Syndrome, panhypopituitarism, Prader-Willi Syndrome, renal function impairment growth disorders, short stature shox deficiency, Turner Syndrome or history of cranial irradiation • **Age < 18 years** • Diagnosis of approvable pediatric diagnosis or history of cranial irradiation **Minimum Age Limit** • **3 years**: NGENLA **Maximum Age Limit** • **18 years**: NGENLA **Non-Preferred Criteria** Age ≥ 18 years
NORDITROPIN FLEXPRO (somatropin)	NGENLA (somatrogon-ghla)	
SKYTROFA (lonapegsomatropin-tcgd)	OMNITROPE (somatropin)	
	SEROSTIM (somatropin)	
	SOGROYA (somapacitan-beco)	
	ZOMACTON (somatropin)	

		• Documented approvable diagnosis for age as above diagnosis of craniopharyngioma, HIV associated cachexia, iatrogenic growth deficiency due to drug-induced or post-procedural hypopituitarism, Noonan Syndrome, panhypopituitarism, Prader-Willi Syndrome, renal function impairment growth disorders, short stature shox deficiency, Turner Syndrome or history of cranial irradiation **AND** • History of 28 days of therapy with a preferred Growth Hormone in the past 6 months **OR** • 84 days of therapy with the requested agent in the past 105 days Age < 18 years • Diagnosis of congenital malformation syndrome, HIV associated cachexia, hypopituitarism, iatrogenic growth deficiency due to drug-induced or post-procedural hypopituitarism, mosaicism 45, Prader-Willi Syndrome, renal function impairment growth disorders, short stature due to endocrine disorder, small for gestational age or Turner Syndrome **AND** • History of 28 days of therapy with a preferred Growth Hormone in the past 6 months **OR** • 84 days of therapy with the requested agent in the past 105 days **SKYTROFA** Age ≥ 18 years • Documented diagnosis of craniopharyngioma, HIV associated cachexia, iatrogenic growth deficiency growth deficiency due to drug-induced or post-procedural hypopituitarism, Noonan Syndrome, panhypopituitarism, renal function impairment growth disorders, short stature shox deficiency, Turner Syndrome or history of cranial irradiation **AND** • No history of diagnosis of Prader Willi Syndrome **AND** • History of 28 days of therapy with a preferred Short-Acting Growth Hormone in the past 6 months **OR** • 84 days of therapy with Skytrofa in the past 105 days Age < 18 years • No history of diagnosis of Prader Willi Syndrome **AND** • History of 28 days of therapy with a preferred Short-Acting Growth Hormone in the past 6 months **OR** • 84 days of therapy with Skytrofa in the past 105 days
H. PYLORI COMBINATION TREATMENTS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
PYLERA (bismuth subcitrate potassium/metronidazole/tetracycline)	bismuth subcitrate potassium/metronidazole/tetracycline	**Quantity Limit** • **1 treatment course/year**: all agents
	lansoprazole/amoxicillin/clarithromycin	
	OMECLAMOX (omeprazole/clarithromycin/amoxicillin)	
	TALICIA (omeprazole/amoxicillin/rifabutin)	
	VOQUEZNA DUAL PAK (vonoprazan/amoxicillin)	
	VOQUEZNA TRIPLE PAK (vonoprazan/amoxicillin/clarithromycin)	
HEPATITIS B TREATMENTS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
entecavir	adefovir dipivoxil	
lamivudine HBV	BARACLUDE (entecavir)	

tenofovir disoproxil fumarate	VEMLIDY (tenofovir alafenamide)	
	VIREAD (tenofovir disoproxil fumarate)	

HEPATITIS C TREATMENTS

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
MAVYRET (glecaprevir/pibrentasvir)	EPCLUSA (sofosbuvir/velpatasvir)	**EPCLUSA, HARVONI, MAVYRET, SOVALDI, VOSEVI, ZEPATIER** • Require **MANUAL PA** Note: • **EPCLUSA, HARVONI, MAVYRET and SOVALDI have FDA-approved pediatric indications**
PEGASYS (peginterferon alfa-2a)	HARVONI (ledipasvir/sofosbuvir)	
ribavirin tablet	ledipasvir/sofosbuvir	
sofosbuvir/velpatasvir	ribavirin capsule	
	SOVALDI (sofosbuvir)	
	VIEKIRA PAK (ombitasvir/paritaprevir/ritonavir)	
	VOSEVI (sofosbuvir/velpatasvir/voxilaprevir)	
	ZEPATIER (elbasvir/grazoprevir)	

HEREDITARY ANGIOEDEMA TREATMENTS

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
PROPHYLAXIS		**Non-Preferred Criteria** • Requires clinical review
HAEGARDA (C1 esterase inhibitor)	ANDEMBRY (garadacimab-gxii)	
	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 DUR+

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
allopurinol	ALOPRIM (allopurinol)	**Non-Preferred Criteria** • Have tried 2 different preferred agents in the past 6 months
colchicine tablet	colchicine capsule	
probenecid	COLCRYS (colchicine)	
probenecid/colchicine	febuxostat	
	GLOPERBA (colchicine)	

	MITIGARE (colchicine)	
	ULORIC (febuxostat)	
	ZYLOPRIM (allopurinol)	

HYPOGLYCEMIA TREATMENT

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
BAQSIMI (glucagon)	GVOKE (glucagon) Step Edit	**Minimum Age Limit** • **1 year**: BAQSIMI • **2 years**: GVOKE • **6 years**: ZEGALOGUE **Quantity Limit** (per 31 days) • **2 packs (or kits)**: BAQSIMI, glucagon, GVOKE, ZEGALOGUE **Non-Preferred Criteria GVOKE** • 1 claim with preferred BAQSIMI or ZEGALOGUE in the past 30 days
GLUCAGEN (glucagon)		
glucagon emergency kit		
glucagon vial		
ZEGALOGUE (dasiglucagon)		

HYPOGLYCEMICS, BIGUANIDES

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
metformin 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 DUR+

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

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
BYETTA (exenatide)	BYDUREON (exenatide)	**Minimum Age Limit** • **10 years**: BYDUREON BCISE, MOUNJARO, TRULICITY, VICTOZA • **18 years**: BYETTA, OZEMPIC, RYBELSUS **Preferred Criteria** • Documented diagnosis of Type 2 Diabetes **AND** • No history of SAXENDA or WEGOVY in the past 30 days **OR** • No documented diagnosis for Type 2 Diabetes **AND** • 84 days of therapy with the requested agent in the past 105 days **Non-Preferred Criteria** • Documented diagnosis of Type 2 Diabetes **AND** • No history of SAXENDA or WEGOVY in the past 30 days **AND** • 84 days of therapy with TRULICITY in the past 6 months **AND** • 84 days of therapy with either preferred BYETTA or VICTOZA in the past 6 months **OR** • Documented diagnosis of Type 2 Diabetes **AND** • 84 days of therapy with the request agent in the past 105 days Note: • Concomitant use of a GLP-1 agonist and a DPP-4 agent requires clinical review. • Please see the PDL category Anti-obesity Select Agents for a list of covered agents. **RYBELSUS 1.5 mg and 3 mg** • Requires clinical review
MOUNJARO (tirzepatide)	exenatide	
TRULICITY (dulaglutide)	liraglutide	
VICTOZA (liraglutide)	OZEMPIC (semaglutide)	
	RYBELSUS (semaglutide)	
	SOLIQUA (insulin glargine/lixisenatide)	
	SYMLINPEN (pramlintide)	
	XULTOPHY (insulin degludec/liraglutide)	

HYPOGLYCEMICS, INSULINS & RELATED AGENTS DUR+

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
HUMALOG MIX 75/25 vial (insulin lispro/lispro protamine)	ADMELOG (insulin lispro)	**Non-Preferred Criteria** • Documented diagnosis of Diabetes Mellitus **AND** • Have tried 1 preferred agent in the past 6 months **OR** • 1 claim with the requested agent in the past 105 days **Quantity Limit** • **Insulin quantity limits can be found here** **Note**: • Insulin pen formulations are not covered for Long Term Care (LTC) beneficiaries. **BASAGLAR**
HUMULIN 70/30 vial (insulin NPH/regular)	AFREZZA (insulin regular)	
HUMULIN N (insulin NPH)	APIDRA (insulin glulisine)	
HUMULIN R (insulin regular)	BASAGLAR (insulin glargine)	
HUMULIN R U-500 (insulin regular)	FIASP (insulin aspart/niacinamide)	
insulin aspart	HUMALOG; HUMALOG JUNIOR, KWIKPEN, TEMPO PEN (insulin lispro)	

insulin aspart protamine mix 70/30 vial	HUMALOG MIX KWIKPEN 50/50, 75/25 (insulin lispro/lispro protamine)	• Requires clinical review
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)	
	MERILOG (insulin aspart-szjj)	
	NOVOLIN 70/30 (insulin NPH/regular)	
	NOVOLIN N (insulin NPH)	
	NOVOLIN R (insulin regular)	
	NOVOLOG (insulin aspart)	
	NOVOLOG MIX 70/30 (insulin aspart protamine/aspart)	
	REZVOGLAR (insulin glargine-aglr)	
	SEMGLEE (insulin glargine-yfgn)	
	TRESIBA (insulin degludec)	
HYPOGLYCEMICS, MEGLITINIDES DUR+		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
nateglinide		
repaglinide		
HYPOGLYCEMICS, SODIUM GLUCOSE COTRANSPORTER-2 (SGLT-2) INHIBITORS DUR+		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
SGLT-2 INHIBITORS		**Non-Preferred Criteria** • Have tried 2 different preferred SGLT-2 inhibitors in the past 6 months **OR** • 90 days of therapy with the requested agent in the past 105 days
FARXIGA (dapagliflozin)	dapagliflozin	
JARDIANCE (empagliflozin)	INPEFA (sotagliflozin)	
	INVOKANA (canagliflozin)	
	STEGLATRO (ertugliflozin)	
SGLT-2 INHIBITOR COMBINATIONS		
GLYXAMBI (empagliflozin/linagliptin)	dapagliflozin/metformin ER	
SYNJARDY (empagliflozin/metformin)	dapagliflozin/saxagliptin	
SYNJARDY XR (empagliflozin/metformin)	INVOKAMET (canagliflozin/metformin)	

TRIJARDY XR (empagliflozin/linagliptin/metformin)	INVOKAMET XR (canagliflozin/metformin)	
	SEGLUROMET (ertugliflozin/metformin)	
	STEGLUJAN (ertugliflozin/sitagliptin)	
	XIGDUO XR (dapagliflozin/metformin)	

HYPOGLYCEMICS, THIAZOLIDINEDIONES (TZDs) and TZD Combinations

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

IDIOPATHIC PULMONARY FIBROSIS DUR+

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
OFEV (nintedanib)	ESBRIET (pirfenidone)	**All Agents** • Documented diagnosis of Idiopathic Pulmonary Fibrosis **OFEV** • Documented diagnosis of Idiopathic Pulmonary Fibrosis, Progressive Pulmonary Fibrosis, or Systemic Sclerosis-associated Interstitial Lung Disease **OR** • 90 days of therapy with Ofev in the past 105 days **pirfenidone** • Documented diagnosis of Idiopathic Pulmonary Fibrosis **OR** • 90 days of therapy with pirfenidone or Esbriet in the past 105 days **ESBRIET, nintedanib** • Requires clinical review **JASCAYD MANUAL PA**
pirfenidone	JASCAYD (nerandomilast)	
	nintedanib	

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	
HIZENTRA	GAMMAKED	
HYQVIA	GAMMAPLEX	
PANZYGA	OCTAGAM	
PRIVIGEN	QIVIGY	
XEMBIFY		

IMMUNOLOGIC THERAPIES FOR ASTHMA

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
DUPIXENT (dupilumab) DUR+	NUCALA (mepolizumab)	**DUPIXENT** • 1 claim with DUPIXENT in the past 60 days **OR** • New starts require clinical review (see manual PA links below) ○ **Allergic Fungal Rhinosinusitis MANUAL PA** ○ **Asthma MANUAL PA** ○ **Atopic Dermatitis MANUAL PA** ○ **Bullous Pemphigoid MANUAL PA** ○ **COPD MANUAL PA** ○ **Chronic Spontaneous Urticaria MANUAL PA** ○ **Eosinophilic Esophagitis MANUAL PA** ○ **Nasal Polyposis MANUAL PA** ○ **Prurigo Nodularis MANUAL PA** **FASENRA** • Requires clinical review **MANUAL PA** **NUCALA** • Requires clinical review **TEZSPIRE** • Requires clinical review **XOLAIR** • 1 claim with XOLAIR in the past 45 days **OR** • New starts require clinical review ○ **Asthma MANUAL PA** ○ **Chronic Spontaneous Urticaria MANUAL PA** ○ **Nasal Polyposis MANUAL PA**
FASENRA (benralizumab)	TEZSPIRE (tezepelumab-ekko)	
XOLAIR (omalizumab)		

IMMUNOSUPPRESSIVE AGENTS, ORAL

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
AZASAN (azathioprine)	ASTAGRAF XL (tacrolimus)	**Minimum Age Limit** • **13 years**: RAPAMUNE • **18 years**: ZORTRESS **Maximum Age Limit** • **12 years**: PROGRAF Granules **Preferred Criteria** • **AZASAN** ○ Documented diagnosis of kidney transplant, RA, or a State-accepted diagnosis • **CELLCEPT** ○ Documented diagnosis of heart, kidney, or liver transplant or a State-accepted diagnosis • **GENGRAF, NEORAL, SANDIMMUNE** ○ Documented diagnosis of heart transplant, kidney transplant, liver transplant, psoriasis, RA, or a State-accepted diagnosis • **everolimus** ○ Documented diagnosis of kidney or liver transplant • **RAPAMUNE** ○ Documented diagnosis of kidney transplant • **tacrolimus**
azathioprine	ENVARSUS XR (tacrolimus)	
CELLCEPT (mycophenolate)	LUPKYNIS (voclosporin)	
cyclosporine	MYFORTIC (mycophenolate)	
everolimus	MYHIBBIN (mycophenolate)	
mycophenolate	PROGRAF (tacrolimus)	
mycophenolic acid	REZUROCK (belumosudil)	
NEORAL (cyclosporine)	tacrolimus XL	
RAPAMUNE (sirolimus)	YULITHIRA (everolimus)NR	
SANDIMMUNE (cyclosporine)	ZORTRESS (everolimus)	
sirolimus		
tacrolimus		

		○ Documented diagnosis of heart, kidney, liver, or lung transplant or a State-accepted diagnosis **Non-Preferred Criteria** • **ASTAGRAF XL or ENVARSUS XR** ○ Documented diagnosis of heart, kidney, liver, or lung transplant or a State-accepted diagnosis **AND** ○ 30 days of therapy with tacrolimus XL in the past 105 days **OR** ○ 90 days of therapy with the requested agent in the past 105 days • **PROGRAF Granules** ○ Age ≤ 11 years **AND** ○ Documented diagnosis of heart, kidney, liver, or lung transplant or a State-accepted diagnosis • **MYFORTIC** ○ Documented diagnosis of kidney transplant or psoriasis • **MYHIBBIN** ○ Documented diagnosis of heart, kidney, or liver transplant or a State-accepted diagnosis **AND** ○ 30 days of therapy with mycophenolate suspension in the past 105 days **OR** ○ 90 days of therapy with MYHIBBIN Suspension in the past 105 days • **tacrolimus XL** ○ Documented diagnosis of heart, kidney, liver, or lung transplant or a State-accepted diagnosis **AND** ○ 30 days of therapy with tacrolimus IR in the past 105 days **OR** ○ 90 days of therapy with the requested agent in the past 105 days • **ZORTRESS** ○ Documented diagnosis of kidney or liver transplant **LUPKYNIS and REZUROCK** • Requires clinical review
INTRANASAL RHINITIS AGENTS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
ANTICHOLINERGICS		**Non-Preferred Criteria Corticosteroids** • Documented diagnosis of allergic rhinitis **AND** • Have tried 1 different preferred agent in the past 6 months
ipratropium		
ANTIHISTAMINE/CORTICOSTEROID COMBINATIONS		
	azelastine/fluticasone	
	DYMISTA (azelastine/fluticasone)	
	RYALTRIS (olopatadine/mometasone)	
ANTIHISTAMINES		
azelastine	olopatadine	
	PATANASE (olopatadine)	
CORTICOSTEROIDS		
fluticasone	BECONASE AQ (beclomethasone)	
NASONEX 24 HOUR ALLERGY SPRAY OTC	flunisolide	
	mometasone	
	NASONEX (mometasone)	
	OMNARIS (ciclesonide)	
	QNASL (beclomethasone)	
	XHANCE (fluticasone)	
	ZETONNA (ciclesonide)	
IRON CHELATING AGENTS		

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
deferasirox (all manufacturers except those listed as non-preferred)	deferasirox (manufacturers starting with 45963, 62332)	**JADENU and JADENU SPRINKLE MANUAL PA**
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 DUR+		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
IRRITABLE BOWEL SYNDROME CONSTIPATION DUR+		**Minimum Age Limit** • **1 year**: GATTEX • **6 years**: LINZESS 72 mcg • **7 years**: LINZESS 145 mcg • **18 years**: AMITIZA, IBSRELA, LINZESS 290 mcg, MOTEGRITY, MOVANTIK, MYTESI, SYMPROIC, VIBERZI **Gender Limit** • **Female** AMITIZA 8 mcg
LINZESS (linaclotide)	AMITIZA (lubiprostone)	
lubiprostone	IBSRELA (tenapanor)	
	MOTEGRITY (prucalopride)	
	MOVANTIK (naloxegol)	
	prucalopride	
	SYMPROIC (naldemedine)	
IRRITABLE BOWEL SYNDROME DIARRHEA		
dicyclomine	alosetron	
ED-SPAZ (hyoscyamine)	LOTRONEX (alosetron) DUR+	
hyoscyamine, hyoscyamine ER	VIBERZI (eluxadoline) DUR+	
HYOSYNE (hyoscyamine)		
LEVSIN, LEVSIN-SL (hyoscyamine)		
NULEV (hyoscyamine)		
OSCIMIN, OSCIMIN SL (hyoscyamine)		
SHORT BOWEL SYNDROME AND SELECTED GI AGENTS DUR+		
	GATTEX (teduglutide)	
	MYTESI (crofelemer)	
IRRITABLE BOWEL SYNDROME CONSTIPATION DUR+		
Chronic Idiopathic Constipation (CIC): Amitiza 24 mcg, LINZESS, MOTEGRITY • **LINZESS 72 mcg** ○ Age 6-17 years **AND** ○ Documented diagnosis pediatric functional constipation in the past year **AND** ○ No history of GI or bowel obstruction **OR**	**Irritable Bowel Syndrome Constipation Dominant (IBS-C):** AMITIZA 8 mcg, IBSRELA, LINZESS 290 mcg • **Preferred IBS-C Agents** ○ Documented diagnosis of IBS-C in the past year **AND** ○ No history of GI or bowel obstruction • **Non-Preferred IBS-C Agents**	**Opioid Induced Constipation (OIC):** AMITIZA 24 mcg, MOVANTIK, SYMPROIC • **Preferred OIC Agents** ○ Documented diagnosis of OIC **and** chronic pain in the past year **AND** ○ No history of GI or bowel obstruction **AND** ○ 1 claim for an opioid in the past 30 days • **Non-Preferred OIC Agents** ○ All preferred criteria met **AND** ○ Have tried 1 preferred OIC agents in the past 6 months **OR** ○ 1 claim with the requested agent in the past 105 days

○ Age 18 years or older **AND** ○ Documented diagnosis of CIC in the past year **AND** ○ No history of GI or bowel obstruction • **LINZESS 145 mcg and lubiprostone 24 mcg** ○ Age 18 years or older **AND** ○ Documented diagnosis of CIC in the past year **AND** ○ No history of GI or bowel obstruction • **LINZESS 290 mcg** ○ Age 18 years or older **AND** ○ Documented diagnosis of CIC in the past year **AND** ○ No history of GI or bowel obstruction **AND** ○ 1 claim with LINZESS 145 mcg in the past 45 days • **Non-Preferred CIC Agents** ○ Documented diagnosis of CIC **AND** ○ No history of GI or bowel obstruction **AND** ○ Have tried 2 preferred CIC agents in the past 6 months **OR** ○ 1 claim with the requested agent in the past 105 days	○ Documented diagnosis of IBS-C in the past year **AND** ○ No history of GI or bowel obstruction **AND** ○ Have tried 2 preferred IBS-C agents in the past 6 months **OR** ○ 1 claim with the requested agent in the past 105 days	

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 DUR+

HIV/AIDS Non-infectious Diarrhea	Short Bowel Syndrome (SBS)
• **MYTESI** ○ Documented diagnosis of HIV/AIDS **and** non-infectious diarrhea in the past year **AND**	• **GATTEX** ○ 1 claim for GATTEX in the past 105 days **OR** ○ New starts require clinical review

○ 1 claim for an antiretroviral in the past 30 days	

LEUKOTRIENE MODIFIERS DUR+

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

LIPOTROPICS, OTHER (NON-STATINS)

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
ACL INHIBITORS AND COMBINATIONS		**JUXTAPID MANUAL PA** **KYNAMRO** • Requires clinical review **LEQVIO** • Requires clinical review **NEXLETOL and NEXLIZET** • Require clinical review **PRALUENT MANUAL PA** **REPATHA MANUAL PA** **WELCHOL** • Documented diagnosis of Type 2 Diabetes **AND** • 30 days of therapy with an antidiabetic agent in the past 6 months **OR** • 90 days of therapy with WELCHOL in the past 105 days
	NEXLETOL (bempedoic acid)	
	NEXLIZET (bempedoic acid/ezetimibe)	
ANGIOPOIETIN-LIKE 3 INHIBITORS		
	EVKEEZA (evinacumab-dgnb)	
BILE ACID SEQUESTRANTS		
cholestyramine	colesevelam	
cholestyramine light	COLESTID (colestipol)	
colestipol tablet	colestipol packet	
	PREVALITE (cholestyramine)	
	QUESTRAN (cholestyramine)	
	QUESTRAN LIGHT (cholestyramine)	
	WELCHOL (colesevelam)	
CHOLESTEROL ABSORPTION INHIBITORS		
ezetimibe	ZETIA (ezetimibe)	
FIBRIC ACID DERIVATIVES		
fenofibrate	fenofibric acid	
gemfibrozil	FENOGLIDE (fenofibrate)	
	FIBRICOR (fenofibric acid)	
	LIPOFEN (fenofibrate)	
	LOPID (gemfibrozil)	
	TRICOR (fenofibrate)	
	TRILIPIX (fenofibric acid)	
MTP INHIBITOR		
	JUXTAPID (lomitapide)	
NIACIN		
niacin ER	niacin	
OMEGA-3 FATTY ACIDS		
omega-3 acid ethyl esters	icosapent ethyl	
	LOVAZA (omega-3 acid ethyl esters)	
PCSK-9 INHIBITORS		

REPATHA (evolocumab)	LEQVIO (inclisiran)	
	PRALUENT (alirocumab)	

LIPOTROPICS, STATINS

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
STATINS DUR+		**Minimum Age Limit** • **10 years**: ATORVALIQ Suspension **Non-Preferred Criteria Statins** • Have tried 2 different preferred statin or statin combination agents in the past 6 months **OR** • 90 days of therapy with the requested agent in the past 105 days **Simvastatin** • Daily doses ≥ 80 mg require clinical review
atorvastatin	ALTOPREV (lovastatin)	
lovastatin	ATORVALIQ (atorvastatin)	
pravastatin	CRESTOR (rosuvastatin)	
rosuvastatin	EZALLOR SPRINKLE (rosuvastatin)	
simvastatin	FLOLIPID (simvastatin)	
	fluvastatin	
	fluvastatin ER	
	LESCOL XL (fluvastatin)	
	LIPITOR (atorvastatin)	
	LIVALO (pitavastatin)	
	pitavastatin	
	ZOCOR (simvastatin)	
	ZYPITAMAG (pitavastatin)	
STATIN COMBINATIONS		
ezetimibe/simvastatin	amlodipine/atorvastatin	
	CADUET (amlodipine/atorvastatin)	
	VYTORIN (ezetimibe/simvastatin)	

MISCELLANEOUS BRAND/GENERIC

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
ALLERGEN EXTRACT IMMUNOTHERAPY		**CUMULATIVE Quantity Limit** (per 31 days) • **31 tablets**: alprazolam ER **Quantity Limit** (per 31 days) • **2 kits**: epinephrine **EVRYSDI MANUAL PA** **PALSONIFY MANUAL PA** **RHAPSIDO MANUAL PA** ***The Miscellaneous subclass contains drugs that do not belong to any PDL drug classes. A non-preferred drug in this subclass may not require a documented history of preferred agents within the Miscellaneous subclass except for a brand name product with a generic equivalent.**
	GRASTEK	
	ORALAIR	
	RAGWITEK	
ANXIOLYTICS		
alprazolam	alprazolam ER	
hydroxyzine HCL	VISTARIL (hydroxyzine pamoate)	
hydroxyzine pamoate	XANAX, XANAX XR (alprazolam)	
EPINEPHRINE		
epinephrine (Mylan)	AUVI-Q (epinephrine)	
	epinephrine (all other manufacturers)	
	EPIPEN (epinephrine)	
	EPIPEN JR (epinephrine)	
	NEFFY (epinephrine)	
FAMILIAL CHYLOMICRONEMIA SYNDROME		
	REDEMPLO (plozasiran sodium)	
	TRYNGOLZA (olezarsen)	
MISCELLANEOUS*		

megestrol	BLUJEPA (gepotidacin)	
REVLIMID (lenalidomide)	BRINSUPRI (brensocatib)	
	CAMZYOS (mavacamten)	
	CRENESSITY (crinecerfont)	
	ERGOMAR (ergotamine)	
	EVRYSDI (risdiplam)	
	HARLIKU (nitisinone)	
	KORLYM (mifepristone)	
	lenalidomide	
	MYQORZO (aficamten)	
	PALSONIFY (paltusotine)	
	pomalidomide	
	POMALYST (pomalidomide)	
	RHAPSIDO (remibrutinib)	
	TARPEYO (budesonide)	
	VERQUVO (vericiguat)	
SUBLINGUAL NITROGLYCERIN		
nitroglycerin		
NITROLINGUAL (nitroglycerin)		
NITROSTAT (nitroglycerin)		

MOVEMENT DISORDER AGENTS DUR+

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
AUSTEDO (deutetrabenazine)	INGREZZA INITIATION PACK (valbenazine)	**AUSTEDO and AUSTEDO XR** • Documented diagnosis of Huntington's chorea **AND** • 30 days of therapy with tetrabenazine in the past 180 days **OR** • 90 days of therapy with either agent in the past 105 days • Documented diagnosis of tardive dyskinesia **AND** • 90 days of therapy with either agent in the past 105 days **OR** • New starts require clinical review **MANUAL PA** **INGREZZA and INGREZZA SPRINKLE** • Documented diagnosis of Huntington's chorea **AND** • 30 days of therapy with tetrabenazine in the past 180 days **OR** • 90 days of therapy with the requested agent in the past 105 days • Documented diagnosis of tardive dyskinesia **AND** • 90 days of therapy with the requested agent in the past 105 days **OR** • New starts require clinical review **MANUAL PA**
AUSTEDO XR (deutetrabenazine)	XENAZINE (tetrabenazine)	
INGREZZA (valbenazine)		
INGREZZA SPRINKLE (valbenazine)		
tetrabenazine		

MULTIPLE SCLEROSIS AGENTS DUR+

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
HIGHLY ACTIVE		**Preferred Agents** • Documented diagnosis of multiple sclerosis **Preferred Agents** • Documented diagnosis of multiple sclerosis
TYSABRI (natalizumab)	BRIUMVI (ublituximab-xiiy)	
	cladribine	
	KESIMPTA PEN (ofatumumab)	
	MAVENCLAD (cladribine)	
	OCREVUS (ocrelizumab)	

	OCREVUS ZUNOVO (ocrelizumab/hyaluronidase-ocsq)	**Non-Preferred Criteria (Highly Active)** • Requires clinical review **Non-Preferred Criteria (Mildly Active)** • Documented diagnosis of multiple sclerosis **AND** • Have tried 2 different preferred agents in the past 6 months **OR** • 3 claims with the requested agent in the last 105 days **GILENYA, KESIMPTA, PONVORY, TASCENSO ODT, and ZEPOSIA** • Requires clinical review **cladribine and MAVENCLAD MANUAL PA** **MAYZENT MANUAL PA** **OCREVUS and OCREVUS ZUNOVO MANUAL PA**
	TYRUKO (natalizumab-sztn)	
MODERATELY ACTIVE		
fingolimod	GILENYA (fingolimod)	
	MAYZENT (siponimod)	
	PONVORY (ponesimod)	
	TASCENSO ODT (fingolimod)	
	ZEPOSIA (ozanimod)	
MILDLY ACTIVE		
BETASERON (interferon beta-1b)	AMPYRA (dalfampridine)	
COPAXONE (glatiramer) 20 mg	AUBAGIO (teriflunomide)	
dalfampridine ER	AVONEX (interferon beta-1a)	
dimethyl fumarate	BAFIERTAM (monomethyl fumarate)	
REBIF (interferon beta-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)	**AGAMREE MANUAL PA** **AMONDYS-45 MANUAL PA** **DUVYZAT MANUAL PA** **ELEVIDYS MANUAL PA** **EMFLAZA MANUAL PA** **EXONDYS MANUAL PA** **JAYTHARI MANUAL PA** **KYMBEE MANUAL PA** **VILTEPSO MANUAL PA** **VYONDYS MANUAL PA**
	AMONDYS-45 (casimersen)	
	deflazacort	
	DUVYZAT (givinostat)	
	ELEVIDYS (delandistrogene moxeparvovec-rokl)	
	EXONDYS-51 (eteplirsen)	
	JAYTHARI (deflazacort)	
	KYMBEE (deflazacort)	
	VILTEPSO (viltolarsen)	
	VYONDYS-53 (golodirsen)	

NSAIDS

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
COX II SELECTIVE		**Quantity Limit** (per 31 days) • **20 tablets**: ketorolac tablets **Non-Preferred Criteria** • Requires clinical review
CELEBREX (celecoxib)	ELYXYB (celecoxib)	
celecoxib	meloxicam capsule	
meloxicam tablet	VYSCOXA (celecoxib)	
	ZYBIC (meloxicam)	
NON-SELECTIVE		
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	ibuprofen 300 mg	
ketorolac	indomethacin suppository	
nabumetone	ketoprofen	
naproxen 250 mg, 500 mg	LOFENA (diclofenac potassium)	
piroxicam	meclofenamate	
sulindac	mefenamic acid	
	NALFON (fenoprofen)	
	NAPRELAN (naproxen)	
	NAPROSYN 375 mg (naproxen)	
	naproxen 375 mg, naproxen CR 375 mg, naproxen ER 500 mg	
	ORUDIS (ketoprofen)	
	oxaprozin	
	RELAFEN DS (nabumetone)	
	TOLECTIN (tolmetin)	
	tolmetin	
NSAID/GI PROTECTANT COMBINATIONS		
	ARTHROTEC 50 mg, 75 mg (diclofenac/misoprostol)	
	diclofenac/misoprostol	
	ibuprofen/famotidine	
	naproxen/esomeprazole	
	VIMOVO (naproxen/esomeprazole)	

OPHTHALMIC AGENTS

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
ANTIBIOTICS		**Minimum Age Limit** • **16 years**: RESTASIS • **17 years**: XIIDRA
bacitracin/polymyxin	AZASITE (azithromycin)	
ciprofloxacin	bacitracin	

erythromycin	besifloxacin
gentamicin	BESIVANCE (besifloxacin)
moxifloxacin	CILOXAN (ciprofloxacin)
ofloxacin	gatifloxacin
polymyxin B/trimethoprim	NATACYN (natamycin)
tobramycin	neomycin/bacitracin/polymyxin
	OCUFLOX (ofloxacin)
	sulfacetamide
	TOBREX (tobramycin)
	VIGAMOX (moxifloxacin)
ANTIBIOTIC-STEROID COMBINATIONS	
BLEPHAMIDE S.O.P. (sulfacetamide/prednisolone)	MAXITROL (neomycin/polymyxin/dexamethasone)
neomycin/bacitracin/polymyxin/hydrocortisone	neomycin/polymyxin/gramicidin
neomycin/polymyxin/dexamethasone	TOBRADEX ST (tobramycin/dexamethasone)
PRED-G (gentamicin/prednisolone)	tobramycin/loteprednol
sulfacetamide/prednisolone	
TOBRADEX (tobramycin/dexamethasone)	
tobramycin/dexamethasone	
ZYLET (tobramycin/loteprednol)	
ANTI-INFLAMMATORY AGENTS[DUR+]	
dexamethasone	ACULAR, ACULAR LS (ketorolac)
diclofenac sodium	ACUVAIL (ketorolac)
difluprednate	bromfenac
FLAREX (fluorometholone)	BROMSITE (bromfenac)
fluorometholone	BYQLOVI (clobetasol)
flurbiprofen	DUREZOL (difluprednate)
FML FORTE (fluorometholone)	FML (fluorometholone)
ketorolac	ILEVRO (nepafenac)
MAXIDEX (dexamethasone)	INVELTYS (loteprednol)
PRED MILD (prednisolone)	LOTEMAX, LOTEMAX SM (loteprednol)
prednisolone acetate	loteprednol
prednisolone sodium phosphate	NEVANAC (nepafenac)
	PRED FORTE (prednisolone)
	PROLENSA (bromfenac)
DRY EYE AGENTS	
EYSUVIS (loteprednol)	CEQUA (cyclosporine)
RESTASIS Droperette (cyclosporine)	cyclosporine

- **18 years**: CEQUA, EYSUVIS, MIEBO, TRYPTYR, VEVYE

Quantity Limit (per 31 days)
- **2 mL**: VEVYE
- **3 mL**: MIEBO
- **5.5 mL**: RESTASIS Multidose
- **8.3 mL**: EYSUVIS
- **60 units**: CEQUA, RESTASIS Droperette, TRYPTYR, XIIDRA
- **1 bottle (150 mL)**: diclofenac 1.5% solution

Non-Preferred Criteria
- **Anti-Inflammatory Agents**
  - Have tried 2 different preferred agents in the past 6 months
- **Dry Eye Agents**
  - History of 1 claim for both RESTASIS Droperette and XIIDRA in the past 6 months

BYQLOVI, MIEBO, RESTASIS Multidose, TRYPTYR, TYRVAYA, VEVYE
- Requires clinical review

XIIDRA (lifitegrast)	MIEBO (perfluorohexyloactane)	
	RESTASIS Multidose (cyclosporine)	
	TYRVAYA (varenicline)	
	VEVYE (cyclosporine)	

OPHTHALMIC, GLAUCOMA AGENTS

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

OPHTHALMICS FOR ALLERGIC CONJUNCTIVITIS

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

OPIATE DEPENDENCE TREATMENTS

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

OTIC ANTIBIOTICS

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
CIPRO HC (ciprofloxacin/hydrocortisone)	ciprofloxacin	**Maximum Age Limit** • **9 years**: CIPRO HC and ciprofloxacin/hydrocortisone **Ciprofloxacin/Dexamethasone Suspension Criteria** • Age ≥ 6 months **AND** • Experiencing otorrhea secondary to recent, post-tympanostomy tube placement **AND** • Continued otorrhea after 10 days of otic treatment with ciprofloxacin ophthalmic solution **and** dexamethasone ophthalmic suspension
CORTISPORIN-TC (neomycin/colistin/hydrocortisone)	ciprofloxacin/dexamethasone	
fluocinolone	ciprofloxacin/fluocinolone	
neomycin/polymyxin/hydrocortisone	ciprofloxacin/hydrocortisone	
	DERMOTIC (fluocinolone)	
	FLAC OTIC OIL (fluocinolone)	
	hydrocortisone/acetic acid	

	OTOVEL (ciprofloxacin/fluocinolone)	

PANCREATIC ENZYMES

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
CREON (lipase/protease/amylase)	VIOKACE (lipase/protease/amylase)	**Non-Preferred Criteria** • 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)	
	RENVELA (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)	**Non-Preferred Criteria** • Documented diagnosis **AND** • Have tried 2 different preferred agents in the past 6 months **OR** • 90 days of therapy with the requested agent in the past 105 days **ZONTIVITY MANUAL PA**
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)	
	DOPTELET SPRINKLE (avatrombopag maleate)	
	MULPLETA (lusutrombopag)	
	PROMACTA (eltrombopag) packet	
	TAVALISSE (fostamatinib)	

POTASSIUM REMOVING AGENTS

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

PRENATAL VITAMINS

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
CLASSIC PRENATAL	All prenatal vitamins are non-preferred except for those specifically indicated as preferred.	List of Preferred NDC's for Prenatal Vitamins can be found **here**
COMPLETE NATAL DHA		
COMPLETENATE		
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		

PSEUDOBULBAR AFFECT AGENTS

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	NUEDEXTA (dextromethorphan/quinidine)	**Non-Preferred Criteria** • Documented diagnosis of pseudobulbar affect disorder **OR** • 90 days of therapy with NUEDEXTA in the past 105 days

PULMONARY ANTIHYPERTENSIVE AGENTS

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
ACTIVIN SIGNALING INHIBITORS		**Minimum Age Limit** • **18 years**: ADEMPAS, OPSYNVI, TADLIQ **Maximum Age Limit** • **12 years**: REVATIO suspension **Preferred Criteria** • **PAH Agents** ○ Documented diagnosis of pulmonary hypertension • **Sildenafil tablets** ○ ≤ 1 year of age **and** documented diagnosis of pulmonary hypertension, patent ductus arteriosus, or persistent fetal circulation **OR** ○ ≥ 1 year of age **and** documented diagnosis of pulmonary hypertension **OR** ○ 90 days of therapy with the requested agent in the past 105 days • **Sildenafil suspension** • < 12 years of age **AND** • Documented diagnosis of pulmonary hypertension, patent ductus arteriosus, or persistent fetal circulation, or a history of a heart transplant **OR** • 90 days stable therapy with sildenafil suspension in the past 105 days **Non-Preferred Criteria** • Documented diagnosis of pulmonary hypertension **AND** • Have tried 1 preferred PAH agent in the past 6 months **OR** • 90 days of therapy with the requested agent in the past 105 days **OPSUMIT, OPSYNVI, ORENITRAM ER, TYVASO, and VENTAVIS** • Require clinical review
	WINREVAIR (sotatercept-csrk)	
COMBINATION AGENTS		
	OPSYNVI (macitentan/tadalafil)	
ENDOTHELIN RECEPTOR ANTAGONISTS		
ambrisentan	macitentan[NR]	
bosentan	OPSUMIT (macitentan)	
LETAIRIS (ambrisentan)	TRACLEER (bosentan)	
	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)	

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

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

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

ROSACEA TREATMENTS

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

SEDATIVE HYPNOTIC AGENTS

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
BENZODIAZEPINES DUR+		**MS DOM Opioid Initiative Criteria details found here** • Concomitant use of Opioids and Benzodiazepines **Maximum Age Limit** • **64 years**: zolpidem 7.5 mg, 10 mg, and 12.5 mg
estazolam	flurazepam	
temazepam 15 mg, 30 mg capsule	HALCION (triazolam)	
	quazepam	
	RESTORIL (temazepam)	

	temazepam 7.5 mg, 22.5 mg capsule	**Gender and Dose Limit** • **Female**: AMBIEN 5 mg, AMBIEN CR 6.25 mg, INTERMEZZO 1.75 mg • **Male**: all strengths of zolpidem **Non-Preferred Criteria** • Have tried 2 different preferred agents in the past 6 months **HETLIOZ capsules** • Age 18 years or older **AND** • Documented diagnosis of circadian rhythm sleep disorder OR • Age 16 years and older **AND** • Documented diagnosis of Smith-Magenis syndrome **HETLIOZ liquid** • Age 3-15 years **AND** • Documented diagnosis of Smith-Magenis syndrome Note: • Single-source benzodiazepines and barbiturates are NOT covered. ○ PA s will NOT be issued for these drugs. See below for additional PA Criteria/DUR+ Rules
	triazolam	
OTHERS DUR+		
eszopiclone	AMBIEN (zolpidem)	
ramelteon	AMBIEN CR (zolpidem)	
zaleplon	BELSOMRA (suvorexant)	
zolpidem tablet	DAYVIGO (lemborexant)	
	doxepin	
	EDULAR (zolpidem)	
	HETLIOZ LQ (tasimelteon)	
	LUNESTA (eszopiclone)	
	QUVIVIQ (daridorexant)	
	ROZEREM (ramelteon)	
	tasimelteon	
	zolpidem capsule	
	zolpidem sublingual tablet	
	zolpidem ER	

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

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

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

CUMULATIVE Quantity Limit HETLIOZ LQ
- **1 bottle (48 mL or 158 mL)**: Quantity limit per rolling days for all strengths. DUR+ will allow an early refill override for one dose or therapy change per year.

CUMULATIVE Quantity Limit ZOLPIMIST
- **1 canister/31 days**: male; Quantity limit per rolling days for all strengths. DUR+ will allow an early refill override for one dose or therapy change per year.
- **1 canister/62 days:** female; Quantity limit per rolling days for all strengths. DUR+ will allow an early refill override for one dose or therapy change per year.

SELECT CONTRACEPTIVE PRODUCTS

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

ORAL CONTRACEPTIVES DUR+		
All oral contraceptives are preferred except for those specifically indicated as non-preferred.	AMETHIA (levonorgestrel/ethinyl estradiol)	
	AMETHYST (levonorgestrel/ethinyl estradiol)	
	BALCOLTRA (levonorgestrel/ethinyl estradiol)	
	BEYAZ (drospirenone/ethinyl estradiol/levomefolate)	
	CAMRESE (levonorgestrel/ethinyl estradiol)	
	CAMRESE LO (levonorgestrel/ethinyl estradiol)	
	JOLESSA (levonorgestrel/ethinyl estradiol)	
	LO LOESTRIN FE (norethindrone/ethinyl estradiol/iron)	
	LOESTRIN (norethindrone/ethinyl estradiol)	
	LOESTRIN FE (norethindrone/ethinyl estradiol/iron)	
	MINZOYA (levonorgestrel/ethinyl estradiol/iron)	
	NATAZIA (estradiol valerate/dienogest)	
	NEXTSTELLIS (drospirenone/estetrol)	
	OCELLA (ethinyl estradiol/drospirenone)	
	SAFYRAL (drospirenone/ethinyl estradiol/levomefolate)	
	SIMPESSE (levonorgestrel/ethinyl estradiol)	
	TAYTULLA (norethindrone/ethinyl estradiol/iron)	
	TYDEMY (drospirenone/ethinyl estradiol/levomefolate)	
	YASMIN (ethinyl estradiol/drospirenone)	
	YAZ (ethinyl estradiol/drospirenone)	

TRANSDERMAL CONTRACEPTIVES		
TWIRLA (levonorgestrel/ethinyl estradiol)	norelgestromin/ethinyl estradiol	
XULANE (norelgestromin/ethinyl estradiol)		
ZAFEMY (norelgestromin/ethinyl estradiol)		

SICKLE CELL AGENTS

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

SKELETAL MUSCLE RELAXANTS DUR+

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
baclofen 5 mg, 10 mg, 20 mg tablet	AMRIX (cyclobenzaprine)	**Quantity Limit** • **84 tablets/180 days**: carisoprodol **Non-Preferred Criteria** • Documented diagnosis of an approvable indication **AND** • Have tried 2 different preferred agents in the past 6 months **Baclofen granules, solution, and suspension** • Require clinical review. **Carisoprodol** • Documented diagnosis of acute musculoskeletal condition **AND** • No history with meprobamate in the past 105 days **AND** • History of 1 claim for cyclobenzaprine in the past 21 days **AMRIX, ATMEKSI, cyclobenzaprine ER, metaxalone 640 mg, ONTRALFY, TANLOR, and tizanidine capsules** • Requires clinical review
chlorzoxazone	ATMEKSI (methocarbamol suspension)	
cyclobenzaprine 5 mg, 10 mg tablet	baclofen 15 mg tablet	
methocarbamol	baclofen suspension	
tizanidine tablet	carisoprodol	
	carisoprodol/aspirin	
	cyclobenzaprine 7.5 mg tablet	
	cyclobenzaprine ER	
	DANTRIUM (dantrolene)	
	dantrolene	
	FEXMID (cyclobenzaprine)	
	FLEQSUVY (baclofen)	
	LORZONE (chlorzoxazone)	
	LYVISPAH (baclofen)	
	metaxalone	
	NORGESIC (orphenadrine/aspirin/caffeine)	
	NORGESIC FORTE (orphenadrine/aspirin/caffeine)	
	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
NICOTINE TYPE		**Minimum Age Limit** • **18 years**: CHANTIX **Quantity Limit** • **336 tablets/year**: CHANTIX 0.5 mg tabs, 1 mg tabs, and continuing pack • **2 treatment courses/year**: CHANTIX Starter Pack
nicotine gum OTC	NICOTROL INHALER CARTRIDGE	
nicotine lozenge OTC	NICOTROL NASAL SPRAY	
nicotine patch OTC		
NON-NICOTINE TYPE		
bupropion SR		
CHANTIX (varenicline)		
varenicline		

STEROIDS (TOPICAL) DUR+

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
LOW POTENCY		**Non-Preferred Criteria** • **Low Potency** ○ Have tried 2 different preferred low potency agents in the past 6 months • **Medium Potency** ○ Have tried 2 different preferred medium potency agents in the past 6 months • **High Potency** ○ Have tried 2 different preferred high potency agents in the past 6 months • **Very High Potency** ○ Have tried 2 different preferred very high potency agents in the past 6 months **amcinonide, clobetasol 0.025%, hydrocortisone 2% gel, HYDROXYM, MICORT-HC, PROCTOCORT** • Requires clinical review.
alclometasone	fluocinolone	
DERMA-SMOOTHE-FS (fluocinolone)	hydrocortisone gel, lotion	
desonide	HYDROXYM (hydrocortisone)	
hydrocortisone cream, ointment, solution	MICORT-HC (hydrocortisone)	
	PROCTOCORT (hydrocortisone)	
MEDIUM POTENCY		
fluticasone	BESER (fluticasone)	
mometasone	CAPEX (fluocinolone)	
PANDEL (hydrocortisone probutate)	clocortolone	
prednicarbate cream	CLODERM (clocortolone)	
	flurandrenolide	
	fluticasone lotion	
	LOCOID (hydrocortisone butyrate)	
	prednicarbate ointment	
	SYNALAR (fluocinolone)	
HIGH POTENCY		
betamethasone dipropionate cream, lotion	amcinonide	
betamethasone dipropionate augmented	betamethasone dipropionate ointment	
betamethasone valerate	desoximetasone	

fluocinolone	diflorasone
fluocinonide	Halcinonide
fluocinonide-E	HALOG (halcinonide)
triamcinolone cream, ointment, lotion	KENALOG (triamcinolone)
	TOPICORT (desoximetasone)
	triamcinolone spray
VERY HIGH POTENCY	
clobetasol cream, foam, gel, ointment, shampoo, solution	APEXICON E (diflorasone)
clobetasol-E	clobetasol emulsion
halobetasol 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)

STIMULANTS AND RELATED AGENTS DUR+

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
SHORT-ACTING		**Minimum Age Limit** • **3 years**: ADDERALL, EVEKEO, PROCENTRA, ZENZEDI • **6 years**: ADDERALL XR, ADHANSIA XR, ADZENYS ER SUSPENSION, ADZENYS XR ODT, APTENSIO XR, ARYNTA, 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 • **7 years**: XYREM • **13 years**: MYDAYIS • **16 years**: modafinil • **18 years**: armodafinil, SUNOSI **Maximum Age Limit** • **18 years**: clonidine ER, COTEMPLA XR ODT, DAYTRANA, EVEKEO ODT, guanfacine ER **Quantity Limit Stimulants** (per 31 days) • **31 tablets**: ADDERALL XR, ADHANSIA XR, ADZENYS XR ODT, APTENSIO XR, AZSTARYS, CONCERTA ER 18, 27, & 54 mg, COTEMPLA XR-ODT 8.6 mg, DAYTRANA, DEXEDRINE Spansule, DYANAVEL XR Tablet, FOCALIN XR, JORNAY PM, METADATE CD, METHYLIN ER, MYDAYIS 37.5 mg & 50 mg, QUILLICHEW, RELEXXII ER, RITALIN LA & SR, VYVANSE, XELSTRYM • **62 tablets**: ADDERALL, CONCERTA ER 36 mg, COTEMPLA XR-ODT 17.3 & 25.9 mg, DESOXYN, EVEKEO, FOCALIN, METHYLIN, RITALIN, ZENZEDI • **248 mL**: DYANAVEL XR Suspension • **310 mL**: METHYLIN, PROCENTRA
dexmethylphenidate	ADDERALL (dextroamphetamine/amphetamine)	
dextroamphetamine	amphetamine	
dextroamphetamine/amphetamine	EVEKEO (amphetamine)	
methylphenidate tablet, solution	dextroamphetamine solution	
PROCENTRA (dextroamphetamine)	EVEKEO ODT (amphetamine)	
	FOCALIN (dexmethylphenidate)	
	methamphetamine	
	METHYLN (methylphenidate)	
	methylphenidate chewable tablet	
	RITALIN (methylphenidate)	
	ZENZEDI (dextroamphetamine)	
LONG-ACTING		

ADDERALL XR (dextroamphetamine/amphetamine)	ADZENYS XR ODT (amphetamine)
CONCERTA (methylphenidate)	amphetamine ER ODT (generic ADZENYS XR ODT)
dexmethylphenidate ER	APTENSIO XR (methylphenidate)
dextroamphetamine ER	ARYNTA (lisdexamfetamine) solution
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/amphetamine)
	RELEXXII (methylphenidate)
	RITALIN LA (methylphenidate)
	VYVANSE (lisdexamfetamine) chewable tablets
	XELSTRYM (dextroamphetamine)
NARCOLEPSY	
armodafinil	NUVIGIL (armodafinil)
modafinil	PROVIGIL (modafinil)
SUNOSI (solriamfetol)	sodium oxybate
XYREM (sodium oxybate)	WAKIX (pitolisant)
	XYWAV (calcium/magnesium/potassium/sodium oxybate)
NON-STIMULANTS	
atomoxetine	INTUNIV (guanfacine)

- **372 mL**: QUILLIVANT XR

Quantity Limit Narcolepsy (per 31 days)
- **31 tablets**: armodafinil 150, 200 & 250 mg, modafinil 200 mg, SUNOSI
- **46.5 tablets**: modafinil 100 mg
- **62 tablets**: armodafinil 50 mg, WAKIX

Quantity Limit Non-Stimulants (per 31 days)
- **31 tablets**: atomoxetine, guanfacine ER
- **93 tablets**: QELBREE 200 mg
- **124 tablets**: clonidine ER
- **1 bottle (30 mL or 60 mL)**: ONYDA XR Suspension

ARYNTA
- Requires clinical review

clonidine ER (generic Kapvay only)	ONYDA XR (clonidine)	
guanfacine ER	STRATTERA (atomoxetine)	
QELBREE (viloxazine)		

Non-Preferred Short Acting Criteria

ADD/ADHD

- Documented diagnosis of ADD/ADHD **AND**
- Have tried 2 different preferred Short Acting agents in the past 6 months **OR**
- 1 claim for a 30-day supply with the requested agent in the past 105 days

Narcolepsy: ADDERALL, EVEKEO, METHYLIN, PROCENTRA, RITALIN, ZENZEDI

- Documented diagnosis of narcolepsy **AND**
- 30 days of therapy with preferred modafinil or armodafinil in the past 6 months **AND**
- 1 preferred agent indicated for narcolepsy in the past 6 months **OR**
- Have tried 1 claim for a 30-day supply with the requested agent in the past 105 days

Non-Preferred Long Acting Criteria

ADD/ADHD

- Documented diagnosis of ADD/ADHD **AND**
- Have tried 2 different preferred Long-Acting agents in the past 6 months **OR**
- 1 claim for a 30-day supply with the requested agent in the past 105 days

Narcolepsy: ADDERALL XR, APTENSIO XR, CONCERTA ER, DEXEDRINE, METADATE CD, METHYLIN ER, MYDAYIS, NUVIGIL, PROVIGIL, QUILLICHEW, QUILLIVANT XR, RITALIN LA

- Documented diagnosis of narcolepsy **AND**
- 30 days of therapy with preferred modafinil or armodafinil in the past 6 months **AND**
- 1 different preferred agent indicated for narcolepsy in the past 6 months **OR**
- 1 claim for a 30-day supply with the requested agent in the past 105 days

Armodafinil

- Documented diagnosis of narcolepsy, obstructive sleep apnea, shift work sleep disorder, or bipolar depression

Atomoxetine

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

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

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**
- 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 </= 2 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

disorder, depression, sleep deprivation or Steinert Myotonic Dystrophy Syndrome **ONYDA XR MANUAL PA**	**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	**Non-Preferred Agents** • Have tried 2 different preferred agents in the past 6 months **Demeclocycline** • Documented diagnosis of Syndrome of Inappropriate Antidiuretic Hormone Secretion (SIADH) will allow for automatic approval **ORACEA** • Requires clinical review
doxycycline monohydrate capsule	DORYX (doxycycline hyclate)	
minocycline capsule	DORYX MPC (doxycycline hyclate)	
tetracycline capsule	doxycycline hyclate DR	
	doxycycline IR/DR	
	doxycycline monohydrate suspension, tablet	
	LYMEPAK (doxycycline hyclate)	
	MINOCIN (minocycline)	
	minocycline tablet	
	minocycline ER	
	MINOLIRA ER (minocycline)	
	MORGIDOX (doxycycline hyclate)	
	NUZYRA (omadacycline)	
	ORACEA (doxycycline monohydrate)	
	SOLODYN (minocycline)	
	tetracycline tablet	

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

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
ORAL		**Non-Preferred Criteria** • Documented diagnosis of Ulcerative Colitis **AND** • Have tried 2 different preferred agents in the past 6 months **OR** • 90 days of therapy with the requested agent in the past 105 days
balsalazide	AZULFIDINE (sulfasalazine)	
budesonide	DELZICOL (mesalamine)	
PENTASA (mesalamine)	DIPENTUM (olsalazine)	
sulfasalazine	LIALDA (mesalamine)	

sulfasalazine DR	mesalamine	**VELSIPITY** • Requires clinical review
	mesalamine DR, mesalamine ER	
	VELSIPITY (etrasimod)	
RECTAL		
mesalamine suppository	budesonide	
	CANASA (mesalamine)	
	mesalamine enema	
	ROWASA (mesalamine)	
	SFROWASA (mesalamine)	
UREA CYCLE DISORDER AGENTS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
CARBAGLU (carglumic acid)	BUPHENYL (sodium phenylbutyrate)	
	carglumic acid	
	glycerol phenylbutyrate	
	OLPRUVA (sodium phenylbutyrate)	
	PHEBURANE (sodium phenylbutyrate)	
	RAVICTI (glycerol phenylbutyrate)	